1999

JOINT APPROPRIATIONS – HEALTH & HUMAN SERVICES

MINUTES

JOINT APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

1999 SESSION

COMMITTEE CHAIRMEN

Representative Beverly Earle
Representative Edd Nye

FISCAL STAFF

Karen Hammonds-Blanks
Ramona Burton
Carol Shaw
Mary Ellen Sylvester

COMMITTEE ASSISTANTS

Ann Raeford
Jo Bobbitt

JOINT APPROPRIATION SUBCOMITTEE
ON
HUMAN RESOURCES
1999 – 2000 SESSION

Senate Membership

Senator William N. Martin, Chair
Senator Charlie Dannelly, Vice Chair

Senator James Forrester
Senator John Kerr
Senator Jim Phillips
Senator William Purcell
Senator Larry Shaw

House Membership

Rep. Beverly Earle, Chair
Rep. Edd Nye, Chair
Rep. Martha Alexander,Vice-Chair

Rep. Lanier Cansler
Rep. Theresa Esposito
Rep. H. M. Mickey Michaux
Rep. Trudie Walend

FISCAL STAFF
Karen Hammonds-Blanks
Ramona Burton
Carol Shaw
Mary Ellen Sylvester

733-4910

Joyce Hodge
Senate Committee Assistant

Jo Bobbitt
Ann Raeford
House Committee Assistants

SENATE APPROPRIATIONS SUBCOMITTEE ON HUMAN RESOURCES

MEMBERSHIP
1999

MEMBER	TELEPHONE	OFFICE	SEAT
Senator William N Martin, Chair	715-3042	411 LOB	10
Senator Charlie Dannelly, Vice-Chair	733-5955	2106 LB	
Senator James Forrester	733-5708	1121 LB	
Senator John Kerr	733-5621	526	
Senator Jim Phillips	733-5870	628 LOB	
Senator William Purcell	715-0690	2117 LB	
Senator Larry Shaw	733-4809	625 LOB	

ATTENDANCE

Committee: SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

MEMBERS / DATES	8:30 2/23	8:30 03/02	8:30 03/02	03/09	8:30 03/16	2:00 03/16	03/23	8:30 03/29	1:30 03/29	04/06	3:15 04/06	04/13	1:30 04/20	2:30 04/20		4/09
Sen. Bill Martin, Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Sen. Charlie Dannelly	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓
Sen. James Forrester	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓		✓
Sen. John Kerr	✓	✓		✓	✓		✓	✓		✓		✓				
Sen. Jim Phillips	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Sen. William Purcell		✓		✓		✓	✓	✓		✓		✓	✓	✓		✓
Sen. Larry Shaw			✓	Dropped from Committee Membership												

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
1999-00

Member/Clerk	Telephone	Room
Rep. Beverly **Earle**, Chair Ann Raeford	3-5747	535
Rep. Edd **Nye**, Chair Jo Bobbitt	3-5477	639
Rep. Martha **Alexander**, Vice Chair Ann Faust	3-7208	2121
Rep. Alma **Adams** Troy Williams	3-5902	542
Rep. Lanier **Cansler** Barbara Cansler	3-5605	1209
Rep. Theresa **Esposito** Judy Lowe	5-3009	418C
Rep. Mickey **Michaux** Anne Peele	3-5772	1325
Rep. Trudi **Walend** Ken Walend	5-3012	418A
Rep. Gene **Wilson** Rebecca Jones	3-7727	1109
Staff		
Karen Hammonds-Blanks Ramona Burton Carol Shaw Mary Ellen Sylvester	3-4910	619

SENATE APPROPRIATIONS SUBCOMITTEE ON HUMAN RESOURCES

MEMBERSHIP
1999

MEMBER	TELEPHONE	OFFICE	SEAT
Senator William N Martin	715-3042	411 LOB	10
Senator Charlie Dannelly	733-5955	2106 LB	
Senator James Forrester	733-5708	1121 LB	
Senator John Kerr	733-5621	526	
Senator Jim Phillips	733-5870	628 LOB	
Senator William Purcell	715-0690	2117 LB	
Senator Larry Shaw	733-4809	625 LOB	

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
1999 - 2000

Rep. Beverly Earle, Chair

Rep. Edd Nye, Chair

Rep. Martha Alexander, Vice Chair

Rep. Alma Adams

Rep. Lanier Cansler

Rep. Theresa Esposito

Rep. Mickey Michaux

Rep. Trudi Walend

Rep. Gene Wilson

Ex-Officio Members

Rep. Phil Baddour

Rep. Pete Cunningham

Rep. Andy Dedmon

Rep. Joe Hackney

ATTENDANCE

Appropriations Subcommittee on Health and Human Services

DATES	2-25	3-4	3-11	3-18	3-25	4-1	4-8	4-15	4-22	4-22	5-27
Chair – Rep. Beverly Earle	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chair – Rep. Edd Nye	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vice Chair – Rep. Alexander	✓			✓	✓	✓	✓	✓	✓		✓
Rep. Adams	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓
Rep. Cansler		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rep. Esposito	✓	✓	✓	✓	✓	✓		✓	✓		✓
Rep. Walend	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Rep. Wilson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ex officio Members:											
Rep. Hackney											
Rep. Baddour											
Rep. Dedmon											✓
Rep. Cunningham			✓								
Rep. Easterling – Chair- Approp.											✓

ATTENDANCE

Appropriations Subcommittee on

Health and Human Services

1999 Session

DATES	2/24 AM	3/3 AM	3/3 PM	3/10 PM	3/17 AM	3/17 PM	3/24 AM	3/24 PM	3/31 AM	4/7 AM	4/7 PM	4/14 AM	4/14 PM	4/21 AM	4/21 PM	4/23
Chair- Rep. Earle	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓
Chair-Rep. Nye	—	—	✓	✓	✓	✓	✓	—	✓	✓	—	✓	✓	✓	✓	✓
Vice Chair-Rep. Alexander	✓	✓	ex	ex	✓	✓	✓	✓	✓	✓	ex	✓	✓	✓	ex	✓
Rep. Adams	—	—		✓	✓		✓			✓	✓	✓	✓	✓	✓	✓
Rep. Cansler	✓	✓	✓	✓	✓		✓	—	✓	✓	✓	✓	✓	✓	✓	✓
Rep. Esposito	✓	✓	✓		✓		✓	✓	✓	✓	✓	✓	✓	✓		
~~Rep. Michaux~~	✓	✓	no longer on Committee													
Rep. Walend	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rep. G. Wilson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ex officio Members:																
Rep. Hackney																
Rep. Baddour																
Rep. Dedmon																
Rep. Cunningham	✓															

ATTENDANCE

Appropriations Subcommittee on

Health and Human Services

			9:30			3:00		8:30	1:30	9:30	3:15	8:30	4:30	3:30
DATES	2/23	03/02	03/07	03/09	03/16	03/14	03/23	03/29	03/29	04/06	04/06	04/13	04/20	4/30
Chair- Rep. Earle	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Chair-Rep. Nye	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Vice Chair-Rep. Alexander	✓			✓	✓		✓	✓		✓		✓	✓	
Rep. Adams	✓	✓	✓	✓	✓		✓	✓	✓	✓		✓	✓	✓
Rep. Cansler	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rep. Esposito	✓	✓	✓		✓	✓	✓	✓		✓		✓	✓	
Rep. Michaux		✓	Dropped from Committee											
Rep. Walend	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Rep. G. Wilson		✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	
Ex officio Members:														
Rep. Hackney														
Rep. Baddour														
Rep. Dedmon														
Rep. Cunningham		✓			✓									

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium — HOUSE: APPROPRIATIONS--HEALTH & HUMAN SERVICES — Valid Through 9-SEP-1999

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
H 3=	**BLACK**	**SMART START FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 10=	**NESBITT**	**FIRST STEP FARM FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 25=	**CLARY**	**ADULT DAY CARE FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 28=	**CLARY**	**ALZHEIMERS FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 47=	**JUSTUS**	**HEART DISEASE PREV. FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 49	**NYE**	**TOUCHING CHILDREN'S LIVES FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 59=	EARLE	SPEC ASSIS/ALT LIVING	H -ASSIGNED TO APP-HRES	04-05-99	
H 70=	**CANSLER**	**GENETICS CENTER FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 99	**NYE**	**CAMP ROYALL FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 100=	**NYE**	**AUTISM SOCIETY OF NC FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 141	**WRIGHT**	**AIDS PREVENTION FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 167	**MCALLISTER**	**WORK ORDER DY PROGRAM FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 257=	**LUEBKE**	**ADULT PROTECTIVE SERVICES FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 313	**BOYD-MCINTYRE**	**OSTEOPOROSIS PROGRAM**	**H -RE-ASSIGNED TO APP-HRES**	**04-19-99**	
H 599	**ALEXANDER**	**MATERNITY HOME FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 643	**NYE**	**CHILD-CARING INSTITUTION FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 690=	**EASTERLING**	**SUD PROGRAM FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 732	**EARLE**	**TRAUMATIC BRAIN INJURY FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 733	**EARLE**	**NEUROBEHAVIORAL TREATMENT FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 747=	**EARLE**	**FOOD BANK FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 750	**GARDNER**	**211 FEASIBILITY STUDY FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-05-99**	
H 902	**ALEXANDER**	**MENTAL HEALTH PROGRAM FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-12-99**	
H 904=	**ALEXANDER**	**AREA MENTAL HEALTH PROGRAMS FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-12-99**	
H 905=	ALEXANDER	DENTAL BENEFITS/HEALTH CHOICE	*H -RE-ASSIGNED TO APP-HRES	05-10-99	
H 911	**NYE**	**EXPAND AGING SERVICES/FUNDS**	**H -ASSIGNED TO APP-HRES**	**04-12-99**	
H 927	**THOMPSON**	**FUNDS FOR SENIOR CENTER COORD.**	**H -ASSIGNED TO APP-HRES**	**04-12-99**	
H 981=	**BADDOUR**	**CHILDHOOD VACCINE FUNDS**	**H -RE-ASSIGNED TO APP-HRES**	**04-19-99**	
H 993	**WRIGHT**	**ASTHMA EDUCATION FUNDS**	**H -RE-ASSIGNED TO APP-HRES**	**04-19-99**	
H 994=	**WRIGHT**	**DIABETES CONTROL FUNDS**	**H -RE-ASSIGNED TO APP-HRES**	**04-19-99**	
H 995	**WRIGHT**	**OFFICE OF MINORITY HEALTH FUNDS**	**H -RE-ASSIGNED TO APP-HRES**	**04-19-99**	

NOTES- = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL, AS INTRODUCED, TO ANOTHER BILL.
* AFTER NUMBERS INDICATES THAT TEXT OF BILL WAS ALTERED BY ACTION ON THE BILL.
BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium — HOUSE: APPROPRIATIONS--HEALTH & HUMAN SERVICES — Valid Through 9-SEP-1999

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
H1000	**ALEXANDER**	**ADDICTION RESEARCH AUTHORITY**	**H -RE-ASSIGNED TO APP-HRES**	**05-10-99**	
H1059=	**JEFFUS**	**HEALTHY SCHOOLS ACT**	**H -RE-ASSIGNED TO APP-HRES**	**04-19-99**	
H1062	**MORRIS**	**AREA MENTAL HEALTH PROGRAM FUNDS - 2**	**H -RE-ASSIGNED TO APP-HRES**	**04-19-99**	
H1079=	**HUNTER**	**HEALTHY CAROLINIANS FUNDS**	**H -RE-ASSIGNED TO APP-HRES**	**04-19-99**	
H1083	**ALEXANDER**	**ARTHRITIS EDUC. TASK FORCE**	**H -ASSIGNED TO APP-HRES**	**05-03-99**	
H1102	**DEDMON**	**AREA MH MERGER FUNDS**	**H -RE-ASSIGNED TO APP-HRES**	**04-19-99**	
H1110=	**WRIGHT**	**HEPATITIS C EDUCATION AWARENESS FUND**	**H -RE-ASSIGNED TO APP-HRES**	**04-19-99**	
H1165=	LUEBKE	SPEC. ASST./INCREASE PERS. ALLOW.	H -RE-ASSIGNED TO APP-HRES	04-19-99	
H1253=	**EARLE**	**EXPAND TRANSITIONAL MEDICAID**	**H -RE-ASSIGNED TO APP-HRES**	**04-19-99**	
H1272=	**LUEBKE**	**ADULT PROTECTIVE SERVICES FUNDS**	**H -RE-ASSIGNED TO APP-HRES**	**04-19-99**	
H1310	**CANSLER**	**MH/DD/SA/TRAINING BDS. FUNDS**	**H -RE-ASSIGNED TO APP-HRES**	**04-26-99**	
H1312	**MOSLEY**	**PEDIATRIC CANCER FUNDS**	**H -RE-ASSIGNED TO APP-HRES**	**04-26-99**	
H1329	**NYE**	**INDEPENDENT LIVING FUNDS**	**H -ASSIGNED TO APP-HRES**	**05-03-99**	
H1331	**WRIGHT**	**HEALTHY START FUNDS**	**H -ASSIGNED TO APP-HRES**	**05-03-99**	
H1334=	**MORRIS**	**FUNDS/BIRTH DEFECT MONITORING PROGRA**	**H -ASSIGNED TO APP-HRES**	**05-03-99**	
H1335	**ALEXANDER**	**CUED SPEECH FUNDS**	**H -ASSIGNED TO APP-HRES**	**05-03-99**	
H1345=	**EASTERLING**	**HEALTHY CAROLINIANS FUNDS**	**H -ASSIGNED TO APP-HRES**	**05-03-99**	
H1348	**HOWARD**	**TANF FAMILY INITIATIVE FUNDS**	**H -RE-ASSIGNED TO APP-HRES**	**05-10-99**	
H1353	**CULP**	**VOCATIONAL REHABILITATION FUNDS**	**H -ASSIGNED TO APP-HRES**	**05-03-99**	
H1368=	**BADDOUR**	**TRAUMATIC BRAIN INJURY/DHHS STUDY**	**H -ASSIGNED TO APP-HRES**	**05-03-99**	
H1384	**HUNTER**	**ADOPTION ASSISTANCE SUPP. FUNDS**	**H -ASSIGNED TO APP-HRES**	**05-03-99**	
H1404	**NYE**	**RATE INCR. FOR SPECIAL ASST. FUNDS**	**H -ASSIGNED TO APP-HRES**	**05-03-99**	
H1405	**NYE**	**ADULT CARE HOME/RATE INCREASE**	**H -ASSIGNED TO APP-HRES**	**05-03-99**	
H1407	CANSLER	ENHANCE SPEC. ASSISTANCE PMTS. FUNDS	H -ASSIGNED TO APP-HRES	05-03-99	
H1408	ADAMS	EMERGENCY ASSISTANCE	H -RE-ASSIGNED TO APP-HRES	05-10-99	

NOTES- = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL, AS INTRODUCED, TO ANOTHER BILL.
* AFTER NUMBERS INDICATES THAT TEXT OF BILL WAS ALTERED BY ACTION ON THE BILL.
BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

APPROPRIATIONS SCHEDULE
1999 LONG SESSION

February 25, 1999

February 16 – February 18

Office of State Budget & Management
Presents Governor's Budget

⇓

February 22 – April 9

Appropriations Subcommittees
Review Continuation Budget

⇓

April 12 – April 23

Appropriations Subcommittees
Continuation Budget Recommendations
Finalized and Presented

⇓

April 26 – May 7

Appropriations Subcommittees
Review Expansion & Capital Budgets

⇓

May 10 – May 14

Appropriations Subcommittees
Expansion & Capital Budgets Finalized
and Presented

⇓

May 17 – May 28

Joint Appropriations Subcommittees
Each Chamber
Resolve Budget Differences
Prepare and Pass Final Budget

NORTH CAROLINA GENERAL ASSEMBLY

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

February 23, 1999
8:30 a.m.

MINUTES

The North Carolina General Assembly Joint Appropriations Subcommittee on Human Resources met in Room 424 of the Legislative Office Building, Tuesday, February 23, 1999. The meeting was called to order by Senator William N. Martin, Chair, at 8:30 a.m. with five Senate members present and the following House members present: Representatives Earle, Nye, Alexander, Adams, Cansler, Esposito and Walend. Rep. Cunningham, Ex-Officio member was also present. After introduction of members and staff, the Chair proceeded with the attached Agenda.

Carol Shaw, Fiscal Analyst, Fiscal Research Division, gave an overview of procedures and schedule for the committee. She stated that the staff and Chairs are in the process of developing a final schedule and time frame for meetings.

Dr. David Bruton, Secretary of Department of Health and Human Services was recognized for remarks, introduction of Department staff and to give an overview of the Department. He stated that the Department does not have any deputy secretaries at this time. He reviewed the mission and goals of the Department. Secretary Burton then gave an overview of key budget facts (from attachment 1). He said that the department receives 54% of the total budget from federal sources and 32% comes from the State. He stated that 84% of the budget goes for programs and benefits such as TANF, Medicaid payments and grants to organizations for programs; and that Medicaid receives 57% of that amount.

Secretary Burton also gave an overview of key personnel facts for the Department. He stated that the Department has increased 504% in the past eighteen years, however the number of positions has increased by a total of only 16% (2,772 positions). This figure does not include 100% of the federally funded positions; that position growth rate is 11%. He also stated that there is an approximate two-week time frame for addressing correspondence and requests to the Department. All correspondence is scanned into the computer and is processed within a reasonable time frame.

Secretary Burton then answered questions from the Committee. Senator Phillips stated that unless it is a policy decision, there is no reason that a response or acknowledgement should not be received before a two-week time frame, even if it is only a form letter acknowledging receipt of the correspondence or request.

Senator Dannelly inquired if the two-week response time if to the general public or to the members of the General Assembly.

The Secretary stated that the response to the legislative members is immediate. He also thanked the Committee and agreed that the two-week time frame for responses to correspondence is too long. He stated that staff has heard this from him over and over, response to all requests should be immediate.

Rep. Adams asked what is the client staff ratio. She also asked if there is a plan in place to improve the client staff ratio.

The Chair, Sen. Martin, asked if we could get the figures for federal and non-federal staff as well as a comparative break down for the non-federal clients.

Secretary Bruton stated that a program is being developed by the State and also at the federal level to improve client staff ratio.

The Chair asked about the percentage of the clients presently being served by non-federal staff.

Rep. Cansler stated that the chart included in the handout (handout #1) indicates that the budget has increased about 2 ½ times. He requested a chart of the Division that would ??

Sen. Dannelly requested a quick update on property and construction, such as the Dorothea Dix Campus regarding replacement and upgrading of facilities, etc.

Sen. Kerr inquired as to what is being done in the way of forecasting what would it look like next year? Senator Martin stated that the committee would try to get real time projections as to what is going to happen.

Regarding long term care proposals, Rep. Cansler said the committee really needs to make sure that we address the employee turn over rate as a major problem. He is concerned that it is taking a lot more than what we have in the budget to provide quality care for long term care.

Rep. Adams inquired as to whether the Department would share information regarding criminal and background checks for employees.

There was discussion of protecting the rights of citizens and due process of appeals rights and procedures for residents of long tern care facilities. (Attachment # 2)

Sen. Phillips asked what are we doing with patients who are in long term care facilities, and who will be responsible for their level of care.

Secretary Burton stated that the Committee is on target and that his job is to make sure the committee has the facts and faces the truth.

The Committee agreed that safety in long -term care homes is an area of major concern. The following concerns were addressed: requirement for certification of supervisors of adult Care homes; training of the adult care home employees; adjustment of staff to resident requirements. Sen. Martin stated that the current emergency situation in adult care requires a design and blueprint of what is correct in safety and long term care. This package is completely financed in the Governor's budget (page D1A).

The Chairman thanked everyone for their presence and adjourned the meeting at 9:55 a.m.

Sen. William N. Martin, Chair

Joyce Crews Hodge, Clerk

AGENDA

Joint Appropriations Subcommittee on Human Resources

February 23, 1998

8:30 am

Opening Remarks	Senator Bill Martin Representative Beverly Earle Representative Edd Nye
Introduction of Committee Members	
Introduction of Legislative Staff	
Procedures and Schedule	Carol Shaw Fiscal Research Division
Department of Health & Human Services Opening Remarks Department Overview – Introduction of Key Staff	Dr. David Bruton, Secretary

Bill Daughtry Jan Watson
Connie Hewey

APPROPRIATIONS COMMITTEE PROCESS/ROLE OF 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, annualization of programs funded part year in the previous fiscal year and operating funding for newly completed facilities.

- The Subcommittee reviews the continuation budget of each program area in the Department of Health and Human Services and identifies areas for possible budget reduction/increase or policy change.

- Continuation budget process lasts approximately 6 to 8 weeks (1999 Schedule to be determined)

- **Expansion Budget** is normally reviewed by the Subcommittee after the Continuation budget – Expansion includes new programs; expansion of existing programs; or permanently funding programs originally funded as pilots or with one time funding.

- Expansion items include member's bills or suggestions and Governor's recommendations.

Role of Fiscal Staff

- **Budget and Policy Analysis** -- Review continuation and expansion budgets for the Department of Health and Human Resources with State Budget staff and departmental staff prior to Subcommittee review. Analysts will then highlight for Subcommittee discussion the following: (1) cost components of each major program (staffing, contracts etc); (2) recent reductions or expansion of these programs; (3) the details of the major budget changes proposed by the Governor for 1999-2001; and, (4) other budgetary or policy options. During this process, analysts will conduct further analysis of budget and policy issues identified by members.

- **"Flagging "** of budget issues – Since votes on budget reductions or increases are generally not taken until later in the subcommittee process, Subcommittee members will **flag** budget items for further information and review. The fiscal staff will keep track of flagged items and go through a final **"Flag"** list when requested by the Subcommittee chairs, usually after all HHS programs have been reviewed.

- **Special Budget 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/ Follow-up** -- Fiscal staff also coordinate daily meetings and agenda with subcommittee chairs; develop and track subcommittee schedules for chairs; work with departments and State Budget to answer members' general information requests, both for individual members and for the Subcommittee; and, prepare the Subcommittee budget reports.

Role of Other Staff

- **General Assembly Bill Drafting Staff** – Assist members with research on legal issues affecting Subcommittee deliberations and assist members in writing special budget provisions. Two bill drafters are normally assigned to this subcommittee.

- **Departmental Staff** – Departmental staff will answer member's questions during committee meetings and work with fiscal staff to obtain additional information if needed. Departmental staff may also make presentations on budget issues and on studies required by the General Assembly.

- **Office of State Budget and Management and Office of State Planning** – State Budget will assist members and fiscal staff with information on departmental budgets and programs. State Planning acts as a resource on program budgeting and departmental performance measures.

Department of Health and Human Services
Central Management and Support

Budget Overview

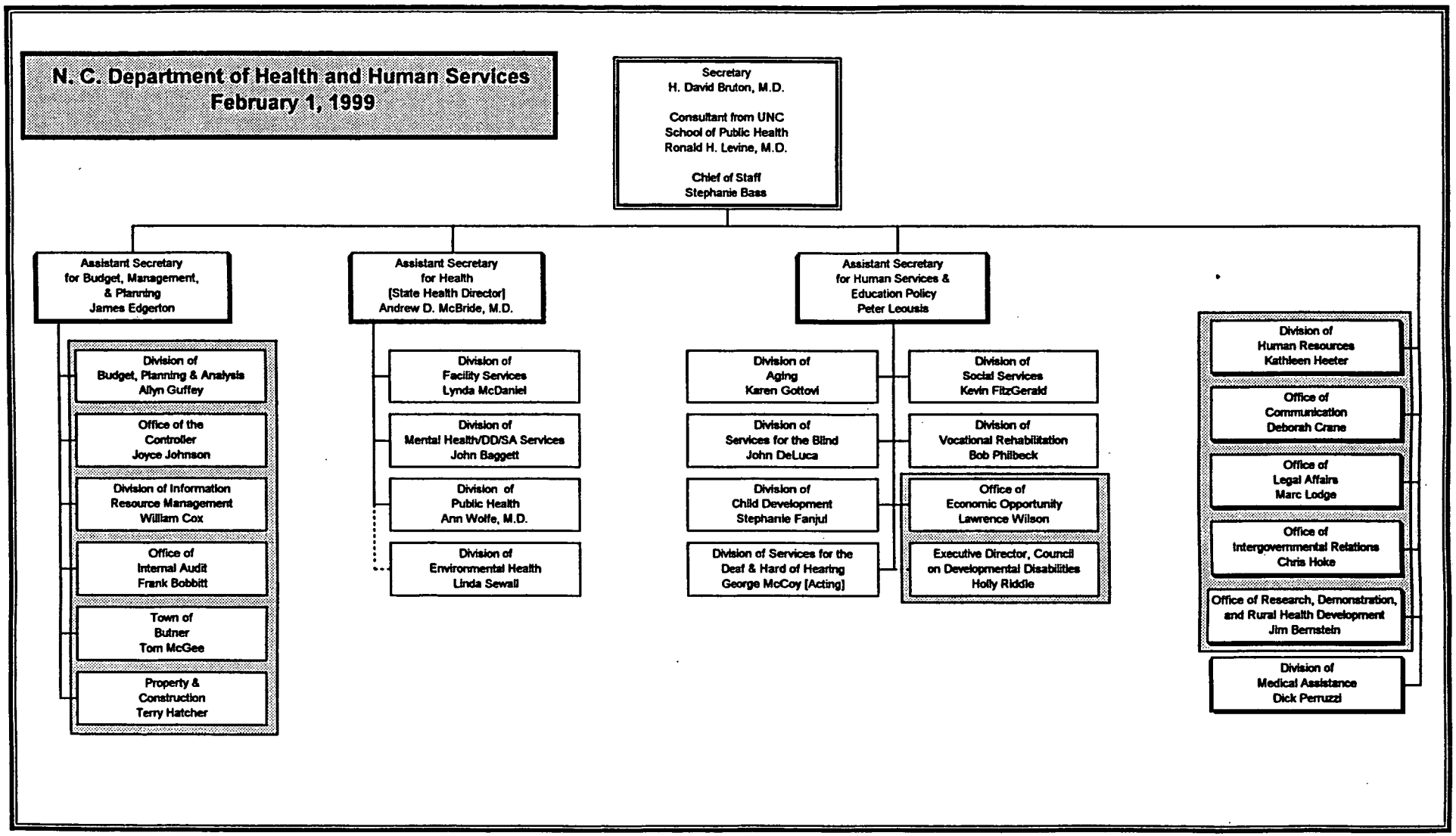
February 1999

02.23.99
Attachment I

Table of Contents

O-chart	1
Mission Statements	2
Central Management and Support Funds	4
Chart 1, DHHS Total Budget SFY 98-99	5
Chart 2, Central Management and Support Funding by Purpose SFY 98-99	6
Chart 3, Central Management and Support Total Positions SFY 98-99	7
Central Management and Support Budget Summary	8
Central Management and Support Programs and Services	11

N. C. Department of Health and Human Services
February 1, 1999



Mission Statements

Central Management and Support:

To direct operations and provide services for the Department's agencies and institutions.

Office of Research, Demonstration, and Rural Health Development

To work with local and state leaders to design and implement strategies for improving health care.access for rural residents.

Office of Economic Opportunity:

To provide opportunities through local nonprofit agencies for low income families that lead to economic self sufficiency.

The North Carolina Council on Developmental Disabilities:

Promotes and supports activities and opportunities which empower people with developmental disabilities to become fully participating members of their communities.

Division of Information Resource Management:

To provide information and technology solutions for DHHS.

Office of the Controller:

Perform all accounting and financial functions for the Department and provide accountability for the resources appropriated to the Department.

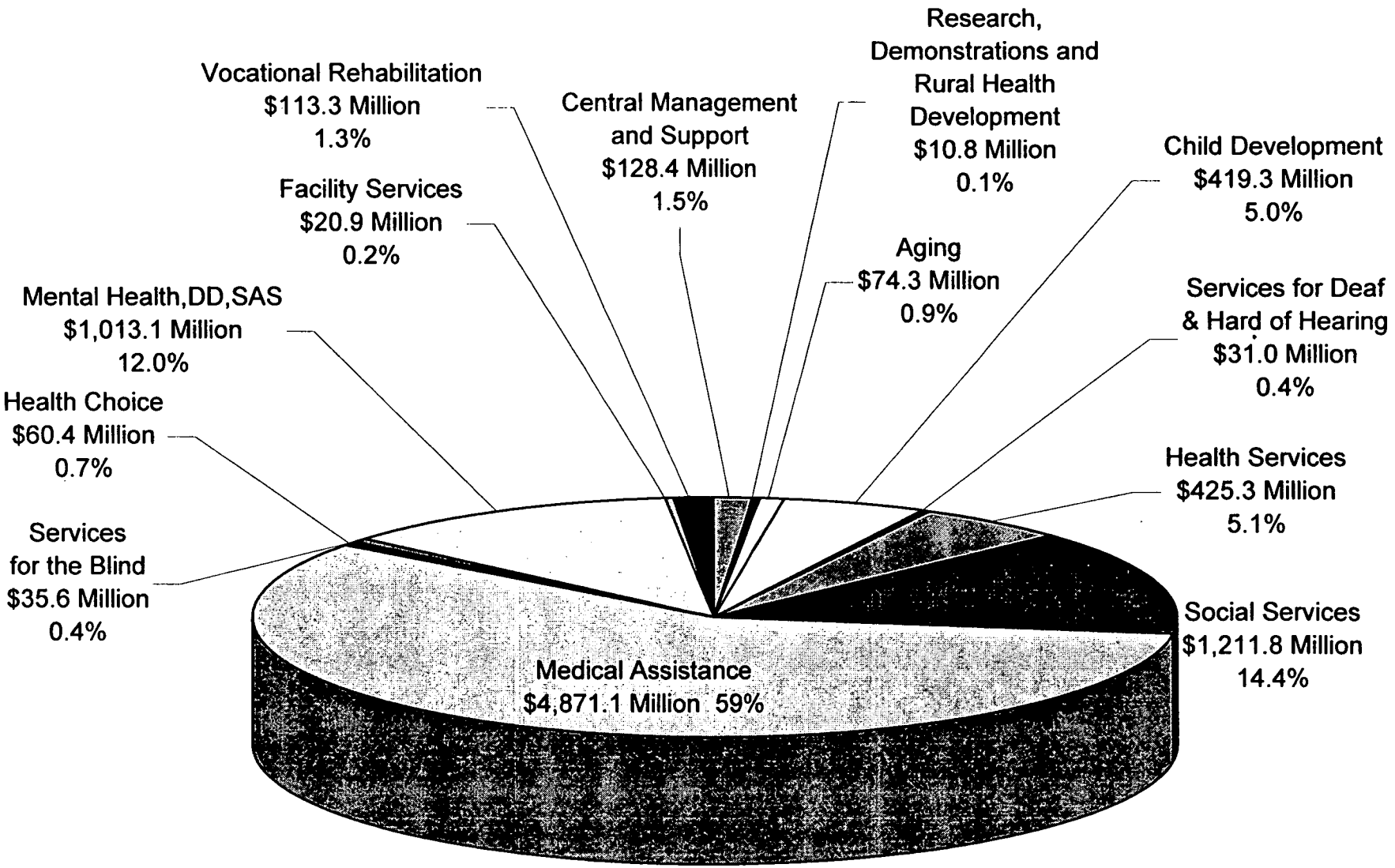
Division of Budget, Planning and Analysis

To execute the budget of the Department through the provision of guidance and support to Department and Division management...

Central Management and Support Funds

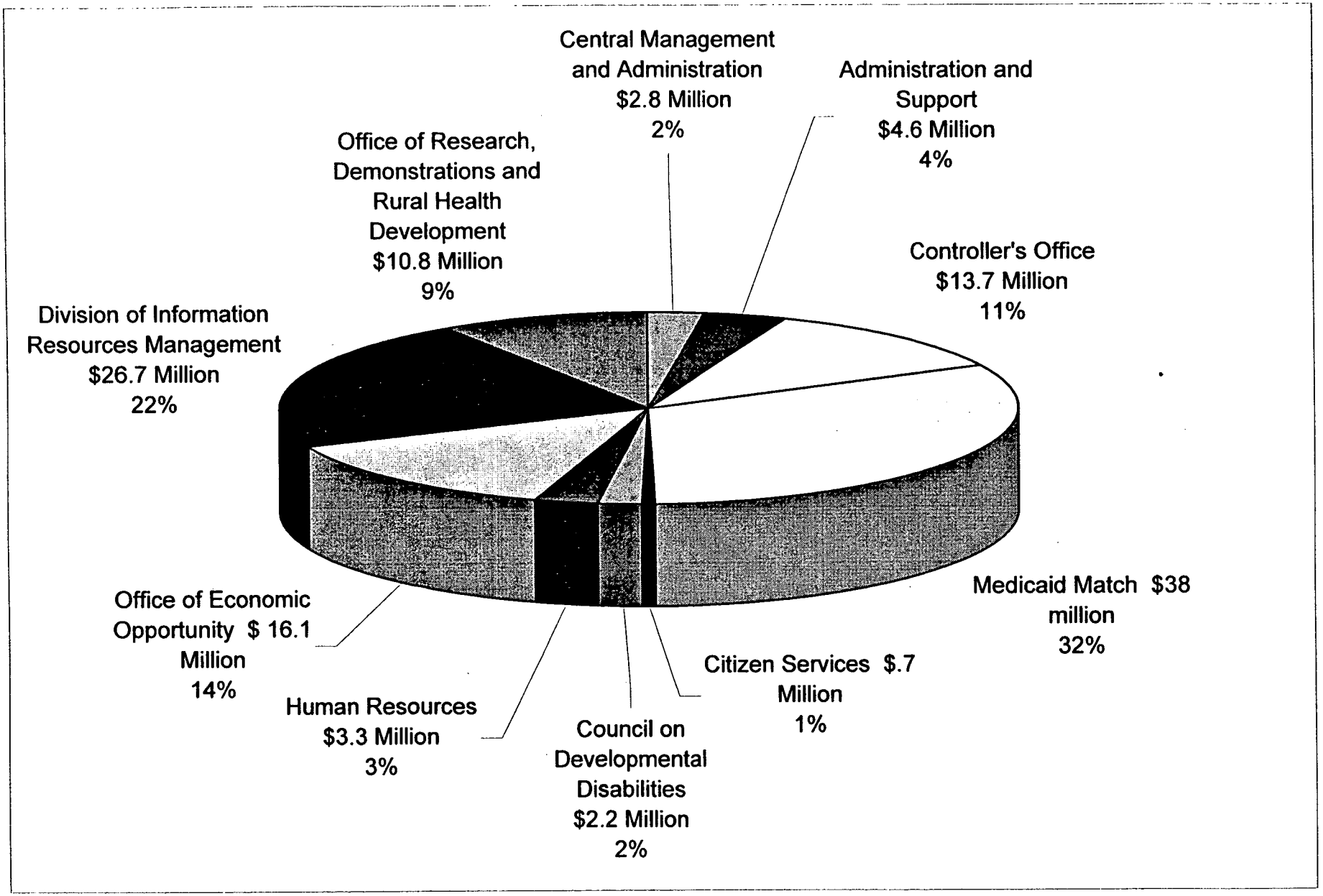
	1998-99 Budget	Positions
Central Management and Administration • Secretary's Office • Office of Intergovernmental Relations • Communications Office	$2.8 Million	43
Administration and Support • Budget, Planning and Analysis • Internal Auditor • Property and Construction • Central Purchasing and Mail Services	$4.6 Million	59.5
Controller's Office	$13.7 Million	279.1
Medicaid Match Reserve for Mental Health	$38 million	0
Citizen Services	$.7 Million	11
Council on Developmental Disabilities	$2.2 Million	10
Human Resources	$3.3 Million	58.8
Office of Economic Opportunity	$16.1 Million	10
Division of Information Resources Management	$26.7 Million	150
Office of Research, Demonstrations and Rural Health Development	$10.8 Million	37
Total	$121.5 Million	658

How Does Central Management and Support Compare to Total Department



DHHS Total Budget SFY 98-99 $8.5 Billion

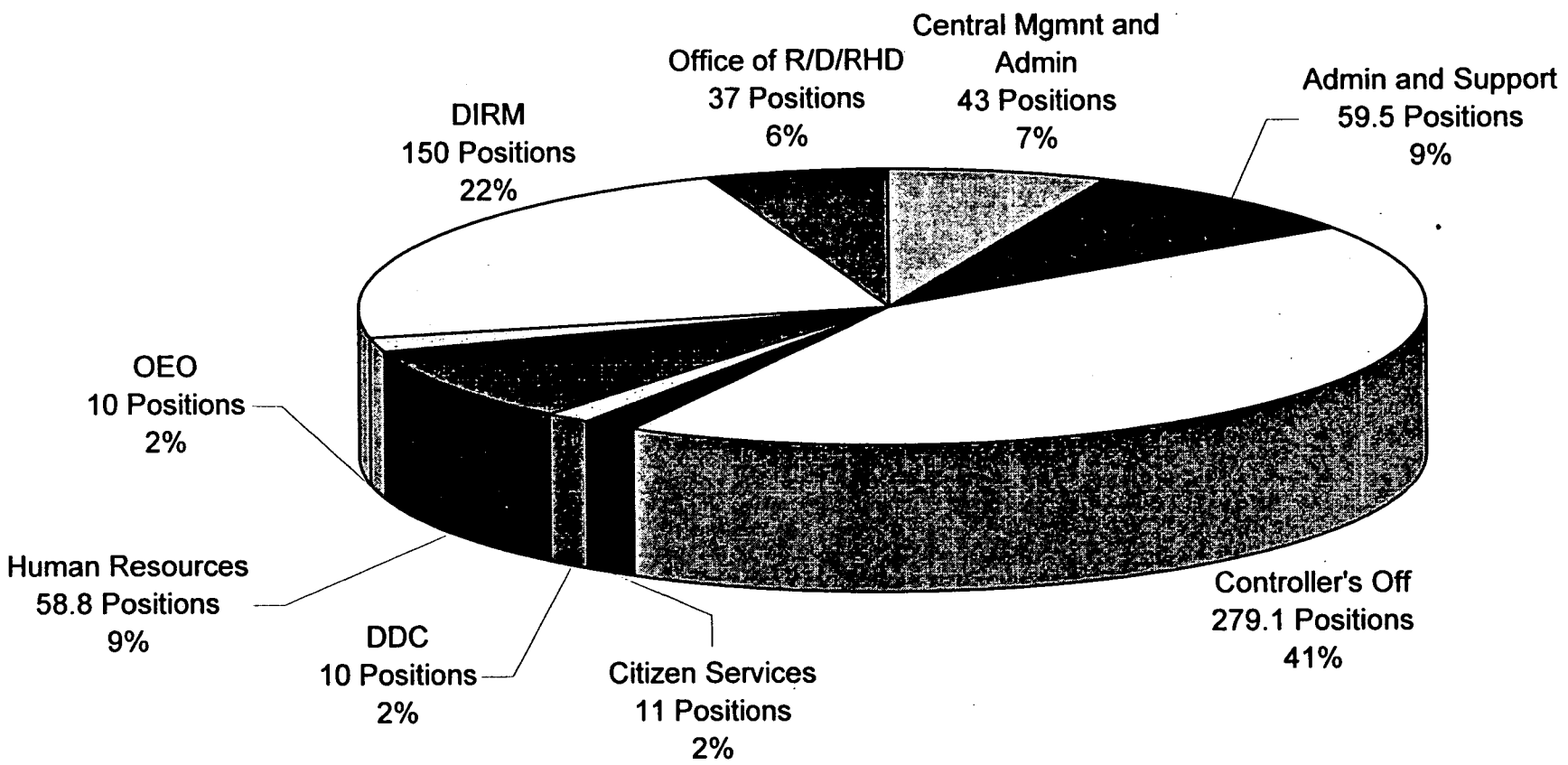
Chart 1



Central Management and Support
Funding by Purpose SFY 98-99 $121.5 Million

Chart 2

Of DHHS's 20,194 positions, 3.3 percent or 658 are in Central Management and Support



Central Management and Support
Total Positions SFY 98-99

Central Management and Support

Budget Summary

	1997/98 Actual	1998/99 Authorized	Net Inc (Dec) 1999/2000	1999/2000 Recommended	Net Inc (Dec) 2000/2001	2000/2001 Recommended
Total Requirements	$ 93,737,140	$ 121,522,532	$ 6,415,990	$ 127,938,522	$ 7,235,663	$ 128,758,195
Total Receipts	47,849,682	34,121,471	4,496,753	38,618,224	4,496,753	38,618,224
Net Appropriations	$ 45,887,458	$ 87,401,061	$ 1,919,237	$ 89,320,298	$ 2,738,910	$ 90,139,971
Number of Positions	659.00	658.00	0.00	658.00	0.00	658.00

Increases(Decreases) for 1999-2001

Item		Net Inc (Dec) 1999/2000	Net Inc (Dec) 2000/2001
1. Increase in Medicaid Match Reserve as established by the 1998 Session of the General Assembly to ensure that there are sufficient funds to match federal Medicaid dollars spent by the Area Mental Health Programs. The SFY 1999/00 increase is based on projected SFY 1998/99 spending with adjustments for increases in eligibles (utilization) of 2.66%, and the average cost per eligible (inflation) of 6.0%. The SFY 99/00 increases are built upon the SFY 99/00 projected spending with adjustments for utilization (3.79%) and inflation (6.0%). The projections assume that the state and county will share equally in funding the increases.	**Requirements**	$ 3,355,090	$ 4,174,763
	Receipts	$ -	$ -
	Appropriation	$ 3,355,090	$ 4,174,763
2. Increase in the DIRM Misc. Contractor account is to enable DIRM to continue to provide the required maintenance and modifications to over 150 systems maintained and operated on behalf of the department. These systems provide client benefits and services to the citizens of N.C. and any reduction in the division's capabilities to maintain and modify these systems as required would result in the incorrect and non-timely distribution of eligible benefits to those citizens of N.C. These systems also are needed to meet the federal reporting requirements. The projected annual expenditures for this current SFY are $7.1 Million. Like many organizations, DHHS has significant problems recruiting and retaining qualified information tecnology staff because competition for employees with the necessary skills is fierce. DIRM has had to rely on contractor staff to ensure that vital automation systems are maintained and modified. Contractors come at a higher rate than employees. State funds requested are matched with applicable federal funds for a total requirement increase of $4,400,800.	**Requirements**	$ 4,400,800	$ 4,400,800
	Receipts	$ 1,393,026	$ 1,393,026
	Appropriation	$ 3,007,774	$ 3,007,774

3. Increase in DIRM SIPS account is requested to enable the division to budget for actual cost anticipated to be required over the next biennium. Based on annualized expenditure figures, approximately 16.5 million dollars will be expended for this service in SFY 1998/99. The increase in cost is due to the large increase in the number of state and local users brought about by the implementation of the NCAS and ACTS system, along with the transition of Health Services back to DHHS. NCAS has added approximately 1,500 new users to the system, while the implementation of the ACTS system brought 7,408 new users to the system. Daily transactions for this system alone total 875,000 to 925,000 per day. State funds requested are matched with applicable federal funds for a total requirement increase of $7,500,000.	**Requirements**	$ 7,500,000	$ 7,500,000
	Receipts	$ 3,057,053	$ 3,057,053
	Appropriation	$ 4,442,947	$ 4,442,947
4. Misc. other increases are for the adjustment of salary, longevity payments, social security requirements, and retirement requirements as authorized by the budgeted salary amounts in each fund.	**Requirements**	$ 474,500	$ 474,500
	Receipts	$ 46,675	$ 46,675
	Appropriation	$ 427,825	$ 427,825
5. Misc. other deductions are for non-recurring appropriations funded by the 1998 Short Session of the General Assembly for the Hearts and EIS Y2K projects ($6,864,399) in DIRM and the ABC Education Plan ($2,450,000).	**Requirements**	$ (9,314,399)	$ (9,314,399)
	Receipts	$ -	$ -
	Appropriation	$ (9,314,399)	$ (9,314,399)
TOTAL NET INCREASES	**Requirements**	$ 6,415,991	$ 7,235,664
	Receipts	$ 4,496,754	$ 4,496,754
	Appropriation	$ 1,919,237	$ 2,738,910

HEALTH AND HUMAN SERVICES
Program and Services by Division

CENTRAL MANAGEMENT AND SUPPORT

Office of Communications
Debbie Crane, Director, 919-733-9190
Office of Legal Affairs
Marc Lodge, General Counsel, 919-733-6920
Office of Legislative and External Affairs
Chris Hoke, Acting Chief, 919-733-2173
Office of Citizens' Services
Leslie Mann, Director, 919-733-4261 (Voice), 919-733-4851 (TTY)
Council on Developmental Disabilities
Holly Riddle, Director, 919-733-6566
Office of Economic Opportunity
Lawrence Wilson, Director, 919-773-2818
Division of Human Resources
Kathy Heeter, Director, 919-733-2940
Division of Budget, Planning and Analysis
Allyn Guffey, Director, 919-733-6396
Office of the Controller
Joyce Johnson, Controller, 919-733-0169
Division of Information Resource Management
Bill Cox, Director, 919-733-8900
Office of Internal Audit
Frank Bobbitt, Director, 919-715-4791

Services Provided to Divisions/Management

Legal Services
Accounting Services
Budget Management and Program Analysis
Purchasing and Contracting
Mail Services
Information Resource Management
Government Liaison Services
Public Information
Coordination of Education Programs
Personnel Management
Grants Management
Property Management & Constructions
Community Involvement Services
Disabilities Act Management & Services

Services Provided to Local Agencies/Individuals

Citizens Affairs & Referral Services
Holocaust Council
- Education
Community Action Grants
Audit Services
Developmental Disabilities Grants
Provide consultation on personnel issues to Local Human Services Agency Board Chairs, Ageny Directors & Staff

OFFICE OF RESEARCH, DEMONSTRATIONS, AND RURAL HEALTH DEVELOPMENT

James D. Bernstein, Director, 919-733-2040

- Aid for Clinic Operation
- Aid for Clinic Construction
- Primary Care Provider Recruitment
- Loan Repayment Program
- High Needs Service Program
- Residential Stipend Program
- Rural Health Scholars Program
- Farmworker Health Program
- Long Term Care Demonstration
- Community Hospital Technical Assistance Program.
- Essential Access Community Hospital Program
- Community Primary Care Program
- Access II/III Program
- Dental Recruitment and Development
- Health Professional Shortage Analysis
- Physician Assistant/Family Nurse Practitioner Residency Program
- Primary Care Technical Assistance Service
- Architectural design
- Graphic design
- Maternity services
- Laboratory services
- Computer systems
- Financial/Reimbursement services
- Practice Management
- Managed Care

02.23.99
Attachment 2

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

SAFETY IN LONG TERM CARE

INTRODUCTION

North Carolina's elderly and disabled population needs safe, high-quality long term care. North Carolina has many very sick people in adult care homes (formerly "rest homes" or "retirement homes"). Many of these residents now experience significant problems with the activities of daily living, and need what is termed "heavy care." While many homes have adapted to these more demanding residents and provide adequate care and a good quality of life, others are understaffed and provide inadequate service. Staff shortfalls go beyond mere numbers to include insufficient training and competency for the more sophisticated tasks. In some homes, residents have not received needed services. Too often, lapses in care have led to unhealthy, unkind, and occasionally tragic results.

The Department of Health and Human Services proposes this initiative to address safety issues, requesting the General Assembly to provide it with the authority to take immediate action in three major areas: (1) Improving Quality of Care; (2) Protecting Residents; and (3) Improving Regulatory Oversight.

Improving Quality of Care

The General Assembly and DHHS have acted to improve conditions in what are familiarly known as "family care homes," "rest homes" and "retirement homes" over the past decade by raising staff-to-resident ratios, instituting Medicaid payments for personal care, and establishing a loan pool for the installation of safety equipment in institutions. These changes have brought about significant improvement in the lives of many residents. Still needed are higher training requirements and certification for managers of facilities and those who give hands-on care to the residents. Medication error rates are alarming and special attention is vital to training staff who administer medications. Homes that hold themselves out as having special Alzheimer's units should meet special regulations to safeguard patients and improve their mental health and well being.

Protecting Residents

Homes with a mix of disabled and frail residents, and those that care for individuals who might pose a risk to others, must ensure the safety of all residents. Safety standards for each resident in every adult care home should be based on a complete assessment that meets the same standards as for nursing homes. Residents must be free to raise issues without fear of reprisal, and must be allowed due process appeals from transfer and discharge procedures instituted by the facilities. Investigators must respond quickly to complaints by residents, families or ombudsmen. When a disabled or frail resident is in jeopardy, the local Department of Social Services must immediately intervene to protect that individual.

Improving Regulatory Oversight

Residents and their families must be assured that they are safe and receiving care appropriate to their needs. At the same time, the public deserves to know that its tax dollars are spent wisely on behalf of those who reside in homes. Inspectors and monitors of homes must be free of conflicts of interest in their assessments. The use of provisional licenses for facilities should be limited. When homes fail to meet compliance standards, the state should be able to respond rapidly to protect the residents, including arranging for temporary management of the facilities when necessary. Owners or managers of nursing homes and adult care homes who engage in egregious conduct should be subject to civil and criminal charges, and the State should prosecute to the fullest extent of the law.

In addition to the legislative action proposed here, the Department of Health and Human Services intends to take actions within its authority to enhance safety and quality of care for long term care residents. Timely, maximum-allowable penalties for significant violations of resident safety will become the norm. The Department also is exploring ways to improve access to care.

The Department will continue developing a long-range comprehensive plan to care for elderly and disabled North Carolinians in the 21st century. The system must address financing, managed care, guardianship and adult protective services, and a spectrum of questions raised by societal changes. Safety and minimum quality issues, however, cannot wait. To protect North Carolinians, corrective action must be taken as soon as possible, including methods for measuring effectiveness and ensuring accountability.

The Department of Health and Human Services requests that the legislative initiatives described on the following pages be considered and enacted by the General Assembly. It is time to address and solve these problems.

2/9/99

SAFETY IN LONG TERM CARE
Summary

I. Improving Quality of Care

A. Require training and staff for medication administration in adult care homes

B. Require training for staff in behavioral interventions

C. Adopt Special Care Unit rules for long term care facilities with specialized units for substantial behavioral management problems

D. Require certification for supervisors and administrators of adult care homes

E. Improve Nurse Aide/Personal Care Aide availability and retention

F. Adjust staff-to-resident requirements in adult care homes and nursing homes to ensure quality care

II. Protecting Residents

A. Give due process and appeals rights for transfer and discharge to residents in adult care homes

B. Develop complete initial assessment and case management to improve resident security and treatment in adult care homes

C. Modify adult care home payment system to accomplish desired results

D. Require standard response time for complaints

III. Improving Regulatory Oversight

A. Develop system of financing to expand local DSS and DFS monitoring

B. Improve accountability for monitoring activities and authorize State takeover of activities when necessary

C. Require local service agencies to develop and provide to DHHS an annual plan for implementing adult care home policy

D. Revise Temporary Management law

E. Provide criminal and civil penalties for egregious activity by home owners and operators

F. Limit use of provisional licenses

G. Move to outcome measurements rather than process measurement.

H. Give the Secretary rule-making authority for this initiative

2/9/99

SAFETY IN LONG TERM CARE

I. Improving Quality of Care

A. Require training and staff for medication administration in adult care homes

Staff who administer or supervise the administration of medications in adult care homes should complete a specific training program. Research studies have shown medication error rates in North Carolina adult care homes of at least 20 percent. In medication reviews of nursing facilities, the acceptable error rate for the federal Health Care Financing Administration (HCFA) is no more than 5 percent. The lack of specific training requirements leaves 25,000+ residents of North Carolina's adult care homes at risk daily from medication administration errors, threatening the health and safety of this vulnerable population.

State standards should ensure that adult care homes have sufficient trained staff designated as medication aides. All medication aides should complete a DHHS-approved medication training program and an annual DHHS-approved refresher course. Supervisors should be credentialed to oversee this activity. Specific standards should address management of complex medication regimens such as those involving invasive techniques and psychotropic drugs. Medication administration standards should more closely reflect those that apply in nursing homes, including appropriate provider review and approval of any psychotropic drugs.

B. Require training for staff in behavioral interventions

Adult care home staff should receive specific training in behavioral interventions. Many residents of adult care homes have conditions that cause behavioral problems. Caring for these residents can be difficult for staff who are not trained in appropriate responses. Lack of training also endangers residents who might be subjected to unnecessary and inappropriate restraint. DHHS should establish standards for such training, including oversight training for supervisors.

C. Adopt Special Care Unit rules for long term care facilities with specialized units for substantial behavioral management problems

A long term care facility that holds itself out as having a unit for residents with substantial behavioral management problems should meet higher standards. Specific requirements should address the more specialized care implied by the title of "special care unit." These standards include higher staff-to-resident ratios, specially trained staff, quarterly functional assessments of residents, activity programs specifically designed for cognitively impaired residents, special consultative services and physical plant improvements to ensure safety.

D. Require certification for supervisors and administrators of adult care homes

No current requirements specifically address the supervision of personal care aides in adult care homes. Supervisors-in-charge, who are responsible for carrying out the program of the home in the absence of the administrator, only have to meet the same training requirements as personal care aides and do not have to have a high school diploma or G.E.D. if they pass an alternative examination established by the Department. Administrator qualifications also are minimal.

A certification program should be put into place for adult care home administrators, and overall administration and management of the home should be the responsibility of a certified administrator. Qualifications for the position of supervisor-in-charge should be increased to require at least a high school diploma or G.E.D. (no alternative examination) and additional training prior to or soon after employment.

Functional requirements for the supervisor-in-charge should specify that the primary responsibility is direct supervision of staff, rather than administrative and management functions in the absence of the administrator. Homes with a capacity of 21 or more residents should be required to have a supervisor-in-charge on duty within the home at all times to assure the proper supervision of staff. Presently, the supervisor-in-charge may be as far away as 500 feet from the home if other staff is within the home.

E. Improve Nurse Aide/Personal Care Aide availability and retention

Adult care homes and nursing homes have increasing difficulty finding and retaining sufficient competent staff to provide day-to-day care of long term care residents in their facilities. A potential solution may be found in the TEACH program, a nationally-acclaimed program developed in North Carolina to address workforce problems in child day care settings. This model should be tested to address the similar problems in adult care and nursing homes. DHHS has been awarded a three-year grant from the Kate B. Reynolds Charitable Trust to test this approach. The legislature should monitor the progress of this effort to see if statewide implementation is warranted.

F. Adjust staff-to-resident requirements in adult care homes and nursing homes to ensure quality care

Existing staffing requirements in adult care homes and nursing homes must be adjusted to accommodate the changing populations and their needs. Minimum staff-to-resident ratios on first and second shifts in adult care homes have not changed since 1977, despite an increase in residents with complex medical and mental health needs and significant cognitive impairments. Many of these residents need additional staff time to ensure appropriate care, supervision and safe evacuation in the case of an emergency. Nursing home minimum requirements also are inadequate.

Simply establishing a staff-to-resident ratio for each shift, without further refinement, does not address quality of care issues. Staffing requirements should be based on the needs of the facility's residents, and the population mix will vary from one home to another. The Secretary should be authorized to adopt rules establishing the minimum staffing requirements necessary to deliver quality care to meet the residents' needs in any facility.

II. Protecting Residents

A. Give due process and appeals rights for transfer and discharge to residents in adult care homes

Adult care home residents should have formal discharge and transfer appeal rights in line with state and federal requirements for nursing homes. Present adult care home rules only require the administrator to provide the resident, resident's family or responsible person and the county department of social services with a two-week written notice citing the reason for discharge or transfer. Rules also allow for exceptions to this notice in the case of jeopardy to the health or safety of the resident or others in the home. The protections afforded to nursing home residents should be extended to adult care home residents.

B. Develop complete initial assessment and case management to improve resident security and treatment in adult care homes

Adult care homes serve a mixed population, including frail elderly, mentally ill and developmentally disabled persons. A Research Triangle Institute study has shown that service needs vary widely among individual residents. The present reimbursement system can only distinguish among differing service needs in a limited way through enhanced care.

There is no present requirement for an adequate assessment to identify mental health conditions needing follow-up and treatment by a mental health professional. Adult care home residents need a comprehensive mental health assessment, treatment plan and close follow-up to make sure needed mental health services are provided. In addition, these residents with certain mental health problems must be identified so that they do not pose a danger to other residents. Safety standards based on initial assessments must be put into place. County departments of social services should be charged with ensuring that these assessments are conducted and the results incorporated into the resident's care plan. Area mental health authorities should be charged with accomplishing the assessments and treatment plans as requested by the county DSS.

Residents who do not require a mental health treatment plan will continue to be assessed by DSS care managers to determine their need for enhanced care.

Eventually, a more comprehensive assessment system is needed to accurately identify personal care and other service needs for all adult care residents. Developing such an assessment system will require a commitment of time and administrative resources from both the industry and the State. DHHS is beginning the planning process to develop a comprehensive assessment system for residents of adult care homes.

C. Modify adult care home payment system to accomplish desired results

The system used to pay operators of adult care homes should serve as an incentive for good care. Currently, operators all receive the same amount for each State-County

Special Assistance resident, regardless of the level of resident needs. As a result, any funds not spent on personal care, food, staff supervision, or other services can become profit for the operator.

Adoption of a system that divides the payment between direct care and indirect care, as is done with nursing homes, can solve this problem. Funds allocated for direct care that are not spent for direct care would be paid back to the State. Payment increases intended to improve staffing would be spent for that purpose. An improved payment system would help maximize federal funds and end reliance on state and county appropriations as the sole source of increased payment rates.

Family care homes (adult care homes with six or fewer beds) should shift to a market rate reimbursement system, eliminating the requirement to submit cost reports.

The change in payment system cannot be implemented unilaterally by the State without jeopardizing Medicaid eligibility for some residents. Therefore, these changes would be conditioned upon receipt of a federal waiver allowing the changes without adverse affect on the Medicaid population.

D. Require standard response time for complaints

The law should establish a minimum time within which responsible agencies must initiate complaint investigations. DFS presently takes from 60 to 90 days to investigate routine complaints against nursing homes. Citizens should not have to wait so long to have their grievances addressed, and substantiating a stale complaint becomes difficult after so much time. County departments of social services currently have no specific time frame to investigate complaints in adult care homes.

For life-threatening situations, an investigation should be initiated immediately and in any event within 24 hours. 48 hours would be satisfactory for less serious conditions , and two weeks is appropriate for routine matters. Investigation completion standards also should be established.

III. Improving Regulatory Oversight

A. Develop system of financing to expand local DSS and DFS monitoring

The number of currently available county adult home specialists should be expanded by collecting a fee to support the monitoring activity. In recent years the monitoring demands on the county departments of social services have increased significantly because of expansive growth in the number of adult care homes. Over 1,500 homes with more than 36,000 beds require monitoring. Current projections indicate approximately 15,552 additional beds may become available within the next two years.

The adult home specialists' monitoring role has become more complex with additional laws and licensure rules addressing staff training, staffing, resident assessment and care plans and licensed health professional support. Specialists also are responsible for investigating complaints, and many have other duties, such as case management and adult protective services.

Demands have increased on DFS as well. The Division's consultants support the local specialists through consultation, technical assistance, training and facility surveying. DFS is currently filling vacant consultant positions with licensed professionals such as nurses to increase its capabilities.

Other DFS consultants have direct responsibility for inspection and monitoring of group homes for those in need of mental health, developmental disabilities and substance abuse services. More consultant positions should be filled to permit timely monitoring and complaint investigation in these homes.

As required by Session Laws 1998-0212, DFS has provided a report to the legislature on the potential collection of fees to support plan review and routine physical plant inspections by the Construction Section. The Construction Section reviews initial plans but has not been able to perform routine on-site physical plant inspections for the past ten years. Implementation of these fees will help increase program resources that can be devoted to facility monitoring.

B. Improve accountability for monitoring activities and authorize State takeover of activities when necessary

DHHS should have the authority to take over a county's adult care home monitoring function if necessary, using guidelines similar to those established for the Child Protective Services program. A number of studies have noted inconsistent quality of the adult care home monitoring effort by county departments of social services. DFS currently oversees the county monitoring function but has no explicit authority to take over the function when a county is doing an unacceptable job. In addition, the Secretary should be given discretion to provide State inspections if requested by a county DSS on terms and conditions deemed suitable by the Secretary.

C. Require local service agencies to develop and provide to DHHS an annual plan for implementing adult care home policy

The local departments of public health and social services, the area mental health programs, and the boards of county commissioners should work together to coordinate their many responsibilities relating to adult care homes (such as sanitation monitoring and reporting, placement of residents, case management, provision of mental health services and monitoring of rules designed to ensure quality and protection of residents' rights). Local agencies and county boards should be required to develop, with public input, a joint annual plan in which they address adult care home activities. DHHS should review and approve the plan, with authority to require corrective changes as necessary.

D. Revise Temporary Management law

The temporary management law for nursing homes and adult care homes (G.S. 131E, Article 13) needs to be amended to correct flaws that inhibit the use of a temporary manager when needed. This statute allows the court to appoint a temporary manager when certain criteria are met, but the procedural steps restrict prompt action in life-threatening situations. Other features of the law make finding temporary managers very difficult.

E. Provide criminal and civil penalties for egregious activity by home owners and operators

The State should implement recommendations of the Department of Crime Control and Public Safety to impose criminal sanctions for egregious conduct by owners and operators of adult care homes. In addition, enhanced civil enforcement should be developed to discourage disreputable home owners and operators. Civil remedies should include treble damages and the means to hold the true wrong-doers liable for their actions.

F. Limit use of provisional licenses

Adult care homes may be downgraded to a provisional license for substantial failure to comply with regulations, so long as corrections are expected and attainable in a reasonable time. DFS may extend the provisional license, and some have been extended over too long a period of time.

DFS should extend provisional licenses beyond six months only under extraordinary circumstances. If deemed necessary to avoid legal challenges, this policy should be codified.

G. Move to outcome measurements rather than process measurement

Success in delivery of quality care to long term care recipients should be measured in terms of outcomes and results rather than by statistical compilations of activity. For example, the medication aide training is successful if the medication error rate falls. Defining measurable outcomes is difficult in the human services area, and particularly in long term care, because of the nature of the service and the complex factors affecting results. Valid assessment of the initiatives presented here, however, depends on developing these goals. DHHS should take the lead in implementing this system.

H. Give the Secretary rule-making authority for this initiative

To coordinate the diverse requirements of safety in long term care, the Secretary of Health and Human Services should be authorized and directed to adopt the necessary rules to implement this initiative. Currently, the Social Services Commission has rulemaking authority for adult care homes; the Medical Care Commission for nursing homes. The Divisions of Aging, Medical Assistance, Mental Health, Developmental Disabilities, and Substance Abuse Services, Social Services, Facility Services, Public Health, and the Secretary's Office all have responsibility for aspects of long term care policy.

Department of Health and Human Services

Overview

February 1999

TABLE OF CONTENTS

Mission	1
Goals	2
O-Chart	4
Key Budget and Personnel Facts	5
Program and Services by Division	14
Key Initiatives and Accomplishments - SFY 1997-98	26

The Mission of the Department of Health and Human Services is...

"To serve the people of North Carolina by enabling individuals, families, and communities to be healthy, and secure, and to achieve social and economic well-being."

To achieve this mission, the Department will...

Provide comprehensive and coordinated services for.prevention, intervention, assistance, education, and empowerment;

assure equal access to services;
be accountable for achieving meaningful results;
continuously improve service delivery by involving citizens; and
support and develop employees as diverse, invaluable resources.

The Goals of the Department of Health and Human Services are...

The mission statement sets broad direction for departmental efforts. To put a working framework around the mission, the Department developed six primary goals. These goals target populations and functions and reflect the services and programs provided by the Department.

Support Family Development and Independence

The Department shall promote equitable access to high quality services that assist families in their efforts to improve, achieve or maintain health, social well-being, and economic self-sufficiency.

Safe and Healthy Children At Risk

The Department will identify children under 18 years of age, with or at risk for physical handicaps, developmental disabilities, substance abuse, delinquency, emotional illness, or abuse or neglect and provide or refer families to services for these children. In order to maximize limited resources the Department will emphasize prevention, early intervention and outreach activities to reduce the number of children requiring clinical and institutional services.

Improve Quality of Life for Adults at Risk

The Department will enhance the quality of life and promote independence for at-risk adults and their families. The Department will emphasize health promotion, safety, protection, and expanded choice and access to appropriate and quality services.

Improve Quality of Life for Individuals with Physical and Mental Disabilities

The Department shall enhance the quality of life for persons affected by mental illness, substance abuse, developmental disabilities, blindness, deafness, and other disabilities through prevention, intervention, and treatment services so that they may secure and maintain maximum independence, contribution and inclusion into the community.

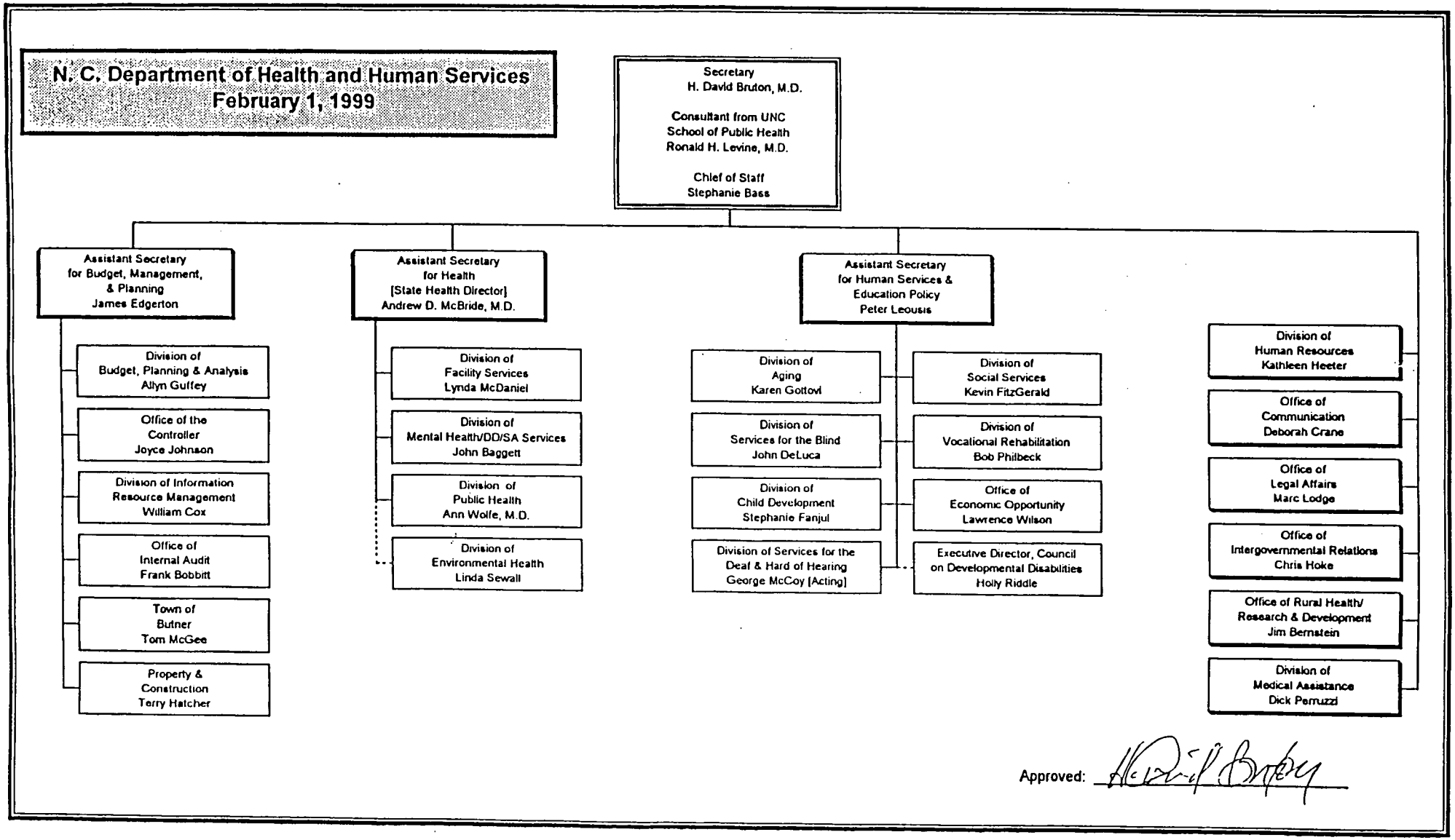
Promote Optimum Health

The Department will strive to enhance the health of our people, our communities and our environment through programs that promote health and ensure economic and geographic access to high quality health services.

Provide Quality Education for DHHS Students

The Department will provide appropriate and challenging individualized educational programs and services which enable at-risk and special needs children from birth to age 21 to succeed in a changing world.

O-Chart


N. C. Department of Health and Human Services
February 1, 1999
Secretary
H. David Bruton, M.D.
Consultant from UNC
School of Public Health
Ronald H. Levine, M.D.
Chief of Staff
Stephanie Bass
Assistant Secretary
for Budget, Management,
& Planning
James Edgerton
Division of
Budget, Planning & Analysis
Allyn Guffey
Office of the
Controller
Joyce Johnson
Division of Information
Resource Management
William Cox
Office of
Internal Audit
Frank Bobbitt
Town of
Butner
Tom McGee
Property &
Construction
Terry Hatcher
Assistant Secretary
for Health
[State Health Director]
Andrew D. McBride, M.D.
Division of
Facility Services
Lynda McDaniel
Division of
Mental Health/DD/SA Services
John Baggett
Division of
Public Health
Ann Wolfe, M.D.
Division of
Environmental Health
Linda Sewall
Assistant Secretary
for Human Services &
Education Policy
Peter Leousis
Division of
Aging
Karen Gottovi
Division of
Services for the Blind
John DeLuca
Division of
Child Development
Stephanie Fanjul
Division of Services for the
Deaf & Hard of Hearing
George McCoy [Acting]
Division of
Social Services
Kevin FitzGerald
Division of
Vocational Rehabilitation
Bob Philbeck
Office of
Economic Opportunity
Lawrence Wilson
Executive Director, Council
on Developmental Disabilities
Holly Riddle
Division of
Human Resources
Kathleen Heeter
Office of
Communication
Deborah Crane
Office of
Legal Affairs
Marc Lodge
Office of
Intergovernmental Relations
Chris Hoke
Office of Rural Health/
Research & Development
Jim Bernstein
Division of
Medical Assistance
Dick Pemuzzi
Approved:

Key Budget and Personnel Facts

Key Budget Facts

- 54% of DHHS's total budget comes from federal sources; 32% comes from the state.
- 84% of the total budget goes for programs & benefits such as TANF, Medicaid payments, and grants to organizations for programs.
- 57% of total budget goes solely for Medicaid.
- In the last 23 years, DHHS's federal entitlement commitments have grown from 48% to 56% of its budget.

Key Personnel Facts

- While DHHS's budget has grown 504% in the last 18 years, DHHS's number of positions has increased by a total of just 16% (2,772 positions). Excluding 100% federally funded positions, the position growth rate is 11%.

- DHHS now has 20,195 positions (FTEs) Of those:

    - 70% are in institutions (14,214.0)
    - 17% are based in Raleigh (3,444.5)
    - 13% are in field offices (2,546.5)

- More than 14,000 DHHS employees are in 30 institutions and schools that provide 24-hour, 7-day per week care. All institutions operate 3 full shifts.

- The number of people served directly by DHHS has increased by 194% from 1982 to 1999.

- DHHS's workforce today includes:

    - nearly 7,600 health care personnel
    - more than 3,500 teachers, youth counselors and others who help children and
    - adults in state schools and institutions
    - more than 2,500 counselors and therapists who help people in areas ranging from substance abuse to physical rehabilitation
    - about 1,800 professionals like day care specialists and child support enforcers
    - nearly 5,000 professionals like nursing home inspectors, day care inspectors and legal/accounting staff who ensure the safety of DHHS institutions and facilities

Budget Summary and Overview

The Department of Health and Human Services has a total general fund budget of $8.5 billion dollars after adjusting for intra-departmental transfers. Of this amount, 32% or $2.7 billion is in state appropriations, 54% or $4.6 billion are federal funds, and 14% or $1.2 billion are other receipts.

Charts 1 and 2 present the portion of DHHS's general fund budget to the total state general fund budget. DHHS's portion is 40% of the total general funds and 23% of the total state funds. Most of DHHS's general funds come from federal dollars (54%). State appropriations account for 32% and county and other funds account for the remaining 14% (see Chart 3).

Chart 4 displays the allocation of DHHS's budget by category. Most of the funds go for Entitlements (56% of the total requirements). Non-entitlements account for 28% of the total. Entitlements reflect refugee assistance, special assistance for blind and adults, foster care assistance, and direct services benefiting individuals in hospitals, facilities, etc. Relatively small percentages go to salaries and fringes or to other support services such as printing, travel, and data processing. The largest percentage in these categories is for division support (7%). Salary and fringes for institutions and schools account for the next highest percentage (6%).

Chart 5 displays the total requirements by Program--that is, by the Department's divisions. The divisions of Medical Assistance (DMA), Social Services (DSS), and Mental Health/Developmental Disabilities/Substance Abuse Services (DMHDDSAS) receive the greater shares of the Department's total general fund budget, receiving 57%, 14%, and 12%, respectively. Since these are the divisions which account for most of the funds going to Aid and Public Assistance, their share of the budget is commensurate with their functions and responsibilities.

Chart 6 shows where the positions are by location and major function. Institutions and schools account for 70% of the total positions, regional direct services at 9%, program support at 16%; Raleigh-based administration, 4%; and regional administration at 1%.

The Department's growth in budget, clients, and positions through the 80's and 90's is compared in Chart 7. Generally, the budget has been incrementally growing commensurate to steady increases in clients served, while position changes have been relatively lower. The chart highlights the addition of health services in SFY 1997-98, which created a significant upswing in the budget, clients served (1.2 million approximate increase), and positions.

State Fiscal Year 1998-1999
General Fund Operating Budget as of November 30, 1998

DHHS's budget is 40% of all State government's total budget

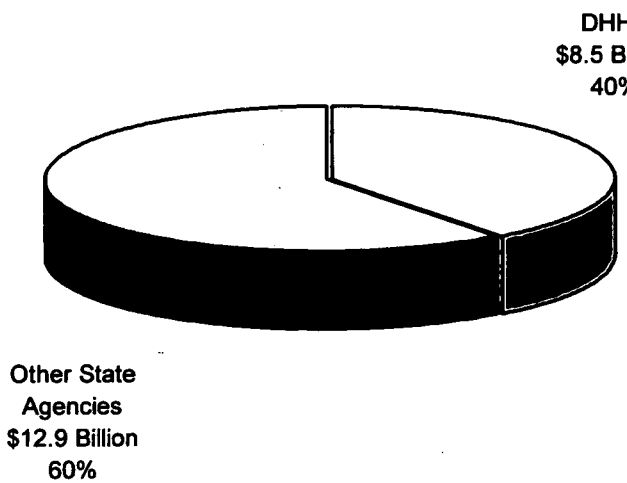


Chart 1
Total Budget

23% of all State appropriations go to DHHS

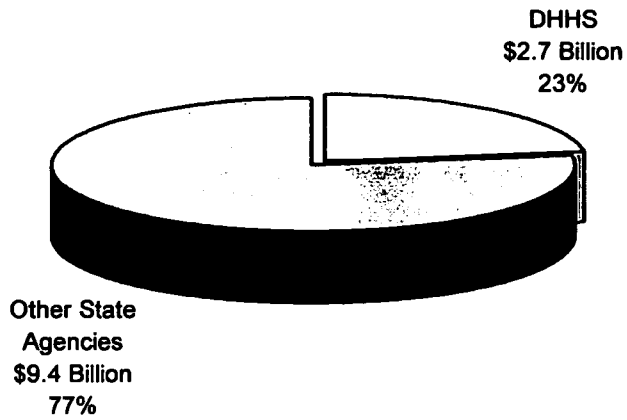


Chart 2
State Appropriation

- Includes only General Fund Budget Codes.
- Other State Agencies intra-department transfers not netted out.

54% of DHHS's budget comes from federal sources; 32% comes from the state

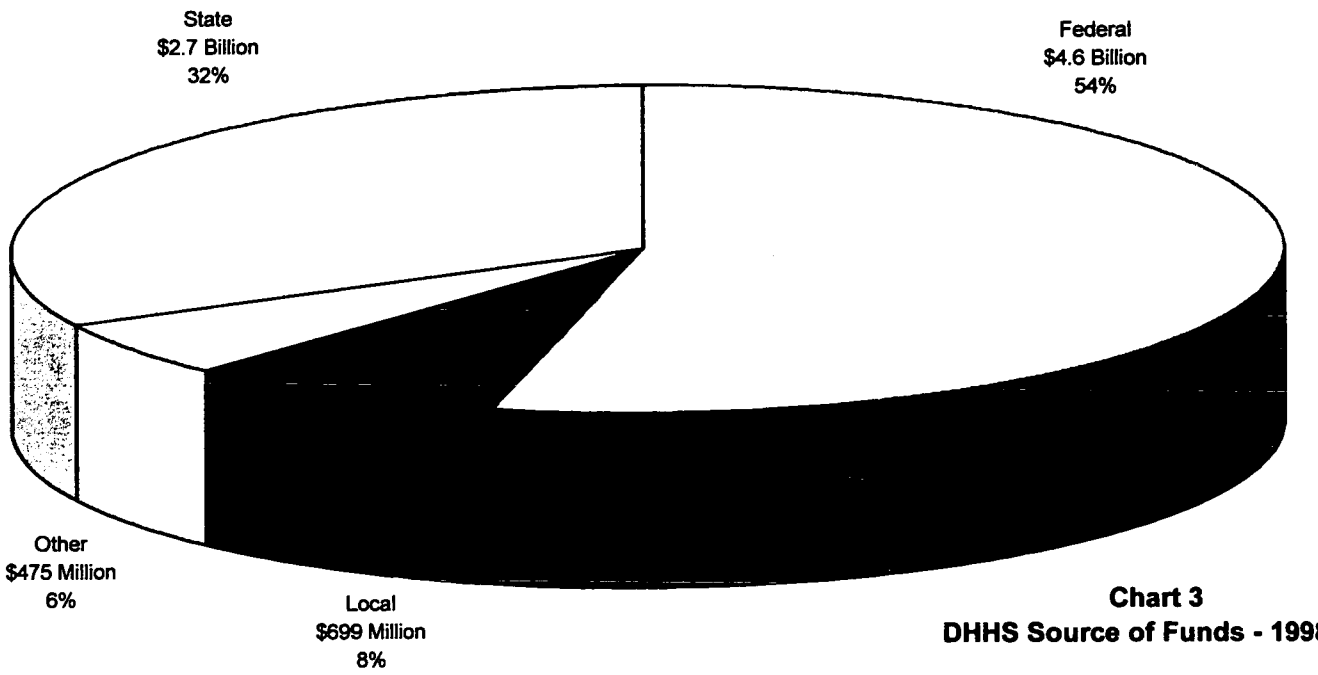


Chart 3
DHHS Source of Funds - 1998-99

84% of the total budget goes for programs & benefits to individuals, such as TANF and Medicaid

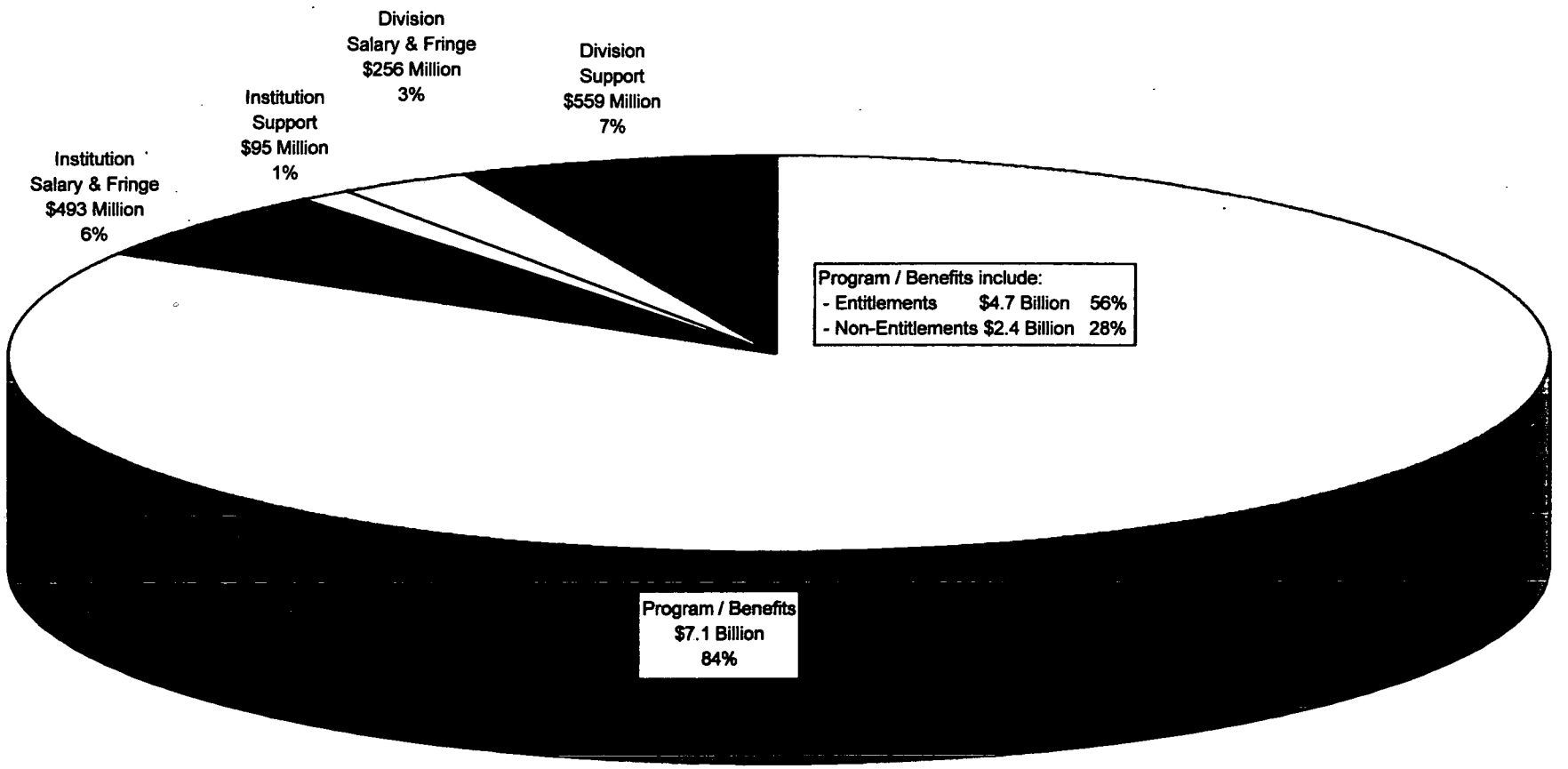
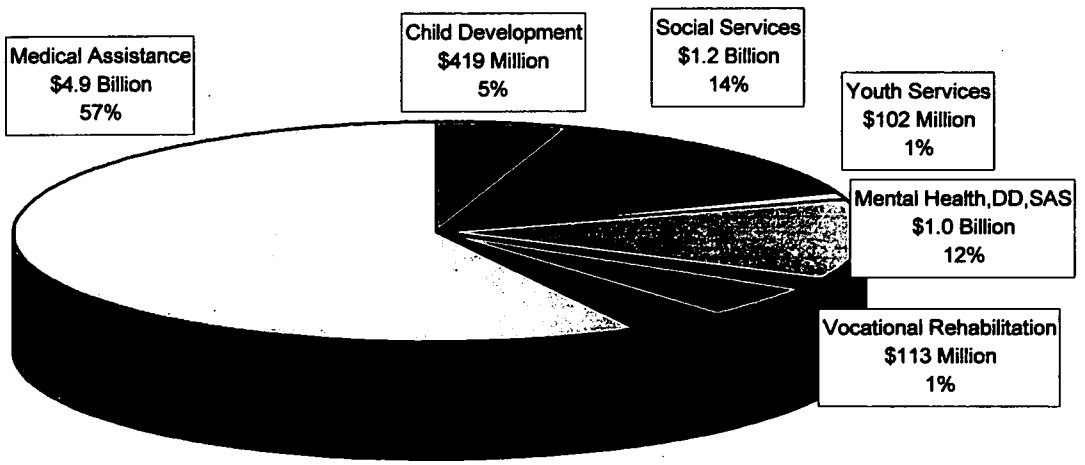


Chart 4
DHHS Total Budget By Category - 1998-99

57% of DHHS's total budget goes solely for Medicaid



Other Divisions:		
Aging	$74 Million	0.87%
Health Choice	60 Million	0.71%
Services for the Blind	36 Million	0.42%
Information Resources Mgt.	32 Million	0.38%
Central Administration	31 Million	0.36%
Deaf & Hard of Hearing	31 Million	0.36%
Facility Services	21 Million	0.25%
Economic Opportunity	16 Million	0.19%
Rural Health	11 Million	0.13%
DIRM Welfare Automation	9 Million	0.10%
DD Council	2.2 Million	0.03%
Citizen Affairs	.7 Million	0.01%

Chart 5
DHHS Total Budget By Division - 1998-99

Note: Budget has been adjusted for transfers.

Of DHHS's 20,194 positions, 70% are in institutions,
17% are based in Raleigh, and 13% are in field offices

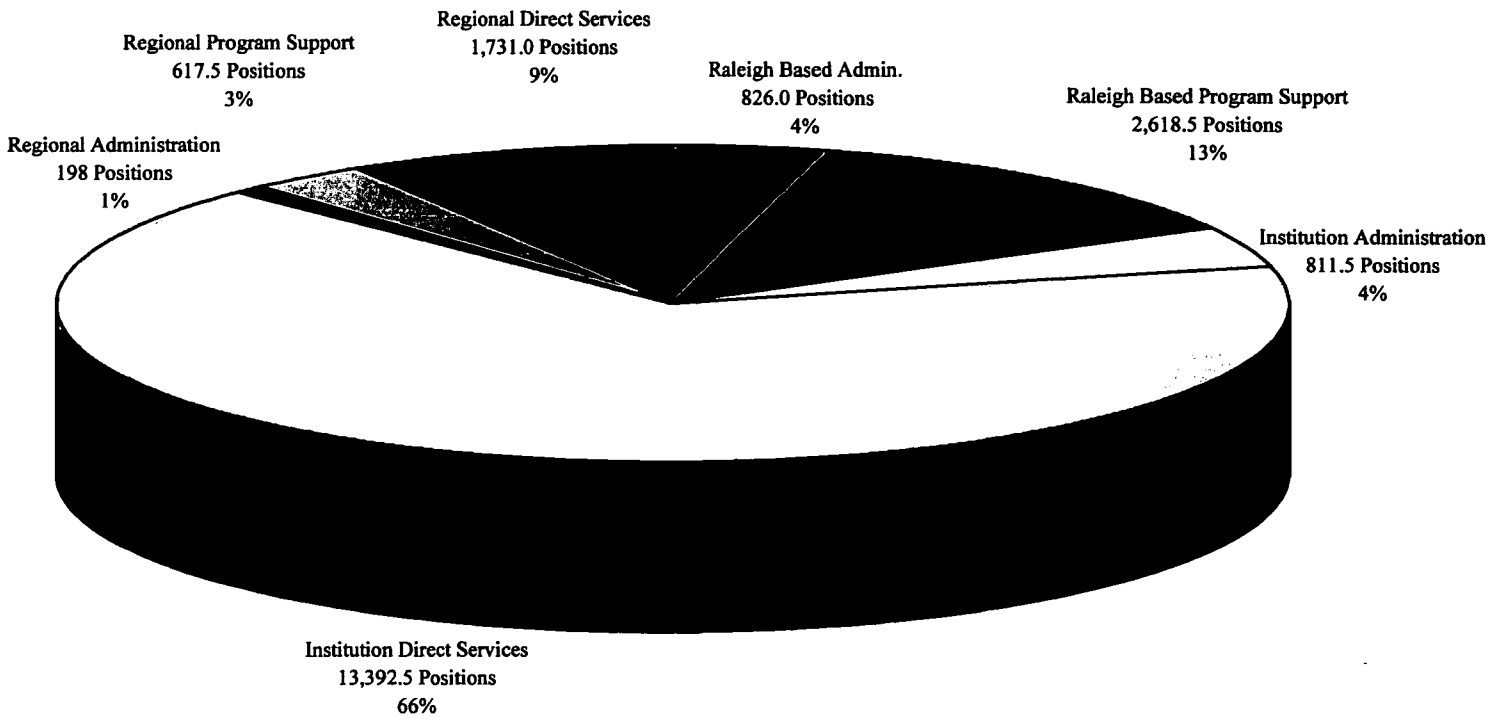
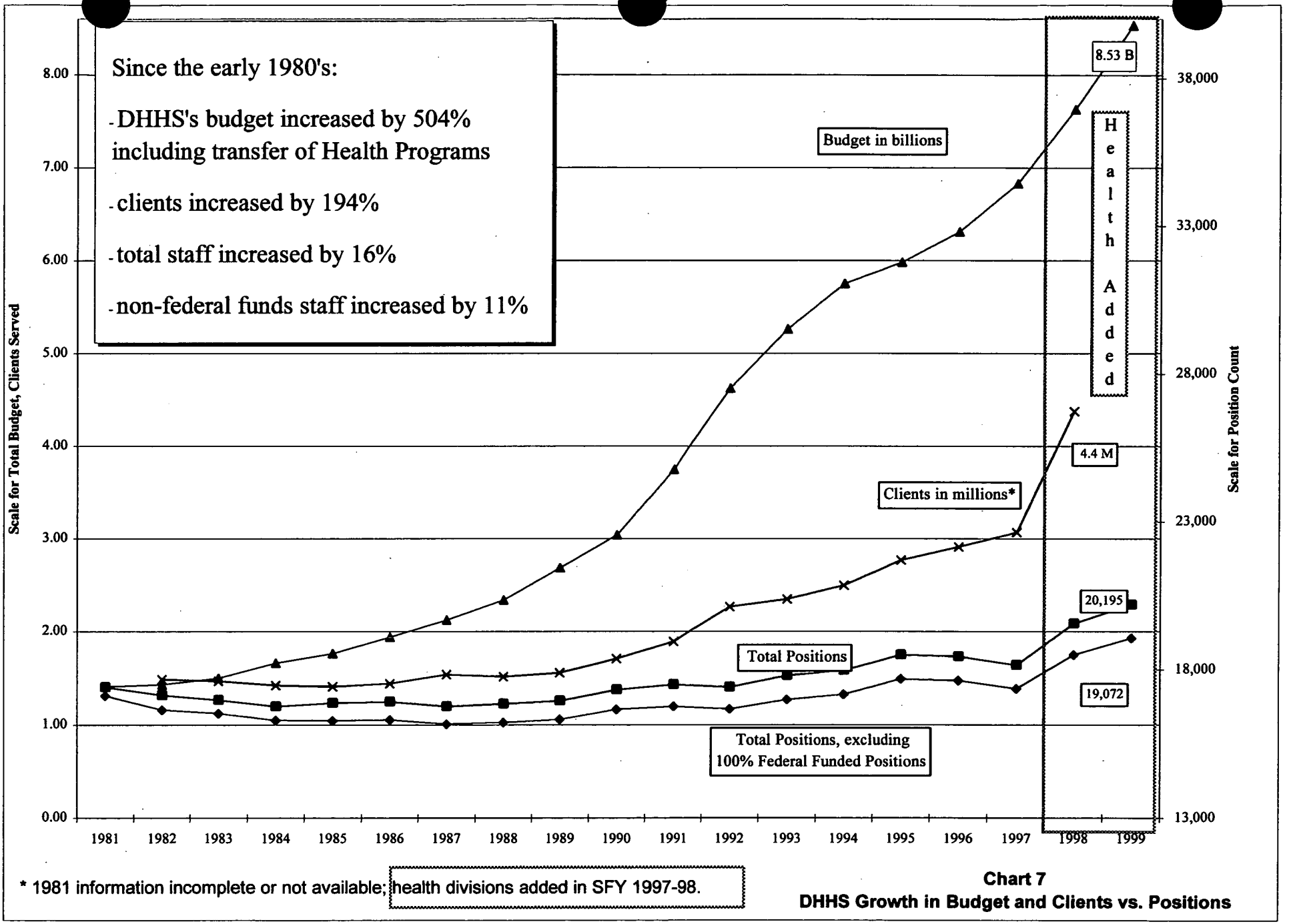


Chart 6
DHHS Positions By Location and Function - 1998-99



* 1981 information incomplete or not available; health divisions added in SFY 1997-98.

Chart 7
DHHS Growth in Budget and Clients vs. Positions

Program and Services by Division

HEALTH AND [redacted]AN SERVICES

Program and Services by Division

CENTRAL MANAGEMENT AND SUPPORT

Office of Communications
Debbie Crane, Director, 919-733-9190

Office of Legal Affairs
Marc Lodge, General Counsel, 919-733-6920

Office of Legislative and External Affairs
Chris Hoke, Acting Chief, 919-733-2173

Office of Citizens' Services
Leslie Mann, Director, 919-733-4261 (Voice), 919-733-4851 (TTY)

Council on Developmental Disabilities
Holly Riddle, Director, 919-733-6566

Office of Economic Opportunity
Lawrence Wilson, Director, 919-773-2818

Division of Human Resources
Kathy Heeter, Director, 919-733-2940

Division of Budget, Planning and Analysis
Allyn Guffey, Director, 919-733-6396

Office of the Controller
Joyce Johnson, Controller, 919-733-0169

Division of Information Resource Management
Bill Cox, Director, 919-733-8900

Office of Internal Audit
Frank Bobbitt, Director, 919-715-4791

Services Provided to Divisions/Management

Legal Services
Accounting Services
Budget Management and Program Analysis
Purchasing and Contracting
Mail Services Information Resource Management Government Liaison Services
Public Information
Coordination of Education Programs
Personnel Management
Grants Management
Property Management & Constructions
Community Involvement Services
Disabilities Act Management & Services

Services Provided to Local Agencies/Individuals

Citizens Affairs & Referral Services
Holocaust Council
- Education
Community Action Grants
Audit Services
Developmental Disabilities Grants

HEALTH AND HUMAN SERVICES

Program and Services by Division

DIVISION OF AGING

Karen E. Gottovi, Director, 919-733-3983

Adult Day Care/Day Health Care
Advocacy
Alzheimer's Support
Care Management
Congregate Nutrition
Elder Rights
Grandparents Support
Group Respite Services
Health Promotion/Disease Prevention
Health Screening
Home Care (Skilled)
Home Delivered Meals
Housing and Home Improvement
In-Home Aide
Information and Case Assistance
Institutional Respite
Legal Services
Long Term Care Ombudsman Program
Senior Center Development and Outreach
Senior Center Operations
Senior Community Service Employment Program
Senior Companion
Senior Education Corps
Senior Games
Transportation
Volunteer Program Development

DIVISION OF CHILD DEVELOPMENT

Stephanie Fanjul, Director, 919-662-4499

Regulation of Child Care Centers and Homes. Includes:
- Investigation of Abuse/Neglect Reports
- Criminal Background Record Checks and Pre-Licensing Workshops

Smart Start
Subsidized Child Care Program
Head Start Wrap-Around Program
Head Start Supplemental Program
Head Start Collaboration Project
Early Head Start
NC Interagency Coordinating Council
T.E.AC.H.
Child Care Resources Directory Website
Child Care Personnel Education Registry
Child Care Injury Evaluation
Early Childhood Initiatives (Quality and Availability)
- Inclusion of Children with Special Needs
- School Age Child Care
- Child Care Resource & Referral
- Revolving Loan Fund
- NC Early Childhood Credential
- NC Family Child Care Credential
- NC Early Childhood Administration Credential
- NC Institute for Early Childhood Professional Development
- Healthy Child Care Initiative
- Monitoring Improvement

DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING

George McCoy, Director, 919-733-5196 (Voice, TTY)

NC School for the Deaf at Morganton (K-12)
Central NC School for the Deaf at Greensboro (K-8)
Eastern NC School for the Deaf at Wilson (K-12)
Preschool Satellite Classes and Early Intervention Program
Telecommunications Equipment Distribution Program
Community Services Centers for the Deaf and Hard of Hearing
- Interpreter Support Services
- Consulting Services
- Training for providers, families, and clients

Family orientation (deafness), emotional support, and training
Telecommunications Relay System
Interpreter Certification Program
Hearing Ear Dog Certification

DIVISION OF FACILITY SERVICES

Lynda McDaniel, Director, 919-733-2342

Certificate of Need
Health Care Facilities Finance Program
Medical Facilities Planning
Regulatory Services - Bingo
Certificate of Public Advantage Program
Medical Care Data Act Program
Medicare/Medicaid Certification Inspection
Construction/Life Safety Inspection
Emergency Medical Services
Health Care Personnel Registry and Investigations

Licensure
- Medical Facilities (including hospitals and nursing homes)
- Adult Care Homes
- Mental Health Group Homes
- Jails and Detention Facilities

Adult Care Homes - Oversight of SB864 Implementation

HEALTH AND HUMAN SERVICES

Program and Services by Division

DIVISION OF MEDICAL ASSISTANCE

Dick Perruzzi, Director, 919-733-2060

Programs:

- Baby Love
- Health Check for Children
- Community Alternatives Program
  - for Children
  - for AIDS
  - for Disabled Adults
  - for Mentally Retarded. Developmentally Disabled
- Carolina Access (Managed Care)
- High Cost Case Management
- Drug Utilization Review Program
- Medicare Buy-In
- Nursing Home Placement
- Health Care Connection
- Health Related Services
- Independent Practitioner
- Health Choice

Regulatory:

- Provider Enrollment
- Provider Reimbursement
- Utilization Review/Audits
- Medical Policy
- Eligibility Policy
- Quality Control-Eligibility and Systems
- Drug Utilization Review
- Third Party Recovery
- Contracts Management-claims Processing System, Bulk Purchase
- Pre/Post Admission Reviews, Audits
- Interagency Agreements
- Federal Plan/APA
- Provider Service Organizations (PSOs)
- Program Integrity

Services:

- Inpatient Hospital Services
- Hospital Outpatient Services
- Other Laboratory and X-ray
- Nursing Facility
- Physician Services
- Home Health Services
- Health Check
- Family Planning Services
- Federally Qualified Health Centers and Rural Health Centers
- Durable Medical Equipment
- Nurse Midwife and Nurse Practitioner Services
- Medical Transportation
- Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
- Personal Care Services
- Prescription Drugs
- Dental Services
- Eye Care Services
- Hearing Aid Services
- Mental Health Services
- Adult Health Screening Program

HEALTH AND [redacted]IAN SERVICES

Program and Services by Division

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

John Baggett, Director, 919-733-7011

Periodic Services
After Hours Services
Assertive Outreach
Case Management
Consultation, Education and Primary Prevention
Evaluation
Help Line
High Risk Intervention
Methadone Treatment
Outpatient Treatment/Habilitation
Screening
Hourly Respite
Personal Assistance

Day/Night Services
Adult Development Activity Program
Day/Evening Activity
Intensive Child Care
Intensive Day Treatment/Partial Hospitalization
Developmental Day
Drop in Center
Psychosocial Rehabilitation
Sheltered Workshop
Individual and Group Supported Employment

24-Hour Services
Community Respite
Non-Hospital Medical Detoxification
Social Setting Detoxification
Family Living; Low and Moderate Intensity
Group Living; Low, Moderate and High Intensity
Inpatient Hospitalization
Residential Acute Treatment
Supervised Living; Low and Moderate Intensity

Other Services
Alcohol and Drug Education Traffic Schools (ADETS)
DWI (Driving While Impaired) Substance Abuse Assessments
Employee Assistance Program (EAP)
Family Support
Parent-to-Parent
Treatment Alternatives to Street Crime (TASC)
Drug Education Schools (DES)
Perinatal Substance Abuse Services

Institution Services

8 state institutions provide mental health inpatient services
5 state institutions provide residential and respite services for persons with developmental disabilities
3 state institutions provide short-term substance abuse residential treatment and rehabilitation services

HEALTH AND HUMAN SERVICES

Program and Services by Division

OFFICE OF RESEARCH, DEMONSTRATIONS, AND RURAL HEALTH DEVELOPMENT

James D. Bernstein, Director, 919-733-2040

- Aid for Clinic Operation
- Aid for Clinic Construction
- Primary Care Provider Recruitment
- Loan Repayment Program
- High Needs Service Program
- Residential Stipend Program
- Rural Health Scholars Program
- Farmworker Health Program
- Long Term Care Demonstration
- Community Hospital Technical Assistance Program.
- Essential Access Community Hospital Program
- Community Primary Care Program
- Access II/III Program
- Dental Recruitment and Development
- Health Professional Shortage Analysis
- Physician Assistant/Family Nurse Practitioner Residency Program
- Primary Care Technical Assistance Service
- Architectural design
- Graphic design
- Maternity services
- Laboratory services
- Computer systems
- Financial/Reimbursement services
- Practice Management
- Managed Care

HEALTH AND [redacted]AN SERVICES

Program and Services by Division

DIVISION OF PUBLIC HEALTH

Ann Wolfe, M.D., Director, 919-733-3011

Office of the Director

Training to reduce access barriers (i.e., Cultural Diversity Training/Interpreter Training/other agency-capacity building trainings)
Training for the public health workforce
Minority-focused health status/health assessment reports
Consultation/technical assistance to address health disparity issues.
Healthy Carolinians (community-based primary prevention program)

Community Health

Breast and Cervical Cancer Control
Cancer Control
Community Traffic Safety Program
Diabetes Control Program
Governor's Council on Physical Fitness (Be Active NC)
Home Health
Injury prevention
Kidney Program
Older adult health program
Osteoporosis prevention program
Project ASSIST
Residential Fire Injury Prevention
Safe Communities (rape prevention)
Screening, follow-up, diagnosis and treatment services for selected chronic diseases
Statewide policies and plans for selected chronic diseases

Dental Health

Access to Dental Care
Dental Field Staff
Dental Health Education
Dental Screenings in Schools
Fluoride Guidelines
Fluoridated Community Water Systems
Screening, diagnostic, treatment and referral services
Statewide dental health plan

HEALTH AND HUMAN SERVICES
Program and Services by Division

Epidemiology

Animal bite consultations

Collection and dissemination of health information

Collection, registration, and issuance of vital records

Communicable disease control programs

- Consultation about, investigation of, and institution of control measures for non-HIV/STD, non-zoonotic communicable disease problems.
- Provision of funding and drugs through local health departments for the prevention and treatment of TB.
- Collaboration in the training and education of health care professionals and the general public in communicable disease prevention and control.

Consultations and assessments.

Control system for asbestos/lead abatement operations

Diagnose, treat and educate individuals about STD/HIV

Dusty trades exposure assessments and medical consultations

Expert witness testimony in criminal proceedings

HIV/AIDS Care Programs, medication, case management

Investigation of childhood deaths

Investigate HIV reports, locate partners, provide consultation

Lab certification and consultation for CLIA

Laboratory examinations

Medical/legal death investigations, autopsies and toxicology tests

Medical/legal education

Medical toxicological and industrial hygiene risk

Mobile breath testing unit (BAT Mobile) in enforcement and/or educational venues.

Occupational Health consultations

Occupational injury or illness surveillance

Pesticide contamination consultations

Postmortem medicolegal examinations

Public and private water supply contamination consultations

Rabies tag program

Review medical, driving and related records of referred individuals.

Statewide plan HIV/STD policies

Training and certifying state and local law enforcement officers to operate breath testing devices

Toxic and hazardous chemical contamination consultations

Train employees, citizens and local health departments in occupational and/or environmental health hazard control

Training, testing, and certification to other laboratories

Zoonotic disease consultations

Women's and Children's Health

Adolescent Parenting Program
Adolescent Pregnancy Prevention Program
Adult Cystic Fibrosis Program
Assistive Technology Program
Baby Love
Baby Love Plus (Healthy Start)
Child and Adult Care Food Program
Child Fatality Task Force
Child Health Program (Well Child Services)
Child Health Training Program
Child Service Coordination Program
Children's Special Health Services (CSHS)
Comprehensive Adolescent Health Care Projects
Developmental Evaluation Centers (DECs)
Family Planning
Family Support/Family Preservation Services
Farmers Market Nutrition Program
FIRST STEP Public Awareness Campaign and Hotline
Genetic Counseling Services
Healthy Child Care Initiative
High Risk Maternity Clinics
Immunization Assessment
Immunization Education, Outreach and Promotion
Intensive Home Visiting Programs
Intensive Psycho-Social Counseling for Pregnant Women
Local Child Fatality Prevention Teams
Maternal Health Program
Maternal Health Videos-in-Sign Project
Maternal Outreach Workers
Maternal Serum Alpha Fetoprotein Screening
Maternity Care Coordination
Medical Nutrition Therapy for Children and Adolescents
Medical Nutrition Therapy for Pregnant and Postpartum Women
Minority Infant Mortality Reduction Projects
Newborn Screening Services
North Carolina Hemophilia Assistance Plan
North Carolina Immunization Registry
North Carolina Infant-Toddler Program
Nurse-Midwifery Projects
Office for Disabilities and Health
Office of Women's Health
Parenting Education Services
Pediatric Primary Care Program
Perinatal Education and Training
Prenatal Care Services
Rural Obstetrical Care Incentive Program
School Health Fund
School Health Program
Sickle Cell Syndrome Program
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
Sudden Infant Death Syndrome Grief Counseling
Summer Food Service Program for Children
Targeted Infant Mortality Reduction Projects
Universal Childhood Vaccine Distribution Program
Vaccine-Preventable Disease Surveillance
Voluntary Sterilization Services
Women's Health Nurse Training Program
Women's Preventive Health Services

HEALTH AND HUMAN SERVICES
Program and Services by Division

DIVISION OF SERVICES FOR THE BLIND
John DeLuca, Director, 919-733-9822

Vocational Rehabilitation Program
Vocational assessment
Vocational guidance and counseling
Job placement
Postsecondary training
Reader service
On-the-job training
Supported employment/job coach services
Physical restoration
Rehabilitation engineering services
Orientation and mobility instruction
Braille instruction
Adaptive technology evaluation, training and purchase
Specialized school-to-work transition services
Job seeking skills training
Occupational tools and equipment
Specialized services for deaf-blind consumers
Consultation to employers and blind consumers on the American with Disabilities Act

Business Enterprises Program
Training and employment opportunities for licensed blind foodservice vendors

Governor Morehead School
Pre-school services in some local communities
K-12 residential school
Consultation and technical support for LEAs serving children who are blind/visually impaired

Medical Eye Care Program
Eye exams and eyeglasses
Surgery, medication and other treatment to preserve or restore vision
Prostheses
Low vision evaluations
Glaucoma screening
Eye care education
In-home personal care services (Level II)

Independent Living Services Program
In-home aide service (Level I)
Adjustment to blindness services
Special Assistance for the Blind
Orientation and mobility instruction
Vision-specific aids and devices
Community-based independent living skills classes
Community-based support groups
Information and referral
Production of Braille and large print material for the general public

NOTE: Blind and visually impaired individuals seeking services must meet program eligibility guidelines which, in some programs, includes an economic needs test.

HEALTH AND [redacted]AN SERVICES

Program and Services by Division

DIVISION OF SOCIAL SERVICES

Kevin FitzGerald, Director, 919-733-3055

Economic Independence
- CP&L's Project Share
- Crisis Intervention Program
- Food Stamp Employment & Training
- Food Stamp Program
- Job Corp
- Low Income Energy Assistance Program
- Work First Family Assistance
- Work First Family Assistance Employment Services

Child Support Enforcement

Adult and Family Services
- Adult Care Home Case Management
- Adult Placement Services
- Adult Protective Services
- Case Management and Counseling (Individual & Family Adjustment, Health Support Services, Personal & Family Counseling)
- Family Planning Services
- Family Violence Prevention
- Guardianship Services
- Refugee Program (Cash, Medical Assistance and Social Services)
- State/County Special Assistance for Adults
- State Abortion Fund
- State Maternity Home Fund
- Transportation

Children Services
- Adoption Services, Adoption Assistance, and Special Children's Adoption Fund
- At-Risk Case Management
- Child Protective Services
- Day Care
- Delinquency Prevention Services
- Family Preservation
- Family Resource Centers
- Foster Care Services and Assistance
- Health Support Services
- Housing & Home Improvement
- Independent Living Skills for Foster Care Children
- Individual and Family Adjustment
- In-Home Aide Services
- Intensive Family Preservation
- Interstate Compacts
- Other Child Welfare Services
- Personal and Family Counseling
- Preparation and Delivery of Meals
- Transportation Services

HEALTH AND HUMAN SERVICES
Program and Services by Division

DIVISION OF VOCATIONAL REHABILITATION SERVICES
Bob Philbeck, Director, 919-733-3364

Vocational Rehabilitation Program

Community Rehabilitation Work Adjustment/Job Coaching
Supported Employment
On the Job training/Apprenticeship
Sponsorships at colleges, universities, community colleges and vocational schools
Individualized job placement services
Job seeking skills with emphasis on Americans with Disabilities Act (ADA) and rights for people with disabilities
Career counseling
Work, Home and Vehicle Modifications
Occupational/small business expenses: tools, equipment, licenses, initial stocks, rent, insurance
Transition from school to work services
Personal assistance services
Assessment services (vocational evaluations; employment strengths)
Physical and Mental Restoration: hospitalization/convalescent care surgery, cardiac rehabilitation programs, prescription drugs, physical therapy, occupational therapy, psychotherapy, speech therapy, etc.
Work hardening (use work activities for physical stamina building)
Assistive Technology: computers, communication aids, health aids/ prosthetic devices, wheelchairs, etc.
Rehabilitation Engineering consulting service: home, vehicle and job site modifications
Information, consulting on ADA
Job analysis
Employer/employee assistance services

Assistive Technology Project

Regional Assistive Technology Centers
Technical Consultation
Demonstration and tryout of equipment
Equipment loan
Outreach/Training and awareness
Funding information and advocacy

Disability Determination Services

Determine eligibility for: Social Security disability (Title II) Supplemental Security Income disability (Title XVI) Medicaid disability (Title XIX)
Assist as necessary the Federal Emergency Management Administration (FEMA) in processing disaster assistance claims under the Individual & Family Grant

Independent Living Rehab Program

Counseling and Joint Planning for Independence
Information and Advocacy
Home Modifications
Vehicle Modifications
Technological Aids and Devices
Rehabilitation Engineering
Prosthetics and Orthotics
Part-time, Consumer-managed Personal Assistance Services
Assistance with Recreational Therapy/Leisure Pursuits and Activities
Peer Counseling
Independent Living Skills Training

Client Assistance Program

Information about rehabilitation services
Referral to appropriate rehabilitation programs
Advice and interpretation on program policies and procedures
Negotiation of client or service delivery concerns
Assist consumers in the appeals process
Assist consumers in legal remedies

Key Initiatives and Accomplishments SFY 1997-98

DEPARTMENT OF HEALTH AND HUMAN SERVICES
1997-98
KEY INITIATIVES AND ACCOMPLISHMENTS

AGING

- **Established a Legal Resource Center** under the direction of an attorney to provide legal advice and resources to the elderly.

- **Baby Boomer Initiative** – This initiative educates North Carolina policymakers about the coming demographic population shift to an older society. People in the Boomer age bracket are educated about the need to take care of themselves so that they will age successfully both physically and financially.

CHILD DEVELOPMENT

- **Smart Start has been expanded statewide.** All 100 counties have access to funding to make improvements in child care programs based on local needs. (Partial funding for 55 counties and planning funds for 45 counties.)

- The child care law now requires certain teachers and directors of child care centers to take early childhood education classes at the community college. The **T.E.A.C.H. Early Childhood Scholarship Program**, which pays for the classes and provides a bonus to staff who complete the classes, **has helped to reduce the teacher turnover rate** from 42% to 10% in the centers where teachers received T.E.A.C.H. scholarships.

- **Smart Start Recognition** – Smart Start **received the 1998 Innovations in American Government Award**, which is one of the highest honors a government program can receive. This award is given annually by the Ford Foundation and Harvard University to recognize a state's solution to a pressing problem.

ECONOMIC OPPORTUNITY

- **Enabled 921 low-income families to move out of poverty** through the 36 community action agencies receiving funding under the Community Services Block Grant program.

- **Provided overnight shelter to an average of 2,800 homeless individuals per day** through the 121 homeless providers funded through the Emergency Shelter Grants Program. The shelter facilities include traditional overnight shelters, day shelters, domestic violence shelters, transitional shelters, runaway homes, and halfway homes.

- Sponsored the **first homeless conference** that focused on assessing the problems of the homeless in North Carolina and identifying solutions. Over 200 homeless service providers, homeless and formerly homeless persons, local, state and federal officials attended.

FACILITY SERVICES

- **Eden Alternatives – Division recognized by the Association of Health Facility Survey Agencies** for its work in promoting the concept of introducing animals, plants and children into nursing homes to improve the quality of life for nursing home residents. The Division has staffed and helped coordinate a public/private coalition to guide this effort and has made available $195,000 in grants (from federal fines collected) to nursing homes to encourage participation.

- Completed the **upgrade of the health care personnel registry telephone voice response system.** This made all of the information on the registries available to the public 24-hours-a-day, 7-days-a-week. The information is updated daily. This system processed over 200,000 inquiries this past fiscal year.

HUMAN RESOURCES

- **Instituted merit-based hiring** by developing the policy, training HR staff in five sites across the state, and implementing the procedures. Updates for training were conducted in May 1998.

INFORMATION RESOURCE MANAGEMENT

- **Year 2000** – Remedial work to fix non-compliant application systems has obtained funding from the Department of Commerce's Year 2000 Steering Committee. Assessment work initiated on non-information technology assets (i.e., elevators, PC's, HVAC, state laboratory medical equipment, motor pool vehicles, etc.)

- The **Health Choice** program was implemented October 1, 1998. A number of substantial system changes were made to the Eligibility Information System to support this initiative.

- The **Electronic Benefits Transfer** (EBT) project, a joint venture for DHHS, Citibank, and the Southern Alliance of States, was successfully piloted, and is in the roll out phase currently, providing point of sale benefits to Food Stamp recipients. DIRM staff led development of an EBTIS system to interface with the department's food stamp information system and Citibank's data center, as well as supporting security, training and connectivity. DIRM is supporting rollout activities.

MEDICAL ASSISTANCE

- DRIVE – The **Medicaid Data Retrieval and Information Verification Engine (DRIVE)** has put Medicaid claims data (3 years worth at 60 million claims per year) into data warehouses so that information can be manipulated quickly and easily. This will lead to major improvements in planning, evaluation, and care management feedback to providers, quality assurance, and fraud and abuse detection.

- N.C. **Health Choice** for Children – Implemented the subsidized child health insurance program for lower income working families which was enacted by the General Assembly. Since N.C. Health Choice for Children was implemented on October 1, 1998, about 8,000 children have been enrolled.

- **Carolina ACCESS** – now operational in 92 counties and will be statewide by the end of CY 1998. In addition to expanding statewide, Carolina ACCESS is being enhanced by adding incentives for providers to increase care management of their enrollees in 9 sites, referred to as ACCESS II (7) and ACCESS III (2).

MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

- **Accountability of Area Programs** – In an effort to improve the area program accountability and standardization of care for persons suffering from mental illness, substance abuse or dependence and developmental disabilities, the Division developed a comprehensive process for accrediting area programs. The National Council on Accreditation of Services for Families and Children has been engaged to phase in national accreditation requirements for area programs.

- **Relief from court oversight in the Thomas S and Willie M. Class Action Law Suits** because the Department is addressing the needs of those populations.

- **NC-TOPPS Initiative (Treatment Outcomes Performance Pilot Study)** – One of 14 states awarded a competitive grant by the Center for Substance Abuse Treatment (CSAT) to develop and implement client outcome measures to determine the effectiveness of substance abuse treatment services. Six area programs and contract agencies have participated in a consensus process for identifying critical client outcomes and are now piloting these measures for clients with substance abuse problems. It is anticipated that the results of this pilot project will be the basis for implementation of a statewide system of substance abuse outcome measures.

DIVISION OF PUBLIC HEALTH

COMMUNITY HEALTH

- **Established the Osteoporosis Task Force** which developed three reports on the disease, the state of care by physicians, and the recommendations on a public awareness campaign, and began to develop a comprehensive plan to address the prevention and treatment of osteoporosis.

- Initiated a **Pain Control Professional Education and Public Awareness Effort** through the Cancer Control Advisory Committee.

- Secured a 5-year grant from the Centers for Disease Control for $1.25 million annual effort to implement a **cardiovascular health program.**

- Received funding from the Kate B. Reynolds Foundation to implement a training program to **increase the ability of Spanish speaking people to be medical interpreters in health departments.**

Dental Health

- **Seal the State in '98** – Single largest sealant promotion event in the nation. Over 39,000 free sealants to at-risk children – 8,000 volunteers – $2 million in free care. **Received the American Dental Association's award for Community Preventive Dentistry.**

- **Establish locally operated dental clinics to serve low-income families** in local health departments and community health centers. The number of clinics increased from 6 in1994 to 25 this year.

- **Provided preventive dental health** services including screening, referral, follow-up, and education to over 300,000 school children. In addition, over 275,000 children participated in the state supported fluoride mouth rinse program.

EPIDEMIOLOGY

Occupational and Environmental Epidemiology

- CDC Grant/**Pfiesteria-Related Illness Surveillance and Prevention** – five-year project, first year budget $958,460.

- Under contract, Duke Medical Center provided clinical evaluations of the residents living near Trinity Foam which indicated that the symptoms reported by the residents were related to emissions from the facility. After several abatement orders, the State Health Director issued the final order which permanently closed Trinity Foam thus **ensuring a healthier and safer environment.**

HIV/STD Prevention and Care

- **Reported congenital syphilis cases decreased** by 81% between 1993 and 1997.

- Annual **gonorrhea and syphilis rates declined** between 1993 and 1997 by 35% and 64%, respectively.

- Secured **new CDC funding for enhancement of STD services** in the form of a Syphilis Elimination Project to be carried out in five of the counties with the highest syphilis morbidity. These counties are Forsyth, Guilford, Alamance, Orange, and Durham.

WOMEN'S AND CHILDREN'S HEALTH

- **School Health** – The Division has received a CDC grant to work with DPI on school health issues, and has convened a statewide task force of health and education leaders to develop a blueprint for school health in NC.

- **Office of Women's Health** – The General Assembly established an Office of Women's Health to "expand the State's public health concerns and focus to include a comprehensive outlook on the overall health status of women." The Office sponsored a successful statewide summit to obtain input from a wide cross-section of men and women on the key women's health issues to be addressed in North Carolina.

SERVICES FOR THE BLIND

- **Cosponsored two Hispanic outreach events** in Pitt and Beaufort Counties to provide Spanish-speaking people with information about blindness, DSB services, and other human services. More than 650 people attended the two events.

- **Entered into two new cooperative agreements** with the Cumberland and Forsyth School Systems, to prepare blind or visually impaired young people with work skills and opportunities during their high school years. DSB and the school systems share in the funding of the program in each county to provide school-to-work transition services to blind and visually impaired students.

- **GMS Preschool Early Intervention Expansion** – An expansion of GMS' "Smart Start for Visually Impaired Children" is providing a sound educational base for approximately 500 eligible blind or visually impaired children, birth through age 5, in all 100 counties of North Carolina.

- **GMS 2001 Technology Consortium** – An outgrowth of the Vision Partnership between DHHS, DPI and NCCU, this multi-funded (state, federal and university) consortium provides vision-specific and technology courses for credit and licensure through distance learning.

SERVICES FOR THE DEAF AND HARD OF HEARING

- Established with the State Emergency Management System **a 1-800 number that is dedicated to TTY use for deaf and hard of hearing individuals during emergency situations.**

- Established a **statewide network of more than 200 educational interpreters** to provide support, training, and evaluation.

- **Expanded the Early Intervention services for deaf and hard of hearing children and their families**, through an appropriation which established new technology, teaching positions, audiologist positions, and other support positions which more than doubled the amount of services provided to the youngest deaf and hard of hearing children in North Carolina.

- Legislation was approved to require **mandatory universal screening of newborns for hearing loss.**

DIVISION OF SOCIAL SERVICES

Food Stamp Program

- **Began implementation of the Electronic Benefits Transfer (EBT) System** in three pilot counties. Statewide rollout will be completed by June 30, 1999. This system replaces the paper Food Stamps with a debit-like ATM card that will be used to authorize food purchases in local stores.

Low Income Energy Assistance Program

- Received and distributed approximately $9 million of federal funds provided to North Carolina as **Heat Relief to eligible, low-income families** in the summer of 1998. This assistance helped families with cooling related expenses due to the excessive heat experienced in North Carolina this past summer.

Work First

- **Federal welfare reform changes were implemented in North Carolina's Work First Program** in January 1997. Under this plan, North Carolina continued its efforts to move families from welfare to work. Since Work First was implemented in June 1995, the welfare rolls have declined over 45 percent—down from 113,485 families in June 1995 to 62,144 families in October 1998.

- **Collaborative efforts have been strengthened** with the Business Community through the Governor's Work First Business Council to find jobs for Work First participants and with the Faith community which provides supportive services such as mentoring and job counseling to help families make the transition from welfare to work.

Program Integrity

- **Enhanced county departments' Program Integrity efforts** with a $2,500,000 appropriation from the Legislature in August 1997. Counties have primarily used the appropriation to hire Program Integrity Investigators. Millions of dollars have been recovered from prior overpayments in Food Stamps and Work First with Tax Intercept projects that have been launched to recover outstanding claims.

Initiatives Related to Child Abuse and Neglect

- The **median length of time children remain in foster care has been reduced** from 522 days to 419 days over the past three years through a series of system reform initiatives (Families for Kids, Child Welfare Waiver Demonstration, Challenge for Children). Likewise, the number of children in the foster care backlog (i.e. in the custody of a county DSS agency for more than one year) has been reduced by 37% in the same period of time.

- The **annual number of foster children who are adopted more than doubled** in recent years to over 600 children during SFY 97-98 through establishing critical partnerships with private adoption agencies, securing important statutory changes, providing additional staff positions to county DSS agencies, and implementing the Special Children's Adoption Fund.

Child Support Enforcement

- **On target to meet the Governor's Collection goal to increase collections by 50% by the year 2000** through the statewide implementation of the Automated Tracking and Collection System (ACTS) and the state directory of New Hires. ACTS streamlines case management and speeds collections to families by supporting a 24-hour turnaround from receipt of payment to distribution to family. The New Hires directory expedites the location of newly employed absent parents because employers report employees to the state directory within 20 days of hiring.

- **Public Awareness Campaign: Fatherhood Initiative:** Partnered with Carolina Panthers to provide young males with positive role models who take parenting seriously. Campaign includes Eric Davis and children in Public Service Announcements on TV and radio, billboards, transit ads and posters.

Adult Day Care

- **Awarded ten Start-Up Grants** in the amount of $35,000 each **to initiate new adult day care programs**, particularly in counties with no adult day care program. County departments of social services in the counties where the new programs were started were provided with an ongoing allocation of funds with which to purchase services on behalf of their clients.

- **Awarded 3 Conversion Grants** in the amount of $25,000 each **to facilitate conversion of existing adult day care programs to adult day health**, resulting in improved capacity to provide health related services under the direction of a Registered Nurse.

Adult Protective Services

- **Translated existing Elder Abuse materials into Spanish** for distribution to county departments of social services with the goal of educating the Hispanic community about laws protecting the elderly and disabled from abuse, neglect, and exploitation.

- Developed a **Domestic Violence Curriculum** and conducted pilot training for adult protective services workers on recognition of signs of domestic violence involving disabled and elderly adults.

- Completed training Adult Services staff in our Division, Adult Protective Services (APS) staff in county DSSs and regional ombudsmen on **materials designed to train "first responders" (i.e., EMS professionals) on recognition of abuse, neglect, or exploitation of elderly and disabled adults**. Materials include booklets, a video, and visor cards that concisely provide legal reporting requirements for first responders to follow when APS referrals are necessary. These individuals will deploy the local network to train first responders in all communities in NC.

Guardianship

- **Outreach to Communities - piloted workshops to familiarize the public with guardianship**, the petitioning process, and the responsibilities of the guardian. Training conducted by Clerks of Superior Court and attorneys, under the initiative and direction of Division of Social Services staff.

- **Produced a user-friendly brochure, "Guardianship of Incompetent Adults in North Carolina,"** for use by communities across the state. The brochure briefly describes the adjudication of incompetence and the appointment of guardianship proceedings. Copies were disseminated to the Administrative Office of the Courts and local human service agencies across the state.

State/County Special Assistance for Adults

- In response to S.L. 1997-443, Section 11.73, the Division of Social Services, in conjunction with the Divisions of Medical Assistance, Facility Services, and Aging, conducted an extensive **study of ways to provide assistance that supports a range of living arrangements for elderly and disabled adults who are eligible for Medicaid or State/County Special Assistance for Adults**. Findings and recommendations with regard to whether changes are needed in the Medicaid or Special Assistance programs to support alternative living arrangements, and the costs associated with these changes, were reported to the General Assembly in June 1998.

VOCATIONAL REHABILITATION

- **VR evaluated and served over 60,000 disabled people** in SFY 97-98. Approximately 25,000 were deemed eligible for services. The average turnaround from point of application to services being ended is approximately 22 months. VR trained every person requesting services this year without having to create a waiting list.

- **8,527 people were trained and placed on a job**. NC ranks about fifth in the nation for placement. Approximately 98% of VR trainees were mainstreamed into the job market and local economy. Less than 1/2 of 1% are in a sheltered workshop. The 8,527 individuals with disabilities who became employed earned a combined total of $9.3 million dollars per month or an average weekly earning of $251.98.

###

HUMAN RESOURCES

DEPARTMENTS/ASSIGNMENTS	ANALYSTS
DEPARTMENT OF HEALTH AND HUMAN SERVICES	
Division of Aging	
Adult Care Homes	Carol Shaw
Long Term Care	
Senior Centers	
Home and Community Based Services	
Division of Child Development	
Smart Start	Mary Ellen Sylvester
Child Care Subsidy	
Division of Mental Health, Developmental Disabilities and Substance Abuse Services	
Court Mandated Programs (Willie M & Thomas S)	Karen Hammonds-Blanks
Carolina Alternatives	
CAP-MR/DD	
State Psychiatric Hospitals	
Area Mental Health Authorities/Programs	
Division of Medical Assistance	
Medicaid	Carol Shaw
Office of Rural Health/Research and Demonstration	
Health Choice	
Children's Health Insurance	
Division of Facility Services	
Medical Care Commission	Carol Shaw
Health Care Facilities Regulation	
Certificate of Need	
Division of Social Services	
Welfare Reform	Karen Hammonds-Blanks
Work First	
Food Stamps	
Social Services Block Grant	
Child Protective Services/Foster Care/Adoptions	
Child Support	
TANF Block Grant	
Division of Vocational Rehabilitation Services	Mary Ellen Sylvester
Division of Services for the Blind	Mary Ellen Sylvester
Division of Services for the Deaf and Hard of Hearing	Mary Ellen Sylvester

Division of Public Health — Ramona Burton

Women's and Children's Health (Immunizations, WIC, Infant Mortality)
Communicable Diseases
Office of Minority Health
Chronic Diseases
Epidemiology
State Laboratory
Office of Chief Medical Examiner
AIDS/HIV, STDs
ADAP

Dr. David Bruton
Mental Health Association of Wayne County
Annual Luncheon
Friday, January 15, 1999

[redacted]ld like to thank the membership of this association for the opportunity to come to Wayne County today to speak for a few minutes on the future of the state's Mental Health delivery system.

It also gave me the opportunity to visit with my friend, Dave Tayloe, Jr., and see the wonderful work they are doing in school health.

My entire discussion today could be distilled down to one simple, yet perplexing question . . . ***Where do we go from here?***

That's what I plan to talk about this afternoon: My vision of where public mental health care should go and how we might get started on that journey in the remaining two years of this administration.

Throughout history, people with mental diseases have perplexed and challenged healers. An early Hindu text from the fifteenth century *B.C.E.* described a man who was *"gluttonous, filthy, walks naked, has lost his memory, and moves about in an uneasy manner."*

There are numerous references in the Bible to conditions we recognize as psychiatric disorders. In ancient Greece, Horace described a man who sat in an empty theater daily, claiming he could hear actors talking on the empty stage and applauding their nonexistent theatrical performances.

A[redacted]k of effective treatment for mental disorders during the Middle Ages created serious problems for [redacted]ing nations. One solution was to gather the disturbed together, put them on sailing vessels that came to be [redacted]d "ships of fools" and sail continuously from port to port.

This strategy helped relieve communities of the problems created by significant numbers of mentally ill individuals. It provided an efficient, and by the standards of the Middle Ages, humane way to manage their behaviors. Later asylums and lunatic hospitals were employed to remove the insane from their communities.

The earliest mental hospital in England – Bethlehem Hospital – gave us the word "bedlam," probably describing the hospital's noisy confusion. The gathering of mentally diseased persons into hospitals provided an opportunity for symptom descriptions, the development of diagnostic categories and experimental treatment.

The first American mental hospital opened in Williamsburg, Virginia, in 1773. By 1848, only North Carolina and Delaware of the original 13 colonies had no state institution for the mentally ill. Most of the 19th century mental institutions were established, in a large part, through the advocacy of one person – Dorothea Dix.

When Miss Dix came to North Carolina, she found more than 1,000 mentally ill people being housed in jails, poorhouses and private homes. She methodically went about the state listing the details and the conditions of individual mentally ill people. She gathered the information into a "memorial" which she presented to the legislature.

It was a compelling document.

[redacted]mphasized that it was important to remove the insane from jails for their own benefit and that of other [redacted]es. She pointed out the economies other states had realized through moderate employment and moderate exercise, and gave details of needed buildings and equipment.

A mental hospital bill passed the legislature. However, the bill required $100,000 for construction and operation at a time when the entire state budget, outside of education funding, was only $200,000. The legislature passed the bill but the appropriation failed on several different votes. It could never get out of committee.

She was having no luck with the North Carolina legislature until an unfortunate series of life events intervened.

Mr. James C. Dobbin of Fayetteville was one of the most powerful members of the General Assembly. He was an opponent of the hospital appropriation. He and his wife, Louisa, were staying in the same hotel as Miss Dix. The two women got to know each other and became friends. It soon became clear that Louisa Dobbin was very ill and Miss Dix, a nurse, voluntarily looked after the dying woman.

Before she died, Mrs. Dobbin asked Miss Dix what she could do to thank her. Dorothea told her to ask Mr. Dobbin to support the hospital bill. Mr. Dobbin acceded to his wife's deathbed request. The day after her funeral in Fayetteville, he returned to Raleigh and addressed his colleagues in the General Assembly.

In what the *Raleigh Register* called, *"one of the most touchingly beautiful efforts we have ever heard. It's noble and eloquent conception, impressive delivery, and the circumstances which prompted and attended it – all combined to render it truly worthy of the occasion."*

His eloquence resulted in the passage of the Hospital bill. In the committee where it had failed repeatedly, the vote was 14 to 1.

The first legislative appropriation for the hospital came in 1849 and construction began in May, 1850. The first unit erected to accommodate 40 patients opened on February 1, 1856. The first patient was admitted on February 23, 1856 – We have a special provision in 1998 to design a new Dix Hospital (142 years).

The asylum movement represented a dramatic change in the care of persons with mental disease in our state. Dorothea Dix Hospital moved the mentally ill out of jails and private homes into a facility where they could be cared for – and on occasion rehabilitated. For almost the next 100 years, psychiatric hospitalization was the best alternative we had to deal with severe and persistent mental illness.

It was a great improvement from being jailed with common criminals – oft chained to the walls while criminals could move around within the cell. It was only with the advent of effective antipsychotic drugs in the 1950s that the possibility for more dramatic change was created. Treatments that could make a substantial difference in patients suffering from the serious mental illness became available.

In 1950, The Mental Health Association was formed out of the National Committee for Mental Hygiene, formed by Clifford Beers in 1909, the National Mental Health Foundation and the Psychiatric Foundation. This created a united consumer and advocacy organization that would play a significant role in creating a community-based system of care. President John Kennedy in 1963 articulated the vision of community-based care.

Community-based care set the stage for the transition of large numbers of persons from mental institutions back to their communities and families. In 1970, North Carolina established 41 Area Mental Health Authorities for the purpose of providing community-based services. We reduced by approximately two-thirds the number of residents in its four hospitals from an average daily enrollment of 4,841 in 1975 to 1,865 today.

Both the asylum movement and the community care movement were great steps forward. But there were downsides to both of these progressive movements. The asylum movement carried with it the potential for patients being neglectfully warehoused – out of sight and out of mind.

[redacted]ave recently restored the inmate cemetery at Dix Hospital where the remains of Dix patients were interred from 1856 through 1973. These were patients who came to Dix, lived out their lives on her wards and died – no longer admitted members of a family or a community.

Deinstitutionalization has had the unforeseen result of many mental patients being literally abandoned on the streets, or thrust back on their families or communities ill prepared to care for them. In some cases, this generation of patients found themselves placed in the very jails that Dorothea Dix deplored – and helped move them out of more than 100 years ago!

North Carolina's leaders have finally come to understand that our mental health system is once again at a crossroads.

It is facing major problems generated by a combination of the dramatic changes in the economics of health care delivery, the unique evolutionary history of the North Carolina system of behavioral health care, and, most important, the massive disconnect between the resources ***needed*** for mental health care and the resources ***available*** to provide that care.

In view of these circumstances, the North Carolina General Assembly has funded comprehensive studies of our mental health system. Last year we had a study of our psychiatric hospitals. Now we are engaged in extensive studies of the rest of the system. We may be guilty of overstudying the system!

[redacted] Carolina is not alone in dealing with the changes in healthcare, the challenges of managed care and [redacted]ges in Medicaid and Medicare. Most states are in a time of uncertainty and turmoil in the delivery of mental health and disability care.

In some states changes have resulted in disastrous consequences. Disrupting the care of hundreds of thousands of vulnerable people. Fortunately, North Carolina still has the opportunity to avoid such major disruptions in care and to use the present crisis atmosphere to make major improvements in our systems of care.

The greatest problem confronting the mental health system today is the lack of adequate resources to provide care for the large numbers of unserved and underserved seriously disabled persons in our communities. Of the more than 84,000 persons with serious mental illness needing services from our community based public system, more than 50,000 are unserved.

As many as 7,000 of the unserved are estimated to be homeless – another 6,000 are believed to be in jail on any given day – while the remaining are living with aging parents generally unable to be effective caregivers.

Of the 31,000 seriously mentally ill persons currently being served by Area Mental Health Programs, more than a third are still in need of residential, vocational and psycho-social services for which resources are not available.

Approximately 40,000 children with serious emotional problems receive outpatient therapy from the public m[redacted]l health system. Only 4 percent of these children receive the residential and day treatment services they [redacted] The deficit in services for adults and children with serious mental disorders has been estimated to exceed $[redacted] million each.

While new resources are urgently needed, I don't see the political "will" to get this job done. Modest financial growth over time is probably the best we can hope for. This means that until a public consensus develops to provide the resources, we've got to spend the limited resources we have well and wisely.

During this decade, Area Programs were encouraged to maximize Medicaid funding in order to address service deficits. As a result they became increasingly dependent on Medicaid as a funding source for services. That was the right thing to do and we are wrong today in our restrictions on the use of federal funds. We should use as many 36 cent dollars as possible.

The rapid growth of Medicaid in Area Program budgets from 4.7 percent in 1990 to more than 35 percent in 1998 has been accompanied by a variety of Medicaid match, rate setting, documentation and compliance problems. These problems have resulted recently in some area programs being forced into making major paybacks to Medicaid. We have several multimillion-dollar federal paybacks pending.

The services Area Programs provided with these Medicaid funds were provided in good faith but, upon review, the Feds disallowed payments for many of these services.

We have made great progress over the past year in addressing our Medicaid management issues, but there are more comprehensive management issues that must be addressed. It has become clear to health care policy makers that efficient care in today's environment requires economies of scale and sophisticated infrastructure that are not likely to be achieved by the community agencies designed more than 25 years ago.

North Carolina is at a crossroads with regard to the future of the public system in the era of managed care. Since 1994, a mental health and substance abuse managed care pilot in 10 area programs called Carolina Alternatives has reshaped services for Medicaid eligible children. But plans to expand statewide for children and adults have been delayed due to questions about the system's ability to do managed care effectively. HCFA requires a showing that capitated care does not cost ***more*** than fee-for-service

The health care and Medicaid landscape has changed so much since Carolina Alternatives began that it has become necessary to step back and re-evaluate the direction of mental health and substance abuse Medicaid services before proceeding with expansion. My fear is that we will become entrapped into a capitation rate far short of what's required for adequate care.

This re-examination is now underway in the Department with the assistance of nationally recognized consultants.

The General Assembly has authorized the planning for a new facility at Dorothea Dix and appropriated $750,000 for the State Auditor to contract for a study of the area programs and the mental health system.

This study builds upon an efficiency study of the four psychiatric hospitals last year that recommended further downsizing of the hospitals, newly designed facilities and shifting substance abuse treatment, geriatric nursing care, and children's services to communities. We must not repeat the mistakes of the past. With deinstitutionalization we promised but did not deliver, the resources necessary to build community capacity.

The hospital study projected a potential for multi-million dollars in savings that could be directed toward improved community care. The new study will focus on the area programs, their structure and capacity to meet the challenges. It will also look at the Division's and Department's operations.

One of the things the new study will examine is the current configuration of area authorities. There are currently 40 area mental health programs – 17 are single county programs serving populations that range from 58,000 to 600,000. The rest are multi-county that range from three to seven counties.

[redacted] people believe that there need to be fewer area programs with catchment areas that lend themselves to more efficient operation. Another issue to be examined is the fact that area programs vary in quality and ability to respond to client needs throughout the state. County participation in funding is uneven ranging from 84 cents per capita to $43.60. This session of the legislature will see a major effort by the county commissioners association to repeal the current maintenance-of-effort clause requiring their support of area mental health authorities

Historically uneven state and federal funding has also led to uneven resources and care. Per capita funding of state and Federal funds range from $20 to $42. If the goal is to assure that mentally disabled persons seeking services will have equal access to quality care wherever they live in North Carolina it is obvious that some major changes are needed.

It is clear that the future of the public mental health system in North Carolina is being questioned and examined. Major changes in structure and financial management are likely to occur as a result of these efforts. Such changes will bring with them new risks for citizens with mental illness. It is therefore critical at this juncture to identify those things in the current system worth saving and what's ready for the scrap heap.

The most important thing worth saving is the *safety net* of care.
It is imperative that any proposed changes to the system do not diminish the very real gains that have been made for clients over the past quarter century. This means preserving the public nature of our system however we choose to reconfigure and reform it.

[redacted] must also preserve the clinical expertise that has been developed in the public system to serve the more complicated and difficult clients. Many are long-term clients that require a lifetime of supports to ensure basic dignity and quality of life. These conditions require an expertise that has been gained through research and experience in the public system.

North Carolina has also developed services that are reasonably close to home for consumers. While there is significant geographical unevenness of service availability, there are basic services available in every North Carolina county. This geographical distribution of core services must be preserved. Consumers should not have to arrange transportation for substantial distances to receive these vital services.

We must also strengthen and improve the responsiveness to consumers and families that has characterized the public system in North Carolina. The private HMO world is notorious for the lack of the ability of consumers and family members to influence care decisions. They provide a form of rationing of care that we do not need.

There are also some things that are ***not*** worth saving. Among these are our complicated and confusing funding system, the current inefficient configuration of area mental health programs, our structural separation of hospital and community care, our current unevenness in resources and quality of care, and the traditional incentives to use high-end services inappropriately.

There are also a number of "holes" in our safety net that need fixing – such as waiting lists for services, and our [redacted]ity to assure treatment follow up and compliance for high-risk clients released from our hospitals and drug [redacted]ment centers.

As North Carolina moves toward the next century, it is important to identify the strengths in our mental health system, to build upon them, and to clarify a vision for the future. That vision must include the ability to assure: *a[redacted]*, ***quality***, and ***fiscal integrity***.

[redacted]ivision of Mental Health has instituted a quality and accountability initiative to assure that community program are providing quality services that are consumer and family friendly.

This initiative includes accreditation reviews, consumer satisfaction and outcome data collection, and assistance with achieving best professional practice. As the current healthcare environment continues to change, this quality initiative will provide the absolutely essential basis to assure that policy and funding decisions are correct.

The Division has contracted with a national accrediting agency, The Council on Accreditation, to assist it with this vital task.

The Division of Mental Health is currently focusing attention on the development of a new business model for the purchasing of mental health services. This model will emphasize the "purchaser" role of the division implemented through performance contracts with area providers.

This business model will assure that the state's responsibility for the long term seriously mentally ill population is given priority in the use of limited resources.

Twice before in the history of North Carolina we have made dramatic changes in our mental health system.

T[redacted]irst was in the last century when Dorothea Dix convinced the General Assembly to establish the first [redacted]n.

The second was in the late 1960s when the state, in keeping with a national initiative, began to develop the community mental health system. Such times of change present great risks and great opportunities.

The important challenge for us today is to assure that during this present time of examination and change that we will be wise enough to preserve the things worth keeping and to change those things necessary to assure a better system of care in the next century.

[redacted]

Study	Origin Bill/Section	Task	Study to Whom	Due Date	Study Responsible Division/Staff/ Update
Study of Provider Reimbursement Rates/Report-Final	SB 352/11.7	Contract with an independent consultant to develop an evaluation design (including an assessment of the impact of the Program on the economic security and health of children and their families). The Department is to report on the results of this evaluation.	Approp. Subcomm./ FRD	2/1/99	The study has been completed by a consultant. Comments are in the process of being reviewed and incorporated. The report will be provided by March 1, 1999.
Study the Advisability of Creating an Office of Strategic Planning in the Office of the Secretary of Health and Human Services	SB1366/12.2	Conduct study and report findings and recommendations, which shall include the advantages and disadvantages, of creating an Office of Strategic Planning in the Office of the Secretary and projected costs of implementation.	H&S Appropr/HR	3/15/99	Internal study has been conducted to identify staff and planning procedures within the divisions. We are in the process of securing an outside contractor to complete study. The study will not be complete by the due date and a request to extend until June 15, 1999 has been made.
Study existing laws and propose changes that will improve dental treatment for Medicaid recipients and other patients	SB1366/12.12C	Review laws and rules. In consultation with NC Dental Society, propose recommended changes to improve the opportunity for quality dental treatment for Medicaid and other patients.	H&S Approp/HR	4/30/99	The study is being conducted by the Institute of Medicine in conjunction with Lt. Gov. Wicker's office.
Improve Quality of Academic Programs at Residential Schools - Collaborative Effort to Improve Quality of Academic Programs At Residential Schools/Program Review of Disability Services and conduct a compressive review of policies, programs and services managed by the DVR, DSB and DHH and recommend organizational changes to improve the department's effectiveness in serving citizens with disabilities.	SB1366/12.3C(a) and (b)	Conduct a study to identify and evaluate ways to improve services and cost-effectiveness of residential schools to persons with disabilities. The study will assess changes in structure and functions of selected DHHS divisions and residential schools, assess the organizational context for ABC's , examine ways to improve services to disabled persons and define organizational options.	Approp Sub-Com on Education & H&S Approp/HR	4/15/99	DHHS has contracted with PricewaterhouseCoopers (PwC) to conduct the Education and Disability Organizational Study. An advisory group has been named consisting of representatives of statutory defined groups such as the NC Council for the Deaf and Hard of Hearing, Commission for the Blind, Chair of the VR Council, The Mental Health Study Commission, division staff and interested persons. There have been three meetings that included overall project design, report of peer organizations, and preliminary findings, etc. A final meeting is scheduled for March 5 with the contractor and final recommendations regarding organizational options for consolidation will be presented.

	Origin Bill/Section	Task	Study to Whom	Due Date	Study Responsible Division/Staff/ Update
Licensed Child Placing Agencies Rate Study	SB1366/12.29A	Contract with an independent consultant to study the rate setting; review the agencies current rate-setting process; determine if current process results in adequate reimbursement; department to report results of study to gather with any recommendations.	H&S Approp/HR	5/15/99	DSS Staff has been working with the Controller's Office on this study. The independent consultant has been selected. The study is anticipated to be completed by the reporting date.
Dorothea Dix Hospital Redesign	SB 1366/29.5B	- hire planning and design contractor - study cost of construction and operation of new as compared to re-design and long term operation of existing psych hospitals - work in conjunction with Study of PsychHosp/Area Prog. -	H&S Approp Comm/HR	5/1/99	Designer has been selected and study is underway.

Study	Origin Bill/Section	Task	Study to Whom	Due Date	Study Responsible Division/Staff/ Update
Studies done by non-DHHS agencies on DHHS programs or related services.					
Study need to increase Medicaid reimbursement rates for physicians	SB1366/12.13	Provide data as requested.	General Assembly	1999 Session	Joint Leg Comm on Health Care Over.
Early Intervention Services/Referral/Study	SB1366/12.32A	- conduct study/review of NC system of delivering early intervention services to children birth - 5 yrs old in areas such as eligibility, quality, availability and timeliness - study the transition from infant-toddler to pre-school - manage and focus on pre-school services to children with vision and hearing impairment - study/review inter-agency coordination and funding	H&S Appropr/HR, FRD & Ed Oversight	3/1/99	Interagency Coordinating Council
Study of Psychiatric Hospitals/Area Mental Health Programs.	SB1366/12.35A	Requires collaboration and consultation with the Department. - Area pgm progress rpt ; current operations/admin policies procedures/ funding streams.	HHS Approp. Comm.	Interim 3/15/99 5/1/99 11/1/99 12/1/99 Final 4/1/00	State Auditor
State Veterans Nursing Home Study	SB1366/25.1	OSBM report but required to consult with DHHS.		April 1, 1999	OSBM

Study	Origin Bill/Section	Task	Study to Whom	Due Date	Study Responsible Division/Staff/ Update
Reports involving DYS					
Study the funding process for juvenile delinquency and substance abuse prevention programs provided for in the Act	SB1260/Sec. 31	To be determined by the Office of Juvenile Justice.	FRD & H&S Approp/HS & H&S/Approp	5/1/99	Office of Juvenile Justice & DHHS
Study over-representation of racial minorities in juvenile justice system	SB1260/Sec. 33	To be determined by the Office of Juvenile Justice.	Governor, Chief Justice and General Assembly	5/1/99	Office of Juvenile Justice
Study the use of detention facilities and make recommendations as to how detention facilities could be utilized more efficiently	SB1260/Sec. 34	To be determined by the Office of Juvenile Justice.	FRD & H&S Approp	5/1/99 & 1/15/2001	Office of Juvenile Justice
Study blended sentencing and direct filing of certain juvenile cases	SB1260/Sec. 30	To be determined by the Office of Juvenile Justice and NC Sentencing and Policy Advisory Commission.		3/15/00	Office of Juvenile Justice and NC Sentencing and Policy Advisory Comm.
Study the need for one or more residential treatment centers for youth with crimes containing and element sexual conduct	SB1366/8.1 (g)	To be determined by the Office of Juvenile Justice.	H&S Approp	4/1/99	Governor's Office & Office of Juvenile Justice

JOINT SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS REPORTING REQUIREMENTS

1997 SESSION, SENATE BILL 352

Section	Page	Topic	Committee	Due Date
11.7	Pg. 100	DHR Study of Provider Reimbursement Rates	Appropriations	2/1/99
15.22 (b)	Pg. 304	Communicable Disease Control Aid to Counties Flexibility	Joint Legislative Commission on Governmental Operations	Annually
15.25 (1)	Pg. 305	Heart Disease and Stroke Prevention Task Force Report	Governor, General Assembly	within 1st week of convening of the GA, 6/30/99
15.28	Pgs. 306-307	Adolescent Pregnancy Prevention Coalition of NC Report/Financial Statement	Joint Legislative Commission on Governmental Operations, FRD/FRD	1/15/99, within 30 days of issuance of statement
15.32 (l)	Pgs. 313-315	Osteoporosis Task Force Report	General Assembly, Governor, FRD	10/1/99

1998 SESSION, SENATE BILL 1366

PART V. BLOCK GRANTS

5. (b)	Pg.11	Decreases in Federal Fund Availability (SSBG)	Appropriations	4/1/99
5. (f)	Pg. 13	Work First Evaluation (Governor's Waiver Program)	Appropriations	3/1/99

5. (f)	Pg. 14	Work First Evaluation Plan and Design	Appropriations	4/1/99
5. (g)	Pg. 14	Substance Abuse Program Plan for Families	Appropriations	4/1/99
5. (h)	Pg. 14	WF Job Retention Pilots	Appropriations	4/1/99
5. (k)	Pg. 15	Cost-Effectiveness in Adoption Agencies	Appropriations	5/1/99
5. (p)	Pg. 16	Enhanced Employee Assistance Program	Appropriations, FRD	4/1/99

PART XII. DEPARTMENT OF HEALTH AND HUMAN SERVICES

12.	Pg. 72	Standards for Health Care Quality	General Assembly	5/1/99
12.2	Pg. 73	Office of Strategic Planning	Appropriations	3/15/99
12.3C (a)	Pg. 75	Collaborative Effort to Improve Quality of Academic Programs At Residential Schools	Joint Legislative Educ. Oversight Appropriations, FRD	4/1/99
12.3C (b)	Pg. 76	Comprehensive Review of VR/DDHH/DSB & Recommendations	Joint Legislative Educ. Oversight Appropriations, FRD	4/1/99
12.5 (e)	Pg. 77	Medicaid Growth Reduction	Appropriations	2/1/99
12.7 (b)	Pg. 78	Continuous Medicaid Coverage For Categorically Needy Families With Children	Appropriations	interim report 10/1/99 final report 1/1/2000

12.12 (a)	Pg. 79	Child Health Insurance Study (DHHS Savings Resulting Due to CHIP)	Appropriations	3/1/99
12.12 (b)	Pg. 79	Child Health Insurance Study (State Savings Report)	Appropriations	3/1/99
12.12B (o)	Pg. 85	Budget Medicaid Program by Administration	FRD, Appropriations	@ time of request for funds
12.12B (u)	Pg.85	Medicaid/Report on Changes or Waivers	FRD, Appropriations	prior to effective date
12.12B (v)	Pg. 86	Medicaid Long Term Care Waiver and Pilots	Appropriations, Study Commission on Aging	30 days of receiving waiver
12.12C	Pg. 87	Participation in Medicaid Dental Program	Appropriations	4/30/99
12.12C	Pg. 87	Participation in Medicaid Dental Program (study results)	Appropriations	4/30/99
12.25	Pg. 99	Report on Progress Towards Automated Application System	Appropriations	within 1st week of the convening of the GA
12.26A (b)	Pg. 100	Biometrics Law Changes (Progress on Implementation)	Joint Legislative Public Assistance Commission	quarterly
12.26A (d)	Pg.100	Biometrics Law Changes	Joint Legislative Public Assistance Commission	when needed
12.27A (a)	Pg.101	Welfare Law Changes (Final State Plan)	Appropriations	1/1/99

12.27A (b)	Pgs.101-102	Welfare Law Changes (Proposed State Plan)	Director of the Budget and the Joint Legislative Public Assistance Comm.	biennially
12.27A (g)	Pgs. 104-105	Welfare Law Changes (General Duties of the Dept.) Progress Reports (8), (10)		
12.27A (k)	Pg. 107	Welfare Law Changes (Projected Expenditures for WFFA)	Director of the Budget, FRD	15th of each month
12.27A (b)	Pg.108	Welfare Law Changes (Use of Work First Reserve Fund)	Joint Legislative Comm. on Governmental Operations, Joint Legislative Public Assistance Commission	prior to transfer
12.27A (q)	Pgs. 110-111	Welfare Law Changes (Recommendations for Improving First Stop Employment Assistance)	Joint Legislative Public Assistance Commission	end of each calendar year
12.27A (r)	Pg. 111	Welfare Law Changes (Study on the Working Poor- NC WORKS)	Joint Legislative Public Assistance Commission, Appropriations	May 1st of each year
12.27A (s)	Pg. 112	Welfare Law Changes (First Stop Employment Assistance) (r1), (r4)	(r1) Appropriations, Joint Legislative Public Assistance Committee, FRD, (r4) General Assembly	(r1) quarterly, (r4) prior to to US Dept. of Labor
12.29A	Pg. 113	Child Placing Agencies' Rate Study	Appropriations	5/15/99
12.29D (c)	Pg. 114	Child Welfare System Pilots	Appropriations	4/1/99
12.30	Pg. 115	Thomas S. Containment Report Extension	Appropriations, FRD	5/1/99

12.32A	Pg.116	Early Intervention Services Study	Appropriations, Education Oversight Committee, FRD	3/1/99
12.34	Pg. 118	Funds to Reduce Waiting List for Services for Developmentally Disabled	Appropriations	5/1/99
12.35A (b)	Pg. 119	Study of State Psychiatric Hospitals/Area Mental Health Programs	Appropriations	interim report 3/15/99
12.35C (f)	Pg. 121	Area Mental Health Authority Accountability	Legislative Study Commission on MH/DD/SAS, Joint Legislative Health Care Oversight Committee	3/1/99
12.35D	Pg. 122	Agency Oversight of Care Provided to Persons With Mental Illness and Developmental Disabilities	Legislative Study Commission On MH/DD/SAS, Joint Legislative Health Care Oversight Committee	4/1/99
12.35G	Pg. 122	Substance Abuse Grant-In-Aid (Day-by-Day, Inc.)	Appropriations	3/1/99
12.37B	Pg. 128	Smart Start Needs & Resources Assessment	General Assembly	4/1/99
12.37B	Pg. 138	Smart Start Regionalization Plan	Appropriations, FRD	4/15/99
12.39	Pg. 139	Funding for Special Education Services in Training Schools	Appropriations, FRD	11/30/98
12.40	Pgs. 139-140	NC Healthy Start Foundation Report/ Financial Statement	Appropriations, FRD/ FRD	4/15/99, within 30 days of issuance of Statement

12.41	Pg. 140	Prevent Blindness, Inc. Report/ Financial Statement	Appropriations, FRD/ FRD	4/15/99, within 30 days of issuance of statement
12.43 (d)	Pg. 142	Healthy Mothers/ Healthy Children Pilot Program	Appropriations	4/1/99
12.44	Pg. 143	Child Fatality Task Force	Governor, General Assembly	within 1st week of the convening of the GA
12.45 (b)	Pg. 144	Maternal Outreach	Appropriations, FRD	2/1/99
12.46A (b) (d)	Pg. 144	AIDS Drug Assistance Program (ADAP)	Appropriations	3/15/99
12.51	Pg. 147	HIV/STD Prevention Services/Evaluation and Accountability of Grantees	Appropriations	5/1/99
12.52 (a)(b)	Pgs. 147-148	Improve Immunization Program Accountability	Appropriations	4/1/99
29.5 (b)	Pg. 304	Funds for Dorothea Dix Hospital Design	Appropriations	5/1/99
29.5C	Pg. 305	Whitaker School Planning Funds	Appropriations	5/1/99

JOINT SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS REPORTING REQUIREMENTS

1997 SESSION, SENATE BILL 352

Section	Page	Topic	Committee	Due Date
11.7	Pg. 100	DHR Study of Provider Reimbursement Rates	Appropriations	2/1/99
15.22 (b)	Pg. 304	Communicable Disease Control Aid to Counties Flexibility	Joint Legislative Commission on Governmental Operations	Annually
15.25 (1)	Pg. 305	Heart Disease and Stroke Prevention Task Force Report	Governor, General Assembly	within 1st week of convening of the GA, 6/30/99
15.28	Pgs. 306-307	Adolescent Pregnancy Prevention Coalition of NC Report/Financial Statement	Joint Legislative Commission on Governmental Operations, FRD/FRD	1/15/99, within 30 days of issuance of statement
15.32 (l)	Pgs. 313-315	Osteoporosis Task Force Report	General Assembly, Governor, FRD	10/1/99

1998 SESSION, SENATE BILL 1366

PART V. BLOCK GRANTS

5. (b)	Pg.11	Decreases in Federal Fund Availability (SSBG)	Appropriations	4/1/99
5. (f)	Pg. 13	Work First Evaluation (Governor's Waiver Program)	Appropriations	3/1/99

5. (f)	Pg. 14	Work First Evaluation Plan and Design	Appropriations	4/1/99
5. (g)	Pg. 14	Substance Abuse Program Plan for Families	Appropriations	4/1/99
5. (h)	Pg. 14	WF Job Retention Pilots	Appropriations	4/1/99
5. (k)	Pg. 15	Cost-Effectiveness in Adoption Agencies	Appropriations	5/1/99
5. (p)	Pg. 16	Enhanced Employee Assistance Program	Appropriations, FRD	4/1/99

PART XII. DEPARTMENT OF HEALTH AND HUMAN SERVICES

12.	Pg. 72	Standards for Health Care Quality	General Assembly	5/1/99
12.2	Pg. 73	Office of Strategic Planning	Appropriations	3/15/99
12.3C (a)	Pg. 75	Collaborative Effort to Improve Quality of Academic Programs At Residential Schools	Joint Legislative Educ. Oversight Appropriations, FRD	4/1/99
12.3C (b)	Pg. 76	Comprehensive Review of VR/DDHH/DSB & Recommendations	Joint Legislative Educ. Oversight Appropriations, FRD	4/1/99
12.5 (e)	Pg. 77	Medicaid Growth Reduction	Appropriations	2/1/99
12.7 (b)	Pg. 78	Continuous Medicaid Coverage For Categorically Needy Families With Children	Appropriations	interim report 10/1/99 final report 1/1/2000

12.12 (a)	Pg. 79	Child Health Insurance Study (DHHS Savings Resulting Due to CHIP)	Appropriations	3/1/99
12.12 (b)	Pg. 79	Child Health Insurance Study (State Savings Report)	Appropriations	3/1/99
12.12B (o)	Pg. 85	Budget Medicaid Program by Administration	FRD, Appropriations	@ time of request for funds
12.12B (u)	Pg.85	Medicaid/Report on Changes or Waivers	FRD, Appropriations	prior to effective date
12.12B (v)	Pg. 86	Medicaid Long Term Care Waiver and Pilots	Appropriations, Study Commission on Aging	30 days of receiving waiver
12.12C	Pg. 87	Participation in Medicaid Dental Program	Appropriations	4/30/99
12.12C	Pg. 87	Participation in Medicaid Dental Program (study results)	Appropriations	4/30/99
12.25	Pg. 99	Report on Progress Towards Automated Application System	Appropriations	within 1st week of the convening of the GA
12.26A (b)	Pg. 100	Biometrics Law Changes (Progress on Implementation)	Joint Legislative Public Assistance Commission	quarterly
12.26A (d)	Pg.100	Biometrics Law Changes	Joint Legislative Public Assistance Commission	when needed
12.27A (a)	Pg.101	Welfare Law Changes (Final State Plan)	Appropriations	1/1/99

12.27A (b)	Pgs.101-102	Welfare Law Changes (Proposed State Plan)	Director of the Budget and the Joint Legislative Public Assistance Comm.	biennially
12.27A (g)	Pgs. 104-105	Welfare Law Changes (General Duties of the Dept.) Progress Reports (8), (10)		
12.27A (k)	Pg. 107	Welfare Law Changes (Projected Expenditures for WFFA)	Director of the Budget, FRD	15th of each month
12.27A (b)	Pg.108	Welfare Law Changes (Use of Work First Reserve Fund)	Joint Legislative Comm. on Governmental Operations, Joint Legislative Public Assistance Commission	prior to transfer
12.27A (q)	Pgs. 110-111	Welfare Law Changes (Recommendations for Improving First Stop Employment Assistance)	Joint Legislative Public Assistance Commission	end of each calendar year
12.27A (r)	Pg. 111	Welfare Law Changes (Study on the Working Poor- NC WORKS)	Joint Legislative Public Assistance Commission, Appropriations	May 1st of each year
12.27A (s)	Pg. 112	Welfare Law Changes (First Stop Employment Assistance) (r1), (r4)	(r1) Appropriations, Joint Legislative Public Assistance Committee, FRD, (r4) General Assembly	(r1) quarterly, (r4) prior to to US Dept. of Labor
12.29A	Pg. 113	Child Placing Agencies' Rate Study	Appropriations	5/15/99
12.29D (c)	Pg. 114	Child Welfare System Pilots	Appropriations	4/1/99
12.30	Pg. 115	Thomas S. Containment Report Extension	Appropriations, FRD	5/1/99

12.32A	Pg.116	Early Intervention Services Study	Appropriations, Education Oversight Committee, FRD	3/1/99
12.34	Pg. 118	Funds to Reduce Waiting List for Services for Developmentally Disabled	Appropriations	5/1/99
12.35A (b)	Pg. 119	Study of State Psychiatric Hospitals/Area Mental Health Programs	Appropriations	interim report 3/15/99
12.35C (f)	Pg. 121	Area Mental Health Authority Accountability	Legislative Study Commission on MH/DD/SAS, Joint Legislative Health Care Oversight Committee	3/1/99
12.35D	Pg. 122	Agency Oversight of Care Provided to Persons With Mental Illness and Developmental Disabilities	Legislative Study Commission On MH/DD/SAS, Joint Legislative Health Care Oversight Committee	4/1/99
12.35G	Pg. 122	Substance Abuse Grant-In-Aid (Day-by-Day, Inc.)	Appropriations	3/1/99
12.37B	Pg. 128	Smart Start Needs & Resources Assessment	General Assembly	4/1/99
12.37B	Pg. 138	Smart Start Regionalization Plan	Appropriations, FRD	4/15/99
12.39	Pg. 139	Funding for Special Education Services in Training Schools	Appropriations, FRD	11/30/98
12.40	Pgs. 139-140	NC Healthy Start Foundation Report/ Financial Statement	Appropriations, FRD/ FRD	4/15/99, within 30 days of issuance of Statement

12.41	Pg. 140	Prevent Blindness, Inc. Report/ Financial Statement	Appropriations, FRD/ FRD	4/15/99, within 30 days of issuance of statement
12.43 (d)	Pg. 142	Healthy Mothers/ Healthy Children Pilot Program	Appropriations	4/1/99
12.44	Pg. 143	Child Fatality Task Force	Governor, General Assembly	within 1st week of the convening of the GA
12.45 (b)	Pg. 144	Maternal Outreach	Appropriations, FRD	2/1/99
12.46A (b) (d)	Pg. 144	AIDS Drug Assistance Program (ADAP)	Appropriations	3/15/99
12.51	Pg. 147	HIV/STD Prevention Services/Evaluation and Accountability of Grantees	Appropriations	5/1/99
12.52 (a)(b)	Pgs. 147-148	Improve Immunization Program Accountability	Appropriations	4/1/99
29.5 (b)	Pg. 304	Funds for Dorothea Dix Hospital Design	Appropriations	5/1/99
29.5C	Pg. 305	Whitaker School Planning Funds	Appropriations	5/1/99

LEGISLATIVE HIGHLIGHTS

1997 GENERAL ASSEMBLY

Presented by:
FISCAL RESEARCH DIVISION
February 24, 1999

PAST TWO BIENNIA

SUMMARY

FUNDING

- DHHS's Share of Total Budget Reductions (30% to 46%) Has Been Disproportionate to
  - -- Its Share of NC's General Fund Budget (23%)
  - -- Its Share of Total Expansion Funding (8% to 14%)

- Budget Reductions Have Been Departmentwide; However,
  - -- Significant Expansion Increases Have Been Limited to a Few, High Priority Programs
  - -- Only a Small Percentage of Funds Has Been Appropriated for Services Provided Directly by the Department

POSITIONS

- Eliminated Approximately 313 Positions in 1996, Many in Institutions

- Subsequent Increases Have Been in Targeted Areas

1997 GENERAL ASSEMBLY
AGING

HOME AND COMMUNITY BASED SERVICES

- Increased funding for Home and Community Based Services by $13 million during the 1997-99 biennium.
- Provided funding to start new Adult Day Care Programs and provide additional support for existing programs.

SENIOR CENTERS

- Provided $4.5 million for the development and operation of Senior Centers.

ADULT CARE HOME IMPROVEMENTS

- Required adult care homes to increase staff on the third shift from 1 per 50 residents to 1 per 30 residents.

1997 GENERAL ASSEMBLY
HEALTH CARE

MEDICAID EXPANSION

- Expanded Medicaid eligibility to elderly and disabled persons with incomes at or below 100% of the Federal Poverty Level.
    -- Effective January 1, 1999.
    -- Annual state cost is $65 million.

HEALTH INSURANCE FOR CHILDREN

- Authorized a new health insurance program for children -- North Carolina Health Choice
    -- Effective October 1, 1998.
    -- Serves children ages birth to 18 in families with incomes at or below 200% of the federal poverty level. ($32,900 for family of 4)
    -- Expected to serve over 60,000 uninsured children.
    -- Benefit package is based on the State Employees Health Plan and also includes optical, dental and hearing aids
    -- Annual state cost is $27 million. Rolls down 2 $80M in fed $ $

1997 GENERAL ASSEMBLY

SOCIAL SERVICES

CHILD WELFARE SYSTEM IMPROVEMENTS

- Increased Child Welfare Positions at Local Departments of Social Services in Adoptions, Foster Care and Child Protective Services ($2.3M)
- Created a State Child Fatality Review Team
- Mandated Pre- and Post-service Training for Child Welfare Workers
- Mandated Criminal Background Checks for Prospective Adoptive Parents

WELFARE REFORM

1997 Highlights

- Replaced AFDC with Work First Program
- Created Standard and Electing Counties
- Created First Stop Employment Services
- Created Work First Reserve
- Mandated Biometrics Recipient Identification System Implementation
- Mandated Monitoring of Child Well Being under Welfare Reform

1998 Highlights

- Approved Work First State Plan
- Selected 21 Counties to Operate as Electing Counties
- Expanded Work First Support Services to Recipients/Former Recipients with Incomes up to 150% FPL

1997 GENERAL ASSEMBLY

MENTAL HEALTH

STATE LEVEL SERVICES

- Mandated Efficiency Study of State Psychiatric Hospitals
- Created 72-bed Forensic Unit at Dorothea Dix Hospital ($1.1M FY97/98 and $2.5M FY98/99)
- Appropriated Funds for Planning & Design of Replacement Facility for Dorothea Dix Hospital ($2M)
- Mandated Continuation of 1997 Study of Psychiatric Hospitals

COMMUNITY MENTAL HEALTH/AREA PROGRAM SERVICES

- Provided $6M in Expansion Funding
- Provided Funding for Early Intervention Services ($2.7M FY97/98 and $5M FY98/99)
- Dissolved & Realigned Tri-County Mental Health Center ($1.45M FY97/98 and $1.2M FY98/99)
- Expanded Funding for Individuals on Waiting List for Developmental Disabilities Services ($12M FY98/99)
- Mandated Study of Area Program System ($750K FY98/99)
- Created Medicaid Match Reserve for Area Programs ($38M FY98/99)

1997 GENERAL ASSEMBLY
CHILD CARE

CHILD CARE SUBSIDIES

- Increased TANF Block Grant Funding for Subsidies by $61 million in 1998-99

SMART START

- Expanded Smart Start Services to all 100 Counties

	1997-98	1998-99
1997 Session:	$22.3 million	$25.3 million
1998 Session		$42.5 million
Total		$67.8 million

- Directed Substantive Policy Changes:
  - -- Strengthened authority of NC Partnership to approve local partnerships' plans, monitor their contracts, and implement sanctions in the event of poor performance
  - -- Reduced NC Partnership Board from 38 to 25 members, with specific categories for most appointments
  - -- Prohibited legislators from serving as Board members
  - -- Required NC Partnership to submit a Regionalization Plan by April 15, 1999

SB 929

- Changed Licensing Standards and Provider Education Requirements Significantly

1997 GENERAL ASSEMBLY
RESIDENTIAL SCHOOLS

HOUSE BILL 1477

- Implements the ABCs Plan in the Governor Morehead School and the Schools for the Deaf, Including
  - -- Annual Performance Goals (beginning in 1999-2000)
  - -- School Technology Plans
  - -- School Improvement Plans
  - -- Criminal History Checks

- Directs DHHS to Change the Administration of its Schools to
  - -- Improve Student Academic Performance
  - -- Redirect Resources from Administration to Instructional Services (Goal: 50% Reduction in Administrator/Supervisor Positions)

- Additional Requirements:
  - -- Train Direct Services Staff at Deaf Schools to be Proficient in Sign Language Within Two Years
  - -- Develop a Prioritized, Three-Year Capital Improvement Plan
  - -- Adopt Rules for Newborn Hearing Screening
  - -- Conduct a Longitudinal Study to Assess Student Performance and Communication Methods Used

APPROPRIATION

- $2.45 million for Technical Assistance and Technology to Implement the ABCs Plan
- Report Due April 15, 1999

1997 GENERAL ASSEMBLY

PUBLIC HEALTH

AIDS DRUG ASSISTANCE PROGRAM

- Provides Life-Sustaining Medications to Low-Income North Carolinians with HIV Infection and AIDS
- Increased State Funding from $771,000 to $8,771,000 in 1998-99
- Total Budget: $13.9 million

PUBLIC HEALTH DIVISIONS

- Transferred From DEHNR to DHR Effective 7/1/97
- Environmental Health Functions Remain with DENR

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

February23, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lyn Wilson	NCAHTCH.
Katherine M	Harrison Kaplan
Stephanie Fangul	DHHS - DCD
Kevin Fitz-Gerald	NC DHHS - DSS
NELS ROSELAND	STATE BUDGET
Beckie Street	PPAB
Patricia Lowder	NCACC
Lawrence Wilson	NCDHHS - OEO
Marc Lodge	NCDHHS - Legal
Ann Schwindaman	NC Council of Community MH/DD/SA Programs
Jimmy Jo Bain	NCMS
[illegible]	NCMS

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 2-23, 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mary Green	OSBM
Jo Perkins	DVRS
John DeJuca	DSB
Terry Hatcher	DHHS
John Baggett	"
Kathy Heeter	"
Frank Bilbrill	"
Joyce Johnson	"
Jim Hoskins	NC Food Banks
Jenny Wolfe	DHHS
J Bunstein	DHHS
H. Perrugi	DHHS
Stacy Flaudery	NC Health Care Facilities Assoc
Roslyn Savitt	NC Child Care Coalition
Lynda McDaniel	DHHS / DFS
Wiegel	OSBM
Anna Tefft	OSBM
Wayne Williams	OSBM
Karen Gottovi	Div. of Aging
Shannon Ransom	DSS
Bill Cont	DHHS / DIRM
Katherine Miller	Harrison Kaplan
[illegible]	DHHS
Patrice Rowley	NCACC
John Kirst	NC FPC
Dave Richard	[illegible]
MICHELLE COTTON	DMH (NB) SAS
Joanne Schoen	NCNF

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 2-23, **1999**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Peggy Bone	Bone + Assoc. - LTC
Brenda Summers	NC Equity
Robert Tyson	N.C. Community Action
Nigel Bazour.	Rep. Alma Adams.
[illegible]	AHHC

AGENDA

Joint Appropriations Subcommittee on Human Resources

February 23, 1993

8:30 am

Opening Remarks	Senator Bill Martin Representative Beverly Earle Representative Edd Nye
Introduction of Committee Members	
Introduction of Legislative Staff	
Procedures and Schedule	Carol Shaw Fiscal Research Division
Department of Health & Human Services Opening Remarks Department Overview Introduction of Key Staff	Dr. David Bruton, Secretary

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
February 24, 1999
8:30

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Tuesday, February 24, 1999, at 8:30 A.M. in Room 424 of the Legislative Office Building.

House Chairman Representative Edd Nye presided. Other House members present were Representative Beverly Earle (Co-Chairman), Representative Martha Alexander (Vice Chairman), Representative Alma Adams, Representative Lanier Cansler, Representative Theresa Esposito, Representative Mickey Michaux, Representative Trudi Walend, Representative Gene Wilson and Representative Pete Cunningham (Ex officio). There were four senators present.

Representative Nye called the meeting to order at 8:30 A.M. Carol Shaw of Fiscal Research Division was introduced. Ms. Shaw discussed the APPROPRIATIONS COMMITTEE PROCESS/ROLE OF STAFF handout. (See Attachment #1) Ms. Shaw briefly explained the Continuation and Expansion Budget, role of fiscal staff, and role of other staff.

Ms. Shaw presented the handouts to the members titled LEGISLATIVE HIGHLIGHTS. (See Attachment #2) Ms. Shaw discussed the sections on Past Two Biennia Summary, Aging, and Health Care. Rep. Nye questioned why there were budget reductions. Ms. Shaw said there was reduction in case load. Senator Phillips expressed concern that if there is a reduction, why hasn't there been an expansion to those that are in need. Ms. Shaw stated that questions would be covered in a couple of weeks.

Karen Hammonds-Blanks from Fiscal Research was asked to address the section on Social Services. (See Page 5, Attachment #2). Senator Phillips commented that in the review of Rowan and Guilford, the Review Team was professional and the review made the board stronger .

Mary Ellen Sylvester from Fiscal Research explained the sections on Child Care and Residential Schools. (See Attachment #2). Following Ms. Sylvester, Ms. Ramona Burton of Fiscial Research reviewed the section on Public health.

The meeting adjourned. The next meeting is scheduled for Thursday, February 25, 1999 at 8:30 a.m.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbitt
Committee Assistant

Department of Health and Human Services

Overview

February 1999

TABLE OF CONTENTS

Mission	1
Goals	2
O-Chart	4
Key Budget and Personnel Facts	5
Program and Services by Division	14
Key Initiatives and Accomplishments - SFY 1997-98	26

The Mission of the Department of Health and Human Services is...

"To serve the people of North Carolina by enabling individuals, families, and communities to be healthy, and secure, and to achieve social and economic well-being."

To achieve this mission, the Department will...

Provide comprehensive and coordinated services for.prevention, intervention, assistance, education, and empowerment;

assure equal access to services;
be accountable for achieving meaningful results;
continuously improve service delivery by involving citizens; and
support and develop employees as diverse, invaluable resources.

The Goals of the Department of Health and Human Services are...

The mission statement sets broad direction for departmental efforts. To put a working framework around the mission, the Department developed six primary goals. These goals target populations and functions and reflect the services and programs provided by the Department.

Support Family Development and Independence

The Department shall promote equitable access to high quality services that assist families in their efforts to improve, achieve or maintain health, social well-being, and economic self-sufficiency.

Safe and Healthy Children At Risk

The Department will identify children under 18 years of age, with or at risk for physical handicaps, developmental disabilities, substance abuse, delinquency, emotional illness, or abuse or neglect and provide or refer families to services for these children. In order to maximize limited resources the Department will emphasize prevention, early intervention and outreach activities to reduce the number of children requiring clinical and institutional services.

Improve Quality of Life for Adults at Risk

The Department will enhance the quality of life and promote independence for at-risk adults and their families. The Department will emphasize health promotion, safety, protection, and expanded choice and access to appropriate and quality services.

Improve Quality of Life for Individuals with Physical and Mental Disabilities

The Department shall enhance the quality of life for persons affected by mental illness, substance abuse, developmental disabilities, blindness, deafness, and other disabilities through prevention, intervention, and treatment services so that they may secure and maintain maximum independence, contribution and inclusion into the community.

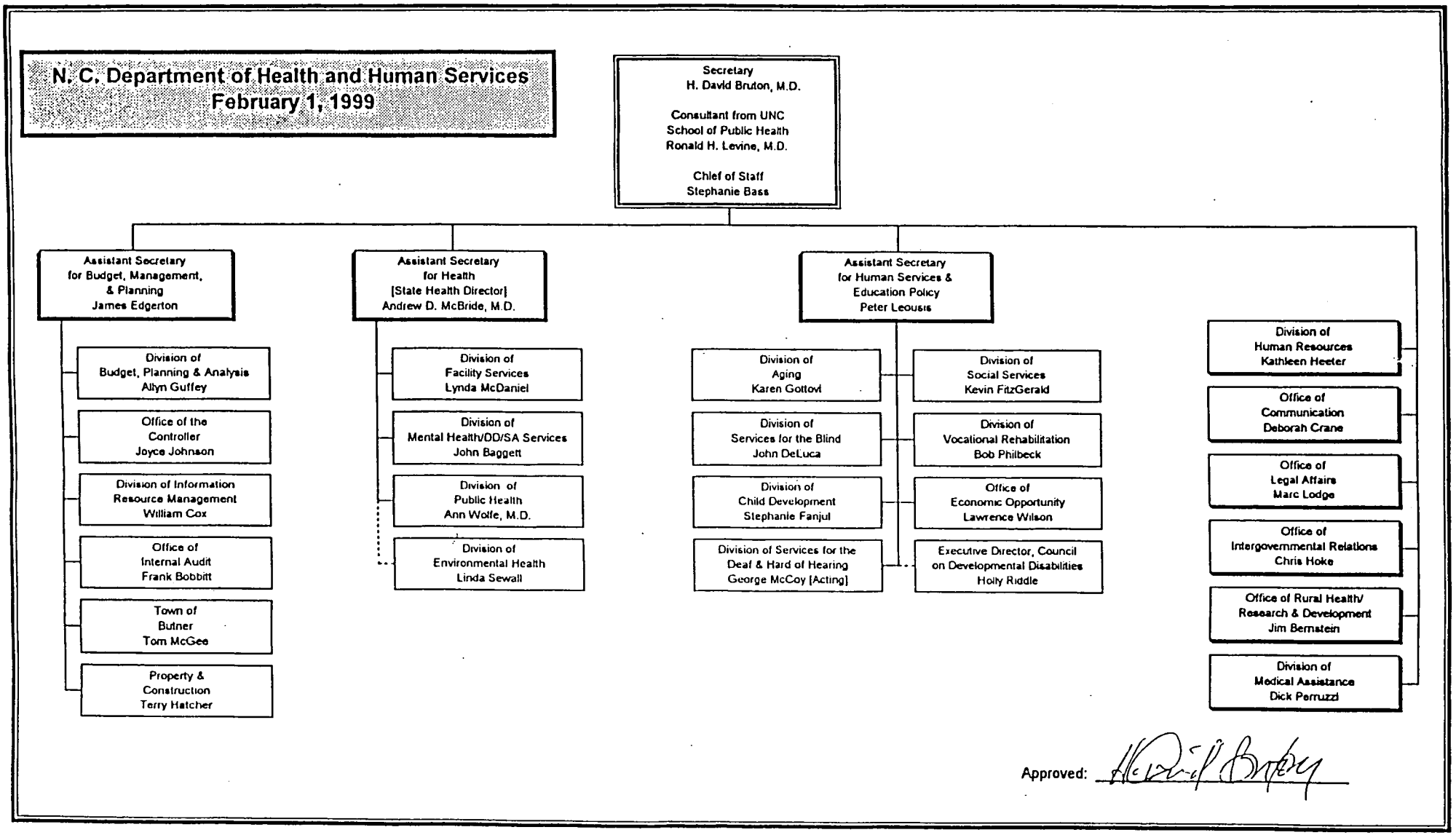
Promote Optimum Health

The Department will strive to enhance the health of our people, our communities and our environment through programs that promote health and ensure economic and geographic access to high quality health services.

Provide Quality Education for DHHS Students

The Department will provide appropriate and challenging individualized educational programs and services which enable at-risk and special needs children from birth to age 21 to succeed in a changing world.

O-Chart


N. C. Department of Health and Human Services
February 1, 1999
Secretary
H. David Bruton, M.D.
Consultant from UNC
School of Public Health
Ronald H. Levine, M.D.
Chief of Staff
Stephanie Bass
Assistant Secretary for Budget, Management, & Planning
James Edgerton
Division of Budget, Planning & Analysis
Allyn Guffey
Office of the Controller
Joyce Johnson
Division of Information Resource Management
William Cox
Office of Internal Audit
Frank Bobbitt
Town of Butner
Tom McGee
Property & Construction
Terry Hatcher
Assistant Secretary for Health [State Health Director]
Andrew D. McBride, M.D.
Division of Facility Services
Lynda McDaniel
Division of Mental Health/DD/SA Services
John Baggett
Division of Public Health
Ann Wolfe, M.D.
Division of Environmental Health
Linda Sewall
Assistant Secretary for Human Services & Education Policy
Peter Leousis
Division of Aging
Karen Gottovi
Division of Services for the Blind
John DeLuca
Division of Child Development
Stephanie Fanjul
Division of Services for the Deaf & Hard of Hearing
George McCoy [Acting]
Division of Social Services
Kevin FitzGerald
Division of Vocational Rehabilitation
Bob Philbeck
Office of Economic Opportunity
Lawrence Wilson
Executive Director, Council on Developmental Disabilities
Holly Riddle
Division of Human Resources
Kathleen Heeter
Office of Communication
Deborah Crane
Office of Legal Affairs
Marc Lodge
Office of Intergovernmental Relations
Chris Hoke
Office of Rural Health/ Research & Development
Jim Bernstein
Division of Medical Assistance
Dick Perruzzi
Approved:

Key Budget and Personnel Facts

Key Budget Facts

- 54% of DHHS's total budget comes from federal sources; 32% comes from the state.
- 84% of the total budget goes for programs & benefits such as TANF, Medicaid payments, and grants to organizations for programs.
- 57% of total budget goes solely for Medicaid.
- In the last 23 years, DHHS's federal entitlement commitments have grown from 48% to 56% of its budget.

Key Personnel Facts

- While DHHS's budget has grown 504% in the last 18 years, DHHS's number of positions has increased by a total of just 16% (2,772 positions). Excluding 100% federally funded positions, the position growth rate is 11%.

- DHHS now has 20,195 positions (FTEs) Of those:

    - 70% are in institutions (14,214.0)
    - 17% are based in Raleigh (3,444.5)
    - 13% are in field offices (2,546.5)

- More than 14,000 DHHS employees are in 30 institutions and schools that provide 24-hour, 7-day per week care. All institutions operate 3 full shifts.

- The number of people served directly by DHHS has increased by 194% from 1982 to 1999.

Budget Summary and Overview

The Department of Health and Human Services has a total general fund budget of $8.5 billion dollars after adjusting for intra-departmental transfers. Of this amount, 32% or $2.7 billion is in state appropriations, 54% or $4.6 billion are federal funds, and 14% or $1.2 billion are other receipts.

Charts 1 and 2 present the portion of DHHS's general fund budget to the total state general fund budget. DHHS's portion is 40% of the total general funds and 23% of the total state funds. Most of DHHS's general funds come from federal dollars (54%). State appropriations account for 32% and county and other funds account for the remaining 14% (see Chart 3).

Chart 4 displays the allocation of DHHS's budget by category. Most of the funds go for Entitlements (56% of the total requirements). Non-entitlements account for 28% of the total. Entitlements reflect refugee assistance, special assistance for blind and adults, foster care assistance, and direct services benefiting individuals in hospitals, facilities, etc. Relatively small percentages go to salaries and fringes or to other support services such as printing, travel, and data processing. The largest percentage in these categories is for division support (7%). Salary and fringes for institutions and schools account for the next highest percentage (6%).

Chart 5 displays the total requirements by Program--that is, by the Department's divisions. The divisions of Medical Assistance (DMA), Social Services (DSS), and Mental Health/Developmental Disabilities/Substance Abuse Services (DMHDDSAS) receive the greater shares of the Department's total general fund budget, receiving 57%, 14%, and 12%, respectively. Since these are the divisions which account for most of the funds going to Aid and Public Assistance, their share of the budget is commensurate with their functions and responsibilities.

Chart 6 shows where the positions are by location and major function. Institutions and schools account for 70% of the total positions, regional direct services at 9%, program support at 16%; Raleigh-based administration, 4%; and regional administration at 1%.

The Department's growth in budget, clients, and positions through the 80's and 90's is compared in Chart 7. Generally, the budget has been incrementally growing commensurate to steady increases in clients served, while position changes have been relatively lower. The chart highlights the addition of health services in SFY 1997-98, which created a significant upswing in the budget, clients served (1.2 million approximate increase), and positions.

State Fiscal Year 1998-1999
General Fund Operating Budget as of November 30, 1998

DHHS's budget is 40% of all State government's total budget

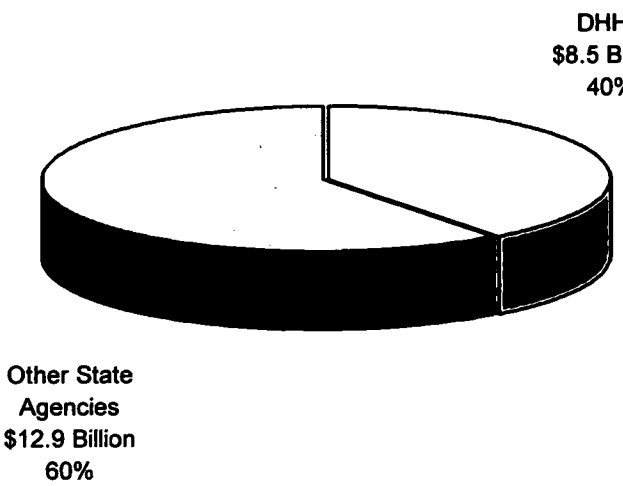


Chart 1
Total Budget

23% of all State appropriations go to DHHS

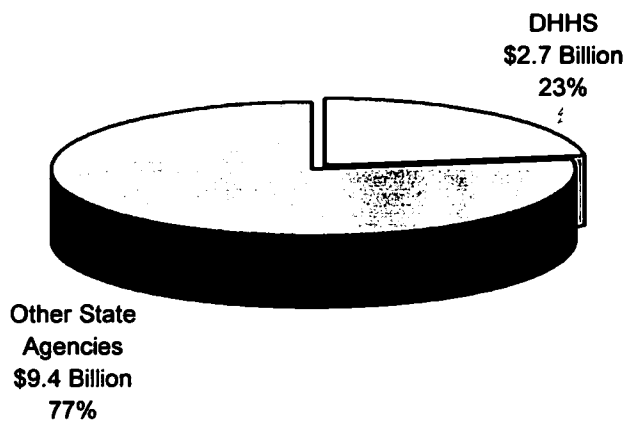


Chart 2
State Appropriation

- Includes only General Fund Budget Codes.
- Other State Agencies intra-department transfers not netted out.

54% of DHHS's budget comes from federal sources; 32% comes from the state

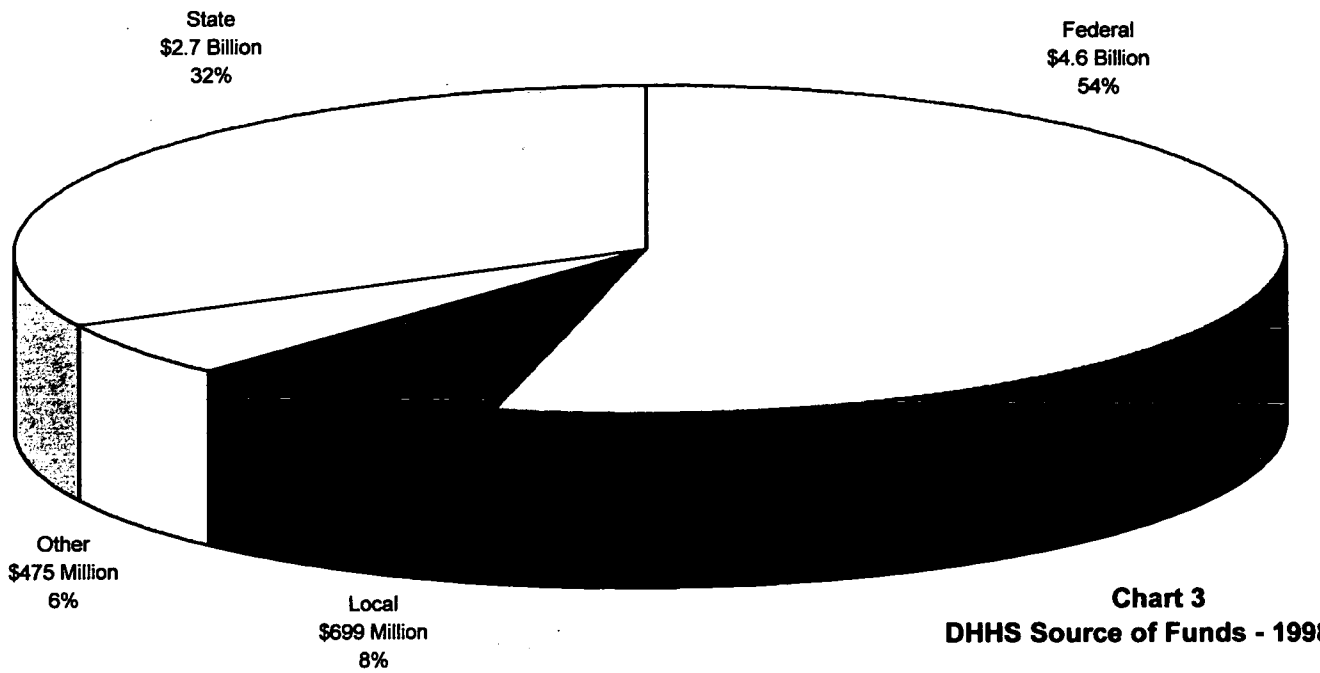


Chart 3
DHHS Source of Funds - 1998-99

84% of the total budget goes for programs & benefits to individuals, such as TANF and Medicaid

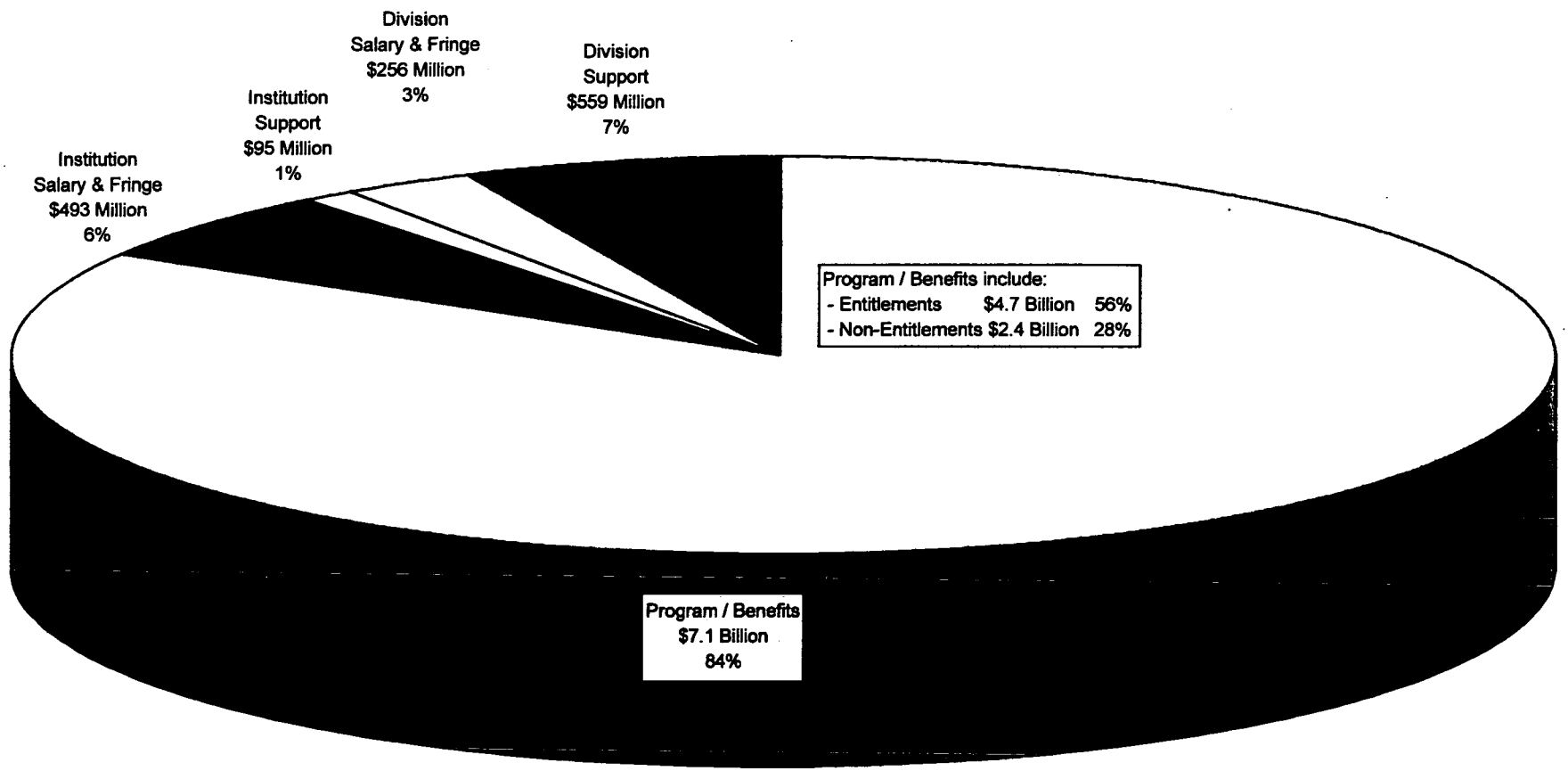
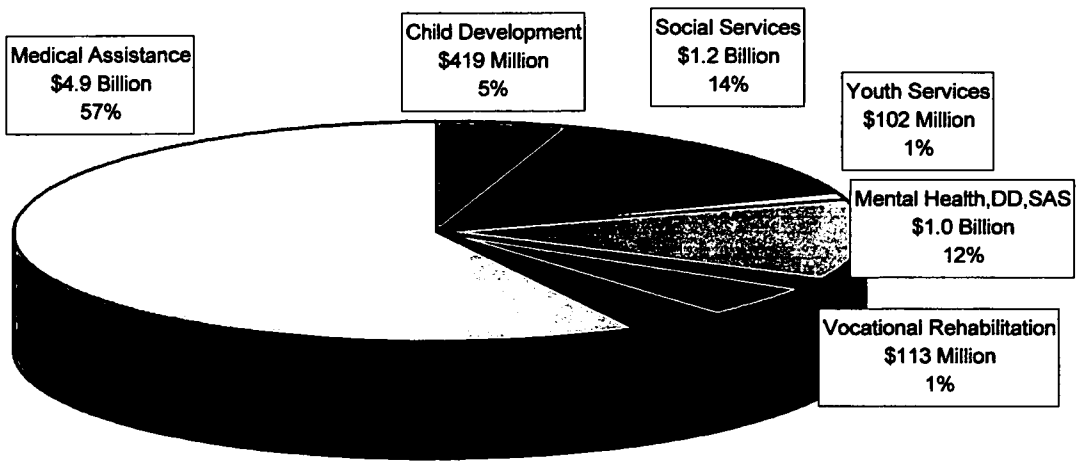


Chart 4
DHHS Total Budget By Category - 1998-99

57% of DHHS's total budget goes solely for Medicaid



Other Divisions:		
Aging	$74 Million	0.87%
Health Choice	60 Million	0.71%
Services for the Blind	36 Million	0.42%
Information Resources Mgt.	32 Million	0.38%
Central Administration	31 Million	0.36%
Deaf & Hard of Hearing	31 Million	0.36%
Facility Services	21 Million	0.25%
Economic Opportunity	16 Million	0.19%
Rural Health	11 Million	0.13%
DIRM Welfare Automation	9 Million	0.10%
DD Council	2.2 Million	0.03%
Citizen Affairs	.7 Million	0.01%

Chart 5
DHHS Total Budget By Division - 1998-99

Note: Budget has been adjusted for transfers.

Of DHHS's 20,194 positions, 70% are in institutions,
17% are based in Raleigh, and 13% are in field offices

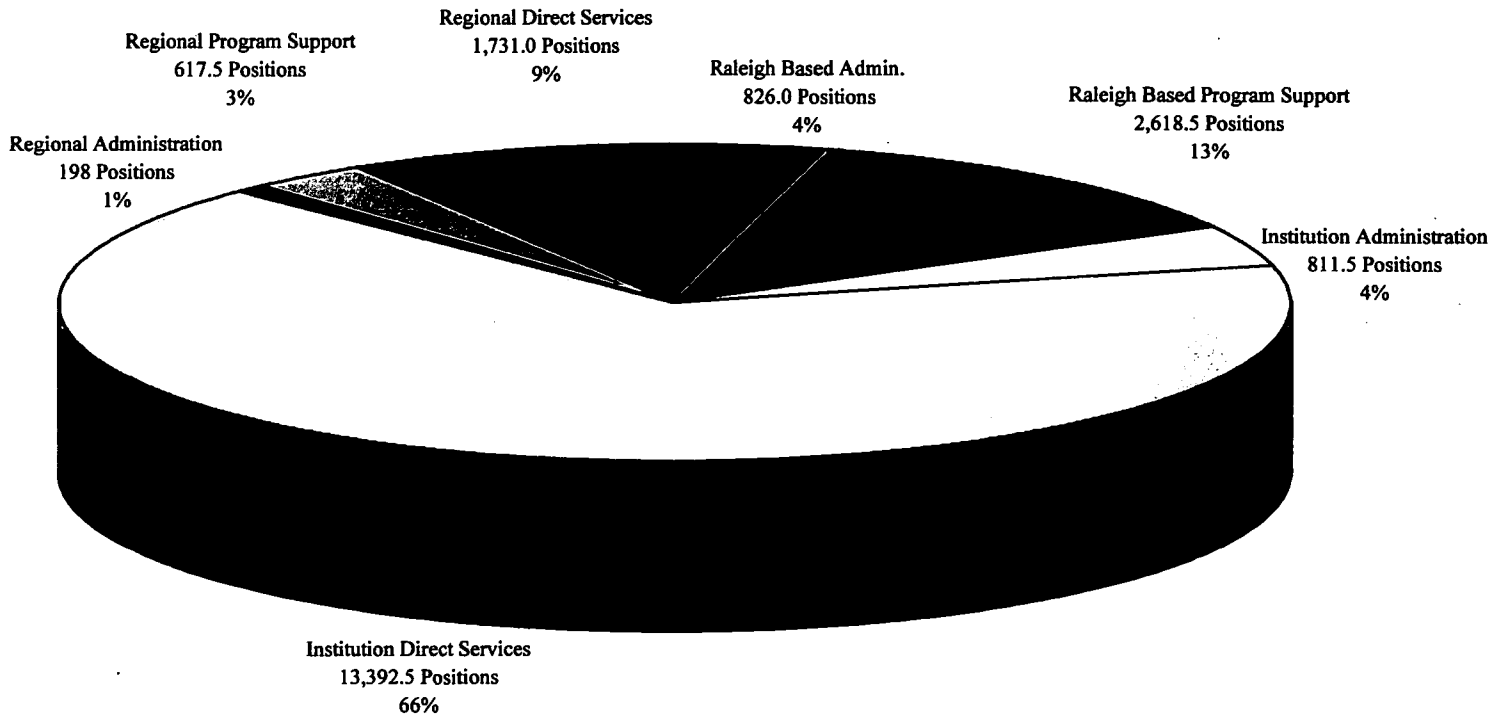
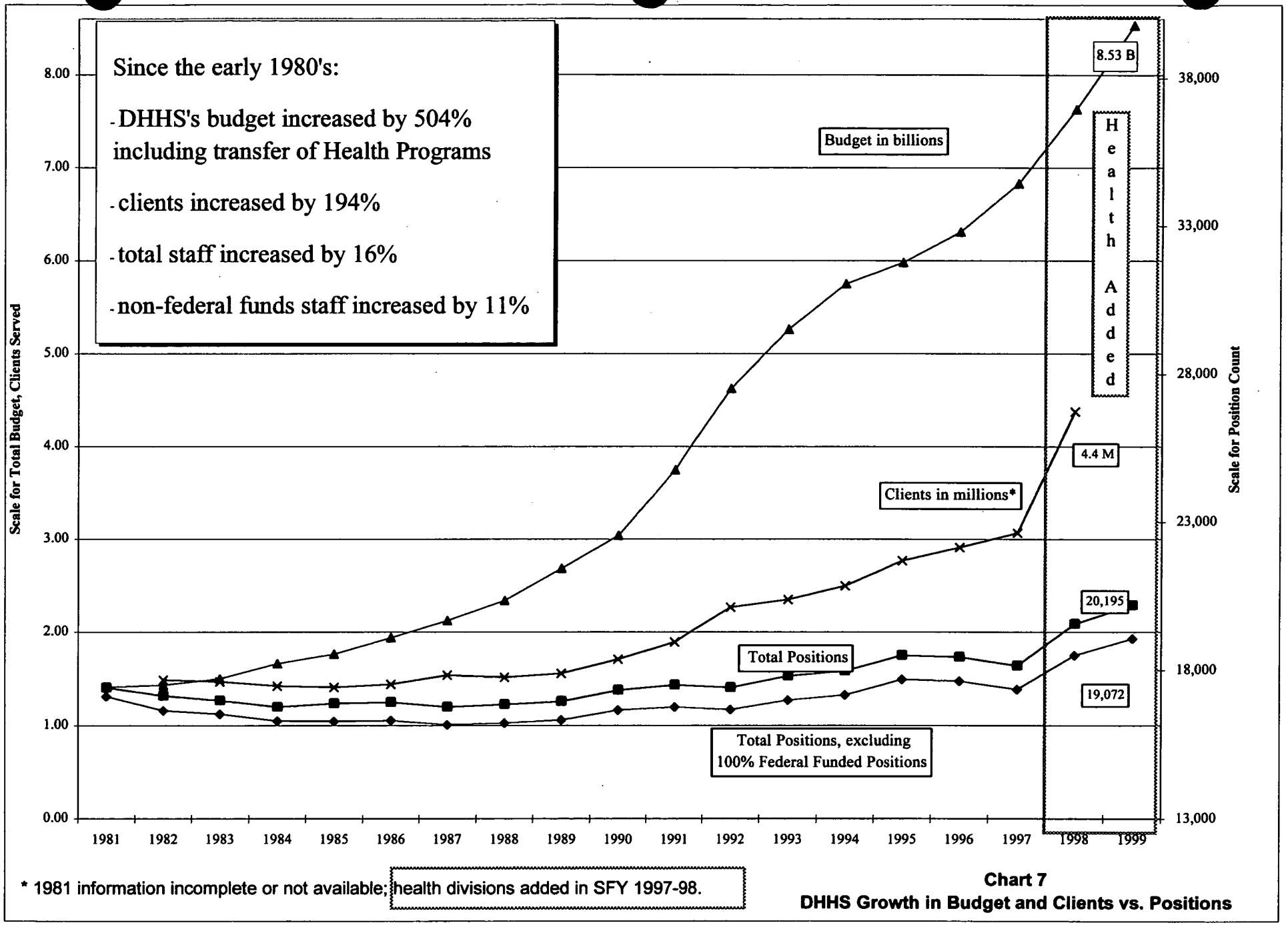


Chart 6
DHHS Positions By Location and Function - 1998-99



* 1981 information incomplete or not available; health divisions added in SFY 1997-98.

Chart 7
DHHS Growth in Budget and Clients vs. Positions

Program and Services by Division

HEALTH AND HUMAN SERVICES
Program and Services by Division

CENTRAL MANAGEMENT AND SUPPORT

Office of Communications
Debbie Crane, Director, 919-733-9190
Office of Legal Affairs
Marc Lodge, General Counsel, 919-733-6920
Office of Legislative and External Affairs
Chris Hoke, Acting Chief, 919-733-2173
Office of Citizens' Services
Leslie Mann, Director, 919-733-4261 (Voice), 919-733-4851 (TTY)
Council on Developmental Disabilities
Holly Riddle, Director, 919-733-6566
Office of Economic Opportunity
Lawrence Wilson, Director, 919-773-2818
Division of Human Resources
Kathy Heeter, Director, 919-733-2940
Division of Budget, Planning and Analysis
Allyn Guffey, Director, 919-733-6396
Office of the Controller
Joyce Johnson, Controller, 919-733-0169
Division of Information Resource Management
Bill Cox, Director, 919-733-8900
Office of Internal Audit
Frank Bobbitt, Director, 919-715-4791

Services Provided to Divisions/Management

Legal Services
Accounting Services
Budget Management and Program Analysis
Purchasing and Contracting
Mail Services Information Resource Management Government Liaison Services
Public Information
Coordination of Education Programs
Personnel Management
Grants Management
Property Management & Constructions
Community Involvement Services
Disabilities Act Management & Services

Services Provided to Local Agencies/Individuals

Citizens Affairs & Referral Services
Holocaust Council
- Education
Community Action Grants
Audit Services
Developmental Disabilities Grants

HEALTH AND HUMAN SERVICES
Program and Services by Division

DIVISION OF AGING
Karen E. Gottovi, Director, 919-733-3983

Adult Day Care/Day Health Care
Advocacy
Alzheimer's Support
Care Management
Congregate Nutrition
Elder Rights
Grandparents Support
Group Respite Services
Health Promotion/Disease Prevention
Health Screening
Home Care (Skilled)
Home Delivered Meals
Housing and Home Improvement
In-Home Aide
Information and Case Assistance
Institutional Respite
Legal Services
Long Term Care Ombudsman Program
Senior Center Development and Outreach
Senior Center Operations
Senior Community Service Employment Program
Senior Companion
Senior Education Corps
Senior Games
Transportation
Volunteer Program Development

DIVISION OF CHILD DEVELOPMENT
Stephanie Fanjul, Director, 919-662-4499

Regulation of Child Care Centers and Homes. Includes:
- Investigation of Abuse/Neglect Reports
- Criminal Background Record Checks and Pre-Licensing Workshops

Smart Start
Subsidized Child Care Program
Head Start Wrap-Around Program
Head Start Supplemental Program
Head Start Collaboration Project
Early Head Start
NC Interagency Coordinating Council
T.E.A.C.H.
Child Care Resources Directory Website
Child Care Personnel Education Registry
Child Care Injury Evaluation
Early Childhood Initiatives (Quality and Availability)
- Inclusion of Children with Special Needs
- School Age Child Care
- Child Care Resource & Referral
- Revolving Loan Fund
- NC Early Childhood Credential
- NC Family Child Care Credential
- NC Early Childhood Administration Credential
- NC Institute for Early Childhood Professional Development
- Healthy Child Care Initiative
- Monitoring Improvement

DIVISION OF SERVICES FOR THE DEAF AND HARD OF HEARING

George McCoy, Director, 919-733-5196 (Voice, TTY)

NC School for the Deaf at Morganton (K-12)
Central NC School for the Deaf at Greensboro (K-8)
Eastern NC School for the Deaf at Wilson (K-12)
Preschool Satellite Classes and Early Intervention Program
Telecommunications Equipment Distribution Program
Community Services Centers for the Deaf and Hard of Hearing
- Interpreter Support Services
- Consulting Services
- Training for providers, families, and clients

Family orientation (deafness), emotional support, and training
Telecommunications Relay System
Interpreter Certification Program
Hearing Ear Dog Certification

DIVISION OF FACILITY SERVICES

Lynda McDaniel, Director, 919-733-2342

Certificate of Need
Health Care Facilities Finance Program
Medical Facilities Planning
Regulatory Services - Bingo
Certificate of Public Advantage Program
Medical Care Data Act Program
Medicare/Medicaid Certification Inspection
Construction/Life Safety Inspection
Emergency Medical Services
Health Care Personnel Registry and Investigations

Licensure
- Medical Facilities (including hospitals and nursing homes)
- Adult Care Homes
- Mental Health Group Homes
- Jails and Detention Facilities

Adult Care Homes - Oversight of SB864 Implementation

HEALTH AND HUMAN SERVICES
Program and Services by Division

DIVISION OF MEDICAL ASSISTANCE
Dick Perruzzi, Director, 919-733-2060

Programs:

Baby Love
Health Check for Children
Community Alternatives Program
- for Children
- for AIDS
- for Disabled Adults
- for Mentally Retarded: Developmentally Disabled

Carolina Access (Managed Care)
High Cost Case Management
Drug Utilization Review Program
Medicare Buy-In
Nursing Home Placement
Health Care Connection
Health Related Services
Independent Practitioner
Health Choice

Regulatory:

Provider Enrollment
Provider Reimbursement
Utilization Review/Audits
Medical Policy
Eligibility Policy
Quality Control-Eligibility and Systems
Drug Utilization Review
Third Party Recovery
Contracts Management-claims Processing System, Bulk Purchase
Pre/Post Admission Reviews, Audits
Interagency Agreements
Federal Plan/APA
Provider Service Organizations (PSOs)
Program Integrity

Services:

Inpatient Hospital Services
Hospital Outpatient Services
Other Laboratory and X-ray
Nursing Facility
Physician Services
Home Health Services
Health Check
Family Planning Services
Federally Qualified Health Centers and Rural Health Centers
Durable Medical Equipment
Nurse Midwife and Nurse Practitioner Services
Medical Transportation
Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
Personal Care Services
Prescription Drugs
Dental Services
Eye Care Services
Hearing Aid Services
Mental Health Services
Adult Health Screening Program

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

John Baggett, Director, 919-733-7011

Periodic Services
After Hours Services
Assertive Outreach
Case Management
Consultation, Education and Primary Prevention
Evaluation
Help Line
High Risk Intervention
Methadone Treatment
Outpatient Treatment/Habilitation
Screening
Hourly Respite
Personal Assistance

Day/Night Services
Adult Development Activity Program
Day/Evening Activity
Intensive Child Care
Intensive Day Treatment/Partial Hospitalization
Developmental Day
Drop in Center
Psychosocial Rehabilitation
Sheltered Workshop
Individual and Group Supported Employment

24-Hour Services
Community Respite
Non-Hospital Medical Detoxification
Social Setting Detoxification
Family Living; Low and Moderate Intensity
Group Living; Low, Moderate and High Intensity
Inpatient Hospitalization
Residential Acute Treatment
Supervised Living; Low and Moderate Intensity

Other Services
Alcohol and Drug Education Traffic Schools (ADETS)
DWI (Driving While Impaired) Substance Abuse Assessments
Employee Assistance Program (EAP)
Family Support
Parent-to-Parent
Treatment Alternatives to Street Crime (TASC)
Drug Education Schools (DES)
Perinatal Substance Abuse Services

Institution Services

8 state institutions provide mental health inpatient services
5 state institutions provide residential and respite services for persons with developmental disabilities
3 state institutions provide short-term substance abuse residential treatment and rehabilitation services

HEALTH AND HUMAN SERVICES

Program and Services by Division

OFFICE OF RESEARCH, DEMONSTRATIONS, AND RURAL HEALTH DEVELOPMENT

James D. Bernstein, Director, 919-733-2040

- Aid for Clinic Operation
- Aid for Clinic Construction
- Primary Care Provider Recruitment
- Loan Repayment Program
- High Needs Service Program
- Residential Stipend Program
- Rural Health Scholars Program
- Farmworker Health Program
- Long Term Care Demonstration
- Community Hospital Technical Assistance Program.
- Essential Access Community Hospital Program
- Community Primary Care Program
- Access II/III Program
- Dental Recruitment and Development
- Health Professional Shortage Analysis
- Physician Assistant/Family Nurse Practitioner Residency Program
- Primary Care Technical Assistance Service
- Architectural design
- Graphic design
- Maternity services
- Laboratory services
- Computer systems
- Financial/Reimbursement services
- Practice Management
- Managed Care

HEALTH AND HUMAN SERVICES
Program and Services by Division

DIVISION OF PUBLIC HEALTH
Ann Wolfe, M.D., Director, 919-733-3011

Office of the Director

Training to reduce access barriers (i.e., Cultural Diversity Training/Interpreter Training/other agency-capacity building trainings)
Training for the public health workforce
Minority-focused health status/health assessment reports
Consultation/technical assistance to address health disparity issues.
Healthy Carolinians (community-based primary prevention program)

Community Health

Breast and Cervical Cancer Control
Cancer Control
Community Traffic Safety Program
Diabetes Control Program
Governor's Council on Physical Fitness (Be Active NC)
Home Health
Injury prevention
Kidney Program
Older adult health program
Osteoporosis prevention program
Project ASSIST
Residential Fire Injury Prevention
Safe Communities (rape prevention)
Screening, follow-up, diagnosis and treatment services for selected chronic diseases
Statewide policies and plans for selected chronic diseases

Dental Health

Access to Dental Care
Dental Field Staff
Dental Health Education
Dental Screenings in Schools
Fluoride Guidelines
Fluoridated Community Water Systems
Screening, diagnostic, treatment and referral services
Statewide dental health plan

Epidemiology

Animal bite consultations
Collection and dissemination of health information
Collection, registration, and issuance of vital records
Communicable disease control programs

- Consultation about, investigation of, and institution of control measures for non-HIV/STD, non-zoonotic communicable disease problems.
- Provision of funding and drugs through local health departments for the prevention and treatment of TB.
- Collaboration in the training and education of health care professionals and the general public in communicable disease prevention and control.

Consultations and assessments.
Control system for asbestos/lead abatement operations
Diagnose, treat and educate individuals about STD/HIV
Dusty trades exposure assessments and medical consultations
Expert witness testimony in criminal proceedings
HIV/AIDS Care Programs, medication, case management
Investigation of childhood deaths
Investigate HIV reports, locate partners, provide consultation
Lab certification and consultation for CLIA
Laboratory examinations
Medical/legal death investigations, autopsies and toxicology tests
Medical/legal education
Medical toxicological and industrial hygiene risk
Mobile breath testing unit (BAT Mobile) in enforcement and/or educational venues.
Occupational Health consultations
Occupational injury or illness surveillance
Pesticide contamination consultations
Postmortem medicolegal examinations
Public and private water supply contamination consultations
Rabies tag program
Review medical, driving and related records of referred individuals.
Statewide plan HIV/STD policies
Training and certifying state and local law enforcement officers to operate breath testing devices
Toxic and hazardous chemical contamination consultations
Train employees, citizens and local health departments in occupational and/or environmental health hazard control
Training, testing, and certification to other laboratories
Zoonotic disease consultations

Women's and Children's Health

Adolescent Parenting Program
Adolescent Pregnancy Prevention Program
Adult Cystic Fibrosis Program
Assistive Technology Program
Baby Love
Baby Love Plus (Healthy Start)
Child and Adult Care Food Program
Child Fatality Task Force
Child Health Program (Well Child Services)
Child Health Training Program
Child Service Coordination Program
Children's Special Health Services (CSHS)
Comprehensive Adolescent Health Care Projects
Developmental Evaluation Centers (DECs)
Family Planning
Family Support/Family Preservation Services
Farmers Market Nutrition Program
FIRST STEP Public Awareness Campaign and Hotline
Genetic Counseling Services
Healthy Child Care Initiative
High Risk Maternity Clinics
Immunization Assessment
Immunization Education, Outreach and Promotion
Intensive Home Visiting Programs
Intensive Psycho-Social Counseling for Pregnant Women
Local Child Fatality Prevention Teams
Maternal Health Program
Maternal Health Videos-in-Sign Project
Maternal Outreach Workers
Maternal Serum Alpha Fetoprotein Screening
Maternity Care Coordination
Medical Nutrition Therapy for Children and Adolescents
Medical Nutrition Therapy for Pregnant and Postpartum Women
Minority Infant Mortality Reduction Projects
Newborn Screening Services
North Carolina Hemophilia Assistance Plan
North Carolina Immunization Registry
North Carolina Infant-Toddler Program
Nurse-Midwifery Projects
Office for Disabilities and Health
Office of Women's Health
Parenting Education Services
Pediatric Primary Care Program
Perinatal Education and Training
Prenatal Care Services
Rural Obstetrical Care Incentive Program
School Health Fund
School Health Program
Sickle Cell Syndrome Program
Special Supplemental Nutrition Program for Women, Infants and Children (WIC)
Sudden Infant Death Syndrome Grief Counseling
Summer Food Service Program for Children
Targeted Infant Mortality Reduction Projects
Universal Childhood Vaccine Distribution Program
Vaccine-Preventable Disease Surveillance
Voluntary Sterilization Services
Women's Health Nurse Training Program
Women's Preventive Health Services

HEALTH AND HUMAN SERVICES
Program and Services by Division

DIVISION OF SERVICES FOR THE BLIND
John DeLuca, Director, 919-733-9822

Vocational Rehabilitation Program
Vocational assessment
Vocational guidance and counseling
Job placement
Postsecondary training
Reader service
On-the-job training
Supported employment/job coach services
Physical restoration
Rehabilitation engineering services
Orientation and mobility instruction
Braille instruction
Adaptive technology evaluation, training and purchase
Specialized school-to-work transition services
Job seeking skills training
Occupational tools and equipment
Specialized services for deaf-blind consumers
Consultation to employers and blind consumers on the American with Disabilities Act

Business Enterprises Program
Training and employment opportunities for licensed blind foodservice vendors

Governor Morehead School
Pre-school services in some local communities
K-12 residential school
Consultation and technical support for LEAs serving children who are blind/visually impaired

Medical Eye Care Program
Eye exams and eyeglasses
Surgery, medication and other treatment to preserve or restore vision
Prostheses
Low vision evaluations
Glaucoma screening
Eye care education
In-home personal care services (Level II)

Independent Living Services Program
In-home aide service (Level I)
Adjustment to blindness services
Special Assistance for the Blind
Orientation and mobility instruction
Vision-specific aids and devices
Community-based independent living skills classes
Community-based support groups
Information and referral
Production of Braille and large print material for the general public

NOTE: Blind and visually impaired individuals seeking services must meet program eligibility guidelines which, in some programs, includes an economic needs test.

HEALTH AND HUMAN SERVICES
Program and Services by Division

DIVISION OF SOCIAL SERVICES
Kevin FitzGerald, Director, 919-733-3055

Economic Independence
- CP&L's Project Share
- Crisis Intervention Program
- Food Stamp Employment & Training
- Food Stamp Program
- Job Corp
- Low Income Energy Assistance Program
- Work First Family Assistance
- Work First Family Assistance Employment Services

Child Support Enforcement

Adult and Family Services
- Adult Care Home Case Management
- Adult Placement Services
- Adult Protective Services
- Case Management and Counseling (Individual & Family Adjustment, Health Support Services, Personal & Family Counseling)
- Family Planning Services
- Family Violence Prevention
- Guardianship Services
- Refugee Program (Cash, Medical Assistance and Social Services)
- State/County Special Assistance for Adults
- State Abortion Fund
- State Maternity Home Fund
- Transportation

Children Services
- Adoption Services, Adoption Assistance, and Special Children's Adoption Fund
- At-Risk Case Management
- Child Protective Services
- Day Care
- Delinquency Prevention Services
- Family Preservation
- Family Resource Centers
- Foster Care Services and Assistance
- Health Support Services
- Housing & Home Improvement
- Independent Living Skills for Foster Care Children
- Individual and Family Adjustment
- In-Home Aide Services
- Intensive Family Preservation
- Interstate Compacts
- Other Child Welfare Services
- Personal and Family Counseling
- Preparation and Delivery of Meals
- Transportation Services

HEALTH AND HUMAN SERVICES
Program and Services by Division

DIVISION OF VOCATIONAL REHABILITATION SERVICES
Bob Philbeck, Director, 919-733-3364

Vocational Rehabilitation Program

Community Rehabilitation Work Adjustment/Job Coaching
Supported Employment
On the Job training/Apprenticeship
Sponsorships at colleges, universities, community colleges and vocational schools
Individualized job placement services
Job seeking skills with emphasis on Americans with Disabilities Act (ADA) and rights for people with disabilities
Career counseling
Work, Home and Vehicle Modifications
Occupational/small business expenses: tools, equipment, licenses, initial stocks, rent, insurance
Transition from school to work services
Personal assistance services
Assessment services (vocational evaluations; employment strengths)
Physical and Mental Restoration: hospitalization/convalescent care surgery, cardiac rehabilitation programs, prescription drugs, physical therapy, occupational therapy, psychotherapy, speech therapy, etc.
Work hardening (use work activities for physical stamina building)
Assistive Technology: computers, communication aids, health aids/ prosthetic devices, wheelchairs, etc.
Rehabilitation Engineering consulting service: home, vehicle and job site modifications
Information, consulting on ADA
Job analysis
Employer/employee assistance services

Assistive Technology Project

Regional Assistive Technology Centers
Technical Consultation
Demonstration and tryout of equipment
Equipment loan
Outreach/Training and awareness
Funding information and advocacy

Disability Determination Services

Determine eligibility for: Social Security disability (Title II) Supplemental Security Income disability (Title XVI) Medicaid disability (Title XIX)
Assist as necessary the Federal Emergency Management Administration (FEMA) in processing disaster assistance claims under the Individual & Family Grant

Independent Living Rehab Program

Counseling and Joint Planning for Independence
Information and Advocacy
Home Modifications
Vehicle Modifications
Technological Aids and Devices
Rehabilitation Engineering
Prosthetics and Orthotics
Part-time, Consumer-managed Personal Assistance Services
Assistance with Recreational Therapy/Leisure Pursuits and Activities
Peer Counseling
Independent Living Skills Training

Client Assistance Program

Information about rehabilitation services
Referral to appropriate rehabilitation programs
Advice and interpretation on program policies and procedures
Negotiation of client or service delivery concerns
Assist consumers in the appeals process
Assist consumers in legal remedies

Key Initiatives and Accomplishments SFY 1997-98

DEPARTMENT OF HEALTH AND HUMAN SERVICES
1997-98
KEY INITIATIVES AND ACCOMPLISHMENTS

AGING

- **Established a Legal Resource Center** under the direction of an attorney to provide legal advice and resources to the elderly.

- **Baby Boomer Initiative** – This initiative educates North Carolina policymakers about the coming demographic population shift to an older society. People in the Boomer age bracket are educated about the need to take care of themselves so that they will age successfully both physically and financially.

CHILD DEVELOPMENT

- **Smart Start has been expanded statewide**. All 100 counties have access to funding to make improvements in child care programs based on local needs. (Partial funding for 55 counties and planning funds for 45 counties.)

- The child care law now requires certain teachers and directors of child care centers to take early childhood education classes at the community college. The **T.E.A.C.H. Early Childhood Scholarship Program**, which pays for the classes and provides a bonus to staff who complete the classes, **has helped to reduce the teacher turnover rate** from 42% to 10% in the centers where teachers received T.E.A.C.H. scholarships.

- **Smart Start Recognition** – Smart Start **received the 1998 Innovations in American Government Award**, which is one of the highest honors a government program can receive. This award is given annually by the Ford Foundation and Harvard University to recognize a state's solution to a pressing problem.

ECONOMIC OPPORTUNITY

- **Enabled 921 low-income families to move out of poverty** through the 36 community action agencies receiving funding under the Community Services Block Grant program.

- **Provided overnight shelter to an average of 2,800 homeless individuals per day** through the 121 homeless providers funded through the Emergency Shelter Grants Program. The shelter facilities include traditional overnight shelters, day shelters, domestic violence shelters, transitional shelters, runaway homes, and halfway homes.

- Sponsored the **first homeless conference** that focused on assessing the problems of the homeless in North Carolina and identifying solutions. Over 200 homeless service providers, homeless and formerly homeless persons, local, state and federal officials attended.

FACILITY SERVICES

- **Eden Alternatives – Division recognized by the Association of Health Facility Survey Agencies** for its work in promoting the concept of introducing animals, plants and children into nursing homes to improve the quality of life for nursing home residents. The Division has staffed and helped coordinate a public/private coalition to guide this effort and has made available $195,000 in grants (from federal fines collected) to nursing homes to encourage participation.

- Completed the **upgrade of the health care personnel registry telephone voice response system.** This made all of the information on the registries available to the public 24-hours-a-day, 7-days-a-week. The information is updated daily. This system processed over 200,000 inquiries this past fiscal year.

HUMAN RESOURCES

- **Instituted merit-based hiring** by developing the policy, training HR staff in five sites across the state, and implementing the procedures. Updates for training were conducted in May 1998.

INFORMATION RESOURCE MANAGEMENT

- **Year 2000** – Remedial work to fix non-compliant application systems has obtained funding from the Department of Commerce's Year 2000 Steering Committee. Assessment work initiated on non-information technology assets (i.e., elevators, PC's, HVAC, state laboratory medical equipment, motor pool vehicles, etc.)

- The **Health Choice** program was implemented October 1, 1998. A number of substantial system changes were made to the Eligibility Information System to support this initiative.

- The **Electronic Benefits Transfer** (EBT) project, a joint venture for DHHS, Citibank, and the Southern Alliance of States, was successfully piloted, and is in the roll out phase currently, providing point of sale benefits to Food Stamp recipients. DIRM staff led development of an EBTIS system to interface with the department's food stamp information system and Citibank's data center, as well as supporting security, training and connectivity. DIRM is supporting rollout activities.

MEDICAL ASSISTANCE

- DRIVE – The **Medicaid Data Retrieval and Information Verification Engine (DRIVE)** has put Medicaid claims data (3 years worth at 60 million claims per year) into data warehouses so that information can be manipulated quickly and easily. This will lead to major improvements in planning, evaluation, and care management feedback to providers, quality assurance, and fraud and abuse detection.

- N.C. **Health Choice** for Children – Implemented the subsidized child health insurance program for lower income working families which was enacted by the General Assembly. Since N.C. Health Choice for Children was implemented on October 1, 1998, about 8,000 children have been enrolled.

- **Carolina ACCESS** – now operational in 92 counties and will be statewide by the end of CY 1998. In addition to expanding statewide, Carolina ACCESS is being enhanced by adding incentives for providers to increase care management of their enrollees in 9 sites, referred to as ACCESS II (7) and ACCESS III (2).

MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

- **Accountability of Area Programs** – In an effort to improve the area program accountability and standardization of care for persons suffering from mental illness, substance abuse or dependence and developmental disabilities, the Division developed a comprehensive process for accrediting area programs. The National Council on Accreditation of Services for Families and Children has been engaged to phase in national accreditation requirements for area programs.

- **Relief from court oversight in the Thomas S and Willie M. Class Action Law Suits** because the Department is addressing the needs of those populations.

- **NC-TOPPS Initiative (Treatment Outcomes Performance Pilot Study)** – One of 14 states awarded a competitive grant by the Center for Substance Abuse Treatment (CSAT) to develop and implement client outcome measures to determine the effectiveness of substance abuse treatment services. Six area programs and contract agencies have participated in a consensus process for identifying critical client outcomes and are now piloting these measures for clients with substance abuse problems. It is anticipated that the results of this pilot project will be the basis for implementation of a statewide system of substance abuse outcome measures.

DIVISION OF PUBLIC HEALTH

COMMUNITY HEALTH

- **Established the Osteoporosis Task Force** which developed three reports on the disease, the state of care by physicians, and the recommendations on a public awareness campaign, and began to develop a comprehensive plan to address the prevention and treatment of osteoporosis.

- Initiated a **Pain Control Professional Education and Public Awareness Effort** through the Cancer Control Advisory Committee.

- Secured a 5-year grant from the Centers for Disease Control for $1.25 million annual effort to implement a **cardiovascular health program.**

- Received funding from the Kate B. Reynolds Foundation to implement a training program to **increase the ability of Spanish speaking people to be medical interpreters in health departments.**

Dental Health

- **Seal the State in '98** – Single largest sealant promotion event in the nation. Over 39,000 free sealants to at-risk children – 8,000 volunteers – $2 million in free care. **Received the American Dental Association's award for Community Preventive Dentistry.**

- **Establish locally operated dental clinics to serve low-income families** in local health departments and community health centers. The number of clinics increased from 6 in1994 to 25 this year.

- **Provided preventive dental health** services including screening, referral, follow-up, and education to over 300,000 school children. In addition, over 275,000 children participated in the state supported fluoride mouth rinse program.

EPIDEMIOLOGY

Occupational and Environmental Epidemiology

- CDC Grant/**Pfiesteria-Related Illness Surveillance and Prevention** – five-year project, first year budget $958,460.

- Under contract, Duke Medical Center provided clinical evaluations of the residents living near Trinity Foam which indicated that the symptoms reported by the residents were related to emissions from the facility. After several abatement orders, the State Health Director issued the final order which permanently closed Trinity Foam thus **ensuring a healthier and safer environment.**

HIV/STD Prevention and Care

- **Reported congenital syphilis cases decreased** by 81% between 1993 and 1997.

- Annual **gonorrhea and syphilis rates declined** between 1993 and 1997 by 35% and 64%, respectively.

- Secured **new CDC funding for enhancement of STD services** in the form of a Syphilis Elimination Project to be carried out in five of the counties with the highest syphilis morbidity. These counties are Forsyth, Guilford, Alamance, Orange, and Durham.

WOMEN'S AND CHILDREN'S HEALTH

- **School Health** – The Division has received a CDC grant to work with DPI on school health issues, and has convened a statewide task force of health and education leaders to develop a blueprint for school health in NC.

- **Office of Women's Health** – The General Assembly established an Office of Women's Health to "expand the State's public health concerns and focus to include a comprehensive outlook on the overall health status of women." The Office sponsored a successful statewide summit to obtain input from a wide cross-section of men and women on the key women's health issues to be addressed in North Carolina.

SERVICES FOR THE BLIND

- **Cosponsored two Hispanic outreach events** in Pitt and Beaufort Counties to provide Spanish-speaking people with information about blindness, DSB services, and other human services. More than 650 people attended the two events.

- **Entered into two new cooperative agreements** with the Cumberland and Forsyth School Systems, to prepare blind or visually impaired young people with work skills and opportunities during their high school years. DSB and the school systems share in the funding of the program in each county to provide school-to-work transition services to blind and visually impaired students.

- **GMS Preschool Early Intervention Expansion** – An expansion of GMS' "Smart Start for Visually Impaired Children" is providing a sound educational base for approximately 500 eligible blind or visually impaired children, birth through age 5, in all 100 counties of North Carolina.

- **GMS 2001 Technology Consortium** – An outgrowth of the Vision Partnership between DHHS, DPI and NCCU, this multi-funded (state, federal and university) consortium provides vision-specific and technology courses for credit and licensure through distance learning.

SERVICES FOR THE DEAF AND HARD OF HEARING

- Established with the State Emergency Management System **a 1-800 number that is dedicated to TTY use for deaf and hard of hearing individuals during emergency situations.**

- Established a **statewide network of more than 200 educational interpreters** to provide support, training, and evaluation.

- **Expanded the Early Intervention services for deaf and hard of hearing children and their families**, through an appropriation which established new technology, teaching positions, audiologist positions, and other support positions which more than doubled the amount of services provided to the youngest deaf and hard of hearing children in North Carolina.

- Legislation was approved to require **mandatory universal screening of newborns for hearing loss.**

DIVISION OF SOCIAL SERVICES

Food Stamp Program

- **Began implementation of the Electronic Benefits Transfer (EBT) System** in three pilot counties. Statewide rollout will be completed by June 30, 1999. This system replaces the paper Food Stamps with a debit-like ATM card that will be used to authorize food purchases in local stores.

Low Income Energy Assistance Program

- Received and distributed approximately $9 million of federal funds provided to North Carolina as **Heat Relief to eligible, low-income families** in the summer of 1998. This assistance helped families with cooling related expenses due to the excessive heat experienced in North Carolina this past summer.

Work First

- **Federal welfare reform changes were implemented in North Carolina's Work First Program** in January 1997. Under this plan, North Carolina continued its efforts to move families from welfare to work. Since Work First was implemented in June 1995, the welfare rolls have declined over 45 percent—down from 113,485 families in June 1995 to 62,144 families in October 1998.

- **Collaborative efforts have been strengthened** with the Business Community through the Governor's Work First Business Council to find jobs for Work First participants and with the Faith community which provides supportive services such as mentoring and job counseling to help families make the transition from welfare to work.

Program Integrity

- **Enhanced county departments' Program Integrity efforts** with a $2,500,000 appropriation from the Legislature in August 1997. Counties have primarily used the appropriation to hire Program Integrity Investigators. Millions of dollars have been recovered from prior overpayments in Food Stamps and Work First with Tax Intercept projects that have been launched to recover outstanding claims.

Initiatives Related to Child Abuse and Neglect

- The **median length of time children remain in foster care has been reduced** from 522 days to 419 days over the past three years through a series of system reform initiatives (Families for Kids, Child Welfare Waiver Demonstration, Challenge for Children). Likewise, the number of children in the foster care backlog (i.e. in the custody of a county DSS agency for more than one year) has been reduced by 37% in the same period of time.

- The **annual number of foster children who are adopted more than doubled** in recent years to over 600 children during SFY 97-98 through establishing critical partnerships with private adoption agencies, securing important statutory changes, providing additional staff positions to county DSS agencies, and implementing the Special Children's Adoption Fund.

Child Support Enforcement

- **On target to meet the Governor's Collection goal to increase collections by 50% by the year 2000** through the statewide implementation of the Automated Tracking and Collection System (ACTS) and the state directory of New Hires. ACTS streamlines case management and speeds collections to families by supporting a 24-hour turnaround from receipt of payment to distribution to family. The New Hires directory expedites the location of newly employed absent parents because employers report employees to the state directory within 20 days of hiring.

- **Public Awareness Campaign: Fatherhood Initiative:** Partnered with Carolina Panthers to provide young males with positive role models who take parenting seriously. Campaign includes Eric Davis and children in Public Service Announcements on TV and radio, billboards, transit ads and posters.

Adult Day Care

- **Awarded ten Start-Up Grants** in the amount of $35,000 each **to initiate new adult day care programs**, particularly in counties with no adult day care program. County departments of social services in the counties where the new programs were started were provided with an ongoing allocation of funds with which to purchase services on behalf of their clients.

- **Awarded 3 Conversion Grants** in the amount of $25,000 each **to facilitate conversion of existing adult day care programs to adult day health**, resulting in improved capacity to provide health related services under the direction of a Registered Nurse.

Adult Protective Services

- **Translated existing Elder Abuse materials into Spanish** for distribution to county departments of social services with the goal of educating the Hispanic community about laws protecting the elderly and disabled from abuse, neglect, and exploitation.

- Developed a **Domestic Violence Curriculum** and conducted pilot training for adult protective services workers on recognition of signs of domestic violence involving disabled and elderly adults.

- Completed training Adult Services staff in our Division, Adult Protective Services (APS) staff in county DSSs and regional ombudsmen on **materials designed to train "first responders" (i.e., EMS professionals) on recognition of abuse, neglect, or exploitation of elderly and disabled adults**. Materials include booklets, a video, and visor cards that concisely provide legal reporting requirements for first responders to follow when APS referrals are necessary. These individuals will deploy the local network to train first responders in all communities in NC.

Guardianship

- **Outreach to Communities - piloted workshops to familiarize the public with guardianship**, the petitioning process, and the responsibilities of the guardian. Training conducted by Clerks of Superior Court and attorneys, under the initiative and direction of Division of Social Services staff.

- **Produced a user-friendly brochure, "Guardianship of Incompetent Adults in North Carolina,"** for use by communities across the state. The brochure briefly describes the adjudication of incompetence and the appointment of guardianship proceedings. Copies were disseminated to the Administrative Office of the Courts and local human service agencies across the state.

State/County Special Assistance for Adults

- In response to S.L. 1997-443, Section 11.73, the Division of Social Services, in conjunction with the Divisions of Medical Assistance, Facility Services, and Aging, conducted an extensive **study of ways to provide assistance that supports a range of living arrangements for elderly and disabled adults who are eligible for Medicaid or State/County Special Assistance for Adults**. Findings and recommendations with regard to whether changes are needed in the Medicaid or Special Assistance programs to support alternative living arrangements, and the costs associated with these changes, were reported to the General Assembly in June 1998.

VOCATIONAL REHABILITATION

- **VR evaluated and served over 60,000 disabled people** in SFY 97-98. Approximately 25,000 were deemed eligible for services. The average turnaround from point of application to services being ended is approximately 22 months. VR trained every person requesting services this year without having to create a waiting list.

- **8,527 people were trained and placed on a job.** NC ranks about fifth in the nation for placement. Approximately 98% of VR trainees were mainstreamed into the job market and local economy. Less than 1/2 of 1% are in a sheltered workshop. The 8,527 individuals with disabilities who became employed earned a combined total of $9.3 million dollars per month or an average weekly earning of $251.98.

###

North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

H. David Bruton, M.D., Secretary

SAFETY IN LONG TERM CARE

INTRODUCTION

North Carolina's elderly and disabled population needs safe, high-quality long term care. North Carolina has many very sick people in adult care homes (formerly "rest homes" or "retirement homes"). Many of these residents now experience significant problems with the activities of daily living, and need what is termed "heavy care." While many homes have adapted to these more demanding residents and provide adequate care and a good quality of life, others are understaffed and provide inadequate service. Staff shortfalls go beyond mere numbers to include insufficient training and competency for the more sophisticated tasks. In some homes, residents have not received needed services. Too often, lapses in care have led to unhealthy, unkind, and occasionally tragic results.

The Department of Health and Human Services proposes this initiative to address safety issues, requesting the General Assembly to provide it with the authority to take immediate action in three major areas: (1) Improving Quality of Care; (2) Protecting Residents; and (3) Improving Regulatory Oversight.

Improving Quality of Care

The General Assembly and DHHS have acted to improve conditions in what are familiarly known as "family care homes," "rest homes" and "retirement homes" over the past decade by raising staff-to-resident ratios, instituting Medicaid payments for personal care, and establishing a loan pool for the installation of safety equipment in institutions. These changes have brought about significant improvement in the lives of many residents. Still needed are higher training requirements and certification for managers of facilities and those who give hands-on care to the residents. Medication error rates are alarming and special attention is vital to training staff who administer medications. Homes that hold themselves out as having special Alzheimer's units should meet special regulations to safeguard patients and improve their mental health and well being.

Protecting Residents

Homes with a mix of disabled and frail residents, and those that care for individuals who might pose a risk to others, must ensure the safety of all residents. Safety standards for each resident in every adult care home should be based on a complete assessment that meets the same standards as for nursing homes. Residents must be free to raise issues without fear of reprisal, and must be allowed due process appeals from transfer and discharge procedures instituted by the facilities. Investigators must respond quickly to complaints by residents, families or ombudsmen. When a disabled or frail resident is in jeopardy, the local Department of Social Services must immediately intervene to protect that individual.

Improving Regulatory Oversight

Residents and their families must be assured that they are safe and receiving care appropriate to their needs. At the same time, the public deserves to know that its tax dollars are spent wisely on behalf of those who reside in homes. Inspectors and monitors of homes must be free of conflicts of interest in their assessments. The use of provisional licenses for facilities should be limited. When homes fail to meet compliance standards, the state should be able to respond rapidly to protect the residents, including arranging for temporary management of the facilities when necessary. Owners or managers of nursing homes and adult care homes who engage in egregious conduct should be subject to civil and criminal charges, and the State should prosecute to the fullest extent of the law.

In addition to the legislative action proposed here, the Department of Health and Human Services intends to take actions within its authority to enhance safety and quality of care for long term care residents. Timely, maximum-allowable penalties for significant violations of resident safety will become the norm. The Department also is exploring ways to improve access to care.

The Department will continue developing a long-range comprehensive plan to care for elderly and disabled North Carolinians in the 21st century. The system must address financing, managed care, guardianship and adult protective services, and a spectrum of questions raised by societal changes. Safety and minimum quality issues, however, cannot wait. To protect North Carolinians, corrective action must be taken as soon as possible, including methods for measuring effectiveness and ensuring accountability.

The Department of Health and Human Services requests that the legislative initiatives described on the following pages be considered and enacted by the General Assembly. It is time to address and solve these problems.

2/9/99

SAFETY IN LONG TERM CARE
Summary

I. Improving Quality of Care

A. Require training and staff for medication administration in adult care homes

B. Require training for staff in behavioral interventions

C. Adopt Special Care Unit rules for long term care facilities with specialized units for substantial behavioral management problems

D. Require certification for supervisors and administrators of adult care homes

E. Improve Nurse Aide/Personal Care Aide availability and retention

F. Adjust staff-to-resident requirements in adult care homes and nursing homes to ensure quality care

II. Protecting Residents

A. Give due process and appeals rights for transfer and discharge to residents in adult care homes

B. Develop complete initial assessment and case management to improve resident security and treatment in adult care homes

C. Modify adult care home payment system to accomplish desired results

D. Require standard response time for complaints

III. Improving Regulatory Oversight

A. Develop system of financing to expand local DSS and DFS monitoring

B. Improve accountability for monitoring activities and authorize State takeover of activities when necessary

C. Require local service agencies to develop and provide to DHHS an annual plan for implementing adult care home policy

D. Revise Temporary Management law

E. Provide criminal and civil penalties for egregious activity by home owners and operators

F. Limit use of provisional licenses

G. Move to outcome measurements rather than process measurement.

H. Give the Secretary rule-making authority for this initiative

2/9/99

SAFETY IN LONG TERM CARE

I. Improving Quality of Care

A. Require training and staff for medication administration in adult care homes

Staff who administer or supervise the administration of medications in adult care homes should complete a specific training program. Research studies have shown medication error rates in North Carolina adult care homes of at least 20 percent. In medication reviews of nursing facilities, the acceptable error rate for the federal Health Care Financing Administration (HCFA) is no more than 5 percent. The lack of specific training requirements leaves 25,000+ residents of North Carolina's adult care homes at risk daily from medication administration errors, threatening the health and safety of this vulnerable population.

State standards should ensure that adult care homes have sufficient trained staff designated as medication aides. All medication aides should complete a DHHS-approved medication training program and an annual DHHS-approved refresher course. Supervisors should be credentialed to oversee this activity. Specific standards should address management of complex medication regimens such as those involving invasive techniques and psychotropic drugs. Medication administration standards should more closely reflect those that apply in nursing homes, including appropriate provider review and approval of any psychotropic drugs.

B. Require training for staff in behavioral interventions

Adult care home staff should receive specific training in behavioral interventions. Many residents of adult care homes have conditions that cause behavioral problems. Caring for these residents can be difficult for staff who are not trained in appropriate responses. Lack of training also endangers residents who might be subjected to unnecessary and inappropriate restraint. DHHS should establish standards for such training, including oversight training for supervisors.

C. Adopt Special Care Unit rules for long term care facilities with specialized units for substantial behavioral management problems

A long term care facility that holds itself out as having a unit for residents with substantial behavioral management problems should meet higher standards. Specific requirements should address the more specialized care implied by the title of "special care unit." These standards include higher staff-to-resident ratios, specially trained staff, quarterly functional assessments of residents, activity programs specifically designed for cognitively impaired residents, special consultative services and physical plant improvements to ensure safety.

D. Require certification for supervisors and administrators of adult care homes

No current requirements specifically address the supervision of personal care aides in adult care homes. Supervisors-in-charge, who are responsible for carrying out the program of the home in the absence of the administrator, only have to meet the same training requirements as personal care aides and do not have to have a high school diploma or G.E.D. if they pass an alternative examination established by the Department. Administrator qualifications also are minimal.

A certification program should be put into place for adult care home administrators, and overall administration and management of the home should be the responsibility of a certified administrator. Qualifications for the position of supervisor-in-charge should be increased to require at least a high school diploma or G.E.D. (no alternative examination) and additional training prior to or soon after employment.

Functional requirements for the supervisor-in-charge should specify that the primary responsibility is direct supervision of staff, rather than administrative and management functions in the absence of the administrator. Homes with a capacity of 21 or more residents should be required to have a supervisor-in-charge on duty within the home at all times to assure the proper supervision of staff. Presently, the supervisor-in-charge may be as far away as 500 feet from the home if other staff is within the home.

E. Improve Nurse Aide/Personal Care Aide availability and retention

Adult care homes and nursing homes have increasing difficulty finding and retaining sufficient competent staff to provide day-to-day care of long term care residents in their facilities. A potential solution may be found in the TEACH program, a nationally-acclaimed program developed in North Carolina to address workforce problems in child day care settings. This model should be tested to address the similar problems in adult care and nursing homes. DHHS has been awarded a three-year grant from the Kate B. Reynolds Charitable Trust to test this approach. The legislature should monitor the progress of this effort to see if statewide implementation is warranted.

F. Adjust staff-to-resident requirements in adult care homes and nursing homes to ensure quality care

Existing staffing requirements in adult care homes and nursing homes must be adjusted to accommodate the changing populations and their needs. Minimum staff-to-resident ratios on first and second shifts in adult care homes have not changed since 1977, despite an increase in residents with complex medical and mental health needs and significant cognitive impairments. Many of these residents need additional staff time to ensure appropriate care, supervision and safe evacuation in the case of an emergency. Nursing home minimum requirements also are inadequate.

Simply establishing a staff-to-resident ratio for each shift, without further refinement, does not address quality of care issues. Staffing requirements should be based on the needs of the facility's residents, and the population mix will vary from one home to another. The Secretary should be authorized to adopt rules establishing the minimum staffing requirements necessary to deliver quality care to meet the residents' needs in any facility.

II. Protecting Residents

A. Give due process and appeals rights for transfer and discharge to residents in adult care homes

Adult care home residents should have formal discharge and transfer appeal rights in line with state and federal requirements for nursing homes. Present adult care home rules only require the administrator to provide the resident, resident's family or responsible person and the county department of social services with a two-week written notice citing the reason for discharge or transfer. Rules also allow for exceptions to this notice in the case of jeopardy to the health or safety of the resident or others in the home. The protections afforded to nursing home residents should be extended to adult care home residents.

B. Develop complete initial assessment and case management to improve resident security and treatment in adult care homes

Adult care homes serve a mixed population, including frail elderly, mentally ill and developmentally disabled persons. A Research Triangle Institute study has shown that service needs vary widely among individual residents. The present reimbursement system can only distinguish among differing service needs in a limited way through enhanced care.

There is no present requirement for an adequate assessment to identify mental health conditions needing follow-up and treatment by a mental health professional. Adult care home residents need a comprehensive mental health assessment, treatment plan and close follow-up to make sure needed mental health services are provided. In addition, these residents with certain mental health problems must be identified so that they do not pose a danger to other residents. Safety standards based on initial assessments must be put into place. County departments of social services should be charged with ensuring that these assessments are conducted and the results incorporated into the resident's care plan. Area mental health authorities should be charged with accomplishing the assessments and treatment plans as requested by the county DSS.

Residents who do not require a mental health treatment plan will continue to be assessed by DSS care managers to determine their need for enhanced care.

Eventually, a more comprehensive assessment system is needed to accurately identify personal care and other service needs for all adult care residents. Developing such an assessment system will require a commitment of time and administrative resources from both the industry and the State. DHHS is beginning the planning process to develop a comprehensive assessment system for residents of adult care homes.

C. Modify adult care home payment system to accomplish desired results

The system used to pay operators of adult care homes should serve as an incentive for good care. Currently, operators all receive the same amount for each State-County

Special Assistance resident, regardless of the level of resident needs. As a result, any funds not spent on personal care, food, staff supervision, or other services can become profit for the operator.

Adoption of a system that divides the payment between direct care and indirect care, as is done with nursing homes, can solve this problem. Funds allocated for direct care that are not spent for direct care would be paid back to the State. Payment increases intended to improve staffing would be spent for that purpose. An improved payment system would help maximize federal funds and end reliance on state and county appropriations as the sole source of increased payment rates.

Family care homes (adult care homes with six or fewer beds) should shift to a market rate reimbursement system, eliminating the requirement to submit cost reports.

The change in payment system cannot be implemented unilaterally by the State without jeopardizing Medicaid eligibility for some residents. Therefore, these changes would be conditioned upon receipt of a federal waiver allowing the changes without adverse affect on the Medicaid population.

D. Require standard response time for complaints

The law should establish a minimum time within which responsible agencies must initiate complaint investigations. DFS presently takes from 60 to 90 days to investigate routine complaints against nursing homes. Citizens should not have to wait so long to have their grievances addressed, and substantiating a stale complaint becomes difficult after so much time. County departments of social services currently have no specific time frame to investigate complaints in adult care homes.

For life-threatening situations, an investigation should be initiated immediately and in any event within 24 hours. 48 hours would be satisfactory for less serious conditions , and two weeks is appropriate for routine matters. Investigation completion standards also should be established.

III. Improving Regulatory Oversight

A. Develop system of financing to expand local DSS and DFS monitoring

The number of currently available county adult home specialists should be expanded by collecting a fee to support the monitoring activity. In recent years the monitoring demands on the county departments of social services have increased significantly because of expansive growth in the number of adult care homes. Over 1,500 homes with more than 36,000 beds require monitoring. Current projections indicate approximately 15,552 additional beds may become available within the next two years.

D. Revise Temporary Management law

The temporary management law for nursing homes and adult care homes (G.S. 131E, Article 13) needs to be amended to correct flaws that inhibit the use of a temporary manager when needed. This statute allows the court to appoint a temporary manager when certain criteria are met, but the procedural steps restrict prompt action in life-threatening situations. Other features of the law make finding temporary managers very difficult.

E. Provide criminal and civil penalties for egregious activity by home owners and operators

The State should implement recommendations of the Department of Crime Control and Public Safety to impose criminal sanctions for egregious conduct by owners and operators of adult care homes. In addition, enhanced civil enforcement should be developed to discourage disreputable home owners and operators. Civil remedies should include treble damages and the means to hold the true wrong-doers liable for their actions.

F. Limit use of provisional licenses

Adult care homes may be downgraded to a provisional license for substantial failure to comply with regulations, so long as corrections are expected and attainable in a reasonable time. DFS may extend the provisional license, and some have been extended over too long a period of time.

DFS should extend provisional licenses beyond six months only under extraordinary circumstances. If deemed necessary to avoid legal challenges, this policy should be codified.

G. Move to outcome measurements rather than process measurement

Success in delivery of quality care to long term care recipients should be measured in terms of outcomes and results rather than by statistical compilations of activity. For example, the medication aide training is successful if the medication error rate falls. Defining measurable outcomes is difficult in the human services area, and particularly in long term care, because of the nature of the service and the complex factors affecting results. Valid assessment of the initiatives presented here, however, depends on developing these goals. DHHS should take the lead in implementing this system.

H. Give the Secretary rule-making authority for this initiative

To coordinate the diverse requirements of safety in long term care, the Secretary of Health and Human Services should be authorized and directed to adopt the necessary rules to implement this initiative. Currently, the Social Services Commission has rulemaking authority for adult care homes; the Medical Care Commission for nursing homes. The Divisions of Aging, Medical Assistance, Mental Health, Developmental Disabilities, and Substance Abuse Services, Social Services, Facility Services, Public Health, and the Secretary's Office all have responsibility for aspects of long term care policy.

1998 Session of the General Assembly
Studies

Study	Origin Bill/Section	Task	Study to Whom	Due Date	Study Responsible Division/Staff/ Update
Study of Provider Reimbursement Rates/Report-Final	SB 352/11.7	Contract with an independent consultant to develop an evaluation design (including an assessment of the impact of the Program on the economic security and health of children and their families). The Department is to report on the results of this evaluation.	Approp. Subcomm./ FRD	2/1/99	The study has been completed by a consultant. Comments are in the process of being reviewed and incorporated. The report will be provided by March 1, 1999.
Study the Advisability of Creating an Office of Strategic Planning in the Office of the Secretary of Health and Human Services	SB1366/12.2	Conduct study and report findings and recommendations, which shall include the advantages and disadvantages, of creating an Office of Strategic Planning in the Office of the Secretary and projected costs of implementation.	H&S Appropr/HR	3/15/99	Internal study has been conducted to identify staff and planning procedures within the divisions. We are in the process of securing an outside contractor to complete study. The study will not be complete by the due date and a request to extend until June 15, 1999 has been made.
Study existing laws and propose changes that will improve dental treatment for Medicaid recipients and other patients	SB1366/12.12C	Review laws and rules. In consultation with NC Dental Society, propose recommended changes to improve the opportunity for quality dental treatment for Medicaid and other patients.	H&S Approp/HR	4/30/99	The study is being conducted by the Institute of Medicine in conjunction with Lt. Gbv. Wicker's office.
Improve Quality of Academic Programs at Residential Schools - Collaborative Effort to Improve Quality of Academic Programs At Residential Schools/Program Review of Disability Services and conduct a compressive review of policies, programs and services managed by the DVR, DSB and DHH and recommend organizational changes to improve the department's effectiveness in serving citizens with disabilities.	SB1366/12.3C(a) and (b)	Conduct a study to identify and evaluate ways to improve services and cost-effectiveness of residential schools to persons with disabilities. The study will assess changes in structure and functions of selected DHHS divisions and residential schools, assess the organizational context for ABC's , examine ways to improve services to disabled persons and define organizational options.	Approp Sub-Com on Education & H&S Approp/HR	4/15/99	DHHS has contracted with PricewaterhouseCoopers (PwC) to conduct the Education and Disability Organizational Study. An advisory group has been named consisting of representatives of statutory defined groups such as the NC Council for the Deaf and Hard of Hearing, Commission for the Blind, Chair of the VR Council, The Mental Health Study Commission, division staff and interested persons. There have been three meetings that included overall project design, report of peer organizations, and preliminary findings, etc. A final meeting is scheduled for March 5 with the contractor and final recommendations regarding organizational options for consolidation will be presented.

Study	Origin Bill/Section	Task	Study to Whom	Due Date	Study Responsible Division/Staff/ Update
Licensed Child Placing Agencies Rate Study	SB1366/12.29A	Contract with an independent consultant to study the rate setting; review the agencies current rate-setting process; determine if current process results in adequate reimbursement; department to report results of study to gather with any recommendations.	H&S Approp/HR	5/15/99	DSS Staff has been working with the Controller's Office on this study. The independent consultant has been selected. The study is anticipated to be completed by the reporting date.
Dorothea Dix Hospital Redesign	SB 1366/29.5B	- hire planning and design contractor - study cost of construction and operation of new as compared to re-design and long term operation of existing psych hospitals - work in conjunction with Study of PsychHosp/Area Prog. -	H&S Approp Comm/HR	5/1/99	Designer has been selected and study is underway.

Study	Origin Bill/Section	Task	Study to Whom	Due Date	Study Responsible Division/Staff/ Update
Studies done by non-DHHS agencies on DHHS programs or related services.					
Study need to increase Medicaid reimbursement rates for physicians	SB1366/12.13	Provide data as requested.	General Assembly	1999 Session	Joint Leg Comm on Health Care Over.
Early Intervention Services/Referral/Study	SB1366/12.32A	- conduct study/review of NC system of delivering early intervention services to children birth - 5 yrs old in areas such as eligibility, quality, availability and timeliness - study the transition from infant-toddler to pre-school - manage and focus on pre-school services to children with vision and hearing impairment - study/review inter-agency coordination and funding	H&S Appropr/HR, FRD & Ed Oversight	3/1/99	Interagency Coordinating Council
Study of Psychiatric Hospitals/Area Mental Health Programs.	SB1366/12.35A	Requires collaboration and consultation with the Department. - Area pgm progress rpt ; current operations/admin policies procedures/ funding streams.	HHS Approp. Comm.	Interim 3/15/99 5/1/99 11/1/99 12/1/99 Final 4/1/00	State Auditor
State Veterans Nursing Home Study	SB1366/25.1	OSBM report but required to consult with DHHS.		April 1, 1999	OSBM

	Origin Bill/Section	Task	Study to Whom	Due Date	Study Responsible Division/Staff/ Update
Reports involving DYS					
Study the funding process for juvenile delinquency and substance abuse prevention programs provided for in the Act	SB1260/Sec. 31	To be determined by the Office of Juvenile Justice.	FRD & H&S Approp/HS & H&S/Approp	5/1/99	Office of Juvenile Justice & DHHS
Study over-representation of racial minorities in juvenile justice system	SB1260/Sec. 33	To be determined by the Office of Juvenile Justice.	Governor, Chief Justice and General Assembly	5/1/99	Office of Juvenile Justice
Study the use of detention facilities and make recommendations as to how detention facilities could be utilized more efficiently	SB1260/Sec. 34	To be determined by the Office of Juvenile Justice.	FRD & H&S Approp	5/1/99 & 1/15/2001	Office of Juvenile Justice
Study blended sentencing and direct filing of certain juvenile cases	SB1260/Sec. 30	To be determined by the Office of Juvenile Justice and NC Sentencing and Policy Advisory Commission.		3/15/00	Office of Juvenile Justice and NC Sentencing and Policy Advisory Comm.
Study the need for one or more residential treatment centers for youth with crimes containing and element sexual conduct	SB1366/8.1 (g)	To be determined by the Office of Juvenile Justice.	H&S Approp	4/1/99	Governor's Office & Office of Juvenile Justice

Department of Health and Human Services
Central Management and Support

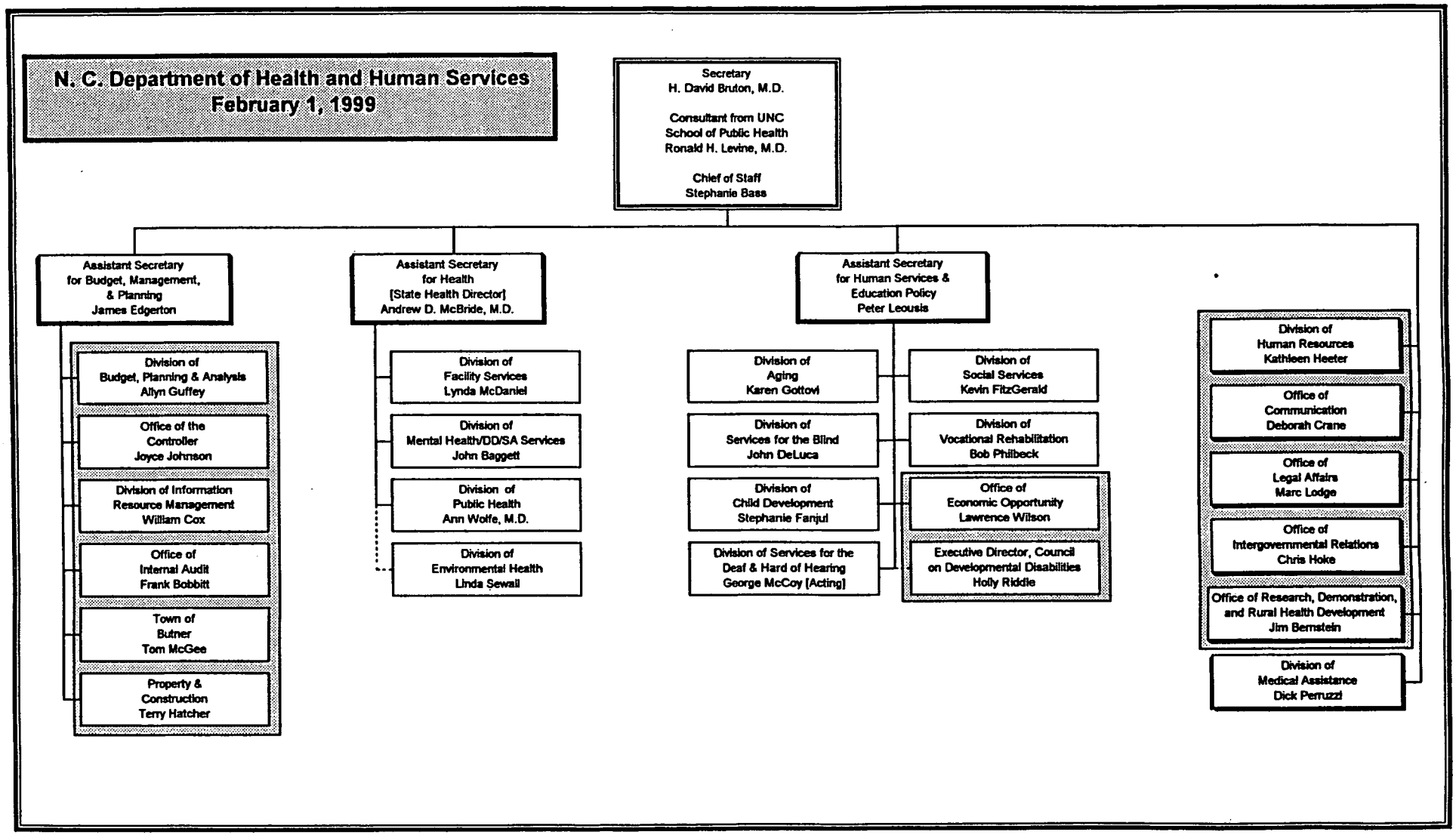
Budget Overview

Presented by: James B. Edgerton, Assistant Secretary for
Budget, Management and Planning
February 25, 1999

Table of Contents

O-chart	1
Central Management and Support Mission and Operations	2
Central Management and Support Funds	4
Chart 1, DHHS Total Budget SFY 98-99	5
Chart 2, Central Management and Support Funding by Purpose SFY 98-99	6
Chart 3, Central Management and Support Total Positions SFY 98-99	7
Central Management and Support Budget Summary	8
Central Management and Support Programs and Services	11

N. C. Department of Health and Human Services
February 1, 1999



Mission Statement

Direct operations and provide services for the department's agencies and institutions.

Operations

Demonstrations and Rural Health

- Develop and provide on-going technical assistance to rural health centers.
- Provide operational and capital support to primary care health centers.
- Recruit and place health care professionals in underserved areas.
- Develop and provide ongoing technical assistance for local development efforts for managed care (ACCESS II/III) and long-term care systems.

Council on Developmental Disabilities

- Conduct systems change, advocacy, and capacity building activities for people with developmental disabilities and their families.
- Assess and promote interagency coordination; promote public awareness.
- Monitor and evaluate utilization of grant awards.

Economic Opportunity

- Provide Emergency Shelter Grants Program funds to local homeless shelters.
- Assist local shelters in identifying additional program resources.
- Provide Community Services Block Grants to local community action agencies.
- Provide training and technical assistance to local grantees.

Central Management and Support

- Set policy and coordinate program administration for the department's agencies and institutions.
- Provide public information and media relations support for DHHS agencies, local agencies, and the general public.
- Provide direction and guidance to assure that department staff receive sound legal advice and legal services.
- Coordinate the Administrative Procedures Act (APA) rule-making process for the department.
- Direct the intergovernmental liaison activities between the department and federal and local governments and human service provider associations.
- Coordinate department responses to legislative requests.
- Review, approve, and oversee grants, State Plan development, and federal funding related interactions.
- Provide information and referral services including the toll free telephone service, CARE-LINE; provide problem resolution via an ombudsman component.
- Provide independent reviews and analyses of various functions and programs within the department.
- Provide guidance to department staff in implementation of the American with Disabilities Act (ADA).

Human Resources

- Facilitate recruitment services for all divisions.
- Facilitate supervisory and employee development programs in all divisions.
- Promote effective administration of position classification, salary administration, and compensation programs.
- Process local human services agencies' position actions.
- Conduct site visits to monitor compliance with State Personnel Act (G.S. 126) and Education Act (G.S. 115) policies and procedures.
- Provide consultation/technical assistance on personnel issues to board chairs, agency directors, and staff.
- Promote safety program compliance.
- Promote positive employer/employee relations.

Budget, Planning, and Analysis

- Execute all budget functions for the department; provide information and analysis of budget and program issues.
- Plan, coordinate, and supervise the preparation and submission of the operating and capital budgets; strategic and program plans, and senior management reviews.
- Review and approve contracts and receive requisitions and quotes, and issue purchase orders for goods and services.
- Provide property management, and intradepartmental mail and courier service.

Controller

- Account for all fiscal activities within the department.
- Process all invoices/benefits for payment and receipts for deposit.
- Maintain financial records and source documents; prepare and file financial reports; automate processes to increase efficiency.
- Recommend and administer fiscal policy; conduct training for division and local staff on fiscal policy and procedures.

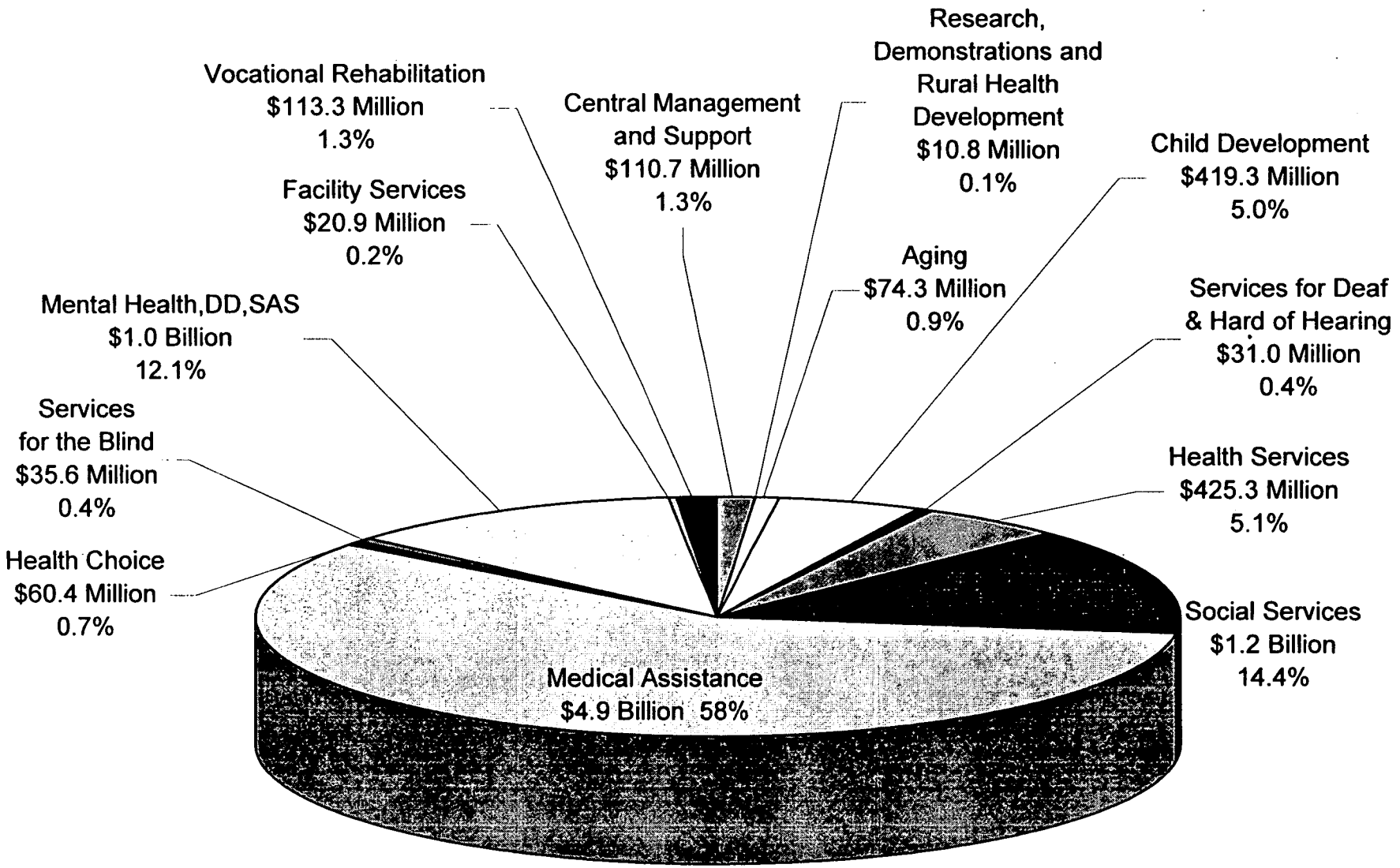
Information Resource Management

- Provide high quality, adaptable information systems: on time, within budget, conforming to business functional requirements, satisfying client expectations, with minimal defects.
- Provide networks that support the business requirements.
- Lead DHHS partners to leverage technology to assist in solving business problems.

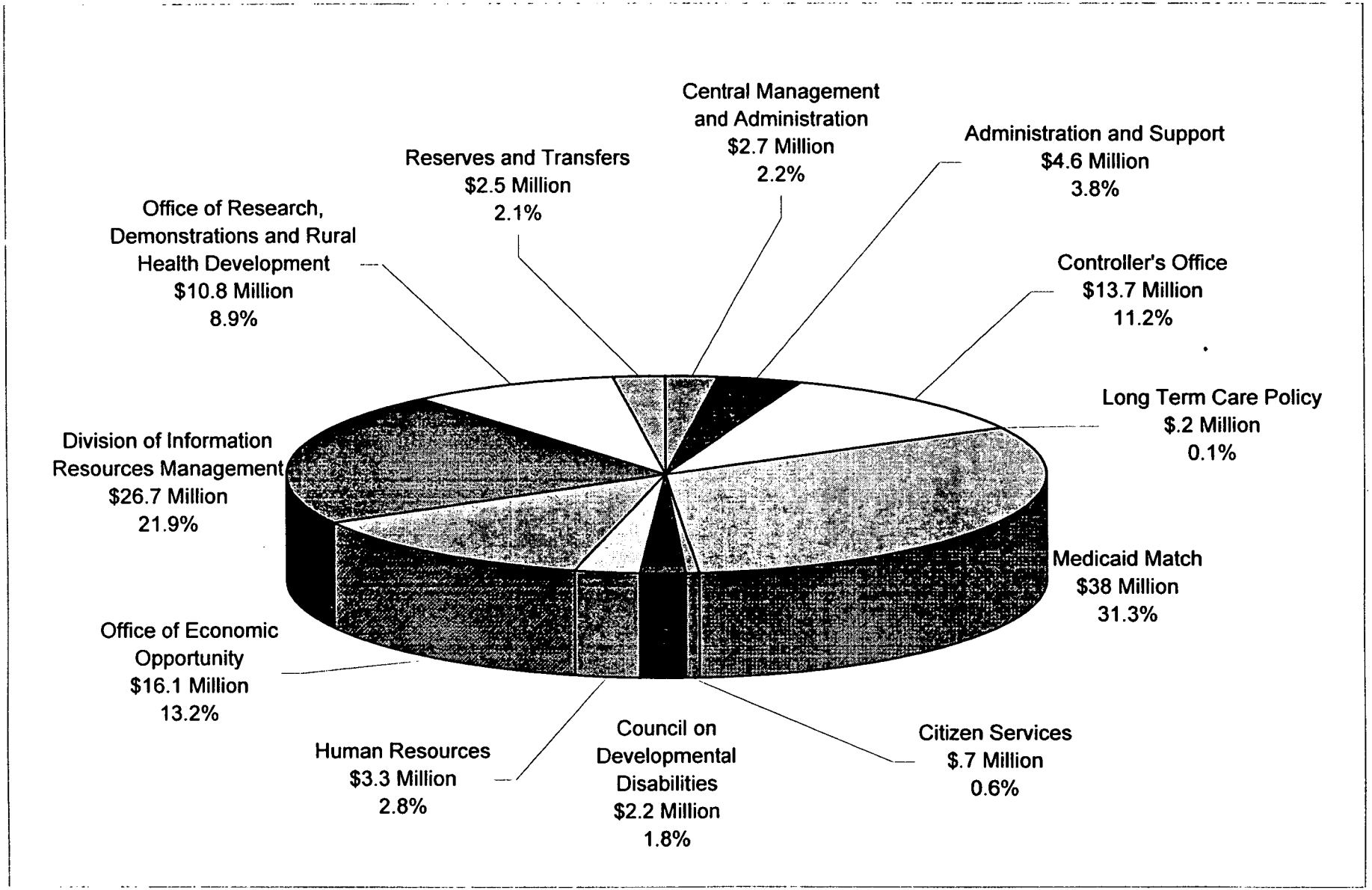
Central Management and Support Funds

	1998-99 Budget	Positions
Central Management and Administration • Secretary's Office • Office of Intergovernmental Relations • Communications Office	$2.7 Million	41
Administration and Support • Budget, Planning and Analysis • Internal Auditor • Property and Construction • Central Purchasing and Mail Services	$4.6 Million	59.5
Controller's Office	$13.7 Million	279.1
Long Term Care Policy	$0.2 Million	2
Medicaid Match Reserve for Mental Health	$38 million	0
Citizen Services	$.7 Million	11
Council on Developmental Disabilities	$2.2 Million	10
Human Resources	$3.3 Million	58.8
Office of Economic Opportunity	$16.1 Million	10
Division of Information Resources Management	$26.7 Million	150
Office of Research, Demonstrations and Rural Health Development	$10.8 Million	37
Reserves and Transfers	$2.5 Million	0
Total	$121.5 Million	658

How Does Central Management and Support Compare to Total Department



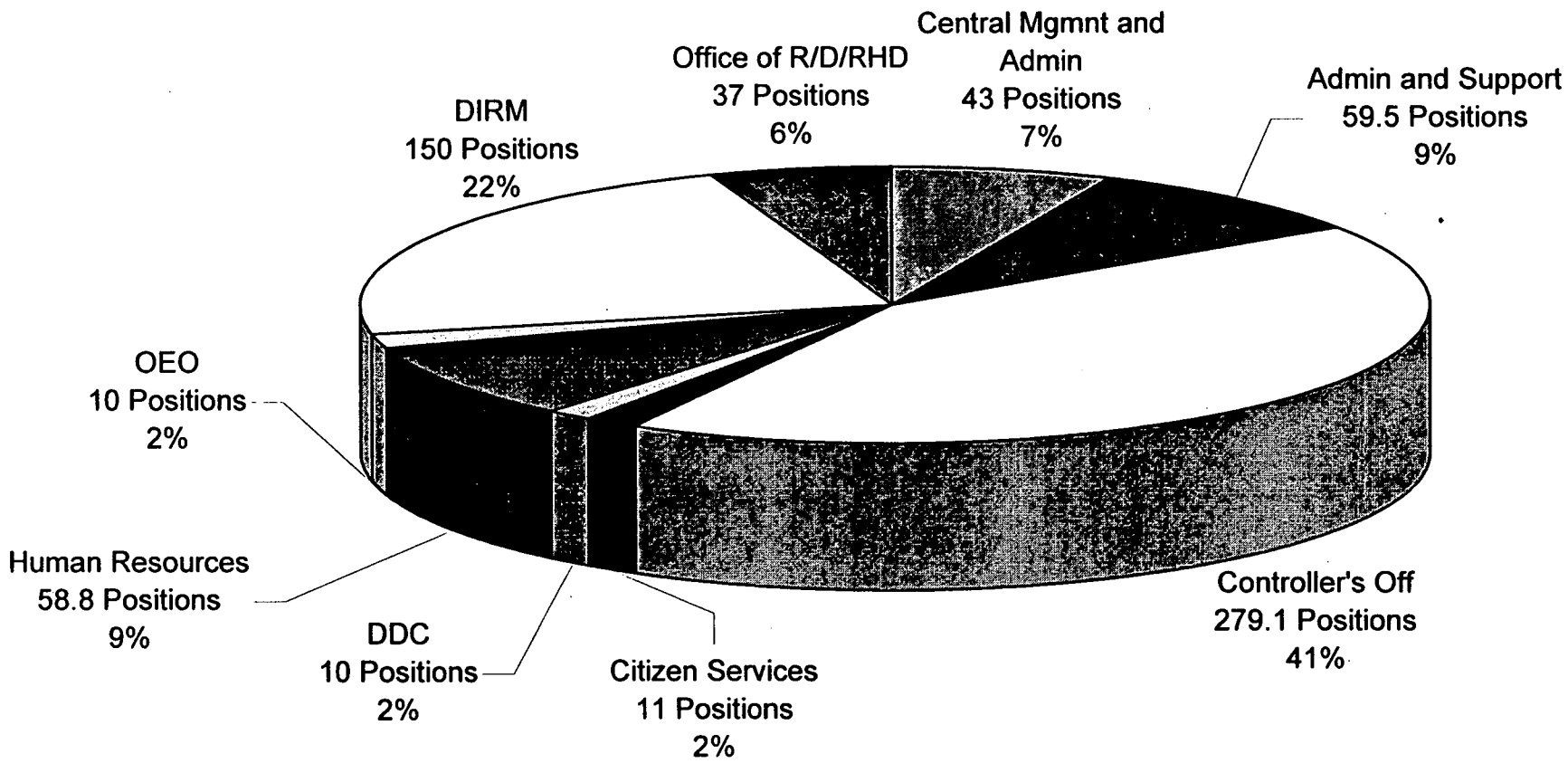
DHHS Total Budget SFY 98-99 $8.4 Billion



Central Management and Support
Funding by Purpose SFY 98-99 $121.5 Million

Chart 2

Of DHHS's 20,194 positions, 3.3 percent or 658 are in Central Management and Support



Central Management and Support
Total Positions SFY 98-99

Central Management and Support

Budget Summary

	1997/98 Actual	1998/99 Authorized	Net Inc (Dec) 1999/2000	1999/2000 Recommended	Net Inc (Dec) 2000/2001	2000/2001 Recommended
Total Requirements	$ 93,737,140	$ 121,522,532	$ 6,415,990	$ 127,938,522	$ 7,235,663	$ 128,758,195
Total Receipts	47,849,682	34,121,471	4,496,753	38,618,224	4,496,753	38,618,224
Net Appropriations	$ 45,887,458	$ 87,401,061	$ 1,919,237	$ 89,320,298	$ 2,738,910	$ 90,139,971
Number of Positions	659.00	658.00	0.00	658.00	0.00	658.00

Increases(Decreases) for 1999-2001

Item		Net Inc (Dec) 1999/2000	Net Inc (Dec) 2000/2001
1. Increase in Medicaid Match Reserve as established by the 1998 Session of the General Assembly to ensure that there are sufficient funds to match federal Medicaid dollars spent by the Area Mental Health Programs. The SFY 1999/00 increase is based on projected SFY 1998/99 spending with adjustments for increases in eligibles (utilization) of 2.66%, and the average cost per eligible (inflation) of 6.0%. The SFY 99/00 increases are built upon the SFY 99/00 projected spending with adjustments for utilization (3.79%) and inflation (6.0%). The projections assume that the state and county will share equally in funding the increases.	**Requirements**	$ 3,355,090	$ 4,174,763
	Receipts	$ -	$ -
	Appropriation	$ 3,355,090	$ 4,174,763
2. Increase in the DIRM Misc. Contractor account is to enable DIRM to continue to provide the required maintenance and modifications to over 150 systems maintained and operated on behalf of the department. These systems provide client benefits and services to the citizens of N.C. and any reduction in the division's capabilities to maintain and modify these systems as required would result in the incorrect and non-timely distribution of eligible benefits to those citizens of N.C. These systems also are needed to meet the federal reporting requirements. The projected annual expenditures for this current SFY are $7.1 Million. Like many organizations, DHHS has significant problems recruiting and retaining qualified information tecnology staff because competition for employees with the necessary skills is fierce. DIRM has had to rely on contractor staff to ensure that vital automation systems are maintained and modified. Contractors come at a higher rate than employees. State funds requested are matched with applicable federal funds for a total requirement increase of $4,400,800.	**Requirements**	$ 4,400,800	$ 4,400,800
	Receipts	$ 1,393,026	$ 1,393,026
	Appropriation	$ 3,007,774	$ 3,007,774

3. Increase in DIRM SIPS account is requested to enable the division to budget for actual cost anticipated to be required over the next biennium. Based on annualized expenditure figures, approximately 16.5 million dollars will be expended for this service in SFY 1998/99. The increase in cost is due to the large increase in the number of state and local users brought about by the implementation of the NCAS and ACTS system, along with the transition of Health Services back to DHHS. NCAS has added approximately 1,500 new users to the system, while the implementation of the ACTS system brought 7,408 new users to the system. Daily transactions for this system alone total 875,000 to 925,000 per day. State funds requested are matched with applicable federal funds for a total requirement increase of $7,500,000.	**Requirements**	$ 7,500,000	$ 7,500,000
	Receipts	$ 3,057,053	$ 3,057,053
	Appropriation	$ 4,442,947	$ 4,442,947
4. Misc. other increases are for the adjustment of salary, longevity payments, social security requirements, and retirement requirements as authorized by the budgeted salary amounts in each fund.	**Requirements**	$ 474,500	$ 474,500
	Receipts	$ 46,675	$ 46,675
	Appropriation	$ 427,825	$ 427,825
5. Misc. other deductions are for non-recurring appropriations funded by the 1998 Short Session of the General Assembly for the Hearts and EIS Y2K projects ($6,864,399) in DIRM and the ABC Education Plan ($2,450,000).	**Requirements**	$ (9,314,399)	$ (9,314,399)
	Receipts	$ -	$ -
	Appropriation	$ (9,314,399)	$ (9,314,399)
TOTAL NET INCREASES	**Requirements**	$ 6,415,991	$ 7,235,664
	Receipts	$ 4,496,754	$ 4,496,754
	Appropriation	$ 1,919,237	$ 2,738,910

HEALTH AND HUMAN SERVICES
Program and Services by Division

CENTRAL MANAGEMENT AND SUPPORT

Office of Communications
Debbie Crane, Director, 919-733-9190
Office of Legal Affairs
Marc Lodge, General Counsel, 919-733-6920
Office of Legislative and External Affairs
Chris Hoke, Acting Chief, 919-733-2173

Office of Citizens' Services
Leslie Mann, Director, 919-733-4261 (Voice), 919-733-4851 (TTY)
Council on Developmental Disabilities
Holly Riddle, Director, 919-733-6566
Office of Economic Opportunity
Lawrence Wilson, Director, 919-773-2818
Division of Human Resources
Kathy Heeter, Director, 919-733-2940

Division of Budget, Planning and Analysis
Allyn Guffey, Director, 919-733-6396
Office of the Controller
Joyce Johnson, Controller, 919-733-0169
Division of Information Resource Management
Bill Cox, Director, 919-733-8900
Office of Internal Audit
Frank Bobbitt, Director, 919-715-4791

Services Provided to Divisions/Management

Legal Services
Accounting Services
Budget Management and Program Analysis
Purchasing and Contracting
Mail Services
Information Resource Management
Government Liaison Services
Public Information
Coordination of Education Programs
Personnel Management
Grants Management
Property Management & Constructions
Community Involvement Services
Disabilities Act Management & Services

Services Provided to Local Agencies/Individuals

Citizens Affairs & Referral Services
Holocaust Council
- Education
Community Action Grants
Audit Services
Developmental Disabilities Grants
Provide consultation on personnel issues to Local Human Services Agency Board Chairs, Ageny Directors & Staff

HEALTH AND HUMAN SERVICES

Program and Services by Division

OFFICE OF RESEARCH, DEMONSTRATIONS, AND RURAL HEALTH DEVELOPMENT

James D. Bernstein, Director, 919-733-2040

- Aid for Clinic Operation
- Aid for Clinic Construction
- Primary Care Provider Recruitment
- Loan Repayment Program
- High Needs Service Program
- Residential Stipend Program
- Rural Health Scholars Program
- Farmworker Health Program
- Long Term Care Demonstration
- Community Hospital Technical Assistance Program.
- Essential Access Community Hospital Program
- Community Primary Care Program
- Access II/III Program
- Dental Recruitment and Development
- Health Professional Shortage Analysis
- Physician Assistant/Family Nurse Practitioner Residency Program
- Primary Care Technical Assistance Service
- Architectural design
- Graphic design
- Maternity services
- Laboratory services
- Computer systems
- Financial/Reimbursement services
- Practice Management
- Managed Care

Department of Health and Human Services (DHHS)
Division of Information Resource Management

Systems Supported in DHHS Grouped by Division or Office

Division of Facility Services
- Jails and Detention Inspection System
- Emergency Medical Services Certification/Manpower/Inventory
- Master File
- Nurse Aid Registry
- Nurse Aid Abuse
- Master File Reporting System
- Voice Response Interface

Office of the Secretary
- Personnel Management Services System
- Purchase Order System
- Safety Reporting System
- Public Affairs Office System
- Legislative Tracking System
- Red System
- Rural Health

Division of Services for the Deaf and Hard of Hearing
- Student Billing System

Division of Information Resource Management
- Operations Support System
- Project Control System
- Vacancy System
- Public Records Law System
- Output Reporting System
- Survey Reporting System
- Skills Inventory System
- Microman Time Reporting System

Division of Aging
- Aging Resources Management System

Division of Child Development
- Day Care Regulatory System
- Criminal Background Check
- Contract System

Division of Child Development and Office of the Controller
- Day Care Reimbursement (Subsidy Child Care)

Division of Social Services
- Central Registry Child Abuse and Neglect
- Central Registry Fatalities
- Foster Care Licensing
- JOBS
- Adult Protective Services

Division of Social Services (Continued)

- Services Information System/County Administration Cost Interface
- Daysheets
- Services Information System
- Emergency Assistance
- Records Management System
- Adoption Indexing Management System
- DPAG System
- Leave System
- Forms Inventory System
- Refugee Information System
- Child Support Enforcement
- ACTS-FKY
- ACTS
  - Title IV-D Child Support SPEC Training
- ADCS
- Case Tracking
- IV-D Letters
- CAMS
- Food Stamp Information System
  - County Test
  - Client Acceptance Test
  - Client Acceptance Test for Welfare Reform
  - Year 2000 client Acceptance
  - Year 2000 Development
  - Year 2000 Base
  - DIRM Development and Test
  - Food Stamp User Test Region
  - Work First/Food Stamps for Food Stamp Information System
- Food Stamp Quality Control Sampling System
- Statewide Automated Child Welfare System
- Housing and Urban Development
- Thomas DR System
- Electronic Benefits Transfer
  - Development
  - Client Acceptance
- Duke Power
- Telephone Waiver
- Social Services Quality Control Sampling System

Division of Social Services and Office of the Controller

- Child Placement System
- Energy Assistance

Division of Social Services and Division of Medical Assistance

- Eligibility Information System (EIS)
  - Work First Family Assistance for EIS
- Claims Processing Contractor
- Third Party Recovery
- Claims Processing Assessment System
- Medical Assistance Quality Control Sampling System
- Medicaid Accounting System
- Hospital Based Cost Report
- Intermediate Care Facility/Mental Handicapped Cost Report

Division of Social Services and Division of Medical Assistance (Continued)

- Beneficiary Earnings Exchange Report
- Bendex
- Employment Security Commission Match
- Income Eligibility Verification System Internal Revenue Services
- Master Client Index
- Supplemental Social Security Data Exchange
- State On-Line Query
- Social Security Third Party Query
- Nursing Cost Report
- On Line Verifications

Office of the Controller

- Allocations
- County Administration
- Domiciliary Care Rate Set (Subsid Child Care)
- Food Stamp Federal Grant Reporting
- Transaction Billing System
- Electronic Funds Transfer

Division of Mental Health, Developmental Disabilities and Substance Abuse

- Healthcare Enterprise Accounts Receivable and Tracking System
- Client Information Online System
- Cost Accounting
- Institutional Client Database/Movement System
- Pioneer Unit Cost Recovery II Reimbursement System
- Thomas S Client Tracking System
- Willie M System
- Controlled Substance Regulatory System
- Unit Cost Recovery Data Download System
- MC Plus Pharmacy

Division of Services for the Blind

- County Billing
- Business Enterprise Relief Worker Payroll
- Business Enterprise Manager Payroll
- Electronic Service System
- State Aid to the Blind Reporting
- Governor Morehead School Purchase Order System

Division of Vocational Rehabilitation

- Client/Vendor/Authorization System
- Financial Systems
- Social Security Reimbursement
- Supported Employment System
- Community Rehabilitation Program Online
- Community Rehabilitation Program Batch
- Batman Data Entry

Division of Youth Services

- Community Based Alternative
- Non-Secure Detention Centers
- Secure Detention Centers
- Training Centers
- Treatment Services

Division of Public Health

- North Carolina Accounting System (NCAS)
- NCAS/County Administration Budget Interface
- Purchase of Medical Care Services
- Consolidated Contract Data Systems
- Immunization School Survey
- Tuberculosis Control Assessment System

Departmental Enterprise Systems

- Program Integrity Tracking System
- Common Data System

Project Status Tracking

✓ on-track

YIELD issues

STOP no progress or potential showstopper

Focus Project	Pre-Planning	Planning	Requirements	Design	Construction	Testing	Training	Roll out	Production	Comments
ACTS 4.0	✓	✓	✓	✓	✓	✓	✓	✓	✓	In Production February 1, 1999
Acts 5.0	✓									
After Hours Query	✓									Start up planned for 1st Qtr 99.
Biometrics	✓	✓	YIELD							Legislation finalized; submitting documents for federal approval and funding.
Common Name Database Service	✓	✓	✓	✓	✓					On Schedule
County State Interface	✓	✓	✓	✓						
DRIVE (Phase 2)	✓	✓	✓	✓	✓	✓	✓	✓		In Production during month of February
EBT)	✓	✓	✓	✓	✓	✓	✓	✓		On Schedule.
eLINC (ASAP)	✓	✓	✓	✓						On Schedule

Project Status Tracking

on-track

issues

no progress or potential showstopper

Focus Project	Pre-Planning	Planning	Requirements	Design	Construction	Testing	Training	Roll out	Production	Comments
EPICS	✓	✓	✓	YIELD						Potential budget cut and scope discussion in progress
HEALTH CHOICE PHASE 2 & 3	✓	✓	✓	✓	✓					On schedule for 4/30
HEARTS	✓	✓	✓	YIELD	YIELD	YIELD	✓			Working with the vendor to expedite finalization of one outstanding design specification.
Infrastructure Services Initiative (SCI)	✓	✓	✓	YIELD	YIELD					
INSYNC (SACWIS) Phase 2	✓	✓	✓	✓	✓					Conversions of screens to browser technology in progress.
Online Manuals	✓	✓	✓	✓	✓					Proof of concept with Wake County.
Strategic Projects Convenience Type Contract	✓	✓	✓	✓	✓					Superceded by ITS convenience contract
Welfare Reform BPR	✓	✓	✓	✓						RFP submitted. Vendor to be chosen in March or April.

Project Status Tracking

on-track

issues

no progress or potential showstopper

Focus Project	Pre-Planning	Planning	Requirements	Design	Construction	Testing	Training	Roll out	Production	Comments
Work First	✓	✓	✓	✓	✓	✓	✓	✓	✓	Recently delivered electing county functionality for County Admin System. Other mods in various stages.
Year 2000	✓	✓	✓	✓	✓	✓				

February 22, 1999

www.sips.state.nc.us/DHR/DIRM/focus.htm

DHHS Mission

To serve the people of North Carolina by enabling individuals, families, and communities to be healthy and secure, and to achieve social and economic well-being.

To achieve this mission, the department will...

- provide comprehensive and coordinated services for prevention, intervention, assistance, education, and empowerment;
- ensure equal access to services;
- be accountable for achieving meaningful results;
- continuously improve service delivery by involving citizens; and
- support and develop employees as diverse, invaluable resources.

DHHS Partners

- Federal agencies
  - USDHHS, USDA
  - Financial participation
  - Program administration
  - System guidance
- Other State agencies
  - Shared population
  - Interfaces
- Local agencies & stakeholders
  - Department of Social Services, Area Mental Health Programs, Health Department
  - Private non-profit
  - Advocates
  - Providers

DHHS Serves

- Direct service contacts: 20,400,000/year
- Indirect services touch all citizens
- Locations in all 100 counties, regional, and Raleigh based facilities
- Continuum of care - birth through death

DHHS Budget

- DHHS Total Budget $ 8.4 Billion
- DHHS IT Expenditures $109.4 Million

Comparison to Industry Standard

- Industry standard for IT expenditures:
  - 7.7% of revenue for public agencies
  - 4.1% of revenue for all industries
- DHHS IT Expenditures is 1.30%

DHHS Automation Budgets

Operations, Maintenance & Development	$74,444,805.00
DMA Fiscal Agent Contract	$19,824,745.00
SIPS Data Processing Charges	$15,174,933.00
Total DHHS Information Technology Budgets	$109,444,483.00

DHHS IT Budgets by Division

Division	Total $	%
Central Administration	1,183,211	1.08%
Division of Aging	270,566	0.25%
Division of Facility Services	488,167	0.45%
Division of Medical Assistance	41,952,704	38.33%
Division of Vocational Rehabilitation	1,491,504	1.36%
Division of Youth Services	153,681	0.14%
Division of Social Services	53,873,233	49.22%
Division of Services for the Blind	318,946	0.29%
Division of Mental Health	5,502,207	5.03%
Division of Child Development	1,584,594	1.45%
Division of Deaf and Hard of Hearing	885,670	0.81%
Health Services	1,740,000	1.59%
Total DHHS Information Technology Budgets	109,444,483	100%

AGENDA

Joint Appropriations Subcommittee on Human Resources

March 2, 1993

8:30 am

Opening Remarks	Senator Bill Martin Representative Beverly Earle Representative Edd Nye
This Week's Schedule	Carol Shaw Fiscal Research Division
Division of Facility Services	Carol Shaw Fiscal Research Division

APPROPRIATIONS SCHEDULE
1999 LONG SESSION

February 25, 1999

February 16 – February 18

Office of State Budget & Management
Presents Governor's Budget

⇓

February 22 – April 9

Appropriations Subcommittees
Review Continuation Budget

⇓

April 12 – April 23

Appropriations Subcommittees
Continuation Budget Recommendations
Finalized and Presented

⇓

April 26 – May 7

Appropriations Subcommittees
Review Expansion & Capital Budgets

⇓

May 10 – May 14

Appropriations Subcommittees
Expansion & Capital Budgets Finalized
and Presented

⇓

May 17 – May 28

Joint Appropriations Subcommittees
Each Chamber
Resolve Budget Differences
Prepare and Pass Final Budget

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF FACILITY SERVICES BUDGET OVERVIEW

FISCAL RESEARCH DIVISION
MARCH 1999

DIVISION OF FACILITY SERVICES

MISSION

Provide for the health, safety, and well-being of individuals through effective regulatory and remedial activities including appropriate consultation and training opportunities and by improving access to health care delivery systems through the rational allocation of needed facilities and services.

DIVISION OF FACILITY SERVICES

1999-2001 CONTINUATION BUDGET

Description	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Total Requirements	$20,489,403	$19,591,582	$19,561,888	$19,561,888
Estimated Receipts*	($12,249,560)	($8,332,948)	($10,626,579)	($10,626,579)
Net Appropriation*	$8,239,843	$11,258,634	$11,553,285	$11,553,285
Total Number of Positions**	298.5	330.7	330.7	330.7

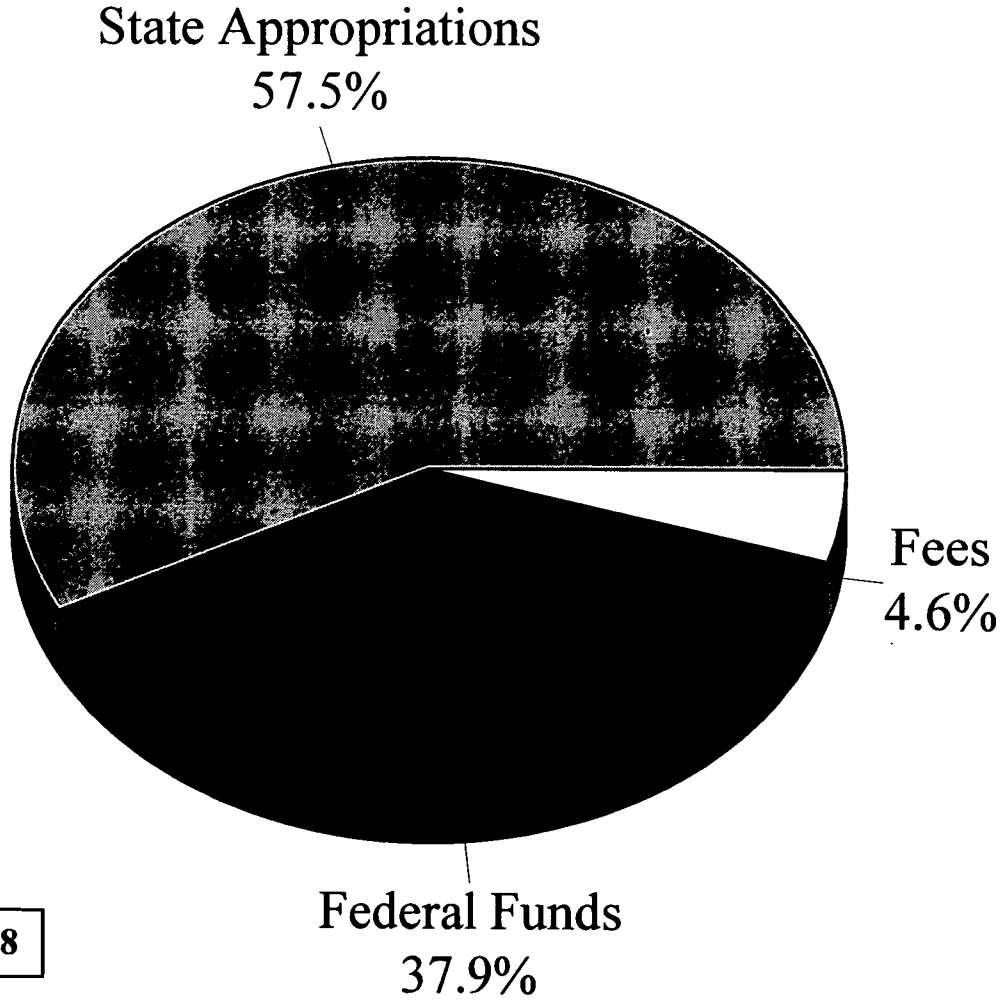
Continuation Budget Document: Volume 3, pages 151 - 158

***Appropriations and receipts have been adjusted to reflect state appropriations to match Medicaid receipts.**

****Position totals for fiscal years 1998-99 through 2000-01 have been updated.**

DIVISION OF FACILITY SERVICES

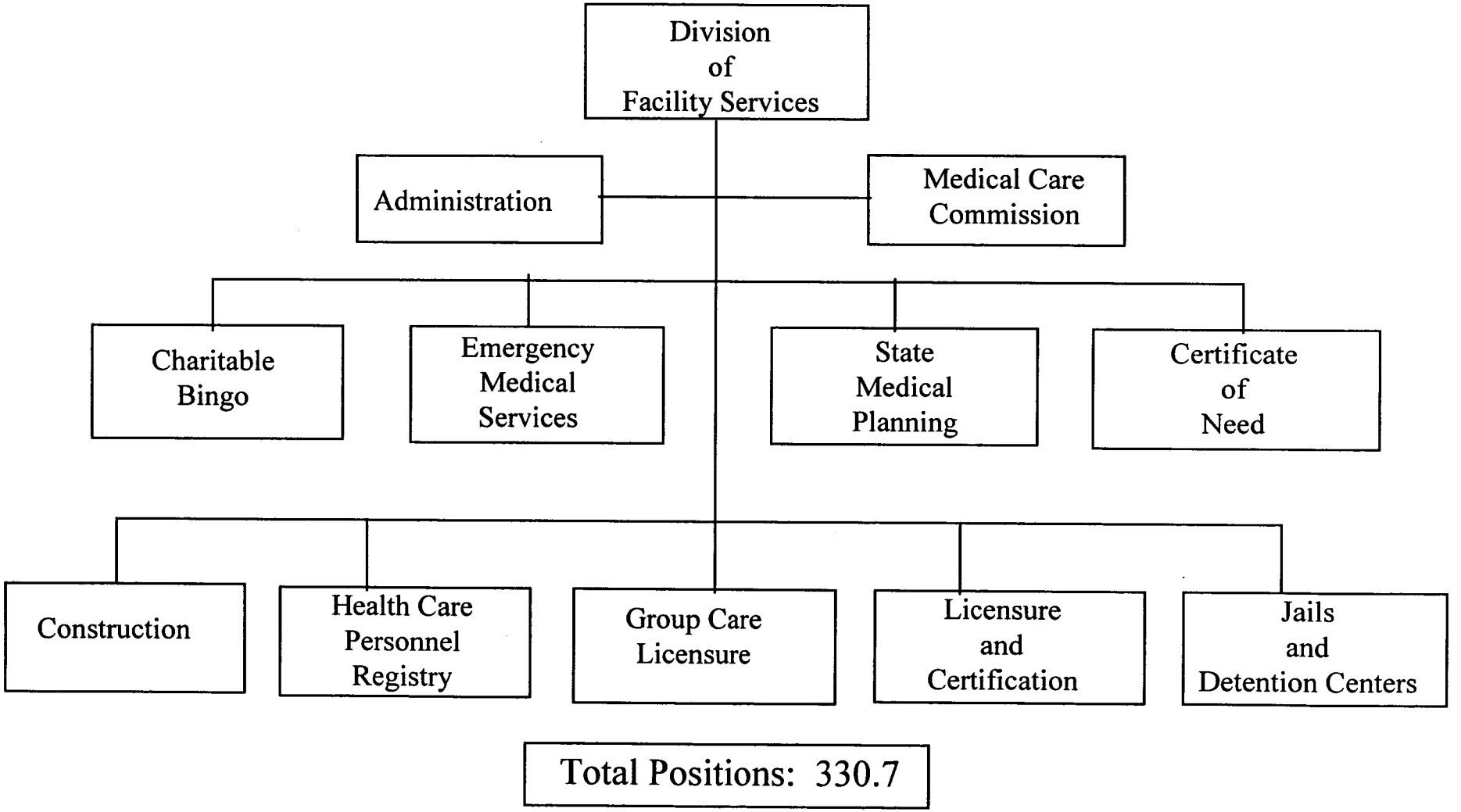
SOURCES OF FUNDING



State Fiscal Year 1997-98

DIVISION OF FACILITY SERVICES

ORGANIZATION



Total Positions: 330.7

DIVISION OF FACILITY SERVICES

MAJOR PROGRAMS

State Medical Planning Section: Determines the degree of unmet need for health facilities throughout the state.

Certificate of Need Section: Restricts unnecessary increases in health care costs and limits unnecessary services and facilities based on geographic, demographic, and economic considerations.

Construction Section: Reviews plans and specifications, makes inspections, and provides consultation to ensure a safe environment in those facilities wishing to be licensed, certified or receive financial assistance.

Health Care Personnel Registry Section: Maintains a registry of nurse aides and other health care personnel and investigates alleged abuse, neglect, or misappropriation of resident's property in health and social care facilities.

Jail and Detention Section: Ensures compliance with NC statutes and administrative rules through inspection of all jails in North Carolina.

DIVISION OF FACILITY SERVICES

MAJOR PROGRAMS

Group Care Licensure Section: Licenses and regulates adult care homes and mental health, mental retardation, and substance abuse facilities, while also and providing supervision, consultation, training and technical assistance to county department's of social services staff who monitor the compliance status of adult care homes.

Licensure and Certification Section: Conducts surveys and complaint investigations in health care facilities. Manages and directs administrative services and quality assurance to ensure compliance with federal regulations for Medicare/Medicaid certification.

Medical Care Commission: Issues tax-exempt revenue bonds to nonprofit and public health care facilities for construction, renovation and expansion of facilities.

Emergency Medical Services Sections: Ensures all citizens have access to quality emergency medical care by providing technical assistance and regulatory oversight to all local EMS systems.

Bingo Section: Regulates charitable bingo activities.

DIVISION OF FACILITY SERVICES

LEGISLATIVE HIGHLIGHTS

Eliminate Positions

1995-96	-$ 152,528 (6 positions)
1996-97	-$ 568,923 (19.5 positions)
1997-98	-$ 48,692 (2 positions)

Smoke Detector/Sprinkler Loan Fund

1996-97	$1,000,000 **NR**

Health Care Personnel Registry

1996-97	$ 160,000 (From HHS funds)
1997-98	-$ 80,000 (Medicaid Receipts)
1998-99	$ 150,000 (4 positions for mental health facilities) **NR**
1998-99	$ 75,000 (2 positions to reduce backlog) **NR**

DIVISION OF FACILITY SERVICES

LEGISLATIVE HIGHLIGHTS

Construction Section

1998-99	$ 225,000 (8 positions)	**NR**

Poison Control Center

1997-98	$ 200,000 (Grant-in-aid to Carolinas Medical Center)	**NR**
1998-99	$ 300,000 (Grant-in-aid to Carolinas Medical Center)	**NR**

Certificate of Need Program

Replaced CON fees with appropriations for support of the CON program and deposited fees as a nontax revenue into the General Fund. The net effect to the General Fund was zero. Effective July 1, 1994.

Charitable Solicitation

This program was transferred to the Secretary of State effective January 1, 1999.

DIVISION OF FACILITY SERVICES

STATUS OF NEW POSITIONS

- During the 1998 Session the General Assembly appropriated nonrecurring funding for 14 new positions in the Division of Facility Services effective January 1, 1999.
    - 6 positions for the Health Care Personnel Registry
    - 8 positions for the Construction Section
- The 1998 General Assembly also required the Division to develop a fee proposal to defray the cost of processing and reviewing construction plans for health and social care facilities and for conducting physical plant inspections by December 1, 1998.
- The Division is in the process of filling the new positions and has submitted a fee proposal to the General Assembly.
- The 1999-2001 continuation budget for the Division includes recurring funding for the annualized cost of the 14 new positions ($803,508).

DIVISION OF FACILITY SERVICES

STAFFING ISSUES

Does the Division of Facility Services have adequate staff to regulate the facilities mandated under state law?

During the past ten years, Division of Facility Services had a net gain of 1 state full time equivalent position.

-- 33 positions were created.
-- 32 positions were eliminated.
-- 24 of the positions were eliminated since 1995.

During the past five years, the number of facilities and programs regulated by Division of Facility Services has increased 40%.

The 1998 General Assembly appropriated nonrecurring funding for 14 new positions for the Construction Section and the Health Care Personnel Registry to meet the most pressing needs. Nineteen new federal positions (3.87 state full time equivalents) have also been created during 1998-99.

DIVISION OF FACILITY SERVICES

REGULATED FACILITIES AND PROGRAMS

Type of Facility/Program	Number of Facilities/Programs	Actual Beds
Nursing Facilities	421	41,026
Adult Care Homes	1,513	39,822
Mental Health Facilities	2,976	10,599
Home Care Agencies	741	NA
Hospitals	148	24,186
Ambulatory Surgery Facilities	53	NA
Hospice	72	121
Cardiac Rehab Programs	62	NA
Abortion Clinics	18	NA
End Stage Renal Disease Dialysis	99	2,050 stations
Home Health Agencies	166	NA
Rural Health Clinics	136	NA
Jails and Detention Facilities	120	13,891
Grand Total	**6,857**	**123,021**

DIVISION OF FACILITY SERVICES

STAFFING BY PROGRAM AND FUNDING SOURCE

SECTION	TOTAL POSITIONS	STATE FUNDED	RECEIPT FUNDED
Administration	19.75	14.7	5.05
Licensure/Certification	154.9	26.76	128.14
Group Care	32	21.44	10.56
Health Care Personnel Registry	31	10.7	20.3
State Medical Planning	5	5	0
Emergency Medical Services	38	33	5
Jails and Detention	4	4	0
Certificate of Need	13	13	0
Construction	32	21.1	10.9
Bingo	1	0	1
TOTAL	**330.65**	**149.7**	**180.95**

DIVISION OF FACILITY SERVICES

STAFFING ISSUES

The following programs appear to still have staffing shortages even with the recent state and federal expansions:

- Group Care Section
- Construction Section
- Licensure and Certification
- Health Care Personnel Registry

DIVISION OF FACILITY SERVICES

GROUP CARE SECTION

- The Group Care Section of Division of Facility Services is required to inspect all mental health facilities prior to initial licensure and upon relicensure biennially.

- Currently, there are 2,685 mental health, developmentally disabled, and substance abuse programs and facilities. The number of facilities and programs has increased 45% since 1995 as a result of an increased emphasis on placing clients in appropriate community settings. The number of facilities is projected to increase to 3,250 by July 2000.

- Four mental health consultants and one processing assistant are assigned to the licensure of mental health facilities and programs. The consultants already have average caseloads of 671 facilities.

- On-site inspections are done during the initial licensure of residential facilities. The licensure of day programs and the relicensure of existing residential facilities is completed through a paper process with no routine on-site inspection.

- Complaints are referred to local officials such as county departments of social services or area mental health programs. The Group Care Section does not have enough staff to routinely respond to complaints with an on-site inspection.

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION RESPONSIBILITIES

The Construction section has the following responsibilities:

- ✓ Review plans for new construction, conversions, additions, and renovations of all health and social care facilities
- ✓ On-site inspection of each project's regulatory compliance with licensure standards related to physical plant systems and life safety code requirements during the building process and a final inspection once the project is completed
- ✓ Routine inspections of existing facilities to monitor continued compliance with licensure requirements
- ✓ Consultation services

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION OVERSIGHT

Approximately 5,020 health and social care facilities have Construction Section oversight -- a 40% increase since 1993.

- Hospitals
- Nursing Homes
- Adult Care Homes
- Child Caring Institutions
- Abortion Clinics
- Hospice Facilities
- Outpatient Surgery
- Family Care Homes
- DDA Group Homes
- Mental Health Facilities -- Residential
- Mental Health Facilities -- Day Programs

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

PLAN REVIEWS AND INSPECTIONS

- Plan review turn around times have increased from an average of 4 to 5 weeks in 1987 to an average of 18-24 weeks in 1998.

- Interim inspections of construction/alteration projects were discontinued in 1989 as the workload increased.

- Final inspections of completed construction/alteration projects for hospitals, nursing homes, adult care homes, and outpatient surgery facilities are conducted by the Construction Section.

- Final inspections of completed construction/alteration projects for residential facilities -- family care homes, DDA group homes, and mental health group homes -- are completed by local officials who supply the Construction Section with written documentation.

- Plans for mental health facilities day programs are not directly reviewed by the Construction Section. Consultation services are supplied upon request.

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

PLAN REVIEWS AND INSPECTIONS

Delays in the plan review process and limitations on inspections have several consequences:

-- Increased cost for providers who must wait for plan review and approval before they can build

-- Decreased or delayed availability of social and health care services for consumers

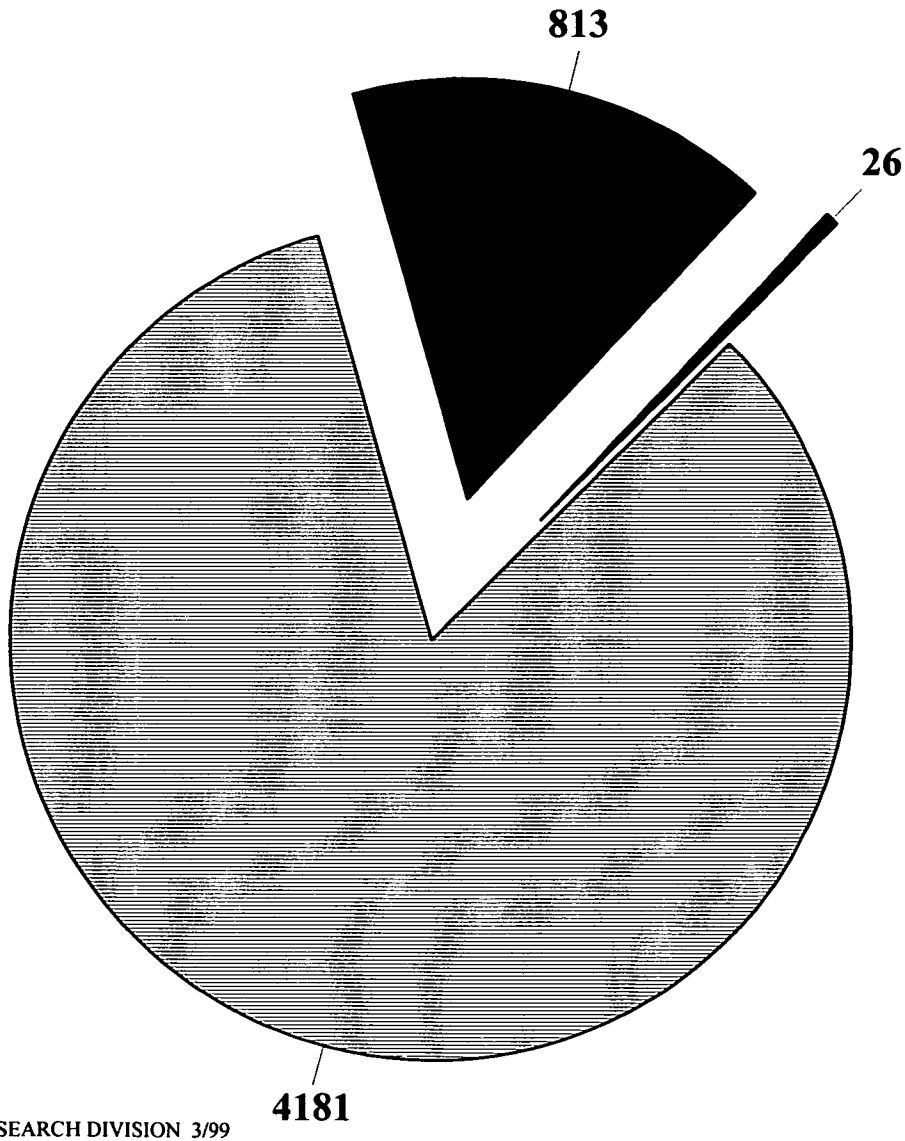
-- Increased cost for providers to solve problems uncovered during a final inspection after a project is completed

-- Decreased safety in residential facilities not inspected by the Construction Section after a construction/alteration project is completed

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

INSPECTION OF EXISTING FACILITIES FOR 1997-98



- Complaints
- Mandated Federal Inspections
- Facilities Not Routinely Inspected

Total Facilities: 5,020

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

INSPECTION OF EXISTING FACILITIES

Federal Inspections

Federal law mandates that nursing homes, intermediate care facilities for the mentally retarded, outpatient surgery facilities and at least 5% of all hospitals be inspected annually for Life Safety Code requirements.

The federal inspections are supported by funding through Medicare and Medicaid; the positions conducting these inspections are not permitted to conduct state licensure inspections.

State Inspections

Inspections of existing state facilities for regulatory compliance with licensure standards related to physical plant systems and life safety code requirements were discontinued in 1989 due to increased workloads and to maintain a plan review turn around time of 8 to 9 weeks.

In the past ten years, over **4,100 existing health and social care facilities** have not received a routine inspection for regulatory compliance with licensure standards related to physical plant systems and life safety code requirements.

All complaints relating to problems with physical plant systems or life safety code requirements are investigated and a routine inspection is conducted as a part of the investigation.

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

FEE SCHEDULE PROPOSAL

Background

The 1998 General Assembly directed the Division of Facility Services to develop a schedule of fees to defray the cost of processing and reviewing construction plans for social and health care facilities and for conducting physical plant inspection of these facilities.

Since the Division does not charge social and health care facilities for these services, the Division surveyed other states to obtain data on similar fees charged by them.

Fee Schedule Proposal

The Department recommended the following fee schedule in its report:

> The Department shall establish and collect fees from all applicants for licensure under GS 131D, 131E, and 122C who submit construction plans for review and approval. The fee schedule established should generate sufficient funds to offset one-half on the entire cost of the unit charged with the responsibility of reviewing and approving the construction of licensed facilities. This fee may not exceed $30,000 and may not be less than $125.

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION
FEE SCHEDULE PROPOSAL

Based on the following assumptions, the Department's proposed fee schedule is expected to generate $1.3 million in revenue -- enough funding to support 17 new positions:

- ✓ $125 plan submittal fee is all-inclusive for projects with $25,000 value or less
- ✓ An additional .4% fee charged on portion of a project value above $25,000
- ✓ Maximum plan review fee of $30,000 for projects valued above $7.5 million.
- ✓ Average per project fee ranges from $125 to $3,739
- ✓ Larger and more complicated projects requiring more review will cost more
- ✓ Minimum $125 processing fee eliminates frivolous submission of plans

DIVISION OF FACILITY SERVICES

LICENSURE AND CERTIFICATION SECTION
COMPLAINT INVESTIGATIONS

Complaint Investigations: The Division of Facility Services is required under State law to investigate all complaints in nursing homes within 60 days. Federal policy require complaints in nursing homes which are considered serious and an immediate danger to patients to be investigated within 2 days. There are no State mandated time frames for complaint investigations in other health care facilities.

Staffing: 20 positions are assigned to handle all complaints -- 17 positions for nursing homes and 3 positions for all other health care facilities. Complaint investigation staff has not been increased since 1989 when the General Assembly authorized 8 positions.

Workload: The number of complaints in health care facilities has increased from 996 in 1995-96 to 1,428 in 1987-98 -- a 30% increase. Over 92% of the complaints come from nursing homes and intensive care facilities for the mentally retarded.

DIVISION OF FACILITY SERVICES

LICENSURE AND CERTIFICATION SECTION

COMPLAINT INVESTIGATIONS

Does the Licensure and Certification Section have adequate staff to investigate complaints in a timely manner?

The Division of Facility Services began tracking the number of complaint investigations completed within 60 days in July 1998. During the first quarter, 32% of the investigations were not completed within 60 days. During the second quarter, the number of investigations not completed within 60 days increased to 45%.

Is a 60-day complaint investigation time-frame reasonable?

- Evidence relating to a complaint investigation may disappear before the investigation is completed.
- The public demands that investigations be more timely than 60 days.
- A shorter time-frame will require significantly more staff to investigate complaints.

DIVISION OF FACILITY SERVICES

HEALTH CARE PERSONNEL REGISTRY

Creation: The Health Care Personnel Registry was established by the General Assembly in 1996 by expanding the existing Nurse Aide Registry for nursing homes to include a second registry that lists all unlicensed health care assistive personnel that provide hands on care to residents in health and social care facilities that have a finding of abuse, neglect, misappropriation of resident or facility property, fraud against a resident or facility, and diversion of resident or facility drugs.

The law applies to the following facilities:

- Nursing Homes
- Hospitals
- Hospice Agencies
- Nursing Pools
- **State Operated Facilities**
- **Residential Facilities and Hospitals for the Mentally Ill, Developmental Disabled, or Substance Abusers**
- Adult Care Homes
- Family Care Homes
- DDA Group Homes
- Home Care Agencies

DIVISION OF FACILITY SERVICES

HEALTH CARE PERSONNEL REGISTRY

Regulated Programs and Facilities: Under the new law, the number of facilities and programs covered under the Health Care Personnel Registry has increased from 396 to 6,181 -- a 1500% increase. Over 2.500 facilities and programs were added in 1996 and 3,300 were added in 1999.

Staffing: Under the new law, staff has increased from 13 to 31 positions. 10.7 positions are state funded and 20.3 positions are federal funded. 6 of the state positions were authorized effective January 1, 1999.

Does the Health Care Personnel Registry have adequate staff to regulate the facilities and programs mandated under state law?

???

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 2-26, 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Burnie Patterson	NC Office of Rural Health
Stacy Flannery	NC Health Care Facilities Assoc.
Jerry Cooper	N.C. Assisted Living association
HUGH TILSON	NCHA
VINCE BATTS	DHHS
ANNA TEFFT	OSBM
Jon Jones	DD Council
Tom Wilson	N.C. ALTC7.
Harry Taylor	
Patrice Roesler	NCACC
Mary Greene	OSBM
Jim Richardson	OSPL
Lawrence Wilson	DHHS/OEO
LESLIE MANN	Citizen Services
DEBBIE CRANE	DHHS PUBLIC AFFAIRS
MARC LODGE	DHHS - Legal
Frank Bobbitt	DHHS - Internal Audit
Joyce Johnson	DHHS Controller's Office
Terry Hatcher	DHHS - Property & Construction
Kathy Heeter	DHHS - Human Resources Div.
Chris Holce	DHHS - Sec's Office
Roslyn Savitt	NC Child Care Coalition
NELS ROSELAND	OSBM
[illegible]	OSBM
Jim Dean	DHHS - Budget & Analysis
Allyn Duffey	DHHS - Budget, Planning + Analysis
Jim Edgerton	DHHS " "
Daphne Lyon	DMA - DHHS

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 2-24, **1999**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sorien Schmidt	NCJCDC
Bill Coy	DHHS / DIRM
Paula A. Woy	Covenant W/ NC's Children
[illegible]	Food Banks of NC.
Amy Jo Baum	NCMS
John Bowditch	Zeb Alley P.A.
Marie Smith	NC 54

AGENDA

Joint Subcommittee on Health and Human Services
Appropriations

Legislative Office Building – Room 424
Thursday, February 25, 1999
8:30 a.m.

Opening Remarks	**Senator Bill Martin, Co-Chair** **Rep. Beverly Earle, Co-Chair** **Rep. Edd Nye, Co-Chair**
Reporting Requirements	**Karen Hammonds-Blanks**
Secretary of Budget	**Jim Edgerton** **Central Management and Support**

HOUSE APPROPRIATIONS SUBCOMMITTEE FOR HEALTH AND HUMAN SERVICES

Minutes
February 25, 1999
8:30

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Thursday, February 25, 1999, at 8:35 a.m. in Room 424 of the Legislative Office Building.

House Co-Chair Representative Beverly Earle presided. Other House members present were Representative Edd Nye, Co-Chair, Representative Martha Alexander, Vice-Chair, Representative Alma Adams, Theresa Esposito, Trudi Walend, and Gene Arnold. Five Senate Subcommittee members were present.

Representative Earle called the meeting to order at 8:35 a.m. Karen Hammonds-Blanks of Fiscal Research Division was asked to present the results of studies that were asked by the Subcommittee to be bought back to them from the last session. The document was titled Reporting Requirements. (See Attachment II). Ms Hammonds-Bland only highlighted a few items of the reports. The members contributed to the reports with questions concerning Medicaid, Early Intervention Services, the Study of State Psychiatric Hospitals/Area Mental Health Programs, and numerous other issues. The Committee received comments and answers to some of the members' questions from Karen Hammonds-Blank and Mary Ellen Sylvester of Fiscal Research Division.

Carol Shaw of the Fiscal Research Division, asked Jim Edgerton, Assistant Secretary of Budget, Management and Planning to give a presentation of Central Management and Support. Mr. Edgerton gave a breakdown of all the divisions and their directors. (See Attachment III).

Nearing the time of adjournment, Mr. Edgerton concluded his presentation.

Respectfully submitted,

Presiding Co-Chair, Representative Beverly Earle

Ann Raeford, Committee Clerk

Attachment I	Agenda
Attachment II	Reporting Requirements
Attachment III	Central Management and Support
Attachment IV	DHHS Mission
Attachment V	Visitor Registration

Attachment II

JOINT SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES APPROPRIATIONS REPORTING REQUIREMENTS

1997 SESSION, SENATE BILL 352

Section	Page	Topic	Committee	Due Date
11.7	Pg. 100	DHR Study of Provider Reimbursement Rates	Appropriations	2/1/99
15.22 (b)	Pg. 304	Communicable Disease Control Aid to Counties Flexibility	Joint Legislative Commission on Governmental Operations	Annually
15.25 (l)	Pg. 305	Heart Disease and Stroke Prevention Task Force Report	Governor, General Assembly	within 1st week of convening of the GA, 6/30/99
15.28	Pgs. 306-307	Adolescent Pregnancy Prevention Coalition of NC Report/Financial Statement	Joint Legislative Commission on Governmental Operations, FRD/FRD	1/15/99, within 30 days of issuance of statement
15.32 (l)	Pgs. 313-315	Osteoporosis Task Force Report	General Assembly, Governor, FRD	10/1/99

1998 SESSION, SENATE BILL 1366

PART V. BLOCK GRANTS

5. (b)	Pg.11	Decreases in Federal Fund Availability (SSBG)	Appropriations	4/1/99
5. (f)	Pg. 13	Work First Evaluation (Governor's Waiver Program)	Appropriations	3/1/99

5. (f)	Pg. 14	Work First Evaluation Plan and Design	Appropriations	4/1/99
5. (g)	Pg. 14	Substance Abuse Program Plan for Families	Appropriations	4/1/99
5. (h)	Pg. 14	WF Job Retention Pilots	Appropriations	4/1/99
5. (k)	Pg. 15	Cost-Effectiveness in Adoption Agencies	Appropriations	5/1/99
5. (p)	Pg. 16	Enhanced Employee Assistance Program	Appropriations, FRD	4/1/99

PART XII. DEPARTMENT OF HEALTH AND HUMAN SERVICES

12.	Pg. 72	Standards for Health Care Quality	General Assembly	5/1/99
12.2	Pg. 73	Office of Strategic Planning	Appropriations	3/15/99
12.3C (a)	Pg. 75	Collaborative Effort to Improve Quality of Academic Programs At Residential Schools	Joint Legislative Educ. Oversight Appropriations, FRD	4/1/99
12.3C (b)	Pg. 76	Comprehensive Review of VR/DDHH/DSB & Recommendations	Joint Legislative Educ. Oversight Appropriations, FRD	4/1/99
12.5 (e)	Pg. 77	Medicaid Growth Reduction	Appropriations	2/1/99
12.7 (b)	Pg. 78	Continuous Medicaid Coverage For Categorically Needy Families With Children	Appropriations	interim report 10/1/99 final report 1/1/2000

12.12 (a)	Pg. 79	Child Health Insurance Study (DHHS Savings Resulting Due to CHIP)	Appropriations	3/1/99
12.12 (b)	Pg. 79	Child Health Insurance Study (State Savings Report)	Appropriations	3/1/99
12.12B (o)	Pg. 85	Budget Medicaid Program by Administration	FRD, Appropriations	@ time of request for funds
12.12B (u)	Pg.85	Medicaid/Report on Changes or Waivers	FRD, Appropriations	prior to effective date
12.12B (v)	Pg. 86	Medicaid Long Term Care Waiver and Pilots	Appropriations, Study Commission on Aging	30 days of receiving waiver
12.12C	Pg. 87	Participation in Medicaid Dental Program	Appropriations	4/30/99
12.12C	Pg. 87	Participation in Medicaid Dental Program (study results)	Appropriations	4/30/99
12.25	Pg. 99	Report on Progress Towards Automated Application System	Appropriations	within 1st week of the convening of the GA
12.26A (b)	Pg. 100	Biometrics Law Changes (Progress on Implementation)	Joint Legislative Public Assistance Commission	quarterly
12.26A (d)	Pg.100	Biometrics Law Changes	Joint Legislative Public Assistance Commission	when needed
12.27A (a)	Pg.101	Welfare Law Changes (Final State Plan)	Appropriations	1/1/99

12.27A (b)	Pgs.101-102	Welfare Law Changes (Proposed State Plan)	Director of the Budget and the Joint Legislative Public Assistance Comm.	biennially
12.27A (g)	Pgs. 104-105	Welfare Law Changes (General Duties of the Dept.) Progress Reports (8), (10)		
12.27A (k)	Pg. 107	Welfare Law Changes (Projected Expenditures for WFFA)	Director of the Budget, FRD	15th of each month
12.27A (b)	Pg.108	Welfare Law Changes (Use of Work First Reserve Fund)	Joint Legislative Comm. on Governmental Operations, Joint Legislative Public Assistance Commission	prior to transfer
12.27A (q)	Pgs. 110-111	Welfare Law Changes (Recommendations for Improving First Stop Employment Assistance)	Joint Legislative Public Assistance Commission	end of each calendar year
12.27A (r)	Pg. 111	Welfare Law Changes (Study on the Working Poor- NC WORKS)	Joint Legislative Public Assistance Commission, Appropriations	May 1st of each year
12.27A (s)	Pg. 112	Welfare Law Changes (First Stop Employment Assistance) (r1), (r4)	(r1) Appropriations, Joint Legislative Public Assistance Committee, FRD, (r4) General Assembly	(r1) quarterly, (r4) prior to to US Dept. of Labor
12.29A	Pg. 113	Child Placing Agencies' Rate Study	Appropriations	5/15/99
12.29D (c)	Pg. 114	Child Welfare System Pilots	Appropriations	4/1/99
12.30	Pg. 115	Thomas S. Containment Report Extension	Appropriations, FRD	5/1/99

12.32A	Pg.116	Early Intervention Services Study	Appropriations, Education Oversight Committee, FRD	3/1/99
12.34	Pg. 118	Funds to Reduce Waiting List for Services for Developmentally Disabled	Appropriations	5/1/99
12.35A (b)	Pg. 119	Study of State Psychiatric Hospitals/Area Mental Health Programs	Appropriations	interim report 3/15/99
12.35C (f)	Pg. 121	Area Mental Health Authority Accountability	Legislative Study Commission on MH/DD/SAS, Joint Legislative Health Care Oversight Committee	3/1/99
12.35D	Pg. 122	Agency Oversight of Care Provided to Persons With Mental Illness and Developmental Disabilities	Legislative Study Commission On MH/DD/SAS, Joint Legislative Health Care Oversight Committee	4/1/99
12.35G	Pg. 122	Substance Abuse Grant-In-Aid (Day-by-Day, Inc.)	Appropriations	3/1/99
12.37B	Pg. 128	Smart Start Needs & Resources Assessment	General Assembly	4/1/99
12.37B	Pg. 138	Smart Start Regionalization Plan	Appropriations, FRD	4/15/99
12.39	Pg. 139	Funding for Special Education Services in Training Schools	Appropriations, FRD	11/30/98
12.40	Pgs. 139-140	NC Healthy Start Foundation Report/ Financial Statement	Appropriations, FRD/ FRD	4/15/99, within 30 days of issuance of Statement

12.41	Pg. 140	Prevent Blindness, Inc. Report/ Financial Statement	Appropriations, FRD/ FRD	4/15/99, within 30 days of issuance of statement
12.43 (d)	Pg. 142	Healthy Mothers/ Healthy Children Pilot Program	Appropriations	4/1/99
12.44	Pg. 143	Child Fatality Task Force	Governor, General Assembly	within 1st week of the convening of the GA
12.45 (b)	Pg. 144	Maternal Outreach	Appropriations, FRD	2/1/99
12.46A (b) (d)	Pg. 144	AIDS Drug Assistance Program (ADAP)	Appropriations	3/15/99
12.51	Pg. 147	HIV/STD Prevention Services/Evaluation and Accountability of Grantees	Appropriations	5/1/99
12.52 (a)(b)	Pgs. 147-148	Improve Immunization Program Accountability	Appropriations	4/1/99
29.5 (b)	Pg. 304	Funds for Dorothea Dix Hospital Design	Appropriations	5/1/99
29.5C	Pg. 305	Whitaker School Planning Funds	Appropriations	5/1/99

II

Department of Health and Human Services
Central Management and Support

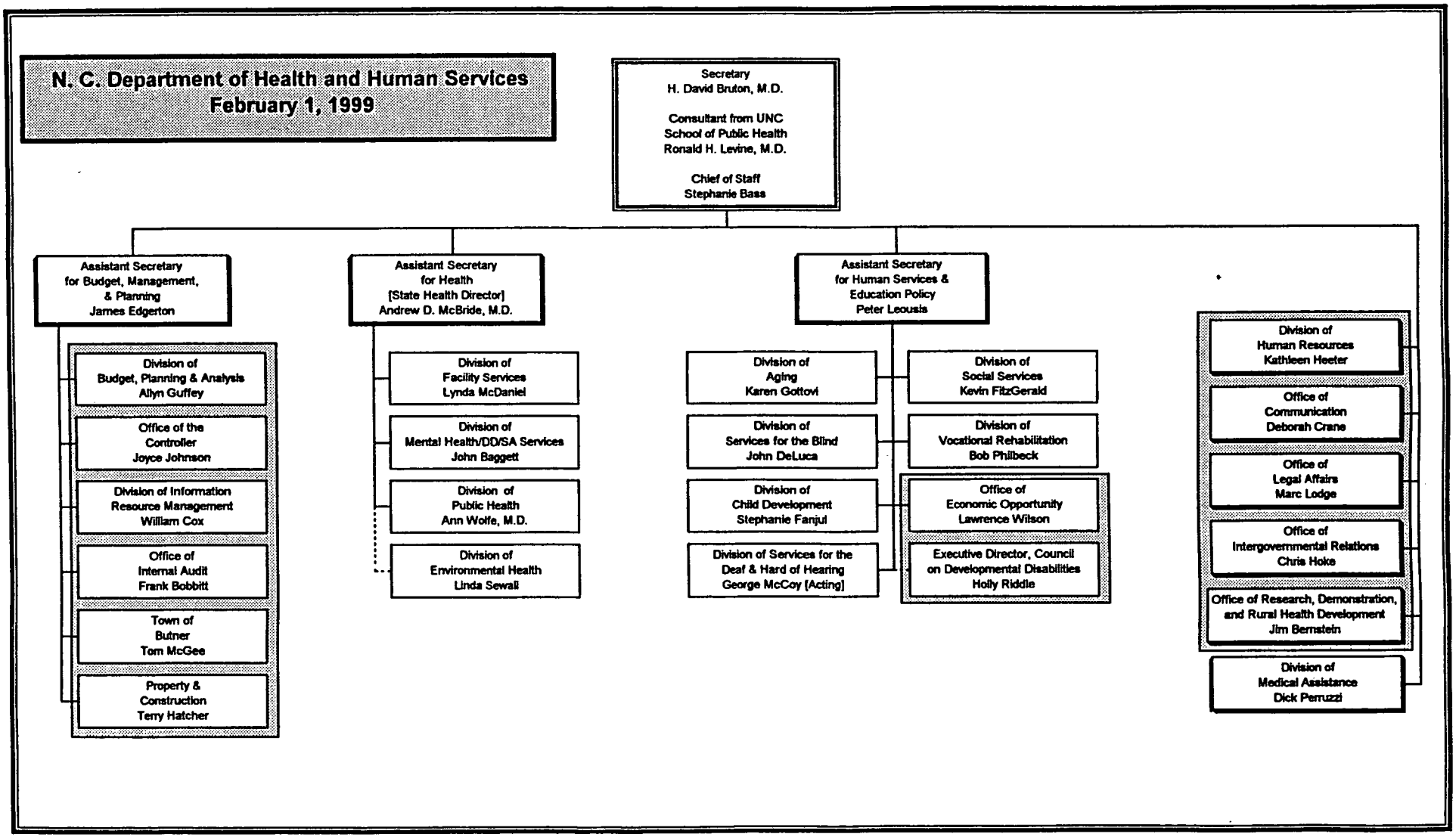
Budget Overview

Presented by: James B. Edgerton, Assistant Secretary for
Budget, Management and Planning
February 25, 1999

Table of Contents

O-chart	1
Central Management and Support Mission and Operations	2
Central Management and Support Funds	4
Chart 1, DHHS Total Budget SFY 98-99	5
Chart 2, Central Management and Support Funding by Purpose SFY 98-99	6
Chart 3, Central Management and Support Total Positions SFY 98-99	7
Central Management and Support Budget Summary	8
Central Management and Support Programs and Services	11

N. C. Department of Health and Human Services
February 1, 1999



Mission Statement

Direct operations and provide services for the department's agencies and institutions.

Operations

Demonstrations and Rural Health

- Develop and provide on-going technical assistance to rural health centers.
- Provide operational and capital support to primary care health centers.
- Recruit and place health care professionals in underserved areas.
- Develop and provide ongoing technical assistance for local development efforts for managed care (ACCESS II/III) and long-term care systems.

Council on Developmental Disabilities

- Conduct systems change, advocacy, and capacity building activities for people with developmental disabilities and their families.
- Assess and promote interagency coordination; promote public awareness.
- Monitor and evaluate utilization of grant awards.

Economic Opportunity

- Provide Emergency Shelter Grants Program funds to local homeless shelters.
- Assist local shelters in identifying additional program resources.
- Provide Community Services Block Grants to local community action agencies.
- Provide training and technical assistance to local grantees.

Central Management and Support

- Set policy and coordinate program administration for the department's agencies and institutions.
- Provide public information and media relations support for DHHS agencies, local agencies, and the general public.
- Provide direction and guidance to assure that department staff receive sound legal advice and legal services.
- Coordinate the Administrative Procedures Act (APA) rule-making process for the department.
- Direct the intergovernmental liaison activities between the department and federal and local governments and human service provider associations.
- Coordinate department responses to legislative requests.
- Review, approve, and oversee grants, State Plan development, and federal funding related interactions.
- Provide information and referral services including the toll free telephone service, CARE-LINE; provide problem resolution via an ombudsman component.
- Provide independent reviews and analyses of various functions and programs within the department.
- Provide guidance to department staff in implementation of the American with Disabilities Act (ADA).

Human Resources

- Facilitate recruitment services for all divisions.
- Facilitate supervisory and employee development programs in all divisions.
- Promote effective administration of position classification, salary administration, and compensation programs.
- Process local human services agencies' position actions.
- Conduct site visits to monitor compliance with State Personnel Act (G.S. 126) and Education Act (G.S. 115) policies and procedures.
- Provide consultation/technical assistance on personnel issues to board chairs, agency directors, and staff.
- Promote safety program compliance.
- Promote positive employer/employee relations.

Budget, Planning, and Analysis

- Execute all budget functions for the department; provide information and analysis of budget and program issues.
- Plan, coordinate, and supervise the preparation and submission of the operating and capital budgets; strategic and program plans, and senior management reviews.
- Review and approve contracts and receive requisitions and quotes, and issue purchase orders for goods and services.
- Provide property management, and intradepartmental mail and courier service.

Controller

- Account for all fiscal activities within the department.
- Process all invoices/benefits for payment and receipts for deposit.
- Maintain financial records and source documents; prepare and file financial reports; automate processes to increase efficiency.
- Recommend and administer fiscal policy; conduct training for division and local staff on fiscal policy and procedures.

Information Resource Management

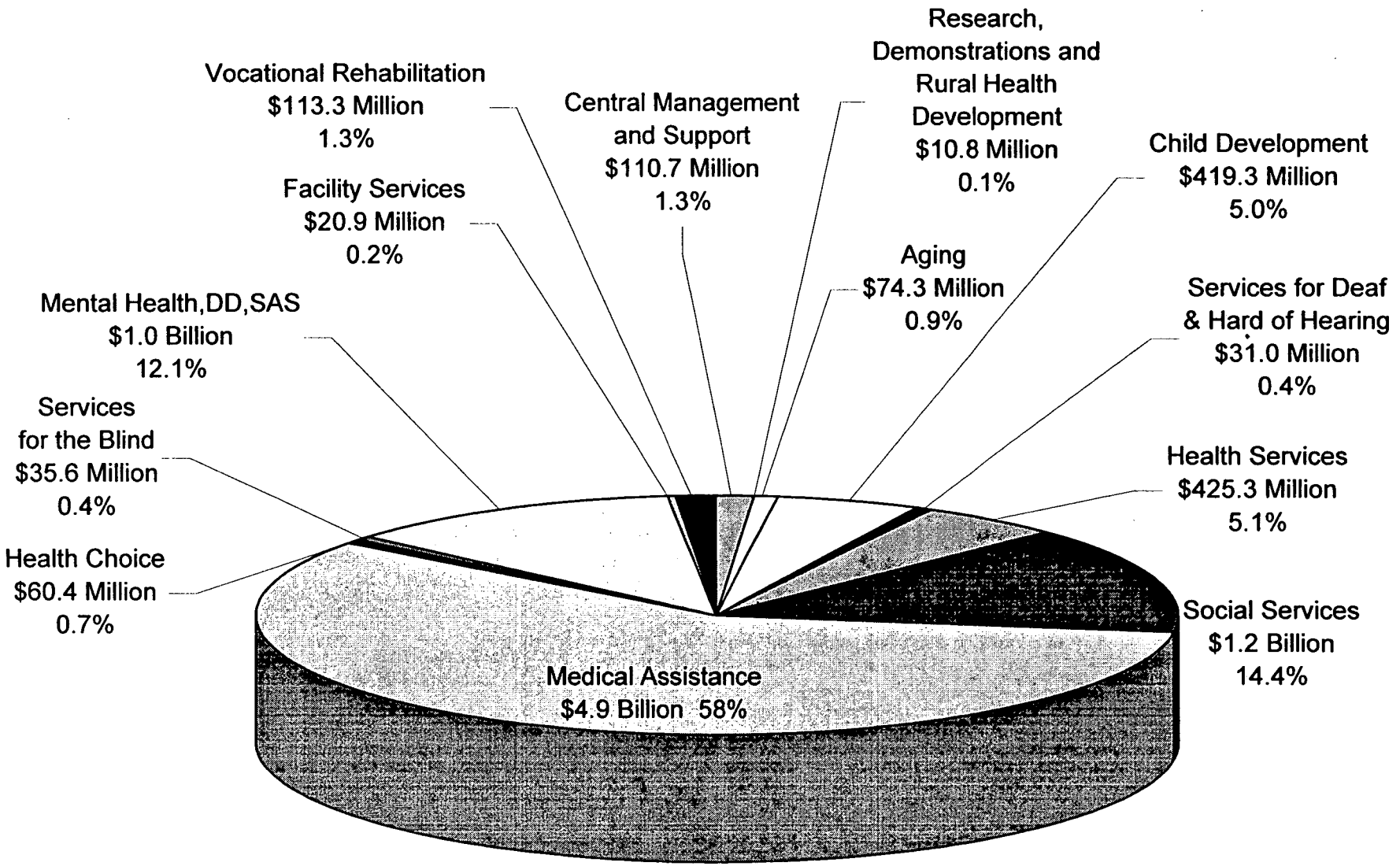
- Provide high quality, adaptable information systems: on time, within budget, conforming to business functional requirements, satisfying client expectations, with minimal defects.
- Provide networks that support the business requirements.
- Lead DHHS partners to leverage technology to assist in solving business problems.

Central Management and Support Funds

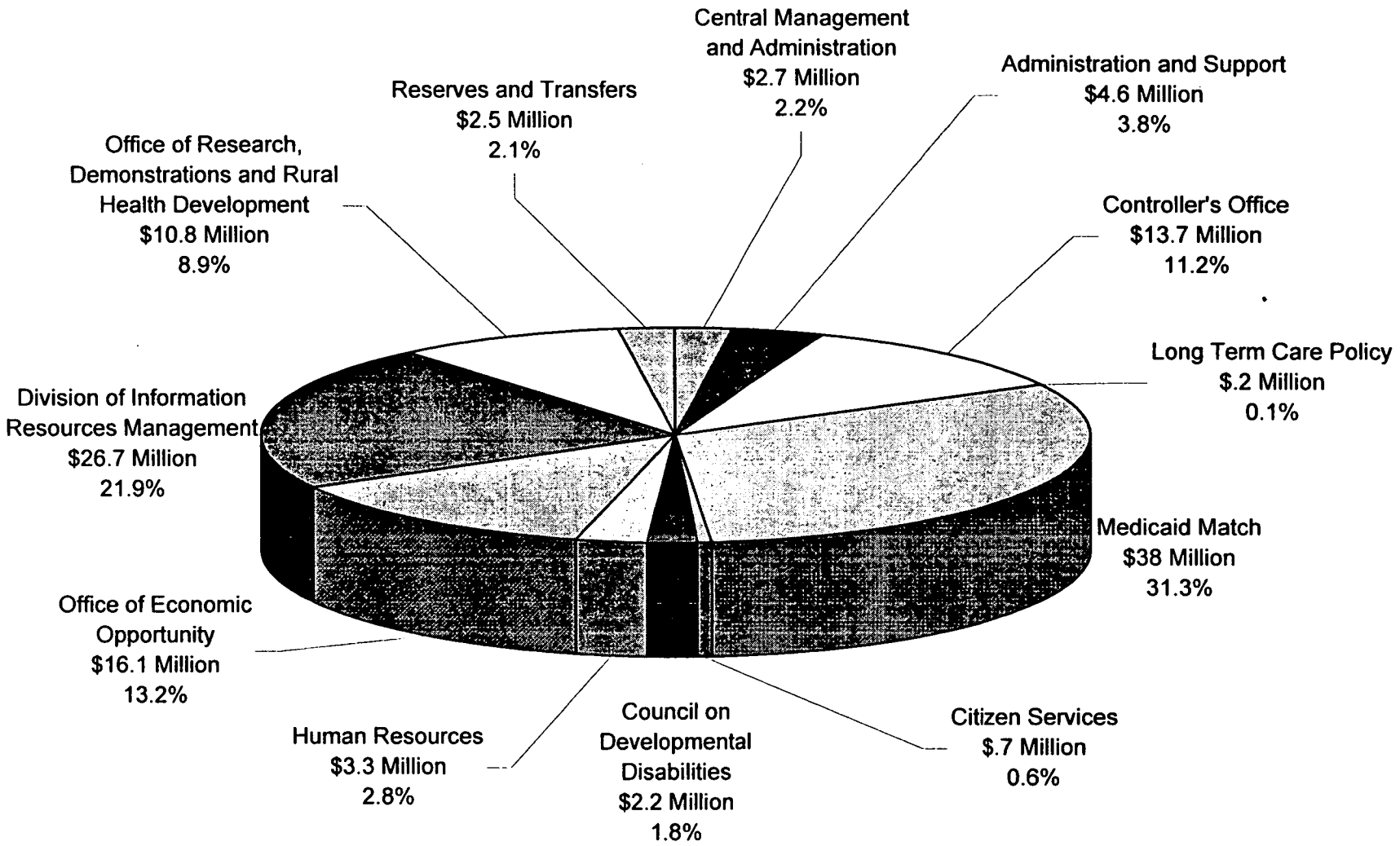
	1998-99 Budget	Positions
Central Management and Administration • Secretary's Office • Office of Intergovernmental Relations • Communications Office	$2.7 Million	41
Administration and Support • Budget, Planning and Analysis • Internal Auditor • Property and Construction • Central Purchasing and Mail Services	$4.6 Million	59.5
Controller's Office	$13.7 Million	279.1
Long Term Care Policy	$0.2 Million	2
Medicaid Match Reserve for Mental Health	$38 million	0
Citizen Services	$.7 Million	11
Council on Developmental Disabilities	$2.2 Million	10
Human Resources	$3.3 Million	58.8
Office of Economic Opportunity	$16.1 Million	10
Division of Information Resources Management	$26.7 Million	150
Office of Research, Demonstrations and Rural Health Development	$10.8 Million	37
Reserves and Transfers	$2.5 Million	0
Total	$121.5 Million	658

Citizen Services

How Does Central Management and Support Compare to Total Department

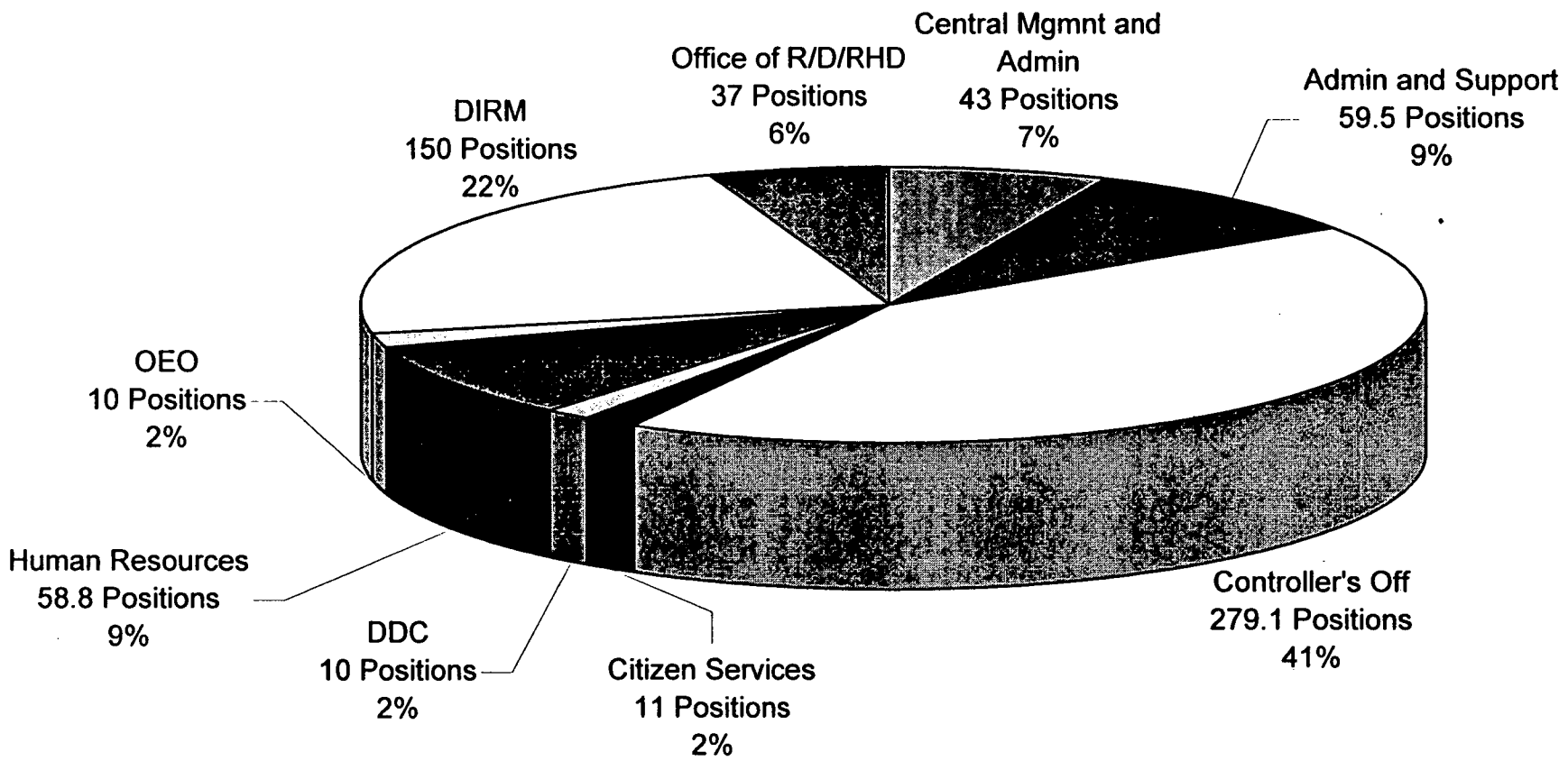


DHHS Total Budget SFY 98-99 $8.4 Billion



Central Management and Support
Funding by Purpose SFY 98-99 $121.5 Million

Of DHHS's 20,194 positions, 3.3 percent or 658 are in Central Management and Support



Central Management and Support
Total Positions SFY 98-99

Central Management and Support

Budget Summary

	1997/98 Actual	1998/99 Authorized	Net Inc (Dec) 1999/2000	1999/2000 Recommended	Net Inc (Dec) 2000/2001	2000/2001 Recommended
Total Requirements	$ 93,737,140	$ 121,522,532	$ 6,415,990	$ 127,938,522	$ 7,235,663	$ 128,758,195
Total Receipts	47,849,682	34,121,471	4,496,753	38,618,224	4,496,753	38,618,224
Net Appropriations	$ 45,887,458	$ 87,401,061	$ 1,919,237	$ 89,320,298	$ 2,738,910	$ 90,139,971
Number of Positions	659.00	658.00	0.00	658.00	0.00	658.00

Increases(Decreases) for 1999-2001

Item		Net Inc (Dec) 1999/2000	Net Inc (Dec) 2000/2001
1. Increase in Medicaid Match Reserve as established by the 1998 Session of the General Assembly to ensure that there are sufficient funds to match federal Medicaid dollars spent by the Area Mental Health Programs. The SFY 1999/00 increase is based on projected SFY 1998/99 spending with adjustments for increases in eligibles (utilization) of 2.66%, and the average cost per eligible (inflation) of 6.0%. The SFY 99/00 increases are built upon the SFY 99/00 projected spending with adjustments for utilization (3.79%) and inflation (6.0%). The projections assume that the state and county will share equally in funding the increases.	**Requirements**	$ 3,355,090	$ 4,174,763
	Receipts	$ -	$ -
	Appropriation	$ 3,355,090	$ 4,174,763
2. Increase in the DIRM Misc. Contractor account is to enable DIRM to continue to provide the required maintenance and modifications to over 150 systems maintained and operated on behalf of the department. These systems provide client benefits and services to the citizens of N.C. and any reduction in the division's capabilities to maintain and modify these systems as required would result in the incorrect and non-timely distribution of eligible benefits to those citizens of N.C. These systems also are needed to meet the federal reporting requirements. The projected annual expenditures for this current SFY are $7.1 Million. Like many organizations, DHHS has significant problems recruiting and retaining qualified information tecnology staff because competition for employees with the necessary skills is fierce. DIRM has had to rely on contractor staff to ensure that vital automation systems are maintained and modified. Contractors come at a higher rate than employees. State funds requested are matched with applicable federal funds for a total requirement increase of $4,400,800.	**Requirements**	$ 4,400,800	$ 4,400,800
	Receipts	$ 1,393,026	$ 1,393,026
	Appropriation	$ 3,007,774	$ 3,007,774

3. Increase in DIRM SIPS account is requested to enable the division to budget for actual cost anticipated to be required over the next biennium. Based on annualized expenditure figures, approximately 16.5 million dollars will be expended for this service in SFY 1998/99. The increase in cost is due to the large increase in the number of state and local users brought about by the implementation of the NCAS and ACTS system, along with the transition of Health Services back to DHHS. NCAS has added approximately 1,500 new users to the system, while the implementation of the ACTS system brought 7,408 new users to the system. Daily transactions for this system alone total 875,000 to 925,000 per day. State funds requested are matched with applicable federal funds for a total requirement increase of $7,500,000.	**Requirements**	$ 7,500,000	$ 7,500,000
	Receipts	$ 3,057,053	$ 3,057,053
	Appropriation	$ 4,442,947	$ 4,442,947
4. Misc. other increases are for the adjustment of salary, longevity payments, social security requirements, and retirement requirements as authorized by the budgeted salary amounts in each fund.	**Requirements**	$ 474,500	$ 474,500
	Receipts	$ 46,675	$ 46,675
	Appropriation	$ 427,825	$ 427,825
5. Misc. other deductions are for non-recurring appropriations funded by the 1998 Short Session of the General Assembly for the Hearts and EIS Y2K projects ($6,864,399) in DIRM and the ABC Education Plan ($2,450,000).	**Requirements**	$ (9,314,399)	$ (9,314,399)
	Receipts	$ -	$ -
	Appropriation	$ (9,314,399)	$ (9,314,399)
TOTAL NET INCREASES	**Requirements**	$ 6,415,991	$ 7,235,664
	Receipts	$ 4,496,754	$ 4,496,754
	Appropriation	$ 1,919,237	$ 2,738,910

HEALTH AND HUMAN SERVICES

Program and Services by Division

CENTRAL MANAGEMENT AND SUPPORT

Office of Communications
Debbie Crane, Director, 919-733-9190

Office of Legal Affairs
Marc Lodge, General Counsel, 919-733-6920

Office of Legislative and External Affairs
Chris Hoke, Acting Chief, 919-733-2173

Office of Citizens' Services
Leslie Mann, Director, 919-733-4261 (Voice), 919-733-4851 (TTY)

Council on Developmental Disabilities
Holly Riddle, Director, 919-733-6566

Office of Economic Opportunity
Lawrence Wilson, Director, 919-773-2818

Division of Human Resources
Kathy Heeter, Director, 919-733-2940

Division of Budget, Planning and Analysis
Allyn Guffey, Director, 919-733-6396

Office of the Controller
Joyce Johnson, Controller, 919-733-0169

Division of Information Resource Management
Bill Cox, Director, 919-733-8900

Office of Internal Audit
Frank Bobbitt, Director, 919-715-4791

Services Provided to Divisions/Management

Legal Services
Accounting Services
Budget Management and Program Analysis
Purchasing and Contracting
Mail Services
Information Resource Management
Government Liaison Services
Public Information
Coordination of Education Programs
Personnel Management
Grants Management
Property Management & Constructions
Community Involvement Services
Disabilities Act Management & Services

Services Provided to Local Agencies/Individuals

Citizens Affairs & Referral Services
Holocaust Council
- Education
Community Action Grants
Audit Services
Developmental Disabilities Grants
Provide consultation on personnel issues to Local Human Services Agency Board Chairs, Ageny Directors & Staff

HEALTH AND HUMAN SERVICES

Program and Services by Division

OFFICE OF RESEARCH, DEMONSTRATIONS, AND RURAL HEALTH DEVELOPMENT

James D. Bernstein, Director, 919-733-2040

- Aid for Clinic Operation
- Aid for Clinic Construction
- Primary Care Provider Recruitment
- Loan Repayment Program
- High Needs Service Program
- Residential Stipend Program
- Rural Health Scholars Program
- Farmworker Health Program
- Long Term Care Demonstration
- Community Hospital Technical Assistance Program.
- Essential Access Community Hospital Program
- Community Primary Care Program
- Access II/III Program
- Dental Recruitment and Development
- Health Professional Shortage Analysis
- Physician Assistant/Family Nurse Practitioner Residency Program
- Primary Care Technical Assistance Service
- Architectural design
- Graphic design
- Maternity services
- Laboratory services
- Computer systems
- Financial/Reimbursement services
- Practice Management
- Managed Care

Department of Health and Human Services (DHHS)
Division of Information Resource Management

Systems Supported in DHHS Grouped by Division or Office

Division of Facility Services
- Jails and Detention Inspection System
- Emergency Medical Services Certification/Manpower/Inventory
- Master File
- Nurse Aid Registry
- Nurse Aid Abuse
- Master File Reporting System
- Voice Response Interface

Office of the Secretary
- Personnel Management Services System
- Purchase Order System
- Safety Reporting System
- Public Affairs Office System
- Legislative Tracking System
- Red System
- Rural Health

Division of Services for the Deaf and Hard of Hearing
- Student Billing System

Division of Information Resource Management
- Operations Support System
- Project Control System
- Vacancy System
- Public Records Law System
- Output Reporting System
- Survey Reporting System
- Skills Inventory System
- Microman Time Reporting System

Division of Aging
- Aging Resources Management System

Division of Child Development
- Day Care Regulatory System
- Criminal Background Check
- Contract System

Division of Child Development and Office of the Controller
- Day Care Reimbursement (Subsidy Child Care)

Division of Social Services
- Central Registry Child Abuse and Neglect
- Central Registry Fatalities
- Foster Care Licensing
- JOBS
- Adult Protective Services

Division of Social Services (Continued)

- Services Information System/County Administration Cost Interface
- Daysheets
- Services Information System
- Emergency Assistance
- Records Management System
- Adoption Indexing Management System
- DPAG System
- Leave System
- Forms Inventory System
- Refugee Information System
- Child Support Enforcement
- ACTS-FKY
- ACTS
  - Title IV-D Child Support SPEC Training
- ADCS
- Case Tracking
- IV-D Letters
- CAMS
- Food Stamp Information System
  - County Test
  - Client Acceptance Test
  - Client Acceptance Test for Welfare Reform
  - Year 2000 client Acceptance
  - Year 2000 Development
  - Year 2000 Base
  - DIRM Development and Test
  - Food Stamp User Test Region
  - Work First/Food Stamps for Food Stamp Information System
- Food Stamp Quality Control Sampling System
- Statewide Automated Child Welfare System
- Housing and Urban Development
- Thomas DR System
- Electronic Benefits Transfer
  - Development
  - Client Acceptance
- Duke Power
- Telephone Waiver
- Social Services Quality Control Sampling System

Division of Social Services and Office of the Controller

- Child Placement System
- Energy Assistance

Division of Social Services and Division of Medical Assistance

- Eligibility Information System (EIS)
  - Work First Family Assistance for EIS
- Claims Processing Contractor
- Third Party Recovery
- Claims Processing Assessment System
- Medical Assistance Quality Control Sampling System
- Medicaid Accounting System
- Hospital Based Cost Report
- Intermediate Care Facility/Mental Handicapped Cost Report

Division of Social Services and Division of Medical Assistance (Continued)

- Beneficiary Earnings Exchange Report
- Bendex
- Employment Security Commission Match
- Income Eligibility Verification System Internal Revenue Services
- Master Client Index
- Supplemental Social Security Data Exchange
- State On-Line Query
- Social Security Third Party Query
- Nursing Cost Report
- On Line Verifications

Office of the Controller

- Allocations
- County Administration
- Domiciliary Care Rate Set (Subsid Child Care)
- Food Stamp Federal Grant Reporting
- Transaction Billing System
- Electronic Funds Transfer

Division of Mental Health, Developmental Disabilities and Substance Abuse

- Healthcare Enterprise Accounts Receivable and Tracking System
- Client Information Online System
- Cost Accounting
- Institutional Client Database/Movement System
- Pioneer Unit Cost Recovery II Reimbursement System
- Thomas S Client Tracking System
- Willie M System
- Controlled Substance Regulatory System
- Unit Cost Recovery Data Download System
- MC Plus Pharmacy

Division of Services for the Blind

- County Billing
- Business Enterprise Relief Worker Payroll
- Business Enterprise Manager Payroll
- Electronic Service System
- State Aid to the Blind Reporting
- Governor Morehead School Purchase Order System

Division of Vocational Rehabilitation

- Client/Vendor/Authorization System
- Financial Systems
- Social Security Reimbursement
- Supported Employment System
- Community Rehabilitation Program Online
- Community Rehabilitation Program Batch
- Batman Data Entry

Division of Youth Services

- Community Based Alternative
- Non-Secure Detention Centers
- Secure Detention Centers
- Training Centers
- Treatment Services

Division of Public Health

- North Carolina Accounting System (NCAS)
- NCAS/County Administration Budget Interface
- Purchase of Medical Care Services
- Consolidated Contract Data Systems
- Immunization School Survey
- Tuberculosis Control Assessment System

Departmental Enterprise Systems

- Program Integrity Tracking System
- Common Data System

Attachment IV

DHHS Mission

To serve the people of North Carolina by enabling individuals, families, and communities to be healthy and secure, and to achieve social and economic well-being.

To achieve this mission, the department will...

- provide comprehensive and coordinated services for prevention, intervention, assistance, education, and empowerment;
- ensure equal access to services;
- be accountable for achieving meaningful results;
- continuously improve service delivery by involving citizens; and
- support and develop employees as diverse, invaluable resources.

DHHS Partners

- Federal agencies
  - USDHHS, USDA
  - Financial participation
  - Program administration
  - System guidance
- Other State agencies
  - Shared population
  - Interfaces
- Local agencies & stakeholders
  - Department of Social Services, Area Mental Health Programs, Health Department
  - Private non-profit
  - Advocates
  - Providers

DHHS Serves

- Direct service contacts: 20,400,000/year
- Indirect services touch all citizens
- Locations in all 100 counties, regional, and Raleigh based facilities
- Continuum of care - birth through death

DHHS Budget

- DHHS Total Budget $ 8.4 Billion
- DHHS IT Expenditures $109.4 Million

Comparison to Industry Standard

- Industry standard for IT expenditures:
  - 7.7% of revenue for public agencies
  - 4.1% of revenue for all industries
- DHHS IT Expenditures is 1.30%

DHHS Automation Budgets

Operations, Maintenance & Development	$74,444,805.00
DMA Fiscal Agent Contract	$19,824,745.00
SIPS Data Processing Charges	$15,174,933.00
Total DHHS Information Technology Budgets	$109,444,483.00

DHHS IT Budgets by Division

Division	Total $	%
Central Administration	1,183,211	1.08%
Division of Aging	270,566	0.25%
Division of Facility Services	488,167	0.45%
Division of Medical Assistance	41,952,704 50% Feb	38.33%
Division of Vocational Rehabilitation	1,491,504	1.36%
Division of Youth Services	153,681	0.14%
Division of Social Services	53,873,233	49.22%
Division of Services for the Blind	318,946	0.29%
Division of Mental Health	5,502,207	5.03%
Division of Child Development	1,584,594	1.45%
Division of Deaf and Hard of Hearing	885,670	0.81%
Health Services	1,740,000	1.59%
Total DHHS Information Technology Budgets	109,444,483	100%

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 2-25-[redacted], 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joanne Schaer	NCNA
Patrice Roeder	NCACC
HUGH TILSON	NCHA
Stacy Flannery	NC Health Care Facilities Assoc
Sharon Hirsch	NC Social Services Consortium
Jim Bernstein	DHHS
[illegible]	DHHS
Beatrice Albert	PPAB
[illegible]	Food Banks
Lon Walker	NCALTCF
Jack W. Chappell	DHHS Controller's Office
Vincent A Batts	DHHS - DIRM
John Bowdish	Zeb Alley P.A.
Mary Greene	OSBM
Wayne Williams	OSBM
[illegible] Richardson	OSPL
Anna Tefft	OSBM
Lawrence Wilson	DHHS/OEO
[illegible]	DHHS/IA
Sharnese Parsons	DSS
Terry Hatcher	DHHS / Property + Construction
MICHELLE COTTON	DMH/DD/SAS
Onnie Crane	DHHS PUBLIC AFFAIRS
LESLIE MANN	DHHS CITIZEN SERVICES
MARC Lodge	DHHS - Legal
BILL COX	DHHS/DIRM
Roslyn Savitt	NC Child Care Coalition
Kathy Heeler	DHHS/ Human Resources

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 2-23, 1999

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
M. Yeager	OSBM
NELS ROSBLAND	OSBM
Anna Wasdell	DHHS
Allyn Guffey	DHHS
Jim Edwards	DHHS
H. DAVID BRUTON	DHHS
Sorien Schmidt	NCJCDC

JOINT APPROPRIATIONS SUB COMMITTEE ON HUMAN RESOURCES

MINUTES

March 2, 1999
8:30 a.m.

The North Carolina General Assembly Joint Appropriations Subcommittee on Human Resources met on Tuesday, March 2, 1999 at 8:30 a.m. in Room 424 of the Legislative Office Building. The meeting was called to order by Senator William Martin, Chairman. Six Senate members were present and the following Members of the House were present: Representative Earl, Representative Nye, Representative Adams, Representative Cansler, Representative Esposito, Representative Michaux, Representative Walend, and Representative G. Wilson.

After introduction of the pages, the Chair reviewed the attached schedule for the Full Appropriations Committee. Regarding the Committee schedule, he said that the Committee would meet mornings and afternoons on Tuesdays and Wednesdays and morning on Thursdays until April 9, to review the Continuation Budget. There will be no afternoon meetings on Thursdays. He stated that the projected date for the final budget is June 1, 1999. (Attachment 1) The Chair stated that the Committee would focus on Facility Services.

Carol Shaw, Fiscal Analyst, was recognized to give the schedule for this week. She stated that the Division of Mental Health would be discussed Wednesday and Thursday of this week and next week we will start with the Division of Aging.

The Chair then recognized Carol Shaw to give an overview of the budget of the Department of Health and Human Services Division of Facility Services. She covered both the budget and the major program areas of the Division of Facility Services and discussed staffing issues related to several of the programs. She stated that the Division of Facility Services has a unique role in that it is the only regulatory agency in the Department. It serves the people indirectly through its regulatory mission. She continued her presentation of the attached handout of the Budget Overview of the Division of Facility Services. (Attachment 2). She stated that it is the smallest division, budget wise, not people wise, and 75% of the budget goes to personnel salaries. Therefore, when budget reductions are made in this area, it generally results in a reduction in personnel because that is where the money is spent.

Carol Shaw also referred to the budget document, Volume 3, noting that there are different position counts and the receipts from the net appropriation amounts are different. She stated that there are two reasons for that:

1) When the snapshot was taken for positions for the Division of Facility Services, fourteen new positions that the General Assembly authorized had not come on line yet. Additionally, they had received funding to support new federal positions.

2) In the past year, the Department of Health and Human Services has initiated a new practice – when a program spends Medicaid receipts, they are now showing the Medicaid receipts only in the budget where the money is spent. The Division of Facility Service receives Medicaid receipts because a number of its programs are involved in the certification and licensure of health care services that Medicaid purchases. This means that when we look at the Medicaid budget, we will not see the expenditures for this program or expenditures that are spent in other divisions outside the Division of Medical Assistance.

Page 3 of the handout shows that most of the receipts are received from federal funds with a small amount from fees.

Carol Shaw also discussed the staffing issue – does the Division of Facility Services have adequate staff to regulate the facilities mandated under State Law. The smallest program is Charitable Bingo, which is the only program left in Facility Services that is related to charitable solicitation. It has one person. The licensure and certification program is the largest program, which has 155 people.

A review of the personnel changes of the Division over the past ten years shows that there has been a net gain of State full-time equivalent position. She said that the term state full time equivalent position refers to the positions taken out of the federal funds for state funding. The positions have been adjusted to reflect only the state funded positions. Carol said that thirty-three positions were created, thirty-two positions were eliminated (most eliminated since 1995). Overall, the number of facilities and programs regulated by the Division of Facility Services has increased by 40%. She stated that the 1999-2001 Continuation Budget for the Division includes recurring funds for the annualized cost of 14 new positions, $803,000. In addition the Division has received permission to create 19 new federal positions.

In her discussion of the licensure and certification section, she focused on the responsibilities of complaint investigations. This is the area where most concern has been expressed. Most of the resources are use to conduct annual inspection on all health care facilities in the State. The licensure and certification section is required under state law to investigate all complaints within sixty days. The federal regulations require all complaints of nursing homes that are considered serious and immediate danger to patients to be investigated within two days. Complaint investigation staff has not been increased since 1989. At that time the General Assembly authorized eight new positions.

At the conclusion of her presentation of the overview of the budget, there were questions from the committee members.

Sen. Phillips stated that if we are not doing inspections, then what is the role of the Agency, why do we have to wait a certain length of time to get inspections or investigations. He said that it is obvious that we do not have oversight, if we are going to have contractors and we certify the submitted proposals and not have on-site inspections before the conclusion or completion of the project. He also stated that when a complaint is received about the possibility of neglect or abuse and someone has to wait for sixty days before it is investigated, is not an inspection and it is not a follow up. However, he realizes that they are doing the best that they can. He stated that we really don't have a very good program to protect people.

Sen. Martin asked if there is a list or information on what is permitted in the Federal inspection. He also asked if there have been any discussions in terms of any other arrangements that could be made with the federal government.

During the discussion of what other arrangements can be made, Carol Shaw stated that sixty days is the State standard, and they are meeting their federal commitments. She said that the State is not in any danger of having the federal inspectors come in and say we're not doing our job. The federal standard is to look at it the next time you go into the facility, which could be nine to fifteen months later. In the construction section, no portions are doing annual inspections. She also said that the State has done a good job of maximizing the federal fund to do the job.

Rep. Adams agreed with Sen. Phillips and asked what is the completion time of the 32% of investigations that were not completed within sixty days. She also asked who determines the priority or seriousness of the process. Rep. Adams inquired as to what has been done to determine what it would take in terms of staff numbers to bring us to a point where we would have a reasonable case load in order to properly address these complaints in a reasonable time period.

Lynda McDaniel, Division of Facility Services, Department of Health and Human Services, stated that Branch Head of the complaint investigation branch prioritizes the complaints. In every category of complaint, there are four levels extremely dangerous, moderate, serious and least serious complaints.

Sen. Dannelly stated that he is pleased with the presentation procedure. In reference to page 14, the last two bullets, in the case of negligence, who enforces the action is it the federal or state. Sen. Dannelly further noted that on page 20 the federal inspectors are not permitted to conduct state inspections and asked if there is a difference in federal and state inspections.

Sen. Dannelly said that regarding the fee schedule on page 20 the $125.00 minimum accomplishes a good thing, however, the $30,000 maximum disturbs him. He can see $30,000 for a $20 million facility. If the private sector decides to petition the state to take over the construction operation then will the State do their work for $30,000? Sen. Dannelly stated that he is aware that we should serve our citizens, but should we do that much corporate welfare?

The Chair stated that the committee would continue this discussion at 2:30 p.m. today and adjourned the meeting at 10:00 a.m.

Sen. William N. Martin, Chair

Joyce Crews Hodge, Clerk

JOINT APPROPRIATIONS SUB COMMITTEE ON HUMAN RESOURCES

MINUTES

March 2, 1999
2:30 p.m.

The North Carolina General Assembly Joint Appropriations Subcommittee on Human Resources met Tuesday, March 2, 1999 at 2:30 p.m. in Room 424 Legislative Office Building. Sen. William Martin, Chair called the meeting to order with five Senate Members present and the following members of the House present: Representative Earl, Representative Nye, Representative Adams, Representative Esposito, Representative Walend and Representative Gene Wilson. Rep. Michaux was dropped from the membership of the Committee.

After recognition of the Pages, Senator Martin called Carol Shaw to continue discussion of the Division of Facility Services.

She began by clarifying her answer to Sen. Dannelly's question regarding the differences between federal and state inspections. She said that there are some differences in the federal and state inspections. The federal inspections only look at the life safety code requirements and are not allowed to look at the state licensure requirement. The State goes in and looks at both the life safety code and the licensure requirement.

Regarding the cap, Carol Shaw stated that the Department looked at fee proposals over the past eighteen months, and would estimate that if similar projects were on line in future years, instead of $1.3 million of revenue, the cap would allow them to generate approximately $2 million.

Rep. Adams asked if the complaints currently being addressed came in October, then would the October complaints be scheduled for March? How long is it taking Facility Services to address the complaints?

Carol Shaw stated that the Division is currently scheduling complaints received in October, so there is a five-month delay. Those were the complaints that they were not able to refer to a survey team that was going out within the 60-day limit.

Rep. Esposito asked who has the authority to change the recommendation made by the State Health Coordinator, under the Division of Facility Services and it is agreed upon?

Bob Fitzgerald, Deputy Director, stated that the way that can be changed was the subject of a recent Supreme Court Case. They determined that the language in the Statute says that the plan in place was developed by the State Health Coordinator and approved by the Governor. The issue is whether the right to improve the plan includes the right to change it, and they concluded that it does and the Governor has the right to amend the plan prior to approval if he chooses to do so.

Sen. Forrester stated that it has been his experience in the nursing homes is that the Department of Social Services will come immediately to look at a patient when responding to a complaint. He said that a lot of this is done at the county level and may not have to be done at the State level. Sen. Forrester question how many of the 1428 complaints received last year, how many are substantiated?

Carol Shaw stated that it varies from area to area. In the nursing homes 27% were substantiated; hospitals 37% were substantiated; intensive care facilities for the mentally retarded 41% and home health agency 23% were substantiated.

Sen. Forrester asked what is the response rate for Emergency Medical Service (EMS)?

The Chair stated that there are some discussions in the General Assembly in terms of possible program consolidation of EMS, training and health and human services. Could we get more information on what functions are served in those three areas, Community Colleges, Facility Services and Insurance, relative to EMS and what the differences are?

The Chair stated that in reference to the group care section, consultants case loads being an average of 671, is there any information on what would be a reasonable case load.

Linda McDaniel stated that the appropriate load is 167.

The Chair then stated that in reference Home Health Care (in home care), he has received correspondence to the effect that persons coming in are not trained in some instances, taking property of the elderly. He said that thought has been given to introducing legislation requiring background checks and some level of training so that the persons would know exactly what is expected and how to deal with the elderly. He asked to what extent is this a significant problem and are there other methods in terms of addressing these problems.

Linda McDaniel stated that there is a criminal background check. It is a listed criteria that the agency has to consider in hiring someone. The health Care personnel registry does investigate allegations received. The nurse-aid functions require the 75 hour training.

Sen. Forrester asked if charitable bingo could be transferred out, maybe to the office of the Secretary of State.

Sen. Phillips stated that in 1997 an audit was done on the various groups and organizations that look at patient care. There were 11 different categories, 11 different inspections made in some period of time of facilities – from the case manager to fire marshal. His question, if we have this many, how much more can we do if we go back and look. If a worker in DSS has a responsibility to make sure that the level of care, the quality of care being provided to the patient is accurate, what else can we do? He asked if the 1400 complaints are only the ones that filter through to this office, or is that the total number received from all 100 counties?

Linda McDaniel stated that the 1400 complaints are outside the adult care home. They are general complaints that come in from health care facilities. She said that they do not generally make efforts are made to track county complaints. There is a complaint hotline that anyone can call.

Sen. Phillips asked Linda McDaniel if she is satisfied with the way complaints are addressed. She answered no, certainly not.

Rep. Nye asked if the counties want to be in charge, or take care of complaints and the state is there as back up?

Linda McDaniel stated that that is correct, it is somewhat a partnership.

Rep. Nye asked to receive more information on the following items in the budget:
Poision Control Center Funding
Construction and Health Care Personnel Registry Positions
19 Federal Positions
State Funded Positions in the EMS Program

The Chair thanked everyone for attending and adjourned the meeting at 3:15 p.m.

Sen. William N. Martin, Chair

Joyce Crews Hodge, Clerk

AGENDA

Joint Appropriations Subcommittee on Human Resources

March 2, 1993

8:30 am

Opening Remarks	Senator Bill Martin Representative Beverly Earle Representative Edd Nye
This Week's Schedule	Carol Shaw Fiscal Research Division
Division of Facility Services	Carol Shaw Fiscal Research Division

03.02.99

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF FACILITY SERVICES BUDGET OVERVIEW

FISCAL RESEARCH DIVISION
MARCH 1999

DIVISION OF FACILITY SERVICES

MISSION

Provide for the health, safety, and well-being of individuals through effective regulatory and remedial activities including appropriate consultation and training opportunities and by improving access to health care delivery systems through the rational allocation of needed facilities and services.

DIVISION OF FACILITY SERVICES

1999-2001 CONTINUATION BUDGET

Description	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Total Requirements	$20,489,403	$19,591,582	$19,561,888	$19,561,888
Estimated Receipts*	($12,249,560)	($8,332,948)	($10,626,579)	($10,626,579)
Net Appropriation*	$8,239,843	$11,258,634	$11,553,285	$11,553,285
Total Number of Positions**	298.5	330.7	330.7	330.7

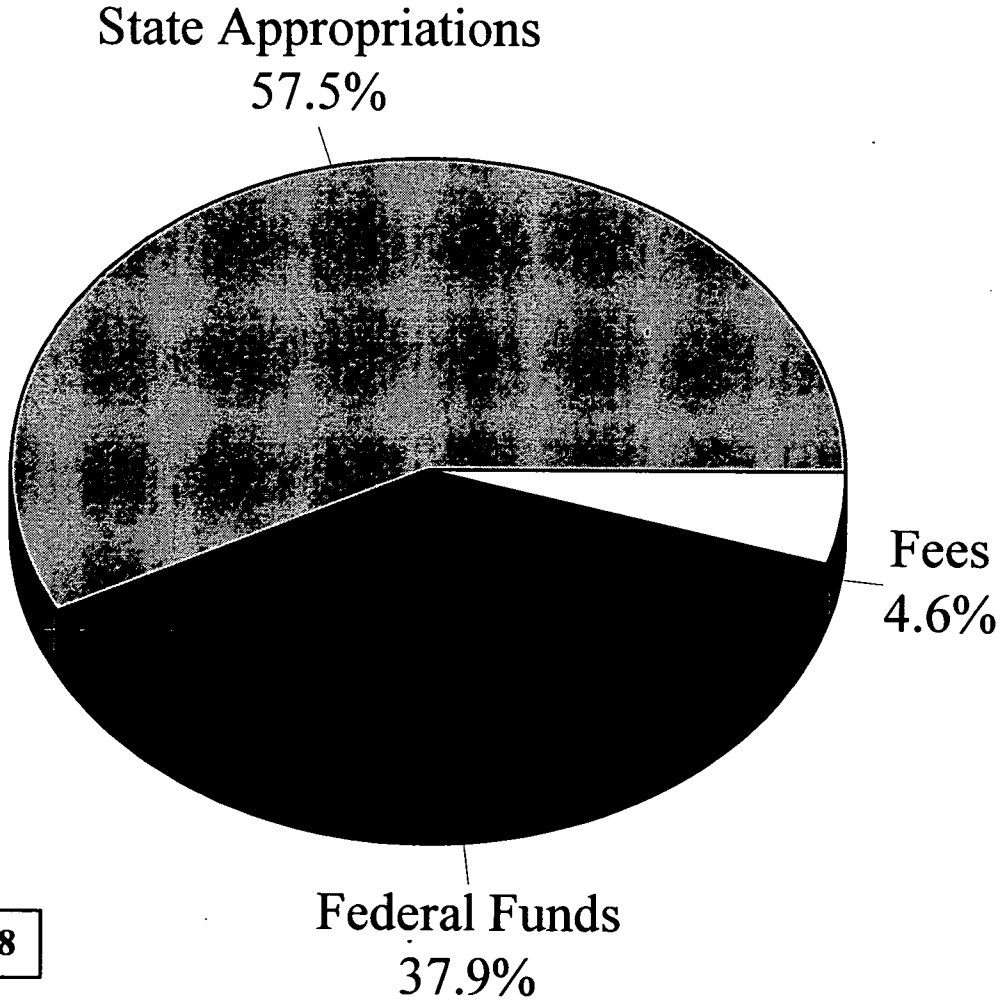
Continuation Budget Document: Volume 3, pages 151 - 158

***Appropriations and receipts have been adjusted to reflect state appropriations to match Medicaid receipts.**

****Position totals for fiscal years 1998-99 through 2000-01 have been updated.**

DIVISION OF FACILITY SERVICES

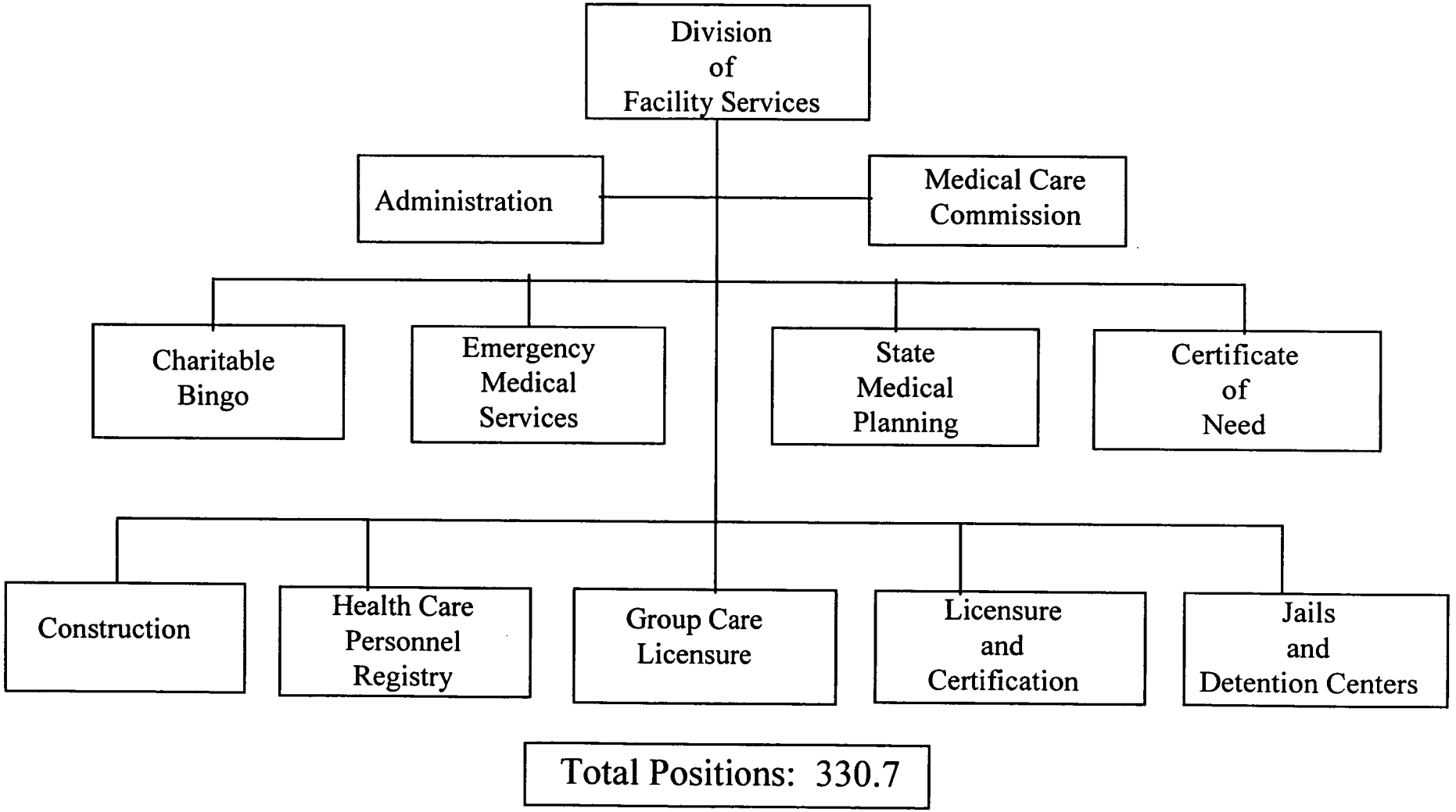
SOURCES OF FUNDING



State Fiscal Year 1997-98

DIVISION OF FACILITY SERVICES

ORGANIZATION



Total Positions: 330.7

DIVISION OF FACILITY SERVICES

MAJOR PROGRAMS

State Medical Planning Section: Determines the degree of unmet need for health facilities throughout the state.

Certificate of Need Section: Restricts unnecessary increases in health care costs and limits unnecessary services and facilities based on geographic, demographic, and economic considerations.

Construction Section: Reviews plans and specifications, makes inspections, and provides consultation to ensure a safe environment in those facilities wishing to be licensed, certified or receive financial assistance.

Health Care Personnel Registry Section: Maintains a registry of nurse aides and other health care personnel and investigates alleged abuse, neglect, or misappropriation of resident's property in health and social care facilities.

Jail and Detention Section: Ensures compliance with NC statutes and administrative rules through inspection of all jails in North Carolina.

DIVISION OF FACILITY SERVICES

MAJOR PROGRAMS

Group Care Licensure Section: Licenses and regulates adult care homes and mental health, mental retardation, and substance abuse facilities, while also and providing supervision, consultation, training and technical assistance to county department's of social services staff who monitor the compliance status of adult care homes.

Licensure and Certification Section: Conducts surveys and complaint investigations in health care facilities. Manages and directs administrative services and quality assurance to ensure compliance with federal regulations for Medicare/Medicaid certification.

Medical Care Commission: Issues tax-exempt revenue bonds to nonprofit and public health care facilities for construction, renovation and expansion of facilities.

Emergency Medical Services Sections: Ensures all citizens have access to quality emergency medical care by providing technical assistance and regulatory oversight to all local EMS systems.

Bingo Section: Regulates charitable bingo activities.

DIVISION OF FACILITY SERVICES

LEGISLATIVE HIGHLIGHTS

Eliminate Positions

1995-96	-$ 152,528	(6 positions)
1996-97	-$ 568,923	(19.5 positions)
1997-98	-$ 48,692	(2 positions)

Smoke Detector/Sprinkler Loan Fund

1996-97	$1,000,000	**NR**

Health Care Personnel Registry

1996-97	$ 160,000	(From HHS funds)
1997-98	-$ 80,000	(Medicaid Receipts)
1998-99	$ 150,000	(4 positions for mental health facilities) **NR**
1998-99	$ 75,000	(2 positions to reduce backlog) **NR**

DIVISION OF FACILITY SERVICES

LEGISLATIVE HIGHLIGHTS

Construction Section

1998-99	$ 225,000 (8 positions)	**NR**

Poison Control Center

1997-98	$ 200,000 (Grant-in-aid to Carolinas Medical Center)	**NR**
1998-99	$ 300,000 (Grant-in-aid to Carolinas Medical Center)	**NR**

Certificate of Need Program

Replaced CON fees with appropriations for support of the CON program and deposited fees as a nontax revenue into the General Fund. The net effect to the General Fund was zero. Effective July 1, 1994.

Charitable Solicitation

This program was transferred to the Secretary of State effective January 1, 1999.

DIVISION OF FACILITY SERVICES

STATUS OF NEW POSITIONS

- During the 1998 Session the General Assembly appropriated nonrecurring funding for 14 new positions in the Division of Facility Services effective January 1, 1999.
    - 6 positions for the Health Care Personnel Registry
    - 8 positions for the Construction Section
- The 1998 General Assembly also required the Division to develop a fee proposal to defray the cost of processing and reviewing construction plans for health and social care facilities and for conducting physical plant inspections by December 1, 1998.
- The Division is in the process of filling the new positions and has submitted a fee proposal to the General Assembly.
- The 1999-2001 continuation budget for the Division includes recurring funding for the annualized cost of the 14 new positions ($803,508).

DIVISION OF FACILITY SERVICES

STAFFING ISSUES

Does the Division of Facility Services have adequate staff to regulate the facilities mandated under state law?

During the past ten years, Division of Facility Services had a net gain of 1 state full time equivalent position.

-- 33 positions were created.
-- 32 positions were eliminated.
-- 24 of the positions were eliminated since 1995.

During the past five years, the number of facilities and programs regulated by Division of Facility Services has increased 40%.

The 1998 General Assembly appropriated nonrecurring funding for 14 new positions for the Construction Section and the Health Care Personnel Registry to meet the most pressing needs. Nineteen new federal positions (3.87 state full time equivalents) have also been created during 1998-99.

DIVISION OF FACILITY SERVICES

REGULATED FACILITIES AND PROGRAMS

Type of Facility/Program	Number of Facilities/Programs	Actual Beds
Nursing Facilities	421	41,026
Adult Care Homes	1,513	39,822
Mental Health Facilities	2,976	10,599
Home Care Agencies	741	NA
Hospitals	148	24,186
Ambulatory Surgery Facilities	53	NA
Hospice	72	121
Cardiac Rehab Programs	62	NA
Abortion Clinics	18	NA
End Stage Renal Disease Dialysis	99	2,050 stations
Home Health Agencies	166	NA
Rural Health Clinics	136	NA
Jails and Detention Facilities	120	13,891
Grand Total	**6,857**	**123,021**

DIVISION OF FACILITY SERVICES

STAFFING BY PROGRAM AND FUNDING SOURCE

SECTION	TOTAL POSITIONS	STATE FUNDED	RECEIPT FUNDED
Administration	19.75	14.7	5.05
Licensure/Certification	154.9	26.76	128.14
Group Care	32	21.44	10.56
Health Care Personnel Registry	31	10.7	20.3
State Medical Planning	5	5	0
Emergency Medical Services	38	33	5
Jails and Detention	4	4	0
Certificate of Need	13	13	0
Construction	32	21.1	10.9
Bingo	1	0	1
TOTAL	**330.65**	**149.7**	**180.95**

DIVISION OF FACILITY SERVICES

STAFFING ISSUES

The following programs appear to still have staffing shortages even with the recent state and federal expansions:

- Group Care Section
- Construction Section
- Licensure and Certification
- Health Care Personnel Registry

DIVISION OF FACILITY SERVICES

GROUP CARE SECTION

- The Group Care Section of Division of Facility Services is required to inspect all mental health facilities prior to initial licensure and upon relicensure biennially.

- Currently, there are 2,685 mental health, developmentally disabled, and substance abuse programs and facilities. The number of facilities and programs has increased 45% since 1995 as a result of an increased emphasis on placing clients in appropriate community settings. The number of facilities is projected to increase to 3,250 by July 2000.

- Four mental health consultants and one processing assistant are assigned to the licensure of mental health facilities and programs. The consultants already have average caseloads of 671 facilities.

- On-site inspections are done during the initial licensure of residential facilities. The licensure of day programs and the relicensure of existing residential facilities is completed through a paper process with no routine on-site inspection.

- Complaints are referred to local officials such as county departments of social services or area mental health programs. The Group Care Section does not have enough staff to routinely respond to complaints with an on-site inspection.

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION RESPONSIBILITIES

The Construction section has the following responsibilities:

- ✓ Review plans for new construction, conversions, additions, and renovations of all health and social care facilities
- ✓ On-site inspection of each project's regulatory compliance with licensure standards related to physical plant systems and life safety code requirements during the building process and a final inspection once the project is completed
- ✓ Routine inspections of existing facilities to monitor continued compliance with licensure requirements
- ✓ Consultation services

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION OVERSIGHT

Approximately 5,020 health and social care facilities have Construction Section oversight -- a 40% increase since 1993.

- Hospitals
- Nursing Homes
- Adult Care Homes
- Child Caring Institutions
- Abortion Clinics
- Hospice Facilities
- Outpatient Surgery
- Family Care Homes
- DDA Group Homes
- Mental Health Facilities -- Residential
- Mental Health Facilities -- Day Programs

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

PLAN REVIEWS AND INSPECTIONS

- Plan review turn around times have increased from an average of 4 to 5 weeks in 1987 to an average of 18-24 weeks in 1998.

- Interim inspections of construction/alteration projects were discontinued in 1989 as the workload increased.

- Final inspections of completed construction/alteration projects for hospitals, nursing homes, adult care homes, and outpatient surgery facilities are conducted by the Construction Section.

- Final inspections of completed construction/alteration projects for residential facilities -- family care homes, DDA group homes, and mental health group homes -- are completed by local officials who supply the Construction Section with written documentation.

- Plans for mental health facilities day programs are not directly reviewed by the Construction Section. Consultation services are supplied upon request.

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

PLAN REVIEWS AND INSPECTIONS

Delays in the plan review process and limitations on inspections have several consequences:

-- Increased cost for providers who must wait for plan review and approval before they can build

-- Decreased or delayed availability of social and health care services for consumers

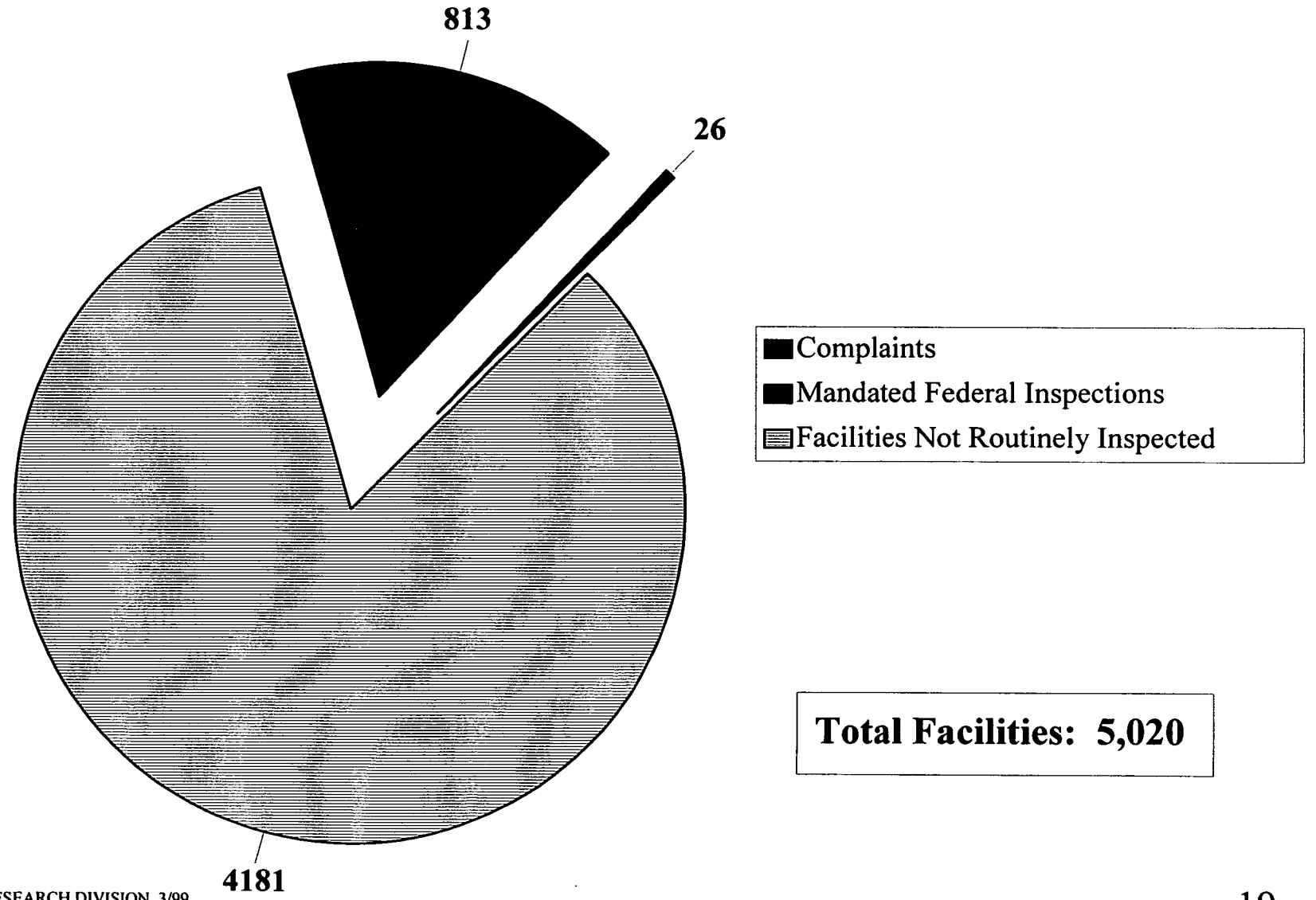
-- Increased cost for providers to solve problems uncovered during a final inspection after a project is completed

-- Decreased safety in residential facilities not inspected by the Construction Section after a construction/alteration project is completed

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

INSPECTION OF EXISTING FACILITIES FOR 1997-98



Total Facilities: 5,020

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

INSPECTION OF EXISTING FACILITIES

Federal Inspections

Federal law mandates that nursing homes, intermediate care facilities for the mentally retarded, outpatient surgery facilities and at least 5% of all hospitals be inspected annually for Life Safety Code requirements.

The federal inspections are supported by funding through Medicare and Medicaid; the positions conducting these inspections are not permitted to conduct state licensure inspections.

State Inspections

Inspections of existing state facilities for regulatory compliance with licensure standards related to physical plant systems and life safety code requirements were discontinued in 1989 due to increased workloads and to maintain a plan review turn around time of 8 to 9 weeks.

In the past ten years, over **4,100 existing health and social care facilities** have not received a routine inspection for regulatory compliance with licensure standards related to physical plant systems and life safety code requirements.

All complaints relating to problems with physical plant systems or life safety code requirements are investigated and a routine inspection is conducted as a part of the investigation.

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

FEE SCHEDULE PROPOSAL

Background

The 1998 General Assembly directed the Division of Facility Services to develop a schedule of fees to defray the cost of processing and reviewing construction plans for social and health care facilities and for conducting physical plant inspection of these facilities.

Since the Division does not charge social and health care facilities for these services, the Division surveyed other states to obtain data on similar fees charged by them.

Fee Schedule Proposal

The Department recommended the following fee schedule in its report:

> The Department shall establish and collect fees from all applicants for licensure under GS 131D, 131E, and 122C who submit construction plans for review and approval. The fee schedule established should generate sufficient funds to offset one-half on the entire cost of the unit charged with the responsibility of reviewing and approving the construction of licensed facilities. This fee may not exceed $30,000 and may not be less than $125.

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION
FEE SCHEDULE PROPOSAL

Based on the following assumptions, the Department's proposed fee schedule is expected to generate $1.3 million in revenue -- enough funding to support 17 new positions:

- ✓ $125 plan submittal fee is all-inclusive for projects with $25,000 value or less
- ✓ An additional .4% fee charged on portion of a project value above $25,000
- ✓ Maximum plan review fee of $30,000 for projects valued above $7.5 million.
- ✓ Average per project fee ranges from $125 to $3,739
- ✓ Larger and more complicated projects requiring more review will cost more
- ✓ Minimum $125 processing fee eliminates frivolous submission of plans

DIVISION OF FACILITY SERVICES

LICENSURE AND CERTIFICATION SECTION
COMPLAINT INVESTIGATIONS

Complaint Investigations: The Division of Facility Services is required under State law to investigate all complaints in nursing homes within 60 days. Federal policy require complaints in nursing homes which are considered serious and an immediate danger to patients to be investigated within 2 days. There are no State mandated time frames for complaint investigations in other health care facilities.

Staffing: 20 positions are assigned to handle all complaints -- 17 positions for nursing homes and 3 positions for all other health care facilities. Complaint investigation staff has not been increased since 1989 when the General Assembly authorized 8 positions.

Workload: The number of complaints in health care facilities has increased from 996 in 1995-96 to 1,428 in 1987-98 -- a 30% increase. Over 92% of the complaints come from nursing homes and intensive care facilities for the mentally retarded.

DIVISION OF FACILITY SERVICES

LICENSURE AND CERTIFICATION SECTION

COMPLAINT INVESTIGATIONS

Does the Licensure and Certification Section have adequate staff to investigate complaints in a timely manner?

The Division of Facility Services began tracking the number of complaint investigations completed within 60 days in July 1998. During the first quarter, 32% of the investigations were not completed within 60 days. During the second quarter, the number of investigations not completed within 60 days increased to 45%.

Is a 60-day complaint investigation time-frame reasonable?

- Evidence relating to a complaint investigation may disappear before the investigation is completed.
- The public demands that investigations be more timely than 60 days.
- A shorter time-frame will require significantly more staff to investigate complaints.

DIVISION OF FACILITY SERVICES

HEALTH CARE PERSONNEL REGISTRY

Creation: The Health Care Personnel Registry was established by the General Assembly in 1996 by expanding the existing Nurse Aide Registry for nursing homes to include a second registry that lists all unlicensed health care assistive personnel that provide hands on care to residents in health and social care facilities that have a finding of abuse, neglect, misappropriation of resident or facility property, fraud against a resident or facility, and diversion of resident or facility drugs.

The law applies to the following facilities:

- Nursing Homes
- Hospitals
- Hospice Agencies
- Nursing Pools
- **State Operated Facilities**
- **Residential Facilities and Hospitals for the Mentally Ill, Developmental Disabled, or Substance Abusers**
- Adult Care Homes
- Family Care Homes
- DDA Group Homes
- Home Care Agencies

DIVISION OF FACILITY SERVICES

HEALTH CARE PERSONNEL REGISTRY

Regulated Programs and Facilities: Under the new law, the number of facilities and programs covered under the Health Care Personnel Registry has increased from 396 to 6,181 -- a 1500% increase. Over 2.500 facilities and programs were added in 1996 and 3,300 were added in 1999.

Staffing: Under the new law, staff has increased from 13 to 31 positions. 10.7 positions are state funded and 20.3 positions are federal funded. 6 of the state positions were authorized effective January 1, 1999.

Does the Health Care Personnel Registry have adequate staff to regulate the facilities and programs mandated under state law?

???

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3.02 . 1999 8:30 a.m.

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jerry Cooper	N.C. Assisted Living Association
HUGH TILSON	NCHA
Stacy Flannery	NC Health Care Facilities Assoc
Jenifer Bubenik	NASW
John Kirsten	NCFPC
Peyton Maynard	GPM
Glenn Wells	DHHS/Health
Chris Hofer	DHHS
Jan Rarrquist	NCDHA
Lynda McDaniel	DHHS/DFS
Bob Fitzgerald	DHHS/DFS
Pam Seamans	NC Social Services Consortium/Covenant
Amy Jo Bain	NCMS
Dave Richard	Pfizer/NC
Stuart Dixon	NCNG
Sonia Schmidt	NCJCDC
Mark Smith	NCSA
[illegible]	NCMS

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 03.02, **1999** 8:30 a.m.

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Edgerton	DHHS
DAVE BRUTON	DHHS
A Dennis McBride	DHHS
Allyn Duffey	DHHS
Mark Benton	"
M Yeager	OSBM
Steve White	DFS / DHHS
Jesse Goodman	DFS / DHHS
Bonnie Cramer	DHHS - DFS
Alice Taylor	DHHS - DFS
Jackie Shepard	DHHS - DFS
Jim Upchurch	DHHS - DFS
Bill Warren	DHHS - DFS
Heather Laffler	OSA
Christina Madlin	Covenant w/ NC's Children
Tommy Worth	Carolinas HealthCare System
Tami Richardson	OSPL
Anne Tefft OSBM	OSBM
Walter Stelle	DHHS - DMH DDSAS
Anne King	DHHS - DMH / DD / SAS - DD Section
Marie Metcalf	NCANPHA
Lon Wilson	NCALTC7
[illegible]	[illegible], PA
[illegible]	[illegible]
Patrice Roesch	NCACC
Jim Tott	MHAI NC - C2001
Janet Simmons	NCARF
[illegible]	NASW-NC

VISITOR REGISTRATION SHEET

Health & Human Resource — 3-2-99 2:30 p.m.

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Katherine Miller	Harry Kaplan
Amy Jo Bain	NCMS
Will Lang	AHHC
Stacy Flannery	HCFA
HUGH TILSON	NCHA
Jerry Cooper	NCALA
Roger Bone	Bone & Assoc.
Tommy Worth	Carolina Healthcare System
Lori Wilson	NCAGTCF.
~~OS~~ Anne Teft	OSBM
Pam Richardson	OSPL
Patricia A. Yaney	APPCNC/SCSL
Bill Warren	DHHS/DFS
Jim Upchurch	DHHS/DFS
Alice Taylor	DHHS - DFS
Jackie Sheppard	DHHS/DFS

VISITOR REGISTRATION SHEET

Joint Appropriations on Human Resources — 03.02.99 2:30 p.m.
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Jesse Goodman	DFS/DHHS
Steve White	DFS/DHHS
Bonnie Cramer	DHHS - DFS
[illegible]	OSBM
Bob Fitzgerald	DHHS/DFS
Lynda McDaniel	DHHS/DFS
Mark Bruton	DHHS
Allyn [illegible]	DHHS
A. Dennis McBride	DHHS
Dave Bruton	DHHS
Jim Edgerton	DHHS
Peggy Mayfield	

AGENDA

Joint Appropriations Subcommittee on Human Resources

March 3, 1993

8:30 am & 2:30 pm

Opening Remarks	Senator Bill Martin Representative Beverly Earle Representative Edd Nye
Division of Mental Health, Developmental Disabilities, and Substance Abuse	Karen Hammonds-Blanks Fiscal Research Division

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
March 3, 1999
8:30

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Wednesday, March 3, 1999, at 8:30A.M in Room 424 of the Legislative Office Building.

House Chairman, Representative Edd Nye presided. Other House members present were Representative Beverly Earle (Co-Chairman), Representative Martha Alexander (Vice Chairman), Representative Alma Adams, Representative Lanier Cansler, Representative Theresa Esposito, Representative Mickey Michaux, Representative Trudi Walend, and Representative Gene Wilson. There were six Senators present.

Representative Nye recognized Karen Hammonds-Blanks of Fiscal Research Division. Ms. Hammonds-Blanks had brought handouts titled Division of Mental Health/Developmental Disabilities/Substance Abuse Services Budget/Program Overview. (See Attachment #1)

Ms. Hammonds-Blanks discussed some of the disability areas within the Division. She pointed out on page 5 of the handout, the history of overall budget and on page 6, the breakdown of positions.

Rep. Esposito asked for an explanation of the difference between authorized and certified budget. Ms. Hammonds-Blanks stated the authorized budget is the working budget.

Rep. Nye asked if the General Administration amount was Dr. John Baggett's staff. Ms. Hammond-Blanks said it was spread over 52 people in General Administration.

Ms. Hammonds-Blanks stated a report is due later this Session concerning the design of the replacement facility for Dix Hospital and that the Division would be providing a status report.

Sen. Martin asked what percentage of Developmental Disabilities funding goes for local services. Ms. Hamonds-Blanks stated she would get that information for him.

Ms. Hammonds-Blanks discussed page 12; the overview of the recommended adjustments in the continuation budget. She stated the State Hospitals and M.R. centers are having receipt problems, which the Department is looking into. Rep. Nye stated to Jim Edgerton of the Department that they need to get hold on receipts.

Sen. Dannelly asked about vocational training for Willie M clients. Charles Davis, with the Department, stated the teachers in the schools are able to teach the skills necessary and residential staff take them out to job sites. He stated some of the clients do get full time employment.

Ms. Hammond-Blanks discussed the Business Redesign Team. Rep. Nye asked Flo Stein, with the Department, how they purchased services from Raleigh when there are 40 local mental health programs purchasing services themselves. Ms. Stein stated she plans to have a report for them soon. Rep. Esposito also had questions concerning size and function of team.

Sen. Phillips asked questions concerning ratio of patients to staff in state hospitals and how NC compares with other states in this area. Mr. Donison Willis, with the Department, stated NC spends millions of dollars to keep facilities operable. He stated Dorothy Dix Hospital dates back to the Civil War and the newest state hospital is 50 years old.

There was a discussion between the representatives and senators concerning the age of state hospitals and the cost of building new ones. Mr. Willis stated the cost would be 40 to 45 million to build a 250- bed facility.

Chairman Nye adjourned the meeting at 9:50.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbitt
Committee Assistant

DIVISION OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE SERVICES

BUDGET/PROGRAM OVERVIEW

Fiscal Research Division

March 3, 1999

Division of Mental Health/Developmental Disabilities/Substance Abuse Services

Mission

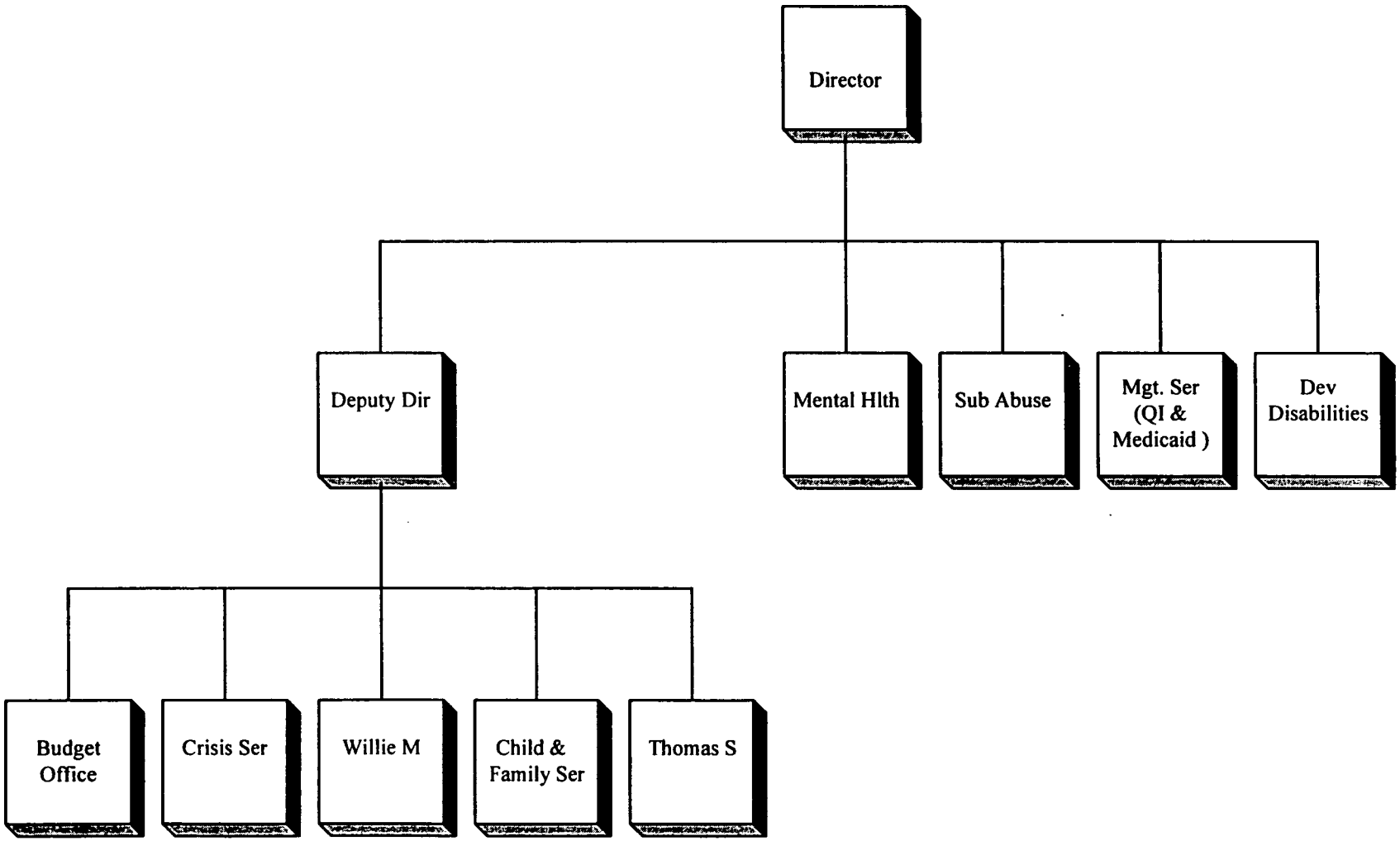
The Mission of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services is...to enable North Carolina's most vulnerable and disabled persons with mental, developmental and substance abuse problems to exercise their rights and responsibilities as citizens.

§ Policy (G.S. Section 122C-2)

The policy of the State is to assist individuals with mental illness, developmental disabilities, and substance abuse problems in ways consistent with the dignity, rights, and responsibilities of all North Carolina citizens. Within available resources, it is the obligation of the State and local government to provide services to eliminate, reduce, or prevent the disabling effects of mental illness, developmental disabilities, and substance abuse through a service delivery system designed to meet the needs of clients in the least restrictive available setting, if the least restrictive setting is therapeutically most appropriate, and to maximize their quality of life.

DEPARTMENT OF HUMAN RESOURCES

Division of Mental Health/Developmental Disabilities/Substance Abuse Services



January 1999

DIVISION OF MH/DD/SAS

Oversight & Regulatory Commissions

- *Commission for MH/DD/SAS*

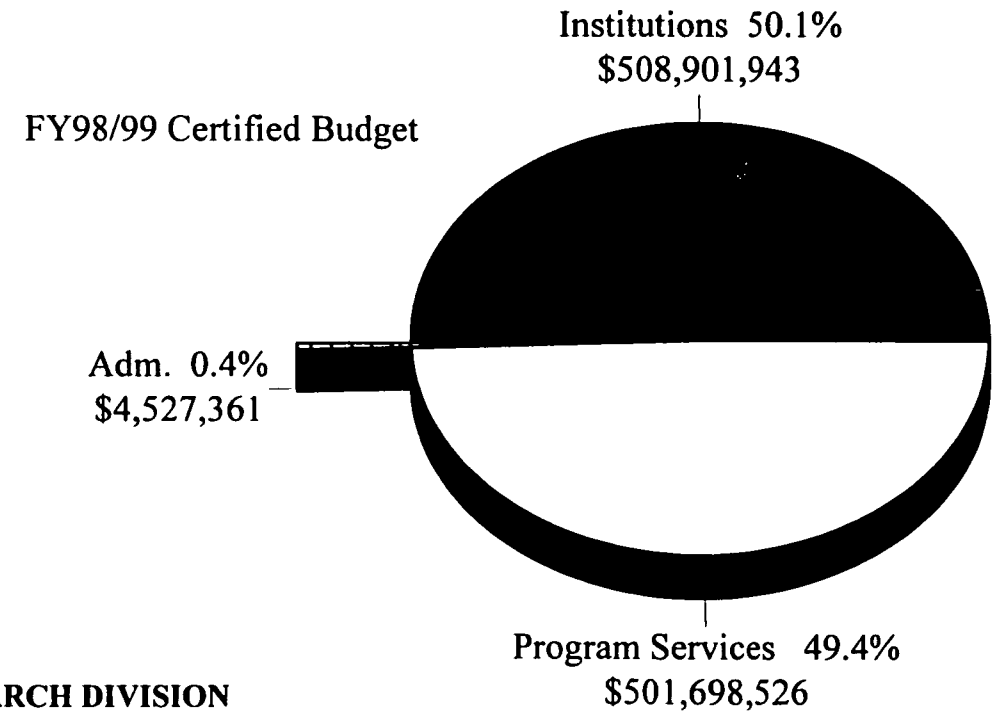
  -G.S. 143B-147 through 143B-150
  -26-member regulatory body
  -adopt/amend/repeal rules for state & local mh/dd/sas

- *Legislative Study Commission on MH/DD/SAS*

  -G.S. 120-204 through 120-207
  -22 members
  -review systemwide issues affecting mh/dd/sas

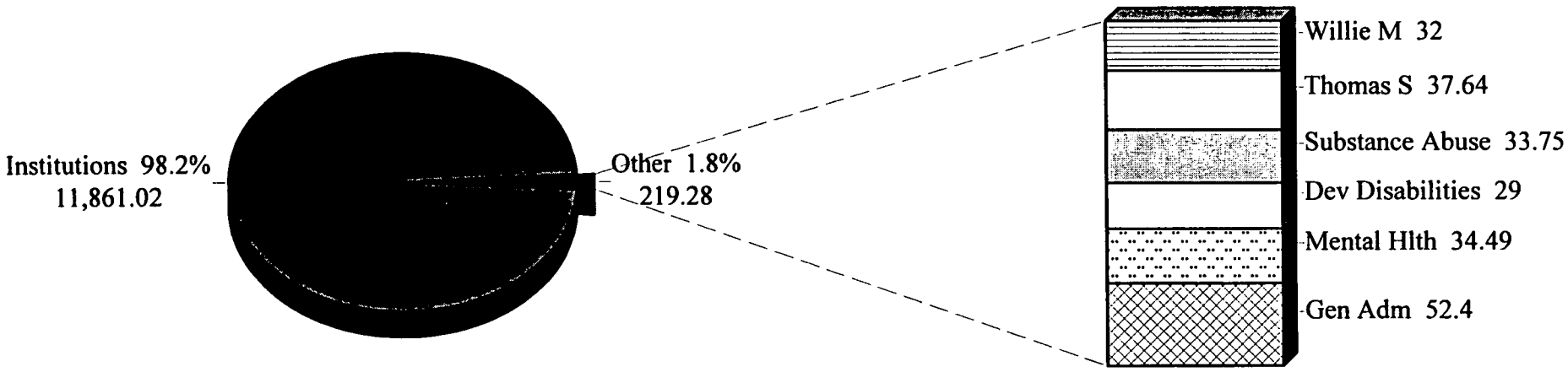
DIVISION OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE SERVICES

BUDGET SUMMARY:	FY97/98 Actual	FY98/99 Certified	FY98/99 Authorized	FY99/00 Rec'd.	FY00/01 Rec'd.
REQUIREMENTS	$1,140,329,329	$1,035,395,786	$1,035,404,786	$1,036,810,957	$1,034,547,177
REVENUES	($594,053,430)	($451,182,876)	($451,191,876)	($432,714,411)	($432,692,635)
APPROPRIATION	$546,275,899	$584,212,910	$584,212,910	$604,096,546	$601,854,542
POSITIONS	11,995.32	12,094.45	12,080.35	12,076.3	$12,076



DIVISION OF MH/DD/SAS

FY1998-99 Positions



Total Positions: 12,080.30

DIVISION OF MH/DD/SAS

Highlights of Legislative/Budget Actions

1997 Session:

✓ Area Mental Health Expansion	$5M
✓ Tri-County Dissolution & Realignment	$1.45M
✓ Forensic Treatment Unit @ Dorothea Dix Hospital	$1.1M
✓ Crisis Services Expansion	$1M
✓ Early Intervention Services	$2.7M
✓ Efficiency Study of State Psychiatric Hospitals	
✓ Whitaker School Replacement Facility	

DIVISION OF MH/DD/SAS

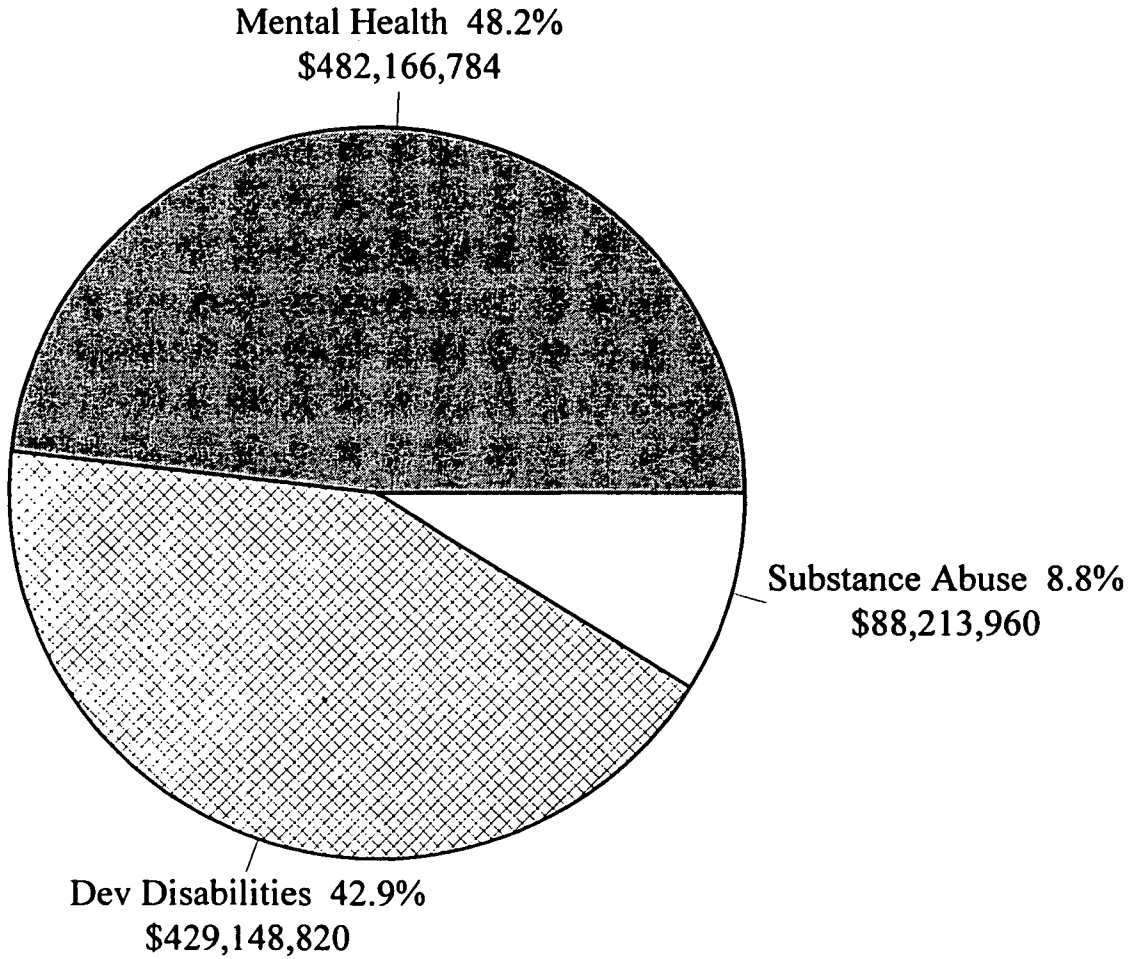
Highlights of Legislative/Budget Actions

1998 Session:

✓ Creation of Medicaid Match Reserve	$38M
✓ Funding for Developmental Disabilities Waiting List	$12M
✓ Atypical Antipsychotic Medications	$1.3M
✓ Violent & Assaultive Children	$5.3M
✓ Continuation/Expansion of the Hospital Study	$750K
✓ Design of Replacement Facility for Dix Hospital	$2M
✓ Whitaker School Planning	$250K
✓ Increased Area Program Accountability Initiatives	

DIVISION OF MH/DD/SAS

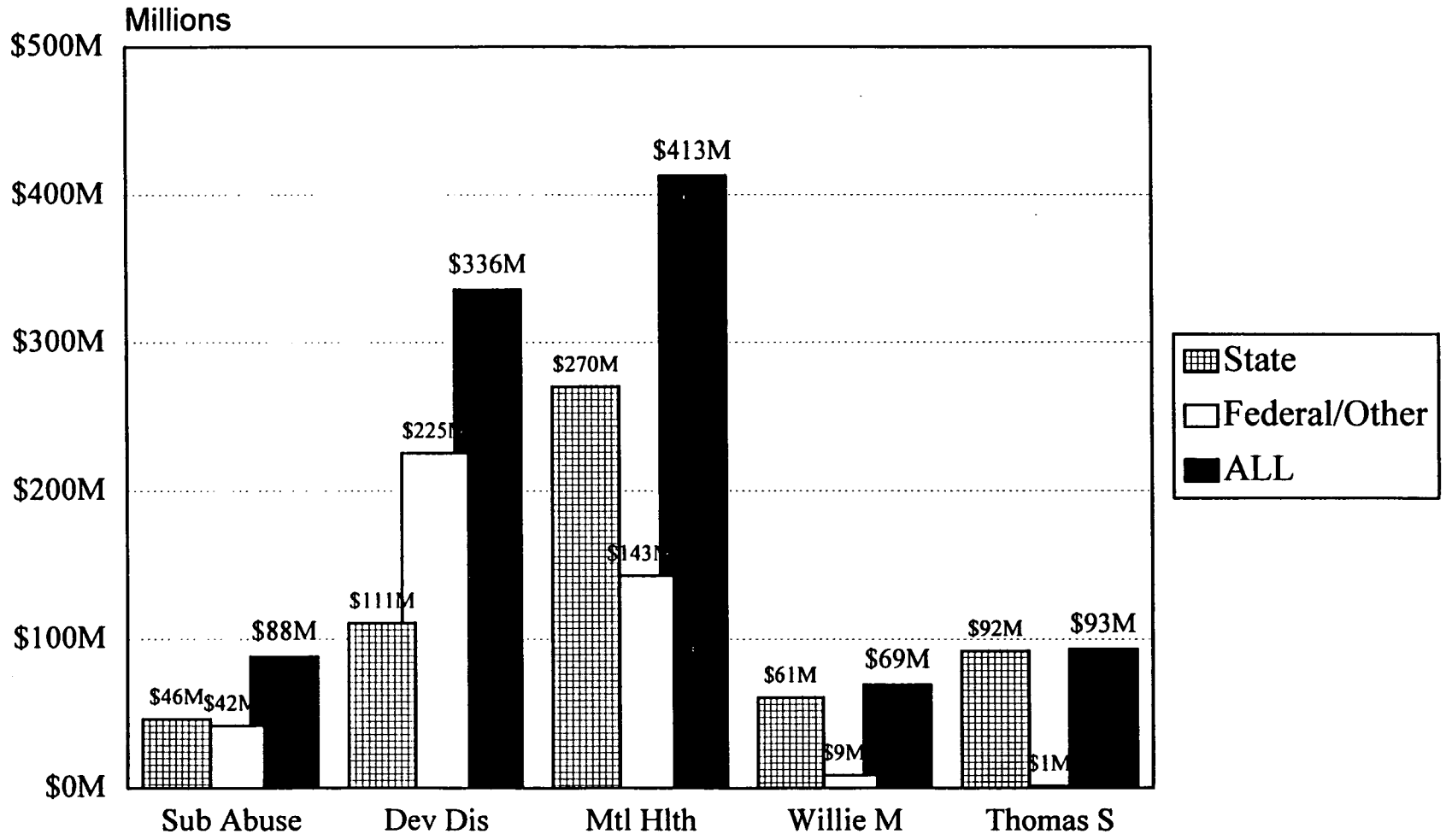
Total Expenditures by Disability



FY98/99 Certified Budget

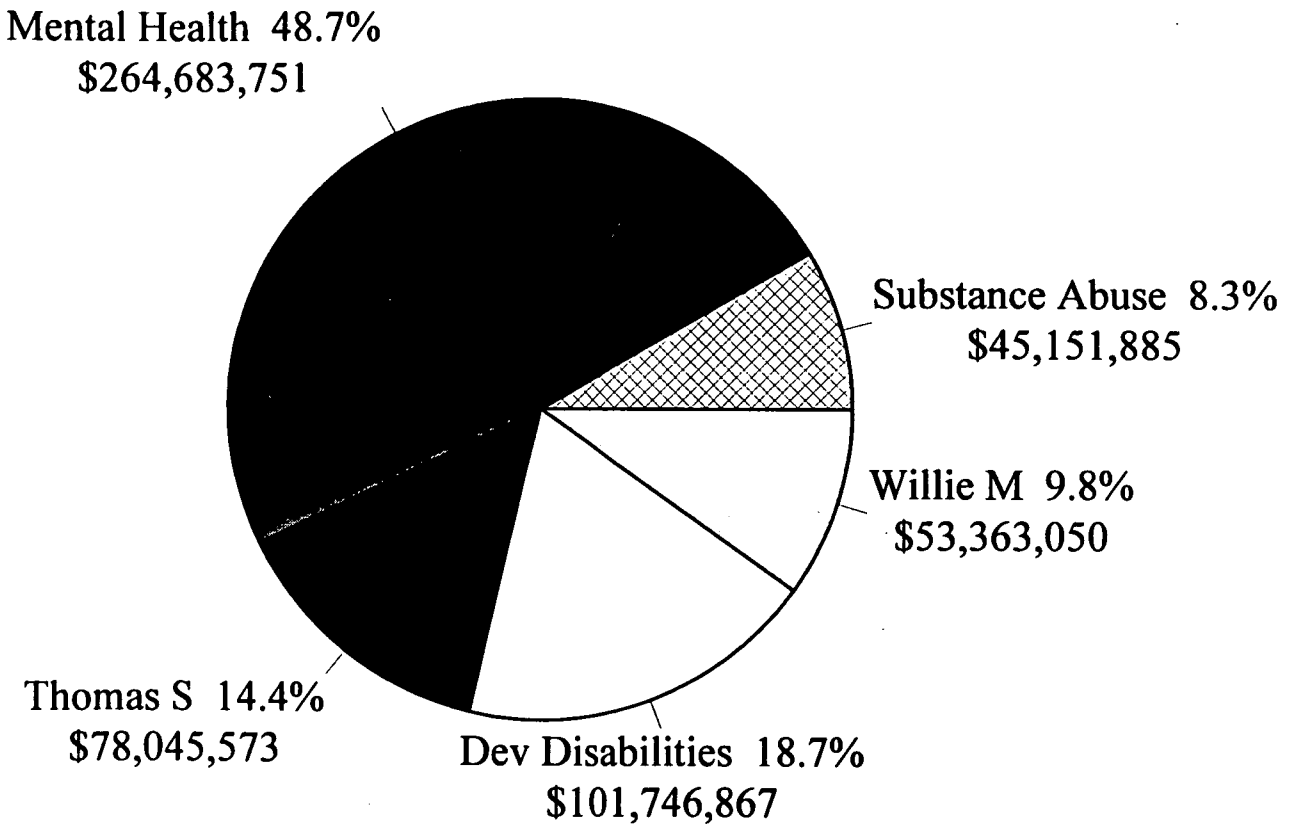
DIVISION OF MH/DD/SAS

FY98/99 Funding by Disability Area and Source



DIVISION OF MH/DD/SAS

State Appropriations by Disability Area



FY97/98 Appropriations: $546,275,899

Division of Mental Health/ Developmental Disabilities/Substance Abuse Services

1999-00 Governor's Recommended Continuation Budget Adjustments

		FY99/00	FY00/01
1.	Replace Institutional Receipts with State Appropriations	$18,200,000	18,200,000
2.	Replace Equipment in Institutions	1,500,000	800,000
3.	Eliminate 4 Vacant Positions	(78,722)	(78,722)
4.	Developmental Disabilities Waiting List & Management	6,000,000 500,000	6,000,000 500,000
5.	Atypical Antipsychotic Medications	1,326,998	1,326,998
6.	Violent & Assaultive Children Services (Does Not Include the Continuation of $5,353,003 for Children in Existing Services)		

DIVISION OF MH/DDSAS

DIVISION-WIDE INITIATIVES

- ***Cross Disability Comprehensive Outcomes Initiative:***
  -Cross Disability Comprehensive Review
  -Includes State and Area Program Services
  -Measures Consumers Outcomes in Five Areas:
  Functioning; Reduction of Symptoms; Involvement in Employment and Education; Involvement in the Criminal Justice System; Crisis Services Utilization; and Residential Appropriateness

- ***Business Redesign Initiative:***

  -Appointed Division Design Team
  -Developing Recommendations for Comprehensive Redesign of System;
  -Goals: Optimize *Effectiveness of State's Purchase of Mental Health Services to Ensure High Quality, Accessibility, and Cost Efficiency.*

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, SUBSTANCE ABUSE SERVICES

PROGRAMS/SERVICES

DIVISION OF MH/DD/SAS

SERVICES WITHIN DMH/DD/SAS

Programs

- Mental Health
- Child & Family Services
- Willie M Services
- Developmental Disabilities
- Thomas S Services
- Crisis Services
- Substance Abuse Services

Support

- Management Services
- Budget Office

MENTAL HEALTH SERVICES

MISSION:

To promote the development of services for adults with severe and persistent mental illness and seriously emotionally disturbed minors through supervision of state mental health institutions, policy guidance, special grant initiatives and advocacy within the Division, the Department of Human Resources and other departments and offices of state government.

What Is Mental Illness and Who Is Disabled?

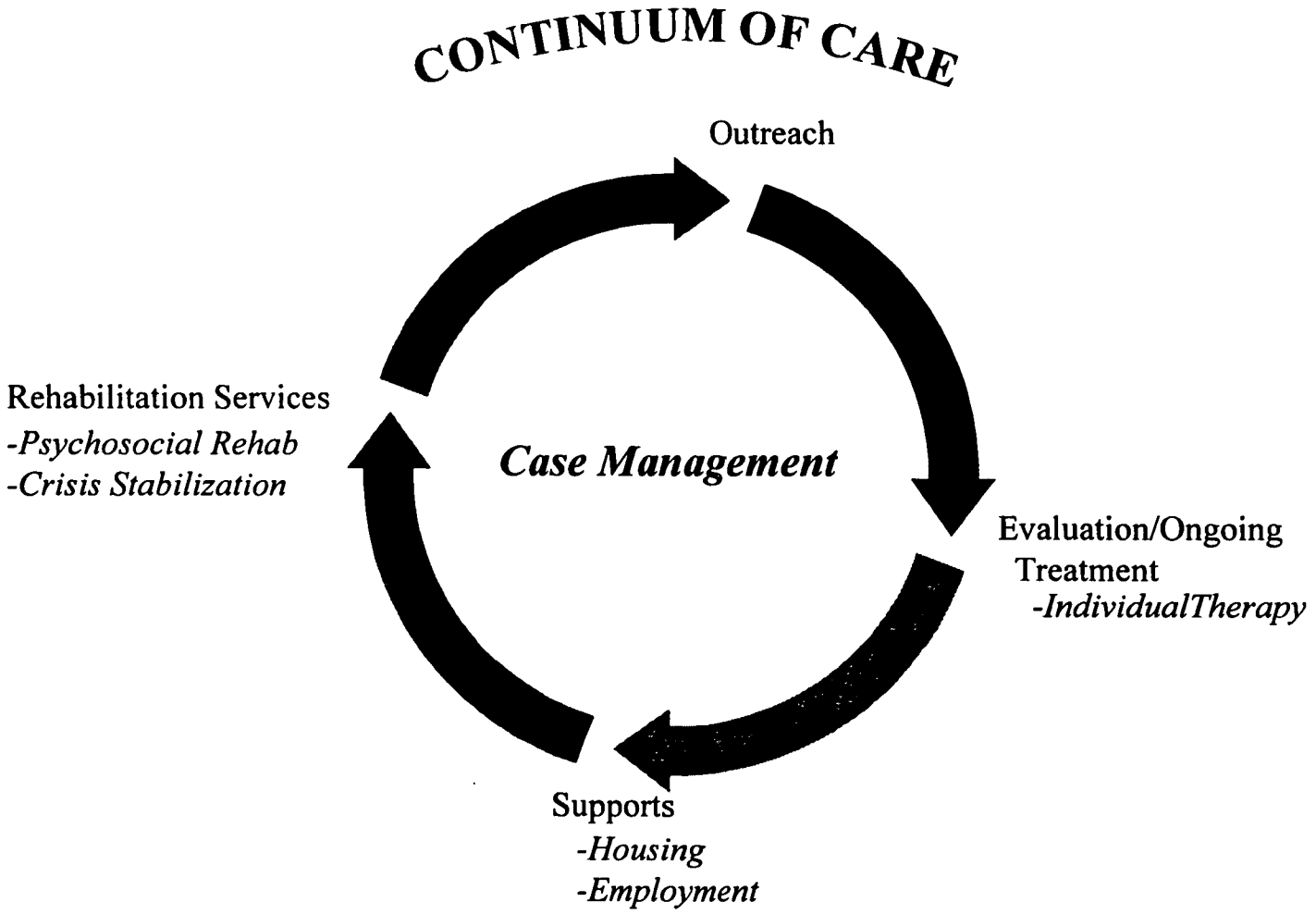
In adults, the most disabling forms of Mental Illness are *Schizophrenia, Clinical Depression And Manic-Depressive Disease*

Subpopulations Exist With Special and Different Needs -*Homeless, Dually Diagnosed, Children, Young Adults and Elderly*

Characteristics of Serious & Chronic Mental Illness:
- difficulty with tasks of daily living;
- recurrent problems in meeting basic survival needs;
- extreme vulnerability to stress;
- tendency toward episodes of "acting out";
- lack of ability to develop personal social networks; and
- lack of ability to seek help from others.

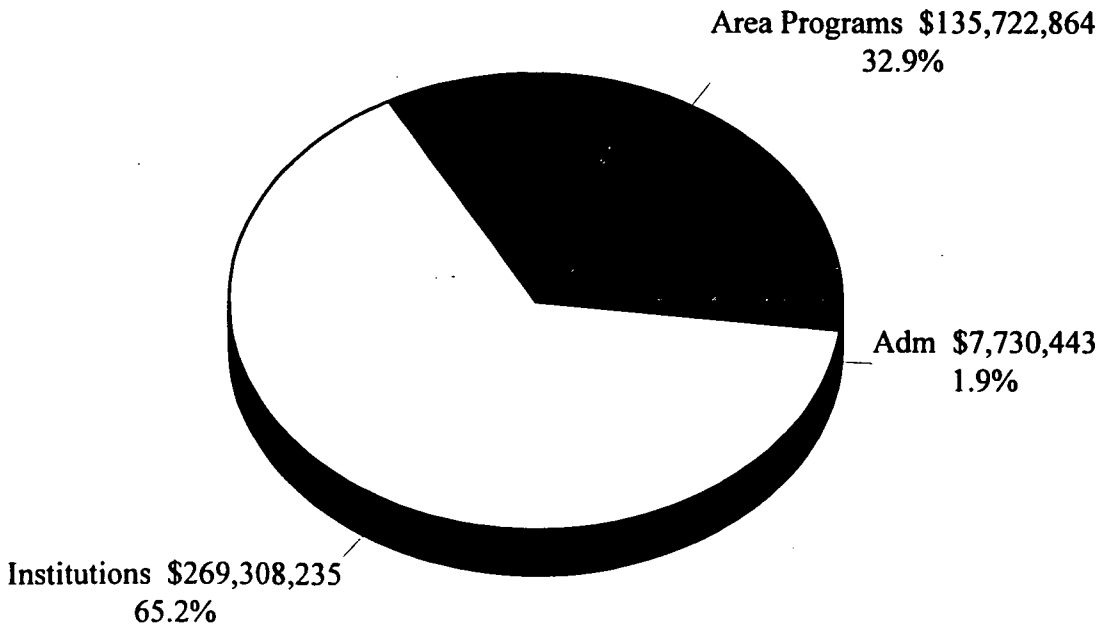
MENTAL HEALTH SERVICES

SERVICES FOR PERSONS WITH MENTAL ILLNESS



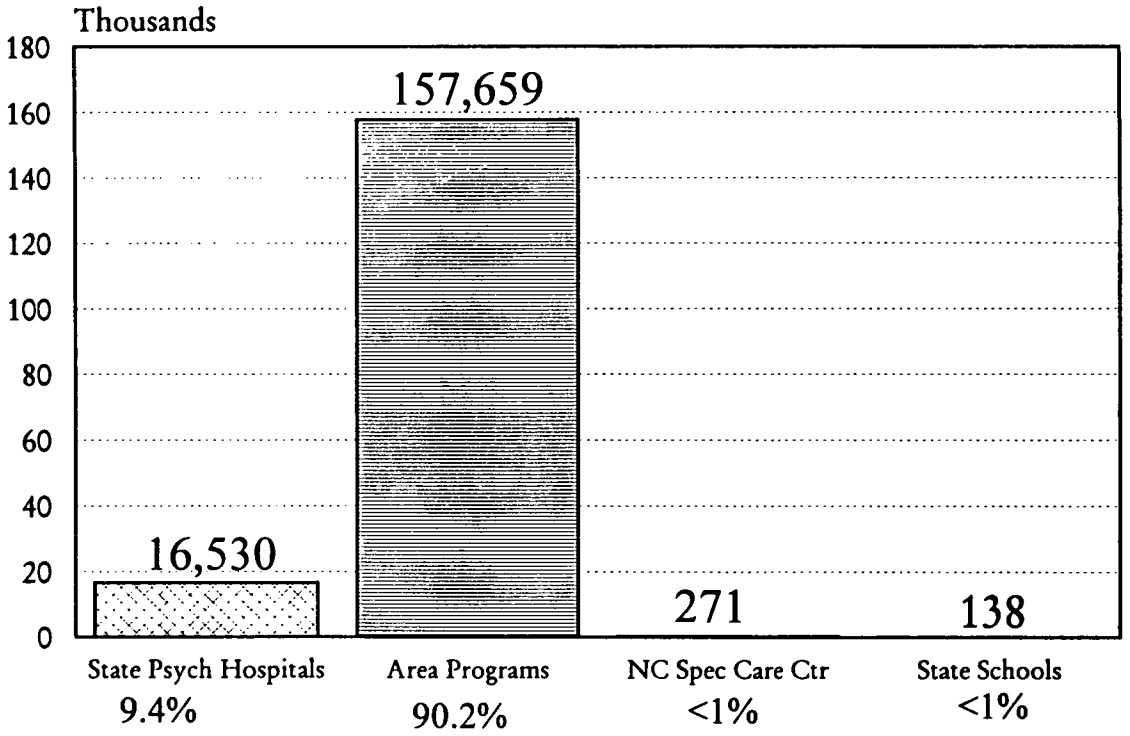
MENTAL HEALTH SERVICES

BUDGET SUMMARY:	FY98/99 CERTIFIED	FY99/00 RECOMMENDED
REQUIREMENTS	$412,761,542	$417,988,889
REVENUES	(142,773,942)	(130,070,744)
APPROPRIATIONS	$269,987,600	$287,918,145
POSITIONS	5,751.04	5,751.04



FY 98/99 Certified Budget

Where Are the Mentally Ill?
What Services Do They Receive?
FY1997/98

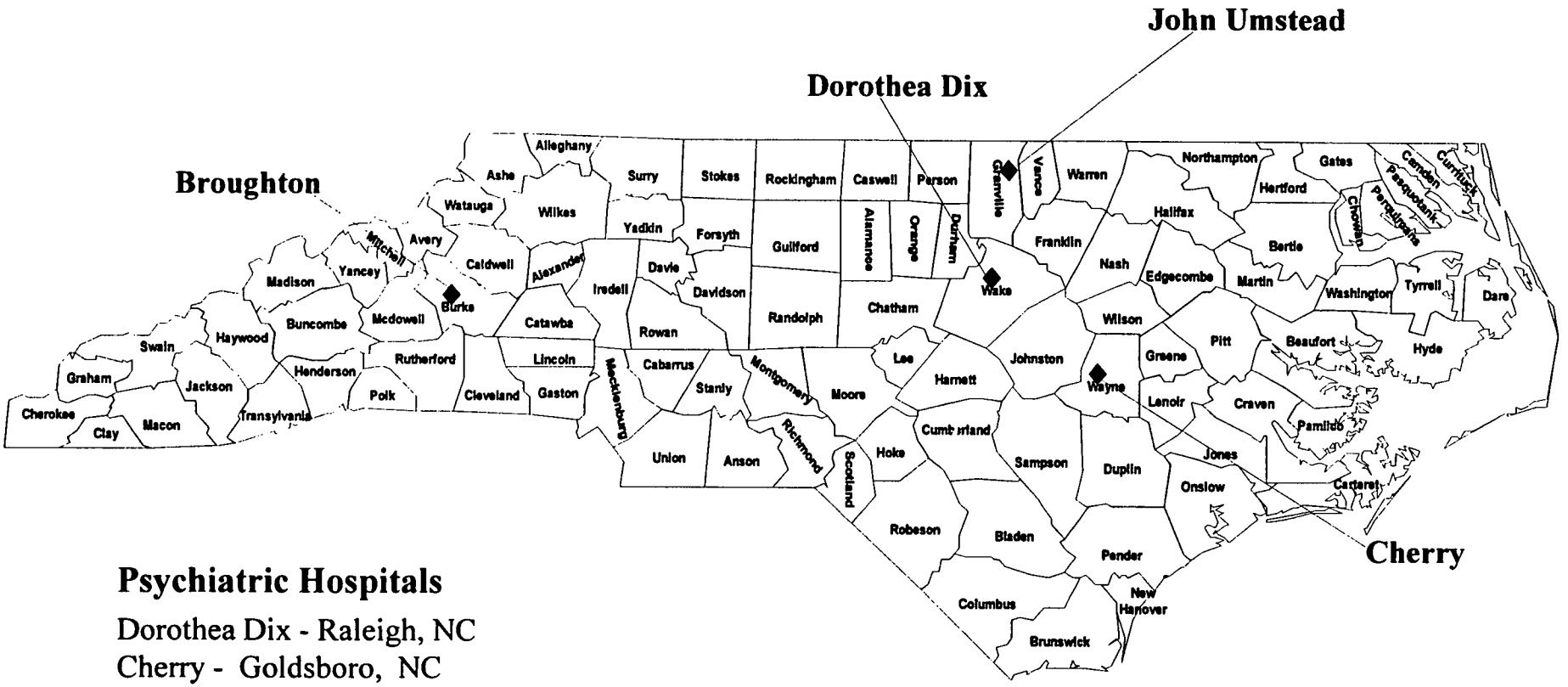


SERVICES:

- ✓ **Assessment**
- ✓ **Treatment**
- ✓ **Case Management**
- ✓ **Supervised Independent Living**
- ✓ **Family Living**
- ✓ **Group Living**
- ✓ **Residential Treatment**
- ✓ **Inpatient Services**
- ✓ **Day Treatment**
- ✓ **Specialized Care for Deaf/Mentally Ill**

MENTAL HEALTH SERVICES

STATE PSYCHIATRIC HOSPITALS



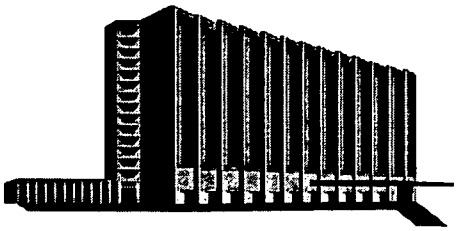
Psychiatric Hospitals

Dorothea Dix - Raleigh, NC
Cherry - Goldsboro, NC
John Umstead - Butner, NC
Broughton - Morganton, NC

MENTAL HEALTH SERVICES

STATE PSYCHIATRIC HOSPITALS

Dorothea Dix Hospital



- Opened in 1856
- Serves South Central Region (16 Counties)
- Bed Capacity of 340
- F98/99 Operating Budget: $67.4M
- Persons Served FY97/98: 4,151
- 1375.14 Staff
- Special Units: Forensic, Medical/Surgical, Residency Training & Pre-Trial Evaluation

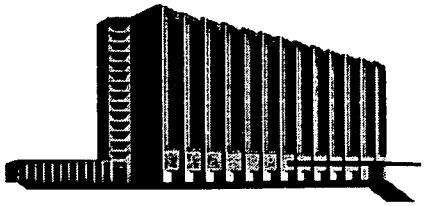
Broughton Hospital

- Opened 1882
- Serves Western Region (32 Counties)
- Bed Capacity
- FY98/99 Operating Budget: $60.1M
- Persons Served FY97/98: 4,200
- 1325.3 Staff
- Special Units: Medical/Surgical

MENTAL HEALTH SERVICES

STATE PSYCHIATRIC HOSPITALS

Cherry Hospital



- Opened in 1880
- Serves Eastern Region (33 Counties)
- Bed Capacity of 340
- F98/99 Operating Budget: $59.8M
- Persons Served FY97/98: 2,991
- 1271.08 Staff
- Special Units: Tuberculosis

John Umstead Hospital

- Opened in 1944
- Serves North Central Region (16 Counties)
- Bed Capacity of 340
- F98/99 Operating Budget: $63.1M
- Persons Served FY97/98: 5,188
- 1305.67 Staff
- Special Units: Residency Training

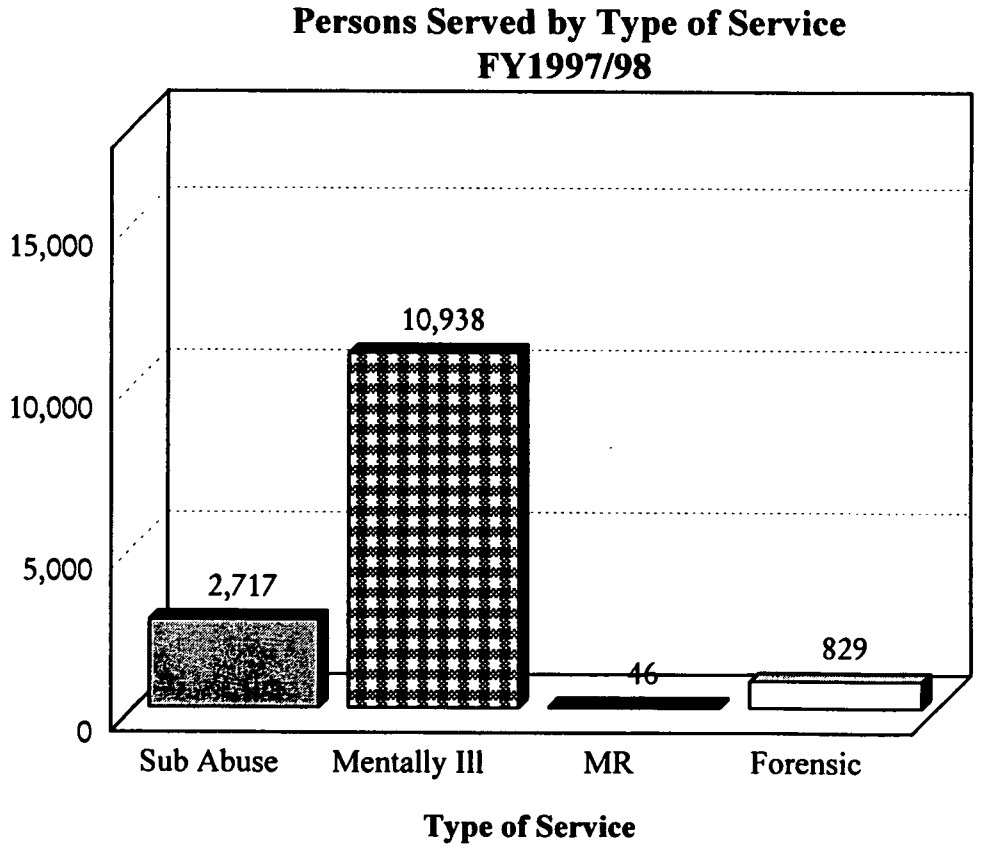
MENTAL HEALTH SERVICES

STATE PSYCHIATRIC HOSPITALS

State Hospitals Provide an Array of Services - medical, psychiatric nursing and rehabilitative services to adults, children and geriatric individuals.

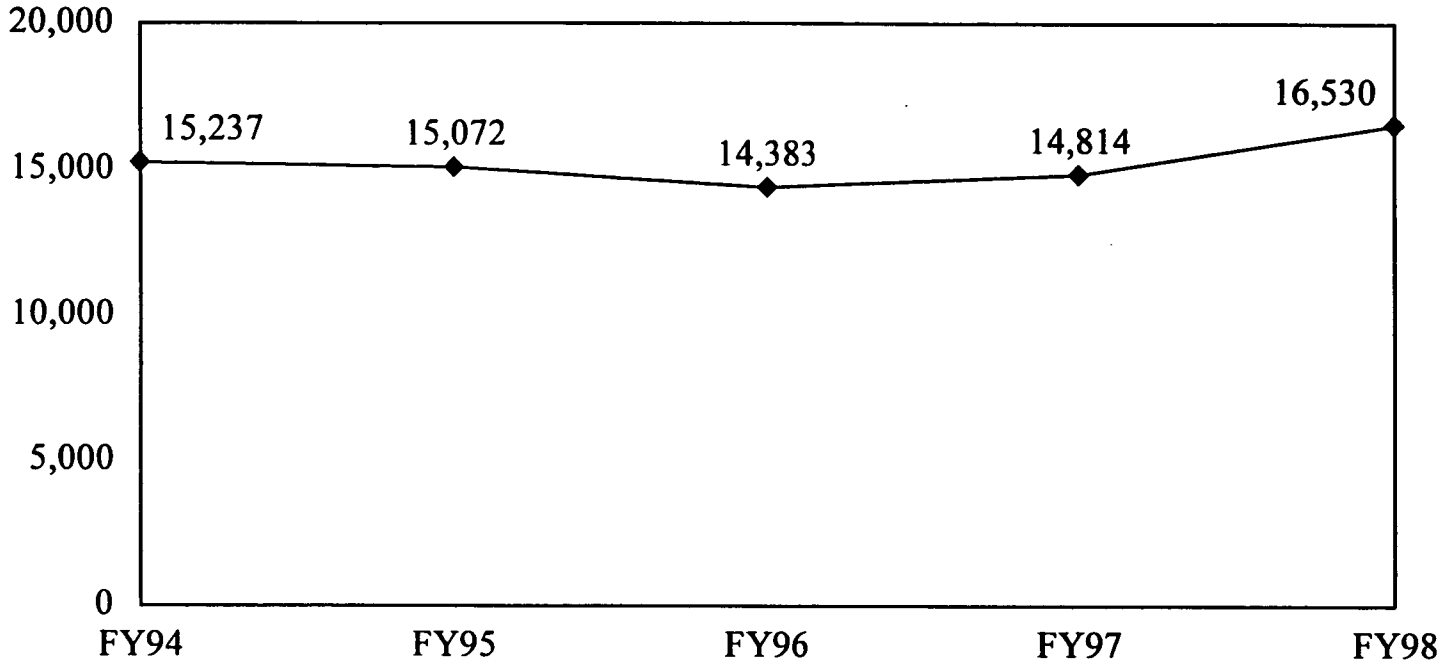
Patient Characteristics:

- Primary Diagnosis Schizophrenia - 13.5%
- Alcohol & Drug Diagnoses - 28.6%
- 53.4% or 8,836 Persons Ages 25 - 44 yrs
- 64% Male
- 10,042 or 61% White
- 6,040 or 36.5% African American
- 67.5% or 11,160 Involuntary Admissions



MENTAL HEALTH SERVICES

TRENDS IN PERSONS SERVED IN STATE HOSPITALS

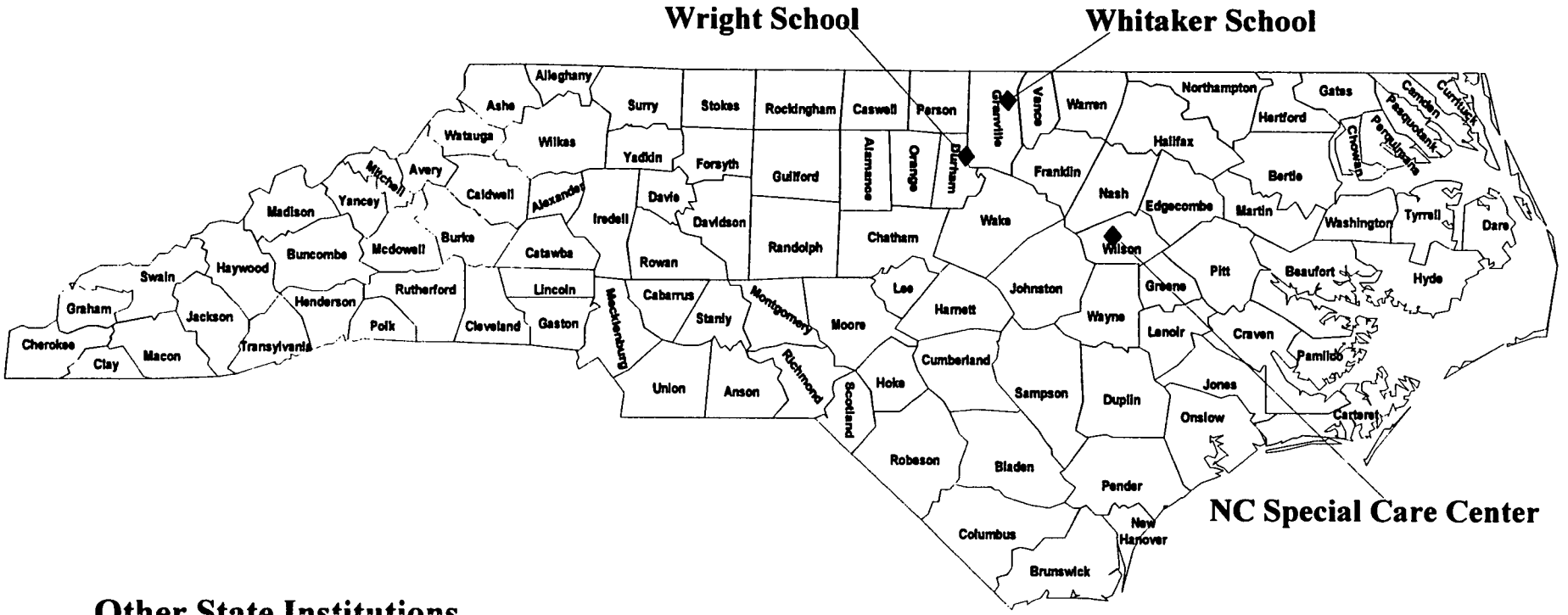


NOTE:

11.6% Increase in Persons Served Since FY97
8.4% Increase in Persons Served Since FY94

MENTAL HEALTH SERVICES

OTHER INSTITUTIONAL SERVICES



Other State Institutions

Whitaker School - Butner, NC
Wright School - Durham, NC
NC Special Care Center - Wilson, NC

MENTAL HEALTH SERVICES

OTHER INSTITUTIONAL SERVICES

N.C. Special Care Facility

- Opened in 1978
- Provides Nursing Level Care to Former State Psychiatric Hospital Patients
- Service Region Statewide
- Referrals From State Psychiatric Hospitals
- Bed Capacity of 208
- Persons Served FY97/98: 271
- F98/99 Operating Budget: $14.3M
- 351 Staff

Client Profile:

- 62% Require Intermediate Care Nursing
- 60% White
- 61% 65+ Years
- Average Stay: 4.3 Years

MENTAL HEALTH SERVICES

OTHER INSTITUTIONAL SERVICES

Whitaker School

- Opened in 1978
- Adolescent Re-educational Model
- Providing Secure, Residential Treatment to Behaviorally and Emotionally Disturbed Youth 12-17 Years
- Service Region Statewide
- Referrals From Area Mental Health Programs
- Bed Capacity of 24
- Persons Served FY97/98: 61
- F98/99 Operating Budget: $2.2M
- 51 Staff

Client Profile:

- 65% Male
- 53% Non-White
- Average Age: 15 Years
- Average Stay: 8.8 Months

MENTAL HEALTH SERVICES

OTHER INSTITUTIONAL SERVICES

Wright School

- Providing Residential Treatment to Behaviorally and Emotionally Disturbed Youth 6-12 Years
- Service Region Statewide
- Referrals From Area Mental Health Programs
- Bed Capacity of 24
- Persons Served FY97/98: 77
- F98/99 Operating Budget: $1.7M
- 37.36 Staff

Client Profile:

- 89% Male
- 56% Non-White
- Average Age: 10 Years
- Average Stay: 5.9 Months

MENTAL HEALTH SERVICES

WILLIE M SERVICES

The Willie M Services Section coordinates a system of services which are primarily provided by area mental health programs And include least restrictive, individualized treatment and educational services to children identified as Willie M Class members under the age of eighteen (18) who have serious emotional, mental or neurological impairments and whose impairments are accompanied by violent or assaultive behavior.

Chronology:

- October 1979 - Lawsuit Filed
- November 1980 - Review Panel Appointed
- October 1981 - Court Approves Timetable for All Class Members In Service
- April 1992 - Adopted Comprehensive Plan for Service to Members
- January 1995 - Motion Filed for Relief From Court Oversight

MENTAL HEALTH SERVICES

WILLIE M SERVICES

Chronology:

- February 1997 - Judge provided updated copy of the Compliance Plan and Proposals to Terminate Review Panel & Willie M Case
- January 1998 - Judge Dismissed Class/Case

Program Information:

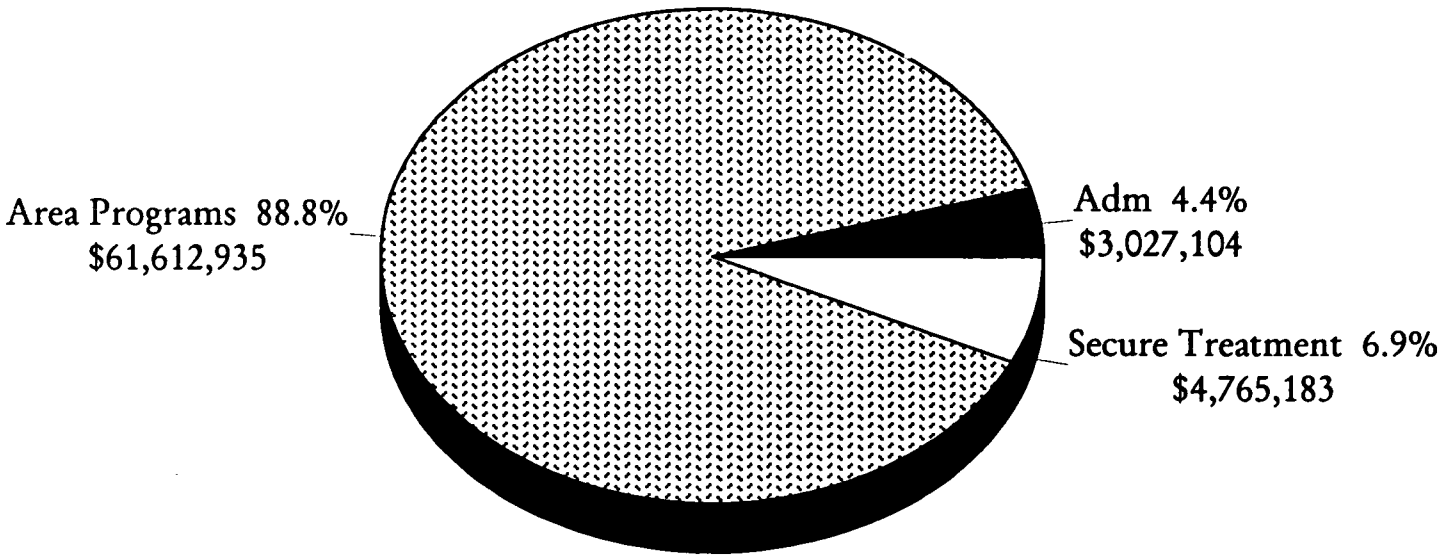
- Class Criteria: (1) presence of a diagnosed mental, emotional, or neurological handicap; (2) behavior characterized as violent or assaultive; (3) prior involvement of the state in child's life; and (4) need for residential treatment and absence of appropriate services.
- Class Membership is Voluntary
- Area Mental Health Programs provide or arrange most services; DHHS provides special residential services and contracts for some local services.

MENTAL HEALTH SERVICES

WILLIE M SERVICES

BUDGET SUMMARY:	FY98/99 CERTIFIED	FY99/00 RECOMMENDED
REQUIREMENTS	$69,405,222	$64,097,200
REVENUES	($8,572,032)	($8,572,032)
APPROPRIATIONS	60,833,190	55,525,168
POSITIONS	$155	$155

FY98/99 CERTIFIED BUDGET



MENTAL HEALTH SERVICES

WILLIE M SERVICES

Willie M Client Profile:

- 1,931 Children Served FY97/98
- 42% Cost Average $5,130/year
- 7% Cost $20,000-39,000/year
- 12% Cost $40,000-59,000/year
- 10.5% Cost $100,000+
- Approximately 70% Served by Public School System
- 30% Live in Their Homes

WILLIE M SERVICES

Willie M Client Profile:

- 12% Reside in Locked Facilities
- 75% Removed from Their Homes by State/Local Government
- 52% Have Been Physically Abused
- 33% Have Been Sexually Abused
- 57% Come From Families With Mental Disorders
- 53% Come From Families With Substance Abuse Problems

MENTAL HEALTH SERVICES

CHILD AND FAMILY SERVICES

MISSION:

Implementing the N.C. Child Mental Health Plan Statewide and Facilitating the Development and Monitoring of Nonresidential and Residential Child Mental Health Services in Each of the 40 Area Authorities, Children's Units in the State Psychiatric Hospitals and the Wright and Whitaker Schools.

INITIATIVE:

Futures Committee
-State and Multiple Child Service Agencies
-Working Collaboratively to Develop a Response to 1998 MGT of America Study
-Evaluating Role of State Hospitals in the Continuum of Care for Seriously Emotionally Disturbed Children

MENTAL HEALTH SERVICES

INITIATIVES

1. **Follow Up on MGT, Study**
   -Three (3) Committees Established to Respond to the Recommendations for Special Populations

2. **Dix Hospital Planning & Design**

3. **Cherry Hospital Children's Unit**
   -Design Phase is Well Underway

DEVELOPMENTAL DISABILITIES SERVICES

The purpose of the Developmental Disabilities Section is to direct, manage and facilitate services and supports for individuals with developmental disabilities and their families. Services for persons with developmental disabilities are administered by the Division and operated by the forty (40) Area Programs or their contract agencies and the five state operated mental retardation centers.

What is a Developmental Disability?

A severe, chronic disability of a person which:

- is attributable to a mental /physical impairment or combination,

- is manifested before the age of 22 , unless the disability is caused by a traumatic head injury after age 22;

DEVELOPMENTAL DISABILITIES SERVICES

- Results in substantial functional limitations in 3 or more of the following:

  -self-care
  -receptive & expressive language
  -capacity for independent living
  -self-direction & self sufficiency
  -mobility
  -learning, and

- Reflects the person's need for a combination or sequence of interdisciplinary or generic care, treatment, or other services which are of a lifelong orextended duration and are individually planned and coordinated; or

- When applied to children from birth through four years of age, may be evidenced as a developmental delay.

CONDITIONS WHICH CAN LEAD TO A DEVELOPMENTAL DISABILITY:

- Autism
  Cerebral Palsy
  Polio
  Spinal Cord Injury
  Severe Head Injury
  Severe Learning Disabilities
- Spina Bifida
  Congenital Heart Disease
  Sickle Cell Anemia
  Epilepsy
  Blindness
  Mental Retardation

DEVELOPMENTAL DISABILITIES SERVICES

SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

ARRAY OF SERVICE OPTIONS

Early Intervention Services

-Early Identification & Screening
-Multidisciplinary Assessment
-Services Include Respite, Speech Therapy, and Other Special Therapies

Case Management

Day Services

-Community Inclusion
-Parent Training

Case Management

Vocational/Employment Services & Supports

-Supported Employment
-Sheltered Workshops

Case Management

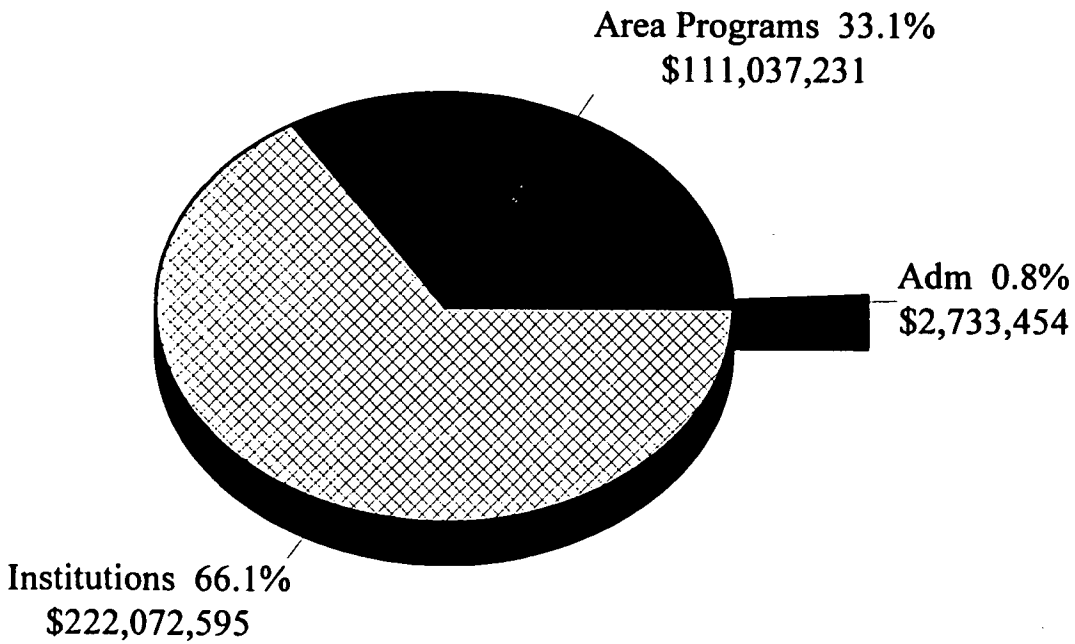
Housing Supports

-Supported Living
-Intermediate Care Facility for the Mentally Retarded (ICF/MR)
-Developmentally Disabled Adult Group Homes (DDA)

Case Management

DEVELOPMENTAL DISABILITIES SERVICES

BUDGET SUMMARY:	FY98/99 CERTIFIED	FY99/00 RECOMMENDED
REQUIREMENTS	$335,843,280	$338,194,750
REVENUES	(225,281,357)	(218,043,386)
APPROPRIATIONS	$110,561,923	$120,151,364
POSITIONS	5,795.75	5,795.75



FY98/99 Certified Budget

DEVELOPMENTAL DISABILITIES SERVICES

Where Do the Developmentally Disabled Receive Services?

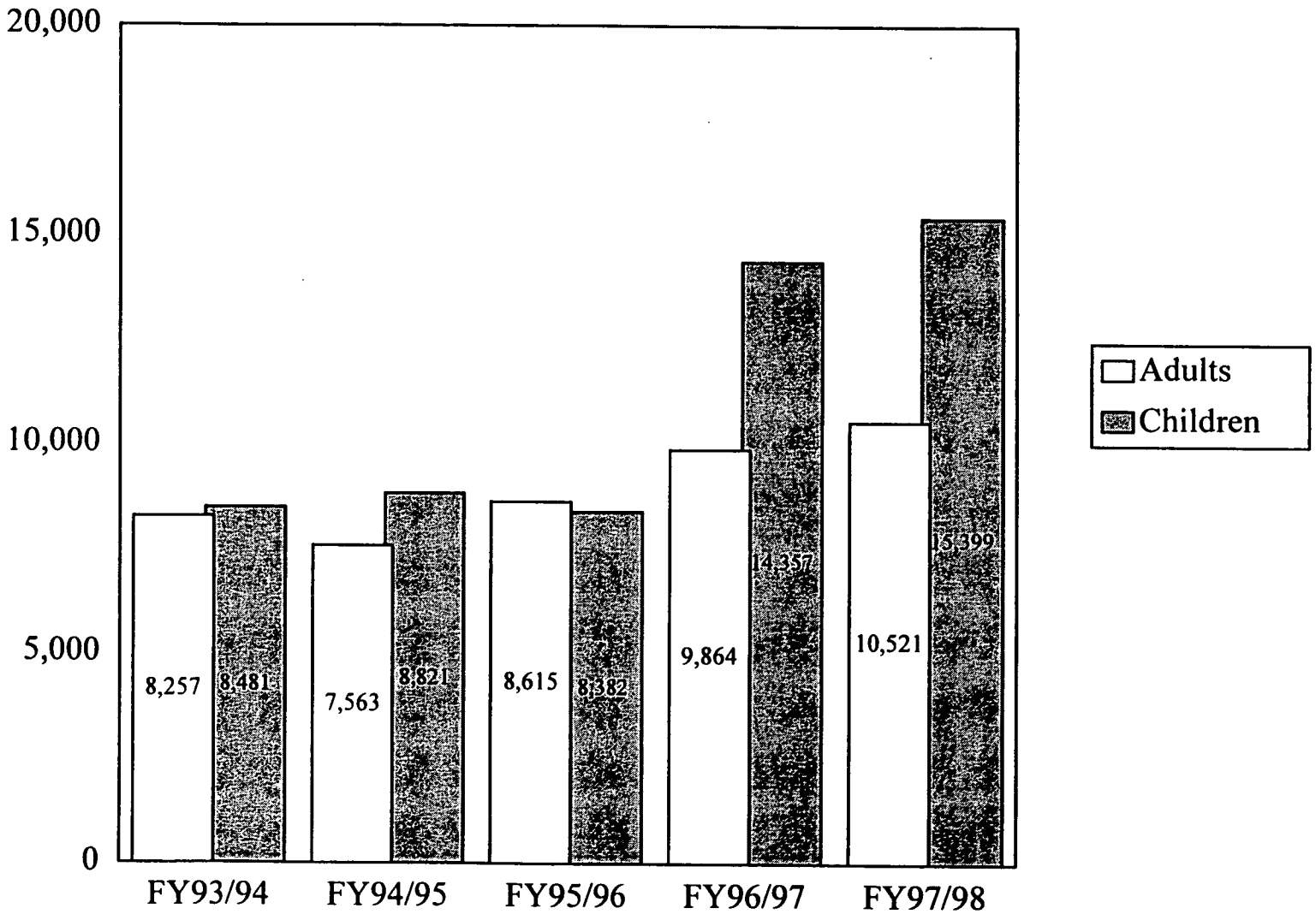
1. Area Mental Health Programs

2. State Intermediate Care Facility for Mentally Retarded (ICF-MR)

3. Community Alternatives Program for the Mentally Retarded/Developmentally Disabled (CAP-MR/DD)

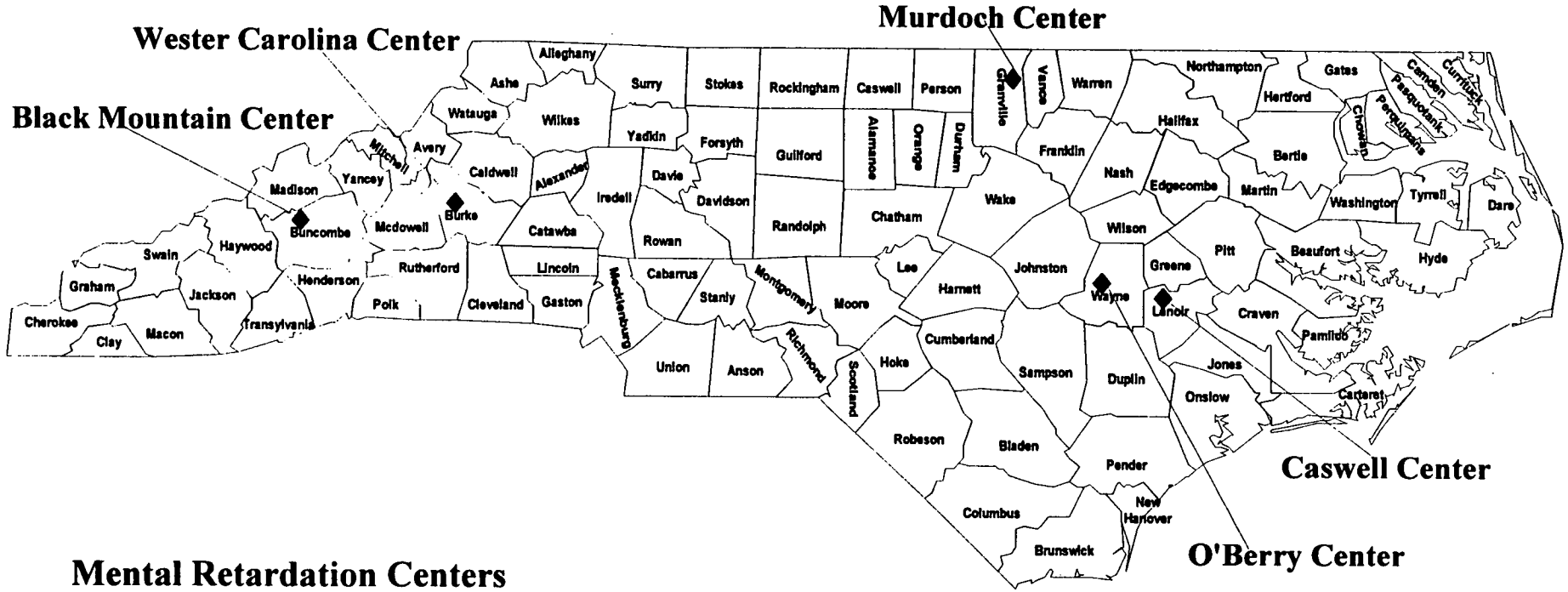
Developmentally Disabled Clients Served

Through Area Programs



DEVELOPMENTAL DISABILITIES SERVICES

MENTAL RETARDATION CENTERS



Mental Retardation Centers

Western Carolina Center - Morganton, NC
O'Berry Center - Goldsboro, NC
Murdoch Center - Butner, NC
Caswell Center - Kinston, NC
Black Mountain Center - Black Mountain, NC

DEVELOPMENTAL DISABILITIES SERVICES

MENTAL RETARDATION CENTERS

Black Mountain Center

- Opened in 1937
- Serves Western NC
- Bed Capacity of 190
- F98/99 Operating Budget: $41M
- Persons Served FY97/98: 336
- 444 Staff
- Special Units: 71-Bed Alzheimer Unit

Caswell Center

- Authorized by General Assembly in 1911 (NC's First MR Center)
- Serves Central NC
- Bed Capacity of 813
- F98/99 Operating Budget: $64M
- Persons Served FY97/98: 699
- 1,715 Staff

DEVELOPMENTAL DISABILITIES SERVICES

MENTAL RETARDATION CENTERS

Murdoch Center

- Began 1948
- Serves Central NC
- Bed Capacity of 676
- F98/99 Operating Budget: $60.4M
- Persons Served FY97/98: 653
- 1,593 Staff

O'Berry Center

- Opened in 1957
- Serves Eastern NC
- Bed Capacity of 485
- F98/99 Operating Budget: $38.9M
- Persons Served FY97/98: 404
- 1,018 Staff

DEVELOPMENTAL DISABILITIES SERVICES

MENTAL RETARDATION CENTERS

Western Carolina Center

- Began 1948
- Serves Western NC
- Bed Capacity of 493
- F98/99 Operating Budget: $41.2M
- Persons Served FY97/98: 416
- 996.25 FTE/Staff

DEVELOPMENTAL DISABILITIES SERVICES

Clients Served In State Mental Retardation Centers

Client Profile: (as of 6/30/98)

Persons Served: 2,508 (2,284 Residents & 224 Respite Services)

- 58% Male -42% Female

- 70% White -30% Non-White

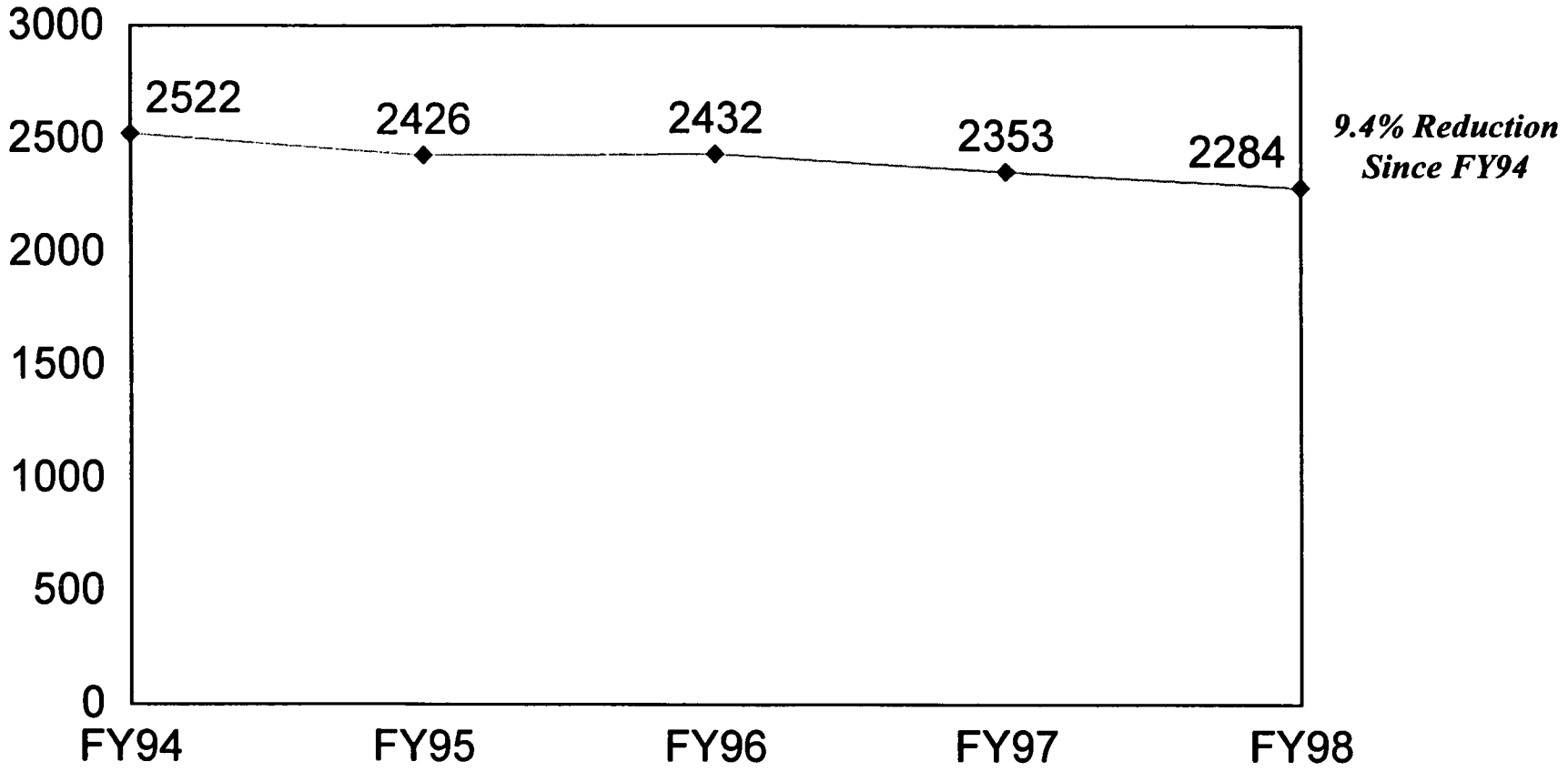
- 78% Age 25-54 Years - 73% Average Length of Stay: >21 years

-89% Severly/Profoundly Impaired

-Impairments Other Than M R: Cerebral Palsy, Autism, Epilepsy, Language Impairment & Alzheimer's Disease

DEVELOPMENTAL DISABILITIES SERVICES

PERSONS SERVED IN MENTAL RETARDATION CENTERS



DEVELOPMENTAL DISABILITIES SERVICES

COMMUNITY ALTERNATIVES PROGRAM FOR THE MENTALLY RETARDED OR DEVELOPMENTALLY DISABLED (CAP-MR/DD)

- Medicaid Waiver Program
  -Income and Resources of the Consumer (Not Parents or Spouse) Are Considered When Application is Made
  -Level of Disability is the Major Determination of Eligibility
- Began 1983, Program Serving Individuals Who Would Otherwise Require Care in an Intermediate Care Facility for People with Mental Retardation or Developmental Disabilities (ICF-MR)
- "Benefits Cap" Approach to Managed Care
- Maximum Annual Benefit Limit $68,088/Slot
  -Total of 5,127 Slots (FY98/99)
  -1,700 Additional Slots Made Available During FY98/99
  -Average Cost Per Consumer $28K Per Year
  -Approximately 800 Slots Are Currently Not Filled

COMMUNITY ALTERNATIVES PROGRAM FOR THE MENTALLY RETARDED OR DEVELOPMENTALLY DISABLED (CAP-MR/DD)

Array of Service Options

- Case Management
- Adult Day Health Care & Adult Day Care
- Augmentative Communication Equipment
- Supplies & Equipment **(expanded 1995)**
- Crisis Stabilization
- Supported Living Services
- Environmental Accessibility Adaptations
- Vehicle Adaptations **(new service 1995)**
- In-Home Aide Services
- Personal Emergency Response System
- MR Personal Care
- Respite Services **(revised service 1995)**
- Personal Habilitation Services {E.g.. Supported Employment} **(revised & new services 1995)**

THOMAS S SERVICES

The Thomas S Services Section directs the administrative and programmatic activities in response to the Thomas S versus Bruton class action lawsuit. This Section provides oversight in planning, fiscal management, and programmatic consultation activities in institutional settings and the 40 area mental health programs which provide services.

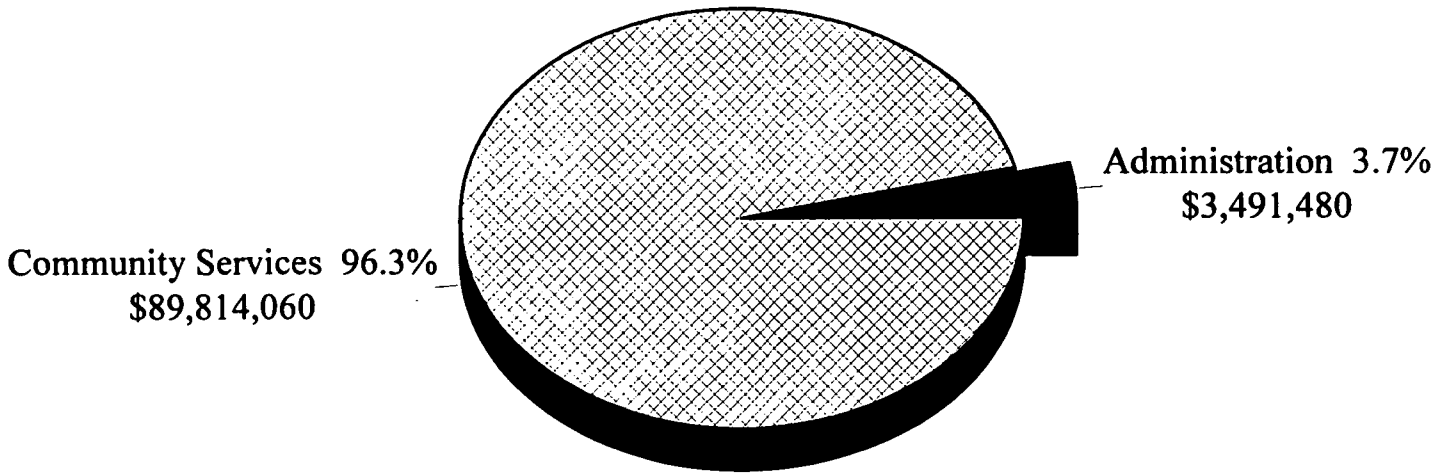
Chronology:

- 1982 - Lawsuit Originated
- 1988 - U.S. District Court Ruled Constitutional Rights of Class Violated
- 1990 - (May) U.S. Court of Appeals Affirmed Lower Court Ruling
- 1990 - (October) U.S. Supreme Court Denied Request to Hear Case
- 1991 - Special Master Appointed
- 1994 - Focus Class Agreement Approved by District Court
- 1995 - Petition Filed for Relief from Court
- **1998 - Court Dismissed Case**

THOMAS S SERVICES

BUDGET SUMMARY:	FY98/99 CERTIFIED	FY99/00 RECOMMENDED
REQUIREMENTS	$93,305,640	$93,319,369
REVENUES	(1,260,792)	(1,260,792)
APPROPRIATIONS	$92,044,748	$92,058,577
POSITIONS	37.64	37.64

FY98/99 Certified Budget



THOMAS S SERVICES

Thomas S Client Profile:

- 1,166 Clients Served FY97/98
- 68% Male Class Members
- Average Gross Cost $94K Per Class Member (FY97/98)
- Class Members Typically Exhibit Multiple Disabilities
  -mental illness, mental retardation and substance abuse
- Largest Group in Class are Geriatric
- Second Largest Subgroup Range 30 - 50 Years Old with Mental Illness
- Most Members are Mild-to-Moderately Mentally Retarded
- Approximately 88% Medicaid Eligible

DEVELOPMENTAL DISABILITIES SERVICES

INITIATIVES

1. **Developmental Disabilities Waiting List**
   - -January 1998 Waiting List Total: 7,148
   - -General Assembly Appropriated $12M to Address Need
   - -Funds Were Allocated to Area Programs Based on Waiting List Data
   - -Collection of Management & Utilization Data

2. **Special Services at Mental Retardation Centers**
   - -Respite
   - -Crisis Intervention
   - -Diagnostic/Therapeutic Admission

CRISIS SERVICES

FY98/99 Appropriations: $10.6M

- Established in FY94/95;
- Develop a System of Services for Individuals in Crisis, Regardless of Disability;
- Decrease Inappropriate Institutionalization of Clients (Oversight/Implementation of State Hospital Diversion Law);
- Assist Local Programs in the Development and Expansion of Crisis Services; and
- Support Local Programs Through Technical Assistance, Coordination Between Area Programs, Funding and Development & Monitoring of Outcome Measures.

CRISIS SERVICES

Crisis Service System Components

- Crisis Prevention - A set of services designed to reduce the incidence of recurring crises.
  -Assertive Community Treatment Teams
  -Family Support & Education

- Crisis Response - A set of services designed to assist with immediate signs and symptoms reduction and safely transition persons in acute crises to appropriate crisis stabilization services.
  -Emergency Transportation
  -Mobile Response Teams
  -24-Hour Crisis Telephone
  -Walk-In Crisis Services

- Crisis Stabilization - A set of services designed to restore persons to be able to function in the community at their best previous level and/or get individual to appropriate long-term care.
  -Medical/Social Detoxification
  -Continuity of Care Case Management
  -Transitional Living Services/Centers
  -Acute Ambulatory Services
  -Inpatient Acute Care & Crisis Follow-up

CRISIS SERVICES

INITIATIVES

1. **Mental Illness/Substance Abuse *Integrated* Treatment Initiative**

   -Began March 1998
   -15 Area Programs Participating
   -Area Programs Implemented One Best Practice Clinical Model
   -Client Tracking & Outcomes Based
   -State Provides Training in Best Practice Crisis Intervention Service

2. **Statewide Best Practice Training**

   -Training & Consultation with Area Programs, Hospitals & Other Providers
   -Extensive Training Schedule

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-3-1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVE BRUTON	DHHS
Jim Edgerton	DHHS
Allyn Duffey	DHHS
Terry Stelle	DMHDDSAS
John Baggett	"
A Dennis McBride	DHHS
Don Willis	DMHDDSAS
Flo Stein	DMH/DD/SAS
Lonnie Behar	DMH/DD/SAS
Jean Farmer Butterfield	The Arc/NC - Coalition 2001
NELS ROSELAND	OSBM
Tara Larson	DMH/DD/SAS
John G. Fisher MD	Mental Health Ass. Wayne County
Patricia Brunson MSW	Mental Health Ass Wayne / Wayne Mem Hosp.
Ted Scovel	Mental Health Assn Wayne County
Mary Eldridge	DMH/DD/SAS
Stephen Moss	DMH/DD/SAS
Lisa Abatemarco	DHHS/BP+A
Marc Ledger	DHHS
MICHELLE COTTON	DMH/DD/SAS
Heather Laffler	OSA
Wayne Williams	OSBM
Tam Richardson	OSPL
Bob Hedrick	CNC
Anna Tefft	OSBM
Myrna Mill	NASW-NC
Jo Frazier (Mas.)	NAMI - Wilmington
Victor Smith	NAMI - Wilmington
John Rustin	NCFPC
Lon Wilson	NCALTC 7

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services — **1999**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JIM JARRARD	THOMAS S. SERVICES
Sheila Codo	Gran Co Health Dept & parent of disabled child
BILL CHEATHAM	VANCE, WARREN, GRANVILLE, FRANKLIN AREA MH, DD, SA PROGRAM
Peggy Balak	Thomas S. Services - MH/DD/SAS
Jim Tate	MHA/NC - C2001
David Richard	Arc/NC
Charles Davis	Willie M Services - MHDDSAS
[illegible]	NC Counsels
Pat Kiesow	VGFW area Mental Health
Mary Nell Newcomb	VGFW Area Mental Health
Steve Stone	Tri-County Industries / NCARF
Megan Souster	Easter Seals NC
Adele Foschia	Easter Seals NC
Helen Lipman	Meck. Co. Social Services
Stacy Flannery	NC Health Care Facilities Assoc.
C L. Cochran	UCPNC - C-2001
Tommy Worth	Carolinas Healthcare System
Roslyn Sanitt	NC Child Care Coalition
JACK McGEE	MARCH OF DIMES BIRTH DEFECTS FOUNDATION
[illegible]	NCMS
HUGH PILSON	NCHA
Pat Porter	AMH DD SAS
Beth Melcher	NAFMI NC
[illegible]	NC SAS

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
March 3, 1999
2:30 PM

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Wednesday, March 3, 1999, at 2:00pm in Room 424 of the Legislative Office Building.

House Chairman, Representative Edd Nye presided. Other House members present were Representative Beverly Earle (Co-Chairman), Representative Esposito, Representative Lanier Cansler, Representative Trudi Walend, and Representative Gene Wilson. There were six Senators present.

Karen Hammonds-Blanks was recognized to continue from morning meeting. Ms. Hammonds-Blanks stated she wanted to answer Senator Martins' question from morning meeting concerning amount of state money that goes to area programs. Ms. Hammonds-Blanks stated the amount in the 1997-1998 budget in state funds alone was 323.4 million dollars. The amount for non-court programs was 201.5 million.

Ms. Hammonds-Blanks continued with morning handout by discussing the state hospitals. She explained that each of the four hospitals is accredited. Dorothy Dix serves 16 counties, and has the fewest number of beds of the four hospitals, with 429 beds. Dix has the most specialty units compared to the other institutions, has a residency training program, and pretrial evaluation unit which serves the courts and law enforcement, and has a forensic unit as well.

Ms. Hammonds-Blanks stated Broughton Hospital serves 32 counties, has the largest bed capacity with 632 beds, and has a medical surgical unit. Cherry Hospital, in Goldsboro, serves 33 counties and has a bed capacity of 616. John Umstead Hospital, in Butner, serves 16 counties, has a bed capacity of 513, and has a residency-training component. Dr. John Baggett, with the department, stated the patient mix issues effect the difference in cost to run hospitals. Senator Phillips asked what was the average stay of patients and if they are at constant capacity all the time. Ms. Hammonds-Blanks stated the average was 1800 per day and that there was a decline in short-stay people. Senator Phillips asked if the patients were getting follow-up care in area programs. Department staff responded that the issue of connection has improved. Senator Kerr asked if they were satisfied with psychiatrics that they hire. Department staff stated they have a relationship with some medical schools in the state and feel comfortable with quality of medical care.

Ms. Hammonds-Blanks then discussed the three smaller institutions; Whitaker, Wright and NC Special Care. Senator Martin asked if they have measure of impact on Children that are admitted. Department staff responded there are few readmissions and that area program follow-up can go back and check, and get information on impact on lives of children after they are in program.

Ms. Hammonds-Blanks stated that in 1998, the Willie M and Thomas S lawsuits were dismissed. There was a discussion between committee members and department staff concerning operating on 5 million dollars less.

Chairman Nye adjourned the meeting at 3:45.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbitt
Committee Assistant

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-3-1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Flo Stein	DMH/DD/SAS
Mary Eldridge	DMH/DD/SAS
Charles Daring	DMHDDSAS
MICHELLE COTTON	DMH/DD/SAS
Laura Nuss	DMH/DD/SAS
[illegible]	DMH/DD/SAS
Pat Porter	DMH.DD.SAS
Mary Ladge	DHHS
Lisa Abatemarco	DHHS/BP+A
Heather Caffey	OSA
[illegible]	OSPL
Wayne Williams	OSBM
Amy Jo Bain	NCMS
HUGH Tuson	NCHA
Roger Bone	Bone & Assoc.
Lon Wilson	NCALTCF
C.L. Cochran	UCPNC - C 2001
Adele Faschia	Easter Seals C 2001
Megan Sorster	Easter Seals C 2001
Ann Schwindaman	NC Council of Community Programs
Janet Simoneau	NC Council of Community Programs
Steve Stone	Tri-County Industries/NCARF
Peggy Balak	Thomas S. - MH/DD/SAS
[illegible]	Thomas S. MH/DD/SAS
[illegible]	DMHDDSAS
Lewis Baker	DMH/DD/SAS
[illegible]	OSBM
A Dennis McBride	DHHS
John Baggett	DMHDDSAS

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-3-1999

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Terry Stelle	DMHDDSAS
Allen Duffy	DHHS
Jim Edgerton	DHHS
DAVID BRUTON	DHHS

AGENDA

Joint Subcommittee on Health and Human Services
Appropriations

Legislative Office Building – Room 424
Thursday, March 4, 1999
8:30 a.m.

Opening Remarks	**Sen. Bill Martin, Co-Chair** **Rep. Beverly Earle, Co-Chair** **Rep. Edd Nye, Co-Chair**
Mental Health Services	**Karen Hammonds-Blanks** **Fiscal Research**
Child and Family Services	**Dr. Lenore Behar** **DSS**

HOUSE APPROPRIATIONS SUBCOMMITTEE FOR HEALTH AND HUMAN SERVICES

MINUTES

MARCH 4, 1999

8:30

The North Carolina Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Thursday, March 4, 1999, at 8:40 a.m. in Room 424 of the Legislative Office Building.

House Co-Chair, Representative Beverly Earle presided. Other House members present were:

Representative Edd Nye, Co-Chair
Representative Alma Adams
Representative Lanier Cansler
Representative Theresa Esposito
Representative Trudi Walend
Representative Gene Wilson

Representative Martha Alexander had an excused absence. Five Senators were present.

Due to circumstances beyond her control, Co-Chair, Representative Beverly Earle was not present to open the meeting. Senate Subcommittee Chair, Sen. Bill Martin begins the meeting at 8:40 a.m. Pages were introduced and the meeting began with Karen Hammonds-Blank to conclude her presentation on the overview of the Mental Health Services. (See Attachment from the March 3rd meeting). She went on to explain the services offered by the Willie M Section. Once a person reaches the age of eighteen, they are no longer in the Willie M program. Charles Davis, of the Willie M Section gave comments and answered questions from the Subcommittee.

Dr. Lenore Behar of Child and Family Services gave an overview of the services. She explained in details how a case-manager is used to integrate the variety of services that a child may have. (See Attachment from March 3rd meeting).

The Representatives and Senators contributed to the overview with questions concerning the cost of services, asking for clarification of how a child may receive a particular service and asking for an explanation of budget figures and sources.

Nearing the time for adjourned, Dr. Behar concluded her presentation.

The meeting adjournment at 9:55 a.m.

Respectfully submitted,

Presiding Co-Chair, Representative Beverly Earle

Ann Raeford, Committee Clerk

Attachment I	Agenda
Attachment II	Visitor Registration

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3- 4- 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mari Smith	NCSA
Stacy Flannery	NCHCFA
Jim Tate	MHA/NC - C2001
[illegible] Cochran	UCPNC - C 2001
Patricia Rawles	NCACC
Julie Bhemingdale	DMH/DD/SAS
Christina Medlin	Covenant w/ NCs Children
Janet Simonson	NC Council of Community Programs
Peggy Balak	Thomas S. - MH/DD/SAS
Jim Jarrard	Thomas S. MH/DD/SAS
Lori Wilson	NCALTCF
Tommy Worth	Carolina Health Care Sys
Megan Sowter	Easter Seals NC
Bob Hedrick	CNC
Pam Richardson	OSPL
Heather Laffler	OSA
Wayne Williams	OSBM
Lisa Abatemarco	DHHS/BP+A
NELS ROSELAND	OSBM
Charles DAVIS	Willie M.
Wayne Smith	Willie M.
[illegible] Stein	DMH/DD/SAS
Tara Larson	DMH/DD/SAS
Don Willis	DMH/DD/SAS
Mary Eldridge	DMH/DD/SAS
David Richard	ARC/NC
Roz Sawitt	NCCCC
Katherine Miller	Harry Kaplan
[illegible] Porter	DMH DD SAS

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-4-1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Beckie Gerrit	PPAB
Lenore Behar	DMH/DD/SAS
A. Dennis McBride	DHHS
John Baggett	MHDDSAS
Terry Stelle	MHDDSAS
T Yeager	OSBM
Allyn Duffey	DHHS
Jim Edgerton	DHHS
DAVE BRUTON	DHHS
John Bowdish	Zeb Alley P.A.

NORTH Carolina GENERAL ASSEMBLY

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

March 9, 1999
8:30: a.m.
2:30 pm.

Minutes

The Joint Appropriations Subcommittee on Human resources met in Room 424 of the Legislative Office Building at 8:30 a.m. and 2:30 p.m. The Chair, Sen. Bill Martin called the meeting to order. Seven members of the Senate were present and the following members of the House were present: Representative Earle, Representative Nye, Representative Alexander, Representative Adams, Representative Cansler, Representative Walend, Representative Wilson.

After introduction of the pages, he stated that the Committee would continue discussions from last week from the Division of Mental Health, Developmental Disabilities Section and Substance Abuse Services. He then recognized Karen Hammonds-Blanks.

Karen stated that she hoped to complete the Thomas S services and Crisis Services and if time permits would go into Substance Abuse. She then began the discussion of the Thomas S services on page 50 of the handout.

The Thomas S services Section is the second court mandated program in the Division of Mental Health. Karen noted that the courts have acted to dismiss all court oversight and involvement in these programs. She stated that unlike the Willie M lawsuit, the State decided to fight this to the Supreme Court. The basis of he case was individuals had been living in state institutions and hospitals for long periods of time after being placed there because of a mental retardation diagnosis. The ruling found that their constitutional rights had been violated. In 1990 the U.S. Supreme Court denied the request to hear the case, and a special master was appointed in 1991. That individual over saw the operations of this particular area until the ruling in favor of the state last year.

Referring to page 51 of the handout, she stated that the certified budget for Thomas S services includes $93.3 million. The majority of those funds go directly to community services provided by the program.

Karen Hammonds-Blanks stated that the second largest subgroup in this population is actually between fifty and thirty years of age. They have serious mental illness; most have mild to moderate mental retardation. Approximately 88% of them are Medicaid eligible. She stated that the Committee has an opportunity to look at this area and decide if it is satisfied with the Thomas S Services system, or expand the use of these dollars to serve other individuals. She stated that Thomas S has used some of its diversion funds to keep people from going into institutions.

During the presentation from Karen Hammonds-Blanks the following questions were asked:

Sen. Kerr – What is the average per person cost for Thomas S.? How many are in institution and how many are in the group homes, and what is the average per person cost in these facilities? He said that he would like to be able to compare Thomas S with Willie M, if possible.

He requested a copy of Hospital Diversion policy.

To what extent is the state involved in funding detoxification? How much is it costing to place persons in Crisis Services facilities/ diversion sites vs. detoxification-type facilities?

Karen recommended flagging Crisis Services initiatives, p.56 of handout.

Sen. Kerr - Where can a person go to get detoxification services other that Walter Jones in eastern NC?
How many persons are served by eastern NC Area Program detox and how many beds do they have? Where are persons served on an outpatient basis?

What is the percentage of persons with addictions who are also mentally ill?

Sen. Martin - Is there an estimate for how much (in Medicaid expenditures) it would cost to provide substance abuse services to all persons who need them?

Sen. Dannelly - Are there any substance abuse statistics for college and university students in NC?

Sen. Kerr - asked are there any studies about drinking in countries where alcohol is an important part of the culture? Suggests that comparative studies may be helpful in guiding policy development in this nation. (Flo Stein will respond)

Sen. Phillips - asked about % from some special study that reflects the groups of persons who abuse alcohol and drugs. This question was prompted by statistics quoted by Karen that indicates that the % of substance abusers has declined. (Flo Stein is suppose to provide information)

Rep. Cansler requested Information on what county Medicaid match for mental health will be and how this will impact counties.

Rep. Nye - Where is the incinerator for drugs? Expansion request on computer access to prescription drug data in pharmacy.???

Sen. Martin –Requested a copy of the report on outcomes as it relates to substance abuse and DWI. He stated that they might have received the study during the meeting. How many of the people that are served by area programs are DWI???

Sen. Phillips - What are the costs of different levels of substance abuse residential services? Some of the rates were supplied in committee.

Sen. Dannelly - Cost of prison beds.

Rep. Cansler - Why are there differences between the average length of stay at ADATC? Flo Stein says the role of ADATC is changing to short term stays.

Sen. Martin - Are ADATCs being underutilized by area programs? May have been answered by Flo on the changing role of ADATC.

Rep. Nye - Are there still individuals abusing the ADATC system with repeated visits? May have been answered in committee

Sen. Martin - *Status* of Substance abuse services available to pregnant women and women with infants. Only available at Jones - 6 beds.

Sen. Forester - *Are* they changing the names of the ADATCs and calling them hospitals? Answered

Sen. Martin - Are there any numbers on the number of people voluntarily committed length of stay? Are they completing the program or leaving before finished.

Sen. Martin - What are other states doing in the area of prevention? (Next Step for Youth)

Sen. Forester - Flag that there are not any State funds in prevention

Sen. Kerr - DARE program where is it funded?
Flo answered. $275,000 federal

Rep. Nye - Does *DARE* get Community Alternatives funding?

Sen. Purcell - Is DARE affective? Flo answered that it is not.

Sen. Kerr - What is the Willie M per client average cost?

The Chairman thanked everyone for attending and adjourned the meeting.

Sen. William N. Martin, Chair

Joyce C. Hodge, Clerk

AGENDA

Joint Subcommittee on Health and Human Services Appropriations

Legislative Office Building - Room 424
Tuesday, March 9, 1999
2:30 p.m.

Opening Remarks	Sen. Bill Martin, Co-Chair Rep. Beverly Earle, Co-Chair Rep. Edd Nye, Co-Chair
Division of Mental Health, Developmental Disabilities & Substance Abuse Services	Karen Hammonds-Blanks Fiscal Research Division
Adjourn	

B. MARTIN

DIVISION OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE SERVICES

SUBSTANCE ABUSE SERVICES

FISCAL RESEARCH DIVISION

MARCH 9, 1999

SUBSTANCE ABUSE SERVICES

THE PROBLEM IN NORTH CAROLINA

- Estimated 784,000 North Carolinians Need Substance Abuse Services
  -Estimated 47% (or 370,005) Need Comprehensive Substance Abuse Treatment (≥18 years)
  -Of These, Approximately 24% Report No Health Insurance

- Estimated 16,048 IV Drug Users

- Of Pregnant Women Surveyed, 59.4% Reported Alcohol Use Within the Last 12 Months and 11.6% Reported Illicit Drug Use

- Estimated 53,138 High School Students Need Substance Abuse Services

- 89,032 DWI Arrests in the State in 1997 (5% Increase from 1995)

- 41,535 Drug Related Arrests During 1997 (22% Increase from 1995)

- Estimated 40% of Welfare Recipients Need SA Treatment

SUBSTANCE ABUSE SERVICES

IMPACT ON CRIME/CRIMINAL JUSTICE

- 41,535 Drug Related Arrests During 1997 (22% Increase From 1995)
  -4,778 Were Less Than 18 Years Old
- 2,305 < 18 Years Old Arrested for DWI's & Liquor Laws
- 89,032 DWI's (1997 - 5% Increase from 1995)
- 28,208 Filings (10% of total filings) in Superior Court for Controlled Substances (FY98) - Up 5% From FY96
- Estimated $136.3 Million in Costs for Public Programs for Drug-Involved Violent Crime
- 23.8% of Rapes Included Victims Under the Influence of Alcohol/Drugs (1997)
- 17% of Rapes Included Offenders Under the Influence of Alcohol/Drugs (1997)

SUBSTANCE ABUSE SERVICES

IMPACT ON HEALTH

- Estimated 7,400 Infants Born Exposed to Illicit Drugs
- Estimated 16,048 IV Drug Users
- Estimated Large Percentage of Teen Pregnancies are Linked to Substance Abuse
- 11,115 Crashes Involving Alcohol *(N.C. Department of Transportation)*
- 51.1 Deaths per 100,000 Attributed to Alcohol - Compared to 44 Nationally
- $27.6M in Medicaid Payments for Substance Abuse Services (FY98)
- A 1994 NC Study Found that 7.4% (or 2,842) of Pregnant Women in the Sample Tested Positive for Illicit Drug Use

SUBSTANCE ABUSE SERVICES

IMPACT ON EDUCATION

High School:

- 75% of High School Students Had Used Alcohol at Least Once by the Age of 17;
- 44% Drank Alcohol Within the Past Month
- 10.5% Used Alcohol Heavily;
- 25% Reported Using Marijuana During the Past Month;
- 2.5% Ever Injected Drugs; and
- 23% of High School Students are Considered Risky Drug Users

Middle School:

- 57.1% Middle School Students Reported They Had Used Alcohol;
- 20% Reported Using Marijuana;
- 5.6% Had Used Cocaine; and 2.2% Reported Injecting Drugs

SUBSTANCE ABUSE SERVICES

IMPACT ON FAMILIES

- Domestic Violence
- Divorce
- Poor School Performance
  -high school & college dropouts
  -developmental delays
- Children in Training Schools
- Poverty
- Infant Mortality
- Parents in Prison
- Teen Pregnancies
- 34% of All Substantiated Cases of Child Abuse & Neglect Involved at Least One Substance Abusing Parent/Caretaker (FY97/98)

How does this work with their families, what impact on children? What studies?

SUBSTANCE ABUSE SERVICES

UNTREATED SUBSTANCE ABUSE COSTS NORTH CAROLINA IN MANY WAYS

- Annual Cost of a Child in Foster Care
  -$4,200 - $4,980 Per Year {private home}
  -$9,600 - $19,200 Per Year for HIV/AIDS Child
  -Range of $22,630 - $62,050 Per Year for Residential/Institutional Care

- Average Cost Per Child in Training School {1997 average length of stay 8.5 months} - $34,314

- Average Cost Per Year for NC Inmate in Prison - $22,933

- Annual Cost of Public Assistance {family of 3} - $7,116 cash assistance and food stamps only

- Estimated $146.5 Million Spent Per Year on Public Programs as a Result of Violent Crimes Related to Substance Abuse (National Public Services Research Institute, 1996)

SUBSTANCE ABUSE SERVICES

North Carolina's Substance Abuse Services Are Grounded in Three Basic Beliefs

1. Addiction is Chronic and Life Threatening, Rooted in Genetic Susceptibility, Social Circumstances and Personal Behavior; Certain Drugs are Highly Addictive and Others Become Addictive Over Longer Periods of Time.

2. Substance Abuse Treatment is Provided in Many Settings (Outpatient and Inpatient With Different Levels of Intensity; In Many Different Ways (Short-Term Treatment and Therapeutic Communities); For Different Lengths of Time {Four General Phases Include 1) Detoxification, 2) Rehabilitation, 3) Continuing/Transitional Care, and 4) Relapse Prevention.}

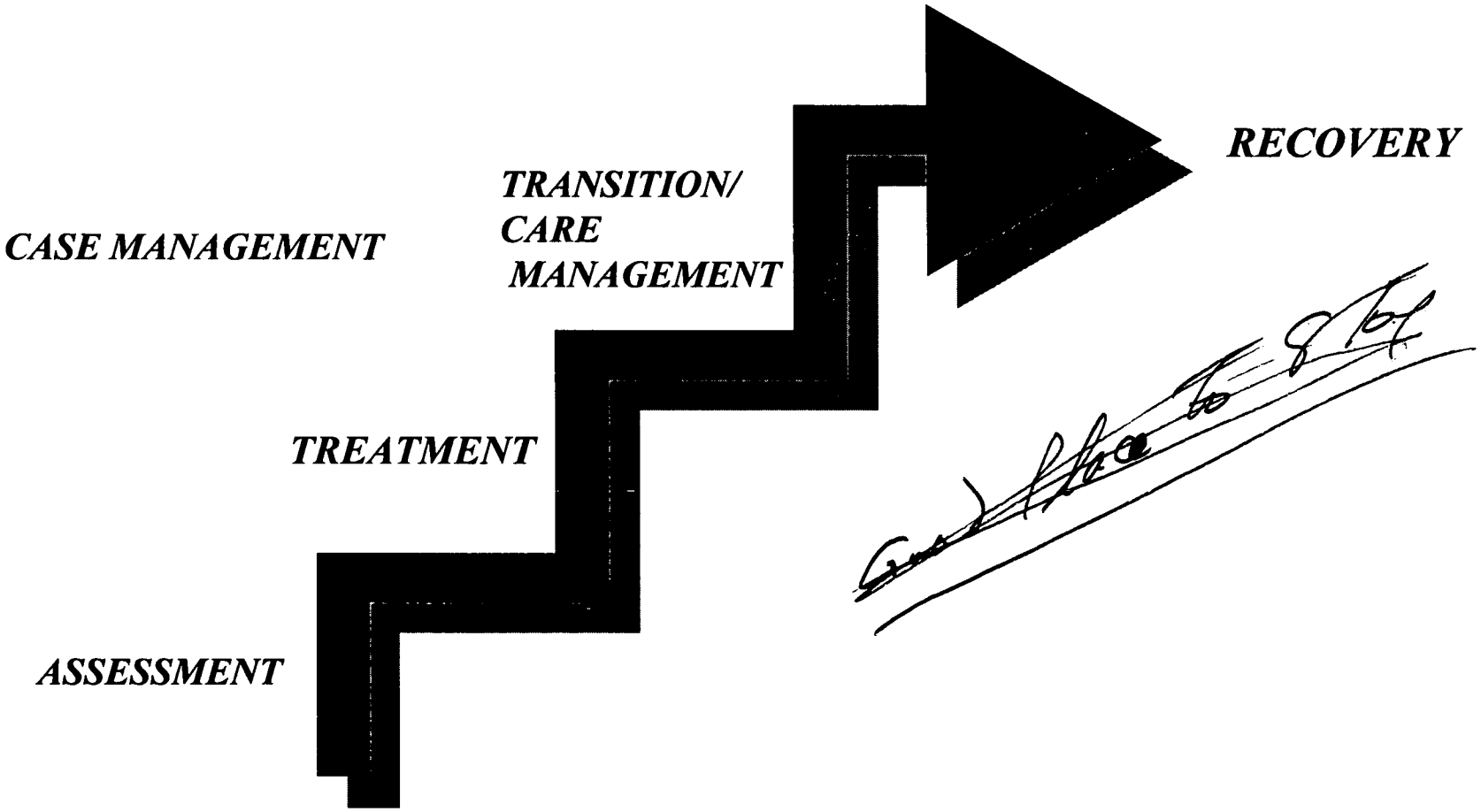
3. Treatment Works.

SUBSTANCE ABUSE TREATMENT...

- ✓ CUTS DRUG USE IN HALF
- ✓ REDUCES CRIMINAL ACTIVITY UP TO 80%
- ✓ INCREASES EMPLOYMENT/DECREASES HOMELESSNESS
- ✓ IMPROVES PHYSICAL AND MENTAL HEALTH AND REDUCES MEDICAL COSTS
- ✓ REDUCES RISKY SEXUAL BEHAVIORS

SUBSTANCE ABUSE SERVICES

CONTINUUM OF CARE



SUBSTANCE ABUSE SERVICES

Mission: to provide leadership in the planning, development and organization of a statewide system of alcohol and other drug services; to coordinate and communicate policies and strategies that educate, encourage, and respond proactively to alcohol and other drug prevention, intervention, and treatment issues.

The Division Supports This Mission Through:

- Institutional Services
- Community Services
- Regulatory Unit
- DWI/Criminal Justice
- Employee Assistance Program
- Prevention Services

SUBSTANCE ABUSE SERVICES

- Institutional Services
  -Provides inpatient services through the State Alcohol and Drug Abuse Treatment Centers (ADATC).

- Community Services
  -Provide support to 40 Area Programs in the implementation of substance abuse plans; 2) Coordinate and develop programs to reduce HIV/AIDS; 3) Coordinate and develop programs and services to women, including TANF recipients and their families; and 4) Provide leadership and support for the development of a comprehensive system of prevention and treatment services for children and youth.

- Regulatory Unit
  -Prevents controlled substances into illicit markets

SUBSTANCE ABUSE SERVICES

- DWI/Criminal Justice
  -Provide leadership and support for services targeted at clients involved with the criminal justice system (e.g., Treatment Alternatives to Street Crime - TASC).

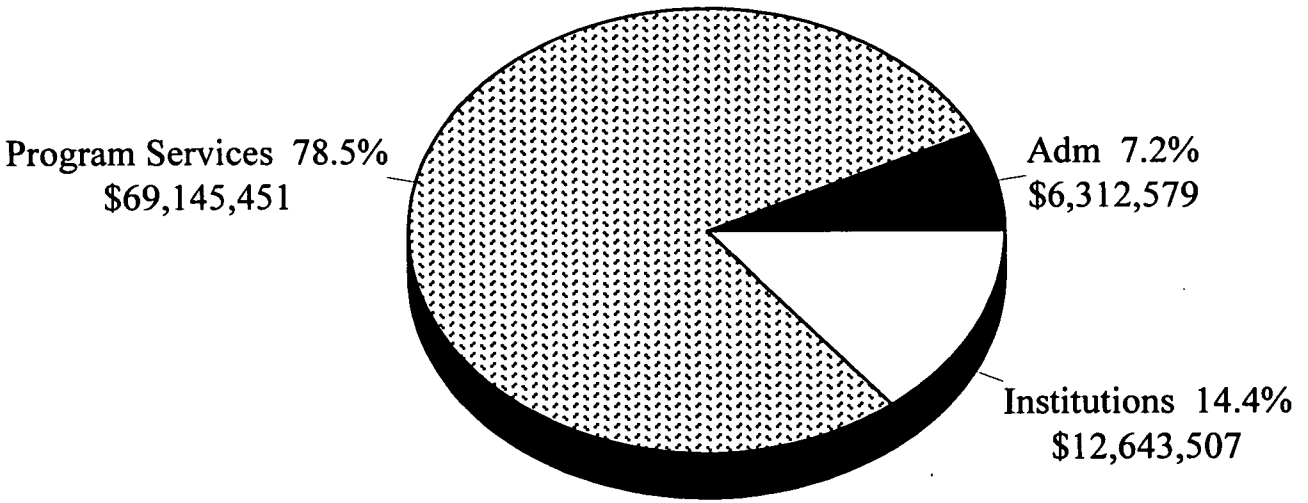
- Employee Assistance Program
  -Assist employees impaired by stress, substance abuse or other personal concerns; Develop of Enhance EAP to private employers and TANF recipients; provide technical assistance to Area Programs; and provides guidance for DHHS's Alcohol & Drug-Free Workplace Initiative.

- Prevention Services
  -Develop and coordinate prevention efforts statewide including the infusion of science-based prevention strategies into existing prevention programs.

SUBSTANCE ABUSE SERVICES

Budget Summary:	FY97/98 Actual	FY98/99 Authorized	FY99/00 Rec'd.	FY00/01 Rec'd.
Requirements	$85,966,782	$88,213,590	$88,441,570	$88,474,684
Revenues	(40,814,897)	(41,946,397)	(42,125,175)	(42,124,975)
Appropriations	$45,151,885	$46,267,193	$46,316,395	$46,349,709
Positions	286.48	286.48	286.48	286.48

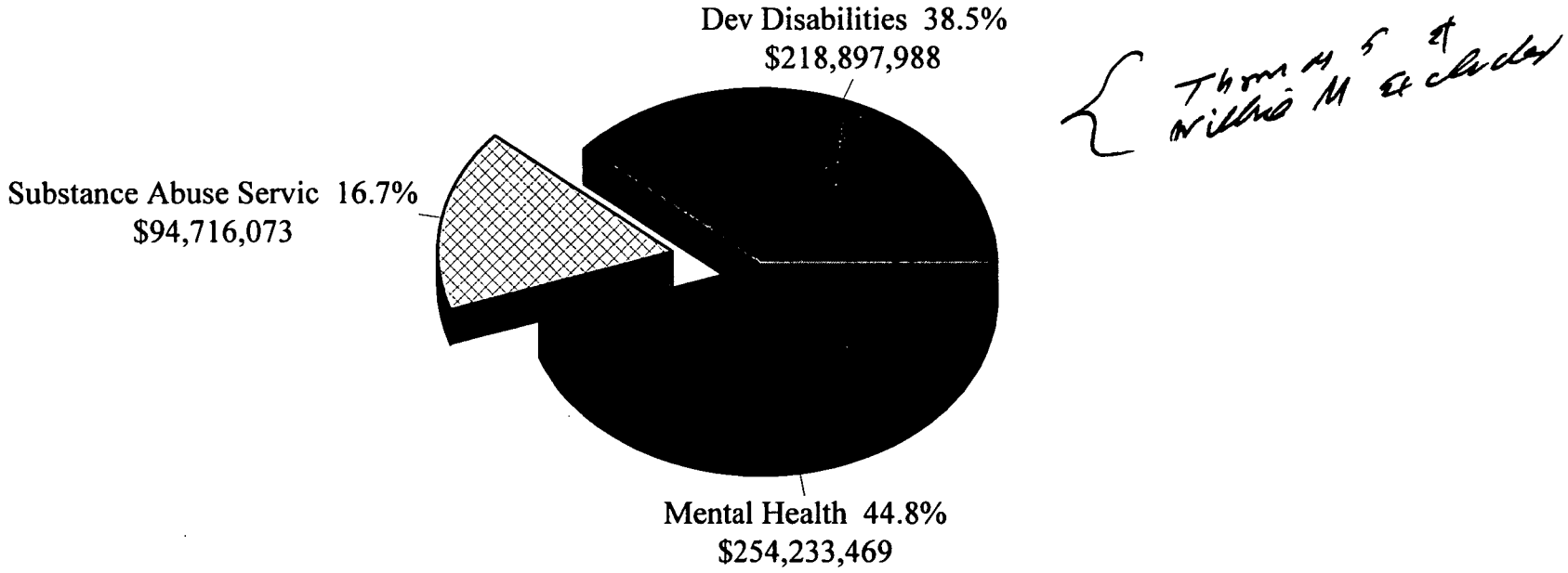
FY98/99 Authorized Budget



SUBSTANCE ABUSE SERVICES

AREA MENTAL HEALTH PROGRAMS

ESTIMATED PROGRAM SERVICES BY DISABILITY (FY97/98)

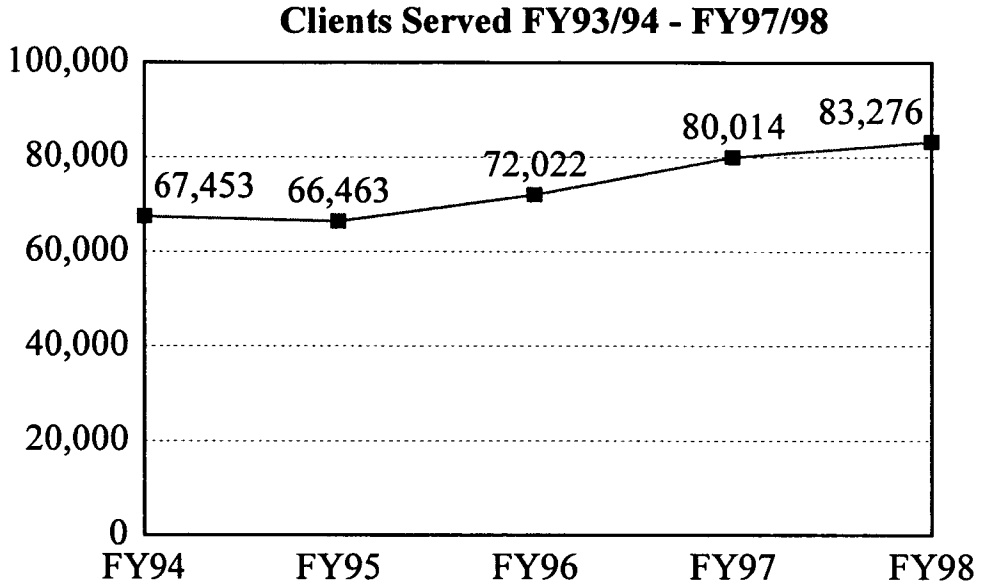


Thomas S & Willie M excluded

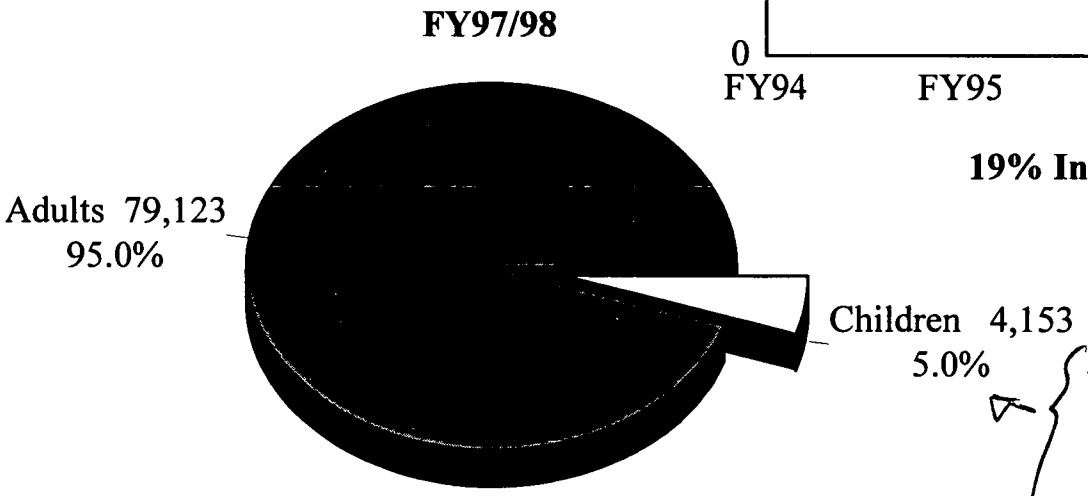
TOTAL: $567.8M
(excludes Willie M & Thomas S)

SUBSTANCE ABUSE SERVICES

AREA MENTAL HEALTH PROGRAMS



19% Increase Since FY94



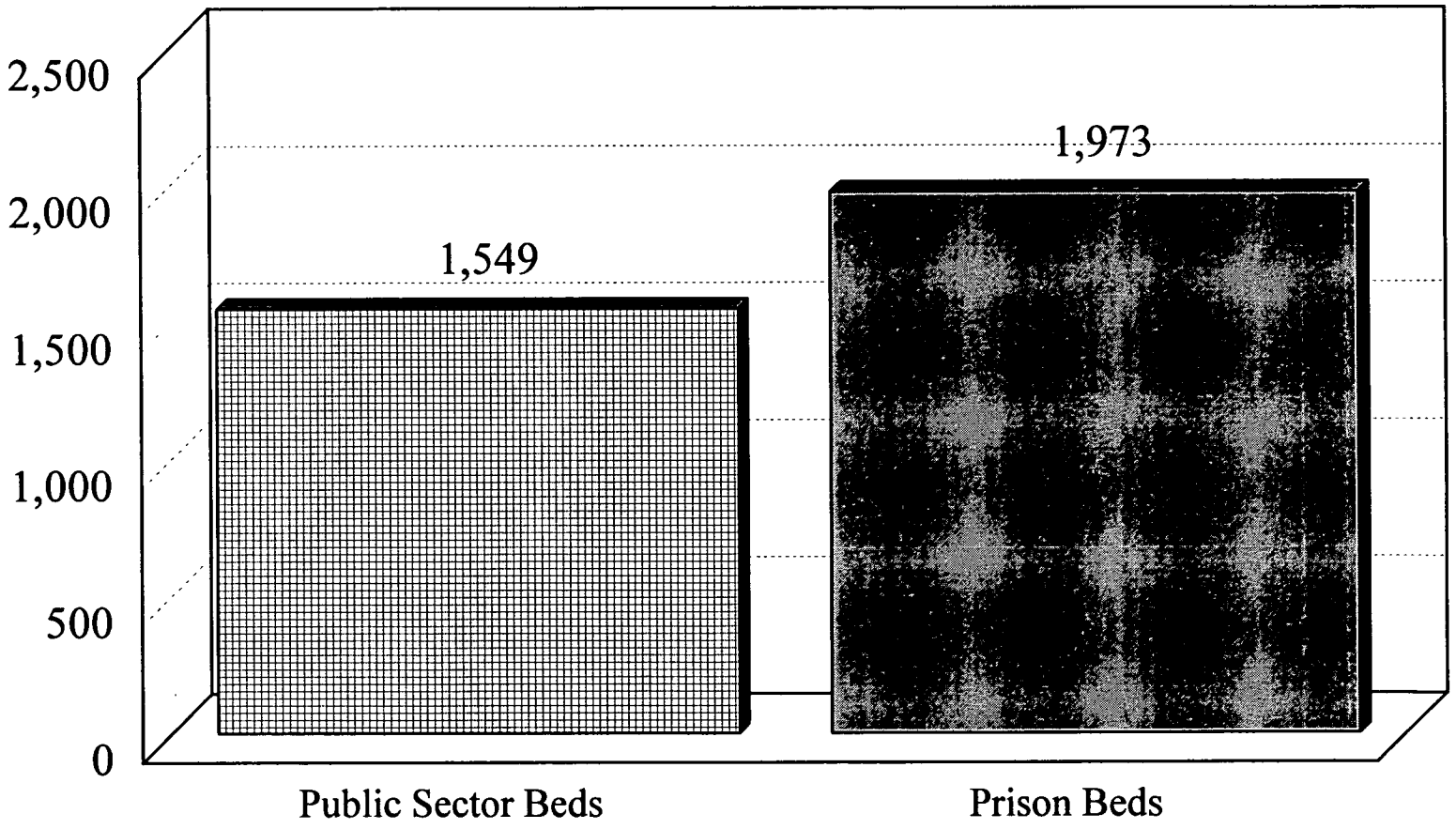
replacts those not those receiving Prevent & other intervention -- if added in, that would be ≈ 13,000 ≈ 9%.

Area Programs - provide services in the areas of assessment, screening, education, half-way house, detoxification, inpatient and residential treatment, and day activity.

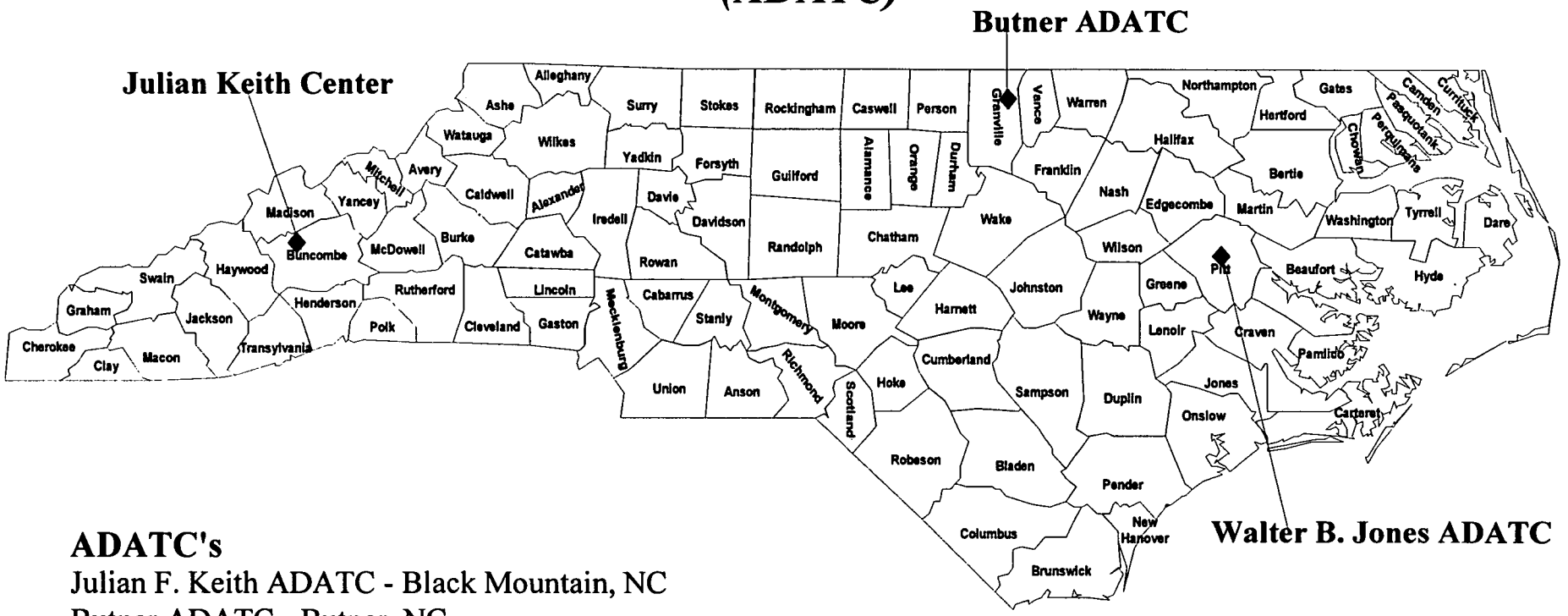
Residential Services in North Carolina

Service	Total Beds Available
Detoxification (Medical)	296
Social Setting Detoxification	112
Half-way House	376
Residential Treatment	284
Therapeutic Homes/TC	93
ADATC	236
TOTAL	1549

PUBLIC SECTOR TREATMENT BEDS



ALCOHOL AND DRUG ADDICTION TREATMENT CENTERS (ADATC)



ADATC's

Julian F. Keith ADATC - Black Mountain, NC

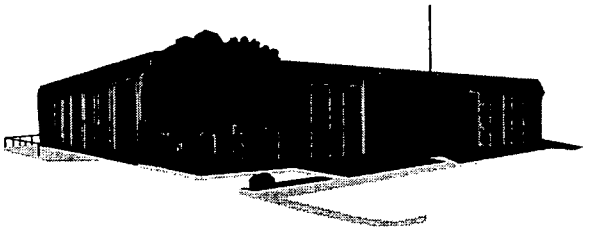
Butner ADATC - Butner, NC

Walter B. Jones ADATC - Greenville, NC

SUBSTANCE ABUSE SERVICES

STATE ALCOHOL & DRUG ABUSE TREATMENT CENTERS

Julian F. Keith ADATC



- Serves Western NC
- Bed Capacity: 100
- Persons Served FY97/98: 1,389
- Average Length of Stay: 26.2 Days
- Average Daily Population: 87
- FY97/98 Occupancy Rate: 89%
- Operating Budget FY98/99: $6.5M

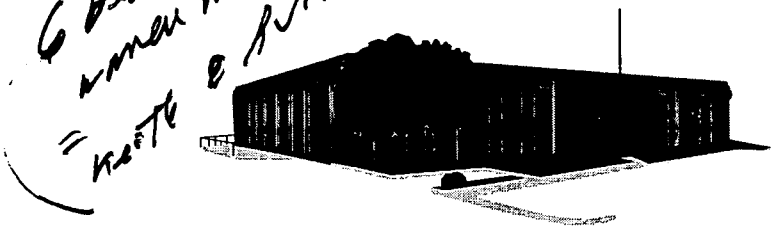
Butner ADATC

- Serves Central NC
- Bed Capacity: 80 (temporarily at 60 due to construction)
- Persons Served FY97/98: 1,255
- Average Length of Stay: 14 days
- Average Daily Population: 63
- FY97/98 Occupancy Rate: 80%

SUBSTANCE ABUSE SERVICES

STATE ALCOHOL & DRUG ABUSE TREATMENT CENTERS

Walter B. Jones ADATC



- Serves Eastern NC
- Bed Capacity: 76
- Persons Served FY97/98: 1,329
- Average Length of Stay: 19.9 Days
- Average Daily Population: 45
- FY97/98 Occupancy Rate: 76%
- Operating Budget FY98/99: $6.1M
- Unique Characteristics:
  -SA/Deaf Unit

SUBSTANCE ABUSE SERVICES

STATE ALCOHOL & DRUG ABUSE TREATMENT CENTERS

CLIENT PROFILE (FY97/98)

- Total Beds 256
- 3,973 Persons Served
- Avg Length of Stay: 23.1 days
- Avg Daily Population: 194
- Avg Occupancy Rate: 83%
- 20% Treated for Drugs Only
- 22.2% Treated for Alcohol Only
- 57.3% Alcohol & Drugs
- 39% Reported Cocaine as the Drug of Choice
- 5% IV Drug Users
- 37% Women Served
- 8% Clients Were Pregnant Women
- 43% Nonwhite Clients
- 95.3 Voluntarily Committed

How Has North Carolina Impacted The Problem?

- Provided Funding Which Supported Services to 88,000 North Carolinians (FY98)
- Rank 38th. in Nation for SA Spending *(1998, SAMHSA)*
- State Funding:
  -$37M (FY97)
  -$41M (FY98)
  -$42M (FY99)
- No **State** Funds Dedicated for Prevention
- Among the Highest in the Country for Alcohol Related Deaths 100,000 {51.1 per 100,000 compared to national average of 44}
- No Central Policy Making Body/Department
- Developed Clinical Practice Guidelines (to be Disseminated April 1999)
- Inability to Hold Providers Accountable for Outcomes

SUBSTANCE ABUSE INITIATIVES

1. WORK FIRST/TANF SERVICES

- Initiative Targeted at Welfare Recipients Needing SAS
- Qualified Substance Abuse Professionals Provided for Each Area Program
- Applicants Screened & Referred For Assessment
- Child Care & Transportation Provided to Facilitate Treatment
- During 7-Month Period 2,225 TANF Applicants Screened for Substance Abuse # referred for services
  - -68% Were Assessed for SA
  - -25% Were Admitted for Treatment
- Extensive Training for Area Programs and County Departments of Social Services
- Funding Source: Temporary Assistance for Needy Families (TANF) Block Grant

SUBSTANCE ABUSE INITIATIVES

2. MANAGING ACCESS FOR JUVENILE OFFENDER RESOURCES AND SERVICES (MAJORS)

- **Target Population:** 12-17 Year Old Juvenile Offienders **At Risk** for Placement in Residential Treatment or Juvenile Detention/Training Schools
- **Target Population:** 12-17 Year Olds **Returning to the Community** Following Placement in a Residential Treatment or Juvenile Detention/Training School
- Clinical Assessments Upon Referral from Court Counselor
- Substance Abuse Counselor/Care Coordinator Provides Case Management
- 10 Area Programs Will Begin Implementation FY98/99
- Funding: $2M (Social Services Block Grant, Governor's Crime Commission and State)

SUBSTANCE ABUSE INITIATIVES

3. "NEXT STEP FOR YOUTH"

- Directed by Office of Substance Abuse Policy
- Statewide Comprehensive Initiative to Prevent and Reduce the Use of Drugs and Alcohol by Youth
- Coordination of All Substance Abuse Prevention Funding Statewide
- Incorporate Scientifically-Based Prevention Programs in Existing Programs
- Evaluation Component Included
- Funding: $9M Three-Year Federal Grant & TANF Block Grant Funds

SUBSTANCE ABUSE INITIATIVES

4. ENHANCED EMPLOYEE ASSISTANCE PROGRAM

- Pilot/Initiative Which Provides Private Employers Enhanced EAP Services for Hiring Welfare Recipients
- Places Special Emphasis on Prevention, Intervention, Mentoring, Training and Case Monitoring of Clients
- Seven Area Programs Participating (Covering 11 Counties)
- Projected 1,000 Work First Participants
- Includes a Longitudinal Evaluation to Assess Effectiveness
- Funding: $1M Social Services Block Grant

SUBSTANCE ABUSE INITIATIVES

5. TREATMENT ALTERNATIVES TO STREET CRIME (TASC)

- Began in 1978
- Program Targets Offenders Whose Criminal Behavior is Driven by Drugs
- Based on the "Breaking the Cycle" Model Which Includes Frequent Drug Testing & Continuum of Sanctions and Treatment
- Includes Identification, Assessment, Treatment Matching, Referral & Treatment Management
- 23 Programs Serving 43 Judicial Districts
- During FY98, 7,433 Offenders Were Served
- Funding: $2.8M (State Appropriations and Substance Abuse Prevention and Treatment Block Grant)

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

DRIVING WHILE IMPAIRED (DWI) SUBSTANCE ABUSE ASSESSMENT REPORT

Prepared for:

NORTH CAROLINA GENERAL ASSEMBLY JOINT LEGISLATIVE COMMISSION ON GOVERNMENTAL OPERATIONS

Prepared by:

PETE MARTIN
DWI/CRIMINAL JUSTICE BRANCH
SUBSTANCE ABUSE SERVICES SECTION
and
MARY JANE HART
DATA SUPPORT BRANCH
MANAGEMENT SERVICES

February 1999

B. Martin

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

DWI SUBSTANCE ABUSE ASSESSMENT REPORT

(January 1, 1996 – June 30, 1998)

BACKGROUND:

Since 1909, North Carolina has had laws targeting DWI behavior and statewide programs aimed at identifying and intervening with the substance abuse problems among DWI offenders since 1980. North Carolina has contracted over the past fifteen years for external evaluations of this effort. These evaluations have resulted in the refinement of the State statutes, the development of program standards and the promulgation of minimum rules for service providers. A 1995 evaluation conducted by the UNC-Chapel Hill Highway Safety Research Center, is the largest study of a DWI population conducted to date, followed 109,216 offenders for two years after their DWI arrests between January 1, 1990 and November 15, 1992. **The study found that "persons who had not completed assessment and treatment, regardless of blood alcohol concentration (BAC), were 74% more likely than those who had completed treatment to be re-arrested for DWI within 24 months."**

In a November 1998 evaluation report, the UNC Highway Research Center followed nearly 21,000 DWI offenders convicted in the first six months of 1996. Approximately one-half completed the required substance abuse assessment and the recommended education or treatment while the other half either failed to comply or was in the process of complying at the time of the study. This report concluded in part; "A failure rate model showed recidivism to be nearly 2.5 times as likely for non-compliant individuals as for compliant individuals when the other factors (level of conviction, race and gender) were examined."

Ratification of Chapter 496 (HB 458) during the 1995 Session of the General Assembly imposed "additional conditions for the restoration of drivers license after a conviction for certain alcohol-related driving offenses and promotes compliance with these conditions" This act became effective for persons arrested and convicted on or after January 1, 1996. A provision of this law directs the Department of Health and Human Services to provide an annual report on the substance abuse assessment process to the Joint Legislative Commission on Governmental Operations by February 1st each year.

PROCESS:

An initial six- month report was filed representing persons from January 1, 1996 – June 30, 1996. The first full year report represented persons who after January 1, 1996 were:

1. Arrested and convicted of DWI, commercial DWI, or driving while less than 21 years old after consuming alcohol or drugs,

2. Received a substance abuse assessment in accordance with State law and

3. Completed the educational component "Alcohol and Drug Education Traffic School" (ADETS) or a level of treatment recommended by the assessing agency between July 1, 1996 and June 30, 1997.

There were 14,475 DWI CERTIFICATES OF COMPLETION (DMH 508-R) FORMS received through June 30,1998. These Certificates document that offender/clients satisfied the three conditions cited above. In addition, it is estimated that 40 to 50% of the completion forms received daily document the compliance with substance abuse sanctions imposed by the courts from 1983 until December 31, 1995. These cases are not included in this report.

The DMH 508-R Form was originated in 1987 and was revised effective January 1, 1996 to facilitate the data collection for the annual reports. A single copy of this four-page form serves as **ATTACHMENT A**. This Form is important for the offending population as it is the only documentation accepted by the Division for Mental Health, Developmental Disabilities and Substance abuse Services and the Division of Motor Vehicles to remove the "stop" that is entered on a convicted DWI offender's driving record; thereby requiring a substance abuse assessment and ADETS or treatment.

Upon completion of services, forms are forwarded to the Division's Substance Abuse Services Section where they are reviewed for accuracy and compliance with State Statutes and Administrative Rules. The original top copy is delivered to the Division of Motor Vehicles normally within twelve hours. The second copies are forwarded weekly to the Data Support Branch of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services for keypunching.

NOTE: It was intended that each annual report would be an unduplicated count of persons who had completed the DWI administrative intervention program required for driver license reinstatement after the revocation period imposed by the Division of Motor Vehicles for the DWI related conviction. Rather than possibly misrepresent the data and the subsequent findings, this report represents an accumulative accounting all persons arrested and convicted on or after January 1, 1996.

INFORMATION REQUESTED (G. S. 122C - 142.1 [I] Report)

(1) The number of persons required to obtain a certificate of completion during the previous fiscal year as a condition of restoring the person's drivers license under G. S. 20-17.6

The following statistical information was obtained from data generated by the Information Services Division of the Administrative Office of the Courts for persons convicted of alcohol-related driving offenses during the State fiscal years 96-97 and 97-98

CHARGE CONVICTED FY 96-97 and FY 97-98	
DWI (Levels 1-5)	96,534
DWI (aid and abet)	160
Driving after drinking by persons under 21 years of age	3,134
DWI (commercial vehicle)	72
Habitual DWI*	1,061
TOTAL	100,961

*For information only; offenders convicted of this charge in North Carolina cannot ever be re-licensed to drive.

All persons arrested and convicted of DWI offenses on or after January 1, 1996 are notified by the Division of Motor Vehicles of their obligation to obtain a substance abuse assessment and to comply with the recommendations prior to being eligible for license reinstatement in this or other states. Persons are also to be notified that if they fail to comply with these intervention sanctions, they may be arrested and charged with the more serious charge of "driving while license revoked" (prior to January 1, 1996, the chargeable offense was "no operator's license").

In addition, ratification of S. L. 1997-379 (HB 448) - AN ACT TO IMPLEMENT THE GOVERNOR' S RECOMMENDATIONS ON DRIVING WHILE IMPAIRED; effective December 1, 1997 mandates trial judges to include these intervention provisions as a condition of a probationary sentence. This amendment is anticipated to increase the rate of compliance by offenders. It is noted however, that in addition to any court imposed probationary sanctions or amended orders, offenders must continue to comply with the provisions of the administrative system to be licensed to operate a motor vehicle.

(2.) The number of substance abuse assessments conducted during the previous year for the purpose of obtaining a certificate of completion as required by North Carolina General Statute 122C-142.1 (I) (2).

Since State laws require offenders to obtain a substance abuse assessment and an intervention service based upon the results, the DWI Certificates of Completion (DMH 508-R) Form is forwarded only after both conditions are satisfied. During this report period, fourteen thousand four hundred and seventy-five (14,475) forms meeting these criteria were forwarded to the Substance Abuse Services Section, processed and forwarded to the Division of Motor Vehicles.

Attachment B documents the characteristics of DWI offenders in this study and are as follows: white (75%), males (80%), never married (39%) and completed high school or received a GED education (36%). The age grouping of offenders is of particular interest since 42% are between 21 and 34 years of age. According to the National Highway Traffic Safety Administration (NHTSA), this population is involved in 50% of the alcohol related highway fatalities annually. It is imperative to intervene with this legal but lethal driving population to have any chance of reducing alcohol related highway fatalities to the National goal of 11,000 by 2005.

Attachment C, in part, indicates a maximum alcohol content of 0.45% which is a lethal dose for most persons and a mean of 0.13% which is one and a half times greater than the legal limit of intoxication (0.08%) in North Carolina. The number of prior DWI convictions ranged from "0" to "20" with 3,935 or 36% being convicted of at least one prior offense. This is an increase from the 27% of multiple offenders that completed the intervention process during fiscal year 96-97. These findings provide both a unique opportunity and a challenge to appropriately match the level of substance abuse services to the presenting needs exhibited by these offenders/clients. These findings also support that the majority of persons convicted of DWI are in need of substance abuse treatment; rather than an educational program.

(3.) Of the number of assessments reported under subdivision (2) of this subsection, the number recommending attendance at an ADET school, the number recommending treatment and, for those recommending treatment, the level of treatment recommended as required by North Carolina General Statute 122C-142.1 (I) (3).

Service Level Recommended	# of Assessments	% of Assessments
ADET School	5441	37.6
All Treatment Levels	8745	50.4
*Short term	6402	44.2
*Long term	1804	12.5
*Intensive outpatient	337	2.3
*Inpatient and continuing care	114	0.8
*Special services plan	88	0.6
Unknown	289	2.0
TOTALS:	14475	100.0

The above levels of treatment are based upon patient placement criteria developed and accepted by the American Society of Addiction Medicine. North Carolina is one of a few states that hold both public and private providers of DWI treatment services to such high standards.

Services are based upon a combination of a minimum of hours and days. For example, the minimum services accepted for "short term" treatment is twenty hours of treatment extending over at least thirty days; hence the abbreviation symbol "20/30". These minimum hour/day combinations apply to each of the treatment levels. "Special Services Plans" are developed for persons who exhibit unusual circumstances, such as severe physical or psychiatric illnesses, language or intractable problems of distance. See **Figure 1** for DWI service levels definitions and an illustration of the recommended services levels.

(4.) Of the number of persons recommended for an ADET School or treatment under subdivision (3) of this subsection, the number who completed the school or treatment as required by North Carolina General Statute 122C-142.1 1) (4).

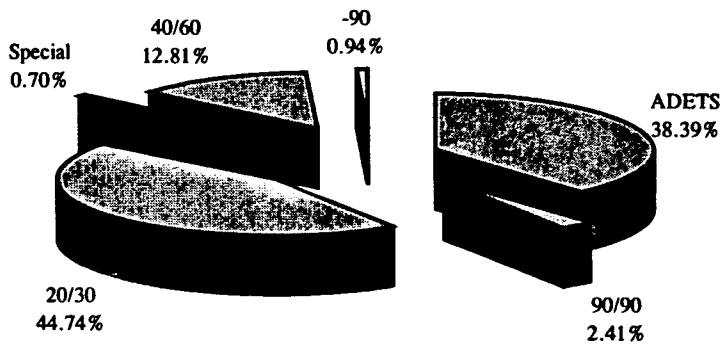
The chart in **Attachment C** shows the ADETS and treatment levels completed as compared to the level recommended by the assessor. A clear majority of clients completed at least the level of service that was originally recommended. Forty-six (46) persons completed a higher level of treatment while ninety (90) completed a lower level. The percentages for completing the recommended service level are as follows:

ADETS – 99.9%,
Short term treatment – 99.5%,
Long term treatment – 96.8%,
Intensive outpatient treatment – 93.8%,
Residential treatment followed by continuing care – 80.6%.

Figure-1

DWI 508-R FORMS*

Service Level Recommended



DWI Service Levels Definitions

"ADETS" (Alcohol and Drug Education Traffic School) means an approved curriculum consisting of 10-13 contact hours in a classroom setting, provided by area programs or their designated agencies and taught by certified ADETS instructors.

"20/30" (Short-term Outpatient Treatment) means a structured program meeting the broad definition of 'ASAM Level 1, Outpatient Treatment', and requiring a minimum of 20 contact hours over a period of at least 30 days.

"40-60" (Longer-term Outpatient Treatment) means a structured program meeting the ASAM definition of Level I, outpatient treatment, and requiring a minimum of 40 contract hours scheduled to maintain the client in active treatment for a minimum period of 60 days.

"90-90" (Day treatment) meets the ASAM Level II, Outpatient Treatment of psychoactive substance dependence, moderate or severe and requires a minimum of 90 contact hours over a period of at least 90 days.

"- 90" (Inpatient Residential Treatment) meets the Day treatment criteria but client does not respond to outpatient treatment. Upon discharge, the client participates in continuing care to meet the required minimum 90-day time frame for treatment.

"Special" (Special Services Plan) requires documentation of the need for a special program to correspond with the recommendation of the assessment. Such condition may include severe physical disabilities and concurrent psychiatric illness.

*DWI offenders arrested after 1/1/96.

Administrative rules promulgated by the Commission for Mental Health, Developmental Disabilities and Substance Abuse Services specifically require under .0317 RESPONSIBILITIES OF ASSESSING AGENCY (c) that "Any facility accepting a transferred case shall provide, at least, the level of intervention recommended by the assessor, unless there is a subsequent negotiated agreement between the assessor and the service provider." However, there are cases where the level of treatment recommended is not readily available. For example, intensive outpatient services are not available in every county of the State. In other situations, clients may be moved to a more intense level of treatment based upon individual needs surfaced in the therapeutic process. No one diagnosed as being in need of treatment was referred to the ADETS educational program.

(5.) The number of substance abuse assessments conducted by each facility and, of these assessments, the number that recommended attendance at an ADET school and the number that recommended treatment as required by North Carolina General Statute 122C-142.1 (I) (5).

The number of assessments conducted by all public and private licensed facilities and subsequent referrals to the various treatment levels are shown in **Attachment D**. Together, service providers referred 5422 individuals to the educational program ADETS and 8909 to treatment. Thirty-seven percent (37%0 of the individuals were to ADETS which is consistent with National estimations that between 50-60% of all DWI offenders are in need of substance abuse treatment services. Sixty-three percent (63%) of all assessments were conducted pre-trial affording the defendant a mitigating factor for consideration by the trial judge and also making first offenders eligible for consideration for limited driving privileges. **Figure –2** graphically demonstrates that DWI offenders/clients overwhelming completed the service level that was recommended by the assessing agency. Attachment **E** is an accounting of assessments conducted by each licensed facility and their referrals to ADETS or treatment by the facility identification number assigned by the Substance Abuse Services Section.

(6.) The fees paid to a facility for providing services for persons to obtain a certificate of completion and the facility's costs in providing those services as required by North Carolina General Statute 122C-142.1 (I) (6).

State laws established the DWI substance abuse assessment fee at $50.00 and the fee for the ten to twelve hour educational program ADETS at $75.00. An additional minimum fee of $75.00 has been set by State Statute to offset the costs of treatment. Service providers may charge additional fees for treatment; however, the public system providers may not delay nor deny services pending the up front payment of fees. They may however delay forwarding the DMH 508-R DWI Services of Completion form to the State office pending the receipt of fees
the client has been determined to have the ability to pay. The average amounts of fees charged and received are documented in **Attachment F**.

SUMMARY OF FINDINGS:

- It appears that the majority of offenders convicted of DWI are currently failing to comply with the required substance abuse intervention sanctions. However, a system to track offender compliance is recommended to determine if individuals are in the process of complying or continuing to operate a motor vehicle without complying with the mandated sanctions.

- It appears from a review of the data in Attachment E; some facilities are either over or under referring to ADETS or treatment based upon the widely accepted estimate that between 50-60% of offenders are in need of treatment services. Effective January 1, 1998, the Substance Abuse Services Section has been empowered by the Division of Facility Services (the facility licensing agency) to monitor and enforce both the core license and the DWI specific rules.

- Offenders are completing the levels of services matched to their assessed level of need.

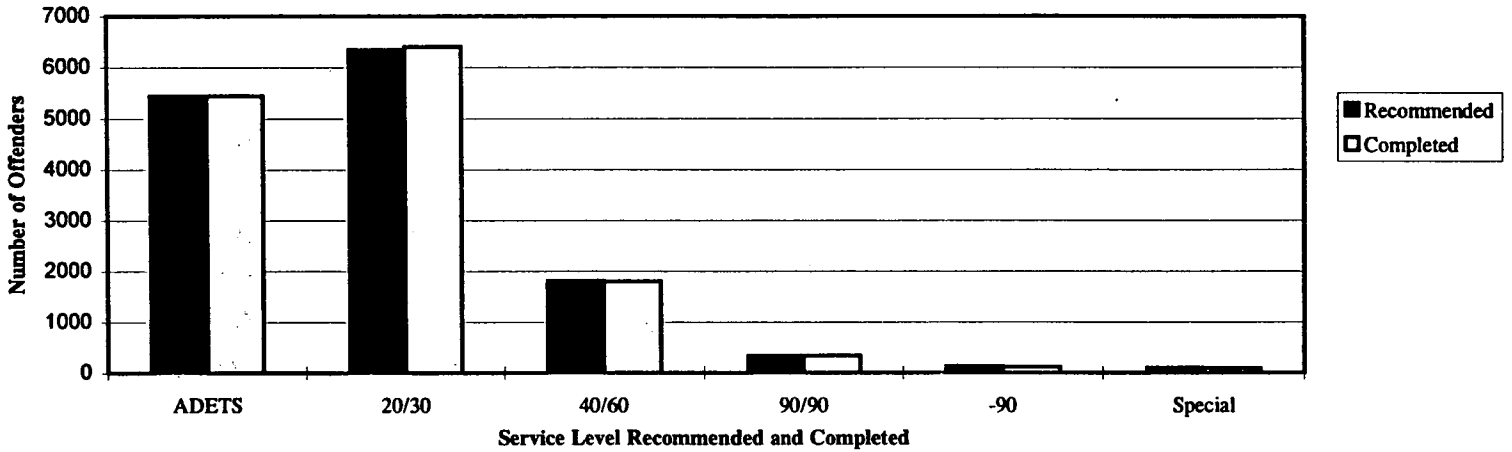
- Offenders are being charged and are paying a fair hourly rate for treatment services.

- Additional monitoring of DMH 508-R Forms is needed to minimize missing data elements.

Figure-2

DWI 508-R FORM*

Service Level Recommended and Completed



DWI Service Levels Definitions

"ADETS" (Alcohol and Drug Education Traffic School) means an approved curriculum consisting of 10-13 contact hours in a classroom setting, provided by area programs or their designated agencies and taught by certified ADETS instructors.

"20/30" (Short-term Outpatient Treatment) means a structured program meeting the broad definition of 'ASAM Level 1, Outpatient Treatment', and requiring a minimum of 20 contact hours over a period of at least 30 days.

"40-60" (Longer-term Outpatient Treatment) means a structured program meeting the ASAM definition of Level I, outpatient treatment, and requiring a minimum of 40 contract hours scheduled to maintain the client in active treatment for a minimum period of 60 days.

"90-90" (Day treatment) meets the ASAM Level II, Outpatient Treatment of psychoactive substance dependence, moderate or severe and requires a minimum of 90 contact hours over a period of at least 90 days.

"- 90" (Inpatient Residential Treatment) meets the Day treatment criteria but client does not respond to outpatient treatment. Upon discharge, the client participates in continuing care to meet the required minimum 90-day time frame for treatment.

"Special" (Special Services Plan) requires documentation of the need for a special program to correspond with the recommendation of the assessment. Such condition may include severe physical disabilities and concurrent psychiatric illness.

*DWI offenders arrested after 1/1/96.

ATTACHMENTS

ATTACHMENT A. DMH 508-R FORM

ATTACHMENT B. DEMOGRAPHIC CHARACTERISTICS

ATTACHMENT C. SERVICE LEVEL RECOMMENDED/COMPLETED

ATTACHMENT D. SUBSTANCE ABUSE ASSESSMENTS

ATTACHMENT E. ADETS and TREATMENT REFERRALS by ASSESSED FACILITY

ATTACHMENT F. MINIMUM FEES CHARGED AND RECEIVED FOR SUBSTANCE ABUSE TREATMENT COMPLETION

Attachment A

County of Arrest: _____

Transferred to: _____

Transferred to: _____

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
DWI CERTIFICATES OF COMPLETION* (DMH 508-R)

1. Name: _____ *First* *Middle* *Last* *Maiden*
2. Address: _____ *Street/Route* *City* *State* *Zip*
3. Telephone No.: ( ) _____ *home* ( ) _____ *work*
4. Driver's License #: ☐☐☐☐☐☐☐☐ 5. State Other than NC: ☐☐
6. Gender: 01☐ Male 02☐ Female
7. Race/Ethnicity: 01☐ White 02☐ African American 03☐ Native American 04☐ Asian/Pacific Islander 05☐ Hispanic 06☐ Other (List): _____
8. Education Completed: 01☐ Less than 6th Grade 02☐ Less than 9th Grade 03☐ Less than 12th Grade 04☐ Completed HS/GED 05☐ Some College 06☐ Bachelor's Degree 07☐ Graduate Degree
9. Marital Status: 01☐ Never Married 02☐ Married 03☐ Divorced 04☐ Separated 05☐ Widowed
10. Date of Birth: ___/___/___ *mm dd yy*
11. County of Res.: _____
12. Arrest Date: ___/___/___ *mm dd yy* 13. Conviction Date: ___/___/___ *mm dd yy* 14. Docket #: ☐☐ CR ☐☐☐☐☐☐

SUBSTANCE ABUSE ASSESSMENT COMPLETION

15. Interview Date: ___/___/___ *mm dd yy* 16. Number of Prior DWI Convictions: ☐
01☐ Pre-Trial 02☐ Post-Trial 18. BAC 0.☐☐
Local Agency Use Only:
19. Service Level Recommended: 01☐ ADETS 02☐ 20/30 03☐ 40/60 04☐ 90/90 05☐☐ 90 06☐ Special
20. Facility Code: ☐☐☐☐☐ 21. Release of Information on File? YES ____ NO ____
22. ASAM Certified Physician's Signature: _____ 23. Certificate #: ☐☐☐☐
24. Certified Counselor's Signature: _____ 25. Certification #: ☐☐☐☐☐
26. Expire. Date: ___/___/___ *mm dd yy*
27. Assessor's Name (Please Print) if different from #22 or #24: _____

ALCOHOL & DRUG EDUCATION TRAFFIC SCHOOL (ADETS) COMPLETION

28. Date Started: ___/___/___ *mm dd yy* 29. Date Completed: ___/___/___ *mm dd yy* 30. School #: ☐☐☐☐☐
31. Certified Instructor's Signature: _____ 32. Expire. Date: ___/___/___ *mm dd yy*

SUBSTANCE ABUSE TREATMENT PROGRAM COMPLETION

33. Date Sessions Started: __/__/__ *mm dd yy* 34. Date Sessions Completed: __/__/__ *mm dd yy* 35. Facility Code: ☐☐☐☐☐
36. Service Level Completed: 01☐ ADETS 02☐ 20/30 03☐ 40/60 04☐ 90/90 05☐☐ 90 06☐ Special
Fees Charged: $☐☐☐☐☐ 38. Fees Received: $☐☐☐☐☐
39. Clinician's Signature: _____ 40. Completion Date**: ___/___/___ *mm dd yy*

* Statutory Authority: G.S. 122-C-142.1/G.S.20 - 17.6 Effective 01-01-96

** Entered only upon completion of financial obligations.

Copies: Top - DMV 2nd - DHR 3rd - Agency 4th - Client

Attachment-B

DWI 508-R FORM*
DEMOGRAPHIC CHARACTERISTICS

CHARACTERISTICS	# DWI OFFENDERS (N=14475)	% DWI OFFENDERS
SEX:		
Male	11595	80.10%
Female	2773	19.16%
Unknown	107	0.74%
RACE:		
White	10792	74.56%
African American	2193	15.15%
Native American	107	0.74%
Asian/Pacific Islander	92	0.64%
Hispanic	1070	7.39%
Other/Unknown	221	1.53%
MARITAL STATUS:		
Never Married	5599	38.68%
Married	4690	32.40%
Divorced	2370	16.37%
Separated	1023	7.07%
Widowed	269	1.86%
Other/Unknown	524	3.62%
EDUCATION:		
Less than 6th grade	375	2.59%
Less than 9th grade	906	6.26%
Less than 12th grade	2427	16.77%
HS grad/GED	5245	36.23%
Some College	3316	22.91%
Bachelor's Degree	1350	9.33%
Graduate Degree	306	2.11%
Other/Unknown	550	3.80%
AGE GROUP:		
0-14	56	0.39%
15-18	554	3.83%
19-20	869	6.00%
21-24	1870	12.92%
25-34	4318	29.83%
35-44	3735	25.80%
45-54	1924	13.29%
55-64	732	5.06%
Over 64	310	2.14%
Other/Unknown	107	0.74%

*DWI offenders arrested after 1/1/96.

12/30/98

Attachment-C

DWI 508-R FORM*

SERVICE LEVEL RECOMMENDED BY SERVICE LEVEL COMPLETED

SERVICE LEVEL REC.	SERVICE LEVEL COMPLETED												TOTAL	
	ADETS		20/30		40/60		90/90		-90		SPECIAL			
	# ADETS	% ADETS	# 20/30	% 20/30	# 40/60	% 40/60	# 90/90	% 90/90	#- 90	% -90	# SPC	% SPCL	# TOT	% TOT
ADETS	5441	99.9%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	5441	37.6%
20/30	3	0.1%	6320	99.6%	48	2.6%	10	2.9%	9	6.7%	12	12.0%	6402	44.2%
40/60	1	0.0%	23	0.4%	1759	96.8%	8	2.3%	8	6.0%	5	5.0%	1804	12.5%
90/90	0	0.0%	1	0.0%	7	0.4%	321	93.9%	7	5.2%	1	1.0%	337	2.3%
-90	0	0.0%	1	0.0%	1	0.1%	3	0.9%	108	80.6%	1	1.0%	114	0.8%
Special	1	0.0%	2	0.0%	2	0.1%	0	0.0%	2	1.5%	81	81.0%	88	0.6%
Unknown													289	2.0%
TOTAL	5446	100.0%	6347	100.0%	1817	100.0%	342	100.0%	134	100.0%	100	100.0%	14475	100.0%

ALCOHOL CONTENT

Minimum = 0.00 %
Maximum = 0.45 %
Mean = 0.13 %
# Refused = 961

OF PRIOR DWI CONVICTIONS

Minimum = 1
Maximum = 20
Number of offenders with
one or more prior convictions = 3,935

* DWI offenders arrested after 1/1/96.

Attachment-D

DWI 508-R FORM*
SUBSTANCE ABUSE ASSESSMENTS

SUBSTANCE ABUSE ASSESSMENT	PUBLIC		PRIVATE		FEDERAL		TOTAL	
	#offenders	%offenders	#offenders	%offenders	#offenders	%offenders	#offenders	%offenders
SERVICE LVL. REC.								
ADETS	2301	45.60%	3113	33.57%	8	66.67%	5422	37.47%
20/30	1804	35.75%	4718	50.88%	3	25.00%	6525	45.09%
40/60	700	13.87%	1128	12.16%	1	8.33%	1829	12.64%
90/90	132	2.62%	213	2.30%	0	0.00%	345	2.38%
-90	51	1.01%	68	0.73%	0	0.00%	119	0.82%
Special	58	1.15%	33	0.36%	0	0.00%	91	0.63%
Unknown							140	0.97%
TOTAL	5046	100.00%	9273	100.00%	12	100.00%	14471	100.00%
DISPOSITION:								
Pre-Trial	2285	46.04%	6837	75.32%	1	100.00%	9123	63.09%
Post-Trial	2678	53.96%	2240	24.68%	0	0.00%	4918	34.01%
Unknown							419	2.90%
TOTAL	4963	100.00%	9077	100.00%	1	100.00%	14460	100.00%

*DW[redacted]nders arrested after 1/1/96.

[redacted]/30/98

Attachment-E

DWI 508-R FORM*

ADETS AND TREATMENT REFERRALS BY ASSESSED FACILITY

Facility ID	ADETS	Treatment	Total	Facility ID	ADETS	Treatment	Total
	2822				3182		
12032	0	1	1	23011	3	7	10
13011	30	51	81	23012	0	1	1
13012	6	8	14	23013	6	13	19
13013	14	44	58	23014	5	2	7
13014	6	13	19	23020	1	0	1
13015	18	45	63	23021	40	59	99
13016	19	47	66	23022	5	0	5
13017	3	22	25	23031	29	34	63
13020	1	0	1	23041	44	56	100
13021	35	57	92	23046	0	1	1
13022	0	1	1	23051	71	55	126
13030	25	52	77	23052	16	15	31
13031	0	1	1	23057	1	0	1
13032	33	27	60	23061	52	26	78
13035	2	0	2	23062	29	37	66
13041	36	45	81	23071	24	30	54
13045	0	1	1	23081	32	52	84
13050	1	0	1	23051	0	1	1
13051	2	8	10	30265	0	1	1
13053	1	0	1	30402	1	0	1
13054	18	40	58	30801	0	1	1
13061	16	23	39	33021	8	29	37
13062	2	9	11	33031	141	143	284
13071	9	8	17	33041	45	37	82
13081	75	47	122	33042	58	29	87
13082	0	1	1	33043	37	32	69
13091	45	82	127	33044	18	31	49
13097	0	1	1	33047	1	0	1
13101	117	162	279	33051	86	35	121
13107	1	0	1	33061	64	61	125
13111	71	69	140	33071	9	12	21
13112	0	3	3	33081	158	258	416
13113	7	12	19	33101	63	58	121
13120	0	1	1	33501	1	1	2
13121	49	103	152	40031	1	0	1
13141	0	2	2	40066	0	1	1
13401	1	1	2	40311	1	1	2
13501	1	2	3	41111	1	0	1
13601	1	0	1	41313	0	1	1
18101	1	0	1	41321	1	0	1
20701	0	1	1	42111	2	0	2
20852	1	0	1	43011	22	56	78

*DWI offenders arrested after 1/1/96.

Attachment-E

DWI 508-R FORM*

SERVICE LEVEL ASSESSED BY FACILITY

Facility ID	ADETS	Treatment	Total	Facility ID	ADETS	Treatment	Total
43012	1	0	1	50030	1	4	5
43021	88	66	154	50034	1	0	1
43031	38	59	97	50035	1	0	1
43041	17	17	34	50037	232	253	485
43051	13	23	36	50039	32	69	101
43061	42	43	85	50045	1	1	2
43071	60	86	146	50046	48	95	143
43081	49	63	112	50047	1	3	4
43091	84	100	184	50048	18	21	39
43101	22	24	46	50049	12	4	16
43111	63	45	108	50050	0	2	2
43121	50	61	111	50051	0	3	3
43131	43	28	71	50053	35	46	81
43401	1	0	1	50054	1	9	10
43651	1	0	1	50057	19	55	74
43701	0	1	1	50059	10	33	43
45121	1	0	1	50063	0	7	7
50003	71	9	80	50064	7	33	40
50004	1	0	1	50066	81	132	213
50005	3	2	5	50067	20	26	46
50008	93	98	191	50068	9	25	34
50009	0	2	2	50073	1	6	7
50013	1	1	2	50075	0	272	272
50018	141	52	193	50078	40	91	131
50019	17	12	29	50079	2	0	2
50020	9	36	45	50080	4	1	5
50021	81	139	220	50083	48	87	135
50022	5	2	7	50088	22	41	63
50023	7	17	24	50089	3	4	7
50027	34	60	94	50090	105	221	326
50028	33	46	79	50091	0	1	1
50029	9	23	32	50093	0	1	1

*DWI offenders arrested after 1/1/96.

Attachment-E

DWI 508-R FORM*

SERVICE LEVEL ASSESSED BY FACILITY

Facility ID	ADETS	Treatment	Total	Facility ID	ADETS	Treatment	Total
50095	30	34	64	50150	0	2	2
50096	0	1	1	50151	11	33	44
50097	0	1	1	50152	0	4	4
50100	9	13	22	50154	0	1	1
50102	5	12	17	50155	11	119	130
50104	0	1	1	50156	17	30	47
50105	0	1	1	50158	3	6	9
50106	6	12	18	50159	17	13	30
50107	1	5	6	50161	2	2	4
50108	52	80	132	50162	16	39	55
50110	0	1	1	50163	1	11	12
50114	1	2	3	50166	1	1	2
50115	14	85	99	50167	0	2	2
50116	9	16	25	50168	47	99	146
50117	0	3	3	50169	3	4	7
50119	7	24	31	50170	11	49	60
50121	0	1	1	50172	30	42	72
50123	24	47	71	50173	1	5	6
50124	0	23	23	50174	5	31	36
50126	29	96	125	50175	0	1	1
50128	4	15	19	50178	8	82	90
50129	1	14	15	50180	20	20	40
50132	10	2	12	50181	39	57	96
50135	0	54	54	50182	2	33	35
50138	6	78	84	50183	1	3	4
50143	24	50	74	50184	2	2	4
50144	1	19	20	50185	0	11	11
50146	3	21	24	50189	1	0	1
50147	0	2	2	50190	20	22	42
50148	3	30	33	50191	9	3	12
50149	3	31	34	50192	68	92	160
				50193	0	12	12

*DWI offenders arrested after 1/1/96.

DWI 508-R FORM*

SERVICE LEVEL ASSESSED BY FACILITY

Facility ID	ADETS	Treatment	Total	Facility ID	ADETS	Treatment	Total
50194	2	8	10	50244	27	52	79
50195	99	80	179	50245	0	1	1
50196	1	0	1	50248	3	18	21
50197	11	45	56	50249	0	46	46
50198	16	57	73	50250	19	51	70
50201	0	1	1	50251	2	6	8
50203	55	70	125	50252	15	15	30
50204	0	2	2	50253	0	6	6
50205	5	22	27	50254	6	42	48
50206	3	3	6	50255	2	34	36
50207	6	9	15	50258	3	3	6
50209	3	15	18	50263	12	54	66
50210	0	6	6	50264	1	1	2
50211	17	63	80	50265	6	32	38
50212	9	26	35	50266	2	1	3
50215	11	6	17	50267	15	20	35
50216	0	1	1	50269	2	8	10
50218	159	310	469	50271	5	15	20
50219	1	15	16	50272	0	1	1
50221	1	1	2	50273	11	8	19
50222	3	1	4	50274	0	1	1
50223	2	0	2	50275	42	59	101
50224	1	4	5	50276	6	15	21
50227	4	2	6	50277	2	2	4
50228	6	3	9	50278	43	64	107
50234	1	1	2	50280	0	6	6
50235	10	9	19	50281	19	33	52
50238	0	2	2	50282	1	14	15
50240	32	87	119	50283	6	17	23
50241	42	84	126	50284	0	4	4
50242	43	70	113	50285	4	20	24
50243	1	2	3	50287	2	39	41

*DWI offenders arrested after 1/1/96.

Attachment-E

DWI 508-R FORM*

SERVICE LEVEL ASSESSED BY FACILITY

Facility ID	ADETS	Treatment	Total
50288	0	4	4
50289	0	1	1
50290	1	58	59
50291	26	76	102
50292	6	32	38
50293	1	3	4
50294	5	17	22
50295	2	3	5
50296	12	33	45
50297	1	1	2
50298	2	4	6
50301	1	1	2
50302	0	2	2
50303	1	8	9
50304	3	13	16
50306	1	1	2
50307	0	1	1
50309	1	2	3
50311	0	3	3
50312	0	1	1
50313	0	1	1
50314	2	1	3
50315	1	18	19
50316	1	0	1
50319	1	0	1
50322	0	2	2
50325	1	0	1
50330	0	1	1
50337	0	1	1
50338	0	2	2
50340	0	1	1
50343	0	1	1

Facility ID	ADETS	Treatment	Total
50347	0	3	3
50429	0	1	1
50443	1	0	1
50746	1	0	1
50811	0	1	1
50821	1	4	5
50912	0	1	1
51002	0	1	1
51004	4	10	14
51006	38	23	61
51008	27	47	74
51010	3	10	13
51011	12	30	42
51014	235	274	509
51015	15	35	50
51017	0	1	1
51018	1	1	2
51019	37	69	106
51020	13	27	40
51021	2	1	3
51023	4	21	25
51025	0	1	1
51108	1	1	2
51156	1	0	1
52071	0	1	1
52218	0	1	1
54207	0	1	1
59003	0	2	2
60186	8	4	12
70001	0	1	1
80185	0	1	1
83081	0	1	1
90058	0	1	1
90078	5	6	11
90255	0	1	1
91015	1	1	2
UNKNOWN	6	9	15

*DWI offenders arrested after 1/1/96.

Attachment-F

DWI 508-R FORM*
MINIMUM FEES CHARGED AND RECEIVED
FOR SUBSTANCE ABUSE TREATMENT COMPLETION

SUB. ABUSE TREATMENT	AVERAGE FEES CHARGED		AVERAGE FEES RECEIVED		CLIENTS SERVED	MINIMUM FEES RECEIVED
	TOTAL	PER HOUR	TOTAL	PER HOUR		
Service Level ADETS	$75.00	Mandated by	State	Statute	5435	$407,625
20/30	$357.61	$17.88	$342.43	$17.12	6271	$2,147,378
40/60	$598.19	$14.95	$554.48	$13.86	1768	$980,320
90/90	$1,081.60	$12.02	$1,017.08	$11.30	328	$333,602
-90	$1,850.16	**	$1,731.18	**	124	$214,666
Special	$714.98	**	$600.10	**	97	$58,209
Unknown	$206.98	**	$190.10	**	219	$41,631
						Approx. total=$4,183431***

* DWI offenders arrested after 1/1/96.

** Insufficient information to determine.

*** Approximate Minimum Fees received is calculated by multiplying average fee received by the number of clients served in each Substance Abuse Treatment service level (e.g. for Service level 20/30: $342.43*6271=$2,147,378)

B. MARTIN

DIVISION OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE SERVICES

BUDGET/PROGRAM OVERVIEW

Fiscal Research Division

March 3, 1999

Division of Mental Health/Developmental Disabilities/Substance Abuse Services

Mission

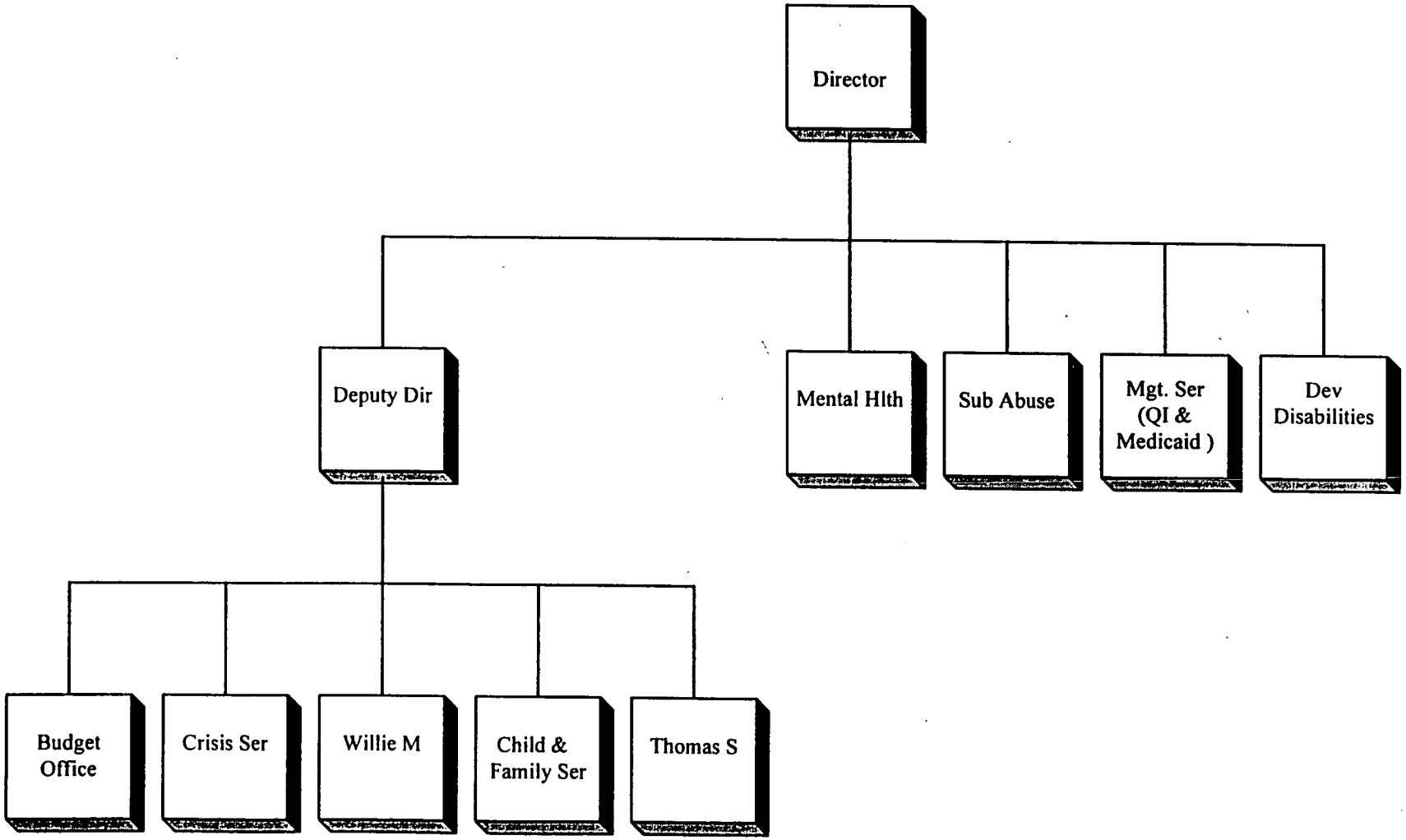
The Mission of the Division of Mental Health, Developmental Disabilities and Substance Abuse Services is...to enable North Carolina's most vulnerable and disabled persons with mental, developmental and substance abuse problems to exercise their rights and responsibilities as citizens.

§ Policy (G.S. Section 122C-2)

The policy of the State is to assist individuals with mental illness, developmental disabilities, and substance abuse problems in ways consistent with the dignity, rights, and responsibilities of all North Carolina citizens. Within available resources, it is the obligation of the State and local government to provide services to eliminate, reduce, or prevent the disabling effects of mental illness, developmental disabilities, and substance abuse through a service delivery system designed to meet the needs of clients in the least restrictive available setting, if the least restrictive setting is therapeutically most appropriate, and to maximize their quality of life.

DEPARTMENT OF HUMAN RESOURCES

Division of Mental Health/Developmental Disabilities/Substance Abuse Services



January 1999

DIVISION OF MH/DD/SAS

Oversight & Regulatory Commissions

- *Commission for MH/DD/SAS*

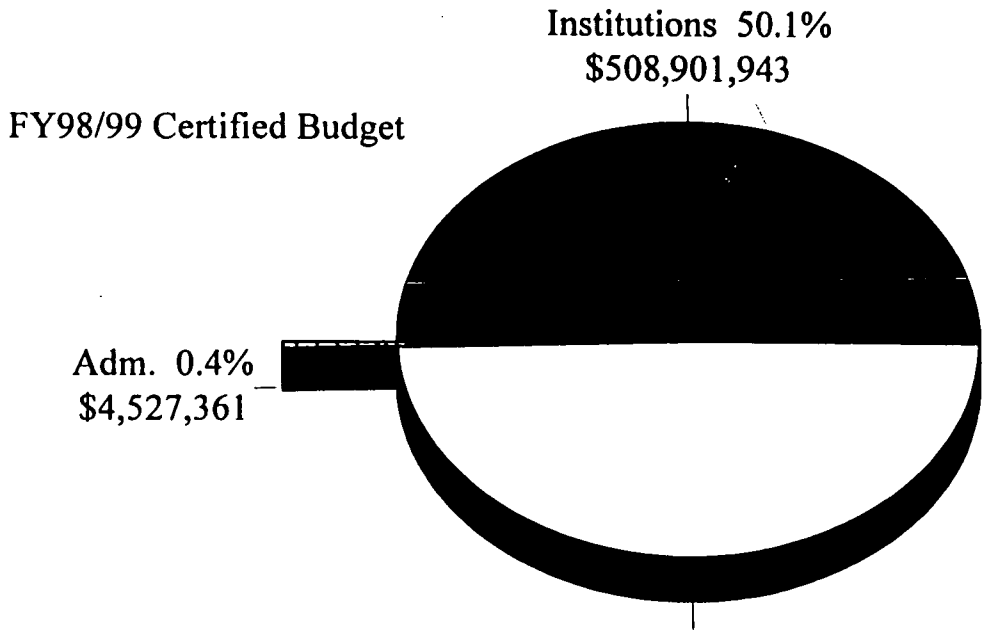
  -G.S. 143B-147 through 143B-150
  -26-member regulatory body
  -adopt/amend/repeal rules for state & local mh/dd/sas

- *Legislative Study Commission on MH/DD/SAS*

  -G.S. 120-204 through 120-207
  -22 members
  -review systemwide issues affecting mh/dd/sas

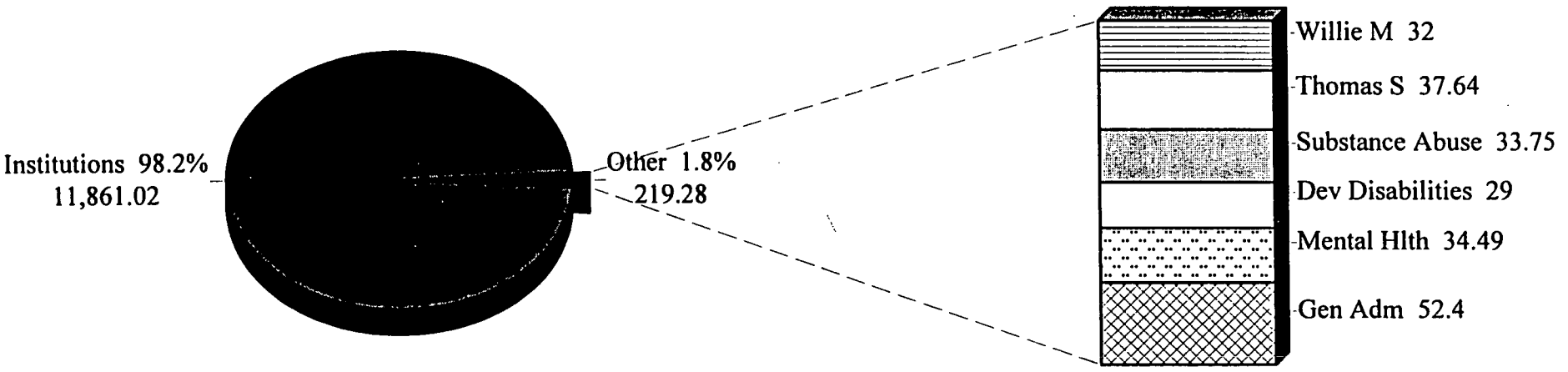
DIVISION OF MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE SERVICES

BUDGET SUMMARY:	FY97/98 Actual	FY98/99 Certified	FY98/99 Authorized	FY99/00 Rec'd.	FY00/01 Rec'd.
REQUIREMENTS	$1,140,329,329	$1,035,395,786	$1,035,404,786	$1,036,810,957	$1,034,547,177
REVENUES	($594,053,430)	($451,182,876)	($451,191,876)	($432,714,411)	($432,692,635)
APPROPRIATION	$546,275,899	$584,212,910	$584,212,910	$604,096,546	$601,854,542
POSITIONS	11,995.32	12,094.45	12,080.35	12,076.3	$12,076



DIVISION OF MH/DD/SAS

FY1998-99 Positions



Total Positions: 12,080.30

DIVISION OF MH/DD/SAS

Highlights of Legislative/Budget Actions

1997 Session:

✓ Area Mental Health Expansion	$5M
✓ Tri-County Dissolution & Realignment	$1.45M
✓ Forensic Treatment Unit @ Dorothea Dix Hospital	$1.1M
✓ Crisis Services Expansion	$1M
✓ Early Intervention Services	$2.7M
✓ Efficiency Study of State Psychiatric Hospitals	
✓ Whitaker School Replacement Facility	

DIVISION OF MH/DD/SAS

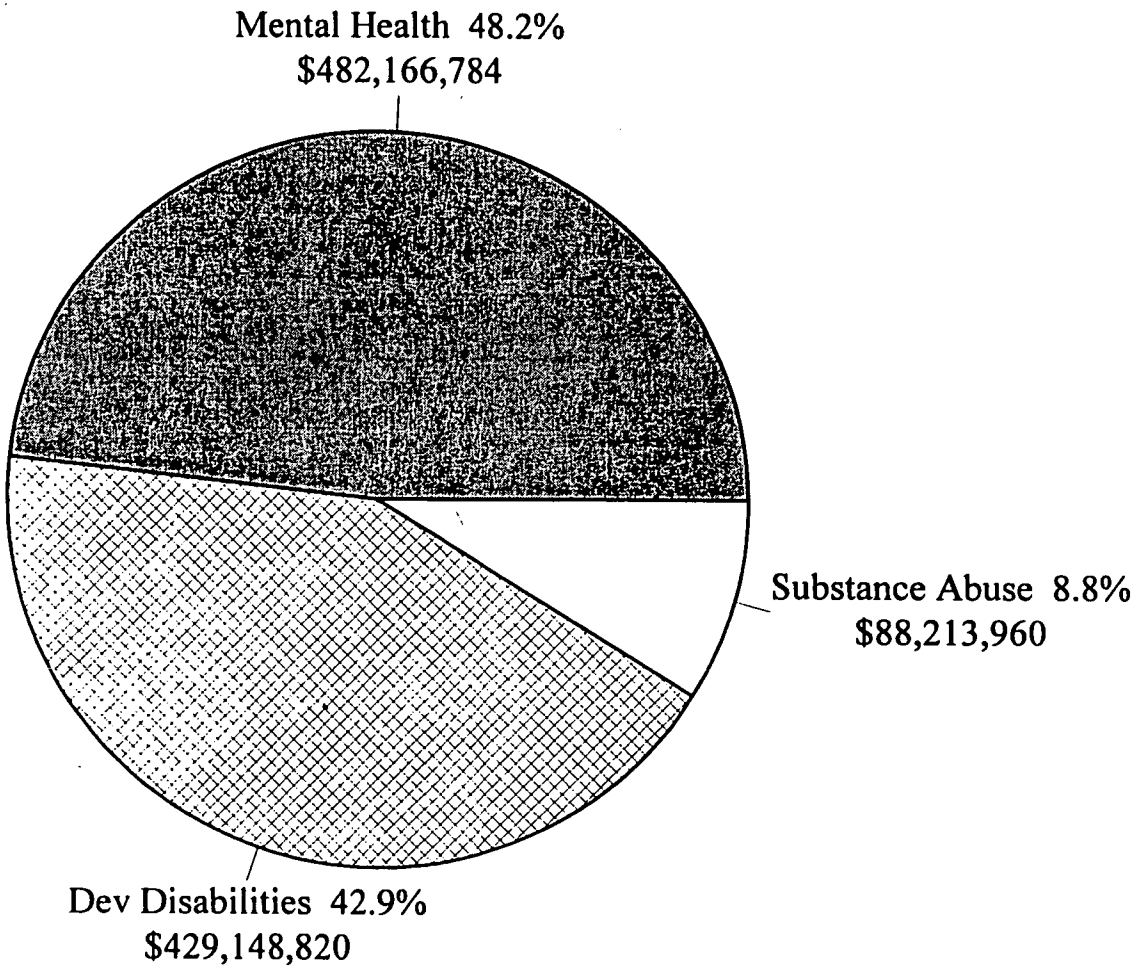
Highlights of Legislative/Budget Actions

1998 Session:

✓ Creation of Medicaid Match Reserve	$38M
✓ Funding for Developmental Disabilities Waiting List	$12M
✓ Atypical Antipsychotic Medications	$1.3M
✓ Violent & Assaultive Children	$5.3M
✓ Continuation/Expansion of the Hospital Study	$750K
✓ Design of Replacement Facility for Dix Hospital	$2M
✓ Whitaker School Planning	$250K
✓ Increased Area Program Accountability Initiatives	

DIVISION OF MH/DD/SAS

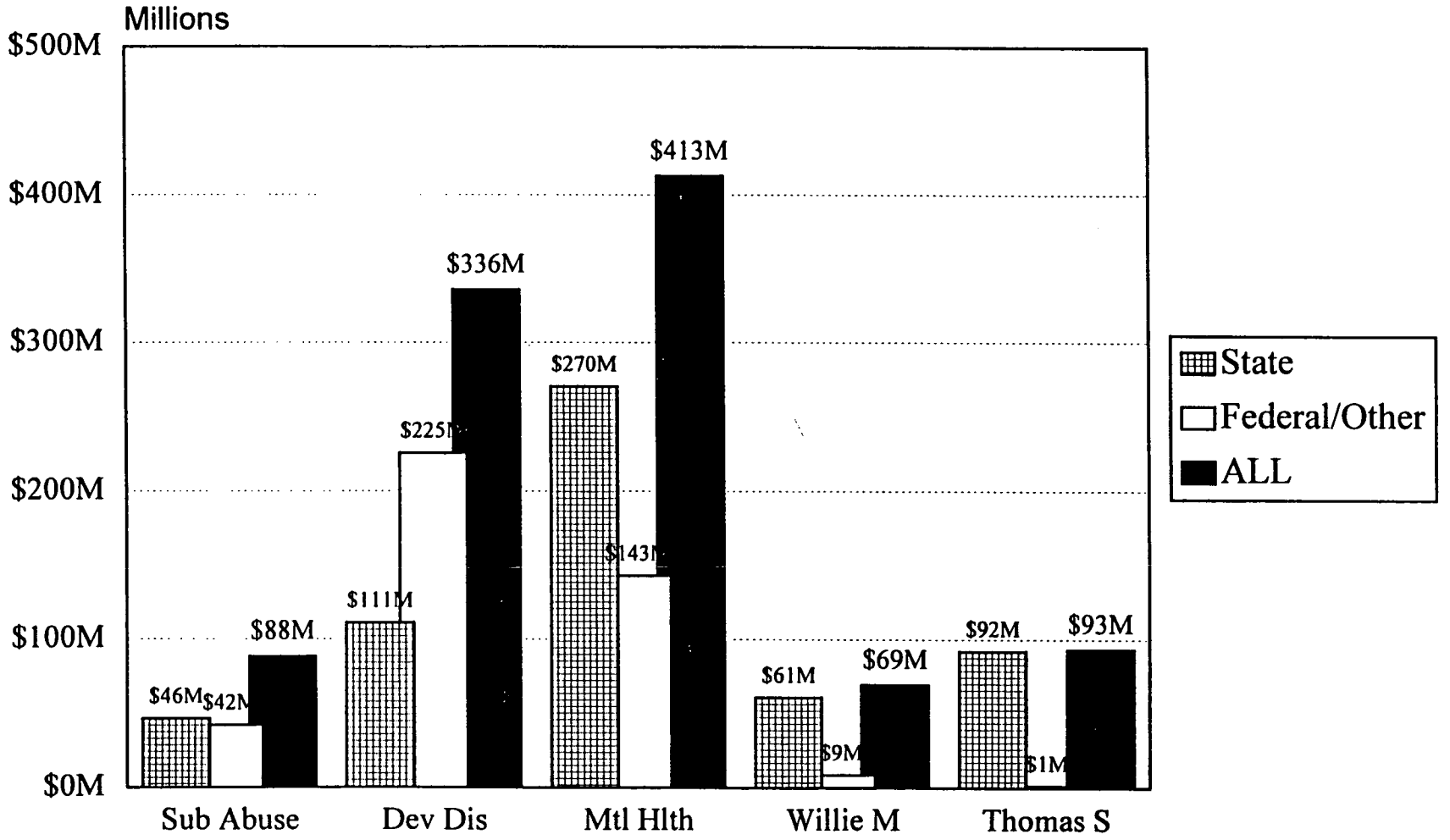
Total Expenditures by Disability



FY98/99 Certified Budget

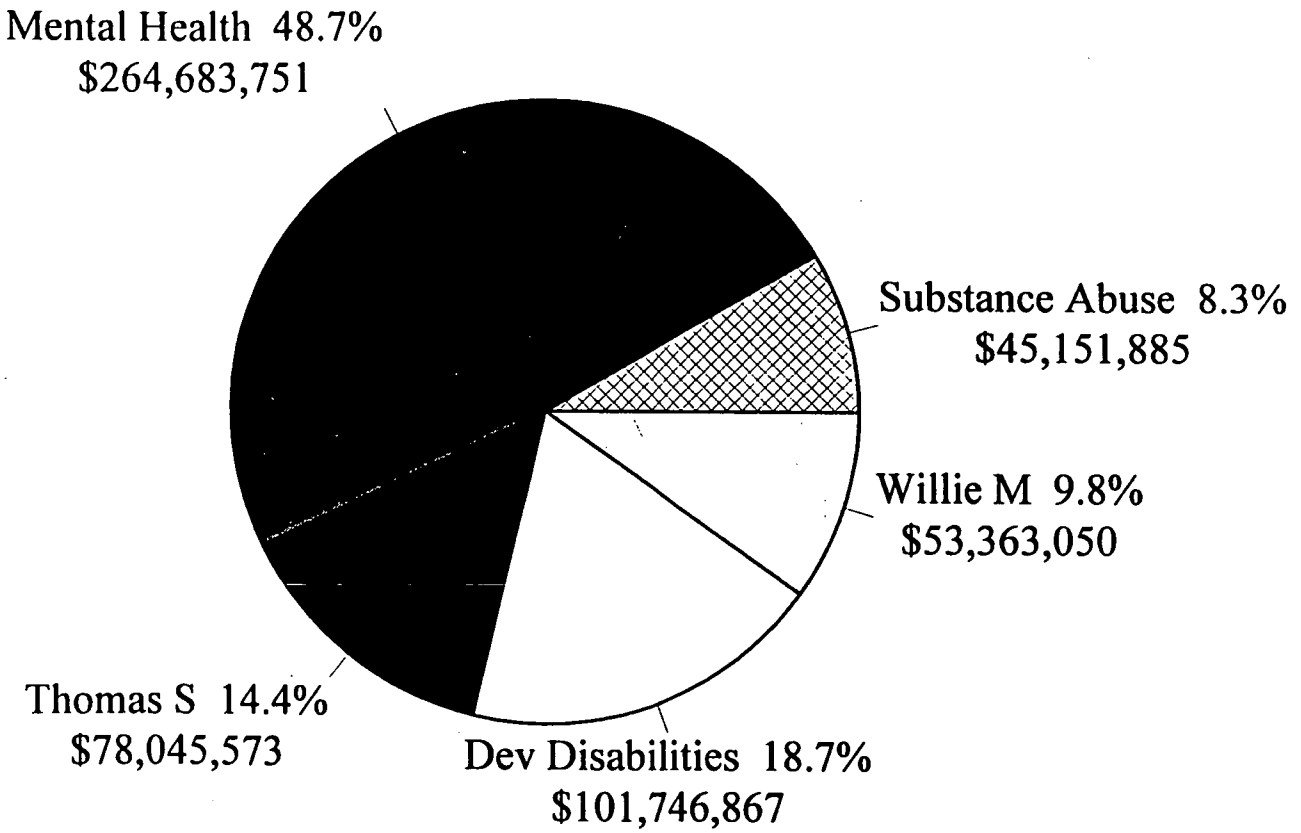
DIVISION OF MH/DD/SAS

FY98/99 Funding by Disability Area and Source



DIVISION OF MH/DD/SAS

State Appropriations by Disability Area



FY97/98 Appropriations: $546,275,899

Division of Mental Health/ Developmental Disabilities/Substance Abuse Services

1999-00 Governor's Recommended Continuation Budget Adjustments

		FY99/00	FY00/01
1.	Replace Institutional Receipts with State Appropriations	$18,200,000	18,200,000
2.	Replace Equipment in Institutions	1,500,000	800,000
3.	Eliminate 4 Vacant Positions	(78,722)	(78,722)
4.	Developmental Disabilities Waiting List & Management	6,000,000 500,000	6,000,000 500,000
5.	Atypical Antipsychotic Medications	1,326,998	1,326,998
6.	Violent & Assaultive Children Services (Does Not Include the Continuation of $5,353,003 for Children in Existing Services)		

DIVISION OF MH/DDSAS

DIVISION-WIDE INITIATIVES

- ***Cross Disability Comprehensive Outcomes Initiative:***
  -Cross Disability Comprehensive Review
  -Includes State and Area Program Services
  -Measures Consumers Outcomes in Five Areas:
  Functioning; Reduction of Symptoms; Involvement in Employment and Education; Involvement in the Criminal Justice System; Crisis Services Utilization; and Residential Appropriateness

- ***Business Redesign Initiative:***

  -Appointed Division Design Team
  -Developing Recommendations for Comprehensive Redesign of System;
  -Goals: Optimize *Effectiveness of State's Purchase of Mental Health Services to Ensure High Quality, Accessibility, and Cost Efficiency.*

DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, SUBSTANCE ABUSE SERVICES

PROGRAMS/SERVICES

DIVISION OF MH/DD/SAS

SERVICES WITHIN DMH/DD/SAS

Programs

- Mental Health
- Child & Family Services
- Willie M Services
- Developmental Disabilities
- Thomas S Services
- Crisis Services
- Substance Abuse Services

Support

- Management Services
- Budget Office

MENTAL HEALTH SERVICES

MISSION:

To promote the development of services for adults with severe and persistent mental illness and seriously emotionally disturbed minors through supervision of state mental health institutions, policy guidance, special grant initiatives and advocacy within the Division, the Department of Human Resources and other departments and offices of state government.

What Is Mental Illness and Who Is Disabled?

In adults, the most disabling forms of Mental Illness are *Schizophrenia, Clinical Depression And Manic-Depressive Disease*

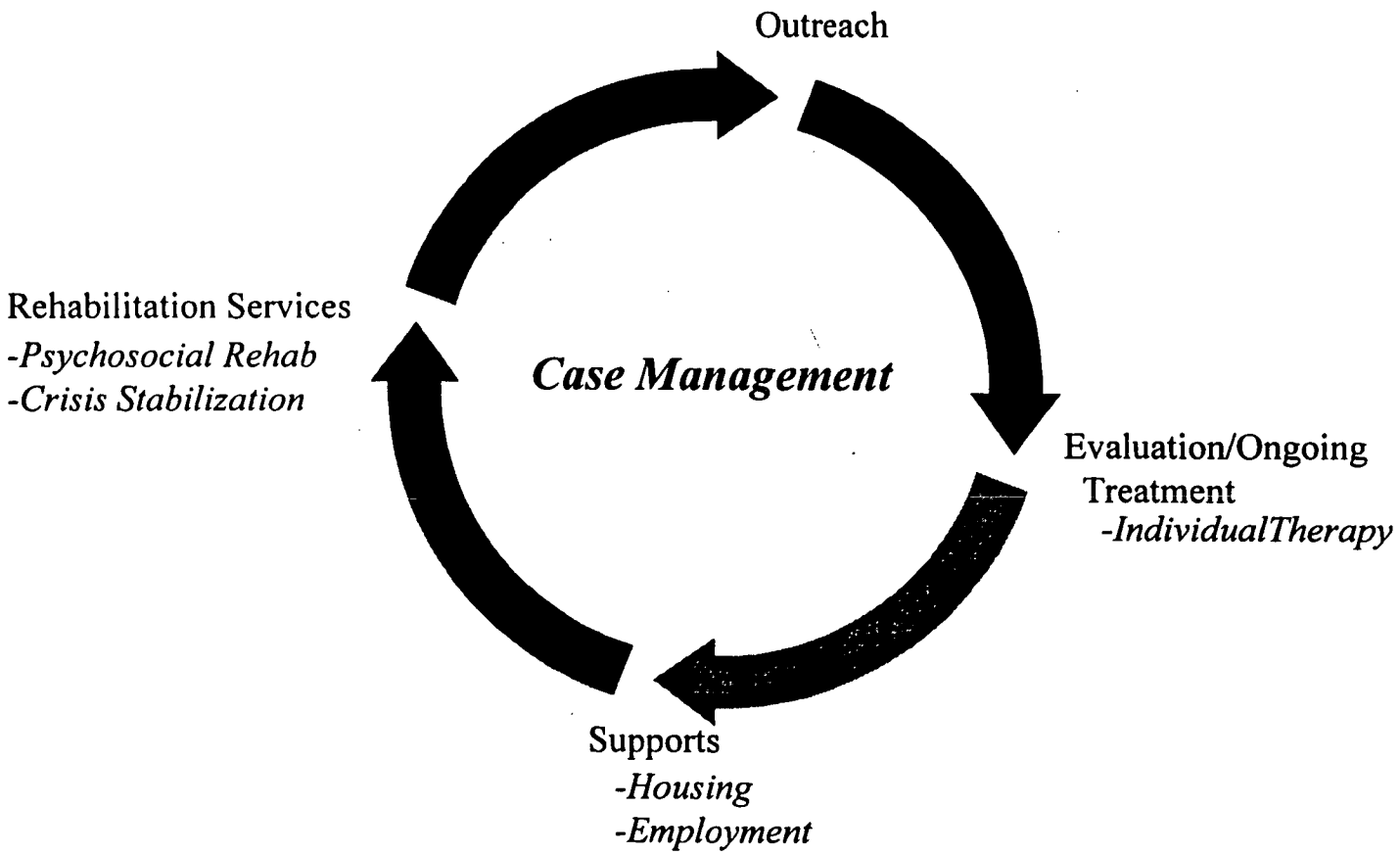
Subpopulations Exist With Special and Different Needs -*Homeless, Dually Diagnosed, Children, Young Adults and Elderly*

Characteristics of Serious & Chronic Mental Illness:
- difficulty with tasks of daily living;
- recurrent problems in meeting basic survival needs;
- extreme vulnerability to stress;
- tendency toward episodes of "acting out";
- lack of ability to develop personal social networks; and
- lack of ability to seek help from others.

MENTAL HEALTH SERVICES

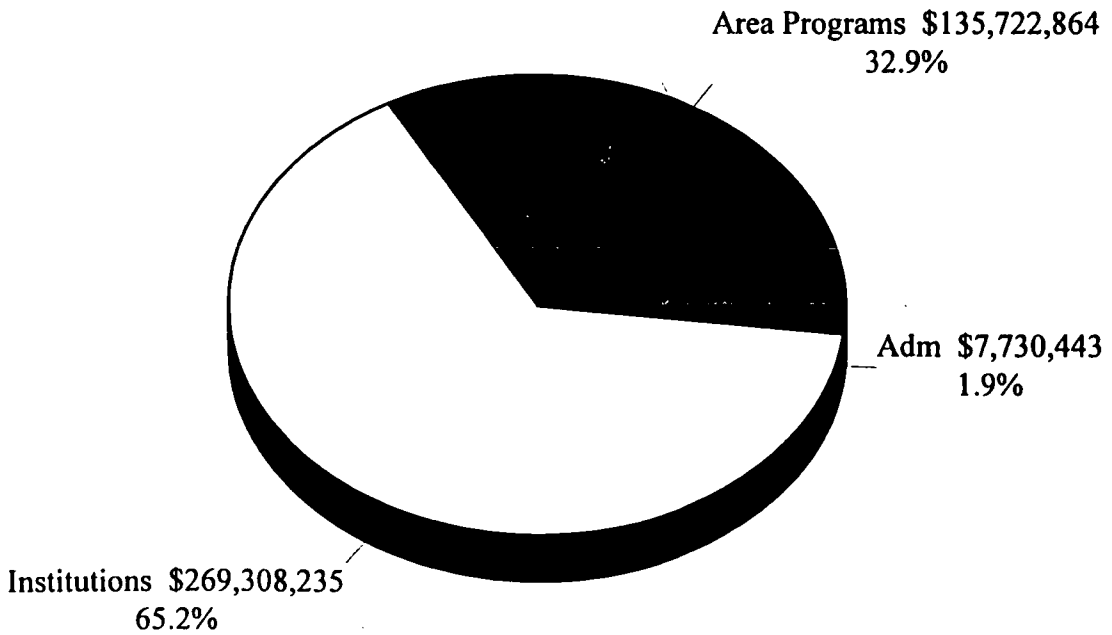
SERVICES FOR PERSONS WITH MENTAL ILLNESS

CONTINUUM OF CARE



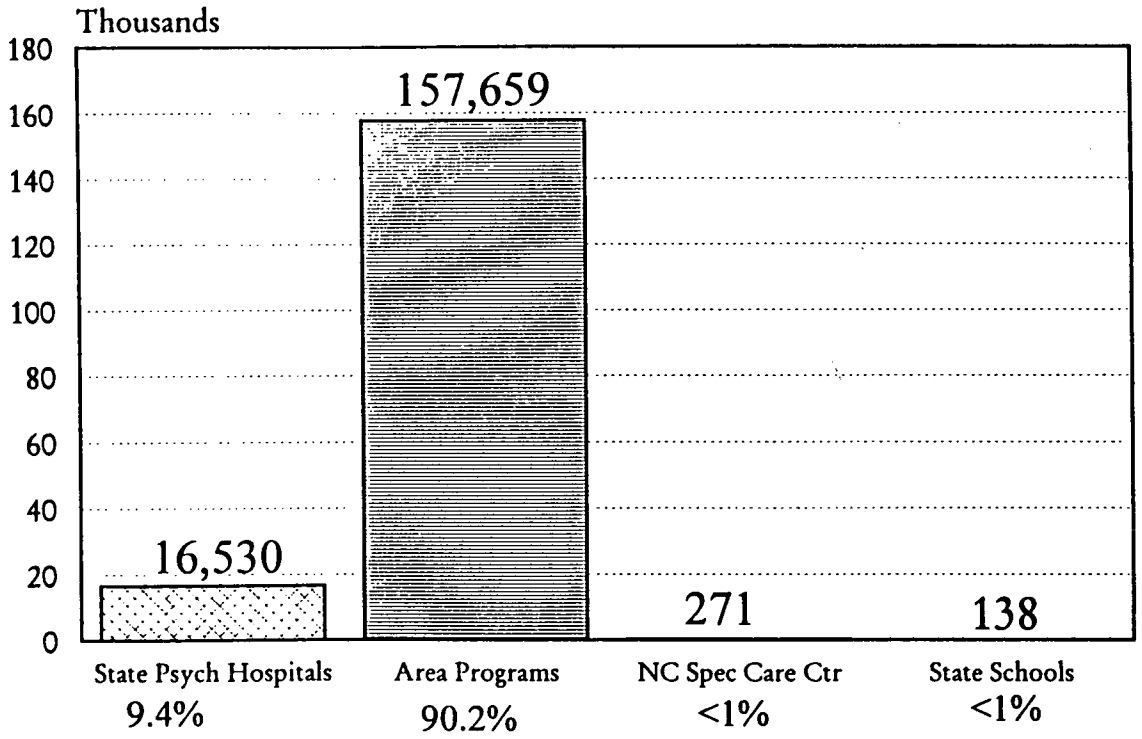
MENTAL HEALTH SERVICES

BUDGET SUMMARY:	FY98/99 CERTIFIED	FY99/00 RECOMMENDED
REQUIREMENTS	$412,761,542	$417,988,889
REVENUES	(142,773,942)	(130,070,744)
APPROPRIATIONS	$269,987,600	$287,918,145
POSITIONS	5,751.04	5,751.04



FY 98/99 Certified Budget

Where Are the Mentally Ill?
What Services Do They Receive?
FY1997/98

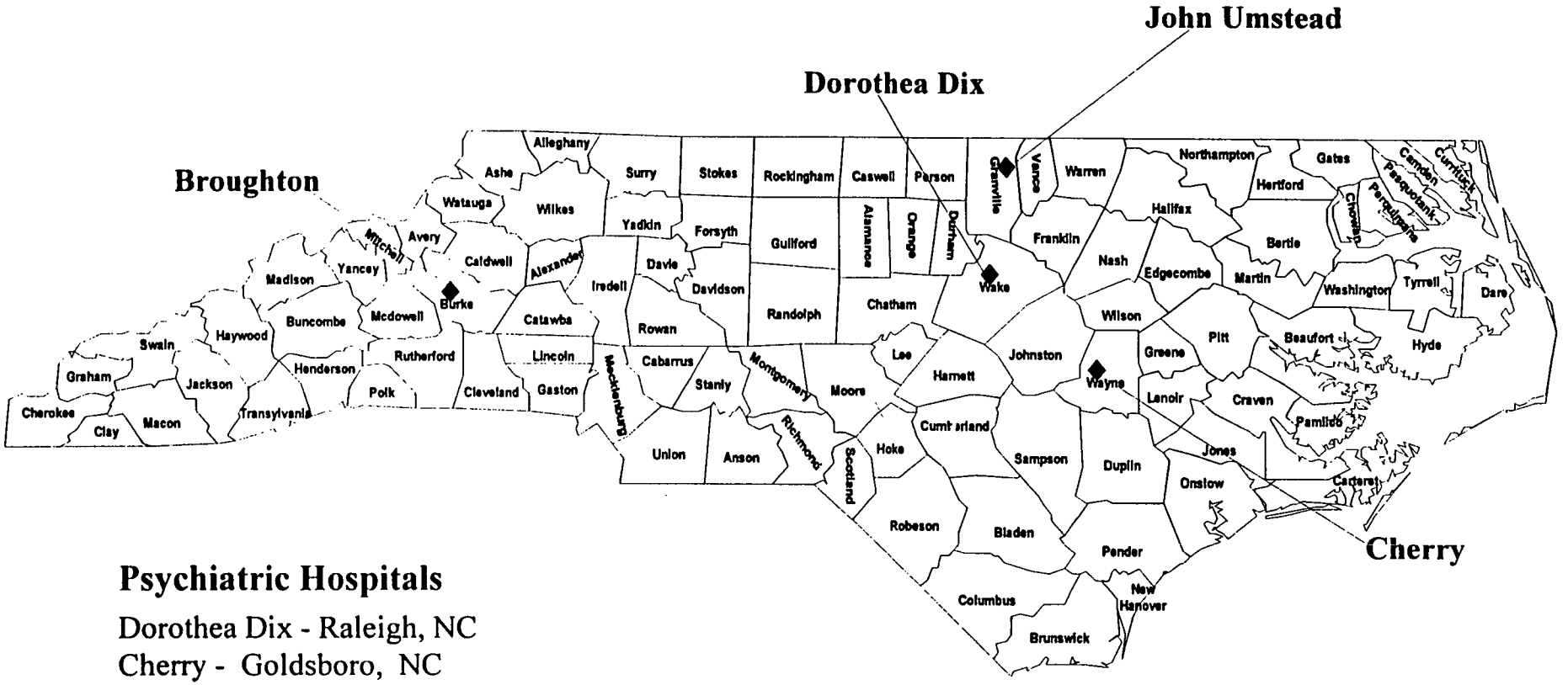


SERVICES:

- ✓ **Assessment**
- ✓ **Treatment**
- ✓ **Case Management**
- ✓ **Supervised Independent Living**
- ✓ **Family Living**
- ✓ **Group Living**
- ✓ **Residential Treatment**
- ✓ **Inpatient Services**
- ✓ **Day Treatment**
- ✓ **Specialized Care for Deaf/Mentally Ill**

MENTAL HEALTH SERVICES

STATE PSYCHIATRIC HOSPITALS



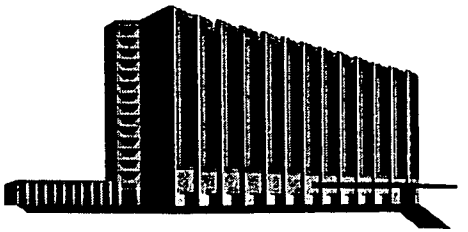
Psychiatric Hospitals

Dorothea Dix - Raleigh, NC
Cherry - Goldsboro, NC
John Umstead - Butner, NC
Broughton - Morganton, NC

MENTAL HEALTH SERVICES

STATE PSYCHIATRIC HOSPITALS

Dorothea Dix Hospital



- Opened in 1856
- Serves South Central Region (16 Counties)
- Bed Capacity of 340
- F98/99 Operating Budget: $67.4M
- Persons Served FY97/98: 4,151
- 1375.14 Staff
- Special Units: Forensic, Medical/Surgical, Residency Training & Pre-Trial Evaluation

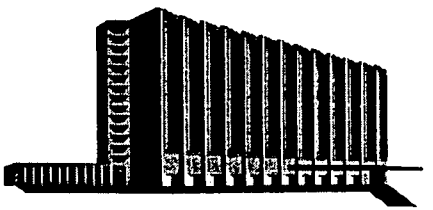
Broughton Hospital

- Opened 1882
- Serves Western Region (32 Counties)
- Bed Capacity
- FY98/99 Operating Budget: $60.1M
- Persons Served FY97/98: 4,200
- 1325.3 Staff
- Special Units: Medical/Surgical

MENTAL HEALTH SERVICES

STATE PSYCHIATRIC HOSPITALS

Cherry Hospital



- Opened in 1880
- Serves Eastern Region (33 Counties)
- Bed Capacity of 340
- F98/99 Operating Budget: $59.8M
- Persons Served FY97/98: 2,991
- 1271.08 Staff
- Special Units: Tuberculosis

John Umstead Hospital

- Opened in 1944
- Serves North Central Region (16 Counties)
- Bed Capacity of 340
- F98/99 Operating Budget: $63.1M
- Persons Served FY97/98: 5,188
- 1305.67 Staff
- Special Units: Residency Training

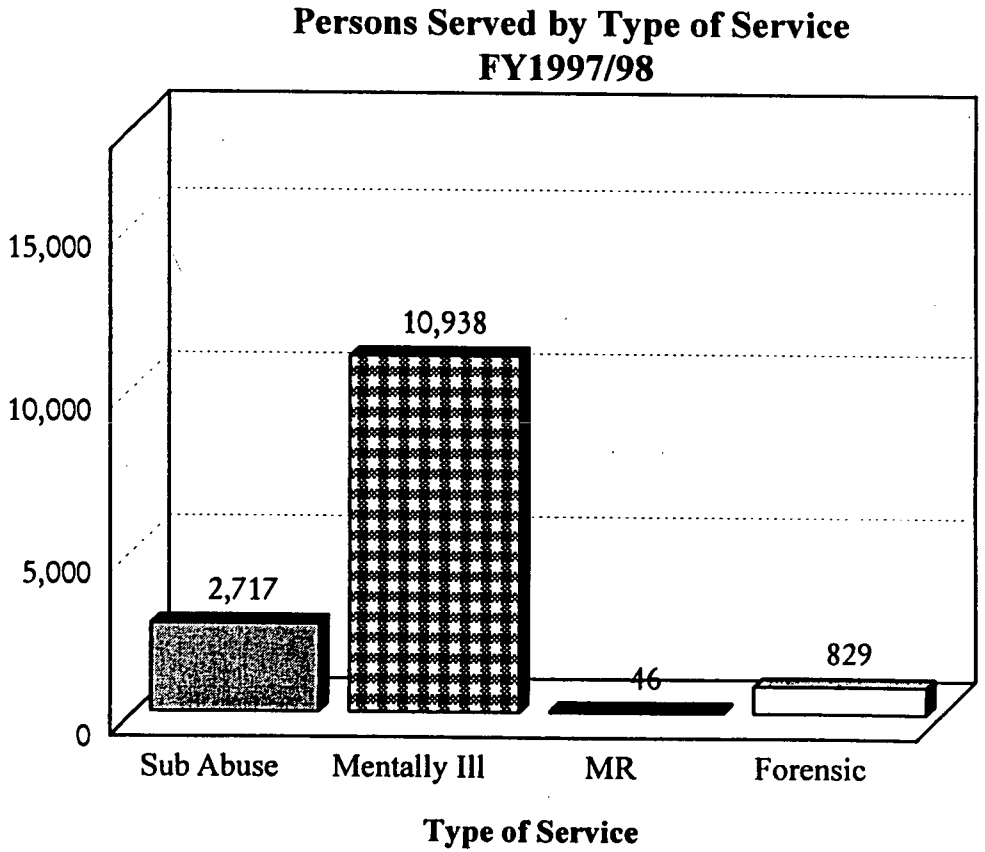
MENTAL HEALTH SERVICES

STATE PSYCHIATRIC HOSPITALS

State Hospitals Provide an Array of Services - medical, psychiatric nursing and rehabilitative services to adults, children and geriatric individuals.

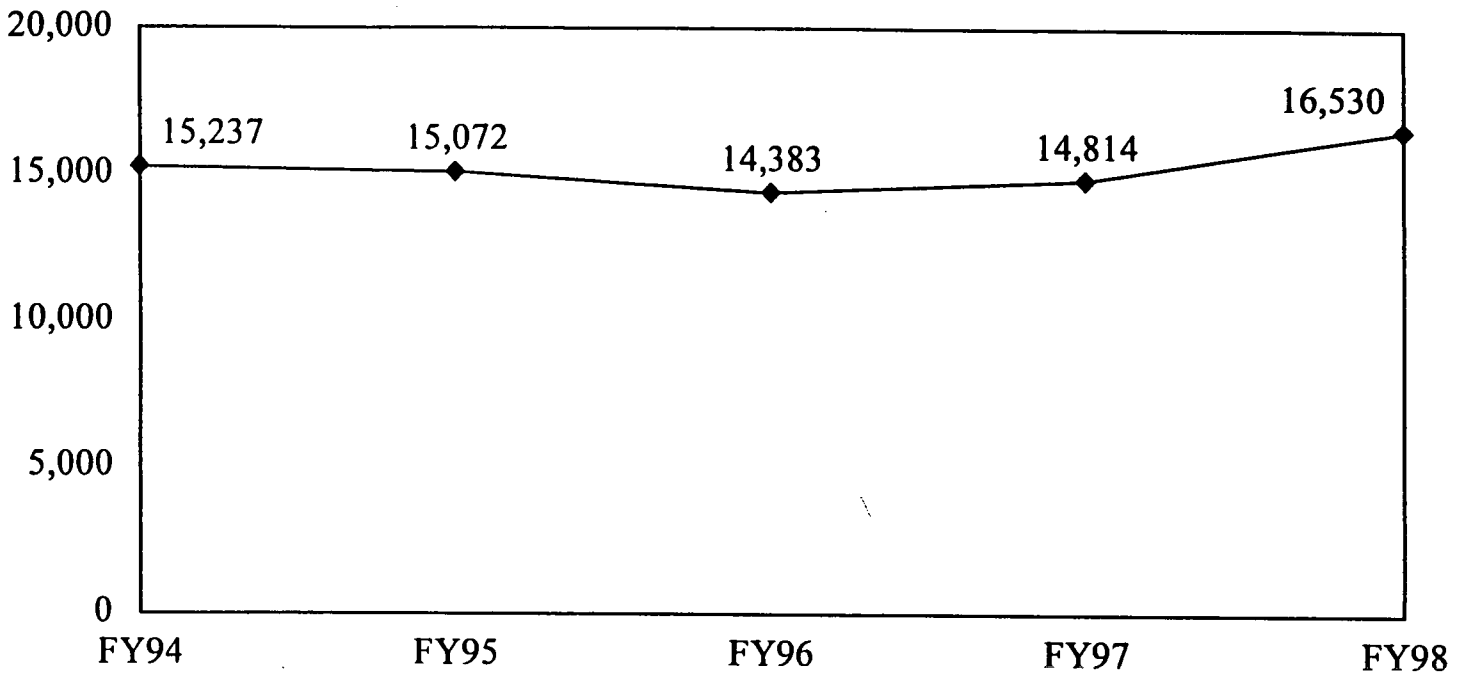
Patient Characteristics:

- Primary Diagnosis Schizophrenia - 13.5%
- Alcohol & Drug Diagnoses - 28.6%
- 53.4% or 8,836 Persons Ages 25 - 44 yrs
- 64% Male
- 10,042 or 61% White
- 6,040 or 36.5% African American
- 67.5% or 11,160 Involuntary Admissions



MENTAL HEALTH SERVICES

TRENDS IN PERSONS SERVED IN STATE HOSPITALS

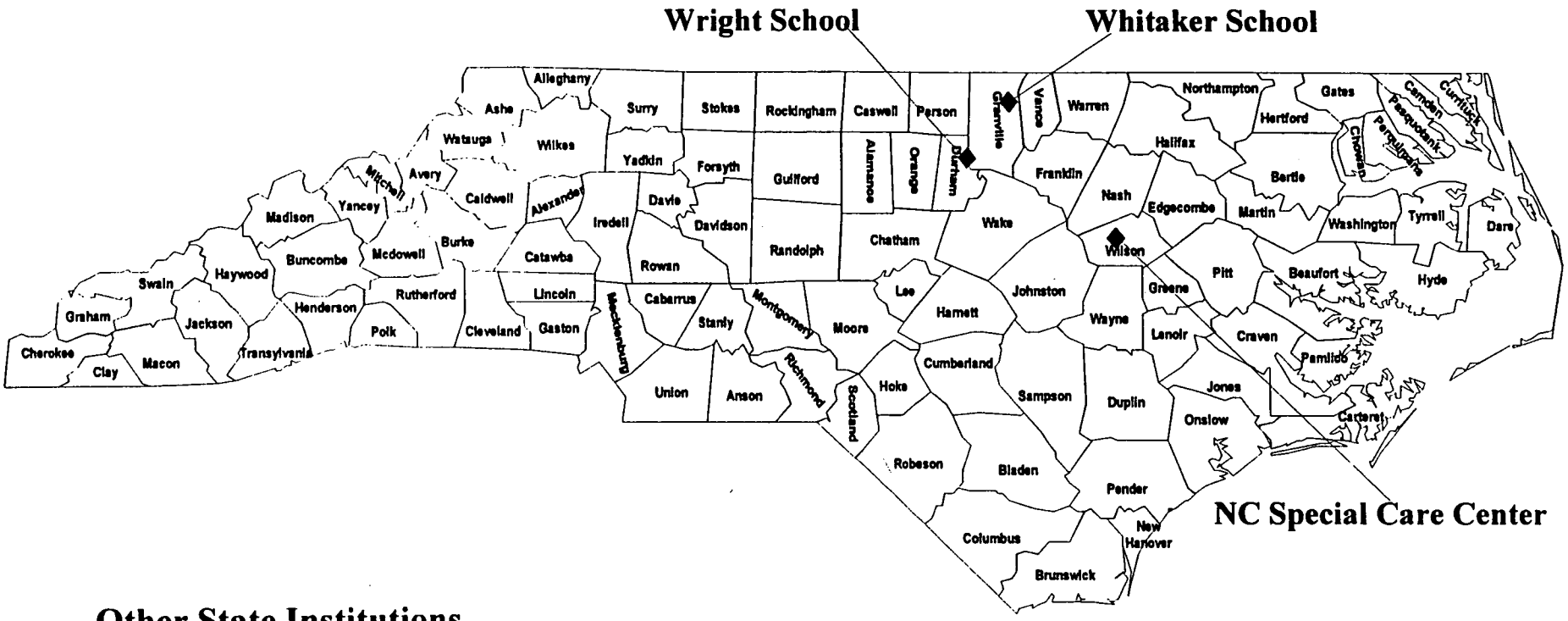


NOTE:

11.6% Increase in Persons Served Since FY97
8.4% Increase in Persons Served Since FY94

MENTAL HEALTH SERVICES

OTHER INSTITUTIONAL SERVICES



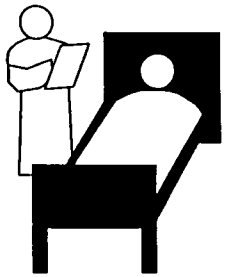
Other State Institutions

Whitaker School - Butner, NC
Wright School - Durham, NC
NC Special Care Center - Wilson, NC

MENTAL HEALTH SERVICES

OTHER INSTITUTIONAL SERVICES

N.C. Special Care Facility



- Opened in 1978
- Provides Nursing Level Care to Former State Psychiatric Hospital Patients
- Service Region Statewide
- Referrals From State Psychiatric Hospitals
- Bed Capacity of 208
- Persons Served FY97/98: 271
- F98/99 Operating Budget: $14.3M
- 351 Staff

Client Profile:

- 62% Require Intermediate Care Nursing
- 60% White
- 61% 65+ Years
- Average Stay: 4.3 Years

MENTAL HEALTH SERVICES

OTHER INSTITUTIONAL SERVICES

Whitaker School

- Opened in 1978
- Adolescent Re-educational Model
- Providing Secure, Residential Treatment to Behaviorally and Emotionally Disturbed Youth 12-17 Years
- Service Region Statewide
- Referrals From Area Mental Health Programs
- Bed Capacity of 24
- Persons Served FY97/98: 61
- F98/99 Operating Budget: $2.2M
- 51 Staff

Client Profile:

- 65% Male
- 53% Non-White
- Average Age: 15 Years
- Average Stay: 8.8 Months

MENTAL HEALTH SERVICES

OTHER INSTITUTIONAL SERVICES

Wright School

- Providing Residential Treatment to Behaviorally and Emotionally Disturbed Youth 6-12 Years
- Service Region Statewide
- Referrals From Area Mental Health Programs
- Bed Capacity of 24
- Persons Served FY97/98: 77
- F98/99 Operating Budget: $1.7M
- 37.36 Staff

Client Profile:

- 89% Male
- 56% Non-White
- Average Age: 10 Years
- Average Stay: 5.9 Months

MENTAL HEALTH SERVICES

WILLIE M SERVICES

The Willie M Services Section coordinates a system of services which are primarily provided by area mental health programs And include least restrictive, individualized treatment and educational services to children identified as Willie M Class members under the age of eighteen (18) who have serious emotional, mental or neurological impairments and whose impairments are accompanied by violent or assaultive behavior.

Chronology:

- October 1979 - Lawsuit Filed
- November 1980 - Review Panel Appointed
- October 1981 - Court Approves Timetable for All Class Members In Service
- April 1992 - Adopted Comprehensive Plan for Service to Members
- January 1995 - Motion Filed for Relief From Court Oversight

MENTAL HEALTH SERVICES

WILLIE M SERVICES

Chronology:

- February 1997 - Judge provided updated copy of the Compliance Plan and Proposals to Terminate Review Panel & Willie M Case

- January 1998 - Judge Dismissed Class/Case

Program Information:

- Class Criteria: (1) presence of a diagnosed mental, emotional, or neurological handicap; (2) behavior characterized as violent or assaultive; (3) prior involvement of the state in child's life; and (4) need for residential treatment and absence of appropriate services.

- Class Membership is Voluntary

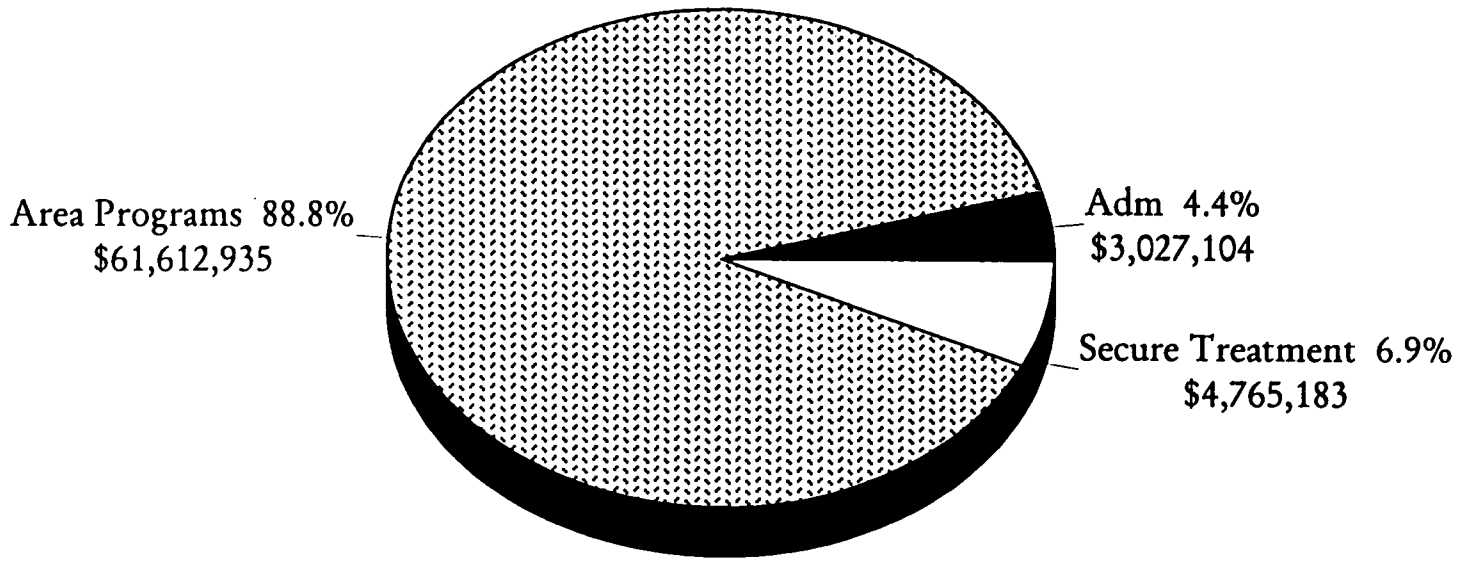
- Area Mental Health Programs provide or arrange most services; DHHS provides special residential services and contracts for some local services.

MENTAL HEALTH SERVICES

WILLIE M SERVICES

BUDGET SUMMARY:	FY98/99 CERTIFIED	FY99/00 RECOMMENDED
REQUIREMENTS	$69,405,222	$64,097,200
REVENUES	($8,572,032)	($8,572,032)
APPROPRIATIONS	60,833,190	55,525,168
POSITIONS	$155	$155

FY98/99 CERTIFIED BUDGET



MENTAL HEALTH SERVICES

WILLIE M SERVICES

Willie M Client Profile:

- 1,931 Children Served FY97/98
- 42% Cost Average $5,130/year
- 7% Cost $20,000-39,000/year
- 12% Cost $40,000-59,000/year
- 10.5% Cost $100,000+
- Approximately 70% Served by Public School System
- 30% Live in Their Homes

WILLIE M SERVICES

Willie M Client Profile:

- 12% Reside in Locked Facilities
- 75% Removed from Their Homes by State/Local Government
- 52% Have Been Physically Abused
- 33% Have Been Sexually Abused
- 57% Come From Families With Mental Disorders
- 53% Come From Families With Substance Abuse Problems

MENTAL HEALTH SERVICES

CHILD AND FAMILY SERVICES

MISSION:

Implementing the N.C. Child Mental Health Plan Statewide and Facilitating the Development and Monitoring of Nonresidential and Residential Child Mental Health Services in Each of the 40 Area Authorities, Children's Units in the State Psychiatric Hospitals and the Wright and Whitaker Schools.

INITIATIVE:

Futures Committee
-State and Multiple Child Service Agencies
-Working Collaboratively to Develop a Response to 1998 MGT of America Study
-Evaluating Role of State Hospitals in the Continuum of Care for Seriously Emotionally Disturbed Children

MENTAL HEALTH SERVICES

INITIATIVES

1. **Follow Up on MGT, Study**
   -Three (3) Committees Established to Respond to the Recommendations for Special Populations

2. **Dix Hospital Planning & Design**

3. **Cherry Hospital Children's Unit**
   -Design Phase is Well Underway

DEVELOPMENTAL DISABILITIES SERVICES

The purpose of the Developmental Disabilities Section is to direct, manage and facilitate services and supports for individuals with developmental disabilities and their families. Services for persons with developmental disabilities are administered by the Division and operated by the forty (40) Area Programs or their contract agencies and the five state operated mental retardation centers.

What is a Developmental Disability?

A severe, chronic disability of a person which:

- is attributable to a mental /physical impairment or combination,

- is manifested before the age of 22 , unless the disability is caused by a traumatic head injury after age 22;

DEVELOPMENTAL DISABILITIES SERVICES

- Results in substantial functional limitations in 3 or more of the following:

  -self-care
  -receptive & expressive language
  -capacity for independent living
  -self-direction & self sufficiency
  -mobility
  -learning, and

- Reflects the person's need for a combination or sequence of interdisciplinary or generic care, treatment, or other services which are of a lifelong orextended duration and are individually planned and coordinated; or

- When applied to children from birth through four years of age, may be evidenced as a developmental delay.

CONDITIONS WHICH CAN LEAD TO A DEVELOPMENTAL DISABILITY:

- Autism
  Cerebral Palsy
  Polio
  Spinal Cord Injury
  Severe Head Injury
  Severe Learning Disabilities
- Spina Bifida
  Congenital Heart Disease
  Sickle Cell Anemia
  Epilepsy
  Blindness
  Mental Retardation

DEVELOPMENTAL DISABILITIES SERVICES

SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

ARRAY OF SERVICE OPTIONS

Early Intervention Services

-Early Identification & Screening
-Multidisciplinary Assessment
-Services Include Respite, Speech Therapy, and Other Special Therapies

Case Management

Day Services

-Community Inclusion
-Parent Training

Case Management

Vocational/Employment Services & Supports

-Supported Employment
-Sheltered Workshops

Case Management

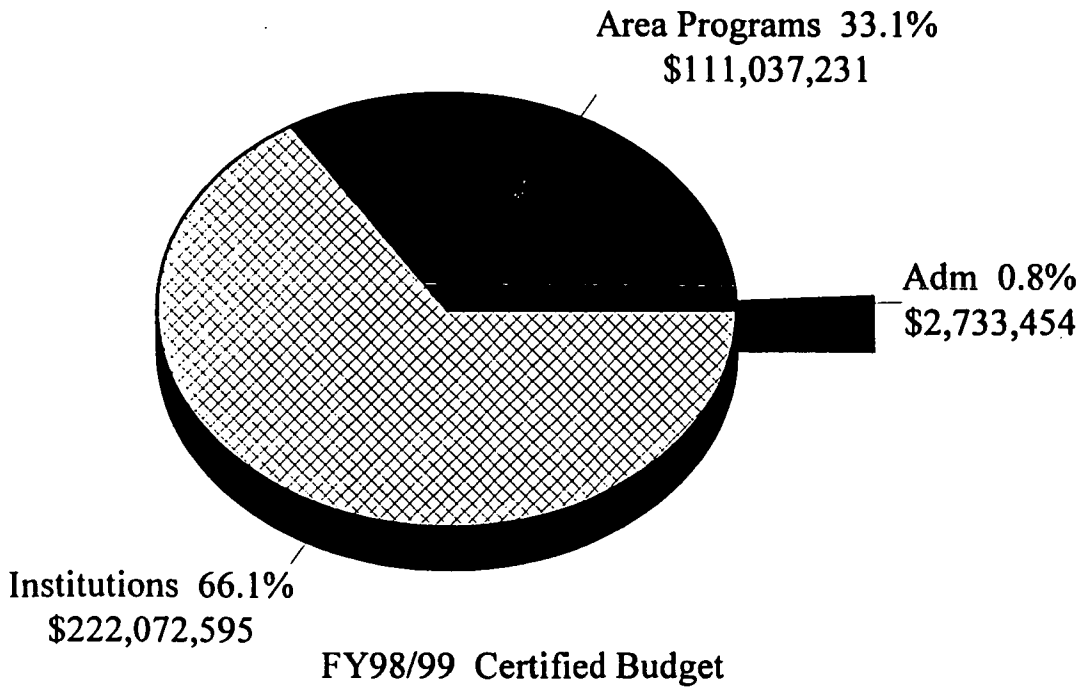
Housing Supports

-Supported Living
-Intermediate Care Facility for the Mentally Retarded (ICF/MR)
-Developmentally Disabled Adult Group Homes (DDA)

Case Management

DEVELOPMENTAL DISABILITIES SERVICES

BUDGET SUMMARY:	FY98/99 CERTIFIED	FY99/00 RECOMMENDED
REQUIREMENTS	$335,843,280	$338,194,750
REVENUES	(225,281,357)	(218,043,386)
APPROPRIATIONS	$110,561,923	$120,151,364
POSITIONS	5,795.75	5,795.75



FY98/99 Certified Budget

DEVELOPMENTAL DISABILITIES SERVICES

Where Do the Developmentally Disabled Receive Services?

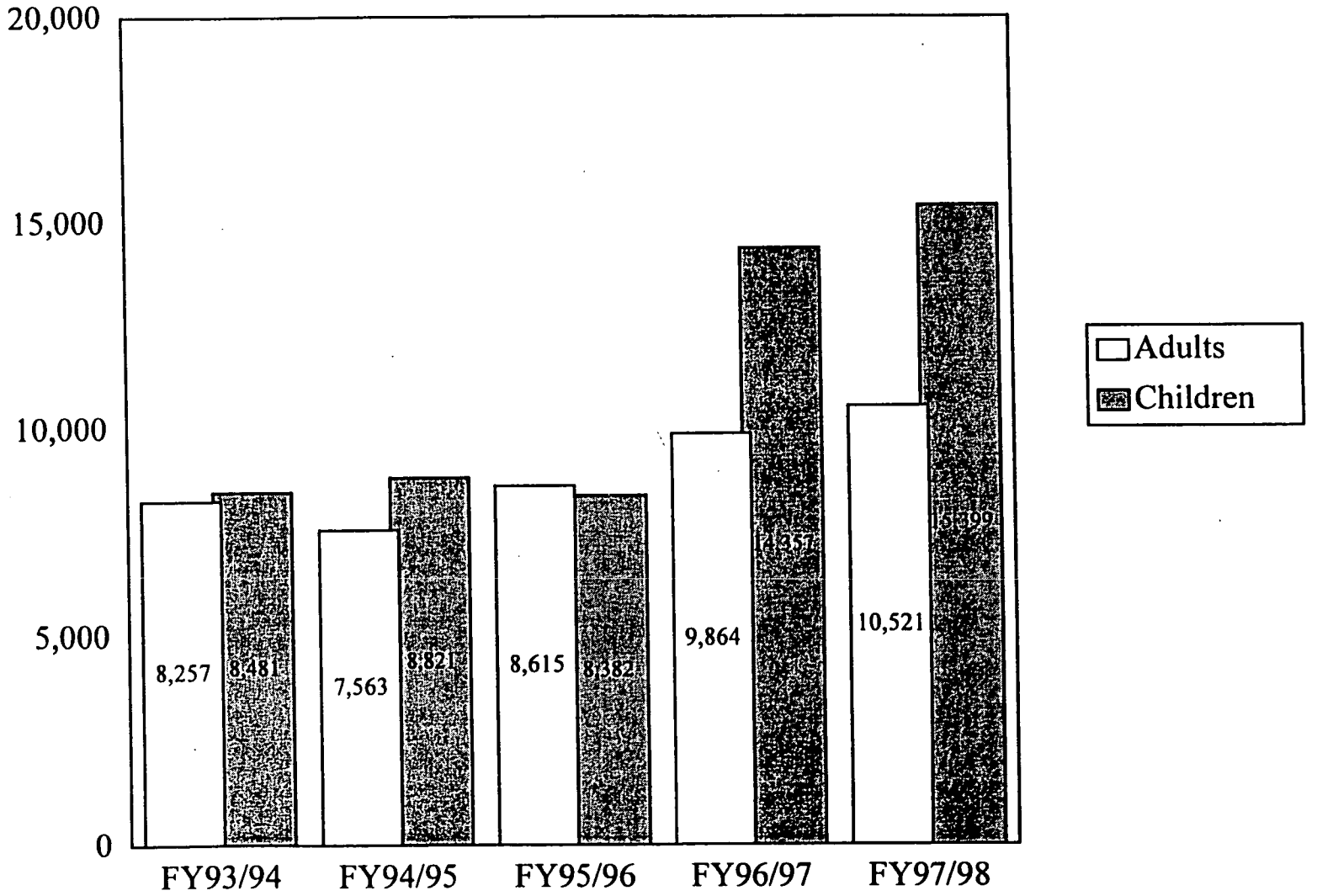
1. Area Mental Health Programs

2. State Intermediate Care Facility for Mentally Retarded (ICF-MR)

3. Community Alternatives Program for the Mentally Retarded/Developmentally Disabled (CAP-MR/DD)

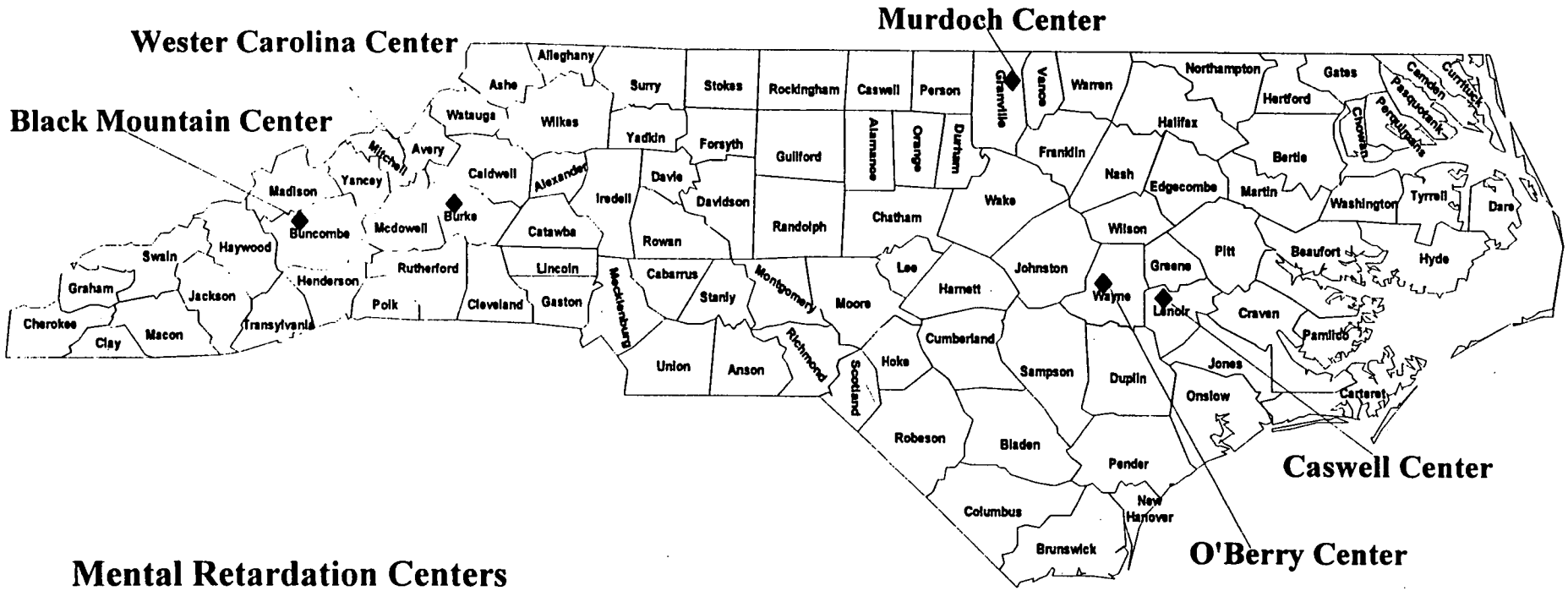
Developmentally Disabled Clients Served

Through Area Programs



DEVELOPMENTAL DISABILITIES SERVICES

MENTAL RETARDATION CENTERS



Mental Retardation Centers

Western Carolina Center - Morganton, NC
O'Berry Center - Goldsboro, NC
Murdoch Center - Butner, NC
Caswell Center - Kinston, NC
Black Mountain Center - Black Mountain, NC

DEVELOPMENTAL DISABILITIES SERVICES

MENTAL RETARDATION CENTERS

Black Mountain Center

- Opened in 1937
- Serves Western NC
- Bed Capacity of 190
- F98/99 Operating Budget: $41M
- Persons Served FY97/98: 336
- 444 Staff
- Special Units: 71-Bed Alzheimer Unit

1.3

370 — are for Alzheimers

Caswell Center

- Authorized by General Assembly in 1911 (NC's First MR Center)
- Serves Central NC
- Bed Capacity of 813
- F98/99 Operating Budget: $64M
- Persons Served FY97/98: 699
- 1,715 Staff

2.3

DEVELOPMENTAL DISABILITIES SERVICES

MENTAL RETARDATION CENTERS

Murdoch Center

- Began 1948
- Serves Central NC
- Bed Capacity of 676
- F98/99 Operating Budget: $60.4M
- Persons Served FY97/98: 653
- 1,593 Staff

2.7

O'Berry Center

- Opened in 1957
- Serves Eastern NC
- Bed Capacity of 485
- F98/99 Operating Budget: $38.9M
- Persons Served FY97/98: 404
- 1,018 Staff

7.1

DEVELOPMENTAL DISABILITIES SERVICES

MENTAL RETARDATION CENTERS

Western Carolina Center

- Began 1948
- Serves Western NC
- Bed Capacity of 493
- F98/99 Operating Budget: $41.2M
- Persons Served FY97/98: 416
- 996.25 FTE/Staff

DEVELOPMENTAL DISABILITIES SERVICES

Clients Served In State Mental Retardation Centers

Client Profile: (as of 6/30/98)

Persons Served: 2,508 (2,284 Residents & 224 Respite Services)

- 58% Male -42% Female

- 70% White -30% Non-White

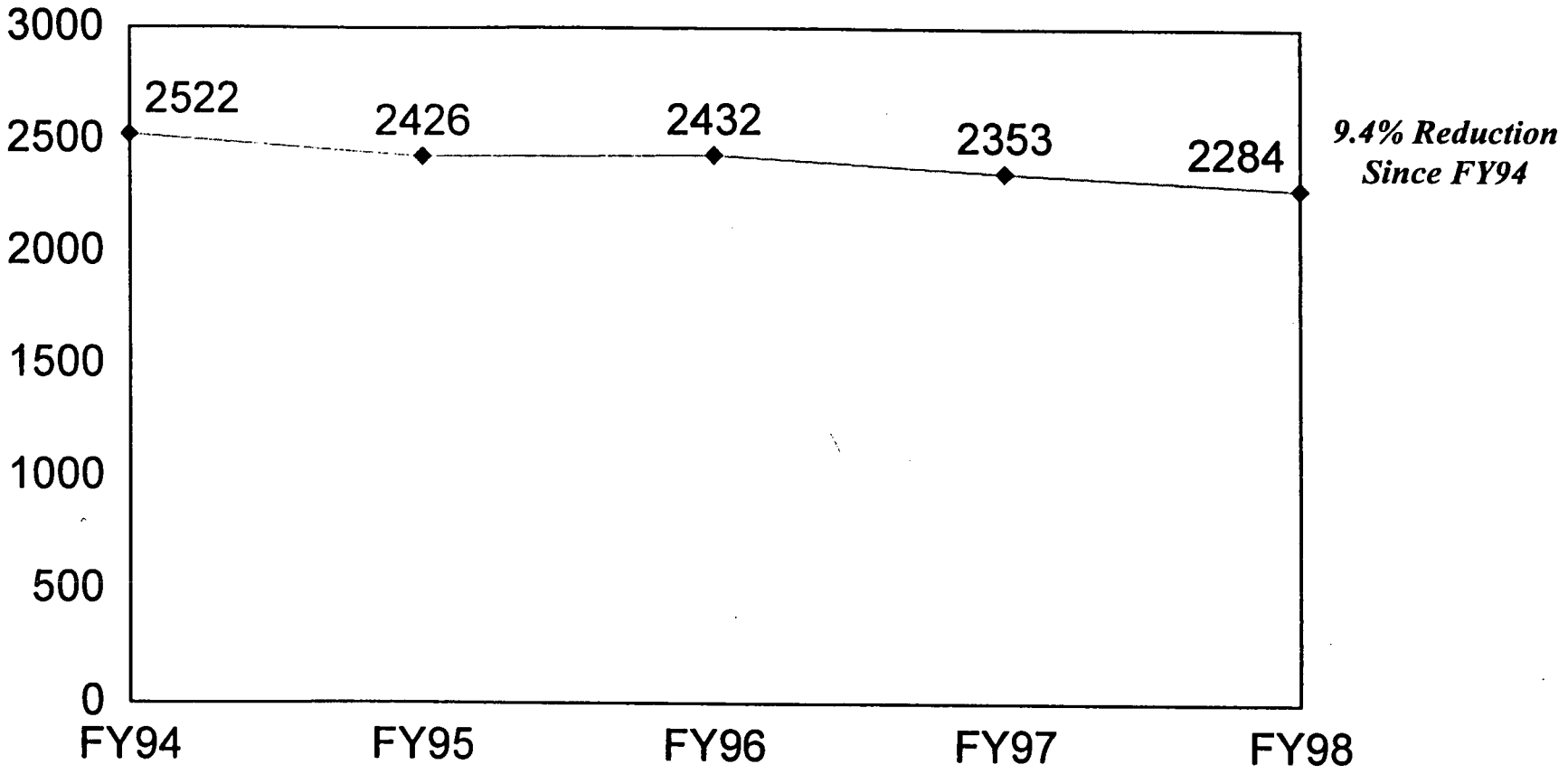
- 78% Age 25-54 Years - 73% Average Length of Stay: >21 years (95 % less than over 30 years)

-89% Severly/Profoundly Impaired

-Impairments Other Than M R: Cerebral Palsy, Autism, Epilepsy, Language Impairment & Alzheimer's Disease

DEVELOPMENTAL DISABILITIES SERVICES

PERSONS SERVED IN MENTAL RETARDATION CENTERS



DEVELOPMENTAL DISABILITIES SERVICES

COMMUNITY ALTERNATIVES PROGRAM FOR THE MENTALLY RETARDED OR DEVELOPMENTALLY DISABLED (CAP-MR/DD)

- Medicaid Waiver Program
  -Income and Resources of the Consumer (Not Parents or Spouse) Are Considered When Application is Made
  -Level of Disability is the Major Determination of Eligibility
- Began 1983, Program Serving Individuals Who Would Otherwise Require Care in an Intermediate Care Facility for People with Mental Retardation or Developmental Disabilities (ICF-MR)
- "Benefits Cap" Approach to Managed Care
- Maximum Annual Benefit Limit $68,088/Slot
  -Total of 5,127 Slots (FY98/99)
  -1,700 Additional Slots Made Available During FY98/99
  -Average Cost Per Consumer $28K Per Year
  -Approximately 800 Slots Are Currently Not Filled

DEVELOPMENTAL DISABILITIES SERVICES

COMMUNITY ALTERNATIVES PROGRAM FOR THE MENTALLY RETARDED OR DEVELOPMENTALLY DISABLED (CAP-MR/DD)

Array of Service Options

- Case Management
- Adult Day Health Care & Adult Day Care
- Augmentative Communication Equipment
- Supplies & Equipment **(expanded 1995)**
- Crisis Stabilization
- Supported Living Services
- Environmental Accessibility Adaptations
- Vehicle Adaptations **(new service 1995)**
- In-Home Aide Services
- Personal Emergency Response System
- MR Personal Care
- Respite Services **(revised service 1995)**
- Personal Habilitation Services {E.g.. Supported Employment} **(revised & new services 1995)**

THOMAS S SERVICES

The Thomas S Services Section directs the administrative and programmatic activities in response to the Thomas S versus Bruton class action lawsuit. This Section provides oversight in planning, fiscal management, and programmatic consultation activities in institutional settings and the 40 area mental health programs which provide services.

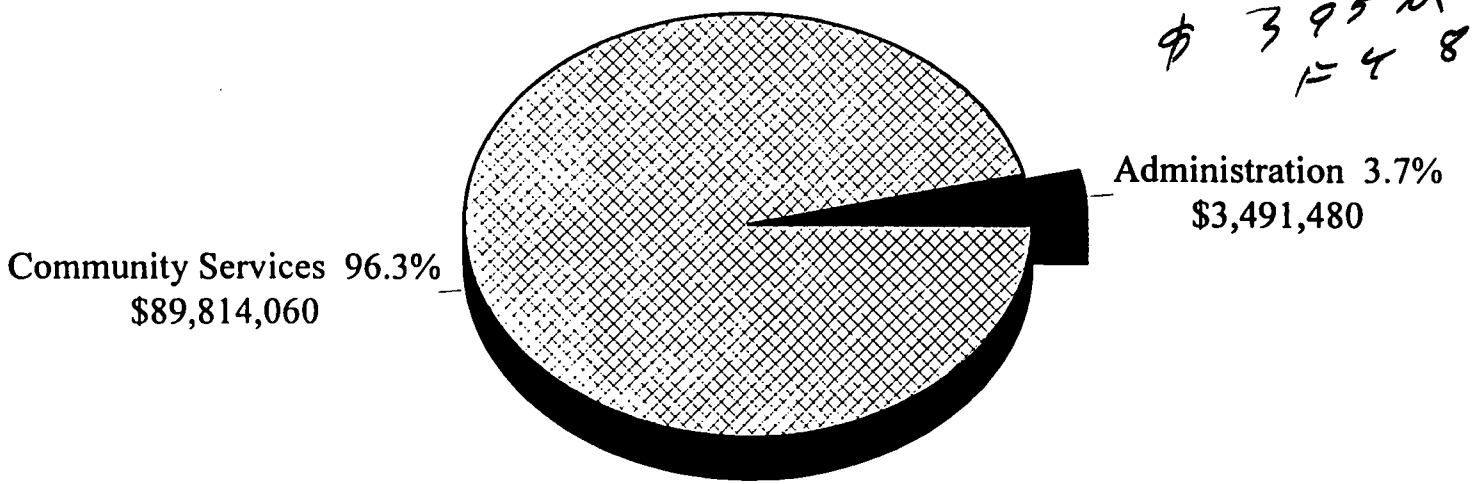
Chronology:

- 1982 - Lawsuit Originated
- 1988 - U.S. District Court Ruled Constitutional Rights of Class Violated
- 1990 - (May) U.S. Court of Appeals Affirmed Lower Court Ruling
- 1990 - (October) U.S. Supreme Court Denied Request to Hear Case
- 1991 - Special Master Appointed
- 1994 - Focus Class Agreement Approved by District Court
- 1995 - Petition Filed for Relief from Court
- **1998 - Court Dismissed Case**

THOMAS S SERVICES

BUDGET SUMMARY:	FY98/99 CERTIFIED	FY99/00 RECOMMENDED
REQUIREMENTS	$93,305,640	$93,319,369
REVENUES	(1,260,792)	(1,260,792)
APPROPRIATIONS	$92,044,748	$92,058,577
POSITIONS	37.64	37.64

FY98/99 Certified Budget



$ 395 M spent in 89-90

THOMAS S SERVICES

Thomas S Client Profile:

- 1,166 Clients Served FY97/98
- 68% Male Class Members
- Average Gross Cost $94K Per Class Member (FY97/98)
- Class Members Typically Exhibit Multiple Disabilities
  -mental illness, mental retardation and substance abuse
- Largest Group in Class are Geriatric
- Second Largest Subgroup Range 30 - 50 Years Old with Mental Illness
- Most Members are Mild-to-Moderately Mentally Retarded
- Approximately 88% Medicaid Eligible

DEVELOPMENTAL DISABILITIES SERVICES

INITIATIVES

1. **Developmental Disabilities Waiting List**
   - -January 1998 Waiting List Total: 7,148
   - -General Assembly Appropriated $12M to Address Need
   - -Funds Were Allocated to Area Programs Based on Waiting List Data
   - -Collection of Management & Utilization Data

2. **Special Services at Mental Retardation Centers**
   - -Respite
   - -Crisis Intervention
   - -Diagnostic/Therapeutic Admission

CRISIS SERVICES

FY98/99 Appropriations: $10.6M

- Established in FY94/95;
- Develop a System of Services for Individuals in Crisis, Regardless of Disability;
- Decrease Inappropriate Institutionalization of Clients (Oversight/Implementation of State Hospital Diversion Law);
- Assist Local Programs in the Development and Expansion of Crisis Services; and
- Support Local Programs Through Technical Assistance, Coordination Between Area Programs, Funding and Development & Monitoring of Outcome Measures.

CRISIS SERVICES

Crisis Service System Components

- Crisis Prevention - A set of services designed to reduce the incidence of recurring crises.
  -Assertive Community Treatment Teams
  -Family Support & Education

- Crisis Response - A set of services designed to assist with immediate signs and symptoms reduction and safely transition persons in acute crises to appropriate crisis stabilization services.
  -Emergency Transportation
  -Mobile Response Teams
  -24-Hour Crisis Telephone
  -Walk-In Crisis Services

- Crisis Stabilization - A set of services designed to restore persons to be able to function in the community at their best previous level and/or get individual to appropriate long-term care.
  -Medical/Social Detoxification
  -Continuity of Care Case Management
  -Transitional Living Services/Centers
  -Acute Ambulatory Services
  -Inpatient Acute Care & Crisis Follow-up

CRISIS SERVICES

INITIATIVES

1. **Mental Illness/Substance Abuse *Integrated* Treatment Initiative**

   -Began March 1998
   -15 Area Programs Participating
   -Area Programs Implemented One Best Practice Clinical Model
   -Client Tracking & Outcomes Based
   -State Provides Training in Best Practice Crisis Intervention Service

2. **Statewide Best Practice Training**

   -Training & Consultation with Area Programs, Hospitals & Other Providers
   -Extensive Training Schedule

B. Martin

Developmental Disabilities
Waiting List Reduction
March 1, 1999

- January 1, 1998, Area MH/DD/SAS waiting list process revealed 7,178 children and adults with developmental disabilities waiting for service.

- $9.3 million ($6 million state appropriation; $3.3 million TANF transfer) were allocated to the Area Programs in December 1998 using a formula based on numbers of persons waiting in each of the Areas. The commitment was made to use these funds to reduce the number of persons waiting for service by 750 by June 30, 1999.

- The Area Programs were provided technical assistance, consultation and support by the Developmental Disability Services Section and Regional DD Coordinators. Areas are required to report on the utilization of DD waiting list dollars every month with the first report due on February 15.

- The attached is a summary of the information submitted in these first Area reports.

Developmental Disabilities Waiting List Reduction: March 1, 1999

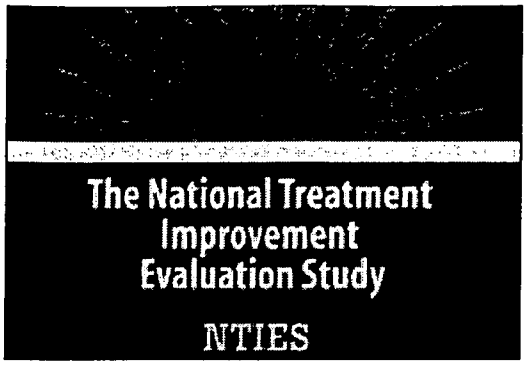
Individuals Removed from the DD Waiting List (Summary)

	Individuals	CAP	State	TANF	Medicaid	Other	TBI	Sum of Services Received	Ave # of Services Received
State Totals	*992	301	247	20	197	393	31	1335	1.5

Individuals Remaining on the DD Waiting List Receiving Services (Summary)

	Individuals	CAP	State	TANF	Medicaid	Other	TBI	Sum of Services Received	Ave # of Services Received	Sum of Additional Service Needs	Ave # of Additional Service Needs
State Totals	384	134	89	6	99	128	20	362	1.3	465	1.2

*Reflects the unduplicated count of persons removed from the waiting list. Each person may have had services funded through multiple sources.
*Data does not include Albemarle.



The National Treatment Improvement Evaluation Study

Fact Sheet

The National Treatment Improvement Evaluation Study (NTIES) is a Congressionally-mandated five-year study of the effectiveness of drug and alcohol treatment programs that received public support in fiscal year 1990-1991 from the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT). Substance abuse treatment clients were interviewed at admission to treatment, when they left treatment, and then at follow-up, approximately 12 months after the end of treatment. Based on the final analysis conducted on 4,411 respondents, NTIES offers evidence that positive outcomes for substance abuse treatment are sustained over time. In-depth analysis of treatment outcomes for specific populations, drugs, and the impact on criminal activity are highlighted below.

NTIES showed that clients served by Federally-funded substance abuse treatment programs were able to reduce their drug use by about 50 percent for as long as one year after leaving treatment.

- Client's use of their primary drug(s) -- the one(s) that led them into treatment -- declined from 73 percent to 38 percent one year after treatment;
- Cocaine use decreased from 40 percent before treatment to 18 percent one year after treatment;
- Heroin use, which most experts believe is the most treatment resistant of drugs, was reduced by almost half, from 24 percent the year before to 13 percent a year after treatment;
- Crack, a drug used by approximately half of the NTIES respondents, showed a significant decrease between the 12 months before and the 12 months after treatment -- down from 50 percent to 25 percent.

For women in treatment, NTIES found the following sustained results one year after treatment:

- Illicit drug use declined by 43 percent. Specifically, marijuana use declined by 53 percent; cocaine use declined by 53 percent; crack use declined by 50 percent; and heroin use declined by 45 percent.
- Primary drug use (the drug cited as the reason a participant entered treatment), including alcohol, declined by 42 percent.
- The number of women troubled by their own alcohol use declined by 65 percent.
- Arrests declined by 67 percent and illegal activities showed large decreases: 82 percent decrease in respondents selling drugs; 88 percent decrease in reported

shoplifting; and an 89 percent decrease in reports of beating someone up.

- Employment increased by 25 percent, with nearly half of the respondents reporting employment. Income rose modestly, up 6 percent, while those receiving public assistance declined by 8 percent.

For adolescents and young adults in treatment, NTIES found:

- Both adolescents and young adults experienced significant reductions in drug use approximately one year after treatment in long-term residential facilities.
- For adolescents, primary drug use declined 22 percent; marijuana use declined 26 percent; cocaine use declined 43 percent; any drug use declined 22 percent; and alcohol intoxication declined 15 percent.
- For young adults, primary drug use declined 45 percent, marijuana use declined 42 percent; cocaine use declined 70 percent, any drug use declined 47 percent, and alcohol intoxication declined 62 percent.

For those clients receiving treatment for marijuana, NTIES found:

- A sustained 45-percent reduction in use by those who chronically used marijuana but not other illicit drugs approximately one year after treatment.
- A sustained 50-percent reduction in use by those who used marijuana with other drugs approximately one year after treatment.
- Every type of treatment (non-methadone outpatient, short-term residential, long-term residential, correctional) produced large and statistically significant reductions in marijuana use.

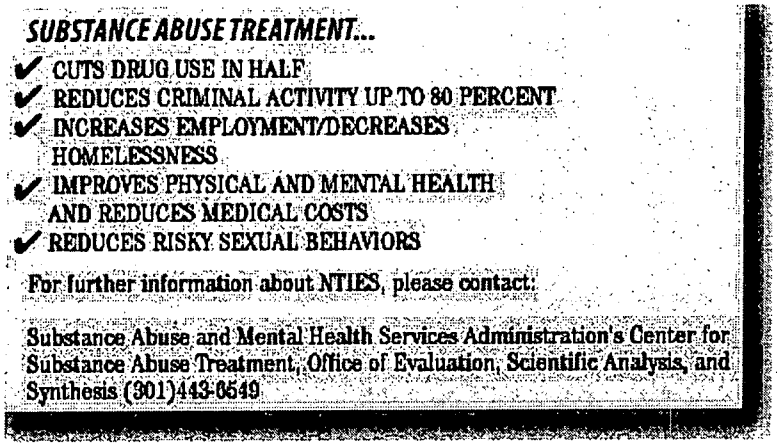
For those clients receiving treatment for cocaine and/or crack, NTIES found:

- A sustained 55-percent reduction in cocaine use approximately one year after treatment.
- A sustained 51-percent reduction in crack use approximately one year after treatment.
- A sustained 47-percent reduction in either crack or cocaine use approximately one year after treatment.
- Every type of treatment (non-methadone outpatient, short-term residential, long-term residential, correctional) produced large and statistically significant reductions in either crack or cocaine use.

Regarding treatment's impact on criminal activity one year after treatment, NTIES found that:

- Selling drugs declined by 78 percent.
- Shoplifting or arrests for shoplifting declined by 82 percent.
- Beating someone up declined by 78 percent.
- Arrests for drug possession declined by 51 percent.

- Arrests for any crime declined by 64 percent.
- Those who reported supporting themselves through illegal activity declined by 49 percent.
- Illicit and risky sexual behavior declined significantly. Specifically, those having sex for drugs/money declined by more than 50 percent, giving drugs/money for sex declined by 50 percent, and having sex with an IV drug user declined by more than 50 percent.



Introduction

The National Treatment Improvement Evaluation Study (NTIES) is a Congressionally-mandated five-year study of the impact of drug and alcohol treatment on thousands of clients in hundreds of treatment units that received public support from the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). The CSAT-commissioned study was conducted by the National Opinion Research Center, University of Chicago, in conjunction with Research Triangle Institute.

The full report provides a wealth of data useful in improving today's treatment programs and in designing new programs to advance treatment in the future. The "Methodology" section, found in the Appendix, contains information about study design and detail about participants.

Who Was Surveyed?

The information reported here was gathered from 4,411 clients from across the country. It includes clients who completed an intake interview and returned for at least a single visit. Since these people did not really become involved in treatment, their inclusion in the study may lower the overall estimates of the success of treatment. Substance abuse is a chronic relapsing disease and the NTIES study reflects that not everyone who enters treatment completes it. The individuals served by CSAT grants were from vulnerable and underserved populations (minorities, pregnant women and at-risk women, youth, public housing residents, welfare recipients, and those in the criminal justice system), and may also have been the most difficult to treat.

NTIES Table of Contents | Introduction | Conclusions | Appendix | NTIES Findings on: Drug and Alcohol Use | Changes in Criminal Behavior | Employment, Income, and Homelessness | Changes in Physical and Mental Health | Changes in Sexual Behavior | Variation in Treatment Outcomes | Costs of Treatment

Conclusions

The National Treatment Improvement Evaluation Study (NTIES) was one of the largest and most rigorous studies of substance abuse treatment ever conducted. In the course of its conduct, the study carefully examined many of the most important issues related to substance abuse treatment and came back with clear, unambiguous answers.

Among the key findings of the NTIES study:

- Clients served by CSAT-funded programs significantly reduced their alcohol and other drug use.
- Treatment has lasting benefits. Significant reductions in drug and alcohol use were still reported a full year after treatment. Reductions were noted regardless of the amount of time spent in treatment or the amount of treatment received.
- Clients reported increases in employment and income; improvements in mental and physical health; decreases in criminal activity; decreases in homelessness; and decreases in behaviors that put them at risk for HIV/AIDS infections, one year after treatment.
- CSAT grants reached their intended clients. Grants made in 1990-1991 distributed approximately $240 million over three years to improve services in more than 430 treatment units serving about 100,000 clients.

NTIES Table of Contents | **Introduction** | **Conclusions** | **Appendix** | **NTIES Findings on:** Drug and Alcohol Use | Changes in Criminal Behavior | Employment, Income, and Homelessness | Changes in Physical and Mental Health | Changes in Sexual Behavior | Variation in Treatment Outcomes | Costs of Treatment

EMBARGOED UNTIL:
10:00 A.M.

Contact: SAMHSA Press Office
(301) 443-5052

Wednesday, September 17, 1997

SAMHSA

National Study Finds Federal Drug Treatment Programs Have Dramatic Impact on Drug Use, Crime and High-Risk Populations

Washington, D.C. -- Hard-to-reach populations enrolled in federally funded substance abuse treatment cut their illegal drug use by nearly half, according to the National Treatment Improvement Evaluation Study (NTIES). It also shows that substance abuse treatment reduced criminal activity among clients; significantly increased employment and decreased homelessness; was linked to a substantial improvement of physical and mental health; and reduced risky sexual behaviors among participants.

NTIES evaluated the impact of drug and alcohol treatment on 4,411 people who participated in programs funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). These programs focused on reaching underserved and vulnerable populations such as minorities, pregnant and at-risk women, youth, public housing residents, welfare recipients, and those in the criminal justice system.

"The study confirms what we have been saying for years -- that federal alcohol and drug treatment programs work and have lasting, positive effects on individuals in critical need of help," said Nelba Chavez, Ph.D., SAMHSA's Administrator. "Clearly, our investment in substance abuse treatment is making a difference in people's lives," she added.

The new findings include:

- Among women in treatment, drug use declined by more than 40 percent for as long as a year after leaving treatment.
- Among young adults, depending on the treatment setting any drug use was reduced by 31 to 47 percent and primary drug use (the drug cited as the reason a participant entered treatment) was reduced by 23 to 45 percent.
- Among the chronic users of marijuana, treatment resulted in a 45 percent reduction in use, and for those who used marijuana in combination with other drugs a 50 percent reduction.
- Among users of cocaine and/or crack, treatment reduced cocaine use by 55 percent and reduced crack use by 51 percent.
- Among those who reported supporting themselves through criminal activity, treatment reduced illegal activity by 49 percent.

"Few people addicted to alcohol or illicit drugs can simply stop using these substances no matter how strong their inner resolve," added Dr. Chavez. "NTIES shows that proper treatment, client support and follow-up services can significantly improve quality of life, strengthen families and increase productivity."

"NTIES obtained information from clients who were interviewed at admission to treatment,

when they left treatment, and then 12 months following the end of treatment," said CSAT Director, David J. Mactas. He added, "we are encouraged by these findings and will use this information in our efforts to identify new approaches and to strengthen existing treatment programs."

The new NTIES findings are being released during "Treatment Works! Month," a joint effort by the National Coalition on Alcohol and Other Drug Issues, the National Association of Alcoholism and Drug Abuse Counselors, and SAMHSA/CSAT. This month-long effort takes place annually in September and is designed to raise awareness about the importance and effectiveness of treatment for substance abusers and to reduce the stigma associated with treatment.

NTIES was commissioned by SAMHSA/CSAT, and was conducted by the National Opinion Research Center of the University of Chicago and the Research Triangle Institute.

SAMHSA is the federal government's lead agency for improving the quality and availability of substance abuse prevention, addiction treatment and mental health services in the U.S., and is a public health agency in HHS. Copies of the report are available via the Internet at www.samhsa.gov or by calling the National Clearinghouse for Alcohol and Drug Information, a service of SAMHSA, at 1-800-729-6686.

###

Agenda for Action

Why does North Carolina need to be concerned with mental health services for children?

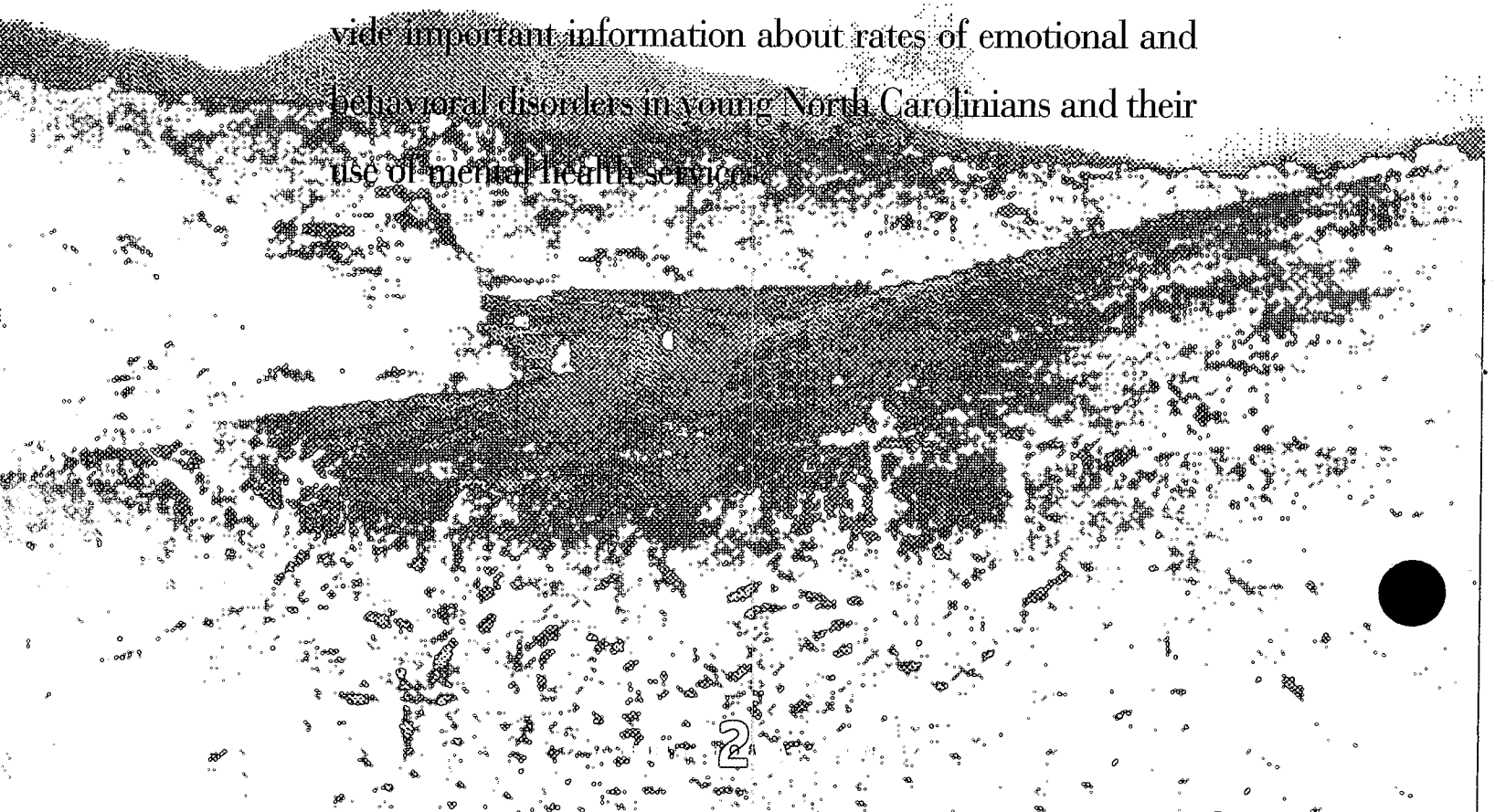
Most of America's children will have relatively normal, healthy childhoods and will grow up to be productive, well adjusted adults. But five out of every 100 children will not. These children, at an early age, will develop an emotional or behavioral disorder that meets the federal definition of *serious emotional disturbance* (SED), which requires both a psychiatric diagnosis and functional impairment.* They will need mental health and other special services, such as special education, not only during childhood but, in many cases, throughout their lives. For them, mental health services are essential. Another group of 20 to 25 out of every 100 children will develop a less severe emotional or behavioral problem that can resolve with proper care, but they run the risk of disabling mental health problems as adults. ***It is this in-between group of vulnerable children for whom timely and appropriate mental health intervention can make a real difference in long-term outcome.*** Yet only about one in four children with a moderate or serious emotional or behavioral problem has seen a mental health professional in the past year.

How can North Carolina make informed mental health policy decisions?

Rates of childhood emotional and behavioral disorders in North Carolina mirror those observed nationally, based on studies conducted to date; and the state, to its credit, has been a national leader in comprehensive and coordinated mental health services for children. Nonetheless, current, accurate local-level information can help North Carolina take this enlightened policy to the next level of excellence, providing tangible benefit to the state's children, from birth to age 18, while continuing to set a national example.

An important program of research, the *Duke Developmental Epidemiology Program*, is currently under way in North Carolina to evaluate mental health service needs and use in an ethnically diverse sample of the state's children. The *Great Smoky Mountains Study*, which is summarized in this report, is the first component of this research program to yield findings. These findings can assist the state to respond to the mental health needs of its children.

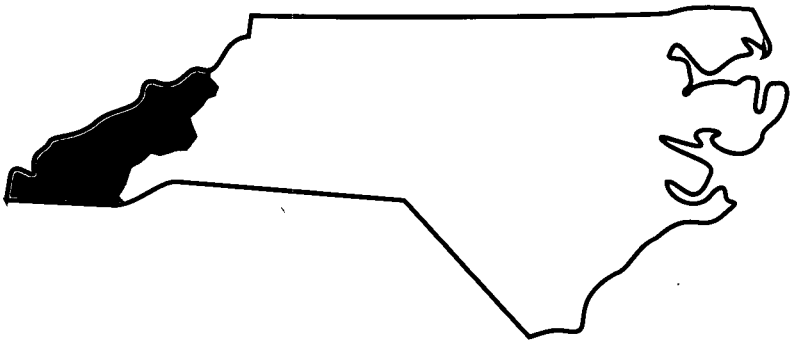
The *Great Smoky Mountains Study* (GSMS) is a longitudinal, population-based community survey of children and adolescents in North Carolina funded by the National Institute of Mental Health. The study is a collaboration between *Duke University* and the *North Carolina State Division of Developmental Disabilities, Mental Health, and Substance Abuse Services*. It began in 1992 and will continue until 2003. The findings from GSMS will provide important information about rates of emotional and behavioral disorders in young North Carolinians and their use of mental health services.



What are the study's goals?

Among the *goals* of the Great Smoky Mountains Study are to *estimate* :

- The number of children with emotional and behavioral disorders
- The number of new cases of such disorders that develop in children each year
- The persistence of emotional and behavioral disorders in children and adolescents over time
- The need for and use of services for emotional and behavioral disorders
- The effects of family income, health insurance, and other related factors on service use
- Which children are most at risk for emotional and behavioral disorders
- Which children are most at risk for bad outcomes (school dropout, teen pregnancy, encounters with the criminal justice system, etc.)



Who is participating in the Great Smoky Mountains Study?

The participants in the Great Smoky Mountains Study are:

- 1,073 children aged 9 through 16, and their parents, from 11 counties in western North Carolina (8.1% of the children are African-American, which is consistent with the proportion of African-Americans in the counties surveyed). These counties include both urban and rural areas. Children were selected on the basis of a screening questionnaire completed by the child's parent. All children scoring above a predetermined point on questions about behavioral problems were invited to participate in the study. A random one-in-ten sample of children scoring in the normal range was also recruited. Eighty percent of invited families agreed to participate.
- 349 children who are enrolled members of the Eastern Band of the Cherokee Nation (80% of families with a child in the study's age group)
- All agencies providing child mental health services in the 11-county area

Participating Counties

Buncombe

Cherokee

Clay

Graham

Haywood

Jackson

Macon

Madison

Mitchell

Swain

Yancey

How is the study being conducted?

Starting in 1992, each child in the Great Smoky Mountains Study, and one of his/her parents, is visited once a year by trained interviewers for a face-to-face interview using structured evaluation instruments. Between these annual interviews, each child and family has received a telephone follow-up call once every three months. In addition, three teachers have completed questionnaires about each child. The study also includes a comprehensive study of mental health service providers working in schools, social services, juvenile justice, and child welfare, as well as those working in specialty mental health settings.

Children and their parents are interviewed using instruments that evaluate the child's symptoms of behavioral and emotional disorders, physical health, and development. These instruments seek to answer the following questions:

- Does the child meet diagnostic criteria for a specific emotional or behavioral disorder?
- Does he or she exhibit impaired functioning (inability to function in developmentally appropriate ways at school, at home, and with peers)?
- Does he or she need mental health services?

Federal guidelines define children to be suffering from *serious emotional disturbance* (SED) if they have a psychiatric diagnosis that impairs their ability to develop and function normally at home, at school, or in their relationships with others. Since many federal agencies target their services specifically to these children, North Carolina has also adopted this definition of urgent need for mental health care.

The GSMS also evaluates the following:

- Family psychiatric history
- Impact of the child's illness on the family
- Impact of family resources, including health and mental health insurance, on service use
- Services sought and received for the child's disorder
- Access and barriers to this care

A *distinguishing characteristic* of the Great Smoky Mountains Study is that *service use is linked to mental health problems*. The study is evaluating how children use services in five sectors:

Mental health
psychiatric hospital, psychiatric unit in a general hospital, residential treatment center, group home, partial hospitalization, therapeutic foster care, mental health center, detoxification unit, outpatient drug/alcohol clinic, case management, private mental health professional

Education
guidance counselor/school psychologist, special schools and classes

Health
family doctor/other non-psychiatric physician, community health center, medical inpatient unit, hospital emergency room, nontraditional healer

Child welfare
social services counseling, therapeutic foster care, child protective services

Juvenile justice
detention center/jail, probation officer/court counselor

Mental health resources in the study area

It is important to note that the 11 counties participating in GSMS are served by a relatively well developed service system. The area comprises two public mental health authorities: the Blue Ridge Area Program and the Smoky Mountain Area Program. Both programs are recognized throughout the state for their comprehensive, up-to-date services for children and their families. From 1989 to 1994, these programs were among seven sites across the nation that participated in the Robert Wood Johnson Foundation's Mental Health Services Program for Youth. This program contributed resources to local communities to enrich the availability of community-based programs and also emphasized interagency collaboration. As a result, the area programs improved, solidified, and formalized their relationships with other agencies serving children in an effort to *actively implement the principles of a system and continuum of care*. All of this was already well under way when the Great Smoky Mountains Study began.

TRAVIS:
The need for services

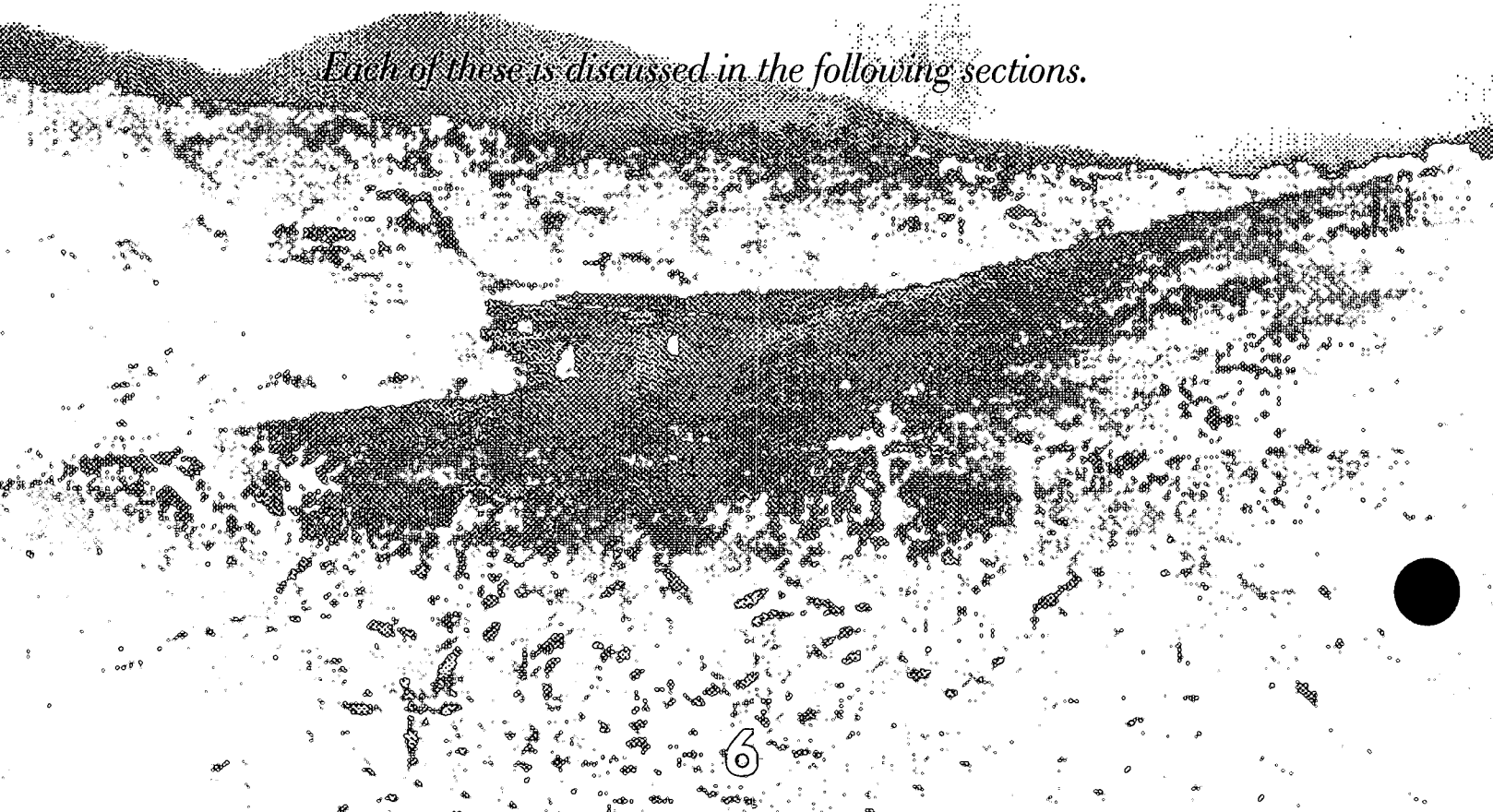
Travis, age 10, has a variety of behavioral and emotional problems. He was eight when his parents divorced and, since then, has moved back and forth between them with no consistency. While with his father, he was repeatedly taken to an outbuilding and raped by teenage boys in the neighborhood. At one point, Travis set a fire that burned down the trailer in which his family was living. Travis is currently living with his mother, stepfather, and sisters. He shows a range of behavior problems that make people afraid to be around him. His older sister tried to commit suicide, and his younger sister has a neurological disorder. Travis knows he has problems but cannot control his behavior. This upsets him because he wants people to like him. Travis's mother knows her family needs help and is trying to identify and use those health and social services for which her family qualifies. However, she has difficulty negotiating the "red tape." This family continues to participate in the Great Smoky Mountains Study because the mother believes participation will help her get the services she needs for her children.

All vignettes included in this report are composites o several actual cases created for illustrative purposes.

The Great Smoky Mountains Study has provided policy-relevant information in the areas of:

1. need for mental health services,
2. risks for emotional and behavioral disorders,
3. outcomes of serious emotional disorders,
4. use of mental health services across sectors, and
5. effectiveness of mental health care.

Each of these is discussed in the following sections.



How many children need mental health services?

- Most children will *never* need professional mental health care: In each year of GSMS, seven children out of ten (70%) *had no diagnosable emotional or behavioral disorder.*
- Another 25% had *moderately severe*, though still distressing, disorders.
- The remaining 5% of children have serious emotional or behavioral disorders (SED) accompanied by *marked impairment* in ability to develop and function normally at school, at home, or with peers.
- Among the children with SED,

  70% have a disruptive behavior disorder

  27% have an anxiety disorder

  20% have a depressive disorder

  16% have a substance use disorder

  13% have attention deficit hyperactivity disorder (ADHD)

  4% have tic disorders

  2% have an eating disorder (anorexia or bulimia)

  1% are encopretic

  41% have more than one of these disorders
- African-American and Indian children have rates of disorder and comorbidity similar to those of white children.
- Rural and urban children have similar levels of need for mental health care. . .

What puts children at risk for serious emotional disturbance?

The risk of SED increases with the number of *family stress factors*. Compared with children with mild or no emotional or behavioral disorders, children with SED had one or more of these stress factors in their lives:

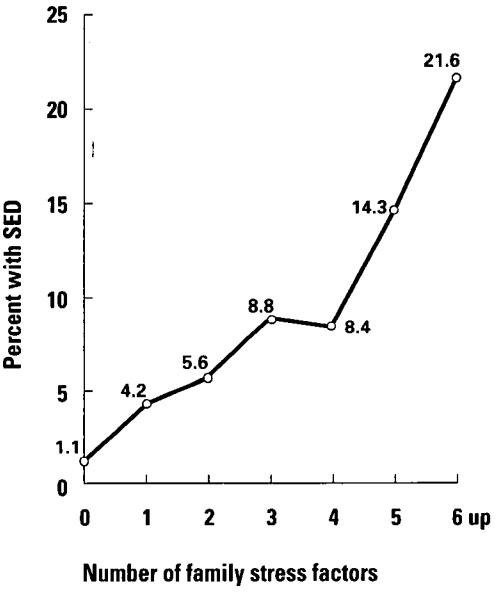
- Twice as likely to be living in poverty (40% versus 22%)
- 40% more likely to have a parent who has been arrested (17% versus 12%)
- 50% more likely to have a parent with a drug or alcohol problem (11% versus 7%)
- Three times as likely to have a mother who is depressed (18% versus 6%)
- 25% more likely to have a parent who did not finish high school (42% versus 32%)
- Nearly three times as likely to have a poor relationship with his/her parents (49% versus 17%)
- Nearly twice as likely to have witnessed physical violence between parents (13% versus 8%)
- Nearly twice as likely to have one or both parents unemployed (17% versus 9%)
- 50% more likely to come from a family other than one with two biological or adoptive parents (77% versus 50%)

Among children living with six or more stress factors, one in five has SED. This is *forty times* the rate of SED in children with no stress factors.

SED was slightly more common in boys, children over 12, and African-American or American Indian children. However, these differences were small, with one exception: by age 15, substance abuse was increasing faster among American Indian youths than in other groups.

Figure 1.

How family stress factors increase risk of SED



Family stress factors:

Parent with less than high school education

Unemployment

Poverty

Family mental illness

Parental drug or alcohol problems

Parental criminal conviction

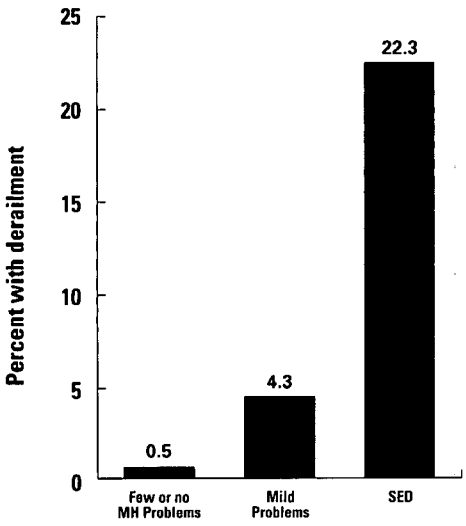
Violence between parents

Poor relations with children

Mother depressed

Figure 2.

How mental illness increased risk of "derailment"



Types of derailment

School dropout

Expelled from school

Unplanned teen pregnancy

Convicted of a crime

Drug or alcohol abuse

How well do children with mental health problems cope with daily life?

Without guidance and support, children can be "derailed" in their path to healthy adulthood. For example, they can:

- Be expelled from school
- Drop out of school
- Become pregnant
- Be convicted of a crime
- Begin using alcohol and illicit drugs

Most young people successfully avert such derailments. Children with few or no mental health problems were highly unlikely to experience such a derailment (only one in 200 did so). The rate was 4.3% in children with mental health disorders without functional impairment but rose to *22.3% of children with SED* (Figure 2). Thus, childhood SED had long-term educational, legal, and reproductive consequences that could seriously affect children's futures and their adult lives.

The risk of derailment among children with less severe disorders, while lower than in SED youths, was still eight times that of healthy children (Figure 2). ***Efforts to reduce risk in this group could have a substantial impact on outcomes for adolescents because they make up 20% of the population.***

Does mental health treatment work?

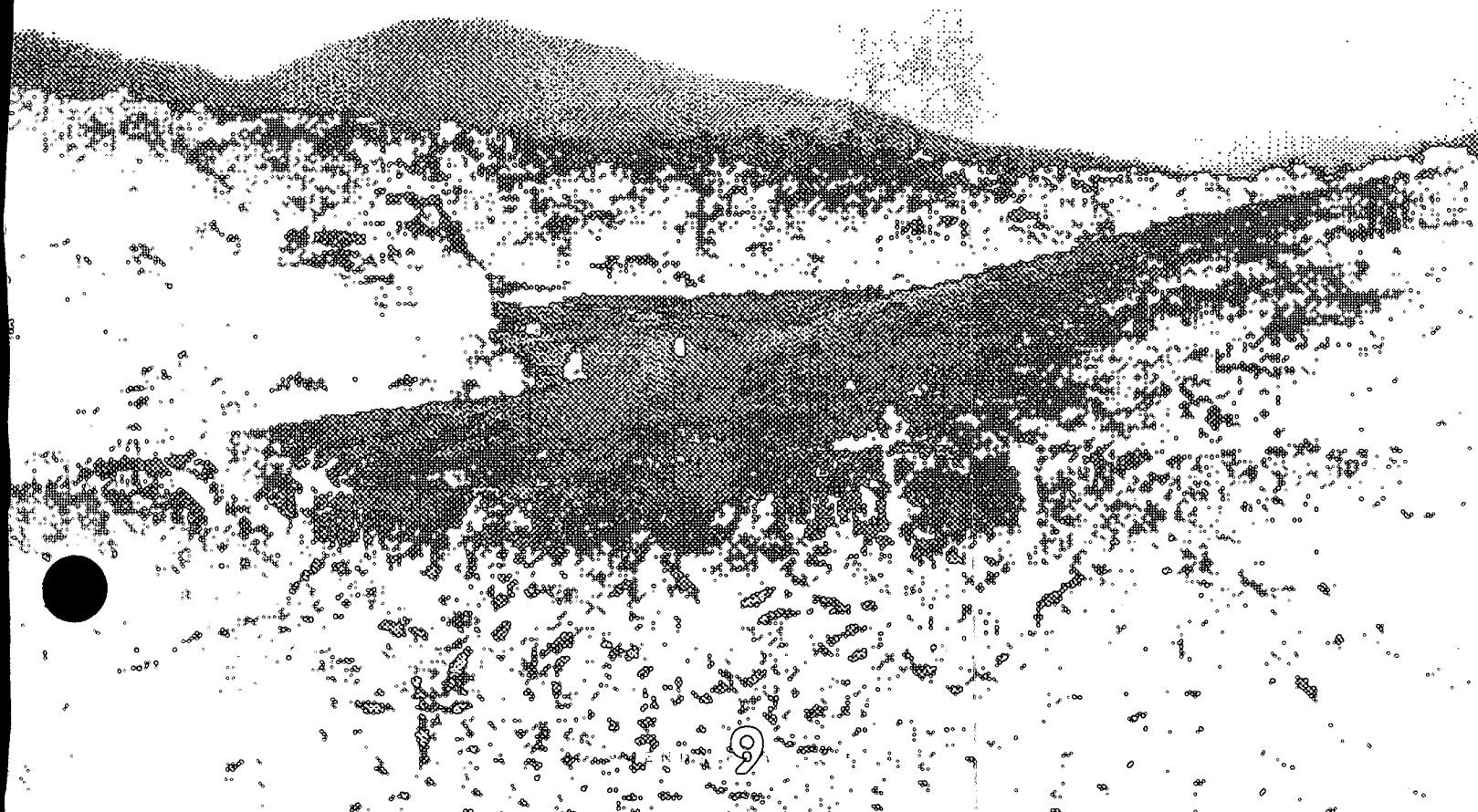
The Great Smoky Mountains Study is one of t first studies nationally to look at whether treatment in community mental health settings improves children's mental health. Those children whose symptoms were getting worse between assessments, that is, those children who clearly needed help, were identified and followed for another year to see who would receive treatment and whether this treatment would have an effect a year later. Outcomes examined included emotional and behavioral problems, functioning at school and home, and impact on parents.

- Compared with untreated youths, those who had nine or more sessions with a mental health professional had *significantly fewer emotional and behavioral problems* following treatment.
- Children receiving fewer than nine sessions of treatment showed no improvement.
- The more treatment children had (about nine sessions) the fewer symptoms were displayed a year later, demonstrating a *dose–response effect* for treatment.

These findings suggest that, given adequate treatment (at least nine sessions on average), children's emotional and behavioral symptoms showed a marked improvement over a year. However, a year may be *too short a time* to see a marked improvement in functioning at school or at home in seriously disturbed youths. Serious problems require serious intervention.

In a climate of shrinking mental health benefits, it is important to know what mental health services children use, how long they stay enrolled in services, how much service they receive, and what helps and hinders their use of services. These data can then be used to ask the questions:

1. Are children who need mental health care getting it?
2. Does insurance lead to overuse by children with low need?



How many children and adolescents need mental health services?

The Great Smoky Mountains Study divided participating children and adolescents into three groups based on *level of need*

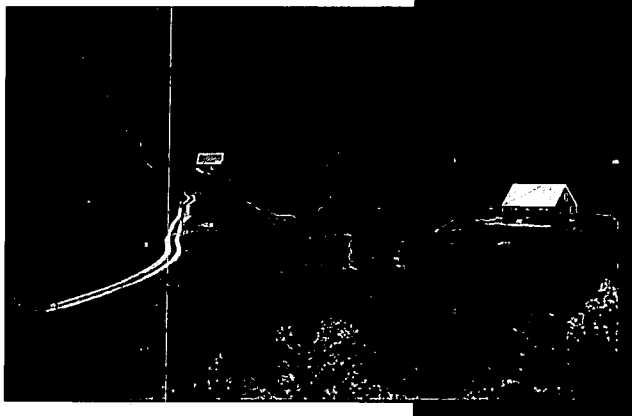
- **High need** children, defined as SED (seriously emotionally disturbed), had both a psychiatric diagnosis and impaired functioning. This group made up 5% of the sample in any one year, and 10% over the course of the study.
- **Moderate need** children had either a diagnosis or impaired functioning but not both. This group made up 25% of the sample in any year, and 45% over the course of the study.
- **Low need** children had neither a diagnosis nor impairment at their annual assessment but might have some symptoms. They made up 70% of the sample in any year, and 45% over the course of the study.

Results from GSMS to date have shown the following:

- Every year, *only one in five children with a diagnosable disorder saw a mental health specialist* (psychiatrist, psychologist, psychiatric social worker).
- In the course of a year, *70% of the children with SED had received some mental health services from one or more agencies serving children* (mental health, pediatric primary care, schools, child welfare, juvenile justice).
- However, *only two in five SED children received care from a specialty mental health agency.*

How do children get to a mental health care provider?

One key to children receiving services is *parental recognition* of an emotional or behavioral problem in the child or adolescent. Parental recognition of the child's problem is more likely when the problem impinges on the parents' life. Parental recognition that a child with SED had a problem was associated with a *doubling of the rate of mental health service use* (from 20% to 40%) in the study. Children's problems could affect parents in many ways: they could be forced to give up work, to have to take a lower-paying job, or to work fewer hours. Children's problems could cause friction or breakdown in relations with spouses, children, family, or friends. Some parents became depressed or felt shame or embarrassment because of their child's behavior, which led some to seek mental health treatment for themselves. In other words, parents' help-seeking for their child's problems was often driven by problems of their own.



EVELYN:

School as a source of mental health care

Evelyn, age 14, has been diagnosed with manic depressive disorder and regularly has auditory hallucinations of a male voice similar to her father's telling her that she is "no good." She also has flashbacks to age five when her father beat her for spilling her milk. Evelyn has made several suicide attempts, none of them life-threatening and all in conjunction with an episode of illness. She began drinking at age 12 and has already undergone rehabilitation for her alcohol problem. Evelyn currently liv with her mother and brother; she no longer sees her father. Evelyn's mother, who is highly stressed herself, is concerned enough about her daughter to have sought help for her, and Evelyn sees both an outpatient therapist and the guidance counselor at her school.

Where do children and adolescents typically receive mental health services?

Data from the Great Smoky Mountains Study have yielded findings regarding use of various service sectors that should be of great interest in planning future mental health services for the state's youths.

- Over the course of a year, 40% of children in the study received some type of mental health service, though not necessarily from a trained mental health professional.
- *School counselors and psychologists* provided mental health services to more children than did any other mental health professionals. More than *75% of children receiving mental health services* were seen in the education sector. For many children, the education sector was *the sole source of care.*
- Twelve percent of children received services from the *specialty mental health sector*, most via a public mental health center or private professional.
- The *general medical sector* provided mental health-related services to only 6% of youths in the study, mainly the younger ones. For most (89%), such services were provided by the child's primary physician.
- In-home services, partial hospitalization, and specialized substance abuse services were used rarely.
- Older children were less likely to use school mental health services and more likely to be seen in the juvenile justice sector.
- Overall, 50% of children who used services during the year received services *from only one agency.* One in four used two agencies, and the rest used three or more. More than 50% of children who used only one agency received their services through the *education system.*

Use of both outpatient and inpatient services was dramatically influenced by *level of need.* Thus, Figure 3 shows that although youths with SED were only 5% of the population, they made up over a quarter of those using specialty mental health and school guidance services and almost half of those seen in the juvenile justice system.

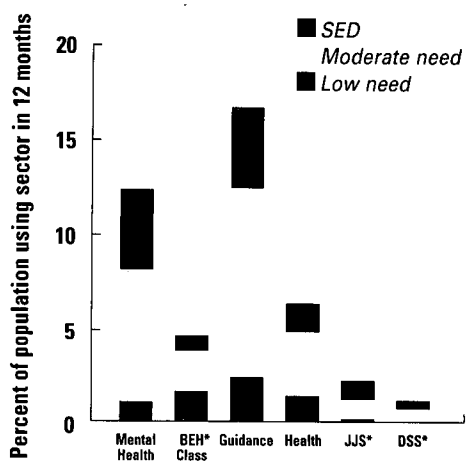
High need youths also tended to use multiple services, as shown in Figure 4. Although they are only 5% of the population in any year, four out of five youths with SED use services, and half use services in two or more sectors.

The great majority of mental health service use occurred in outpatient settings, including day hospitals, drug/alcohol clinics, mental health centers, and private mental health professionals.

The role of the specialty mental health system was greatest for children with the most severe problems. Moreover, the care of children with severe problems tended to involve multiple agencies, particularly the school and mental health agencies, pointing to the importance of *coordination across agencies.*

Figure 3.

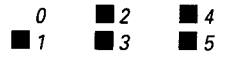
Role of the major sectors in providing mental health services to children by child's clinical status

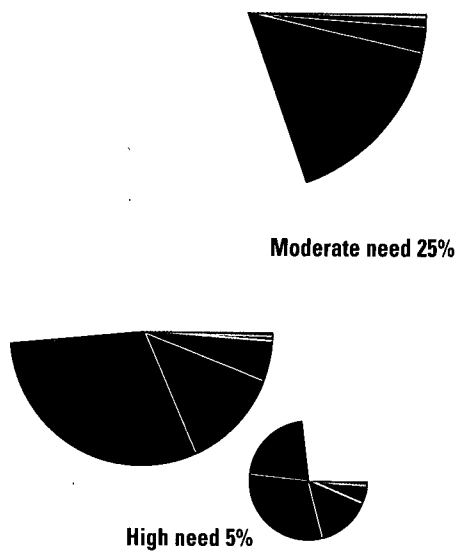


DSS Department of Social Service
JJS Juvenile Justice Services
BEH Class for behavioral or emotional problems

Figure 4.

Number of service sectors used in one year by low, moderate, and high need children





How persistent and intense is service use?

Persistence of service use refers to the *continuation in service across time*. There was a complex pattern of movement into and out of services across the year in the Great Smoky Mountains Study. Fewer than 10% of children persisted in service use for more than three months at a time. However, many came back into the system after a year or two.

In the Great Smoky Mountains Study, *intensiveness* referred to the level of service provided by a particular agency. In general, children who received highly intensive service were the exceptions. For example, fewer than 2% of children received out-of-home placements in any year. Of those who did, 50% were in such placements for fewer than five days, and only 15% were in such a placement for more than a month.

No children with low need received out of home placements, but 15% of youths with SED spent at least one night away from home in a treatment setting in the course of a year, compared with 3.6% of moderate need youths. But only 1% of moderate need youths spent more than a week out of home, compared with 10% of SED youths. The average annual out-of-home stay was half a day for moderate need youths, compared with four days for SED youths.

Persistent service users were more likely to be *older* and to come from families with *less education*, with *incomes below the federal poverty line*. Persistent service users had more emotional and behavioral problems, and their families suffered *high levels of economic, social, and psychological hardship*.

Who pays for services?

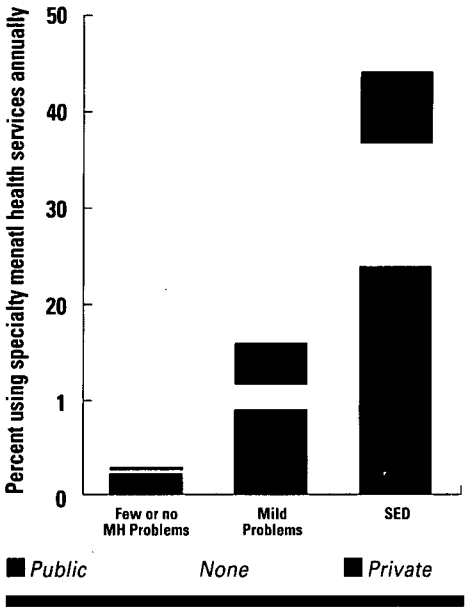
In the Great Smoky Mountains Study, 70% of families had private insurance, 19% had public insurance (Medicaid), and 11% had no insurance, closely resembling the distribution for the entire state. For those families with private insurance, 18% of plans offered full mental health coverage and 58% offered partial coverage. Typical benefit packages under private insurance were 20-30 outpatient visits with a 50% co-payment and 30-60 days of psychiatric hospitalization.

Key findings related to insurance status and use of mental health services include the following:

- Service use was driven more by *level of need* than by insurance status. Among high need youths, about two in ten received some mental health care regardless of insurance type. Fewer than one in five youths with moderate need, and only 2% of low need youths, received specialty mental health care.
- Given need for care, *public insurance (Medicaid)* increased service use more than private insurance. Although uninsured and publicly insured youths were only 30% of the population, they made up half of all children with SED receiving specialty mental health care.
- Almost no children with low need and public or no insurance received specialty mental health care. **Public insurance did not lead to unneeded access to mental health services.**

Figure 5.

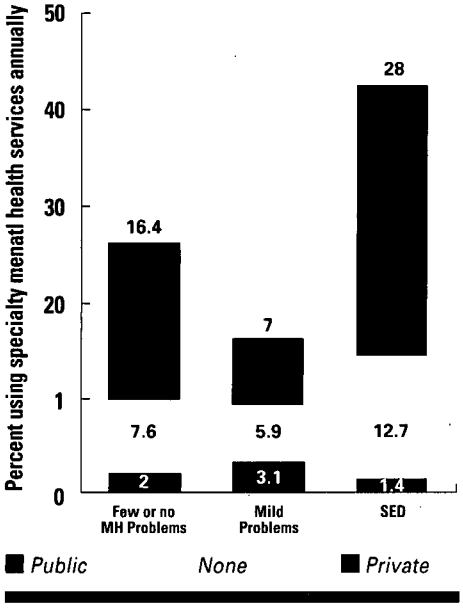
Impact of health insurance on likelihood of one or more mental health visits by level of need



- Relatively few privately insured youths received any inpatient care, *regardless of level of need*. For youths with public insurance, there was a strong positive relationship between level of need and receipt of inpatient care. The number of outpatient visits was also strongly associated with level of need, with high need youths receiving the most visits within each insurance group. Nonetheless, even children with high need received mental health care at low rates, particularly children *with private insurance*, suggesting *limited treatment once contact with the service system occurred*. This is worrisome when taken in conjunction with the findings cited earlier, that only youths receiving nine or more visits showed significant improvement a year later.

Figure 6.

Mean number of specialty mental health visits in one year, by health insurance and level of need



Uninsured youths in the Great Smoky Mountains Study fared as well as privately insured youths, in part due to the availability of "free" or "no cost" services provided by public mental health services. However, uninsured children and families were characterized by high rates of poverty, family histories of mental illness for all levels of need, and high family burden—thus, a group with multiple needs for service use.

To summarize, in the Great Smoky Mountains Study area, even with relatively advanced child mental health services systems and generous Medicaid benefits, *only 44% of youths with SED received professional mental health care at any time during a two-year period.* SED children with Medicaid were better served than children covered by private insurance or no insurance, especially in terms of the volume of services received. The reason for the difference was not due to the high level of services provided to Medicaid patients but to the *very low level of services provided to privately insured and uninsured children.* Since uninsured children had a high level of need for care, this last group is particularly disturbing.

How has North Carolina's Medicaid waiver affected service provision?

In North Carolina, child mental health services have been managed in ten pilot areas under a Medicaid waiver since 1994. A study by the Duke Developmental Epidemiology Program has looked at the impact of a Medicaid carve-out pilot, Carolina Alternatives (CA), on mental health service use, service setting, and cost. Carolina Alternatives is public sector-managed with a single portal of entry into services and a phase-in of full risk after two years. The two Area Mental Health Programs covered by GSMS were included in the CA study.

Overall access to and volume of mental health and substance abuse services increased over the study time period (1992-1996), although substantial variation by service type occurred. A strong shift from inpatient to alternative treatment and outpatient services was observed. Intensive services (group homes, therapeutic foster care, partial hospitalization), which could potentially serve as an alternative to inpatient care, were developed or their capacity increased over the study period. Use of these alternative services increased until 1995 (by 150% in the Great Smoky Mountains sample) but began to decline when Area Programs assumed full fiscal risk.

Changes in costs between 1992 and 1996 were reflected in a dramatic reduction in inpatient costs and a corresponding increase in outpatient costs from roughly one-third to over one-half of Medicaid costs (with one-third of costs being in alternative treatments). The costs per eligible enrollee increased across CA sites until 1995 and then declined in 1996, an indication of the transition to full risk and a reduction in the capitation rates that occurred in 1996. Mean capitation rates increased from $321 to $532 between 1992 and 1995, then declined to $395 by 1996.

This first longitudinal examination of public sector-managed mental health and substance abuse services for children on Medicaid with significant mental health need (more than 20% with SED) reveals overall success in achieving the goals of CA. The pilot demonstrates that institutional care can be dramatically reduced while increasing access to community-based services and continuing to provide a substantial volume of intensive, community-based care. After initial increases, costs appear to have stabilized with full risk, but further years of observation are needed to confirm this trend.

The Great Smoky Mountains Study has produced several important findings related to mental health service utilization and financing in children and adolescents that may be relevant as the state sets future health care policy.

- *Serious emotional disturbance* is strongly related to use of any mental health services.
- The family's *history of psychiatric illness* is among the most consistent and powerful predictors of use of mental health services. Others include *poverty* and *the impact of the child's mental health problems on the family*.
- Service use is much more likely to occur with *public insurance coverage* (Medicaid) than either private or no insurance.
- Considerable unmet need was observed even for youths with SED.
- School-based counseling services potentially substituted for professional mental health services.
- Current services provide only minimal care for most children, even those with SED.
- There was little *unnecessary use* of mental health services in the low need group.

The findings of multiple sector use, particularly in high need youths, in the Great Smoky Mountains Study reinforce the importance of *interagency relationships* between specialty mental health and other child-serving sectors. Relatively few children received services solely from the specialty sector. Rather, specialty mental health was a common provider for children who received services from multiple sectors. This finding suggests that coordination, *particularly with schools*, is crucial for the provision of services.

How can the state respond to unmet need in a cost-effective way?

A number of factors must work together to achieve positive outcomes for children with emotional and behavioral disorders. Among them are principles of care, adequacy of the service system, including, quality of treatment, and child and family preferences.

Principles of care that currently guide both public and private sector mental health service delivery include:

- *Individualization* of services based on the specific needs of the individual child and family
- Involvement of the *child's family* as a partner in treatment
- Provision of services in *community-based settings* rather than in institutions
- Provision of service in the *least restrictive setting* to normalize and mainstream the child and his/her experiences as much as possible
- Services that are sensitive to *ethic and cultural values*

A number of questions directed toward the service system address its overall adequacy:

- Is the full continuum of care in place?
- Are the services provided ones with evidence-based, demonstrable effectiveness?
- Are the resources in the continuum sufficient to meet the needs of the population?
- Are mental health services coordinated with those provided in other human services sectors?
- Are families involved in service planning and delivery?
- Are services provided in a timely and flexible manner?

When these questions can be answered in the affirmative, North Carolina's children and adolescents will be more likely to get the care they need for emotional and behavioral disturbances. However, in evaluating the effectiveness of such a service system, it is important to keep three assumptions in mind:

- *Treatment is a process, not an event.* Children with persistent (chronic) conditions need a range of treatment interventions over time.
- *Outcomes are affected by a larger world than formal treatment.* Thus, it is not sufficient to assess mental health specialist services only; inclusion of other sectors and informal services is also essential. The role of schools in service provision has been well demonstrated in the Great Smoky Mountains Study.
- *Outcomes will vary with the type and stage of treatment and the child's developmental status.* Thus, it is important to assess both short- and long-term outcomes.

The high proportion of mental health care provided to North Carolina's children and adolescents through the education sector raises a question about the potential of school personnel with limited mental health expertise to respond adequately to the clinical needs of emotionally and behaviorally disturbed youths. This concern is underscored by the high rate of seriously emotionally and behaviorally disturbed children seen only in the education sector and suggests a need to *improve the linkages between schools and mental health centers*. Mental health advocates are pursuing federal legislation to strengthen school-based services for the entire child population as well as for children identified as seriously emotionally disturbed. North Carolina is in the process of following this lead by adding mental health services to school-based health clinics. The state should be commended for this effort.

Recommendations for Action

Results to date from the Great Smoky Mountains Study suggest that North Carolina can take a number of steps to improve state-wide mental health services to children and adolescents and to sustain this improvement over time. Recommendations for consideration include the following:

- Increase *professional mental health resources in the schools*, where children can easily take advantage of them. Develop and expand models for area health programs to deliver services in schools.
- Adopt *standardized assessment methods and instruments to examine children for early detection of SED* and access to services. Such instruments can be utilized in real-world settings by child welfare workers, disability examiners, school psychologists, and other mental health care providers.
- Take active steps to enhance *interagency relationships* between specialty mental health and other child-serving sectors, particularly schools.
- Incorporate *need for services* into policy as the criterion for use of psychiatric benefits instead of arbitrary benefit limits.

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

March 9, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amy Jo Bain	NCMS
Roger Bone	Bone + Assoc - NCALTF
[illegible]	NC. Food Banks
Stacy Flannery	NC Health Care Facilities Assoc
Shamese Ramone	DSS
Terry Stelle	DMHDDSAS
John Baggett	"
Allyn Guffey	DHHS
Jim Edgerton	DHHS
DAVE BRUTON	DHHS
Patrick Ruely	NCACC
Doug Baker	DMH/DD/SAS

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

March 9, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Flo Stein	DMH/DD/SAS
Lenore Bohan	DMH/DD/SAS
Mary Eldridge	DMH/DD/SAS
ART ECCLESTON	DMH/DD/SAS
NELS ROSELAND	OSBM
Janice Petersen	committee on substance abuse TX & prevention
Spence Clark	DMH/DD/SAS
Harlen Scott Robbins	DMH/DD/SA
Lisa Abatemarco	OAHS/BP&A
Ann Willis	DMH DD SAS
John Bowdish	Zeb Alley P.A.

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

March 9, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Peggy Balak	Thomas S. Services MH/DD/SAS
Jim Jarrett	Thomas S. Services MH/DD/SAS
Ann Schwindaman	NC Council of Community Programs
Charles Davis	Willie M - MHDDSHS
Lou Wilson	NCALTCF.
Helen Lipman	Meck. Co. DSS
Anna Tefft	OSBM
Pam Richardson	OSPL
Wayne Williams	OSBM
Marian Hartman	DD Council
Dave Richard	The Arc/NC

AGENDA

Joint Subcommittee on Health and Human Services Appropriations

Legislative Office Building - Room 424
Wednesday, March 10, 1999
2:30 p.m.

Opening Remarks	Sen. Bill Martin, Co-Chair Rep. Beverly Earle, Co-Chair Rep. Edd Nye, Co-Chair
Division of Mental Health, Developmental Disabilities & Substance Abuse Services	Karen Hammonds-Blanks Fiscal Research Division
Adjourn	

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
March 10, 1999
2:30 PM

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Wednesday, March 3, 1999, at 2:00pm in Room 424 of the Legislative Office Building.

House Chairman, Representative Edd Nye presided. Other House members present were Representative Beverly Earle (Co-Chairman), Representative Alma Adams, Representative Lanier Cansler, Representative Trudi Walend, and Representative Gene Wilson. There were six senators present.

Representative Edd Nye chaired and after introducing the Pages, recognized Ms. Karen Hammonds-Blanks to present to the committee. Ms. Hammonds-Blanks discussed the handout "National Treatment Improvement Evaluation Study." (Attachment #1) She continued with the discussion from previous meeting on substance abuse services.

Senator Purcell asked for explanation on regulatory unit, who does it and how it is done. Ms. Flo Stein from the department answered that the regulatory unit of the division office is designed to regulate and manage the NC version of the US Control Substance Act. There was a discussion by several members and department staff concerning controlled substances being purchased by an individual from several different doctors and getting assessments on these controlled substances.

Senator Phillips asked the difference between price range to keep detox and medical patients, and also level of problem for 24 -month program. He asked if there is a shorter program and do they have any success with it. Flo Stein stated there are all levels of programs and that the 24 month program is for people who have had multiple treatment and problems with the criminal justice system, and mental health disorders.

Senator Dannelly asked about the difference in cost of bed for private sector and ones reserved for prison beds. Ms. Hammonds-Blanks stated that there is a difference and will get the cost information for him.

Senator Martin questioned the inadequacy of facilities assisting women with children. Department staff stated that at the Walter Jones facility, women can have children on campus and pointed out this is the only facility to serve deaf patients.

Senator Forrester asked if the facilities could have their names changed to be called hospitals. Dr. John Baggett said they can consider doing that.

Senator Martin asked for figures on percent of people committed voluntarily. Flo Strin stated she will get this information. Senator Martin also noted there are no state funds dedicated for prevention and requested information on what other states are doing in this area.

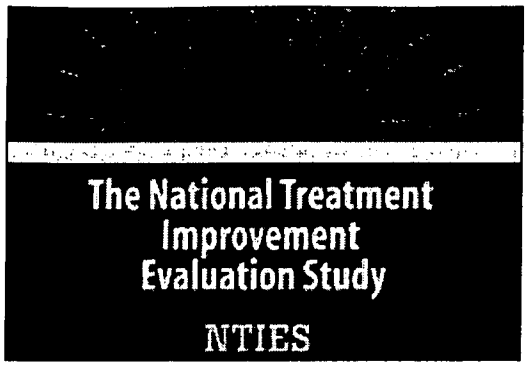
Senator Kerr asked who finances the DARE program. Flo Strin responded DARE funds are $275,000 federal dollars, and they do not have comprehensive enough study.

Representative Nye adjourned the meeting at 3:45.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbitt
Committee Assistant



The National Treatment Improvement Evaluation Study

Fact Sheet

The National Treatment Improvement Evaluation Study (NTIES) is a Congressionally-mandated five-year study of the effectiveness of drug and alcohol treatment programs that received public support in fiscal year 1990-1991 from the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment (CSAT). Substance abuse treatment clients were interviewed at admission to treatment, when they left treatment, and then at follow-up, approximately 12 months after the end of treatment. Based on the final analysis conducted on 4,411 respondents, NTIES offers evidence that positive outcomes for substance abuse treatment are sustained over time. In-depth analysis of treatment outcomes for specific populations, drugs, and the impact on criminal activity are highlighted below.

NTIES showed that clients served by Federally-funded substance abuse treatment programs were able to reduce their drug use by about 50 percent for as long as one year after leaving treatment.

- Client's use of their primary drug(s) -- the one(s) that led them into treatment -- declined from 73 percent to 38 percent one year after treatment;
- Cocaine use decreased from 40 percent before treatment to 18 percent one year after treatment;
- Heroin use, which most experts believe is the most treatment resistant of drugs, was reduced by almost half, from 24 percent the year before to 13 percent a year after treatment;
- Crack, a drug used by approximately half of the NTIES respondents, showed a significant decrease between the 12 months before and the 12 months after treatment -- down from 50 percent to 25 percent.

For women in treatment, NTIES found the following sustained results one year after treatment:

- Illicit drug use declined by 43 percent. Specifically, marijuana use declined by 53 percent; cocaine use declined by 53 percent; crack use declined by 50 percent; and heroin use declined by 45 percent.
- Primary drug use (the drug cited as the reason a participant entered treatment), including alcohol, declined by 42 percent.
- The number of women troubled by their own alcohol use declined by 65 percent.
- Arrests declined by 67 percent and illegal activities showed large decreases: 82 percent decrease in respondents selling drugs; 88 percent decrease in reported

shoplifting; and an 89 percent decrease in reports of beating someone up.

- Employment increased by 25 percent, with nearly half of the respondents reporting employment. Income rose modestly, up 6 percent, while those receiving public assistance declined by 8 percent.

For adolescents and young adults in treatment, NTIES found:

- Both adolescents and young adults experienced significant reductions in drug use approximately one year after treatment in long-term residential facilities.
- For adolescents, primary drug use declined 22 percent; marijuana use declined 26 percent; cocaine use declined 43 percent; any drug use declined 22 percent; and alcohol intoxication declined 15 percent.
- For young adults, primary drug use declined 45 percent, marijuana use declined 42 percent; cocaine use declined 70 percent, any drug use declined 47 percent, and alcohol intoxication declined 62 percent.

For those clients receiving treatment for marijuana, NTIES found:

- A sustained 45-percent reduction in use by those who chronically used marijuana but not other illicit drugs approximately one year after treatment.
- A sustained 50-percent reduction in use by those who used marijuana with other drugs approximately one year after treatment.
- Every type of treatment (non-methadone outpatient, short-term residential, long-term residential, correctional) produced large and statistically significant reductions in marijuana use.

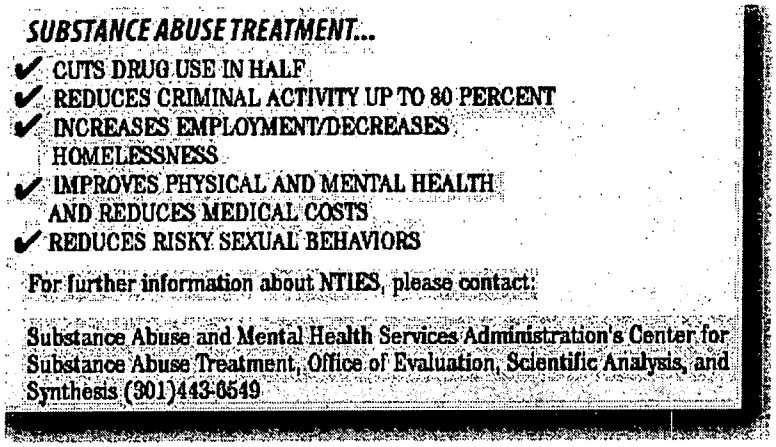
For those clients receiving treatment for cocaine and/or crack, NTIES found:

- A sustained 55-percent reduction in cocaine use approximately one year after treatment.
- A sustained 51-percent reduction in crack use approximately one year after treatment.
- A sustained 47-percent reduction in either crack or cocaine use approximately one year after treatment.
- Every type of treatment (non-methadone outpatient, short-term residential, long-term residential, correctional) produced large and statistically significant reductions in either crack or cocaine use.

Regarding treatment's impact on criminal activity one year after treatment, NTIES found that:

- Selling drugs declined by 78 percent.
- Shoplifting or arrests for shoplifting declined by 82 percent.
- Beating someone up declined by 78 percent.
- Arrests for drug possession declined by 51 percent.

- Arrests for any crime declined by 64 percent.
- Those who reported supporting themselves through illegal activity declined by 49 percent.
- Illicit and risky sexual behavior declined significantly. Specifically, those having sex for drugs/money declined by more than 50 percent, giving drugs/money for sex declined by 50 percent, and having sex with an IV drug user declined by more than 50 percent.



Introduction

The National Treatment Improvement Evaluation Study (NTIES) is a Congressionally-mandated five-year study of the impact of drug and alcohol treatment on thousands of clients in hundreds of treatment units that received public support from the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). The CSAT-commissioned study was conducted by the National Opinion Research Center, University of Chicago, in conjunction with Research Triangle Institute.

The full report provides a wealth of data useful in improving today's treatment programs and in designing new programs to advance treatment in the future. The "Methodology" section, found in the Appendix, contains information about study design and detail about participants.

Who Was Surveyed?

The information reported here was gathered from 4,411 clients from across the country. It includes clients who completed an intake interview and returned for at least a single visit. Since these people did not really become involved in treatment, their inclusion in the study may lower the overall estimates of the success of treatment. Substance abuse is a chronic relapsing disease and the NTIES study reflects that not everyone who enters treatment completes it. The individuals served by CSAT grants were from vulnerable and underserved populations (minorities, pregnant women and at-risk women, youth, public housing residents, welfare recipients, and those in the criminal justice system), and may also have been the most difficult to treat.

NTIES Table of Contents | Introduction | Conclusions | Appendix | NTIES Findings on: Drug and Alcohol Use | Changes in Criminal Behavior | Employment, Income, and Homelessness | Changes in Physical and Mental Health | Changes in Sexual Behavior | Variation in Treatment Outcomes | Costs of Treatment

Conclusions

The National Treatment Improvement Evaluation Study (NTIES) was one of the largest and most rigorous studies of substance abuse treatment ever conducted. In the course of its conduct, the study carefully examined many of the most important issues related to substance abuse treatment and came back with clear, unambiguous answers.

Among the key findings of the NTIES study:

- Clients served by CSAT-funded programs significantly reduced their alcohol and other drug use.
- Treatment has lasting benefits. Significant reductions in drug and alcohol use were still reported a full year after treatment. Reductions were noted regardless of the amount of time spent in treatment or the amount of treatment received.
- Clients reported increases in employment and income; improvements in mental and physical health; decreases in criminal activity; decreases in homelessness; and decreases in behaviors that put them at risk for HIV/AIDS infections, one year after treatment.
- CSAT grants reached their intended clients. Grants made in 1990-1991 distributed approximately $240 million over three years to improve services in more than 430 treatment units serving about 100,000 clients.

NTIES Table of Contents | **Introduction** | **Conclusions** | **Appendix** | **NTIES Findings on:** Drug and Alcohol Use | Changes in Criminal Behavior | Employment, Income, and Homelessness | Changes in Physical and Mental Health | Changes in Sexual Behavior | Variation in Treatment Outcomes | Costs of Treatment

EMBARGOED UNTIL:
10:00 A.M.

Contact: SAMHSA Press Office
(301) 443-5052

Wednesday, September 17, 1997

SAMHSA

National Study Finds Federal Drug Treatment Programs Have Dramatic Impact on Drug Use, Crime and High-Risk Populations

Washington, D.C. -- Hard-to-reach populations enrolled in federally funded substance abuse treatment cut their illegal drug use by nearly half, according to the National Treatment Improvement Evaluation Study (NTIES). It also shows that substance abuse treatment reduced criminal activity among clients; significantly increased employment and decreased homelessness; was linked to a substantial improvement of physical and mental health; and reduced risky sexual behaviors among participants.

NTIES evaluated the impact of drug and alcohol treatment on 4,411 people who participated in programs funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT). These programs focused on reaching underserved and vulnerable populations such as minorities, pregnant and at-risk women, youth, public housing residents, welfare recipients, and those in the criminal justice system.

"The study confirms what we have been saying for years -- that federal alcohol and drug treatment programs work and have lasting, positive effects on individuals in critical need of help," said Nelba Chavez, Ph.D., SAMHSA's Administrator. "Clearly, our investment in substance abuse treatment is making a difference in people's lives," she added.

The new findings include:

- Among women in treatment, drug use declined by more than 40 percent for as long as a year after leaving treatment.
- Among young adults, depending on the treatment setting any drug use was reduced by 31 to 47 percent and primary drug use (the drug cited as the reason a participant entered treatment) was reduced by 23 to 45 percent.
- Among the chronic users of marijuana, treatment resulted in a 45 percent reduction in use, and for those who used marijuana in combination with other drugs a 50 percent reduction.
- Among users of cocaine and/or crack, treatment reduced cocaine use by 55 percent and reduced crack use by 51 percent.
- Among those who reported supporting themselves through criminal activity, treatment reduced illegal activity by 49 percent.

"Few people addicted to alcohol or illicit drugs can simply stop using these substances no matter how strong their inner resolve," added Dr. Chavez. "NTIES shows that proper treatment, client support and follow-up services can significantly improve quality of life, strengthen families and increase productivity."

"NTIES obtained information from clients who were interviewed at admission to treatment,

when they left treatment, and then 12 months following the end of treatment," said CSAT Director, David J. Mactas. He added, "we are encouraged by these findings and will use this information in our efforts to identify new approaches and to strengthen existing treatment programs."

The new NTIES findings are being released during "Treatment Works! Month," a joint effort by the National Coalition on Alcohol and Other Drug Issues, the National Association of Alcoholism and Drug Abuse Counselors, and SAMHSA/CSAT. This month-long effort takes place annually in September and is designed to raise awareness about the importance and effectiveness of treatment for substance abusers and to reduce the stigma associated with treatment.

NTIES was commissioned by SAMHSA/CSAT, and was conducted by the National Opinion Research Center of the University of Chicago and the Research Triangle Institute.

SAMHSA is the federal government's lead agency for improving the quality and availability of substance abuse prevention, addiction treatment and mental health services in the U.S., and is a public health agency in HHS. Copies of the report are available via the Internet at www.samhsa.gov or by calling the National Clearinghouse for Alcohol and Drug Information, a service of SAMHSA, at 1-800-729-6686.

###

A report from:

Duke University Medical Center

Department of Psychiatry and Behavioral Sciences

E. Jane Costello, Ph.D.

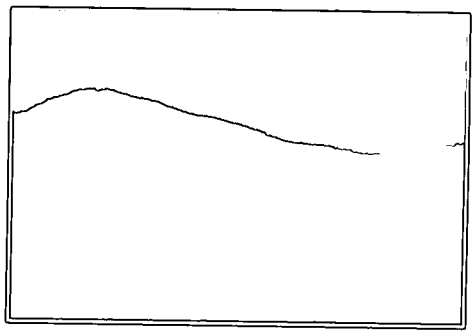
Adrian Angold, M.R.C.Psych.

Barbara J. Burns, Ph.D.

and

North Carolina State Division of Developmental Disabilities, Mental Health, and Substance Abuse Services

Lenore Behar, Ph.D.



Improving Mental Health Services for Children in North Carolina

Why does North Carolina need to be concerned with mental health services for children?

Most of America's children will have relatively normal, healthy childhoods and will grow up to be productive, well adjusted adults. But five out of every 100 children will not. These children, at an early age, will develop an emotional or behavioral disorder that meets the federal definition of *serious emotional disturbance* (SED), which requires both a psychiatric diagnosis and functional impairment.* They will need mental health and other special services, such as special education, not only during childhood but, in many cases, throughout their lives. For them, mental health services are essential. Another group of 20 to 25 out of every 100 children will develop a less severe emotional or behavioral problem that can resolve with proper care, but they run the risk of disabling mental health problems as adults. ***It is this in-between group of vulnerable children for whom timely and appropriate mental health intervention can make a real difference in long-term outcome.*** Yet only about one in four children with a moderate or serious emotional or behavioral problem has seen a mental health professional in the past year.

How can North Carolina make informed mental health policy decisions?

Rates of childhood emotional and behavioral disorders in North Carolina mirror those observed nationally, based on studies conducted to date; and the state, to its credit, has been a national leader in comprehensive and coordinated mental health services for children. Nonetheless, current, accurate local-level information can help North Carolina take this enlightened policy to the next level of excellence, providing tangible benefit to the state's children, from birth to age 18, while continuing to set a national example.

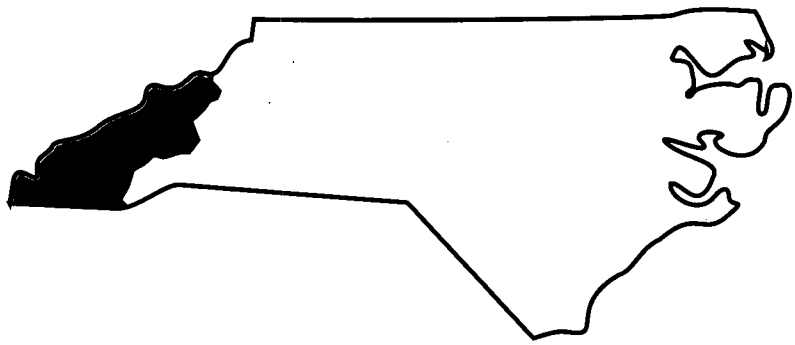
An important program of research, the *Duke Developmental Epidemiology Program*, is currently under way in North Carolina to evaluate mental health service needs and use in an ethnically diverse sample of the state's children. The *Great Smoky Mountains Study*, which is summarized in this report, is the first component of this research program to yield findings. These findings can assist the state to respond to the mental health needs of its children.

The *Great Smoky Mountains Study* (GSMS) is a longitudinal, population-based community survey of children and adolescents in North Carolina funded by the National Institute of Mental Health. The study is a collaboration between *Duke University* and the *North Carolina State Division of Developmental Disabilities, Mental Health, and Substance Abuse Services*. It began in 1992 and will continue until 2003. The findings from GSMS will provide important information about rates of emotional and behavioral disorders in young North Carolinians and their use of mental health services.

What are the study's goals?

Among the *goals* of the Great Smoky Mountains Study are to *estimate* :

- The number of children with emotional and behavioral disorders
- The number of new cases of such disorders that develop in children each year
- The persistence of emotional and behavioral disorders in children and adolescents over time
- The need for and use of services for emotional and behavioral disorders
- The effects of family income, health insurance, and other related factors on service use
- Which children are most at risk for emotional and behavioral disorders
- Which children are most at risk for bad outcomes (school dropout, teen pregnancy, encounters with the criminal justice system, etc.)



Who is participating in the Great Smoky Mountains Study?

The participants in the Great Smoky Mountains Study are:

- 1,073 children aged 9 through 16, and their parents, from 11 counties in western North Carolina (8.1% of the children are African-American, which is consistent with the proportion of African-Americans in the counties surveyed). These counties include both urban and rural areas. Children were selected on the basis of a screening questionnaire completed by the child's parent. All children scoring above a predetermined point on questions about behavioral problems were invited to participate in the study. A random one-in-ten sample of children scoring in the normal range was also recruited. Eighty percent of invited families agreed to participate.
- 349 children who are enrolled members of the Eastern Band of the Cherokee Nation (80% of families with a child in the study's age group)
- All agencies providing child mental health services in the 11-county area

Participating Counties

Buncombe

Cherokee

Clay

Graham

Haywood

Jackson

Macon

Madison

Mitchell

Swain

Yancey

How is the study being conducted?

Starting in 1992, each child in the Great Smoky Mountains Study, and one of his/her parents, is visited once a year by trained interviewers for a face-to-face interview using structured evaluation instruments. Between these annual interviews, each child and family has received a telephone follow-up call once every three months. In addition, three teachers have completed questionnaires about each child. The study also includes a comprehensive study of mental health service providers working in schools, social services, juvenile justice, and child welfare, as well as those working in specialty mental health settings.

Children and their parents are interviewed using instruments that evaluate the child's symptoms of behavioral and emotional disorders, physical health, and development. These instruments seek to answer the following questions:

- Does the child meet diagnostic criteria for a specific emotional or behavioral disorder?
- Does he or she exhibit impaired functioning (inability to function in developmentally appropriate ways at school, at home, and with peers)?
- Does he or she need mental health services?

Federal guidelines define children to be suffering from *serious emotional disturbance* (SED) if they have a psychiatric diagnosis that impairs their ability to develop and function normally at home, at school, or in their relationships with others. Since many federal agencies target their services specifically to these children, North Carolina has also adopted this definition of urgent need for mental health care.

The GSMS also evaluates the following:

- Family psychiatric history
- Impact of the child's illness on the family
- Impact of family resources, including health and mental health insurance, on service use
- Services sought and received for the child's disorder
- Access and barriers to this care

A *distinguishing characteristic* of the Great Smoky Mountains Study is that *service use is linked to mental health problems*. The study is evaluating how children use services in five sectors:

Mental health
psychiatric hospital, psychiatric unit in a general hospital, residential treatment center, group home, partial hospitalization, therapeutic foster care, mental health center, detoxification unit, outpatient drug/alcohol clinic, case management, private mental health professional

Education
guidance counselor/school psychologist, special schools and classes

Health
family doctor/other non-psychiatric physician, community health center, medical inpatient unit, hospital emergency room, nontraditional healer

Child welfare
social services counseling, therapeutic foster care, child protective services

Juvenile justice
detention center/jail, probation officer/court counselor

How many children need mental health services?

- Most children will *never* need professional mental health care: In each year of GSMS, seven children out of ten (70%) *had no diagnosable emotional or behavioral disorder.*
- Another 25% had *moderately severe*, though still distressing, disorders.
- The remaining 5% of children have serious emotional or behavioral disorders (SED) accompanied by *marked impairment* in ability to develop and function normally at school, at home, or with peers.
- Among the children with SED,

  70% have a disruptive behavior disorder

  27% have an anxiety disorder

  20% have a depressive disorder

  16% have a substance use disorder

  13% have attention deficit hyperactivity disorder (ADHD)

  4% have tic disorders

  2% have an eating disorder (anorexia or bulimia)

  1% are encopretic

  41% have more than one of these disorders
- African-American and Indian children have rates of disorder and comorbidity similar to those of white children.
- Rural and urban children have similar levels of need for mental health care.

What puts children at risk for serious emotional disturbance?

The risk of SED increases with the number of *family stress factors*. Compared with children with mild or no emotional or behavioral disorders, children with SED had one or more of these stress factors in their lives:

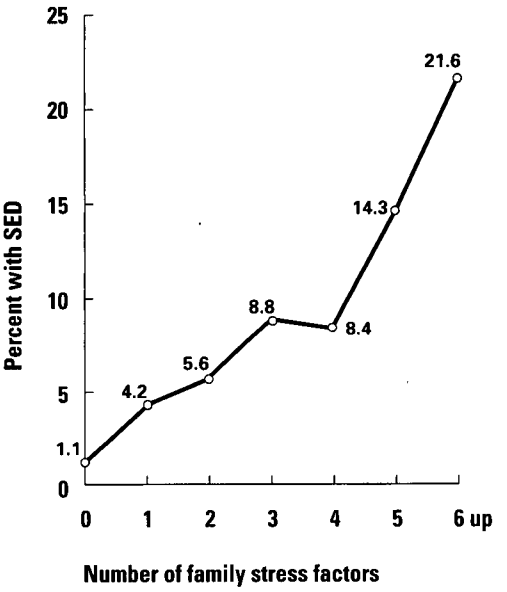
- Twice as likely to be living in poverty (40% versus 22%)
- 40% more likely to have a parent who has been arrested (17% versus 12%)
- 50% more likely to have a parent with a drug or alcohol problem (11% versus 7%)
- Three times as likely to have a mother who is depressed (18% versus 6%)
- 25% more likely to have a parent who did not finish high school (42% versus 32%)
- Nearly three times as likely to have a poor relationship with his/her parents (49% versus 17%)
- Nearly twice as likely to have witnessed physical violence between parents (13% versus 8%)
- Nearly twice as likely to have one or both parents unemployed (17% versus 9%)
- 50% more likely to come from a family other than one with two biological or adoptive parents (77% versus 50%)

Among children living with six or more stress factors, one in five has SED. This is *forty times* the rate of SED in children with no stress factors.

SED was slightly more common in boys, children over 12, and African-American or American Indian children. However, these differences were small, with one exception: by age 15, substance abuse was increasing faster among American Indian youths than in other groups.

Figure 1.

How family stress factors increase risk of SED



Family stress factors:

Parent with less than high school education

Unemployment

Poverty

Family mental illness

Parental drug or alcohol problems

Parental criminal conviction

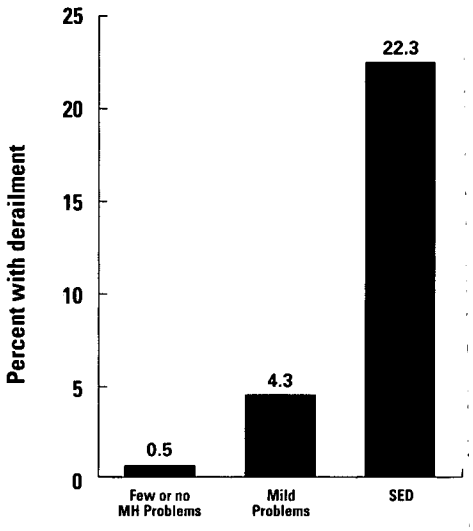
Violence between parents

Poor relations with children

Mother depressed

Figure 2.

How mental illness increased risk of "derailment"



Types of derailment

School dropout

Expelled from school

Unplanned teen pregnancy

Convicted of a crime

Drug or alcohol abuse

How well do children with mental health problems cope with daily life?

Without guidance and support, children can be "derailed" in their path to healthy adulthood. For example, they can:

- Be expelled from school
- Drop out of school
- Become pregnant
- Be convicted of a crime
- Begin using alcohol and illicit drugs

Most young people successfully avert such derailments. Children with few or no mental health problems were highly unlikely to experience such a derailment (only one in 200 did so). The rate was 4.3% in children with mental health disorders without functional impairment but rose to ***22.3% of children with SED*** (Figure 2). Thus, childhood SED had long-term educational, legal, and reproductive consequences that could seriously affect children's futures and their adult lives.

The risk of derailment among children with less severe disorders, while lower than in SED youths, was still eight times that of healthy children (Figure 2). ***Efforts to reduce risk in this group could have a substantial impact on outcomes for adolescents because they make up 20% of the population.***

Does mental health treatment work?

The Great Smoky Mountains Study is one of the first studies nationally to look at whether treatment in community mental health settings improves children's mental health. Those children whose symptoms were getting worse between assessments, that is, those children who clearly needed help, were identified and followed for another year to see who would receive treatment and whether this treatment would have an effect a year later. Outcomes examined included emotional and behavioral problems, functioning at school and home, and impact on parents.

- Compared with untreated youths, those who had nine or more sessions with a mental health professional had ***significantly fewer emotional and behavioral problems*** following treatment.
- Children receiving fewer than nine sessions of treatment showed no improvement.
- The more treatment children had (about nine sessions) the fewer symptoms were displayed a year later, demonstrating a ***dose–response effect*** for treatment.

These findings suggest that, given adequate treatment (at least nine sessions on average), children's emotional and behavioral symptoms showed a marked improvement over a year. However, a year may be ***too short a time*** to see a marked improvement in functioning at school or at home in seriously disturbed youths. Serious problems require serious intervention.

Where do children and adolescents typically receive mental health services?

Data from the Great Smoky Mountains Study have yielded findings regarding use of various service sectors that should be of great interest in planning future mental health services for the state's youths.

- Over the course of a year, 40% of children in the study received some type of mental health service, though not necessarily from a trained mental health professional.
- *School counselors and psychologists* provided mental health services to more children than did any other mental health professionals. More than *75% of children receiving mental health services* were seen in the education sector. For many children, the education sector was *the sole source of care.*
- Twelve percent of children received services from the *specialty mental health sector*, most via a public mental health center or private professional.
- The *general medical sector* provided mental health-related services to only 6% of youths in the study, mainly the younger ones. For most (89%), such services were provided by the child's primary physician.
- In-home services, partial hospitalization, and specialized substance abuse services were used rarely.
- Older children were less likely to use school mental health services and more likely to be seen in the juvenile justice sector.
- Overall, 50% of children who used services during the year received services *from only one agency.* One in four used two agencies, and the rest used three or more. More than 50% of children who used only one agency received their services through the *education system.*

Use of both outpatient and inpatient services was dramatically influenced by *level of need.* Thus, Figure 3 shows that although youths with SED were only 5% of the population, they made up over a quarter of those using specialty mental health and school guidance services and almost half of those seen in the juvenile justice system.

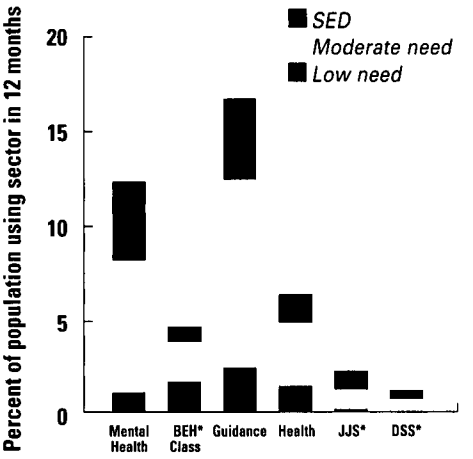
High need youths also tended to use multiple services, as shown in Figure 4. Although they are only 5% of the population in any year, four out of five youths with SED use services, and half use services in two or more sectors.

The great majority of mental health service use occurred in outpatient settings, including day hospitals, drug/alcohol clinics, mental health centers, and private mental health professionals.

The role of the specialty mental health system was greatest for children with the most severe problems. Moreover, the care of children with severe problems tended to involve multiple agencies, particularly the school and mental health agencies, pointing to the importance of *coordination across agencies.*

Figure 3.

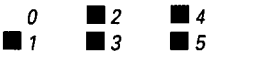
Role of the major sectors in providing mental health services to children by child's clinical status

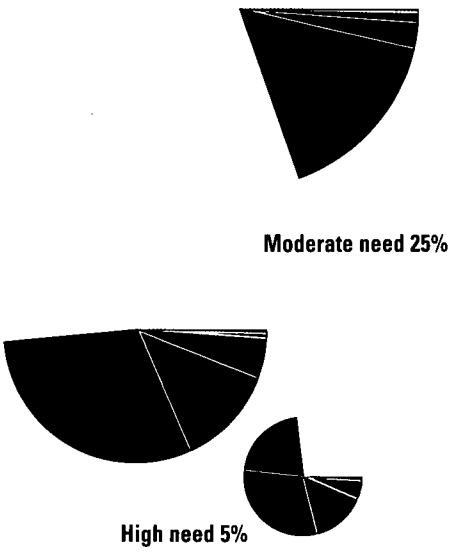


DSS Department of Social Service
JJS Juvenile Justice Services
BEH Class for behavioral or emotional problems

Figure 4.

Number of service sectors used in one year by low, moderate, and high need children





How persistent and intense is service use?

Persistence of service use refers to the *continuation in service across time*. There was a complex pattern of movement into and out of services across the year in the Great Smoky Mountains Study. Fewer than 10% of children persisted in service use for more than three months at a time. However, many came back into the system after a year or two.

In the Great Smoky Mountains Study, *intensiveness* referred to the level of service provided by a particular agency. In general, children who received highly intensive service were the exceptions. For example, fewer than 2% of children received out-of-home placements in any year. Of those who did, 50% were in such placements for fewer than five days, and only 15% were in such a placement for more than a month.

No children with low need received out of home placements, but 15% of youths with SED spent at least one night away from home in a treatment setting in the course of a year, compared with 3.6% of moderate need youths. But only 1% of moderate need youths spent more than a week out of home, compared with 10% of SED youths. The average annual out-of-home stay was half a day for moderate need youths, compared with four days for SED youths.

Persistent service users were more likely to be *older* and to come from families with *less education*, with *incomes below the federal poverty line*. Persistent service users had more emotional and behavioral problems, and their families suffered *high levels of economic, social, and psychological hardship*.

Who pays for services?

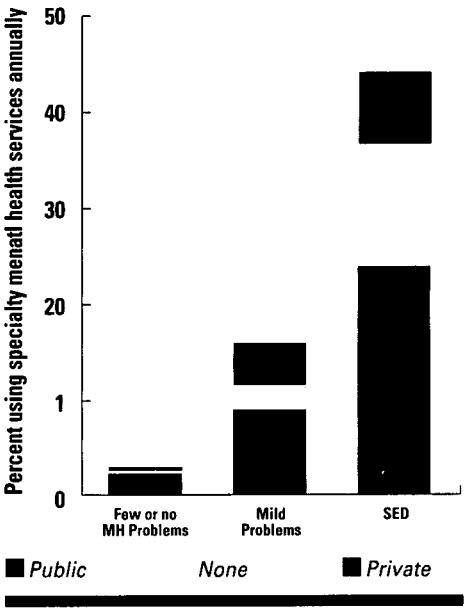
In the Great Smoky Mountains Study, 70% of families had private insurance, 19% had public insurance (Medicaid), and 11% had no insurance, closely resembling the distribution for the entire state. For those families with private insurance, 18% of plans offered full mental health coverage and 58% offered partial coverage. Typical benefit packages under private insurance were 20-30 outpatient visits with a 50% co-payment and 30-60 days of psychiatric hospitalization.

Key findings related to insurance status and use of mental health services include the following:

- Service use was driven more by *level of need* than by insurance status. Among high need youths, about two in ten received some mental health care regardless of insurance type. Fewer than one in five youths with moderate need, and only 2% of low need youths, received specialty mental health care.
- Given need for care, *public insurance (Medicaid)* increased service use more than private insurance. Although uninsured and publicly insured youths were only 30% of the population, they made up half of all children with SED receiving specialty mental health care.
- Almost no children with low need and public or no insurance received specialty mental health care. **Public insurance did not lead to unneeded access to mental health services.**

Figure 5.

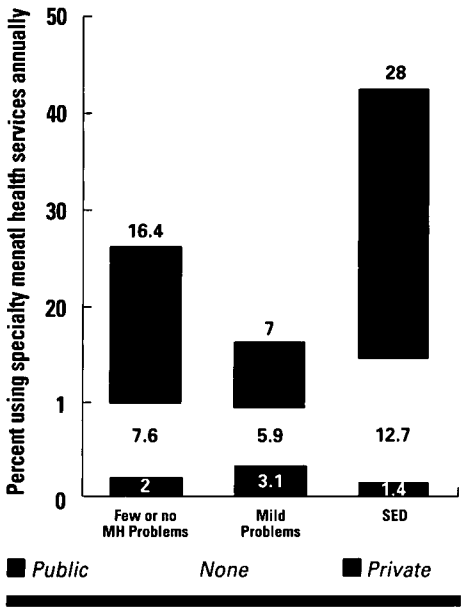
Impact of health insurance on likelihood of one or more mental health visits by level of need



- Relatively few privately insured youths received any inpatient care, *regardless of level of need*. For youths with public insurance, there was a strong positive relationship between level of need and receipt of inpatient care. The number of outpatient visits was also strongly associated with level of need, with high need youths receiving the most visits within each insurance group. Nonetheless, even children with high need received mental health care at low rates, particularly children *with private insurance*, suggesting *limited treatment once contact with the service system occurred*. This is worrisome when taken in conjunction with the findings cited earlier, that only youths receiving nine or more visits showed significant improvement a year later.

Figure 6.

Mean number of specialty mental health visits in one year, by health insurance and level of need



Uninsured youths in the Great Smoky Mountains Study fared as well as privately insured youths, in part due to the availability of "free" or "no cost" care provided by public mental health services. However, uninsured children and families were characterized by high rates of poverty, family histories of mental illness for all levels of need, and high family burden—thus, a group with multiple needs for service use.

To summarize, in the Great Smoky Mountains Study area, even with relatively advanced child mental health services systems and generous Medicaid benefits, ***only 44% of youths with SED received professional mental health care at any time during a two-year period.*** SED children with Medicaid were better served than children covered by private insurance or no insurance, especially in terms of the volume of services received. The reason for the difference was not due to the high level of services provided to Medicaid patients but to the ***very low level of services provided to privately insured and uninsured children.*** Since uninsured children had a high level of need for care, this last group is particularly disturbing.

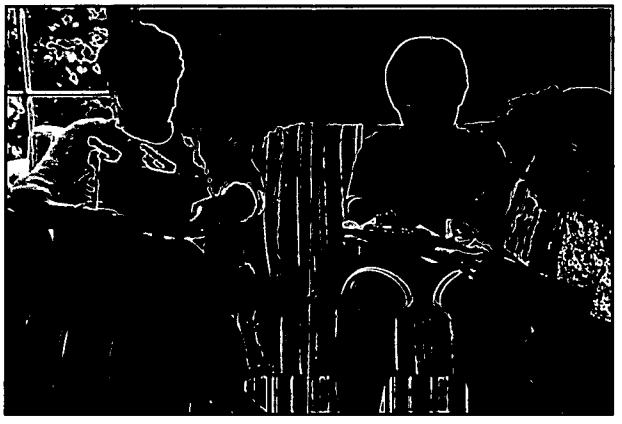
How has North Carolina's Medicaid waiver affected service provision?

In North Carolina, child mental health services have been managed in ten pilot areas under a Medicaid waiver since 1994. A study by the Duke Developmental Epidemiology Program has looked at the impact of a Medicaid carve-out pilot, Carolina Alternatives (CA), on mental health service use, service setting, and cost. Carolina Alternatives is public sector-managed with a single portal of entry into services and a phase-in of full risk after two years. The two Area Mental Health Programs covered by GSMS were included in the CA study.

Overall access to and volume of mental health and substance abuse services increased over the study time period (1992-1996), although substantial variation by service type occurred. A strong shift from inpatient to alternative treatment and outpatient services was observed. Intensive services (group homes, therapeutic foster care, partial hospitalization), which could potentially serve as an alternative to inpatient care, were developed or their capacity increased over the study period. Use of these alternative services increased until 1995 (by 150% in the Great Smoky Mountains sample) but began to decline when Area Programs assumed full fiscal risk.

Changes in costs between 1992 and 1996 were reflected in a dramatic reduction in inpatient costs and a corresponding increase in outpatient costs from roughly one-third to over one-half of Medicaid costs (with one-third of costs being in alternative treatments). The costs per eligible enrollee increased across CA sites until 1995 and then declined in 1996, an indication of the transition to full risk and a reduction in the capitation rates that occurred in 1996. Mean capitation rates increased from $321 to $532 between 1992 and 1995, then declined to $395 by 1996.

This first longitudinal examination of public sector-managed mental health and substance abuse services for children on Medicaid with significant mental health need (more than 20% with SED) reveals overall success in achieving the goals of CA. The pilot demonstrates that institutional care can be dramatically reduced while increasing access to community-based services and continuing to provide a substantial volume of intensive, community-based care. After initial increases, costs appear to have stabilized with full risk, but further years of observation are needed to confirm this trend.



The Great Smoky Mountains Study has produced several important findings related to mental health service utilization and financing in children and adolescents that may be relevant as the state sets future health care policy.

- *Serious emotional disturbance* is strongly related to use of any mental health services.
- The family's *history of psychiatric illness* is among the most consistent and powerful predictors of use of mental health services. Others include *poverty* and *the impact of the child's mental health problems on the family*.
- Service use is much more likely to occur with *public insurance coverage* (Medicaid) than either private or no insurance.
- Considerable unmet need was observed even for youths with SED.
- School-based counseling services potentially substituted for professional mental health services.
- Current services provide only minimal care for most children, even those with SED.
- There was little *unnecessary use* of mental health services in the low need group.

The findings of multiple sector use, particularly in high need youths, in the Great Smoky Mountains Study reinforce the importance of *interagency relationships* between specialty mental health and other child-serving sectors. Relatively few children received services solely from the specialty sector. Rather, specialty mental health was a common provider for children who received services from multiple sectors. This finding suggests that coordination, *particularly with schools*, is crucial for the provision of services.

How can the state respond to unmet need in a cost-effective way?

A number of factors must work together to achieve positive outcomes for children with emotional and behavioral disorders. Among them are principles of care, adequacy of the service system, including, quality of treatment, and child and family preferences.

Principles of care that currently guide both public and private sector mental health service delivery include:

- *Individualization* of services based on the specific needs of the individual child and family
- Involvement of the *child's family* as a partner in treatment
- Provision of services in *community-based settings* rather than in institutions
- Provision of service in the *least restrictive setting* to normalize and mainstream the child and his/her experiences as much as possible
- Services that are sensitive to *ethic and cultural values*

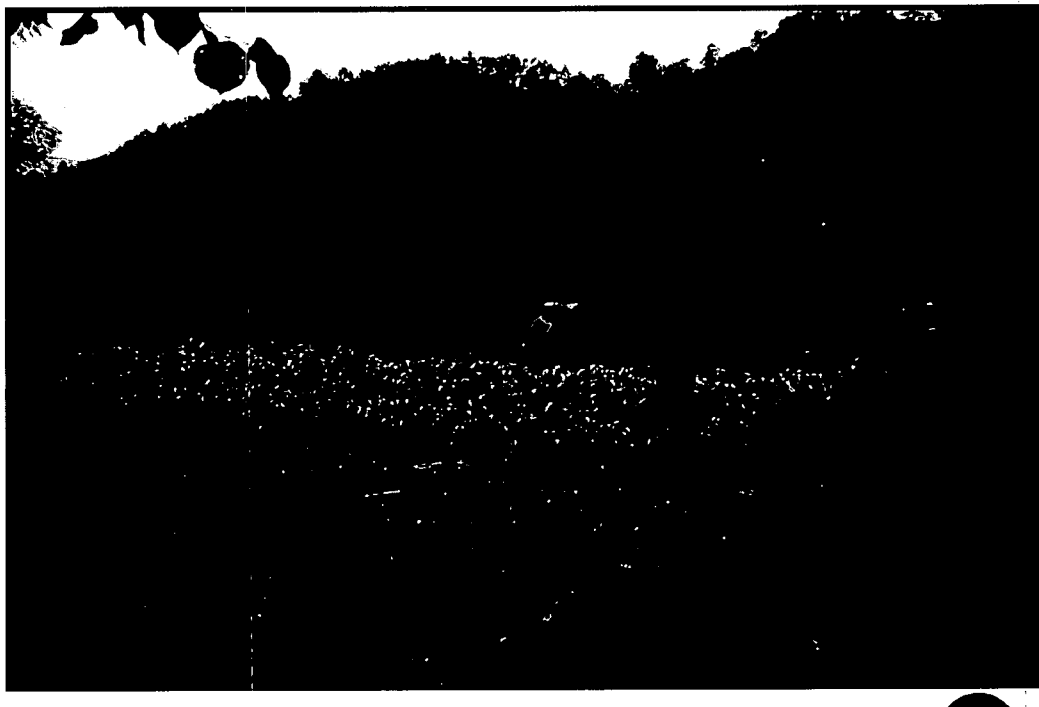
A number of questions directed toward the service system address its overall adequacy:

- Is the full continuum of care in place?
- Are the services provided ones with evidence-based, demonstrable effectiveness?
- Are the resources in the continuum sufficient to meet the needs of the population?
- Are mental health services coordinated with those provided in other human services sectors?
- Are families involved in service planning and delivery?
- Are services provided in a timely and flexible manner?

When these questions can be answered in the affirmative, North Carolina's children and adolescents will be more likely to get the care they need for emotional and behavioral disturbances. However, in evaluating the effectiveness of such a service system, it is important to keep three assumptions in mind:

- *Treatment is a process, not an event.* Children with persistent (chronic) conditions need a range of treatment interventions over time.
- *Outcomes are affected by a larger world than formal treatment.* Thus, it is not sufficient to assess mental health specialist services only; inclusion of other sectors and informal services is also essential. The role of schools in service provision has been well demonstrated in the Great Smoky Mountains Study.
- *Outcomes will vary with the type and stage of treatment and the child's developmental status.* Thus, it is important to assess both short- and long-term outcomes.

The high proportion of mental health care provided to North Carolina's children and adolescents through the education sector raises a question about the potential of school personnel with limited mental health expertise to respond adequately to the clinical needs of emotionally and behaviorally disturbed youths. This concern is underscored by the high rate of seriously emotionally and behaviorally disturbed children seen only in the education sector and suggests a need to *improve the linkages between schools and mental health centers*. Mental health advocates are pursuing federal legislation to strengthen school-based services for the entire child population as well as for children identified as seriously emotionally disturbed. North Carolina is in the process of following this lead by adding mental health services to school-based health clinics. The state should be commended for this effort.



Recommendations for Action

Results to date from the Great Smoky Mountains Study suggest that North Carolina can take a number of steps to improve state-wide mental health services to children and adolescents and to sustain this improvement over time. Recommendations for consideration include the following:

- Increase *professional mental health resources in the schools*, where children can easily take advantage of them. Develop and expand models for area health programs to deliver services in schools.
- Adopt *standardized assessment methods and instruments to examine children for early detection of SED* and access to services. Such instruments can be utilized in real-world settings by child welfare workers, disability examiners, school psychologists, and other mental health care providers.
- Take active steps to enhance *inter-agency relationships* between specialty mental health and other child-serving sectors, particularly schools.
- Incorporate *need for services* into policy as the criterion for use of psychiatric benefits instead of arbitrary benefit limits.

30

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-10-1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
1. Dave Richard	The Arc INC
2. Edward NARTEY	
3. Jon Wilson	NC AIDCF.
4. Patsy Kinsey	Mental Health Association - Charlotte
5. [illegible]	NC Council
6. Mary Eldridge	Div. MH/DD/SAS
7. ART ECCLESTON	DIV MH/DD/SAS
8. Pam Seaman	NC Social Services Consortium/Covenant
9. [illegible]	NC Equity
10. Jim Blackburn	NC Assoc. County Commissioners
11. Heather Jaffen	OSA
12. ANNA TEFFT	OSBM
13. HUGH TILSON	NCHA
14. J. Craig [illegible]	PCMH
15. [illegible]	OSPL
16. Wayne Williams	OSBM
17. Lisa Abatemarco	DHHS/BP&A
18. John Bowdish	Zeb Alley P.A.
19. Pat Porter	DMH-DD-SAS
20. Don Willis	DMH DD SAS
21. MICHELLE COTTON	DMH/DD/SAS
22. Doug Baker	DMH/DD/SAS
23. Spencer Clark	DMH/DD/SAS
24. Starleen Scott Robbins	DMH/DD/SAS
25. Lewis Baker	DMH/DD/SAS
26. NELS ROSELAND	OSBM
27. PETE MARTIN	DMH DD SAS
28. JANICE PETERSEN	Com. on substance Abuse

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-10-1999

Name of Committee　　　　Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
29. Shawnese Ransome	DSS
30 Roslyn Savitt	NC Child Care Coalition

AGENDA

Joint Subcommittee on Health and Human Services Appropriations

Legislative Office Building – Room 424
Thursday, March 11, 1999
8:30 a.m.

Opening Remarks	**Sen. Bill Martin, Co-Chair** **Rep. Beverly Earle, Co-Chair** **Rep. Edd Nye, Co-Chair**
Division of Facility Services	**Karen Hammonds-Blanks** **Fiscal Research**
Developmental Disabilities	**Karen Hammonds-Blanks** **Fiscal Research**
Child and Family Services	**Dr. Lenore Behar**

HOUSE APPROPRIATIONS SUBCOMMITTEE FOR HEALTH AND HUMAN SERVICES

MINUTES
MARCH 11, 1999
8:30

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Thursday, March 11, 1999 in Room 424 of the Legislative Office Building.

In the absence of Representative Beverly Earle, Co-Chair, Representative Edd Nye opened the meeting by introducing the Pages. Co-Chair, Representative Beverly Earle joined the meeting later. The following members were present:

Representative Edd Nye, Co-Chair
Representative Beverly Earle, Co-Chair
Representative Alma Adams
Representative Lanier Cansler
Representative Theresa Esposito
Representative Trudi Walend
Representative Gene Wilson

Representative Martha Alexander had an excused absence. Five Senators were present.

Representative Nye asked Karen Hammonds-Blanks to conclude her presentation from the March 3rd meeting. She began her presentation with the Division of Facility Services Budget Overview. (See Attachment II). She talked about new positions, staffing issues, regulating facilities and programs, and other services. In conclusion of the budget overview, the committee had questions and concerns that were answered by Ms Hammonds-Blank.

The next topic of discussion was dealing with the Developmental Disabilities Waiting List Reduction. Ms Hammonds-Blank handed out documents showing the reduction of children and adults waiting for services. A commitment of $9.3 million was made to reduce the number of persons waiting for service by 750 by June 30, 1999. (See Attachment III).

The last presentation was done by Dr. Lenore Behar, Chief of Child and Family Services Section. Dr. Behar spoke on services offered to meet the mental health needs of children and adolescents and their families. In conclusion, Dr. Behar discussed the units of case management provided to children and adolescents in area programs. (See Attachment IV).

The meeting adjourned at 9:55 a.m.

Respectfully submitted,

Presiding Co-Chair, Representative Beverly Earle

Ann Raeford, Committee Clerk

Attachment I	Agenda
Attachment II	Division of Facility Services Budget Overview
Attachment III	Developmental Disabilities Waiting List Reduction
Attachment IV	Child and Family Services Section
Attachment V	Visitor Registration

Ramona Ann Rayford March 11, 1999 II

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF FACILITY SERVICES BUDGET OVERVIEW

FISCAL RESEARCH DIVISION
MARCH 1999

DIVISION OF FACILITY SERVICES

MISSION

Provide for the health, safety, and well-being of individuals through effective regulatory and remedial activities including appropriate consultation and training opportunities and by improving access to health care delivery systems through the rational allocation of needed facilities and services.

Smallest Budget of the Division

DIVISION OF FACILITY SERVICES

1999-2001 CONTINUATION BUDGET

Description	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Total Requirements	$20,489,403	$19,591,582	$19,561,888	$19,561,888
Estimated Receipts*	($12,249,560)	($8,332,948)	($10,626,579)	($10,626,579)
Net Appropriation*	$8,239,843	$11,258,634	$11,553,285	$11,553,285
Total Number of Positions**	298.5	330.7	330.7	330.7

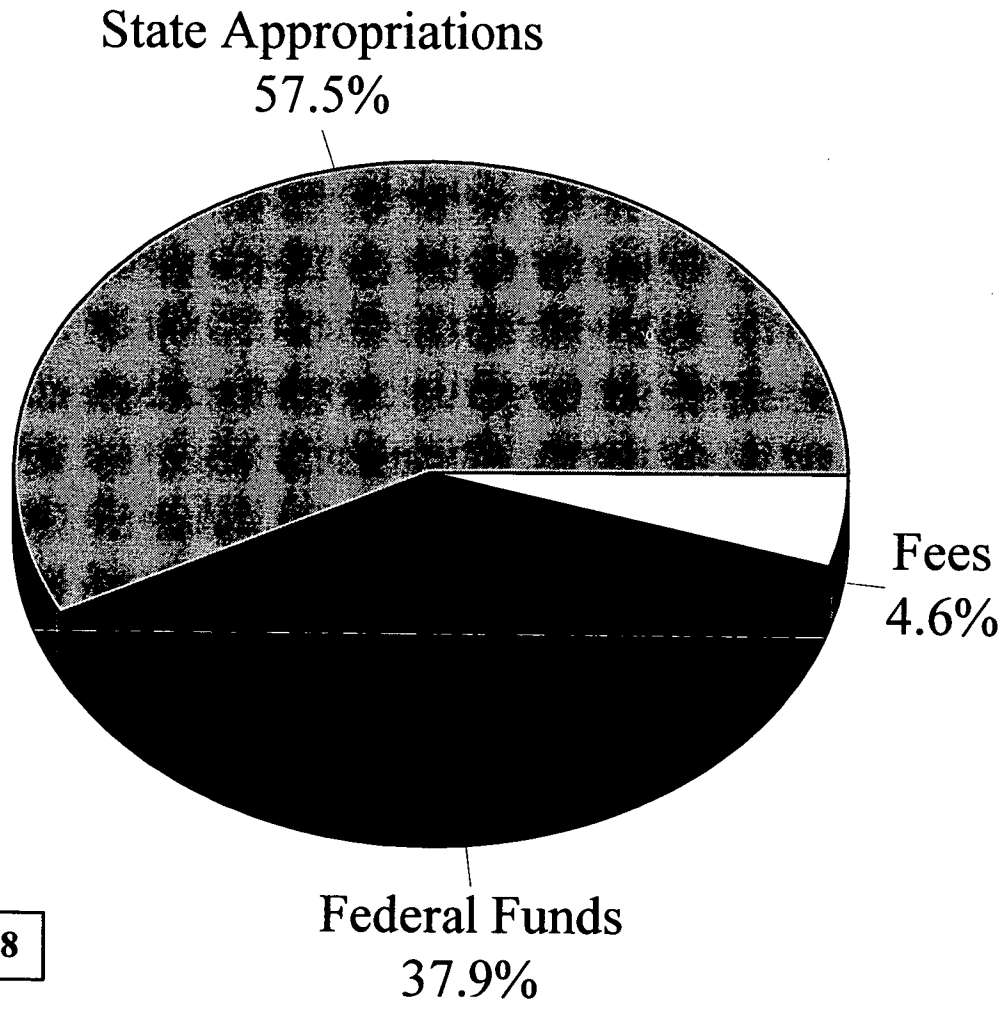
Continuation Budget Document: Volume 3, pages 151 - 158

***Appropriations and receipts have been adjusted to reflect state appropriations to match Medicaid receipts.**

****Position totals for fiscal years 1998-99 through 2000-01 have been updated.**

DIVISION OF FACILITY SERVICES

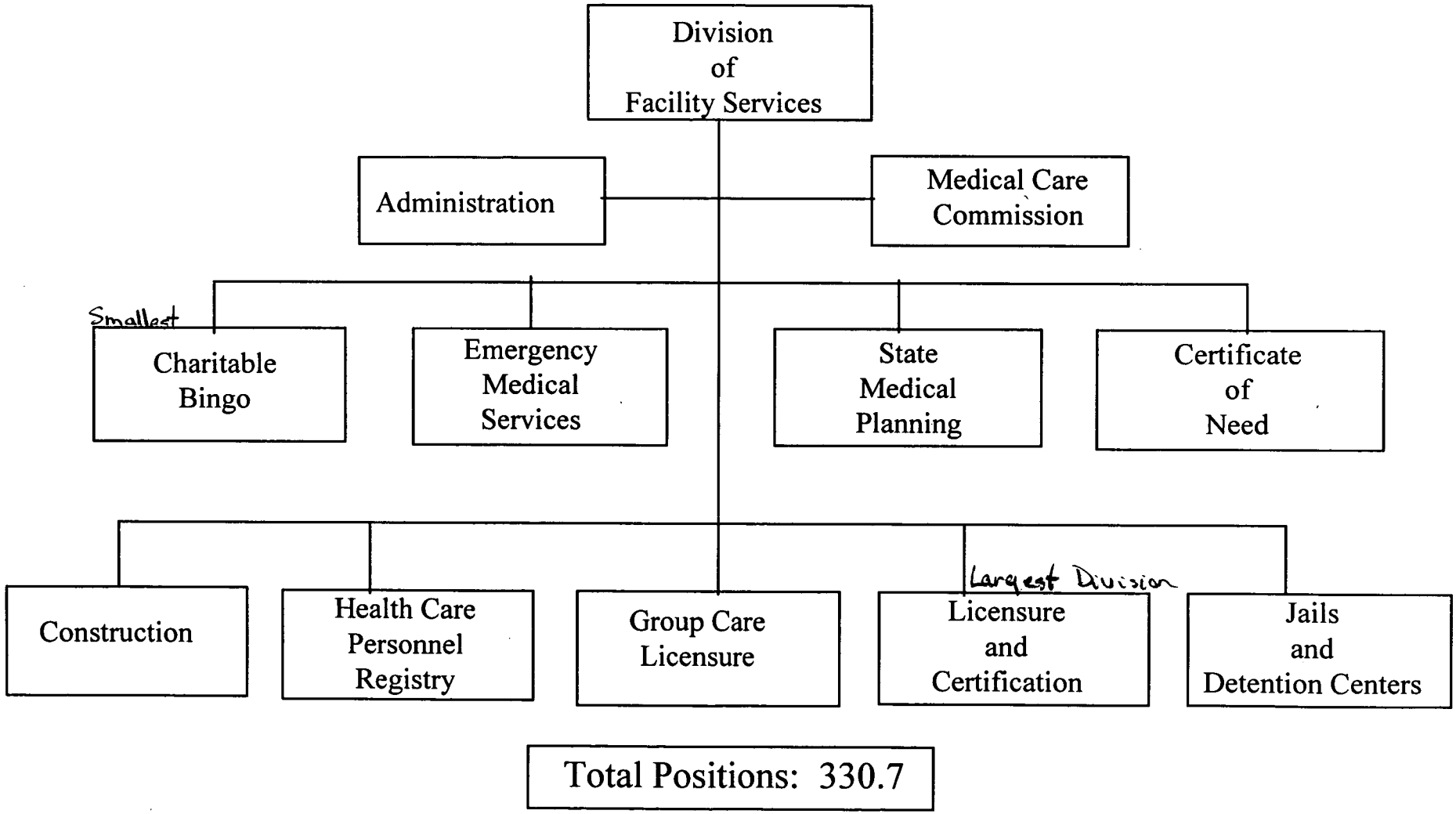
SOURCES OF FUNDING



State Fiscal Year 1997-98

DIVISION OF FACILITY SERVICES

ORGANIZATION



Total Positions: 330.7

DIVISION OF FACILITY SERVICES

MAJOR PROGRAMS

State Medical Planning Section: Determines the degree of unmet need for health facilities throughout the state.

Certificate of Need Section: Restricts unnecessary increases in health care costs and limits unnecessary services and facilities based on geographic, demographic, and economic considerations.

Construction Section: Reviews plans and specifications, makes inspections, and provides consultation to ensure a safe environment in those facilities wishing to be licensed, certified or receive financial assistance.

Health Care Personnel Registry Section: Maintains a registry of nurse aides and other health care personnel and investigates alleged abuse, neglect, or misappropriation of resident's property in health and social care facilities.

Jail and Detention Section: Ensures compliance with NC statutes and administrative rules through inspection of all jails in North Carolina.

DIVISION OF FACILITY SERVICES

MAJOR PROGRAMS

Group Care Licensure Section: Licenses and regulates adult care homes and mental health, mental retardation, and substance abuse facilities, while also and providing supervision, consultation, training and technical assistance to county department's of social services staff who monitor the compliance status of adult care homes.

Licensure and Certification Section: Conducts surveys and complaint investigations in health care facilities. Manages and directs administrative services and quality assurance to ensure compliance with federal regulations for Medicare/Medicaid certification.

Medical Care Commission: Issues tax-exempt revenue bonds to nonprofit and public health care facilities for construction, renovation and expansion of facilities.

Emergency Medical Services Sections: Ensures all citizens have access to quality emergency medical care by providing technical assistance and regulatory oversight to all local EMS systems.

Bingo Section: Regulates charitable bingo activities.

DIVISION OF FACILITY SERVICES

LEGISLATIVE HIGHLIGHTS

Eliminate Positions

1995-96	-$ 152,528	(6 positions)
1996-97	-$ 568,923	(19.5 positions)
1997-98	-$ 48,692	(2 positions)

Smoke Detector/Sprinkler Loan Fund

1996-97	$1,000,000	**NR**

Health Care Personnel Registry

1996-97	$ 160,000	(From HHS funds)
1997-98	-$ 80,000	(Medicaid Receipts)
1998-99	$ 150,000	(4 positions for mental health facilities) **NR**
1998-99	$ 75,000	(2 positions to reduce backlog) **NR**

DIVISION OF FACILITY SERVICES

LEGISLATIVE HIGHLIGHTS

Construction Section

1998-99	$ 225,000 (8 positions)	**NR**

Poison Control Center

1997-98	$ 200,000 (Grant-in-aid to Carolinas Medical Center)	**NR**
1998-99	$ 300,000 (Grant-in-aid to Carolinas Medical Center)	**NR**

Certificate of Need Program

Replaced CON fees with appropriations for support of the CON program and deposited fees as a nontax revenue into the General Fund. The net effect to the General Fund was zero. Effective July 1, 1994.

Charitable Solicitation

This program was transferred to the Secretary of State effective January 1, 1999.

DIVISION OF FACILITY SERVICES

STATUS OF NEW POSITIONS

- During the 1998 Session the General Assembly appropriated nonrecurring funding for 14 new positions in the Division of Facility Services effective January 1, 1999.
    - 6 positions for the Health Care Personnel Registry
    - 8 positions for the Construction Section
- The 1998 General Assembly also required the Division to develop a fee proposal to defray the cost of processing and reviewing construction plans for health and social care facilities and for conducting physical plant inspections by December 1, 1998.
- The Division is in the process of filling the new positions and has submitted a fee proposal to the General Assembly.
- The 1999-2001 continuation budget for the Division includes recurring funding for the annualized cost of the 14 new positions ($803,508).

DIVISION OF FACILITY SERVICES

STAFFING ISSUES

Does the Division of Facility Services have adequate staff to regulate the facilities mandated under state law?

During the past ten years, Division of Facility Services had a net gain of 1 state full time equivalent position.

-- 33 positions were created.
-- 32 positions were eliminated.
-- 24 of the positions were eliminated since 1995.

During the past five years, the number of facilities and programs regulated by Division of Facility Services has increased 40%.

The 1998 General Assembly appropriated nonrecurring funding for 14 new positions for the Construction Section and the Health Care Personnel Registry to meet the most pressing needs. Nineteen new federal positions (3.87 state full time equivalents) have also been created during 1998-99.

DIVISION OF FACILITY SERVICES

REGULATED FACILITIES AND PROGRAMS

Type of Facility/Program	Number of Facilities/Programs	Actual Beds
Nursing Facilities	421	41,026
Adult Care Homes	1,513	39,822
Mental Health Facilities	2,976	10,599
Home Care Agencies	741	NA
Hospitals	148	24,186
Ambulatory Surgery Facilities	53	NA
Hospice	72	121
Cardiac Rehab Programs	62	NA
Abortion Clinics	18	NA
End Stage Renal Disease Dialysis	99	2,050 stations
Home Health Agencies	166	NA
Rural Health Clinics	136	NA
Jails and Detention Facilities	120	13,891
Grand Total	**6,857**	**123,021**

DIVISION OF FACILITY SERVICES

STAFFING BY PROGRAM AND FUNDING SOURCE

SECTION	TOTAL POSITIONS	STATE FUNDED	RECEIPT FUNDED
Administration	19.75	14.7	5.05
Licensure/Certification	154.9	26.76	128.14
Group Care	32	21.44	10.56
Health Care Personnel Registry	31	10.7	20.3
State Medical Planning	5	5	0
Emergency Medical Services	38	33	5
Jails and Detention	4	4	0
Certificate of Need	13	13	0
Construction	32	21.1	10.9
Bingo	1	0	1
TOTAL	**330.65**	**149.7**	**180.95**

DIVISION OF FACILITY SERVICES

STAFFING ISSUES

The following programs appear to still have staffing shortages even with the recent state and federal expansions:

- Group Care Section
- Construction Section
- Licensure and Certification
- Health Care Personnel Registry

DIVISION OF FACILITY SERVICES

GROUP CARE SECTION

- The Group Care Section of Division of Facility Services is required to inspect all mental health facilities prior to initial licensure and upon relicensure biennially.

- Currently, there are 2,685 mental health, developmentally disabled, and substance abuse programs and facilities. The number of facilities and programs has increased 45% since 1995 as a result of an increased emphasis on placing clients in appropriate community settings. The number of facilities is projected to increase to 3,250 by July 2000.

- Four mental health consultants and one processing assistant are assigned to the licensure of mental health facilities and programs. The consultants already have average caseloads of 671 facilities.

- On-site inspections are done during the initial licensure of residential facilities. The licensure of day programs and the relicensure of existing residential facilities is completed through a paper process with no routine on-site inspection.

- Complaints are referred to local officials such as county departments of social services or area mental health programs. The Group Care Section does not have enough staff to routinely respond to complaints with an on-site inspection.

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION RESPONSIBILITIES

The Construction section has the following responsibilities:

- ✓ Review plans for new construction, conversions, additions, and renovations of all health and social care facilities
- ✓ On-site inspection of each project's regulatory compliance with licensure standards related to physical plant systems and life safety code requirements during the building process and a final inspection once the project is completed
- ✓ Routine inspections of existing facilities to monitor continued compliance with licensure requirements
- ✓ Consultation services

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION OVERSIGHT

Approximately 5,020 health and social care facilities have Construction Section oversight -- a 40% increase since 1993.

- Hospitals
- Nursing Homes
- Adult Care Homes
- Child Caring Institutions
- Abortion Clinics
- Hospice Facilities
- Outpatient Surgery
- Family Care Homes
- DDA Group Homes
- Mental Health Facilities -- Residential
- Mental Health Facilities -- Day Programs

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

PLAN REVIEWS AND INSPECTIONS

- Plan review turn around times have increased from an average of 4 to 5 weeks in 1987 to an average of 18-24 weeks in 1998.

- Interim inspections of construction/alteration projects were discontinued in 1989 as the workload increased.

- Final inspections of completed construction/alteration projects for hospitals, nursing homes, adult care homes, and outpatient surgery facilities are conducted by the Construction Section.

- Final inspections of completed construction/alteration projects for residential facilities -- family care homes, DDA group homes, and mental health group homes -- are completed by local officials who supply the Construction Section with written documentation.

- Plans for mental health facilities day programs are not directly reviewed by the Construction Section. Consultation services are supplied upon request.

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

PLAN REVIEWS AND INSPECTIONS

Delays in the plan review process and limitations on inspections have several consequences:

-- Increased cost for providers who must wait for plan review and approval before they can build

-- Decreased or delayed availability of social and health care services for consumers

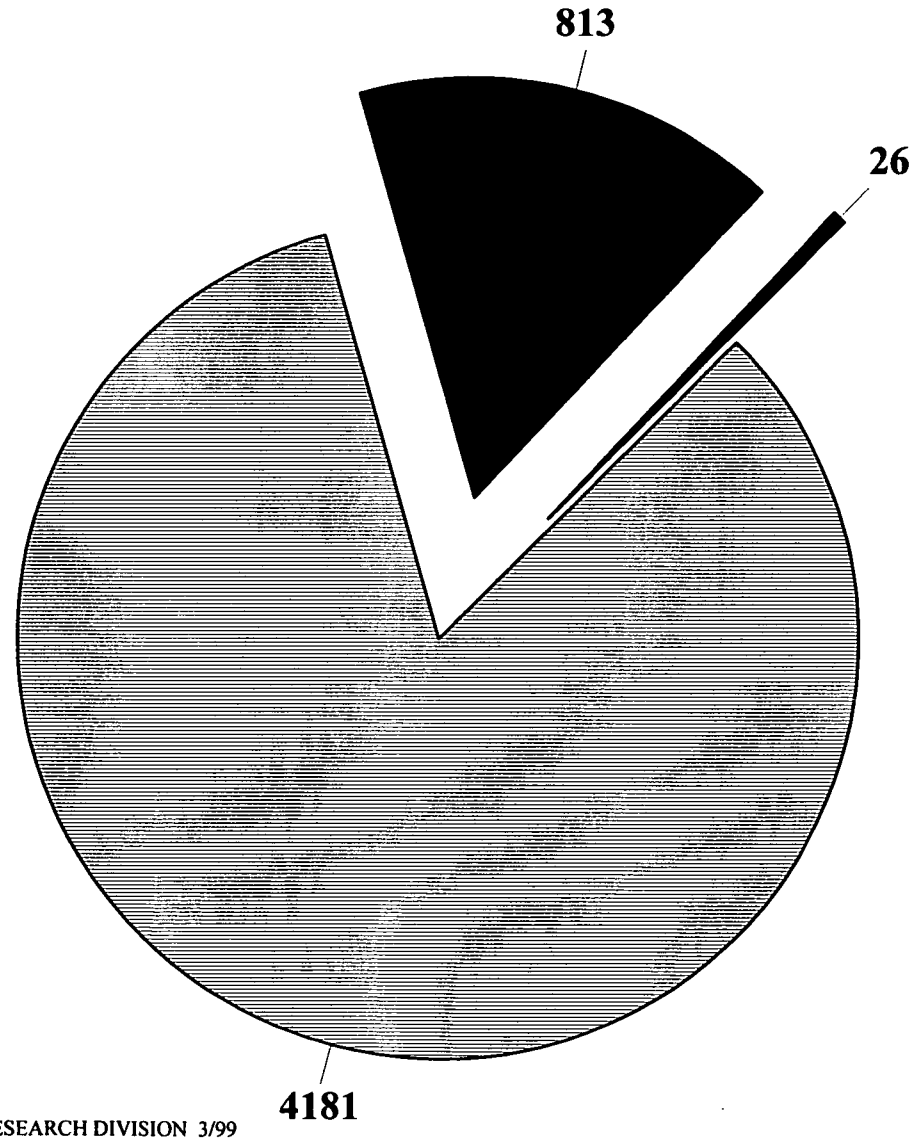
-- Increased cost for providers to solve problems uncovered during a final inspection after a project is completed

-- Decreased safety in residential facilities not inspected by the Construction Section after a construction/alteration project is completed

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

INSPECTION OF EXISTING FACILITIES FOR 1997-98



- Complaints
- Mandated Federal Inspections
- Facilities Not Routinely Inspected

Total Facilities: 5,020

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

INSPECTION OF EXISTING FACILITIES

Federal Inspections

Federal law mandates that nursing homes, intermediate care facilities for the mentally retarded, outpatient surgery facilities and at least 5% of all hospitals be inspected annually for Life Safety Code requirements.

The federal inspections are supported by funding through Medicare and Medicaid; the positions conducting these inspections are not permitted to conduct state licensure inspections.

State Inspections

Inspections of existing state facilities for regulatory compliance with licensure standards related to physical plant systems and life safety code requirements were discontinued in 1989 due to increased workloads and to maintain a plan review turn around time of 8 to 9 weeks.

In the past ten years, over **4,100 existing health and social care facilities** have not received a routine inspection for regulatory compliance with licensure standards related to physical plant systems and life safety code requirements.

All complaints relating to problems with physical plant systems or life safety code requirements are investigated and a routine inspection is conducted as a part of the investigation.

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION

FEE SCHEDULE PROPOSAL

Background

The 1998 General Assembly directed the Division of Facility Services to develop a schedule of fees to defray the cost of processing and reviewing construction plans for social and health care facilities and for conducting physical plant inspection of these facilities.

Since the Division does not charge social and health care facilities for these services, the Division surveyed other states to obtain data on similar fees charged by them.

Fee Schedule Proposal

The Department recommended the following fee schedule in its report:

> The Department shall establish and collect fees from all applicants for licensure under GS 131D, 131E, and 122C who submit construction plans for review and approval. The fee schedule established should generate sufficient funds to offset one-half on the entire cost of the unit charged with the responsibility of reviewing and approving the construction of licensed facilities. This fee may not exceed $30,000 and may not be less than $125.

DIVISION OF FACILITY SERVICES

CONSTRUCTION SECTION
FEE SCHEDULE PROPOSAL

Based on the following assumptions, the Department's proposed fee schedule is expected to generate $1.3 million in revenue -- enough funding to support 17 new positions:

- ✓ $125 plan submittal fee is all-inclusive for projects with $25,000 value or less
- ✓ An additional .4% fee charged on portion of a project value above $25,000
- ✓ Maximum plan review fee of $30,000 for projects valued above $7.5 million.
- ✓ Average per project fee ranges from $125 to $3,739
- ✓ Larger and more complicated projects requiring more review will cost more
- ✓ Minimum $125 processing fee eliminates frivolous submission of plans

FRD

DIVISION OF FACILITY SERVICES

LICENSURE AND CERTIFICATION SECTION
COMPLAINT INVESTIGATIONS

Complaint Investigations: The Division of Facility Services is required under State law to investigate all complaints in nursing homes within 60 days. Federal policy require complaints in nursing homes which are considered serious and an immediate danger to patients to be investigated within 2 days. There are no State mandated time frames for complaint investigations in other health care facilities.

Staffing: 20 positions are assigned to handle all complaints -- 17 positions for nursing homes and 3 positions for all other health care facilities. Complaint investigation staff has not been increased since 1989 when the General Assembly authorized 8 positions.

Workload: The number of complaints in health care facilities has increased from 996 in 1995-96 to 1,428 in 1987-98 -- a 30% increase. Over 92% of the complaints come from nursing homes and intensive care facilities for the mentally retarded.

DIVISION OF FACILITY SERVICES

LICENSURE AND CERTIFICATION SECTION

COMPLAINT INVESTIGATIONS

Does the Licensure and Certification Section have adequate staff to investigate complaints in a timely manner?

The Division of Facility Services began tracking the number of complaint investigations completed within 60 days in July 1998. During the first quarter, 32% of the investigations were not completed within 60 days. During the second quarter, the number of investigations not completed within 60 days increased to 45%.

Is a 60-day complaint investigation time-frame reasonable?

- Evidence relating to a complaint investigation may disappear before the investigation is completed.
- The public demands that investigations be more timely than 60 days.
- A shorter time-frame will require significantly more staff to investigate complaints.

DIVISION OF FACILITY SERVICES

HEALTH CARE PERSONNEL REGISTRY

Creation: The Health Care Personnel Registry was established by the General Assembly in 1996 by expanding the existing Nurse Aide Registry for nursing homes to include a second registry that lists all unlicensed health care assistive personnel that provide hands on care to residents in health and social care facilities that have a finding of abuse, neglect, misappropriation of resident or facility property, fraud against a resident or facility, and diversion of resident or facility drugs.

The law applies to the following facilities:

- Nursing Homes
- Hospitals
- Hospice Agencies
- Nursing Pools
- Adult Care Homes
- Family Care Homes
- DDA Group Homes
- Home Care Agencies
- **State Operated Facilities**
- **Residential Facilities and Hospitals for the Mentally Ill, Developmental Disabled, or Substance Abusers**

DIVISION OF FACILITY SERVICES

HEALTH CARE PERSONNEL REGISTRY

Regulated Programs and Facilities: Under the new law, the number of facilities and programs covered under the Health Care Personnel Registry has increased from 396 to 6,181 -- a 1500% increase. Over 2.500 facilities and programs were added in 1996 and 3,300 were added in 1999.

Staffing: Under the new law, staff has increased from 13 to 31 positions. 10.7 positions are state funded and 20.3 positions are federal funded. 6 of the state positions were authorized effective January 1, 1999.

Does the Health Care Personnel Registry have adequate staff to regulate the facilities and programs mandated under state law?

???

Attachment III

March 11, 1999

III

Developmental Disabilities
Waiting List Reduction
March 1, 1999

- January 1, 1998, Area MH/DD/SAS waiting list process revealed 7,178 children and adults with developmental disabilities waiting for service.

- $9.3 million ($6 million state appropriation; $3.3 million TANF transfer) were allocated to the Area Programs in December 1998 using a formula based on numbers of persons waiting in each of the Areas. The commitment was made to use these funds to reduce the number of persons waiting for service by 750 by June 30, 1999.

- The Area Programs were provided technical assistance, consultation and support by the Developmental Disability Services Section and Regional DD Coordinators. Areas are required to report on the utilization of DD waiting list dollars every month with the first report due on February 15.

- The attached is a summary of the information submitted in these first Area reports.

Developmental Disabilities Waiting List Reduction: March 1, 1999

Individuals Removed from the DD Waiting List (Summary)

	Individuals	CAP	State	TANF	Medicaid	Other	TBI	Sum of Services Received	Ave # of Services Received
State Totals	*992	301	247	20	197	393	31	1335	1.5

267 people from Waiting List

Individuals Remaining on the DD Waiting List Receiving Services (Summary)

	Individuals	CAP	State	TANF	Medicaid	Other	TBI	Sum of Services Received	Ave # of Services Received	Sum of Additional Service Needs	Ave # of Additional Service Needs
State Totals	384	134	89	6	99	128	20	362	1.3	465	1.2

*Reflects the unduplicated count of persons removed from the waiting list. Each person may have had services funded through multiple sources.
*Data does not include Albemarle.

March 11, 1999

IV

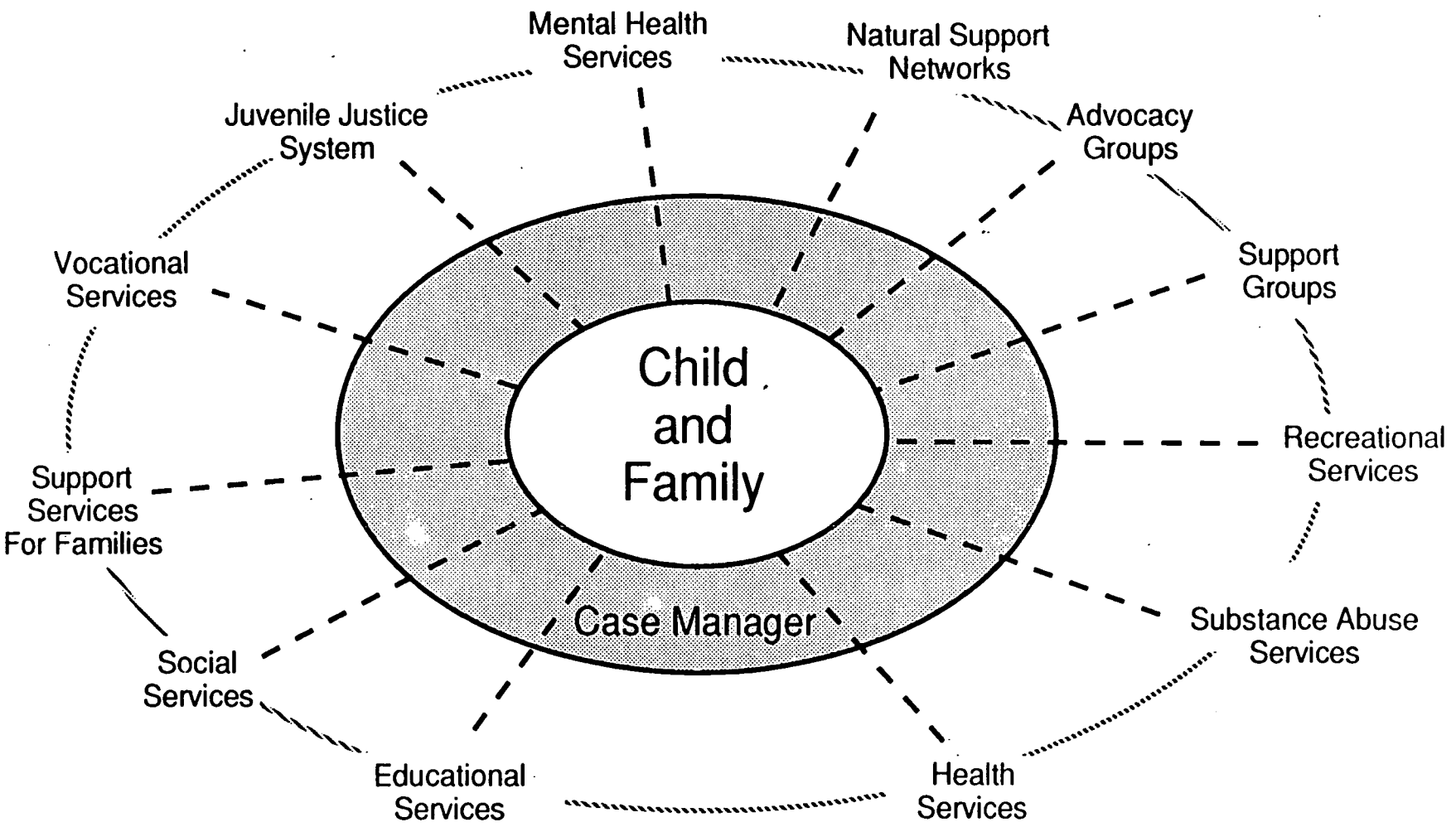
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

Child and Family Services Section

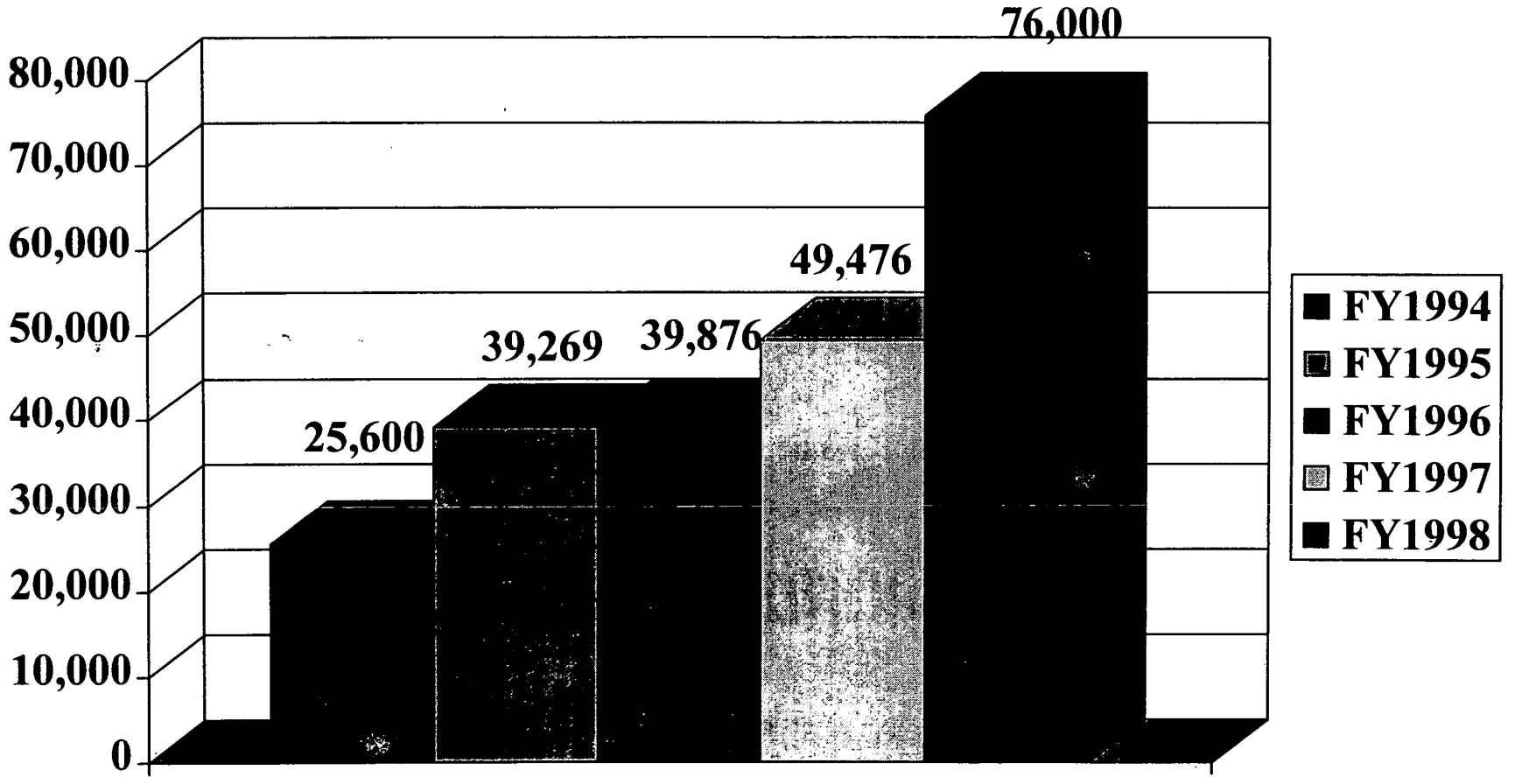
Lenore Behar, Ph.D. - Speaker

Chief

Service Network to Meet Mental Health Needs of Children and Adolescents and Their Families

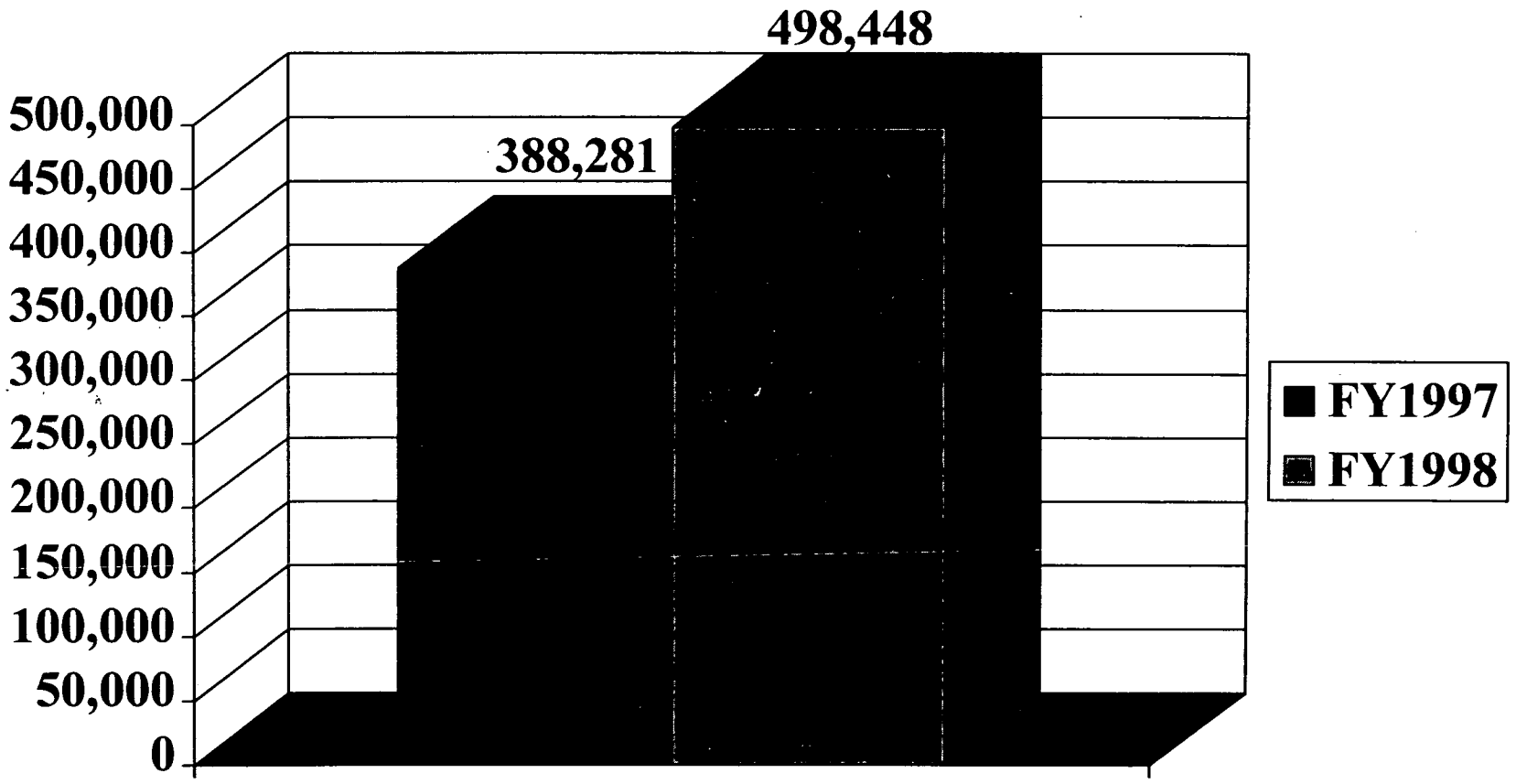


Number of Children and Adolescents Receiving Services from Area Programs



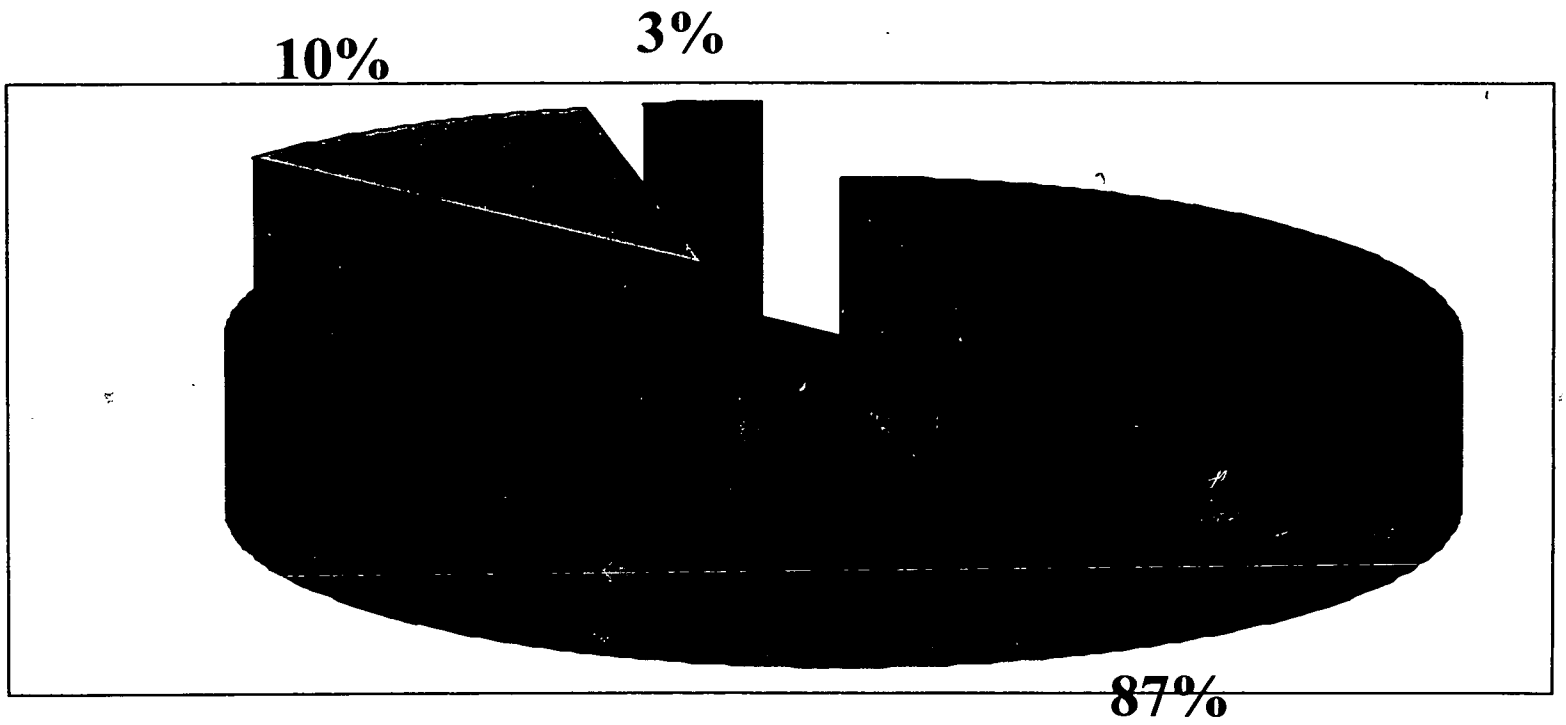
DMH/DD/SAS, Child and Family Services

Units of Case Management Provided to Children and Adolescents in Area Programs



DMH/DD/SAS, Child and Family Services

Level of Severity of Children Served by Area Programs During FY98



DMH/DD/SAS, Child and Family Services Section

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-11- 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Heather Jaffler	OSA
Lon Walker	NCALTCF
Brenda Williamson	DET
Patrice Rowley	NCACC
C. L. Cochran	UCPNC - C2001
Dan Richard	Arc Me
Janet Simoneau	NC Council
NELS ROSELAND	OSBM
[illegible]	OSPL
HUGH TILSON	NCHA
Peggy Balak	Thomas S MH/DD/SAS
Charles Davis	William MH/DD/SAS
Lisa Abatemarco	DHHS/BP&A
ART ECCLESTON	DIV MH/DD/SAS
Mary Eldridge	DIV MH/DD/SAS
MICHELLE COTTON	DMH/DD/SAS
Roslyn Sawitt	NC Child Care Coalition
[illegible] Behar	DMH/DD/SAS
Don Willis	DMH DD SAS
[illegible] Stein	DMH/DD/SAS
Jara Larson	DMH/DD/SAS
Pat Porter	DMH/DD/SAS
Wayne Williams	OSBM
John Bowdish	Zeb Alley P.A.
[illegible]	OSBM
John Baggett	MH DD GA
Allyn Duffey	DHHS
A. Donna McBride	DHHS

NORTH CAROLINA GENERAL ASSEMBLY

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

March 16, 1999
8:30 a.m.

Sen. Bill Martin, Chair called the meeting to order and introduced the pages. He then recognized Karen Hammonds-Blanks to continue covering the area Mental Health Program Systems. There were five members of the Senate present and the following members of the House were present: Representative Earle, Representative Nye, Representative Alexander, Representative Adams, Representative Cansler, Representative Esposito, Representative Walend.

Karen Hammonds-Blanks spoke from the attached handout on Area Health Program Systems. She began with an overview of the system and profiled three specific areas of the system and ended with the situation that the area programs find themselves in today.

Karen went over the organization of the system and stated that they must operate within the limitations of the State law. However each board sets the policies and guidelines the area programs. There is a relationship with the Department of Health and Human Services in that the Secretary has the authority to approve their plans and budgets.

During her presentation Committee members asked the following questions:

Rep. Nye - A breakdown by counties of how much each is contributing to Area Programs?

Sen. Martin - Would it help to have more regular reporting of expenditures?

Rep. Alexander - Why and under what circumstances are counties seeking to reduce their appropriations?

Sen. Phillips - Do counties feel that they are involved in decision-making that affects the Mental Health Authorities?

Do we have a proactive, sincere Area Program with a program board that's knowledgeable of what's going on in its community?

Rep. Esposito - Once the County Commissioners appoint these boards are they autonomous,

Sen. Martin - Model programs and their characteristics, will you provide it to the entire committee a listing of a few of the model programs and some of the characteristics?

Sen. Dannelly - What contributed to the significant growth from page 13 to page 18?

Sen. Kerr - Have we mandated match increases on Medicaid? How much of the increase spending by counties can be attributed to legislative mandates?

Rep. Cansler - If the total state $ are added to state match then what is the total state contribution? (See p. 17)

Sen. Dannelly - Questioned all state funds (p.14) and state funds (p. 17), the numbers should be the same for FY98? (Karen will check on numbers)

Sen. Dannelly - *Who* determines ranking? (prompted by Swann presentation, p. 3) Why do dollars received from the state not reflect clients served? Sen. Martin suggested that we take a look at equity issue and formulas.

Sen. Martin stated recognized three Area Directors David Swan, of The Crossroads, Mike Watson of Sandhills and Ron Morton.

David Swan, Area Director of the Crossroads Health Care Area Program stated that he is concerned about the public image of Community Mental Health Centers. He represents Iredell, Yadkin and Surry Counties. (Handout Attached)

Questions to Mr. Swan:

Sen. Dannelly - Who determines the ranking and how are they determined?
When we look at page 3, and see them ranking in the bottom 6, and I see not too much of a span between a population of 195 and 215. The population of 215 is getting $14.3 Million and the population of 195 is getting $28 Million, where is the fairness? Can someone show me in writing, in a concise form, how we arrive at a $14 Million difference and a difference of 20,000 people?

Sen. Kerr – Regarding inequities and unfairness, we need to get into it and find out what is going on.

Sen. Martin agreed that the Committee should examine the different elements that constitute the final figure and the inequities that exist.

The Chair thanked everyone for their participation and recessed the meeting at 9:55 a.m. to continue this discussion at 2:00 p.m. today.

APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES
March 16, 1999 2:00 p.m.
Continuation of morning meeting

Sen. Bill Martin called the meeting to order and stated that the Committee would continue the discussion on Area Health programs. There were five members of the Senate present and the following members of the House were present: Representative Earle, Representative Nye, Representative Cansler, Representative Esposito, Representative Walend, Representative Wilson.

The Chair stated Mike Watson from Sandhills will come before the Committee to be followed by Tom Maynard, from Orange Person and Chatham Counties. He asked Karen Hammonds-Blanks to complete her presentation.

In response to Sen. Dannelly's question, Karen pointed out that on page 17, the correct number is $201 Million, not $210 Million. Beginning with page 21 of the handout, she then completed her presentation.

Karen identified four areas, three of which she recommended that the Committee take a position on and act on during this session. They are Medicaid Match Reserve; County Appropriations; Financial Incentive for existing Programs and the future of the system. After review each of the areas, the following questions were asked of Karen:

Rep. Earle – are the Area Programs still in charge of the day to day activities? She suggested that the Committee needs to act on #1 of page 38.

Sen. Martin stated that the Committee would spend some time in the near future on the issues that Karen raised.

Sen. Forrester – asked if the Department would give a presentation on Year 2000 and the Area Programs?
Sen. Martin stated that the Committee will continue questions on Karen's presentation during the next meeting.

In his remarks to the Committee, Tom Maynard reviewed the accomplishments of the Area Mental Health Programs.

The meeting was adjourned at 3:00 p.m.

Sen. William N. martin, Chair

Joyce C. Hodge, Clerk

AGENDA

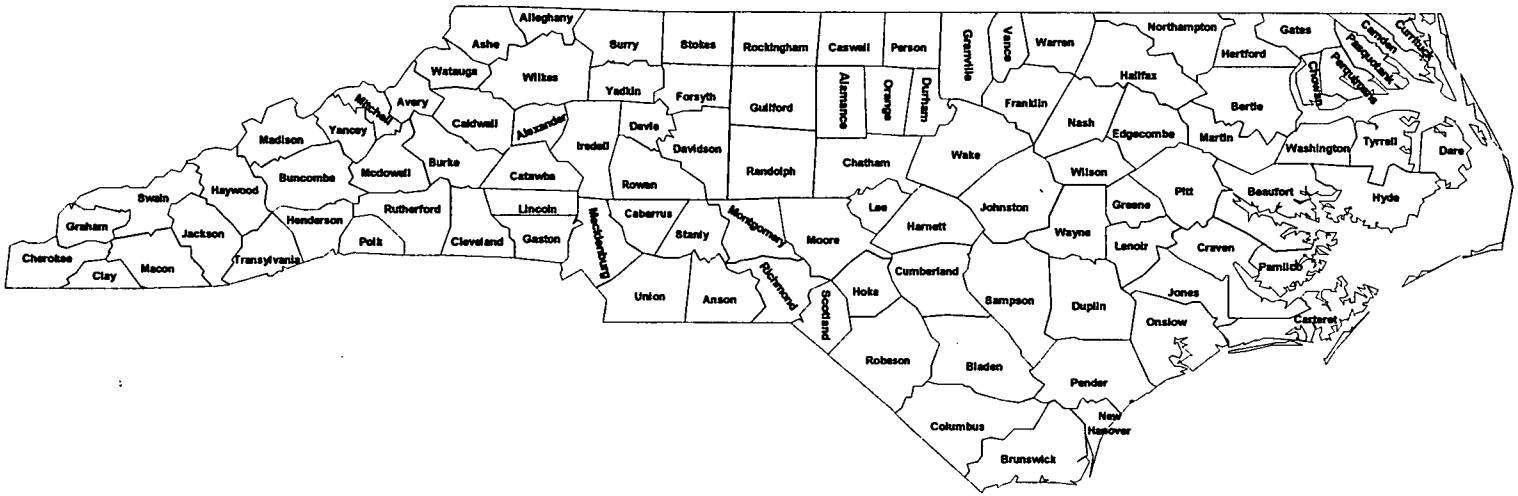
Joint Subcommittee on Health and Human Services Appropriations

Legislative Office Building - Room 424
Tuesday, March 16, 1999
8:30 a.m.

Opening Remarks	Sen. Bill Martin, Co-Chair Rep. Beverly Earle, Co-Chair Rep. Edd Nye, Co-Chair
Division of Mental Health, Developmental Disabilities & Substance Abuse Services	Karen Hammonds-Blanks Fiscal Research Division
Adjourn	

Phillips

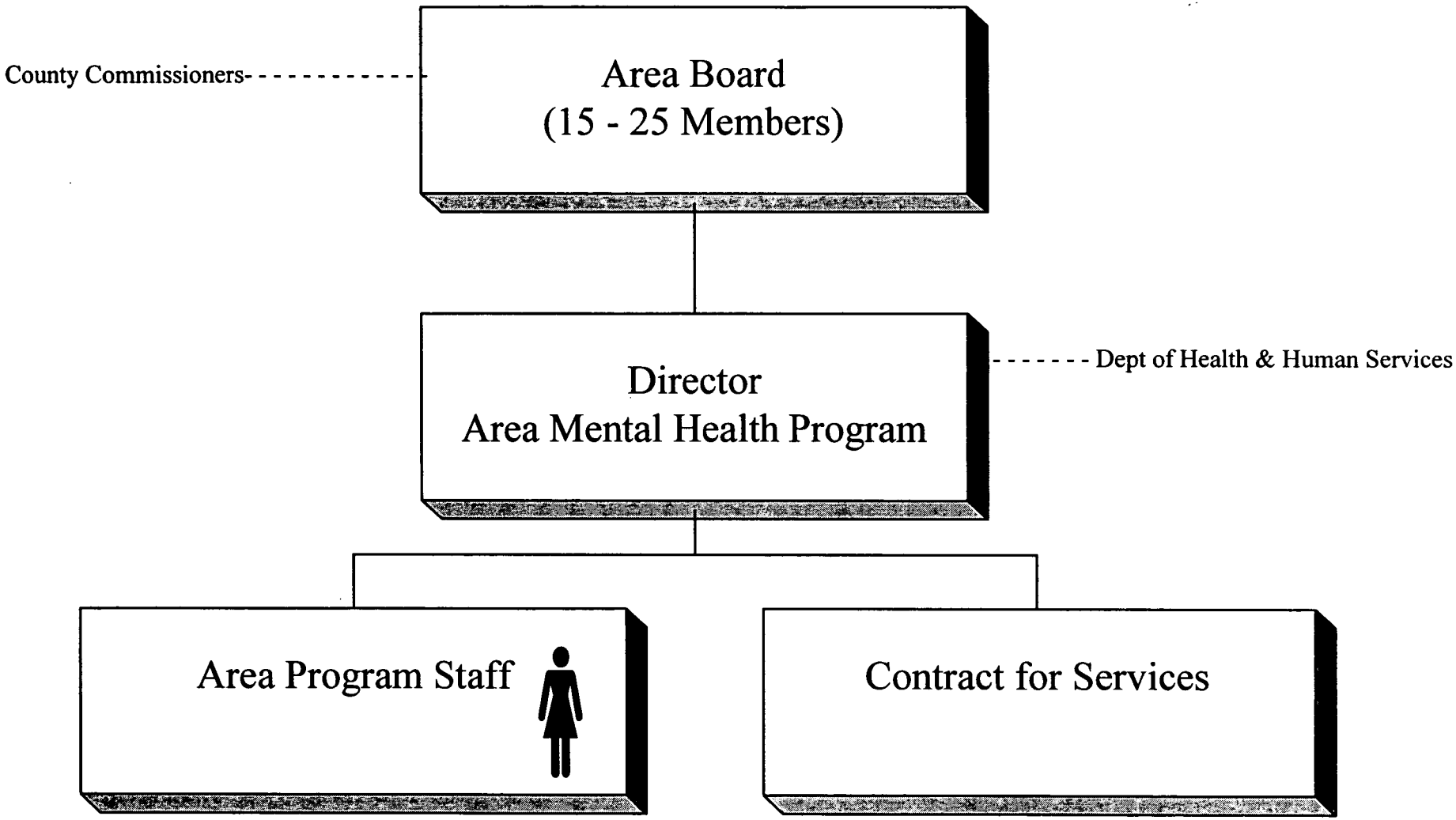
NORTH CAROLINA'S PUBLIC MENTAL HEALTH SYSTEM



FISCAL RESEARCH DIVISION

MARCH 16, 1999

NORTH CAROLINA AREA MENTAL HEALTH PROGRAMS



NORTH CAROLINA'S PUBLIC MENTAL HEALTH SYSTEM

AREA MENTAL HEALTH PROGRAMS

The provision of mental health in North Carolina is a cooperative effort of the state and local governments. Public mental health services are coordinated and delivered primarily on the local level by Area Mental Health Authorities/Programs. Area Programs provide services directly or under contract with other service providers. All funds appropriated by the General Assembly for the purpose of providing these services are administered by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

§ *G.S. 122C-2. North Carolina Policy*

State and local governments shall develop and maintain a unified system of services centered in area programs. The public service system will strive to provide a continuum of services for clients while considering the availability of services in the private sector. The furnishing of services to implement the policy of this section requires the cooperation and financial assistance of counties, the State, and the federal government.

AREA MENTAL HEALTH AUTHORITIES/PROGRAMS

N.C. STATUTORY AUTHORITY

§ **G.S. 122C-115. (a)** Except as provided in G.S. 153A-77, a county shall provide mental health, developmental disabilities, and substance abuse services through an area authority.

§ **G.S. 122C-116. (a)** An area authority is a local political subdivision of the State except that a single county area authority is considered a department of the county in which it is located for purposes of Chapter 159 of the General Statutes.

§ **G.S. 122C-124. Area Authority funding suspended.** - liability to recipient funds

§ **G.S. 122C-125. Area Authority financial failure; State assumption of financial control.** ✓

§ **G.S. 122C-125.1 Area Authority failure to provide services; State assumption of service delivery.** ✓

AREA MENTAL HEALTH AUTHORITIES/PROGRAMS

N.C. STATUTORY AUTHORITY

§ **G.S. 122C-115. Powers and duties of counties and cities.**
(d) Counties shall not reduce county appropriations and expenditures for area authorities because of the availability of State allocated funds, fees, capitation amounts, or fund balance to the area authority.

§ **G.S. 143-10.1A. Budget required to include State cost of local programs -- Continuation and expansion costs.**
(d) Effective July 1, 1991, the Office of Budget and Management and the Director of the Budget, with advice of the Advisory Budget Commission, shall prepare the State Budget in a format that adequately and fairly reflects the continuation costs for the State's share of locally operated programs established by statute or State appropriation.

AREA MENTAL HEALTH PROGRAMS

SELECTED FACTS

1997- Last change

- Authority System Created by State Statute 1977
- 40 Area Mental Health Authorities/Programs
  (24 are Multi-County; 16 Single County) ✓
- Governed by an Area Board
- Area Board is a Policy Making Body
- County Commissioners Appoint Area Board
- Employees Work for Area Authority

AREA MENTAL HEALTH PROGRAMS

SELECTED FACTS

- State is Divided into Four Regions (Western, North & South Central and Eastern)
- Regional Management Teams Facilitate State-Local Communication
- Area Programs Act as Gatekeepers to State Facilities (Single Portal of Entry and Exit
- N.C. Council of Community Programs

SELECTED FACTS

Catchment Area Size (population 7/97):

- Single County Range:
  - Riverstone (formerly known as Halifax) - 55,814
  - Mecklenburg - 608,567

- Multi-County Range:
  - Roanoke-Chowan (Includes Bertie, Gates, Hertford & Northampton Counties) - 87,097
  - Centerpoint (Includes Forsyth and Stokes Counties) - 330,008

Area Program Budgets:

- Budget Range:
  $3M to $46M (FY94/95)
  $6M to $73M (FY98/99)

- County Funds Range: Approximately $150,000 to $24.6M

NORTH CAROLINA'S PUBLIC MENTAL HEALTH SYSTEM

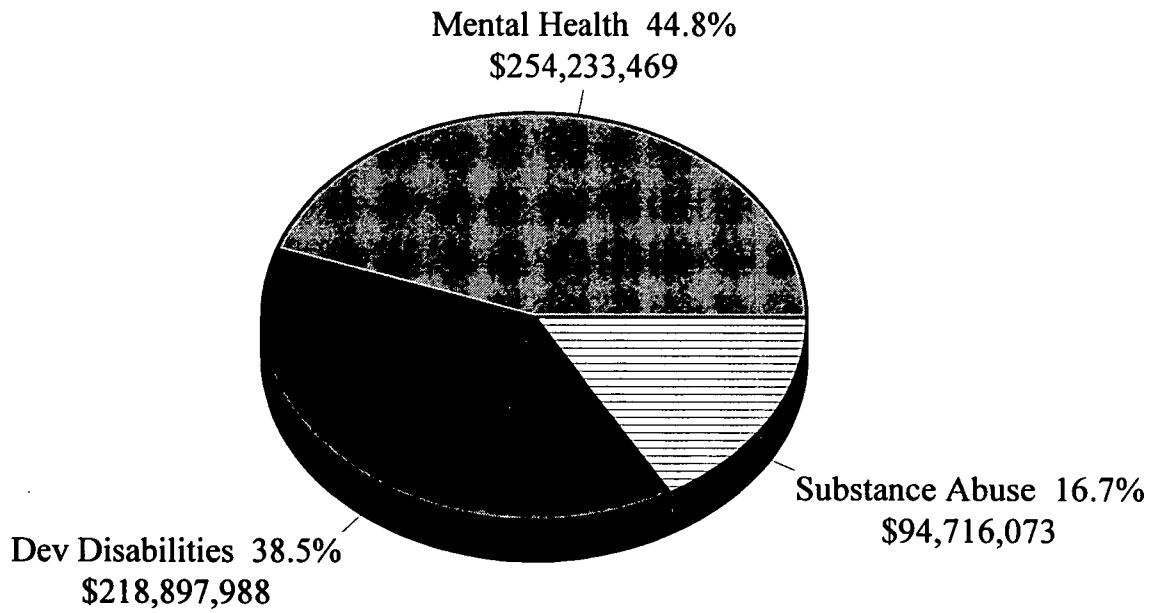
AREA MENTAL HEALTH PROGRAMS

WHAT SERVICES DO THEY PROVIDE?

- SUBSTANCE ABUSE SERVICES
- DEVELOPMENTAL DISABILITIES SERVICES
- MENTAL HEALTH SERVICES
- COORDINATION/INTEGRATION WITH OTHER HUMAN SERVICES AREAS

AREA MENTAL HEALTH PROGRAMS

PROGRAM SERVICES BY DISABILITY
FY97/98

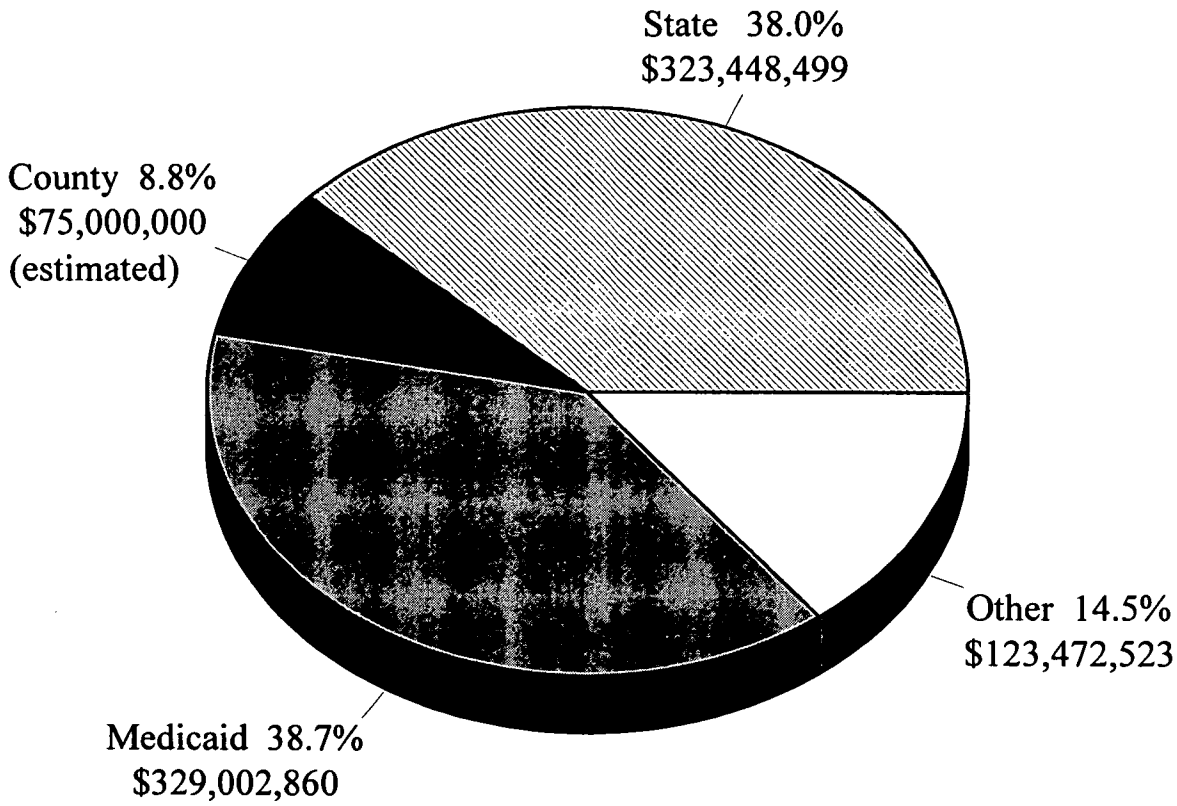


TOTAL $567.8M
(excludes Thomas S & Willie M funds)

AREA MENTAL HEALTH PROGRAMS

AREA PROGRAM FUNDS BY SOURCE

FY97/98

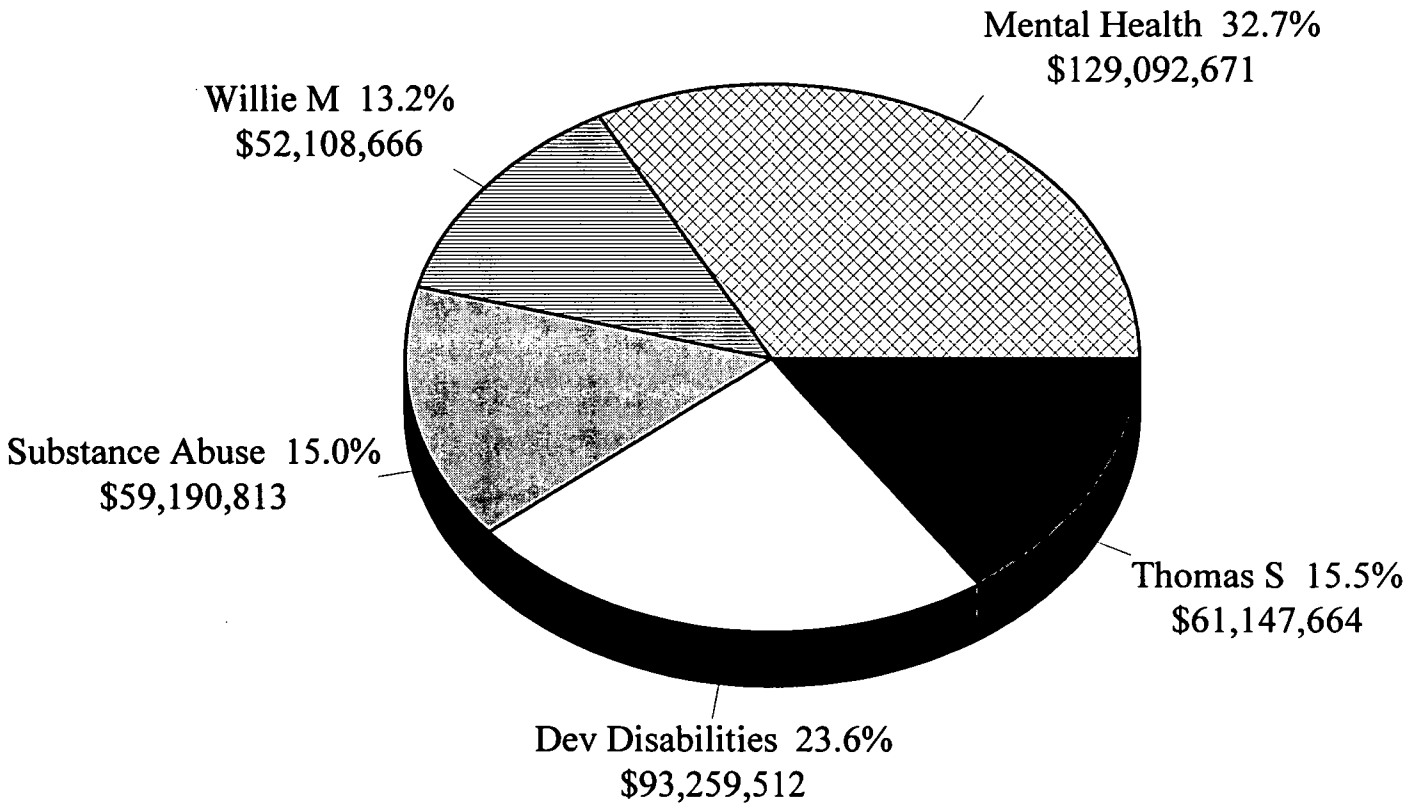


TOTAL: $850.1M

AREA MENTAL HEALTH PROGRAMS

STATE FUNDS FOR PROGRAM SERVICES

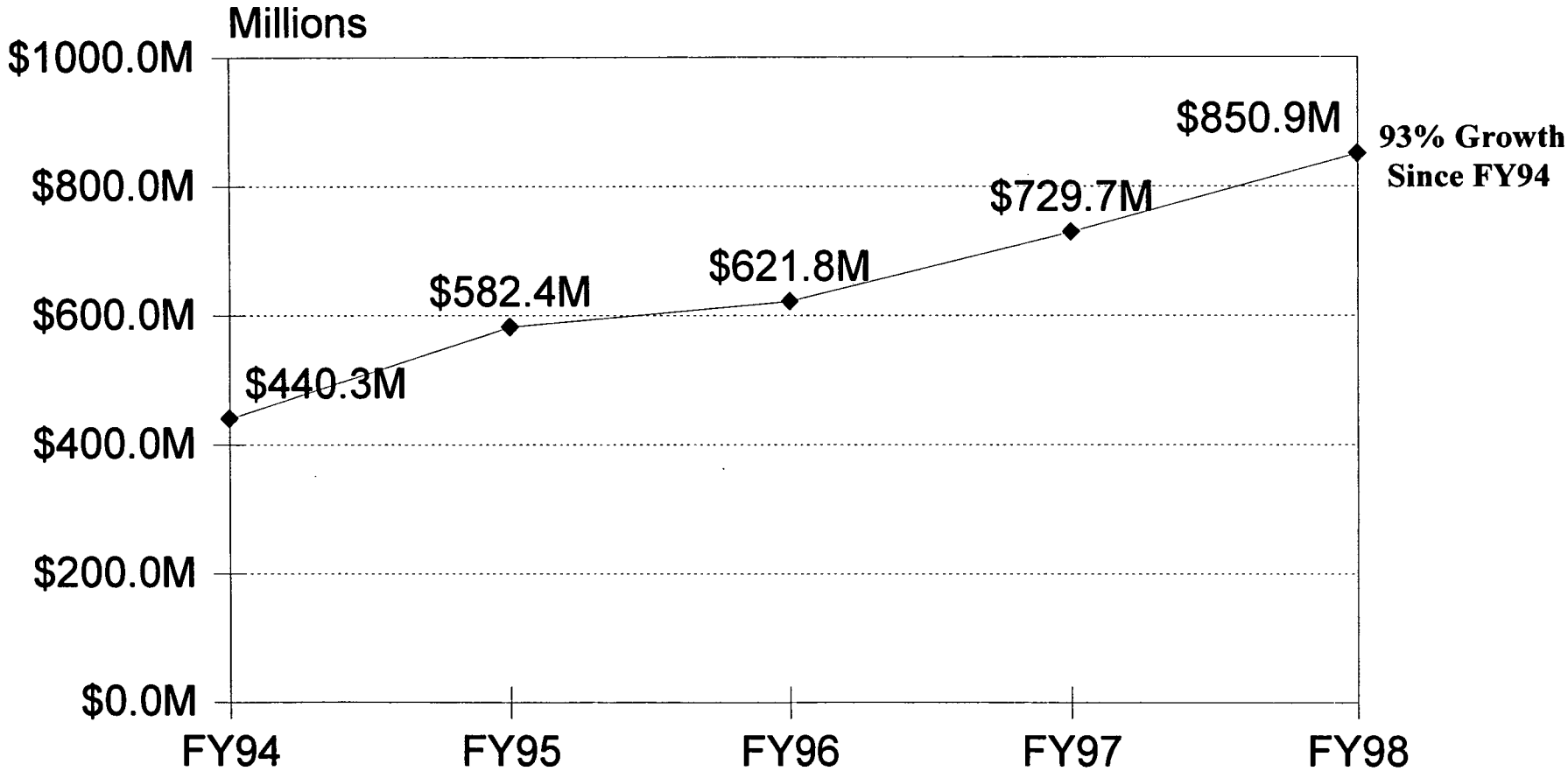
FY1997-98



TOTAL: $394,799,326

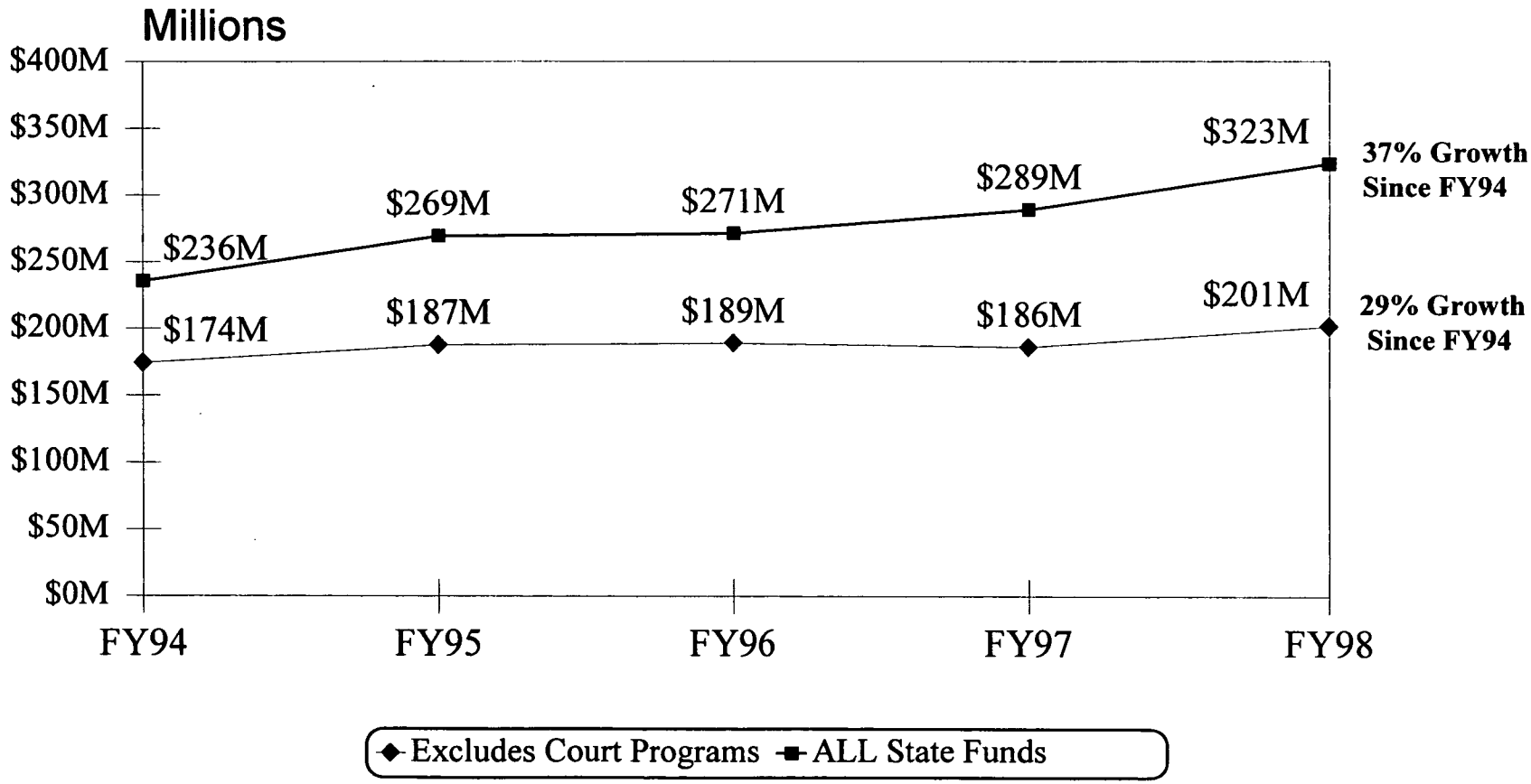
AREA MENTAL HEALTH PROGRAMS

GROWTH IN AREA PROGRAM RESOURCES



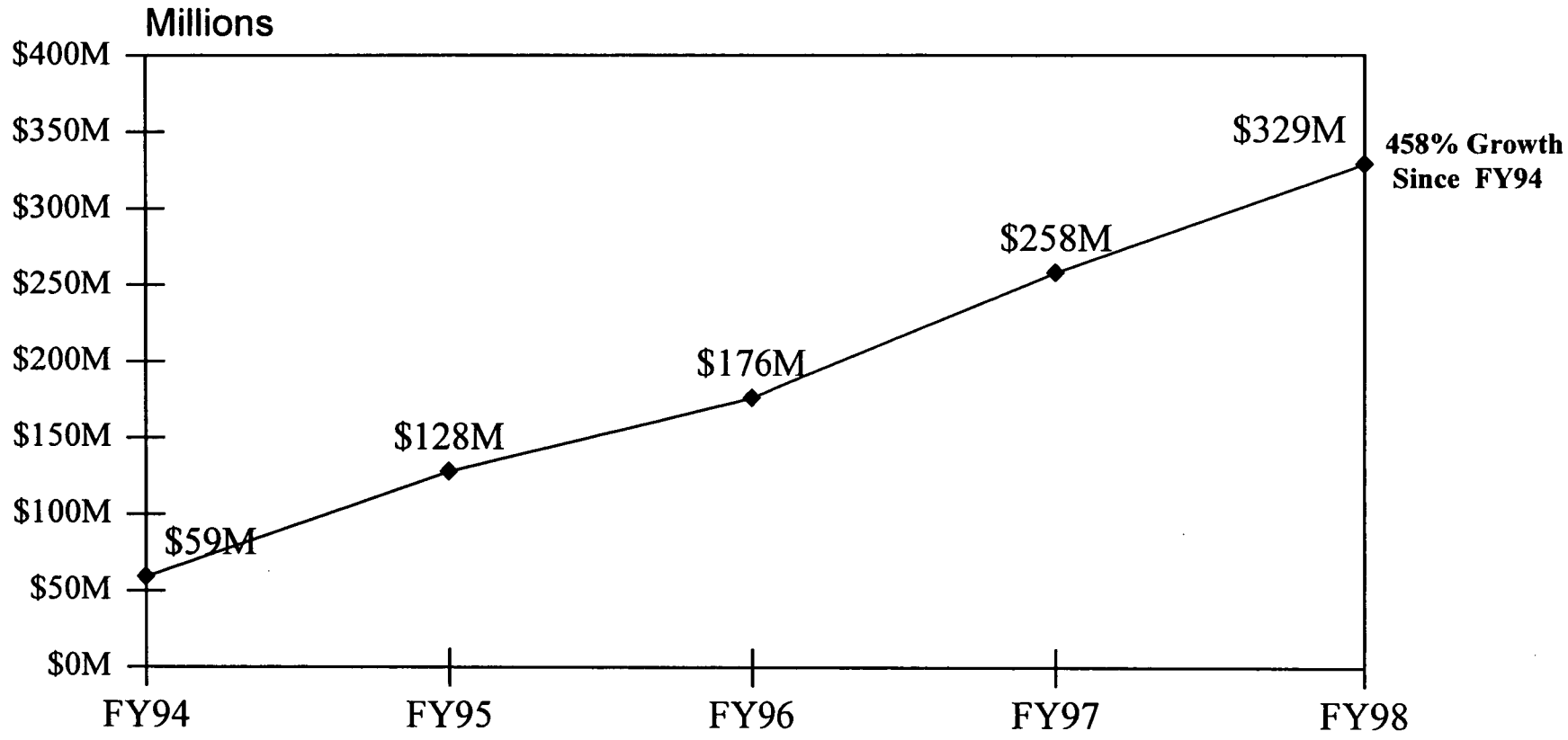
AREA MENTAL HEALTH PROGRAMS

GROWTH IN STATE APPROPRIATIONS



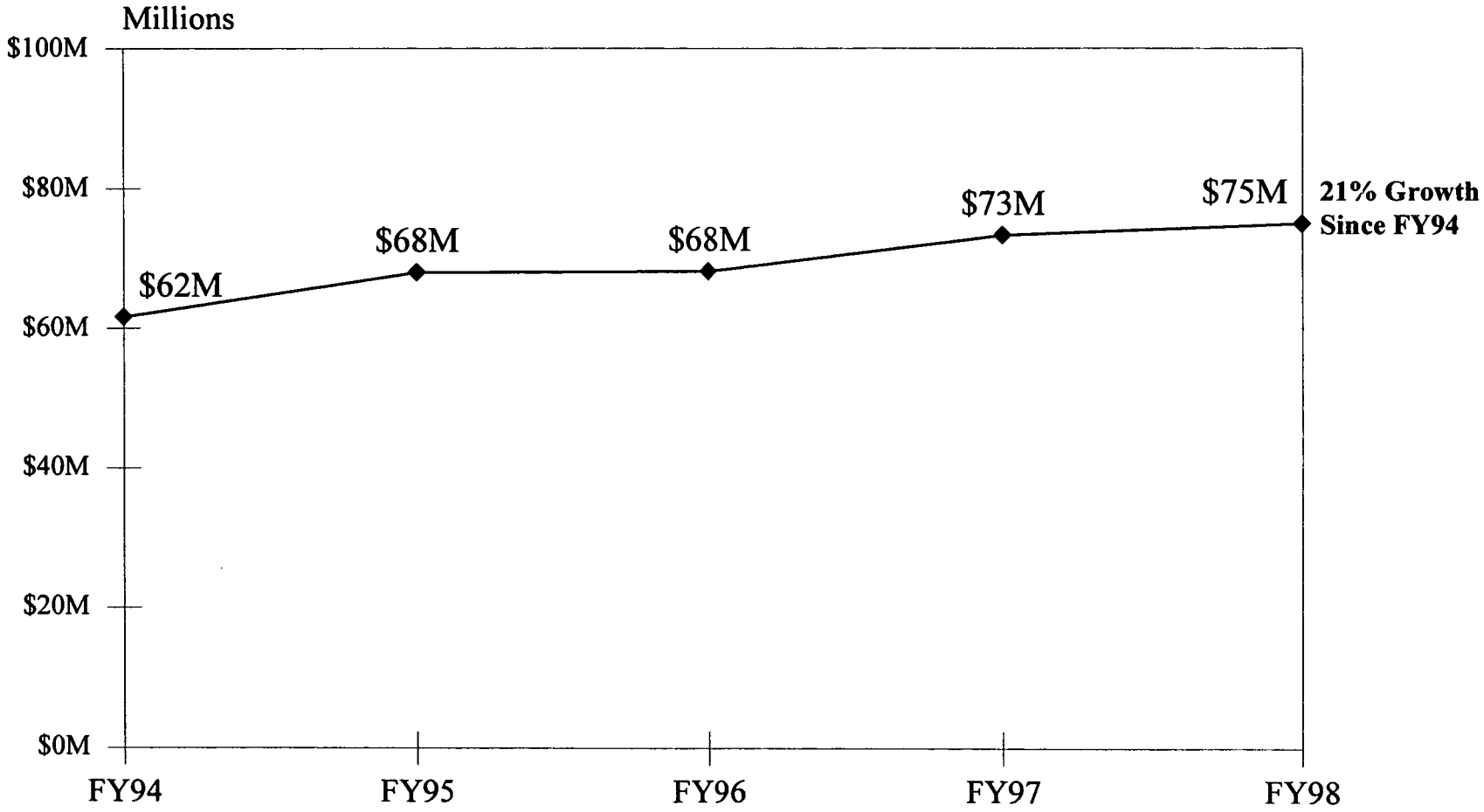
AREA MENTAL HEALTH PROGRAMS

GROWTH IN MEDICAID EXPENDITURES



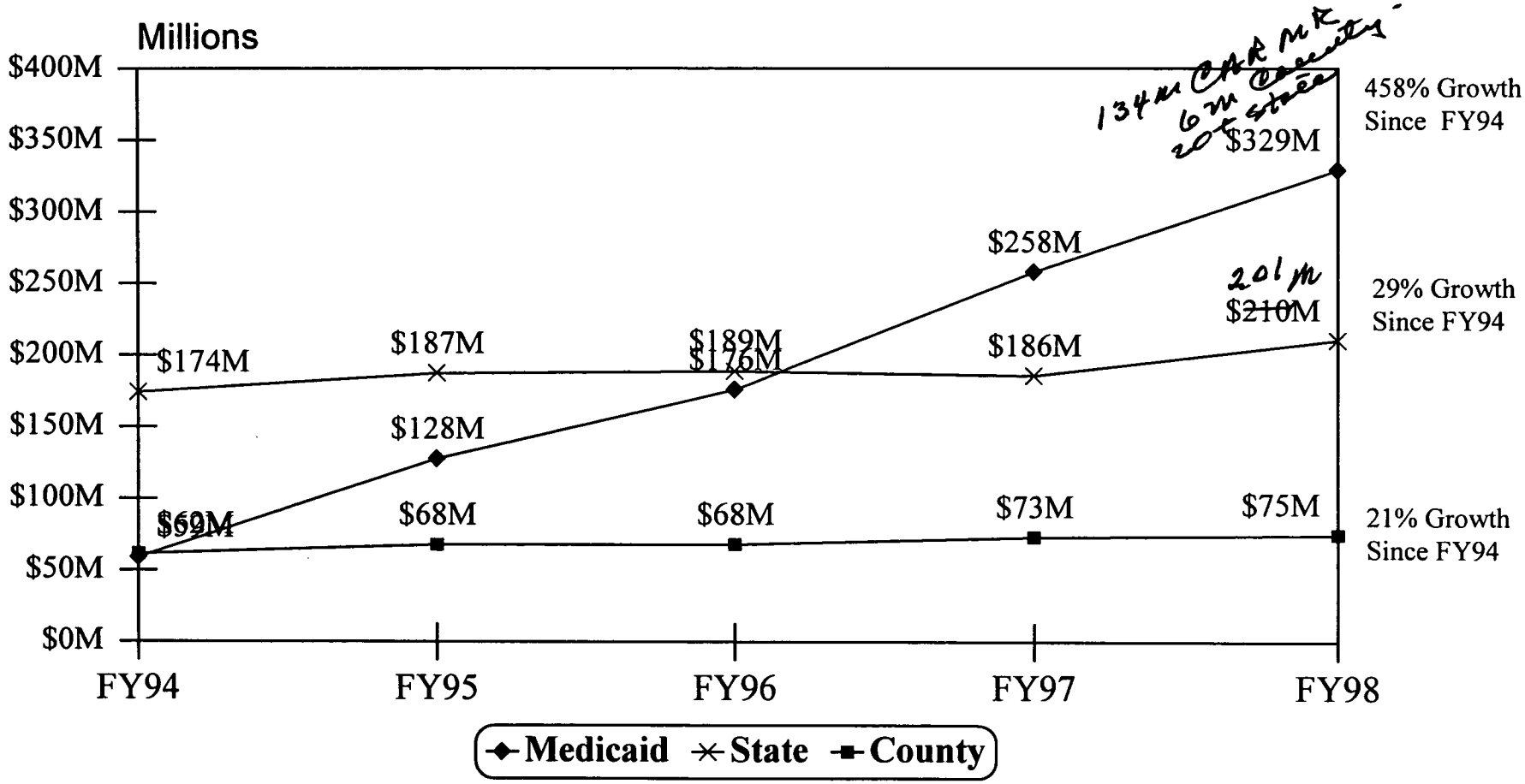
AREA MENTAL HEALTH PROGRAMS

GROWTH IN COUNTY APPROPRIATIONS



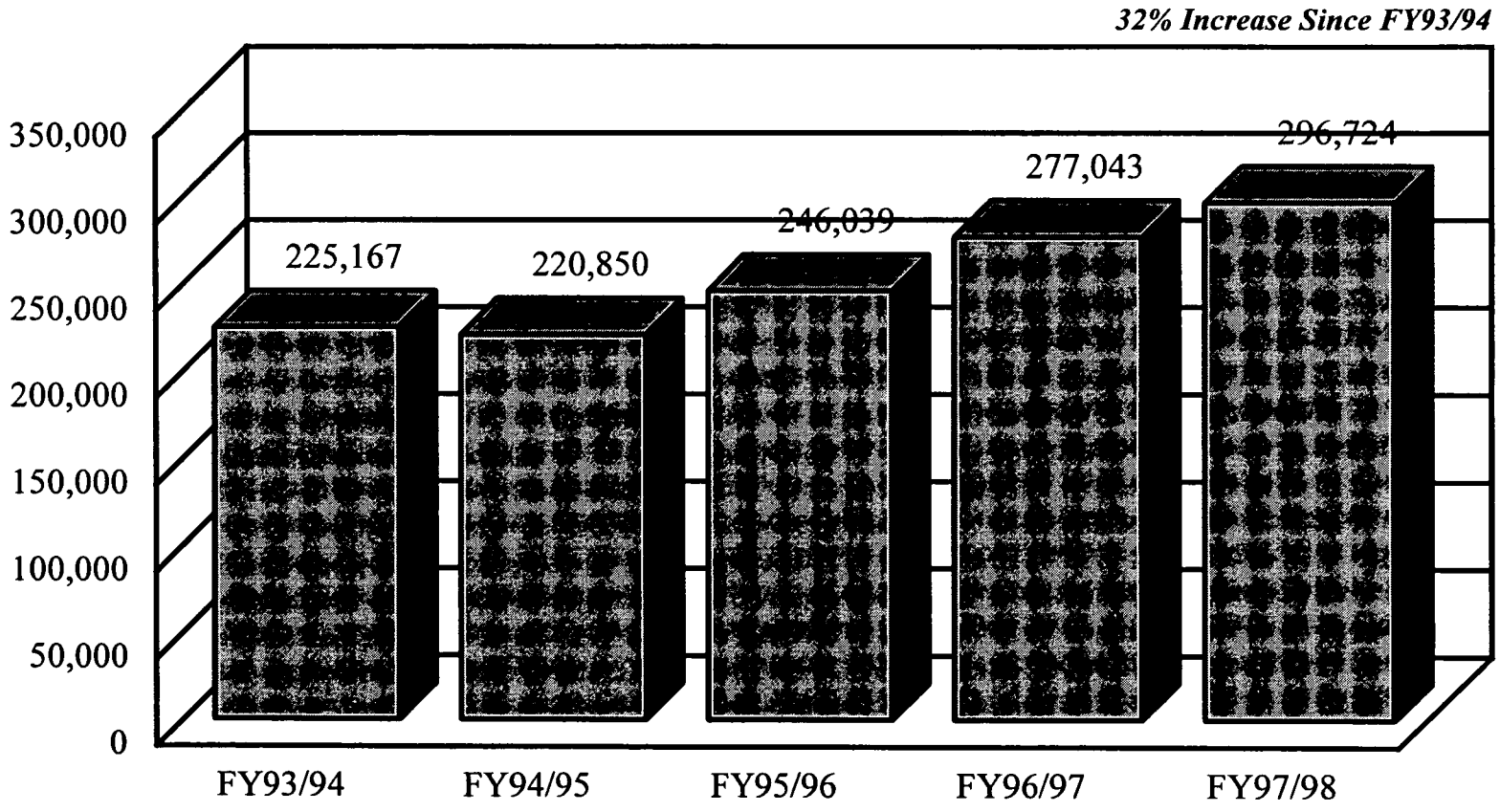
AREA MENTAL HEALTH PROGRAMS

GROWTH IN REVENUES SOURCES



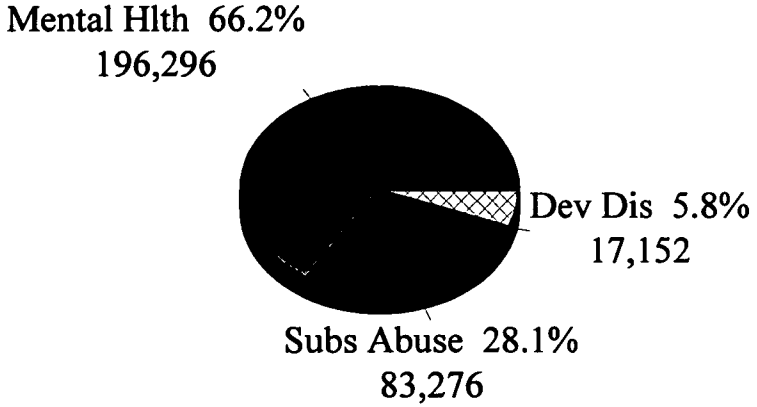
AREA MENTAL HEALTH PROGRAMS

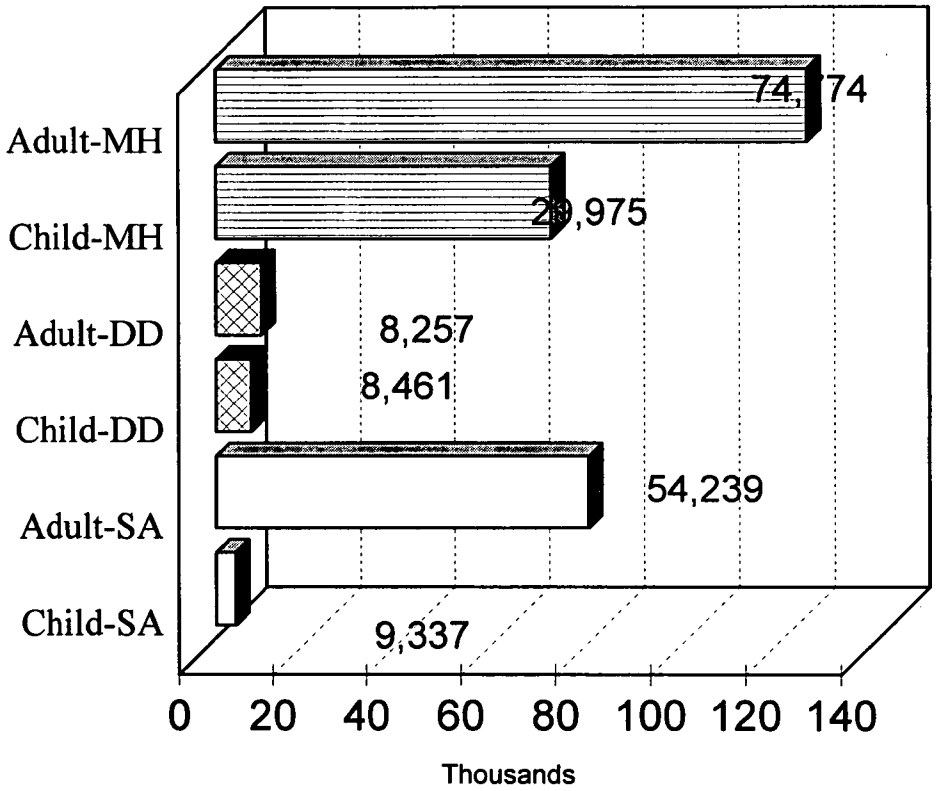
TOTAL CLIENTS SERVED
FY91/92 - FY97/98



AREA MENTAL HEALTH PROGRAMS

CLIENTS SERVED BY DISABILITY AND AGE
FY97/98

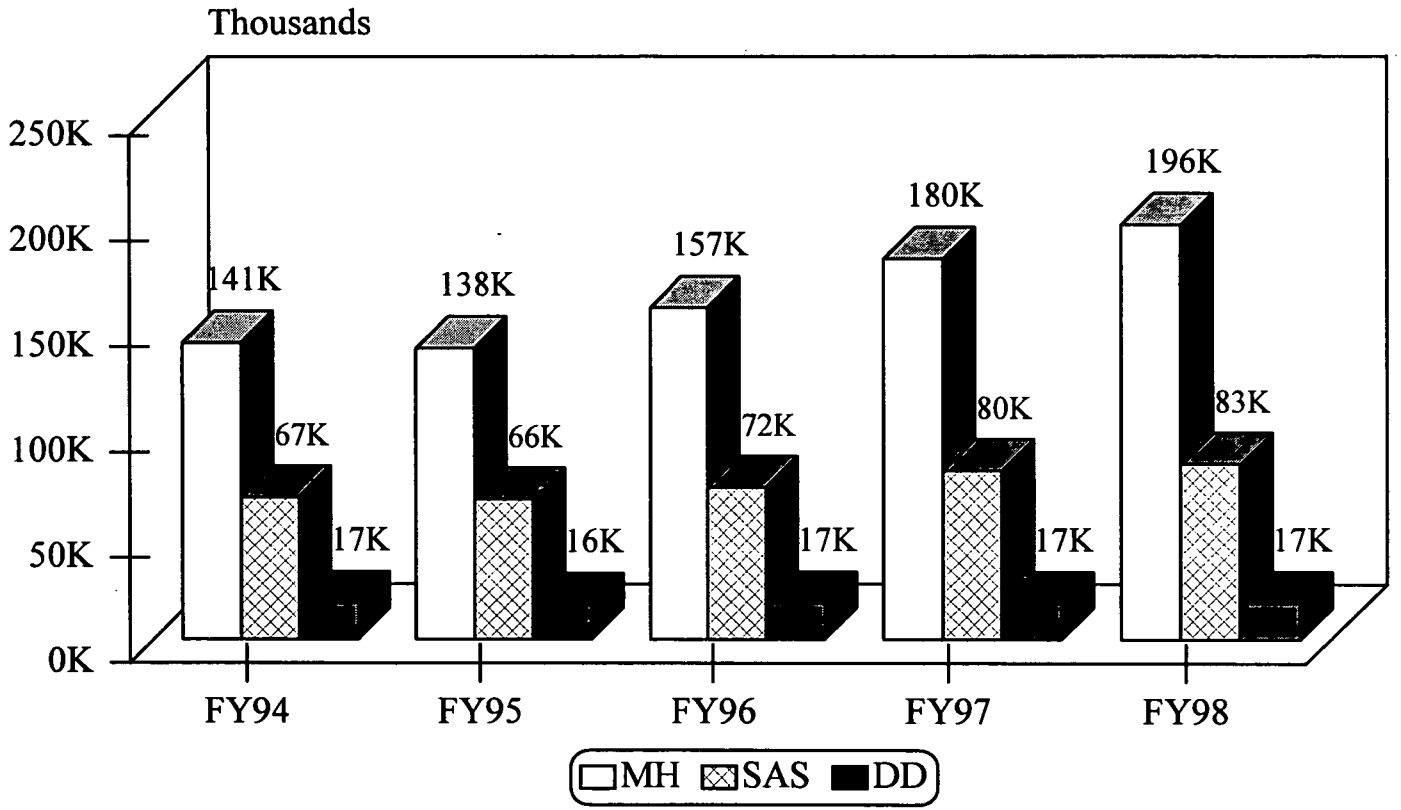




Total Clients Served: 296,724

AREA MENTAL HEALTH PROGRAMS

GROWTH IN CLIENT SERVICES BY DISABILITY



AREA MENTAL HEALTH PROGRAMS

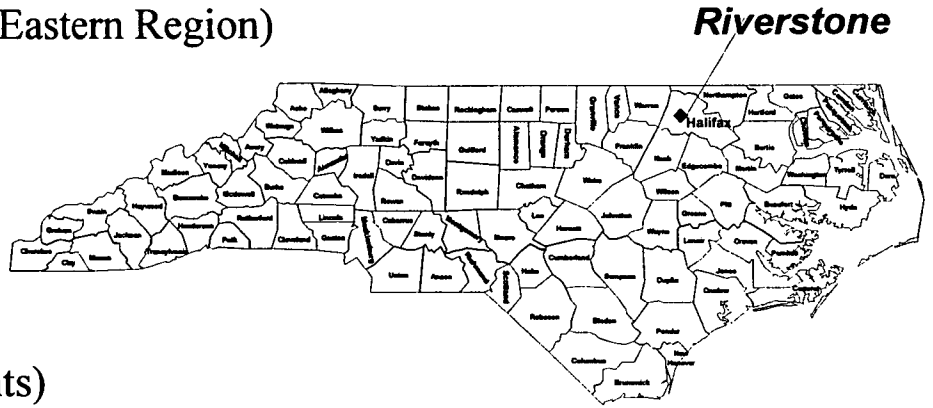
Factors Impacting the Current "Crisis" in the Area Program System

- MANAGED CARE INITIATIVES
- STATE POLICY TO MAXIMIZE FEDERAL FUNDS
- EROSION OF SUPPORT
- INADEQUATE MANAGEMENT & OVERSIGHT
- DRAMATIC SYSTEM GROWTH

AREA MENTAL HEALTH PROGRAMS

AREA PROGRAM PROFILE: RIVERSTONE

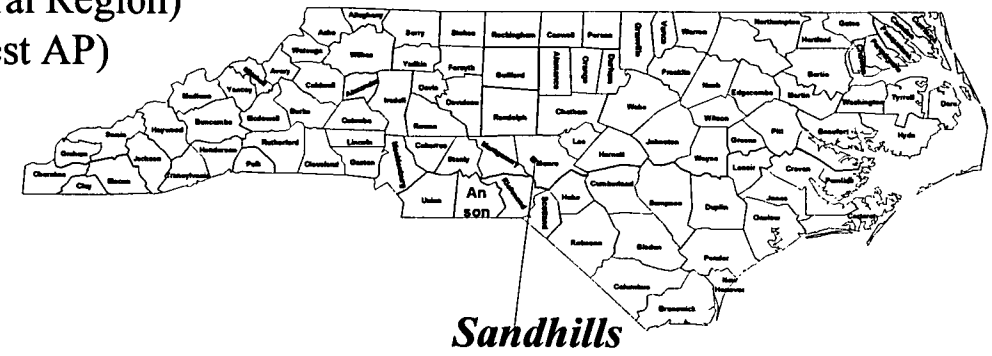
- Catchment Area: Halifax County (Eastern Region)
- Population: 55,814
- Persons Served FY97/98: 4,231
- Operating Budget: $7.86M
- Positions: 141.2 FTE's
- Financial Support:
  -4.5% County
  -39% State (Excludes Federal Grants)
  -14% Medicaid
- Patient Mix:
  -57% Medicaid
  -27% Uninsured/Indigent
- 215% Growth in Medicaid Revenues Since FY93/94
- Economic Characteristics:
  -Median Income 1998: $29,400
  -Unemployment Rate: 8.7%
  -People of All Ages in Poverty: 25.3%



AREA MENTAL HEALTH PROGRAMS

AREA PROGRAM PROFILE: SANDHILLS

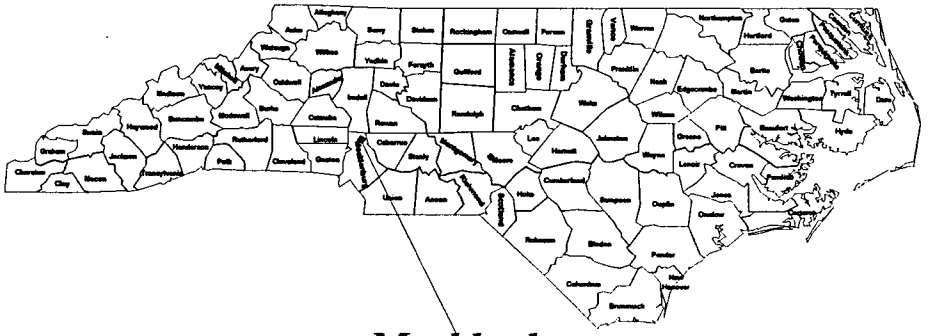
- Catchment Area: Moore, Montgomery, Hoke, Anson & Richmond Counties (South Central Region)
- Population: 192,369 (14th. Largest AP)
- Persons Served FY97/98: 6,491
- Operating Budget: $26.2M
- Positions:
- Financial Support:
  -2% County
  -22% State
  -46% Medicaid
- 215% Growth in Medicaid Revenues Since FY93/94
- Economic Characteristics:
  -Range in Median Income 1998: $25,717 - $34,412
  -Unemployment Ranges: 3.5-5.9%
  -Range of People of All Ages in Poverty: 20.2% - 10.8%



AREA MENTAL HEALTH PROGRAMS

AREA PROGRAM PROFILE: MECKLENBURG

- Catchment Area: Mecklenburg County (South Central Region)
- Population: 608,567 (Largest AP)
- Persons Served FY97/98: 25,631
- Operating Budget: $68.4M
- Positions: 713 FTE'S
- Financial Support:
  -31.2% County
  -32% State
  -21.5% Medicaid
- 215% Growth in Medicaid Revenues Since FY93/94
- Economic Characteristics:
  -Median Income 1998: $55,875
  -Unemployment Rate: 2.6%
  -People of All Ages in Poverty: 10.9%



Factors Impacting Current "Crisis" in Area Program System

1. EROSION OF AREA PROGRAMS' STATE SUPPORT:

Began with State's 1990/91 Fiscal Crisis
- Elimination of State Regional Offices
- Elimination of Jordan-Adams Inflationary Increases
- Funds for Capital & Renovations Ceased 1994 for 94-95

Reductions Peaked in 1995 & 1996:
- $17.8M Cut in State Appropriations to Area Programs
- Net Reduction in State Expenditures in FY96/97

IMPACT:

- Reduced Direct Communication with Area Programs
- Reduced Technical Support
- Continual Erosion of Funding for Area Program Infrastructure
- Significant Staff Turnover & Difficulty in Attracting/Retaining Staff
- Increased Reliance on Contract Services

AREA MENTAL HEALTH PROGRAMS

Factors Impacting Current "Crisis" in Area Program System

2. DRAMATIC SYSTEM GROWTH:

- State Emphasis on "Growing the System"
- Since 1994 the Number of Clients Served Increased 29%,
- Of That Growth, Substance Abuse Clients Served Increased 20%, Mental Health Increased 33.2% & Developmentally Disabled Increased 34.5%
- Area Program Budgets Grew by 93% (From $440M to $851M)

IMPACT:

- New Services Were Created (e.g., Community Based Inclusion)
- Two-Tiered Service System Began Developing
- Cost Shifting from Other Local Agencies Increased

Factors Impacting Current "Crisis" in Area Program System

What is going to happen?

3. MANAGED CARE: CAROLINA ALTERNATIVES

- Implemented in 10 Area Programs in 1994
- Division of MH & Area Programs' Goal: "Grow the System"
- Expansion Delays Occurred Repeatedly
- Termination Anticipated in June 1999

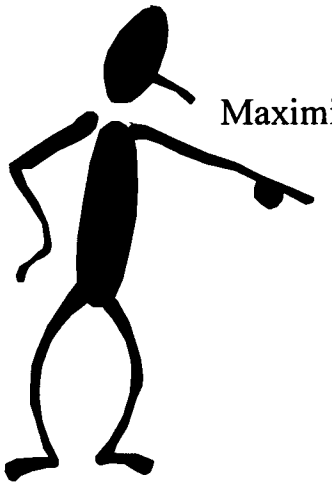
IMPACT:

- Improved Services to Children
- Improved Management of Some Area Programs
- Fostered an Atmosphere of Care Management
- Reduced Rates Began to Drain Resources for Indigent Clients
- Created Chaos for Some Area Programs

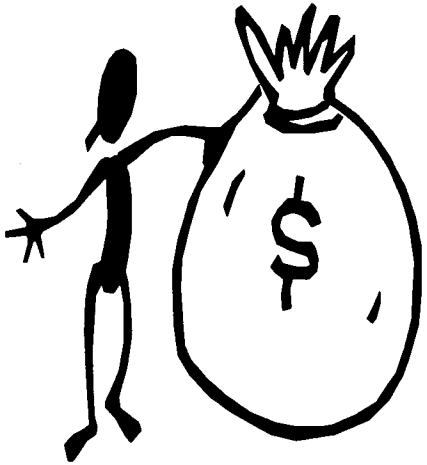
AREA MENTAL HEALTH PROGRAMS

1990'S INCONSISTENT FISCAL POLICIES

(Early-to-Mid 1990's)



Maximize Federal $$$



From FY94-FY98 Federal Revenue Grew by 486% ($59M to $347M)

By FY96, State & Area Programs Were Celebrating Their Success!

AREA MENTAL HEALTH PROGRAMS

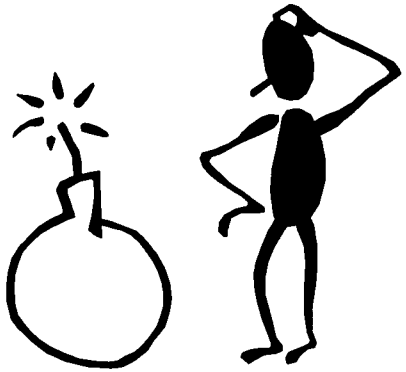
1990'S INCONSISTENT FISCAL POLICIES

1997 Medicaid Growth Reduction Policy

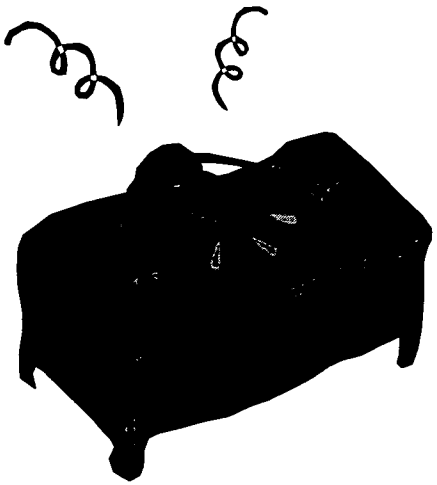
Early 1997

"How can we grow our services while you're reducing Medicaid growth?"

Mid-Late 1997



1998: Medicaid Paybacks & Fraud!



AREA MENTAL HEALTH PROGRAMS

Factors Impacting Current "Crisis" in Area Program System

4. STATE POLICY TO MAXIMIZE FEDERAL FUNDS:

- State Funds Reduced in Anticipation of Increased Federal Funds
- Regular Medicaid Maximized (Primarily DD & MH)
- Title IVA-EA Maximized for Children's Services

IMPACT:

- Mental Health Service System Grew
- Specialized Services Were Developed
- Area Programs Became Increasingly Reliant Upon Federal Funds
- Cost Shifting at the Local Level Increased

AREA MENTAL HEALTH PROGRAMS

Factors Impacting Current "Crisis" in Area Program System

5. INADEQUATE MANAGEMENT AND OVERSIGHT:

- Local Autonomy Was Emphasized
- Increased Need for Management Information Systems
- Involvement of Area Boards Wasn't Always Adequate
- State Emphasis was on System Growth
- State & Local Oversight of Area Program Fiscal Management Inadequate in Many Situations

IMPACT:

- Poor Budgeting & Accounting Practices
- Fraud & Abuse of Medicaid
- Poor Documentation for Billing Purposes
- Cash Advances to Maintain Services in Certain Programs
- Tri-County Area Program Dissolved
- System Grew Too Quickly for Infrastructure

AREA MENTAL HEALTH PROGRAMS

POLICY/ISSUES

1. **Medicaid Match Reserve**
   - County Financial Participation
   - Accurate Projections
   - Area Program Portion (how to handle the excess/shortages?)

2. **County Appropriations**
- **- G.S. 122C-115 (d) Powers and duties of counties and cities**
   - County Commissioners Association Legislative Agenda to Repeal Eliminate Language

3. **Financial Incentives for Program Mergers**

4. **Future of Area Program System**

AREA MENTAL HEALTH PROGRAMS

MEDICAID MATCH RESERVE

1. What is the Medicaid Match Reserve (MMR)?

- A Reserve Created To Facilitate the Transition of "Certified Match" to Real Match

- The Reserve Contains the Non-Federal Share (approximately 37%) of the Cost of Medicaid for Eligible Area Mental Health Clients

- The Reserve was Necessitated by Significant Medicaid Rate Reductions, Inappropriate Management of Medicaid Funds and a Projected Lack of State and Local Funds for Indigent Care

- State Funds ($38M) Were Appropriated & Placed in the Reserve During 1998 to Alleviate the Impending Financial Crisis in Area Programs

AREA MENTAL HEALTH PROGRAMS

MEDICAID MATCH RESERVE

Medicaid Cost Sharing in Area Mental System (pre-FY98/99)

Payor/Source	Regular	Carolina Alternatives	CAP-MR/DD	MH Inpatient (Non-State)	Other Non-Area Program Providers
Federal	63.09%	63.09%	63.09%	63.09%	63.09%
Area Programs	Certified Match	12.31%	0	0	0
State	0	20.9%	31.37%	31.37%	31.37%
County	0	3.7	5.54%	5.54%	5.54%

AREA MENTAL HEALTH PROGRAMS

MEDICAID MATCH RESERVE

Medicaid Cost Sharing in Area Mental System (FY98/99)

Payor/Source	Regular	Carolina Alternatives	CAP-MR/DD	MH Inpatient (Non-State)	Other Non-Area Program Providers
Federal	63.09%	63.09%	63.09%	63.09%	63.09%
Area Programs		12.31%			
State	36.91%	20.9%	31.37%	31.37%	31.37%
County		3.7%	5.54%	5.54%	5.54%

AREA MENTAL HEALTH PROGRAMS

MEDICAID MATCH RESERVE

"Proposed" Medicaid Cost Sharing in Area Mental System (FY99/00)

Payor/Source	Regular	CAP-MR/DD	MH Inpatient (Non-State)	Other Non-Area Program Providers
Federal	62.87%	62.87%	62.87%	62.87%
Area Programs				
State	35.63%	37.56%	31.56%	31.56%
County	1.50%	5.57%	5.57%	5.57%

Note: The County Proposed Share of 1.5% Would Increase Incrementally Until It Reaches a Cap of 15% of the Non-Federal Share (Approximately 5% of the Total).

Subcommittee Policy/Issues

1. MEDICAID MATCH RESERVE:

1. Should Counties Participate in Area Mental Health Medicaid Costs?

2. If So, At What Rate of Financial Participation? Should Each County Share Proportionally?

3. How Much in State (Division of MH/DD/SAS) Funds Should be Transferred Into the Medicaid Match Reserve for FY99/00?

4. How Should FY98/99 Unspent State (Division of MH/DD/SAS) Funds Originally Identified for Inclusion in the MMR be Handled?

5. Since Another Payback is Anticipated, Should the State Offset This or Future Medicaid Paybacks Owed by Area Programs? I'm last yr - 1996. I'm 1997 –

AREA MENTAL HEALTH PROGRAMS

Subcommittee Policy/Issues -

2. COUNTY APPROPRIATIONS:

§ **G.S. 122C-115.** Powers and duties of counties and cities. (d) Counties shall not reduce county appropriations and expenditures for area authorities because of the availability of State allocated funds, fees, capitation amounts, or fund balance to the area authority.

1. Should G.S. 122C-115 Remain, Be Amended, or Repealed?

Area Programs - County Comm: Wants to be able to reduce funding - Laws.

AREA MENTAL HEALTH PROGRAMS

Subcommittee Policy/Issues

3. FINANCIAL INCENTIVES FOR PROGRAM MERGERS:

- Many Area Programs are Too Small to Become Efficient
  -Catchment Area Size (Population) is Too Small
  -Administrative Infrastructure is Sometimes Inadequate
  -Gaps in Services Are Generally Greater Due to Lack of Ability to Attract & Retain Staff/Providers

- Funding Inequities Are Disincentives to Program Mergers
  -Per Capita Spending Varies Widely

5.7 million to merge?

- State/Local Funds Are Needed to Facilitate Program Mergers
  -Startup Funds Are Needed to Plan and Transition Programs

AREA MENTAL HEALTH PROGRAMS

Subcommittee Policy/Issues

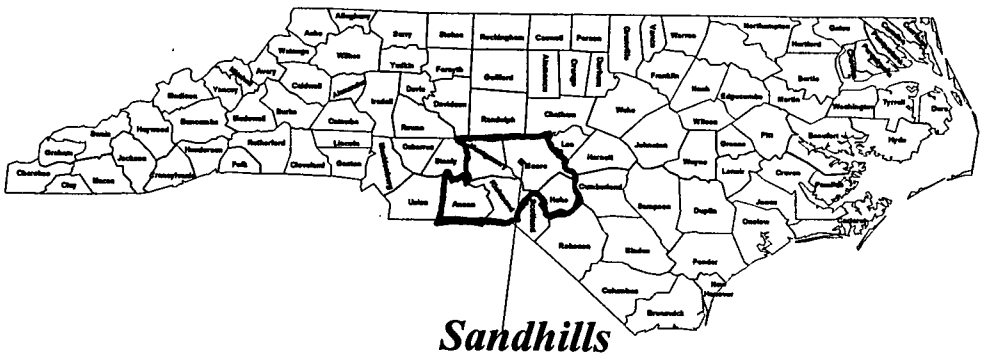
4. FUTURE OF THE AREA PROGRAM SYSTEM

- Where does the Public Consulting Group, Inc. Study Fit In?
- How does the State's Redesign Initiative Fit?

AREA MENTAL HEALTH PROGRAMS

AREA PROGRAM PROFILE: SANDHILLS

- Catchment Area: Moore, Montgomery, Hoke, Anson & Richmond Counties (South Central Region)
- Population: 192,369 (14th. Largest AP)
- Persons Served FY97/98: 6,491
- Operating Budget: $26.2M
- Financial Support:
  -2% County
  -22% State
  -46% Medicaid
- Patient Mix: 35% Medicaid & 38% Unisured
- Economic Characteristics:
  -Range in Median Income 1998: $25,717 - $34,412
  -Unemployment Ranges: 3.5-5.9%
  -Range of People of All Ages in Poverty: 20.2% - 10.8%



PHILLIPS

Crossroads Behavioral Healthcare Child Mental Health Services and the Medicaid Match Reserve FY 1998-99

Child MH Unit Cost State Funds FY 1998-99

$378,424

Match Needed Based On Usage FY 1998-99

$395,000

Difference

$16,576

David R. Swann
Area Director/CEO
336-386-7425

Crossroads Behavioral Healthcare Child Mental Health Services and the Medicaid Match Reserve FY 1998-99

Total Medicaid Match Required FY 98-99

$713,249

Child MH State Match Required FY 98-99

$395,000 or 55% of Total

Response to Shortfall

$100,000 withheld from Child MH State Funds

Balance Removed From Adult Mental Health, Adult Substance Abuse, Adult Developmental Disabilities, and Child Developmental Disabilities.

Crossroads Behavioral Healthcare is Grossly Underfunded 1998-99

Area Program	Rank By Size	Population	Annual Budget
S. Eastern Regional	10th	230,000	$34 M
Foothills	11th	228,000	$24 M
Crossroads	**12th**	**215,000**	**$14.3** M
Durham	13th	200,000	$23.6 M
Sandhills	14th	195,000	$28 M

Crossroads Behavioral Healthcare Budget Needs for FY 1999-2000

Current Budget FY 98-99 **$1.4 Million**

Funds Necessary to Maintain **$1.1 Million**
Existing Level of Services
FY 1999-2000

Reductions in Services Must Begin July 1, 1999 to come in line with budget unless additional funds become available.

Area Program and County Relationships/Funding in 1998-99

County	Population	Percapita	00 Proposed
Iredell	111,624	$2.89 ($323,006)	$3.50 ($390,684)
Surry	67,611	$2.99 ($202,208)	$3.50 ($236,638)
Yadkin	35,384	$2.96 ($105.000)	$3.50 ($123,844)

Source: N.C. Data Center August 1998

Crossroads Ranks 28 of 39 Area Programs in Local Government Funding.

Phillips

DHHS-DMH/DD/SAS SYSTEM REDESIGN PROCESS

- ANALYSES
- OPTIONS
- RECOMMENDATIONS

- Final Plan: November, 1999

- Appropriations Subcommittee on Human Resources

- March 16, 1999

System Redesign: Overview

- Division moving from being a relatively passive "funder" of services to a more proactive "purchaser" of services
- System is in need of major overhaul
- Substantial room for improving the quality, access, accountability and cost-effectiveness of purchased services
- Everything on the table; nothing is sacred

System Redesign: Goals

- Develop consistency in quality, availability & access of services across the state
- Strengthen clinical and financial accountability
- Utilize competition to improve quality
- Clarify and recommend optimal roles of Division, counties, and service providers
- Develop & manage performance contracts
- Implement utilization management

System Redesign: Stakeholder Involvement

- There is no "predetermined" plan.
- The Division is committed to an open process in which all consumers, families, advocates, and other interested stakeholders have ongoing opportunities to contribute to the new system design.
- Send comments to:

  www.state.nc.us/dhr/dmh

System Redesign: Primary Components

- Priority populations
- Benefit design; covered services
- System structure and provider network
- Quality management
- Management Information Systems (MIS)
- Financial structure & strategies
- Consumer issues: rights, protections, and meaningful involvement

System Redesign: Key Policy Issues

- Overall system structure and service provider network
- Community-based & institutional services: structural and financial relationship
- Establishment of clinical & financial accountability throughout system
- Role of competition & marketplace in redesigned system

System Redesign: Design Plan & Auditor Report

- Complementary studies; commitment to coordination / collaboration
- Auditor Report: ✓
  - Legislatively mandated study of MGT ✓ recommendations and of Area Programs ✓
  - Final recommendations due April 1, 2000 ✓
- Design Plan:
  - Division mandated study
  - Final recommendations due November 19, 1999

System Redesign: Workplan

Design Team/SAT: Report Development	Jan-May, 1999
Draft 1	May 28
Public input/ public forums	June
Draft 2	September 17
Public input / public forum	Sept 17-Oct 4
Final Division Plan	November 19
Auditors Final Report	April 1, 2000
Implementation Plan: Phase 1	July1, 2000
Implementation Plan: Phase 2 & 3	2001, 2002

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

March 16, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TOM MAYNARD	Orange-Person-Chatham Area Program
Janet Simoneau	NC Council of Community Programs
Michael Watson	Smoky Hill Area Program
Glenn Welch	DHHS/Public Health
HUGH TILSON	NCHA
Megan Snyster	Easter Seals NC - C2001
Adele Foschia	Easter Seals NC - C2001
Jaclyn Dixon	Rep Easterling's intern
C.L. Cochran	UCPNC - C2001
JIM JARKARD	THOMAS S. MH/DD/SAS
Ann Schwindaman	NC Council of Community Programs

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

March 16, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Flo Stein	DMH/DD/SAS
Stephen Moss	DMH/DD/SAS
TARA LARSON	DMH/DD/SAS
David Swann	Crossroads Behavioral Healthcare Iredell, Surry, Yadkin Counties
Roslyn Sawit	NC Child Care Coalition
Dave Richard	Arc/NC
Peggy Balak	Thomas S. MH/DD/SAS
Katherine Miller	Harry Kaplan
Patricia Roesler	NCACC
Beth Melchor	NAMI NC
Dave Peterson	Thomas S MH/DD/SA

VISITOR REGISTRATION SHEET

Name of Committee

Date

~~May 22~~, 1996
3-16

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Terry Stelle	DMHDDSAS
A Dennis McBride	DHHS
[illegible]	OSBM
Allen Duffey	DHHS
Jim Evington	DHHS
DAVE BRUTON	DHHS

VISITOR REGISTRATION SHEET

H. _____ 3-16-99

Name of Committee Date

~~May 22, 1996~~

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Christina Medina	Covenant w/ NCs Children
Heather Laffen	OSD
Myrna Miller	(NASW-NC) Nat'l Assoc. of Social Workers - NC Chapter
ANNA TEFFT	OSBM
Pam Richardson	OSNC
Wayne Williams	OSBM
Lisa Abatemarco	DHHS/BP&A
Bob Hedrick	CNC/ResCare
Mary Eldridge	Div MH/DD/SAS
ART ECCLESTON	DIV MH/DD/SAS
Carol Robertson	DMA
MICHELLE COTTON	DMH/DD/SAS
Don Willis	DMH DD SAS
John Bowdish	Zebulon Pl.
Charles Davis	DHHDDSAS
Spencer Clark	DMH/DD/SAS

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

March 16, 1999 ~~2:30 p.m.~~ 2:00 pm

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
X/BLS ROSELAND	OSBM
Flo Stein	DMH/DD/SAS
Stephen Mars	DMH/DD/SAS
Tara Larson	DMH/DD/SAS
Laurel Baker	DMH/DD/SAS
Mary Eldridge	DMH/DD/SAS
Don Willis	DMH DDSAS
Phillip Hoffman	DMH DD SAS
Charles Davis	DMH DD SAS
Doug Baker	DMH/DD/SAS
Spencer Clark	DMH/DD/SAS

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

March 16, 1999 ~~2:30 p.m.~~ 2:00 pm

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lisa Abatemarco	DHHS/BP+A
Wayne Williams	OSBM
Pam Richardson	OSPL
Dave Richard	Arc NC
Fred Waddell	NCCSPC
Heather Jeffers	OSA
George Cockenham	DMA
Amy Jo Bain	NCMS
Gayle Butzgy	N.C. Asso of Co. Commissioners
Megan Smyth	Easter Seals NC - C2001
Connie Cochran	UCP of NC - C2001

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

March 16, 1999 ~~2:30 p.m.~~ 2:00 pm

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Hedrick	CNC, Inc.
Katherine Miller	Harry Kaplan
Allan Zaden	NC Council of Community Programs

AGENDA

Joint Subcommittee on Health and Human Services Appropriations

Legislative Office Building - Room 424
Wednesday, March 17, 1999
8:30 a.m.

Opening Remarks	Sen. Bill Martin, Co-Chair Rep. Beverly Earle, Co-Chair Rep. Edd Nye, Co-Chair
Division of Mental Health, Developmental Disabilities & Substance Abuse Services	Karen Hammonds-Blanks Fiscal Research Division
DHHS Redesign Initiative	Flo Stein, Chief Substance Abuse Services
Division of Child Development	Mary Ellen Sylvester Fiscal Research Division
Adjourn	

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
March 17, 1999
Afternoon

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Wednesday, March 17, 1999, in the afternoon, in Room 424 of the Legislative Office Building.

House Chairman, Representative Edd Nye presided. Other House members present were Representative Beverly Earle (Co-Chairman), Representative Martha Alexander (Vice-Chairman, Representative Trudi Walend, and Representative Gene Wilson. There were six senators present.

Chairman Nye called the meeting to order and Flo Stein, DHHS, was asked to continue speaking from the morning meeting. Senator Dannelly expressed concern with the altering of the resign process and that the services are not diminished for clients while the redesign is in process. Ms. Stein noted his concern and stated they are ending Carolina Alternative, that system is changing anyway and one reason the division has started this process is to make sure services are being met. She stated they are aware they need to change way of doing business so area programs are not having Medicaid audits result in paybacks. They are looking at how services delivery can be delivered, reduce some of the redundancy so there will be more dollars available for services. Senator Dannelly wanted to be assured this won't complicate the process of client receiving services and was told this would make services less complicated for clients and their families.

Chairman Nye stated he has never understood present system, which allocates availability based on number of people in geographical location and assumes twenty percent of the people in that area might have some type of mental illness. Ms. Stein responded they do plan to use data and make services more geographically available. There was more discussion by the members of the committee concerning the mental health system.

Ms. Karen Hammonds-Blanks continued the presentation concerning issue of statue that requires the county commissioners, once they have appropriated the funds, to keep them at the same level, and she stated the county commissioners want to see this statue repealed, which would give them the authority to increase or decrease appropriations to area programs. After discussion by the members, Chairman Nye made a motion this issue to be presented to Flo Stein and Redesign Team to study. Senator Martin made a motion that the provision regarding county appropriations not be changed. The motion carried.

Chairman Nye adjourned the meeting.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbitt
Committee Assistant

DHHS-DMH/DD/SAS SYSTEM REDESIGN PROCESS

- ANALYSES
- OPTIONS
- RECOMMENDATIONS

- Final Plan: November, 1999

- Appropriations Subcommittee on Human Resources

- March 16, 1999

System Redesign: Overview

- Division moving from being a relatively passive "funder" of services to a more proactive "purchaser" of services
- System is in need of major overhaul
- Substantial room for improving the quality, access, accountability and cost-effectiveness of purchased services
- Everything on the table; nothing is sacred

System Redesign: Goals

- Develop consistency in quality, availability & access of services across the state
- Strengthen clinical and financial accountability
- Utilize competition to improve quality
- Clarify and recommend optimal roles of Division, counties, and service providers
- Develop & manage performance contracts
- Implement utilization management

System Redesign: Stakeholder Involvement

- There is no "predetermined" plan.
- The Division is committed to an open process in which all consumers, families, advocates, and other interested stakeholders have ongoing opportunities to contribute to the new system design.
- Send comments to:

  www.state.nc.us/dhr/dmh

System Redesign: Primary Components

- Priority populations
- Benefit design; covered services
- System structure and provider network
- Quality management
- Management Information Systems (MIS)
- Financial structure & strategies
- Consumer issues: rights, protections, and meaningful involvement

System Redesign: Key Policy Issues

- Overall system structure and service provider network
- Community-based & institutional services: structural and financial relationship
- Establishment of clinical & financial accountability throughout system
- Role of competition & marketplace in redesigned system

System Redesign: Design Plan & Auditor Report

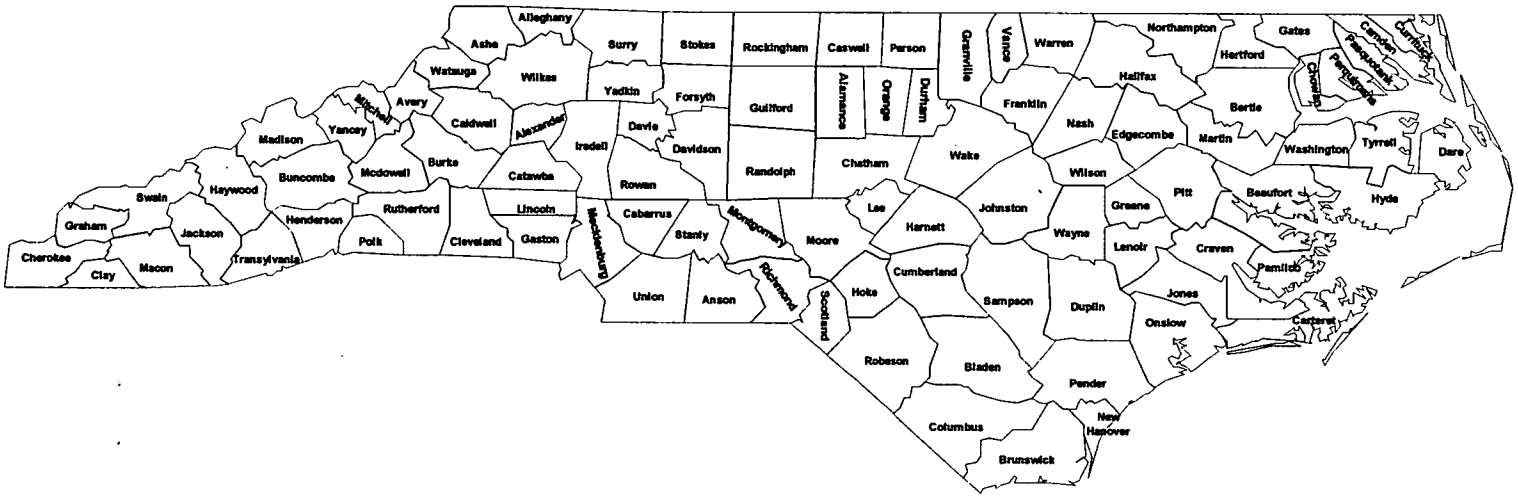
- Complementary studies; commitment to coordination / collaboration
- Auditor Report:
  - Legislatively mandated study of MGT recommendations and of Area Programs
  - Final recommendations due April 1, 2000
- Design Plan:
  - Division mandated study
  - Final recommendations due November 19, 1999

System Redesign: Workplan

Design Team/SAT: Report Development	Jan-May, 1999
Draft 1	May 28
Public input/ public forums	June
Draft 2	September 17
Public input / public forum	Sept 17-Oct 4
Final Division Plan	November 19
Auditors Final Report	April 1, 2000
Implementation Plan: Phase 1	July1, 2000
Implementation Plan: Phase 2 & 3	2001, 2002

3/17
Pg 32 + 37

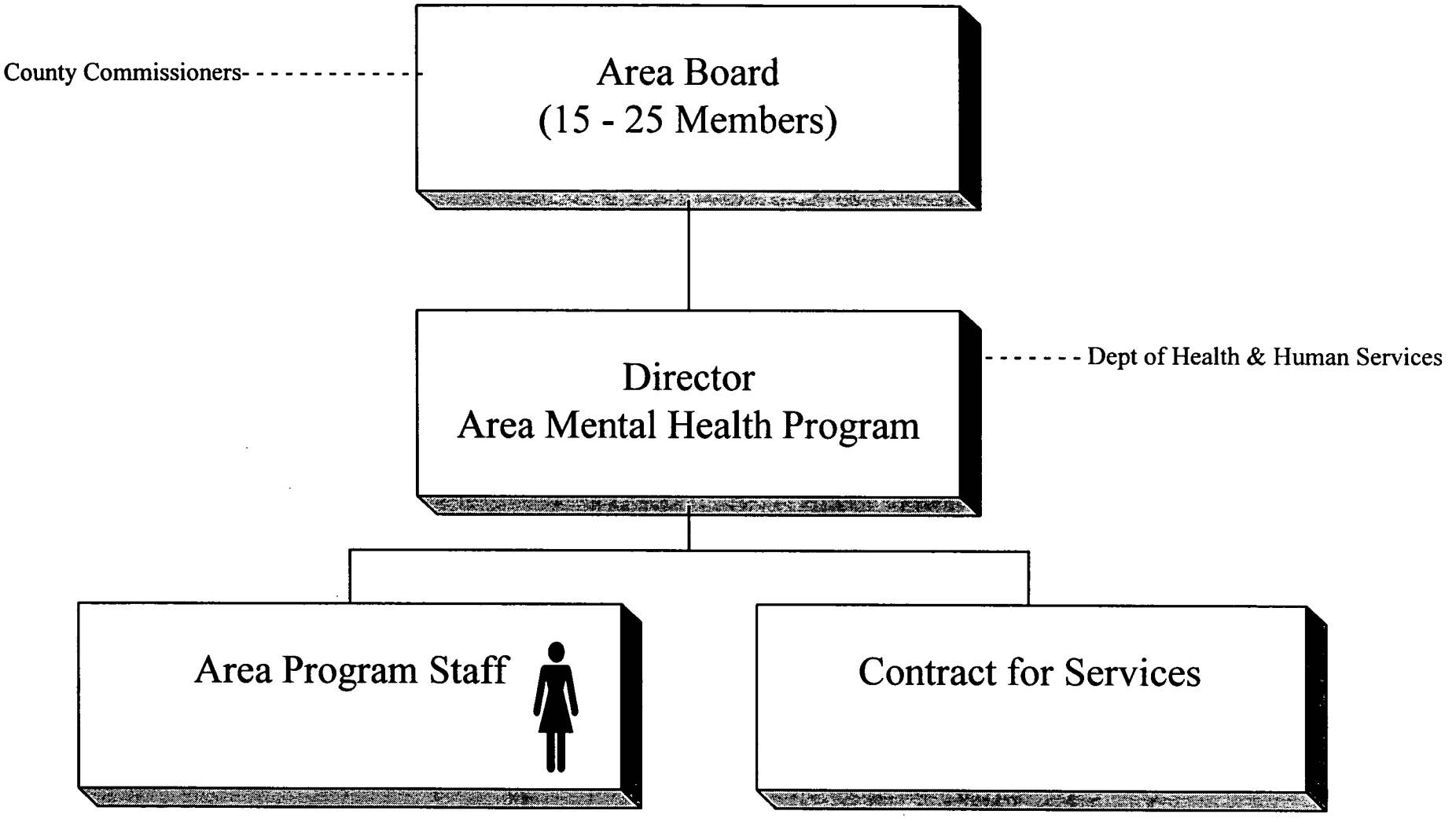
NORTH CAROLINA'S PUBLIC MENTAL HEALTH SYSTEM



FISCAL RESEARCH DIVISION

MARCH 16, 1999

NORTH CAROLINA AREA MENTAL HEALTH PROGRAMS



NORTH CAROLINA'S PUBLIC MENTAL HEALTH SYSTEM

AREA MENTAL HEALTH PROGRAMS

The provision of mental health in North Carolina is a cooperative effort of the state and local governments. Public mental health services are coordinated and delivered primarily on the local level by Area Mental Health Authorities/Programs. Area Programs provide services directly or under contract with other service providers. All funds appropriated by the General Assembly for the purpose of providing these services are administered by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

§ *G.S. 122C-2. North Carolina Policy*

State and local governments shall develop and maintain a unified system of services centered in area programs. The public service system will strive to provide a continuum of services for clients while considering the availability of services in the private sector. The furnishing of services to implement the policy of this section requires the cooperation and financial assistance of counties, the State, and the federal government.

AREA MENTAL HEALTH AUTHORITIES/PROGRAMS

N.C. STATUTORY AUTHORITY

§ **G.S. 122C-115. (a)** Except as provided in G.S. 153A-77, a county shall provide mental health, developmental disabilities, and substance abuse services through an area authority.

§ **G.S. 122C-116. (a)** An area authority is a local political subdivision of the State except that a single county area authority is considered a department of the county in which it is located for purposes of Chapter 159 of the General Statutes.

§ **G.S. 122C-124. Area Authority funding suspended.**

§ **G.S. 122C-125. Area Authority financial failure; State assumption of financial control.**

§ **G.S. 122C-125.1 Area Authority failure to provide services; State assumption of service delivery.**

AREA MENTAL HEALTH AUTHORITIES/PROGRAMS

N.C. STATUTORY AUTHORITY

§ **G.S. 122C-115. Powers and duties of counties and cities.** (d) Counties shall not reduce county appropriations and expenditures for area authorities because of the availability of State allocated funds, fees, capitation amounts, or fund balance to the area authority.

§ **G.S. 143-10.1A. Budget required to include State cost of local programs -- Continuation and expansion costs.** (d) Effective July 1, 1991, the Office of Budget and Management and the Director of the Budget, with advice of the Advisory Budget Commission, shall prepare the State Budget in a format that adequately and fairly reflects the continuation costs for the State's share of locally operated programs established by statute or State appropriation.

SELECTED FACTS

- Authority System Created by State Statute 1977
- 40 Area Mental Health Authorities/Programs
  (24 are Multi-County; 16 Single County)
- Governed by an Area Board
- Area Board is a Policy Making Body
- County Commissioners Appoint Area Board
- Employees Work for Area Authority

AREA MENTAL HEALTH PROGRAMS

SELECTED FACTS

- State is Divided into Four Regions (Western, North & South Central and Eastern)
- Regional Management Teams Facilitate State-Local Communication
- Area Programs Act as Gatekeepers to State Facilities (Single Portal of Entry and Exit
- N.C. Council of Community Programs

SELECTED FACTS

Catchment Area Size (population 7/97):

- Single County Range:
  - Riverstone (formerly known as Halifax) - 55,814
  - Mecklenburg - 608,567

- Multi-County Range:
  - Roanoke-Chowan (Includes Bertie, Gates, Hertford & Northampton Counties) - 87,097
  - Centerpoint (Includes Forsyth and Stokes Counties) - 330,008

Area Program Budgets:

- Budget Range:
  $3M to $46M (FY94/95)
  $6M to $73M (FY98/99)

- County Funds Range: Approximately $150,000 to $24.6M

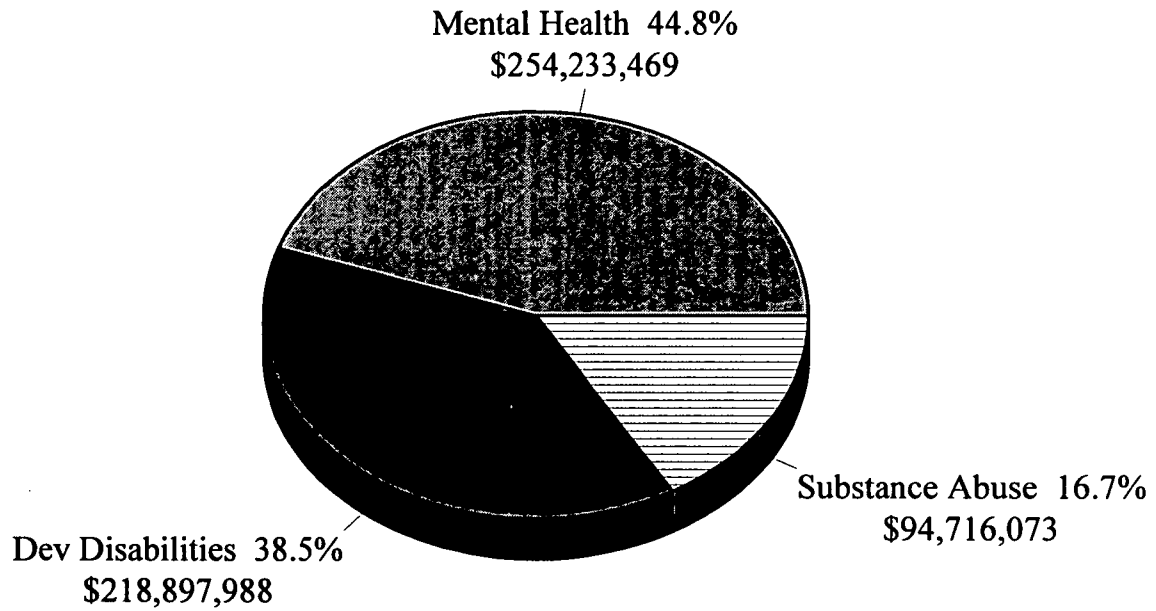
AREA MENTAL HEALTH PROGRAMS

WHAT SERVICES DO THEY PROVIDE?

- SUBSTANCE ABUSE SERVICES
- DEVELOPMENTAL DISABILITIES SERVICES
- MENTAL HEALTH SERVICES
- COORDINATION/INTEGRATION WITH OTHER HUMAN SERVICES AREAS

AREA MENTAL HEALTH PROGRAMS

PROGRAM SERVICES BY DISABILITY
FY97/98

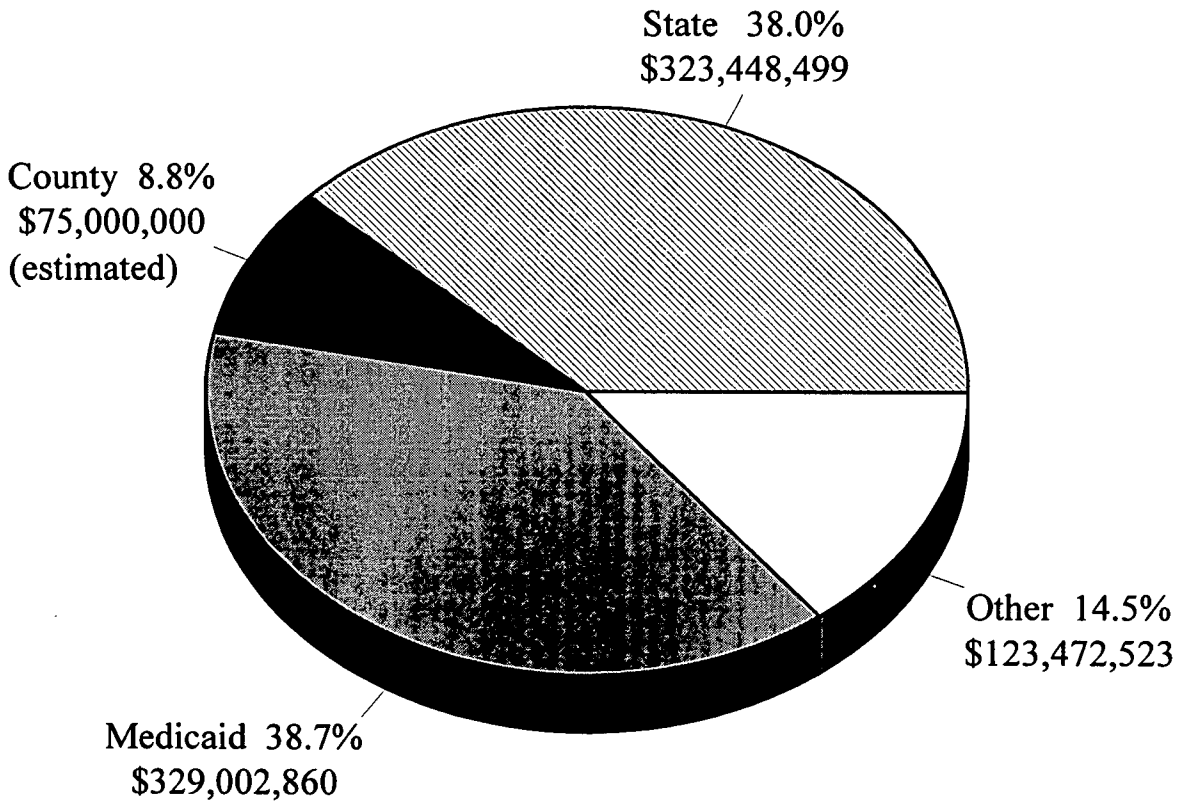


TOTAL $567.8M
(excludes Thomas S & Willie M funds)

AREA MENTAL HEALTH PROGRAMS

AREA PROGRAM FUNDS BY SOURCE

FY97/98

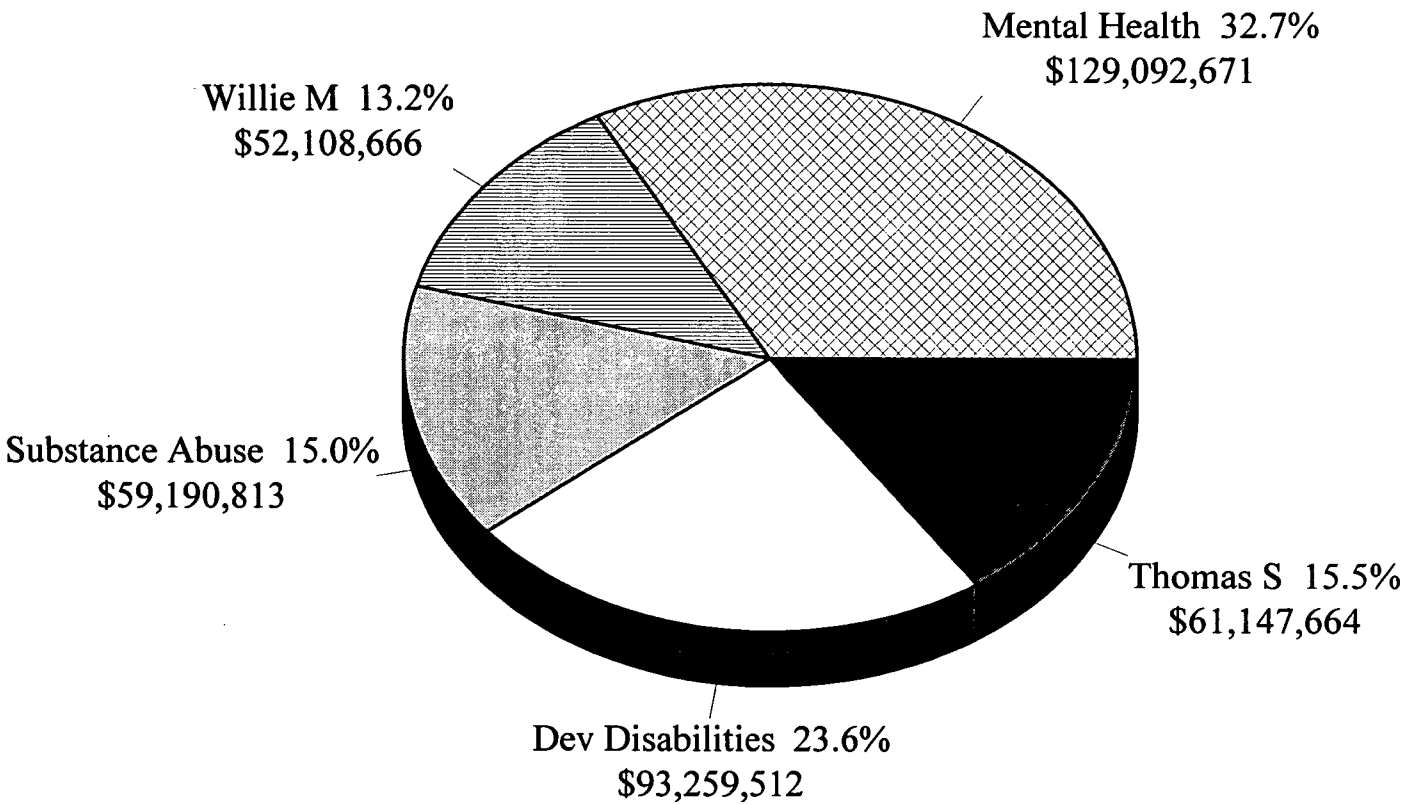


TOTAL: $850.1M

AREA MENTAL HEALTH PROGRAMS

STATE FUNDS FOR PROGRAM SERVICES

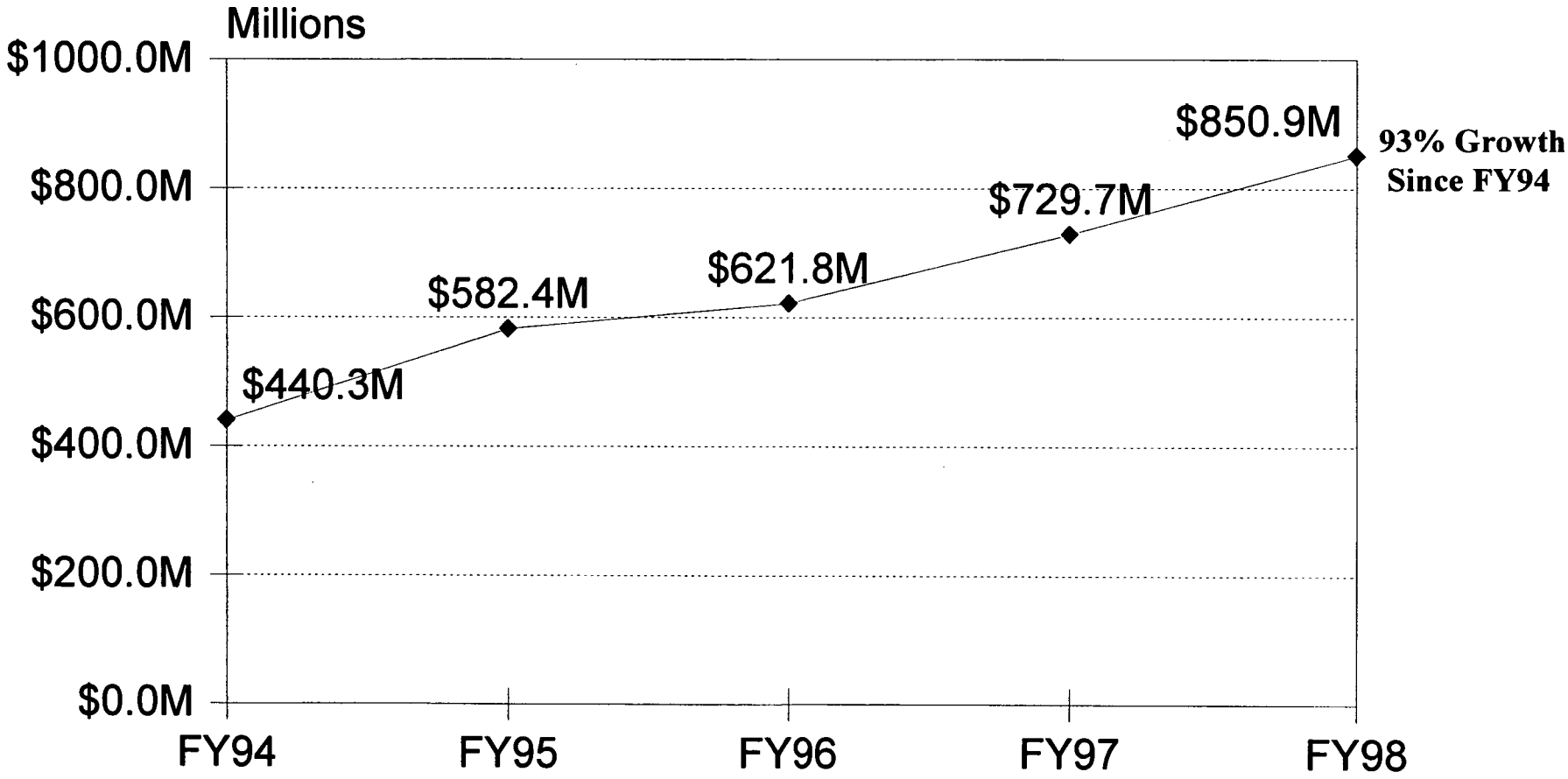
FY1997-98



TOTAL: $394,799,326

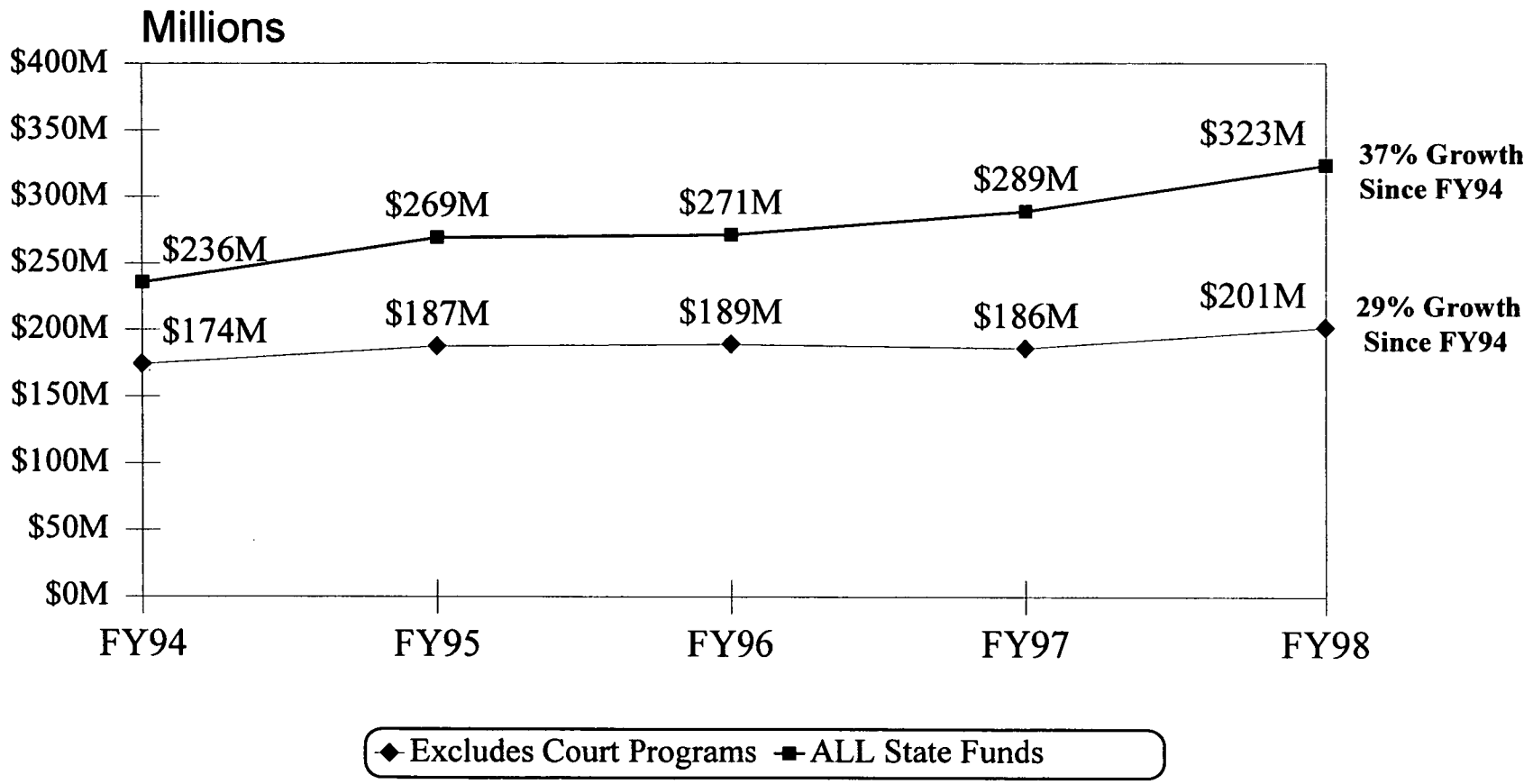
AREA MENTAL HEALTH PROGRAMS

GROWTH IN AREA PROGRAM RESOURCES



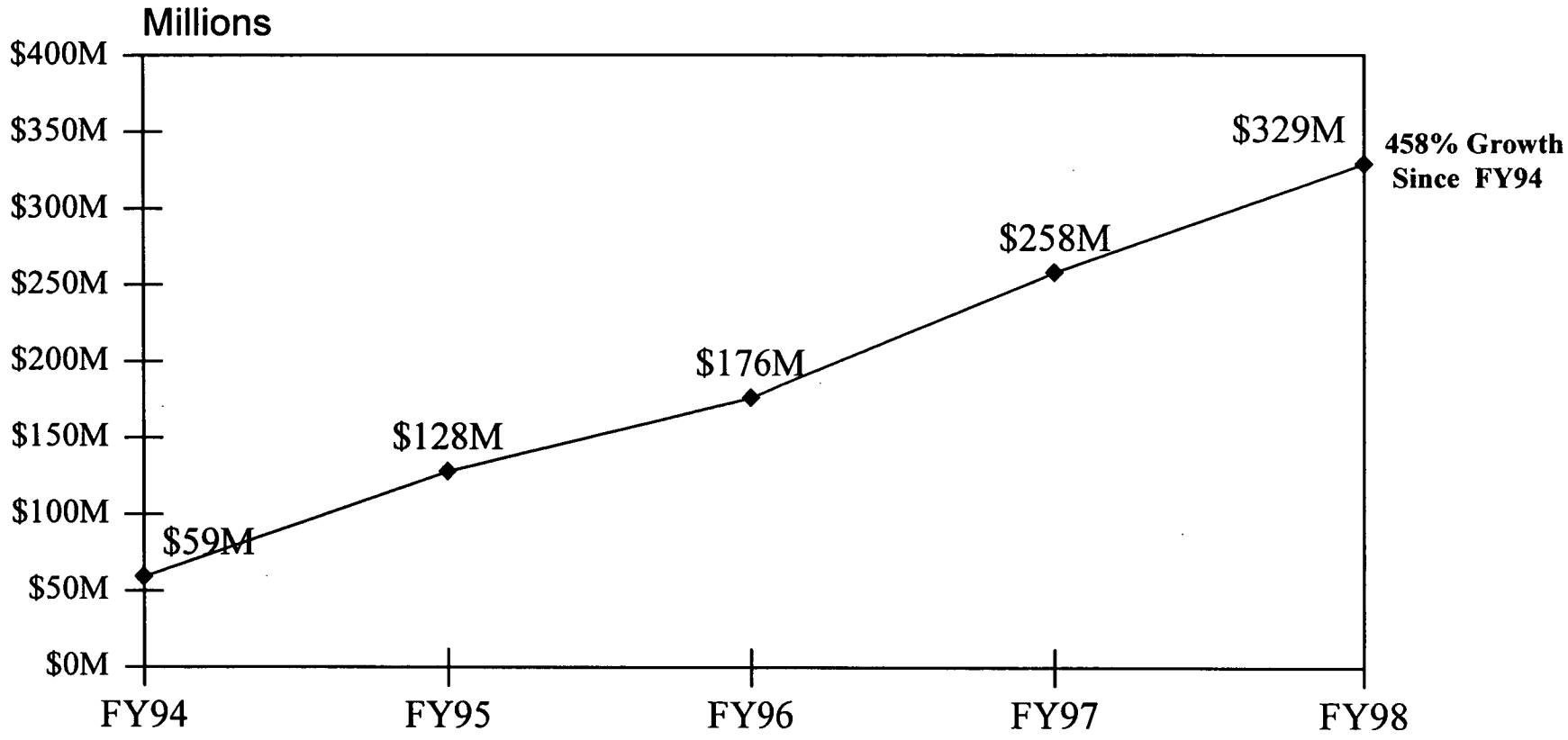
AREA MENTAL HEALTH PROGRAMS

GROWTH IN STATE APPROPRIATIONS



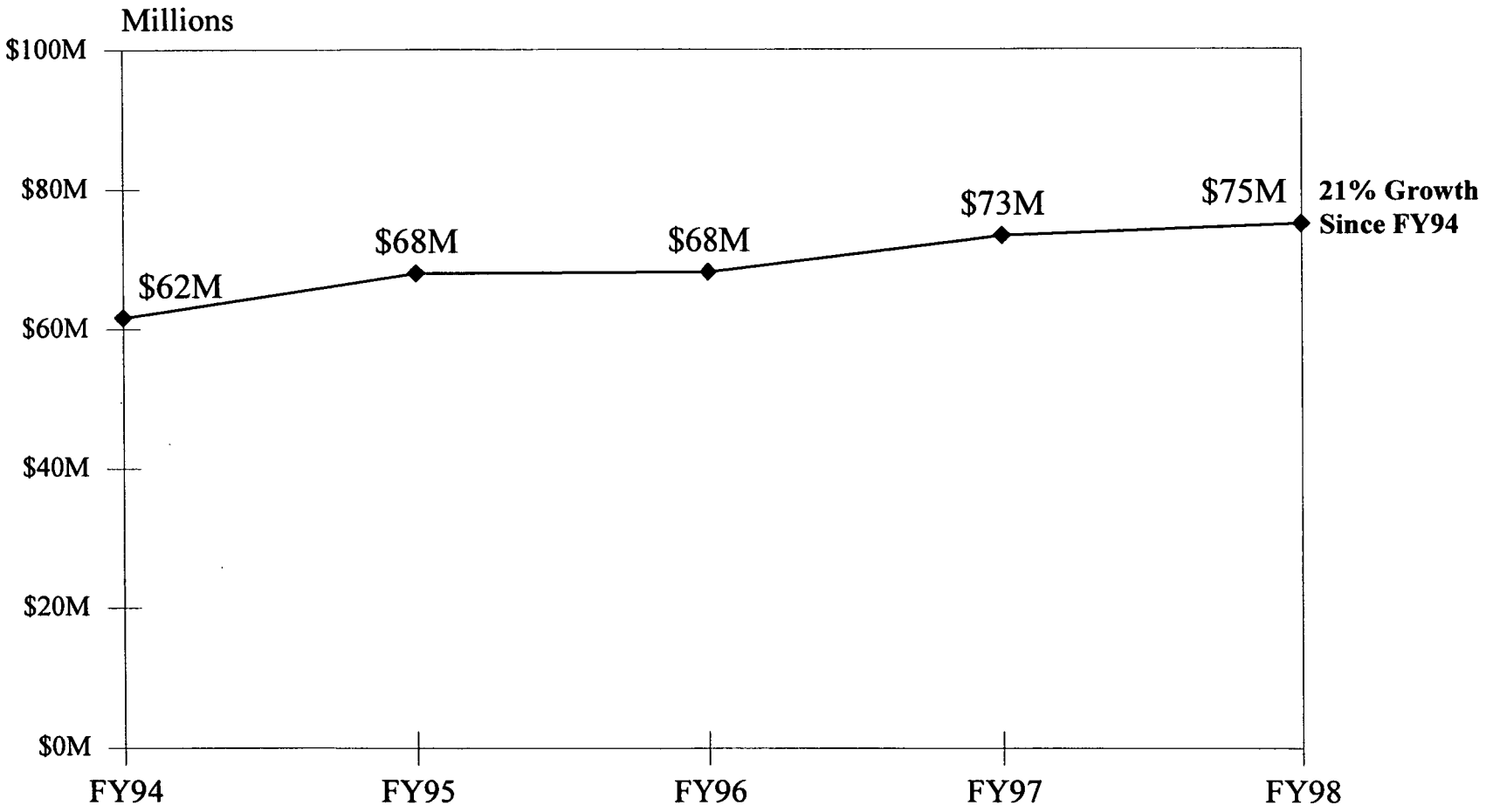
AREA MENTAL HEALTH PROGRAMS

GROWTH IN MEDICAID EXPENDITURES



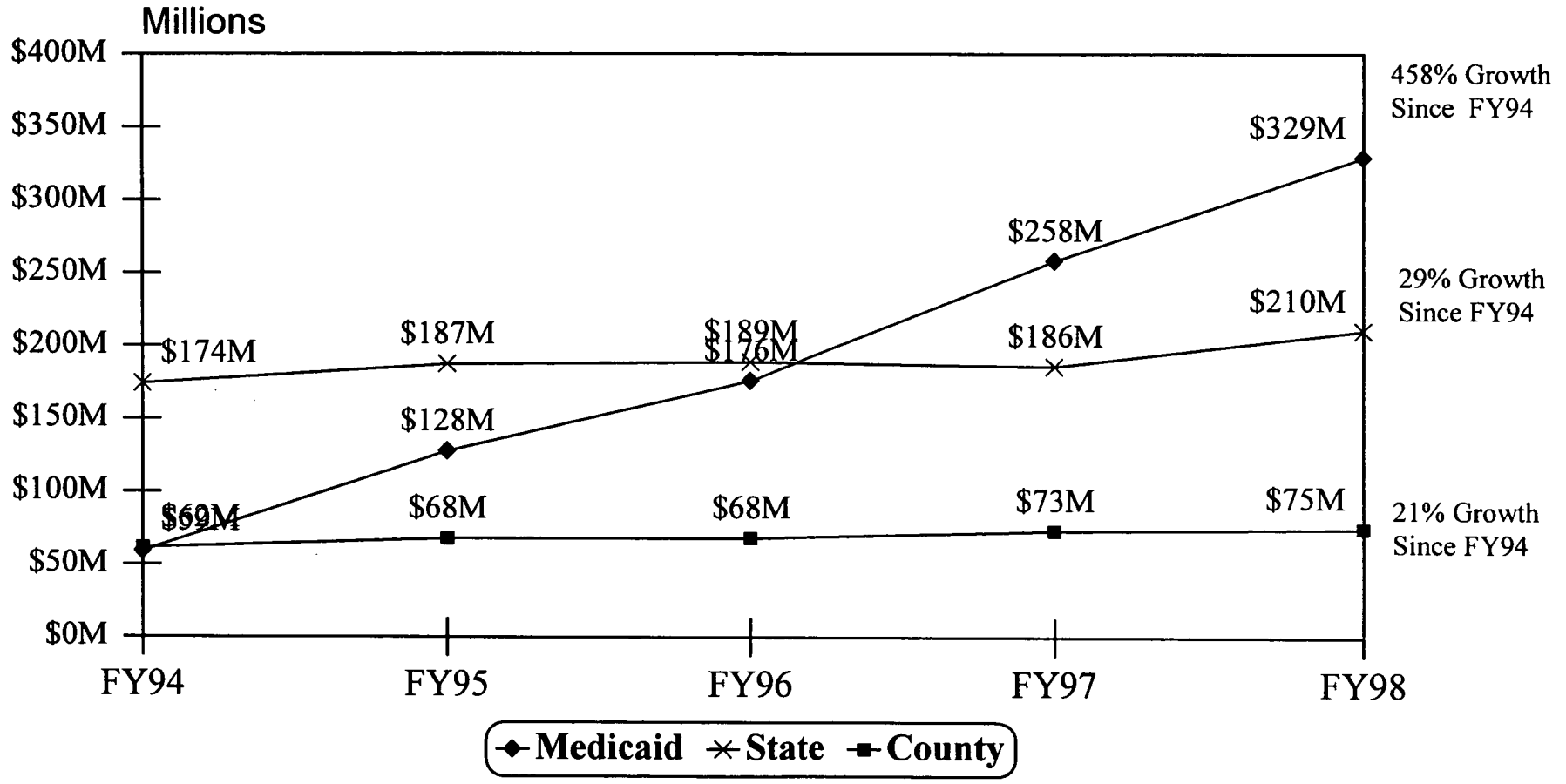
AREA MENTAL HEALTH PROGRAMS

GROWTH IN COUNTY APPROPRIATIONS



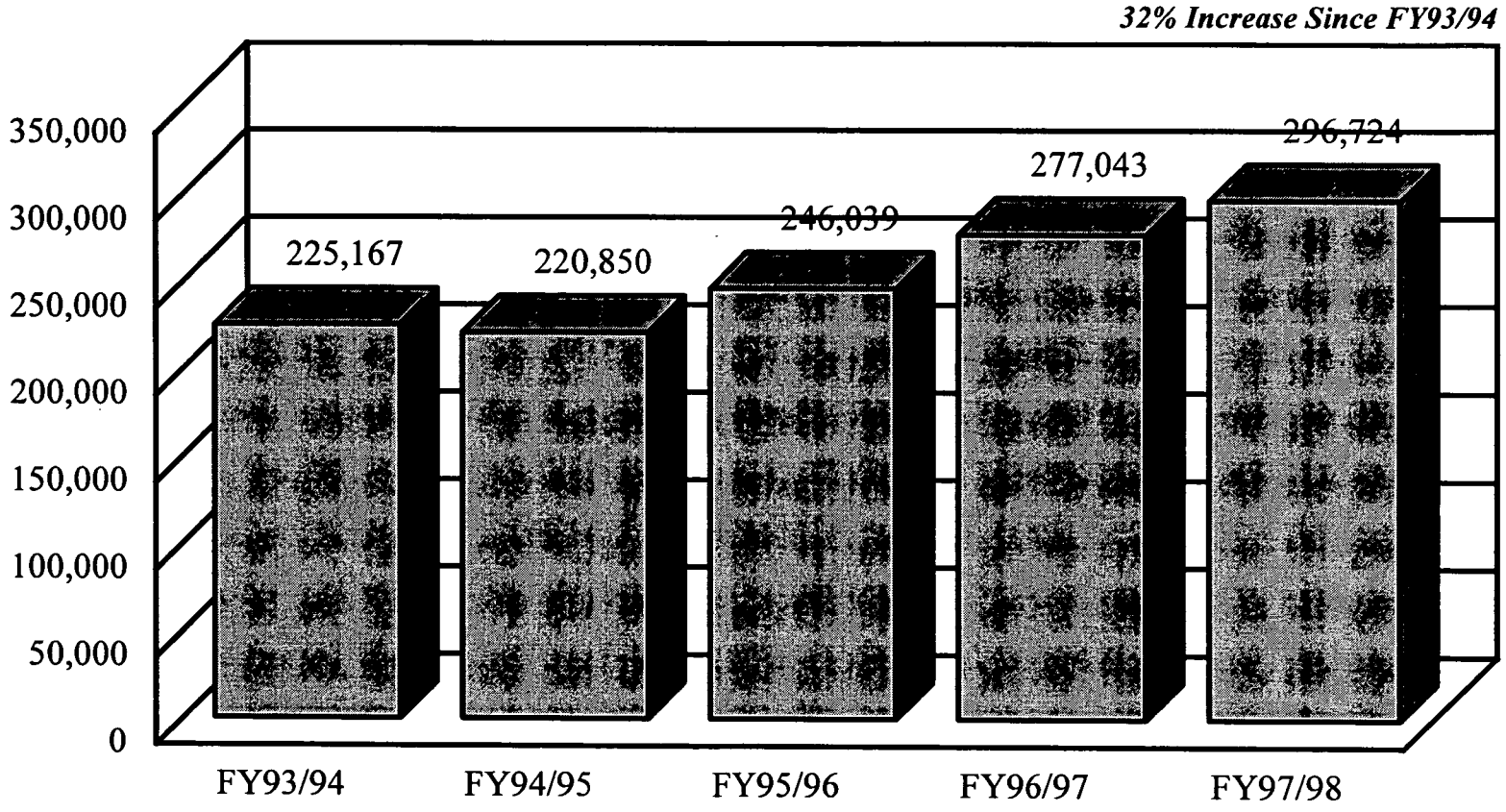
AREA MENTAL HEALTH PROGRAMS

GROWTH IN REVENUES SOURCES



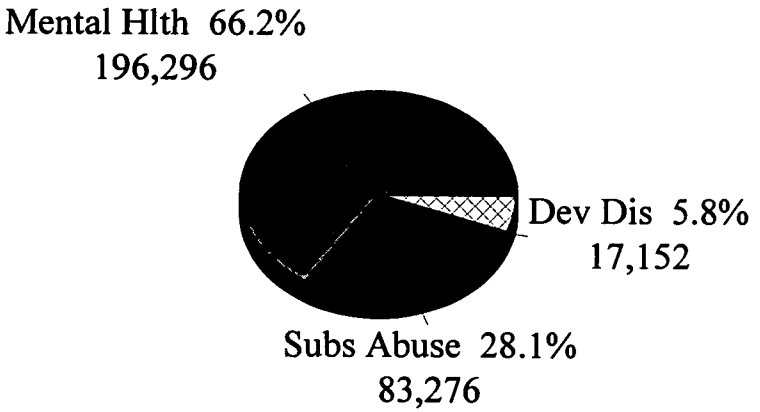
AREA MENTAL HEALTH PROGRAMS

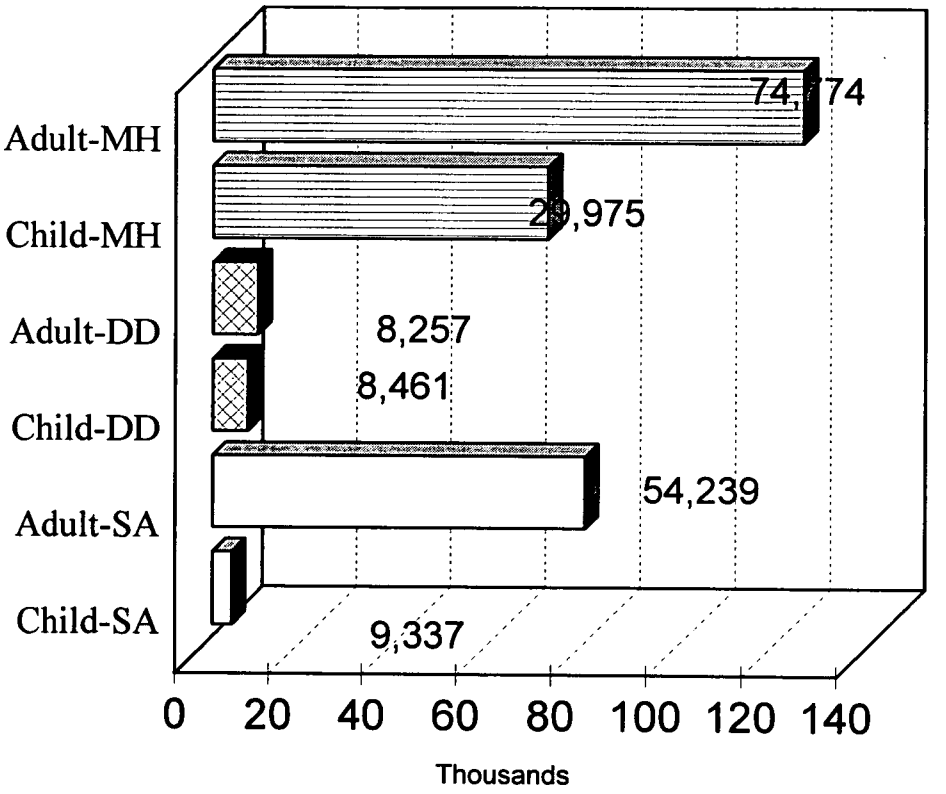
TOTAL CLIENTS SERVED
FY91/92 - FY97/98



AREA MENTAL HEALTH PROGRAMS

CLIENTS SERVED BY DISABILITY AND AGE
FY97/98

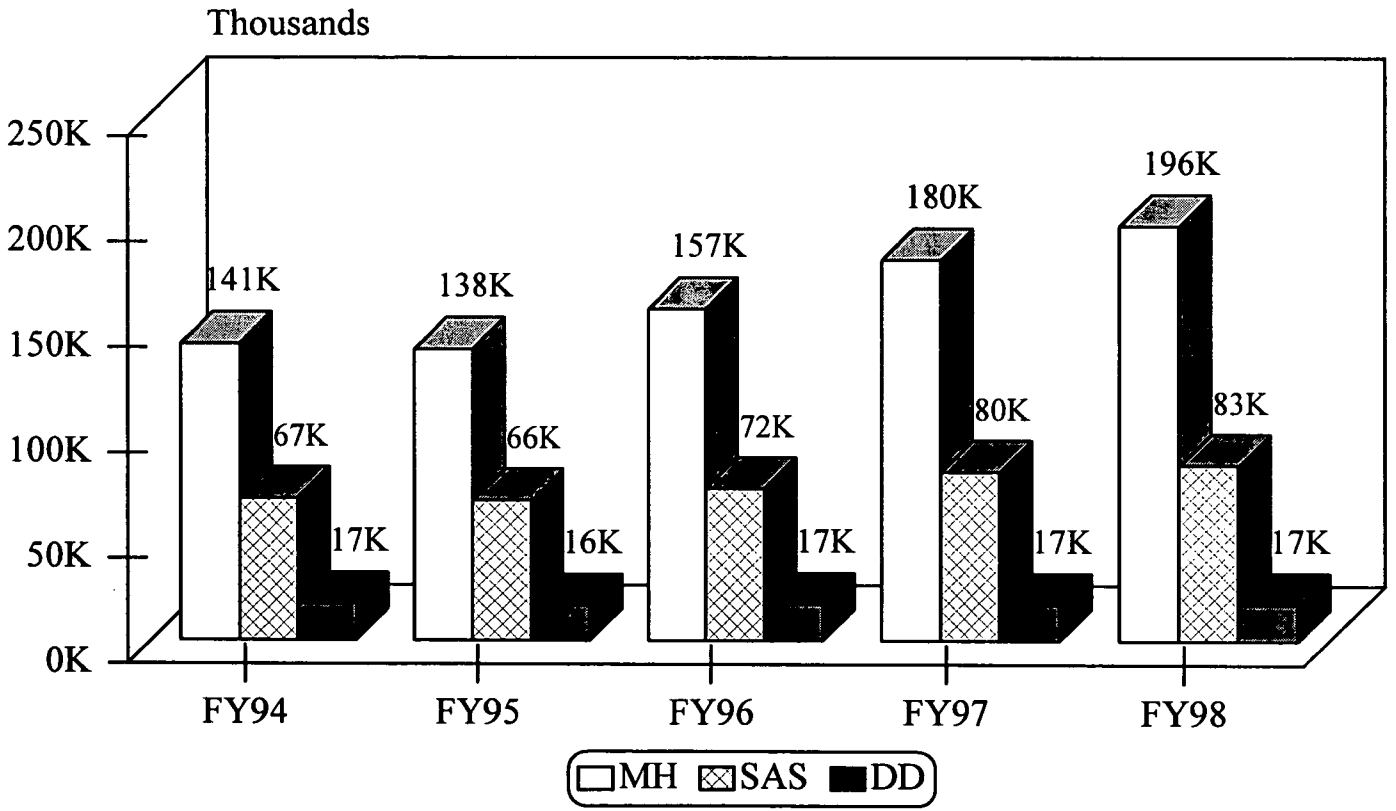




Total Clients Served: 296,724

AREA MENTAL HEALTH PROGRAMS

GROWTH IN CLIENT SERVICES BY DISABILITY



AREA MENTAL HEALTH PROGRAMS

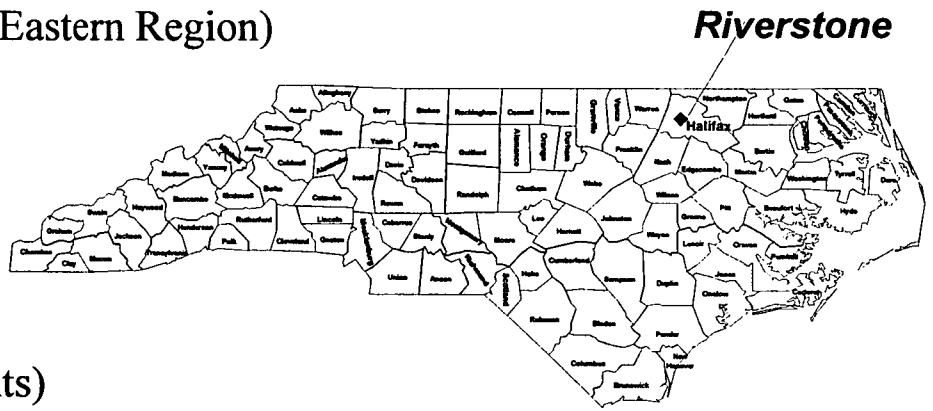
Factors Impacting the Current "Crisis" in the Area Program System

- MANAGED CARE INITIATIVES
- STATE POLICY TO MAXIMIZE FEDERAL FUNDS
- EROSION OF SUPPORT
- INADEQUATE MANAGEMENT & OVERSIGHT
- DRAMATIC SYSTEM GROWTH

AREA MENTAL HEALTH PROGRAMS

AREA PROGRAM PROFILE: RIVERSTONE

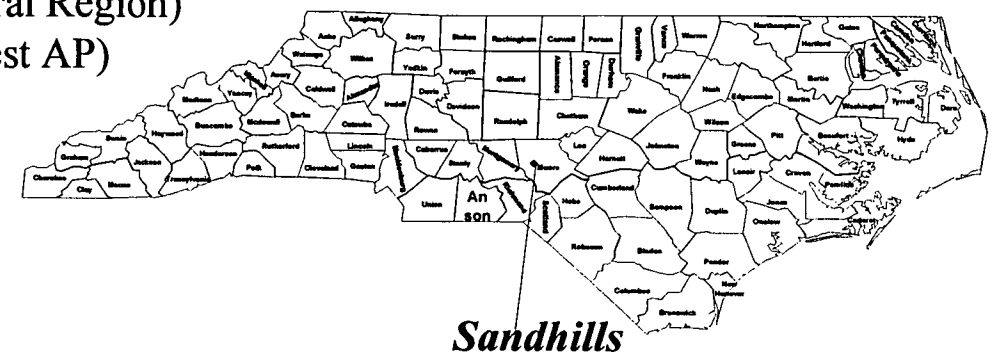
- Catchment Area: Halifax County (Eastern Region)
- Population: 55,814
- Persons Served FY97/98: 4,231
- Operating Budget: $7.86M
- Positions: 141.2 FTE's
- Financial Support:
  -4.5% County
  -39% State (Excludes Federal Grants)
  -14% Medicaid
- Patient Mix:
  -57% Medicaid
  -27% Uninsured/Indigent
- 215% Growth in Medicaid Revenues Since FY93/94
- Economic Characteristics:
  -Median Income 1998: $29,400
  -Unemployment Rate: 8.7%
  -People of All Ages in Poverty: 25.3%



AREA MENTAL HEALTH PROGRAMS

AREA PROGRAM PROFILE: SANDHILLS

- Catchment Area: Moore, Montgomery, Hoke, Anson & Richmond Counties (South Central Region)
- Population: 192,369 (14th. Largest AP)
- Persons Served FY97/98: 6,491
- Operating Budget: $26.2M
- Positions:
- Financial Support:
  -2% County
  -22% State
  -46% Medicaid
- 215% Growth in Medicaid Revenues Since FY93/94
- Economic Characteristics:
  -Range in Median Income 1998: $25,717 - $34,412
  -Unemployment Ranges: 3.5-5.9%
  -Range of People of All Ages in Poverty: 20.2% - 10.8%



AREA MENTAL HEALTH PROGRAMS

AREA PROGRAM PROFILE: MECKLENBURG

- Catchment Area: Mecklenburg County (South Central Region)
- Population: 608,567 (Largest AP)
- Persons Served FY97/98: 25,631
- Operating Budget: $68.4M
- Positions: 713 FTE'S
- Financial Support:
  -31.2% County
  -32% State
  -21.5% Medicaid
- 215% Growth in Medicaid Revenues Since FY93/94
- Economic Characteristics:
  -Median Income 1998: $55,875
  -Unemployment Rate: 2.6%
  -People of All Ages in Poverty: 10.9%

Factors Impacting Current "Crisis" in Area Program System

1. EROSION OF AREA PROGRAMS' STATE SUPPORT:

Began with State's 1990/91 Fiscal Crisis
- Elimination of State Regional Offices
- Elimination of Jordan-Adams Inflationary Increases
- Funds for Capital & Renovations Ceased

Reductions Peaked in 1995 & 1996:
- $17.8M Cut in State Appropriations to Area Programs
- Net Reduction in State Expenditures in FY96/97

IMPACT:
- Reduced Direct Communication with Area Programs
- Reduced Technical Support
- Continual Erosion of Funding for Area Program Infrastructure
- Significant Staff Turnover & Difficulty in Attracting/Retaining Staff
- Increased Reliance on Contract Services

Factors Impacting Current "Crisis" in Area Program System

2. DRAMATIC SYSTEM GROWTH:

- State Emphasis on "Growing the System"
- Since 1994 the Number of Clients Served Increased 29%,
- Of That Growth, Substance Abuse Clients Served Increased 20%, Mental Health Increased 33.2% & Developmentally Disabled Increased 34.5%
- Area Program Budgets Grew by 93% (From $440M to $851M)

IMPACT:

- New Services Were Created (e.g., Community Based Inclusion)
- Two-Tiered Service System Began Developing
- Cost Shifting from Other Local Agencies Increased

Factors Impacting Current "Crisis" in Area Program System

3. MANAGED CARE: CAROLINA ALTERNATIVES

- Implemented in 10 Area Programs in 1994
- Division of MH & Area Programs' Goal: "Grow the System"
- Expansion Delays Occurred Repeatedly
- Termination Anticipated in June 1999

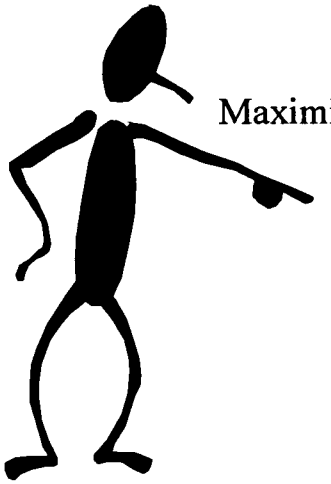
IMPACT:

- Improved Services to Children
- Improved Management of Some Area Programs
- Fostered an Atmosphere of Care Management
- Reduced Rates Began to Drain Resources for Indigent Clients
- Created Chaos for Some Area Programs

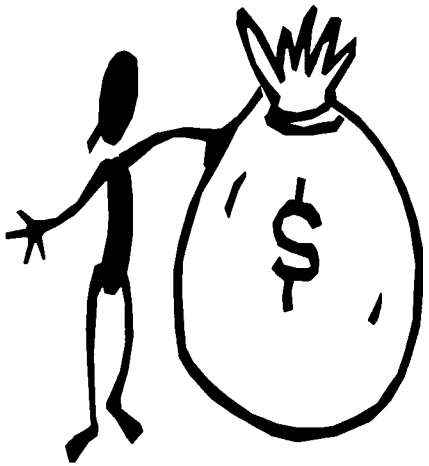
AREA MENTAL HEALTH PROGRAMS

1990'S INCONSISTENT FISCAL POLICIES

(Early-to-Mid 1990's)



Maximize Federal $$$



From FY94-FY98 Federal Revenue Grew by 486% ($59M to $347M)

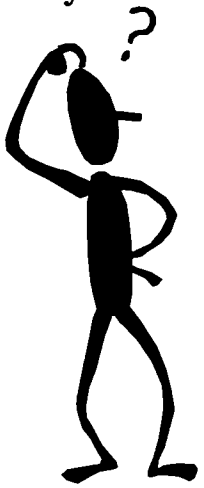
By FY96, State & Area Programs Were Celebrating Their Success!

AREA MENTAL HEALTH PROGRAMS

1990'S INCONSISTENT FISCAL POLICIES

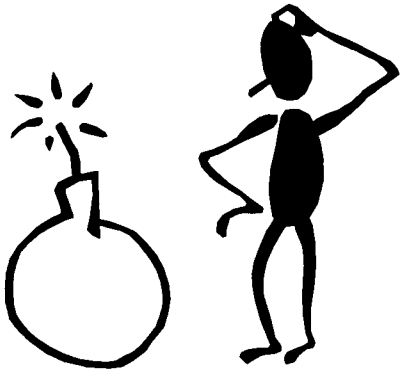
1997 Medicaid Growth Reduction Policy

Early 1997

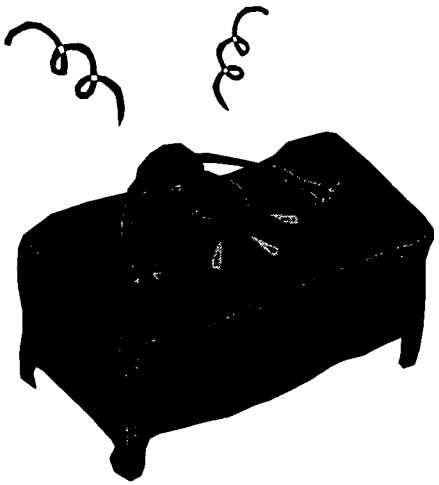


"How can we grow our services while you're reducing Medicaid growth?"

Mid-Late 1997



1998: Medicaid Paybacks & Fraud!



AREA MENTAL HEALTH PROGRAMS

Factors Impacting Current "Crisis" in Area Program System

4. STATE POLICY TO MAXIMIZE FEDERAL FUNDS:

- State Funds Reduced in Anticipation of Increased Federal Funds
- Regular Medicaid Maximized (Primarily DD & MH)
- Title IVA-EA Maximized for Children's Services

IMPACT:

- Mental Health Service System Grew
- Specialized Services Were Developed
- Area Programs Became Increasingly Reliant Upon Federal Funds
- Cost Shifting at the Local Level Increased

AREA MENTAL HEALTH PROGRAMS

Factors Impacting Current "Crisis" in Area Program System

5. INADEQUATE MANAGEMENT AND OVERSIGHT:

- Local Autonomy Was Emphasized
- Increased Need for Management Information Systems
- Involvement of Area Boards Wasn't Always Adequate
- State Emphasis was on System Growth
- State & Local Oversight of Area Program Fiscal Management Inadequate in Many Situations

IMPACT:

- Poor Budgeting & Accounting Practices
- Fraud & Abuse of Medicaid
- Poor Documentation for Billing Purposes
- Cash Advances to Maintain Services in Certain Programs
- Tri-County Area Program Dissolved
- System Grew Too Quickly for Infrastructure

AREA MENTAL HEALTH PROGRAMS

POLICY/ISSUES

1. **Medicaid Match Reserve**
   - County Financial Participation
   - Accurate Projections
   - Area Program Portion (how to handle the excess/shortages?)

2. **County Appropriations**
- - **G.S. 122C-115 (d) Powers and duties of counties and cities**
   - County Commissioners Association Legislative Agenda to Repeal Eliminate Language

3. **Financial Incentives for Program Mergers**

4. **Future of Area Program System**

AREA MENTAL HEALTH PROGRAMS

MEDICAID MATCH RESERVE

1. What is the Medicaid Match Reserve (MMR)?

- A Reserve Created To Facilitate the Transition of "Certified Match" to Real Match

- The Reserve Contains the Non-Federal Share (approximately 37%) of the Cost of Medicaid for Eligible Area Mental Health Clients

- The Reserve was Necessitated by Significant Medicaid Rate Reductions, Inappropriate Management of Medicaid Funds and a Projected Lack of State and Local Funds for Indigent Care

- State Funds ($38M) Were Appropriated & Placed in the Reserve During 1998 to Alleviate the Impending Financial Crisis in Area Programs

AREA MENTAL HEALTH PROGRAMS

MEDICAID MATCH RESERVE

Medicaid Cost Sharing in Area Mental System (pre-FY98/99)

Payor/Source	Regular	Carolina Alternatives	CAP-MR/DD	MH Inpatient (Non-State)	Other Non-Area Program Providers
Federal	63.09%	63.09%	63.09%	63.09%	63.09%
Area Programs	Certified Match	12.31%	0	0	0
State	0	20.9%	31.37%	31.37%	31.37%
County	0	3.7	5.54%	5.54%	5.54%

AREA MENTAL HEALTH PROGRAMS

MEDICAID MATCH RESERVE

Medicaid Cost Sharing in Area Mental System (FY98/99)

Payor/Source	Regular	Carolina Alternatives	CAP-MR/DD	MH Inpatient (Non-State)	Other Non-Area Program Providers
Federal	63.09%	63.09%	63.09%	63.09%	63.09%
Area Programs		12.31%			
State	36.91%	20.9%	31.37%	31.37%	31.37%
County		3.7%	5.54%	5.54%	5.54%

AREA MENTAL HEALTH PROGRAMS

MEDICAID MATCH RESERVE

"Proposed" Medicaid Cost Sharing in Area Mental System (FY99/00)

Payor/Source	Regular	CAP-MR/DD	MH Inpatient (Non-State)	Other Non-Area Program Providers
Federal Area Programs	62.87%	62.87%	62.87%	62.87%
State	35.63%	37.56%	31.56%	31.56%
County	1.50%	5.57%	5.57%	5.57%

Note: The County Proposed Share of 1.5% Would Increase Incrementally Until It Reaches a Cap of 15% of the Non-Federal Share (Approximately 5% of the Total).

Subcommittee Policy/Issues

1. MEDICAID MATCH RESERVE:

1. Should Counties Participate in Area Mental Health Medicaid Costs?

2. If So, At What Rate of Financial Participation? Should Each County Share Proportionally?

3. How Much in State (Division of MH/DD/SAS) Funds Should be Transferred Into the Medicaid Match Reserve for FY99/00?

4. How Should FY98/99 Unspent State (Division of MH/DD/SAS) Funds Originally Identified for Inclusion in the MMR be Handled?

5. Since Another Payback is Anticipated, Should the State Offset This or Future Medicaid Paybacks Owed by Area Programs?

Subcommittee Policy/Issues

2. COUNTY APPROPRIATIONS:

§ **G.S. 122C-115.** Powers and duties of counties and cities. (d) Counties shall not reduce county appropriations and expenditures for area authorities because of the availability of State allocated funds, fees, capitation amounts, or fund balance to the area authority.

1. Should G.S. 122C-115 Remain, Be Amended, or Repealed?

AREA MENTAL HEALTH PROGRAMS

Subcommittee Policy/Issues

3. FINANCIAL INCENTIVES FOR PROGRAM MERGERS:

- Many Area Programs are Too Small to Become Efficient
  -Catchment Area Size (Population) is Too Small
  -Administrative Infrastructure is Sometimes Inadequate
  -Gaps in Services Are Generally Greater Due to Lack of Ability to Attract & Retain Staff/Providers

- Funding Inequities Are Disincentives to Program Mergers
  -Per Capita Spending Varies Widely

- State/Local Funds Are Needed to Facilitate Program Mergers
  -Startup Funds Are Needed to Plan and Transition Programs

Subcommittee Policy/Issues

4. FUTURE OF THE AREA PROGRAM SYSTEM:

- Where does the Public Consulting Group, Inc. Study Fit In?
- How does the State's Redesign Initiative Fit?

VISITOR REGISTRATION SHEET

Sub. Cmt. on H+H Services 3-17-99

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
1. Art Jones	Substance Abuse Services
2. Flo Stein	DHHS - SAS
3. Don Willis	DMHDDSAS
4. Marc Lodge	DHHS
5. DORIS DICK	SR. TAR HEEL LEGISLATURE
6. Mark Benton	DHHS
7. Grady Burgin	Yadkinville Enterprise
8. MICHELLE COTTON	DMH/DD/SAS
9. ANN KAEHLER-CAMPBELL	DMH/DD/SAS WILLIEM.
10. Charles Davis	DMH/DD/SAS "
11. Doug Baker	DMH/DD/SAS
12. Stephen Moss	DMH/DD/SAS
13. Christina Medlin	Covenant w/ NCs Children
14. Lisa Watkins	MHA-NC C2001
15. Jim Tate	MHA-NC C2001
16. Bob Hedrick	CNC, INC.
17. [illegible]	OSPL
18. Wayne Williams	OSBM
19. Lisa Apatemarco	DHHS/BP&A
20. Bill RAFTER	JULIAN F. KEITH ADATC
21. Patrice Roerler	ACACC

VISITOR REGISTRATION SHEET

Sub. Cmt. on H + H Services 3-17-99

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
1. Duke Richard	The Arc/NC
2. Stacy Flannery	NC HCFA
3. ART ECCLESTON	DIV MH/DD/SAS
4. NELS ROSELAND	OSBM
5. Nancy Corey	Area Prog; AMI; MHA
6. Allan Zander	NC Council of Comm Programs
7. Ann Schwindaman	NC Council of Community Programs
8. Janet Simoneau	NC Council of Community Programs
9. Jim Jarrare	Thomas S. DMH/DD/SAS
10. Stan Slawinski	DIV MH/DD/SAS DD SECTION
11. Megan Sizstro	Easter Seals NC
12. Bryant Edgerton	Easter Seals NC
13. Larry Thompson	Blue Ridge Center, Asheville
14. John Nist	NCFPC
15. Peggy Balak	Thomas S. MH/DD/SAS
16. Fred Wilde	NC Providers Council
17. Glenn Wells	DHHS/Public Health
18. Sharon Hirsch	NC Social Services Consortium
19. Jean Jones	UCP-NC
20. Tom Worth	CHS
21. Bob Hargett	Justice

VISITOR REGISTRATION SHEET

Subcommittee on H + Human Services 3-17-99

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
1. C. L. Cochran	UCPNC C2001
2. Beth Melden	NAMI C2001
3. Peyton Maynard	GPMA
4. ANNA TEFFT	OSBM
5. Jane Cox	Second Harvest
6. Jim Hardesty	NC Food Banks
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	
21.	

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
March 17, 1999
Afternoon

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Wednesday, March 17, 1999, in the afternoon, in Room 424 of the Legislative Office Building.

House Chairman, Representative Edd Nye presided. Other House members present were Representative Beverly Earle (Co-Chairman), Representative Martha Alexander (Vice-Chairman, Representative Trudi Walend, and Representative Gene Wilson. There were six senators present.

Chairman Nye called the meeting to order and Flo Stein, DHHS, was asked to continue speaking from the morning meeting. Senator Dannelly expressed concern with the altering of the resign process and that the services are not diminished for clients while the redesign is in process. Ms. Stein noted his concern and stated they are ending Carolina Alternative, that system is changing anyway and one reason the division has started this process is to make sure services are being met. She stated they are aware they need to change way of doing business so area programs are not having Medicaid audits result in paybacks. They are looking at how services delivery can be delivered, reduce some of the redundancy so there will be more dollars available for services. Senator Dannelly wanted to be assured this won't complicate the process of client receiving services and was told this would make services less complicated for clients and their families.

Chairman Nye stated he has never understood present system, which allocates availability based on number of people in geographical location and assumes twenty percent of the people in that area might have some type of mental illness. Ms. Stein responded they do plan to use data and make services more geographically available. There was more discussion by the member of the committee concerning mental health system.

Ms. Karen Hammonds-Blanks continued the presentation concerning issue of statue that requires the county commissioners, once they have appropriated the funds, to keep them at the same level, and she stated the county commissioners want to see this statue repealed, which would give them the authority to increase or decrease appropriations to area programs. After discussion by the members, Chairman Nye made a motion this issue to be presented to Flo Stein and Redesign Team to study. Senator Martin made a motion that the provision regarding county appropriations not be changed. The motion carried.

Chairman Nye adjourned the meeting.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbitt
Committee Assistant

Memorandum

North Carolina Association of County Commissioners

Mailing Address: P. O. Box 1488, Raleigh, NC 27602-1488
Street Address: Albert Coates Local Government Center, 215 N. Dawson Street, Raleigh, NC 27603
Telephone: 919-715-2893 • *Fax*: 919-733-1065 • *Email:* ncacc@ncacc.org
Home Page Address: http://www.ncacc.org

MEMORANDUM

TO: Members, Human Resources Subcommittee on Appropriations

FROM: Patrice C. Roesler, Director of Intergovernmental Programs

SUBJECT: County Data Requested During Meeting of 3/17/99 (a.m.)

DATE: March 17, 1999

Attached to this memo you will find fiscal information requested during the discussion pertaining to county match for Area Mental Health Medicaid services. The materials included are:

- tax rates by county - five year history
- fund balances by county - five year history
- fund balances by Area Mental Health program - three years only
- Medicaid costs by county - five year history (services only; does not include $47 Million the counties pay as 50% of the non-federal share of the costs of determining eligibility).

Further clarification regarding enclosed tables:

(1) The counties are required by statute to carry a fund balance equaling 8% of general fund expenditures. The purpose is to cover government operations for the six month period between the time the tax rates are set (July 1) and the time tax payments are due (January 1), to cover emergencies and unexpected expenditures (such as the Dare County Landfill fire), to provide a reserve for future projects such as schools or other government facilities, and for financial opportunities that may unexpectedly arise. According to the Local Government Commission, (Office of the State Treasurer) smaller counties generally have a lower fund balance in dollars and a higher fund balance as a percentage of expenditures.
(2) Decreases in county tax rates will usually occur upon completion of the octennial revaluation.
(3) The tax rate information and county fund balance information was taken from the Annual Financial Information Report (AFIR) required to be submitted to the Local Government Commission each year.
(4) The Area Mental Health fund balance information was manually taken from records of the Local Government Commission by LGC staff.

We hope this information is helpful to you in your deliberations. Should you have any questions, please do not hesitate to call.

NORTH CAROLINA ASSOCIATION OF COUNTY COMMISSIONERS
COMPARISON OF ACTUAL COUNTY GENERAL PROPERTY TAX RATES: FY1995 - FY1999

County	1994-95 Prop. Rate	1995-96 Prop. Rate	1996-97 Prop. Rate	1997-98 Prop. Rate	1998-99 Prop. Rate
Alamance	$0.4900	$0.5150	$0.5300	$0.5300	$0.5300
Alexander	$0.4650	$0.5300	$0.5300	$0.5700	$0.5300
Alleghany	$0.5800	$0.5800	$0.5800	$0.5800	$0.5800
Anson	$0.8500	$0.8400	$0.8350	$0.8350	$0.8450
Ashe	$0.5800	$0.5800	$0.5800	$0.5800	$0.4500
Avery	$0.5800	$0.5800	$0.5800	$0.5800	$0.5800
Beaufort	$0.6000	$0.6000	$0.6000	$0.6000	$0.6000
Bertie	$0.8300	$0.8300	$0.7600	$0.7500	$0.7500
Bladen	$0.7525	$0.7525	$0.7375	$0.7375	$0.7375
Brunswick	$0.5850	$0.6850	$0.6850	$0.6850	$0.6850
Buncombe	$0.7300	$0.7300	$0.7300	$0.7300	$0.6300
Burke	$0.6100	$0.6100	$0.5900	$0.5900	$0.5900
Cabarrus	$0.6200	$0.5650	$0.6100	$0.6600	$0.7000
Caldwell	$0.6490	$0.6490	$0.6490	$0.5900	$0.5900
Camden	$0.7500	$0.7500	$0.7500	$0.7500	$0.7500
Carteret	$0.4600	$0.5050	$0.5050	$0.4200	$0.4200
Caswell	$0.7450	$0.7900	$0.7050	$0.7050	$0.7050
Catawba	$0.4685	$0.5200	$0.5200	$0.5500	$0.5500
Chatham	$0.7400	$0.6650	$0.7400	$0.7900	$0.7900
Cherokee	$0.4700	$0.4700	$0.4700	$0.4700	$0.4700
Chowan	$0.7700	$0.7700	$0.7700	$0.8000	$0.6900
Clay	$0.4300	$0.4300	$0.4300	$0.4300	$0.4300
Cleveland	$0.6500	$0.6200	$0.6200	$0.6270	$0.6270
Columbus	$0.7600	$0.7800	$0.7800	$0.6950	$0.6950
Craven	$0.6000	$0.5850	$0.5850	$0.5800	$0.5700
Cumberland	$0.7900	$0.7900	$0.7500	$0.7500	$0.8400
Currituck	$0.5600	$0.6500	$0.6500	$0.6400	$0.6400
Dare	$0.3700	$0.4000	$0.4000	$0.4700	$0.4700
Davidson	$0.5400	$0.5400	$0.5400	$0.4800	$0.4800
Davie	$0.5600	$0.5600	$0.6000	$0.6000	$0.6000
Duplin	$0.7350	$0.7350	$0.7750	$0.7750	$0.7750
Durham	$0.9427	$0.9427	$0.9597	$0.9597	$0.9397
Edgecombe	$0.8300	$0.8500	$0.8800	$0.9100	$0.9100
Forsyth	$0.7350	$0.7264	$0.7264	$0.6515	$0.6515
Franklin	$0.8200	$0.9000	$0.9000	$0.9350	$0.8200
Gaston	$0.7890	$0.7890	$0.8410	$0.8470	$0.8250
Gates	$0.8700	$0.8800	$0.8800	$0.9000	$0.9000
Graham	$0.5700	$0.5700	$0.6000	$0.6000	$0.6000
Granville	$0.7200	$0.7150	$0.7200	$0.7000	$0.7000
Greene	$0.8100	$0.8350	$0.8350	$0.7500	$0.7500
Guilford	$0.7899	$0.7548	$0.6572	$0.6572	$0.6372
Halifax	$0.6700	$0.6900	$0.6900	$0.6900	$0.6900
Harnett	$0.7000	$0.7000	$0.7000	$0.6800	$0.6800
Haywood	$0.7400	$0.7400	$0.6100	$0.6100	$0.6100
Henderson	$0.5400	$0.5050	$0.5150	$0.5450	$0.5850
Hertford	$1.0200	$0.9600	$0.9600	$0.9900	$0.9900
Hoke	$0.8900	$0.9400	$0.9400	$0.9400	$0.7500
Hyde	$1.0300	$0.8900	$0.8900	$0.9000	$0.8000
Iredell	$0.4500	$0.4500	$0.4500	$0.4500	$0.4500
Jackson	$0.4500	$0.5300	$0.5300	$0.5300	$0.5300
Johnston	$0.8900	$0.7400	$0.7400	$0.8400	$0.8500
Jones	$0.8200	$0.8400	$0.8400	$0.8400	$0.7100
Lee	$0.8400	$0.6800	$0.6800	$0.7100	$0.7100
Lenoir	$0.7700	$0.7700	$0.7500	$0.6700	$0.6700
Lincoln	$0.5600	$0.6150	$0.6150	$0.6150	$0.6150

NORTH CAROLINA ASSOCIATION OF COUNTY COMMISSIONERS
COMPARISON OF ACTUAL COUNTY GENERAL PROPERTY TAX RATES: FY1995 - FY1999

County	1994-95 Prop. Rate	1995-96 Prop. Rate	1996-97 Prop. Rate	1997-98 Prop. Rate	1998-99 Prop. Rate
Macon	$0.4300	$0.4300	$0.4950	$0.4600	$0.4300
Madison	$0.8200	$0.8200	$0.6500	$0.6500	$0.6500
Martin	$0.7700	$0.7700	$0.7700	$0.7700	$0.7700
Mcdowell	$0.6975	$0.6375	$0.6375	$0.6375	$0.6375
Mecklenburg	$0.8050	$0.8050	$0.7300	$0.7300	$0.6850
Mitchell	$0.5400	$0.5400	$0.5400	$0.5400	$0.5400
Montgomery	$0.7300	$0.7300	$0.6700	$0.6200	$0.5900
Moore	$0.5100	$0.4500	$0.4500	$0.4500	$0.4900
Nash	$0.6100	$0.6100	$0.6100	$0.6600	$0.6600
New Hanover	$0.6150	$0.6300	$0.6450	$0.6650	$0.6650
Northampton	$0.9900	$0.9900	$0.7600	$0.7600	$0.7600
Onslow	$0.5750	$0.6150	$0.6440	$0.6440	$0.6940
Orange	$0.8850	$0.9475	$0.9975	$0.8730	$0.9020
Pamlico	$0.7245	$0.7245	$0.6943	$0.6943	$0.6943
Pasquotank	$0.7200	$0.7200	$0.7700	$0.7700	$0.7300
Pender	$0.8960	$0.6500	$0.6100	$0.6100	$0.6100
Perquimans	$0.7800	$0.7800	$0.7800	$0.7800	$0.7800
Person	$0.6300	$0.6300	$0.6500	$0.6100	$0.6500
Pitt	$0.7239	$0.7239	$0.6600	$0.6800	$0.6800
Polk	$0.4800	$0.4850	$0.4933	$0.5433	$0.5433
Randolph	$0.4650	$0.4650	$0.4650	$0.4650	$0.4650
Richmond	$0.8600	$0.9100	$0.9700	$0.8200	$0.8200
Robeson	$0.9900	$0.9900	$0.8100	$0.8100	$0.8100
Rockingham	$0.6480	$0.6400	$0.6400	$0.6700	$0.6700
Rowan	$0.6500	$0.6375	$0.6375	$0.6375	$0.6375
Rutherford	$0.5900	$0.5600	$0.5500	$0.5500	$0.5450
Sampson	$0.8200	$0.6700	$0.6700	$0.6700	$0.6700
Scotland	$1.0500	$0.9800	$0.9500	$0.9300	$0.9300
Stanly	$0.5700	$0.6675	$0.6675	$0.6675	$0.6675
Stokes	$0.5700	$0.5700	$0.5700	$0.5700	$0.5700
Surry	$0.5400	$0.5200	$0.5200	$0.5300	$0.5300
Swain	$0.5700	$0.5700	$0.5700	$0.5500	$0.5500
Transylvania	$0.6380	$0.5410	$0.5410	$0.5410	$0.6410
Tyrrell	$1.0300	$1.0300	$1.0300	$0.9900	$0.9900
Union	$0.6600	$0.6600	$0.6600	$0.6600	$0.6600
Vance	$0.8000	$0.8000	$0.8000	$0.8300	$0.8900
Wake	$0.7600	$0.6300	$0.6300	$0.6300	$0.6300
Warren	$0.8950	$0.9300	$0.8800	$0.9000	$0.9200
Washington	$0.8700	$0.9200	$0.9200	$0.8700	$0.8700
Watauga	$0.5350	$0.4350	$0.4350	$0.4350	$0.4350
Wayne	$0.7300	$0.6500	$0.6500	$0.6500	$0.6500
Wilkes	$0.6500	$0.6400	$0.6300	$0.6300	$0.5000
Wilson	$0.8100	$0.7700	$0.7700	$0.7700	$0.7300
Yadkin	$0.6400	$0.6800	$0.6800	$0.6800	$0.6800
Yancey	$0.5000	$0.5000	$0.5000	$0.5000	$0.5000
High	**$1.0500**	**$1.0300**	**$1.0300**	**$0.9900**	**$0.9900**
Low	**$0.3700**	**$0.4000**	**$0.4000**	**$0.4200**	**$0.4200**
Avg. Unweigh	**$0.6934**	**$0.6867**	**$0.6790**	**$0.6757**	**$0.6680**
Increases	**21**	**27**	**19**	**23**	**12**
Unchanged	**59**	**43**	**60**	**54**	**68**
Decreases	**6**	**9**	**9**	**7**	**10**
Revalues	**14**	**21**	**11**	**16**	**10**

rth Carolina Association of County Commissioners

County Fund Balances

County	1992 Available Fund Balance	Fund Balance as % of Gen. Fund	1993 Available Fund Balance	Fund Balance as % of Gen. Fund	1994 Available Fund Balance	Fund Balance as % of Gen. Fund	1995 Available Fund Balance	Fund Balance as % of Gen. Fund	1996 Available Fund Balance	Fund Balance as % of Gen. Fund	1997 Available Fund Balance	Fund Balance as % of Gen. Fund
Alamance County	17,095,865	36.06	15,260,438	33.83	14,361,467	28.50	13,860,461	25.47	15,042,005	26.11	16,939,731	28.48
Alexander County	1,623,177	16.27	1,347,396	12.38	1,488,739	12.86	1,958,085	15.62	2,457,487	17.84	3,652,190	26.14
Alleghany County	817,987	16.96	558,237	10.32	806,171	12.67	1,300,922	20.65	1,509,485	21.88	1,522,629	19.24
Anson County	1,740,506	14.71	2,451,583	12.57	2,392,031	13.96	2,910,455	17.87	3,520,260	19.22	3,833,324	19.06
Ashe County	1,957,420	21.03	1,747,114	16.12	2,314,181	21.82	3,648,177	33.83	3,506,208	27.62	3,147,691	23.20
Avery County	621,622	7.60	689,905	8.27	2,199,938	25.11	2,556,647	24.23	2,570,199	22.27	2,840,839	21.57
Beaufort County	4,682,286	22.71	4,984,680	21.49	5,559,347	19.94	5,870,345	19.64	5,930,401	19.20	6,442,885	20.70
Bertie County	2,951,590	31.60	2,900,227	30.23	2,892,149	26.71	3,105,569	28.47	3,298,398	27.73	3,653,536	30.56
Bladen County	2,601,536	16.05	2,138,753	12.65	2,651,264	14.96	2,774,720	14.52	2,593,924	12.32	2,440,287	10.69
Brunswick County	20,320,181	50.87	20,884,506	45.19	18,245,407	34.82	22,642,393	42.93	28,323,516	47.41	27,300,358	38.32
Buncombe County	10,659,798	11.13	9,577,770	9.71	13,284,687	12.15	19,239,486	16.02	18,210,943	13.99	24,545,604	17.39
Burke County	5,833,143	18.16	4,849,347	14.16	3,003,851	8.34	3,415,126	8.37	5,118,184	12.49	6,107,564	14.16
Cabarrus County	9,165,517	18.06	6,783,725	12.00	9,241,274	15.77	14,021,481	19.99	17,218,133	23.95	18,776,451	24.29
Caldwell County	2,180,306	6.73	2,923,145	8.59	4,150,024	11.38	5,138,639	12.64	3,992,465	8.88	4,596,741	10.28
Camden County	486,791	18.69	490,013	18.56	587,453	20.98	809,673	27.07	1,031,004	30.83	921,291	24.42
Carteret County	3,292,205	11.35	5,648,701	19.71	9,066,063	26.30	8,819,359	25.58	9,573,203	27.45	8,910,834	23.28
Caswell County	2,728,651	25.87	2,955,602	26.43	2,388,727	18.80	1,531,620	11.00	2,562,918	18.68	2,801,278	18.61
Catawba County	14,172,472	22.70	12,793,527	19.47	16,334,450	22.25	17,241,826	21.23	18,692,800	20.30	19,737,495	19.73
Chatham County	4,046,103	21.13	3,465,672	16.15	3,121,586	13.18	3,915,300	14.63	4,690,878	16.01	4,851,452	14.23
Cherokee County	861,359	9.02	1,205,812	12.50	936,896	9.14	1,478,645	13.24	1,976,020	16.85	3,139,500	26.90
Chowan County	695,404	10.69	688,913	8.93	822,825	10.19	1,159,621	13.53	1,031,307	11.70	817,954	8.53
Clay County	1,539,328	53.69	1,512,373	46.52	1,272,729	33.54	1,727,510	42.69	1,543,474	30.27	1,707,617	30.60
Cleveland County	8,268,290	18.87	8,324,552	17.73	10,201,176	20.82	11,151,399	19.97	11,574,524	20.93	14,315,327	24.88
Columbus County	3,154,778	12.02	4,451,991	15.33	5,166,620	16.70	7,010,100	20.84	6,340,084	17.54	5,778,145	15.48
Craven County	4,404,895	10.83	4,679,612	10.72	5,194,210	11.75	7,386,017	15.82	9,484,702	19.55	11,326,047	22.05
Cumberland County	15,399,029	12.86	17,085,156	13.58	21,246,979	15.17	16,512,766	10.41	18,364,542	11.19	26,869,389	15.74
Currituck County	5,599,500	49.79	5,660,351	37.96	6,389,186	46.95	6,021,911	40.90	8,266,030	56.26	11,665,806	67.85
Dare County	6,559,320	21.53	7,734,949	25.17	9,172,163	29.64	10,277,367	30.81	10,049,480	27.04	11,064,095	28.73
Davidson County	7,844,132	16.11	9,074,480	17.57	9,295,642	16.36	11,940,801	19.11	13,730,183	20.31	14,614,937	19.76
Davie County	7,699,532	55.89	7,333,660	46.40	7,735,201	44.99	6,028,380	29.69	14,506,224	78.12	9,330,940	34.72
Duplin County	4,458,621	26.24	2,991,404	13.85	3,136,015	14.42	3,672,583	16.25	4,643,850	19.41	5,994,268	23.64
Durham County	32,346,011	24.16	36,270,299	23.33	10,809,839	13.37	21,295,937	11.25	16,715,891	8.73	22,418,799	11.12
Edgecombe County	4,733,301	16.56	4,802,459	16.07	3,787,829	12.13	8,100,367	24.32	9,784,882	27.31	11,511,166	30.13
Forsyth County	20,659,802	12.65	23,834,712	13.84	30,527,215	16.43	34,119,565	17.11	36,789,593	17.62	34,267,455	15.54
Franklin County	3,380,896	16.19	3,092,147	16.86	1,628,949	6.84	1,837,767	7.09	4,024,839	15.68	5,803,851	21.77
Gaston County	19,558,194	27.04	20,178,237	26.20	24,423,980	30.56	21,638,598	24.49	22,044,218	25.04	28,597,066	32.39
Gates County	890,981	22.72	862,495	20.24	984,195	22.86	1,128,864	23.97	1,287,868	26.75	1,464,016	27.27
Graham County	164,882	5.18	269,603	7.42	465,861	12.08	377,794	8.76	425,406	9.00	514,148	10.21
Granville County	3,302,029	20.50	3,754,039	22.19	3,912,249	22.17	4,826,575	25.21	5,529,907	27.04	8,157,960	38.38
Greene County	1,199,146	20.61	1,202,370	17.45	847,053	10.79	901,428	10.55	573,452	5.71	555,002	5.60
Guilford County	21,739,783	10.51	25,704,033	12.42	37,572,633	14.88	50,048,526	18.26	57,998,882	19.95	63,653,208	20.17
Halifax County	9,214,894	31.49	9,936,554	32.59	7,319,250	20.21	6,354,017	17.19	7,057,962	15.45	8,419,744	18.01
Harnett County	6,932,098	26.15	5,059,841	17.70	4,510,074	15.07	5,398,519	16.92	4,731,370	13.28	6,792,540	17.33
Haywood County	5,175,543	20.43	5,714,582	20.16	6,534,442	21.65	5,410,707	16.15	5,913,053	17.45	7,179,130	20.29
Henderson County	2,987,715	9.01	3,511,974	9.50	2,021,228	4.82	2,391,681	5.59	2,203,959	4.79	2,330,548	4.78
Hertford County	1,230,438	10.65	570,159	4.92	1,312,136	10.30	2,387,685	17.30	2,254,084	15.74	1,991,761	13.06
Hoke County	1,557,276	16.08	1,271,513	11.72	750,972	5.80	251,241	1.86	1,624,216	11.79	2,770,453	19.79
Hyde County	1,213,701	24.81	1,203,202	22.94	1,217,115	23.53	1,579,242	30.48	1,666,011	30.54	1,977,364	32.61
Iredell County	6,836,555	16.67	8,225,313	18.74	9,523,512	20.10	12,757,455	24.84	12,211,763	20.51	14,118,274	23.21
Jackson County	1,624,837	13.11	2,400,830	17.26	(1,063,880)	(5.61)	(841,026)	(4.93)	1,444,724	8.49	2,774,609	14.97
Johnston County	9,889,617	24.84	8,793,429	19.85	11,458,375	25.28	12,708,735	25.33	13,380,000	24.63	16,989,225	26.52
Jones County	1,379,054	31.96	1,724,014	37.47	2,062,705	40.10	2,123,839	35.97	2,411,400	39.68	2,757,429	42.91

North Carolina Association of County Commissioners

County Fund Balances

County	1992 Available Fund Balance	Fund Balance as % of Gen. Fund	1993 Available Fund Balance	Fund Balance as % of Gen. Fund	1994 Available Fund Balance	Fund Balance as % of Gen. Fund	1995 Available Fund Balance	Fund Balance as % of Gen. Fund	1996 Available Fund Balance	Fund Balance as % of Gen. Fund	1997 Available Fund Balance	Fund Balance as % of Gen. Fund
Lee County	5,064,642	21.90	5,262,184	20.69	6,387,360	23.83	6,471,808	21.99	7,955,061	28.13	8,545,564	27.42
Lenoir County	7,993,480	26.14	7,969,366	24.44	8,222,309	23.18	8,477,112	21.61	8,580,624	21.34	10,235,454	24.44
Lincoln County	1,941,609	8.77	1,893,397	7.68	2,245,431	8.39	2,692,559	9.25	2,859,298	8.65	2,617,318	7.15
Macon County	3,012,714	21.81	3,555,290	22.63	3,883,302	23.98	5,613,366	35.25	7,719,077	46.29	10,499,990	55.70
Madison County	381,243	4.66	720,226	8.04	651,372	6.64	704,961	6.99	289,014	2.95	(448,667)	(4.12)
Martin County	3,407,770	25.65	3,218,485	22.34	3,495,190	21.18	3,790,480	20.35	4,050,356	21.73	3,878,089	19.08
McDowell County	405,414	2.72	755,876	4.83	1,274,296	7.71	1,613,944	8.94	1,666,176	8.49	2,048,506	9.81
Mecklenburg County	46,261,293	11.71	46,611,630	10.15	55,162,945	10.87	72,024,836	13.14	90,056,221	15.62	109,494,649	18.05
Mitchell County	1,595,046	26.46	1,214,956	17.23	1,222,528	16.56	845,649	10.05	557,228	6.38	1,079,807	12.41
Montgomery County	3,476,076	30.79	3,271,023	26.69	3,813,282	29.61	4,616,498	34.45	5,533,797	37.82	5,647,152	36.28
Moore County	3,188,030	11.69	2,403,187	8.43	3,213,819	10.26	4,827,330	14.05	7,983,592	20.65	8,877,684	21.82
Nash County	6,750,177	19.40	6,155,833	16.50	6,648,437	16.69	7,538,376	17.67	8,010,531	17.51	8,892,051	15.89
New Hanover County	12,135,510	15.46	17,633,239	20.93	22,915,575	24.00	23,201,038	22.35	23,591,631	21.02	25,339,987	19.29
Northampton County	3,910,865	38.78	3,851,609	32.20	3,990,695	28.88	3,635,682	23.08	2,881,776	17.69	2,787,128	15.57
Onslow County	4,722,481	9.81	3,095,514	5.70	7,181,802	13.62	9,677,553	16.66	11,601,165	18.08	12,692,557	18.07
Orange County	5,471,682	10.78	5,943,217	11.09	6,821,862	11.31	7,359,253	11.06	8,840,495	12.30	10,495,114	13.25
Pamlico County	861,386	12.84	864,101	12.52	656,623	8.91	481,103	6.35	935,271	12.39	1,702,692	20.09
Pasquotank County	2,328,170	19.43	2,746,275	20.87	2,885,032	19.52	3,225,408	19.80	3,515,789	19.22	2,921,760	15.09
Pender County	641,726	4.14	1,009,151	5.44	4,556,624	26.26	8,016,283	41.50	10,894,671	54.18	12,953,828	63.60
Perquimans County	897,467	20.67	866,281	18.49	1,078,369	19.58	1,492,411	25.52	1,824,754	31.68	2,101,424	34.13
Person County	2,929,884	17.05	4,490,548	21.91	4,030,682	16.75	4,807,129	19.66	4,300,684	15.94	4,551,025	15.83
Pitt County	10,303,003	18.71	9,673,337	15.54	9,732,569	14.42	10,282,251	14.12	8,740,952	11.06	9,188,184	12.38
Polk County	1,724,296	25.18	1,283,716	16.50	1,268,422	15.92	1,299,629	15.17	1,111,907	12.17	547,361	5.52
Randolph County	9,365,835	22.69	11,016,274	24.29	11,797,457	22.87	16,720,653	31.49	14,231,424	23.69	15,293,247	23.03
Richmond County	1,730,363	9.91	1,723,872	8.83	4,629,308	20.90	754,308	3.03	1,522,908	6.17	3,647,031	14.81
Robeson County	18,715,101	40.57	22,809,124	45.06	14,613,389	26.30	30,943,570	51.09	18,008,944	28.12	18,658,982	27.51
Rockingham County	10,680,625	27.37	11,669,151	28.96	12,324,627	26.57	12,867,681	25.45	13,450,444	24.55	16,122,125	28.16
Rowan County	3,633,166	7.83	6,822,733	15.68	6,401,741	12.96	9,019,246	15.85	6,466,065	9.49	10,230,747	15.12
Rutherford County	3,637,214	13.86	3,440,365	11.03	3,313,691	10.04	4,196,448	12.56	3,243,903	9.19	3,265,239	8.90
Sampson County	4,750,473	23.08	4,379,189	19.37	5,658,204	24.37	6,622,382	24.93	6,847,452	24.24	6,104,227	20.52
Scotland County	3,388,205	17.48	3,236,788	15.42	4,231,945	18.32	4,931,668	19.61	6,389,619	24.30	7,703,949	27.96
Stanly County	2,436,790	11.86	2,582,878	12.10	2,911,073	12.82	3,772,518	15.43	4,931,764	18.17	6,046,323	21.68
Stokes County	1,730,537	8.91	2,635,145	13.72	3,758,028	17.76	5,128,975	22.37	5,220,713	20.95	5,626,381	22.76
Surry County	13,991,714	53.41	14,350,804	49.97	15,055,055	48.76	15,953,079	49.18	15,752,158	42.97	15,718,594	40.24
Swain County	286,143	5.12	158,275	2.43	214,974	4.11	364,357	6.57	777,696	14.03	738,843	12.74
Transylvania County	2,623,430	15.95	2,718,421	16.24	3,576,349	19.86	5,554,286	29.45	8,648,590	41.79	10,166,046	46.36
Tyrrell County	1,086,125	34.78	954,505	36.34	937,978	32.30	790,401	25.59	576,438	17.23	544,034	17.74
Union County	14,972,344	37.35	15,611,888	33.50	17,621,544	34.32	23,580,588	44.85	29,201,331	50.85	34,016,967	55.38
Vance County	1,804,626	10.70	2,669,865	13.73	2,531,911	11.85	2,920,571	12.66	3,181,503	13.10	3,829,989	14.91
Wake County	42,611,007	15.12	58,217,268	19.89	73,833,988	21.50	84,338,029	21.60	110,813,684	31.61	110,769,253	28.93
Warren County	1,093,002	10.38	1,338,443	11.75	1,831,323	15.30	3,243,225	25.29	3,964,750	27.98	4,222,224	28.79
Washington County	978,447	15.05	903,289	12.48	768,941	10.32	873,464	11.17	732,381	9.24	757,294	8.79
Watauga County	3,859,880	25.09	3,666,821	22.75	4,277,283	24.48	5,249,808	26.93	6,085,570	29.91	5,686,261	22.87
Wayne County	5,088,168	12.13	5,070,863	11.35	7,286,837	15.64	9,475,218	18.32	16,319,136	32.96	18,921,841	32.38
Wilkes County	2,834,272	11.02	2,064,917	7.26	4,225,262	14.80	5,618,845	17.80	6,567,373	19.20	6,569,895	18.12
Wilson County	7,733,294	22.50	6,608,399	17.80	7,518,098	18.57	9,487,478	21.74	9,070,983	18.58	9,447,863	19.19
Yadkin County	2,657,512	19.45	1,745,625	11.39	2,742,645	16.80	3,422,650	19.79	5,684,015	31.80	6,744,739	38.33
Yancey County	361,907	6.20	604,274	8.93	1,078,240	15.72	1,152,416	14.56	1,308,399	15.44	1,193,977	14.23

Source: Local Government Commission, NC Dept of State Treasurer

MULTI-[redacted]TY/AREA MENTAL HEALTH AUTHORITIES, SERVICES & PROGRAMS									
	Fund Balances for FYE June 30, 1998			Fund Balances for FYE June 30, 1997			Fund Balances for FYE June 30, 1996		
	Reserved	Unreserved	Totals	Reserved	Unreserved	Totals	Reserved	Unreserved	Totals
Alamance-Caswell Area	3,481,299	3,758,521	7,239,820	1,096,059	2,572,493	3,668,552	798,276	2,526,289	3,324,565
Albemarle	3,919,691	4,510,948	8,430,639	861,171	1,738,659	2,599,830	248,770	799,905	1,048,675
Blue Ridge Area Authority	5,413,485	6,305,075	11,718,560	719,841	6,651,011	7,370,852	1,650,322	4,466,660	6,116,982
Carolina East Behavioral Health Care Consortium	(141,275)	(140,687)	(281,962)	8,463	133,973	142,436	N/A	N/A	N/A
Duplin-Sampson	921,533	1,004,526	1,926,059	24,362	1,148,932	1,173,294	23,579	1,142,159	1,165,738
Edgecombe-Nash	4,303,167	4,834,033	9,137,200	172,583	2,946,785	3,119,368	64,517	2,573,068	2,637,585
Foothills Area Program	4,179,333	5,018,279	9,197,612	3,682,377	5,853,529	9,535,906	3,708,460	4,227,002	7,935,462
Centerpoint Human Svcs, fka Forsyth -Stokes	(2,220,024)	3,210,266	990,242	4,897,921	(1,720,756)	3,177,165	3,292,018	(1,777,510)	1,514,508
Gaston-Lincoln	8,283,489	9,247,963	17,531,452	2,970,884	1,519,507	4,490,391	2,099,934	783,332	2,883,266
Lee-Harnett Area	2,235,692	2,893,977	5,129,669	1,321,664	1,522,104	2,843,768	1,124,319	1,491,313	2,615,632
Neuse Center	2,626,130	5,007,335	7,633,465	1,807,591	2,741,219	4,548,810	1,848,752	1,042,742	2,891,494
New River Area Board	1,742,480	3,159,922	4,902,402	1,574,528	1,869,791	3,444,319	1,444,799	1,624,901	3,069,700
Orange-Person-Chatham Area	3,434,348	3,786,163	7,220,511	742,677	2,441,483	3,184,160	427,560	1,700,776	2,128,336
Piedmont Area	6,211,417	7,440,998	13,652,415	1,968,824	2,879,248	4,848,072	1,209,725	1,831,197	3,040,922
Roanoke-Chowan Human Services Center	1,311,337	1,485,517	2,796,854	75,165	1,471,580	1,546,745	101,077	1,099,577	1,200,654
Rutherford-Polk	1,922,386	2,220,603	4,142,989	1,182,276	1,120,010	2,302,286	1,041,225	938,028	1,979,253
Sandhills Center	2,158,165	3,885,762	6,043,927	2,088,112	2,464,618	4,552,730	2,212,493	1,691,296	3,903,789
Smoky Mountain Center	3,784,653	5,409,465	9,194,118	1,795,770	3,472,005	5,267,775	1,539,056	2,622,024	4,161,080
Southeastern Regional - Lumberton	6,752,569	7,367,534	14,120,103	1,859,106	4,555,090	6,414,196	1,541,450	3,424,489	4,965,939
Southeastern Center f - Wilmington	-	-	-	1,246,651	6,536,589	7,783,240	865,403	4,706,246	5,571,649
Surry-Yadkin Area	-	-	-	396,179	1,776,912	2,173,091	277,027	1,175,676	1,452,703
Tideland Mental Health Center	568,942	1,223,066	1,792,008	264,913	1,072,932	1,337,845	231,122	1,351,444	1,582,566
Trend Area	1,166,062	2,514,426	3,680,488	1,474,488	2,365,953	3,840,441	881,787	2,808,209	3,689,996
Tri-County Area	-	-	-	1,329,136	564,567	1,893,703	328,236	632,505	960,741
Vance, Warren, Granville, and Franklin Counties	2,519,462	3,039,024	5,558,486	1,016,929	4,088,900	5,105,829	1,293,341	2,659,582	3,952,923
Wilson-Greene	1,975,423	1,994,511	3,969,934	230,799	1,504,677	1,735,476	341,300	1,327,113	1,668,413

North Carolina Association of County Commissioners
Seven Yrs of Medicaid Payments by County

COUNTY	Actual Costs*				Projected Costs			Percent Change
	1993-94	1994-95	1995-96	1996-97	1997-98	1998-99	1999-2000	
Alamance	2,015,500	2,327,402	2,678,298	2,797,428	3,165,916	3,562,754	3,850,929	91.07%
Alexander	428,663	524,911	676,740	724,771	765,999	810,206	887,675	107.08%
Alleghany	210,834	237,396	287,023	328,774	397,468	410,352	486,999	130.99%
Anson	825,510	952,550	1,083,868	1,159,403	1,399,661	1,493,682	1,597,671	93.54%
Ashe	587,860	686,281	825,241	910,650	1,105,237	1,201,504	1,306,404	122.23%
Avery	471,634	406,456	764,184	675,416	744,555	815,762	921,694	95.43%
Beaufort	1,277,170	1,363,666	1,708,282	1,971,658	2,065,894	2,239,239	2,251,503	76.29%
Bertie	728,620	820,417	917,830	1,098,771	1,259,472	1,303,768	1,402,480	92.48%
Bladen	885,049	1,125,937	1,371,195	1,539,379	1,710,972	2,015,590	2,115,687	139.05%
Brunswick	1,288,101	1,709,009	1,747,523	1,817,454	2,077,773	2,408,431	2,414,382	87.44%
Buncombe	3,601,965	4,222,155	5,126,331	6,052,154	6,499,089	6,901,099	7,411,658	105.77%
Burke	1,619,167	1,892,653	2,273,530	2,541,863	2,829,153	3,218,616	3,394,581	109.65%
Cabarrus	1,924,283	2,164,035	2,204,623	2,574,286	2,947,317	3,360,826	3,615,666	87.90%
Caldwell	1,500,327	1,838,919	2,020,725	2,100,234	2,410,732	2,628,652	2,860,243	90.64%
Camden	79,491	130,194	52,612	154,258	198,876	186,305	215,603	171.23%
Carteret	948,044	1,054,121	1,236,380	1,393,388	1,743,761	1,895,607	2,002,109	111.18%
Caswell	507,559	602,402	690,866	774,771	844,712	925,138	966,852	90.49%
Catawba	1,870,568	2,167,495	2,621,927	2,877,260	3,191,691	3,524,878	3,642,376	94.72%
Chatham	782,415	885,338	923,695	981,292	1,108,889	1,432,646	1,354,837	73.16%
Cherokee	565,731	629,031	791,321	891,811	1,094,435	1,213,761	1,362,661	140.87%
Chowan	414,116	512,812	604,559	702,301	767,284	856,850	826,535	99.59%
Clay	182,583	205,587	248,564	284,720	344,210	346,308	377,055	106.51%
Cleveland	1,713,480	1,890,031	2,305,801	2,716,967	3,174,898	3,586,847	3,815,022	122.65%
Columbus	1,806,803	2,106,400	2,450,825	2,569,151	3,026,279	3,533,749	3,737,979	106.88%
Craven	1,664,849	1,973,630	2,286,994	2,249,095	2,827,193	3,056,381	3,122,012	87.53%
Cumberland	4,017,196	4,597,258	5,513,273	6,321,993	7,071,128	7,648,469	8,239,239	105.10%
Currituck	226,201	351,932	305,842	285,757	376,609	388,849	435,138	92.37%
Dare	307,244	376,043	436,019	488,526	608,805	711,206	649,172	111.29%
Davidson	2,047,901	2,406,505	2,826,846	3,118,769	3,422,152	3,944,069	4,021,565	96.37%
Davie	465,051	506,030	642,428	663,407	796,443	880,485	903,690	94.32%
Duplin	1,115,791	1,261,575	1,482,342	1,830,052	1,902,320	2,069,139	2,202,459	97.39%
Durham	3,900,147	4,336,536	5,086,330	5,732,242	5,951,025	6,925,839	6,515,258	67.05%
Edgecombe	1,677,837	1,780,125	2,360,993	2,462,754	2,837,280	3,205,512	3,362,319	100.40%
Forsyth	4,529,819	5,457,907	5,813,964	7,324,594	7,488,710	8,311,154	8,732,497	92.78%
Franklin	1,088,568	1,255,531	1,387,737	1,450,140	1,690,441	1,843,041	1,839,511	68.98%
Gaston	3,664,003	4,388,716	5,078,934	5,696,326	6,105,360	6,687,510	6,734,702	83.81%
Gates	243,188	258,064	294,369	360,020	431,533	422,195	422,914	73.90%
Graham	194,296	253,449	313,730	379,303	450,991	500,379	513,425	164.25%
Granville	817,441	967,650	1,150,554	1,317,364	1,281,340	1,523,030	1,575,841	92.78%
Greene	393,121	430,736	517,060	623,915	760,140	825,893	822,431	109.21%
Guilford	6,352,206	7,289,050	8,600,490	8,961,176	10,516,034	12,124,299	11,960,029	88.28%
Halifax	1,852,443	2,087,975	2,544,935	2,673,525	2,994,461	3,327,532	3,371,449	82.00%
Harnett	1,666,927	1,894,680	2,279,377	2,536,087	2,727,481	2,940,116	3,231,883	93.88%
Haywood	981,965	1,242,442	1,452,067	1,599,192	1,821,452	2,029,364	1,983,570	102.00%
Henderson	1,345,102	1,685,092	1,856,342	2,292,001	2,424,677	2,644,442	2,927,412	117.63%
Hertford	779,669	784,541	1,092,760	1,275,609	1,407,215	1,358,357	1,525,110	95.61%
Hoke	651,497	746,152	805,468	956,144	1,085,371	1,205,274	1,166,094	78.99%
Hyde	161,120	165,223	211,890	218,859	306,449	366,087	336,999	109.16%
Iredell	1,718,856	1,991,991	2,321,011	2,546,803	2,748,576	3,033,947	3,216,412	87.13%
Jackson	530,494	640,365	730,060	732,415	1,021,608	1,123,153	1,316,300	148.13%
Johnston	2,121,824	2,331,020	2,672,902	3,014,176	3,404,112	3,813,947	3,820,114	80.04%
Jones	343,651	363,466	385,053	403,950	463,607	515,711	518,433	50.86%
Lee	948,116	1,068,175	1,262,882	1,411,827	1,465,075	1,573,006	1,772,314	86.93%
Lenoir	1,745,392	1,886,819	2,252,796	2,569,069	2,872,489	2,971,579	3,096,121	77.39%
Lincoln	950,597	907,942	1,130,324	1,308,268	1,543,776	1,470,870	1,594,601	67.75%
Macon	502,695	582,629	649,566	836,785	939,841	1,011,059	1,071,389	113.13%

North Carolina Association of County Commissioners
Seven Yrs of Medicaid Payments by County

COUNTY	Actual Costs* 1993-94	1994-95	1995-96	1996-97	Projected Costs 1997-98	1998-99	1999-2000	Percent Change
Madison	496,377	551,917	647,344	776,563	786,784	876,469	892,415	79.79%
Martin	726,616	835,235	1,085,199	1,229,712	1,246,558	1,360,960	1,501,372	106.63%
McDowell	669,042	820,070	992,479	1,037,715	1,230,331	1,314,890	1,427,165	113.31%
Mecklenburg	9,400,035	10,072,883	11,841,433	12,528,600	13,958,478	15,508,683	16,129,620	71.59%
Mitchell	370,962	451,124	463,324	491,180	623,128	663,561	688,185	85.51%
Montgomery	605,809	654,788	840,298	901,940	1,066,170	1,168,400	1,203,178	98.61%
Moore	1,123,334	1,291,756	1,442,710	1,638,187	2,010,641	2,251,727	2,392,829	113.01%
Nash	1,612,042	1,882,053	2,329,776	2,446,041	2,920,470	3,079,964	3,126,188	93.93%
New Hanover	2,740,345	3,392,493	3,858,491	4,077,815	4,587,507	5,160,047	5,033,576	83.68%
Northampton	709,948	838,743	962,211	1,066,304	1,266,764	1,269,216	1,389,361	95.70%
Onslow	1,630,622	1,904,730	2,285,012	2,361,328	2,852,728	3,317,988	3,122,475	91.49%
Orange	1,355,337	1,481,579	1,413,818	1,787,742	1,886,024	1,998,420	2,314,730	70.79%
Pamlico	313,975	367,149	399,057	401,630	509,124	566,650	582,808	85.62%
Pasquotank	722,853	858,384	1,010,134	1,161,420	1,361,132	1,566,539	1,616,734	123.66%
Pender	825,706	986,814	1,207,283	1,258,469	1,435,560	1,595,898	1,743,771	111.19%
Perquimans	244,073	279,999	334,663	375,182	438,531	465,300	456,207	86.91%
Person	768,488	865,308	1,046,197	1,191,381	1,292,801	1,433,600	1,486,927	93.49%
Pitt	2,658,649	3,383,761	3,783,874	4,164,172	4,775,443	4,924,584	5,043,896	89.72%
Polk	54,430	61,288	336,681	370,050	540,776	555,304	576,185	958.57%
Randolph	1,610,314	1,989,706	2,494,900	2,692,146	3,103,376	3,361,671	3,412,179	111.90%
Richmond	1,184,267	1,480,190	1,803,925	2,069,859	2,538,700	2,663,628	2,604,101	119.89%
Robeson	3,527,558	3,978,950	4,360,996	5,540,668	6,355,169	7,311,591	7,576,144	114.77%
Rockingham	1,868,310	2,162,963	2,649,814	2,957,015	3,322,654	3,863,964	4,052,417	116.90%
Rowan	2,127,988	2,299,900	2,824,745	2,860,296	3,417,140	3,749,882	3,861,620	81.47%
Rutherford	1,131,155	1,191,778	1,613,838	1,819,625	2,158,679	2,401,979	2,477,655	119.04%
Sampson	1,471,414	1,637,558	2,026,336	2,244,119	2,368,400	2,674,101	2,881,250	95.82%
Scotland	938,216	1,161,398	1,381,085	1,547,288	1,884,292	2,101,900	2,259,179	140.80%
Stanly	1,049,579	1,198,021	1,464,342	1,430,816	1,781,923	2,017,340	2,068,606	97.09%
Stokes	709,484	786,282	913,638	947,746	1,122,748	1,251,337	1,260,140	77.61%
Surry	1,237,975	1,426,860	1,723,792	1,984,090	2,244,846	2,348,859	2,713,445	119.18%
Swain	233,013	290,221	371,370	456,401	639,663	612,841	616,730	164.68%
Transylvania	566,987	759,196	693,572	802,506	916,568	908,323	1,011,834	78.46%
Tyrrell	122,476	133,956	149,563	179,085	223,651	210,658	212,487	73.49%
Union	1,373,057	1,600,732	1,855,713	2,112,599	2,336,935	2,590,956	2,495,974	81.78%
Vance	1,142,719	1,393,731	1,663,418	1,851,294	2,148,043	2,280,459	2,252,976	97.16%
Wake	5,493,928	6,618,713	6,023,075	8,857,657	8,882,875	10,126,391	10,531,167	91.69%
Warren	501,018	671,575	752,325	830,109	963,328	1,027,369	983,318	96.26%
Washington	430,778	451,526	532,159	588,238	630,308	753,071	767,316	78.12%
Watauga	461,882	556,473	687,036	715,152	883,228	937,920	995,555	115.54%
Wayne	2,104,720	2,167,527	2,657,923	3,518,934	3,880,729	4,278,242	4,231,818	101.06%
Wilkes	1,320,100	1,607,085	1,845,774	2,110,448	2,406,074	2,499,984	2,870,303	117.43%
Wilson	1,664,562	1,897,406	2,177,283	2,824,778	2,913,179	3,340,067	3,291,281	97.73%
Yadkin	534,612	678,920	805,052	827,654	925,893	1,067,659	1,165,058	117.93%
Yancey	364,341	466,303	492,358	522,734	658,629	796,038	884,018	142.63%
Total	135,439,777	156,311,490	181,601,296	204,834,991	230,113,947	254,578,894	264,023,197	94.94%
		15%	16%	13%	12%	11%	4%	

The above figures do not include the costs of administering the Medicaid program. County employees at county expense manage the elibility determination process. North Carolina is the 1 of 2 states in the nation whereby the counties are required to fully fund the non-federal share of Medicaid administration, 50% of the total administrative costs. For 1999-2000, an estimated $47 million will be spent by counties to administer Medicaid.

Note* Actual costs from Annual Financial Information Reports.
Missing data estimated by moving forward/backward real costs by statewide percent change.
Projected costs from DHHS budget projections issued in Feb. of each year.

3/17/99
Hand out

DHHS-DMH/DD/SAS SYSTEM REDESIGN PLAN

- ANALYSES
- OPTIONS
- RECOMMENDATIONS

- Planning Begun: November, 1998
- Phase 1 Implementation: July 1, 2000

System Redesign: Overview

- Division moving from being a relatively passive "funder" of services to a more proactive "purchaser" of services
- System is in need of major overhaul
- Substantial room for improving the quality, access, accountability and cost-effectiveness of purchased services
- Everything on the table; nothing is sacred

System Redesign: Goals

- Develop consistency in quality, availability & access of services across the state
- Strengthen clinical and financial accountability
- Utilize competition to improve quality
- Clarify and recommend optimal roles of Division, counties, and service providers
- Develop & manage performance contracts
- Implement utilization management

System Redesign: Stakeholder Involvement

- There is no "predetermined" plan.
- The Division is committed to an open process in which all consumers, families, advocates, and other interested stakeholders have ongoing opportunities to contribute to the new system design.
- Send comments to:

  www.state.nc.us/dhr/dmh

System Redesign: Primary Components

- Priority populations
- Benefit design; covered services
- System structure and provider network
- Quality management
- Management Information Systems (MIS)
- Financial structure & strategies
- Consumer issues: rights, protections, and meaningful involvement

System Redesign: Key Policy Issues

- Overall system structure and service provider network
- Community-based & institutional services: structural and financial relationship
- Establishment of clinical & financial accountability throughout system
- Role of competition & marketplace in redesigned system

System Redesign: Design Plan & Auditor Report

- Complementary studies; commitment to coordination / collaboration
- Auditor Report:
  - Legislatively mandated study of MGT recommendations and of Area Programs
  - Final recommendations due April 1, 2000
- Design Plan:
  - Division mandated study
  - Final recommendations due November 19, 1999

System Redesign: Workplan

Design Team/SAT: Report Development	Jan-May, 1999
Draft 1: Public review and comment	May21
Public input/ public forums	May21-June25
Draft 2: Public Review and comment	September
Public input/ public forums	October
Final Division Plan	November
Auditors Final Report	Spring, 2000
Implementation Plan: Phase 1	July1, 2000
Implementation Plan: Phase 2 & 3	2001, 2002

System Redesign: Structural Options (preliminary)

- "Franchise"- Based
  - Status quo
  - Management of A.P.'s competitively bid
  - A.P.'s Authorization and services separated
- Regional Purchasers (e.g, 4-5)
  - Competitively bid management entities
  - State regional offices as the management entities
- Division as Direct Purchaser
  - Existing Division capabilities
  - Division with ASO / MCO assistance

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-17, 1999 PM
Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Allan Spader	NC Council of C.P.
Janet Simoneau	NC Council of CP
Peggy Balch	Thomas S. - MH/DD/SAS
[illegible]	MHA/NC - C'2001
Bob Hedrick	CNC, Inc.
C. L. Cochran	NCPNC - C 2001
Stacy Flannery	NC Health Care Facilities Assoc.
Stan Slawinski	Div of MH/DD/SAS DD SECTION
ANNA TEFFT	OSBM
Wayne Williams	OSBM
John Bowdish	Zeb Alley P.A.
Lisa Abatemarco	DHHS/BRFA
Charles Lewis	DMHMSAS
Stephen Moss	DMH-DDSA
NELS ROSELAND	OSBM
[illegible]	OSBM
Phillip Hoffman	DMHDDSAS
Lara Carson	DMH/DD/SAS
John Baggett	"
A Dennis McBride	DHHS
Allyn Dutton	DHHS
Jim Edgerton	DHHS
DAVE BRUTON	DHHS
ART ECCLESTON	DIV MH/DD/SAS
Glenn Wells	DHHS/Public Health

AGENDA

Joint Appropriations Subcommittee on
Health and Human Services

Thursday, March 18,1999, 8:30 a.m.
Room 424, LOB

Overview: Division of Child Development	Mary Ellen Sylvester Fiscal Research Division

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

MINUTES
MARCH 18, 1999
12:00

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Thursday, March 18, 1999, at 8:30 a.m. in Room 424 of the Legislative Office Building.

House Co-Chair Representative Beverly Earle presided. Other House members present were:

Representative Edd Nye, Co-Chair
Representative Martha Alexander, Vice Chair
Representative Alma Adams
Representative Lanier Cansler
Representative Theresa Esposito
Representative Trudi Walend
Representative Gene Wilson

Five Senate members were present.

Representative Beverly Earle called the meeting to order at 8:30. Pages were introduced and the meeting began with statements from Representative Theresa Esposito concerning the mismanagement of 4.4 million dollars at a Fort Bragg Mental Health Clinic. Rep. Esopsito had strong concerns of why the committee was not made aware of this lawsuit before it appeared in the newspapers. She also wanted to how when the committee will discuss this case. Dr. Bruton, Secretary of the Department of Health and Human Services, stated that this case was discussed in another committee, not Health and Human Services. It was so-noted that this case would be discussed at a future meeting, once it is out of litigation.

Following the agenda, Representative Earle, asked Mary Ellen Sylvester of the Fiscal Research Division, to give an overview of the Division of Child Development. She started with a budget summary, showing what the Governor has presented in his continuation budget for this division. She highlighted two sources of major increases for the budget, which were, TANF*Transfer for Child Care Subsidies, and the Smart Start Program Expansion. (See Attachment II).

Members of the committee contributed to the overview with questions and concerns of the services being offered. Ms. Sylvester answered their questions.

Nearing the time for adjournment, Ms Sylvester ended her presentation.

The meeting adjourned at 9:45 a.m.

Respectfully submitted,

Beverly Earle

Presiding Co-Chair, Representative Beverly Earle

Ann Raeford

Ann Raeford, Committee Clerk

Attachment I	Agenda
Attachment II, III & IV	Division of Child Development
Attachment IV	Visitor Registration

Attachment II
3-18-1999

DIVISION OF CHILD DEVELOPMENT

DIVISION OVERVIEW

Presented by : Mary Ellen Sylvester
Fiscal Research Division
March 18, 1999

DIVISION OF CHILD DEVELOPMENT

BUDGET SUMMARY

	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Requirements	$329,775,735	$412,933,263	$428,504,493	$428,504,493
Receipts	$157,631,631	$201,739,082	$203,234,766	$203,234,766
Net Appropriation	$172,144,104	$211,194,181	$225,269,727	$225,269,727
Positions	193.8	193.8	193.8	193.8

Sources of Major Increases:

- ***TANF* Transfer for Child Care Subsidies***
- ***Smart Start Program Expansion***

**Temporary Assistance For Needy Families (TANF) Block Grant*

DIVISION OF CHILD DEVELOPMENT

OUTLINE

- THE STATE'S ROLE IN CHILD CARE
- WHAT IS QUALITY CHILD CARE? WHY IS IT IMPORTANT?
- DOES STATE POLICY PROMOTE QUALITY CARE?
- WHAT ARE THE RESULTS OF NC'S INVESTMENT IN CHILD CARE?

DIVISION OF CHILD DEVELOPMENT

RESPONSIBILITIES

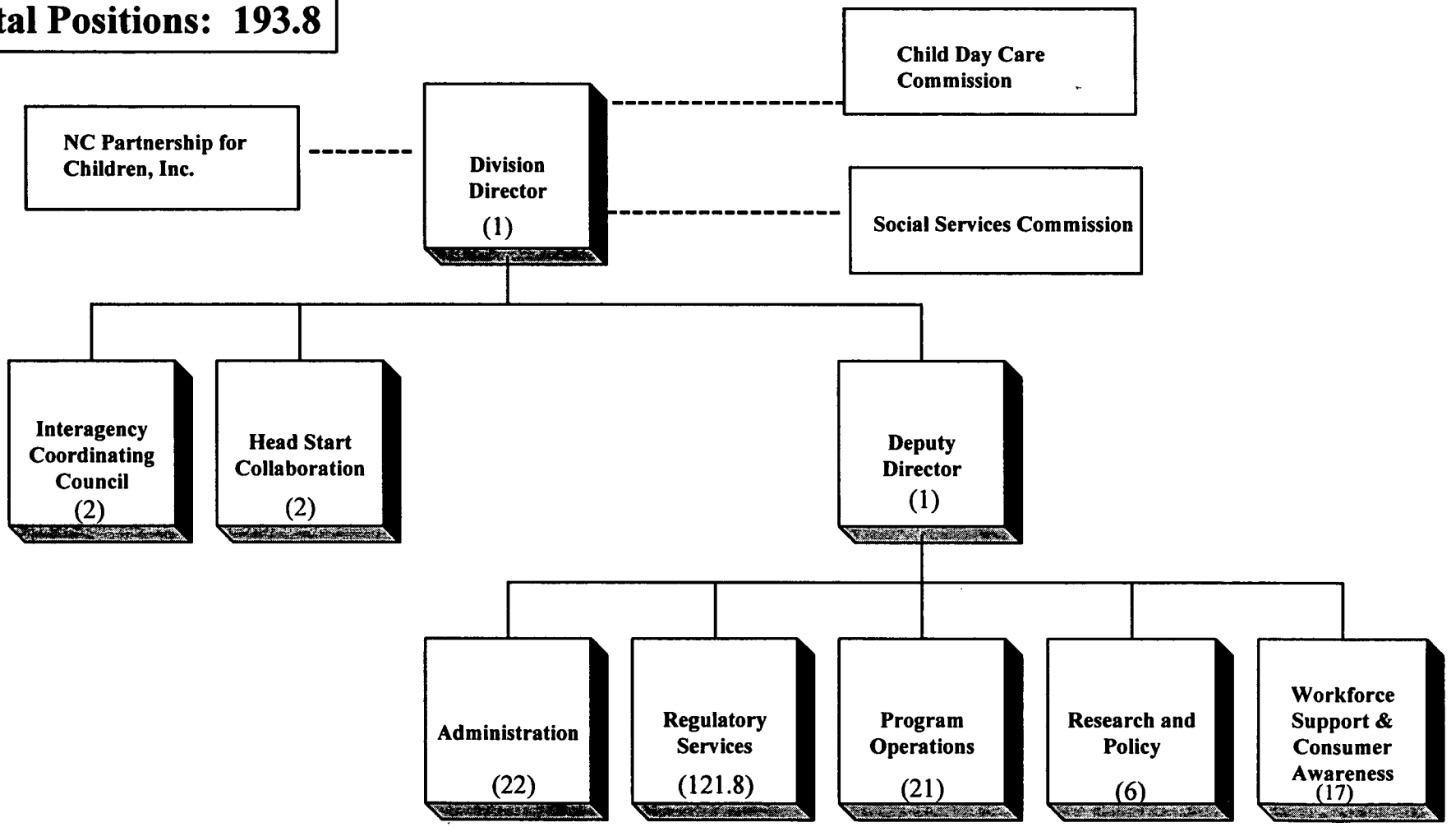
- **Inspects, Licenses, Monitors, and Sanctions** Child Care Centers and Homes Statewide
- Administers the Publicly **Subsidized Child Care** Program
- Provides **Training and Technical Assistance** to Child Care Providers
- Investigates **Abuse and Neglect** Complaints in Regulated Child Care Settings
- Administers the **Criminal Records Check** Process
- Maintains the **Child Care Personnel Education Registry**
- **Informs the Public** through the Division's Home Page and Resources in Child Care Web Site*
- Provides Administrative and Technical Assistance to the **Smart Start** Program
- Coordinates and Implements **Initiatives to Improve Child Care Quality and Availability**
- Provides Administrative Support and Staff to the **Interagency Coordinating Council** and the **Child Care Commission**
- Administers the **Head Start Collaboration** Project Grant
- Administers the North Carolina Early Childhood **Credential Programs**; Supports the North Carolina Institute for Early Childhood **Professional Development**

* http://www.dhr.state.nc.us/DHR/DCD/dcdpage.htm

DIVISION OF CHILD DEVELOPMENT

ORGANIZATION

Total Positions: 193.8

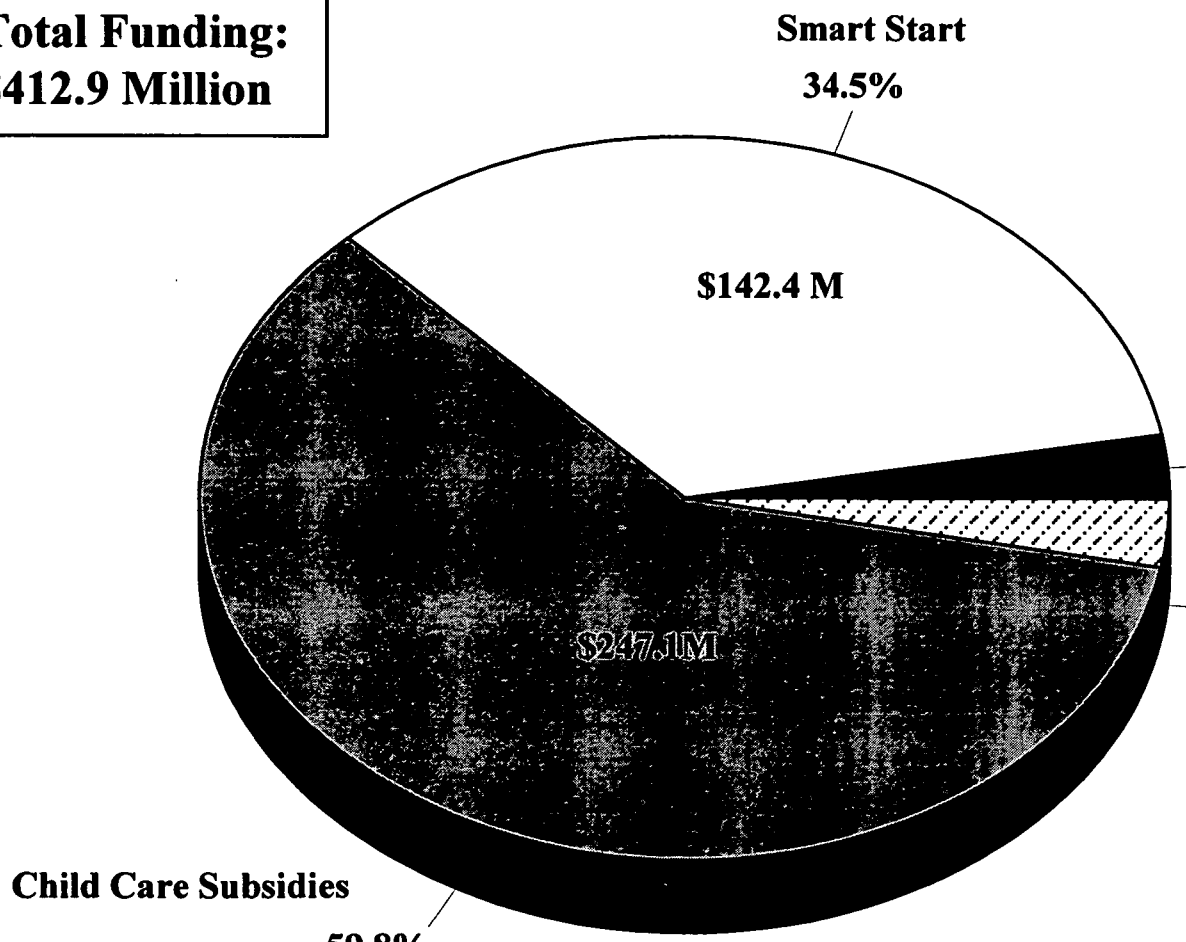


( ) Indicates No. of Positions

DIVISION OF CHILD DEVELOPMENT

FUNDS BY PURPOSE (1998-99)

Total Funding: $412.9 Million



Approximately 50% is Federal Funding (CCDF, TANF, SSBG)*

* Child Care and Development Fund, Temporary Assistance to Needy Families, and Social Services Block Grants

DIVISION OF CHILD DEVELOPMENT

EXTRAORDINARY GROWTH AND CHANGE

Division Established in 1992, Combining
Licensing and Subsidy Functions From the Division of Facility Services
Head Start Coordination and Interagency Coordinating Council From the Division of Social Services

Since 1992 --

Establishment of Smart Start Programs in 100 Counties ($0 to $142 Million)

Dramatic Increases in Funding and Capacity of State's Child Care System

	1992-93	1996-97	1998-99	Increase Since 1996-97
Subsidy Funding	$99.8M	$193.1M	$278.8M	44%
Number of Regulated Facilities	5,998	8,012	9,058	13%
Children Served in Subsidized Care	88,766	140,033	208,471 (est.)	49%

Substantial Changes in Federal Child Care Policy

- Title IV-A Family Support Act 1990-91
- Title IV-A At-Risk 1991-92
- Child Care Development Block Grant 1991-92
- Welfare Reform/Child Care and Development Fund 1996-97

Criminal Background Checks Required on Employees in Child Care Programs (1995-96)

Business Functions Automated Within the Division (1996-97)

Ratification of **SB 929** (August 1997); Implementation of **Rated License System** (April 1999)

DIVISION OF CHILD DEVELOPMENT

DEMAND FOR CHILD CARE

Population by Age Group in North Carolina (1999)

Ages 0-5	618,261
Ages 6-13	843,656
Total	1,461,917

Percentage of Mothers in the Work Force (1990 Census)

	Children 0-5	Children 6-17
North Carolina	67%	80%
United States	56%	73%

Number of Children in Regulated Child Care (January 1999)

	Number of Children	% of Population
Ages 0-5	161,541	26%
Ages 6-12	49,429	7%
Total	210,970	16%

Estimated Annual Demand for Subsidized Child Care (1998-99):

208,471 Children (Increasing to 291,791 Children in 2001-02)

Percentage of Demand Being Met Each Month?

89% (January 1999 - 11,245 Children on Waiting List)

Approximately 40% of All Children in Regulated Care are Subsidized

Approximately 5.5% of the Children Who Receive Subsidies are in Unregistered Care

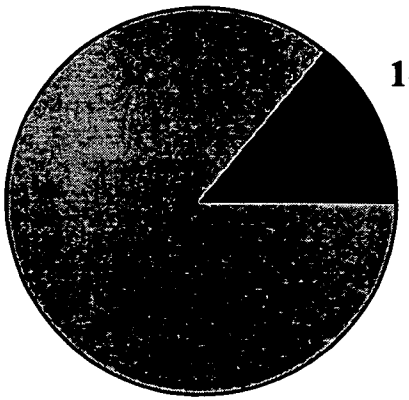
DIVISION OF CHILD DEVELOPMENT
COST OF CHILD CARE

Range of County Market Rates

	Infant/Toddler Rates	2-Yr Old Rates	3-5 Yr Old Rates
A Licensed Centers	$250-$550	$228 to-$481	$225 to $457
Child Care Homes	$250 to $410	$250 to $410	$281 to $410

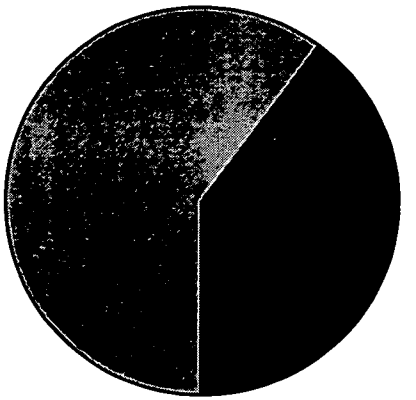
Percentage of Family Income for Infant/Toddler Center-Based Care

Statewide Median



$459/Month (Statewide Market Rate - 1998 Study)
Median Family Income: $39,100

Subsidy-Eligible



$250/Month (Current Lowest County Rate)
Family Income: $15-000 - $20,000

DIVISION OF CHILD DEVELOPMENT
CHILD CARE QUALITY

What is Good Quality Child Care?

Child Care Which Fosters the Physical, Emotional, Cognitive, and Social Development of Children

What are the Indicators of Good Quality Care?

- High Staff-to-Child Ratios
- Educated Staff/Experienced Administrators
- Teacher Continuity/Compensation
- Safe, Healthy Environment/Availability of Developmentally-Appropriate Materials
- Parental Involvement

√Parents Don't Always Understand the Importance of These Factors When Seeking Child Care

DIVISION OF CHILD DEVELOPMENT
CHILD CARE QUALITY (CONT'D)

Why is Quality Important?

-- Children Demonstrate Higher Math, Language, and Social Skills

-- Children are Healthier

-- Children are More Engaged in Activities, Less Aggressive, More Task Persistent, and More Self-Confident

-- Teachers are More Attentive/Responsive to Children's Needs, More Adept at Managing Behavior, and Less Likely to Leave

Effective Licensing Can Prevent Harm *and* Promote Quality
However, Licensing is Not the Only Strategy for Improving Quality

DIVISION OF CHILD DEVELOPMENT

COST, QUALITY, & CHILD OUTCOMES STUDY (APRIL 1995)

Objectives:

- Examine Relationship Between Cost and Quality of Child Care
- Determine Effect of Quality on Children's Developmental Outcomes

Study Regions: CA (Los Angeles County)
CO (Denver/Colorado Springs/Ft. Collins)
CT (Hartford/New Haven)
NC (Greensboro/Winston-Salem/High Point)

Study Size:

401 Centers (Approximately 100 Per State -- 50 For Profit/50 Non-Profit) ✓
749 Classrooms [228 Infant-Toddler and 521 Preschool (i.e., 2 1/2 $^{+}$ years)] ✓
826 Individual Assessments of Preschoolers (Approximately 200 Per State) ✓

DIVISION OF CHILD DEVELOPMENT

COST, QUALITY, & CHILD OUTCOMES

STUDY FINDINGS

Center Quality

- Child Care at Most Centers is Poor to Mediocre, esp. for Infants/Toddlers
- Children in Higher Quality Care Demonstrate Improvements in Receptive Language Ability, Pre-Math Skills, Social Skills, Attitudes about Self, and Teacher-Child Relationships
- Higher Quality Related Primarily to Staff-Child Ratios, Staff Education, and Administrators' Prior Experience (Other Factors: Wages, Specialized Training)
- States With More Demanding Licensing Standards Have Fewer Poor Quality Centers

Economics of Child Care

- Even Mediocre Care is Costly to Provide; Extra Resources Contribute to Higher Quality
- Market Setting (Competition, Subsidy Dependence) Affects Quality
- Inadequate Consumer Knowledge Creates Market Imperfections and Reduces Incentives to Provide Good Quality Care

Child Outcomes

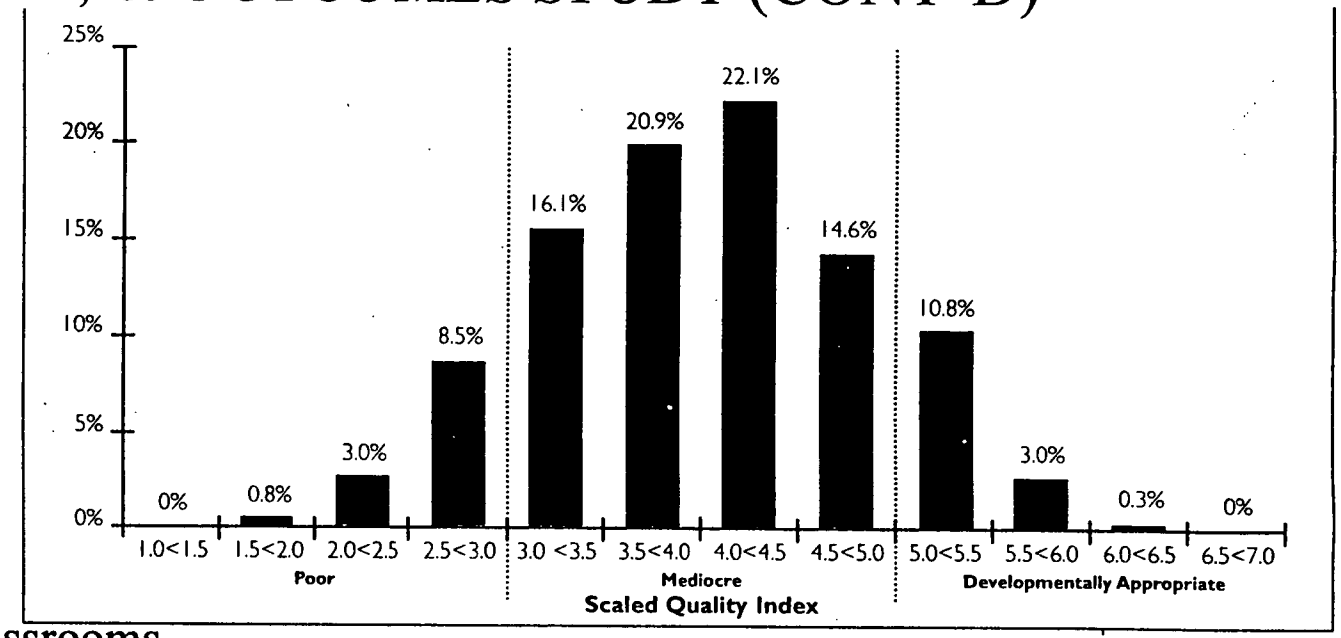
- Children's Developmental Outcomes are Positively Related to Child Care Quality
- Poor Quality Care Negates the Positive Effects of Higher Family Income, Higher Maternal Education, etc.

WHAT ARE THE IMPLICATIONS FOR STATE POLICY?

DIVISION OF CHILD DEVELOPMENT

COST, QUALITY, & OUTCOMES STUDY (CONT' D)

Quality in Child Care Centers



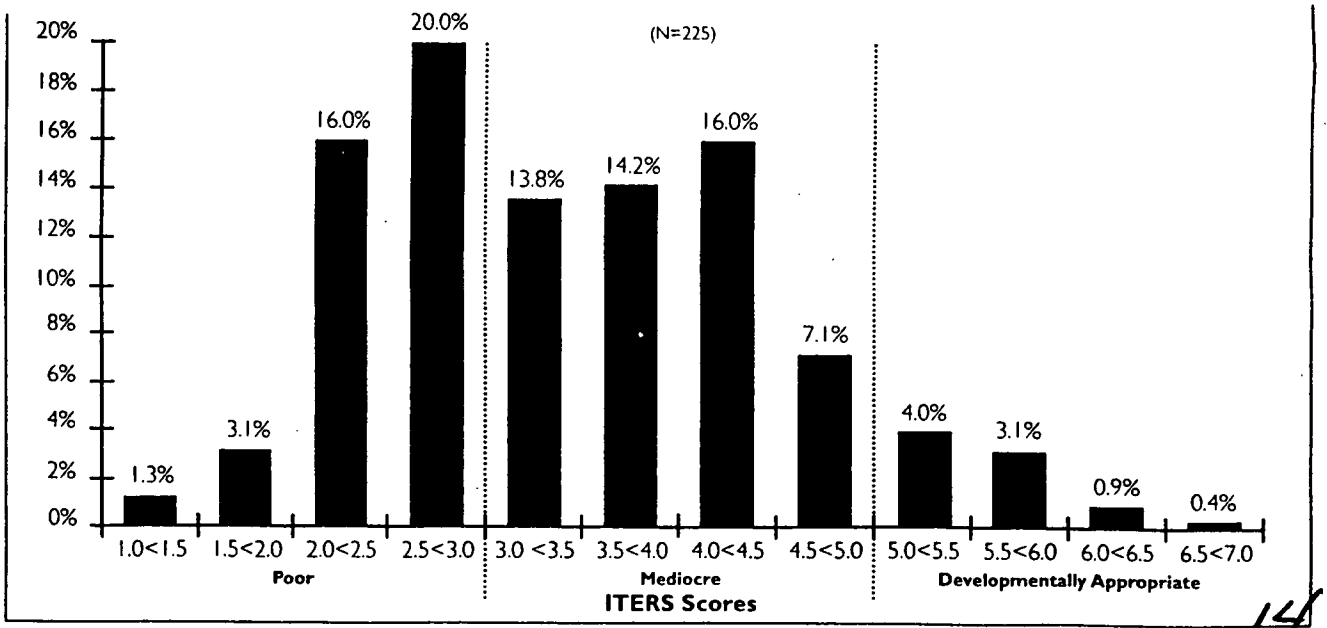
Quality in Infant/Toddler Classrooms

1=Inadequate ("Poor")
- Health & Safety Needs Not Met
- No Warmth/Support From Adults
- No Learning is Encouraged

3= Minimal ("Mediocre")
- Basic Health & Safety Needs Met
- Little Warmth/Support From Adults
- Few Learning Experiences

5=Good ("Developmentally Appropriate")
- Health & Safety Needsmet Fully
- Caring & Supportive Staff
- Learning Through Fun, Interesting Activities

7=Excellent
- Children Encouraged to be Independent
- Teachers Plan for Individual Learning Needs
- Close, Personal Relationships With Adults



DIVISION OF CHILD DEVELOPMENT

COST, QUALITY, & OUTCOMES STUDY (CONT'D)

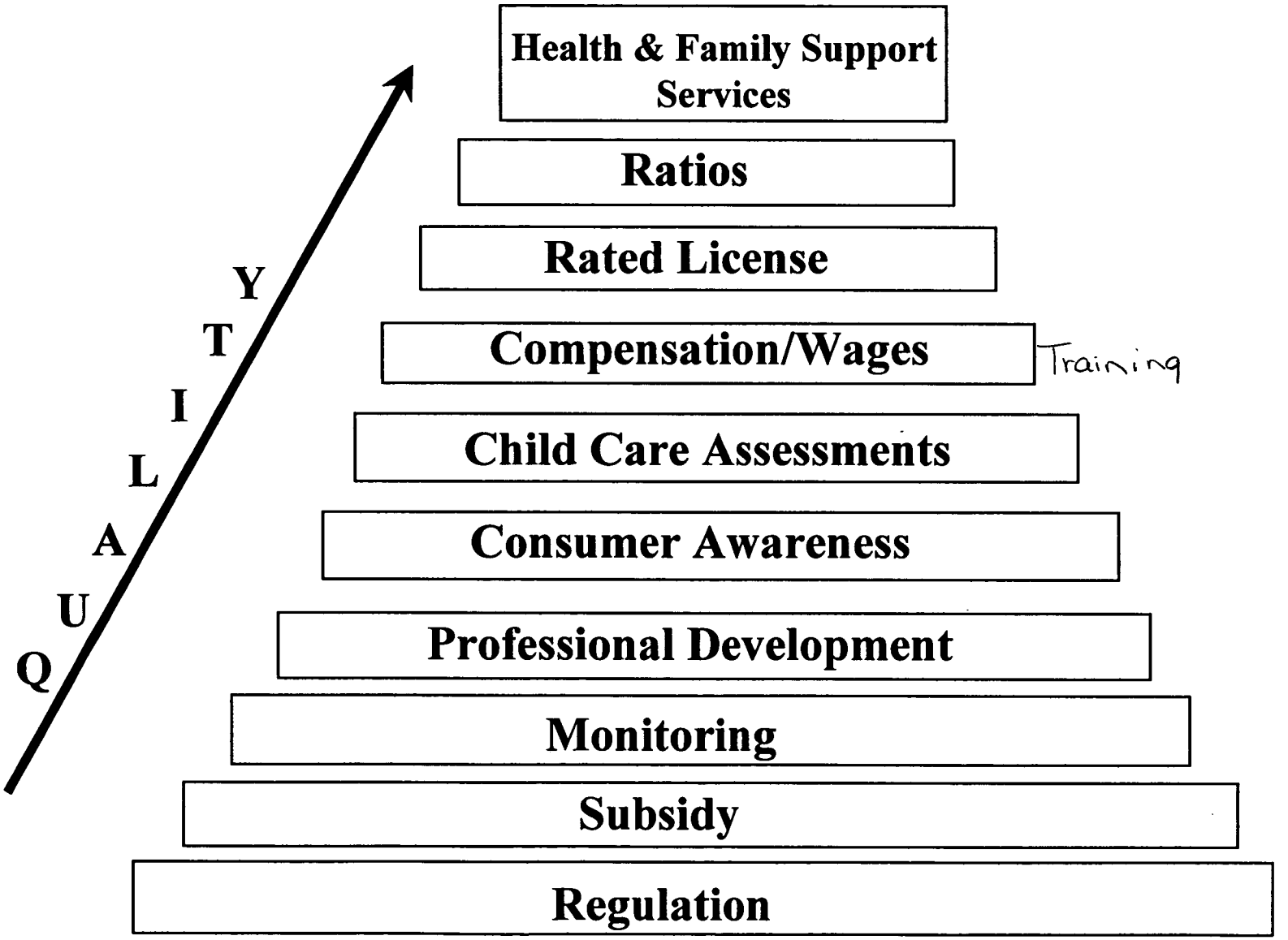
Children's Developmental Outcomes by Quality

Develepmental Outcomes		Quality of Care			
	N	Poor 141-154	Mediocre 385-416	Developmentally Appropriate 239-251	Overall 768-821
Receptive Language* **	Mean	85.6	93.3	99.7	93.8
	Std	19.2	17.4	17.4	18.4
Pre-Academic Skills:					
Pre-Math*	Mean	98.9	101.9	105.4	102.4
	Std	14.1	13.2	13.4	13.6
Pre-Reading	Mean	96.7	99.6	102.2	99.9
	Std	15.0	12.2	12.8	13.1
Attitudes/Perceptions*	Mean	4.2	4.4	4.4	4.3
	Std	0.6	0.6	0.6	0.6
Teacher-Child Relationship:					
Positive Aspects***	Mean	4.0	4.1	4.3	4.2
	Std	0.7	0.7	0.6	0.6
Negative Aspects	Mean	2.1	2.1	2.0	2.1
	Std	0.6	0.6	0.6	0.6
Social Skills:					
Positive Behavior*	Mean	3.5	3.6	3.8	3.6
	Std	0.7	0.7	0.7	0.7
Sociability*	Mean	3.8	4.0	4.1	4.0
	Std	0.7	0.7	0.7	0.7
Problem Behavior	Mean	2.6	2.4	2.4	2.4
	Std	0.9	0.9	0.9	0.9

• $p < .05$, •• $p < .01$, ••• $p < .001$

DIVISION OF CHILD DEVELOPMENT

NC IS BUILDING AN INFRASTRUCTURE FOR QUALITY



DIVISION OF CHILD DEVELOPMENT

COMPARISON OF STATES' STAFF/CHILD RATIOS

Age	North Carolina A License	North Carolina AA License	National Health & Safety Standards (NHSS)*	No. States Meeting NHSS Stds.	No. States More Stringent Than NC	No. States Less Stringent Than NC
0 - 1 Year	1:5	1:5	5 1:3	5 (28 Have 1:4)	33	6
1 - 2 Years	1:6	1:6	1:3	3 (15 Have 1:4)	29	6
2 - 3 Years	1:10	1:9	1:4-5	8	33	4
3 - 4 Years	1:15 ✓	1:10	1:7 ✓	1	43	0
4 - 5 Years	1:20	1:13	1:8	2	41	0
5 - 6 Years	1:25	1:15	1:8	0	46	0
6 + Years	1:25	1:20	1:10 - 12	2	40	1

* NHSS are Joint Recommendations of the American Public Health Association and the American Academy of Pediatrics

DIVISION OF CHILD DEVELOPMENT

REGULATORY SERVICES
&
RELATED INITIATIVES

DIVISION OF CHILD DEVELOPMENT
REGULATORY SERVICES (March 1999)

DEFINITIONS OF FACILITIES:

	MAXIMUM ENROLLMENT
Child Care Home	5 Preschool Children plus 3 School-Age Children
Child Care Center	
Residential	15 School-Age Children (12 If Any Child is Preschool Age)
Nonresidential	Unlimited, Providing 25 Sq. Ft. of Indoor Space and 75 Sq. Ft. of Outdoor Space Per Child

TYPES OF PERMITS:

Child Care Home	Registration Certificate or Notice of Compliance
Child Care Center	A License, AA License, or Notice of Compliance

Other: 1) Provisional, 2) Probationary, and
3) Accreditation (Not Administered or Issued by the State)

LICENSING PROCESS:

- Non-Expiring Licenses -- No Annual Renewal Required
- Annual Local Inspections [fire, sanitation, & building inspections (if necessary)]
- Compliance Visits: Centers Annually; Random Sampling of Child Care Homes
- Unannounced Visits to Investigate Complaints, Monitor Corrective Actions

REGULATED FACILITIES:

	NUMBER	**ENROLLMENT** (January 1999)
Child Care Center	3,826	188,511
Child Care Home	5,232	22,459
	9,058 ✓	210,970 ✓

WORKLOAD:

Number of Licensing Consultants:	66.75	Consultants
Average Caseload Per Consultant:	136	Facilities (Recommended Level: 75 Facilities)

DIVISION OF CHILD DEVELOPMENT

SENATE BILL 929 (August 1997)

"An Act to Enhance and Improve Child Care in NC"

- Increased Minimum Staff Qualifications for Critical Positions --

On-Site Administrator:	1) At Least 21 Years Old 2) NC Early Childhood Administrator's Credential or Equivalent 4 hrs
Lead Teacher:	1) At Least 18 Years Old 2) NC Early Childhood Credential or Equivalent
✓ Child Care Home Operator	1) At Least 21 Years Old 2) High School Diploma or Equivalent

- Expanded Criminal Background Checks for Child Care Homes

- Authorized Non-Expiring Licenses for Child Care Centers

- Modified Playground Rules

- Authorized Development of Voluntary, Enhanced Program Standards (i.e., Rated License)

DIVISION OF CHILD DEVELOPMENT

RATED LICENSE SYSTEM

- System to Encourage Providers to Achieve Higher Standards Voluntarily

- Three Components:
  - Program Standards
    - Staff/Child Ratios (AA Requirements)
    - Scores on Environmental Rating Scales
  - Education Standards
    - Administrator, Lead Teachers, Teachers
  - Compliance History

- May Earn Up to Five Points For Each Component -- Final Rating is a Composite Score

Rating	Points	
One Star	3 to 4	(= A License)
Two Stars	5 to 7	
Three Stars	8 to 10	(= AA License)
Four Stars	11 to 13	
Five Stars	14 to 15	

- Program Will Begin Implementation in April 1999

- DCD Will Reassess Rated Licenses Every Three Years

DIVISION OF CHILD DEVELOPMENT
"A" LICENSE STANDARDS

•Space 25 Square Feet per Child Indoor Space and 75 Square Feet per Child Outdoor Space

•Staff/Child Ratios

Age Group	Staff/Child Ratio
Birth to 1 Year	1:5
1 Year Olds	1:6
2 Year Olds	1:10
3 Year Olds	1:15
4 Year Olds	1:20
5 Year Olds and Older	1:25

•Activities/Curriculum

- •4 Activity Areas Available Daily; 5th Area Rotated in Monthly
- •Music/Rhythm, Sand/Water, and Science/Nature Activities Once per Month

•Staff Qualifications

- •**Teacher** - 18 Years Old, Literate, and Have 1 of the Following:
  - •High School Diploma/GED Plus 1 of the Following:
    - • 1 Year Experience in Child Care,
    - • 20 Additional Hours of Training in First 6 Months,
    - • Completion of DPI Child Care Services Program, or
    - • Passing Grade for 4, college-level semester hrs. in Child Development, or
  - •Child Development Associate Credential, or
  - •Graduation From Child Care/Early Childhood Education Curriculum at a Community College, or
  - •5 Years Experience in Child Care.

- •**Administrator** - 21 Years Old, Literate, High School Diploma/GED, and
  - •2 Years Experience in Child Care, or
  - •Associate Degree or Higher with 12 hrs. in Child Development or Early Childhood, or
  - •Child Development Associate Credential, or
  - •Completion of Community/Technical College Early Childhood Curriculum and 1 Year Administrative Experience, or
  - •Completion or Enrollment in Child Care Program Administration Course.

RATED LICENSE FOR CHILD CARE CENTERS

POINTS EARNED	PROGRAM REQUIREMENT	EDUCATION REQUIREMENT	COMPLIANCE HISTORY

1 Pt.	• Meets minimum licensing requirements in N. C. General Statute 110 and 10 NCAC 3U.	• Staff must meet minimum licensing requirements contained in N. C. General Statute 110-91(8) and 10 NCAC 3U .0700 which includes:
		  • On site child care administrator: must have a Level I NCECAC[3] or equivalent.
		  • Lead teachers: must have the NCECC[4] or equivalent.
			Compliance history rating of 60% or higher with req. in the areas of supervision, staff/child ratios, staff qualifications, health, safety, sanitation/fire/building, transportation, program, management, and sanitation.

2 Pts.	• Meets minimum licensing requirements; • Meets all "AA" requirements, except may meet "AA" ratio or space requirement.	• On site child care administrator: must meet minimum requirements and have a Level I NCECAC[3] or equivalent and 2 years of full-time verifiable early childhood experience. Centers with a licensed capacity of 200 or more must also have a second on site child care administrator who meets min. requirements and has a Level I NCECAC[3] or equiv. • Lead teachers: all must meet minimum requirements and have the NCECC[4] or equivalent; 75% must have or be enrolled in 3 semester hours in ECE/CD[5] or have 1 year of full-time verifiable early childhood experience. • Teachers counted in the ratios: all must meet minimum requirements; 50% must have or be enrolled in 2 semester hours in ECE/CD[5] or have 1 year of full-time verifiable early childhood experience.	Compliance history rating of 65% or higher with requirements in the areas of supervision, staff/child ratios, staff qualifications, health, safety, sanitation/fire/building, transportation, program, management and sanitation.
3 Pts.	• Meets minimum licensing requirements; • Meets all "AA" requirements; • Average score of 4.0 on ITERS[1]/ECERS[2]/ SACERS[6] in each classroom evaluated.	• On site child care administrator: must meet minimum requirements and have a Level I NCECAC[3] or equivalent and 6 semester hours in ECE/CD[5] and at least 2 years of full-time verifiable early childhood experience. Centers with a licensed capacity of 200 or more must also have a second on site child care administrator who meets minimum requirements and has a Level I NCECAC[3] or equivalent. • Lead teachers: all must meet minimum requirements and have the NCECC[4] or equivalent; 75% must have 3 semester hours in ECE/CD[5] or have 2 years of full-time verifiable early childhood experience. • Teachers counted in the ratios: all must meet minimum requirements; 50% must have or be enrolled in the NCECC[4] or equivalent or have or be enrolled in 4 semester hours in ECE/CD[5] or have 3 years of full-time verifiable early childhood experience.	Compliance history rating of 70% or higher with requirements in the areas of supervision, staff/child ratios, staff qualifications, health, safety, sanitation/fire/building, transportation, program, management and sanitation.
4 Pts.	• Meets minimum licensing requirements; • Meets all "AA" requirements; • Average score of 4.5 on ITERS[1]/ECERS[2]/ SACERS[6] in each classroom evaluated.	• On site child care administrator: must meet minimum requirements and have a Level II NCECAC[3] or equivalent and at least 2 years of full-time verifiable early childhood experience. Centers with a licensed capacity of 200 or more must also have a second on site child care administrator who meets minimum requirements and has a Level I NCECAC[3] or equivalent. • Lead teachers: all must meet minimum requirements and have the NCECC[4] or equivalent; 75% must have 9 semester hours in ECE/CD[5] and 2 years of full-time verifiable early childhood experience. • Teachers counted in the ratios: all must meet minimum requirements; 50% must have the NCECC[4] or equivalent, or 4 semester hours in ECE/CD[5], or 5 years of full-time verifiable early childhood experience.	Compliance history rating of 75% or higher with requirements in the areas of supervision, staff/child ratios, staff qualifications, health, safety, sanitation/fire/building, transportation, program, management and sanitation.

[1]ITERS = Infant/Toddler Environment Rating Scale
[2]ECERS = Early Childhood Environment Rating Scale
[3]NCECAC = North Carolina Early Childhood Administrator Credential
[4]NCECC = North Carolina Early Childhood Credential
[5]ECE/CD = Early Childhood Education/Child Development
[6]SACERS = School-Age Care Environment Rating Scale

RATED LICENSE FOR CHILD CARE CENTERS

5 Pts.	• Meets minimum licensing requirements; • Meets all "AA" requirements • Staff/child ratio reduced by one child per age group; • Average score of 5.0 on ITERS[1]/ECERS[2]/ SACERS[6] in each classroom evaluated.	• On site child care administrator: must meet minimum requirements and have a Level III NCECAC[3] or equivalent and at least 4 years full-time verifiable work exp. teaching in an early childhood center or administrative experience (or combination of both). Centers with a licensed capacity of 200 or more must also have a second on site child care administrator who meets min. requirements and has a Level I NCECAC[3] or equivalent. • Lead teachers: all must meet minimum requirements; 75% must have an AAS degree in ECE/CD[5] or an AAS degree in any major with 12 semester hours in ECE/CD[5], and 2 years full-time verifiable early childhood work experience. • Teachers counted in ratios: all must meet minimum requirements; 50% must have the NCECC[4] or equivalent and 4 semester hours in ECE/CD[5] and 2 years full-time verifiable early childhood work experience.	Compliance history rating of 80% or higher with requirements in the areas of supervision, staff/child ratios, staff qualifications, health, safety, sanitation/fire/building, transportation, program, management and sanitation.

Composite Scoring for Star Rating

Total Number of Points	Star Rating
5 through 7	**Two Stars**
8 through 10	**Three Stars**
11 through 13	**Four Stars**
14 through 15	**Five Stars**

[1]ITERS = Infant/Toddler Environment Rating Scale
[2]ECERS = Early Childhood Environment Rating Scale
[3]NCECAC = North Carolina Early Childhood Administrator Credential
[4]NCECC = North Carolina Early Childhood Credential
[5]ECE/CD = Early Childhood Education/Child Development
[6]SACERS = School-Age Care Environment Rating Scale

DIVISION OF CHILD DEVELOPMENT

CRIMINAL HISTORY CHECKS

Required for all Child Care Providers Working in Regulated Child Care Facilities and Nonregistered Homes Which Receive State or Federal Funds

-- Local Criminal History and SBI Checks for Providers Who Have Lived in North Carolina Continuously for the Previous Five Years
-- Local Criminal History, SBI, and FBI Checks for All Others

Statistics: May 1, 1996 Through November 30, 1998

	Total Applications Received	Number Qualified W/No Record	Number Qualified W/Record	Number Disqualified
Regulated Programs	56,274	45,185	3,156	53
Unregulated	11,223	8,303	1,193	64
Total	67,497	53,488	4,349	117 (0.2%)

Most Common Convictions for Providers Who Were "Qualified With a Record:"

1. Worthless Checks
2. Traffic Offense (Not DWI)
3. Fraud
4. Larceny

Process:
Phased-In With Annual License Renewal Process
Response Time From SBI is 3-4 Weeks
Approximately 10% of Applicants Require Both SBI and FBI Checks
None of the 117 Individuals Who Were Disqualified Have Appealed (as of 11/30/98)

DIVISION OF CHILD DEVELOPMENT

PROFESSIONAL DEVELOPMENT/ COMPENSATION-RELATED INITIATIVES

Good Info

DIVISION OF CHILD DEVELOPMENT

T.E.A.C.H. (Teacher Education and Compensation Helps)

Purpose:
- Increase the Education of Child Care Directors/Teachers 4 hrs C.C.
  (Currently, 50% of Directors and 70% of Teachers Have No Formal Education Past High School)
- Encourage Child Care Programs to Support the Continuing Education of Their Staffs
- Increase Compensation With More Education
  (Average Wages Statewide: Directors - $8.71/Hour
  Child Care Center Teachers - $6.25/Hour
  Family Child Care Home Providers - $3.97/Hour)
- Reduce Staff Turnover
- Provide a Sequential Professional Development Path

Program:
- Shares the Cost of Education With the Sponsoring Child Care Program and the Scholarship Recipient
- Requires Participants to Work in Child Care for 3 Months to 1 Year Following the Contract Period

6.25 hourly

Accomplishments (1997-98):

Scholarship Recipients:	4,357	(Double Previous Year's Level) Jan-93
Children Affected:	76,521	(1/3 of All Licensed Centers had at Least One TEACH Recipient)

✓ **Results:**

Turnover Rate:	Reduced from 32% to 10% per Year (Prior to TEACH, Turnover Rate was 42%)
Compensation:	Either a 4% - 5% Raise or a $100 - $700 Bonus, Depending on Credit Hours Completed

Future:
- SB 929 Requirements Will Increase Demand for TEACH Scholarships
- More TEACH Recipients Continuing Their Education by Enrolling in Degree Programs

TEACH is Licensed in Illinois, Florida, New York, Colorado, Georgia, Massachusetts, Pennsylvania, and Indiana

DIVISION OF CHILD DEVELOPMENT

NC CARES

(NC Committed to Attracting and Retaining Educated Staff)

***PURPOSE*:**

- Recruit and Retain Good Quality Child Care Teachers
- Encourage Teachers to Participate in Specialized Higher Education

1) WAGE$ -- Salary Supplement Program

- Provides Teachers and Directors a Bonus Every Six Months for Continuing to Work in a Participating, Regulated Child Care Facility

- Bonus is Tied to Level of Education

  - Must Have at Least an NC Early Childhood Credential
  - Bonus Amount Varies From $300/Year to $3,000/Year

2) T.E.A.C.H. Early Childhood Health Insurance Program

- Provides Child Care Staff Access to Health Insurance Coverage

- State Pays 1/3 of the Premium (CCDF Funds), Facility Pays 1/3, and Employee Pays 1/3

- Facilities Must Have at Least 1 Staff Member Participating in a T.E.A.C.H. Scholarship Program (Early Childhood Associate, Bachelor, or Model/Mentor Teacher Program)

- Facilities Must Ensure Employees' Dependent Children Have Health Insurance Coverage or are Enrolled in NC Health Choice, if Eligible

DIVISION OF CHILD DEVELOPMENT

SUBSIDY PROGRAM

DIVISION OF CHILD DEVELOPMENT

ELIGIBILITY CRITERIA

Criteria for Receiving Subsidized Child Care:

Support Child Protective Services

Maintain or Seek Employment (30 Days)

Attend School* or Job Training Activities Which Lead to Employment

Meet Developmental Needs of Child

Support Child Welfare Services

Counties Determine Their Own Priorities

* Post-Secondary Education is Limited to Two Years

DIVISION OF CHILD DEVELOPMENT
SUBSIDIZED CHILD CARE

Eligibility:

- Family Income Less Than 75% of State Median Income, Adjusted for Family Size
- Child Protective Services (CPS)
- Other Welfare Services, e.g., Foster Care

Fees:

- Family Pays Between 7% and 9% of Gross Countable Monthly Income, Adjusted for Family Size

Fee %	9%	9%	9%	8%	8%	7%	7%	7%	7%	7%	7%	7%
Family Size	1	2	3	4	5	6	7	8	9	10	11	12
Max. Monthly Income	$1,449	$1,895	$2,341	$2,786	$3,232	$3,678	$3,762	$3,845	$3,929	$4,012	$4,096	$4,180

- One Fee is Assessed for Subsidized Child Care, Regardless of the Number of Children in Care
- No Fees for Child Protective Services

Parental Choice:

- Parents are Issued a Voucher and May Choose a Provider From Among Regulated Facilities Who Will Accept Public Funds for Their Services

Program Administration:

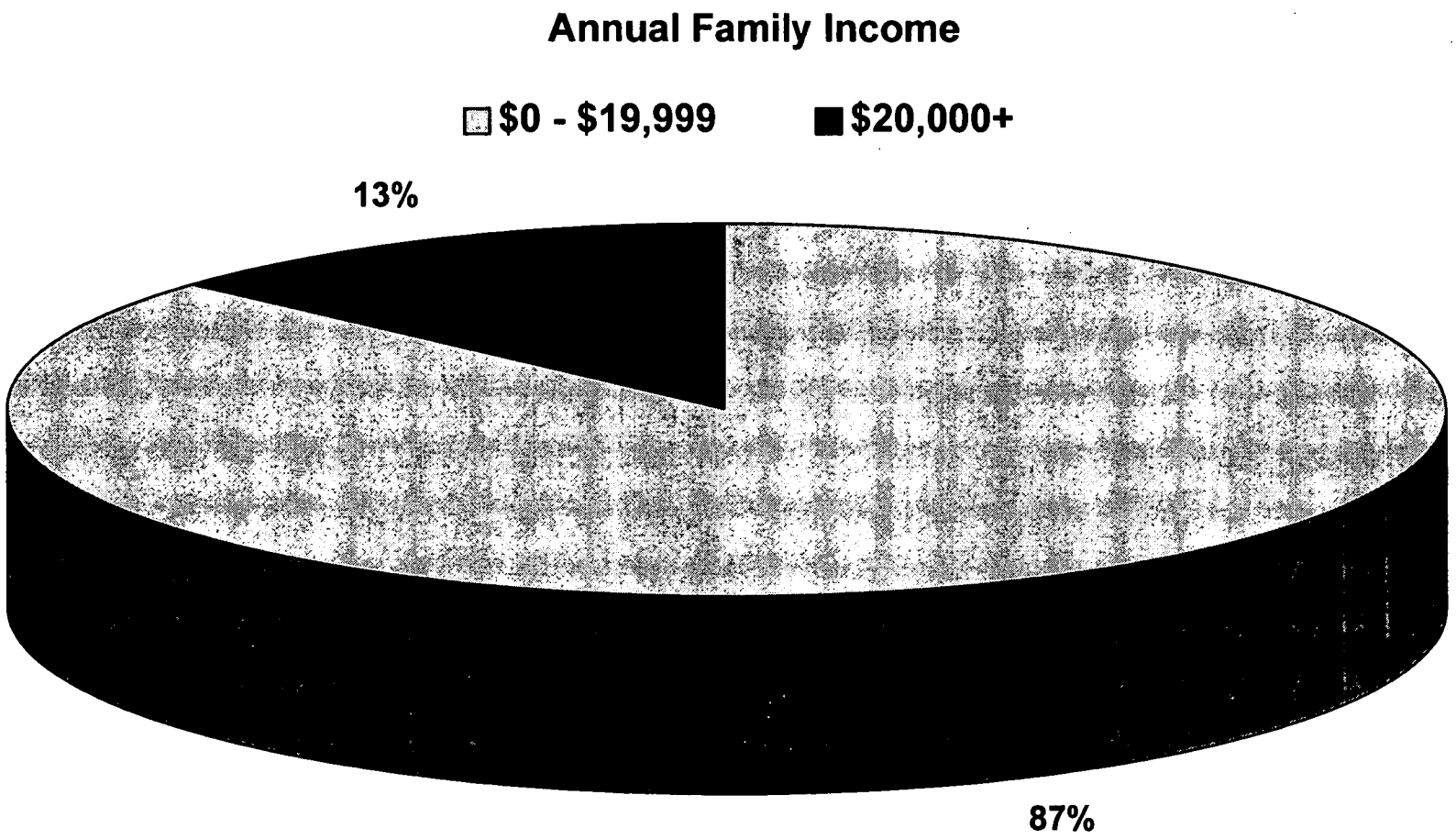
- Administered by local Departments of Social Services or, in Some Counties, by a Resource and Referral Agency

Provider Payment Rates:

- Vary By County, Age of Children, Type of Facility, Licensing Level, and Number of Children in Facility Receiving Subsidized Child Care

Average Cost to the State: $238/Month per Child (February 1999)

Number of Families Served with Subsidized Child Care by Family Income
November, 1998

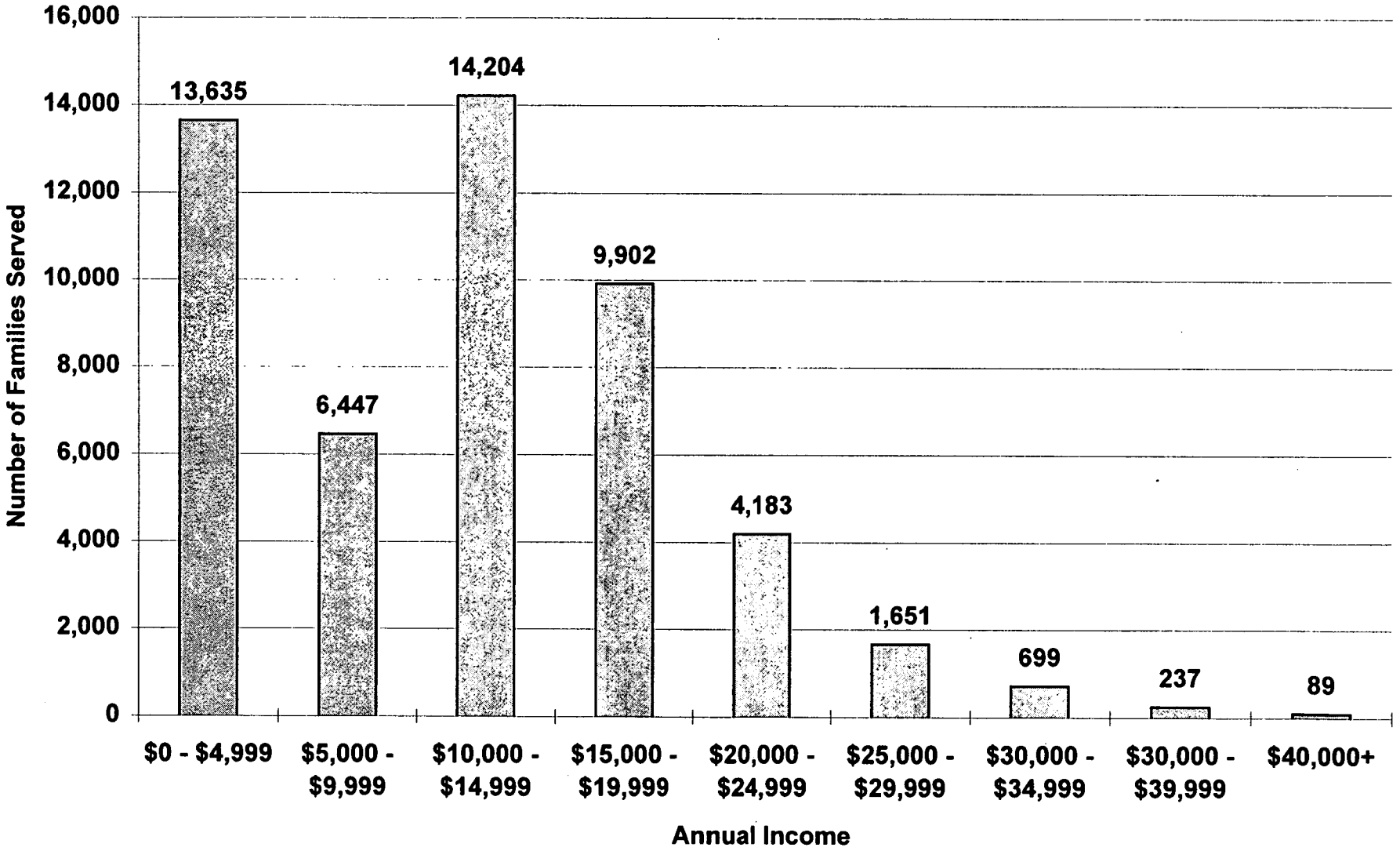


Based upon 51,047 families served. A total of 398 records did not have income data and were not included in this chart.

DCD\rk\h:Charts Chart 3

3/15/99

Number of Families Served with Subsidized Child Care by Family Income*
November, 1998



Based upon 51,047 families served. A total of 398 records did not have income data and were not included in this chart.

DCD\rk\h:Charts Chart 1

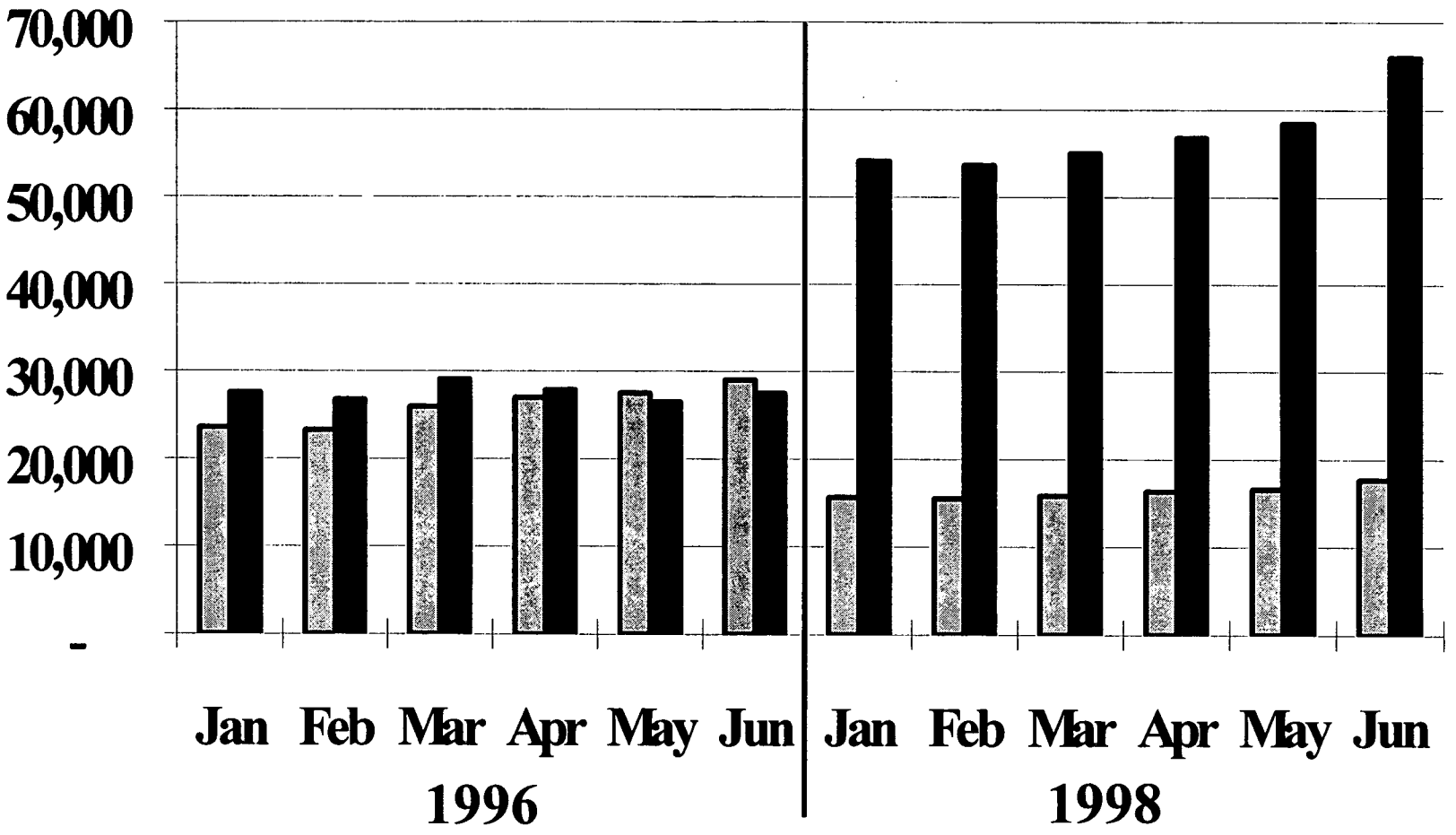
3/15/99

DIVISION OF CHILD DEVELOPMENT

SUBSIDY POLICY AND QUALITY

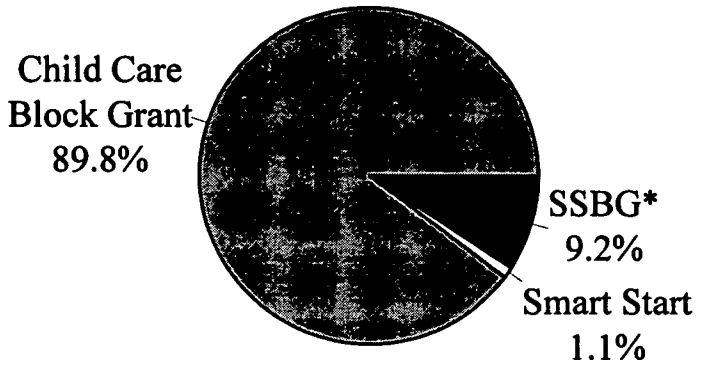
- SUPPORTS FAMILIES' TRANSITION FROM WELFARE TO WORK
- DIVERTS FAMILIES FROM ENTERING THE WORK FIRST SYSTEM
- PROVIDES FINANCIAL INCENTIVES FOR HIGHER QUALITY CARE
  - 10% Above Market Rate for AA Licensed Centers
  - 50% of Market Rate for Unregistered Providers

Shift in the Subsidized Child Care Population

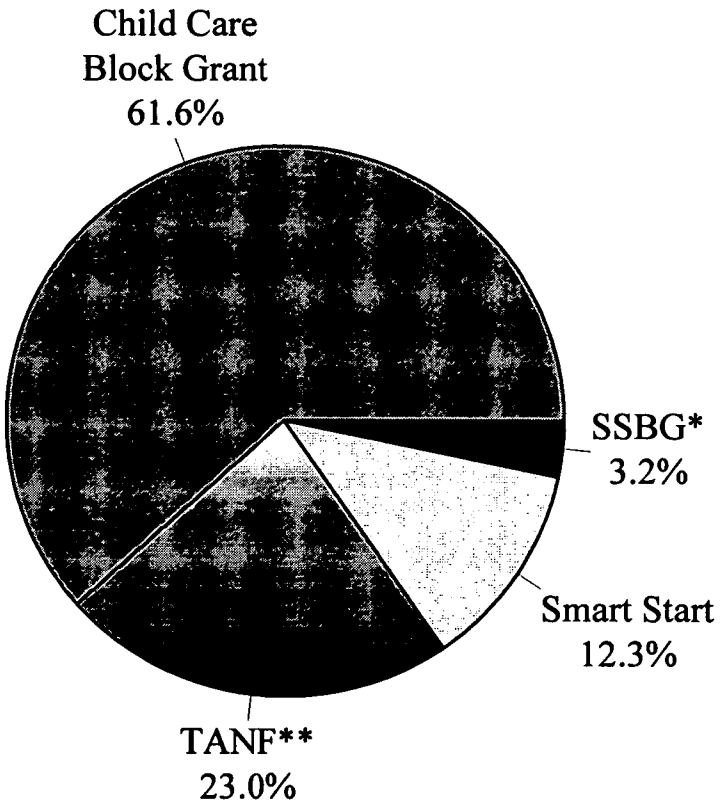


DIVISION OF CHILD DEVELOPMENT

SOURCES OF SUBSIDY FUNDING OVER TIME



1993-94
$134.5 M

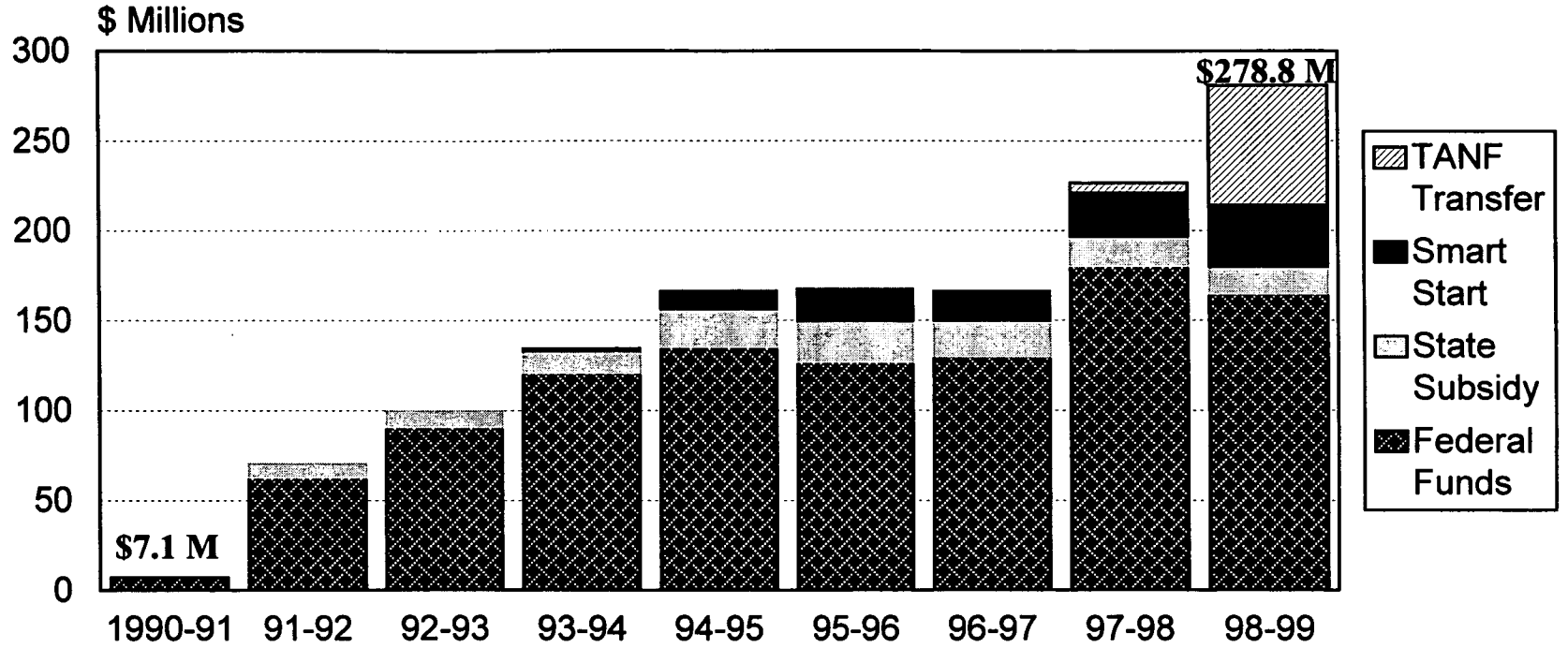


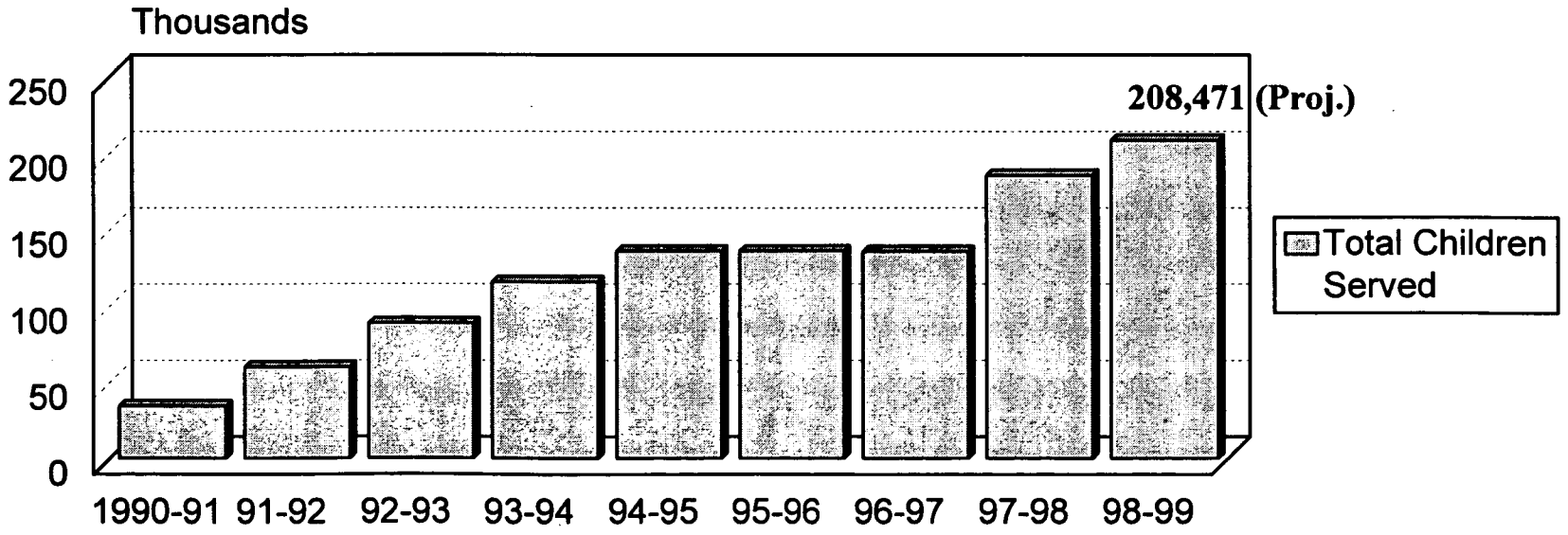
1998-99
$278.8 M (+107%)
(State Funding is 34% of Total)

*SSBG = Social Services Block Grant
**TANF = Temporary Assistance to Needy Families Block Grant

DIVISION OF CHILD DEVELOPMENT

SUBSIDIZED CHILD CARE EXPENDITURES





DIVISION OF CHILD DEVELOPMENT

CHILD CARE AND DEVELOPMENT FUND (CCDF) BLOCK GRANT

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996:

- **Eliminates Child Care as an Entitlement**

- **Consolidates All Federal Child Care Funding Into the CCDF Block Grant**

  Establishes Three Funding Categories Within CCDF:
  Mandatory (100% Federal)
  Discretionary (100% Federal), and
  Matching [Available to Match Allowable State Costs Above Maintenance of Effort Thresholds (NC's MOE Threshold is $37,927,282)]

  Mandates 4% of Total Funds be Used for Quality Initiatives

  Caps Administrative Costs at 5%

Funding Transferred From the TANF Block Grant May Be Used For Any Purpose Allowable Under CCDF (i.e., Not Just to Subsidize Work First Children)

Social Services Block Grant Funding is Still Available to Support Child Care Subsidies (Currently $8,897,137)

DIVISION OF CHILD DEVELOPMENT

IMPACT OF SMART START SUBSIDY FUNDS

Fiscal Year	Total Subsidized Child Care Expenditure	Smart Start Subsidized Child Care Expenditures	% of Subsidy Funds That Are Smart Start Funds
1993-94	$134,451,570	$1,455,336	1%
1994-95	$166,374,250	$10,217,650	6%
1995-96	$167,322,177	$17,750,798	11%
1996-97	$193,149,130	$18,806,620	10%
1997-98	$226,644,449	$24,371,872	11%
1998-99	$278,824,557	$34,237,057*	12%

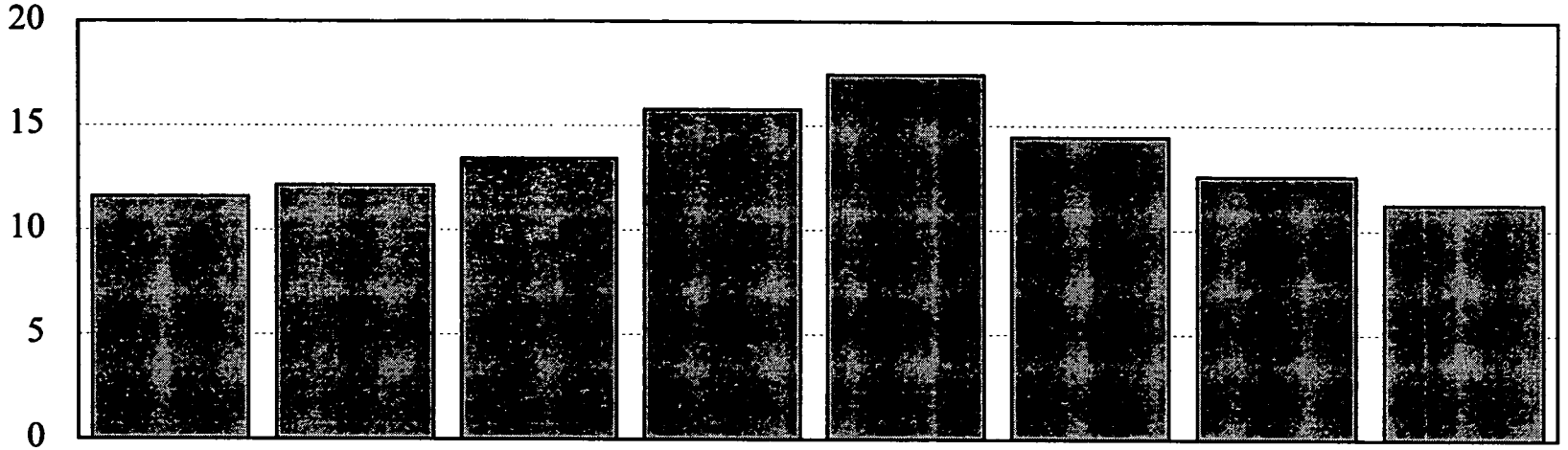
- Strain on Subsidy System -- No Additional Supporting Resources

- Years 1 - 4 Partnerships are Serving 54% of The Children Who are Eligible for Subsidized Care (Versus 36% in Other Counties)

* January 1999 Estimate - Does Not Include Total Year 5 Partnerships' Expansion Funding for Subsidies

DIVISION OF CHILD DEVELOPMENT

WAITING LIST FOR SUBSIDIES (1998-99)



	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
No. Children Waiting	11596	12142	13414	15773	17446	14450	12574	11245
% Change From Previous Month		5%	10%	18%	11%	(17%)	(13%)	(11%)

- System is Slow to Adjust to Changes in Funding Levels

- Waiting List Affected by Uncertainty Over 1998-99 Funding Level

  -- TANF Funds Required Just to Maintain 1997-98 Service Levels
  -- Couldn't Sustain 1997-98 Levels Beyond August Without Budget Approval

- Waiting List Is Improving with Availability of Additional TANF and Smart Start Funding

- 1998-99 Funding is Adequate to Serve Projected Demand -- *at Current Market Rates*

DIVISION OF CHILD DEVELOPMENT

1998 MARKET RATE STUDY

First Study Conducted Since 1993 (Two Minimum Wage Increases in Interim)

Data Collected in October 1997

Local Market Rates are Established at the 75th Percentile of Fees Paid by Parents of Children Enrolled in Centers and Paying Undiscounted Rates

- Rates Vary Widely by County
- Counties with Fewer Than 75 Children in an Age Group May Reimburse Providers at the Statewide Market Rate

Child Care Centers	Current Statewide Rate*	Rate Resulting From 1998 Market Study*	Difference
Infants/1 Year Olds	$368	$459	$91
2 Year Olds	$329	$424	$95
3 - 5 Year Olds	$303	$390	$87

*Includes both A and AA Licensed Centers

- Study Highlights Differences in Resources Available to Providers Operating Rural and Urban Child Care Centers

Rural	1998 Study Results	Urban
$368	$459	$533
$342	$424	$480
$325	$390	$450

75th Percentile Fees are between 28% and 31% lower in Rural Counties -- Explained by Fewer AA Centers and Lower Operating Costs -- However, May Need Access to Extra Resources to Afford to Provide Higher Quality Care

DIVISION OF CHILD DEVELOPMENT

MARKET RATE STUDY -- IMPLICATIONS FOR CARE

- **Center Reimbursement Rates Vary by Population Served:**
  - Category A Centers --
    - Serve Fewer than 50% Subsidized Children
    - Providers Reimbursed for Subsidized Care at Same Rate as Private Paying Parents
  - Category B Centers --
    - Serve More Than 50% Subsidized Children
    - Providers Reimbursed at County Market Rate (Statewide Market Rate if Fewer Than 75 Children/Age Group)
- **Current Market Rates Penalize Category B Centers**
  - In Long Term, Could Affect Availability and Quality of Care for Subsidized Children
- **Legislative Approval is Not Required to Implement Higher Market Rates**
  - DCD Estimates a 7% Increase in the State's Average Payment for Child Care
  - Cost Impact - 1998-99: $1.7M (Effective May 1, 1999); 1999-2000: $22.3 M
  - Without Additional Funding, Higher Rates Could Reduce Total Number of Children Served
- **Current Situation Jeopardizes Compliance with CCDF Rules,** Which Require
  - Market Rate Study Every Two Years
  - Subsidy Reimbursement Rates to be Set at Levels Which Provide Subsidized Children Equal Access to Quality Care -- Common Standard for Compliance: 75th Percentile of Fees Paid by Private Paying Parents

DIVISION OF CHILD DEVELOPMENT

RESULTS OF NC's INVESTMENT IN CHILD CARE

Healthy System Response

1) *Capacity Continues to Grow -- System is not Saturated*

Total Number of Regulated Facilities:

1990	1999	
6,170	9,058	**+47%**

	Child Care Homes			***Child Care Centers***		
	1996	1999		1996	1999	
Enrollment	19,351	22,546	**+17%**	178,868	188,761	**+6%**
# Facilities	4,432	5,282	**+19%**	3,536	3,822	**+8%**
# Slots	32,508	38,037	**+17%**	231,143	259,183	**+12%**

2) *Center Quality Continues to Improve With Growth in Capacity*

- 26% Increase in Number of AA-Licensed Centers Since 1996 (+220 Centers)

- Growth in AA-Licensed Centers Equals 77% of the Total Increase in New Center Capacity

- Since 1996,
  - -- Increased % of Centers With AA Licenses From 26% to 30%
  - -- Increased % of Children Enrolled in AA Centers From 27% to 33%

- Smart Start Counties Have a Higher Percentage of AA-Licensed Centers:

Year 1	**Year 2**	**Year 3**	**Year 4**	**Year 5**
44%	32%	27%	22%	20%

DIVISION OF CHILD DEVELOPMENT

RESULTS OF INVESTMENT (CONT'D)

3) *Subsidy System is Supporting Families' Transitions From Welfare to Work*

- Work First Clients Continue to Decline as a Percentage of the Subsidized Child Care Population

- Waiting Lists are Declining as a Result of Increased Funding

4) *Workforce is Taking Advantage of Professional Development Opportunities,* Which are Succeeding in Reducing Staff Turnover Rates

- 42% to 32% Statewide Since 1993

- 10% for TEACH Participants

5) *System Can Improve Through Voluntary Efforts* (With Financial Incentives)

DIVISION OF CHILD DEVELOPMENT

Child Care Subsidy

Stephanie D. Fanjul

March 18, 1999

Division of Child Development Monthly Statistical Summary
February 1999*
Information About the Subsidized Child Care (SCC) Program

Children Served/Expenditures/Average Costs by Type of Arrangement

	SCC Children			SCC-Work First Children			Total Children				
	Children Served	Expenditures	Avg. Cost **	Children Served	Expenditures	Avg. Cost **	Children Served	% of Total Children	Expenditures	% of Total Expend.	Avg. Cost **
Child Care Facilities	51,306	$12,003,056	$234	11,688	$3,026,804	$259	62,994	83.1%	$15,029,859	85.4%	$239
Family Child Care Homes	7,155	$1,710,643	$239	1,563	$367,249	$235	8,718	11.5%	$2,077,893	11.8%	$238
Non Licensed Homes	3,244	$390,055	$120	834	$107,855	$129	4,078	5.4%	$497,911	2.8%	$122
Total	**61,705**	**$14,103,754**	**$229**	**14,085**	**$3,501,908**	**$249**	**75,790**	**100.0%**	**$17,605,662**	**100.0%**	**$232**

Children Served/Expenditures/Average Costs by Client Need Category

	SCC Children			SCC-Work First Children			Total Children				
	Children Served	Expenditures	Avg. Cost **	Children Served	Expenditures	Avg. Cost **	Children Served	% of Total Children	Expenditures	% of Total Expend.	Avg. Cost **
Seeking Employment	155	$36,353	$235	582	$141,076	$242	737	1.0%	$177,429	1.0%	$241
Support Employment	54,293	$12,056,999	$222	9,828	$2,424,240	$247	64,121	84.6%	$14,481,239	82.3%	$226
Child Protective Services	1,866	$533,779	$286	0	$0	-	1,866	2.5%	$533,779	3.0%	$286
Post Secondary Education	2,892	$666,556	$230	3,130	$757,861	$242	6,022	7.9%	$1,424,417	8.1%	$237
Developmental Needs	599	$276,849	$462	201	$84,914	$422	800	1.1%	$361,764	2.1%	$452
Child Welfare Services	1,024	$284,456	$278	0	$0	-	1,024	1.4%	$284,456	1.6%	$278
High School Education	876	$248,763	$284	344	$93,816	$273	1,220	1.6%	$342,579	1.9%	$281
Total	**61,705**	**$14,103,754**	**$229**	**14,085**	**$3,501,908**	**$249**	**75,790**	**100.0%**	**$17,605,662**	**100.0%**	**$232**

Children Served/Expenditures/Average Costs by Income Eligibility Category

	SCC Children			SCC-Work First Children			Total Children				
	Children Served	Expenditures	Avg. Cost **	Children Served	Expenditures	Avg. Cost **	Children Served	% of Total Children	Expenditures	% of Total Expend.	Avg. Cost **
Family Assistance				13,969	$3,460,137	$248	13,969	18.4%	$3,460,137	19.7%	$248
Employment Services				0	$0	$0	0	0.0%	$0	0.0%	$0
Teen Parent	561	$166,415	$297	116	$41,771	$360	677	0.9%	$208,186	1.2%	$308
With Regard to Income	56,102	$12,509,399	$223				56,102	74.0%	$12,509,399	71.1%	$223
Without Regard to Income	2,761	$783,370	$284				2,761	3.6%	$783,370	4.4%	$284
Foster Care	2,281	$644,570	$283				2,281	3.0%	$644,570	3.7%	$283
Total	**61,705**	**$14,103,754**	**$229**	**14,085**	**$3,501,908**	**$249**	**75,790**	**100.0%**	**$17,605,662**	**100.0%**	**$232**

* Represents payments made in February, 1999 for children served in January.

** Includes part time and part month care.

Total number of children statewide on subsidized child care waiting lists.

SCC Children	SCC-Work First Children	Total Children
11,074	171	11,245

Children served with Smart Start funding through the DCD Reimbursement System.

Children Served	Expenditures
10,336	$2,653,284

Division of Child Development Monthly Statistical Summary
Februa 1999

Information About Child Care Arrangements Regulated by the Division

Regulated Child Care Arrangements by License Type

	Child Care Centers		Family Child Care Homes	
	Number	Enrollment	Number	Enrollment
A License	1,963	100,827		
AA License	1,162	62,148		
Special Provisional License	8	472	3	17
Religious Sponsored Notice of Compliance	393	18,178	1	7
Provisional License	11	552		
Temporary License	292	6,802		
Family Child Care Homes			5,191	22,389
Temporary License			39	83
Probationary License	3	263	2	7
Other	1	4	2	10
Total	**3,833**	**189,246**	**5,238**	**22,513**

Combined Facility/Family Child Care Home Totals	Child Care Centers	Family Child Care Homes	All Regulated Arrangements	Increase/ Decrease Since Previous Month
Number of Regulated Arrangements	3,833	5,238	**9,071**	**+13**
Total Enrollment	189,246	22,513	**211,759**	**+789**
Number of First Shift Slots Available	261,151	38,012	**299,163**	**+1,119**

Information About Abuse and Neglect Investigations by the Division

	Centers	Family Child Care Homes	Total	Increase/ Decrease Since Previous Month
Abuse/Neglect Reports Investigated in February, 1999	55	15	70	-17

Children on the Su[redacted]ed Child Care Waiting List

County	July-98			August-98			September-98			October-98			November-98			December-98			January-99		
	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total
Alamance	276		276				73		73	175		175	240		240	224		224	271		271
Alexander	89	2	91	89	2	91	89	2	91	123	2	125	128	2	130	128	2	130	27	2	29
Alleghany	27		27	27		27	14		14	4		4									
Anson							28		28	28		28	80		80	93		93	118		118
Ashe							25		25	36		36	35		35	19		19			
Avery*										20	2	22	24	2	26	25	2	27	31	2	33
Beaufort																			1		1
Bertie				75		75	110		110	135		135	137		137	136		136	107		107
Bladen	338	61	399	376	68	444	403	68	471	435	64	499	449	59	508	470	53	523	494	64	558
Brunswick																					
Buncombe*																					
Burke*							122	10	132	194	10	204	265	10	275	224	10	234			
Cabarrus													1		1	1		1	1		1
Caldwell*													1		1						
Camden																					
Carteret										22		22	22		22	22		22	22		22
Caswell							11		11	32	11	43	48	11	59	18	1	19			
Catawba																					
Chatham	143		143	152		152	70		70	92		92	113		113	72		72	79		79
Cherokee*																					
Chowan	12	5	17	38	20	58	49	37	86	59	39	98	70	47	117	78	49	127	67	45	112
Clay*																					
Cleveland													1		1	1		1	1		1
Columbus	128		128	128		128	128		128	128		128	128		128	128		128	128		128
Craven																					
Cumberland*																					
Currituck	20		20	30		30	34		34	37		37	51		51	22		22			
Dare							15		15	43		43	66		66	22		22	10		10
Davidson																					
Davie*										45	10	55	30		30	30	6	36	30	3	33
Duplin				45		45	116		116	130		130	137		137	159		159	174		174
Durham																					
Edgecombe	292		292	222		222	260		260	166		166	174		174	161		161	197		197
Forsyth*																					
Franklin							45	7	52	75	1	76	24		24	25		25			
Gaston																					
Gates													4	2	6	7	4	11			
Graham*																					
Granville																					

* Subsidized child care program is fully or partially administered through a state-level contractor.

Children on the Subsidized Child Care Waiting List

County	July-98			August-98			September-98			October-98			November-98			December-98			January-99		
	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total
Greene																					
Guilford				59		59	345		345	849		849	1,044		1,044	1,167		1,167	883		883
Halifax										105		105	93	1	94	82		82	72	1	73
Harnett	794		794	883		883	926		926	903		903	928		928	560		560	553	1	554
Haywood*																					
Henderson							32		32	45		45									
Hertford	152		152	181		181	201		201	216		216	221		221	231		231	231		231
Hoke							165		165	218	25	243									
Hyde													2		2						
Iredell																					
Jackson*																					
Johnston																					
Jones	58	6	64	68	8	76	114	7	121	113	7	120	113	7	120	113	7	120	113	7	120
Lee	125		125	209		209	239		239	271	1	272	298		298	326		326	275		275
Lenoir																					
Lincoln																					
Macon*																					
Madison																					
Martin	243	2	245	271	2	273	298	3	301	304	3	307	317	3	320	309	5	314	318	2	320
McDowell																					
Mecklenburg*	4,021		4,021	4,498		4,498	4,957		4,957	5,145		5,145	2,665		2,665	1,979		1,979	2,216		2,216
Mitchell*																					
Montgomery																					
Moore	201		201	250		250	244		244	253		253	208		208	116		116	87		87
Nash	368		368	434		434	472		472	497	1	498	527	1	528	545		545	417		417
New Hanover*																					
Northampton																1		1	2		2
Onslow	726		726	781		781	891		891	823		823	865		865	852		852	698		698
Orange	226		226	267		267	302		302	319		319	334		334	162		162	154		154
Pamlico																					
Pasquotank	24		24	75		75	131		131	174		174	76		76	64		64	64		64
Pender	39		39																		
Perquimans	37	4	41	38	4	42	38	4	42	38	4	42	38	8	46	29		29	8		8
Person	232		232	255		255	255		255	253		253	144		144	119		119			
Pitt*	346		346	390		390	409		409	417		417	445		445	446		446	443		443
Polk							17	3	20	34	13	47	30	3	33	41		41	38	12	50
Randolph							24		24	96		96	90		90						
Richmond							39		39	84		84	112		112	129		129	98		98
Robeson																					

* Subsidized child care program is fully or partially administered through a state-level contractor.

Children on the S[illegible]zed Child Care Waiting List

County	July-98			August-98			September-98			October-98			November-98			December-98			January-99		
	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total	Subsid. Child Care	Work First Related SCC	Total
Rockingham																					
Rowan							131	16	147	131	16	147									
Rutherford	76		76	130		130	216		216	269		269	264		264	243		243	199		199
Sampson	96		96	169		169	154		154	125		125	103		103	86		86	110		110
Scotland	282		282	224		224	173		173	164		164	170		170	120		120	77		77
Stanly																					
Stokes*	100	4	104	141	13	154	57	9	66	14	5	19	23	4	27						
Surry							33		33	2		2									
Swain*																					
Transylvania										26	5	31									
Tyrrell																					
Union*				5		5	44		44	86		86	138		138	171		171	244		244
Vance	32		32	76		76	258		258	311		311	350		350	298		298	257		257
Wake*	949		949	1,177		1,177	1,177		1,177	1,064		1,064	728		728	434		434			
Warren																10	5	15			
Washington																					
Watauga	95		95	123		123	137		137	159		159	169		169	152		152	151		151
Wayne	130	92	222	20	96	116	17	92	109	305	36	341	372	36	408	435	33	468	398	19	417
Wilkes	56		56	105	5	110	103	2	105	97		97	66	2	68	24		24	16	1	17
Wilson	525	18	543	629	17	646	655	17	672	381	15	396	421	12	433	486	12	498	571	12	583
Yadkin*																1		1	1		1
Yancey*							6		6	6		6	6		6						
State Contracts																					
Southwestern	184		184	168	5	173	263		263	350	3	353	255	3	258	192		192	201		201
Region D													1		1	1		1	1		1
Northwest													1		1						
Buncombe CDC	506		506	366		366	381		381	547		547	392		392	396		396	419		419
Blue Ridge																			1		1
Florence C																					
UCP																					
Totals	11,948	194	12,142	13,174	240	13,414	15,496	277	15,773	17,173	273	17,446	14,237	213	14,450	12,385	189	12,574	11,074	171	11,245
Change from Prior Month	553	(7)	546	1,226	46	1,272	2,322	37	2,359	1,677	(4)	1,673	(2,936)	(60)	(2,996)	(1,852)	(24)	(1,876)	(1,311)	(18)	(1,329)

* Subsidized child care program is fully or partially administered through a state-level contractor.

DCD\Rkindsvatter\h:WAITLIST.XLS

3/11/99

Comparison of Federal Poverty Guidelines and North Carolina State Median Income (SMI) for 1996

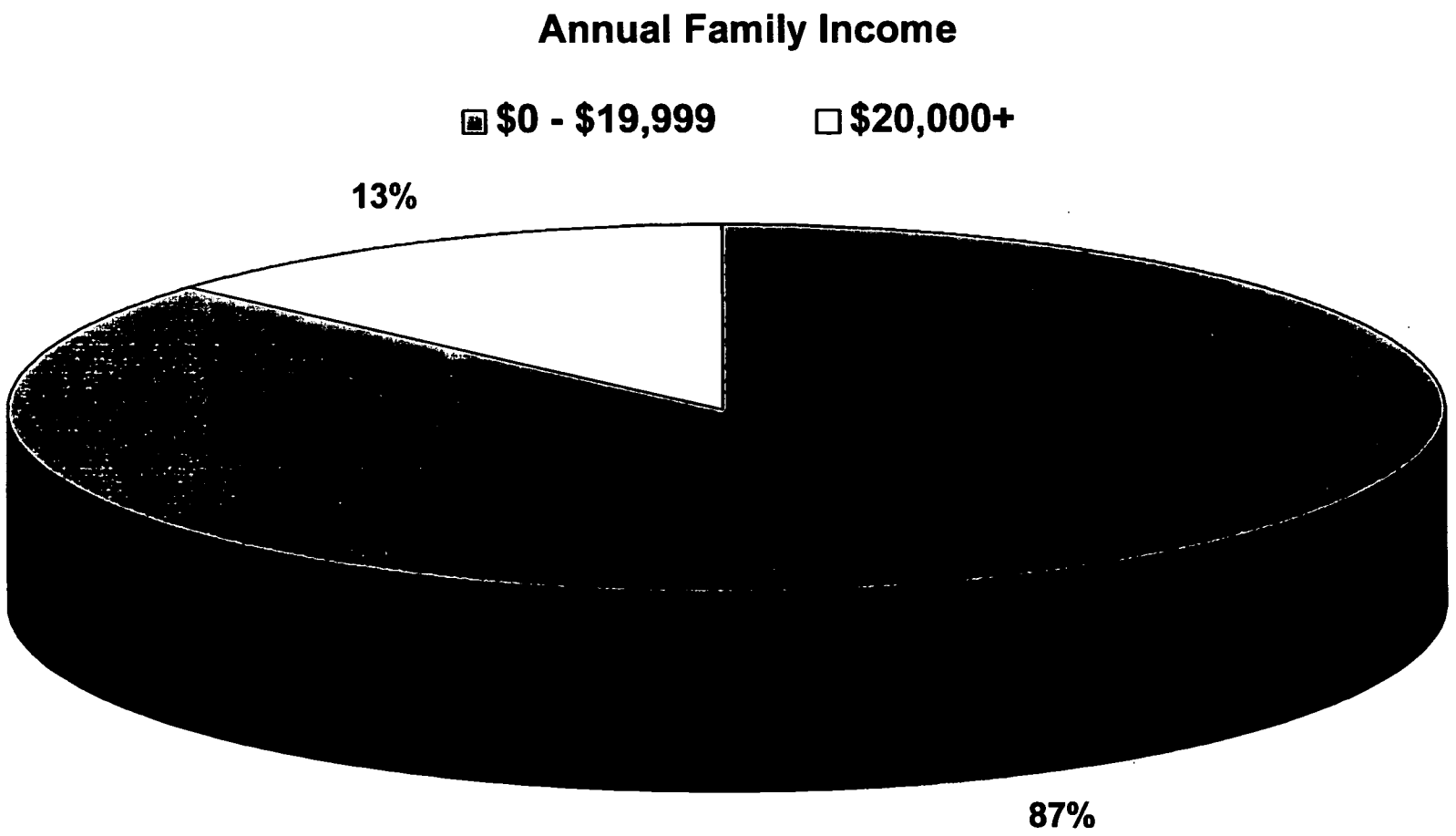
Annual

Family Size	Federal Poverty Guideline	150% of Poverty	185% of Poverty	200% of Poverty	NC State Median Income	75% SMI	% Federal Poverty
1	$7,740	$11,610	$14,319	$15,480	$23,183	$17,387	225%
2	$10,360	$15,540	$19,166	$20,720	$30,316	$22,737	219%
3	$12,980	$19,470	$24,013	$25,960	$37,449	$28,087	216%
4	**$15,600**	**$23,400**	**$28,860**	**$31,200**	**$44,582**	**$33,437**	**214%**
5	$18,220	$27,330	$33,707	$36,440	$51,715	$38,786	213%
6	$20,840	$31,260	$38,554	$41,680	$58,848	$44,136	212%
7	$23,460	$35,190	$43,401	$46,920	$60,186	$45,139	192%
8	$26,080	$39,120	$48,248	$52,160	$61,523	$46,142	177%

Monthly

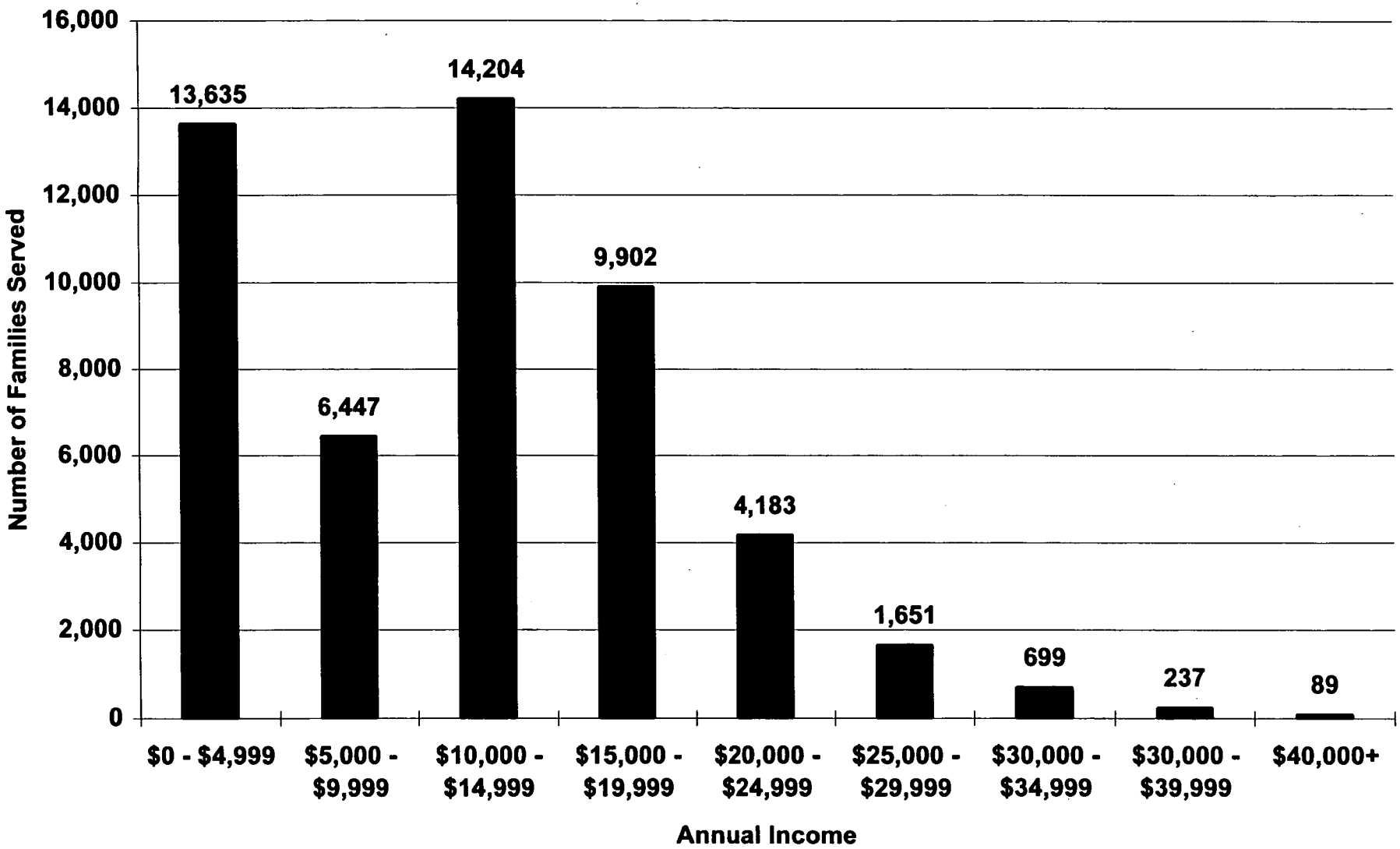
Family Size	Federal Poverty	150%	185%	200%	NC SMI	75%	% Federal Poverty
1	$645	$968	$1,193	$1,290	$1,932	$1,449	225%
2	$863	$1,295	$1,597	$1,727	$2,526	$1,895	219%
3	$1,082	$1,623	$2,001	$2,163	$3,121	$2,341	216%
4	**$1,300**	**$1,950**	**$2,405**	**$2,600**	**$3,715**	**$2,786**	**214%**
5	$1,518	$2,278	$2,809	$3,037	$4,310	$3,232	213%
6	$1,737	$2,605	$3,213	$3,473	$4,904	$3,678	212%
7	$1,955	$2,933	$3,617	$3,910	$5,015	$3,762	192%
8	$2,173	$3,260	$4,021	$4,347	$5,127	$3,845	177%

Number of Families Served with Subsidized Child Care by Family Income
November, 1998



Based upon 51,047 families served. A total of 398 records did not have income data and were not included in this chart.

Number of Families Served with Subsidized Child Care by Family Income
November, 1998



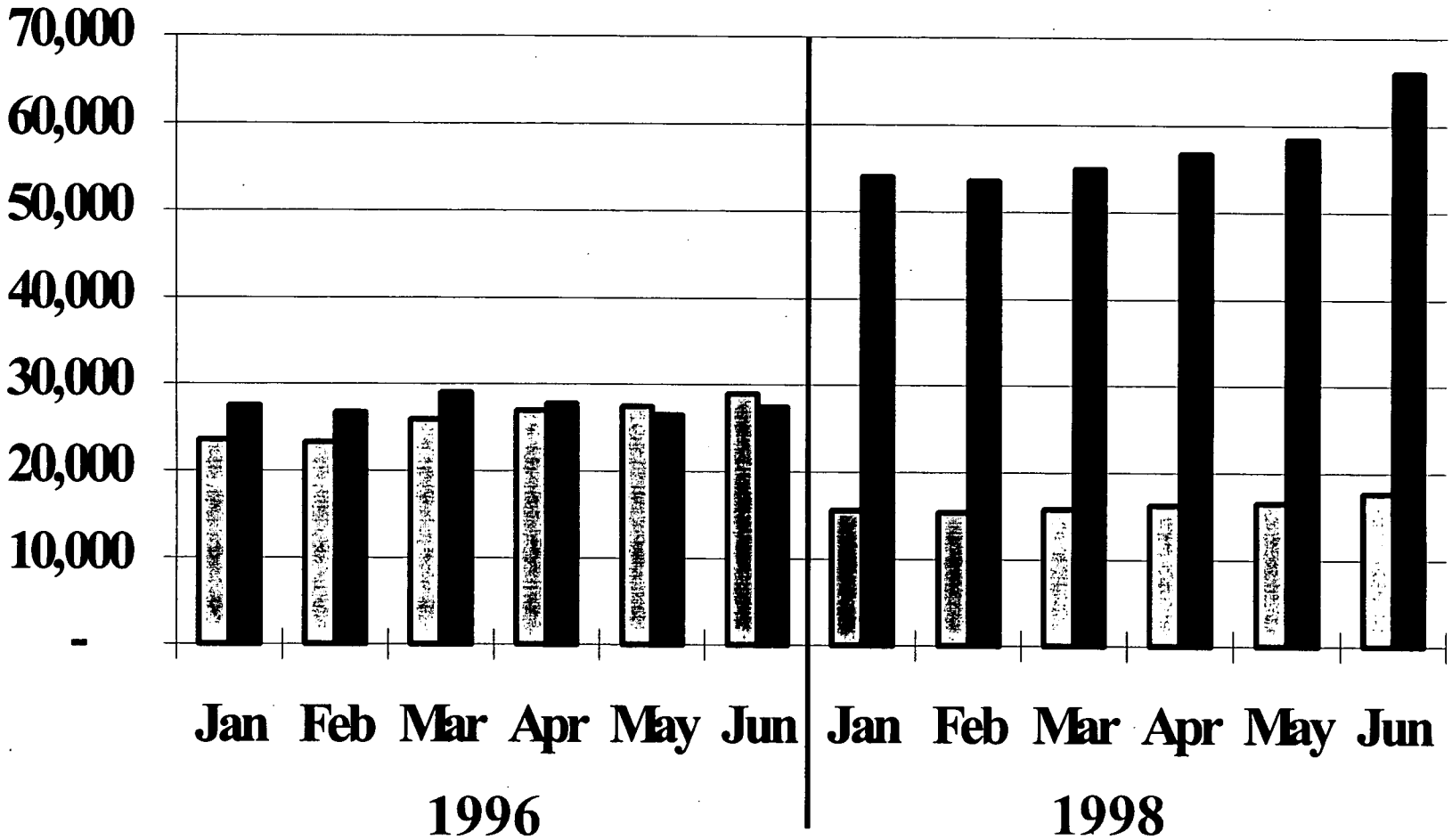
Based upon 51,047 families served. A total of 398 records did not have income data and were not included in this chart.

MAXIMUM INCOME ELIGIBILITY LIMITS AND FEE PERCENTAGES FOR SUBSIDIZED CHILD CARE SERVICES
(Effective 9/1/96)

Fee Percentage	9%			8%	
Family Size	1	2	3	4	5
Maximum Gross Monthly Income	$1,449	$1,895	$2,341	$2,786	$3,232

Fee Percentage	7%						
Family Size	6	7	8	9	10	11	12
Maximum Gross Monthly Income	$3,678	$3,762	$3,845	$3,929	$4,012	$4,096	$4,180

Shift in the Subsidized Child Care Population



IV

SFY 98 County General - Budgeted				
(1)	(2)	(3)	(4)	(5)
		SFY 98	SFY 98	SFY 98
		Budgeted	Co. Gen.	Budgeted
Area and	7/1/98	County	Budgeted	Per Capita
County	Population	General	Per Capita	Rank
Alamance-Caswell	**144,333**	**1,798,717**	**12.46**	**8**
Alamance	121,937	1,711,130	14.03	
Caswell	22,396	87,587	3.91	
Albemarle	**111,996**	**150,895**	**1.35**	**40**
Camden	6,320	9,095	1.44	
Chowan	14,325	17,364	1.21	
Currituck	16,947	19,765	1.17	
Dare	28,218	52,104	1.85	
Pasquotank	35,146	39,099	1.11	
Perquimans	11,040	13,468	1.22	
Blue Ridge	**242,241**	**662,000**	**2.73**	**30**
Buncombe	192,459	600,000	3.12	
Madison	18,592	20,000	1.08	
Mitchell	14,716	18,000	1.22	
Yancey	16,474	24,000	1.46	
Catawba	**131,256**	**1,148,436**	**8.75**	**14**
Cleveland	**91,410**	**935,000**	**10.23**	**11**
Cumberland	**295,053**	**5,303,891**	**17.98**	**4**
Davidson	**142,512**	**355,000**	**2.49**	**33**
Duplin-Sampson	**98,270**	**227,000**	**2.31**	**37**
Duplin	44,639	114,000	2.55	
Sampson	53,631	113,000	2.11	
Durham	**200,219**	**6,557,049**	**32.75**	**2**
Edgecombe-Nash	**143,341**	**1,084,661**	**7.57**	**15**
Edgecombe	54,872	502,111	9.15	
Nash	88,469	582,550	6.58	
Foothills	**231,271**	**317,395**	**1.37**	**39**
Alexander	31,540	37,825	1.20	
Burke	83,996	100,000	1.19	
Caldwell	75,278	100,000	1.33	
McDowell	40,457	79,570	1.97	

(1)	(2)	(3)	(4)	(5)
		SFY 98	SFY 98	SFY 98
		Budgeted	Co. Gen.	Budgeted
Area and	7/1/98	County	Budgeted	Per Capita
County	Population	General	Per Capita	Rank
CenterPoint	**366,318**	**5,858,973**	**15.99**	**5**
Forsyth	290,790	5,246,610	18.04	
Stokes	43,647	523,439	11.99	
Davie	31,881	88,924	2.79	
Gaston-Lincoln	**240,149**	**1,247,011**	**5.19**	**21**
Gaston	181,028	940,000	5.19	
Lincoln	59,121	307,011	5.19	
Guilford	**388,519**	**8,593,837**	**22.12**	**3**
Halifax/Riverstone	**55,182**	**349,473**	**6.33**	**17**
Johnston	**106,918**	**1,191,525**	**11.14**	**10**
Lee-Harnett	**132,867**	**332,373**	**2.50**	**32**
Harnett	83,411	146,057	1.75	
Lee	49,456	186,316	3.77	
Lenoir	**59,024**	**594,995**	**10.08**	**12**
Mecklenburg	**624,464**	**26,463,045**	**42.38**	**1**
Neuse	**170,250**	**421,006**	**2.47**	**34**
Carteret	59,881	122,780	2.05	
Craven	89,546	242,550	2.71	
Jones	8,786	25,083	2.85	
Pamlico	12,037	30,593	2.54	
New River	**154,021**	**692,583**	**4.50**	**22**
Alleghany	9,733	78,074	8.02	
Ashe	23,870	130,668	5.47	
Avery	15,595	47,325	3.03	
Watauga	41,160	184,516	4.48	
Wilkes	63,663	252,000	3.96	
Onslow	**148,324**	**352,152**	**2.37**	**36**
Orange-Per-Chatham	**188,245**	**1,807,188**	**9.60**	**13**
Chatham	46,163	383,424	8.31	
Orange	108,752	950,124	8.74	
Person	33,330	473,640	14.21	

(1)	(2)	(3)	(4)	(5)
		SFY 98	SFY 98	SFY 98
		Budgeted	Co. Gen.	Budgeted
Area and	7/1/98	County	Budgeted	Per Capita
County	Population	General	Per Capita	Rank
Piedmont	**409,928**	**1,391,092**	**3.39**	**25**
Cabarrus	119,494	705,283	5.90	
Stanly	55,752	160,570	2.88	
Union	109,995	206,802	1.88	
Rowan	124,687	318,437	2.55	
Pitt	**123,155**	**1,774,851**	**14.41**	**6**
Randolph	**124,444**	**648,343**	**5.21**	**20**
Roanoke-Chowan	**72,609**	**198,617**	**2.74**	**29**
Bertie	20,102	44,590	2.22	
Gates	9,986	28,938	2.90	
Hertford	21,684	63,669	2.94	
Northampton	20,837	61,420	2.95	
Rockingham	**89,510**	**1,035,634**	**11.57**	**9**
Rutherford-Polk	**76,251**	**216,105**	**2.83**	**28**
Polk	16,683	112,905	6.77	
Rutherford	59,568	103,200	1.73	
Sandhills	**194,809**	**570,244**	**2.93**	**27**
Anson	23,894	44,933	1.88	
Hoke	29,624	25,000	0.84	
Montgomery	24,661	39,800	1.61	
Moore	70,839	346,060	4.89	
Richmond	45,791	114,451	2.50	
Smoky Mountain	**160,260**	**492,642**	**3.07**	**26**
Cherokee	22,692	30,000	1.32	
Clay	8,206	29,500	3.59	
Graham	7,536	10,000	1.33	
Haywood	51,922	215,061	4.14	
Jackson	29,354	123,081	4.19	
Macon	28,350	75,000	2.65	
Swain	12,200	10,000	0.82	

(1)	(2)	(3)	(4)	(5)
		SFY 98	SFY 98	SFY 98
		Budgeted	Co. Gen.	Budgeted
Area and	7/1/98	County	Budgeted	Per Capita
County	Population	General	Per Capita	Rank
Southeastern	**255,840**	**1,757,591**	**6.87**	**16**
Brunswick	67,441	546,869	8.11	
New Hanover	149,975	1,073,834	7.16	
Pender	38,424	136,888	3.56	
Southeastern Reg.	**231,690**	**390,834**	**1.69**	**38**
Bladen	30,551	57,232	1.87	
Columbus	52,261	153,750	2.94	
Robeson	113,682	106,935	0.94	
Scotland	35,196	72,917	2.07	
Crossroads	**215,069**	**570,620**	**2.65**	**31**
Surry	67,611	198,250	2.93	
Yadkin	35,834	105,000	2.93	
Iredell	111,624	267,370	2.40	
Tideland	**91,017**	**329,069**	**3.62**	**24**
Beaufort	43,468	120,000	2.76	
Hyde	5,301	34,972	6.60	
Martin	25,545	113,229	4.43	
Tyrrell	3,625	17,390	4.80	
Washington	13,078	43,478	3.32	
TREND	**108,767**	**574,399**	**5.28**	**19**
Henderson	80,562	483,553	6.00	
Transylvania	28,205	90,846	3.22	
V-G-F-W	**147,682**	**356,808**	**2.42**	**35**
Franklin	44,414	108,237	2.44	
Granville	43,650	94,504	2.17	
Vance	41,448	119,550	2.88	
Warren	18,170	34,517	1.90	
Wake	**575,696**	**7,443,570**	**12.93**	**7**
Wayne	**114,246**	**623,140**	**5.45**	**18**
Wilson-Greene	**87,204**	**335,190**	**3.84**	**23**
Greene	18,071	53,069	2.94	
Wilson	69,133	282,121	4.08	
GRAND TOTAL	**7,544,360**	**85,152,954**	**11.29**	

(1)	(2)	(3)	(4)	(5)
		SFY 98	**SFY 98**	**SFY 98**
		Budgeted	**Co. Gen.**	**Budgeted**
Area and	**7/1/98**	**County**	**Budgeted**	**Per Capita**
County	**Population**	**General**	**Per Capita**	**Rank**
	SFY 98	SFY 98	Division	
	Budgeted	Division	P/C	
	Co. Gen.	Per	above (below)	
Area Program	Per Capita	Capita	Co. Gen.	
Alamance-Caswell	12.46	40.12	27.66	
Albemarle	1.35	33.47	32.12	
Blue Ridge	2.73	32.79	30.06	
Catawba	8.75	26.89	18.14	
Centerpoint	15.99	27.58	11.59	
Cleveland	10.23	32.86	22.63	
Crossroads	2.65	30.56	27.91	
Cumberland	17.98	23.05	5.07	
Davidson	2.49	26.74	24.25	
Duplin-Sampson	2.31	34.17	31.86	
Durham	32.75	35.72	2.97	
Edgecombe-Nash	7.57	29.66	22.09	
Foothills	1.37	28.05	26.68	
Gaston-Lincoln	5.19	28.78	23.59	
Guilford	22.12	28.77	6.65	
Johnston	11.14	30.82	19.68	
Lee-Harnett	2.50	36.38	33.88	
Lenoir	10.08	38.21	28.13	
Mecklenburg	**42.38**	**27.52**	**(14.86)**	
Neuse	2.47	28.55	26.08	
New River	4.50	41.73	37.23	
Onslow	2.37	22.82	20.45	
OPC	9.60	36.42	26.82	
Piedmont	3.39	28.79	25.40	
Pitt	14.41	34.58	20.17	
Randolph	5.21	33.42	28.21	
Riverstone	6.33	43.45	37.12	
Roanoke-Chowan	2.74	39.61	36.87	
Rockingham	11.57	33.74	22.17	
Rutherford-Polk	2.83	44.06	41.23	
Sandhills	2.93	36.65	33.72	
Smoky Mountain	3.07	38.24	35.17	
Southeastern	6.87	23.52	16.65	
Southeastern Reg.	1.69	30.68	28.99	
Tideland	3.62	47.17	43.55	
TREND	5.28	31.78	26.50	
VGFW	2.42	34.52	32.10	
Wake	12.93	21.32	8.39	
Wayne	5.45	28.04	22.59	
Wilson-Greene	3.84	34.42	30.58	

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-18-, 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sharon Hurd	Social Services Consortium
Patrice Rowler	NCACC
Jane H Smith	NCDHHS-DSS
JoAnn Lamm	NCDHHS-DSS
Sharrise Ransome	NCDHHS-DSS
Heather Laffler	OSA
ANNA TEFFT	OSBM
Mary Greene	OSBM
John Bowdish	Zeb Alley P.A.
Lori Wilson	NCALTCF
HUGH TILSON	NCHA
Roslyn Savitt	NC Child Care Coalition
JACK McGEE	MARCH OF DIMES BIRTH DEFECTS FOUNDATION
C Medlin	Advocate w/ NCS Children
by Avent-Farmer	DHHS-DCD
Stephanie Gaugel	DCD-DHHS
Karen Ponder	NC Partnership for Children
Peter Leousis	DHHS
N Pager	OSBM
Allyn Duffey	DHHS
Jim Edgerton	DHHS
DAVE BRUTON	DHHS
[illegible]	NCMS

NORTH CAROLINA GENERAL ASSEMBLY

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

March 23, 1999
Room 424, LOB

8:30 a.m.

The Meeting was called to order by Sen. Bill Martin, Chair. He stated that the Committee would not meet this afternoon. There were six members of the Senate present and the following members of the House were present: Representative Earle, Representative Nye, Representative Alexander, Representative Adams, Representative Cansler, Representative Esposito, Representative Walend, Representative Wilson. After introduction of pages he recognized Mary Ellen Sylvester to speak on the Division of Child Development and the Child Care Issue.

Mary Ellen stated that she would be speaking from the same handout as last week, beginning on page 30. She went over the Child Care Subsidies. She reviewed the criteria for qualification of subsidized Child Care. She then went over the Smart Start policy.

The following questions directed to Mary Ellen Sylvester:

Sen. Kerr: - Do we have any statistics on pages 31 and 32 as to the make-up of the families – single parent families, etc?

Rep. Adams has there been a division of those funds just for work first and the other will go toward the other children. Do you have a specific amount that is used only for work first?
Rep. Adams further stated that she has a concern that there may be children who may not be a part of Work First that really need the services. She shared an experience of one of her constituents as an example. She said that the information she has is that there are positions reserved for some children and others are denied because they are not a part of Work First.

Stephanie Fanjul, Division of Child Development, DHHS, stated that it is all a matter of availability of funds. There is a constant challenge between making Work First the only priority and not closing the door on others who are not Work First recipients.

Sen. Martin followed up with are you saying that primarily this is because one a person becomes ineligible as a result of taking medical leave, there is a waiting list and therefore cannot be accessed until the slot is available.

Stephanie Fanjul stated that that is correct, however each county has different limits as to how long a slot will be held for an individual family.

Sen. Kerr: What is happening with the cut in TANF funds – is that a rumor?

Sen. Martin stated that it was not a rumor but the cut was not approved.

Sen. Dannelly asked when we speak of slots, are we speaking of space rather than money.

Mary Ellen continued her presentation, noting that the figure on page 39 would actually increase by June 30, 1999. She also covered the dynamics of the waiting list for this year.

Sen. Martin asked what is the rough estimate of the current period of time that a child is on the waiting list now, is there an average?

Sen. Dannelly: Looking at the reasons for the uncertainty of the funding levels, not being able to maintain the 97-98 levels, is that because the General Assembly is slow in getting a budget out. The General Assembly is responsible for not diminishing the waiting list by not getting the budget out.

Mary Ellen: The reason they needed a budget decision to maintain the prior years level was because they had $20 million additional dollars that was a one time grant from the federal government in 97-98. The Governor had proposed transferring TANF funds in that amount to replace that $20 million.

Sen. Martin had one final question - the indicator had been 75% percentile are there other indicators that the state is looking at or that the federal government would consider? How in depth is the state going in trying to determine the differentiation of the level of care and how it might be addressed and how the federal issue might be addressed?

Sen. Forrester asked for clarification of Category A and Category AA facilities.

In summarizing her presentation, Mary Ellen stated that North Carolina (the General Assembly) has made a lot of investments in terms of its time and policy making and also in terms of resources over the past five years. There has also been a very healthy system response to this issue.

The Chair adjourned the meeting at 9:50 a.m.

Sen. William N. Martin, Chair

Joyce C. Hodge, Clerk

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-23, 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Peter Leousis	DHHS
Brenda Williamson	DET/Commerce
C Medlin	Covenant w/ NCS Children
Jim Hardesty	NC. Food Banks
Jack Simmons	NC Council
Glenn Wells	DHHS/Pub. Health
Mari [illegible]	G-W
Heather Gaffler	OSA
Anna Tefft	OSBM
Pam Richardson	OSPI
Ron Penney	Div of Child Devel.
Margaret Guen	Child Development
JACK McEEE	MPEG of Times
Stephanie Jaquel	DHHS - DCD
Rob Kindsvatter	DHHS - DCD
by Avent-Farmer	DHHS - DCD
DAVE BENTON	DHHS
C. L. Cochran	UCPNC - C20001
Patrice Rowler	NLACC
[illegible]	OSBM
Jim Edgerton	DHHS
Tommy Worth	CHS
[illegible] Summers	NC Equity
[illegible]	Gov's office
Shannon Ransome	DSS
Katherine Miller	Harry Kaplan
Lou B. Wilson	

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services **, 1999**

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Pam Seamans	Consortium
Allan Zader	NC Council

AGENDA

Joint Appropriations Subcommittee on Human Resources

March 24, 1999

8:30 am

Opening Remarks	Senator Bill Martin Representative Beverly Earle Representative Edd Nye
Division of Aging Budget Overview	L. Carol Shaw Fiscal Research Division
1999-2003 State Aging Services Plan	Dennis Streets Division of Aging

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
March 24, 1999
Morning

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Wednesday, March 17, 1999, in Room 424 of the Legislative Office Building.

House Chairman, Representative Edd Nye presided. Other House members present were Representative Beverly Earle (Co-Chairman), Representative Martha Alexander (Vice-Chairman, Representative Alma Adams, Representative Lanier Cansler, Representative Theresa Esposito, Representative Trudi Walend, and Representative Gene Wilson. There were six senators present.

Chairman Nye introduced the Pages for the meeting and then asked Ms. Carol Shaw, Fiscal Research Staff, to begin presentation. Ms. Shaw presented an overview of the Division of Aging budget. (See Attachment.) Some points she discussed are:

1. The budget is prepared every four years.
2. The division has 35 positions.
3. Increase in state appropriations for home, community, and senior centers.
4. Counties must provide a ten percent match for services.

Chairman Nye asked for a list of the twenty centers that received non-recurring money for senior center capital.

Senator Phillips asked if county governments should continue to be involved if not required by federal requirement, and how much money could be spent on area programs that is currently paid to county governments. He asked that this be flagged.

Ms. Shaw continued with presentation and Representative Adams wanted to know if there is more than one center in counties. Ms. Shaw will get list of where centers are located.

Ms. Shaw then introduced Mr. Dennis Streets, Division of Aging, who presented highlights of long-term care in an aging society. Mr. Streets presentation is attached to be made part of these minutes.

Chairman Nye adjourned the meeting.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbitt
Committee Assistant

Speakers notes

LONG-TERM CARE IN AN AGING SOCIETY -- HIGHLIGHTS

PROJECTIONS FOR SERVICE DEMAND ARE SOBERING

EVEN BEFORE LARGE NUMBERS OF BABY BOOMERS REACH THE POINT OF NEEDING LONG-TERM CARE FOR THEMSELVES, WE WILL SEE A LARGE INCREASE IN THE DEMAND FOR SERVICES AMONG THEIR PARENTS AND OTHERS--NEEDING ALL TYPES OF SERVICES ON THE LONG-TERM CARE CONTINUUM. EVEN WITH GOOD NEWS ABOUT DECLINING DISABILITY RATES AMONG OLDER ADULTS, PEOPLE ARE LIVING LONGER AND WITH THEIR GROWING NUMBERS COMES GREATER HEALTH AND SOCIAL SOCIAL SERVICE NEEDS. THE NUMBER OF OLDER PERSONS WHO ARE IMPAIRED OR SEVERELY DISABLED WILL INCREASE BY ALMOST 70% BETWEEN 1998 AND 2020 (FROM ABOUT 206,000 IN 1998 TO MORE THAN 348,000 OLDER ADULTS IN 2020).

COSTS WILL INCREASE; NO EASY SOLUTIONS EXIST

COSTS WILL INCREASE -- COSTS TO FAMILIES, COMMUNITIES AND THE GOVERNMENT. BASED ON 1993 NATIONAL DATA, FAMILIES CONTRIBUTE SUBSTANTIALLY (ABOUT 42% OF THE TOTAL PAYMENTS FOR LONG TERM CARE) -- STILL GOVERNMENT (AND ULTIMATELY THE TAXPAYERS) PAY OVER HALF OF THE COST (19% THROUGH MEDICARE, 34% MEDICAID; AND ANOTHER 4% THROUGH OTHER STATE AND FEDERAL FUNDS). NORTH

CAROLINA MAKES A MAJOR FINANCIAL INVESTMENT IN LONG TERM CARE FOR OLDER AND DISABLED ADULTS. THE TOTAL LTC *PUBLIC* EXPENDITURES, NOT COUNTING MEDICARE, FOR OLDER NORTH CAROLINIANS GREW FROM $486 MILLION IN 1990 TO NEARLY $1.2 BILLION IN 1997. [DMA, AGING, DSS, DSB, PUBLIC HEALTH, VR, AND DMH)

NEED TO CONTINUE REFORM OF SERVICES DELIVERY AND ENCOURAGE PERSONAL RESPONSIBILITY FOR COSTS

ESPECIALLY BECAUSE OF THE PROJECTED SERVICE DEMAND AND ASSOCIATED COSTS, WE MUST CONTINUE TO LOOK FOR WAYS TO IMPROVE OUR SERVICES DELIVERY SYSTEM FOR LONG TERM CARE TO MAKE BEST USE OF THE PUBLIC DOLLAR AND ALSO ENCOURAGE AND REWARD THE PLANNING AND ASSUMPTION OF PERSONAL RESPONSIBILITY FOR THE COSTS OF LONG TERM CARE--AS THE GENERAL ASSEMBLY DID LAST YEAR WITH THE TAX CREDIT FOR LONG-TERM CARE INSURANCE.

MANY OF OUR EFFORTS SHOULD GO TOWARD FURTHER DEVELOPMENT OF HOME AND COMMUNITY CARE OPTIONS AND SUPPORT OF FAMILY CAREGIVING

ABOUT THREE-FOURTHS OF OLDER ADULTS WITH IMPAIRMENTS LIVE AT HOME (160,485 IN YEAR 2000). OF THE OLDER NORTH CAROLINIANS WHO ARE SEVERELY DISABLED (112,214 IN 2000), MORE THAN HALF LIVE AT

HOME. PEOPLE ARE CONSIDERED SEVERELY DISABLED PERSONS IF THEY NEED HELP WITH AT LEAST THREE BASIC PERSONAL CARE TASKS SUCH AS EATING, BATHING, DRESSING, GETTING AROUND THEIR HOUSE, AND USING THE BATHROOM. THEY ARE ABLE TO LIVE OUTSIDE OF LONG-TERM CARE FACILITIES LARGELY BECAUSE OF THE SUPPORT OF FAMILY CAREGIVERS. NATIONAL STUDIES CONTINUE TO FIND THAT FAMILY AND OTHER SO-CALLED INFORMAL CAREGIVERS PROVIDE ABOUT 80% OF ALL THE LONG-TERM CARE NEEDED BY IMPAIRED PERSONS LIVING AT HOME. ABOUT HALF OF THESE CAREGIVERS WORK, WHICH HAS IMPLICATIONS FOR EMPLOYERS IN TERMS OF ABSENTEEISM, TURNOVER AND LOST PRODUCTIVITY. ENSURING THAT FAMILY CAREGIVERS CONTINUE TO ASSUME THIS VITAL ROLE IS ESSENTIAL TO THE CAPACITY OF OUR STATE TO MEET AND AFFORD THE LONG-TERM CARE NEEDS OF AN AGING SOCIETY. EXPANDING HOME AND COMMUNITY CARE AS A RESOURCE FOR FAMILIES IS AN IMPORTANT PART OF THIS. WE SHOULD BE ENCOURAGED THAT OUR RATIO OF MEDICAID SPENDING FOR HOME AND COMMUNITY CARE COMPARED TO OUT-OF-HOME SPENDING IS HIGHER THAN THE NATIONAL AVERAGE; HOWEVER, IT IS STILL HEAVILY WEIGHTED TOWARD OUT-OF-HOME OPTIONS. WE MUST MAKE SURE THAT THERE ARE NOT DISINCENTIVES FOR HOME AND COMMUNITY-BASED CARE.

PARAPROFESSIONAL WORKFORCE IS KEY TO SERVICE QUALITY

WHILE FAMILY CAREGIVING IS CRITICAL TO THE FUTURE OF LONG TERM CARE, SO IS THE DAY-TO-DAY CAREGIVING PROVIDED BY PAID PARAPROFESSIONALS THROUGH HOME CARE, AT ADULT DAY CARE CENTERS, IN NURSING HOMES, ADULT CARE HOMES, AND IN OTHER SETTINGS. WE ARE HEARING MORE AND MORE ABOUT THE PROBLEMS SURROUNDING THE RECRUITMENT AND RETENTION OF PARAPROFESSIONAL AIDES. THERE ARE ECONOMIC AND HUMAN COSTS TO THE LACK OF A STABLE AND TRAINED LTC WORKFORCE.

OUR LONG TERM CARE CHAPTER DISCUSSES THESE AND OTHER ISSUES. WE INTEND TO CONTINUE UPDATING WHAT INFORMATION IS AVAILABLE TO YOUR ON THESE TOPICS THROUGH OUR WEB SITE. OUR ENTIRE PLAN IS ALREADY ON-LINE AND WE ARE IN THE PROCESS OF CREATING A SECOND ON-LINE VERSION THAT WE WILL USE TO POST UPDATES, TO REPORT PROGRESS, AND TO DISCUSS NEW ISSUES AS THEY ARISE.

THANK YOU FOR YOUR TIME THIS MORNING.

Gary
Byrus

Steve
Freedman
Chief of Tennis
Oper.

North Carolina:
A Leader in Aging

A report on the 1999--2003
State Aging Services Plan
NCGS 143B-181.1A

Prepared by
the Division of Aging, DHHS
for the Joint Appropriations Subcommittee
on Health and Human Services
March 1999

Theme: North Carolina A Leader in Aging

- our past and present responses
  - health insurance counseling
  - adult day care
  - adult protective services
  - tax credit for LTC insurance and related bill of rights
  - study of boomers at mid-life
  - leading web site
  - recognized education and research centers for aging
- major shift in demographics

Major Focus of Plan

A look at:

- today's older adults
- boomers at mid-life

In terms of:

- long-term caregiving
- healthy aging
- work and financial security
- implications for local aging programs

Steps & Considerations in Development

- *March 1998*--draft outline distributed widely
- *May-June 1998*--Boomer forums held (240 attend)
- *May-October 1998*--AARP/AAA Citizen Speak-outs (>900)
- *Fall 1998*--Priorities set by key aging advocates (i.e., Senior Tar Heel Legislature, Governor's Advisory Council, NC Coalition on Aging, NC Study Commission on Aging)
- *Summer-Fall 1998*--Plan developed by staff members of the Division of Aging with input from others
- *December 1998*--draft of Plan distributed widely for review and comment
- *March 1, 1999*--Plan submitted to the General Assembly

Goals for Entering the 21st Century

- **Continue developing a system for long-term care that is responsive to individual needs and choices, including the overwhelming preference for home and community-based services; that rewards acceptance of personal and family responsibility for caregiving; that assures the prudent expenditure of public funds; that values and supports the contributions of volunteers; and that guarantees quality service in all care settings.**
- **Assure timely access to information and assistance that enables people to exercise their rights, to make decisions among choices, and to protect themselves against fraudulent practices.**

Goals for Entering the 21st Century

- **Assure that older people can access quality and affordable health care, including prescription drugs, mental health services, and dental services.**
- **Encourage and reward actions that promote the economic security of persons in their later years, including lifelong learning, the provision of health and pension benefits through employment, and fair treatment of older workers.**
- **Invest in preparing for the major demographic shift that will dramatically increase the numerical and proportionate size of our older population over the next 35 years.**

Basic Outline of Plan

- Introduction
- Community Voices: Service Needs and Issues
- The Demographic Imperative
- Long-Term Care in an Aging Society
- Healthy Aging
- Work and Financial Security
- The Future of the Aging Network

Appendices

- Inventory of State Resources for Older Adults
- Views from the Community
- Growth of the Older Population by County
- Glossary
- Model Senior Centers
- Area Agencies on Aging
- Objectives for the Older Americans Act

Outline of Typical Chapter

- Highlights
- Major Actions since 1995
- Discussion of Major Issues and Trends
- Identification of Some Exemplary Efforts
- Objectives and Strategies
- Notes/References

Long-term care in an aging society--Highlights

- **Projections for service demand are sobering**
- **Costs will increase; no easy solutions exist**
- **Need to continue reform of services delivery and encourage personal responsibility for costs**
- **Need further development of home and community care options and support of family caregiving**
- **Paraprofessional workforce is key to service quality**

Division of Aging's Web Site

http://www.dhhs.state.nc.us/aging/home.htm

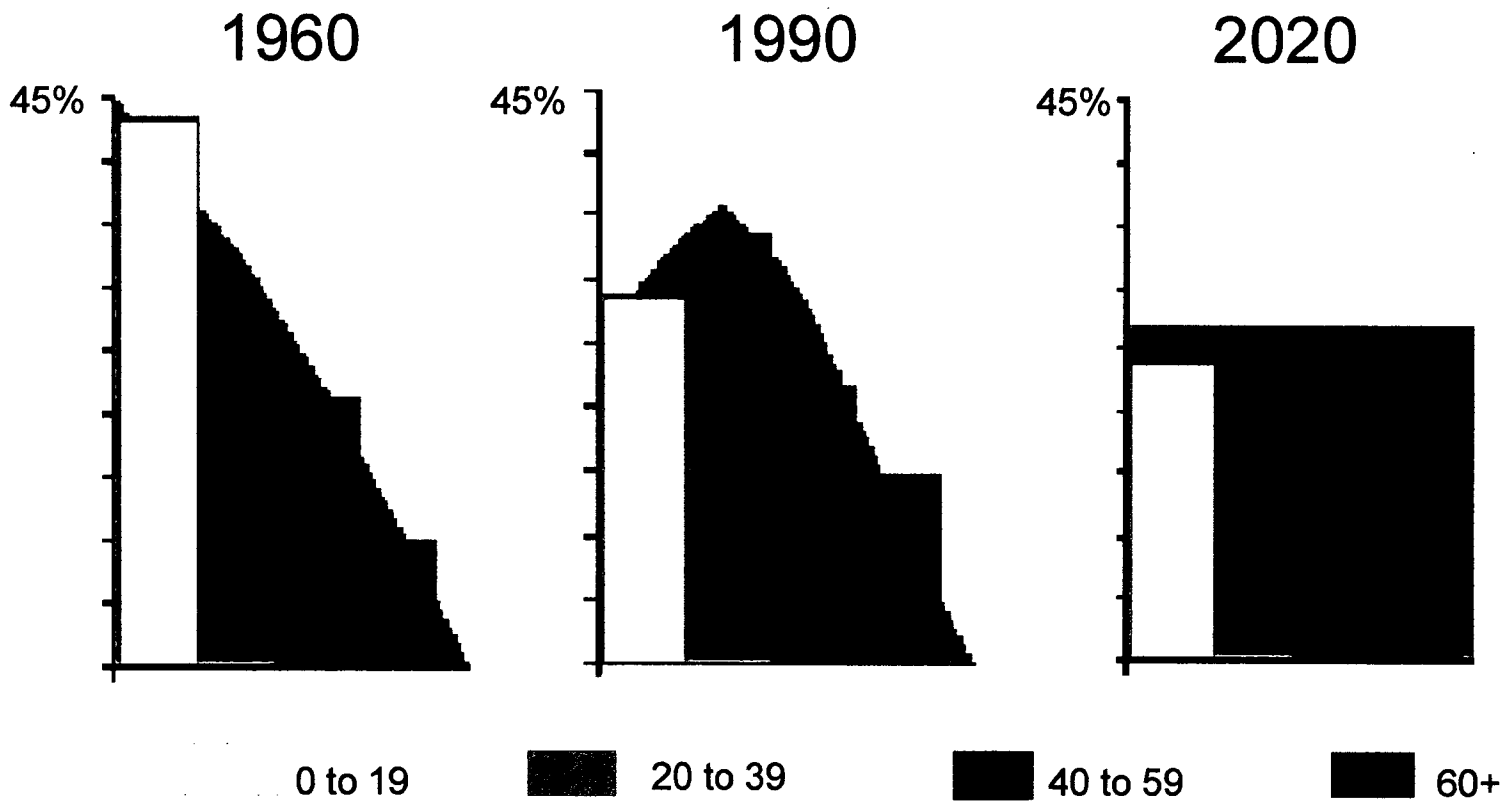
- ***Selected by AoA as "First Choice" site***
- ***Searchable databases***

✓ *elder housing locator*
✓ *demographics*
✓ *aging services directory*

- ***Information on over 120 topics (A to Z)***
- ***"Top ten" list of "hot topics"***

✓ *Aging-related legislation from the 1998 Session*
✓ *Access America for Seniors*
✓ *State Aging Services Plan*
✓ *International Year of Older Persons 1999*

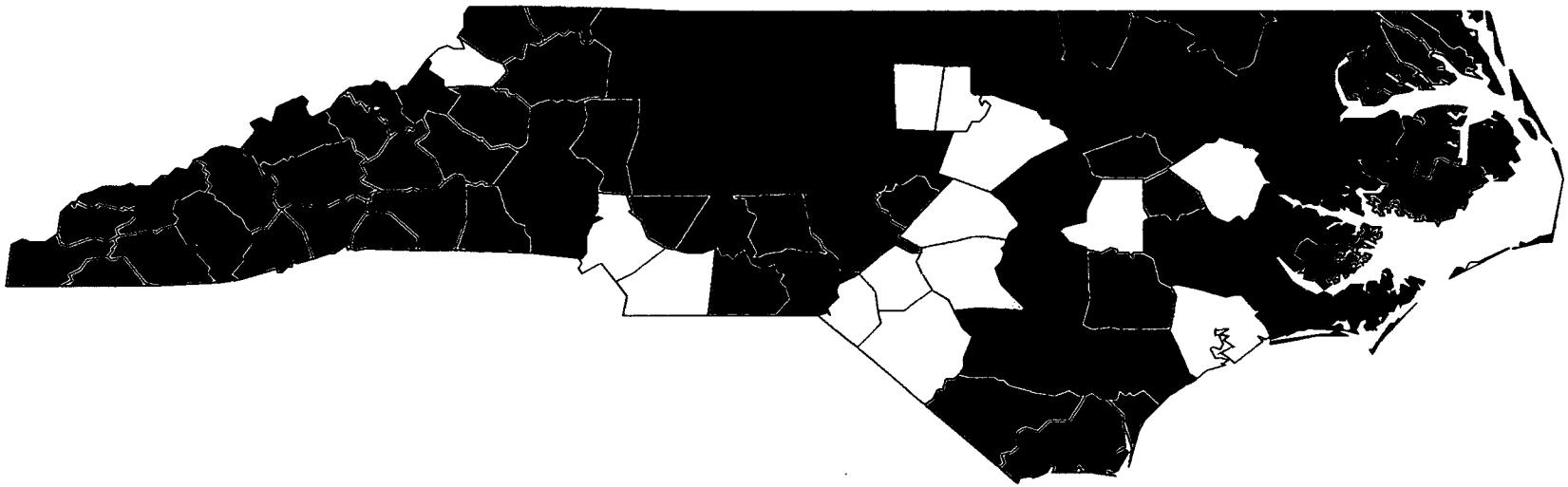
NC: In the Middle of a Major Population Shift



North Carolina's Changing Age Distribution

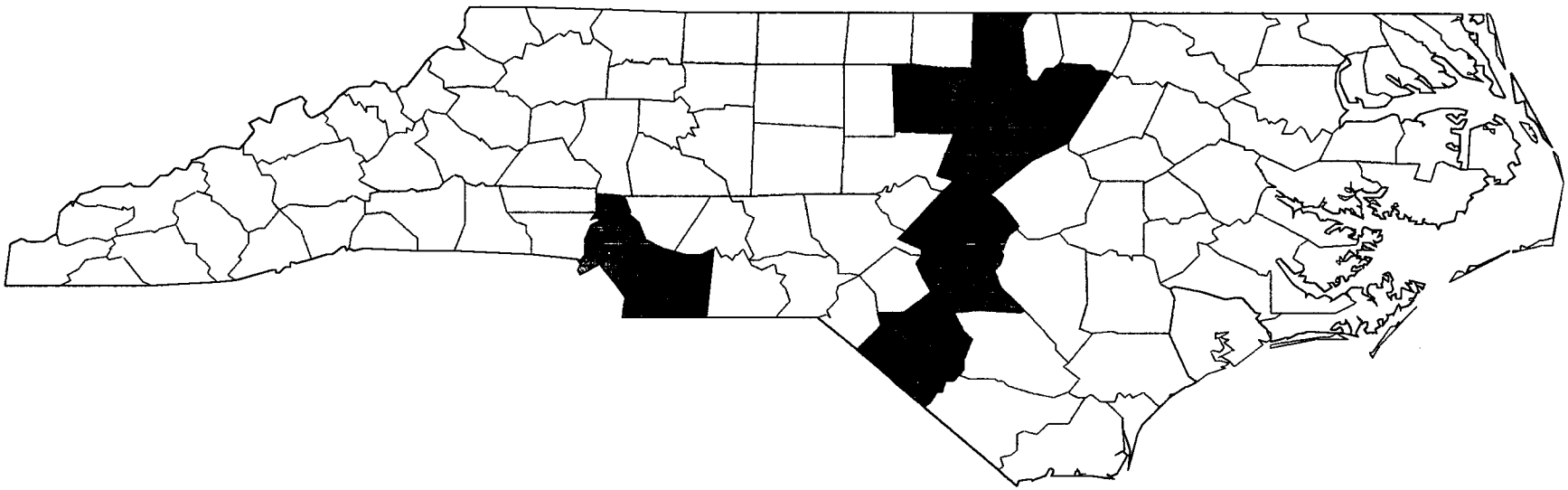
Population 65+ in 1996

12.7% in the state—county range: 5.4% to 25.2%



Population 65+ in 2020

17.5% in the state—county range: 9.2% to 31.8%



Percent of population age 65+

- 12.0% or less
- 12.1% to 13.0%
- 13.1% to 14.4%
- 14.5% to 15.9%
- 16% or more

A Synopsis of Recommendations

Tools for Today's Older Adults

- reliable transportation to remain mobile and active
- adaptable, affordable, and safe housing
- access to home and community care services appropriate for functional needs
- assurance of quality care in a nursing home or adult care home if this option is needed
- reliable and readily available information and counseling on a wide range of matters
- lifelong learning opportunities for work, enrichment, health, and civic participation
- adequate consumer protections
- opportunities to be involved in personally meaningful activities
- affordable and reliable health care, including prescription drugs
- ability to afford the costs of independent living such as utility bills, property taxes, rent, and repairs

Tools for Baby Boomers at Mid-Life

- employment that offers health and pension benefits as well as a living wage
- motivation and opportunities for practicing good health habits
- motivation and opportunities for financial planning, including preparing for the cost of long-term care
- motivation and opportunities for continuing education and training
- information, respite, and support to assist and reward family caregiving
- participation in shaping the future of Social Security, Medicare, managed care, and other policies and programs that may have a bearing on their well-being in later life

Tools for an Aging Society

- organizational support for family caregiving
- senior centers as community focal points for information and access to other resources
- use of technologies to promote lifelong learning, functional literacy, easy access to information, and independent living
- a stable, well-trained, and adequately paid workforce of paraprofessionals to provide services
- effective use of volunteers
- awareness, interest, and commitment on the part of public and private leaders to address aging issues
- coordination and commitment on the part of service providers to manage resources wisely
- recognition of the diversity in the population and sensitivity to cultural differences
- recognition that families and communities experience aging differently and have varying capacities to respond as needs arise
- a promise to assure fairness in striving to leave no one behind
- education and discussion about aging among the generations

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF AGING
BUDGET OVERVIEW

FISCAL RESEARCH DIVISION
MARCH 1999

DIVISION OF AGING

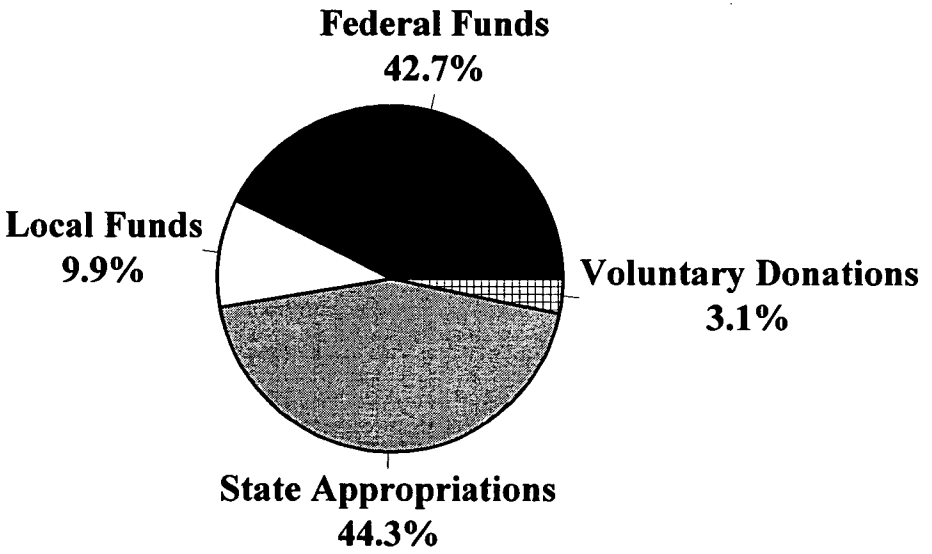
MISSION

- The Division of Aging is the State Agency responsible for planning, administering, coordinating, and evaluating the activities, programs, and services developed under the Older Americans Act and related programs for older state populations. Activities include:
    - Developing, administering and monitoring the activities of the State Plan on Aging required by state and federal law
    - Coordinating statewide activities related to the purposes of the Older Americans Act
    - Reviewing, approving, and monitoring the plans developed by Area Agencies on Aging
    - Providing technical assistance and training for the 18 Area Agencies on Aging and over 300 local service providers
    - Allocating state and federal funding to the Area Agencies on Aging which administer and monitor various home and community based services for older adults
    - Administering the Elder Rights program which advocates on the behalf of residents in long term facilities to protect them from abuse and neglect

DIVISION OF AGING

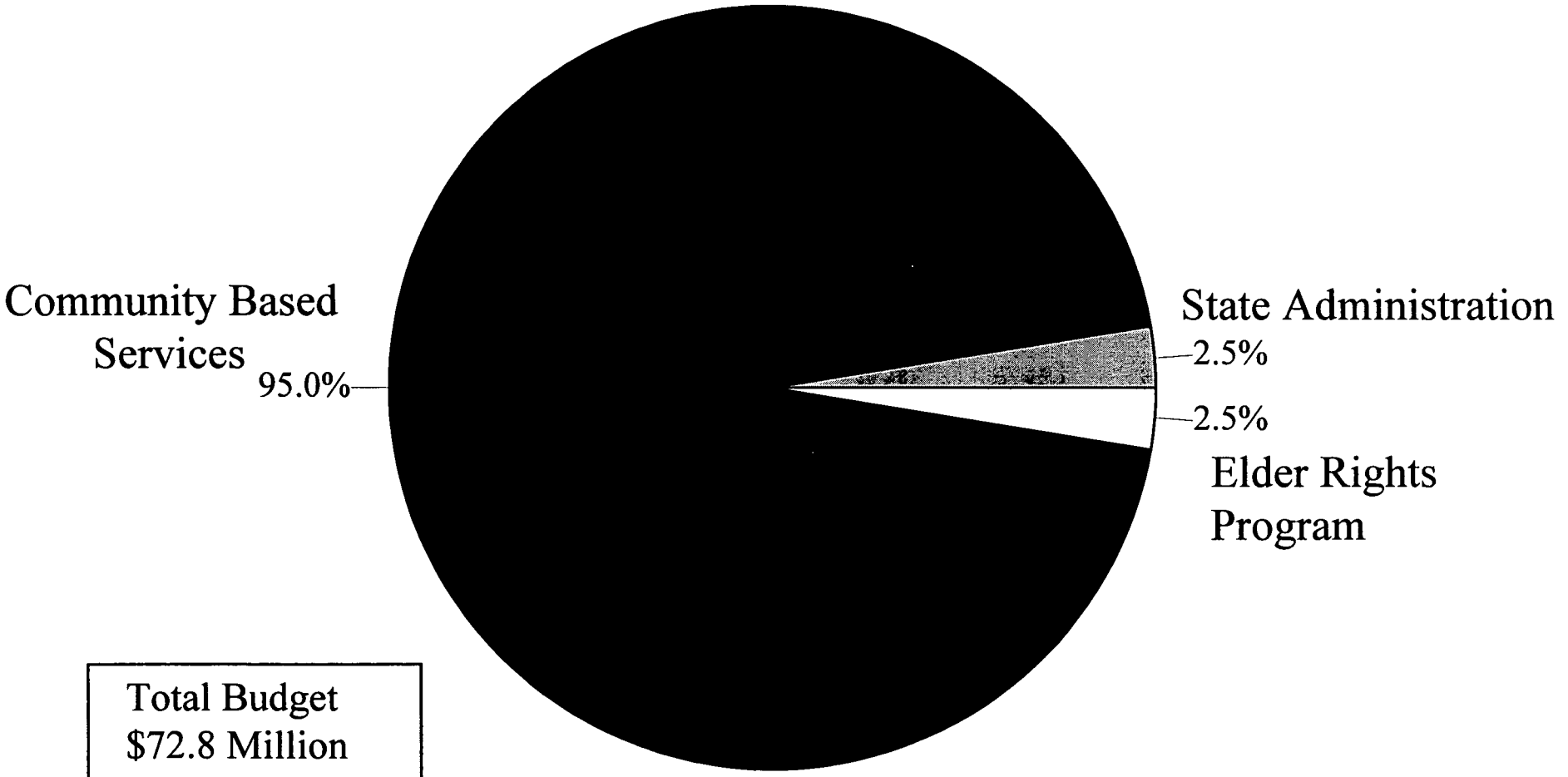
1999-2001 CONTINUATION BUDGET

Description	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Total Requirements	$60,430,490	$72,768,757	$69,676,159	$69,676,159
Estimated Receipts	$35,886,779	$40,548,615	$39,943,042	$39,943,042
Net Appropriation	$24,543,711	$32,220,142	$29,742,117	$29,742,117
Total Number of Positions	31.0	35.0	35.0	35.0



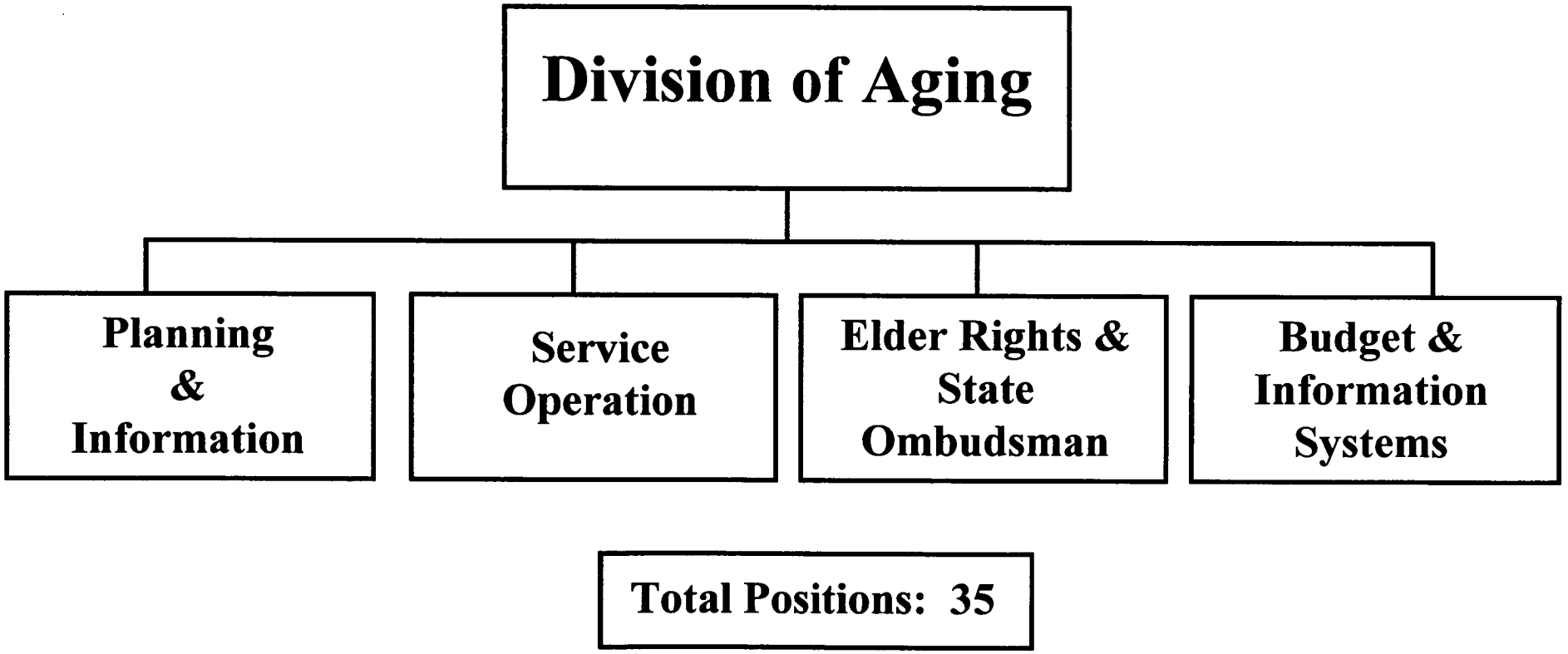
DIVISION OF AGING

FUNDING BY PURPOSE



Total Budget
$72.8 Million
1998-99

DIVISION OF AGING ORGANIZATION



DIVISION OF AGING

ORGANIZATIONAL CHANGES

- Effective July 1, 1998, the Department of Health and Human Services transferred the Adult Day Care, Adult Day Health, and In-Home Services programs from the Division of Social Services to the Division of Aging.

- The purpose of the transfer is to streamline responsibility the administration of these services and focus the responsibility in one division.

- Two positions from the Division of Social Services were transferred to the Division of Aging to carry out these program responsibilities.

- No changes in how the program allocations are distributed to counties have occurred as a result of this move. The funding for these programs remain in the Division of Social Services' budget.

  - ✓ Adult Day Services $3,452,146
  - ✓ In-Home Services $2,401,272

DIVISION OF AGING

AREA AGENCIES ON AGING

- Area Agencies on Aging (AAAs) were established through the Older Americans Act amendments of 1973.

- The purpose of the AAAs is to facilitate and support the development of programs to address the needs of older adults in a defined geographic region and support investment in their talents and interests.

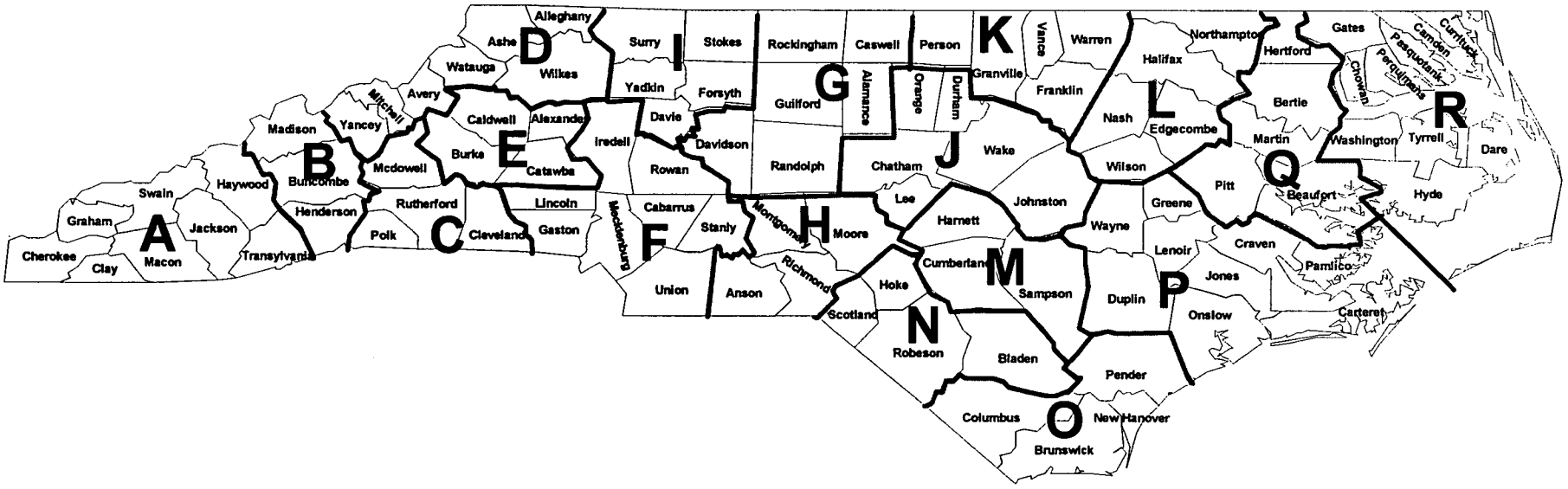
- In North Carolina, the 18 AAAs are located within the regional Councils of Government (COGs).

- The AAAs major functions include the following:

  - ✓ Advocacy and information brokerage
  - ✓ Planning and coordination
  - ✓ Program and resource development
  - ✓ Administration and quality assurance
  - ✓ Training and capacity building

DIVISION OF AGING

Regional Planning and Service Areas For Aging



18 Area Agencies on Aging

DIVISION OF AGING

LEGISLATIVE HIGHLIGHTS

Home and Community Care Block Grant

1995-96	$ 500,000
1996-97	$5,000,000
1997-98	$5,000,000
1998-99	$8,000,000 (General Fund and Block Grant funding)

Senior Centers

1997-98	$1,000,000 (Operation and development support) NR
1998-99	$1,000,000 (Operation and development support) NR
1998-99	$1,000,000 (Operation and development support)
1998-99	$1,500,000 (Construction grants) NR

Area Agencies on Aging

1998-99	$ 900,000 (Additional administrative funding)

State Adult Day Care Fund

1997-98	$1,655,750 (Social Services Block Grant)
1998-99	$2,171,750 (General Fund and Social Services Block Grant)

DIVISION OF AGING

HOME AND COMMUNITY CARE BLOCK GRANT

- In July 1992, the Home and Community Care Block Grant Legislation was implemented. The purpose of the legislation was to improve the planning, management, and coordination of in-home and community based services provided to older North Carolinians.

- The Block Grant combined state and federal funding which had been allocated separately before the legislation was enacted.

- To receive funding, the county commissioners of each county must designate a lead agency to develop a block grant funding plan for their county. The lead agency may be an area agency on aging, a department or council on aging, a social services department, other public agencies, or other private nonprofit agency.

- The county aging funding plan must identify services to be provided, the funding levels for their services, unit costs, and the agencies designated by the county commissioners to provide or purchase services on behalf on the county.

- The plan must be approved by the county commissioners, including a public hearing.

- After the plan is approved, it is sent to the area agency on aging for funding and the Division of Aging so that county, area, and State Aging Services Plans can be coordinated.

DIVISION OF AGING

HOME AND COMMUNITY CARE BLOCK GRANT ALLOCATIONS

- The Division of Aging allocates the Home and Community Care Block Grant to counties through its intrastate funding formula.

- The formula includes the following weighted factors:

  - ✓ 60+ population in the county - 50%
  - ✓ 60+ population in poverty - 30%
  - ✓ 60+ minority population - 10%
  - ✓ 60+ rural population - 10%

- The Division of Aging calculates each county's share and awards funds to counties through the Area Agencies on Aging (AAA). AAAs may not modify county allocations of state appropriations.

- Counties must provide a 10% match.

DIVISION OF AGING

HOME AND COMMUNITY CARE BLOCK GRANT SERVICES

- ✓ Adult Day Care
- ✓ Adult Day Health Care
- ✓ Care Management
- ✓ Congregate Nutrition
- ✓ Health Promotion and Disease Promotion
- ✓ Health Screening
- ✓ Home Delivered Meals
- ✓ Home Health
- ✓ Housing and Home Improvement
- ✓ Information and Care Assistance
- ✓ In-Home Aide
- ✓ Institutional Respite Care
- ✓ Mental Health Counseling
- ✓ Senior Companion
- ✓ Senior Center Operations
- ✓ Transportation
- ✓ Volunteer Program Development

DIVISION OF AGING

HOME AND COMMUNITY CARE BLOCK GRANT
EXPENDITURES AND ALLOCATIONS

SERVICES	1997-98 Expenditures	1998-99 Allocations
Adult Day Care	$2,250,242	$2,934,971
Care Management	$832,752	$1,009,725
Nutrition Services	$13,636,999	$14,956,176
Respite Care	$434,631	$505,158
In-Home Aid	$14,987,814	$17,174,163
Information and Case Assistance	$1,325,905	$1,587,653
Senior Centers	$1,553,029	$1,585,405
Transportation	$5,150,372	$5,893,265
Housing & Home Improvement	$659,186	$763,926
Miscellaneous	$293,895	$381,411
Total 1996-97 Allocation	**$41,124,825**	**$46,791,853**

DIVISION OF AGING

HOME AND COMMUNITY CARE BLOCK GRANT

CLIENT INFORMATION

- ✓ 67,181 clients received services in 1997-98
- ✓ 58% were 75+, 1 in 5 were 85+
- ✓ 56% of persons served had incomes at or below 100% of the federal poverty level
- ✓ 72% were female
- ✓ 66% were white, 32% were black, and 2% were other races
- ✓ 16% were very frail - impairments in 3 or more activities of daily living
- ✓ 32% received more than one service

DIVISION OF AGING

SENIOR CENTER OPERATIONS

- Currently, 138 senior centers are located in 92 counties.

- The following counties do not have a senior center: Caswell, Gates, Henderson, Hoke, Moore*, Nash*, Stokes*, and Transylvania.

- A senior center must meet the following standards:

  - ✓ Provide information and case assistance, outreach , and health promotion;
  - ✓ Complete the *Senior Center Standards and Self-Assessment Workbook Guideline for Practice;*
  - ✓ Operate on a 5 day - 40 hour per week schedule; and
  - ✓ Employ a full-time director and have adequate paid and/or volunteer staff to carry out a program.

*Indicates that a senior center is under active development.

DIVISION OF AGING

SENIOR CENTER FUNDING

Federal Funding: Senior center funding is authorized through Title III-B of the Older Americans Act as a Home and Community Care Block Grant service and is budgeted at the discretion of counties. 43 counties allocated for $1.6 million of Home and Community Care Block Grant funding to senior center operations during 1998-99.

Senior Center Outreach: State appropriations for senior center outreach ($365,316) are awarded by AAAs and usually supports the ongoing outreach efforts of senior centers. A 10% match is required. 99 senior centers received funding from this source during 1997-98 to reach elderly in unserved or underserved areas of the state.

Senior Center Operations: State appropriations for senior center operations are awarded by the Division of Aging and usually support one-time expenses such as facility maintenance and improvement, equipment purchases, and short-term classes and programs. A 10% match is required. 151 centers (138 existing and 13 developing centers) were each awarded $13,245 from the $2,000,000 appropriation for 1998-99.

Senior Center Capital: State appropriations for the construction, renovation, and equipping of new senior centers are awarded by the Division of Aging through a Request for Application process. The Division was appropriated $1,500,000 for 1998-99 and the legislation required a 25% local match. 34 applications totaling $2,525,980 were received and the Division made awards to 20 centers. Three counties received funding to develop their first center.

DIVISION OF AGING

AAAs PLANNING AND ADMINISTRATIVE FUNDING

- Planning and Administrative funding for the AAAs is provided through federal, state, and local funding and is allocated to AAAs using the state funding formula developed for the Home and Community Care Block Grant.

- The 1998 General Assembly increased state funding for planning and administration from $300,000 to $1.2 million -- an increase of $900,000.

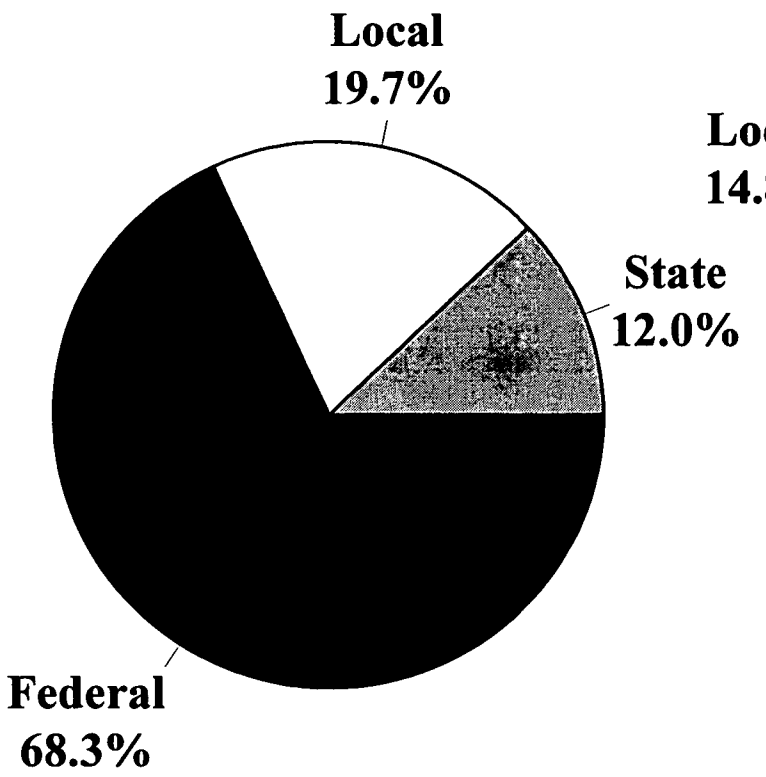
- Each AAA receives $50,000 for planning and administration through the expanded state funding while existing funding for planning and administration continues to be allocated using the funding formula.

- The AAAs were directed by the General Assembly to use the expanded funding for planning, coordination, and operational activities that enhance each agency's ability to provide services, information, and education for consumers, and to better meet the data and technical assistance needs of providers, local planning committees, and local governments.

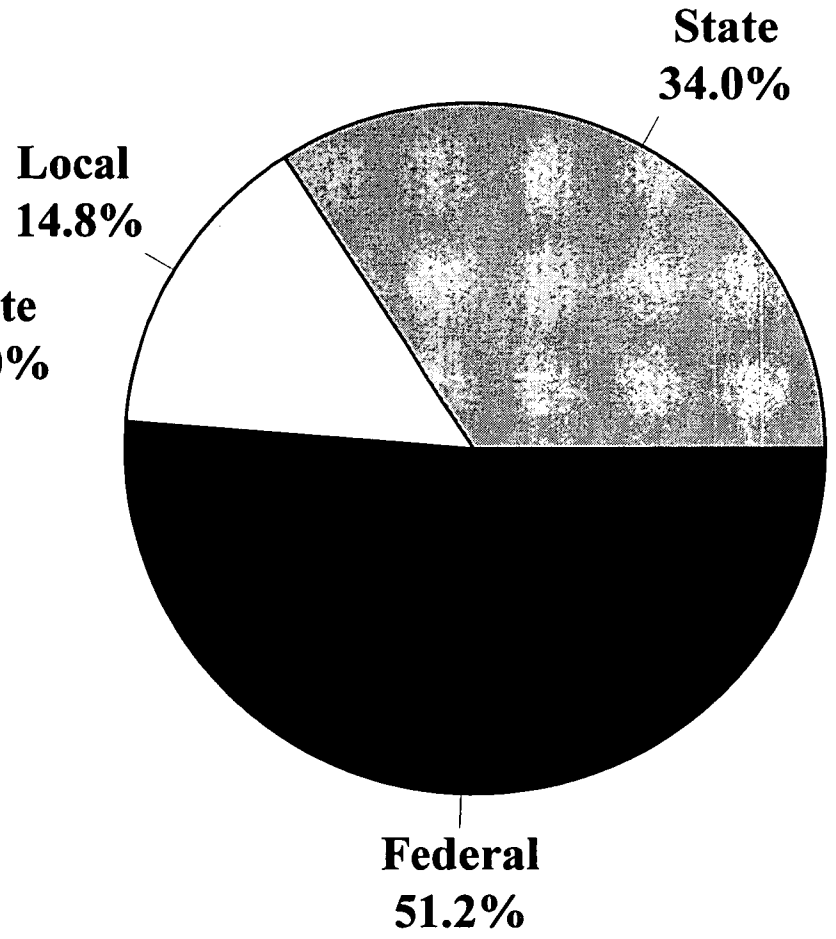
DIVISION OF AGING

AAAs PLANNING AND ADMINISTRATIVE FUNDING

1997-98



1998-99



DIVISION OF AGING

1998-99 AAAs PLANNING AND ADMINISTRATIVE FUNDING

Region	Federal	State*	Local	Total
A	$68,520	$64,325	$19,790	$152,635
B	$89,029	$66,248	$25,714	$180,991
C	$72,747	$64,721	$21,011	$158,479
D	$71,154	$64,572	$20,551	$156,277
E	$80,006	$65,402	$23,108	$168,516
F	$213,307	$77,901	$61,608	$352,816
G	$170,579	$73,894	$49,267	$293,740
H	$68,161	$64,291	$19,686	$152,138
I	$111,184	$68,325	$32,112	$211,621
J	$162,470	$73,134	$46,925	$282,529
K	$80,728	$65,470	$23,316	$169,514
L	$96,912	$66,987	$27,990	$191,889
M	$94,390	$66,751	$27,262	$188,403
N	$79,560	$65,390	$22,979	$167,899
O	$91,140	$66,446	$26,323	$188,909
P	$129,344	$70,028	$37,357	$236,729
Q	$86,501	$66,010	$24,983	$177,494
R	$63,174	$63,823	$18,246	$145,243
Total	**$1,828,906**	**$1,213,688**	**$528,230**	**$3,570,822**

*Includes $50,000 per AAA that was appropriated in 1998.

DIVISION OF AGING

ADULT DAY SERVICES

Adult Day Care - Provides an organized program of services during the day in a community group setting for the purpose of supporting the personal independence of older adults and promoting their social, physical, and emotional well-being. Programs offer a variety of activities designed to meet the needs and interests of participants, including referral to and assistance with using other community resources.

Adult Day Health Care - Provides the same services as adult day care and also provides health care services to meet the needs of individual participants.

Certification - Adult Day Services providers must meet certification standards which are set by the Social Services Comission and enforced by the Division of Aging.

Outcomes - Adult day care and adult day health care services are part of the continuum of long term care for older and disabled adults. These services provide an impaired adult with a safe and supervised environment and an opportunity for group involvement and individually planned services. The programs also provide respite for family caregivers.

DIVISION OF AGING

ADULT DAY SERVICES

- Currently, 112 centers are located in 62 counties.
  - ✓ 59 centers provide adult day care
  - ✓ 49 centers provide both adult day and adult day health care
  - ✓ 4 centers provide adult day health care

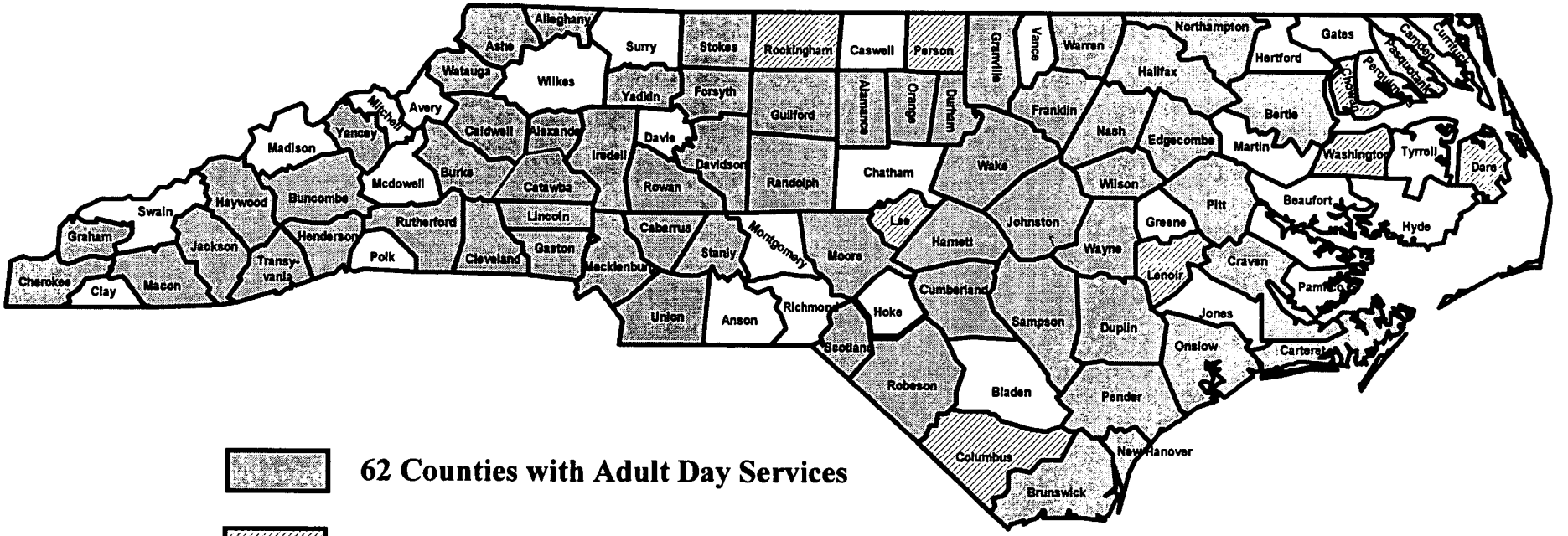
- 383 slots are subsidized through the State Adult Day Care Fund -- Annual per slot cost is $6,780 for adult day care and $8,580 for adult day health care

- Expansion funding for the State Adult Day Care Fund has provided the following increases in services:
  - ✓ 23 start-up grants for adult day services
  - ✓ 6 conversion grants to convert adult day programs to adult day health care programs
  - ✓ 227 more state subsidized adult day care and adult day health care slots

- Total funding for the State Adult Day Care Fund for 1998-99 is $3,452,148.
  - ✓ State Appropriations -- $732,875
  - ✓ Social Services Block Grant -- $1,675,253
  - ✓ Local Match -- $344,018

DIVISION OF AGING

ADULT DAY SERVICES



62 Counties with Adult Day Services

8 Counties Developing Adult Day Services

30 Counties with no Adult Day Services

DIVISION OF AGING

1997-98 AGING EXPENDITURES BY AGENCY

Agency	Agency Total	Agency Percent
Aging	$47,655,078	2.62%
Blind	$4,817,094	0.27%
Medical Assistance	$1,520,219,641	83.70%
Mental Health	$134,032,656	7.38%
Public Health	$1,549,920	0.09%
Social Services	$105,737,754	5.82%
Transportation	$1,507,064	0.08%
Vocational Rehab.	$703,750	0.04%
Total	**$1,816,222,957**	**100%**

DIVISION OF AGING

1997-98 AGING EXPENDITURES BY SERVICE CATEGORY

Service Category	Category Total	Category Percent
Adult Care Homes	$104,911,923	5.78%
Economic Support	$160,161,398	8.82%
Health Care	$355,126,458	19.55%
Home Health & In-Home Care	$236,406,315	13.02%
Institutional Care	$929,852,504	51.20%
Social/Supportive Services	$29,764,359	1.64%
Total	**$1,816,222,957**	**100%**

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-24, 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Slate	Division of Aging
Gary Cyrus	Div. of Aging
Steven Freedman	Division of Aging
Sharon Hirsch	NC Social Services Consortium
Christina Medlin	Covenant w/ NCs Children
Helen Lipman	Meck Co. Social Services
[illegible]	Food BANKS
Mary Smith	G.W
Glenn Wells	DHHS/Public Health
Patrice Rowler	NCACC
Mary Miller	NAMI - Forsyth County
Lyndia Kleeberg	NAMI-Guilford County
Eileen Silber	NAMI - Guilford
Anne Tefft	OSBM
Pam Richardson	OSPI
Megan Soyster	Easter Seals
JACE McFEE	MASCE of DI MES
Deodice Brantley	Div. of Aging - DHHS
Mary Bethel	" " " "
Bill Lamb	" " "
WIL EDGERTON	MHA/NC
Dennis Streets	NC Division of Aging, DHHS
Karen E. Gottovi	NC Division of Aging, DHHS
Peter Leonsis	DHHS
Gei Brogden	DHHS
Jim Edgerton	DHHS
DAVE BRUTON	DHHS
Beth McCrae	NAMI NC
Lou Watson	NCALTCF

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-24, 1999

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dorothy James	NAMI Rockingham County
Carol Matthieu	PO Box 147, Madison NC 27025
	→ NAMI-Rockingham County
C. Porter	Bone & Associates
Hugh Tilson	NCHA
Heather Laffler	OSA
N Meager	OSBM
Joan Schoen	NCNA

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
March 24, 1999
Afternoon

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Wednesday, March 17, 1999, in the afternoon, in Room 424 of the Legislative Office Building.

House Chairman, Representative Edd Nye presided. Other House members present were Representative Beverly Earle (Co-Chairman), Representative Martha Alexander (Vice-Chairman, Representative Lanier Cansler, Representative Theresa Esposito, Representative Trudi Walend, and Representative Gene Wilson. There were six senators present.

Chairman Nye introduced Dr. Stelle, Deputy Director of Division of Mental Health, to provide information on the Fort Bragg Demonstration Project. (See Attachments.) He first provided an overview of the program, its purpose, and the outcome. He stated Gary Fuquay, assistant controller with DHHS, would explain how it was monitored, and then Bob Hargett, with the Attorney General office, would provide information with regard to the civil lawsuit action occurring between the state and the US Government.

Dr. Stelle stated that 15 years ago, there was only two kinds of treatment for children, outpatient and inpatient. This program was started for the Department of Defense as an alternative to these two ways of treatment, which would provide wrap around services.

Senator Forrester asked about the 4.4 million the federal government wants back from the state. Dr. Stelle stated he would defer to the Attorney General, Bob Hargett, to reply to that question.

Senator Phillips asked how state got to point to set up system and not use area program. He was told the Army requested private non-profit group.

Gary Fuquay, Assistant Controller with DHHS, then spoke to the Committee and stated Army wanted the state to be principal monitor of program. He stated that from 1992 thru 1995, state did audit, as well as independent CPA firm. After some questions from the Committee Members, Mr. Fuquay concluded his presentation.

Bob Hargett with the Attorney Generals Office, spoke next and discussed the civil lawsuit action .(See Attached) After much discussion between the members with Mr.

Hargett, Senator Phillips stated it shows a need for control over state contracting, and stated he would like to see someone in state system to be in control of contract negotiations.

Chairman Nye adjourned the meeting.

Respectfully submitted,

Representative Edd Nye
Chairman Edd Nye

Jo Bobbitt
Committee Assistant

Financial Monitoring of the Contract with the Army and State Of North Carolina

- State was required to provide a Progress Report to the Army on a quarterly
- basis. One of the sections of the progress report contained a Surveillance Monitoring Activity for Cardinal Mental Health Group for both programmatic and financial activities.

- The primary Financial Monitoring Activities contained in the Surveillance Plan required the State to:
  - Review vouchers from Cardinal on a monthly basis for accuracy, allowability and proper documentation.
  - Monitor and track all budget revisions and track expenditures against approved budget.
  - Identify trends in spending that could result in over/underspending.
  - Perform monitoring of financial records to ensure records are accurate and in accordance with proper financial practices.
  - Review contractor system for paying bills for client services and ensure payments do not exceed approved rates.
  - Monitor expenditures for capital expenditures.
  - Require an audit by an independent CPA firm.

Financial Monitoring of the Contract with the Army and State Of North Carolina

- **Monthly Process:**

1. Each month Cardinal provided the Controller's Office a summary of expenditures by the approved budgeted line items (Salary, Fringe, Travel, Rental Costs, Equipment, Contract Costs, etc.).
2. The Controller's Office Project Accountant reviewed the vouchered costs against the budgeted line items and prepared expenditure trend reports for management.
3. Monthly expenditure reports were prepared as prescribed by the Army and submitted to the Army Contract Officer.
4. Army Contract Officer reviewed and defined monthly sample of expenditures to be reviewed in detail.
5. The Controller's Office Project Accountant and Army Contract Officer Representative made monthly on-site visits to Cardinal to review supporting documentation for selected sample. Sample expenditures were reviewed for accuracy, allowability and completeness of documentation.
6. Army paid state for vouchered costs. If costs were considered unallowable by state, cost were not vouchered to the Army. If Army considered costs unallowable, payment reflected reduced amount.
7. Controller's Office Project Accountant made additional monthly monitoring visits to review financial records.

Ft. Bragg Audit by Defense Contract Audit Agency (DCAA)
Audits for 1992-1995

Questioned Cost Title	DCAA Questioned Cost Amount	Narrative Description
Total Contract Costs of $92,000,000		
Travel	$3,484.00	Questioned Travel costs for Exec. Director and Board Chair. Was approved by Board Chair.
24 Hour Services	$4,176,941.00	Questioned residential services costs. Army contends costs are in excess of statewide ave. rates. State doesn't agree with Army's comparison of statewide rates as the Carndinal rates residential rates include outpatien services. For the State outpatient services are billed separately. Willie Ms. Other residential costs were paid at the CHAMPUS approved rate.
Medical Director-Salary	$155,698.00	DMH/DD/SA Personnel determined Stein's experience and qualifications qualified him for salary paid.
Medical Director-Travel	$42,772.00	Travel was more cost efficient than moving. Moving costs $90k vs travel $42k for all 4 years.
G & A Allocability	$9,058.00	Army questioned portion of Cardinal admin cost as it appeared to benefit the partnership. State: transaction was charged to Cardinal that benefited partnership, but was corrected.
Provider Cost	$23,538.00	Questioned contract provider services costs. Cardinal reimbursed per the contractor negotiated rate which was at 90% of the CHAMPUS rate or less.
Training/Education	$5,435.00	Questioned employee post graduate degree costs. State contends costs are allowable under OMB A-122. Army itself defines that OMB A-122 governs the non-profit organization.
Dues & Subscriptions	$3,239.00	Questioned membership to Chamber of Commerce. OMB A-122 provides for memberships as allowable.
Legal Cost	$9,050.00	Questioned Legal Fees. Fees were related to Army request to extend contracts and client related activity-confidentiality .
	$4,429,215.00	

United States Court of Federal Claims
Washington D.C.

FILED
OCT 6 1998
U.S. COURT OF
FEDERAL CLAIMS

State of North Carolina,
Plaintiff,

v.

United States of America,
Defendant,

No. 98-776 C

COMPLAINT

COMPLAINT

For its Complaint in this action, plaintiff alleges as follows:

1. This Court has jurisdiction over this action pursuant to the Contract Disputes Act of 1978, 41 U.S.C. § 609, and 28 U.S.C. § 1491.

2. The State of North Carolina, through its Department of Health and Human Services, (Plaintiff herein) is the contractor. The federal agency which placed the contract, administers the contract and which failed to render a final decision under the contract is the Department of the Army, Headquarters, United States Army Health Services Command, Fort Sam Houston, Texas.

3. On August 17, 1989, the Department of the Army entered into a letter contract (DADA10-89-C-0013) ("the contract", "Attachment A") with the State of North Carolina, Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Pursuant to the terms of this contract the Plaintiff was to provide Child and Adolescent Psychiatric Services in the Fort Bragg Catchment Area to military dependents.

4. The contract began as a cost reimbursement contract. Defendant was billed for actual costs incurred by Plaintiff.

5. On October 4, 1994, the contract was modified from a cost reimbursement contract to a cost-plus-incentive-fee contract. (Modification P00063) ("the modification", "Attachment B")

6. Pursuant to paragraph 14a of the modification, an incentive fee could be earned by Plaintiff if costs under the contract were reduced. The maximum amount of the incentive fee under paragraph 14b of the modification was set at $775,337.00.

7. Plaintiff was successful in lowering costs and met the contractual requirements to receive the maximum incentive fee.

8. Documentation supporting the Plaintiff's entitlement to the maximum incentive fee was provided to the Defendant on February 14, 1996.

9. On March 19, 1996, the Defendant, through its contracting officer, notified Plaintiff that the Department of Justice was performing an investigation and requested a delay of 120 days.

10. On October 15, 1997, Plaintiff resubmitted a claim to Defendant for the $775,337.00 owed as an incentive fee. The Defendants replied that the claim was premature because audits had not been finalized.

11. On December 1, 1997, the Plaintiff submitted its certified claim to the Defendant's Contracting Officer.

12. On December 15, 1997, the defendant through its Contracting Officer stated that the Department of Justice investigation was continuing and it would not be prudent to release those funds, and further stated that the payment would be withheld pending resolution of the investigation.

13. On February 20, 1998, the defendant through its Contracting Officer notified Plaintiff

that the letter of December 15, 1997, was not a denial of Plaintiff's claim.

14. On September 1, 1998, Plaintiff requested from Defendant, through its contracting Officer, a final decision on its claim for $775,337.00. During the five weeks since there has been no written response from defendants.

15. Defendant has had a reasonable period of time to determine Plaintiff's claim but Defendant has failed to issue a final decision.

16. The Plaintiff has complied with its obligations under the aforesaid contract.

WHEREFORE, Plaintiff demands: (1) That Plaintiff have judgment against Defendant for $775,337.00 and interest as allowed by law. (2) That Plaintiff have judgment against Defendant for costs.

This the 5th day of October, 1998.

[redacted]

Robert T. Hargett, Attorney of Record
Special Deputy Attorney General
North Carolina Department of Justice
P.O. Box 629
Raleigh, N.C. 27602-0629
(919) 716-6880

[redacted]

Special Deputy Attorney General
North Carolina Department of Justice
P.O. Box 629
Raleigh, N.C. 27602-0629
(919) 716-6900

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

STATE OF NORTH CAROLINA,	)	
	)	
Plaintiff,	)	**No. 98-776C**
	)	**(Judge Merow)**
v.	)	
	)	
THE UNITED STATES,	)	
	)	
Defendant.	)	

RECEIVED
MAR 9 1999
NC Department Of Justice
Human Services Legal Section

ANSWER, COUNTERCLAIMS, SET-OFF, AND SPECIAL PLEA IN FRAUD

For its answer to the Complaint, defendant, the United States, admits, denies and alleges as follows:

1. The allegations contained in paragraph 1 are conclusions of law to which no responsive pleading is required; to the extent that they may be deemed allegations of fact, they are denied.

2. Admits.

3. Admits.

4. Admits the allegations contained in the first sentence of paragraph 4. Denies the allegations contained in the second sentence of paragraph 4.

5. Admits the allegations contained in paragraph 5 to the extent supported by the contract and modification cited, which are the best evidence of their contents; otherwise denies the allegations contained in paragraph 5.

6. Admits the allegations contained in paragraph 6 to the extent supported by the contract cited, which is the best evidence of its contents; otherwise denies the allegations contained in paragraph 6.

7. Denies.

8. Admits the allegation of paragraph 8 that plaintiff submitted documentation regarding its claim to the incentive fee on or about February 14, 1996; otherwise denies the allegations contained in paragraph 8.

9. Admits.

10. Admits.

11. Admits.

12. Admits.

13. Admits.

14. Admits.

15. The allegations contained in paragraph 15 are conclusions of law to which no responsive pleading is required; to the extent that they may be deemed allegations of fact, they are denied.

16. Denies.

17. Denies that plaintiff is entitled to the relief requested in its prayer for relief or to any relief whatsoever.

18. Denies each and every allegation not previously admitted or qualified.

COUNTERCLAIMS AND SET-OFF

Background

19. On or about August 19, 1989, a letter agreement was entered into by and between the United States Department of the Army ("Army") and the State of North Carolina (the "State"). The agreement provided that the State would conduct a demonstration project for the provision of mental health services to children and adolescents in the Ft. Bragg catchment area (the "Demonstration Project").

20. On or about October 30, 1989, the letter agreement was formalized into a cost reimbursement contract between the Army and the State (the "State Contract").

21. The State Contract provided that the State would provide all or virtually all mental health services for children and adolescents in the Fort Bragg catchment area who were eligible for mental health services through the Civilian Health and Medical Program of the Uniformed Services ("CHAMPUS").

22. The State was responsible for management and coordination of the State Contract. The State Contract contemplated that all of the mental health services would be actually provided by one or more tiers of subcontractors.

23. On or about September 14, 1989, the State entered into a subcontract (the "First Tier Subcontract") with the Cumberland County Mental Health Area Authority ("Cumberland County MHA") to administer the patient care provisions of the State Contract.

24. The First Tier Subcontract provided that the Cumberland County Area MHA would only be responsible for administrative oversight rather than actual patient care. Actual

patient care would be provided by Cardinal Mental Health Group, Inc. ("CMHG"), a North Carolina not-for-profit company.

25. On or about September 14, 1989, the Cumberland County Area MHA entered into a subcontract (the "Second Tier Subcontract") with CMHG to provide direct patient care under the State Contract.

26. On or about May 31, 1990, the State replaced Cumberland County MHA with the Lee Harnett Area Mental Health Authority ("Lee Harnett MHA") to act as the first tier subcontractor.

27. On or about June 1, 1990, CMHG and Lee Harnett MHA entered into an agreement acknowledging that Lee Harnett MHA had taken over the responsibilities of Cumberland County MHA as the first tier subcontractor.

28. Although the original term of the State Contract ended on May 18, 1994, on or about June 3, 1994, the Army and the State entered into a modification of the State Contract which extended the State Contract through September 30, 1994. Pursuant to the modification, the Army was also given an option to extend the State Contract from October 1, 1994 through September 30, 1995. The Army exercised the option on September 22, 1994 ("FY 1995 Modification").

29. On or about October 4, 1994, the State Contract was modified from a cost-reimbursement contract to a cost-plus-incentive-fee contract for fiscal year 1995.

30. The State Contract, including the FY 1995 Modification, provided that all expenses incurred by the State or its subcontractors must be reasonable, allowable, and allocable

to the State Contract and/or FY 1995 Modification, and that all such costs were subject to final audit.

31. Under the State Contract, including the FY 1995 Modification, and the FAR and OMB provisions specifically incorporated therein, the State was required to repay to the United States any expenses for which the State had been reimbursed that were not in fact reasonable, allowable, and allocable to the State Contract and/or FY 1995 Modification.

32. The State Contract, including the FY 1995 Modification, provided that all clinical expenses incurred by the contractor or any subcontractors must be the lower of the CHAMPUS prevailing rate, the community standard rate, or a negotiated rate.

33. During the administration of the State Contract, including the FY 1995 Modification, the State made various representations concerning the Demonstration Project costs which the State would pass through to the United States, including, but not limited to: (a) that the State would use the Pioneer System to control costs, consistent with the State Contract and the FY 1995 Modification; (b) that the costs for all salaries would be comparable to the State salaries; and (c) that the clinical costs for inpatient hospitalization were below applicable CHAMPUS rates.

34. On a periodic basis, generally monthly, CMHG would submit to the State a voucher for the expenses it had incurred during the relevant period. The State would also receive vouchers from Vanderbilt University, which had a separate subcontract to perform a study of the effectiveness of the Demonstration Project. The State would combine the vouchers from CMHG and Vanderbilt University, add its own allowable costs allocable to the State Contract and/or the FY 1995 Modification, and submit one voucher ("Voucher") to the Army for payment.

35. From November 26, 1991, through at least January 16, 1996, the State submitted at least 63 Vouchers to the United States, representing services provided during fiscal years 1992 through 1995. In addition, at the conclusion of each fiscal year, the State submitted an audit of the costs for that fiscal year, which constituted the incurred cost submission (required under the State Contract and/or FY 1995 Modification), summarizing all reasonable, allowable, and allocable costs claimed during that fiscal year by the State on behalf of its subcontractors.

36. Each such Voucher contained a certification that all expenditures reported (or payments requested) were for appropriate purposes and in accordance with the State Contract and/or FY 1995 Modification. The incurred cost submissions reiterated the State's claim that the costs submitted to the State were reasonable, allowable and allocable costs to the State Contract and/or FY 1995 Modification.

37. Each such Voucher and incurred cost submission contained claims for one or more of the following categories of costs that were not reasonable, allowable or allocable to the State Contract and/or FY 1995 Modification:

a. Clinical expenses for inpatient hospitalizations, residential treatment centers, group homes or foster homes which exceed the lower of the CHAMPUS prevailing rate, the community standard rate or a negotiated rate.

b. Salaries to employees or agents of CMHG in excess of reasonable rates, in excess of the equivalent State salaries for similar job duties, and not consistent with the representations made by the State that salaries would be comparable to State salaries.

c. Retirement contributions that were in excess of reasonable retirement contributions for similar companies, in excess of State retirement contributions, and not consistent with the representations made by the State that such benefits would be comparable to State benefits.

d. Rent that was in excess of reasonable rates for the area and that was, in at least one instance, in excess of rent for the same space at a later date.

e. Hotel bills for subcontractor employees who were not on travel status.

f. Salaries and expenses incurred by and for the benefit of other for-profit entities not entitled to reimbursement under the State Contract and/or FY 1995 Modification, including without limitation: Cardinal Clinic, Cardinal R&D Partnership, and Cardinal Behavioral Sciences Institute.

g. Overall administrative costs that were unreasonable, especially in light of the State's Pioneer System reports which indicated that such costs were unreasonable when compared to Area Mental Health Authorities' costs.

38. Based upon the above-described representations and certifications that the expenditures reported (or payments requested) were for appropriate purposes and in accordance with the State Contract and/or FY 1995 Modification, the Army paid each and every Voucher, and incurred cost submission submitted by the State.

39. On January 19, 1999, the Army contracting officer issued a final decision, finding that the State owes the United States $4,429,215.00 for costs that were not reasonable, allowable, and/or allocable to the State Contract and/or FY 1995 Modification.

First Counterclaim
(Contract Disputes Act)

40. This is a claim for damages under 41 U.S.C. § 605, over which the Court has jurisdiction pursuant to 28 U.S.C. § 2508.

41. The allegations of paragraphs 19 through 39 above are realleged here as if set out in full.

42. As set forth in paragraph 39, the Army contracting officer issued a final decision , finding that the State owes the United States $4,429,215.00 for costs that were not reasonable, allowable, and/or allocable to the State Contract and/or FY 1995 Modification.

43. The State owes the United States $4,429,215.00 pursuant to the Army contracting officer's decision.

Second Counterclaim
(Set-Off)

44. This is a claim for set-off, over which the Court has jurisdiction pursuant to 28 U.S.C. §§ 1503 and 2508.

45. The allegations of paragraphs 19 through 39 above are realleged here as if set out in full.

46. As stated above, the Army contracting officer found that the State owes the United States $4,429,215.00 for costs that were not reasonable, allowable, and allocable, but were charged to the State Contract, including the FY 1995 Modification, and paid by the United States.

47. To the extent that the United States may be found to owe an incentive fee to the State, as alleged by the Complaint, the United States is entitled to a set-off of any such amount

against the costs that were not reasonable, allowable, and allocable to the State Contract, including the FY 1995 Modification, but were charged to the State Contract, including the FY 1995 Modification, and paid by the United States.

Third Counterclaim
(False Claims Act - False Claims)

48. This is a claim for civil penalties and treble damages under 31 U.S.C. § 3729(a)(1), over which the Court has jurisdiction pursuant to 28 U.S.C. §§ 1503 and 2508.

49. The allegations of paragraphs 19 through 39 above are realleged here as if set out in full.

50. By virtue of the acts described above, the State knowingly presented or caused to be presented to the Army false or fraudulent Vouchers for payment or approval.

51. The Army paid false or fraudulent claims because of the acts of the State.

52. By virtue of these false claims, the Army has sustained substantial damages in an amount to be established at trial.

Fourth Counterclaim
(False Claims Act - False Statements)

53. This is a claim for civil penalties and treble damages under 31 U.S.C. § 3729(a)(2), over which the Court has jurisdiction pursuant to 28 U.S.C. §§ 1503 and 2508.

54. The allegations of paragraphs 19 through 39 above are realleged here as if set out in full.

55. By virtue of the acts described above, the State knowingly made, used or caused to made or used, false Vouchers and incurred cost submissions to get false or fraudulent claims paid or approved by the Army.

56. The Army paid false or fraudulent claims because of the acts of the State.

57. By virtue of these false claims, the Army has sustained substantial damages in an amount to be established at trial.

Fifth Counterclaim
(False Claims Act - Reverse False Claim)

58. This is a claim for civil penalties and treble damages under 31 U.S.C. § 3729(a)(7), over which the Court has jurisdiction pursuant to 28 U.S.C. §§ 1503 and 2508.

59. The allegations of paragraphs 19 through 39 above are realleged here as if set out in full.

60. In submitting false or fraudulent incurred cost submissions to the Army for fiscal years 1992 through 1995, the State knowingly made, used, or caused to be made or used, false statements to conceal, avoid, or decrease an obligation to pay or transmit money to the Government.

61. The State failed to pay money owing to the Army because of the acts described above.

62. By virtue of this failure to pay, the Army has sustained substantial damages in an amount to be established at trial.

Sixth Counterclaim
(28 U.S.C. § 2514 -- Special Plea in Fraud)

63. This is a special plea in fraud pursuant to 28 U.S.C. § 2514, over which the Court has jurisdiction pursuant to 28 U.S.C. § 2508.

64. The allegations of paragraphs 19 through 39 above are realleged here as if set out in full.

65. On or about October 1994, the State submitted a Voucher to the Army which contained approximately $53,000.00 in expenses incurred by Cardinal R & D. The expenses incurred by Cardinal R & D were not allowable or allocable to the State Contract .

66. Prior to the submission of the Voucher described in paragraph 65, the Army had expressly advised the State that expenses incurred by Cardinal R & D were not allowable or allocable to the State Contract.

67. The State submitted the Voucher described in paragraph 65 with the knowledge that the expenses described therein would not be approved for payment if they had been clearly identified by the State, and with the intent to deceive the United States.

68. The State also submitted one or more Vouchers to the Army that included approximately $11,000 for rent paid by CMHG that was actually incurred by and for the benefit of Cardinal Clinic, and therefore was not allowable or allocable to the State Contract and/or the FY 1995 Modification.

69. The State submitted to the Army incurred cost submissions that covered the costs described in paragraphs 65 and 68.

70. Prior to requesting from the Army payment of an incentive fee in the amount of $775,337, the State discovered that the $11,000 rent claim was actually incurred by and for the benefit of Cardinal Clinic, and therefore was not allowable or allocable to the State Contract and/or the FY 1995 Modification. The State, however, with actual knowledge of the falsity of

the claim for the $11,000 in rent, failed to disclose that the $11,000 rent claim was not allowable or allocable to the State Contract and/or the FY 1995 Modification.

71. Through the conduct described in paragraphs 65 through 70, the State has practiced or attempted fraud in the proof, statement, establishment, or allowance of a claim against the United States. Accordingly, pursuant to 28 U.S.C. § 2514, the Court should render a judgment of forfeiture of the State's right to recover upon the claim advanced by the State in this litigation.

Seventh Counterclaim
(Money Paid Under Mistake of Fact)

72. This is a claim for recovery of monies paid to the State by the United States under mistake of fact, over which the Court has jurisdiction pursuant to 28 U.S.C. §§ 1503 and 2508.

73. The allegations of paragraphs 19 through 39 above are realleged here as if set out in full.

74. The Army made payments on Vouchers submitted by the State under the erroneous beliefs that the costs submitted by the State were reasonable, allowable and allocable to the State Contract, including the FY 1995 Modification.

75. The Army's erroneous beliefs referenced in paragraph 74 were material to the amount of the payments made by the Army to the State, and such payments were made by the Army without legal liability or authority.

76. Because of these mistakes of fact, the State has received money to which it is not entitled, in an amount to be determined at trial.

Eighth Counterclaim
(Breach of Contract)

77. This is a claim against the State for breach of contract, over which the Court has jurisdiction pursuant to 28 U.S.C. §§ 1503 and 2508.

78. The allegations of paragraphs 19 through 39 above are realleged here as if set out in full.

79. As a result of the conduct described in paragraphs 19 through 39, the State materially breached the State Contract and/or the FY 1995 Modification.

80. In consequence of the acts set forth above, the Army has been damaged in an amount to be established at trial.

Ninth Counterclaim
(Unjust Enrichment)

81. This is a claim for the recovery of monies by which the State has been unjustly enriched, over which the Court has jurisdiction pursuant to 28 U.S.C. §§ 1503 and 2508.

82. The allegations of paragraphs 19 through 39 above are realleged here as if set out in full.

83. As a result of the acts described in paragraphs 19 through 39, the United States overpaid the State under the State Contract and/or FY 1995 Modification, and the State knowingly accepted the overpayments .

84. The State is not entitled to retain such payments and was unjustly enriched in an amount to be determined at trial.

WHEREFORE, defendant requests that the Court:

(1) Enter judgment in favor of defendant on the First Counterclaim in the amount of $4,429,215 or such other amount as is proven at trial, with interest as provided by law;

(2) Enter judgment in favor of defendant on the Second Counterclaim permitting defendant a set-off against any amount that may be owing to plaintiff;

(3) Enter judgment in favor of the defendant on the Third Counterclaim for treble the amount of damages which the Government sustained because of the acts of the State, plus civil penalties and interest as provided by law;

(4) Enter judgment in favor of defendant on the Fourth Counterclaim for treble the amount of damages which the Government sustained because of the acts of the State, plus civil penalties and interest as provided by law;

(5) Enter judgment in favor of defendant on the Fifth Counterclaim for treble the amount of damages which the Government sustained because of the acts of the State, plus civil penalties and interest as provided by law;

(6) Enter judgment in favor of defendant on the Sixth Counterclaim forfeiting the State's claim in this case, in its entirety;

(7) Enter judgment in favor of defendant on the Seventh Counterclaim in an amount to be proven at trial, with interest as provided by law;

(8) Enter judgment in favor of defendant on the Eighth Counterclaim in an amount to be proven at trial, with interest as provided by law;

(9) Enter judgment in favor of defendant on the Ninth Counterclaim in an amount to be proven at trial, with interest as provided by law;

(10) Deny all relief sought by plaintiff;

(11) Dismiss the Complaint; and

(12) Grant defendant such other and further relief as the Court may deem just and proper.

Respectfully submitted,

DAVID W. OGDEN
Acting Assistant Attorney General

DAVID M. COHEN
Director

Sharon Y. Eubanks

SHARON Y. EUBANKS
Deputy Director

Lawrence N. Minch

LAWRENCE N. MINCH
Trial Attorney
Commercial Litigation Branch
Civil Division
Department of Justice
Attn: Classification Unit,
8th Floor, 1100 L St.
Washington, D.C. 20530
Tele: (202) 514-7300

Attorneys for Defendant

March 4, 1999

CERTIFICATE OF SERVICE

I hereby certify under penalty of perjury that on this 4 day of March, 1999, I caused to be placed in the United States mail, (first class mail, postage prepaid) copies of the foregoing "ANSWER, COUNTERCLAIMS, SET-OFF, AND SPECIAL PLEA IN FRAUD " addressed as follows:

Robert T. Hargett
Special Deputy Attorney General
North Carolina Department of Justice
P.O. Box 629
Raleigh, North Carolina 27602-0629

State of North Carolina
Department of Health and Human Services
Division of Mental Health, Developmental
Disabilities and Substance Abuse Services

APSM 40-3
05/01/98

STANDARDS FOR MONITORING AND ACCREDITATION OF AREA PROGRAMS

EFFECTIVE: May 1, 1998
OPR: Head, Quality Improvement Branch
DISTRIBUTION: A

PUBLICATION COST: 300 copies of this manual were printed at a cost of $689.00 or $2.29 per copy by the Division of Mental Health, Developmental Disabilties and Substance Abuse Services.

PUBLICATION DATE: May 1, 1998

"The N.C. Department of Health and Human Services does not discriminate on the basis of race, color, national origin, sex, religion, or disabililty in employment or the provision of services."

Rev. 6/24/98

TABLE OF CONTENTS

INTRODUCTION.....1

CHAPTER ONE: COMMUNITY AWARENESS AND RESPONSIVENESS.....5

1.1. The Area Program knows the composition of the community it serves.....5
1.2. The Area Program is actively engaged in the identification of the needs of the community.....5
1.3. The Area Program coordinates with local and state agencies to gather feedback on area program operations, promote program development, and improve services.....7
1.4. The Area Program provides information about services and programs.....8
1.5. The Area Program identifies areas needing improvement and demonstrates improvement in those areas.....9

CHAPTER TWO: CLINICAL SERVICES MANAGEMENT.....11

2.1. The Area Program provides consistent, timely and comprehensive assessments of the service needs of individual clients.....11
2.2. The Area Program consistently develops service plans that are responsive to the full range of assessed client needs and client determination of supports.....12
2.3. The Area Program appropriately provides supports and services for clients as defined in service plans.....12
2.4. The Area Program consistently and periodically monitors services to determine client outcomes and modifies services and supports as needed.....13
2.5. Available services (Area Program operated, contracted, and state facilities) are sufficient to respond to client needs.....13
2.6. Services (Area Program, contracted, and state facilities) are sufficient to permit an adequate array which promotes client choice.....19
2.7. Coordination of services within the area program.....21
2.8. Access.....22
2.9. The Area Program provides clients with information on services and programming.....24
2.10. The Area Program utilizes existing natural supports and generic resources to address client needs.....25
2.11. Treatment and habilitation facilities help people feel safe and comfortable.....25
2.12. Clients are satisfied with services.....25
2.13. The Area Program identifies areas for improvement and demonstrates improvement in those areas.....25A

CHAPTER THREE: ADMINISTRATIVE SERVICES MANAGEMENT.....26

3.1. The Area Program will comply with all operational requirements.....26
3.2. Effective integration of Area Program clinical, business and administrative functions results in problem identification and resolution.....26
3.3. The Area Program is fiscally responsible.....27
3.4. The Area Program has a system for gathering and coordinating information.....28
3.5. Providers, both internal and external, understand the mission and expectations of the Area Program regarding the services they are to provide.....29
3.6. The Area Program seeks and is responsive to external provider input.....30
3.7. Consumer and advocacy groups are involved in Area Program policy development.....30
3.8. The Area Program ensures the protection of client rights.....31
3.9. The Area Program identifies areas for improvement and demonstrates improvement in those areas.....31

CHAPTER FOUR: MANAGED CARE.....34

4.1. The Area Program has a strategic plan for operating under a managed care resource service system.....34
4.2. The responsible county government understands CA and is supportive.....35
4.3. The Area Program has an effective transition plan.....35
4.4. Consumer information.....36
4.5. Care management.....39
4.6. The Area Program manages its provider network to create a coordinated continuum of community-based services, assure compliance with requirements, and promote quality services.....42
4.7. The Area Program has an effective utilization management system.....46
4.8. The Area Program authorizes services.....46
4.9. The Area Program is fiscally sound, has effective fiscal controls, and is prepared to process claims and operate under a capitated payment system.....48
4.10. The Area Program has a management information system capable of supporting it client care and managed care operations.....49
4.11. The Area Program has procedures to ensure that certification of need (CON) forms are properly issued and maintained.....50

APPENDICES

Appendix A Child And Family Services
Appendix B Adult Mental Health Services
Appendix C Substance Abuse Services
Appendix D Crisis Services

INTRODUCTION

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services (hereafter, Division) is delegated statutory and other responsibilities to assure the public system of mental health, developmental disabilities and substance abuse services is of the highest possible quality within available resources. In partial fulfillment of this responsibility the Division developed a *Quality Improvement Plan for Monitoring and Accreditation of Area Programs*, January 1998. The plan goals are to assure:

- Area programs are operating in compliance with basic Medicaid requirements;
- Area programs are being managed effectively in fiscal, administrative, program and clinical domains; and
- Area programs that function, or plan to function, as managed care organizations demonstrate a capacity to do so.

The first purpose is to be addressed through the conduct of reviews of randomly selected Medicaid client and billing records.

The latter two goals are to be addressed through monitoring reviews. This manual is designed to guide Area Programs and Division staff in preparing for and conducting such reviews. The monitoring reviews will serve to satisfy Division review responsibilities contained in Section .0600 of the Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services, effective May 1, 1996. Additionally, the reviews are designed to be:

- an in-depth analysis of area program strengths, weaknesses and untapped capacities;
- a systemic assessment of the area program overall management and service delivery system; and
- an opportunity for collaborative efforts to develop a sound course of action to improve service delivery and client outcomes.

Description of the Review Process

The monitoring review process has three major phases:

1. Pre-site preparation, data collection and analysis;
2. On-site visits and interviews; and
3. Post-site evaluation, reporting and follow-up.

Representatives from each of the Division's service sections will comprise the review team. Team members will meet prior to each on site review visit to analyze Area Program data that have been collected by the Division and the Area Program.

Review team members will then meet on site with Area Program management and staff, clients and their family members (as appropriate), public and private agencies in the community, Area Board Members, County Commissioners, County/City Managers, other local government officials and others as determined by the pre site review meeting. Additionally, a Client Forum will be held during the on site visit to provide Area Program clients, advocates, and the public the opportunity to meet with and provide information to the review team. The Client Forum also will afford Area Program clients the opportunity to discuss their experience with services at the Area Program and to learn about advocacy groups such as the Alliance for the Mental Ill (AMI), the Association for Retarded Citizens (ARC), or the Alcohol and Drug Council of North Carolina (ADCNC).

After the review team has met on site, a post-review meeting will be held at the Division central office, where results of the on site review will be discussed, ratings assigned, and initial reports drafted, including a recommendation to the Division Director regarding the accreditation and managed care status of the Area Program. The final report and the Division Director's decision letter will be sent to the Area Program Director and Area Board Chair. Following receipt of the final report, the Area Program will submit any required corrective action plans to the Quality Improvement Branch for appropriate follow-up.

Monitoring Instrument and Development

The first efforts to conduct comprehensive reviews of this present type were initiated in November and December of 1997. Following the first reviews, the monitoring instrument was revised, resulting in the present *Standards for Monitoring and Accreditation of Area Programs* manual. This product is designed to highlight those processes and information that are needed for an Area Program to be accredited and to operate effectively within a managed care environment. Implicit in the development of the manual and monitoring process is the requirement that Area Programs maintain compliance with Division rules governing the provision of mental health, developmental disability, and substance abuse services for both area operated and contracted services.

Organization of the Manual

The Manual has four chapters and four appendices. The four chapters establish the general standards judged necessary for sound program functioning, regardless of the disability group served. The appendices contain disability section specific criteria, such as grant requirements, that must be met beyond the general standards.

Chapter One: Community Awareness and Responsiveness, focuses on the Area Program's community-at-large. The basic tenet here is that an Area Program must first be aware of the community that it is intended to serve if it is to be effective in the delivery of services. It is

recognized that community can be broadly defined in a number of different ways. Race, sex, age, employment, special populations, geography, public and private agencies and services are a few examples. But merely defining the community does not guarantee effectiveness of the service delivery system. The true value of the Area Program is ultimately determined by its responsiveness to the community.

Chapter Two: Clinical Services Management, directs monitoring attention toward key clinical service management components, including assessment, planning, service array and access, and assessment of client outcomes. The intent is to ensure that Area Program clients receive the full range of services necessary to meet their support needs, leading to improved functioning.

Chapter Three: Administrative Services Management, focuses monitoring efforts on the Area Program's demonstrable ability to integrate all management, fiscal, and data process functions in support of improved service delivery.

Chapter Four: Managed Care, contains standards that must be met prior to an Area Program beginning Carolina Alternatives (CA) and assuming lead agency responsibilities for Community Alternative Programs for the Mentally Retarded and Developmentally Disabled (CAP MR/DD).

Quality Improvement is viewed as critical to service delivery and the overall functioning of Area Programs. Therefore, each of the four chapters contains a specific standard regarding continuous quality improvement.

Rating System

During the review, individual team members will rate the Area Program on each standard reviewed. Reviewer judgments of Area Program achievement of the standards will be based upon pre, on site, and post-review information. Ratings will then be made using the six point rating scale depicted in Table I, below.

Table I

Non-functional	Inadequate	Limited	Adequate	Good	Excellent
1	2	3	4	5	6
Poor results, little if any evidence of adequate system functioning.	Fragmented, inconsistent, inadequate, implementation, incoherent with uncertain results (Hit or miss, don't understand why it works, when it works.)	Partial, intermittent, occasional, limited integration, limited implementation (Have basic understanding, but can't always make it happen.)	Services adequate for the average client. Have much more difficulty with complex clients.	Good, usually works well, services generally meet needs, good integration.	Excellent status/ results, optimal functioning.

After a rating is determined, the reviewer will note his/her justification for that particular rating, recommendations (if appropriate), and whether or not corrective action is required. A standard will be viewed as being met if it receives a score of 4 or above. Reviewers will make recommendations for any standard receiving a score of 4 or below.

CHAPTER ONE: COMMUNITY AWARENESS AND RESPONSIVENESS

EXPECTATION 1: ***The Area Program is guided by the needs of its community.***

1.1. The Area Program knows the composition of the community it serves.

The Area Program identifies persons who are in need of services. Collection and use of data such as catchment area demographics (e.g., race, sex, age, geographic distribution of the population) and special populations (e.g., at-risk, visually or hearing impaired, dual diagnoses, traumatic brain injury, and pregnant women) are examined along with the penetration rate into these identified populations.

What are the population demographics?

Data:	Source
1) Table of total catchment area population broken out by age, race, ethnicity, gender, and income;	AP
2) Table by county as above;	AP
3) Number of Medicaid eligible:	DIV.
• by county, race, ethnicity, gender; and	
• by capitation category (age/disability grouping).	

1.2. The Area Program is actively engaged in the identification of the needs of the community.

There are two components to this standard. The first component is a determination of the methods used by the Area Program to maintain an informed understanding of the *aggregate* needs of the community (e.g., inclusion of consumer groups and external providers). Second, this standard looks for evidence that the Area Program assesses for the following:

- Consumers with health risks that commonly accompany particular disabilities;
- Establishment and utilization of policies and mechanisms to include potential clients, family members, advocates, external providers, community law enforcement, human service and education agencies in the assessment of community needs;
- Housing or placement;
- Recidivism (including admissions to Area Program, inpatient services, State hospitals, ADATCs, Mental Retardation Centers, detox facilities, crisis facilities); and
- Employment.

Evaluation of this standard includes review of the Quality Improvement Plan and Quality Improvement Committee meeting minutes, management team meeting minutes; interviews with clients, family members, consumer and advocate groups, other agencies, and staff; examination

of DD Single Portal waiting list data; review of any past accreditation reviews or longitudinal studies that may have been done, QA/QI plans and annual reports; school and community-based data from needs assessments and prevalence surveys, community surveys, United Way surveys, social needs surveys; and Area Program comparison to national epidemiological data for diagnostic analysis.

1.2.a. The Area Program knows the composition of its clients served.

What is the demographic profile of the clients served?

Data:	Source:
1) Same data elements as in 1.1. for clients served, with respect to state-wide averages;	AP and DIV.
2) ICF/MR clients;	AP
3) Single Portal client and other tracking data; and	AP
4) Number and percentages of diagnostic categories by unduplicated count of clients served, including multiple diagnosis.	DIV.

1.2.b. The Area Program compares 1.1. and 1.2.a. to identify potential disparities in populations served.

Are there significant variances between overall population demographics and demographics of clients served that might indicate failure to serve portions of the population (access problems)?

Data:	Source:
1) Variance analysis between data in 1.1 and 1.2; and	DIV.
2) Variance analysis of Area Program diagnostic categories.	DIV.

1.2.c. The Area Program identifies and quantifies the service populations in the community.

What are the MH/DD/SA service needs in the community?

Data:	Source:
1) Prevalence data on Medicaid recipients, ED, SED, SPMI, Thomas S., Willie M., Traumatic Brain Injured, DD, SA, MI/SA by catchment area, by county, by rate/10,000;	AP

2) Waiting lists (DD and other); AP
3) Children's Consortium minutes (for last 6 months); AP
4) Interagency Council and Interagency Coordinating Council minutes (for the last 6 months); and AP
5) Copies of appeals and grievances (for the last 12 months). AP

1.2.d. The Area Program knows its penetration rates for various target populations.

What percentage of the various target populations are being served?

Data:		Source:
1) % of target population served	$\frac{\text{unduplicated clients served}}{\text{target population}}$	DIV.

1.2.e. The Area Program compares 1.2c. and 1.2.d. to identify potential disparities in populations served.

To what extent is the Area Program meeting the identified needs of the community?

Data:	Source:
1) Variance analysis of data in 1.2.c. and 1.2.d.	DIV.

1.3. The Area Program coordinates with local and state agencies to gather feedback on Area Program operations, promote program development, and improve services.

The Area Program demonstrates its efforts, successful or otherwise, to establish effective links and/or interagency agreements that clarify roles, identify and resolve problems, and coordinate service delivery and funding of services for clients. Typical agencies with whom linkages would be expected include Developmental Evaluation Centers (DECs), Health Departments, Departments of Social Services (e.g., Protective Custody and Foster Care Divisions), Magistrates' Offices, local law enforcement agencies (including juvenile services), local education agencies, local government officials, housing authorities, hospital emergency rooms, inpatient units, and State institutions. Examples of information to assess this standard would include: interviews with other agency staff; review of minutes and formal documents stemming from interagency and Developmental Disabilities Single Portal meetings; review of copies of applicable Memoranda of Agreement; review of QA/QI Plan and documentation of the QI problem identification and problem-solving activities (e.g. minutes, reports of findings, etc.), technical assistance report and Area Program annual report; and interviews with Area Program staff. Other agencies include private organizations, local organizations, and individuals who provide support such as the Association of Retarded Citizens, Interagency Coordinating Councils, Interagency Councils, and civic groups. The Area Program must have a letter of agreement and formal plan with local school administrative units (LEA's). These will specify

the provision of primary prevention programming and a means of referring youth from other human service organizations for the appropriate primary prevention programming.

What local interagency planning processes have been established to improve service delivery?

How complex is the interagency environment and how effectively does the Area Program deal with these agencies?

Data:	Source:
1) Listing and description of formal and informal interagency planning groups;	AP
2) Interagency minutes, formal reports, special studies, and needs assessments (for the past 6 months);	AP
3) Summary description of relationships with regional mental retardation centers Alcohol and Drug Abuse Treatment Centers and psychiatric hospitals;	AP
4) List of allied agencies which operate in the catchment area (e.g., DSS, Health Department, etc.); and	AP
5) List of agency representatives who serve on and attend interagency meetings.	AP

1.4. The Area Program provides information about services and programs.

This standard assesses the methods that the Area Program uses to publicize its services. This standard holds that a percentage of Area Program staff time is devoted to providing information to targeted and general populations in the catchment area concerning programs, eligibility, cost and other dimensions of available services.

- Information is designed for, distributed and/or posted at targeted agencies such as the Health Departments, Social Services Departments, court houses, schools, hospital emergency rooms, local law enforcement agencies, court officials, advocacy and consumer groups.
- Information is communicated in a manner that is understood by the citizens in the community (e.g., information is provided in Spanish and Braille and interpreters are provided as needed).
- Information discusses specific services, the range of services, how to access services, hours of operation, cost and payment of services, internal and external providers of services.
- Information informs people about the confidentiality of participation in services.

What steps has the Area Program taken to disseminate information about its services and avenues for consumer access to services?

Data:	Source:
1. Information as to how the Area Program publicizes its services to the community;	AP
2. Copies of public service announcements (radio and television spots, etc.); newspaper articles, pamphlets, flyers, brochures, and telephone directory listings; and	AP
3. Listing of public meetings, health fairs, interagency training events, etc. (for the	AP

last 12 months.)

1.5. The Area Program identifies areas needing improvement and demonstrates improvement in those areas.

This standard, as applied to Chapter One, evaluates the Area Program's Quality Improvement (QI) efforts to enhance the awareness of the Area Program's unmet/potential service needs and its response to these identified potential service needs.

Information considered when assessing this standard includes review of the QI Plan and its results, review of QI Committee minutes to determine if the Area Program is actively engaged in the identification of service needs in the community and, when needs are identified, implements problem-solving activities to address the needs. Additional ways to assess 1.5. include review of policies; staff interviews to determine their level of involvement and empowerment within the QI process; client and advocate group interviews; and examples of advertisements and public services announcements.

What systematic efforts has the Area Program undertaken to improve its understanding of community needs, its profile in the community, and its responsiveness to the community?

Data:	Source:
1) QI plan;	AP
2) Strategic planning documents developed within the last 2 years;	AP
3) QI committee minutes (for the last 6 months);	AP
4) Interagency Council minutes (for the last 6 months);	AP
5) Management team minutes (for the last 12 months);	AP
6) Area Board minutes (for the last 12 months);	AP
7) Children's Consortium minutes (for the last 6 months); and	AP
8) Single Portal client and other tracking data.	AP

1.5.a. The Area Program distributes resources in a manner that is responsive to community needs.

What percentage of the Area Program total budget is invested in each age disability category?

How does this compare to the percentage of each age/disability category in the total service population?

Data:	Source:
1) Area Program total budget and age disability budgets for the last fiscal year;	AP & DIV.
2) State, local and Medicaid expenditures (federal, state, and local shares) for last fiscal year by age, disability: • Rehabilitation Plan; • CAP-MR/DD; • CA; • CASPs.	AP & DIV.

1.5.b. The Area Program follows a planned strategy to target services toward high priority populations and the services they require.

Does the Area Program have and follow a plan designed to ensure that service resources are directed toward high priority populations and identified service gaps?

Does this plan include a strategy to address disparities identified in 1.2.b. and 1.2.e.?

Data:	Source:
1) Strategic planning documents developed in the last 2 years;	AP
2) Evidence the Area Program considered State disability planning documents in developing its strategic plan; and	AP
3) List of Area Program high priority populations to be served.	AP

CHAPTER TWO: CLINICAL SERVICES MANAGEMENT

EXPECTATION 2: ***The Area Program provides clients access to an array of services that are responsive to assessed and changing needs, promote client choice, are effectively integrated and coordinated, consistently monitored and improved to promote desired client outcomes, and ensure the protection of the health, safety, and welfare of the persons served.***

The standards described in 2.1 through 2.4 address the elements of the process for assessment and treatment of client needs. The elements are presented in a graduated framework which begins with assessments and progresses to development of treatment plans and services to respond to the client's needs. These standards are intended to review the *quality* of how these elements are performed/provided.

In subsequent sections, standards 2.5.a. through 2.5.g., the same elements of assessment and treatment are re-examined in light of the quantity and variety of services available through the Area Program to meet client needs.

2.1. The Area Program provides consistent, timely and comprehensive assessments of the service needs of individual clients.

This standard evaluates Area Program methods of determining individual client needs and looks at the breadth of the assessed needs. Client needs are determined by a comprehensive evaluation and diagnoses or multiple diagnoses.

Are assessments done in a timely manner with respect to Division standards?

Do clients consistently receive assessments which identify all relevant areas of service needs?

Data:	Source:
1) Logs of client contact and screening appointment assignments 24/7 at all service sites;	AP on site
2) Privileging and credentialing information on staff providing assessments, as a result of emergent, urgent, and routine presentations;	AP
3) Assessment policies, procedures, and protocols that ensure consistency in evaluations, including evaluations for multiple disorders;	AP
4) Intake forms and chart review;	AP on site
5) Waiting list data (DD and others);	AP
6) DD Single Portal plan and procedures; and	AP
7) Interviews with clients and/or family members.	AP on site

2.2. The Area Program consistently develops service plans that are responsive to the full range of assessed client needs and client determination of supports.

Service plans are developed with clients and, as appropriate, their family member(s) participating in person-centered planning.

What processes are used to determine who is invited "to the table" to discuss the treatment/habilitation needs of the client?

How is client choice factored into the process?

How are decisions processed when the client wants a service that is not in his/her best interest?

Data:	Source:
1. Interview case manager(s) and clients to determine degree of empowerment of case manager to act as a support broker/advocate for the client;	AP on site
2. Review of client records, randomly selected by each section; and	AP on site
3. Review of client records for Advanced Instructions (Senate Bill 757).	AP on site

2.3. The Area Program appropriately provides supports and services for clients as defined in service plans.

This standard assesses, based on the identification and breadth of client needs, what measures the Area Program is taking to provide those defined services.

Question: Are appropriate services and supports provided to clients?

Data:	Source:
1) Interagency Council minutes (for the last 6 months);	AP
2) Single portal plan and procedures;	AP
3) Reviews of plans, client observations and visits;	AP on site
4) Client outcomes;	AP on site
5) Evidence of integrated services of clients with co-occurring disorders (service plans, client and staff interviews);	AP on site
6) List of service needs not met (e.g., DD wait list or comparable data); and	AP
7) Client interviews.	AP on site

2.4. The Area Program consistently and periodically monitors services to determine client outcomes and modifies services and supports as needed.

This standard evaluates Area Program practices for evaluating the impact of services upon a client and making adjustments as indicated.

Has the Area Program established minimum standards for service plan review based on changes in the client's life, diagnostic categories, or other relevant clinical considerations?

Does the Area Program have a defined and systematic way of monitoring services, and is the frequency of individual service plan review and modification appropriate to client needs and preference?

Data:	Source:
1) Utilization review policy and procedures;	AP
2) On site reviews;	AP on site
3) Person centered treatment planning;	AP on site
4) Evidence of client/family participation in service planning;	AP on site
5) Client outcomes;	AP on site
6) Monitoring reports (for the last 12 months);	AP
7) Incident analyses (for the last 12 months);	AP
8) QI Plan; and	AP
9) Evidence of services being modified in response to problem identification and client outcomes.	AP

2.5. Available services (Area Program operated, contracted, and state facilities) are sufficient to respond to clients needs.

This standard evaluates the array and availability of services to clients.

The standards 2.5.a. through 2.5.g. are designed to examine the quantity of services available through the Area Program to meet client needs. The elements are descriptive of broad categories of service provision areas such as outreach and information/education, clinical evaluations, brief/time limited treatment, etc. Beneath each standard is a list of the variety of services that an Area Program *may* provide to address that standard.

The services that are listed with an asterisk are required by rule or block grant to be provided by the Area Program. It *is* expected that all Area Programs are providing these required services. It *is not* expected that every Area Program will provide every other service.

In examining an Area Program's readiness to participate in the managed care environment, the variety of services that is already in place will be considered significant. An Area Program may assume that it is advantageous to provide an array of services, as described in the list, or functionally equivalent to those listed.

Is the array of services, and the service capacity within that array, sufficient to meet the needs of the service populations?

Do service utilization patterns and waiting list data indicate that clients are receiving sufficient quantities and choice of services?

Data (1-5 are to be broken down by gender and race):		Source:
(1) The array of services, units provided, and numbers served;		DIV.
(2) Average units/10,000 population	$\frac{\text{total service units by service}}{\text{total population}}$	DIV.
(3) Average units per client served by type of service	$\frac{\text{total service units by service}}{\text{unduplicated clients by service}}$	DIV.
(4) Percentage of clients by type of service	$\frac{\text{unduplicated number receiving service}}{\text{total unduplicated in age/disability}}$	DIV.
(5) Percentage of population by type of service	$\frac{\text{unduplicated \# receiving service}}{\text{total population by age disability}}$	DIV.
(6) Measures of access of service components fall within access standards in the Access Targets;		AP on site
(7) Client satisfaction survey results-State and/or Area program-in last 12 months;		AP
(8) Area Program determined Client Outcomes data;		AP on site
(9) On-site reviews; and		AP on site
(10) Waiting lists (DD and other).		AP

2.5.a. The Area Program has the capacity and provides outreach, information and education to, and collaborates with, other agencies, families, and people with service needs.

Assertive Outreach	Seek out and engage people who are at high risk for multiple crisis events, including inpatient hospitalizations, and for substance abuse those at risk for infectious disease (e.g., follow-up contact with referrals; and with people being discharged from hospitals).
Consultation/education*	Provide consultation and education to other agencies.
Case consultation	Receive input and incorporate it by working in partnership with other professionals outside the area program who provide services to high risk clients.
Alcohol & Drug Education Traffic School*	Provide ADETS per 10 NCAC 14V .3800.
Drug Education School*	Provide DES per 10 NCAC 14V .3900.
Substance Abuse Primary Prevention*	Conduct a broad array of prevention strategies for individuals not identified to be in need of treatment as per 45 CFR Part 96.125 and listed in MOA with Division.

2.5.b. The Area Program has the capacity and provides clinical evaluations, service plans and transitional services.

Screening*	Initial screening/triage available by experienced clinical staff and for substance abuse clients screening for infectious disease, including but not limited to, tuberculosis with state approved protocol and for gender specific issues.
Evaluation*	Evaluate biopsychosocial needs of client including medication and treatment; those with multiple disorders and/or supportive service needs, and for substance abuse clients infectious disease status and gender specific issues.
Treatment/Services or Habilitative Planning*	Develop appropriate clinical treatment/service or habilitative plans (e.g. measurable, timely, family & client - center/involvement , etc.); and for women substance abuse clients inclusive of gender specific treatment.

Transitional Services	Provide or assist children and adults who are in transition to have safe, affordable housing, to refer to employment opportunities and to assist them with vocational goals, and to gain skills needed for successful community functioning (home, school, other). *NOTE: While this is not a required service, it is viewed as being necessary for coordinated care and access to transitions in/out of service.*
Tuberculosis Services for Substance Abusers*	Referral, coordination, service provision and tracking for tuberculosis in substance abusers either directly or through arrangements with qualified providers per 45 CFR Part 96.127 and listed in MOA with Division.

2.5.c. The Area Program has the capacity and provides appropriate time limited prevention, intervention, and treatment for clients of all ages/disabilities whose needs are less intensive and short term.

Outpatient treatment*	Providers/staff trained and privileged to provide short term individual and group treatment and for all ages and disability groups.
Detoxification*	Provision of, or arrangement for, appropriate detoxification services matched to the level of need of the client.
Day Treatment / Intensive Outpatient Treatment	Provision of intensive programming including, but not limited to, psychoeducational group activities and group therapy matched to the level of need for all clients.

2.5.d. The Area Program has the capacity to implement service plans and provide a range of services, including intensive levels of services that divert unnecessary out-of-home treatment/care, or hospitalization for adults with developmental disabilities, serious, long-term mental illness, chronic disease and/or multiple diagnoses, that enable them to maintain treatment gains and successfully live in the community.

Outpatient Treatment*	Medication management; individual and group therapy; intensive outpatient SA services; habilitation services; and services that meet the multiple needs of people, including gender specific treatment for substance abusing women.
Case Management*	Provision of case management with the extent/intensity determined by the client's needs.

Client Behavior Intervention (CBI)	Provide individual or group approaches that enable individuals to learn appropriate skills/behaviors and provide supports needed for successful functioning, and for substance abusing women gender specific treatment.
Partial Hospitalization*	Provide intensive treatment including medication and therapy.
or	
Psychosocial Rehabilitation*	Opportunities to regain skills needed for successful community functioning.
Supported Housing	Provide or assist clients to have safe, affordable housing. Provide level of support needed.
Supported Employment	Provide or refer clients to employment opportunities and to assist them with vocational goals. Provide long-term support.
Assertive Community Treatment Team (ACTT)	Provide a full range of services to clients who have had multiple hospitalizations and/or who have not responded to office/facility based services.
Inpatient Services*	Provide or arrange inpatient treatment for all clients, including gender specific treatment for substance abusing women.
Day Treatment/ Intensive Outpatient Treatment	Provision of intensive programming including, but not limited to, psychoeducational and group therapy matched to the level of need for all clients.

2.5.e. The Area Program has the capacity and provides a range of services, including more intensive levels of services that divert unnecessary out-of-home treatment/care or hospitalization, for children and adolescents who need on-going assistance maintain prevention, intervention, treatment and habilitation gains and live successfully in the community.

Case Management*	Provision of case management with the extent/intensity determined by the client's needs.
Outpatient Treatment*	Medication management, individual, group and family therapy; intensive outpatient SA services, habilitation services and services that meet the multiple needs of children with co-occurring disorders, personal care and utilization of existing community supports and services.

Client Behavior Intervention (CBI)	Provide individual or group approaches that enable an individual to learn appropriate skills/behaviors and provide supports needed for successful functioning.
High Risk Intervention-Periodic (HRI-P)	Provide individual or group prevention, intervention, and/or treatment to children who are at high risk of developing or increasing the degree of mental health, substance abuse, developmental problem or other co-occurring disorder. This includes providing education/training to caregivers, service providers, and relevant others.
Partial Hospitalization	Provide intensive treatment including medication and therapy.
Day Treatment	Provision of intensive programming including but not limited to psychoeducational and group therapy matched to the level of need for all clients.
High Risk Intervention-Residential (HRI-R)	Provide HRI in the context of residential treatment.
Inpatient Services*	Provide or arrange inpatient treatment and facilitate transitions into and out of the community for all clients.

2.5.f. The Area Program has the capacity and provides 24/7 immediate screening and assessment of presenting problems as well as crisis stabilization services for all ages/disabilities.

Crisis/Emergency Services*	24/7 toll free number as well as crisis calls received through other Area Program numbers during regularly scheduled clinic hours.
Timely crisis telephone response	Toll free number is answered by a person within four rings.
Triage	Timely and clinically competent triage is provided 24/7 by a qualified professional within 15 minutes from when the initial call is received or within 15 minutes from when the client presents in person for services.
Assessment/evaluation	Timely and clinically competent face-to-face assessment that results from triage for emergent, urgent, and non-urgent/routine client service needs.

Crisis Stabilization Services	Must provide access to hospital inpatient and for clients of all ages and disabilities who cannot be safely treated in a less restrictive environment, at least one alternative to more intensive, inpatient services or other out-of-home care/treatment. Example: Immediate in-home CBI; HRI-P; 23-hr., observation; immediate short-term respite; family preservation; crisis stabilization facility; crisis appointment; detox services; host homes; and mobile outreach services.
Capacity management for pregnant substance abusing women and Intravenous Drug Abusers*	Provision of, or referral to, gender specific and intravenous drug services through the respective statewide capacity management programs as per 45 CFR Part 96.124 and 126 and listed in MOA with Division.

2.5.g. The Area Program has the capacity to provide crisis response, crisis intervention, and relapse prevention services to identified high-risk individuals of all ages/ disabilities, including those with co-occurring disorders. These services are developed and based on accepted standards of practice for clients with co-occurring disorders.

Specialized traditional services that are integrated and focused to meet the needs of "high-risk" clients may include integrated services which have a special focus on serving individuals who fall into the following diagnostic categories:

Adults	MI/SA; MI/MR; MI/MR/SA.
Minors at-risk for/with a typical/atypical development	SED/SA; SED/MR; SED/DD; SED/MR/SA; co-morbid Axis III; hearing impaired and other high risk categories.
Treatment matching for substance abuse clients.*	Provision of or arrangement for treatment services matched to meet the needs of clients as per 45 CFR Part 96.132.

2.6. Services (Area Program, contracted, and state facilities) are sufficient to permit an adequate array which promotes client choice.

This standard looks at the service network. The essential feature of this standard is that there must be an array of services that not only meets clients' needs, but also supports clients choosing services and providers. The absence of a particular element may be critical to an Area Program

unless the service strategies provide for client alternatives. The Area Program must describe how to deal with specific examples.

Evaluation of the array of services includes client, family member and staff interviews; lists of available services, public and private service providers and information about the providers; review of Area Program policies and procedures related to client choice of services and providers; and an assessment of how choice is offered.

Evaluation of how the Area Program supports client choice of services and providers includes consideration of the following:

- The unique needs of the client (e.g., Is the client visually or hearing impaired? Does the client speak only Spanish? Is the client Native American?);
- Provider profiles;
- Explanation of MH/SA benefits;
- Determination of costs and methods of payment for services;
- Hours of operation;
- Services available;
- Who provides the services;
- Can the service sites be visited prior to receiving services;
- If receiving services outside of the Mental Health Center, how does the client access them;
- Procedures for having questions answered;
- Grievance and appeals process and how is it accessed;
- Rights of client;
- Confidentiality;
- Client satisfaction with services and provider data;
- Active recruitment of providers; and
- Transition from hospital to less intensive/restrictive services.

Does the Area Program have a sufficiently broad service array and an adequate number of providers to offer clients meaningful choice of providers and services?

Does the Area Program actively recruit providers of services when services are identified?

Does the Area Program have a procedure to ensure client choice?

Data:	Source:
1) Service array;	AP & DIV.
2) Percent of clients and population who receive specific services;	DIV.
3) Number of providers by type, utilization and location;	AP
4) Services provided by location;	AP
5) Client choice documented in records;	AP on site
6) Local client choice policy;	AP

7) Interagency Council minutes (for the last 6 months);	AP
8) Area Program determined Client Outcomes;	AP
9) Medical staff meeting minutes (for last 6 months); and	AP
10) Medical Director's curriculum vitae.	AP

2.7. Coordination of services within the Area Program

This standard seeks to determine the general level of success that the Area Program has achieved in developing and coordinating services, both area operated and contracted, that form a continuum of care. Such a continuum incorporates cross-disability planning, services for persons with more than one disability, and use of waiting lists. There should be minimal instances of people waiting for services, or providers not receiving referrals, due to coordination issues within the Area Program. Support for such a continuum is evidenced by the Area Program shifting and making resources available to meet client needs, and by staff knowledge and utilization of such resources. There is coordination among age and disability service units to provide appropriately credentialed and privileged back-up clinical supports 24/7.

Evaluative methods include demonstration by the Area Program of a continuum of services; interviews with clients, family members and staff; and review of policies and procedures, including those for evaluation and authorization for State hospital admission, coordination of treatment including medications, discharge planning and community follow-up.

How does the Area Program plan and coordinate services for clients with co-occurring disorders?

How does the Area Program plan and coordinate services with clients who have multiple service needs and are within one age/disability category?

How does the Area Program coordinate transitional services from child to adult; when funding eligibility is gained or lost; when a client is entering/exiting a hospital setting; or when changes in treatment intensity are necessitated?

How does the Area Program coordinate services for clients when the service is outside of the catchment area?

Data:	Source:
1) Copy of Area Program policies and procedures regarding coordination of services;	AP
2) Summary report on provider training in cross-disability service provision offered in the last 12 months;	AP
3) Case manager staffing (i.e. number of full-time employees), number and percent who receive case management, average unit of case management per client served and per population;	AP & DIV.

4) Case manager case load and productivity (for last 6 months);	AP
5) Review of service plans and notes;	AP on site
6) List of, and plans for, clients served outside of the catchment area;	AP
7) Single portal plan;	AP
8) On-site interviews;	AP on site
9) Plans for, and evidence of, monitoring service coordination;	AP
10) Review of intervention for clients with co-occurring disorders and other special needs;	AP on site
11) Area Program determined Client Outcomes; and	AP
12) UCR Report.	DIV.

2.8. Access

This standard defines and evaluates access for all clients in terms of entry into the system, movement among various services, and convenience in hours of service delivery.

Except as noted below*, this standard requires the following:

* Exceptions: (1) SA-TASC: Rule .4003, Operations, mandates a client be seen within 48 hours of assessment;
(2) Willie M. Rules require:
(a) provision of needed services immediately, if available;
(b) development and provision of new, non-residential services within 30 days of need identified;
(c) development and provision of needed residential;
(d) service consistent with timetable agreed upon with Treatment/Habilitation Planning (T/HP) team; and
(e) timely completion of Willie M. applications (within 30 days of receipt from referral source.).
(3) For children under three eligible for early intervention the evaluation must be completed and the Individual/Family Service Plan (I/FSP) developed within 45 days from referral. Services must be started within 30 days of (I/FSP) development; and
(4) Developmentally Disabled clients are subject to Single Portal entry/exit guidelines, including emergency component.

1) Timeliness: Entry into the service system is quick, easy, and convenient.

2) Assessment Timeliness. The maximum length of time from request of services to the first face-to-face meeting with an appropriate professional who has access to service specific back-up:

a) Emergency: Within 1 hour
b) Urgent: Within 48 hours.
c) Routine: Within 7 calendar days.

3) Initial Treatment Timeliness. The maximum length of time from first face-to-face meeting with an appropriately privileged professional to start of treatment:

a) Urgent: Within 48 hours of assessment.
b) Routine: Within 14 calendar days of assessment.

Compliance with 2.8.1-3 above is based on the following:
a) Summary description and organizational chart of 24/7 Crisis Services;
b) Copies of the publication of the toll free numbers;
c) Schedules of 24/7 Clinical back-up;
d) Tracking log for 24/7 crisis calls;
e) Contact sheets for each caller referred for phone triage that allows calculation of length of time between phone triage and face to face assessment for emergent, urgent, and non-urgent/routine response;
f) Division monitoring team calls to toll free crisis number; and
g) Interviews with clients, their families, and significant others.

4) Continuity Of Care Timeliness:
a) Post Discharge Follow-up. Within 5 days. Refers to the average length of time from discharge from an intensive level of care (e.g. inpatient, crisis service, etc.) to initiation of follow-up care by a less intensive level of care or outpatient therapist.

b) Interservice Timeliness. Waiting times are reasonable, within 1 standard deviation of state average. Refers to the average length of time from referral/request to entry into a specialized MH/SA or DD service in the essential service array (e.g. residential treatment, day treatment, family preservation, etc.). Transition between services occurs within clinically acceptable time frames.

*Exception: Standard for DD clients is defined in G.S. 122C-63.

Note: The above four items should be measured two ways: (1) average length of time in the sample, and (2) percent of cases in the sample that fall within the time standard. Note: All days referenced above are calendar days. For 2nd measure, compliance with timeframe occurs in 90% of the cases.

5) Convenient Hours:
The Area Program will operate with convenient hours and offer appointment times that are convenient to clients.

A measure of convenience will be the percent of total scheduled routine appointment hours that are offered after hours or on weekends (after 5 PM and before 9 AM on weekdays, or on Saturdays or Sundays). One target measure is that 25% of appointment hours for outpatient services are available other than 9 AM - 5 PM weekdays.

Crisis calls to the Area Program are addressed according to the following:

1. Toll free phone number is available 24/7;
2. Toll free number is answered by a person within four rings;
3. Telephone triage is begun by a Qualified Professional within 15 minutes from when the call is received (95% of the time);
4. Back-up clinical supports are available to the Qualified Professional doing phone triage and face-to-face assessment.

Data:	Source:
1. Summary description and staffing schedules for 24/7 Crisis Services;	AP
2. Copies of the publication of the toll free phone numbers;	AP
3. Schedules of 24/7 clinical back-up;	AP
4. Tracking log for 24/7 crisis calls and walk-in clients that receive crisis triage;	AP
5. Contact sheets for each caller who received phone or walk-in triage that calculates length of time between phone triage and face-to-face assessment for emergent and urgent crisis response;	AP on Site
6. Documentation in clinical record showing dates of assessment, treatment, referral and discharge from each service component that allows calculation of treatment and continuity of care timeliness;	AP on Site
7. Policies and contracts regarding local Emergency Rooms, inpatient services and access to ERs;	AP
8. Division monitoring team calls to toll free crisis number; and	AP on Site
9. Interview of clients, their families, and significant others.	AP on site

2.9. The Area Program provides clients with information on services and programming.

This standards evaluates how the Area Program provides clients with information that they need in order to actively participate in their care.

How does the Area Program provide information on services and programming?

Is this information adapted to special populations (e.g. Spanish speaking, hearing or visually impaired, etc.)?

Data:	Source:
1. Toll free number;	AP
2. Client information packages, brochures and pamphlets;	AP

3. Immediate access to a person by phone;	AP
4. Evidence of efforts to educate clients, client advocacy and self-advocacy groups during the last 12 months;	AP
5. Compliance with procedures outlined in the Single Portal process; and	AP on site
6. Client interviews.	AP on site

2.10. The Area Program utilizes existing natural supports and generic resources to address client needs.

This standard holds that, when possible and with appropriate consent, the Area Program encourages and involves the client's family and friends in the treatment/habilitation process. It also links the client with community groups such as places of worship and community support groups such as AA, NA, community advocacy and self advocacy groups. The Area Program supports existing family support groups and encourages the formation of others, thus building and using community-based services whenever appropriate. Efforts to utilize existing natural supports may be indicated by signatures on the service plan.

Data:	Source:
1. Client, family and staff interviews;	AP on site
2. Review of Screening/Client Profile;	AP on site
3. Review of Service Plans and Service Notes; and	AP on site
4. List of commonly used generic resources in the community.	AP

2.11. Treatment and habilitation facilities help people feel safe and comfortable.

This standard holds that all therapeutic and habilitation environments are conducive to effective treatment, including respect for client dignity and safety. It evaluates whether or not the facility offers appropriate space for privacy and the delivery of therapy sessions and services; meets the accessibility standards and requirements of the Americans with Disabilities Act and related State requirements; is maintained in accordance with community norms for cleanliness, safety and repair; and satisfies reasonable environmental expectations of both clients and staff.

Assessed by on site review.

2.12. Clients are satisfied with services.

This standard assesses the level of client, and when appropriate family, satisfaction with the services received and with the providers of those services. In addition to reviewing the results of the satisfaction survey, the number and kind of client and family complaints, grievances, results and the minutes of client rights committee meetings will be examined.

What percentage of clients are satisfied with services?

Data:	Source:
1. Client satisfaction survey results -State and/or Area Program -in last 12 months;	AP
2. ADA accessible facility;	AP on site
3. Appeals and grievance reports (for last 12 months);	AP
4. Client interviews; and	AP on site
5. Results of client forum.	AP on site

2.13. The Area Program identifies areas for improvement and demonstrates improvement in those areas.

As applied to Chapter Two, this standard evaluates Area Program quality improvement (QI) efforts to continuously identify and improve upon problem areas within the clinical services management system.

In assessing the standard, the Area Program QI efforts are reviewed for a number of components:

- Existence and use of an active QI plan;
- Clients, family/guardian and others, as appropriate, are involved in identifying needs;
- Line staff are involved in problem identification and resolution;
- Resolutions are implemented and monitored;
- Services are reviewed to determine the appropriateness and adequacy of treatment;
- Services and service providers;
- Demonstrated competence of external and internal providers according to applicable standards of practice in delivering client services; and
- Identification and monitoring of utilization to improve practices.

Does the area program continuously improve its service delivery system, consumer outcomes, and administrative/organizational operation?

Data:	Source:
1. Evidence that the Area Program reexamines the service array to identify service needs, strengths and deficits of its service system, and has a plan for appropriate enhancement of the service system;	AP
2. Client and staff interviews;	AP on site
3. Privileging and credentialing documentation; and	AP on site
4. QI committee minutes (for last 6 months).	AP

CHAPTER THREE: ADMINISTRATIVE SERVICES MANAGEMENT

EXPECTATION 3: ***In meeting client needs, the Area Program uses responsible business practices which foster sound fiduciary decision-making, communication, planning, problem solving, quality assurance and improvement, and protection of client rights throughout services delivery.***

3.1. The Area Program will comply with all operational requirements.

This standard evaluates Area Program compliance with operational and related requirements such as: Federal regulations, General Statutes, Commission and Secretary rules, memoranda of agreement, court orders, Division requirements, and other applicable rules (e.g., Division of Medical Assistance).

3.1.a. Memorandum of Agreement with the Division
The Area Program shall provide evidence that it is complying with the MOA.

3.1.b. Expansion Funds
The Area Program shall provide evidence that it is complying with requirements of expansion funds.

3.2. Effective integration of Area Program clinical, business and administrative functions results in problem identification and resolution.

This standard requires the demonstration of intra-organizational communication that results in identifying and solving operational problems in an efficient and effective manner. Staff at all levels are viewed as being stakeholders and contributors to this process; therefore, they should have at least a knowledge of the organization layout and how the various departments of the organization fit and work together.

Evaluation of the standard includes review of the QI Plan, Management Team and QI Committee minutes, interviews with staff, evidence of an effective MIS and sharing of information, and evidence of fiscal staff receiving Pioneer information.

3.3. The Area Program is fiscally responsible.

This standard holds that the Area Program must have a sound financial management and reimbursement system which has the following characteristics:

1. No outstanding fiscal control issues that would indicate an inability to function fiscally;
2. Internal control system for claims processing and payment; prior to payment, verifies client Medicaid or other insurance eligibility, a valid contract, that contract requirements have been met, and third party payment has been received (if applicable);
3. An established system for billing that ensures payment of invoices in a timely manner and in accordance with contract requirements:
    - Payment is made only when a valid contract exists and contract terms have been met;
    - Necessary staffing and procedures to process and pay invoices to contract providers;
4. Established method of documentation and monitoring to support billing;
5. Mechanisms for coordinating benefits and collecting third-party payments and maximizing revenue from other sources;
6. Timely submission of required reports, including cost findings and volume of service reports:
    - Processes for gathering data to complete required financial and workload reports;
7. Allows creativity in resource utilization and funding of services;
8. Provides clients with information regarding methods for paying for services and expectations for payment:
    - Answers client questions about account balance;
    - Resolves client complaints related to billing in a timely and respectful manner;
9. Expansion funds are used in accordance with Legislative/Division expectations;
10. Single audit reports:
    - Audit report and management letter from past two years that indicates acceptable internal fiscal controls, and that corrective action was taken;
11. System to identify clients who are eligible for other funding sources, and to indicate payment priorities for clients with multiple funding sources;
12. Plan for budgeting funds, tracking costs, avoiding overstating costs and revenues, and serving as both payer and provider. Plan includes how the Area Program will pay itself for services provided and how it will pay contract providers;
13. Evidence that funds are directed and redirected to newly identified client needs; and
14. Evidence that program/service managers are knowledgeable of fiscal issues.

Does the area program maintain effective and responsible control over revenues and expenditures?

Do program/service directors know their budget, how to do a budget revision, and their role in working with contractors?

Data:	Source:
1) Division fiscal report (for last two fiscal years);	Controller's Office
2) Single audit report (for most recent fiscal year);	AP
3) Interviews (e.g. County Manager, clients, etc.);	AP on site
4) UCR lists;	AP
5) Revenues and revenue adjustments (for last fiscal year); and	AP
6) Medicaid payments by "Y" code.	DIV.

3.4. The Area Program has a system for gathering and coordinating information.

This Standard requires that the Area Program have an established method and tools for data collection and coordination that is capable of maintaining and providing case load data, utilization, financial claims processing, eligibility checking, contract monitoring, credentialing and privileging, and quality improvement information.

Does the Area Program have a system for gathering relevant MIS data?

What data is collected for this system?

How is this data processed?

Who receives this data, and how is it used to improve services?

Data:	Source:
1. Client: • Who is being served; • Repeat users of crisis services, including inpatient; • Diagnostic data; and • Waiting lists information.	AP
2. Services: • Volume of services.	AP
3. Quality Improvement: • Timeliness of crisis response, crisis stabilization interventions, and service delivery; • Program performance indicators; • Client outcomes; • Client satisfaction; • Credentialing/privileging; and • Client rights, incidence, appeals and grievances.	AP

4. Management: AP
   - Current Area Program organizational chart;
   - List of all Area Program positions and personnel (full and part-time), arranged by major organizational unit (linked to the above organizational chart), and showing position or working title, employee name and date of initial hire;
   - Staff productivity;
   - Provider contracts;
   - After hours service utilization;
   - State Hospital, Alcohol and Drug Addition Treatment Center, and Mental Retardation Center utilization; and
   - History of success in completing special projects.

5. Samples of MIS reports. AP

6. Routing pattern for MIS reports. AP

7. Use of reports in service management. AP

3.5. Providers, both internal and external, understand the mission and expectations of the Area Program regarding the services they are to provide.

This standard highlights the responsibility of the Area Program to develop orientation and ongoing processes that consistently afford internal and external providers information on the following areas:

- The Area Program mission;
- Description of services;
- Service availability within the Area Program;
- The Area Program appeals and grievance process;
- Client Rights;
- Confidentiality;
- Contract requirements;
- The privileging and credentialing process;
- Documentation requirements;
- QI and providers role within the development and implementation of the QI Plan;
- Risk management efforts; and
- Communiqués and routine newsletters.

Do Area Program and contract staff understand and practice in a manner consistent with the agency mission?

Data:	Source:
1. Internal and external training calendar and attendance;	AP
2. Area Program newsletters for internal and external providers;	AP
3. Internal and external provider orientation program materials; and	AP
4. Current provider manual.	AP

3.6. The Area Program seeks and is responsive to external provider input

This standard examines how external providers are afforded opportunities for input into the Area Program planning process and the results of such input.

How are providers involved?

Is input accepted?

How is provider input used?

Data:	Source:
1. Interviews with external providers; and	AP on site
2. Interviews with administrative staff.	AP on site

3.7. Consumer and advocacy groups are involved in Area Program policy development

This standard assumes that consumer and advocacy groups are, where appropriate, involved in the design, implementation, and policy development of the Area Program service system. Involvement may include serving on committees or participation in other areas such as the following:

- Client Rights;
- Appeals and grievance process;
- Needs identification process;
- Range of services;
- Range of providers;
- Client Satisfaction;
- Client outcomes;
- DD Interagency council; and
- Area Board.

Does the area program systematically involve consumers and advocates in the decision making process?

Data:	Source:
1) Review advisory committee minutes, including IAC (for last 6 months);	AP
2) Lists of consumers and advocates on planning and administrative committees; and	AP
3) Client Rights Committee membership and minutes (for the last 6 months).	AP

3.8. The Area Program ensures the protection of client rights.

This standard holds that one demonstration of good client care is evidenced through practices that serve to ensure that clients maintain and exercise their rights. Such practices include the following efforts:

- Distribution and explanation of client rights pamphlets;
- Establishment of an active Client Rights Committee with disability appropriate composition;
- Minutes from Client Rights Committee meetings that include descriptions of the cases and grievances heard, decisions made, and disposition;
- System to review client incident trends that feed into quality improvement; and
- Efforts at oversight of rights restrictions and restoration of rights.

Does the area program actively promote the observance of clients rights standards?

Data:	Source:
1) Client Rights policy;	AP
2) Client Rights Committee membership and minutes (for last 6 months);	AP
3) Visibility of information and materials; and	AP on site
4) Consumer sign-off.	AP on site

3.9. The Area Program identifies areas for improvement and demonstrates improvement in those areas.

As applied to Chapter Three, this standard evaluates Area Program QI efforts to continuously identify and improve upon problem areas within the management of Administrative Services. The result of these efforts is the assurance of quality services. Assessment of this standard occurs on a number of fronts, each of which is assumed to be actively addressed in the Area Program's QI Plan.

3.9.a. Quality Assurance

The Area Program must have a system to monitor providers, contracts and services for quality of care, adequacy of documentation, and contract compliance. This includes the review of staff training records and certifications.

The Area Program must establish and maintain a system to protect client records from inappropriate disclosure. The system must comply with all applicable State and Federal laws and regulations, including 42 CFR Part 2 and shall include: (a) provisions for employee education on the confidentiality requirements; and (b) establishment of disciplinary sanctions upon inappropriate disclosure.

Data:
1. Monitoring of organizational and client service processes; and
2. Fiscal monitoring.

Staff
1. Internal provider turnover;
2. Internal provider retention;
3. Internal provider recruitment;
4. Compliance with County, State, and Federal hiring and dismissal requirements, (e.g., EEO, ADA, etc.);
5. Internal provider orientation and training;
6. Privileging and credentialing; and
7. Internal provider productivity.

Participation
1. Established QI Committee (QIC);
2. QIC member training;
3. Inclusion of staff, external providers, and consumer and advocacy groups in the problem identification, resolution, follow-up process, and policy development and implementation; and
4. Data collection, interpretation, and utilization.

Management
1. Contracting;
2. External provider orientation and training;
3. Protection of client rights; and
4. Accountability

3.9.b. Quality Improvement

The Area Program shall monitor reports on tracking of process and clinical outcomes, QI activities and self identified "problematic" outcome measures. Measures of services process outcomes and clinical outcomes established for performance expectations are systematically

collected, reviewed, and incorporated into the QI plan. There are privileging requirements for staff, including criteria for serving clients with multiple disorders. There is evidence of training with particular attention to cross-training of staff responding to clients of all ages and disabilities.

The Area Program opens participation in the network to all qualified internal and external providers who meet published Area Program requirements.

- Mechanisms are in place that solicit provider input for changing the clinical services management system.
- Coordination with other local and state agencies is carried out in providing and funding services.
- Clinical competencies are demonstrated that can lead to desired outcomes for all clients identified.
- Training or remediation are made available to staff that can lead to desired client outcomes.
- There is an effective peer review and consultative process for staff.
- There is consistent practice among all staff of protecting client rights and adhering to disability specific confidentiality laws.
- There is monitoring of benchmarks for providing an array of services, access to services and client choice.
- There a list of high-risk clients by categories that include, but are not limited to Willie M., MI/SA, MI/MR, MI/MR/SA, SED/SA, SED/MR, SED/MR/SA; and co-morbid Axis II diagnosis.
- There is on-going monitoring of organizational and client service processes (from intake to discharge).

Has the area program developed an organization wide QI system which involves all levels and categories of staff in a comprehensive effort to identify and define improvement targets, to implement change strategies within all areas of organizational operation, to gather data on the status of improvement efforts, and to systematically analyze and report on the outcomes of this process?

Data:	Source
1. QI Plan;	AP
2. QI Committee minutes (for last 6 months); and	AP
3. Other Area Program reports and analysis of QI data.	AP

CHAPTER FOUR: MANAGED CARE

In addition to the standards in the previous Chapters, the standards in this Chapter must be met prior to an Area Program beginning Carolina Alternatives (CA) and assuming all lead agency responsibilities for Community Alternative Programs for the Mentally Retarded and Developmentally Disabled (CAP MR/DD).

EXPECTATION 4: ***In order to implement Carolina Alternatives or the proposed changes in CAP MR/DD, an Area Program must demonstrate that it is able to meet the intent of and comply with specific requirements of the waiver and has put in place the necessary procedures, systems and infrastructure to successfully operate (under) a managed care service system.***

4.1. The Area Program has a strategic plan for operating under a managed care resource service system.

Area Program leadership and staff have a good understanding of the waiver and have developed an effective plan for organizing and operating a managed care service system under the waiver.

Have Area Program Board members been adequately informed about and understand CA or CAP MR/DD?

Does the Area Program have a vision for operating a managed care organization, and has the Area Program developed a strategic plan for implementing CA?

Will the Area Program serve as the managed care organization (MCO)? If not, who will do it?

How will the Area Program organize itself to operate under managed care?

Has the Area Program hired the staff it will need and effectively organized itself to successfully implement the waivers?

Do staff understand the waivers, the Area Program's approach and their role in providing a comprehensive, well managed, cost-effective system of community-based mh/dd/sa services to clients?
Do staff understand the importance of effective clinical management (meaningful assessments and treatment plans, appropriate services, care coordination, utilization management)?

Data:	Source:
1. Area Program Board minutes for the last 12 months;	AP
2. Area Program strategic plan within the last 2 years;	AP
3. Staff training materials and meeting minutes;	AP
4. Organizational charts documenting functions;	AP
5. Staff and provider interviews; and	AP on site
6. Contract agreements with other agencies/organizations regarding the waiver operations.	AP

4.2. The Responsible County Government understands CA and is supportive.

Has the Area Program explained CA to county officials, the requirements for operating CA, and any potential risks and liabilities?

Do county officials understand CA, and are they supportive of the Area Program's operation?

If the Area Program is a single county program, has it developed agreements or memoranda of understanding with its county government to ensure the Area Program has the necessary resources and operational support (e.g. fund balance, MIS, contracting, claims processing, staffing) to enable it to successfully manage a full-risk capitation system?

Data:	Source:
1. Correspondence, meeting minutes, memos, or other evidence of communication between the Area Program and county officials;	AP
2. Agreements or memoranda of understanding between Area Program and county government in single county Area Program; and	AP
3. Signatures of county officials on contract between Area Program and Division on the CA contract.	AP

4.3. The Area Program has an effective transition plan.

Area Program has an effective transition plan that ensures the continuity of care for clients.

Does the Area Program's transition plan include and satisfactorily address the following?

- An effective mechanism for identifying eligible Medicaid recipients prior to CA implementation who are receiving MH or SA treatment from a provider other than the Area Program and are likely to continue to need treatment after CA implementation;

- An effective mechanism for identifying eligible Medicaid applicants and recipients following CA implementation who are receiving MH or SA treatment from a provider other than the Area Program or a CA network provider who are likely to continue to need treatment after CA implementation;
- An effective mechanism for informing recipients and providers about care management and authorization requirements and their options for receiving services;
- Arrangements for handling and responding to questions and concerns from (prospective) clients and providers;
- A mechanism for inviting non-approved providers to become a part of the provider network to ensure continuity of care for clients;
- A mechanism for entering into short-term or one-time contracts with private providers outside the CA provider network who do not desire or do not qualify to participate under CA in order to allow clients to either complete their treatment or to smoothly transition to an Area Program or CA network provider, whichever is most appropriate;
- A mechanism for early identification of recipients receiving services who (1) are anticipated to be losing their eligibility in the near future; or (2) have recently lost their eligibility without prior warning to the Area Program in order that they be assisted in transitioning to appropriate services and providers; and
- Clear assignment of implementation and oversight responsibilities.

Data:	Source:
1. Area Program's Transition Plan and any associated policies and procedures;	AP
2. Provider and client education materials; and	AP on site
3. Sample of short-term, one-time provider contract.	AP

4.4. Consumer Information

The Area Program ensures that consumers (and their families or guardians) have full information about their benefits and rights (including right to services, choice of providers when available and appropriate, and appeal rights) and how to access services.

4.4.a. Area Program has a user friendly system to provide information to clients.

The Area Program has a user friendly system to provide information to clients about their mh/dd/sa benefits, to explain how to access services, to answer questions, and to assist clients resolve any problems and complaints.

What written information does the Area Program (plan to) provide to clients?

How will the Area Program make this information available?

What system has the Area Program established to handle client questions, resolve problems, etc.? How user friendly is it?

Data:	Source:
1. Written information (to be) provided to clients; and	AP
2. Area Program's system for providing information and handling questions from clients.	AP on site

4.4.b. Area Program provides a toll-free telephone line to provide information to clients about accessing services and to handle requests for services.

Does the Area Program provide a toll-free telephone line answered by a person 24 hours per day, 7 days per week to provide information to clients about accessing services and to handle requests for services?

Data:	Source:
1. Toll-free number is printed on materials available to clients, including information provided by DSS and SSA to clients about Carolina Alternatives at the time of enrollment in Medicaid; and	AP on site
2. Any data that the Area Program collects and monitors on the utilization and/or effectiveness of this phone line.	AP on site

4.4.c. The Area Program has a plan for implementing the Provider Choice Policy.

The Area Program has designed its system and has an acceptable plan for implementing the Provider Choice Policy which provides clients an opportunity (1) to choose a provider to the extent available and appropriate prior to beginning treatment and (2) to change provider(s) upon request.

What are the Area Program's procedures for informing clients that they may choose/change a provider within the provider network?

- At what point in the intake process will it be handled?
- If the Area Program permits network providers to do intakes for clients, how will clients be informed about provider choice?
- What written information and assistance will the Area Program provide to clients to answer questions about provider choice and to help them make an appropriate selection?

- How will referrals/assignments to providers be handled if the client does not state a preference?
- How will client choice be handled in cases of emergencies and involuntary commitments?

How will the Area Program document and ensure that choice is systematically offered?

What are the Area Program's procedures for handling requests by clients to change providers?

- What role will network providers play in handling and referring these requests?
- Will the Area Program place any therapeutic restrictions on the number of times or the circumstances under which a client may request to change providers, and how will this be handled?
- How will the Area Program monitor requests for change of providers for appropriateness, and how will this information be incorporated into the Area Program's QI/RM program?

What are the Area Program's procedures for informing and ensuring that Area Program and network providers are knowledgeable about the provider choice policy?

Data:	Source:
1. Area Program provider choice policies, procedures, and/or plans;	AP
2. Materials provided to clients and providers explaining choice policy and procedures;	AP on site
3. List of available providers;	AP
4. Documentation that choice was offered to clients (look at sample of client records) at Area Program sites and other intake sites; and	AP on site
5. Provider choice and/or change request data that the Area Program (intends to) monitors and how this information is used.	AP on site

4.4.d. The Area Program implements the Carolina Alternatives Appeals Policy.

The Area Program implements the Appeals Policy which is required for all Medicaid recipients as set forth in 42 CFR 431 SubPart E.

Does the Area Program have the appropriate policies and procedures in place to implement the Policy?

How does the Area Program inform clients and providers about their appeals and grievances rights and process?

Has the Area Program designated a staff member (and alternate) to be its contact point and to handle appeals and grievances?

Have all Area Program staff and contract providers received training on implementation of the Appeals Policy?

Are procedures in place to ensure that clients are appropriately notified of their rights to appeal authorization denials, terminations and reduction of services decisions? For current CA sites, are these procedures working?

Does the Area Program have a mechanism for centrally tracking and reporting appeals and grievances to DMH/DD/SAS?

Does the Area Program monitor appeals and grievances issues and trends as part of its QI/RM/UM program, is this information used to correct problems and improve services, and is relevant information regarding providers included in the reprivileging process?

Data:	Source:
1. Area Program appeals and grievances policies and procedures;	AP
2. Information provided to clients and providers about the appeals and grievances process;	AP on site
3. Client interviews to determine knowledge about appeals policy;	AP on site
4. Provider interviews to determine knowledge about appeals policy;	AP on site
5. Copies of notification letters that have been given out for denials, terminations and reduction of services;	AP on site
6. Area Program QI/RM/UM data regarding appeals and grievances issues and trends and actions taken, statistics on average numbers of denials per 1,000 clients, numbers of appeals per notification issued for the last 6 months;	AP
7. Number and analysis of appeals received at DMH/DD/SAS; and	DIV.
8. Number and analysis of appeals received at OAH.	DIV.

4.5. Care Management

The Area Program provides coordinated care that provides the most appropriate level and amount of services and is responsive to the individual needs of clients, and is cost-effective.

4.5.a. The Area Program ensures that all CA and CAP MR/DD clients have a Care Manager and Case Manager.

The Area Program ensures that all clients are assigned a care manager/case manager to oversee implementation of their treatment plan, to ensure that the treatment plan is effectively used and updated in a timely manner, and to serve as a liaison with other providers and supports as needed.

How does the Area Program handle care management/case management for clients?

How does the Area Program ensure that responsibility for this function is clearly assigned for each clients?

Data:	Source:
1. Area Program policies and procedures;	AP
2. Provider education materials, handbooks, instructions;	AP on site
3. Interviews with providers; and	AP on site
4. Evidence of effective care management in client records.	AP on site

4.5.b. The Area Program utilizes the approved Levels of Care Criteria or Utilization Management Criteria.

Area Program staff and network providers who will be handling intake and/or authorizing care under CA are trained, privileged, and know how to appropriately apply the Levels of Care Criteria. Levels of Care information is documented in client records. CAP MR/DD case managers are trained, privileged in Utilization Management Criteria for service definitions and level of care criteria.

Have Area Program staff and network providers who will be handling intake and/or authorizing care been trained and privileged to apply the Levels of Care Criteria or Utilization Management Criteria? Have they participated in reliability testing?

Does the Area Program have an ongoing and systematic QI/RM/UM process to review LOC decisions and utilization service definition criteria for appropriateness and consistency?

Data:	Source:
1. List of names and credentials of staff and network providers who handle intake and/or authorize care;	AP
2. List of names and credentials of staff and network providers who have been trained and privileged to apply Levels of Care;	AP on site
3. Evidence of documentation of Level of Care in client record; and	AP on site
4. Evidence of ongoing and systematic QI/RM/UM process for review of LOC decisions for appropriateness and consistency, any findings, actions taken as a result, etc.	AP on site

4.5.c. The Area Program has a sufficient array of readily accessible 24-hour crisis intervention and hospital diversion services.

The Area Program can demonstrate that it has established a sufficient array of readily accessible 24-hour crisis intervention and hospital diversion services throughout its catchment area to meet the emergency needs of clients and successfully divert unnecessary hospitalization/utilization.

Has the Area Program analyzed Medicaid data for its expected population and projected the kinds and amounts of crisis services that it will need to be put in place to meet the emergency mh/dd/sa needs of its clients and to divert unnecessary hospitalization/utilization?

Will the Area Program have at implementation a sufficient array and capacity of these services throughout its catchment area to meet the emergency needs of its clients and to successfully divert unnecessary hospitalization/utilization?

Do the Area Program's emergency services policies, procedures, and practices emphasize rapid face-to-face clinician assessment and intervention and the mobilization of appropriate after-hour crisis services rather than over relying on hospitalizing clients after hours?
What arrangements has the Area Program made to provide rapid 24-hour face-to-face clinician response to clients throughout its catchment area?

What after-hour crisis intervention and hospital diversion services will the Area Program be able to mobilize to respond to the emergency needs of clients throughout its catchment area?

Data:	Source:
1. Analysis and projections of the emergency services/hospital diversion services capacity it will need to serve clients;	AP on site
2. Emergency services and on-call provider policies, procedures, practices, and arrangements; and	AP
3. Capacity of Area Program's emergency and diversion services to appropriately respond to clients' needs after-hours.	AP on site

4.5.d. The Area Program has effective links with local emergency services, hospitals, emergency rooms, institutions, and other crisis services providers.

The Area Program has established effective links with local emergency services, hospitals, emergency rooms, institutions, and other crisis services providers within the catchment area to ensure that clients receive timely and appropriate emergency services and to divert unnecessary inpatient admissions. Area Program has established procedures and has the capacity to review requests for authorization and payment for emergency services and inpatient hospitalization and to set up one-time contracts for paying emergency rooms, hospitals, and other crisis services providers outside the Area Program's catchment area.

Does the Area Program have clear, written protocols and agreements with local emergency services, hospitals, emergency rooms, institutions, and other crisis services providers to ensure that clients receive timely and appropriate emergency services and to divert unnecessary inpatient admissions?

Do these protocols/agreements:

- Explain both during and after normal working hours how emergency MH and SA services and inpatient admissions are to be authorized and provided?
- Explain roles and responsibilities and provide contact persons and telephone numbers of all parties involved?
- Differentiate between what is considered medical and covered by Medicaid outside of CA and what is considered to be MH/SA and covered under CA?

Has the Area Program set up procedures and does it have the capacity to review requests for authorization and payment for emergency and inpatient services and to set up one-time contracts for paying emergency rooms, hospitals, and other crisis services providers outside its catchment area?

Data:	Source:
1. Written protocols and procedures;	AP
2. Agreements with local emergency services, hospitals, emergency rooms, and other crisis services providers; and	AP on site
3. Meeting minutes, documentation of training provided, lists of contact persons/telephone numbers, etc.	AP

4.6. The Area Program manages its provider network to create a coordinated continuum of community-based services, assure compliance with requirements, and promote quality services.

4.6.a. Provider recruitment, credentialing and privileging.

Area Program informs providers in its catchment area about waivers, how to participate and recruit quality professionals and agencies into its provider network in sufficient numbers to provide an effective continuum of appropriate community-based services coverage throughout its catchment area and to provide choices to clients.

What efforts have the Area Program made to inform providers about the waivers and to develop an effective provider network?

Does the Area Program open participation in its provider network to all willing and qualified providers who meet published Area Program requirements or have a method to fairly select providers?

How many private providers have agreed to participate in the Area Program's provider network?

Is the Area Program's provider network sufficient to cost-effectively meet the treatment needs of clients? Does it include sufficient hospital alternative, outpatient service providers, and support providers throughout the catchment area to permit hospital diversion, reduce unnecessary inpatient and out-of-home placements, and to provide timely step-down to the least-restrictive, clinically appropriate services?

Does the Area Program verify credentials and (re)privilege network providers for each service it authorizes the provider to provide?

Does the Area Program verify provider agreements for each service the provider provides?

Data:	Source:
1. List of potential providers in the catchment area;	AP on site and DIV.
2. Area Program provider participation requirements, policies and procedures;	AP
3. Area Program correspondence with providers;	AP on site
4. Documentation of meetings/correspondence with providers; and	AP on site
5. Area Program credentialing and privileging documents.	AP

4.6.b. Provider training/orientation.

Area Program provides effective training/orientation to Area Program and contract providers on the purpose of the waivers, waiver and contract requirements, client benefits and services available within and around the catchment area, provider access, credentialing and (re)privileging process and requirements, accreditation process and requirements, intake/referral process for clients, levels of care criteria, client care coordination and management through the use of effective treatment plans, service payment (re)authorization, and discharge planning; participation in Area Program's quality improvement, risk management, and utilization management programs; client rights, client and provider appeals and grievances procedures; provider choice policy, promoting and ensuring client/family participation and satisfaction; interagency service coordination; claims processing, Certification of Need requirements, Area Program contacts/phone numbers for clients and providers, etc.

How does the Area Program educate its internal and contract providers about the requirements of the waivers?

What written materials does the Area Program provide to providers?

Does the Area Program have an ongoing system for educating new staff and contract providers about waivers?

How does the Area Program intend to keep providers up-to-date on program changes, new providers and services, etc.? How often?

Data:	Source:
1. Provider orientation/training materials;	AP on site
2. Provider manuals, handbooks, correspondence;	AP on site
3. Training schedules, documentation that training was provided; and	AP on site
4. Interviews with providers.	AP on site

4.6.c. Provider performance monitoring.

The Area Program has a process for monitoring individual provider and system performance that includes waiver and contract compliance, clinical performance, client outcomes, client satisfaction, and utilization review. Performance indicators for network providers are monitored as part of the Area Program's QI/RM/UM program, feedback is provided to individual providers, and appropriate action to correct problems/improve services is taken when indicated. Provider performance is used as part of the re-privileging process.

Does the Area Program collect information on providers that allows it to evaluate the quality of services provided, documentation adequacy, and contract compliance?

Does the Area Program use the information collected to develop provider profiles and make reprivileging and contracting decisions?

Does the Area Program use the information collected as part of its QI/RM/UM program to monitor system performance?

Does the Area Program look at both staff and contract providers in this process?

Does the Area Program provide feedback to individual providers to promote excellence and to improve services?

Does the Area Program take appropriate action when problems or opportunities for improvement are identified?

Data:	Source:
1. Area Program QI/RM/UM plan;	AP
2. Client satisfaction information on service providers in network.;	AP on site
3. Provider profiles used by the Area Program;	AP on site
4. QI/RM/UM meeting minutes or reports showing evidence of provider performance monitoring activities, findings, and actions taken; and	AP on site
5. Any evidence that providers have received feedback.	AP on site

4.6.d. Contracting.

The Area Program is able to contract for services for clients.

Does the Area Program use the standard provider contract for contracting with network providers?

Does the Area Program have and is it able to enter into time-limited and/or one-time contracts for out of catchment area emergency care and for care provided under its transition plan?

Does the Area Program have a sufficient number of provider contracts in place or in process that will be operational by CA implementation to meet continuum and client access requirements?

Data:	Source:
1. Signed provider contracts; and	AP on site
2. Sample of one-time and/or time-limited contract.	AP

4.6.e. Interagency Agreements.

Area Program has met with and has established effective links and/or interagency agreements with local DSS, DYS, and school system(s) for children and with magistrates and law enforcement agencies for adults to enable it to clarify roles, resolve problems, and to successfully coordinate service delivery and funding of services.

What interagency links and agreements have the Area Program established?

What kind of ongoing interagency activities is the Area Program involved with to coordinate services. How often do these activities take place?

What has been the Area Program's experience to date (successes, problems)?

Data:	Source:
1. Area Program interagency agreements on behalf of clients;	AP on site
2. Meeting minutes, memos, or correspondence regarding interagency activities	AP on site

on behalf of clients; and
3. Staff interviews regarding interagency activities. AP on site

4.7. The Area Program has an effective utilization management system.

The Area Program has an effective utilization management (UM) system for monitoring the appropriateness and cost-effectiveness of services provided to clients.

How will UM be handled within the organization? Is the Area Program following its plan?

Does the Area Program look at service utilization and cost, services provided to high cost clients, and services provided to clients receiving multiple levels of care for appropriateness and cost-effectiveness? Has this been done for Medicaid recipients who are anticipated to become CA clients?

Does the Area Program review or have plans to review requests for services that have been denied for appropriateness?

Has the Area Program looked at provider and system performance and attempted to identify under as well as over utilization of services?

As a result of any of its UM activities to date, has the Area Program learned anything or identified any opportunities to improve the appropriateness or cost-effectiveness of its service system?

How often are UM activities conducted?

Data:	Source:
1. Area Program UM plan or section in QI plan;	AP
2. Minutes of meetings including UM activities (for last six months); and	AP
3. UM reports or data used by the Area Program.	AP on site

4.8. The Area Program authorizes services.

The Area Program has an authorization system that is capable of quickly authorizing emergency services 24-hours a day and providing timely service (re)authorizations for non-emergency services. The Area Program has the capacity to process/authorize local approval of initial, Continued Need Review (CNR), and cost revision. The Area Program has a service payment authorization system in place that requires all services to be authorized and payment to be made only when a valid contract exists and contract terms have been met.

Does the Area Program have written authorization/local approval procedures?

How will the Area Program authorize emergency services after-hours? How will it authorize non-emergency services?

What are the credentials of the person(s) authorizing and/or approving services, and what training do they receive?

Has the Area Program established reasonable guidelines for initial authorizations and reauthorizations that permit the Area Program to maintain reasonable control over service authorization while minimizing the administrative burden to the Area Program and providers?

Has the Area Program developed an effective system to provide written authorization or orders to providers? Do written authorizations specify the services, numbers of units, and time limit of the authorization? Do these authorizations inform providers how to request authorization of additional units or extension of time?

Has the Area Program made arrangements with hospitals in their catchment area to do informal service authorization for clients who are pending or are potential Medicaid recipients at the time of admission to inpatient facilities?

Is the Area Program's authorization system tied into its reimbursement system to ensure that payment is not made unless services have been authorized? How is this ensured?

Does the Area Program have a system for notifying clients of their appeal rights whenever requests for (re)authorization are denied?

Does the Area Program's authorization/tracking system keep track of the number of units and time periods authorized to ensure that the authorized number/time period has not been exceeded?

Does it adjust for unused authorizations, and is it tied into the Area Program's cash forecasting system to ensure that funds are available to pay for authorized services and the Area Program does not financially over obligate itself?

Does the Area Program have procedures for retrospectively reviewing and authorizing services provided to clients who may receive emergency MH/SA services outside the catchment area from providers unfamiliar with CA preauthorization requirements and to clients who become retroactively eligible for Medicaid?

Data:	Source:
1. Area Program authorization/local approval policy and procedures;	AP
2. Area Program claims processing policy and procedures;	AP
3. Instructions/procedures provided to emergency services or on-call providers;	AP
4. Computerized authorization/tracking systems; and	AP on site
5. Materials provided to service providers explaining authorization procedures.	AP on site

4.9. The Area Program is fiscally sound, has effective fiscal controls, and is prepared to process claims and operate under a capitated payment system.

The Area Program has the financial resources and has implemented the necessary changes in its fiscal operations to successfully operate (under) a capitated, managed care system.

Do Area Program audits and management letters over the last two years indicate any outstanding fiscal control issues that would interfere with its ability to function under a managed care system?

If a multi-county program, does the Area Program have a fund balance of at least 8%?

If a single county program, does the Area Program have the authority to retain a fund balance or designated MHC reserve? What level and what may it be used for and are there any restrictions? If there is not a fund balance or designated MHC reserve, what access does the program have for additional funds (e.g. increased budget and/or increased access to cash) that may be needed?

Does the Area Program have a plan of how to adjust capitation revenues received (if there is an overall loss or gain in money)?

Does the Area Program routinely generate and use cash forecasts?

Does the Area Program have an accounts payable system that accurately reflects liabilities?

Has the Area Program established a system for forecasting, and adjusting for unused authorizations, the value of authorized client services for which it is potentially liable for payment, and will the Area program be able to compare these forecasts to expected revenues to ensure that it does not financially over-obligate itself?

Does the Area Program have a plan for budgeting funds, tracking costs, avoiding over-stating costs and revenues, and serving as both payer and provider? Does the plan include how the Area Program will pay itself for services provided, how it will pay contract providers, and how it will pay for alternative services?

Does the Area Program have an internal control system for claims processing and payment, that prior to payment, verifies client Medicaid eligibility, rates, service payment authorization, a valid contract, contract requirements have been met, and all applicable third party payments have been received?

Is the Area Program able to provide contract providers an EOB for each claim adjudicated?

Does the Area Program have the infrastructure, staff, and procedures necessary to adjudicate and pay network provider claims within contract time-frames.

Data:	Source:
1. Area Program audits and management letters for past two years;	DIV.
2. Area Program fund balance or MHC reserve;	AP on site
3. Area Program plan for adjusting capitation revenues received;	AP on site
4. Area Program sample cash forecasts;	AP on site
5. Area Program plan for budgeting funds, paying itself, paying contract providers;	AP on site
6. Area Program controls for claims processing and payment; and	AP on site
7. Sample EOB for contract providers produced by claims processing system.	AP on site

4.10. The Area Program has a management information system capable of supporting its client care and managed care operations.

The Area Program has a MIS capable of supporting its client care and managed care operations, providing timely decision support information, and meeting Division reporting requirements.

How integrated/interconnected is the Area Program's MIS? How much is handled by a central system vs. by separate systems or computers?

Does the Area Program have the capability of electronically communicating with the Division?

How easily can the Area Program's MIS manage/produce client workload, utilization management, financial, service (re)authorization tracking, claims processing, eligibility checking, contract monitoring, credentialing and privileging, and quality improvement information?

Is the Area Program's MIS capable of fully supporting its client care and managed care operations?

Can the Area Program produce internal decision support data needed to effectively manage?

Can the Area Program produce required reports in the accepted timeframe?

If its MIS is not fully functional or able to fully support its managed care operations, how will the Area Program handle these functions at CA implementation? What plans does the Area Program have to enhance its MIS? Over what time frame?

Data:	Source:
1. Area Program MIS;	AP on site
2. Sample MIS report;	AP on site
3. Interview with MIS staff; and	AP on site
4. Plans to enhance MIS.	AP on site

4.11. The Area Program has procedures to ensure that Certification Of Need (CON) forms are properly issued and maintained (applicable to CA only.

The Area Program will comply with Federal and State CON requirements.

Does the Area Program have a copy of CON requirements and understand its responsibilities for managing CONs under the CA waiver?

Does the Area Program understand it will be financially at risk for any paybacks required of the state if CONs are not in compliance with federal requirements?

Does the Area Program have procedures to ensure that CON forms are properly completed for all inpatient admissions to psychiatric hospitals, with the original provided to the DMH/DD/SAS CA Branch and copies filed in the hospital medical record and at the Area Program?

Has the Area Program communicated with each psychiatric hospital in its catchment area its procedures for properly completing and handling CONs?

Have the Area Program and hospital determined who will complete CON's for emergency admissions? Will it be the hospital or Area Program? If it will be the Area Program, are both prepared to follow the more stringent preauthorization requirements and time frames?

Does the Area Program have procedures to quality control the completeness and accuracy of all CON forms issued or received and to ensure that payments to hospitals are in strict compliance with CON requirements?

Data:	Source:
1. Area Program CON procedures;	AP on site
2. Area Program meeting minutes, correspondence, memos, agreements with psychiatric hospitals regarding CON procedures; and	AP on site
3. Area Program system for quality controlling CONs and ensuring payments to hospitals are in compliance with CON requirements.	AP on site

APPENDICES

APPENDIX A

Child and Family Services

SERVICE SPECIFIC CRITERIA FOR CHILD AND FAMILY SERVICES

The reader is referred to two resources:

North Carolina Community Mental Health Services Block Grant Plan for FY 98, September 1997.

North Carolina Child Mental Health Plan, 1986.

APPENDIX B

Adult Mental Health Services

SERVICE SPECIFIC CRITERIA FOR ADULT MENTAL HEALTH SERVICES

The review of Adult Mental Health Services may cover any expectation of area program activity, including those that are defined in Memoranda of Agreement, allocation letters and specific grant documents.

We recommend particular attention to the following:

Expectations/Requirements for the Community Mental Health Services Block Grant:

1) With respect to mental health services, the centers provide:
   A) Services principally to individuals residing in a defined geographic area.
   B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
   C) 24-hour emergency care services.
   D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
   E) Screening for patients being considered for admission to State mental health facilities to determine the appropriateness of such admission.

2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

4) The Area Program has an active peer review program as part of its quality assurance/quality improvement efforts.

Supported Housing

The review will address the Area Program's housing strategies and resources, including housing units funded by the Division. The review will also address, where appropriate, the use of the Revolving Loan Fund and the implementation of Supported Housing positions funded by the Division.

Homelessness
The review will address the Area Program's efforts to assist homeless people with mental illness, including outreach activities and the implementation, where appropriate, of PATH, ACCESS and Shelter Plus Care programs.

Deaf and Hard of Hearing
The review will address the accessibility of appropriate services for the deaf and hard of hearing, including the utilization of interpreter services.

Adult Care Homes
The review will address the Area Programs implementation and reporting of Adult Care Home Wraparound Services.

Use of and Linkage with State Hospital
The review will include consideration of compliance with State Hospital Admission and Discharge rules and the use of State Hospital bed day allocations.

Case Management
The review will address the organization, availability, and appropriateness of case management services for adults with serious mental illness.

Staff qualifications and training.
The expectation is that staff will have qualifications and training opportunities related to state of the art services in their area of responsibility.

APPENDIX C

Substance Abuse Services

SERVICE SPECIFIC CRITERIA FOR SUBSTANCE ABUSE SERVICES

CHAPTER ONE: *COMMUNITY AWARENESS AND RESPONSIVENESS*

EXPECTATION 1: *The Area Program is guided by the needs of its community.*

1.1. The Area Program knows the composition of the community it serves.

1.1.SA.PREVENTION. The AP will describe a means for identifying populations "at-risk" for SA, and will provide demographics of the population within their catchment area.

1.1.SA.GENERAL. The AP will provide demographics on special Substance Abuse populations including but not limited to pregnant women, HIV positive rates, ethnic/cultural rations, alcohol abuse, drug abuse, deaf and hard of hearing, IV drug users, and Work First participants.

1.2. The Area Program is actively engaged in the identification of the needs of the community.

1.2.SA.GENERAL All programs that receive SAPTBG must:

Implement infection control procedures approved by the State and designed to prevent the transmission of TB, including the following:

a) Screening of patients;
b) Identification of those individual. who are at high risk of becoming infected; and
c) Meeting all State reporting requirements while adhering to Federal & State confidentiality requirements including 42 CFR Part 2.

1.2.SA.PREVENTION. Review school and community-based substance abuse data from appropriate needs assessments and prevalence surveys. The three classifications of primary prevention are to be used appropriately (universal, selective, and indicated). Additionally, each Program's plan of action should clearly state the element(s) of prevention programming.

1.2a.SA.EEAP. Number of Enhanced Employee Assistance Program Work First Participants receiving treatment prior to employment.

1.3. The Area Program coordinates with local and state agencies to gather feedback on Area Program operations, promote program development, and improve services.

1.3.SA.HIV. All programs awarded SAPTBG HIV Early Intervention set aside funds must: establish linkages with a comprehensive community network of related health and social services organizations to ensure a wide-based knowledge of the availability of HIV early intervention services.

1.3.SA.GENERAL. All programs that receive SAPTBG funds must: coordinate prevention and treatment activities with the provision of other appropriate services (including health, social, correctional and criminal justice, educational, vocational rehabilitation, and employment services).

1.3.SA.DWI. DWI, DES, and TASC awards require effective MOA's.

1.3.SA.DWI. Evidence that Area Program has a mechanism in place for communication and coordination with other community agencies who are competing for the same clients, i.e. DWI Service Providers; and makes DWI offenders aware of private agencies in the catchment area that can deliver the level of care appropriate to the assessed need of the diagnosed person.

1.3.SA.PREVENTION. Area Programs must have a letter of agreement and formal plan with local education agencies (LEA'S), and others as deemed appropriate, specific to provision of primary prevention programming and a means of referring youth from other human service organizations for the appropriate provision of primary prevention programming.

1.3.SA.EEAP. Evidence of Planning Advisory Committee and MOAs with Area Program, DSS, and Employment Security Commission.

1.4. The Area Program provides information about services and programs.

1.4.SA.GENERAL. Area Programs that receive SAPTBG must:

Publicize the availability of services to women and preferential status by means of the following:

a) street outreach;
b) programs, ongoing public service announcements;
c) regular advertisements in local/regional print media;
d) posters placed in targeted areas; and
e) frequent notification of availability of treatment distributed to community-based organizations, health care providers, and social services agencies.

1.4.SA.IV. that treat individuals for intravenous substance abuse must:

a) Promote awareness among injection drug abusers about the relationship between injection drug abuse and communicable disease such as HIV;
b) Recommend steps that can be taken to ensure that HIV transmission does not occur; and
c) Encourage entry into treatment.

1.4.SA.EAP. Evidence of marketing techniques and awareness for Employee Assistance Programs.

1.4.SA.PREVENTION. Publicize the availability of prevention services to citizens within the catchment area.

1.5. The Area Program identifies areas needing improvement and demonstrates improvement in those areas.

1.5 SA. SAPTBG. Area Programs that receive SAPTBG must: provide continuing education or activities to employees of the facility who provide the services or activities.

1.5 SA. GENERAL. Area Programs demonstrate their mission, vision, or plans through the adoption of best practice guidelines, outcomes, systematic collection of data, use of outcomes to direct system priorities.

1.5b.SA. GENERAL. The following populations are high priority populations: Women, Intravenous Drug Users, TANF recipients (including EEAP clients), Justice, HIV, Deaf and Hard of Hearing, and children of substance abusers.

1.5c.SA.PREVENTION. Programs should show evidence of working toward comprehensive prevention programming (i.e. the six elements of prevention).

CHAPTER TWO: *CLINICAL SERVICES MANAGEMENT*

EXPECTATION 2: ***The Area Program provides clients access to an array of services that are responsive to assessed and changing needs, promote client choice, are effectively integrated and coordinated, consistently monitored and improved to promote desired client outcomes, and ensure the protection of the health, safety, and welfare of the persons served.***

2.1. The Area Program provides consistent, timely and comprehensive assessments of the service needs of individual clients.

2.1.SA.SAPTBG. All programs that receive SAPTBG must:

1. Directly or through arrangements with other public or nonprofit entities, routinely make available tuberculin (TB) services to each individual receiving treatment for substance abuse (SA) which include:
   a) Counseling the individual with respect to TB;
   b) Testing to determine whether the individual has been infected with mycobacterium TB to determine the appropriate form of treatment for the individual;
   c) Providing for or referring the individual infected by mycobacterium TB for appropriate medical evaluation and treatment; and
   d) In the case of an individual in need of treatment for mycobacterium TB who is denied admission to a program on the basis of the lack of the capacity of the program to admit the individual, will refer the individual to another provider of TB services.

2. Conduct case management activities to ensure that individuals receive TB services.

3. Admit or refer individual to treatment facilities that can provide to the individual the treatment modality that is most appropriate for the individual including but not limited to the following activities:
   a) The utilization to standardized assessment procedures adopted by the State that facilitate the referral process; and
   b) Participation in a capacity management/waiting list management program designed and adopted by the State for individual seeking SA treatment.

4. At the sites at which the individual are undergoing SA treatment provide services that include:
    a) Appropriate pretest counseling for HIV and AIDS;
    b) Testing individual with respect to such disease, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease;
    c) Appropriate post-test counseling; and
    d) Providing the therapeutic measures described in Part (b).

AP that receive SAPTBG 5% women's set aside funds must:

1. Treat the family as a unit and admit both women and their children into treatment services if appropriate; and

2. At a minimum provide or arrange for the provision of the following services to pregnant women and women with dependent children, including women who are attempting to regain custody of their children:
    a) Primary medical care for women, including referral for prenatal care and, while the women are receiving such services, child care;
    b) Primary pediatric care, including immunization for their children;
    c) Gender specific substance abuse treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse and parenting, and child care while the women are receiving these services;
    d) Therapeutic interventions for children in custody of women in treatment which may, among other things, address their development needs, their issues of sexual and physical abuse, and neglect; and
    e) Sufficient case management and transportation to ensure that women and their children have access to services provided by paragraphs 1.a) through d) or this section.

Programs that treat individuals for intravenous substance abuse must:

1. Provide interim services to include at a minimum counseling and education about HIV and TB, the risks of needle-sharing, risks of transmission to sexual partner and infants, steps that can be taken to ensure that HIV and TB transmission does not occur, referral for HIV or TB treatment services if necessary, and for pregnant women counseling on the effects of alcohol and drug use on the fetus as well as referral for prenatal care;

2. Provide outreach to individual in need of intravenous drug abuse treatment services through:
   a) a scientifically sound model, or if no such models are available, which are applicable to the local situation and can reasonably be expected to be effective, or
   b) an outreach efforts that include:
      1) Selecting, training and supervising outreach workers;
      2) Contacting, communicating and following-up with high-risk Substance Abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including 42 CFR Part 2;
      3) Promoting awareness among injection drug abusers about the relationship between injection drug abuse and communicable disease such as HIV;
      4) Recommend steps that can be taken to ensure that HIV transmission does not occur; and
      5) Encouraging entry into treatment.

2.1.SA. PREVENTION. Services are provided in "at risk" communities and to identified youth and their families. Services to youth are focused on reducing risk factors and strengthening protective factors.

2.1.SA.DWI:

1) Assessments include: standardized test and clinical interview; approved by CSAC or ASAM certified; and ASAM placement criteria used to match identified needs to services per G.S. 122C-142.1.

2) DMH 508-R Reports able to track levels of treatment and services by other referral sources per GS 122C-142.1.

3) Commendations and complaints received.

4) Spanish translations of DWI assessment, ADETS and treatment available.

2.1.SA.EAP. Assessments include job performance problems, i.e., absenteeism, positive drug testing, disciplinary actions.

2.2. The Area Program consistently develops treatment / habilitation service plans that are responsive to the full range of assessed client needs and client determination of supports.

2.2.SA.DWI. Clients must be notified of other providers, if requested, and invokes GS122C-146 after payment of mandated fees.

2.3. The Area Program appropriately provides supports and services for clients as defined in treatment/habitation plans.

2.4. The Area Program consistently and periodically monitors services to determine client outcomes and response and modifies services/supports as needed.

2.4.SA.OUTCOMES. Review of Substance Abuse Outcomes in the following areas: MTQAS, Perinatal, TASC, Governor's Prevention, Majors, EEAP, and other pilot initiatives.

2.5. Available services (Area Program operated, contracted, and state facilities) are sufficient to respond to clients needs.

2.5a.SA.EAP. Provide Employee Assistance Programs per 10 NCAC 14V .6500.

2.5a. SA.EAP. Consultation with, training of, and assistance to work organization leadership (managers, supervisors, and union stewards) seeking to manage the troubled employee, enhance the work environment, and improve employee job performance; and, outreach to and education of employees and their family members about availability of EAP services (EAP Core Technology Function #1).

2.5a. SA.EAP. Consultation to work organization to encourage availability of and employee access to employee health benefits covering medical and behavioral problems, including, but not limited to, alcoholism, drug abuse, and mental and emotional disorders (EAP Core Technology Function #6).

2.5b. SA.EAP. Referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow-up service (EAP Core Technology Function #4).

2.5b.SA.DWI. Substance abuse assessments are required to be conducted by area programs under G.S. 122c-143.1 for persons convicted of DWI offenses G.S.20-138.1, 20-138.2, and 20-138.3.

2.5c. SA.EAP. Use of constructive confrontation, motivation, and short-term intervention with employee clients to address problems that affect job performance (EAP Core Technology Function #4).

2.5c. SA.PREVENTION. Evidence of provision of Substance Abuse High Risk Intervention Services to at-risk youth and families.

2.5e. SA.EAP. Consultation to work organization in establishing and maintaining effective relations with treatment and other service providers, and in managing provider contracts (EAP Core Technology Function #5).

2.5f. SA.EAP. Confidential and timely problem identification/assessment services for employee clients with personal concerns that affect job performance (EAP Core Technology Function #2).

2.6. Services (Area Program, contracted, and state facilities) are sufficient to permit an adequate array which promotes client choice.

2.6. SA.EAP. Employee Assistance Program clients are given options as to providers based on health benefits coverage and/or co-payment.

2.7. Coordination of services within the Area Program

2.7.SA.PREVENTION. Substance Abuse Primary Prevention Services are coordinated with child, adolescents, and adult substance abuse treatment services.

2.8. Access

2.8.SA.PRIORITY ADMISSION: Area Programs that receive SAPTBG must:

Give preference in admissions to each pregnant woman in the State who seeks, or is referred for, and would benefit from, substance abuse treatment. Priority admission must be given in the following order:

a) pregnant injecting drug users;
b) pregnant substance abusers;
c) injection drug users; and
d) all others.

2.8.SA.IV. Area Programs that treat individuals for intravenous substance abuse must: Admit any individual who requests and is in need of treatment for intravenous drug abuse not later than:

a) 14 days after making the request for admission to such a program; or
b) 120 days after the date of such request, if at capacity to admit the individual on the date of such request arrange for interim services, including referral for prenatal care to the individual not later than 48 hours after such request.

2.8.SA.EAP. Routine assessment is conducted within 72 hours.

2.8.SA.TASC. Rule .4003 Operations mandates client seen within 48 hours of assessment.

2.9. The Area Program provides clients with information on services and programming.

2.9.SA.DWI. Listing of "on-line" public and private providers.

2.9.SA.PREV. Provision of information about the availability and type of substance abuse primary prevention programs available, including the FTE's for the provision of primary prevention services.

2.10. The Area Program utilizes existing natural supports and resources to address client needs.

2.10.SA.PREVENTION. Appropriate linkages are made with local organizations, community-based groups, and schools.

2.12. Clients are satisfied with services

2.12.SA.PREVENTION. In the provision of primary prevention services efforts are made to assess the satisfaction of recipients of services and the results of such surveys are utilized to improve provision of services.

2.13. The Area Program identifies areas for improvement and demonstrates improvement in those areas.

2.13.SA. SAPTBG Requirement: Programs that treat individuals for intravenous substance abuse must:

1. Provide to the State, upon reaching 90 percent capacity to admit individuals to the program, a notification of the fact.
2. Establish a mechanism for maintaining contact with individual awaiting admission;
3. Document activities to admit individuals. who are on the waiting list at the earliest possible time to a program providing such treatment within a reasonable geographic area;
4. Only remove individual from the waiting list if they cannot be located or, they refuse treatment.
5. Participate in a waiting list management program established by the State and an outreach effort that includes establishing a program waiting list with unique patient identifiers for each injecting drug abuser seeking treatment including those receiving interim services, while awaiting admission to such services; and
6. Selecting, training and supervising outreach workers.

2.13.SA.PREVENTION. Governor's Safe & Drug-Free Schools & Communities Statement of Assurances. Documentation of primary prevention services by direct-service provider, recipient, location, elements and strategies. Face-to-face interview with recipients regarding quality of performance of programming within their community.

2.13.SA. TASC. "ADM & DIS" client outcome forms track Criminal Justice clients and results are utilized to improve services.

2.13.SA.EAP. Identification of the effects of Employee Assistance Program services on the work organization and individuals job performance. (EAP Core Technology Function #7).

CHAPTER THREE: *ADMINISTRATIVE SERVICES MANAGEMENT*

EXPECTATION 3: ***In meeting client needs, the Area Program uses responsible business practices which foster sound fiduciary decision-making, communication, planning, problem solving, quality assurance and improvement, and protection of client rights throughout services delivery.***

3.1. The Area Program will comply with all requirements.

3.1.a: SA-Memorandum of Agreements with the Division *related to SA.*

3.1.b: SA-Expansion Funds *related to SA.*

3.2. Effective integration of Area Program functions, clinical, business, and administrative, results in problem identification and resolution.

3.2.SA.GENERAL. Does the Substance Coordinator manage or influence or have knowledge of the Substance Abuse Budget? Is the Substance Abuse Coordinator aware of the budget priorities of the Area Program and rationale? Is the Substance Abuse Coordinator a member of the Area Program Management Team?

3.2.SA.TASC. Review of ten TASC Critical Program Elements:

1) A broad base of support from the criminal justice system with a formal system for effective communication.
2) A broad base of support from the treatment community with a formal system for effective communication.
3) An independent TASC unit with a designated administrator.
4) Required staff training, outlined in TASC policies and procedures.
5) A system of data collection for both program management and evaluation.
6) Explicit and agreed upon eligibility criteria.
7) Screening procedures for the early identification of eligible offenders.
8) Documented procedures for assessment and referral.
9) Documented policies, procedures, and technology for drug testing.
10) Procedures for offender monitoring with established success/failure criteria, and for constant reporting to criminal justice referral source.

3.3. The Area Program is fiscally responsible.

3.3.SA.SAPTBG. The Area Program will expend SAPTBG funds as follows:

1) not less than 35 percent for prevention and treatment activities regarding alcohol;

2) not less than 35 percent for prevention and treatment activities regarding other drugs; and
3) not less than 20 percent for primary prevention programs for individuals who do not require treatment for substance abuse.

The Area Program shall not expend the BG on the following activities:
1) to provide inpatient hospital services, (unless special approval is granted);
2) to make cash payments to intended recipients of health services;
3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
4) to satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;
5) to provide financial assistance to any entity other than a public or nonprofit private entity; or
6) to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

3.3.SA.GENERAL. Earned Substance Abuse funds are reinvested in service specific enhancements for substance abuse.

3.3.SA.DWI. DWI fees charged and received can be tracked per DMH 508-R. Separate accounting rules for DES and ADETS.

3.4. The Area Program has a system for gathering and coordinating information.

3.4.SA.SAPTBG. Area Programs who cannot admit pregnant substance abusers or intravenous drug users shall comply with timely admissions requirements, participate in a statewide capacity management system, make appropriate referrals to interim services for both populations, and maintain waiting lists which include ongoing attempts to engage the individuals in the pursuit of treatment.

3.4.SA.GENERAL. Area Programs shall comply with special categorical funding requirements on substance abuse funds.

3.4.SA.PPP. Area Programs shall comply with the special MOA condition for the expenditure of Public Private Partnership Funds.

3.5. Providers, both internal and external, understand through orientation and on-going processes, the mission and expectations of the Area Program regarding the services they are to provide.

3.5.SA.SAPTBG. All recipients of SAPTBG funds must:

1) The Area Program is required to have in effect a system to protect from inappropriate disclosure patient records and such system shall be in compliance with all applicable State and Federal laws and regulations, including 42 CFR part 2. This shall include provisions for employee education on the confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosures.

2) The Area Program shall provide continuing education in substance abuse prevention and treatment services or activities to all employees who provide such services and activities.

3.5.SA.PREVENTION. Evidence that substance abuse primary prevention activities and services are provided by substance abuse prevention professionals.

3.6. The Area Program seeks and is responsive to external provider input.

3.5.SA.PREVENTION. Evidence that substance abuse prevention professionals are included in the planning and evaluation of area programs continuum of care.

3.6.SA.DWI. DWI/CJ Branch advocates regular meetings of all providers. Referrals among providers can be tracked per DMH 508-R data.

3.7. Consumer and advocacy groups are involved in the policy development of the Area Program.

3.7.SA.SUPPORT GROUPS. The Area Program has fully integrated the use of support groups into the substance abuse program.

3.9. The Area Program identifies areas for improvement and demonstrates improvement in those areas.

3.9.SA.DWI.TASC. TASC Rule requires 32 hours training annually. ADETS and DES instructors required to have pre-certification, certification, and recertification training.

3.9.SA.PREVENTION. Review of staff training records and certifications, progress towards certification, GAPP. Prevention staff seek certification and attend Governor's Academy.

CHAPTER FOUR: MANAGED CARE

In addition to the standards in the previous Chapters, the standards in this Chapter must be met prior to an Area Program beginning Carolina Alternatives (CA) and assuming all lead agency responsibilities for Community Alternative Programs for the Mentally Retarded and Developmentally Disabled (CAP MR/DD).

EXPECTATION 4: ***In order to implement Carolina Alternatives or the proposed changes in CAP MR/DD, an Area Program must demonstrate that it is able to meet the intent of and comply with specific requirements of the waiver and has put in place the necessary procedures, systems and infrastructure to successfully operate (under) a managed care service system.***

4.5. Care Management

4.5.b. The Area Program utilizes the approved Levels of Care Criteria or Utilization Management Criteria.

4.5.SA.ASAM. Area program providers are trained and appropriately credentialed to use ASAM Patient Placement Criteria in conjunction with the Adult Levels of Care Criteria.

APPENDIX D

Crisis Services

Crisis Services Performance Expectations

The Appendix for Crisis Services contains the Crisis Services Performance Expectations distributed to Area Programs in November, 1997. The Crisis Service Performance Expectations are consistent with the *Standards for Monitoring and Accreditation of Area Programs*, Division publication, APSM 40-3 as well as the *Rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services,* Division publication, APSM 30-1, Section .6100 Emergency Services for Individuals of All Disability Groups. The Crisis Services Section believes the Area Program will find it helpful to reference these Crisis Service Performance Expectations and the Rule for Emergency Services in one location during the monitoring and accreditation review.

Crisis Services Section Monitoring of Area Programs

Performance Expectations	Evidence to be reviewed by area program prior to review (self-study) and by Crisis Services Monitoring Team during review.
Crisis Prevention for high-risk clients. [See the following elements in the Standards for Monitoring and Accreditation of Area Programs: 1.1, 1.2.a-c, 1.3, 1.4, 1.5 for possible unmet service needs of the community. See 2.1, 2.2, 2.5.a-g, 2.8, 2.9, and 2.13 for Area Program clients. See also 3.4, 3.5, 3.6, 3.9, and 4.5.c.] 1. Overview. The issues to be monitored are (a) whether the area program is assessing clients for being at "high-risk" for repeated use of crisis services, including inpatient; and (b) when clients are identified as being at high risk, and especially for those clients having multiple diagnoses/disabilities, the extent to which their multiple treatment/habilitation needs are addressed. These needs may be met through specialized services (e.g., specialized services for clients with MI/SA) or through traditional services that are integrated and focused to meet multiple needs. Indicators of "high risk" status include: *Multiple inpatient admissions (or first admission and future multiple admissions are likely without prevention services) *Repeated use of crisis/emergency services *Presence of two or more diagnoses *Non-compliance with treatment *Episodes of homelessness *Contact with protective services *Encounters with criminal justice system *Inability to provide for basic needs *Insufficient social and family supports	1. Listings of clients at high risk for repeated use of crisis services, including inpatient. NOTE: The following categories of individuals may be especially likely to be current or potential high users of crisis services. a. Willie M. Clients age, especially those 17+years b. Multiple diagnostic categories: For adults: MI (Axis I)/SA and SA/MI (Axis II); MI/MR and SA/MR; and MI/MR/SA For minors: Serious Emotion Disturbance/SA; SED/SA; *SED/MR; SED/SA; SED/MR/SA And Adult and minor clients with MI, SED, SA, or DD and Co-morbid Axis III. 2. Treatment protocols developed for various categories of high-risk clients. 3. Documentation in high-risk clients' service records of Crisis Plans and of appropriate service plans and services provided to prevent or respond to crises. 4. "Hot sheets" available to after-hours crisis staff that provide information that is useful in responding to crises. 5. Reports of Quality Improvement studies and problem solving conducted in response to self-identified unmet needs of high-risk clients.

Performance Expectations	Evidence to be reviewed by area program prior to review (self-study) and by Crisis Services Monitoring Team during review.
	6. Results of interviews with identified high-risk clients, their families, significant others, area program staff, and contract providers.
Crisis Response & Crisis Stabilization Services. [See the following elements in the Standards for Monitoring and Accreditation of Area Programs: 2.1, 2.2, 2.5.a-g, 2.8, 2.9, 2.13, 3.4, 3.5, 3.6, 3.9, and 4.5.c.] **1. Overview.** Performance expectations for crisis/emergency telephone response apply to all crisis/emergency calls received 24/7. This includes crisis/emergency calls received through the toll free number as well as crisis/emergency calls received through other area program numbers during regularly scheduled clinic hours. Performance expectations for crisis/emergency walk-in response also applies to all sites where response is provided, whether during regularly scheduled clinic hours or at after-hours sites.	1. Summary description and organizational chart (indicating both administrative and clinical lines of supervision) of 24/7 crisis response services. In addition, the following are provided for both telephone and walk-in crisis response services for both business hours and after hours. 2. Description of each crisis response service, including location and hours of availability of each service. 3. Written policies, procedures, and clinical protocols (that operationalize practice guidelines) used in each service. 4. Credentialing and privileging criteria for staff responsible for crisis response for each service. 5. Privileges that have been granted to crisis response staff for each service. 6. Records of staff development trainings offered and attendance for all crisis response staff.
2. Telephone response:	
2.1 Toll free number is well-publicized and is available 24/7.	1. Copies of the publication of the toll-free number, and tracking log for 24/7 crisis/emergency calls. 2. Documentation of routine Q.I. review for process outcome measures and Q.I. activities for self-identified "problematic" process outcome measures and clinical outcome measures. 3. Results of interviews with clients, their families, significant others, and providers.

Performance Expectations	Evidence to be reviewed by area program prior to review (self-study) and by Crisis Services Monitoring Team during review.
2.2. Toll free number and all other 24/7 crisis/emergency calls are answered by a person within four rings (95% of the time), and less than 5% of calls are lost (abandonment rate).	1. Tracking log for 24/7 crisis/emergency calls and all other crisis/emergency calls received through other area program numbers from which the timeliness of response and the abandonment rate is calculated. 2. Results of phone calls to toll free number and other clinic phones made by Crisis Section reviewers 24/7. 3. Documentation of routine Q.I. review for process outcome measures and Q.I. activities for self-identified "problematic" process and clinical outcome measures. 4. Results of interviews with clients, families, significant others and providers.
2.3. Telephone triage is begun by an appropriately privileged professional within 15 minutes from the end of the initial contact (95% of the time).	1. Contact sheets for each caller referred for phone triage from which the length of time from initial phone contact to phone triage is calculated. 2. Documentation of routine Q.I. review for process outcome measures and Q.I activities for self-identified "problematic" process and clinical outcome measures.
2.4. Back-up supports by appropriate clinicians are available 24/7 to privileged professionals doing phone triage.	1. Credentials, privileges, and schedules of 24/7 back-up professionals. 2. Documentation of consultation by appropriate clinicians.
2.5. Emergent response following phone triage results in face-to-face assessment by an appropriately privileged professional (contingent upon the client presenting at the designated site for the face-to-face assessment within one hour of the phone triage (95% of the time); and privileged professional contacts law enforcement of need to provide timely face-to-face and ensures safety of client and others.	1. Contact sheets for each caller referred for emergent face-to-face assessment from which the length of time from the phone triage to the face-to-face assessment has been calculated. 2. Documentation of Routine Q.I. review for process measures and Q.I. activities for self-identified "problematic" process and clinical outcome measures. 3. Results of client service record reviews.

Performance Expectations	Evidence to be reviewed by area program prior to review (self-study) and by Crisis Services Monitoring Team during review.
2.6. Urgent response following phone triage results in face-to-face assessment by an appropriately privileged professional (contingent upon the client presenting at the designated site for the face-to-face assessment) within 48 hours of the phone triage (95% of the time).	1. Contact sheets for each caller referred for urgent face-to-face assessment from which the length of time from the phone triage and the face-to-face assessment has been calculated. 2. Documentation of Q.I. activities. 3. Results of client service record reviews.
2.7. Non-urgent/routine response following phone triage results in face-to-face assessment by an appropriately privileged professional within seven calendar days of the phone triage (95% of the time).	1. Contact sheets for each caller referred for non-urgent face-to-face assessment from which the length of time from the phone triage and the face-to-face assessment has been calculated. 2. Documentation of Q.I. activities. 3. Results of client service record reviews. NOTE: THIS ELEMENT, 3.5. and 3.6. BELOW WILL NOT BE MONITORED BY THE CRISIS SERVICES SECTION BUT MAY BE MONITORED BY OTHER SECTIONS WITHIN THE DIVISION.
3. Walk-in response:	
3.1. Triage is begun by an appropriately privileged professional within 15 minutes from when the client walks in (95% of the time).	1. See Evidence for telephone triage (2.3) above.
3.2. Back-up support by appropriate clinicians are available 24/7 to privileged professional doing walk-in triage and face-to-face assessment.	1. See Evidence for back-up support (2.4) above.
3.3. Emergent Response following walk-in triage results in face-to-face assessment by appropriately privileged professional within one hour (95% of the time).	1. See Evidence for Emergency Response (2.5) above.
3.4. Urgent response following walk-in triage results in face-to-face assessment by appropriately privileged professional within 48 hours (95% of the time).	1. See Evidence for Urgent Response (2.6) above.

Performance Expectations	Evidence to be reviewed by area program prior to review (self-study) and by Crisis Services Monitoring Team during review.
3.5. Non-urgent/routine response following the walk-in triage results in face-to-face assessment by appropriately privileged professional within seven calendar days (95% of the time).	1. See Evidence for Routine Response (2.7) above.
3.6. Treatment begins within 14 calendar days of a non-urgent/routine face-to-face assessment.	1. Documentation in client service record of dates of service, interviews with clients, their families, significant others, and providers. 2. See Evidence for Routine Response (2.7) above.
4 Crisis Stabilization Services.	
4.1. Clients are able to access crisis stabilization services 24/7. Crisis stabilization services include both: a. Hospital inpatient services AND b. At least ONE of the following services, which should be available immediately as alternatives to inpatient care for ALL clients: *Immediate in-home intervention and/or supports (e.g., mobile outreach crisis staff, CBI/HRI staff, family preservation staff) *23 hour observation *Short-term respite *Crisis stabilization facility *Crisis apartment *Non-hospital detox services *Host homes *Other	1. Summary description and organizational chart (indicating both administrative and clinical lines of supervision) of 24/7 crisis stabilization services. 2. Description of each service. 3. Hours of availability (and hours of access if different than availability) for each service. 4. Number of admissions, LOS of clients and occupancy rate for each crisis stabilization service component. 5. Written policies, procedures, protocols, and practice guidelines for each service. 6. Credentialing and privileging criteria. 7. Privileges that have been granted. 8. Records of staff development trainings offered and attendance for all crisis stabilization staff. 9. Reports of routine Q.I. review of process and clinical outcomes established by the area program and Q.I. activities for self-identified "problematic" outcome measures.

RULES FOR MH/DD/SA FACILITIES AND SERVICES - APSM 30-1
10 NCAC 14V SECTION .6100
EMERGENCY SERVICES FOR INDIVIDUALS OF ALL DISABILITY GROUPS

.6101 SCOPE

Each area program shall make provisions for emergency services on a 24-hour non-scheduled basis to individuals of all ages and disability groups and their families, for immediate screening or assessment of presenting problems including emotional or behavioral problems or problems resulting from the abuse of alcohol or other drugs.

History Note: Authority G.S. 143B-147;
Eff. May 1, 1996.

.6102 STAFF

(a) At least one staff member shall be designated to coordinate and supervise activities of the emergency services network.

(b) A qualified professional, as appropriate to the client's needs, shall be available for immediate consultation and for direct face-to-face contact with clients.

(c) Prior to providing emergency services, each staff member or volunteer shall be trained in:

(1) available resources;
(2) interviewing techniques;
(3) characteristics of substance abuse disorders, developmental disabilities, and mental illness;
(4) crisis intervention;
(5) making referrals; and
(6) commitment procedures.

(d) Volunteers shall be supervised by a qualified professional.

History Note: Authority G.S. 122C-117; 122C-121; 122C-154; 122C-155; 143B-147;
Eff. May 1, 1996.

.6103 OPERATIONS

(a) Emergency services shall include at least the following:

(1) 24-hour access to personnel trained in emergency services;
(2) 24-hour telephone coverage at no cost to the client;
(3) provision for emergency hospital services; and
(4) provision of emergency back-up or consultation by a qualified mental health professional and a qualified alcoholism, drug abuse or substance abuse professional.

(b) The emergency telephone number shall be listed separately in the local telephone directory and publicized in the community through such means as brochures, appointment cards and public service announcements.

(c) At least one designated staff member of the area program shall review emergency services records to assure that arrangements with treatment/habilitation staff are made for follow-up services.

History Note: Authority G.S. 143B-147;
Eff. May 1, 1996.

AREA MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE AUTHORITY PROGRAM ACCOUNTABILITY PLAN

MARCH 1, 1999

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and Substance Services

1999 Legislative Session

TABLE OF CONTENTS

		Page Number(s)
	Executive Summary	1 - 2
I.	Temporary Rules	3
II.	Methods of Compliance	3 - 5
	Fiscal Accountability	
	Administrative Accountability	
III.	Methods of Compliance for Standards of Clinical Practice	6 - 8
IV.	Methods for Assisting Compliance with Standards of Practice	8 - 17
V.	Proposed Legislation	17

Appendix: *Standards for Monitoring and Accreditation of Area Programs*

SB 1366, Section 12.35C, 1997 Session

SB 1366, Section 12.35A, 1997 Session

Executive Summary

Pursuant to Senate Bill 1366, Section 12.35C of the 1997 Session of North Carolina's General Assembly (see appendix), the statutory powers and duties of the Secretary, Department of Human Services (herein referred to as the Secretary) were amended to ensure closer monitoring of the fiscal and administration practices of Area Mental Health, Developmental Disabilities and Substance Abuse Authorities (herein referred to as area programs). These enhanced powers and duties include: 1) The authority to adopt temporary rules, 2) contract with private providers, and reallocate area program funds following a "finding" of area program failure to provide available services, and 3) authority to evaluate area program compliance with applicable standards of administrative and clinical practice. The powers and duties of the Secretary are delegated to the Director, Division of Mental Health, Developmental Disabilities and Substance Abuse Services (herein referred to as the Division or Division Director).

Section 12.35C (f) also requires that the Secretary shall submit a report on methods taken or planned to enhance area program accountability no later than March 1, 1999 to the Legislative Study Commission on Mental Health, Developmental Disabilities and Substance Abuse Services and the Joint Legislative Health Care Oversight Committee.

Background

In September of 1997, the newly appointed Division Director embarked upon a comprehensive initiative to improve area program accountability under applicable laws, rules and standards and to restore public confidence in the twenty-five year old system of local units of government and public authorities referred to as "area programs" which are charged with the planning and delivery of community based mental health, developmental disabilities and substance abuse services.

This alleged and real "crisis in confidence" in area programs had its origin in a number of historical events, the confluence of which culminated in a growing consensus among legislators and stakeholders that at least some area programs were operating at a substandard level in their delivery of clinical services and management of public funds. While it is not the intent of this executive summary or the purpose of this report to find fault or identify all antecedents to the "crisis in confidence", it is believed that several key events and developments over the last decade made substantial contributions to current concerns: growth, infrastructure lag, regional office elimination and revenue maximization.

Growth: From 1987 - 1997, total resources allocated or earned by area programs rose from 1987 - $212,600,000 to 1997 -$729,700,800. This equates to 244% growth in ten years or an average of $51,710,080 per annum. Of this total, 48% can be attributed to Medicaid and the attendant requirement for improved record keeping and reimbursement practices. The administration capacity of area programs to manage and accommodate such rapid growth was thereby stretched to and beyond its limits.

Infrastructure Lag: The capacity of area programs to recruit, develop, understand and implement modern health care business practices was severely compromised during a decade of remarkable growth. New and vastly more sophisticated budget, accounting, contracting, management information, service documentation and personnel systems were developed to varying degrees contingent upon agency leadership, area board oversight, labor market conditions, and the willingness of funding sources, including local governing bodies to invest in business practices needed to ensure public accountability.

Regional Offices: It is ironic that in the midst of a 244% growth in area program funding, State budgetary constraints during FY 91-92 resulted in a decision to close the Division's regional offices and abolish, through a reduction-in-force, 65 regional office and central office positions. The primary misson of the regional offices had been to monitor area program compliance with applicable rules, laws, and standards and to provide technical assistance and facilitate "best practice" program delivery. The monitoring and compliance arm of the Division was amputated at a time which hindsight reveals to have been the worst of times.

Revenue Maximization: Beginning in 1991-92, area programs were strongly encouraged by the Division, Department and the Legislature to maximize third party reimbursement, especially Medicaid. New Medicaid eligible services and new rates were established. Though unplanned, during this period of time area programs relied upon Medicaid receipts to absorb a perennial loss of inflationary adjustments to State allocations while responding to the growing service demands of medically indigent clients. Marginal documentation and unsophisticated reimbursement systems were practically assured under the strain of mandated revenue maximization.

Lastly, the collapse of the Tri-County Area Program (Rowan, Iredell, and Davie Counties) due to questionable management, a series of unsuccessful area directors, and an internicine history of governing body conflict became the proximate cause of the "crisis in confidence" and symptomatic of the underlying stresses and strains gathering momentum across the area program system during a decade of explosive growth, infrastructure lag, regional office elimination and revenue maximization.

Body of Report

The body of this report identifies methods of compliance completed or on-going by the Division, subsequent to the Division Director's September 1997 initiative to reestablish confidence in North Carolina's Area Mental Health, Developmental Disabilities and Substance Abuse Authorities.

I. TEMPORARY RULES

Currently, no temporary rules have been implemented. The Division of MH/DD/SAS has provided policy directives to the area programs that have resulted in change without the implementation of rule. These policies have included: 1) Maximum 16% administrative/overhead charge on contract services to support monitoring and proper accountability related to contracted services, and 2) Statewide Medicaid Appeal procedures.

A Secretarial rule is also being processed for implementation of the CAP-MR/DD Provider Choice Policy. This policy requires a separation of the direct service provision and case management services. Although this rule has not been officially implemented, area programs are adhering to this practice prior to formal rule adoption.

II. METHODS OF COMPLIANCE

Fiscal Accountability

Problems:

- Area Programs did not submit cost reports in a timely manner and once submitted, reports were inaccurate and practices for reporting were inconsistently applied.
- There was insufficient state match for Medicaid billing at the expenditure level.
- Excessive Medicaid rates were paid to area programs.
- There was significant variance in the cost of a Medicaid service between an area program and a contract provider.

Solutions:

Medicaid Match Reserve Fund

- Effective July 1, 1998 -
  - State and federal matching share is paid at time of Medicaid payment to each area program.
  - DMH/DD/SAS provides monthly reports to each area program regarding utilization of the Medicaid Match Reserve Fund.
  - Medicaid reimbursements are withheld from Area Programs that do not meet cost reporting deadlines.

Area Program and Provider Contractual Rates

- DMH/DD/SAS monitoring of contract rates with providers
- Effective December 4, 1998 the Area Program/Provider Relations Committee was formed.
- Effective January 25, 1999, a maximum of 16% administrative charge may be applied to the contractual rate.
- In FY-99-00, a standardized contract between providers and area programs will be implemented.

Area Program Governance

- Technical assistance provided to area programs regarding:
  - County relations
  - Possible mergers of area programs to improve economy of scale
    - Gaston-Lincoln and Cleveland area programs have announced negotiations.
    - Lenoir and Wayne and Duplin-Sampson
    - Edgecombe-Nash, Wilson-Greene and Halifax
  - Management training and oversight.
- DMH/DD/SAS monitoring of quarterly fiscal reports regarding area program financial viability.

Cost Reports

- Effective July 1, 1998, the Department's Controller's office is responsible for cost finding reports.
  - A Work group consisting of area program, DHHS, DMA, and DMH/DD/SAS staff was formed to ensure existing software is functional for FY 98-99 and new software will be implemented effective July, 1999 for FY 99-00.
    - Effective July 1, 1998 modifications were made to existing software.
    - Training scheduled in August, 1998 and training occurred in September and October, 1998.
- Timelines were established for submission of cost reports and submission was linked to the area program's ability to bill Medicaid.
- Accuracy statements are required at the time of cost report submission. The Regional Accountants and DMH/DD/SAS review reports for accuracy.
- Cost Settlement for Medicaid rates for area programs is anticipated for FY 1999-2000.

Integrated Claims Processing

Cross Department Division work group has been established to review MIS capabilities to:

- Insure single payment by one fund for a specific claim
- Insure non-duplication of payment for a single claim
- Contract has been signed with EDS to provide an analysis of the business fit for claims processing with the Medicaid payment process.

Memorandum of Agreement

- Effective July, 1, 1999, Performance Based Contracts between DMH/DD/SAS and area programs
- Allocation of funding will be based upon adherence to the contract.

Administrative Accountability

Problems:

- Allegations were made against the area programs for misuse of Medicaid funds and for billing Medicaid for services that were not rendered to clients.
- Several federal investigations were conducted in certain area programs regarding their billing for Medicaid funds and other federal dollars.
- Allegations were made against area programs and providers that staff did not meet minimum training and educational standards.

Solutions

- **All 40 area programs were reviewed October-December, 1998; 8,000 paid claims were audited by Medicaid TA Team**
    - Plans of corrections were submitted, implemented, and correction action was verified by the DMH/DD/SAS.
    - Targeted technical assistance was provided to Cleveland, Pitt, Durham and CenterPoint Area Programs from January 1998-September, 1998.
    - Reports were forwarded to DMA for initiation of payback.

- **The DMH/DD/SAS Medicaid TA Team will complete annual Medicaid record review of each area program. This review is being completed from January - March, 1999.**
    - Effective, August, 1998 DMH/DD/SAS and DMA developed a standardized record audit tool.
    - Effective August, 1998, DMH/DD/SAS and DMA developed joint procedures of conducting audits, sharing of reports and monitoring of corrective action plan implementation.

- **Standardized documentation format**
    - Effective September, 1998, standardized forms were designed and required for use by area programs and contract agencies for documentation of services.
    - 10 training sessions were conducted; over 2000 clinicians and contract providers were trained in treatment plan development, medical necessity and documentation requirements (service orders and progress notes).

- **Medicaid Services Project**
    - Effective July 1, 1999, modification of existing Medicaid service definitions and the development of new service definitions will be completed in order to meet best practice standards including provider qualifications, utilization criteria, level of care criteria, and access to services standards.
    - Rates will be established based upon cost of service delivery.
    - Training will be conducted area programs and contract providers.
    - Publication of Medicaid Manual and quarterly updates will be distributed.

III. METHOD OF COMPLIANCE FOR STANDARDS OF CLINCIAL PRACTICE

Problems

- Inconsistency in the service options and service array and continuum in the area programs and across disabilities within the area program.
- Inconsistency in the delivery of clinical and programmatic best practices among the area programs.
- Allegations of insufficient training and clinical supervision of staff in the area programs and contract agencies.
- Excessive delays between referrals and appointments for clients.
- Excessive delays in the delivery of services to clients
- Area programs and contracts provider failure to correct identified problems.
- Insufficient network of providers to insure access to services for clients in a timely manner.
- Extensive waiting lists and unmet identified needs for clients who are not Medicaid eligible or have insurance.

Solutions

Area Program Intensive and Disability Reviews were completed March, 1998

- Three (3) Area program intensive reviews conducted (Wayne, Onslow, Pitt)
  - Plan of corrections were required and implemented.
    - Results indicated:
      - Need for better coordination of service delivery across disabilities and agencies
      - Need to expand/reallocate service options and consistency of services across disabilities
      - Needed improvement in the documentation of service provision
      - Need for MIS development and data support
      - Needed improvement in communication across agency
  - Focused reviews were completed January, 1999.
- Seven (7) Disability/Program Specific Reviews were completed by March, 1998.
  - Plan of corrections were required or combined with existing corrective action plans.
    - Results indicated:
      - Need to be more proactive in treatment approaches rather than reactive.
      - Need to improve communication and coordination among internal staff and external agencies.
      - Need to increase service array and options.
      - Need to increase in community education and outreach to address area program role access to services, co-ordination of services.

- Technical assistance and training was provided by each disability section in DMH/DD/SAS.

- **Area Program Accreditation**
- Effective June, 1998, the Division of MH/DD/SAS initiated accreditation visits for area programs.
  - Standards were established in the areas of:
    - Area Program's Community Awareness and Responsiveness
    - Clinical Service Management
    - Administrative Service Management
    - Readiness for Managed Care
  - Standards for Monitoring and Accreditation of Area Programs, APSM 40-3 (see appendix) was written and distributed to area programs.
  - Consumer/Advocates were recruited and will be participants as Review Team members by summer, 1999.
  - As of March 1999, 17 programs had received accreditation visits.
  - Area Programs submitted corrective action plans. Failure to submit plans results in withholding of funding allocations. Corrective action plans are accepted and status reports for plan implementation is received and monitored by the DMH/DD/SAS.

- **National Accreditation will be achieved by all Area Programs by 2001**
  - Contract was signed with the Council on Accreditation of Services for Families and Children (COA).
  - Council on Accreditation will conduct accreditation reviews based upon North Carolina's DMH/DD/SAS Standards and Rules.
  - Pilot reviews will occur with Duplin-Sampson, Smoky Mountain, Cumberland, and Johnston area programs. Site visits are scheduled from February, 1999 through June, 1999.
  - All remaining area programs will be reviewed by July, 2001.

- **Effective September, 1998, Consumer Satisfaction Surveys were completed by all area programs**
  - The survey format is a nationally recognized format that will allow for national comparison of MH/DD/SA services in North Carolina.
  - A component was added to reflect a client self-assessment of improvement of his/her condition or problems.
  - January 1999, the area programs received their reports from the fall, 1998 administration. The second administration will be spring, 1999.

- **Outcomes**
- A project team consisting of area program staff and DMH/DD/SAS staff was formed. The team developed indicators in 5 domains to measure effectiveness of treatment and services provided.

- The five (5) domains identified are:
  - Functioning/Reduction of symptoms
  - Involvement in employment or education
  - Involvement with the criminal justice system
  - Utilization of crisis services
  - Appropriateness of Residential setting
- First administration will be spring, 1999.

IV. METHODS FOR ASSISTING COMPLIANCE WITH STANDARDS OF PRACTICE

The eight Program and Management sections of the Division dedicate substantial resources, primarily staff, to training, training facilitation, on-site technical assistance and consultation as requested by the area programs and their contract agencies. Program development rivals program compliance monitoring as the primary mission of each section. Professional section staff are recruited and retained due to their individual experience, education and currency in models, and standards of best practice.

The volume and variety of requests for information and assistance received every day from area programs, private providers, consumers, advocates and families cannot be enumerated; however, the salient training and technical assistance events and initiatives during calendar year 1998 have been summarized below for each of the Division's sections:

MENTAL HEALTH SECTION

Best practice training was offered on an ongoing basis at different locations throughout the State through a contract with UNC-CH Behavioral Healthcare Resource Program. Structured curriculum includes:

- Curriculum Working with Consumers with Severe and Persistent Mental Illness
  - 10 days of training in Jan/Feb/March, 98 in Fayetteville (37 participants).
  - 10 days of training in March/April/May, 98 in Charlotte (27 participants).
  - 10 days of training Sept/Oct/Nov, 98 in New Bern (41 participants).
- Dual Diagnosis Curriculum (MI/SA)
  - 6 days of training in June, 98 in Winston-Salem (57 participants, plus 40 participants for a pre-conference administrators' workshop).

Statewide Conferences

- Geriatric Mental Health Conference in Asheboro in April '98 (90 participants).
- Supported Housing Conference in Raleigh in April '98 (85 participants).
- Assertive Community Treatment Team Conference in Clemmons in May '98 (60 participants).
- Case Management Conference in Clemmons, in Nov '98 (162 participants).
- Homeless Services Conference in cooperation with in Raleigh in Dec '98 (300 participants).

University-Based Training Programs that received support include:

- Training Program at East Carolina University in Greenville to increase the number of clinical mental health professionals who are able to provide services to individuals who are deaf or hard of hearing.
- Training Program with UNC-CH for psychology interns.

Training in 1998 on Special Topics as Requested by Regional Teams &/or Area Programs:

- Diagnosis and Treatment Planning 1 day in Raleigh in Jan, 98 (27 participants).
- New Directions in Case Management, 1day in Hickory/Western Region in Feb, 98 (25 participants).
- Making the Transition to Managed Behavioral Healthcare 2 days in Greenville in Feb, 98 (85 participants).
- Tailoring Clinical Skills to the SPMI Client in Greenville in April, 98 (25 participants).
- Case Management and CBI Supervision 1 day in Raleigh in May, 98 (69 participants).
- Dialectical Behavior Therapy, 3 days in Western Region in July, 98 (60 participants) and 3 days in North Central Region in spring (35 participants).
- Sex Offender Treatment, 5 days July through October, 98 in Raleigh (62 participants).
- Case Management Services, Wake MHC, 8/25, (35 participants).
- Dual Diagnosis: MI/SA. Greenville, 11/12/98 (30 participants).
- Best Practices in Case Management, Kenansville, 11/24/98, (15 participants).
- Quality Improvement & Monitoring of Case Management 1 day in 5 sites in cooperation with DDTI during Nov/Dec, 98 (271 participants).

CHILD & FAMILY SERVICES SECTION

- "Sexually Aggressive Youth", 350 attendees Statewide Conference held in Chapel Hill in March 1998-(2 days of training) all regions of the state were represented.
- Regional Monthly Technical Assistance Meetings, Sexually Aggressive Youth, training/technical assistance in" best practices" held in each region with area programs as attendees, approximately 60 meetings per year.

- "Cultural Competency Training", May, 1998, (2 days) 400 participants co-sponsored with Urban League of Winston Salem, Old North State Medical Society and the Commission on Indian Affairs; all area programs and institutions invited.
- WE CARE Inc, a Family Advocacy Organization offered training entitled " Promotion of Family Advocacy", 2 events in May and June, total of 30 Staff emphasizing the promotion of organizational stability involving Pitt, Edgecombe-Nash area programs.
- Families Can Inc., a Family Advocacy Organization funded to provided technical assistance /training entitled" Supporting Family Advocacy".
- Five separate Training Sessions were held for the following area programs: Blue Ridge, Sandhills, Vance-Granville-Franklin-Warren, Guilford and Cleveland 1998.
- NC Indian Affairs, 4 Conferences, regarding" Culturally Appropriate Care" involving Cumberland, Halifax, Southeastern Regional Area Programs with the East Band of the Cherokee Nation.
- Mental Health Association In NC and Sandhills Area Program offered training for residential providers in "Appropriate Management Techniques" and "Respite Care Best Practices"- between 1/1/98-6/30/98 in Blue Ridge, Crossroads, Cumberland, Edgecombe-Nash, Foothills, Forsyth-Stokes, Neuse, Orange-Person-Chatham, Smoky Mt. and Wayne.

Curricula

- UNC-CH Training for Case Managers, entitled "Collaboration for Case Management" by the Child Mental Health Project at Halifax (Oct 7,1998), and Crossroads Area Programs, Oct 16, 1998).
- UNC-CH Technical Assistance regarding "Culturally Responsive Care"- three community based training sessions in Foothills, Blue Ridge and Guilford Area Programs, June 1998.
- ECU, Pitt, Edgecombe-Nash Area Programs.
  - Training in skills associated with "Interagency Family and Community Collaboration in Service Planning and Development" ongoing 1998.
- UNC-Greensboro, Guilford Area Program.
  - Training in skills associated with "Interagency Family and Community Collaboration in Service Planning and Development" ongoing 1998.

DEVELOPMENTAL DISABILITIES SECTION

Tech/Assistance Consultation	
# Hours	32,885
# Clients	4,704
Training	
# Session Hours Provided	9,172
# Persons Served	9,475

Waiting List

Training was provided at 10 regional and state trainings. In addition, 40 on-site TA visits with and average of 12 hours a week of TA over the phone for the last 46 weeks for a total of 552 hours.

TBI (Traumatic Brain Injury)

Technical assistance to area programs on behalf of persons with TBI. This TA consists of assisting the Area Program to identify care providers and funding to serve individuals with complex needs.

During 1998, technical assistance was provided on behalf of 125 consumers; information and referral was provided to 100 family members; 45 families were provided resource materials; 680 individuals who sustained brain injury have been entered into the Central Registry; and 12 training events were held.

Family Support

Technical Assistance in this area includes community forums, direct assistance to area programs and community–based agencies, direct support to consumer leadership teams, written materials and guidance about Family Support, and special topic training around Family Support (i.e., family support and self-determination, family support and single portal).

In 1998, five forums were held from Fayetteville to Franklin. Approximately 10 area programs received direct technical assistance in some form. Seven consumer leadership teams received support, and various written materials were developed, including an information packet which is regularly mailed to families and professionals requesting more information.

Early Childhood Intervention

Technical assistance provided about Early Intervention includes conferences, collegial support, university and college continuing education, on-site technical assistance, teleconferences, train-the-trainer events, workshops, retreats and forums.

Data for 1998 indicates that approximately 150 Area Program representatives received technical assistance. In addition, 830 representatives from public and private, state and local agencies received technical assistance. Topic areas included: child development, family development, screening and assessment, IFSP, intervention strategies, interagency and community process, personal and professional values, and assistive technology.

SUBSTANCE ABUSE SECTION

Technical Assistance

- Quarterly "Directors Forums" designed for the Area Program Substance Abuse Coordinators and selected staff. The content of these forums in 1998 addressed compliance issues related to the Division's Accreditation/Monitoring Initiative and specific " best practice" information related to TANF/Work First.
- Ongoing intensive technical assistance (with training when needed) to seven Enhanced EAP sites for the Welfare Reform and SA project. The seven sites are: Foothills, Centerpoint, Cumberland, Duplin-Sampson, Presbyterian Hospital in Mecklenburg County, Gaston-Lincoln, and Cleveland.
- Statewide technical assistance on establishment of policy for area programs and institutions on serving substance abusing clients in state psychiatric facilities.

Curricula

- Two-day collaborative training in Welfare Reform and Substance Abuse Services for DSS workers and area program substance abuse practitioners across the state. A total of 11 trainings were offered, with a total of approximately 300 trainees from area programs and DSS.
- Intensive half-day trainings across the state in substance abuse screening techniques for DSS workers and area program QSAPs serving TANF populations. A total of 51 trainings were offered and approximately 1025 DSS staff and QSAPs trained.
- Half day Pre-Conference Institute and 5-day curriculum on serving clients with dual diagnosis (MI/SA). Statewide training in Winston-Salem. June 9 (Pre-Conference), 10, 16, 17, 23, 24. Forty attended the pre-conference, and 57 the 5 day training.
- NC School for Alcohol and Drug Studies, "Working with addicted offenders" 32 participants--week long track.
- NC School for Alcohol and Drug Studies, "Enhanced Employee Assistance Programs and Work First", approximately 25 participants.

Training

- Confidentiality and Substance Abuse Services for Randolph MHC. 35 participants.
- Training on Welfare reform and on Managed Care at the Women and Addictions conference in Kanuga. 68 participants.
- ASAM and LOC, in collaboration with Mountain AHEC, 33 participants.

- Behavioral Implications of Welfare Reform, in collaboration with Charlotte AHEC and Wake AHEC, and in Greensboro, 60 participants.
- Conference for Area Programs on new SA initiatives--facilitated QSAP focus groups. 10/30/98, Burlington, approximately 150 participants.

WILLIE M. SECTION

The Willie M. Section provides general guidance in the form of rules, manuals, printed materials, telephone guidance and one-on-one help on request to local programs in meeting the Program's requirements and incorporating best practices. The Section also provides two types of specialized assistance that are delineated below.

Direct Consultation, Coordination, and Monitoring by Regional Staff

The Willie M. Section Service Management Branch provides technical assistance and consultation to all Area Programs with regard to client evaluation case management, program management, budgeting, interagency coordination and program evaluation for Willie M. services. The Section's Regional Service Managers (RSMs) provide ongoing, on site consultation to area programs on individual client treatment issues as well as systems management issues. The RSMs are responsible for implementation of Willie M. program development and service delivery standards through the use and integration of several standardized processes, all of which are delivered from a Total Quality Management approach (TQM): (1) Appropriateness Reviews (currently utilized by Area Programs for the purpose of self-monitoring of individual client service quality); (2) Assessment and Outcome Instrument (an annual thorough review of individual client status which is currently providing year four outcome data relative to consumer progress); (3) Systems Performance Quality Indicators (initially developed by the Willie M. Section) later adopted by the Division's Quality Improvement Section for use in area program accreditation reviews; (4) and the Systems Improvement Plan (the development of which involves all systems stakeholders via local meetings facilitated by Willie M. regional service managers, and focuses on areas of need for quality improvement related to best practice standards). With the first two processes, the RSMs provide training, consultation and advice in interpreting results of the measurement systems. With the latter two processes, the RSMs are directly involved in the analysis of data and development of quality improvement strategies with the local staff.

Specific Training Events Sponsored and Organized by Central Training Unit:

- March 1998 - Child and Adolescent Clinical Symposium, Charlotte - 241 people.
- April and October 1998 - Case Manager Orientations - 89 people.
- June 1998 Crisis Prevention Instructor training with 37 people certified to train others in this method of defusing possibly violent situations.
- Trained Crisis Prevention Instructors held over 103 training sessions across the State with over 1209 caregivers learning to defuse potentially violent situations peacefully.
- September 1998 – Willie M. Program Leadership workshop for local Mental Health and Public School Willie M. coordinators with 98 people attending.

- January and March 1998 - Two Residential instructor trainings held with a total of 30 people attending.
- May/June, 1998 - Training in the use of the new Treatment and Habilitation Plan for 66 people.
- Seven teleconferences were held across the state during the year covering topics of interest to case managers with over 312 people participating.
- Information Systems Branch staff conducted one-on-one trainings at local area programs in the Willie M. Information System (WMIS) and use of the computer system.
- The Section's Evaluation Branch conducted trainings in the use of Assessment and Outcome Instruments (the program's primary vehicle for collection of individual client outcome data).

THOMAS S. SECTION

Technical Assistance

- Area program staff monitored the services and outcomes of 1105 Thomas S. class members, using tools specified by the Section. Area program Thomas S. Coordinators and Thomas S. Section Service Managers conducted monitoring of 101 of these same individuals as a validation of the quality of monitoring.
- The Section supported the hiring of 32 area program, full or part-time, Quality Improvement Coordinators. One roundtable discussion was held for training and feedback with these Coordinators, and a number of resources were disseminated in a notebook.
- The Section required that each area program develop a local annual plan and quality improvement plan for Thomas S. Services. Thomas S. Service Managers assisted in this process throughout the year, culminating in written products for most of the area programs by December.
- Thomas S. Service Managers and Regional Administrators conducted a minimum of one technical assistance visit per month, per area program, including programmatic, fiscal and infrastructure issues. Additional technical assistance was offered around specific issues needed by individual area programs.
- Accreditation reviews were conducted by The Council on Quality and Leadership in Supports for People With Disabilities for 23 area programs (all others had current accreditation status).
- The Section conducted an analysis of Incident Frequency Reports submitted by area programs and disseminated information regarding the reported trends of incidents by provider, area program and class member.

Training

- The Section provided the following number of training events:
  Personal Outcomes Assessment—27
  Essential Lifestyle Planning— 24
  Gentle Teaching—6
  Social Role Valorization—3
  Behavioral Supports—3

- The Section conducted the first Thomas S. Conference; co-sponsored the Institute on Dual Diagnosis; Developed a Self-Directed Learning Curriculum for direct care providers, which is included as a course in the Community Colleges; held two Best Practices sessions with national speakers; sponsored joint Thomas S./Vocational Rehabilitation training.
- The Section made a transition to new service planning and monitoring processes that are more centered around the person, and conducted four training events throughout the state regarding the new processes.

CRISIS SERVICES SECTION

Activities of the Crisis Services Section for 1998 in support of area programs providing best-practice services include the following:

Technical Assistance and Teleconferences:

- Mental Illness/Substance Abuse Integrated Treatment Initiative – 2/10/98 (45 attendees at Raleigh, Winston/Salem, Wilmington, Greenville and Newton teleconference sites).
- Three Follow-up Face-to-Face Meetings with 15 area programs awarded MI/SA funds:
  5/14 – 5/15/98 in Durham with 43 attendees
  10/14/98 in Concord with 8 attendees
  10/27/98 at Kenansville with 8 attendees
- Crisis Response in Substance Abuse Disorders – 4/14/98 (47 attendees – same sites).
- Crisis Elements in Monitoring & Accreditation – 6/9/98 (52 attendees – same sites).
  Follow-up Face-to-Face Meetings regarding Crisis Elements in Monitoring and Accreditation:
  7/28/98 in Greensboro with 25 attendees
  7/29/98 in Kinston with 20 attendees
  7/29/98 in Asheville with 6 attendees
- Diagnosing Mental Retardation: Criteria & Critical Issues – (same sites as teleconference listed above with 18 attendees).

Crisis Response Planning Seminars - This training instructs area programs in the development of Crisis Prevention/Intervention Plans for high-risk individuals with co-occurring MH/DD/SA problems, who are frequently hospitalized. Seminars took place on a monthly basis, rotating from Kinston to Burlington; total attendees for 1998 = 115. This training was also provided, upon request, for Pitt Area Program (Greenville) for 50 attendees on 6/10/98.

Crisis Intervention in Behavioral Healthcare - This is a three-day training focused on Crisis Response, Crisis Stabilization and Crisis Prevention for staff who provide care for individuals with MH, SA, DD and co-occurring disorders, and especially for staff responding to crisis calls. Below are the trainings presented in 1998:

- Wilmington at Coastal AHEC 1/20/98, 2/9/98, 2/16/98 = 41 attendees X 3 days
- Fayetteville at S. Regional AHEC 3/23/98, 3/30/98, 4/21/98 = 36 attendees X 3 days
- Rocky Mount at Area L AHEC 5/19/98, 5/26/98, 6/9/98 = 31 attendees X 3 days
- Greenville at Eastern AHEC 9/14/98, 9/21/98, 9/28/98 = 20 attendees X 3 days

- Asheville at Mountain AHEC 11/9/98, 11/23/98, 11/30/98 = 28 attendees X 3 days

Training for Area Programs/Private Providers/Families/Advocates:

- Crisis Response for Individuals with MI and SA on 10/7/98 at Rocky Mt. (Area L AHEC) with 11 attendees.
- Crisis Prevention & Intervention for Individuals with Autism on 10/8/98 in Asheville (Mountain AHEC) with 11 attendees, 10/16/98 in Wilmington (Coastal AHEC) with 40 attendees, and 11/13/98 in Greensboro (AHEC) with 40 attendees.
- NC Clinical Update – "Dialectical Behavior Therapy Training," presented by Dr. Liz Simpson, MD, on 9/14/98 at Southern Pines with 60 attendees.
- NC Council Conference, Crisis Institute - "Treating MI/SA Disorders in a Managed Care Environment," presented by Dr. Kenneth Minkoff, MD, at Pinehurst on 12/7/98 with 75 attendees.

MANAGEMENT SERVICES SECTION

The Management Services Section provides training and technical assistance to the area programs and private providers regarding Medicaid services, Carolina Alternatives, CAP-MR/DD, Cost Finding, Service Records Standards, Client Rights and Area Program Rules. The following training opportunities were offered from July 1, 1998 through January 30, 1999 by Management Services:

- Service Records Manual and Documentation Requirements: Eight sessions held across North Carolina, over 218 agency and area programs in attendance.
- CAP-MR/DD Case Manager Orientation: Five two-day orientations for 256 case managers and staff of private providers.
- CAP-MR/DD Annual Conference: Two-day conference with 607 participants. Next conference is scheduled for March, 1999.
- Second Annual Client Right's Conference: Two-day conference with 300 participants.
- Annual Cost Finding Training: 40 area programs.
- Carolina Alternatives Level of Care Training: 42 area program staff in attendance.
- Medicaid Appeals and Grievance Process: Four sessions held with 103 staff in attendance.
- CAP-MR/DD Waiver Change Training: Four, one-day training for area programs and private providers – 832 participants.
- Council on Accreditation (COA) Mentor Training
- Council on Accreditation (COA) Orientation

In addition to the above training and accreditation visits, Management Services staff provided over 17,000 hours of targeted technical assistance to area programs and providers. The technical assistance visits concentrated in MIS consultation, cost finding, documentation requirements, appeal and grievance requirements, mediation and dispute resolution between

providers and area programs, Medicaid standards, case consultations, service definition and provider qualifications, organizational management, strategic planning and parent/advocacy group education.

V. PROPOSED LEGISLATION

Pursuant to Senate Bill 1366, Section 12.35A of the 1997 Session, (see appendix) the Office of State Auditor is coordinating a comprehensive study of the State psychiatric hospitals and area mental health programs. These studies are being coordinated with the Fiscal Research Division of the NC General Assembly, the NC Department of Health & Human Services, the Division of Mental Health/Developmental Disabilities/Substance Abuse Services. The legislation directs that the study shall include an assessment of the overall structure of the mental health delivery system including:

- Changes that should be made to ensure an operating structure through which improved and adequate quality of services to clients will be delivered efficiently;
- The kinds of structures and process that should be established to ensure the most efficient and effective systems for governance, service delivery, program administration, and oversight;
- Any changes that should be made in relationships and roles pertaining to State and local government so as to create a faster and more efficient/effective program operations;
- Current operational and administrative policies and procedures, and current funding streams.

It is anticipated that this comprehensive study (to be completed no later than December 1, 1999) will include recommended legislation which the Department and Division will consider through the customary legislative process; therefore, it is believed that a proposal for legislative changes to improve area program accountability would be premature at this time.

APPENDICES

SB 1366, SECTION 12.35A, 1997 SESSION

Requested by: Representatives Gardner, Cansler, Clary, Howard, Senators Martin of Guilford, Cooper, Dannelly, Phillips, Purcell

STUDY OF STATE PSYCHIATRIC HOSPITALS/AREA MENTAL HEALTH PROGRAMS

Section 12.35A. (a) Of the funds appropriated in this act to the Department of Health and Human Services, the sum of seven hundred fifty thousand dollars ($750,000) for the 1998-99 fiscal year shall be transferred to the Office of the State Auditor. The State Auditor shall use these funds to coordinate a comprehensive study of the State psychiatric hospitals and area mental health programs and shall involve the Fiscal Research Division throughout the study process on such matters as Requests for Proposals and study content. Also throughout the study process, the State Auditor shall consult with the Fiscal Research Division and with the Department of Health and Human Services on other matters pertaining to the study. In coordinating the study project, the State Auditor shall contract with independent consultants with expertise in the structure, administration, and programs of mental health systems and state psychiatric hospitals. The study shall build upon results of the MGT, Inc., study, shall include costs of construction and operation of new facilities as compared to redesign and long-term operation of other existing State psychiatric hospitals, and, weighing both cost efficiencies and the availability of and access to quality patient care, shall assess all of the following:

(1) How many and what type of beds are needed statewide, in a manner that provides adequate and efficient access.

(2) The capacity and ability of area mental health programs to efficiently and effectively absorb specific services now provided within the existing State hospital system.

(3) The overall structure of the mental health delivery system, including:

a. Changes that should be made to ensure an operating structure through which improved and adequate quality of services to clients will be delivered efficiently;

b. The kinds of structures and processes that should be established to ensure the most efficient and effective systems for governance, service delivery, program administration, and oversight;

c. Any changes that should be made in the relationships and roles pertaining to State and local government agencies so as to create and foster more efficient and effective program operations.

(4) Current operational and administrative policies and procedures, and current funding streams.

(b) The State Auditor shall make the following reports to the members of the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Human Resources:

(1) An interim report on the study of the State psychiatric hospitals not later than May 1, 1999, and a final report not later than December 1, 1999.

(2) A progress report on the study of the area mental health programs not later than March 15, 1999, a first interim report not later than May 1, 1999, a second interim report not later than November 1, 1999, and a final report not later than April 1, 2000.

(3) An interim report on items required under subsection (a)(4) of this section not later than March 15, 1999, and a final report not later than May 1, 1999.

(c) In coordinating this study project, the State Auditor shall ensure that reasonable opportunity during the study is provided for collaboration and consultation between the entity conducting the study, the Department of Health and Human Services, and other affected parties.

Requested by: Representatives Gardner, Cansler, Clary, Howard, Senators Martin of Guilford, Cooper, Dannelly, Phillips, Purcell

CIVIL COMMITMENT/FORENSIC UNIT

Section 12.35B. (a) G.S. 15A-1321 reads as rewritten:

"**§ 15A-1321. Automatic civil commitment of defendants found not guilty by reason of insanity.**

(a) When a defendant charged with a ~~crime~~ crime, wherein it is not alleged that the defendant inflicted or attempted to inflict serious physical injury or death, is found not guilty by reason of insanity by verdict or upon motion pursuant to G.S. 15A-959(c), the presiding judge shall enter an order finding that the defendant has been found not guilty by reason of insanity of a crime and committing the defendant to a State 24-hour facility designated pursuant to G.S. 122C-252. The court order shall also grant custody of the defendant to a law enforcement officer who shall take the defendant directly to that facility. Proceedings thereafter are in accordance with Part 7 of Article 5 of Chapter 122C of the General Statutes.

(b) When a defendant charged with a crime, wherein it is alleged that the defendant inflicted or attempted to inflict serious physical injury or death, is found not guilty by reason of insanity, by verdict, or upon motion pursuant to G.S. 15A-959(c), notwithstanding any other provision of law, the presiding judge shall enter an order finding that the defendant has been found not guilty by reason of insanity of a crime and committing the defendant to a Forensic Unit operated by the Department of Health and Human Services, where the defendant shall reside until the defendant's release in accordance with Chapter 122C of the General Statutes. The court order shall also grant custody of the defendant to a law enforcement officer who shall take the defendant directly to the facility. Proceedings not inconsistent with this section shall thereafter be in accordance with Part 7 of Article 5 of Chapter 122C of the General Statutes."

(b) This section becomes effective January 1, 1999, and applies to offenses committed on and after that date.

Requested by: Senators Martin of Guilford, Phillips, Dannelly, Cooper, Purcell, Representatives Gardner, Cansler, Clary, Howard

AREA MENTAL HEALTH AUTHORITY PROGRAM ACCOUNTABILITY

Section 12.35C. (a) G.S. 122C-112(a) is amended by adding the following new subdivision to read:

"(16) Monitor the fiscal and administrative practices of area mental health programs to ensure that the programs are accountable to the State for the management and use of federal and State funds allocated for mental health, developmental disabilities, and substance abuse services. The Secretary shall ensure maximum accountability by area programs for rate-setting methodologies, reimbursement procedures, billing procedures, provider contracting procedures, record keeping, documentation, and other matters pertaining to financial management and fiscal accountability. The Secretary shall further ensure that the practices are consistent with professionally accepted accounting and management principles."

(b) Notwithstanding G.S. 150B-21.1, the Secretary may adopt temporary rules to implement subsection (a) of this section, provided that the temporary rules

SB 1366, SECTION 12.35C, 1997 SESSION

(c) In coordinating this study project, the State Auditor shall ensure that reasonable opportunity during the study is provided for collaboration and consultation between the entity conducting the study, the Department of Health and Human Services, and other affected parties.

Requested by: Representatives Gardner, Cansler, Clary, Howard, Senators Martin of Guilford, Cooper, Dannelly, Phillips, Purcell

CIVIL COMMITMENT/FORENSIC UNIT

Section 12.35B. (a) G.S. 15A-1321 reads as rewritten:

"**§ 15A-1321. Automatic civil commitment of defendants found not guilty by reason of insanity.**

(a) When a defendant charged with a ~~crime~~ crime, wherein it is not alleged that the defendant inflicted or attempted to inflict serious physical injury or death, is found not guilty by reason of insanity by verdict or upon motion pursuant to G.S. 15A-959(c), the presiding judge shall enter an order finding that the defendant has been found not guilty by reason of insanity of a crime and committing the defendant to a State 24-hour facility designated pursuant to G.S. 122C-252. The court order shall also grant custody of the defendant to a law enforcement officer who shall take the defendant directly to that facility. Proceedings thereafter are in accordance with Part 7 of Article 5 of Chapter 122C of the General Statutes.

(b) When a defendant charged with a crime, wherein it is alleged that the defendant inflicted or attempted to inflict serious physical injury or death, is found not guilty by reason of insanity, by verdict, or upon motion pursuant to G.S. 15A-959(c), notwithstanding any other provision of law, the presiding judge shall enter an order finding that the defendant has been found not guilty by reason of insanity of a crime and committing the defendant to a Forensic Unit operated by the Department of Health and Human Services, where the defendant shall reside until the defendant's release in accordance with Chapter 122C of the General Statutes. The court order shall also grant custody of the defendant to a law enforcement officer who shall take the defendant directly to the facility. Proceedings not inconsistent with this section shall thereafter be in accordance with Part 7 of Article 5 of Chapter 122C of the General Statutes."

(b) This section becomes effective January 1, 1999, and applies to offenses committed on and after that date.

Requested by: Senators Martin of Guilford, Phillips, Dannelly, Cooper, Purcell, Representatives Gardner, Cansler, Clary, Howard

AREA MENTAL HEALTH AUTHORITY PROGRAM ACCOUNTABILITY

Section 12.35C. (a) G.S. 122C-112(a) is amended by adding the following new subdivision to read:

"(16) Monitor the fiscal and administrative practices of area mental health programs to ensure that the programs are accountable to the State for the management and use of federal and State funds allocated for mental health, developmental disabilities, and substance abuse services. The Secretary shall ensure maximum accountability by area programs for rate-setting methodologies, reimbursement procedures, billing procedures, provider contracting procedures, record keeping, documentation, and other matters pertaining to financial management and fiscal accountability. The Secretary shall further ensure that the practices are consistent with professionally accepted accounting and management principles."

(b) Notwithstanding G.S. 150B-21.1, the Secretary may adopt temporary rules to implement subsection (a) of this section, provided that the temporary rules

shall not become effective until 60 days after the Secretary has provided notice and opportunity for written comment to the general public of the Secretary's intent to adopt temporary rules, the purpose and subject matter of the rules, and the effective date of the rules. Notice and comment shall be through publication in the North Carolina Register, in the print media, and through mailings to area mental health authorities and other appropriate mental health institutions and providers that will be subject to the temporary rules.

(c) G.S. 122C-112(b) is amended by adding the following new subdivisions to read:

"(10) Contract with one or more private providers or other public service agencies to serve clients of an area authority and reallocate the area authority's funds to pay for services under the contract if the Secretary finds all of the following:

a. The area authority refuses or has failed to provide the services to clients within its service area in a manner that is at least adequate.

b. Clients within the area authority's service area will either not be served or will suffer an unreasonable hardship if required to obtain the services from another area authority.

c. There is at least one private provider or public service agency within the area authority's service area willing and able to provide services under contract.

Before contracting with a private provider as authorized under this subdivision, the Secretary shall provide written notification to the area board of the Secretary's intent to contract, and shall provide the area authority an opportunity to be heard.

(11) Contract with one or more private providers or other public service agencies to serve clients from more than one area authority and reallocate the funds of the applicable area authorities to pay for services under the contract if the Secretary finds either that there is no area program available to act as the administrative entity under contract with the provider or that the administering area program refuses or has failed to properly manage and administer the contract with the contract provider and clients will either not be served or will suffer unreasonable hardship if services are not provided under the contract. Before contracting with a private provider as authorized under this subdivision, the Secretary shall provide written notification to the area board of the Secretary's intent to contract, and shall provide the area authority an opportunity to be heard."

(d) G.S. 122C-191(d) reads as rewritten:

"(d) The Secretary shall develop rules for a review process to monitor area facilities and State facilities for compliance with the required quality assurance activities as well as other rules of the Commission and the Secretary. The rules may provide that the Secretary has the authority to determine whether applicable standards of practice have been met."

(e) The Secretary shall ensure that contracts between the Department and area mental health authorities are in standardized form to the extent practicable.

(f) The Secretary shall submit a report to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Legislative Health Care Oversight Committee not later than March 1, 1999. The report shall include all of the following:

(1) Temporary rules adopted pursuant to subsection (a) of this section.

(2) Methods for ensuring area mental health authority compliance with the rules. Methods shall take into account the Secretary's existing authority over area programs under G.S. 122C-124, 122C-125, 122C-125.1, and 122C-126, as well as the general powers and duties conferred upon the Secretary under Chapter 122C of the General Statutes.

(3) Methods for ensuring area mental health program compliance with applicable standards of practice and with existing laws, rules, and regulations governing clinical practices.

(4) Methods for assisting area mental health programs in complying with applicable standards of practice and with State and federal laws, rules, regulations, and standards.

(5) Any recommendations, including proposed legislation, the Secretary may have to enhance accountability of area mental health programs.

Requested by: Representatives Cansler, Gardner, Clary, Howard, Senators Martin of Guilford, Cooper, Dannelly, Phillips, Purcell

AGENCY OVERSIGHT OF CARE PROVIDED TO PERSONS WITH MENTAL ILLNESS AND DEVELOPMENTAL DISABILITIES

Section 12.35D. The Department of Health and Human Services shall review the effectiveness of existing agency oversight with respect to family care centers, foster homes, nursing homes, and adult care homes which provide care for persons with mental illness and for persons with developmental disabilities. The report shall include, but not be limited to, all of the following:

(1) The current status of enforcement of existing laws, rules, and regulations in local settings, who is responsible for enforcement and under what authority,

(2) Whether and to what extent clients, families, and staff in small residential settings feel free to speak to responsible authorities empowered to resolve problems without fear of reprisal, and

(3) What can be done about problems in facilities that require immediate resolution for which no enforcement remedies are immediately available.

The Department shall report its findings and recommendations to the Joint Legislative Health Care Oversight Committee and the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than April 1, 1999.

Requested by: Representatives Gardner, Cansler, Clary, Howard, Senators Martin of Guilford, Cooper, Dannelly, Phillips, Purcell

SUBSTANCE ABUSE GRANT-IN-AID

Section 12.35G. Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of one hundred thousand dollars ($100,000) shall be used as a grant-in-aid to Day-by-Day, Inc., for the provision of substance abuse services statewide. The Department, in conjunction with Day-by-Day, Inc., shall report to the House of Representatives Appropriations Subcommittee on Human Resources and the Senate Appropriations Committee on Human Resources on the use of these funds and on the following:

(1) The number of clients served by Day-by-Day, Inc.,

(2) The types of services provided,

(3) Demographic information on clients served,

Financial Monitoring of the Contract with the Army and State Of North Carolina

- State was required to provide a Progress Report to the Army on a quarterly
- basis. One of the sections of the progress report contained a Surveillance Monitoring Activity for Cardinal Mental Health Group for both programmatic and financial activities.

- The primary Financial Monitoring Activities contained in the Surveillance Plan required the State to:
  - Review vouchers from Cardinal on a monthly basis for accuracy, allowability and proper documentation.
  - Monitor and track all budget revisions and track expenditures against approved budget.
  - Identify trends in spending that could result in over/underspending.
  - Perform monitoring of financial records to ensure records are accurate and in accordance with proper financial practices.
  - Review contractor system for paying bills for client services and ensure payments do not exceed approved rates.
  - Monitor expenditures for capital expenditures.
  - Require an audit by an independent CPA firm.

Financial Monitoring of the Contract with the Army and State Of North Carolina

- **Monthly Process:**

1. Each month Cardinal provided the Controller's Office a summary of expenditures by the approved budgeted line items (Salary, Fringe, Travel, Rental Costs, Equipment, Contract Costs, etc.).
2. The Controller's Office Project Accountant reviewed the vouchered costs against the budgeted line items and prepared expenditure trend reports for management.
3. Monthly expenditure reports were prepared as prescribed by the Army and submitted to the Army Contract Officer.
4. Army Contract Officer reviewed and defined monthly sample of expenditures to be reviewed in detail.
5. The Controller's Office Project Accountant and Army Contract Officer Representative made monthly on-site visits to Cardinal to review supporting documentation for selected sample. Sample expenditures were reviewed for accuracy, allowability and completeness of documentation.
6. Army paid state for vouchered costs. If costs were considered unallowable by state, cost were not vouchered to the Army. If Army considered costs unallowable, payment reflected reduced amount.
7. Controller's Office Project Accountant made additional monthly monitoring visits to review financial records.

Ft. Bragg Audit by Defense Contract Audit Agency (DCAA)
Audits for 1992-1995

Questioned Cost Title	DCAA Questioned Cost Amount	Narrative Description
Total Contract Costs of $92,000,000		
Travel	$3,484.00	Questioned Travel costs for Exec. Director and Board Chair. Was approved by Board Chair.
24 Hour Services	$4,176,941.00	Questioned residential services costs. Army contends costs are in excess of statewide ave. rates. State doesn't agree with Army's comparison of statewide rates as the Carndinal rates residential rates include outpatien services. For the State outpatient services are billed separately. Willie Ms. Other residential costs were paid at the CHAMPUS approved rate.
Medical Director-Salary	$155,698.00	DMH/DD/SA Personnel determined Stein's experience and qualifications qualified him for salary paid.
Medical Director-Travel	$42,772.00	Travel was more cost efficient than moving. Moving costs $90k vs travel $42k for all 4 years.
G & A Allocability	$9,058.00	Army questioned portion of Cardinal admin cost as it appeared to benefit the partnership. State: transaction was charged to Cardinal that benefited partnership, but was corrected.
Provider Cost	$23,538.00	Questioned contract provider services costs. Cardinal reimbursed per the contractor negotiated rate which was at 90% of the CHAMPUS rate or less.
Training/Education	$5,435.00	Questioned employee post graduate degree costs. State contends costs are allowable under OMB A-122. Army itself defines that OMB A-122 governs the non-profit organization.
Dues & Subscriptions	$3,239.00	Questioned membership to Chamber of Commerce. OMB A-122 provides for memberships as allowable.
Legal Cost	$9,050.00	Questioned Legal Fees. Fees were related to Army request to extend contracts and client related activity-confidentiality .
	$4,429,215.00	

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-24, **1999**

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Bowdish	Zeb Alley P.A.
John Boggett	MH/DD/SA
Jim Edgerton	DHHS
David Bruton	DHHS
Mé Broyden	DHHS
Gary Guyer	DHHS
Tara Larson	DMH/DD/SAS
Marc Lodge	DHHS
Bob Hargett	Justice
Don Willis	DMHDDSAS
Dave Richard	Arc/NC
Allan Zeader	NC Council of Comm Programs
MICHELLE COTTON	DMH/DD/SAS
Wayne Williams	OSBM
Lisa Abatemarco	DHHS/BP+A
Debbie Crane	DHHS
Mark Van Sciver	DHHS
Beth Melcher	NAMI NC
John Wiles	Cheshire Parker, Schneider, Wells & Bryan
Craig Jarvis	N&O
Kathy Boyette	ARC / HIGH Point
Patricia A. Yancey	Hospice of the Carolinas / APPCNC
J. Craig Lewis	PCMH
Janet Simmons	NC Council of Community Programs
Stacy Flannery	NC Health Care Facilities Ass.
HUGH TILSON	NCHA
Lou Wilson	NCALTCF.
Peyton Maynard	[illegible]

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-24, **1999**
Name of Committee   Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
George Irving	Johnson & Johnson
[illegible]	OSBM
Paula A. Wolf	Covenant w/NC's Children

AGENDA

Joint Subcommittee on Health and Human Services Appropriations

Legislative Office Building - Room 424
Thursday, March 25, 1999
8:30 a.m.

Opening Remarks	Sen. Bill Martin, Co-Chair Rep. Beverly Earle, Co-Chair Rep. Edd Nye, Co-Chair
Division of Mental Health Area Program Accountability Plan	John Baggett, DMH/DD/SAS
Briefing: Special Education & Medical Services	Robin Johnson, Counsel Education Committee
Adjourn	

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

MINUTES
MARCH 25, 1999
8:30

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Thursday, March 25, 1999 at 8:30 a.m. in Room 424 of the Legislative Office Building.

House Co-Chair Representative Beverly Earle presided. Other House members present were:

Representative Edd Nye, Co-Chair
Representative Martha Alexander, Vice Chair
Representative Alma Adams
Representative Lanier Cansler
Representative Theresa Esposito
Representative Trudi Walend
Representative Gene Wilson

All six Senate members were present.

Representative Beverly Earle called the meeting to order at 8:30 a.m. Pages were introduced and Dr. Baggett, from the Department Mental Health, Developmental Disabilities and Substance Abuse Service gave a presentation on Area Program Accountability Plan. (See Attachment II) Dr. Baggett began by stating that this information was prepared in the response to Senate Bill 1366, Section 1235C from last year's legislation. He also said that there has been a tremendous effect to improve area program accountability and to restore public confidence in the area program system in our state. He highlighted factors impacting current "crisis" in the area program system, such as, inadequate management, erosion of area programs, fraud and abuse of Medicaid, and other issues. (See Attachment)

The Representatives and Senators contributed to the presentation with questions concerning the area programs. Dr. Baggett and Dr. Bruton, Secretary of Health and Human Services gave explanations and answers. Dr. Bruton concluded the meeting saying the system is not perfect or honest, but they are getting there.

Due to the length of the presentation from Dr. Baggett, time did not allow for a briefing from Robin Johnson, Counsel of the Education Committee. She will present her presentation at the next meeting.

The meeting adjourned at 9:45.

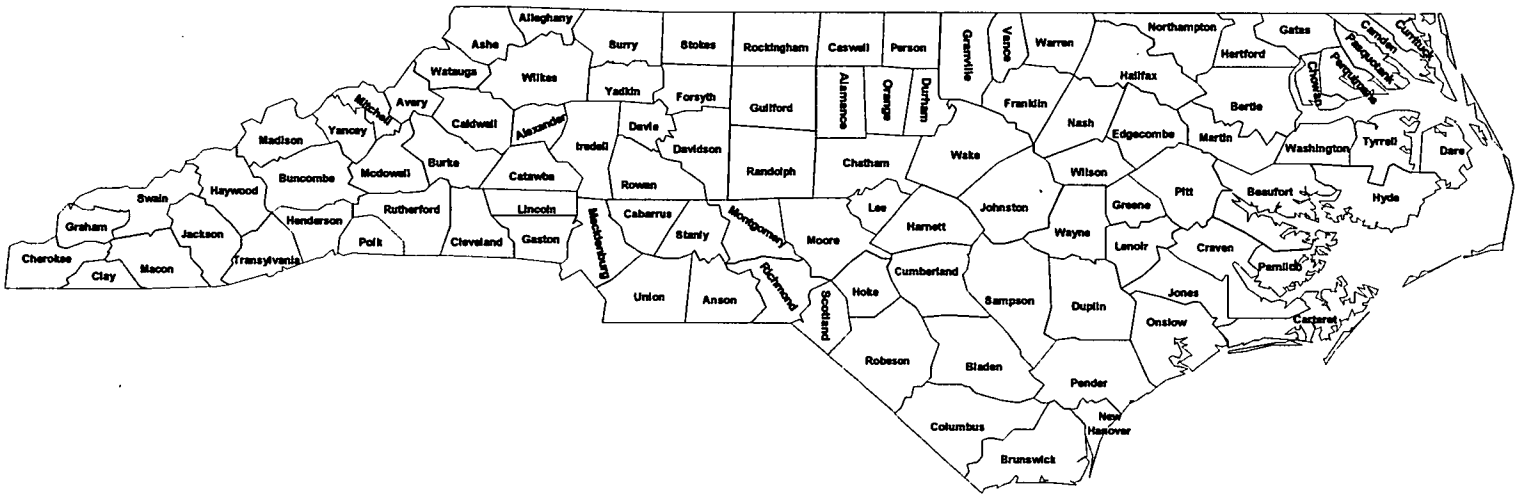
Respectfully submitted,

Presiding Co-Chair, Representative Beverly Earle

Ann Raeford, Committee Clerk

Attachment I	Agenda
Attachment II	North Carolina Area Mental Health Programs
Attachment III	Visitor Registration

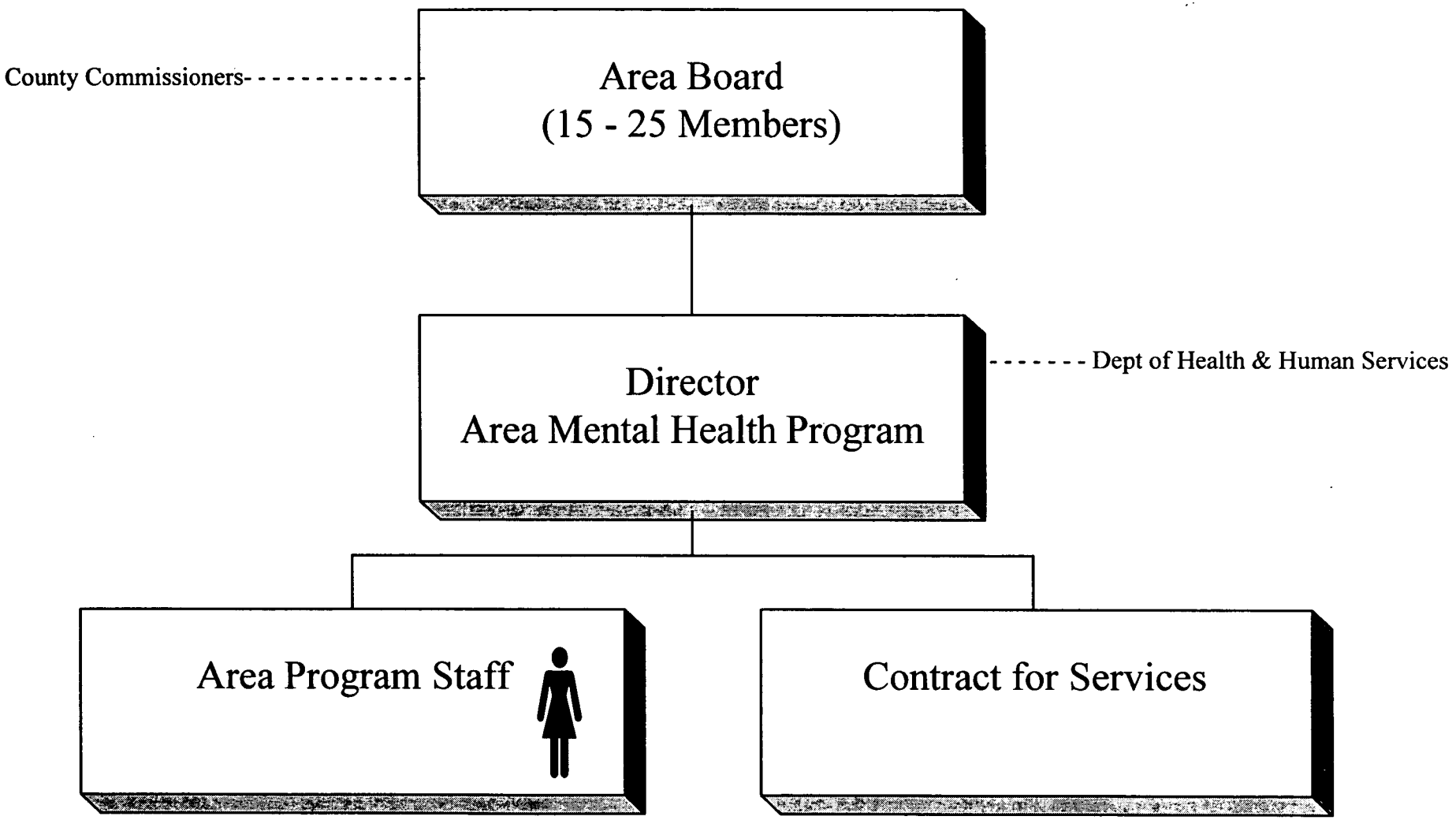
NORTH CAROLINA'S PUBLIC MENTAL HEALTH SYSTEM



FISCAL RESEARCH DIVISION

MARCH 16, 1999

NORTH CAROLINA AREA MENTAL HEALTH PROGRAMS



NORTH CAROLINA'S PUBLIC MENTAL HEALTH SYSTEM

AREA MENTAL HEALTH PROGRAMS

The provision of mental health in North Carolina is a cooperative effort of the state and local governments. Public mental health services are coordinated and delivered primarily on the local level by Area Mental Health Authorities/Programs. Area Programs provide services directly or under contract with other service providers. All funds appropriated by the General Assembly for the purpose of providing these services are administered by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

§ *G.S. 122C-2. North Carolina Policy*

State and local governments shall develop and maintain a unified system of services centered in area programs. The public service system will strive to provide a continuum of services for clients while considering the availability of services in the private sector. The furnishing of services to implement the policy of this section requires the cooperation and financial assistance of counties, the State, and the federal government.

AREA MENTAL HEALTH AUTHORITIES/PROGRAMS

N.C. STATUTORY AUTHORITY

§ **G.S. 122C-115. (a)** Except as provided in G.S. 153A-77, a county shall provide mental health, developmental disabilities, and substance abuse services through an area authority.

§ **G.S. 122C-116. (a)** An area authority is a local political subdivision of the State except that a single county area authority is considered a department of the county in which it is located for purposes of Chapter 159 of the General Statutes.

§ **G.S. 122C-124. Area Authority funding suspended.**

§ **G.S. 122C-125. Area Authority financial failure; State assumption of financial control.**

§ **G.S. 122C-125.1 Area Authority failure to provide services; State assumption of service delivery.**

AREA MENTAL HEALTH AUTHORITIES/PROGRAMS

N.C. STATUTORY AUTHORITY

§ **G.S. 122C-115. Powers and duties of counties and cities.** (d) Counties shall not reduce county appropriations and expenditures for area authorities because of the availability of State allocated funds, fees, capitation amounts, or fund balance to the area authority.

§ **G.S. 143-10.1A. Budget required to include State cost of local programs -- Continuation and expansion costs.** (d) Effective July 1, 1991, the Office of Budget and Management and the Director of the Budget, with advice of the Advisory Budget Commission, shall prepare the State Budget in a format that adequately and fairly reflects the continuation costs for the State's share of locally operated programs established by statute or State appropriation.

AREA MENTAL HEALTH PROGRAMS

SELECTED FACTS

- Authority System Created by State Statute 1977
- 40 Area Mental Health Authorities/Programs
  (24 are Multi-County; 16 Single County)
- Governed by an Area Board
- Area Board is a Policy Making Body
- County Commissioners Appoint Area Board
- Employees Work for Area Authority

AREA MENTAL HEALTH PROGRAMS

SELECTED FACTS

- State is Divided into Four Regions (Western, North & South Central and Eastern)
- Regional Management Teams Facilitate State-Local Communication
- Area Programs Act as Gatekeepers to State Facilities (Single Portal of Entry and Exit
- N.C. Council of Community Programs

SELECTED FACTS

Catchment Area Size (population 7/97):

- Single County Range:
  - Riverstone (formerly known as Halifax) - 55,814
  - Mecklenburg - 608,567

- Multi-County Range:
  - Roanoke-Chowan (Includes Bertie, Gates, Hertford & Northampton Counties) - 87,097
  - Centerpoint (Includes Forsyth and Stokes Counties) - 330,008

Area Program Budgets:

- Budget Range:
  $3M to $46M (FY94/95)
  $6M to $73M (FY98/99)

- County Funds Range: Approximately $150,000 to $24.6M

NORTH CAROLINA'S PUBLIC MENTAL HEALTH SYSTEM

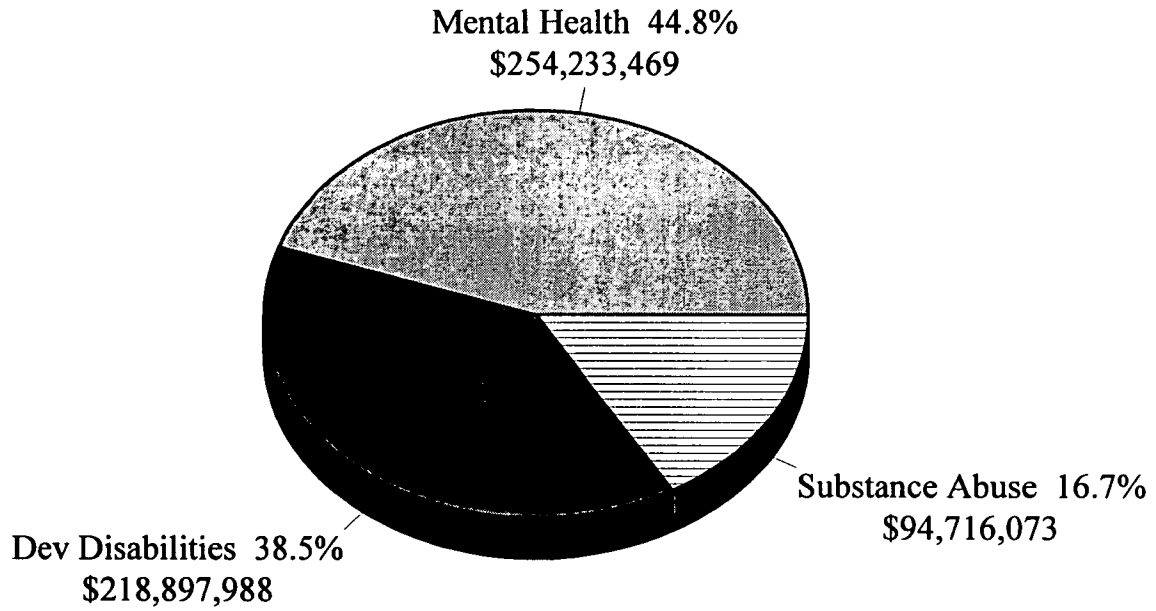
AREA MENTAL HEALTH PROGRAMS

WHAT SERVICES DO THEY PROVIDE?

- SUBSTANCE ABUSE SERVICES
- DEVELOPMENTAL DISABILITIES SERVICES
- MENTAL HEALTH SERVICES
- COORDINATION/INTEGRATION WITH OTHER HUMAN SERVICES AREAS

AREA MENTAL HEALTH PROGRAMS

PROGRAM SERVICES BY DISABILITY
FY97/98

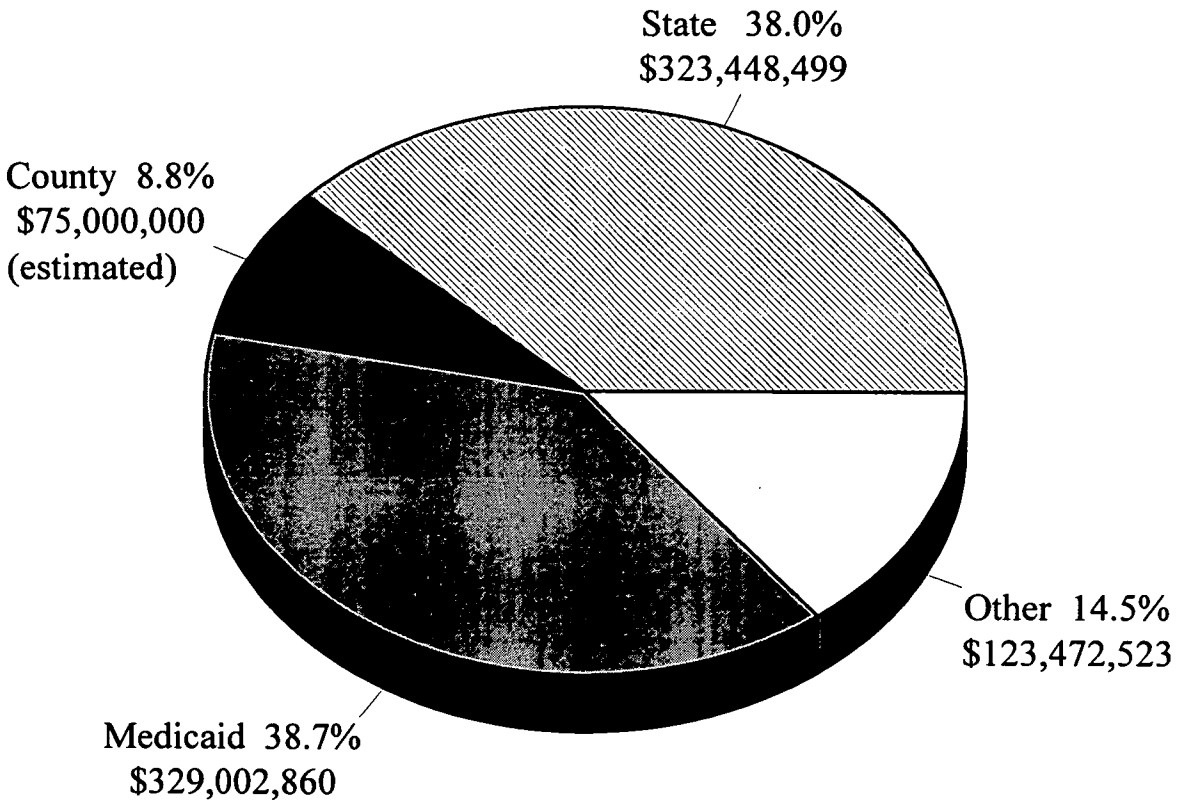


TOTAL $567.8M
(excludes Thomas S & Willie M funds)

AREA MENTAL HEALTH PROGRAMS

AREA PROGRAM FUNDS BY SOURCE

FY97/98

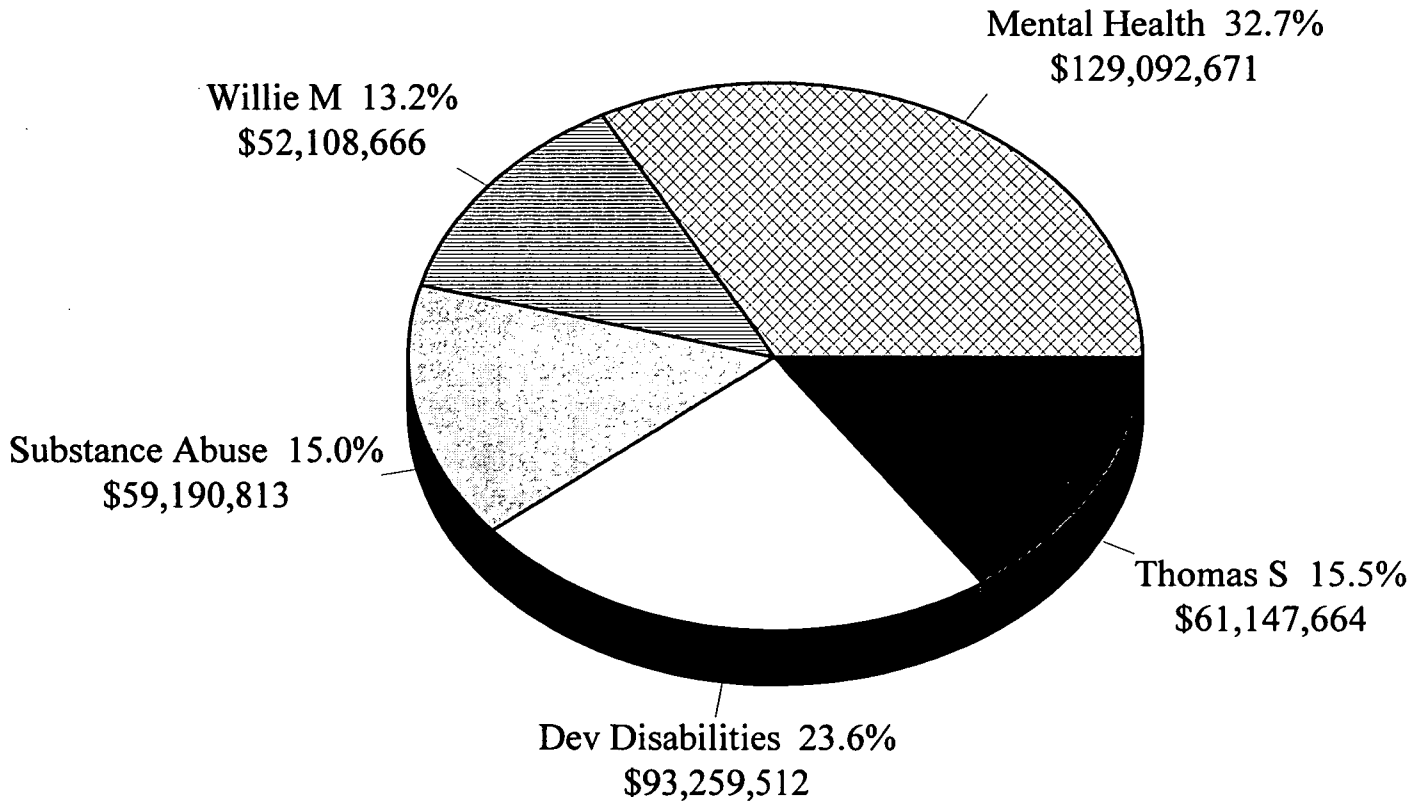


TOTAL: $850.1M

AREA MENTAL HEALTH PROGRAMS

STATE FUNDS FOR PROGRAM SERVICES

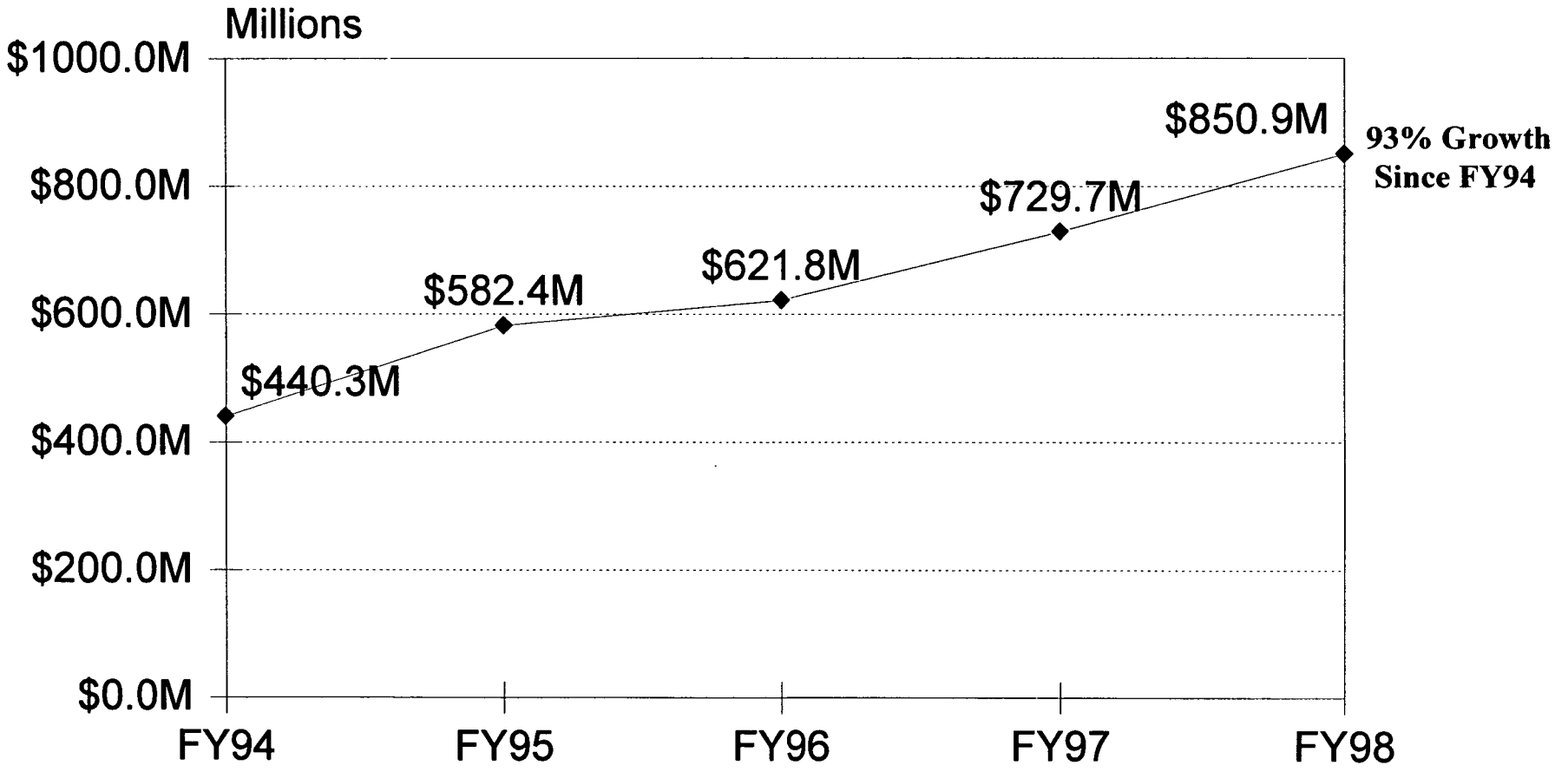
FY1997-98



TOTAL: $394,799,326

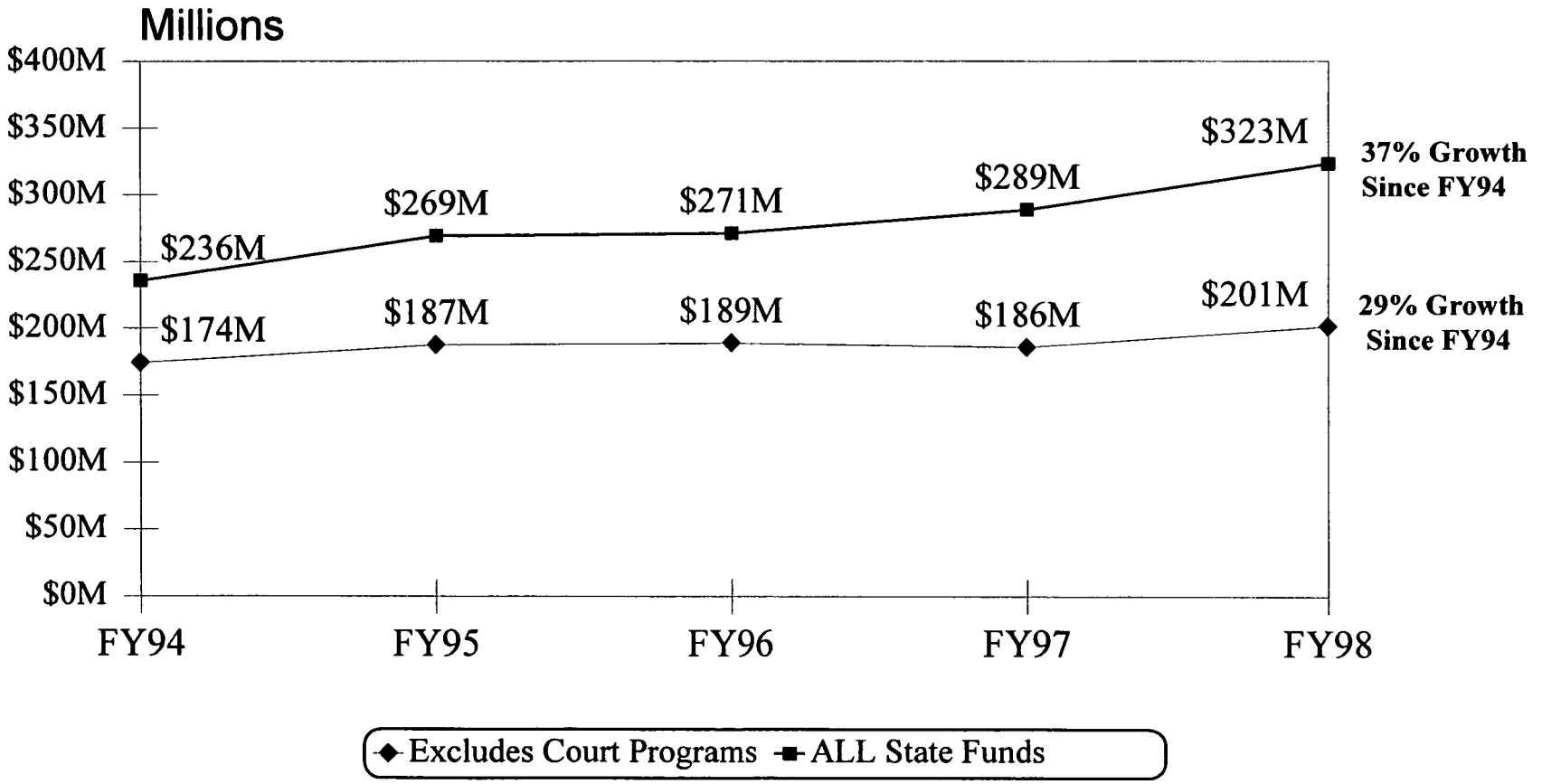
AREA MENTAL HEALTH PROGRAMS

GROWTH IN AREA PROGRAM RESOURCES



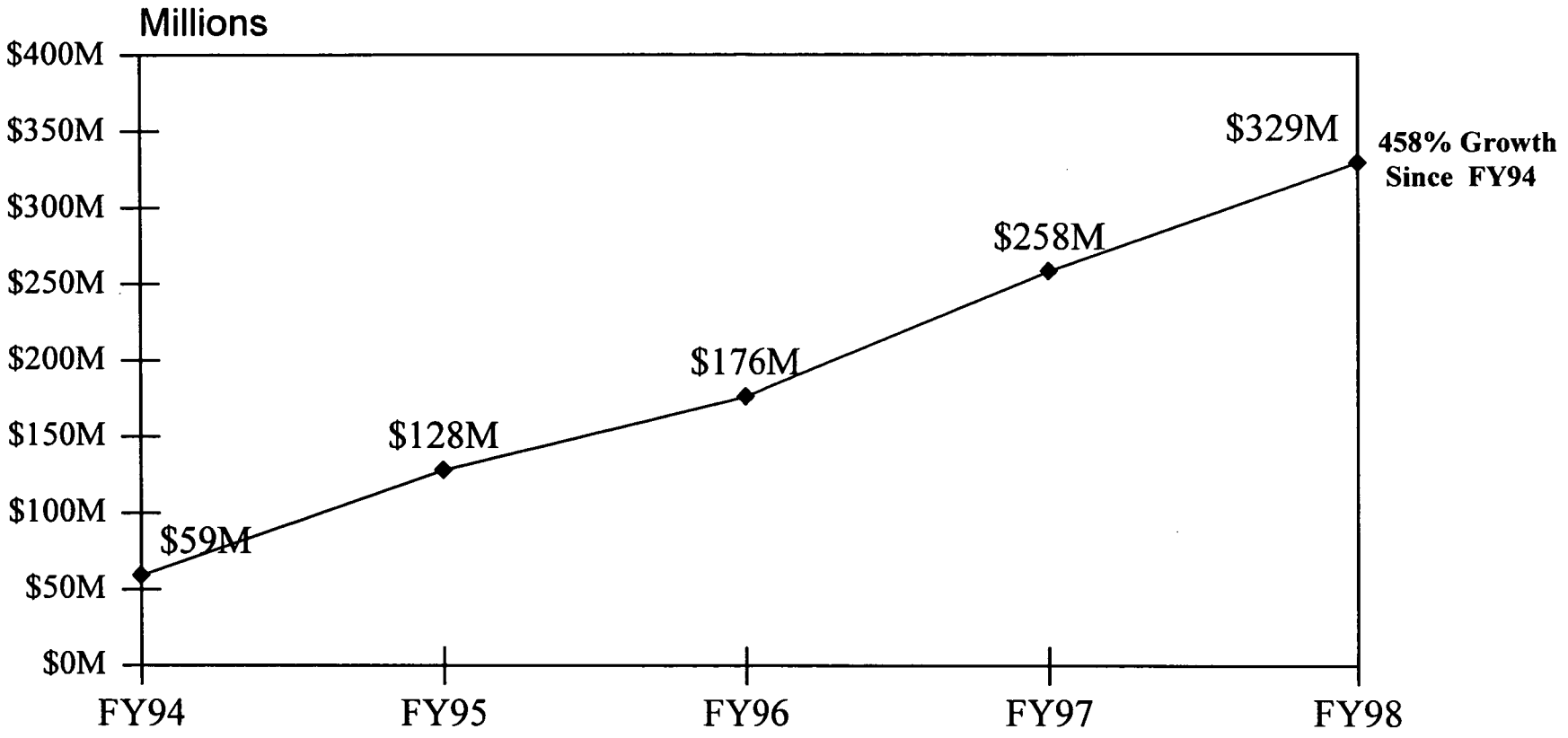
AREA MENTAL HEALTH PROGRAMS

GROWTH IN STATE APPROPRIATIONS



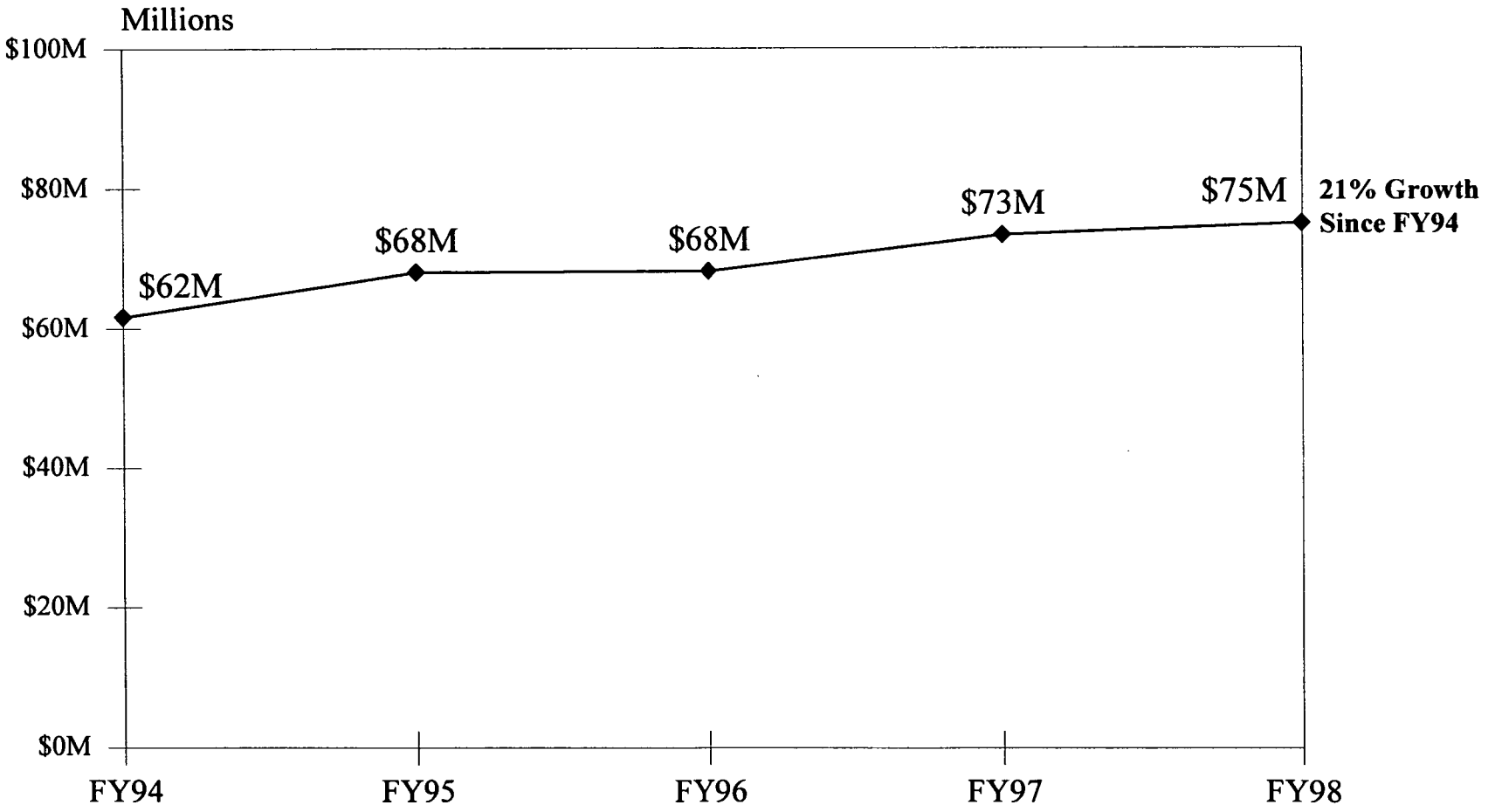
AREA MENTAL HEALTH PROGRAMS

GROWTH IN MEDICAID EXPENDITURES



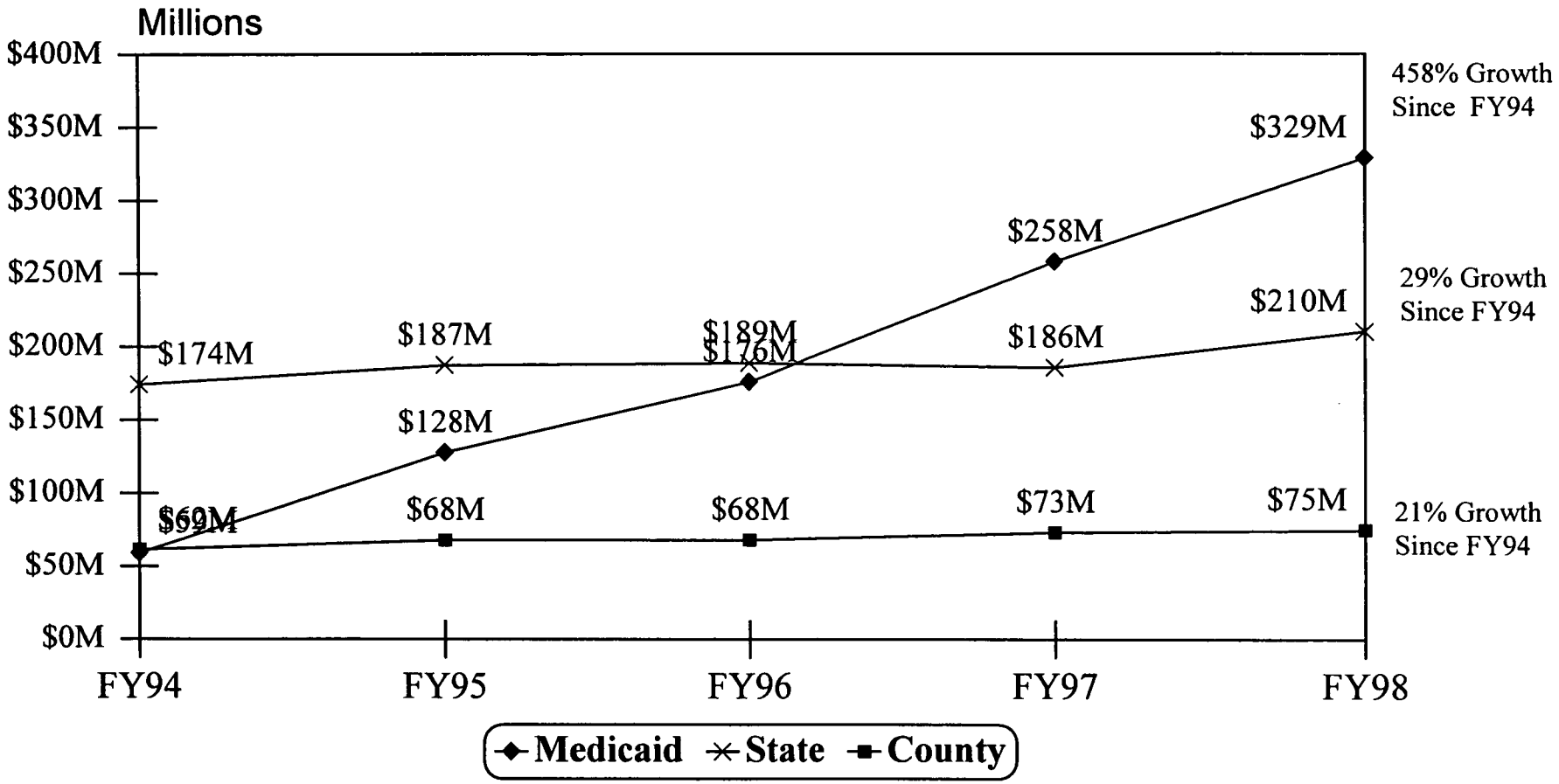
AREA MENTAL HEALTH PROGRAMS

GROWTH IN COUNTY APPROPRIATIONS



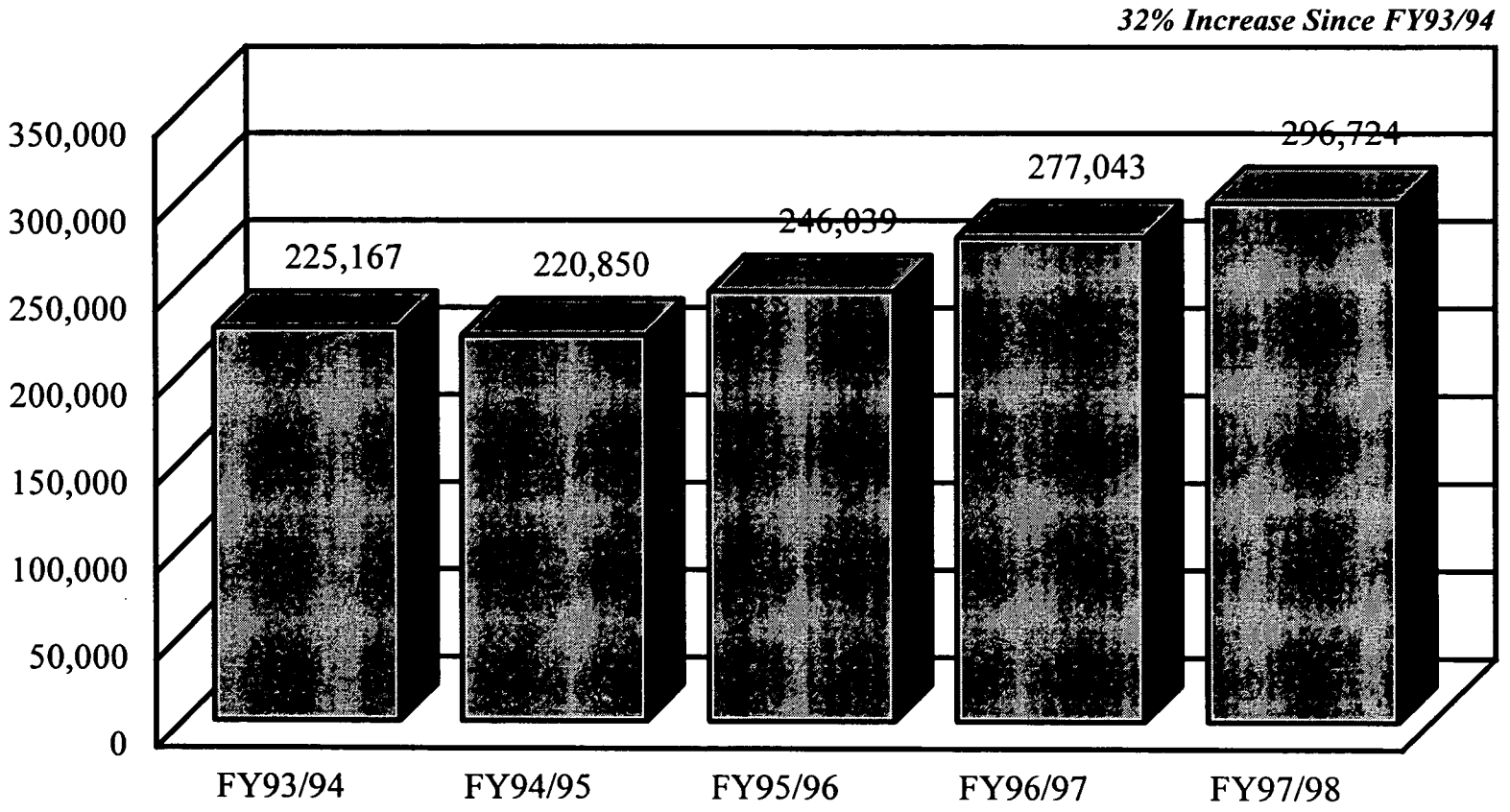
AREA MENTAL HEALTH PROGRAMS

GROWTH IN REVENUES SOURCES



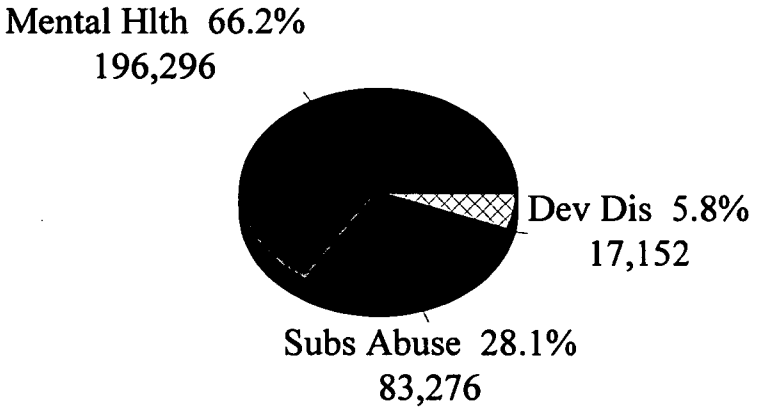
AREA MENTAL HEALTH PROGRAMS

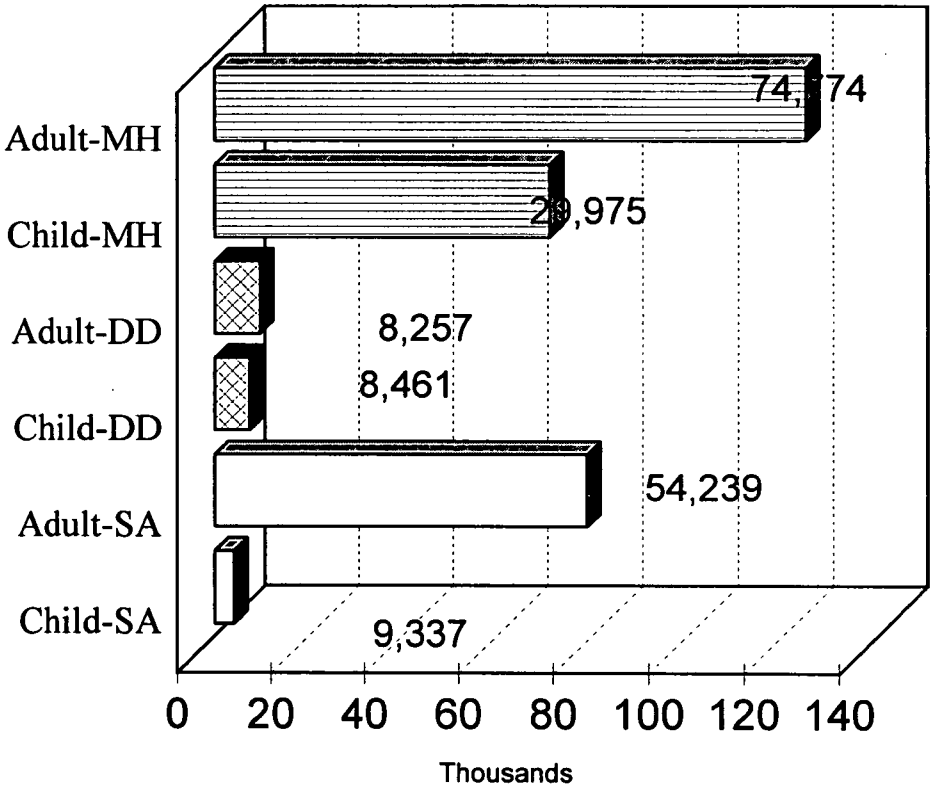
TOTAL CLIENTS SERVED
FY91/92 - FY97/98



AREA MENTAL HEALTH PROGRAMS

CLIENTS SERVED BY DISABILITY AND AGE FY97/98

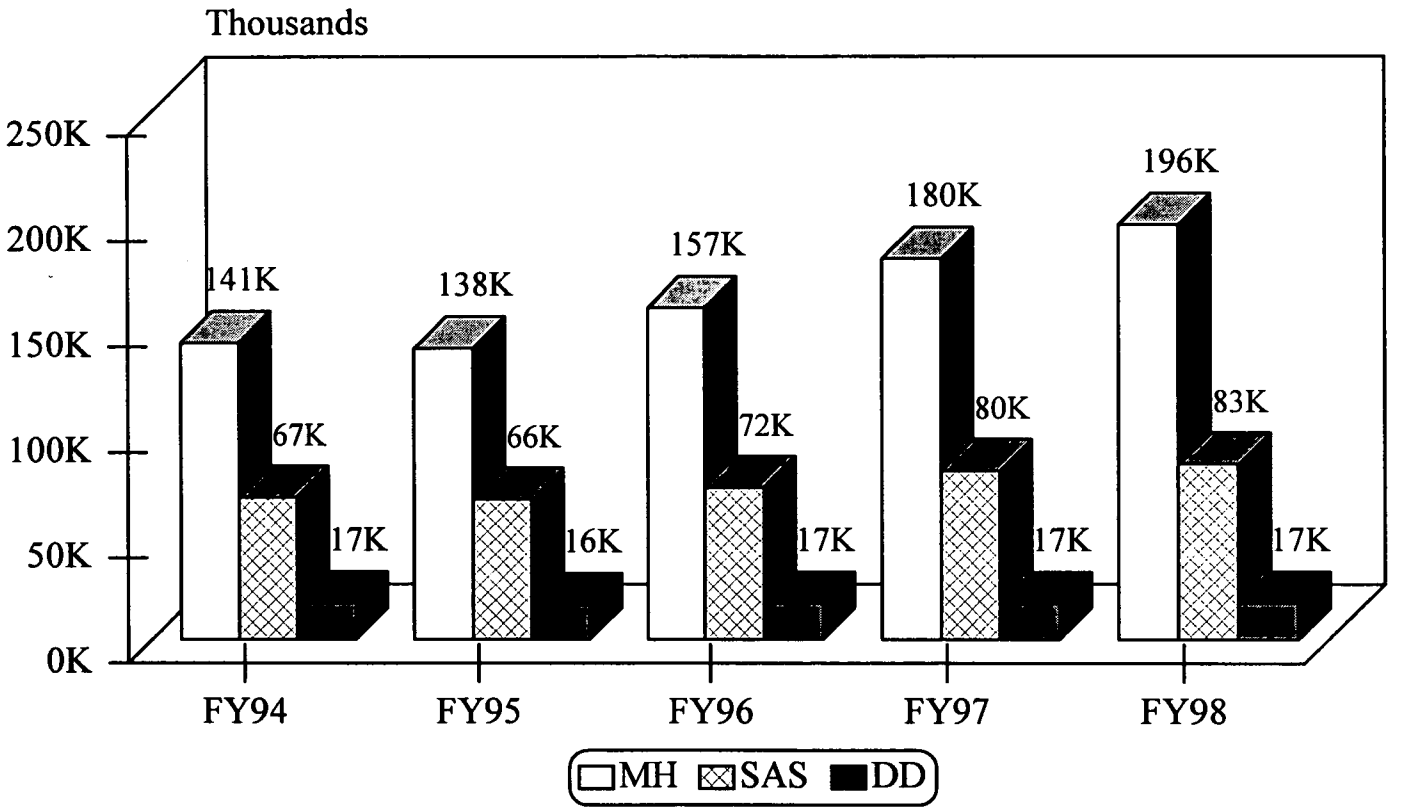




Total Clients Served: 296,724

AREA MENTAL HEALTH PROGRAMS

GROWTH IN CLIENT SERVICES BY DISABILITY



AREA MENTAL HEALTH PROGRAMS

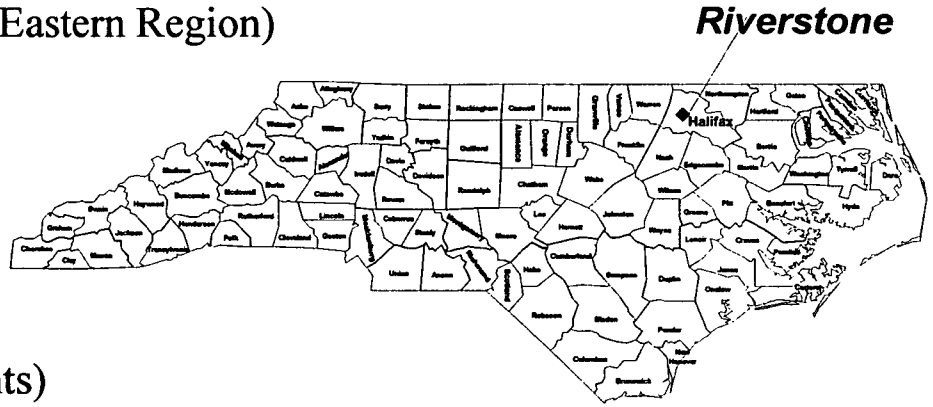
Factors Impacting the Current "Crisis" in the Area Program System

- MANAGED CARE INITIATIVES
- STATE POLICY TO MAXIMIZE FEDERAL FUNDS
- EROSION OF SUPPORT
- INADEQUATE MANAGEMENT & OVERSIGHT
- DRAMATIC SYSTEM GROWTH

AREA MENTAL HEALTH PROGRAMS

AREA PROGRAM PROFILE: RIVERSTONE

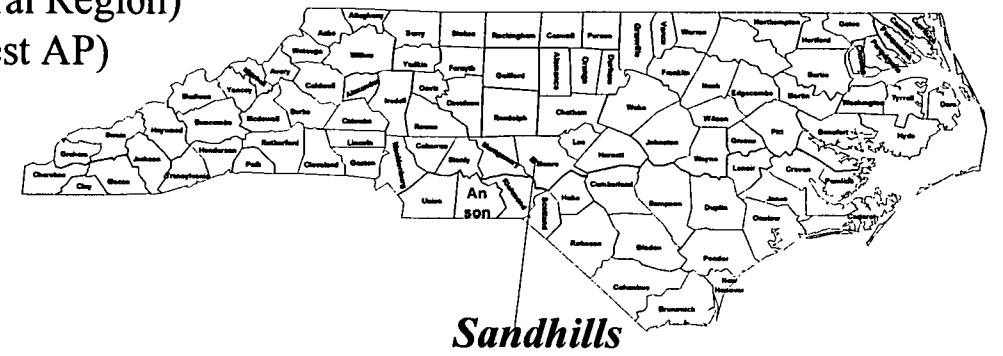
- Catchment Area: Halifax County (Eastern Region)
- Population: 55,814
- Persons Served FY97/98: 4,231
- Operating Budget: $7.86M
- Positions: 141.2 FTE's
- Financial Support:
  -4.5% County
  -39% State (Excludes Federal Grants)
  -14% Medicaid
- Patient Mix:
  -57% Medicaid
  -27% Uninsured/Indigent
- 215% Growth in Medicaid Revenues Since FY93/94
- Economic Characteristics:
  -Median Income 1998: $29,400
  -Unemployment Rate: 8.7%
  -People of All Ages in Poverty: 25.3%



AREA MENTAL HEALTH PROGRAMS

AREA PROGRAM PROFILE: SANDHILLS

- Catchment Area: Moore, Montgomery, Hoke, Anson & Richmond Counties (South Central Region)
- Population: 192,369 (14th. Largest AP)
- Persons Served FY97/98: 6,491
- Operating Budget: $26.2M
- Positions:
- Financial Support:
  -2% County
  -22% State
  -46% Medicaid
- 215% Growth in Medicaid Revenues Since FY93/94
- Economic Characteristics:
  -Range in Median Income 1998: $25,717 - $34,412
  -Unemployment Ranges: 3.5-5.9%
  -Range of People of All Ages in Poverty: 20.2% - 10.8%



AREA MENTAL HEALTH PROGRAMS

AREA PROGRAM PROFILE: MECKLENBURG

- Catchment Area: Mecklenburg County (South Central Region)
- Population: 608,567 (Largest AP)
- Persons Served FY97/98: 25,631
- Operating Budget: $68.4M
- Positions: 713 FTE'S
- Financial Support:
  -31.2% County
  -32% State
  -21.5% Medicaid
- 215% Growth in Medicaid Revenues Since FY93/94
- Economic Characteristics:
  -Median Income 1998: $55,875
  -Unemployment Rate: 2.6%
  -People of All Ages in Poverty: 10.9%

Factors Impacting Current "Crisis" in Area Program System

1. EROSION OF AREA PROGRAMS' STATE SUPPORT:

Began with State's 1990/91 Fiscal Crisis
- Elimination of State Regional Offices
- Elimination of Jordan-Adams Inflationary Increases
- Funds for Capital & Renovations Ceased

Reductions Peaked in 1995 & 1996:
- $17.8M Cut in State Appropriations to Area Programs
- Net Reduction in State Expenditures in FY96/97

IMPACT:
- Reduced Direct Communication with Area Programs
- Reduced Technical Support
- Continual Erosion of Funding for Area Program Infrastructure
- Significant Staff Turnover & Difficulty in Attracting/Retaining Staff
- Increased Reliance on Contract Services

AREA MENTAL HEALTH PROGRAMS

Factors Impacting Current "Crisis" in Area Program System

2. DRAMATIC SYSTEM GROWTH:

- State Emphasis on "Growing the System"
- Since 1994 the Number of Clients Served Increased 29%,
- Of That Growth, Substance Abuse Clients Served Increased 20%, Mental Health Increased 33.2% & Developmentally Disabled Increased 34.5%
- Area Program Budgets Grew by 93% (From $440M to $851M)

IMPACT:

- New Services Were Created (e.g., Community Based Inclusion)
- Two-Tiered Service System Began Developing
- Cost Shifting from Other Local Agencies Increased

Factors Impacting Current "Crisis" in Area Program System

3. MANAGED CARE: CAROLINA ALTERNATIVES

- Implemented in 10 Area Programs in 1994
- Division of MH & Area Programs' Goal: "Grow the System"
- Expansion Delays Occurred Repeatedly
- Termination Anticipated in June 1999

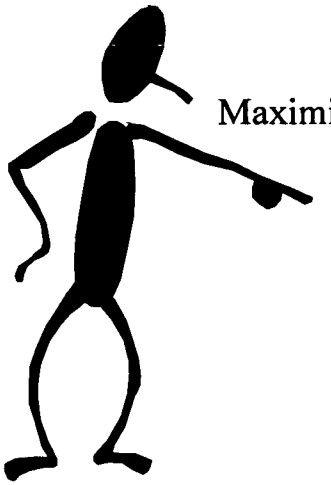
IMPACT:

- Improved Services to Children
- Improved Management of Some Area Programs
- Fostered an Atmosphere of Care Management
- Reduced Rates Began to Drain Resources for Indigent Clients
- Created Chaos for Some Area Programs

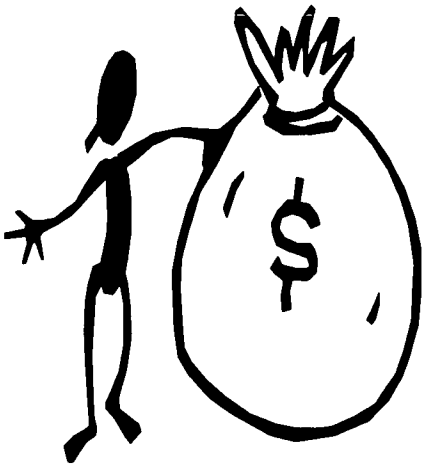
AREA MENTAL HEALTH PROGRAMS

1990'S INCONSISTENT FISCAL POLICIES

(Early-to-Mid 1990's)



Maximize Federal $$$



From FY94-FY98 Federal Revenue Grew by 486% ($59M to $347M)

By FY96, State & Area Programs Were Celebrating Their Success!

AREA MENTAL HEALTH PROGRAMS

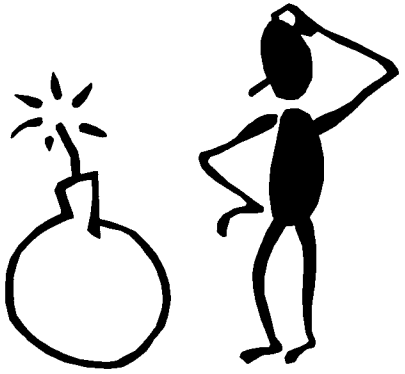
1990'S INCONSISTENT FISCAL POLICIES

1997 Medicaid Growth Reduction Policy

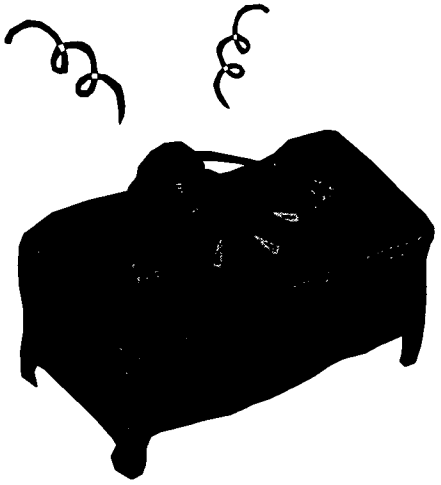
Early 1997

"How can we grow our services while you're reducing Medicaid growth?"

Mid-Late 1997



1998: Medicaid Paybacks & Fraud!



AREA MENTAL HEALTH PROGRAMS

Factors Impacting Current "Crisis" in Area Program System

4. STATE POLICY TO MAXIMIZE FEDERAL FUNDS:

- State Funds Reduced in Anticipation of Increased Federal Funds
- Regular Medicaid Maximized (Primarily DD & MH)
- Title IVA-EA Maximized for Children's Services

IMPACT:

- Mental Health Service System Grew
- Specialized Services Were Developed
- Area Programs Became Increasingly Reliant Upon Federal Funds
- Cost Shifting at the Local Level Increased

AREA MENTAL HEALTH PROGRAMS

Factors Impacting Current "Crisis" in Area Program System

5. INADEQUATE MANAGEMENT AND OVERSIGHT:

- Local Autonomy Was Emphasized
- Increased Need for Management Information Systems
- Involvement of Area Boards Wasn't Always Adequate
- State Emphasis was on System Growth
- State & Local Oversight of Area Program Fiscal Management Inadequate in Many Situations

IMPACT:

- Poor Budgeting & Accounting Practices
- Fraud & Abuse of Medicaid
- Poor Documentation for Billing Purposes
- Cash Advances to Maintain Services in Certain Programs
- Tri-County Area Program Dissolved
- System Grew Too Quickly for Infrastructure

AREA MENTAL HEALTH PROGRAMS

POLICY/ISSUES

1. **Medicaid Match Reserve**
   - County Financial Participation
   - Accurate Projections
   - Area Program Portion (how to handle the excess/shortages?)

2. **County Appropriations**
- **- G.S. 122C-115 (d) Powers and duties of counties and cities**
   - County Commissioners Association Legislative Agenda to Repeal Eliminate Language

3. **Financial Incentives for Program Mergers**

4. **Future of Area Program System**

AREA MENTAL HEALTH PROGRAMS

MEDICAID MATCH RESERVE

1. What is the Medicaid Match Reserve (MMR)?

- A Reserve Created To Facilitate the Transition of "Certified Match" to Real Match
- The Reserve Contains the Non-Federal Share (approximately 37%) of the Cost of Medicaid for Eligible Area Mental Health Clients
- The Reserve was Necessitated by Significant Medicaid Rate Reductions, Inappropriate Management of Medicaid Funds and a Projected Lack of State and Local Funds for Indigent Care
- State Funds ($38M) Were Appropriated & Placed in the Reserve During 1998 to Alleviate the Impending Financial Crisis in Area Programs

AREA MENTAL HEALTH PROGRAMS

MEDICAID MATCH RESERVE

Medicaid Cost Sharing in Area Mental System (pre-FY98/99)

Payor/Source	Regular	Carolina Alternatives	CAP-MR/DD	MH Inpatient (Non-State)	Other Non-Area Program Providers
Federal	63.09%	63.09%	63.09%	63.09%	63.09%
Area Programs	Certified Match	12.31%	0	0	0
State	0	20.9%	31.37%	31.37%	31.37%
County	0	3.7	5.54%	5.54%	5.54%

AREA MENTAL HEALTH PROGRAMS

MEDICAID MATCH RESERVE

Medicaid Cost Sharing in Area Mental System (FY98/99)

Payor/Source	Regular	Carolina Alternatives	CAP-MR/DD	MH Inpatient (Non-State)	Other Non-Area Program Providers
Federal	63.09%	63.09%	63.09%	63.09%	63.09%
Area Programs		12.31%			
State	36.91%	20.9%	31.37%	31.37%	31.37%
County		3.7%	5.54%	5.54%	5.54%

AREA MENTAL HEALTH PROGRAMS

MEDICAID MATCH RESERVE

"Proposed" Medicaid Cost Sharing in Area Mental System (FY99/00)

Payor/Source	Regular	CAP-MR/DD	MH Inpatient (Non-State)	Other Non-Area Program Providers
Federal Area Programs	62.87%	62.87%	62.87%	62.87%
State	35.63%	37.56%	31.56%	31.56%
County	1.50%	5.57%	5.57%	5.57%

Note: The County Proposed Share of 1.5% Would Increase Incrementally Until It Reaches a Cap of 15% of the Non-Federal Share (Approximately 5% of the Total).

Subcommittee Policy/Issues

1. MEDICAID MATCH RESERVE:

1. Should Counties Participate in Area Mental Health Medicaid Costs?

2. If So, At What Rate of Financial Participation? Should Each County Share Proportionally?

3. How Much in State (Division of MH/DD/SAS) Funds Should be Transferred Into the Medicaid Match Reserve for FY99/00?

4. How Should FY98/99 Unspent State (Division of MH/DD/SAS) Funds Originally Identified for Inclusion in the MMR be Handled?

5. Since Another Payback is Anticipated, Should the State Offset This or Future Medicaid Paybacks Owed by Area Programs?

Subcommittee Policy/Issues

2. ***COUNTY APPROPRIATIONS:***

§ **G.S. 122C-115.** Powers and duties of counties and cities. (d) Counties shall not reduce county appropriations and expenditures for area authorities because of the availability of State allocated funds, fees, capitation amounts, or fund balance to the area authority.

1. Should G.S. 122C-115 Remain, Be Amended, or Repealed?

AREA MENTAL HEALTH PROGRAMS

Subcommittee Policy/Issues

3. FINANCIAL INCENTIVES FOR PROGRAM MERGERS:

- Many Area Programs are Too Small to Become Efficient
  -Catchment Area Size (Population) is Too Small
  -Administrative Infrastructure is Sometimes Inadequate
  -Gaps in Services Are Generally Greater Due to Lack of Ability to Attract & Retain Staff/Providers

- Funding Inequities Are Disincentives to Program Mergers
  -Per Capita Spending Varies Widely

- State/Local Funds Are Needed to Facilitate Program Mergers
  -Startup Funds Are Needed to Plan and Transition Programs

Subcommittee Policy/Issues

4. FUTURE OF THE AREA PROGRAM SYSTEM:

- Where does the Public Consulting Group, Inc. Study Fit In?
- How does the State's Redesign Initiative Fit?

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-25, **1999**

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stacy Flannery	NCHCFA
Glenn Wells	DHHS/Public Health
[illegible]	Food Banks
Mary Greene	OSBM
Wayne Williams	OSBM
Lisa Abatemarco	DHHS/BP+A
Tara Larson	DMH/DD/SAS
Jeanne Fenner	NASW Co.
Dave Richard	Arc/NC
[illegible]	OSBM
Terry Stelle	DMHDDSAS
Allyn Duffey	DHHS
Jim Edgerton	DHHS
David Bruton	DHHS
HUGH TILSON	NCHA
Myrna Millis	NASW-NC
PEYTON MAYNARD	GPM INC.
Patrice Rowler	NCACC
Heather Lafflin	OSA
C Medlin	Covenant w/ NC's Children
K Harrell	Gov's Office
Lou Wilson	NCALTC
Ken Burrow	Therapeutic Alternatives
Denny Wilson	Therapeutic Alternatives
B Summers	NC Equity
Katherine Miller	Harry Kaplan
Tommy Worth	Carolinas Healthcare System
[illegible] Bone	Bone & Assoc = NCALTC
Dan Palmer	Davidson Co. Schools Bd Member

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-25, 1999

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Fred Mah	Davidson County Schools
Kenny Meredith	Davidson Co Schools
Don Palmer	Davidson Co Schools
A.A. "Butch" Justice	McDowell County DSS + School Board
John Borsellino	Zeb Alley P.A.

AGENDA

Joint Subcommittee on Health and Human Services Appropriations

Legislative Office Building - Room 424
Wednesday, March 31, 1999
8:30 a.m.

Opening Remarks	Sen. Bill Martin, Co-Chair Rep. Beverly Earle, Co-Chair Rep. Edd Nye, Co-Chair
Division of Public Health	Ramona L. Burton Fiscal Research Division
ADAP Report	J. Steven Cline, D.D.S., M.P.H. Acting Section Chief, Communicable Disease & Epidemiology, DHHS
Immunization Program Report	Beth Rowe-West, R.N., B.S.N. Acting Branch Head, Immunization Branch, DHHS
Adjourn	

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
March 31, 1999
Morning

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Wednesday, March 31, 1999, in Room 424 of the Legislative Office Building.

Senate Chairman, Senator Bill Martin, presided. House members present were Representative Edd Nye, (Co-Chairman), Representative Beverly Earle (Co-Chairman), Representative Martha Alexander (Vice-Chairman, Representative Lanier Cansler, Representative Theresa Esposito, Representative Trudi Walend, and Representative Gene Wilson. There were six senators present.

Chairman Martin introduced the Pages at the meeting and then recognized Ms. Ramona Burton, Fiscal Research Division, for continuation of discussion of Division of Public Health. There was much discussion between the members concerning sexual diseases being at a higher rate in NC than in other states. Senator Phillips questioned whether state isn't doing a good job of educating young people about these diseases. Dr. McBride, DHHS, stated young people aren't taking heed. Senator Dannelly stated moral groups limit what educated people can teach and that legislators won't tell educators to teach what they need to teach.

Ms. Burton continued with discussion of cost of sexually transmitted diseases and HIV to nation. Chairman Martin requested information on number of babies born in NC with HIV and was told staff would get information for him. Dr. McBride stated intravenous drug use is on the rise, which leads to unsafe sex practices. Representative Nye stated DAPAA in eastern part of state isn't funded by the state. Senator Dannelly questioned since it isn't funded by the state, are they adequately funded.

Ms. Burton noted Case Management Services are provided by Medicaid and not as many dollars go into prevention as to care of people with the diseases. Representative Earle asked for a breakdown of where dollars go.

A discussion continued concerning ADAP, (Aids Drug Assistance Program.) Senator Phillips asked the cost per patient in medication and was told by staff it was nine hundred monthly and ten thousand, eight hundred yearly. Representative Cansler stated using medication consistently is important and do they know if patients are using them regularly. Ms. Burton stated there was a special provision for funds to keep track of that.

Mr. Steve Cline, DHHS, then spoke to the committee on the ADAP Program Report. Representative Earle asked if funds from ADAP were used to pay for drugs in Department of Correction. Mr. Cline stated that was a separate issue and these funds do not go to them. After more discussion concerning this issue, Chairman Martin adjourned the meeting.

Respectfully submitted,

Senator Bill Martin
Chairman

Jo Bobbitt
Committee Assistant

DIVISION OF PUBLIC HEALTH

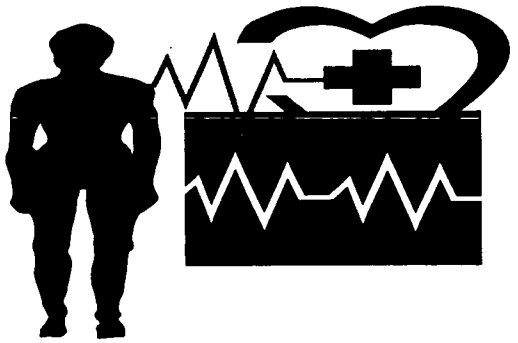
BUDGET /PROGRAM OVERVIEW

Presented by: Ramona L. Burton
Fiscal Research Division
March 30, 1999

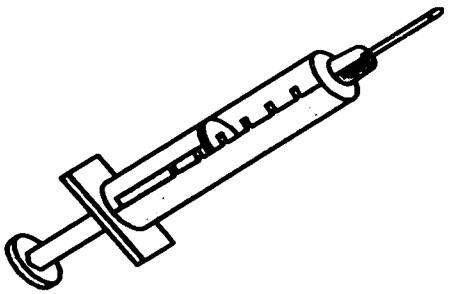
DIVISION OF PUBLIC HEALTH

Outline

- **Division of Public Health Overview**
- **HIV/STD Prevention & CARE Branch**
- **Other Issues: Immunization Branch**
  Infant Mortality Programs
  Hispanic/Latino Public Health Issues

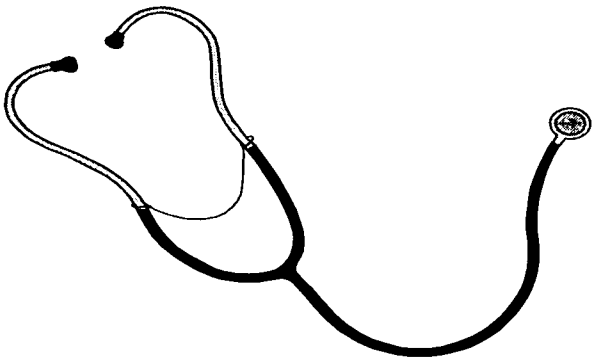


DIVISION OF PUBLIC HEALTH



Mission Statement:

- Improve the health of communities and individuals in North Carolina
- Develop and promote programs and services that enhance the health, growth, and development of infants, children, youth, and women of childbearing age
- Reduce the impact of communicable and environmental diseases in North Carolina



DIVISION OF PUBLIC HEALTH

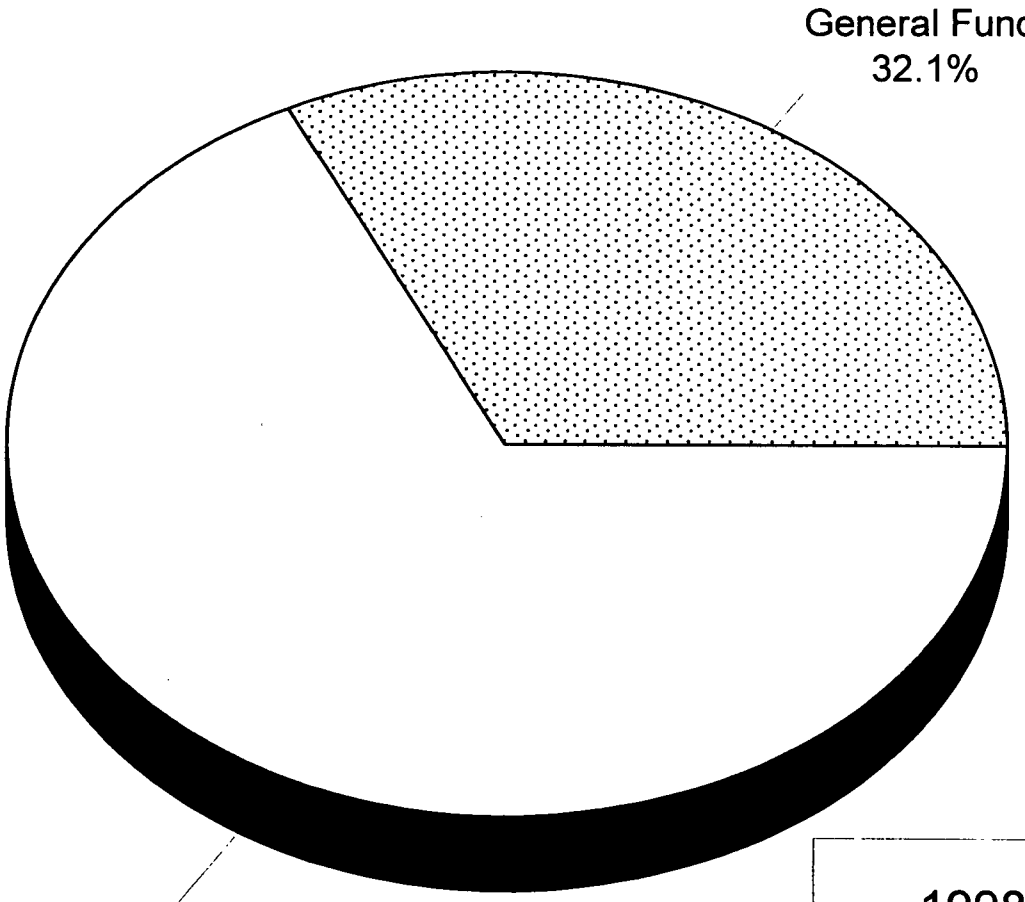
Budget Summary:

	1997-98 Actual	1998-99 Certified	1998-99 Authorized	1999-2000 Rec'd	2000-2001 Rec'd
Requirements	$417,293,370	$401,692,400	$401,692,400	$403,510,313	$405,153,189
Receipts	$303,480,999	$272,900,217	$272,900,217	$272,849,110	$272,849,110
Net Appropriation	$113,812,371	$128,792,183	$128,792,183	$130,661,203	$132,304,079
Total Positions	1329.92	1337.66	1338.66	1338.66	1338.66

Reference Document: 1999-2001 North Carolina State Budget, Health and Human Services, Volume 3 (Pages 45-61)

DIVISION OF PUBLIC HEALTH

Sources Of Funds



1998-1999
TOTAL BUDGET
$401.7 Million

DIVISION OF PUBLIC HEALTH

Legislative Highlights

1997 Session	Recurring	Nonrecurring
Public Health Divisions Transferred from DEHNR to DHHS		
Heart Disease & Stroke Prevention Awareness	$170,500	$29,500
Heart Disease Data Funds		$100,000
Healthy Start Foundation		$650,000
Maternal Outreach Worker Program	$825,000	
Children's Vision Screening Program		$419,000
Non-Medicaid Maternity Care Coordination	$170,900	

1998 Session	Recurring	Nonrecurring
Fullerton Genetics Center		$280,000
Maternal Outreach Programs		$200,000
Sickle Cell Services	$1,200,000	
Heart Disease/Stroke Prevention Programs		$300,000
Diabetes Program		$150,000
Children's Vision Screening		$319,000
Healthy Start Foundation		$650,000
AIDS Drug Assistance Program		$8,000,000

DIVISION OF PUBLIC HEALTH

Public Health Reorganizations

DEPT. OF HUMAN RESOURCES
Public Health

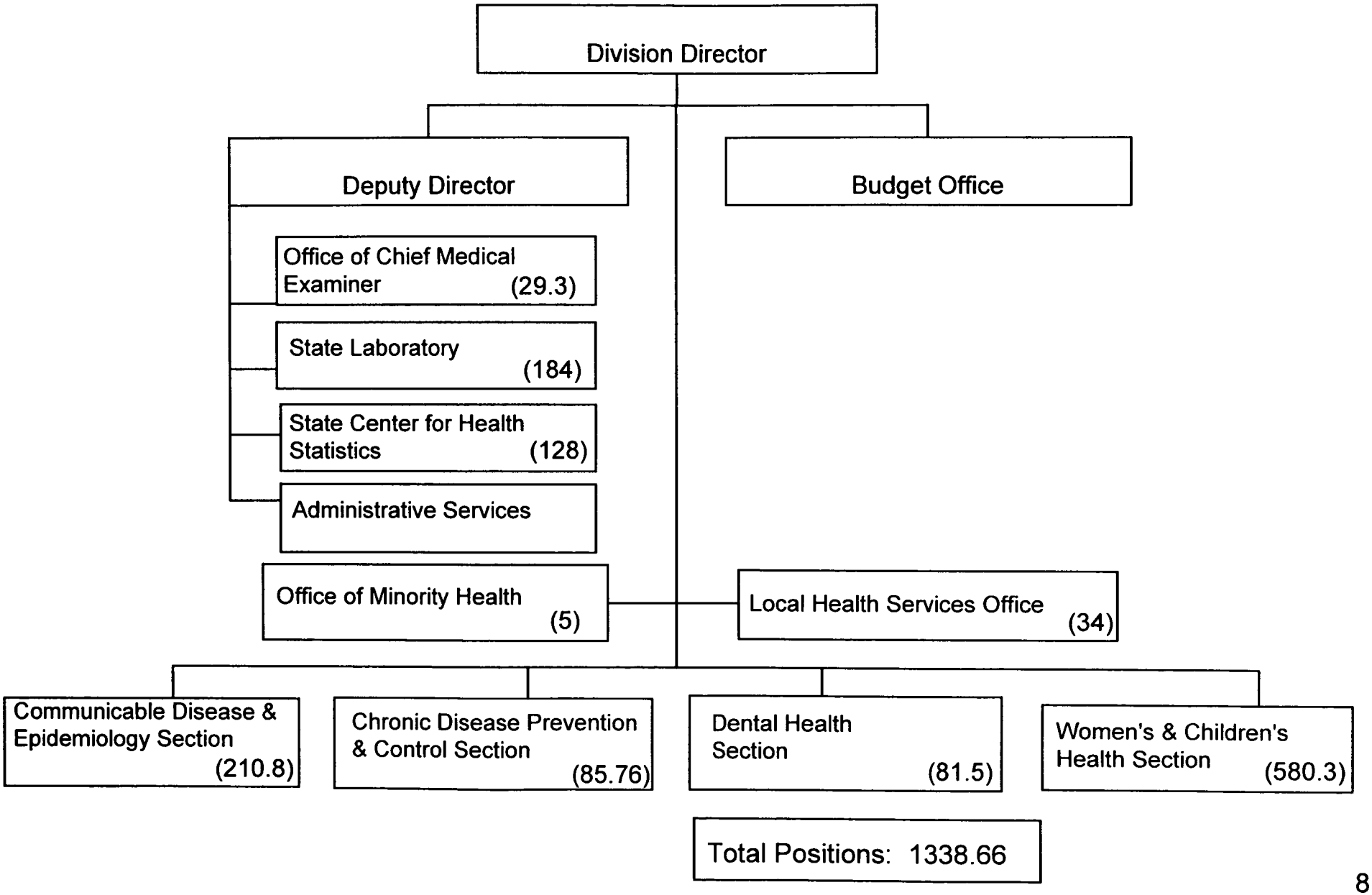
1989
DEPT. OF ENVIRONMENT, HEALTH & NATURAL RESOURCES
Health Promotion
Dental Health
Epidemiology
Maternal-Child Health
Center for Health Statistics
Laboratory Services
Post Mortem Medicolegal Examination
Environmental Health

Environmental Health

1997
DEPT. OF HEALTH & HUMAN SERVICES
Community Health
Epidemiology
Women's & Children's Health

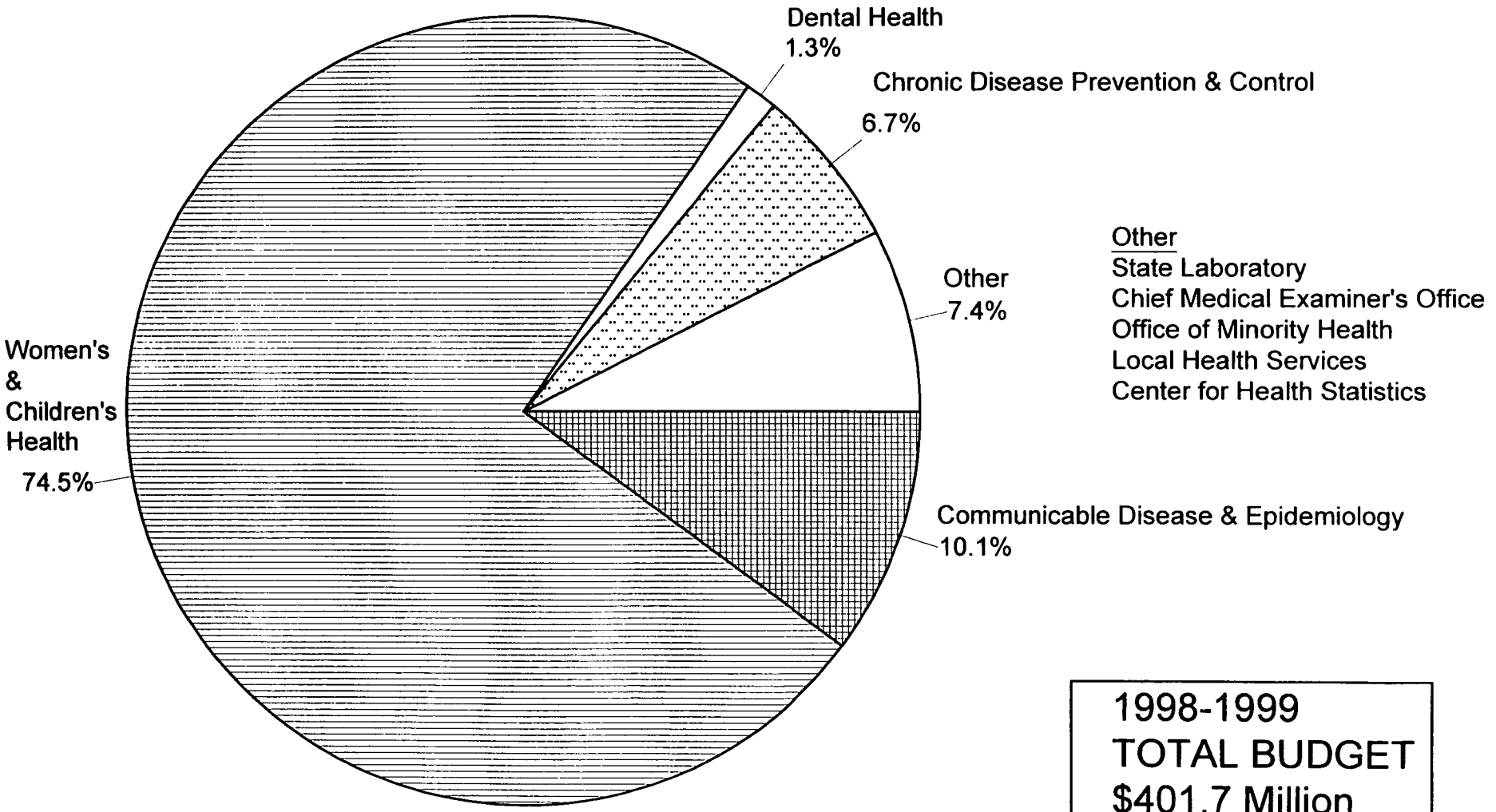
1999
DEPT. OF HEALTH & HUMAN SERVICES
Public Health

DIVISION OF PUBLIC HEALTH: Organization Chart



DIVISION OF PUBLIC HEALTH

Funding By Sections



1998-1999
TOTAL BUDGET
$401.7 Million

DIVISION OF PUBLIC HEALTH

Section Overview

Women's and Children's Health

⇒ Promotes, and protects the health and development of families with an emphasis on women of childbearing age, infants, children and youth

⇒ Administers programs serving individuals who are developmentally disabled or chronically ill

- Special Supplemental Nutrition Program for Women, Infants and Children
- Developmental Evaluation Centers
- School-Based Health Centers

Communicable Disease & Epidemiology

⇒ Seeks to prevent and control communicable diseases and their negative effects

⇒ Identifies environmental or occupation threats to health from asbestos, lead, chemicals, "dusty trades" and other environmental factors

⇒ Conducts medical evaluations for workers in hazardous trades

- TB Control
- Veterinary Public Health
- Industrial Hygiene Consultation

DIVISION OF PUBLIC HEALTH

Section Overview

Dental Health

⇒ Seeks to reduce the impact of tooth decay, periodontal disease, cancer and injuries through education, prevention and surveillance activities

- Seal the State in '98
- Fluoride Mouthrinse Program

Chronic Disease Prevention & Control

⇒ Works to reduce the risk and consequences of disease, build healthy communities, promote healthful living

- Cancer Prevention and Control
- Kidney Program

Offices

⇒ Minority Health
⇒ Local Health Services
⇒ Chief Medical Examiner
⇒ State Laboratory
⇒ State Center for Health Statistics

DIVISION OF PUBLIC HEALTH

Who Provides Public Health Services and Programs?

State-Provided Direct Services, Benefits, and Program Support

Direct services are provided by the Division through the Office of the Chief Medical Examiner, State Laboratory, State Center for Health Statistics, Dental Health, 13 Developmental Evaluation Centers (DEC), and program counselors and investigators.

Programmatic support is provided to local agencies through consultation, training, technical assistance, and oversight.

Through the Office of Purchase of Care, reimbursements totaling $16.8 million are provided for Children's Special Health Services, Assistive Technology, Adult Cystic Fibrosis, Sickle Cell, Cancer Control, Kidney Disease, Migrant Health, and the AIDS Drug Assistance Program.

Contract Grantees

The Division contracts with approximately 404 organizations, excluding contracts with health departments, for the provision of public health services. Among these organizations are community based organizations, universities, medical centers and health departments.

Contractually provided services include pregnancy prevention, AIDS/STD prevention, developmental evaluations, intensive home-visiting, genetic testing and counseling, sickle cell services, and high-risk maternity services.

DIVISION OF PUBLIC HEALTH

Who Provides Public Health Services and Programs?

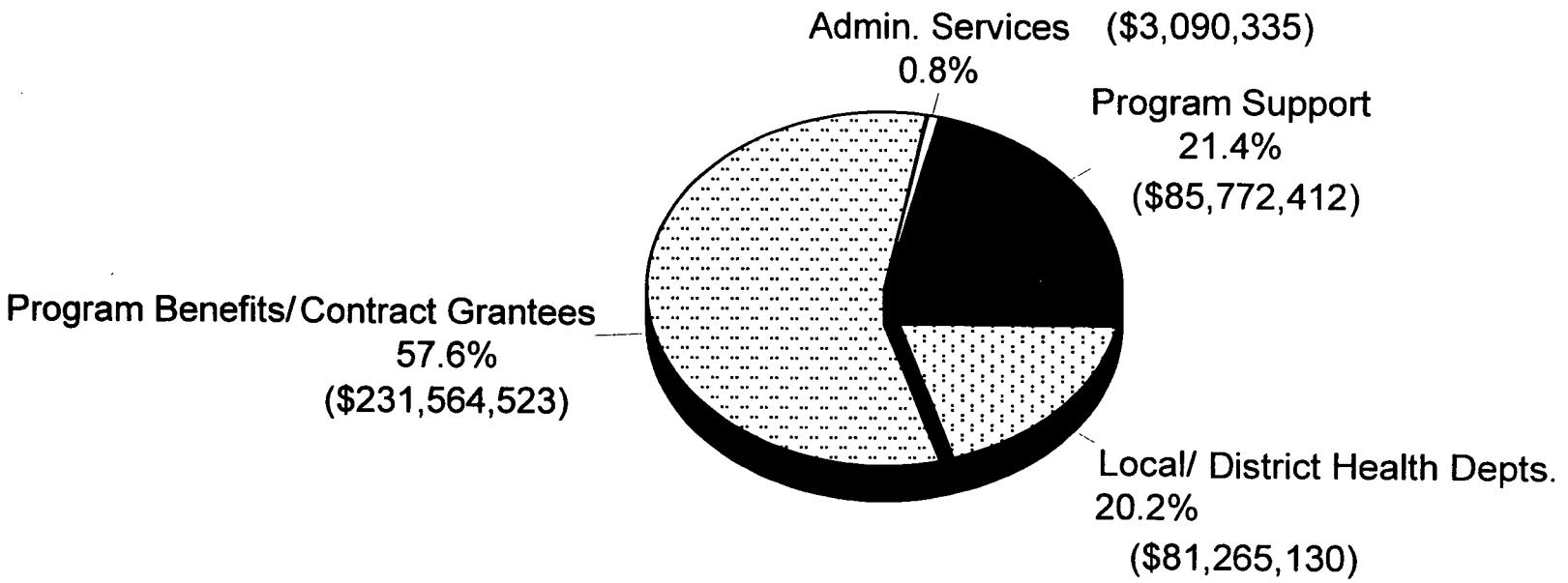
Local/District Health Departments

There are 87 Health Departments in NC, 7 district and 80 single-county departments.

Essential public health services provided by health departments include: communicable disease control, chronic disease control, patient and community education, child health, maternal health, family planning, dental public health, and health promotion and risk reduction.

A county or district board of health is the policy-making, rulemaking and adjudicatory body for health departments.

1998-99 Division of Public Health Budget by Service Provider



DIVISION OF PUBLIC HEALTH

Summary of Select Expenditures By Local Health Departments

Summary of DHHS Expenditures for All Health Departments

SFY 1997-98	State & Federal	Local	Total
General Aid	$4,980,816	$87,355,050	$92,335,866
Categorical Grants	$72,260,153	$175,811,036	$248,071,189
Total Expenditures	$77,240,969	$263,166,086	$340,407,055

Summary of Expenditures for Select Health Departments

SFY 1997-98	State/Federal	Local	Total Exp.	Per Capita Exp.
Allegheny/Ashe/ Watauga	$1,452,412	$2,021,370	$3,473,782	$46.85
Bladen	$582,148	$1,832,080	$2,414,228	$79.64
Buncombe	$1,730,849	$10,112,460	$11,843,309	$61.96
Forsyth	$1,449,694	$8,825,801	$10,275,495	$35.78
Greene	$369,884	$381,645	$751,529	$42.57
Guilford	$3,567,004	$17,289,732	$20,856,736	$54.42
Hoke	$475,172	$565,353	$1,040,525	$36.02
Iredell	$730,587	$2,250,953	$2,981,540	$27.28
Mecklenburg	$3,798,286	$16,885,221	$20,683,507	$33.98
Pasquotank/ Perquimans/Camden/ Chowan	$1,847,849	$2,478,409	$4,326,258	$65.60

DIVISION OF PUBLIC HEALTH

How Does NC Compare to the National Average On Public Health Indicators?

Selected Health Indicators - 1996	North Carolina	United States
Pregnancy Outcome Statistics		
Birth Rate, Females 15-44[1]	62.9	65.3
Birth Rate, Females 15-19[1]	63.5	54.4
Infant Deaths per 1,000 Live Births, 1996	9.2	7.3
Morbidity Rates 1996:[2]		
Reported Syphilis (all stages)[3]	36.4	20
Reported Gonorrhea (all sites)[3]	248.9	122.8
AIDS	12.2	25.2
Verified TB	7.6	8
Age-Adjusted Mortality Rates 1996:[4]		
Heart Disease	142.3	134.5
Cerebrovascular Disease	33.5	26.4
Atherosclerosis	2	2.2
Cancer	131.7	127.9
Diabetes Mellitus	15	13.6
Pneumonia/Influenza	14.6	12.8
Chronic Liver Disease & Cirrhosis	7.4	7.5
Motor Vehicle Deaths	20.1	16.2
Other Deaths by Injury	15.6	14.2

[1]Live births per 1,000 females. [2]Cases per 100,000 population. Cases are from the Centers for Disease Control. [3]Cases updated through June 13, 1997. [4]Deaths per 100,000 population using 10-year age groups and U.S. 1940 population as standard for direct age adjustment.

Source: North Carolina Health Statistics Pocket Guide - 1997

DIVISION OF PUBLIC HEALTH

HIV/STD Prevention & Care Branch

HIV/STD PREVENTION & CARE BRANCH

STDs and HIV/AIDS in North Carolina

- In calendar year 1996, NC reported the greatest number of primary/ secondary syphilis cases for all states and ranked fifth in cases per 100,000.
- According to Morbidity and Mortality Weekly Report, in 1997 NC ranked third in primary/secondary syphilis cases reported (behind Maryland and Tennessee) and remained fifth in rates per 100,000.
- In 1997 NC ranked fifth in the nation with 227 cases of gonorrhea per 100,000 persons.
- Data indicates that people who are infected with gonorrhea and chlamydia are 3 to 5 times as likely to contract HIV, and those with lesion diseases such as herpes and syphilis have 9 times the risk.
- There are currently 11,554 persons living with HIV/AIDS in NC.
- Recent data from the CDC's National Center for Health Statistics indicates a 47% decline in HIV-related deaths between 1996 to 1997; however, the rate of HIV infections has remained steady.

HIV/STD PREVENTION & CARE BRANCH

Why Is The Issue Of Sexually Transmitted Diseases Important For Policymakers?

- Nationally, estimated total costs for selected STDs and related syndromes, excluding sexually transmitted HIV infections, in 1994 dollars were nearly $10 billion.
- Costs of sexually transmitted HIV infections are estimated to be at least $6.7 billion.
- Costs include: 1) direct costs, i.e. expenditures of health care, and 2) indirect costs, i.e. lost productivity.

Estimated Costs of Selected STDs and Resulting Conditions, U.S. 1994
(1994 dollars, in millions)

STDs	Direct Cost	Total Cost
Pelvic Inflammatory Disease (PID)	$3,119.0	$4,148.0
Human Papillomavirus (HPV)	2,878.0	3,838.0
Chlamydia	1,514.0	2,014.0
Gonorrhea	791.0	1,052.0
Cervical Cancer	554.0	737.0
Hepatitis B Virus (HBV)	117.0	156.0
Herpes	178.0	237.0
Syphilis	79.0	106.0
Chancroid	7.0	9.0
Subtotal STDs (excluding HIV/AIDS)	**$7,484.0**	**$9,954.0**
Sexually Transmitted HIV	$5,025.0	$6,683.0
Total (including HIV)	**$12,509.0**	**$16,638.0**

Source: Institute of Medicine, 1996

HIV/STD PREVENTION & CARE BRANCH

HIV/AIDS Trends

⇒ In 1996 AIDS was the leading cause of death in 15 to 44-year-olds in Guilford, Lenoir and Mecklenburg counties.

⇒ Reported cases of HIV attributed to heterosexual transmission increased from 11% during 1990-1993 to 39% between 1994-1996.

⇒ African-Americans account for nearly 25 percent of North Carolina's population but more than 75 percent of all HIV cases reported since 1990.

⇒ Nearly 80% of pediatric AIDS cases were in African-American children.

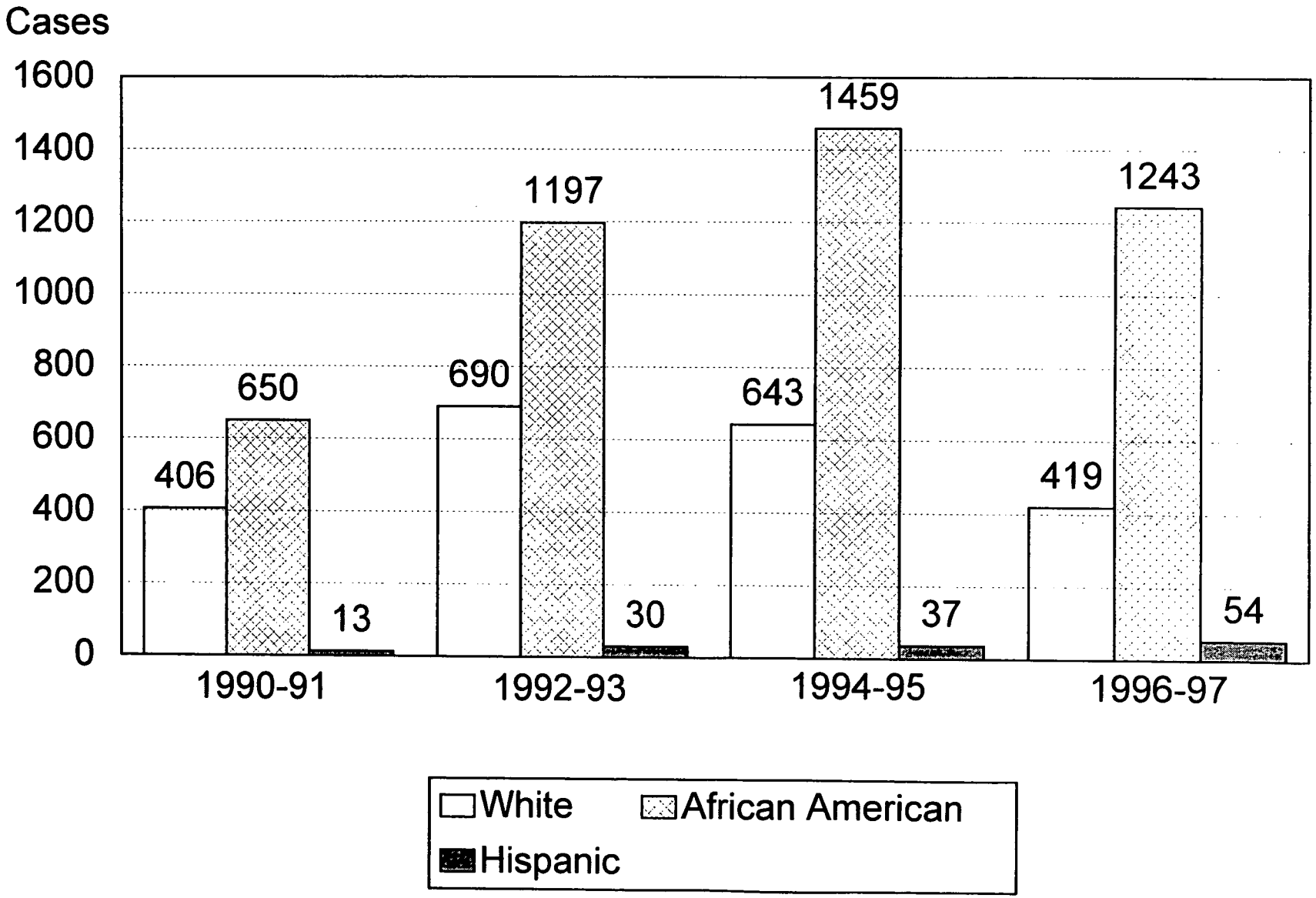
⇒ Using CDC figures, the HIV/STD Prevention & CARE Branch estimated in 1998 that up to 12,607 NC residents are living with HIV/AIDS, meaning that more than 2,100 people may be infected and not know their status.

Living HIV/AIDS Cases
February 1999

	HIV/AIDS Cases	Percent of Total
Gender		
Males	7974	69%
Females	3580	31%
Total	11554	100%
Race/Ethnicity		
White	2742	24%
Black	8457	73%
Hispanic	176	2%
Am. Indian/Alaska Native	93	1%
Other	86	0%
Total	11554	100%
Age		
Under 12	157	1%
13-19	337	3%
20-29	3383	29%
30-39	4813	42%
40-49	2226	19%
Over 49	638	6%
Total	11554	100%

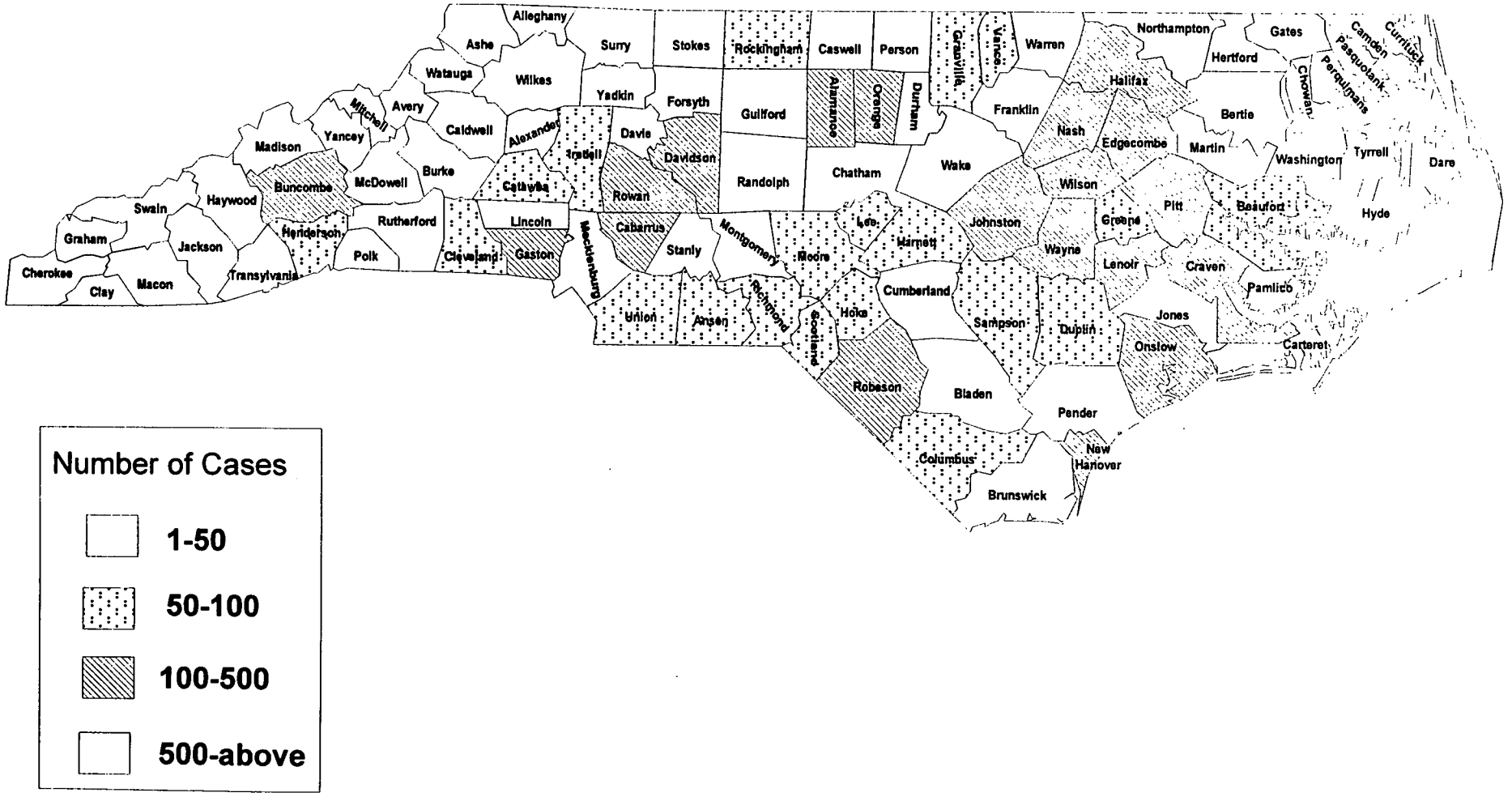
HIV/STD PREVENTION & CARE BRANCH

AIDS Cases in North Carolina By Year of Report, Race and Ethnicity



HIV/STD PREVENTION & CARE BRANCH

Cumulative Living HIV/AIDS Reports By County



HIV/STD PREVENTION & CARE BRANCH

What Services Does NC Provide To Persons With STDs And HIV/AIDS?

AIDS CARE Unit:

Administers HIV medications program (ADAP)
Supports outpatient medical and support services coordinated by 13 regionally-based HIV care consortia
Supports primary medical and dental care services
Supports housing and related services

Prevention and Field Services Units:

Interview and notify patients diagnosed with syphilis/HIV and notifies partners
Consults on syphilis/HIV control measures
Provides consultation and technical support to HIV/STD laboratories and clinics
Coordinates and monitors HIV counseling/testing programs
Distributes STD drugs, gonorrhea culture plates, condoms, and patient brochures
Acts as an HIV/STD training resource for NC
Provides consultation, training, educational materials and financial assistance to local health departments and community based organizations

Surveillance Unit:

Analyzes and reports data on the diagnosis of HIV/AIDS, and other STDs
Conducts special studies and evaluations

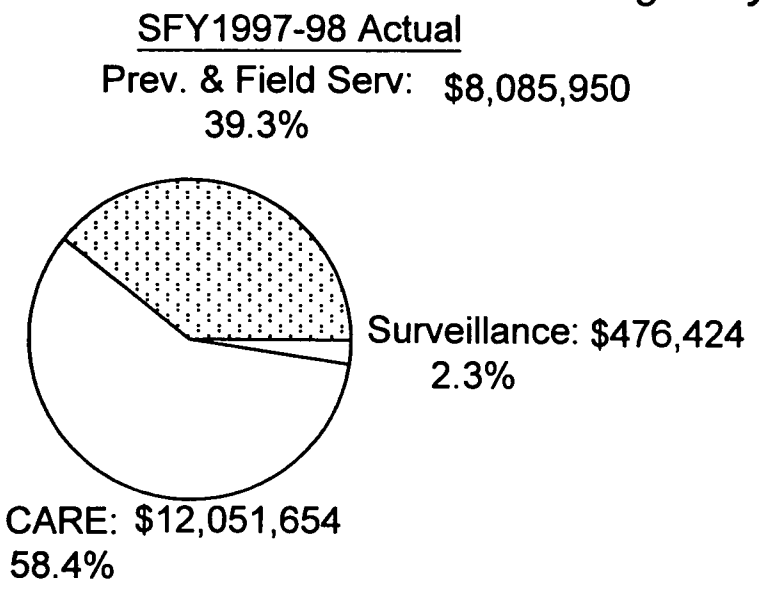
HIV/STD PREVENTION & CARE BRANCH

Budget Summary

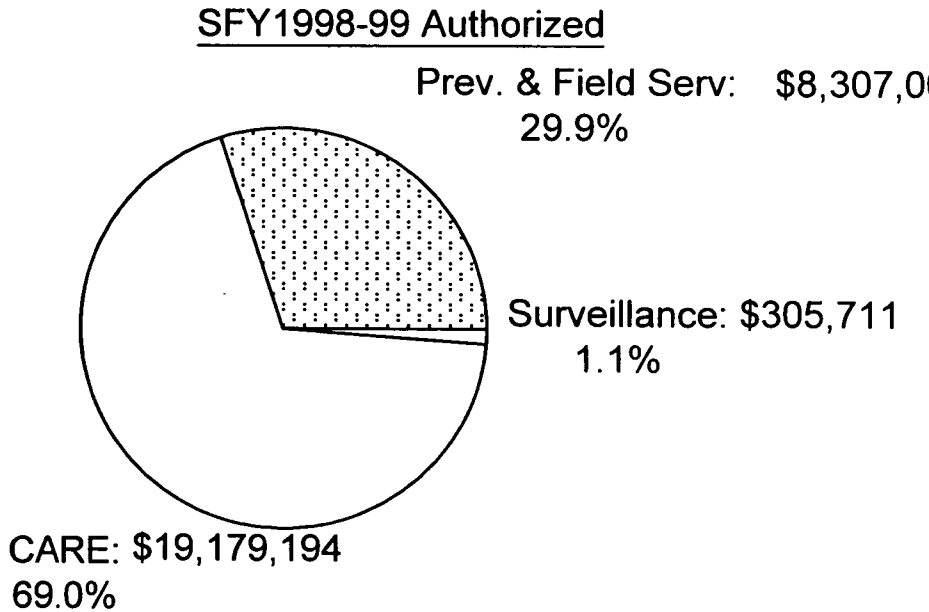
Budget Summary	1997-98 Actual	1998-99 Authorized	1999-2000 Rec'd	2000-2001 Rec'd
Requirements	$20,614,028	$27,791,906	$29,649,629	$29,883,949
Receipts	$15,408,265	$15,928,632	$15,928,632	$15,928,632
Appropriation	$5,205,763	$11,863,274	$13,720,997	$13,955,317

Budget By Purpose

SFY1997-98 Actual



SFY1998-99 Authorized



HIV/STD PREVENTION & CARE BRANCH

AIDS Drug Assistance Program (ADAP)

What is ADAP?

ADAP is a state-administered drug reimbursement program that provides access to HIV/AIDS medications for low income, uninsured and underinsured individuals. ADAPs operate in all fifty states, the District of Columbia and Puerto Rico.

How is ADAP funded?

ADAP is funded through Title II of the Federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, state appropriations, and drug rebates. The Title II formula grant is based on a calculation of the estimated number of people living with AIDS in each state or territory. The Title II program has two components: 1) medication set-asides that provide support for HIV/AIDS medications, and administration of ADAP programs; and 2) base or general funds that are used to support program administration and all other services.

When did ADAP begin?

The CARE Act became law in 1990 and was first funded in fiscal year 1991.

Who is eligible for ADAP?

An individual must: 1) be determined by a physician to be infected with HIV, 2) have a net income of less than 125% of the Federal Poverty Level, and 3) not be Medicaid eligible (or have any other insurance that will pay for their medications).

HIV/STD PREVENTION & CARE BRANCH

ADAP Issues To Consider

A. ADAP Funds Included In Continuation Budget

ADAP Budget Summary	1997-98 Actual	1998-99 Authorized	1999-2000 Rec'd	2000-2001 Rec'd
Requirements	$6,252,282	$13,158,734	$14,990,725	$15,219,724
Receipts (Ryan White)	$3,460,257	$3,887,697	$3,887,697	$3,887,697
Other (rebates)	$476,211	$500,000	$500,000	$500,000
Appropriation	$2,315,814	$8,771,037	$10,603,028	$10,832,027

B. Ryan White Funding Increase

Ryan White Funding Increase	1998 Budget	1999 Budget	Increase
Base Award	$4,818,886	$5,301,431	$482,545
Designated ADAP	$3,838,516	$6,371,503	$2,532,987
Total Ryan White	$8,657,402	$11,672,934	$3,015,532

HIV/STD PREVENTION & CARE BRANCH

C. ADAP Funding and Expected Growth?

- Since ADAP reopened in November 1998, 701 persons have been authorized for the program. This brings the total number of persons authorized to 1,716 as of February 1999.
- Each person authorized for ADAP is estimated to cost the state an average of $900 monthly, or $10,800 each year.
- The Department has estimated that of the persons authorized for the program, 40 to 60% are likely to use the program during any given month.
- Demand for the program is likely to increase as persons infected with the virus live longer, and additional persons contract the virus.
- Pharmacists have traditionally had 12 months from the date in which a prescription is filled to bill the DHHS, Purchase of Care Office.
- The ADAP has a larger budget today than ever before, including an addition $3 million from Ryan White.

HIV/STD PREVENTION & CARE BRANCH

D. Needed -- "The Most Bang For The Buck"

Senate Bill 1366
Section 12.46A
AIDS DRUG ASSISTANCE PROGRAM

Summary:

(a) The Department of Health and Human Services shall develop and implement a cost-containment plan for the purpose of serving additional clients of the HIV Medications Program.

(b) The Department shall implement cost-containment programs or mechanisms, other than pharmaceutical rebates, by January 1, 1999, and shall report to the members of the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Human Resources not later that March 15, 1999.

(c) Savings realized through cost-containment measures shall be used to serve additional ADAP participants in fiscal year 1998-99. Funds not expended for authorized program costs shall revert to the General Fund.

(d) The Department shall also develop a comprehensive information system on AIDS/HIV clients receiving services from the State. The system shall include information on program usage patterns of ADAP participants, including, but not limited to frequency of prescription purchases, and types of medications prescribed. The Department shall also develop a plan for monitoring patient compliance with physician treatment recommendations. In developing the plan, the Department shall identify ways of obtaining information without interfering with physician-patient confidentiality.

DIVISION OF PUBLIC HEALTH

Other Issues: Immunization Branch
Infant Mortality Programs
Hispanic/Latino Public Health Issues

IMMUNIZATION BRANCH

Mission and Purpose:

The Immunization Branch promotes public health by reducing the spread of or eliminating vaccine-preventable diseases. To this end, the Branch attempts to break down barriers which prevent children from receiving timely immunizations. The Branch is also responsible for management and control of vaccine-preventable diseases and disease outbreaks.

Immunization Branch Program Areas:

1. Vaccine service delivery and customer support, including the Universal Childhood Vaccine Distribution Program (UCVDP) and the federal Vaccines For Children (VFC) program;

2. Immunization assessment, including participation in national, state and local assessment projects and research studies;

3. Immunization education, outreach and promotion for the general public and health professionals;

4. Vaccine-preventable disease surveillance, including epidemiologic investigation and outbreak control; and

5. North Carolina Immunization Registry (NCIR), which is primarily responsible for the development, implementation and maintenance of a statewide computerized immunization tracking and follow-up system.

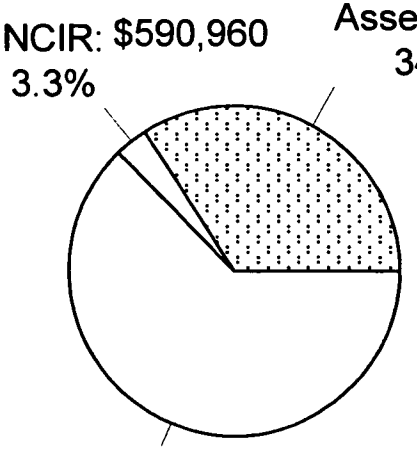
IMMUNIZATION BRANCH

Budget Summary

Budget Summary	1997-98 Actual	1998-99 Authorized	1999-2000 Rec'd	2000-2001 Rec'd
Requirements*	$17,700,869	$18,061,443	$18,791,506	$20,342,116
Receipts	$5,859,414	$6,027,113	$5,985,417	$5,985,417
Appropriation	$11,841,455	$12,034,330	$12,806,089	$14,356,699

Budget By Purpose

SFY 1998-99 Authorized



*Requirements do not include between thirteen and nineteen million dollars a year in vaccines provided by the U.S. Center for Disease Control and Prevention.

IMMUNIZATION BRANCH

The What, When and Why of NC's Universal Immunization Status

What does it mean to say that NC is a Universal Immunization State?

North Carolina, through its Universal Childhood Vaccine Distribution Program (UCVDP), and in cooperation with the federal government's Vaccine For Children Program (VFC), pays for virtually *all* recommended childhood vaccines. The VFC provides vaccines for all children from birth through 18 years of age who are American-Indian/Alaskan Native, Medicaid-eligible, uninsured, and for children who attend a federally-qualified or rural health center and have insurance which does not cover immunizations. The state pays to immunize all other children.

When did NC become a Universal Immunization State?

January 1, 1994

Why did NC become a Universal Immunization State?

North Carolina became a Universal State for two reasons; first, to remove costs as a barrier to immunizations, and secondly, to keep children in their medical homes for all services.

IMMUNIZATION BRANCH

Immunization Issues To Consider

A. Recently Adopted Vaccine Reporting and Accountability Measures

The NC Immunization Program failed to comply with NC Administrative Code requirements. A 1998 audit of the program conducted by the Office of the State Auditor found:

- Reports submitted by private providers are incomplete of required data.
- Private providers file reports untimely.
- Private providers are not suspended from the Program for failure to meet reporting requirements.
- The NCIR does not include the ability for private providers to enter data directly.
- The program failed to promptly enter private provider reports into the tracking system.

B. Newly Implemented Vaccine Provider Financial Restitution Program

Division records for calendar year 1997 documented examples of vaccine wastage. Reasons for wastage included: expired vaccines due to failure to rotate, vaccine spoilage due to power outages or failure to properly store and handle vaccines, etc.

The costs of vaccines vary. As of January 5, 1999 a dose may cost anywhere from $1.53 to $34.39 (at CDC costs), to $2.15 to $44.26 (at private sector costs).

For calendar year 1997 35,955 doses, or 1.4 percent, of 2,494,696 were reported as wasted.

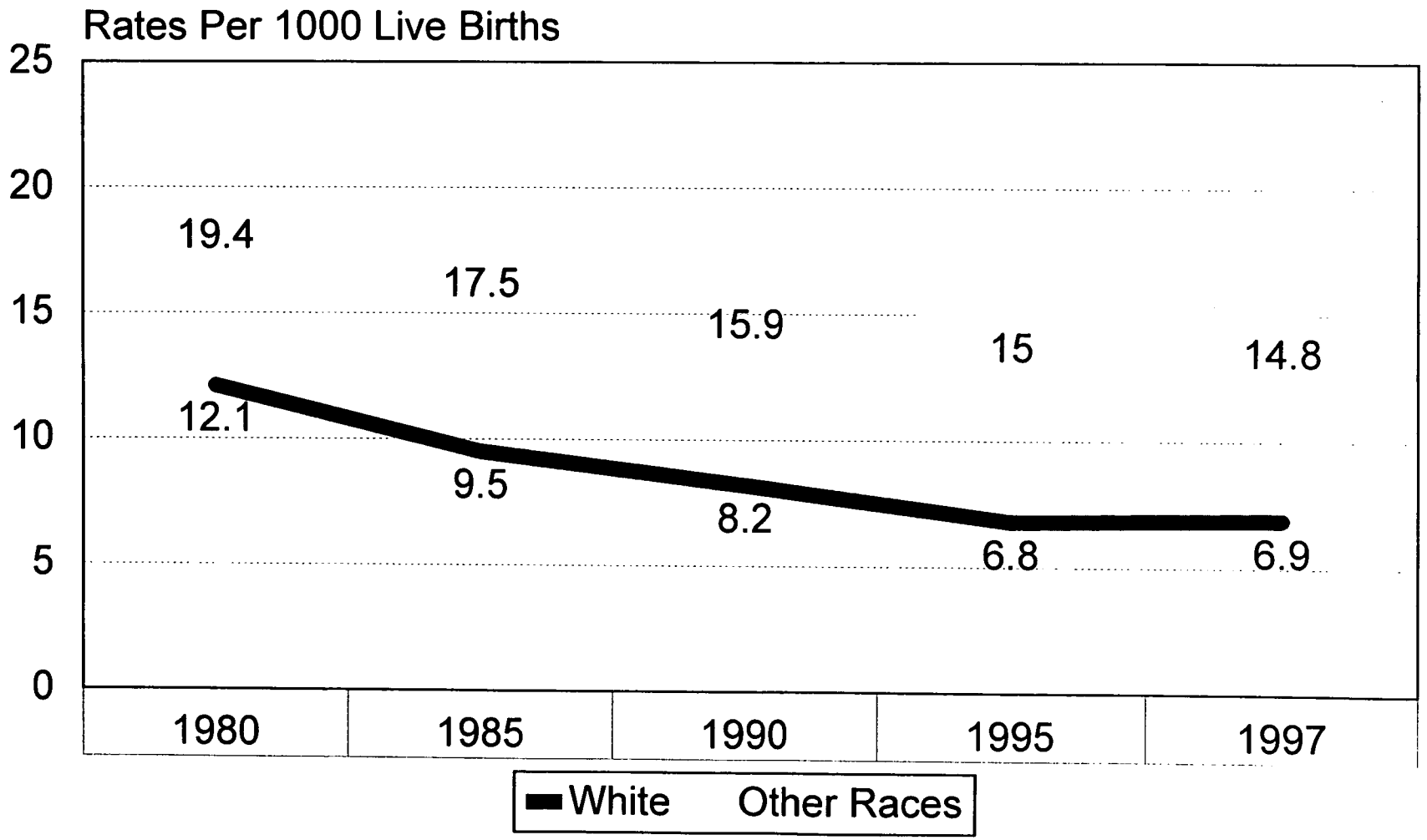
INFANT MORTALITY PROGRAMS

Facts About Infant Mortality in NC

- North Carolina's 1997 infant mortality rate was 9.2 deaths per 1,000 live births. This rate has remained unchanged from the rate of the previous two years.
- There were 982 infant deaths recorded in 1997.
- Approximately 1% of women giving birth in 1997 received no prenatal care, a 5.2% reduction form 1996. Approximately 83% of women began prenatal care in the first trimester (first three months) of pregnancy.
- The percentage of women who smoked during pregnancy decreased by 3.9% (to 15.1%) in 1997, continuing a downward trend over the past 10 years.
- The 1997 mortality rate was 6.9 per 1,000 births (522 deaths) for white infants, while for other races combined the rate was 14.8 per 1,000 births (460 deaths).
- For both whites and minorities, infant mortality rates were the second lowest ever recorded in the state; yet, preliminary national data for 1997 indicate that NC had the 2nd highest infant mortality rate in the nation.
- The percentage of infants delivered very low birth weight (less than 3lb., 5oz.; or 1,500 grams) continued to increase in 1997. In 1997, 1.9% of all infants were delivered very low birthweight, representing an increase of about 6% over the percentage from 1996.
- The percentage of births to women under age 18 declined in 1997, accounting for 5.5% of all live births.

INFANT MORTALITY PROGRAMS

NC Infant Mortality Rates 1980-1997



INFANT MORTALITY PROGRAMS

Selected Programs

⇒ Baby Love Program

⇒ Targeted Infant Mortality Reduction Projects

⇒ Minority Infant Mortality Reduction Projects

⇒ High Risk Maternity Clinics

⇒ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

⇒ Maternal Serum Alpha Fetoprotein Screening

⇒ First Step Campaign

⇒ Adolescent Pregnancy Prevention & Adolescent Parenting Programs

⇒ Maternal Health Programs

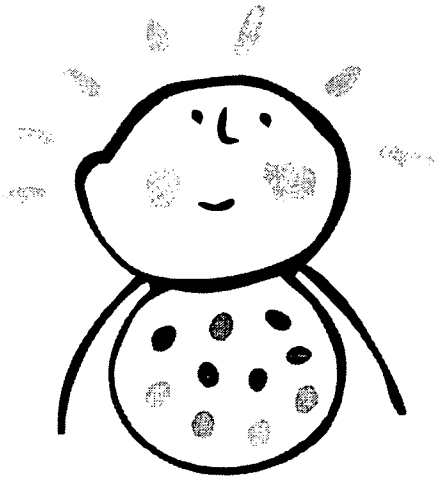
INFANT MORTALITY PROGRAMS

NC Healthy Start Foundation

⇒ Supports operating expenses of the FIRST STEP Campaign, the state's perinatal health public awareness effort

- Minority Infant Mortality Reduction Public Awareness Campaign
- Back to Sleep Public Awareness and Education Campaign

⇒ Supports Community Grants program that provides minigrants to communities to carry out local initiatives to improve birth outcomes



HISPANIC/LATINO PUBLIC HEALTH ISSUES

National Hispanic/Latino Facts & Health Trends

- Hispanics in the U.S. include a diverse mixture of ethnic groups and cultures, including Puerto Ricans, Cubans, Mexicans and Central and South Americans.
- Although Mexicans represent an estimated 10% of the total U.S. population, they account for 18% of the 641,086 AIDS cases reported in 1997 (Centers for Disease Control and Prevention).
- Approximately one in every 10 Hispanic adults has diabetes (American Diabetes Association).
- In 1995, nearly 11 percent of Hispanic teenagers gave birth, compared with about 10 percent of black teenagers and 4 percent of non-Hispanic white teenagers (National Center for Health Statistics).
- Hispanics of all ages were the most likely to be uninsured; nearly 3 in 10 (the federal Agency for Health Care Policy and Research).
- Families headed by Hispanics were the most likely to report barriers to obtaining health care (the federal Agency for Health Care Policy and Research).

HISPANIC/LATINO PUBLIC HEALTH ISSUES

Growth in NC's Hispanic/Latino Population for Select Counties

County	1990	1997	% Change
Buncombe	1,298	2,425	86.83%
Craven	1,838	3,327	81.01%
Cumberland	13,638	23,411	71.66%
Duplin	1,041	1,873	79.92%
Durham	2,469	3,842	55.61%
Forsyth	2,389	4,084	70.95%
Guilford	3,240	5,564	71.73%
Harnett	1,486	2,437	64.00%
Johnston	1,324	2,844	114.80%
Mecklenburg	7,368	14,409	95.56%
New Hanover	1,057	2,069	95.74%
Onslow	8,251	12,587	52.55%
Orange	1,451	2,775	91.25%
Pitt	1,088	1,911	75.64%
Wake	6,751	12,648	87.35%
Wayne	1,776	2,625	47.80%
North Carolina	**86,831**	**149,390**	**72.05%**

Source: Population Estimates Program, Population Division, U.S. Bureau of the Census, Washington, DC 20233

HISPANIC/LATINO PUBLIC HEALTH ISSUES

Public Health Emergency: 1996 Rubella Outbreak

Rubella causes:	It can lead to:	Babies can be born with birth defects, such as:
• rash • swollen glands • arthritis	• ear infection • pneumonia • diarrhea • seizures • hearing loss • brain damage • death • meningitis	• deafness • blindness • heart disease • brain damage • other serious problems

⇒ Between 1987 and 1995, North Carolina reported only 9 confirmed cases of rubella.

⇒ From March 26 to June 15, 1996 there were two simultaneous, but unrelated outbreaks of rubella affecting mostly Hispanics of Mexican origin reported to the NC Immunization Section.

⇒ Eighty-three confirmed cases of rubella were reported. Of the 83 cases, 79 were Hispanic.

⇒ Two cases occurred in children under age 5. Six confirmed cases in the first outbreak involved women who were pregnant at the time of exposure; one in the first trimester, three in the second, and two in the third.

⇒ The first outbreak involved four neighboring counties in central NC: Chatham, Guilford, Lee, Randolph. The outbreak started in a poultry processing plant in Chatham County, which employed mostly Hispanics.

⇒ The second outbreak occurred in a young Hispanic male who traveled to NC from Sonora, Mexico. After exposing his immediate family, he transmitted the disease to coworkers at a local plastics factory.

HISPANIC/LATINO PUBLIC HEALTH ISSUES

*Preliminary Findings of the NC Center for Public Policy Research Study on Hispanic/Latino Health in North Carolina**

Do you think health care is a problem for Hispanics/Latinos in your community?

	Yes	No
Health Departments	92.7%	7.3%
Rural Health Centers	65.0%	35.0%
Community/Migrant Health Centers	66.7%	33.3%
Rural Hospitals	75.6%	24.4%
Total	82.4%	17.6%

What are the three most significant health issues affecting Hispanics/Latinos in your community?

	Males	Females	Children
1	No/Inadequate health insurance	Prenatal Care	Access to health care
2	Access to health care	Access to health care	No/Inadequate health insurance
3	On-the-job-injuries	No/Inadequate health insurance	Immunization Rates

*This study included a review of recent literature, extensive interviews and field visits, and a survey of 87 health departments, community and migrant health centers, rural health centers, and rural hospitals. The survey response rate was 72.9%, with 92% of health departments responding.

HISPANIC/LATINO PUBLIC HEALTH ISSUES

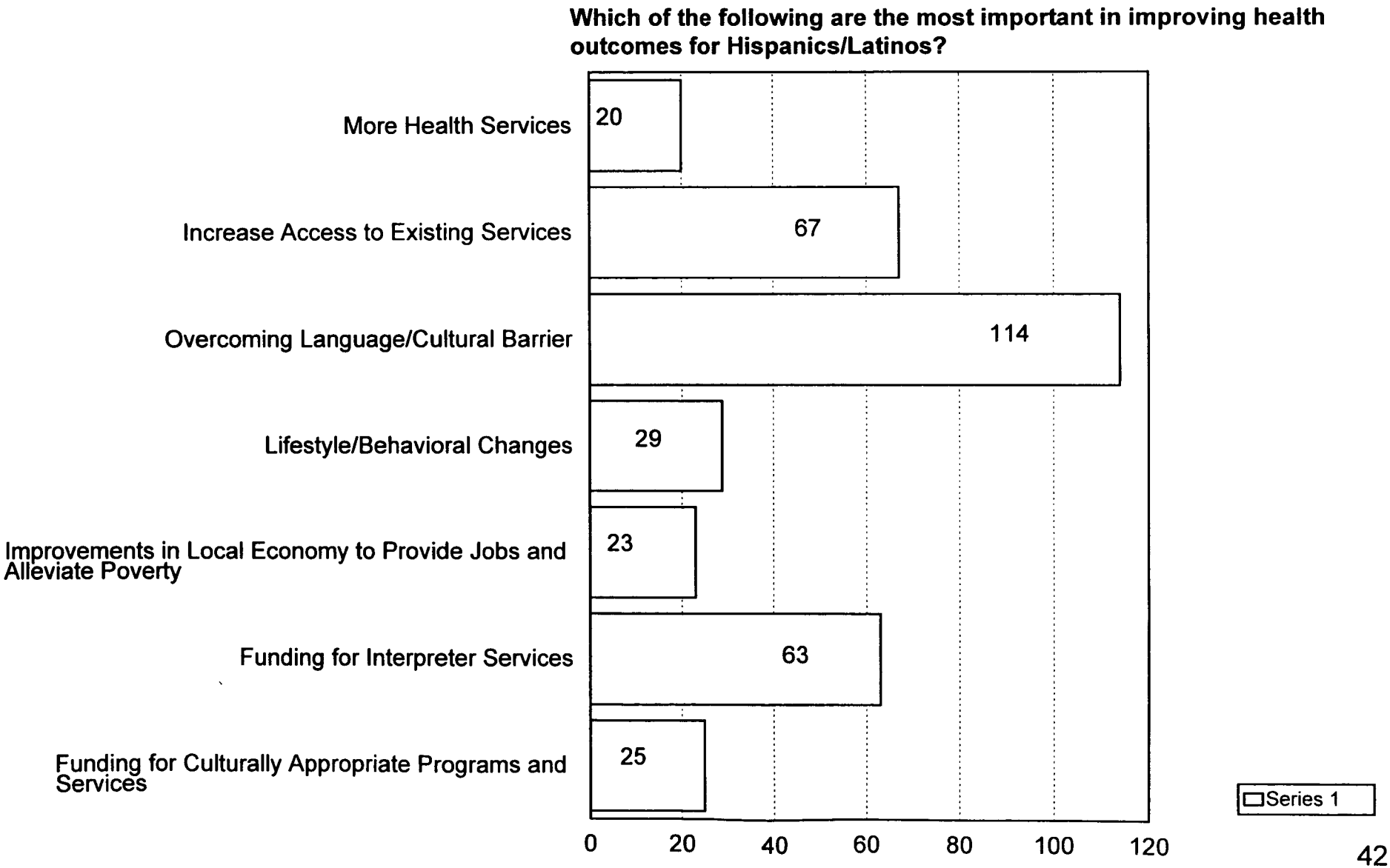
Preliminary Findings of the NC Center for Public Policy Research Study on Hispanic/Latino Health in North Carolina

In your opinion, how do health services for Hispanics/Latinos in your community compare to those available to whites and other minorities?

To Whites?	Much Better	Better	About the Same	Worse	Much Worse
Health Departments	0.0%	0.0%	72.0%	20.7%	7.3%
Rural Health Departments	0.0%	0.0%	52.9%	41.2%	5.9%
Community/Migrant Health Centers	0.0%	0.0%	58.3%	33.3%	8.3%
Rural Hospitals	0.0%	2.3%	90.7%	4.7%	2.3%
Total	0.0%	0.6%	74.0%	19.5%	5.8%
To Other Minorities?					
Health Departments	0.0%	0.0%	84.1%	12.2%	3.7%
Rural Health Departments	0.0%	0.0%	62.5%	31.3%	6.3%
Community/Migrant Health Centers	0.0%	8.3%	58.3%	33.3%	0.0%
Rural Hospitals	0.0%	2.3%	93.0%	4.7%	0.0%
Total	0.0%	1.3%	82.4%	13.7%	2.6%

HISPANIC/LATINO PUBLIC HEALTH ISSUES

Preliminary Findings of the NC Center for Public Policy Research Study on Hispanic/Latino Health in North Carolina



North Carolina
Department of Health and Human Services
101 Blair Drive • Post Office Box 29526 • Raleigh, North Carolina 27626-0526
(919) 733-4534 • Courier 56-20-00

James B. Hunt Jr., Governor

March 12, 1999

H. David Bruton, M.D., Secretary

The Honorable Beverly M. Earle, Chair
The Honorable Edd Nye, Chair
House Appropriations Subcommittee on
Health and Human Services

Senator William N. Martin, Chair
Senate Appropriations Subcommittee on
Human Resources

North Carolina General Assembly
Legislative Office Building
Raleigh, North Carolina 27601-1096

Dear Representative Earle, Representative Nye, and Senator Martin:

Attached please find, as required of the Department by Section 12.46A of Senate Bill 1366, 1998 Session, the report on The North Carolina AIDS Drug Assistance Program. I trust that it will prove valuable to you and your colleagues as you discuss and deliberate the issues around this most important program.

The Department welcomes your interest and your questions. We would be pleased to meet with you and the respective committees to discuss any of the information presented in the report and/or any other questions and issues you might have about the HIV/STD program area.

Sincerely,

H. David Bruton, M.D.

HDB:sc

Attachments

cc: Senate Appropriations Subcommittee on Human Resources
House Appropriations Subcommittee on Health and Human Services
Ramona Burton
James B. Edgerton
A. Dennis McBride, M.D.
Ann Wolfe, M.D.
Chris Hoke
Allyn Guffey
Nina Yeager
Legislative Library

DEPARTMENT OF HEALTH AND HUMAN SERVICES REPORT

ON

THE NORTH CAROLINA AIDS DRUG ASSISTANCE PROGRAM

PRESENTED TO

THE HOUSE OF REPRESENTATIVES APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

AND

THE SENATE APPROPRIATIONS COMMITTEE ON HUMAN RESOURCES

Submitted in fulfillment of the requirements of Special Provision 12.46A

For further information contact:
J. Steven Cline, DDS, MPH, Acting Director, Division of Epidemiology, 715-6471

EXECUTIVE SUMMARY: REPORT ON NORTH CAROLINA AIDS DRUG ASSISTANCE PROGRAM

In the fall of 1998, the General Assembly issued Special Provision 12.46A for North Carolina's AIDS Drug Assistance Program (ADAP). This provision requires the Department of Health and Human Services to report to the General Assembly by March 15, 1999 on plans to contain ADAP costs, develop a comprehensive ADAP information system, and monitor patient compliance with physician treatment recommendations. The table below summarizes the Department's efforts to address these three concerns. The body of the report describes these efforts in greater detail.

Table 1: ADAP Executive Summary

ISSUE	*STRATEGIES*	*COST IMPACT*
Cost Containment	*Current:*	
	Conservative income eligibility criterion	Allows only persons earning ≤ 125% FPL[1] to enroll in program; 49th most restrictive state
	Monitoring Medicaid eligibility	Saves ~$1 million/yr.
	Monitoring Private health insurance	Minimal - 8 applicants and claims denied in past year
	Drug manufacturers' rebates	Increased FY99 program resources by ~$1million; likely to increase in future years
	6 month reauthorization periods	Reserves program resources for those who are most in need and use services
	Proposed:	
	Medicaid waiver	• Because the federal government pays ~2/3rds of Medicaid expenditures in NC, the waiver would use available state funds to leverage additional federal dollars, thereby increasing resources available to serve HIV+ persons. • Administrative costs for ADAP: None beyond developing waiver application • Administrative costs for DMA: Moderate; developing waiver application, setting up and operating waiver program. • **Budget Impact: No additional State appropriation required.**
	Health insurance continuation program	• Would save ~$7,800/yr. for each ADAP client enrolled • Potential number of enrollees: 50-200 for annual savings of $390,000-$1.56 million. • Minimal increase in annual ADAP or Department of Insurance administrative costs. • **Budget Impact: No additional State appropriation required.**
	High risk insurance pool	• Would save $1,800-$4,800/yr. in ADAP dollars for each client enrolled • Potential number of enrollees: 1,000 for total annual savings of $1.8-$ 4.8 million. • Moderate increases in ADAP administrative costs for HCIP set up and operations. • Significant increase in Dept. of Insurance administrative costs to develop and administer high risk pool. • **Budget Impact: Additional appropriations would be required.**

[1] Federal poverty level. For example, the FPL for a family of one is annual income less than or equal to $8,050.

Table 1 (continued): ADAP Executive Summary

ISSUE	*STRATEGIES*	*COST IMPACT*
Comprehensive ADAP Information System	Contract with Pharmacy Network National Corporation to establish an ADAP claims tracking system	• Annual operating costs: $20-28,000 to be absorbed by ADAP, recovered through reduced pharmacy dispensing fees, or a $1.00 co-payment per prescription. • Minimal implementation costs to upgrade Purchase of Care computers. • **Budget Impact: No additional State appropriation required.**
Monitoring Patient Compliance	Patient education using Glaxo Wellcome curriculum	• Improved patient compliance increases the effectiveness of medications, keeping people healthier longer resulting in significant economic benefits of decreased hospitalizations, Medicaid utilizations, and SSI/SSDI expenditures. • Estimated annual ADAP costs to support use of Glaxo curriculum ~$100,000. • **Budget Impact: No additional State appropriation required.**
	Adherence support programs	• Operating and administrative costs: Unknown; will depend on specific program implemented. • **Budget Impact: No additional State appropriation required.**
	Provider surveys on patient compliance	• Minimal administrative costs. • **Budget Impact: No additional State appropriation required.**

INTRODUCTION

Jointly funded by State and federal dollars, the North Carolina AIDS Drug Assistance Program (ADAP) is designed to provide low income residents with financial assistance for the purchase of medications to combat HIV and the opportunistic infections specific to AIDS. The importance of this program can be viewed from a variety of perspectives:

- The medications ADAP provides have saved lives and maintained infected individuals' health for longer periods of time. National figures indicate that since the introduction of protease inhibitors in late 1996, AIDS deaths have decreased by as much as 50%. In addition, progression to AIDS has been significantly reduced, in some instances by as much as 80%.

- By reducing mortality and morbidity, these medications have helped keep families intact. They have allowed HIV-infected individuals to continue working, supporting their families, caring for their children, and assuming an active role in community and family life.

- Providing anti-HIV medications is also important from a public health perspective. Anecdotal reports indicate that patients on these medications are less likely to transmit the virus to others, presumably because they have lower levels of virus in their systems. Formal studies are under way to confirm these reports.

- ADAP also allows the public health system to maintain regular contact with HIV-infected persons to provide them with continuing support and education about their disease.

- By facilitating continuity in treatment therapy, ADAP also makes it less likely that HIV-infected persons will develop drug resistant virus.

- Providing medications to HIV-infected persons yields a significant economic benefit. This includes fewer hospitalizations, lower Medicaid utilization, and lower expenditures for programs such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), all because infected persons stay healthier longer and need fewer services. In addition, many of these individuals can continue working and paying taxes.

While very effective, protease inhibitors are also very expensive. Once these medications were introduced, expenditures for ADAP began to rise rapidly, and in September 1997, the program was forced to stop enrolling new clients. In the fall of 1998, the General Assembly appropriated a total of $8.77 million to enable ADAP to reopen enrollment and provide services to all eligible clients - both old and new.

At the same time, the General Assembly issued Special Provision 12.46A for North Carolina's AIDS Drug Assistance Program (ADAP). This provision requires the Department of Health and Human Services to report to the General Assembly by March 15, 1999 on plans to:

- develop and implement a cost-containment plan for the purpose of serving additional clients;
- develop a comprehensive information system on ADAP services and clients; and
- develop a plan for monitoring patient compliance with physician treatment recommendations.

This report documents progress towards meeting the three requirements set forth in this provision.

A. CONTAINING COSTS

The Department currently uses various strategies to contain program costs and ensure that ADAP provides appropriate services to as many qualified clients as possible. Several other strategies are currently under development.

1. Current Strategies:

- **Conservative ADAP financial eligibility criteria.** As Table 2 indicates, only one state has a stricter requirement than North Carolina, which limits income of eligible persons to 125% of the federal poverty level ($10,063 for a family of one).

Table 2. ADAP Financial Eligibility Criteria by State

% of Federal Poverty Level – FPL ($ Range for a Family of One)	*States*
100-124% FPL ($8,050-10,062)	Arkansas
125-149% FPL ($10,063-12,074)	*North Carolina*
150-199% FPL ($12,075-$16,099)	Colorado, Michigan, Mississippi, Missouri, North Dakota, Oklahoma,
200-299% FPL ($16,100-24,149)	Alabama, Alaska, Arizona, Connecticut, Delaware, Florida, Illinois, Iowa, Louisiana, Maine, Nebraska, Nevada, Ohio, Oregon, Texas, Vermont, **Virginia**, Wisconsin
≥ 300% FPL (≥ $24,150)	California, District of Columbia, **Georgia**, Hawaii, Idaho, Indiana, Kansas, **Kentucky**, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, **South Carolina**, South Dakota, **Tennessee**, Utah, Washington, West Virginia, Wyoming

- **Monitor client Medicaid eligibility** to reserve ADAP funds for clients without other payment options. Staff check to see if a client is Medicaid eligible four times, twice during the authorization process and twice during claims processing. In a two-month period, 37 applicants (approximately 9% of total applications received) were denied authorization because of Medicaid eligibility. In addition, between July 1 and December 15, 1998, 177 claims for HIV medications were received and denied by Purchase of Care staff because the patient was Medicaid eligible on the date the prescription was filled. They represented 3.5% of all claims processed during that time period. As shown in Table 3, taken together these Medicaid eligibility checks should save ADAP an estimated $1 million in the current fiscal year.

Table 3. Estimated Annual Savings Attributable to Monitoring Medicaid Eligibility

Eligibility Monitoring	% Denied	Estimated ADAP Annual Savings
During authorization	9% of applicants	~$ 650,000
During claims processing	3.5% of claims	~$ 350,000
TOTAL SAVINGS		~$1,000,000

- **Monitoring private health insurance coverage** to assure ADAP is the payer of last resort. There are two checkpoints for private insurance. In the past year, applications or claims have been denied eight times because of private insurance coverage.

- Participation in **drug manufacturers' voluntary rebate programs.** The Department estimates that of the $14.85 million dollars available to NC ADAP through all sources in FY99, a little over $1 million will come from manufacturers' rebates.

2. *Strategies Implemented in 1999:*

- Participation in the **340B ADAP Rebate Program**, a new federal program that should enable NC ADAP to achieve greater savings than those realized from the old voluntary rebate system. Although rebates for the most commonly prescribed medications will not be substantially higher than under the old system, the new program will allow ADAP to obtain rebates on more drugs in its formulary and make it easier to negotiate rebate agreements with multiple manufacturers. The exact savings are unclear at this time, but they will become apparent as the State begins receiving rebates under the new program later this year.

- **Six-month reauthorization periods.** Biannual reauthorizations increase the likelihood that those who no longer meet eligibility requirements and those who do not access services may be removed from program rolls in a timely manner, thus reserving program resources for those clients who truly need and use ADAP.

3. *Strategies Currently Under Consideration*

The Department has considered a variety of other strategies. The three most promising are described below. Although it is difficult to estimate with any precision the savings that the State would realize, a general statement on the cost impact of each strategy is included.

- **Medicaid waiver.** ADAP and Medicaid staff are actively exploring the feasibility of submitting a federal Medicaid waiver application for an HIV/AIDS demonstration project that would provide medications and certain other benefits to non-disabled persons with HIV disease. Under current medical eligibility criteria, it is not until persons with HIV disease have been disabled by their disease that they qualify for the Medicaid assistance that could have kept them relatively healthy. The project would waive this disability requirement.

  Under such a waiver, many persons currently enrolled in ADAP would qualify for Medicaid assistance. Even a limited benefits package would provide more services than ADAP, which can only cover the cost of medications. Thus, the project could also improve the overall quality of health care that ADAP clients are currently receiving.

In studying a possible Medicaid waiver application for North Carolina, ADAP staff have:

  * Secured commitment from the State Medicaid Director to explore the feasibility of a Medicaid waiver.

  * Secured commitment from the Kaiser Family Foundation to collaborate on the economic analysis required as part of the waiver application. Kaiser has assisted other states with waiver applications and has collaborated with the University of California at San Francisco to develop an economic model for analyzing costs associated with HIV disease. Kaiser has offered this model for use in North Carolina's economic analysis. In addition, Kaiser has offered the services of a Washington-based consulting firm with extensive experience working with State Medicaid programs. All of these services will be provided at no cost to NC ADAP and represent a significant in-kind contribution to North Carolina's exploration of a Medicaid waiver.

* Obtained agreement from the Center for Health Policy, Law, and Management at Duke University to work with State and Kaiser staff on the economic analysis, again at no cost to the program.

* Working with DMA staff, requested and received from the State Center for Health Statistics a preliminary analysis of Medicaid expenditures for HIV-related services.

* Scheduled first meeting of Kaiser, Duke, DMA, and ADAP staff for March 31.

Kaiser's experience working with other states suggests that the analysis will take at least six months in order to determine the feasibility of applying for a Medicaid waiver. If it does appear feasible, additional time will be needed for preparation of the waiver application and for its review by the Health Care Financing Administration to assess "budget neutrality."

Cost impact: *Moving ADAP clients to Medicaid would free up ADAP slots for other individuals in need, assuring that more low income persons with HIV disease received some kind of medical assistance, without expenditure of additional ADAP dollars. Furthermore, because the federal government pays about two-thirds of Medicaid expenses in North Carolina, the waiver would use available state funds to leverage additional federal dollars, thereby increasing the overall resources available to serve North Carolinians with HIV disease. This could allow North Carolina to consider raising its ADAP income eligibility criterion to bring it into line with most other states and serve more needy persons.*

For ADAP, administrative costs of implementing the project should be limited to the staff time needed to develop the waiver application. For the Division of Medical Assistance, administrative expenses will also include the costs of setting up and operating the waiver program. It is not anticipated that additional appropriations will be required.

- **Health insurance continuation program (HICP).** States are authorized to use Ryan White funds to maintain continuity of existing health insurance coverage for low income individuals with HIV disease. At least 39 states, including Virginia and Georgia, administer some type of insurance continuation program. Staff from NC ADAP have met with staff at the NC Department of Insurance (DOI) to explore the creation of a health insurance continuation program for eligible North Carolinians with HIV disease. ADAP and DOI staff are committed to continued cooperation in this venture. HICP would pay premiums for either employer-sponsored or private-pay health insurance plans that are about to lapse due to the insured's lack of financial resources. This could include insurance premiums paid by employed persons, COBRA premiums for former employees, and premiums for conversion policies once the COBRA period has expired. Health insurance plans generally provide a much broader range of services than solely the medications currently provided by ADAP. Thus, HICP would help clients maintain more comprehensive health care services, without using all their limited resources on insurance premiums. It would also allow them to work part-time or sporadically, as their health allows, without concern about loss of insurance.

Cost impact: *Averaging between $200 and $250 per client, a monthly insurance premium would be considerably less than the current average ADAP monthly prescription cost of $900.00. With $250/month premiums, savings of $7,800/year would be realized for each ADAP client enrolled in the insurance continuation program. However, the number of ADAP clients that might be served by the program is relatively small (50-200, depending on eligibility criteria) because not many clients have health insurance policies to continue. Even so, as Table 4 indicates, a health insurance continuation program could yield considerable savings to ADAP. These savings could be used to enroll additional clients or to raise the program's current low income eligibility level. The program would also save Medicaid dollars by keeping ADAP clients who might soon qualify for Medicaid in the private insurance market. HICPs have proven cost-effective in a number of states. A study of Wisconsin's insurance continuation program indicated that every dollar spent on insurance subsidies*

yielded net savings of $5.52 in Medicaid costs. The cost-benefit ratios in three other states ranged from 1:3 in Maryland to 1:9 in both Michigan and Georgia. In general, HICPs contribute to a more equitable sharing of costs for HIV/AIDS care across private and public health insurance programs.

Table 4: Estimated Annual Savings from an Health Insurance Continuation Program (HICP)

Current Average Monthly ADAP Cost per Client	Projected Average Monthly HICP Premium	Projected Monthly Savings per Client	Projected Number of Clients on HICP	Projected Annual ADAP Savings
$900	$250*	$650	50	$ 390,000
$900	$250	$650	100	$ 780,000
$900	$250	$650	200	$1,560,000

* The $250 figure reflects discussions with eight states currently administering HICPs.

It is expected that ADAP could cover the administrative costs of setting up and operating HICP with savings realized by the program. No additional appropriation of state or federal funds would be required.

- **High risk insurance pool (HRIP).** States are also authorized to use federal Ryan White dollars to purchase insurance policies for persons with HIV disease through high risk pools. An HRIP would make health insurance accessible to North Carolinians who are generally uninsurable because of pre-existing medical conditions. These conditions include cancer, diabetes, kidney disease, and cardiovascular disease, as well as HIV/AIDS. An HRIP could serve persons who were able to pay for their own premiums (if they could get insurance), as well as low-income persons whose premiums would be paid by public programs. Policies purchased through an HRIP would provide ADAP clients with a much broader array of health care services than the medications provided by ADAP. Whereas participation in a health insurance continuation program requires existing insurance coverage, a high risk pool could assist persons who have never had insurance or have already lost it. A number of state ADAPs currently provide insurance coverage to clients through risk pools, among them Minnesota, Wisconsin, Indiana, and Louisiana.

  Cost impact: High risk insurance premiums vary greatly from state to state. As indicated in Table 5, even at $750/month, three times the average standard premium of $250/month, the cost of insurance coverage would be considerably less than the cost of purchasing medications for an ADAP client. Because of higher premiums, a high risk pool would realize lower savings per client than a health insurance continuation program. However, because so many more ADAP clients might qualify for a high risk pool, the total annual savings to ADAP would be considerably larger than that associated with an insurance continuation program. Based on discussions with ADAPs operating in states with high risk pools, it seems reasonable to assume that an estimated 1,000 NC ADAP clients might obtain insurance through a high risk pool. Again, the savings could be applied to expanding ADAP enrollment and/or broadening eligibility criteria. Since the insurance pool would be open to all persons with health problems, not just people with HIV disease, it would keep many more people from becoming Medicaid clients than an HIV-specific insurance continuation program.

Table 5: Estimated Annual Savings from an High Risk Insurance Pool (HRIP)

Current Average Monthly ADAP Cost per Client	Projected Average Monthly HRIP Premium	Projected Monthly Savings per Client	Projected Number of HRIP Clients	Projected Annual ADAP Savings
$900	$500	$400	1,000	$4,800,000
$900	$600	$300	1,000	$3,600,000
$900	$750	$150	1,000	$1,800,000

The administrative costs associated with a high risk insurance pool would likely prove considerable. The program would be large and complex. While federal regulations allow states to use Ryan White funds to pay premiums for health insurance programs, they prohibit the use of these funds to establish or administer risk pools. Thus, the cost to develop and manage a HRIP would have to be supported with State funds. While the resulting NC ADAP prescription savings would offset a portion of the HRIP costs, additional State appropriations would be required.

B. DEVELOPING AN ADAP INFORMATION SYSTEM

To better determine whether clients are using the program appropriately, ADAP needs more timely information on program utilization. The Department is exploring the following strategy to improve its ADAP monitoring capacity:

- Contract with Pharmacy Network National Corporation (PNNC) to establish an **ADAP claims tracking system.** Virtually all North Carolina pharmacies are members of the PNNC network. An electronic system already installed in pharmacies could be used to simultaneously check ADAP eligibility and file a claim with PNNC each time an ADAP client presents a prescription to a pharmacist. The system would be similar to that used in authorizing credit card purchases. PNNC would then pay the claim and the State would reimburse PNNC within two weeks.

  At present, pharmacies have up to a year to file claims by mail with POC, making it difficult to accurately assess program utilization at any given time. The proposed system would provide the State with "real time" ADAP utilization data. At the same time, it would benefit pharmacies by expediting the submission and payment of claims.

  One additional benefit of the proposed system is that it would lay the groundwork for future efforts to optimize program utilization rates. With current utilization data, ADAP staff could accurately identify clients who don't fill any prescriptions over a certain period of time and then investigate why they aren't using the program. For example, a letter could be sent to both the non-utilizing client and their provider, informing them that unless the provider contacted POC with information about the client's status, the client would be dropped from the program at the end of the following month. This would help ensure that only those who really need and use the program are enrolled.

  Cost impact: Annual ADAP system costs would range from $20,000 to $28,000, depending upon the number of prescriptions filled. (PNNC will charge between $.50 and $.55 per prescription. The Department estimates that between 3,000 and 4,200 prescriptions will be filled each month in the next state fiscal year.) In addition to these annual costs, a one-time expenditure would be necessary to upgrade the Purchase of Care computers to accept files from PNNC. Procedures would also need to be built into the system to preserve client confidentiality. However, the system would substantially reduce the ADAP workload of Purchase of Care staff, thereby avoiding the addition of another staff person (annual cost: $25-28,000) that anticipated growth of ADAP would necessitate. Operating costs for the system could be absorbed by ADAP, or recovered by either reducing the pharmacy dispensing fee from $5.60 to $5.00 per prescription or by instituting a $1.00 per prescription co-payment. The pharmacy dispensing fee is the legislated Medicaid rate to cover

pharmacy processing costs. A co-pay would create an ADAP client contribution comparable to that of Medicaid clients. No additional appropriation would be required to set up or operate the ADAP claims tracking system.

C. PROMOTING PATIENT COMPLIANCE

Unless taken as prescribed, the effectiveness of antiretroviral medications in combating HIV will be compromised, and patients will not realize the benefits of these powerful therapies. Patient compliance is important from a public health perspective as well. The likelihood of developing drug-resistant virus is much higher in those who do not take these medications properly. Ideally, patient compliance would be closely monitored, but it is difficult - from both technical and ethical standpoints. The Department is exploring two strategies to facilitate patient compliance and one strategy to study the issue:

- **Patient education.** The Department is considering supporting the use of a new patient education curriculum in HIV consortia, AIDS service organizations, and HIV/AIDS clinics. The curriculum was designed by Glaxo Wellcome to empower persons with HIV to manage their disease effectively; a primary objective is increased adherence to medications regimens. Glaxo has agreed to test market the curriculum in two North Carolina cities in spring 1999. The Department will use these market tests to evaluate the curriculum's effectiveness.

- **Compliance support programs.** The Department will follow the progress of pilot programs in Massachusetts that use case managers, other health care providers, paid mentors, peer educators, and "treatment buddies" to support clients in taking medications appropriately. The Department will attempt to replicate cost-effective programs in North Carolina. Besides increasing adherence, such programs would provide clients another contact point with the public heath system for support in meeting the many other challenges that HIV disease poses.

- **Provider surveys on patient compliance.** Mindful of the importance of patient privacy and the confidentiality of the patient-provider relationship, the Department will survey health care providers regarding the adherence behavior of their patients and continue to encourage providers to take an active role in patient compliance with treatment.

Cost Impact: *Programs that improve patients' adherence to their medications regimens will increase the effectiveness of those medications and thus help patients stay healthier longer. This, in turn, should yield significant economic benefits by decreasing hospitalizations, Medicaid utilizations, and SSI /SSDI expenditures. Healthy people can also continue working and paying taxes.*

With figures supplied by Glaxo Wellcome, ADAP staff estimate that supporting the use of Glaxo's patient education curriculum across North Carolina would cost approximately $100,000 the first year. This includes a state-wide train-the-trainer workshop, as well as trainer and participant materials for courses for 15 HIV clients, to be held twice a year in each of the 14 consortia regions in North Carolina. (for a total of 420 clients/year). Future costs could drop if new trainers did not have to be trained each year. Existing Ryan White funds could be used for this purpose. No additional state or federal appropriation would be required.

The cost of implementing an adherence support program would depend on the specific program selected for replication. The cost of administering provider surveys on patient adherence would be minimal. Again, no additional appropriation would be required.

E. PLANNED DEPARTMENTAL ACTIONS

The Department has directed staff of the HIV/STD Prevention and Care Section to take the four actions listed below. **None would require additional State or federal appropriations.**

1. Work with the Division of Medical Assistance, the State Center for Health Statistics, the Kaiser Family Foundation and the Duke Center for Health Policy, Law, and Management to determine the feasibility of a Medicaid waiver. Such a waiver would provide medications and certain other Medicaid benefits to non-disabled persons with HIV disease. If demonstrated to be cost-effective, the Department will prepare and submit a waiver application.

2. Work with the Department of Insurance to establish a health insurance continuation program (HICP) for eligible persons with HIV disease. HICP would pay premiums on health insurance policies about to lapse due to the client's lack of financial resources.

3. Contract with Pharmacy Network National Corporation to establish an AIDS claims tracking system to improve managing and monitoring ADAP resources.

4. Continue investigating strategies to increase patient adherence to medications regimens and implement those identified as feasible and cost-effective.

F. RECOMMENDATIONS FOR LEGISLATIVE ACTION

The Department recommends two legislative actions to assist NC ADAP in managing rising program costs and to ensure that low income citizens with HIV disease receive the health care services they need:

1. The Department is currently studying the feasibility of a Medicaid waiver for non-disabled persons with HIV disease. If the waiver proves cost-effective, the Department requests that the General Assembly approve its incorporation into the North Carolina Medicaid Program. **It is not expected that this would require additional State appropriations.**

2. The Department recommends that the General Assembly reconsider creating a high risk insurance pool in North Carolina to provide an option for health insurance to persons with HIV disease and other health problems that generally render them uninsurable. **The creation and management of a high risk insurance pool would require additional State appropriations.**

Questions About the HIV Medications Program (ADAP)
March 1999

1. **How many people are currently living in N.C. with either HIV infection or AIDS?**
   There are **18,000** individuals estimated to be living in N.C. who are HIV positive or diagnosed with AIDS. However, only **11,554** individuals have been tested and their status reported to the state.

2. **How many people living with HIV and AIDS in N.C. have incomes at or below 125% of the Federal Poverty Level (FPL)?**
   Based on data from programs where client income information is collected, **80%** of patients served are at or below 125% of FPL. This translates to approximately **9245** individuals.

   This data also suggests there are approximately 15% or 1730 individuals between 125-200% of FPL and 5% or 580 with incomes greater than 200% FPL.

3. **How many of the currently eligible individuals are served by ADAP?**
   For the most recent year, Medicaid served 6400 of the estimated 9245 who are eligible leaving 2,845 individuals who were below 125%FPL and not eligible for Medicaid. The ADAP program expects to serve 1361 clients in 1998-99. Allowing for a small number of overlap clients who were eligible for Medicaid part of the year, the ADAP program serves **approximately 50% of the target population**.

4. **How many new cases of HIV infection and AIDS will be eligible for ADAP next year?**
   In calendar year 1998 there were 1085 new cases of HIV reported and 788 cases of AIDS. Only 437 AIDS cases were not previously reported as HIV cases. An estimated 10% of AIDS cases will either die or leave the program for a total of 1485 new cases. Using the 80% estimate of patients eligible for ADAP, there will be approximately 1200 potential ADAP clients in 1999-2000. ADAP has traditionally served 50% of the target population or **600 additional clients**.

ADAP UTILIZATION PROJECTIONS PRORATED BUDGET REQUIREMENTS - 1998-99

Serve all Eligible Individuals - Expect 60% Utilization - $900/month/client (prepared March 1999)

Requirements

Months	# Authorized	Rate of Utilization	Calculated # Served	# Months 98 - 99	Cost per Month ($)	Total ($)
July - June	1,015	60%	609	12	900	6,577,200
Nov - June	96	60%	58	8	900	417,600
Dec - June	196	60%	118	7	900	743,400
Jan - June	221	60%	133	6	900	718,200
Feb - June	188	60%	113	5	900	508,500
Mar - June	175	60%	105	4	900	378,000
Apr - June	150	60%	90	3	900	243,000
May - June	125	60%	75	2	900	135,000
June	100	60%	60	1	900	54,000
Total Requirements	**2,266**		**1361**			**$ 9,774,900**

Revenues

Ryan White ADAP	3,887,697
State Appropriations	8,771,037
Rebates	500,000
Total Revenues	**$ 13,158,734**

ADAP UTILIZATION PROJECTIONS PRORATED BUDGET REQUIREMENTS - 1999-2000

Serve all Eligible Individuals - Expect 60% Utilization - $900/month/client
(prepared March 1999)

Requirements

Months	# Authorized	Rate of Utilization	Calculated # Served	# Months 99-00	Cost per Month ($)	Total ($)
July - June	2,316	60%	1390	12	900	15,012,000
Aug - June	50	60%	30	11	900	297,000
Sept - June	50	60%	30	10	900	270,000
Oct - June	50	60%	30	9	900	243,000
Nov - June	50	60%	30	8	900	216,000
Dec - June	50	60%	30	7	900	189,000
Jan - June	50	60%	30	6	900	162,000
Feb - June	50	60%	30	5	900	135,000
March - June	50	60%	30	4	900	108,000
April - June	50	60%	30	3	900	81,000
May - June	50	60%	30	2	900	54,000
June	50	60%	30	1	900	27,000
Total Requirements	**2,866**		**1720**			**$ 16,794,000**

Revenues

Ryan White ADAP	6,371,503
State Appropriations	8,771,037
Rebates (11.4%)	1,726,250
Total Revenues	**$ 16,868,790**

ADAP UTILIZATION PROJECTIONS PRORATED BUDGET REQUIREMENTS 2000 - 2001

Serve all Eligible Individuals - Expect 60% Utilization - $900/month/client (prepared March 1999)

Requirements

Months	# Authorized	Rate of Utilization	Calculated # Served	# Months 00-01	Cost per Month ($)	Total ($)
July - June	2,866	60%	1720	12	900	18,571,680
Aug - June		60%	0	11	900	0
Sept - June		60%	0	10	900	0
Oct - June		60%	0	9	900	0
Nov - June		60%	0	8	900	0
Dec - June		60%	0	7	900	0
Jan - June		60%	0	6	900	0
Feb - June		60%	0	5	900	0
March - June		60%	0	4	900	0
April - June		60%	0	3	900	0
May - June		60%	0	2	900	0
June		60%	0	1	900	0
Total Requirements	**2,866**		**1720**			**$ 18,571,680**

Revenues

Ryan White ADAP	6,371,503
State Appropriations	8,771,037
Rebates (11.4%)	1,726,250
Total Revenues	**$ 16,868,790**

AIDS Drug Assistance Program (ADAP)
Mar-99

			SFY 98-99	SFY 99-00	SFY 00-01
Total Projected Requirements			**$9,774,900**	**$16,794,000**	**$18,571,680**
Federal Grant Award					
Grant Budget Year (4/1/98-3/31/99)	1998	4,498,516	3,887,697		
	1999	6,371,503		6,371,503	
	2000	6,371,503			6,371,503
Total Federal Award			3,887,697	6,371,503	6,371,503
Total Other (rebates)			500,000	1,726,250	1,726,250
Total State Appropriation			8,771,037	8,771,037	8,771,037
Total Revenue (all sources)			**$13,158,734**	**$16,868,790**	**$16,868,790**
Estimated Surplus (Deficit)			**$3,383,834**	**$74,790**	**($1,702,890)***

***Will be controlled/avoided through patient enrollment and cost containment measures.**

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 3-31, 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	OSBM
	DHHS
	DHHS
	DHHS / DPH
	DHHS
	DHHS - DPH
	DHHS - DPH
	DHHS-DPH
	DHHS BPA
	DHHS - DPH
	HIV/STD Prevention Care
	DHHS-Epi
	GlaxoWellcome
	NCHA
	NC Council of Community Programs
	AHEC
	UNC School of Public Health
	DHHS, OMH
	DHHS/WCH
	DHHS/CH
	DWCH/DHHS
	Triangle Assn Health Underwriters
	DWCH/DHHS
	NCIMC
	NY State Parks Commission
	NCFPC
	NCFPC

AGENDA

Joint Subcommittee on Health and Human Services Appropriations

Legislative Office Building - Room 424
Thursday, April 1, 1999
8:30 a.m.

Opening Remarks	Sen. Bill Martin, Co-Chair Rep. Beverly Earle, Co-Chair Rep. Edd Nye, Co-Chair
Division of Public Health	Ramona L. Burton Fiscal Research Division
Immunization Program Report	Beth Rowe-West, R.N., B.S.N. Acting Branch Head, Immunization Branch, DHHS
Adjourn	

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

MINUTES
APRIL 1, 1999
8:30

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Thursday, April 1, 1999, at 8:30 a.m. in Room 424 of the Legislative Office Building.

House Co-Chair, Representative Beverly Earle presided. Other House members present were:

Representative Edd Nye, Co-Chair
Representative Martha Alexander, Vice Chair
Representative Alma Adams
Representative Lanier Cansler
Representative Theresa Esposito
Representative Trudi Walend
Representative Gene Wilson

All six Senate members were present.

The meeting was called to order by Co-Chair, Representative Beverly Earle at 8:40 a.m. Pages were introduced and the meeting began with a continuation from Ramona Burton, of Fiscal Research, from the March 31st meeting. Ramona Burton's presentation dealt with public health issues. She began with the immunization branch. (See Attachment II) The Immunization Branch is responsible for trying to prevent and eliminate vaccine preventable diseases. They also are responsible for managing and controlling vaccine preventable diseases, and disease out-breaks. She explained why North Carolina is called a Universal Immunization State. North Carolina is called a Universal State because the state, along with the Federal Government, pay for all vaccines that is given to children in the state of North Carolina. North Carolina became a Universal State for two reasons; first, to remove costs as a barrier to immunizations, and secondly, to keep children in their medical homes.

Following the agenda, Beth Rowe-West, R.N., B.S.N., Acting Branch Head, and Immunization Branch, continued with the presentation on the Immunization Branch. She also discussed the Infant Mortality Programs, and highlighted facts about infant mortality in North Carolina. (See Attachment II)

The Committee contributed to the presentation with questions and concerns about the immunization programs and infant mortality in North Carolina. Their questions were answered by Ms Rowe-West and Ramona Burton.

Nearing time for adjournment Beth Rowe-West reached a point to conclude.

The meeting adjourned at 9:50 a.m.

Respectfully submitted,

Beverly Earle

Presiding Co-Chair, Representative Beverly Earle

Ann Raeford, Committee Clerk

Attachment I	Agenda
Attachment II	Division of Public Health Budget Program Overview
Attachment III	Visitor Registration

Attachment III

DEPARTMENT OF HEALTH & HUMAN SERVICES

MEDICAID PROGRAM OVERVIEW

FISCAL RESEARCH DIVISION
April 1999

MEDICAID PROGRAM

THREE PROGRAMS IN ONE

- HEALTH INSURANCE
- LONG TERM CARE FOR THE ELDERLY
- SERVICES FOR PEOPLE WITH DISABILITIES

MEDICAID

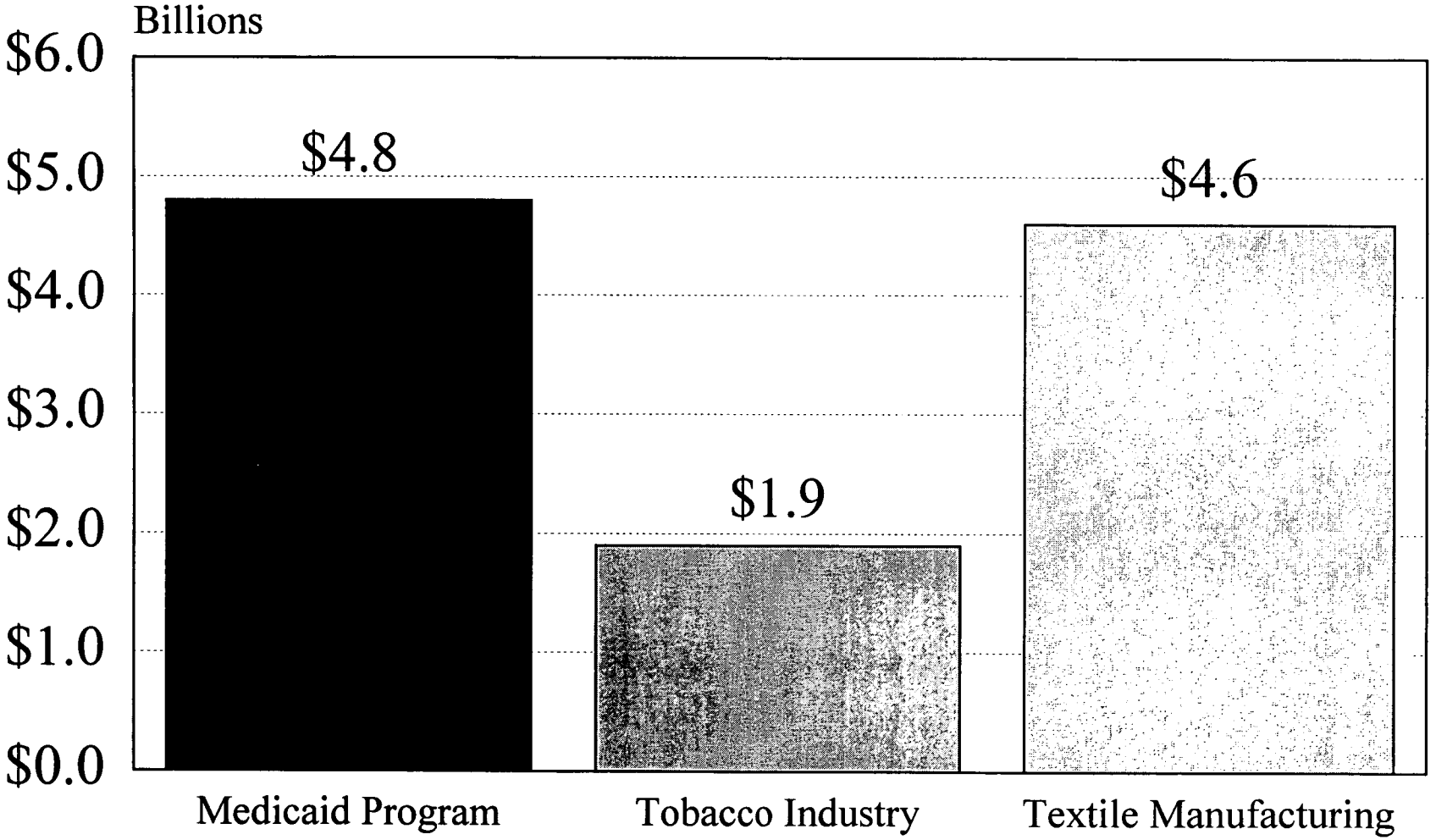
MEDICAID VS. MEDICARE

Medicaid is health care for certain groups of poor persons, including single parent families, persons over age 65 and the disabled. Coverage is based on a person falling into one of the target groups and passing income and resources tests. Medicaid is administered by states and counties and financed with federal, state and county funds.

Medicare is health care for persons over age 65 and for the disabled who receive Social Security payments. Medicare is administered by the Health Care Financing Administration and financed by employer/employee contributions to the Social Security Trust Fund.

MEDICAID PROGRAM

ROLE IN STATE ECONOMY



NOTE: Tobacco Industry includes the value of the 1998 crop and the estimated 1998 salaries and wages for tobacco manufacturing. Textile Manufacturing includes the estimated salaries and wages for the industry for 1998.

FISCAL RESEARCH DIVISION 2/99

MEDICAID PROGRAM

OTHER COMPARISONS

- The FY 1997-98 Medicaid Program expenditures are equal to the estimated total income of the citizens of Durham County for 1996.

- Assuming an average private sector salary of $26,884 for 1998, the FY 1997-98 Medicaid expenditures would pay the salary of 179,725 employees in the private sector.

MEDICAID PROGRAM

N. C. MEDICAID SNAPSHOTS

- Covered 1.1 Million state residents in SFY 1997-98 -- 16% of N.C.'s population
- Covered over 674,000 children during 1998 - 56% of Medicaid eligibles
- Covers 45% of the babies born each year
- 31 % of recipients consume 72 % of resources -- includes aged, blind, and disabled
- Inpatient care consumes 47 % of expenditures for services -- includes hospitals, nursing homes, and mental retardation centers
- 76 % of the state's nursing home beds serve Medicaid patients
- 14 % of N. C. hospital charges are paid by Medicaid -- 49% are paid by Medicare

MEDICAID PROGRAM

IMPACT ON STATE AGENCIES

- About 12% of the Medicaid budget is paid to State and Local agencies to provide medical services to Medicaid recipients

- The following State and Local agencies receive reimbursement from Medicaid: Mental Retardation Centers, State Psychiatric Hospitals, Special Care Center, N.C. Memorial, Area Mental Health Agencies, Public Health Departments, Social Services Departments, County Owned Home Health Agencies, and Some School Clinics

MEDICAID PROGRAM
HISTORY OF TOTAL EXPENDITURES

STATE FISCAL YEAR	TOTAL EXPENDITURES
1978-79	$379,769,848
1982-83	$570,309,294
1987-88	$983,464,113
1992-93	$2,836,335,468
1997-98	$4,831,721,654

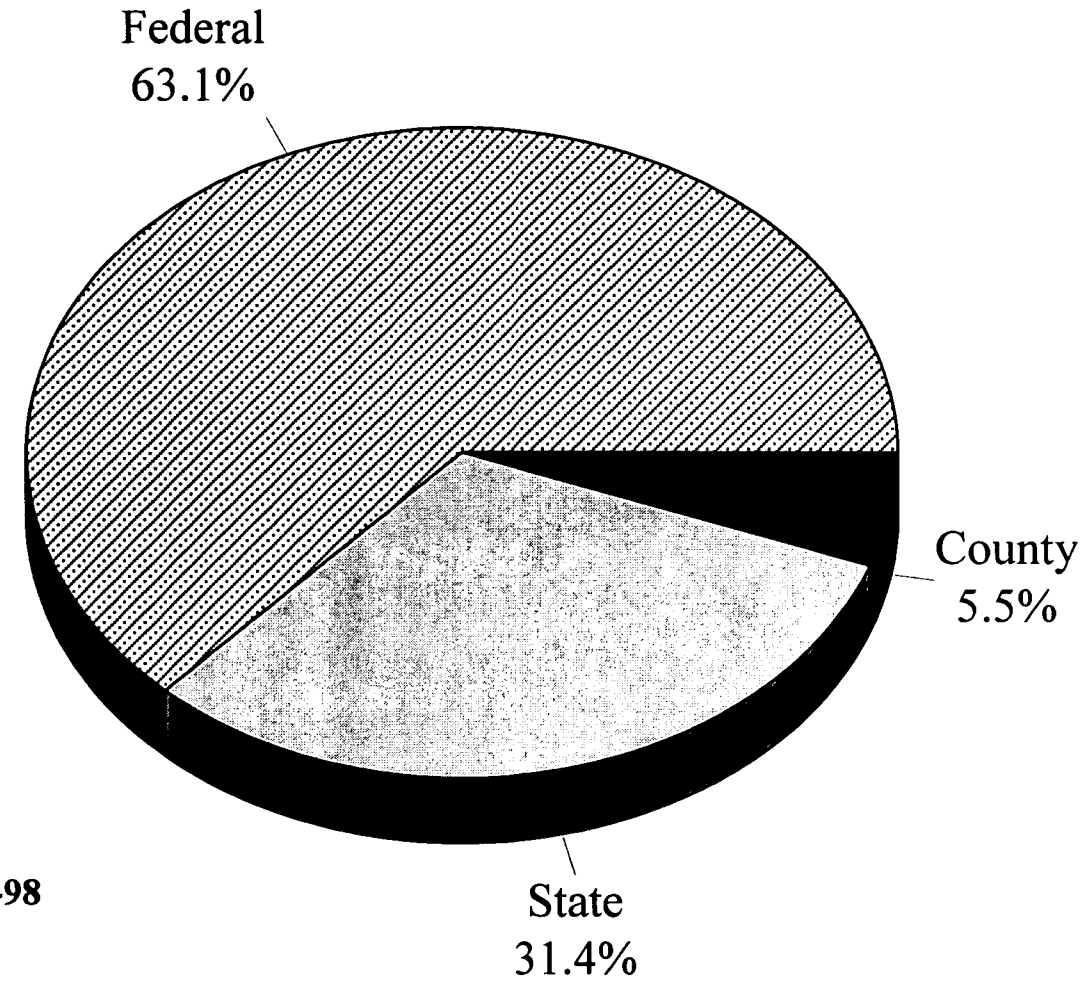
MEDICAID PROGRAM

EXPENDITURES 1997-98

SOURCES OF FUNDS	SFY 1997-98
FEDERAL	$3,048,333,192
STATE APPROPRIATIONS	$1,119,111,669
OTHER STATE FUNDS	$396,599,413
COUNTY	$267,677,380
TOTAL	**$4,831,721,654**

MEDICAID PROGRAM

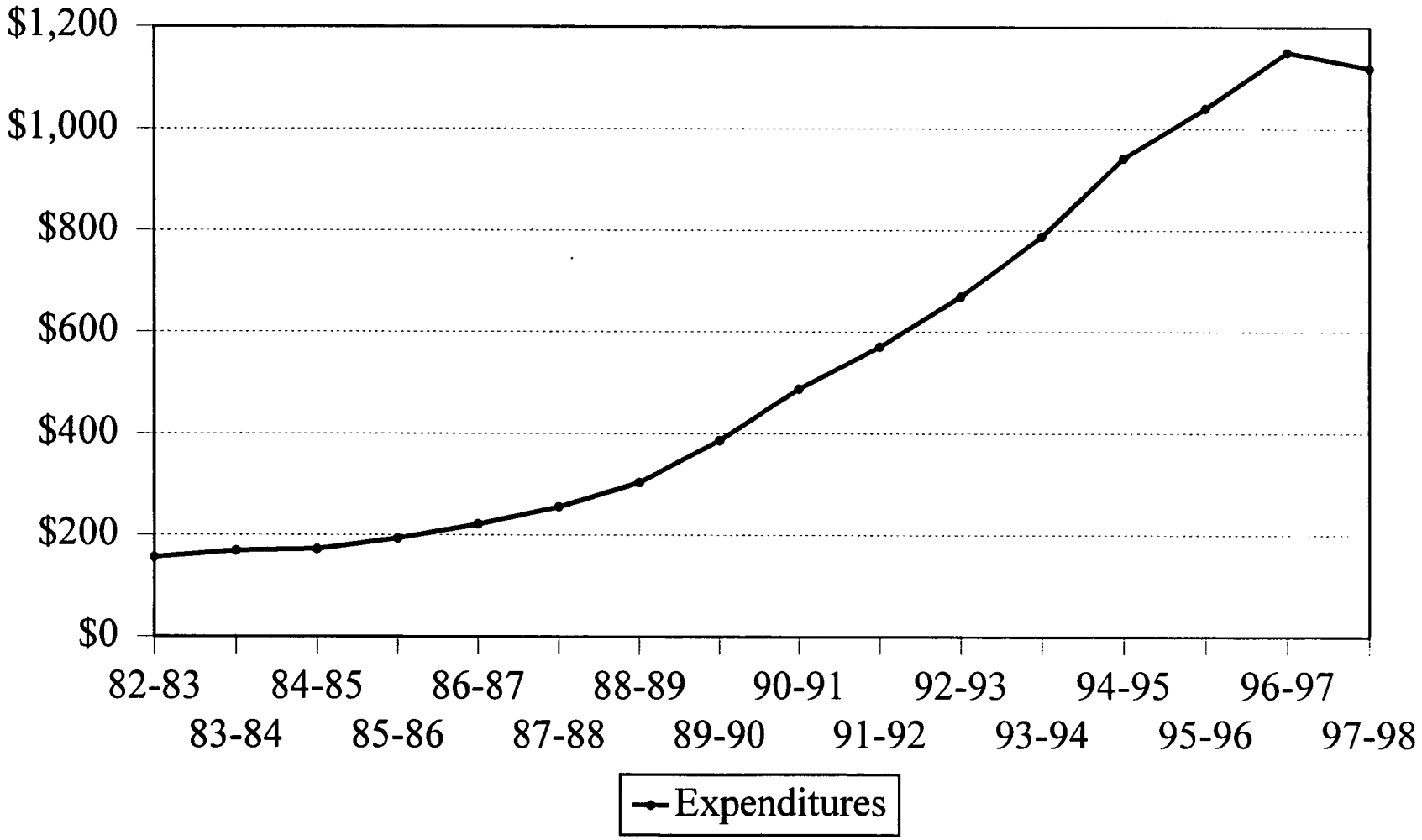
SOURCE OF FUNDS



State Fiscal Year 1997-98

MEDICAID PROGRAM

HISTORY OF GENERAL FUND EXPENDITURES



MEDICAID PROGRAM

BUDGET RULES OF THUMB

- 10 YEARS AGO, MEDICAID WAS 4% OF THE GENERAL FUND OPERATING BUDGET; TODAY IT IS 11%

- A 1% INCREASE IN THE MEDICAID BUDGET EQUALS A $15 MILLION INCREASE IN GENERAL FUND REQUIREMENTS

MEDICAID PROGRAM

FACTORS AFFECTING GROWTH

- UTILIZATION
- INTENSITY
- INFLATION
- FEDERAL PARTICIPATION RATE

MEDICAID PROGRAM

METHODS FOR REDUCING COSTS

- ELIGIBLES
- PROVIDERS
- SERVICES

MEDICAID PROGRAM

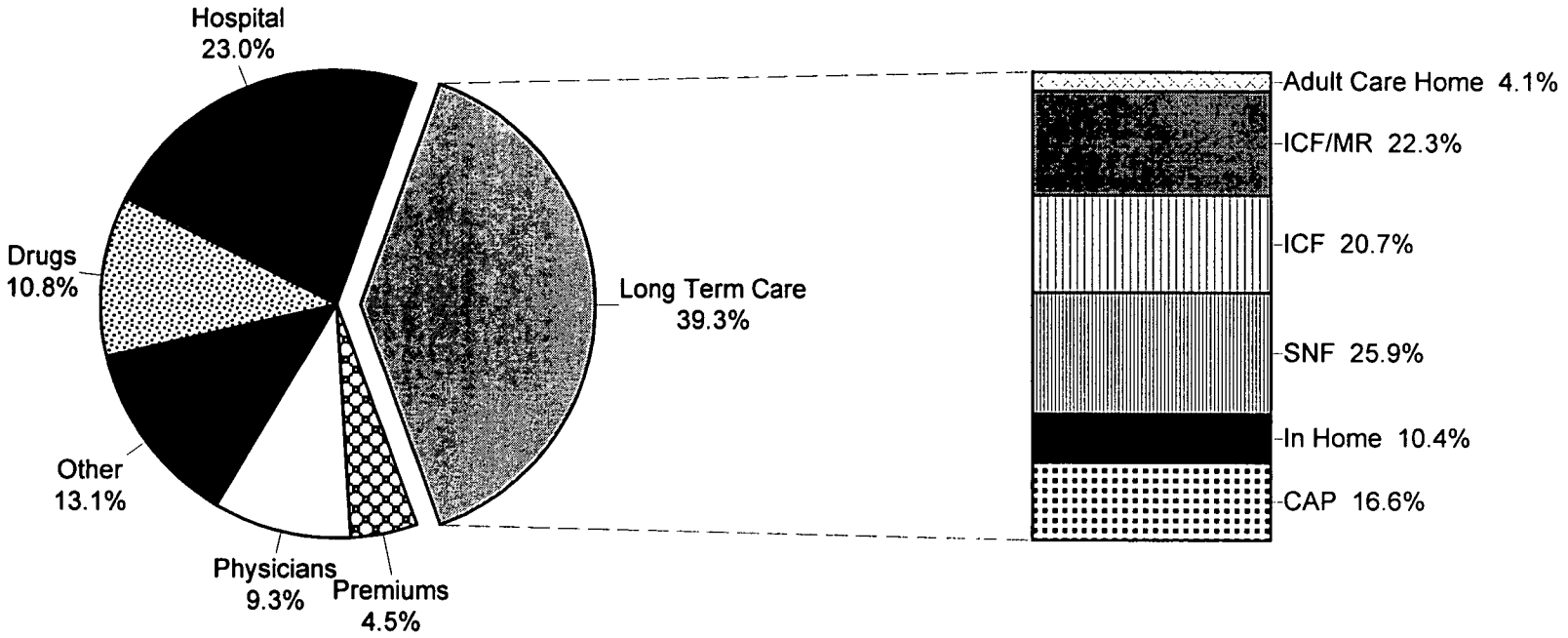
EXPENDITURES FOR SERVICES

- Total expenditures for services and premiums was $4.2 Billion for SFY 1997-98.

- 95.5 % of expenditures for services paid for direct medical services while the remaining 4.5 % paid for Medicare and HMO premiums.

MEDICAID PROGRAM

EXPENDITURES BY SERVICES



State Fiscal Year 1997-98

MEDICAID PROGRAM

MANDATORY SERVICES

- Durable Medical Equipment
- Health Check Services (ESPDT)
- Family Planning Services
- Hearing Aids (children)
- Home Health Services
- Inpatient Hospital Services
- Outpatient Hospital Services
- Laboratory & X-Ray Services
- Nurse Midwives
- Nurse Practitioners
- Nursing Facilities (NF)
- Physicians
- Prosthetics & Orthotics (children)
- Specialty Hospitals
- Transportation

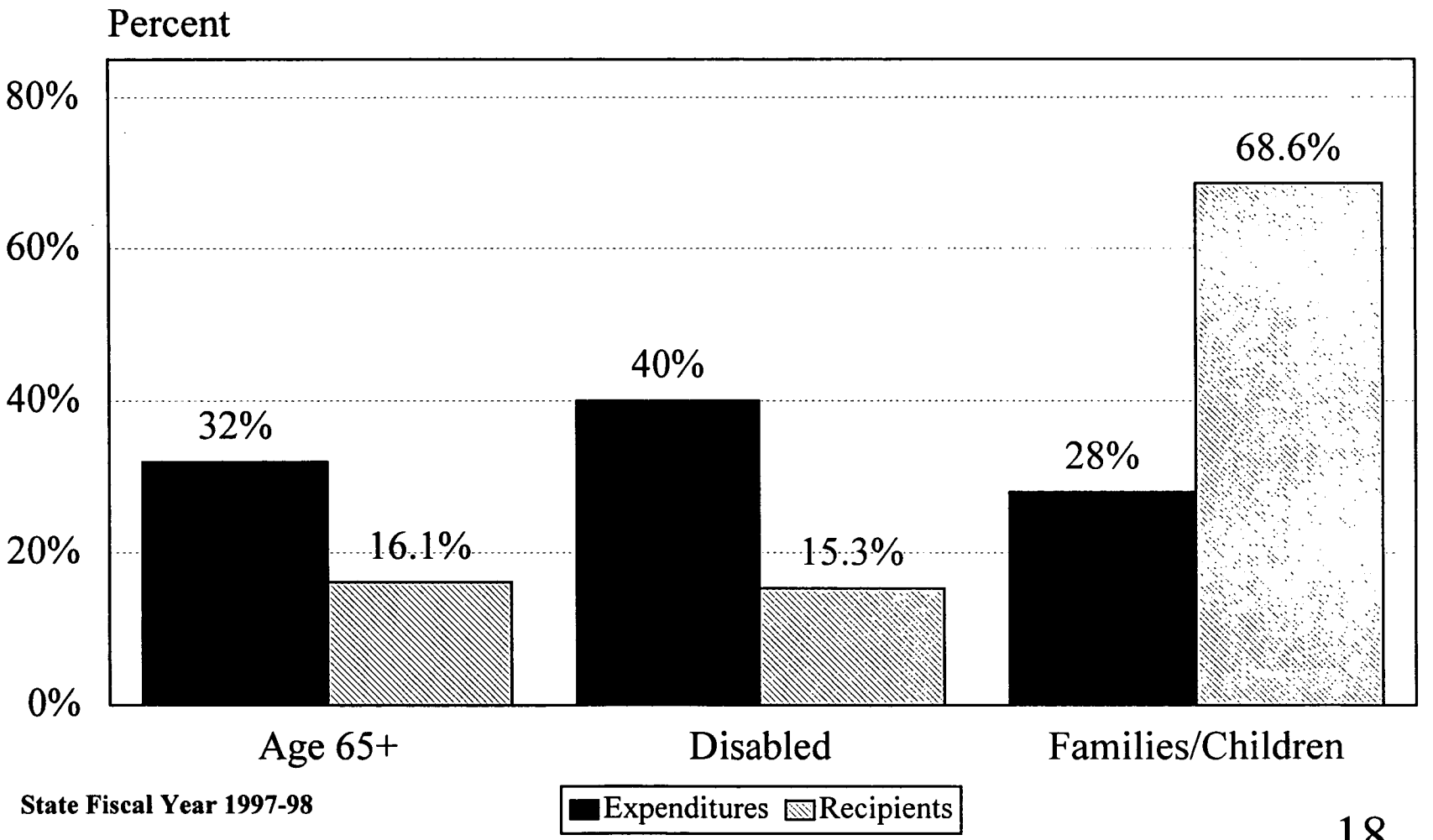
MEDICAID PROGRAM

OPTIONAL SERVICES

- Ambulance Transportation
- Case Management for:
  - Pregnant Women
  - High Risk Children (0-5)
  - Chronically mentally ill adults
  - Emotionally disturbed children
  - Chronic substance abusers
  - At-Risk adults & Children
  - Persons with HIV disease
- Chiropractors
- Clinic Services
- Community Alternatives Program (CAP)
- Dental Care Services
- Home Infusion Therapy Services
- Hospice
- Intermediate Care Facilities for the Mentally Retarded (ICF-MR)
- Mental Hospitals (age 65 & over)
- Migrant Health Clinics
- Optical Supplies
- Optometrists
- Personal Care Services
- Podiatrists
- Prepaid Health Plan Services
- Prescription Drugs
- Private Duty Nursing Services
- Rehab. Services (mental health)
- Rural Health Clinics

MEDICAID PROGRAM

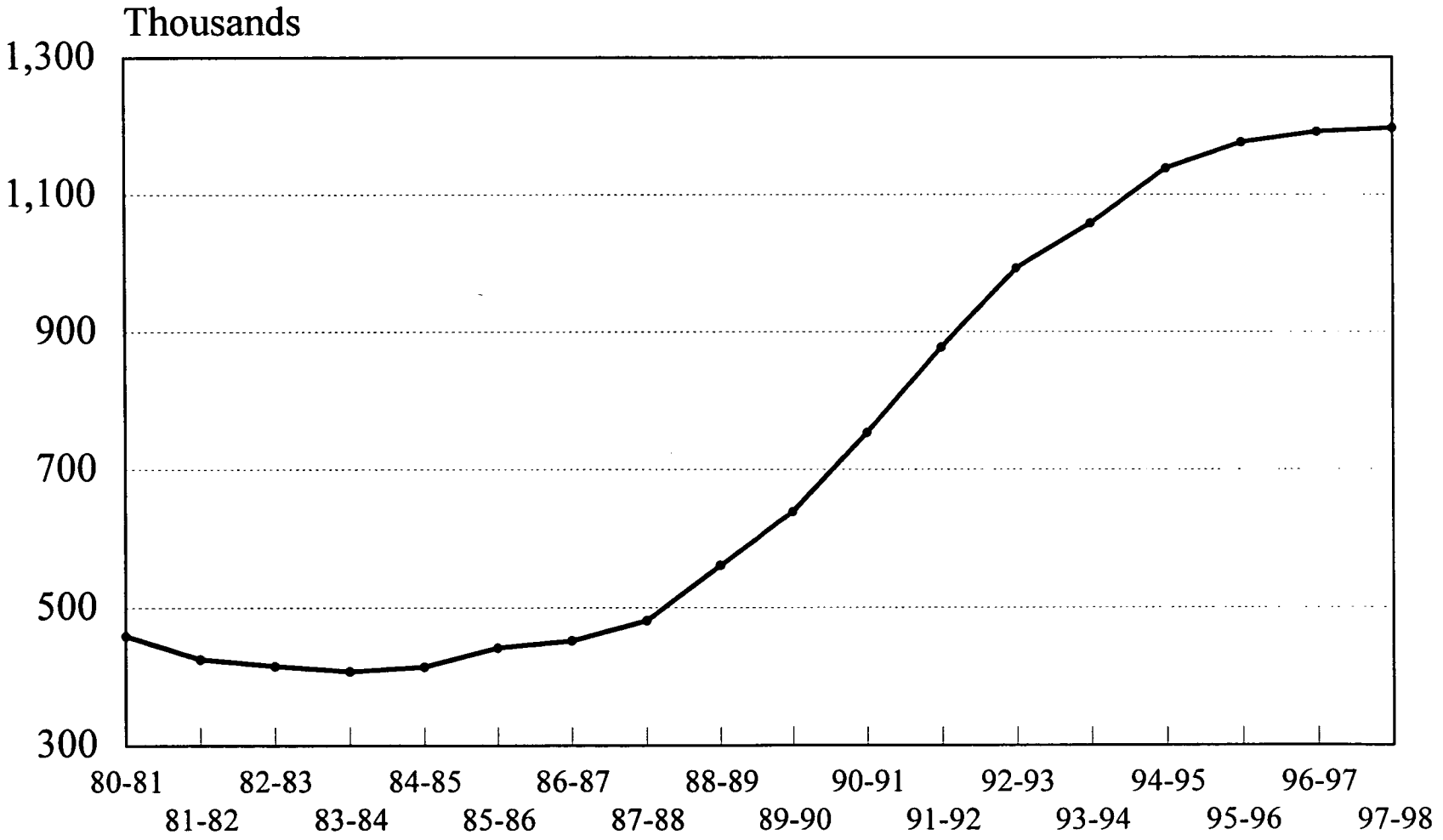
RECIPIENTS AND EXPENDITURES



State Fiscal Year 1997-98

MEDICAID PROGRAM

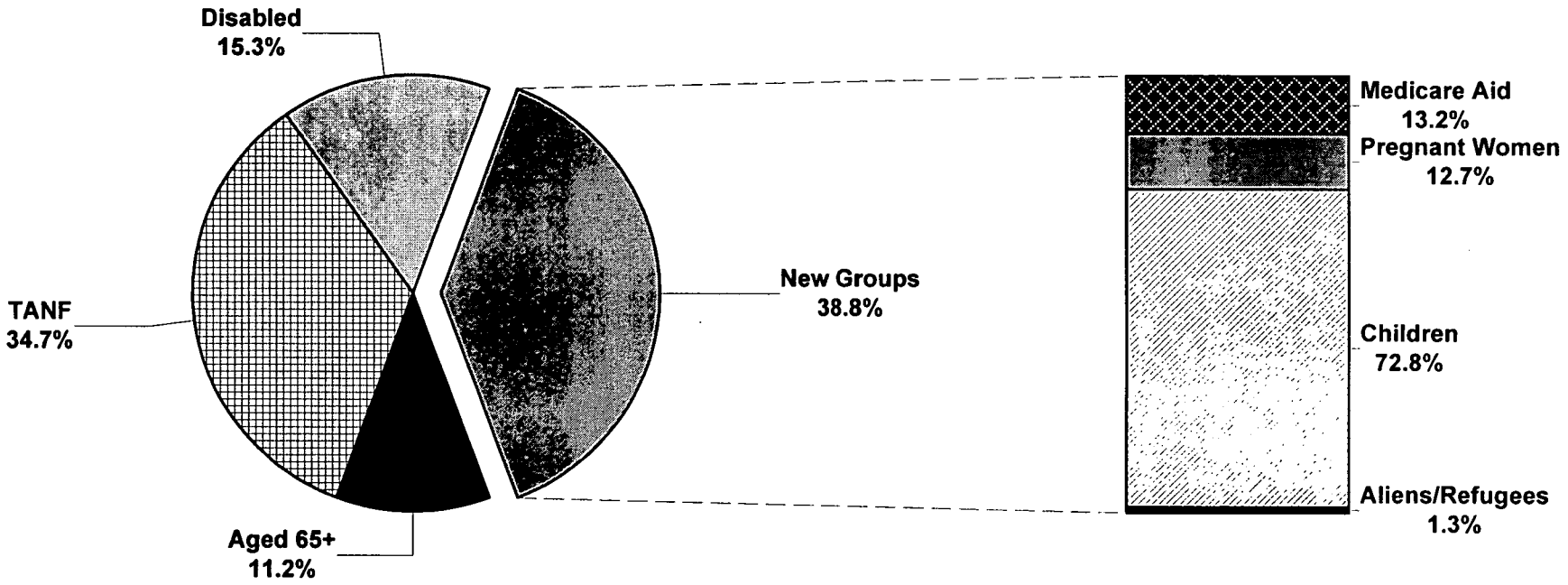
HISTORY OF ANNUAL ELIGIBLES



FISCAL RESEARCH DIVISION 2/99

MEDICAID PROGRAMS

NEW GROUPS SINCE 1987

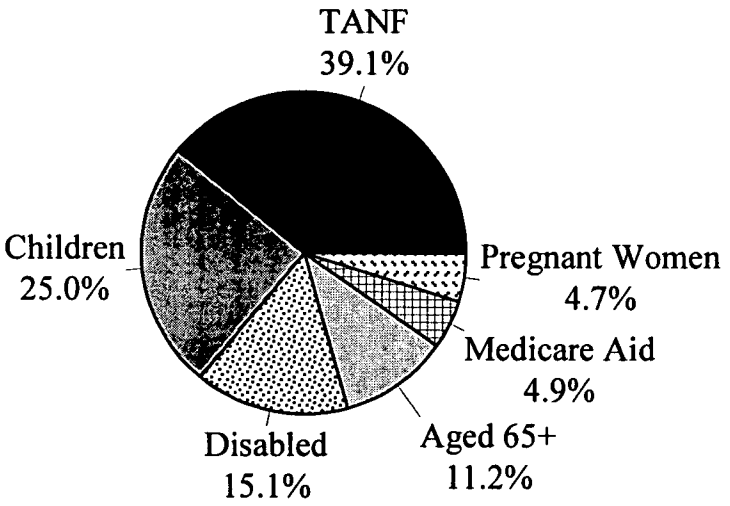


State Fiscal Year 1997-98

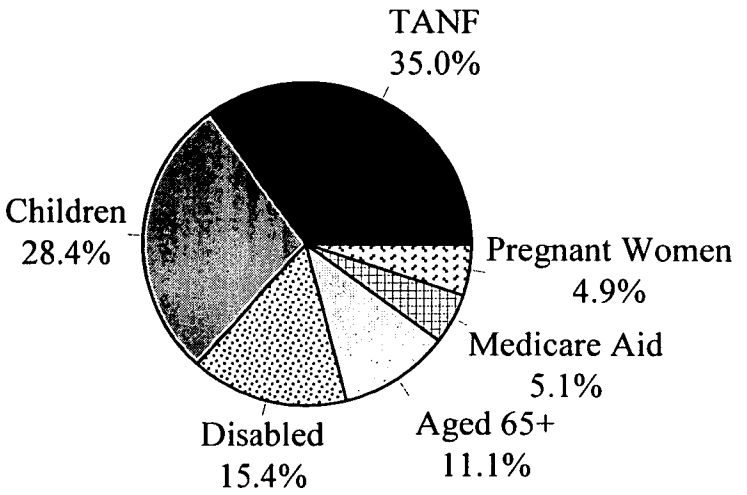
MEDICAID PROGRAM

MEDICAID ELIGIBLES

SFY 1997



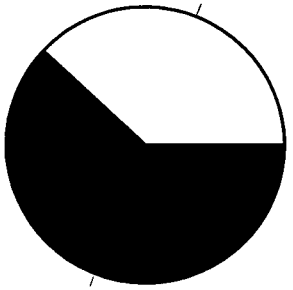
SFY 1998



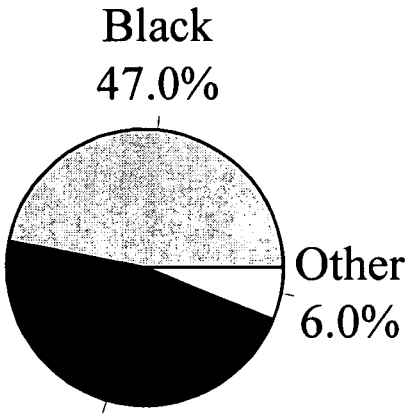
MEDICAID PROGRAM

RECIPIENT INFORMATION

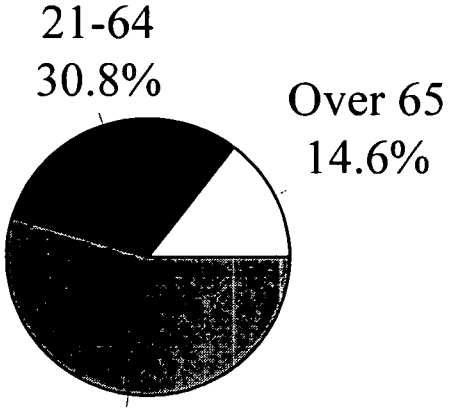
BY GENDER



BY RACE



BY AGE



State Fiscal Year 1997-98

MEDICAID PROGRAM
MANDATORY ELIGIBLES

- TANF Recipients (Based on State Plan as of July 16, 1996)
- Aged, Blind, and Disabled SSI Recipients
- Infants born to Medicaid eligible women (to 133% of FPL)
- Children under age 6 (to 133% of FPL)
- Pregnant Women (to 133% of FPL)
- All Children born after 9/30/83 (to 100% of FPL)
- Recipients of Adoption Assistance and Foster Care
- Certain Medicare Recipients
  - Dual Eligibles
  - Qualified Medicare Beneficiaries
  - Specified Low-Income Medicare beneficiaries
  - Qualified Disabled and Working Individuals

Note: FPL is the Federal Poverty Level

MEDICAID PROGRAM

OPTIONAL ELIGIBLES

- Infants born to Medicaid eligible women (134% to 185% of FPL)
- Pregnant Women (134% to 185% of FPL)
- Children age 19, 20, and 21 meeting AFDC income standards
- Recipients of State/County Special Assistance
- Recipients of State Assistance to the Blind
- Persons receiving care under home and community-based waivers
- Aged, Blind, and Disabled persons presumed eligible for but not receiving SSI
- Aged, Blind, and Disabled persons with non-SSI income (to 100% of the FPL)
- Medically Needy persons
- Refugees/Aliens

Note: FPL is the Federal Poverty Level

MEDICAID PROGRAM

Managed Care Initiatives

- **CAROLINA ACCESS** coordinates care by linking eligible recipients with a primary care provider who has agreed to act as a gatekeeper and to provide or arrange for health care services (99 counties).

- **HEALTH CARE CONNECTIONS** is a pre-paid capitated risk contract with a group of Health Maintenance Organizations (HMOs) to provide a comprehensive range of medical and other services to Medicaid recipients residing in Mecklenburg County.

- **ACCESS II and ACCESS III** are new managed community care demonstration projects which are designed to build on the Carolina ACCESS program by assisting local providers to develop enhanced managed care delivery systems that coordinate a continuum of care with processes to influence cost and quality of care (25 counties).

MEDICAID PROGRAM

PROGRAM CHANGES DURING THE 1990s

- **Eligibility Expansions**
  - Increase pregnant women and infant coverage to 150% of FPL - Effective 1/1/90
  - Increase pregnant women and infant coverage to 185% of FPL - Effective 10/1/90
  - Increase children ages 1 to 6 coverage to 133% of FPL - Effective 10/1/90
  - Increase children ages 11 to 19 coverage to 100% of FPL - Effective 7/1/94
  - Add adoptive children with special rehabilitative needs - Effective 10/1/94
  - Automatic coverage of SSI eligible aged, blind and disabled persons - Effective 1/1/95
  - Add non-SSI eligible aged, blind, and disabled persons to 100% of FPL- Effective 1/1/99
- **Managed Care Initiatives**
  - Carolina ACCESS program was implemented - Effective 4/1/91
  - Carolina Alternatives program was implemented - Effective 1/1/94
  - Health Care Connections program was implemented -Effective 6/1/96
  - ACCESS II and ACCESS III demonstration was implemented - Effective 7/1/98
- **Federal Revenue Maximization Efforts**
- **Growth Reduction Efforts**

Note: FPL is the Federal Poverty Level

MEDICAID PROGRAM

1999 ISSUES

- Source of potential budget reductions
- Continuation of growth reduction efforts
- Continuation of federal revenue maximization efforts
- Federal proposals to reduce federal participation in administrative cost sharing
- Federal proposals to recoup the federal share of the tobacco settlement relating to Medicaid expenditures for tobacco related illnesses

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-8, **1999**

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jerry Cooper	N.C. Assisted Living Association
Nels Roseland	OSBM
Mark Benton	DHHS
Allen Gambill	Dio of Medical Asst.
Paul Perrussi	" " "
Thee McCeff	MPCV of Dimes
[illegible]	NC Food Banks
HUGH TILSON	NCHA
Janet Simoneau	NC Council
Stacy Flannery	NC HCFA
Mary Green	OSBM
ANNA TEFFT	OSBM
Wayne Williams	OSBM
[illegible]	OSBM
Barbara Matulis	NCMS Foundation
Roslyn Savitt	NC Child Care Coalition
Megan Primavera	NC ACDSS
Lou Wilson	NC ALTCF.
Amy Jo Bain	NCMS
Steve Kleve	NCMS
[illegible]	AHHC
[illegible] Summer	NC Equity
Sonia Schmidt	NC Justice Center
by Arrent-Farmer	NC DCD
Tommy Worth	Carolina Health Care System
Katherine Miller	Harry Kaplan
Chris Souza	NCHCFA
Roger Bone	Bone & Assoc.

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-8 **, 1999**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	[illegible]
Paula A. Wolf	Covenant W/NC's Children
Karen [illegible]	North Carolina Head Start Coalition
Peggy McNamara	[illegible]

April 1, 1999

DIVISION OF PUBLIC HEALTH

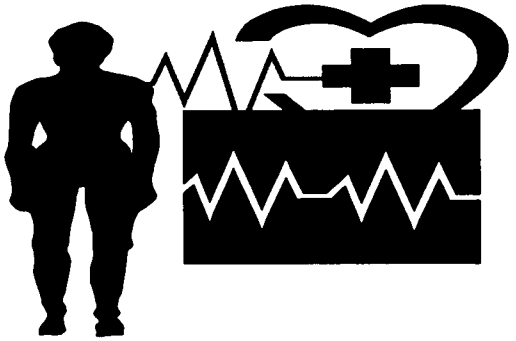
BUDGET /PROGRAM OVERVIEW

Presented by: Ramona L. Burton
Fiscal Research Division
March 30, 1999

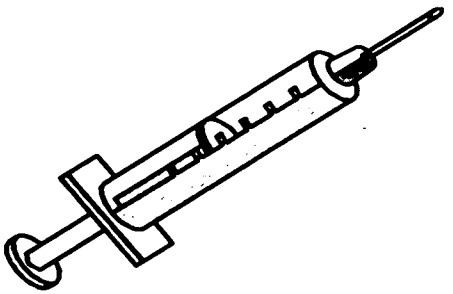
DIVISION OF PUBLIC HEALTH

Outline

- **Division of Public Health Overview**
- **HIV/STD Prevention & CARE Branch**
- **Other Issues: Immunization Branch**
  Infant Mortality Programs
  Hispanic/Latino Public Health Issues

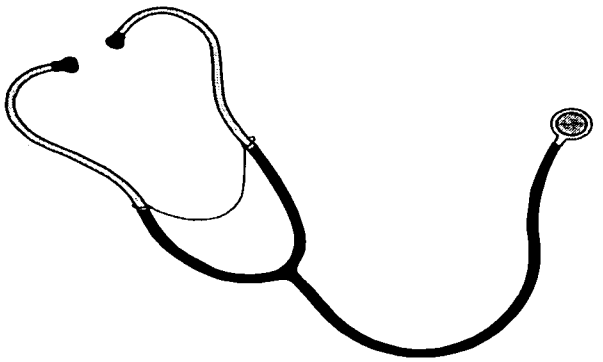


DIVISION OF PUBLIC HEALTH



Mission Statement:

- Improve the health of communities and individuals in North Carolina
- Develop and promote programs and services that enhance the health, growth, and development of infants, children, youth, and women of childbearing age
- Reduce the impact of communicable and environmental diseases in North Carolina



DIVISION OF PUBLIC HEALTH

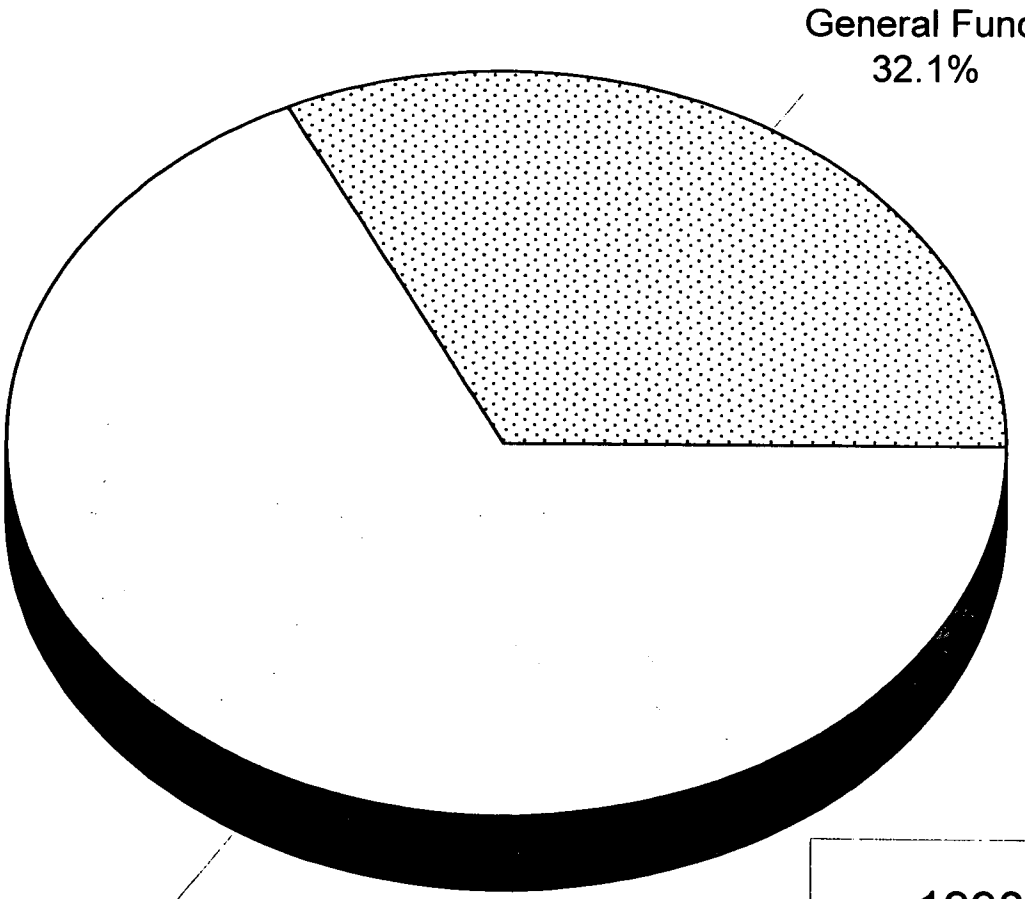
Budget Summary:

	1997-98 Actual	1998-99 Certified	1998-99 Authorized	1999-2000 Rec'd	2000-2001 Rec'd
Requirements	$417,293,370	$401,692,400	$401,692,400	$403,510,313	$405,153,189
Receipts	$303,480,999	$272,900,217	$272,900,217	$272,849,110	$272,849,110
Net Appropriation	$113,812,371	$128,792,183	$128,792,183	$130,661,203	$132,304,079
Total Positions	1329.92	1337.66	1338.66	1338.66	1338.66

Reference Document: 1999-2001 North Carolina State Budget, Health and Human Services, Volume 3 (Pages 45-61)

DIVISION OF PUBLIC HEALTH

Sources Of Funds



1998-1999
TOTAL BUDGET
$401.7 Million

DIVISION OF PUBLIC HEALTH

Legislative Highlights

1997 Session	Recurring	Nonrecurring
Public Health Divisions Transferred from DEHNR to DHHS		
Heart Disease & Stroke Prevention Awareness	$170,500	$29,500
Heart Disease Data Funds		$100,000
Healthy Start Foundation		$650,000
Maternal Outreach Worker Program	$825,000	
Children's Vision Screening Program		$419,000
Non-Medicaid Maternity Care Coordination	$170,900	

1998 Session	Recurring	Nonrecurring
Fullerton Genetics Center		$280,000
Maternal Outreach Programs		$200,000
Sickle Cell Services	$1,200,000	
Heart Disease/Stroke Prevention Programs		$300,000
Diabetes Program		$150,000
Children's Vision Screening		$319,000
Healthy Start Foundation		$650,000
AIDS Drug Assistance Program		$8,000,000

DIVISION OF PUBLIC HEALTH

Public Health Reorganizations

DEPT. OF HUMAN RESOURCES
Public Health

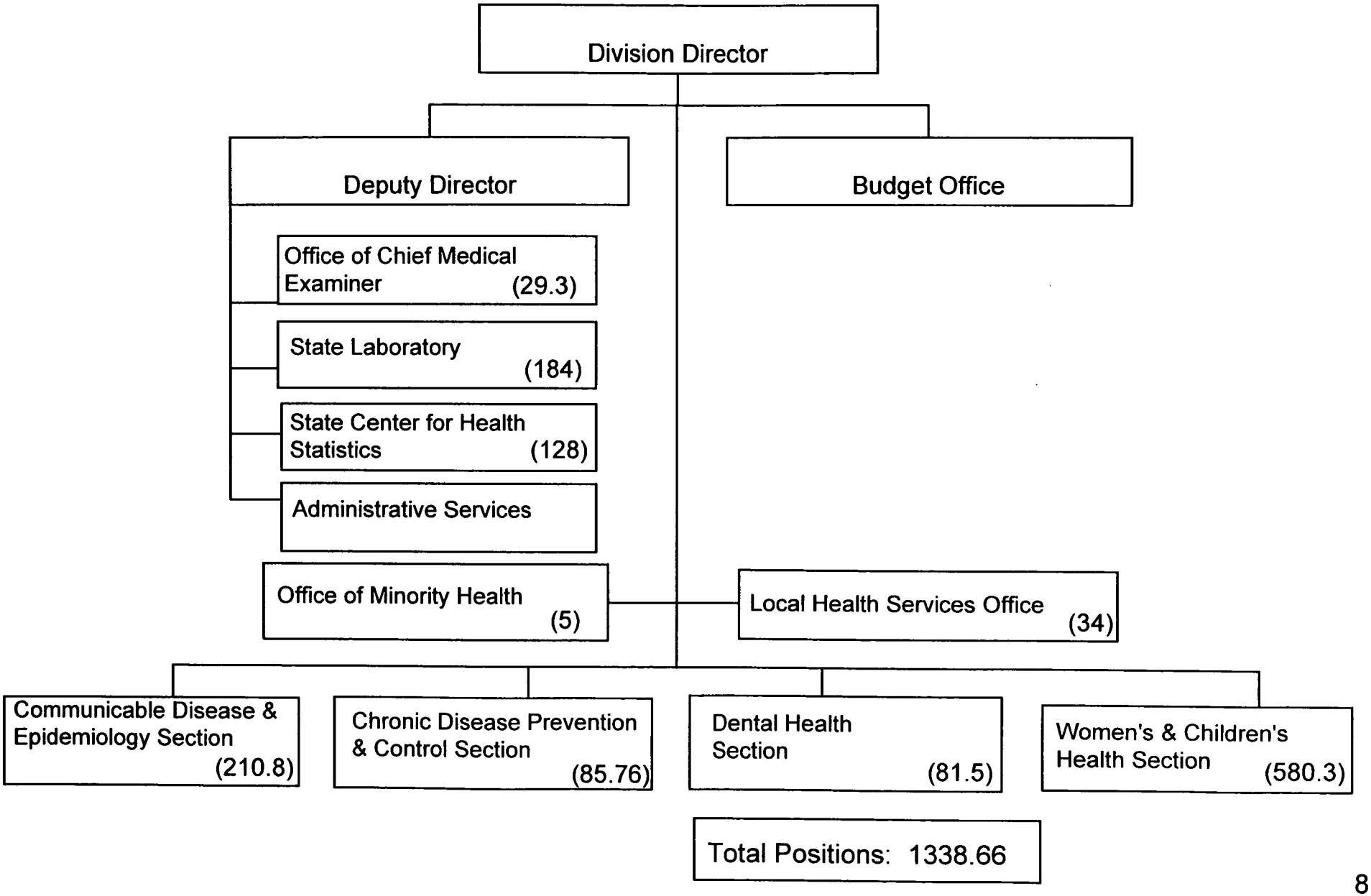
1989
DEPT. OF ENVIRONMENT, HEALTH & NATURAL RESOURCES
Health Promotion
Dental Health
Epidemiology
Maternal-Child Health
Center for Health Statistics
Laboratory Services
Post Mortem Medicolegal Examination
Environmental Health

Environmental Health

1997
DEPT. OF HEALTH & HUMAN SERVICES
Community Health
Epidemiology
Women's & Children's Health

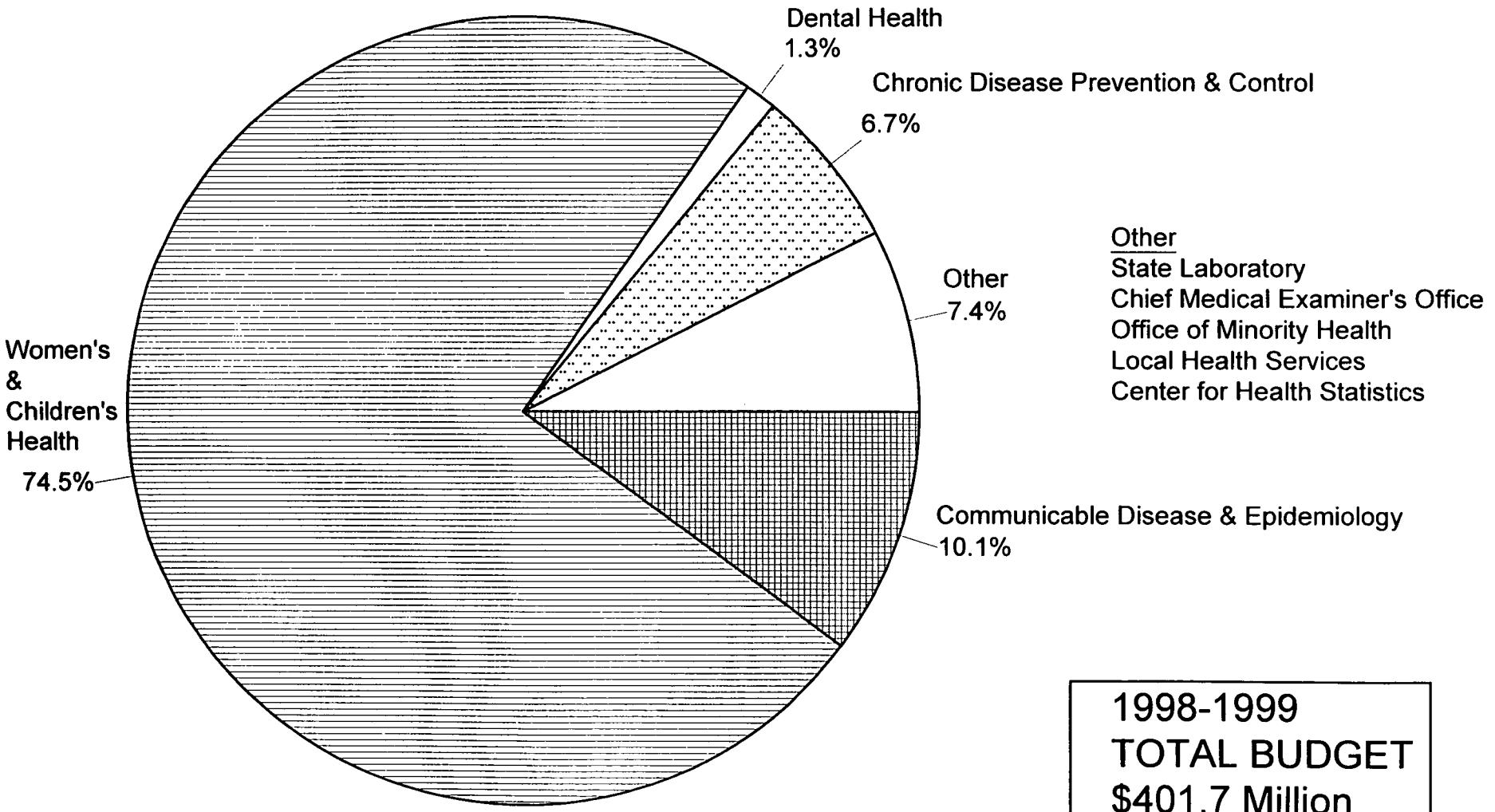
1999
DEPT. OF HEALTH & HUMAN SERVICES
Public Health

DIVISION OF PUBLIC HEALTH: Organization Chart



DIVISION OF PUBLIC HEALTH

Funding By Sections



1998-1999
TOTAL BUDGET
$401.7 Million

DIVISION OF PUBLIC HEALTH

Section Overview

Women's and Children's Health

⇒ Promotes, and protects the health and development of families with an emphasis on women of childbearing age, infants, children and youth

⇒ Administers programs serving individuals who are developmentally disabled or chronically ill

- Special Supplemental Nutrition Program for Women, Infants and Children
- Developmental Evaluation Centers
- School-Based Health Centers

Communicable Disease & Epidemiology

⇒ Seeks to prevent and control communicable diseases and their negative effects

⇒ Identifies environmental or occupation threats to health from asbestos, lead, chemicals, "dusty trades" and other environmental factors

⇒ Conducts medical evaluations for workers in hazardous trades

- TB Control
- Veterinary Public Health
- Industrial Hygiene Consultation

DIVISION OF PUBLIC HEALTH

Section Overview

Dental Health

⇒ Seeks to reduce the impact of tooth decay, periodontal disease, cancer and injuries through education, prevention and surveillance activities

- Seal the State in '98
- Fluoride Mouthrinse Program

Chronic Disease Prevention & Control

⇒ Works to reduce the risk and consequences of disease, build healthy communities, promote healthful living

- Cancer Prevention and Control
- Kidney Program

Offices

⇒ Minority Health
⇒ Local Health Services
⇒ Chief Medical Examiner
⇒ State Laboratory
⇒ State Center for Health Statistics

DIVISION OF PUBLIC HEALTH

Who Provides Public Health Services and Programs?

State-Provided Direct Services, Benefits, and Program Support

Direct services are provided by the Division through the Office of the Chief Medical Examiner, State Laboratory, State Center for Health Statistics, Dental Health, 13 Developmental Evaluation Centers (DEC), and program counselors and investigators.

Programmatic support is provided to local agencies through consultation, training, technical assistance, and oversight.

Through the Office of Purchase of Care, reimbursements totaling $16.8 million are provided for Children's Special Health Services, Assistive Technology, Adult Cystic Fibrosis, Sickle Cell, Cancer Control, Kidney Disease, Migrant Health, and the AIDS Drug Assistance Program.

Contract Grantees

The Division contracts with approximately 404 organizations, excluding contracts with health departments, for the provision of public health services. Among these organizations are community based organizations, universities, medical centers and health departments.

Contractually provided services include pregnancy prevention, AIDS/STD prevention, developmental evaluations, intensive home-visiting, genetic testing and counseling, sickle cell services, and high-risk maternity services.

DIVISION OF PUBLIC HEALTH

Who Provides Public Health Services and Programs?

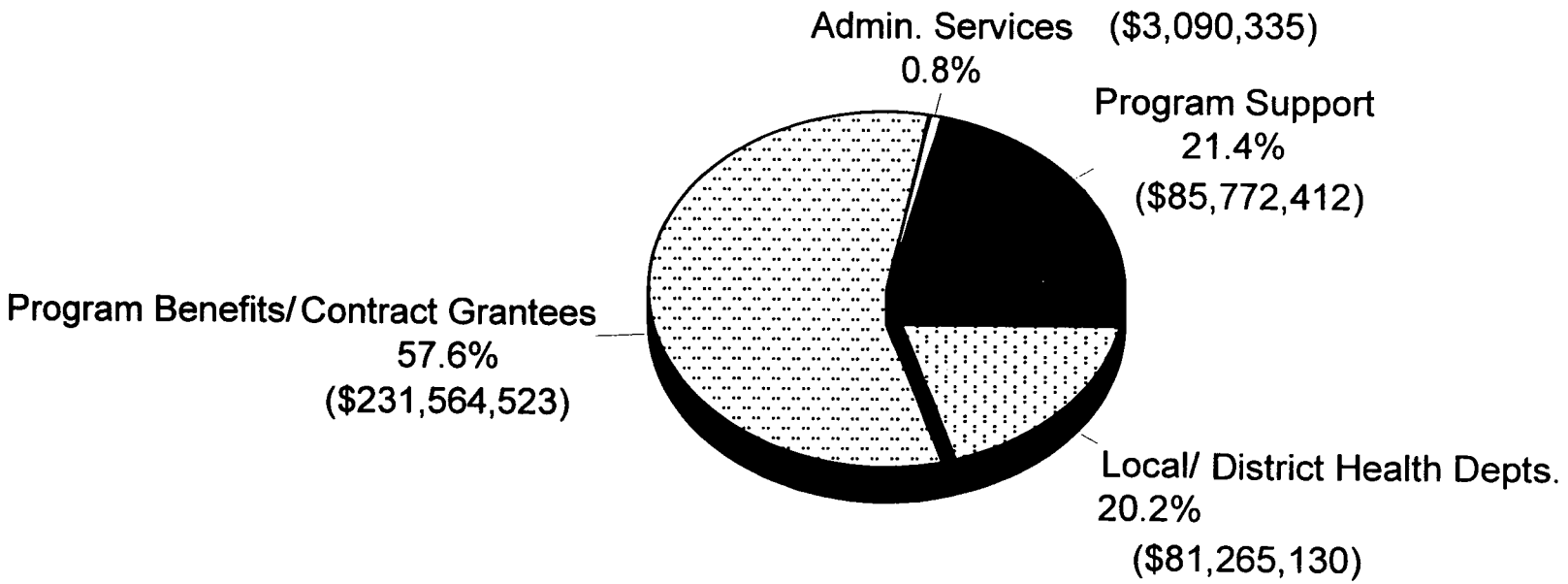
Local/District Health Departments

There are 87 Health Departments in NC, 7 district and 80 single-county departments.

Essential public health services provided by health departments include: communicable disease control, chronic disease control, patient and community education, child health, maternal health, family planning, dental public health, and health promotion and risk reduction.

A county or district board of health is the policy-making, rulemaking and adjudicatory body for health departments.

1998-99 Division of Public Health Budget by Service Provider



DIVISION OF PUBLIC HEALTH

Summary of Select Expenditures By Local Health Departments

Summary of DHHS Expenditures for All Health Departments

SFY 1997-98	State & Federal	Local	Total
General Aid	$4,980,816	$87,355,050	$92,335,866
Categorical Grants	$72,260,153	$175,811,036	$248,071,189
Total Expenditures	$77,240,969	$263,166,086	$340,407,055

Summary of Expenditures for Select Health Departments

SFY 1997-98	State/Federal	Local	Total Exp.	Per Capita Exp.
Allegheny/Ashe/ Watauga	$1,452,412	$2,021,370	$3,473,782	$46.85
Bladen	$582,148	$1,832,080	$2,414,228	$79.64
Buncombe	$1,730,849	$10,112,460	$11,843,309	$61.96
Forsyth	$1,449,694	$8,825,801	$10,275,495	$35.78
Greene	$369,884	$381,645	$751,529	$42.57
Guilford	$3,567,004	$17,289,732	$20,856,736	$54.42
Hoke	$475,172	$565,353	$1,040,525	$36.02
Iredell	$730,587	$2,250,953	$2,981,540	$27.28
Mecklenburg	$3,798,286	$16,885,221	$20,683,507	$33.98
Pasquotank/ Perquimans/Camden/ Chowan	$1,847,849	$2,478,409	$4,326,258	$65.60

DIVISION OF PUBLIC HEALTH

How Does NC Compare to the National Average On Public Health Indicators?

Selected Health Indicators - 1996	North Carolina	United States
Pregnancy Outcome Statistics		
Birth Rate, Females 15-44[1]	62.9	65.3
Birth Rate, Females 15-19[1]	63.5	54.4
Infant Deaths per 1,000 Live Births, 1996	9.2	7.3
Morbidity Rates 1996:[2]		
Reported Syphilis (all stages)[3]	36.4	20
Reported Gonorrhea (all sites)[3]	248.9	122.8
AIDS	12.2	25.2
Verified TB	7.6	8
Age-Adjusted Mortality Rates 1996:[4]		
Heart Disease	142.3	134.5
Cerebrovascular Disease	33.5	26.4
Atherosclerosis	2	2.2
Cancer	131.7	127.9
Diabetes Mellitus	15	13.6
Pneumonia/Influenza	14.6	12.8
Chronic Liver Disease & Cirrhosis	7.4	7.5
Motor Vehicle Deaths	20.1	16.2
Other Deaths by Injury	15.6	14.2

[1]Live births per 1,000 females. [2]Cases per 100,000 population. Cases are from the Centers for Disease Control. [3]Cases updated through June 13, 1997. [4]Deaths per 100,000 population using 10-year age groups and U.S. 1940 population as standard for direct age adjustment.

Source: North Carolina Health Statistics Pocket Guide - 1997

DIVISION OF PUBLIC HEALTH

HIV/STD Prevention & Care Branch

HIV/STD PREVENTION & CARE BRANCH

STDs and HIV/AIDS in North Carolina

- In calendar year 1996, NC reported the greatest number of primary/ secondary syphilis cases for all states and ranked fifth in cases per 100,000.
- According to Morbidity and Mortality Weekly Report, in 1997 NC ranked third in primary/secondary syphilis cases reported (behind Maryland and Tennessee) and remained fifth in rates per 100,000.
- In 1997 NC ranked fifth in the nation with 227 cases of gonorrhea per 100,000 persons.
- Data indicates that people who are infected with gonorrhea and chlamydia are 3 to 5 times as likely to contract HIV, and those with lesion diseases such as herpes and syphilis have 9 times the risk.
- There are currently 11,554 persons living with HIV/AIDS in NC.
- Recent data from the CDC's National Center for Health Statistics indicates a 47% decline in HIV-related deaths between 1996 to 1997; however, the rate of HIV infections has remained steady.

HIV/STD PREVENTION & CARE BRANCH

Why Is The Issue Of Sexually Transmitted Diseases Important For Policymakers?

- Nationally, estimated total costs for selected STDs and related syndromes, excluding sexually transmitted HIV infections, in 1994 dollars were nearly $10 billion.
- Costs of sexually transmitted HIV infections are estimated to be at least $6.7 billion.
- Costs include: 1) direct costs, i.e. expenditures of health care, and 2) indirect costs, i.e. lost productivity.

Estimated Costs of Selected STDs and Resulting Conditions, U.S. 1994
(1994 dollars, in millions)

STDs	Direct Cost	Total Cost
Pelvic Inflammatory Disease (PID)	$3,119.0	$4,148.0
Human Papillomavirus (HPV)	2,878.0	3,838.0
Chlamydia	1,514.0	2,014.0
Gonorrhea	791.0	1,052.0
Cervical Cancer	554.0	737.0
Hepatitis B Virus (HBV)	117.0	156.0
Herpes	178.0	237.0
Syphilis	79.0	106.0
Chancroid	7.0	9.0
Subtotal STDs (excluding HIV/AIDS)	**$7,484.0**	**$9,954.0**
Sexually Transmitted HIV	$5,025.0	$6,683.0
Total (including HIV)	**$12,509.0**	**$16,638.0**

Source: Institute of Medicine, 1996

HIV/STD PREVENTION & CARE BRANCH

HIV/AIDS Trends

⇒ In 1996 AIDS was the leading cause of death in 15 to 44-year-olds in Guilford, Lenoir and Mecklenburg counties.

⇒ Reported cases of HIV attributed to heterosexual transmission increased from 11% during 1990-1993 to 39% between 1994-1996.

⇒ African-Americans account for nearly 25 percent of North Carolina's population but more than 75 percent of all HIV cases reported since 1990.

⇒ Nearly 80% of pediatric AIDS cases were in African-American children.

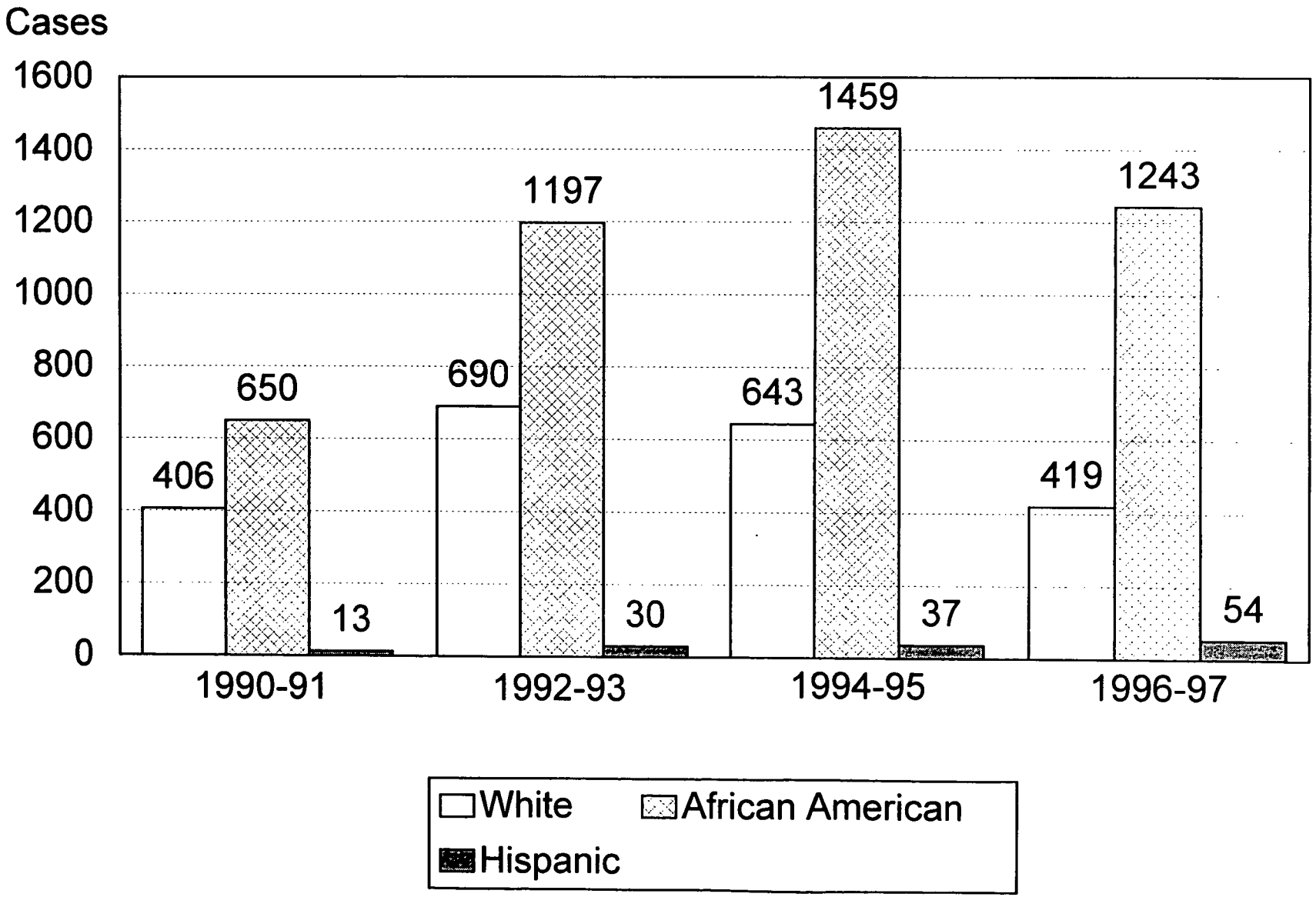
⇒ Using CDC figures, the HIV/STD Prevention & CARE Branch estimated in 1998 that up to 12,607 NC residents are living with HIV/AIDS, meaning that more than 2,100 people may be infected and not know their status.

Living HIV/AIDS Cases
February 1999

	HIV/AIDS Cases	Percent of Total
Gender		
Males	7974	69%
Females	3580	31%
Total	11554	100%
Race/Ethnicity		
White	2742	24%
Black	8457	73%
Hispanic	176	2%
Am. Indian/Alaska Native	93	1%
Other	86	0%
Total	11554	100%
Age		
Under 12	157	1%
13-19	337	3%
20-29	3383	29%
30-39	4813	42%
40-49	2226	19%
Over 49	638	6%
Total	11554	100%

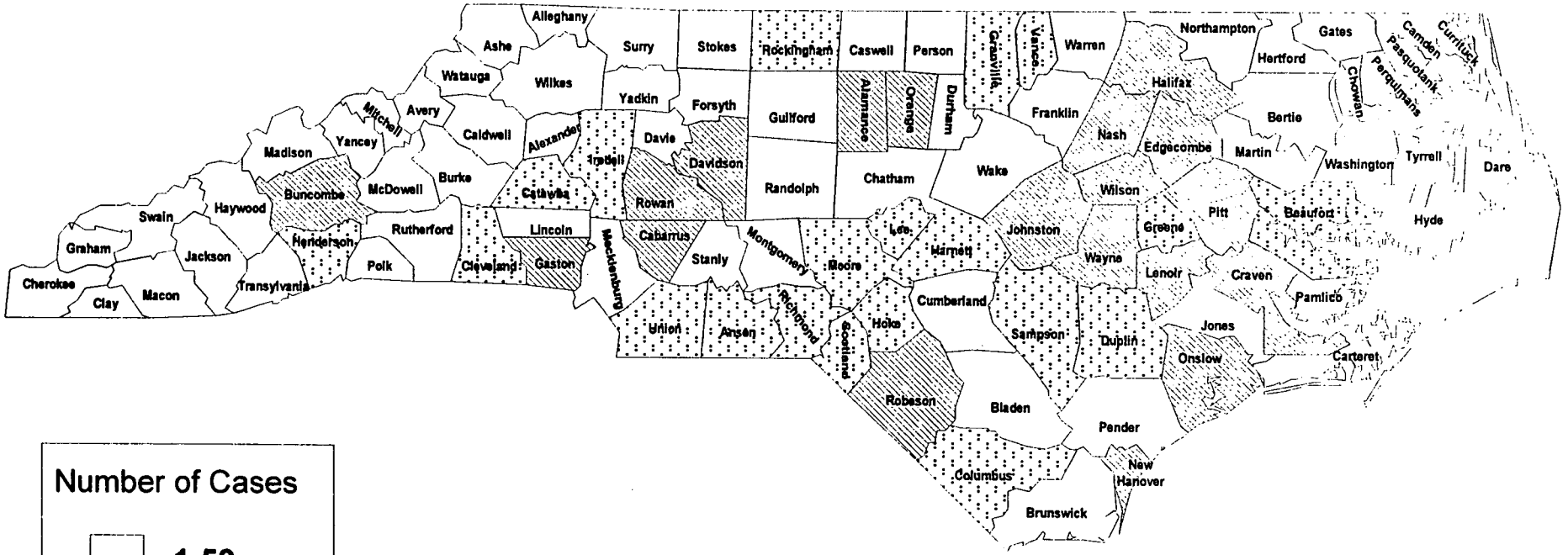
HIV/STD PREVENTION & CARE BRANCH

AIDS Cases in North Carolina By Year of Report, Race and Ethnicity



HIV/STD PREVENTION & CARE BRANCH

Cumulative Living HIV/AIDS Reports By County



Number of Cases

- 1-50
- 50-100
- 100-500
- 500-above

HIV/STD PREVENTION & CARE BRANCH

What Services Does NC Provide To Persons With STDs And HIV/AIDS?

AIDS CARE Unit:

Administers HIV medications program (ADAP)
Supports outpatient medical and support services coordinated by 13 regionally-based HIV care consortia
Supports primary medical and dental care services
Supports housing and related services

Prevention and Field Services Units:

Interview and notify patients diagnosed with syphilis/HIV and notifies partners
Consults on syphilis/HIV control measures
Provides consultation and technical support to HIV/STD laboratories and clinics
Coordinates and monitors HIV counseling/testing programs
Distributes STD drugs, gonorrhea culture plates, condoms, and patient brochures
Acts as an HIV/STD training resource for NC
Provides consultation, training, educational materials and financial assistance to local health departments and community based organizations

Surveillance Unit:

Analyzes and reports data on the diagnosis of HIV/AIDS, and other STDs
Conducts special studies and evaluations

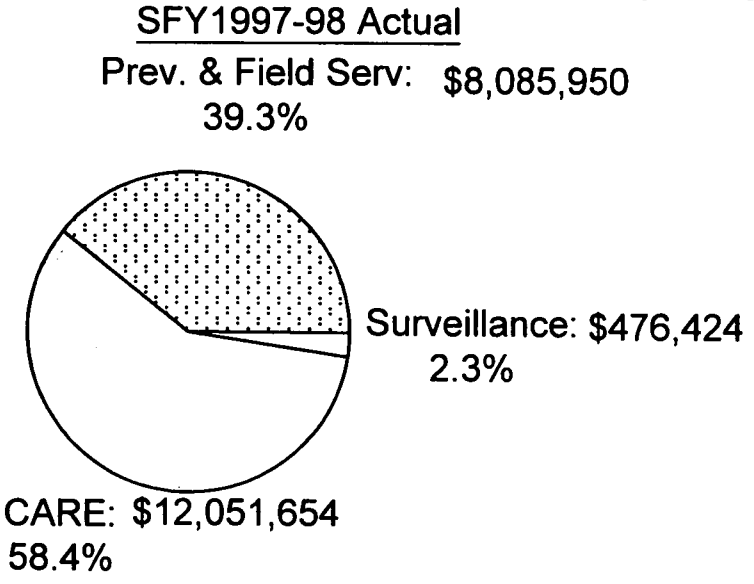
HIV/STD PREVENTION & CARE BRANCH

Budget Summary

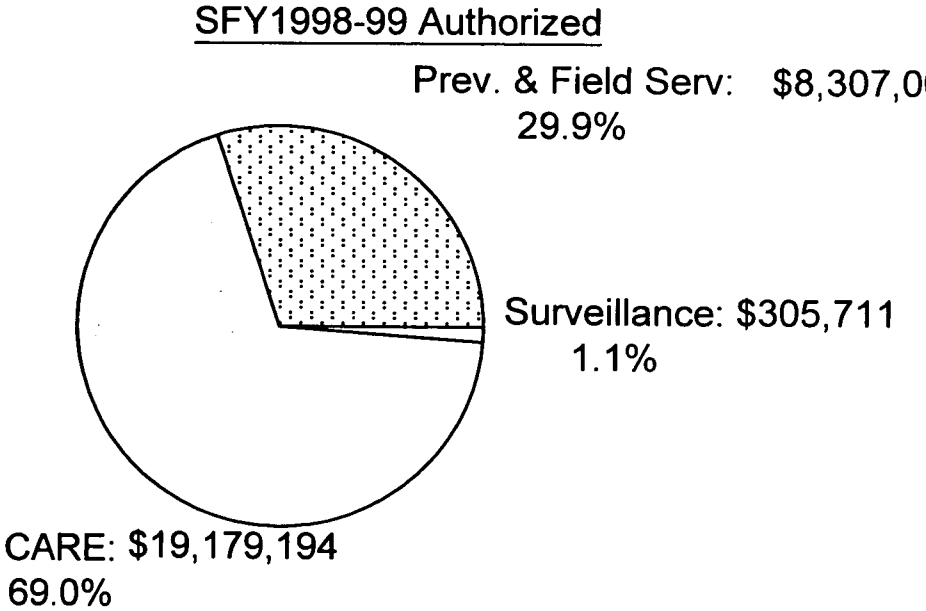
Budget Summary	1997-98 Actual	1998-99 Authorized	1999-2000 Rec'd	2000-2001 Rec'd
Requirements	$20,614,028	$27,791,906	$29,649,629	$29,883,949
Receipts	$15,408,265	$15,928,632	$15,928,632	$15,928,632
Appropriation	$5,205,763	$11,863,274	$13,720,997	$13,955,317

Budget By Purpose

SFY1997-98 Actual



SFY1998-99 Authorized



HIV/STD PREVENTION & CARE BRANCH

AIDS Drug Assistance Program (ADAP)

What is ADAP?

ADAP is a state-administered drug reimbursement program that provides access to HIV/AIDS medications for low income, uninsured and underinsured individuals. ADAPs operate in all fifty states, the District of Columbia and Puerto Rico.

How is ADAP funded?

ADAP is funded through Title II of the Federal Ryan White Comprehensive AIDS Resources Emergency (CARE) Act, state appropriations, and drug rebates. The Title II formula grant is based on a calculation of the estimated number of people living with AIDS in each state or territory. The Title II program has two components: 1) medication set-asides that provide support for HIV/AIDS medications, and administration of ADAP programs; and 2) base or general funds that are used to support program administration and all other services.

When did ADAP begin?

The CARE Act became law in 1990 and was first funded in fiscal year 1991.

Who is eligible for ADAP?

An individual must: 1) be determined by a physician to be infected with HIV, 2) have a net income of less than 125% of the Federal Poverty Level, and 3) not be Medicaid eligible (or have any other insurance that will pay for their medications).

HIV/STD PREVENTION & CARE BRANCH

ADAP Issues To Consider

A. ADAP Funds Included In Continuation Budget

ADAP Budget Summary	1997-98 Actual	1998-99 Authorized	1999-2000 Rec'd	2000-2001 Rec'd
Requirements	$6,252,282	$13,158,734	$14,990,725	$15,219,724
Receipts (Ryan White)	$3,460,257	$3,887,697	$3,887,697	$3,887,697
Other (rebates)	$476,211	$500,000	$500,000	$500,000
Appropriation	$2,315,814	$8,771,037	$10,603,028	$10,832,027

B. Ryan White Funding Increase

Ryan White Funding Increase	1998 Budget	1999 Budget	Increase
Base Award	$4,818,886	$5,301,431	$482,545
Designated ADAP	$3,838,516	$6,371,503	$2,532,987
Total Ryan White	$8,657,402	$11,672,934	$3,015,532

HIV/STD PREVENTION & CARE BRANCH

C. ADAP Funding and Expected Growth?

- Since ADAP reopened in November 1998, 701 persons have been authorized for the program. This brings the total number of persons authorized to 1,716 as of February 1999.
- Each person authorized for ADAP is estimated to cost the state an average of $900 monthly, or $10,800 each year.
- The Department has estimated that of the persons authorized for the program, 40 to 60% are likely to use the program during any given month.
- Demand for the program is likely to increase as persons infected with the virus live longer, and additional persons contract the virus.
- Pharmacists have traditionally had 12 months from the date in which a prescription is filled to bill the DHHS, Purchase of Care Office.
- The ADAP has a larger budget today than ever before, including an addition $3 million from Ryan White.

HIV/STD PREVENTION & CARE BRANCH

D. Needed -- "The Most Bang For The Buck"

Senate Bill 1366
Section 12.46A
AIDS DRUG ASSISTANCE PROGRAM

Summary:

(a) The Department of Health and Human Services shall develop and implement a cost-containment plan for the purpose of serving additional clients of the HIV Medications Program.

(b) The Department shall implement cost-containment programs or mechanisms, other than pharmaceutical rebates, by January 1, 1999, and shall report to the members of the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Human Resources not later that March 15, 1999.

(c) Savings realized through cost-containment measures shall be used to serve additional ADAP participants in fiscal year 1998-99. Funds not expended for authorized program costs shall revert to the General Fund.

(d) The Department shall also develop a comprehensive information system on AIDS/HIV clients receiving services from the State. The system shall include information on program usage patterns of ADAP participants, including, but not limited to frequency of prescription purchases, and types of medications prescribed. The Department shall also develop a plan for monitoring patient compliance with physician treatment recommendations. In developing the plan, the Department shall identify ways of obtaining information without interfering with physician-patient confidentiality.

DIVISION OF PUBLIC HEALTH

Other Issues: Immunization Branch
Infant Mortality Programs
Hispanic/Latino Public Health Issues

IMMUNIZATION BRANCH

Mission and Purpose:

The Immunization Branch promotes public health by reducing the spread of or eliminating vaccine-preventable diseases. To this end, the Branch attempts to break down barriers which prevent children from receiving timely immunizations. The Branch is also responsible for management and control of vaccine-preventable diseases and disease outbreaks.

Immunization Branch Program Areas:

1. Vaccine service delivery and customer support, including the Universal Childhood Vaccine Distribution Program (UCVDP) and the federal Vaccines For Children (VFC) program;

2. Immunization assessment, including participation in national, state and local assessment projects and research studies;

3. Immunization education, outreach and promotion for the general public and health professionals;

4. Vaccine-preventable disease surveillance, including epidemiologic investigation and outbreak control; and

5. North Carolina Immunization Registry (NCIR), which is primarily responsible for the development, implementation and maintenance of a statewide computerized immunization tracking and follow-up system.

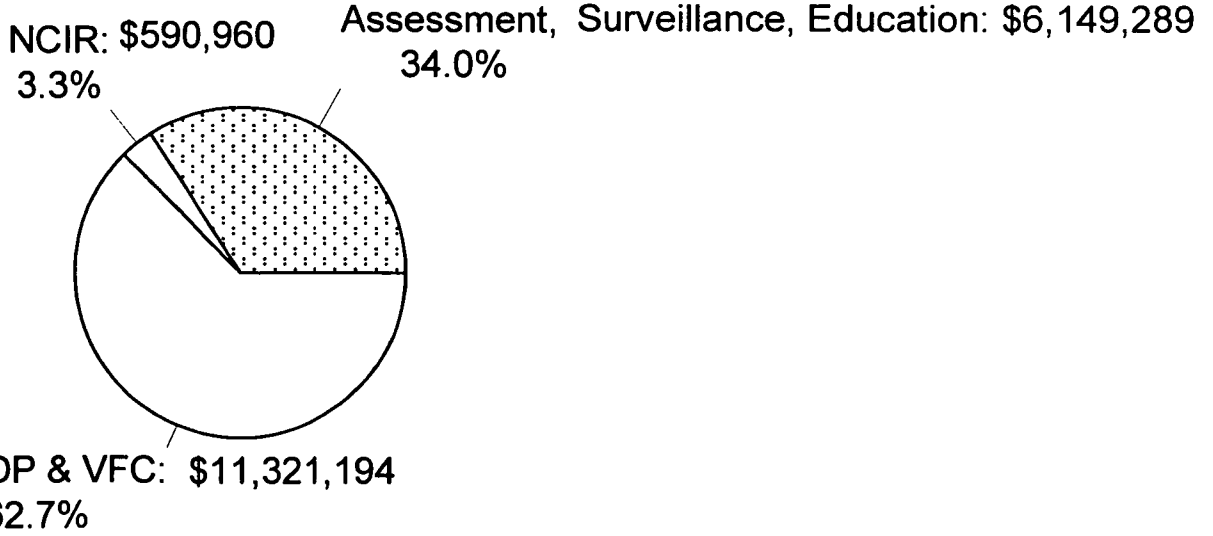
IMMUNIZATION BRANCH

Budget Summary

Budget Summary	1997-98 Actual	1998-99 Authorized	1999-2000 Rec'd	2000-2001 Rec'd
Requirements*	$17,700,869	$18,061,443	$18,791,506	$20,342,116
Receipts	$5,859,414	$6,027,113	$5,985,417	$5,985,417
Appropriation	$11,841,455	$12,034,330	$12,806,089	$14,356,699

Budget By Purpose

SFY 1998-99 Authorized



*Requirements do not include between thirteen and nineteen million dollars a year in vaccines provided by the U.S. Center for Disease Control and Prevention.

IMMUNIZATION BRANCH

The What, When and Why of NC's Universal Immunization Status

What does it mean to say that NC is a Universal Immunization State?

North Carolina, through its Universal Childhood Vaccine Distribution Program (UCVDP), and in cooperation with the federal government's Vaccine For Children Program (VFC), pays for virtually *all* recommended childhood vaccines. The VFC provides vaccines for all children from birth through 18 years of age who are American-Indian/Alaskan Native, Medicaid-eligible, uninsured, and for children who attend a federally-qualified or rural health center and have insurance which does not cover immunizations. The state pays to immunize all other children.

When did NC become a Universal Immunization State?

January 1, 1994

Why did NC become a Universal Immunization State?

North Carolina became a Universal State for two reasons; first, to remove costs as a barrier to immunizations, and secondly, to keep children in their medical homes for all services.

IMMUNIZATION BRANCH

Immunization Issues To Consider

A. Recently Adopted Vaccine Reporting and Accountability Measures

The NC Immunization Program failed to comply with NC Administrative Code requirements.
A 1998 audit of the program conducted by the Office of the State Auditor found:

- Reports submitted by private providers are incomplete of required data.
- Private providers file reports untimely.
- Private providers are not suspended from the Program for failure to meet reporting requirements.
- The NCIR does not include the ability for private providers to enter data directly.
- The program failed to promptly enter private provider reports into the tracking system.

B. Newly Implemented Vaccine Provider Financial Restitution Program

Division records for calendar year 1997 documented examples of vaccine wastage. Reasons for wastage included: expired vaccines due to failure to rotate, vaccine spoilage due to power outages or failure to properly store and handle vaccines, etc.

The costs of vaccines vary. As of January 5, 1999 a dose may cost anywhere from $1.53 to $34.39 (at CDC costs), to $2.15 to $44.26 (at private sector costs).

For calendar year 1997 35,955 doses, or 1.4 percent, of 2,494,696 were reported as wasted.

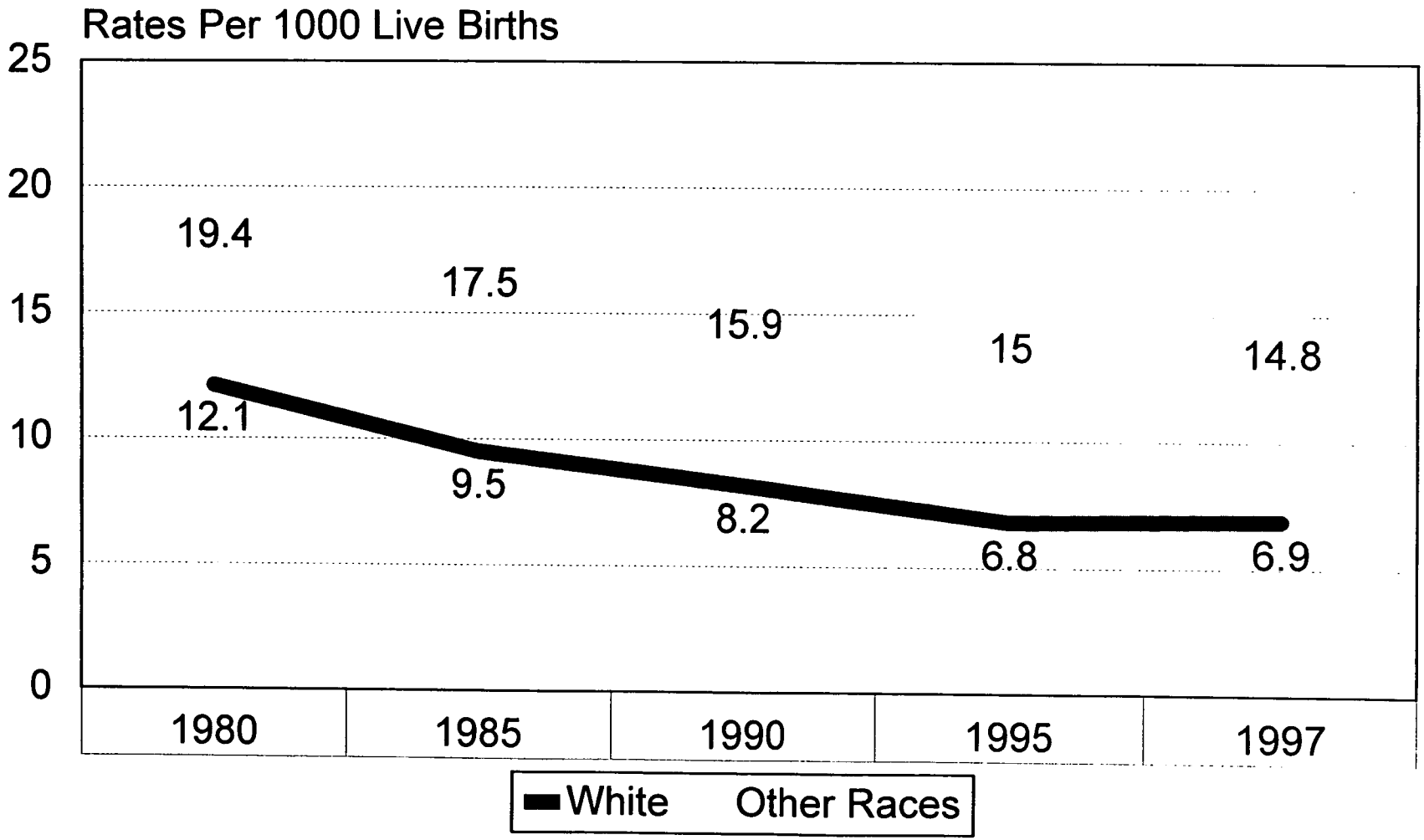
INFANT MORTALITY PROGRAMS

Facts About Infant Mortality in NC

- North Carolina's 1997 infant mortality rate was 9.2 deaths per 1,000 live births. This rate has remained unchanged from the rate of the previous two years.
- There were 982 infant deaths recorded in 1997.
- Approximately 1% of women giving birth in 1997 received no prenatal care, a 5.2% reduction form 1996. Approximately 83% of women began prenatal care in the first trimester (first three months) of pregnancy.
- The percentage of women who smoked during pregnancy decreased by 3.9% (to 15.1%) in 1997, continuing a downward trend over the past 10 years.
- The 1997 mortality rate was 6.9 per 1,000 births (522 deaths) for white infants, while for other races combined the rate was 14.8 per 1,000 births (460 deaths).
- For both whites and minorities, infant mortality rates were the second lowest ever recorded in the state; yet, preliminary national data for 1997 indicate that NC had the 2nd highest infant mortality rate in the nation.
- The percentage of infants delivered very low birth weight (less than 3lb., 5oz.; or 1,500 grams) continued to increase in 1997. In 1997, 1.9% of all infants were delivered very low birthweight, representing an increase of about 6% over the percentage from 1996.
- The percentage of births to women under age 18 declined in 1997, accounting for 5.5% of all live births.

INFANT MORTALITY PROGRAMS

NC Infant Mortality Rates 1980-1997



INFANT MORTALITY PROGRAMS

Selected Programs

⇒ Baby Love Program

⇒ Targeted Infant Mortality Reduction Projects

⇒ Minority Infant Mortality Reduction Projects

⇒ High Risk Maternity Clinics

⇒ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

⇒ Maternal Serum Alpha Fetoprotein Screening

⇒ First Step Campaign

⇒ Adolescent Pregnancy Prevention & Adolescent Parenting Programs

⇒ Maternal Health Programs

INFANT MORTALITY PROGRAMS

NC Healthy Start Foundation

⇒ Supports operating expenses of the FIRST STEP Campaign, the state's perinatal health public awareness effort SID

- Minority Infant Mortality Reduction Public Awareness Campaign
- Back to Sleep Public Awareness and Education Campaign

⇒ Supports Community Grants program that provides minigrants to communities to carry out local initiatives to improve birth outcomes

HISPANIC/LATINO PUBLIC HEALTH ISSUES

National Hispanic/Latino Facts & Health Trends

- Hispanics in the U.S. include a diverse mixture of ethnic groups and cultures, including Puerto Ricans, Cubans, Mexicans and Central and South Americans.
- Although Mexicans represent an estimated 10% of the total U.S. population, they account for 18% of the 641,086 AIDS cases reported in 1997 (Centers for Disease Control and Prevention).
- Approximately one in every 10 Hispanic adults has diabetes (American Diabetes Association).
- In 1995, nearly 11 percent of Hispanic teenagers gave birth, compared with about 10 percent of black teenagers and 4 percent of non-Hispanic white teenagers (National Center for Health Statistics).
- Hispanics of all ages were the most likely to be uninsured; nearly 3 in 10 (the federal Agency for Health Care Policy and Research).
- Families headed by Hispanics were the most likely to report barriers to obtaining health care (the federal Agency for Health Care Policy and Research).

HISPANIC/LATINO PUBLIC HEALTH ISSUES

Growth in NC's Hispanic/Latino Population for Select Counties

County	1990	1997	% Change
Buncombe	1,298	2,425	86.83%
Craven	1,838	3,327	81.01%
Cumberland	13,638	23,411	71.66%
Duplin	1,041	1,873	79.92%
Durham	2,469	3,842	55.61%
Forsyth	2,389	4,084	70.95%
Guilford	3,240	5,564	71.73%
Harnett	1,486	2,437	64.00%
Johnston	1,324	2,844	114.80%
Mecklenburg	7,368	14,409	95.56%
New Hanover	1,057	2,069	95.74%
Onslow	8,251	12,587	52.55%
Orange	1,451	2,775	91.25%
Pitt	1,088	1,911	75.64%
Wake	6,751	12,648	87.35%
Wayne	1,776	2,625	47.80%
North Carolina	**86,831**	**149,390**	**72.05%**

Source: Population Estimates Program, Population Division, U.S. Bureau of the Census, Washington, DC 20233

HISPANIC/LATINO PUBLIC HEALTH ISSUES

Public Health Emergency: 1996 Rubella Outbreak

Rubella causes:	It can lead to:	Babies can be born with birth defects, such as:
• rash • swollen glands • arthritis	• ear infection • pneumonia • diarrhea • seizures • hearing loss • brain damage • death • meningitis	• deafness • blindness • heart disease • brain damage • other serious problems

⇒ Between 1987 and 1995, North Carolina reported only 9 confirmed cases of rubella.

⇒ From March 26 to June 15, 1996 there were two simultaneous, but unrelated outbreaks of rubella affecting mostly Hispanics of Mexican origin reported to the NC Immunization Section.

⇒ Eighty-three confirmed cases of rubella were reported. Of the 83 cases, 79 were Hispanic.

⇒ Two cases occurred in children under age 5. Six confirmed cases in the first outbreak involved women who were pregnant at the time of exposure; one in the first trimester, three in the second, and two in the third.

⇒ The first outbreak involved four neighboring counties in central NC: Chatham, Guilford, Lee, Randolph. The outbreak started in a poultry processing plant in Chatham County, which employed mostly Hispanics.

⇒ The second outbreak occurred in a young Hispanic male who traveled to NC from Sonora, Mexico. After exposing his immediate family, he transmitted the disease to coworkers at a local plastics factory.

HISPANIC/LATINO PUBLIC HEALTH ISSUES

*Preliminary Findings of the NC Center for Public Policy Research Study on Hispanic/Latino Health in North Carolina**

Do you think health care is a problem for Hispanics/Latinos in your community?

	Yes	No
Health Departments	92.7%	7.3%
Rural Health Centers	65.0%	35.0%
Community/Migrant Health Centers	66.7%	33.3%
Rural Hospitals	75.6%	24.4%
Total	82.4%	17.6%

What are the three most significant health issues affecting Hispanics/Latinos in your community?

	Males	Females	Children
1	No/Inadequate health insurance	Prenatal Care	Access to health care
2	Access to health care	Access to health care	No/Inadequate health insurance
3	On-the-job-injuries	No/Inadequate health insurance	Immunization Rates

*This study included a review of recent literature, extensive interviews and field visits, and a survey of 87 health departments, community and migrant health centers, rural health centers, and rural hospitals. The survey response rate was 72.9%, with 92% of health departments responding.

HISPANIC/LATINO PUBLIC HEALTH ISSUES

Preliminary Findings of the NC Center for Public Policy Research Study on Hispanic/Latino Health in North Carolina

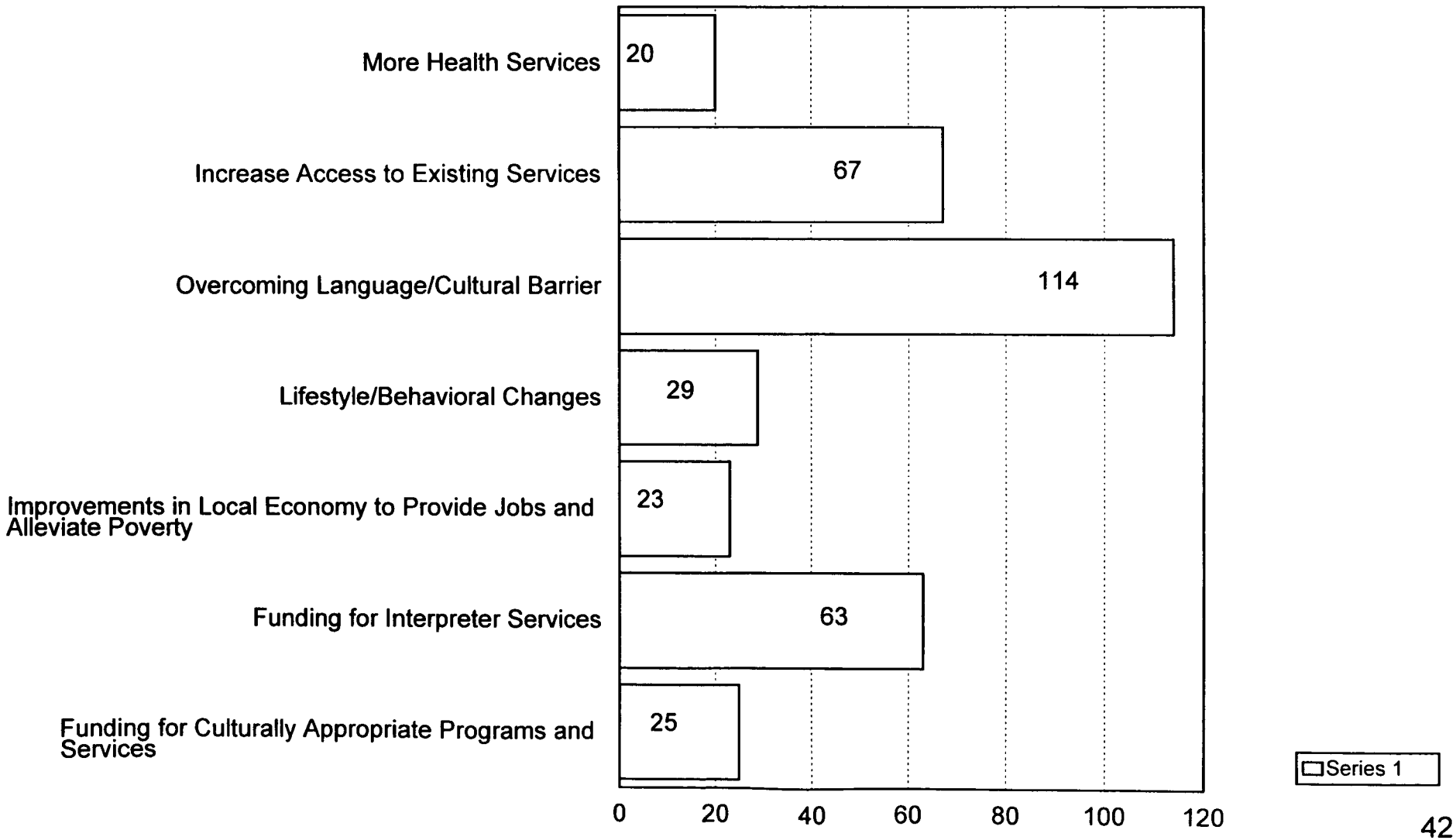
In your opinion, how do health services for Hispanics/Latinos in your community compare to those available to whites and other minorities?

To Whites?	Much Better	Better	About the Same	Worse	Much Worse
Health Departments	0.0%	0.0%	72.0%	20.7%	7.3%
Rural Health Departments	0.0%	0.0%	52.9%	41.2%	5.9%
Community/Migrant Health Centers	0.0%	0.0%	58.3%	33.3%	8.3%
Rural Hospitals	0.0%	2.3%	90.7%	4.7%	2.3%
Total	0.0%	0.6%	74.0%	19.5%	5.8%
To Other Minorities?					
Health Departments	0.0%	0.0%	84.1%	12.2%	3.7%
Rural Health Departments	0.0%	0.0%	62.5%	31.3%	6.3%
Community/Migrant Health Centers	0.0%	8.3%	58.3%	33.3%	0.0%
Rural Hospitals	0.0%	2.3%	93.0%	4.7%	0.0%
Total	0.0%	1.3%	82.4%	13.7%	2.6%

HISPANIC/LATINO PUBLIC HEALTH ISSUES

Preliminary Findings of the NC Center for Public Policy Research Study on Hispanic/Latino Health in North Carolina

Which of the following are the most important in improving health outcomes for Hispanics/Latinos?



VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-1, 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Steve Cline	DHHS-Epi
JACK McEEF	MARCH OF DIMET
Dorothy Cilenti	DHHS- WCH
Kevin Ryan	DHHS-WCH
NELS ROSELAND	OSBM
Mary Greene	OSBM
[illegible]	NCFPC
[illegible]	NCFPC
[illegible]	Grayson Wellcare
[illegible]	Food Banks
Dean Searing	NCHAC
Robert Moses	NY Parks Commsn
Sharon Hirsch	NC Social Services Consortium
Megan Primavera	NCACDSS
[illegible]	DHHS
Glenn Wells	DHHS/Public Health
Leah Devlin	DHHS
C. Medlin	Covenant w/ NCs Children
[illegible]	DHHS
Jim Edgerton	DHHS
Allyn Gluppy	DHHS
Barbara Pullen-Smith	DHHS, DMH
Beth Rowe-West	DHHS, DPH, WCH
Ann Wolfe	DHHS, DPH
Pam Kilpatrick	DHHS-DPH
Dennis Harrington	DHHS-DPH
Denise Thomas	DHHS/BPA
[illegible]	OSBM

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-1, **1999**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tommy Worth	Carolinas HealthCare System

NORTH CAROLINA GENERAL ASSEMBLY
JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES
April 6, 1999
8:30 a.m.

The Joint Appropriations Subcommittee on Human Resources met in Room 424 of the Legislative Office Building, April 6, 1999. Sen. Bill Martin, Chair, called the meeting to order and announced that the committee will also meet this afternoon. There were six Senate Members present and the following House members were present: Representative Earle, Representative Nye, Representative Alexander, Representative Adams, Representative Cansler, Representative Esposito, Representative Walend, Represenative Wilson. After introduction of the pages, he recognized Ramona Burton to continue her presentation on Public Health.

During the presentation on Public Health from the attached handout (beginning on page 37), the following questions were asked:

Sen. Purcell - Do you have any explanation as to why Hispanic/Latino communities are located in certain counties, is it occupation?

Sen. Phillips – he realizes that the numbers are growing, however, will they be able to get service. There is a language problem, and it requires interpreter, can someone tell us how much time they are able to give and how much service they are able to get from the agency.

Sen. Phillips: - What I hear from the Latino community at home is that the attorneys are not taking new clients and the doctors are not taking new patients. Ultimately, we will have to provide some kind of interpretation for these citizens.

Rep. Adams – regarding immunizations, how many members of the Latino community are included in the information you gave us last week? On page 42, is there a relationship between the access issue and the funding issue?

Sen. Dannelly – On page 41, did anyone ask the Hispanics?

Sen. Martin stated that it would be well for the Committee to explore this issue more.

Sen. Purcell – How do we immunize these Latino children, who pays for that?

Dr. Wolf stated that there are certain services that immigrants, both legal and illegal qualify for – such as WIC, treatment of STD - however, one has to qualify.

Sen. Purcell – are there any preferential hiring practices in reference to bi-lingual requirements?

Sen. Kerr – Does the Advisory Commission on Spanish and Latino Affairs that the Governor established have any knowledge of the ???

Sen. Martin stated that there would be some follow up by the Committee.

Carol Shaw was recognized to give an overview of the Medicaid Program (handout attached). She gave an overview of how the program works as it relates to who is eligible, what types of services are supplied to recipients, its role in the State budget, Managed Care and a summary of the changes that we made in the program.

She also gave a comparison definition of the Medicaid program and Medicare. Medicaid is an entitlement program. That means that if you are eligible for this program and you show up, services must be provided, eligibility is determined. It is a health care program for certain groups of poor persons including single parent families, persons over age 65 and the disabled. It is a State administered program.

Medicare is health care for all persons over the age of 65 or for the disabled receiving social security payments. It is administered by the health Care Financing Administration and financed by employer and employee contributions.

During the presentation by Carol Shaw, the following questions were asked:

Rep. *Cansler* – Looking at the cost increase, the counties paid about $267 million in 1997 and was paying approximately $20 million in 78-78 that was a substantial increase. Do we have any idea what percent of the counties' budget goes to Medicaid?

Sen. Purcell – Has the Work First Program had any impact at all on the Medicaid expenditures – the people coming off public assistance as a result of Work First?

Sen. Martin stated that one other factor to consider is that during the transition to work, some would still maintain eligibility for Medicaid.

Rep. Alexander – You mentioned that the people have doubled; however the expenses have tripled. What did you mean by that?

Carol Shaw stated that the cost tripled at a time when health care cost was increasing.

Sen. Phillips – Have we reached any conclusion as to why we have the continuing increase with the elderly? Our observation for a number of years is that as long as we limit the number of prescriptions that elderly people can have, we set ourselves up for long term care or hospitalization that is more expensive. The consensus is that even though they have access to Medicare they do not always have access to medical care.

Sen. Phillips stated that he is really thinking primarily about hospitalization. He shared that he has worked cases where people were denied medication, but the system was willing to pay a $25,000 - $50,000 hospital bill that had we provided medication for, would not have been hospitalized at that time.

Dr. Bruton – stated that Sen. Phillips was really addressing the fundamental problem of health care. Until we start focusing on care and financing in that direction, we will continue to have that problem.

Rep. Cansler – Do we any feel of what the impact of reducing Home Health Services is on Medicaid services?

Rep. Wilson – Has there been any study or research done on tracing Medicaid fraud?

Rep. Alexander – What percentage of the people come off the program – example if they are on the program for a particular reason and the situation changes, are people pretty good at acknowledging that their situation has improved and they are willing to rotate off?

Carol Shaw – if they are children, they only have to have their eligibility determined once annually. A child is on the program for one year. If a pregnant woman goes on, they are off 60 days after the birth of the baby. In the case of people on TAN or Work First, their Medicaid eligibility is related to their tenure on that program. The elderly and disabled have to be verified every six months. They are required to report changes of their circumstances.

Rep. Nye – asked for explanation of the percentages on the right side of the chart on page 15.

Rep. Esposito – could we get a short explanation of the premium that we pay for that class of people that are on Medicare as to who they are?

Sen. Martin – on page 11 in reference to the $15 Million increase in general fund requirement, do we have information available in terms of how far the estimates have been on or off during the past five or six years?

Sen. Dannelly - Will you discuss reducing cost relative to providers?

Sen. Phillips – Asked if there is any evidence that since the inception of ??? and ??? care that we are a healthier environment?

The Chair stated that Carol Shaw would conclude the Medicaid overview during the afternoon meeting. The meeting was adjourned until 3:00.

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES
(Continuation of morning meeting)
April 6, 1999
3:15 p.m.

The Joint Appropriations Sub Committee on Human Resources met in Room 424 at 3:15.p.m. Senator Bill Martin called the meeting to order with two Senate Members present and the following House members were present: Representative Earle, Representative Nye, Representative Cansler, Representative Walend, Representative Wilson. Senator Martin called Carol Shaw was to conclude the overview of Medicaid. She continued from page 16 of the attachment from previous minutes.

She gave a brief update on the three of the four Medicaid Managed Care Initiatives that are being managed by the Division of Medical Assistance, Carolina Access, Access Two and Access Three. The Carolina Alternatives Program was discussed earlier.

During Committee discussion, *Representative Earle* asked if there are plans to expand the program based on this information and when will the next evaluation be conducted.

Mr. Dick Perusse, Division of Medical Assistance, stated that they are in the process of obtaining information from the HMO's and also conducting interviews with clients.

Representative Nye asked what procedure would be used to conduct an evaluation of the regular Medicaid Program and the HMOs. He said that he thought these would be very difficult comparisons.

Sen. Purcell shared examples of saving incentives to work with Carolina Access.

Carol Shaw continued her overview by going over changes in activity of the Medicaid program that occurred during the 1990s. She further referred to the issues for 1999 on page 27 of the handout. She stated that there are serious proposals at the federal level to reduce federal participation in administration. Any reduction in administrative cost sharing will impact the State's budget.

The meeting adjourned at 3:50 p.m.

Senator William N. Martin, Chair

Joyce Crews Hodge, Clerk

AGENDA

Joint Subcommittee on Health and Human Services Appropriations

Legislative Office Building - Room 424
Tuesday, April 6, 1999
8:30 a.m.

Opening Remarks	Sen. Bill Martin, Co-Chair Rep. Beverly Earle, Co-Chair Rep. Edd Nye, Co-Chair
Division of Public Health	Ramona L. Burton Fiscal Research Division
Medicaid Program Overview	Carol Shaw Fiscal Research Division
Adjourn	

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

April ~~5~~ 6, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stacy Flannery	NC HCFA
Barbara Matula	NCMS-Foundation
Millie R. Harding	NCHA
Megan Snyder	Easter Seals NC
James Simoncini	NC Council of Community Programs
Carmen Hooker Buell	Carolina's Health Care System
Tommy Worth	CHS
Lou Nelson	NCALTCF
Gé Brogden	NC DHHS
Mark Benton	"
Allen Gamhill	Div of Medical Asst.

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

April ~~5~~ 6, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
P. Perruzzi	DMA - DHHS

8:30

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

April 5, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JACK McGEE	MMEY of Times
Pam Kilpatrick	DHHS - Public Health
NELS ROSELAND	OSBM
Allan Gambill	Div of Medical Asst.
P. Perruzzi	" " "
Denise Thomas	DHHS/BPA
Mark Benton	" "
Barbara Pullen-Smith	DHHS/ Public Health
Ann F. Wolfe	DHH/DPH
M Yeager	OSBM
A. Dennis McBride	DHHS

8:30

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

~~March~~ 2, 1999
April 5,

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jim Edgerton	DHHS
Dave Benton	DHHS
Ken Howell	Gov's Office
Lori Wilson	NCALTCF
Katherine Miller	Harry Kaplan
Will Fay	AHHC
Mike McLaughlin	N.C. Center for Public Policy Research
B Summers	NC Equity
Tommy Worth	Carolina Healthcare System
Marion Smith	Glaxo-Wellcome
Beckie Street	PPAB

8:30

Name of Committee JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

April 5, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Glenn Wilder	DHHS/Public Health
Stacy Flannery	NC HCFA
Hugh Tilson	NCHA
Millie R. Harding	NCHA
[illegible] Singleton	Eastern Seals NC
Peter Andersen	DHHS
R. Pierce	RLCSEP
Terry Hardest	Food Banks
Kim Carter	NC Budget & Tax Center
Wayne Williams	OSBM
AL DEITCH	YAIO/DOA

VISITOR REGISTRATION SHEET 6.30

[redacted]nT 6-6-99

Name of Committee Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
[redacted]	NCDHHS
[redacted]	Bowe Assoc - NCALTF
Adam Searing	NCNAC
Allyn Duffey	DHHS
MICHELLE COTTON	DMH DD SAS
[redacted]	NCMS
[redacted]	FMS

AGENDA

Joint Appropriations Subcommittee on Human Resources

April 7, 1999

8:30 am

Opening Remarks	Senator Bill Martin Representative Beverly Earle Representative Edd Nye
Division of Medical Assistance Budget Overview	L. Carol Shaw Fiscal Research Division

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
April 7, 1999
Morning

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Wednesday, April 7, 1999, in Room 424 of the Legislative Office Building.

House Chairman, Representative Edd Nye presided. Other House members present were Representative Beverly Earle (Co-Chairman), Representative Martha Alexander (Vice-Chairman, Representative Alma Adams, Representative Lanier Cansler, Representative Theresa Esposito, Representative Trudi Walend, and Representative Gene Wilson. There were six senators present.

Chairman Nye introduced the Pages for the meeting and then recognized Ms. Carol Shaw, Fiscal Research Division, to begin her presentation. Ms. Shaw presented the handout titled Division of Medical Assistance Budge Overview: 1999-2000 Budget. Ms. Shaw stated the Governor's Budget does not show whole picture for Medicaid. If Medicaid is cut, it will affect other programs. A discussion by the members followed. Senator Phillips and Senator Kerr asked if they have lobbyist in Washington. Dr. Bruton, DHHS, stated he hasn't been to see Washington Delagation.

Ms. Shaw continued with Governor's proposed reductions summary. Senator Martin asked what services would be affected with Carolina Alternatives Program being terminated and Dr. Bruton will get information for him. Representative Adams asked for number of people that will be effected by this.

Department staff discussed charts on Mental Health Services stating charts show downward trend in expenditures and upward trend in recipients. More people at less cost per person. Senator Kerr asked what can the legislature do to get doctors and dentists to take Medicaid patients. Dr. Bruton stated they are trying to do something about that. On the border of losing physician group program. Legislature left out intensity money and need to allow intensity increases to get up. Senator Forrester stated that on the drug rebate eighteen percent of every dollar spent on drugs is refunded, with counties getting a portion and federal getting a portion.

Chairman Nye adjourned the meeting.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbitt
Committee Assistant

DEPARTMENT OF HEALTH & HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE

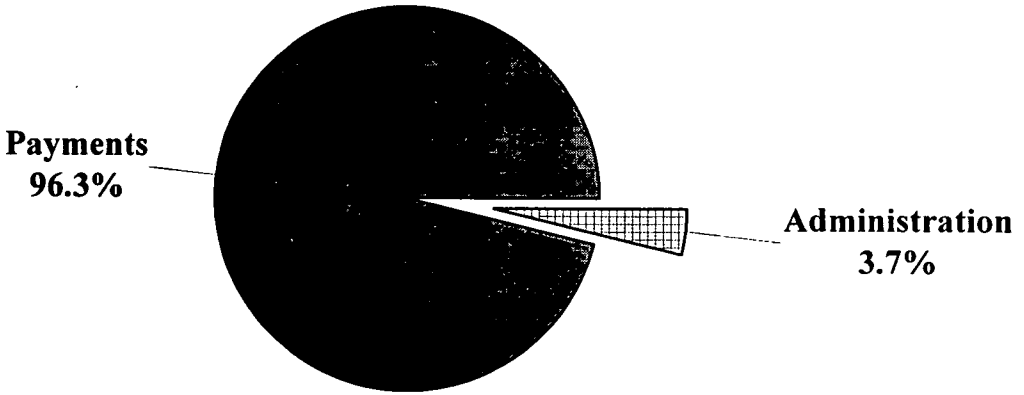
1999-2001 BUDGET

FISCAL RESEARCH DIVISION
April 1999

DIVISION OF MEDICAL ASSISTANCE

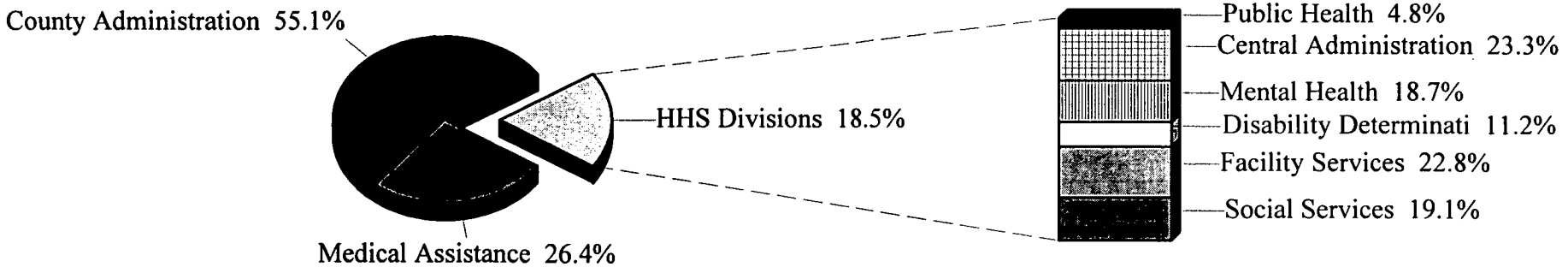
1999-2001 CONTINUATION BUDGET

Description	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Total Requirements	$4,834,428,976	$4,655,633,030	$5,128,671,652	$5,590,566,938
Estimated Receipts	($3,694,772,173)	($3,300,703,393)	($3,607,181,891)	($3,918,000,650)
Net Appropriation	$1,139,656,803	$1,354,929,637	$1,521,489,761	$1,672,566,288
Total Number of Positions	348	348	348	348



DIVISION OF MEDICAL ASSISTANCE
FUNDING FOR MEDICAID ADMINISTRATION

HHS Division	1998-99 Total Requirements	1998-99 General Fund
Medical Assistance	$45,085,825	$18,491,272
Social Services	$6,070,159	$2,936,248
County Administration	$94,142,197	$3,130,082
Facility Services	$7,230,555	$3,656,496
Mental Health	$5,924,733	$2,641,520
Disability Determination	$3,544,058	$1,772,013
Public Health	$1,535,238	$696,630
Central Administration	$7,398,916	$3,699,458
Total	**$170,930,681**	**$37,023,719**



DIVISION OF MEDICAL ASSISTANCE

MEDICAID ADMINISTRATION BY PROGRAM

Medical Assistance: Supports the overall management and oversight of the Medicaid program.

Social Services: Based on the approved cost allocation plan, supports a portion of the state level administration including the director's office, hearing officers, and other administrative activities in the division related to the Medicaid program.

County Administration: Supports eligibility determination staff, Carolina ACCESS coordinators, adult care home case management, medical transportation, Adolescent Parenting Program, and a portion of the overhead costs in county departments of social services.

Facility Services: Supports licensing and certification staff that regulate health care facilities certified to provided Medicaid/Medicare services.

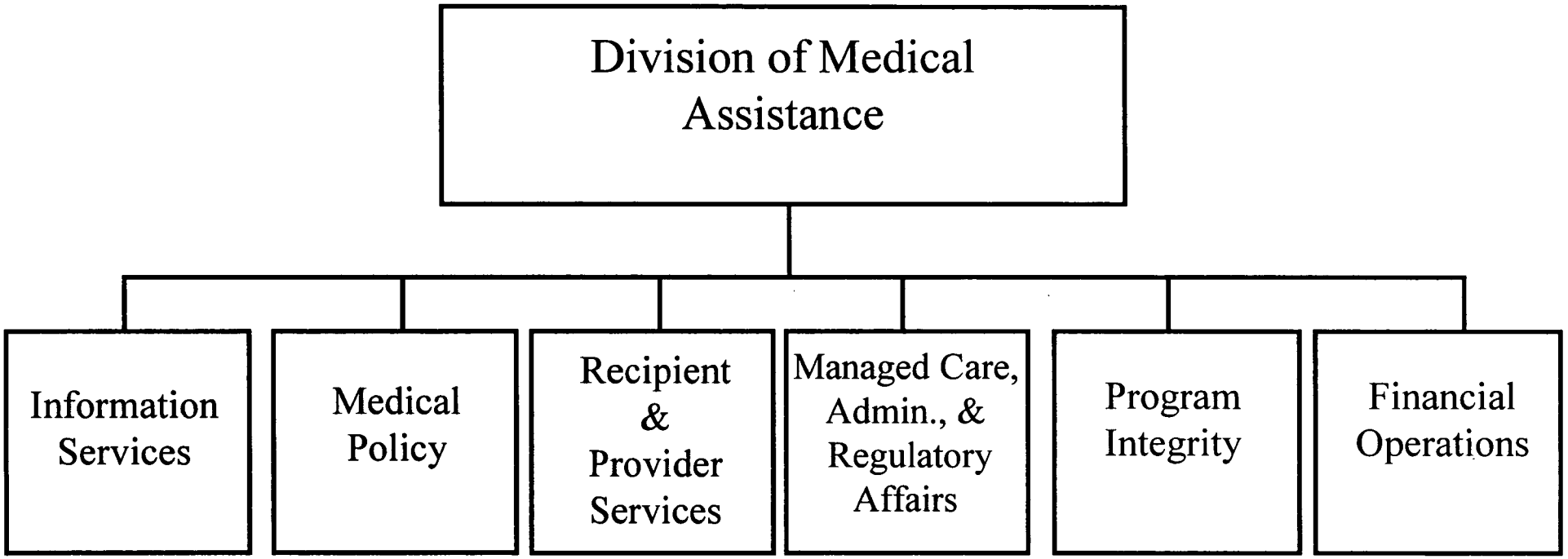
Mental Health: Supports administrative staff in the Willie M program, the Thomas S program, CAP-MR/DD program, MR Centers, and other administrative activities in the division related to the Medicaid program.

Disability Determination: Supports staff that determine Medicaid eligibility for disabled adults and covers the expense of physicians who are asked to provide a medical opinion.

Public Health: Supports staff in the CAP-AIDS program, the child and maternal health programs, the Adolescent Parenting Program, the Medicaid Reimbursement Unit, and the Public Health Training and Information Network.

Central Administration: Based on an approved cost allocation plan, supports staff in the following programs: Mailroom and Receiving Section, HHS Controller's Office, Office of Citizen Services, Information System Services, and the Office of Rural Health and Development.

DIVISION OF MEDICAL ASSISTANCE
ORGANIZATION



Total Positions - 348

DIVISION OF MEDICAL ASSISTANCE

MAJOR PROGRAMS

Financial Operations: This section is responsible for reimbursement policy, budgeting, audit policy, contracts accounting, rate setting and financial reporting.

Managed Care, Administration, & Regulatory Affairs: This section is responsible for the development, operation and oversight of DMA's managed care initiatives. This section also oversees rulemaking and the hearing process related to services.

Recipient & Provider Services: This section is responsible for developing and implementing eligibility policies, assuring that qualified medical providers are enrolled in the Medicaid program, and assuring that claims processing for providers meets their needs.

Medical Policy: This section is responsible for structuring the medical benefits and service coverage available to Medicaid clients that promotes access to medically appropriate and cost effective health care.

Information Services: This section is responsible for procurement, implementation, and contract oversight of automation and information services for DMA including the Decision Support System, and the Medicaid Management Information System.

Program Integrity: This section is responsible for identifying and recovering overpayments to providers of health services and Medicaid recipients occurring due to error, abuse or fraud. This section also assures that third party payments are applied prior to Medicaid payment or recovered after payment.

DIVISION OF MEDICAL ASSISTANCE

STAFFING BY PROGRAM

Program	Number of Staff	New Positions
Director's Office	8	2
Financial Operations	54	13
Managed Care, Admin., & Regulatory Affairs	43	5
Recipient & Provider Services	59	5
Medical Policy	59	14
Program Integrity	90	11
Information Services	35	13
Total Positions	**348**	**63**

MEDICAL ASSISTANCE PAYMENTS

1999-2001 CONTINUATION BUDGET (Fund 1310)

Description	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Total Requirements	$4,106,345,838	$4,522,263,830	$4,989,414,497	$5,450,048,606
Estimated Receipts	($3,094,692,285)	($3,204,016,887)	($3,508,734,078)	($3,818,716,688)
Net Appropriation	$1,011,653,553	$1,318,246,943	$1,480,680,419	$1,631,331,918

The Medical Assistance Payment Fund budgets the payments to the providers of medical and other services for Medicaid recipients. Payments to providers represent 96.3% of the total budget for the Division of Medical Assistance.

The recommended budget does not include the Governor's proposed reductions.

MEDICAL ASSISTANCE PAYMENTS

INCREASES IN THE RECOMMENDED BUDGET

(In Millions)

Description	1999-00 Increase	2000-01 Increase
Total Requirements	$467.1	$460.7
Estimated Receipts	($304.6)	($310.1)
Net Appropriation	$162.5	$150.6

Notes: The 1999-00 increase is the difference between 1998-99 Authorized Budget and the 1999-00 Recommended Budget. The 2000-01 increase is the difference between he 1999-00 Recommended Budget and the 2000-01 Budget.

MEDICAL ASSISTANCE PAYMENTS

1998-99 INITIAL ESTIMATE OF EXPENDITURES

(In Millions)

Source of Funds (In Millions)	1998-99 Authorized Budget	1998-99 Initial Estimated Expenditures	Difference
Federal	$2,917.4	$2,827.9	($89.5)
State	$1,318.4	$1,291.9	($26.5)
County	$247.9	$243.6	($4.3)
Other Receipts	$38.6	$38.6	$0.0
Total	$4,522.3	$4,402.0	($120.3)

Notes: The initial 1998-99 estimated expenditures is based on the November expenditure report.

MEDICAL ASSISTANCE PAYMENTS

ELDERLY AND DISABLED EXPANSION

The 1998 General Assembly expanded full Medicaid eligibility to over 35,000 elderly and disabled persons with incomes at or below 1000% of the federal poverty level effective January 1, 1999. The estimated impact on the Medicaid budget is shown below. Since the expansion started in January, it is too early to tell whether the estimated impact of the expansion is accurate. Based on past experience, it usually takes 18 months to two years before the full impact of a Medicaid eligibility expansion is completed.

ESTIMATED IMPACT OF ELDERLY AND DISABLED EXPANSION

Description	1998-99	1999-00	2000-01	2001-02	2002-03
Federal	$54,194,645	$113,761,461	$122,966,116	$125,256,461	$131,201,192
State	$26,955,790	$57,097,624	$62,244,805	$64,343,031	$68,177,292
County	$4,756,904	$10,076,051	$10,309,949	$11,354,652	$12,031,287
Total	**$85,907,339**	**$180,935,136**	**$195,520,870**	**$200,954,144**	**$211,409,771**

MEDICAL ASSISTANCE PAYMENTS

INCREASES IN THE GOVERNOR'S RECOMMENDED BUDGET

Growth Factors (In Millions)	1999-00 Total Requirements	2000-01 Total Requirements
Inflation	$236.4	$267.2
Utilization	$126.7	$142.3
Intensity	$130.4	$31.1
Annualize Elderly & Disabled Expansion	$93.9	$20.5

MEDICAL ASSISTANCE PAYMENTS

GOVERNOR'S PROPOSED REDUCTIONS

Description	1999--00 GF	2000-01 GF
Revised Forecast	($19,096,115)	($30,070,813)
Reduced Inflation	($3,895,412)	($4,251,124)
Lower Utilization	($21,702,472)	($23,319,692)
Eliminate Intensity Increases	($24,180,718)	($26,058,464)
Drug Rebate Increase	($12,606,396)	($12,606,396)
Carolina Alternatives Adjustment	($2,500,000)	($2,500,000)
Reduced Administrative Overhead	($64,073)	($64,714)
Increase Transfer from Medicaid Trust Fund	($31,000,000)	($16,000,000)
Total Reductions**	**($115,045,187)**	**($114,871,203)**

** The Governor's proposed reduction for 2000-01 was $116.2 million, but the initial forecast with the reductions contained some errors. The $114.9 million reduction for 2000-01reflects the correction.

MEDICAL ASSISTANCE PAYMENTS

1998-99 REVISED ESTIMATE OF EXPENDITURES

Source of Funds (In Millions)	1998-99 Authorized Budget	1998-99 Revised Estimated Expenditures	Difference
Federal	$2,917.4	$2,780.4	($137.0)
State	$1,318.4	$1,270.8	($47.6)
County	$247.9	$239.6	($8.3)
Other Receipts	$38.6	$38.6	$0
Total	**$4,522.3**	**$4,329.4**	**($192.9)**

Notes: The revised 1998-99 estimated expenditures is based on the December expenditure report The revised forecast for 1998-99 reduced the 1999-00 recommended budget by $19.1 million and the 2000-01 recommended budget by $30.1 Million.

MEDICAL ASSISTANCE PAYMENTS

INFLATION ADJUSTMENTS

- Most provider's inflation rates were reduced by 20% in 1999-00 to more accurately reflect the estimated cost of providing the services..

- Inflation rates for hospitals and nursing homes were not reduced in 1999-00.

  - ✓ Hospitals received no inflation increase in 1997-98.
  - ✓ Nursing homes received a significantly lower inflation increase in 1997-98.
  - ✓ Estimating inflation for hospitals and nursing homes is more complicated because their rates are based on a market basket of services.
  - ✓ Medicaid growth reduction efforts and the elimination of the Boren amendment led to changes in hospital and nursing home inflation rates during 1997-98.

- Inflation rates for 2000-01 were not adjusted under the Governor's proposed reductions.

- Inflation for prescription drugs was increased from 9.67% in 1998-99 to 12.5% for 1999-00 and 2000-01.

MEDICAL ASSISTANCE PAYMENTS

INFLATION RATES

ACCOUNT	CATEGORY OF SERVICE	SFY 1998-99 PROJECTED INFLATION RATES	SFY 1999-00 PROJECTED INFLATION RATES	SFY 1999-00 ADJUSTED INFLATION RATES	SFY 2000-01 PROJECTED INFLATION RATES
536101	HOSP INPT-GENERAL	4.77%	4.80%	4.80%	4.80%
536102	HOSP INPT-SPECIALITY	4.77%	4.80%	4.80%	4.80%
536103	HOSP INPT-MTL, SO < 21	0.00%	0.00%	0.00%	0.00%
536104	HOSP OUTPT-MTL, SO <21	0.00%	0.00%	0.00%	0.00%
53610A	HOSP INPT-MTL, NSO < 21	4.77%	4.80%	4.80%	5.30%
53610B	HOSP INPT-MTL, NSO > 65	4.77%	4.80%	4.80%	5.30%
536106	HOSP INPT-MTL, SO > 65	0.00%	0.00%	0.00%	0.00%
536107	HOSP OUTPT-MTL, SO >65	0.00%	0.00%	0.00%	0.00%
536108	HOSP OUTPT-MTL, NSO	5.67%	4.30%	4.30%	4.30%
536109	LTC-SNF SO AND NSO	4.60%	4.15%	4.15%	5.15%
536110	LTC NF-SNF SWING BEDS	4.27%	4.15%	3.28%	5.15%
536111	LTC-ICF SO AND NSO	4.60%	4.15%	4.15%	5.15%
536112	LTC NF-ICF SWING BEDS	4.27%	4.15%	3.28%	5.15%
536113	LTC-ICF MRC, NSO	2.98%	3.50%	3.50%	3.70%
536114	LTC-ICF MRC, SO	0.00%	0.00%	0.00%	0.00%
536115	PHYSICIAN	3.17%	3.60%	2.85%	3.60%
536116	DENTAL	3.17%	3.60%	2.85%	3.60%
536117	OPTICAL SUPPLIES	3.67%	3.60%	2.85%	3.60%
536118	CHIROPRACTIC	3.17%	3.60%	2.85%	3.60%
536119	OPTICAL	3.17%	3.60%	2.85%	3.60%
536120	PODIATRY	3.17%	3.60%	2.85%	3.60%
536121	HOSP OUTPT-GENERAL	5.67%	5.50%	5.50%	5.50%
536122	HOSP OUTPT-SPECIALITY	5.67%	5.50%	5.50%	5.50%
536123	CLINICS-MENTAL HEALTH-FSO	5.67%	6.00%	4.74%	6.00%
536124	CLINICS-HEALTH DEPT	5.67%	6.00%	4.74%	6.00%
536125	CLINICS-FREE STANDING	5.67%	6.00%	4.74%	6.00%
536126	CLINICS-RURAL HEALTH	5.67%	6.00%	4.74%	6.00%
536128	LAB AND X-RAY	3.17%	3.60%	2.85%	3.60%
536129	LTC HOME HEALTH	3.17%	3.60%	2.85%	3.60%
536130	PRESCRIBED DRUGS	9.67%	12.50%	12.50%	12.50%
536132	FAMILY PLAN-STERILIZATION	4.77%	4.80%	3.80%	4.80%
536133	FAMILY PLAN-HOSP INPT	4.77%	4.80%	3.80%	4.80%
536134	FAMILY PLAN-HOSP OUTPT	5.67%	5.50%	4.35%	5.50%
536135	FAMILY PLAN-PHYSICIAN	3.17%	3.60%	2.85%	3.60%
536136	FAMILY PLAN-HEALTH DEPT	5.67%	6.00%	4.74%	6.00%
536137	FAMILY PLAN-FREE STANDING	5.67%	6.00%	4.74%	6.00%
536139	HEALTH CHECK-HEALTH DEPT	5.67%	6.00%	4.74%	6.00%
536140	PART B BUY-IN NON CASH	5.32%	5.25%	5.25%	5.25%
536141	PART B BUY-IN CAT NEEDY	5.32%	5.25%	5.25%	5.25%
536142	AMBULANCE	3.17%	3.60%	2.85%	3.60%
536143	HEARING AIDS	3.67%	4.00%	3.16%	4.00%
536144	LTC PERSONAL CARE	3.17%	3.50%	2.77%	3.50%
536146	HEALTH CHECK-RURAL HLTH CTR	5.67%	6.00%	4.74%	6.00%
536147	HEALTH CHECK-OTHER PROV	4.67%	5.00%	3.95%	5.00%
536148	FAMILY PLAN-RURAL HLTH CTR	5.67%	6.00%	4.74%	6.00%
536149	FAMILY PLAN-DRUGS	4.67%	12.50%	12.50%	12.50%

MEDICAL ASSISTANCE PAYMENTS

INFLATION RATES

ACCOUNT	CATEGORY OF SERVICE	SFY 1998-99 PROJECTED INFLATION RATES	SFY 1999-00 PROJECTED INFLATION RATES	SFY 1999-00 ADJUSTED INFLATION RATES	SFY 2000-01 PROJECTED INFLATION RATES
536151	CAROLINA ALT - MGD CARE	3.67%	4.00%	3.16%	4.00%
536152	HOSP INPT-LONG TERM CARE	4.77%	4.80%	4.80%	4.80%
536154	HOSP OUTPT-EMERGENCY ROOM	5.67%	6.00%	6.00%	6.00%
536155	LTC NF-HEAD LEVEL OF CARE	4.27%	4.15%	3.28%	5.15%
536156	HOSP INPT-GENERAL-XOVERS	4.77%	4.80%	4.80%	4.80%
536157	LTC NF-VENT LEVEL OF CARE	4.27%	4.15%	3.28%	5.15%
536158	HOSP OUTPT-GENERAL-XOVERS	5.67%	5.50%	5.50%	5.50%
536159	LTC CAP-DISABLED	3.07%	3.45%	2.73%	3.45%
536160	LTC CAP-MENTALLY RETARDED	3.07%	3.45%	2.73%	3.45%
536161	LTC CAP-CHILDREN	3.07%	3.45%	2.73%	3.45%
536162	CASE MANAGEMENT-FSO	3.17%	3.50%	2.77%	3.50%
536163	LOCAL EDUCATION AGENCIES-FSO	3.17%	3.50%	2.77%	3.50%
536165	DURABLE MED EQUIPMENT	3.67%	4.00%	3.16%	4.00%
536166	LTC NF-SNF SWING VENT CARE	4.27%	4.15%	3.28%	5.15%
536167	HOSP INPT-VENT CARE	4.77%	4.15%	4.15%	5.15%
536168	CLINICS-DHS IMMUNIZATIONS	5.67%	6.00%	4.74%	6.00%
536169	PHYSICAL MED-NON PHYSICIAN	3.17%	3.60%	2.85%	3.60%
536170	HMO PREMIUMS	5.67%	5.00%	3.95%	5.00%
536171	HOME INFUSION THERAPY	3.17%	3.60%	2.85%	3.60%
536172	HOSPICE	4.77%	5.00%	3.95%	5.00%
536173	PART A MEDICARE SUB-TOTAL	9.61%	7.21%	5.70%	7.21%
536174	PART B BUY-IN MQBQ	7.00%	5.25%	5.25%	5.25%
536175	PART B BUY-IN DUAL Q	7.00%	5.25%	5.25%	5.25%
53617A	PART B BUY-IN MQBB	7.00%	5.25%	5.25%	5.25%
53617B	PART B BUY-IN DUAL B	7.00%	5.25%	5.25%	5.25%
536177	CLINICS-FQHC, CORE & AMBULATO	5.67%	6.00%	4.74%	6.00%
536178	FAMILY PLANNING-FQHC	5.67%	6.00%	4.74%	6.00%
536179	HEALTH CHECK-FQHC	5.67%	6.00%	4.74%	6.00%
53618A	LTC ACF - PCS BASIC	3.17%	3.50%	2.77%	3.50%
53618D	LTC ACF - PCS BASIC/EATING ASS	3.17%	3.50%	2.77%	3.50%
53618E	LTC ACF - PCS BASIC/TOILET ASSI	3.17%	3.50%	2.77%	3.50%
53618F	LTC ACF - PCS BASIC/EATING/TOIL	3.17%	3.50%	2.77%	3.50%
53618G	CAP AIDS	3.07%	3.60%	2.85%	3.60%
53618H	HIV CASE MANAGEMENT	4.67%	3.60%	2.85%	3.60%
536180	HEAD START	0.00%	3.60%	2.85%	3.60%
536181	HOSP INPT-INDIAN HEALTH	4.77%	4.80%	4.80%	4.80%
536182	HOSP OUTPT-INDIAN HEALTH	5.67%	5.50%	5.50%	5.50%
536183	NF-INDIAN HEALTH	4.27%	4.15%	3.28%	5.15%
536186	HOME HEALTH-INDIAN HEALTH	3.17%	3.60%	2.85%	3.60%
536187	AMBULATORY SURG CENTER	4.77%	5.50%	4.35%	5.50%
536188	TRANSPORTATION-CNTY ADMIN	3.17%	3.50%	2.77%	3.50%
536189	ACF-TRANSPORTATION	3.17%	3.50%	2.77%	3.50%
536194	EDS-A/R INELIGIB CLAIMS	0.00%	0.00%	0.00%	0.00%
536195	PART B BUY-IN MQBE	0.00%	0.00%	0.00%	0.00%
536196	INDO-CHINESE MED ASS'T	0.00%	0.00%	0.00%	0.00%

MEDICAL ASSISTANCE PAYMENTS

AVERAGE MONTHLY ELIGIBLES

1990-91 TO 2000-01

Fiscal Year	Average Monthly Eligible
1990-91	467,925
1991-92	573,140
1992-93	657,649
1993-94	715,234
1994-95	773,680
1995-96	814,875
1996-97	826,250
1997-98	821,111
1998-99 est.	813,684
1999-00 est.	842,573
2000-01 est.	892,206

MEDICAL ASSISTANCE PAYMENTS

AVERAGE MONTHLY ELIGIBLES

INITIAL VS. REVISED ESTIMATES

Fiscal Year	Initial Estimate	Revised Estimate	Percent Change
1996-97	832,612	826,250	-0.8%
1997-98	867,013	821,111	-5.3%
1998-99	878,510	813,684	-7.4%
1999-00	924,541	842,573	-8.7%
2000-01	967,153	892,206	-7.7%

MEDICAL ASSISTANCE PAYMENTS

PROJECTION OF WORK FIRST UTILIZATION RATES

Work First Eligible Forecast	1998-99	1999-00	2000-01
April 1997 Estimate	323,973	323,973	323,973
March 1998 Estimate	270,793	270,793	270,793
April 1998 Estimate	255,124	270,793	270,793
October 1998 Estimate	245,305	247,758	250,235
January 1999 Estimate	245,305	215,150	217,302
Percent Change	-24.3%	-33.6%	-32.9%

Notes: Revising the average monthly eligibles estimate for Work First reduced the 1999-00 recommended budget by $21.7 million and the 2000-01 recommended budget by $23.3 million.

MEDICAL ASSISTANCE PAYMENTS

1999-2001 ESTIMATED UTILIZATION INCREASES

Category of Eligible	1999-00 Utilization Rate	1999-00 Average Monthly Eligibles	2000-01 Utilization Rate	2000-01 Average Monthly Eligibles
Aged	22.4%	126,627	1.5%	128,526
Blind	0.0%	2,266	0.0%	2,266
Disabled	5.6%	158,813	3.0%	163,585
Work First	(12.3%)	215,150	1.0%	217,302
Other Children	2.5%	3,032	2.5%	3,108
Pregnant Women	5.5%	25,053	5.5%	26,441
MIC Children	13.0%	274,345	13.0%	310,010
MQBQ	(57.6%)	16,864	0.1%	16,881
MQBB	18.0%	20,413	18.0%	24,087

MEDICAL ASSISTANCE PAYMENTS
INTENSITY CHANGES
TOTAL REQUIREMENTS (IN MILLIONS)

Description	Initial 1999-00	Revised 1999-00	Initial 2000-01	Revised 2000-01
Physicians	$11,269,051	$0	$0	$0
Dental	$22,635,196	$0	$0	$0
CAP-Disabled	$55,205,543	$17,674,047	$31,142,730	$0
CAP-MR/DD	$32,709,926	$30,846,443	$0	$0
CAP-Children	$8,593,959	$4,984,016	$0	$0
Total Intensity	$130,413,675	$53,504,506	$31,142,730	$0

Notes: Eliminating and reducing intensity changes reduced the 1999-00 recommended General Fund budget by $24.2 million and the 2000-01 recommended General Fund Budget by $26.1 million.

MEDICAL ASSISTANCE PAYMENTS

INTENSITY CHANGES

Physicians: DMA was proposing to increase physician fees to 100% of Medicare fees. Increase was eliminated in the revised budget.

Dental: DMA was proposing to make further increases in fees for dental services. Increase was eliminated in the revised budget.

CAP-Disabled: DMA proposed serving an average of 9,405 slots each month at an annual cost of $23,000 per slot. The original proposal was revised to an average of 8,472 slots each month at an annual cost of $20,664 per slot.

CAP-MR/DD: DMA proposed serving 5,527 slots at an annual cost of $31,123 per slot. The original proposal was revised to 5,332 slots at the same annual cost.

CAP-Children: DMA proposed serving 330 slots at an annual cost of $60,000 per slot. The original proposal was revised to 273 slots at an annual cost of $58,632 per slot.

MEDICAL ASSISTANCE PAYMENTS

WHAT IS THE DRUG REBATE PROGRAM?

- The Medicaid Drug Rebate Program was created by the OBRA 1990, and it requires drug manufacturers to enter into a national drug rebate agreement with the U.S. Department of Health and Human Services for states receiving federal funds to pay for outpatient drugs dispensed to Medicaid patients. Over 500 pharmaceutical companies participate in the program.

- To participate in the program, a state must have an open formulary which allows any prescribed drug to be dispensed and paid for by Medicaid.

- The Division of Medical Assistance is receiving about an 18% rebate on prescription drug expenditures through its participation in the drug rebate program. The state share of these recoveries has been transferred to the Medicaid program and used to reduce state appropriations.

- Projected expenditures for prescription drugs for the next biennium are expected to increase 15% for 1999-00 and an additional 15% for 2000-01. The higher expenditures will increase the general fund share of the drug rebate recovery by $12.6 million in 1999-00 and $18.3 million in 2000-01.

- The Governor proposes increasing the transfer from drug rebates by $12.6 million in 1999-00 and 2000-01and reducing state appropriations for Medicaid by the same amount.

MEDICAL ASSISTANCE PAYMENTS

HISTORY OF DRUG REBATE PROGRAM

Fiscal Year	Drug Rebate Recovery	Program Support
1993-94	$38,695,114	$6,434,405
1994-95	$41,039,657	$6,738,984
1995-96	$39,222,161	$11,022,700
1996-97	$76,458,308	$14,423,755
1997-98	$86,475,994	$22,397,512
1998-99 est	$95,396,739	$25,508,815
1999-00 est.	$120,273,979	$37,810,602
2000-01 est.	$120,273,979	$37,810,602

DISPROPORTIONATE SHARE HOSPITALS

BACKGROUND INFORMATION

- Disproportionate Share Hospital (DSH) payments are allowed by federal law to help cover the costs of hospitals which have a disproportionate share of patients with little or no insurance.

- 1997 federal law set DSH allotments for N.C. through 2002. The 1998 allotment is $278 million and declines each year to $236 million in 2002. Even though N.C.'s allotment declines, DSH payments are projected to remain stable at $85 to $105 million per year through 2002.

- North Carolina earns DSH payments by making payments to the five state hospitals for uninsured care by using state appropriations in the Medicaid budget to provide the nonfederal match.

- The federal share of the DSH payments is usually deposited as nontax revenue and is included in the revenue estimates for each fiscal year.

- The 1998-99 DSH payment is $105 million -- the highest payment N.C. can receive. The governor's budget assumes that DSH payments will continue at the $105 million level during the 1999-2001 biennium.

DISPROPORTIONATE SHARE HOSPITALS

Payments to State Hospitals

Fiscal Year	Payments
1991-92	$37,000,000
1992-93	$159,000,000
1993-94	$303,000,000
1994-95	$96,000,000
1995-96	$78,000,000
1996-97	$90,000,000
1997-98	$97,000,000
1998-99	$105,000,000
1999-00 est.	$105,000,000
2000-01 est.	$105,000,000

NOTE: DSH stands for Disproportionate Share Hospitals

MEDICAID TRUST FUND

BACKGROUND INFORMATION

- G.S. 143-23(a) of the Executive Budget Act allows public and private hospitals to transfer a portion of federal revenues to the Department of Human Resources for the Medicaid program. The Medicaid Trust Fund receives these funds.

- The Medicaid Trust Fund can only be used to benefit the Medicaid program and cannot be used to reduce state general fund revenues.

- The Medicaid Trust Fund does not revert to the General Fund, but these funds can be allocated as provided in the current appropriations act.

DISPROPORTIONATE SHARE HOSPITALS

Payments to Non-State Hospitals

Fiscal Year	Medicaid Trust Fund	Hospital Payments
1995-96	$50,000,000	$88,000,000
1996-97	$35,000,000	$174,000,000
1997-98	$40,000,000	$166,000,000
1998-99	$29,000,000	$170,000,000
Total	$154,000,000	$598,000,000

MEDICAID TRUST FUND

RECURRING OR NONRECURRING?

- The Division of Medical Assistance has been successful for the past four federal fiscal years in working with non-state public hospitals to draw down additional DSH payments.

- The federal law for DSH payments has stabilized and allotments have been set through federal fiscal year 2001-2002. Federal actions after 2002 are uncertain.

- The Division of Medical Assistance must negotiate with non-state public hospitals to continue these DSH payments in future years since $13 million of the Medicaid budget is now supported by these receipts.

- The Division of Medical Assistance needs public hospitals to draw down DSH payments. The number of public hospitals in N.C. is declining and this decline may have an impact on the amount of additional DSH payments the state can receive

MEDICAID TRUST FUND

OPTIONS FOR USING THE FUND

- The governor has proposed increasing the $13 million transfer from the Medicaid Trust Fund to support Medicaid program expenditures and reduce the need for state appropriations by $31 million in 1999-00 and $16 million in 2000-01. His proposed budget continues to recommend that the Medicaid Trust Fund maintain a minimum balance of $100 million to meet unanticipated future Medicaid needs.

- The Governor's proposal assumes that payments into the Medicaid Trust Fund will continue at the $29 million level during the biennium. If the payment level drops below $29 million then the trust fund balance will fall below $100 million.

- Other options for using the Medicaid Trust Fund are as follows:

  - ✓ A Medicaid Rainy Day Fund which can be used when Medicaid expenditures grow unexpectedly due to a recession or other causes
  - ✓ Cash flow for establishing capitated managed care programs
  - ✓ Nonrecurring Medicaid expenditures such as automation improvements
  - ✓ Cost settlements
  - ✓ Other activities which benefit the Medicaid program

MEDICAL ASSISTANCE PAYMENTS

IMPACT OF GOVERNOR'S PROPOSED REDUCTIONS

- The proposed reductions do not impact Medicaid eligibility or the level of services provided Medicaid recipients.

- The proposed reductions do impact the normal cost increases provided under the Medicaid program by reducing inflation for some services and more accurately predicting the cost of these services.

- The proposed reductions eliminate any major policy changes such as increasing physician and dental rates or limits the number of CAP slots available to the number budgeted in 1997-98.

- The proposed reductions realistically adjust utilization rates to reflect the decreases in the Work First population.

- The proposed increase in drug rebate recovery is based on the growing expenditures for prescription drugs.

- The proposed increased transfer from the Medicaid Trust Fund equals the expected payments into the trust fund.

MEDICAL ASSISTANCE PAYMENTS
1999-2001 CONTINUATION BUDGET (FUND 1310)
COMPARISON OF INITIAL VS. FINAL ESTIMATE

Governor's Original Budget for fund 1310

Description	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Total Requirements	$4,106,345,838	$4,522,263,830	$4,989,414,497	$5,450,048,606
Estimated Receipts	($3,094,692,285)	($3,204,016,887)	($3,508,734,078)	($3,818,716,688)
Net Appropriation	$1,011,653,553	$1,318,246,943	$1,480,680,419	$1,631,331,918

Governor's Revised Budget for Fund 1310

Description	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Total Requirements	$4,106,345,838	$4,522,263,830	$4,755,796,914	$5,160,867,908
Estimated Receipts	($3,094,692,285)	($3,204,016,887)	($3,389,897,138)	($3,645,658,276)
Net Appropriation	$1,011,653,553	$1,318,246,943	$1,365,899,777	$1,515,209,632

MEDICAID PROGRAM

OTHER ISSUES

- New Forecast Based on March Expenditures
- Federal Financial Participation Rate Decrease
- Medicaid Growth Reduction Final Report
- Federal Revenue Maximization

FEDERAL FINANCIAL PARTICIPATION RATE

IMPACT OF RATE DECREASES

- The Federal Financial Participation (FFP) Rate determines the federal share of the Medicaid program. The rate is based on the relationship between each state's per capita personal income and that of the nation as a whole. The 2000 federal share is calculated using per capita income data for 1995-97.

- Since N.C.'s per capita income has increased significantly in recent years, the state's FFP rate has declined. The rate has decreased from 68.01% for federal fiscal year 1989 to 62.49% for federal fiscal year 2000 -- an 8.1% decrease in eleven years.

- The Division of Medical Assistance estimates how much the state's FFP rate will decline based on historical trends during budget forecasting, but the rate of change is difficult to predict.

- The FFP rate for state fiscal year 1997-98 decreased .85%. This decline resulted in an $19 million increase in state appropriations. The estimated FFP rate for state fiscal year 1998-99 only decreased .34%. This lower decline resulted in an $14 million decrease in state appropriations.

- The final FFP rate for state fiscal year 1999-00 decreased .7%. The budget forecast for 1999-00 assumed the FFP rate would decrease .33%. The additional decline results in a **$9.3 million increase in state appropriations which are not included in the Governor's recommended budget.**

MEDICAID GROWTH REDUCTION
FINAL REPORT

- The 1997 General Assembly, at the Governor's recommendation, established a goal to reduce the annual growth in Medicaid spending to 8% by the year 2001.

- Medicaid growth has slowed significantly during the past three years. Appropriations growth slowed to 3.4% in 1997-98 and appropriations for 1998-99 are projected to be below the growth target.

- The slowed growth has occurred due to the following factors:

  - ✓ Growth in eligibles has been stable for most groups and Work First has decreased significantly.
  - ✓ Low medical cost inflation
  - ✓ Managed Care
  - ✓ Limited modifications to rate setting methodologies

- The Governor's revised budget projections for 1999-00 and 2000-01 are also below the growth reduction targets which were set by the 1997 General Assembly -- including the expanded eligibility for the elderly and disabled.

Fiscal Year (In Millions)	Appropriations Budget Target	Projected State Appropriations
1998-99	$1,389.0	$1,307.3
1999-00	$1,507.1	$1,406.4
2000-01	$1,627.6	$1,557.7

FEDERAL REVENUE MAXIMIZATION

A SUCCESS STORY FOR N.C.!

- North Carolina has successfully maximized the receipt of federal funds by using its Medicaid program to pay for services previously covered through 100% state or local funding.

  - ✓ Intermediate Care Facilities for the Mentally Retarded
  - ✓ Thomas S program
  - ✓ Willie M program
  - ✓ Adult Care Home Personal Care Services
  - ✓ DSH Payments
  - ✓ Health Departments & Area Mental Health Programs

- North Carolina has also been successful at using its Medicaid program to provide health care to uninsured persons by expanding eligibility to optional categories of people.

  - ✓ Pregnant Women to 185% of FPL
  - ✓ Recipients of State/County Special Assistance
  - ✓ Medically Needy persons
  - ✓ Aged, Blind, and Disabled Persons With Non-SSI Income to 100% of the FPL

WHAT IS THE GOAL OF NORTH CAROLINA'S MEDICAID PROGRAM?

COST CONTAINMENT
OR
FEDERAL
REVENUE MAXIMIZATION
???

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-7 **, 1999**

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JACK McGEE	MARCH OF DIMES
Patricia A. Yancey	APPCNC/SCSL
[illegible]	OSBM
Barbara Matula	NCMS Foundation
Mari Smith	GlaxoWellcome
HUGH TILSON	NCHA
Janet Simonsen	NC Council
LANDA TEFFT	OSBM
NELS ROSELAND	OSBM
Gé Broyden	NC DHHS
Mark Benton	"
Albert Gambell	Div of Medical Asst.
R. Perry	DMA
Jim Elgert	DHHS
Dave Bruton	DHHS
Helen Lipman	Meck CoDSS
Wayne Williams	OSBM
Bryant Edgerton	Easter Seals NC
Peg Rumaneus	[illegible]
Stacy Flannery	NCHCFA
Evelyn Hawthorne	UNC·CH
Jim Hubert	NC Food Banks
Ron Aycock	NC Co. Com Assoc
RICHARD COBB	DIV OF MEDICAL ASSISTANCE
Roslyn Savitt	NC Child Care Coalition
Lou Wilds	LOCALTC 2
Johnny Worth	Carolina Health Care Sys. Inc
[illegible]	NC Equity

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4·7, **1999**

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Adam Searing	NCHAC
Megan Primavera	NCACDSS
Will [illegible]	AHHC
[illegible]	NCMS
Kim Carlton	NC BTC

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
April 7, 1999
2:30 P.M.

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Wednesday, April 7, 1999, in Room 424 of the Legislative Office Building.

House Chairman, Representative Edd Nye presided. Other House members present were Representative Beverly Earle (Co-Chairman), Representative Alma Adams, Representative Lanier Cansler, Representative Theresa Esposito, Representative Trudi Walend, and Representative Gene Wilson. There were six senators present.

Chairman Nye introduced the Pages serving the committee and then asked Ms. Carol Shaw, Fiscal Research Division, to continue with the agenda from the morning meeting. She discussed the changes as they relate to number of people using Medicaid, stating it has been hard the last couple of years to estimate average monthly number of people on Medicaid. She stated Work First is on target. Senator Ferrester asked for figures on TANF Block Grant money and Ms. Shaw will get those for him. Senator Martin expressed concern in making utilization estimates; stating negative downturns aren't taken into effect. He asked if there are ways in which the Department plans impact of downturn economy. Ms. Shaw stated negative downturn in economy isn't taken into account. Medicaid is a lagging indicator. Dr. Bruton suggests discussion of this later.

Department staff stated seventy percent of patients in nursing homes are receiving Medicaid and that if thirty percent are on Medicare, they can turn a small profit. Changes federal government is making in Medicare will effect Medicaid.

Ms. Shaw continued her presentation with a discussion in intensity changes stating the State Budget Division said they do not want to make any changes. After questions from the committee, Chairman Nye ended the meeting.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbitt
Committee Assistant

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-7 **, 1999**

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
P. Perruzzi	DMA · DHHS
Allen Daniell	Div of Medical Asst.
Mark Benton	DHHS
NELS ROSELAND	OSBM
RICHARD H. COBB	DMA
Mary Jane Ferrell	NCNA
[illegible]	NCNA
Bryant Edgerton	Easter Seals NC
[illegible]	[illegible]
Soren Schmidt	NC Justice Center
Megan Primavera	NC County DSS Directors Assn
Stacy Flannery	NCHCFA
Hugh Tilson	NCHA
CRAIG SOUZA	NCHCFA
Barbara Matula	NCMS-F
Lou B. Wilson	NCA&TC7
Jim [illegible]	DHHS
Dave Benton	DHHS
JACK McCEE	MARCH OF DIMES
[illegible]	OSBM
Anna Teeft	OSBM
Wayne Williams	OSBM
Mar [illegible]	[illegible]

Joint Subcommittee on Health and Human Services Appropriations

Legislative Office Building – Room 424
Thursday, April 8, 1999
8:30 a.m.

Opening Remarks	Sen. Bill Martin, Co-Chair Rep. Beverly Earle, Co-Chair Rep. Edd Nye, Co-Chair
Division of Medical Assistance 1999-2001 Budget Medicaid Program Overview	Carol Shaw Fiscal Research Division
Adjourn	

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

MINUTES
APRIL 8, 1999
8:30

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Thursday, April 8, 1999, at 8:30 a.m. in Room 424 on the Legislative Office Building.

House Co-Chair, Representative Beverly Earle presided. Other House members present were:

Representative Edd Nye, Co-Chair
Representative Martha Alexander, Vice Chair
Representative Alma Adams
Representative Lanier Cansler
Representative Trudi Walend
Representative Gene Wilson

Five Senate members were present.

Representative Beverly Earle called the meeting to order at 8:30. Pages were introduced and the meeting began with Carol Shaw, of the Fiscal Research Division to continue her presentation on the Medicaid Program. (See Attachment III) She gave background information of the Medicaid Trust Funds. She explained the major programs under the division of Medical Assistance, such as, Financial Operations, Medical Policy, Information Services and Program Integrity. She also explained the different options for using the Medicaid Fund. (See Attachment II)

Carol Shaw informed the committee of a success story for North Carolina. North Carolina has successfully maximized the receipt of federal funds by using its Medicaid program to pay for services previously covered through 100% state or local funding. North Carolina has also been successful at using its Medicaid program to provide health care to uninsured persons by expanding eligibility to optional categories of people.
(See Attachment II)

After completion on the overview, Ms. Shaw received comments and/or questions concerning the Medicaid Program. Responding to questions were Carol Shaw and Dr. Bruton, Secretary of Health and Human Services.

The meeting adjourned at 9:45 a.m.

Respectfully submitted,

Presiding Co-Chair, Representative Beverly Earle

Ann Raeford, Committee Clerk

Attachment I	Agenda
Attachment II	Division of Medical Assistance 1999-2001 Budget
Attachment III	Medicaid Overview
Attachment IV	Visitor Registration

Attachment II

DEPARTMENT OF HEALTH & HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE

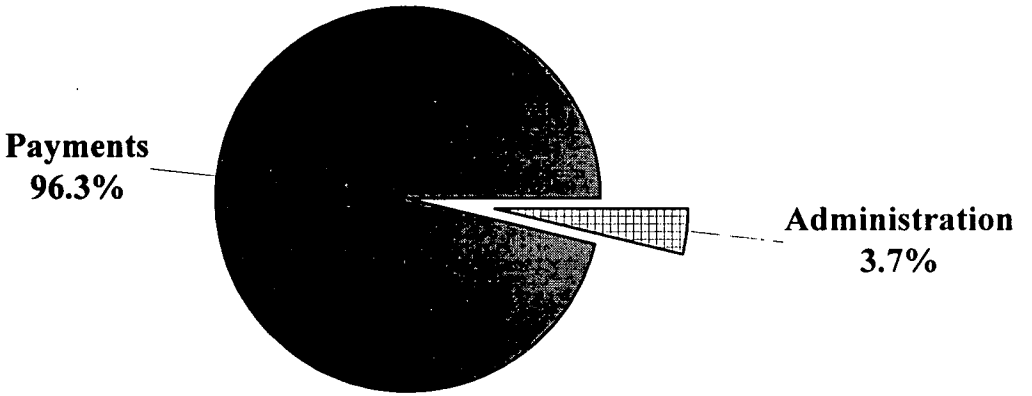
1999-2001 BUDGET

FISCAL RESEARCH DIVISION
April 1999

DIVISION OF MEDICAL ASSISTANCE

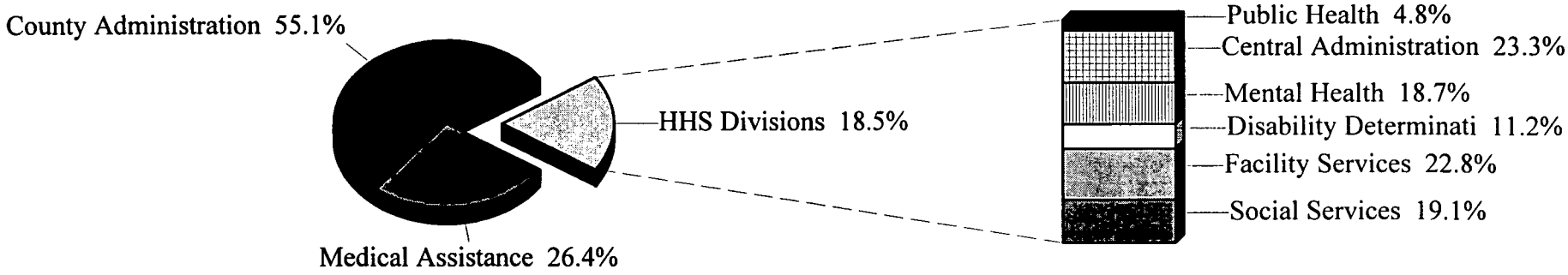
1999-2001 CONTINUATION BUDGET

Description	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Total Requirements	$4,834,428,976	$4,655,633,030	$5,128,671,652	$5,590,566,938
Estimated Receipts	($3,694,772,173)	($3,300,703,393)	($3,607,181,891)	($3,918,000,650)
Net Appropriation	$1,139,656,803	$1,354,929,637	$1,521,489,761	$1,672,566,288
Total Number of Positions	348	348	348	348



DIVISION OF MEDICAL ASSISTANCE
FUNDING FOR MEDICAID ADMINISTRATION

HHS Division	1998-99 Total Requirements	1998-99 General Fund
Medical Assistance	$45,085,825	$18,491,272
Social Services	$6,070,159	$2,936,248
County Administration	$94,142,197	$3,130,082
Facility Services	$7,230,555	$3,656,496
Mental Health	$5,924,733	$2,641,520
Disability Determination	$3,544,058	$1,772,013
Public Health	$1,535,238	$696,630
Central Administration	$7,398,916	$3,699,458
Total	**$170,930,681**	**$37,023,719**



DIVISION OF MEDICAL ASSISTANCE

MEDICAID ADMINISTRATION BY PROGRAM

Medical Assistance: Supports the overall management and oversight of the Medicaid program.

Social Services: Based on the approved cost allocation plan, supports a portion of the state level administration including the director's office, hearing officers, and other administrative activities in the division related to the Medicaid program.

County Administration: Supports eligibility determination staff, Carolina ACCESS coordinators, adult care home case management, medical transportation, Adolescent Parenting Program, and a portion of the overhead costs in county departments of social services.

Facility Services: Supports licensing and certification staff that regulate health care facilities certified to provided Medicaid/Medicare services.

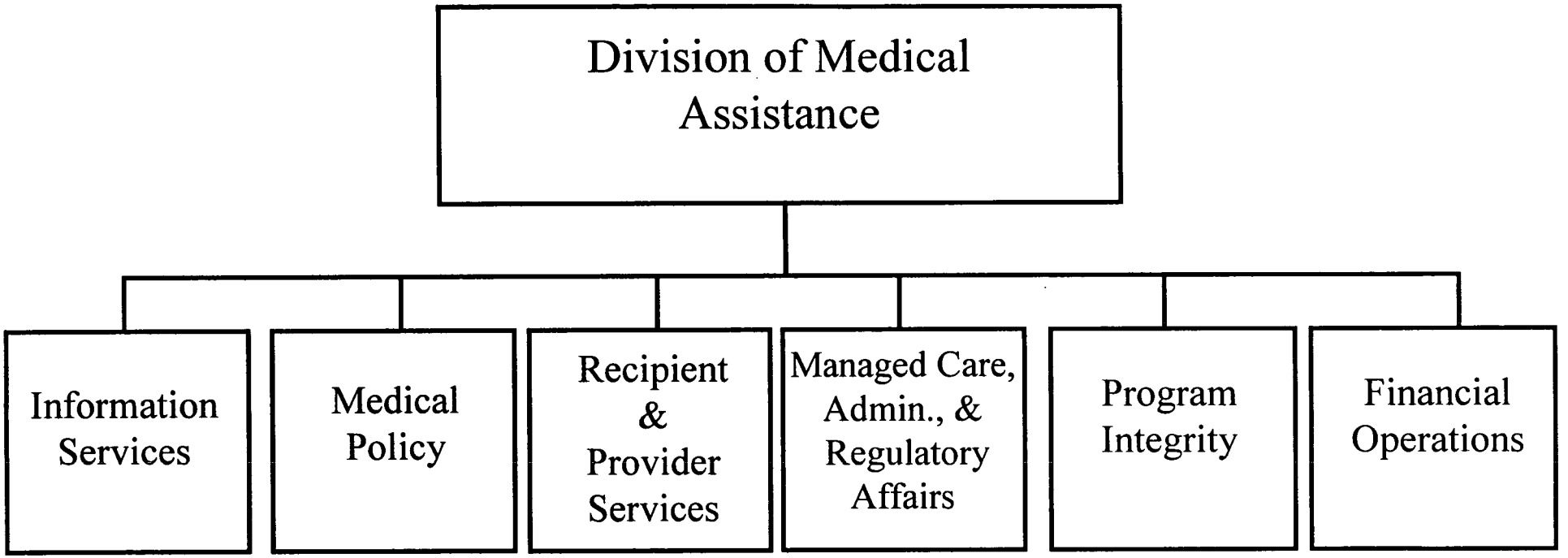
Mental Health: Supports administrative staff in the Willie M program, the Thomas S program, CAP-MR/DD program, MR Centers, and other administrative activities in the division related to the Medicaid program.

Disability Determination: Supports staff that determine Medicaid eligibility for disabled adults and covers the expense of physicians who are asked to provide a medical opinion.

Public Health: Supports staff in the CAP-AIDS program, the child and maternal health programs, the Adolescent Parenting Program, the Medicaid Reimbursement Unit, and the Public Health Training and Information Network.

Central Administration: Based on an approved cost allocation plan, supports staff in the following programs: Mailroom and Receiving Section, HHS Controller's Office, Office of Citizen Services, Information System Services, and the Office of Rural Health and Development.

DIVISION OF MEDICAL ASSISTANCE
ORGANIZATION



Total Positions - 348

DIVISION OF MEDICAL ASSISTANCE

MAJOR PROGRAMS

Financial Operations: This section is responsible for reimbursement policy, budgeting, audit policy, contracts accounting, rate setting and financial reporting.

Managed Care, Administration, & Regulatory Affairs: This section is responsible for the development, operation and oversight of DMA's managed care initiatives. This section also oversees rulemaking and the hearing process related to services.

Recipient & Provider Services: This section is responsible for developing and implementing eligibility policies, assuring that qualified medical providers are enrolled in the Medicaid program, and assuring that claims processing for providers meets their needs.

Medical Policy: This section is responsible for structuring the medical benefits and service coverage available to Medicaid clients that promotes access to medically appropriate and cost effective health care.

Information Services: This section is responsible for procurement, implementation, and contract oversight of automation and information services for DMA including the Decision Support System, and the Medicaid Management Information System.

Program Integrity: This section is responsible for identifying and recovering overpayments to providers of health services and Medicaid recipients occurring due to error, abuse or fraud. This section also assures that third party payments are applied prior to Medicaid payment or recovered after payment.

DIVISION OF MEDICAL ASSISTANCE

STAFFING BY PROGRAM

Program	Number of Staff	New Positions
Director's Office	8	2
Financial Operations	54	13
Managed Care, Admin., & Regulatory Affairs	43	5
Recipient & Provider Services	59	5
Medical Policy	59	14
Program Integrity	90	11
Information Services	35	13
Total Positions	**348**	**63**

MEDICAL ASSISTANCE PAYMENTS

1999-2001 CONTINUATION BUDGET (Fund 1310)

Description	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Total Requirements	$4,106,345,838	$4,522,263,830	$4,989,414,497	$5,450,048,606
Estimated Receipts	($3,094,692,285)	($3,204,016,887)	($3,508,734,078)	($3,818,716,688)
Net Appropriation	$1,011,653,553	$1,318,246,943	$1,480,680,419	$1,631,331,918

The Medical Assistance Payment Fund budgets the payments to the providers of medical and other services for Medicaid recipients. Payments to providers represent 96.3% of the total budget for the Division of Medical Assistance.

The recommended budget does not include the Governor's proposed reductions.

MEDICAL ASSISTANCE PAYMENTS

INCREASES IN THE RECOMMENDED BUDGET

(In Millions)

Description	1999-00 Increase	2000-01 Increase
Total Requirements	$467.1	$460.7
Estimated Receipts	($304.6)	($310.1)
Net Appropriation	$162.5	$150.6

Notes: The 1999-00 increase is the difference between 1998-99 Authorized Budget and the 1999-00 Recommended Budget. The 2000-01 increase is the difference between he 1999-00 Recommended Budget and the 2000-01 Budget.

MEDICAL ASSISTANCE PAYMENTS

1998-99 INITIAL ESTIMATE OF EXPENDITURES

(In Millions)

Source of Funds (In Millions)	1998-99 Authorized Budget	1998-99 Initial Estimated Expenditures	Difference
Federal	$2,917.4	$2,827.9	($89.5)
State	$1,318.4	$1,291.9	($26.5)
County	$247.9	$243.6	($4.3)
Other Receipts	$38.6	$38.6	$0.0
Total	$4,522.3	$4,402.0	($120.3)

Notes: The initial 1998-99 estimated expenditures is based on the November expenditure report.

MEDICAL ASSISTANCE PAYMENTS

ELDERLY AND DISABLED EXPANSION

The 1998 General Assembly expanded full Medicaid eligibility to over 35,000 elderly and disabled persons with incomes at or below 1000% of the federal poverty level effective January 1, 1999. The estimated impact on the Medicaid budget is shown below. Since the expansion started in January, it is too early to tell whether the estimated impact of the expansion is accurate. Based on past experience, it usually takes 18 months to two years before the full impact of a Medicaid eligibility expansion is completed.

ESTIMATED IMPACT OF ELDERLY AND DISABLED EXPANSION

Description	1998-99	1999-00	2000-01	2001-02	2002-03
Federal	$54,194,645	$113,761,461	$122,966,116	$125,256,461	$131,201,192
State	$26,955,790	$57,097,624	$62,244,805	$64,343,031	$68,177,292
County	$4,756,904	$10,076,051	$10,309,949	$11,354,652	$12,031,287
Total	**$85,907,339**	**$180,935,136**	**$195,520,870**	**$200,954,144**	**$211,409,771**

MEDICAL ASSISTANCE PAYMENTS

INCREASES IN THE GOVERNOR'S RECOMMENDED BUDGET

Growth Factors (In Millions)	1999-00 Total Requirements	2000-01 Total Requirements
Inflation	$236.4	$267.2
Utilization	$126.7	$142.3
Intensity	$130.4	$31.1
Annualize Elderly & Disabled Expansion	$93.9	$20.5

MEDICAL ASSISTANCE PAYMENTS

GOVERNOR'S PROPOSED REDUCTIONS

Description	1999--00 GF	2000-01 GF
Revised Forecast	($19,096,115)	($30,070,813)
Reduced Inflation	($3,895,412)	($4,251,124)
Lower Utilization	($21,702,472)	($23,319,692)
Eliminate Intensity Increases	($24,180,718)	($26,058,464)
Drug Rebate Increase	($12,606,396)	($12,606,396)
Carolina Alternatives Adjustment	($2,500,000)	($2,500,000)
Reduced Administrative Overhead	($64,073)	($64,714)
Increase Transfer from Medicaid Trust Fund	($31,000,000)	($16,000,000)
Total Reductions**	**($115,045,187)**	**($114,871,203)**

** The Governor's proposed reduction for 2000-01 was $116.2 million, but the initial forecast with the reductions contained some errors. The $114.9 million reduction for 2000-01reflects the correction.

MEDICAL ASSISTANCE PAYMENTS

1998-99 REVISED ESTIMATE OF EXPENDITURES

Source of Funds (In Millions)	1998-99 Authorized Budget	1998-99 Revised Estimated Expenditures	Difference
Federal	$2,917.4	$2,780.4	($137.0)
State	$1,318.4	$1,270.8	($47.6)
County	$247.9	$239.6	($8.3)
Other Receipts	$38.6	$38.6	$0
Total	**$4,522.3**	**$4,329.4**	**($192.9)**

Notes: The revised 1998-99 estimated expenditures is based on the December expenditure report The revised forecast for 1998-99 reduced the 1999-00 recommended budget by $19.1 million and the 2000-01 recommended budget by $30.1 Million.

MEDICAL ASSISTANCE PAYMENTS

INFLATION ADJUSTMENTS

- Most provider's inflation rates were reduced by 20% in 1999-00 to more accurately reflect the estimated cost of providing the services..

- Inflation rates for hospitals and nursing homes were not reduced in 1999-00.

  - ✓ Hospitals received no inflation increase in 1997-98.
  - ✓ Nursing homes received a significantly lower inflation increase in 1997-98.
  - ✓ Estimating inflation for hospitals and nursing homes is more complicated because their rates are based on a market basket of services.
  - ✓ Medicaid growth reduction efforts and the elimination of the Boren amendment led to changes in hospital and nursing home inflation rates during 1997-98.

- Inflation rates for 2000-01 were not adjusted under the Governor's proposed reductions.

- Inflation for prescription drugs was increased from 9.67% in 1998-99 to 12.5% for 1999-00 and 2000-01.

MEDICAL ASSISTANCE PAYMENTS

INFLATION RATES

ACCOUNT	CATEGORY OF SERVICE	SFY 1998-99 PROJECTED INFLATION RATES	SFY 1999-00 PROJECTED INFLATION RATES	SFY 1999-00 ADJUSTED INFLATION RATES	SFY 2000-01 PROJECTED INFLATION RATES
536101	HOSP INPT-GENERAL	4.77%	4.80%	4.80%	4.80%
536102	HOSP INPT-SPECIALITY	4.77%	4.80%	4.80%	4.80%
536103	HOSP INPT-MTL, SO < 21	0.00%	0.00%	0.00%	0.00%
536104	HOSP OUTPT-MTL, SO <21	0.00%	0.00%	0.00%	0.00%
53610A	HOSP INPT-MTL, NSO < 21	4.77%	4.80%	4.80%	5.30%
53610B	HOSP INPT-MTL, NSO > 65	4.77%	4.80%	4.80%	5.30%
536106	HOSP INPT-MTL, SO > 65	0.00%	0.00%	0.00%	0.00%
536107	HOSP OUTPT-MTL, SO >65	0.00%	0.00%	0.00%	0.00%
536108	HOSP OUTPT-MTL, NSO	5.67%	4.30%	4.30%	4.30%
536109	LTC-SNF SO AND NSO	4.60%	4.15%	4.15%	5.15%
536110	LTC NF-SNF SWING BEDS	4.27%	4.15%	3.28%	5.15%
536111	LTC-ICF SO AND NSO	4.60%	4.15%	4.15%	5.15%
536112	LTC NF-ICF SWING BEDS	4.27%	4.15%	3.28%	5.15%
536113	LTC-ICF MRC, NSO	2.98%	3.50%	3.50%	3.70%
536114	LTC-ICF MRC, SO	0.00%	0.00%	0.00%	0.00%
536115	PHYSICIAN	3.17%	3.60%	2.85%	3.60%
536116	DENTAL	3.17%	3.60%	2.85%	3.60%
536117	OPTICAL SUPPLIES	3.67%	3.60%	2.85%	3.60%
536118	CHIROPRACTIC	3.17%	3.60%	2.85%	3.60%
536119	OPTICAL	3.17%	3.60%	2.85%	3.60%
536120	PODIATRY	3.17%	3.60%	2.85%	3.60%
536121	HOSP OUTPT-GENERAL	5.67%	5.50%	5.50%	5.50%
536122	HOSP OUTPT-SPECIALITY	5.67%	5.50%	5.50%	5.50%
536123	CLINICS-MENTAL HEALTH-FSO	5.67%	6.00%	4.74%	6.00%
536124	CLINICS-HEALTH DEPT	5.67%	6.00%	4.74%	6.00%
536125	CLINICS-FREE STANDING	5.67%	6.00%	4.74%	6.00%
536126	CLINICS-RURAL HEALTH	5.67%	6.00%	4.74%	6.00%
536128	LAB AND X-RAY	3.17%	3.60%	2.85%	3.60%
536129	LTC HOME HEALTH	3.17%	3.60%	2.85%	3.60%
536130	PRESCRIBED DRUGS	9.67%	12.50%	12.50%	12.50%
536132	FAMILY PLAN-STERILIZATION	4.77%	4.80%	3.80%	4.80%
536133	FAMILY PLAN-HOSP INPT	4.77%	4.80%	3.80%	4.80%
536134	FAMILY PLAN-HOSP OUTPT	5.67%	5.50%	4.35%	5.50%
536135	FAMILY PLAN-PHYSICIAN	3.17%	3.60%	2.85%	3.60%
536136	FAMILY PLAN-HEALTH DEPT	5.67%	6.00%	4.74%	6.00%
536137	FAMILY PLAN-FREE STANDING	5.67%	6.00%	4.74%	6.00%
536139	HEALTH CHECK-HEALTH DEPT	5.67%	6.00%	4.74%	6.00%
536140	PART B BUY-IN NON CASH	5.32%	5.25%	5.25%	5.25%
536141	PART B BUY-IN CAT NEEDY	5.32%	5.25%	5.25%	5.25%
536142	AMBULANCE	3.17%	3.60%	2.85%	3.60%
536143	HEARING AIDS	3.67%	4.00%	3.16%	4.00%
536144	LTC PERSONAL CARE	3.17%	3.50%	2.77%	3.50%
536146	HEALTH CHECK-RURAL HLTH CTR	5.67%	6.00%	4.74%	6.00%
536147	HEALTH CHECK-OTHER PROV	4.67%	5.00%	3.95%	5.00%
536148	FAMILY PLAN-RURAL HLTH CTR	5.67%	6.00%	4.74%	6.00%
536149	FAMILY PLAN-DRUGS	4.67%	12.50%	12.50%	12.50%

MEDICAL ASSISTANCE PAYMENTS

INFLATION RATES

ACCOUNT	CATEGORY OF SERVICE	SFY 1998-99 PROJECTED INFLATION RATES	SFY 1999-00 PROJECTED INFLATION RATES	SFY 1999-00 ADJUSTED INFLATION RATES	SFY 2000-01 PROJECTED INFLATION RATES
536151	CAROLINA ALT - MGD CARE	3.67%	4.00%	3.16%	4.00%
536152	HOSP INPT-LONG TERM CARE	4.77%	4.80%	4.80%	4.80%
536154	HOSP OUTPT-EMERGENCY ROOM	5.67%	6.00%	6.00%	6.00%
536155	LTC NF-HEAD LEVEL OF CARE	4.27%	4.15%	3.28%	5.15%
536156	HOSP INPT-GENERAL-XOVERS	4.77%	4.80%	4.80%	4.80%
536157	LTC NF-VENT LEVEL OF CARE	4.27%	4.15%	3.28%	5.15%
536158	HOSP OUTPT-GENERAL-XOVERS	5.67%	5.50%	5.50%	5.50%
536159	LTC CAP-DISABLED	3.07%	3.45%	2.73%	3.45%
536160	LTC CAP-MENTALLY RETARDED	3.07%	3.45%	2.73%	3.45%
536161	LTC CAP-CHILDREN	3.07%	3.45%	2.73%	3.45%
536162	CASE MANAGEMENT-FSO	3.17%	3.50%	2.77%	3.50%
536163	LOCAL EDUCATION AGENCIES-FSO	3.17%	3.50%	2.77%	3.50%
536165	DURABLE MED EQUIPMENT	3.67%	4.00%	3.16%	4.00%
536166	LTC NF-SNF SWING VENT CARE	4.27%	4.15%	3.28%	5.15%
536167	HOSP INPT-VENT CARE	4.77%	4.15%	4.15%	5.15%
536168	CLINICS-DHS IMMUNIZATIONS	5.67%	6.00%	4.74%	6.00%
536169	PHYSICAL MED-NON PHYSICIAN	3.17%	3.60%	2.85%	3.60%
536170	HMO PREMIUMS	5.67%	5.00%	3.95%	5.00%
536171	HOME INFUSION THERAPY	3.17%	3.60%	2.85%	3.60%
536172	HOSPICE	4.77%	5.00%	3.95%	5.00%
536173	PART A MEDICARE SUB-TOTAL	9.61%	7.21%	5.70%	7.21%
536174	PART B BUY-IN MQBQ	7.00%	5.25%	5.25%	5.25%
536175	PART B BUY-IN DUAL Q	7.00%	5.25%	5.25%	5.25%
53617A	PART B BUY-IN MQBB	7.00%	5.25%	5.25%	5.25%
53617B	PART B BUY-IN DUAL B	7.00%	5.25%	5.25%	5.25%
536177	CLINICS-FQHC, CORE & AMBULATO	5.67%	6.00%	4.74%	6.00%
536178	FAMILY PLANNING-FQHC	5.67%	6.00%	4.74%	6.00%
536179	HEALTH CHECK-FQHC	5.67%	6.00%	4.74%	6.00%
53618A	LTC ACF - PCS BASIC	3.17%	3.50%	2.77%	3.50%
53618D	LTC ACF - PCS BASIC/EATING ASS	3.17%	3.50%	2.77%	3.50%
53618E	LTC ACF - PCS BASIC/TOILET ASSI	3.17%	3.50%	2.77%	3.50%
53618F	LTC ACF - PCS BASIC/EATING/TOIL	3.17%	3.50%	2.77%	3.50%
53618G	CAP AIDS	3.07%	3.60%	2.85%	3.60%
53618H	HIV CASE MANAGEMENT	4.67%	3.60%	2.85%	3.60%
536180	HEAD START	0.00%	3.60%	2.85%	3.60%
536181	HOSP INPT-INDIAN HEALTH	4.77%	4.80%	4.80%	4.80%
536182	HOSP OUTPT-INDIAN HEALTH	5.67%	5.50%	5.50%	5.50%
536183	NF-INDIAN HEALTH	4.27%	4.15%	3.28%	5.15%
536186	HOME HEALTH-INDIAN HEALTH	3.17%	3.60%	2.85%	3.60%
536187	AMBULATORY SURG CENTER	4.77%	5.50%	4.35%	5.50%
536188	TRANSPORTATION-CNTY ADMIN	3.17%	3.50%	2.77%	3.50%
536189	ACF-TRANSPORTATION	3.17%	3.50%	2.77%	3.50%
536194	EDS-A/R INELIGIB CLAIMS	0.00%	0.00%	0.00%	0.00%
536195	PART B BUY-IN MQBE	0.00%	0.00%	0.00%	0.00%
536196	INDO-CHINESE MED ASST	0.00%	0.00%	0.00%	0.00%

MEDICAL ASSISTANCE PAYMENTS

AVERAGE MONTHLY ELIGIBLES

1990-91 TO 2000-01

Fiscal Year	Average Monthly Eligible
1990-91	467,925
1991-92	573,140
1992-93	657,649
1993-94	715,234
1994-95	773,680
1995-96	814,875
1996-97	826,250
1997-98	821,111
1998-99 est.	813,684
1999-00 est.	842,573
2000-01 est.	892,206

MEDICAL ASSISTANCE PAYMENTS

AVERAGE MONTHLY ELIGIBLES

INITIAL VS. REVISED ESTIMATES

Fiscal Year	Initial Estimate	Revised Estimate	Percent Change
1996-97	832,612	826,250	-0.8%
1997-98	867,013	821,111	-5.3%
1998-99	878,510	813,684	-7.4%
1999-00	924,541	842,573	-8.7%
2000-01	967,153	892,206	-7.7%

MEDICAL ASSISTANCE PAYMENTS

PROJECTION OF WORK FIRST UTILIZATION RATES

Work First Eligible Forecast	1998-99	1999-00	2000-01
April 1997 Estimate	323,973	323,973	323,973
March 1998 Estimate	270,793	270,793	270,793
April 1998 Estimate	255,124	270,793	270,793
October 1998 Estimate	245,305	247,758	250,235
January 1999 Estimate	245,305	215,150	217,302
Percent Change	-24.3%	-33.6%	-32.9%

Notes: Revising the average monthly eligibles estimate for Work First reduced the 1999-00 recommended budget by $21.7 million and the 2000-01 recommended budget by $23.3 million.

MEDICAL ASSISTANCE PAYMENTS

1999-2001 ESTIMATED UTILIZATION INCREASES

Category of Eligible	1999-00 Utilization Rate	1999-00 Average Monthly Eligibles	2000-01 Utilization Rate	2000-01 Average Monthly Eligibles
Aged	22.4%	126,627	1.5%	128,526
Blind	0.0%	2,266	0.0%	2,266
Disabled	5.6%	158,813	3.0%	163,585
Work First	(12.3%)	215,150	1.0%	217,302
Other Children	2.5%	3,032	2.5%	3,108
Pregnant Women	5.5%	25,053	5.5%	26,441
MIC Children	13.0%	274,345	13.0%	310,010
MQBQ	(57.6%)	16,864	0.1%	16,881
MQBB	18.0%	20,413	18.0%	24,087

MEDICAL ASSISTANCE PAYMENTS
INTENSITY CHANGES
TOTAL REQUIREMENTS (IN MILLIONS)

Description	Initial 1999-00	Revised 1999-00	Initial 2000-01	Revised 2000-01
Physicians	$11,269,051	$0	$0	$0
Dental	$22,635,196	$0	$0	$0
CAP-Disabled	$55,205,543	$17,674,047	$31,142,730	$0
CAP-MR/DD	$32,709,926	$30,846,443	$0	$0
CAP-Children	$8,593,959	$4,984,016	$0	$0
Total Intensity	$130,413,675	$53,504,506	$31,142,730	$0

Notes: Eliminating and reducing intensity changes reduced the 1999-00 recommended General Fund budget by $24.2 million and the 2000-01 recommended General Fund Budget by $26.1 million.

MEDICAL ASSISTANCE PAYMENTS

INTENSITY CHANGES

Physicians: DMA was proposing to increase physician fees to 100% of Medicare fees. Increase was eliminated in the revised budget.

Dental: DMA was proposing to make further increases in fees for dental services. Increase was eliminated in the revised budget.

CAP-Disabled: DMA proposed serving an average of 9,405 slots each month at an annual cost of $23,000 per slot. The original proposal was revised to an average of 8,472 slots each month at an annual cost of $20,664 per slot.

CAP-MR/DD: DMA proposed serving 5,527 slots at an annual cost of $31,123 per slot. The original proposal was revised to 5,332 slots at the same annual cost.

CAP-Children: DMA proposed serving 330 slots at an annual cost of $60,000 per slot. The original proposal was revised to 273 slots at an annual cost of $58,632 per slot.

MEDICAL ASSISTANCE PAYMENTS

WHAT IS THE DRUG REBATE PROGRAM?

- The Medicaid Drug Rebate Program was created by the OBRA 1990, and it requires drug manufacturers to enter into a national drug rebate agreement with the U.S. Department of Health and Human Services for states receiving federal funds to pay for outpatient drugs dispensed to Medicaid patients. Over 500 pharmaceutical companies participate in the program.

- To participate in the program, a state must have an open formulary which allows any prescribed drug to be dispensed and paid for by Medicaid.

- The Division of Medical Assistance is receiving about an 18% rebate on prescription drug expenditures through its participation in the drug rebate program. The state share of these recoveries has been transferred to the Medicaid program and used to reduce state appropriations.

- Projected expenditures for prescription drugs for the next biennium are expected to increase 15% for 1999-00 and an additional 15% for 2000-01. The higher expenditures will increase the general fund share of the drug rebate recovery by $12.6 million in 1999-00 and $18.3 million in 2000-01.

- The Governor proposes increasing the transfer from drug rebates by $12.6 million in 1999-00 and 2000-01and reducing state appropriations for Medicaid by the same amount.

MEDICAL ASSISTANCE PAYMENTS

HISTORY OF DRUG REBATE PROGRAM

Fiscal Year	Drug Rebate Recovery	Program Support
1993-94	$38,695,114	$6,434,405
1994-95	$41,039,657	$6,738,984
1995-96	$39,222,161	$11,022,700
1996-97	$76,458,308	$14,423,755
1997-98	$86,475,994	$22,397,512
1998-99 est	$95,396,739	$25,508,815
1999-00 est.	$120,273,979	$37,810,602
2000-01 est.	$120,273,979	$37,810,602

DISPROPORTIONATE SHARE HOSPITALS

BACKGROUND INFORMATION

- Disproportionate Share Hospital (DSH) payments are allowed by federal law to help cover the costs of hospitals which have a disproportionate share of patients with little or no insurance.

- 1997 federal law set DSH allotments for N.C. through 2002. The 1998 allotment is $278 million and declines each year to $236 million in 2002. Even though N.C.'s allotment declines, DSH payments are projected to remain stable at $85 to $105 million per year through 2002.

- North Carolina earns DSH payments by making payments to the five state hospitals for uninsured care by using state appropriations in the Medicaid budget to provide the nonfederal match.

- The federal share of the DSH payments is usually deposited as nontax revenue and is included in the revenue estimates for each fiscal year.

- The 1998-99 DSH payment is $105 million -- the highest payment N.C. can receive. The governor's budget assumes that DSH payments will continue at the $105 million level during the 1999-2001 biennium.

DISPROPORTIONATE SHARE HOSPITALS

Payments to State Hospitals

Fiscal Year	Payments
1991-92	$37,000,000
1992-93	$159,000,000
1993-94	$303,000,000
1994-95	$96,000,000
1995-96	$78,000,000
1996-97	$90,000,000
1997-98	$97,000,000
1998-99	$105,000,000
1999-00 est.	$105,000,000
2000-01 est.	$105,000,000

NOTE: DSH stands for Disproportionate Share Hospitals

MEDICAID TRUST FUND

BACKGROUND INFORMATION

- G.S. 143-23(a) of the Executive Budget Act allows public and private hospitals to transfer a portion of federal revenues to the Department of Human Resources for the Medicaid program. The Medicaid Trust Fund receives these funds.

- The Medicaid Trust Fund can only be used to benefit the Medicaid program and cannot be used to reduce state general fund revenues.

- The Medicaid Trust Fund does not revert to the General Fund, but these funds can be allocated as provided in the current appropriations act.

DISPROPORTIONATE SHARE HOSPITALS

Payments to Non-State Hospitals

Fiscal Year	Medicaid Trust Fund	Hospital Payments
1995-96	$50,000,000	$88,000,000
1996-97	$35,000,000	$174,000,000
1997-98	$40,000,000	$166,000,000
1998-99	$29,000,000	$170,000,000
Total	$154,000,000	$598,000,000

MEDICAID TRUST FUND

RECURRING OR NONRECURRING?

- The Division of Medical Assistance has been successful for the past four federal fiscal years in working with non-state public hospitals to draw down additional DSH payments.

- The federal law for DSH payments has stabilized and allotments have been set through federal fiscal year 2001-2002. Federal actions after 2002 are uncertain.

- The Division of Medical Assistance must negotiate with non-state public hospitals to continue these DSH payments in future years since $13 million of the Medicaid budget is now supported by these receipts.

- The Division of Medical Assistance needs public hospitals to draw down DSH payments. The number of public hospitals in N.C. is declining and this decline may have an impact on the amount of additional DSH payments the state can receive

MEDICAID TRUST FUND

OPTIONS FOR USING THE FUND

- The governor has proposed increasing the $13 million transfer from the Medicaid Trust Fund to support Medicaid program expenditures and reduce the need for state appropriations by $31 million in 1999-00 and $16 million in 2000-01. His proposed budget continues to recommend that the Medicaid Trust Fund maintain a minimum balance of $100 million to meet unanticipated future Medicaid needs.

- The Governor's proposal assumes that payments into the Medicaid Trust Fund will continue at the $29 million level during the biennium. If the payment level drops below $29 million then the trust fund balance will fall below $100 million.

- Other options for using the Medicaid Trust Fund are as follows:

  - ✓ A Medicaid Rainy Day Fund which can be used when Medicaid expenditures grow unexpectedly due to a recession or other causes
  - ✓ Cash flow for establishing capitated managed care programs
  - ✓ Nonrecurring Medicaid expenditures such as automation improvements
  - ✓ Cost settlements
  - ✓ Other activities which benefit the Medicaid program

MEDICAL ASSISTANCE PAYMENTS

IMPACT OF GOVERNOR'S PROPOSED REDUCTIONS

- The proposed reductions do not impact Medicaid eligibility or the level of services provided Medicaid recipients.

- The proposed reductions do impact the normal cost increases provided under the Medicaid program by reducing inflation for some services and more accurately predicting the cost of these services.

- The proposed reductions eliminate any major policy changes such as increasing physician and dental rates or limits the number of CAP slots available to the number budgeted in 1997-98.

- The proposed reductions realistically adjust utilization rates to reflect the decreases in the Work First population.

- The proposed increase in drug rebate recovery is based on the growing expenditures for prescription drugs.

- The proposed increased transfer from the Medicaid Trust Fund equals the expected payments into the trust fund.

MEDICAL ASSISTANCE PAYMENTS
1999-2001 CONTINUATION BUDGET (FUND 1310)
COMPARISON OF INITIAL VS. FINAL ESTIMATE

Governor's Original Budget for fund 1310

Description	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Total Requirements	$4,106,345,838	$4,522,263,830	$4,989,414,497	$5,450,048,606
Estimated Receipts	($3,094,692,285)	($3,204,016,887)	($3,508,734,078)	($3,818,716,688)
Net Appropriation	$1,011,653,553	$1,318,246,943	$1,480,680,419	$1,631,331,918

Governor's Revised Budget for Fund 1310

Description	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Total Requirements	$4,106,345,838	$4,522,263,830	$4,755,796,914	$5,160,867,908
Estimated Receipts	($3,094,692,285)	($3,204,016,887)	($3,389,897,138)	($3,645,658,276)
Net Appropriation	$1,011,653,553	$1,318,246,943	$1,365,899,777	$1,515,209,632

MEDICAID PROGRAM

OTHER ISSUES

- New Forecast Based on March Expenditures
- Federal Financial Participation Rate Decrease
- Medicaid Growth Reduction Final Report
- Federal Revenue Maximization

FEDERAL FINANCIAL PARTICIPATION RATE

IMPACT OF RATE DECREASES

- The Federal Financial Participation (FFP) Rate determines the federal share of the Medicaid program. The rate is based on the relationship between each state's per capita personal income and that of the nation as a whole. The 2000 federal share is calculated using per capita income data for 1995-97.

- Since N.C.'s per capita income has increased significantly in recent years, the state's FFP rate has declined. The rate has decreased from 68.01% for federal fiscal year 1989 to 62.49% for federal fiscal year 2000 -- an 8.1% decrease in eleven years.

- The Division of Medical Assistance estimates how much the state's FFP rate will decline based on historical trends during budget forecasting, but the rate of change is difficult to predict.

- The FFP rate for state fiscal year 1997-98 decreased .85%. This decline resulted in an $19 million increase in state appropriations. The estimated FFP rate for state fiscal year 1998-99 only decreased .34%. This lower decline resulted in an $14 million decrease in state appropriations.

- The final FFP rate for state fiscal year 1999-00 decreased .7%. The budget forecast for 1999-00 assumed the FFP rate would decrease .33%. The additional decline results in a **$9.3 million increase in state appropriations which are not included in the Governor's recommended budget.**

MEDICAID GROWTH REDUCTION
FINAL REPORT

- The 1997 General Assembly, at the Governor's recommendation, established a goal to reduce the annual growth in Medicaid spending to 8% by the year 2001.

- Medicaid growth has slowed significantly during the past three years. Appropriations growth slowed to 3.4% in 1997-98 and appropriations for 1998-99 are projected to be below the growth target.

- The slowed growth has occurred due to the following factors:

  - ✓ Growth in eligibles has been stable for most groups and Work First has decreased significantly.
  - ✓ Low medical cost inflation
  - ✓ Managed Care
  - ✓ Limited modifications to rate setting methodologies

- The Governor's revised budget projections for 1999-00 and 2000-01 are also below the growth reduction targets which were set by the 1997 General Assembly -- including the expanded eligibility for the elderly and disabled.

Fiscal Year (In Millions)	Appropriations Budget Target	Projected State Appropriations
1998-99	$1,389.0	$1,307.3
1999-00	$1,507.1	$1,406.4
2000-01	$1,627.6	$1,557.7

FEDERAL REVENUE MAXIMIZATION

A SUCCESS STORY FOR N.C.!

- North Carolina has successfully maximized the receipt of federal funds by using its Medicaid program to pay for services previously covered through 100% state or local funding.

  - ✓ Intermediate Care Facilities for the Mentally Retarded
  - ✓ Thomas S program
  - ✓ Willie M program
  - ✓ Adult Care Home Personal Care Services
  - ✓ DSH Payments
  - ✓ Health Departments & Area Mental Health Programs

- North Carolina has also been successful at using its Medicaid program to provide health care to uninsured persons by expanding eligibility to optional categories of people.

  - ✓ Pregnant Women to 185% of FPL
  - ✓ Recipients of State/County Special Assistance
  - ✓ Medically Needy persons
  - ✓ Aged, Blind, and Disabled Persons With Non-SSI Income to 100% of the FPL

WHAT IS THE GOAL OF NORTH CAROLINA'S MEDICAID PROGRAM?

COST CONTAINMENT
OR
FEDERAL
REVENUE MAXIMIZATION
???

NORTH CAROLINA GENERAL ASSEMBLY

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

April 13, 1999

8:30 a.m.

The Joint Appropriations Subcommittee on Human Resources met in Room 424 of the Legislative Office Building, April 13, 1999. Sen. Bill Martin, Chair, called the meeting to order and announced that the committee will also meet this afternoon. There were six Senate Members present and the following House members were present: Representative Earle, Representative Nye, Representative Alexander, Representative Adams, Representative Cansler, Representative Esposito, Representative Walend, Representative Wilson. After introduction of the pages, The Chair stated that last Session the Committee had requested information on Early Intervention.

Senator Martin introduced Sandy Steel, and Susan Peel, Co-Chairs, North Carolina Interagency Coordinating Council, to give the report.

Ms. Steel began her presentation by introducing other persons who assisted in compiling the report on the Status of Early Intervention Services for children ages birth to five. (Attachment 1) The report was sent to the Committee Members prior to the meeting. She went over the eligibility for services, the quality, availability and timeliness of services, improving transition from infant toddler program into the pre-school program, the management of and focus on preschool services for children with vision and hearing impairments and matters pertaining to the Interagency coordination and to funding.

Ms. Steel gave an overview of early intervention including some background of what has occurred legislatively during the last 20 years. She also shared her personal experience with the Committee.

After Ms. Peel went over the findings of the report. She stated that throughout the study, there were three consistent areas in each of the issues. The study revealed ten areas of findings. Eligibility, timeliness, availability of service, quality of service, transition, locating eligible children with visual impairment, early identification of and providing service to service to children with hearing impairment, identification of children under the age of three with autism, coordination of services that result in better child and family outcome, and finally, funding – funding has not increased with the increased number of children in the program.

Ms. Steel gave details of the recommendations in the report. She stated that three things 1) additional staff is needed because of the rate of increase; 2) a single integrated consistent data collection system should be put in place to insure greater accountability, and 3) there is a need to improve services to children with low incident condition and also establish regional trans-disciplinary teams.

Next Step: Ms. Steel stated that they would like to set up the trans-disciplinary models. This would be done by starting with one the first year and expand the next two years. The integrated data system is needed to ensure more accountability.

During committee discussion, the following questions were asked and comments were made:
Sen. Kerr asked if there has been effort to involve the Medical Society to assist in identifying and screening children.

Sen. Dannelly if our University System has a range of from fourteen to sixty hours for certification requirements and that there is no continuity. He also asked if the integration of services is done at the expense of other children.

Sen. Purcell stated that the hearing test of newborn infants is a very complex procedure.

Rep. Adams asked if there was any input by the institutions for the deaf as to their process for their areas for their children. She wanted to know if there has been any dialogue and if so, was it considered in making the recommendations.

Sen. Phillips and Rep. Earl thanked the members of the North Carolina Interagency Coordinating Council for all that is being done and their efforts.

Ms. Peel thanked the committee for the opportunity to conduct and present the study. It provided an opportunity to look at the system and what is going on and give perspective as to where to go from here.

The Chair thanked everyone for coming and adjourned the meeting at 10:00.

Senator William N. Martin, Chair

Joyce Crows Hodge, Clerk

Joint Health and Human Services Appropriations Committee

AGENDA

April 13, 1999
8:30 a.m. and 2:30 p.m., Room 424 LOB

Study on Early Intervention Services For Children Ages Birth to Five Years	Sandy Steele, Parent Co-Chair NC Interagency Coordinating Council Susan Peele, Professional Co-Chair NC Interagency Coordinating Council
Division Overviews Vocational Rehabilitation Services Services for the Blind Services for the Deaf & Hard of Hearing	Mary Ellen Sylvester Fiscal Research Division

04.13.99 8:30

Timothy

Our son, Timothy L. Reeves, Jr., has diverse needs stemming from a visual impairment and cerebral palsy. When we review Timothy's progress over the last seven years, it is evident that early intervention really works! With the assistance of EI teachers, physical therapists, occupational therapists, and speech and language therapists, not only have we learned how to help Timothy reach his developmental milestones, we learned how to be better advocates for his medical and educational needs. We have made important investments of our time, love and finances to ensure that he reaches his fullest potential to become a productive citizen in society.

The early intervention programs and services in the state of North Carolina continue to show tremendous gains in helping children with special needs develop skills and spark their imaginations. But, when the hopes and dreams of families and children with special needs unite with professionals who have vision and skills, our children can have bright futures.

Tim and Azell Reeves
Greensboro, NC

Drew

Drew Steele (age 12) lives in Greenville, NC and will start middle school this fall. His first five years in early intervention introduced Drew and our family to many wonderful people and services that left numerous lasting effects. Advocating for his needs, locating family friendly services, helping develop new services needed, and finding people to support Drew in school and the community are a few of the skills we learned from his early intervention years. Drew is a happy, healthy and vibrant person who is now becoming his own advocate. His long term goal? Drew wants to work for a grocery store that is "really nice to their customers and helps them find what they need." Our family says thank you for supporting early intervention. Drew is living proof that it makes a big difference, not just for him but for the whole community.

Sandy & Mike Steele
Greenville, NC

April 13, 1999

Joint Human Resources Appropriations Committee Meeting

AGENDA

North Carolina Interagency Coordinating Council's
North Carolina Legislative Study on Early Intervention Services for Children Ages Birth to Five Years

Presenters: Sandy Steele, Parent Co-Chair
Susan Peele, Professional Co-Chair

1. What is Early Intervention?

2. Does it work?

3. What makes it work?

4. Background
   -Individuals with Disabilities Education Act (IDEA)
   -North Carolina's response to the federal legislation
   -North Carolina Early Intervention History
   -North Carolina Early Intervention Agencies and Organizations
   -Primary Responsibilities of Service Funding/Providing Agencies
   -Early Intervention Funding Profile

5. North Carolina Legislative Study on Early Intervention Services for Children Ages Birth to Five Years

   -Findings
   -Recommendations

6. What are our next steps?

BACKGROUND

Individuals with Disabilities Education Act--IDEA

- first enacted in 1975, amended "Education of Handicapped Children Act of 1975 (PL 94-142)
- -guarantees right to a free appropriate education for all children ages 3-21.
- -provides federal funding to assist states & local school systems to pay for special education and related services

Amendments in 1986 provided by PL 99-457 had 2 major objectives

- establish new state grant programs for infants and toddlers
- to extend all rights and protections of PL 94-142 to children ages 3 - 5 years.

*IDEA put strong emphasis on interagency coordination and collaboration to develop a multi-agency service system and in partnership with parents of children with disabilities.

NORTH CAROLINA'S RESPONSE TO THE FEDERAL LEGISLATION

IDEA amendments passed in late 1986

-January of 1987, then Governor James Martin, declared NC would participate in the infant-toddler program and NC was one of the first states in the nation to become officially involved with the infant-toddler program.

- federal law stipulated that the 3-5 yr. old program must have a state's Public Education Agency/Department as the lead agency for that age group

-however, was up to individual state to determine lead agency for the infant-toddler program.

-NC designated the Dept. of Human Resources (now, Dept. of Health and Human Services)

-March of 1987, then Secretary of DHR Phillip Kirk, designated the Div. of MH/DD/SAS as lead division for NC's infant-toddler program.

* Although federal legislation mandated services to young children with disabilities, the North Carolina Legislature had been building a service system for many years.

NC EARLY INTERVENTION HISTORY

** NC Legislature has a long, distinguished history of building and supporting a quality system of services for young children with disabilities.**

- NC's network of 18 Developmental Evaluation Centers became operational in 1961 and continues today to be the primary provider of multi-disciplinary assessment services to all young children with or at risk for disabilities, ages 5 and under

- Center-based early intervention services through the Developmental Day Center Network were established in 1967

- NC Dept. of Public Instruction initiated services for preschool children with special needs in 1968. And DPI's involvement was significantly expanded in 1975 through participation in the new law's preschool grant program

- Home-based early intervention services have been in existence through a state legislative appropriation since 1971. Prior to passage of PL 99-457 (IDEA amendments in 1986) NC had these services available in 70 or almost 3/4 of NC already--and served approx. 1,900 annually.

- NC was 1st state in the nation to mandate services to autistic preschool children and established Division TEACCH (Treatment and Education of Autistic and Related Communication Handicapped Children) in 1972

- the state schools for the deaf developed their first programs for hearing impaired preschoolers in 1973--as a result of major state legislative appropriations that established both center-based and itinerant programs

- In the 1987-88 session of the General Assembly a substantial amount of state funds was appropriated to expand preschool services for visually impaired children

- And, in 1991--the NC General Assembly passed an infant/toddler entitlement statement so that early intervention services are the right of every eligible child age birth through four years

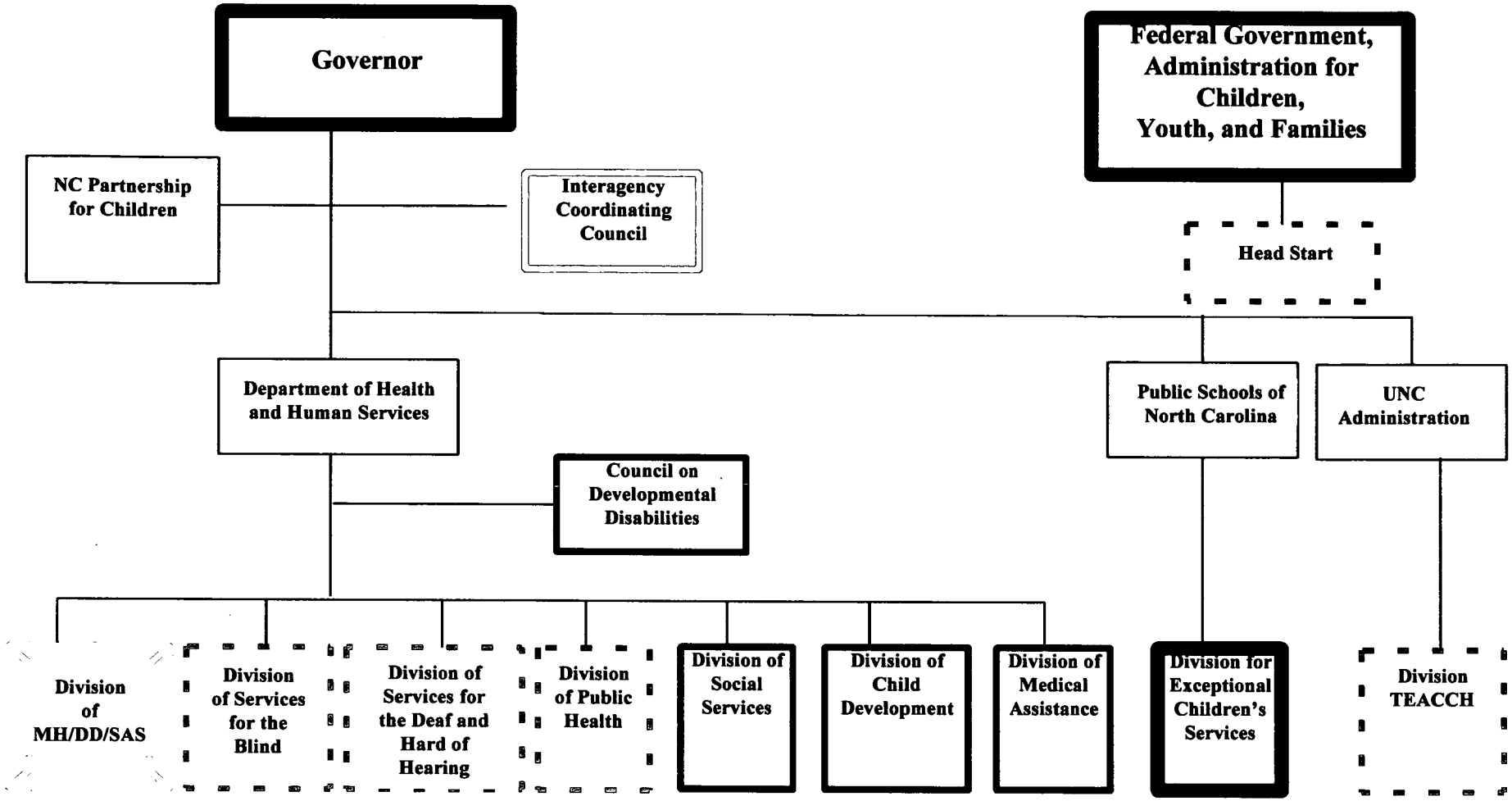
- These are some of the most extensive and comprehensive supports and services through state and local government--last year this system served over 8,000 children ages birth to three years and over 14,000 children ages three to five were served.

	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
Birth thru 2	3,144	3,981	4,459	4,762	4,912	5,104	6,107	7,144	7,846	8,317
3 & 4 year olds	1,908	2,652	3,441	4,002	4,825	5,991	8,471	9,400	10,020	11,300

What are the services in Infant-Toddler Early Intervention and Preschool Early Intervention?

	Services offered under the Infant-Toddler and Preschool Program	
Definitions	Infant-Toddler Early Intervention	Preschool Early Intervention
<u>Early Intervention Birth through Five</u> Early intervention means professionals working in partnership with parents to support and empower those parents and to help their children with special needs develop the knowledge and skills to reach their potential. It builds on the strengths found in all children and families. <u>Special Education</u> Special education is specially designed instruction, at no cost to the parent, to meet the unique needs of the exceptional child, including classroom instruction, instruction in physical education, home instruction, instruction in hospitals and institutions. <u>Related Services</u> Related services means transportation and developmental, corrective and other supportive services, required to assist a child to benefit from special education.	• Assistive Technology Services and Devices Audiological • Child Service Coordination • Early Identification & Screening • Family Counseling & Therapy Services • Health Services • Medical Services for Evaluation/Assessment • Multidisciplinary Evaluation • Nursing Services • Nutrition Services • Occupational Therapy • Parent Training & Information • Physical Therapy • Psychological Services • Respite Services • Social Work Services • Special Instruction/Education • Speech-Language Therapy • Transportation • Vision Services	• Assistive Technology Services • Audiology/Hearing • Early Identification and Screening • Health Services • Medical Services for Evaluation • Multidisciplinary Evaluations • Occupational Therapy • Parent Training & Information • Physical Therapy • Psychological Services • Special Education • Speech/Language Therapy • Transportation • Vision • Social Work Services • Recreation including Therapeutic Recreation

NORTH CAROLINA EARLY INTERVENTION AGENCIES AND ORGANIZATIONS



KEY:

Lead Agency Part C (Infants and Toddlers)

Lead Agency Part B (Preschoolers)

Service Provider Agency

Service Funding Agency

System Planning, Coordinating, and Evaluating

PRIMARY RESPONSIBILITIES OF SERVICE FUNDING/PROVIDING AGENCIES

A. Service Provision

Agency	Age Group	Primary Services
Division for Exceptional Children's Services	3,4, and Pre-Kindergarten 5	Special Education and Related Services
Division of MH/DD/SAS	Birth to Five (Primary Focus on Infants and Toddlers)	Center and home based special instruction, respite, family counseling/therapy, service coordination
Division of Public Health	Birth to Five	Child service coordination, multidisciplinary assessments, speech, physical, occupational therapy, assistive technology, nutrition
Division of Services for the Blind	Birth to Five	Vision (children with vision impairments)
Division of Services for the Deaf/Hard of Hearing	Birth to Five	Audiology/Hearing (children with hearing impairments)
Division TEACCH	Birth to Five	Evaluations, special instruction (children with autism)
Head Start	Birth to Five	Special instruction, speech, physical, and occupational therapy
Division of Social Services	Birth to Five	Child service coordination, transportation

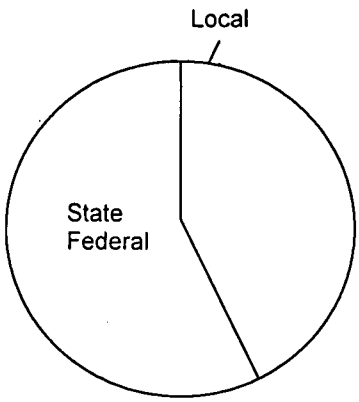
B. Service Funding

Agency	Age Group	Primary Services
Division of Child Development	Birth to Five	Child care, other early intervention services
Division of Medical Assistance	Birth to Five	Evaluations, child service coordination, speech, physical, occupational therapy, and special instruction
North Carolina Partnership for Children	Birth to Five	Child care, other early intervention services

Note: The full range of agency services and responsibilities is determined through the "North Carolina Interagency Agreement for the Provision of Services to Children With or at Risk for Disabilities Ages Birth to Five."

EARLY INTERVENTION FUNDING PROFILE

A. Infant-Toddler Program



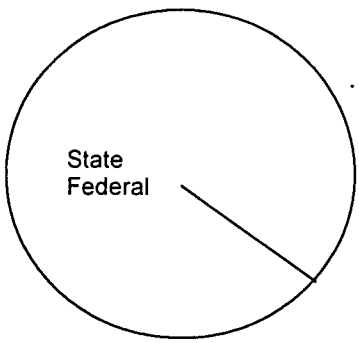
Federal	34%
State	60%
Local	6%

1. Federal Sources Include:
   - a) IDEA Part C Funds
   - b) Medicaid
   - c) Child Care Block Grant
   - d) Social Services Block Grant
   - e) Title V – Maternal and Child Health Block Grant
   - f) Council on Developmental Disabilities Demonstration Grants

2. State Sources Include:
   - b) Categorical early intervention appropriations
   - c) Child mental health funds
   - d) Smart Start

3. Local Sources Include
   - c) Insurance
   - d) Parent fees

B. Preschool Program



Federal	33%
State	67%

2. Federal Sources Include:
   - b) IDEA Part B funds
   - c) Medicaid

2. State Sources Include
   - b) State Education Appropriations
   - c) Smart Start

DIVISION OVERVIEWS

Vocational Rehabilitation Services

Services for the Blind

Services for the Deaf & Hard of Hearing

Presented by:
Mary Ellen Sylvester
Fiscal Research Division
April 13, 1999

VOCATIONAL REHABILITATION (VR) SERVICES

REHABILITATION ACT of 1973, TITLE I

(as Reauthorized in 1998)

Individuals With Disabilities, Including the Most Significant Disabilities,

- Are Presumed Capable of Engaging in Gainful Employment (With VR Services)
- Need Opportunities for Gainful Employment in Integrated Settings
- Must Be Full, Active Partners, Making Meaningful and Informed Choices

Eligibility for VR Services

- Physical or Mental Impairment Which is a Substantial Impediment to Employment
- VR Services are Required to Prepare for, Secure, Retain, or Regain Employment

VR Services

- Individualized, Consumer-Driven, Goal-Oriented, Time-Limited

Significant 1998 Amendments:

1) Presumed Eligibility for SSI/SSDI Clients
2) Qualified Vocational Rehabilitation Counselor
3) Informed Client Choice
4) Integration into a Statewide Workforce Investment System

VOCATIONAL REHABILITATION SERVICES

MISSION

To Promote Employment and Independence for Persons with Disabilities
Through Customer Partnerships and Community Leadership

VISION

- Be Leading Employment Resource for Persons With Disabilities, Business, and Industry
- Promote Inclusion into the Community

PROGRAMS	*SERVICES*
Vocational Rehabilitation	Evaluation, Counseling & Guidance, Physical/Mental Restoration, Training, Job Placement, Interpreter Services
Supported Employment	Extensive On-Site Training in Competitive Employment with Long Term Support Services
Client Assistance Program	Information & Referral, Assistance With Appeals Process
Assistive Technology	Statewide Awareness and Demonstration of Assistive Technology for Disabled Persons (4 Demo Centers)
Independent Living Rehabilitation	Rehabilitation Engineering, Adaptive Equipment Purchases, Personal Assistance Services, and Rehabilitation Therapy
ACCESS, North Carolina	NC Travel and Tourism Guide for Disabled Persons and Accessibility/Barrier Removal Projects at Travel Sites
Disability Determination Services	Processing of SSI/SSDI Applications From Social Security Administration Offices and Medicaid Eligibility Claims From Local Depts. of Social Services

VOCATIONAL REHABILITATION SERVICES

CLIENTS: - Evaluate More Than 28,000 *New* Clients Each Year

- Serve Approximately 60,000 Clients in Total

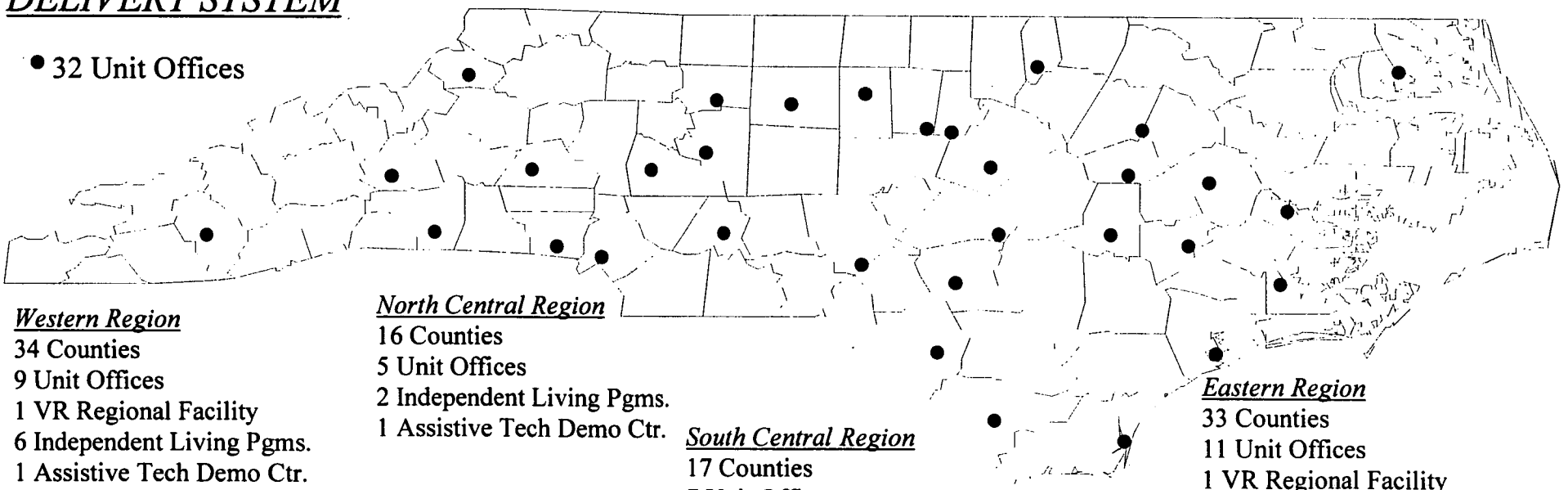
  -- 74% Have a "Significant Disability" (Limits 1 or More Functional Capacities/ Requires Multiple VR Services Over an Extended Period)

  -- 25% Have a "Most Significant Disability" (In NC, 3+ Functional Limitations)

- 60% Complete Their Individual Written Rehabilitation Program Successfully

- In 1997-98, 37% were 22 Years Old or Younger

DELIVERY SYSTEM



- 32 Unit Offices

Western Region
34 Counties
9 Unit Offices
1 VR Regional Facility
6 Independent Living Pgms.
1 Assistive Tech Demo Ctr.

North Central Region
16 Counties
5 Unit Offices
2 Independent Living Pgms.
1 Assistive Tech Demo Ctr.

South Central Region
17 Counties
7 Unit Offices
3 Independent Living Pgms.
1 Assistive Tech Demo Ctr.

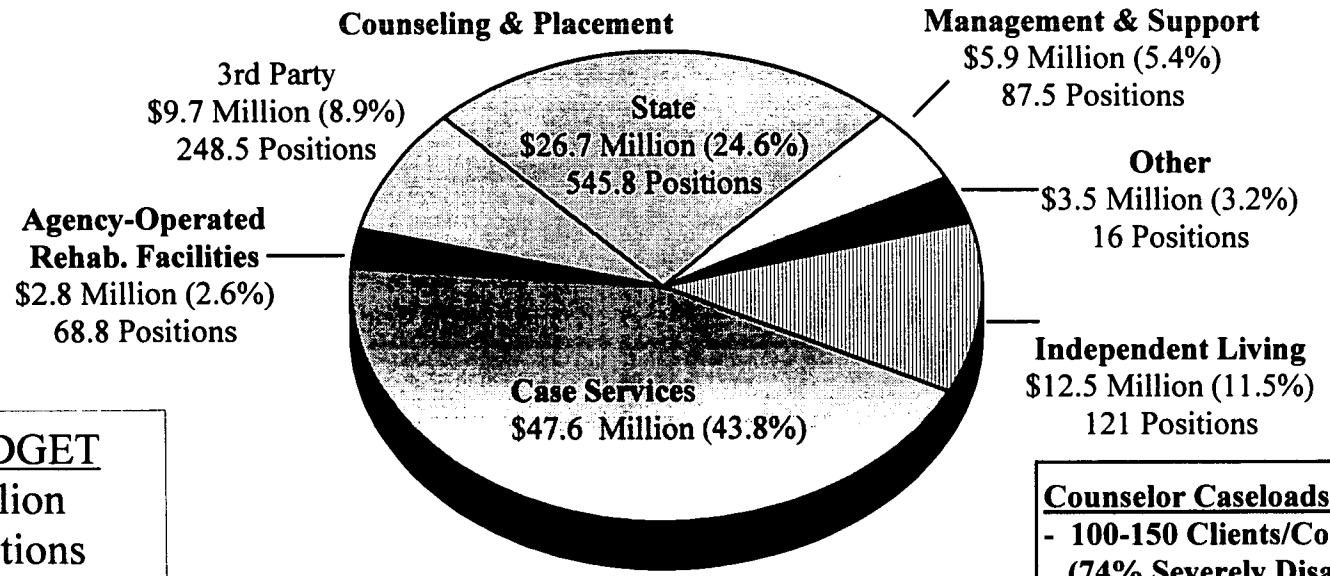
Eastern Region
33 Counties
11 Unit Offices
1 VR Regional Facility
5 Independent Living Pgms.
1 Assistive Tech Demo Ctr.

Plus,
One-Stop Career Centers and 3rd Party Locations

CONTINUATION BUDGET SUMMARY

VOCATIONAL REHABILITATION SERVICES

	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Requirements*	$112,074,630	$108,685,514	$110,054,438	$111,995,775
Receipts	$78,452,334	$72,909,660	$74,411,084	$75,137,905
Net Appropriation	$33,622,296	$35,775,854	$35,643,354	$36,857,870
Positions	1,087.6	1,087.6	1,087.6	1,135.6



1998-99 BUDGET
$108.7 Million
1,087.6 Positions

Counselor Caseloads:
- **100-150 Clients/Counselor (74% Severely Disabled)**
- **25 Clients Rehabilitated/Year (Min.)**

**** Does Not Include Funding for Disability Determination Services (1998-99: $43 M, 640 Positions)***

VOCATIONAL REHABILITATION SERVICES

CLIENT OUTCOMES (1997-98)

8,527 Clients Rehabilitated

	At Application		At Closure	
Work Status	**Number of Clients**	**%**	**Number of Clients**	**%**
Competitive Labor Market	1,712	20.1%	**8,156**	**95.7%**
Self-Employed	42	0.5%	**173**	**2.0%**
Sheltered Workshop	80	0.9%	63	0.8%
State Employee	0	0%	1	0%
Homemaker	30	0.4%	106	1.2%
Unpaid Family Worker	4	0%	28	0.3%
Not Working	**6,659**	**78.1%**	0	0%
Primary Source of Support				
Earnings	1,581	**18.5%**	6,809	**79.9%**
Public Assistance	900	10.6%	381	4.5%
No Weekly Earnings	6,693	**78.5%**	134	**1.6%**
Hours Worked Week Before				
None	6,693	78.5%	134	1.6%
1-39	1,339	15.7%	2,979	34.9%
40+	495	**5.8%**	5,414	**63.5%**

VOCATIONAL REHABILITATION SERVICES

LEGISLATIVE HIGHLIGHTS

- Legislation Establishing a State Vocational Rehabilitation/Independent Living Program (1995)

- Completion/Expansion of the Independent Living Rehabilitation Program (1990s)

- Provision of "Establishment of Facility" Funding ($500,000 NR -- 1998-99)

- New, Specialized Programming for Traumatic Brain Injury, Spinal Cord Injury, and Significantly Disabled Deaf Clients [including Vocational Evaluation, Training, and Transitional Housing] ($300,000 -- 1998-99)

- Replacement Funding for NC Assistive Technology Project ($200,000 NR -- 1998-99)

VOCATIONAL REHABILITATION SERVICES

FUNDING-RELATED ISSUES

NC Assistive Technology Project

Independent Living Rehabilitation Program

- *Waiting List*
- *NC Brain Injury Association Project*

Elimination of Two Vacant Positions

VOCATIONAL REHABILITATION SERVICES

NC ASSISTIVE TECHNOLOGY PROJECT

Purpose:
- Provide Information, Technical Assistance, and Demonstration of Assistive Technology
- Serve All Ages, All Disabilities, All Aspects of Life

4 Demo Centers: Greenville, Raleigh, Winston-Salem, Charlotte *

1998-99 Budget:

$ 597,800	Federal Funds
$ 361,940	General Fund ($200,000 is non-recurring)
$ 19,954	Local Funds
$ 50,000	Kate B. Reynolds Grant
$1,029,694	

Scheduled Phase-out of Federal Funding:

97-98	98-99	99-00	00-01	03-04
- $0	-$199,266	-$398,533	-$398,533	-$797,066
- 0%	- 25%	- 50%	- 50%	- 100%

General Assembly Replaced Reduced Federal Funds in 1998-99 With $200,000 Non-Recurring Funds

Now, Program Needs $398,533 in State Funds to Maintain Current Service Level for Next 4 Years

Impact of Reduced Budget: Close 2 Centers in 1999-00

1997-98 Accomplishments:
- Information and Referral to 3,230 People
- 198 Training/Awareness Sessions Attended By 8,413 Individuals
- 7th Annual NC Assistive Technology Expo Attended by 1,200 People
- 1,417 Consumers and 1,777 Professionals Visited Demonstration Centers
- 372 Requests for Professional Assistance in Financing Assistive Technology

* *Plus, New Satellite Center in Elizabeth City, Funded With Kate B. Reynolds Grant*

VOCATIONAL REHABILITATION SERVICES
INDEPENDENT LIVING REHABILITATION PROGRAM

Purpose: **Promote Personal Independence of Severely Disabled Individuals**
- Provide an Alternative to Institutionalization
- Improve Functioning in One's Family, Home, and Community
- Prepare for Traditional VR Services

Services:
- Rehabilitation Engineering
- Assistive Equipment Purchases
- Home and Vehicle Modifications
- Guidance and Counseling
- Consumer-Managed Personal Assistance

Typical Office:

Budget:	$650,000 to $800,000 Per Year ($225,000 for Case Services; $150,000 for Personal Assistance)
Staffing:	6-9 Rehabilitation Specialists (22% Disabled)
Expected Outcomes:	Serve 200+ Clients/Year, With 80+ Clients Achieving Goals
Avg. Expenditure:	Personal Assistance $8,755/Client One-Time Eqpt. $3,150/Client Expenditures

1997-98 Accomplishments:

		1995-96
Clients Served:	3,778	2,382 (+59%)
New Clients:	2,773	1,765 (+57%)
Achieved Goals:	1,504 Clients	874 (+72%)
Personal Assistance:	248 Clients	179 (+39%)

37 Clients Relocated from Nursing Homes to Community-Based Arrangements

232 Clients Prevented From Being Institutionalized

VOCATIONAL REHABILITATION SERVICES

INDEPENDENT LIVING REHABILITATION PROGRAM

Waiting Lists
(as of 3/31/99)

OFFICE	CASE SERVICES # Clients	CASE SERVICES Funds Needed	PERSONAL ASSISTANCE # Clients	PERSONAL ASSISTANCE Funds Needed
Albemarle	88	$130,327	4	$21,702
Asheville	41	$165,960	0	$0
Boone	64	$237,050	2	$5,088
Charlotte	91	$295,450	5	$40,800
Durham	22	$66,800	0	$0
Elizabeth City	51	$99,483	2	$17,472
Fayetteville	38	$90,500	9	$56,250
Greensboro	31	$233,650	31	$202,560
Greenville	103	$376,757	0	$0
Hickory	106	$458,750	10	$63,677
New Bern	33	$82,985	2	$25,000
Raleigh	69	$186,825	0	$0
Rocky Mount	99	$363,589	9	$48,840
Sylva	30	$86,075	0	$0
Wilmington	37	$136,500	0	$0
Winston-Salem	63	$298,473	13	$97,932
Total	**966**	**$3,309,174**	**87**	**$579,321**

Annual Budget: Case Services: $4.3 Million
Personal Assistance: $2.3 Million

Total Budget for Case Services and Personal Assistance Funding is 93% Obligated as of 3/31/99

//

VOCATIONAL REHABILITATION SERVICES

NC BRAIN INJURY ASSOCIATION PROJECT

- Purpose
  - Provide intensive early intervention, followed by assistance in coordinating a network of services, to individuals with brain injuries who have the potential to live independently

- Funded with an 18-month Kate B. Reynolds demonstration grant (expired Oct 98)
  - Developed at the request of the NC Brain Injury Association
  - IL Counselor/Care Coordinator positions established in Winston-Salem and Greenville
  - In Oct 98, Foundation extended funding for the 2 positions by one year
  - However, IL Rehab Program is contributing case services funds

- Active Caseloads: 30+ Clients/Office

- Cost to Maintain Existing Services in 1999-00: $350,000 (2 positions and case services funds)

SERVICES FOR THE BLIND

MISSION

To Empower Individuals Who are Blind or Visually-Impaired to Achieve Their Maximum Potential Through Services Provided by Competent and Caring Professionals

PROGRAMS	*SERVICES*
Vocational Rehabilitation	Evaluation, Counseling & Guidance, Physical/Mental Restoration, Orientation and Mobility, Training, Job Placement, Reader Services
Supported Employment	Extensive On-Site Training in Competitive Employment With Long Term Support Services
Business Enterprises	Job Opportunities as Operators of Food Service Facilities and Vending Operations
Technology Resource Center	Assistive Technology Demonstration, Evaluation, and Training; Rehabilitation Engineering Services
Deaf-Blind Program	Evaluation, Training, Information and Referral, Advocacy and Support
Independent Living/Social Services	Chore Services and Adjustment to Blindness Services
Medical Eye Care Program	Eye Exams, Eyeglasses, and Surgery for Low Income Individuals; Screenings, Education, and Low Vision Services
Governor Morehead School	Early Intervention, K through 12th Grades, Counseling, Therapy, Braille, Orientation and Mobility, Transition, Outreach, and Teacher Training

SERVICES FOR THE BLIND

CLIENTS:

Definition of "Legally Blind:"

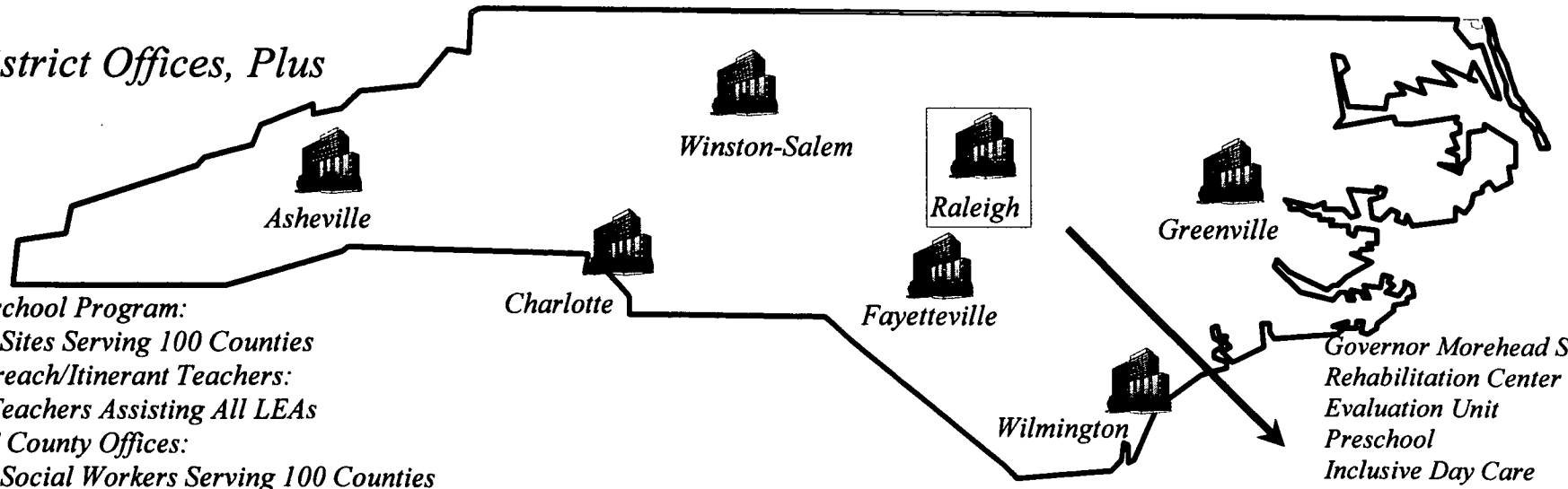
- *20/200 or Less Vision in the Better Eye with Corrective Lenses, or*
- *Field of Vision Constricted to 20 Degrees or Less*

Clients Referred From the General VR Agency:

- *Legally Blind*
- *Vision Between 20/100 and 20/200, If Having Difficulty Adjusting to Loss of Vision*
- *Night Blindness, Limited Field of Vision, or Rapidly Progressive Eye Condition (Leading to Legal Blindness)*
- *All Who Need Eye Treatment and/or Surgery, Regardless of Vision*

DELIVERY SYSTEM:

7 District Offices, Plus



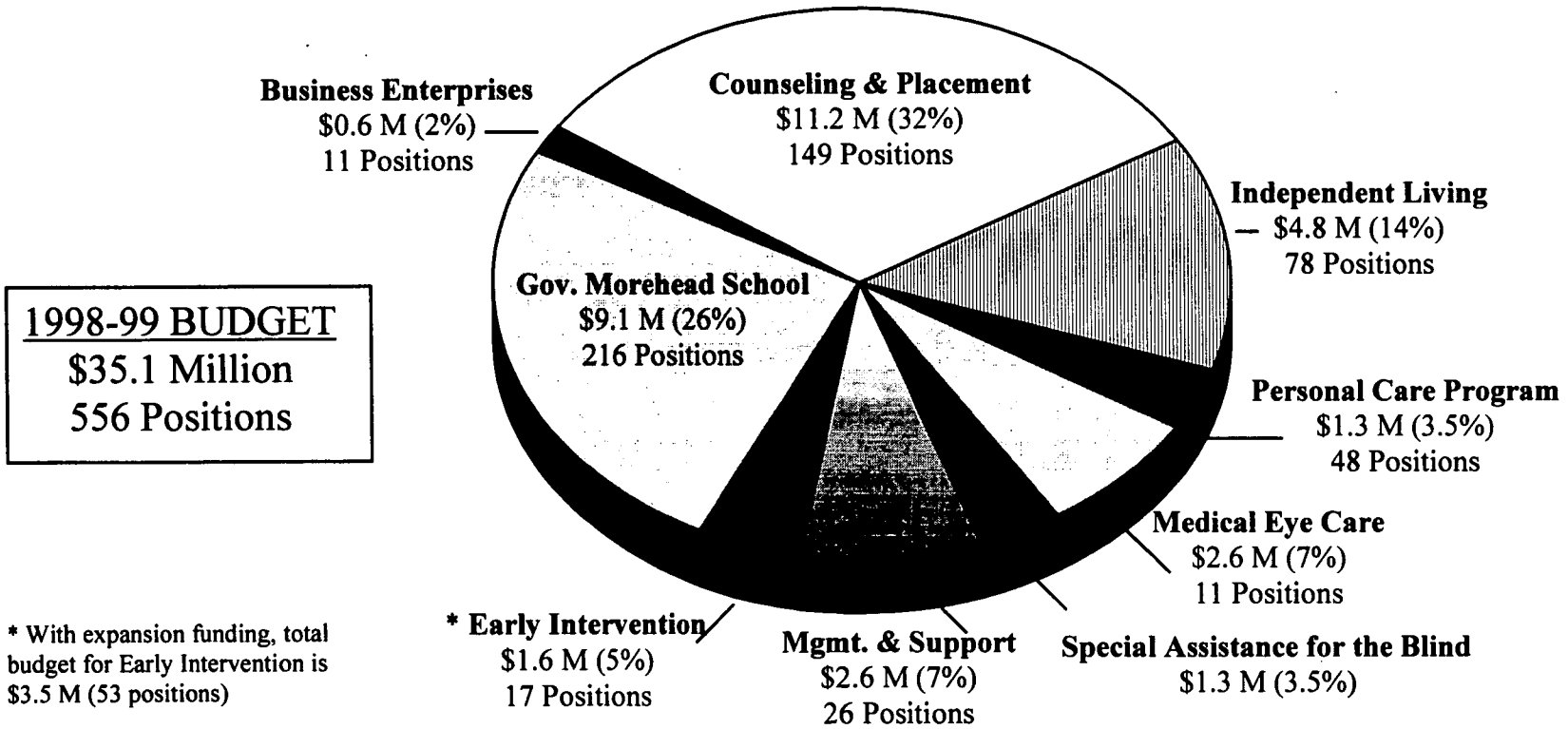
Preschool Program:
17 Sites Serving 100 Counties
Outreach/Itinerant Teachers:
6 Teachers Assisting All LEAs
DSS County Offices:
57 Social Workers Serving 100 Counties
5 Supported Employment Locations
7 Workshops for the Blind

Governor Morehead School
Rehabilitation Center
Evaluation Unit
Preschool
Inclusive Day Care
Supported Employment
Resource Center
Workshop for the Blind

CONTINUATION BUDGET SUMMARY

SERVICES FOR THE BLIND

	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Requirements	$32,434,832	$35,140,241	$35,130,567	$35,126,212
Receipts	$18,755,653	$17,797,445	$17,877,888	$17,881,370
Appropriation	$13,679,179	$17,342,796	$17,252,679	$17,244,842
Positions	554	556	556	556



* With expansion funding, total budget for Early Intervention is $3.5 M (53 positions)

SERVICES FOR THE BLIND

LEGISLATIVE HIGHLIGHTS

- Provided Funding to Maintain Extended Service Provider Positions in the Supported Employment Program ($250,000 -- 1995 Session)

- Requested State Auditor Conduct a Performance Audit of the Division of Services for the Blind (1996 Session)

SERVICES FOR THE BLIND

ISSUES

- Are Blind People Being Served?

- Are Resources Adequate to Deliver Specialized Services?

SERVICES FOR THE BLIND

VR CLIENT OUTCOMES (1997-98)

Total Clients Served		3,679
- Severely Disabled		2,875 (78%)
- Legally Blind		1,146 (31%)
Number of Clients Rehabilitated		810
- Severely Disabled		600 (74%)
- Legally Blind		178 (22%)
Number of Non-Wage Earners		174 (21%)
Number of Wage Earners		636
- Legally Blind, Placed in Remunerative Employment, Earning Minimum Wage or Better		119
- Legally Blind, Placed in Competitive Employment, Earning Minimum Wage or Better		98 (12%)
Number of Clients Receiving Physical Restoration Only		45 (6%)
Number of Clients Placed in Jobs by Division Staff		65 (8%)
Average Cost of Purchased Services:		$3,079/Client
Average Earnings:	<u>At Application</u>	<u>At Closure</u>
	$113.55	$263.77 (+132%)

SERVICES FOR THE BLIND

CLIENT OUTCOMES (1997-98)

810 Clients Rehabilitated

	At Application		At Closure	
Work Status	**Number of Clients**	**%**	**Number of Clients**	**%**
Competitive Labor Market	338	42%	515	64%
Self-Employed	56	7%	100	12%
Business Enterprises	1	0%	5	1%
Sheltered Workshop	5	1%	16	2%
Student	25	3%	0	0%
Homemaker	76	9%	167	20%
Unpaid Family Worker	2	0%	7	1%
Not Working	307	**38%**	0	0%

SERVICES FOR THE BLIND

CONSUMER SATISFACTION SURVEY RESULTS (1996-97)*

Did the Division of Services for the Blind work with you on how to get a job, such as how to interview, complete an application, write a resume, etc.?

Yes	37	(19%)
No	27	(14%)
Not Needed	132	(67%)
Total	196	(100%)

Did the Division of Services for the Blind staff help make any changes in a job so that you could do the work?

Yes	16	(8%)
No	40	(21%)
Not Needed	137	(71%)
Total	193	(100%)

Did the Division of Services for the Blind staff help you find a job?

Yes	21	(11%)
No	42	(22%)
Not Needed	130	(67%)
Total	193	(100%)

If your answer was "No" or "Not Needed," please check one of the following which best describes your situation:

Already Working	122	(68%)
Found own Job	37	(20%)
Other	22	(12%)
Total	181	(100%)

If you got a job with help from the Division of Services for the Blind, were you satisfied with the job?

Very Satisfied	26	(74%)
Somewhat Satisfied	5	(14%)
Somewhat Dissatisfied	2	(6%)
Very Dissatisfied	2	(6%)
Total	35	(100%)

** Mailed to 662 individuals whose cases were closed with an employment outcome -- 204 surveys were returned (31%)*

SERVICES FOR THE BLIND

ADEQUATE RESOURCES FOR SPECIALIZED SERVICES?

- **Social Workers for the Blind** (57 Social Worker III Positions)
  - Lack of Training in Providing Adjustment to Blindness Services to Clients
  - Inadequate Case Services Funds
    - Average Caseload: 101 Clients (Ranges from 58 to 179)
    - Case Service Funds: $2,928/Social Worker
  - Day-to-Day Supervision is at Local DSS Office

- **Orientation and Mobility Specialists** (8)
  - Average Caseload: 140 Clients/Year
  - Difficult to Recruit for These Positions

- **Independent Living Rehabilitation Counselors** (11)
  - Average Caseload: 79 Clients/Year
  - Case Services Budget: $12,000 Statewide

- **Management Issues**
  - Lack of Comprehensive Training Program for All Staff
  - Lack of Automation, esp. Assistive Technology for Staff
  - Lack of Centralized Database to Determine No. of Individual Clients Served
  - Opportunities to Deploy Existing Staff Differently?
  - Opportunities to Strengthen the Medical Eye Care Program or to Redirect Resources to Other Uses?

DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING

MISSION:

- Provide Access and Equitable Opportunities for Deaf and Hard of Hearing Individuals to Achieve Maximum Participation and Productivity in Society.

- Provide Innovative Administrative Leadership and Regulatory Authority in the Areas of Education, Employment, and Human Services, Accessibility, Certification of Interpreters, Staff Development, Parent/Public Awareness, and Advocacy.

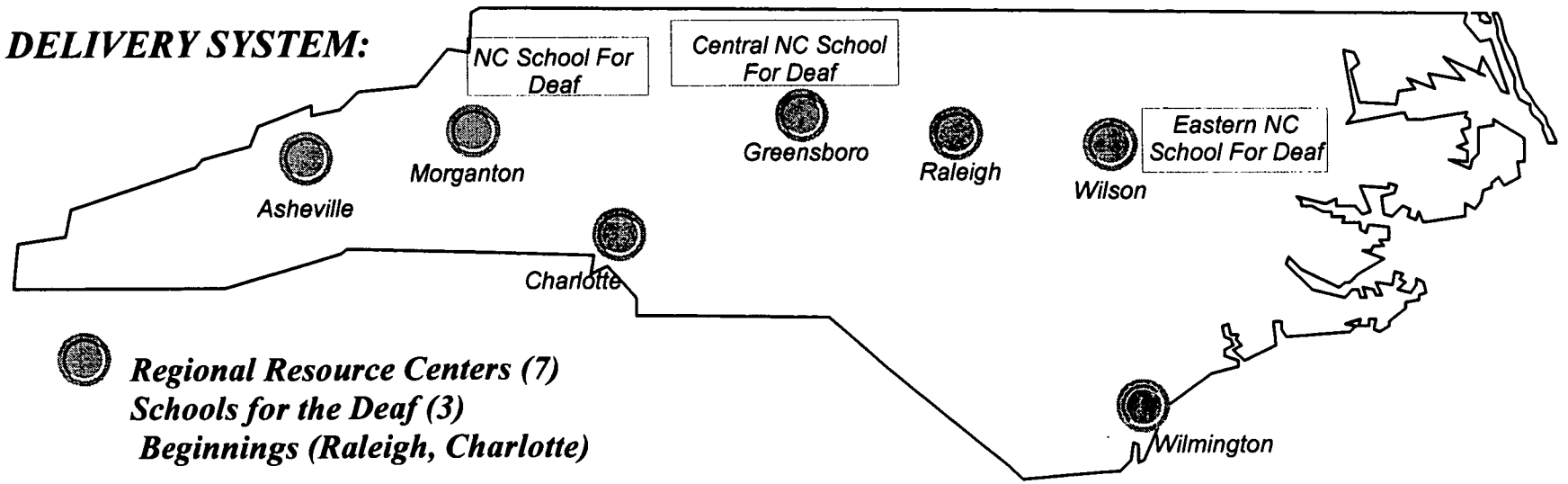
CLIENTS:

- An Estimated 660,000 North Carolinians Are Deaf (60,000) or Hard of Hearing (600,000)

- 665 Students Attend the North Carolina Schools for the Deaf (as of 12/1/98)
  K through 12: 413 Students
  0 to 5 Years: 252 Students

- Approximately 1,700 Deaf and Hard of Hearing Students (K-12) Are Served By Local Education Agencies

DELIVERY SYSTEM:

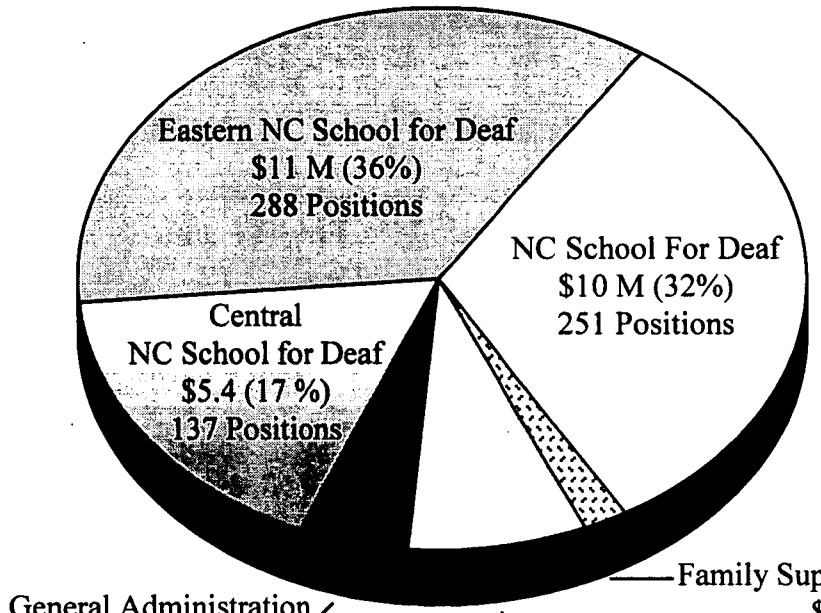


CONTINUATION BUDGET SUMMARY

SERVICES FOR THE DEAF/HARD OF HEARING

	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Requirements	$28,849,026	$30,851,538	$31,863,652	$32,507,618
Receipts	$774,801	$797,191	$774,841	$785,941
Net Appropriation	$28,074,225	$30,054,347	$31,088,811	$31,721,677
Positions	736	736	736	736

1998-99 BUDGET
$30.9 Million
736 Positions



Schools = 85% Funding,
92% Positions

DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING
REGIONAL RESOURCE CENTERS

MISSION:

- Provide Interpreter Services Coordination, Employment Assistance, Advocacy, Outreach, Information Access and Referral, Training, Assistive Technology, and Human Services Coordination

STAFFING:

- Deaf Specialist
- Interpreter Support Service Consultant
- Deaf/Blind Specialist
- Office Assistant
- Hard of Hearing Specialist
- Communications Support Service Consultant
- Regional Manager

SERVICES:

Individuals	Agencies
Information and Referral	Information and Referral
Counseling	Consultation
Skill Development	Technical Assistance
Advocacy	Advocacy

CLIENT NEEDS:

Hard of Hearing Clients:
- Assistive Listening Technology

Deaf Clients:
- Support Interacting With the "System" (e.g., Court, Hospital)
- Assistive Technology/Interpreter Services

REORGANIZATION PROPOSAL

Disability-Related Offices in Select NC Cities

CITIES	VR UNIT OFFICE	DSB DISTRICT OFFICE	REGIONAL RESOURCE CENTER	IL OFFICE
ASHEVILLE	Yes	Yes	Yes	Yes
CHARLOTTE	Yes	Yes	Yes	Yes
WINSTON-SALEM	Yes	Yes	No	Yes
GREENSBORO	Yes	No	Yes	Yes
HICKORY	Yes	No	No	Yes
MORGANTON	Training Facility	No	Yes	No
RALEIGH	Yes	Yes	Yes	Yes
WILMINGTON	Yes	Yes	Yes	Yes
WILSON	Yes	No	Yes	No
GREENVILLE	Yes	Yes	No	Yes
FAYETTEVILLE	Yes	Yes	No	Yes

ADULT SERVICES

SUMMARY

- No Significant Expansion Proposed in Last Five Years

- Only Targeted Appropriations (e.g., Independent Living Rehab Program)

- "Specialization" in Services to Blind, Deaf and Hard of Hearing Adults Cannot Not Exist Without

  - Staff Training
  - Case Services Funds
  - Automation and Assistive Technology

- May be Time to Reevaluate the Status Quo
  - Reduce Costly Duplication of Sites and Administration
  - Invest in Specialized Services,
  - Improve Client Access to Services, and
  - Address Gaps in Common, Core Service Needs (Housing, Transportation, Technology, etc.)

EDUCATION PROGRAMS

LEGISLATIVE HIGHLIGHTS

DHHS:

- Expanded Early Intervention Services (1997 Session)
- Directed Feasibility Study of Implementing ABCs Plan in DHHS Schools (1997 Session)
- Directed Early Intervention System Study (1998 Session)
- Implemented ABCs Plan with Provisions for Technical Assistance (HB 1477, 1998 Session)
- Authorized Teacher Salary Supplements (1998 Session)
- Directed Collaborative Effort to Strengthen Working Relationships Between LEAs and Residential Schools

Governor Morehead School:

- Provided 4 Itinerant VI-Certified Teachers to Assist LEAs (1995 Session)
- Directed UNC Board of Governors to Implement a Special Education Masters Degree in VI (1995)

Schools for the Deaf:

- Appropriated Funding to Improve Deaf Education (1995 Session)
- Provided Substantial Capital and Repair and Renovation Funding (1995 Session)
- Privatized Family Support Services (1995 Session)
- Funded Cued Speech Center (Annually)
- Authorized Universal Newborn Hearing Screenings (1998 Session)

DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING

SCHOOL ENROLLMENT DATA (as of 12/1/98)

K Through 12

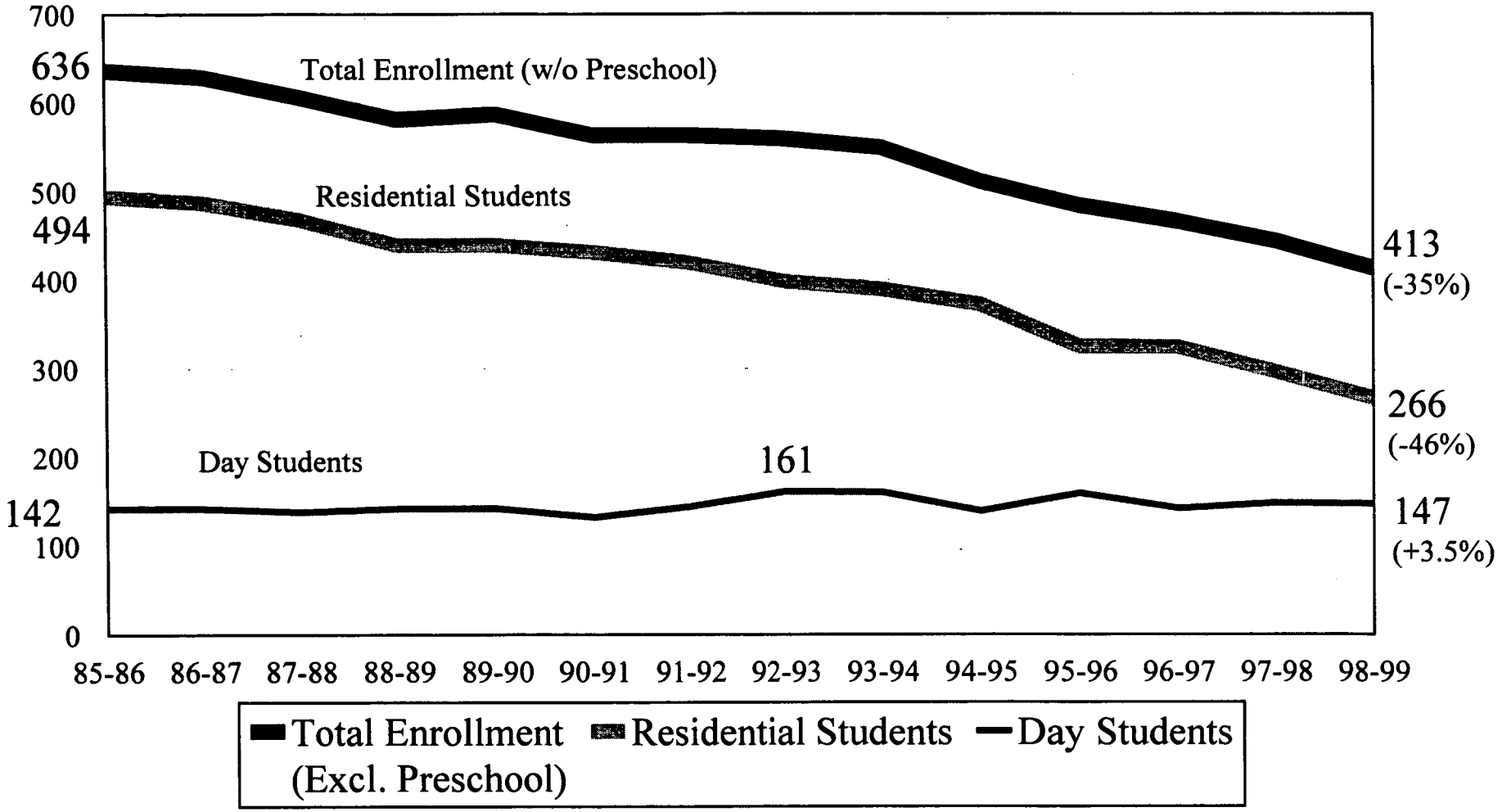
Number of Students	NCSD	CNCSD	ENCSD	TOTAL
Residential	98	46	122	266
Day	42	36	69	147
Total	**140**	**82**	**191**	**413**
Design Capacity	450 (280 Res.)	240 (128 Res.)	403 (265 Res.)	1,093 (673 Res.)

Preschool

Number of Students	NCSD	CNCSD	ENCSD	TOTAL
Total	**103**	**56**	**93**	**252**

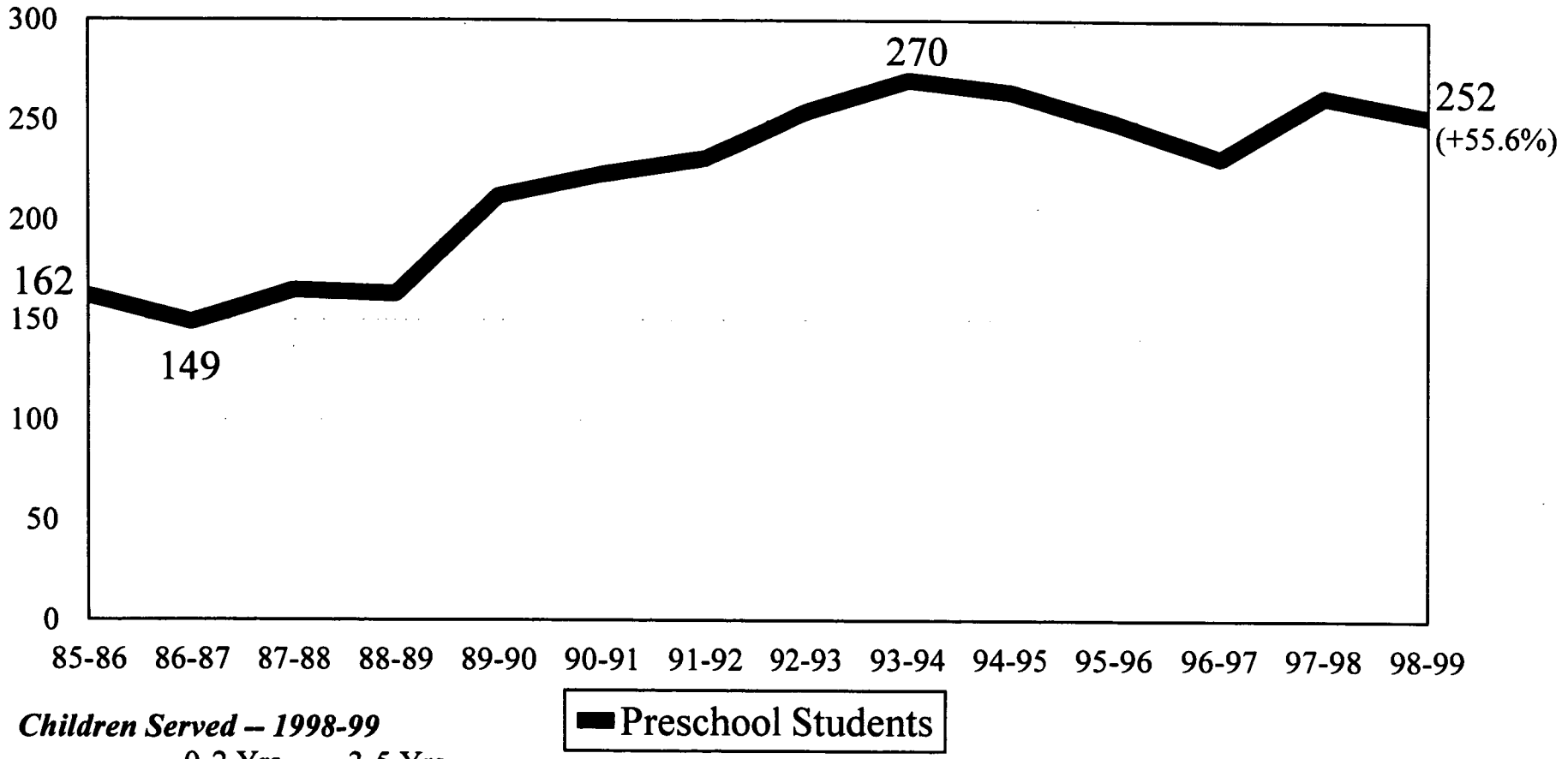
DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING

RESIDENTIAL SCHOOL ENROLLMENT TRENDS
(Excluding Preschool)



DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING

PRESCHOOL ENROLLMENT TRENDS



Children Served – 1998-99

	0-2 Yrs.	3-5 Yrs.
NCSD	37	61
CNCSD	12	42
ENCSD	36	65
Total	85	168

1998-99 Budget: $5.2 M

RESIDENTIAL SCHOOLS FOR THE DEAF
COST

K Through 12

1998-99	NCSD	CNCSD	ENCSD
Avg. Educational Cost/Student	$42,384	$32,107	$34,927
Avg. Residential Cost/Student	$21,789	$22,043	$24,905
Total Cost/Residential Student	**$64,173**	**$54,150**	**$59,832**

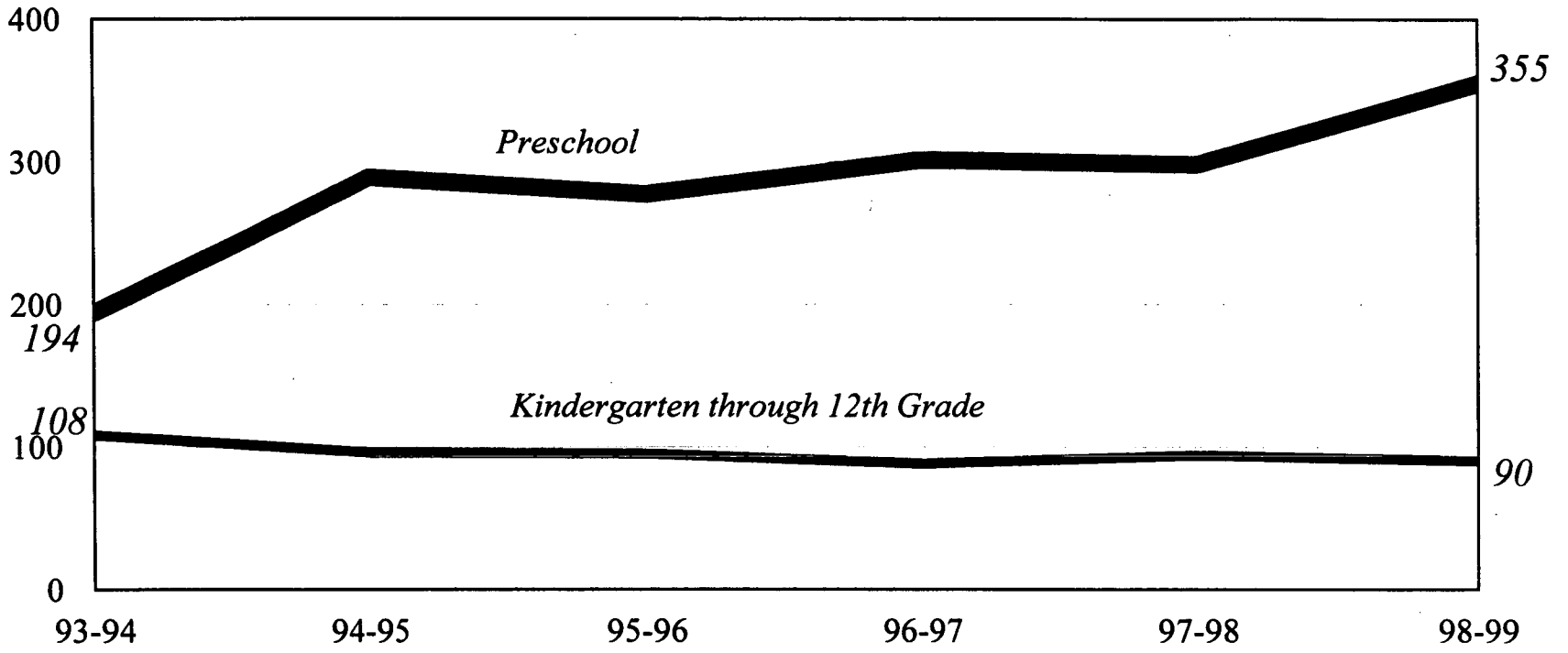
1995-96			
Avg. Educational Cost/Student	$26,397	$28,635	$25,773
Avg. Residential Cost/Student	$14,542	$13,524	$14,699
Total Cost/Residential Student	**$40,939**	**$42,159**	**$40,472**

Preschool

	NCSD	CNCSD	ENCSD
1998-99			
Total Expenditures	$959,819	$860,852	$1,115,730
Avg. Cost/Student	**$10,547**	**$14,348**	**$11,157**
1995-96			
Total Expenditures	$1,592,613	$1,785,040	$2,032,078
Avg. Cost/Student	**$15,614**	**$31,316**	**$21,167**

SERVICES FOR THE BLIND

GOV. MOREHEAD SCHOOL ENROLLMENT/COST



K Through 12th Grade	1998-99	1995-96
Avg. Educational Cost/Student	$47,198	$21,415
Avg. Residential Cost/Student:	$21,499	$19,578
Total Cost/Residential Student	$68,697	$40,993

Preschool - 1998-99
0 to 2 Yrs.: 150 Children
3 to 5 Yrs: 205 Children
Budget: $3.5M

RESIDENTIAL SCHOOLS

DPI ASSISTANCE TEAMS (May 1998)

- ***FINDINGS***

- Not Following the Standard Course of Study; Do Not Understand Concepts/Processes of the ABCs Plan
- Testing Procedures Not Adequate to Determine Student Performance on Grade Level
- IEPs Not Being Followed by Classroom Teachers
- Libraries Out of Date/Inadequate Materials for Implementing Standard Course of Study
- Need Additional Braille Texts and Other Materials

- ***RECOMMENDATIONS***

- On-Site Assistance Teams in 1998-99
- In-Depth Staff Training on the Standard Course of Study
- Accountability Plan for Students Exempt From End of Grade Testing
- Modality and Amplification Decisions Based on IEPs
- Collaborative Programs with Local School Systems

GOVERNOR MOREHEAD SCHOOL (GMS)

EVOLVING ROLE AS A STATEWIDE RESOURCE

- 850 Visually-Impaired (VI) Students Served in LEAs (K through 12th Grade)
- More Than Half of All LEAs Serve Students Without a VI-Certified Teacher
- More Than 40% of NC's VI-Certified Teachers Work at GMS

GMS SERVICES:

- Preschool Program
- Field Staff and Outreach Program
- Special Skills Program and Extended School Year
- Teacher Training and Development
    - Masters Degree in Visual Impairment (with NCCU)
    - Distance Learning
- Advocacy for Students, Parents, and Professionals

EDUCATION PROGRAMS

FUNDING-RELATED ISSUES

Cued Speech Center	$185,000 NR
GMS Early Intervention Services	$200,000 NR
Teacher Salary Supplements	N/A
Proposed Elimination of Vacant Positions	$233,425 R

RECOMMENDED POSITION ELIMINATIONS

VOCATIONAL REHABILITATION SERVICES

POSITION TITLE	TOTAL VALUE	GENERAL FUND SAVINGS
1. Administrative Officer	$28,732	$20,687
2. Printing Operator	$47,167	$11,320
Subtotal	$75,899	$32,007
Benefits	$16,944	$7,348
Total	**$92,843**	**$39,355**

SERVICES FOR THE BLIND

1. Assistant Principal	$28,307	
2. Processing Assistant II	$11,189	
3. Educational Diagnostician I	$31,652	
4. Educational Diagnostician I	$31,652	
Subtotal	$102,800	
Benefits	$25,191	
Total	**$127,991**	**$127,991**

SERVICES FOR THE DEAF AND HARD OF HEARING

1. Administrative Officer II (NCSD)	$30,609	
2. Guidance Counselor (ENCSD)	$23,110	
3. Parent Trainer (ENCSD)	$22,693	
4. Staff Dev. Specialist II (CNCSD)	$29,022	
5. Deaf-Blind Program Consultant	$31,337	
Subtotal	$136,771	
Benefits	$32,957	
Total	**$169,728**	**$169,728**

EDUCATION PROGRAMS

ISSUES

Preschool

- Consistent Management Across Programs/ Integration into Early Intervention System
- Recruitment
- Support for Cued Speech Oral Auditory Programming
- Improved Outcome Data

K Through 12th Grades

- Student Safety
- Implementation of ABCs Plan (HB 1477)
- Resource Needs
- Role of Residential Schools
- Management of Residential Schools

EDUCATION PROGRAMS

SUMMARY

- Continued Dilligence and Commitment Required to Improve School Safety and Academic Performance

- Need Management With Strong Education Background to Succeed

- Need a Well-Defined Role for the Schools -- or Succumb to Declining Enrollments, Escalating Costs, and Unmet Program Needs

- Establish Consistent Management Across Campuses
  - -Business Management Functions
  - -Policy and Programs

- Integrate Preschools into the Early Intervention System

- Address Recruitment Issues

VISITOR REGISTRATION SHEET

[illegible]th & Human Res. 4-13-99

[illegible] of Committee Date 8:30

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
[illegible]	OSBM
[illegible]	UAB.
George Lee	Gov. Morehead Sch.
John DeLuca	Director Div. Serv. Blind
Roslyn Savitt	NC Child Care Coalition
Karen Chester	NC-ICC
[illegible]	DMT/DD/SOS
Kathryn Baars	Excep. Children DPI
C.L. Cochran	C2001 - UCPNC
Bob [illegible]	DHHS
[illegible] Williamson	DIV. PUBLIC HEALTH
Tom Vitaglione	DPH
Mary Greene	OSBM
[illegible]	OSPL
Jo Perkins	DVRS
Ed Cochrane Brown	DHHS-BP&A
Jewell [illegible]	DPI.
Beckie Stout	PPAB -
Joanne Schaa	NC nurses
Herman Gruber	NFB of NC
Dixie Gruber	NFB of NC

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
April 14, 1999
8:30 A.M.

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Wednesday, April 14, 1999, in Room 424 of the Legislative Office Building.

House Chairman, Representative Edd Nye presided. Other House members present were Representative Beverly Earle (Co-Chairman), Representative Martha Alexander (Vice Chairman), Representative Alma Adams, Representative Lanier Cansler, Representative Theresa Esposito, Representative Trudi Walend, and Representative Gene Wilson. There were six senators present.

Chairman Nye acknowledged Ms. Mary Ellen Sylvester, Fiscal Research Division, who discussed the Vocational Rehabilitation Services. She stated General Vocational Rehabilitation Agencies were requested to review the services. ACCESS, NC is funded with special license plates funds. There are four Technology Project Centers in the state; Greenville, Raleigh, Winston- Salem and Charlotte. Fifteen percent of clients were prevented from being institutionalized. Representative Esposito asked the committee and staff to speak slowly and louder when asking and answering questions due to deaf population in meeting and asked that an interpreter be in meetings. Senator Kerr asked questions concerning the brain injury group.

Ms. Sylvester then discussed the second section, services for the blind. The federal definition of legally blind is two hundred or less in better eye, or field of vision constricted to twenty degrees or less. Department staff stated Vocational Agency services enable people who are working to keep on working, helps people with skills to find their own jobs, and try to help people with disabilities early enough to keep their job rather than find another one.

Mr. John Deluca, Blind Services, DHHS, was present and was asked questions by the committee. He stated the Lions Clubs contribute to the Vocational Rehabilitation Services for the Blind. Senator Martin stated the training program for social workers needs to be looked at throughout the Department. Mr. Deluca stated there is a problem finding resources for training social workers.

Chairman Nye ended the meeting.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbitt
Committee Assistant

DIVISION OVERVIEWS

Vocational Rehabilitation Services

Services for the Blind

Services for the Deaf & Hard of Hearing

Presented by:
Mary Ellen Sylvester
Fiscal Research Division
April 13, 1999

VOCATIONAL REHABILITATION (VR) SERVICES

REHABILITATION ACT of 1973, TITLE I

(as Reauthorized in 1998)

Individuals With Disabilities, Including the Most Significant Disabilities,

- Are Presumed Capable of Engaging in Gainful Employment (With VR Services)
- Need Opportunities for Gainful Employment in Integrated Settings
- Must Be Full, Active Partners, Making Meaningful and Informed Choices

Eligibility for VR Services

- Physical or Mental Impairment Which is a Substantial Impediment to Employment
- VR Services are Required to Prepare for, Secure, Retain, or Regain Employment

VR Services

- Individualized, Consumer-Driven, Goal-Oriented, Time-Limited

Significant 1998 Amendments:

1) Presumed Eligibility for SSI/SSDI Clients
2) Qualified Vocational Rehabilitation Counselor
3) Informed Client Choice
4) Integration into a Statewide Workforce Investment System

VOCATIONAL REHABILITATION SERVICES

MISSION

To Promote Employment and Independence for Persons with Disabilities
Through Customer Partnerships and Community Leadership

VISION

- Be Leading Employment Resource for Persons With Disabilities, Business, and Industry
- Promote Inclusion into the Community

PROGRAMS	*SERVICES*
Vocational Rehabilitation	Evaluation, Counseling & Guidance, Physical/Mental Restoration, Training, Job Placement, Interpreter Services
Supported Employment	Extensive On-Site Training in Competitive Employment with Long Term Support Services
Client Assistance Program	Information & Referral, Assistance With Appeals Process
Assistive Technology	Statewide Awareness and Demonstration of Assistive Technology for Disabled Persons (4 Demo Centers)
Independent Living Rehabilitation	Rehabilitation Engineering, Adaptive Equipment Purchases, Personal Assistance Services, and Rehabilitation Therapy
ACCESS, North Carolina	NC Travel and Tourism Guide for Disabled Persons and Accessibility/Barrier Removal Projects at Travel Sites
Disability Determination Services	Processing of SSI/SSDI Applications From Social Security Administration Offices and Medicaid Eligibility Claims From Local Depts. of Social Services

VOCATIONAL REHABILITATION SERVICES

CLIENTS: - Evaluate More Than 28,000 *New* Clients Each Year

- Serve Approximately 60,000 Clients in Total

  -- 74% Have a "Significant Disability" (Limits 1 or More Functional Capacities/ Requires Multiple VR Services Over an Extended Period)

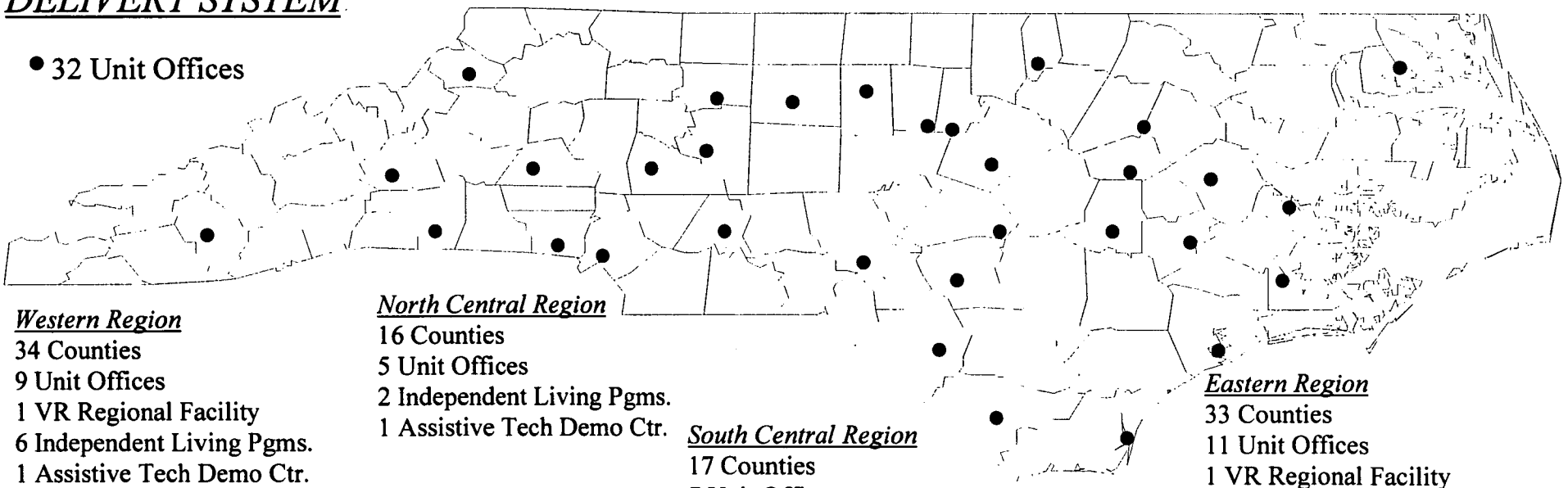
  -- 25% Have a "Most Significant Disability" (In NC, 3+ Functional Limitations)

- 60% Complete Their Individual Written Rehabilitation Program Successfully

- In 1997-98, 37% were 22 Years Old or Younger

DELIVERY SYSTEM

- 32 Unit Offices



Western Region
34 Counties
9 Unit Offices
1 VR Regional Facility
6 Independent Living Pgms.
1 Assistive Tech Demo Ctr.

North Central Region
16 Counties
5 Unit Offices
2 Independent Living Pgms.
1 Assistive Tech Demo Ctr.

South Central Region
17 Counties
7 Unit Offices
3 Independent Living Pgms.
1 Assistive Tech Demo Ctr.

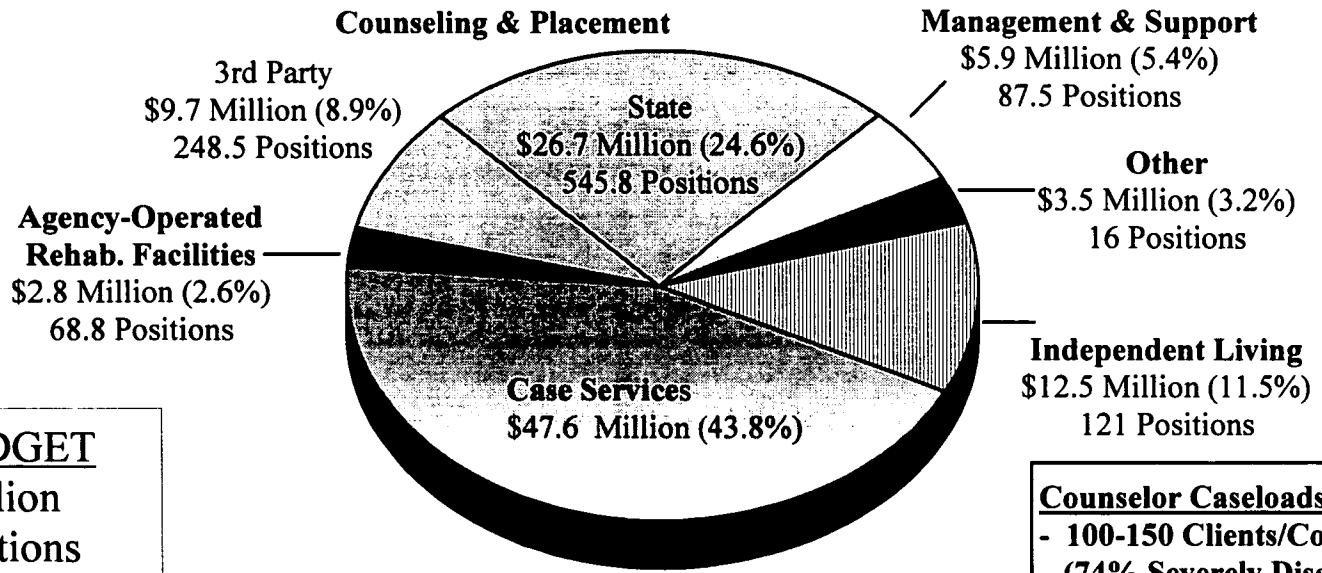
Eastern Region
33 Counties
11 Unit Offices
1 VR Regional Facility
5 Independent Living Pgms.
1 Assistive Tech Demo Ctr.

Plus,
One-Stop Career Centers and 3rd Party Locations

CONTINUATION BUDGET SUMMARY

VOCATIONAL REHABILITATION SERVICES

	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Requirements*	$112,074,630	$108,685,514	$110,054,438	$111,995,775
Receipts	$78,452,334	$72,909,660	$74,411,084	$75,137,905
Net Appropriation	$33,622,296	$35,775,854	$35,643,354	$36,857,870
Positions	1,087.6	1,087.6	1,087.6	1,135.6



1998-99 BUDGET
$108.7 Million
1,087.6 Positions

Counselor Caseloads:
- **100-150 Clients/Counselor (74% Severely Disabled)**
- **25 Clients Rehabilitated/Year (Min.)**

** Does Not Include Funding for Disability Determination Services (1998-99: $43 M, 640 Positions)*

VOCATIONAL REHABILITATION SERVICES

CLIENT OUTCOMES (1997-98)

8,527 Clients Rehabilitated

	At Application		At Closure	
Work Status	**Number of Clients**	**%**	**Number of Clients**	**%**
Competitive Labor Market	1,712	20.1%	**8,156**	**95.7%**
Self-Employed	42	0.5%	**173**	**2.0%**
Sheltered Workshop	80	0.9%	63	0.8%
State Employee	0	0%	1	0%
Homemaker	30	0.4%	106	1.2%
Unpaid Family Worker	4	0%	28	0.3%
Not Working	**6,659**	**78.1%**	0	0%
Primary Source of Support				
Earnings	1,581	**18.5%**	6,809	**79.9%**
Public Assistance	900	10.6%	381	4.5%
No Weekly Earnings	6,693	**78.5%**	134	**1.6%**
Hours Worked Week Before				
None	6,693	78.5%	134	1.6%
1-39	1,339	15.7%	2,979	34.9%
40+	495	**5.8%**	5,414	**63.5%**

VOCATIONAL REHABILITATION SERVICES

LEGISLATIVE HIGHLIGHTS

- Legislation Establishing a State Vocational Rehabilitation/Independent Living Program (1995)

- Completion/Expansion of the Independent Living Rehabilitation Program (1990s)

- Provision of "Establishment of Facility" Funding ($500,000 NR -- 1998-99)

- New, Specialized Programming for Traumatic Brain Injury, Spinal Cord Injury, and Significantly Disabled Deaf Clients [including Vocational Evaluation, Training, and Transitional Housing] ($300,000 -- 1998-99)

- Replacement Funding for NC Assistive Technology Project ($200,000 NR -- 1998-99)

VOCATIONAL REHABILITATION SERVICES

FUNDING-RELATED ISSUES

NC Assistive Technology Project

Independent Living Rehabilitation Program

- *Waiting List*
- *NC Brain Injury Association Project*

Elimination of Two Vacant Positions

VOCATIONAL REHABILITATION SERVICES

NC ASSISTIVE TECHNOLOGY PROJECT

Purpose:
- Provide Information, Technical Assistance, and Demonstration of Assistive Technology
- Serve All Ages, All Disabilities, All Aspects of Life

4 Demo Centers: Greenville, Raleigh, Winston-Salem, Charlotte *

1998-99 Budget:

$ 597,800	Federal Funds
$ 361,940	General Fund ($200,000 is non-recurring)
$ 19,954	Local Funds
$ 50,000	Kate B. Reynolds Grant
$1,029,694	

Scheduled Phase-out of Federal Funding:

97-98	98-99	99-00	00-01	03-04
- $0	-$199,266	-$398,533	-$398,533	-$797,066
- 0%	- 25%	- 50%	- 50%	- 100%

General Assembly Replaced Reduced Federal Funds in 1998-99 With $200,000 Non-Recurring Funds

Now, Program Needs $398,533 in State Funds to Maintain Current Service Level for Next 4 Years

Impact of Reduced Budget: Close 2 Centers in 1999-00

1997-98 Accomplishments:
- Information and Referral to 3,230 People
- 198 Training/Awareness Sessions Attended By 8,413 Individuals
- 7th Annual NC Assistive Technology Expo Attended by 1,200 People
- 1,417 Consumers and 1,777 Professionals Visited Demonstration Centers
- 372 Requests for Professional Assistance in Financing Assistive Technology

** Plus, New Satellite Center in Elizabeth City, Funded With Kate B. Reynolds Grant*

VOCATIONAL REHABILITATION SERVICES
INDEPENDENT LIVING REHABILITATION PROGRAM

Purpose: **Promote Personal Independence of Severely Disabled Individuals**
- Provide an Alternative to Institutionalization
- Improve Functioning in One's Family, Home, and Community
- Prepare for Traditional VR Services

Services:
- Rehabilitation Engineering
- Assistive Equipment Purchases
- Home and Vehicle Modifications
- Guidance and Counseling
- Consumer-Managed Personal Assistance

Typical Office:

Budget:	$650,000 to $800,000 Per Year ($225,000 for Case Services; $150,000 for Personal Assistance)
Staffing:	6-9 Rehabilitation Specialists (22% Disabled)
Expected Outcomes:	Serve 200+ Clients/Year, With 80+ Clients Achieving Goals
Avg. Expenditure:	Personal Assistance $8,755/Client One-Time Eqpt. Expenditures $3,150/Client

1997-98 Accomplishments:

		1995-96
Clients Served:	3,778	2,382 (+59%)
New Clients:	2,773	1,765 (+57%)
Achieved Goals:	1,504 Clients	874 (+72%)
Personal Assistance:	248 Clients	179 (+39%)

37 Clients Relocated from Nursing Homes to Community-Based Arrangements

232 Clients Prevented From Being Institutionalized

VOCATIONAL REHABILITATION SERVICES

INDEPENDENT LIVING REHABILITATION PROGRAM

Waiting Lists
(as of 3/31/99)

OFFICE	CASE SERVICES # Clients	CASE SERVICES Funds Needed	PERSONAL ASSISTANCE # Clients	PERSONAL ASSISTANCE Funds Needed
Albemarle	88	$130,327	4	$21,702
Asheville	41	$165,960	0	$0
Boone	64	$237,050	2	$5,088
Charlotte	91	$295,450	5	$40,800
Durham	22	$66,800	0	$0
Elizabeth City	51	$99,483	2	$17,472
Fayetteville	38	$90,500	9	$56,250
Greensboro	31	$233,650	31	$202,560
Greenville	103	$376,757	0	$0
Hickory	106	$458,750	10	$63,677
New Bern	33	$82,985	2	$25,000
Raleigh	69	$186,825	0	$0
Rocky Mount	99	$363,589	9	$48,840
Sylva	30	$86,075	0	$0
Wilmington	37	$136,500	0	$0
Winston-Salem	63	$298,473	13	$97,932
Total	**966**	**$3,309,174**	**87**	**$579,321**

Annual Budget: **Case Services:** **$4.3 Million**
Personal Assistance: **$2.3 Million**

Total Budget for Case Services and Personal Assistance Funding is 93% Obligated as of 3/31/99

//

VOCATIONAL REHABILITATION SERVICES

NC BRAIN INJURY ASSOCIATION PROJECT

- Purpose
  - Provide intensive early intervention, followed by assistance in coordinating a network of services, to individuals with brain injuries who have the potential to live independently

- Funded with an 18-month Kate B. Reynolds demonstration grant (expired Oct 98)
  - Developed at the request of the NC Brain Injury Association
  - IL Counselor/Care Coordinator positions established in Winston-Salem and Greenville
  - In Oct 98, Foundation extended funding for the 2 positions by one year
  - However, IL Rehab Program is contributing case services funds

- Active Caseloads: 30+ Clients/Office

- Cost to Maintain Existing Services in 1999-00: $350,000 (2 positions and case services funds)

SERVICES FOR THE BLIND

MISSION

To Empower Individuals Who are Blind or Visually-Impaired to Achieve Their Maximum Potential Through Services Provided by Competent and Caring Professionals

PROGRAMS	*SERVICES*
Vocational Rehabilitation	Evaluation, Counseling & Guidance, Physical/Mental Restoration, Orientation and Mobility, Training, Job Placement, Reader Services
Supported Employment	Extensive On-Site Training in Competitive Employment With Long Term Support Services
Business Enterprises	Job Opportunities as Operators of Food Service Facilities and Vending Operations
Technology Resource Center	Assistive Technology Demonstration, Evaluation, and Training; Rehabilitation Engineering Services
Deaf-Blind Program	Evaluation, Training, Information and Referral, Advocacy and Support
Independent Living/Social Services	Chore Services and Adjustment to Blindness Services
Medical Eye Care Program	Eye Exams, Eyeglasses, and Surgery for Low Income Individuals; Screenings, Education, and Low Vision Services
Governor Morehead School	Early Intervention, K through 12th Grades, Counseling, Therapy, Braille, Orientation and Mobility, Transition, Outreach, and Teacher Training

SERVICES FOR THE BLIND

CLIENTS:

Definition of "Legally Blind:"

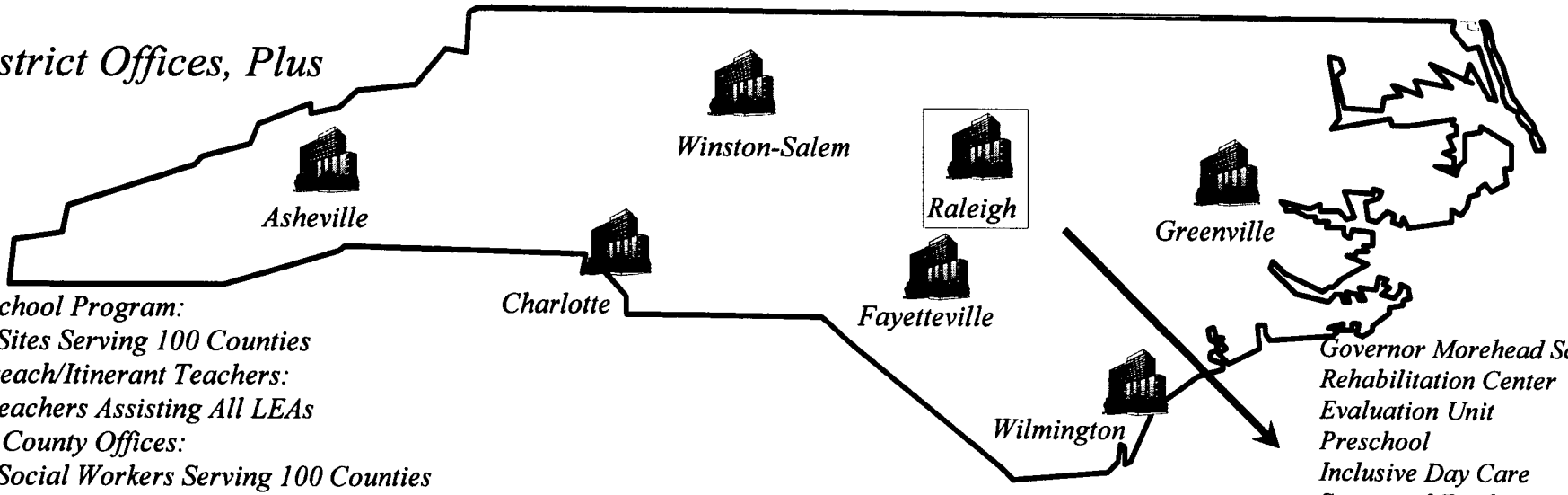
- *20/200 or Less Vision in the Better Eye with Corrective Lenses, or*
- *Field of Vision Constricted to 20 Degrees or Less*

Clients Referred From the General VR Agency:

- *Legally Blind*
- *Vision Between 20/100 and 20/200, If Having Difficulty Adjusting to Loss of Vision*
- *Night Blindness, Limited Field of Vision, or Rapidly Progressive Eye Condition (Leading to Legal Blindness)*
- *All Who Need Eye Treatment and/or Surgery, Regardless of Vision*

DELIVERY SYSTEM:

7 District Offices, Plus



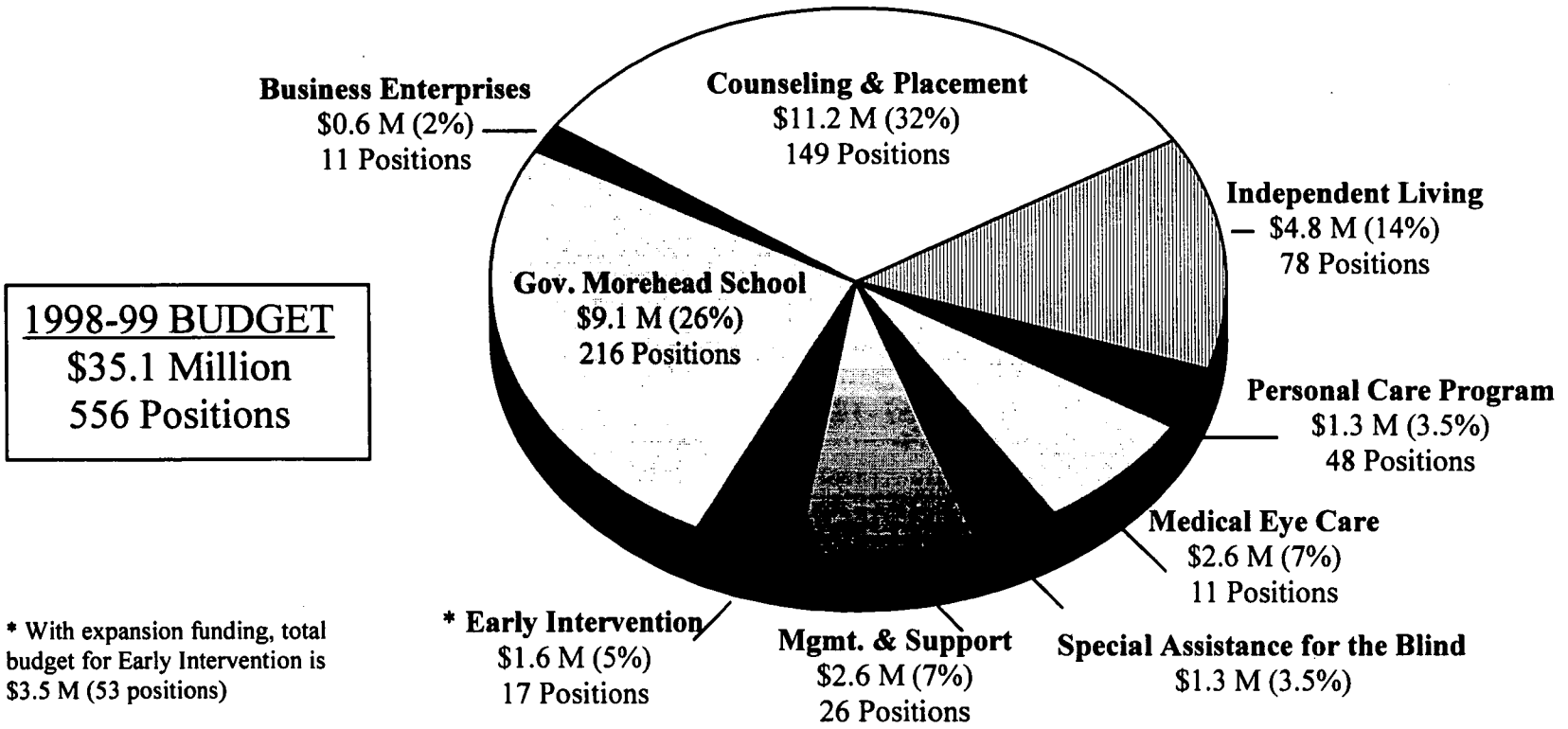
Preschool Program:
17 Sites Serving 100 Counties
Outreach/Itinerant Teachers:
6 Teachers Assisting All LEAs
DSS County Offices:
57 Social Workers Serving 100 Counties
5 Supported Employment Locations
7 Workshops for the Blind

Governor Morehead School
Rehabilitation Center
Evaluation Unit
Preschool
Inclusive Day Care
Supported Employment
Resource Center
Workshop for the Blind

CONTINUATION BUDGET SUMMARY

SERVICES FOR THE BLIND

	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Requirements	$32,434,832	$35,140,241	$35,130,567	$35,126,212
Receipts	$18,755,653	$17,797,445	$17,877,888	$17,881,370
Appropriation	$13,679,179	$17,342,796	$17,252,679	$17,244,842
Positions	554	556	556	556



* With expansion funding, total budget for Early Intervention is $3.5 M (53 positions)

SERVICES FOR THE BLIND

LEGISLATIVE HIGHLIGHTS

- Provided Funding to Maintain Extended Service Provider Positions in the Supported Employment Program ($250,000 -- 1995 Session)

- Requested State Auditor Conduct a Performance Audit of the Division of Services for the Blind (1996 Session)

SERVICES FOR THE BLIND

ISSUES

- Are Blind People Being Served?

- Are Resources Adequate to Deliver Specialized Services?

SERVICES FOR THE BLIND

VR CLIENT OUTCOMES (1997-98)

Total Clients Served		3,679
- Severely Disabled		2,875 (78%)
- Legally Blind		1,146 (31%)
Number of Clients Rehabilitated		810
- Severely Disabled		600 (74%)
- Legally Blind		178 (22%)
Number of Non-Wage Earners		174 (21%)
Number of Wage Earners		636
- Legally Blind, Placed in Remunerative Employment, Earning Minimum Wage or Better		119
- Legally Blind, Placed in Competitive Employment, Earning Minimum Wage or Better		98 (12%)
Number of Clients Receiving Physical Restoration Only		45 (6%)
Number of Clients Placed in Jobs by Division Staff		65 (8%)
Average Cost of Purchased Services:		$3,079/Client
Average Earnings:	<u>At Application</u>	<u>At Closure</u>
	$113.55	$263.77 (+132%)

SERVICES FOR THE BLIND

CLIENT OUTCOMES (1997-98)

810 Clients Rehabilitated

	At Application		At Closure	
Work Status	**Number of Clients**	**%**	**Number of Clients**	**%**
Competitive Labor Market	338	42%	515	64%
Self-Employed	56	7%	100	12%
Business Enterprises	1	0%	5	1%
Sheltered Workshop	5	1%	16	2%
Student	25	3%	0	0%
Homemaker	76	9%	167	20%
Unpaid Family Worker	2	0%	7	1%
Not Working	307	**38%**	0	0%

SERVICES FOR THE BLIND

CONSUMER SATISFACTION SURVEY RESULTS (1996-97)*

Did the Division of Services for the Blind work with you on how to get a job, such as how to interview, complete an application, write a resume, etc.?

Yes	37	(19%)
No	27	(14%)
Not Needed	132	(67%)
Total	196	(100%)

Did the Division of Services for the Blind staff help make any changes in a job so that you could do the work?

Yes	16	(8%)
No	40	(21%)
Not Needed	137	(71%)
Total	193	(100%)

Did the Division of Services for the Blind staff help you find a job?

Yes	21	(11%)
No	42	(22%)
Not Needed	130	(67%)
Total	193	(100%)

If your answer was "No" or "Not Needed," please check one of the following which best describes your situation:

Already Working	122	(68%)
Found own Job	37	(20%)
Other	22	(12%)
Total	181	(100%)

If you got a job with help from the Division of Services for the Blind, were you satisfied with the job?

Very Satisfied	26	(74%)
Somewhat Satisfied	5	(14%)
Somewhat Dissatisfied	2	(6%)
Very Dissatisfied	2	(6%)
Total	35	(100%)

** Mailed to 662 individuals whose cases were closed with an employment outcome -- 204 surveys were returned (31%)*

SERVICES FOR THE BLIND

ADEQUATE RESOURCES FOR SPECIALIZED SERVICES?

- **Social Workers for the Blind** (57 Social Worker III Positions)
  - Lack of Training in Providing Adjustment to Blindness Services to Clients
  - Inadequate Case Services Funds
    - Average Caseload: 101 Clients (Ranges from 58 to 179)
    - Case Service Funds: $2,928/Social Worker
  - Day-to-Day Supervision is at Local DSS Office

- **Orientation and Mobility Specialists** (8)
  - Average Caseload: 140 Clients/Year
  - Difficult to Recruit for These Positions

- **Independent Living Rehabilitation Counselors** (11)
  - Average Caseload: 79 Clients/Year
  - Case Services Budget: $12,000 Statewide

- **Management Issues**
  - Lack of Comprehensive Training Program for All Staff
  - Lack of Automation, esp. Assistive Technology for Staff
  - Lack of Centralized Database to Determine No. of Individual Clients Served
  - Opportunities to Deploy Existing Staff Differently?
  - Opportunities to Strengthen the Medical Eye Care Program or to Redirect Resources to Other Uses?

DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING

MISSION:

- Provide Access and Equitable Opportunities for Deaf and Hard of Hearing Individuals to Achieve Maximum Participation and Productivity in Society.

- Provide Innovative Administrative Leadership and Regulatory Authority in the Areas of Education, Employment, and Human Services, Accessibility, Certification of Interpreters, Staff Development, Parent/Public Awareness, and Advocacy.

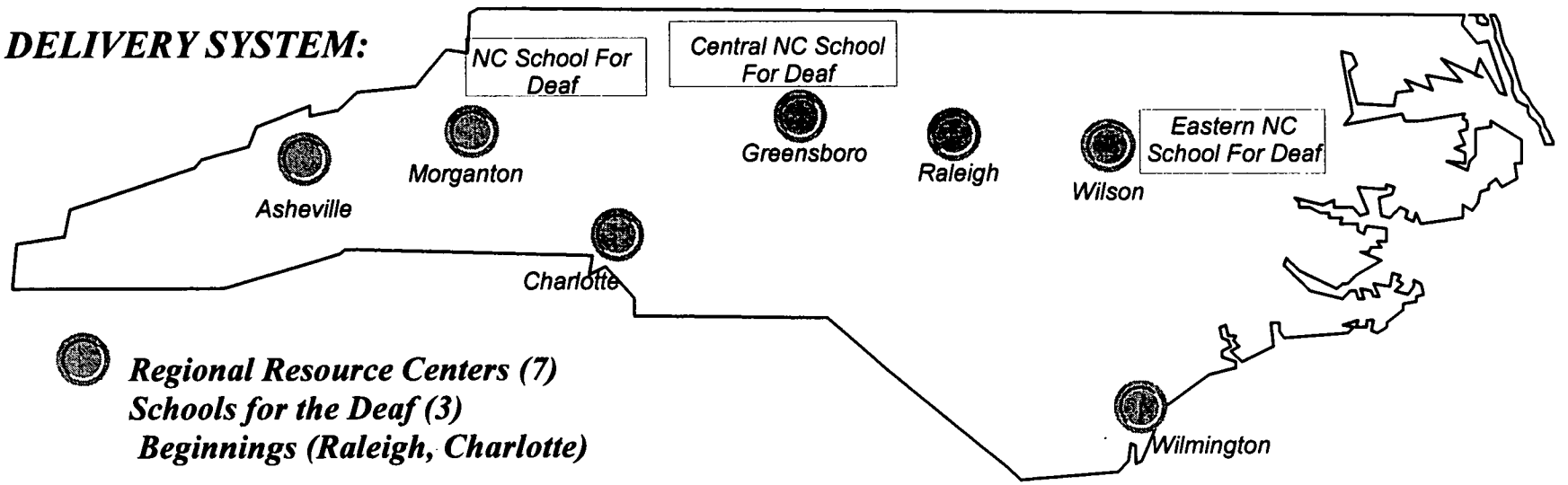
CLIENTS:

- An Estimated 660,000 North Carolinians Are Deaf (60,000) or Hard of Hearing (600,000)

- 665 Students Attend the North Carolina Schools for the Deaf (as of 12/1/98)
  K through 12: 413 Students
  0 to 5 Years: 252 Students

- Approximately 1,700 Deaf and Hard of Hearing Students (K-12) Are Served By Local Education Agencies

DELIVERY SYSTEM:

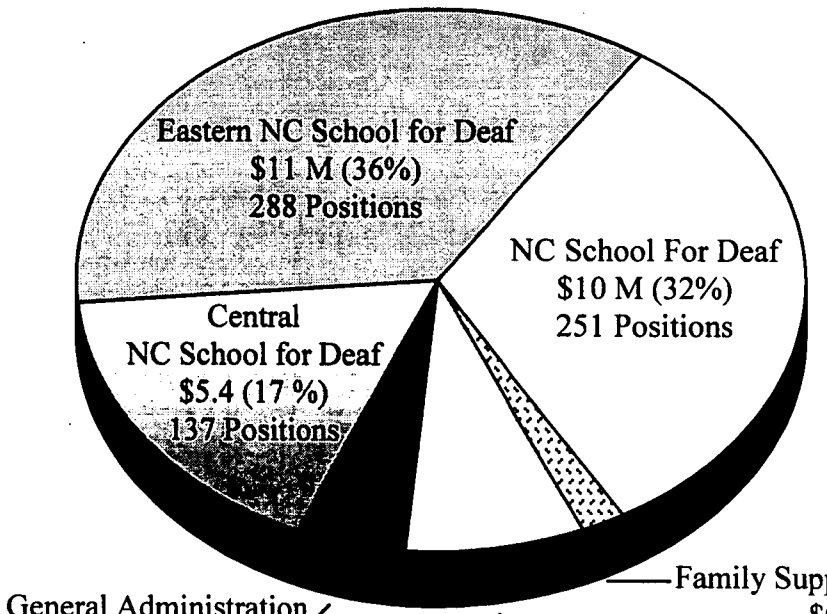


CONTINUATION BUDGET SUMMARY

SERVICES FOR THE DEAF/HARD OF HEARING

	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Requirements	$28,849,026	$30,851,538	$31,863,652	$32,507,618
Receipts	$774,801	$797,191	$774,841	$785,941
Net Appropriation	$28,074,225	$30,054,347	$31,088,811	$31,721,677
Positions	736	736	736	736

1998-99 BUDGET
$30.9 Million
736 Positions



Schools = 85% Funding,
92% Positions

DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING
REGIONAL RESOURCE CENTERS

MISSION:

- Provide Interpreter Services Coordination, Employment Assistance, Advocacy, Outreach, Information Access and Referral, Training, Assistive Technology, and Human Services Coordination

STAFFING:

- Deaf Specialist
- Interpreter Support Service Consultant
- Deaf/Blind Specialist
- Office Assistant
- Hard of Hearing Specialist
- Communications Support Service Consultant
- Regional Manager

SERVICES:

Individuals	Agencies
Information and Referral	Information and Referral
Counseling	Consultation
Skill Development	Technical Assistance
Advocacy	Advocacy

CLIENT NEEDS:

Hard of Hearing Clients:
- Assistive Listening Technology

Deaf Clients:
- Support Interacting With the "System" (e.g., Court, Hospital)
- Assistive Technology/Interpreter Services

REORGANIZATION PROPOSAL

Disability-Related Offices in Select NC Cities

CITIES	VR UNIT OFFICE	DSB DISTRICT OFFICE	REGIONAL RESOURCE CENTER	IL OFFICE
ASHEVILLE	Yes	Yes	Yes	Yes
CHARLOTTE	Yes	Yes	Yes	Yes
WINSTON-SALEM	Yes	Yes	No	Yes
GREENSBORO	Yes	No	Yes	Yes
HICKORY	Yes	No	No	Yes
MORGANTON	Training Facility	No	Yes	No
RALEIGH	Yes	Yes	Yes	Yes
WILMINGTON	Yes	Yes	Yes	Yes
WILSON	Yes	No	Yes	No
GREENVILLE	Yes	Yes	No	Yes
FAYETTEVILLE	Yes	Yes	No	Yes

ADULT SERVICES

SUMMARY

- No Significant Expansion Proposed in Last Five Years

- Only Targeted Appropriations (e.g., Independent Living Rehab Program)

- "Specialization" in Services to Blind, Deaf and Hard of Hearing Adults Cannot Not Exist Without

  - Staff Training
  - Case Services Funds
  - Automation and Assistive Technology

- May be Time to Reevaluate the Status Quo
  - Reduce Costly Duplication of Sites and Administration
  - Invest in Specialized Services,
  - Improve Client Access to Services, and
  - Address Gaps in Common, Core Service Needs (Housing, Transportation, Technology, etc.)

EDUCATION PROGRAMS

LEGISLATIVE HIGHLIGHTS

DHHS:
- Expanded Early Intervention Services (1997 Session)
- Directed Feasibility Study of Implementing ABCs Plan in DHHS Schools (1997 Session)
- Directed Early Intervention System Study (1998 Session)
- Implemented ABCs Plan with Provisions for Technical Assistance (HB 1477, 1998 Session)
- Authorized Teacher Salary Supplements (1998 Session)
- Directed Collaborative Effort to Strengthen Working Relationships Between LEAs and Residential Schools

Governor Morehead School:
- Provided 4 Itinerant VI-Certified Teachers to Assist LEAs (1995 Session)
- Directed UNC Board of Governors to Implement a Special Education Masters Degree in VI (1995)

Schools for the Deaf:
- Appropriated Funding to Improve Deaf Education (1995 Session)
- Provided Substantial Capital and Repair and Renovation Funding (1995 Session)
- Privatized Family Support Services (1995 Session)
- Funded Cued Speech Center (Annually)
- Authorized Universal Newborn Hearing Screenings (1998 Session)

DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING

SCHOOL ENROLLMENT DATA (as of 12/1/98)

K Through 12

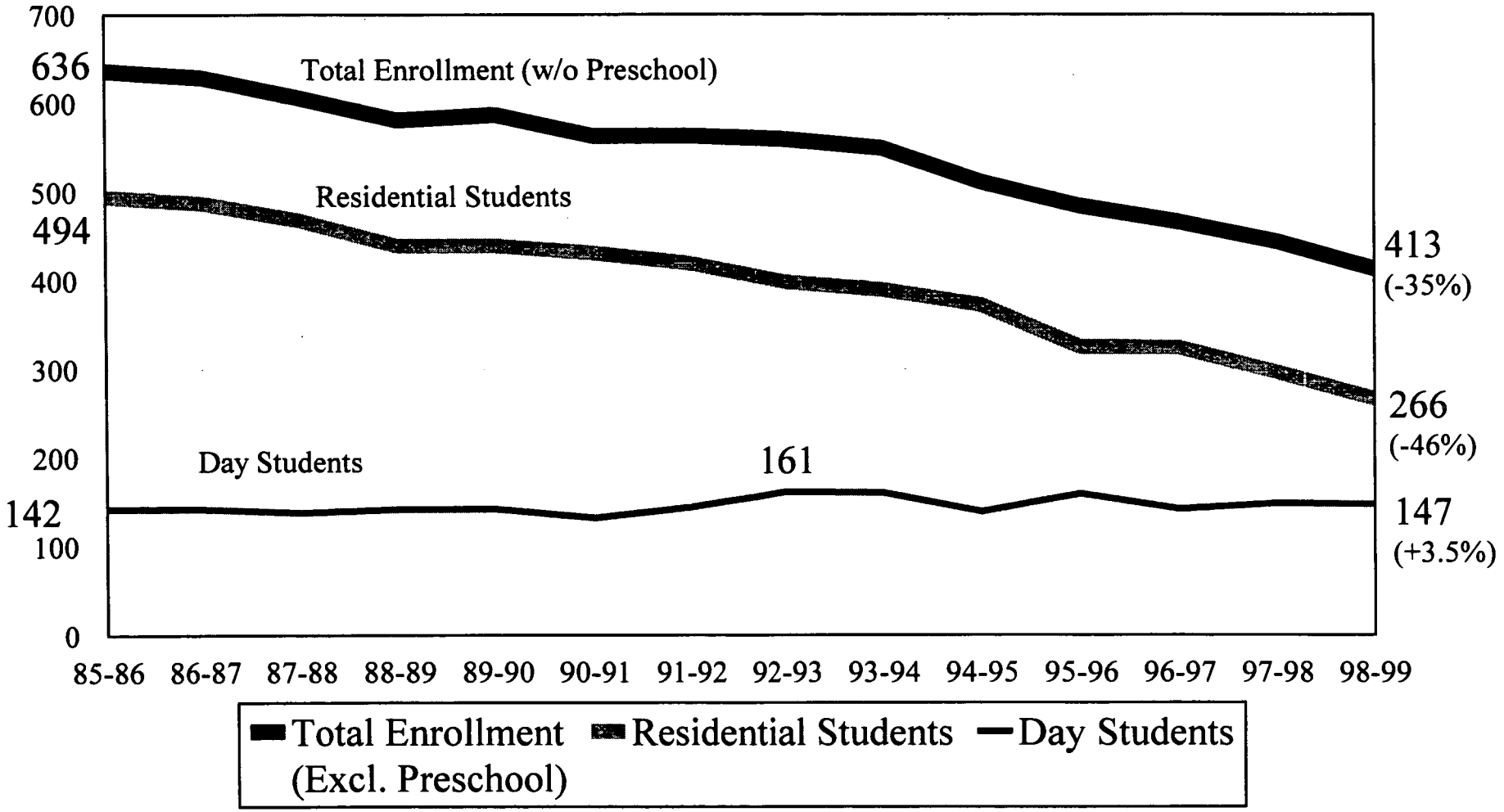
Number of Students	NCSD	CNCSD	ENCSD	TOTAL
Residential	98	46	122	266
Day	42	36	69	147
Total	**140**	**82**	**191**	**413**
Design Capacity	450 (280 Res.)	240 (128 Res.)	403 (265 Res.)	1,093 (673 Res.)

Preschool

Number of Students	NCSD	CNCSD	ENCSD	TOTAL
Total	**103**	**56**	**93**	**252**

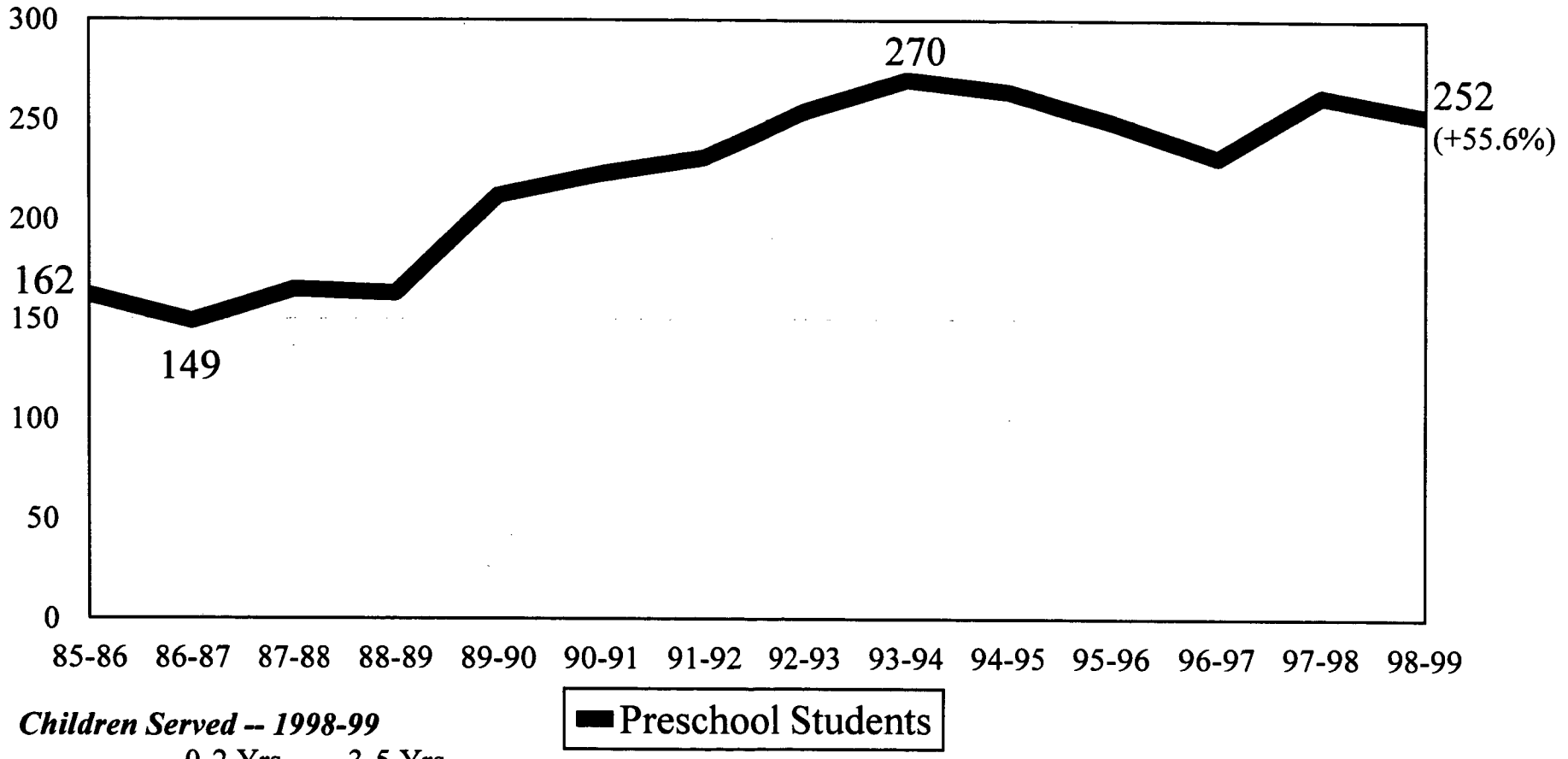
DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING

RESIDENTIAL SCHOOL ENROLLMENT TRENDS
(Excluding Preschool)



DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING

PRESCHOOL ENROLLMENT TRENDS



Children Served -- 1998-99

	0-2 Yrs.	3-5 Yrs.
NCSD	37	61
CNCSD	12	42
ENCSD	36	65
Total	85	168

1998-99 Budget: $5.2 M

RESIDENTIAL SCHOOLS FOR THE DEAF
COST

K Through 12

1998-99	NCSD	CNCSD	ENCSD
Avg. Educational Cost/Student	$42,384	$32,107	$34,927
Avg. Residential Cost/Student	$21,789	$22,043	$24,905
Total Cost/Residential Student	**$64,173**	**$54,150**	**$59,832**

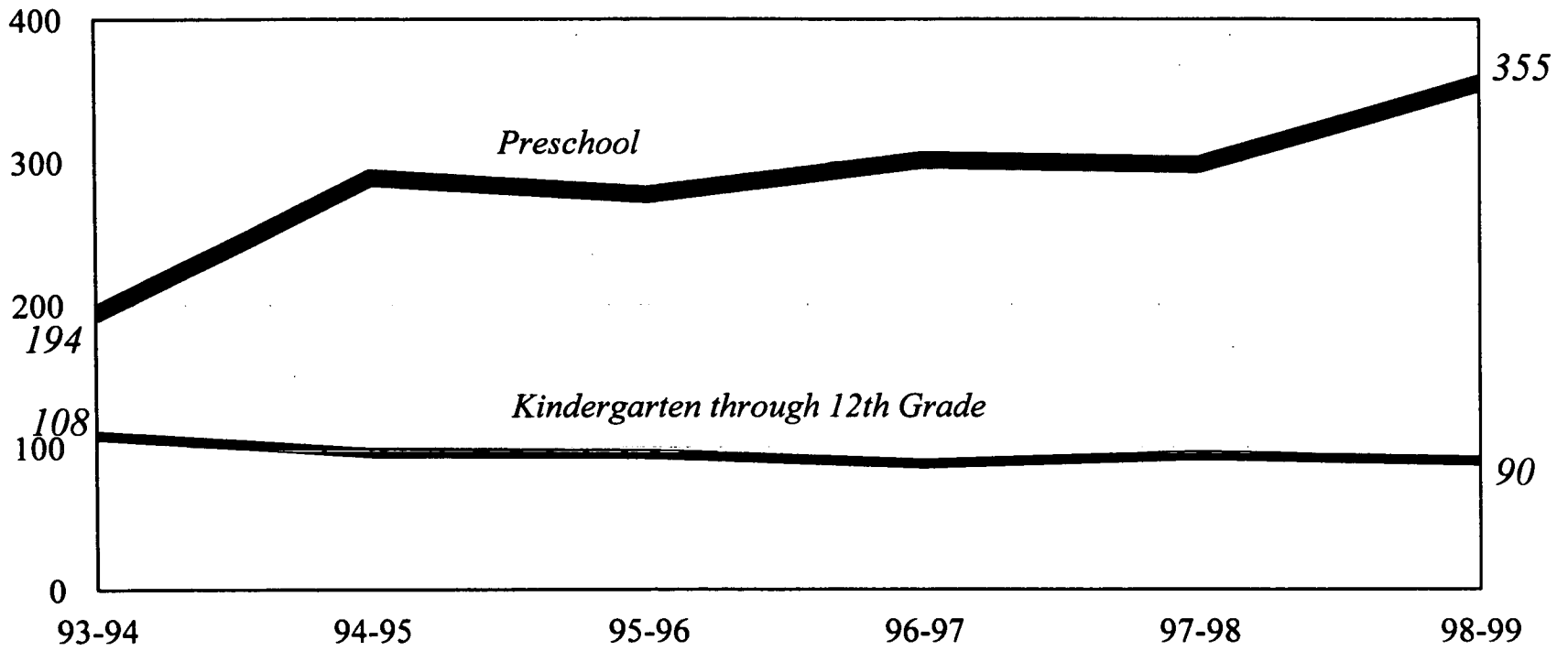
1995-96			
Avg. Educational Cost/Student	$26,397	$28,635	$25,773
Avg. Residential Cost/Student	$14,542	$13,524	$14,699
Total Cost/Residential Student	**$40,939**	**$42,159**	**$40,472**

Preschool

	NCSD	CNCSD	ENCSD
1998-99			
Total Expenditures	$959,819	$860,852	$1,115,730
Avg. Cost/Student	**$10,547**	**$14,348**	**$11,157**
1995-96			
Total Expenditures	$1,592,613	$1,785,040	$2,032,078
Avg. Cost/Student	**$15,614**	**$31,316**	**$21,167**

SERVICES FOR THE BLIND

GOV. MOREHEAD SCHOOL ENROLLMENT/COST



K Through 12th Grade	1998-99	1995-96
Avg. Educational Cost/Student	$47,198	$21,415
Avg. Residential Cost/Student:	$21,499	$19,578
Total Cost/Residential Student	$68,697	$40,993

Preschool - 1998-99
0 to 2 Yrs.: 150 Children
3 to 5 Yrs: 205 Children
Budget: $3.5M

RESIDENTIAL SCHOOLS

DPI ASSISTANCE TEAMS (May 1998)

- ***FINDINGS***

- Not Following the Standard Course of Study; Do Not Understand Concepts/Processes of the ABCs Plan
- Testing Procedures Not Adequate to Determine Student Performance on Grade Level
- IEPs Not Being Followed by Classroom Teachers
- Libraries Out of Date/Inadequate Materials for Implementing Standard Course of Study
- Need Additional Braille Texts and Other Materials

- ***RECOMMENDATIONS***

- On-Site Assistance Teams in 1998-99
- In-Depth Staff Training on the Standard Course of Study
- Accountability Plan for Students Exempt From End of Grade Testing
- Modality and Amplification Decisions Based on IEPs
- Collaborative Programs with Local School Systems

GOVERNOR MOREHEAD SCHOOL (GMS)

EVOLVING ROLE AS A STATEWIDE RESOURCE

- 850 Visually-Impaired (VI) Students Served in LEAs (K through 12th Grade)
- More Than Half of All LEAs Serve Students Without a VI-Certified Teacher
- More Than 40% of NC's VI-Certified Teachers Work at GMS

GMS SERVICES:

- Preschool Program
- Field Staff and Outreach Program
- Special Skills Program and Extended School Year
- Teacher Training and Development
    - Masters Degree in Visual Impairment (with NCCU)
    - Distance Learning
- Advocacy for Students, Parents, and Professionals

EDUCATION PROGRAMS

FUNDING-RELATED ISSUES

Cued Speech Center	$185,000 NR
GMS Early Intervention Services	$200,000 NR
Teacher Salary Supplements	N/A
Proposed Elimination of Vacant Positions	$233,425 R

RECOMMENDED POSITION ELIMINATIONS

VOCATIONAL REHABILITATION SERVICES

POSITION TITLE	TOTAL VALUE	GENERAL FUND SAVINGS
1. Administrative Officer	$28,732	$20,687
2. Printing Operator	$47,167	$11,320
Subtotal	$75,899	$32,007
Benefits	$16,944	$7,348
Total	**$92,843**	**$39,355**

SERVICES FOR THE BLIND

1. Assistant Principal	$28,307	
2. Processing Assistant II	$11,189	
3. Educational Diagnostician I	$31,652	
4. Educational Diagnostician I	$31,652	
Subtotal	$102,800	
Benefits	$25,191	
Total	**$127,991**	**$127,991**

SERVICES FOR THE DEAF AND HARD OF HEARING

1. Administrative Officer II (NCSD)	$30,609	
2. Guidance Counselor (ENCSD)	$23,110	
3. Parent Trainer (ENCSD)	$22,693	
4. Staff Dev. Specialist II (CNCSD)	$29,022	
5. Deaf-Blind Program Consultant	$31,337	
Subtotal	$136,771	
Benefits	$32,957	
Total	**$169,728**	**$169,728**

EDUCATION PROGRAMS

ISSUES

Preschool

- Consistent Management Across Programs/ Integration into Early Intervention System
- Recruitment
- Support for Cued Speech Oral Auditory Programming
- Improved Outcome Data

K Through 12th Grades

- Student Safety
- Implementation of ABCs Plan (HB 1477)
- Resource Needs
- Role of Residential Schools
- Management of Residential Schools

EDUCATION PROGRAMS
SUMMARY

- Continued Dilligence and Commitment Required to Improve School Safety and Academic Performance

- Need Management With Strong Education Background to Succeed

- Need a Well-Defined Role for the Schools -- or Succumb to Declining Enrollments, Escalating Costs, and Unmet Program Needs

- Establish Consistent Management Across Campuses
  - -Business Management Functions
  - -Policy and Programs

- Integrate Preschools into the Early Intervention System

- Address Recruitment Issues

COMPARISON OF CLIENT OUTCOMES

FY 1996

Number of Clients Rehabilitated:

Vocational Rehabilitation 8,035

Services for the Blind 860

Category	Vocational Rehabilitation	National Rank (N=56)	Services for the Blind	National Rank (N=25)
Persons With an Employment Outcome	62.8%	22	72.7%	16
Persons With Employment Outcomes -- Target Group	98%	6	75.8%	6
Mean Weekly Wages - All	$235.81	18	$190.76	7
Mean Weekly Wages - Target Group	$239.79	28	$240.84	20
Employment Outcomes at/above Poverty Level	79.6%	8	64.8%	2
Employment Outcomes at/above Minimum Wage	80.9%	12	64.8%	4
Persons With Severe Disabilities at/above Minimum Wage as a Percentage of All Outcomes at/above Minimum Wage	69.1%	38	34.8%	25
Working 20+ Hrs./Week	87.7%	5	70.5%	3
Mean Cost of Purchased Services	$2,731.47	15	$3,115.92	2

VOCATIONAL REHABILITATION SERVICES

CONSUMER SATISFACTION SURVEY RESULTS (Jan - Jun 1998)*

* Mailed to all VR customers who discontinued their involvement with VR Services -- 13,803 survey forms sent; 4,817 returned (35%)

31% of customers responding did not complete their rehabilitation program (i.e., not employed at program exit)

	Number Responded	Percent Satisfied
VR Services helped me gain job skills	2,169	66%
VR staff helped make changes in a job so that I could do the work	2,168	56%
VR staff helped me find a job	2,172	50%
"Satisfied" to "Somewhat Satisfied" with the job I got with help from VR	654	92%

DIVISION OVERVIEWS

Vocational Rehabilitation Services

Services for the Blind

Services for the Deaf & Hard of Hearing

Presented by:
Mary Ellen Sylvester
Fiscal Research Division
April 13, 1999

VOCATIONAL REHABILITATION (VR) SERVICES

REHABILITATION ACT of 1973, TITLE I

(as Reauthorized in 1998)

Individuals With Disabilities, Including the Most Significant Disabilities,

- Are Presumed Capable of Engaging in Gainful Employment (With VR Services)
- Need Opportunities for Gainful Employment in Integrated Settings
- Must Be Full, Active Partners, Making Meaningful and Informed Choices

Eligibility for VR Services

- Physical or Mental Impairment Which is a Substantial Impediment to Employment
- VR Services are Required to Prepare for, Secure, Retain, or Regain Employment

VR Services

- Individualized, Consumer-Driven, Goal-Oriented, Time-Limited

Significant 1998 Amendments:

1) Presumed Eligibility for SSI/SSDI Clients
2) Qualified Vocational Rehabilitation Counselor
3) Informed Client Choice
4) Integration into a Statewide Workforce Investment System

VOCATIONAL REHABILITATION SERVICES

MISSION

To Promote Employment and Independence for Persons with Disabilities
Through Customer Partnerships and Community Leadership

VISION

- Be Leading Employment Resource for Persons With Disabilities, Business, and Industry
- Promote Inclusion into the Community

PROGRAMS	*SERVICES*
Vocational Rehabilitation	Evaluation, Counseling & Guidance, Physical/Mental Restoration, Training, Job Placement, Interpreter Services
Supported Employment	Extensive On-Site Training in Competitive Employment with Long Term Support Services
Client Assistance Program	Information & Referral, Assistance With Appeals Process
Assistive Technology	Statewide Awareness and Demonstration of Assistive Technology for Disabled Persons (4 Demo Centers)
Independent Living Rehabilitation	Rehabilitation Engineering, Adaptive Equipment Purchases, Personal Assistance Services, and Rehabilitation Therapy
ACCESS, North Carolina	NC Travel and Tourism Guide for Disabled Persons and Accessibility/Barrier Removal Projects at Travel Sites
Disability Determination Services	Processing of SSI/SSDI Applications From Social Security Administration Offices and Medicaid Eligibility Claims From Local Depts. of Social Services

VOCATIONAL REHABILITATION SERVICES

CLIENTS: - Evaluate More Than 28,000 *New* Clients Each Year

- Serve Approximately 60,000 Clients in Total

  -- 74% Have a "Significant Disability" (Limits 1 or More Functional Capacities/ Requires Multiple VR Services Over an Extended Period)

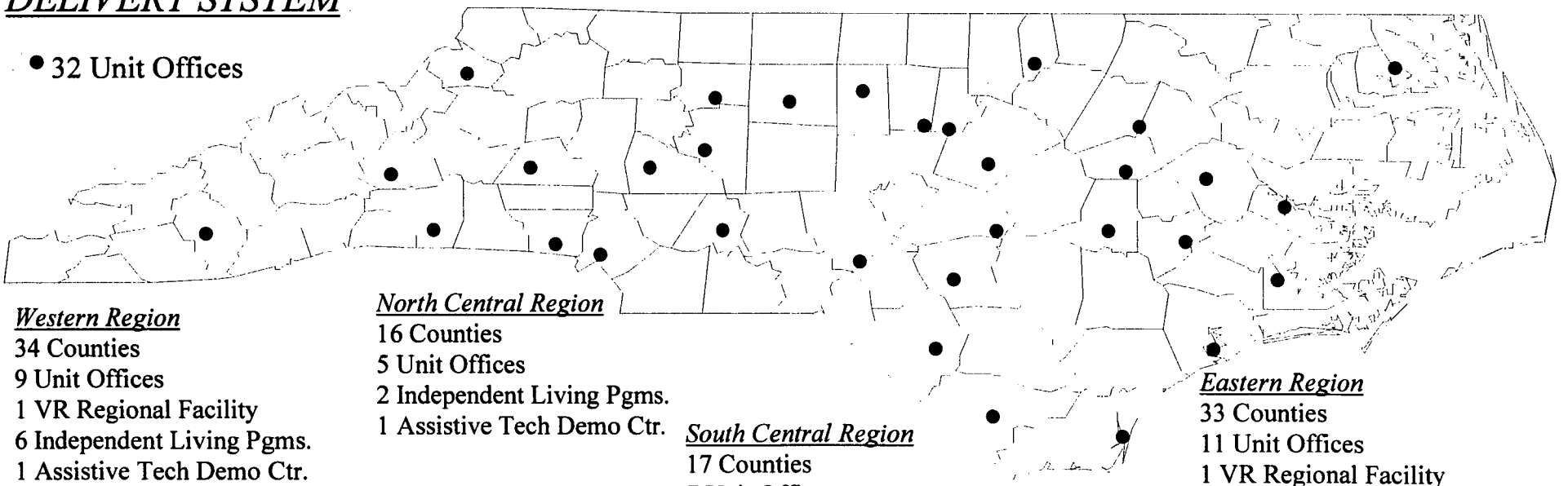
  -- 25% Have a "Most Significant Disability" (In NC, 3+ Functional Limitations)

- 60% Complete Their Individual Written Rehabilitation Program Successfully

- In 1997-98, 37% were 22 Years Old or Younger

DELIVERY SYSTEM

- 32 Unit Offices



Western Region
34 Counties
9 Unit Offices
1 VR Regional Facility
6 Independent Living Pgms.
1 Assistive Tech Demo Ctr.

North Central Region
16 Counties
5 Unit Offices
2 Independent Living Pgms.
1 Assistive Tech Demo Ctr.

South Central Region
17 Counties
7 Unit Offices
3 Independent Living Pgms.
1 Assistive Tech Demo Ctr.

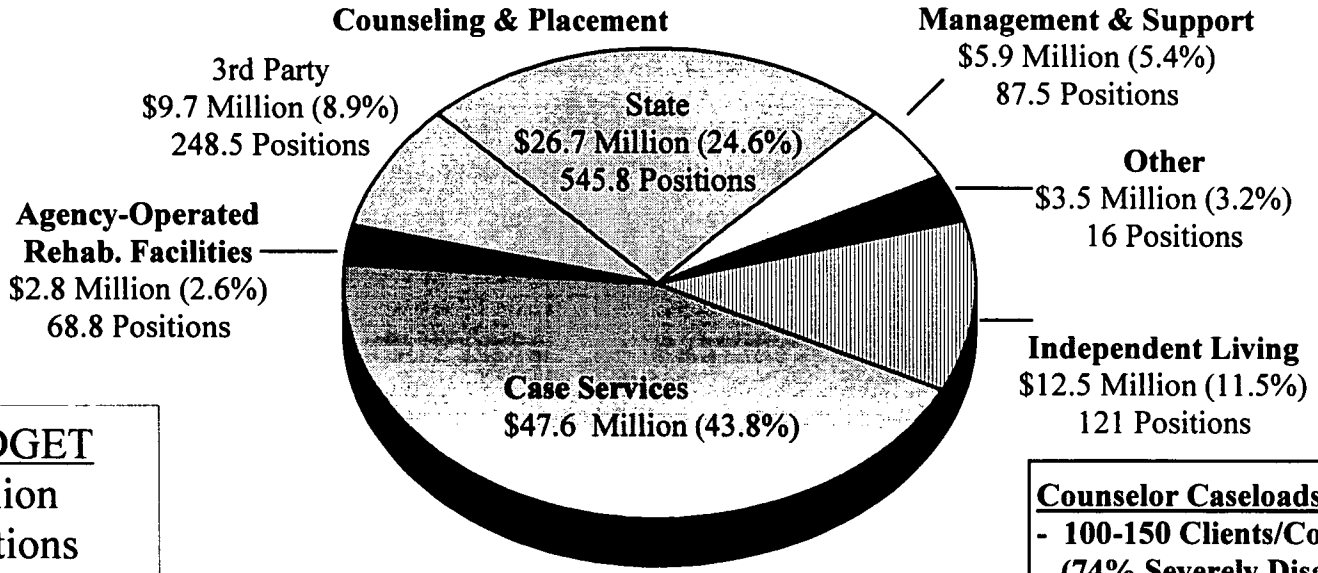
Eastern Region
33 Counties
11 Unit Offices
1 VR Regional Facility
5 Independent Living Pgms.
1 Assistive Tech Demo Ctr.

Plus,
One-Stop Career Centers and 3rd Party Locations

CONTINUATION BUDGET SUMMARY

VOCATIONAL REHABILITATION SERVICES

	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Requirements*	$112,074,630	$108,685,514	$110,054,438	$111,995,775
Receipts	$78,452,334	$72,909,660	$74,411,084	$75,137,905
Net Appropriation	$33,622,296	$35,775,854	$35,643,354	$36,857,870
Positions	1,087.6	1,087.6	1,087.6	1,135.6



1998-99 BUDGET
$108.7 Million
1,087.6 Positions

Counselor Caseloads:
- **100-150 Clients/Counselor (74% Severely Disabled)**
- **25 Clients Rehabilitated/Year (Min.)**

** Does Not Include Funding for Disability Determination Services (1998-99: $43 M, 640 Positions)*

VOCATIONAL REHABILITATION SERVICES

CLIENT OUTCOMES (1997-98)

8,527 Clients Rehabilitated

	At Application		At Closure	
Work Status	**Number of Clients**	**%**	**Number of Clients**	**%**
Competitive Labor Market	1,712	20.1%	**8,156**	**95.7%**
Self-Employed	42	0.5%	**173**	**2.0%**
Sheltered Workshop	80	0.9%	63	0.8%
State Employee	0	0%	1	0%
Homemaker	30	0.4%	106	1.2%
Unpaid Family Worker	4	0%	28	0.3%
Not Working	**6,659**	**78.1%**	0	0%
Primary Source of Support				
Earnings	1,581	**18.5%**	6,809	**79.9%**
Public Assistance	900	10.6%	381	4.5%
No Weekly Earnings	6,693	**78.5%**	134	**1.6%**
Hours Worked Week Before				
None	6,693	78.5%	134	1.6%
1-39	1,339	15.7%	2,979	34.9%
40+	495	**5.8%**	5,414	**63.5%**

VOCATIONAL REHABILITATION SERVICES

LEGISLATIVE HIGHLIGHTS

- Legislation Establishing a State Vocational Rehabilitation/Independent Living Program (1995)

- Completion/Expansion of the Independent Living Rehabilitation Program (1990s)

- Provision of "Establishment of Facility" Funding ($500,000 NR -- 1998-99)

- New, Specialized Programming for Traumatic Brain Injury, Spinal Cord Injury, and Significantly Disabled Deaf Clients [including Vocational Evaluation, Training, and Transitional Housing] ($300,000 -- 1998-99)

- Replacement Funding for NC Assistive Technology Project ($200,000 NR -- 1998-99)

VOCATIONAL REHABILITATION SERVICES

FUNDING-RELATED ISSUES

NC Assistive Technology Project

Independent Living Rehabilitation Program

- *Waiting List*
- *NC Brain Injury Association Project*

Elimination of Two Vacant Positions

VOCATIONAL REHABILITATION SERVICES

NC ASSISTIVE TECHNOLOGY PROJECT

Purpose:
- Provide Information, Technical Assistance, and Demonstration of Assistive Technology
- Serve All Ages, All Disabilities, All Aspects of Life

4 Demo Centers: Greenville, Raleigh, Winston-Salem, Charlotte *

1998-99 Budget:

$ 597,800	Federal Funds
$ 361,940	General Fund ($200,000 is non-recurring)
$ 19,954	Local Funds
$ 50,000	Kate B. Reynolds Grant
$1,029,694	

Scheduled Phase-out of Federal Funding:

97-98	98-99	99-00	00-01	03-04
- $0	-$199,266	-$398,533	-$398,533	-$797,066
- 0%	- 25%	- 50%	- 50%	- 100%

General Assembly Replaced Reduced Federal Funds in 1998-99 With $200,000 Non-Recurring Funds

Now, Program Needs $398,533 in State Funds to Maintain Current Service Level for Next 4 Years

Impact of Reduced Budget: Close 2 Centers in 1999-00

1997-98 Accomplishments:
- Information and Referral to 3,230 People
- 198 Training/Awareness Sessions Attended By 8,413 Individuals
- 7th Annual NC Assistive Technology Expo Attended by 1,200 People
- 1,417 Consumers and 1,777 Professionals Visited Demonstration Centers
- 372 Requests for Professional Assistance in Financing Assistive Technology

** Plus, New Satellite Center in Elizabeth City, Funded With Kate B. Reynolds Grant*

VOCATIONAL REHABILITATION SERVICES
INDEPENDENT LIVING REHABILITATION PROGRAM

Purpose: **Promote Personal Independence of Severely Disabled Individuals**
- Provide an Alternative to Institutionalization
- Improve Functioning in One's Family, Home, and Community
- Prepare for Traditional VR Services

Services:
- Rehabilitation Engineering
- Assistive Equipment Purchases
- Home and Vehicle Modifications
- Guidance and Counseling
- Consumer-Managed Personal Assistance

Typical Office:

Budget:	$650,000 to $800,000 Per Year ($225,000 for Case Services; $150,000 for Personal Assistance)
Staffing:	6-9 Rehabilitation Specialists (22% Disabled)
Expected Outcomes:	Serve 200+ Clients/Year, With 80+ Clients Achieving Goals
Avg. Expenditure:	Personal Assistance $8,755/Client One-Time Eqpt. Expenditures $3,150/Client

1997-98 Accomplishments:

		1995-96
Clients Served:	3,778	2,382 (+59%)
New Clients:	2,773	1,765 (+57%)
Achieved Goals:	1,504 Clients	874 (+72%)
Personal Assistance:	248 Clients	179 (+39%)

37 Clients Relocated from Nursing Homes to Community-Based Arrangements

232 Clients Prevented From Being Institutionalized

VOCATIONAL REHABILITATION SERVICES

INDEPENDENT LIVING REHABILITATION PROGRAM

Waiting Lists
(as of 3/31/99)

OFFICE	CASE SERVICES # Clients	CASE SERVICES Funds Needed	PERSONAL ASSISTANCE # Clients	PERSONAL ASSISTANCE Funds Needed
Albemarle	88	$130,327	4	$21,702
Asheville	41	$165,960	0	$0
Boone	64	$237,050	2	$5,088
Charlotte	91	$295,450	5	$40,800
Durham	22	$66,800	0	$0
Elizabeth City	51	$99,483	2	$17,472
Fayetteville	38	$90,500	9	$56,250
Greensboro	31	$233,650	31	$202,560
Greenville	103	$376,757	0	$0
Hickory	106	$458,750	10	$63,677
New Bern	33	$82,985	2	$25,000
Raleigh	69	$186,825	0	$0
Rocky Mount	99	$363,589	9	$48,840
Sylva	30	$86,075	0	$0
Wilmington	37	$136,500	0	$0
Winston-Salem	63	$298,473	13	$97,932
Total	**966**	**$3,309,174**	**87**	**$579,321**

Annual Budget: Case Services: $4.3 Million
Personal Assistance: $2.3 Million

Total Budget for Case Services and Personal Assistance Funding is 93% Obligated as of 3/31/99

//

VOCATIONAL REHABILITATION SERVICES

NC BRAIN INJURY ASSOCIATION PROJECT

- Purpose
  - Provide intensive early intervention, followed by assistance in coordinating a network of services, to individuals with brain injuries who have the potential to live independently

- Funded with an 18-month Kate B. Reynolds demonstration grant (expired Oct 98)
  - Developed at the request of the NC Brain Injury Association
  - IL Counselor/Care Coordinator positions established in Winston-Salem and Greenville
  - In Oct 98, Foundation extended funding for the 2 positions by one year
  - However, IL Rehab Program is contributing case services funds

- Active Caseloads: 30+ Clients/Office

- Cost to Maintain Existing Services in 1999-00: $350,000 (2 positions and case services funds)

SERVICES FOR THE BLIND

MISSION

To Empower Individuals Who are Blind or Visually-Impaired to Achieve Their Maximum Potential Through Services Provided by Competent and Caring Professionals

PROGRAMS	*SERVICES*
Vocational Rehabilitation	Evaluation, Counseling & Guidance, Physical/Mental Restoration, Orientation and Mobility, Training, Job Placement, Reader Services
Supported Employment	Extensive On-Site Training in Competitive Employment With Long Term Support Services
Business Enterprises	Job Opportunities as Operators of Food Service Facilities and Vending Operations
Technology Resource Center	Assistive Technology Demonstration, Evaluation, and Training; Rehabilitation Engineering Services
Deaf-Blind Program	Evaluation, Training, Information and Referral, Advocacy and Support
Independent Living/Social Services	Chore Services and Adjustment to Blindness Services
Medical Eye Care Program	Eye Exams, Eyeglasses, and Surgery for Low Income Individuals; Screenings, Education, and Low Vision Services
Governor Morehead School	Early Intervention, K through 12th Grades, Counseling, Therapy, Braille, Orientation and Mobility, Transition, Outreach, and Teacher Training

SERVICES FOR THE BLIND

CLIENTS:

Definition of "Legally Blind:"

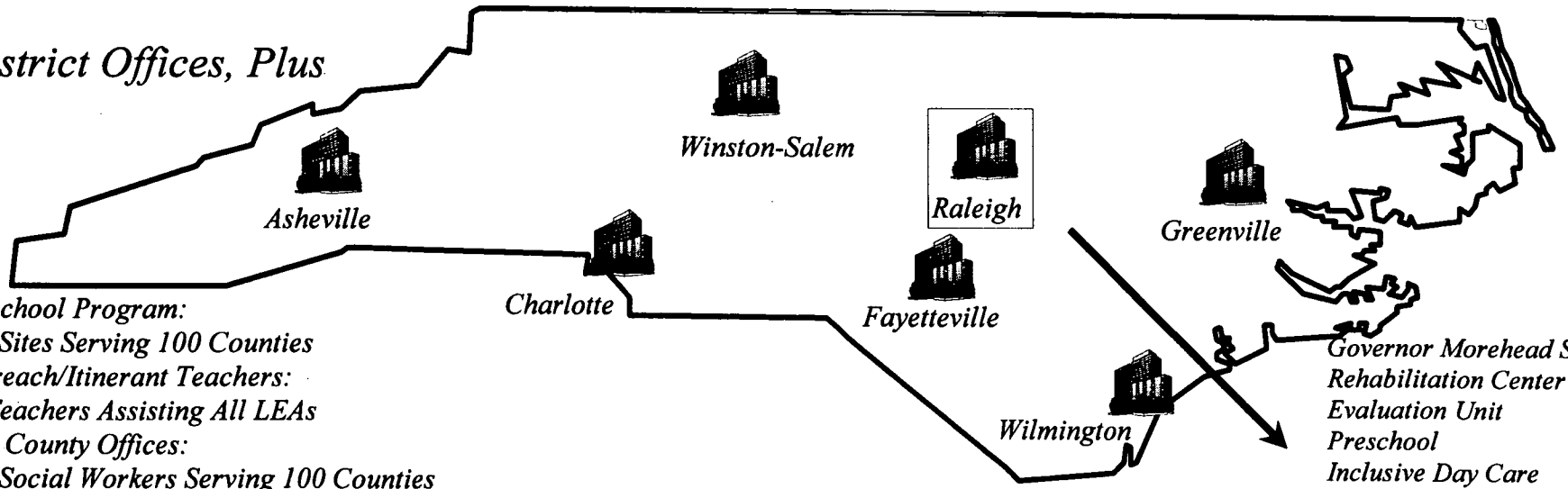
- *20/200 or Less Vision in the Better Eye with Corrective Lenses, or*
- *Field of Vision Constricted to 20 Degrees or Less*

Clients Referred From the General VR Agency:

- *Legally Blind*
- *Vision Between 20/100 and 20/200, If Having Difficulty Adjusting to Loss of Vision*
- *Night Blindness, Limited Field of Vision, or Rapidly Progressive Eye Condition (Leading to Legal Blindness)*
- *All Who Need Eye Treatment and/or Surgery, Regardless of Vision*

DELIVERY SYSTEM:

7 District Offices, Plus



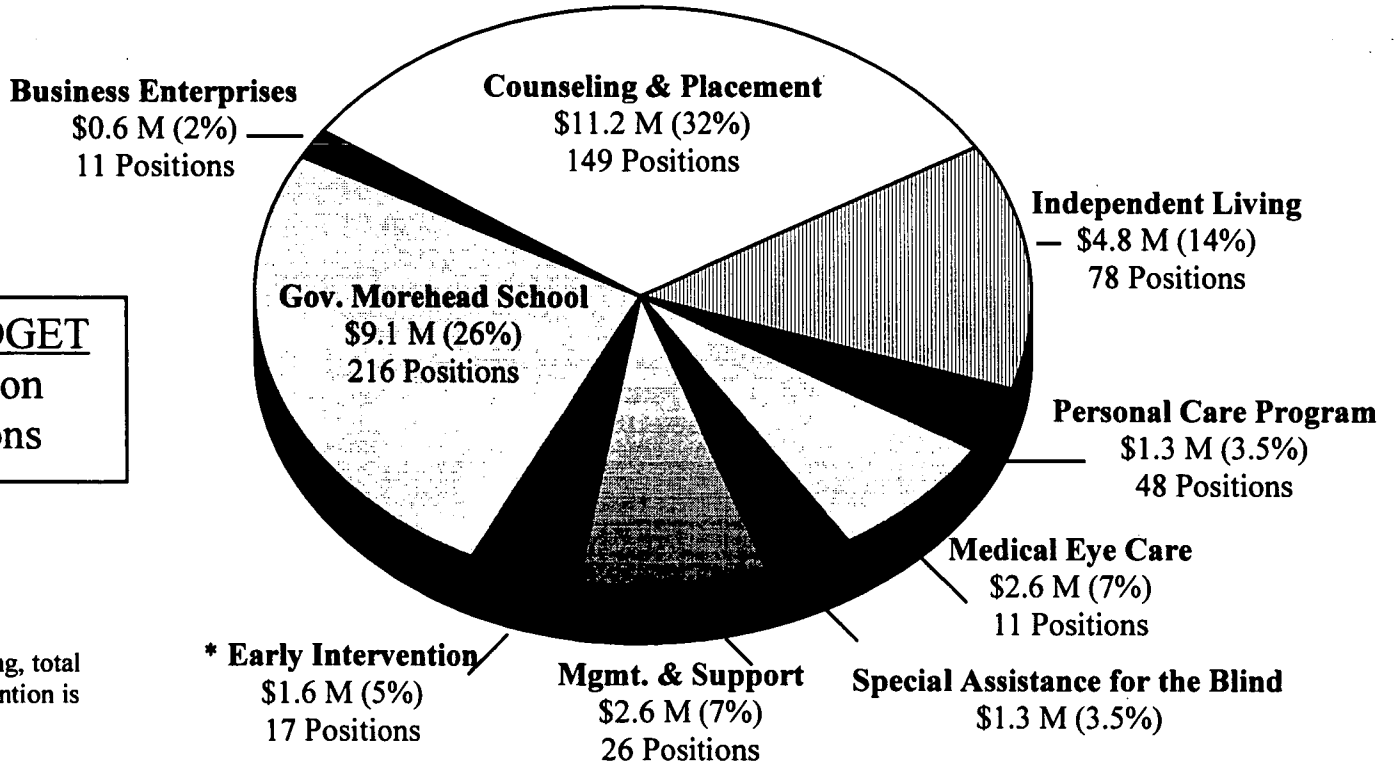
Preschool Program:
17 Sites Serving 100 Counties
Outreach/Itinerant Teachers:
6 Teachers Assisting All LEAs
DSS County Offices:
57 Social Workers Serving 100 Counties
5 Supported Employment Locations
7 Workshops for the Blind

Governor Morehead School
Rehabilitation Center
Evaluation Unit
Preschool
Inclusive Day Care
Supported Employment
Resource Center
Workshop for the Blind

CONTINUATION BUDGET SUMMARY

SERVICES FOR THE BLIND

	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Requirements	$32,434,832	$35,140,241	$35,130,567	$35,126,212
Receipts	$18,755,653	$17,797,445	$17,877,888	$17,881,370
Appropriation	$13,679,179	$17,342,796	$17,252,679	$17,244,842
Positions	554	556	556	556



1998-99 BUDGET
$35.1 Million
556 Positions

* With expansion funding, total budget for Early Intervention is $3.5 M (53 positions)

SERVICES FOR THE BLIND

LEGISLATIVE HIGHLIGHTS

- Provided Funding to Maintain Extended Service Provider Positions in the Supported Employment Program ($250,000 -- 1995 Session)

- Requested State Auditor Conduct a Performance Audit of the Division of Services for the Blind (1996 Session)

SERVICES FOR THE BLIND

ISSUES

- Are Blind People Being Served?

- Are Resources Adequate to Deliver Specialized Services?

SERVICES FOR THE BLIND

VR CLIENT OUTCOMES (1997-98)

Total Clients Served		3,679
- Severely Disabled		2,875 (78%)
- Legally Blind		1,146 (31%)
Number of Clients Rehabilitated		810
- Severely Disabled		600 (74%)
- Legally Blind		178 (22%)
Number of Non-Wage Earners		174 (21%)
Number of Wage Earners		636
- Legally Blind, Placed in Remunerative Employment, Earning Minimum Wage or Better		119
- Legally Blind, Placed in Competitive Employment, Earning Minimum Wage or Better		98 (12%)
Number of Clients Receiving Physical Restoration Only		45 (6%)
Number of Clients Placed in Jobs by Division Staff		65 (8%)
Average Cost of Purchased Services:		$3,079/Client
Average Earnings:	<u>At Application</u>	<u>At Closure</u>
	$113.55	$263.77 (+132%)

SERVICES FOR THE BLIND

CLIENT OUTCOMES (1997-98)

810 Clients Rehabilitated

	At Application		At Closure	
Work Status	**Number of Clients**	**%**	**Number of Clients**	**%**
Competitive Labor Market	338	42%	515	64%
Self-Employed	56	7%	100	12%
Business Enterprises	1	0%	5	1%
Sheltered Workshop	5	1%	16	2%
Student	25	3%	0	0%
Homemaker	76	9%	167	20%
Unpaid Family Worker	2	0%	7	1%
Not Working	307	**38%**	0	0%

SERVICES FOR THE BLIND

CONSUMER SATISFACTION SURVEY RESULTS (1996-97)*

Did the Division of Services for the Blind work with you on how to get a job, such as how to interview, complete an application, write a resume, etc.?

Yes	37	(19%)
No	27	(14%)
Not Needed	132	(67%)
Total	196	(100%)

Did the Division of Services for the Blind staff help make any changes in a job so that you could do the work?

Yes	16	(8%)
No	40	(21%)
Not Needed	137	(71%)
Total	193	(100%)

Did the Division of Services for the Blind staff help you find a job?

Yes	21	(11%)
No	42	(22%)
Not Needed	130	(67%)
Total	193	(100%)

If your answer was "No" or "Not Needed," please check one of the following which best describes your situation:

Already Working	122	(68%)
Found own Job	37	(20%)
Other	22	(12%)
Total	181	(100%)

If you got a job with help from the Division of Services for the Blind, were you satisfied with the job?

Very Satisfied	26	(74%)
Somewhat Satisfied	5	(14%)
Somewhat Dissatisfied	2	(6%)
Very Dissatisfied	2	(6%)
Total	35	(100%)

** Mailed to 662 individuals whose cases were closed with an employment outcome -- 204 surveys were returned (31%)*

SERVICES FOR THE BLIND

ADEQUATE RESOURCES FOR SPECIALIZED SERVICES?

- **Social Workers for the Blind** (57 Social Worker III Positions)
  - Lack of Training in Providing Adjustment to Blindness Services to Clients
  - Inadequate Case Services Funds
    - Average Caseload: 101 Clients (Ranges from 58 to 179)
    - Case Service Funds: $2,928/Social Worker
  - Day-to-Day Supervision is at Local DSS Office

- **Orientation and Mobility Specialists** (8)
  - Average Caseload: 140 Clients/Year
  - Difficult to Recruit for These Positions

- **Independent Living Rehabilitation Counselors** (11)
  - Average Caseload: 79 Clients/Year
  - Case Services Budget: $12,000 Statewide

- **Management Issues**
  - Lack of Comprehensive Training Program for All Staff
  - Lack of Automation, esp. Assistive Technology for Staff
  - Lack of Centralized Database to Determine No. of Individual Clients Served
  - Opportunities to Deploy Existing Staff Differently?
  - Opportunities to Strengthen the Medical Eye Care Program or to Redirect Resources to Other Uses?

DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING

MISSION:

- Provide Access and Equitable Opportunities for Deaf and Hard of Hearing Individuals to Achieve Maximum Participation and Productivity in Society.

- Provide Innovative Administrative Leadership and Regulatory Authority in the Areas of Education, Employment, and Human Services, Accessibility, Certification of Interpreters, Staff Development, Parent/Public Awareness, and Advocacy.

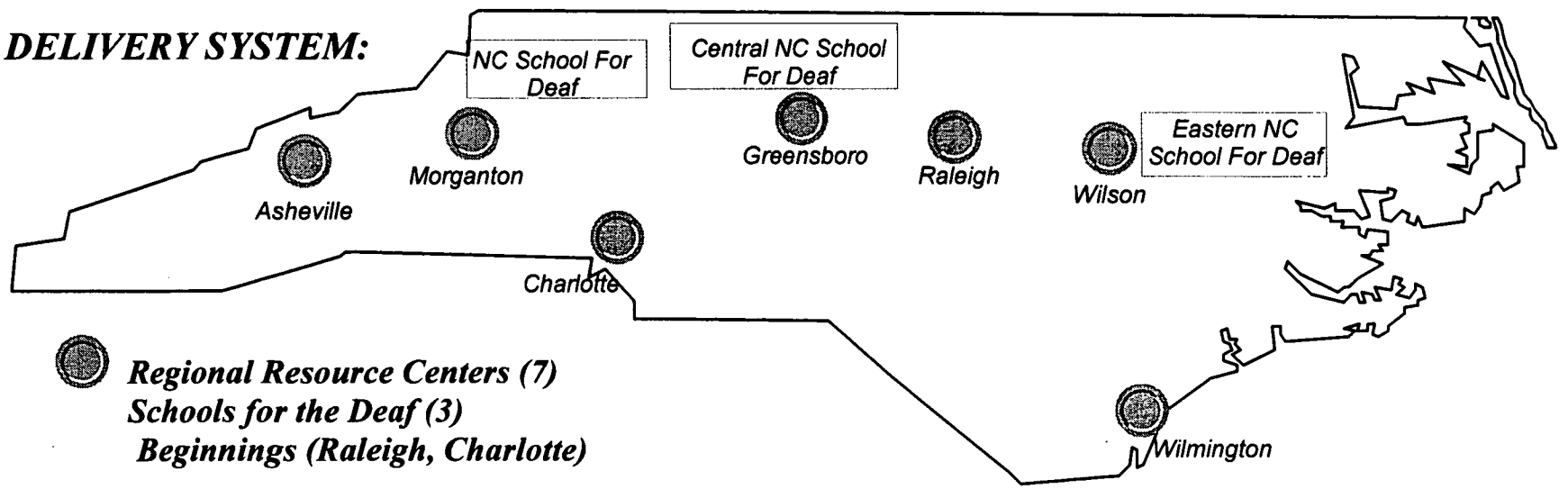
CLIENTS:

- An Estimated 660,000 North Carolinians Are Deaf (60,000) or Hard of Hearing (600,000)

- 665 Students Attend the North Carolina Schools for the Deaf (as of 12/1/98)
  K through 12: 413 Students
  0 to 5 Years: 252 Students

- Approximately 1,700 Deaf and Hard of Hearing Students (K-12) Are Served By Local Education Agencies

DELIVERY SYSTEM:

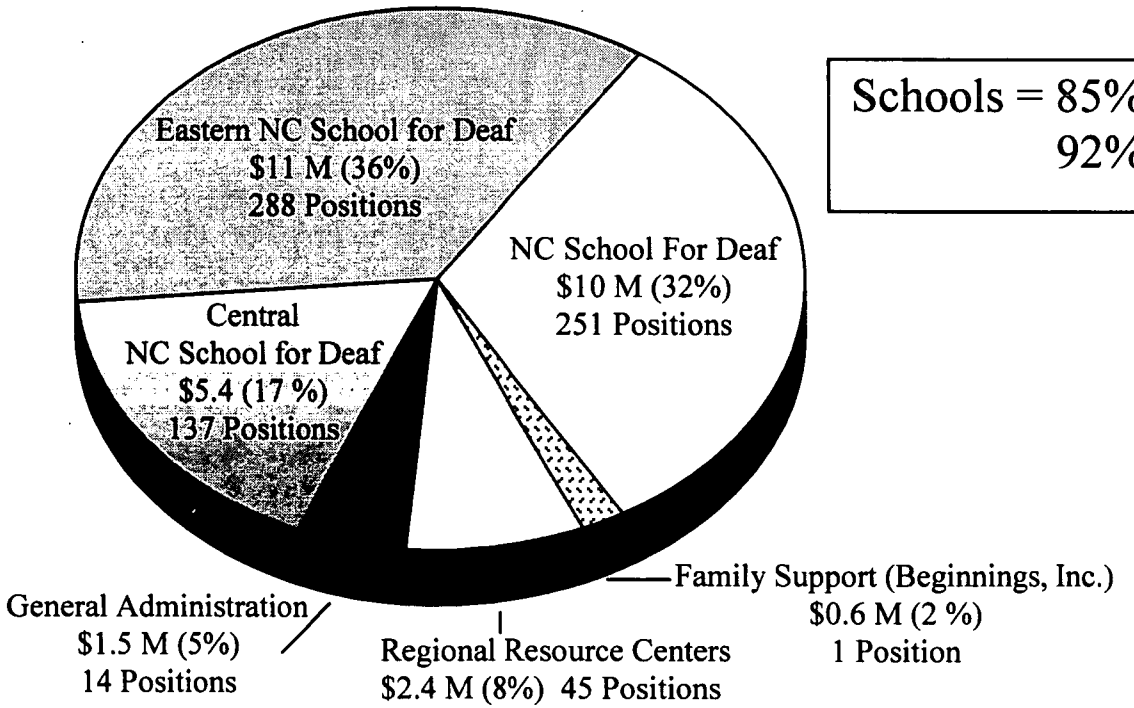


CONTINUATION BUDGET SUMMARY

SERVICES FOR THE DEAF/HARD OF HEARING

	1997-98 Actual	1998-99 Authorized	1999-00 Recommended	2000-01 Recommended
Requirements	$28,849,026	$30,851,538	$31,863,652	$32,507,618
Receipts	$774,801	$797,191	$774,841	$785,941
Net Appropriation	$28,074,225	$30,054,347	$31,088,811	$31,721,677
Positions	736	736	736	736

1998-99 BUDGET
$30.9 Million
736 Positions



Schools = 85% Funding,
92% Positions

DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING
REGIONAL RESOURCE CENTERS

MISSION:

- Provide Interpreter Services Coordination, Employment Assistance, Advocacy, Outreach, Information Access and Referral, Training, Assistive Technology, and Human Services Coordination

STAFFING:

- Deaf Specialist
- Interpreter Support Service Consultant
- Deaf/Blind Specialist
- Office Assistant
- Hard of Hearing Specialist
- Communications Support Service Consultant
- Regional Manager

SERVICES:

Individuals	Agencies
Information and Referral	Information and Referral
Counseling	Consultation
Skill Development	Technical Assistance
Advocacy	Advocacy

CLIENT NEEDS:

Hard of Hearing Clients:
- Assistive Listening Technology

Deaf Clients:
- Support Interacting With the "System" (e.g., Court, Hospital)
- Assistive Technology/Interpreter Services

REORGANIZATION PROPOSAL

Disability-Related Offices in Select NC Cities

CITIES	VR UNIT OFFICE	DSB DISTRICT OFFICE	REGIONAL RESOURCE CENTER	IL OFFICE
ASHEVILLE	Yes	Yes	Yes	Yes
CHARLOTTE	Yes	Yes	Yes	Yes
WINSTON-SALEM	Yes	Yes	No	Yes
GREENSBORO	Yes	No	Yes	Yes
HICKORY	Yes	No	No	Yes
MORGANTON	Training Facility	No	Yes	No
RALEIGH	Yes	Yes	Yes	Yes
WILMINGTON	Yes	Yes	Yes	Yes
WILSON	Yes	No	Yes	No
GREENVILLE	Yes	Yes	No	Yes
FAYETTEVILLE	Yes	Yes	No	Yes

ADULT SERVICES

SUMMARY

- No Significant Expansion Proposed in Last Five Years

- Only Targeted Appropriations (e.g., Independent Living Rehab Program)

- "Specialization" in Services to Blind, Deaf and Hard of Hearing Adults Cannot Not Exist Without

  - Staff Training
  - Case Services Funds
  - Automation and Assistive Technology

- May be Time to Reevaluate the Status Quo
  - Reduce Costly Duplication of Sites and Administration
  - Invest in Specialized Services,
  - Improve Client Access to Services, and
  - Address Gaps in Common, Core Service Needs (Housing, Transportation, Technology, etc.)

EDUCATION PROGRAMS

LEGISLATIVE HIGHLIGHTS

DHHS:

- Expanded Early Intervention Services (1997 Session)
- Directed Feasibility Study of Implementing ABCs Plan in DHHS Schools (1997 Session)
- Directed Early Intervention System Study (1998 Session)
- Implemented ABCs Plan with Provisions for Technical Assistance (HB 1477, 1998 Session)
- Authorized Teacher Salary Supplements (1998 Session)
- Directed Collaborative Effort to Strengthen Working Relationships Between LEAs and Residential Schools

Governor Morehead School:

- Provided 4 Itinerant VI-Certified Teachers to Assist LEAs (1995 Session)
- Directed UNC Board of Governors to Implement a Special Education Masters Degree in VI (1995)

Schools for the Deaf:

- Appropriated Funding to Improve Deaf Education (1995 Session)
- Provided Substantial Capital and Repair and Renovation Funding (1995 Session)
- Privatized Family Support Services (1995 Session)
- Funded Cued Speech Center (Annually)
- Authorized Universal Newborn Hearing Screenings (1998 Session)

DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING

SCHOOL ENROLLMENT DATA (as of 12/1/98)

K Through 12

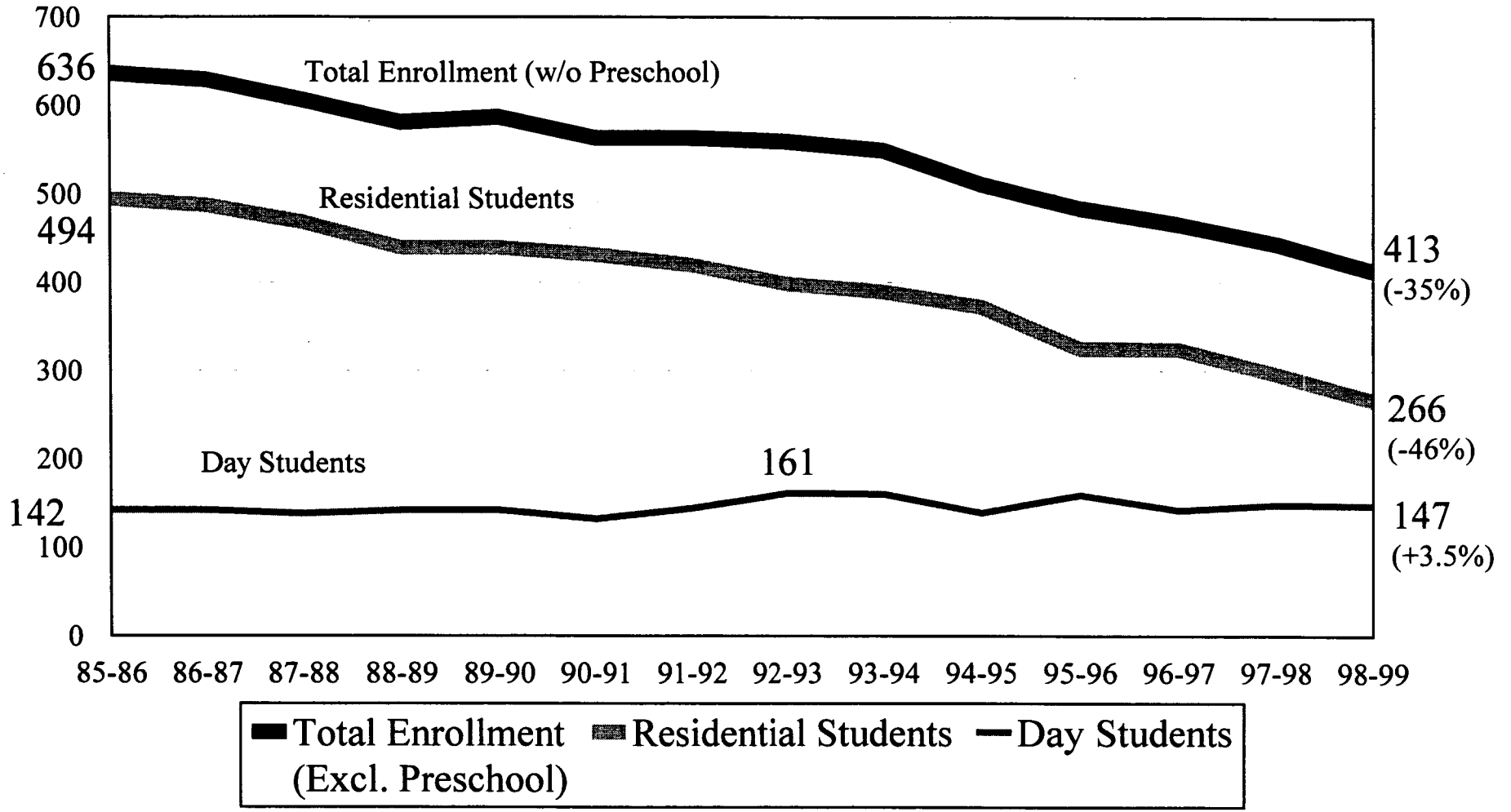
Number of Students	NCSD	CNCSD	ENCSD	TOTAL
Residential	98	46	122	266
Day	42	36	69	147
Total	**140**	**82**	**191**	**413**
Design Capacity	450 (280 Res.)	240 (128 Res.)	403 (265 Res.)	1,093 (673 Res.)

Preschool

Number of Students	NCSD	CNCSD	ENCSD	TOTAL
Total	**103**	**56**	**93**	**252**

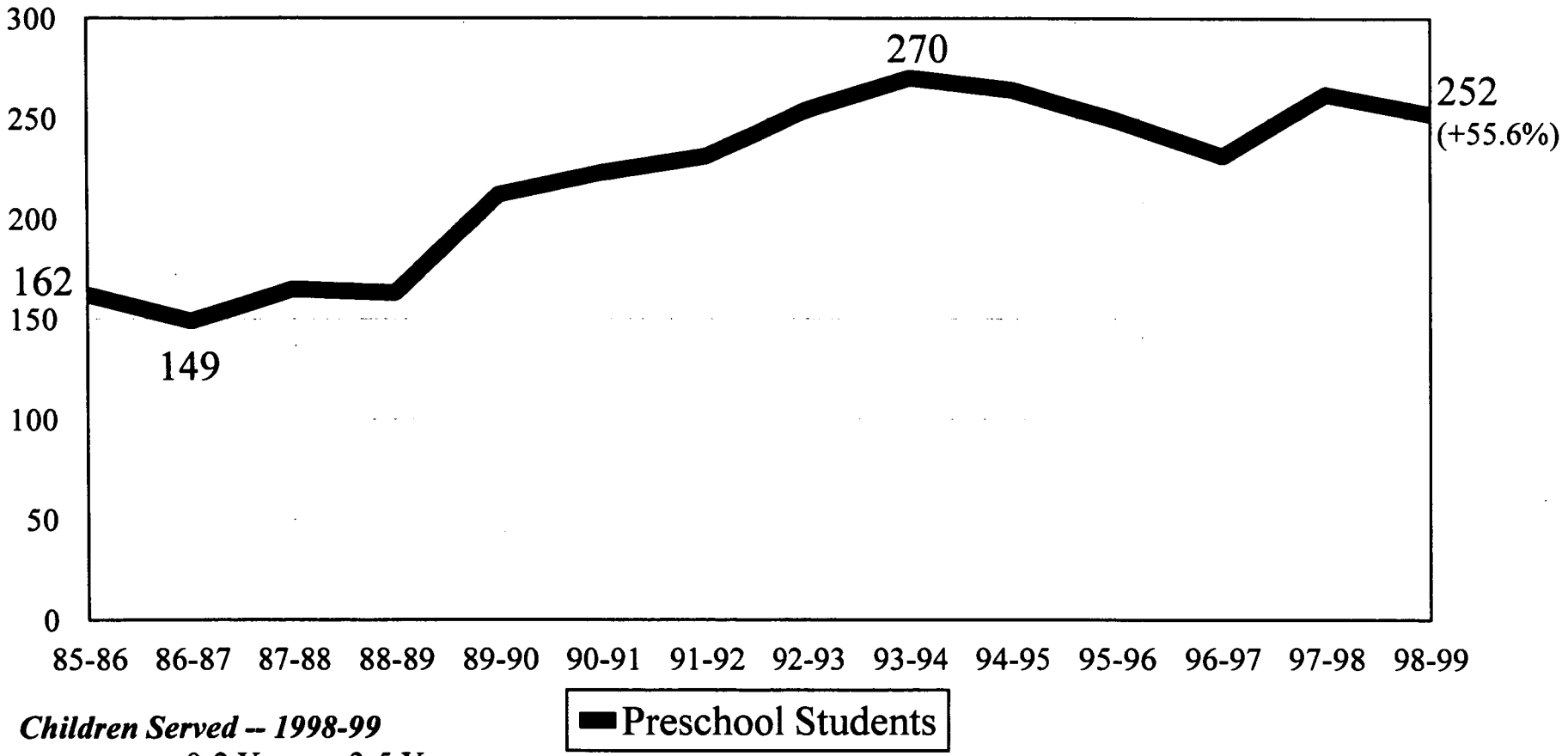
DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING

RESIDENTIAL SCHOOL ENROLLMENT TRENDS
(Excluding Preschool)



DIVISION OF SERVICES FOR THE DEAF/HARD OF HEARING

PRESCHOOL ENROLLMENT TRENDS



Children Served -- 1998-99

	0-2 Yrs.	3-5 Yrs.
NCSD	37	61
CNCSD	12	42
ENCSD	36	65
Total	85	168

1998-99 Budget: $5.2 M

RESIDENTIAL SCHOOLS FOR THE DEAF
COST

K Through 12

1998-99	NCSD	CNCSD	ENCSD
Avg. Educational Cost/Student	$42,384	$32,107	$34,927
Avg. Residential Cost/Student	$21,789	$22,043	$24,905
Total Cost/Residential Student	**$64,173**	**$54,150**	**$59,832**

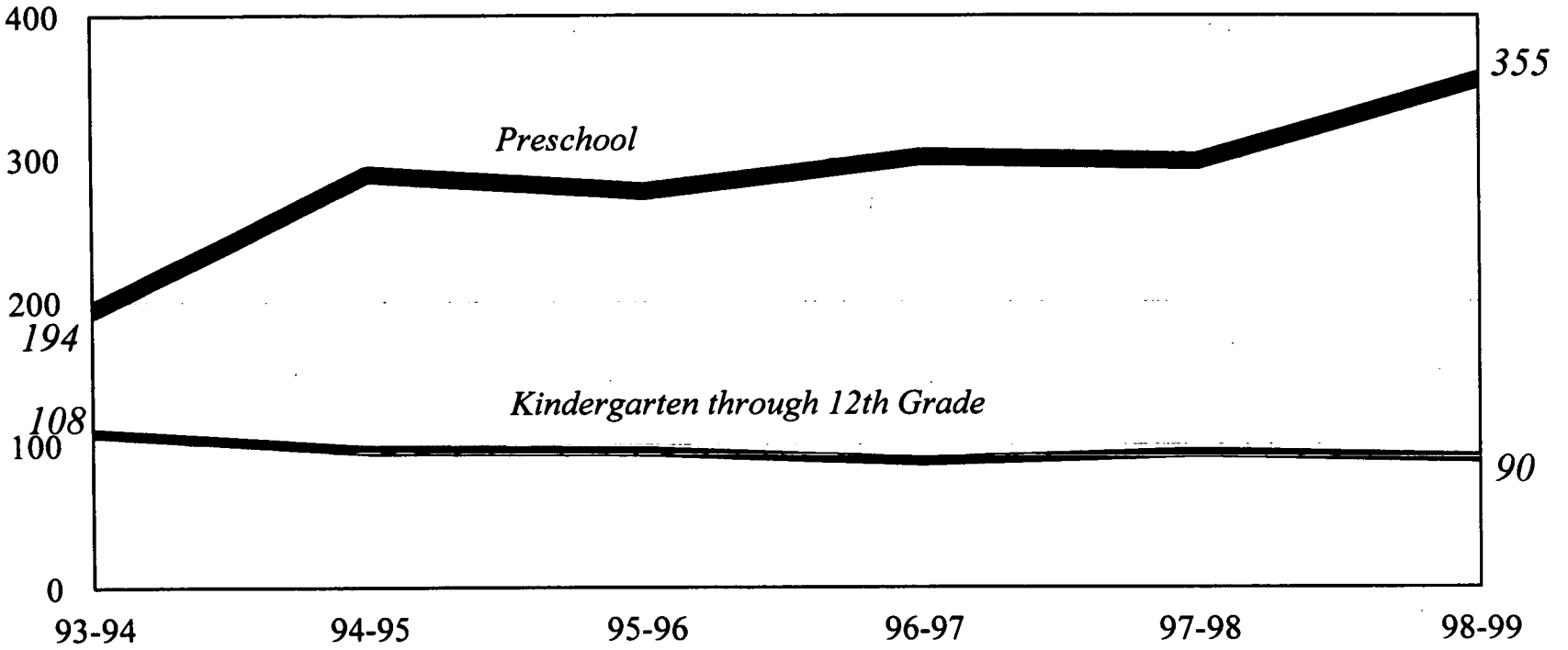
1995-96			
Avg. Educational Cost/Student	$26,397	$28,635	$25,773
Avg. Residential Cost/Student	$14,542	$13,524	$14,699
Total Cost/Residential Student	**$40,939**	**$42,159**	**$40,472**

Preschool

	NCSD	CNCSD	ENCSD
1998-99			
Total Expenditures	$959,819	$860,852	$1,115,730
Avg. Cost/Student	**$10,547**	**$14,348**	**$11,157**
1995-96			
Total Expenditures	$1,592,613	$1,785,040	$2,032,078
Avg. Cost/Student	**$15,614**	**$31,316**	**$21,167**

SERVICES FOR THE BLIND

GOV. MOREHEAD SCHOOL ENROLLMENT/COST



K Through 12th Grade	1998-99	1995-96
Avg. Educational Cost/Student	$47,198	$21,415
Avg. Residential Cost/Student:	$21,499	$19,578
Total Cost/Residential Student	$68,697	$40,993

Preschool - 1998-99
0 to 2 Yrs.: 150 Children
3 to 5 Yrs: 205 Children
Budget: $3.5M

RESIDENTIAL SCHOOLS

DPI ASSISTANCE TEAMS (May 1998)

- ***FINDINGS***

- Not Following the Standard Course of Study; Do Not Understand Concepts/Processes of the ABCs Plan
- Testing Procedures Not Adequate to Determine Student Performance on Grade Level
- IEPs Not Being Followed by Classroom Teachers
- Libraries Out of Date/Inadequate Materials for Implementing Standard Course of Study
- Need Additional Braille Texts and Other Materials

- ***RECOMMENDATIONS***

- On-Site Assistance Teams in 1998-99
- In-Depth Staff Training on the Standard Course of Study
- Accountability Plan for Students Exempt From End of Grade Testing
- Modality and Amplification Decisions Based on IEPs
- Collaborative Programs with Local School Systems

GOVERNOR MOREHEAD SCHOOL (GMS)

EVOLVING ROLE AS A STATEWIDE RESOURCE

- 850 Visually-Impaired (VI) Students Served in LEAs (K through 12th Grade)
- More Than Half of All LEAs Serve Students Without a VI-Certified Teacher
- More Than 40% of NC's VI-Certified Teachers Work at GMS

GMS SERVICES:

- Preschool Program
- Field Staff and Outreach Program
- Special Skills Program and Extended School Year
- Teacher Training and Development
    - Masters Degree in Visual Impairment (with NCCU)
    - Distance Learning
- Advocacy for Students, Parents, and Professionals

EDUCATION PROGRAMS

FUNDING-RELATED ISSUES

Cued Speech Center	$185,000 NR
GMS Early Intervention Services	$~~200~~ 25,000 NR
Teacher Salary Supplements	N/A
Proposed Elimination of Vacant Positions	$233,425 R

RECOMMENDED POSITION ELIMINATIONS

VOCATIONAL REHABILITATION SERVICES

POSITION TITLE	TOTAL VALUE	GENERAL FUND SAVINGS
1. Administrative Officer	$28,732	$20,687
2. Printing Operator	$47,167	$11,320
Subtotal	$75,899	$32,007
Benefits	$16,944	$7,348
Total	**$92,843**	**$39,355**

SERVICES FOR THE BLIND

1. Assistant Principal	$28,307	
2. Processing Assistant II	$11,189	
3. Educational Diagnostician I	$31,652	
4. Educational Diagnostician I	$31,652	
Subtotal	$102,800	
Benefits	$25,191	
Total	**$127,991**	**$127,991**

SERVICES FOR THE DEAF AND HARD OF HEARING

1. Administrative Officer II (NCSD)	$30,609	
2. Guidance Counselor (ENCSD)	$23,110	
3. Parent Trainer (ENCSD)	$22,693	
4. Staff Dev. Specialist II (CNCSD)	$29,022	
5. Deaf-Blind Program Consultant	$31,337	
Subtotal	$136,771	
Benefits	$32,957	
Total	**$169,728**	**$169,728**

EDUCATION PROGRAMS

ISSUES

Preschool

- Consistent Management Across Programs/ Integration into Early Intervention System
- Recruitment
- Support for Cued Speech Oral Auditory Programming
- Improved Outcome Data

K Through 12th Grades

- Student Safety
- Implementation of ABCs Plan (HB 1477)
- Resource Needs
- Role of Residential Schools
- Management of Residential Schools

EDUCATION PROGRAMS

SUMMARY

- Continued Dilligence and Commitment Required to Improve School Safety and Academic Performance

- Need Management With Strong Education Background to Succeed

- Need a Well-Defined Role for the Schools -- or Succumb to Declining Enrollments, Escalating Costs, and Unmet Program Needs

- Establish Consistent Management Across Campuses
  - Business Management Functions
  - Policy and Programs

- Integrate Preschools into the Early Intervention System

- Address Recruitment Issues

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-14, 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daniel Dornan	Pricewaterhouse Coopers / Raleigh, N.C.
Jann Harris	DHHS
Karen Chester	NC-ICC / DHHS
Rachael Ragin	DSD/HH
George McCoy	DSD/HH
Roslyn Sawitt	NC Child Care Coalition
Janet Simoneau	NC Council
Debbie Jackson	DSD/Blind Services
John Delucca	"
Wayne Shevlin	NFB of NC
Herman Gruber	NFB of NC
Dixie Gruber	NFB of NC
Bob [illegible]	NCDVRS - DHHS
John [illegible]	NCDVRS - DHHS - JL
[illegible]	NCSA
[illegible]	NCSEP
CP Medlin	Covenant w/ NC's Children
[illegible]	OSPL
Lee [illegible]	DHHS
Ed Cochrane Brown	DHHS — BP&A
Mary Greene	OSBM
Anne Tefft	OSBB
Ricki Cook	DVRS
Marjorie Donaldson	NC-DVRS
[illegible] Perkins	DVRS
[illegible]	OSBM

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
April 14, 1999
2:30 P.M.

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee at 2:30 P.M. on Wednesday, April 14, 1999, in Room 424 of the Legislative Office Building.

House Chairman, Representative Edd Nye presided. Other House members present were Representative Martha Alexander (Vice Chairman), Representative Alma Adams, Representative Lanier Cansler, Representative Theresa Esposito, Representative Trudi Walend, and Representative Gene Wilson. There were six senators present.

Chairman Nye asked Ms. Mary Ellen Sylvester, Fiscal Research Division, to continue her presentation for the morning meeting. Ms. Sylvester stated safety was a problem last year on campuses. Ms. Rachel Regin, DSD-Human Resources, was present and stated management needs to be more uniform. It isn't as centralized as it could be. The committee members asked questions. Senator Forrester asked about SAT being in Braille and percentage of students that go to college. He was told ten graduated, and five received diplomas. There were four students that want reading test so they can get diploma, but they do not use Braille. There is a real issue concerning how diplomas are issued. Department staff stated SAT is in Braille. Dr. David Bruton, DHHS, stated they want to combine resources to provide more and better services.

There was a discussion concerning the restructuring. Senator Forrester asked if the goal to combine administrative services was to have more money in General Services and stated he would like a list of administrative positions. Department staff stated the information was gathered through the study. They contracted with Price Waterhouse/Coopers to help with fact-finding concerning changes in the structure and functions of state residential schools with view to improving them.

Representative Adams stated she was getting lots of mail and phone calls concerning this issue. She said they are frightened. Dr. Bruton stated they are working hard to build understanding and that the money would stay in the system. Department staff recommended combining the services.

Chairman Nye adjourned the meeting.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbit
Committee Assistant

Department of Health and Human Services

Report on the Collaborative Effort To Improve Quality Of Academic Programs At Residential Schools/Program Review Of Disability Services

April 14, 1999

Recommendations for DHHS Residential Schools and Disability Divisions

Summary: In 1998, the General Assembly directed the Department of Health and Human Services to look at how its residential schools for deaf and blind children are run and to assess the feasibility of integrating its adult disability services into a single division. This report highlights the department's recommendation to integrate three of its divisions and to establish a position of superintendent to head a new division of education services.

Background

In 1998, the General Assembly adopted a special provision directing the department to "evaluate the feasibility of integrating adult services into a single Division of Disability Services." The three divisions were the Division of Services for the Blind, the Division of Services for the Deaf and the Hard of Hearing, and the Division of Vocational Rehabilitation. An earlier attempt to mandate merger was defeated on the House floor in a close vote.

In a second 1998 law, the General Assembly told the department to take a broad look at how its schools are organized and run and to "make changes in the structure and functions of the State residential schools with a view to improving student performance, increasing flexibility and control, and promoting economy and efficiency."

Because two of the divisions in the study were included in a study of the department's residential schools and education services and both called for looking at how the divisions were organized, the department combined the two studies.

Along with the three divisions, the department looked at pros and cons of including the developmental disabilities section in the Division of Mental Health, Developmental Disabilities, and Substance Abuse. This unit offers services to children and adults with developmental disabilities, including mental retardation.

Guiding principles

Although the department began the study without a set notion of what its recommendations would be, the principles that guided its work were clear:

- ❑ Improve and expand services to individuals who are blind, deaf or severely physically or mentally challenged.
- ❑ Streamline management and direct resources to services.
- ❑ Strengthen accountability for results.
- ❑ Help people live as independently as possible.

These are not the only principles that ought to guide service delivery in the department, but they are the most important. The recommendations that follow strike a balance between granting flexibility in the use of resources in the field and making sure that staff are held accountable for producing measurable results, including outcomes for those who are blind, deaf or severely physically or mentally challenged.

How the study was done

The General Assembly adjourned October 30, 1998, and the Secretary's recommendations were due in April 1999. To help it complete the two studies on time, the department enlisted outside help.

A committee of representatives of the four divisions and chairs of disability advisory groups advised the department on the study and served as a sounding board. The committee gave people and groups that would be affected by the reorganization the opportunity to participate in the study and to voice their concerns and views. The committee met four times. Attachment A is a list of committee members who participated in the study.

The department also contracted with PriceWaterhouse/Coopers, a national accounting and consulting firm, to gather information, interview and survey consumers and other stakeholders, and assess the potential impact of creating a new division and reorganizing education services. PriceWaterhouse/Coopers' findings are included in its report, "Education and Disability Organization Study." As part of its work, PriceWaterhouse/Coopers staff interviewed, surveyed, or included in focus groups 200 stakeholders.

The department also engaged three outside consultants – one an expert in deaf education at the University of Tulsa, another an expert in blind services with the American Federation of the Blind, and the executive director of the leading national developmental disabilities association – to help with the study.

Recommendations

Create the Division of Blind, Deaf and Rehabilitation Services

1. **Create a new Division of Blind, Deaf and Rehabilitation Services by reorganizing the existing divisions of Services for the Blind, Services for the Deaf and the Hard of Hearing, and Vocational Rehabilitation.**

   Creating a new division would strengthen delivery of services by allowing the department to redirect resources to consumers. It would consolidate budgeting, contracting, purchasing, personnel, and management functions under one roof. No loss of specialization in service delivery is planned. The reorganization would greatly strengthen the regional service delivery system in all counties. This would be accomplished by putting the redundant administrative positions to work in direct service delivery activities.

   We believe that concerns raised by representatives of the blind and the deaf that their voices would no longer be heard and that specialized services would decrease can be addressed

effectively through: (1) the organization and structure of the division and its field offices; (2) accountability measures that focus on outcomes for specific disabilities; (3) involvement of advocates and stakeholders in division-level and department-level oversight; and (4) the establishment of a consumer complaints office. (Recommendations on these issues follow.)

No change is contemplated in the current structure of the NC Commission for the Blind, NC Council for the Deaf and the Hard of Hearing, Consumer and Advocacy Advisory Committee for the Blind, the Vocational Rehabilitation Council, or other legislated committees or councils. The Assistant Secretary for Human Services would form an unofficial Advisory Group representing all concerned. One welcome benefit of reorganizing the three divisions (and moving the residential schools to a new education services division) is that it clarifies the mission and sharpens the focus of the department in providing services to adults, as well as children. Thus, the primary focus of a new division would be specialized services, independent living, employment, and advocacy.

We would not have the situation that we currently have in which school staff comprises more than 40% of one division and 91.7% of another. Running residential facilities (which is fundamentally what the schools are) is far different from teaching orientation and mobility skills to newly blinded adults or helping a deaf or hard of hearing persons live more independently.

2. **Expand and improve the quality of services by streamlining administration and eliminating duplication.**

   Reorganizing the three divisions would allow the department to eliminate duplication and streamline administration. One of the major findings of the PWC study was that available resources are spread thin to cover separate state, regional, and local offices. This is partly so because of the three separate administrative structures needed to run the three divisions.

   For example, not including teachers and staff of the three schools for the deaf, the Division of Services for the Deaf and the Hard of Hearing has only 60 employees (of whom only 34 are in regional offices) to serve an estimated 60,000 deaf residents and 600,000 people who are hard of hearing. It is impossible for this few staff to cover the state adequately. Field offices are too small and some are relatively isolated because of the need to serve many counties.

3. **Address management, accountability and funding issues with the Developmental Disabilities Section through the legislatively mandated study of the state's mental health system.**

   The General Assembly asked the department to study the feasibility of combining disability services for adults in a single division. In the department, the definition of those services includes adults who have developmental disabilities, including mental retardation. One focus of the PWC study included an assessment of the feasibility of including the developmental disabilities section in the reorganization. Although there clearly is a need to look at issues surrounding that section, those issues can best be examined in the department's two-year

study of the state's mental health delivery system (which includes developmental disabilities services and substance abuse treatment).

4. **Involve representatives of consumers and stakeholders in designing a new Division of Blind, Deaf and Rehabilitation Services**

   We believe that the functions of a newly created division are clear: specialized services, independent living, employment, and advocacy. What isn't immediately obvious is the best way to deliver services and perform those functions.

   The department would establish a work team of individuals from inside and outside the department (including many of the same advocates and stakeholders on the study advisory committee) to design a new structure. The Assistant Secretary for Human Services would lead the work group, which would report its recommendations to the Secretary for his approval by October 1, 1999.

   Although involving stakeholders in this process will take more time, it is well worth the effort to make sure that we have their involvement and support as we move forward.

5. **Make sure those individuals with low-incidence disabilities such as blindness or deafness can get specialized services and help they need to live as independently as possible.**

   One of the major concerns of advocates for the deaf and the blind is that specialized services for low-incidence disabilities would decrease or disappear. That is a legitimate concern. While some independent living services could be provided by general case workers or counselors, others such as orientation & mobility training and interpreting using American Sign Language (ASL) could not.

   Following the creation of the new division, there would be more employees providing those specialized services than before the reorganization. Employees would meet education and training standards no less rigorous than those currently in place. We would expect all of the support structures to be enhanced by the reorganization.

6. **Hold the new division accountable for results.**

   The department, working with the new division and with stakeholders, would create an annual "report card" which looks at the number of individuals served each year and how many were able to resume work or some degree of independent living. The department would track progress from year to year and for specific disabilities such as blindness or deafness; results would be used as part of the employee assessment and evaluation.

7. **Guarantee consumers and stakeholders an advisory and oversight role in management and policy for the new division.**

   The department recommends continuing existing advisory councils for specific disabilities. These councils work most of the time at the division level and would continue to do so. The

department would create an unofficial cross-disability committee at the department level. This committee would be comprised of chairs of the existing disability committees.

This would do three things: (1) it would continue to recognize differences among disabilities and allow them to continue oversight of services for those they represent; (2) it would raise discourse about important issues to the highest levels in the department; and (3) it would promote coordination and sharing of information.

Residential schools

8. **Establish a Division of Education Services to streamline and clarify department governance and management of its schools and education programs.**

   The Department of Health and Human Services employees roughly 500 certified school teachers. That is equivalent to a regular school district with 7,000 to 8,000 students. Of course, the department doesn't have that many students because our classes are much smaller, but it still has to carry out many of the same functions as regular school districts.

   We believe that the creation of a Division of Education Services in the department will simplify management and make it easier to hold schools accountable for educating our special needs children.

9. **Create the position of superintendent and reorganize existing school and division-based staff to form a support team to work with schools.**

   The team would include (along with the superintendent) positions for: (1) instruction and curriculum, (2) staff development and training, (3) licensure and certification, (4) preschool programs and early intervention, and (5) technology. The education division would also include a business office composed of employees from the two divisions, which previously ran the schools. It may also be necessary to add other functions, such as a director of clinical services, to the team. Administrative support staff and personnel staff (assigned from the Division of Human Resources) would also be added.

10. **Reorganize the three residential schools for the deaf and the Governor Morehead School.**

    The schools currently are a hodge-podge of positions, classifications, and job descriptions. This situation evolved over many years. Fixing the problem will not be easy, but it needs to be done.

    We recommend using the following position titles and brief job descriptions at each of the four residential schools:

    School director. Responsible for running all aspects of the school and the residential program; reports to the department's superintendent.
    Principal. The instructional leader of the school; reports to the school director.
    Assistant principal. Helps the principal do his or her job; assigned to grades 9-12 or K-8; reports to the principal.

Business services manager. Responsible for overseeing all business matters, including purchasing, payroll, contracts, etc.; reports to school director.
Student support services manager. Oversees all counseling and clinical services for students; reports to school director.
Residential services manager. Oversees dormitory and residential staff, dining facilities, recreation, etc.; reports to school director.
Dorm director. Oversees and runs a dormitory; reports to residential services manager.

11. Continue to explore satellite programs for school-age deaf and hard of hearing children and weigh the feasibility of using one or more of the schools to expand transitional living programs for graduates of the schools.

Total enrollment at the three schools for the deaf has declined 28% in the last ten years (six percent last year alone); residential enrollment has dropped 40% over the same time (12% last year). In the long run, the need for three residential schools will continue to decline. (In fact, the Central North Carolina School for the Deaf in Greensboro has more than 180 beds, but only 46 residential students.)

Advances in early detection of deafness and hearing loss in infants, improvements in technology (including but not limited to cochlear implants) and early intervention services, and the growing capacity of school districts to serve deaf and hard of hearing students will contribute to that trend.

All things being equal, children almost always are better off living with their families than at a residential school. The Eastern North Carolina School for the Deaf in Wilson is working with Cumberland County Schools to offer a satellite program in that community for deaf and hard of hearing students in which the public schools would provide transportation and classrooms and Eastern would provide the teachers and staff. We need to undertake more of these efforts.

We also need to start thinking about teaching and learning in different ways. Sometimes it will take profoundly deaf students more than 13 years to gain the equivalent of what in the public schools is 13 years of education. According to a study of students who attended the Eastern North Carolina School for the Deaf, more than 43% depended on federal disability payments for all or some of their support.

A residential program for deaf children with multiple disabilities or with severe behavior disorders should continue to be an option for children who need that level of care and education. *But if current enrollment trends continue, eventually it will be impossible to justify operating three residential schools for the deaf.* We recommend that the General Assembly support a study to determine the feasibility of (1) expanding or strengthening independent living programs and (2) developing one campus as a transitional living center for students who have finished high school but are not yet ready to live and work on their own.

Note: Under the federal Individuals with Disabilities Education Act (IDEA) special needs students are eligible for services up to age 21.

12. Transfer responsibility for preschools from school directors to a division level preschool and outreach coordinator.

Running a residential school is a full-time job. The school director is responsible for overseeing a management operation of 139 to 307 staff. It is hard enough to manage and supervise staff on campus; we believe it is asking too much to expect directors to supervise and run preschool programs located throughout the state.

The group studying early intervention programs for the department (as required by the General Assembly) also recommended taking the preschools out from under the residential schools. We recommend that supervising and running the department's preschool program should be someone's full time responsibility. There would, of course, still need to be coordination with the schools, and the preschool coordinator would report to the department's superintendent. The coordinator would also be responsible for making sure that they supported the department's overall early identification and early intervention efforts.

Next Steps

The department believes these recommendations represent a rare opportunity to design a new, more responsive, and expanded system of education and adult services. These recommendations sharpen the mission and role of disability programs. To carry out these recommendations, the department would:

- Review its mission and long-term vision.
- Solicit comments and suggestions of stakeholders and involve them in the planning, design, and oversight processes.
- Generate an implementation plan, consisting of:
  - A series of milestones, timelines, and action steps needed to accomplish the plan;
  - Expected outcomes and monitoring process.
  - A communications strategy and plan to notify all stakeholders of impending changes and timelines.
- Assign an implementation team consisting of a sponsor (Assistant Secretary for Human Services), change agents, and change participants and initiate the implementation plan.
- Monitor implementation and change the plan as needed.

Disability Services Study Committee

Attachment A

Dr. John Baggett, Director Division of Mental Health 325 North Salisbury Street Raleigh, NC 27603 919-733-7011 (Phone) 919-733-9455 (Fax) jbaggett@dhr.state.nc.us	Kathy Heeter Personnel Director 101 Blair Drive Raleigh, NC 27603 919-733-2940 (Phone) 919-733-6087 (Fax) kheeter@dhr.state.nc.us
Dr. H. David Bruton Secretary, DHHS 101 Blair Drive Raleigh, NC 27603 919-733-4534 (Phone) 919-715-4645 (Fax) gparker@dhr.state.nc.us	Tim Jones, Chairperson Consumer Committee 128 Summerlea Drive Charlotte, NC 28214 704-399-4977 1-800-344-7113
John DeLuca, Director Division of Services for the Blind 301 Ashe Avenue Raleigh, NC 27603 919-733-9622 jdeluca@dhr.state.nc.us	Dr. Lee Kittredge Project Manager 101 Blair Drive Raleigh, NC 27603 919-733-4534 (Phone) 919-715-4645 (Fax) kittredgel@aol.com
Tommy Donnelly NC Council for the Deaf and Hard of Hearing Route 6, Post Office Box 28331 Raleigh, NC 27502 919-772-2319, TTY	Norma Krajczar, Chairman Commission for the Blind 100 Noyes Avenue Morehead City, NC 28557 252-726-7567 (Phone)
Jim Edgerton, Assistant Secretary for Budget, Management and Planning 101 Blair Drive Raleigh, NC 27603 919-733-4534 (Phone) 919-715-4645 (Fax) jedgerton@dhr.state.nc.us	Peter Leousis Assistant Secretary for Human Services 101 Blair Drive Raleigh, NC 27603 919-733-4534 (Phone) 919-715-4645 (Fax) pleousis@dhr.state.nc.us
Roger Goble, Chairperson Independent Living Advisory Committee 3492 Wilkesboro Boulevard Lenoir, NC 28645 828-758-7800 (Phone) 828-758-2093 (Fax) drgsr41@aol.com	Dr. Glenn Lloyd Chair of the VR Council 4419 Cobb Avenue Morganton, NC 28655 828-584-4164 (Phone) 828-584-3871 (Fax) g&clloyd@vistatech.net

Disability Services Study Committee

Jann Harris Policy and Program Coordinator for Human Services 101 Blair Drive Raleigh, NC 27603 919-733-4534 (Phone) 919-715-4645 (Fax) jannharris@dhr.state.nc.us	Marc Lodge General Counsel 101 Blair Drive Raleigh, NC 27603 919-733-6920 (Phone) 919-733-7447 (Fax) mlodge@dhr.state.nc.us
Peyton Maynard 401 Transylvania Avenue Raleigh, NC 27609 919-781-7946 (Phone) 919-786-0237 (Fax)	Dr. Pat Porter, Chief, Developmental Disabilities Division of Mental Health 325 North Salisbury Street Raleigh, NC 27603 919-733-3654 (Phone) 919-733-9455 (Fax) pporter@dhr.state.nc.us
Dr. Dennis McBride State Health Director 101 Blair Drive Raleigh, NC 27603 919-733-4392 (Phone) 919-733-0513 (Fax) amcbride@dhr.state.nc.us	Holly Riddle, Director Council on Developmental Disabilities 1001 Navaho Drive, Suite GL-103 Raleigh, NC 27609 919-850-2833 (Phone) 91-850-2895 (Fax) hriddle@dhr.state.nc.us
George McCoy, Interim Director Division of Deaf & Hard of Hearing 319 Chapanoke Road Raleigh, NC 27603 919-773-2970 (Phone) 919-773-2990 (Fax) gmccoy2@dhr.state.nc.us	Susan Sien, Superintendent Central NC School for the Deaf Post Office Box 14670 Greensboro, NC 27415-4670 336-621-6490 (Phone) 336-621-2713 (Fax) ssien@dhr.state.nc.us
Allen Perry, Executive Director GACPD 2113 Cameron Street, Suite 218 Raleigh, NC 27603 919-733-9250 (Phone) 919-733-9173 (Fax) allen_perry@mail.doa.state.nc.us	J. W. Smith, Program Director United Action for the Blind 6824 New Salem Road Marshville, NC 28103 704-385-9195 (Phone)

Disability Services Study Committee

Bob Philbeck, Director Division of Vocational Rehabilitation 805 Ruggles Drive Raleigh, NC 27603 919-733-3364 (Phone) 919-733-7968 (Fax) bphilbeck@dhr.state.nc.us	Mary Ellen Sylvester Division of Fiscal Research North Carolina General Assembly 300 North Salisbury Street Raleigh, NC 27603-5925 919-733-4910 (Phone) 919-715-3589 (Fax)
Emily Moore Chairperson, MH Study Commission 3505 Lakeview Trail Kinston, NC 28501 252-522-2391 (Phone)	Allan Spader NC Council for Community Programs 1318 Dale Street Suite 120 Raleigh, NC 27605-1275 919-755-0680 (Phone) 919-755-0697 adscnc@mindspring.com

Disability Services Study Committee

GUEST

Catherleen Thomas, Vice-Chairperson Commission for the Blind 308 Peartree Lane Raleigh, NC 27610 919-231-1047 (Phone)	Herman Gruber, Vice-Chairman Consumer Committee 116 Argonne Drive Durham, NC 27704 919-477-0445 (Phone)
Ben Aiken 1613 Beechgrove Road Raleigh, NC 27612 919-848-0199 (Phone)	Janet Simoneau, Director NCARF 801 Oberlin Road, Suite 305 Raleigh, NC 27605 919-829-9665 (Phone)
Dave Richard, Executive Director ARC Post Office Box 20545 Raleigh, NC 27619 919-782-4632 (Phone)	George Cheek, VP, MRA 206 West Greenway Drive, South Greensboro, NC 27403 336-273-5182 (Phone)
Beth Melcher NCAMI 309 West Millbrook Road, Suite 121 Raleigh, NC 27609 919-788-0801 (Phone)	Catherine Hux NCAPA 4917 Waters Edge Drive Raleigh, NC 27606 919-859-3370 (Phone)
June Cumming, Area Director Lenoir Area Mental Health Program 2901 North Heritage Kinston, NC 28501 919-527-7086 (Phone)	Marcel Mitchell Rockingham Area Mental Health Post Office Box 30 Wentworth, NC 27675 336-342-8419 (Phone)
Dr. Terry Stelle Division of Mental Health 325 North Salisbury Street Raleigh, NC 27603 919-733-7011 (Phone) 919-733-9455 (Fax)	Craig Ensley 4205 Ragsdale Court Fuquay-Varina, NC 27526 919-557-3652 (TTY)
Steve Barber 104 Sylvan Grove Cary, NC 27511 919-851-4244 (Phone)	Randall Pope, President North Carolina Deaf-Blind Associates 1525 North Rhyne Street Gastonia, NC 28054 704-864-3757 (Phone)
Steve Witchey Eastern NC School for the Deaf Post Office Box 2768 Wilson, NC 27894-2768 252-237-2450 (Phone)	

Department of Health and Human Services

Report on the Collaborative Effort To Improve Quality Of Academic Programs At Residential Schools/Program Review Of Disability Services

April 14, 1999

H. David Bruton, M.D.
Secretary

Background

- 1998 General Assembly directed DHHS to "evaluate the feasibility of integrating adult services into a single Division of Disability Services."

- Considered Developmental Disability Services but left for other study

- 1998 General Assembly directed DHHS to make changes in the structure and functions of State residential schools with a view to improving:

    - student performance
    - increasing flexibility and control
    - promoting economy and efficiency

Guiding principles

- Improve and expand services to individuals who are blind, deaf or severely physically or mentally challenged.
- Streamline management and direct resources to services.
- Strengthen accountability for results.
- Help people live as independently as possible.

How the study was done

- ❑ Disability Services Study Committee Established
  - Chairs of legislated councils represented
  - Stakeholders, division staff, and interested parties represented

- ❑ Contracted with PriceWaterhouse/Coopers
  - Interviewed 200 stakeholders
  - Reviewed budgets, organizational charts and other information from divisions
  - Presented findings to DHHS on March 12

- ❑ Consulted with national experts
  - Deaf Education expert from the University of Tulsa
  - Representative from the American Federation of the Blind
  - Executive Director of the National Association of Directors of Developmental Disabilities

- ❑ Received additional input via letters, phone calls and informal discussions

Recommendations Overview

- ❑ Create a Division of Blind, Deaf and Rehabilitation Services
- ❑ Establish a Division of Education
- ❑ Create the position of DHHS Superintendent
- ❑ Reorganize the three residential schools for the deaf and the Governor Morehead School
- ❑ Address management, accountability and funding issues with Developmental Disabilities Section through the legislatively mandated study of the state's mental health system

Create a Division of Blind, Deaf and Rehabilitation Services

- ❑ Clarifies mission and focus on adult services

- ❑ Streamline services and eliminate redundancy

- ❑ Strengthen delivery of services by re-directing resources to direct services
  - Eliminate duplication of administration

- ❑ No loss of specialized services delivery is planned
  - Reorganization would strengthen regional service delivery
  - Accountability measure focus on outcomes
  - Continued involvement of stakeholders
  - Establish a consumer complaints office

- ❑ No change in current councils and commissions
  - NC Commission for the Blind
  - NC Council for the Deaf and the Hard of Hearing
  - Consumer and Advocacy Advisory Committee for the Blind
  - Vocational Rehabilitation Council

Create a Division of Blind, Deaf and Rehabilitation Services (continue)

- ❑ Establish cross-disability committee at department level
  - Recognize differences of groups
  - Opportunities for input on important matters at department level
  - Promote coordination and sharing of information

- ❑ Establish work team to design new structure
  - Plan takes effect October 1, 1999
  - Develop annual report card to track services and successful outcomes

Establish Division of Education and create Superintendent position

- ❑ Clarify governance and management of schools
- ❑ Clarify mission and focus on children's services
- ❑ Create position of superintendent and reallocate staff from Division/schools to provide leadership and direction:
  - Instruction and curriculum – ABCs
  - Staff Development and Training
  - Licensure and Certification
  - Preschool and Early Intervention Services
  - Technology
  - Clinical Services
  - Administrative, budget, personnel, etc.

Establish Division of Education and create Superintendent position (continue)

- ❑ Realign classifications to conform with DPI classes
- ❑ Assess feasibility of offering satellite programs for school age children and expanding transitional living programs for graduates of schools
- ❑ Put supervision of preschools at Division/Superintendent level

Next steps

- ❑ Review missions and long term vision
- ❑ Keep stakeholders involved in planning, design and oversight processes
- ❑ Generate implementation plan
  - Milestones, timelines, action steps
  - Communication plan
- ❑ Assign implementation team
  - Sponsor
  - Change agents
  - Change participants
- ❑ Monitor implementation and change plan as needed

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-14, 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daniel Dornan	PricewaterhouseCoopers / Raleigh, NC -
Jann Harris	DHHS
Rachael Ragan	DSD/HH
George McCoy	DSD/HH
Karen Chester	NC-ICC / DHHS
Ben Hiken	NCPH-UAB
Ricki Cook	DVRS
Marjorie Donaldson	DVRS
Jo Perkins	DVRS
Mary Greene	OSBM
Anna Teeft	OSBM
Bob Pollock	DVRS - DHHR
John Dalrymple	DVRS - DHHS - (IC)
Wayne Shaplin	NFB of NC
Herman Gruber	NFB of NC
Dixie Gruber	NFB of NC
Debbie Jackson	DSB
John DeLuca	DSB
[illegible]	DDR/YRID

Joint Health and Human Services Appropriations Committee

AGENDA

April 15, 1999
8:30 a.m., Room 424 LOB

Responses to DHHS Proposal:

Mr. Dave Binning
Chair, NC Association for the Deaf

Mr. Herman Gruber
Consumer
Former Director, Division of Services for the Blind

Block Grants:

Preventive Health Services

Maternal and Child Health Services

Mental Health Services

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

MINUTES
APRIL 15, 1999
8:30

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Thursday, April 15, 1999 at 8:35 a.m. in Room 424 of the Legislative Office Building.

House Co-Chair, Representative Beverly Earle presided. Other House members present were:

Representative Edd Nye, Co-Chair
Representative Martha Alexander, Vice Chair
Representative Alma Adams
Representative Lanier Cansler
Representative Theresa Esposito
Representative Turdi Walend
Representative Gene Wilson

All Senate members were present.

Representative Beverly Earle called the meeting to order at 8:35 a.m. Pages were introduced and the meeting began with Rep. Earle asking for questions or comments from any of the members who had not had a chance to do so at earlier meetings. No one had questions.

Mr. Dave Binning, Chair of the North Carolina Association for the Deaf, and also representing the North Carolina Council for the Hearing Impaired, was asked to response to the Department of Health and Human Service proposal to merge the Services for the Deaf with the Services for the Blind. An interrupter was also present for Mr. Binning. He spoke very highly of the services that are being offered through the department, and do not understand why the Department of Health and Human Services are proposing a possible merger. He asked that the Department of Health and Human Services to have hard of hearing people, deaf people and deaf blind people, be a part of the interviewing and staffing of positions, since they will be working with the deaf and blind people. There are seven centers in North Carolina to be fully staffed. If these centers are properly staffed, there will not be a need for a merger. He ended his presentation with a quote, "We have been telling people this a thousand times, but we have not yet been heard."
Mr. Greg Insley, representing the North Carolina Association for the Deaf, spoke briefly on behalf of the deaf community.

Mr. Herman Gruber, Former Director of the Division of Services for the Blind, spoke on services being offered through the Department of Health and Human Services. He spoke very strongly against the merger of the two divisions. He stated that the division is not perfect, but a merger is not the answer. Specialization is a major issue. It is difficult to maintain specialization, even in an agency that is dedicated to specialization. If the divisions merge, specialization will become less effective. In concluding his presentation, Mr. Gruber stated he find no advantage in a merger.

The Representatives and Senators contributed to the presentations with comments and questions. Mr. Binnings, Mr. Insley (with an interrupter) and Mr. Gruber answered the questions.

The meeting adjourned at 9:50 a.m.

Respectfully submitted,

Beverly Earle

Presiding Co-Chair, Representative Beverly Earle

Ann Raeford, Committee Clerk

Attachment I Agenda
Attachment II Visitor Registration

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-15, 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daniel Dornan	PricewaterhouseCoopers / Raleigh
Jann Harris	DHHS
Craig Ensley	Rep. for NCAD + Deaf Community
Rachael Ragan	DSD/HH
LINDA NELSON	DSDHH
Pat Stoyland	DSDHH
Marjorie Donaldson	DVRS
Richi Cook	DVRS
J. Perkins	DVRS
Bonnie Morell	DMH/DD/SAS
Susan E Robinson	DMH/DD/SAS
Ed Cochrane Brown	DHHS - BP&A
Jerge McCoy	DSDHH
Mary Greene	OSBM
Joshua Sheppard	DHAS/DFS
Tom Vitaglio	DHHS/DWCH
Pam Kilpatrick	DHHS-DPH
Kevin Ryan	DHHS-DPH
Dorothy Cilento	DHHS-DPH
Barbara Pulley-Smith	DHHS/DPH
AL DEITCH	DOA/YAIO
Peter Andersen	DHHS
Pam Richardson	OSPL
Rane Pierce	NCSEP
CP Medlin	Covenant w/ NC's Children
Catherleen Thomas	N.C. Council of the Blind
John W. Dalrymple	DVR, IL, DHHS
Bob Gulloch	DVR-DHHS

VISITOR REGISTRATION SHEET

Health & Human Services 4/15/99

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
1. Herman Gruber	NFB of NC
2. Dixie Gruber	NFB of NC
3. Wayne Shevlin	NFB of NC
4. John DeLuca	DSB
5. Debbie Jackson	DSB
6. Charles M. Bernardo	The Governor Morehead School
7. M T Burnette	GACPD
8. Joel Sawitt	visitor
9. Roz Sawitt	NC Child Care Coalition
10. Karen Chester	NC-ICC
11. Steve Cline	DHHS - Epi/Dental
12. MICHELLE COTTON	DMH/DD/SAS
13. A Dennis McBride	DHHS
14. Dennis Harrington	DHHS - Local Health Serv.
15. [illegible] Wolfe	DHHS - DPH
16. Allen Duffey	DHHS
17. Peter Jeanson	DHHS
18. [illegible]	DSBM
19. Jim Adams	DHHS
20. David Barton	DHHS
21. Katherine Miller	Harry Kaplan

VISITOR REGISTRATION SHEET

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

	NAME	FIRM OR AGENCY
1.	David Branch	NC Council for the Deaf & HH
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		

NORTH CAROLINA GENERAL ASSEMBLY

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

April 20, 1999
8:30 a.m.

The Joint Appropriations Subcommittee on Human Resources met in Room 424 of the Legislative Office Building, April 20, 1999. Sen. Bill Martin, Chair, called the meeting to order. There were five Senate Members present and the following House members were present: Representative Earle, Representative Nye, Representative Alexander, Representative Adams, Representative Cansler, Representative Esposito, Representative Walend, Representative Wilson. After introduction of the Pages, Senator Martin stated that meeting would follow the attached agenda. During this meeting the Division of Social Services, the Division of Children Services and later Long Term Care Proposals will be reviewed.

Karen Hammonds Blanks was recognized to present the information on the Division of Social Services. Karen's presentation was from the attached handout. (Attachment 1) She stated that because the time frame has been condensed she would give an overview of the Division of Social Services. She began by giving the mission of the Division as defined by the Statutes (on page 2 of the handout). She stated that there are two commissions identified on page 5, the Social Services Commission that gets its origin in the Statutes and the Joint Legislative Public Assistance Commission, created in 1997 has the specific responsibility of overseeing Welfare Reform.

She reviewed the Organizational Chart and the broad area of responsibilities for the Division of Social Services. The budget summary for the Division was also discussed. In the area of Children Services she briefly discussed initiatives and services of Foster Care, Adoption and Child Protective Services and the budget. She stated that 52 per cent of the funds are dedicated to Foster Care and the next largest amount would be for Child Protective Services. She stated that the areas of supervision recruitment, study and development of foster families should be emphasized in order to get children out of foster care. She stated that federal law that requires the State to expedite process of getting children out of Foster Care into permanent homes.

During Committee discussion Rep. Adams referred to page 22 of the handout and asked for an explanation of what happens to children that remain with foster families for more than one year.

Representative Earl asked for further information on Intensive Family Preservation Services and how the 39-counties are located and how the families are selected.

Sen. Phillips asked if the sense of urgency to get children out of foster care into a safe, permanent home causes less efficient and effective in matching children with adoptive parents and in making sure the parent is able to provide the necessary services for the children. He is concerned that corners might be cut in the historically long adoption process. He said that he is concerned that the system is not ensuring the protection of both the child and adoptive parent as well as the family that is giving up the child.

Mr. Chuck Harris, Children Services Section of the Division of Social Services was recognized to give a brief review of the Adoption and Safe Families Act and what it means to North Carolina.

Mr. Harris stated at the time that the Intensive Family Preservation Program began, four or five years ago, the resources were not available to implement the program statewide. Information regarding indicators of need for every county was collected. The selection of the counties was based on the strength of the proposal submitted, and those indicators of need. The selection of families is based primarily on families with children who are at eminent risk of being placed in the Foster Care System, Juvenile Justice System or a Mental Health Treatment Facility.

He further stated that there is not a lot of federal legislation that guides Child Protective Services. Child-abuse and child neglect is defined by each state. There is, however, significant federal legislation for foster care and adoptions. The Adoption and Safe Families act is intended to 1) make sure that safety is our primary consideration in all decision regarding children, 2) ensure that children do not grow up in foster care.

During Committee discussion Senator Purcell stated that he is concerned that the Social Workers feel that their job is to see if a law has been broken or if they define and address the real problem.

Continuing her presentation from page 25 of the handout, Karen Hammonds-blanks concluded her presentation on Children Services.

Representative Nye gave directions for the Committee. He stated that the House Chairs have been directed to have a report ready a week from today for the 6th Floor. He stated that the Committee has seven days to complete the report.

The Committee adjourned until 2:30 today.

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

Continuation of Morning meeting

April 20, 1999
2:30 p.m.

Senator Martin called the meeting to order with five Senate Members present and the following House members were present: Representative Earle, Representative Nye, Representative Alexander, Representative Adams, Representative Cansler, Representative Esposito, Representative Walend, Representative Wilson.

After introduction of the pages, the Chair recognized Linda McDaniel, to begin the review of the Long Term Proposal as prepared and submitted the Governor's Office. He stated that Jim Edgerton from the Department would follow her.

Ms. McDaniel, Division of Facility Services, spoke from the attached handout. She stated that there are three primary parts to this initiative. They are improving quality of care, protecting residents and improving regulatory oversight. She reviewed the specifics of each primary part. She stated that training of staff for medication administration in adult care homes should be required. She suggested that an enhanced curriculum should be available, on the web, through community colleges and that the Department should develop a competency exam that each employee would be required to pass. The problem with the required training for staff in behavioral intervention is that twenty-nine per cent of residents in adult care home have some type of behavioral problems and there are no specific requirements regarding the mixing of population in adult care homes. She suggested that a partial solution would be to provide training to staff in the area of adult care behavioral intervention. She stated that if a facility advertises that it provides special care, they must be required to meet higher standards. Homes with twenty-one residents or more should be required to have a full-time administrator in addition to a supervisor. Nurse aide personal care aide availability and retention should be improved. She said that the Kate B. Reynolds grant would provide an opportunity to study this area and develop proposed solutions. The TEACH program for day care workers has been highly successful and the avenues available it will be explored.

In the area of Mental Health, Ms. McDaniel reminded the Committee of the situation at the Grandfather Home in the Western part of the State (the restraint death). She stated that the conclusion is that that facility should be licensed under the Mental Health Law and Rule. She stated that that requires that home and others like to be under the direction of the four consultants who have 3,000 other facilities to monitor. She expressed concern that without additional staff, there will be greater limitations on the level of oversight given to these facilities.

Jim Edgerton came before the committee to continue reviewing the budget beginning on page 5 of the attached handout. He stated that the package review by Ms. McDaniel is funded by redirection of funds in the Continuation Budget and by Expansion Funds in the Governor's budget. He stated that the proposed 17 positions for the Division of Facility Services will be supported by fees.

Dr. Ann Wolf, Director, Division of Public Health was recognized to review Preventative Health Services and Maternal and Child Health Block Grants. She stated that review changes in the two public health block grants. Both of these grants are focused on prevention. The Preventative health Care Block Grant comes from the Center for Disease Control and Prevention is directed to preventing injury, illness and early death. The only change will be a small increase for the next fiscal year, approximately $66,000 that will be prorated proportionally. The Maternal and Child Health Block Grant comes from the Maternal and Child Health Bureau. It can be used in a variety of ways to serve pregnant women, women of childbearing age, infants and children, and children with special health care needs. The only mandate is to spend 30% on children with special health care needs. The grant award for next fiscal year is approximately $16,750,000. This represents an increase of $254,085 over last year. The increase will be used to enhance led poisoning prevention, services in the community, promote asthma control activities and fund some fetal and infant mortality reviews which deals with reviewing the records of deceased babies.

Ms. Morrell was recognized to review the Mental Health Block Grant. It is federal funding that North Carolina and other states have received for many years. There was a small increase of $260,000 this year. She stated that the primary proposed use is to increase services in area programs for adults with serious mental illness and children with serious emotional disturbance. In addition to community based service under the terms of this grant and the findings of efficient uses of it, a small portion is used for training and technical assistance to ensure quality services. She stated that there is no change in program direction from previous years.

After brief committee discussion, the meeting was adjourned at 3:40 p.m.

Senator William n. Martin, Chair

Joyce C. Hodge, Committee Assistant

AGENDA

Joint Subcommittee on Health and Human Services Appropriations

Legislative Office Building - Room 424
Tuesday, April 20, 1999
8:30 a.m.

Opening Remarks	Sen. Bill Martin, Co-Chair Rep. Beverly Earle, Co-Chair Rep. Edd Nye, Co-Chair
Division of Social Services & Children's Services Overview	Karen Hammonds-Blanks Fiscal Research Division
Governor's Longterm Care Proposal	DHHS
Block Grants:	
Preventive Health Services	Leah Devlin, DHHS
Mental Health Services	Bonnie Morell, DHHS Susan Robinson, DHHS
Maternal & Child Health	Ann Wolfe, DHHS

Adjourn

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM BLOCK GRANT (LIHEAP)

For State Fiscal Year 1999-2000, the total State Low Income Energy Program allocation is currently estimated to be $20,087,280 based on current projections that the FFY 2000 award will be this amount. The Lumbee Regional Development Association (LRDA) will receive $166,521 from this amount. **The total available for LIHEAP is $19,920,759.**

GENERAL DESCRIPTION

The purpose of the Low Income Home Energy Assistance Program Block Grant is to provide funds to help low-income families cope with cost increases of heating fuel and to provide emergency assistance. There are two components:

1. Low Income Home Energy Assistance Payments – Funds are used to provide a one-time payment to eligible households to help pay heating bills.

2. Crisis Intervention Assistance – Funds are used to assist low-income people when a heating or cooling related crisis occurs. Allocations are provided to county departments of social services to make direct payments, vendor payments, or to provide in-kind services for eligible households.

RECOMMENDATIONS

		PERCENT	*DOLLARS*
1.	Allocation for Low Income Energy Assistance payments	37.8	7,530,047
2.	Allocation for the Crisis Intervention Program	37.0*	7,370,681*
3.	Allocation to the Department of Commerce for Weatherization Program	15.0	2,988,114
4.	Allocation for application-taking by the Commission On Indian Affairs	00.20	39,841
5.	Allocation for administrative cost of the Low Income Energy Assistance Payments Program and the Crisis Intervention Program	10.00	1,992,076
		TOTAL LIHEAP BLOCK GRANT	**$19,920,759**
			$19,920,759

*The component is budgeted at $7,370,681. Of this amount, $5,976,228 (30%) is expected to be allocated to counties. The remaining $1,394,453 (7%) is expected to be transferred to the Department of Commerce for the Heating Assistance Repair and Replacement Program (HARRP).

DIVISION OF SOCIAL SERVICES
ANALYSIS IF LIHEAP BLOCK GRANT
SFY 1999-2000

Item Number	Title	Actual SFY 97/98	Appropriated SFY 98/99 (SB 1366)	Recommended Amount SFY 99/00	Appropriated/ Recommended Difference	Explanation of Difference
1	Low Income Energy Assistance Payments	9,454,924	6,350,240	7,530,047	1,179,807	The number of people have been increasing and, therefore, the payment has been decreasing. In order to compensate, the allocation was increased.
2	Crisis Intervention Program	7,025,497	6,461,000	7,370,681	909,681	See statement below.
3	Allocation to Department of Commerce for Weatherization Program	5,008,802	4,171,960	2,988,114	(1,183,846)	See statement below.
4	Allocation for Application Taking by the Commission on Indian Affairs	26,778	33,228	39,841	6,613	Increasing because of allocation increase. Percentage of total allocation remains constant.
5	Allocation for administrative cost of the Low Income Energy Assistance Program and the Crisis Intervention Program	2,861,009	1,443,572	1,992,076	548,504	There has been an increase in the number of walk-ins applying for Low Income Energy Assistance Payments which increases administrative costs.
	Total	24,377,010	18,460,000	19,920,759	1,460,759	

Component 2 is budgeted at $7,370,681. Of this amount, $5,976,228 (30%) is expected to be allocated to counties. The remaining $1,394,453 (7%) is expected to be transferred to the Department of Commerce for the Heating Assistance Repair and Replacement Program (HAARP).

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

Substance Abuse Prevention & Treatment Block Grant (SAPTBG) SFY 1999-2000

FUNDING LEVEL

Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funding available to North Carolina is $33,404,937 for FFY99 and an estimated amount of $29,096,347 for FFY 2000. The proposed plan utilizes the remaining FFY 99 amount of $12,850,753 plus $25,689157 from the FFY 2000 award.

GENERAL DESCRIPTION

The ADAMHA Reorganization Act of 1992 (P.L. 102-321) split the Alcohol, Drug, and Mental Health Services Block Grant (ADMBG) creating the Block Grant for Substance Abuse Prevention & Treatment. The SAPTBG provides federal financial assistance to state for the provision of prevention and treatment of alcohol and drug abuse.

SIGNIFICANT FEDERAL REQUIREMENTS

Federal requirements begun in 1993 continue into 1999-2000:

1. State agrees to utilize not less than 35% of the grant for alcohol and drug respectively.

2. Not less than 20% of the funds are to be set aside for prevention programs for individuals who do not require treatment for substance abuse to reduce the risk for such abuse. Prevention programs will include strategies to discourage the use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such products, The Synar Amendment requires that each state adopt and enforce laws prohibiting sale or distribution of tobacco products to those younger than 18 years of age. Effective October 1, 1994, if the Secretary of HHS determines that a state has failed to comply with the law, the State will lose significant federal funding from the SAPTBG. (Failure to comply with the Synar Amendment could result in a 40% non-compliance penalty amounting to $13,362,000 for FFY 99.) Final rules were published on January 19, 1996 (45 CFR Part 96).

3. The state will spend not less than 10% of grant monies to increase the availability of treatment services for pregnant women and women with dependent children with the provision that prenatal and child care be provided to those women while they are in treatment.

4. Interim services must be provided to those individuals in need of treatment for intravenous substance abuse if they cannot be admitted to treatment within 14 days.

5. The state will require treatment entities receiving funds under the grant to make available tuberculosis services to each individual receiving treatment.

6. States such as North Carolina where the rate of AIDs is 10 or more per 100,000 must spend at least 5% of the total award to provide early intervention services for person with or at risk for HIV/AIDs.

PROPOSED EXPENDITURE PLAN	ALLOCATION
1. Adult Substance Abuse Continuation of community and ADATC based alcohol and drug services including prevention, intervention, treatment, rehabilitation, and detoxification. Funding to support intervention and treatment services for offenders who remain in the community. Funds will be used to provide treatment services for offenders with substance abuse problems in community punishment programs. Continue support for group homes for recovering substance abusers. Tuberculosis services will be provided to all program participants. Special services for the deaf will be provided at the ADATC in Greenville, NC, with outpatient services for the deaf established in each region. Programs will be required to screen clients for TB and other infectious diseases.	$15,350,132
2. Child Substance Abuse Continue services to children and adolescent including prevention, high risk intervention and regional residential services. Services will include treatment for children in detention and training schools. Prevention activities will include strategies to discourage use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such products. Services will be delivered in accordance with the 1993 Mental Health Study Commission Child and Adolescent Alcohol and Other Drug Abuse Plan. Legislative action increased service to young offenders and established a	$7,754,702

network of services for youth in the juvenile justice system.

3.	**Women's Substance Abuse** Continuation of services for pregnant women and women with dependent children. Specialized services will be provided at the ADATCs for women. Continue to develop specialized services for TANF participants whose substance abuse is a barrier to self-sufficiency.	6,567,532
4.	**Intravenous (IV) Drug** Continuation of services to IV drug abusers and others at risk for HIV disease. Special services for IV drug users will be provided at the ADATCs.	5,390,497
5.	**Substance Abuse Focus on Families** Prevention and treatment services will be provided for children who are impacted by parental addiction.	893,811
6.	**Administration** Applicable to 5%Administrative Cap (Planning, Quality Assurance, Development of new treatment and prevention services and training for providers receiving Block Grant funds.)	1,670,246
	Not applicable to 5% Administrative Cap (Statutory requirement to identify those populations, areas, and localities with a need for substance abuse services). Continue the development of a performance management system based on outcomes, support the design of an improved behavioral health system and monitor prescription drug diversion.	952,803
TOTAL REQUIREMENTS		**$38,539,910**
Source of Funds		
SAPTBG FFY 99		12,850,753
SAPTBG FFY 2000		25,689,157
TOTAL FUNDS		**$38,539,910**

DIVISION OF Mental Health/Developmental Disabilities/Substance Abuse Services

th Block Gr TANCE ABUSE PREVENTION AND TREATMENT BG

SFY 1999-2000

Item Number	Title	Actual SFY 97-98	Appropriated SFY 98-99 (SB 1366)	Recommended Amount SFY 99-00	Appropriated/ Recommended Difference	Explanation of Difference
1	Adult Substance Abuse	$ 11,502,939	$ 11,502,939	$ 15,350,132	$ 3,847,193	Funds will ve used to complete the statewide network of offender management and treatment services for those sentenced to Intermediate punishments and to provide transition services for offenders leaving DART and Impact programs This program will operate cooperatively with the the Div.of Community Corrections as the result of a year long strategic planning process.
2	Child Substance Abuse	$ 6,477,706	$ 6,477,706	$ 7,754,702	$ 1,276,996	Expand treatment services for children in the juvenile justice system, expand residential services
3	Women's Substance Abuse	$ 5,065,766	$ 5,065,766	$ 6,567,532	$ 1,501,766	Expand residential services for women and their children and replace TANF funds in work demonstration programs for TANF participants
4	Intravenous (IV) Drug	$ 4,843,456	$ 4,843,456	$ 5,390,497	$ 507,228	Requirement to spend not less than 5% of the award for outreach and treatment for those at risk for HIV disease.
5	SSI	$ 1,123,757	$ 1,123,757	$ -	$ (1,123,757)	No longer required
6	Substance Abuse Focus on Families	$ 893,811	$ 893,811	$ 893,811	$ -	
6	Administration	$ 1,454,812	$ 1,454,812	$ 1,670,246	$ 215,434	5% of BG to be spent for administrative infrastructure.
		$ 502,803	$ 502,803	$ 952,803	$ 450,000	Performance requirements of BG depend on the ability to continue to collect outcome data.
	TOTAL	$ 31,865,050	$ 31,865,050	$ 38,539,910	$ 6,674,860	Funds will be used to support planning for the SIG, design,and prescription monitoring

s:\bna\blkgr99\blgtcht.xls

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ECONOMIC OPPORTUNITY
COMMUNITY SERVICES BLOCK GRANT PLAN FOR SFY 1999-2000

GENERAL DESCRIPTION

For State Fiscal Year 1999-2000, funds available through the Community Services Block Grant Program (CSBG) for appropriation are projected to be $13,030,672. CSBG funds are projected to be available October 1, 1999.

Since 1981, the Community Services Block Grant Program has made federal funds available to states to provide a range of services designed to assist low-income persons attain the skills, knowledge, and motivation necessary to achieve self-sufficiency.

The primary providers of services under this grant, as required by federal law, are the thirty-six Community Action Agencies (CAAs) in the state. Other grantees are seven Limited Purpose Agencies (LPAs) who were recipients of similar funds prior to the inception of the Community Services Block Grant Program. CAAs operate programs under the Community Services Block Grant in coordination with other federal, state, and local programs such as Head Start, Job Training Partnership Act (JTPA), Weatherization, and Section 8 Rental Assistance.

In August 1995, the federal Community Services Block Grant Monitoring and Assessment Task Force produced a National Strategic Plan which endorsed a results-oriented management approach for the Community Service Network. The plan includes a set of six broadly stated umbrella national goals, with suggested measures to assess progress towards the goals. States and local agencies are required to address these goals and measures in their program planning and reporting.

The six national goals of the Community Services Network are:

Goal 1. Low-income people become more self-sufficient.

Goal 2. The conditions in which low-income people live are improved.

Goal 3. Low-income people own a stake in their community.

Goal 4. Partnerships among supporters and providers of services to low-Income people are achieved.

Goal 5. Agencies increase their capacity to achieve results.

Goal 6. Low-income people, especially vulnerable populations, achieve their potential by strengthening family and other support systems.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ECONOMIC OPPORTUNITY
COMMUNITY SERVICES BLOCK GRANT PLAN FOR SFY 1999-2000

Community Services Block Grant funds are used to provide a wide variety of services in local communities to serve identified needs of poor families. Programs allowed under the Community Services Block Grant Act are those which provide activities designed to assist low-income participants including the elderly poor:

- to secure and retain meaningful employment;
- to attain an adequate education;
- to make better use of available income;
- to obtain and maintain adequate housing and a suitable living environment;
- to obtain emergency assistance through loans or grants to meet immediate and urgent individual and family needs, including the need for health services, nutritious food, housing, and employment-related assistance;
- to remove obstacles and solve problems which block the achievement of self sufficiency;
- to achieve greater participation in the affairs of the community; and
- to make more effective use of other programs related to promoting the well being of the low-income population.

The specific services operated in each local community are determined by the local agency as a result of an assessment of the needs of low-income individuals and families in their service area which is used to develop a multi-year plan for services.

As required by the Community Services Block Grant Act, ninety per cent of the funds received are distributed to the thirty-six Community Action Agencies (CAAs) located throughout the state. Five percent, which is the maximum allowed by federal law, is used by the Department to administer the Program. The remainder is used to fund seven non-profit organizations known as Limited Purpose Agencies (LPAs).

Over twenty-five thousand low-income individuals are served annually by the North Carolina Community Services Block Grant Program.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ECONOMIC OPPORTUNITY
COMMUNITY SERVICES BLOCK GRANT PLAN FOR SFY 1999-2000

RECOMMENDATIONS	ALLOCATION
1. Allocate $651,534 to the Department of Health and Human Services to administer the grant. Staff renders technical assistance and monitors the Community Action Agencies and Limited Purpose Agencies for compliance with federal laws and regulations.	$651,534
2. Allocate $11,727,604 to the 36 Community Action Agencies (CAAs) which serve 90 counties for the purpose of providing administrative costs and to assist low-income families with housing, emergency assistance, education, energy, nutrition, income management, information and referral, and outreach. Federal rules require that 90% of the grant be allocated to CAAs.	$11,727,604
3. Allocate the remaining 5% of the grant in the amount of $651,534 to Limited Purpose Agencies which are agencies that address a specific need or population. The allocation and agency is as follows: - Telamon which provides assistance to seasonal and migrant farm workers ($81,442) - Low Income Housing Development Corporation (LIHDC) which assists non-profit agencies in packaging loans for housing construction and rehabilitation ($99,685) - N.C. Rural Fund for Development (NCRFD) which provides technical assistance to credit unions and cooperatives which serve low-income individuals and families ($237,158)	$651,534

- N.C. Senior Citizens' Federation which sponsors statewide activities for low-income senior citizens ($118,579)
- Western Economic Development Organization (WEDO) which assists organizations serving low-income and handicapped individuals secure manufacturing contracts ($62,547)
- United Senior Services which provides activity programs for senior citizens in Craven County ($24,758)
- N.C. Commission of Indian Affairs which provides programs for low-income Native Americans in the state in coordination with local tribal organizations ($27,365)

TOTAL FUNDING SFY 1999-00	$13,030,671
SOURCE OF FUNDS:	
BLOCK GRANT FUND FFY 1999	$3,257,668
BLOCK GRANT FUND FFY 2000	$9,773,003

OFFICE OF ECONOMIC OPPORTUNITY
Analysis of Community Services Block Grant
SFY 1999-2000

Item Number	Title	Actual SFY 97-98	Appropriated SFY 98-99 (SB 1366)	Recommended Amount SFY 99-00	Appropriated/ Recommended Difference	Explanation of Difference
1	Admin	$384,507	$642,964	$651,534	$8,570	Administration is limited to 5% of the grant award and varies based on the award amount.
2	CAAs	$11,408,741	$11,573,346	$11,727,604	$154,258	Funds awarded to CAAs must be 90% of the total allocation and is based on award amount.
3	LPAs	$635,618	$642,964	$651,534	$8,570	Funds awarded to LPAs is 5% of the grant. award and varies based on the award amount.
TOTAL		$12,428,866	$12,859,274	$13,030,672	$171,398	Difference represents the expected increase in federal grant award for this period.

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities
And Substance Abuse Services
(MHBG SFY 2000)

FUNDING LEVEL

Federal funding available to North Carolina is $6,498,831 for FFY 99 and an estimated amount of $6,498,831 for FFY 00. The proposed MHBG plan utilizes the remaining FFY 99 amount of $2,809,490 plus $3,689,341 from the anticipated FFY 00 award.

GENERAL DESCRIPTION

The MHBG provides federal financial assistance to states for the provision of community-based services for people with mental illness. Services provided through the use of the block grant must be those described in the State's Plan in accordance with Federal P.L. 102-321. These services include outpatient, day treatment, psychosocial rehabilitation, emergency services, residential services, etc. for adults and children. The funds may also be used for evaluating programs and services carried out under the plan and planning, administration, and educational activities related to providing services under the State Plan.

SIGNIFICANT FEDERAL REQUIREMENTS

The primary Federal requirements related to the MHBG are that funds must be used for services specified within the States' Plan for Comprehensive Community Mental Health Services in accordance with P.L. 102-321; for evaluating programs and services carried out under the plan; and planning, administration, and educational activities related to providing services under the plan.

The State must expend an amount equal to the amount expended by the State for fiscal year, 1994 for a system of services for children.

	PROPOSED MHBG PLAN for SFY 00	ALLOCATION
I.	**Adult Mental Health Plan**	
	Allocate funds to local programs to provide community-based services for adults with severe and persistent mental illness in accordance with the NC Community Mental Health Services Plan and Block Grant Application. Community-based programs provide an array of services, including crisis stabilization designed to divert individuals from institutional admission; liaison and case management services which facilitate the discharge of individuals from the state's psychiatric hospitals; special programs for the hearing impaired; and training activities.	$3,895,179
II	**Child Mental Health Plan**	
	Continuation of Child Mental Health services in accordance with the NC Community Mental Health Services Plan and Block Grant Application such as programs for adolescent sex offenders, respite services, family preservation programs, group homes, specialized foster care, therapeutic homes, professional parenting programs, training, and special initiatives to develop systems of care for serving children with serious emotional disturbance and their families.	$1,913,917
III	**Administration**	
	Applicable to the 5% Administrative Cap (Monitoring, Data Collection, Budgeting, Payments, and Accounting	$324,941
	Not Applicable to the 5 % Administrative Cap (Contracts for non-administrative activities and technical assistance to service providers	$364,794
	TOTAL REQUIREMENTS	$6,498,831
	Source of Funds	
	MHBG FFY 99	$2,809,490
	MHBG FFY 00	$3,689,341
	TOTAL FUNDS	$6,498,831

DIVISION OF Mental Health/Developmental Disabilites/Substance Abuse Services
Analysis of Mental Health Block Grant (Title of Block Grant)
SFY 1999-2000

Item Number	Title	Actual SFY 97-98	Appropriated SFY 98-99 (SB 1366)	Recommended Amount SFY 99-00	Appropriated/ Recommended Difference	Explanation of Difference
1	Adult Mental Health	$ 3,818,909	$ 3,794,179	$ 3,895,179	$ 101,000	Increase in MHBG budgeted for use in 99-00
2	Child Mental Health	$ 1,793,982	$ 1,819,931	$ 1,913,917	$ 93,986	Increase in MHBG budgeted for use in 99-00
3	Administration	$ 577,907	$ 624,231	$ 689,736	$ 65,505	Increase in MHBG budgeted for use in 99-00
	TOTAL	$ 6,190,798	$ 6,238,341	$ 6,498,832	$ 260,491	Increase in MHBG budgeted for use in 99-00

s:\bna\blkgrt99\blgtcht.xls

Safety in Long Term Care

North Carolina
Department of Health and Human Services

April 20, 1999

Safety in Long Term Care

- Improve Quality of Care
- Protect Residents
- Improve Regulatory Oversight

Improve Quality of Care

- Require training/staff for medication in adult care homes
- Require training for staff in behavioral interventions
- Adopt special care unit rules for long term care facilities with specialized units for substantial behavioral management problems
- Require certification for supervisors and administrators of adult care homes
- Improve nurse aide/personal care aid availability/retention
- Increase staff time in adult care homes

Protect Residents

- Give due process and appeals rights for transfer and discharge to residents in adult care homes
- Develop complete initial assessment and case management to improve resident security and treatment in adult care homes
- Modify adult care home payment system to accomplish desired results
- Require standard response time for complaints

Improve Regulatory Oversight

- Develop finance system to expand local monitoring
- Improve monitoring accountability/authorize State takeover
- Require local annual plan for adult care home policy
- Revise temporary management law
- Provide criminal/civil penalties for bad actors
- Limit use of provisional licenses
- Move to outcome, not process, measurement
- Give Secretary rule-making authority

ESTIMATED COSTS TO IMPROVE QUALITY OF CARE

North Carolina Department of Health and Human Services

Recommendation		Estimated Costs Jan - June 2000		July 2000 - June 2001
CONTINUATION BUDGET				
Reallocate State/County Special Assistance (S/C SA) in the Continuation Budget to match federal Medicaid funds for the provision of additional services for "Assistance with Medication" and "Assistance with Locomotion."	Federal:	5,947,148	Federal:	11,894,296
	State:	1,709,957	State:	3,419,914
	County:	1,709,957	County:	3,419,914
	Other:	0	Other:	0
	Total:	9,367,062	Total:	18,734,124
EXPANSION BUDGET				
Require training for adult care home staff in behavioral interventions	Federal:	0	Federal:	0
	State:	96,992	State:	193,984
	County:	0	County:	0
	Other:	0	Other:	0
	Total:	96,992	Total:	193,984
TOTAL QUALITY IMPROVEMENTS	**Federal:**	**5,947,148**	**Federal:**	**11,894,296**
	State:	**1,806,949**	**State:**	**3,613,898**
	County:	**1,709,957**	**County:**	**3,419,914**
	Other:	**0**	**Other:**	**0**
	Total:	**9,464,054**	**Total:**	**18,928,108**

NOTE: Other quality initiatives are cost-neutral.

ESTIMATED COSTS TO PROTECT RESIDENTS

North Carolina Department of Health and Human Services

Recommendation		Estimated Costs Jan - June 2000		July 2000 - June 2001
EXPANSION BUDGET				
Develop initial screening by county departments of social services and make referral to area mental health for further assessment and case management.	Federal:	1,860,732	Federal:	3,706,666
	State:	934,066	State:	1,881,154
	County:	164,852	County:	331,480
	Other:	0	Other:	0
	Total:	2,959,650	Total:	5,919,300
Require standard response time for adult care home and nursing home home complaints by adding 25 FTEs in Division of Facility Services	Federal:	376,875	Federal:	753,750
	State:	185,625	State:	371,250
	County:	0	County:	0
	Total:	562,500	Total:	1,125,000
TOTAL PROTECTING RESIDENTS	**Federal:**	**2,237,607**	**Federal:**	**4,460,416**
	State:	**1,119,691**	**State:**	**2,252,404**
	County:	**164,852**	**County:**	**331,480**
	Other:	**0**	**Other:**	**0**
	Total:	**3,522,150**	**Total:**	**7,044,300**

Note: Other protection initiatives are cost-neutral.

ESTIMATED COSTS TO IMPROVE REGULATORY OVERSIGHT

North Carolina Department of Health and Human Services

Recommendation		Estimated Costs Jan - June 2000		July 2000 - June 2001
CONTINUATION BUDGET				
Reallocate State/County Special Assistance (S/C SA) in the Continuation Budget to expand local monitoring of adult care homes by funding 59 FTE's in county departments of social services. Funding will also provide training to staff on new standards and permit after-hours monitoring.	Federal:	0	Federal:	0
	State:	0	State:	2,050,000
	County:	0	County:	2,050,000
	Total:	0	Total:	4,100,000
EXPANSION BUDGET				
Develop finance system to improve local monitoring by adding 17 positions for construction plan review and inspections	Federal:	0	Federal:	0
	State:	0	State:	0
	County:	0	County:	0
	Other:	650,000	Other:	1,300,000
	Total:	650,000	Total:	1,300,000
Fund 30 FTEs in the Division of Facility Services to monitor mental health/developmental disability group homes effective July 1, 1999.	Federal:	0	Federal:	0
	State:	1,562,617	State:	1,463,617
	County:	0	County:	0
	Total:	1,562,617	Total:	1,463,617
TOTAL REGULATORY IMPROVEMENTS	**Federal:**	**0**	**Federal:**	**0**
	State:	**1,562,617**	**State:**	**3,513,617**
	County:	**0**	**County:**	**2,050,000**
	Other:	**650,000**	**Other:**	**1,300,000**
	Total:	**2,212,617**	**Total:**	**6,863,617**

Note: Other regulatory initiatives are cost-neutral.

ESTIMATED COSTS FOR ADULT CARE HOME CARE

North Carolina Department of Health and Human Services

Total Funding By Service	Actual SFY 97-98	Governor's Recommended Budget: Authorized Budget SFY 98-99	SFY 99-00	SFY 00-01
ACH Personal Care Services	$62,484,371	$71,834,749	$86,977,211	$100,691,588
S/C Special Assistance	98,563,306	113,060,070	122,934,744	134,438,027
Staffing Grants	0	2,000,000	4,000,000	1,000,000
Transportation- ACH	3,459,307	3,715,841	4,248,958	4,515,872
Total	**$164,506,984**	**$190,610,660**	**$218,160,913**	**$240,645,487**
% Change			**14.5%**	**10.3%**

Total Funding By Source		Actual SFY 97-98	Governor's Recommended Budget: Authorized Budget SFY 98-99	SFY 99-00	SFY 00-01
Medicaid	Federal	41,735,754	48,911,157	59,878,215	66,507,111
	State	20,574,428	24,343,130	20,787,873	24,257,784
	County	3,633,497	4,296,303	14,560,081	15,442,565
	Total	**$65,943,678**	**$77,550,590**	**$95,226,169**	**$106,207,460**
S/C Special Assistance	Federal	0	0	0	0
	State	49,281,653	56,530,035	61,467,372	67,219,014
	County	49,281,653	56,530,035	61,467,372	67,219,014
	Total	**$98,563,306**	**$113,060,070**	**$122,934,744**	**$134,438,027**

Note: This summary is based upon the Governor's Continuation and Expansion Budget.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF SOCIAL SERVICES

FISCAL RESEARCH DIVISION

APRIL 20, 1999

DIVISION OF SOCIAL SERVICES

MISSION

§ G.S. 153A-255. Authority to provide social services.

Each County Shall Provide Social Service Programs...intended to Further the Health, Welfare, Education, Employment, Safety, Comfort, and Convenience of its Citizens.

Assist and Provide Opportunities for Individuals and Families in Need of Basic Support, Protection, and Services to Become Self-Supporting and Self-Reliant.

The Division of Social Services Oversees and Supervises Public Assistance and Social Services Programs Which are Administered Primarily by Local Social Services Agencies but Also May be Delivered by Nonprofit Agencies and Related Organizations.

DIVISION OF SOCIAL SERVICES

STATE SUPERVISED - COUNTY ADMINISTERED SYSTEM

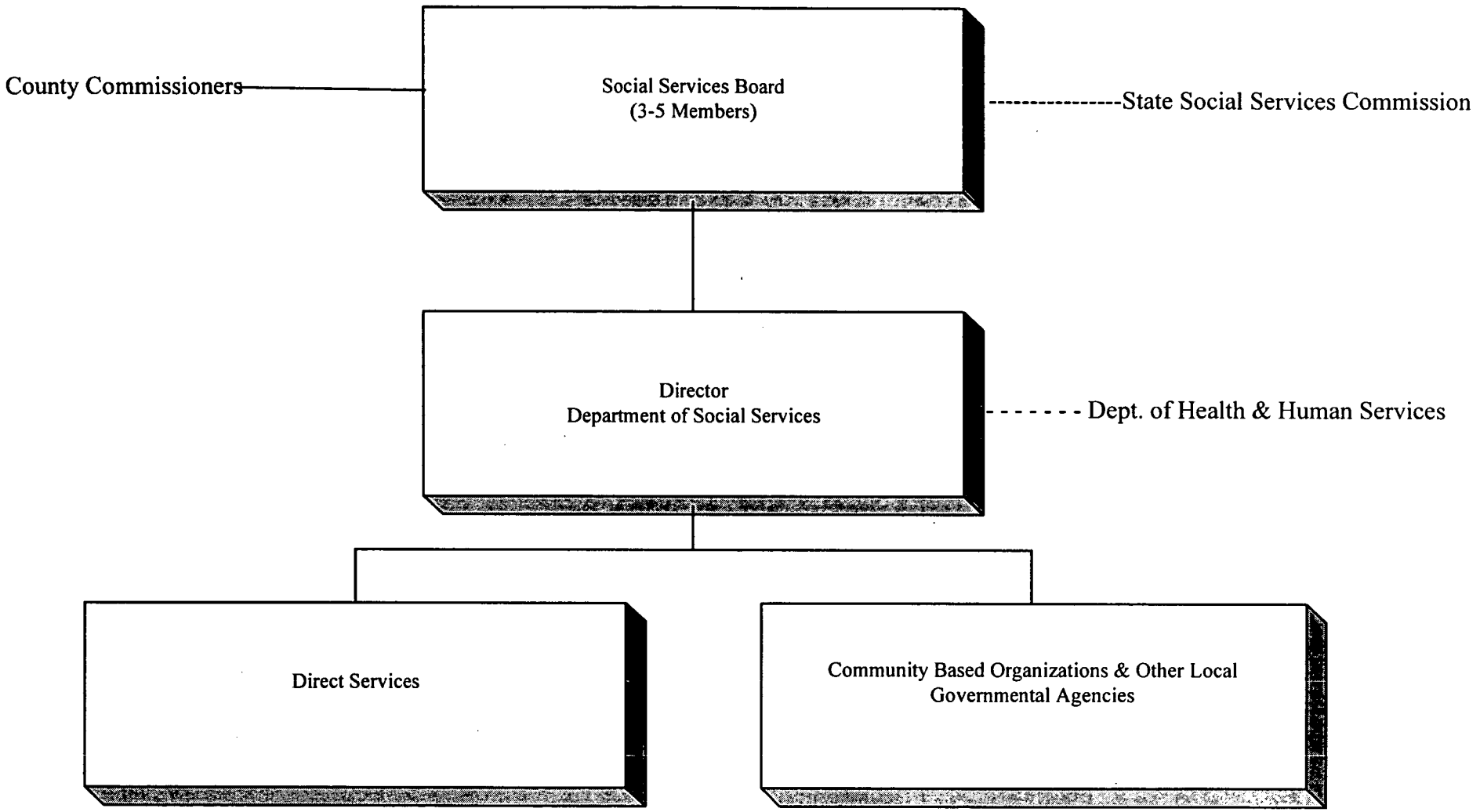
North Carolina has One of 11 State Supervised Social Services Systems

- Legislature Makes the Laws & Appropriates Funding
- State Sets Policy & Regulations
- Counties Set Priorities, Appropriate Funds & Deliver Services

System Funding is a Partnership of State, Local and Federal Governments

- Mandatory Services
- No Mandated Levels of Services
- Variations in Service Levels Across the State

NORTH CAROLINA'S LOCAL SOCIAL SERVICES SYSTEM



DIVISION OF SOCIAL SERVICES

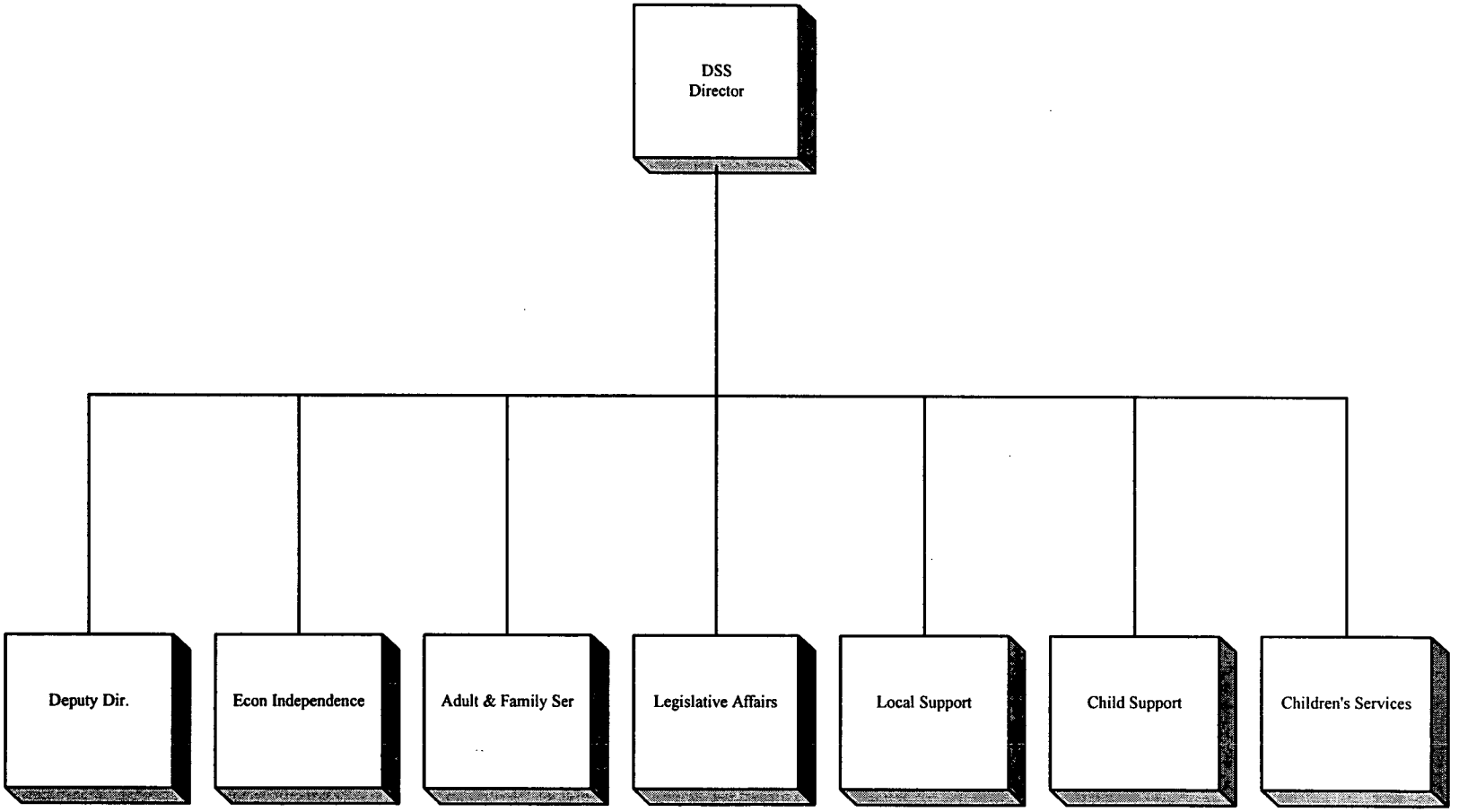
OVERSIGHT AND REGULATORY COMMISSIONS

- Social Services Commission
  -G.S. 143B-153
  -Members Appointed by the Governor
  -Members Serve 4-Year Terms
  -Adopt/Amend/Repeal Rules for State & Local Departments of Social Services

- Joint Legislative Public Assistance Commission
  -1997 Session Laws Section 12.18
  -20 members
  -Provide Oversight of Implementation of Welfare Reform

DEPARTMENT OF HEALTH AND HUMAN SERVICES

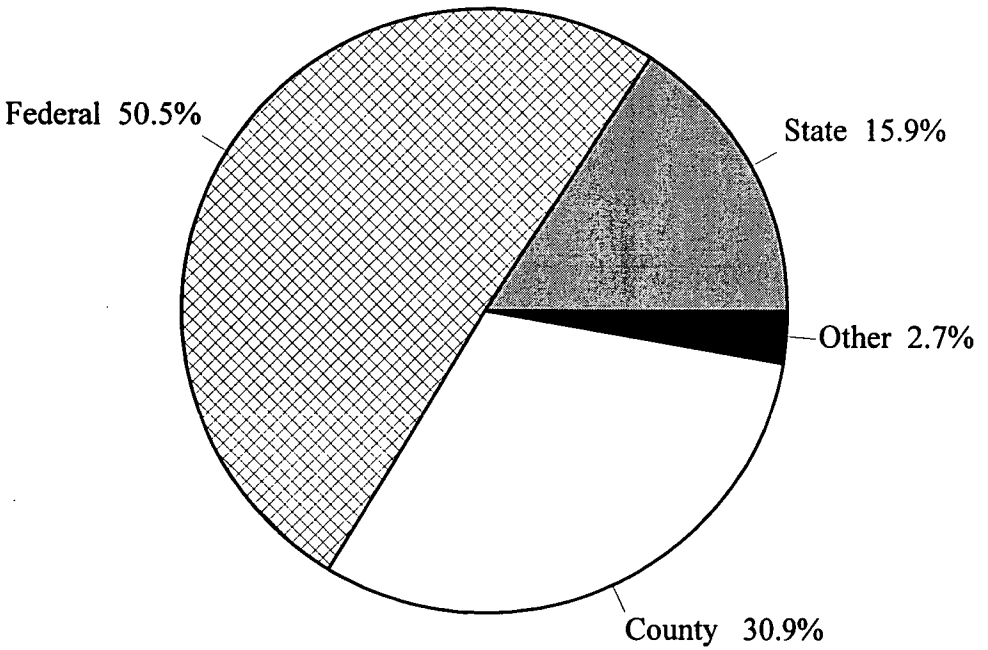
DIVISION OF SOCIAL SERVICES



DIVISION OF SOCIAL SERVICES

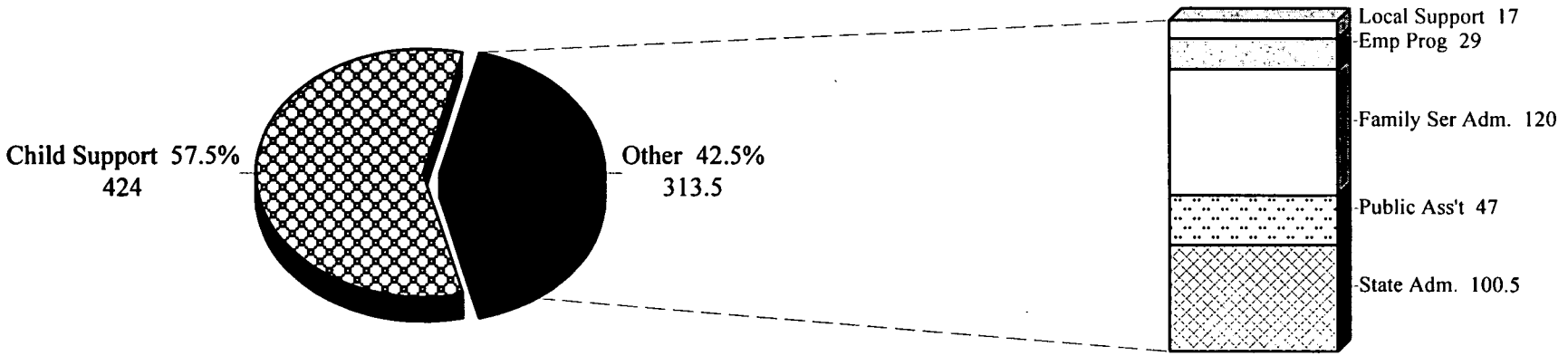
BUDGET SUMMARY:	FY97/98 Actual	FY98/99 Certified	FY98/99 Authorized	FY99/00 Rec'd.	FY00/01 Rec'd.
Requirements	$1,111,825,074	$1,198,813,691	$1,198,813,691	$1,236,668,775	$1,268,405,186
Revenues	943,787,316	1,040,524,333	1,040,524,333	1,066,272,379	1,087,361,535
Appropriations	168,037,758	158,289,358	158,289,358	170,396,396	181,043,651
TOTAL POSITIONS	736.5	737.5	737.5	737.5	737.5

FY97/98 Actual Expenditures: $1.1B
16% State Appropriations
37% Cash Payments
5% Administration



DIVISION OF SOCIAL SERVICES

POSITIONS BY FUNCTION
FY1998-99



DIVISION OF SOCIAL SERVICES

LEGISLATIVE HIGHLIGHTS

1997 Session:

- ✓ Child Welfare System Improvements $5.30M
  - -State Child Fatality Review Team
  - -Child Caring Institutions
  - -Additional Social Workers for Local DSS's
  - -Special Children's Adoption Fund

- ✓ Additional Funds for Food Banks 1.35M
- ✓ Adult Day Care Funds 2.80M
- ✓ Reformed NC's Welfare System

1998 Session:

- ✓ Intensive Family Preservation $400K
- ✓ Adoptive Parents Criminal Records Check 95K
- ✓ Additional Funds for Food Banks 1M

DIVISION OF SOCIAL SERVICES

PROGRAMS/SERVICES

- ✓ Adult and Family Services
- ✓ Child Support Enforcement
- ✓ ***Children's Services***
- ✓ ***Economic Independence***

DIVISION OF SOCIAL SERVICES

CHILDREN'S SERVICES

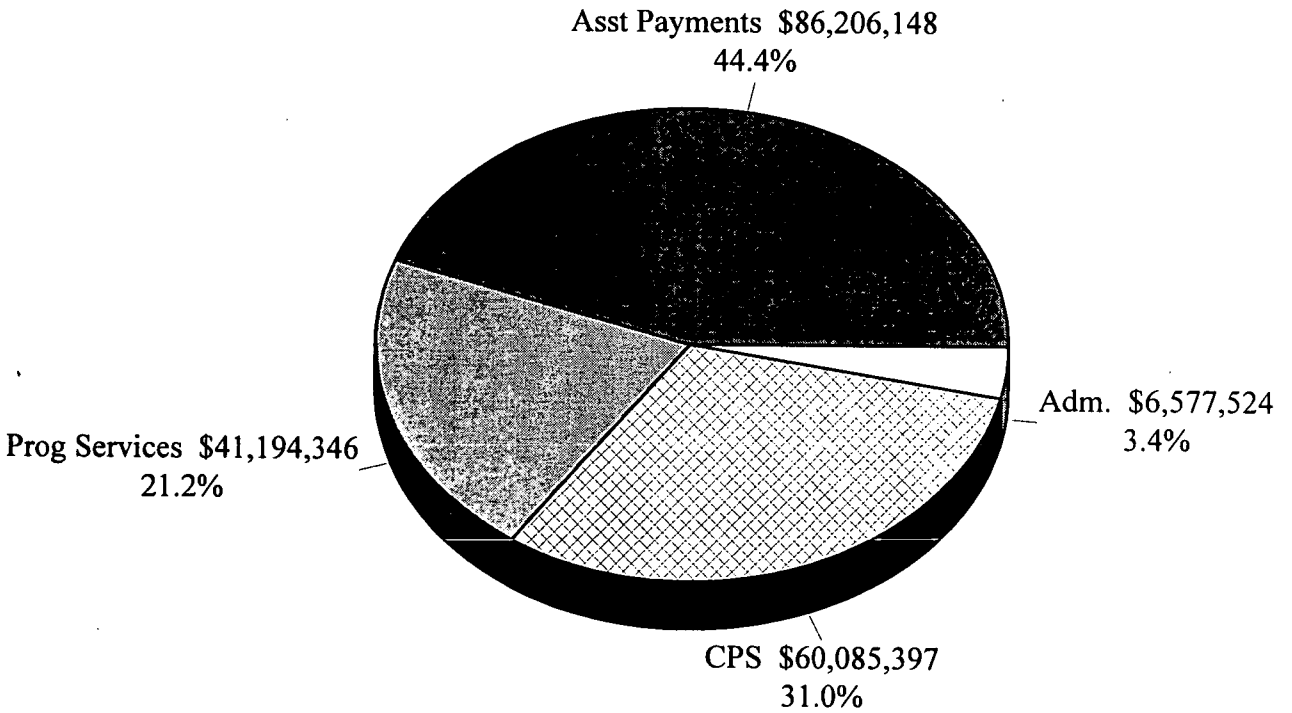
- *CHILD PROTECTIVE SERVICES*
- *FOSTER CARE*
- *ADOPTIONS*
- *OTHER INITIATIVES/SERVICES*

DIVISION OF SOCIAL SERVICES

CHILDREN'S SERVICES

Children Served During FY97/98: 144,245

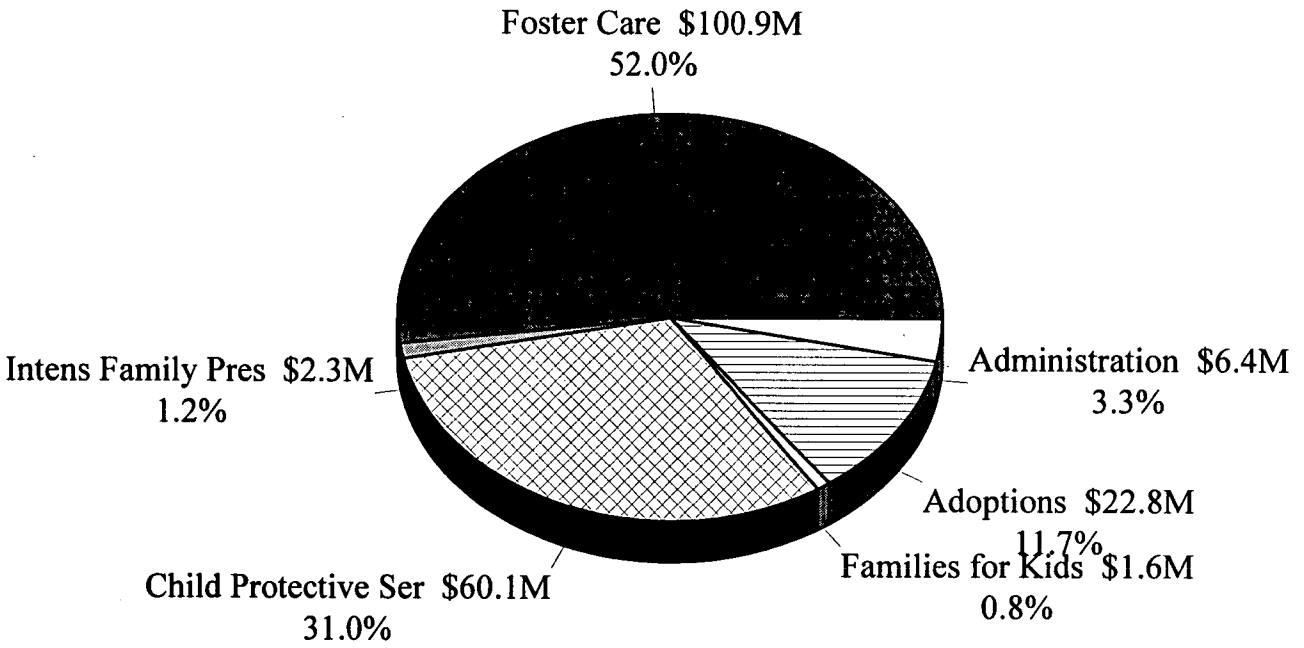
ESTIMATED SYSTEM FUNDING FY97/98: $194.1M
- $92.4M Federal Funds
- $38.7M State Funds
- $63.0M County Funds



DIVISION OF SOCIAL SERVICES

CHILDREN'S SERVICES FUNDING BY PROGRAM AREA FY97/98

ESTIMATED SYSTEM FUNDING: $194.1M



DIVISION OF SOCIAL SERVICES

CHILD PROTECTIVE SERVICES

- North Carolina Laws Mandate That Any Person or Institution Who Has Cause to Suspect That a Child is Abused, Neglected or Dependent Must Report to the Director of the Local Department of Social Services.
- Local Departments of Social Services are Mandated to Accept and Investigate Reports of Child Abuse, Neglect and Dependency.
- GS 7A-544 Requires Local Staff to Initiate an Investigation Immediately, But No Later Than 24 Hours When Physical or Sexual Abuse is Alleged and an Investigation Must Begin Within 72 Hours for Reports of Neglect or Dependency.
- ***Child Protective Services is the Portal of Entry Into the Child Welfare System of Services.***

DIVISION OF SOCIAL SERVICES

CHILD PROTECTIVE SERVICES

Strengthen the Ability of Families to Protect and Care for Their Children.

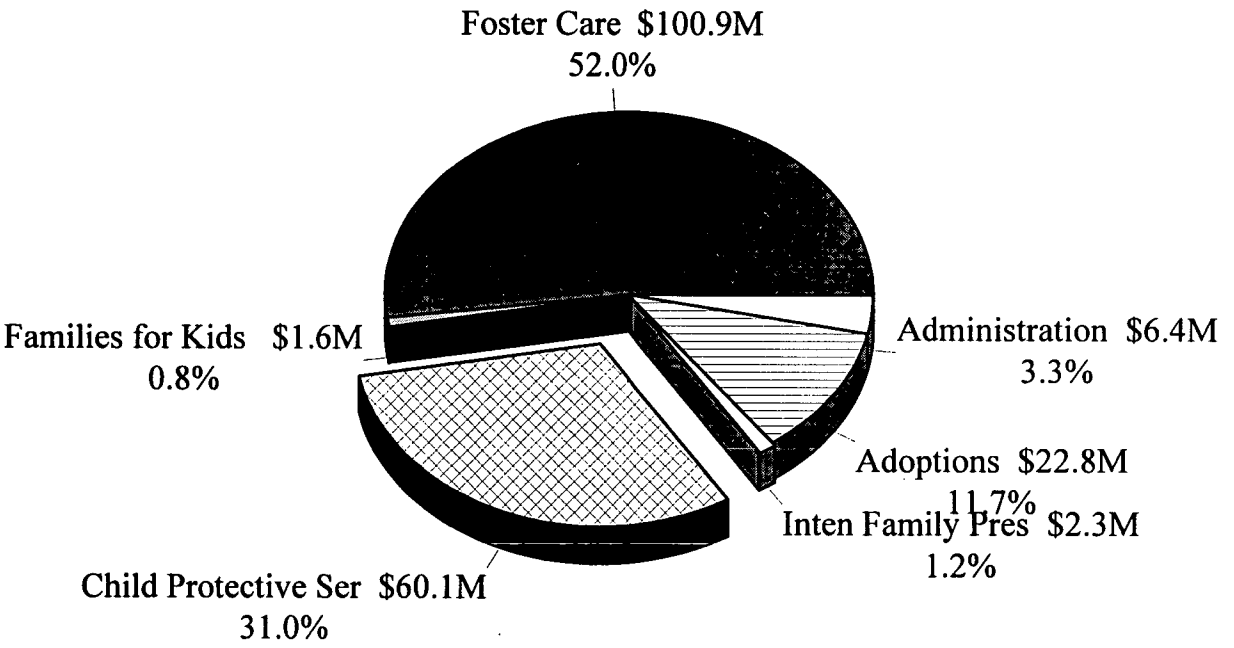
Child Protective Service System,

- ✓ Includes Investigation and Treatment Services
- ✓ Law Enforcement Investigative Services
- ✓ Judicial System Activities
- ✓ State Review Team Investigates Child Deaths and Works With the Local Community to Identify Weaknesses and Make Recommendations for Systemic Changes.

DIVISION OF SOCIAL SERVICES

CHILD PROTECTIVE SERVICES

Total Estimated System Funding FY97/98: $60.1M
- $23.1M Federal Funds
- $15.2M State Funds
- $21.8M County Funds



DIVISION OF SOCIAL SERVICES

CHILD PROTECTIVE SERVICES

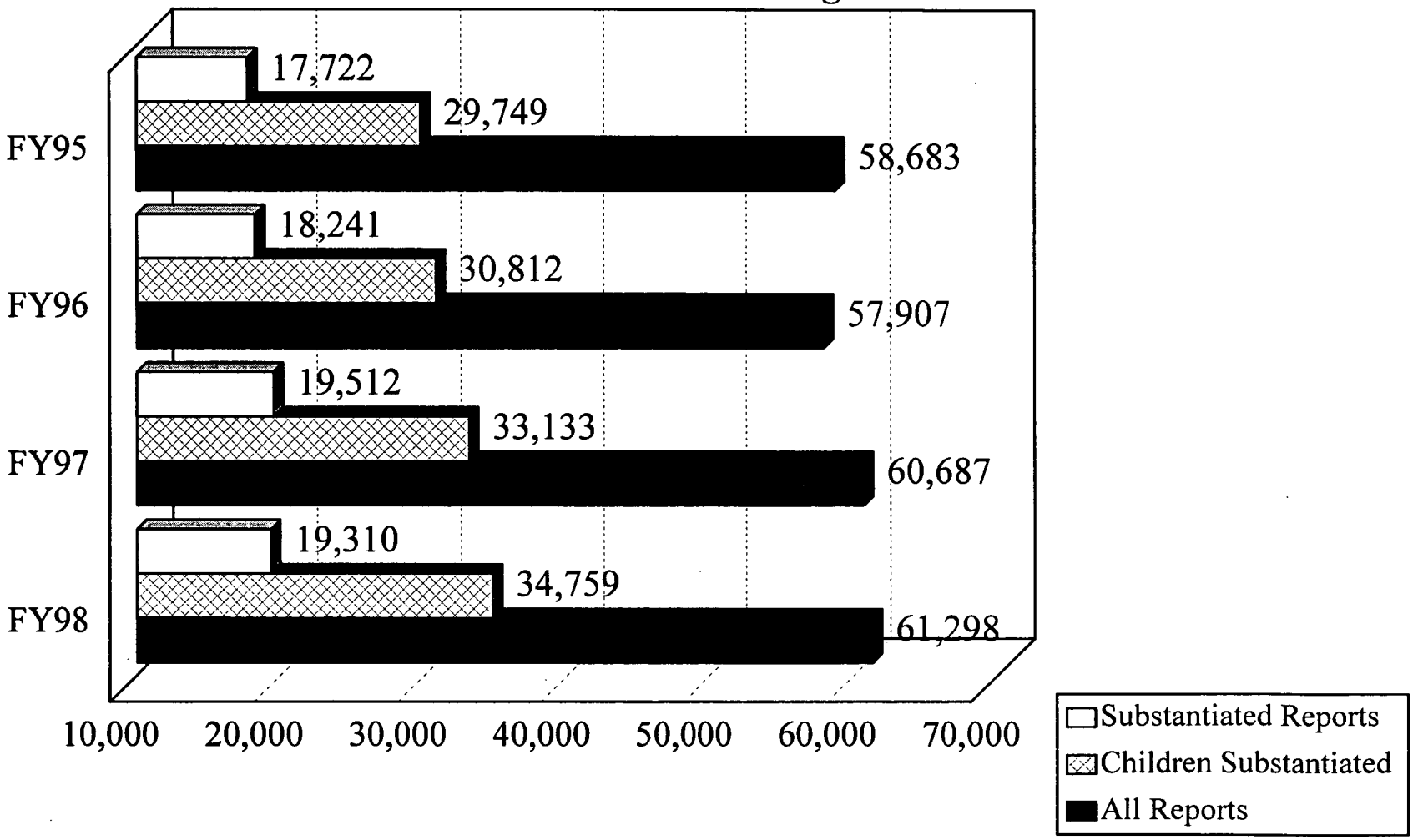
FY97/98 CPS Selected Facts:

- 19,310 Substantiated Cases of Abuse & Neglect
- 34,759 Children in Cases of Substantiated Abuse and Neglect
- 31,759 Neglect (90%)
  - 11,850 Injurious Environment (34%)
  - 10,669 Improper Care/Lack of Discipline (31%)
  - 7,615 Improper Supervision (22%)

- 3,073 Abuse (9%)
- 5,154 Children Entered Foster Care For the First Time During FY97/98
- 13,593 or 39% Were African American
- 1,815 or 5% Hispanic
- 49% Male
- 50% Were 0-6 Years

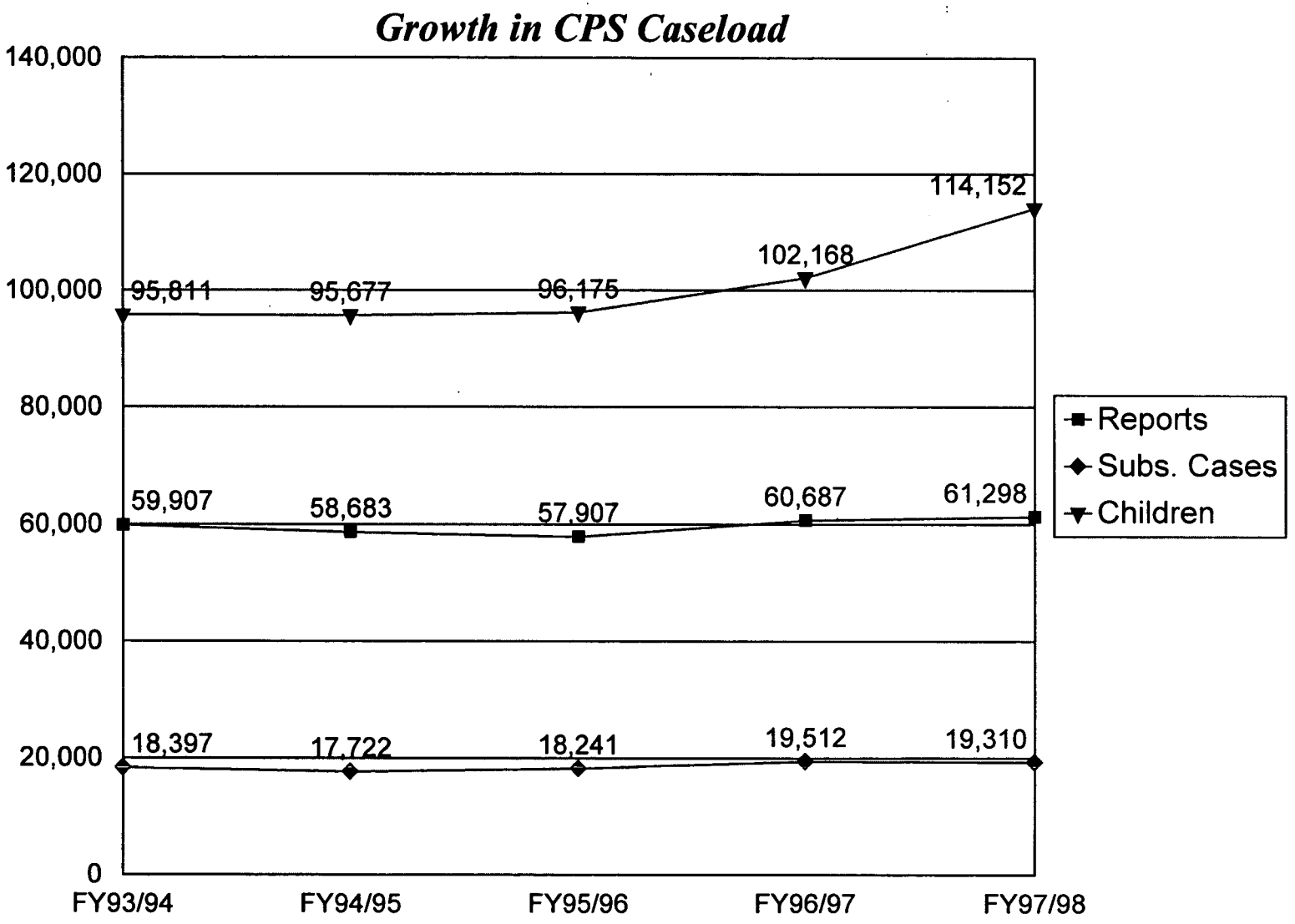
DIVISION OF SOCIAL SERVICES
CHILD PROTECTIVE SERVICES

Trends in Child Abuse and Neglect



DIVISION OF SOCIAL SERVICES

CHILD PROTECTIVE SERVICES



DIVISION OF SOCIAL SERVICES

INTENSIVE FAMILY PRESERVATION SERVICES

Designed to Help Families Alleviate Crises that Might Lead to Out-of-Home Placement of Children at Imminent Risk; Maintain the Safety of Children in Their Own Homes; and Assist Families in Obtaining Services and Other Supports Necessary to Address Their Multiple Needs in a Culturally Sensitive Manner.

Services Include,

- ✓ Family Assessment
- ✓ Intensive Individual & Family Counseling
- ✓ Client Advocacy
- ✓ Case Management
- ✓ Development and Enhancement of Parenting Skills
- ✓ Referral to Other Services

DIVISION OF SOCIAL SERVICES

INTENSIVE FAMILY PRESERVATION SERVICES

Intensive Family Preservation Services Program Began in 1991/92

- Currently 21 Programs Serving 39 Counties
- FY97/98 Funding: $2.3M
- During FY97/98 57% of All Referrals Came From DSS's (Area Mental Health Authorities and Juvenile Justice Operate IFPS Programs Also)
- Cases Lasted an Average of 39 days
- 91% of Families Were Referred to Other Services

DIVISION OF SOCIAL SERVICES

INTENSIVE FAMILY PRESERVATION SERVICES

Intensive Family Preservation Services Program (IFPS) is:

- ✓ A Set of Services Designed to Help Families Alleviate Crise
- ✓ Short Term
- ✓ Intensive Staffing (1:4 Families)
- ✓ Crisis Intervention
- ✓ Targets Children at Imminent Risk of Removal

IFPS Program Results:

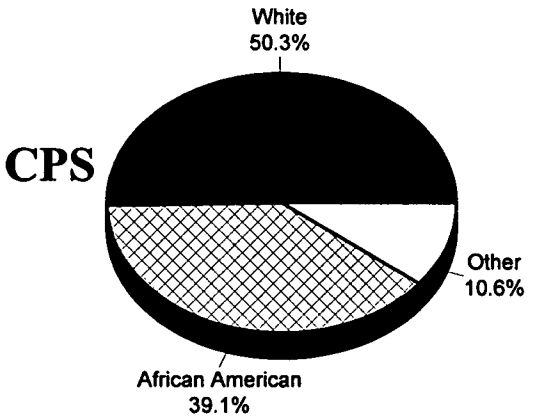
- ✓ 564 Families Served (915 Children)
- ✓ 750 Children (81%) Remained With Their Families After One Year
- ✓ Evaluation Results Include Reports of Improved Family Functioning
- ✓ Family/Caregiver (Supervision, Personal Problems, Domestic Violence)
- ✓ Child Well Being (Physical Health, Substance Abuse & Emotional Abuse)
- ✓ Environment (Housing & Food/Nutrition)

DIVISION OF SOCIAL SERVICES

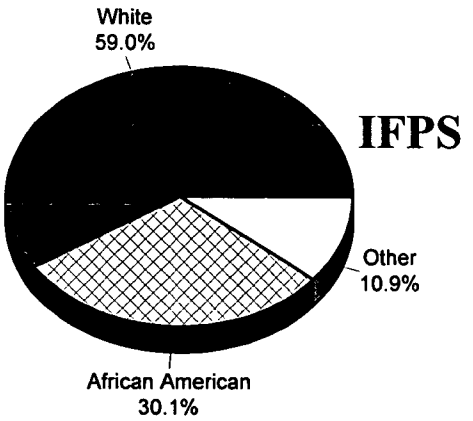
CHILD WELFARE SERVICES SYSTEM

How Do Children & Families Move Through the System?

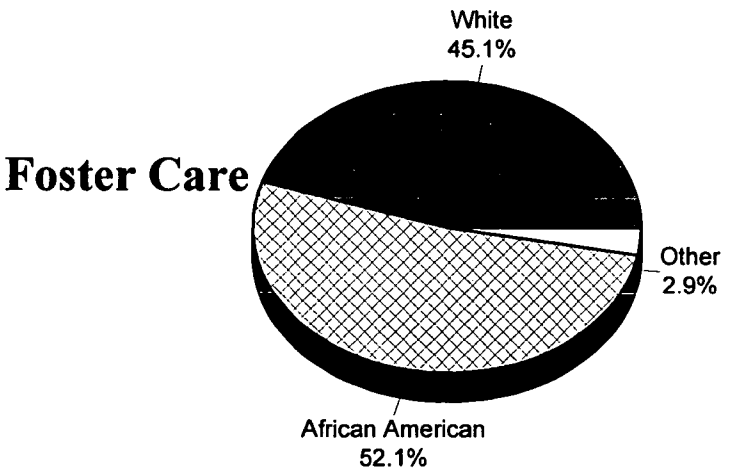
Portal of Entry



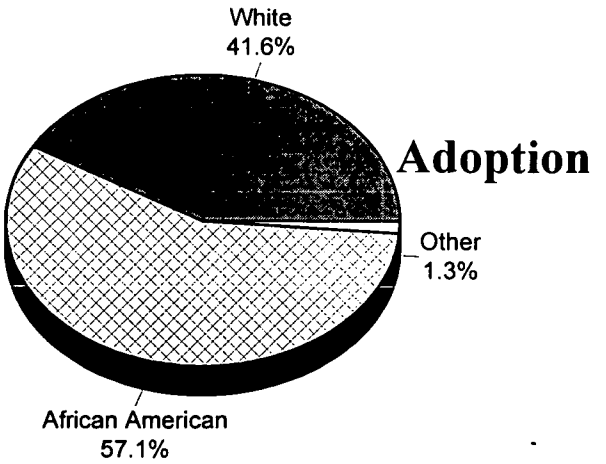
Diversion



Temporary Placement



Permanent Placement



DIVISION OF SOCIAL SERVICES

FOSTER CARE SERVICES

Foster Care Services Include,

- ✓ Evaluation and Arrangement of Placement Resources
- ✓ Supervision of the Care of the Child and of the Foster Care Facility
- ✓ Preparation of the Child and Family for Separation and Placement
- ✓ Planning and Preparation for Family Reunification
- ✓ ***Supervision, Recruitment, Study and Development of Foster Families***
- ✓ Other Casework Services

DIVISION OF SOCIAL SERVICES

FOSTER CARE SERVICES

Who Receives and Provides Foster Care Services?

- ✓ Any Child in the Legal Custody or Placement of a Licensed Child-Placing Agency
- ✓ 100 County Departments of Social Services
- ✓ 28 Child-Placing Agencies
- ✓ 240 Group Homes
- ✓ 4,149 Family Foster Homes

Foster Care Assistance Payments:

Assists Families and Child-Placing Agencies With Costs of Caring for Children in Foster Care

Graduated Assistance Payment: $315 (Birth - 5 Years)
$365 (6 - 12 Years)
$415 (13 - 18 Years)

Funding Sources:

Federal (Title IV-E and IV-B and SSBG), State and County

FY97/98 Funding: $100.9M

DIVISION OF SOCIAL SERVICES

FOSTER CARE SERVICES

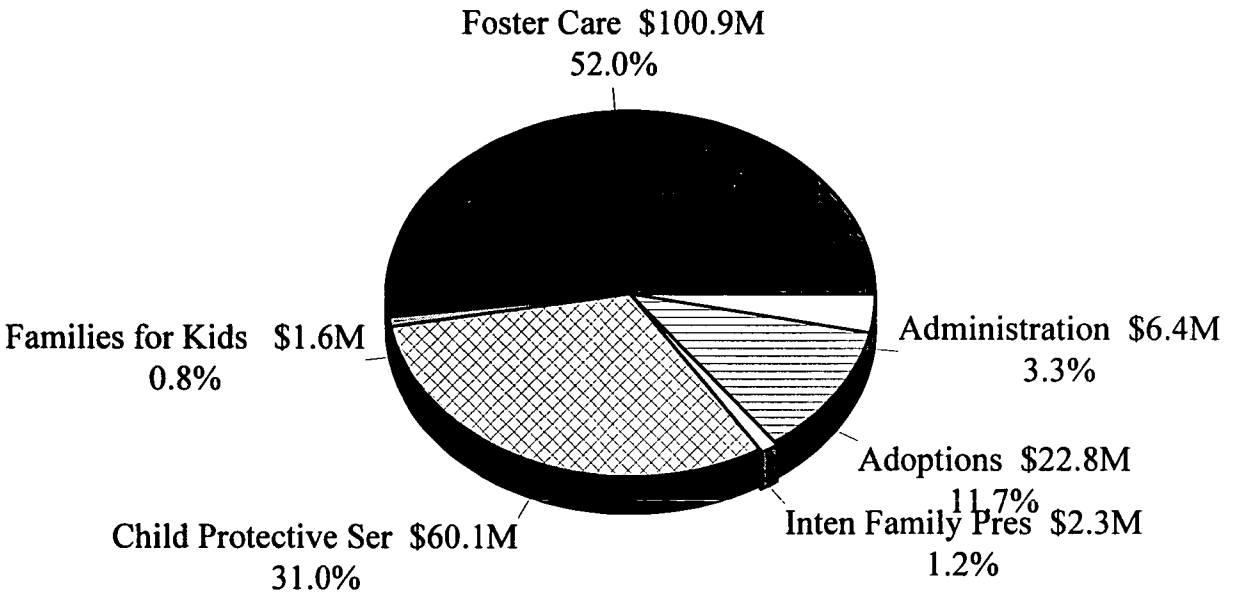
SELECTED FACTS

- 11,379 Children Were in Custody or Placement Responsibility
- 5,154 Entered Custody for the First Time During FY97/98
- 52% African American & 45% White
- 37% 6-12 Years Old
- 51% Are Males
- Median Length of Stay in Foster Care Dropped 26% From FY93/94 to FY96/97 (419 Days from 568 Days)
- Number of Children in Legal Custody for More Than 12 Months Decreased by 18.5% From 1997 to 1998

DIVISION OF SOCIAL SERVICES

FOSTER CARE SERVICES

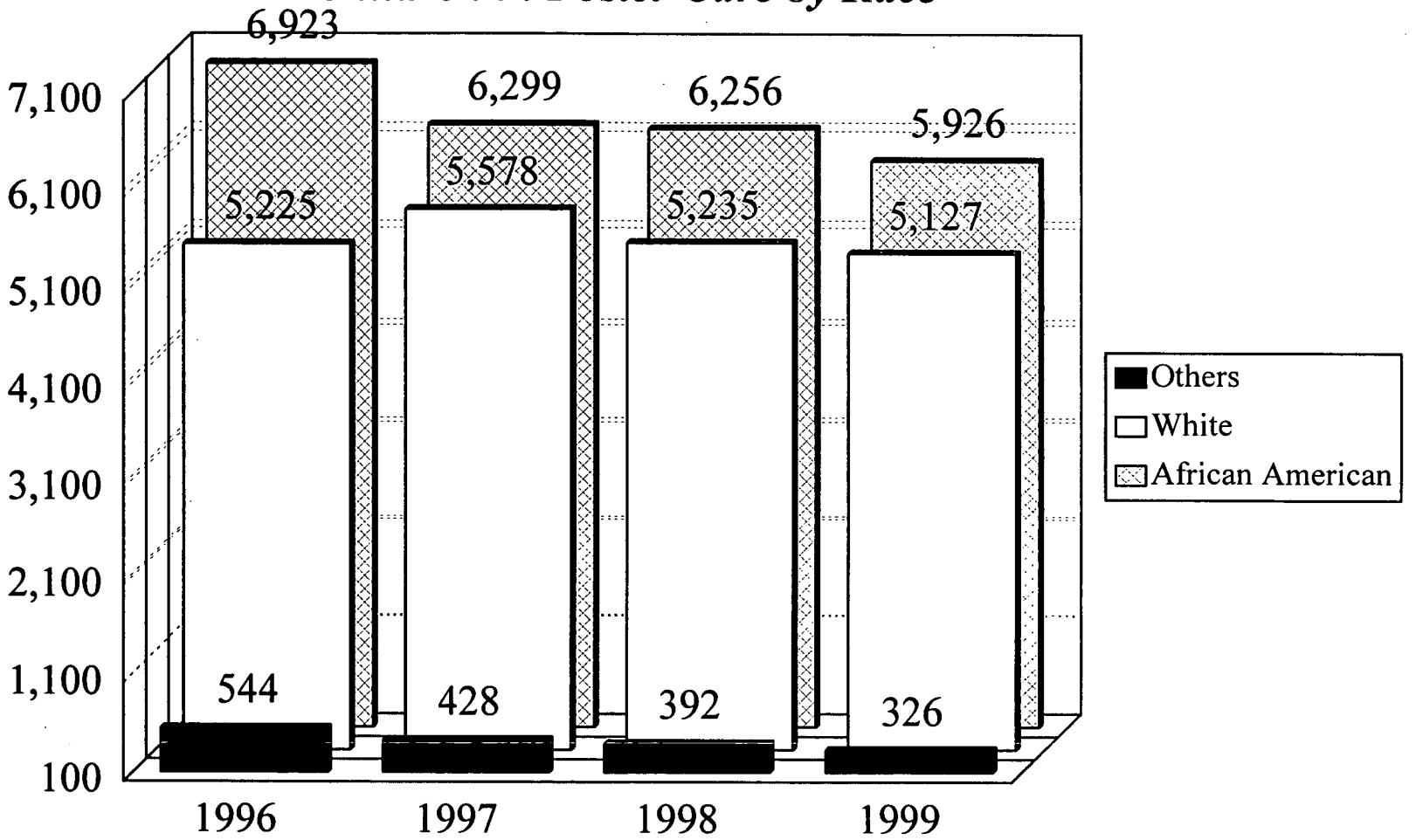
Total Estimated System Funding FY97/98: $100.9M
- $50.8M Federal Funds
- $14.3M State Funds
- $28.4M County Funds
- $ 7.4M Provider Match



DIVISION OF SOCIAL SERVICES

FOSTER CARE SERVICES

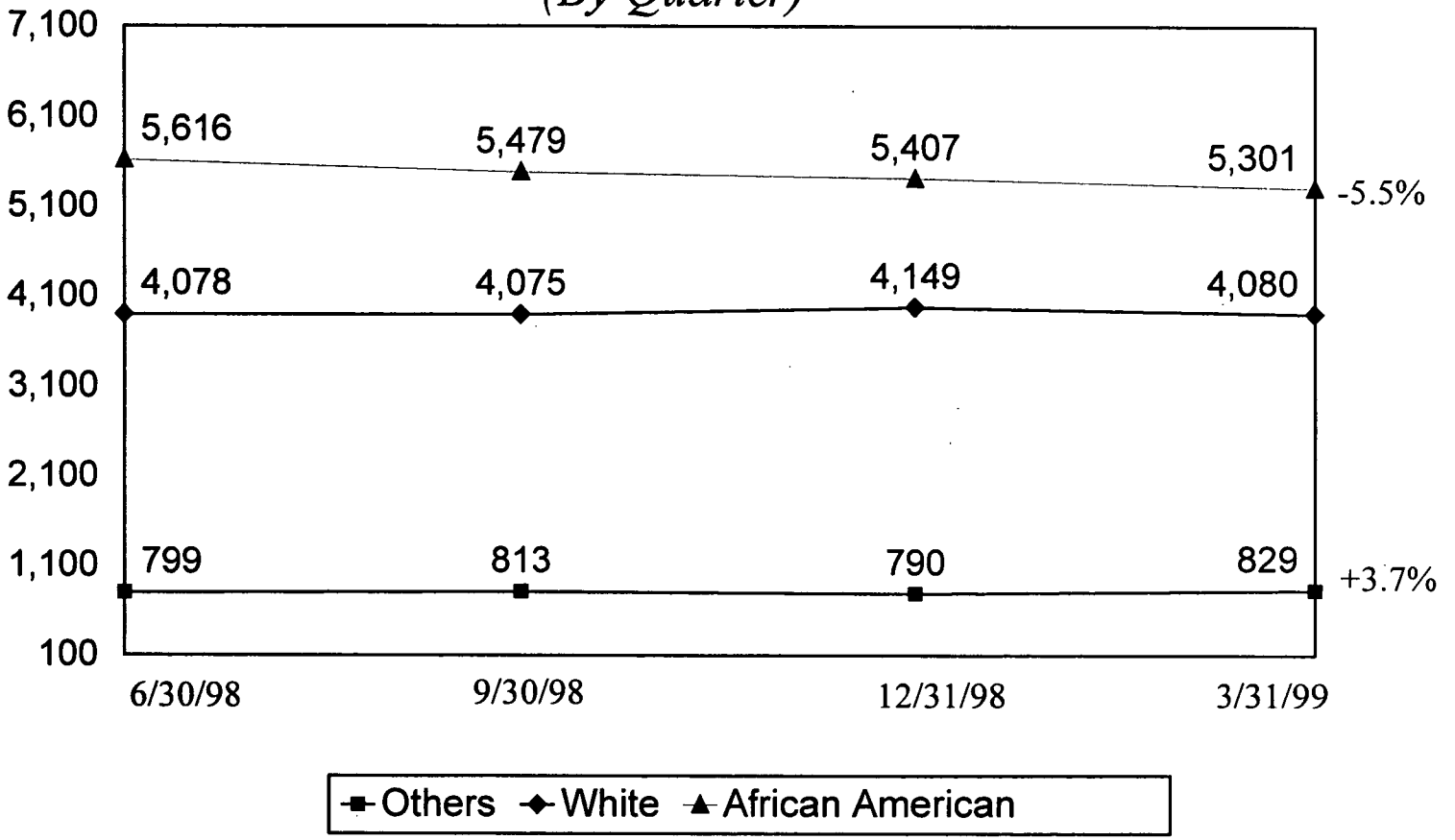
Children in Foster Care by Race



DIVISION OF SOCIAL SERVICES

FOSTER CARE SERVICES

Out-Of-Home Placements by Race
(By Quarter)



DIVISION OF SOCIAL SERVICES

ADOPTION SERVICES

Adoption Services:

- ✓ Recruitment, Study and Selection
- ✓ Counseling and Support Services
- ✓ Management of Legal Process
- ✓ Post-Adoption Support

As of February 1999,

2,870 Children Awaiting Adoption *(Only 777 are Legally Available for Adoption)*

603 children Were Adopted During FY97/98

(168% Increase Since FY92/93)

Of the 777 Children Awaiting Adoption,

57% are African American

49% are Between the Ages of 6-12 Years

54% are Males

DIVISION OF SOCIAL SERVICES

ADOPTION SERVICES

Adoption Assistance Program,

- ✓ Assists Families With Costs of Caring for Children Adopted Out of the Foster Care System
- ✓ Graduated Monthly Assistance Payment:
  $315 (Birth - 5 Years)
  $365 (6 - 12 Years)
  $415 (13 - 18 Years)
- ✓ Medicaid Coverage is Available to Special Needs Children

Special Children Adoption Fund,

- Created in 1997
- $911K
- 141 Children Adopted During FY97/98

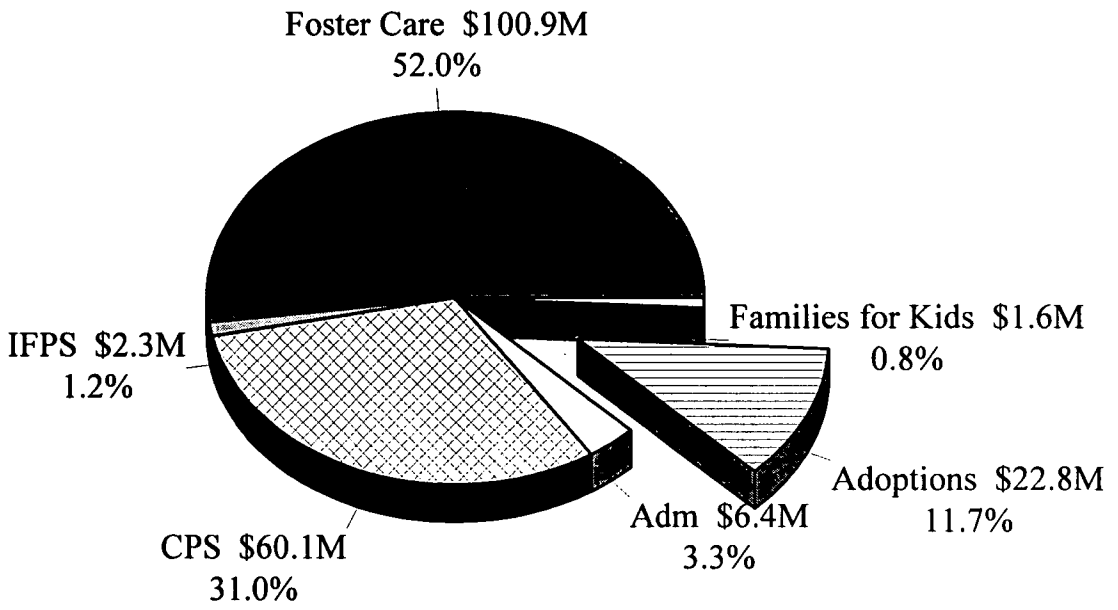
Funding Sources:

- FY97/98 Funding: $19.7M
- Federal (Title IV-E and IV-B), State and County

DIVISION OF SOCIAL SERVICES

ADOPTION SERVICES

FY97/98 Funding: $19.7M
-50% Adoption Assistance
-Only $3.1M for Services



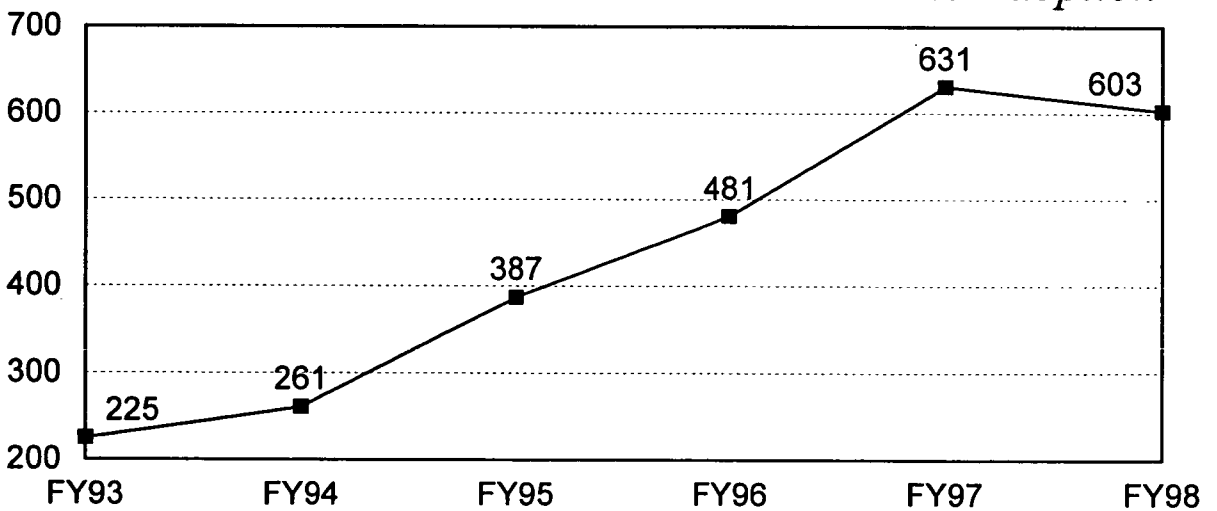
DIVISION OF SOCIAL SERVICES

ADOPTION SERVICES

North Carolina is Partnering With Various Children's Programs

- Children's Home Society
- Another Choice
- Adoption Plus
- Local Departments of Social Services
- Other Children's Programs/Agencies

Children Removed From Foster Care Due to Adoption



DIVISION OF SOCIAL SERVICES

OTHER INITIATIVES AND SERVICES

Families For Kids Initiative,

-Began January 1996
-Focuses on System Reform & Reducing the Length of Stay in Foster Care
-8 Original Counties; 12 New Counties
-Impetus for "Challenge for Children" Initiative

Child Welfare Demonstration Project,

-Focuses on Reducing the Initial Rate of Entry & Length of Stay in Foster Care
-Allows Flexibility in the Use of Federal Entitlement Funds For,

- ✔ Began July 1997
- ✔ 19 Counties
- ✔ Intensive Family Preservation
- ✔ Assisted Guardianship
- ✔ Respite Care
- ✔ Family Mediation
- ✔ Intensive Family Unification & Post-Placement Support

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-20, 1999 2:30

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jack Meeff	Mayor of Dimet
[illegible]	[illegible]
Jim Lipchurch	DFS/DHHS
Will [illegible]	AHHC
Stacy Flannery	NC HCFA
Phyllis Thomas	DFS/DHHS
Jesse Goodman	DFS/DHHS
Bill Warren	" "
Bonnie Cramer	DHHS- DFS
Jackie Shyppard	DHHS/DFS
Pam Seamans	NC Social Services Consortium
[illegible]	OSPL
Ann Rodriguez	NC Council of Community Programs
Bill Warren	DFS- DHHS
Mike Eddinger	DHHS/DFS
Lou Wilson	NCALTC7
[illegible]	NCALTCF
John Weeks	NCALTC7
Susan E Robinson	DMH/DD/SAS - Ch+Fam Succ
Bryant Edgerton	Easter Seals
Jeff Smith	Easter Seals
Megan Snyder Heinz	Easter Seals
Mary Bethel	Div. of Aging
Anna Tefft	OSBM
Mary Greene	OSBM
Nels Roseland	OSBM
Dennis Harrington	DHHS -
Don Willis	DMH DDSAS

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4.20, 1999 2:30
Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carol Bunch	Council for Women
Jeanne Givens	DHHS - Community Health
Bonnie Morell	DMH/DD/SAS
Peter Andersen	DHHS
Leah Devlin	DHHS
Barbara Fuller-Smith	DHHS
Steve Cline	DHHS
Tom Washburn	DHHS
[illegible]	DHHS/DSS
[illegible]	OSBM
Scott Johnson	DHHS BP&A
Karen Chester	NC-ICC-DHHS
T. Perruzzi	DMH-DHHS

AGENDA

Joint Subcommittee on Health and Human Services Appropriations

Legislative Office Building - Room 424
Wednesday, April 21, 1999
8:30 a.m.

Opening Remarks	Sen. Bill Martin, Co-Chair Rep. Beverly Earle, Co-Chair Rep. Edd Nye, Co-Chair
Open Block Grant Public Hearing:	
Low Income Home Energy Assistance	Kevin Fitzgerald, DHHS
Community Services Block Grant	Lawrence Wilson, DHHS
Public Comments	
Close Public Hearing	
Substance Abuse and Prevention and Treatment Block Grant	Flo Stein, DHHS
Smart Start Expansion	N.C. Partnership for Children
Adjourn	

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
April 21, 1999
Morning

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee. on Wednesday, April 21, 1999, in Room 424 of the Legislative Office Building.

House Chairman, Representative Edd Nye presided. Other House members present were Representative Beverly Earle (Co-Chairman), Representative Martha Alexander (Vice Chairman), Representative Alma Adams, Representative Lanier Cansler, Representative Theresa Esposito, Representative Trudi Walend, and Representative Gene Wilson. There were five senators present.

Chairman Nye called the meeting to order. The meeting was an open Block Grant Public Hearing.

Mr. Kevin Fitzgerald, DHHS, was introduced to give a presentation on Low Income Home Energy Assistance Program Block Grant. (See Attachment) Mr. Fitzgerald concluded his presentation.

Mr. Lawrence Wilson, DHHS, was introduced next to speak on Community Services Block Grant. Mr. Wilson concluded his presentation with questions from the Members of the Committee.

Chairman Nye asked for public speakers. Ms. Roberta Faison, NC Community Action Providers, spoke on Weatherization Program. (See Attachment) Ms. Faison concluded her presentation with questions from the Members of the Committee.

After the Public Hearing, Ms. Flo Stein, DHHS, was introduced to speak on Substance Abuse and Prevention and Treatment Block Grant. (See Attached) After some questions from the Committee Members, Ms. Stein concluded her presentation.

Chairman Nye adjourned the meeting.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbitt
Committee Assistant

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM BLOCK GRANT (LIHEAP)

For State Fiscal Year 1999-2000, the total State Low Income Energy Program allocation is currently estimated to be $20,087,280 based on current projections that the FFY 2000 award will be this amount. The Lumbee Regional Development Association (LRDA) will receive $166,521 from this amount. **The total available for LIHEAP is $19,920,759.**

GENERAL DESCRIPTION

The purpose of the Low Income Home Energy Assistance Program Block Grant is to provide funds to help low-income families cope with cost increases of heating fuel and to provide emergency assistance. There are two components:

1. Low Income Home Energy Assistance Payments – Funds are used to provide a one-time payment to eligible households to help pay heating bills.

2. Crisis Intervention Assistance – Funds are used to assist low-income people when a heating or cooling related crisis occurs. Allocations are provided to county departments of social services to make direct payments, vendor payments, or to provide in-kind services for eligible households.

RECOMMENDATIONS

		PERCENT	*DOLLARS*
1.	Allocation for Low Income Energy Assistance payments	37.8	7,530,047
2.	Allocation for the Crisis Intervention Program	37.0*	7,370,681*
3.	Allocation to the Department of Commerce for Weatherization Program	15.0	2,988,114
4.	Allocation for application-taking by the Commission On Indian Affairs	00.20	39,841
5.	Allocation for administrative cost of the Low Income Energy Assistance Payments Program and the Crisis Intervention Program	10.00	1,992,076
		TOTAL LIHEAP BLOCK GRANT	**$19,920,759**
			$19,920,759

*The component is budgeted at $7,370,681. Of this amount, $5,976,228 (30%) is expected to be allocated to counties. The remaining $1,394,453 (7%) is expected to be transferred to the Department of Commerce for the Heating Assistance Repair and Replacement Program (HARRP).

DIVISION OF SOCIAL SERVICES
ANALYSIS IF LIHEAP BLOCK GRANT
SFY 1999-2000

Item Number	Title	Actual SFY 97/98	Appropriated SFY 98/99 (SB 1366)	Recommended Amount SFY 99/00	Appropriated/ Recommended Difference	Explanation of Difference
1	Low Income Energy Assistance Payments	9,454,924	6,350,240	7,530,047	1,179,807	The number of people have been increasing and, therefore, the payment has been decreasing. In order to compensate, the allocation was increased.
2	Crisis Intervention Program	7,025,497	6,461,000	7,370,681	909,681	See statement below.
3	Allocation to Department of Commerce for Weatherization Program	5,008,802	4,171,960	2,988,114	(1,183,846)	See statement below.
4	Allocation for Application Taking by the Commission on Indian Affairs	26,778	33,228	39,841	6,613	Increasing because of allocation increase. Percentage of total allocation remains constant.
5	Allocation for administrative cost of the Low Income Energy Assistance Program and the Crisis Intervention Program	2,861,009	1,443,572	1,992,076	548,504	There has been an increase in the number of walk-ins applying for Low Income Energy Assistance Payments which increases administrative costs.
	Total	24,377,010	18,460,000	19,920,759	1,460,759	

Component 2 is budgeted at $7,370,681. Of this amount, $5,976,228 (30%) is expected to be allocated to counties. The remaining $1,394,453 (7%) is expected to be transferred to the Department of Commerce for the Heating Assistance Repair and Replacement Program (HAARP).

Roberta Jamison
(2nd Handout)

COMMUNITY SERVICES BLOCK GRANT
PUBLIC HEARING COMMENTS
APRIL 21, 1999

ON BEHALF OF THE NORTH CAROLINA COMMUNITY ACTION ASSOCIATION, THANK YOU FOR ALLOWING US THIS OPPORTUNITY TO COMMENT ON THE COMMUNITY SERVICES BLOCK GRANT, ITS PROGRAMS AND ACTIVITIES.

MANY CHANGES HAVE OCCURRED IN THE PAST FEW YEARS IN OUR NATION'S POLITICAL, SOCIAL AND ECONOMIC STRUCTURE; MAINSTREAM AMERICA HAS REDISCOVERED THE NEED TO ADDRESS THE IMPORTANCE OF FAMILY IN CORRECTING OUR SOCIETY'S ILLS. WELFARE REFORM HAS BECOME THE FOCUS OF THESE CHANGES. WHILE THIS HEARING TODAY IS DESIGNED TO MEET FEDERAL REQUIREMENTS TO ADDRESS THE STATE'S ALLOCATION OF C.S.B.G., WHICH BY FEDERAL LAW IS ALLOCATED SOLELY TO COMMUNITY ACTION AND LIMITED PURPOSE AGENCIES, WE WISH TO POINT OUT A FEW OF THE MANY WAYS THESE AGENCIES HAVE SERVED AND CONTINUE TO SERVE OUR STATE'S LOW INCOME AND DISADVANTAGED POPULATION.

90 COUNTIES WILL BE ALLOCATED $13,030,672. POPULATION INCREASES, WITH A CORRESPONDING NUMBER OF INCREASED POOR AND WORKING POOR, ESPECIALLY THE RECENT INFLUX OF ADDITIONAL WORKING POOR LEAVING WELFARE UNDER WORK FIRST, POSITIONS COMMUNITY ACTION AND LIMITED PURPOSE AGENCIES AT THE HEART OF THE PROBLEM AREAS THESE INDIVIDUALS AND FAMILIES ARE EXPERIENCING. WE ARE DISCOVERING MANY FAMILIES ARE

HAVING EXTREME DIFFICULTY REMAINING IN COMPLIANCE WITH EXISTING WELFARE REFORM REGULATIONS, AS TRANSPORTATION PROBLEMS IN BOTH URBAN AND RURAL AREAS ALIKE CREATE OBSTACLES WITH WORK SCHEDULES AND CHILD CARE CENTER HOURS OF OPERATIONS. RURAL AREAS, AS YOU MIGHT IMAGINE, ARE HARDEST HIT, AS A LACK OF AN AFFORDABLE AND RELIABLE MEANS OF TRANSPORTATION FOR THE WORKING POOR HAS ALWAYS EXISTED IN RURAL NORTH CAROLINA AND THIS IS ESPECIALLY TRUE FOR THOSE INDIVIDUALS ENTERING THE WORK PLACE UNDER WORK FIRST.

COMMUNITY ACTION, ALONG WITH THE FAITH COMMUNITY TOO FREQUENTLY FINDS ITSELF THE ONLY AVAILABLE SAFETY NET FOR THE MANY POOR AND WORKING POOR WHO ARE JUST ONE PAY CHECK, ONE UNEXPECTED EMERGENCY OR ILLNESS FROM A CRISIS SITUATION IN MEDICINE, FOOD OR SHELTER. YET DESPITE RISES IN REQUESTS FOR SERVICES, DUE TO BUDGET SHORTFALLS IN FY97-98, COMMUNITY ACTION LOST $413,000 IN STATE FUNDING SUPPLEMENTING THIS BLOCK GRANT. $500,000 NOW REPRESENTS THE TOTAL STATE CONTRIBUTION TO CAA'S AND LPA'S. WE STILL NEED THESE FUNDS REPLACED!

WE URGE YOU TO UTILIZE YOUR EXISTING C.S.B.G. DOLLARS IN NORTH NETWORK BY PARTNERING WHENEVER POSSIBLE WITH LOCAL COMMUNITY ACTION/LIMITED PURPOSE AGENCIES ON NEW AS WELL AS EXISTING INITIATIVES. G.A.O. AUDITS HAVE FOUND OUR AGENCIES TO BE ONE OF THE MOST COST EFFECTIVE NETWORKS AVAILABLE AS A PROVIDER OF HUMAN SERVICES. WE HAVE BEEN BRINGING FAMILIES TO ECONOMIC SELF SUFFICIENCY FOR MANY

YEARS VIA COORDINATION OF EMPLOYMENT ASSISTANCE, JOB TRAINING AND EDUCATION, DAY CARE, HEAD START, BUDGETING AND INCOME MANAGEMENT, HOUSING REHABILITATION, WEATHERIZATION, SECTION 8 RENTAL ASSISTANCE, NUTRITION EDUCATION, COUNSELING AND EMERGENCY ASSISTANCE TO NAME A FEW. WE WORK WITH SENIOR CITIZENS VIA CONGREGATE MEAL SITES, MEALS ON WHEELS AND OTHER SERVICES ESPECIALLY DESIGNED TO MEET THE NEEDS OF SENIORS. WE OPERATE MCKINNEY HOMELESS FUNDING, WRAP-AROUND PROGRAMS FOR HEAD START AND MORE AND MORE AGENCIES ARE CONSTRUCTING SINGLE AND MULTIFAMILY HOUSING.

WE ARE NOT IDENTICALLY THE SAME NAME, FACE, OR SERVICES IN ANY GIVEN AREA, FOR LOCAL BOARDS DIRECT AGENCIES TO ADDRESS LOCAL POVERTY CONCERNS BASED UPON AVAILABLE RESOURCES AND NETWORKING WITH OTHER EXISTING RESOURCES. BUT ALL COMMUNITY ACTION AGENCIES WORK PRIMARILY TO BRING FAMILIES OUT OF POVERTY AND OFF WELFARE VIA A COMPREHENSIVE ASSESSMENT OF THE INDIVIDUAL'S AND FAMILIES NEEDS THROUGH A CASE MANAGEMENT SYSTEM. FROM THIS EVALUATION THE TOTAL NEEDS AND CONCERNS OF THE FAMILY ARE MET FROM THAT AGENCY AND THROUGH REFERRAL TO OTHER LOCAL AVAILABLE RESOURCES.

WE WANT TO EMPHASIZE THIS SO THAT THE STATE MIGHT BE MORE AWARE OF OUR EXPERIENCE AND EXPERTISE IN WORKING WITH THE TOTAL FAMILY AND CONSIDER OUR NETWORK AS THE FIRST ALTERNATIVE AS AN OPTIONAL SERVICE DELIVERY.

WE CAUTION OUR LAWMAKERS TO STRONGLY ADVOCATE FOR EDUCATION AND ADVANCED TRAINING FOR WORK FIRST PARTICIPANTS THAT THEY MIGHT HOPE TO BE MORE THAN JUST WORKING, BUT STILL IN POVERTY. OUR EXPERIENCE HAS SHOWN THAT IT IS POSSIBLE FOR FAMILIES TO RISE ABOVE DEPENDENCY, BUT ARE MUCH MORE LIKELY TO REMAIN INDEPENDENT WHEN GIVEN THE PROPER TOOLS. ADDITIONALLY, OF THOSE WHO BECOME EMPLOYED, ACTUAL JOB READINESS WILL BE A CRUCIAL FACTOR. MANY THINGS WHICH WE IN THE WORKING WORLD TAKE AS SECOND NATURE WILL NOT COME SO EASILY FOR THOSE WHO HAVE BEEN CHRONICALLY UNEMPLOYED. FOR THESE, THE MORE DIFFICULT TASK WILL BE TO KEEP THEM FROM RETURNING TO WELFARE.

WE WISH TO THANK THIS COMMITTEE FOR ITS TIME, AND FOR ITS SUPPORT OF OUR PROGRAMS AND SERVICES. SHOULD RESOURCES AGAIN BECOME AVAILABLE, WE WOULD URGE YOU TO PLEASE RETURN THE STATE'S SUPPLEMENTS TO THE CSBG BLOCK GRANT. THANK YOU FOR THIS OPPORTUNITY TO APPEAR BEFORE YOU TODAY.

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

PUBLIC HEARING COMMENTS

APRIL 21, 1999

COMMITTEE CHAIRS, MEMBERS OF THE COMMITTEE, SECRETARY BRUTON/HUMAN RESOURCE STAFF, LEGISLATIVE AND FISCAL STAFF; ON BEHALF OF THE N.C. COMMUNITY ACTION ASSOCIATION, PROVIDERS OF NORTH CAROLINA'S RESIDENTIAL ENERGY CONSERVATION ASSISTANCE PROGRAM (KNOWN TO YOU BEST AS THE WEATHERIZATION ASSISTANCE PROGRAM), A RECIPIENT OF CRUCIAL LIHEAP FUNDING, WE THANK YOU FOR THIS OPPORTUNITY TO COMMENT ON THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM.

FOR THREE PRIOR YEARS, THIS COMMITTEE HAS APPROVED A BALANCE WITHIN THE LIHEAP PROGRAM OF 75% CASH ASSISTANCE PAYMENTS AND 25% FOR THE WEATHERIZATION ASSISTANCE PROGRAM; 15% DIRECTLY TO WEATHERIZATION AND 10% DIRECT VIA A WAIVER PROCESS APPLICATION TO U.S. DEPT. OF HHS. FY 98-99, 7.6% WAS DECIDED UNANIMOUSLY UPON IN MUTUAL AGREEMENT BY N.C. DEPT. HUMAN RESOURCES, THE N.C. DIVISION OF ENERGY AND MEMBERS OF THIS COMMITTEE. THIS WAS AN IMPORTANT STEP IN RECOGNIZING THE NEED TO ADDRESS THE ROOT PROBLEM OF HIGH ENERGY COSTS IN A MORE COMPREHENSIVE AND EXTENSIVE MANNER.

UPON RECOMMENDATION FROM THE U.S. DEPT. OF HHS, STAFF OF THE N.C. DEPT. HHS, THE N.C. DIVISION OF ENERGY AND ITS PROGRAM PROVIDERS, LAST YEAR, THIS YEAR AND SUBSEQUENT YEARS IT WAS OUR UNDERSTANDING THE LEGISLATURE DESIRED TO APPROPRIATE AS A PERMANENT BUDGET ITEM 15% DIRECTLY TO WEATHERIZATION AND

7.6% INTO CRISIS ASSISTANCE DIRECTLY FOR THE HEATING APPLIANCE REPAIR AND REPLACEMENT PROGRAM. THIS PROCEDURAL CHANGE WAS RECOMMENDED DUE TO THE ADMINISTRATIVE TIME NECESSARY TO COMPLETE THE WAIVER PROCESS AND FEDERAL STATUTES WHICH ALLOW HEATING REPAIR AND REPLACEMENT PROGRAM SERVICES TO BE PROVIDED IN OTHER LIHEAP BUDGET CATEGORIES. ADDITIONALLY, WE SHOULD ADD THAT ALL LIHEAP PROGRAM ENTITIES MET TO DISCUSS THIS ISSUE AND AGREED ON THE DATA. WE WERE SURPRISED TO LEARN UPON SEEING A COPY OF THIS YEAR'S LIHEAP BUDGET LAST WEEK THIS FIGURE WAS REDUCED TO 22% WITHOUT OUR KNOWLEDGE. BECAUSE THE FEDERAL ALLOCATION IS HIGHER THIS YEAR, OUR *OVERALL* FUNDING IS NOT REDUCED, IN FACT IT IS HIGHER THAN THE PREVIOUS YEAR'S. WE QUESTION SUCH A CHANGE DUE TO THE AMOUNT OF TIME, WORK AND EFFORT EXPENDED BY THIS LEGISLATIVE COMMITTEE AND OTHERS ESTABLISHING SET AMOUNTS FOR CATEGORIES OF SERVICES FROM THE LIHEAP BLOCK GRANT.

HEATING REPAIR REPLACEMENT PROGRAM IF YOU WILL RECALL IS A SPECIAL PART OF THE RESIDENTIAL ENERGY CONSERVATION ASSISTANCE PROGRAM. IN NORTH CAROLINA ONE IN TEN HOMES ELIGIBLE FOR WEATHERIZATION HAVE SIGNIFICANT LEVELS OF CARBON MONOXIDE. THREE TIMES AS MANY HOMES HAVE SIGNIFICANT LEVELS OF NITROGEN DIOXIDE. BOTH GASES ARE DANGEROUS. CARBON MONOXIDE IS A SILENT, DEADLY KILLER. NITROGEN DIOXIDE CAN CAUSE LONG TERM CHRONIC ILLNESS. <u>THESE ARE SERIOUS HEALTH AND SAFETY ISSUES CAUSING POTENTIAL DEATHS AND IN CERTAIN PROBABILITY HEALTH PROBLEMS WHICH REFLECT UPON THE INDIGENT HEALTH CARE COSTS IN ALL 100 COUNTIES.</u> CURRENTLY WE HAVE A STATEWIDE H.A.R.R.P. WHICH ALLOWS US TO EVALUATE, REPAIR OR REPLACE FAULTY HEATING SYSTEMS THAT POSE HEALTH AND

SAFETY RISKS.

IN A REPORT BY THE NATIONAL CONSUMER LAW CENTER, LOW INCOME NORTH CAROLINIANS CAN SPEND UP TO 35% OF THEIR INCOME ON ENERGY. THE 90'S HAVE BROUGHT ABOUT AN INCREASE IN THE NUMBER OF WORKING POOR WHO HAVE MINIMUM WAGE, SERVICE SECTOR JOBS. ONE IN FIVE NORTH CAROLINIAN FAMILIES SUBSIST ON AN INCOME BELOW 150% OF THE POVERTY LEVEL. TWO THIRDS OF OUR COUNTIES IN NORTH CAROLINA HAVE SEEN POPULATION RATES OUTPACE JOB GROWTH. IN MOST COUNTIES OF NORTH CAROLINA LOW WAGE JOBS ARE THE NORM, RATHER THAN THE EXCEPTION. THESE LOW WEALTH FAMILIES FREQUENTLY OCCUPY OLDER HOUSING STOCK BUILT WITHOUT ENERGY CONSERVATION IN MIND. THE WORKING POOR, WHO ARE MARGINALLY ABLE TO MAKE IT ON THEIR INCOME, ARE PARTICULARLY ASSISTED BY OUR PROGRAM OF WEATHERIZATION. ENERGY REMAINS A HIGH COST ITEM FOR LOW INCOME FAMILIES AND WEATHERIZATION IS LONG TERM SOLUTION WHICH HELPS ALLEVIATE THIS PROBLEM WHILE ALSO REDUCING THE NEED FOR FUEL ASSISTANCE PAYMENTS. WEATHERIZATION GREATLY REDUCES THIS BURDEN. THE WEATHERIZATION ASSISTANCE PROGRAM ACTUALLY IMPROVES THE ENERGY EFFICIENCY OF THE HOME, THEREBY LOWERING CLIENTS MONTHLY FUEL BILLS. REDUCTIONS IN FUEL BILLS ARE ESPECIALLY IMPORTANT TO LOW INCOME FAMILIES WHO WALK THE LINE BETWEEN PAYING FOR HOUSING AND BEING HOMELESS. A 30% REDUCTION IN A MONTHLY FUEL BILL MAKES A SIGNIFICANT IMPACT FOR LOW INCOME FAMILIES STRUGGLING TO PAY FOR NECESSITIES. DOLLARS SAVED ON FUEL BILLS CAN THEREFORE BE DIRECTED TO THESE OTHER NECESSITIES, REDUCING DEPENDENCY ON OTHER FEDERAL AND STATE PROGRAMS. WEATHERIZATION IS A SOLUTION RATHER THAN A QUICK FIX, PROVIDING LONG ERM BENEFITS TO LOW INCOME FAMILIES. OUR EXPECTED "LIFETIME OF ENERGY REDUCTION" IS BASED ON A TWENTY YEAR TIME LINE.

INVESTMENT IS A KEY WORD DESCRIBING THE FEDERAL DOLLARS SPENT IN THE WEATHERIZATION PROGRAM. 1989 NEW TECHNOLOGIES AND PROGRAM IMPROVEMENTS HAVE INCREASED OUR COST EFFECTIVENESS. WE BELIEVE THAT A $3 RETURN ON INVESTMENT IS POSSIBLE WITHIN LESS THAN 5 YEARS. THESE SAVINGS ARE DRAMATIC AND CONTINUE TO ACCUMULATE OVER THE LIFE TIME OF THE UNIT WEATHERIZED; ONE HOUSEHOLD @ $ 413.00 ANNUALLY X 20 YEARS $ 8,260. WE HAVE WEATHERIZED OVER 86,000 UNITS SINCE THE BEGINNING OF THE PROGRAM. THE MATH ON THOSE NUMBERS IS OVERWHELMING. ANOTHER AMAZING STATISTIC OTHER THAN THE REAL DOLLAR SAVINGS IN ENERGY COST IS THE NET DOLLAR VALUE OF NON-ENERGY IMPACTS; EXTENDING THE LIFE OF THE DWELLING $171, REDUCED FIRES $4, REDUCED ARREARAGES $44, FEDERAL TAXES GENERATED BY DIRECT EMPLOYMENT $75, INCOME GENERATED BY DIRECT EMPLOYMENT $688, AVOIDED COSTS OF UNEMPLOYMENT BENEFITS $112, ENVIRONMENTAL EXTERNALITIES $234 FOR A TOTAL OF $1,328 DOLLARS IN ADDITIONAL ECONOMIC BENEFITS.THIS IS WHY WE ARE SO PASSIONATE ABOUT OUR PROGRAM. NORTH CAROLINA, WE ARE PROUD TO SAY HAS ONE OF THE MOST EFFECTIVE IF NOT THE MOST EFFECTIVE AND EFFICIENT *PROGRAMS* IN THE NATION. WE THINK THAT IT SHOWS IN THIS DATA.

ANOTHER EXTREMELY IMPORTANT AND SOMETIMES OVER LOOKED BENEFIT OF THE WEATHERIZATION ASSISTANCE PROGRAM IS ITS ECONOMIC IMPACT ON LOCAL AND STATE ECONOMIES, FOR WEATHERIZATION CREATES AND SUSTAINS JOBS. 52 INDIVIDUALS ARE DIRECTLY EMPLOYED AND 22 JOBS ARE INDIRECTLY SUPPORTED FOR EVERY ONE MILLION DOLLARS INVESTED INTO THE PROGRAM. THAT EQUATES TO 32 MILLION IN ECONOMIC OUTPUT GENERATED

EACH YEAR. IN A GREAT TIME OF SKEPTICISM ABOUT THE EFFECTIVENESS OF PUBLIC PROGRAMS, WEATHERIZATION IS AN EXAMPLE OF A FEDERAL/STATE/ COMMUNITY PARTNERSHIP THAT RETURNS MORE VALUE THAN THE TAXPAYER INVESTS AND DELIVERS MEASURABLE AND LONG-LASTING RESULTS.

COMMUNITY ACTION'S PRIMARY GOAL IS TO ASSIST FAMILIES ACHIEVE ECONOMIC SELF SUFFICIENCY, PROVIDING SERVICES TO MOVE THEM ABOVE THE POVERTY LEVEL. ECONOMIC SELF SUFFICIENCY PROGRAMS REMOVE THE BARRIERS THAT MAY BE KEEPING FAMILIES IN POVERTY. WASTED ENERGY BRINGS HUGE ENERGY COSTS, CREATES MANY POTENTIAL EVICTION SITUATIONS, AND CAUSES MANY TO CHOOSE BETWEEN HEATING, EATING, OR BUYING NECESSARY MEDICATION. 65% OF WEATHERIZATION SERVICES ARE PROVIDED TO LOW INCOME HOMEOWNERS IN OLDER HOUSING. IMPROVEMENTS IN HOUSING STOCK SUCH AS INSULATION AND FURNACE MODIFICATIONS REMAIN WITH A HOME AND BENEFIT LOW INCOME CLIENTS FOR MANY YEARS, THEREBY PRESERVING HOUSING STOCK AND ENERGY EFFICIENCY. ITS EFFECT IN MANY AREAS IS VERY PRONOUNCED WHERE WEATHERIZATION SERVICES CAN REPRESENT THE ALTERNATIVE TO ABANDONMENT. 23% OF UNITS WEATHERIZED ARE FOR THE ELDERLY. THESE SERVICES OFTEN ALLOWS SENIORS TO REMAIN IN THEIR HOMES LONGER REDUCING THE NEED FOR GOVERNMENT SUBSIDIES ON LONG TERM CARE IN EXPENSIVE NURSING OR REST HOMES. 35% OF WEATHERIZATION SERVICES ARE PROVIDED TO RENTERS OF WHICH LANDLORDS MUST CONTRIBUTE 10% IN CASH TOWARD THE COST OF SINGLE FAMILY DWELLINGS AND 25% FOR MULTI-FAMILY DWELLINGS. THESE FUNDS ARE RETURNED TO THE WEATHERIZATION PROGRAM TO INCREASE THE NUMBER OF UNITS WEATHERIZED. WEATHERIZATION IS A COMPREHENSIVE PROGRAM THAT

PROVIDES ECONOMIC BENEFITS TO LOW INCOME AMERICANS WHILE CONTRIBUTING TO ENERGY CONSERVATION, LESSENING ENVIRONMENTAL DEGRADATION CAUSED BY THE BUILDUP OF CARBON DIOXIDE IN THE ATMOSPHERE AND STIMULATES LOCAL ECONOMIES. IT IS THE TRUEST EXAMPLE OF THE KIND OF ASSISTANCE PROGRAM TO LOW INCOME FAMILIES THAT LEADS THEM TO ECONOMIC INDEPENDENCE SOUGHT BY THE STATE IN ITS EFFORTS OF WELFARE REFORM.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ECONOMIC OPPORTUNITY
COMMUNITY SERVICES BLOCK GRANT PLAN FOR SFY 1999-2000

GENERAL DESCRIPTION

For State Fiscal Year 1999-2000, funds available through the Community Services Block Grant Program (CSBG) for appropriation are projected to be $13,030,672. CSBG funds are projected to be available October 1, 1999.

Since 1981, the Community Services Block Grant Program has made federal funds available to states to provide a range of services designed to assist low-income persons attain the skills, knowledge, and motivation necessary to achieve self-sufficiency.

The primary providers of services under this grant, as required by federal law, are the thirty-six Community Action Agencies (CAAs) in the state. Other grantees are seven Limited Purpose Agencies (LPAs) who were recipients of similar funds prior to the inception of the Community Services Block Grant Program. CAAs operate programs under the Community Services Block Grant in coordination with other federal, state, and local programs such as Head Start, Job Training Partnership Act (JTPA), Weatherization, and Section 8 Rental Assistance.

In August 1995, the federal Community Services Block Grant Monitoring and Assessment Task Force produced a National Strategic Plan which endorsed a results-oriented management approach for the Community Service Network. The plan includes a set of six broadly stated umbrella national goals, with suggested measures to assess progress towards the goals. States and local agencies are required to address these goals and measures in their program planning and reporting.

The six national goals of the Community Services Network are:

Goal 1. Low-income people become more self-sufficient.

Goal 2. The conditions in which low-income people live are improved.

Goal 3. Low-income people own a stake in their community.

Goal 4. Partnerships among supporters and providers of services to low-Income people are achieved.

Goal 5. Agencies increase their capacity to achieve results.

Goal 6. Low-income people, especially vulnerable populations, achieve their potential by strengthening family and other support systems.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ECONOMIC OPPORTUNITY
COMMUNITY SERVICES BLOCK GRANT PLAN FOR SFY 1999-2000

Community Services Block Grant funds are used to provide a wide variety of services in local communities to serve identified needs of poor families. Programs allowed under the Community Services Block Grant Act are those which provide activities designed to assist low-income participants including the elderly poor:

- to secure and retain meaningful employment;
- to attain an adequate education;
- to make better use of available income;
- to obtain and maintain adequate housing and a suitable living environment;
- to obtain emergency assistance through loans or grants to meet immediate and urgent individual and family needs, including the need for health services, nutritious food, housing, and employment-related assistance;
- to remove obstacles and solve problems which block the achievement of self sufficiency;
- to achieve greater participation in the affairs of the community; and
- to make more effective use of other programs related to promoting the well being of the low-income population.

The specific services operated in each local community are determined by the local agency as a result of an assessment of the needs of low-income individuals and families in their service area which is used to develop a multi-year plan for services.

As required by the Community Services Block Grant Act, ninety per cent of the funds received are distributed to the thirty-six Community Action Agencies (CAAs) located throughout the state. Five percent, which is the maximum allowed by federal law, is used by the Department to administer the Program. The remainder is used to fund seven non-profit organizations known as Limited Purpose Agencies (LPAs).

Over twenty-five thousand low-income individuals are served annually by the North Carolina Community Services Block Grant Program.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ECONOMIC OPPORTUNITY
COMMUNITY SERVICES BLOCK GRANT PLAN FOR SFY 1999-2000

RECOMMENDATIONS	ALLOCATION
1. Allocate $651,534 to the Department of Health and Human Services to administer the grant. Staff renders technical assistance and monitors the Community Action Agencies and Limited Purpose Agencies for compliance with federal laws and regulations.	$651,534
2. Allocate $11,727,604 to the 36 Community Action Agencies (CAAs) which serve 90 counties for the purpose of providing administrative costs and to assist low-income families with housing, emergency assistance, education, energy, nutrition, income management, information and referral, and outreach. Federal rules require that 90% of the grant be allocated to CAAs.	$11,727,604
3. Allocate the remaining 5% of the grant in the amount of $651,534 to Limited Purpose Agencies which are agencies that address a specific need or population. The allocation and agency is as follows: - Telamon which provides assistance to seasonal and migrant farm workers ($81,442) - Low Income Housing Development Corporation (LIHDC) which assists non-profit agencies in packaging loans for housing construction and rehabilitation ($99,685) - N.C. Rural Fund for Development (NCRFD) which provides technical assistance to credit unions and cooperatives which serve low-income individuals and families ($237,158)	$651,534

- N.C. Senior Citizens' Federation which sponsors statewide activities for low-income senior citizens ($118,579)
- Western Economic Development Organization (WEDO) which assists organizations serving low-income and handicapped individuals secure manufacturing contracts ($62,547)
- United Senior Services which provides activity programs for senior citizens in Craven County ($24,758)
- N.C. Commission of Indian Affairs which provides programs for low-income Native Americans in the state in coordination with local tribal organizations ($27,365)

TOTAL FUNDING SFY 1999-00	$13,030,671
SOURCE OF FUNDS:	
BLOCK GRANT FUND FFY 1999	$3,257,668
BLOCK GRANT FUND FFY 2000	$9,773,003

OFFICE OF ECONOMIC OPPORTUNITY
Analysis of Community Services Block Grant
SFY 1999-2000

Item Number	Title	Actual SFY 97-98	Appropriated SFY 98-99 (SB 1366)	Recommended Amount SFY 99-00	Appropriated/ Recommended Difference	Explanation of Difference
1	Admin	$384,507	$642,964	$651,534	$8,570	Administration is limited to 5% of the grant award and varies based on the award amount.
2	CAAs	$11,408,741	$11,573,346	$11,727,604	$154,258	Funds awarded to CAAs must be 90% of the total allocation and is based on award amount.
3	LPAs	$635,618	$642,964	$651,534	$8,570	Funds awarded to LPAs is 5% of the grant. award and varies based on the award amount.
TOTAL		$12,428,866	$12,859,274	$13,030,672	$171,398	Difference represents the expected increase in federal grant award for this period.

Jlo Stein

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

Substance Abuse Prevention & Treatment Block Grant (SAPTBG) SFY 1999-2000

FUNDING LEVEL

Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funding available to North Carolina is $33,404,937 for FFY99 and an estimated amount of $29,096,347 for FFY 2000. The proposed plan utilizes the remaining FFY 99 amount of $12,850,753 plus $25,689157 from the FFY 2000 award.

GENERAL DESCRIPTION

The ADAMHA Reorganization Act of 1992 (P.L. 102-321) split the Alcohol, Drug, and Mental Health Services Block Grant (ADMBG) creating the Block Grant for Substance Abuse Prevention & Treatment. The SAPTBG provides federal financial assistance to state for the provision of prevention and treatment of alcohol and drug abuse.

SIGNIFICANT FEDERAL REQUIREMENTS

Federal requirements begun in 1993 continue into 1999-2000:

1. State agrees to utilize not less than 35% of the grant for alcohol and drug respectively.

2. Not less than 20% of the funds are to be set aside for prevention programs for individuals who do not require treatment for substance abuse to reduce the risk for such abuse. Prevention programs will include strategies to discourage the use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such products, The Synar Amendment requires that each state adopt and enforce laws prohibiting sale or distribution of tobacco products to those younger than 18 years of age. Effective October 1, 1994, if the Secretary of HHS determines that a state has failed to comply with the law, the State will lose significant federal funding from the SAPTBG. (Failure to comply with the Synar Amendment could result in a 40% non-compliance penalty amounting to $13,362,000 for FFY 99.) Final rules were published on January 19, 1996 (45 CFR Part 96).

3. The state will spend not less than 10% of grant monies to increase the availability of treatment services for pregnant women and women with dependent children with the provision that prenatal and child care be provided to those women while they are in treatment.

4. Interim services must be provided to those individuals in need of treatment for intravenous substance abuse if they cannot be admitted to treatment within 14 days.

5. The state will require treatment entities receiving funds under the grant to make available tuberculosis services to each individual receiving treatment.

6. States such as North Carolina where the rate of AIDs is 10 or more per 100,000 must spend at least 5% of the total award to provide early intervention services for person with or at risk for HIV/AIDs.

PROPOSED EXPENDITURE PLAN	ALLOCATION
1. Adult Substance Abuse Continuation of community and ADATC based alcohol and drug services including prevention, intervention, treatment, rehabilitation, and detoxification. Funding to support intervention and treatment services for offenders who remain in the community. Funds will be used to provide treatment services for offenders with substance abuse problems in community punishment programs. Continue support for group homes for recovering substance abusers. Tuberculosis services will be provided to all program participants. Special services for the deaf will be provided at the ADATC in Greenville, NC, with outpatient services for the deaf established in each region. Programs will be required to screen clients for TB and other infectious diseases.	$15,350,132
2. Child Substance Abuse Continue services to children and adolescent including prevention, high risk intervention and regional residential services. Services will include treatment for children in detention and training schools. Prevention activities will include strategies to discourage use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such products. Services will be delivered in accordance with the 1993 Mental Health Study Commission Child and Adolescent Alcohol and Other Drug Abuse Plan. Legislative action increased service to young offenders and established a	$7,754,702

network of services for youth in the juvenile justice system.

3.	**Women's Substance Abuse** Continuation of services for pregnant women and women with dependent children. Specialized services will be provided at the ADATCs for women. Continue to develop specialized services for TANF participants whose substance abuse is a barrier to self-sufficiency.	6,567,532
4.	**Intravenous (IV) Drug** Continuation of services to IV drug abusers and others at risk for HIV disease. Special services for IV drug users will be provided at the ADATCs.	5,390,497
5.	**Substance Abuse Focus on Families** Prevention and treatment services will be provided for children who are impacted by parental addiction.	893,811
6.	**Administration** Applicable to 5%Administrative Cap (Planning, Quality Assurance, Development of new treatment and prevention services and training for providers receiving Block Grant funds.)	1,670,246
	Not applicable to 5% Administrative Cap (Statutory requirement to identify those populations, areas, and localities with a need for substance abuse services). Continue the development of a performance management system based on outcomes, support the design of an improved behavioral health system and monitor prescription drug diversion.	952,803
TOTAL REQUIREMENTS		**$38,539,910**
Source of Funds		
	SAPTBG FFY 99	12,850,753
	SAPTBG FFY 2000	25,689,157
TOTAL FUNDS		**$38,539,910**

DIVISION OF Mental Health/Developmental Disabilities/Substance Abuse Services

th Block Gr TANCE ABUSE PREVENTION AND TREATMENT BG

SFY 1999-2000

Item Number	Title	Actual SFY 97-98	Appropriated SFY 98-99 (SB 1366)	Recommended Amount SFY 99-00	Appropriated/ Recommended Difference	Explanation of Difference
1	Adult Substance Abuse	$ 11,502,939	$ 11,502,939	$ 15,350,132	$ 3,847,193	Funds will ve used to complete the statewide network of offender management and treatment services for those sentenced to Intermediate punishments and to provide transition services for offenders leaving DART and Impact programs This program will operate cooperatively with the the Div.of Community Corrections as the result of a year long strategic planning process.
2	Child Substance Abuse	$ 6,477,706	$ 6,477,706	$ 7,754,702	$ 1,276,996	Expand treatment services for children in the juvenile justice system, expand residential services
3	Women's Substance Abuse	$ 5,065,766	$ 5,065,766	$ 6,567,532	$ 1,501,766	Expand residential services for women and their children and replace TANF funds in work demonstration programs for TANF participants
4	Intravenous (IV) Drug	$ 4,843,456	$ 4,843,456	$ 5,390,497	$ 507,228	Requirement to spend not less than 5% of the award for outreach and treatment for those at risk for HIV disease.
5	SSI	$ 1,123,757	$ 1,123,757	$ -	$ (1,123,757)	No longer required
6	Substance Abuse Focus on Families	$ 893,811	$ 893,811	$ 893,811	$ -	
6	Administration	$ 1,454,812	$ 1,454,812	$ 1,670,246	$ 215,434	5% of BG to be spent for administrative infrastructure.
		$ 502,803	$ 502,803	$ 952,803	$ 450,000	Performance requirements of BG depend on the ability to continue to collect outcome data.
	TOTAL	$ 31,865,050	$ 31,865,050	$ 38,539,910	$ 6,674,860	Funds will be used to support planning for the SIG, design,and prescription monitoring

s:\bna\blkgrt99\blgtcht.xls

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-21-1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Scott A. Johnson	DHHS BP&A
Flo Stein	DMH/DD/SAS
Ben Watts	NC DHHS/DSS
Pheon Beal	NC DHHS/DSS
Shannon Kansone	DHHS/DSS
Nancy Coston	DHHS/DSS
Karen E Anderson	DSS
[illegible]	DOC
Sonya Brown	DHHS
Lisa Abatemarco	BP&A/DHHS
Stanleen Scott Robbins	DMH/DD/SAS
Doug Baker	DMH/DD/SAS
Spencer Clark	DMH/DD/SAS
Roberta Faison	N.C. Community Action Assn.
Lawrence Wilson	DHHS/OEO
Greg Richardson	N.C. Commission of Indian Affairs
[illegible]	Gov't Consultants
[illegible] Smith	Easter Seals NC
Bryant Edgerton	Easter Seals NC
Megan Soyster	Easter Seals NC
ANNA TEFFT	OSBM
Percy A. Carter	Commerce, Energy Division
Kathy Ashcroft	Commerce, Energy Division
Chuck Ellerson	Energy Division
Patrick Rowler	NCAEC
Herbert Carter	Energy Division
[illegible]	Div. of Community Corrections
Brenda Williamson	DOC/DET

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-21-1999
Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Nels Roseland	OSBM
NINA YEAGER	OSBM
Janet Simoneau	NC Council
Drek McCKF	MARCH of Dimes
Kevin Howell	Gov's office

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
April 21, 1999
2:30 P.M.

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee, on Wednesday, April 21, 1999, in Room 424 of the Legislative Office Building.

House Chairman, Representative Edd Nye presided. Other House members present were Representative Beverly Earle (Co-Chairman), Representative Alma Adams, Representative Lanier Cansler, Representative Trudi Walend, and Representative Gene Wilson. There were five senators present.

Chairman Nye called the meeting to order and asked Ms. Mary Ellen Sylvester for presentation on Smart Start Expansion. Ms. Sylvester introduced Karen Ponder, Acting Executive Director for NC Partnership for Children to speak. She explained the concept of Smart Start and discussed the importance of fully funding the initiative. She explained the importance of good dental care for children. More than one hundred thousand children are receiving better care as a result of Smart Start. Ms. Ponder concluded her presentation with questions from the Members of the Committee. Chairman Nye stated he heard there was an arrangement the program was paying someone to stay at home with their children. Ms. Ponder stated there was one county with this arrangement. Stanley County has a program which allows one of the parents to stay at home the first year of their child's life and the program will provide some funding to buy the necessities for taking care of the child. She stated the county is very proud of this program and thinks it is filling an important need. Cumberland County has a program that helps families with children with special needs, and this is a model program they are using for other counties to emulateChairman Nye asked if there was anyone on their staff that doesn't mind telling the Partnerships some things are bad public policy. She stated the problem sometimes is that the Partnership may not see the big picture and they try to work with them on this. Senator Phillips stated his support for the Stanley County program. Ms. Ponder ended her presentation.

Mr. Ashley Thrift, CEO of NC Partnership for Children, was introduced to make a presentation. Mr. Thrift stated they hope to have Smart Start in every county in the state shortly. Because the program has been phased in over five years, all of the Partnerships are at different levels of funding. He stated the program works and there are many states beginning to copy the program. Chairman Nye asked about private donations. As of last year, there have been over one million volunteer hours and raised over thirty millions

dollars since the General Assembly gave them this requirement. This year they have raised eighteen and a half million dollars. Mr. Thrift concluded his presentation.

Ms. Stephanie Fanjul, DHHS DCD, was introduced to discuss the evaluation and the TEACH Program. Ms. Fanjul stated the Frank Porter Graham Foundation at Chapel Hill was conducting the evaluation, and has done seventeen different studies, which show the progress of Smart Start through the years. Local Partnerships are doing other forms of evaluations. Ms. Fanjul asked for questions concerning the Frank Porter Graham Evaluation. There were no questions. Ms. Fanjul then discussed the TEACH Program. The TEACH Program is associated with Smart Start but is an independent program. It provides a three-way partnership between individual childcare teachers, their boss, and the state. They staff to pursue further education and it rewards them with higher compensation after they have completed that education. The program provides scholarships to teachers and the teachers are getting early childhood courses. Chairman Nye asked if the TEACH money was just for daycare program or if any money goes toward scholarships. Ms. Fanjul stated most of the state money goes to scholarships and the teachers who participate in program usually stay put and the turnover rate is below ten percent. Chairman Nye asked that if the turnover rate would be zero with one third of the health insurance being paid by the state. Ms. Fanjul stated they are hoping this will keep it lower. Ms. Fanjul concluded her presentation.

Chairman Nye adjourned the meeting.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbitt
Committee Assistant

SMART START
FUNDING

	1993-94	1994-95	1995-96	1996-97	1997-98
Appropriation	$20M	$46.7M	$57.3M	$67.4M	$97.4M
# Counties	18	32	43	55	100

1998-99

Local Partnerships	$136,755,828
NC Partnership for Children, Inc.	$ 4,400,000
Division of Child Development	$ 905,000
Program Evaluation	$ 850,000
Total:	**$142,910,828***

*Annualizes to $157,077,495 in 1999-00 Continuation Budget

SMART START

EXPANSION BUDGET REQUEST

	1999-00	2000-01
Local Partnerships	$78,928,826	$164,780,766
County Collaboration	$ 1,500,000	$ 1,250,000
Program Evaluation	$ 165,000	$ 297,000
T.E.A.C.H.*	$ 778,000	$ 1,178,000

* Teacher Education And Compensation Helps

SMART START
FUNDING

	1993-94	1994-95	1995-96	1996-97	1997-98
Appropriation	$20M	$46.7M	$57.3M	$67.4M	$97.4M
# Counties	18	32	43	55	100

1998-99

Local Partnerships	$136,755,828
NC Partnership for Children, Inc.	$ 4,400,000
Division of Child Development	$ 905,000
Program Evaluation	$ 850,000
Total:	**$142,910,828***

*Annualizes to $157,077,495 in 1999-00 Continuation Budget

SMART START

EXPANSION BUDGET REQUEST

	1999-00	2000-01
Local Partnerships	$78,928,826	$164,780,766
County Collaboration	$ 1,500,000	$ 1,250,000
Program Evaluation	$ 165,000	$ 297,000
T.E.A.C.H.*	$ 778,000	$ 1,178,000

* Teacher Education And Compensation Helps

SMART START
FUNDING

	1993-94	1994-95	1995-96	1996-97	1997-98
Appropriation	$20M	$46.7M	$57.3M	$67.4M	$97.4M
# Counties	18	32	43	55	100

1998-99

Local Partnerships	$136,755,828
NC Partnership for Children, Inc.	$ 4,400,000
Division of Child Development	$ 905,000
Program Evaluation	$ 850,000
Total:	**$142,910,828***

*Annualizes to $157,077,495 in 1999-00 Continuation Budget

SMART START

EXPANSION BUDGET REQUEST

	1999-00	2000-01
Local Partnerships	$78,928,826	$164,780,766
County Collaboration	$ 1,500,000	$ 1,250,000
Program Evaluation	$ 165,000	$ 297,000
T.E.A.C.H.*	$ 778,000	$ 1,178,000

* Teacher Education And Compensation Helps

SMART START
FUNDING

	1993-94	1994-95	1995-96	1996-97	1997-98
Appropriation	$20M	$46.7M	$57.3M	$67.4M	$97.4M
# Counties	18	32	43	55	100

1998-99

Local Partnerships	$136,755,828
NC Partnership for Children, Inc.	$ 4,400,000
Division of Child Development	$ 905,000
Program Evaluation	$ 850,000
Total:	**$142,910,828***

*Annualizes to $157,077,495 in 1999-00 Continuation Budget

SMART START

EXPANSION BUDGET REQUEST

	1999-00	2000-01
Local Partnerships	$78,928,826	$164,780,766
County Collaboration	$ 1,500,000	$ 1,250,000
Program Evaluation	$ 165,000	$ 297,000
T.E.A.C.H.*	$ 778,000	$ 1,178,000

* Teacher Education And Compensation Helps

SMART START
FUNDING

	1993-94	1994-95	1995-96	1996-97	1997-98
Appropriation	$20M	$46.7M	$57.3M	$67.4M	$97.4M
# Counties	18	32	43	55	100

1998-99

Local Partnerships	$136,755,828
NC Partnership for Children, Inc.	$ 4,400,000
Division of Child Development	$ 905,000
Program Evaluation	$ 850,000
Total:	**$142,910,828***

*Annualizes to $157,077,495 in 1999-00 Continuation Budget

SMART START

EXPANSION BUDGET REQUEST

	1999-00	2000-01
Local Partnerships	$78,928,826	$164,780,766
County Collaboration	$ 1,500,000	$ 1,250,000
Program Evaluation	$ 165,000	$ 297,000
T.E.A.C.H.*	$ 778,000	$ 1,178,000

* Teacher Education And Compensation Helps

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-21, 1999 (afternoon meeting)
Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Julie Robertson	NCPC
Helen Lipman	Mech Co.
Wanda Mandeville	DHHS (Budget, Planning + Analysis)
Roslyn Sawitt	NC Child Care Coalition
by Avent Farmer	DHHS / DCD
Stephanie Fanyul	" "
Monica Hans	NCPC
Denny Cobb	NCPC
Ashley D. Thrift	NCPC
Thabiti Anyabwile	NCPC
Pam Seamans	NC Social Services Consortium & Covenant w/ NC's Children
[illegible]	OSBM
Anne Tefft	OSBM
Jack Meeff	Mayor of Dimet
Sue Russell	Day Care Services Assn
Ashley Westbrook	Governor's office
Ed Regan	N.C. Assoc. of Co. Comm.
K Chestes	NC ICC
[illegible] Howell	Gov's Office

AGENDA

Joint Subcommittee on Health and Human Services Appropriations

Legislative Office Building - Room 424
Thursday, April 22, 1999
8:30 a.m.

Opening Remarks	Sen. Bill Martin, Co-Chair Rep. Beverly Earle, Co-Chair Rep. Edd Nye, Co-Chair
Welfare Reform & Work First Overview	Karen Hammonds-Blanks, FRD Pheon Beal, DHHS
Governor's Temporary Assistance for Needy Families Block Grant Plan	Kevin FitzGerald, DHHS
Governor's Social Services Block Grant Plan	Kevin FitzGerald, DHHS
Governor's Child Care Development Block Grant Plan	Stephanie Fanjul, DHHS
Adjourn	

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

MINUTES

APRIL 22, 1999

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Thursday, April 22, 1999, at 8:30 a.m. in Room 424 of the Legislative Office Building.

House Co-Chair, Representative Beverly Earle presided. Other House members present were:

Representative Edd Nye, Co-Chair
Representative Martha Alexander, Vice-Chair
Representative Alma Adams
Representative Lanier Cansler
Representative Theresa Esposito
Representative Trudi Walend
Representative Gene Wilson

Five Senate members were present.

Representative Beverly Earle called the meeting to order at 8:30. Pages were introduced and the meeting began with a brief overview from Karen Hammonds-Blank, Fiscal Research, on Welfare Reform. She began by stating that she would be talking on four subjects, Pre-Welfare Reform AFDC/Entitlement, 1996 Governor's Waiver, 1996 Federal Welfare Reform and the 1997 & 1998 NC Legislative Reform. (See Attachment II) In concluding the first part of her presentation, Karen Hammonds-Blank stated that a two-year plan for Welfare Reform would be coming before the General Assembly for approval.

The next presenter was Pheon Beal from the Department of Health and Human Services, to give a Work First overview. She began with the goals of the Work First Program. The primary goal for Work First is employment. The most successful goal for the program is for an applicant for public assistant to avoid the need to become a recipient. Ms Beal spoke on the Work First caseloads, the length of time families have been on Work First from January 1995 through January 1999, and the Work First families on the two year time clock as of February 1, 1999. (See Attachment III) In concluding her presentation she stated that changes have been made, but there are still a lot of goals to be accomplished.

At this time the meeting focused on Karen Hammonds-Blank. With the next handout, Karen talked about Temporary Assistance For Needy Families (TANF) Block Grant. She gave a complete overview of all changes that were made, and spoke on all the programs that are currently in progress. She also gave an overview of the Work First Budget FY98/99. She spoke briefly on the Maintenance of Effort (MOE) and their requirements. (See Attachment IV)

At the end of the presentation, it was announced by the Co-Chair, Rep. Beverly Earle that the committee would meet again today 15 minutes after the last body adjourned.

The meeting adjourned at 9:55 a.m.

Respectfully submitted,

Presiding Co-Chair, Rep. Beverly Earle

Ann Raeford, Committee Clerk

Attachment I	Agenda
Attachment II	Welfare Reform
Attachment III	Work First Program Goals
Attachment IV	Work First Programs (TANF) Block Grant
Attachment V	Visitor Registration

Attachment II
4-22-99

Karen Blank
Hammond

DIVISION OF SOCIAL SERVICES

WELFARE REFORM

Pre-Welfare Reform AFDC/Entitlement	1996 Governor's Waiver	1996 Federal Welfare Reform	1997 & 1998 NC Legislative Reform
Statewideness	Demonstration Counties	N/A	Standard/Electing Counties
Cash Assistance Mandated	Cash Assistance	Flexibility	Cash Assistance
Some Work Requirements	Some Work Requirements	Specific Work Participation Goals	Specific Work Participation Goals
Emphasis on Regulatory Role & Provision of Cash Assistance	Emphasis on Changing Philosophy (Work/Intensive Training)	Emphasis on Personal Responsibility & Work	Emphasis on Personal Responsibility, Work & Services
No Time Limits	2-Year Time Limits	5-Year Lifetime Limit	2-Year Time Limits
Human Investment Philosophy	Work First Philosophy	Work First	Work First
Matching Requirements	Matching Requirement	80% MOE	100% State & County MOE
Emphasis on Rules	Relaxation of Rules	Further Relaxation of Rules	Flexibility
State Plan	Waiver	Biennial State Plan	Biennial State Plan

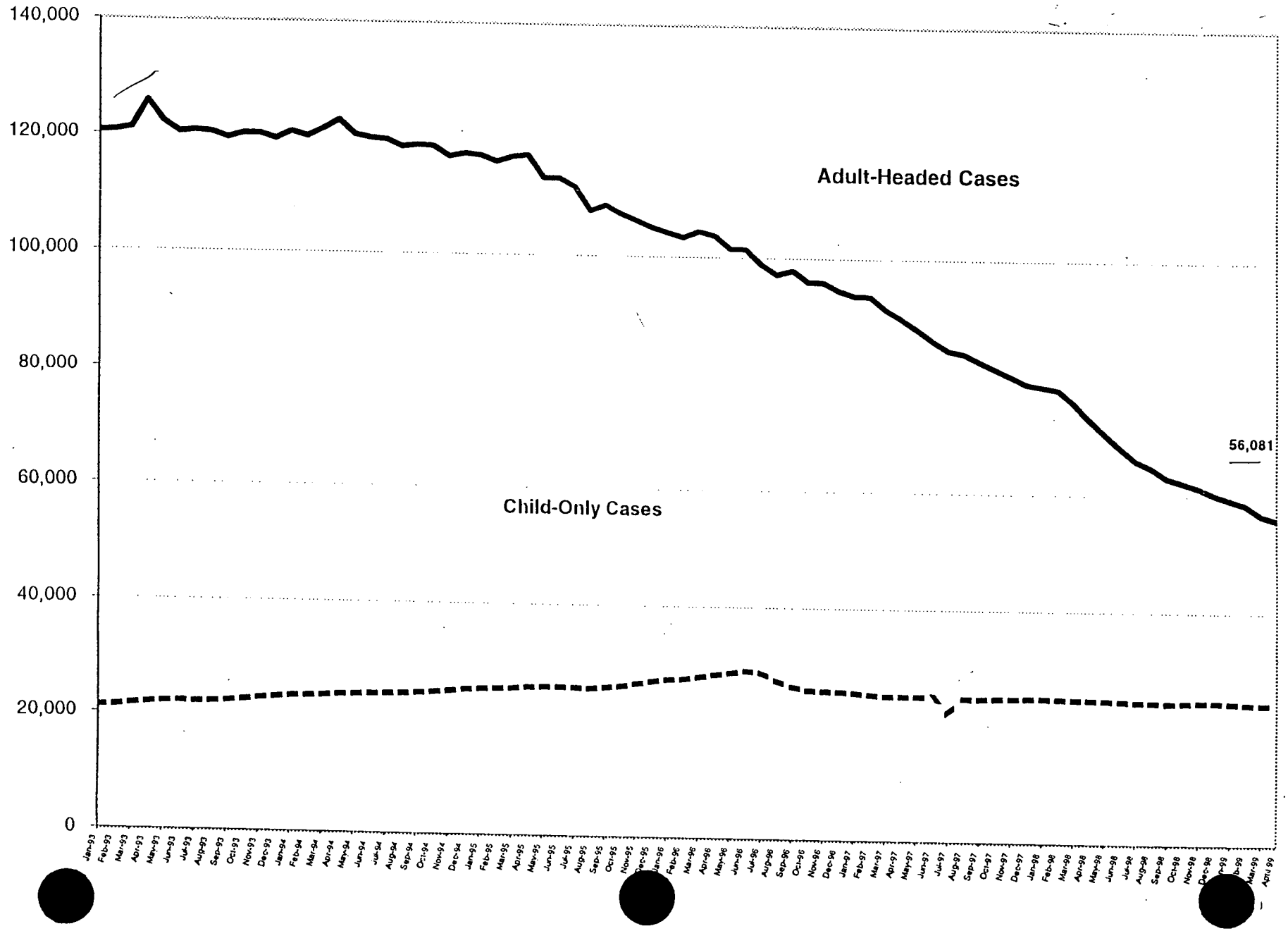
Attachment III
Pheon Beal

WORK FIRST PROGRAM GOALS

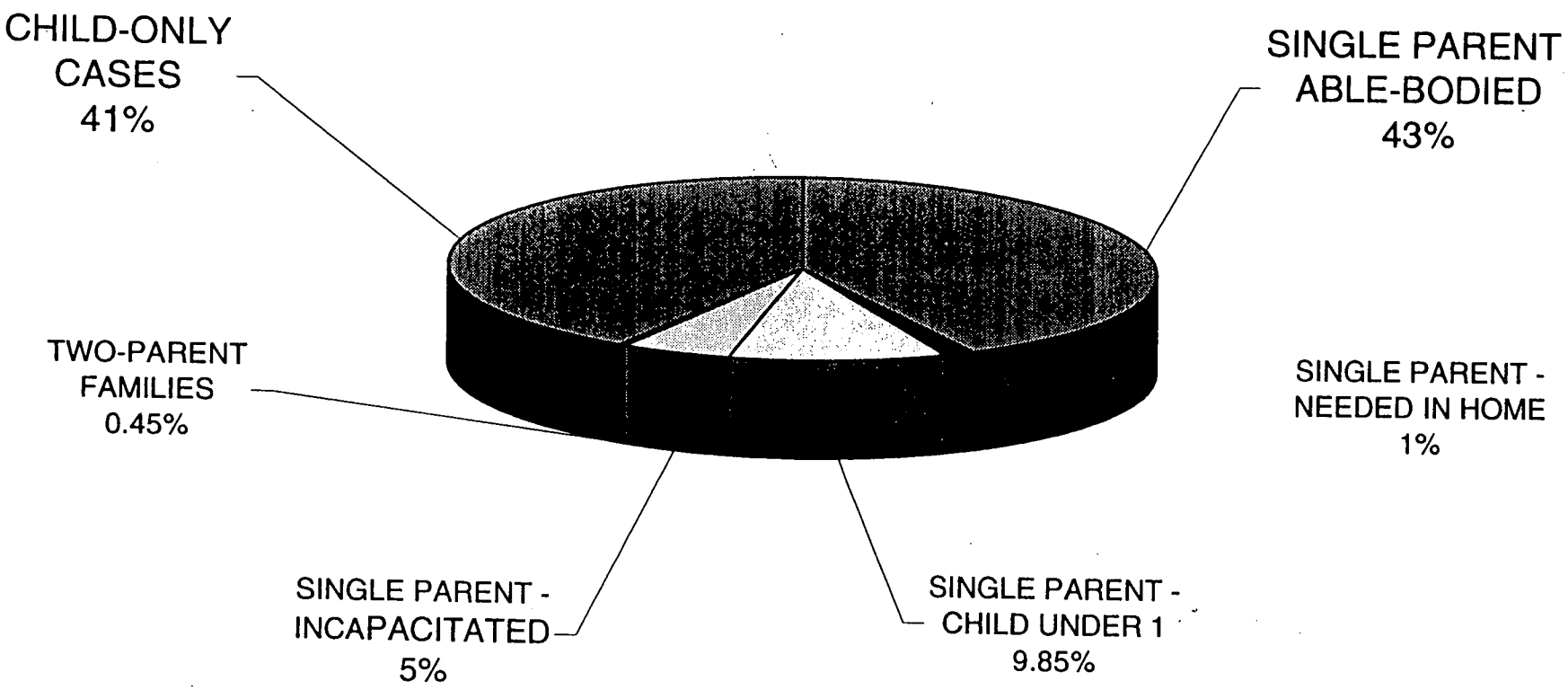
4-22-99

Employment	Self-sufficiency and caseload reductions will be realized primarily through the employment of Work First clients. The local block grant plan will reflect the number of Work First recipients who should be employed based on the information provided to counties by the Department.
Diversion Assistance	The most successful outcome possible for an applicant for public assistance is to avoid the need to become a recipient. This is also recognized in the federal law, which specifies diversion from public assistance as a desired outcome. Each county's goal is their relative proportion of a state total of 1,000.
Staying Off Welfare	Efforts to reduce welfare rolls, help adults find jobs, and increase self-sufficiency are undermined when families return to welfare. Families leaving Work First will be tracked to determine if they return to cash assistance. The goal is that 85% of those families that leave welfare for work will not be on cash assistance 12 months later.
All Family Federal Participation Rate	Active participation in employment services and activities will lead to full time employment. For FFY 1999, the federal participation rate requires that at least 35% of families must have adults working or participating in federally countable work activities a minimum of 25 hours per week.
Two-Parent Federal Participation Rate	Active participation in employment services and activities will lead to full time employment. For FFY 1999, the federal participation rate requires that at least 90% of families with two able-bodied parents must have adults working or participating in federally countable work activities a minimum of 35 hours per week or 55 hours per week if federally funded child care is provided.
Child Support	An effective child support effort will help prevent families from returning to welfare. New federal changes enhance the ability to pursue support. The key components of this measure are (1) the number of child support orders established, and (2) the dollar amount of each child support collection among Work First families. Each county's goal is to increase each of these measures by 10%.
Child Well-Being	A critical function of every local department of social services is to ensure that children are safe from abuse, neglect and dependency. This goal will measure the percentage of *Work First* children receiving intensive CPS services that have a safety plan in place. 100% is the expectation for all counties. This requirement already exists and will be monitored to ensure compliance.
Caseload Reduction	North Carolina anticipates a steady decline in the overall Work First caseload because of the success of the families at moving to work. Each county is expected to reduce its Work First caseload by 15%.

WORK FIRST CASELOAD OVER TIME
April 1, 1999 Report

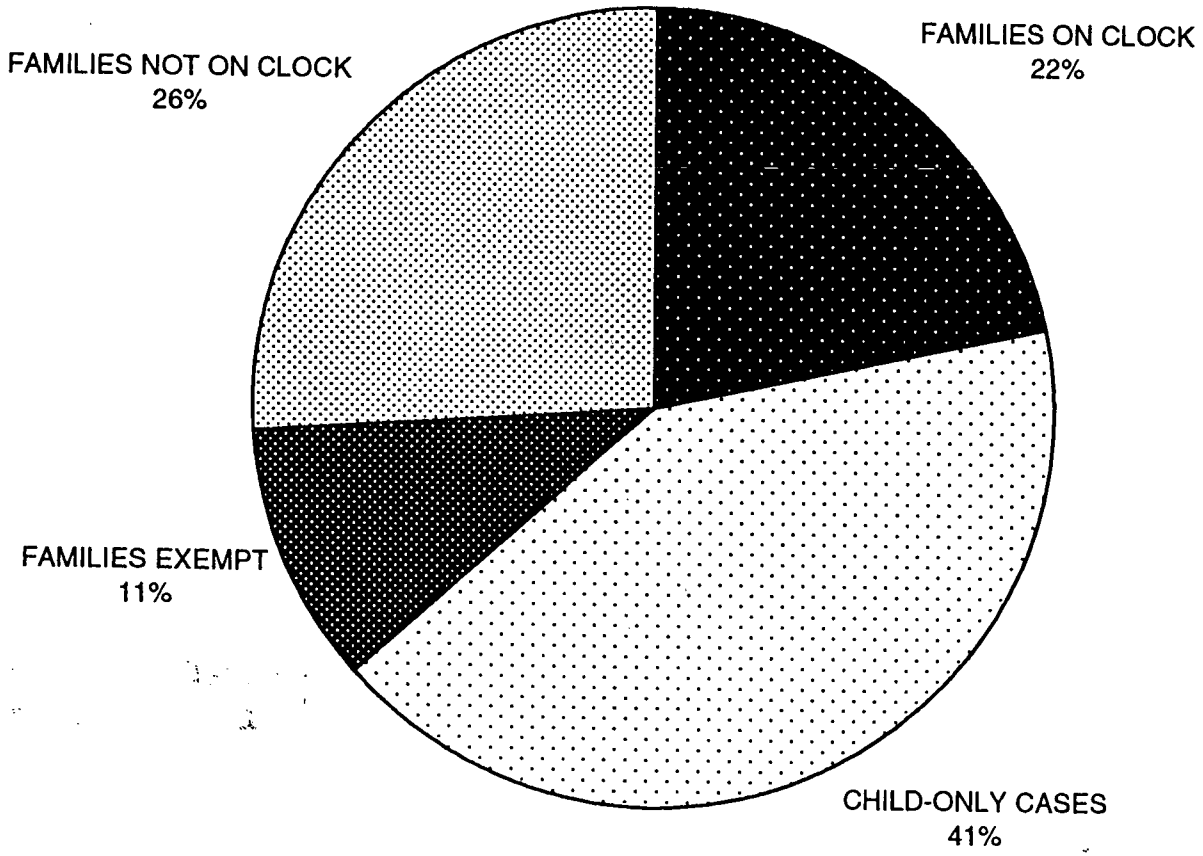


WORK FIRST CASELOAD CHARACTERISTICS
AS OF FEBRUARY 1, 1999



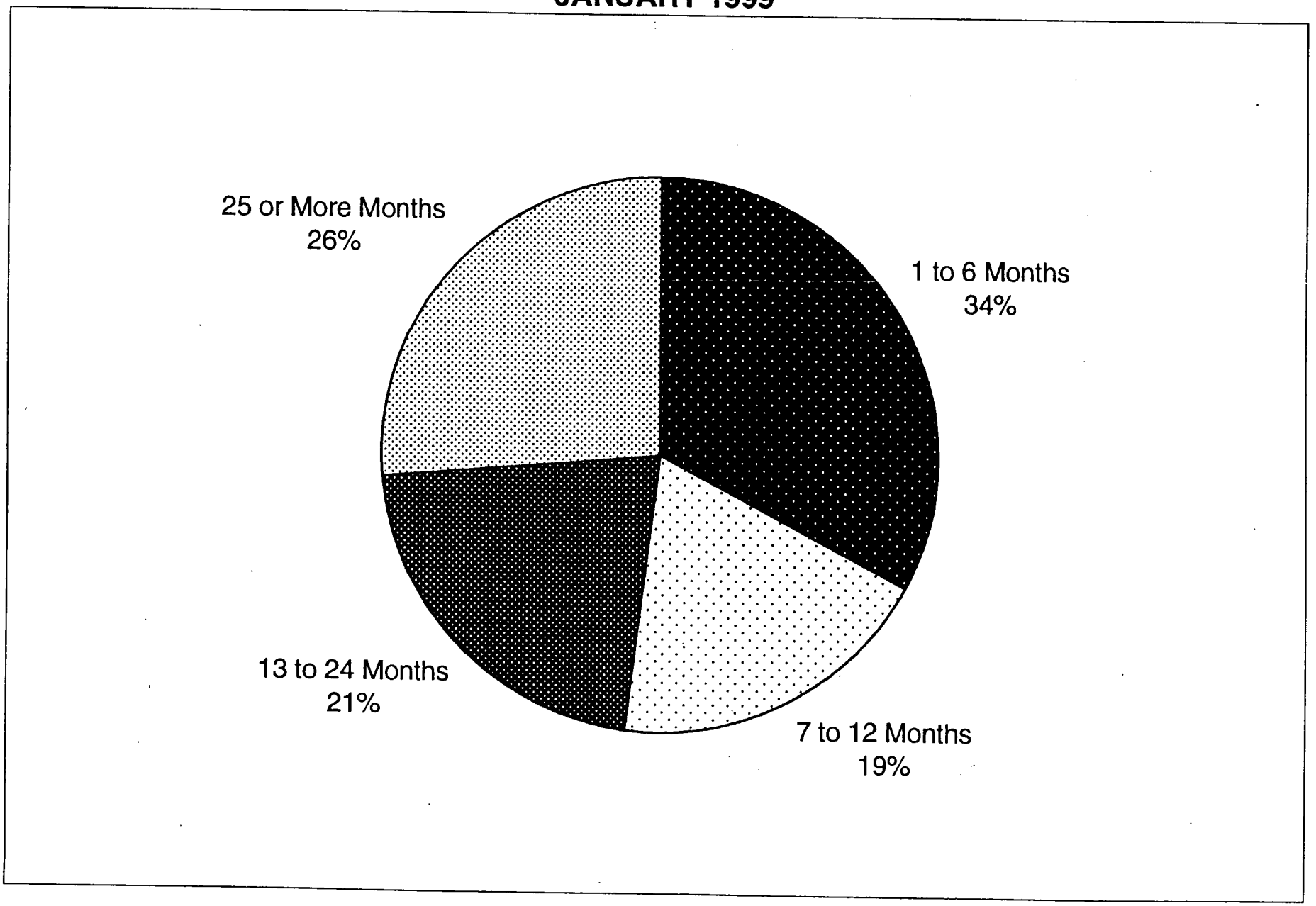
DSS/ECONOMIC INDEPENDENCE
3/2/99

WORK FIRST FAMILIES AND THE TWO-YEAR TIME CLOCK AS OF FEBRUARY 1, 1999



DSS/ECONOMIC INDEPDNDENCE 2/26/99

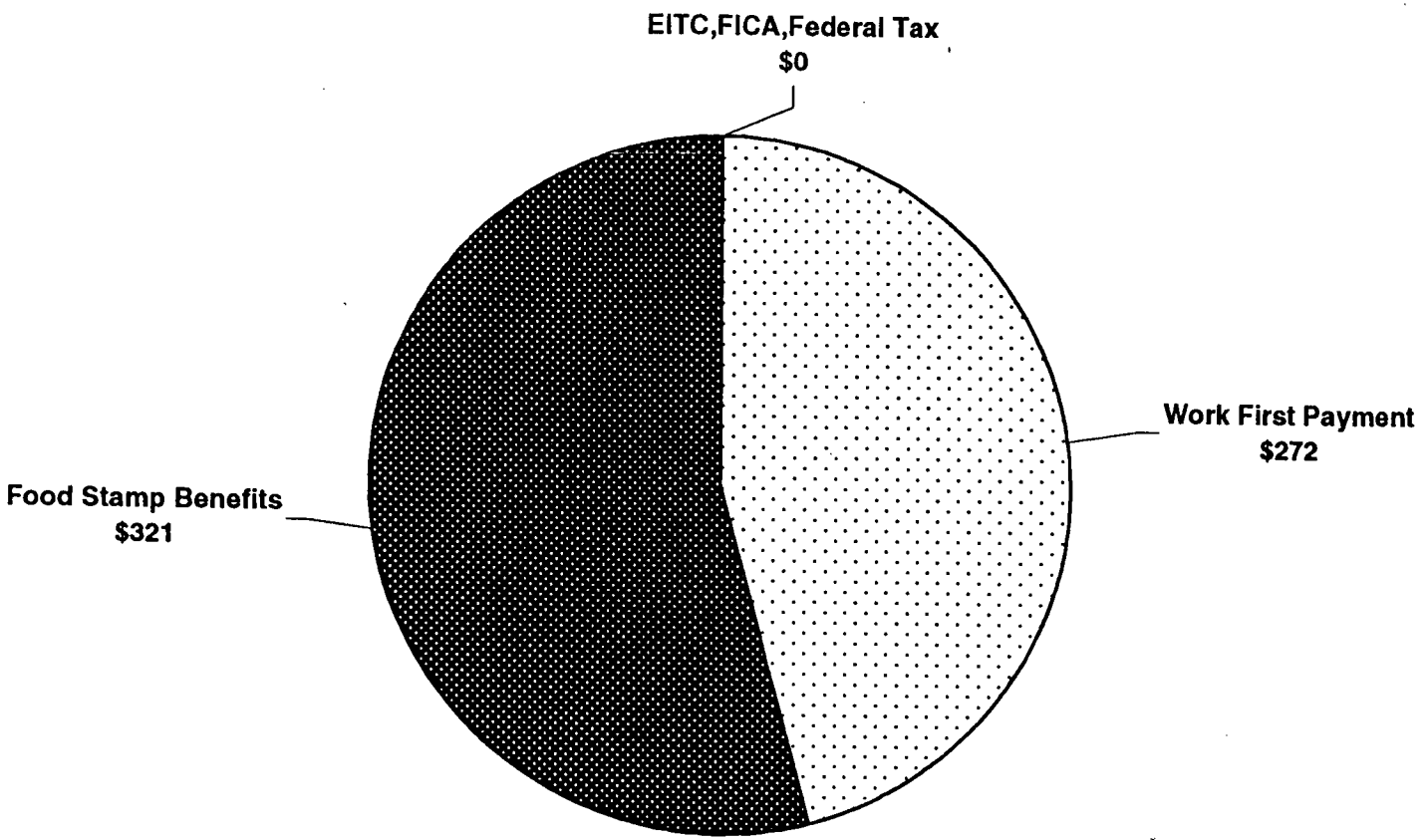
LENGTH OF TIME FAMILIES HAVE BEEN ON WORK FIRST, JANUARY 1995 THROUGH JANUARY 1999



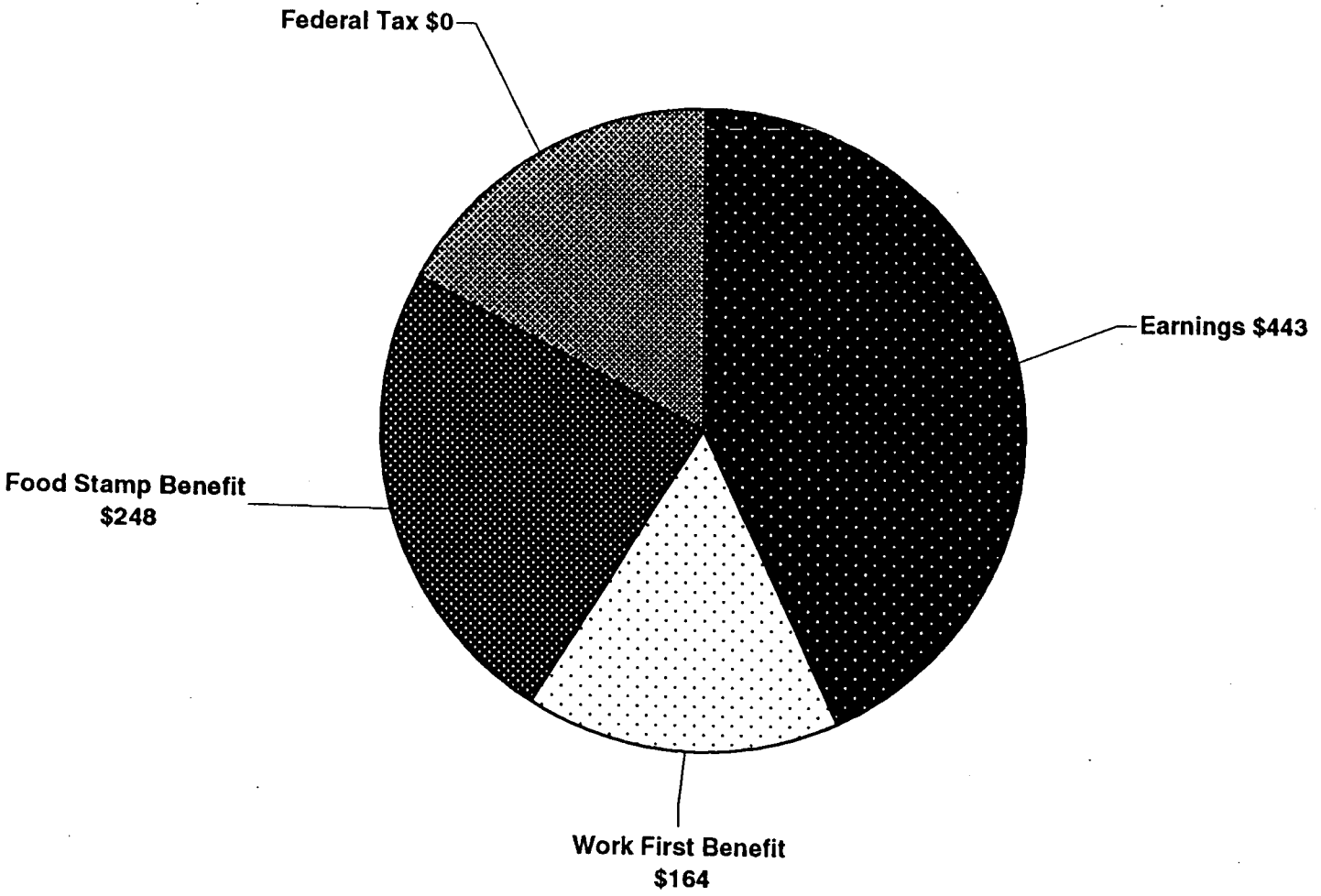
DSS/Economic Independence
2/24/99

Child Care
Housing

Work First Three Person Family With No Earnings
Total Monthly Income $593



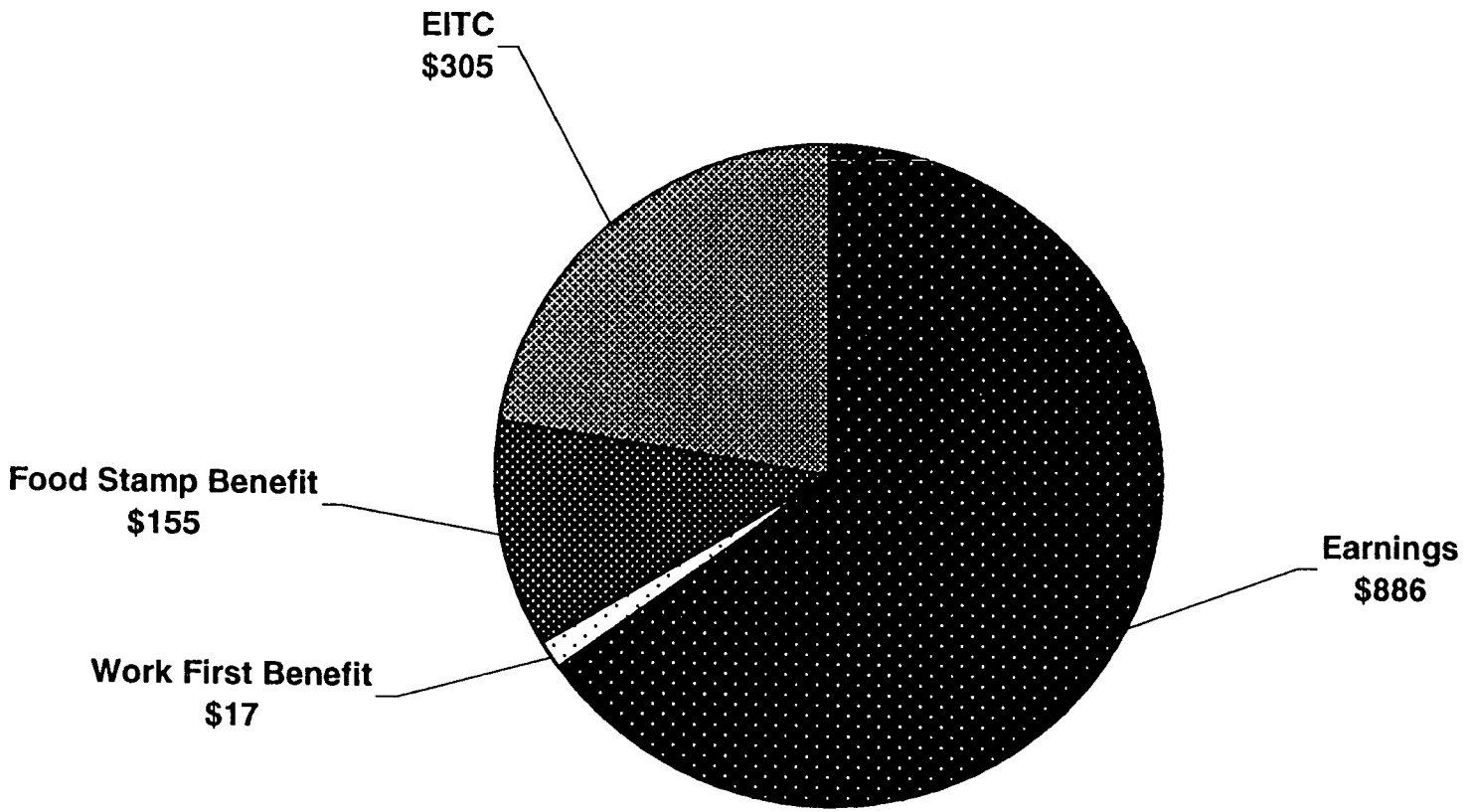
Work First Three Person Family Working 20 Hours Weekly
Minimum Wage: Total Income $1032*



DSS/Economic Independence 3/2/99

*Includes FICA withholding of $34.00

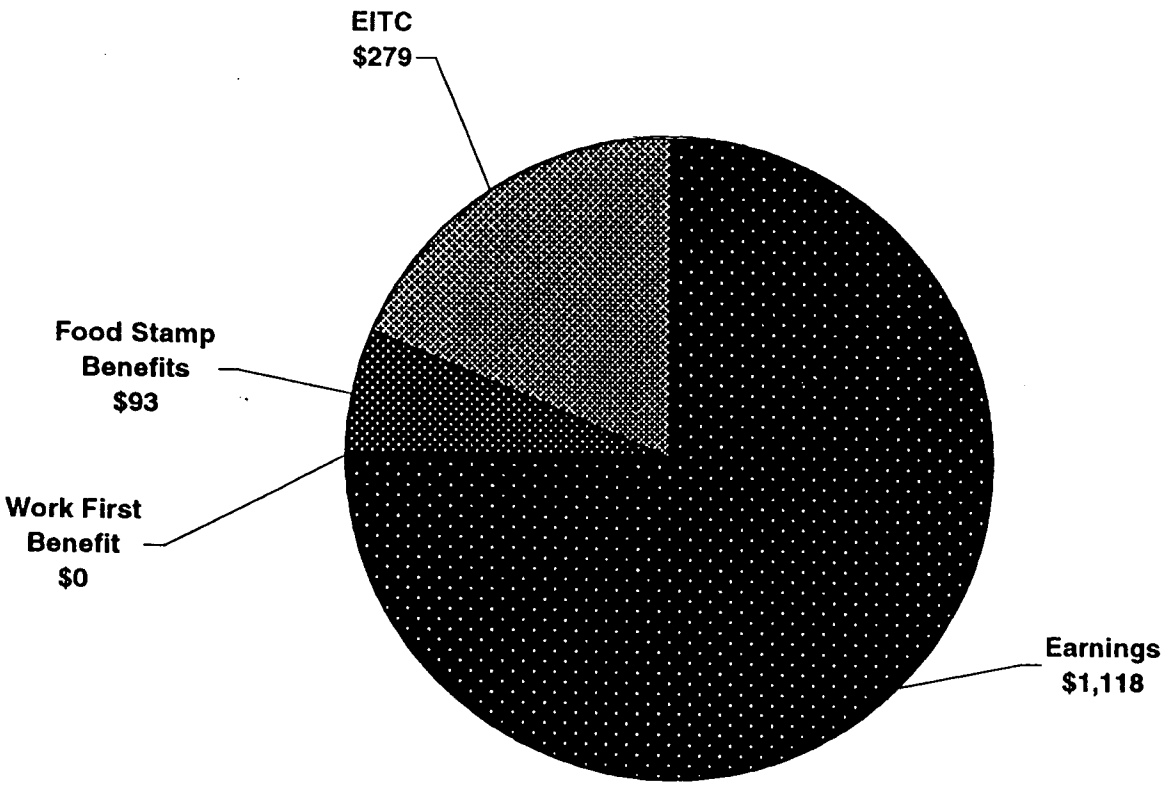
Work First Three Person Family Working
40 Hours Weekly Minimum Wage: Total Income $1,363*



DSS/Economic Independence 3/2/99

*Includes FICA withholding of $68.

Former Work First Family Working 40 Hours Weekly at $6.50/Hr: Total Income $1,490*



DSS/Economic Independence
3/2/99

*Includes FICA withholding of $86.

Attachment IV

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF SOCIAL SERVICES

WORK FIRST PROGRAM

FISCAL RESEARCH DIVISION

APRIL 22, 1999

DIVISION OF SOCIAL SERVICES

ECONOMIC INDEPENDENCE

- Job Corps
- Food Stamps
- **Work First**

- ✓ Helping Young People Complete Their Education and Learn a Skill
- ✓ Helping Low-Income Families Pay for Food
- ✓ Helping Low-Income Households in Crisis
- ✓ Moving Welfare Families to Self-Sufficiency

DIVISION OF SOCIAL SERVICES

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) BLOCK GRANT

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 is the Federal Welfare Reform Initiative Which Focuses on,

- ✓ Ending Welfare Dependence
- ✓ Encouraging the Formation and Maintenance of Two-Parent Families
- ✓ Reducing the Incidence of Out-of-Wedlock Births
- ✓ Providing States Flexibility to Help Achieve These Goals

Federal Requirements for States' Participation in TANF Include,

- ✓ Work Requirements
- ✓ Cumulative 5-Year Lifetime Limit on Benefits
- ✓ 80% Maintenance of Effort
- ✓ ~~Certified~~ State Plan & Data Reporting
  Complete

QSAP

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES BLOCK GRANT

NO.	ITEM	FY98/99
1	Work First Cash Assistance	
1(a)	WF Cash: Standard Counties	$158,500,000
1(b)	WF Cash: Electing Counties	43,787,170
2	WF County Block Grants	60,056,503
3	Transfer to CCDF for CC Centers	500,000
4	Transfer to CCDF for Child Care	66,669,460
5	Allocation to DMH for Substance Abuse activities	3,000,000
6	DSS WF Evaluation	1,000,000
7	DSS for Staff Development	500,000
8	Div of Women's & Children's for Reduction of Out-of-Wedlock Births	1,600,000
9	Allocation to the DMH for Substance Abuse Services	2,300,000
10	SSBG Transfer for Substance Abuse Services for Juveniles	1,182,280
11	SSBG Transfer for Special Children Adoption Fund	300,000
12	N.C. Works Study and Information Systems/ESC	500,000
13	Funding for First Stop/ESC	1,100,000
14	Teen Pregnancy Prevention	2,000,000
15	WF Job Retention Pilots	1,777,529
16	SAS Model Programs	900,000
17	WF Substance Abuse Coordinator	75,000
18	Planning for "Next Step" TANF	150,000
19	ESC W-t-W Initiative	19,000,000
20	Transfer to SSBG for Various Human Services Needs	11,353,956
	TOTAL FEDERAL TANF FUNDS	**$376,251,898**

DIVISION OF SOCIAL SERVICES

WORK FIRST BUDGET FY98/99

TANF

Purpose	Federal	State	Local	TOTAL
Work First (Cash) Standard	158,500,000			158,500,000
Work First (Cash) Electing	43,787,170			43,787,170
Work First County Block Grants	60,056,500	47,092,970	103,106,500	210,256,000
DMH/DD/SAS		23,078,000		23,078,000
State DSS Contracts		2,019,818		2,019,818
State Administration		10,403,610		10,403,610
Child Support		431,504		431,504
Automation		18,746,700		18,746,700
TOTAL	**$262,343,670**	**$101,772,602**	**$103,106,500**	**$467,222,802**

DIVISION OF SOCIAL SERVICES

WORK FIRST FUNDING BY SOURCE

SOURCE	FY98/99	FY99/00	FY00/01	FY01/02
FEDERAL	386,273,697	364,119,968	337,632,005	308,960,000
STATE	91,908,985	88,804,949	88,699,872	91,593,745
COUNTY	101,151,122	99,432,057	99,432,057	99,432,057
TOTAL	**$579,333,804**	**$552,356,974**	**$525,763,934**	**$499,985,802**

FEDERAL WORK FIRST FUNDING

SOURCE:	FY98/99	FY99/00	FY00/01	FY01/02
Base Grant	302,240,000	302,240,000	302,240,000	302,240,000
Supplemental	15,380,000	24,460,000	26,860,000	6,720,000
Carry Forward	68,653,697	37,419.968	8,532,005	0
TOTAL	**$386,273,697**	**$364,119,968**	**$337,632,005**	**$308,960,000**

Projections

DIVISION OF SOCIAL SERVICES

WORK FIRST COUNTY BLOCK GRANTS

	FY97/98 Actual	FY98/99 Budget	FY98/99 (YTD) (Through Feb. '99)	FY99/00 (Gov's Proposal)
FEDERAL	$50,811,743	$60,056,503	$24,911,700	$62,086,434
STATE	$24,362,119	$47,092,968	$10,883,219	$41,508,333
COUNTY	$68,354,687	$103,106,504	$58,664,786	$99,432,057
TOTAL	**$143,528,549**	**$210,255,975**	**$94,459,705**	**$203,026,824**

TANF Mandated Activities Include,

- ✓ Employment Services -
- ✓ Transportation -
- ✓ Child Care -
- ✓ Educational Assistance -
- ✓ Participant Cost -
- ✓ Case Management -
- ✓ Diversion Assistance -

Optional Activities Include,

- ✓ Child Protective Services -
- ✓ Services to Child Only Cases -

DIVISION OF SOCIAL SERVICES

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) BLOCK GRANT

Maintenance of Effort (MOE)

Two Maintenance of Effort Requirements,

1. ***Federal** TANF - Which Allowed States to Choose Which Fiscal Year Period to Base the TANF Block Grant and Corresponding/Required Spending Level*

2. ***State** Work First MOE - Which Requires Counties to Appropriate Local Funds at the Same Level of FY96/97.*

Federal MOE	State	County
80% of FFY94 Actual Expenditures	100% of Budgeted FY96/97	100 % of Budgeted FY96/97
$164,454,147	$114,812,599	$103,106,504

DIVISION OF SOCIAL SERVICES

ANALYSIS OF FEDERAL TANF MAINTENANCE OF EFFORT REQUIREMENT

Item/Activity	FFY98 (Actual)	FFY99 (YTD)	FFY99 Projected*
Cash Assistance/Other	16,030,679	80,180	131,033
WF County Block Grants	99,434,286	44,331,774	109,158,482
DMH/DD/SAS	137,041	0	0
Division of Child Development	48,002,108	123,033	33,720,877
State Administration	6,542,776	3,556,786	7,682,809
New Items	0	0	20,400,000
TOTAL	**$170,146,890**	**$48,091,773**	**$171,093,201**
FEDERAL MOE	**$164,454,147**	**$164,454,147**	**$164,454,147**
DIFFERENCE	**(5,692,743)**	**116,362,374**	**(6,639,054)**

NOTE: *Preliminary Estimates Provided by DHHS Contract/Consultant

DIVISION OF SOCIAL SERVICES

COUNTY FISCAL FLEXIBILITY UNDER WELFARE REFORM

CATEGORY	STANDARD	ELECTING
A. Who Pays?		
--Cash Assistance	Federal	Federal
--County Block Grant	Federal/State/County	Federal/State/County
B. Participation Rate	Varies	Varies
C. Who Administers?		
--Cash Assistance*	State	State
--County Block Grant	Counties	Counties
D. Funds Advanced for Block Grant:		
--Federal	NO	NO
--State	NO	YES
--County	N/A	YES
E. Block Grant Reversions		
--Federal	NO	NO
--State	NO	YES
--County	N/A	YES

Note:

*As per G.S. 108A-27.11(c) Electing Counties' cash is constant.

DIVISION OF SOCIAL SERVICES

WORK FIRST/TANF ISSUES

- President's Proposed Budget
- Establishment of Programs Built on Declining TANF Funds
- Uncertainty of Work First Services Expenditures/Needs
- Meeting TANF Maintenance of Effort Requirements

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-22 **1999**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NCDHHS-DSS
JoAnn Lamm	NCDHHS-DSS
Megan Snyder	Easter Seals
Adele Faschelis	Easter Seals
Jeff Smith	Easter Seals
Bryant Edgerton	Easter Seals
[illegible]	Child Support Enf.
Blaine Miller	" " "
Gerald K. Robbins	DOJ
Flo Stein	DMH/DD/SAS
[illegible]	DMH/DD/SAS
Patricia Lawler	NCACC
Carl Pruette	DHHS - DSB
Helen Lipman	Mecklenburg Co.
Ben Watts	DHHS - DSS
[illegible]	NC Council
Sonya Toman	NC DHHS - DSS
Adolph Simmons, Jr	NC DHHS - Division of Social Services
[illegible]	PPAB
Chuck Harris	DHHS/DSS
Brenda Williamson	Commerce/DET
[illegible]	DHHS/DVR
Neal Rosegand	OSBM
[illegible]	DHHS/DCD
[illegible]	dhhs - dcd
Wanda Mandrilla	DHHS - Budget, Planning & Analysis
Anna Toft	OSBM
Anne Scharff	DCD-DHHS

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4-22, **1999**
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible signature]	NCDSS
Al Deitch	DOA/IAFD
Scott Johnson	DHHS BP&A
Gary Fuquay	DHHS -
[illegible signature]	DHHS
[illegible signature]	DHHS - DSS
[illegible signature]	DHHS
[illegible signature]	"

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

MINUTES
APRIL 22, 1999

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Thursday, April 22, 1999, at 6:40 p.m. in the Legislative Office Building.

House Co-Chair, Representative Beverly Earle presided. Other House members present were:

Representative Edd Nye, Co-Chair
Representative Lanier Cansler
Representative Trudi Walend
Representative Gene Wilson

Only one Senate member was present.

Representative Beverly Earle, Co-Chair, called the meeting to order by announcing that there will be three brief presentations. Kevin Fitzgerald was the first presenter. He began by stating the intent of TANF, which is to provide federal funds to help people achieve and maintain a greater degree of economic self-sufficiency. Mr. Fitzgerald spoke on the Temporary Assistance For Needy Families Block Grant. (TANF) (See Attachment I) He highlighted on how the Federal dollars would be spent. He stated that Child Care was the most important component of services to families to remain in the work force. He gave twenty one recommendations to be used to when the federal law governing the TANF allows the state to transfer up to 30% of the grant per year to the Child Care Development Fund and to the Social Services Block Grant. The recommendations were explained in details and questions were asked. (Attachment I)

Part two of his presentation pertained to the Social Services Block Grant (SSBG). The Social Services Block Grant is intended to provide federal funds which support helping people achieve or maintain a greater degree of economic self-support, preventing abuse or exploitation of children and adults who are unable to protect their own interests. At this time he gave the twenty-five recommendations of transferring funds into the Social Services Block Grant. (See Attachment II)

The next presenter was Ms. Stephanie Fanjul, Division of Child Development. Ms. Fanjul gave an overview of the Child Care and Development Fund Block Grant. She stated that there is a connection between the Child Care Block Grant and the Social Service Block Grant.

The purpose of this funding is to provide subsidies to low-income working families. She spoke briefly on how the dollars are divided. (See Attachment III)
On her second handout, she spoke on Child Care Statistics from January 94 through January 99. (See Attachment IV) The committee received questions and comments.

The meeting was adjourned.

Respectfully submitted,

Presiding Co-Chair, Representative Beverly Earle

Ann Raeford, Committee Clerk

Attachment I	Temporary Assistance For Needy Families Block Grant
Attachment II	Social Services Block Grant
Attachment III	Child Care And Development Fund Plan
Attachment IV	Child Care Statistics Jan 94 – Jan 99
Attachment V	Visitor Registration

Attachment I Part I
April 22, 1999 6:40pm meeting
Presenter - Kevin

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES BLOCK GRANT (TANF)

The Temporary Assistance for Needy Families (TANF) Block Grant is a two year-old grant from the Federal government created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L 104-193). The grant was created by combining several former entitlement programs into one capped grant: Aid To Families With Dependent Children (AFDC), Job Opportunities and Basic Skills (JOBS), AFDC Emergency Assistance cash and services (AFDC-EA), and AFDC state and county administration. Amounts provided to states were determined based on FFY 1995 expenditures for the programs combined into the TANF grant, with additional funds provided to states, including North Carolina, which have above-average population growth and below-average cash benefit levels.

For the State Fiscal Year 1999-2000 the TANF Block Grant funding level is projected to be $364.119.968 as is shown on page 4.

GENERAL DESCRIPTION

The Temporary Assistance for Needy Families Block Grant is intended to provide federal funds to help people achieve and maintain a greater degree of economic self-sufficiency, through a combination of cash assistance; case management, employment and training services; system automation and administrative expenses in support of service delivery; and other activities intended to reduce and prevent welfare dependency and promote self-sufficiency. In addition, purposes of the TANF funds are to provide assistance to needy families so that children may be cared for in their own homes or in the homes of relatives; to prevent and reduce and incidence of out-of-wedlock pregnancies; and to encourage the formation and maintenance of two-parent families. As a result of the inclusion of the former AFDC-Emergency Assistance program, the TANF block grant also funds a significant portion of North Carolina's child welfare system.

North Carolina has realized significant success in helping parents go to work and leave the welfare roles. The TANF Block Grant funds will continue to be focused on this issue. However, job retention and advancement is a critical issue that needs attention so that families can stay off welfare once they leave. Part of the funds within this block grant are proposed to be used to help meet the rapidly growing demand for day care services for children of families moving to work. Child care is critical to assisting families enter employment and it is vitally important that these services be available to assist families in keeping their job. In addition, many families have a parent who is a substance abuser. This poses a barrier to initial employment and limits job retention. Therefore, we have proposed reinvestments into substance abuse screening, testing and treatment. These TANF reinvestments will also be supported with increased Substance Abuse Prevention and Treatment Block Grant funding in 1999-2000. Appropriate and affordable housing for low-income families and those who are newly employed is important in helping parents stay employed and

helping families stay together. Therefore, we have proposed significant reinvestment of funds to deal with the housing issue.

We have also proposed funding efforts by local health departments to prevent out-of-wedlock births, as called for in the federal legislation.

In order to test innovative strategies for assisting families to achieve self-sufficiency, we propose continuation of funding for implementation of special demonstration projects aimed at job retention and follow-up and the development of new projects. The funds would be awarded on a grant basis to counties and other providers interested in conducting such special demonstrations and projects. We have also proposed funding for an evaluation of North Carolina's welfare reform efforts and funding for staff development to train State and county staff on welfare reform policies and procedures.

Current federal law governing the TANF grant allows for transfer of up to 30% of the grant per year to the Child Care Development Fund and to the Social Services Block Grant with no more than one-third of the transfers being for SSBG. The proposed transfer these other block grants, as detailed in the following recommendations, are within these parameters.

RECOMMENDATIONS:

1.	Allocation to the state Division of Social Services for payment of cash assistance benefit payments to Work First families. Also for allocation to county Departments of Social Services as partial funding for block grants to counties. Within flexible, locally developed plans, counties will use funds to provide for program eligibility determination and case management services, emergency assistance cash and services, employment and training services, child welfare services, and administration of the program. Balance of county block grant funding to come from State and county funds.	$233,621,434
2.	Transfer to Community Colleges for Pathways program.	$ 500,000
3.	Transfer to the Child Care Development Fund for child care subsidies for former Work First recipients and other working families.	$ 51,669,460
4.	Allocation to Division of Child Development for child care subsidies for Work First cash recipients.	$ 15,000,000
5.	Allocation to the Division of Mental Health/Development Disabilities/ Substance Abuse Services for substance abuse treatment, testing, and counseling services for Work First participants who require such treatment in order to achieve and maintain employment.	$ 3,500,000

6.	Allocation to the State Division of Social Services to provide funds to contract for a short-term and long-range evaluation of North Carolina's implementation of federal welfare reform requirements and the Work First program.	$ 1,000,000
7.	Allocation to the State Division of Social Services to provide funds to train state and county staff on operational changes as a result of Work First and federal welfare reform.	$ 1,000,000
8.	Allocation to the Division of Women's and Children's Health for funds to reduce out-of-wedlock births.	$ 1,600,000
9.	Transfer to the Social Services Block Grant for substance abuse services for juveniles.	$ 1,182,280
10.	Transfer to the Social Services Block Grant to fund the Special Children Adoption Fund.	$ 300,000
11.	Transfer to the Employment Security Commission for the First Stop program.	$ 4,100,000
12.	Transfer to Social Services Block Grant for allocation to the Division of Mental Health/Developmental Disabilities/Substance Abuse Services to award to small-to-medium sized companies who agree to hire Work First participants to develop Enhanced Employee Assistance Programs.	$ 1,000,000
13.	Allocation to the Division of Social Services for Work First Job Retention and Follow Up. Includes funding for the Work First Business Council of $100,000.	$ 1,777,529
14.	Allocation to the Division of Women's and Children's Health for prevention of teen pregnancies.	$ 2,000,000
15.	Transfer to Social Services Block Grant (SSBG) for allocation to the Division of Social Services for Child Caring Agencies.	$ 1,500,000
16.	Transfer to Social Services Block Grant (SSBG) to restore federal funding.	$ 10,199,259
17.	Allocation to the Division of Social Services for housing assistance for Work First and former Work First families.	$ 3,000,000

18.	Transfer to Social Services Block Grant (SSBG) for Child Welfare improvements, including staffing increases at the county Departments of Social Services. Each county will have the necessary staff to recruit, train, and support prospective foster/adoptive families and to provide post-adoption supportive services. In addition, this allocation includes funding to provide appropriate incentives to encourage private child-caring agencies to expand their role in finding safe, permanent homes for foster children.	$ 5,256,773
19.	Allocation to the Division of Social Services for Child Welfare improvements, including expansion of child abuse prevention services and funding to implement a demonstration project in five counties to expand the role of law enforcement in cases of severe child abuse and the role of the community in less serious cases.	$ 4,899,040
20.	Transfer to the Child Care Development Fund (CCDF) for child care rate increases.	$ 12,482,188
21.	Allocation to Central Management and Support to fund a contract with an independent consultant to identify additional sources of maintenance of effort (MOE).	$ 500,000

Total Expenditures:	**$ 355,587,963**
Carry-forward federal fund availability to FY 2000-2001 as permitted by federal legislation.	$ 8,532,005
Total Planned Expenditures and Carryforward	**$364,119,968**

Base TANF Block Grant	$302,240,000
Federal Supplemental Funds	24,460,000
Projected Carry-Forward from FY 99	37,419,968
Total Funds Available:	**$364,119,968**

DIVISION OF SOCIAL SERVICES
ANALYSIS OF TANF BLOCK GRANT PLAN
SFY 1999-2000

Item Number	Title	Actual SFY 97/98	Appropriated SFY 98/99 (SB 1366)	Recommended Amount SFY 99/00	Appropriated/ Recommended Difference	Explanation of Difference
1	County Block Grants & Cash Assistance	$ 276,788,106	$ 262,343,673	$ 233,121,434	$ (29,222,239)	Decrease due to anticipated caseload reductions.
2	Transfer to Community College - Pathways	0	0	500,000	500,000	Currently on plan as 'Transfer to CCDF for Community College Child Care'. See Line 21 below.
3	Transfer to CCDF for child care subsidies.	5,599,759	66,669,460	51,669,460	(15,000,000)	New line item to allow direct charge to TANF for WF Cash recipients.
4	Allocation to DCD for child care of TANF-eligible families.	0	0	15,000,000	15,000,000	New line item to allow direct charge to TANF for WF Cash recipients.
5	Allocation to DMH/DD/SAS for substance abuse treatment services and drug testing.	4,578,624	4,300,000	3,500,000	(800,000)	Reduced to provide funding for other needs.
6	Allocation to DSS for evaluation.	334,481	1,000,000	1,000,000	0	
7	Allocation to DSS for State and County staff development.	218,125	500,000	1,000,000	500,000	Increased to allow additional training needs to be met.
8	Allocation to DWCH for reduction of out-of-wedlock births.	1,600,000	1,600,000	1,600,000	0	
9	Transfer to SSBG for substance abuse services for juveniles.	970,581	1,182,280	1,182,280	0	
10	Transfer to SSBG for Special Children's Adoption Fund.	0	300,000	300,000	0	
11	Transfer to ESC for First Stop.	488,000	20,100,000	4,100,000	(16,000,000)	Reduced to reflect anticipated needs of ESC.
12	Transfer to SSBG for EAP.	0	1,000,000	1,000,000	0	
13	Allocation to DSS for WF Job Retention and Follow-Up.	0	1,777,529	1,777,529	0	
14	Allocation to DWCH for prevention of teen pregnancies.	0	2,000,000	2,000,000	0	
15	Transfer to SSBG for Child Caring Agencies.	0	1,500,000	1,500,000	0	
16	Transfer to SSBG to restore federal funding levels.	0	9,853,956	10,199,259	345,303	Reflects anticipated needs to replace SSBG funds.
17	Allocation to DSS for housing.	0	0	3,000,000	3,000,000	New initiative to provide housing assistance to current and former WF clients.
18	Transfer to SSBG for child welfare improvements.	0	0	5,256,773	5,256,773	New initiative to increase county staffing for foster care / adoptive services.
19	Allocation to DSS for child welfare improvements.	0	0	4,899,040	4,899,040	New initiative to fund Child Welfare system improvements.
20	Transfer to CCDF for rate increase.	0	0	12,482,188	12,482,188	To provide federal funding for market rate increase needed to maintain access to day care for subsidy slots.
21	Transfer to CCDF for Community College Child Care	500,000	500,000	0	(500,000)	See line 2 Above.
22	Planning for "Next Step"		150,000	0	(150,000)	Reduced to provide funding for other needs.
23	WF Substance Abuse Coordinator		75,000	0	(75,000)	Service to be funded with increased federal funds in the Substance Abuse Prevention and Treatment Block Grant
24	WF Substance Abuse Model		900,000	0	(900,000)	Service to be funded with increased federal funds in the Substance Abuse Prevention and Treatment Block Grant
25	Allocation to ESC for Labor Market		500,000	0	(500,000)	Non-recurring award in 1999-00.
26	Allocation to Central Management & Support for contract t to identify additional Maintenance of Effort (MOE)		0	500,000	500,000	NR funds. Service will ensure that NC does not lose federal TANF or Welfare-to-Work funds
	TOTAL	$ 291,077,676	$ 376,251,898	$ 355,587,963	$ (20,663,935)	

Attachment II Part 2
Presenter - Kevin

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES

SOCIAL SERVICES BLOCK GRANT (SSBG)

For the State Fiscal Year 1999-2000 the Social Services Block Grant (SSBG) funding level is projected to be $71,840,552 as is shown on page 3. This includes three fourths (75%) of the FFY 2000 block grant ($39,301,680), one fourth (25%) of the FFY 99 block grant ($13,100,560), and a transfer from the Temporary Assistance for Needy Families (TANF) Block Grant in the amount of $19,438,312. Transfer We have estimated the FFY 2000 Social Services Block Grant funding level at the same level as FFY 99, $52,402,240. The Federal funding available for SSBG was significantly reduced in FFY 99. The Base President's budget for FFY 2000 includes a proposal to restore SSBG to its original funding level but due to uncertainty regarding that proposal, we have not projected the impact of that funding restoration in this plan.

GENERAL DESCRIPTION

The Social Services Block Grant is intended to provide federal funds which support helping people achieve or maintain a greater degree of economic self-support or self-sufficiency, preventing abuse or exploitation of children and adults who are unable to protect their own interests, and preventing inappropriate institutional care or securing appropriate institutional care when other forms of care are not appropriate.

The primary providers of these services are the one hundred county departments of social services. These funds are mostly being used for mandated services such as foster care services for adults and children, protective services for adults and children, and adoption services. Other uses of these funds include day care for child welfare cases, community-based services for elderly and disabled adults (such as in-home aid services, adult day care, and preparation of meals), mental health services, and other human services programs. Increasing demands for services in these areas and anticipated federal cuts are addressed in the plan through transfers from the TANF block grant.

RECOMMENDATIONS

1.	Allocation to the 100 county departments of social services for basic/mandatory services. Includes Transfer from TANF of $4,500,000.	$	30,395,663
2.	Allocation for in-home services provided by county departments of social services.	$	2,101,113

3.	Allocation to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services for residential treatment, day treatment, ADAP, and developmental day care services, related cost of administration, and Community Living Skills Program.	$	4,764,124
4.	Allocation to the Division of Services for the Blind for case management, chore and independent living services, and related costs of administration.	$	3,205,711
5.	Allocation to the Office of Juvenile Justice for therapeutic residential, therapeutic camping, intensive treatment program (STEP), and One-on-One volunteer services.	$	950,674
6.	Allocation to the Division of Facility Services for Adult Care Home licensure staff. This includes $83,495 previously presented on line 10 – Administration.	$	426,836
7.	Allocation to the Division of Aging for the Home and Community Care Block Grant for persons age 60 and older, for training and education, and for respite care services. Decrease	$	1,915,234
8.	Allocation to the Division of Child Development for the purchase of day care by county departments of social services and state level contracts. Includes Transfer from TANF of $5,699,259.	$	10,971,241
9.	Allocation to the Division of Vocational Rehabilitation Services - United Cerebral Palsy.	$	71,484
10.	Allocation to the Division of Social Services to support direct and indirect state and regional administration.	$	1,870,742
11.	Allocation to the Division of Social Services for the Child Medical Evaluation Program.	$	238,321
12.	Allocation to county departments of social services for Adult Day Care Services.	$	2,255,301

13.	Allocation to county departments of social services for Child Abuse/Prevention and Permanency Planning	$	394,841
14.	Transfer to the Preventive Health Block Grant for the Emergency Medical Services Program in the Division of Facility Services, including the Trauma Registry.	$	213,128
15.	Transfer to the Preventive Health Block Grant for AIDS education, counseling and testing.	$	66,939
16.	Transfer to the Department of Administration for the N.C. Commission of Indian Affairs In Home Services Program for the elderly.	$	203,198
17.	Allocation to the Division of Vocational Rehabilitation - Easter Seals Society.	$	116,779
18.	Allocation to the Division of Social Services for the UNC-CH CARES Program for training and consultation services.	$	247,920
19.	Allocation to the Division of Public Health Services for community-based services designed to reduce maternal and infant mortality and morbidity and to promote the health of mothers and children.	$	239,261
20.	Allocation to the Office of the Secretary - Office of Economic Opportunity for N.C. Senior Citizens' Federation for outreach services to low-income elderly.	$	41,302
21.	Allocation to county departments of social services for Child Welfare improvement initiatives. Includes Transfer from TANF of $300,000.	$	2,211,687
22	Transfer from TANF to DMH/DD/SAS for juvenile substance abuse offenders	$	1,182,280
23	Transfer from TANF to DMH/DD/SAS for Enhanced Employee Assistance Programs for Work First participants and other low-income employees	$	1,000,000
24	Transfer from TANF to Division of Social Services for Child Caring Agencies.	$	1,500,000

25	Transfer from TANF to Division of Social Services for Child Welfare improvements, including staffing increases at county DSS agencies to support recruitment, training, and supportive services for prospective foster/adoptive families; funding for Child Caring Agencies to expand their roles in finding safe, permanent homes for foster children.	$	5,256,773
	TOTAL	$	**71,840,552**
SOURCE OF FUNDS:			
	SSBG FFY 1999	$	13,100,560
	SSBG FFY 2000	$	39,301,680
	Transfer from TANF	$	19,438,312

DIVISION OF SOCIAL SERVICES
ANALYSIS OF SSBG BLOCK GRANT
SFY 1999-2000

Item Number	Title	Appropriated SFY 98/99 (SB 1366)	Recommended Amount SFY 99/00	Appropriated/ Recommended Difference	Explanation of Difference
1	County Departments of Social Services	30,395,663	30,395,663	0	
2	Allocation for In-Home Services	2,101,113	2,101,113	0	
3	Allocation to DMH/DD/SAS	4,764,124	4,764,124	0	
4	Allocation to Division of Services for the Blind	3,205,711	3,205,711	0	
5	Allocation to Office of Juvenile Justice	950,674	950,674	0	
6	Allocation to Division of Facility Services	343,341	426,836	83,495	Correct Funding for ACH Licensure Staffing
7	Allocation to Division of Aging - HCCBG	5,769,190	1,915,234	(3,853,956)	Reduced transfer from TANF in 1998/99
8	Allocation to DCD	10,971,241	10,971,241	0	
9	Allocation to Division of Vocational Rehabilitation - United Cerebral Palsy	71,484	71,484	0	
10	State Administration	1,954,237	1,870,742	(83,495)	Correct Funding for ACH Licensure Staffing
11	Allocation to DSS for Child Medical Evaluation program	238,321	238,321	0	
12	County Departments of Social Services for Adult Day Care	2,255,301	2,255,301	0	
13	County Departments of Social Services for Child Abuse Prevention	394,841	394,841	0	
14	Transfer to Preventive Health Block Grant for EMS	213,128	213,128	0	
15	Transfer to Preventive Health Block Grant for Aids education	66,939	66,939	0	
16	Transfer to Department of Administration	203,198	203,198	0	
17	Allocation to Division of Vocational Rehabilitation - Easter Seals Society	116,779	116,779	0	
18	UNC-CH CARES Program	247,920	247,920	0	
19	Allocation to Div. Of Public Health Services for adolescent pregnancy prevention	239,261	239,261	0	
20	Office of the Secretary - Office of Economic Opportunity	41,302	41,302	0	
21	County Departments of Social Services for child welfare improvements	2,211,687	2,211,687	0	
22	Transfer from TANF for juvenile substance abuse offenders	1,182,280	1,182,280	0	
23	Transfer from TANF for enhanced EAP	1,000,000	1,000,000	0	
24	Transfer from TANF for Child Caring Agencies	1,500,000	1,500,000	0	
25	Transfer from TANF for Child Welfare improvements	0	5,256,773	5,256,773	New item
	Allocation to DMH/DD/SAS for DD Waiting List	6,000,000	0	(6,000,000)	Reduced transfer from TANF in 1998/99
		76,437,735	71,840,552	(4,597,183)	

Attachment III Part 3

DIVISION OF CHILD DEVELOPMENT
CHILD CARE AND DEVELOPMENT FUND PLAN FOR SFY 99-00

GENERAL DESCRIPTION

Stephanie Fanjul
Director of Child Care Services

For State Fiscal Year 1999-2000, federal and state funds available through the Child Care and Development Fund (CCDF) for appropriation are projected to be $185,499,027. In addition, the NC Department of Health and Human Services is proposing to transfer $64,151,648 in federal Temporary Assistance for Needy Families (TANF) funds to the Child Care and Development Fund. Funding for Federal Fiscal Year 1999-2000 is estimated to be $188,549,097 and is anticipated to be available on October 1, 1999.

The purpose of the Child Care and Development Fund is to improve the availability, quality, and affordability of child care. The CCDF is comprised of three funding streams: Mandatory, Matching, and Discretionary. The federal legislation requires that a preponderance of the Mandatory and Matching funds be used to provide child care assistance to families that are receiving public assistance, families that are attempting through work activities to transition off of such assistance, and families that are at risk of becoming dependent on such assistance. A substantial portion of the Discretionary funds must also be used to provide assistance to low-income working families.

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 limits administrative costs (as defined by the Federal Administration for Children and Families) to a maximum of 5% of the total CCDF allocation. The NC Division of Child Development plans to set aside 5% of the federal CCDF funds for administrative costs at the state and local level. Funding not used for administration will be used for child care subsidies.

Also a requirement of the PRWORA, the Division plans to reserve at least 4% of the total CCDF allocation for quality and availability initiatives.

Child Care Services

North Carolina uses CCDF "Services" funding to provide subsidies to low-income working families, support effective implementation of the Subsidized Child Care Program, and subsidize "wrap-around" care for children enrolled in Head Start. Families are eligible for CCDF-funded child care based on income and pay a fee of 7-9% of their income.

Welfare reform, known as Work First in North Carolina, requires able-bodied welfare recipients to work, resulting in a high demand for child care subsidies. The Division of Child Development is charged with administering all subsidized child care programs, including the provision of child care to Work First participants.

Over the past year, the Subsidized Child Care Program (funded primarily through the Child Care and Development Fund) supported families in their transition off public assistance by:

- Providing subsidized care to an average of 16,000 Work First children a month
- Enabling families that moved off Work First to continue to receive subsidized child care as they worked to stabilize their family budgets.

Under the current eligibility policy, the Subsidized Child Care Program also reduced the need for Work First and other public assistance in the first place. At the local level, subsidized child care has been used to divert families from going on Work First and other forms of public assistance.

To meet the demand for subsidized child care from Work First and other low-income working families, DHHS is proposing to continue to transfer TANF funds to CCDF. Transferred funds will supplement the Discretionary funding stream reserved for low-income working families. Coordination between the Division of Child Development and Division of Social Services will continue as Work First is further implemented.

In addition to general child care subsidies, CCDF services funding is used to provide Head Start Wrap Around care -- child care that "wraps around" partial-day Head Start programs to enable parents to work, search for work, or participate in education or training.

Child care services funding supports the *quality* as well as the affordability and availability of child care. Additional funding for CCDF for child care rate increases will be disbursed in such a manner to compensate for quality child care services with the rated license system.

Quality and Availability Initiatives

The need for quality care is critical. Recent studies have demonstrated the importance of brain development in the first three years of life. A safe and nurturing environment that provides the opportunity to learn is crucial to fostering healthy brain development and establishing the foundation for success later in life. In addition, it is important to ensure that the licensed child care system has the capacity to serve all children.

Since 1991 (through the Child Care and Development Fund and its precursor, the Child Care and Development Block Grant), North Carolina has supported initiatives that improve the quality and availability of child care. Examples of ongoing initiatives include: child care resource and referral services; school-age child care (improving quality and expanding available child care spaces); efforts to support inclusion of children with special needs in mainstream child care programs; Child Care Revolving Loan Fund (increasing the supply and quality of child care through low-interest loans to providers); and training and compensation of child care staff.

DCD plans to continue funding for several current activities and expand three areas: efforts to develop a more qualified and stable child care work force; parent outreach; and activities to increase the availability of quality care for infants and toddlers. A major compensation initiative planned for SFY 1999-2000 is NC Cares (Committed to Attracting and Retaining Educated Staff), which is composed of the new T.E.A.C.H. Early Childhood Health Insurance Program for child care facilities that invest in staff education and an expansion of WAGE$ wage supplements for child care staff that invest in their own educations. Parent outreach will also be a major focus, with special emphasis on making parents aware of the components of quality child care through the proposed rated license for child care providers. The Division of Child Development also plans to increase the availability of high-quality infant/toddler care, using new CCDF funds especially designated for this purpose.

DIVISION OF CHILD DEVELOPMENT
CHILD CARE AND DEVELOPMENT FUND PLAN FOR SFY 99-00

CCDF RECOMMENDATIONS	ALLOCATION
1. Allocate funds to local agency for services support and the provision of child care subsidies for low income working and other needy families. This includes funds for automation to support subsidy reimbursement.	$112,624,103
2. Federal law requires states to spend at least 4% of their CCDF allotment for activities to improve the quality and increase the availability of child care. In addition, specific funding amounts of the CCDF have been earmarked for specific quality activities. The quality funds will provide for the continuation of existing projects, such as improving the quality and expanding the options for care of children with special needs and school-age children, providing resource and referral services to parents and providers, promoting provider education and training, and improving the monitoring of child care facilities. New or expanding projects include increasing the availability of information about child care options for consumers and providing funding for the T.E.A.C.H. Early Childhood Health Insurance Program and Child Care WAGE$ supplements through NC Cares.	$11,378,046
3. Limit administrative costs of lead agency and local agencies which administer the child care subsidy program to 5% of the total CCDF allocation.	$6,526,429
4. Transfer funding from TANF to CCDF for child care services for former Work First recipients and other low income working families.	$51,669,460
Transfer funding from TANF to CCDF for child care rate increases and quality initiatives.	$12,482,188
The majority of the TANF funds will be used for child care subsidies. The transferred funds are subject to the same requirements that apply to all other CCDF funding (minimum of 4% for quality; 5% cap on administration).	
5. Designate state funds to maximize available federal funds for child care services and activities.	$54,970,449
TOTAL REQUIREMENTS	**$249,650,675**

SOURCE OF FUNDS	
FFY 98 CCDF	$30,866,895
FFY 99 CCDF	$99,661,683
TANF Transfer	$64,151,648
State Maintenance of Effort (MOE)	$37,927,282
State Matching	$17,043,167

DIVISION OF CHILD DEVELOPMENT
Analysis of Child Care and Development Fund
SFY 1999-2000

Item Number	Title	Actual SFY 97-98	Appropriated SFY 98-99 (SB 1366)	Recommended Amount SFY 99-00	Appropriated/ Recommended Difference	Explanation of Difference
01.	Child care services	$ 107,546,552	$ 108,625,251	$ 112,624,103	$ 3,998,852	Anticipated incr. in matching portion of grant
02.	Quality and availability initiatives	$ 3,064,370	$ 4,774,736	$ 11,378,046	$ 6,603,310	Includes new awards for infant/toddler improvements and anticipated increase in quality set asides
03.	Administrative expenses	$ 2,118,099	$ 5,968,420	$ 6,526,429	$ 558,009	5% of increase in total grant amount
04.	Transfer from TANF Block Grant for child care subsidies	$ 5,599,759	$ 66,669,460	$ 64,151,648	$ (2,517,812)	Proposed decrease in TANF amount in Business Plan; however, $15M of child care expenses will be directly expended to federal TANF funds (not transferred into CCDF), resulting in a net increase in TANF supported child care of $12,482,188.
05.	Transfer from TANF Block Grant for 3 centers at community colleges	$ 500,000	$ 500,000	$ -	$ (500,000)	Activity included in TANF plan for 99-00 is for the Pathways Program at community colleges.
	Totals	**$ 118,828,780**	**$ 186,537,867**	**$ 194,680,226**	**$ 8,142,359**	
	State Requirements			$ 54,970,449		
	Total Requirements			**$ 249,650,675**		

Attachment IV

Child Care Statistics Jan 94 - Jan 99

Child Care Statistics	Jan-94	Jan-99
Number of Children in Regulated Child Care	183,395	210,970
Number of Children in Subsidized Child Care	55,517	86,126
% of Children in Subsidized Child Care*	30%	41%
% of Children in AA Licensed Child Care Centers*	21%	33%
* Of children in regulated child care		
Minimum Wage	$4.25	$5.15
Statewide Market Rates (for center based care)		
- Infants\Toddlers	$368	$424
- 2 year olds	$329	$390
- 3-5 year olds	$303	$368
- School-age children	$301	$346
Subsidy Funds Available	$134.5M	$266.6M
Children on the Subsidized Child Care Waiting List	14,888	11,245

VISITOR REGISTRATION SHEET

EVENING

Appropriations Subcommittee on Health and Human Services 4-22, 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	OSBM
Anna Tefft	OSBM
Wayne Williams	OSBM
NELS ROSELAND	OSBM
Flo Stein	DMH/DD/SAS
Starleen Scott Robbins	DMH/DD/SAS
Jane Smith	DSS
Kevin Ryan	DPH
Adolph Simmons, Jr.	DHHS - Division of Social Services
Sonya A. Toman	DHHS - DSS
JoAnn Lamm	DHHS - DSS
Chuck Harris	DHHS-DSS
[illegible]	NC-Food BANKS
[illegible]	DHHS-DSS
[illegible]	DHHS
[illegible]	DHHS - DCD
[illegible]	" "
Elizabeth Bishop	Voc. Rehab.
Margaret Guen	DHHS - DCD
Anne Scharff	DHHS-DCD
[illegible]	NCATTC-Z
[illegible]	DHHS BP&A
[illegible]	DHHS - DSS-CSE
Rod Sawitt	NC CCC
Patricia A. Yancey	APPCNC/SCSL
Paula S. Wolf	Covenant w/ NC's children

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services , 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Patrice Powell	NCACC
Rheon Beal	DHHS/DSS
Karen E Anders	DHHS/DSS
Nancy Coston	DHHS/DSS
Allyn Duffey	DHHS
Jim Elanton	DHHS
DAVE BELTON	DHHS
Kevin Howell	Governor's office

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
April 23, 1999
8:30 a.m.

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met on Friday, April 23, 1999, in Room 424 of the Legislative Office Building.

Representative Edd Nye presided. House members present were Representative Beverly Earle (Co-Chairman), Representative Martha Alexander (Vice-Chairman), Representative Alma Adams, Representative Lanier Cansler, Representative Trudi Walend, and Representative Gene Wilson.

Chairman Nye called the meeting to order. The following bills were heard and all were reported favorably to the House Appropriations Committee.

Rep. Martha Alexander

HB-599	MATERNITY HOME FUNDS
HB-902	MENTAL HEALTH PROGRAM FUNDS
HB-904	AREA MENTAL HEALTH PROGRAMS FUNDS

Rep. Boyd-McIntyre

HB-313	OSTEOPOROSIS PROGRAM

Rep. Lanier Cansler

HB-70	GENETIC CENTER FUNDS
HB-1310	MD/DD/SA TRAINING BOARDS FUNDS

Rep. Andy Dedmon

HB-1102	AREA MH MERGER FUNDS

Rep. Greg Thompson

HB-927	FUNDS FOR SENIOR CENTER COORD

Rep. Beverly Earle

HB-723	TRAUMATIC BRAIN INJURY FUNDS
HB-733	NEUROBEHAVIORAL TREATMENT FUNDS
HB-747	FOOD BANK FUNDS
HB-1253	EXPAND TRANSITIONAL MEDICAID

Rep. Ruth Easterling
HB-690 SUD PROGRAM FUNDS
HB-1079 HEALTHY CAROLINIANS FUNDS

Rep. Margaret Jeffus
HB-1059 HEALTHY SCHOOLS ACT

Rep. Thomas Justus
HB-47 HEART DISEASE PREV. FUNDS

Rep. Paul Luebke
HB-257 ADULT PROTECTIVE SERVICES FUNDS
HB-1165 SPEC. ASS./INCREASE PERS. ALLOW.
HB-1272 ADULT PROTECTIVE SERVICES FUNDS

Rep. Mary McAllister
HB-167 WORK ORDER DAY PROGRAM FUNDS

Rep. Mia Morris
HB-1062 AREA MENTAL HEALTH PROGRAM FUNDS

Rep. Jane Mosley
HB-1312 PEDIATRIC CANCER FUNDS

Rep. Martin Nesbitt
HB-10 FIRST STEP FARM FUNDS

Rep. Edd Nye
HB-49 TOUCHING CHILDREN'S LIVES FUNDS
HB-58 KEYS REHABILITATION CAPITAL FUNDS
HB-99 CAMP ROYALL FUNDS
HB-100 AUTISM SOCIETY OF NC FUNDS
HB-101 TEACCH FUNDS
HB-643 CHILD-CARING INSTITUTION FUNDS
HB-911 EXPAND AGING SERVICES/FUNDS
HB-1324 EAST ARCADIA FUNDS
HB-1329 INDEPENDENT LIVING FUNDS

Rep. Thomas Wright
HB-141 AIDS PREVENTION FUNDS

Chairman Nye ended the meeting.

Respectfully submitted,

Representative Edd Nye
Chairman

Jo Bobbitt
Committee Assistant

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 4/23, 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Patrice Roesler	NCACC
[illegible]	NC Food BANKS
[illegible]	Arc/NC
Janet Simoneau	NC Council
Beth Melcher	NAMI NC
Megan Sorster	Easter Seals
Vikki Earp	Pediatric Cancer Funds
Dana Reason	Pediatric Cancer Funds
Bryant Edgerton	Easter Seals
Jeff Smith	Easter Seals
Nels ROSELAND	OSBM
[illegible]	OSBM
[illegible]	BIC
C. Porter	B&A.
[illegible]	AHHC
AL DEITCH	DDA/YAIO
Mike Wilkins	Speakers Office

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

MINUTES
MAY 22, 1999

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met Tuesday, May 27, 1999 at 1:00 p.m. in Room 424, of the Legislative Office Building.

The meeting was opened by Co-Chair, Representative Edd Nye, and concluded by Co-Chair, Representative Beverly Earle. Other House members present were:

Representative Beverly Earle, Co-Chair
Representative Martha Alexander, Vice Chair
Representative Alma Adams
Representative Lanier Cansler
Representative Theresa Esposito
Representative Trudi Walend
Representative Gene Wilson

Representative Ruth Easterling, Appropriations Co-Chair, was also present for the meeting, and Representative Andy Dedmon, ex-officio member.

The meeting begin with the passing out of the Continuation and Expansion Budget Report. (See Attachment I) Everyone was asked to turn to page one of the Budget Report, and to read it carefully. There were a total of 84 recommendations from the Governor. Each recommendation was explained in detailed by the staff member of their expertise. After the recommendations were discussed, if there were any amendments, they were allowed to be made at this time.

After carefully discussing the Continuation and Expansion Budget Report from the Governor, the next item for discussion was the Special Provisions. (See Attachment II) The presentation began with Carol Shaw, from the Fiscal Research Division. Ms Shaw asked everyone to turn to page one to begin the discussion. She explained in great details all the special provisions requested by the legislators. No questions were asked from the members. Ms Shaw completed her presentation and gave way to Mary Ellen Sylvester. Ms Shaw announced that all the proper names would be added at a later date.

Mary Ellen Sylvester, Fiscal Research, continued the presentation, beginning on page eight. Ms Sylvester discussed the changes from last year's budget and made mention of all the language that stayed the same. Karen Hammonds-Blank continued with the presentation of the Special Provision. One of the items of discussion during her presentation was the change that was made to the Electing Counties under the Welfare Law Changes.

The changes that were made in the Special Provision was explained by Jim Edgerton, Asst. Sec., Budget, Management and Planning Division, and Dr. David Bruton, Secretary of the Department of Health and Human Services. Mary Ellen Sylvester continued the presentation. Ms Sylvester handed out materials requested by Rep. Esposito, which was in reference to the recommended position eliminated of the deaf and hard of hearing. (See Attachment III) The presentation highlighted the special provisions for Child Care and Early Childhood Education.

Ramona Burton, Fiscal Research, explained the special provisions for Public Health. The last areas of special provisions are Block Grant Provisions. Karen Hammonds-Blank explained these special provisions. As she completed her presentation, it also ended the report of the Special Provisions.

The meeting was in recess for 20 minutes while amendments were being prepared. Rep. Alma Adams explained her amendment to the committee, which will be added to the subcommittee report on page 46, line 44. (See Attachment IV) A motion was made to accept the amendment, the committee voted, and the amendment was accepted. The amendment will be incorporated into the report for Appropriations on Monday, May 31, 1999. Rep. Edd Nye amended three items in the Expansion Budget Report. On page H2 of the report, changes will be made to line 15, from 10,000,000 to 4,000,000, page H3, line 18, from 11,000,000 to 17,000,000 and page H11, for language to be added to add one administrative position. A motion was made by Rep. Martha Alexander to accept the amendments. The committee voted, and the amendments accepted. A second motion was made by Rep. Edd Nye to accept the Special Provision Report. The committee voted, report accepted.

The meeting adjourned.

Respectfully submitted,

Beverly Earle

Presiding Co-Chairs, Rep. Beverly Earle and Rep. Edd Nye

Ann Raeford

Ann Raeford, Committee Clerk

Attachment I	Continuation and Expansion Budget Report
Attachment II	Special Provisions
Attachment III	Recommended Position Eliminations
Attachment IV	NC General Assembly Amendment
Attachment V	Visitor Registration

HOUSE APPROPRIATIONS

SUBCOMMITTEE ON

HUMAN RESOURCES

CONTINUATION AND EXPANSION BUDGET REPORT

5/27/99

Attachment I

Health and Human Services

GENERAL FUND

Recommended Budget	FY 99-2000 $2,871,957,449		FY 2000-01 $3,038,135,255	
Legislative Changes				
(1.00) Office of the Secretary				
1 **Eliminate Rural Health Reserve** Eliminates reserve in the Rural Health Section which is no longer needed due to increased federal receipts.	($380,370)	R	($380,370)	R
2 **Eliminate Vacant Positions** Eliminates 2.05 positions: Film Library Supervisor, Information Processing Assistant II, and Computing Consultant I.	($52,798) -2.05	R	($52,798) -2.05	R
3 **Reduce Mental Health Medicaid Match Reserve** Reduces state appropriations to bring the budget into line with revised projections.	($500,000)	R	($500,000)	R
4 **Reduce Funding to Office of Economic Opportunity** Reduces funding to the Office of Economic Opportunity due to increased federal receipts.	($200,000)	R	($200,000)	R
(2.00) Division of Medical Assistance				
5 **Increase Drug Rebate Receipts** Increases receipts from the Drug Rebate Program due to the increased expenditures for prescription drugs.	($12,606,396)	R	($18,481,741)	R
6 **Revise Forecast** Reduces appropriations to reflect the most current projections for the Medicaid Program.	($19,096,115)	R	($30,070,813)	R
7 **Reduce Inflation for Most Services by 20%** Reduces inflationary increases for most services by 20%.	($3,895,412)	R	($4,251,124)	R

	FY 99-2000		FY 2000-01	
8 Eliminate Intensity Increases Eliminates all policy changes which would increase the continuation budget.	($24,180,718)	R	($26,058,464)	R
9 Adjust Carolina Alternatives Reduces state funding for the Carolina Alternatives program due to a change in the cost-sharing formula.	($2,500,000)	R	($2,500,000)	R
10 Reduce Administrative Overhead Reduces expenditures for printing and postage due lower utilization by Work first eligibles.	($64,073)	R	($64,714)	R
11 Transfer Reserve Funds Transfers funds from the G.S. 143-23.2 reserve to support current services and to reduce appropriations.	($16,000,000) ($55,000,000)	R NR	($16,000,000) $0	R NR
12 Reduce Inflation for Hospitals/Nursing Homes Reduces inflationary increases for hospitals and nursing homes by 20%.	($5,044,920)	R	($5,399,610)	R
13 Lower Utilization for NC Health Choice Reduces expenditures because utilization of the NC Health Choice Program will be lower than the initial projections for 1999-2000.	($1,900,000)	NR	$0	NR
14 Lower Utilization by Work First Eligibles Reduces expenditures because utilization by Work First recipients is projected to be lower.	($21,702,472)	R	($23,319,692)	R
(3.00) Division of Social Services				
15 Reduce Work First Automation Funds Reduces state funds for various automation projects.	4000 ($10,000,000) 4,000,000	NR	$0	NR
16 Eliminate Vacant Positions Eliminates 3.0 Computer Consultant II and IV positions.	($14,476) -3.00	R	($14,476) -3.00	R

	FY 99-2000		FY 2000-01	
17 Adjust State/County Special Assistance Reduces funding to reflect an October 1, 1999 start date for rate increase.	($1,036,000)	NR	$0	NR
18 Reduce Work First Reserve Reduces funds in the Work First Reserve.	($11,000,000) 17,000,000	NR	$0	NR
19 Increase Revenues Decreases appropriations in anticipation of increased revenues for prior year earned revenues based on actual experience.	($1,000,000)	NR	$0	NR
(4.00) Div. of Services for Deaf/Hard of Hearing				
20 Eliminate Vacant Positions Eliminates five positions: Administrative Officer II, Guidance Counselor, Parent Trainer, Staff Development Specialist II, and Deaf-Blind Program Consultant.	($169,728) -5.00	R	($169,728) -5.00	R
(5.00) Div. of Services for the Blind				
21 Eliminate Vacant Positions Eliminates an Assistant Principal and a Processing Assistant II position.	($64,687) -2.00	R	($64,687) -2.00	R
(6.00) Division of Mental Health				
22 Eliminate Area Program Capital Reserves Eliminates funds appropriated in 1994 for capital needs for area programs.	($500,000)	NR	$0	NR
23 Eliminate Vacant Positions Eliminates 2.0 Community Employment Specialists I & II, 1.0 Food Service Assistant I, and 1.0 Housekeeping Supervisor II positions.	($78,722) -4.00	R	($78,722) -4.00	R
24 Increase Patient Revenues Reduces state appropriations in anticipation of patient revenues at the various mental health facilities.	($1,300,000)	R	($2,500,000)	R

	FY 99-2000		FY 2000-01	
25 **Eliminate Waiting List Management Funds** Eliminates funds appropriated for FY98/99 for nonrecurring purposes. These funds were originally appropriated from the Work First Reserve for one-time items.	($500,000)	R	($500,000)	R
26 **Reduce State Funds to DMH Schools/Facilities** Reduces state appropriations for Wright and Whitaker Schools as well as the residential treatment programs for violent and assaultive children (located in Wilson and Butner) in anticipation of Medicaid revenues.	($650,000)	R	($960,000)	R
(7.00) Division of Health Services				
27 **Reduce Tuberculosis Program Pharmaceutical Budget** Reduces Tuberculosis Program pharmaceutical budget to reflect program need.	($198,762)	R	($198,762)	R
28 **Eliminate Vacant Positions** Eliminates four positions: Physician III-A, Processing Unit Supervisor V, Processing Assistant III, Office Assistant III	($185,558) -2.75	R	($185,558) -2.75	R
29 **Reduce AIDS Drug Assistance Program Funding** Reduces AIDS Drug Assistance Program (HIV Medications Program) funding due to increased federal receipts. Nonrecurring reduction due to reversions.	($1,000,000)	R	($1,000,000)	R
(8.00) Division of Facility Services				
30 **Reduce Fire Protection Loan Fund** Eliminates uncommitted funding appropriated for the Fire Protection Loan Fund which is managed by the NC Housing Finance Agency.	($200,000)	NR	$0	NR
(9.00) Division of Mental Health				
31 **Camp Royall** Provides a grant-in-aid to the Autism Society of North Carolina to be used to complete Camp Royall, a camp for autistic children and adults.	$471,000	NR	$0	NR

	FY 99-2000		FY 2000-01	
32 **Area Mental Health Program Merger** Provides funds to complete the merger of the Cleveland County and Gaston-Lincoln Area Authorities.	$800,000	R	$800,000	R
33 **ACH Resident Assessment Services** Provides funding for professional mental health assessments and follow-up treatment services for residents in adult care homes who have been identified as posing a risk to other residents during the initial assessment. Effective January 1, 2000.	$302,866	R	$609,953	R
34 **Deaf/Mentally Ill Services** Provides funds to expand services to individuals who are deaf and have mental illness. Services include specialized mental health treatment and residential support.	$247,000	R	$247,000	R
35 **Mental Health Housing** Provides funds for residential services for the mentally ill including funds for clients who have a mental illness and are deaf.	$495,000	R	$495,000	R
36 **Area Mental Health Board Training** - Provides funds for training for local area mental health authorities.	$150,000	NR	$0	NR
37 **Autism Society Funds of NC** Provides funds to help support programs for autistic children and adults: $200,000 for residential services, $150,000 to expand advocacy and $270,000 to provide weekend camping.	$620,000	NR	$0	NR
38 **First Step Farms** Provides a grant-in-aid to the Blue Ridge Area Mental Health Center for allocation to the First Step Farm of Western North Carolina, Inc. to increase contracted bed utilization.	$158,000	R	$158,000	R
39 **Violent and Assaultive Children** Replaces FY98/99 nonrecurring funds appropriated for the violent and assaultive children's program and maintains existing service levels.	$5,353,003	R	$5,353,003	R

	FY 99-2000		FY 2000-01	
40 **Early Intervention Services** Provides funding to develop an integrated client database and to establish a pilot site for a regional transdisciplinary team of experts to serve children ages birth through five years with low incidence disabilities, such as visual or hearing impairment or autism.	$203,000 5.00	R	$610,000 5.00	R
41 **Community Mental Health Programs** Provides expansion funds for community mental health programs to address the needs of individuals waiting for mental health, developmental disabilities and substance abuse services.	$6,000,000	R	$6,000,000	R
42 **Neurobehavioral Treatment Unit** Provides funds to establish a 12-bed unit at the Black Mountain Center for individuals with traumatic brain injury and who require behavioral health services.	$571,526 $120,246 51.00	R NR	$571,526 $0 51.00	R NR
43 **TEACCH** Provides funds to UNC-CH, Division of TEACCH Administration and Research to meet the expanding needs of people with autism. The funds shall be used as follows: $434,693 for the Gastonia Center, $236,345 for the Raleigh Satellite Center, $199,472 for the Carolina Living and Learning Center Vocational Expansion and $181,190 for administration and research. These funds shall not be used by UNC-CH for administrative costs.	$1,052,000	NR	$0	NR
(10.00) Office of the Secretary				
44 **UNC Institute of Medicine** Transfers funds to UNC-CH for the Institute of Medicine.	$200,000	NR	$0	NR
45 **NC/Israel Project** Provides funds for the NC/Israel Project.	$99,000	NR	$0	NR
46 **Human Services Grants-in-Aid** Reserve for grants-in-aid to public and non-profit human services organizations for programs that provide services to older adults, adults with disabilities, at-risk children and youth and families.	$4,000,000	NR	$0	NR

	FY 99-2000		FY 2000-01	
47 **ABCs Plan in DHHS Schools** Provides funding for professional development and to increase the pay grades of cottage and residential staff positions.	$400,000	R	$400,000	R
(11.00) Division of Child Development				
48 **Touching the Lives of Children Program** Provides funding for the Touching the Lives of Children Program.	$300,000	R	$300,000	R
49 **Smart Start Services** Provides funding to expand direct services statewide.	$58,000,000	R	$78,928,826	R
50 **Smart Start Evaluation and Collaboration** Provides additional funding for program evaluation to accommodate the increased need for data collection and reporting resulting from statewide expansion. Also, provides funding for county collaboration for the Years 3 through 5 local partnerships.	$165,000 $1,500,000	R NR	$165,000 $0	R NR
51 **T.E.A.C.H. Program** Provides funding to expand the Teacher Education and Compensation Helps (T.E.A.C.H.) Program.	$778,000	R	$778,000	R
(12.00) Division of Vocational Rehabilitation				
52 **Independent Living (IL) Rehabilitation Program** Provides funding to alleviate the backlog of client needs at program offices statewide. The Department may establish up to 9 positions in the areas of rehabilitation engineering, casework technicians, and central office support. Provides funding for two IL Counselor/Care Coordinator positions to work with individuals with brain injuries and their families. The Department may use up to $100,000 to contract with the NC State University's Center for Universal Design to provide technical assistance to the housing industry on design requirements for multifamily housing which improve accessibility for disabled individuals.	$1,000,000 $2,000,000 11.00	R NR	$1,000,000 $0 11.00	R NR

	FY 99-2000		FY 2000-01	
53 **NC Assistive Technology Project** Provides funding to support the Assistive Technology Demonstration Centers in providing technical assistance, training, and equipment loans to individuals with disabilities and their families.	$398,533	R	$398,533	R
(13.00) Division of Health Services				
54 **Children's Vision Screening** Provides funding for a statewide training and certification program for school-based vision screeners.	$419,000	R	$419,000	R
55 **Arthritis Prevention Project** Continues grant-in-aid for private, local project providing services for arthritis patients in Mecklenburg County.	$25,000	NR	$0	NR
56 **Cancer Control Program** Provides funding to the Advisory Committee on Cancer Coordination and Control to promote the prevention, early detection, data collection, and optimal care in the control of cancer.	$250,000	NR	$0	NR
57 **Osteoporosis Task Force** Provides funding to continue support for the Osteoporosis Task Force.	$100,000	NR	$0	NR
58 **Healthy Start Foundation** Provides funding for the statewide public information and education activities of the First Step Campaign and for local communities to implement pilot programs aimed at reducing infant mortality.	$650,000	NR	$0	NR
59 **State Games of North Carolina** Provides funding for the Governor's Council on Physical Fitness to support the State Games.	$200,000	NR	$0	NR
60 **Asthma Education Program** Provides funding to support asthma management, control, surveillance, and education.	$250,000	NR	$0	NR

	FY 99-2000		FY 2000-01	
61 **Office of Minority Health** Provides funding to support Office of Minority Health activities.	$150,000	NR	$0	NR
62 **Hepatitis C Education Awareness** Provides funding for Hepatitis C education and awareness activities.	$150,000	NR	$0	NR
63 **SUD Program** Provides funding to start-up and operate improved, intensive investigation of sudden unexpected deaths of infants and young children.	$190,000 2.00	R	$190,000 2.00	R
64 **Central Cancer Registry** Provides funding for additional Central Cancer Registry personnel.	$200,300 5.00	R	$200,300 5.00	R
65 **Healthy Carolinians** Provides funding for the creation of Healthy Carolinian Task Forces throughout the state.	$1,000,000	NR	$0	NR
66 **Heart Disease and Stroke Prevention** Provides funding to the Heart Disease and Stroke Prevention Task Force for implementation of the NC Plan to Prevent Heart Disease and Stroke, 1999-2003.	$100,000	NR	$0	NR
67 **Pediatric Cancer Services** Provides funding for pediatric cancer awareness, victim assistance, and clinical trials of experimental treatments.	$250,000	NR	$0	NR
(14.00) Division of Services for the Blind				
68 **Early Intervention Services** Provides funding to expand early intervention services for visually-impaired children ages birth through five years.	$225,000 3.00	R	$225,000 3.00	R

	FY 99-2000		FY 2000-01	
69 **Governor Morehead School** Provides funding for library materials, textbooks, and education-related technology.	$50,000	R	$50,000	R
(15.00) Division of Social Services				
70 **Adult Protective Services** Provides additional funds to support additional social worker positions providing adult protective services through local departments of social services.	$1,000,000	R	$2,000,000	R
71 **Special Assistance Personal Needs Allowance** Increases the monthly personal needs allowance for State/County Special Assistance recipients from $31 to $36.	$750,000	R	$750,000	R
72 **State Maternity Homes Fund** Provides funds to bring the budget in line with actual expenditures.	$250,000	R	$250,000	R
73 **Adoption Records and Registry** Provides funds to establish a voluntary adoptions registry including 2.0 Social Work Consultants and 2.0 Clerk V positions.	$167,000 3.50	R	$159,000 4.00	R
74 **ACH Resident Assessment Services** Provides funding to establish 83 positions in county departments of social services to assess individuals requesting Special Assistance to pay for care in an adult care home, and to determine the level of care and services needed, including identifying individuals who pose a risk to other residents and may need further mental health assessments and treatment. These positions will also provide technical assistance to adult care homes on how to conduct functional assessments and develop care plans. Effective January 1, 2000.	$631,200	R	$1,271,200	R
75 **Family Success Initiative/Pilots** Provides funds for pilot programs targeting at-risk children and families.	$250,000	NR	$0	NR

	FY 99-2000		FY 2000-01	
76 **Food Banks** Provides funds for the Second Harvest Food Banks.	$1,000,000	NR	$0	NR
(16.00) Division of Aging				
77 **Alzheimer's Association** Increases funding for the three chapters of the North Carolina Alzheimer's Association.	$50,000	R	$50,000	R
78 **Start-up Grants For Adult Day Care Programs** Provides funding for up to 10 start-up grants for new Adult Day Care Programs.	$250,000	NR	$0	NR
(17.00) Division of Facility Services				
79 **Complaint Investigations** Provides funding for 15 nurse consultants to improve the timeliness of complaint investigations in long term care facilities. Effective January 1, 2000.	$111,375 15.00	R	$222,750 15.00	R
80 **Group Care Monitoring Staff** Provides 15 additional positions to monitor group care facilities. 1 Administative Position	$781,617 15.00	R	$731,809 15.00	R
(18.00) Division of Medical Assistance				
81 **Physician Rates** Increases physician rates to match Medicare rates.	$3,600,000	R	$3,800,000	R
82 **Expand Transitional Medicaid to 24 Months** Expands transitional Medicaid for former TANF recipients from 12 to 24 months. Effective no earlier than October 1, 1999.	$2,073,000	R	$8,271,143	R

	FY 99-2000		FY 2000-01	
(19.00) Div. Of Services for Deaf/Hard of Hearing				
83 **Cued Speech Center, Inc.** Provides a grant-in-aid for the Cued Speech Center, Inc. for preschool, transitional, and resource services.	$135,000	R	$135,000	R
84 **North Carolina School for the Deaf** Provides funding for 4 positions (Occupational Therapist III, Physical Therapist III, Staff Development Specialist, and Community Employment Specialist II), establishment and operational support of an NC Information Highway classroom, library materials and automation, an elevator in the elementary school, and playground equipment.	$275,000	R	$302,600	R
	$275,000	NR	$0	NR
	4.00		4.00	
Total Legislative Changes	**($24,304,787)**	**R**	**($17,108,616)**	**R**
	($65,523,754)	**NR**	**$0**	**NR**
Total Position Changes	95.70		96.20	
Revised Budget	**$2,782,128,908**		**$3,021,026,639**	

HOUSE APPROPRIATIONS

SUBCOMMITTEE ON

HUMAN RESOURCES

SPECIAL PROVISIONS

5/27/99

Attachment II

CODE NO. 99DHHS-H031A

Requested by: Representative

DHHS EMPLOYEES/IN KIND MATCH

Sec. @. G.S. 143B-139.4 reads as rewritten:

"**§ 143B-139.4. Department of Health and Human Services; authority to assist private nonprofit ~~foundations.~~ organizations.**

(a) The Secretary of the Department of Health and Human Services may allow employees of the Department or provide other appropriate services to assist any private nonprofit ~~foundation~~ organization which works directly with services or programs of the Department and whose sole purpose is to support the services and programs of the Department. A Department employee shall be allowed to work with ~~a foundation~~ an organization no more than twenty hours in any one month. These services are not subject to the provisions of Chapter 150B of the General Statutes.

(b) The board of directors of each private, nonprofit ~~foundation~~ organization shall secure and pay for the services of the State Auditor's Office or employ a certified public accountant to conduct an annual audit of the financial accounts of the ~~foundation.~~ organization. The board of directors shall transmit to the Secretary of the Department a copy of the annual financial audit report of the private nonprofit ~~foundation.~~ organization.

(c) Notwithstanding the limitations of subsection (a) of this section, the Secretary of the Department of Health and Human Services may assign employees of the Office of Rural Health and Resource Development to serve as in-kind match to nonprofit organizations working to establish health care programs that will improve health care access while controlling costs."

CODE NO. 99DHHS-H021

Requested by: Representatives

NONMEDICAID REIMBURSEMENT CHANGES

Section @. Providers of medical services under the various State programs, other than Medicaid, offering medical care to citizens of the State shall be reimbursed at rates no more than those under the North Carolina Medical Assistance Program. Hospitals that provide psychiatric inpatient care for Thomas S. class members or adults with mental retardation and mental illness may be paid an additional incentive payment not to exceed fifteen percent (15%) of their regular daily per diem reimbursement.

The Department of Health and Human Services may reimburse hospitals at the full prospective per diem rates without regard to the Medical Assistance Program's annual limits on hospital days. When the Medical Assistance Program's per diem rates for inpatient services and its interim rates for outpatient services are used to reimburse providers in non-Medicaid medical service programs, retroactive adjustments to claims already paid shall not be required.

Notwithstanding the provisions of paragraph one, the Department of Health and Human Services may negotiate with providers of medical services under the various Department of Health and Human Services programs, other than Medicaid, for rates as close as possible to Medicaid rates for the following purposes: contracts or agreements for medical services and purchases of medical equipment and other medical supplies. These negotiated rates are allowable only to meet the medical needs of its non-Medicaid eligible patients, residents, and clients who require such services which cannot be provided when limited to the Medicaid rate.

Maximum net family annual income eligibility standards for services in these programs shall be as follows:

Family Size	Medical Eye Care Adults	All Rehabilitation	Other
1	$ 4,860	$ 8,364	$ 4,200
2	5,940	10,944	5,300
3	6,204	13,500	6,400
4	7,284	16,092	7,500
5	7,824	18,648	7,900
6	8,220	21,228	8,300
7	8,772	21,708	8,800

2

8	9,312	22,220	9,300

The eligibility level for children in the Medical Eye Care Program in the Division of Services for the Blind and for adults in the Atypical Antipsychotic Medication Program in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall be one hundred percent (100%) of the federal poverty guidelines, as revised annually by the United States Department of Health and Human Services and in effect on July 1 of each fiscal year. The eligibility level for people in the Atypical Antipsychotic Medication Program in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall be one hundred twenty-five percent (125%) of the federal poverty guidelines, as revised annually by the United States Department of Health and Human Services and in effect on July 1 of each fiscal year. Additionally, those adults enrolled in the Atypical Antipsychotic Medication Program who become gainfully employed may continue to be eligible to receive State support, in decreasing amounts, for the purchase of atypical antipsychotic medication and related services up to three hundred percent (300%) of the poverty level.

State financial participation in the Atypical Antipsychotic Medication Program for those enrollees who become gainfully employed is as follows:

Income (% of poverty)	State Participation	Client Participation
0-115%	100%	0%
116-130%	95%	5%
131-150%	85%	15%
151-170%	75%	25%
171-190%	65%	35%
191-210%	55%	45%
211-230%	45%	55%
231-250%	35%	65%
251-270%	25%	75%
271-290%	15%	85%
291-300%	5%	95%
301%-over	0%	100%.

The Department of Health and Human Services shall contract at, or as close as possible to, Medicaid rates for medical services provided to residents of State facilities of the Department.

CODE NO. 99DHHS-H070

Requested by: Representatives Earle and Nye

RECODIFICATION OF ADMINISTRATIVE RULES

Section @. The Codifier of Rules may reorganize Titles 10 and 15A of the North Carolina Administrative Code to reflect the recent reorganization of the Department of Health and Human Services and the Department of Environment and Natural Resources. The reorganization of the Code may include replacing Title 10 with a new title 10A if desireable for clarity. The Codifier of Rules may make changes in the text of the affected rules to reflect changes in organizational structure of the Department of Health and Human Services and the Department of Environment and Natural Resources. So long as the changes in text do not change the substance of the rules, the reorganization by the Codifier is exempt from the requirements of Chapter 150B of the General Statutes and does not require the review or approval of the Rules Review Commission.

4

CODE NO. 99DHHS-H058

Requested by:

PRESCRIPTION DRUG ASSISTANCE PROGRAM STUDY

Section @. (a) The Department of Health and Human Services shall work with the Fiscal Research Division of the Legislative Services Office to develop a proposal for a prescription drug assistance program. The purpose of the program shall be to serve low-income elderly and disabled persons who are not eligible for Medicaid and who need prescription drugs to treat a condition which, if left untreated, could result in the person's admission to a nursing facility or otherwise qualifying for Medicaid. The Department shall utilize the expertise of the Prescription Drug Work Group which authored "A Study of Options for Making Prescription Drugs More Affordable for Older Adults" to complete the analysis necessary for developing the proposal. In developing the proposal the Department shall do the following:

(1) Identify health conditions that need prescription drug treatment and, if not treated, that can lead to nursing home admission or otherwise qualifying the person for Medicaid;

(2) Identify the group of low-income elderly and disabled persons in most need of assistance;

(3) Estimate the number of persons potentially eligible for assistance under the program;

(4) Identify appropriate limitations on levels of assistance;

(5) Estimate the cost of providing drug assistance and the cost of administering the program;

(6) Review similar programs in other states;

(7) Develop a simple and cost-effective system for administering a drug assistance program;

(8) Develop a timetable for program implementation; and

(9) Conduct other activities that will assist in the development of the proposal.

(b) Not later than May 1, 2000, the Department shall report to the 1999 General Assembly, Regular Session 2000, with a complete proposal for a prescription drug assistance program. The report shall include several options for consideration by the General Assembly.

5

CODE NO. 99DHHS-H055

Requested by: Representatives Earle, Cansler,

STUDY ON TRAUMATIC BRAIN INJURY

Section @. The Department of Health and Human Services shall study the following:

(1) The long-range costs of treating and caring for persons with Traumatic Brain Injury; and

(2) The feasibility and cost to the State of obtaining a Home and Community-Based Medicaid Waiver to provide Medicaid services to 100 individuals with Traumatic Brain Injury and for administrative support to manage the waiver.

The Department shall report the results of its study to the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Resources by May 1, 2000.

6

CODE NO. 99DHHS-H077A

Requested by: Representatives Earle and Nye

PROCEDURE FOR AWARD OF HUMAN SERVICES GRANTS

Section @. Of the funds appropriated in this act to the Department of Health and Human Services the sum of four million dollars ($4,000,000) for the 1999-2000 fiscal year shall be used for grants for programs that provide services to older adults, adults with disabilities, at-risk children, and youth and families.

In awarding grants, the Secretary shall consider the merits of the program, the benefit to the State and local communities of the program, and the cost of the program.

7

CODE NO. 99DHHS-H069C

Requested by: Representative

ESTABLISHMENT OF DIVISION OF EDUCATION SERVICES

Sec. @. (a) Notwithstanding any other provision of law, the Secretary of the Department of Health and Human Services shall create a Division of Education Services to manage the Governor Morehead School and the three residential schools for the deaf. The Secretary may include in this new Division any or all of the schools and educational programs currently managed by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

The purpose of creating a Division of Education Services is to focus management attention and resources on the following:

(1) Improving student academic and postsecondary outcomes.

(2) Increasing staff development and training.

(3) Achieving administrative consistency and access to expert support services across campuses.

(4) Strengthening collaborative relationships with local education agencies and with the State Board of Education.

The Department's goals and plans for this new Division shall be consistent with the recommendations proposed by the Department in its report entitled, "Program Review of Disability Services," dated April 14, 1999.

The Division of Education Services shall be led by a Superintendent of Education Services. The Superintendent shall have a strong background in public education. The Superintendent shall implement a support team of managers and specialists at the division-level which will include, at a minimum, individual managers responsible for business management services, clinical services, and early intervention services.

The Secretary shall make a progress report on the establishment and staffing of the Division of Education Services to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than April 1, 2000.

The Secretary shall continue to review, evaluate, and recommend opportunities for improving the utilization of campus resources for the benefit of special needs children statewide, including the possibilities for year round schooling and postsecondary

transitional programming. The Secretary shall report the results of this review to the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Health and Human Services no later than April 1, 2000. The State Board of Education and the Superintendents of the local education agencies in which the residential schools are located shall cooperate in this effort.

Sec. @. (b) G.S. 143B-216.33(a)(2) is repealed.

Sec. @. (c) The Secretary of the Department of Health and Human Services shall evaluate opportunities, within the limits of existing law, for reorganizing the administration and delivery of the Department's services to visually-impaired, deaf and hard of hearing, and vocational rehabilitation clients. The goals of this evaluation shall be to improve services to clients and to maximize the use of existing resources for the benefit of clients served. The Secretary shall report any reorganization resulting from this evaluation to the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Health and Human Services no later than April 1, 2000. Any reorganization under this subsection shall be within the limits of existing law.

CODE NO. 99DHHS-H039

Requested by: Representative

ABCs PLAN IN DHHS SCHOOLS

Sec. @. (a) The Department of Health and Human Services shall retain any unobligated portion of the nonrecurring funds appropriated by the 1997 General Assembly, 1998 Regular Session, to implement the ABCs Plan in the Governor Morehead School and the Schools for the Deaf.

(b) This section becomes effective June 30, 1999.

10

CODE NO. 99DHHS-H040A

Requested by: Representatives Earle, Nye

DISPOSITION OF DISPROPORTIONATE SHARE RECEIPT CHANGE

Section @. (a) Disproportionate share receipts reserved at the end of the 1998-99 fiscal year shall be deposited with the Department of State Treasurer as a nontax revenue for the 1999-2000 fiscal year.

(b) For the 1999-2000 and 2000-2001 fiscal years, as it receives funds associated with Disproportionate Share Payments from the State hospitals, the Department of Health and Human Services, Division of Medical Assistance, shall deposit up to one hundred five million dollars ($105,000,000) of these Disproportionate Share Payments to the Department of State Treasurer for deposit as nontax revenues. Any Disproportionate Share Payments collected in excess of the one hundred five million dollars ($105,000,000) shall be reserved by the State Treasurer for future appropriations.

11

CODE NO. 99DHHS-H041A

Requested by: Representatives

MEDICAID/REPORTING ANTICIPATED CHANGES

Section @. (a) Funds appropriated in this act for services provided in accordance with Title XIX of the Social Security Act (Medicaid) are for both the categorically needy and the medically needy. Funds appropriated for these services shall be expended in accordance with the following schedule of services and payment bases. All services and payments are subject to the language at the end of this subsection.

Services and payment bases:

(1) Hospital-Inpatient - Payment for hospital inpatient services will be prescribed in the State Plan as established by the Department of Health and Human Services.

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

(3) Nursing Facilities - Payment for nursing facility services will be prescribed in the State Plan as established by the Department of Health and Human Services. Nursing facilities providing services to Medicaid recipients who also qualify for Medicare, must be enrolled in the Medicare program as a condition of participation in the Medicaid program. State facilities are not subject to the requirement to enroll in the Medicare program.

(4) Intermediate Care Facilities for the Mentally Retarded - As prescribed in the State Plan as established by the Department of Health and Human Services.

(5) Drugs - Drug costs as allowed by federal regulations plus a professional services fee per month excluding refills for the same drug or generic equivalent during the same month. Reimbursement shall be available for up to six prescriptions per recipient, per month, including refills. Payments for drugs are subject to the provisions of subsection (h) of this section and to the provisions at the end of subsection (a) of this section, or in accordance with the State Plan

adopted by the Department of Health and Human Services consistent with federal reimbursement regulations. Payment of the professional services fee shall be made in accordance with the State Plan adopted by the Department of Health and Human Services, consistent with federal reimbursement regulations. The professional services fee shall be five dollars and sixty cents ($5.60) per prescription. Adjustments to the professional services fee shall be established by the General Assembly.

(6) Physicians, Chiropractors, Podiatrists, Optometrists, Dentists, Certified Nurse Midwife Services - Fee schedules as developed by the Department of Health and Human Services. Payments for dental services are subject to the provisions of subsection (g) of this section.

(7) Community Alternative Program, EPSDT Screens - Payment to be made in accordance with rate schedule developed by the Department of Health and Human Services.

(8) Home Health and Related Services, Private Duty Nursing, Clinic Services, Prepaid Health Plans, Durable Medical Equipment - Payment to be made according to reimbursement plans developed by the Department of Health and Human Services.

(9) Medicare Buy-In - Social Security Administration premium.

(10) Ambulance Services - Uniform fee schedules as developed by the Department of Health and Human Services.

(11) Hearing Aids - Actual cost plus a dispensing fee.

(12) Rural Health Clinic Services - Provider-based, reasonable cost; nonprovider-based, single-cost reimbursement rate per clinic visit.

(13) Family Planning - Negotiated rate for local health departments. For other providers - see specific services, for instance, hospitals, physicians.

(14) Independent Laboratory and X-Ray Services - Uniform fee schedules as developed by the Department of Health and Human Services.

(15) Optical Supplies - One hundred percent (100%) of reasonable wholesale cost of materials.

(16) Ambulatory Surgical Centers - Payment as prescribed in the reimbursement plan established by the Department of Health and Human Services.

(17) Medicare Crossover Claims - An amount up to the actual coinsurance or deductible or both, in accordance with the State Plan, as approved by the Department of Health and Human Services.

(18) Physical Therapy and Speech Therapy - Services limited to EPSDT eligible children. Payments are to be made only to qualified providers at rates negotiated by the Department of Health and Human Services.

(19) Personal Care Services - Payment in accordance with the State Plan approved by the Department of Health and Human Services.

(20) Case Management Services - Reimbursement in accordance with the availability of funds to be transferred within the Department of Health and Human Services.

(21) Hospice - Services may be provided in accordance with the State Plan developed by the Department of Health and Human Services.

(22) Other Mental Health Services - Unless otherwise covered by this section, coverage is limited to agencies meeting the requirements of the rules established by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services, and reimbursement is made in accordance with a State Plan developed by the Department of Health and Human Services not to exceed the upper limits established in federal regulations.

(23) Medically Necessary Prosthetics or Orthotics for EPSDT Eligible Children - Reimbursement in accordance with the State Plan approved by the Department of Health and Human Services.

(24) Health Insurance Premiums - Payments to be made in accordance with the State Plan adopted by the Department of Health and Human Services consistent with federal regulations.

(25) Medical Care/Other Remedial Care - Services not covered elsewhere in this section include related services in schools; health professional services provided outside the clinic setting to meet maternal and infant health goals; and services to

meet federal EPSDT mandates. Services addressed by this paragraph are limited to those prescribed in the State Plan as established by the Department of Health and Human Services. Except for related services in schools, providers of these services shall be certified as meeting program standards of the Department of Health and Human Services, Division of Women's and Children's Health.

(26) Pregnancy Related Services - Covered services for pregnant women shall include nutritional counseling, psychosocial counseling, and predelivery and postpartum home visits by maternity care coordinators and public health nurses.

Services and payment bases may be changed with the approval of the Director of the Budget.

Reimbursement is available for up to 24 visits per recipient per year to any one or combination of the following: physicians, clinics, hospital outpatient, optometrists, chiropractors, and podiatrists. Prenatal services, all EPSDT children, and emergency rooms are exempt from the visit limitations contained in this paragraph. Exceptions may be authorized by the Department of Health and Human Services where the life of the patient would be threatened without such additional care. Any person who is determined by the Department to be exempt from the 24-visit limitation may also be exempt from the six-prescription limitation.

(b) Allocation of Nonfederal Cost of Medicaid. The State shall pay eighty-five percent (85%); the county shall pay fifteen percent (15%) of the nonfederal costs of all applicable services listed in this section.

(c) Copayment for Medicaid Services. The Department of Health and Human Services may establish copayment up to the maximum permitted by federal law and regulation.

(d) Medicaid and Work First Family Assistance, Income Eligibility Standards. The maximum net family annual income eligibility standards for Medicaid and Work First Family Assistance and the Standard of Need for Work First Family Assistance shall be as follows:

Categorically Needy		Medically Needy	
Family Size	WFFA* Standard of Need	Families and Children Income Level	AA, AB, AD*

1	1	$ 4,344	$ 2,172	$ 2,900
2	2	5,664	2,832	3,800
3	3	6,528	3,264	4,400
4	4	7,128	3,564	4,800
5	5	7,776	3,888	5,200
6	6	8,376	4,188	5,600
7	7	8,952	4,476	6,000
8	8	9,256	4,680	6,300

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

The payment level for Work First Family Assistance shall be fifty percent (50%) of the standard of need.

These standards may be changed with the approval of the Director of the Budget with the advice of the Advisory Budget Commission.

(e) The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to all elderly, blind, and disabled people who have incomes equal to or less htan one hundred percent (100%) of the federal poverty guidelines, as revised each April 1. Coverage authorized under this section shall become effective no earlier than January 1, 1999.

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

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

(g) Dental Coverage Limits. Dental services shall be provided on a restricted basis in accordance with rules adopted by the Department to implement this subsection.

(h) Dispensing of Generic Drugs. Notwithstanding G.S. 90-85.27 through G.S. 90-85.31, under the Medical Assistance Program (Title XIX of the Social Security Act) a prescription order for a drug designated by a trade or brand name shall be considered to be an order for the drug by its established or generic name, except when the prescriber personally indicates, either orally or in the prescriber's own handwriting on the prescription order, 'dispense as written' or words of similar meaning. Generic

drugs, when available in the pharmacy, shall be dispensed at a lower cost to the Medical Assistance Program rather than trade or brand name drugs, subject to the prescriber's 'dispense as written' order as noted above.

As used in this subsection 'brand name' means the proprietary name the manufacturer places upon a drug product or on its container, label, or wrapping at the time of packaging; and 'established name' has the same meaning as in section 502(e)(3) of the Federal Food, Drug, and Cosmetic Act as amended, 21 U.S.C. § 352(e)(3).

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

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

(k) Cost Containment Programs. The Department of Health and Human Services, Division of Medical Assistance, may undertake cost containment programs including preadmissions to hospitals and prior approval for certain outpatient surgeries before they may be performed in an inpatient setting.

(l) For all Medicaid eligibility classifications for which the federal poverty level is used as an income limit for eligibility determination, the income limits will be updated each April 1 immediately following publication of federal poverty guidelines.

(m) The Department of Health and Human Services shall provide Medicaid to 19-, 20-, and 21-year olds in accordance with federal rules and regulations.

(n) The Department of Health and Human Services shall provide coverage to pregnant women and to children according to the following schedule:

(1) Pregnant women with incomes equal to or less than one hundred eighty-five percent (185%) of the federal poverty guidelines as revised each April 1 shall be covered for Medicaid benefits.

(2) Infants under the age of 1 with family incomes equal to or less than one hundred eighty-five percent (185%) of the federal poverty guidelines as revised each April 1 shall be covered for Medicaid benefits.

(3) Children aged 1 through 5 with family incomes equal to or less than one hundred thirty-three percent (133%) of the federal poverty guidelines as revised each April 1 shall be covered for Medicaid benefits.

(4) Children aged 6 through 18 with family incomes equal to or less than the federal poverty guidelines as revised each April 1 shall be covered for Medicaid benefits.

(5) The Department of Health and Human Services shall provide Medicaid coverage for adoptive children with special or rehabilitative needs regardless of the adoptive family's income.

Services to pregnant women eligible under this subsection continue throughout the pregnancy but include only those related to pregnancy and to those other conditions determined by the Department as conditions that may complicate pregnancy. In order to reduce county administrative costs and to expedite the provision of medical services to pregnant women, to infants, and to children described in subdivisions (3) and (4) of this subsection, no resources test shall be applied.

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

(p) The Department of Health and Human Services shall submit a monthly status report on expenditures for acute care and long-term care services to the Fiscal Research Division and to the Office of State Budget and Management. This report shall include an analysis of budgeted versus actual expenditures for eligibles by category and for long-term care beds. In addition, the Department shall revise the program's projected spending for the current fiscal year and the estimated spending for the subsequent fiscal year on a quarterly basis. Reports for the preceding month shall be forwarded to the Fiscal Research Division and to the Office of State Budget and Management no later than the third Thursday of the month.

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

(r) If first approved by the Office of State Budget and Management, the Division of Medical Assistance, Department of Health and Human Services, may use funds that are identified to support the cost of development and acquisition of equipment and software through contractual means to improve and enhance information systems that provide management information and claims processing.

(s) The Division of Medical Assistance, Department of Health and Human Services, may administer Medicaid estate recovery mandated by the Omnibus Budget Reconciliation Act of 1993, (OBRA 1993), 42 U.S.C. § 1396p(b), and G.S. 108-70.5 using temporary

rules pending approval of final rules promulgated pursuant to Chapter 150B of the General Statutes.

(t) The Department of Health and Human Services may adopt temporary rules according to the procedures established in G.S. 150B-21.1 when it finds that these rules are necessary to maximize receipt of federal funds, to reduce Medicaid expenditures, and to reduce fraud and abuse. Prior to the filing of these temporary rules with the Office of Administrative Hearings, the Department shall consult with the Office of State Budget and Management on the possible fiscal impact of the temporary rule and its effect on State appropriations and local governments.

(u) The Department shall report to the Fiscal Research Division of the Legislative Services Office and to the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Human Resources or the Joint Legislative Commission on Health Care Oversight on any change it anticipates making in the Medicaid Program that impacts the type or level of service, reimbursement methods, or waivers, any of which require a change in the State Plan or other approval by the Health Care Financing Administration. The reports shall be provided at the same time they are submitted to HCFA for approval.

(v) If the Department of Health and Human Services obtains a Medicaid waiver to implement two long-term care pilot projects, then the Department shall report the particulars of the waiver, the pilot projects, and the status of implementation to members of the House of Representatives Appropriations Subcommittee on Human Resources, the Senate Appropriations Committee on Human Resources, and the Study Commission on Aging within 30 days of receiving the waiver. The Department shall not expand the pilot project beyond the two initial pilots without first reporting the proposed expansion to the members of the House of Representatives Appropriations Subcommittee on Human Resources and the Senate Appropriations Committee on Human Resources.

(w) The Department of Health and Human Services shall study the effect of subsection (o) of this section on both the Medicaid Program and the Health Insurance Program for Children. The Department shall make an interim report on the results of this study to the members of the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Human Resources by October 1, 1999, and shall make a final report by January 1, 2000.

CODE NO. 99DHHS-H017B

Requested by: Representatives

ALLOCATION OF G.S. 143-23.2 MEDICAID FUNDS

Sec. @. Of the funds transferred to the Department of Health and Human Services for Medicaid programs pursuant to G.S. 143-23.2, the sum of eighty-four million dollars ($84,000,000) for the 1999-2000 fiscal year and the sum of twenty-nine million dollars ($29,000,00) for the 2000-2001 fiscal year shall be allocated as prescribed by G.S. 143-23.2(b) for Medicaid programs. Notwithstanding the prescription in G.S. 143-23.2(b) that these funds not reduce State general revenue funding, these funds shall replace the reduction in general revenue funding effected in this act.

Section @. (b) G.S. 143-23.2(b) reads as rewritten:

" (b) Contributed funds shall be subject to the Department of Health and Human Services administrative control and shall be allocated only as specifically ~~as~~ provided in the current operations appropriations act, except such contributions shall not reduce State general revenue funding. At the end of any fiscal year, the unobligated balance of any such funds shall not revert to the General Fund, but shall be reappropriated for these purposes in the next fiscal year."

20

CODE NO. 99DHHS-H072

Requested by: Representatives

AUTHORIZATION TO EXPAND TRANSITIONAL MEDICAID

Section @. Effective no earlier than October 1, 1999, the Department of Health and Human Services shall expand transitional Medicaid benefits for Work First families, including parents, from 12 months to 24 months. The Department shall structure the expansion in a way that maximizes the federal fund share in transitional Medicaid for 24 months. The Department shall apply for federal approval or waiver, as necessary, to effectuate the expansion required in this section.

21

CODE NO. 99DHHS-H074

Requested by: Representative Gillespie

DEPARTMENTAL STUDY/MEDICAID COVERAGE FOR MEDICALLY NECESSARY PROSTHETICS OR ORTHOTICS

Section @. The Department of Heatlh and Human Services shall study providing Medicaid coverage for medically necessary prosthetics or orthotics for Medicaid eligible persons age 21 and older. The Department shall report its findings and recommendations, including the cost of providing these benefits, to the members of the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources not later than May 1, 2000.

22

CODE NO. 99DHHS-H054

Requested by: Representative Nye

STUDY INCREASE IN RESOURCE LIMITS FOR AGED, BLIND, DISABLED PERSONS TO QUALIFY FOR MEDICAID

Section @. The Department of Health and Human Services shall conduct a study of the feasibility and cost to triple the amount of the resource limits for aged, blind, and disabled persons to qualify for Medicaid. The Department shall report the results of its study to members of the House Appropriations Subcommittee on Health and Human Services and the members of the Senate Appropriations Committee on Human Resources not later than May 1, 2000.

CODE NO. 99DHHS-H078A

Requested by: Representatives Earle, Nye

DENTIST PARTICIPATION IN MEDICAID

Section @. The Joint Legislative Health Care Oversight Committee shall review the report of the North Carolina Institute of Medicine's Task force on Dental Care Access, and other reports and information pertinent to access to dental care, and shall consider the findings and recommendations of these reports. The Committee shall report its recommendations resulting from this review to the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources not later than May 1, 2000.

CODE NO. 99DHHS-H067

Requested by: Representatives

ADDITIONAL DENTAL BENEFITS UNDER HEALTH INSURANCE PROGRAM FOR CHILDREN

Section @. G.S. 108A-70.21(b)(1) reads as rewritten:

"(1) Dental: Oral examinations, teeth cleaning, and scaling twice during a 12-month period, full mouth X rays once every 60 months, supplemental bitewing X rays showing the back of the teeth once during a 12-month period, fluoride applications ~~once~~ twice during a 12-month period, sealants, simple extractions, therapeutic pulpotomies, prefabricated stainless steel crowns, and routine fillings of amalgam or other tooth-colored filling material to restore diseased teeth. No benefits are to be provided for services under this subsection that are not performed by or upon the direction of a dentist, doctor, or other professional provider approved by the Plan nor for services and materials that do not meet the standards accepted by the American Dental Association."

25

CODE NO. 99DHHS-H047

Requested by: Representatives

SENIOR CENTER OUTREACH

Section @. (a) Funds appropriated to the Department of Health and Human Services, Division of Aging, for the 1999-2001 fiscal biennium, shall be used by the Division of Aging to enhance senior center programs as follows:

(1) To expand the outreach capacity of senior centers to reach unserved or underserved areas; or

(2) To provide start-up funds for new senior centers.

All of these funds shall be allocated by October 1 of each fiscal year.

(b) Prior to funds being allocated pursuant to this section for start-up funds for a new senior center, the county commissioners of the county in which the new center will be located shall:

(1) Formally endorse the need for a center;

(2) Formally agree on the sponsoring agency for the center; and

(3) Make a formal commitment to use local funds to support the ongoing operation of the center.

(c) State funding shall not exceed ninety percent (90%) of reimbursable costs.

CODE NO. 99DHHS-H042A

Requested by: Representatives

FUNDS FOR ALZHEIMER'S ASSOCIATION CHAPTERS IN NC

Section @. Of the funds appropriated in this act to the Department of Health and Human Services, Division of Aging, the sum of one hundred fifty thousand dollars ($150,000) for the 1999-2000 fiscal year and the sum of one hundred fifty thousand dollars ($150,000) for the 2000-2001 fiscal year shall be allocated among the three chapters of the Alzheimer's Association, as follows:

(1) $50,000 in each fiscal year for the Western Alzheimer's Chapter;

(2) $50,000 in each fiscal year for the Southern Piedmont Alzheimer's Chapter; and

(3) $50,000 in each fiscal year for the Eastern Alzheimer's Chapter.

Before funds may be allocated to any Chapter under this section, the Chapter shall submit to the Division of Aging, for its approval, a plan for the use of these funds.

27

CODE NO. 99DHHS-H032C

Requested by: Representatives Earle, Nye

FIRE PROTECTION FUND

Section @. G.S. 122A-5.13 is amended by adding a new subsection to read:

"(c) Proceeds from the Fire Protection Fund, not to exceed ten thousand dollars ($10,000) annually, may be used to provide staff support to the North Carolina Housing Finance Agency for loan processing under this section and to the Department of Health and Human Services for review and approval of fire protection plans and inspection of fire protection systems."

CODE NO. 99DHHS-H020

Requested by: Representatives

TRANSFER BINGO PROGRAM TO CRIME CONTROL AND PUBLIC SAFETY

Sec. @. The Bingo Program previously in the Department of Health and Human Services, Division of Facility Services, and all functions, powers, duties, and obligations previously vested in the Department of Health and Human Services for the Bingo Program, are transferred to and vested in the Department of Crime Control and Public Safety by a Type I transfer, as defined in G.S. 143A-6.

CODE NO. 99DHHS-H018

Requested by: Representatives

ADULT CARE HOME BED VACANCIES/EXTENSION

Sec. @.Section 11.69(b) of S.L. 1997-443, as amended by Section 12.16C(a) of S.L. 1998-212, reads as rewritten:

"(b) Effective until ~~August 26, 1999,~~ September 30, 2000, the Department of Health and Human Services shall not approve the addition of any adult care home beds for any type home or facility in the State, except as follows:

(1) Plans submitted for approval prior to May 18, 1997, may continue to be processed for approval;

(2) Plans submitted for approval subsequent to May 18, 1997, may be processed for approval if the individual or organization submitting the plan demonstrates to the Department that on or before August 25, 1997, the individual or organization purchased real property, entered into a contract to purchase or obtain an option to purchase real property, entered into a binding real property lease arrangement, or has otherwise made a binding financial commitment for the purpose of establishing or expanding an adult care home facility. An owner of real property who entered into a contract prior to August 25, 1997, for the sale of an existing building together with land zoned for the development of not more than 50 adult care home beds with a proposed purchaser who failed to consummate the transaction may, after August 25, 1997, sell the property to another purchaser and the Department may process and approve plans submitted by the purchaser for the development of not more than 50 adult care home beds. It shall be the responsibility of the applicant to establish, to the satisfaction of the Department, that any of these conditions have been met;

(3) Adult care home beds in facilities for the developmentally disabled with six beds or less which are or would be licensed under G.S. 131D or G.S. 122C may continue to be approved;

(4) If the Department determines that the vacancy rate of available adult care home beds in a county is fifteen percent (15%) or less of the total number

of available beds in the county as of August 26, 1997, and no new beds have been approved or licensed in the county or plans submitted for approval in accordance with subdivision (1) or (2) of this section which would raise the vacancy rate above fifteen percent (15%) in the county, then the Department may accept and approve the addition of beds in that county; or

(5) If a county board of commissioners determines that a substantial need exists for the addition of adult care home beds in that county, the board of commissioners may request that a specified number of additional beds be licensed for development in their county. In making their determination, the board of commissioners shall give consideration to meeting the needs of Special Assistance clients. The Department may approve licensure of the additional beds from the first facility that files for licensure and subsequently meets the licensure requirements."

CODE NO. 99DHHS-H079

Requested by: Representatives Earle, Nye, Cansler

PLAN FOR ACCREDITATION OF ADULT CARE HOMES AND ASSISTED LIVING FACILITIES

Section @. The Department of Health and Human Services shall study and develop a plan and criteria for accreditation of adult care homes and assisted living facilities. The plan shall provide for enhanced payments to adult care homes and assisted living facilities which meet accreditation criteria. The Department shall report the findings and recommendations of its study, including the plan developed, to the Joint Legislative Health Care Oversight Committee and to the North Carolina Study Commission on Aging no later than April 1, 2000.

CODE NO. 99DHHS-H016C

Requested by: Representatives

ADULT CARE HOMES REIMBURSEMENT RATE/ADULT CARE HOMES ALLOCATION OF NONFEDERAL COST OF MEDICAID PAYMENTS/STAFFING GRANT

Sec. @. (a) The eligibility of Special Assistance recipients residing in adult care homes on August 1, 1995, shall not be affected by an income reduction in the Special Assistance eligibility criteria resulting from adoption of the Rate Setting Methodology Report and Related Services, providing these recipients are otherwise eligible. The maximum monthly rate for these residents in adult care home facilities shall be one thousand two hundred thirty-one dollars ($1,231) per month per resident.

(b) Effective August 1, 1995, the State shall pay fifty percent (50%) and the county shall pay fifty percent (50%) of the nonfederal costs of Medicaid services paid to adult care home facilities. As Medicaid personal care requirements increase due to increases in inflation and the number of eligibles, the county matching share shall be capped until it equals fifteen percent (15%) of the nonfederal Medicaid personal care requirements.

(c) Effective October 1, 1998, the maximum monthly rate for residents in adult care home facilities shall be nine hundred fifty-six dollars ($956.00) per month per resident.

(d) Effective October 1, 1999 the maximum monthly rate for residents in adult care home facilities shall be nine hundred eighty-two dollars ($982.00) per month per resident.

(e) Effective October 1, 2000, the maximum monthly rate for residents in adult care home facilities shall be one thousand sixteen dollars ($1,016) per month per resident.

(f) Of the funds appropriated in this act to the Department of Health and Human Services, the sum of two million dollars ($2,000,000) for the 1999-2000 fiscal year and the sum of five hundred thousand dollars ($500,000) for July through September of the 2000-2001 fiscal year, shall be used by the Department for staffing grants for adult care homes as authorized under this subsection. These funds shall be matched equally by county funds. Effective January 1, 1999, grants shall be awarded to those adult care homes that are required to add staff or that have added staff in order to comply with the increase in third shift staffing requirements under G.S. 131D-4.3(a)(5), from eight hours of aide duty per 50 or fewer residents to eight hours of aide duty per 30 or fewer residents, as enacted under subsection

(a) of this section. The Department shall determine eligibility for these grants based upon factors which shall include:

(1) Licensed capacity as of August 1, 1999,

(2) Occupancy rate, and

(3) Percentage of residents receiving State and county special assistance of the total residents in the adult care home.

Adult care homes that receive staffing grants under this subsection shall provide documentation to the Department showing that the home has complied with staffing ratios established under G.S. 131D-4.3(a)(5). An adult care home that receives grant funds under this subsection and is found by the Department not to have complied with staffing requirements of G.S. 131D-4.3(a)(5) shall refund to the Department a prorated share of the staffing grant funds received by the adult care home. The Department shall incorporate the staffing grants authorized under this subsection into the existing Special Assistance payment methodology or the Medicaid Personal Care Services reimbursement methodology effective October 1, 2000.

(g) Effective January 1, 2000, the Department of Health and Human Services may transfer funds from the State/County Special Assistance program to support expansion of Medicaid Personal Care Services for residents of adult care homes.

(h) Effective January 1, 2000, the State shall pay fifty percent (50%) and the county shall pay fifty percent (50%) of the nonfederal share of new levels of Medicaid Personal Care Services paid to adult care homes. Effective July 1, 2001, the State shall pay fifty-seven percent (57%) and each county shall pay forty-three percent (43%) of the nonfederal share of new levels of Medicaid Personal Care Services paid to adult care homes. Each year thereafter, the State share of the nonfederal cost will increase by seven percent (7%) until the county share equals fifteen percent (15%) of the nonfederal share of new levels of Medicaid Personal Care Services.

CODE NO. 99DHHS-H019A

Requested by: Representatives

SPECIAL ASSISTANCE DEMONSTRATION PROJECT

Sec. @. The Department of Health and Human Services may use funds from the existing State/County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals in in-home living arrangements. These payments may be made for up to four hundred (400) individuals participating in the two long-term care demonstration projects sponsored by the Department. These payments may be made for up to a two-year period beginning July 1, 1999 and ending June 30, 2001. To the maximium extent possible, the Department shall consider geographic balance in the dispersion of payments to individuals across the State. The Department shall make an interim report to the co-chairs of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Chair of the Senate Appropriations Committee on Human Resources by June 30, 2000 and a final report by October 1, 2001.

CODE NO. 99DHHS-H001

Requested by: Representative

FOSTER CARE ASSISTANCE PAYMENTS

Sec. @. The maximum rates for State participation in the foster care assistance program are established on a graduated scale as follows:

(1) $315.00 per child per month for children aged birth through 5;

(2) $365.00 per child per month for children aged 6 through 12; and

(3) $415.00 per child per month for children aged 13 through 18.

Of these amounts, fifteen dollars ($15.00) is a special needs allowance for the child.

CODE NO. 99DHHS-H002

Requested by: Representatives

ADOPTION ASSISTANCE PAYMENTS

Sec. @. The maximum rates for State participation in the adoption assistance program are established on a graduated scale as follows:

(1) $315.00 per child per month for children aged birth through 5;

(2) $365.00 per child per month for children aged 6 through 12; and

(3) $415.00 per child per month for children aged 13 through 18.

CODE NO. 99DHHS-H010

Requested by: Representative

AUTHORIZED ADDITIONAL USE OF HIV FOSTER CARE AND ADOPTIVE FAMILY FUNDS

Sec. @. (a) In addition to providing board payments to foster and adoptive families of HIV-infected children, as prescribed in Chapter 324 of the 1995 Session Laws, any additional funds remaining that were appropriated for this purpose shall be used to provide medical training in avoiding HIV transmission in the home.

(b) The maximum rates for State participation in HIV foster care and adoption assistance are established on a graduated scale as follows:

(1) $800.00 per month per child with indeterminate HIV status;

(2) $1,000 per month per child confirmed HIV-infected, asymptomatic;

(3) $1,200 per month per child confirmed HIV-infected, symptomatic; and

(4) $1,600 per month per child terminally ill with complex care needs.

CODE NO. 99DHHS-H003A

Requested by: Representatives

LIMITATIONS ON STATE ABORTION FUND

Sec. @. The limitations on funding of the performance of abortion established in Section 23.27 of Chapter 324 of the 1995 Session Laws, as amended by Section 23.8A of Chapter 507 of the 1995 Session Laws, apply to the 1999-2000 and 2000-2001 fiscal years.

CODE NO. 99DHHS-H012

Requested by: Representative

CHILD PROTECTIVE SERVICES

Sec. @. (a) The funds appropriated in this act to the Department of Health and Human Services, Division of Social Services, for the 1999-2001 fiscal biennium for Child Protective Services shall be allocated to county departments of social services based upon a formula which takes into consideration the number of Child Protective Services cases and the number of Child Protective Services workers and supervisors necessary to meet recommended standards adopted by the North Carolina Association of County Directors of Social Services.

(b) Funds allocated under subsection (a) of this section shall be used by county departments of social services for carrying out investigative assessments of child abuse or neglect or for providing protective or preventive services in cases in which the department confirms abuse, neglect, or dependency.

CODE NO. 99DHHS-H013

Requested by: Representative

CHILD WELFARE SYSTEM PILOTS

Sec. @. (a) The Department of Health and Human Services, Division of Social Services, shall develop a plan, working with local departments of social services, to implement a dual response system of child protection in no fewer than two and no more than five demonstration areas in this State. The plan should provide for the pilots to implement dual response systems in which:

(1) Local child protective services and law enforcement work together as coinvestigators in serious abuse cases; and

(2) Local departments of social services respond to reports of child abuse or neglect with a family assessment and services approach.

(b) The Department of Health and Human Services shall plan for the development of data collection processes that would enable the General Assembly to assess the impact of these pilots on:

(1) Child safety;

(2) Timeliness of response;

(3) Timeliness of services;

(4) Coordination of local human services;

(5) Cost effectiveness;

(6) Any other related issues.

(d) The Department of Health and Human Services may proceed to implement the pilot dual response systems if non-State funds are identified for this purpose.

CODE NO. 99DHHS-H011A

Requested by: Representative

CHILD WELFARE SYSTEM IMPROVEMENTS

Sec. @. (a) The Division of Social Services, Department of Health and Human Services, shall report semi-annually to the members of the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division on the activities of the State Child Fatality Review Team and shall provide a final report to the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Health and Human Services no later than April 1, 2000, including recommendations for changes in the statewide child protection system.

(b) Subsection (d) of Section 11.57 of S.L. 1997-443, as amended by Section 12.22 of S.L. 1998-212, reads as rewritten:

"(d) Notwithstanding G.S. 131D-10.6A, the Division of Social Services shall establish training requirements for child welfare services staff initially hired on and after January 1, 1998. The minimum training requirements established by the Division shall be as follows:

(1) Child welfare services workers must complete a minimum of 72 hours of preservice training before assuming direct client contact responsibilities;

(2) Child protective services workers must complete a minimum of 18 hours of additional training that the Division determines is necessary to adequately meet training needs;

(3) Foster care and adoption social workers must complete a minimum of 39 hours of additional training that the Division determines is necessary to adequately meet training needs;

(4) Child Welfare Services supervisors must complete a minimum of 72 hours of preservice training before assuming supervisory responsibilities, and a minimum of 54 hours of additional training that the Division determines is necessary to adequately meet training needs; and

(5) Child welfare services staff must complete 24 hours of continuing education annually thereafter.

The Division of Social Services may grant an exception in whole or in part to the minimum 72 hours of preservice training for

Repeat of Provision

42

child welfare workers who satisfactorily complete or are enrolled in a Master's or Bachelor's Degree program after July 1, 1999, from an accredited North Carolina social work program pursuant to the Council on Social Work Education. The program's curricula must cover the specific preservice training requirements as established by the Division.

The Division of Social Services shall ensure that training opportunities are available for county departments of social services and consolidated human services agencies to meet the training requirements of this subsection.

This subsection shall continue in effect until explicitly repealed."

CODE NO. 99DHHS-H076

Requested by: Representative Redwine

CHILD CARING INSTITUTION RULES EFFECTIVE

Section @. Notwithstanding G.S. 150B-21.3(b), Administrative Rules 10 NCAC 41S and 41T, adopted by the Social Services Commission on January 13, 1999 and approved by the Rules Review Commission on February 18, 1999, and Administrative Rules 10 NCAC 41E, 41G, and 41R, repealed by the Social Services Commission on January 13, 1999, and approved by the Rules Review Commission on February 18, 1999, shall become effective July 1, 1999.

CODE NO. 99DHHS-H066H

Requested by: Representatives

WELFARE LAW CHANGES

Section @. (a) The General Assembly approves the Temporary Assistance for Needy Families State Plan. The State Plan approved under this section applies to the two-year federal fiscal period commencing October 1, 1999 and ending September 30, 2001. The Department of Health and Human Services shall submit the approved State Plan to the United States Department of Health and Human Services in accordance with this Section. Prior to submission of the State Plan to the United States Department of Health and Human Services, the Department shall ensure that the general public has had an opportunity to comment on the State Plan, that any amendments to the State Plan made in this act or any other act of the 1999 General Assembly are incorporated into the State Plan, that the State Plan is approved by the 1999 General Assembly in a ratified act signed by the Governor, and that the Governor has signed the State Plan.

Section @. (b) Support services under North Carolina's Temporary Assistance for Needy Families (TANF) State Plan shall be available to families whose family income does not exceed two hundred percent (200%) of the federal poverty level. Other services including pregnancy prevention, child protection, family preservation, job retention, and tracking and follow-up activities, may be provided without regard to income. Child care subsidies for child protective services cases may also be provided without regard to income. Work-related services under TANF may be provided to a noncustodial parent of a minor child whose custodial parent is a TANF recipient, or to a noncustodial parent of a minor child in a child-only case, except that no work-related services shall be provided to the noncustodial parent if the services would limit or reduce Work First assistance to the custodial parent or caretaker and children. In order to be eligible for work-related services under this subsection, the noncustodial parent's family income must be not more than two hundred percent (200%) of the federal poverty level.

Section @. (c) Not later than January 1 of each year the Department of Health and Human Services shall report to members of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources, and to the Joint Legislative Public

Assistance Commission, for their review, all amendments made to the State Plan to conform with changes in the welfare law required by this section and any other act of the General Assembly, and any other corrections made to ensure that the State Plan conforms with State law.

Section @. (d) G.S. 108A-27.2(4) and G.S. 108A-27.2(9) read as rewritten:

"The Department shall have the following general duties with respect to the Work First Program:

. . .

(4) Establish a schedule for counties to submit their County Plans to ensure that all Standard County Plans are adopted by the Standard Program Counties by January 15 of each ~~even-numbered~~ odd-numbered year and all Electing County Plans are adopted by Electing Counties by February 1 of each ~~even-numbered~~ odd-numbered year and review and then recommend a State Plan to the General Assembly;

(9) Develop and implement a system to monitor and evaluate the impact of the Work First Program on children and families, including the impact of the Work First Program on ~~the economic security and health of children and families,~~ job retention and advancement, child abuse and neglect, caseloads for child protective services and foster care, school attendance, ~~and~~ academic and behavioral ~~performance.~~ performance, and other measures of the economic security and health of children and families. The system should be developed to allow monitoring and evaluation of impact based on both aggregated and disaggregated data. State and county agencies shall cooperate in providing information needed to conduct these evaluations, sharing data and information except where prohibited specifically by federal law or regulation;".

Section @. (e) Section 12.27A(g1) of S.L. 1998-212 reads as rewritten:

"(g1) The counties approved as Electing Counties in North Carolina's Temporary Assistance for Needy Families State Plan FY ~~1998-2000~~ 1998-2001 as approved by this section are: Alamance, Caldwell, Caswell, Chatham, Cherokee, Davie, Forsyth, Henderson, Iredell, Lincoln, Macon, McDowell, New Hanover, Polk, Randolph, Rutherford, Sampson, Stokes, Surry, Transylvania, and Wilkes."

Section @. (f) G.S. 108A-27.11 reads as rewritten:

"**§ 108A-27.11. Work First Program funding.**

(a) County block grants, except funds for Work First Family Assistance, shall be computed based on the percentage of each county's total AFDC (including AFDC-EA) and JOBS expenditures, except expenditures for cash assistance, to statewide actual expenditures for those programs in fiscal year 1995-96. The resulting percentage shall be applied to the State's total certified budget enacted by the General Assembly for each fiscal year, except ~~funds budgeted for Work First Family Assistance, for Work First Program expenditures at the county level.~~ for State funds budgeted for State and county demonstration projects authorized by the General Assembly and for Work First Family Assistance payments.

(b) The following shall apply to funding for Standard Program Counties:

(1) The Department shall make payments of Work First Family Assistance and Work First Diversion Assistance subject to the availability of federal, State, and county funds.

(2) The Department shall reimburse counties for county expenditures under the Work First Program subject to the availability of federal, State, and county funds.

~~(c) Each Electing County's allocation for Work First Family Assistance shall be computed based on the percentage of each Electing County's total expenditures for cash assistance to statewide actual expenditures for cash assistance in 1995-96. The resulting percentage shall be applied to the federal TANF block grant funds appropriated for cash assistance by the General Assembly each fiscal year. The Department shall transmit the federal funds contained in the county block grants to Electing Counties as soon as practicable after they become available to the State and in accordance with federal cash management laws and regulations. The Department shall transmit one-fourth of the State funds contained in county block grants to Electing Counties at the beginning of each quarter. Once paid, the county block grant funds shall not revert.~~"

Section @. (g) G.S. 108A-12 reads as rewritten:

"**§ 108A-27.12. Maintenance of effort.**

(a) The Department shall define in the State Plan ~~or by rule the term "maintenance of effort" based on that term as defined in Title IV-A and shall provide to counties a list of activities that qualify for federal maintenance of effort requirements.~~ the

services that can be provided with TANF federal funds and with State and county maintenance of effort. The Department shall work with counties to allow flexibility in the spending of county, State, and federal funds so as to maximize the use of resources while assuring that federal maintenance of effort requirements are met.

(b) ~~If a county fails to comply with the maintenance of effort requirement in subsection (a) of this section, the Director of the Budget may withhold State moneys appropriated to the county pursuant to G.S. 108A-93.~~ Counties that fail to meet maintenance of effort requirements and that fail to meet the performance indicators for reducing maintenance of effort shall submit a corrective action plan to the Department and shall be subject to G.S. 108A-27.14. The Department may reduce block grant allocations to counties that fail to meet maintenance of effort requirements and performance indicators or may use some of the county's block grant allocation to secure needed services for clients in that county. If a county fails to comply with maintenance of effort requirements, the Director of the Budget may also withhold State funds appropriated to the county pursuant to G.S. 108A-93.

(c) ~~The Department shall maintain the State's maintenance of effort at one hundred percent (100%) of the State certified budget enacted by the General Assembly for programs under this Part during fiscal year 1996-97.~~ At no time shall the Department reduce or reallocate State ~~or county~~ funds previously obligated or appropriated for Work First ~~County Block Grants~~ or child welfare services.

(d) ~~For Standard Program Counties, using the 1996-97 fiscal year as the base year, counties shall maintain a financial commitment to the Work First Program equal to the proportion of State funds allocated to the Work First Program. At no time shall a Standard Program County reduce State or county funds previously obligated or appropriated for child welfare services.~~ Each standard county shall maintain funding in Work First, child welfare, and related activities as defined by the Department at 100% of the county funds budgeted in State Fiscal Year 1996-97 for AFDC Administration, JOBS employment and training, and AFDC Emergency Assistance (cash and services). A county may request to reduce its block grant and maintenance of effort if that county can demonstrate that it is meeting all the needs of its clients, as defined by the Department's performance indicators, without spending all of the block grant funds. The needs of clients include child protection, employment services, and

related supportive services such as childcare. The Department may reallocate any State or federal funds released from a county that reduced its maintenance of effort or from counties not spending their block grants. Funds reallocated to counties will require county match.

(e) During the first year a county operates as an Electing County, the county's maintenance of effort shall be no less than ninety percent (90%) of the amount the county budgeted for programs under this Part during fiscal year 1996-97. If during the first year of operation as Electing the Electing County achieves one hundred percent (100%) of its goals as set forth in its Electing County Plan, then the Electing County may reduce its maintenance of effort to eighty percent (80%) of the amount the county budgeted for programs under this Part during fiscal year 1996-97 for the second year of the Electing County's operation and for all years thereafter that the county maintains Electing Status.

(f) The Department may realign federal, State, and local funds if the realignment will assure that maintenance of effort requirements are met while maximizing federal revenues."

Section @. (h) G.S. 108A-27.2 is amended by adding the following new subdivision to read:

"The Department shall have the following general duties with respect to the Work First Program:

. . .

(1c) Ensure that two-parent families receive assistance for three months after qualifying for assistance without being subject to pay for performance requirements, in order to encourage families to stay together and to overcome barriers to self-sufficiency and gainful employment."

Section @. (i) G.S. 108A-27.9(c) is amended by adding the following new subdivision to read:

"(c) The State Plan shall include the following generally applicable provisions:

(1c) Provisions to ensure that two-parent families receive assistance for three months after qualifying for assistance without being subject to pay for performance requirements, in order to encourage families to stay together and to overcome barriers to self-sufficiency and gainful employment."

Section @. (j) G.S. 108A-27.3(a) is amended by adding the following new subdivision to read:

"(a) The duties of the county boards of commissioners in Electing Counties under the Work First Program are as follows:

. . .

(10a) Ensure that all Work First cases are reviewed no later than three months prior to expiration of time limitations for receiving cash assistance to:

a. Ensure that time limitations on assistance have been computed correctly;

b. Ensure that the family is informed in writing about public assistance benefits, including child care, Medicaid, and food stamps, for which the family is eligible even while cash assistance is no longer available;

c. Provide for an extension of cash assistance benefits if the family qualifies for an extension; and

d. Review family status and assist the family in identifying resources and support the family needs to maintain employment and family stability."

Section @. (k) G.S. 108A-27.4(e) is amended by adding the following new subdivision to read:

"(e) Each county shall include in its County Plan the following:

. . .

(7) The process by which the county will review all Work First caseloads no later than three months prior to expiration of time limitations for receiving cash assistance to:

a. Ensure that time limitations on assistance have been computed correctly;

b. Ensure that the family is informed in writing about public assistance benefits, including child care, Medicaid, and food stamps, for which the family is eligible even while cash assistance is no longer available;

c. Provide for an extension of cash assistance benefits if the family qualifies for an extension; and

d. Review family status and assist the family in identifying resources and support the family needs to maintain employment and family stability."

Section @. (l) G.S. 108A-27.6(a) is amended by adding the following new subdivision to read:

"(a) Except as otherwise provided in this Article, the Standard Work First Program shall be administered by the county departments of social services. The county departments of social services in Standard Program Counties shall:

. . .

(10) Ensure that all Work First cases are reviewed no later than three months prior to expiration of time limitations for receiving cash assistance to:

a. Ensure that time limitations on assistance have been computed correctly;

b. Ensure that the family is informed about public assistance benefits, including child care, Medicaid, and food stamps, for which the family is eligible even while cash assistance is no longer available;

c. Provide for an extension of cash assistance benefits if the family qualifies for an extension; and

d. Review family status and assist the family in identifying resources and support the family needs to maintain employment and family stability."

Section @. (m) G.S. 108A-27.2 is amended by adding the following new subdivision to read:

"The Department shall have the following general duties with respect to the Work First Program:

. . .

(14) Review the county Work First Program of each electing county and recommend whether the county should continue to be designated an electing county or whether it should be redesignated as a standard county. In conducting its review and making its recommendation, the Department shall:

a. Examine and consider the results of the Department's monitoring and evaluation of the impact of the electing county's Work First Program as required under subdivision (9) of this section;

b. Determine whether the electing county's Work First Program's unique design requires implementation by an electing county or whether the Work First Program could be

50A

implemented by a county designated as a standard county;

c. Determine whether the electing county's Work First Program and policies are unique and innovative in meeting the purpose of the Work First Program as stated under G.S. 108A-27, and State and federal laws, rules, and regulations, as compared to other standard and electing county Work First programs.

The Department shall make its recommendation and the reasons therefor to the Joint Legislative Public Assistance Commission at the time the Department submits the State Plan to the Commission for review as required under G.S. 108A-27.9(a)."

Section @. (n) The Department of Health and Human Services shall report quarterly on the extent to which the State and counties are meeting federal maintenance of effort requirements under Temporary Assistance for Needy Families. The Department and the counties shall work together to maximize full achievement of the State and county maintenance of effort. The Department shall make its report to members of the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Joint Legislative Public Assistance Committee, and to the Fiscal Research Division.

Section @. (o) The Department shall continue to work with counties, area mental health authorities, and other public and private entities or partnerships that provide services to Temporary Assistance for Needy Families recipients paid for with State and local funds to identify those services and activities that meet federal maintenance of effort requirements. The Department shall report the status of identifying services and activities in its quarterly report on meeting federal maintenance of effort requirements as required under subsection (n) of this section.

Section @. (p) Cash assistance payments under Work First shall be calculated on the same basis as applied for the 1997-98 fiscal year. The Department of Health and Human Services shall make the necessary changes to the Temporary Assistance for Needy Families State Plan to comply with this subsection.

Section @. (q) G.S. 143-15.3C reads as rewritten:

"**§ 143-15.3C. Work First Reserve Fund.**

(a) The State Controller shall establish a restricted reserve in the General Fund to be known as the Work First Reserve Fund.

50-B

Funds from the Work First Reserve Fund shall not be expended until appropriated by the General Assembly. ~~At the end of each fiscal year, the State Controller shall reserve State funds into this reserve in an amount equalling one-fourth of any Work First Program funds from State General Fund appropriations remaining unexpended at the end of the fiscal year, up to a maximum balance in the account of fifty million dollars ($50,000,000). The General Assembly may appropriate additional funds into this reserve.~~

~~(b) Funds in the Work First Reserve Fund shall be used only for the purposes described in Title IV of the Social Security Act and only as provided in G.S. 108A-27.16.~~

~~(c) The Director of the Budget shall report to the Joint Legislative Commission on Governmental Operations, the Joint Legislative Public Assistance Commission, and the House and Senate Appropriations Subcommittees on Human Resources prior to using the funds described in subsection (a) of this section.~~"

Section @. (r) G.S. 108A-27.16 is repealed.

Section @. (s) Subsections (q) and (r) of this section become effective June 30, 1999.

50-C

CODE NO. 99DHHS-H022

Requested by: Representatives

PHYSICIAN SERVICES

Section @. With the approval of the Office of State Budget and Management, the Department of Health and Human Services may use funds appropriated in this act for across-the-board salary increases and performance pay to offset similar increases in the costs of contracting with private and independent universities for the provision of physician services to clients in facilities operated by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. This offsetting shall be done in the same manner as is currently done with constituent institutions of The University of North Carolina.

CODE NO. 99DHHS-H023

Requested by: Representatives

LIABILITY INSURANCE

Section @. The Secretary of the Department of Health and Human Services, the Secretary of the Department of Environment and Natural Resources, and the Secretary of the Department of Correction may provide medical liability coverage not to exceed one million dollars ($1,000,000) per incident on behalf of employees of the Departments licensed to practice medicine or dentistry, all licensed physicians who are faculty members of The University of North Carolina who work on contract for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for incidents that occur in Division programs, and on behalf of physicians in all residency training programs from The University of North Carolina who are in training at institutions operated by the Department of Health and Human Services. This coverage may include commercial insurance or self-insurance and shall cover these individuals for their acts or omissions only while they are engaged in providing medical and dental services pursuant to their State employment or training.

The coverage provided under this section shall not cover any individual for any act or omission that the individual knows or reasonably should know constitutes a violation of the applicable criminal laws of any state or the United States, or that arises out of any sexual, fraudulent, criminal, or malicious act, or out of any act amounting to willful or wanton negligence.

The coverage provided pursuant to this section shall not require any additional appropriations and shall not apply to any individual providing contractual service to the Department of Health and Human Services, the Department of Environment and Natural Resources, or the Department of Correction, with the exception that coverage may include physicians in all residency training programs from The University of North Carolina who are in training at institutions operated by the Department of Health and Human Services and licensed physicians who are faculty members of The University of North Carolina who work for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

52

CODE NO. 99DHHS-H024

Requested by: Representatives

PRIVATE AGENCY UNIFORM COST FINDING REQUIREMENT

Section @. To ensure uniformity in rates charged to area programs and funded with State-allocated resources, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services may require a private agency that provides services under contract with two or more area programs, except for hospital services that have an established Medicaid rate, to complete an agencywide uniform cost finding in accordance with G.S. 122C-143.2(a) and G.S. 122C-147.2. The resulting cost shall be the maximum included for the private agency in the contracting area program's unit cost finding.

53

CODE NO. 99DHHS-H043

Requested by: Representatives

FUNDS TO REDUCE WAITING LIST FOR SERVICES FOR DEVELOPMENTALLY DISABLED PERSONS

Section @. Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of six million dollars ($6,000,000) for the 1999-2000 fiscal year shall be used to provide family support services to developmentally disabled individuals who are not eligible for the Medicaid Community Alternative Program for Mentally Retarded/Developmentally Disabled persons and who are on the Department's waiting list for services.

54

CODE NO. 99DHHS-H044-P

Requested by: Representatives Earle, Nye, Cansler

STUDY OF STATE PSYCHIATRIC HOSPITALS/AREA MENTAL HEALTH PROGRAMS

Section @. In accordance with Section 12.35A of S.L. 1998-212, the State Auditor shall make the following reports to the members of the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Health and Human Services:

(1) Final report on the study of State psychiatric hospitals not later than December 1, 1999, and

(2) Second interim report on the study of the area mental health programs not later than November 1, 1999, and a final report not later than April 1, 2000.

CODE NO. 99DHHS-H050

Requested by: Representatives

BUTNER COMMUNITY LAND RESERVATION

Section @. The Department of Health and Human Services shall reserve and dedicate the following described land for the construction of a Community Building and related facilities to serve the Butner Reservation:

"Approximately 2 acres, on the east side it borders Central Avenue with a line running along the Wallace Bradshur property on the north back to the tree line next to the ADATC. From there it follows the tree line south and west to and including the softball field. From the softball field it turns east to the State Employees Credit Union and follows the Credit Union property on the south side back to Central Avenue."

This land shall be reserved and dedicated for the project which shall be funded with contributions from Granville County, contributions from the residents of the Butner Reservation, the use of cablevision franchise rebate funds received by the Department of Health and Human Services on behalf of the Butner Reservation, and other public and private sources.

The Butner Planning Council shall advise the Secretary of Health and Human Services, through resolutions adopted by the Council, regarding the use of this reserved and dedicated land, the construction of the Community Building, and the expenditure of the cablevision franchise rebate funds.

The Department of Health and Human Services shall reserve and dedicate the above described property for the above described purposes until the time, if any, that a permanent local government is established on the Butner Reservation at which time the land shall be transferred to the local government.

CODE NO. 99DHHS-H052

Requested by: Representatives

MENTAL HEALTH FUNDS FOR CRISIS SERVICES

Section @. Purposes for which funds are appropriated in this act to the Department of Health and Human Services, Division of Mental Health, for the development of local crisis services shall include, but not be limited to, meeting the short-term crisis needs of mentally retarded children determined by the Division to need crisis services. The Division shall pursue the use of available State resources and services for these children, including mental retardation centers, for short-term crisis treatment for appropriate minors, as determined by the Division.

57

CODE NO. 99DHHS-H049A

Requested by: Representatives

AUTHORITY TO ACCESS CASH RESERVES OF DMH/DD/SAS AREA PROGRAM FOUNDATIONS FOR REIMBURSEMENT FOR DISALLOWED EXPENDITURES

Section @. G.S. Part 2 of Article 4 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-123A. Area authority reimbursement to State for disallowed expenditures.**

Any funds or part thereof of an area authority that are transferred by the area authority to any entity including a firm, partnership, corporation, company, association, joint stock association, agency, or non-profit private foundation shall be subject to reimbursement by the area authority to the State when expenditures of the area authority are disallowed pursuant to a State or federal audit."

CODE NO. 99DHHS-H064C

Requested by: Representatives Earle, Nye

USE OF WILLIE M./THOMAS S. FUNDS

Section @. (a) 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 1999-2000 fiscal year and the 2000-2001 fiscal year to provide services required by State and federal to Willie M. class members shall be used to:

(1) Maintain existing services to children with special needs who were identified as members of the class at the time of dissolution of the class, and

(2) Provide services to violent and assaultive children, and other children at risk for institutionalization.

Not later than May 1, 2000, the Department shall report to the members of the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Resources on its efforts to transition the formerly court mandated Willie M. program into the larger mental health disability service areas in order to maximize the efficient and effective use of the funds while also maintaining services to former class members. The report shall include information on the Department's progress in complying with this section and the Department's proposed plans for maximizing the use of these funds in the future.

Section @. (b) 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 1999-2000 fiscal year and the 2000-2001 fiscal year to provide services to Thomas S. class members required by State and federal law shall be used to provide services to multiply-diagnosed adults who were identified as members of the class at the time of dissolution of the class. Not later than May 1, 2000, the Department shall report to members of the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources on its efforts to maximize the efficient and effective use of the funds while also maintaining services to former class members. The report shall specifically address the following:

(1) Positive clinical, functional, and personal outcomes for consumers;

59

(2) Positive systems outcomes;
(3) Identification and elimination of redundant, inefficient, or unnecessary process oriented tasks;
(4) Single stream funding;
(5) Use of Medicaid waivers;
(6) Elimination of barriers to full access to community and treatment services; and
(7) Improved mechanisms for supporting consumers with multiple or challenging disabilities in the areas of education, housing, employment, and other supports needed for long term stability in the community.

The report shall also include the status of development and implementation of cost containment measures required under Section 12.30(a) of S.L. 1998-212, and any other related cost containment measures developed by the Department.

CODE NO. 99DHHS-H068A

Requested by: Representatives

MENTAL HEALTH RESERVE FOR MEDICAID MATCH

Section @. (a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the 1999-2000 fiscal year, the Department shall transfer to the Mental Health Restricted Reserve not more than the amount of actual expenditures for Medicaid payments for the 1998-99 fiscal year for services provided by area mental health authorities, plus the estimated amount needed to match Medicaid payments for the former Carolina Alternatives Programs. The Department shall not transfer from area program allocations funds to cover Medicaid payment expenditures that exceed the amount of funds in the Reserve for the 1999-2000 fiscal year.

Section @. (b) Any non-federal increases in the cost of Medicaid services provided by area mental health authorities will be borne in equal parts by the State and county funding entity until the county share reaches fifteen percent (15%) of the non-federal share.

61

CODE NO. 99DHHS-H038B

Requested by: Representative

EARLY INTERVENTION SERVICES

Sec. @. (a) Of the funds appropriated in this act to the Department of Health and Human Services, the sum of two hundred three thousand dollars ($203,000) for the 1999-2000 fiscal year and the sum of six hundred ten thousand dollars ($610,000) for the 2000-2001 fiscal year shall be used to implement two recommendations from the Interagency Coordinating Council's "Study on Early Intervention Services for Children Ages Birth to Five Years," dated March 1999. The Department of Health and Human Services, the Department of Public Instruction, and The University of North Carolina's Division TEACCH (Treatment and Education of Autistic and other Communications Handicapped Children and Adults), shall participate jointly, in collaboration with the Interagency Coordinating Council, in the planning, design, and implementation of the following provisions:

(1) Of the funds allocated by this subsection, the sum of seventy-eight thousand dollars ($78,000) in the 1999-2000 fiscal year and the sum of one hundred ten thousand dollars ($110,000) in the 2000-2001 fiscal year shall be used to plan, design, and implement an integrated, interagency database for children with or at risk for disabilities who receive early intervention services. The purpose of the database is to:

a. Assist in identifying gaps in services;

b. Project and plan for future service needs;

c. Improve the quality and accessibility of services; and

d. Document outcomes of early intervention services.

This database shall be compatible with the State Board of Education's new Student Information Management System. These agencies shall initiate use of the database in a pilot program in at least one community by July 1, 2000 and shall evaluate this pilot for statewide implementation by July 1, 2001. The agencies shall submit a progress report by April 1, 2000, to the Senate Appropriations Committee on Human Resources, the House of Representative Appropriations Subcommittee on

62

Health and Human Services, and the Fiscal Research Division.

(2) Of the funds allocated by this subsection, the sum of one hundred twenty-five thousand dollars ($125,000) in fiscal year 1999-2000 and the sum of five hundred thousand dollars ($500,000) in fiscal year 2000-2001 shall be used to plan for and implement regional transdisciplinary teams to provide training, technical assistance, and other support services to existing early intervention agencies and providers. The teams will maintain expertise on low incidence populations, such as children with visual and hearing impairments, autism, and child mental health needs. These agencies shall implement a pilot program establishing a regional transdisciplinary team no later than March 2000. These agencies shall submit an interim report by March 15, 2000, and a final plan for statewide implementation of the transdisciplinary teams by March 15, 2001, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Sec. @. (b) The North Carolina Schools for the Deaf and other agencies providing early intervention services to children from birth through five years of age shall implement procedures to ensure that:

(1) Parents of children newly identified with hearing loss and determined to be eligible for services are informed of the services available to them through Beginnings for Parents of Hearing Impaired Children, Inc.; and

(2) Beginnings for Parents of Hearing Impaired Children, Inc., with the consent of parents, is notified of these children in a timely and appropriate manner.

CODE NO. 99DHHS-H006

Requested by: Representative

CHILD CARE ALLOCATION FORMULA

Sec. @. (a) To simplify current child care allocation methodology and more equitably distribute State child care funds, the Department of Health and Human Services shall apply the following allocation formula to all noncategorical federal and State child care funds used to pay the costs of necessary child care for minor children of needy families:

(1) One-third of budgeted funds shall be distributed according to the county's population in relation to the total population of the State;

(2) One-third of the budgeted funds shall be distributed according to the number of children under 6 years of age in a county who are living in families whose income is below the State poverty level in relation to the total number of children under 6 years of age in the State in families whose income is below the poverty level; and

(3) One-third of budgeted funds shall be distributed according to the number of working mothers with children under 6 years of age in a county in relation to the total number of working mothers with children under 6 years of age in the State.

(b) A county's initial allocation shall not be less than that county's total expenditures for both FSA and non-FSA child care in fiscal year 1995-96.

(c) The Department of Health and Human Services may re-allocate child care subsidy funds in order to meet the child care needs of low income families.

64

CODE NO. 99DHHS-H007

Requested by: Representative

CHILD CARE FUNDS MATCHING REQUIREMENT

Sec. @. No local matching funds may be required by the Department of Health and Human Services as a condition of any locality's receiving any State child care funds appropriated by this act unless federal law requires such a match. This shall not prohibit any locality from spending local funds for child care services.

65

CODE NO. 99DHHS-H008

Requested by: Representative

CHILD CARE REVOLVING LOAN FUND

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

66

CODE NO. 99DHHS-H033

Requested by: Representative

CHILD CARE MARKET RATE FUNDS

Sec. @. The sum of three million three hundred thousand dollars ($3,300,000) appropriated to the Division of Social Services in this act shall be transferred to the Division of Child Development to fund the non-federal share of the child care market rate increase.

CODE NO. 99DHHS-H034A

Requested by: Representative

CHILD CARE SUBSIDIES

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

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

FAMILY SIZE	PERCENT OF GROSS FAMILY INCOME
1-3	9%
4-5	8%
6 or more	7%

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

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

(2) Licensed child care centers and homes that are receiving a higher rate than the market rates that will be implemented with this provision shall continue to receive that higher rate for a period of three years from the effective date of this section.

(3) Licensed child care centers and homes with two or more stars may receive a higher payment rate per child per month as follows: two stars - $14, three stars - $17, four stars - $20, and five stars - $23.

(4) Nonlicensed homes shall receive 50% of the county market rate or the rate they charge privately paying parents; whichever is lower.

(5) Maximum payment rates shall also be calculated periodically by the Division of Child Development for transportation to and from child care provided

by the child care provider, individual transporter or transportation agency and for fees charged providers to parents. These payment rates shall be based upon information collected by market rate surveys.

(d) Provision of payment rates for child care providers in counties who do not have at least 75 children in each age group for center-based and home-based care are as follows:

(1) Payment rates shall be set at the statewide market rate for licensed child care centers and homes.

(2) If it can be demonstrated that the application of the statewide market rate to a county with fewer than 75 children in each age group is lower than the county market rate and would inhibit the ability of the county to purchase child care for low-income children, then the county market rate may be applied.

(e) A market rate shall be calculated for child care centers and homes that meet minimum licensing standards for each county and for each age group or age category of enrollees and shall be representative of fees charged to unsubsidized privately paying parents for each age group of enrollees within the county. The Division of Child Development shall also calculate a statewide market rate for each age category. The Division of Child Development may also calculate regional market rates for each age group and age category.

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

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

CODE NO. 99DHHS-H037C

Requested by: Representative

EARLY CHILDHOOD EDUCATION AND DEVELOPMENT INITIATIVES

Sec. @. (a) G.S. 143B-168.12(a)(1) reads as rewritten:

"(1) The North Carolina Partnership shall have a Board of Directors consisting of the following 25 members:

a. The Secretary of Health and Human Services, ex officio, or the Secretary's designee;

b. Repealed by Session Laws 1997, c. 443, s. 11A.105.

c. The Superintendent of Public Instruction, ex officio, or the Superintendent's designee;

d. The President of the Department of Community Colleges, ex officio, or the President's designee;

e. Three members of the public, including one child care provider, one other who is a parent, and one other who is a board chair of a local partnership serving on the North Carolina Partnership local partnership advisory committee, appointed by the General Assembly upon recommendation of the President Pro Tempore of the Senate;

f. Three members of the public, including one who is a parent, one other who is a representative of the faith community, and one other who is a board chair of a local partnership serving on the North Carolina Partnership local partnership advisory committee, appointed by the General Assembly upon recommendation of the Speaker of the House of Representatives;

g. Twelve members, appointed by the Governor. Three of these 12 members shall be members of the party other than the Governor's party, appointed by the Governor. Seven of these 12 members shall be appointed as follows: one who is a child care provider, one other who is a pediatrician, one other who is a health care provider, one other who is a parent, one other who is a member of the business community, one

70

other who is a member representing a philanthropic agency, and one other who is an early childhood educator;

h. Repealed by Session Laws 1998-212, s. 12.37B(a).

h1. The Chair of the North Carolina Partnership Board shall be appointed by the Governor;

i. Repealed by Session Laws 1998-212, s. 12.37B(a).

j. One member of the public appointed by the General Assembly upon recommendation of the Majority Leader of the Senate;

k. One member of the public appointed by the General Assembly upon recommendation of the Majority Leader of the House of Representatives;

l. One member of the public appointed by the General Assembly upon recommendation of the Minority Leader of the Senate; and

m. One member of the public appointed by the General Assembly upon recommendation of the Minority Leader of the House of Representatives.

All members appointed to succeed the initial members and members appointed thereafter shall be appointed for three-year terms. Members may succeed themselves.

All appointed board members shall avoid conflicts of interests and the appearance of impropriety. Should instances arise when a conflict may be perceived, any individual who may benefit directly or indirectly from the North Carolina Partnership's disbursement of funds shall abstain from participating in any decision or deliberations by the North Carolina Partnership regarding the disbursement of funds.

All ex officio members are voting members. Each ex officio member may be represented by a designee. These designees shall be voting members. No members of the General Assembly shall serve as members.

The North Carolina Partnership may establish a nominating committee and, in making their recommendations of members to be appointed by the General Assembly or by the Governor, the President

Pro Tempore of the Senate, the Speaker of the House of Representatives, the Majority Leader of the Senate, the Majority Leader of the House of Representatives, the Minority Leader of the Senate, the Minority Leader of the House of Representatives, and the Governor shall consult with and consider the recommendations of this nominating committee.

The North Carolina Partnership may establish a policy on members' attendance, which policy shall include provisions for reporting absences of at least three meetings immediately to the appropriate appointing authority.

Members who miss more than three consecutive meetings without excuse or members who vacate their membership shall be replaced by the appropriate appointing authority, and the replacing member shall serve either until the General Assembly and the Governor can appoint a successor or until the replaced member's term expires, whichever is earlier.

The North Carolina Partnership shall establish a policy on membership of the local board, which policy shall include the requirement that all local board ~~members~~ members, other than any member appointed because of a position held by that individual, be residents of the county or the partnership region they are representing. Within these requirements for local board membership, the North Carolina Partnership shall allow local partnerships that are regional to have flexibility in the composition of their boards so that all counties in the region have adequate representation.

All appointed local board members shall avoid conflicts of interests and the appearance of impropriety. Should instances arise when a conflict may be perceived, any individual who may benefit directly or indirectly from the partnership's disbursement of funds shall abstain from participating in any decision or deliberations by the partnership regarding the disbursement of funds."

72

Sec. @. (b) The General Assembly finds that it is essential to continue developing comprehensive programs that provide high quality early childhood education and development services locally for children and their families. The General Assembly intends to expand the Early Childhood Education and Development Initiatives Program (the 'Program') in a manner which ensures quality assurance and performance-based accountability for the Program.

Sec. @. (c) Notwithstanding any provision of Part 10B of Article 3 of Chapter 143B of the General Statutes or any other provision of law or policy, the Department of Health and Human Services and the North Carolina Partnership for Children, Inc., jointly shall continue to implement the recommendations contained in the Smart Start Performance Audit prepared pursuant to Section 27A(1)b. of Chapter 324 of the 1995 Session Laws, as modified by Section 24.29 of Chapter 18 of the Session Laws, Second Extra Session 1996. The North Carolina Partnership for Children, Inc., shall continue to report quarterly to the Joint Legislative Commission on Governmental Operations on its progress toward full implementation of the modified audit recommendations.

Sec. @. (d) The Joint Legislative Commission on Governmental Operations shall, consistent with current law, continue to be the legislative oversight body for the Program. The President Pro Tempore of the Senate and the Speaker of the House of Representatives may appoint a subcommittee of the Joint Legislative Commission on Governmental Operations to carry out this function. This subcommittee may conduct all initial reviews of plans, reports, and budgets relating to the Program and shall make recommendations to the Joint Legislative Commission on Governmental Operations.

Sec. @. (e) Administrative costs shall be equivalent to, on an average statewide basis for all local partnerships, not more than eight percent (8%) of the total statewide allocation to all local partnerships. What counts as administrative costs shall be as defined in the Smart Start Performance Audit.

Sec. @. (f) Any local partnership, before receiving State funds, shall be required annually to submit a plan and budget for State funds for appropriate programs to the North Carolina Partnership for Children, Inc., and the Joint Legislative Commission on Governmental Operations. State funds to implement the programs shall not be allocated to a local partnership until the program plan is approved by the North Carolina Partnership for Children, Inc.

73

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

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

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

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

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

Sec. @. (h) The role of the North Carolina Partnership for Children, Inc., shall continue to be expanded to incorporate all the aspects of the new role determined for the Partnership in the Smart Start Performance Audit recommendations and to provide technical assistance to local partnerships, assess outcome goals for children and families, ensure that statewide goals and legislative guidelines are being met, help establish policies and outcome measures, obtain non-State resources for early childhood and family services, and document and verify the cumulative contributions received by the partnerships.

Sec. @. (i) The North Carolina Partnership for Children, Inc., and all local partnerships shall, in the aggregate, be required to match no less than fifty percent (50%) of the total amount budgeted for the Program in each fiscal year of the biennium as follows: contributions of cash equal to at least ten percent (10%) and in-kind donated resources equal to no more than ten percent (10%) for a total match requirement of twenty percent (20%) for each fiscal year. Only in-kind contributions that are quantifiable, as determined in the Smart Start Performance Audit, shall be applied to the in-kind match requirement. Expenses, including both those paid by cash and in-kind contributions, incurred by other participating non-State entities contracting with the North Carolina Partnership for Children or the local partnerships, also may be considered resources available to meet the required private match. In order to qualify to meet the required private match, the expenses shall:

(1) Be verifiable from the contractor's records;
(2) If in-kind, be quantifiable in accordance with generally accepted accounting principles for nonprofit organizations;
(3) Not include expenses funded by State funds;
(4) Be supplemental to and not supplant preexisting resources for related program activities;
(5) Be incurred as a direct result of the Early Childhood Initiatives Program and be necessary and reasonable for the proper and efficient accomplishment of the Program's objectives;
(6) Be otherwise allowable under federal or State law;
(7) Be required and described in the contractual agreements approved by the North Carolina Partnership for Children or the local partnership; and
(8) Be reported to the North Carolina Partnership for Children or the local partnership by the contractor in the same manner as reimbursable expenses.

The North Carolina Partnership shall establish uniform guidelines and reporting format for local partnerships to document the qualifying expenses occurring at the contractor level. Local partnerships shall monitor qualifying expenses to ensure they have occurred and meet the requirements prescribed in this subsection.

Failure to obtain a twenty percent (20%) match by May 1 of each fiscal year shall result in a dollar-for-dollar reduction in the appropriation for the Program for the next fiscal year. The North Carolina Partnership for Children, Inc., shall be responsible for compiling information on the private cash and in-kind contributions into a report that is submitted to the Joint Legislative Commission on Governmental Operations in a format that allows verification by the Department of Revenue. The same match requirements shall apply to any expansion funds appropriated by the General Assembly.

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

Statutes, with other applicable requirements of State law or rule, including rules adopted for nonregistered child care by the Social Services Commission, and with applicable federal regulations.

Sec. @. (k) The Department of Health and Human Services shall continue to implement the performance-based evaluation system.

Sec. @. (l) The Frank Porter Graham Child Development Center shall continue its evaluation of the Program. Notwithstanding any policy to the contrary, the Frank Porter Graham Child Development Center may use any method legally available to it to track children who are participating or who have participated in any Early Childhood Education and Development Initiative in order to carry out its ongoing evaluation of the Program.

Sec. @. (m) There is allocated from the funds appropriated to the Department of Health and Human Services, Division of Child Development, in this act, the sum of fifty-nine million six hundred sixty-five thousand dollars ($59,665,000) for the 1999-2000 fiscal year and the sum of seventy-eight million nine hundred twenty-eight thousand eight hundred twenty-six dollars ($78,928,826) for the 2000-2001 fiscal year to be used as follows:

(1) The sum of fifty-eight million dollars ($58,000,000) in the 1999-2000 fiscal year and the sum of seventy-eight million nine hundred twenty-eight thousand eight hundred twenty-six dollars ($78,928,826) in the 2000-2001 fiscal year shall be used to administer and deliver services in all 100 counties. These funds may be used as financial incentives to encourage regionalization at the local level and to complete development of contracting and accounting systems at the local level. Any funds used to encourage regionalization or to complete development of contracting and accounting systems at the local level shall not be included in computations affecting the administrative cost limitations under subsection (e) of this section.

(2) The North Carolina Partnership for Children, Inc., may use the sum of one million five hundred thousand dollars ($1,500,000) in the 1999-2000 fiscal year to assist local partnerships in their efforts to develop local collaboration.

Sec. @. (n) Of the funds appropriated to the Department of Health and Human Services for the Program for the 1999-2001 biennium, the Frank Porter Graham Child Development Center shall receive the sum of one million fifteen thousand dollars ($1,015,000) in the 1999-2000 fiscal year and the sum of one million fifteen thousand dollars ($1,015,000) in the 2000-2001 fiscal year.

CODE NO. 99DHHS-H035

Requested by: Representative

REIMBURSEMENT AND COMPENSATION OF MEMBERS OF THE NORTH CAROLINA VOCATIONAL REHABILITATION ADVISORY COUNCIL, THE STATEWIDE INDEPENDENT LIVING COUNCIL, AND THE COMMISSION FOR THE BLIND

Sec. @. G.S. 138-5(a) reads as rewritten:

"(a) Except as provided in subsections (c) and (f) of this section, members of State boards, commissions, committees and councils which operate from funds deposited with the State Treasurer shall be compensated for their services at the following rates:

(1) ~~Compensation~~ Except as otherwise provided by this subdivision, compensation at the rate of fifteen dollars ($15.00) per diem for each day of ~~service;~~ service. Members of the North Carolina Vocational Rehabilitation Advisory Council, the Statewide Independent Living Council, and the Commission for the Blind who are unemployed or who shall forfeit wages from other employment to attend council or commission meetings or to perform related duties, may receive compensation not to exceed fifty dollars ($50.00) per diem for attending these meetings or performing related duties, as authorized by sections 105 and 705 of the Rehabilitation Act of 1973, P.L. 102-569, 42 U.S.C. § 701, et seq., as amended.

(2) Reimbursement of subsistence expenses at the rates allowed to State officers and employees by subdivision (3) of G.S. 138-6(a).

(3) Reimbursement of travel expenses at the rates allowed to State officers and employees by subdivisions (1) and (2) of G.S. 138-6(a).

(4) For convention registration fees, the actual amount expended, as shown by receipt."

78

CODE NO. 99DHHS-H004A

Requested by: Representatives

FAMILY SUPPORT/DEAF AND HARD OF HEARING SERVICES CONTRACT

Sec. @. Of the funds appropriated in this act to the Division of Services for the Deaf and the Hard of Hearing, Department of Health and Human Services, for family support services, the sum of five hundred three thousand two hundred thirty-eight dollars ($503,238) for the 1999-2000 fiscal year and the sum of five hundred three thousand two hundred thirty-eight dollars ($503,238) for the 2000-2001 fiscal year shall be used to contract with a private, nonprofit corporation licensed to do business in North Carolina to perform those services, including family support and advocacy services as well as technical assistance to professionals who work with families of hearing-impaired children aged birth to 21 years.

CODE NO. 99DHHS-H005

Requested by: Representative

SERVICES FOR BLIND/EXTENDED SERVICE PROVIDER POSITIONS

Sec. @. Of the funds appropriated in this act to the Department of Health and Human Services, Division of Services for the Blind, the sum of two hundred fifty thousand dollars ($250,000) in each fiscal year of the 1999-2001 biennium shall be used to maintain extended service provider positions at local, nonprofit supported employment programs.

80

CODE NO. 99DHHS-H073

Requested by: Representatives

IMMUNIZATION PROGRAM RESTITUTION POLICY

Section @. In implementing the restitution procedures adopted pursuant to Section 12.52(d) of S.L. 1998-212, the Department of Health and Human Services shall require restitution from immunization program providers under the following circumstances:

(1) When vaccine in the provider's inventory has expired due to the provider's negligence and unreasonable failure to properly rotate the inventory.

(2) When vaccine in the provider's inventory has become spoiled or unstable due to the provider's negligence and unreasonable failure to properly handle or store the vaccine.

81

CODE NO. 99DHHS-H026

Requested by: Representatives

IMMUNIZATION PROGRAM FUNDING

Section @. (a) Of the funds appropriated to the Department of Health and Human Services for the 1999-2001 fiscal biennium for childhood immunization programs for positions, operating support, equipment, and pharmaceuticals, the sum of up to one million dollars ($1,000,000) each fiscal year may be used for projects and activities that are also designed to increase childhood immunization rates in North Carolina. These projects and activities shall include the following:

(1) Outreach efforts at the State and local levels to improve service delivery of vaccines. Outreach efforts may include educational seminars, media advertising, support services to parents to enable children to be transported to clinics, longer operating hours for clinics, and mobile vaccine units; and

(2) Continued development of an automated immunization registry.

(b) Funds authorized to be used for immunization efforts under subsection (a) of this section shall not be used to fund additional State positions in the Department of Health and Human Services.

82

CODE NO. 99DHHS-H061B

Requested by: Representatives

INTENSIVE HOME VISITATION PROGRAM FOR CHILDREN

Section @. (a) Notwithstanding G.S. 143-15C, there is appropriated from the Work First Reserve Fund to the Department of Health and Human Services the sum of nine hundred forty-five thousand dollars ($945,000) for the 1999-2000 fiscal year. These funds shall be used to match federal funds in the Intensive Home Visitation Program for Children.

(b) Not later than April 1, 2000, the Department of Health and Human Services shall report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division, on the following:

(1) Preliminary maternal outcome data, including adequacy of prenatal care, breast feeding, return to school or work, use of contraception, occurrence of repeat pregnancy, substance abuse, domestic violence, parenting knowledge, parenting satisfaction, and use of government programs;

(2) Preliminary child outcome data, including birth weight and gestational age, quality of the home environment, home safety, reported and substantiated episodes of child abuse or neglect, episodes of injury and ingestions, and hospitalizations;

(3) Evidence of the efficacy of the Linkages Model when compared to the Healthy Families Model and the traditional Olds Model and, to the extent evidence is available, to the targeted population at large; and

(4) The progress that has been made in implementing intensive home visitation programs in participating counties, including information on the number of families being served and the extent to which county programs rely upon Medicaid to sustain themselves.

83

CODE NO. 99DHHS-H014B

Requested by: Representative

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Sec. @. (a) The Department of Health and Human Services shall develop and implement a cost-containment plan for the purpose of serving additional clients of the AIDS Drug Assistance Program (ADAP). In developing the Plan, the Department shall do the following:

(1) Explore the feasibility of obtaining a Medicaid expansion waiver;

(2) Estimate the potential cost savings to the State of participating in the 340B Drug Pricing Program by studying various ways of adhering to program requirements while also realizing cost savings;

(3) Examine, for possible adoption, ADAP and other similar program cost-saving strategies in other states, including, but not limited to, restrictive formularies, prescription limitations, insurance continuity, and insurance purchasing programs, and biannual or quarterly reauthorizations; and

(4) Conduct other activities that will assist in the development of a viable plan.

(b) The Department shall implement cost-containment programs or mechanisms, other than the current pharmaceutical rebates approach, by July 1, 1999, and shall report to the members of the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division not later than May 15, 2000, on the following:

(1) The realized and projected savings;

(2) Findings from subdivisions (1), (2), and (3) of subsection (a) of this section; and

(3) Recommendations for legislative action.

(c) Savings realized through cost-containment measures shall be used to serve additional ADAP participants in each fiscal year. Funds not expended for authorized program costs shall revert to the General Fund.

(d) The Department shall also develop a comprehensive information system on AIDS/HIV clients receiving services from the State. This system shall include information on program usage patterns of ADAP participants, including, but not limited to, frequency of prescription purchases, and types of medications

84

prescribed. The Department shall also develop a plan for promoting patient adherence to physician treatment recommendations. In developing the plan, the Department shall identify ways of obtaining information without interfering with physician-patient confidentiality. The Department shall report on this plan to the members of the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division not later than May 15, 2000.

(e) For the 1999-2000 fiscal year, HIV-positive individuals with incomes at or below one hundred twenty-five percent (125%) of the federal poverty level are eligible for participation in ADAP. Notwithstanding any other provision of law, eligibility for participation in ADAP during the 1999-2000 fiscal year shall not be extended to individuals with incomes above one hundred twenty-five percent (125%) of the federal poverty level. All individuals who are eligible for participation in ADAP shall be served by the Department of Health and Human Services. If sufficient funds are not available from funds allocated to ADAP, the Department of Health and Human Services shall transfer available funds from other programs within the Department to meet the funding needs of ADAP.

(f) The Department of Health and Human Services shall study the estimated participation rates and costs if eligibility for participation in ADAP were raised to two hundred percent (200%) or to two hundred fifty percent (250%) of the federal poverty level. The Department of Health and Human Services shall report the findings of this study to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division not later than May 15, 2000.

repeat

CODE NO. 99DHHS-H015

Requested by: Representative

HIV/STD PREVENTION SERVICES/EVALUATION AND ACCOUNTABILITY OF GRANTEES

Sec. @. (a) The Department of Health and Human Services, Division of Epidemiology, shall continue the practice of contracting with community-based organizations, local health departments, and other entities to provide services to high-risk individuals. Contracts shall require quarterly reports to the Department on the entity's use of funds, number of clients served under the contract, details on program expenditures, and any other information needed by the Department to enable it to evaluate the efficiency and effectiveness of the entity's use of funds and provision of services. Entities under contract with the Department shall provide to the Department, at least annually, a copy of the entity's financial statement and most recent audit report.

(b) If the entity with which the Department of Health and Human Services contracts in accordance with subsection (a) of this section is a nonprofit organization, then the entity shall also provide the same quarterly report to the appropriate local health department for information purposes only.

(c) The Department of Health and Human Services shall adopt standards for the annual evaluation and certification of entities with which the Department contracts under this section. The evaluation and certification standards shall provide sanctions, including discontinuing of funding, for an entity's failure to comply with DHHS standards and State law. The Department shall adopt the standards not later than July 1, 1999, and the standards shall apply to contracts entered into on and after January 1, 2000.

(d) The Department of Health and Human Services shall report to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources no later than July 1, 1999, on the standards adopted, on entities currently under contract with the Department, and on those entities' experience in providing effective and efficient services under contract with the Department.

(e) Effective January 1, 2000, the Department of Health and Human Services shall not allocate HIV Prevention Funds to any

1 entity unless the entity has met the certification standards
2 adopted by the Department.

87

CODE NO. 99DHHS-H025

Requested by: Representatives

EXTEND HEART DISEASE AND STROKE PREVENTION TASK FORCE

Section @. Subsections (l) and (m) of Section 26.9 of Chapter 507 of the 1995 Session Laws, as amended by Section 15.25 of S.L. 1997-443, read as rewritten:

"(l) The Task Force shall submit to the Governor and to the General Assembly a preliminary report by January 1, 1996; an interim report within the first week of the convening of the 1997 General Assembly; a second interim report within the first week of the convening of the 1997 General Assembly, Regular Session 1998; a third interim report within the first week of the convening of the 1999 General Assembly, a fourth interim report within the first week of the convening of the 2000 General Assembly; a fifth interim report within the first week of the convening of the 2001 General Assembly, and a final report by June 30, ~~1999.~~ 2001. The reports shall address the Plan, actions and resources needed to fully implement the Plan, and progress in achieving implementation of the Plan to reduce the occurrence of and burden from heart disease and stroke in North Carolina. The reports shall include an accounting of funds expended and anticipated funding needs for full implementation of recommended plans and programs.

(m) Upon submission of its final report to the Governor and the ~~1999~~ 2001 General Assembly, the Task Force shall expire."

88

CODE NO. 99DHHS-H057

Requested by: Representatives

new

CANCER CONTROL ADVISORY COMMITTEE FUNDS

Section @. Of the funds appropriated to the Department of Health and Human Services, Division of Public Health, for the Advisory Committee on Cancer Coordination and control, a portion shall be used for prostate cancer control activities.

89

CODE NO. 99DHHS-H059

Requested by: Representatives

PUBLIC HEALTH PREVENTION ACTIVITIES REPORT

Section @. (a) By April 15, 2000 and more frequently as requested, the Department of Health and Human Services, Division of Public Health, shall report on the activities of each of the following:

(1) Children's Vision Screening program of Prevent Blindness, Inc.;

(2) North Carolina Healthy Start Foundation; and

(3) Adolescent Pregnancy Prevention Coalition of North Carolina.

(b) The report shall include the following information for each of the organizations named in subsection (a) of this section:

(1) How organization initiatives singularly or in concert with other programs, contribute to the Department's overall goal of reducing teen pregnancy and infant mortality, and addressing vision problems of children in North Carolina. This information shall also include data and research that supports the approach the Department has taken in achieving its goal;

(2) Output data demonstrating the effects of the organization's activities;

(3) State fiscal year 1998-99 program objectives and activities;

(4) State fiscal year 1998-99 itemized expenditures and fund sources;

(5) State fiscal year 1999-2000 planned objectives, activities, and accomplishments; and

(6) State fiscal year 1999-2000 estimated itemized expenditures and fund sources, including actual expenditures and fund sources through April 15, 2000.

90

CODE NO. 99DHHS-H009

Requested by: Representative

Repeat

COMMUNICABLE DISEASE CONTROL AID TO COUNTIES FLEXIBILITY

Sec. @. (a) For the 1999-2000 and 2000-2001 fiscal years, the Department of Health and Human Services may combine and allocate funds appropriated for Aid to Counties in the Acute Communicable Disease Control Fund, the Tuberculosis Control Fund, and the Sexually Transmitted Disease Control Fund into one Acute Communicable Disease Control Aid to Counties Grant. Communicable Disease Aid to Counties funding to local health departments and other authorized recipients will be based on a general communicable disease formula to be developed by the Department of Health and Human Services.

(b) The Department of Health and Human Services, in conjunction with local health departments, will maintain a system to monitor and identify Aid to Counties communicable disease expenditures by each communicable disease group.

CODE NO. 99DHHS-H036

Requested by: Representative

TRANSFER FUNDS DESIGNATED FOR THE CHEMICAL ALCOHOL TESTING PROGRAM

Sec. @. (a) The Administrative Office of the Courts shall transfer all funds collected under G.S. 20-16.5(j) that are designated for the chemical alcohol testing program to the Department of Health and Human Services on a monthly basis.

(b) Any funds collected under G.S. 20-16.5(j) that are designated for the chemical alcohol testing program of the Department of Health and Human Services and are not needed for that program shall be transferred annually to the Governor's Highway Safety program for grants to local law enforcement agencies for training and enforcement of the laws on driving while impaired. The Governor's Highway Safety Program shall expend funds transferred to it under this section within 13 months of receipt of the funds. Amounts received by the Governor's Highway Safety Program shall not revert until the June 30 following the 13-month period.

92

new extend program

CODE NO. 99DHHS-H063

Requested by: Representatives

OSTEOPOROSIS PROGRAM FUNDS

Section @. (a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Public Health, the sum of one hundred thousand dollars ($100,000) for the 1999-2000 fiscal year shall be allocated for the continuing work of the Osteoporosis Task Force established by Section 15.32 of S.L. 1997-443.

(b) The Task Force shall submit a progress report to members of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Approprations Committee on Human Resources, the Governor, and the Fiscal Research Division not later than April 1, 2000. The progress report shall address:

(1) Progress being made in fulfilling the duties of the Task Force and in developing the Osteoporosis Prevention Plan,

(2) The anticipated time frame for completion of the Prevention Plan, and

(3) Recommended strategies or actions to reduce the occurrence of and burdens suffered from osteoporosis by citizens of this State.

The Task Force shall submit its final report to the 1999 General Assembly, the Governor, and the Fiscal Research Division not later than October 1, 2000.

Section @. (c) Subsection (m) of Section 15.32 of S.L. 1997-443 reads as rewritten:

"(m) Upon submission of its final report to the Governor and the 1999 General Assembly, Regular Session 2000, the Task Force shall expire."

CODE NO. 99DHHS-H053

Requested by: Representatives

HEALTHY MOTHERS/HEALTHY CHILDREN PROGRAM

Section @. (a) The Department of Health and Human Services may initiate a Healthy Mothers/Healthy Children Grant Program in up to eight local health departments. The Department may consolidate federal Maternal and Child Health Block Grant funds and State funds appropriated for the Maternal Health, Women's Preventive Health, Child Health, Child Service Coordination and Immunization programs into a Healthy Mothers/Healthy Children Grant Program for each participating local health department. Local health departments participating in the Healthy Mothers/Healthy Children Grant Program may use grant funds to do any of the following:

(1) Improve the health status of women of childbearing age by expanding preventive health services and reducing and/or controlling health risk factors.

(2) Reduce infant mortality and morbidity by preventing high-risk pregnancies, improving the health status of women before pregnancy, improving access to prenatal care, reducing prematurity, and improving survival rates of preterm and other high-risk infants.

(3) Reduce mortality and morbidity among children and youth by reducing the incidence of communicable disease and other preventable conditions, the occurrence and severity of injuries, the incidence of genetic disorders, and the incidence of chronic illnesses and developmental disabilities.

(4) Enhance the health and functional status of children and youth with chronic handicapping conditions by reducing the severity of the conditions through the provision of early identification, diagnosis, treatment, and care coordination services.

(b) The Department shall not include federal categorical funds, competitive special project funds, and funds for regionalized services in grant funds awarded to local health departments under the Healthy Mothers/Healthy Children Grant Program.

(c) The Department shall require participating local health departments to identify and report expenditures by program

in order to monitor and track the use of Healthy Mothers/Healthy Children Grant Program funds to meet federal and State reporting requirements. In addition, the Department shall require local health departments to report on the administrative, programmatic, and health outcome benefits which are realized by providing localities greater flexibility.

(d) The Department shall report to members of the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Health and Human Services on the implementation of the Healthy Mothers/Healthy Children Grant Program not later than April 1, 2000.

CODE NO. 99DHHS-H065B

Requested by: Representatives

PREVENTIVE HEALTH PROGRAM PLAN

Section @. The Department of Health and Human Services shall develop a plan to reduce duplication among preventive health programs and initiatives, focusing on task forces, advisory committees, local health departments, and other entities supported by and within the Chronic Disease Prevention and Control Section of the Division of Public Health. In developing the plan, the Department shall do the following:

(1) Examine the goals of each program or initiative to identify areas of commonality and differences;

(2) Explore alternative ways of organizing the Section to achieve greater efficiency and effectiveness.

The Department shall report on the development of its plan to members of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division not later than April 1, 2000.

96

CODE NO. 99DHHS-H075C

Requested by: Representatives Earle, Nye

DHHS BLOCK GRANT PROVISIONS

Section @. (a) Appropriations from federal block grant funds are made for the fiscal year ending June 30, 2000, according to the following schedule:

COMMUNITY SERVICES BLOCK GRANT	
01. Community Action Agencies	$ 11,927,604
02. Limited Purpose Agencies	651,534
03. Department of Health and Human Services to administer and monitor the activities of the Community Services Block Grant	451,534
TOTAL COMMUNITY SERVICES BLOCK GRANT	$ 13,030,672
SOCIAL SERVICES BLOCK GRANT	
01. County departments of social services (Transfer from TANF - $4,500,000)	$ 30,395,663
02. Allocation for in-home services provided by county departments of social services	2,101,113
03. Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	4,764,124
04. Division of Services for the Blind	3,205,711
05. Office of Juvenile Justice	950,674
06. Division of Facility Services	343,341
07. Division of Aging - Home and Community Care Block Grant	1,915,234
08. Transfer from TANF Block Grant for Child Care Subsidies	10,971,241
09. Division of Vocational Rehabilitation - United Cerebral Palsy	71,484
10. State administration	1,954,237

97

11.	Child Medical Evaluation Program	238,321
12.	Adult day care services	2,255,301
13.	County departments of social services for child abuse prevention and permanency planning	394,841
14.	Transfer to Preventive Health Services Block Grant for emergency medical services	213,128
15.	Transfer to Preventive Health Services Block Grant for AIDS education, counseling, and testing	66,939
16.	Department of Administration for the N.C. Commission of Indian Affairs In-Home Services Program for the elderly	203,198
17.	Division of Vocational Rehabilitation - Easter Seals Society	116,779
18.	UNC-CH CARES Program for training and consultation services	247,920
19.	Transfer from TANF Block Grant for Allocation to the Adolescent Pregnancy Prevention Program	239,261
20.	Office of the Secretary - Office of Economic Opportunity for N.C. Senior Citizens' Federation for outreach services to low-income elderly persons	41,302
21.	County departments of social services for child welfare improvements (Transfer from TANF - $300,000)	2,211,687
22.	Transfer from TANF Block Grant for Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for juvenile offenders	1,182,280
23.	Transfer from TANF Block Grant for Enhanced Employee Assistance Program	1,000,000
24.	Transfer from TANF Block Grant for Division of Social Services - Child Caring Institutions	1,500,000
25.	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services - Developmentally	

Disabled Waiting List for services	5,000,000
26. Enhance Special Children Adoption Fund	1,900,000
27 Local County Child Welfare Workers	1,427,550
TOTAL SOCIAL SERVICES BLOCK GRANT	$ 74,911,329
LOW-INCOME ENERGY BLOCK GRANT	
01. Energy Assistance Programs	$ 7,530,047
02. Crisis Intervention	7,370,681
03. Administration	1,992,076
04. Department of Commerce - Weatherization Program	2,988,114
05. Department of Administration - N.C. Commission of Indian Affairs	39,841
TOTAL LOW-INCOME ENERGY BLOCK GRANT	$ 19,920,759
MENTAL HEALTH SERVICES BLOCK GRANT	
01. Provision of community-based services in accordance with the Mental Health Study Commission's Adult Severe and Persistently Mentally Ill Plan	$ 3,895,179
02. Provision of community-based services in accordance with the Mental Health Study Commission's Child Mental Health Plan	1,913,917
03. Administration	689,735
TOTAL MENTAL HEALTH SERVICES BLOCK GRANT	$ 6,498,831
SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT	
01. Provision of community-based alcohol and drug abuse services, tuberculosis services, and services provided by the Alcohol, Drug Abuse Treatment Centers	$ 15,350,132
02. Continuation of services for pregnant women and women with dependent children	6,567,532

03. Continuation and expansion of services to IV drug abusers and others at risk for HIV diseases	5,390,497
04. Provision of services in accordance with the Mental Health Study Commission's Child and Adolescent Alcohol and Other Drug Abuse Plan	7,454,702
05. Juvenile Services - Family Focus	893,811
06. Juvenile offender services and substance abuse pilot	300,000
07. Administration	2,623,049
TOTAL SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT	$ 38,579,723
CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT	
01. Child care subsidies	$112,624,103
02. Quality and availability initiatives	11,378,046
03. Administrative expenses	6,526,429
04. Transfer from TANF Block Grant for child care subsidies	51,669,460
05. Transfer from TANF Block Grant for child care rate increases and quality initiatives	12,482,188
TOTAL CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT	$194,680,226
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) BLOCK GRANT	
01. Work First Cash Assistance	$171,035,000
02. Work First County Block Grants	62,086,434
03. Transfer to the Child Care and Development Fund Block Grant for child care subsidies	51,669,480
04. Allocation to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for Work First substance abuse screening, diagnostic, and support treatment services and drug testing	3,500,000

05.	Allocation to the Division of Social Services for Work First Evaluation	1,000,000
06.	Allocation to the Division of Social Services for staff development	500,000
07.	Reduction of out-of-wedlock births	1,600,000
08.	Transfer to the Social Services Block Grant for substance abuse services for juveniles	1,182,280
09.	Transfer to the Social Services Block Grant for the Special Children Adoption Fund	2,200,000
10.	Employment Security Commission - First Stop Employment Assistance	4,100,000
11.	Transfer to Social Services Block Grant - Enhanced Employee Assistance Program	1,000,000
12.	Work First Job Retention and Follow-up Initiatives	1,677,529
13.	Allocation to the Division of Public Health for teen pregnancy prevention	2,000,000
14.	Transfer to Social Services Block Grant for Child Caring Agencies	1,500,000
15.	Child Care Subsidies for TANF Recipients	15,000,000
16.	Work First Business Council	100,000
17.	Work First Housing Initiative	3,000,000
18.	Transfer to Child Care and Development Fund Block Grant for Child Care Rate Increases	12,482,188
19.	Allocation to the Divsion of Social Services for Domestic Violence	1,000,000
20.	Implementation of HB 1159 - Protection from Violent Caregivers	160,000
21.	Transfer to Social Services Block Grant for Additional County Foster Care and Adoption Workers	1,427,550
22.	Intensive Family Preservation Program Expansion	2,000,000
23.	Contract for MOE Analysis and Assistance	500,000

24.	Work First/Boys and Girls Clubs	1,000,000
25.	Work First Pilots	6,189,025
26.	Community Colleges - Enhanced Pathways	500,000
27.	Transfer to Social Services Block Grant for Child Care Subsidies	10,971,241
28.	Transfer to Social Services Block Grant for County Departments of Social Services for Children's Services	4,500,000
29.	Transfer to Social Services Block Grant for Adolescent Pregnancy Prevention Program	239,261
TOTAL TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) BLOCK GRANT		$364,119,968
MATERNAL AND CHILD HEALTH BLOCK GRANT		
01.	Healthy Mother/Healthy Children Block Grants to Local Health Departments	$ 9,838,074
02.	High Risk Maternity Clinic Services, Perinatal Education and Training, Childhood Injury Prevention, Public Information and Education, and Technical Assistance to Local Health Departments	1,910,747
03.	Services to Children With Special Health Care Needs	5,035,209
TOTAL MATERNAL AND CHILD HEALTH BLOCK GRANT		$ 16,784,030
PREVENTIVE HEALTH SERVICES BLOCK GRANT		
01.	Transfer from Social Services Block Grant - Emergency Medical Services	$ 213,128
02.	Hypertension and Statewide Health Promotion Programs	3,364,469
03.	Dental Health for Fluoridation of Water Supplies	216,123
04.	Rape Prevention and Rape Crisis Programs	190,134

05.	Rape Prevention and Rape Education	1,159,292
06.	Transfer from Social Services Block Grant - AIDS/HIV Education, Counseling, and Testing	66,939
07.	Office of Minority Health and Minority Health Council	179,784
08.	Administrative and Indirect Cost	209,914
TOTAL PREVENTIVE HEALTH SERVICES BLOCK GRANT		$ 5,599,783

Section @. (b) Decreases in Federal Fund Availability - If the United States Congress reduces federal fund availability in the Social Services Block Grant below the amounts appropriated in this section, then the Department of Health and Human Services shall allocate these decreases giving priority first to those direct services mandated by State or federal law, then to those programs providing direct services that have demonstrated effectiveness in meeting the federally and State mandated services goals established for the Social Services Block Grant. The Department shall not include transfers from TANF for specified purposes in any calculations of reductions to the Social Services Block Grant.

If the United States Congress reduces the amount of TANF funds below the amounts appropriated in this section after the effective date of this act, then the Department shall allocate the decrease in funds after considering any underutilization of the budget and the effectiveness of the current level of services. Any TANF Block Grant fund changes shall be reported to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

The Department of Health and Human Services shall make a report in collaboration with all other State and local agencies and public and private entities (i) that are impacted by the Social Services or TANF Block Grants and (ii) that will be affected by future reductions in either of these block grants detailing plans for dealing with future reductions or adjustments in either of these block grants, including plans for programs funded wholly or in part with transfers from the TANF Block Grant.

Decreases in federal fund availability shall be allocated for the Maternal and Child Health and Preventive Health Services federal block grants by the Department of Health and Human Services after considering the effectiveness of the current level of services.

Section @. (c) Increases in Federal Fund Availability - Any block grant funds appropriated by the United States Congress in addition to the funds specified in this act shall be expended by the Department of Health and Human Services, with the

approval of the Office of State Budget and Management, provided the resultant increases are in accordance with federal block grant requirements and are within the scope of the block grant plan approved by the General Assembly.

Section @. (d) Changes to the budgeted allocations to the Block Grants appropriated in this act due to decreases or increases in federal funds shall be reported immediately to the the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Section @. (e) Limitations on Preventive Health Services Block Grant Funds - Twenty-five percent (25%) of funds allocated for Rape Prevention and Rape Education shall be allocated as grants to nonprofit organizations to provide rape prevention and education programs targeted for middle, junior high, and high school students.

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 1999-2000 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). The Department of Public Instruction shall carefully and strictly follow federal guidelines in implementing and administering the abstinence education grant funds.

Section @. (f) The sum of one million dollars ($1,000,000) appropriated to the Department of Health and Human Services, Division of Social Services, in the TANF Block Grant for the 1999-2000 fiscal year for the evaluation of the Work First Program shall be used to do each of the following:

(1) Expand the current evaluation of the Work First Program to assess former recipients' earnings, barriers to advancement to economic self-sufficiency, utilization of community support services, and other longitudinal employment data. Assessment periods shall include 6 and 18 months following closure of the case.

(2) Expand the current evaluation of the Work First Program to profile the State's child only caseload to include indicators of economic and social well-being, academic and behavioral performance, demographic data, description of living arrangements including length of placement out of the home, social and other human services provided to families, and other information needed to assess the needs of the child-only Work First Family Assistance clients and families.

(3) Expand the current evaluation to profile clients and families, exempted from federal and state work participation requirements. The evaluation shall

include an assessment of the client and family needs including why clients and families have been exempted.

The Department of Health and Human Services shall make a report on its progress in complying with this subsection to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than May 1, 2000.

Section @. (g) The sum of one million six hundred seventy-seven thousand five hundred twenty-nine dollars ($1,677,529) appropriated to the Department of Health and Human Services, Division of Social Services, in this section in the TANF BLock Grant in the 1999-2000 fiscal year for the Work First job retention and follow-up model programs shall be used to implement pilots and strategies that support TANF recipients in attaining and maintaining self-sufficiency through job retention, family support services, and pre- and post-TANF follow-up.

The Department of Health and Human Services shall make a report on its use of TANF funds for the Work First job retention pilots. This report shall include each of the following:

(1) A description of the clients served by the program. This description shall include demographic and geographic information about the clients.

(2) A description of services provided by the program.

(3) The effectiveness of services to clients. Effectiveness of services to clients shall be measured, in part, by the percentage of clients who remain employed at intervals of six months and one year after commencement of employment.

(4) The estimated cost of services per client.

(5) A description of the development and design of the program and of any evaluation mechanisms.

(6) A description of coordination efforts among local departments of social services with other human services agencies.

(7) A description of progress in achieving other outcome goals such as family economic progress and child/family well-being.

This report shall be made to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than May 1, 2000.

Section @. (h) The sum of two million dollars ($2,000,000) appropriated to the Department of Health and Human Services, Division of Public Health, in this section in the TANF Block Grant for the 1999-2000 fiscal year for teen pregnancy prevention shall be used to develop and implement local programs and initiatives aimed at reducing teen pregnancy. The programs developed with these funds shall be based on model programs that have been proven successful by extensive evaluation. The programs and initiatives shall include:

(1) Adolescent parenting programs.

(2) Adolescent pregnancy prevention programs.
(3) Local coalition programs combining adolescent parenting and adolescent pregnancy prevention components.
(4) Teen care coordination projects.
(5) A media campaign to raise awareness of teens and their parents.

The Department of Health and Human Services shall report on the use of these funds and the effectiveness of the funded programs and initiatives in reducing teen pregnancy to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than April 1, 2000.

Section @. (i) The sum of two million eight hundred eleven thousand six hundred eighty-seven dollars ($2,811,687) appropriated in this section in (i) the Social Services Block Grant and (ii) in the TANF Block Grant transferred to the Social Services Block Grant to the Department of Health and Human Services, Special Children Adoption Fund, for the 1999-2000 fiscal year shall be used to implement this subsection. 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 and licensed child caring agencies, shall develop guidelines for the awarding of funds to licensed public and private adoption agencies and licensed child caring agencies upon successful placement for 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 to enhance the adoption services program. No local match shall be required as a condition for receipt of these funds.

Section @. (j) If funds appropriated through the Child Care and Development Fund 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 other programs, in accordance with federal requirements of the grant, in order to use the federal funds fully.

Section @. (k) The sum of one million five hundred thousand dollars ($1,500,000) appropriated in this act in the TANF Block Grant and transferred to the Social Services Block Grant for the Department of Health and Human Services, Division of Social Services, for Child Caring Agencies for the 1999-2000 fiscal year shall be allocated to the State Private Child Caring Agencies Fund. These funds shall be combined with all other funds allocated to the State Private Child Caring Agencies Fund for the reimbursement of the State's portion of the cost of care for the placement of certain children by the county departments of social services who are not eligible for federal IV-E funds. These funds shall not be used to match other federal funds.

Section @. (l) The sum of one million dollars ($1,000,000) appropriated in this section in the TANF Block Grant and transferred to the Social Services Block Grant to the

Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall be used for the Enhanced Employee Assistance Program, to continue a grant program of financial incentives for private businesses employing former and current Work First recipients. These grants may supply funds to private employers who agree to hire former or current Work First recipients or their spouses at entry level positions and wages and to supply enhanced grant funds to private employers who agree to hire former or current Work First recipients or their spouses at a level higher than entry level position, paying more than the minimum wage, including fringe benefits.

Section @. (m) The sum of one million four hundred twenty-seven thousand five hundred fifty dollars ($1,427,550) appropriated in this act in the TANF Block Grant transferred to the Social Services Block Grant to the Department of Health and Human Services, Division of Social Services, for the 1999-2000 fiscal year for Child Welfare Improvements shall be allocated to the county departments of social services for hiring or contracting additional staff on or after January 1, 2000, to recruit, train, and support prospective foster and adoptive families, and to provide post-adoption services.

Section @. (n) The sum of two million dollars ($2,000,000) appropriated in this act in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, for the 1999-2000 fiscal year for the Intensive Family Preservation Services (IFPS) Program shall be used by the Division, in consultation with local departments of social services and other human services agencies, to plan and implement a revised IFPS Program.

Notwithstanding the provisions of G.S. 143B-150.6, the program shall provide intensive services to children and families in cases of neglect and dependency where a child is at imminent risk of removal from the home and to children and families in cases of abuse where a child is not at imminent risk of removal. The program shall be developed and implemented on a regional basis in areas of high foster care placements as compared to the numbers of children substantiated for abuse, neglect, or dependency. The revised IFPS Program shall ensure the application of standardized assessment criteria for determining imminent risk and clear criteria for determining out-of-home placement.

The Department shall reexamine the existing IFPS Program design to ensure the application of a standardized assessment of imminent risk and clear criteria for placement. Additionally, the Department shall assess the education and skill levels required of staff providing intensive family preservation services in existing programs.

The Department shall develop a revised evaluation model for the current and expanded IFPS Program. This evaluation shall not include area mental health or juvenile justice programs. The model shall be scientifically rigorous, including the use of treatment control groups, a review and description of

interventions provided to families as compared to customary services provided to other child welfare children and families, and data regarding the number and type of referrals made for other human services and the utilization of those services.

The Department shall report on the use of the funds appropriated under this subsection, including the revised evaluation model and IFPS program, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than May 1, 2000.

Section @. (o) The Department of Health and Human Services and the Employment Security Commission shall report on the use of funds appropriated under this section from the TANF Block Grant to the First Stop Employment Assistance Program. This report shall include each of the following:

(1) The number of clients served since the inception of the program by fiscal year.

(2) The amount of funds expended each fiscal year.

(3) A description of the clients served. This description shall include demographic information about these clients.

(4) A description of coordination efforts with other human services agencies, including local departments of social services.

(5) A description of specific services provided to both initial and intensive First Stop clients.

(6) The placement rates of clients in both the initial and intensive programs.

(7) Statistics related to job retention, measured at least at intervals of six months and one year after the commencement of employment.

(8) Statistics related to the wage history of clients.

(9) Any other information the Department and the Employment Security Commission find relevant to an evaluation of the program.

This report shall be made to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than May 1, 2000.

Section @. (p) The sum of six million one hundred eighty-nine thousand twenty-five dollars ($6,189,025) appropriated in this section to the Department of Health and Human Services, Division of Social Services, in the TANF Block Grant for the the 1999-2000 fiscal year for Work First pilot programs shall be used to make grants to pilot programs developed in collaboration with the Employment Security Commission, business entities, faith communities, educational institutions, law enforcement agencies, community organizations, and other human services agencies. These pilot programs shall be designed to address problems of families with special or multiple employment barriers to economic self-sufficiency and shall target one or more of the following outcomes:

(1) To improve work advancement, job training, and wage improvement of non-custodial parents and to promote responsible fatherhood.
(2) To involve pre-school aged children in programs designed to develop and enhance science-based cognitive development activities and to expand access to such programs.
(3) To track and work with families that have returned to receiving public assistance after having left public assistance due to employment.
(4) To assist recipients in eliminating criminal activity and other dangers in their neighborhoods.
(5) To identify and assist homeless families in moving from poverty to self-sufficiency.
(6) To involve children in programs, such as peer mediation, non-violent conflict resolution, and community service, that teach self-discipline and responsibility and that provide positive motivation.
(7) To identify families that have been sanctioned under TANF and to provide programs and services designed to eliminate barriers to compliance.
(8) To assist families with special problems such as language barriers.

Grants for pilot programs under this subsection shall be made by the Department of Health and Human Services. Any local or State governmental agency or non-profit, tax-exempt organization may apply for funds under this subsection. All grant proposals shall contain specific goals and objectives and an evaluation mechanism with which progress towards attaining these goals and objectives can be measured. All grant proposals shall provide evidence of collaboration between agencies in developing or administering the program or both. All pilot programs under this subsection shall be required to report on the program to the Department of Health and Human Services.

The Secretary of the Department of Health and Human Services shall, in consultation with the Employment Security Commission, the Department of Public Instruction, the Office of Juvenile Justice, the local departments of social services, advocacy organizations, and other human services agencies, establish a set of guidelines for reviewing, evaluating, and awarding the grants. The Department of Health and Human Services shall make progress reports to the Joint Legislative Public Assistance Commission, the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division at least quarterly, beginning no later than December 1, 1999.

Section @. (q) The sum of one million dollars ($1,000,000) appropriated in this section to the Department of Health and Human Services in the TANF Block Grant for Boys and Girls Clubs shall be used to make grants for approved programs. The Department of Health and Human Services, in accordance with

federal regulations for the use of TANF Block Grant funds, shall develop and implement a grant program to award funds to the Boys and Girls Clubs across the State in order to implement programs that improve the motivation, performance, and self-esteem of youth and to implement other initiatives that would be expected to reduce school dropout and teen pregnancy rates. Additionally, in developing the grant program, the Department shall encourage and facilitate collaboration between the Boys and Girls Clubs and Support our Students and Communities in Schools programs to submit joint applications for the funds if appropriate. If joint applications are not appropriate, the Support our Students and Communities in Schools programs may submit separate applications for these funds. The Department shall report on its progress in complying with this subsection to the Senate Appropriations Committee on Human Resources, the House of Representative Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later that May 1, 2000.

Section @. (r) The sum of one million dollars ($1,000,000) appropriated in this section to the Department of Health and Human Services, Division of Social Services, for domestic violence programs shall be used to develop and implement a grant program to support programs which provide domestic violence services and to support programs aimed at preventing domestic violence. The Department, in consultation with the North Carolina Council for Women, the Governor's Crime Commission, local domestic violence programs and other human services programs, shall develop a process to award grants to community based organizations that demonstrate the ability to collaborate and coordinate services with other local human service organizations to serve children and families where domestic violence has occurred or is occurring. The Department shall report to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division on its use of these funds no later than May 1, 2000.

Section @. (s) G.S. 143-16.1(b) reads as rewritten:

"(b) The Secretary of each State agency that receives and administers federal Block Grant funds shall prepare and submit the agency's Block Grant plans to the Fiscal Research Division of the General Assembly not later than February 20 of each odd-numbered calendar year and not later than April 20 of each ~~fiscal~~ even-numbered calendar year. The agency shall submit a separate Block Grant plan for each Block Grant received and administered by the agency, and each plan shall include, but not be limited to, the following:

(1) A delineation of the proposed dollar amount allocations by activity and by category, including dollar amounts to be used for administrative costs; and

110

(2) A comparison of the proposed funding with two prior years' program budgets.

The Director of the Budget shall review for accuracy, consistency, and uniformity each State agency's Block Grant plans prior to submission of the plans to the General Assembly."

Attachments III

RECOMMENDED POSITION ELIMINATIONS

VOCATIONAL REHABILITATION SERVICES

POSITION TITLE	TOTAL VALUE	GENERAL FUND SAVINGS
1. Administrative Officer	$28,732	$20,687
2. Printing Operator	$47,167	$11,320
Subtotal	$75,899	$32,007
Benefits	$16,944	$7,348
Total	**$92,843**	**$39,355**

SERVICES FOR THE BLIND

1. Assistant Principal	$28,307	
2. Processing Assistant II	$11,189	
3. Educational Diagnostician I	$31,652	
4. Educational Diagnostician I	$31,652	
Subtotal	$102,800	
Benefits	$25,191	
Total	**$127,991**	**$127,991**

SERVICES FOR THE DEAF AND HARD OF HEARING

1. Administrative Officer II (NCSD)	$30,609	
2. Guidance Counselor (ENCSD)	$23,110	
3. Parent Trainer (ENCSD)	$22,693	
4. Staff Dev. Specialist II (CNCSD)	$29,022	
5. Deaf-Blind Program Consultant (Reg'l Resource Center)	$31,337	
Subtotal	$136,771	
Benefits	$32,957	
Total	**$169,728**	**$169,728**

Attachment IV

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT

AMENDMENT NO._____
(to be filled in by
Principal Clerk)
Page 1 of __

Date_____,1998

Comm. Sub. []
Amends Title []

Representative Adams

moves to amend the House Appropriations Health and Human Services subcommittee report on page 46, line 44,
by inserting after line 44, the following new subsections to read:

"(e1) G.S. 108A-27.4 is amended by adding the following new subsection to read:

'(h) County plans in electing counties shall provide for an emergency assistance program. Counties shall use funds from the Work First county block grant to provide emergency cash assistance for families whose income does not exceed two hundred percent (200%) of the federal poverty level. Emergency cash assistance shall be not less than three hundred dollars ($300.00) per year per family.'

(e2) G.S. 108A-27.7 is amended by adding the following new subsection to read:

'(d) County plans in standard counties shall provide for an emergency assistance program. Counties shall use funds from the Work First county block grant to provide emergency cash assistance for families whose income does not exceed two hundred percent (200%) of the federal poverty level. Emergency cash assistance shall be not less than three hundred dollars ($300.00) per year per family.'".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 5-27, 1999

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	OSBM
[illegible]	
[illegible]	
[illegible]	NCHA
[illegible]	AHHC
[illegible]	NCACC
[illegible]	PPAT
[illegible]	NCHCFA
Stacy Flannery	NCHCFA
Dessie Jackson	DSB
Tommy Allen	DVA
[illegible]	DVR
[illegible]	NCMS
[illegible]	[illegible]
Bryant Edgerton	Easter Seals NC
[illegible]	NC. Food Banks
[illegible]	DHR-IL
[illegible]	Bone & Assoc
[illegible]	NCALTCF.
Mary Greene	OSBM
[illegible]	OSBM
[illegible]	NC. Justice Center
Thomas V. Bennett	NCCFTF
Amy Fullbright	Hunton & Wms.
Adam Searing	NCHAC
Paula Wolf.	Covenant w/NC's Children
[illegible]	Poe Center
Pam Seamans	NC Social Services Consortium

VISITOR REGISTRATION SHEET

Appropriations Subcommittee on Health and Human Services 527 **, 1999**

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Wayne Williams	OSBM
Beth Melchior	NAMI NC
Janet Simmons	NC Council
[illegible]	[illegible]
Roslyn Savutt	NC Child Care Coalition
Sharnese Ransome	DSS
NELS ROSELAND	OSBM
Lynda McDaniel	DFS
Michelle Cotton	DMH/DD/SAS
by Avent - Farmer	DCD
P Perruzzi	DMA
[illegible]	DHHS - DSS
[illegible]	DHHS
Anna Wasdell	DHHS
Allyn Duffey	DHHS
Jim Edgerton	DHHS
David Barton	DHHS

NORTH CAROLINA GENERAL ASSEMBLY

SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 9, 1999
8:30 a.m.

The Senate Appropriations Subcommittee on Human Resources met at 8:30 a.m., Wednesday, June 9, 1999 in Room 422 of the Legislative Office Building. Senator Bill Martin, Chair, called the meeting to order with all members present. After introducing the pages, he stated that the purpose of this meeting is to review the House Budget, in terms of reductions, expansions and special provisions. He stated that this is an opportunity to discuss and review any differences.

Sen. Martin stated that during the development of the budget, there was involvement from the Senate Subcommittee Chairs and Senate Full Appropriations Committee Chairs. He then recognized Carol Shaw to review the Unofficial Report of the House Appropriations Committee. She stated that the rules do not allow amendments to the report on the House Floor, however changes were made that impact the report. She stated that this unofficial report reflects the technical corrections/changes and the amendments adopted on the Floor of the House on June 2, 1999. She began the review of the changes affecting the department of Health and Human Services G-1 through G-4, the reduction made by the House.

Karen Hammonds-Blanks came before the committee to review the Division of Social Services and Mental Health (page G-2).

During Committee discussion, regarding Item 24, increase patient revenues, Senator Purcell asked how would that revenue become available.

Mary Ellen Sylvester came before the Committee to discuss items 20 and 21 on Page G3. These items affect the Divisions of Services for the Blind, Services for the Deaf and Vocational Rehabilitation. The Governor recommended eliminating a total of eleven long-term vacant positions. The House decided that four of those positions would have a programmatic impact and those positions should not be eliminated. However, they did take five positions in the Division of Services for the Deaf and two positions in Services for the Blind.

Ramona Burton reviewed the items on page G1, Reduce Funding to the Office of Economic Opportunity. She stated that this reduction reflects an increase received by this office in Community Services Block Grant. The Governor's cuts are reflected on page G4, Division of Health Services, Item 27, reduce Tuberculosis Program Pharmaceutical Budget, is one of the Governor's recommended cuts that reflects a realization that there was excessive funding in this area. Item 28, also one of the Governor's cuts that eliminates four vacant positions. Item 29, reduce aids drug assistance program, is a

reduction resulting form an increase received by the Ryan White Aids Drug Assistance Program Fund.

She then went over the budgetary expansions beginning on page G-8, Division of Health Services.

Karen Hammonds Blanks explained the Expansion items included by the House beginning on page G-4 of the attachment.

The Chair thanked the members and staff for their presence and adjourned the meeting at 9:50 a.m.

Sen. William N. Martin, Chair

Joyce Crews Hodge, Clerk

Senate Appropriations Committee on Human Resources

AGENDA

June 9, 1999
8:30 a.m., Room 422 LOB

Review of House Bill 168, Appropriations Act of 1999	Fiscal Research Staff
Committee Discussion	

8:30 a.m.

Name of Committee SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 9, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jerry Cooper	N.C. Assisted Living Association
Janet Simonsen	NC Council of Community Programs
Roz Savitt	NC Child Care Coalition
DAN GERLACH	BIC
Amy Fullbright	Hunton & Williams
Wayne Williams	OSBM
Anna Lefft	OSBM
Mary Green	OSBM
Nancy Coston	DHS Social Services
Kevin FitzGerald	DHHS - DSS
[illegible]	OSBM
Lou Wilson	NCAATCF

9:50. am

Name of Committee SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 9, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Peter Leoning	DHHS
Allyn Duffey	DHHS
Jim Egan	DHHS
DAVE BRUTON	DHHS
Tommy North	Carolinas Healthcare System
NELS ROSELAND	OSBM
Roger LeBow	Bowe + Assoc -

Name of Committee SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June ~~10,~~ 1999

9

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stacy Flannery	NCHCFA
Beth Melcher	NAMI NC
Janet Smoreans	NC Council
Roz Sawitt	NC Child Care Coalition
Jeary Hardesty	Food BANKS
Pam Kohl	Poe Center For Health Education
Christina Medlin	NC Equity
Mary Greene	OSBM
Anna Tefft	OSBM
[illegible]	DHHS
Niels Roseland	OSBM

Name of Committee SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 10, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stephanie Fairyal	DHHS - DCD
Elena Fairyal-Debnam	Visitor
Peter Leonard	DHHS
Allyn Guffey	DHHS
Jim Edgerton	DHHS
David Brunton	DHHS
Beckie Stuart	PPAB
A. Dennis McBride	DHHS
Bernard Farmer	dhhs - dcd
JACK McGEE	MARCH OF DIMES
HUGH TILSON	NCHA

Name of Committee SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 10, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	Parker Poe Cedar & Bernstein
Kevin FitzGerald	DHHS - DSS
Lou Wilson	NC ALTCF
S Ransome	DSS
[illegible]	[illegible]
Sonia Schmidt	NC Justice Center
Pam Seamans	NC Social Services Consortium
[illegible]	Bone & Assoc.
[illegible]	UNC-CH
[illegible]	[illegible]
[illegible]	OSBM

Name of Committee SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 10, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS

SENATE APPROPRIATIONS SUBCOMMITTEE
ON HUMAN RESOURCES

Agenda for September 29, 1999 Meeting
10:00 a.m. Room 544 LOB

Topic: Dental Health Care for Children Eligible for CHIP or Medicaid

Opening Comments --	Senator William N. Martin Chair, Senate Appropriations Subcommittee on Human Resources NC General Assembly
National Overview of the Problem --	Burton L. Edelstein, D.D.S., M.P.H. Director, Children's Dental Health Project American Academy of Pediatrics, and American Association of Dental Schools
Reforming States Groups Project -- How it relates to addressing the problem nationally and in NC	Senator Raymond D. Rawson, D.D.S. Assistant Majority Leader and Chair, Human Resources and Facilities Committee Nevada Senate
NC Institute of Medicine Task Force -- on Dental Care Access	Pam Silberman, J.D., Dr.P.H. Vice President NC Institute of Medicine
NC Division of Medical Assistance -- Dental Program	Paul R. Perruzzi, Director NC Division of Medical Assistance Betty King-Sutton, D.M.D., M.P.H. Dental Program Director
NC Dental Society Perspective --	Scott Goodman, D.D.S. Private Practitioner, Matthews, NC
Consumer Perspective --	Adam Searing NC Justice & Community Development Center
Demonstration of the RSG actuarial -- model, utilizing NC data	Senator Raymond D. Rawson, D.D.S James J. Crall, D.D.S, Sc.D. Department of Pediatric Dentistry University of Connecticut Health Center Farmington, CT
Roundtable Discussion --	(general participation)
Closing Comments & Adjournment --	Senator William N. Martin

SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES
Wednesday, September 29, 1999
10:00 a.m.
Room 544 Legislative Office Building

Topic: Dental Health Care for Children eligible for CHIP or Medicaid

The Senate Appropriation Subcommittee on Human Resources met, Wednesday, September 29, 1999 at 10:00 in Room 544 of the Legislative Office Building. The meeting was called to order by the Chair Senator Bill Martin.

In his opening comments he thanked everyone for their presence, especially the persons representing Reforming States Groups who have done extensive work and research in the area of Dental Health for Children. He stated that there have been discussions and uncertainty among General Assembly Members as to just what should be done regarding adequate access to dental care for children eligible for CHIP or Medicaid. There have been a number of national conferences sponsored by the Reforming States Groups, The American Dental Association and various groups in North Carolina. In an attempt to a get a handle on the situation, he attended a meeting in August sponsored by the Reforming States Groups and the American Dental Association, in which he received a better perspective of the issue. He thought it would be helpful to the NC General Assembly and other people associated with this issue to try to get an understanding of the situation. As a result, we have presentations per the attached Agenda.

Senator Martin thanked Dr. Daniel Fox, President and CEO, Milbank Memorial Fund for his attendance and acknowledged the following persons who were involved in planning this meeting and could not attend:

Mr. Rob Fordham, Director of Program Operations, Milbank Memorial Fund
Senator Sandy Preager, State Senator, Kansas

The Milbank Fund is a national fund out of New York that focuses upon health care issues and also is the primary support and source of funding for Reforming States Groups.

Rep. Beverly Earle, Co-chair of House Appropriations Subcommittee on Health and Human Services, thanked Senator Martin for taking the initiative to put this meeting together. She asked those present to pause for a moment of silence in remembrance of Representative Jane Mosley, who died September 28, 1999 after a courageous fight with Breast Cancer.

Senator Martin stated that the presentations would follow the Agenda at listed.

- **National Overview of the Problem - Dr. Burt Edelstein**
  - **Medicaid Dental Situation and how it affects children**

-- Problems

Low Income – Children living in poverty or of low-income families consistently suffer more tooth decay than their more affluent peers do. Children with the greatest

need for dental care have the least access to dental care. Children eligible for Medicaid experience twice the rate of untreated dental disease as the affluent.

This problem is being addressed because disease in children is consequential; children are predisposed to dental disease because of dietary, behavioral, and socioeconomic factors that overwhelm preventive interactions available to them.

-- **Status and Trends that impact how Children are treated**

The National Dental supply is declining. As the supply goes down, the distributors are also declining. Few states perform well. North Carolina is positioned well below the mid-range of states.

The safety net is inadequate. 90% of all dentists are in one or two person practices; 20% of those are in specialty care and 80% are in primary care.

-- **Known Barriers – Children who need the care are not getting the adequate care.**

Finance and Administration – Adequate funding is a necessary but not sufficient. Access opens doors; however, will people choose to walk through these doors? Dental Care is greatly under funded. Medicaid engages few dentists in the market.

North Carolina has addressed administrative problems. However Dental availability is low, there are some counties in North Carolina that have no dentists or no participating dentist. One way to effectively restore programs is to set reform expectations. North Carolina should look at engaging more care as well as more dentists. Based on the National American Dental Association the dentist to population ratio is lower in North Carolina than in most states.

North Carolina has mobile dental care units. The vans park in the school and nursing homes parking lots. However, mobile dental units are cost inefficient.

Some successful exemplary reform efforts are Indiana, Oregon, and Western, and Pennsylvania. Reform efforts will succeed first in delivering more services to children currently being served; followed by more children receiving services and finally more dentists choosing to participate in the Medicaid and CHIP Dental programs.

- **Reforming States Groups Project – How it relates to addressing the problem nationally and in North Carolina. – Senator Raymond D. Rawson,**
  - Reforming States Group (RSG) is a group of state legislators that met to deal with health care issues to determine what national reform is accomplishing and evaluate what is needed. RSG represents forty states and are taking in other states. Nevada has concerns and issues very similar to North Carolina. North Carolina ranks 47th in the national dentist to patient ratio and Nevada ranks 50th.

-- **Understanding the Need**

Things are not always as they seem on the surface. What is needed and what are we actually getting. Achieving Improvements in Medicaid's health Program for unde served children.

We need adequate coverage for 20 million children. We need to develop a hassle free plan that will promptly approve these cases and be willing to pay for them. We need more dentists that are willing to treat more Medicaid patients. There is a need for less regulation and more trust in the process. We have broad dental coverage but limited access. The range is anywhere from 10% to 60% of patients who in various states that will actually receive the services that they should receive.

Reasons for lack of access: Low provider reimbursement, poor education (of eligible patients), disruptive patients, legal repercussions, high failure to show rate, government program, cottage industry (dentistry is most conservative profession and does not want government control), difficult dental problems requiring specialized treatment.

-- **Solutions**

RSG designed a basic dental insurance program. It provides for fiscal responsibility and accountability.

Dental care is the most prevalent chronic disease in childhood. 50% of our first graders to some degree have this disease and a substantial percentage of our teenagers We can radically change this percentage if we get to our children before they reach the first grade. North Carolina should be aware of and consider the consequences of not providing adequate dental care.

- **Institute of Medicine Task Force on Dental Access – Dr. Pam Silberman**

  - **Problems identified by the task force specific to North Carolina** – Access to dental care is a critical health problem especially for children. 25% of all children entering Kindergarten have untreated dental disease; an average of only 20% of eligible Medicaid children visit the dentist annually; low dentist participation in Medicaid (16% of dentists actively participate in Medicaid); institutionalized adults have problems getting access to dental care.

    -- **Other barriers which prevent Medicaid recipients from accessing dental services:**
    Non Financial Barriers to Access include transportation; inability to take off work; difficulty in obtaining appointments; dental care is low priority; lack of awareness of importance of ongoing dental services.

  - **Solutions – The Task Force developed strategies in the following areas:**

Increasing dentist participation; Increasing supply of dental professionals; Increasing access to dental services for young children; Educating Medicaid Recipients; establishing advisory committee.

How much effort has been made to involve SmartStart, which has a great opportunity to reach a large number of children in this category, in trying to identify children and express the importance of dental care?

Rebecca King, Division of Dental Health – the division is currently working with SmartStart programs in the mountains to identify children; working with the fluoride varnish program. It is the hope that that will be a model for the proposed pre-school preventive dentistry program.

In 1998-99 3% of all Smart Start activities focused on Dental initiatives. Those initiatives were in thirty-six of the fifty-five Smart Start counties.

♦ **Demonstration of the RSG Actuarial Model, Utilizing North Carolina Data – Dr. James J. Crall**

RSG contracted with PricewaterhouseCoopers, LLP, to construct and develop an interactive actuarial model that permits states to calculate the cost of implementing the program in a proposed or modified form.

- **Background Issues –**
  Prevention is the most important long-term strategy for reducing restoration needs.
  Financing/funding levels must be structured from a market-based perspective.
  Dental workforce is aging and diminishing.
  North Carolina Background: 17% of the children do not receive any kind of service. Of the 674,000 children eligible there are over one half million children in North Carolina receiving no benefits out of this program.

- **The Model as it relates to North Carolina**
  The actuarial model is available on the World Wide Web for officials to adapt to the particular demographics of the covered population and budgetary restrictions in any state. The Model is intended to be a tool.

  The model as it reflects the recommendations of the NC Institute of Medicine Task Force -- according to the model, estimated cost for the proposed program are approximately $4.60 per enrolled member per month for direct services and approximately $2.50 per member per month for administrative costs.

  North Carolina has taken steps to address the needs of children in CHIP, however nothing is being done to address the needs of Medicaid recipients. Prevention is not a substitute for treatment.

Financing and funding need to be structured from a market based perspective. In an effort to target one percent of the dentists desired to engage in the particular program, reimbursement levels should be geared to the percentile of fees that are in the market. Special needs require special providers.

- **North Carolina Division of Medical Assistance – Paul R. Peruzzi, Director**

  - **Overview of Medical Dental Program**

    -- Medicaid Dental Expenditures
    -- Breakdown of how money was spent between children and adults

  - **Overview of Dental Program – Dr. Betty King-Sutton, Director**

    Medicaid Dental Programs must continue to be viable and effective in providing primary dental and preventative care to those patients who need it. Millions of people are continuing to receive these services, however, because of all the reasons that have been given, they don't do enough.

    There are three questions that should be answered:
    -- Who should be covered?
    -- What services should be furnished?
    -- How should the cost of care be managed and shared?

    When we think of who should be covered, we think of our children, because they are the future. We cannot forget the young adults as well as the elderly. Focus should also be on low socio-economic groups and minority persons with special needs as well.

    The Office of Dental Health Program receives from twenty-five to thirty calls daily from persons that cannot find dentists.

    Solutions:
    Recruit private practitioners to provide care; Increase payment rate; Target groups with special needs; Link recipient with provider; Form Medical dental Advisory Group; Educate.

- **North Carolina Dental Society Perspective – Dr. Scott Goodman**

  - **There are three areas of concern:** (page 4 of handout from Dr. Silberman)

    -- There are few centers in the State that have pediatric dental treatment.
    -- Low dentist participation in Medicaid
    -- Shortage of Dental Professionals

- **Consumer Perspective – Adam Searing**
  - **There is a critical need**
  - **Fully support increase in reimbursement rate**
  - **Establish second dental school in the State**

NC Institute of Medicine Task Force on Dental Care Access

Presentation by: Pam Silberman, J.D., Dr.P.H.
Vice President, NC Institute of Medicine
Sept. 29, 1999

Charge to Task Force

NC•IOM asked to develop strategies to:

- Assist dentists in increasing numbers of Medicaid patients
- Increase Medicaid patients' access to quality dental services
- Inform dental professional on how to better integrate Medicaid patients into their practices; and
- Expand capacity of health departments and M/CHCs to provide preventive dental services

Task Force Members

- Task Force included representatives of various dental societies, dental board, dental school, dental hygienists, dental assistants, public health, CHC and non-profit safety-net providers.
- Study funded through grants from Duke Endowment and Kate B. Reynolds Charitable Trust
- Report delivered to NC General Assembly and Secretary of DHHS

Attachment

Access to Dental Care: Critical Health Care Problem

A lack of dental care for low-income and Medicaid-eligible adults and children often results in severe or persistent pain, inability to eat, swollen faces, and increased susceptibility to other medical conditions.

Source: Wagner J and Raynor D. Poor Children Facing a Crisis in Dental Care. The Raleigh News and Observer. August 2, 1998.

Dental Access Problems

- 25% of children entering kindergarten have untreated dental disease.
- On average, only 20% of Medicaid recipients visit the dentists each year.
- Only 16% of NC dentists actively participate in Medicaid (only 6 states with lower active participation rates).
- Shortage of dental professionals: NC ranks 47th in the supply of dentists to population
- Institutionalized and other special needs populations also experience access barriers.
- Some Medicaid families are unaware of importance of good dental health.

Access Problems: Children

- 36% of all children entering kindergarten have a history of dental caries.
- Most decay can be found in small number of children: 30% of kindergarten students have 95% of all tooth decay (more prevalent in low-income and rural communities without fluoridation)
- Not enough pediatric dentists, and general dentists often unwilling to serve very young children.

Access to Dental Services Particular Problem for Children

Severe baby bottle tooth decay in an 18-month old child (photo courtesy of NC Dental Health Section, DHHS)

For children, failure to prevent dental disease can result in missed school days, dysfunctional speech, and compromised nutrition.

Percentage of Medicaid Recipients who used Dental Services (1998)

Age	% of Recipients who Used Services
<1	0.1%
1-5	12.2%
6-14	26.7%
15-20	18.9%
21-64	19.3%
65+	16.4%

Source: Petruzzi, Testimony to Dental Task Force, 1999

Use of Dental Services Low Among Medicaid Recipients

- North Carolina covers dental services for all Medicaid recipients.
- On average, only 20% of Medicaid Recipients visited the dentist in SFY 1998.
  - Young children least likely to have dental visit
  - Use of dental services varies by county from a low of 10% in Alexander county to a high of 26% in Henderson and New Hanover counties.
- Primary reason for low use of dental services is the inability to find dentists who will treat Medicaid recipients.

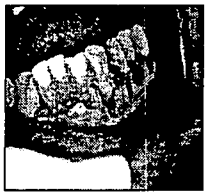
Low Dentist Participation in Medicaid

- Only 16% of NC dentists actively participate in Medicaid.
- Medicaid has made significant changes to simplify the program for dentists, *but*
- Low reimbursement rates makes participation unaffordable to many dentists:
  - On average, Medicaid pays dentists 62% of UCR charges for 44 most common dental procedures for children; 42% of UCR for other procedures
  - Dental overhead is approx. 60% of total revenues
- High cancellation and "no-show" rates also contribute to low levels of provider participation.

Shortage of Dental Professionals Compounds the Problem

- NC ranks 47th in the supply of dentists to population:
  - In NC: 38 dentists per 100,000 population
  - Nationally: 60 dentists per 100,000 population
- Maldistribution of dental professionals
  - 4 counties with no dentists, 36 counties have no dentists willing to serve Medicaid patients
  - ORDRHD estimates that 79 of state's 100 counties qualify as dental health professional shortage areas
- Net gain of approx. 44 dentists per year in NC, which just keeps up with increase in population.

Access Barriers for Special Needs Populations



71 year-old with gingival recession and root caries (Courtesy J. Kountz, DDS, Carolinas Medical Center)

- Growing number of institutionalized individuals as the population ages
- A 1991 study study showed that only 30% of long-term care facilities could obtain needed dental care for the residents.
- In addition to institutionalized adults, there are other adults with mental or physical impairments who are unable to easily access dental services in the community.

Non-Financial Barriers to Access

- Other barriers which prevent Medicaid recipients from accessing dental services:
  - transportation
  - inability to take off work to go to dentist
  - difficulty obtaining appointments
  - some families make dental services a lower priority, and are unaware of the importance of ongoing dental services.

Source: OIG. Children's Dental Services Under Medicaid: Access and Utilization. Dept. of Health and Human Services. 1996.

Dental Access Problems: Solutions

- Task Force developed strategies in the following areas:
  - increasing dentist participation in Medicaid
  - increasing overall supply of dentists and dental hygienists to practice with underserved populations
  - increasing the number of pediatric dentists and expanding access to preventive dental services to young children
  - training dental professionals to serve special needs patients
  - educating Medicaid recipients about the importance of ongoing dental care, and removing non-financial barriers to access

Increasing Dentist Participation

- Increase Medicaid reimbursement up to 80% UCR ($9.6 mil. FY 2001).
- NC Dental Societies will develop an outreach campaign to encourage dentists to participate.
- Medicaid will establish a Dental Advisory Committee.

Expanding Access for Special Needs Populations

- Intensify and strengthen special-care education programs.
- Support the development of comprehensive care programs designed to serve special needs and other difficult-to-serve populations.

Educating Medicaid Recipients

- Outreach campaign to educate Medicaid recipients about the importance of ongoing dental care.
- Pilot test dental care coordination services to enhance the ability of low-income families and people with special needs to overcome non-financial barriers to dental care.

The North Carolina Dental Society supports, as now written, the NC Institute of Medicine's 23 recommendations to improve access to dental care. Many people, including twelve members of NCDS, spent numerous hours away from their practices and positions to work on those recommendations. NCDS is disappointed that the General Assembly did not implement two of the most important recommendations - funding two additional pediatric residency positions at the UNC School of Dentistry and providing adequate reimbursement for dentists treating Medicaid patients. We hope that this committee will strive to endorse and implement the 23 recommendations.

Dental care for children is the key issue. Children from low-income families have the highest rate of tooth decay and are the least likely to have access to dental care. Lack of dental care often results in severe or persistent pain, inability to eat, swollen faces, and increased susceptibility to other medical conditions. Dental decay is the single most common non-limiting health problem among school children, four times more common than asthma (the 2nd most common problem). However, the North Carolina Medicaid program only spends 1 percent of its budget on dental care. Nationally, dental expenditures represent 5 percent of health care dollars.

Private dentists want to help and they do volunteer in clinics. We realize that reimbursement is not the big issue, children are the big issue. However, raising reimbursement rates is the first step to improve dental care for children. However, the last rate increase discriminated against pediatric procedures. A 1996 survey by the Dental Health Section showed that 56 percent of dentists in the state would be willing to see more Medicaid patients if reimbursement rates were increased to 80 percent of UCR. On average, NC dentists are paid approximately 62 percent of their usual, customary and reasonable charges (UCR) for 44 of the most common dental procedures for children, and only 42 percent of UCR for other procedures. Yet the average overhead cost of operating a dental practice is anywhere between 60 and 80 percent. Many dentists lose money or can only cover overhead expenses when treating Medicaid patients. This is especially difficult for new dentists, who are in a lot of debt. Your local food store accepts food stamps and is reimbursed at 100 percent of the face value of groceries. There would not be a major grocery chain in North Carolina accepting food stamps if they had to take a 38 - 58 percent cut.

In addition to low reimbursement rates, other problems need to be addressed. Examples include educating the Medicaid population on the importance of keeping and arriving on time for appointments and proper in-office behavior, adequate transportation and administration problems such as lag time in payment, unreasonable denials, and equal pay for equal treatment.

The North Carolina Dental Society will do its part. We want dentists to participate in Medicaid. We will build upon past efforts to launch, in conjunction with the Old North State Dental Society, an extensive outreach campaign to encourage dentists in private practice to treat low-income patients. NCDS will also educate dentists on the Medicaid program's administrative improvements. We will also work closely with the Division of Medical Assistance and other appropriate groups to expand already established advisory committees.

Gary Oyster, DDS
NCDS Legislation Co
9/29/99
(919)677-1396
Phone: (919)876-2887

Attached

NC Dental Services

(Many open door and hospital/health dept. clinics not mentioned)

Reynolds Clinic owned by CMI - Forsyth Hospital
ABCCM Doctors Clinic - Asheville
Billy and Ruth Graham Children's Center "Tooth Bus" - Asheville
Moses County Hospital Practices - Greensboro
Urban Ministry Volunteer Clinic - Greensboro
Masonic Temple - Greensboro
Bloomenthal Jewish Home - Greensboro
Well Spring Retirement Village/Cone Extended Care - Greensboro
Raleigh Open Door Clinic
Orange Shack Program (Assoc. of UNC students)
Health Serve Medical Center - Greensboro
High Point Dental Society free clinic at Guilford Tech
Merci Clinic - Craven, Jones and Pamlico Dental Society
Haywood Christian Ministries Dental Clinic - Haywood, Buncombe Counties
Asheville-Buncombe Christian Community Ministries
Buncombe County Project Access - Buncombe Co. Health Dept. and Buncombe County Dental Society
Samaritan Ministries - Forsyth and Surry Counties
Iglesia Christiana Wesleyana Clinic (for Spanish speaking patients) - Forsyth and Surry Counties
Doctor's Care Program - Forsyth and Surry Counties
Dr. Bruce Wham Fair Clinic - (sponsored by Baptist Men's Group) - Forsyth and Surry Counties
Vantage Golf Clinic - (10 dentists volunteer clinic during golf tournament) Forsyth and Surry Counties
Living Waters Clinic - Forsyth and Surry County
Surry County Health and Nutrition Center
Blue Ridge Community Health Center - Hendersonville
Navy-Marine Corps Relief - Cherry Point
Better Health Foundation - Fayetteville
Care Clinic - Fayetteville
Guilford Dental Clinic - Jamestown
Anderson Creek Dental Clinic - Spring Lake
Haywood Christian Ministry - Waynesville
Urban Ministries of Raleigh
Dentistry for Handicapped - Stanfield
Saint Bernadette Church - Fuquay-Varina
Davidson Medical Clinic - Lexington
Doctors Care - Winston-Salem
Baptist Association - Gastonia
Gaston Community Foundation - Gastonia
Snowbird Health Clinic - Robbinsville
Gateway Education Center - Greensboro
Urban Ministry - Greensboro
High Point Open Door Clinic
Rowan Baptist Dental Clinic - Salisbury
NC Baptist Medical, Dental Bus - Cary
UNC School of Dentistry - Chapel Hill

Special Geriatric Clinic - Chapel Hill
Mercy Medical Clinic - Asheboro
Medical Ministries Clinic - Mount Airy
Anderson Creek Dental Clinic - Spring Lake
Helping Hand Medical Clinic - Sanford
Ministry of Lincoln County - Lincolnton
East Lincoln County Ministry - Denver
Tileston Outreach Clinic - Wilmington

SENATE APPROPRIATIONS SUBCOMMITTEE
ON HUMAN RESOURCES

Agenda for September 30, 1999 Meeting
9:00 a.m. Room 544 LOB

Topic A: Dental Health Issues

Committee Discussion

Topic B: Human Services Issues Related to Hurricane Floyd

Opening Comments –	Senator William N. Martin Chair, Senate Appropriations Subcommittee on Human Resources NC General Assembly
Overview –	Dr. H. David Bruton Secretary NC Department of Health and Human Services
Presentations focusing on Mental Health, Social Services, Public Health, and Facility Services	Terry Steele Deputy Director, MH/DD/SAS NC DHHS Kevin Fitzgerald Director, Division of social Services NC DHHS Dr. Dennis McBride Director, Division of Public Health NC DHHS Lynda McDaniel Director, Division of Facility Services NC DHHS Terry Hatcher Engineer, Division of Facility Services NC DHHS
Particular Problems for Hispanic/Latino Population	Nolo Martinez Special Assistant to Governor Hunt, For Hispanic/Latino Affairs

Committee Discussion

Adjournment

SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES
Thursday, September 30, 1999
9:00 a.m.

The Senate Appropriations Subcommittee on Human Resources met Thursday, September 30, 1999 at 9:00 a.m. in Room 544 of the Legislative Office Building. Senator Bill Martin, Chair, called the meting to order. He stated that the meeting on September 29 was very beneficial and provided a good framework in which to get started in the area of Dental Health Area. It is the hope of the Committee that the Executive Branch will work to get this included in the Governor's Budget for the Short Session. Because of the demands that will be placed upon the budget, it will be difficult to get anything done in this area.

The Agenda for today is Human Services Issues Related to the Hurricane Floyd disaster. The Chair stated that the situation is devastating for the entire State but especially for the citizens of the eastern part of the State. Today we will have an in-depth presentation from the Public Health and Human Services representatives. This will give us a clearer understanding of what is being done, some of the problems and barriers, what this will mean in terms of budgetary and program impact for subsequent years and what is needed.

Dr. Burton, Secretary of the Department of Health and Human Services, was recognized to lead us into the discussion. Dr. Burton stated that he is extremely proud of the DHHS staff and the work they are doing. He shared a video of the Governor's Press Conference and a survey of the area. DHHS is meeting this emergency in a way that when this emergency is over, our infrastructure will be stronger than it was before this storm. This is the largest public disaster in America.

Dr. Burton stated that the DHHS staff made appeals, at the federal level, for dollars that would revert at the end of the fiscal year. They have shaken millions of dollars and the promise of continued assistance. To the degree that the department is successful, the General Assembly has a job to come up with the State match. They are working on faith that General Assembly will provide the State match.

- This disaster occurred in an area of the state that was already economically deprived and this will set the citizens of that region back maybe fifty years.
  - General Assembly has to rebuild Eastern North Carolina in a way for people to live and make a living, not just repair from this flood
  - Small businesses cannot repair and start over, and they are going to leave
  - There are tens of thousands of people with negative net worth that cannot meet their mortgage
  - The General Assembly will probably have to address paying more than the current share
  - There are over 2000 people still in shelters. When they leave the shelters, they move into mobile homes, hotel, motels, friends and relatives
  - There is a large group of migrant workers who need assistance
  - The creative way to assist counties in obtaining the county match funds is to have the courage to write the check

Senator Martin stated that there is a much greater need than is indicated on the news media such as:

- Psychological impact
- Forgiveness of loans
- Utility bills
- Required resources to meet individual and family needs over the next few years

Dr. Dennis McBride, Director, Division of Public Health (handout)

- ♦ Search and Rescue Mode
  - Community Health Assessment Teams (CHAT) combined social services, public health and mental health volunteers are doing various health assessment
  - This disaster is still occurring in these communities and towns
  - Worked with Medical and Pediatric Societies Hospital Association and others to organize the health manpower
- ♦ Recovery Mode
  - Housing – most houses submerged under water for three days are lost. It is the hope that FEMA will give fair market value for these homes
  - Wells, water systems and septic tank - some have been destroyed
  - Concerned for outbreak of communicable diseases
  - Massive destruction of animals
  - When we get off the front pages of the press we will still have these problems
  - The U.S. Surgeon General will be visiting in October
- ♦ Strategic Approach – framework has been established
  - The most heavily hit counties are grouped into seven zones of one to two counties
  - The coordinator of each zone will work with the key leader to expedite all areas of help Primary areas – environmental health and housing, social services, mental health services
  - We will inform persons of the health risk, however we cannot destroy them
  - Wells should be chlorinated
  - Epidemic surveillance
  - Mental Health and Health coordinators will work together on an on-going basis. Mental Health will be linked to environmental specialists

Dr. Burton stated that the General Assembly will have to step up to the plate and stop passing off the decision of the appropriate organization and reorganization of the health structure and moving those areas that are in DHENR to where they belong. This disaster points out the weakness of the separation.

Ann Wolf stated that she is deeply touched by the volunteers to go and relieve the staff of the local health departments.

Dr. Terry Steele, Deputy of Mental Health (attachment)

- ♦ Response to disaster continues
  - People in each county to identify needs
  - Submitted grant for emergency funding for $350,000 to FEMA
  - Will submit FEMA outreach grant application for long term assistance

Kevin Fitzgerald, Director of Division of Social Services gave a status of what is happening now. (attachment)

- This is an involving disaster
  - Eighteen shelters are open and serving more than 2,000 persons
  - There is a need to set up to get the to the people with the right mission
  - Churches are involved and engaged with outreach
  - As winter approaches, families will need to deal with shelter replacement
  - Electronic Benefits Transfer (EBT) for food stamps is in place
  - There should be a line between health and family stability

Linda McDaniel, Director, Division of Facility Services

- The SORT (Special Operations Response Team) are in place
- There is an effort to include Floyd Disaster Relief in the United Campaign

Terry Hatcher, Engineer, Division of Facility Services

- The Department buildings and structure were lightly damaged.
- Estimated Damage to all facilities except Cherry Hospital is $200,000
- Approximately $1 million damage at Cherry Hospital
- Water damage will occur later
- Proceeding with reconstruction

Dr. Nolo Martinezz, Special Assistant to Governor Hunt, for Hispanic/Latino Affairs (attachment)

The storm uncovered the invisible and the uninformed and unknown.

Census Estimate (reliable) of Hispanics in North Carolina is over 160,000.
The estimated number of Hispanics in Counties hit the hardest:
Pitt County – 4,300; Nash – 3,400; Wayne 6.400 and Edgecombe 1,800

If there is an act of God like this one, the H2A worker will not be paid for the labor contract.
Many of them as of last week received $20 to buy meals. They have not been transported back as yet.

In the case of Migrant and Seasonal Workers, many of them did not get to the shelters. If they did not, a number of them may be in one trailer. They are also desperate. Because they would rather be where they can work, but there is no transportation. Many of the crew leaders have left them.

Lessons learned:

- We do not want to want until disaster occurs to have interpreters in health departments our counties.
- The main job now is to find out how we can provide transportation for those that can migrate and are ready to go, without families and need the job.

- Those that need assistance with rent for at least two or three months, until they get back on their feet.
- In terms of the H2A individuals, (with special visa) they will be fine. The problem is t under the contract, they have to be transported when there is no activity (work). That is not happening, many are getting very desperate and paying their own way.
- Many of the migrant workers don't have proper documents and therefore cannot get the benefits that they are entitled. We need to go through some of our established organizations to provide transportation and some place to live. At the State or Federal level, there is not much that can be done because of the immigration issue.
- There are facilities that provide medical assistance without any questions asked. In terms of what is needed now to get back on their feet, transportation is the biggest issue. It will be difficult to get transportation.

Dr. Burton reminded the Committee to refer to the handout, DHHS needs to respond to Hurricane Floyd.

Rep. Wilson commended Dr. Burton and his staff for going over and above the call of duty and stated that he is ready to face his responsibility as a member of the General Assembly. The committee unanimously agreed with Rep Wilson.

The Chairman thanked the Committee for their attendance and stated that there is a lot of work to be done together to address the needs discussed today. The Committee will be looking at what needs to be done at the State level

The meeting was adjourned at 11:55 a.m.

Sen. William N. Martin, Chair

Joyce C. Hodge, Clerk

T, Terry Steele

NC Department of Health and Human Services
Division of Mental Health, Developmental Disabilities, and
Substance Abuse Services

HURRICANE FLOYD RELIEF ACTIVITY REPORT
9/15/99 – 9/29/99

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, a division of the NC Department of Health and Human Services, has been involved before, during, and after regular work hours and over the weekend immediately following the advent of Hurricane Floyd in the following areas of disaster response. For each area of participation, one or more of the many examples of this type of assistance are included.

- **Daily Staffing of the State Emergency Operation Center**
  - Staff of the Division's Central Office have been trained and are staffing the Mental Health Desk in the State EOC twelve hours a day, seven days a week. In addition to responding to requests coming in over the mental health telephone, Division staff frequently take messages for the Aging desk and Public Health desk adjacent to the MH desk.

- **Preparing Application for Immediate Services Program for Crisis Counseling (FEMA/CMHS funds)**

- **Recruiting and deploying professional staff to support community needs:**
  - More than forty seven nurses from State institutions have been recruited and deployed, including arranging transportation, by the Division's medical director.

- **Deployment of Central Office staff to assess health and other community needs:**
  - Staff participated with Health and Social Services staff on Community Health Assessment Teams deployed to ten affected counties during the period 9/17 – 9/22.

- **Deployment of Central Office staff to transport volunteers and supplies:**
  - Transporting volunteers and tetanus vaccine to Lenoir County.

- **Sharing State institution resources with those in need:**
  - Providing sleeping accommodations for 135 military personnel at the Walter B. Jones Alcohol and Drug Treatment Center.
  - Housing flooded-out group homes residents in Wayne County at the O'Berry Mental Retardation Center.
  - Housing fifteen Red Cross volunteers at Caswell Mental Retardation Center.
  - Caswell Center is housing, feeding, and providing medical services, pharmaceuticals, and recreation activities to approximately 100 residents and staff of group homes.

- O'Berry Center is housing and feeding sixteen individuals and families whose homes were destroyed, including Center staff and other community members.
- Loaning equipment from O'Berry Center – fans and pumps to assist in clean up in the community; nonambulatory vehicles for relocation of clients to other hospitals; wheelchair for an elderly woman whose chair is submerged in her flooded home.
- Murdoch Mental Retardation Center sent maintenance workers to spend a week at Cherry Hospital to help with flooding

- **Redeployment of professional staff within state institutions:**
  - Professional staff at all affected state institutions, in addition to covering service needs of residents, served meals, folded laundry, cleaned outdoor areas, and in general performed whatever work needed to get done.

- **Communicating offers of help from area programs and other professionals to area programs in need:**
  - By e-mail broadcast the Central Office solicited offers of, and requests for, assistance from area programs. Received 44 offers of help by 9/23 and established a database to track all offers and uses of those offers. Received 8 requests for assistance, also put into a database for tracking.

- **Linking volunteers to communities in need:**
  - Offers of assistance were connected by Central Office staff to all area programs and shelters requesting mental health assistance. Transportation was arranged, including arranging an airlift of staff from Rockingham County area program to Lenoir, where mental health staff were in short supply in shelters.
  - Division employees have cleaned roads with chainsaws, helped others clear trees from yards, worked in shelters serving meals and entertaining children, taken other community members into their homes, provided monetary contributions, moved personal possessions of flood victims, and in general been outstanding members of the family of North Carolina residents.

- **Substance Abuse Section Activities**
  - Division personnel (4) will assist the Duplin-Sampson Area Program EAP in providing critical incidence stress debriefing for employees who have been affected by the flooding disaster. This effort should last about four weeks and extend to 4 to 15 employers.

- **Medical Services Section Activities**

  - **Deployment of Nurses to Needed Areas**
    - Nurses offered daily
      - Volunteers from Broughton Hospital, Murdoch Center, Dorothea Dix Hospital, John Umstead Hospital and Western Carolina Center
      - Sufficient volunteer nurses and public health nurses.

- Institution volunteer pool available if needed- eager to help
- Nurse involvement (worked in shelters)
  - cardiac arrests
  - other serious medical problems
  - respite care for SPMI rest home clients
  - organizing field hospital
  - tube feedings
  - diapering
  - triage to medical or psychiatric hospitals

- **Deployment of Mental Health Specialist Teams (MHS)**
  - began organizing on Sunday 9/26
  - MHS mobility- a transportation logistical problem
  - need to coordinate efforts with APs
  - assignments (72 hrs)
    - Coordinating efforts with DHS Social Work
    - 9/27- sent 9- (JUH-5; DDH-3; Central office-1)
      - psychologists, social workers
      - Lenoir Community College; Tarboro
    - 9/28- 7 MHSs dispatched
      - DDH (3 social workers)- Pitt EOC
      - JUH (3 nurses/ 1 social worker)- sent to Pitt
        - nurses trained as counselors
    - 9/29-
      - 3 MHSs dispached to Wayne County Shelter
      - DDH- 2 psychiatric nurses/ 1 social worker

- **Coordination of Volunteer Transportation**
  - Dix motor pool
  - 2 vans daily
  - transport nurses to and from shelters and other sites

- **Team Debriefings.**
  - Extensive debriefings were held by the medical director of the 4 MHSs that went to Tarboro on Monday.
  - Medical director is in touch by phone or email with all MHSs in the field.
  - These debriefings are fed to the EOC Medical Director in Raleigh.
  - Efforts continue to be coordinated with Health head of SW

- **Cherry Hospital.**
  - Most seriously affected state facility
  - Evacuated 28 medically fragile as precaution
  - Staff on duty around clock
  - On emergency generator for part of time

- Heroic efforts by staff and volunteers to keep water out of building

- **John Umstead Hospital, Broughton Hospital, Murdoch Center, Western Carolina Center, Dorothea Dix Hospital**
  - have provided larger number of volunteers than could so far be used.
  - Wonderful response.
  - All institutions professional staff planning for next phase of support to area programs.

- **Pharmacy Activities.**
  - Sep 19 (Sunday)- contacted by EOC. Contacted Caswell Center pharmacy- coordinated pharmacist relief for National Guard Armory at Kinston Airport.
  - Sep 20-22 worked on pharmacy issues at EOC in Raleigh with DHS pharmacist and Board of Pharmacy inspector. Examples of worked performed:
    - arranged for drug shipments from Bindley Western Drug Co. to Kinston, Greenville, Tarboro utilizing resources of National Guard, Highway Patrol.
    - assisted community pharmacies and hospital pharmacies get drug shipments
    - assisted residents in having needed prescriptions filled
    - arranged for rapid deployment of rabies vaccine, tetanus toxoid to Kinston and Tarboro.
  - Sep 23- met with representatives from Board of Pharmacy and NC Association of Pharmacists (NCAP) in Chapel Hill. NCAP agreed to coordinate requests for pharmacy assistance (manpower) in stricken areas.
  - Sep 24-
    - worked on pharmacy issues at EOC with Board of Pharmacy representative. Available over the weekend as needed.
    - in Dr Veenhuis' absence, was contact person to coordinate request for nurses and other MH professional volunteers needed in stricken areas.

DMHDDSAS VOLUNTEERS, primarily for EOC
*** denotes EOC coordinator**

Crisis Services Section- 733-1763

Mary Eldridge	919/929-3020 (H)	CHAT Team DMH/DD/SA Coordinator
	1-888-366-1475 (pager)	Contact for FEMA (Judy Thomas) and CMHS
(Portland Ridley)		
Don Herring-	783-8348 (H)	EOC Coordination
Art Eccleston	733-1763	Grant Coordinator
Bill Harris-	552-3293 (H)	Grant Writing
	888/366-1476 (pager)	
Alicia Graham	733-1763	Linking volunteers to areas in need

Willie M 571-4878

Charles Davis-	787-2685 (H)	EOC
*Joan Kaye-	571-4894 (W)	EOC
	851-2074 (H)	
Susan Ward	571-4889 (W)	EOC
	557-5290 (H)	
Wayne Smith	870-8694	
Shealy Thompson		
Cathy Oliver		
Bill League	872-5056	EOC
Latonia Toms	402-8812 or 602-7156	
Ethel Eason	266-5434 (H)	

Substance Abuse 733-4671

Flo Stein	518-2581 (H)	EOC
Starleen Scott-Robbins	477-0959 (H)	
Helen Wolstenholme	596-9876 (H)	EOC
*Spencer Clark	782-7544	EOC
Terrie Qadura	851-1860 (H)	EOC
Morris Godwin		EOC
Pat Connelly	471-6658	EOC
Jilma Shackelford	850-0022	Gov.'s Office
Doug Baker	772-7033	EOC
Erma Judge		EOC

Child and Family- 733-0598

Dick Oliver	718-5666 (H)	218-9746 (cell)
*Susan Robinson	919/572-0628	EOC
Susan Shea	431-9256	EOC
Susan Roehrig	919/477-3211	EOC
Julie Seibert	831-1816	EOC
Mark O'Donnell	919/477-7137	EOC

Budget 733-7013

Phillip Hoffman-	783-9342 (H)	
Sharon Smith	496-5846 (H)	
*Charles Henderson	661-0154 (H)	EOC
Koren Reberg	790-6721 (H)	EOC
Elizabeth Brown		EOC
Gary Cannan		EOC

Thomas S. 420-7995

Kent Woodson	571-0931 (W)	EOC
Margaret Steeves	878-3575 (H)	EOC
*Ann Geller	380-7185 (H)	EOC
Val Carmine	518-0353 (H)	
Rhoda Miller	790-6721 (H)	
Chris Egan		EOC

Developmental Disabilities- 733-3654

Stan Slawinski	779-3903 (H)	
Pat Porter	942-8386 (H)	
Duncan Munn	847-7721 (H)	EOC
Michelle Meadors	870-0238 (H)	EOC
Susan Autry	910/893-4298 (H)	EOC
Mariam Hartman	571-7809 (H)	EOC
Ann Elmore	772-7803 (H)	EOC
Cindy Parkey	212-2523 (H)	EOC
Vannia Conti	839-0160 (H)	
*Laura Nuss		EOC

Management Services 715-7773

Judy Rebold	461-9809	
Gary Imes	557-2312 or 656-3022	EOC
*Stuart Berde	848-6019	EOC
Vivian Avent	833-6038	EOC
Candy Helms	503-9363	EOC
Carol Donin	929-2126	EOC
Cindy Kornegary	779-9956	EOC
Tara Larson	829-4961 or 1/800/591-6104	
Scarlett Smith	496-5846	
Kitty Herrin	828-4772 or 616-5594	EOC
Rob Bertman	550-6038	EOC

Medical Services 733-4772

Philip Veenhuis	850-0690 (H)	EOC
Bob Allen	847-3043 (H)	EOC

Public Health Response Post Hurricane Floyd

September 28, 1999

Background

Hurricane Floyd caused flooding, environmental destruction, and human suffering unlike any other natural disaster in North Carolina history. While it will take years for the families in all the counties in Eastern North Carolina affected by the hurricane to fully recover, there are a significant number of immediate public health needs that must be addressed as these people return to their work and homes. This document provides an overview of how the state public health system is responding to these citizen needs.

Coordination

The State Emergency Response Team through the Emergency Operations Center (EOC) in Raleigh has been operational since the beginning of Hurricane Floyd and will remain in operation as long as necessary. In addition, 30 local Emergency Operation Centers were activated to coordinate local emergency response efforts. Public Health, including Environmental Health, is an active component of the emergency response at both the state and local level. All public health emergency response activities are coordinated with the State EOC.

Public Health Service Philosophy

- Consumer, customer, patient, person, family, citizen oriented.
- Cut red tape and bureaucracy.
- Actions grounded in evidence-based health science.

Regionalization

Certain counties within the disaster area were harder hit than others. Also, the capacity of individual counties to respond varies widely county to county. Requests for assistance will be accepted from any and all counties. However, there is a need to focus time and attention on the 13 hardest hit counties that have been grouped into 7 zones for the purpose of organizing the public health response. A Public Health Zone Coordinator has been assigned to each zone that in turn will report to the Public Health Zone Manager.

	COUNTY	COORDINATOR
Zone 1:	Nash, Edgecombe	Bart Campbell
Zone 2:	Pitt, Beaufort	Paul Webb
Zone 3:	Wilson, Greene	Worth Heath
Zone 4:	Wayne, Lenoir	Wayne Jones
Zone 5:	Duplin	Pat Curran
Zone 6:	Craven, Pamlico, Jones	Kathleen Buckheit
Zone 7:	Halifax	M.L. Tanner

Public Health Zone Manager: Steve Cline

Public Health Zone Coordinator for each zone will:

- Work with the local health directors, local environmental health directors, local EOC directors, local cooperative extension agencies, local building inspectors, and others
- Identify the high priority areas of public health concern
- Establish an implementation plan tailored to the zone with public health priorities, time frames, and desired outcomes
- Act as the point person coordinating public health response for that zone
- Assist in acquiring state and federal assistance.
- Monitor and report progress
- Evaluate and recommend strategies for recovery

Service Approach

- Multidisciplinary teams based on the identified need
- On the spot service

Community involvement and education

- Enlist and involve community leaders and groups (e.g. elected and other local government officials, non-profit groups, and churches).
- Sensitivity to physical and mental disabilities, cultural and language issues.
- Strong emphasis on communication and education through media, printed materials, and conversations with key individuals.

Public Health Focus Areas

Based on previous disaster experience, there are two areas where public health must take immediate and concerted action, environmental health and surveillance of disease/injury.

1. Environmental Health

Goal: ***All residential units in the impacted areas will have an inspection by a qualified professional for habitation, potable water and waste system within two weeks.***

a) Housing

- Assure Safe Housing
- Classification of housing/building status is being managed through local Building Inspections Programs. Houses may be legally condemned for a variety of conditions when they are deemed to be unsafe for human habitation including health risk. State Insurance Commissioner Jim Long issued an order that homes with significant flooding shall have the electricity cut to those buildings until an assessment can be made.
- Local Building Inspection Programs may call on public health expertise in assessing the extent of the health risk of flooded buildings by contacting their local health department.

- *Houses that have been submerged in flood water to depths above the electrical outlets for a period of longer than 72 hours should be considered uninhabitable and not subject to immediate health inspection unless occupied.* If these flooded homes are occupied, then inspections should be performed as a high priority and occupants informed of the health risk associated with living in the dwelling.
- In owner occupied homes, owners live at their own risk. Thus there is not a compelling public health cause to take action to remove or otherwise demolish the uninhabitable home.
- In cases of rented single family or multifamily dwellings, there is a cause for public concern and the office of the State Health Director may take measures to protect citizens from houses deemed unfit for human habitation.
- Houses with lesser degrees of damage will be evaluated and all owners and/or occupants will be appropriately educated regarding appropriate remediation methods to ensure the safety of the housing

b) Assure Safe Water Supply for all residents

- All flooded wells and water supplies servicing habitable areas and residences will be inspected and tested. **Samples should not be collected from community water supplies by individual users.**
- Samples for coliform bacteria will be collected from all flooded wells.
- Nitrate samples will be collected from flooded wells in intensive livestock areas and where the well is used by pregnant women and infants.
- Homeowners should be informed to disinfect their wells as per instructions available from the local health departments/local cooperative extension agents prior to requesting a sample. When practical, samples from disinfected wells should be sent to the State Laboratory of Public Health. This will enable us to maintain a central data base.
- Other certified drinking water labs such as the Shellfish Sanitation Section labs, local health department labs, and water plant labs may supplement the State Lab. Local health departments and other laboratories are asked to report to the zone coordinator the number of samples analyzed by other labs.
- Order water supply sampling supplies from State Lab mail room, (919) 733-7656.
- EPA and Public Water Supply staff will work with transient water systems to bring them back on line.
- Public Water Supply staff will work with community water systems to assure that their water is safe and that the boil water notices can be lifted. The Public Water Supply staff will report daily the community water systems that are ok and request assistance if needed for "problem" systems.

c) Assure Properly Functioning Septic Systems

- Property owners need to contact the local health department regarding damaged or malfunctioning septic systems before they begin repairing systems
- Local health departments will provide septic system evaluations and issue permits for repairs
- State toll-free hotline for Septic System Questions is 1-800-973-9243 or 1-800-9-SEWAGE

d) Assure Safe Food

- Adequate supplies and availability and access to nutritious and safe food
- Guidelines for reopening of restaurants and food service institutions

2. Epidemiologic Surveillance

Goal: *Active surveillance will be conducted daily with selected hospital emergency departments to monitor and respond to reports of communicable diseases, injuries, and other health issues of public health importance.*

- Active surveillance sites identified and reporting mechanism established
- Surveillance contact for flood shelters established
- "Epi" response teams are prepared to investigate all identified outbreaks/incidences. Local health departments should contact the Division of Public Health, Epidemiology Section to report a potential outbreak, (919) 733-3419.
- Preventive measures identified and communicated to affected communities
- Surveillance reports submitted daily

3. Other Public Health Concerns

a) Laboratory Support

- Drinking water supply testing including private wells
- Communicable disease reporting
- Food and lodging

b) Health Care

- Assure continuity of medical needs
- Begin to reconnect patients back into systems of care.
- Continue interim care
- Institute preventive health measures

c) Mental Health

- Attend to psychological needs
- Crisis counseling
- Pre-existing conditions

d) Animal Control

- Domestic
- Wild
- Agriculture

e) Vector Control

- Spray policy
- Removal of sources

f) Chemical Pollution Hazards

- Identification of sources of ground, water and air pollution that could have occurred as a result of the flood

Reporting

- Communications
- Briefing Reports
- Documentation of efforts
- Evaluation

PUBLIC HEALTH ZONE COORDINATORS
Hurricane Floyd
September 27,1999

Zone Manager: **Steve Cline**
office: (919) 715-6733
fax: (919) 733-0195
pager: 1 (800) 903-6002
email: Steve.Cline@ncmail.net

Zone 1:	**Nash, Edgecombe**
Coordinator:	Bart Campbell
office:	(919) 715-7148
fax:	(919) 714-4739
pager:	(919) 737-0442
email:	Bart.Campbell@ncmail.net

Zone 2:	**Pitt, Beaufort**
Coordinator:	Paul Webb
office:	(919) 717-2794
fax:	(919) 733-9555
pager:	1(800) 614-2092
email:	Paul.Webb@ncmail.net

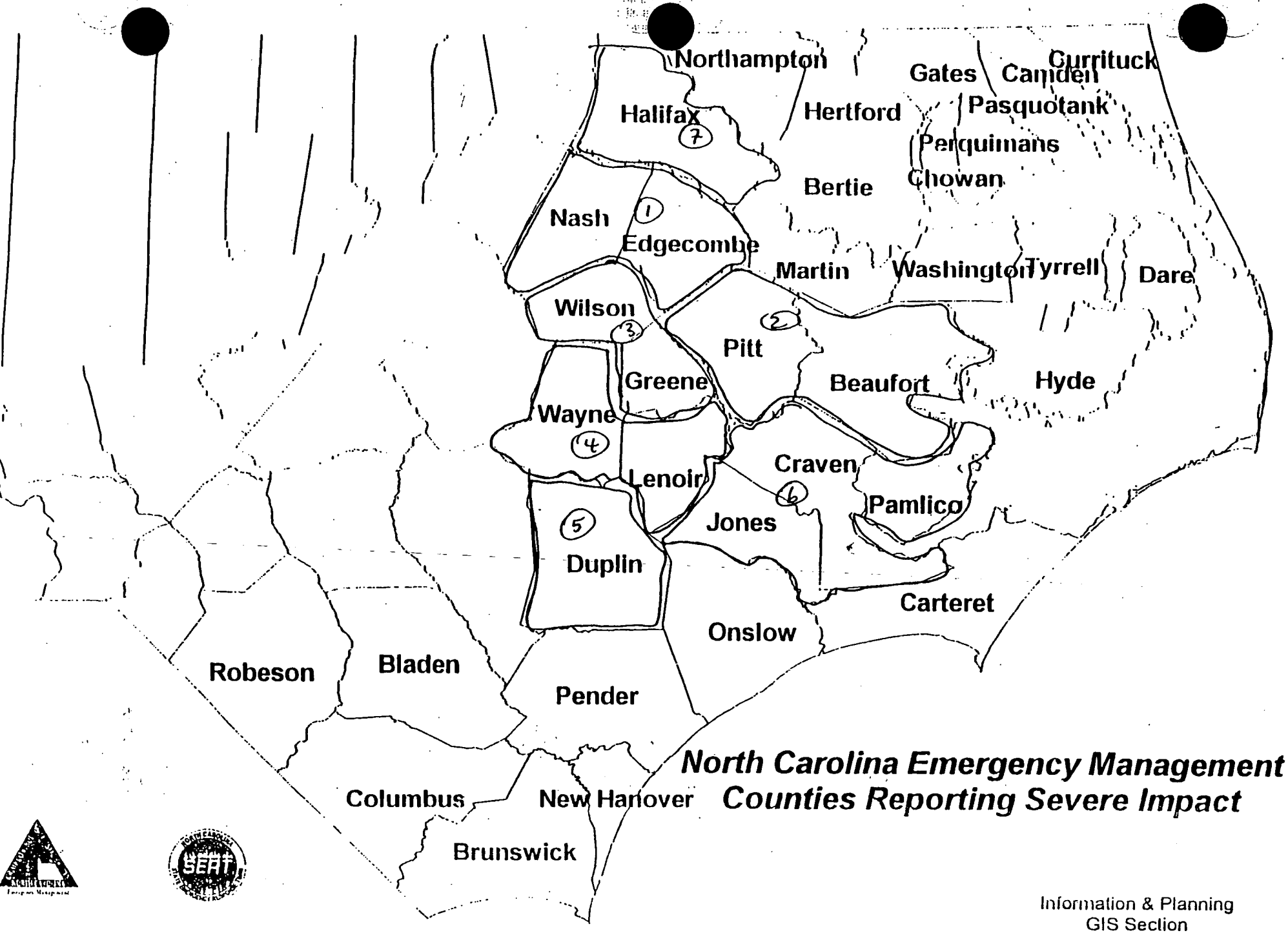
Zone 3:	**Wilson, Greene**
Coordinator:	Worth Heath
office:	(252) 747-8183
fax:	(252) 747-4040
mobile:	(252) 559-7917
office home:	(252) 522-2253
fax home:	(252)523-9299
email:	Worth.Heath@ncmail.net

Zone 4:	**Wayne, Lenior**
Coordinator:	Wayne Jones
office home:	(910) 296-2046
fax home:	(910) 296-2046
mobile:	(910) 290-2153
email:	Wayne.Jones@ncmail.net

Zone 5:	**Duplin**
Coordinator:	Pat Curran
office:	(919) 733-0200
fax:	(919) 733-9555
pager:	(919) 737-0109
email:	Pat.Curran@ncmail.net

Zone 6:	**Craven, Pamlico, Jones**
Coordinator:	Kathleen Buckheit
office:	(919) 715-6422
fax:	(919) 733-9555
mobile:	(919) 218-7003
email:	Kathleen.Buckheit@ncmail.net

Zone 7:	**Halifax**
Coordinator:	M.L. Tanner
office:	(919) 715-8497
email:	Mildred.Tanner@ncmail.net
home:	(252) 586-7219
email home:	hogheaven@coastalnet.com



North Carolina Emergency Management
Counties Reporting Severe Impact

Information & Planning
GIS Section
09/16/99
g:\hurricane floyd\ass ent.apr

DHHS Needs to Respond to Hurricane Floyd

Item			Federal Funds Requested
Food Stamps and Medicaid Administrative Costs			
	Food Stamps	$ 3,287,250	
	Federal	1,643,625	
	County	1,643,625	$ **1,643,625**
	Medicaid	1,243,890	
	Federal	621,945	
	County	621,945	**621,945**
Emergency Cash Assistance			
	Administration	5,000,000	
	TANF	2,500,000	
	Other	2,500,000	**2,500,000**
	Cash Payments	25,000,000	
	TANF	12,500,000	
	Other	12,500,000	**12,500,000**
LIHEAP allocation increase **		23,000,000	**23,000,000**
Child Care		21,000,000	**21,000,000**
Women's, Infants and Children's Special			
	Formula	2,700,000	**2,700,000**
	WIC Expansion	3,450,000	**3,450,000**
Public Health Laboratory*			
	Local Health Depts	1,200,000	**1,200,000**
	State Lab	601,207	**601,207**
Vaccination Costs		156,380	**156,380**
Total Federal Funds Requested			$ **69,373,157**

* We have been advised that FEMA will cover both the county and state increased costs.

** This allocation will come from other states' reversions.

DFS – SUMMARY OF FLOOD RELIEF ACTIVITIES

- **Non-Regulatory Emphasis**
  - Asking HCFA for waiver of some of their requirements, for example, going into nursing homes only for serious complaints

- **Senate Bill 34 Waivers**
  - Ragged – but new process
  - New Hanover – Emergency Management agency used correctly
  - Some requests when they didn't need to get waiver
  - We're being flexible

- **EMS**
  - Emergency Operations Center – manned until recently 24 hours a day
  - Field staff went to local emergency management agencies and in several cases were asked to take over emergency operations
  - Delay of inspections for ambulances/facilitating certifications of staff
  - Medical Board approval for any EMT at ALS level to assist public health with any initiatives related to Floyd (i.e., immunizations)

- **Press Releases – Relief Staff**

- **Nurse Aide Registry Process – Fast tracking**

- **SORT Team** (Special Operations Response Team)

  - We've been working since week-end after the storm

- **Assessment**
  - healthcare facilities in area
  - shelters (both official and unofficial)
  - delivering supplies – anything needed

- **Phone Assessment** – vacancies vs. evacuees needing facility

- **Emergency Certification of Medicare/Medicaid beds**

- **Construction Section**
  - Consultation
  - Cherry Hospital – helped find pumps – sent staff to help
  - Damage Assessment

- **At least 20 volunteers answering Governor's Hotline**

- **SECC – trying to get designation**

REMARKS FOR JOINT APPROPRIATIONS SUBCOMMITTEE – SEPT. 30, 1999

Division of Public Health

- Mission of Public Health is to protect the health of the people. The Division of Public Health has been actively involved in serving the needs of hurricane and flood victims of Eastern NC.

  Local health departments are playing a major role in addressing the problem. The Division of Public Health, through working with other agencies, service groups and the Special Operations Rescue Team, is playing a vital role.

- Some Activities

Assessment – CHAT Teams

- Managing the phones at the EOC – responding to needs of local agencies and private citizens.

Attention to the Health and Safety of the People

- Dispatching nurses, social workers, industrial hygienists to work in shelters and providing care to relieve local health department staff.
- Arrange for dialysis for people.
- A teleconference for health providers regarding major health problems – tapes made to send out to providers.
- Dispatch vaccine, infant formula, drugs and various supplies to needed areas.
- Work with Medical Society, pediatric society, hospital association and Academy of Family Physicians to develop a system whereby volunteer physicians can be dispatched as needed.
- Work with the AHEC, School of Pharmacy at Chapel Hill, and the Board of Pharmacy to develop a mechanism to receive donated drugs and supplies and dispatch them to counties in need.

Communication

- Developed multiple press releases, PSAs and pamphlets for local agencies and victims on information regarding multiple public health issues on health and safety.

The Aftermath of the Hurricane – The Flood

Major Issues

- Water, food, health and safety in flooded houses, mosquitoes, communicable diseases.
- Information out on dealing with these issues.
- Sampling wells – State Lab geared up to receive water samples for testing.
- EPI surveillance of communicable disease and injuries.
- Training of local staff in East and volunteer staff coming from other counties on how to inspect for mildew or mold.
- Personal training for Eastern counties and teleconference for volunteer counties.
- Developing guidance and providing consultation on dealing with issues such as animal carcasses, floating caskets, immunizations.
- Zone concept

Needs

- Rebuilding infrastructure of local health departments.
- Vaccine replacement.
- Help the lab with supplies and personnel costs.
- Replace formula and WIC funded computers
- Improve telecommunications.

What are we doing?

- Seeking federal and private funds

Hurricane Floyd Disaster Response
Division of Social Services
September 30, 1999

1. Mass Care

   - Shelter
   - Feeding
   - Special Care populations

2. Community Health Assessment Teams (CHAT) Teams

   - Coordination of Mutual Aid

3. Community Relations Teams

4. Individual and Family Grant Program Administration

   - FEMA Teleregistration
   - Case review and eligibility determination

5. Food Stamps

   - Replacement benefits for current recipients
   - Disaster Food Stamps
   - Policy Work to expand benefit eligibility
   - Other ideas to improve nutrition

Lt. Nilo Martinez

RE: Presentation to the Senate Appropriations Subcommittee on Human Resources on Particular Problems for Hispanic/Latino Population after Hurricane Floyd

Hurricane Floyd: The Need

On September 16, 1999 Hurricane Floyd hit North Carolina.

Hurricane Floyd has been particularly difficult for Latinos. Much of the warnings and information about the hurricane were disseminated in English; Latinos had little experience with disasters such as hurricanes; there was fear in the community about the shelters that were secured. During and after the flood, many Latinos were found in isolated shelters, some of them accessible only by boat or via helicopter. A large number of the Latinos in the area have lost their jobs, homes, cars and small businesses. There have also been casualties due to the hurricane.

Activities Initiated and Sustained at the Hispanic/Latino Affairs Office

The Hispanic/Latino Affairs Office, under the Office of the Governor, coordinated the following hurricane relief activities to assist Hispanic population in the state:

* maintaining a toll-free bilingual information line before and after hurricane
* allocated bilingual medical personnel to affected areas
* helped establish a Hispanic Relief fund

Hispanic Population Estimates Affected Counties

Edgecombe	1,870	Lenoir	1,722
Nash	3,477	Wayne	6,457
Pitt	4,398	Greene	1,559

Special Relief Funds

A Hispanic relief fund for eastern NC Hispanics will fill a gap, specifically assisting individuals (most of whom are Latino) who - because of worker visa status or immigrant status - do not qualify for funds made available through FEMA and other federal sources, or who otherwise would not seek assistance because of the language barrier or lack of knowledge about government agencies. The Office of Hispanic/Latino Affairs, under the Office of the Governor, will work closely with organizations that serve these individuals and that do not stand to receive adequate funds to address their clients' needs in this emergency. One hundred percent of all funds will go directly t

assist individuals affected by the flood. The fund is administered by El PUEBLO, Inc., non-profit statewide Hispanic organization.

Funds can be allocated through a network of established organizations to ensure they have maximum impact. Some of these organizations include the migrant Head Start centers of Telamon; Catholic Social Ministries; The Episcopal Farmworkers Ministry; Episcopal Hispanic Ministry; Harvest Community Health Center, and Green County Health Center. These organizations:

* Serve a large number of Latinos
* Have the trust of their local Latino communities and long experience working with them
* Have bilingual resources
* Cover multiple counties
* Have the necessary infrastructure - staff and other resources - to track the use of funds and ensure accountability, and to act as a major center of activity during relief efforts

* Have good relationships with smaller organizations and informal associations serving Latinos in the affected areas, and can work with them to ensure that the most needy are served by these funds.

Uses of the funds will be reported to the El Pueblo, Inc office on a bi-weekly basis through a simple report form, and Dr. Martinez will also visit the organizations to be of assistance in utilizing the funds in the most effective manner possible.

Participating organizations will have the ability to decide the best use of funds to address the most pressing needs of particular individuals and communities they are serving. Some anticipated uses of the funds include:

* Providing food, personal care items, and cleaning supplies
* Providing rental deposits and 1st/2nd month rent for those forced to relocate due to the hurricane
* Providing necessary transportation for moving or to jobs for those who lost cars
* Replacing lost wages for those suddenly without work
* Providing living expenses and transportation costs for migrant farmworkers who must seek new employment or return to their native country

* Providing bilingual information regarding the resources available in relief and the new employment and housing opportunities available during the clean-up period.

LONG-TERM NEEDS

HEALTH AND HUMAN SERVICES NEEDS: What the Senate Appropriations Subcommittee on Human Resources needs to know.

Background

Health and human services in North Carolina are challenged to meet the growing demand for services posed by the emerging Latino community. Throughout the years, as public entities, health and human service agencies have been expected to serve an array of services, including public health, mental health, developmental disabilities, substance abuse, and social services to all populations, regardless of citizenship, language, and race/ethnicity.

Additionally, Title VI of the Civil Rights Act stipulates that all persons in the U.S. regardless of race, color, or national origin are eligible to participate in any program or activity that receives federal financial assistance. Whereas many populations are currently facing barriers to health and human services, the Latino community (and other immigrant groups) are especially challenged in accessing these services due to the inability to understand and speak English, cultural differences, and lack of knowledge of the health and other systems. Issues of ineligibility and limited financial resources further complicate this. These barriers to services have resulted in poor health status, untreated mental health and substance abuse problems, and marginal living conditions for some Latinos, which in turn impact the community at large.

Recommendation #1: Increase institutions, providers, and individuals' awareness of Title VI of the Civil Rights Act as it pertains to culturally and linguistically appropriate health and human services.

Recommendation #2: Increase the number of bilingual/bicultural health and human services providers.

a. Recruit, educate, and provide financial support to Hispanic/Latino students to become health and human services providers.

b. Recruit bilingual providers from within and outside of North Carolina.

c. Provide financial incentives for bilingual personnel to ensure retention.

d. Involve the NC Department of Community Colleges; health, allied health, and other professional schools within the University of North Carolina system; and the Area Health Education Programs (AHECs)

Recommendation #3: Fund interpreter services at the local level.
a. Include at least $2.3 million in recurring funds in his budget to fund interpreters at the local level.

b. Local funding should be available on a competitive basis for local health departments, rural health centers, community and migrant health centers, social service agencies, and mental health centers.

FINAL REQUEST

The Hispanic/Latino Affairs Office and the Governors Advisory Council on Hispanic/Latino Affairs is also very interested in having members of the NC General Assembly endorse the following resolution addressed to President William Clinton.

Copy of the a draft letter is included.

October 1, 1999
Honorable William Jefferson Clinton
President of the United States
The White House
Washington, D.C.

Dear President Clinton,

We, the undersigned, urgently appeal to you to allocate aid to our North Carolina residents who have been ruled ineligible for federal disaster relief. Many of these residents are lawfully immigrants not eligible for FEMA assistance or undocumented aliens of Hispanic descent, but most of their children are United States citizens. All of our residents are in urgent need of humanitarian assistance since Hurricane Floyd inflicted devastation on the property, livelihoods, and communities in the eastern third of the state. No North Carolina residents should be denied humanitarian aid after a tragedy as severe as our state has experienced.

Your administration has consistently demonstrated that it feels a strong responsibility to foreign countries and their citizenry in disastrous moments, which bring about times of great need. Since you provide federal assistance to foreign nationals in their native countries, you would be hypocritical not to provide similar assistance to foreign nationals and their citizen-children in our country.

It is challenging to determine precise figures that will accurately and adequately reflect the extent of loss and subsequent need confronting many Hispanic farmworkers, workers in other industries and their families. However, based on first-hand accounts from outreach staff working in counties where agricultural crops have suffered the most extensive damage, at least, we are able to provide the following unofficial estimates of farmworkers who are currently without work, money, shelter, food, and transportation to relocate.

* Approximately 18,000 farmworkers were employed in agriculture in the following counties most severely affected by Hurricane Floyd: Bertie, Duplin, Edgecombe, Greene, Nash, Pender, Pitt, Robeson, Sampson, Wayne, Wilson, Yadkin.

* Of the twelve counties most severely affected, nine suffered very extensive to complete crop loss and the other three experienced significant but not complete crop losses.

* With fields inundated with water and crops rotting in the fields, an estimated 75% or 13,500 farmworkers previously employed in these counties have lost their jobs and are in desperate need of income generating work.

* While short supplies of food are being distributed by local food distribution centers, many sites require the victim to be present to receive items. For the majority of farmworkers who are without transportation or have lost their vehicles in the flood, this rule makes it virtually impossible to receive items. An estimated 50-75% of farmworkers and their families are in need of basic food staples, including bottled water.

* A large number of farmworkers were flooded out of their homes and fled to nearby shelters or churches. With the waters receding, many farmworkers have returned to find empty shells of the structures that used to be their homes. An estimated 15-20% or 2,700-3,600 farmworkers and their families remain in need of housing at this time.

* An estimated 60-75% of farmworkers desperately need some form of transportation; whether it be repair or replacement of vehicles flooded or swept away by rushing waters, or money for gasoline or bus vouchers to relocate to other areas of the state or other states to return to their native lands.

The losses suffered by Hispanic farmworkers only represents a fraction of the devastation Hurricane Floyd inflicted on the Hispanic community. We estimate that anywhere between 50,000 and

100,000 Hispanic men, women, and children have been displaced by the storm. President Clinton, we hope this information provides you an understanding of the dire situation faced by thousands of our Hispanic residents in Eastern NC. Although many are undocumented, these residents are the backbone of the region's agricultural economy and many other industries. Winter will fall soon upon NC and will bring more suffering. We urgently appeal to you for financial assistance that can be offered to help ease their great burden and suffering.

Your engagement and leadership in the effort to bring humanitarian relief to all North Carolina residents impacted by Hurricane Floyd would demonstrate that the United States government is truly consistent in its distribution of aid to people in need.

Respectfully,

Dr. H. Nolo Martinez

North Carolina Governor's Advisory Council on Hispanic/Latino Affairs Catholic Diocese of North Carolina - confirmed Members of the NC General Assembly ?

H. Nolo Martinez, Ed.D.
Director of Hispanic/Latino Affairs
116 West Jones Street
Raleigh, NC 27603
(919) 733-5361
(919) 733-2120 fax
nolom@gov.state.nc.us <mailto:nolom@gov.state.nc.us>

Pediatric Dental Care in CHIP and Medicaid:

Paying for What Kids Need

Getting Value for State Payments

Reforming States Group

Milbank Memorial Fund

©1999 Milbank Memorial Fund

Milbank Memorial Fund
645 Madison Avenue
New York, NY 10022

All rights reserved. No part of this publication may be reproduced, stored in any retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise without prior permission.

Printed in the United States of America.

ISBN 1-887748-28-8

TABLE OF CONTENTS

Foreword ..... *v*

Acknowledgments ..... *ix*

1999 Reforming States Group Steering Committee ..... *x*

Executive Summary *1*

The CHIP Opportunity *3*
- *New CHIP Programs* *3*
- *The Medicaid Legacy* *3*
- *The Disparity Problem* *4*
- *The Contributions and Limits of Public Health* *4*
- *The Public and Private Dental Delivery Systems* *5*
- *Reimbursement for Dental Services* *6*
- *Public and Private Funding of Dental Services for Children* *7*

The RSG Dental Work Group Insurance Program *9*
- *Goals* *9*
- *Levels of Children's Needs and Thus of Care* *9*
- *Level 1: Diagnostic, Preventive, and Disease Management Services* *10*
- *Level 2: Basic Restorative Care* *10*
- *Level 3: Advanced Restorative Care* *11*
- *Level 4: Catastrophic Care* *11*
- *Maintenance Care in Levels 1–4* *11*
- *Orthodontic Services* *12*
- *Age Eligibility* *12*
- *Administration* *12*
- *Costs* *12*
- *Accountability* *13*
- *Advantages of the Proposed Program* *14*

A Program for Each State: Using the Interactive Model *16*

FOREWORD

This report proposes a new approach to policy for state financing of dental care for the 20 million children who are at substantial risk of pain and disfigurement because they lack access to appropriate preventive and reparative services. The new approach attempts to improve children's access to care by simplifying the interaction between dentists and public agencies as well as by increasing the reimbursement to providers. The authors of this new approach are dentists who hold elective state office, other members of the Reforming States Group (RSG), and experts on dental care for children.

The RSG is a voluntary organization of leaders in government from more than 40 states who meet regularly to assess their experience in making health policy and frequently report to colleagues about it. The Milbank Memorial Fund, the RSG's co-publisher, is an endowed national foundation established in 1905 that has collaborated with the RSG since its inception in 1992.

In 1997, Ray Rawson, a Nevada legislative leader who is also a dentist, recommended to his colleagues on the steering committee of the RSG that they develop model policy to finance adequate dental coverage for children eligible for the recently enacted federal–state Children's Health Insurance Program (CHIP). Rawson graphically described the suffering that frequently results from untreated dental disease in children and the inadequacies of Medicaid dental programs in most states.

"Dentistry works for children who have access to it," but dentists frequently decline to participate in public dental programs, he continued. Dentists are "independent; many of them distrust government." Many dentists, moreover, are impatient with the problems of patients on Medicaid. Effective policy to improve children's access to dental care would attempt to "eliminate as many as possible" of dentists' concerns about public programs. "All dentists will never agree," but "access can be improved if half of them" accept state dental plans that encourage continuity of care and reimburse them for their costs.

The steering committee asked Rawson and Sandy Praeger, then chair of the RSG, to organize a meeting of experts to consider how to improve children's access to dental care. Participants in this meeting, held in November 1997, were dentists serving in state legislatures and in the executive branch of both federal and state government, academic experts in children's dentistry, an official of the American Dental Association, and an advocate for children. These persons, as well as many others who contributed to this report, are listed in the Acknowledgments.

As a result of this meeting, a work group devised a model dental insurance

plan for children eligible for CHIP and supervised the writing and review of a report describing its coverage and cost. In addition to Rawson and Praeger, two legislators who are also dentists joined the work group: State Representatives Peter Knudson of Utah and Gerald Sveen of North Dakota. The Milbank Memorial Fund commissioned James Crall and Burton Edelstein, two children's dentists with experience in research, patient care, and government, to draft the report.

The Fund also engaged Sandra Hunt of PricewaterhouseCoopers, LLP (PwC), to estimate the cost of the model insurance plan, using recent data from California. The percentage of eligible children receiving dental care under Medi-Cal, that state's Medicaid program, had increased after the state raised reimbursement to dentists in response to a court decision. Kimberly Belshé, then director of health services for California and a member of the RSG steering committee, made available recent data on utilization and payment for dental services for children under MediCal. Hunt also used the data to construct an interactive model, available on the World Wide Web, that officials and dentists in any state can use to change assumptions about reimbursement and the number of eligible children and then to calculate the approximate cost of the model plan.

More than 100 members of the Reforming States Group and leaders in dentistry in several states reviewed drafts of this report. Many of these reviewers were skeptical about the appeal of this plan to dentists, even though it would increase their reimbursement from state programs. Some RSG members criticized dentists in their states for opposing both public programs to prevent dental disease and broader licensure for dental hygienists. Others said that increased reimbursement for dentists under Medicaid in their states had neither improved dentists' participation nor increased their willingness to understand why poor children and their caregivers often had difficulty keeping scheduled appointments.

The dentist–legislator members of the work group urged their colleagues in state government to address the causes of dentists' reluctance to participate in public programs. Most dentists are solo providers. They rely entirely on fees to pay for equipment, supplies, and staff and for their personal income. Reimbursement from public programs that only just meets or falls below their costs is a hardship, which is intensified by missed appointments and public agency administrative requirements that consume more time than those of commercial insurers or patients who pay privately.

The dentist–legislators also emphasized that better access to dental care needs to be integrated with more effective programs of dental public health. These programs include outreach to poor children and their families, health promotion, attuning practitioners to the culture of their patients, and school-related prevention and treatment. They also include water fluoridation where there is community acceptance of the practice.

Although public health interventions prevent or postpone dental disease for many children, they are not substitutes for the diagnostic and reparative services that dentists provide to children with disease. The model insurance plan described in this report could address the need for access to diagnostic and curative services among children eligible for CHIP, and perhaps Medicaid as well, in ways that remove, or at least reduce, some of the current disincentives to participation among dentists. Moreover, the plan could increase access at a cost per child that is comparable to what most Americans and their insurers are spending to prevent, diagnose, and treat dental disease.

John M. Colmers
Chair, Reforming States Group
Executive Director, Maryland Health Care Access and Cost Commission

Daniel M. Fox
President, Milbank Memorial Fund

Sandy Praeger
Immediate Past Chair,
Reforming States Group
Chair, Public Health and Welfare Committee
Kansas Senate

Raymond D. Rawson
Assistant Majority Leader and Chair,
Human Resources and Facilities Committee
Nevada Senate

ACKNOWLEDGMENTS

The following persons participated in meetings to plan this report and/or reviewed it in draft. They are listed in the positions they held at the time of their participation.

Robert Isman, Director, Children's Dental Health Initiative, The Dental Health Foundation, Davis, California; Kay A. Johnson, Senior Research Staff Scientist, The George Washington University, Center for Health Policy Research; Peter C. Knudson, Chair, Business, Labor and Economic Development Committee, Utah House of Representatives; Kim Moore, President, United Methodist Health Ministry Fund, Hutchinson, Kansas; Sandy Praeger, Chair, RSG Steering Committee, Chair, Public Health and Welfare Committee, Kansas Senate; Judith Pulice, Director, State Governmental Affairs, American Dental Association, Chicago, Illinois; Raymond D. Rawson, Assistant Majority Leader, Chair, Human Resources and Facilities Committee, Nevada Senate; Don Schneider, Chief Dental Officer, Center for Medicaid and State Operations, Health Care Financing Administration, Baltimore, Maryland; Mark Siegal, Chief, Bureau of Oral Health Services, Ohio Department of Health; Richard Simms, Member, Council on Government Affairs, American Dental Association, Harbor City, California; and Gerald O. Sveen, Member, Judiciary Committee, North Dakota House of Representatives.

1999 REFORMING STATES GROUP STEERING COMMITTEE

Robert A. Bittenbender*
President, NASBO
Secretary of the Budget
Commonwealth of Pennsylvania

Harriette L. Chandler
Chair, Joint Health Care Committee
Massachusetts House of Representatives

John M. Colmers
Chair, RSG Steering Committee
Executive Director
Maryland Health Care Access and Cost Commission

John F. Cosgrove
Deputy Democratic Leader
Florida House of Representatives

Mark Gibson
Vice Chair at Large, RSG Steering Committee
Policy Advisor for Health Care, Human Services and Labor
Office of the Governor of Oregon

Richard N. Gottfried
Chair, Health Committee
New York State Assembly

Lee Greenfield
Lead DFL Member, Health and Human Services Finance Committee
Minnesota House of Representatives

Kemp Hannon*
Chair, Health Committee, National Council of State Legislators
Chair, Health Committee
New York Senate

Patrick J. Johnson
Executive Director
Utah Health Policy Commission

Mary E. Kramer
President, Iowa Senate
Vice President, Community Investments
Willmark Inc.

Andrew Levin
Co-chair, Ways and Means Committee
Hawaii Senate

William N. Martin
Chair, Appropriations–Human Resources Committee
North Carolina Senate

S. Peter Mills
Member, Taxation and Labor Committees
Maine Senate

Angela Z. Monson
Vice Chair, Business and Labor Committee
Oklahoma Senate

*ex-officio member

Andrew W. Nichols
Member, Subcommittee on Health and
Welfare of the Appropriations Committee
Arizona House of Representatives

Sandy Praeger
Immediate Past Chair, RSG Steering
Committee
Chair, Public Health and Welfare Committee
Kansas Senate

Raymond D. Rawson
Assistant Majority Floor Leader
Chair, Human Resources and Facilities
Committee
Nevada Senate

George M. Reider, Jr.*
President, National Association of
Insurance Commissioners
Commissioner
Connecticut Department of Insurance

Peggy A. Rosenzweig
Vice Chair, RSG Steering Committee
Ranking Member, Audit Committee
Wisconsin Senate

Richard A. Westman
Vice Chair, Appropriations Committee
Vermont House of Representatives

*ex-officio member

EXECUTIVE SUMMARY

This report proposes a publicly funded dental insurance program for the states that targets children-in-need and takes full advantage of prevailing dental financing and delivery systems in the context of the new Children's Health Insurance Program (CHIP). States can modify this program to take account of the number of eligible children and their policy for reimbursing dentists by using interactive actuarial software devised for this report and available on the World Wide Web.

Tooth decay (dental caries) is the most common chronic disease of childhood; it is five times more frequent than asthma, for example. Twenty million children—25 percent of persons under age 19—suffer 80 percent of all tooth decay. For an estimated 4–5 million of these children, tooth decay interferes with routine activities.

Children living in poverty consistently suffer more tooth decay than their more affluent peers. Yet children with the greatest dental treatment needs have the least access to dental care. This disconnect between the presence of dental disease and access to care is worsening despite public health and dental care programs for poor children.

Millions of children are predisposed to dental disease because of dietary, behavioral, and socioenvironmental factors that overwhelm preventive interventions available to them. Children eligible for Medicaid experience twice the rate of untreated dental disease as more affluent children. But states spend only one-tenth as much on dental care for Medicaid enrollees as the national average for all children.

The Reforming States Group (RSG) convened a work group to design a dental insurance program that would use public funds to achieve enhanced access. This program emphasizes broad participation by public- and private-sector dentists, accountability, and fiscal responsibility. The members of the work group included legislators, pediatric dentists, public health officials, and representatives of organized dentistry.

This program defines four levels of dental treatment needs, based on disease severity and the cost of services necessary to prevent tooth decay and restore a child's dentition to a condition of health. The levels are:

- diagnosis, prevention, and disease management
- basic restorative care
- advanced restorative care
- catastrophic care

The program would be linked to new and existing public health interventions that have a major role in improving children's dental health.

At the request of the RSG, the Milbank Memorial Fund commissioned the firm of

PricewaterhouseCoopers, LLP, to develop an interactive actuarial model that permits a state to calculate the cost of implementing the program in the proposed or in a modified form. According to the actuarial model, estimated costs for the proposed program are approximately $14.50 per enrolled member per month (PMPM) for direct services and roughly $2.50 PMPM for administrative costs. Officials also can use the interactive actuarial model, which is available on the World Wide Web, to adapt this proposal to the particular demographic characteristics of the covered population and budgetary constraints in any state.

New CHIP Programs

This report explores the opportunity that the Children's Health Insurance Program (CHIP) presents to legislators and state policymakers to develop effective new pediatric oral health programs, reform ineffective pediatric dental Medicaid programs, and maximize the impact of public health approaches to improve the oral health of children who suffer the most dental disease. The report describes the elements of a new state dental program for children in the context of historical problems with state-financed dental coverage for low-income children and of prevailing dental finance and delivery systems.

CHIP allows states considerable flexibility in designing programs. CHIP dental insurance plans proposed by states to date seek to improve the oral health of children by enhancing access to necessary dental services. However, coverage does not ensure access to dental services under Medicaid. Moreover, access promotes children's use of services but it does not ensure that programs will use resources effectively.

There is evidence, however, that well-designed and administered plans can assure coverage that provides value and leads to better health. Such plans are backed by proper financing, implemented with meaningful outreach, and linked to a responsive public and private dental provider community. For example, a state-financed CHIP program in western Pennsylvania was modeled on commercial dental insurance and actively engaged private-sector dentists. This program doubled the number of children who had a dental visit (from 30% to 64%), dramatically increased the percentage who have a regular source of dental care (from 51% to 86%), and almost eradicated unmet dental treatment needs (from 52% to 10%).

Similarly, Michigan's "MIChild" dental plan, implemented in May 1998, serves children enrolled in CHIP. These children are eligible for up to $600 of dental care a year. Dentists who participate in Blue Cross and Delta Dental—85 percent of Michigan dentists—are providing the care. Eligible children are identified only as members of one of these plans. Michigan officials estimate that the plan, which costs approximately $9 per child per month, meets all the needs of about 95 percent of the enrolled children.

The Medicaid Legacy

Publicly funded dental coverage for poor children—principally the 32-year-old Medicaid EPSDT program—has not secured their oral health. Medicaid has provided

broad dental coverage but only limited access and services. A 1996 report by the Inspector General of the Department of Health and Human Services concluded that only one in five children enrolled in Medicaid received even a single preventive dental service in a 12-month period and that few enrollees have all of their dental care needs met.

Dental Medicaid programs are unpopular with dental providers as well as consumers. In many states, they have been the subject of successful federal lawsuits on behalf of beneficiaries. Dentists and state officials characterize these programs as underfinanced, cumbersome, at variance with contemporary dental practice guidelines and technologies, and grossly inadequate in their outreach and disease management.

By adapting successful features of private-sector coverage, state CHIP plans can improve on Medicaid and leverage changes in it, because more than 40 CHIP plans are, at least in part, expansions of Medicaid.

The Disparity Problem

The 20 million children and adolescents under age 19 in families with low incomes account for 80 percent of tooth decay. The consequences of this disease for them are at best a frequent distraction and at worst a physical handicap. For an estimated 4–5 million of these children and adolescents, tooth decay severely interferes with eating, sleeping, speaking, learning, playing, and working. The suffering of these children includes the distraction of chronic toothache, searing pain from dental abscesses, disfigured smiles, dysfunctional speech, and eating difficulties. These children struggle through meals, are distracted from play and study, and are embarrassed and humiliated by how they appear to others.

The 20 million children and adolescents under age 19 in families with low incomes account for 80 percent of tooth decay.

Dental caries is an easily treated disease for most children. For children with extreme dental disease, however, dental caries frequently contributes to distracted behavior and associated poor educational performance. Chronically poor oral health is associated with failure to thrive in toddlers, compromised nutrition in children, and cardiac and obstetric dysfunctions in adulthood.

The Contributions and Limits of Public Health

The overall oral health of American children has improved substantially over the past several decades as a result of public health programs. Increased availability of fluorides

is credited with substantial reduction in dental caries. Water fluoridation, a highly cost-effective community-wide preventive approach, reaches 62 percent of the population. The prevalence and extent of tooth destruction is dampened by fluoride exposure. However, disease rates among low-income children in fluoridated areas continue to be high relative to rates among children in more affluent households. Similarly, public programs that provide sealants—plastic coatings for chewing surfaces of permanent teeth that are particularly susceptible to decay—reduce but do not eliminate the need for restorative care.

Disease rates among low-income children in fluoridated areas continue to be high relative to rates among children in more affluent households.

Federal-state Maternal and Child Health (Title V) programs support many fluoridation, sealant, and dental public health efforts. However, these programs have not focused aggressively on children at high risk for dental disease through health promotion and early intervention.

The Public and Private Dental Delivery Systems

Ninety percent of the nation's 153,000 dentists are private practitioners in single- or two-person practices. Fewer than one in five dentists (18%) are specialists and of those, only 3,600 limit their practice to pediatric dental care. These pediatric dentists contribute substantial care to low-income children, particularly those who are more difficult to treat because of developmental disabilities or behavioral or medical conditions.

Dentists are located disproportionately in the more affluent and suburban communities where most of their patients live. The Health Resources and Services Administration of the Department of Health and Human Services (DHHS) designates one-third of cities and two-thirds of rural areas as Dental Shortage Areas.

Moreover, the total dental workforce is shrinking relative to population. The supply of newly trained dentists has declined substantially over the past two decades. The number of new dentists is projected to be stable or to increase at only about 1 percent annually. As a result, the current ratio of 1 dentist for every 1,725 people is likely to decline over the next 20 years to 1 dentist for every 1,925 people. However, demand for dental services is growing because an aging population retains teeth longer and because more people are purchasing cosmetic and elective dental services.

There are few safety net providers that

offer dental care to underserved populations. Less than half of federally supported community and migrant health centers provide dental care. These facilities target underserved populations but treat both disadvantaged patients and those covered by insurance or able to pay for care out of pocket. Most of the 54 dental schools generate only a small fraction of their clinical income from Medicaid.

Dental hygienists deliver significant preventive services, primarily in private practice settings. If hygienists are linked effectively to dentists who provide necessary restorative care, they can expand access to care for children with caries by performing outreach, screening, referral, and follow-up.

Dental practices that treat large numbers of Medicaid clients profitably by offsetting quality with volume are often disparaged as Medicaid "mills." Many of these practices are, however, the primary source of care for Medicaid clients. Many of them provide mainly low-cost, easily delivered diagnostic and preventive services and pain relief. They do not meet more extensive restorative needs, which are time-consuming and more expensive to deliver. These practices are an unintended consequence of Medicaid reimbursement that is significantly below market rates and of programs that measure productivity by the numbers of clients seen rather than the appropriateness of the services delivered.

Medicaid "mills" are an unintended consequence of Medicaid reimbursement that is significantly below market rates and of programs that measure productivity by the numbers of clients seen.

Reimbursement for Dental Services

Fee for service is the predominant method of payment for dental services. Less than half the population is covered under dental insurance, most of which is employer-based. Dental coverage typically pays a percentage of the dentists' "usual, customary, and reasonable" (UCR) fees, requires copayments, and has fixed annual and lifetime limits.

Approximately one-third of dentists participate in any managed care program, and only a small portion of their patients have managed care coverage. Capitated managed care has made little impact on dental financing because most dental offices lack sufficient patient volume over which to spread financial risk. Most dentists who do participate in managed care contract only for discounted fee-for-service payment and limit involvement to a small proportion of their practices.

Dentists typically own and operate their own surgical suites and are responsible for all facility, personnel, and administrative

costs associated with their operative treatments. Medical surgeons, in contrast, rely on hospitals to bear most of these costs. The American Dental Association reports that dentists' mean overhead costs are 60 percent. These high fixed costs make missed appointments expensive for dentists. Dentists' experience is that patients covered by Medicaid miss a disproportionate number of appointments.

Medicaid programs frequently set administrative requirements that demand additional time from dentists because they are different from what commercial health insurers require. These requirements include unique claim forms, prior authorization requirements, and cumbersome eligibility verification.

The relationship between Medicaid payment rates and the number of dentists who participate is complex. When California raised its Medicaid dental fees significantly under federal court order, the number of participating dentists and children receiving care increased. But overutilization as well as fraud and abuse also increased until the state reinstituted utilization review. Anecdotes from other states that have raised dental fees in response to evidence about dentists' costs suggest that, initially, children who are already getting care get more services. Subsequently, dentists who are already active Medicaid providers see more patients, and more dentists join the program.

Higher reimbursement for dental services will not by itself increase provider participation. Other ways to increase the participation of dentists include effective linkage between school oral health and sealant programs and comprehensive dental care providers, active information and support programs by state and local agencies, tactics that reduce missed appointments, and education to help families get access to dental care.

Public and Private Funding of Dental Services for Children

Medicaid underfunds dental care for children. Dental care is 25–27 percent of total health care spending for children, but it is only 2.3 percent of Medicaid spending for children. That low funding translates to an average expenditure in 1997 of $161 for children who received dental care under Medicaid.

Dental care is 25–27 percent of total health care spending for children, but it is only 2.3 percent of Medicaid spending for children.

THE RSG DENTAL WORK GROUP INSURANCE PROGRAM

Goals

The RSG dental work group proposes a dental insurance program that would offer children in low-income homes services that are comparable to the care available to children in middle-income families. The program would:

- promote access to continuous primary dental care
- encourage dental provider participation
- assure accountability without undue administrative burden
- achieve more cost-effective use of resources
- target higher-needs children
- provide comprehensive dental care
- lead to improved oral health outcomes

The program emphasizes early and ongoing risk assessment and disease management, market-based fee-for-service reimbursement to dentists, and administrative oversight that is proportional to the intensity of treatment needs and services. After a comprehensive diagnostic workup, each child would be assigned to the appropriate level of restorative care.

Levels of Children's Needs and Thus of Care

The work group described four levels of dental treatment that children need:

1. *Diagnostic, Preventive, and Disease Management Services* (including health promotion, risk assessment, primary prevention, and disease suppression needed for all children)
2. *Basic Restorative Care* (for children with modest needs)
3. *Advanced Restorative Care* (for children with more complex needs)
4. *Catastrophic Care* (for children with severe needs)

The cost of the restorative care a child requires sets the boundaries for the second, third, and fourth levels of care. Restorative care includes dental sealants, fillings, nerve treatments, stainless steel crowns,

THE FOUR LEVELS OF TREATMENT

1. Diagnostic, Preventive, and Disease Management Services (including health promotion, risk assessment, primary prevention, and disease suppression needed for all children)
2. Basic Restorative Care (for children with modest needs)
3. Advanced Restorative Care (for children with more complex needs)
4. Catastrophic Care (for children with severe needs)

Dentists may treat children at Levels 1 and 2 without prior authorization or even submittal of x-rays.

extractions, and other services that rehabilitate a child's dentition or address other oral diseases and condition.

Actuaries estimated the cost of the program using a fee schedule that reflects current market rates for purchasing dental care. In a state implementing the program, payment would be made according to a fee schedule devised in the relationship between dentists and that state or between dentists and the state's contracted vendors. Fees would be adjusted for inflation.

Enrollees would receive services from public sector or private practice dental providers. Emergency care to relieve pain and/or eliminate infection would be covered on a direct-fee basis outside the four levels of care.

Level 1: Diagnostic, Preventive, and Disease Management Services

At Level 1 dentists have responsibility for diagnostic and preventive care, including the frequency and content of visits. Dentists could receive a fixed annual primary care case management fee that bundles a set of diagnostic and preventive services. Diagnostic services are those necessary to develop a comprehensive treatment plan that both addresses current disease findings and reflects a child's risk of future disease. Preventive services emphasize oral health counseling and fluoride regimens that are specific for each patient.

Dentists would use their clinical judgment to determine the extent of diagnostic work-up appropriate to a particular child (e.g., number and type of radiographs). State officials and the dental profession could devise principles to help practitioners determine the extent of diagnostic work-ups appropriate to children with various clinical presentations. Such guidance would also be useful in oversight to ensure that children receive adequate evaluations.

Assignment of children to Levels 2, 3, and 4 with their attendant billing caps depends upon their initial evaluation. Individual dentists may elect to treat children at any level. Most Level 1 dentists would also take responsibility for Level 2; many for Level 3 as well. Dentists who provide large quantities of diagnostic and preventive care but fall below utilization management standards for providing reparative services would be candidates to be investigated for "skimming."

Level 2: Basic Restorative Care

Children requiring up to $400 of reparative treatment (in 1999 dollars) based on reimbursement schedules (which could be statewide or regional) would receive Level 2 or Basic Care. Their dentists would submit

charges on a fee-for-service basis using a standard American Dental Association claim form with no prior authorization requirements.

Dentists whose profiles reflect consistent billing near the $400 Level 2 cap could be evaluated for possible fraud and abuse. Nearly 80 percent of beneficiaries and 25 percent of total program expenditures are likely to be in Level 2, according to the actuarial study commissioned for this report.

Dentists whose profiles reflect consistent billing near the $400 Level 2 cap could be evaluated for possible fraud and abuse.

Level 3: Advanced Restorative Care

Children with service needs that require between $400 and $1,000 of treatment (in 1999 dollars) would receive Level 3, Advanced Care. Dentists would request prior authorization for all nonemergency care, in order to ensure that these children do not receive excessive or unnecessary care. The actuaries report that about 15 percent of children and 45 percent of expenditures are likely to be in Level 3.

Level 4: Catastrophic Care

Children with exceptional treatment needs—whose estimated reparative services exceed $1,000 in costs—would receive Level 4, Catastrophic Care. These children would receive comprehensive treatment from dentists with whom the program contracts to provide tertiary-level services. Dentists providing comprehensive services for Level 4 patients would be reimbursed, where feasible, at a negotiated modest discount from market-based fees, but with a guaranteed minimum payment per case.

Fees for Level 4 children would be discounted as a market offset for the greater volume of services these children require and the greater efficiency with which Level 4 dentists under contract can provide those more intensive services. The relatively small number of dentists with suitable training and/or experience to provide Level 4 care could compete for contracts to provide care for children with catastrophic needs. Level 4 care would require prior authorization that would include consultation with a specialist in pediatric dentistry. Children requiring Level 4 care frequently require dental surgery that is performed under general anesthesia or sedation. These few children—less than 5 percent of beneficiaries—are likely to absorb 30 percent of program expenditures.

Maintenance Care in Levels 1–4

Maintenance care regimens would be

established for all children covered by the program. These regimens would be based on formalized risk assessment approaches that could be developed by state officials collaborating with a state's dental community. Maintenance care would normally be provided semiannually for Level 2 children and more frequently for children receiving services in Levels 3 and 4. This care would include ongoing risk assessment, health promotion, and disease prevention. Reimbursement for this maintenance care would be the same as for children who only receive Level 1 services.

States could offer additional financial incentives to dentists for identifying high-needs children and completing their care. Such incentives to provide comprehensive care could be funded by CHIP or Medicaid or through such sources as Title V Maternal and Child Health Block Grants, Head Start, state public health funds, and philanthropy.

Orthodontic Services

Medically necessary orthodontic services would be determined through an objective severity index and provided within Level 4 coverage by suitably qualified dentists. These services could be financed by a reserve fund estimated at 5 percent of the dental program, and reimbursed at 60 percent of the UCR fees in a state or region.

Age Eligibility

Caries is established as a disease process in infant and toddler years. Many experts recommend that children begin to receive dental care by their first birthday, especially anticipatory guidance to their caregivers and primary disease prevention. Medicaid programs cover children from birth through age 21, CHIP to age 18.

Administration

The proposed program would be advertised in ways that resemble commercial insurance. Dentists would be more eager to participate in the program if it uses the standard American Dental Association claim form as well as electronic billing and enrollment verification. The program could also achieve economies of scale by requiring each dentist to treat a minimum number of children.

Costs

At the request of the RSG, the Milbank Memorial Fund commissioned an actuarial analysis of the proposed program from PricewaterhouseCoopers, LLP (PwC). The actuary used data from the California dental Medicaid (DentiCal) program to project the costs and utilization of pediatric dental services for populations of children whose

utilization is similar to those enrolled in California Medicaid. The PwC analysis calculated fees at 100 percent of what dentists submitted to Denti-Cal for diagnosis and prevention, and 80 percent of fees for treatment. Based on utilization in California, the resulting estimate for the direct cost of services under the RSG program was determined to be $14 PMPM; $16–17 PMPM with administrative costs included.

Based on utilization in California, the resulting estimate for the direct cost of services under the RSG program was determined to be $14 PMPM; $16–17 PMPM with administrative costs included.

Also during 1998 the American Academy of Pediatrics (AAP) commissioned the firm of Towers Perrin to study the cost of providing comprehensive health benefits, including dental services, for children covered by CHIP. Using different methods than PwC, the Towers Perrin actuaries concluded that the sum of direct and administrative costs for providing coverage for preventive, diagnostic, and rehabilitative dental services (with medically necessary orthodontic services) for CHIP-eligible children was $20 PMPM, which was 20 percent of the total cost of comprehensive child health care. This estimate includes administrative costs. After adjusting for this difference using a 15–20 percent administrative cost factor, the Towers Perrin and PwC studies yield similar estimates of $17–18 PMPM to cover basic dental services and program administrative costs.

A $17–18 PMPM cost, the average of the two estimates, is much greater than historical expenditures for Medicaid dental programs but it is consistent with national data on dental spending for all children. About 25–27 percent of child health expenditures are dental care costs, 10 times what Medicaid currently spends for children's dental care.

Accountability

Program/Plan Performance

Tools are available to hold programs and plans accountable. For example, the Health Care Financing Administration's HCFA-416 indicator is a performance measure that could improve the ability of states to assess their overall dental programs, to compare performance across plans where responsibility has been delegated to managed care organizations, and to evaluate service delivery by individual dental care providers. Other performance indicators to evaluate vendors who contract to administer benefits for groups of enrolled children could include the length of time between enrollment and first dental visit, the percentage of children

receiving selected preventive services, the percentage of children whose treatments are completed in a timely manner, the claims-loss ratio, and the timeliness of response to requests for prior authorization and of claims paid. HCFA and the National Committee on Quality Assurance (NCQA) recently recommended additional measures of dental plan performance.

Provider Performance

Criteria for accountability could include the percentage of children at Levels 3 and 4 whose submitted treatment plans are completed and the time intervals required to complete treatment plans.

Outcomes Assessment

Positive outcome indicators include reductions in the percentage of enrolled children with unmet treatment needs and increases in the percentage of parents who report having a regular source of dental care for their children and who have obtained dental services. Negative indicators could include the percentage of children whose parents report unmet treatment needs or protracted delays in obtaining dental care, the rate at which parents report dissatisfaction with care, and the percentage of enrolled children who require emergency dental care of nontraumatic etiology.

Advantages of the Proposed Program

The program is simple and understandable by consumers and providers. Its flexibility, levels of care, and use of market-based fees could generate dentists' interest and participation.

The program is simple and understandable by consumers and providers. Its flexibility, levels of care, and use of market-based fees could generate dentists' interest and participation. For example, dentists can treat children in the program on diagnosis; no approval is necessary.

The program provides children in low-income households with a source of preventive, basic, advanced, and catastrophic dental services, as well as management of trauma and other dental emergencies. It encourages an ongoing relationship among parent, child, dentist, and dental program. Expanded preventive services allow patients to benefit from up-to-date information about preventing and managing oral disease. The program utilizes a market-based fee-for-service payment mechanism, the only mechanism acceptable to most dentists. According to the policy of a state, it could either welcome any provider willing to accept its levels of payment or

require a minimum number of Medicaid enrollees per dentist. The program is focused on prevention and encourages case management. Each general or specialist dentist could treat children up to his or her level of comfort and competence. Difficult cases, qualifying for catastrophic coverage, could be referred. Dentists would, for the first time under a public program, be paid and accountable for providing care that addresses the full range of children's dental needs.

A PROGRAM FOR EACH STATE: USING THE INTERACTIVE MODEL

The RSG and the Milbank Memorial Fund asked PricewaterhouseCoopers to devise software that would make it possible to predict the approximate cost of the proposed program to any state by changing some of the assumptions in the actuarial study. This software uses the familiar format of an Excel spreadsheet to calculate the cost, per-member-per-month, of the program in a particular state.

Using this software, data can be entered that is specific to any state's population of eligible children, policies for reimbursing dental providers, and state/federal shares of program cost.

The software is available to anyone on the World Wide Web at www.milbank.org. Visitors to this Website will find worksheets and exhibits and a "Users Guide to the Dental Pricing Model" that was prepared by PwC. This guide leads users through three worksheets, on each of which they can input state-specific data. The guide also explains how the model uses these data to calculate a per-member-per-month cost using data arrayed by PwC actuaries that is displayed in six accompanying exhibits.

The three interactive worksheets are printed on the pages that follow, in order to clarify how they can be used to generate information for policymakers in a state. The first of the three is headed "Assumptions." Persons using this worksheet on the Web can:

- change the age distribution of children covered
- change the percentage of children expected to use dental services in a particular year, in total, by age or by types of service
- choose to use the Medical dental fee schedule or to input a different fee schedule (this is done in Worksheet 2; see below)
- adjust payments to providers based on the amount claimed

The second worksheet, headed "Dental Fee Schedule," is for users who prefer not to base their calculations on MediCal fees. It consists of a list (only partially printed here) of procedures that constitute 80 percent of billings in the MediCal data. PwC describes each procedure in a phrase as well as by Dental Group and Procedure Code. In the far right column, users in any state can change the average fee under MediCal by age or by type of service. As described above, PwC used Denti-Cal fees to calculate the cost of the program described in this report.

The final worksheet is headed "Summary of Rate." Users of this worksheet can:

- input the average number of children covered under the program in a year
- estimate administrative expenses
- adjust state and federal shares of program costs

Although PwC's "Users Guide" was field-tested by several state officials, questions about it are likely to arise. Hence the Website also facilitates sending e-mail messages to persons familiar with both the software and the proposed program of dental insurance for children.

WORKSHEET 1: ASSUMPTIONS

Users can adjust payments to providers based on the amount claimed.

Contract Assumptions

Diagnosis and Prevention Covered at: 100%

	Under 2	Ages 2-5	Ages 6-14	Ages 15-18
Estimated Diagnosis and Prevention Costs per year (first threshold)	$150.00	$150.00	$150.00	$150.00

Services up to (not including Prophylaxis): $1,000 covered at 80%

Remaining Services Covered at: 80%

Results	
Under 2	$0.93
Ages 2-5	$13.59
Ages 6-14	$16.85
Ages 15-18	$19.48
Total	$14.55

See Worksheet 2.

User Defined Fee Schedule

○ User Defined Fee Schedule
◉ Use MediCal Fee Schedule

Users can input different dental fee schedules.

Fee Schedule Assumptions

	Under 2	Ages 2-5	Ages 6-14	Ages 15-18
Adjunctive General	1.00	1.00	1.00	1.00
Anesthesia Surgical	1.00	1.00	1.00	1.00
Diagnostic	1.00	1.00	1.00	1.00
Endodontics	1.00	1.00	1.00	1.00
Implant/Pros Fixed	1.00	1.00	1.00	1.00
Maxillofacial Pros	1.00	1.00	1.00	1.00
Oral Surgery	1.00	1.00	1.00	1.00
Orthodontics	1.00	1.00	1.00	1.00
Other	1.00	1.00	1.00	1.00
Periodontics	1.00	1.00	1.00	1.00
Preventive	1.00	1.00	1.00	1.00
Pros Removable	1.00	1.00	1.00	1.00
Restorative	1.00	1.00	1.00	1.00

Results	
Under 2	$0.93
Ages 2-5	$13.59
Ages 6-14	$16.85
Ages 15-18	$19.48
Total	$14.55

Aggregate Fee Schedule Factor: 1.00

Users can input different levels of utilization of each service.

Utilization Assumptions

	Under 2	Ages 2-5	Ages 6-14	Ages 15-18
Adjunctive General	1.00	1.00	1.00	1.00
Anesthesia Surgical	1.00	1.00	1.00	1.00
Diagnostic	1.00	1.00	1.00	1.00
Endodontics	1.00	1.00	1.00	1.00
Implant/Pros Fixed	1.00	1.00	1.00	1.00
Maxillofacial Pros	1.00	1.00	1.00	1.00
Oral Surgery	1.00	1.00	1.00	1.00
Orthodontics	1.00	1.00	1.00	1.00
Other	1.00	1.00	1.00	1.00
Periodontics	1.00	1.00	1.00	1.00
Preventive	1.00	1.00	1.00	1.00
Pros Removable	1.00	1.00	1.00	1.00
Restorative	1.00	1.00	1.00	1.00

Results	
Under 2	$0.93
Ages 2-5	$13.59
Ages 6-14	$16.85
Ages 15-18	$19.48
Total	$14.55

Aggregate Utilization Factor: 1.00

WORKSHEET 1: ASSUMPTIONS (CONTINUED)

Cost Distribution Assumptions

Percentage of members using services	Under 2	Ages 2-5	Ages 6-14	Ages 15-18
Percentage of members using services from data:	2.67%	28.66%	38.84%	28.58%
1. User Defined	2.67%	28.66%	38.84%	28.58%
2. Costs of additional users in excess of average	100%			

Input any percentage. 100% = average; 125% = 25% above average; 97% = 3% below average

Note: If the User Defined percentage is set **below** the Default, the costs removed are still assumed to be average (100%).

Results	
Under 2	$0.93
Ages 2-5	$13.59
Ages 6-14	$16.85
Ages 15-18	$19.48
Total	$14.55

Users can change the percentage of children expected to use services by age or in total.

Membership Distribution Assumptions

Percentage of Members by Age Group	Under 2	Ages 2-5	Ages 6-14	Ages 15-18
Distribution of members by age group from data:	10.96%	28.57%	46.11%	14.36%
1. User Defined (need not sum to 100%)	10.96%	28.57%	46.11%	14.36%

Results	
Under 2	$0.93
Ages 2-5	$13.59
Ages 6-14	$16.85
Ages 15-18	$19.48
Total	$14.55

Users can change the age distribution of children covered.

Users can enter a fee schedule

Dental Group	Procedure Code	Description	MediCal Average Billed Fee	User Defined Fee Schedule
Diagnostic	D0110	Initial oral examination	$34.86	$34.86
Diagnostic	D0210	Intraoral, complete series (including bitewings)	$68.92	$68.92
Diagnostic	D0230	Intraoral-periapical-each additional film	$8.85	$8.85
Diagnostic	D0272	Bitewings-two films	$25.68	$25.68
Diagnostic	D0274	Bitewings-four films	$35.17	$35.17
Endodontics	D3220	Therapeutic pulpotomy (excluding final restoration)	$64.02	$64.02
Endodontics	D3330	Three canals (exluding final restoration)	$456.32	$456.32
Oral Surgery	D7110	Extraction-single tooth	$68.23	$68.23
Oral Surgery	D7120	Extraction-each additional tooth	$63.65	$63.65
Oral Surgery	D7240	Removal of impacted tooth-completely bony	$263.86	$263.86
Orthodontics	D9951	Occlusional adjustment - limited	$87.19	$87.19
Preventive	D1110	Prophylaxis, adult	$57.81	$57.81
Preventive	D1201	Topical application of flouride (including prophylaxis) - child	$58.48	$58.48
Restorative	D2110	Amalgam-one surface, primary	$50.98	$50.98
Restorative	D2120	Amalgam-two surfaces, primary	$61.89	$61.89
Restorative	D2130	Amalgam-three surfaces, primary	$72.87	$72.87
Restorative	D2140	Amalgam-one surface, permanent	$58.47	$58.47
Restorative	D2150	Amalgam-two surfaces, permanent	$70.75	$70.75
Restorative	D2160	Amalgam-three surfaces, permanent	$83.33	$83.33
Restorative	D2330	Resin- one surface, anterior	$88.57	$88.57
Restorative	D2331	Resin- two surface, anterior	$122.75	$122.75
Restorative	D2930	Prefabricated stainless steel crown-primary tooth	$120.53	$120.53

Procedures are listed by dental group and procedure code as well as by a descriptive phrase.

WORKSHEET 3: SUMMARY OF RATE

	Per Member Per Month Costs			
	Under 2	Ages 2-5	Ages 6-14	Ages 15-18
Adjunctive General	$0.03	$0.23	$0.20	$0.28
Anesthesia Surgical	$0.01	$0.16	$0.09	$0.15
Diagnostic	$0.19	$2.53	$3.50	$3.08
Endodontics	$0.08	$0.94	$0.80	$1.47
Implant/Pros Fixed	$0.00	$0.12	$0.19	$0.00
Maxillofacial Pros	$0.00	$0.00	$0.02	$0.19
Oral Surgery	$0.06	$0.70	$1.71	$2.83
Orthodontics	$0.00	$0.00	$0.70	$1.46
Other	$0.03	$0.14	$0.04	$0.03
Periodontics	$0.00	$0.01	$0.05	$0.17
Preventive	$0.13	$1.44	$2.12	$1.39
Pros Removable	$0.00	$0.00	$0.01	$0.05
Restorative	$0.39	$7.31	$7.43	$8.36
Total	**$0.93**	**$13.59**	**$16.85**	**$19.48**

Displays cost estimate by age and service category based on assumptions input by user (Worksheets 1 and 2) and underlying data.

Resulting PMPM $14.55

Program Administration

State Plan Administration	5%
Assumed Carrier Administration	10%

Users can estimate administrative expenses.

(•) Assume carrier expenses in addition to dental cl
( ) Assume carrier expenses come from plan saving

Dental Claims Expense	$14.55
State Plan Administration	$0.77
Carrier Administration	$1.62
Total Required Revenue PMPM	**$16.94**

Federal/State Funding

Percentage of Total Cost Covered by the State Government	40.0%
Percentage of Total Cost Covered by the Federal Government	60.0%

Users can adjust state and federal shares of program costs.

Estimated Average Number of Children Covered per Year	10,000
Resulting Annual State Cost	**$812,974**
Resulting Annual Federal Cost	**$1,219,460**
Total Annual Cost	**$2,032,434**

Users can input the average number of children covered in a year.

SELECTED PUBLICATIONS OF THE MILBANK MEMORIAL FUND

The following reports are available without charge from the Fund:

*New Foundations in Health: Six Stories**
1999 168 pages

*Public-Private Collaboration in Health Information Policy**
co-published with the Reforming States Group
1999 32 pages

1997 State Health Care Expenditure Report
co-published with the National Association of State Budget Officers and the Reforming States Group
1999 192 pages

*Converting and Merging Hospitals: Trustees Talk to Each Other**
by Harry Nelson and Ann F. Monroe
co-published with the Health Research and Educational Trust
1999 28 pages

*End-of-Life Care and Hospital Legal Counsel: Current Involvement and Opportunities for the Future**
by Connie Zuckerman with an introduction by Robert A. Burt and Christine K. Cassel
co-published with the United Hospital Fund
1999 44 pages

*Enhancing the Accountability of Alternative Medicine**
1998 44 pages

*Mental Health Parity: What Can It Accomplish in a Market Dominated by Managed Care?**
by Alan L. Otten
1998 44 pages

Improving State Law to Prevent and Treat Infectious Disease
by Lawrence O. Gostin, Scott Burris, Zita Lazzarini, and Kathleen Maguire
1998 56 pages

Expanding Health Coverage for Children: Matching Federal Policies and State Strategies
by Kay A. Johnson and John E. McDonough
co-published with the Reforming States Group
1998 48 pages

Preventing Violence Against Women and Children
by Ronald B. Taylor
1997 64 pages

State Oversight of Integrated Health Systems
co-published with the Reforming States Group
1997 296 pages

Nonprofit and For-Profit HMOs: Converging Practices but Different Goals?
by Harry Nelson
1997 36 pages

*Available online at www.milbank.org

The following books are available from their publishers, Aspen Publishers (1-800-638-8437); Blackwell Publishers (1-800-216-2522); Oxford University Press (1-800-451-7556); and University of California Press (1-800-822-6657).

Educated Guesses: Making Policy About Medical Screening Tests
by Louise B. Russell
1994 144 pages
co-published with and distributed by the University of California Press $11.95

Five States That Could Not Wait: Lessons for Health Reform from Florida, Hawaii, Minnesota, Oregon, and Vermont
edited by Daniel M. Fox and John K. Iglehart
1994 224 pages
distributed by Blackwell Publishers $21.95

Implementing the Americans with Disabilities Act
edited by Jane West
1996 440 pages
co-published with and distributed by Blackwell Publishers $33.95

Public Health Leaders Tell Their Stories
edited by Lloyd F. Novick, Carol Spain Woltring, and Daniel M. Fox
1997 192 pages
co-published with and distributed by Aspen Publishers $35.00

American Nursing: From Hospitals to Health Systems
Joan E. Lynaugh and Barbara L. Brush
1997 112 pages
co-published with and distributed by Blackwell Publishers $26.95

Home-Based Care for a New Century
edited by Daniel M. Fox and Carol Raphael
1997 320 pages
co-published with and distributed by Blackwell Publishers $62.95

Treating Drug Abusers Effectively
edited by Daniel M. Fox, Joel A. Egertson and Alan I. Leshner
1997 368 pages
co-published with and distributed by Blackwell Publishers $62.95

Doctoring: The Nature of Primary Care Medicine
by Eric J. Cassell
1997 224 pages
co-published with and distributed by Oxford University Press $24.00

The Fund also publishes the *Milbank Quarterly*, a journal of public health and health care policy. Information about subscribing to the *Quarterly* is available by calling toll-free 1-800-835-6770, or at www.milbank.org/quarterly/

Information about other work of the Fund is available from the Fund at 645 Madison Ave., 15th Floor, New York, NY 10022, (212)355-8400. Fax: (212)355-8599. E-mail: mmf@milbank.org. On the Web: www.milbank.org

2000

JOINT APPROPRIATIONS – HEALTH & HUMAN SERVICES

MINUTES

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

1999 – 2000 SESSION

COMMITTEE CHAIRMEN

Representative Beverly Earle
Representative Edd Nye

FISCAL STAFF

Karen Hammonds-Blanks
Ramona Burton
Carol Shaw
Mary Ellen Sylvester

COMMITTEE ASSISTANTS

Jo Bobbitt
Ann Raeford

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
1999-00

Member/Clerk	Telephone	Room
Rep. Beverly **Earle**, Chair Ann Raeford	3-5747	535
Rep. Edd **Nye**, Chair Jo Bobbitt	3-5477	639
Rep. Martha **Alexander**, Vice Chair Ann Faust	3-7208	2121
Rep. Alma **Adams** Troy Williams	3-5902	542
Rep. Lanier **Cansler** Barbara Cansler	3-5605	1209
Rep. Theresa **Esposito** Judy Lowe	5-3009	418C
~~Rep. Mickey **Michaux**~~ ~~Anne Peele~~	3-5772	1325
Rep. Trudi **Walend** Ken Walend	5-3012	418A
Rep. Gene **Wilson** Rebecca Jones	3-7727	1109
Staff		
Karen Hammonds-Blanks Ramona Burton Carol Shaw Mary Ellen Sylvester	3-4910	619

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
1999 - 2000

Rep. Beverly Earle, Chair

Rep. Edd Nye, Chair

Rep. Martha Alexander, Vice Chair

Rep. Alma Adams

Rep. Lanier Cansler

Rep. Theresa Esposito

Rep. Mickey Michaux

Rep. Trudi Walend

Rep. Gene Wilson

Ex-Officio Members

Rep. Phil Baddour

Rep. Pete Cunningham

Rep. Andy Dedmon

Rep. Joe Hackney

JOINT APPROPRIATION SUBCOMMITTEE ON HUMAN RESOURCES 1999 – 2000 SESSION

Senate Membership

Senator William N. Martin, Chair
Room 411 Lob
Phone – 715-3042

Senator Charlie Dannelly, Vice Chair
Room 2106 LB
Phone 733-5955

Senator James Forrester
Room 1121 LB
Phone 733-5708

Senator William Purcell
Room 2117 LB
Phone 715-0690

Senator John Kerr
Room 526 LOB
Phone 733-5621

Senator Larry Shaw

DROPPED

Senator Jim Phillips
Room 628 LOB
Phone 733-5870

House Membership

Rep. Beverly Earle, Chair
Room 535 LOB Phone 733-5747

Rep. Edd Nye, Chair
Room 639 Phone 733-5477

Rep. Martha Alexander,Vice-Chair
Room 2121 LB Phone 733-7208

Rep. Lanier Cansler
Room 1209 LB
Phone 733-5605

Rep. H. M. Mickey Michaux
DROPPED

Rep. Theresa Esposito
Room 418C
Phone 715-3009

Rep. Trudie Walend
Room 418 A
Phone 715-3012

FISCAL STAFF

Karen Hammonds-Blanks — **Carol Shaw**

Ramona Burton — **Mary Ellen Sylvester**

733-4910

BILL DRAFTING STAFF

Gann Watson — **Canaan Huie**

733-6660

Committee Assistants House

Senate

Joyce Hodge

House

Jo Bobbitt

Anne Raeford

ATTENDANCE

HOUSE

APPROPRIATIONS SUBCOMMITTEE ON

HEALTH AND HUMAN SERVICES

2000

HEALTH AND HUMAN SERVICES

DATES	5/23	5/24	5/25	5/30	5/31	6/6	6/12								
REPRESENTATIVES:															
EDD NYE, CO-CHAIRMAN	✓	✓	✓	✓	✓	✓	✓								
BEVERLY EARLE, CO-CHAIRMAN	✓	✓	✓	✓	✓	✓	✓								
MARTHA ALEXANDER	✓		✓	✓	✓	✓	✓								
ALMA ADAMS	✓	✓	✓	✓	✓	✓	✓								
LANIER CANSLER	✓	✓	✓	✓	✓	✓	✓								
THERESA ESPOSITO	✓	✓	✓	✓	✓		✓								
TRUDI WALEND	✓	✓	✓	✓	✓	✓	✓								
GENE WILSON	✓	✓	✓	✓	✓	✓	✓								

2000 SESSION

JOINT MEETINGS OF THE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

MAY 23, 2000
MAY 24, 2000
MAY 25, 2000
MAY 30, 2000
MAY 31, 2000

HOUSE MEETINGS OF THE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

JUNE 6, 2000
JUNE 12, 2000

SENATE MEETINGS OF THE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

JUNE 15, 2000
JUNE 20, 2000

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 23, 2000
Room 424, LOB

The Joint Appropriations Subcommittee on Human Resources met Tuesday, May 23 at 8:30 a.m. in Room 424, LOB at 8:30 a.m. Sen. Bill Martin, presiding Chair called the meeting to order with all the members present. Lisa Hollowell, Fiscal Research Division; Misha Neely, Intern, Rep. Beverly Earle's Office; James Allred and Zach Moore, House Pages were also introduced.

Karen Hammonds-Blanks was recognized to give an overview of the work of the Committee last Session and review the Governor's recommended budget. Karen spoke from the attached handout (attachment 1), Joint Health and Human Services Appropriations Budget Overview. Karen stated that last Session, the General Assembly reduced the Department's budget by approximately $196 million. Approximately 83% of the reductions were made in the Medicaid Budget. The budget for the second year of the Biennium is reduced by $136 Million (again, most of the reduction is in the area of Medicaid).

In the area of expansion, the General Assembly expanded this budget by about $101 million. The majority of those funds were directed to the expansion Smart Start program. The expansion for the second year of the Biennium is about $113 Million and most of that is directed to the Smart Start Program.

She stated that there are 92.2 net position increases to the budget. These positions are directed to two programs that have not yet begun. In the western part of the State a program for traumatic brain injured individuals as well as a vocational rehab program in the eastern part of the State.

She stated that last session was the first time the General Assembly has provided funds for local departments of social services for staff at the local level to provide adult protective services. In the area of child development, there is a Smart Start appropriation of $58 million in the first year and approximately $79 million in the second year. For the first time, that provides direct service funds for all 100 counties. Smart Start Collaboration $1.5 million and $778,000 for the TEACH program.

Lisa Hollowell came before the Committee to review the reductions of the department for Hurricane Floyd Relief.

During committee discussion, Sen. Phillips asked if the redirection of allocations include the entire allocation of some of the programs or just a portion. Sen. Martin stated some of the new programs were not funded and never began. Sen. Martin stated that the committee would have detailed discussion of Medicaid early next week.

Sen. Purcell asked if any of the reduced or cut items are in the new budget. Rep. Esposito asked for clarification regarding the redirection of funds cut from the Human Resources Budget last Session for Hurricane Floyd Relief. She wanted to know if the funds have actually been used. Jim Edgerton stated that the Floyd Relief Fund is a consolidation of all monies. Nina Yeager, Office of State Budget stated that the $131 million (anticipated revisions) have been redirected. She stated that those funds would have reverted if they had not been redirected to Floyd. She also said that there have been no cuts in the human service area.

Regarding the deferred repairs and renovations, Sen. Martin asked if those funds would have been utilized had they not been redirected.

Sen. Phillips asked for an estimate of expansion in the area of human needs, and if any other divisions.

Sen. Dannelly stated that he is disturbed that the Federal Government complains that the State is not drawing the money, as we should and the Medicaid monies for CHIP. North Carolina has not utilized $70 of the $96 million. That discussion will be continued during the discussion of Medicaid.

Rep. Cansler expressed his belief that there are areas of need where the dollars could have been utilized. He stated that in the last three or four years, over $200 million, in recurring money have been taken from Medicaid. Where these shifts have not resulted in a reduction of services, they have resulted in an inability to properly provide services (serve everyone needs services).

Dr. Ashley Thrift, North Carolina Partnership for Children, was recognized to speak about Smart Start and TEACH. He stated that Smart Start has a statewide network of 81 local partnerships. They are at different levels of funding and accomplishments. $49 Million were reduced from the budget. This was a one-time reduction from existing funds. The General Assembly has allowed flexible funding (carry-forward). North Carolina. He stated that no state has a comprehensive statewide plan.

During Committee discussion, Sen. Phillips expressed his concern about the participation in "Bright Beginnings." He asked how many counties are participating in the four-year old Bright Beginnings Program for birth to e years of age. He shared with the Committee that the key is identity of the help needed early.

Dr. Majorie Tart, Carolina Poison Center, Charlotte, gave an update of the activities of the Center. She stated that the entire state utilizes the 800 toll free number. She also hared information regarding the cases the center has assisted. (Attachment 3)

The meeting adjourned until 1:00.

May 23, 2000 – Afternoon

The Chair stated that the Committee would continue from this morning. The next item was on page 5 of attachment 1 item 4, AIDS Drug.

After Committee discussion, Representative Nye suggested that the committee flag page 5. He stated that there is a need for the committee to know the total Medicaid drug budget; how many perceptions are written; what drugs are given and the top ten items.

The Chair suggested that that information be presented Thursday, morning.

Sen. Martin thanked everyone for attending and adjourned the meeting.

William N. Martin, Chair

Joyce Crews Hodge, Clerk

Attachment 1 – Agenda
Attachment 2 – Budget Overview
Attachment 3 – Carolina Poison Center
Attachment 4 -- Recommended Changes DHHS Budget
Attachment 5 – Visitor Registration

Joint Health and Human Services Appropriations Sub-Committee

May 23, 2000
8:30 AM
Legislative Office Building Rm# 424

----- Agenda Topics -----

Opening Remarks	Senator Bill Martin, Representative Edd Nye and Representative Beverly Earle
FY99 Session Highlights	Karen Hammonds-Blanks, Fiscal Research
Overview of DHHS Budget Cuts for Hurricane Floyd Relief and Redevelopment	Lisa Hollowell, Fiscal Research
Budget Reductions	James B. Edgerton, Deputy Secretary; Department of Health and Human Services
Expansion - Smart Start Poison Control Center	Ashley Thrift, NC Partnership for Children
Expansion - NC Health Choice	H. David Bruton, MD; Secretary, Department of Health and Human Services
Expansion - School Based Mental Health and Substance Abuse Services	Secretary Bruton
Expansion - Other	Deputy Secretary Edgerton

Joint Health and Human Services Appropriations Sub-Committee

Budget Overview

Fiscal Research Division
General Assembly
May 23, 2000

JOINT HEALTH AND HUMAN SERVICES APPROPRIATIONS SUBCOMMITTEE

1999 LEGISLATIVE FISCAL/BUDGETARY HIGHLIGHTS

Department of Health & Human Services	**FY99/00**	**FY00/01**
➢ Reductions ($163.2M - Medicaid Program)	($196,054,207)	($136,951,259)
➢ Expansion ($ 58.0M - Smart Start Program)	$100,875,666	$112,911,640
♦ Net Adjustment	($ 95,178,541)	($ 24,039,619)
➢ Positions (Net)	92.2	92.2
Mental Health		
➢ Community Mental Health Programs	$ 6,000,000	$ 6,000,000
➢ Willie M. Services	$ 4,353,003	$ 0
➢ Neurobehavioral Treatment Unit	$ 691,772	$ 571,526
Social Services		
➢ Food Banks	$ 1,000,000	$ 0
➢ Adult Protective Services	$ 1,000,000	$ 2,000,000
Child Development		
➢ Smart Start Direct Services	$ 58,000,000	$ 78,928,826
➢ Smart Start Collaboration	$ 1,500,000	$ 0
➢ T.E.A.C.H. Program	$ 778,000	$ 778,000
Early Intervention and Education		
➢ Early Intervention System Pilots	$ 203,000	$ 610,000
Vocational Rehabilitation		
➢ Independent Living	$ 3,000,000	$ 1,000,000
Public Health		
➢ Prescription Drug Program for the Elderly	$ 500,000	$ 500,000
➢ Various Public Health Initiatives	$ 3,025,000	$ 0

JOINT HEALTH AND HUMAN SERVICES APPROPRIATIONS SUBCOMMITTEE

1999 FISCAL/BUDGETARY HIGHLIGHTS (Cont'd)

Medical Assistance	**FY99/00**	**FY00/01**
➢ Physician Rate Increase	$ 3,600,000	$ 3,800,000
➢ Transitional Medicaid Expansion	$ 2,100,000	$ 8,300,000

Senate Bill 10 –Long Term Care Reform

➢ Adult Care Home Resident Assessment Services	$ 930,000	$ 1,900,000
➢ Complaint Investigations and Monitoring	$ 1,000,000	$ 1,000,000
➢ Payment for Medication and Locomotion Assistance in Adult Care Homes	$ 1,700,000	$ 3,400,000

Fiscal Research Division
05/23/2000

DEPARTMENT OF HEALTH AND HUMAN SERVICES
FUNDING REDIRECTED TO SUPPORT
HURRICANE FLOYD RELIEF

Category of Funding	*Amount Redirected*
Lapsed Salaries	$9,789,813
Funding for Local Providers/Direct Services	$49,550,435
Operating Reserves	$669,367
Indirect Costs	$3,413,063
Prior Year Earned Revenues	$3,721,047
Other Revenues	$14,781,895
Capital Appropriations	$13,809,206
State Employees Health Benefit Increase	$2,270,507
Deferred Repair and Renovation	$18,400,000
Miscellaneous (Utility, Refunds of Prior Year Expenditures)	$3,743,063
Non-recurring 1999 Session Appropriations	$7,637,947
Negative Reserve - Division of Medical Assistance	$3,451,675
Total	**$131,238,018**

Department of Health and Human Services
Non-Recurring Appropriation
Redirected for Hurricane Floyd Recovery

CMS	Human Services Grant-in-Aid	$4,000,000
Aging	Start-up Grants for Adult Day Care Programs	$250,000
DMH	Area Mental Health Board Training	$150,000
	Neurobehavioral Treatment Unit	$120,246
DPH	Asthma Education Program	$250,000
	Office of Minority Health - Grants	$138,939
	Hepatitis C Education Awareness	$150,000
	Healthy Carolinians	$1,000,000
	Pediatric Cancer Services	$250,000
	Birth Defects Monitoring Program	$100,000
DSS	Project Homestead Pilots	$200,000
	Family Success Initiative/Pilots	$250,000
DVR	Independent living Rehab Program	$685,762
DSDHH	NC Schools for the Deaf	$93,000
	Total	**$7,637,947**

DEPARTMENT OF HEALTH HUMAN SERVICES REPORTS AND RELATED AUDITS

JOINT SUBCOMMITTEE ON HEALTH HUMAN SERVICES APPROPRIATIONS

SECTION	TITLE	DESCRIPTION	COMMITTEE	DUE DATE
11.1(b)	Prescription Drug Assistance Program	Report on the development of a proposal for a prescription drug program to serve low-income elderly and disabled persons	General Assembly	05/01/2000
11.2	Study on Traumatic Brain Injury	Report on cost of serving persons with traumatic brain injury and the feasibility of obtaining a Medicaid CAP waiver to serve persons with traumatic brain injury	Appropriations	05/01/2000
11.4(a)	Establishment of Division of Education Services	Progress report on establishing and staffing the Division of Education Services	Appropriations	04/01/2000
11.4(a)	Establishment of Division of Education Services	Report on improving the utilization of campus resources for the benefit of special needs children statewide	Appropriations	04/01/2000
11.4(c)	Review of Disability Services	Recommend opportunities for reorganizing the administration and delivery of services to visually-impaired, deaf/hard of hearing, and vocational rehabilitation clients	Appropriations	04/01/2000
11.4(d)	Review of Disability Services	Report on the adequacy and effectiveness of programs and services for deaf-blind adults and children	Appropriations	04/01/2000

DEPARTMENT OF HEALTH HUMAN SERVICES REPORTS AND RELATED AUDITS

JOINT SUBCOMMITTEE ON HEALTH HUMAN SERVICES APPROPRIATIONS

SECTION	TITLE	DESCRIPTION	COMMITTEE	DUE DATE
11.7A	Long Term Care Continuum of Care	Report on the development of a system of long term care services that provides a continuum of long-term care for the elderly and disabled	Appropriations, General Assembly, and Aging Study Commission	Progress Report 04/15/200
11.11	Study Increase in Resource Limits for Aged, Blind, and Disabled Persons to Qualify for Medicaid	Report on the cost and feasibility of tripling the resource limits for aged, blind, and disabled persons to qualify for Medicaid	Appropriations	05/01/2000
11.13	Departmental Study/Medicaid Coverage for Medically necessary Prosthetics or Orthotics	Report on the cost and feasibility of providing Medicaid coverage for medically necessary prosthetics or orthotics for Medicaid eligible persons age 21 or older	Appropriations	05/01/2000
11.14	Dental Participation in Medicaid	Report from the Joint Legislative Health Care Oversight Committee on its review of all reports on the access to dental care.	Appropriations	05/01/2000
11.20	Plan for Accreditation of Adult Care Homes and Assisted Living Facilities	Report on the development of a plan and criteria for the accreditation of adult care homes and assisted living facilities	Aging Commission and Health Care Oversight Committee	04/01/2000

DEPARTMENT OF HEALTH HUMAN SERVICES REPORTS AND RELATED AUDITS

JOINT SUBCOMMITTEE ON HEALTH HUMAN SERVICES APPROPRIATIONS

SECTION	TITLE	DESCRIPTION	COMMITTEE	DUE DATE
11.21	Special Assistance Demonstration Project	Report on the use of State/County Special Assistance funding to fund pilot projects which will provide special assistance payments to individuals in in-home living arrangements	Appropriations	Interim Report 06.01/2000 Final Report 10/01/2001
11.28	Child Welfare System Improvements	Annual report including recommended changes in the statewide child protection system.	Appropriations	04/01/2000
11.36	Study of State Psychiatric Hospitals/Area Mental Health Programs	Final report from Public Consulting Group, Inc. including recommendations for downsizing hospitals and reforming local area mental health authority system	Appropriations	04/01/2000
11.4	Use of Willie M./Thomas S. Funds	Report on operational and organizational changes and efficiencies realized as a result of the dissolution of the two court programs.	Appropriations	05/01/2000
11.42(a)	Early Intervention Services	Progress report on implementation of integrated database and regional transdiciplinary team pilots	Appropriations	04/01/2000

JOINT SUBCOMMITTEE ON HEALTH HUMAN SERVICES APPROPRIATIONS

SECTION	TITLE	DESCRIPTION	COMMITTEE	DUE DATE
11.53	Intensive Home Visitation Program for Children	Preliminary maternal and child outcome data and the progress that has been made in implementing intensive visitation programs in participating counties.	Appropriations	04/01/2000
11.55	AIDS Drug Assistance Program (ADAP)	Report on the realized and projected savings in the recently implemented cost-containment plan and on exploring ways to better manage prescription drug costs for AIDS patients.	Appropriations	05/15/2000
11.57	Extend Heart Disease and Stroke Prevention Task Force	Report on the actions and resources needed to fully implement the Plan of reducing the occurrence of and burden from heart disease and stroke in this state.	Governor and General Assembly	05/08/2000
11.58	Osteoporosis Program Funds	Report on progress made in fulfilling the duties of the Task Force in developing the Osteoporosis Prevention Plan.	Appropriations	04/01/2000
11.6	Kenneth C. Royall, Jr. Children's Vision Screening Improvement Program	Report on therogress of the organization's activities in achieving the department's overall goal of addressing vision problems among children.	Appropriations	04/15/2000

DEPARTMENT OF HEALTH HUMAN SERVICES REPORTS AND RELATED AUDITS

JOINT SUBCOMMITTEE ON HEALTH HUMAN SERVICES APPROPRIATIONS

SECTION	TITLE	DESCRIPTION	COMMITTEE	DUE DATE
11.6	North Carolina Healthy Start Foundation	Progress report of the organization's activities in achieving the department's overall goal of reducing infant mortality.	Appropriations	04/15/2000
11.6	Adolescent Pregnancy Prevention Coalition of North Carolina	Progress report of how the coalition's activities contribute to department's overall goal of reducing teen pregnancy.	Appropriations	04/15/2000
11.63	Healthy Mothers/Healthy Children Grant Program	Report on the eight-county-pilot project of consolidation of federal grants and state appropriations related to women and children's healthcare.	Appropriations	04/01/2000
11.64	Preventive Health Program Plan	Report on the development of a plan to reduce duplication among preventive health programs and initiatives.	Appropriations	04/01/2000

Part 5. BLOCK GRANTS

5(f)	Work First Evaluation	Expansion of Work First Evaluation to include child-only cases and exemptions from work requirements.	Appropriations	05/01/2000
5(g)	Work First Job Retention Pilots	Description of populations served, cost per client, program effectiveness and coordination activities.	Appropriations	05/01/2000
5(h)	Teen Pregnancy Prevention	Report on $2,000,000 expenditures for teen pregnancy prevention	Appropriations	04/01/2000
5(n)	Intensive Family Preservation	Report on the revised evaluation and design of the Intensive Family Preservation Program.	Appropriations	05/01/2000
5(o)	First Stop Employment Assistance Program	Report on the use of TANF funds including information on the number and demographics of clients served, services provided, placement rates and job retention data.	Appropriations	05/01/2000
5(p)	Boys and Girls Clubs	Report on the use of TANF funds including coordination activities.	Appropriations	05/01/2000
5(q)	Domestic Violence	Report on the use of TANF funds for the development and implementation of a program to provide grants to local domestic violence prevention and intervention programs.	Appropriations	05/01/2000

DEPARTMENT OF HEALTH HUMAN SERVICES REPORTS AND RELATED AUDITS

JOINT SUBCOMMITTEE ON HEALTH HUMAN SERVICES APPROPRIATIONS

AUDITS

DIVISION/PROGRAM	DESCRIPTION	DATE
Thomas S. Rate Increase	Review of 1999 Thomas S. provider rate increase.	Released May 2000
Child Support Enforcement Section	Review of development and implementation of mandated central collections office.	Released April 2000
Division of Services for the Deaf/Hard of Hearing	Performance Audit	Released April 2000

CAROLINAS POISON CENTER

■ CAROLINAS POISON CENTER DELIVERED *COST-EFFECTIVE* CARE IN 1999

- ♦Total calls 89,547 (8.1% increase over 1998)
- ♦Total human exposures 66,269
  - ✔54.5% in children < 6 years old
  - ✔65.8% for all children and teens < 20 years
  - ✔ 3.8% for senior citizens ≥ 60 years
- ◆79.52% of all exposures (52,712 calls) were managed without further medical evaluation.

■ CAROLINAS POISON CENTER DELIVERS *EFFECTIVE* CARE

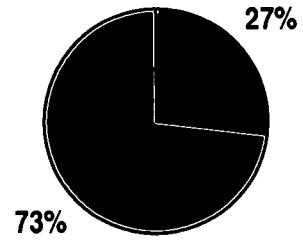
- ♦ Case vignettes are detailed in Appendix A

■ NET HEALTH CARE DOLLARS SAVED TOTALED $ 3.7 MILLION IN 1999[1]

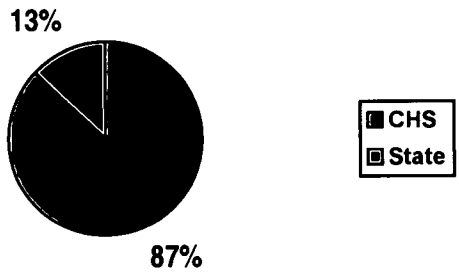
- ◆ On-site case management avoided medical care in more costly venues
- ◆ Gross estimated dollars saved totaled $ 5,401,333
- ◆ Adjusted for Carolinas Poison Center budget ($ 1,700,057)

■ HOWEVER, STATE FUNDING CONTINUES TO BE INADEQUATE

- ♦ CPC budget for FY 2000 is $1,814,556
  - ✔State will contribute $236,492. North Carolina continues to trail other Southeastern states in per capita funding of its poison center (see Appendix B)
- ♦ Disparity continues between population served versus expense burden
  - ✔ CHS continues to support CPC disproportionately



% Population Served



% Expenses Shared

[1]Utilized benefit-cost methodology employed in: Miller TR. Costs of poisoning in the United States and savings from poison control centers: A benefit-cost analysis. Ann Emerg Med 1997;29:239-245. 1997 cost data for the average outpatient visit for NC hospitals was $273.25 (from 1998-99 Almanac of Hospital Financial and Operating Indicators published by Center for Healthcare Industry Performance Studies).

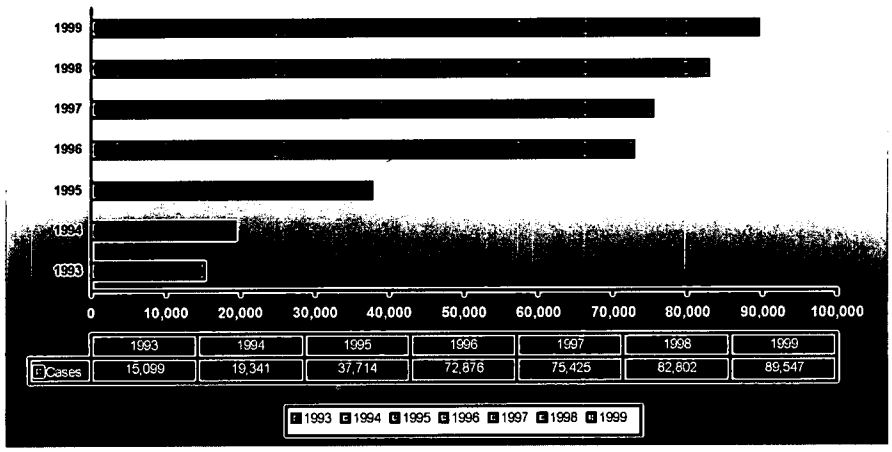
05.23.00 attachment 2 a.m.

◆ CHS has expended approximately $225,000 since 1998 on capital expenditures for CPC, including increased space and Y2K computer upgrades.

■ EXPENSES ARE INCREASING

◆ Call volume increased 9.8% and 8.1%, respectively, in 1998 and 1999

Growth in Call Volume



◆ Increased staff will be needed to handle the increasing volume

✔ CPC staff already handle an average 4,587 exposure cases annually, compared to the AAPCC national benchmark of 3,650 cases per specialist. This places CPC staff in the 85% productivity bracket.

◆ CPC administration strives to contain costs

✔In 1999 the cost of a poisoning exposure call to Carolinas Poison Center was $25.77, compared with the national American Association of Poison Control Centers 1998 benchmark of $33.30 per case.

✔ Lower wage poison information providers are used to handle non-urgent calls

✔ The Caution Curriculum has been developed to teach caregivers of children ages 0 to 5 years how to avoid accidental poisonings. The goal is to decrease the number of exposure calls. CPC has obtained a $40,000 grant from Smart Start of Mecklenburg County to teach this curriculum in Mecklenburg County.

■ STATE FUNDING NEEDS TO BE INCREASED

✔ $1.5 million is requested in recurring budgetary funds

APPENDIX A

♦Some recent case highlights.....

✔ A 16 year old teen became unresponsive after working on a car, and his family thought he might have overdosed on prescription medicine. The CPC toxicologist reviewed the case with the treating physician and made the diagnosis of ethylene glycol (antifreeze) toxicity. Appropriate therapy was instituted and the patient was transferred to a tertiary hospital for hemodialysis.

✔A 2 year old male aspirated kerosene from a siphon pump. Mom called the CPC and the specialist, hearing the child coughing in the background, advised that the child be taken immediately to an ED. The child was intubated shortly after arrival due to respiratory failure. With proper care the child recovered.

✔The case of a 3 year old boy at a major North Carolina teaching hospital with an unknown, life-threatening metabolic acidosis was reviewed with the CPC toxicologist and a correct diagnosis of antifreeze toxicity was made. The antidote and hemodialysis were instituted with a good outcome.

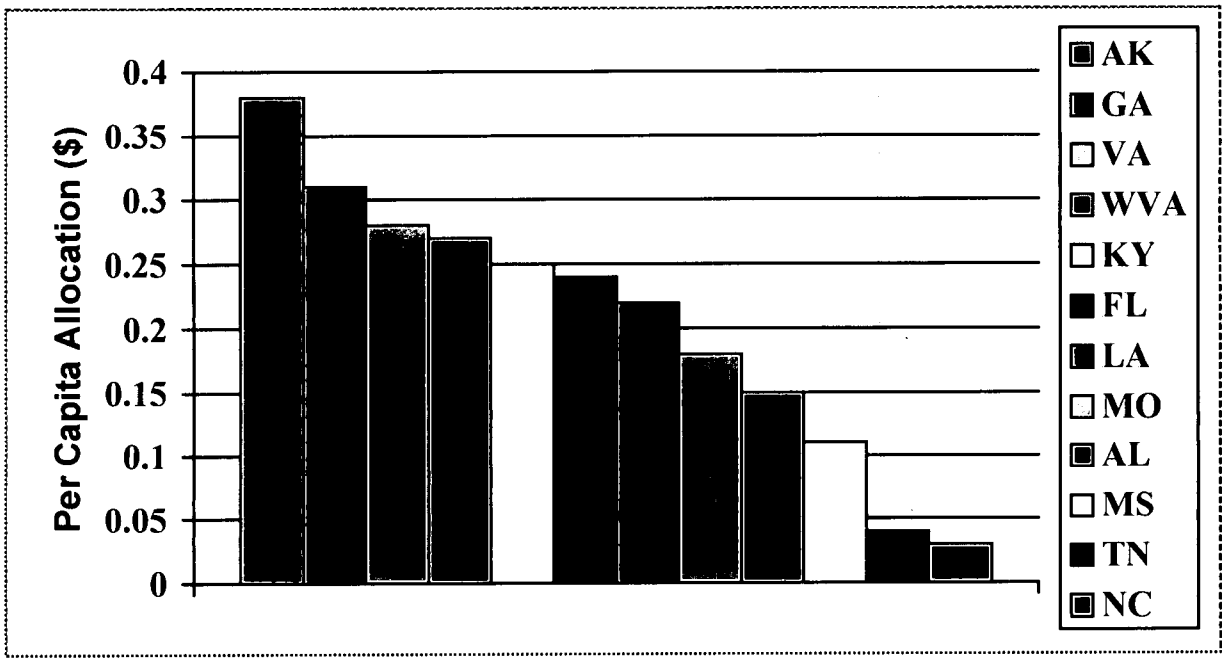
✔A 3 year old child in western NC presented with a bluish appearance and seizures after ingesting a chemical. CPC was consulted, and the diagnosis of methemoglobinemia was made. The correct antidote was recommended. The child improved so rapidly that transfer to a tertiary hospital was cancelled. Later that evening the child was up and playing.

✔Several 14 year old boys were drinking alcohol at a home, and one of the boys called the CPC concerned about another who had passed out. After the boys failed to heed the advice to call 911, the CPC dispatched EMS to the home. Medics found the boy barely breathing; he was intubated and found to have life-threatening alcohol poisoning with a level greater than 500 mg%. He made a full recovery.

✔The 14 year old daughter of NC missionaries stationed in Cameroon drank an arsenic-containing insecticide. A NC physician who works with the group contacted the CPC for assistance. The CPC toxicologist arranged for the appropriate chelating drug to be flown to Cameroon and then for the girl to be flown to Paris, where she was treated by a group of French toxicologists. Her arsenic levels were elevated and the chelating drug was continued. The patient made an uneventful recovery.

APPENDIX B

Self-Reporting of State Funding Southeastern Poison Centers Feb 2000



COMPARISON CHART

How Does Carolinas Poison Center Compare to Other Certified Centers?

	Carolinas Poison Center	Certified Regional Poison Centers National Average
	1998 Data	1998 Survey Data[+]
Average Population Served By the Center	7,546,493	4,019,184
Total Calls/Year	82,802	59,632
Specialist FTE per 1,000,000 population served	1.99	2.7
Average Governmental Funding/Case	*$ 5.88[#]*	*$ 13.33*
Average Cost Per Human Exposure	$26.00	$33.30
Average Number of Human Exposures per FTE	4,587*	3,650

[+]Source: Youniss J, Litovitz TL, Villanueva P: Characterization of U.S. Poison Centers: A 1998 Survey Conducted by the American Association of Poison Control Centers (AAPCC)

[#]Includes additional $250,000 state funding ($200,000 prorated for 1997-1998 and $300,000 prorated for 1998-1999). Without this additional funding, the average governmental funding/case would have been $3.83.

*Nearly 81% of all certified US poison centers have a ratio lower than that of Carolinas Poison Center; this percentage increases to nearly 85% when considering non-certified as well as certified US poison centers. Thus CPC specialists are in the top 20% in productivity.

Call Volume By County

County	Population	Call Volume	County	Population	Call Volume	County	Population	Call Volume
Alamance	119,397	974	Forsyth	287,701	2,881	Onslow	142,358	1,816
Alexander	31,280	202	Franklin	44,743	231	Orange	110,116	1,493
Alleghany	9,842	79	Gaston	184,247	2,937	Pamlico	12,345	92
Anson	24,354	216	Gates	10,070	88	Pasquotank	35,474	406
Ashe	24,025	229	Graham	7,647	105	Pender	39,510	218
Avery	15,742	208	Granville	42,908	442	Perquimans	11,282	51
Beaufort	44,531	408	Greene	18,308	63	Person	33,647	315
Bertie	20,459	152	Guilford	387,722	2,531	Pitt	126,630	936
Bladen	30,717	275	Halifax	56,433	452	Polk	16,835	259
Brunswick	68,416	661	Harnett	82,391	856	Randolph	121,289	720
Buncombe	194,873	3,789	Haywood	51,422	710	Richmond	46,221	563
Burke	82,687	1,045	Henderson	80,822	1,332	Robeson	115,589	828
Cabarrus	120,057	1,836	Hertford	22,289	65	Rockingham	90,039	842
Caldwell	76,096	1,120	Hoke	30,424	233	Rowan	125,505	1,159
Camden	6,878	39	Hyde	5,612	24	Rutherford	60,842	946
Cateret	60,054	711	Iredell	113,247	1,134	Sampson	52,438	323
Caswell	22,215	108	Jackson	30,210	327	Scotland	35,802	382
Catawba	132,545	1,880	Johnston	106,582	1,095	Stanly	56,083	728
Chatham	45,406	291	Jones	9,456	51	Stokes	43,292	388
Cherokee	22,758	381	Lee	49,328	481	Surry	67,052	666
Chowan	14,191	137	Lenoir	59,046	460	Swain	12,300	254
Clay	8,575	67	Lincoln	58,093	971	Transylvania	28,481	378
Cleveland	92,753	1,213	Macon	28,338	296	Tyrrell	3,734	19
Columbus	52,634	316	Madison	18,756	179	Union	110,017	1,712
Craven	88,129	967	Martin	26,192	178	Vance	42,155	339
Cumberland	284,629	3,136	McDowell	40,048	566	Wake	570,615	7,050
Currituck	17,908	186	Mecklenburg	630,848	12,060	Warren	18,297	89
Dare	28,952	506	Mitchell	14,831	259	Washington	13,615	145
Davidson	141,178	1,044	Montgomery	24,080	171	Watauga	40,965	491
Davie	32,095	270	Moore	71,394	634	Wayne	112,227	827
Duplin	42,993	289	Nash	90,968	872	Wilkes	62,837	624
Durham	202,411	2,512	New Hanover	149,832	1,878	Wilson	68,188	556
Edgecombe	55,199	189	Northhampton	21,184	50	Yadkin	34,955	453
						Yancey	16,607	194

Recommended Changes to the 2000-2001 DHHS Budget

Presentation

to the

House Appropriations Subcommittee on Health and Human Services

Tuesday, May 23, 2000

H. David Bruton, M.D., Secretary

James B. Edgerton, Deputy Secretary

05.23.2000 p.m. #1

Recommended Adjustments

ITEM # 1: *Development Evaluation Centers Budget*

The department's efforts to increase receipts from federal funding sources have generated additional Medicaid receipts for services delivered by the Developmental Evaluation Centers. It is recommended that these receipts be budgeted to support services and reduce appropriations.

	Authorized		Reduction
	SFY 99-00 (1)	SFY 00-01	SFY 00-01
Requirements	25,785,776	26,327,051	0
Total Receipts	6,467,833	6,461,446	1,000,000
Federal	23,352	19,455	0
Local	0	0	0
Other	6,444,481	6,441,991	1,000,000
Appropriations	19,317,943	19,865,605	(1,000,000)
No. of Positions	347	347	0

(1) Excludes transfer from Prior Fiscal Year = $1,278,039
Excludes transfer for Hurricane Floyd = $2,013,250
$3,291,289

Recommended Adjustments

ITEM # 2: *Medical Examiner's Fees*

Effective January 1, 1999, autopsy fees in the Medical Examiner's Office were increased from $400 to $600. It is recommended that increased receipts from the fees be budgeted to support the Medical Examiner's Office and appropriations be reduced accordingly.

	Authorized		Reduction
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	4,006,502	3,396,124	0
Total Receipts	885,560	418,150	100,000
Federal	0	0	0
Local	0	0	0
Other	885,560	418,150	100,000
Appropriations	3,120,942	2,977,924	(100,000)
No. of Positions	31.3	31.3	0

Other Pertinent Information:

- 1999-00 includes additional receipts budgeted for Hurricane Floyd relief.

Recommended Adjustments

ITEM # 3: *Public Health Laboratory Medicaid Receipts*

Efforts to increase federal support for the Public Health Laboratory are expected to generate additional Medicaid receipts. It is recommended that these receipts be budgeted to support functions in the Laboratory and offset appropriations.

	Authorized		Reduction
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	12,074,864	11,559,331	
Total Receipts	4,157,048	3,527,791	220,000
Federal	809,600	652,308	
Local			
Other	3,347,448	2,875,483	220,000
Appropriations	7,917,816	8,028,540	(220,000)
No. of Positions	188.0	188.0	0

Other Pertinent Information:

- 1999-00 includes additional receipts budgeted for Hurricane Floyd relief.

Recommended Adjustments

7/08 **ITEM # 4: *AIDS Drugs***

It is recommended that the AIDS Drugs budget be adjusted to reflect an anticipated increase in funding from the Federal Ryan White Grant and drug rebates from pharmaceutical companies. NC's Federal Ryan White grant is anticipated to be $8,627,151 in SFY 00-01, an increase of approximately $2.26M from SFY 99-00. Since 1998, North Carolina has been participating in the expanded 340B Rebate Program.

Even with this adjustment, there are sufficient funds to raise the eligibility for AIDS drugs from 125% FPL to 250% FPL.

	Authorized		Reduction
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	17,168,860	19,367,362	
Total Receipts	7,737,862	9,535,335	2,000,000
Federal	6,371,503	8,168,976	458,175
Local	0	0	0
Other (Drug Rebates)	1,366,359	1,366,359	1,541,825
Appropriations	9,430,998	9,832,027	(2,000,000)
No. of Positions	0.25	0.25	

Other Pertinent Information:

- Raising the eligibility to 250% FPL will provide assistance to 1,144 additional clients (Total auth. Pop.: 3,713)
- Currently, NC has the most restrictive and lowest financial eligibility requirement of any state. The eligibility limits of some neighboring states are: SC: 300%; TN: 300%; GA: 300%; Virginia: 200%; Alabama: 250% and MS: 400%.
- Increased requirements in 2000-01 are from Ryan White federal funds.

Recommended Adjustments

ITEM # 5: *Forensic Test for Alcohol Program*

Prior to 1999-00, G.S. 20-16.5(j) required that 50% of the fee collected to restore a revoked driver license be deposited into a Non-Tax Revenue Code to fund a statewide Forensic Test for Alcohol Program. These funds accumulated in the account and established a baseline against which the Forensic Test for Alcohol Program was supported by appropriations. Section 11.62(a) of Chapter 168 redirected deposit of these funds directly into the Department of Health and Human Resources. It is recommended that these fees be budgeted to support functions in the Forensic Test for Alcohol Program and appropriations be reduced accordingly. As a result of this action, fourteen (14) positions will be changed to receipt supported from appropriation.

	Authorized		Reduction
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	964,861	964,861	0
Total Receipts	0	0	964,871
Federal	0	0	0
Local	0	0	0
Other	0	0	964,871
Appropriations	964,871	964,871	(964,871)
No. of Positions	14.00	14.00	0

Recommended Adjustments

ITEM # 6: *Operating Reserve for Goldsboro TBI Unit*

In anticipation of the scheduled January 1, 2001, opening of a Traumatic Brain Injury Unit in Goldsboro, the General Assembly appropriated funds to support operations. Capital funds to renovate the building were redirected after Hurricane Floyd to assist recovery in Eastern North Carolina delaying this effort.

	Authorized		Reduction
	SFY 99-00	SFY 00-01	SFY 00-01
Requirement	0	956,328	(956,328)
Total Receipts	0		
Federal	0		
Local	0		
Other	0		
Appropriations	0	956,328	(956,328)
No. of Positions	0	48.0	(48.0)

Recommended Adjustments

ITEM # 7: *Neurobehavioral Treatment Unit - Black Mountain Center*

Appropriations for renovation and first year operating funds appropriated for the Neurobehavioral Treatment Unit were redirected to services to support victims of Hurricane Floyd. In the absence of available renovation funds, it is recommended that the remaining operating funds be eliminated from the budget.

	Authorized		Reduction
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	19,484,888	19,241,045	(571,526)
Total Receipts	16,373,602	16,096,581	
Federal	13,928,402	14,113,840	
Local			
Other	2,445,200	1,982,741	
Appropriations	3,111,286	3,144,464	(571,526)
No. of Positions	494	545	(51)

Recommended Adjustments

ITEM # 8: *Smart Start*

A one-time reduction to the Smart Start program is recommended. Spending in Smart Start has been slower than originally projected due to: (1) the complex process of building human service delivery infrastructure in less developed counties, (2) the impact of Hurricane Floyd on Partnerships in Eastern North Carolina and (3) the length of the 1998 short session of the legislature. Based on an analysis of current Smart Start spending patterns the Governor recommends a one-time reduction of $49,000,000.

	Authorized		Reduction
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	256,376,542	236,171,320	(49,000,000)NR
Total Receipts	39,634,047		
Federal			
Local			
Other			
Appropriations	216,742,475	236,171,320	(49,000,000)NR
No. of Positions	0	0	0

Recommended Adjustments

ITEM # 9: *Medicaid Program*

The 1999-01 budget was originally prepared in January 1999. A reduction to the Medicaid program is recommended based on a revised forecast that considers more current expenditure and utilization information. This adjustment will not reduce the number of eligibles, nor will it reduce the number of available services.

	Total
Total Requirements	
Estimated 1999-00 Expenditures	4,736,962,079
Adjustment for Projected Eligibles Increase	271,123,363
Adjustment for Inflation	136,088,035
Annualization of New PCS Services	19,409,285
Projected Expenditures for 2000-01	5,163,582,762
Current Budget for 2000-01	5,282,323,082
Requirements Available for Reduction	(118,740,320)
Funding Analysis of Budget Reduction	
Federal	(78,620,461)
State	(32,388,631)
Local	(7,731,228)
Total Reduction in Funding	(118,740,320)
No. of Positions	0

Recommended Adjustments

ITEM # 9: *Medicaid Program* (cont'd)

Other Pertinent Information:

- DMA's budget for SFY 00-01 was adjusted based upon current expenditures and eligibles. If costs were up (or down) in the current SFY, they were adjusted accordingly for SFY 00-01.
- DMA's budget does not reduce the number of eligibles, nor does it reduce the number of available services.
- The budget for SFY 00-01 does reflect utilization and inflationary increases. The inflationary increases ranged from a high of 12.50% (Drugs) to a low of 0.41% (LTC-ICF Non-State Owned). Utilization increases are included and provide for additional eligibles. Some examples include: CAP-MR/DD (+200 slots); CAP-Disabled (+280 slots) and CAP-Children & CAP-AIDS (13 slots).

Recommended Adjustments

ITEM # 10: *Additional Medicaid Drug Rebate Receipts*

Due to increased spending in prescribed drugs in the Medicaid program additional drug rebate receipts have become available which offsets the need for state appropriations.

In 1991, the federal government began requiring drug manufacturers to pay a rebate if they wanted their products to be covered by Medicaid. Today, approximately 400 manufacturers participate in the program. The minimum, guaranteed rebate is 15.1%, but the average is actually closer to 20%.

The following data reflects only the state share of drug rebates.

	Authorized		Reduction
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements			
Total Receipts	50,467,841	44,295,135	12,146,498
Federal			
Local			
Other	50,467,841	44,295,135	12,146,498
Appropriations	(50,467,841)	(44,295,135)	(12,146,498)
No. of Positions	0	0	0

Other Pertinent Information:

- The drug manufacturer pays the rebate to each state. Payments are made on a quarterly basis.
- Each state is responsible for returning the federal share to HCFA. In NC, we also share the rebate with county governments based on their share of Medicaid expenditures.
- Only state share of the additional Drug Rebates is shown.

Recommended Adjustments

ITEM # 11: *Transfer Medicaid Reserve Funds*

G.S. 143-23.2 limits the use of the Division of Medical Assistance Reserve to support the Medicaid program. Currently, $29 million in recurring revenues are transferred from this reserve to support the Medicaid program. It is recommended that an additional $70 million in one-time revenues be used to support the Medicaid program. The remaining funds in this reserve are needed to support future cost settlements with the United States Health Care Financing Administration (HCFA).

	Authorized		Reduction
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements			
Total Receipts	55,000,000 NR 29,000,000 R	0 NR 29,000,000 R	70,000,000 NR
Federal			
Local			
Other			
Appropriations	(55,000,000) NR (29,000,000) R	0 NR (29,000,000) R	(70,000,000) NR
No. of Positions	0	0	0

Other Pertinent Information:

- The cost settlement process determines if the public hospital accurately reported the cost of indigent care.
- Cost settlement payments to HCFA are estimated to be $19.4M in SFY 99-00 and $13.7M in SFY 00-01.

Recommended Changes to the 2000-01 Expansion

ITEM # 1: *Smart Start*

It is recommended that the Smart Start program be fully funded in 2001. To this end, funding of $64,388,955 is recommended with an effective date of October 1, 2000. It is also recommended that $50,750 be provided to support program evaluation costs; $500,000 in nonrecurring funds be provided to support county collaboration efforts; $750,000 in nonrecurring funds be provided to support the triennial assessment of children's needs and resources as required by G.S. 143B-168.3; and $964,351 be provided for the North Carolina Partnership for Children to support the cost of personnel, rent, utilities and related administrative costs that have not kept pace with program expansion needs.

	Authorized		Request
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	256,376,542	236,171,320	66,654,056
Total Receipts	39,634,047		
Federal	0		
Local	0		
Other	0		
Appropriations	216,742,495	236,171,320	66,654,056
No. of Positions	0	0	0

Other Pertinent Information:

- Receipts in 99-00 are funds carried forward from 98-99.
- Of $66,654,056 , $1,250,000 is non-recurring.

Recommended Changes to the 2000-01 Expansion

ITEM # 2: *T.E.A.C.H. Program*

Additional funding is recommended for the T.E.A.C.H. program to support increased cost for tuition, increased number of enrollees, and an increase in the number of participants enrolled in the Associate Degree scholarship program. The Teacher Education and Compensation Helps (T.E.A.C.H.) Early Childhood Project provides a variety of educational scholarship opportunities for people working in regulated child care centers and homes.

	Authorized		Request
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	2,288,006	2,200,000	400,000
Total Receipts	88,006		
Federal			
Local			
Other			
Appropriations	2,200,000	2,200,000	400,000
No. of Positions	0	0	0

Other Pertinent Information:

- Receipts in 99-00 represent funds carried forward from 98-99.

Recommended Changes to the 2000-01 Expansion

ITEM # 3: *Health Choice Expansion*

It is recommended that eligibility for NC Health Choice be expanded from 200% of the federal poverty level (FPL) to 300%. This will provide coverage to a potential population of 65,690 children. We estimate that 20% of this population will enroll over a 3-year period. Expansion costs will be partially offset by monthly premiums paid by parents. For families between 200-249% FPL, the monthly premium per child will be $25 with a limit of two children per family. For families between 250-299% FPL, the monthly premium per child will be $35 with a limit of two children per family. Four positions including a support staff assistant, two computer systems' professionals and financial operation's professional are recommended. This expansion is effective October 1, 2000.

	Authorized		Request
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	85,980,083	98,438,921	5,355,153
Total Receipts	64,056,065	73,098,420	3,941,928
Federal	62,478,602	71,489,408	3,357,386
Local	0	0	
Other	1,577,463	1,609,012	584,542
Appropriations	21,924,018	25,340,501	1,413,225
No. of Positions	2.0	2.0	4.0

Other Pertinent Information:

- Base enrollment for SFY 99-00 is estimated to be 64,245. By SFY 04-05 (with the expansion), we estimate 83,154 children will be enrolled in NC Health Choice for Children.
- Proposal includes a full buy-in for families above 300% FPL. Their monthly premium will reflect all costs.
- Includes $1M for Special Needs and a one-time administrative cost of $1M for SEHP system changes.

Recommended Changes to the 2000-01 Expansion

ITEM # 4: *Healthy Start Foundation*

Funding is recommended to continue the public information and education activities of North Carolina's nationally recognized First Step Campaign. It will also enable the Healthy Start Foundation to provide mini-grants to local communities to fund activities and services designed to reduce infant mortality and low birth weight, which is the leading cause of infant mortality.

	Authorized		Request
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	650,000	0	650,000 NR
Total Receipts		0	
Federal		0	
Local		0	
Other		0	
Appropriations	650,000	0	650,000 NR
No. of Positions	0	0	0.0

Recommended Changes to the 2000-01 Expansion

ITEM # 4: *Healthy Start Foundation (cont'd)*

Other Pertinent Information:

The North Carolina Healthy Start Foundation's mission is to reduce infant mortality and morbidity in North Carolina and to improve the health of the State's youngest children.

The $650,000 appropriation will support the following three main activities:

(1) **FIRST STEP Public Education Campaign activities**

• $250,000 will support the operating expenses of the FIRST STEP Campaign.

• This statewide public education campaign to reduce infant mortality focuses on preventing babies from being born too sick or too small to be healthy. Now in its tenth year, this national award winning campaign educates the public about lifestyle and behavioral issues that positively impact the health of North Carolina's mothers and babies (e.g. Back To Sleep Campaign, Folic Acid Campaign, etc.).

• In the first 9 months of SFY 1999-00, the FIRST STEP Campaign filled more than 1,850 orders for materials, distributing 1.3 million pieces of educational materials to local programs.

(2) Community Grants Program

• $350,000 will support the Community Grants Program by providing second year funding for grants selected in SFY 1999-00 and will also be the basis for requesting matching funds from the Robert Woods Johnson Foundation's Local Initiative Funding Partners Program.

• Priority will be given to community organizations that address one of three major causes of infant mortality and low birth weight: reproductive tract infections, smoking cessation for pregnant women, and improved timing of pregnancies were prioritized.

Recommended Changes to the 2000-01 Expansion

ITEM # 4: *Healthy Start Foundation (cont'd)*

Other Pertinent Information:

(3) Minority Infant Mortality Reduction Public Awareness Campaign

• $50,000 will be used to focus public awareness and public education efforts towards North Carolina's ethnic and racial minority communities.

• North Carolina's minority infant mortality rates are more than double those of white babies. Using culturally appropriate strategies to deliver relevant messages to improve the health of minority babies is essential to improving the state's infant mortality rates.

• This funding would continue and expand the Foundation's Minority Infant Mortality Public Education Campaign started in SFY 1995-96 to reach African Americans and in SFY 1998-99 to reach Latinos.

Recommended Changes to the 2000-01 Expansion

ITEM # 5: *State Games*

Funding is recommended to continue the support for the State Games of North Carolina to promote health and fitness through athletic activities.

	Authorized		Request
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	200,000	0	200,000 NR
Total Receipts	0	0	
Federal		0	
Local		0	
Other		0	
Appropriations	200,000	0	200,000 NR
No. of Positions	0	0	0

Other Pertinent Information:

• The primary function of State Games of North Carolina is to promote health and physical fitness through athletic activities.

• The $200,000 will support State Games of North Carolina which involves over 11,000 athletes from across the State including regional competitions culminating in a championship in Raleigh. These funds will assist with promotion activities and assist with operational expenses required for the athletic events.

Recommended Changes to the 2000-01 Expansion

ITEM # 6: *Atypical Antipsychotics*

The newer class of atypical antipsychotics (chlozaphine, risperdone, quietiapine, and olanaphine) offers greater efficacy, but is far more costly than traditional medications. To continue to meet the demand for these medications, the Governor recommends additional funds for the State's psychiatric hospitals and mental retardation centers.

	Authorized		Request
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	13,563,974	14,068,651	1,500,000
Total Receipts	6,781,987	7,034,326	
Federal	6,781,987	7,034,326	
Local			
Other			
Appropriations	6,781,987	7,034,326	1,500,000
No. of Positions	NA	NA	NA

Other Pertinent Information:

Older drug therapies cost cents per day and have potential adverse side-effects. New drug therapies cost dollars per day but have significantly decreased potential side-effects. New drugs therapies are more effective and help keep patients out of institutions once they are discharged.

Recommended Changes to the 2000-01 Expansion

ITEM # 7: *School Based Mental Health and Substance Abuse Services*

The Governor proposes a multi-agency collaboration to improve child mental health and substance abuse services in North Carolina's public school system. The Divisions of Mental Health, Developmental Disabilities and Substance Abuse Services and Public Health will partner with the Department of Public Instruction to establish 24 demonstration centers in at-risk schools. Center staff, including a special education teacher, nurse, mental health professional and substance abuse counselor, will provide direct and referral services to maintain an enhance students' well being and opportunities for academic success. Planning funds are also requested for 24 additional centers. Total program cost is $5,870,000, which includes block grant support and an anticipated award from the Governor's Crime Commission.

	Authorized		Request
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	0	0	5,870,000
Total Receipts	0	0	4,940,000
Federal	0	0	3,500,000
Local	0	0	
Other	0	0	1,440,000
Appropriations	0	0	930,000
No. of Positions	0	0	0

Recommended Changes to the 2000-01 Expansion

ITEM # 7: ***School Based Mental Health and Substance Abuse Services*** (cont'd)

Other Pertinent Information:

- Federal receipts include $1M from the Substance Abuse Block Grant and $1.5M from the Mental Health Block Grant. Other receipts include Medicaid, Health Choice, DPI and other third party receipts, and a $1M grant from the Governor's Crime Commission.
- The average cost of each demonstration site is $200,000 per year and the planning sites are projected to to cost an average of $30,000 per year.
- Centers and Planning Sites are to be selected through a Request For Proposal (RFP) process.

Recommended Changes to the 2000-01 Expansion

ITEM # 8: *Child Mental Health Services*

The state's thirty-nine Area Mental Health Programs provide mental health services to our children, including those in foster care. To better serve these children, the Governor recommends funds be appropriated to the Area Mental Health Programs to increase the availability of child mental health services.

	Authorized		Request
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	20,268,533	20,268,533	1,000,000
Total Receipts	4,682,610	4,682,610	
Federal	4,682,610	4,682,610	
Local			
Other			
Appropriations	15,585,923	15,585,923	1,000,000
No. of Positions			0

Other Pertinent Information:

- Services will be targeted to the following populations: sexually aggressive children needing residential services; hospitalized children needing aftercare programs in order to be discharged; children at high risk of hospitalization needing diversionary programs
- Area Programs will go through a RFP process, in which up to 8 Area Programs will receive a minimum of $100,000.
- Any anticipated unspent funds will be placed in a reserve account for use by other Area Programs.

Recommended Changes to the 2000-01 Expansion

ITEM # 9: *Statewide Poison Control Center*

It is recommended that funding be provided to support the North Carolina's Statewide Poison Control Center (SPCC). The Department of Health and Human Services designated a Statewide poison control center in 1988, in response to G.S. 143-509(3), to serve as a resource to both the medical community and to private citizens. Approximately 28% of the calls received by the Statewide poison control center come from the service area of the Carolinas Poison Center. The remainder is received from other areas of the state. The Statewide Poison Control Center received 89,547 calls in 1999. This represents an 8.1% increase over 1998.

	Authorized		Request
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	736,492	236,492	1,000,000
Total Receipts	0	0	0
Federal	0	0	0
Local	0	0	0
Other	0	0	0
Appropriations	736,492	236,492	1,000,000
No. of Positions	0	0	0

Other Pertinent Information:

- The SPCC is located at the Carolinas Medical Center in Charlotte.
- SFY 99-00 cost of the SPCC are estimated to be $1,814,556 - of which the state will contribute $736,492.
- State funding accounts for 40.6% of budget, while calls outside of their 8-county area account for 72% of all calls handled by the SPCC. The $1M in funding will raise the state share to $1,236,492 (68% of budget).

Recommended Changes to the 2000-01 Expansion

ITEM # 10: *Adult Care Home Inspectors*

It is recommended that new inspectors be added to implement the requirements established in Senate Bill 10 ratified in the long session of the General Assembly. These funds support newly established requirements for special care units, time-limited provisional licenses, complaint investigations, medication administration and compliance history reviews which cannot be handled within current resources. These funds are to be used as match to draw down federal funds. The Governor recommends that this item be implemented effective January 1, 2001.

	Authorized		Request
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	1,990,303	1,990,303	248,327
Total Receipts	311,034	311,034	99,327
Federal	274,789	274,789	99,327
Local			
Other (SSBG)	36,245	36,245	0
Appropriations	1,679,269	1,679,269	149,000
No. of Positions	33.0	33.0	6.0

Recommended Changes to the 2000-01 Expansion

ITEM # 11: *Child Advocacy Institute Children's Services Report*

It is recommended that $250,000 in non-recurring funds be provided to support children's reporting efforts developed by the North Carolina Child Advocacy Institute.

	Authorized		Request
	SFY 99-00	SFY 00-01	SFY 00-01
Requirements	0	0	250,000
Total Receipts	0	0	0
Federal	0	0	0
Local	0	0	0
Other	0	0	0
Appropriations	0	0	250,000
No. of Positions	0	0	0

Other Pertinent Information:

- The $250,000 appropriations will support and enhance the North Carolina Child Advocacy's ***Knowledge Exchange*** which provides a comprehensive, multi-disciplinary source of statistics, indicators of well-being and other public policy relevant information about all young North Carolinians below the age of 18. These data will be compiled and distributed free of charge by the Child Advocacy Institute to state agencies, the General Assembly, local government, child-related professionals, civic organizations, schools, universities, the media, and interested members of the general public.

Recommended Changes to the 2000-01 Expansion

ITEM # 11: ***Child Advocacy Institute Children's Services Report*** (cont'd)

Other Pertinent Information:

- Funds will cover salaries and fringes for staff to perform data collection, preparation and analysis and web development tasks; the dissemination of a printed version of the data for people who do not have access to the internet; and the remaining funds will cover web hosting and computer program upgrades and overhead (phone, supplies, etc.)

-----Carry-forward of Funds for Mental Health, Substance Abuse, and Developmental Disabilities Services in FY 2000-2001

(a) Not withstanding GS 143-18, of the General Fund current operations credit balance remaining in the Department of Health and Human Services, on June 30, 2001 the Department shall carry forward to the next fiscal year funds budgeted for any facility operated by the Division of Mental Health Mental Retardation and Substance Abuse Services and budgeted for community based mental health, substance abuse or developmental disability services. The funds may be used for the following purposes:

(1) To pay one time expenditures that will not impose additional financial obligations on the state;
(2) To establish community-based services if sufficient recurring funds can be identified within the Department from funds currently budgeted for mental health, developmental disabilities, and substance abuse services to support ongoing costs of those community-based services.

(b) The Director of the Budget, under the authority set forth in GS 143-25, shall establish the General Fund current operations credit balance remaining as of June 30,2001, in the Department of Health and Human Services.

-----Use of Lapsed Salaries

Notwithstanding GS 143-23, lapsed salaries within the Division Mental Health, Developmental Disabilities and Substance Abuse Services institutions may be used as start-up funds for programs that more appropriately serve institutionalized clients in community programs provided the ongoing operation of these programs can be continued with recurring funds currently budgeted for mental health, developmental disabilities, and substance abuse services within the Department.

The Department of Human Resources shall report to the Legislative Commission on Governmental Operations in November 2000 on initiatives undertaken by the Department as a consequence of this provision.

#2 05.23.2000 P

Assumptions for Health Choice Expansion for 200-300%
Projected Population Penetration - 20%
Premiums for Families Limited to $25 and $35 for First 2 Children
SEHP Base Premium $120.84 for 100-200%
10% Admin Cap Analysis Included
Increased Copay Amounts Used
Special Needs Funding at $1,000,000

1. Program Expansion begins on 10/1/2000.
2. Population grows at 1.5% per year.
3. Rates grow at 6.7% per year.
4. No programmatic changes to population 100-199%.
5. Enrollment fees of $50/ child, max $100/ family for 150-199% FPL.
6. Premiums collected from families above 200%FPL are:

$300/yr 200-249% FPL	$25/mo
$420/yr 250-300%FPL	$35/mo

7. Premiums would be limited to first two children in the family.
8. Health Choice eligibility determination costs are at $100/application.
9. Children with Special Needs - no waiting period:
    a. up to 300% of poverty - regular premium
    b. over 300% of poverty - full cost
10. Additional positions needed at DMA are 4. These positions are considered effective 10/1/2000. At the present these postions would be housed at the Kirby Building on Dix Campus.
11. Staggered enrollment is used in projections. First year will see 50% enrollment, 2nd year will see 75% enrollment, 3rd year forward will see 100% enrollment.
12. One time adminsitrative cost for SEHP system changes = $1 million.
13. EIS has one time administrative cost for system change in 1st year of expansion, followed by annual system maintenance administrative charges.
14. Copay amounts have been increased for the 200-300% enrollees.
15. Special Needs funded at $1,000,000 annually.
16. Base year enrollment (99-00) is 64,245

5/22/00

Dr. Brata 05.23.2000 #3

Health Choice Expansion Using SEHP Premium SFY99-00

FPL	100-149%	150-199%	Total 100-199%
Population	44,972	19,273	64,245
Premium	$ 96.65	$ 121.18	$ 104.01
Program Expenditures			
Premiums	$52,158,525.60	$28,026,025.68	$ 80,184,551.28
Spec Needs	$ 400,000.00	$ 400,000.00	$ 800,000.00
Total Program Exp	$52,558,525.60	$28,426,025.68	$ 80,984,551.28
Administrative Costs			
Eligibility Determination	$ 4,497,200.00	$ 1,927,300.00	$ 6,424,500.00
Outreach	$ 200,000.00	$ 200,000.00	$ 400,000.00
DWCH Administration	$ 250,000.00	$ 250,000.00	$ 500,000.00
DMA Administration	$ 50,000.00	$ 50,000.00	$ 100,000.00
Total Administration	$ 4,997,200.00	$ 2,427,300.00	$ 7,424,500.00
Collections	$ -	$ 642,433.00	$ 642,433.00
Admin Less Collections	$ 4,997,200.00	$ 1,784,867.00	$ 6,782,067.00
10% Administration Cap	$ 5,839,836.18	$ 3,158,447.30	$ 8,998,283.48
Under/(Over Cap)	$ 842,636.18	$ 1,373,580.30	$ 2,216,216.48
Total Program Costs	$52,558,525.60	$28,426,025.68	$ 80,984,551.28
Total Admin Costs	$ 4,997,200.00	$ 1,784,867.00	$ 6,782,067.00
Grand Total	$57,555,725.60	$30,210,892.68	$ 87,766,618.28
Federal Share (.7385)	$42,504,903.36	$22,310,744.24	$ 64,815,647.60
State Share	$15,050,822.24	$ 7,900,148.44	$ 22,950,970.68

5/22/00

Health Choice Expansion Using SEHP Premiums SFY00-01

FPL	100-149%	150-199%	200-249%	250-300%	Total 100-300%
Population	45,646	19,563	1,760	1,525	68,494
Premium	$ 120.84	$ 120.84	$ 95.26	$ 103.91	$ 108.48
Program Expenditures					
Premiums	$66,190,351.68	$28,367,915.04	$ 1,508,918.40	$ 1,426,164.75	$ 97,493,349.87
Special Needs	$ 250,000.00	$ 250,000.00	$ 250,000.00	$ 250,000.00	$ 1,000,000.00
Total Program Exp	$66,440,351.68	$28,617,915.04	$ 1,758,918.40	$ 1,676,164.75	$ 98,493,349.87
Administrative Costs					
Eligibility Determination	$ 4,564,600.00	$ 1,956,300.00	$ 176,000.00	$ 152,500.00	$ 6,849,400.00
Outreach	$ 100,000.00	$ 75,000.00	$ 75,000.00	$ 75,000.00	$ 325,000.00
SEHP Sys Changes (1 Time)	$ -	$ -	$ 500,000.00	$ 500,000.00	$ 1,000,000.00
EIS Sys Changes & Maint	$ -	$ -	$ 320,000.00	$ 320,000.00	$ 640,000.00
DWCH Administration	$ 100,000.00	$ 100,000.00	$ 100,000.00	$ 100,000.00	$ 400,000.00
DMA Administration	$ 93,057.69	$ 93,057.69	$ 93,057.69	$ 93,057.69	$ 372,230.75
Total Administration	$ 4,857,657.69	$ 2,224,357.69	$ 1,264,057.69	$ 1,240,557.69	$ 9,586,630.75
Collections	$ -	$ 652,100.00	$ 264,132.00	$ 320,410.00	$ 1,236,642.00
Collection Adjustments	Admin	Admin	Program	Program	Total
Program Exp Adjustments	$66,440,351.68	$28,617,915.04	$ 1,494,786.40	$ 1,355,754.75	$ 97,908,807.87
Admin Adjustments	$ 4,857,657.69	$ 1,572,257.69	$ 1,264,057.69	$ 1,240,557.69	$ 8,934,530.75
10% Admin Cap	$ 7,382,261.30	$ 3,179,768.34	$ 166,087.38	$ 150,639.42	$ 10,878,756.43
Under/(Over Cap)	$ 2,524,603.61	$ 1,607,510.65	$ (1,097,970.31)	$ (1,089,918.27)	$ 1,944,225.68
Total Program Costs	$66,440,351.68	$28,617,915.04	$ 1,494,786.40	$ 1,355,754.75	$ 97,908,807.87
Total Admin Costs	$ 4,857,657.69	$ 1,572,257.69	$ 1,264,057.69	$ 1,240,557.69	$ 8,934,530.75
Grand Total	$71,298,009.37	$30,190,172.73	$ 2,758,844.09	$ 2,596,312.44	$106,843,338.62
Federal Share (.7361)	$52,482,464.70	$22,222,986.14	$ 2,030,785.13	$ 1,911,145.59	$ 78,647,381.56
State Share	$18,815,544.67	$ 7,967,186.58	$ 728,058.95	$ 685,166.85	$ 28,195,957.06

5/22/00

Health Choice Expansion Projections Using SEHP Premiums SFY99-00 through SFY04-05

(Dollar Amounts in Millions)

FPL 100-200% (Health Choice Current Coverage)

Federal Fiscal Year	FFY98	FFY99	FFY00	FFY01	FFY02	FFY03	FFY04	FFY05
Federal Allotment	79.50	79.50	79.50	79.50	59.50	59.50	59.50	76.50
State Fiscal Year	SFY97-98	SFY98-99	SFY99-00	SFY00-01	SFY01-02	SFY02-03	SFY03-04	SFY04-05
3/4 Current FFY	59.63	59.63	59.63	59.63	44.63	44.63	44.63	57.38
1/4 Previous FFY	-	19.88	19.88	19.88	19.88	14.88	14.88	14.88
Carry-Over (Prev Yr)	-	59.63	116.05	130.73	135.52	119.65	92.68	59.12
Total Avail Funds	59.63	139.13	195.55	210.23	200.02	179.15	152.18	131.37
FFP Rate (on SFY basis)	0.7430	0.7416	0.7385	0.7361	0.7341	0.7323	0.7306	0.7290
Estimated Expenditure	-	31.12	87.77	101.49	109.48	118.07	127.38	137.45
Federal Share	-	23.08	64.82	74.71	80.37	86.47	93.06	100.20
State Appropriation	-	8.04	22.95	26.78	29.11	31.60	34.32	37.25
Current Carry Over (FSO)	59.63	116.05	130.73	135.52	119.65	92.68	59.12	31.17

FPL 100-250%

Federal Fiscal Year	FFY98	FFY99	FFY00	FFY01	FFY02	FFY03	FFY04	FFY05
Federal Allotment	79.50	79.50	79.50	79.50	59.50	59.50	59.50	76.50
State Fiscal Year	SFY97-98	SFY98-99	SFY99-00	SFY00-01	SFY01-02	SFY02-03	SFY03-04	SFY04-05
3/4 Current FFY	59.63	59.63	59.63	59.63	44.63	44.63	44.63	57.38
1/4 Previous FFY	-	19.88	19.88	19.88	19.88	14.88	14.88	14.88
Carry-Over (Prev Yr)	-	59.63	116.05	130.73	133.49	113.57	80.66	39.77
Total Avail Funds	59.63	139.13	195.55	210.23	197.99	173.07	140.16	112.02
FFP Rate (on SFY basis)	0.7430	0.7416	0.7385	0.7361	0.7341	0.7323	0.7306	0.7290
Estimated Expenditure	-	31.12	87.77	104.25	115.00	126.20	137.41	148.32
Federal Share	-	23.08	64.82	76.74	84.42	92.41	100.39	108.13
State Appropriation	-	8.04	22.95	27.51	30.58	33.79	37.02	40.19
Current Carry Over (FSO)	59.63	116.05	130.73	133.49	113.57	80.66	39.77	3.89

FPL 100-300%

Federal Fiscal Year	FFY98	FFY99	FFY00	FFY01	FFY02	FFY03	FFY04	FFY05
Federal Allotment	79.50	79.50	79.50	79.50	59.50	59.50	59.50	76.50
State Fiscal Year	SFY97-98	SFY98-99	SFY99-00	SFY00-01	SFY01-02	SFY02-03	SFY03-04	SFY04-05
3/4 Current FFY	59.63	59.63	59.63	59.63	44.63	44.63	44.63	57.38
1/4 Previous FFY	-	19.88	19.88	19.88	19.88	14.88	14.88	14.88
Carry-Over (Prev Yr)	-	59.63	116.05	130.73	131.58	108.01	69.73	22.21
Total Avail Funds	59.63	139.13	195.55	210.23	196.08	167.51	129.23	94.46
FFP Rate (on SFY basis)	0.7430	0.7416	0.7385	0.7361	0.7341	0.7323	0.7306	0.7290
Estimated Expenditure	-	31.12	87.77	106.84	119.97	133.52	146.48	158.17
Federal Share	-	23.08	64.82	78.65	88.07	97.78	107.02	115.31
State Appropriation	-	8.04	22.95	28.19	31.90	35.74	39.46	42.86
Current Carry Over (FSO)	59.63	116.05	130.73	131.58	108.01	69.73	22.21	(20.86)

5/22/00

Name of Committee: JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 23, 2000

VISITORS. PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
by Avent Farmer	DHHS-dcd
Peggy Ball	DHHS-DCD
Michelle Cotton	DMH/DD/SAS
Roslyn Sawitt	NC Child Care Coalition
Lynn Martin	Parent Iredell County DD/ASD Child
M Yeager	OSBM
NELS ROSELAND	OSBM
Don Willis	DMHDDSAS
Dennis Harrington	DHHS-DPH
Jack Larson	DMH/DD/SAS
Charles Davis	DMHDDSAS

Name of Committee: JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 23, 2000

VISITORS PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Iverson Ridden	Div. MH/DD/SAS
Arthur Robarge	Deputy Div MH/DD/SAS
Stephen G. Sherman	Div of Pub Health - HIV/STD Prev + Care
Lynda McDaniel	DHHS/DFS
Joannie Wellborn	High Country First in Families
Karen Hayes	High Country First in Families
Darlene Oaks	High Country First in Families
Melanie Murphy	UCP-NC/High Country First in Families
Ed Broyles	PARENT / First In Families of NC. / Macon Co.
KEVIN RYAN	DHHS/DPH
Josie Douglas	NC Assoc of the Deaf
Dennis McBride	DHPS

Name of Committee: JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 23, 2000

VISITORS PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jerry Cooper	N.C. Assisted Living Association
Whitney Ohrig	OSBM
Wayne Williams	OSBM
Mary Greene	OSBM
Anne Doucette	Blue Ridge Center
Don Suggs	New River Area Programs 895 State Farm Boone, NC 28607
Don Clark	Mental Health High Country, P.O. Box 582 Boone, NC 28607
Nancy Carey	NAMI-WC; MHA, Blue Ridge Area Board
John Parham, MD	Area Board Chair, Blue Ridge
Janice Freedman	N.C. Healthy Start Foundation 1300 St. Mary's St, Ste 204 Raleigh, NC 27605
Cindi Dixon	Triad First in Families 4269 Brownsboro Rd. Suite 100 Winston-Salem, NC 27106
Susan Reeves	The Arc of Forsyth Co. " " "
Larry Thompson	Blue Ridge Center, Asheville

VISITOR REGISTRATION SHEET

HEALTH & HUMAN RES. — 5-23-00
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Ashley O. Thrift	NCPC
Clark Plexico	NCPC
DAVID BRADSHAW	DHHS
[illegible]	DHHS
[illegible]	DHHS
Joni Alberg	BEGINNINGS For Parents of Children Who Are Deaf or Hard of Hearing
[illegible]	DHHS
Karen Bottomi	DHHS - Aging
[illegible]	DHHS
[illegible]	Div of Medical Asst.
P. Perruzzi	" " "
Steve Davis	Health/Hum Servs
AL EISELE	Health & Human Res.
DAVID Swann	Crossroads Behavioral Healthcare Surry Yadkin Region
Myra Miller	NASW-NC

VISITOR REGISTRATION SHEET

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Jada Houston	
Janet Schanzlach	NC Councill
Kim Hall	Parent advocate CAPC
Sharon Hirsch	NC Social Services Consortium
[illegible] Bell	Assn. for Home, & Hospice Care of NC
Bob Hedrick	CNC
Sully Cameron	NCPA & Coalition 2001
Helen Lipman	Mecklenburg Co
Gerry Cobb	NC Partnership for Children
Monica Haug	NC Partnership for Children
Joyce Baffi	" " " "
Anthony Sovari	NC PARTNERSHIP FOR Children

Name of Committee: JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

AFTERNOON May 23, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Patrice Young	APPCNC/ACLU/Hospice for the Carolinas
Roz Sawyer	NC Child Care Coalition
Steve Davis	DHHS
Nancy Coston	Div of Social Services
Shannon Ransone	DSS
Michelle Cotton	DMH/DD/SAS
Don Willis	" " "
Tara Larson	DMH/DD/SAS
Overton Rogers	DMH/DD/SAS
Charles Davis	DMH DD SAS
[illegible]	Div of Medical Assist

Name of Committee: JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

AFTERNOON May 23, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
P. Perruzzi	DMA/DHHS
J. Osbey	DMH/DD/SAS
A Robarge	DMH/DD/SAS
[illegible]	OSBM
Gé Brogden	DHHS
Allyn Duffey	DHHS
David Brewer	DHHS
Janet Schanzenbach	NC Council
Sally Cameron	NC Psychological & Coalition 2001
NELS ROSELAND	OSBM
[illegible]	The Arc/NC
C. L. Cochran	UCPNC

Name of Committee: JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

AFTERNOON May 23, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
AL EISELE	Health & Human Ser
Myra L Mills	NASW-NC
Bryant Edgerton	Easter Seals NC
Dennis Harrington	DHHS - DPH
Joni Alberg	BEGINNINGS For Parents of Children Who Are Deaf or Hard of Hearing
Flo Stein	~~DMH~~/DD/SAS
Mary Greene	OSBM
Stephen G. Sherman	Div of Public Health - HIV/STD Prev + Care
Wayne Williams	OSBM
Whitney Obrig	OSBM
Josh Reynolds	NC Gov's Institute on Alcohol + SA

Name of Committee: JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

AFTERNOON May 23, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Martha Lawrence	YAFO
Sara R. Allen	Covenant w/ N.C.'s Children
Amanda Abrams	" "
Paula A Wolf	" "
Janice Freedman	N.C. Healthy Start Foundation
Bob Hedrick	CAC, Inc.
Kevin Ryan	DHHS/DPH
Barry Pennell	NC Amateur Sports
Helen Lipman	Meck. County
Sharon Hirsd	NC Social Services Consortium
Anthony Sobrai	N.C. Partnership For Children
	Food Bank of NC

JOINT APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes
May 24, 2000
Meeting

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Wednesday, May 24, 2000, in Room 643 of the Legislative Office Building.

Representative Edd Nye, Co-Chairman, presided. House members present were: Representative Beverly Earle (Co-Chairman), Representative Alma Adams, Representative Lanier Cansler, Representative Theresa Esposito, Representative Trudi Walend, and Representative Gene Wilson. There were five senators present.

Representative Nye introduced the House and Senate Pages at the meeting and then asked Dr. Bruton, Secretary Health and Human Services, to continue with his presentation from last meeting. Dr. Bruton began on Page 22 of the previous meeting's handout; (Recommended Changes to the 2000-2001 DHHS Budget). He spoke concerning School Based Mental Health and Substance Abuse Services. The Department is asking for $930,000 to help fund this.

Representative Nye noted the are already health centers in schools now. Dr. Bruton responded this service would be an expansion and enhancement of the centers, but would be separate and begin in twenty- four different places.

Mr. Jim Edgerton, Department of Human Services, was introduced to finish discussion from last meeting concerning the expansion. Page 17 of the handout notes their request for $650,000 in non-recurring money for the Healthy Start Foundation. Representative Nye asked if this was related to the Healthy Carolinian's Program. Dr. Ann Wolfe with the Department responded it was not related. It is an effort through public awareness brochures, media to reduce infant mortality by giving education to providers and to the consumer. The Healthy Carolinian money supports local coalitions that plan for other needs of individual counties. Representative Nye noted there seemed to be more need than anticipated.

Senator Forrester questioned the Department as to why the infant mortality rate went up this year. Dr. Bruton responded it is due to the increase in Black population. State continues to have a severe problem of low birthrate in non-white population. Senator Martin asked Dr. Wolfe for the average cost of neonatal stay in hospitals. Dr. Wolfe replied that it is between two and three hundred thousand dollars.

Mr. Edgerton continued with request for $200,000 in non-recurring funds for State Games, and 1.5 million for atypical antipsychotics. Dr. Iverson Riddle stated drug cost is approximating a twenty-five percent increase in general on a yearly basis. More patients can benefit by new class of antipsychotic drugs, which are expensive.

Mr. Edgerton continued with discussion of request for one million dollars for Child Mental Health Services. This would provide additional assistance to community programs. Counties have to spend a lot to serve children who are put into their custody. Representative Cansler pointed out that families in several counties, who do not have resources to get help for their child and are not covered by any existing program, turn their child over to Social Services to get help for the child. He asked if this would address this situation. Mr. Edgerton explained it would help in a small way.

Mr. Edgerton stated that the Department was asking for six more positions for Adult Care Home Inspectors. Senator Kerr said he thought there were Ombudsman Committees to check on these facilities and they would be the ones to receive any complaints. Ms. Linda McDaniel responded there are voluntary community advisory committees in each county, but they do not have any enforcement capability. They help alert the State and County Departments concerning problems, but the primary responsibility for monitoring the Adult Care Homes is done by the Department of Social Services in each county. DHHS staff is used to train these county people. Senate Bill 10 placed a lot of new requirements on the Homes especially in the are of medication administration. There are a number of requirements related to Senate Bill 10 that are extremely complex, such as compliance history reviews, new complaints requirements. Senator Kerr replied that this was a local issue. Maybe the Bill was too complicated.

Mr. Edgerton continued with the next item, which was on page 27, Child Advocacy Institute, Children Services Report. $250,000 recommended for the Institute. Senator Phillips noted the Institute calls attention to what is going on. Senator Martin asked someone from the Institute to explain request for recommended funding. There is a need for better information and money is needed to allow them to gather information. Another staff person is needed. Senator Forrester asked for amount of budget and was told it was $800,000. Representative Adams wanted to know if more funding would allow for fulltime staff. Part of the money would be for two fulltime positions. Nina Yeager, State Budge Office, stated the funds requested would be to support data collection efforts to produce the document for the annual report on the status of children in North Carolina. Representative Esposito asked for a list of programs being funded. Ms. Yeager pointed out the State has not funded the Child Advocacy Institute before, this is the first request. Representative Esposito wanted further clarification as to number of groups being funded by State. Mr. Edgerton replied the Department could supply a list of private non-profit groups the State contracts with. No other non-profit group does the same thing as the Institute. Senator Kerr asked that the Chairs be given a list of all the non-profit advocacy organization groups the Department has a contract with because the members of the committee need to know. Senator Phillips commented he has confidence in the Institute.

This completed discussion of the expansion budget. The Committee adjourned at 9:40 a.m.

Presiding Co-Chairman-Representative Edd Nye

Committee Assistant- Jo Bobbitt

Joint Health and Human Services Appropriations Sub-Committee

May 24, 2000
8:30 AM
Legislative Office Building Rm# 643

----- Agenda Topics -----

Opening Remarks	Senator Bill Martin, Representative Edd Nye and Representative Beverly Earle
Expansion - School Based Mental Health and Substance Abuse Services	H. David Bruton, MD; Secretary, Department of Health and Human Services
Expansion - Other	James B. Edgerton, Deputy Secretary; Department of Health and Human Services
Block Grants	Department of Health and Human Services Staff

Name of Committee: JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 24, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Allyn Duffey	DHHS
Jim Edgerton	DHHS
Tara Larson	DMH/DD/SAS
Karen Gottovi	DHHS - Aging
by Anne Farmer	dhhs ded
Margaret Queen	dhhs - Child dev.
Martha Lowance	YAFO
Louis Guisto	HMCS
Roslyn Savitt	NC Child Care Coalition
John [illegible]	NCFPC
Nancy Cotton	Div Soc'l Services

Name of Committee: JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 24, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stephanie Jaegel	DCD - DHHS
Lynda McDaniel	DHHS/DFS
Don Willis	DMHDDSAS
Renee Baker	MH/DD/SAS
Charles Dean	DMHDDSAS
[illegible]	DMH/DD/SAS
[illegible]	DMA/DHHS
[illegible]	NCDHHS - DSS
ART ROBARGE	DMH/DD/SAS
[illegible]	OSBM
[illegible]	DHHS

Name of Committee: JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 24, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Whitney Oberg	OSBM
Mary Greene	OSBM
Wayne Williams	OSBM
Jimmie Ford	Representative General Assembly
Linda Johnson	FRD
Flo Stein	DMH/DD/SAS
[illegible]	Gov. Office
[illegible]	FTC/NC
Seth Whitaker	House Appropriations Staff
Shannon Ramsey	DSS
John Bowdish	Alley Associates
Becky	

VISITOR REGISTRATION SHEET

Name of Committee

May-24-2000
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bernie Hollers	DHHS
Sona Shandilya	Anne Winner
[illegible]	UCPNC Carol
Larry Pennell	NC Amateur Sports
Amy Fullbright	Hunton and Williams
Janice Freedman	NC Hearthy Start Foundation
Stacy Flannery	NCHCFA
Lily Farel	DHHS
[illegible]	DHHS
Jonathan Shaw	NC Child Advocacy Institute
Brenda Summers	NC Equity
Sharon Hirsch	NC Social Services Consortium
Paula A. Wolf	Covenant w/NC's children
Steve Shore	NC Pediatric Society
Michelle Cotton	OMH/DD/SAS
Lynette Rivenbark	AHA
Anthony Solari	NC Tract for Child
Janet Schaufbach	NC Council
Bryant Edgerton	Easter Seals NC
JOE LIBERA	ASSOC. HOME + HOSPICE CARE
MIKE BELL	"
Deborah Lamon	NCCAA
Lawrence Wilson	DHHS / OEO
NELS ROSELAND	OSBM
Ann Wolfe	DHHS / DPH
Marilyn Asay	DHHS / DPH
[illegible] Reynolds	NC Gov's Institute on Alcohol + SLF
[illegible]	State Budget

Joint Approp-
iations Subcommittee on
human resource

VISITOR REGISTRATION SHEET

Name of Committee

May 24, 2000

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Becky Street	PPAB
Cal Adams	NCCCA + Head Start Assn.
Sarah Paige	NCACC
Ken Howell	Gov's Office
Adam Searing	NCHAC
Randy E. Cloud	R. Cloud & Assoc.
Emily Meeker	Intern

Joint Health and Human Services Appropriations Sub-Committee

May 25, 2000
8:30 AM
Legislative Office Building Rm# 643

----- Agenda Topics -----

Opening Remarks	Senator Bill Martin Representative Edd Nye Representative Beverly Earle
Maternal and Child Health Block Grant Preventive Health Services Block Grant	Ann Wolfe, Director Division of Public Health
Mental Health Block Grant	Don Willis, Director Adult Community Mental Health Programs
Substance Abuse Prevention and Treatment Block Grant	Flo Stein, Chief Substance Abuse Services
School Based Mental Health and Substance Abuse Services	Don Stedman, Professor UNC-CH

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

MINUTES
MAY 25, 2000

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met on Thursday, May 25, 2000 at 8:30 am in Room 643, of the Legislative Office Building.

The meeting was opened by Co-Chair, Representative Edd Nye, by introducing the Pages, and Representative Beverly Earle concluded the meeting. Other House members present were:

Representative Beverly Earle, Co-Chair
Representative Martha Alexander, Vice Chair
Representative Theresa Esposito
Representative Alma Adams
Representative Lanier Cansler
Representative Trudi Walend
Representative Gene Wilson

There were four Senate members present.

The meeting begin with a presentation by Dr. Don Stedman, Professor at UNC-Chapel Hill. Dr. Stedman spoke on "**School Based Mental Health and Substance Abuse Services**". (See Attachment 2) He gave background of various studies performed to indicate the between 3% and 10% of children and adolescents experience mental health or substance related problems serious enough to warrant evaluation and treatment by mental health or substance abuse professionals.

He spoke of a new program called Creating Health Alternatives Targeting Schools (CHATS). He gave all the objective of the project. (See Attachment 2)

Dr. Stedman concluded by presenting information on the Mental Health Services in Schools, and gave all locations of all North Carolina School-Based Health Centers. (See Attachment 2)

The members asked questions, and concerns were answered by Dr. Stedman.

The second presenter was Ann Wolfe, Director of the Division of Public Health. Ms. Wolfe, gave a brief presentation on **Maternal and Child Health Block Grant and Preventive Health Services Block Grant.** (See Attachment 3) She stated that the purpose of the Maternal and Child Health Block Grant is to assist states in assuring that mothers and children, particularly those with low income or limited availability to health services, have access to quality maternal and child health services. The purpose of the Preventive Health Services Block Grant is to provide support for services with reduce preventable injury, illness and early death and which improve the quality of life for the residents of North Carolina for a better quality of health. (See Attachment 4)

Don Williams, Director of Adult Community Mental Health Programs spoke on Mental Health, Developmental Disabilities and Substance Abuse Services Block Grant. He stated that this Block Grant provides federal financial assistance to states for the provision of community based services for people with mental illness. He presented the Federal requirements related to the Mental Health Block Grant. (See Attachment 5)

Flo Stein, Chief of Substance Abuse Services presented information about the **Substance Abuse Prevention and Treatment Block Grant.** (See Attachment 6) The Block Grant for Substance Abuse Prevention and Treatment was organized in 1992, when it was split from the Alcohol, Drug, and Mental Health Services Block Grant. He gave the six Federal requirements to utilize the Block Grant. He concludes by giving the proposed expenditure plan. (See Attachment 6, Page 2)

As time permitted, the Chairs granted permission to Ms Gale Taylor from Statesville, North Carolina to speak briefly on Independent Living. She stated how grateful she was with Independent Living, and asked the committee for recurring money in the budget. Ms Taylor spoke about the services she receives through Independent Living. She concluded by thanking the committee for allowing her to speak.

Representative Beverly Earle gave closing remarking by thanking everyone for coming. The meeting was adjourned.

Respectfully submitted,

Beverly Earle

Presiding Co-Chair, Representative Beverly Earle
Representative Edd Nye

Ann Raeford

Ann Raeford, Committee Assistant

Agenda	Attachment 1
School Based Mental Health And Substance Abuse Services	Attachment 2
Maternal and Child Health Block Grant	Attachment 3
Preventive Health Services Block Grant	Attachment 4
Mental Health Block Grant	Attachment 5
Substance Abuse Prevention and Treatment Block Grant	Attachment 6
Visitor's Registration	Attachment 7

Mental Health, Substance Abuse and Primary Health Care in Schools

Creating Health Alternatives Targeting Schools "CHATS"

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services, the Division of Public Health in the Department of Health and Human Services and the Department of Public Instruction plan to release a Request for Proposal for funding for mental health, substance abuse and primary health care services in schools. Year one (FY 2001) of the project will fund 24 centers and up to 24 planning grants. Year two (FY 2002) of the project will fund up to 48 centers.

Background:
Various studies indicate that between 3% and 10% of children and adolescents experience mental health or substance related problems serious enough to warrant evaluation and treatment by mental health or substance abuse professionals. By high school age, up to 25% may have substance-related problems. Left untreated, these problems can grow to the point where the youth suffer academically or even require hospitalization or intervention from the juvenile justice system. Early identification of children in need of mental health, substance abuse and other health related services can most effectively be achieved in their natural environment, public schools. Historical efforts to provide such services in other environments have been fragmented and segregated and have not provided a comprehensive, integrated model to serve children and adolescents.

Creating Health Alternatives Targeting Schools (CHATS) Project, is a collaborative initiative of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the Division of Public Health within the Department of Health and Human Services and The Department of Public Instruction. The project is offering funding up to $140,000 a year to enhance existing school-based or school linked-health centers or other mental health/substance abuse projects in order to meet the "CHATS" project objectives. The purpose of the "CHATS Project" is to provide funding for enhancing existing centers, projects, programs, or initiatives so that they can evolve into inclusive, multidisciplinary, demonstration model centers. The existing programs could be school-based or school-linked health centers in need of expanded mental health or substance abuse services/staff or school-based or school-linked mental health or substance abuse programs in need of primary health care services/staff. The objectives of the project include:

- Provide children and adolescent services through a comprehensive, integrated model of health care delivery in the school setting;
- Improve access to mental health, substance abuse and primary health care to children and adolescents;
- Provide educators immediate access to health care professionals who may assist in the designing and identification of interventions, modifications and strategies available to assist in successful educational experiences for children and adolescents in need,
- Demonstrate through the center's operation the ability of this model to be sustained financially and replicated in other school settings.
- Identify project models for demonstration and replication in elementary, middle and high school settings throughout North Carolina.
- Provide education, support and training for parents.

I. Implementation Grants

Funding up to $140,000 a year for five years is available to enhance existing school-based or school-linked centers or other school-based service delivery models by adding mental health and substance abuse professionals to other required core team members in the school environment. Local schools will be expected to fund (minimum of $20,000) an Educational Specialist through funds already available to the local schools. The model must include the following staff: mental health professional, substance abuse professional, registered nurse, nurse practitioner or physician assistant, educational specialist, and an administrator.

Who Can Apply for Funding:

Only public or non-profit institutions or agencies may apply for funding. The application must build upon existing school-based or school-linked health center or school-based or school-linked mental health or substance abuse centers or projects. Agencies must also:
Comply with all items contained in the List of Assurances found in the "Content of Proposal."
Currently meet the definition of or as a result of the funding requests will meet the definition of a comprehensive integrated mental health, substance abuse, and primary health care center as defined in elementary, middle and high school models of the "CHATS Project."

Application Process and Selection Criteria

- Applications for project funds must address the thirteen (13) areas described in the Content of Proposal. (Cover page, List of Assurances, Project Abstract, and the 10 categories (listed below) that will be scored.
- A copy of the RFP may be downloaded from the Division of MH/DD/SAS Internet site. The address is www:dhhs.state.nc.us/dmhddsas. Click Division at Work, Request for Proposals.
- Proposals will be reviewed by a committee consisting of staff from the Department of Health and Human Services, the Division of MH/DD/SAS, the Division of Public Health, the Department of Public Instruction, professionals in mental health, substance abuse, primary health care, and education and families/clients.
- A maximum score any one proposal can achieve is 100. The categories include: Organizational Structure, Service Delivery, Staffing, Description of Project or Expansion, Center Goals and Objectives, Center Advisory Council/Board or Other Interagency Planning/Advisory Committee, Evidence of Community Support, Description of Demonstration and Replication, Funding Strategies, and Budget.
- Applicants chosen to receive the grants will be notified in August 2000.

II. Planning Grants

Planning grants will be described at the Regional Preapplication workshops. The planning grants will provide funds for communities that do not currently have sufficient organization or resources to compete in the Implementation Grant process.

- Up to $30,000 will be available under a separate RFP.
- Agencies needing to undertake an extensive community/collaborative planning process in order to implement a "CHATS Project" should apply.
- The CHATS Planning Grant RFP and application will be available after June 16, 2000
- The due date will be August 1, 2000.
- Applicants chosen to receive the planning grants will be notified in mid August.

The Department of Health and Human Services, specifically Division of MH/DD/SAS and the Division of Public Health will be responsible for oversight of the Centers. A Memorandum of Agreement between the two Divisions will outline the duties and responsibilities of each agency. Examples of the duties include providing technical assistance to the centers, monitoring for quality of services and reviewing compliance to standards and requirements associated with funding sources. A joint advisory committee consisting of staff from DHHS, DMH/DD/SAS, DPH, DMA,

DPI and other stakeholders will provide on-going review of the project including review of outcome measures, evaluation results, and other quality assurance activities.

A contract with the University of North Carolina will be initiated July 1, 2000 to assist in the start-up activities of the project and the conceptual oversight. Dr. Don Stedman, Professor of Education at UNC-CH will chair the Joint Advisory Committee.

Each center will be expected to generate third party revenues as a means to become self-sufficient. In addition, one of the goals of the centers is to demonstrate ability to be replicated in other school setting and to be financial viable. Examples of third party revenues include billing Medicaid, Health Choice, private insurance, private pay, etc. These revenues will not be realized during the first 6 to 9 months of operation due to the need to build capacity of billing and establish the required infrastructure and certifications.

MENTAL HEALTH SERVICES IN SCHOOLS

What are the advantages for mental health service delivery in schools?

- Easy access to services
- Eliminates uneasiness of going to a Mental Health Center
- Immediate problem solving ideas and symptom relief
- Most emergency/crisis situations can be handled at the school
- Increased family involvement
- Focus on prevention and early intervention

What kinds of services would a mental health professional deliver in school?

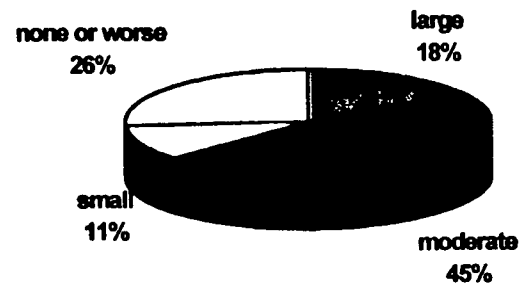
- **Direct services** (screenings, evaluations, assessments, prevention and early intervention activities, individual and group treatment such as anger management and substance abuse treatment, crisis intervention, advocacy)
- **Consultations** (for children, teachers and other school personnel)
- **Training** (mental health promotion and substance abuse prevention skills among school personnel, classroom behavior management, skills in working with parents and other community members)

What are some outcomes of specific programs where mental health services were provided at school?

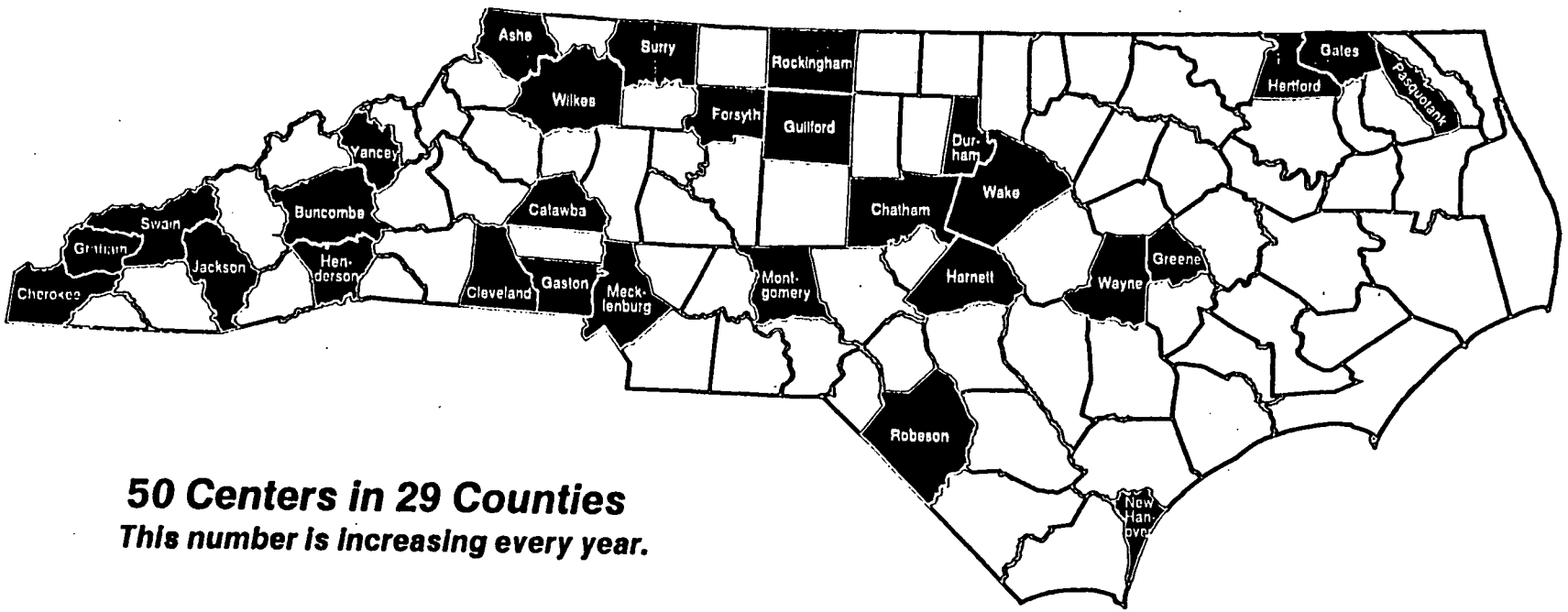
- Increased school attendance and higher grades, decreased alcohol use and sexual activity (at-risk children through New Jersey School Clinics)
- Reduced rate of state hospitalizations and group home placements, improved school attendance (at-risk school children in Ventura, CA)
- 50% reduction in physical aggression at school and overall violence (high-risk African American adolescents)
- Decreased entry into more restrictive, higher cost services, including adult and juvenile justice services; prevented younger siblings from entering the system (adolescents with severe conduct disorder)

Adelman, H. and Taylor, L. (1999). A Sampling of Outcome Findings from Interventions Relevant to Addressing Barriers to Learning. School Mental Health Project, Dept. of Psychology, UCLA.

Improvement in ADHD Symptoms after One Year (School-based Program for Children with ADHD)



Making the Grade in North Carolina Is Making a Difference



50 Centers in 29 Counties

This number is increasing every year.

Centers Bring Good Health Care to Young People

#2

EXP = Expected Growth
EXM = Exemplary
EXC = Sch of Excellence
DST = Sch of Distinction

MI = Most Improved

NORTH CAROLINA SCHOOL-BASED HEALTH CENTERS

County	Health Center(s)		Medical Sponsor
Ashe	Northwest High School	EXM	Appalachian District Health Department
Buncombe	Asheville High School	EXM	Buncombe County Health Department
Buncombe	Asheville Middle School	EXP	Mission St. Joseph's Health System
Catawba	Catawba Valley High School	–	Catawba County Health Department
Chatham	Horton Middle School	EXM	Chatham County Health Department
Cherokee	Hiwassee Dam Union School	EXM	Cherokee County Health Department
	Ranger Elementary School	EXM DIST MI	
Cleveland	Shelby Middle School	EXP	Cleveland County Health Department
	Shelby High School	EXP	
	Kings Mountain Middle School	EXM DIST	
	Kings Mountain High School	EXM	
	Burns High School	EXM	
	Crest High School	EXM	
Cleveland	Crest Middle School	EXM	Cleveland Regional Medical Center
Durham	George Watts Elementary School Wellness Center	LP	Duke University School of Nursing
	Southern High School Wellness Center	EXM	
Durham	Hillside High School Wellness Center	EXM	Lincoln Community Health Center
Durham	NC School of Math and Science	–	Lakewood Family Practice/Scott Medical Center
Eastern Band of Cherokee Indians	Cherokee Elementary School	–	Cherokee Health Delivery
Forsyth	Independence High School (AS)	(AS)	Wake Forest University Baptist Medical Center
	Mineral Springs Middle School	EXP	
Gates	Gates County High School	EXM	Gates County Medical Center
Graham	Robbinsville Middle School	EXM DIST	Graham County Health Department
Greene	Greene Central High School (N.R.)	–	Greene County Health Care, Inc.
Guilford	Grimsley High School	EXM	Guilford School Health Alliance
	High Point Central	EXM	

County (continued)	Health Center(s) (continued)		Medical Sponsor (continued)
Harnett	Dunn Middle School	Exm	Harnett County Health Department
	Harnett Primary School	(NR)	
	Wayne Avenue Elementary School	Exm	
Henderson	Apple Valley Middle School	Exm DIST	Blue Ridge Community Health Services, Inc.
Hertford	Hertford County Middle School	Exm	Roanoke-Chowan Hospital
Jackson	Fairview School	Exm DIST	WestCare Health Systems
Montgomery/Moore	East Middle School	Exp	FirstHealth of the Carolinas
New Hanover	Lakeside High School (AS)		Wilmington Health Access for Teens, Inc.
Pasquotank	Northeastern High School	Exp	Albemarle District Health Department
	Elizabeth City Middle School	(NR)	
Robeson	Purnell Swett High School	Exm	Robeson County Health Department
Rockingham	McMichael High School	Exm	Morehead Memorial Hospital
	Morehead High School	Exm	
	Reidsville High School	Exm	
	Rockingham County High School	Exm	
Surry	Gentry Middle School	Exm DIST	Surry County Health Department
Swain	Swain County Middle School	Exm DIST	Swain Medical Center
Wayne	Brogden Middle School	(NR)	Wayne Initiative for School Health (WISH), Inc.
	Goldsboro Middle School	Exp	

Exp = 7 (19%) Exm = 21 (57%) DIST = 7 (19%) MI = 1 (25) LP = 1 / AS = 2 NR = 4 – = unlisted

N = 37

NORTH CAROLINA SCHOOL-LINKED HEALTH CENTERS

County	Health Center	Medical Sponsor
Eastern Band of Cherokee Indians	Cherokee Teen Center	Cherokee Health Delivery
Gaston	Advocates for Healthy Citizens, Inc.	Private Family Physician
Mecklenburg	Presbyterian TeenCare	Presbyterian TeenCare/NovantHealth
Mecklenburg	Teen Health Connection	Carolinas HealthCare System
New Hanover	Wilmington Health Access for Teens (WHAT)	Wilmington Health Access for Teens, Inc.
Wake	Wake Teen Medical Services	WakeMed

(1/2000-DS)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH
MATERNAL AND CHILD HEALTH BLOCK GRANT

Maternal and Child Health Block Grant Funding for State Fiscal Year 2000-01 is projected at $16,928,823. This represents $144,793 more than the amount available in Fiscal Year 1999-00.

GENERAL DESCRIPTION

The purpose of the Maternal and Child Health Block Grant is to assist states in assuring that mothers and children, particularly those with low income or limited availability to health services, have access to quality maternal and child health services. These services are aimed at (1) reducing maternal and infant mortality; (2) reducing the incidence of preventable disease and disabling conditions among children; (3) promoting the health of mothers and children; and (4) maximizing the health status of children with disabilities. The MCH Block Grant consolidated five programs for which the state received categorical funding. The five programs were (1) Maternal and Child Health, (2) Children's Special Health Services, (3) Supplemental Security Income for Disabled Children, (4) Sudden Infant Death Syndrome, and (5) Lead Based Paint Poisoning Prevention.

RECOMMENDATIONS	ALLOCATIONS
1. Allocate $9,838,074 in Healthy Mothers/Healthy Children Block Grants to local health departments. The proposed allocation is equal to the amount allocated in FY 1999-00. Under this funding concept, local health departments have responsibility for deciding how to use maternal and child health funds to best meet local needs. County and district health departments may use Healthy Mothers/Healthy Children Block Grants to provide prenatal care, preventive and primary care services for children and preventive health services for women of childbearing age. None of the proposed Healthy Mothers/Healthy Children Block Grant allocation is used for state administrative costs.	**$9,838,074**
2. Allocate $2,012,102 for technical assistance to local health departments, high-risk maternity clinics, perinatal education and training, public information and education, and childhood injury prevention. The proposed allocation is $101,355 greater than the amount allocated in FY 1999-00. The Department proposes to use the additional funds to support replication of best practices to address poor health outcomes, particularly among minority populations. Funds will be awarded to local entities to demonstrate effective interventions to reduce infant mortality, improve dental health, and reduce morbidity and mortality among children. From the funds available, the Department proposes to use approximately $120,000 for state administrative costs. This amount includes the salary and fringe benefits of business office and computer support	**$2,012,102**

staff within the Division of Public Health, and associated indirect cost charges.

3. Allocate $5,078,647 for services to children with chronic illnesses, genetic disorders, or developmental disabilities. This also includes the identification, follow up and testing of infants and young children at risk for developmental delays. The proposed allocation is $43,438 more than the amount allocated in FY 1999-00. From the funds allocated, the Department proposes to use approximately $135,000 for state administrative costs. This amount represents indirect cost charges.	**$5,078,647**
TOTAL FUNDS AVAILABLE – SFY 2000-01	**$16,928,823**
SOURCE OF FUNDS:MCH BLOCK GRANT FEDERAL FY 2000	**$4,232,206**
MCH BLOCK GRANT FEDERAL FY 2001	**$12,696,617**

DIVISION OF PUBLIC HEALTH

Analysis of Maternal and Child Health Block Grant

SFY 2000-01

Item Number	Title	Actual SFY 98-99	Appropriated SFY 99 00 (HB 168)	Recommended Amount SFY 00-01	Appropriated Recommended Difference	Explanation of Difference
1	Healthy Mothers/ Healthy Children Block Grants to Local Health Departments	$10,023,671	$9,838,074	$9,838,074	$0	N/A
2	High Risk Clinics, Perinatal Education and Training, Public Information and Education, Injury Prevention, and Technical Assistance to Local Health Departments	$1,910,747	$1,910,747	$2,012,102	$101,355	The Department is requesting approval to budget the additional funds to support replication of best practices to address poor health outcomes, particularly among minority populations.
3	Services for Chronically Ill and Developmentally Delayed Children	$5,035,209	$5,035,209	$5,078,647	$43,438	Title V of the Social Security Act requires states to expend 30% of their MCH Block Grant allocation on services for children with special health care needs. This increase will ensure North Carolina meets the statutory requirements.
	TOTAL	$16,969,627	$16,784,030	$16,928,823	$144,793	

Department of Health and Human Services
Division of Public Health

Preventive Health Services Block Grant
Fiscal Year 2000-2001 Plan

GENERAL DESCRIPTION

The Preventive Health Services Block Grant (PHSBG) is a formula-based grant from the Centers for Disease Control and Prevention that provides support for services which reduce preventable injury, illness and early death and which improve the quality of life of North Carolina's residents through better health.

The PHSBG Plan assumes that federal financial assistance for Federal Fiscal Years (FFY) 2000 will be $4,915,129. This is the same level of funding as available in Federal Fiscal Year 1999-00. The FFY 1999-00 award was reduced by $403,263 from the level of funding in FFY 1998-99.

The State of North Carolina plans to budget this grant in the State Fiscal Year beginning July 1, 2000 as follows:

FFY 99-00 Preventive Health Services Block Grant	$1,228,782
FFY 00-01 Preventive Health Services Block Grant	$3,686,347
Transfers from Social Services Block Grant	$ 280,067
TOTAL SFY 2000-01 FUNDS	$5,195,196

The PHSBG award is divided into 3 components:

1. **The Sexual Assault/Rape Victims Services Program** has an estimated funding level of $190,134 and is set at the federal level consistent with a set aside provision in the PHSBG legislation.

2. **The Rape Prevention and Education Program** which is authorized under the Violence Against Women Act (Crime Bill) which amended the PHSBG authorizing legislation in 1996. The funding level for this component of the plan is estimated at $1,137,186.

3. **The Basic Award**, which provides funding for the following programs, covers the balance of the award, and is estimated to be funded at $3,587,809. This part of the award funds the Statewide Health Promotion Program of the Health Promotion Branch of the Division of Public Health, the Community Fluoridation Program of the Dental Health Section of the Division of Public Health, and staff support for the Minority Health Council. The basic award also includes an administrative cost of $143,151, which supports 1.17 FTE administrative positions and operating costs. The $143,151 includes the salary and fringe benefits for the 1.17 positions (i.e., a Computing Systems Coordinator and a portion of a Public Health Manager position who administers the grant) that provide support for the programs and staff that carry out the grant-supported programs.

The PHSBG state plan also includes transfers from the Social Services Block Grants to support two programs. The plan assumes the transfer amount from the SSBG will be $280,067. Of the SSBG transfer, $213,128 will provide support for the Division of Facility Services, Emergency Medical Services program and $ 66,939 will be used to support HIV/AIDS Education, Testing, and Counseling Services through the Division of Epidemiology.

Plans for each component proposed to receive Preventive Health Services Block Grant funding are described in the following sections.

Preventive Health Services Block Grant Program Plan, State Fiscal Year 2000-2001

Program Title: Rape Crisis/Victims Services Program

Healthy People 2000 Health Status Objective 7.7 is to reduce rape and attempted rape of women aged 12 and older to no more than 108 per 100,000 women. (Baseline: 120 per 100,000 in 1986)

Health Problem Addressed: Rape and sexual assault are widespread problems that primarily affect women. Approximately one in eight women have been raped at least once, and nearly six in 10 women have been victims of sexual assault. Perpetrators are mostly male, and about 85% are known by the victim. The risk is highest among adolescents and young adults. Preliminary North Carolina data indicates that the problem is widespread in this state. In a study of women enrolled in the N.C. Community College System, 17 percent reported being raped, and 4 percent reported being victims of attempted rape at least once since the age of 14. In the 1997 Behavioral Risk Factor Survey (BRFS), 13.5 percent of adult women reported being raped at least once in their lifetime. Rape and sexual assaults are crimes.

Program Description: Funds allocated to this program will be provided to the Department of Administration, Council for Women to contract with community-based organizations to provide services.

Activity Objectives:

1. Provide funds to local rape crisis centers for rape crisis response services, including crisis counseling and operating hotlines.
2. Assist 5,000 victims of rape and sexual assault to return to work sooner.
3. Provide rape crisis response, self-defense and educational programs to 6,000 victims.
4. Provide community education programs to reach 90,000 people.

Funding: **$190,134**

FTE Positions: **0**

Preventive Health Services Block Grant Program Plan, State Fiscal Year 2000-2001

Program Title: Rape Prevention and Education Program

Healthy People 2000 Health Status Objective 7.7 is to reduce rape and attempted rape of women aged 12 and older to no more than 108 per 100,000 women. (Baseline: 120 per 100,000 in 1986)

Health Problem Addressed: Rape and sexual assault are widespread problems that primarily affect women. Approximately one in eight women have been raped at least once, and nearly six in 10 women have been victims of sexual assault. Perpetrators are mostly male, and about 85% are known by the victim. The risk is highest among adolescents and young adults. Preliminary North Carolina data indicates that the problem is widespread in this state. In a study of women enrolled in the N.C. Community College System, 17 percent reported being raped, and 4 percent reported being victims of attempted rape at least once since the age of 14. In the 1997 Behavioral Risk Factor Survey (BRFS), 13.5 percent of adult women reported being raped at least once in their lifetime. Rape and sexual assaults are crimes.

Program Description: A portion of the funds allocated to this program will be provided to the Department of Administration, Council for Women to contract with community-based organizations to provide services. A portion will be used by the Division of Public Health to work with the public health community to support prevention activities, including one position to work with the local agencies.

Activity Objectives:

1. Conduct strategic planning with the Council for Women, N.C. Coalition Against Sexual Assault (NC CASA) and the N.C. Department of Health and Human Services, including assessing rape prevention education activities and staff resources.
2. Assist local rape crisis centers in designing and carrying out collaborative projects.
3. Develop standardized surveys for use in local programs.
4. Carry out campus rape prevention projects, which will establish regional campus rape prevention consortia, assess the state of rape prevention on college campuses, obtain the support of the UNC Board of Trustees and Board of Governors, provide training to colleges for comprehensive rape prevention programs, develop male-oriented campus rape prevention programs.
5. Set up at least two training programs for local rape prevention educators on one or more of following areas: "best practice" in rape prevention; tailoring rape prevention for different audiences; program evaluation; marketing and media relations; involving males in rape prevention. Develop guidelines for comprehensive rape prevention programming.
6. Provide training and tools to rape prevention professionals for working with different ethnic groups and minority communities, including training in culturally-appropriate outreach skills; providing access to culturally appropriate materials; coordinating services and training for professionals who serve special populations.

7. Provide training for community professionals, including law enforcement, health-care, district attorneys and school personnel. Provide regional Sexual Assault Nurse Examiner (SANE) training and increase the number of Sexual Assault Response Team (SART) programs in the state.
8. Help establish 10 new or expanded rape crisis and rape prevention programs in counties without them; provide incentives for new or expanded rape prevention programs and identify additional resources for establishing new rape crisis centers.
9. Establish a rape prevention resource clearinghouse and annotated guide of recommended rape prevention curricula and materials and public awareness campaign materials.
10. Begin development of a rape and sexual assault data collection system: activities to include hiring an epidemiologist; establishing consistent definitions; analyzing current data sources; developing a data collection plan; improving Council for Women reporting procedures.
11. Provide funds to local rape crisis centers for rape prevention education activities for adolescents in schools and other settings.
12. Carry out statewide social marketing programs aimed at adolescent males: current activities include formative research on adolescents and selecting and testing messages.
13. With the endorsement of the North Carolina Department of Public Instruction and local school boards, select, adapt or adopt and distribute curricula for middle schools and high schools. Provide training to health teachers to use the curricula.

Funding: **$ 1,137,186**

FTE Positions: **2.0**

Preventive Health Services Block Grant Program Plan, State Fiscal Year 2000-2001

Program Title: Statewide Health Promotion Program

Healthy People 2000 Health Status Objective 15.1 is to reduce coronary heart disease deaths to no more than 100 per 100,000 people.

Health Problem Addressed: Heart disease and stroke are the first and third leading causes of death, killing 19,265 and 5,220 North Carolinians, respectively in 1997. Risk factors are multiple. Cardiovascular disease is preventable when individuals and communities work together to reduce the major risk factors for these diseases, such as smoking, hypertension, obesity, sedentarianism, dyslipidemia, and uncontrolled diabetes.

Program Description: Funds are allocated to local health departments in each county through the state public health consolidated contract to carry out preventive health services for the target population. In addition, health departments engage in a variety of community based activities focusing on the major cardiovascular risk factors. Some funds are allocated in the Division of Public Health for program support staff and operations, including positions for the Statewide Health Promotion Program, the Older Adult Health Promotion Program, and Local Health Services.

Activity Objectives:

1. Through contractual agreements, continue funding to 87 local health departments to support the delivery of effective community based, multilevel interventions directed at population based strategies which create physical and social environments that promote good cardiovascular health.

2. Provide training and consultation to local health departments and through state/local partnering ensure that all local health departments develop a long range health promotion plan.

3. Integrate activities of the State Wide Health Promotion Program with the Statewide Cardiovascular Health Initiative, Start With Your Heart and Be Active North Carolina.

4. Refine reporting, evaluation and surveillance systems to include community level indicators and improved measurements for collection of process, impact, and outcome data.

Funding: **$3,184,399**

FTE Positions: **7.96**

Preventive Health Services Block Grant Program Plan, State Fiscal Year 2000-2001

Program Title: Preventive Dental Services/Fluoridation

Healthy People 2000 Health Status Objective 13.1 is to reduce dental caries so that the proportion of children with one or more caries in permanent teeth is no more than 35% among children aged 6-8 and no more than 60% among adolescents aged 15.

Health Problem Addressed: Dental disease is widespread in children and is a leading cause of absenteeism as well as pain and disability among adults and older people. Most dental problems can be prevented by relatively simple, inexpensive services for children and young people. In 1997-1998 in North Carolina, at least one out of four fifth grade children had a history of dental disease and about 5,000 fifth grade children had obvious untreated caries.

Program Description: Funds are allocated to the Dental Health Section to assist towns and schools to provide technical assistance and train local personnel in the development of fluoridated water systems, and to support basic preventive dental activities.

Activity Objectives:

1. Provide grants to 2 communities to maintain or increase the number of citizens receiving the decay-reducing benefits of systemic fluoride.
2. Defray the cost of providing sodium fluoride rinse for 225,000 schoolchildren.
3. Defray the cost of the annual surveillance technique used to gather data on 85,000 fifth grade children.
4. Defray the costs of providing analysis on the fluoride levels in community water systems and home wells for 12,000 water samples.
5. Defray the cost of 12 educational/promotional exhibits on preventive topics such as fluorides and sealants for statewide use with an estimated 5,000 health professionals, educators and the general public.

Funding: **$ 100,800**

FTE Positions: **0**

Preventive Health Services Block Grant Program Plan, State Fiscal Year 2000-2001

Program Title: Office of Minority Health

Healthy People 2000 Health Status Objectives: Many of the health objectives for the nation address disparities between minorities and non-minorities in terms of adverse conditions and outcomes, and have established targets for improvement which reflect these disparities.

Health Problem Addressed: The Office of Minority Health does not focus its efforts on a single health problem; however it has recognized that for a number of conditions and risk factors, persons from various minority groups suffer from both acute and chronic health problems to a greater degree than non-minorities.

Program Description: Funds are allocated to the Office of Minority Health to work with the state and local public health system, university and research centers, human services agencies, community groups and organizations with a special focus on minority community based health interventions. Positions supported with these funds include the Director and Assistant Director of the Office, and a clerical employee.

Activity Objectives:

1. Promote state level and statewide coordination and collaboration of information, resources and services.
2. Disseminate the needs assessment reports focusing on three minority groups, Blacks, Native American and Hispanics.
3. Make recommendations for improving the delivery of and access to health services to the Minority Health Advisory council, public health system and community groups.
4. Disseminate minority health information via channels such as media interviews, fact sheets, public services announcements, forums, conferences, and reports.
5. Provide technical assistance to agencies and groups on effective strategies for reaching and serving minorities, potential funding sources and improving grant writing skills.
6. Work with groups and agencies to improve methods for collecting and reporting minority health data and to establish and implement a surveillance system to measure progress towards improving the health status of minorities.
7. Work with groups and agencies to provide cultural diversity training for providers and administrators and to work with groups and agencies to increase the availability of culturally-based and linguistically-appropriate programs and services.

Funding: **$ 159,459**

FTE Positions: **2.93**

Transfers from Social Service Block Grant

1. Division of Facilities Services/Emergency Medical Services

Program Description

Each year, funds from Social Services Block Grant (SSBG) are transferred to the Preventive Health Services Block Grant for distribution to the Office of Emergency Medical Services (OEMS) in the Division of Facility Services (DFS). In SFY 1999, this amount was $213,128 for the fiscal year. For FY 2000, the anticipated transfer is also $213,128. As in the past, the funds will be used by the OEMS in DFS to support federally funded staff positions, the statewide Ambulance Call Reporting (ACR) system and the statewide Trauma Registry. A total of five full time clerical positions in the Division of Facility Services are funded using SSBG money. Salaries and fringe benefits for these positions total $131,709 for SFY 1999. Two of these positions in DFS are data entry clerks for the Ambulance Call Reporting (ACR) system. One is a secretary for communications and public education components, one is the primary secretary for the EMSC grant as well as back-up receptionist, and one is the secretary for the Eastern Regional Office in Greenville.

The remainder of SSBG funds in the Division of Facility Services is used, along with state funds, to support the ACR system through printing of forms, and processing of data and to support the contract for the Central Data Collection Agency for the Trauma Registry. Approximately, $73,000 is used each year to support the Trauma Registry and the remaining $8,419 is used for printing ACR forms or upgrading ACR software, both of which are provided free of charge to EMS agencies using the ACR system.

Budget Summary

Clerical Staff Positions (5 FTE) in the Division of Facility Services	131,709
Ambulance Call Report System (printing ACR Forms/software)/DFS	8,419
Central Data Collection Agency for Trauma Registry/DFS	73,000
TOTAL – Division of Facility Services	**$213,128**

FTE Positions: 5.0

2. Division of Public Health/HIV Prevention

Program Description

This transfer will allocate funds to local health departments to support personnel and programs for HIV/AIDS education, counseling, and testing. The local health departments emphasize AIDS education and testing efforts targeted at persons at highest risk to ensure that these efforts are maximally effective in controlling the epidemic.

TOTAL **$66,939**

FTE Positions: 0

Preventive Health Services Block Grant Program Plan, State Fiscal Year 2000-2001

Summary of Funding Plan

Program		Allocation
A. Preventive Health Services Block Grant funds		
1. Statewide Health Promotion Program Division of Public Health		**$3,184,399**
2. Community Fluoridation Program Division of Public Health		**$ 100,800**
3. Rape Crisis/Victims Services Program Council for Women		**$ 190,134**
4. Rape Prevention and Education Program Division of Public Health and Council for Women		**$ 1,137,186**
5. Office of Minority Health Division of Public Health		**$ 159,459**
6. Administrative Costs		**$ 143,151**
Subtotal	**$ 4,915,129**	
B. Transfers from Social Services Block Grant		
1. HIV/AIDS		**$ 66,939**
2. Emergency Medical Services		**$ 213,128**
Subtotal	**$ 280,067**	
TOTAL FOR FFY 2000-2001		**$5,195,196**

DIVISION OF PUBLIC HEALTH
Analysis of Preventive Health Block Grant
SFY 2000-2001

Item Number	Title	Actual SFY 99-00	Appropriated SFY 99-00 (HB 168)	Recommended Amount SFY 00-01	Appropriated/ Recommended Difference	Explanation of Difference
A. Preventive Health Services Block Grant Funds						
1	Statewide Health Promotion Programs	$2,965,404	$3,364,469	$3,184,399	($180,070)	Decrease in FFY 99-00 award; level funding for FFY 00-01
2	Preventive Dental Services/Fluoridation	$100,801	$216,123	$100,800	($115,323)	Decrease in FFY 99-00 award; level funding for FFY 00-01
3	Rape Crisis/Victims Services Program	$226,260	$190,134	$190,134	$0	N/A
4	Rape Prevention and Education Program	$1,579,361	$1,159,292	$1,137,186	($22,106)	Decrease in FFY 99-00 award; level funding for FFY 00-01
5	Office of Minority Health	$162,589	$179,784	$159,459	($20,325)	Decrease in FFY 99-00 award; level funding for FFY 00-01
6	Administration	$208,542	$209,914	$143,151	($66,763)	Decrease in FFY 99-00 award; level funding for FFY 00-01
	Total - Preventive Health Services Block Grant Funds	$5,242,957	$5,319,716	$4,915,129	($404,587)	
B. Transfers from Social Services Block Grant (SSBG)						
7	Division of Facility Services/Emergency Medical Services	$213,128	$213,128	$213,128	$0	N/A
8	Division of Public Health - AIDS/HIV Education, Counseling, and Testing Services	$66,939	$66,939	$66,939	$0	N/A
	Total - Social Services Block Grant Funds	$280,067	$280,067	$280,067	$0	
	TOTAL	$5,523,024	$5,599,783	$5,195,196	($404,587)	

Department of Health and Human Services
Division of Mental Health, Developmental Disabilities
And Substance Abuse Services
(MHBG SFY 2001)

FUNDING LEVEL

Federal funding available to North Carolina is $8,483,792 for FFY 00 and an estimated amount of $8,483,792 for FFY 01. The proposed MHBG plan utilizes the remaining FFY 00 amount of $4,794,451 plus $3,689,341 from the anticipated FFY 01 award.

GENERAL DESCRIPTION

The MHBG provides federal financial assistance to states for the provision of community-based services for people with mental illness. Services provided through the use of the block grant must be those described in the State's Plan in accordance with Federal P.L. 102-321. These services include outpatient, day treatment, psychosocial rehabilitation, emergency services, residential services, etc. for adults and children. The funds may also be used for evaluating programs and services carried out under the plan and planning, administration, and educational activities related to providing services under the State Plan.

SIGNIFICANT FEDERAL REQUIREMENTS

The primary Federal requirements related to the MHBG are that funds must be used as specified within the States' Plan for Comprehensive Community Mental Health Services in accordance with P.L. 102-321 including community based services for adults with serious mental illness and children with serious emotional disturbance; for planningand, evaluating programs and services carried out under the plan; for educational activities related to providing services under the plan; and for administration.

The State must maintain the level of State funds expenditures for mental health services at a level not less than the average of the preceding two year period and must expend an amount equal to the amount expended by the State for fiscal year, 1994 for a system of services for children.

The State must establish and maintain a State Mental Health Planning Council to advise the State regarding the plan

	PROPOSED MHBG PLAN for SFY 01	ALLOCATION
I.	**Adult Mental Health Plan**	
	Allocate funds to local programs to provide community-based services for adults with severe and persistent mental illness in accordance with the NC Community Mental Health Services Plan and Block Grant Application. Community-based programs provide an array of services, including crisis stabilization designed to divert individuals from institutional admission; liaison and case management services which facilitate the discharge of individuals from the state's psychiatric hospitals; special programs for the hearing impaired; and training activities.	$4,301,361
II	**Child Mental Health Plan**	
	Continuation of Child Mental Health services in accordance with the NC Community Mental Health Services Plan and Block Grant Application such as programs for mental health services in schools, adolescent sex offenders, respite services, family preservation programs, group homes, specialized foster care, therapeutic homes, professional parenting programs, training, and special initiatives to develop systems of care for serving children with serious emotional disturbance and their families.	$3,398,520
III	**Administration**	
	Applicable to the 5% Administrative Cap (Monitoring, Data Collection, Budgeting, Payments, and Accounting	$315,302
	Not Applicable to the 5 % Administrative Cap (Contracts for non-administrative activities and technical assistance to service providers	$468,609
	TOTAL REQUIREMENTS	$8,483,792
	Source of Funds	
	MHBG FFY 00	$4,794,451
	MHBG FFY 01	$3,689,341
	TOTAL FUNDS	$8,483,792

Item #	Title	Actual SFY 98-99	Appropriated SFY 99-00	Recommended SFY 00-0	Difference	Explanation
1	AMH		$3,895,179	$4,301,361	$406,182	Increase in block grant budgeted for use in SFY 00-01
2	Child MH		$1,913,917	$3,398,520	$1,484,603	Increase in block grant budgeted for use in SFY 00-01
3	Admin		$689,736	$783,912	$94,176	Increase in block grant budgeted for use in SFY 00-01
	TOTAl		$6,498,832	$8,483,792	$1,984,961	

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

Substance Abuse Prevention & Treatment Block Grant (SAPTBG) SFY 2000-2001

FUNDING LEVEL

Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funding available to North Carolina is $33,404,937 for FFY2000 and an amount of $33,680,936 for FFY 2001. The proposed plan utilizes the remaining amount of $25,728,970 from the FFY 2000 award plus $13,126,752 from the FFY 2001 award.

GENERAL DESCRIPTION

The ADAMHA Reorganization Act of 1992 (P.L. 102-321) split the Alcohol, Drug, and Mental Health Services Block Grant (ADMBG) creating the Block Grant for Substance Abuse Prevention & Treatment. The SAPTBG provides federal financial assistance to state for the provision of prevention and treatment of alcohol and drug abuse.

SIGNIFICANT FEDERAL REQUIREMENTS

Federal requirements begun in 1993 continue into 2000-2001:

1. State agrees to utilize not less than 35% of the grant for alcohol and drug respectively.

2. Not less than 20% of the funds are to be set aside for prevention programs for individuals who do not require treatment for substance abuse to reduce the risk for such abuse. Prevention programs will include strategies to discourage the use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such products. The Synar Amendment requires that each state adopt and enforce laws prohibiting sale or distribution of tobacco products to those younger than 18 years of age. Effective October 1, 1994, if the Secretary of HHS determines that a state has failed to comply with the law, the State will lose significant federal funding from the SAPTBG. (Failure to comply with the Synar Amendment could result in a 40% non-compliance penalty amounting to $13,362,000 for FFY 99.) Final rules were published on January 19, 1996 (45 CFR Part 96).

3. The state will spend not less than 10% of grant monies to increase the availability of treatment services for pregnant women and women with dependent children with the provision that prenatal and child care be provided to those women while they are in treatment.

4. Interim services must be provided to those individuals in need of treatment for intravenous substance abuse if they cannot be admitted to treatment within 14 days.

5. The state will require treatment entities receiving funds under the grant to make available tuberculosis services to each individual receiving treatment.

6. States such as North Carolina where the rate of AIDs is 10 or more per 100,000 must spend at least 5% of the total award to provide early intervention services for person with or at risk for HIV/AIDs.

PROPOSED EXPENDITURE PLAN	ALLOCATION
1. **Adult Substance Abuse** Continuation of community and ADATC based alcohol and drug services including prevention, intervention, treatment, rehabilitation, and detoxification. Funding to support intervention and treatment services for offenders who remain in the community. Funds will be used to provide treatment services for offenders with substance abuse problems in community punishment programs. Continue support for group homes for recovering substance abusers. Tuberculosis services will be provided to all program participants. Special services for the deaf will be provided at the ADATC in Greenville, NC, with outpatient services for the deaf established in each region. Programs will be required to screen clients for TB and other infectious diseases. Four (4) additional staff required to provide (1) EAP consultation to businesses hiring Work First	$15,043,841 (4 positions)

participants with alcohol and other drug problems;(2) to implement the Offender Management Program; (3) to assure quality for providers delivering treatment to DWI offenders and (4) development of housing and other 24 hour service.

2. **Child Substance Abuse** $8,516,992
Continue services to children and adolescent including prevention, high-risk intervention and regional residential services. Services will include treatment for children in detention and training schools. Prevention activities will include strategies to discourage use of alcoholic beverages and tobacco products by individuals to whom it is unlawful to sell or distribute such products. Services will be delivered in accordance with the 1993 Mental Health Study Commission Child and Adolescent Alcohol and Other Drug Abuse Plan. Legislative action increased service to young offenders and established a network of services for youth in the juvenile justice system. Plan would place a qualified substance abuse counselor in 25 school based health clinics to provide prevention, early intervention and treatment services.

3. **Women's Substance Abuse** 6,567,532
Continuation of services for pregnant women and women with dependent children. Specialized services will be provided at the ADATCs for women. Continue to develop specialized services for TANF participants whose substance abuse is a barrier to self-sufficiency.

4. **Intravenous (IV) Drug** 5,210,497
Continuation of services to IV drug abusers and others at risk for HIV disease. Special services for IV drug users will be provided at the ADATCs.

5.	**Substance Abuse Focus on Families** Prevention and treatment services will be provided for children who are impacted by parental addiction.	893,811
6.	**Administration** Applicable to 5%Administrative Cap (Planning, Quality Assurance, Development of new treatment and prevention services and training for providers receiving Block Grant funds.)	1,670,246
	Not applicable to 5% Administrative Cap (Statutory requirement to identify those populations, areas, and localities with a need for substance abuse services). Continue the development of a performance management system based on outcomes, support the design of an improved behavioral health system and monitor prescription drug diversion.	952,803
TOTAL REQUIREMENTS		**$38,855,722**
	Source of Funds	
	SAPTBG FFY 2000	25,728,970
	SAPTBG FFY 2001	13,126,752
TOTAL FUNDS		**$38,855,722**

Division of Mental Health Developmental Disabilities Substance Abuse Services
Analysis of Substance Abuse Prevention Treatment Block Grant
SFY 2000-2001

Item Number	Title	Actuall SFY 1998-99	Appropriated SFY 1999-2000 (HB 168)	Recommended Amount SFY 2000-01	Appropriated/ Recommended Difference	Explanation of Difference
1	Adult Substance Abuse	$ 11,502,939	$ 15,350,132	$ 15,043,841	$ (306,291)	Transfer to Child Substance Abuse
2	Child Substance Abuse	$ 6,477,706	$ 7,754,702	$ 8,516,992	$ 762,290	Funds will be used to place Masters level Substance Abuse Counselors in 25 school based health clinics. Selection will be based on Substance Abuse Needs Assessment Studies.
3	Women's Substance Abuse	$ 5,065,766	$ 6,567,532	$ 6,567,532	$ -	
4	Intravenous (IV) Drug	$ 4,843,456	$ 5,390,497	$ 5,210,497	$ (180,000)	Transfer to Child Substance Abuse
5	SSI	$ 1,123,757			$ -	
6	Substance Abuse Focus on Families	$ 893,811	$ 893,811	$ 893,811	$ -	
7	Administration	$ 1,454,812	$ 1,670,246	$ 1,670,246	$ -	
		$ 502,803	$ 952,803	$ 952,803	$ -	
	Total	$ 31,865,050	$ 38,579,723	$ 38,855,722	$ 275,999	

H:/EXCEL/SAPTBG/BGCHART00-01

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS HEALTH AND HUMAN SERVICES

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lily Farel	DHHS
Chris Hoke	DHHS
[illegible]	NCFPC
Deborah Lowen	NCCAA
Charlotte Gardner	Rep
Sara R. Allen	Covenant of NC's Children
Amanda Abrams	"
Barry Kennell	NC Amateur Sports
George Irving	Johnson & Johnson
John Bowdish	Alley Associates
Michael Draine	Merck's Co, Inc
Esthering Davis	Electricities
Patrice Loerler	NCACC
Kevin FitzGerald	NC DHHS - DSS
[illegible]	OSBM
Liz Harris	Winston-Salem Chamber of Commerce
Stacy Flannery	NCHCFA
Jerry Cooper	N.C. Assisted Living Association
Sally Cameron	NC Psychological Assoc
C L Cochran	UCP C2001

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS HEALTH AND HUMAN SERVICES 5/25/00

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BRUTON	DHHS
Jim Edgerton	DHHS
Adelyn Griffin	DHHS
Lenore Bellard	DHHS
ART ROBARGE	DMH/SAS/DD
Charles [illegible]	DMH DDSAS
Tara Larson	DMH/DD/SAS
Dan Willis	DMH " "
Michelle Cotton	DMH/DD/SAS
Ann Wolfe	DHHS/DPH
Adrenne McCarty	DHHS
Martha Lawrance	YAID
Louis Giusto	HMCS
Roslyn Sawitt	NC Child Care Coalition
Kevin Ryan	DHHS/DPH
Gail M. Taylor	Independent Living Spokesperson
Peter Andersen	DHHS/DPH
Jackie Sheppard	DHHS/DFS
Mike Eddinger	DHHS/DFS
Janet Schamyenbach	NC Council
Gina [illegible]	MCPA
Flo Stein	DMH/DD/SAS
Harleen Scott Robbins	DMH/DD/SAS
Jason Reynolds	Gov. Institute
Whitney Ohrig	OSBM
Mary Greene	OSBM
Wayne Williams	OSBM

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 30, 2000
Room 643, LOB

The Joint Appropriations Subcommittee on Human Resources met Tuesday, May 23 at 8:30 a.m. in Room 424, LOB at 8:30 a.m. Sen. Bill Martin, presiding Chair called the meeting to order with four Senate members and all the House members present.

After introduction of the Pages, the Chair stated that the meeting would follow the Agenda (Attachment 1). Kevin Fitzgerald, Director of the Division of Social Services was recognized to review the Temporary Assistance for Needy Families (TANF) Block Grant. His presentation is included as Attachments 1 and 2. He gave a brief background review of the TANF Block Grant and reviewed the differences in budget and explained the difference in the federal funds proposed for Fiscal Year 2001.

During Committee discussion Rep. Adams questioned the organization and focus on the availability of the Domestic Violence Planning Grant to assist mothers. She inquired as to the reason the outreach program is not ongoing.

Kevin Fitzgerald stated that the focus is on the availability of services for mothers or abused spouses and that the most appropriate way to do that is through the county block grant. The community education and the various printed materials in support of the outreach are very important; however, the need is for services available. One of the problem is the documentation of the use of the TANF dollars.

Rep. Walend inquired about the effectiveness of the current screening test for substance abuse. She also inquired about the reduction in out of wedlock babies and requested a list of counties at the 60% level. Peter Leousis responded that North Carolina has experienced slight increase.

Rep. Esposito requested staff to provide the amount of actual dollars applied to the area of domestic violence.

Sen. Dannelly asked for further explanation of the Project Access to Health Care for the uninsured and other areas that are pursuing similar initiatives through other funding sources. He also expressed concern about providing health programs for children. There are complaints from the federal level about the state not drawing down dollars to provide health care for children.

Dr. Bruton stated that there are two different areas. This effort is essentially organizing free or reduced cost care. In a family that is uninsured, the children are generally covered through Medicaid. The parents are not. This is a limited number of people. The Medicaid (outreach) money has not been utilized, primarily because of the federal restrictions. North Carolina has been quite successful in the outreach for Medicaid and

health choice. There are still federal dollars left on the table in health choice. That is the bill presented at this time to increase eligibility to utilize all the federal dollars. The children are already covered and this service is primarily for uninsured adults.

Sen. Martin stated that it is his understanding that there are projects similar to what is going on in Buncombe throughout the state that are funded from other sources. He asked why that process cannot be utilized as opposed to TANF dollars.

Dr. Bruton stated that there various pieces of trying to get health care to uninsured people across the state. The demand far exceeds available services and they are relatively unorganized. This is an effort to help a community pull the pieces together and to leverage the free and low cost care.

Senator Phillips had a series of questions regarding the $1.6 million intensive vocational rehab. He also asked about Job Links through out the state.

Mr. Fitzgerald explained the Safe Kids Issue and related child welfare items (page 2 of attachment).

Stephanie Fanjul, Director of Division of Child Development, reviewed the Child Care Development Fund (CCDF) Block Grant.

The Chair thanked everyone for cooperating and announced that there will not be an afternoon meeting.

The meeting was adjourned at 9:55 a.m.

Senator William N. Martin, Chair

Joyce Crews Hodge, Clerk

Joint Health and Human Services Appropriations Sub-Committee

May 30, 2000
8:30 AM
Legislative Office Building Rm# 643

----- Agenda Topics -----

Opening Remarks	Senator Bill Martin, Representative Edd Nye and Representative Beverly Earle
Temporary Assistance for Needy Families (TANF) Block Grant	Kevin Fitzgerald, Director of the Division of Social Services
Child Care Development Fund (CCDF) Block Grant	Stephanie Fanjul, Director of Division of Child Development

Social Service Block Grant

NC Work First/TANF Program: Summary of Federal Funds Proposed for SFY 2001

Cash Assistance and County Block Grants

Description	Approved by GA SFY 2000	Proposed SFY 2001	Increase/ (Decrease)	Explanation of Difference
Cash Assistance and County Block Grants	$233,910,459	$198,209,511	($35,700,948)	Reduction in cash assistance due to declining caseload. County block grant funding remains at SFY 2000 amount.

Support for Working Families and Targeted Initiatives

Description	Approved by GA SFY 2000	Proposed SFY 2001	Increase/ (Decrease)	Explanation of Difference
Family Drug Treatment Demonstration	0	2,000,000	2,000,000	Initiative to develop drug treatment approaches for mothers with young children.
Improving Access to Human Services (Business Process Reengineering)	0	5,011,677	5,011,677	Initiative to streamline and improve public access to human services in counties.
Intensive Vocational Rehabilitation	0	1,600,000	1,600,000	Initiative to address barriers facing families with disabilities on Work First assistance.
Child Care	90,122,889	96,358,513	6,235,624	Increase in this item needed to support the annualized cost of the market rate increase implemented October, 1999, and continue implementation of the five star rated license system.
Job Link/Community Colleges	500,000	1,500,000	1,000,000	Initiative to address barriers facing families on Work First assistance.
Project Access Health Care for Uninsured	70,000	1,000,000	930,000	Community-based initiative to address healthcare concerns for working families.
WF Job Retention	1,607,529	1,900,000	292,471	Includes additional funding for a collaboration grant with the Jordan Institute and the DSS Director's Association.
First Stop Assistance Program (Employment Security Commission)	4,100,000	1,000,000	(3,100,000)	Demand has decreased due to declining caseload. Counties may also purchase this service with their WFCBG.
Domestic Violence Planning Grants	1,000,000	175,000	(825,000)	Outreach campaign completed. Funds will be used for planning grants in counties where programs do not exist.
Housing Incentives	3,000,000	3,000,000	0	
WF Business Council	100,000	100,000	0	
Subtotal	**$100,500,418**	**$113,645,190**	**$13,144,772**	

#1 05.30.2000

Safe Kids & Related Child Welfare Items

Description	Approved by GA SFY 2000	Proposed SFY 2001	Increase/ (Decrease)	Explanation of Difference
Staff for Increased Child Welfare Cases	0	8,855,770	8,855,770	Staff grants to fund growth in caseloads.
Child Welfare Training	0	2,000,000	2,000,000	Cost allocation to TANF to support county DSS staff training initiatives.
Recruitment & Adoption Staff	1,427,550	5,755,100	4,327,550	Provides funding for 77 additional county recruitment FTE's, and statewide efforts to finalize this item of the Safe Kids Initiative.
Intensive Family Preservation	2,000,000	4,200,000	2,200,000	Governor's initiative to expand intensive family preservation to all 100 counties.
Special Needs Adoptions	2,200,000	0	(2,200,000)	Item will be supported with appropriations to allow greater flexibility for use in improving adoption programs.
County Child Welfare Services (Transfer to SSBG)	4,500,000	4,500,000	0	
Child Caring Agencies	1,500,000	1,500,000	0	
Subtotal	**$11,627,550**	**$26,810,870**	**$15,183,320**	

Other Items

Description	Approved by GA SFY 2000	Proposed SFY 2001	Increase/ (Decrease)	Explanation of Difference
After-School Program (Office of Juvenile Justice)	0	1,800,000	1,800,000	Support our Students after-school program.
DSS Administrative Support	0	1,000,000	1,000,000	Funds needed to support state management and oversight of TANF-funded programs.
Teen and Out-of-Wedlock Pregnancy Prevention	3,839,261	4,839,261	1,000,000	Additional funding for fatherhood initiatives.
Work First and Related Evaluations	1,000,000	1,500,000	500,000	Item increased to address expanded evaluation required by the state law and federal mandates.
Welfare Reform Staff Development	500,000	1,500,000	1,000,000	Addresses additional staff development needs including leadership development curriculum for county DSS staff.
One-Time Human Services grants	5,400,000	0	(5,400,000)	One-time awards completed.
Protection from Violent Caregivers	160,000	0	(160,000)	Service not eligible for TANF funding.
Contract to Identify MOE	500,000	0	(500,000)	Analysis completed in SFY 2000.
Boys & Girls Clubs	1,000,000	1,000,000	0	
Substance Abuse Services	5,682,280	5,682,280	0	
Funds to Address Reductions in SSBG	0	2,250,674	2,250,674	
Total Federal TANF Proposals	**$364,119,968**	**$358,237,786**	**($5,882,182)**	

Social Services Block Grant:
Summary of Federal Funds Proposed for SFY 2001

SFY 2000 Total Social Services Block Grant, Excluding Transfers from TANF	$51,890,997
Proposed SFY 2001 Total Social Services Block Grant, Excluding Transfers from TANF	47,558,426
Total Reduction in Social Services Block Grant	**$4,332,571**

Reductions Addressed by the TANF Block Grant Proposal	$2,250,674
Remaining Reductions:	
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	1,529,523
Division of Services for the Blind	100,000
Division of Aging - Home and Community Care Block Grant	75,000
Division of Social Services - Administration	277,374
Adult Day Care Services	100,000
Total Reduction in Social Services Block Grant	**$4,332,571**

#2 05.30.2000
Kevin F. Fitzgerald

DIVISION OF CHILD DEVELOPMENT
CHILD CARE AND DEVELOPMENT FUND PLAN FOR SFY 00-01

GENERAL DESCRIPTION

For State Fiscal Year 2000-01, federal and state funds available through the Child Care and Development Fund (CCDF) for appropriation are projected to be $193,714,205. In addition, the NC Department of Health and Human Services is proposing to transfer $74,737,272 in federal Temporary Assistance for Needy Families (TANF) funds to the Child Care and Development Fund. CCDF funding for Federal Fiscal Year 2000-01 is estimated to be $191,688,201 and is anticipated to be available on October 1, 2000. {Note: the US Department of Health and Human Services has not yet released its estimates for Federal Fiscal Year 2000-01 CCDF grant awards. The estimate shown here is based on the CCDF grant award amount North Carolina received in FFY 1999-2000.}

The purpose of the Child Care and Development Fund is to improve the availability, quality, and affordability of child care. The CCDF is comprised of three funding streams: Mandatory, Matching, and Discretionary. The federal legislation requires that a preponderance of the Mandatory and Matching funds be used to provide child care assistance to families that are receiving public assistance, families that are attempting through work activities to transition off of such assistance, and families that are at risk of becoming dependent on such assistance. A substantial portion of the Discretionary funds must also be used to provide assistance to low-income working families.

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 limits administrative costs (as defined by the Federal Administration for Children and Families) to a maximum of 5% of the total CCDF allocation. The NC Division of Child Development plans to set aside 5% of the federal CCDF funds for administrative costs at the state and local level. Funding not used for administration will be used for child care subsidies.

Also a requirement of the PRWORA, the Division plans to reserve at least 4% of the total CCDF allocation for quality and availability initiatives.

Child Care Services

North Carolina uses CCDF "Services" funding to provide subsidies to low-income working families, support effective implementation of the Subsidized Child Care Program, and subsidize "wrap-around" care for children enrolled in Head Start. Families are eligible for CCDF-funded child care based on income and pay a fee of 7-9% of their income.

Welfare reform, known as Work First in North Carolina, requires able-bodied welfare recipients to work, resulting in a high demand for child care subsidies. The Division of Child Development is charged with administering all subsidized child care programs, including the provision of child care to Work First participants.

Over the past year, the Subsidized Child Care Program (funded primarily through the Child Care and Development Fund) supported families in their transition off public assistance by:

- Providing subsidized care to an average of 91,000 children per month of which 16,000 were children in families receiving Work First benefits;

Revised 4/24/00

#3 05.30.2000

- Enabling families that moved off Work First to continue to receive subsidized child care as they worked to stabilize their family budgets.

Under the current eligibility policy, the Subsidized Child Care Program also reduced the need for Work First and other public assistance in the first place. At the local level, subsidized child care has been used to divert families from going on Work First and other forms of public assistance.

To meet the demand for subsidized child care from Work First and other low-income working families, DHHS is proposing to continue to transfer TANF funds to CCDF. Transferred funds will supplement the Discretionary funding stream reserved for low-income working families. Coordination between the Division of Child Development and Division of Social Services will continue as Work First continues to be implemented.

In addition to general child care subsidies, CCDF Services funding is used to provide Head Start Wrap Around care -- child care that "wraps around" partial-day Head Start programs to enable parents to work, search for work, or participate in education or training. Wrap Around care is now accessed by families through the same local offices that provide vouchers to low-income families for subsidized child care – in many cases, the local department of social services.

Child Care and Development Fund Services funding supports the quality as well as the affordability and availability of child care. Additional funding from CCDF for child care rate increases will continue to be disbursed in a such a manner to compensate for quality child care services identified through the rated license system.

Quality and Availability Initiatives

The need for quality care is critical. Studies released in recent years have highlighted the potential for extensive brain development in the first three years of life and identified the importance of a safe and nurturing environment for healthy brain development. Study findings published during 1999 support existing research on the *long-term* benefits of high-quality early childhood experiences, as well as showing that the quality of early childhood experiences might have an especially large impact on children who are traditionally at risk of not doing well in school. Based upon the findings from the growing body of research on child development and child care, it is important to promote high-quality child care practices and increase the availability of high-quality care.

Since 1991 (through the Child Care and Development Fund and its precursor, the Child Care and Development Block Grant), North Carolina has supported initiatives that improve the quality and availability of child care. Examples of ongoing initiatives include: child care resource and referral services; school-age child care (improving quality and expanding available child care spaces); efforts to support inclusion of children with special needs in mainstream child care programs; Child Care Revolving Loan Fund (increasing the supply and quality of child care through low-interest loans to providers); and training and compensation of child care staff. The Division of Child Development plans to continue ongoing activities such as these during State Fiscal Year 2000-01.

Some major initiatives begun in State Fiscal Year 1999-2000 that the Division of Child Development plans to continue in State Fiscal Year 2000-01 include: NC Cares (composed of health insurance and wage supplements for child care staff that invest in their own education); child care health consultation targeted to providers of infant and toddler care; efforts to rebuild the availability of quality care in flood-affected areas; assistance to child care providers through the Child Care Disaster Recovery Fund (a hybrid loan/grant program that offers partial loan forgiveness based upon the quality of care provided); and implementation of North Carolina's Five Star Rated License.

All regulated child care facilities serving preschool-aged children will need to be switched over to the new Five-Star Rated License system by fall 2000, and rules have been approved by the NC Child Care Commission for a new rated license for providers of school-age care. The Division of Child Development will make investments in projects and staff as needed to carry out extra monitoring, work force assessment, and subsidy program operations functions required for effective implementation of the Five Star Rated License. Parent outreach will also continue to be a major focus, with special emphasis on making parents aware of the components of quality child care through the rated license.

In order to meet state and federal mandates related to monitoring use of child care subsidy funds and compliance with licensing requirements and investigation of child abuse and neglect reports in child care settings, 68 additional staff are needed in the Division of Child Development. The staff is needed in the following areas. Additional licensing staff is needed to visit new and existing child care centers and homes to assure compliance with licensing standards. The number of child care centers in the state continues to grow and licensing staff caseloads are at an unmanageable level. The current level of staffing only allows visits to be made to homes when complaints are received and there has been a significant increase in the number of complaints related to home based care. In addition, the Division continues to have difficulty meeting the seven day mandate for responding to reports of child abuse or neglect and cases remain open for months waiting for staff to complete the necessary follow up activities. Lack of response in these situations leaves children in vulnerable situations. Additional subsidy program staff are needed to provide information in a timely manner to local departments of social services regarding the subsidy program requirements and to provide technical assistance to local programs to assure that program and fiscal standards are met. The number of additional positions also includes some clerical staff to support the work of these individuals.

As funding allows and new needs and opportunities present themselves, the Division of Child Development may also develop additional initiatives that support the goals outlined in the FFY 1999-2001 CCDF plan prepared by the North Carolina Department of Health and Human Services.

DIVISION OF CHILD DEVELOPMENT
CHILD CARE AND DEVELOPMENT FUND PLAN FOR SFY 00-01

CCDF RECOMMENDATIONS	ALLOCATION
1. Allocate funds to local agency for services support and the provision of child care subsidies for low income working and other needy families. This includes funds for automation to support subsidy reimbursement.	$117,145,326
2. Federal law requires states to reserve at least 4% of their CCDF allotment for activities to improve the quality and increase the availability of child care. In addition, specific funding amounts of the CCDF have been earmarked for quality activities. These funds will provide for the continuation of existing projects, as well as support new initiatives to enhance the quality of child care in North Carolina. Anticipated projects include increasing the availability of care for school-age children and children with special needs, expanding resource and referral services and parent outreach, promoting provider education and training, improving the monitoring of child care facilities, and providing funding for the T.E.A.C.H. Early Childhood Health Insurance Program and Child Care WAGE$ through NC Cares.	$12,332,039
3. Limit administrative costs of lead agency and local agencies which administer the child care subsidy program to 5% of the total CCDF allocation.	$6,814,598
4. Transfer funding from TANF to CCDF. The majority of the TANF funds will be used for child care subsidy and support. The transferred funds are subject to the same requirements that apply to CCDF (minimum 4% for quality improvement; 5% cap on administration).	$74,737,272
5. Designate state funds to maximize available federal funds for child care services and activities.	$57,422,242
TOTAL REQUIREMENTS	**$268,451,477**

SOURCE OF FUNDS

FFY 00 CCDF	$35,168,972
FFY 01 CCDF	$101,122,991
TANF Transfer	$74,737,272
State Maintenance of Effort (MOE)	$37,927,282
State Matching	$19,494,960

Division of Child Development

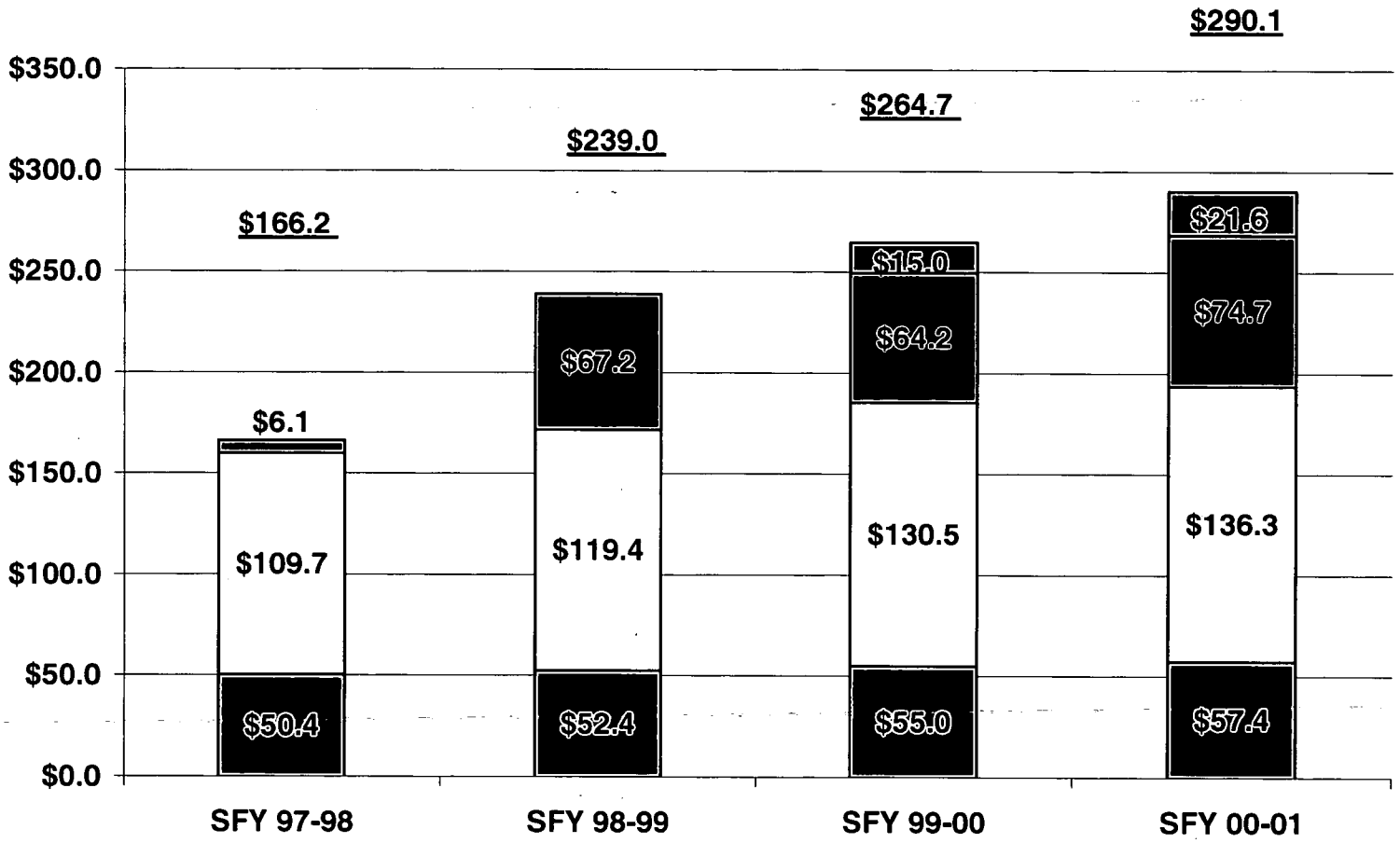
Analysis of Child Care and Development Fund (Title of Block Grant)

SFY 2000-01

Item Number	Title	Actual SFY 1998-99	Appropriated SFY 1999-2000 (HB 168)	Recommended Amount SFY 2000-01	Appropriated/ Recommended Difference	Explanation of Difference
01.	Child Care Subsidies	$ 108,625,251	$ 112,624,103	$ 117,145,326	$ 4,521,223	Recommended amount for sfy 2001 includes unanticipated increases in FFY 2000 grant which were not in sfy 2000 block grant plan approved in 1999 session.
02.	Quality and availability initiatives (inc. $ for Comm Colleges in 98-99)	$ 5,274,736	$ 11,378,046	$ 12,332,039	$ 953,993	Increase in grant requires increase in amount set aside for quality
03.	Administrative expenses	$ 5,968,420	$ 6,526,429	$ 6,814,598	$ 288,169	Increase in grant allows increase in amount which may be used for admin
04.	Transfer from TANF for subsidy	$ 66,669,460	$ 51,669,460	$ 74,737,272	$ 10,585,624	Recommended Amount taken from 3/19/00 version of the DHHS TANF Business Plan.
05.	Transfer from TANF for rate increases	$ -	$ 12,482,188	*	*	
	Totals	$ 186,537,867	$ 194,680,226	$ 211,029,235	$ 16,349,009	

* Funding for rate increases included in amount for item 04.

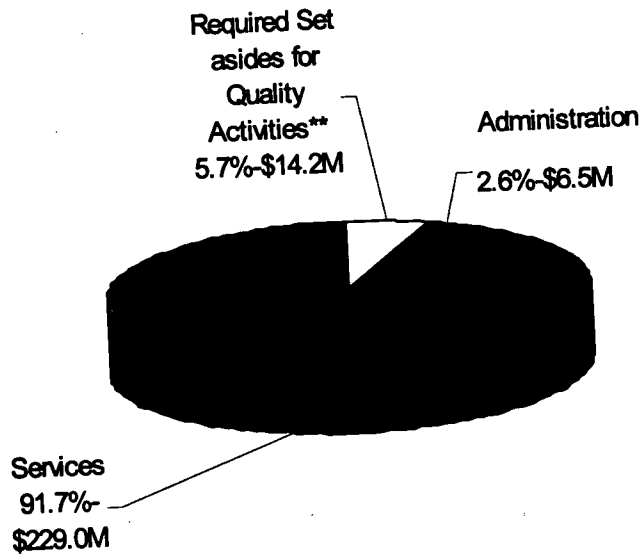
CCDF and TANF Block Grant Funding for Child Care
SFY 1997-98 - Proposed SFY 2000-01
(all dollars in millions)



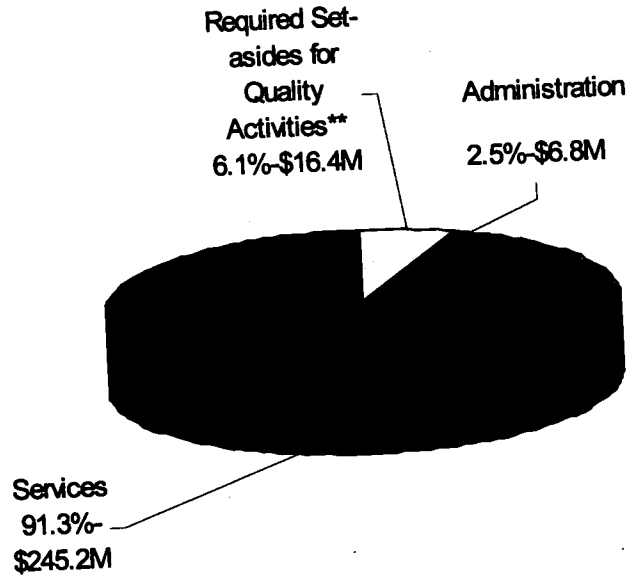
#3A 05.30.2000

Breakdown of CCDF Funding*
By Activity Category

SFY 99-00
Total Funding - $249.7 Million



Proposed SFY 00-01
Total Funding - $268.5 Million



* Includes state matching and maintenance of effort funds.
** Includes quality expansion funds, federal set-asides for infant\toddler and resource and referral activities and funds to meet the 4% CCDF quality requirement.

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

Name of Committee

Date MAY, 30 2000

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Patricia A. Young	APPCNC
HUGH TILSON	NCHA
John [illegible]	NCFPC
Amanda Abrams	Covenant w/ NC's children
Sara R. Allen	"
Lily Farel	DHHS
Chris Hoke	DHHS
Amy Fullbright	Hunton & WMS.
Ann Edmondson	NCRMA
[illegible] Richard	Arc/NC
Whitney Obrig	OSBM
[illegible]	NCPA
[illegible] Summers	NC Equity
[illegible] Street	PPAP
STAN SLAWINSKI	MH/DD/SAS

Name of Committee: JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 30, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mike Eddinger	DHHS/DFS
Jackie Sheppard	DHHS/DFS
JoAnn Lamm	DSS/DHHS
Gary Cyrus	Div of Hoping
Thomas Cheek	Division of Aging/DHHS
Tara Larson	DMH/DD/SAS
Mary Greene	OSBM
Wayne William	OSBM
Martha Lowance	YAFO
Bennett Hollers	DHHS
Rosalyn Savitt	NC Child Care Coalition
Seth Whitaker	House Appropriations Staff

Name of Committee: JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 30, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Flo Stein	DMH/DD/SAS
Charleen Scott Robb	"
ART Robarge	DMH/DD/SAS
C.L. Cochran	UCPNC - C2001
Beth Melcher	NAMI NC - Coalition 2001
John Tate	MHA/NC - C2001
Janet Schaumbach	NC Council C2001
Michelle Cotton	DMH/DD/SAS
Charles Dunn	DMH/DD SAS
Ken Foster	OJJ
Christopher Eaddy	OJJ - SOS

Name of Committee: JOINT APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

May 30, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sharon Hirsch	NC Social Services Consortium
Paula L. Hoff	Covenant w/ NC's Children
[illegible]	Carolinas Healthcare System
Gilbert Marin	NC Div. of Social Services
[illegible] Holliday	NC DT Public Health
[illegible]	NC. Food Banks
Sydney Atkinson	NC Div. of Public Health
Margaret Woodcock	NC Div of Public Health
Kevin Ryan	DHHS/DPH
Linda Kingsdue	APPCNC
Joe Lubera	AAHC

VISITOR REGISTRATION SHEET

Joint appropriations sub committee on Human Resources
Name of Committee

May 30, 2000
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Stacy Flannery	NCHCFA
Heather B. Hudson	UNC GA

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes

May 31, 2000

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met jointly with the Senate Appropriations Subcommittee on Wednesday, May 31, 2000, at 8:30 a.m. in Room 643 of the Legislative Office Building.

Representative Edd Nye, Co-Chairman, presided. House members present were: Representative Beverly Earle, Co-Chairman; Representative Martha Alexander, Vice-Chairman; Representative Alma Adams, Representative Lanier Cansler, Representative Theresa Esposito, Representative Trudi Walend, and Representative Gene Wilson. There were six senators present.

Chairman Nye introduced the House and Senate Pages at the meeting. He then opened the public hearing and introduced Mr. Kevin Fitzgerald, Director of the Division of Social Services, to speak concerning the Low Income Energy Assistance Program Block Grant (See Attachment 1). The program does two things. It provides low -income energy assistance one-time payments for energy to eligible households, generally the elderly. Last year 147,000 households received checks. The State received supplemental appropriations from the federal government. The recipients received two checks. The first one for an average of fifty-two dollars and fifty-seven cents and the second ones averaged thirty-seven dollars and twenty- nine cents. This was higher than in previous years. At the end of last year, the State received 20.3 million dollars for assistants and relief for those affected by the flood. Most of the money has been spent. Up to five thousand dollars was given to eligible families to assist with furnaces and air conditioning systems. This year twenty million is expected and of that amount two hundred thousand will go to the Indians in the Lumbee Regional Development Association. The other money will go to three major programs. The first program is for energy assistance, the crisis intervention program. These are emergency programs operated by the local Department of Social Services or under contract by local non-profit agencies, to assist when there is a fueling and heating related crisis. 1.2 million of the crisis money is sent to the Department of Commerce for the Heating Assistance Repair and Replacement Program (HARPS). The third portion of the allocation goes to the Department of Commerce. Up to fifteen percent can be spent for the Weatherization Program. This program helps modify homes to make them more energy efficient. Ten percent is allowed for administration.

Mr. Lawrence Wilson, Office of Economic Opportunities Director, was introduced to speak on Community Services Block Grant (see Attachment 2). This program has been in effect for thirty-five years under a variety of names. The primary purpose is to provide services that lead to economic self-sufficiency for low-income families. This year the program is expected to be 13.7 million dollars. Ninety percent of the funds must go to community action agencies, which are non-profit entities providing a variety of services to low income families. These agencies also operate the Head-Start Program, rental assistance programs, under contract with various job training programs, and are headed in most instances by a non-profit board. Five percent of funds go for administration; ninety percent goes to thirty-six community action agencies serving ninety counties in the State. The remaining five- percent goes to limited purpose agencies that serve a certain population, such as senior citizens, and to The Indian Commission, which services the Indian Population in the State. Senator Phillips expressed his concerning the number of participants in Head Start Program and asked if the number is increasing or decreasing. Mr. Wilson responded the number has increased. Senator Phillips asked if all areas of the State are now funded so children can participate. Mr. Wilson replied that all counties have access to Heat Start Program. Senator Phillips wanted to know if the thirty-six programs established now are enough to cover the State well. Presently ninety percent of the State is covered. Ten counties are "uncapped", but efforts are being made to extend services to these ten counties. The reason there are no services in these counties is the county commissioners haven't made a decision to warrant these services there.

Representative Adams stated the Community Action Program serving Guilford County has been having difficulty. Mr. Wilson noted clients have to receive services from another agency due to the problems. Chairman Nye noted the one hundred thirty six thousand-dollar administration increase and questioned if it was for more staff. Mr. Wilson expressed the need for one time-limited person to be added to staff to enhance the ability to communicate with grantees and help improve intake systems to be computerized rather than manual.

Ms. Roberta Faison Spensor, Community Action Association, was introduced to speak concerning the programs and activities of the Community Action Block Grant (see Attachment 3). The hearing was designed to meet federal requirements to address the State's allocation of block grants by which federal law was allocated solely to community action and limited purpose agencies. Ms. Spensor pointed out ways they serve the State's low income and disadvantaged population. Community action meets local needs in times of emergency as well as more traditionally thought of programs such as: economic self-sufficiency, day care, aging services, transportation, housing, nutrition, employment assistance, job training, education, Head Start, budgeting and income management, weatherization, Section Eight Rental Assistance, and others. Senator Dannelly commented on the living conditions of the Flood victims and expressed the need to shorten the process for housing. Senator Phillips asked if there was any data that addresses how many clients are being provided services and are these clients new or same clients year after year. He would like to know more about the referral service. Ms. Spencer responded that agencies work hard to determine why a person needs services and try to prevent them from having to return.

Chairman Nye asked if there was anyone else in the audience that would like to be heard in the public hearing in reference to Community Services Block Grant and Low Income Energy. There were no other speakers. Chairman Nye declared the public hearing closed.

The Committee adjourned at 10:00 a.m.

Presiding Co-Chairman- Representative Edd Nye

Committee Assistant-Jo Bobbitt

Joint Health and Human Services Appropriations Sub-Committee

May 31, 2000
8:30 AM
Legislative Office Building Rm# 643

----- Agenda Topics -----

Opening Remarks	Senator Bill Martin, Representative Edd Nye and Representative Beverly Earle
Open Public Hearing	Chairman
Low Income Home Energy Assistance Program (LIHEAP) Block Grant	Kevin Fitzgerald, Director Division of Social Services
Community Services Block Grant (CSBG)	Lawrence Wilson, Director Office of Economic Opportunities

Attachment 1

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SOCIAL SERVICES

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM BLOCK GRANT (LIHEAP)

For State Fiscal Year 2000-2001, the total State Low Income Energy Program allocation is currently estimated to be $20,093,896 based on current projections that the FFY 2001 award will be this amount. The Lumbee Regional Development Association (LRDA) will receive $211,554 from this amount. **The total available for LIHEAP is $19,882,342.**

GENERAL DESCRIPTION

The purpose of the Low Income Home Energy Assistance Program Block Grant is to provide funds to help low-income families cope with cost increases of heating fuel and to provide emergency assistance. There are two components:

1. Low Income Home Energy Assistance Payments – Funds are used to provide a one-time payment to eligible households to help pay heating bills.

2. Crisis Intervention Assistance – Funds are used to assist low-income people when a heating or cooling related crisis occurs. Allocations are provided to county departments of social services to make direct payments, vendor payments, or to provide in-kind services for eligible households.

RECOMMENDATIONS

		DOLLARS
1.	Allocation for Low Income Energy Assistance payments	8,092,113
2.	Allocation for the Crisis Intervention Program	7,078,114*
3.	Allocation to the Department of Commerce for Weatherization Program	2,684,116
4.	Allocation for application-taking by the Commission On Indian Affairs	39,765
5.	Total administrative	1,988,234**
	TOTAL LIHEAP BLOCK GRANT	**$19,882,342**

*The component is budgeted at $7,078,114. Of this amount, $5,825,526 is to be allocated to counties. The remaining $1,252,588 is to be transferred to the Department of Commerce for the Heating Assistance Repair and Replacement Program (HARRP).

Attachment 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ECONOMIC OPPORTUNITY
COMMUNITY SERVICES BLOCK GRANT PLAN FOR SFY 2000-2001

GENERAL DESCRIPTION

For State Fiscal Year 2000-2001, funds available through the Community Services Block Grant Program (CSBG) for appropriation are projected to be $13,752,241. CSBG funds are projected to be available October 1, 2000.

Since 1981, the Community Services Block Grant Program has made federal funds available to states to provide a range of services designed to assist low-income persons attain the skills, knowledge, and motivation necessary to achieve self-sufficiency.

The primary providers of services under this grant, as required by federal law, are the thirty-six Community Action Agencies (CAAs) in the state. Other grantees are seven Limited Purpose Agencies (LPAs) who were recipients of similar funds prior to the inception of the Community Services Block Grant Program. CAAs operate programs under the Community Services Block Grant in coordination with other federal, state, and local programs such as Head Start, Workforce Investment Act (WIA), Weatherization, and Section 8 Rental Assistance.

In August 1995, the federal Community Services Block Grant Monitoring and Assessment Task Force produced a National Strategic Plan which endorsed a results-oriented management approach for the Community Service Network. The plan includes a set of six broadly stated umbrella national goals, with suggested measures to assess progress towards the goals. States and local agencies are required to address these goals and measures in their program planning and reporting.

The six national goals of the Community Services Network are:

Goal 1. Low-income people become more self-sufficient.

Goal 2. The conditions in which low-income people live are improved.

Goal 3. Low-income people own a stake in their community.

Goal 4. Partnerships among supporters and providers of services to low-income people are achieved.

Goal 5. Agencies increase their capacity to achieve results.

Goal 6. Low-income people, especially vulnerable populations, achieve their potential by strengthening family and other support systems.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ECONOMIC OPPORTUNITY
COMMUNITY SERVICES BLOCK GRANT PLAN FOR SFY 2000-2001

Community Services Block Grant funds are used to provide a wide variety of services in local communities to serve identified needs of poor families. Programs allowed under the Community Services Block Grant Act are those which provide activities designed to assist low-income participants including the elderly poor:

- to remove obstacles and solve problems which block the achievement of self sufficiency;
- to secure and retain meaningful employment;
- to attain an adequate education;
- to make better use of available income;
- to obtain and maintain adequate housing and a suitable living environment;
- to obtain emergency assistance through loans, grants or other means to meet immediate and urgent family and individual family needs;
- to achieve greater participation in the affairs of the community; and
- to make more effective use of other programs related to promoting the well being of the low-income population.

The specific services operated in each local community are determined by the local agency as a result of an assessment of the needs of low-income individuals and families in their service area which is used to develop a multi-year plan for services.

As required by the Community Services Block Grant Act, ninety per cent of the funds received are distributed to the thirty-six Community Action Agencies (CAAs) located throughout the state. Five percent, which is the maximum allowed by federal law, is used by the Department to administer the Program. The remainder is used to fund seven non-profit organizations known as Limited Purpose Agencies (LPAs).

Over twenty-five thousand low-income individuals are served annually by the North Carolina Community Services Block Grant Program.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF ECONOMIC OPPORTUNITY
COMMUNITY SERVICES BLOCK GRANT PLAN FOR SFY 2000-2001

RECOMMENDATIONS	ALLOCATION
1. Allocate $687,612 to the Department of Health and Human Services to administer the grant. Staff renders technical assistance and monitors the Community Action Agencies and Limited Purpose Agencies for compliance with federal laws and regulations.	$687,612
2. Allocate $12,377,017 to the 36 Community Action Agencies (CAAs) which serve 90 counties for the purpose of providing administrative costs and to assist low-income families with housing, emergency assistance, education, energy, nutrition, income management, information and referral, and outreach. Federal rules require that 90% of the grant be allocated to CAAs.	$12,377,017
3. Allocate the remaining 5% of the grant in the amount of $687,612to Limited Purpose Agencies which are agencies that address a specific need or population. The allocation and agency is as follows: - Telamon which provides assistance to seasonal and migrant farm workers ($85,952) - Low Income Housing Development Corporation (LIHDC) which assists non-profit agencies in packaging loans for housing construction and rehabilitation ($105,205) - N.C. Rural Fund for Development (NCRFD) which provides technical assistance to credit unions and cooperatives which serve low-income individuals and families ($250,290)	$687,612

- N.C. Senior Citizens' Federation which sponsors statewide activities for low-income senior citizens ($125,145)
- Western Economic Development Organization (WEDO) which assists organizations serving low-income and handicapped individuals secure manufacturing contracts ($66,011)
- United Senior Services which provides activity programs for senior citizens in Craven County ($26,129)
- N.C. Commission of Indian Affairs which provides programs for low-income Native Americans in the state in coordination with local tribal organizations ($28,880)

TOTAL FUNDING SFY 2000-01	$13,752,241
SOURCE OF FUNDS:	
BLOCK GRANT FUND FFY 2000	$3,438,061
BLOCK GRANT FUND FFY 2001	$10,314,180

OFFICE OF ECONOMIC OPPORTUNITY
Analysis of Community Services Block Grant
SFY 2000-2001

Item Number	Title	Actual SFY 98-99	Appropriated SFY 1999-2000 (HB 168)	Recommended Amount SFY 2000-01	Appropriated/ Recommended Difference	Explanation of Difference
1	Admin	$528,719	$551,534	$687,612	$136,078	Administration is limited to 5% of the grant award and varies based on the award amount.
2	CAAs	$11,398,235	$11,827,604	$12,377,017	$549,413	Funds awarded to CAAs must be 90% of the total allocation and is based on award amount.
3	LPAs	$610,508	$651,534	$687,612	$36,078	Funds awarded to LPAs is 5% of the grant. award and varies based on the award amount.
TOTAL		$12,537,462	$13,030,672	$13,752,241	$721,569	Difference represents the expected increase in federal grant award for this period.

Attachment 3

COMMUNITY SERVICES BLOCK GRANT
PUBLIC HEARING COMMENTS
May 31, 2000

GOOD MORNING--MY NAME IS ROBERTA FAISON SPENCER AND ON BEHALF OF THE NORTH CAROLINA COMMUNITY ACTION ASSOCIATION, THANK YOU FOR ALLOWING US THIS OPPORTUNITY TO COMMENT ON THE COMMUNITY SERVICES BLOCK GRANT, ITS PROGRAMS AND ACTIVITIES.

THIS HEARING TODAY IS DESIGNED TO MEET FEDERAL REQUIREMENTS TO ADDRESS THE STATE'S ALLOCATION OF C.S.B.G., WHICH BY FEDERAL LAW IS ALLOCATED SOLELY TO COMMUNITY ACTION AND LIMITED PURPOSE AGENCIES.

WE WANT POINT OUT A FEW OF THE MANY WAYS THESE AGENCIES HAVE SERVED AND CONTINUE TO SERVE OUR STATE'S LOW INCOME AND DISADVANTAGED POPULATION. BUT BEFORE I DO SO, I WOULD LIKE TO PUBLICALLY EXPRESS TO THIS COMMITTEE WHAT AN ENORMOUS ENDEAVOR AND RESPONSIBILITY IS IT IS ADMINISTER, MONITOR, ADVISE AND ASSIST THE 37 COMMUNITY ACTION AGENCIES

AND 7 LIMITED PURPOSE AGENCIES WHO DISTRIBUTE THESE ESSENTIAL FUNDS ACROSS NORTH CAROLINA. EACH ENTITY IS A LOCAL (COUNTY BASED) NON-PROFIT GOVERNED BY ITS OWN BOARD OF DIRECTORS WITH EQUAL, YET OFTEN DIFFERENT PROGRAMS, POLICIES, AND PROCEDURES DICTATED BY LOCAL NEEDS ASSESSMENTS.

THE OFFICE OF ECONOMIC OPPORTUNITY, ITS DIRECTOR LAWRENCE WILSON AND HIS STAFF ARE TO COMMENDED FOR THEIR EXEMPLARY SERVICE TO THE STATE. THEY ARE BOTH OUR WATCHDOG AND PARTNER, ALWAYS FINDING THE TIME TO OFFER COUNSEL AND ADVISE WHEN SOLICITED AND SOMETIMES WHEN IT IS NOT. IT IS EXTREMELY IMPORTANT THIS ARM OF OUR C.S.B.G. PROGRAM IS FULLY FUNDED AT THE FEDERAL AUTHORIZATION LEVEL OF 10%. SHOULD ADMINISTRATIVE FUNDS BE UNDERUTILIZED , THEY WILL BE REDISTRIBUTED AMONG LOCAL AREAS OF NEEDS AS THEY HAVE BEEN SO FOR THE HISTORY OF THE PROGRAM. NORTH CAROLINA HAS MORE CAA'S AND LPA'S THAN MANY STATES IN THE NATION DUE TO NORTH CAROLINA'S PERCENTAGE OF THE POOR IN RELATION TO THE

GENERAL POPULATION AND OF COURSE WE ARE CHIEFLY A RURAL STATE.

90 COUNTIES WILL BE ALLOCATED $13,752.241 IN FY 2000-01, A SLIGHT INCREASE FROM LAST YEAR'S ALLOCATION WHICH IS DESPERATELY NEEDED. INFLATIONARY INCREASES THROUGH THE YEARS, POPULATION INCREASES, WITH A CORRESPONDING NUMBER OF INCREASED POOR AND WORKING POOR, ESPECIALLY THE RECENT INFLUX OF ADDITIONAL WORKING POOR LEAVING WELFARE UNDER WORK FIRST, POSITIONS COMMUNITY ACTION AND LIMITED PURPOSE AGENCIES AT THE HEART OF THE PROBLEM AREAS THESE INDIVIDUALS AND FAMILIES ARE EXPERIENCING; MOST JUST A FEW PAYCHECK S AWAY FROM HOMELESSNESS WITH FEW IF ANY UNITS OF AFFORDABLE HOUSING AVAILABLE, VIRTUALLY NON-EXISTENT IN AREAS HARDEST HID BY HURRICANE FLOYD. BY THE WAY, THEY ASKED ME TO LET YOU KNOW (AND I KNOW YOU ALREADY DO) THAT WE NEED TO GET THE FLOOD VICTIMS RELIEF NOW-- WE HAVE DONE ALL WE CAN DO--! IT'S TAKING TOO LONG!

NORTH CAROLINA'S HUMAN SERVICE PROBLEMS ARE COMMUNITY ACTION'S PROBLEMS. IT IS TO US MANY TIMES THAT THE FIRST CALL IS MADE; SEEKING FLEXIBLE HOURS DAY CARE TO REMAIN OFF WELFARE; FOR ASSISTANCE WITH A LANDLORD PROBLEMS ON LACK OF HEAT, UNSANITARY CONDITIONS, EXCESSIVE RENT; FROM THOSE SEEKING SHELTER FROM DOMESTIC ABUSE, SEXUAL ABUSE OR THOSE JUST SEEKING SHELTER AND FOOD-TOO FREQUENTLY FAMILIES WITH YOUNG CHILDREN. FROM MENTAL HEALTH TO DENTAL HEALTH WE ADDRESS THESE ISSUES WITH A "TOTAL CLIENT" APPROACH OR CASE MANAGEMENT AS ITS REFERRED TO NOW. ITS BEEN OUR WAY FOR 35 YEARS.

WE URGE YOU TO UTILIZE YOUR EXISTING C.S.B.G. DOLLARS IN NORTH NETWORK BY PARTNERING WHENEVER POSSIBLE WITH LOCAL COMMUNITY ACTION/LIMITED PURPOSE AGENCIES ON NEW AS WELL AS EXISTING INITIATIVES.

WE WISH TO THANK THIS COMMITTEE FOR ITS TIME, AND FOR ITS SUPPORT OF OUR PROGRAMS AND SERVICES. THANK YOU FOR THIS OPPORTUNITY TO APPEAR BEFORE YOU TODAY.

LOW INCOME HOME ENERGY ASSISTANCE PROGRAM

PUBLIC HEARING COMMENTS

May 31, 2000

COMMITTEE CHAIRS, MEMBERS OF THE COMMITTEE, SECRETARY BRUTON/HUMAN RESOURCE STAFF, LEGISLATIVE AND FISCAL STAFF; ON BEHALF OF THE N.C. COMMUNITY ACTION ASSOCIATION, PROVIDERS OF NORTH CAROLINA'S RESIDENTIAL ENERGY CONSERVATION ASSISTANCE PROGRAM (KNOWN TO YOU BEST AS THE WEATHERIZATION ASSISTANCE PROGRAM), A RECIPIENT OF CRUCIAL LIHEAP FUNDING, WE THANK YOU FOR THIS OPPORTUNITY TO COMMENT ON THE LOW INCOME HOME ENERGY ASSISTANCE PROGRAM.

FOR THE PAST FOUR YEARS THIS COMMITTEE HAS APPROVED A BALANCE WITHIN THE LIHEAP PROGRAM OF APPROXIMATELY 75% CASH ASSISTANCE PAYMENTS AND 25% FOR THE WEATHERIZATION ASSISTANCE PROGRAM. THIS WAS AN IMPORTANT AND PROGRESSIVE STEP IN RECOGNIZING THE NEED TO ADDRESS THE ROOT PROBLEM OF HIGH ENERGY COSTS OF THE LIHEAP ELIGIBLE POPULATION IN A MORE COMPREHENSIVE AND EXTENSIVE MANNER AND WE THANK YOU.

THESE LOW WEALTH FAMILIES FREQUENTLY OCCUPY OLDER HOUSING STOCK BUILT WITHOUT ENERGY CONSERVATION IN MIND. THE WORKING POOR AND ELDERLY, WHO ARE MARGINALLY ABLE TO MAKE IT ON THEIR INCOME, ARE PARTICULARLY ASSISTED BY OUR PROGRAM OF

WEATHERIZATION. IN A STUDY CONDUCTED BY THE NATIONAL CONSUMER LAW CENTER, LOW INCOME NORTH CAROLINIANS REPORTEDLY CAN SPEND UP TO 35% OF THEIR INCOME ON ENERGY. WEATHERIZATION IS A LONG TERM SOLUTION WHICH HELPS ALLEVIATE THIS PROBLEM WHILE ALSO REDUCING THE NEED FOR FUEL ASSISTANCE PAYMENTS. WEATHERIZATION GREATLY REDUCES THIS BURDEN.

HEATING APPLIANCE REPAIR REPLACEMENT PROGRAM BETTER KNOWN AS HAARP YO SHORTEN THE IDENTIFICATION FUNDED BY THIS LIHEAP BLOCK GRANT IS ALSO A SPECIAL PART OF THE RESIDENTIAL ENERGY CONSERVATION ASSISTANCE PROGRAM ENCOMPASSING WEATHERIZATION. THROUGH HAARP WE IDENTIFY HOMES WITH SIGNIFICANT LEVELS OF CARBON MONOXIDE AND NITROGEN DIOXIDE. BOTH GASES ARE DANGEROUS. CARBON MONOXIDE IS A SILENT, DEADLY KILLER. NITROGEN DIOXIDE CAN CAUSE LONG TERM CHRONIC ILLNESS. <u>THESE ARE SERIOUS HEALTH AND SAFETY ISSUES CAUSING POTENTIAL DEATHS AND IN CERTAIN PROBABILITY HEALTH PROBLEMS WHICH REFLECT UPON THE INDIGENT HEALTH CARE COSTS IN ALL 100 COUNTIES.</u> H.A.R.R.P. WHICH ALLOWS US TO EVALUATE, REPAIR OR REPLACE FAULTY HEATING AND AS OF 1999 COOLING SYSTEMS THAT POSE HEALTH AND SAFETY RISKS.

ANNUALLY, A LIHEAP PROGRAMMATIC MEETING IS HELD TO DISCUSS ISSUES INVOLVING LIHEAP FUNDING. APOLOGIES TO NCHHS STAFF PRESENT HERE TODAY AS OUR OFFICE WAS UNABLE TO ATTEND THIS YEAR DUE TO TIMING CREATED BY ITS RESCHEDULING DUE TO OUR JANUARY INCLEMENT WEATHER,

BUT IN PREVIOUS YEARS WE HAVE BROUGHT TO THE TABLE CONCERNS ABOUT THE DIRECT PAYMENT SYSTEM TO THE INDIVIDUAL OF THE CASH ASSISTANCE PORTION OF THIS PROGRAM. WE FEEL LIHEAP SHOULD BE A MORE VENDOR DRIVEN PROGRAM FOR CASH ASSISTANCE, RETURNING TO ITS ORIGINAL FORMAT OF A TWO PARTY CHECK MADE PAYABLE TO BOTH FUEL VENDOR AND CONSUMER AS A MINIMUM OR A MORE FUTURISTIC APPROACH OF DIRECT DEPOSIT TO FUEL VENDORS CREDITING EACH CONSUMER AT THE LOCAL LEVEL.

JANUARY 15, 2000 OUR OFFICE WAS BEEN FUNDED BY HHS FOR A RESIDENTIAL ENERGY CONSERVATION CHALLENGE OPTION PROGRAM KNOWN NATIONALLY AS R.E.A.C.H. TO WORK WITH ISSUES CONCERNING ELECTRIC UTILITY DEREGULATION , ENERGY AGGREGATION MECHANISMS AND THE LIHEAP ELIGIBLE CLIENT BASE. REACH IS A DEMONSTRATION PROJECT GRANT AWARDED ON AN EXTREMELY COMPETITIVE BASIS TO SEEK INNOVATIVE APPROACHES TO ENERGY SELF SUFFICIENCY OR ENHANCED ENERGY EFFICIENCY. UNDER THIS R.E.A.C.H. UMBRELLA WE WOULD ALSO STRONGLY SUPPORT A SMALL PILOT PROGRAM COLLABORATING WITH LIHEAP TO PURCHASE FUELS FOR LIHEAP ELIGIBLE CLIENTS IN A GIVEN GEOGRAPHIC AREA (WITH THEIR SIGNED CONSENT OF COURSE) TO PURCHASE FUELS AT SUMMER FIELD PRICES THEREBY CAPTURING SIGNIFICANT ADDITIONAL ENERGY SAVINGS . THESE INNOVATIVE OPTIONS ALONG WITH OTHERS YET TO BE IDENTIFIED BY THIS GROUP AND MEMBERS OF THE REACH STEERING COMMITTEE ARE EXCITING OPTIONS FOR THE FUTURE; INCREASING ENERGY SAVINGS ASSISTING WITH OUR COMMON GOAL OF ECONOMIC SELF SUFFICIENCY AND THE AMELIORATION OF THE CONDITIONS OF POVERTY.

THESE AND OTHER OPTIONS ARE BEING DONE SUCCESSFULLY IN OTHER STATES.

THANK YOU FOR THIS OPPORTUNITY TO COMMENT ON THE LIHEAP BLOCK GRANT. WE LOOK FORWARD TO OUR FUTURE TOGETHER IN THE LIHEAP PROGRAM.

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS HEALTH AND HUMAN SERVICES 5/31/2000

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Betsy MacMichael (parent)	N.C. Self-Determination Ldrship Network
Clifton B. Metcalf	UCC GA
Elizabeth Grossman	OSBM
Jack McGee	March of Times
Jim Richard	Arc INC
Martha Lowrance	~~YAFD~~
Jim Hardy	NC Food Banks
John Bowdish	Alley Associates
John [illegible]	NCFPC
Robert Spencer	NCCAA
Paula S. Holt	Covenant w/NC's Children
C.P. Medlin	NC Equity
Vivent Farmer	DHHS - Dcd
Roslyn Sarrett	NC Child Care Coalition
Sona Shandilya	NCCADV
Lawrence Wilson	DHHS/OEO
Wilbert Morris	DHHS/DSS
Kevin FitzGerald	DHHS-DSS
Louis Guist	HMCC
Foster Norman	VGFW
DAVID BRUTON	DHHS
Allyn Duffy	DHHS
Deborah Landry	DHHS-DSS
Nancy Coston	DHHS-DSS
Karen Eanderson	DHHS-DSS
Sharnese Ransome	DSS
NELS ROSBLAND	OSBM

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS HEALTH AND HUMAN SERVICES 5/31/2000

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Karen Garza	Kannapolis
Shannon Garza	Kannapolis
Terri Bobbitt	The Arc - P.O. Box 1367 Concord NC
Billie Alexander	The ARC Alemarble Stanly Co
Sharon Hirsch	NC Social Services Consortium
Eileen Silber	NAMI NC
Frank Sleary	NAMi Guilford Co.
Bennie Holland	DHHS
Lewis Fisher	NC Mental Health Assoc.
Martha Collier	ARC of Moore Co.
Mary Tart	" " "
Beverly Monroe	" " "
Wendy Russell	Arc of Moore Co.
Heather R Dennis	ARC of Moore Co
Denise Mercado	Eastern Seals NC
Jared Schaupeck	NC Council - C-2001
Alan Spader	NC Council of Comm Prog. - C-2001
Connie Carson	UCP
Deborah Lamm	NCCAA
Mary Shuler	OSBM
Wayne Willis	OSBM
Josie Douglas	NCAD/Coalition 2001
Fay Kridel	NC Alliance for Mentally Ill - Coalition 2002
Melinda Boyette	Johnston County Mental Health Assoc.
Joanne Schoen	NC Mental Health Association
Mary Green (parent)	NC Self-Determination Leadership Network
April Gerard (parent)	NC Self-Deter. Leadership Network

VISITOR REGISTRATION SHEET

JOINT APPROPRIATIONS HEALTH AND HUMAN SERVICES 5/31/2000
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Al Adams	Head Start - Community Action
Paul Pulley	NCATL

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

MINUTES
JUNE 6, 2000

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Services met on Tuesday, June 6, 2000 at 8:30 am in Room 643, of the Legislative Office Building.

The meeting was opened by Co-Chair, Representative Edd Nye. Other House members present were:

Representative Beverly Earle, Co-Chair
Representative Martha Alexander – Vice Chair
Representative Alma Adams
Representative Lanier Cansler
Representative Trudi Walend
Representative Gene Wilson

The following bills were heard and all were reported favorably to the House Appropriations Committee.

Representative Martha Alexander
HB 1568 BEGINNINGS FUNDS

Representative Lanier Cansler
HB 1556 MEDICAID FUNDS/CHILD DENTAL CARE

Representative Beverly Earle
HB 1500 FOOD BANK FUNDS
HB 1740 FUNDS/NURSE ASSISTANT TRAINING
HB 1741 HEALTHY START FUNDS

Representative Ruth Easterling
HB 1626 INDEPENDENT LIVING FUNDS
HB 1703 FUNDS/HEALTHY CAROLINIANS

Representative Bill Hurley
HB 1698 CUMBERLAND SR. CTR. FUNDS

Representative Verla Insko
HB 1642 ORANGE/CHATHAM TEEN CT. FUNDS
HB 1763 COALITION 2001 FUNDS
HB 1764 COALITION 2001 CRITICAL NEEDS FUNDS

Representative Mia Morris
HB 1646 BIRTH DEFECTS PROGRAM FUNDS

Representative Edd Nye
HB 1643 ADULT DAY CARE FUNDS
HB 1644 AUTISM SOCIETY FUNDS
HB 1663 POE CENTER FUNDS
HB 1679 FUNDS/ADULT CARE HOMES

Representative Thomas Wright
HB 1706 FUNDS/OFFICE OF MINORITY HEALTH
HB 1707 HEPATITIS C EDUC./AWARENESS FUNDS

The meeting was adjourned.

Respectfully submitted,

Presiding, Representative Edd Nye, Co-Chair

Representative Beverly Earle, Co-Chair

Ann Raeford, Committee Assistant

Attachment
Visitor's Registration — Attachment 1
Bills — Attachment 2 & 3

APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

THE FOLLOWING BILLS WILL BE HEARD:

BILL NUMBER	SHORT TITLE	SPONSOR
HB 1500	Food Band Funds	Earle
HB 1556	Medicaid Funds/Child Dental Care	Cansler
HB 1568	Beginnings Funds	Alexander
HB 1626	Independent Living Funds	Easterling
HB 1642	Orange/Chatham Teen Ct. Funds	Insko
HB 1643	Adult Day Care Funds	Nye
HB 1644	Autism Society Funds	Nye
HB 1646	Birth Defects Program Funds	Morris
HB 1663	Poe Center Funds	Nye
HB 1679	Funds/Adult Care Homes	Nye
HB 1698	Cumberland Sr. Ctr. Funds	Hurley
HB 1703	Funds/Healthy Carolinians	Easterling
HB 1706	Funds/Office of Minority Health	Wright
HB 1707	Hepatitis C Educ./Awareness Funds	Wright
HB 1740	Funds/Nurse Assistant Training	Earle
HB 1741	Healthy Start Funds	Earle
HB 1763	Coalition 2001 Funds	Insko
HB 1764	Coalition 2001 Critical Needs Funds	Insko

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1500

Short Title: Food Bank Funds. (Public)

Sponsors: Representatives Earle, Cansler; and Barefoot.

Referred to: Appropriations.

May 10, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE NORTH CAROLINA FOOD BANKS.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of two million four hundred fifty thousand dollars ($2,450,000) for the 2000-2001 fiscal year. These funds shall be allocated equally among the following North Carolina food banks:

(1) MANNA Food Bank (Asheville).
(2) Second Harvest Food Bank of Metrolina (Charlotte).
(3) The Food Bank of the Albermarle (Elizabeth City).
(4) The Second Harvest Food Bank of Southeastern North Carolina (Fayetteville).
(5) The Food Bank of North Carolina (Raleigh).
(6) Second Harvest Food Bank of Northwest North Carolina (Winston-Salem).

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1556

Short Title: Medicaid Funds/Child Dental Care. (Public)

Sponsors: Representatives Cansler; Sherrill, Walend, and McLawhorn.

Referred to: Appropriations.

May 17, 2000

A BILL TO BE ENTITLED

AN ACT TO INCREASE THE MEDICAID REIMBURSEMENT RATE FOR DENTAL CARE FOR MEDICAID-ELIGIBLE CHILDREN.

The General Assembly of North Carolina enacts:

Section 1. The Department of Health and Human Services shall allocate from existing Medicaid funds the sum of twenty-eight million five hundred thousand dollars ($28,500,000) for the 2000-2001 fiscal year. These funds shall be used to increase the Medicaid reimbursement rate for dental care for Medicaid eligible children to eighty percent (80%) of the dental reimbursement rate applied by the University of North Carolina Dental School.

Section 2. This act becomes effective October 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1568

Short Title: Beginnings Funds. (Public)

Sponsors: Representatives Alexander; Adams, Barefoot, Bonner, Fitch, Luebke, Oldham, Sutton, and Wainwright.

Referred to: Appropriations.

May 17, 2000

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FUNDS FOR BEGINNINGS FOR PARENTS OF CHILDREN WHO ARE DEAF OR HARD OF HEARING, INC.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Division of Early Intervention and Education, Department of Health and Human Services, the sum of two hundred twenty thousand dollars ($220,000) for the 2000-2001 fiscal year. These funds shall be allocated to Beginnings for Parents of Children Who Are Deaf or Hard of Hearing, Inc., to provide for family support services for families with children aged birth to 21 years who are deaf or hard-of-hearing.

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1626

Short Title: Independent Living Funds. (Public)

Sponsors: Representatives Easterling; Wainwright and Melton.

Referred to: Appropriations.

May 18, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE INDEPENDENT LIVING PROGRAM.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Social Services, the sum of five hundred thousand dollars ($500,000) for the 2000-2001 fiscal year for the Independent Living Program to support the transition of foster children into adulthood and to match federal funds for that program.

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1642

Short Title: Orange/Chatham Teen Ct. Funds. (Public)

Sponsors: Representatives Insko and Hackney.

Referred to: Appropriations.

May 22, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO SUPPORT THE TEEN COURT PROGRAMS IN ORANGE AND CHATHAM COUNTIES.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Joint Orange Chatham Community Action, Inc., a nonprofit corporation, the sum of fifty thousand dollars ($50,000) for the 2000-2001 fiscal year to be allocated equally to Orange and Chatham Counties to support each County's Teen Court program.

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1643

Short Title: Adult Day Care Funds. (Public)

Sponsors: Representatives Nye; Smith, Miller, and Insko.

Referred to: Appropriations.

May 22, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR START-UP OF TEN NEW ADULT DAY CARE PROGRAMS.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of two hundred fifty thousand dollars ($250,000) for the 2000-2001 fiscal year. These funds shall be allocated as grants to start up 10 new adult day care projects.

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1644

Short Title: Autism Society Funds. (Public)

Sponsors: Representatives Nye; Miller, Smith, Adams, and Insko.

Referred to: Appropriations.

May 22, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO SUPPORT PROGRAMS OF THE AUTISM SOCIETY OF NORTH CAROLINA.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Autism Society of North Carolina, a nonprofit corporation, the sum of one million eighty-nine thousand eight hundred twenty-two dollars ($1,089,822) for the 2000-2001 fiscal year. These funds shall be allocated as follows:

(1) $250,000 to expand residential day services.

(2) $450,000 for administrative cost-of-living increases.

(3) $64,646 to replace lost funds due to reduction in CAP rates, changes in billing policy, and limits on specific funding categories.

(4) $325,176 for Residential Services, Inc., operational costs.

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1646*

Short Title: Birth Defects Program Funds. (Public)

Sponsors: Representatives Morris; Alexander, Arnold, Baddour, Barbee, Berry, Blue, Bowie, Boyd-McIntyre, Brubaker, Buchanan, Cansler, Capps, Clary, Cox, Culp, Cunningham, Daughtry, Davis, Dockham, Edwards, Ellis, Esposito, Gardner, Gillespie, Goodwin, Gray, Gulley, Hensley, Hiatt, Holmes, Howard, Hunter, Jeffus, Kiser, Luebke, McCombs, McLawhorn, McMahan, Melton, Miller, Mitchell, Nesbitt, Oldham, Preston, Rayfield, Russell, Setzer, Sexton, Teague, Thomas, Wainwright, Walend, Warren, West, G. Wilson, and Womble.

Referred to: Appropriations.

May 22, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE BIRTH DEFECT MONITORING PROGRAM.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of three hundred fifty thousand dollars ($350,000) for the 2000-2001 fiscal year. These funds shall be used as follows:

(1) To implement the Birth Defect Monitoring Program established under Part 7 of Article 5 of Chapter 130A of the General Statutes;

(2) To provide analysis of all birth defect data;

(3) To provide dissemination of birth defect data to health care providers, public health personnel, members of the North Carolina General Assembly, and to the general public; and

(4) To collect and analyze data on low-birth weight babies and premature babies.

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1663

Short Title: Poe Center Funds. (Public)

Sponsors: Representatives Nye; Luebke and Weiss.

Referred to: Appropriations.

May 23, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO SUPPORT THE ALICE AYCOCK POE CENTER FOR HEALTH EDUCATION.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Alice Aycock Poe Center for Health Education, a nonprofit corporation, the sum of one hundred thousand dollars ($100,000) for the 2000-2001 fiscal year to support the Poe Center's health education programs.

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1679

Short Title: Funds/Adult Care Homes. (Public)

Sponsors: Representatives Nye; Cansler, Warner, Barefoot, Cox, Culp, Gardner, Hunter, Morris, Smith, and Warwick.

Referred to: Appropriations.

May 24, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO ENABLE ADULT CARE HOMES TO COMPLY WITH ADDITIONAL STATE LICENSING REQUIREMENTS.

Whereas, safety and protection for elderly and disabled persons in adult care homes is of paramount importance to members of the General Assembly, the adult care home industry, and the general public; and

Whereas, Senate Bill 10, 1999 General Assembly, enacted unfunded mandates to the adult care home industry; and

Whereas, adult care homes are required to submit audited reports of actual costs to the Department of Health and Human Services under G.S. 131D-4.2; and

Whereas, the 1999 audited cost reports verify a current operating deficit; and

Whereas, at least 23,400 adult care home residents rely on public funds to assist with paying for their care; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of thirty-two million two hundred ninety-two thousand dollars ($32,292,000) for the 2000-2001 fiscal year. These funds shall be used to fund increased health and safety protection activities required by newly adopted Medical Care Commission rules applicable to adult care homes, and to fund deficits verified in adult care home audited cost reports.

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1698

Short Title: Cumberland Sr. Ctr. Funds. (Public)

Sponsors: Representatives Hurley, Warner; McAllister, Morris, and Goodwin.

Referred to: Appropriations.

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR A SENIOR CITIZENS' CENTER IN CUMBERLAND COUNTY.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to Cumberland County the sum of two hundred fifty thousand dollars ($250,000) for the 2000-2001 fiscal year for the construction of a Senior Citizens' Center to serve senior citizens in the Cumberland County area.

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1703

Short Title: Funds/Healthy Carolinians. (Public)

Sponsors: Representatives Easterling, Preston; Alexander, Barefoot, Hackney, Insko, Luebke, McLawhorn, Miller, Russell, Sossamon, Wainwright, and Weiss.

Referred to: Appropriations.

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO ASSIST IN THE ESTABLISHMENT OF HEALTHY CAROLINIAN PARTNERSHIP INITIATIVES IN EACH COUNTY.

The General Assembly of North Carolina enacts:

Section 1.(a) There is appropriated from the General Fund to the Department of Health and Human Services the sum of three million seven hundred fifty thousand dollars ($3,750,000) for the 2000-2001 fiscal year. Of these funds, the sum of thirty-six thousand dollars ($36,000) shall be allocated to each county in the State to establish the necessary infrastructure in the county to create or maintain health promotion partnerships to carry out locally defined initiatives inclusive of women and children, youth, work site, minority populations, and aging populations. In order to receive funds under this section, each county shall ensure that partnerships meet established standards developed by the Governor's Task Force on Health Objectives for the year 2000. These standards shall be monitored by the Division of Community Health. Counties shall provide documentation to the Department evidencing an in-kind contribution or match of at least fifty percent (50%) of funds received under this section from local partnerships to provide space, equipment, and supplies.

Section 1.(b) Of the funds appropriated under this section, the Department may use up to one hundred fifty thousand dollars ($150,000) to support technical assistance activities, including data support/analysis, training, and materials.

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1706

Short Title: Funds/Office of Minority Health. (Public)

Sponsors: Representatives Wright; Hunter, Wainwright, Weiss, Sossamon, Miller, Alexander, and Luebke.

Referred to: Appropriations.

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE OFFICE OF MINORITY HEALTH IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Health and Human Services, Office of Minority Health, the sum of three hundred thousand dollars ($300,000) for the 2000-2001 fiscal year. These funds shall be used to support the activities of the Office of Minority Health, which include, but are not limited to:

(1) Providing training to reduce access barriers.

(2) Developing minority-focused health status/health assessment reports.

(3) Providing consultation and technical assistance and developing partnerships to address health disparity issues.

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1707

Short Title: Hepatitis C Educ./Awareness Funds. (Public)

Sponsors: Representatives Wright; Wainwright, Alexander, Miller, and Hill.

Referred to: Appropriations.

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO EDUCATE THE GENERAL PUBLIC AND TO INCREASE AWARENESS OF HEPATITIS C AS A PUBLIC HEALTH THREAT IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of two hundred fifty thousand dollars ($250,000) for the 2000-2001 fiscal year to support education and awareness activities to increase the general public's understanding of the public health threat posed by Hepatitis C and to encourage efforts to prevent the spread of this disease by educating the public on risk factors associated with the disease.

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1740

Short Title: Funds/Nurse Assistant Training. (Public)

Sponsors: Representatives Earle, Cansler; Adams, Arnold, Bonner, Bridgeman, Clary, Cox, Dedmon, Easterling, Esposito, Ford, Hackney, Insko, Jeffus, McAllister, Melton, Miller, Oldham, Saunders, Setzer, Sherrill, Teague, Tucker, Wainwright, Walend, Warren, G. Wilson, and Yongue.

Referred to: Appropriations.

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR AN INTERNET-BASED CERTIFIED NURSING ASSISTANT TRAINING DEMONSTRATION PROGRAM.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the State Board of Community Colleges the sum of five hundred thousand dollars ($500,000) for the 2000-2001 fiscal year for the development and implementation of on-site internet training or other innovative training program designed to improve recruitment and reduce turnover of certified nursing assistants in nursing facilities.

Section 2. Durham Technical Community College shall work with nursing home providers to develop and implement the training program. The program shall be tested in at least five nursing facilities.

Section 3. The program shall be evaluated by a committee composed of individuals representing the community colleges, the North Carolina Health Care Facilities Association, and the Division of Facility Services of the Department of Health and Human Services. The committee shall submit a report of its activities to the North Carolina Study Commission on Aging not later than June 30, 2001.

Section 4. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1741

Short Title: Healthy Start Funds. (Public)

Sponsors: Representatives Earle, Wright, Easterling (Primary Sponsors); Adams, Alexander, Barefoot, Bonner, Bridgeman, Cox, Dedmon, Esposito, Ford, Insko, Luebke, McAllister, McLawhorn, Miller, Nye, Russell, Saunders, Sherrill, Sossamon, Sutton, Wainwright, Warren, Weiss, Womble, and Yongue.

Referred to: Appropriations.

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE HEALTHY START FOUNDATION.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Healthy Start Foundation, Inc., a nonprofit organization, the sum of one million five hundred thousand dollars ($1,500,000) for the 2000-2001 fiscal year to improve access to prenatal care and reduce poor birth outcomes for families in North Carolina.

Section 2. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 1764

Short Title: Coalition 2001 Critical Needs Funds. (Public)

Sponsors: Representatives Insko; Adams, Alexander, Blue, Cansler, Esposito, Goodwin, Hackney, Luebke, Miller, Russell, Sherrill, Sossamon, Wainwright, and Weiss.

Referred to: Appropriations.

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO MEET CRITICAL NEEDS FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of twelve million six hundred sixty-nine thousand two hundred fifty dollars ($12,669,250) for the 2000-2001 fiscal year. These funds shall be used as follows:

(1) $5,360,000 for crisis detoxification services;

(2) $301,000 to match federal funds for mental health residential services for adults;

(3) $150,000 to provide training to members of Mental Health, Developmental Disabilities, and Substance Abuse Services Area Authority Boards;

(4) $30,000 to provide interpreter services for mentally ill deaf persons in accordance with the 1992 settlement agreement between the State and the North Carolina Association for the Deaf;

(5) $1,500,000 to establish a cross-disability ombudsman program. These funds shall be allocated to regional councils of governments for these purposes; and

(6) $5,328,250 for the following programs and services:

a. $500,000 for Family Support Project.
b. $214,000 for Life Guardianship Program.
c. $364,250 for Supported Employment.
d. $250,000 for Durable Medical Equipment Program.
e. $4,000,000 for services to children with autism.

Section 2. The Department of Health and Human Services shall provide residential treatment services for mental illness, developmental disabilities, and substance abuse, including necessary assessments, to Medicaid-eligible children as determined necessary by the child's plan of care.

Section 3. This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE DRH5046*-LN263(5.17)

Short Title: Health Standards/Secretary HHS. (Public)

Sponsors: Representative Nye.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ESTABLISH COMMUNITY HEALTH STANDARDS, AND TO APPROPRIATE FUNDS THEREFOR.

The General Assembly of North Carolina enacts:

Section 1. Article 1 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-5.1. State health standards.**

(a) The Secretary shall adopt measurable standards and goals for community health against which the State's actions to improve the health status of its citizens will be measured. The Secretary shall report annually to the General Assembly upon its convening and to the Governor on all of the following:

(1) How the State compares to national health measurements and established State goals for each standard. Comparisons shall be reported using disaggregated data for health standards.

(2) Steps taken by State and non-State entities to meet established goals.

(3) Additional steps proposed or planned to be taken to achieve established goals.

(b) The Secretary may coordinate and contract with other entities to assist in the establishment of standards and preparation of the report. The Secretary may use resources available to implement this section."

Section 2. There is appropriated from the General Fund to the Department of Health and Human Services the sum of fifty thousand dollars ($50,000) for the 2000-2001 fiscal year to implement this act.

Section 3. Section 1 of this act becomes effective October 1, 2000. Section 2 of this act becomes effective July 1, 2000. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE DRH7293*-LNZ219B(4.24)

Short Title: Mental Health System Reform. (Public)

Sponsors: Representatives Insko, Crawford, Goodwin, Alexander, Cansler, Earle, and Nye.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AND TO DIRECT THE OVERSIGHT COMMITTEE TO DEVELOP A PLAN TO REFORM THE STATE SYSTEM FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

Whereas, in 1998 and 1999 the General Assembly directed the State Auditor to coordinate and contract for a study of the State Psychiatric Hospitals and Area Mental Health Programs; and

Whereas, the "Study of State Psychiatric Hospitals and Area Mental Health Programs" ("Study"), April 1, 2000, was conducted by the Public Consulting Group, Inc., under the coordination of the State Auditor, and with the cooperation and assistance of the Department of Health and Human Services and other organizations and individuals; and

Whereas, the findings and recommendations of the Study present a comprehensive blueprint for reform of the State's mental health system; and

Whereas, the General Assembly endorses the findings of the Study; and

Whereas, effective implementation of mental health reform requires continuous legislative oversight to review and consider the recommendations of the Study and other matters and to recommend the necessary changes to State law and policy; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. Findings. -- The General Assembly finds that:

(1) The State and local government entities are not using effectively and efficiently available resources to administer and provide mental health, developmental disabilities, and substance abuse services uniformly across the State.

(2) Effective implementation of State policy to assist individuals with mental illness, developmental disabilities, and substance abuse problems requires that a standard system of services, designed to identify, assess, and meet client needs within available resources, be available in all regions of the State.

(3) The findings of recent comprehensive independent studies, and recent federal court decisions, compel the State to consider significant changes in the operation and utilization of State psychiatric hospital services.

(4) State and local government funds for mental health, developmental disabilities, and substance abuse services must be committed on a continuing, stabilized basis and will need to be increased over time to ensure that the purposes of mental health system reform are achieved.

(5) Reform of the State mental health, developmental disabilities, and substance abuse services system is necessary and should begin immediately. Reform efforts should focus on correcting system inefficiencies, inequities in service availability, and deficiencies in funding and accountability, and on improving and enhancing services to North Carolina's citizens.

Section 2. Oversight Committee Established. -- Chapter 120 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 27.

"The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

"§ 120-240. Creation and membership of Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(a) Establishment; Definition. -- There is established the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(b) Membership. -- The Committee shall consist of 16 members, as follows:

(1) Eight members of the Senate appointed by the President Pro Tempore of the Senate, as follows:

a. At least two members of the Senate Committee on Appropriations.

b. The chair of the Senate Appropriations Committee on Human Resources.

c. At least two members of the minority party.

(2) Eight members of the House of Representatives appointed by the Speaker of the House of Representatives, as follows:

a. At least two members of the House of Representatives Committee on Appropriations.

b. The cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services.

c. At least two members of the minority party.

(c) Terms. -- Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year, except the terms of the initial members, which begin on appointment and end on the day of the convening of the 2001 General Assembly. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

A member continues to serve until the member's successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

"**§ 120-241. Purpose of Committee.**

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services shall examine, on a continuing basis, systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered. The Committee shall make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of effectiveness and efficiency in system administration at the State and local levels. In conducting its examination, the Committee shall study the budget, programs, administrative organization, and policies of the Department of Health and Human Services to determine ways in which the General Assembly may encourage improvement in mental health, developmental disabilities, and substance abuse services provided to North Carolinians.

"**§ 120-242. Organization of Committee.**

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The Committee shall meet at least once a quarter and may meet at other times upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present. While in the discharge of its official duties, the Committee has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4.

(c) Members of the Committee receive subsistence and travel expenses as provided in G.S. 120-3.1. The Committee may contract for consultants or hire

employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Supervisors of Clerks of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee."

Section 3.(a) Plan for Mental Health System Reform. -- Terms Defined. -- As used in this section, unless the context clearly provides otherwise:

(1) "Committee" means the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) "Mental Health System Reform" includes the system of services for mental health, developmental disabilities, and substance abuse.

(3) "Plan" means the Plan for Mental Health System Reform developed and recommended by the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(4) "State Auditor/PCG, Inc., Study" means the "Study of State Psychiatric Hospitals and Area Mental Health Programs, April 1, 2000", conducted by the Public Consulting Group, Inc., under coordination by and contract with the State Auditor.

Section 3.(b) Development of Plan for Mental Health System Reform. -- The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under Article 27 of Chapter 120 of the General Statutes shall develop a Plan for Mental Health System Reform. It is the intent of the General Assembly that the Plan shall be fully implemented not later than July 1, 2005.

Section 3.(c) Purpose and Content of the Plan. -- The Plan shall provide for systematic, phased-in implementation of changes to the State's mental health system. In developing the Plan, the Committee shall do the following:

(1) Review and consider the findings and recommendations of the State Auditor/PCG, Inc., Study.

(2) Report to the 2001 General Assembly upon its convening the changes that should be made to the governance, structure, and financing of the State's mental health system at the State and local levels. The report shall include:

a. An explanation of how and the extent to which the proposed changes are in accord with or differ from the recommendations of the State Auditor/PCG, Inc., Study.

b. Proposed time frames for implementing mental health system reform on a phased-in basis, and the recommended effective date for full implementation of all recommended changes.

c. An estimate of the amount of State and federal funds necessary to implement the changes. The estimate should indicate costs of each phase of implementation and the total cost of full implementation.

d. An estimate of the amount of savings in State funds expected to be realized from the changes. The estimate should show savings expected in each phase of implementation, and the total amount of savings expected to be realized from full implementation.

e. The potential financial, economic, and social impact of changes to the current governance, structure, and financing of the mental health system on providers, clients, communities, and institutions at the State and local levels.

f. Proposed legislation making the necessary amendments to the General Statutes to enact the recommended changes to the system of governance, structure, and financing.

(3) Study the administration, financing, and delivery of developmental disabilities services. The study shall be in greater depth and detail than addressed in the State Auditor/PCG, Inc., Study. The Committee shall make a progress report on its study of developmental disabilities services to the 2001 General Assembly upon its convening.

(4) Study the feasibility and impact of and best methods for downsizing of the State's four psychiatric hospitals. In conducting this study, the Committee shall:

a. Take into account the need to enhance and improve community services to meet increased demand resulting from downsizing, and

b. Consider the findings and recommendations of the MGT of America Report of 1998, as well as the State Auditor/PCG, Inc., Study.

(5) Consider the impact of mental health system reform on quality of services and patient care and ensure that the Plan provides for ongoing review and improvements to quality of services and patient care.

(6) Ensure that the Plan provides for the active involvement of consumers and families in mental health system reform and ongoing implementation.

(7) Address the need to enhance and improve substance abuse services, including services for the prevention of substance abuse.

(8) Recommend a mental health, developmental disabilities, and substance abuse services benefits package that will provide for basic benefits for these services as well as specific benefits for targeted populations.

(9) Take into account the State's responsibility to enable institutionalized persons and persons at risk for institutionalization to receive services outside of the institution in community-based settings in accordance with the United States Supreme Court decision in Olmstead vs. L.C., (1999).

(10) Identify and address issues pertaining to the administration and provision of mental health services to children.

(11) Address issues, problems, strengths, and weaknesses in the current mental health system that are not addressed in the State Auditor/PCG, Inc., Study but that warrant consideration in the development of a reformed mental health system.

Section 3.(d) Subcommittees. -- The Committee shall establish one or more subcommittees to consider and develop specific focus areas of the Plan. Each subcommittee shall be the working group for the focus area assigned by the Committee cochairs. The Committee cochairs shall appoint the cochairs and members of each subcommittee from the Committee membership. The Committee cochairs shall invite representatives from the following to participate as nonvoting members of each subcommittee:

(1) Providers of mental health, developmental disabilities, and substance abuse services.

(2) Consumers of mental health, developmental disabilities, and substance abuse services and family members of consumers of these services.

(3) State and local government, including area mental health programs.

(4) Business and industry.

(5) Organizations that advocate for individuals in need of mental health, developmental disabilities, and substance abuse services.

Subcommittees shall meet at the call of the subcommittee cochairs.

The Committee cochairs shall assign the focus area for each subcommittee. Each subcommittee shall carry out its assignment as directed by the Committee cochairs and shall provide its findings and recommendations to the Committee cochairs for final decision by the Committee.

Section 3.(e) Reports. -- In addition to the report required under subsection (b) of this section, the Committee shall submit the following reports:

(1) To the 2001 General Assembly, upon its convening:

a. A progress report on the development of the Plan required by this section; and

b. An outline of an implementation process for downsizing the four State psychiatric hospitals.

(2) To the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Appropriations Committees on Health and Human

Services, by October 1, 2001, and March 1, 2002, progress reports on the development and implementation of the Plan.

(3) Interim reports on the development and implementation of the Plan to:

a. The 2001 General Assembly, by May 1, 2002. The report shall include legislative action necessary to continue the implementation of changes to the governance, structure, and financing of the State mental health system as recommended by the Committee in its January 2001 report to the General Assembly.

b. The 2003 General Assembly, upon its convening.

c. The 2003 General Assembly, by May 1, 2004. The report shall include legislative action necessary to continue phased-in implementation of the Plan.

(4) To the 2005 General Assembly, upon its convening, a final report on the Plan for Mental Health System Reform.

Section 4. Oversight Committee Appointments. -- The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall make appointments to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under this act not later than 30 days from the date of adjournment sine die of the 1999 General Assembly. The Committee shall convene its first meeting not later than 15 days after all members have been appointed.

Section 5. Department of Health and Human Services Reports. -- On or before October 1, 2000, and on or before March 1, 2001, the Department of Health and Human Services shall report to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the status of the Department's reorganization efforts pertaining to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall also include efforts underway by the Department to better coordinate policy and administration of the Division of Medical Assistance with policy and administration of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

Section 6. Effective Date. -- This act becomes effective July 1, 2000.

VISITOR REGISTRATION SHEET

Approp. Health & Human Services 6/6/2000
Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Charles Summers	Rep Easterling
Amy Fullbright	Hunton & Williams
Lou Wilson	NC ALTC 7
Jerry Cooper	NCALA
John [illegible]	NCFPC
Martha Lawrance	YAIO
Roslyn Sawitt	NC Child Care Coalition
Sharon Hirsch	NC Social Services Consortium
AL DEITCH	YAIO/DOA
Amanda Abrams	Covenant w/ NC's children
Paula Wolf	"
PAM KOHL	Poe Center For Health Education
Kerri Egan	YAIO
Travis Porter	MTE
Melissa Bishop-Murphy	Pfizer, Inc
Sona Shandilya	NCCADV
Myrna Miller	NASW-NC C2001
Beth McCher	NAMI NC "
Sally Cameron	NC Psychological "
C L Cochran	UCPNC C2001
[illegible]	MHA/NC C2001
[illegible]	NC Food Banks
Wayne Williams	OSBM
Mary Greene	OSBM
[illegible]	OSBM
NELS ROSELAND	OSBM
Sharnese Ramone	DSS
Bennie Hollers	DHSS

VISITOR REGISTRATION SHEET

Approp. Health & Human Services — 6/6/2000
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joan Edgerton	DHHS
Allyn Duffy	DHHS
Sara R. Allen	Covenant w/ NC's Children
Jane Pinsky	Poe Center
Laurent Farmer	DHHS - dcd

HOUSE APPROPRIATIONS SUBCOMMITTEE
HEALTH AND HUMAN SERVICES

Minutes

June 12, 2000

The North Carolina General Assembly House Appropriations Subcommittee on Health and Human Service met on Monday, June 12, 2000, at 2:00 p.m. in Room 643 of the Legislative Office Building.

Representative Edd Nye, Co-Chairman, presided. Members present were: Representative Beverly Earle, Co-Chairman; Representative Martha Alexander, Vice Chairman; Representative Alma Adams, Representative Lanier Cansler, Representative Theresa Esposito, Representative Trudi Walend, and Representative Gene Wilson.

Chairman Nye asked the Sergeant-At-Arms to distribute copies of the budget (see Attachment 1) and then asked staff to present the budget changes. Ms. Karen Hammonds-Blanks, Fiscal Research Division, explained the changes in Division of Mental Health and Division of Social Services. Ms. Carol Shaw went over the changes in the Division of Medical Assistance and Office of the Secretary. Representative Adams asked for the number of vacant positions and was told staff would get that information. Ms. Mary Ellen Sylvester explained the changes in the Division of Child Development and Division of Vocational Rehabilitation. Ms. Lisa Hollowell presented the changes for the Division of Public Health.

Ms. Hammonds-Blanks discussed the changes for the Division of Mental Health and Division of Social Services. Ms. Hollowell explained the changes for Division of Public Health. Representative Esposito questioned the Arthritis Prevention Project and asked how it differs with the arthritis program already being provided. Staff will get that information for her. Ms. Sylvester discussed the two expansion items in the child development program, Division of Service of for Deaf/Hard of Hearing, Division of Services for the Blind and Division of Vocational Rehabilitation. Ms. Shaw highlighted the changes for the Division of Medical Assistance, Division of Facility Services and the Division of Aging. Representative Cansler expressed concerns with Medicaid.

Ms. Hammonds-Blanks reviewed the Block Grant provisions in the Special Provisions handout (see Attachment 2). Special Children Adoption Fund has been increased. Employment Security Commission First Stop Program has been decreased from four million to one million dollars based on utilization. Child Care subsidies for TANF

recipients has been increased from previous year. Expand Support Our Students is a new program located in the Office of Juvenile Justice, which will provide at least one program for each county. Residential Substance Abuse Services for Women and Children is a new item to create and expand residential substance abuse services for TANF recipients with children. Domestic Violence Services for Work First families is a new item. The Responsible Fatherhood Initiative was recommended in the Governor's plan. A new allocation for two million is for After School Services for At-Risk Children. The Business Process Reengineering Project was in the Governor's plan. Five hundred thousand is for seven positions and other cost related to administration in the Division of Social Services Administration. One hundred twenty additional workers would be provided for at the local level in the provision for Child Protective Services and Foster Care and Adoption Services. These positions are to be created on or after July 1, 2000.

Ms. Hollowell explained the Maternal and Child Health Block Grant. This is being recommended as the Governor's plan recommended. There is a slight increase from the previous year. There was a slight decrease in the Preventive Health Services Block Grant of four hundred thousand taken from the statewide health promotions programs. The Dental Services/Fluoridation Program received a slight decrease, as did administrative cost.

Ms. Hammonds-Blanks reviewed the Total Preventive Health Services Block Grant. The three million dollars appropriated for the Work First Housing Initiative is to be used only for direct housing support to Work First clients and not for administration, counseling, or other similar services. Five million dollars is appropriated to establish and expand regional residential substance abuse treatment and services for TANF women with children. One million eight hundred thousand dollars is appropriated for the Support Our Students Program statewide. These funds are to be used for direct services only and not for administration. Three million dollars is appropriated for domestic violence services. The funds are for direct services and not for new shelters. The Department is to work with the Council of Women and local programs to develop a mechanism whereby these funds can serve TANF recipients. Two million dollars is appropriated for at-risk children and after school programs. Five million twelve thousand dollars shall be used to continue the Business Process Reengineering Project. The Department will report directly to the Information Resource Management Commission on the use of these funds.

Ms. Hollowell reviewed the Responsible Fatherhood Initiative. The one million dollars would be used to augment the existing efforts targeted at males and to expand the responsible parenting programs to include young-adult males. The Department will develop guidelines to administer all of the pregnancy prevention activities and the parenting program. The program will be targeted to the counties with the highest teen pregnancy rates, and those that have the greatest need for parenting programs. Administrative expenses shall not exceed ten percent. Annual reporting is required.

Ms. Shaw went over the section on Administration. The Secretary of the Department of Health and Human Services shall adopt measurable standards and goals for community

health. Representative Esposito questioned how measurable standards are described. Dr. David Bruton, Secretary, Department of Health and Human Resources, responded it would be a facts- finding activity to learn causes of the health problems of citizens. Representative Alexander questioned how the group of providers was chosen in section on services and payment. Mr. Dick Perruzzi, Medical Assistance Division DHHS, responded the Department was trying to make Medicaid consistent with NC Health Choice for Children. The goal is to put NC Health Choice for Children behavioral health services in sink with Medicaid's services for children. The same practitioners were chosen that are enrolled by the State health plan. Representative Alexander asked if there were any other eligible providers. Mr. Perruzzi responded the Department was trying to follow what the State employees' health plan is doing and also be consistent with federal regulations.

Ms. Hammonds-Blanks highlighted the section on Child Welfare System Improvements. The special provision continues a report from the Division of Social Services regarding deaths with children that are known to be in the child welfare system. It codifies the training requirement for child welfare workers at the local level. The formerly court-mandated Willie M. Program would be eliminated effective immediately.

Ms. Sylvester reviewed the Early Intervention Services Section. This is being amended to appropriate an additional two hundred and fifty thousand dollars to strengthen the two pilot efforts.

Ms. Hollowell went over the last of the special provisions.

Chairman Nye asked if there were any questions or further debate. Representative Earle made a motion to approve the money report and special provisions. The motion carried.

Chairman Nye ended the meeting.

Presiding Co-Chairman-Representative Edd Nye

Committee Assistant-Jo Bobbitt

Attachment 1

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

BUDGET

JUNE 12, 2000

Health and Human Services

GENERAL FUND

	FY 00-01
Total Budget Approved 1999 Session	**$3,014,095,636**

Budget Changes

(1.0) Division of Mental Health

1 Reduce Operating Reserve ($571,526) NR

Reduces the operating reserve (on a non-recurring basis) for a new neurobehavioral unit to be created within the Black Mountain Center. Allows the unit to open during FY01/02.

(2.0) Division of Social Services

2 Reduce Excess Adoption Assistance Funds ($2,300,000) R

Reduces excess adoption assistance funds and allows for the enhancement of adoptions activities.

3 Eliminate Child Support Call Center ($1,550,000) R

Eliminates a planned Child Support Call Center.

-80.00

(3.0) Division of Medical Assistance

4 Transfer Medicaid Reserve Funds ($70,000,000) NR

Transfers funds from G.S. 143-23.2 reserve to support current services and to reduce appropriations.

5 Adjust Medicaid Funding ($32,388,631) R

Reduces appropriations to reflect current projections for the Medicaid Program.

6 Reduce Administrative Funding ($127,000) R

Reduces program funding to support positions required by federal and state mandates.

7 Increase Medicaid Drug Rebate Receipts ($12,146,498) R

Increases receipts from the Drug Rebate Program to reflect increased expenditures for prescription drugs.

(4.0) Office of the Secretary

8 Eliminate Position $0 R

Eliminates the Health Care Access Coordinator position funded with TANF block grant funds.

-1.00

9 Increase Receipts ($13,120,000)

Reduces appropriations in anticipation of increased receipts for prior year earned revenue.

10 Increase Receipts ($3,000,000)

Reduces appropriations in anticipation of increased receipts across the department.

11 Eliminate 29 Vacant Positions ($2,100,000) R

Eliminates 29 vacant positions across the department except for specific state institutions. -29.00

(5.0) Division of Child Development

12 Reduce Smart Start Funds ($49,000,000) NR

Provides a one-time reduction in Smart Start funding due to lower than anticipated program expenditures.

(6.0) Division of Vocational Rehabilitation

13 Eliminate Operating Reserve for TBI Unit ($956,328) R

Eliminates the operating reserve for the Traumatic Brain Injury (TBI) Unit in Goldsboro since the required capital funding was re-directed to support the Hurricane Floyd recovery effort. -48.00

(7.0) Division of Public Health

14 Reduce Funding to Forensic Test for Alcohol Pgm. ($964,871) R

Reduces appropriations and allows the fees collected to be budgeted to support the functions in the Forensic Test for Alcohol Program.

15 Reduce Funding to Public Health Laboratory ($220,000) R

Decreases appropriations by the amount of increased Medicaid receipts to offset the cost of Laboratory operations.

16 Reduce Funding to AIDS Drug Assistance Program ($2,000,000) R
($3,000,000) NR

Decreases appropriations for the AIDS Drug Assistance Program by $2,000,000 due to increased federal funds. Also, decreases appropriations by $3,000,000 due to under-utilization of the program.

17 Reduce Funding to Developmental Evaluation Centers ($1,000,000) R

Reduces appropriations to the Developmental Evaluation Centers due to increased Medicaid receipts.

18 Reduce Funding to Medical Examiner's Office ($100,000) R

Reduces appropriations by the amount of the increase in Medical Examiner's Fees in 1999.

(8.0) Division of Mental Health

19	**Services for Violent and Assaultive Children** Provides funds to continue current mental health service levels for violent and assaultive children.	$4,353,000	NR
20	**Early Intervention System Pilots** Provides additional funds to support the integrated client database and regional transdisciplinary team pilots for young children receiving early intervention services.	$250,000	NR
21	**Mental Health System Reform Reserve** Establishes a Mental Health System Reform Reserve in order to comply with the Olmstead Supreme Court decision regarding de-institutionalization of individuals with mental health disabilities. Also, provides funds for the anticipated reform of the public mental health system.	$3,000,000	NR
22	**Housing Support for the Mentally Ill** Provides matching funds to draw down federal funds for the support of an additional 38 housing placements for the mentally ill.	$301,000	NR
23	**Funds for Autistic Adults** Provides funds to the N.C. Autism Society for additional services to adults with autism.	$250,000	R
24	**Substance Abuse Services Positions** Adds four (4) positions to the Substance Abuse Services Section to support the (1) Employee Assistance Program, (2) Offender Management Program, (3) Quality assurance services for DWI offenders, and (4) Development of housing and other 24-hour services. The positions are offset by the Substance Abuse Prevention and Treatment Block Grant.	$0 4.00	R
25	**Community Mental Health Programs** Provides funds for area mental health programs as follows: Substance Abuse Services $2,000,000 Developmental Disabilities $2,000,000	$4,000,000	R
26	**Child Residential Treatment/Services Program** Establishes a child mental health residential treatment/services program in order to provide appropriate residential treatment alternatives for children at risk of institutionalization or other out-of-home placement. Also, provides for the creation of six (6) new positions: Division of Mental Health,Developmental Disabilities & Substance Abuse Services 3.0; Controller's Office 1.0 and Division of Social Services 2.0.	$8,000,000 6.00	R

27 Atypical Antipsychotic Medications — $750,000

Provides additional funds for atypical antipsychotic medications for local area mental health programs.

28 Autistic Child & Adolescent Units at Murdoch — $3,000,000 NR

Provides start up and operational funds to establish residential services for autistic children and adolescents within and on the grounds of the Murdoch Mental Retardation Center located at Butner. — 65.00

29 Area Mental Health Board Training — $150,000 NR

Provides funds to train area mental health programs' board members. (This appropriation was included in HB 168 during the 1999 Session but was diverted for flood relief.)

(9.0) Division of Social Services

30 Special Children Adoption Incentives Fund — $500,000 R

Establishes a fund to provide financial incentives for foster care families desiring to adopt special needs children residing in their care.

31 State/County Special Assistance — $6,000,000 R

Increases monthly State/County Special Assistance payment from $982 to $1,062. Effective October 1, 2000.

32 Food Banks — $1,000,000 NR

Provides funds to be equally distributed to the regional network of food banks in North Carolina.

33 Foster Care Independent Living Matching Funds — $500,000 R

Provides the match for federal Independent Living Program funds in order to prepare children for the transition from foster care to independence. Also, provides for the addition of one position to coordinate the program. — 1.00

34 Special Children Adoption Fund — $1,100,000 R

Increases the Special Children Adoption Fund which provides financial incentives to local departments of social services and private non-profit adoption placement programs for the placement of children in foster care. Also, provides post-adoption support funds to ensure placements are successful.

35 Administrative Support — $0 R

Provides for the addition of seven (7) positions within the Division of Social Services to enhance and support the Work First Program and coordinate expanded after school programs for at-risk children. These positions are totally offset with TANF block grant funds. — 7.00

36 Adoptions Program — $200,000 R
Provides additional staff and related funds to address the backlog in processing adoptions information. — 3.00

(10.0) Division of Public Health

37 Office of Minority Health — $200,000 NR
Provides funding to support mini-grants for coalition-building at the local level. Provides funding for minority infant mortality reduction efforts.

38 Healthy Carolinians — $1,000,000 NR
Provides funding for Healthy Carolinians' task forces throughout the state.

39 Osteoporosis Task Force — $150,000 NR
Provides funding to continue support for the Osteoporosis Task Force.

40 Heart Disease and Stroke Prevention — $100,000 NR
Provides funding to the Heart Disease and Stroke Prevention Task Force for implementation of the NC Plan to Prevent Heart Disease and Stroke.

41 Arthritis Prevention Project — $25,000 NR
Provides grant-in-aid for a private, local project providing services for arthritis patients in Mecklenburg County.

42 Alice Aycock Poe Center for Health Education — $200,000 NR
Provides grant-in-aid to the Alice Aycock Poe Center for Health Education.

43 Prescription Drug Assistance Program — $500,000 NR
Provides increased funding for the Prescription Drug Assistance Program for persons over age 65.

44 Healthy Start Foundation — $1,000,000 NR
Funds the statewide public information and education activities of the First Step campaign. Provides mini-grants for local communities to implement pilot programs aimed at reducing infant mortality.

45 Birth Defects Monitoring Program — $200,000 R
Provides funding to initiate the development of a birth defects registry. — 4.00

46 Hepatitis C Education Awareness — $150,000 NR
Provides funding for Hepatitis C education and awareness activities.

47 Asthma Education — $250,000
Provides funding to support asthma management, control, surveillance, and education.

48 State Games — $200,000 NR
Supports the State Games of North Carolina to promote health and fitness.

(11.0) Division of Child Development

49 T.E.A.C.H. Program — $400,000 R
Provides funding to expand the Teacher Education and Compensation Helps (T.E.A.C.H.) Program which assists child care teachers in pursuing higher education in the field of early childhood.

50 Smart Start Program — $43,500,000 R; $500,000 NR
Provides additional funding for direct services statewide, state-level administration, program evaluation, and county collaboration efforts.

(12.0) Div. of Serv. for Deaf/Hard of Hearing

51 Individual Education Plan (IEP) Services — $600,000 NR
Provides additional funding for contractual services required by students' IEPs at the residential schools for the deaf.

52 Teacher Mentor Pay — $56,250 NR
Provides funding to compensate experienced teachers at the schools for the deaf who serve as mentors for new teachers.

53 Day Student Transportation — $375,000 NR
Provides funding for transporting deaf and hard of hearing day students to programs at the Division's three residential campuses.

54 Family Support Services — $220,000 R
Expands support services to families with deaf and hard of hearing children as a result of increased demand from the newborn hearing screening program.

(13.0) Division of Services for the Blind

55 Individual Education Plan (IEP) Services — $200,000 NR
Provides additional funding for contractual services required by students' IEPs at the Governor Morehead School.

56 Teacher Mentor Pay — $18,750 NR
Provides funding to compensate experienced teachers at the Governor Morehead School who serve as mentors for new teachers.

57 Services for Deaf/Blind Children — $225,000 R
Provides funding to establish a specialized program for deaf/blind children at the Governor Morehead School, including expansion of NC Central University's master's degree program in visual impairment to include intervenor training. — 5.00

58 Vocational Rehabilitation Case Services Funds — $235,000 NR
Provides additional funds to offset the increased tuition costs for visually-impaired vocational rehabilitation clients attending in-state universities.

59 Day Student Transportation — $125,000 NR
Provides funding for transporting visually-impaired day students to programs at the Governor Morehead School campus.

(14.0) Division of Vocational Rehabilitation

60 Client Information System — $1,700,000 NR
Completes development and implementation of an automated client information system.

61 Case Services Funds — $615,000 NR
Provides additional funds to offset the increased tuition costs of clients attending in-state universities.

62 Independent Living Rehabilitation Program — $2,000,000 R; $2,000,000 NR
Provides additional funding to address client needs statewide and continue technical assistance to the housing industry on design requirements for multifamily housing for disabled individuals.

(15.0) Division of Medical Assistance

63 Medicaid Positions — $127,000 R
Provides funding to support three positions to meet federal HIPAA requirements and one position to meet increased demands from provider enrollment. — 4.00

64 Additional CAP-MR/DD Slots — $6,890,000 R
Funds 600 CAP-MR/DD slots in the Medicaid Program.

(16.0) Office of the Secretary

65 Child Advocacy Institute — $250,000 NR
Provides funding for the continuation of the Child Advocacy Institute's activities to collect and publish the annual report on the status of children in North Carolina.

66	**North Carolina Council on the Holocaust** Provides funds for Holocaust education in the public schools.	$25,000	
67	**Latin American Resource Center** Provides grant-in-aid to the Latin American Resource Center (LARC) for administration and outreach operations relative to its programs, including DIALOGO.	$75,000	NR
	(17.0) Division of Facility Services		
68	**Statewide Poison Control Center** Provides funding for the Statewide Poison Control Center at Carolinas Medical Center.	$1,000,000	R
69	**Adult Care Home Inspectors** Provides additional inspectors to implement requirements of Senate Bill 10.	$149,000 6.00	R
70	**Nurse Aide Online Training** Provides funding for the State Board of Community Colleges for the development and implementation of on-site internet training or other innovative training programs designed to improve recruitment and reduce turnover of certified nursing assistants in nursing facilities.	$500,000	NR
	(18.0) Division of Aging		
71	**Adult Day Care Start-up Grants** Provides funding for up to 10 start-up grants for new Adult Day Care Programs.	$250,000	NR
	Budget Changes	**$17,157,672**	R
		($112,337,526)	NR
	Total Position Changes	-53.00	
	Revised Total Budget	**$2,918,915,782**	

Attachment 2

HOUSE APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES

SPECIAL PROVISIONS

JUNE 12, 2000

PART V. BLOCK GRANT FUNDS

CODE NO. 2000DHHS-H009D*
Requested by: Representatives Earle, Nye, Easterling, Redwine
DHHS BLOCK GRANT PROVISIONS

Section 5.(a) Appropriations from federal block grant funds are made for the fiscal year ending June 30, 2001, according to the following schedule:

COMMUNITY SERVICES BLOCK GRANT

01.	Community Action Agencies	$ 12,377,017
02.	Limited Purpose Agencies	687,612
03.	Department of Health and Human Services to administer and monitor the activities of the Community Services Block Grant	687,612
TOTAL COMMUNITY SERVICES BLOCK GRANT		$ 13,752,241

SOCIAL SERVICES BLOCK GRANT

01.	County departments of social services (Transfer from TANF - $4,500,000)	$ 27,395,663
02.	Allocation for in-home services provided by county departments of social services	2,101,113
03.	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	3,234,601
04.	Division of Services for the Blind	3,105,711
05.	Division of Facility Services	426,836
06.	Division of Aging - Home and Community Care Block Grant	1,840,234
07.	Child Care Subsidies	3,000,000
08.	Division of Vocational Rehabilitation - United Cerebral Palsy	71,484
09.	State administration	1,693,368
10.	Child Medical Evaluation Program	238,321
11.	Adult day care services	2,155,301
12.	County departments of social services for	

	child abuse prevention and permanency planning	394,841
13.	Transfer to Preventive Health Services Block Grant for emergency medical services	213,128
14.	Transfer to Preventive Health Services Block Grant for AIDS education, counseling, and testing	66,939
15.	Department of Administration for the N.C. Commission of Indian Affairs In-Home Services Program for the elderly	203,198
16.	Division of Vocational Rehabilitation - Easter Seals Society	116,779
17.	UNC-CH CARES Program for training and consultation services	247,920
18.	Office of the Secretary - Office of Economic Opportunity for N.C. Senior Citizens' Federation for outreach services to low-income elderly persons	41,302
19.	Special Children Adoption Fund	511,687
20.	Transfer from TANF Block Grant for Enhanced Employee Assistance Program	1,000,000
21.	Transfer from TANF Block Grant for Division of Social Services - Child Caring Agencies	1,500,000
22.	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services - Developmentally Disabled Waiting List for services	5,000,000
TOTAL SOCIAL SERVICES BLOCK GRANT		$ 54,558,426
LOW-INCOME ENERGY BLOCK GRANT		
01.	Energy Assistance Programs	$ 8,092,113
02.	Crisis Intervention	7,078,114
03.	Administration	1,988,234
04.	Department of Commerce - Weatherization Program	2,684,116
05.	Department of Administration -	

N.C. Commission of Indian Affairs	39,765
TOTAL LOW-INCOME ENERGY BLOCK GRANT	$ 19,882,342
MENTAL HEALTH SERVICES BLOCK GRANT	
01. Provision of community-based services in accordance with the Mental Health Study Commission's Adult Severe and Persistently Mentally Ill Plan	$ 4,301,361
02. Provision of community-based services to children	1,898,520
03. Establish Child Residential Treatment Services Program	1,500,000
04. Administration	783,911
TOTAL MENTAL HEALTH SERVICES BLOCK GRANT	$ 8,483,792
SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT	
01. Provision of community-based alcohol and drug abuse services, tuberculosis services, and services provided by the Alcohol and Drug Abuse Treatment Centers	$ 15,043,841
02. Continuation of services for pregnant women and women with dependent children	6,567,532
03. Continuation of services to IV drug abusers and others at risk for HIV diseases	5,210,497
04. Provision of services to children and adolescents	7,216,992
05. Juvenile Services - Family Focus	893,811
06. Juvenile offender services and substance abuse pilot	300,000
07. Establish Child Residential Treatment Services Program	1,000,000
08. Administration	2,623,049
TOTAL SUBSTANCE ABUSE PREVENTION	

AND TREATMENT BLOCK GRANT	$ 38,855,722
CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT	
01. Child care subsidies	$117,145,326
02. Quality and availability initiatives	12,332,039
03. Administrative expenses	6,814,598
04. Transfer from TANF Block Grant for child care subsidies	57,957,188
05. Transfer from TANF Block Grant for child care rate increases and quality initiatives	18,717,812
TOTAL CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT	$212,966,963
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) BLOCK GRANT	
01. Work First Cash Assistance	
Standard Counties	$ 81,859,561
Electing Counties	24,331,095
02. Work First County Block Grants	92,018,855
03. Transfer to the Child Care and Development Fund Block Grant for child care subsidies	57,957,188
04. Allocation to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for Work First substance abuse screening, diagnostic, and support treatment services and drug testing	3,500,000
05. Allocation to the Division of Social Services for Work First Evaluation	1,500,000
06. Allocation to the Division of Social Services for staff development	500,000
07. Reduction of out-of-wedlock births	1,600,000
08. Substance Abuse Services for Juveniles	1,182,280
09. Special Children Adoption Fund	2,300,000
10. Employment Security Commission - First Stop Employment Assistance	1,000,000

11.	Transfer to Social Services Block Grant - Enhanced Employee Assistance Program	1,000,000
12.	Work First Job Retention and Follow-Up Initiatives	1,607,529
13.	Allocation to the Division of Public Health for teen pregnancy prevention	2,000,000
14.	Transfer to Social Services Block Grant for Child Caring Agencies	1,500,000
15.	Child Care Subsidies for TANF Recipients	26,621,241
16.	Work First Housing Initiative	3,000,000
17.	Transfer to Child Care and Development Fund Block Grant for Child Care Rate Increases	18,717,812
18.	Allocation to the Division of Social Services for Domestic Violence Prevention and Awareness	1,000,000
19.	County Child Protective Services, Foster Care and Adoption Workers	2,727,550
20.	Intensive Family Preservation Program	2,000,000
21.	Work First/Boys and Girls Clubs	1,000,000
22.	Transfer to Social Services Block Grant for County Departments of Social Services for Children's Services	4,500,000
23.	Adolescent Pregnancy Prevention Program	239,261
24.	Governor's One-on-One Program - Office of Juvenile Justice	950,674
25.	Expand Support Our Students - Office of Juvenile Justice	1,800,000
26.	Residential Substance Abuse Services for Women with Children	5,000,000
27.	Domestic Violence Services for Work First families	3,000,000
28.	Responsible Fatherhood Initiative	1,000,000
29.	After School Services for At-Risk Children	2,000,000

30. Business Process Reengineering Project	5,012,000
31. Division of Social Services - Administration	500,000
32. Child Welfare workers for local departments of social services	6,600,000
33. Work First Pilots	5,400,000
TOTAL TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) BLOCK GRANT	$364,925,046
MATERNAL AND CHILD HEALTH BLOCK GRANT	
01. Healthy Mothers/Healthy Children Block Grants to Local Health Departments	$ 9,838,074
02. High-Risk Maternity Clinic Services, Perinatal Education and Training, Childhood Injury Prevention, Public Information and Education, and Technical Assistance to Local Health Departments	2,012,102
03. Services to Children With Special Health Care Needs	5,078,647
TOTAL MATERNAL AND CHILD HEALTH BLOCK GRANT	$ 16,928,823
PREVENTIVE HEALTH SERVICES BLOCK GRANT	
01. Statewide Health Promotion Programs	$3,184,399
02. Dental Services/Fluoridation	100,800
03. Rape Crisis/Victims' Services Program - Council for Women	190,134
04. Rape Prevention and Education Program - Division of Public Health and Council for Women	1,137,186
05. Transfer from Social Services Block Grant - AIDS/HIV Education, Counseling, and Testing	66,939
06. Transfer from Social Services Block Grant - Emergency Medical Services	213,128

07. Office of Minority Health	159,459
08. Administrative Costs	143,151
TOTAL PREVENTIVE HEALTH SERVICES BLOCK GRANT	$5,195,196

Section 5.(b) Decreases in Federal Fund Availability. -- If the United States Congress reduces federal fund availability in the Social Services Block Grant below the amounts appropriated in this section, then the Department of Health and Human Services shall allocate these decreases giving priority first to those direct services mandated by State or federal law, then to those programs providing direct services that have demonstrated effectiveness in meeting the federally and State-mandated services goals established for the Social Services Block Grant. The Department shall not include transfers from TANF for specified purposes in any calculations of reductions to the Social Services Block Grant.

If the United States Congress reduces the amount of TANF funds below the amounts appropriated in this section after the effective date of this act, then the Department shall allocate the decrease in funds after considering any underutilization of the budget and the effectiveness of the current level of services. Any TANF Block Grant fund changes shall be reported to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Decreases in federal fund availability shall be allocated for the Maternal and Child Health and Preventive Health Services federal block grants by the Department of Health and Human Services after considering the effectiveness of the current level of services.

Section 5.(c) Increases in Federal Fund Availability. -- Any block grant funds appropriated by the United States Congress in addition to the funds specified in this act shall be expended by the Department of Health and Human Services, with the approval of the Office of State Budget and Management, provided the resultant increases are in accordance with federal block grant requirements and are within the scope of the block grant plan approved by the General Assembly.

Section 5.(d) Changes to the budgeted allocations to the block grants appropriated in this act due to decreases or increases in federal funds shall be reported immediately to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Section 5.(e) Limitations on Preventive Health Services Block Grant Funds. -- Twenty-five percent (25%) of funds allocated for Rape Prevention and Rape Education shall be allocated as grants to nonprofit organizations to provide rape prevention and education programs targeted for middle, junior high, and high school students.

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 2000-2001 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). The Department of Public Instruction shall carefully and strictly follow federal guidelines in implementing and administering the abstinence education grant funds.

Section 5.(f) The sum of one million five hundred thousand dollars ($1,500,000) appropriated to the Department of Health and Human Services, Division of Social Services, in the TANF Block Grant for the 2000-2001 fiscal year for the evaluation of the Work First Program shall be used to do each of the following:

(1) Expand the current evaluation of the Work First Program to assess former recipients' earnings, barriers to advancement to economic self-sufficiency, utilization of community support services, and other longitudinal employment data. Assessment periods shall include six and 18 months following closure of the case.

(2) Expand the current evaluation of the Work First Program to profile the State's child-only caseload to include indicators of economic and social well-being, academic and behavioral performance, demographic data, description of living arrangements including length of placement out of the home, social and other human services provided to families, and other information needed to assess the needs of the child-only Work First Family Assistance clients and families.

(3) Expand the current evaluation to profile clients and families exempted from federal and State work participation requirements. The evaluation shall include an assessment of the client and family needs including why clients and families have been exempted.

The Department of Health and Human Services shall make a report on its progress in complying with this subsection to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than September 30, 2001, and shall make a final report no later than September 30, 2002.

Section 5.(g) The sum of one million six hundred seven thousand five hundred twenty-nine dollars ($1,607,529) appropriated to the Department of Health and Human Services, Division of Social Services, in this section in the TANF Block Grant in the 2000-2001 fiscal year for the Work First job retention and follow-up model programs shall be used to continue pilots and strategies that support TANF recipients in attaining and maintaining self-sufficiency through job retention, family support services, and pre- and post-TANF follow-up.

The Department of Health and Human Services shall make a report on its use of TANF funds for the Work First job retention pilots. This report shall include each of the following:

(1) A description of the clients served by the program. This description shall include demographic and geographic information about the clients.
(2) A description of services provided by the program.
(3) The effectiveness of services to clients. Effectiveness of services to clients shall be measured, in part, by the percentage of clients who remain employed at intervals of six months and one year after commencement of employment.
(4) The estimated cost of services per client.
(5) A description of the development and design of the program and of any evaluation mechanisms.
(6) A description of coordination efforts among local departments of social services with other human services agencies.
(7) A description of progress in achieving other outcome goals such as family economic progress and child/family well-being.

This report shall be made to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than April 1, 2001.

Section 5.(h) The sum of five hundred eleven thousand six hundred eighty-seven dollars ($511,687) appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Special Children Adoption Fund, for the 2000-2001 fiscal year shall be used to implement this subsection. 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 5.(i) If funds appropriated through the Child Care and Development Fund 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 other programs, in accordance with federal requirements of the grant, in order to use the federal funds fully.

Section 5.(j) The sum of one million five hundred thousand dollars ($1,500,000) appropriated in this act in the TANF Block Grant and transferred to the Social Services Block Grant to the Department of Health and Human Services, Division of Social Services, for Child Caring Agencies for the 2000-2001 fiscal year shall be allocated to the State Private Child Caring Agencies Fund. These funds shall be combined with all other funds allocated to the State Private Child Caring Agencies Fund for the reimbursement of the State's portion of the cost of care for the placement of certain children by the county departments of social services who are

not eligible for federal IV-E funds. These funds shall not be used to match other federal funds.

Section 5.(k) The sum of one million dollars ($1,000,000) appropriated in this section in the TANF Block Grant and transferred to the Social Services Block Grant to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall be used for the Enhanced Employee Assistance Program, to continue a grant program of financial incentives for private businesses employing former and current Work First recipients. These grants may supply funds to private employers who agree to hire former or current Work First recipients or their spouses at entry-level positions and wages and to supply enhanced grant funds to private employers who agree to hire former or current Work First recipients or their spouses at a level higher than entry-level position, paying more than the minimum wage, including fringe benefits.

Section 5.(l) The sum of four million two hundred thirty-seven thousand four hundred fifty dollars ($4,237,450) appropriated in this act in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, for the 2000-2001 fiscal year for Child Welfare Improvements shall be allocated to the county departments of social services for hiring or contracting additional staff on or after July 1, 2000, to recruit, train, license, and support prospective foster and adoptive families, and to provide interstate and post-adoption services for eligible families.

Section 5.(m) The sum of two million dollars ($2,000,000) appropriated in this act in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, for the 2000-2001 fiscal year for the Intensive Family Preservation Services (IFPS) Program shall be used by the Division, in consultation with local departments of social services and other human services agencies, to plan and implement a revised IFPS Program.

Notwithstanding the provisions of G.S. 143B-150.6, the Program shall provide intensive services to children and families in cases of abuse, neglect, and dependency where a child is at imminent risk of removal from the home and to children and families in cases of abuse where a child is not at imminent risk of removal. The Program shall be developed and implemented statewide on a regional basis. The revised IFPS Program shall ensure the application of standardized assessment criteria for determining imminent risk and clear criteria for determining out-of-home placement.

The Department shall reexamine the existing IFPS Program design to ensure the application of a standardized assessment and clear criteria for the determination of imminent risk of removal. Additionally, the Department shall assess the education and skill levels required of staff providing intensive family preservation services in existing programs.

The Department shall develop a revised evaluation model for the current and expanded IFPS Program. This evaluation shall not include area mental health or juvenile justice programs. The model shall be scientifically rigorous, including the use of treatment comparison groups, a review and description of interventions

provided to families as compared to customary services provided to other child welfare children and families, and data regarding the number and type of referrals made for other human services and the utilization of those services.

The Department shall report on the use of the funds appropriated under this subsection, including the revised evaluation model and IFPS Program, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than April 1, 2001.

Section 5.(n) The Department of Health and Human Services and the Employment Security Commission shall report on the use of funds appropriated under this section from the TANF Block Grant to the First Stop Employment Assistance Program. This report shall include each of the following:

(1) The number of clients served since the inception of the program by fiscal year.
(2) The amount of funds expended each fiscal year.
(3) A description of the clients served. This description shall include demographic information about these clients.
(4) A description of coordination efforts with other human services agencies, including local departments of social services.
(5) A description of specific services provided to both initial and intensive First Stop clients.
(6) The placement rates of clients in both the initial and intensive programs.
(7) Statistics related to job retention, measured at least at intervals of six months and one year after the commencement of employment.
(8) Statistics related to the wage history of clients.
(9) Any other information the Department and the Employment Security Commission find relevant to an evaluation of the program.

This report shall be made to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than April 1, 2001.

Section 5.(o) The sum of one million dollars ($1,000,000) appropriated in this section to the Department of Health and Human Services in the TANF Block Grant for Boys and Girls Clubs shall be used to make grants for approved programs. The Department of Health and Human Services, in accordance with federal regulations for the use of TANF Block Grant funds, shall administer a grant program to award funds to the Boys and Girls Clubs across the State in order to implement programs that improve the motivation, performance, and self-esteem of youth and to implement other initiatives that would be expected to reduce school dropout and teen pregnancy rates. The Department shall encourage and facilitate collaboration between the Boys and Girls Clubs and Support Our Students, Communities in Schools, and similar programs to submit joint applications for the funds if

appropriate. The Department shall report on its progress in complying with this subsection to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later that April 1, 2001.

Section 5.(p) 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 5.(q) The sum of three million dollars ($3,000,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, for the Work First Housing Initiative shall be used only for direct housing support to Work First clients and families. Direct housing support includes using funds for rental assistance, loans, moving expenses, and other financial assistance. These funds shall not be used for administration, counseling, or other similar services.

Section 5.(r) The sum of five hundred thousand dollars ($500,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, for the 2000-2001 fiscal year shall be used to support administration of TANF-funded programs.

Section 5.(s) The sum of nine hundred fifty thousand six hundred seventy-four dollars ($950,674) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services and transferred to the Office of Juvenile Justice for the 2000-2001 fiscal year shall be used to continue the Governor's One-on-One Program.

Section 5.(t) The sum of five million dollars ($5,000,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the 2000-2001 fiscal year shall be used to establish and expand regional residential substance abuse treatment and services for women with children. The Department of Health and Human Services, the Division of Social Services, and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in consultation with local departments of social services, area mental health programs, and other State and local agencies or organizations, shall coordinate this effort in order to facilitate the expansion of regionally based substance abuse services for women with children. These services shall be culturally appropriate and designed for the unique needs of TANF women with children.

In order to expedite the expansion of these services, the Secretary of the Department of Health and Human Services may enter into contracts with service providers.

The Department of Health and Human Services, the Division of Social Services, and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall report on their progress in complying with this subsection no later than October 1, 2000, and March 1, 2001, to the Senate Appropriations Committee on Human Resources, the House of Representatives

Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division. These reports shall include all of the following:

(1) The number and location of additional beds created.
(2) The types of facilities established.
(3) The delineation of roles and responsibilities at the State and local levels.
(4) Demographics of the women served, the number of women served, and the cost per client.
(5) Demographics of the children served, the number of children served, and the services provided.
(6) Job placement services provided to women.
(7) A plan for follow-up and evaluation of services provided with an emphasis on outcomes.
(8) Barriers identified to the successful implementation of the expansion.
(9) Identification of other resources needed to appropriately and efficiently provide services to Work First recipients.
(10) Other information as requested.

Section 5.(u) The sum of one million eight hundred thousand dollars ($1,800,000) appropriated under this section in the TANF Block Grant to the Department of Health and Human Services and transferred to the Office of Juvenile Justice for the 2000-2001 fiscal year shall be used to expand the Support Our Students Program statewide. These funds shall not be used for administration of the program.

Section 5.(v) The sum of three million dollars ($3,000,000) appropriated under this section in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, for the 2000-2001 fiscal year shall be used to provide domestic violence services to Work First recipients. The Division of Social Services, in consultation with the Council for Women, shall develop and implement a mechanism by which these funds may be used to facilitate delivery of domestic violence counseling, support, and other direct services to clients. These funds shall not be used to establish new domestic violence shelters, for State administration, or to facilitate lobbying efforts. The Department of Health and Human Services and the Council for Women shall report on the uses of these funds no later than February 1, 2001, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Section 5.(w) The sum of one million dollars ($1,000,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services, Division of Public Health, for the 2000-2001 fiscal year shall be used to support the Responsible Fatherhood Initiative. These funds shall be used to augment the existing efforts targeted at males and to expand the responsible parenting programs to young-adult males. These funds shall be targeted at counties with the highest needs as determined by the Division of Public Health. The evaluation of this

initiative shall be incorporated into the overall evaluation of the pregnancy prevention and responsible parenting activities currently in place. This initiative shall be administered as directed in subsection (x) of this section.

Section 5.(x) The funds appropriated to the Department of Health and Human Services, Division of Public Health, in this act for the 2000-2001 fiscal year for teen pregnancy prevention shall be used in accordance with the provisions of this subsection.

Effective July 1, 2000, the Department of Health and Human Services, Division of Public Health, shall adopt guidelines for the administration of funds for teen pregnancy prevention and for parenting programs. The guidelines shall include the following programmatic requirements:

(1) Council development at the local level is encouraged but not required for program funding. Councils that received first-year funding for the 1999-2000 fiscal year for administrative expenses for coalition building and partnership development shall receive funds committed for the second year of organizational development. The Division shall encourage programs that receive funding under this section to involve Healthy Carolinians task forces in program efforts in lieu of forming additional councils.

(2) In awarding grants, the Department shall target counties with the highest teen pregnancy rates and greatest need for parenting programs. Grants may be renewed based on program efficiency and effectiveness, teen pregnancy rates, and the level of need for parenting programs. Amounts awarded for grant renewals shall not be based on the 5 year program funding cycle established under G.S. 130A-131.15.

(3) The Division shall encourage all programs to implement best practice models. All existing programs not using best practice models shall be encouraged to transition to the use of best practice models.

(4) Programs are not required to provide a cash match for these funds.

Funds for State-level administrative expenses of the Program shall not exceed ten percent (10%) of the total budget for teen pregnancy prevention and parenting programs. Administrative expenses include staffing and contracted services for evaluation and coalition-building activities.

The Department shall contract with an independent private consulting firm to evaluate the programs. The evaluation shall include standard data collection utilizing the mechanism that has been developed by the University of North Carolina at Chapel Hill, School of Social Work and shall be conducted in a manner that objectively measures the effectiveness of each program evaluated.

The Department shall report annually on March 1, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research

Division. The report shall include information on all of the following for each teen pregnancy prevention and parenting program:

(1) The program budget delineating all administrative expenses, contracts for services, and technical assistance.

(2) A narrative describing each project funded and the amount of funds received by the project.

(3) Effectiveness of the program in reducing teen pregnancy or developing responsible parenting skills in young adults, as applicable.

(4) Status of the evaluation.

Section 5.(y) The sum of two million dollars ($2,000,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, shall be used to expand after-school programs and services for at-risk children. The Department shall develop and implement a grant program to award grants to community-based programs that demonstrate the ability to reach children at risk of teen pregnancy and school dropout. The Department shall award grants to community-based organizations that demonstrate the ability to develop and implement linkages with local departments of social services, area mental health programs, schools, and other human services programs in order to provide support services and assistance to the child and family. These funds may be used to establish one position within the Division of Social Services to coordinate at-risk after-school programs and shall not be used for other State administration. The Department shall report no later than March 1, 2001, on its progress in complying with this section to the Senate Appropriations Committee on Human Resources, the House of Representatives Subcommittee on Health and Human Services, and the Fiscal Research Division.

Section 5.(z) The sum of five million twelve thousand dollars ($5,012,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services shall be used to continue the Business Process Reengineering Project. The Department shall report directly to the Information Resource Management Commission in accordance with the Commission's requirements. The Department shall report on the use of these funds no later than April 1, 2001, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Section 5.(aa) The sum of six million six hundred thousand dollars ($6,600,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, for the 2000-2001 fiscal year for Child Welfare Improvements shall be allocated to the county departments of social services for hiring or contracting additional staff on or after July 1, 2000, to investigate and provide services in Child Protective Services cases; to recruit, train, license, and support prospective foster and adoptive families; and to provide interstate and post-adoption services for eligible families.

Section 5.(bb) The sum of one million five hundred thousand dollars ($1,500,000) appropriated in this section in the Mental Health Block Grant to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the 2000-2001 fiscal year and the sum of one million dollars ($1,000,000) 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 2000-2001 fiscal year shall be used to establish a Child Mental Health Residential Treatment/Services Program in accordance with Section 11.40 of this act.

PART XI. DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBPART 1. ADMINISTRATION

CODE NO. 2000DHHS-H036-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
STATE HEALTH STANDARDS

Section 11. Effective October 1, 2000, Article 1 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-5.1. State health standards.**

(a) The Secretary shall adopt measurable standards and goals for community health against which the State's actions to improve the health status of its citizens will be measured. The Secretary shall report annually to the General Assembly upon its convening or reconvening and to the Governor on all of the following:

(1) How the State compares to national health measurements and established State goals for each standard. Comparisons shall be reported using disaggregated data for health standards.

(2) Steps taken by State and non-State entities to meet established goals.

(3) Additional steps proposed or planned to be taken to achieve established goals.

(b) The Secretary may coordinate and contract with other entities to assist in the establishment of standards and preparation of the report. The Secretary may use resources available to implement this section."

CODE NO. 2000DHHS-H039A-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
DHHS STUDY OF NEW FACILITIES DIVISION

Section 11.1. The Department of Health and Human Services shall study whether a new facilities division to consolidate physical plant operations of all State institutions should be established in the Department. Not later than January 1, 2001, the Department shall report its findings and recommendations to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources.

CODE NO. 2000DHHS-H038-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
ELIMINATION OF VACANT DHHS POSITIONS

Section 11.2. The Department of Health and Human Services shall eliminate 29 vacant positions effective July 1, 2000. Positions eliminated shall not be those that impact direct patient care or services and shall not be positions at the State psychiatric hospitals, alcohol and drug abuse treatment centers, the Wright School, or Whitaker School.

CODE NO. 2000DHHS-H031-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
QUALITY CRITERIA FOR LONG-TERM CARE

Section 11.3. The Department of Health and Human Services in conjunction with the North Carolina Institute of Medicine shall convene a special work group to develop criterion-based indicators for the monitoring of quality of care in North Carolina nursing homes, adult care homes, assisted living facilities, and home health care programs. The Institute of Medicine and the Department of Health

and Human Services shall work together to implement these criteria for the monitoring of long-term care in the State and pursue options for the use of these criteria in lieu of current HCFA-mandated standards for surveying North Carolina nursing homes under the federal Medicaid and Medicare programs.

CODE NO. 2000DHHS-H030A-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
LONG-TERM CARE SERVICES DATA

Section 11.4.(a) By January 1, 2001, the Department of Health and Human Services in conjunction with the North Carolina Institute of Medicine shall:

(1) Identify screening, level of services, and care planning instruments to be used for all DHHS long-term care services;
(2) Develop a timetable for testing and implementing these instruments; and
(3) Compile county level data on the number of people age 18 years or older who use DHHS long-term care services and expenditures by Division and type of program.

Section 11.4.(b) Subsection (a) of Section 11.7A of S.L. 1999-237 reads as rewritten:

"Section 11.7A.(a) The Department of Health and Human Services shall, in cooperation with other appropriate State and local agencies and representatives of consumer and provider organizations, develop a system that provides a continuum of long-term care for elderly and disabled individuals and their families. The Department shall define the system of long-term care services to include:

(1) A structure and means for screening, assessment, and care management across settings of care;
(2) A process to determine outcome measures for care;
(3) An integrated data system to track expenditures, consumer characteristics, and consumer outcomes;
(4) Relationships between the Department and the State's universities to provide policy analysis and program evaluation support for the development of long-term care system reforms;
(5) An implementation plan that addresses testing of models, reviewing existing models, evaluation of components, and steps needed to achieve development of a coordinated system; and
(6) Provision for consumer, provider, and agency input into the system design and implementation development.

Effective January 1, ~~2001,~~ 2002, the system developed by the Department shall do the following:

(1) Implement the initial phase of a comprehensive data system that tracks long-term care expenditures, services, consumer profiles, and consumer preferences; and
(2) Develop a system of statewide long-term care services coordination and case management to minimize administrative costs, improve access to services, and minimize obstacles to the delivery of long-term care services to people in need."

SUBPART 2. MEDICAL ASSISTANCE

CODE NO. 2000DHHS-H017C-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
MEDICAID PROGRAM

Section 11.5. Section 11.12 of S.L. 1999-237 reads as rewritten:

"Section 11.12.(a) Funds appropriated in this act for services provided in accordance with Title XIX of the Social Security Act (Medicaid) are for both the categorically needy and the medically needy. Funds appropriated for these services shall be expended in accordance with the following schedule of services and payment bases. All services and payments are subject to the language at the end of this subsection.

Services and payment bases:

(1) Hospital-Inpatient - Payment for hospital inpatient services will be prescribed in the State Plan as established by the Department of Health and Human Services.

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

(3) Nursing Facilities - Payment for nursing facility services will be prescribed in the State Plan as established by the Department of Health and Human Services. Nursing facilities providing services to Medicaid recipients who also qualify for Medicare, must be enrolled in the Medicare program as a condition of participation in the Medicaid program. State facilities are not subject to the requirement to enroll in the Medicare program.

(4) Intermediate Care Facilities for the Mentally Retarded - As prescribed in the State Plan as established by the Department of Health and Human Services.

(5) Drugs - Drug costs as allowed by federal regulations plus a professional services fee per month excluding refills for the same drug or generic equivalent during the same month. Reimbursement shall be available for up to six prescriptions per recipient, per month, including refills. Payments for drugs are subject to the provisions of subsection (h) of this section and to the provisions at the end of subsection (a) of this section, or in accordance with the State Plan adopted by the Department of Health and Human Services consistent with federal reimbursement regulations. Payment of the professional services fee shall be made in accordance with the State Plan adopted by the Department of Health and Human Services, consistent with federal reimbursement regulations. The professional services fee shall be five dollars and sixty cents ($5.60) per prescription. Adjustments to the professional services fee shall be established by the General Assembly.

(6) Physicians, Chiropractors, Podiatrists, Optometrists, Dentists, Certified Nurse Midwife ~~Services~~ Services, Family Nurse Practitioners - Fee schedules as developed by the Department of Health and Human Services. Payments for dental services are subject to the provisions of subsection (g) of this section.

(7) Community Alternative Program, EPSDT Screens - Payment to be made in accordance with rate schedule developed by the Department of Health and Human Services.

(8) Home Health and Related Services, Private Duty Nursing, Clinic Services, Prepaid Health Plans, Durable Medical Equipment - Payment to be made according to reimbursement plans developed by the Department of Health and Human Services.

(9) Medicare Buy-In - Social Security Administration premium.

(10) Ambulance Services - Uniform fee schedules as developed by the Department of Health and Human Services. Public ambulance providers will be reimbursed at cost.

(11) Hearing Aids - Actual cost plus a dispensing fee.

(12) Rural Health Clinic Services - Provider-based, reasonable cost; nonprovider-based, single-cost reimbursement rate per clinic visit.

(13) Family Planning - Negotiated rate for local health departments. For other providers - see specific services, for instance, hospitals, physicians.

(14) Independent Laboratory and X-Ray Services - Uniform fee schedules as developed by the Department of Health and Human Services.

(15) Optical Supplies - One hundred percent (100%) of reasonable wholesale cost of materials.

(16) Ambulatory Surgical Centers - Payment as prescribed in the reimbursement plan established by the Department of Health and Human Services.

(17) Medicare Crossover Claims - An amount up to the actual coinsurance or deductible or both, in accordance with the State Plan, as approved by the Department of Health and Human Services.

(18) Physical Therapy and Speech Therapy - Services limited to EPSDT eligible children. Payments are to be made only to qualified providers at rates negotiated by the Department of Health and Human Services.

(19) Personal Care Services - Payment in accordance with the State Plan approved by the Department of Health and Human Services.

(20) Case Management Services - Reimbursement in accordance with the availability of funds to be transferred within the Department of Health and Human Services.

(21) Hospice - Services may be provided in accordance with the State Plan developed by the Department of Health and Human Services.

(22) Other Mental Health Services - Unless otherwise covered by this section, coverage is limited to (i) agencies meeting the requirements of the rules established by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services, and reimbursement is made in accordance with a State Plan developed by the Department of Health and Human Services not to exceed the upper limits established in federal ~~regulations.~~ regulations, and (ii) only for children eligible for EPSDT services, licensed or certified psychologists, certified mental health nurse practitioners, and licensed clinical social workers when Medicaid eligible children are referred by the primary care physician or the area mental health program. The Department of Health and Human Services may adopt temporary rules in accordance with Chapter 150B of the General Statutes further defining the qualifications of providers and referral procedures in order to implement this provision.

(23) Medically Necessary Prosthetics or Orthotics for EPSDT Eligible Children - Reimbursement in accordance with the State Plan approved by the Department of Health and Human Services.

(24) Health Insurance Premiums - Payments to be made in accordance with the State Plan adopted by the Department of Health and Human Services consistent with federal regulations.

(25) Medical Care/Other Remedial Care - Services not covered elsewhere in this section include related services in schools; health professional services provided outside the clinic setting to meet maternal and infant health goals; and services to meet federal EPSDT mandates. Services addressed by this paragraph are limited to those prescribed in the State Plan as established by the Department of Health and Human Services. Except for related services in schools, providers of these services shall be certified as meeting program standards of the Department of Health and Human Services, Division of Women's and Children's Health.

(26) Pregnancy Related Services - Covered services for pregnant women shall include nutritional counseling, psychosocial counseling, and predelivery and postpartum home visits by maternity care coordinators and public health nurses.

Services and payment bases may be changed with the approval of the Director of the Budget.

Reimbursement is available for up to 24 visits per recipient per year to any one or combination of the following: physicians, clinics, hospital outpatient, optometrists, chiropractors, and podiatrists. Prenatal services, all EPSDT children, ~~and~~ emergency ~~rooms~~ rooms, and mental health services subject to independent utilization review are exempt from the visit limitations contained in this paragraph. Exceptions may be authorized by the Department of Health and Human Services where the life of the patient would be threatened without such additional care. Any person who is determined by the Department to be exempt from the 24-visit limitation may also be exempt from the six-prescription limitation.

Section 11.12.(b) Allocation of Nonfederal Cost of Medicaid. The State shall pay eighty-five percent (85%); the county shall pay fifteen percent (15%) of the nonfederal costs of all applicable services listed in this section.

Section 11.12.(c) Copayment for Medicaid Services. The Department of Health and Human Services may establish copayment up to the maximum permitted by federal law and regulation.

Section 11.12.(d) Medicaid and Work First Family Assistance, Income Eligibility Standards. The maximum net family annual income eligibility standards for Medicaid and Work First Family Assistance and the Standard of Need for Work First Family Assistance shall be as follows:

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

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

The payment level for Work First Family Assistance shall be fifty percent (50%) of the standard of need.

These standards may be changed with the approval of the Director of the Budget with the advice of the Advisory Budget Commission.

Section 11.12.(e) The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to all elderly, blind, and disabled people who have incomes equal to or less than one hundred percent (100%) of the federal poverty guidelines, as revised each April 1.

Section 11.12.(f) ICF and ICF/MR Work Incentive Allowances. The Department of Health and Human Services may provide an incentive allowance to Medicaid-eligible recipients of ICF and ICF/MR facilities who are regularly engaged in work activities as part of their developmental plan and for whom retention of additional income contributes to their achievement of independence. The State funds required to match the federal funds that are required by these allowances shall be provided from savings within the Medicaid budget or from other unbudgeted funds available to the Department. The incentive allowances may be as follows:

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

Section 11.12.(g) Dental Coverage Limits. Dental services shall be provided on a restricted basis in accordance with rules adopted by the Department to implement this subsection.

Section 11.12.(h) Dispensing of Generic Drugs. Notwithstanding G.S. 90-85.27 through G.S. 90-85.31, under the Medical Assistance Program (Title XIX of the Social Security Act) a prescription order for a drug designated by a trade or brand name shall be considered to be an order for the drug by its established or generic name, except when the prescriber personally indicates, either orally or in the prescriber's own handwriting on the prescription order, 'dispense as written' or words of similar meaning. Generic drugs, when available in the pharmacy, shall be dispensed at a lower cost to the Medical Assistance Program rather than trade or brand name drugs, subject to the prescriber's 'dispense as written' order as noted above.

As used in this subsection 'brand name' means the proprietary name the manufacturer places upon a drug product or on its container, label, or wrapping at the time of packaging; and 'established name' has the same meaning as in section 502(e)(3) of the Federal Food, Drug, and Cosmetic Act as amended, 21 U.S.C. § 352(e)(3).

Section 11.12.(i) Exceptions to Service Limitations, Eligibility Requirements, and Payments. Service limitations, eligibility requirements, and payments bases in this section may be waived by the Department of Health and Human Services, with the approval of the Director of the Budget, to allow the Department to carry out pilot programs for prepaid health plans, managed care plans, or community-based services programs in accordance with plans approved by the United States Department of Health and Human Services, or when the Department determines that such a waiver will result in a reduction in the total Medicaid costs for the recipient. The

Department of Health and Human Services may proceed with planning and development work on the Program of All-Inclusive Care for the Elderly and will issue a progress report to the chairs of the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources on or before January 30, 2001.

Section 11.12.(j) Volume Purchase Plans and Single Source Procurement. The Department of Health and Human Services, Division of Medical Assistance, may, subject to the approval of a change in the State Medicaid Plan, contract for services, medical equipment, supplies, and appliances by implementation of volume purchase plans, single source procurement, or other similar processes in order to improve cost containment.

Section 11.12.(k) Cost Containment Programs. The Department of Health and Human Services, Division of Medical Assistance, may undertake cost containment programs including preadmissions to hospitals and prior approval for certain outpatient surgeries before they may be performed in an inpatient setting.

Section 11.12.(l) For all Medicaid eligibility classifications for which the federal poverty level is used as an income limit for eligibility determination, the income limits will be updated each April 1 immediately following publication of federal poverty guidelines.

Section 11.12.(m) The Department of Health and Human Services shall provide Medicaid to 19-, 20-, and 21-year olds in accordance with federal rules and regulations.

Section 11.12.(n) The Department of Health and Human Services shall provide coverage to pregnant women and to children according to the following schedule:

(1) Pregnant women with incomes equal to or less than one hundred eighty-five percent (185%) of the federal poverty guidelines as revised each April 1 shall be covered for Medicaid benefits.

(2) Infants under the age of 1 with family incomes equal to or less than one hundred eighty-five percent (185%) of the federal poverty guidelines as revised each April 1 shall be covered for Medicaid benefits.

(3) Children aged 1 through 5 with family incomes equal to or less than one hundred thirty-three percent (133%) of the federal poverty guidelines as revised each April 1 shall be covered for Medicaid benefits.

(4) Children aged 6 through 18 with family incomes equal to or less than the federal poverty guidelines as revised each April 1 shall be covered for Medicaid benefits.

(5) The Department of Health and Human Services shall provide Medicaid coverage for adoptive children with special or rehabilitative needs regardless of the adoptive family's income.

Services to pregnant women eligible under this subsection continue throughout the pregnancy but include only those related to pregnancy and to those other conditions determined by the Department as conditions that may complicate pregnancy. In order to reduce county administrative costs and to expedite the provision of medical services to pregnant women, to infants, and to children described in subdivisions (3) and (4) of this subsection, no resources test shall be applied.

Section 11.12.(o) Medicaid enrollment of categorically needy families with children shall be continuous for one year without regard to changes in income or assets.

Section 11.12.(p) The Department of Health and Human Services shall submit a ~~monthly~~ quarterly status report on expenditures for acute care and long-term care services to the Fiscal Research Division and to the Office of State Budget and Management. This report shall include an analysis of budgeted versus actual

expenditures for eligibles by category and for long-term care beds. In addition, the Department shall revise the program's projected spending for the current fiscal year and the estimated spending for the subsequent fiscal year on a quarterly basis. ~~Reports for the preceding month~~ The quarterly expenditure report and the revised forecast shall be forwarded to the Fiscal Research Division and to the Office of State Budget and Management no later than the third Thursday of the ~~month.~~ month following the end of each quarter.

Section 11.12.(q) The Division of Medical Assistance, Department of Health and Human Services, may provide incentives to counties that successfully recover fraudulently spent Medicaid funds by sharing State savings with counties responsible for the recovery of the fraudulently spent funds.

Section 11.12.(r) If first approved by the Office of State Budget and Management, the Division of Medical Assistance, Department of Health and Human Services, may use funds that are identified to support the cost of development and acquisition of equipment and software through contractual means to improve and enhance information systems that provide management information and claims processing.

~~Section 11.12.(s) The Division of Medical Assistance, Department of Health and Human Services, may administer Medicaid estate recovery mandated by the Omnibus Budget Reconciliation Act of 1993, (OBRA 1993), 42 U.S.C. § 1396p(b), and G.S. 108-70.5 using temporary rules pending approval of final rules promulgated pursuant to Chapter 150B of the General Statutes.~~

Section 11.12.(t) The Department of Health and Human Services may adopt temporary rules according to the procedures established in G.S. 150B-21.1 when it finds that these rules are necessary to maximize receipt of federal funds, to reduce Medicaid expenditures, and to reduce fraud and abuse. Prior to the filing of these temporary rules with the Office of Administrative Hearings, the Department shall consult with the Office of State Budget and Management on the possible fiscal impact of the temporary rule and its effect on State appropriations and local governments.

Section 11.12.(u) The Department shall report to the Fiscal Research Division of the Legislative Services Office and to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources or the Joint Legislative Health Care Oversight Committee on any change it anticipates making in the Medicaid program that impacts the type or level of service, reimbursement methods, or waivers, any of which require a change in the State Plan or other approval by the Health Care Financing Administration. The reports shall be provided at the same time they are submitted to HCFA for approval.

Section 11.12.(v) If the Department of Health and Human Services obtains a Medicaid waiver to implement two long-term care pilot projects, then the Department shall report the particulars of the waiver, the pilot projects, and the status of implementation to members of the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Study Commission on Aging within 30 days of receiving the waiver. The Department shall not expand the pilot project beyond the two initial pilots without first reporting the proposed expansion to the members of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources.

~~Section 11.12.(w) The Department of Health and Human Services shall study the effect of subsection (o) of this section on both the Medicaid program and the Health Insurance Program for Children. The Department shall make an interim report on the results of this study to the members of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate~~

~~Appropriations Committee on Human Resources by October 1, 1999, and shall make a final report by January 1, 2000.~~

Section 11.12.(x) Effective no earlier than October 1, 2000, the Department of Health and Human Services shall amend the Medicaid State Plan to adopt simplified methodologies for the treatment of assets in determining Medicaid eligibility for aged, blind, and disabled persons. The simplified methodologies are limited to excluding the value of burial plots and the cash value of life insurance when the total face value of cash value bearing life insurance policies does not exceed ten thousand dollars ($10,000).

Section 11.12.(y) The Division of Fiscal Research, through the Legislative Services Office, with the cooperation of the Department of Health and Human Services, shall issue a Request for Proposal (RFP) for an independent consultant to study and review the amount, sufficiency, duration, and scope of each service provided under the North Carolina Medicaid Program. The independent consultant shall make an interim progress report on October 1, 2000, and January 1, 2001, to the cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources. The final report of the independent consultant shall be presented to the North Carolina General Assembly not later than May 1, 2001. The Department shall transfer funding from the Medicaid Program for the cost of the study."

CODE NO. 2000DHHS-H032-P

Requested by: Representatives Earle, Nye, Easterling, Redwine

COUNTY MEDICAID COST-SHARE

Section 11.6.(a) Section 11.39 of S.L. 1999-237 reads as rewritten:

"Section 11.39.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for the 1999-2000 fiscal year, the Department shall transfer to the Mental Health Restricted Reserve not more than the amount of actual expenditures for Medicaid payments for the 1998-99 fiscal year for services provided by area mental health authorities. The Department shall transfer from the Division of Medical Assistance the estimated amount needed to match Medicaid payments for the former Carolina Alternatives Programs. The Department shall not transfer from area program allocations funds to cover Medicaid payment expenditures that exceed the amount of funds in the Reserve for the 1999-2000 fiscal year.

Section 11.39.(b) ~~Any nonfederal increases in the cost of Medicaid services provided by area mental health authorities will be borne in equal parts by the State and county funding entity until the county share reaches fifteen percent (15%) of the nonfederal share.~~ Effective July 1, 2000, the county share of the cost of Medicaid services currently and previously provided by area mental health authorities shall be increased incrementally each fiscal year until the county share reaches fifteen percent (15%) of the nonfederal share by State fiscal year 2009-2010."

Section 11.6.(b) Section 11.22(g) is repealed.

Section 11.6.(c) Section 11.22(h) of S.L. 1999-237 reads as rewritten:

"Section 11.22.(h) ~~Effective January 1, 2000, the State shall pay fifty percent (50%) and the county shall pay fifty percent (50%) of the nonfederal share of new levels of Medicaid Personal Care Services paid to adult care homes. Effective July 1, 2001, the State shall pay fifty-seven percent (57%) and each county shall pay forty-three percent (43%) of the nonfederal share of new levels of Medicaid Personal Care Services paid to adult care homes. Each year thereafter, the State share of the nonfederal cost will increase by seven percent (7%) until the county share equals fifteen percent (15%) of the nonfederal share of new levels of Medicaid Personal Care Services.~~ Effective July 1, 2000, the county share of the cost of Medicaid

Personal Care Services paid to adult care homes shall be decreased incrementally each fiscal year until the county share reaches fifteen percent (15%) of the nonfederal share by State fiscal year 2009-2010."

CODE NO. 2000DHHS-H015-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
MEDICAID RESERVE FUND TRANSFER

Section 11.7. Section 11.10(a) of S.L. 1999-237 reads as rewritten:

"Section 11.10.(a) Of the funds transferred to the Department of Health and Human Services for Medicaid programs pursuant to G.S. 143-23.2, the sum of eighty-four million dollars ($84,000,000) for the 1999-2000 fiscal year and the sum of ~~twenty-nine~~ ninety-nine million dollars ~~($29,000,000)~~ ($99,000,000) for the 2000-2001 fiscal year shall be allocated as prescribed by G.S. 143-23.2(b) for Medicaid programs. Notwithstanding the prescription in G.S. 143-23.2(b) that these funds not reduce State general revenue funding, these funds shall replace the reduction in general revenue funding effected in this act."

CODE NO. 2000DHHS-H023A-P
Requested by: Representatives Earle, Nye, Easterling, Redwine, Baddour
WAIVE NC HEALTH CHOICE WAITING PERIOD FOR SPECIAL NEEDS CHILDREN

Section 11.8.(a) G.S. 108A-70.18(8) reads as rewritten:

"**§ 108A-70.18. Definitions.**

~~Unless~~ As used in this Part, unless the context clearly requires otherwise, the term:

. . .

(8) 'Uninsured' means the applicant for Program benefits ~~was not covered under any private or employer-sponsored comprehensive health insurance plan for the six-month period immediately preceding the date of application for Program benefits. Effective April 1, 1999, 'uninsured' means the applicant~~ is and was not covered under any private or employer-sponsored comprehensive health insurance plan for 60 days immediately preceding the date of application. The waiting periods required under this subdivision shall be waived ~~if~~ if:

a. ~~the~~ The child has been enrolled in Medicaid and has lost Medicaid ~~eligibility,~~ eligibility;

b. The child has lost health care benefits due to cessation of a nonprofit organization program that provides health care benefits to low-income ~~children, or~~ children;

c. The child has lost employer-sponsored comprehensive health care coverage due to termination of employment, cessation by the employer of employer-sponsored health coverage, or cessation of the employer's ~~business.~~ business; or

d. Health insurance benefits available to the family of a special needs child have been terminated due to a long-term disability or a substantial reduction in or limitation of lifetime medical benefits or benefit category. As used in this paragraph, 'special needs child' has the definition applied in G.S. 108A-70.23(a)."

Section 11.8.(b) The total amount of State funds expended for the Health Insurance Program for Children (NC Health Choice) in the 2000-2001 fiscal year

shall not exceed the amount of State funds appropriated to match federal funds for the Program for the 2000-2001 fiscal year.

SUBPART 3. FACILITY SERVICES

CODE NO. 2000DHHS-H013-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
EXTEND ADULT CARE HOME MORATORIUM/STUDY

Section 11.9.(a) Section 11.69(b) of S.L. 1997-443, as amended by Section 12.16C(a) of S.L. 1998-212, and as further amended by Section 1 of S.L. 1999-135, reads as rewritten:

"(b) Effective until ~~September 30, 2000,~~ September 30, 2001, the Department of Health and Human Services shall not approve the addition of any adult care home beds for any type home or facility in the State, except as follows:

(1) Plans submitted for approval prior to May 18, 1997, may continue to be processed for approval;

(2) Plans submitted for approval subsequent to May 18, 1997, may be processed for approval if the individual or organization submitting the plan demonstrates to the Department that on or before August 25, 1997, the individual or organization purchased real property, entered into a contract to purchase or obtain an option to purchase real property, entered into a binding real property lease arrangement, or has otherwise made a binding financial commitment for the purpose of establishing or expanding an adult care home facility. An owner of real property who entered into a contract prior to August 25, 1997, for the sale of an existing building together with land zoned for the development of not more than 50 adult care home beds with a proposed purchaser who failed to consummate the transaction may, after August 25, 1997, sell the property to another purchaser and the Department may process and approve plans submitted by the purchaser for the development of not more than 50 adult care home beds. It shall be the responsibility of the applicant to establish, to the satisfaction of the Department, that any of these conditions have been met;

(3) Adult care home beds in facilities for the developmentally disabled with six beds or less which are or would be licensed under G.S. 131D or G.S. 122C may continue to be approved;

(4) If the Department determines that the vacancy rate of available adult care home beds in a county is fifteen percent (15%) or less of the total number of available beds in the county as of August 26, 1997, and no new beds have been approved or licensed in the county or plans submitted for approval in accordance with subdivision (1) or (2) of this section which would raise the vacancy rate above fifteen percent (15%) in the county, then the Department may accept and approve the addition of beds in that county; or

(5) If a county board of commissioners determines that a substantial need exists for the addition of adult care home beds in that county, the board of commissioners may request that a specified number of additional beds be licensed for development in their county. In making their determination, the board of commissioners shall give consideration to meeting the needs of Special Assistance clients. The Department may approve licensure of the additional beds

from the first facility that files for licensure and subsequently meets the licensure requirements."

Section 11.9.(b) The Department of Health and Human Services shall study the various types of adult care homes covered by the moratorium enacted under Section 11.69(b) of S.L. 1997-443 and amended by Section 12.16C(a) of S.L. 1998-212 and S.L. 1999-135. The study shall identify adult care homes by predominant types of residents currently being served and shall recommend licensure categories appropriate to the population served. As part of this study, the Department shall identify current public funding available to residents of the identified adult care homes as well as additional funding sources appropriate to the population being served. Not later than March 1, 2001, the Department shall report the results of its study to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources.

CODE NO. 2000DHHS-H049-P

Requested by: Representatives Earle, Nye, Easterling, Redwine

USE OF FIRE PROTECTION FUND FOR EMERGENCY GENERATORS

Section 11.10. G.S. 122A-5.13 reads as rewritten:

"**§ 122A-5.13. Adult Care Home, Group Home, and Nursing Home Fire Protection Fund authorized; authority.**

(a) The North Carolina Housing Finance Agency shall establish an Adult Care Home, Group Home, and Nursing Home Fire Protection Fund (hereinafter 'Fire Protection Fund') to assist owners of adult care homes, group homes for developmentally disabled adults, and nursing homes with the purchase and installation of fire protection systems and emergency generators in existing and new adult care homes, group homes for developmentally disabled adults, and nursing homes. The Fire Protection Fund shall be a revolving fund.

(b) The Agency, in consultation with the Department of Health and Human Services, shall adopt rules for the management and use of the Fire Protection Fund. These rules at a minimum shall provide for the following:

(1) Financial incentives for owners of facilities who utilize Fire Protection Fund monies to install sprinkler systems instead of smoke detection equipment.

(2) Maximum loan amounts of one dollar and seventy-five cents ($1.75) per square foot for advanced smoke detectors and digital communication equipment, three dollars and seventy-five cents ($3.75) per square foot for residential sprinkler systems, and six dollars ($6.00) per square foot for institutional sprinkler systems.

(3) Interest rates from three percent (3%) to six percent (6%) for a period not to exceed 20 years for sprinkler systems and 10 years for smoke detection systems.

(4) Documentary verification that owners of facilities obtain fire protection systems and emergency generators at a reasonable cost.

(5) Acceleration of a loan when statutory fire protection requirements are not met by the facility for which the loan was made.

(6) Loan approval priority criteria that considers the frailty level of residents at a facility.

(7) Loan origination and servicing fees.

(c) Proceeds from the Fire Protection Fund, not to exceed ten thousand dollars ($10,000) annually, may be used to provide staff support to the North Carolina Housing Finance Agency for loan processing under this section and to the Department of Health and Human Services for review and approval of fire protection plans and inspection of fire protection systems."

CODE NO. 2000DHHS-H014B-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
STUDY MULTIUNIT ASSISTED HOUSING WITH SERVICES FACILITIES

Section 11.11. The North Carolina Study Commission on Aging shall study Multiunit Assisted Housing with Services (MAHS) facilities. The study shall include the following:

(1) What strategies may be employed at the State and local level to ensure registration of MAHS facilities with the Department of Health and Human Services, as required under G.S. 131D-2(a)(7a).
(2) Whether persons requesting access to MAHS facilities should be included in the assessment process that is part of the uniform portal of entry system.
(3) Whether an advocacy and oversight system for MAHS facilities should be developed that is comparable to the advocacy and oversight system in place for adult care homes.

Not later than February 1, 2001, the Commission shall report its findings and recommendations to the 2001 General Assembly and to the cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources.

SUBPART 4. SOCIAL SERVICES

CODE NO. 2000DHHS-H011C-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
ADULT CARE HOMES REIMBURSEMENT RATE INCREASE/STATE AUDITOR STUDY

Section 11.12.(a) Section 11.22(e) of S.L. 1999-237 reads as rewritten:

"Section 11.22.(e) Effective October 1, 2000, the maximum monthly rate for residents in adult care home facilities shall be one thousand ~~sixteen~~ sixty-two dollars ~~($1,016)~~ ($1,062) per month per resident."

Section 11.12.(b) The Office of the State Auditor shall study the cost reimbursement system used to reimburse adult care homes for residents in those homes who receive public assistance. The study shall include an analysis of the financial information collected on the adult care homes by the Department of Health and Human Services controller's office. The study shall also analyze the impact of occupancy rates on the cost reimbursement system. The Office of the State Auditor shall report the results of the study to the members of the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources not later than March 1, 2001.

CODE NO. 2000DHHS-H012-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
EXTEND SPECIAL ASSISTANCE DEMONSTRATION PROJECT

Section 11.13. Section 11.21 of S.L. 1999-237 reads as rewritten:

"Section 11.21. The Department of Health and Human Services may use funds from the existing State/County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals in in-home living arrangements. These payments may be made for up to 400 individuals. These payments may be made for up to a two-year period beginning July 1, ~~1999,~~ 2000, and ending June 30, ~~2001.~~ 2002. To the maximum extent possible, the Department shall consider geographic balance in the dispersion of payments to individuals across the State. The Department shall make an interim report to the cochairs of the House of Representatives Appropriations Committee, the cochairs of the House of

Representatives Appropriations Subcommittee on Health and Human Services and the cochairs of the Senate Appropriations Committee, the Chair of the Senate Appropriations Committee on Human Resources by June 30, ~~2000,~~ 2001, and a final report by October 1, ~~2001.~~ 2002. This report shall include the following information:

(1) A description of cost savings that could occur by allowing individuals eligible for State/County Special Assistance the option of remaining in the home.

(2) Which activities of daily living or other need criteria are reliable indicators for identifying individuals with the greatest need for income supplements for in-home living arrangements.

(3) How much case management is needed and which types of individuals are most in need of case management.

(4) The geographic location of individuals receiving payments under this section.

(5) A description of the services purchased with these payments.

(6) A description of the income levels of individuals who receive payments under this section and the impact on the Medicaid program.

(7) Findings and recommendations as to the feasibility of continuing or expanding the demonstration program."

CODE NO. 2000DHHS-H003-P

Requested by: Representatives Earle, Nye, Easterling, Redwine

CHILD WELFARE SYSTEM IMPROVEMENTS

Section 11.14. (a) Subsection (a) of Section 11.28 of S.L. 1999-237 reads as rewritten:

"Section 11.28.(a) The Division of Social Services, Department of Health and Human Services, shall report ~~semiannually~~ to the members of the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division on the activities of the State Child Fatality Review Team ~~and shall provide a final report to the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Health and Human Services no later than April 1, 2000,~~ including recommendations for changes in the statewide child protection ~~system.~~ system no later than October 1 of each year."

Section 11.14.(b) Subsection (d) of Section 11.57 of S.L. 1997-443, as amended by Section 12.22 of S.L. 1998-212 and as amended by Section 11.28 of S.L. 1999-237, is repealed.

Section 11.14.(c) G.S. 131D-10.6A reads as rewritten:

"**§ 131D-10.6A. Training by the Division of Social Services required.**

(a) The Division of Social Services, Department of Health and Human Services, shall ~~continue the in-house training component that provides a mandated~~ require a minimum of 30 hours of preservice training for foster care parents either prior to licensure or within six months from the date a provisional license is issued pursuant to G.S. ~~131D-10.3, and 84 hours for foster care workers and adoption social workers~~ 131D-10.3 and a mandated minimum of 10 hours of continuing education for all foster care parents ~~and 18 hours for foster care workers and adoption social workers.~~ annually after the year in which a license is obtained.

(b) The Division of Social Services shall establish minimum training requirements for child welfare services staff. The minimum training requirements established by the Division are as follows:

(1) Child welfare services workers shall complete a minimum of 72 hours of preservice training before assuming direct client contact responsibilities.
(2) Child protective services workers shall complete a minimum of 18 hours of additional training that the Division of Social Services determines is necessary to adequately meet training needs.
(3) Foster care and adoption workers shall complete a minimum of 39 hours of additional training that the Division of Social Services determines is necessary to adequately meet training needs.
(4) Child welfare services supervisors shall complete a minimum of 72 hours of preservice training before assuming supervisory responsibilities and a minimum of 54 hours of additional training that the Division of Social Services determines is necessary to adequately meet training needs.
(5) Child welfare services staff shall complete 24 hours of continuing education annually.

The Division of Social Services may grant an exception in whole or in part to the requirement under subdivision (1) of this subsection to child welfare workers who satisfactorily complete or are enrolled in a masters or bachelors program after July 1, 1999, from a North Carolina social work program accredited pursuant to the Council on Social Work Education. The program's curricula must cover the specific preservice training requirements as established by the Division of Social Services.

The Division of Social Services shall ensure that training opportunities are available for county departments of social services and consolidated human service agencies to meet the training requirements of this subsection."

Section 11.14.(d) G.S. 131D-10.6A(b), as enacted by subsection (b) of this section, applies to child welfare services staff initially hired on or after January 1, 1998.

CODE NO. 2000DHHS-H025A-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
SPECIAL CHILDREN ADOPTION FUND

Section 11.15.(a) Of the funds appropriated to the Department of Health and Human Services in this act, the sum of one million one hundred thousand dollars ($1,100,000) shall be used to support the Special Children Adoption Fund for the 2000-2001 fiscal year. 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. No local match shall be required as a condition for receipt of these funds. In accordance with State rules for allowable costs, the Special Children Adoption Fund may be used for post-adoption services for families whose incomes exceed two hundred percent (200%) of the federal poverty level.

Section 11.15.(b) Of the total funds appropriated for the Special Children Adoption Fund, four hundred thousand dollars ($400,000) shall be reserved for payment to participating private adoption agencies.

CODE NO. 2000DHHS-H026A-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
SPECIAL NEEDS ADOPTIONS INCENTIVE FUND

Section 11.16. There is created a Special Needs Adoptions Incentive Fund to provide financial assistance to facilitate the adoption of certain children residing in licensed foster care homes, effective January 1, 2001. These funds shall be used to remove financial barriers to the adoption of these children and shall be available to foster care families who adopt children with special needs as defined by the Social Services Commission. These funds shall be matched by county funds.

This program shall not constitute an entitlement and is subject to the availability of funds.

The Social Services Commission shall adopt rules to implement the provisions of this section.

SUBPART 5. MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

CODE NO. 2000DHHS-H016-P

Requested by: Representatives Earle, Nye, Easterling, Redwine

NONMEDICAID REIMBURSEMENT CHANGES

Section 11.17. Section 11.7 of S.L. 1999-237 reads as rewritten:

"Section 11.7. Providers of medical services under the various State programs, other than Medicaid, offering medical care to citizens of the State shall be reimbursed at rates no more than those under the North Carolina Medical Assistance Program. Hospitals that provide psychiatric inpatient care for multiply diagnosed adults who were identified as members of the Thomas S. class at the time of dissolution of the class, and other multiply diagnosed adults may be paid an additional incentive payment not to exceed fifteen percent (15%) of their regular daily per diem reimbursement.

The Department of Health and Human Services may reimburse hospitals at the full prospective per diem rates without regard to the Medical Assistance Program's annual limits on hospital days. When the Medical Assistance Program's per diem rates for inpatient services and its interim rates for outpatient services are used to reimburse providers in non-Medicaid medical service programs, retroactive adjustments to claims already paid shall not be required.

Notwithstanding the provisions of paragraph one, the Department of Health and Human Services may negotiate with providers of medical services under the various Department of Health and Human Services programs, other than Medicaid, for rates as close as possible to Medicaid rates for the following purposes: contracts or agreements for medical services and purchases of medical equipment and other medical supplies. These negotiated rates are allowable only to meet the medical needs of its non-Medicaid eligible patients, residents, and clients who require such services which cannot be provided when limited to the Medicaid rate.

Maximum net family annual income eligibility standards for services in these programs shall be as follows:

Family Size	Medical Eye Care Adults	All Rehabilitation	Other
1	$ 4,860	$ 8,364	$ 4,200
2	5,940	10,944	5,300
3	6,204	13,500	6,400
4	7,284	16,092	7,500
5	7,821	18,648	7,900
6	8,220	21,228	8,300
7	8,772	21,708	8,800
8	9,312	22,220	9,300

The eligibility level for children in the Medical Eye Care Program in the Division of Services for the Blind shall be one hundred percent (100%) of the federal poverty guidelines, as revised annually by the United States Department of Health and Human Services and in effect on July 1 of each fiscal year. The eligibility level for adults in the Atypical Antipsychotic Medication Program in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall be one hundred ~~twenty-five~~ fifty percent ~~(125%)~~ (150%) of the federal poverty guidelines, as revised annually by the United States Department of Health and Human Services and in effect on July 1 of each fiscal year. Additionally, those adults enrolled in the Atypical Antipsychotic Medication Program who become gainfully employed may continue to be eligible to receive State support, in decreasing amounts, for the purchase of atypical antipsychotic medication and related services up to three hundred percent (300%) of the poverty level.

State financial participation in the Atypical Antipsychotic Medication Program for those enrollees who become gainfully employed is as follows:

Income (% of poverty)	State Participation	Client Participation
~~0-125%~~	~~100%~~	~~0%~~
~~126-140%~~	~~90%~~	~~10%~~
~~141-160%~~	~~80%~~	~~20%~~
~~161-180%~~	~~70%~~	~~30%~~
~~181-200%~~	~~60%~~	~~40%~~
~~201-220%~~	~~50%~~	~~50%~~
~~221-240%~~	~~40%~~	~~60%~~
~~241-260%~~	~~30%~~	~~70%~~
~~261-280%~~	~~20%~~	~~80%~~
~~281-300%~~	~~10%~~	~~90%~~
~~301%-over~~	~~0%~~	~~100%.~~
0-150%	100%	0%
151-200%	75%	25%
201-250%	50%	50%
251-300%	25%	75%
301% and over	0%	100%."

The Department of Health and Human Services shall contract at, or as close as possible to, Medicaid rates for medical services provided to residents of State facilities of the Department."

CODE NO. 2000DHHS-H019-P
Requested by: Representative Culpepper
AREA BOARD MEMBER PER DIEM

Section 11.18. G.S. 122C-120 reads as rewritten:

"**§ 122C-120. Compensation of area board members.**

(a) Area board members may receive as compensation for their services per diem and a subsistence allowance for each day during which they are engaged in the official business of the area board. The amount of the per diem and subsistence allowances shall be established by the area ~~board and the amounts shall not exceed those authorized by G.S. 138-5 for State boards.~~ board. The amount of per diem allowance shall not exceed fifty dollars ($50.00). Reimbursement of subsistence expenses shall be at the rates allowed to State officers and employees under G.S. 138-6(a)(3).

(b) Area board members may be reimbursed for all necessary travel expenses and registration fees in amounts fixed by the board."

CODE NO. 2000DHHS-H024C-P

Requested by: Representatives Earle, Nye, Easterling, Redwine

CHILD MENTAL HEALTH RESIDENTIAL TREATMENT/SERVICES PROGRAM

Section 11.19.(a) The Department of Health and Human Services shall establish the Child Mental Health Residential Treatment/Services Program. The Program shall be implemented by the Department in consultation with the Office of Juvenile Justice and other affected State agencies. The purpose of the Program is to provide appropriate and medically necessary residential treatment alternatives for children at risk of institutionalization or other out-of-home placement. The Program shall include the following:

(1) Behavioral health screenings for all children at risk of institutionalization or other out-of-home placement.

(2) Appropriate and medically necessary residential treatment placements, including placements for specialized populations such as deaf children, children with serious emotional disturbances, and sexually aggressive youth.

(3) Multidisciplinary case management services, as needed.

(4) A system of utilization review specific to the nature and design of the Program.

(5) Mechanisms to ensure that children are not placed in department of social services custody for the purpose of obtaining mental health residential treatment services.

(6) Mechanisms to maximize current State and local funds and to expand use of Medicaid funds to accomplish the intent of this Program.

(7) Other appropriate components to accomplish the Program's purpose.

Section 11.19.(b) The Department shall not allocate funds appropriated for Program services until a Memorandum of Agreement has been executed between the Department and other affected State agencies. The Memorandum of Agreement shall address specifically the roles and responsibilities of the various departmental divisions and affected State agencies involved in the administration, financing, care, and placement of children at risk of institutionalization or other out-of-home placement. The Department shall not allocate funds appropriated in this act for the Program until Memoranda of Agreement between local departments of social services and area mental health programs, and the Administrative Office of the Courts, and the Office of Juvenile Justice, as appropriate, are executed to effectuate the purpose of the Program. The Memoranda of Agreement shall address issues pertinent to local implementation of the Program.

Section 11.19.(c) Notwithstanding any other provision of law to the contrary, services under the Child Mental Health Residential Treatment/Services Program are not an entitlement for non-Medicaid eligible children served by the Program.

Section 11.19.(d) The Department of Health and Human Services, in conjunction with the Office of Juvenile Justice and other affected agencies, shall report on the following:

(1) The number and other demographic information of children served.

(2) The amount and source of funds expended to implement the Program.

(3) Information regarding the number of children screened, specific placement of children, and treatment needs of children served.
(4) The average length of stay in residential treatment, transition, and return to home.
(5) The number of children diverted from institutions or other out-of-home placements such as training schools and State psychiatric hospitals.
(6) Recommendations on other areas of the Program that need to be improved.
(7) Other information relevant to successful implementation of the Program.

The Department shall submit a progress report on implementation of the Program not later than February 1, 2001, and a final report not later than May 1, 2002, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division.

CODE NO. 2000DHHS-H037-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
FUNDS FOR CHILD AND ADOLESCENT RESIDENTIAL UNIT AT MURDOCH CENTER

Section 11.20.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of three million dollars ($3,000,000) for the 2000-2001 fiscal year shall be used as follows:
(1) To develop and operate a six-bed short-term residential unit to meet the needs of autistic children statewide whose behaviors place them at serious risk of institutionalization. The unit shall be developed within the Murdoch Mental Retardation Center and supported by specialized staff within the Murdoch Mental Retardation Center; and
(2) To develop and operate a four-bed residential program for autistic children statewide whose behaviors place them at serious risk of institutionalization. The program may offer short-term diagnostic/prescriptive services or comprehensive interventions in order to transition children back to their homes and communities. The program shall be developed and supported by staff from the Murdoch Mental Retardation Center.

Section 11.20.(b) The Department shall submit progress reports on December 1, 2000, and on April 1, 2001, on its compliance with this section. The Department shall submit a final report on January 1, 2002. The reports shall be submitted to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division.

CODE NO. 2000DHHS-H040C-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
SERVICES TO CHILDREN AT RISK FOR INSTITUTIONALIZATION OR OTHER OUT-OF-HOME PLACEMENT

Section 11.21.(a) In order to ensure that children at risk for institutionalization or other out-of-home placement are appropriately served by the mental health, developmental disabilities, and substance abuse services system, the Department of Health and Human Services, Division of Mental Health,

Developmental Disabilities, and Substance Abuse Services, shall do the following with respect to services provided to these children:

(1) Provide only those treatment services that are medically necessary.
(2) Implement utilization review of services provided.
(3) Effective immediately:
  a. Eliminate formerly court-mandated Willie M. or Eligible Violent and Assaultive Children Program administration, infrastructure, categorical funding designation, and eligibility determination process at the State and local level;
  b. Identify savings realized from elimination of Program administration and infrastructure at the State and local level;
  c. Adopt the following guiding principles for the provision of services:
    1. Service delivery system must be outcome-oriented and evaluation-based.
    2. Services should be delivered as close as possible to the consumer's home.
    3. Services selected should be those that are most efficient in terms of cost and effectiveness.
    4. Services should not be provided solely for the convenience of the provider or the client.
    5. Families and consumers should be involved in decision making throughout treatment planning and delivery.
  d. Implement all of the following cost reduction strategies:
    1. Preauthorization for all services except emergency services.
    2. Levels of care to assist in the development of treatment plans.
    3. Clinically appropriate services.
    4. State review of individualized service plans for all children served to ensure that service plans focus on delivery of appropriate services rather than optimal treatment and habilitation plans.
(4) Collaborate with other affected State agencies such as the Office of Juvenile Justice and the Administrative Office of the Courts, and with local departments of social services and area mental health programs to eliminate cost-shifting and facilitate cost-sharing among these governmental agencies with respect to the treatment and placement services.

Section 11.21.(b) The Department shall submit a progress report on implementation of this section not later than February 1, 2001, and a final report not later than May 1, 2002, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division.

Section 11.21.(c) G.S. 122C-3(13a) is repealed.

Section 11.21.(d) G.S. 122C-112(14) is repealed.

Section 11.21.(e) Part 7 of Article 4 of Chapter 122C of the General Statutes is repealed. This subsection applies to petitions for contested case review filed on and after the effective date of this act.

CODE NO. 2000DHHS-H041A-P

Requested by: Representatives Earle, Nye, Easterling, Redwine

SERVICES TO MULTIPLY-DIAGNOSED ADULTS

Section 11.22.(a) In order to ensure that multiply-diagnosed adults are appropriately served by the mental health, developmental disabilities, and substance abuse services system, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall do the following with respect to services provided to these adults:

(1) Provide only those treatment services that are medically necessary.
(2) Implement utilization review of services provided.
(3) Effective immediately:
  a. Eliminate formerly court-mandated Thomas S. Program administration, infrastructure, and categorical funding designation at the local level, while continuing to provide services to former Thomas S. clients and other multiply-diagnosed adults;
  b. Identify savings realized from elimination of Program administration and infrastructure;
  c. Adopt the following guiding principles for the provision of services:
    1. Service delivery system must be outcome oriented and evaluation based.
    2. Services should be delivered as close as possible to the consumer's home.
    3. Services selected should be those that are most efficient in terms of cost and effectiveness.
    4. Services should not be provided solely for the convenience of the provider or the client.
    5. Families and consumers should be involved in decision-making throughout treatment planning and delivery; and
  d. Implement all of the following cost reduction strategies:
    1. Preauthorization for all services except emergency services.
    2. Criteria for determining medical necessity.
    3. Clinically appropriate services.
    4. State review of (i) individualized service plans for all adults served to ensure that service plans focus on delivery of appropriate services rather than optimal treatment and habilitation plans, and (ii) staffing patterns of residential services.

Section 11.22.(b) No State funds shall be used for the purchase of single-family or other residential dwellings to house multiply-diagnosed adults.

Section 11.22.(c) The Department shall submit a progress report on implementation of this section not later than February 1, 2001, and a final report not later than May 1, 2002, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division.

CODE NO. 2000DHHS-H034A-P

Requested by: Representatives Earle, Nye, Easterling, Redwine, Insko

FUNDS FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES OVERSIGHT COMMITTEE

Section 11.23.(a) Of the funds appropriated in this act to the Department of Health and Human Services, the Department shall transfer the sum of three

hundred fifty thousand dollars ($350,000) to the General Assembly, Legislative Services Office, for the 2000-2001 fiscal year. These funds shall be used for the mental health, developmental disabilities, and substance abuse services system reform initiative proposed in Senate Bill 1217 and House Bill 1519, 1999 General Assembly, Regular Session 2000. The funds shall be used specifically for a comprehensive study of developmental disabilities services and administration and to hire professional staff to assist the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. These funds may be transferred for these purposes if and only if Senate Bill 1217 or House Bill 1519, 1999 General Assembly, becomes law.

Section 11.23.(b) The Department shall study whether a new division of developmental disabilities should be established in the Department. Not later than January 1, 2001, the Department shall report its findings and recommendations to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources.

CODE NO. 2000DHHS-H020C-P

Requested by: Representatives Earle, Nye, Easterling, Redwine

MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES RESERVE FOR SYSTEM REFORM AND OLMSTEAD DECISION

Section 11.24.(a) There is created in the Office of State Budget and Management the Mental Health, Developmental Disabilities, and Substance Abuse Services Reserve for System Reform and Olmstead. The purposes of the Reserve are to:

(1) Provide start-up funds for programs and services that provide community alternatives for individuals currently residing in the State's mental health, developmental disabilities, and substance abuse services institutions.

(2) Facilitate the State's compliance with the United States Supreme Court decision in Olmstead v. L.C. and E.W.

(3) Facilitate reform of the mental health, developmental disabilities, and substance abuse services system.

Section 11.24.(b) Funds appropriated to the Reserve created in subsection (a) of this section shall be used to:

(1) Pay onetime expenditures that will not impose additional financial obligations on the State, and

(2) Establish or expand community-based services if sufficient recurring funds can be identified within the Department from funds currently budgeted for mental health, developmental disabilities, and substance abuse services, area mental health programs, or local government.

Section 11.24.(c) Before allocating funds from the Reserve, the Director of the Budget shall certify that the planned uses of the funds are in compliance with this section and do not constitute or will not create an ongoing financial obligation to the State.

Section 11.24.(d) Funds in the Mental Health, Developmental Disabilities, and Substance Abuse Services Reserve for System Reform and Olmstead shall not revert to the General Fund but shall remain in the Reserve to be used as authorized in this section.

Section 11.24.(e) The Department of Health and Human Services shall report periodically to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint

Legislative Commission on Governmental Operations on any actions taken under this section.

CODE NO. 2000DHHS-H027A-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
EARLY INTERVENTION SERVICES

Section 11.25. Section 11.42 of S.L. 1999-237 reads as rewritten:

"Section 11.42.(a) Of the funds appropriated in this act to the Department of Health and Human Services, the sum of two hundred three thousand dollars ($203,000) for the 1999-2000 fiscal year and the sum of ~~six hundred ten~~ eight hundred sixty thousand dollars ~~($610,000)~~ ($860,000) for the 2000-2001 fiscal year shall be used to implement two recommendations from the Interagency Coordinating Council's "Study on Early Intervention Services for Children Ages Birth to Five Years," dated March 1999. The Department of Health and Human Services, the Department of Public Instruction, and The University of North Carolina's Division TEACCH (Treatment and Education of Autistic and other Communications Handicapped Children and Adults), shall participate jointly, in collaboration with the Interagency Coordinating Council, in the planning, design, and implementation of the following provisions:

(1) Of the funds allocated by this subsection, the sum of seventy-eight thousand dollars ($78,000) in the 1999-2000 fiscal year and the sum of ~~one hundred ten~~ three hundred thousand dollars ~~($110,000)~~ ($300,000) in the 2000-2001 fiscal year shall be used to plan, design, and implement an integrated, interagency database for children with or at risk for disabilities who receive early intervention services. The purpose of the database is to:
   a. Assist in identifying gaps in services;
   b. Project and plan for future service needs;
   c. Improve the quality and accessibility of services; and
   d. Document outcomes of early intervention services.

   This database shall be compatible with the State Board of Education's new Student Information Management System. These agencies shall initiate use of the database in a pilot program in at least one community by July 1, 2000, and shall evaluate this pilot for statewide implementation by July 1, 2001. Any local education agency participating in the pilot program shall provide the same data for children in the preschool program for children with disabilities as is provided by the Department of Health and Human Services for children served in the infant-toddler program. The agencies shall submit a progress report by April 1, 2000, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

(2) Of the funds allocated by this subsection, the sum of one hundred twenty-five thousand dollars ($125,000) in fiscal year 1999-2000 and the sum of five hundred sixty thousand dollars ~~($500,000)~~ ($560,000) in fiscal year 2000-2001 shall be used to plan for and implement regional transdisciplinary teams to provide training, technical assistance, and other support services to existing early intervention agencies and providers. The teams will maintain expertise on low incidence populations, such as children with visual and hearing impairments, autism, and child mental health needs. These agencies shall implement a pilot program

establishing a regional transdisciplinary team no later than March 2000. These agencies shall submit an interim report by March 15, 2000, and a final plan for statewide implementation of the transdisciplinary teams by March 15, 2001, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Section 11.42.(b) The North Carolina Schools for the Deaf and other agencies providing early intervention services to children from birth through five years of age shall implement procedures to ensure that:

(1) Parents of children newly identified with hearing loss and determined to be eligible for services are informed of the services available to them through Beginnings for Parents of ~~Hearing Impaired Children, Inc.;~~ Children Who Are Deaf or Hard of Hearing, Inc.; and

(2) Beginnings for Parents of ~~Hearing Impaired Children, Inc.,~~ Children Who Are Deaf or Hard of Hearing, Inc., with the consent of parents, is notified of these children in a timely and appropriate manner."

SUBPART 6. CHILD DEVELOPMENT

CODE NO. 2000DHHS-H010-P

Requested by: Representatives Earle, Nye, Easterling, Redwine

TRANSFER FUNDS FOR CLIENT SERVICES

Section 11.26. The sum of three million dollars ($3,000,000) appropriated to the Division of Child Development in this act shall be transferred to the Division of Social Services to fund client services provided by the county departments of social services.

CODE NO. 2000DHHS-H007A-P

Requested by: Representatives Earle, Nye, Easterling, Redwine

CHILD CARE SUBSIDY RATES

Section 11.27.(a) Section 11.47 of S.L. 1999-237 reads as rewritten:

"Section 11.47.(a) The maximum gross annual income for initial eligibility, adjusted biennially, for subsidized child care services shall be seventy-five percent (75%) of the State median income, adjusted for family size.

Section 11.47.(b) Fees for families who are required to share in the cost of care shall be established based on a percent of gross family income and adjusted for family size. Fees shall be determined as follows:

FAMILY SIZE	PERCENT OF GROSS FAMILY INCOME
1-3	9%
4-5	8%
6 or more	7%

Section 11.47.(c) Payments for the purchase of child care services for low-income children shall be in accordance with the following requirements:

(1) Effective October 1, 1999, religious-sponsored child care facilities operating pursuant to G.S. 110-106 and licensed child care centers and homes that meet the minimum licensing standards that are participating in the subsidized child care program shall be paid the ~~county market~~ subsidy rate or the rate they charge privately paying parents, whichever is lower.

(2) Effective October 1, 1999, religious-sponsored child care facilities operating pursuant to G.S. 110-106 and licensed child care centers and homes that are receiving a higher rate than the ~~market~~ subsidy rates that will be implemented with this provision shall continue to receive that higher rate for a period of three years from the effective date of this section.

(3) Effective October 1, 1999, licensed child care centers with two or more stars may receive a higher payment rate per child per month as follows: two stars - $14.00, three stars - $17.00, four stars - $20.00, and five stars - $23.00. Effective January 1, 2000, licensed child care homes with two or more stars may receive a higher payment rate per child per month as follows: two stars - $14.00, three stars - $17.00, four stars - $20.00, and five stars - $23.00. This subdivision expires September 1, 2000.

(3a) Effective September 1, 2000, licensed child care centers and homes with two or more stars shall receive the subsidy rate for that rated quality level for that age group or the rate they charge privately paying parents, whichever is lower.

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

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

~~Section 11.47.(d) Provision of payment rates for child care providers in counties who do not have at least 75 children in each age group for center-based and home-based care are as follows:~~

~~(1) Payment rates shall be set at the statewide market rate for licensed child care centers and homes.~~

~~(2) If it can be demonstrated that the application of the statewide market rate to a county with fewer than 75 children in each age group is lower than the county market rate and would inhibit the ability of the county to purchase child care for low-income children, then the county market rate may be applied.~~

Section 11.47.(e) A market rate shall be calculated for child care centers and homes ~~that meet minimum licensing standards~~ at each rated quality level for each county and for each age group or age category of enrollees and shall be representative of fees charged to unsubsidized privately paying parents for each age group of enrollees within the county. The Division of Child Development shall also calculate a statewide market rate at each rated quality level for each age category. The Division of Child Development may also calculate regional market rates at each rated quality level for each age group and age category.

Section 11.47.(f) Facilities licensed pursuant to Article 7 of Chapter 110 of the General Statutes and facilities operated pursuant to G.S. 110-106 may participate in the program that provides for the purchase of care in child care facilities for minor children of needy families. No separate licensing requirements shall be used to select facilities to participate. In addition, child care facilities shall be required to meet any additional applicable requirements of federal law or regulations. Child care arrangements exempt from State regulation pursuant to Article 7 of Chapter 110 of

the General Statutes shall meet the requirements established by other State law and by the Social Services Commission.

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

Section 11.47.(g) Payment for subsidized child care services provided with Work First Block Grant funds shall comply with all regulations and policies issued by the Division of Child Development for the subsidized child care program."

Section 11.27.(b) Article 7 of Chapter 110 of the General Statutes is amended by adding a new section to read:

"**§ 110-109. Child care subsidy rates.**

(a) The Department shall conduct a statewide market rate study of child care facilities at least once every two years. The study shall include a survey of all licensed facilities. Based on the results of this study, the Department shall establish a market rate for child care centers and homes at each rated quality level for each county and for each age group. The Department shall also calculate a statewide market rate at each rated quality level for each age group. The market rate shall be set at the seventy-fifth percentile of fees charged to unsubsidized, privately paying parents at each rated quality level for each age group.

(b) Within six months of completing a statewide market rate study, the Department shall publish the results of that study and implement market rates based on the results of that study.

(c) When a county has at least 75 children in an age group at a particular rated quality level, the subsidy rate is the county market rate for that age group at that rated quality level. When a county has fewer than 75 children in an age group at a particular rated quality level, the subsidy rate is the statewide market rate for that age group at that rated quality level.

(d) Notwithstanding the provisions of subsection (c) of this section, when it can be demonstrated that the statewide market rate is lower than the county market rate and that setting the subsidy rate at the statewide market rate would inhibit the ability of a county to purchase child care for low-income children, the subsidy rate shall be the county market rate."

Section 11.27.(c) The first market rate study required by G.S. 110-109, as enacted by subsection (b) of this section, shall be completed no later than April 1, 2001.

CODE NO. 2000DHHS-H008D-P

Requested by: Representatives Earle, Nye, Easterling, Redwine

EARLY CHILDHOOD EDUCATION AND DEVELOPMENT INITIATIVES

Section 11.28.(a) G.S. 143B-168.12(a) reads as rewritten:

"(a) In order to receive State funds, the following conditions shall be met:

(1) The North Carolina Partnership shall have a Board of Directors consisting of the following 25 members:

a. The Secretary of Health and Human Services, ex officio, or the Secretary's designee;

b. Repealed by Session Laws 1997, c. 443, s. 11A.105.

c. The Superintendent of Public Instruction, ex officio, or the Superintendent's designee;

d. The President of the Community Colleges System, ex officio, or the President's designee;

e. Three members of the public, including one child care provider, one other who is a parent, and one other who is a board chair of a local partnership serving on the North

Carolina Partnership local partnership advisory committee, appointed by the General Assembly upon recommendation of the President Pro Tempore of the Senate;

f. Three members of the public, including one who is a parent, one other who is a representative of the faith community, and one other who is a board chair of a local partnership serving on the North Carolina Partnership local partnership advisory committee, appointed by the General Assembly upon recommendation of the Speaker of the House of Representatives;

g. Twelve members, appointed by the Governor. Three of these 12 members shall be members of the party other than the Governor's party, appointed by the Governor. Seven of these 12 members shall be appointed as follows: one who is a child care provider, one other who is a pediatrician, one other who is a health care provider, one other who is a parent, one other who is a member of the business community, one other who is a member representing a philanthropic agency, and one other who is an early childhood educator;

h. Repealed by Session Laws 1998-212, s. 12.37B(a).

h1. The Chair of the North Carolina Partnership Board shall be appointed by the Governor;

i. Repealed by Session Laws 1998-212, s. 12.37B(a).

j. One member of the public appointed by the General Assembly upon recommendation of the Majority Leader of the Senate;

k. One member of the public appointed by the General Assembly upon recommendation of the Majority Leader of the House of Representatives;

l. One member of the public appointed by the General Assembly upon recommendation of the Minority Leader of the Senate; and

m. One member of the public appointed by the General Assembly upon recommendation of the Minority Leader of the House of Representatives.

All members appointed to succeed the initial members and members appointed thereafter shall be appointed for three-year terms. Members may succeed themselves.

All appointed board members shall avoid conflicts of interests and the appearance of impropriety. Should instances arise when a conflict may be perceived, any individual who may benefit directly or indirectly from the North Carolina Partnership's disbursement of funds shall abstain from participating in any decision or deliberations by the North Carolina Partnership regarding the disbursement of funds.

All ex officio members are voting members. Each ex officio member may be represented by a designee. These designees shall be voting members. No members of the General Assembly shall serve as members.

The North Carolina Partnership may establish a nominating committee and, in making their recommendations of members to be appointed by the General Assembly or by the Governor, the

President Pro Tempore of the Senate, the Speaker of the House of Representatives, the Majority Leader of the Senate, the Majority Leader of the House of Representatives, the Minority Leader of the Senate, the Minority Leader of the House of Representatives, and the Governor shall consult with and consider the recommendations of this nominating committee.

The North Carolina Partnership may establish a policy on members' attendance, which policy shall include provisions for reporting absences of at least three meetings immediately to the appropriate appointing authority.

Members who miss more than three consecutive meetings without excuse or members who vacate their membership shall be replaced by the appropriate appointing authority, and the replacing member shall serve either until the General Assembly and the Governor can appoint a successor or until the replaced member's term expires, whichever is earlier.

The North Carolina Partnership shall establish a policy on membership of the local board, which policy shall include the requirement that all local board members, other than any member appointed because of a position held by that individual, be residents of the county or the partnership region they are representing. No member of the General Assembly shall serve as a member of a local board. Within these requirements for local board membership, the North Carolina Partnership shall allow local partnerships that are regional to have flexibility in the composition of their boards so that all counties in the region have adequate representation.

All appointed local board members shall avoid conflicts of interests and the appearance of impropriety. Should instances arise when a conflict may be perceived, any individual who may benefit directly or indirectly from the partnership's disbursement of funds shall abstain from participating in any decision or deliberations by the partnership regarding the disbursement of funds.

(2) The North Carolina Partnership and the local partnerships shall agree to adopt procedures for its operations that are comparable to those of Article 33C of Chapter 143 of the General Statutes, the Open Meetings Law, and Chapter 132 of the General Statutes, the Public Records Law, and provide for enforcement by the Department.

(3) The North Carolina Partnership shall oversee the development and implementation of the local demonstration projects as they are selected and shall approve the ongoing plans, programs, and services developed and implemented by the local partnerships and hold the local partnerships accountable for the financial and programmatic integrity of the programs and services. If the North Carolina Partnership determines that it would be more efficient to obtain services or resources at the State level rather than at the local level, the North Carolina Partnership may reallocate and use unspent funds to obtain services or resources that benefit children and families across partnerships.

In the event that the North Carolina Partnership determines that a local partnership is not fulfilling its mandate to provide programs and services designed to meet the developmental needs

of children in order to prepare them to begin school healthy and ready to succeed and is not being accountable for the programmatic and fiscal integrity of its programs and services, the North Carolina Partnership may suspend all funds to the partnership until the partnership demonstrates that these defects are corrected. Further, at its discretion, the North Carolina Partnership may assume the managerial responsibilities for the partnership's programs and services until the North Carolina Partnership determines that it is appropriate to return the programs and services to the local partnership.

(4) The North Carolina Partnership shall develop and implement a comprehensive standard fiscal accountability plan to ensure the fiscal integrity and accountability of State funds appropriated to it and to the local partnerships. The standard fiscal accountability plan shall, at a minimum, include a uniform, standardized system of accounting, internal controls, payroll, fidelity bonding, chart of accounts, and contract management and monitoring. The North Carolina Partnership may contract with outside firms to develop and implement the standard fiscal accountability plan. All local partnerships shall be required to participate in the standard fiscal accountability plan developed and adopted by the North Carolina Partnership pursuant to this subdivision.

(5) The North Carolina Partnership shall develop a ~~centralized~~ regional accounting and contract management system which incorporates features of the required standard fiscal accountability plan described in subdivision (4) of subsection (a) of this section. All local partnerships shall participate in the regional accounting and contract management system. ~~The following local partnerships shall be required to participate in the centralized accountability system developed by the North Carolina Partnership pursuant to this subdivision:~~

~~a. Local partnerships which have significant deficiencies in their accounting systems, internal controls, and contract management systems, as determined by the North Carolina Partnership based on the annual financial audits of the local partnerships conducted by the Office of the State Auditor; and~~

~~b. Local partnerships which are in the first two years of operation following their selection. At the end of this two-year period, local partnerships shall continue to participate in the centralized accounting and contract management system. With the approval of the North Carolina Partnership, local partnerships may perform accounting and contract management functions at the local level using the standardized and uniform accounting system, internal controls, and contract management systems developed by the North Carolina Partnership.~~

~~Local partnerships which otherwise would not be required to participate in the centralized accounting and contract management system pursuant to this subdivision may voluntarily choose to participate in the system. Participation or nonparticipation shall be for a minimum of two years, unless, in the event of nonparticipation, the North Carolina Partnership determines that~~

~~any partnership's annual financial audit reveals serious deficiencies in accounting or contract management.~~

(6) The North Carolina Partnership shall develop a formula for allocating direct services funds appropriated for this purpose to local partnerships.

(7) The North Carolina Partnership may adjust its allocations by up to ten percent (10%) on the basis of local partnerships' performance assessments. In determining whether to adjust its allocations to local partnerships, the North Carolina Partnership shall consider whether the local partnerships are meeting the outcome goals and objectives of the North Carolina Partnership and the goals and objectives set forth by the local partnerships in their approved annual program plans.

The North Carolina Partnership may use additional factors to determine whether to adjust the local partnerships' allocations. These additional factors shall be developed with input from the local partnerships and shall be communicated to the local partnerships when the additional factors are selected. These additional factors may include board involvement, family and community outreach, collaboration among public and private service agencies, and family involvement.

On the basis of performance assessments, local partnerships annually shall be rated "superior", "satisfactory", or "needs improvement". ~~Local partnerships rated "superior" shall receive, to the extent that funds are available, a ten percent (10%) increase in their annual funding allocation. Local partnerships rated "satisfactory" shall receive their annual funding allocation. Local partnerships rated "needs improvement" shall receive up to ninety percent (90%) of their annual funding allocation.~~

The North Carolina Partnership may contract with outside firms to conduct the performance assessments of local partnerships.

(8) The North Carolina Partnership shall establish a local partnership advisory committee comprised of 15 members. Eight of the members shall be chairs of local partnerships' board of directors, and seven shall be staff of local partnerships. Members shall be chosen by the Chair of the North Carolina Partnership from a pool of candidates nominated by their respective boards of directors. The local partnership advisory committee shall serve in an advisory capacity to the North Carolina Partnership and shall establish a schedule of regular meetings. Members shall be chosen from local partnerships on a rotating basis. The advisory committee shall annually elect a chair from among its members.

(9) The North Carolina Partnership shall report (i) quarterly to the Joint Legislative Commission on Governmental Operations and (ii) to the General Assembly and the Governor on the ongoing progress of all the local partnerships' work, including all details of the use to which the allocations were put, and on the continuing plans of the North Carolina Partnership and of the Department, together with legislative proposals, including proposals to implement the program statewide."

Section 11.28.(b) G.S. 143B-168.13(6) reads as rewritten:

"(6) Annually update its funding ~~formula~~ formula, in collaboration with the North Carolina Partnership for Children, Inc., using the most

recent data available. These amounts shall serve as the basis for determining "full funding" amounts for each local partnership."

Section 11.28.(c) G.S. 143B-168.15(b) reads as rewritten:

"(b) Depending on local, regional, or statewide needs, funds may be used to support activities and services that shall be made available and accessible to providers, children, and families on a voluntary basis. Of the funds allocated to local partnerships ~~that are designated by the Secretary~~ for direct services, ~~seventy-five~~ seventy percent ~~(75%)~~ (70%) of the funds spent in each year shall be used ~~for any one or more of the following activities and services:~~

~~(1) Child care services, including:~~

~~a. Child care subsidies to reduce waiting lists;~~

~~b. Raising the county child care subsidy rate to the State market rate, if applicable, in return for improvements in the quality of child care services;~~

~~c. Raising the income eligibility for child care subsidies to seventy-five percent (75%) of the State median family income;~~

~~d. Start-up funding for child care providers;~~

~~e. Assistance to enable child care providers to conform to licensing and building code requirements;~~

~~f. Child care resources and referral services;~~

~~g. Enhancement of the quality of child care provided;~~

~~h. Technical assistance for child care providers;~~

~~i. Quality grants for child care centers or family child care homes;~~

~~j. Expanded services or enhanced rates for children with special needs;~~

~~k. Head Start services;~~

~~l. Development of comprehensive child care services that include child health and family support;~~

~~m. Activities to reduce staff turnover;~~

~~n. Activities to serve children with special needs;~~

~~o. Transportation services related to providing child care services;~~

~~p. Evaluation of plan implementation of child care services; and~~

~~q. Needs and resources assessments for child care services.~~

~~(2) Family- and child-centered services, including early childhood education and child development services, including:~~

~~a. Enhancement of the quality of family- and child-centered services provided;~~

~~b. Technical assistance for family- and child-centered services;~~

~~c. Needs and resource assessments for family- and child-centered services;~~

~~d. Home-centered services; and~~

~~e. Evaluation of plan implementation of family- and child-centered services.~~

~~(3) Other appropriate activities and services for child care providers and for family- and child-centered services, including:~~

~~a. Staff and organizational development, leadership and administrative development, technology assisted education, and long-range planning; and~~

~~b. Procedures to ensure that infants and young children receive needed health, immunization, and related services.~~

in child care related activities and early childhood education programs that improve access to child care and early childhood education services, develop new child care and early childhood education services, and improve the quality of child care and early childhood education services in all settings."

Section 11.28.(d) Effective September 1, 2000, 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 local partnerships shall give priority for the use of these funds to augmenting the State's supplemental subsidy payment rate per child per month for licensed child care centers and homes earning a rated license that exceeds the minimum licensing standards.~~ 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."

Section 11.28.(e) Subsection (c) of Section 11.48 of S.L. 1999-237 is repealed.

Section 11.28.(f) Subsection (h) of Section 11.48 of S.L. 1999-237 is repealed.

Section 11.28.(g) Subsection (i) of Section 11.48 of S.L. 1999-237 reads as rewritten:

"Section 11.48.(i) The North Carolina Partnership for Children, Inc., and all local partnerships shall, in the aggregate, be required to match no less than fifty percent (50%) of the total amount budgeted for the Program in each fiscal year of the biennium as follows: contributions of cash equal to at least ten percent (10%) and in-kind donated resources equal to no more than ten percent (10%) for a total match requirement of twenty percent (20%) for each fiscal year. Any program funding expended for child care subsidies during the previous 12 months is excluded from the match requirement of this subsection. Only in-kind contributions that are quantifiable, as determined in the Smart Start Performance Audit, shall be applied to the in-kind match requirement. Expenses, including both those paid by cash and in-kind contributions, incurred by other participating non-State entities contracting with the North Carolina Partnership for Children, Inc., or the local partnerships, also may be considered resources available to meet the required private match. In order to qualify to meet the required private match, the expenses shall:

(1) Be verifiable from the contractor's records;
(2) If in-kind, be quantifiable in accordance with generally accepted accounting principles for nonprofit organizations;
(3) Not include expenses funded by State funds;
(4) Be supplemental to and not supplant preexisting resources for related program activities;
(5) Be incurred as a direct result of the Early Childhood Initiatives Program and be necessary and reasonable for the proper and efficient accomplishment of the Program's objectives;
(6) Be otherwise allowable under federal or State law;
(7) Be required and described in the contractual agreements approved by the North Carolina Partnership for Children, Inc., or the local partnership; and

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

The North Carolina Partnership for Children, Inc., shall establish uniform guidelines and reporting format for local partnerships to document the qualifying expenses occurring at the contractor level. Local partnerships shall monitor qualifying expenses to ensure they have occurred and meet the requirements prescribed in this subsection.

Failure to obtain a twenty percent (20%) match by May 1 of each fiscal year shall result in a dollar-for-dollar reduction in the appropriation for the Program for the next fiscal year. The North Carolina Partnership for Children, Inc., shall be responsible for compiling information on the private cash and in-kind contributions into a report that is submitted to the Joint Legislative Commission on Governmental Operations in a format that allows verification by the Department of Revenue. The same match requirements shall apply to any expansion funds appropriated by the General Assembly."

Section 11.28.(h) Subsection (m) of Section 11.48 of S.L. 1999-237 reads as rewritten:

"Section 11.48.(m) There is allocated from the funds appropriated to the Department of Health and Human Services, Division of Child Development, in this act, the sum of fifty-nine million five hundred thousand dollars ($59,500,000) for the 1999-2000 fiscal year and the sum of ~~seventy-eight million nine hundred twenty-eight thousand eight hundred twenty-six dollars ($78,928,826)~~ one hundred twenty-two million eight hundred seventy-eight thousand seventy-six dollars ($122,878,076) for the 2000-2001 fiscal year to be used as follows:

(1) The sum of fifty-eight million dollars ($58,000,000) in the 1999-2000 fiscal year and the sum of ~~seventy-eight million nine hundred twenty-eight thousand eight hundred twenty-six dollars ($78,928,826)~~ one hundred twenty-one million four hundred thirteen thousand seven hundred twenty-five dollars ($121,413,725) in the 2000-2001 fiscal year shall be used to administer and deliver services in all 100 counties. These funds may be used as financial incentives to encourage regionalization at the local level and to complete development of contracting and accounting systems at the local level. Any funds used to encourage regionalization or to complete development of contracting and accounting systems at the local level shall not be included in computations affecting the administrative cost limitations under subsection (e) of this section.

(2) The North Carolina Partnership for Children, Inc., may use the sum of one million five hundred thousand dollars ($1,500,000) in the 1999-2000 fiscal year and the sum of five hundred thousand dollars ($500,000) in the 2000-2001 fiscal year to assist local partnerships in their efforts to develop local collaboration. It is the intent of the General Assembly that these funds be nonrecurring.

(3) The North Carolina Partnership for Children, Inc., shall receive the sum of nine hundred sixty-four thousand three hundred fifty-one dollars ($964,351) in the 2000-2001 fiscal year for State-level administration of the Program.

The General Assembly requests that the Governor fully fund the Program in the continuation budget for the 2001-2003 fiscal biennium at the level recommended by the Governor in the 1999-2001 fiscal biennium."

Section 11.28.(i) Subsection (n) of Section 11.48 of S.L. 1999-237 reads as rewritten:

"Section 11.48.(n) Of the funds appropriated to the Department of Health and Human Services for the Program for the 1999-2001 biennium, the Frank Porter Graham Child Development Center shall receive the sum of one million fifteen thousand dollars ($1,015,000) in the 1999-2000 fiscal year and the sum of one million ~~fifteen thousand dollars ($1,015,000)~~ sixty-five thousand seven hundred fifty dollars ($1,065,750) in the 2000-2001 fiscal year."

SUBPART 7. DEAF AND HARD OF HEARING SERVICES

CODE NO. 2000DHHS-H004B-P
Requested by: Representatives Earle, Nye, Easterling, Redwine, Alexander
FAMILY SUPPORT/DIVISION OF SERVICES FOR THE DEAF AND THE HARD OF HEARING SERVICES CONTRACT

Section 11.29. Section 11.50 of S.L. 1999-237 reads as rewritten:

"Section 11.50. Of the funds appropriated in this act to the Division of Services for the Deaf and the Hard of Hearing, Department of Health and Human Services, for family support services, the sum of five hundred three thousand two hundred thirty-eight dollars ($503,238) for the 1999-2000 fiscal year and the sum of ~~five hundred three~~ seven hundred twenty-three thousand two hundred thirty-eight dollars ~~($503,238)~~ ($723,238) for the 2000-2001 fiscal year shall be used to contract with a private, nonprofit corporation licensed to do business in North Carolina to perform those services, including family support and advocacy services as well as technical assistance to professionals who work with families of hearing-impaired children aged birth to 21 years."

SUBPART 8. PUBLIC HEALTH

CODE NO. 2000DHHS-H028-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
MAINTAIN FUNDING FOR DEVELOPMENTAL EVALUATION CENTERS

Section 11.30. The Department of Health and Human Services shall replace any reductions in appropriations for the Developmental Evaluation Centers with Medicaid receipts. The total amount of the Developmental Evaluation Centers program budget shall not be reduced below the amount certified in the 1999-2000 fiscal year program budget.

CODE NO. 2000DHHS-H022E-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
USE OF NEWBORN SCREENING FEES

Section 11.31.(a) G.S. 130A-125 reads as rewritten:

"**§ 130A-125. Screening of newborns for metabolic and other hereditary and congenital disorders.**

(a) The Department shall establish and administer a Newborn Screening Program. The program shall include, but shall not be limited to:

(1) Development and distribution of educational materials regarding the availability and benefits of newborn screening.
(2) Provision of laboratory testing.
(3) Development of follow-up protocols to assure early treatment for identified children, and the provision of genetic counseling and support services for the families of identified children.
(4) Provision of necessary dietary treatment products or medications for identified children as medically indicated and when not otherwise available.

(5) For each newborn, provision of physiological screening in each ear for the presence of permanent hearing loss.

(b) The Commission shall adopt rules necessary to implement the Newborn Screening Program. The rules shall include, but shall not be limited to, the conditions for which screening shall be required, provided that screening shall not be required when the parents or the guardian of the infant object to such screening. If the parents or guardian object to the screening, the objection shall be presented in writing to the physician or other person responsible for administering the test, who shall place the written objection in the infant's medical record.

(b1) The Commission for Health Services shall adopt temporary and permanent rules to include newborn hearing screening in the Newborn Screening Program established under this section.

(c) The Department may impose a fee for a laboratory test performed pursuant to this section by the State Public Health Laboratory. A fee for a test must be based on the actual cost of performing the test. Fees collected shall remain in the Department to be used to offset the cost of the Newborn Screening Program. ~~The fees for laboratory tests shall be used to supplement and not supplant funds appropriated for the Newborn Screening Program.~~

~~The Newborn Screening Fee Account is established as a nonreverting account within the Department. Fees collected pursuant to this section shall be credited to this Account and shall be applied to the Newborn Screening Program.~~"

Section 11.31.(b) Not later than March 1, 2001, the Department of Health and Human Services shall submit a progress report on the implementation of the newborn hearing screening program to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources, and to the Fiscal Research Division. The report shall include findings and recommendations relating to:

(1) Availability and adequacy of screening and diagnostic equipment;
(2) Staff training;
(3) Data on the number of infants screened, the number who failed the hearing screening, and the number fitted for amplification;
(4) The follow-up process for audiological management;
(5) Referral procedures for child service coordination and other early intervention services; and
(6) Outreach efforts to increase public awareness.

CODE NO. 2000DHHS-H043A-P

Requested by: Representatives Earle, Nye, Easterling, Redwine

HEART DISEASE AND STROKE PREVENTION TASK FORCE REPORT

Section 11.32. Subsection (l) of Section 26.9 of Chapter 507 of the 1995 Session Laws, as amended by Section 15.25 of S.L. 1997-443, and as further amended by Section 11.57 of S.L. 1999-237, reads as rewritten:

"(l) The Task Force shall submit to the Governor and to the General Assembly a preliminary report by January 1, 1996; an interim report within the first week of the convening of the 1997 General Assembly; a second interim report within the first week of the convening of the 1997 General Assembly, Regular Session 1998; a third interim report within the first week of the convening of the 1999 General Assembly, a fourth interim report within the first week of the convening of the 2000 General Assembly; a fifth interim report within the first week of the convening of the 2001 General Assembly, and a final report by June 30, 2001. The reports shall address the Plan, actions and resources needed to fully implement the Plan, and progress in achieving implementation of the Plan to reduce the occurrence of and burden from heart disease and stroke in North Carolina. The reports shall include an accounting

of funds expended and anticipated funding needs for full implementation of recommended plans and programs. Not later than October 1, 2000, the Task Force shall submit an additional report on its actual budget and activities for the 1999-2000 fiscal year. The report shall also describe the impact and effectiveness of Task Force activities in the State. The report shall be submitted to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division."

CODE NO. 2000DHHS-H044-P
Requested by: Representatives Earle, Nye, Easterling, Redwine, Boyd-McIntyre
EXTEND OSTEOPOROSIS TASK FORCE

Section 11.33.(a) Subsection (b) of Section 11.58 of S.L. 1999-237 reads as rewritten:

"Section 11.58.(b) The Task Force shall submit a progress report to members of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources, the Governor, and the Fiscal Research Division not later than April 1, 2000. The progress report shall address:

(1) Progress being made in fulfilling the duties of the Task Force and in developing the Osteoporosis Prevention Plan,
(2) The anticipated time frame for completion of the Prevention Plan, and
(3) Recommended strategies or actions to reduce the occurrence of and burdens suffered from osteoporosis by citizens of this State.

The Task Force shall submit its final report to the ~~1999~~ 2001 General Assembly, the Governor, and the Fiscal Research Division not later than October 1, ~~2000.~~ 2001."

Section 11.33.(b) Subsection (m) of Section 1532 of S.L. 1997-443, as amended by subsection (c) of Section 11.58 of S.L. 1999-237, reads as rewritten:

"(m) Upon submission of its final report to the Governor and the ~~1999~~ 2001 General Assembly, ~~Regular Session 2000,~~ the Task Force shall expire."

CODE NO. 2000DHHS-H048-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
LIMITATIONS ON EXPANSION OF INTENSIVE HOME VISITATION PROGRAM

Section 11.34.(a) The Department of Health and Human Services shall not amend the State Medicaid Plan to provide Medicaid reimbursement for intensive home visiting services.

Section 11.34.(b) The Department of Health and Human Services shall arrange for an independent evaluation of Intensive Home Visitation Program first-year pilot programs that began operation in February, 1998. The evaluation shall review and compare outcomes of the three models that were used in the pilot programs to determine whether the pilot programs are effective in North Carolina.

CODE NO. 2000DHHS-H029B-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Section 11.35.(a) Subsections (d) and (e) of Section 11.55 of S.L. 1999-237 read as rewritten:

"Section 11.55.(d) The Department shall also develop a comprehensive information management system on AIDS/HIV clients receiving services from the State. The Department may use up to fifty thousand dollars ($50,000) of the funds appropriated under this act to implement this information management system. This information management system shall be patterned after the information management

system used by the Elderly Drug Assistance Program, shall provide instantaneous internal access to information, and ~~This system~~ shall include information on the following:

(1) ~~program~~ Program usage patterns of ADAP participants, including, but not limited to, frequency of prescription purchases, ~~and~~ types of medications ~~prescribed.~~ prescribed, and the cost of prescribed medications on a monthly basis.

(2) Demographics of participants in the program, including the age, gender, race, ethnicity, and county of residence of participants.

The Department shall also develop a plan for promoting patient adherence to physician treatment recommendations. In developing the plan, the Department shall identify ways of obtaining information without interfering with physician-patient confidentiality. The Department shall report on this plan to the members of the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division not later than May 15, 2000.

Section 11.55.(e) For the 1999-2000 fiscal ~~year,~~ year and for the 2000-2001 fiscal year, HIV-positive individuals with incomes at or below one hundred twenty-five percent (125%) of the federal poverty level are eligible for participation in ADAP. Notwithstanding any other provision of law, eligibility for participation in ADAP during the 1999-2000 fiscal year shall not be extended to individuals with incomes above one hundred twenty-five percent (125%) of the federal poverty level. Eligibility for participation in ADAP during the 2000-2001 fiscal year may be extended to individuals with incomes up to one hundred fifty percent (150%) of the federal poverty level only after the Office of State Budget and Management certifies in writing that the Department has developed an information management system pursuant to subsection (d) of this section. Until the Office of State Budget and Management makes this certification, eligibility for participation in ADAP during the 2000-2001 fiscal year shall not be extended to individuals with incomes above one hundred twenty-five percent (125%) of the federal poverty level. All individuals who are eligible for participation in ADAP shall be served by the Department of Health and Human Services. If sufficient funds are not available from funds allocated to ADAP, the Department of Health and Human Services shall transfer available funds from other programs within the Department to meet the funding needs of ADAP."

Section 11.35.(b) The Department of Health and Human Services shall make an interim report by October 1, 2000, and a final report by April 1, 2001, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division on ADAP. The reports shall include the following:

(1) Monthly data on total cumulative AIDS/HIV cases reported in North Carolina.

(2) Monthly data on the estimated number of individuals eligible to participate in ADAP and the actual number of participants in ADAP.

(3) Monthly data on the number of individuals who have applied to participate in ADAP that have been determined to be ineligible.

(4) Monthly data on the income level of participants in ADAP and of individuals who have applied to participate in ADAP that have been determined to be ineligible.

(5) Monthly data on fiscal-year-to-date expenditures of ADAP. The interim report shall contain monthly data on the calendar-year-to-date expenditures of ADAP.

(6) Monthly data on the actual line-item budget of ADAP.

(7) Monthly data on funding sources of ADAP expenditures.
(8) Monthly data on ADAP funds that are applied to a Medicaid spend-down.
(9) An update on the status of the information management system.
(10) Monthly data on ADAP usage patterns and demographics of participants in ADAP.
(11) Estimated participation rates and costs if eligibility for participation in ADAP were raised to one hundred seventy-five percent (175%) of the federal poverty level or to two hundred percent (200%) of the federal poverty level.

CODE NO. 2000DHHS-H046-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
COMMUNICABLE DISEASE CONTROL AID TO COUNTIES/REPORT

Section 11.36. Not later than October 1, 2000, the Department of Health and Human Services shall report the impact of combining and allocating funds appropriated for the 1999-2000 fiscal year for Aid to Counties in the Acute Communicable Disease Control Fund, the Tuberculosis Control Fund, and the Sexually Transmitted Disease Control Fund into one Acute Communicable Disease Control Aid to Counties Grant. The report shall include the impact of expenditures by county on the individual communicable disease groups. The Department shall submit the report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division of the Legislative Services Office.

CODE NO. 2000DHHS-H045-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
PUBLIC HEALTH PREVENTION ACTIVITIES REPORT

Section 11.37. Section 11.60 of S.L. 1999-237 reads as rewritten:

"Section 11.60.(a) By ~~April 15,~~ October 1, 2000, and more frequently as requested, the Department of Health and Human Services, Division of Public Health, shall report on the activities of each of the following:
(1) Kenneth C. Royall, Jr. Children's Vision Screening Improvement Program;
(2) North Carolina Healthy Start Foundation; and
(3) Adolescent Pregnancy Prevention Coalition of North Carolina.

Section 11.60.(b) The report shall include the following information for each of the organizations named in subsection (a) of this section:
(1) How organization initiatives, singularly or in concert with other programs, contribute to the Department's overall goal of reducing teen pregnancy and infant mortality, and addressing vision problems of children in North Carolina. This information shall also include data and research that supports the approach the Department has taken in achieving its goal;
(2) Output data demonstrating the effects of the organization's activities;
(3) State fiscal year 1998-99 program objectives and activities;
(4) State fiscal year 1998-99 itemized expenditures and fund sources;
(5) State fiscal year 1999-2000 planned objectives, activities, and accomplishments; and
(6) State fiscal year 1999-2000 estimated itemized expenditures and fund sources, including actual expenditures and fund sources through April 15, 2000.

(7) For the 1999-2000 fiscal year:
a. A description of all program activities of the organization;
b. The number of individuals or entities served by each program of the organization;
c. Detailed actual cost of each program funded by the organization, including contracted services;
d. Output data demonstrating the effects of the organization's activities; and
e. Planned budget, objectives, and activities for the 2000-2001 fiscal year.

The Department shall submit the report to the House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division of the Legislative Services Office."

CODE NO. 2000DHHS-H047A-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
PREVENTIVE HEALTH PROGRAM PLAN

Section 11.38. The Department of Health and Human Services shall work with the Fiscal Research Division of the Legislative Services Office to do the following:

(1) Conduct a full inventory on all prevention activities including task forces and committees that receive administrative funding;
(2) Identify linkages among program activities, such as activities involving education and awareness, and those involving services;
(3) Identify all administrative costs and funding sources and number of positions associated with various prevention activities;
(4) Develop an alternative organizational structure that could more effectively and efficiently administer preventive health activities.

Not later than February 1, 2001, the Department shall submit the report required under this section to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division.

CODE NO. 2000DHHS-H050-P
Requested by: Representatives Earle, Nye, Easterling, Redwine
PRESCRIPTION DRUG ASSISTANCE PROGRAM

Section 11.39. Section 11.1.(a) of S.L. 1999-237 reads as rewritten:

"Section 11.1.(a) Of the funds appropriated in this act to the Department of Health and Human Services, the sum of five hundred thousand dollars ($500,000) for the 1999-2000 fiscal year and the sum of ~~five hundred thousand~~ one million dollars ~~($500,000)~~ ($1,000,000) for the 2000-2001 fiscal year shall be used to pay the cost of outpatient prescription drugs for persons:

(1) Over the age of 65 years and not eligible for full Medicaid benefits;
(2) Whose income is not more than one hundred fifty percent (150%) of the federal poverty level; and
(3) Who have been diagnosed with cardiovascular disease or diabetes.

These funds shall be used to pay the cost of outpatient prescription drugs for the treatment of cardiovascular disease or diabetes. Payment shall be not more than the Medicaid cost including rebates. The Department shall develop criteria to maximize the efficient and effective distribution of these drugs."

CODE NO. 2000DHHS-H051*

Requested by: Representatives Earle, Nye, Easterling, Redwine

ADOLESCENT PREGNANCY PREVENTION PROGRAMS

Section 11.40. (a) Effective July 1, 2005, Part 6 of Article 5 of Chapter 130A of the General Statutes is repealed.

Section 11.40. (b) Effective July 1, 2000, guidelines for the administration of funds for parenting programs and teen pregnancy prevention shall be the guidelines adopted under subsection (x) of Section 5 of this act.

Section 11.40. (c) Projects funded under G.S. 130A-131.15 for the 1999-2000 fiscal year shall continue to receive funding through the five-year funding cycle in accordance with G.S. 130A-131.15.

VISITOR REGISTRATION SHEET

APPROPRIATIONS HEALTH AND HUMAN SERVICES — **June 12, 2000**

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jerry Hardesty	NC Food Banks
Andy Ellen	NC Retail Merchants Assoc
Hugh Wilson	NCHA
Jerry Cooper	NCACA
Stacy Flannery	NCHCFA
[illegible]	NCACTC
[illegible]	AHHC
Bob Hedrick	CNC
Dianne Culley	NCMA
Stan Slawinski	DO Section
Jim Osberg	DMH/DD/SAS -
[illegible]	DMH/DD/SAS
[illegible]	DMH/DD/SAS
Tara Larson	DMH/DD/SAS
Charles Vann	" " "
[illegible]	" "
Kerri Egan	YA10
Al Deitch	YAID
Martha Lawrence	YAZD
Pam Kohl	Doe Center
Steve Cline	DHHS/DPH
[illegible]	DHHS/DPH
Kevin Ryan	DHHS/DPH
Annette Ethridge	Governor's Office
W. Mark Porter	MTE
Janice Freedman	NC Healthy Start Foundation
[illegible]	SEANC

VISITOR REGISTRATION SHEET

APPROPRIATIONS HEALTH AND HUMAN SERVICES **June 12, 2000**

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Maya Bhat	NC Council of Community Programs
Janet Schanzenbach	NC Council of Community Programs
Bennie Holler	DHHS
Karen Gottovi	DHHS - Aging
by Ever Farmer	DHHS - dcd
Anthony Solari	Smart Start
Roz Sawitt	NC Child Care Coalition
Sovein Schmidt	NC Justice Center
Kay Michaels	PPOD
Jesse Douglas	NCAD/Coalition 2001
Peter Leonsis	DHHS
John Tate	MHA/NC-C2001
Dan Richard	Ave Inc
NELS ROSELAND	OSBM
Don Willis	DMHDDSAS
Lynda McDaniel	DHHS/DFS
Kevin FitzGerald	DHHS-DSS
Chuck Harris	DHHS - DSS
JoAnn Lamm	DHHS-DSS
Nancy Coston	DHHS-DSS
Roger Manus	attorney
Deborah Greenblatt	Carolina Legal Assistance
Paula L. Wolf	Covenant W/NC's Children
Sharon Hipp	NC Social Services Consortium
CJ Medlin	NC Equity
Karen Anders	DHHS-DSS
Sheron Beal	DSS-DHHS

VISITOR REGISTRATION SHEET

APPROPRIATIONS HEALTH AND HUMAN SERVICES **June 12, 2000**

Name of Committee Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Wilbert R. Morris	DHHS - DSS
[illegible]	DHHS-DSS
JACK McGEE	MALCV of DIMES
Kay James	March of Dimes - 412 Pleasant Valley, Raleigh 27612
Holly Riddle	NC Council on Dev. Disabilities
Melissa A Swartz	NC Council on Developmental Disabilities
Debbie Kahler Siegel	NC Council on Developmental Disabilities
Kim Wales	Carolina Legal Assistance
Suzanne Alford	Carolina Legal Assistance
DAVE BRUTON	DHHS
Jim Edgerton	DHHS
Allyn Duffey	DHHS
Bob Hargett	Justice
MARC LODGE	DHHS
[illegible]	OSBM
Allen Gamble	DHHS - DMA
P. Perrussi	DHHS - DMA
Anna Waddell	DHHS
Jason Reynolds	NC Gov's Inst. on Alcohol + SA
Flo Stein	DMH/DD/SAS
Wayne Williams	OSBM
Mary Green	OSBM
Julie Mitchell	OSBM
Ransome	DSS
Michelle Cotton	DMH/DD/SAS

SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 15, 2000
Room 422, LOB

The Senate Appropriations Subcommittee on Human Resources met, Thursday, June 15, 2000 at 8:30 a.m. in Room 422 of the Legislative Office Building. The meeting was called to order by Senator Bill Martin, Chair with all members present.

After introduction of pages and the welcome to the visitors, he stated that the purpose of the meeting today is to hear from staff in terms of what the budget looks like and to review the actions taken by the House. He stated that the Chairs worked very closely to reach an agreement. When the review of the Senate is complete a timely conclusion can be reached.

Karen Hammonds-Blanks was recognized to begin reviewing the budget. She explained that there are two documents, the money report (attachment 1) and House Bill 1840 (2000 Appropriation Act), which the House passed June 14, 2000.

Carol Shaw followed Karen with a review of the Division of Medical Assistance.

Mary Ellen Sylvester gave an overview of the recommendations by the Governor in the Smart Start funding and elimination of an operating reserve for a traumatic brain injury unit.

Lisa Howell also gave an overview of the area of Public Health.

After Committee discussion, the meeting adjourned.

Senator William N. Martin, Chair

Joyce Crews Hodge, Clerk

Senate Appropriations Committee on Human Resources

June 15, 2000
8:30 AM
Legislative Office Building Rm# 422

----- Agenda Topics -----

Opening Remarks	Senator Bill Martin, Chair
Overview of House Bill 1840: 2000 Appropriations Act	Fiscal Research Division
Committee Discussion	
ADJOURN	

Health and Human Services

GENERAL FUND

	FY 00-01
Total Budget Approved 1999 Session	**$3,014,095,636**

Budget Changes

(1.0) Division of Mental Health			
1	**Reduce Operating Reserve** Reduces the operating reserve (on a non-recurring basis) for a new neurobehavioral unit to be created within the Black Mountain Center. Allows the unit to open during FY01/02.	($571,526)	NR
(2.0) Division of Social Services			
2	**Reduce Excess Adoption Assistance Funds** Reduces excess adoption assistance funds and allows for the enhancement of adoptions activities.	($2,300,000)	R
(3.0) Division of Medical Assistance			
3	**Transfer Medicaid Reserve Funds** Transfers funds from G.S. 143-23.2 reserve to support current services and to reduce appropriations.	($70,000,000)	NR
4	**Adjust Medicaid Funding** Reduces appropriations to reflect current projections for the Medicaid Program.	($32,388,631)	R
5	**Reduce Administrative Funding** Reduces program funding to support positions required by federal and state mandates.	($127,000)	R
6	**Increase Medicaid Drug Rebate Receipts** Increases receipts from the Drug Rebate Program to reflect increased expenditures for prescription drugs.	($12,146,498)	R
(4.0) Office of the Secretary			
7	**Eliminate Position** Eliminates the Health Care Access Coordinator position funded with TANF block grant funds.	$0 -1.00	R
8	**Increase Receipts** Reduces appropriations in anticipation of increased receipts for prior year earned revenue.	($13,120,000)	NR
9	**Increase Receipts** Reduces appropriations in anticipation of increased receipts across the department.	($3,000,000)	R

10 Eliminate 29 Vacant Positions ($2,100,000) R

Eliminates 29 vacant positions across the department except for specific state institutions. -29.00

(5.0) Division of Child Development

11 Reduce Smart Start Funds

Provides a one-time reduction in Smart Start funding due to lower than anticipated program expenditures. ($49,000,000) NR

(6.0) Division of Vocational Rehabilitation

12 Eliminate Operating Reserve for TBI Unit ($956,328) R

Eliminates the operating reserve for the Traumatic Brain Injury (TBI) Unit in Goldsboro since the required capital funding was re-directed to support the Hurricane Floyd recovery effort. -48.00

(7.0) Division of Public Health

13 Reduce Funding to Family Planning ($45,000) R

Reduces appropriations for family planning services to provide the state match for a Medicaid waiver for the provision of family planning services. ($424,000) NR

14 Reduce Funding to Forensic Test for Alcohol Pgm. ($964,871) R

Reduces appropriations and allows the fees collected to be budgeted to support the functions in the Forensic Test for Alcohol Program.

15 Reduce Funding to Public Health Laboratory ($220,000) R

Decreases appropriations by the amount of increased Medicaid receipts to offset the cost of Laboratory operations.

16 Reduce Funding to AIDS Drug Assistance Program ($2,000,000) R

Decreases appropriations for the AIDS Drug Assistance Program by $2,000,000 due to increased federal funds. Also, decreases appropriations by $3,000,000 due to under-utilization of the program. ($3,000,000) NR

17 Reduce Funding to Developmental Evaluation Centers ($1,000,000) R

Reduces appropriations to the Developmental Evaluation Centers due to increased Medicaid receipts.

18 Reduce Funding to Medical Examiner's Office ($100,000) R

Reduces appropriations by the amount of the increase in Medical Examiner's Fees in 1999.

(8.0) Division of Mental Health

19 Services for Violent and Assaultive Children

Provides funds to continue current mental health service levels for violent and assaultive children. $4,353,000 NR

20 Early Intervention System Pilots — $250,000 NR

Provides additional funds to support the integrated client database and regional transdisciplinary team pilots for young children receiving early intervention services.

21 Mental Health System Reform Reserve — $3,000,000 NR

Establishes a Mental Health System Reform Reserve in order to comply with the Olmstead Supreme Court decision regarding de-institutionalization of individuals with mental health disabilities. Also, provides funds for the anticipated reform of the public mental health system.

22 Housing Support for the Mentally Ill — $301,000 NR

Provides matching funds to draw down federal funds for the support of an additional 38 housing placements for the mentally ill.

23 Funds for Autistic Adults — $250,000 R

Provides funds to the N.C. Autism Society for additional services to adults with autism.

24 Substance Abuse Services Positions — $0 R

4.00

Adds four (4) positions to the Substance Abuse Services Section to support the (1) Employee Assistance Program, (2) Offender Management Program, (3) Quality assurance services for DWI offenders, and (4) Development of housing and other 24-hour services. The positions are offset by the Substance Abuse Prevention and Treatment Block Grant.

25 Community Mental Health Programs — $4,000,000 R

Provides funds for area mental health programs as follows:

Substance Abuse Services	$2,000,000
Developmental Disabilities	$2,000,000

26 Child Residential Treatment/Services Program — $8,000,000 R

6.00

Establishes a child mental health residential treatment/services program in order to provide appropriate residential treatment alternatives for children at risk of institutionalization or other out-of-home placement. Also, provides for the creation of six (6) new positions: Division of Mental Health, Developmental Disabilities & Substance Abuse Services 3.0; Controller's Office 1.0 and Division of Social Services 2.0.

✓ **27 Atypical Antipsychotic Medications** — $1,500,000 R

Senate added

Provides additional funds for atypical antipsychotic medications as follows:

(1)	State DHHS facilities	$750,000 ✓R
(2)	Area mental health programs	$750,000

✓ **28 Autistic Child & Adolescent Units at Murdoch** — From $3M to $1,200,000 R

Restored

65.00

Provides start up and operational funds to establish residential services for autistic children and adolescents within and on the grounds of the Murdoch Mental Retardation Center located at Butner.

29 Area Mental Health Board Training — $150,000 NR

Provides funds to train area mental health programs' board members. (This appropriation was included in HB 168 during the 1999 Session but was diverted for flood relief.)

(9.0) Division of Social Services

30 Special Children Adoption Incentives Fund — $500,000 R

Establishes a fund to provide financial incentives for foster care families desiring to adopt special needs children residing in their care.

31 State/County Special Assistance — $4,450,000 R

Increases monthly State/County Special Assistance payment from $982 to $1,062. Effective October 1, 2000.

32 Food Banks — $1,000,000 NR

Provides funds to be equally distributed to the regional network of food banks in North Carolina.

33 Foster Care Independent Living Matching Funds — $500,000 R

Provides the match for federal Independent Living Program funds in order to prepare children for the transition from foster care to independence. Also, provides for the addition of one position to coordinate the program. — 1.00

34 Special Children Adoption Fund — $1,100,000 R

Increases the Special Children Adoption Fund which provides financial incentives to local departments of social services and private non-profit adoption placement programs for the placement of children in foster care. Also, provides post-adoption support funds to ensure placements are successful.

35 Administrative Support — $0 R

Provides for the addition of ten (10) positions within the Division of Social Services to enhance and support the Work First Program; coordinate expanded after school programs for at-risk children; and child welfare training. These positions are totally offset with TANF block grant funds. — 10.00

36 Adoptions Program — $200,000 R

Provides additional staff and related funds to address the backlog in processing adoptions information. — 3.00

(10.0) Division of Public Health

37 Prevention of Birth Defects — $150,000 NR

Provides funding for education and awareness activities on the importance of folate consumption preceding pregnancy to effectively prevent neural tube birth defects and infant mortality.

38 Office of Minority Health — $200,000 NR

Provides funding to support mini-grants for coalition-building at the local level. Provides funding for minority infant mortality reduction efforts.

39	**Healthy Carolinians** Provides funding for Healthy Carolinians' task forces throughout the state.	$1,000,000	NR
40	**Osteoporosis Task Force** Provides funding to continue support for the Osteoporosis Task Force.	$150,000	NR
41	**Heart Disease and Stroke Prevention** Provides funding to the Heart Disease and Stroke Prevention Task Force for implementation of the NC Plan to Prevent Heart Disease and Stroke.	$100,000	NR
42	**Arthritis Prevention Project** Provides grant-in-aid for a private, local project providing services for arthritis patients in Mecklenburg County.	$25,000	NR
43	**Alice Aycock Poe Center for Health Education** Provides grant-in-aid to the Alice Aycock Poe Center for Health Education.	$200,000	NR
44	**Prescription Drug Assistance Program** Provides increased funding for the Prescription Drug Assistance Program for persons over age 65.	$500,000	NR
45	**Healthy Start Foundation** Funds the statewide public information and education activities of the First Step campaign. Provides mini-grants for local communities to implement pilot programs aimed at reducing infant mortality.	$1,000,000	NR
46	**Birth Defects Monitoring Program** Provides funding to initiate the development of a birth defects registry.	$200,000 4.00	R
47	**Hepatitis C Education Awareness** Provides funding for Hepatitis C education and awareness activities.	$150,000	NR
48	**Asthma Education** Provides funding to support asthma management, control, surveillance, and education.	$250,000	NR
49	**State Games** Supports the State Games of North Carolina to promote health and fitness.	$200,000	NR
	(11.0) Division of Child Development		
50	**T.E.A.C.H. Program** Provides funding to expand the Teacher Education and Compensation Helps (T.E.A.C.H.) Program which assists child care teachers in pursuing higher education in the field of early childhood.	$400,000	R

51 Smart Start Program — $43,500,000 R / $500,000 NR

Provides additional funding for direct services statewide, state-level administration, program evaluation, and county collaboration efforts.

52 Child Care Subsidy Program — $0 R / 68.00

Authorizes 68 positions in recognition of the significantly increased demand on licensing and monitoring staff due to the growth in regulated child care centers/homes and the implementation of the rated license system. These positions are funded with federal Child Care and Development Fund quality set-aside funding.

Positions not included handled through Block grant

(12.0) Div. of Serv. for Deaf/Hard of Hearing

53 Individual Education Plan (IEP) Services — $600,000 NR

Provides additional funding for contractual services required by students' IEPs at the residential schools for the deaf.

54 Teacher Mentor Pay — $56,250 NR

Provides funding to compensate experienced teachers at the schools for the deaf who serve as mentors for new teachers.

55 Day Student Transportation — $375,000 NR

Provides funding for transporting deaf and hard of hearing day students to programs at the Division's three residential campuses.

56 Family Support Services — $220,000 R

Expands support services to families with deaf and hard of hearing children as a result of increased demand from the newborn hearing screening program.

(13.0) Division of Services for the Blind

57 Individual Education Plan (IEP) Services — $200,000 NR

Provides additional funding for contractual services required by students' IEPs at the Governor Morehead School.

58 Teacher Mentor Pay — $18,750 NR

Provides funding to compensate experienced teachers at the Governor Morehead School who serve as mentors for new teachers.

59 Services for Deaf/Blind Children — $225,000 R / 5.00

Provides funding to establish a specialized program for deaf/blind children at the Governor Morehead School, including expansion of NC Central University's master's degree program in visual impairment to include intervenor training.

60 Vocational Rehabilitation Case Services Funds — $235,000 NR

Provides additional funds to offset the increased tuition costs for visually-impaired vocational rehabilitation clients attending in-state universities.

61 Day Student Transportation
Provides funding for transporting visually-impaired day students to programs at the Governor Morehead School campus. — $125,000 NR

(14.0) Division of Vocational Rehabilitation

62 Client Information System
Completes development and implementation of an automated client information system. — $1,700,000 NR

63 Case Services Funds
Provides additional funds to offset the increased tuition costs of clients attending in-state universities. — $615,000 NR

64 Independent Living Rehabilitation Program — $2,000,000 R
Provides additional funding to address client needs statewide and continue technical assistance to the housing industry on design requirements for multifamily housing for disabled individuals. — $2,000,000 NR

(15.0) Division of Medical Assistance

65 Family Planning Waiver — $45,000 R
Provides funding for the state match for a Medicaid waiver to provide Medicaid coverage for family planning services to men and women of child bearing ages with family incomes equal to or less than 185% of the federal poverty level. Effective January 1, 2001. — $424,000 NR; 2.00

66 Medicaid Positions — $127,000 R
Provides funding to support three positions to meet federal HIPAA requirements and one position to meet increased demands from provider enrollment. — 4.00

67 Additional CAP-MR/DD Slots — $6,890,000 R
Funds 600 CAP-MR/DD slots in the Medicaid Program.

(16.0) Office of the Secretary

68 Child Advocacy Institute
Provides funding for the continuation of the Child Advocacy Institute's activities to collect and publish the annual report on the status of children in North Carolina. — $250,000 NR

69 North Carolina Council on the Holocaust increased to 50,000 from 25
Provides funds for Holocaust education in the public schools. — $50,000 NR

70 Latin American Resource Center
Provides grant-in-aid to the Latin American Resource Center (LARC) for administration and outreach operations relative to its programs, including DIALOGO. — $75,000 NR

71	**"Closing the Achievement Gap" Pilot Program** Provides funds to establish a pilot program to assist children and families in order to enhance school performance and family functioning.	$250,000	NR
	(17.0) Division of Facility Services		
72	**Statewide Poison Control Center** Provides funding for the Statewide Poison Control Center at Carolinas Medical Center.	$1,000,000	R
73	**Adult Care Home Inspectors** Provides additional inspectors to implement requirements of Senate Bill 10.	$149,000 6.00	R
74	**Nurse Aide Online Training** Provides funding for the State Board of Community Colleges for the development and implementation of on-site internet training or other innovative training programs designed to improve recruitment and reduce turnover of certified nursing assistants in nursing facilities.	$500,000	NR
	(18.0) Division of Aging		
75	**Adult Day Care Start-up Grants** Provides funding for up to 10 start-up grants for new Adult Day Care Programs.	$250,000	NR
	Budget Changes	**$19,107,672**	R
		($114,912,526)	NR
	Total Position Changes	100.00	
	Revised Total Budget	**$2,918,290,782**	

Name of Committee: SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 15, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
S Ransome	DSS
S Saupel	DCD
Janet Schamyn Lamb	NC Council
by Avent Farmer	dhhs - dcd
Roz Sawitt	NC Child Care Coalition
Dave Rohrl	The Actor
C. L. Cochran	UCPNC C2001
Joe Lubera	AHHC
Bill Rehm	NCPA
NELS ROSELAND	OSBM
Tara Larson	DMH/DD/SAS
[illegible]	OSBM
Kay Michaels	PPOD

Name of Committee: SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 15, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michelle Cotton	DMHDDSAS
Charles Ammons	DMHDDSAS
P. Perruzza	DMA/DHHS
Jim Edgerton	DHHS
DAVE BARON	DHHS
Stacy Flannery	NCHCFA
Sona Shandilya	NCCADV
Paula A. Wolf	Covenant w/NC's Children
Amanda Adams	"
Anthony Sutari	N.C. PARTNERSHIP CHILDREN
Jan Hackett	NC Food Banks

Name of Committee: SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 15, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Myrna Miller	Nat'l Assoc. of Social Workers – NC Chapter (NASW-NC)
Don Willis	DMHDDSAS
Wayne Williams	OSBM
Whitney Obrig	OSBM
Mary Greene	OSBM
Roger Bone	Bone + Assoc
Lou Wilson	NCALTCF
Amy Fullbright	Hunton & Williams
John Kent	NCFPC
HUGH TILSON	
Sandra Summers	NC Equity

VISITOR REGISTRATION SHEET

[redacted]
Name of Committee

6/15/00
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Anne Winn	NCCADV

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS

VISITOR REGISTRATION SHEET

Name of Committee _____ Date _____

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS

SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 20, 2000
Room 422, LOB

The Senate Appropriations Subcommittee on Human Resources met, Tuesday, June 20, 2000 at 8:30 a.m. in Room 422 of the Legislative Office Building. The meeting was called to order by Senator Bill Martin, Chair with all members present.

After introduction of the Pages, Sen. Martin stated that there is a short time to complete a lot. He stated that the Committee will go through the two documents attached (attachment 1 and 2). He stated that at the request of the overall Chairs that if there are any amendments, they will be made at the Full Appropriations meeting tomorrow.

He recognized staff to present the budget items and the special provisions. In an effort to complete everything before 10:00 a.m., he asked the committee to review the differences and the items highlighted.

Carol Shaw began the budget discussion followed by Karen Hammonds-Blanks, Mary Ellen Sylvester and Lisa Howell.

In response to a question from Sen. Phillips regarding the increase in caseloads, Nancy Costen, Deputy Director of Division of Social Services stated that the 198 positions would keep pace, with regard to the increase caseload, for where we are now.

In reference to expanding care for children with special needs, Sen. Martin stated that Dr. Burton suggested that a request of waiver through the Federal Department of Health and Human Services, that would permit coverage for those children. He stated that there is additional cost associated with this. It is being considered at this point.

Senator Purcell made a motion that with exception of the provision dealing with vacant DHHS positions on page 16, the Special Provisions be approved. The motion carried by unanimous voice vote.

The Chair added that included in the report to the overall Chairs, emphasis will be placed on the strong desire of the Committee to include the funds so that the Department can pursue modification of the State Plan for serving special needs children. Sen. Dannelly suggested that a reminder of the fact that this department has taken more "hits and cuts" than any other department in the past several years.

Sen. Dannelly moved that the budget document be approved with the exception of item G-10. The motion carried by unanimous voice vote.

Regarding the elimination of the 29 positions, page 16, lines 29-44, Jim Edgerton stated that elimination of these positions would generate $2.1 million. He asked if something could be added to allow the Department to generate the dollars from other sources or areas in the Department.

Senator Forrester inquired about the number of positions that have been vacant for more than a year, and could all the vacant positions in the Department be reviewed.

Sen. Dannelly moved that the flexibility discussed by the Committee be incorporated in the Special Provision. The motion carried by unanimous vote.

The Chair thanked everyone for their conscientious work. The meeting adjourned at 9:58 a.m.

Sen. William N. Martin, Chair

Joyce Crews Hodge, Clerk

SENATE APPROPRIATIONS COMMITTEE
ON
HUMAN RESOURCES

SPECIAL PROVISIONS

JUNE 20, 2000

PART V. BLOCK GRANT FUNDS

CODE NO. 2000DHHS-S5-P
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
DHHS BLOCK GRANT PROVISIONS

Section 5.(a) Appropriations from federal block grant funds are made for the fiscal year ending June 30, 2001, according to the following schedule:

COMMUNITY SERVICES BLOCK GRANT		
01.	Community Action Agencies	$ 12,377,017
02.	Limited Purpose Agencies	687,612
03.	Department of Health and Human Services to administer and monitor the activities of the Community Services Block Grant	687,612
TOTAL COMMUNITY SERVICES BLOCK GRANT		$ 13,752,241
SOCIAL SERVICES BLOCK GRANT		
01.	County departments of social services (Transfer from TANF - $4,500,000)	$ 27,395,663
02.	Allocation for in-home services provided by county departments of social services	2,101,113
03.	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	3,234,601
04.	Division of Services for the Blind	3,105,711
05.	Division of Facility Services	426,836
06.	Division of Aging - Home and Community Care Block Grant	1,840,234
07.	Child Care Subsidies	3,000,000
08.	Division of Vocational Rehabilitation - United Cerebral Palsy	71,484
09.	State administration	1,693,368
10.	Child Medical Evaluation Program	238,321
11.	Adult day care services	2,155,301
12.	County departments of social services for	

	child abuse prevention and permanency planning	394,841
13.	Transfer to Preventive Health Services Block Grant for emergency medical services	213,128
14.	Transfer to Preventive Health Services Block Grant for AIDS education, counseling, and testing	66,939
15.	Department of Administration for the N.C. Commission of Indian Affairs In-Home Services Program for the elderly	203,198
16.	Division of Vocational Rehabilitation - Easter Seals Society	116,779
17.	UNC-CH CARES Program for training and consultation services	247,920
18.	Office of the Secretary - Office of Economic Opportunity for N.C. Senior Citizens' Federation for outreach services to low-income elderly persons	41,302
19.	Special Children Adoption Fund	511,687
20.	Transfer from TANF Block Grant for Enhanced Employee Assistance Program	1,000,000
21.	Transfer from TANF Block Grant for Division of Social Services - Child Caring Agencies	1,500,000
22.	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services - Developmentally Disabled Waiting List for services	5,000,000
TOTAL SOCIAL SERVICES BLOCK GRANT		$ 54,558,426
LOW-INCOME ENERGY BLOCK GRANT		
01.	Energy Assistance Programs	$ 8,092,113
02.	Crisis Intervention	7,078,114
03.	Administration	1,988,234
04.	Department of Commerce - Weatherization Program	2,684,116
05.	Department of Administration -	

N.C. Commission of Indian Affairs	39,765
TOTAL LOW-INCOME ENERGY BLOCK GRANT	$ 19,882,342
MENTAL HEALTH SERVICES BLOCK GRANT	
01. Provision of community-based services in accordance with the Mental Health Study Commission's Adult Severe and Persistently Mentally Ill Plan	$ 4,301,361
02. Provision of community-based services to children	1,898,520
03. Establish Child Residential Treatment Services Program	1,500,000
04. Administration	783,911
TOTAL MENTAL HEALTH SERVICES BLOCK GRANT	$ 8,483,792
SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT	
01. Provision of community-based alcohol and drug abuse services, tuberculosis services, and services provided by the Alcohol and Drug Abuse Treatment Centers	$ 15,043,841
02. Continuation of services for pregnant women and women with dependent children	6,567,532
03. Continuation of services to IV drug abusers and others at risk for HIV diseases	5,210,497
04. Provision of services to children and adolescents	7,216,992
05. Juvenile Services - Family Focus	893,811
06. Juvenile offender services and substance abuse pilot	300,000
07. Establish Child Residential Treatment Services Program	1,000,000
08. Administration	2,623,049
TOTAL SUBSTANCE ABUSE PREVENTION	

AND TREATMENT BLOCK GRANT		$ 38,855,722
CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT		
01.	Child care subsidies	$117,145,326
02.	Quality and availability initiatives	12,332,039
03.	Administrative expenses	6,814,598
04.	Transfer from TANF Block Grant for child care subsidies	57,957,188
05.	Transfer from TANF Block Grant for child care rate increases and quality initiatives	18,717,812
TOTAL CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT		$212,966,963
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) BLOCK GRANT		
01.	Work First Cash Assistance	
	Standard Counties	$ 81,859,561
	Electing Counties	24,331,095
02.	Work First County Block Grants	92,018,855
03.	Transfer to the Child Care and Development Fund Block Grant for child care subsidies	57,957,188
04.	Allocation to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for Work First substance abuse screening, diagnostic, and support treatment services and drug testing	3,500,000
05.	Allocation to the Division of Social Services for Work First Evaluation	1,500,000
06.	Allocation to the Division of Social Services for staff development	500,000
07.	Reduction of out-of-wedlock births	1,600,000
08.	Substance Abuse Services for Juveniles	1,182,280
09.	Special Children Adoption Fund	2,300,000
10.	Employment Security Commission - First Stop Employment Assistance	1,000,000

11.	Transfer to Social Services Block Grant - Enhanced Employee Assistance Program	1,000,000
12.	Work First Job Retention and Follow-Up Initiatives	1,607,529
13.	Allocation to the Division of Public Health for teen pregnancy prevention	2,000,000
14.	Transfer to Social Services Block Grant for Child Caring Agencies	1,500,000
15.	Child Care Subsidies for TANF Recipients	26,621,241
16.	Work First Housing Initiative	3,000,000
17.	Transfer to Child Care and Development Fund Block Grant for Child Care Rate Increases	18,717,812
18.	Allocation to the Division of Social Services for Domestic Violence Prevention and Awareness	1,000,000
19.	County Child Protective Services, Foster Care and Adoption Workers	2,727,550
20.	Intensive Family Preservation Program	2,000,000
21.	Work First/Boys and Girls Clubs	1,000,000
22.	Transfer to Social Services Block Grant for County Departments of Social Services for Children's Services	4,500,000
23.	Adolescent Pregnancy Prevention Program	239,261
24.	Expand Support Our Students - Office of Juvenile Justice	2,750,674
	Consolidated into one item	
25.	Residential Substance Abuse Services for Women with Children	5,000,000
26.	Domestic Violence Services for Work First families	3,000,000
27.	Responsible Fatherhood Initiative	1,000,000
28.	After-School Services for At-Risk Children	2,000,000
29.	Business Process Reengineering Project	5,012,000
30.	Division of Social Services -	

	Administration	500,000
31.	Child Welfare workers for local departments of social services	8,250,000
32.	Work First Pilots	5,400,000
33.	Child Welfare Training	2,000,000
34.	Work First Business Council	100,000
35.	JobLink Pilots	750,000
TOTAL TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) BLOCK GRANT		$369,425,046
MATERNAL AND CHILD HEALTH BLOCK GRANT		
01.	Healthy Mothers/Healthy Children Block Grants to Local Health Departments	$ 9,838,074
02.	High-Risk Maternity Clinic Services, Perinatal Education and Training, Childhood Injury Prevention, Public Information and Education, and Technical Assistance to Local Health Departments	2,012,102
03.	Services to Children With Special Health Care Needs 197 Local Workers 8.25	5,078,647
TOTAL MATERNAL AND CHILD HEALTH BLOCK GRANT	2m child welfare training SP	$ 16,928,823
PREVENTIVE HEALTH SERVICES BLOCK GRANT		
01.	Statewide Health Promotion Programs	$3,184,399
02.	Dental Services/Fluoridation	100,800
03.	Rape Crisis/Victims' Services Program - Council for Women	190,134
04.	Rape Prevention and Education Program - Division of Public Health and Council for Women	1,137,186
05.	Transfer from Social Services Block Grant - AIDS/HIV Education, Counseling, and Testing	66,939

06.	Transfer from Social Services Block Grant - Emergency Medical Services	213,128
07.	Office of Minority Health	159,459
08.	Administrative Costs	143,151
TOTAL PREVENTIVE HEALTH SERVICES BLOCK GRANT		$5,195,196

Section 5.(b) Decreases in Federal Fund Availability. -- If the United States Congress reduces federal fund availability in the Social Services Block Grant below the amounts appropriated in this section, then the Department of Health and Human Services shall allocate these decreases giving priority first to those direct services mandated by State or federal law, then to those programs providing direct services that have demonstrated effectiveness in meeting the federally and State-mandated services goals established for the Social Services Block Grant. The Department shall not include transfers from TANF for specified purposes in any calculations of reductions to the Social Services Block Grant.

If the United States Congress reduces the amount of TANF funds below the amounts appropriated in this section after the effective date of this act, then the Department shall allocate the decrease in funds after considering any underutilization of the budget and the effectiveness of the current level of services. Any TANF Block Grant fund changes shall be reported to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Decreases in federal fund availability shall be allocated for the Maternal and Child Health and Preventive Health Services federal block grants by the Department of Health and Human Services after considering the effectiveness of the current level of services.

Section 5.(c) Increases in Federal Fund Availability. -- Any block grant funds appropriated by the United States Congress in addition to the funds specified in this act shall be expended by the Department of Health and Human Services, with the approval of the Office of State Budget and Management, provided the resultant increases are in accordance with federal block grant requirements and are within the scope of the block grant plan approved by the General Assembly.

Section 5.(d) Changes to the budgeted allocations to the block grants appropriated in this act due to decreases or increases in federal funds shall be reported immediately to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Section 5.(e) Limitations on Preventive Health Services Block Grant Funds. -- Twenty-five percent (25%) of funds allocated for Rape Prevention and Rape Education shall be allocated as grants to nonprofit organizations to provide rape prevention and education programs targeted for middle, junior high, and high school students.

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 2000-2001 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).

The Department of Public Instruction shall carefully and strictly follow federal guidelines in implementing and administering the abstinence education grant funds.

Section 5.(f) The sum of one million five hundred thousand dollars ($1,500,000) appropriated to the Department of Health and Human Services, Division of Social Services, in the TANF Block Grant for the 2000-2001 fiscal year for the evaluation of the Work First Program shall be used to do each of the following:

(1) Expand the current evaluation of the Work First Program to assess former recipients' earnings, barriers to advancement to economic self-sufficiency, utilization of community support services, and other longitudinal employment data. Assessment periods shall include six and 18 months following closure of the case.

(2) Expand the current evaluation of the Work First Program to profile the State's child-only caseload to include indicators of economic and social well-being, academic and behavioral performance, demographic data, description of living arrangements including length of placement out of the home, social and other human services provided to families, and other information needed to assess the needs of the child-only Work First Family Assistance clients and families.

(3) Expand the current evaluation to profile clients and families exempted from federal and State work participation requirements. The evaluation shall include an assessment of the client and family needs including why clients and families have been exempted.

The Department of Health and Human Services shall make a report on its progress in complying with this subsection to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than September 30, 2001, and shall make a final report no later than September 30, 2002.

Section 5.(g) The sum of one million six hundred seven thousand five hundred twenty-nine dollars ($1,607,529) appropriated to the Department of Health and Human Services, Division of Social Services, in this section in the TANF Block Grant in the 2000-2001 fiscal year for the Work First job retention and follow-up model programs shall be used to continue pilots and strategies that support TANF recipients in attaining and maintaining self-sufficiency through job retention, family support services, and pre- and post-TANF follow-up.

The Department of Health and Human Services shall make a report on its use of TANF funds for the Work First job retention pilots. This report shall include each of the following:

(1) A description of the clients served by the program. This description shall include demographic and geographic information about the clients.

(2) A description of services provided by the program.

(3) The effectiveness of services to clients. Effectiveness of services to clients shall be measured, in part, by the percentage of clients who remain employed at intervals of six months and one year after commencement of employment.

(4) The estimated cost of services per client.

(5) A description of the development and design of the program and of any evaluation mechanisms.

(6) A description of coordination efforts among local departments of social services with other human services agencies.

(7) A description of progress in achieving other outcome goals such as family economic progress and child/family well-being.

This report shall be made to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than April 1, 2001.

Section 5.(h) The sum of five hundred eleven thousand six hundred eighty-seven dollars ($511,687) appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Special Children Adoption Fund, for the 2000-2001 fiscal year shall be used to implement this subsection. 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 5.(i) If funds appropriated through the Child Care and Development Fund 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 other programs, in accordance with federal requirements of the grant, in order to use the federal funds fully.

Section 5.(j) The sum of one million five hundred thousand dollars ($1,500,000) appropriated in this act in the TANF Block Grant and transferred to the Social Services Block Grant to the Department of Health and Human Services, Division of Social Services, for child caring agencies for the 2000-2001 fiscal year shall be allocated to the State Private Child Caring Agencies Fund. These funds shall be combined with all other funds allocated to the State Private Child Caring Agencies Fund for the reimbursement of the State's portion of the cost of care for the placement of certain children by the county departments of social services who are not eligible for federal IV-E funds. These funds shall not be used to match other federal funds.

Section 5.(k) The sum of one million dollars ($1,000,000) appropriated in this section in the TANF Block Grant and transferred to the Social Services Block Grant to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall be used for the Enhanced Employee Assistance Program, to continue a grant program of financial incentives for private businesses employing former and current Work First recipients. These grants may supply funds to private employers who agree to hire former or current Work First recipients or their spouses at entry-level positions and wages and to supply enhanced grant funds to private employers who agree to hire former or current Work First recipients or their spouses at a level higher than entry-level positions, paying more than the minimum wage, including fringe benefits.

The Department of Health and Human Services shall report no later than April 1, 2001, on the use of these funds to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division. This report shall include each of the following:

(1) The number of clients served since the inception of the program by fiscal year.
(2) The amount of funds expended each fiscal year.
(3) A description of the clients served. This description shall include demographic information about these clients.

(4) A description of coordination efforts with other human services agencies, including local departments of social services.
(5) A description of specific services provided to clients.
(6) Statistics related to job retention, measured at least at intervals of six months and one year after the commencement of employment.
(7) Statistics related to the wage history of clients.
(8) Any other information the Department and the Employment Security Commission find relevant to an evaluation of the program.

Section 5.(l) The sum of two million dollars ($2,000,000) appropriated in this act in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, for the 2000-2001 fiscal year for the Intensive Family Preservation Services (IFPS) Program shall be used by the Division, in consultation with local departments of social services and other human services agencies, to plan and implement a revised IFPS Program.

Notwithstanding the provisions of G.S. 143B-150.6, the Program shall provide intensive services to children and families in cases of abuse, neglect, and dependency where a child is at imminent risk of removal from the home and to children and families in cases of abuse where a child is not at imminent risk of removal. The Program shall be developed and implemented statewide on a regional basis. The revised IFPS Program shall ensure the application of standardized assessment criteria for determining imminent risk and clear criteria for determining out-of-home placement.

The Department shall reexamine the existing IFPS Program design to ensure the application of a standardized assessment and clear criteria for the determination of imminent risk of removal. Additionally, the Department shall assess the education and skill levels required of staff providing intensive family preservation services in existing programs.

The Department shall develop a revised evaluation model for the current and expanded IFPS Program. This evaluation shall not include area mental health or juvenile justice programs. The model shall be scientifically rigorous, including the use of treatment comparison groups, a review and description of interventions provided to families as compared to customary services provided to other child welfare children and families, and data regarding the number and type of referrals made for other human services and the utilization of those services.

The Department shall report on the use of the funds appropriated under this subsection, including the revised evaluation model and IFPS Program, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than April 1, 2001.

Section 5.(m) The Department of Health and Human Services and the Employment Security Commission shall report on the use of funds appropriated under this section from the TANF Block Grant to the First Stop Employment Assistance Program. This report shall include each of the following:
(1) The number of clients served since the inception of the program by fiscal year.
(2) The amount of funds expended each fiscal year.
(3) A description of the clients served. This description shall include demographic information about these clients.
(4) A description of coordination efforts with other human services agencies, including local departments of social services.
(5) A description of specific services provided to both initial and intensive First Stop clients.

(6) The placement rates of clients in both the initial and intensive programs.

(7) Statistics related to job retention, measured at least at intervals of six months and one year after the commencement of employment.

(8) Statistics related to the wage history of clients.

(9) Any other information the Department and the Employment Security Commission find relevant to an evaluation of the program.

This report shall be made to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later than April 1, 2001.

Section 5.(n) The sum of one million dollars ($1,000,000) appropriated in this section to the Department of Health and Human Services in the TANF Block Grant for Boys and Girls Clubs shall be used to make grants for approved programs. The Department of Health and Human Services, in accordance with federal regulations for the use of TANF Block Grant funds, shall administer a grant program to award funds to the Boys and Girls Clubs across the State in order to implement programs that improve the motivation, performance, and self-esteem of youth and to implement other initiatives that would be expected to reduce school dropout and teen pregnancy rates. The Department shall encourage and facilitate collaboration between the Boys and Girls Clubs and Support Our Students, Communities in Schools, and similar programs to submit joint applications for the funds if appropriate. The Department shall report on its progress in complying with this subsection to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division no later that April 1, 2001.

Section 5.(o) 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 5.(p) The sum of three million dollars ($3,000,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, for the Work First Housing Initiative shall be used only for direct housing support to Work First clients and families. Direct housing support includes using funds for rental assistance, loans, moving expenses, and other financial assistance. *These funds shall not be used for administration, counseling, or other similar services unless it is demonstrated that these services are not otherwise available in the community.

Section 5.(q) The sum of five hundred thousand dollars ($500,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, for the 2000-2001 fiscal year shall be used to support administration of TANF-funded programs.

Section 5.(r) The sum of five million dollars ($5,000,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the 2000-2001 fiscal year shall be used to establish and expand regional residential substance abuse treatment and services for women with children. The Department of Health and Human Services, the Division of Social Services, and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in consultation with local departments of social services, area mental health programs, and other State and local agencies or organizations, shall coordinate this effort in order to facilitate the expansion of regionally based substance abuse services

for women with children. These services shall be culturally appropriate and designed for the unique needs of TANF women with children.

In order to expedite the expansion of these services, the Secretary of the Department of Health and Human Services may enter into contracts with service providers.

The Department of Health and Human Services, the Division of Social Services, and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall report on their progress in complying with this subsection no later than October 1, 2000, and March 1, 2001, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division. These reports shall include all of the following:

(1) The number and location of additional beds created.
(2) The types of facilities established.
(3) The delineation of roles and responsibilities at the State and local levels.
(4) Demographics of the women served, the number of women served, and the cost per client.
(5) Demographics of the children served, the number of children served, and the services provided.
(6) Job placement services provided to women.
(7) A plan for follow-up and evaluation of services provided with an emphasis on outcomes.
(8) Barriers identified to the successful implementation of the expansion.
(9) Identification of other resources needed to appropriately and efficiently provide services to Work First recipients.
(10) Other information as requested.

Section 5.(s) The sum of two million seven hundred fifty thousand six hundred seventy-four dollars ($2,750,674) appropriated under this section in the TANF Block Grant to the Department of Health and Human Services and transferred to the Office of Juvenile Justice for the 2000-2001 fiscal year shall be used to support the existing Support Our Students Program and to expand the Program statewide. These funds shall not be used for administration of the program.

Section 5.(t) The sum of three million dollars ($3,000,000) appropriated under this section in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, for the 2000-2001 fiscal year shall be used to provide domestic violence services to Work First recipients. The Division of Social Services, in consultation with the Council for Women and local departments of social services, shall develop and implement a mechanism by which these funds may be used to facilitate delivery of domestic violence counseling, support, and other direct services to clients. These funds shall not be used to establish new domestic violence shelters, for State administration, or to facilitate lobbying efforts. The Department of Health and Human Services and the Council for Women shall report on the uses of these funds no later than February 1, 2001, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Section 5.(u) The sum of one million dollars ($1,000,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services, Division of Public Health, for the 2000-2001 fiscal year shall be used to support the Responsible Fatherhood Initiative. These funds shall be used for responsible parenting programs targeted at young-adult males. These funds shall be

targeted at counties with the highest needs as determined by the Division of Public Health. The evaluation of this initiative shall be incorporated into the overall evaluation of the pregnancy prevention and responsible parenting activities currently in place. This initiative shall be administered as directed in subsection (v) of this section.

Section 5.(v) The funds appropriated to the Department of Health and Human Services, Division of Public Health, in this act for the 2000-2001 fiscal year for teen pregnancy prevention shall be used in accordance with the provisions of this subsection.

Effective July 1, 2000, the Department of Health and Human Services, Division of Public Health, in collaboration with local program administrators, shall adopt guidelines for the administration of funds for teen pregnancy prevention and for parenting programs. The guidelines shall include the following programmatic requirements:

(1) Council development at the local level is encouraged but not required for program funding. Councils that received first-year funding for the 1999-2000 fiscal year for administrative expenses for coalition building and partnership development shall receive funds committed for the second year of organizational development. The Division shall encourage programs that receive funding under this section to involve other health service organizations, nonprofit organizations, and task forces in program efforts.

(2) In awarding grants, the Department shall target counties with the highest teen pregnancy rates, increasingly higher teen pregnancy rates, or high rates within demographic subgroups, and greatest need for parenting programs. Grants may be renewed annually based on program efficiency and effectiveness, teen pregnancy rates, and the level of need for parenting programs. Grants shall be funded at a particular level and shall not be funded on a multiyear cycle with annually decreasing grant funding.

(3) The Division shall encourage all programs to implement best practice models. While best practice models are encouraged, the Department may fund innovative and promising projects that have not yet been recognized as best practice. All existing programs not using best practice models shall be encouraged to transition to the use of best practice models.

(4) Programs are not required to provide a cash match for these funds, however, the Department may require an in-kind match.

Funds for State-level administrative expenses of the Program shall not exceed ten percent (10%) of the total budget for teen pregnancy prevention and parenting programs. Administrative expenses include staffing and contracted services for evaluation and coalition-building activities.

The Department shall contract with an independent private consulting firm to evaluate the programs. The evaluation shall include standard data collection utilizing the mechanism that has been developed by the University of North Carolina at Chapel Hill, School of Social Work, and shall be conducted in a manner that objectively measures the effectiveness of each program evaluated.

The Department shall report annually on March 1, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division. The report shall include information on all of the following for each teen pregnancy prevention and parenting program:

(1) The program budget delineating all administrative expenses, contracts for services, and technical assistance.

(2) A narrative describing each project funded and the amount of funds received by the project.

(3) Effectiveness of the program in reducing teen pregnancy or developing responsible parenting skills in young adults, as applicable.

(4) Status of the evaluation.

Section 5.(w) The sum of two million dollars ($2,000,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, shall be used to expand after-school programs and services for at-risk children. The Department shall develop and implement a grant program to award grants to community-based programs that demonstrate the ability to reach children at risk of teen pregnancy and school dropout. The Department shall award grants to community-based organizations that demonstrate the ability to develop and implement linkages with local departments of social services, area mental health programs, schools, and other human services programs in order to provide support services and assistance to the child and family. These funds may be used to establish one position within the Division of Social Services to coordinate at-risk after-school programs and shall not be used for other State administration. The Department shall report no later than March 1, 2001, on its progress in complying with this section to the Senate Appropriations Committee on Human Resources, the House of Representatives Subcommittee on Health and Human Services, and the Fiscal Research Division.

Section 5.(x) The sum of five million twelve thousand dollars ($5,012,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services shall be used to continue the Business Process Reengineering Project. The Department shall report directly to the Information Resource Management Commission in accordance with the Commission's requirements. The Department shall report on the use of these funds no later than April 1, 2001, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Section 5.(y) The sum of eight million two hundred fifty thousand dollars ($8,250,000) appropriated in this section in the TANF Block Grant to the Department of Health and Human Services, Division of Social Services, for the 2000-2001 fiscal year for Child Welfare Improvements shall be allocated to the county departments of social services for hiring or contracting additional staff on or after July 1, 2000, to investigate and provide services in Child Protective Services cases; to recruit, train, license, and support prospective foster and adoptive families; and to provide interstate and post-adoption services for eligible families.

Section 5.(z) The sum of one million five hundred thousand dollars ($1,500,000) appropriated in this section in the Mental Health Block Grant to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the 2000-2001 fiscal year and the sum of one million dollars ($1,000,000) 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 2000-2001 fiscal year shall be used to establish a Child Residential Treatment Services Program in accordance with Section 11.19 of this act.

Section 5.(aa) The Department of Health and Human Services, the Department of Commerce, and the Department of Public Instruction may allocate

and Human Services shall work together to implement these criteria for the monitoring of long-term care in the State and pursue options for the use of these criteria in lieu of current HCFA-mandated standards for surveying North Carolina nursing homes under the federal Medicaid and Medicare programs.

CODE NO. 2000DHHS-H11.4 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
LONG-TERM CARE SERVICES DATA

Section 11.4.(a) By January 1, 2001, the Department of Health and Human Services in conjunction with the North Carolina Institute of Medicine shall:

(1) Identify screening, level of services, and care planning instruments to be used for all DHHS long-term care services;
(2) Develop a timetable for testing and implementing these instruments; and
(3) Compile county level data on the number of people age 18 years or older who use DHHS long-term care services and expenditures by Division and type of program.

Section 11.4.(b) Subsection (a) of Section 11.7A of S.L. 1999-237 reads as rewritten:

"Section 11.7A.(a) The Department of Health and Human Services shall, in cooperation with other appropriate State and local agencies and representatives of consumer and provider organizations, develop a system that provides a continuum of long-term care for elderly and disabled individuals and their families. The Department shall define the system of long-term care services to include:

(1) A structure and means for screening, assessment, and care management across settings of care;
(2) A process to determine outcome measures for care;
(3) An integrated data system to track expenditures, consumer characteristics, and consumer outcomes;
(4) Relationships between the Department and the State's universities to provide policy analysis and program evaluation support for the development of long-term care system reforms;
(5) An implementation plan that addresses testing of models, reviewing existing models, evaluation of components, and steps needed to achieve development of a coordinated system; and
(6) Provision for consumer, provider, and agency input into the system design and implementation development.

Effective January 1, ~~2001,~~ 2002, the system developed by the Department shall do the following:

(1) Implement the initial phase of a comprehensive data system that tracks long-term care expenditures, services, consumer profiles, and consumer preferences; and
(2) Develop a system of statewide long-term care services coordination and case management to minimize administrative costs, improve access to services, and minimize obstacles to the delivery of long-term care services to people in need."

CODE NO. 2000DHHS-S11.4A
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
CLOSING THE ACHIEVEMENT GAP

Section 11.4A Of the funds appropriated in this act, the Department of Health and Human Services, Division of Social Services, shall use the sum of two hundred and fifty thousand dollars ($250,000) for the 2000-2001 fiscal year to

establish and administer a pilot program to assist families that have children who are performing below school grade level in strengthening family cohesiveness, functioning, and economic progress and improving the academic performance of their children. The program shall be developed and implemented no later than August 1, 2001, as follows:

(1) Each pilot program shall be family-focused and designed to improve family success in addressing issues pertaining to:
   a. Family functioning and economic progress;
   b. Academic success for children in the family in a manner that reduces the likelihood that the children will have a life of poverty; and
   c. Strengthening the communities in which the family lives.

(2) There shall be at least eight pilot programs initially established which shall be based on components of successful models and concepts. Any nonprofit, tax-exempt organization or local government agency that is part of the collaborative effort to develop the pilot program may serve as the lead agency in applying for and administering grant funds.

(3) Families eligible for participation in a pilot program shall be those families:
   a. Who have at least one child in elementary or middle school who is performing academically at least one year below the child's grade level;
   b. At least one adult member of which agrees to participate in the program and in a culturally appropriate assessment of family functioning; and
   c. Whose income is below two hundred percent (200%) of the federal poverty level or whose income is at or above two hundred percent (200%) of the federal poverty level if authorized by the requirements of the funding source.

(4) The Department and other entities collaborating to develop the program shall identify resources currently available to address the concerns of below-grade-level academic performance and problems related to family cohesiveness, functioning, and family economic progress and shall strive to harness these resources in a manner that increases effectiveness and reduces overall costs of the pilot program. The Department shall also determine which entities can best operate which components of the total pilot program and how those entities can contribute to the abilities of others to be more successful in operating their components.

(5) The Department may obtain the services of consultants in the planning, coordination, implementation, and evaluation of the program.

(6) The Department of Health and Human Services shall establish a task force to collaborate with and advise the Department on the development and implementation of the program. The task force shall consist of, at a minimum, representatives of:
   a. The Department of Public Instruction;
   b. The Cooperative Extension Services at North Carolina Agricultural and Technical State University and at North Carolina State University;
   c. The Office of Juvenile Justice;
   d. Workforce Development Boards;

e. Local education agencies;
f. Local departments or boards of social services, county commissioners, and health departments;
g. Community-based organizations, specifically those that work within low-income communities;
h. Religious organizations or institutions; and
i. Charter schools.

(7) Each of the pilot programs shall have comparable structures for administration, advice, and technical assistance.

(8) Each pilot program shall be developed in a way that results in observable and measurable outcomes and that is subject to sound evaluation techniques. Evaluation measures and techniques shall be designed and implemented to:
a. Identify and explain the components of the pilot program that are successful and those that are not successful;
b. Recommend systemic changes through integration of positive outcomes; and
c. Produce outcomes that, if successful, can be replicated.

(9) The Department shall present a progress report to the Commission on Improving the Academic Achievement of Minority and At-Risk Students by March 1, 2001. This report shall contain a plan to implement and evaluate the program, including:
a. Pilot sites selected;
b. Identification of evaluation tools;
c. Identification of existing sources of federal and State funding that can be used to implement and evaluate the program;
d. Identification of additional resources, fiscal and otherwise, that are available to implement and evaluate the program; and
e. Strategies that utilize school facilities to the maximum reasonable extent possible and that do not place undue burdens on school personnel.

(10) The Department shall make a final report to the Commission on Improving the Academic Achievement of Minority and At-Risk Students by February 1, 2002. This report shall include a recommendation as to whether the program should be extended statewide. If so, the Department shall present a plan that includes the projected cost, process, and time frame for implementation of the program statewide."

SUBPART 2. MEDICAL ASSISTANCE

CODE NO. 2000DHHS-H11.5/S11.5?

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

MEDICAID PROGRAM

Section 11.5. Section 11.12 of S.L. 1999-237 reads as rewritten:

"Section 11.12.(a) Funds appropriated in this act for services provided in accordance with Title XIX of the Social Security Act (Medicaid) are for both the categorically needy and the medically needy. Funds appropriated for these services

shall be expended in accordance with the following schedule of services and payment bases. All services and payments are subject to the language at the end of this subsection.

Services and payment bases:

(1) Hospital-Inpatient - Payment for hospital inpatient services will be prescribed in the State Plan as established by the Department of Health and Human Services.

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

(3) Nursing Facilities - Payment for nursing facility services will be prescribed in the State Plan as established by the Department of Health and Human Services. Nursing facilities providing services to Medicaid recipients who also qualify for Medicare, must be enrolled in the Medicare program as a condition of participation in the Medicaid program. State facilities are not subject to the requirement to enroll in the Medicare program.

(4) Intermediate Care Facilities for the Mentally Retarded - As prescribed in the State Plan as established by the Department of Health and Human Services.

(5) Drugs - Drug costs as allowed by federal regulations plus a professional services fee per month excluding refills for the same drug or generic equivalent during the same month. Reimbursement shall be available for up to six prescriptions per recipient, per month, including refills. Payments for drugs are subject to the provisions of subsection (h) of this section and to the provisions at the end of subsection (a) of this section, or in accordance with the State Plan adopted by the Department of Health and Human Services consistent with federal reimbursement regulations. Payment of the professional services fee shall be made in accordance with the State Plan adopted by the Department of Health and Human Services, consistent with federal reimbursement regulations. The professional services fee shall be five dollars and sixty cents ($5.60) per prescription. Adjustments to the professional services fee shall be established by the General Assembly.

(6) Physicians, Chiropractors, Podiatrists, Optometrists, Dentists, Certified Nurse Midwife ~~Services~~ Services, Nurse Practitioners - Fee schedules as developed by the Department of Health and Human Services. Payments for dental services are subject to the provisions of subsection (g) of this section.

(7) Community Alternative Program, EPSDT Screens - Payment to be made in accordance with rate schedule developed by the Department of Health and Human Services.

(8) Home Health and Related Services, Private Duty Nursing, Clinic Services, Prepaid Health Plans, Durable Medical Equipment - Payment to be made according to reimbursement plans developed by the Department of Health and Human Services.

(9) Medicare Buy-In - Social Security Administration premium.

(10) Ambulance Services - Uniform fee schedules as developed by the Department of Health and Human Services. Public ambulance providers will be reimbursed at cost.

(11) Hearing Aids - Actual cost plus a dispensing fee.

(12) Rural Health Clinic Services - Provider-based, reasonable cost; nonprovider-based, single-cost reimbursement rate per clinic visit.

(13) Family Planning - Negotiated rate for local health departments. For other providers - see specific services, for instance, hospitals, physicians.

(14) Independent Laboratory and X-Ray Services - Uniform fee schedules as developed by the Department of Health and Human Services.

(15) Optical Supplies - One hundred percent (100%) of reasonable wholesale cost of materials.

(16) Ambulatory Surgical Centers - Payment as prescribed in the reimbursement plan established by the Department of Health and Human Services.

(17) Medicare Crossover Claims - An amount up to the actual coinsurance or deductible or both, in accordance with the State Plan, as approved by the Department of Health and Human Services.

(18) Physical Therapy and Speech Therapy - Services limited to EPSDT eligible children. Payments are to be made only to qualified providers at rates negotiated by the Department of Health and Human Services.

(19) Personal Care Services - Payment in accordance with the State Plan approved by the Department of Health and Human Services.

(20) Case Management Services - Reimbursement in accordance with the availability of funds to be transferred within the Department of Health and Human Services.

(21) Hospice - Services may be provided in accordance with the State Plan developed by the Department of Health and Human Services.

(22) Other Mental Health Services - Unless otherwise covered by this section, coverage is limited to (i) agencies meeting the requirements of the rules established by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services, and reimbursement is made in accordance with a State Plan developed by the Department of Health and Human Services not to exceed the upper limits established in federal ~~regulations.~~

regulations, and (ii) only for children eligible for EPSDT services, licensed or certified psychologists, certified mental health nurse practitioners, and licensed clinical social workers when Medicaid eligible children are referred by the primary care physician or the area mental health program. The Department of Health and Human Services may adopt temporary rules in accordance with Chapter 150B of the General Statutes further defining the qualifications of providers and referral procedures in order to implement this provision.

(23) Medically Necessary Prosthetics or Orthotics for EPSDT Eligible Children - Reimbursement in accordance with the State Plan approved by the Department of Health and Human Services.

(24) Health Insurance Premiums - Payments to be made in accordance with the State Plan adopted by the Department of Health and Human Services consistent with federal regulations.

(25) Medical Care/Other Remedial Care - Services not covered elsewhere in this section include related services in schools; health professional services provided outside the clinic setting to meet maternal and infant health goals; and services to meet federal EPSDT mandates. Services addressed by this paragraph are limited to those prescribed in the State Plan as established by the Department of Health and Human Services. Except for related services in schools, providers of these services shall be certified as meeting program standards of the Department of Health and Human Services, Division of Women's and Children's Health.

(26) Pregnancy Related Services - Covered services for pregnant women shall include nutritional counseling, psychosocial counseling, and predelivery and postpartum home visits by maternity care coordinators and public health nurses.

Services and payment bases may be changed with the approval of the Director of the Budget.

Reimbursement is available for up to 24 visits per recipient per year to any one or combination of the following: physicians, clinics, hospital outpatient, optometrists, chiropractors, and podiatrists. Prenatal services, all EPSDT children, ~~and~~ emergency ~~rooms~~ rooms, and mental health services subject to independent utilization review are exempt from the visit limitations contained in this paragraph. Exceptions may be authorized by the Department of Health and Human Services where the life of the patient would be threatened without such additional care. Any person who is determined by the Department to be exempt from the 24-visit limitation may also be exempt from the six-prescription limitation.

Section 11.12.(b) Allocation of Nonfederal Cost of Medicaid. The State shall pay eighty-five percent (85%); the county shall pay fifteen percent (15%) of the nonfederal costs of all applicable services listed in this section.

Section 11.12.(c) Copayment for Medicaid Services. The Department of Health and Human Services may establish copayment up to the maximum permitted by federal law and regulation.

Section 11.12.(d) Medicaid and Work First Family Assistance, Income Eligibility Standards. The maximum net family annual income eligibility standards for Medicaid and Work First Family Assistance and the Standard of Need for Work First Family Assistance shall be as follows:

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

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

The payment level for Work First Family Assistance shall be fifty percent (50%) of the standard of need.

These standards may be changed with the approval of the Director of the Budget with the advice of the Advisory Budget Commission.

Section 11.12.(e) The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to all elderly, blind, and disabled people who have incomes equal to or less than one hundred percent (100%) of the federal poverty guidelines, as revised each April 1.

Section 11.12.(f) ICF and ICF/MR Work Incentive Allowances. The Department of Health and Human Services may provide an incentive allowance to Medicaid-eligible recipients of ICF and ICF/MR facilities who are regularly engaged in work activities as part of their developmental plan and for whom retention of additional income contributes to their achievement of independence. The State funds required to match the federal funds that are required by these allowances shall be provided from savings within the Medicaid budget or from other unbudgeted funds available to the Department. The incentive allowances may be as follows:

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

Section 11.12.(g) Dental Coverage Limits. Dental services shall be provided on a restricted basis in accordance with rules adopted by the Department to implement this subsection.

Section 11.12.(h) Dispensing of Generic Drugs. Notwithstanding G.S. 90-85.27 through G.S. 90-85.31, under the Medical Assistance Program (Title XIX of the Social Security Act) a prescription order for a drug designated by a trade or brand name shall be considered to be an order for the drug by its established or generic name, except when the prescriber personally indicates, either orally or in the prescriber's own handwriting on the prescription order, 'dispense as written' or words of similar meaning. Generic drugs, when available in the pharmacy, shall be dispensed at a lower cost to the Medical Assistance Program rather than trade or brand name drugs, subject to the prescriber's 'dispense as written' order as noted above.

As used in this subsection 'brand name' means the proprietary name the manufacturer places upon a drug product or on its container, label, or wrapping at the time of packaging; and 'established name' has the same meaning as in section 502(e)(3) of the Federal Food, Drug, and Cosmetic Act as amended, 21 U.S.C. § 352(e)(3).

Section 11.12.(i) Exceptions to Service Limitations, Eligibility Requirements, and Payments. Service limitations, eligibility requirements, and payments bases in this section may be waived by the Department of Health and Human Services, with the approval of the Director of the Budget, to allow the Department to carry out pilot programs for prepaid health plans, managed care plans, or community-based services programs in accordance with plans approved by the United States Department of Health and Human Services, or when the Department determines that such a waiver will result in a reduction in the total Medicaid costs for the recipient. The Department of Health and Human Services may proceed with planning and development work on the Program of All-Inclusive Care for the Elderly and will issue a progress report to the chairs of the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources on or before January 30, 2001.

Section 11.12.(j) Volume Purchase Plans and Single Source Procurement. The Department of Health and Human Services, Division of Medical Assistance, may, subject to the approval of a change in the State Medicaid Plan, contract for services, medical equipment, supplies, and appliances by implementation of volume purchase plans, single source procurement, or other similar processes in order to improve cost containment.

Section 11.12.(k) Cost Containment Programs. The Department of Health and Human Services, Division of Medical Assistance, may undertake cost containment programs including preadmissions to hospitals and prior approval for certain outpatient surgeries before they may be performed in an inpatient setting.

Section 11.12.(l) For all Medicaid eligibility classifications for which the federal poverty level is used as an income limit for eligibility determination, the income limits will be updated each April 1 immediately following publication of federal poverty guidelines.

Section 11.12.(m) The Department of Health and Human Services shall provide Medicaid to 19-, 20-, and 21-year olds in accordance with federal rules and regulations.

Section 11.12.(n) The Department of Health and Human Services shall provide coverage to pregnant women and to children according to the following schedule:

(1) Pregnant women with incomes equal to or less than one hundred eighty-five percent (185%) of the federal poverty guidelines as revised each April 1 shall be covered for Medicaid benefits.

(2) Infants under the age of 1 with family incomes equal to or less than one hundred eighty-five percent (185%) of the federal poverty guidelines as revised each April 1 shall be covered for Medicaid benefits.

(3) Children aged 1 through 5 with family incomes equal to or less than one hundred thirty-three percent (133%) of the federal poverty guidelines as revised each April 1 shall be covered for Medicaid benefits.

(4) Children aged 6 through 18 with family incomes equal to or less than the federal poverty guidelines as revised each April 1 shall be covered for Medicaid benefits.

(5) The Department of Health and Human Services shall provide Medicaid coverage for adoptive children with special or rehabilitative needs regardless of the adoptive family's income.

Services to pregnant women eligible under this subsection continue throughout the pregnancy but include only those related to pregnancy and to those other conditions determined by the Department as conditions that may complicate pregnancy. In order to reduce county administrative costs and to expedite the provision of medical services to pregnant women, to infants, and to children described in subdivisions (3) and (4) of this subsection, no resources test shall be applied.

Section 11.12.(o) Medicaid enrollment of categorically needy families with children shall be continuous for one year without regard to changes in income or assets.

Section 11.12.(p) The Department of Health and Human Services shall submit a ~~monthly~~ quarterly status report on expenditures for acute care and long-term care services to the Fiscal Research Division and to the Office of State Budget and Management. This report shall include an analysis of budgeted versus actual expenditures for eligibles by category and for long-term care beds. In addition, the Department shall revise the program's projected spending for the current fiscal year and the estimated spending for the subsequent fiscal year on a quarterly basis. ~~Reports for the preceding month~~ The quarterly expenditure report and the revised forecast shall be forwarded to the Fiscal Research Division and to the Office of State Budget and Management no later than the third Thursday of the ~~month.~~ month following the end of each quarter.

Section 11.12.(q) The Division of Medical Assistance, Department of Health and Human Services, may provide incentives to counties that successfully recover fraudulently spent Medicaid funds by sharing State savings with counties responsible for the recovery of the fraudulently spent funds.

Section 11.12.(r) If first approved by the Office of State Budget and Management, the Division of Medical Assistance, Department of Health and Human Services, may use funds that are identified to support the cost of development and acquisition of equipment and software through contractual means to improve and enhance information systems that provide management information and claims processing.

~~Section 11.12.(s) The Division of Medical Assistance, Department of Health and Human Services, may administer Medicaid estate recovery mandated by the Omnibus Budget Reconciliation Act of 1993, (OBRA 1993), 42 U.S.C. § 1396p(b), and G.S. 108-70.5 using temporary rules pending approval of final rules promulgated pursuant to Chapter 150B of the General Statutes.~~

Section 11.12.(t) The Department of Health and Human Services may adopt temporary rules according to the procedures established in G.S. 150B-21.1 when it finds that these rules are necessary to maximize receipt of federal funds, to reduce Medicaid expenditures, and to reduce fraud and abuse. Prior to the filing of these temporary rules with the Office of Administrative Hearings, the Department shall

consult with the Office of State Budget and Management on the possible fiscal impact of the temporary rule and its effect on State appropriations and local governments.

Section 11.12.(u) The Department shall report to the Fiscal Research Division of the Legislative Services Office and to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources or the Joint Legislative Health Care Oversight Committee on any change it anticipates making in the Medicaid program that impacts the type or level of service, reimbursement methods, or waivers, any of which require a change in the State Plan or other approval by the Health Care Financing Administration. The reports shall be provided at the same time they are submitted to HCFA for approval.

Section 11.12.(v) If the Department of Health and Human Services obtains a Medicaid waiver to implement two long-term care pilot projects, then the Department shall report the particulars of the waiver, the pilot projects, and the status of implementation to members of the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Study Commission on Aging within 30 days of receiving the waiver. The Department shall not expand the pilot project beyond the two initial pilots without first reporting the proposed expansion to the members of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources.

~~Section 11.12.(w) The Department of Health and Human Services shall study the effect of subsection (o) of this section on both the Medicaid program and the Health Insurance Program for Children. The Department shall make an interim report on the results of this study to the members of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources by October 1, 1999, and shall make a final report by January 1, 2000.~~

Section 11.12.(x) Effective no earlier than October 1, 2000, the Department of Health and Human Services shall amend the Medicaid State Plan to adopt simplified methodologies for the treatment of assets in determining Medicaid eligibility for aged, blind, and disabled persons. The simplified methodologies are limited to excluding the value of burial plots and the cash value of life insurance when the total face value of cash value bearing life insurance policies does not exceed ten thousand dollars ($10,000).

Section 11.12.(y) The Division of Fiscal Research, through the Legislative Services Office, with the cooperation of the Department of Health and Human Services, shall issue a Request for Proposal (RFP) for an independent consultant to study and review the amount, sufficiency, duration, and scope of each service provided under the North Carolina Medicaid Program. The independent consultant shall make an interim progress report on October 1, 2000, and January 1, 2001, to the cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources. The final report of the independent consultant shall be presented to the North Carolina General Assembly not later than May 1, 2001. The Department shall transfer funding from the Medicaid Program for the cost of the study.

Section 11.12.(z) The Department of Health and Human Services shall study the feasibility of authorizing Medicaid reimbursement for children eligible for EPSDT services by providers who are eligible for reimbursement for these services under the Teachers' and State Employees' Comprehensive Major Medical Plan pursuant to G.S. 135-40.7B, and under the Health Insurance Program for Children pursuant to G.S. 108A-70.21. The Department shall report its findings and recommendations to the members of the House of Representatives Appropriations Subcommittee on Health

and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division not later than October 1, 2000.

Section 11.12.(aa) Upon approval of a demonstration waiver by the Health Care Financing Administration, the Department of Health and Human Services may provide Medicaid coverage for family planning services to men and women of child-bearing age with family incomes equal to or less than 185% of the federal poverty level. Coverage shall be contingent upon federal approval of the waiver and shall begin no earlier than January 1, 2001."

CODE NO. 2000DHHS-H11.6 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
COUNTY MEDICAID COST-SHARE

Section 11.6.(a) Section 11.39 of S.L. 1999-237 reads as rewritten:

"Section 11.39.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for the 1999-2000 fiscal year, the Department shall transfer to the Mental Health Restricted Reserve not more than the amount of actual expenditures for Medicaid payments for the 1998-99 fiscal year for services provided by area mental health authorities. The Department shall transfer from the Division of Medical Assistance the estimated amount needed to match Medicaid payments for the former Carolina Alternatives Programs. The Department shall not transfer from area program allocations funds to cover Medicaid payment expenditures that exceed the amount of funds in the Reserve for the 1999-2000 fiscal year.

Section 11.39.(b) ~~Any nonfederal increases in the cost of Medicaid services provided by area mental health authorities will be borne in equal parts by the State and county funding entity until the county share reaches fifteen percent (15%) of the nonfederal share.~~ Effective July 1, 2000, the county share of the cost of Medicaid services currently and previously provided by area mental health authorities shall be increased incrementally each fiscal year until the county share reaches fifteen percent (15%) of the nonfederal share by State fiscal year 2009-2010."

Section 11.6.(b) Section 11.22(g) is repealed.

Section 11.6.(c) Section 11.22(h) of S.L. 1999-237 reads as rewritten:

"Section 11.22.(h) ~~Effective January 1, 2000, the State shall pay fifty percent (50%) and the county shall pay fifty percent (50%) of the nonfederal share of new levels of Medicaid Personal Care Services paid to adult care homes. Effective July 1, 2001, the State shall pay fifty-seven percent (57%) and each county shall pay forty-three percent (43%) of the nonfederal share of new levels of Medicaid Personal Care Services paid to adult care homes. Each year thereafter, the State share of the nonfederal cost will increase by seven percent (7%) until the county share equals fifteen percent (15%) of the nonfederal share of new levels of Medicaid Personal Care Services.~~ Effective July 1, 2000, the county share of the cost of Medicaid Personal Care Services paid to adult care homes shall be decreased incrementally each fiscal year until the county share reaches fifteen percent (15%) of the nonfederal share by State fiscal year 2009-2010."

CODE NO. 2000DHHS-H11.7 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
MEDICAID RESERVE FUND TRANSFER

Section 11.7. Section 11.10(a) of S.L. 1999-237 reads as rewritten:

"Section 11.10.(a) Of the funds transferred to the Department of Health and Human Services for Medicaid programs pursuant to G.S. 143-23.2, the sum of eighty-four million dollars ($84,000,000) for the 1999-2000 fiscal year and the sum of ~~twenty-nine~~ ninety-nine million dollars ~~($29,000,000)~~ ($99,000,000) for the 2000-2001

fiscal year shall be allocated as prescribed by G.S. 143-23.2(b) for Medicaid programs. Notwithstanding the prescription in G.S. 143-23.2(b) that these funds not reduce State general revenue funding, these funds shall replace the reduction in general revenue funding effected in this act."

CODE NO. 2000DHHS-H11.8 =
Requested by: Senators Martin of Guilford, Rand, Plyler, Perdue, Odom, Cooper
WAIVE NC HEALTH CHOICE WAITING PERIOD FOR SPECIAL NEEDS CHILDREN

Section 11.8.(a) G.S. 108A-70.18(8) reads as rewritten:

"**§ 108A-70.18. Definitions.**

~~Unless~~ As used in this Part, unless the context clearly requires otherwise, the term:

. . .

(8) 'Uninsured' means the applicant for Program benefits ~~was not covered under any private or employer-sponsored comprehensive health insurance plan for the six-month period immediately preceding the date of application for Program benefits. Effective April 1, 1999, 'uninsured' means the applicant~~ is and was not covered under any private or employer-sponsored comprehensive health insurance plan for 60 days immediately preceding the date of application. The waiting periods required under this subdivision shall be waived ~~if~~ if:

a. ~~the~~ The child has been enrolled in Medicaid and has lost Medicaid ~~eligibility,~~ eligibility;

b. The child has lost health care benefits due to cessation of a nonprofit organization program that provides health care benefits to low-income ~~children, or~~ children;

c. The child has lost employer-sponsored comprehensive health care coverage due to termination of employment, cessation by the employer of employer-sponsored health coverage, or cessation of the employer's ~~business.~~ business; or

d. Health insurance benefits available to the family of a special needs child have been terminated due to a long-term disability or a substantial reduction in or limitation of lifetime medical benefits or benefit category. As used in this paragraph, 'special needs child' has the definition applied in G.S. 108A-70.23(a)."

Section 11.8.(b) The total amount of State funds expended for the Health Insurance Program for Children (NC Health Choice) in the 2000-2001 fiscal year shall not exceed the amount of State funds appropriated to match federal funds for the Program for the 2000-2001 fiscal year.

SUBPART 3. FACILITY SERVICES

CODE NO. 2000DHHS-H11.9 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
EXTEND ADULT CARE HOME MORATORIUM/STUDY

Section 11.9.(a) Section 11.69(b) of S.L. 1997-443, as amended by Section 12.16C(a) of S.L. 1998-212, and as further amended by Section 1 of S.L. 1999-135, reads as rewritten:

"(b) Effective until ~~September 30, 2000,~~ September 30, 2001, the Department of Health and Human Services shall not approve the addition of any adult care home beds for any type home or facility in the State, except as follows:

(1) Plans submitted for approval prior to May 18, 1997, may continue to be processed for approval;

(2) Plans submitted for approval subsequent to May 18, 1997, may be processed for approval if the individual or organization submitting the plan demonstrates to the Department that on or before August 25, 1997, the individual or organization purchased real property, entered into a contract to purchase or obtain an option to purchase real property, entered into a binding real property lease arrangement, or has otherwise made a binding financial commitment for the purpose of establishing or expanding an adult care home facility. An owner of real property who entered into a contract prior to August 25, 1997, for the sale of an existing building together with land zoned for the development of not more than 50 adult care home beds with a proposed purchaser who failed to consummate the transaction may, after August 25, 1997, sell the property to another purchaser and the Department may process and approve plans submitted by the purchaser for the development of not more than 50 adult care home beds. It shall be the responsibility of the applicant to establish, to the satisfaction of the Department, that any of these conditions have been met;

(3) Adult care home beds in facilities for the developmentally disabled with six beds or less which are or would be licensed under G.S. 131D or G.S. 122C may continue to be approved;

(4) If the Department determines that the vacancy rate of available adult care home beds in a county is fifteen percent (15%) or less of the total number of available beds in the county as of August 26, 1997, and no new beds have been approved or licensed in the county or plans submitted for approval in accordance with subdivision (1) or (2) of this section which would raise the vacancy rate above fifteen percent (15%) in the county, then the Department may accept and approve the addition of beds in that county; or

(5) If a county board of commissioners determines that a substantial need exists for the addition of adult care home beds in that county, the board of commissioners may request that a specified number of additional beds be licensed for development in their county. In making their determination, the board of commissioners shall give consideration to meeting the needs of Special Assistance clients. The Department may approve licensure of the additional beds from the first facility that files for licensure and subsequently meets the licensure requirements."

Section 11.9.(b) The Department of Health and Human Services shall study the various types of adult care homes covered by the moratorium enacted under Section 11.69(b) of S.L. 1997-443 and amended by Section 12.16C(a) of S.L. 1998-212 and S.L. 1999-135. The study shall identify adult care homes by predominant types of residents currently being served and shall recommend licensure categories appropriate to the population served. As part of this study, the Department shall identify current public funding available to residents of the identified adult care homes as well as additional funding sources appropriate to the population being served. Not later than March 1, 2001, the Department shall report the results of its

study to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources.

CODE NO. 2000DHHS-H11.10 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
USE OF FIRE PROTECTION FUND FOR EMERGENCY GENERATORS

Section 11.10. G.S. 122A-5.13 reads as rewritten:

"§ 122A-5.13. Adult Care Home, Group Home, and Nursing Home Fire Protection Fund authorized; authority.

(a) The North Carolina Housing Finance Agency shall establish an Adult Care Home, Group Home, and Nursing Home Fire Protection Fund (hereinafter 'Fire Protection Fund') to assist owners of adult care homes, group homes for developmentally disabled adults, and nursing homes with the purchase and installation of fire protection systems and emergency generators in existing and new adult care homes, group homes for developmentally disabled adults, and nursing homes. The Fire Protection Fund shall be a revolving fund.

(b) The Agency, in consultation with the Department of Health and Human Services, shall adopt rules for the management and use of the Fire Protection Fund. These rules at a minimum shall provide for the following:

(1) Financial incentives for owners of facilities who utilize Fire Protection Fund monies to install sprinkler systems instead of smoke detection equipment.

(2) Maximum loan amounts of one dollar and seventy-five cents ($1.75) per square foot for advanced smoke detectors and digital communication equipment, three dollars and seventy-five cents ($3.75) per square foot for residential sprinkler systems, and six dollars ($6.00) per square foot for institutional sprinkler systems.

(3) Interest rates from three percent (3%) to six percent (6%) for a period not to exceed 20 years for sprinkler systems and 10 years for smoke detection systems.

(4) Documentary verification that owners of facilities obtain fire protection systems and emergency generators at a reasonable cost.

(5) Acceleration of a loan when statutory fire protection requirements are not met by the facility for which the loan was made.

(6) Loan approval priority criteria that considers the frailty level of residents at a facility.

(7) Loan origination and servicing fees.

(c) Proceeds from the Fire Protection Fund, not to exceed ten thousand dollars ($10,000) annually, may be used to provide staff support to the North Carolina Housing Finance Agency for loan processing under this section and to the Department of Health and Human Services for review and approval of fire protection plans and inspection of fire protection systems."

CODE NO. 2000DHHS-H11.11 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
STUDY MULTIUNIT ASSISTED HOUSING WITH SERVICES FACILITIES

Section 11.11. The North Carolina Study Commission on Aging shall study Multiunit Assisted Housing with Services (MAHS) facilities. The study shall include the following:

(1) What strategies may be employed at the State and local level to ensure registration of MAHS facilities with the Department of Health and Human Services, as required under G.S. 131D-2(a)(7a).

(2) Whether persons requesting access to MAHS facilities should be included in the assessment process that is part of the uniform portal of entry system.

(3) Whether an advocacy and oversight system for MAHS facilities should be developed that is comparable to the advocacy and oversight system in place for adult care homes.

Not later than February 1, 2001, the Commission shall report its findings and recommendations to the 2001 General Assembly and to the cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources.

CODE NO. 2000DHHS-S005

Requested by: Senators Martin of Guilford, Purcell, Plyler, Perdue, Odom

FUNDS FOR TRAINING PROGRAMS FOR RECRUITMENT OF CERTIFIED NURSING ASSISTANTS IN NURSING FACILITIES

Section 11.11A.(a) Of the funds appropriated in this act to the Department of Health and Human Services, the sum of five hundred thousand dollars ($500,000) for the 2000-2001 fiscal year shall be used for the development and implementation of on-site Internet training or other innovative training programs designed to improve recruitment and reduce turnover of certified nursing assistants in nursing facilities.

Section 11.11A.(b) The Community Colleges System Office shall work with nursing home providers to develop and implement the training program. The program shall be tested in at least five nursing facilities in the State.

Section 11.11A.(c) The Community Colleges System Office shall ensure that the program is evaluated by a committee composed of individuals representing the community colleges, the North Carolina Health Care Facilities Association, and the Division of Facility Services in the Department of Health and Human Services. Not later than June 30, 2001, the Community Colleges System Office shall report to the North Carolina Study Commission on Aging on the use of these funds and implementation of the program.

SUBPART 4. SOCIAL SERVICES

CODE NO. 2000DHHS-H11.12 =

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

ADULT CARE HOMES REIMBURSEMENT RATE INCREASE/STATE AUDITOR STUDY

Section 11.12.(a) Section 11.22(e) of S.L. 1999-237 reads as rewritten:

"Section 11.22.(e) Effective October 1, 2000, the maximum monthly rate for residents in adult care home facilities shall be one thousand ~~sixteen~~ sixty-two dollars ~~($1,016)~~ ($1,062) per month per resident."

Section 11.12.(b) The Office of the State Auditor shall study the cost reimbursement system used to reimburse adult care homes for residents in those homes who receive public assistance. The study shall include an analysis of the financial information collected on the adult care homes by the Department of Health and Human Services controller's office. The study shall also analyze the impact of occupancy rates on the cost reimbursement system. The Office of the State Auditor shall report the results of the study to the members of the House Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources not later than March 1, 2001.

CODE NO. 2000DHHS-H11.13 =

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

EXTEND SPECIAL ASSISTANCE DEMONSTRATION PROJECT

Section 11.13. Section 11.21 of S.L. 1999-237 reads as rewritten:

"Section 11.21. The Department of Health and Human Services may use funds from the existing State/County Special Assistance for Adults budget to provide Special Assistance payments to eligible individuals in in-home living arrangements. These payments may be made for up to 400 individuals. These payments may be made for up to a two-year period beginning July 1, ~~1999,~~ 2000, and ending June 30, ~~2001.~~ 2002. To the maximum extent possible, the Department shall consider geographic balance in the dispersion of payments to individuals across the State. The Department shall make an interim report to the cochairs of the House of Representatives Appropriations Committee, the cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services and the cochairs of the Senate Appropriations Committee, the Chair of the Senate Appropriations Committee on Human Resources by June 30, ~~2000,~~ 2001, and a final report by October 1, ~~2001.~~ 2002. This report shall include the following information:

(1) A description of cost savings that could occur by allowing individuals eligible for State/County Special Assistance the option of remaining in the home.

(2) Which activities of daily living or other need criteria are reliable indicators for identifying individuals with the greatest need for income supplements for in-home living arrangements.

(3) How much case management is needed and which types of individuals are most in need of case management.

(4) The geographic location of individuals receiving payments under this section.

(5) A description of the services purchased with these payments.

(6) A description of the income levels of individuals who receive payments under this section and the impact on the Medicaid program.

(7) Findings and recommendations as to the feasibility of continuing or expanding the demonstration program."

CODE NO. 2000DHHS-H11.14 =

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

CHILD WELFARE SYSTEM IMPROVEMENTS

Section 11.14. (a) Subsection (a) of Section 11.28 of S.L. 1999-237 reads as rewritten:

"Section 11.28.(a) The Division of Social Services, Department of Health and Human Services, shall report ~~semiannually~~ to the members of the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division on the activities of the State Child Fatality Review Team ~~and shall provide a final report to the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Health and Human Services no later than April 1, 2000,~~ including recommendations for changes in the statewide child protection ~~system.~~ system no later than October 1 of each year."

Section 11.14.(b) Subsection (d) of Section 11.57 of S.L. 1997-443, as amended by Section 12.22 of S.L. 1998-212 and as amended by Section 11.28 of S.L. 1999-237, is repealed.

Section 11.14.(c) G.S. 131D-10.6A reads as rewritten:

"§ 131D-10.6A. Training by the Division of Social Services required.

(a) The Division of Social Services, Department of Health and Human Services, shall ~~continue the in-house training component that provides a mandated~~ require a minimum of 30 hours of preservice training for foster care parents either prior to licensure or within six months from the date a provisional license is issued pursuant to G.S. ~~131D-10.3, and 84 hours for foster care workers and adoption social workers~~ 131D-10.3 and a mandated minimum of 10 hours of continuing education for all foster care parents ~~and 18 hours for foster care workers and adoption social workers.~~ annually after the year in which a license is obtained.

(b) The Division of Social Services shall establish minimum training requirements for child welfare services staff. The minimum training requirements established by the Division are as follows:

(1) Child welfare services workers shall complete a minimum of 72 hours of preservice training before assuming direct client contact responsibilities.

(2) Child protective services workers shall complete a minimum of 18 hours of additional training that the Division of Social Services determines is necessary to adequately meet training needs.

(3) Foster care and adoption workers shall complete a minimum of 39 hours of additional training that the Division of Social Services determines is necessary to adequately meet training needs.

(4) Child welfare services supervisors shall complete a minimum of 72 hours of preservice training before assuming supervisory responsibilities and a minimum of 54 hours of additional training that the Division of Social Services determines is necessary to adequately meet training needs.

(5) Child welfare services staff shall complete 24 hours of continuing education annually.

The Division of Social Services may grant an exception in whole or in part to the requirement under subdivision (1) of this subsection to child welfare workers who satisfactorily complete or are enrolled in a masters or bachelors program after July 1, 1999, from a North Carolina social work program accredited pursuant to the Council on Social Work Education. The program's curricula must cover the specific preservice training requirements as established by the Division of Social Services.

The Division of Social Services shall ensure that training opportunities are available for county departments of social services and consolidated human service agencies to meet the training requirements of this subsection."

Section 11.14.(d) G.S. 131D-10.6A(b), as enacted by subsection (b) of this section, applies to child welfare services staff initially hired on or after January 1, 1998.

CODE NO. 2000DHHS-H11.15 =

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

SPECIAL CHILDREN ADOPTION FUND

Section 11.15.(a) Of the funds appropriated to the Department of Health and Human Services in this act, the sum of one million one hundred thousand dollars ($1,100,000) shall be used to support the Special Children Adoption Fund for the 2000-2001 fiscal year. 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. No local match shall be required as a condition for

receipt of these funds. In accordance with State rules for allowable costs, the Special Children Adoption Fund may be used for post-adoption services for families whose incomes exceed two hundred percent (200%) of the federal poverty level.

Section 11.15.(b) Of the total funds appropriated for the Special Children Adoption Fund, four hundred thousand dollars ($400,000) shall be reserved for payment to participating private adoption agencies.

CODE NO. 2000DHHS-H11.16 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
SPECIAL NEEDS ADOPTIONS INCENTIVE FUND

Section 11.16. There is created a Special Needs Adoptions Incentive Fund to provide financial assistance to facilitate the adoption of certain children residing in licensed foster care homes, effective January 1, 2001. These funds shall be used to remove financial barriers to the adoption of these children and shall be available to foster care families who adopt children with special needs as defined by the Social Services Commission. These funds shall be matched by county funds.

This program shall not constitute an entitlement and is subject to the availability of funds.

The Social Services Commission shall adopt rules to implement the provisions of this section.

CODE NO. 2000DHHS-S11.16A
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
CHILD WELFARE SERVICES DATA COLLECTION

Section 11.16A. The Department of Health and Human Services, Division of Social Services, shall report to the House of Representative Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division no later than April 1, 2001, on the following information for this State and for comparable states:

(1) Demographics on the population under the age of 18, including significant trends over a 5-year period.
(2) The number of child welfare cases, including significant trends over a 5-year period. Information regarding cases shall include separate data on reports, investigations, and substantiated cases. This report shall contain information on the definition of these terms.
(3) The total number of Child Welfare Services workers, including significant trends over a 5-year period.
(4) The total budget, from all available sources, for Child Welfare Services, including significant trends over a 5-year period.

The Department shall establish a mechanism for reporting this information on an annual basis and shall develop an estimate of the cost of complying with this Section.

The purpose of this reporting requirement is for the General Assembly to utilize this information as part of a rational decision-making process of identifying and meeting the needs of the Child Welfare Services system.

SUBPART 5. MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES

CODE NO. 2000DHHS-H11.17 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
NONMEDICAID REIMBURSEMENT CHANGES

Section 11.17. Section 11.7 of S.L. 1999-237 reads as rewritten:

"Section 11.7. Providers of medical services under the various State programs, other than Medicaid, offering medical care to citizens of the State shall be reimbursed at rates no more than those under the North Carolina Medical Assistance Program. Hospitals that provide psychiatric inpatient care for multiply diagnosed adults who were identified as members of the Thomas S. class at the time of dissolution of the class, and other multiply diagnosed adults may be paid an additional incentive payment not to exceed fifteen percent (15%) of their regular daily per diem reimbursement.

The Department of Health and Human Services may reimburse hospitals at the full prospective per diem rates without regard to the Medical Assistance Program's annual limits on hospital days. When the Medical Assistance Program's per diem rates for inpatient services and its interim rates for outpatient services are used to reimburse providers in non-Medicaid medical service programs, retroactive adjustments to claims already paid shall not be required.

Notwithstanding the provisions of paragraph one, the Department of Health and Human Services may negotiate with providers of medical services under the various Department of Health and Human Services programs, other than Medicaid, for rates as close as possible to Medicaid rates for the following purposes: contracts or agreements for medical services and purchases of medical equipment and other medical supplies. These negotiated rates are allowable only to meet the medical needs of its non-Medicaid eligible patients, residents, and clients who require such services which cannot be provided when limited to the Medicaid rate.

Maximum net family annual income eligibility standards for services in these programs shall be as follows:

Family Size	Medical Eye Care Adults	All Rehabilitation	Other
1	$ 4,860	$ 8,364	$ 4,200
2	5,940	10,944	5,300
3	6,204	13,500	6,400
4	7,284	16,092	7,500
5	7,821	18,648	7,900
6	8,220	21,228	8,300
7	8,772	21,708	8,800
8	9,312	22,220	9,300

The eligibility level for children in the Medical Eye Care Program in the Division of Services for the Blind shall be one hundred percent (100%) of the federal poverty guidelines, as revised annually by the United States Department of Health and Human Services and in effect on July 1 of each fiscal year. The eligibility level for adults in the Atypical Antipsychotic Medication Program in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall be one hundred ~~twenty-five~~ fifty percent ~~(125%)~~ (150%) of the federal poverty guidelines, as revised annually by the United States Department of Health and Human Services and in effect on July 1 of each fiscal year. Additionally, those adults enrolled in the Atypical Antipsychotic Medication Program who become gainfully employed may continue to be eligible to receive State support, in decreasing amounts, for the purchase of atypical antipsychotic medication and related services up to three hundred percent (300%) of the poverty level.

State financial participation in the Atypical Antipsychotic Medication Program for those enrollees who become gainfully employed is as follows:

Income (% of poverty)	State Participation	Client Participation
~~0-125%~~	~~100%~~	~~0%~~
~~126-140%~~	~~90%~~	~~10%~~
~~141-160%~~	~~80%~~	~~20%~~
~~161-180%~~	~~70%~~	~~30%~~
~~181-200%~~	~~60%~~	~~40%~~
~~201-220%~~	~~50%~~	~~50%~~
~~221-240%~~	~~40%~~	~~60%~~
~~241-260%~~	~~30%~~	~~70%~~
~~261-280%~~	~~20%~~	~~80%~~
~~281-300%~~	~~10%~~	~~90%~~
~~301% over~~	~~0%~~	~~100%.~~
0-150%	100%	0%
151-200%	75%	25%
201-250%	50%	50%
251-300%	25%	75%
301% and over	0%	100%."

The Department of Health and Human Services shall contract at, or as close as possible to, Medicaid rates for medical services provided to residents of State facilities of the Department."

CODE NO: 2000DHHS-H11.18 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
AREA BOARD MEMBER PER DIEM

Section 11.18. G.S. 122C-120 reads as rewritten:

"§ 122C-120. Compensation of area board members.

(a) Area board members may receive as compensation for their services per diem and a subsistence allowance for each day during which they are engaged in the official business of the area board. The amount of the per diem and subsistence allowances shall be established by the area ~~board and the amounts shall not exceed those authorized by G.S. 138-5 for State boards.~~ board. The amount of per diem allowance shall not exceed fifty dollars ($50.00). Reimbursement of subsistence expenses shall be at the rates allowed to State officers and employees under G.S. 138-6(a)(3).

(b) Area board members may be reimbursed for all necessary travel expenses and registration fees in amounts fixed by the board."

CODE NO. 2000DHHS-S11.19
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
CHILD RESIDENTIAL TREATMENT SERVICES PROGRAM

Section 11.19 (a) The Department of Health and Human Services shall establish the Child Residential Treatment Services Program. The Program shall be implemented by the Department in consultation with the Office of Juvenile Justice and other affected State agencies. The purpose of the Program is to provide appropriate and medically necessary residential treatment alternatives for children at risk of institutionalization or other out-of-home placement. The Program shall include the following:

(1) Behavioral health screenings for all children at risk of institutionalization or other out-of-home placement.

(2) Appropriate and medically necessary residential treatment placements, including placements for youths needing substance abuse treatment services and for specialized populations such as deaf children, children with serious emotional disturbances, and sexually aggressive youth.

(3) Multidisciplinary case management services, as needed.

(4) A system of utilization review specific to the nature and design of the Program.

(5) Mechanisms to ensure that children are not placed in department of social services custody for the purpose of obtaining mental health residential treatment services.

(6) Mechanisms to maximize current State and local funds and to expand use of Medicaid funds to accomplish the intent of this Program.

(7) Other appropriate components to accomplish the Program's purpose.

Section 11.19.(b) The Department shall not allocate funds appropriated for Program services until a Memorandum of Agreement has been executed between the Department and other affected State agencies. The Memorandum of Agreement shall address specifically the roles and responsibilities of the various departmental divisions and affected State agencies involved in the administration, financing, care, and placement of children at risk of institutionalization or other out-of-home placement. The Department shall not allocate funds appropriated in this act for the Program until Memoranda of Agreement between local departments of social services and area mental health programs, and the Administrative Office of the Courts, and the Office of Juvenile Justice, as appropriate, are executed to effectuate the purpose of the Program. The Memoranda of Agreement shall address issues pertinent to local implementation of the Program.

Section 11.19.(c) Notwithstanding any other provision of law to the contrary, services under the Child Residential Treatment Services Program are not an entitlement for non-Medicaid eligible children served by the Program.

Section 11.19.(d) The Department of Health and Human Services, in conjunction with the Office of Juvenile Justice and other affected agencies, shall report on the following:

(1) The number and other demographic information of children served.

(2) The amount and source of funds expended to implement the Program.

(3) Information regarding the number of children screened, specific placement of children, and treatment needs of children served.

(4) The average length of stay in residential treatment, transition, and return to home.

(5) The number of children diverted from institutions or other out-of-home placements such as training schools and State psychiatric hospitals.

(6) Recommendations on other areas of the Program that need to be improved.

(7) Other information relevant to successful implementation of the Program.

The Department shall submit a progress report on implementation of the Program not later than February 1, 2001, and a final report not later than May 1, 2002, to the House of Representatives Appropriations Subcommittee on Health and

Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division.

CODE NO. 2000DHHS-H11.20/S11.20

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom, Lucas, Gulley

FUNDS FOR CHILD AND ADOLESCENT RESIDENTIAL UNIT AT MURDOCH CENTER

Section 11.20.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of one million two hundred thousand dollars ($1,200,000) for the 2000-2001 fiscal year shall be used as follows:

(1) To develop and operate a six-bed short-term residential unit to meet the needs of autistic children statewide whose behaviors place them at serious risk of institutionalization. The unit shall be developed within the Murdoch Mental Retardation Center and supported by specialized staff within the Murdoch Mental Retardation Center; and

(2) To develop and operate a four-bed residential program for autistic children statewide whose behaviors place them at serious risk of institutionalization. The program may offer short-term diagnostic/prescriptive services or comprehensive interventions in order to transition children back to their homes and communities. The program shall be developed and supported by staff from the Murdoch Mental Retardation Center.

Section 11.20.(b) The Department shall submit progress reports on December 1, 2000, and on April 1, 2001, on its compliance with this section. The Department shall submit a final report on January 1, 2002. The reports shall be submitted to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division.

CODE NO. 2000DHHS-H11.21 =

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

SERVICES TO CHILDREN AT RISK FOR INSTITUTIONALIZATION OR OTHER OUT-OF-HOME PLACEMENT

Section 11.21.(a) In order to ensure that children at risk for institutionalization or other out-of-home placement are appropriately served by the mental health, developmental disabilities, and substance abuse services system, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall do the following with respect to services provided to these children:

(1) Provide only those treatment services that are medically necessary.

(2) Implement utilization review of services provided.

(3) Effective immediately:

a. Eliminate formerly court-mandated Willie M. or Eligible Violent and Assaultive Children Program administration, infrastructure, categorical funding designation, and eligibility determination process at the State and local level;

b. Identify savings realized from elimination of Program administration and infrastructure at the State and local level;

c. Adopt the following guiding principles for the provision of services:

1. Service delivery system must be outcome-oriented and evaluation-based.
2. Services should be delivered as close as possible to the consumer's home.
3. Services selected should be those that are most efficient in terms of cost and effectiveness.
4. Services should not be provided solely for the convenience of the provider or the client.
5. Families and consumers should be involved in decision making throughout treatment planning and delivery.

d. Implement all of the following cost reduction strategies:
1. Preauthorization for all services except emergency services.
2. Levels of care to assist in the development of treatment plans.
3. Clinically appropriate services.
4. State review of individualized service plans for all children served to ensure that service plans focus on delivery of appropriate services rather than optimal treatment and habilitation plans.

(4) Collaborate with other affected State agencies such as the Office of Juvenile Justice and the Administrative Office of the Courts, and with local departments of social services and area mental health programs to eliminate cost-shifting and facilitate cost-sharing among these governmental agencies with respect to the treatment and placement services.

Section 11.21.(b) The Department shall submit a progress report on implementation of this section not later than February 1, 2001, and a final report not later than May 1, 2002, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division.

Section 11.21.(c) G.S. 122C-3(13a) is repealed.

Section 11.21.(d) G.S. 122C-112(14) is repealed.

Section 11.21.(e) Part 7 of Article 4 of Chapter 122C of the General Statutes is repealed. This subsection applies to petitions for contested case review filed on and after the effective date of this act.

CODE NO. 2000DHHS-H11.22 =

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

SERVICES TO MULTIPLY-DIAGNOSED ADULTS

Section 11.22.(a) In order to ensure that multiply-diagnosed adults are appropriately served by the mental health, developmental disabilities, and substance abuse services system, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall do the following with respect to services provided to these adults:

(1) Provide only those treatment services that are medically necessary.

(2) Implement utilization review of services provided.

(3) Effective immediately:

a. Eliminate formerly court-mandated Thomas S. Program administration, infrastructure, and categorical funding designation at the local level, while continuing to provide

services to former Thomas S. clients and other multiply-diagnosed adults;

b. Identify savings realized from elimination of Program administration and infrastructure;

c. Adopt the following guiding principles for the provision of services:

1. Service delivery system must be outcome oriented and evaluation based.
2. Services should be delivered as close as possible to the consumer's home.
3. Services selected should be those that are most efficient in terms of cost and effectiveness.
4. Services should not be provided solely for the convenience of the provider or the client.
5. Families and consumers should be involved in decision-making throughout treatment planning and delivery; and

d. Implement all of the following cost reduction strategies:

1. Preauthorization for all services except emergency services.
2. Criteria for determining medical necessity.
3. Clinically appropriate services.
4. State review of (i) individualized service plans for all adults served to ensure that service plans focus on delivery of appropriate services rather than optimal treatment and habilitation plans, and (ii) staffing patterns of residential services.

Section 11.22.(b) No State funds shall be used for the purchase of single-family or other residential dwellings to house multiply-diagnosed adults.

Section 11.22.(c) The Department shall submit a progress report on implementation of this section not later than February 1, 2001, and a final report not later than May 1, 2002, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division.

CODE NO. 2000DHHS-S11.23

Requested by: Senators Martin of Guilford, Phillips, Plyler, Perdue, Odom

FUNDS FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES OVERSIGHT COMMITTEE

Section 11.23.(a) Of the funds appropriated in this act to the Department of Health and Human Services, the Department shall transfer the sum of three hundred fifty thousand dollars ($350,000) to the General Assembly, Legislative Services Office, for the 2000-2001 fiscal year. These funds shall be used to carry out the provisions of this section. The funds shall be used specifically for a comprehensive study of developmental disabilities services and administration and to hire professional staff to assist the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

Section 11.23.(b) The Department shall study whether a new division of developmental disabilities should be established in the Department. Not later than January 1, 2001, the Department shall report its findings and recommendations to the

House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources.

Section 11.23.(c) Findings. -- The General Assembly finds that:

(1) The State and local government entities are not using effectively and efficiently available resources to administer and provide mental health, developmental disabilities, and substance abuse services uniformly across the State.

(2) Effective implementation of State policy to assist individuals with mental illness, developmental disabilities, and substance abuse problems requires that a standard system of services, designed to identify, assess, and meet client needs within available resources, be available in all regions of the State.

(3) The findings of recent comprehensive independent studies, and recent federal court decisions, compel the State to consider significant changes in the operation and utilization of State psychiatric hospital services.

(4) State and local government funds for mental health, developmental disabilities, and substance abuse services must be committed on a continuing, stabilized basis and will need to be increased over time to ensure that the purposes of mental health system reform are achieved.

(5) Reform of the State mental health, developmental disabilities, and substance abuse services system is necessary and should begin immediately. Reform efforts should focus on correcting system inefficiencies, inequities in service availability, and deficiencies in funding and accountability, and on improving and enhancing services to North Carolina's citizens.

Section 11.23.(d) Oversight Committee Established. -- Chapter 120 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 27.

"The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

"§ 120-240. Creation and membership of Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(a) Establishment. -- There is established the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(b) Membership. -- The Committee shall consist of 16 members, as follows:

(1) Eight members of the Senate appointed by the President Pro Tempore of the Senate, as follows:

a. At least two members of the Senate Committee on Appropriations.

b. The chair of the Senate Appropriations Committee on Human Resources.

c. At least two members of the minority party.

(2) Eight members of the House of Representatives appointed by the Speaker of the House of Representatives, as follows:

a. At least two members of the House of Representatives Committee on Appropriations.

b. The cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services.

c. At least two members of the minority party.

(c) Terms. -- Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year, except the terms of the initial members, which begin on appointment and end on the day of the convening of the 2001 General Assembly. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

A member continues to serve until the member's successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

"**§ 120-241. Purpose of Committee.**

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services shall examine, on a continuing basis, systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered. The Committee shall make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of effectiveness and efficiency in system administration at the State and local levels. In conducting its examination, the Committee shall study the budget, programs, administrative organization, and policies of the Department of Health and Human Services to determine ways in which the General Assembly may encourage improvement in mental health, developmental disabilities, and substance abuse services provided to North Carolinians.

"**§ 120-242. Organization of Committee.**

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The Committee shall meet at least once a quarter and may meet at other times upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present. While in the discharge

of its official duties, the Committee has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4.

(c) Members of the Committee receive subsistence and travel expenses as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Supervisors of Clerks of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee."

Section 11.23.(e) Plan for Mental Health System Reform. -- Terms Defined. -- As used in this section, unless the context clearly provides otherwise:

(1) "Committee" means the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) "Mental Health System Reform" includes the system of services for mental health, developmental disabilities, and substance abuse.

(3) "Plan" means the Plan for Mental Health System Reform developed and recommended by the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(4) "State Auditor/PCG, Inc., Study" means the "Study of State Psychiatric Hospitals and Area Mental Health Programs, April 1, 2000", conducted by the Public Consulting Group, Inc., under coordination by and contract with the State Auditor.

Section 11.23.(f) Development of Plan for Mental Health System Reform. -- The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under Article 27 of Chapter 120 of the General Statutes shall develop a Plan for Mental Health System Reform. It is the intent of the General Assembly that the Plan shall be fully implemented not later than July 1, 2005.

Section 11.23.(g) Purpose and Content of the Plan. -- The Plan shall provide for systematic, phased-in implementation of changes to the State's mental health system. In developing the Plan, the Committee shall do the following:

(1) Review and consider the findings and recommendations of the State Auditor/PCG, Inc., Study.

(2) Report to the 2001 General Assembly upon its convening the changes that should be made to the governance, structure, and financing of the State's mental health system at the State and local levels. The report shall include:

a. An explanation of how and the extent to which the proposed changes are in accord with or differ from the recommendations of the State Auditor/PCG, Inc., Study.

b. Proposed time frames for implementing mental health system reform on a phased-in basis, and the recommended effective date for full implementation of all recommended changes.

c. An estimate of the amount of State and federal funds necessary to implement the changes. The estimate should indicate costs of each phase of implementation and the total cost of full implementation.

d. An estimate of the amount of savings in State funds expected to be realized from the changes. The estimate should show savings expected in each phase of implementation, and the total amount of savings expected to be realized from full implementation.

e. The potential financial, economic, and social impact of changes to the current governance, structure, and financing of the mental health system on providers, clients, communities, and institutions at the State and local levels.

f. Proposed legislation making the necessary amendments to the General Statutes to enact the recommended changes to the system of governance, structure, and financing.

(3) Study the administration, financing, and delivery of developmental disabilities services. The study shall be in greater depth and detail than addressed in the State Auditor/PCG, Inc., Study. The Committee shall make a progress report on its study of developmental disabilities services to the 2001 General Assembly upon its convening.

(4) Study the feasibility and impact of and best methods for downsizing of the State's four psychiatric hospitals. In conducting this study, the Committee shall:

a. Take into account the need to enhance and improve community services to meet increased demand resulting from downsizing, and

b. Consider the findings and recommendations of the MGT of America Report of 1998, as well as the State Auditor/PCG, Inc., Study.

(5) Consider the impact of mental health system reform on quality of services and patient care and ensure that the Plan provides for ongoing review and improvements to quality of services and patient care.

(6) Ensure that the Plan provides for the active involvement of consumers and families in mental health system reform and ongoing implementation.

(7) Address the need to enhance and improve substance abuse services, including services for the prevention of substance abuse.

(8) Recommend a mental health, developmental disabilities, and substance abuse services benefits package that will provide for basic benefits for these services as well as specific benefits for targeted populations.

(9) Take into account the State's responsibility to enable institutionalized persons and persons at risk for institutionalization to receive services outside of the institution in community-based settings in accordance with the United States Supreme Court decision in Olmstead vs. L.C., (1999).

(10) Identify and address issues pertaining to the administration and provision of mental health services to children.

(11) Address issues, problems, strengths, and weaknesses in the current mental health system that are not addressed in the State Auditor/PCG, Inc., Study but that warrant consideration in the development of a reformed mental health system.

(12) Consider whether the State shall implement a contested case hearings procedure for applicants and recipients of mental health, developmental disabilities, and substance abuse services.

Section 11.23.(h) Subcommittees. -- The Committee shall establish one or more subcommittees to consider and develop specific focus areas of the Plan. Each subcommittee shall be the working group for the focus area assigned by the Committee cochairs. The Committee cochairs shall appoint the cochairs and members of each subcommittee from the Committee membership. The Committee cochairs shall invite representatives from the following to participate as nonvoting members of each subcommittee:

(1) Providers of mental health, developmental disabilities, and substance abuse services.

(2) Consumers of mental health, developmental disabilities, and substance abuse services and family members of consumers of these services.

(3) State and local government, including area mental health programs.

(4) Business and industry.

(5) Organizations that advocate for individuals in need of mental health, developmental disabilities, and substance abuse services.

Subcommittees shall meet at the call of the subcommittee cochairs.

The Committee cochairs shall assign the focus area for each subcommittee. Each subcommittee shall carry out its assignment as directed by the Committee cochairs and shall provide its findings and recommendations to the Committee cochairs for final decision by the Committee.

Section 11.23.(i) Reports. -- In addition to the report required under subsection (g) of this section, the Committee shall submit the following reports:

(1) To the 2001 General Assembly, upon its convening:

a. A progress report on the development of the Plan required by this section; and

b. An outline of an implementation process for downsizing the four State psychiatric hospitals.

(2) To the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Appropriations Committees on Health and Human Services, by October 1, 2001, and March 1, 2002, progress reports on the development and implementation of the Plan.

(3) Interim reports on the development and implementation of the Plan to:

a. The 2001 General Assembly, by May 1, 2002. The report shall include legislative action necessary to continue the implementation of changes to the governance, structure, and financing of the State mental health system as recommended by the Committee in its January 2001 report to the General Assembly.

b. The 2003 General Assembly, upon its convening.

c. The 2003 General Assembly, by May 1, 2004. The report shall include legislative action necessary to continue phased-in implementation of the Plan.

(4) To the 2005 General Assembly, upon its convening, a final report on the Plan for Mental Health System Reform.

Section 11.23.(j) Oversight Committee Appointments. -- The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall make appointments to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under this act not later than 30 days from the date of adjournment sine die of the 1999 General Assembly. The Committee shall convene its first meeting not later than 15 days after all members have been appointed.

Section 11.23.(k) Department of Health and Human Services Reports. -- On or before October 1, 2000, and on or before March 1, 2001, the Department of Health and Human Services shall report to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the status of the Department's reorganization efforts pertaining to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall also include efforts underway by the Department to better coordinate policy and administration of the Division of Medical Assistance with policy and administration of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

CODE NO. 2000DHHS-H11.24 =

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES RESERVE FOR SYSTEM REFORM AND OLMSTEAD DECISION

Section 11.24.(a) There is created in the Office of State Budget and Management the Mental Health, Developmental Disabilities, and Substance Abuse Services Reserve for System Reform and Olmstead. The purposes of the Reserve are to:

(1) Provide start-up funds for programs and services that provide community alternatives for individuals currently residing in the State's mental health, developmental disabilities, and substance abuse services institutions.

(2) Facilitate the State's compliance with the United States Supreme Court decision in Olmstead v. L.C. and E.W.

(3) Facilitate reform of the mental health, developmental disabilities, and substance abuse services system.

Section 11.24.(b) Funds appropriated to the Reserve created in subsection (a) of this section shall be used to:

(1) Pay onetime expenditures that will not impose additional financial obligations on the State, and

(2) Establish or expand community-based services if sufficient recurring funds can be identified within the Department from funds currently budgeted for mental health, developmental disabilities, and substance abuse services, area mental health programs, or local government.

Section 11.24.(c) Before allocating funds from the Reserve, the Director of the Budget shall certify that the planned uses of the funds are in compliance with this section and do not constitute or will not create an ongoing financial obligation to the State.

Section 11.24.(d) Funds in the Mental Health, Developmental Disabilities, and Substance Abuse Services Reserve for System Reform and Olmstead shall not revert to the General Fund but shall remain in the Reserve to be used as authorized in this section.

Section 11.24.(e) The Department of Health and Human Services shall report periodically to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Legislative Commission on Governmental Operations on any actions taken under this section.

CODE NO. 2000DHHS-H11.25 =

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

EARLY INTERVENTION SERVICES

Section 11.25. Section 11.42 of S.L. 1999-237 reads as rewritten:

"Section 11.42.(a) Of the funds appropriated in this act to the Department of Health and Human Services, the sum of two hundred three thousand dollars ($203,000) for the 1999-2000 fiscal year and the sum of ~~six hundred ten~~ eight hundred sixty thousand dollars ~~($610,000)~~ ($860,000) for the 2000-2001 fiscal year shall be used to implement two recommendations from the Interagency Coordinating Council's "Study on Early Intervention Services for Children Ages Birth to Five Years," dated March 1999. The Department of Health and Human Services, the Department of Public Instruction, and The University of North Carolina's Division TEACCH (Treatment and Education of Autistic and other Communications Handicapped Children and Adults), shall participate jointly, in collaboration with the Interagency Coordinating Council, in the planning, design, and implementation of the following provisions:

(1) Of the funds allocated by this subsection, the sum of seventy-eight thousand dollars ($78,000) in the 1999-2000 fiscal year and the sum of ~~one hundred ten~~ three hundred thousand dollars ~~($110,000)~~ ($300,000) in the 2000-2001 fiscal year shall be used to plan, design, and implement an integrated, interagency database for children with or at risk for disabilities who receive early intervention services. The purpose of the database is to:

a. Assist in identifying gaps in services;
b. Project and plan for future service needs;
c. Improve the quality and accessibility of services; and
d. Document outcomes of early intervention services.

This database shall be compatible with the State Board of Education's new Student Information Management System. These agencies shall initiate use of the database in a pilot program in at least one community by July 1, 2000, and shall evaluate this pilot for statewide implementation by July 1, 2001. Any local education agency participating in the pilot program shall provide the same data for children in the preschool program for children with disabilities as is provided by the Department of Health and Human Services for children served in the infant-toddler program. The agencies shall submit a progress report by April 1, 2000, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

(2) Of the funds allocated by this subsection, the sum of one hundred twenty-five thousand dollars ($125,000) in fiscal year 1999-2000 and the sum of five hundred sixty thousand dollars ~~($500,000)~~ ($560,000) in fiscal year 2000-2001 shall be used to plan for and implement regional transdisciplinary teams to provide training, technical assistance, and other support services to existing early intervention agencies and providers. The teams will maintain expertise on low incidence populations, such as children with visual and hearing impairments, autism, and child mental health needs. These agencies shall implement a pilot program establishing a regional transdisciplinary team no later than March 2000. These agencies shall submit an interim report by March 15, 2000, and a final plan for statewide implementation of the transdisciplinary teams by March 15, 2001, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

Section 11.42.(b) The North Carolina Schools for the Deaf and other agencies providing early intervention services to children from birth through five years of age shall implement procedures to ensure that:

(1) Parents of children newly identified with hearing loss and determined to be eligible for services are informed of the services available to them through Beginnings for Parents of ~~Hearing Impaired Children, Inc.;~~ Children Who Are Deaf or Hard of Hearing, Inc.; and

(2) Beginnings for Parents of ~~Hearing Impaired Children, Inc.,~~ Children Who Are Deaf or Hard of Hearing, Inc., with the consent of parents, is notified of these children in a timely and appropriate manner."

CODE NO. 00DHR-001
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
LICENSURE EXCEPTION FOR CERTAIN NONPROFIT SUBSTANCE ABUSE FACILITIES

Section 11.25A. G.S. 122C-22(a) reads as rewritten:

"(a) The following are excluded from the provisions of this Article and are not required to obtain licensure under this Article:

(1) Physicians and psychologists engaged in private office practice;
(2) General hospitals licensed under Article 5 of Chapter 131E of the General Statutes, that operate special units for the mentally ill, developmentally disabled, or substance abusers;
(3) State and federally operated facilities;
(4) Adult care homes licensed under Chapter 131D of the General Statutes;
(5) Developmental child care centers licensed under Article 7 of Chapter 110 of the General Statutes;
(6) Persons subject to licensure under rules of the Social Services Commission;
(7) Persons subject to rules and regulations of the Division of Vocational Rehabilitation Services; and
(8) Facilities that provide occasional respite care for not more than two individuals at a time; provided that the primary purpose of the facility is other than as defined in G.S. 122C-3(14).
(9) Twenty-four hour non-profit facilities established for the purposes of shelter care and recovery from alcohol or other drug addiction through a 12-step, self help, peer role modeling, and self-governance approach."

SUBPART 6. CHILD DEVELOPMENT

CODE NO. 2000DHHS-H11.26 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
TRANSFER FUNDS FOR CLIENT SERVICES

Section 11.26. The sum of three million dollars ($3,000,000) appropriated to the Division of Child Development in this act shall be transferred to the Division of Social Services to fund client services provided by the county departments of social services.

CODE NO. 2000DHHS-S11.27
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
CHILD CARE SUBSIDY RATES

Section 11.27.(a) Section 11.47 of S.L. 1999-237 reads as rewritten:

"Section 11.47.(a) The maximum gross annual income for initial eligibility, adjusted biennially, for subsidized child care services shall be seventy-five percent (75%) of the State median income, adjusted for family size.

Section 11.47.(b) Fees for families who are required to share in the cost of care shall be established based on a percent of gross family income and adjusted for family size. Fees shall be determined as follows:

FAMILY SIZE	PERCENT OF GROSS FAMILY INCOME
1-3	9%
4-5	8%
6 or more	7%

Section 11.47.(c) Payments for the purchase of child care services for low-income children shall be in accordance with the following requirements:

(1) Effective October 1, 1999, religious-sponsored child care facilities operating pursuant to G.S. 110-106 and licensed child care centers and homes that meet the minimum licensing standards that are participating in the subsidized child care program shall be paid the ~~county market~~ subsidy rate or the rate they charge privately paying parents, whichever is lower.

(2) Effective October 1, 1999, religious-sponsored child care facilities operating pursuant to G.S. 110-106 and licensed child care centers and homes that are receiving a higher rate than the ~~market~~ subsidy rates that will be implemented with this provision shall continue to receive that higher rate for a period of three years from the effective date of this section.

(3) Effective October 1, 1999, licensed child care centers with two or more stars may receive a higher payment rate per child per month as follows: two stars - $14.00, three stars - $17.00, four stars - $20.00, and five stars - $23.00. Effective January 1, 2000, licensed child care homes with two or more stars may receive a higher payment rate per child per month as follows: two stars - $14.00, three stars - $17.00, four stars - $20.00, and five stars - $23.00. This subdivision expires September 1, 2000.

(3a) Effective September 1, 2000, licensed child care centers and homes with two or more stars shall receive the subsidy rate for that rated quality level for that age group or the rate they charge privately paying parents, whichever is lower.

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

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

~~Section 11.47.(d) Provision of payment rates for child care providers in counties who do not have at least 75 children in each age group for center-based and home-based care are as follows:~~

~~(1) Payment rates shall be set at the statewide market rate for licensed child care centers and homes.~~

~~(2) If it can be demonstrated that the application of the statewide market rate to a county with fewer than 75 children in each age group is lower than the county market rate and would inhibit the ability of the county to purchase child care for low-income children, then the county market rate may be applied.~~

Section 11.47.(e) A market rate shall be calculated for child care centers and homes ~~that meet minimum licensing standards~~ at each rated quality level for each county and for each age group or age category of enrollees and shall be representative of fees charged to unsubsidized privately paying parents for each age group of enrollees within the county. The Division of Child Development shall also calculate a statewide market rate at each rated quality level for each age category. The Division of Child Development may also calculate regional market rates at each rated quality level for each age group and age category.

Section 11.47.(f) Facilities licensed pursuant to Article 7 of Chapter 110 of the General Statutes and facilities operated pursuant to G.S. 110-106 may participate in the program that provides for the purchase of care in child care facilities for minor children of needy families. No separate licensing requirements shall be used to select facilities to participate. In addition, child care facilities shall be required to meet any additional applicable requirements of federal law or regulations. Child care arrangements exempt from State regulation pursuant to Article 7 of Chapter 110 of the General Statutes shall meet the requirements established by other State law and by the Social Services Commission.

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

Section 11.47.(g) Payment for subsidized child care services provided with Work First Block Grant funds shall comply with all regulations and policies issued by the Division of Child Development for the subsidized child care program."

Section 11.27.(b) Article 7 of Chapter 110 of the General Statutes is amended by adding a new section to read:

"**§ 110-109. Child care subsidy rates.**

(a) The Department shall conduct a statewide market rate study of child care facilities at least once every two years. The study shall include a survey of all licensed facilities. Based on the results of this study, the Department shall establish a market rate for child care centers and homes at each rated quality level for each county and for each age group. The Department shall also calculate a statewide market rate at each rated quality level for each age group. The market rate shall be set at the seventy-fifth percentile of fees charged to unsubsidized, privately paying parents at each rated quality level for each age group.

(b) Within six months of completing a statewide market rate study, the Department shall publish the results of that study and implement market rates based on the results of that study.

(c) When a county has at least 75 children in an age group at a particular rated quality level, the subsidy rate is the county market rate for that age group at that rated quality level. When a county has fewer than 75 children in an age group at a particular rated quality level, the subsidy rate is the statewide market rate for that age group at that rated quality level.

(d) Notwithstanding the provisions of subsection (c) of this section, when it can be demonstrated that the statewide market rate is lower than the county market rate and that setting the subsidy rate at the statewide market rate would inhibit the ability of a county to purchase child care for low-income children, the subsidy rate shall be the county market rate."

Section 11.27.(c) The first market rate study required by G.S. 110-109, as enacted by subsection (b) of this section, shall be completed no later than April 1, 2001.

Section 11.27.(d) The Department of Health and Human Services shall conduct a one-time interim market rate study that shall be completed no later than April 1, 2002. This interim market rate study shall incorporate the results of the April 2001 study and shall contain a survey of rates charged at child care facilities that have changed their rate quality level since the survey conducted for the April 2001 study. The Department shall implement the results of this study within six months of its completion.

Section 11.27.(e) Non-citizen families who reside in this State legally shall be eligible for child care subsidies if all other conditions of eligibility are met. If all other conditions of eligibility are met, non-citizen families who reside in this State

illegally shall be eligible for child care subsidies only if at least one of the following conditions is met:

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

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

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

CODE NO. 2000DHHS-S11.28B

Requested by: Senators Martin of Guilford,

EARLY CHILDHOOD EDUCATION AND DEVELOPMENT INITIATIVES

Section 11.28.(a) G.S. 143B-168.12(a) reads as rewritten:

"(a) In order to receive State funds, the following conditions shall be met:

(1) The North Carolina Partnership shall have a Board of Directors consisting of the following 25 members:

a. The Secretary of Health and Human Services, ex officio, or the Secretary's designee;

b. Repealed by Session Laws 1997, c. 443, s. 11A.105.

c. The Superintendent of Public Instruction, ex officio, or the Superintendent's designee;

d. The President of the Community Colleges System, ex officio, or the President's designee;

e. Three members of the public, including one child care provider, one other who is a parent, and one other who is a board chair of a local partnership serving on the North Carolina Partnership local partnership advisory committee, appointed by the General Assembly upon recommendation of the President Pro Tempore of the Senate;

f. Three members of the public, including one who is a parent, one other who is a representative of the faith community, and one other who is a board chair of a local partnership serving on the North Carolina Partnership local partnership advisory committee, appointed by the General Assembly upon recommendation of the Speaker of the House of Representatives;

g. Twelve members, appointed by the Governor. Three of these 12 members shall be members of the party other than the Governor's party, appointed by the Governor. Seven of these 12 members shall be appointed as follows: one who is a child care provider, one other who is a pediatrician, one other who is a health care provider, one other who is a parent, one other who is a member of the business community, one other who is a member representing a philanthropic agency, and one other who is an early childhood educator;

h. Repealed by Session Laws 1998-212, s. 12.37B(a).

h1. The Chair of the North Carolina Partnership Board shall be appointed by the Governor;

i. Repealed by Session Laws 1998-212, s. 12.37B(a).

j. One member of the public appointed by the General Assembly upon recommendation of the Majority Leader of the Senate;

k. One member of the public appointed by the General Assembly upon recommendation of the Majority Leader of the House of Representatives;

l. One member of the public appointed by the General Assembly upon recommendation of the Minority Leader of the Senate; and

m. One member of the public appointed by the General Assembly upon recommendation of the Minority Leader of the House of Representatives.

All members appointed to succeed the initial members and members appointed thereafter shall be appointed for three-year terms. Members may succeed themselves.

All appointed board members shall avoid conflicts of interests and the appearance of impropriety. Should instances arise when a conflict may be perceived, any individual who may benefit directly or indirectly from the North Carolina Partnership's disbursement of funds shall abstain from participating in any decision or deliberations by the North Carolina Partnership regarding the disbursement of funds.

All ex officio members are voting members. Each ex officio member may be represented by a designee. These designees shall be voting members. No members of the General Assembly shall serve as members.

The North Carolina Partnership may establish a nominating committee and, in making their recommendations of members to be appointed by the General Assembly or by the Governor, the President Pro Tempore of the Senate, the Speaker of the House of Representatives, the Majority Leader of the Senate, the Majority Leader of the House of Representatives, the Minority Leader of the Senate, the Minority Leader of the House of Representatives, and the Governor shall consult with and consider the recommendations of this nominating committee.

The North Carolina Partnership may establish a policy on members' attendance, which policy shall include provisions for reporting absences of at least three meetings immediately to the appropriate appointing authority.

Members who miss more than three consecutive meetings without excuse or members who vacate their membership shall be replaced by the appropriate appointing authority, and the replacing member shall serve either until the General Assembly and the Governor can appoint a successor or until the replaced member's term expires, whichever is earlier.

The North Carolina Partnership shall establish a policy on membership of the local board, which policy shall include the requirement that all local board members, other than any member appointed because of a position held by that individual, be residents of the county or the partnership region they are representing. No member of the General Assembly shall serve as a member of a local board. Within these requirements for local board membership, the North Carolina Partnership shall allow

local partnerships that are regional to have flexibility in the composition of their boards so that all counties in the region have adequate representation.

All appointed local board members shall avoid conflicts of interests and the appearance of impropriety. Should instances arise when a conflict may be perceived, any individual who may benefit directly or indirectly from the partnership's disbursement of funds shall abstain from participating in any decision or deliberations by the partnership regarding the disbursement of funds.

(2) The North Carolina Partnership and the local partnerships shall agree to adopt procedures for its operations that are comparable to those of Article 33C of Chapter 143 of the General Statutes, the Open Meetings Law, and Chapter 132 of the General Statutes, the Public Records Law, and provide for enforcement by the Department.

(3) The North Carolina Partnership shall oversee the development and implementation of the local demonstration projects as they are selected and shall approve the ongoing plans, programs, and services developed and implemented by the local partnerships and hold the local partnerships accountable for the financial and programmatic integrity of the programs and services. The North Carolina Partnership may contract at the State level to obtain services or resources when the North Carolina Partnership determines it would be more efficient to do so.

In the event that the North Carolina Partnership determines that a local partnership is not fulfilling its mandate to provide programs and services designed to meet the developmental needs of children in order to prepare them to begin school healthy and ready to succeed and is not being accountable for the programmatic and fiscal integrity of its programs and services, the North Carolina Partnership may suspend all funds to the partnership until the partnership demonstrates that these defects are corrected. Further, at its discretion, the North Carolina Partnership may assume the managerial responsibilities for the partnership's programs and services until the North Carolina Partnership determines that it is appropriate to return the programs and services to the local partnership.

(4) The North Carolina Partnership shall develop and implement a comprehensive standard fiscal accountability plan to ensure the fiscal integrity and accountability of State funds appropriated to it and to the local partnerships. The standard fiscal accountability plan shall, at a minimum, include a uniform, standardized system of accounting, internal controls, payroll, fidelity bonding, chart of accounts, and contract management and monitoring. The North Carolina Partnership may contract with outside firms to develop and implement the standard fiscal accountability plan. All local partnerships shall be required to participate in the standard fiscal accountability plan developed and adopted by the North Carolina Partnership pursuant to this subdivision.

(5) The North Carolina Partnership shall develop a ~~centralized~~ regional accounting and contract management system which incorporates features of the required standard fiscal accountability plan described in subdivision (4) of subsection (a) of this section.

All local partnerships shall participate in the regional accounting and contract management system. ~~The following local partnerships shall be required to participate in the centralized accountability system developed by the North Carolina Partnership pursuant to this subdivision:~~

~~a. Local partnerships which have significant deficiencies in their accounting systems, internal controls, and contract management systems, as determined by the North Carolina Partnership based on the annual financial audits of the local partnerships conducted by the Office of the State Auditor; and~~

~~b. Local partnerships which are in the first two years of operation following their selection. At the end of this two-year period, local partnerships shall continue to participate in the centralized accounting and contract management system. With the approval of the North Carolina Partnership, local partnerships may perform accounting and contract management functions at the local level using the standardized and uniform accounting system, internal controls, and contract management systems developed by the North Carolina Partnership.~~

~~Local partnerships which otherwise would not be required to participate in the centralized accounting and contract management system pursuant to this subdivision may voluntarily choose to participate in the system. Participation or nonparticipation shall be for a minimum of two years, unless, in the event of nonparticipation, the North Carolina Partnership determines that any partnership's annual financial audit reveals serious deficiencies in accounting or contract management.~~

(6) The North Carolina Partnership shall develop a formula for allocating direct services funds appropriated for this purpose to local partnerships.

(7) The North Carolina Partnership may adjust its allocations by up to ten percent (10%) on the basis of local partnerships' performance assessments. In determining whether to adjust its allocations to local partnerships, the North Carolina Partnership shall consider whether the local partnerships are meeting the outcome goals and objectives of the North Carolina Partnership and the goals and objectives set forth by the local partnerships in their approved annual program plans.

The North Carolina Partnership may use additional factors to determine whether to adjust the local partnerships' allocations. These additional factors shall be developed with input from the local partnerships and shall be communicated to the local partnerships when the additional factors are selected. These additional factors may include board involvement, family and community outreach, collaboration among public and private service agencies, and family involvement.

On the basis of performance assessments, local partnerships annually shall be rated "superior", "satisfactory", or "needs improvement". ~~Local partnerships rated "superior" shall receive, to the extent that funds are available, a ten percent (10%) increase in their annual funding allocation. Local partnerships rated~~

~~"satisfactory" shall receive their annual funding allocation. Local partnerships rated "needs improvement" shall receive up to ninety percent (90%) of their annual funding allocation.~~

The North Carolina Partnership may contract with outside firms to conduct the performance assessments of local partnerships.

(8) The North Carolina Partnership shall establish a local partnership advisory committee comprised of 15 members. Eight of the members shall be chairs of local partnerships' board of directors, and seven shall be staff of local partnerships. Members shall be chosen by the Chair of the North Carolina Partnership from a pool of candidates nominated by their respective boards of directors. The local partnership advisory committee shall serve in an advisory capacity to the North Carolina Partnership and shall establish a schedule of regular meetings. Members shall be chosen from local partnerships on a rotating basis. The advisory committee shall annually elect a chair from among its members.

(9) The North Carolina Partnership shall report (i) quarterly to the Joint Legislative Commission on Governmental Operations and (ii) to the General Assembly and the Governor on the ongoing progress of all the local partnerships' work, including all details of the use to which the allocations were put, and on the continuing plans of the North Carolina Partnership and of the Department, together with legislative proposals, including proposals to implement the program statewide."

Section 11.28.(b) G.S. 143B-168.13(6) reads as rewritten:

"(6) Annually update its funding ~~formula~~ formula, in collaboration with the North Carolina Partnership for Children, Inc., using the most recent data available. These amounts shall serve as the basis for determining "full funding" amounts for each local partnership."

Section 11.28.(c) G.S. 143B-168.15(b) reads as rewritten:

"(b) Depending on local, regional, or statewide needs, funds may be used to support activities and services that shall be made available and accessible to providers, children, and families on a voluntary basis. Of the funds allocated to local partnerships ~~that are designated by the Secretary~~ for direct services, ~~seventy-five~~ seventy percent ~~(75%)~~ (70%) of the funds spent in each year shall be used ~~for any one or more of the following activities and services:~~

~~(1) Child care services, including:~~

~~a. Child care subsidies to reduce waiting lists;~~

~~b. Raising the county child care subsidy rate to the State market rate, if applicable, in return for improvements in the quality of child care services;~~

~~c. Raising the income eligibility for child care subsidies to seventy-five percent (75%) of the State median family income;~~

~~d. Start-up funding for child care providers;~~

~~e. Assistance to enable child care providers to conform to licensing and building code requirements;~~

~~f. Child care resources and referral services;~~

~~g. Enhancement of the quality of child care provided;~~

~~h. Technical assistance for child care providers;~~

~~i. Quality grants for child care centers or family child care homes;~~

~~j. Expanded services or enhanced rates for children with special needs;~~
~~k. Head Start services;~~
~~l. Development of comprehensive child care services that include child health and family support;~~
~~m. Activities to reduce staff turnover;~~
~~n. Activities to serve children with special needs;~~
~~o. Transportation services related to providing child care services;~~
~~p. Evaluation of plan implementation of child care services; and~~
~~q. Needs and resources assessments for child care services.~~

~~(2) Family- and child-centered services, including early childhood education and child development services, including:~~
~~a. Enhancement of the quality of family- and child-centered services provided;~~
~~b. Technical assistance for family- and child-centered services;~~
~~c. Needs and resource assessments for family- and child-centered services;~~
~~d. Home-centered services; and~~
~~e. Evaluation of plan implementation of family- and child-centered services.~~

~~(3) Other appropriate activities and services for child care providers and for family- and child-centered services, including:~~
~~a. Staff and organizational development, leadership and administrative development, technology assisted education, and long-range planning; and~~
~~b. Procedures to ensure that infants and young children receive needed health, immunization, and related services.~~

in child care related activities and early childhood education programs that improve access to child care and early childhood education services, develop new child care and early childhood education services, and improve the quality of child care and early childhood education services in all settings."

Section 11.28.(d) Effective September 1, 2000, 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 local partnerships shall give priority for the use of these funds to augmenting the State's supplemental subsidy payment rate per child per month for licensed child care centers and homes earning a rated license that exceeds the minimum licensing standards.~~ 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."

Section 11.28.(e) Subsection (c) of Section 11.48 of S.L. 1999-237 is repealed.

Section 11.28.(f) Subsection (h) of Section 11.48 of S.L. 1999-237 is repealed.

Section 11.28.(g) Subsection (i) of Section 11.48 of S.L. 1999-237 reads as rewritten:

"Section 11.48.(i) The North Carolina Partnership for Children, Inc., and all local partnerships shall, in the aggregate, be required to match no less than fifty percent (50%) of the total amount budgeted for the Program in each fiscal year of the biennium as follows: contributions of cash equal to at least ten percent (10%) and in-kind donated resources equal to no more than ten percent (10%) for a total match requirement of twenty percent (20%) for each fiscal year. ~~Any program funding expended for child care subsidies during the previous 12 months is excluded from the match requirement of this subsection.~~ Federal funds, other than TANF Block Grant funds, Social Services Block Grant funds or Child Care and Development Fund Block Grant funds, may be used to meet the match requirement of this subsection notwithstanding the provisions of G.S. 143-6.1. In all other respects, G.S. 143-6.1 still applies. Only in-kind contributions that are ~~quantifiable, as determined in the Smart Start Performance Audit,~~ quantifiable shall be applied to the in-kind match requirement. Volunteer services may be treated as an in-kind contribution for the purpose of the match requirement of this subsection. Volunteer services shall be valued at the higher of the minimum wage rate for hours of service performed or the fair market value of professional services performed by a volunteer. Expenses, including both those paid by cash and in-kind contributions, incurred by other participating non-State entities contracting with the North Carolina Partnership for Children, Inc., or the local partnerships, also may be considered resources available to meet the required private match. In order to qualify to meet the required private match, the expenses shall:

(1) Be verifiable from the contractor's records;
(2) If in-kind, other than volunteer services, be quantifiable in accordance with generally accepted accounting principles for nonprofit organizations;
(3) Not include expenses funded by State funds;
(4) Be supplemental to and not supplant preexisting resources for related program activities;
(5) Be incurred as a direct result of the Early Childhood Initiatives Program and be necessary and reasonable for the proper and efficient accomplishment of the Program's objectives;
(6) Be otherwise allowable under federal or State law;
(7) Be required and described in the contractual agreements approved by the North Carolina Partnership for Children, Inc., or the local partnership; and
(8) Be reported to the North Carolina Partnership for Children, Inc., or the local partnership by the contractor in the same manner as reimbursable expenses.

The North Carolina Partnership for Children, Inc., shall establish uniform guidelines and reporting format for local partnerships to document the qualifying expenses occurring at the contractor level. Local partnerships shall monitor qualifying expenses to ensure they have occurred and meet the requirements prescribed in this subsection.

Failure to obtain a twenty percent (20%) match by ~~May 1~~ June 30 of each fiscal year shall result in a dollar-for-dollar reduction in the appropriation for the Program for ~~the next~~ a subsequent fiscal year. The North Carolina Partnership for Children, Inc., shall be responsible for compiling information on the private cash and in-kind contributions into a report that is submitted to the Joint Legislative Commission on Governmental Operations in a format that allows verification by the Department of Revenue. The same match requirements shall apply to any expansion funds appropriated by the General Assembly."

Section 11.28.(h) Subsection (m) of Section 11.48 of S.L. 1999-237 reads as rewritten:

"Section 11.48.(m) There is allocated from the funds appropriated to the Department of Health and Human Services, Division of Child Development, in this act, the sum of fifty-nine million five hundred thousand dollars ($59,500,000) for the 1999-2000 fiscal year and the sum of ~~seventy-eight million nine hundred twenty-eight thousand eight hundred twenty-six dollars ($78,928,826)~~ one hundred twenty-two million eight hundred seventy-eight thousand seventy-six dollars ($122,878,076) for the 2000-2001 fiscal year to be used as follows:

(1) The sum of fifty-eight million dollars ($58,000,000) in the 1999-2000 fiscal year and the sum of ~~seventy-eight million nine hundred twenty-eight thousand eight hundred twenty-six dollars ($78,928,826)~~ one hundred twenty-one million four hundred thirteen thousand seven hundred twenty-five dollars ($121,413,725) in the 2000-2001 fiscal year shall be used to administer and deliver services in all 100 counties. These funds may be used as financial incentives to encourage regionalization at the local level and to complete development of contracting and accounting systems at the local level. Any funds used to encourage regionalization or to complete development of contracting and accounting systems at the local level shall not be included in computations affecting the administrative cost limitations under subsection (e) of this section.

(2) The North Carolina Partnership for Children, Inc., may use the sum of one million five hundred thousand dollars ($1,500,000) in the 1999-2000 fiscal year and the sum of five hundred thousand dollars ($500,000) in the 2000-2001 fiscal year to assist local partnerships in their efforts to develop local collaboration. It is the intent of the General Assembly that these funds be nonrecurring.

(3) The North Carolina Partnership for Children, Inc., shall receive the sum of nine hundred sixty-four thousand three hundred fifty-one dollars ($964,351) in the 2000-2001 fiscal year for State-level administration of the Program.

The General Assembly requests that the Governor fully fund the Program in the continuation budget for the 2001-2003 fiscal biennium at the level recommended by the Governor in the 1999-2001 fiscal biennium."

Section 11.28.(i) Subsection (n) of Section 11.48 of S.L. 1999-237 reads as rewritten:

"Section 11.48.(n) Of the funds appropriated to the Department of Health and Human Services for the Program for the 1999-2001 biennium, the Frank Porter Graham Child Development Center shall receive the sum of one million fifteen thousand dollars ($1,015,000) in the 1999-2000 fiscal year and the sum of one million ~~fifteen thousand dollars ($1,015,000)~~ sixty-five thousand seven hundred fifty dollars ($1,065,750) in the 2000-2001 fiscal year."

SUBPART 7. DEAF AND HARD OF HEARING SERVICES

CODE NO. 2000DHHS-H11.29 =

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

FAMILY SUPPORT/DIVISION OF SERVICES FOR THE DEAF AND THE HARD OF HEARING SERVICES CONTRACT

Section 11.29. Section 11.50 of S.L. 1999-237 reads as rewritten:

"Section 11.50. Of the funds appropriated in this act to the Division of Services for the Deaf and the Hard of Hearing, Department of Health and Human Services,

for family support services, the sum of five hundred three thousand two hundred thirty-eight dollars ($503,238) for the 1999-2000 fiscal year and the sum of ~~five hundred three~~ seven hundred twenty-three thousand two hundred thirty-eight dollars ~~($503,238)~~ ($723,238) for the 2000-2001 fiscal year shall be used to contract with a private, nonprofit corporation licensed to do business in North Carolina to perform those services, including family support and advocacy services as well as technical assistance to professionals who work with families of hearing-impaired children aged birth to 21 years."

SUBPART 8. PUBLIC HEALTH

CODE NO. 2000DHHS-H11.30 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
MAINTAIN FUNDING FOR DEVELOPMENTAL EVALUATION CENTERS

Section 11.30. The Department of Health and Human Services shall replace any reductions in appropriations for the Developmental Evaluation Centers with Medicaid receipts. The total amount of the Developmental Evaluation Centers program budget shall not be reduced below the amount certified in the 1999-2000 fiscal year program budget.

CODE NO. 2000DHHS-H11.31 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
USE OF NEWBORN SCREENING FEES

Section 11.31.(a) G.S. 130A-125 reads as rewritten:

"§ 130A-125. Screening of newborns for metabolic and other hereditary and congenital disorders.

(a) The Department shall establish and administer a Newborn Screening Program. The program shall include, but shall not be limited to:

(1) Development and distribution of educational materials regarding the availability and benefits of newborn screening.
(2) Provision of laboratory testing.
(3) Development of follow-up protocols to assure early treatment for identified children, and the provision of genetic counseling and support services for the families of identified children.
(4) Provision of necessary dietary treatment products or medications for identified children as medically indicated and when not otherwise available.
(5) For each newborn, provision of physiological screening in each ear for the presence of permanent hearing loss.

(b) The Commission shall adopt rules necessary to implement the Newborn Screening Program. The rules shall include, but shall not be limited to, the conditions for which screening shall be required, provided that screening shall not be required when the parents or the guardian of the infant object to such screening. If the parents or guardian object to the screening, the objection shall be presented in writing to the physician or other person responsible for administering the test, who shall place the written objection in the infant's medical record.

(b1) The Commission for Health Services shall adopt temporary and permanent rules to include newborn hearing screening in the Newborn Screening Program established under this section.

(c) The Department may impose a fee for a laboratory test performed pursuant to this section by the State Public Health Laboratory. A fee for a test must be based on the actual cost of performing the test. Fees collected shall remain in the Department to be used to offset the cost of the Newborn Screening Program. ~~The fees for~~

~~laboratory tests shall be used to supplement and not supplant funds appropriated for the Newborn Screening Program.~~

~~The Newborn Screening Fee Account is established as a nonreverting account within the Department. Fees collected pursuant to this section shall be credited to this Account and shall be applied to the Newborn Screening Program.~~"

Section 11.31.(b) Not later than March 1, 2001, the Department of Health and Human Services shall submit a progress report on the implementation of the newborn hearing screening program to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources, and to the Fiscal Research Division. The report shall include findings and recommendations relating to:

(1) Availability and adequacy of screening and diagnostic equipment;
(2) Staff training;
(3) Data on the number of infants screened, the number who failed the hearing screening, and the number fitted for amplification;
(4) The follow-up process for audiological management;
(5) Referral procedures for child service coordination and other early intervention services; and
(6) Outreach efforts to increase public awareness.

CODE NO. 2000DHHS-H11.32 =
Requested by: Senators Martin of Guilford, Warren, Plyler, Perdue, Odom
HEART DISEASE AND STROKE PREVENTION TASK FORCE REPORT

Section 11.32. Subsection (l) of Section 26.9 of Chapter 507 of the 1995 Session Laws, as amended by Section 15.25 of S.L. 1997-443, and as further amended by Section 11.57 of S.L. 1999-237, reads as rewritten:

"(l) The Task Force shall submit to the Governor and to the General Assembly a preliminary report by January 1, 1996; an interim report within the first week of the convening of the 1997 General Assembly; a second interim report within the first week of the convening of the 1997 General Assembly, Regular Session 1998; a third interim report within the first week of the convening of the 1999 General Assembly, a fourth interim report within the first week of the convening of the 2000 General Assembly; a fifth interim report within the first week of the convening of the 2001 General Assembly, and a final report by June 30, 2001. The reports shall address the Plan, actions and resources needed to fully implement the Plan, and progress in achieving implementation of the Plan to reduce the occurrence of and burden from heart disease and stroke in North Carolina. The reports shall include an accounting of funds expended and anticipated funding needs for full implementation of recommended plans and programs. Not later than October 1, 2000, the Task Force shall submit an additional report on its actual budget and activities for the 1999-2000 fiscal year. The report shall also describe the impact and effectiveness of Task Force activities in the State. The report shall be submitted to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division."

CODE NO. 2000DHHS-H11.33 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
EXTEND OSTEOPOROSIS TASK FORCE

Section 11.33.(a) Subsection (b) of Section 11.58 of S.L. 1999-237 reads as rewritten:

"Section 11.58.(b) The Task Force shall submit a progress report to members of the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Human Resources, the

Governor, and the Fiscal Research Division not later than April 1, 2000. The progress report shall address:

(1) Progress being made in fulfilling the duties of the Task Force and in developing the Osteoporosis Prevention Plan,

(2) The anticipated time frame for completion of the Prevention Plan, and

(3) Recommended strategies or actions to reduce the occurrence of and burdens suffered from osteoporosis by citizens of this State.

The Task Force shall submit its final report to the ~~1999~~ 2001 General Assembly, the Governor, and the Fiscal Research Division not later than October 1, ~~2000.~~ 2001."

Section 11.33.(b) Subsection (m) of Section 1532 of S.L. 1997-443, as amended by subsection (c) of Section 11.58 of S.L. 1999-237, reads as rewritten:

"(m) Upon submission of its final report to the Governor and the ~~1999~~ 2001 General Assembly, ~~Regular Session 2000,~~ the Task Force shall expire."

CODE NO. 2000DHHS-H11.34 =

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

LIMITATIONS ON EXPANSION OF INTENSIVE HOME VISITATION PROGRAM

Section 11.34.(a) The Department of Health and Human Services shall not amend the State Medicaid Plan to provide Medicaid reimbursement for intensive home visiting services.

Section 11.34.(b) The Department of Health and Human Services shall arrange for an independent evaluation of Intensive Home Visitation Program first-year pilot programs that began operation in February, 1998. The evaluation shall review and compare outcomes of the three models that were used in the pilot programs to determine whether the pilot programs are effective in North Carolina.

CODE NO. 2000DHHS-H11.35 =

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

Section 11.35.(a) Subsections (d) and (e) of Section 11.55 of S.L. 1999-237 read as rewritten:

"Section 11.55.(d) The Department shall also develop a comprehensive information management system on AIDS/HIV clients receiving services from the State. The Department may use up to fifty thousand dollars ($50,000) of the funds appropriated under this act to implement this information management system. This information management system shall be patterned after the information management system used by the Elderly Drug Assistance Program, shall provide instantaneous internal access to information, and ~~This system~~ shall include information on the following:

(1) ~~program~~ Program usage patterns of ADAP participants, including, but not limited to, frequency of prescription purchases, ~~and~~ types of medications ~~prescribed.~~ prescribed, and the cost of prescribed medications on a monthly basis.

(2) Demographics of participants in the program, including the age, gender, race, ethnicity, and county of residence of participants.

The Department shall also develop a plan for promoting patient adherence to physician treatment recommendations. In developing the plan, the Department shall identify ways of obtaining information without interfering with physician-patient confidentiality. The Department shall report on this plan to the members of the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division not later than May 15, 2000.

Section 11.55.(e) For the 1999-2000 fiscal ~~year,~~ year and for the 2000-2001 fiscal year, HIV-positive individuals with incomes at or below one hundred twenty-five percent (125%) of the federal poverty level are eligible for participation in ADAP. Notwithstanding any other provision of law, eligibility for participation in ADAP during the 1999-2000 fiscal year shall not be extended to individuals with incomes above one hundred twenty-five percent (125%) of the federal poverty level. Eligibility for participation in ADAP during the 2000-2001 fiscal year may be extended to individuals with incomes up to one hundred fifty percent (150%) of the federal poverty level only after the Office of State Budget and Management certifies in writing that the Department has developed an information management system pursuant to subsection (d) of this section. Until the Office of State Budget and Management makes this certification, eligibility for participation in ADAP during the 2000-2001 fiscal year shall not be extended to individuals with incomes above one hundred twenty-five percent (125%) of the federal poverty level. All individuals who are eligible for participation in ADAP shall be served by the Department of Health and Human Services. If sufficient funds are not available from funds allocated to ADAP, the Department of Health and Human Services shall transfer available funds from other programs within the Department to meet the funding needs of ADAP."

Section 11.35.(b) The Department of Health and Human Services shall make an interim report by October 1, 2000, and a final report by April 1, 2001, to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division on ADAP. The reports shall include the following:

(1) Monthly data on total cumulative AIDS/HIV cases reported in North Carolina.
(2) Monthly data on the estimated number of individuals eligible to participate in ADAP and the actual number of participants in ADAP.
(3) Monthly data on the number of individuals who have applied to participate in ADAP that have been determined to be ineligible.
(4) Monthly data on the income level of participants in ADAP and of individuals who have applied to participate in ADAP that have been determined to be ineligible.
(5) Monthly data on fiscal-year-to-date expenditures of ADAP. The interim report shall contain monthly data on the calendar-year-to-date expenditures of ADAP.
(6) Monthly data on the actual line-item budget of ADAP.
(7) Monthly data on funding sources of ADAP expenditures.
(8) Monthly data on ADAP funds that are applied to a Medicaid spend-down.
(9) An update on the status of the information management system.
(10) Monthly data on ADAP usage patterns and demographics of participants in ADAP.
(11) Estimated participation rates and costs if eligibility for participation in ADAP were raised to one hundred seventy-five percent (175%) of the federal poverty level or to two hundred percent (200%) of the federal poverty level.

CODE NO. 2000DHHS-H11.36 =

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

COMMUNICABLE DISEASE CONTROL AID TO COUNTIES/REPORT

Section 11.36. Not later than October 1, 2000, the Department of Health and Human Services shall report the impact of combining and allocating funds

appropriated for the 1999-2000 fiscal year for Aid to Counties in the Acute Communicable Disease Control Fund, the Tuberculosis Control Fund, and the Sexually Transmitted Disease Control Fund into one Acute Communicable Disease Control Aid to Counties Grant. The report shall include the impact of expenditures by county on the individual communicable disease groups. The Department shall submit the report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division of the Legislative Services Office.

CODE NO. 2000DHHS-S11.37
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
PUBLIC HEALTH PREVENTION ACTIVITIES REPORT

Section 11.37.(a) By October 1, 2000, and more frequently as requested, the Department of Health and Human Services, Division of Public Health, shall report on the activities of each of the following:

(1) Kenneth C. Royall, Jr. Children's Vision Screening Improvement Program;
(2) North Carolina Healthy Start Foundation; and
(3) Adolescent Pregnancy Prevention Coalition of North Carolina.

Section 11.37.(b) The report shall include the following for the 1999-2000 fiscal year:

a. A description of all program activities of the organization;
b. Provide a list of activities that were funded by contracts through the State and the amounts, including a program narrative, for fiscal year 1999-2000;
c. Output data demonstrating the effects of the organization's activities; and
d. Planned budget, objectives, and activities for the 2000-2001 fiscal year.

The Department shall submit the report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division of the Legislative Services Office.

CODE NO. 2000DHHS-H11.38 =
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
PREVENTIVE HEALTH PROGRAM PLAN

Section 11.38. The Department of Health and Human Services shall work with the Fiscal Research Division of the Legislative Services Office to do the following:

(1) Conduct a full inventory on all prevention activities including task forces and committees that receive administrative funding;
(2) Identify linkages among program activities, such as activities involving education and awareness, and those involving services;
(3) Identify all administrative costs and funding sources and number of positions associated with various prevention activities;
(4) Develop an alternative organizational structure that could more effectively and efficiently administer preventive health activities.

Not later than February 1, 2001, the Department shall submit the report required under this section to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division.

CODE NO. 2000DHHS-H =
Requested by: Senators Martin of Guilford, Purcell, Plyler, Perdue, Odom
PRESCRIPTION DRUG ASSISTANCE PROGRAM

Section 11.39. Section 11.1.(a) of S.L. 1999-237 reads as rewritten:

"Section 11.1.(a) Of the funds appropriated in this act to the Department of Health and Human Services, the sum of five hundred thousand dollars ($500,000) for the 1999-2000 fiscal year and the sum of ~~five hundred thousand~~ one million dollars ~~($500,000)~~ ($1,000,000) for the 2000-2001 fiscal year shall be used to pay the cost of outpatient prescription drugs for persons:

(1) Over the age of 65 years and not eligible for full Medicaid benefits;
(2) Whose income is not more than one hundred fifty percent (150%) of the federal poverty level; and
(3) Who have been diagnosed with cardiovascular disease or diabetes.

These funds shall be used to pay the cost of outpatient prescription drugs for the treatment of cardiovascular disease or diabetes. Payment shall be not more than the Medicaid cost including rebates. The Department shall develop criteria to maximize the efficient and effective distribution of these drugs."

CODE NO. 2000DHHS-S010
Requested by: Senators Martin of Guilford, Purcell, Plyler, Perdue, Odom
LEGISLATIVE STUDY ON PRESCRIPTION DRUG ASSISTANCE FOR ELDERLY AND DISABLED PERSONS

Section 11.39A. (a) There is established the Legislative Study Commission on Prescription Drug Assistance for Elderly and Disabled Persons. The Commission shall have twelve members, four members of the Senate appointed by the President Pro Tempore of the Senate, four members of the House of Representatives appointed by the Speaker of the House of Representatives, and four members appointed by the Governor.

Section 11.39A. (b) The purpose of the study is to determine the feasibility of assisting all elderly and disabled residents of North Carolina who need assistance with the purchase of prescription drugs because of lack of government sponsored or private health insurance coverage for prescription drugs. The study shall include the following:

(1) A review of the Department of Health and Human Services "Report on Proposal for a Prescription Drug Assistance Program for Low-Income Elderly and Disabled." Because of the high cost of prescription drugs and the critical need for these drugs to maintain or improve health status, it is also important to assist elderly and disabled persons of a higher income bracket who have no health insurance coverage for prescription drugs.
(2) Feasibility of tax credits for the purchase of prescription drugs or for the purchase of health insurance coverage for prescription drugs.
(3) Feasibility of catastrophic or stop-loss insurance coverage for prescription drugs.
(4) Review of other State proposals to address this problem such as The Heinz Plan of Massachusetts.
(5) Review of the use of drug rebates or other types of discounts.
(6) Consider possible interaction between various state proposals and federal actions and proposals.
(7) Other activities as determined by the Commission.

Section 11.39A. (c) The Commission may contract for actuarial services to develop cost estimates for various proposals considered by the Commission. The Commission may receive funds from other sources to carry out its study.

Section 11.39A.(c) Members of the Committee receive subsistence and travel expenses as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Supervisors of Clerks of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee."

Section 11.39A.(d) A quorum of the Committee is six members. No action may be taken except by a majority vote at a meeting at which a quorum is present. While in the discharge of its official duties, the Committee has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4.

Section 11.39A.(e) Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year, except the terms of the initial members, which begin on appointment and end on the day of the convening of the 2001 General Assembly. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

A member continues to serve until the member's successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

Section 11.39A.(f) The Committee shall make an interim report to the 2001 General Assembly on January 1, 2001 and May 1, 2002, and shall make its final report to the 2003 General Assembly upon its convening. Upon making its final report, the Committee shall expire.

CODE NO. 2000DHHS-S11.40A

Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom

ADOLESCENT PREGNANCY PREVENTION PROGRAM CHANGES

Section 11.40.(a) G.S. 130A-131.15 reads as rewritten:

"**§ 130A-131.15. Department to establish program.**

~~(a)~~ The Department shall establish and administer a program to distribute funds appropriated for adolescent pregnancy prevention projects.

~~(b) The Commission shall adopt rules necessary to implement the program.~~

~~(c) The Department shall evaluate all of the adolescent pregnancy prevention projects funded as a result of this program at least yearly and shall report its findings to the Commission for Health Services, the Joint Legislative Commission on Governmental Operations, and the Chairmen of the House Appropriations Subcommittee on Health and Human Services, and the Senate Appropriations Committee on Health and Human Services by April 1 of each year. The evaluation shall be conducted by a firm or individual external to the Department. Any evaluation of these projects shall include a study of the effectiveness of the project in reducing the pregnancy rate within the target population.~~

~~(d) The Commission shall be responsible for monitoring the Department's administration of the Adolescent Pregnancy Prevention Program. The Department shall manage and fund the Adolescent Pregnancy Prevention Program projects as follows:~~

~~(1) Applications. Any local agency or organization or combination of agencies and organizations may apply to the Department for an~~

~~allocation of money to operate a project aimed at preventing adolescent pregnancy. The application shall contain an analysis of the adolescent pregnancy and related problems in the locality the project would serve, and a description of how the project would attempt, over a period of at least five years, to prevent the problems. The application shall state how much money is needed to operate the project and how the money shall be spent. The Department shall conduct annually a proposal-writing session that shall be attended by a representative of any project that wishes to apply for funding; that session shall define the criteria for accountability and evaluation that the Department requires of projects. That session shall also provide information about additional funding sources to which projects might turn to satisfy the matching requirements of subdivision (5) of this subsection.~~

~~(2) Proposal Requirements. The Department shall apply the following minimum standards to projects applying for first-year funding:~~

~~a. Each project shall have a plan of action that extends for at least five years for prevention of adolescent pregnancy.~~

~~b. Each project shall have realistic, specific, and measurable goals and objectives for the prevention of adolescent pregnancy.~~

~~c. Each project, before submitting its proposal, shall send a representative to the proposal-writing session held by the Department.~~

~~(3) Operating Standards. The Department shall apply the following minimum operating standards:~~

~~a. Each project shall have a Board of Advisors composed of members from outside the sponsoring agency of the project. The Board of Advisors shall include representatives from at least four of the following: media, government, charitable organizations, private business, and medical institutions. The Boards of Advisors shall meet at least quarterly and advise project staff on project policies and operations.~~

~~b. Each project shall comply with reporting, contracting, and evaluation requirements of the Department.~~

~~c. Each project shall define and maintain cooperative ties with other community institutions.~~

~~d. Each project shall demonstrate its ability to attract financial support from sources other than the State, including sources in the local community.~~

~~(4) Criteria for Project Selection. For first-year funding, the Department shall choose from among the applicants that meet the minimum standards in subdivision (2) of this subsection the best selection of projects according to the following criteria:~~

~~a. Adequacy of proposed staff to meet project objectives;~~

~~b. Appropriateness of project strategies to reduce adolescent pregnancy;~~

~~c. Level of community support, including endorsement from the appropriate local government entity and documentation from the appropriate local government entity and from community organizations that opportunity has been given for citizen input into the proposed program, and that there is community support for the proposal. Documentation may~~

~~include letters or statements of support from citizens or community organizations, or statements that community support was expressed at public hearings. A public hearing is not required by this paragraph;~~

~~d. Degree of need of the locality, including that the county has a significant adolescent pregnancy problem as evidenced by its attributable risk score developed by the State Center for Health and Environmental Statistics; and~~

~~e. Other appropriate criteria.~~

~~The Department shall make its recommendations for funding to the Commission. The Commission shall make the final determination of which projects are to be funded. The Commission shall consider the recommendations of the Department but shall not be bound by them. The Commission shall notify the projects that are to be funded by June 1 of each year.~~

~~(5) Schedule of Funding. If the Commission, upon consultation with the Department, finds that a project it has chosen for first-year funding continues to meet the operating standards of subdivisions (2) and (3) of this subsection, funding for that project shall continue, to the extent of available money, for an additional four years. The level of funding provided by the Department to approved projects shall be set according to the following schedule:~~

~~a. First year, eighty percent (80%) of the project's annual budget not to exceed the maximum award established by the Commission for Health Services;~~

~~b. Second year, ninety percent (90%) of the State appropriations or federal block grant funds awarded in the first year;~~

~~c. Third year, seventy-five percent (75%) of the State appropriations or federal block grant funds awarded in the first year;~~

~~d. Fourth year, sixty-five percent (65%) of the State appropriations or federal block grant funds awarded in the first year; and~~

~~e. Fifth year, fifty percent (50%) of the State appropriations or federal block grant funds awarded in the first year.~~

~~The portion of a project's budget that must come from sources other than State or federal block grant funds may be provided as in-kind contributions as well as cash.~~

~~(6) Five-Year Limit on Funding. No project shall receive State funding if it has previously received State funding for five full years. Any project that has received State funding before July 1, 1990, will be eligible for consideration for an additional five years' State support, according to the schedule. The Commission may fund any such project that meets the minimum standards if it determines, after considering the experience and impact of the project and measuring its application against those of other applicants, that it should be funded.~~

~~(7) Maximum Level of Funding. The Commission for Health Services shall by rule determine the maximum annual amount that may be made to any one project.~~

~~(8) As adolescent pregnancy prevention project grant funds decrease, a project shall maintain its original budget level, less the amount~~

~~expended for start-up costs. The Department shall develop guidelines for determining start-up costs, which guidelines shall be uniform for all projects. Local match percentage may come from any in-kind source or newly generated funds, public or private, available to the project.~~"

(b) The Department of Health and Human Services, Division of Public Health, in collaboration with local program administrators, shall adopt guidelines for the administration of funds for teen pregnancy prevention and for parenting programs. The guidelines shall include the following programmatic requirements:

(1) Council development at the local level is encouraged but not required for program funding. Councils that received first-year funding for the 1999-2000 fiscal year for administrative expenses for coalition building and partnership development shall receive funds committed for the second year of organizational development. The Division shall encourage programs that receive funding under this section to involve other health service organizations, nonprofit organizations, and task forces in program efforts.

(2) In awarding grants, the Department shall target counties with the highest teen pregnancy rates, increasingly higher teen pregnancy rates, or high rates within demographic sub-groups, and greatest need for parenting programs. Grants may be renewed annually based on program efficiency and effectiveness, teen pregnancy rates, and the level of need for parenting programs. Grants shall be funded at a particular level and shall not be funded on a multi-year cycle with annually decreasing grant funding. All organizations receiving funding prior to June 30, 2000 shall continue to receive their five-year commitment of funding as contracted with the Department.

(3) The Division shall encourage all programs to implement best practice models. While best practice models are encouraged, the Department may fund innovative and promising projects that have not yet been recognized as best practice. All existing programs not using best practice models shall be encouraged to transition to the use of best practice models.

(4) Programs are not required to provide a cash match for these funds, however, the Department may require an in-kind match.

Funds for State-level administrative expenses of the Program shall not exceed ten percent (10%) of the total budget for teen pregnancy prevention and parenting programs. Administrative expenses include staffing and contracted services for evaluation and coalition-building activities.

The Department shall contract with an independent private consulting firm to evaluate the programs. The evaluation shall include standard data collection utilizing the mechanism that has been developed by the University of North Carolina at Chapel Hill, School of Social Work, and shall be conducted in a manner that objectively measures the effectiveness of each program evaluated.

The Department shall report annually on March 1, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Human Resources, and the Fiscal Research Division. The report shall include information on all of the following for each teen pregnancy prevention and parenting program:

(1) The program budget delineating all administrative expenses, contracts for services, and technical assistance.

(2) A narrative describing each project funded and the amount of funds received by the project.
(3) Effectiveness of the program in reducing teen pregnancy or developing responsible parenting skills in young adults, as applicable.
(4) Status of the evaluation."

CODE NO. 2000DHHS-S004
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
DEPARTMENTAL STUDY OF DENTAL PUBLIC HEALTH SERVICES

Section 11.41. The Department of Health and Human Services shall study the feasibility of providing dental public health services to Medicaid recipients. The study shall include:

(1) Identification of other states that are currently providing dental public services and a narrative of the service structure and costs;
(2) Start-up costs associated with setting up dental public health offices in North Carolina;
(3) Operational costs to Medicaid;
(4) Feasibility of incorporating private-pay services with Medicaid services;
(5) Projected number of individuals who would receive services through the dental public health plan; and
(6) Long-term impact of dental public health services.

Not later than January 1, 2001, the Department shall report its findings and recommendations to the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division.

CODE NO. 2000DHHS-S001
Requested by: Senators Martin of Guilford, Purcell, Plyler, Perdue, Odom
FUNDS FOR PREVENTION OF BIRTH DEFECTS AND REDUCTION IN INFANT MORTALITY

Section 11.42. Of the funds appropriated in this act to the Department of Health and Human Services, Division of Public Health, the sum of one hundred fifty thousand dollars ($150,000) shall be used for public awareness activities on the prevention of birth defects and infant mortality reduction. This initiative will include informing women about the importance of folate consumption as an effective means of preventing neural tube birth defects. The campaign shall be targeted at women of child-bearing age and may include a media campaign, creation of literature for dissemination at public health departments and physicians' offices, and workshops.

CODE NO. 2000DHHS-S011
Requested by: Senators Martin of Guilford, Plyler, Perdue, Odom
FUNDS FOR MEDICAID COVERAGE OF FAMILY PLANNING SERVICES

Section 11.42A. Of the funds appropriated in this act to the Department of Health and Human Services, the sum of four hundred sixty-nine thousand dollars ($469,000) for the 2000-2001 fiscal year shall be used to provide the State match for a Medicaid waiver to provide Medicaid coverage for family planning services to men and women of child-bearing age whose family income is equal to or less than one hundred eighty-five percent (185%) of the federal poverty level. Funding may include funding for two staff positions and their related support. The expenditure of funds under this section is contingent upon approval of the waiver by the Health

Care Financing Administration. Funds shall not be expended earlier than January 1, 2001.

SENATE APPROPRIATIONS COMMITTEE
ON
HUMAN RESOURCES

BUDGET

JUNE 20, 2000

Health and Human Services

GENERAL FUND

	FY 00-01
Total Budget Approved 1999 Session	$3,014,095,636

Budget Changes

(1.0) Division of Mental Health

1 Reduce Operating Reserve — ($571,526) NR

Reduces the operating reserve (on a non-recurring basis) for a new neurobehavioral unit to be created within the Black Mountain Center. Allows the unit to open during FY01/02.

(2.0) Division of Social Services

2 Reduce Excess Adoption Assistance Funds — ($2,300,000) R

Reduces excess adoption assistance funds and allows for the enhancement of adoptions activities.

(3.0) Division of Medical Assistance

3 Transfer Medicaid Reserve Funds — ($70,000,000) NR

Transfers funds from G.S. 143-23.2 reserve to support current services and to reduce appropriations.

4 Adjust Medicaid Funding — ($32,388,631) R

Reduces appropriations to reflect current projections for the Medicaid Program.

5 Reduce Administrative Funding — ($127,000) R

Reduces program funding to support positions required by federal and state mandates.

6 Increase Medicaid Drug Rebate Receipts — ($12,146,498) R

Increases receipts from the Drug Rebate Program to reflect increased expenditures for prescription drugs.

(4.0) Office of the Secretary

7 Eliminate Position — $0 R

Eliminates the Health Care Access Coordinator position funded with TANF block grant funds. -1.00

8 Increase Receipts — ($13,120,000) NR

Reduces appropriations in anticipation of increased receipts for prior year earned revenue.

9 Increase Receipts — ($3,000,000) R

Reduces appropriations in anticipation of increased receipts across the department.

10 **Eliminate 29 Vacant Positions** ($2,100,000) R
Eliminates 29 vacant positions across the department except for specific state institutions. -29.00

(5.0) Division of Child Development

11 **Reduce Smart Start Funds**
Provides a one-time reduction in Smart Start funding due to lower than anticipated program expenditures. ($49,000,000) NR

(6.0) Division of Vocational Rehabilitation

12 **Eliminate Operating Reserve for TBI Unit** ($956,328) R
Eliminates the operating reserve for the Traumatic Brain Injury (TBI) Unit in Goldsboro since the required capital funding was re-directed to support the Hurricane Floyd recovery effort. -48.00

(7.0) Division of Public Health

13 **Reduce Funding to Family Planning** ($45,000) R
Reduces appropriations for family planning services to provide the state match for a Medicaid waiver for the provision of family planning services. ($424,000) NR

14 **Reduce Funding to Forensic Test for Alcohol Pgm.** ($964,871) R
Reduces appropriations and allows the fees collected to be budgeted to support the functions in the Forensic Test for Alcohol Program.

15 **Reduce Funding to Public Health Laboratory** ($220,000) R
Decreases appropriations by the amount of increased Medicaid receipts to offset the cost of Laboratory operations.

16 **Reduce Funding to AIDS Drug Assistance Program** ($2,000,000) R
Decreases appropriations for the AIDS Drug Assistance Program by $2,000,000 due to increased federal funds. Also, decreases appropriations by $3,000,000 due to under-utilization of the program. ($3,000,000) NR

17 **Reduce Funding to Developmental Evaluation Centers** ($1,000,000) R
Reduces appropriations to the Developmental Evaluation Centers due to increased Medicaid receipts.

18 **Reduce Funding to Medical Examiner's Office** ($100,000) R
Reduces appropriations by the amount of the increase in Medical Examiner's Fees in 1999.

(8.0) Division of Mental Health

19 **Services for Violent and Assaultive Children**
Provides funds to continue current mental health service levels for violent and assaultive children. $4,353,000 NR

20 Early Intervention System Pilots — $250,000 NR

Provides additional funds to support the integrated client database and regional transdisciplinary team pilots for young children receiving early intervention services.

21 Mental Health System Reform Reserve — $3,000,000 NR

Establishes a Mental Health System Reform Reserve in order to comply with the Olmstead Supreme Court decision regarding de-institutionalization of individuals with mental health disabilities. Also, provides funds for the anticipated reform of the public mental health system.

22 Housing Support for the Mentally Ill — $301,000 NR

Provides matching funds to draw down federal funds for the support of an additional 38 housing placements for the mentally ill.

23 Funds for Autistic Adults — $250,000 R

Provides funds to the N.C. Autism Society for additional services to adults with autism.

24 Substance Abuse Services Positions — $0 R

4.00

Adds four (4) positions to the Substance Abuse Services Section to support the (1) Employee Assistance Program, (2) Offender Management Program, (3) Quality assurance services for DWI offenders, and (4) Development of housing and other 24-hour services. The positions are offset by the Substance Abuse Prevention and Treatment Block Grant.

25 Community Mental Health Programs — $4,000,000 R

Provides funds for area mental health programs as follows:

Substance Abuse Services	$2,000,000
Developmental Disabilities	$2,000,000

26 Child Residential Treatment/Services Program — $8,000,000 R

6.00

Establishes a child mental health residential treatment/services program in order to provide appropriate residential treatment alternatives for children at risk of institutionalization or other out-of-home placement. Also, provides for the creation of six (6) new positions: Division of Mental Health, Developmental Disabilities & Substance Abuse Services 3.0; Controller's Office 1.0 and Division of Social Services 2.0.

27 Atypical Antipsychotic Medications — $1,500,000 R

Provides additional funds for atypical antipsychotic medications as follows:

(1)	State DHHS facilities	$750,000
(2)	Area mental health programs	$750,000

28 Autistic Child & Adolescent Units at Murdoch — $1,200,000 R

65.00

Provides start up and operational funds to establish residential services for autistic children and adolescents within and on the grounds of the Murdoch Mental Retardation Center located at Butner.

29 **Area Mental Health Board Training** — $150,000 NR

Provides funds to train area mental health programs' board members. (This appropriation was included in HB 168 during the 1999 Session but was diverted for flood relief.)

(9.0) Division of Social Services

30 **Special Children Adoption Incentives Fund** — $500,000 R

Establishes a fund to provide financial incentives for foster care families desiring to adopt special needs children residing in their care.

31 **State/County Special Assistance** — $4,450,000 R

Increases monthly State/County Special Assistance payment from $982 to $1,062. Effective October 1, 2000.

32 **Food Banks** — $1,000,000 NR

Provides funds to be equally distributed to the regional network of food banks in North Carolina.

33 **Foster Care Independent Living Matching Funds** — $500,000 R

1.00

Provides the match for federal Independent Living Program funds in order to prepare children for the transition from foster care to independence. Also, provides for the addition of one position to coordinate the program.

34 **Special Children Adoption Fund** — $1,100,000 R

Increases the Special Children Adoption Fund which provides financial incentives to local departments of social services and private non-profit adoption placement programs for the placement of children in foster care. Also, provides post-adoption support funds to ensure placements are successful.

35 **Administrative Support** — $0 R

10.00

Provides for the addition of ten (10) positions within the Division of Social Services to enhance and support the Work First Program; coordinate expanded after school programs for at-risk children; and child welfare training. These positions are totally offset with TANF block grant funds.

36 **Adoptions Program** — $200,000 R

3.00

Provides additional staff and related funds to address the backlog in processing adoptions information.

(10.0) Division of Public Health

37 **Prevention of Birth Defects** — $150,000 NR

Provides funding for education and awareness activities on the importance of folate consumption preceding pregnancy to effectively prevent neural tube birth defects and infant mortality.

38 **Office of Minority Health** — $200,000 NR

Provides funding to support mini-grants for coalition-building at the local level. Provides funding for minority infant mortality reduction efforts.

39	**Healthy Carolinians** Provides funding for Healthy Carolinians' task forces throughout the state.	$1,000,000	NR
40	**Osteoporosis Task Force** Provides funding to continue support for the Osteoporosis Task Force.	$150,000	NR
41	**Heart Disease and Stroke Prevention** Provides funding to the Heart Disease and Stroke Prevention Task Force for implementation of the NC Plan to Prevent Heart Disease and Stroke.	$100,000	NR
42	**Arthritis Prevention Project** Provides grant-in-aid for a private, local project providing services for arthritis patients in Mecklenburg County.	$25,000	NR
43	**Alice Aycock Poe Center for Health Education** Provides grant-in-aid to the Alice Aycock Poe Center for Health Education.	$200,000	NR
44	**Prescription Drug Assistance Program** Provides increased funding for the Prescription Drug Assistance Program for persons over age 65.	$500,000	NR
45	**Healthy Start Foundation** Funds the statewide public information and education activities of the First Step campaign. Provides mini-grants for local communities to implement pilot programs aimed at reducing infant mortality.	$1,000,000	NR
46	**Birth Defects Monitoring Program** Provides funding to initiate the development of a birth defects registry.	$200,000 4.00	R
47	**Hepatitis C Education Awareness** Provides funding for Hepatitis C education and awareness activities.	$150,000	NR
48	**Asthma Education** Provides funding to support asthma management, control, surveillance, and education.	$250,000	NR
49	**State Games** Supports the State Games of North Carolina to promote health and fitness.	$200,000	NR

(11.0) Division of Child Development

50	**T.E.A.C.H. Program** Provides funding to expand the Teacher Education and Compensation Helps (T.E.A.C.H.) Program which assists child care teachers in pursuing higher education in the field of early childhood.	$400,000	R

51 Smart Start Program — $43,500,000 R / $500,000 NR

Provides additional funding for direct services statewide, state-level administration, program evaluation, and county collaboration efforts.

52 Child Care Subsidy Program — $0 R / 68.00

Authorizes 68 positions in recognition of the significantly increased demand on licensing and monitoring staff due to the growth in regulated child care centers/homes and the implementation of the rated license system. These positions are funded with federal Child Care and Development Fund quality set-aside funding.

(12.0) Div. of Serv. for Deaf/Hard of Hearing

53 Individual Education Plan (IEP) Services — $600,000 NR

Provides additional funding for contractual services required by students' IEPs at the residential schools for the deaf.

54 Teacher Mentor Pay — $56,250 NR

Provides funding to compensate experienced teachers at the schools for the deaf who serve as mentors for new teachers.

55 Day Student Transportation — $375,000 NR

Provides funding for transporting deaf and hard of hearing day students to programs at the Division's three residential campuses.

56 Family Support Services — $220,000 R

Expands support services to families with deaf and hard of hearing children as a result of increased demand from the newborn hearing screening program.

(13.0) Division of Services for the Blind

57 Individual Education Plan (IEP) Services — $200,000 NR

Provides additional funding for contractual services required by students' IEPs at the Governor Morehead School.

58 Teacher Mentor Pay — $18,750 NR

Provides funding to compensate experienced teachers at the Governor Morehead School who serve as mentors for new teachers.

59 Services for Deaf/Blind Children — $225,000 R / 5.00

Provides funding to establish a specialized program for deaf/blind children at the Governor Morehead School, including expansion of NC Central University's master's degree program in visual impairment to include intervenor training.

60 Vocational Rehabilitation Case Services Funds — $235,000 NR

Provides additional funds to offset the increased tuition costs for visually-impaired vocational rehabilitation clients attending in-state universities.

61 Day Student Transportation
Provides funding for transporting visually-impaired day students to programs at the Governor Morehead School campus.
$125,000 NR

(14.0) Division of Vocational Rehabilitation

62 Client Information System
Completes development and implementation of an automated client information system.
$1,700,000 NR

63 Case Services Funds
Provides additional funds to offset the increased tuition costs of clients attending in-state universities.
$615,000 NR

64 Independent Living Rehabilitation Program
Provides additional funding to address client needs statewide and continue technical assistance to the housing industry on design requirements for multifamily housing for disabled individuals.
$2,000,000 R
$2,000,000 NR

(15.0) Division of Medical Assistance

65 Family Planning Waiver
Provides funding for the state match for a Medicaid waiver to provide Medicaid coverage for family planning services to men and women of child bearing ages with family incomes equal to or less than 185% of the federal poverty level. Effective January 1, 2001.
$45,000 R
$424,000 NR
2.00

66 Medicaid Positions
Provides funding to support three positions to meet federal HIPAA requirements and one position to meet increased demands from provider enrollment.
$127,000 R
4.00

67 Additional CAP-MR/DD Slots
Funds 600 CAP-MR/DD slots in the Medicaid Program.
$6,890,000 R

(16.0) Office of the Secretary

68 Child Advocacy Institute
Provides funding for the continuation of the Child Advocacy Institute's activities to collect and publish the annual report on the status of children in North Carolina.
$250,000 NR

69 North Carolina Council on the Holocaust
Provides funds for Holocaust education in the public schools.
$50,000 NR

70 Latin American Resource Center
Provides grant-in-aid to the Latin American Resource Center (LARC) for administration and outreach operations relative to its programs, including DIALOGO.
$75,000 NR

71 "Closing the Achievement Gap" Pilot Program Provides funds to establish a pilot program to assist children and families in order to enhance school performance and family functioning.	$250,000	NR
(17.0) Division of Facility Services		
72 Statewide Poison Control Center Provides funding for the Statewide Poison Control Center at Carolinas Medical Center.	$1,000,000	R
73 Adult Care Home Inspectors Provides additional inspectors to implement requirements of Senate Bill 10.	$149,000 6.00	R
74 Nurse Aide Online Training Provides funding for the State Board of Community Colleges for the development and implementation of on-site internet training or other innovative training programs designed to improve recruitment and reduce turnover of certified nursing assistants in nursing facilities.	$500,000	NR
(18.0) Division of Aging		
75 Adult Day Care Start-up Grants Provides funding for up to 10 start-up grants for new Adult Day Care Programs.	$250,000	NR
Budget Changes	**$19,107,672**	R
	($114,912,526)	NR
Total Position Changes	100.00	
Revised Total Budget	**$2,918,290,782**	

Name of Committee: SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 20, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Leah Devlin	DHHS
Irwin Pyon	DHHS
[signature]	Wake Co H.S. Services
Joni Alberg	BEGINNINGS For Parents of Children Who Are Deaf or Hard of Hearing
Wayne Williams	OSBM
Mary Green	OSBM
Karen Bottoni	Div of Aging DHHS
[illegible]	[illegible]
Stephen Daniels	NCFPC
Bryant Edgerton	Easter Seals NC
R. Harbour Partesotti	Div. of Aging DHHS

Name of Committee: SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 20, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
STAN SLAWINSKI	DO SECTION
Charles Nemo	DMHDDSAS
	DMH DDSAS
Christine O Heinbergs	Carolina Legal Assistance
John Bowdish	Alley Associates
A Dennis McBride	DHHS
Stephen G. Sherman	HIV/STD - Div of Pub Health - DHHS
JoAnn Lamm	DHHS/DSS
Sharon Hirsch	NC Social Services Consortium
Ken Foote	OJJ
Chuck Harris	DHHS - DSS

Name of Committee: SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 20, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jack McCaff	Mayor of Dimes
C.L. Cochran	UCPNC C-2001
Lynda McDaniel	DHHS / DFS
Lou Wilson	NCALTCF
Hugh Tilson	NCHA
Jack Schanzenbach	NC Council
CP Medlin	NC Equity
Barbara Solow	Independent newsweekly
Helen Wolstenholme	Div MH/ID/SAS.
Pete Martin	"
Edwin Staton	General Assembly

VISITOR REGISTRATION SHEET

Health & Human Service — 6-20-00

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Stephanie Faugel	DHHS - DCD
Janice Freedman	N.C. Healthy Start Foundation
Don Willis	DMHDDSAS
Bon Dessoe	NCPA UAB
John Tate	MHA/NC - C2001
[illegible]	Arc/NC
Roz Sawitt	NC Child Care Coalition
Myra Mile	NASW-N
Martha Lawrence	YAFO
S Ransome	DSS
Nancy Wilson	DSS
Pheon Beale	DSS
Helen Lipman	Meck Co.
[illegible]	Covenant w/ NC's children
Bennie Holleman	DHHS

Name of Committee: SENATE APPROPRIATIONS SUBCOMMITTEE ON HUMAN RESOURCES

June 20, 2000

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Patrice Roesler	NCACC
DAVE BRUTON	DHHS
Jim Edgerton	DHHS
[illegible]	OSBM
Fay Ogan	DHHS
Peter Leonis	DHHS
NELS ROSELAND	OSBM
[illegible]	DHHS - DMA
P. Perruzzi	DHHS - DMA
Michelle Cotton	DMH DD LSAS
by Avent - Farmer	DHHS - dcd

VISITOR REGISTRATION SHEET

Name of Committee

Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Bob Hedrick	CNC
[signature] Jeff	AHHC
Joann Schoen	NC nurses Assoc.
Adam Levine	NCHAC
Beth Reynolds	Coop Institute on Aging and SJA