2015

HOUSE APPROPRIATIONS – HEALTH & HUMAN SERVICES

MINUTES

Joint Committee on Appropriations, Health and Human Services
Tuesday, February 10, 2015 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The first meeting of the Joint Committees on Appropriations, Health and Human Services started at 8:30 AM on February 10, 2015 in Room 643 of the Legislative Office Building.
Representative Marilyn Avila chaired the meeting.
Representatives Brisson, Dobson, Malone, Pendleton, Insko, Farmer-Butterfield attended.
Seven members of the Senate attended.

Chairman Avila welcomed everyone.
She thanked the Sergeants At Arms and welcomed the Pages.
House Sergeants at Arms were Reggie Sills, Marvin Lee, Rey Cooke and Terry McCraw.
Senate Sergeants of Arms were Canton Lewis and Marcus Kitts.
Pages were Amanda Padden from Orange County and Carrie Ruff from Rutherford County.

Chairman Avila asked members to review the Subcommittee Guidance. (Exhibit 1).
Deborah Landry, Fiscal Research, went over the staff assignments for the various divisions. (Exhibit 2).
Susan Jacobs, Fiscal Research, outlined the strategy for the upcoming session, making a shift from paying for services, to the idea of investing in programs and services that have proven results. Ms. Jacobs also reviewed the planned topics for upcoming meetings. The second part of her presentation concerning the budget was held over to the next meeting.(Exhibit 3).

The next meeting will be Wednesday, February 11 at 8:30 a.m.

The meeting was adjourned by Chairman Avila at 9:53 a.m.

Rep. Marilyn Avila, Presiding Chair

Susan Lewis, Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

February 10, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Jean Farmer-Butterfield
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Representative Marilyn Avila, Presiding Co-Chair
II.	**Committee Introduction and Discussion**	
III.	**Subcommittee Guidance**	Representative Marilyn Avila
IV.	**Team Assignment Areas**	Deborah Landry, Fiscal Research Division
V.	**Committee Presentation Schedule**	Susan Jacobs, Fiscal Research Division
VI.	**Department of Health and Human Services Overview**	Susan Jacobs, Fiscal Research Division
	Adjourn	

Exhibit I

House and Senate Appropriations Chairs' Guidance for Subcommittee Chairs

February 4, 2015

Subcommittee Work

- Conduct joint educational meetings beginning Tuesday, February 10 (see below)
- Rotate presiding over meetings
- Maintain transparency by having open meetings and posting documents to committee websites
- Consult other subcommittees for items that cross multiple agencies
- Refer certain items to the Full Chairs
  - Salary-related items, debt service, capital or other Statewide issues
- Plan to check in with the Full Chairs on your progress reviewing agencies and programs

Joint Educational Meetings

- Evaluate agencies by looking at the programs and services they provide. For each program/service, look at:
  - Does this program fulfill a Constitutional requirement?
  - Is this program required by federal mandate? State mandate?
  - Is this program appropriately funded to complete its mission?
    - Do program outcomes justify expenditures?
    - If funding is too high, reduce funding.
    - If funding is too low,
      - eliminate the program
        OR
      - increase funding so that core services can be provided
  - For mandatory programs, are there ways to manage growth and reduce expenditures?
  - For non-mandatory programs, can priority or rank order be given to them?

- Where appropriate, look at long-term issues that may be addressed by more than one program.
  - Is the set of services or programs the State offers an effective way to address the issue?
  - Can some programs be eliminated?
  - Can the savings from those programs be used more effectively to run other programs?

- Use evaluations that are already available: NC GEAR report, Program Evaluation Division reports, study committee reports, audits, and agency reports submitted to Gov Ops, oversight committees, or Fiscal Research.

Exhibit 2

HEALTH AND HUMAN SERVICES TEAM ASSIGNMENTS

[redacted] Research Division – 733-4910
Legislative Drafting – 733-6660
Research – 733-2578

Fiscal Research Division:
Susan Jacobs
Deborah Landry
Steve Owen
Denise Thomas

Legislative Drafting Division:
Joyce Jones
Lisa Wilks

Research Division:
Jennifer Hillman

Division of Central Management & Support	Susan Jacobs Deborah Landry Joyce Jones – Legislative Drafting Lisa Wilks – Legislative Drafting
Division of Medical Assistance Medicaid for Aged and Adults Federal Medicare and Medicaid Issues Disproportionate Share Hospital Payments [redacted] Administration and Staffing [redacted]dicaid Management Information System	Steve Owen Susan Jacobs Jennifer Hillman – Research
Health Choice	Deborah Landry Steve Owen
Division of Mental Health, Developmental Disabilities and Substance Abuse Medicaid 1915(b) (c) Behavioral Health Waiver Mental Health Services Block Grant Substance Abuse Prevention and Treatment Block Grant Local Management Entities Community Service Funds	Denise Thomas Susan Jacobs Joyce Jones – Legislative Drafting Jennifer Hillman - Research
Division of State Operated Facilities State Psychiatric Hospitals Neuro-medical Centers Development Centers Alcohol and Drug Abuse Treatment Centers	Denise Thomas Susan Jacobs Joyce Jones – Legislative Drafting
Division of Health Service Regulation	Steve Owen Susan Jacobs Joyce Jones – Legislative Drafting

[redacted]

HEALTH AND HUMAN SERVICES (Continued)

Division of Public Health Chronic Disease & Injury Environmental Health Epidemiology Chief Medical Examiner State Health Lab Women's & Children's Health Preventive Health Services Block Grant Maternal and Child Health Block Grant	Denise Thomas Susan Jacobs Joyce Jones – Legislative Drafting
Division of Social Services State and County Administration Child Welfare and Administration Income Maintenance Programs Temporary Assistance to Needy Families Block Grant Social Services Block Grant Low-Income Energy Block Grant NC FAST	Deborah Landry Steve Owen Lisa Wilks – Legislative Drafting
Division of Aging and Adult Services	Deborah Landry Denise Thomas Joyce Jones – Legislative Drafting
Division of Vocational Rehabilitation	Denise Thomas Susan Jacobs Lisa Wilks – Legislative Drafting
Division of Services for the Blind and Deaf and Hard of Hearing	Denise Thomas Susan Jacobs Lisa Wilks – Legislative Drafting
Division of Child Development and Early Education Child Care Subsidy Child Care Licensure Child Care Commission Smart Start Child Care Development Fund Block Grant	Deborah Landry Susan Jacobs Lisa Wilks - Legislative Drafting

Joint Appropriations Committee on Health and Human Services

Committee Schedule and Budget Overview

Susan Jacobs
Fiscal Research Division

February 10, 2015

Exhibit 3

Joint Appropriations Committee on Health and Human Services

FY 2015-17 Session Strategy: Shifting from "*Paying*" to "*Investing*"

FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Joint Appropriations Committee on Health and Human Services Committee Presentation Plan

Session Strategy:
Shifting from "Paying" to "Investing"

"America spends twice as much on health care than any other nation, but we don't have the healthiest people….research indicates that spending on health care to <u>treat</u> people may actually come at the expense of investing in public health programs meant to keep people from getting sick to start with."

Source: Robert Wood Johnson Foundation "Geographic Variations in Public Health Spending: Correlates and Consequences" – October 2009

Session Strategy:
Shifting from "Paying" to "Investing"

- **North Carolina ranked 14th nationally in overall per capita health care expenditures in 2009.**

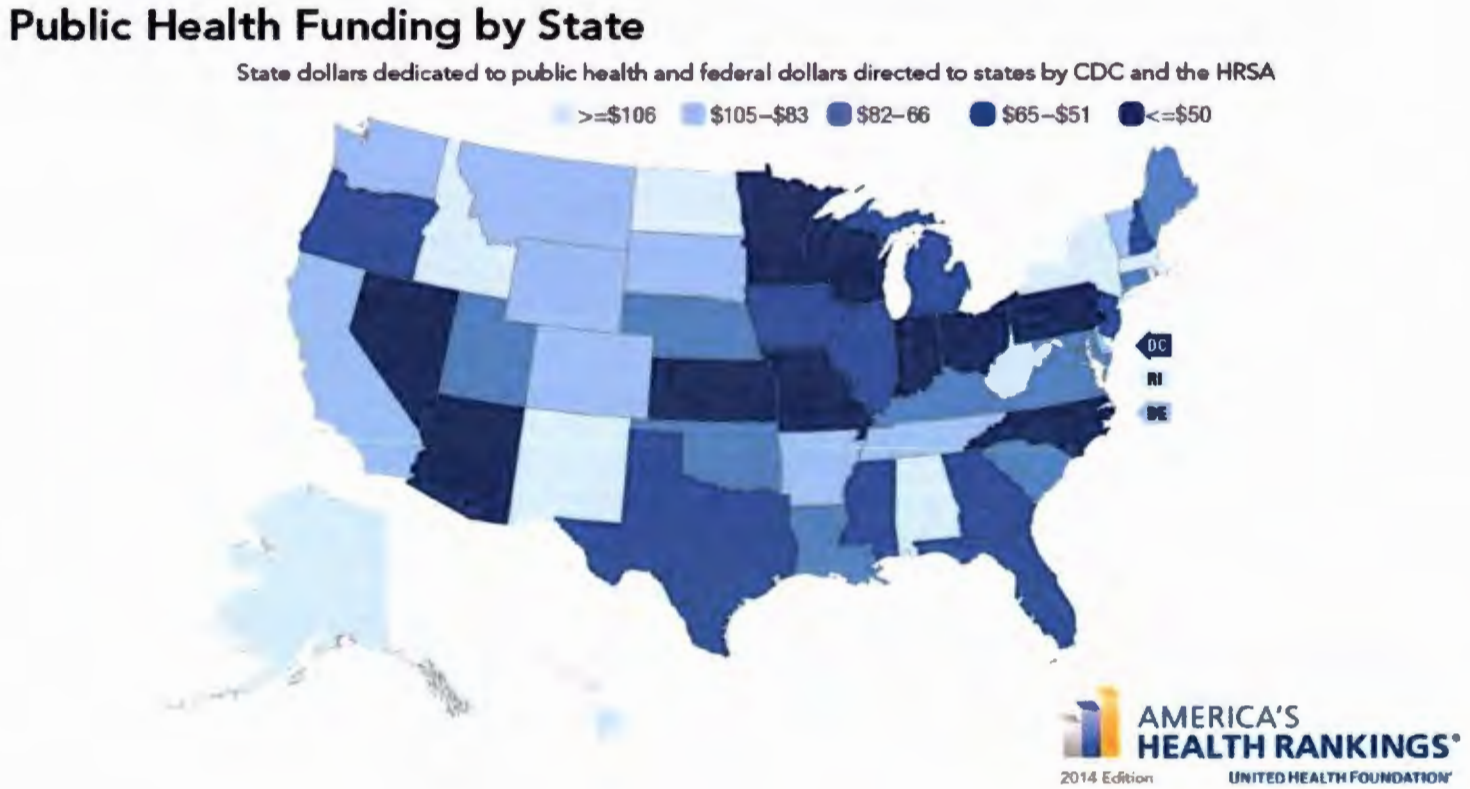
- **North Carolina's spending for public health expenditures was $51 compared to the national average of $94 per capita in 2009.**

- **North Carolina ranked 43rd in the country in public health spending at $50 per capita compared to the national average of $90 in 2014.**

- **North Carolina's overall health outcome ranking in 2014 is 37th in the nation, and was 35th in 2013.**

Source: http://kff.org/other/state-indicator/health-spending-per-capita/
Source: http://americashealthrankings.org/ALL/PH_Spending

Session Strategy:
Shifting from "Paying" to "Investing"



Joint Appropriations Committee on Health and Human Services Committee Presentation Plan

Session Strategy:
Shifting from "*Paying*" to "*Investing*"

Key Question for Any Program:

What outcome will you *require* for the investment you are making? Consider the following:

- **Are resources being targeted for the right purpose/program? Does that purpose "fit" with the overall goal of the agency?**
- **Does the program produce positive, evidence-based outcomes?**
- **Is there an alternative that would yield a better result for the state overall?**
- **Is the program adequately or inadequately funded?**
- **Other committee requirements?**

Where to Start? Focus for Long Session – Children (Birth -5)

Joint Appropriations Committee on Health and Human Services Committee Presentation Plan

Session Strategy:
Shifting from "Paying" to "Investing"

Planned Meeting Topics

- Organizational Meeting/DHHS Overview
- Secretary Wos and DHHS Staff – Goals for FY 2015-17
- Implementation Status of Historical Budget Items and Legislation
- Program Evaluation Division Report – "DHHS Should Integrate Substance Abuse Treatment Facilities into the Community-Based System and Improve Performance Management"
- Program Evaluation Division Report – "Revising State Child Support Incentive System Could Promote Improved Performance of County Program"
- School of Public Health – North Carolina Health Outcome Comparisons (All Populations)
- School of Public Health – North Carolina Health Outcome Comparisons for Children (Ages 0 – 5)
- School of Public Health – North Carolina Health Outcome Comparisons (Birth Weight/Infant Mortality)
- Evidence-Based Policy Making – Pew-MacArthur Results First Initiative
- "How North Carolina Pays Providers" – Fiscal Research Division
- Medical Payments for Pregnant Women and Infants/Cost Analysis of High Risk Deliveries/Preterm Births

Joint Appropriations Committee on Health and Human Services Committee Presentation Plan

Session Strategy:
Shifting from "Paying" to "Investing"

Planned Meeting Topics

- North Carolina Prenatal/Perinatal Programs and Programs Focused on Reducing Infant Mortality
- North Carolina Public Health Programs for Children (Ages 0 – 5)
- "How Can North Carolina Improve Birth Outcomes Through Evidence-Based Practices" – Guest Speaker
- Proven Successes in Improving the Health of Children – Guest Speaker
- Staff Wrap-Up and Committee Discussion
- North Carolina Family Support Programs for Children (Ages 0 – 5) (Approximately 5 Meetings)
- Staff Wrap-Up and Committee Discussion

Joint Appropriations Committee on Health and Human Services

Budget Overview

FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Department of Health and Human Services

Statutory Authority

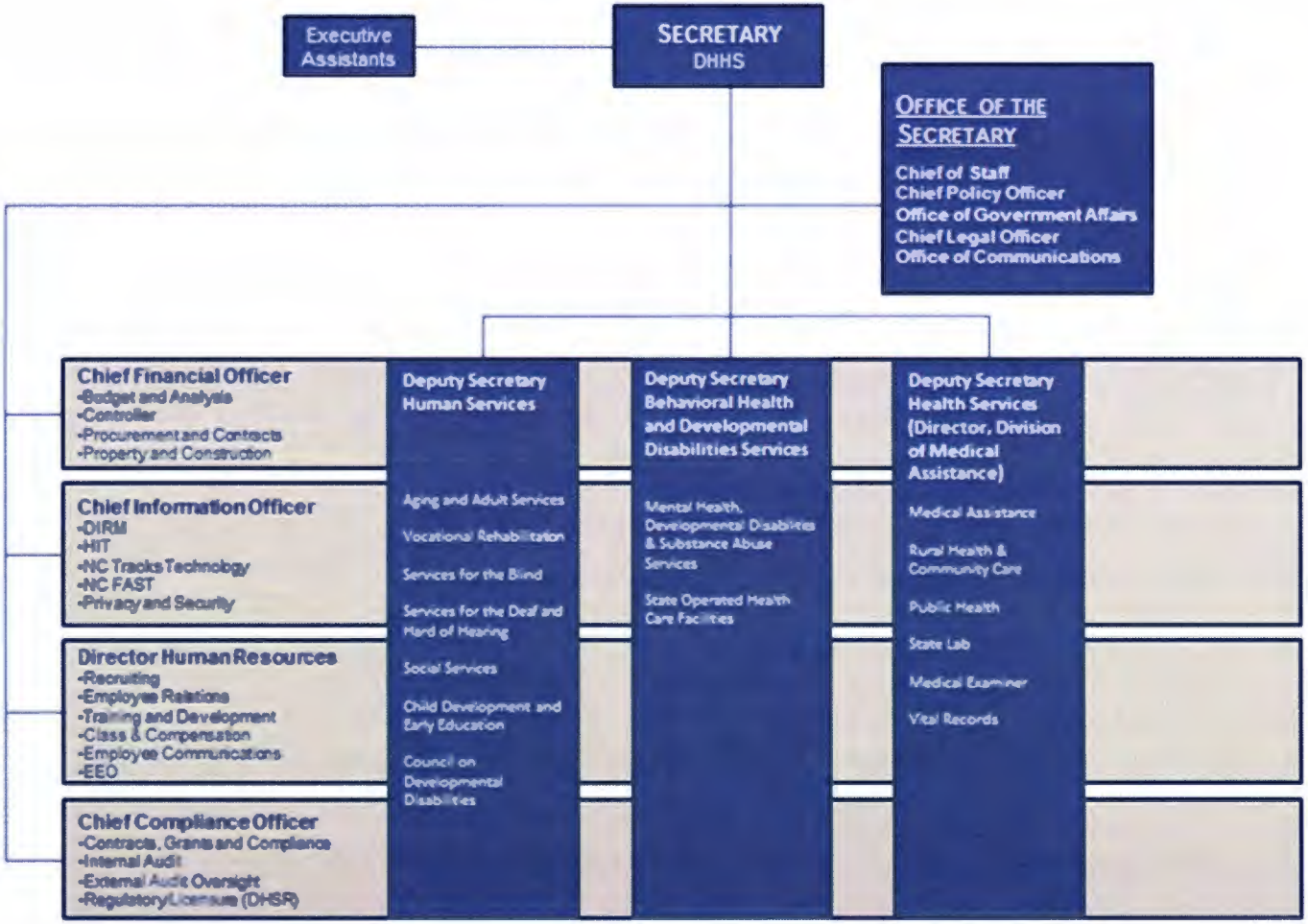
G.S. 143B-137.1. Department of Health and Human Services – duties.

It shall be the duty of the Department to:

- Provide the necessary management, development of policy, and establishment and enforcement of standards for the provisions of services in the fields of public and mental health and rehabilitation.
- With the intent to assist all citizens – as individuals, families, and communities – to achieve and maintain an adequate level of health, social and economic well being, and dignity.
- Whenever possible, the Department shall emphasize preventive measures to avoid or to reduce the need for costly emergency treatments that often result from lack of forethought.
- **The Department shall establish priorities to eliminate those excessive expenses incurred by the State for lack of adequate funding or careful planning of preventive measures.** (1997 443, s. 11A.3.)

Department of Health and Human Services

G.S. 143B-138.1



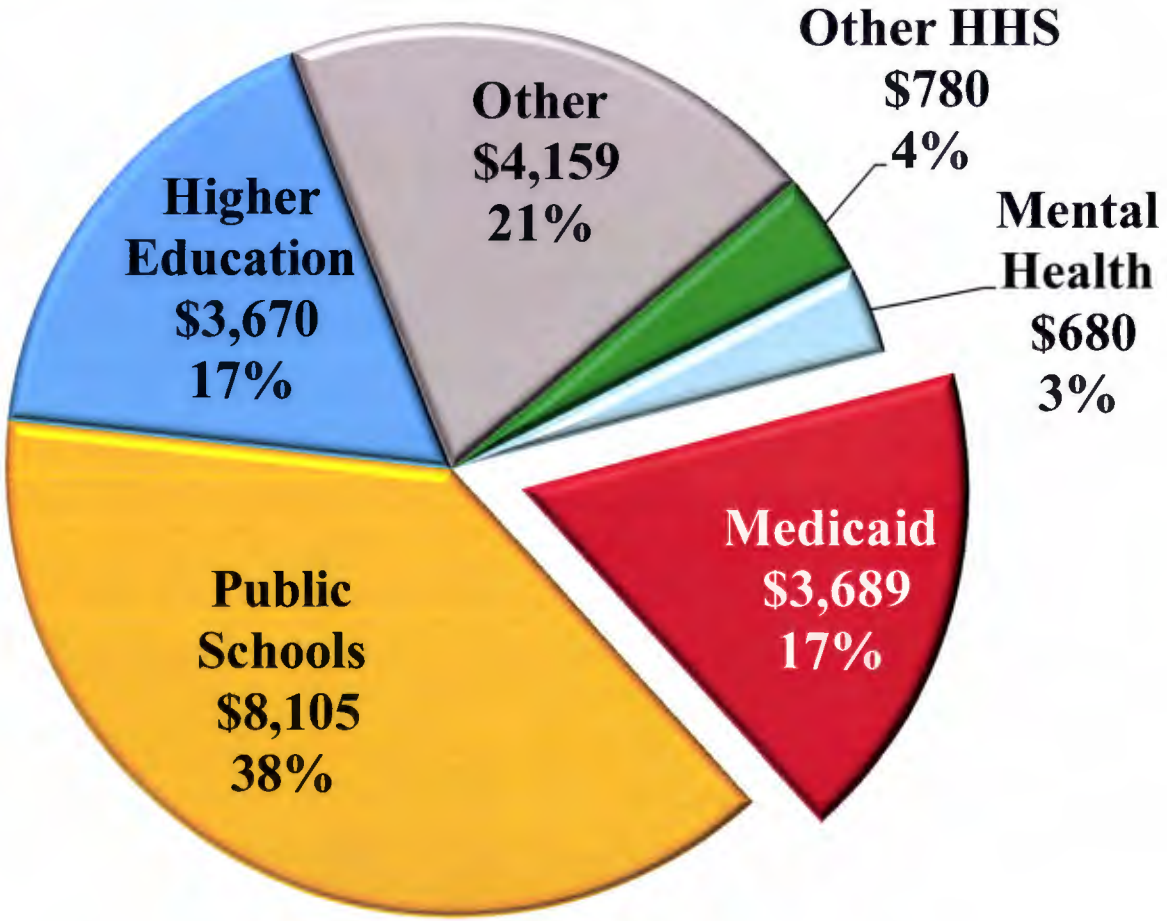
Department of Health and Human Services
2014-15 Certified General Fund Budget

Subcommittee/Area	General Fund Appropriation	% of Total
Education	11,775,270,816	56%
Health & Human Services	**5,148,161,048**	**24%**
Justice & Public Safety	2,366,128,478	11%
Natural & Economic Resources	407,326,212	2%
General Government	427,467,752	2%
Statewide Reserves and Capital	957,755,839	5%
TOTAL	**$21,082,110,145**	**100.00%**

Department of Health and Human Services
2014-15 Certified General Fund Budget

General Fund Appropriations FY 2014-15

Total: $21,082.1 million



Department of Health and Human Services

2014-15 Certified General Fund Budget

Health and Human Services	FY 2014-15	% of Total
Blind and Deaf / Hard of Hearing Services	8,178,618	0.16%
Health Service Regulation	16,123,479	0.31%
Vocational Rehabilitation	38,197,833	0.74%
NC Health Choice	41,933,972	0.81%
Aging and Adult Services	53,472,792	1.04%
Central Management and Support	72,904,800	1.42%
Public Health	136,336,044	2.65%
Social Services	188,765,287	3.67%
Child Development	223,636,354	4.34%
Mental Health, Dev. Disabilities and Sub. Abuse	680,063,746	13.21%
Medical Assistance	3,688,548,123	71.65%
Total Health and Human Services	**5,148,161,048**	**100%**

Department of Health and Human Services

2014-15 Total Certified Budget

Health and Human Services	FY 2014-15	% of Total
Blind and Deaf / Hard of Hearing Services	32,639,127	0.17%
Health Service Regulation	65,399,275	0.34%
Aging and Adult Services	115,311,763	0.61%
Vocational Rehabilitation	138,503,086	0.73%
Central Management and Support	152,152,679	0.80%
NC Health Choice	174,711,677	0.92%
Child Development	667,998,042	3.52%
Public Health	827,356,675	4.36%
Mental Health, Dev. Disabilities and Sub. Abuse	1,364,706,219	7.19%
Social Services	1,668,936,436	8.79%
Medical Assistance	13,769,876,232	72.56%
Total Health and Human Services	**18,977,591,211**	**100%**

Department of Health and Human Services
2013-14 Legislative Budget Adjustments

FY 2013-14	Governor's Continuation Budget	Recurring Adjustments	Nonrecurring Adjustments	Legislative Net Changes	FTE Changes	Revised Appropriation 2013-14	% Change
Central Management and Support	54,028,354	14,840,375	4,917,400	19,757,775	(6.00)	73,786,129	36.57%
Aging and Adult Services	54,443,196	(300,855)	0	(300,855)	0	54,142,341	-0.55%
Blind and Deaf / Hard of Hearing Services	8,178,618	0	0	0	0	8,178,618	0.00%
Child Development	259,254,083	(1,590,625)	(3,348,849)	(4,939,474)	(14.00)	254,314,609	-1.91%
Health Service Regulation	16,761,992	(365,935)	0	(365,935)	10.00	16,396,057	-2.18%
Medical Assistance	3,069,576,810	391,202,327	1,170,982	392,373,309	0	3,461,950,119	12.78%
Mental Health, Dev. Disabilities and Sub. Abuse	706,797,747	(18,660,348)	11,398,203	(7,262,145)	0	699,535,602	-1.03%
NC Health Choice	80,131,026	(12,181,866)	0	(12,181,866)	0	67,949,160	-15.20%
Public Health	156,784,502	(6,605,500)	(6,024,915)	(12,630,415)	(15.00)	144,154,087	-8.06%
Social Services	170,629,904	(847,818)	4,826,346	3,978,528	0	174,608,432	2.33%
Vocational Rehabilitation	39,284,143	(510,974)	0	(510,974)	0	38,773,169	-1.30%
Total Health and Human Services	**4,615,870,375**	**364,978,781**	**12,939,167**	**377,917,948**	**(25.00)**	**4,993,788,323**	**8.19%**

FY 2014-15	Governor's Continuation Budget	Recurring Adjustments	Nonrecurring Adjustments	Legislative Net Changes	FTE Changes	Revised Appropriation 2014-15	% Change
Central Management and Support	54,718,515	20,400,758	1,182,055	21,582,813	(6.00)	76,301,328	39.44%
Aging and Adult Services	54,443,196	(100,855)	0	(100,855)	0	54,342,341	-0.19%
Blind and Deaf / Hard of Hearing Services	8,178,618	0	0	-	0	8,178,618	0.00%
Child Development	259,254,083	(1,590,625)	(3,348,849)	(4,939,474)	(14.00)	254,314,609	-1.91%
Health Service Regulation	16,761,992	(350,513)	0	(350,513)	10.00	16,411,479	-2.09%
Medical Assistance	3,083,576,810	524,542,281	0	524,542,281	0	3,608,119,091	17.01%
Mental Health, Dev. Disabilities and Sub. Abuse	706,797,747	(18,660,348)	16,848,589	(1,811,759)	0	704,985,988	-0.26%
NC Health Choice	80,131,026	(22,383,093)	0	(22,383,093)	0	57,747,933	-27.93%
Public Health	156,784,502	(16,818,000)	1,975,085	(14,842,915)	(175.00)	141,941,587	-9.47%
Social Services	170,629,904	1,102,182	4,826,346	5,928,528	0	176,558,432	3.47%
Vocational Rehabilitation	39,284,143	(510,974)	0	(510,974)	0	38,773,169	-1.30%
Total Health and Human Services	**4,630,560,536**	**485,630,813**	**21,483,226**	**507,114,039**	**(185.00)**	**5,137,674,575**	**10.95%**

Department of Health and Human Services
2014-15 Legislative Budget Adjustments

	Certified Budget	Recurring Adjustments	Nonrecurring Adjustments	Legislative Net Changes	FTE Changes	Revised Appropriation 2014-15	% Change
Central Admin. and Support[1]	76,301,328	(5,396,528)	2,000,000	(3,396,528)	1.00	72,904,800	-4.45%
Aging and Adult Services	54,342,341	(969,549)	100,000	(869,549)	0	53,472,792	-1.60%
Blind and Deaf / Hard of Hearing Services	8,178,618	0	0	0	0	8,178,618	0.00%
Child Development[2]	254,314,609	(1,893,496)	(28,784,759)	(30,678,255)	-1	223,636,354	-12.06%
Health Service Regulation	16,411,479	(288,000)	0	(288,000)	0	16,123,479	-1.75%
Medical Assistance[3]	3,608,119,091	(56,536,746)	136,965,778	80,429,032	0	3,688,548,123	2.23%
Mental Health, Dev. Disabilities and Sub. Abuse	704,985,988	(8,323,653)	(16,598,589)	(24,922,242)	-7	680,063,746	-3.54%
NC Health Choice[4]	57,747,933	(15,813,961)	0	(15,813,961)	0	41,933,972	-27.38%
Public Health	141,941,587	176,620	(5,782,163)	(5,605,543)	(7.00)	136,336,044	-3.95%
Social Services	176,558,432	11,081,105	1,125,750	12,206,855	9.00	188,765,287	6.91%
Vocational Rehabilitation	38,773,169	(575,336)	0	(575,336)	(11.95)	38,197,833	-1.48%
Total Health and Human Services	**5,137,674,575**	**(78,539,544)**	**$ 89,026,017**	**10,486,473**	**(16.95)**	**5,148,161,048**	**0.20%**

1-Department wide reduction of $16 million included in this budget.
2-Federal funds used to offset $33.8 million in general funds.
3-Increase is due to additional funds for FY 13-14 shortfall.
4-Reduction based primarily on moving children from Health Choice to Medicaid.

Questions?

North Carolina General Assembly
Fiscal Research Division
Room 619
Legislative Office Building
Raleigh, NC 27603-5925
(919)-733-4910

http://www.ncleg.net/FiscalResearch/

Health and Human Services Subcommittee 2013-15 Fiscal Biennium Budget Highlights

Fiscal Brief August 29, 2013

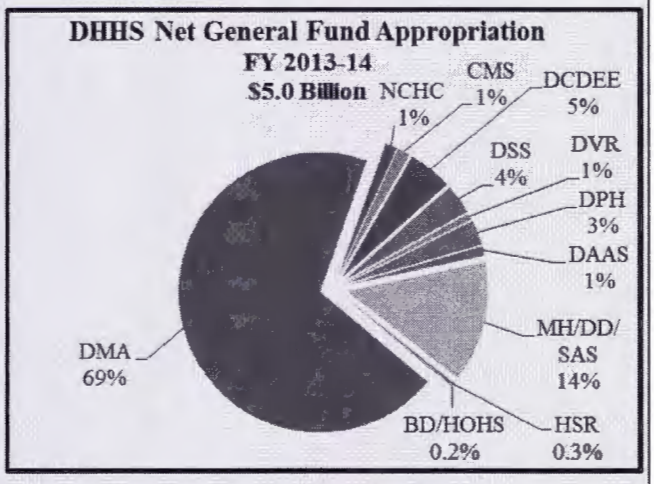
The North Carolina General Assembly House and Senate Appropriations Subcommittees on Health and Human Services (HHS Subcommittee) determine the budget for one State agency: The Department of Health and Human Services (DHHS). DHHS is comprised of twelve divisions, which may be categorized under four broad service areas: health, human services, administration, and support.

	Actual FY 2011-12	Actual FY 2012-13	Enacted FY 2013-14	Enacted FY 2014-15
Expenditures	19,549,995,169	17,897,315,850	19,229,235,008	19,784,216,988
Less: Receipts	14,974,153,064	12,891,599,858	14,235,446,685	14,646,542,413
Net General Fund Appropriations	$4,575,842,105	$5,005,715,992	$4,993,788,323	$5,137,674,575
Positions (FTE)	17,036.1	17,581.7	17,570.7	17,410.7

[1] Division level budget and FTE information is provided in tables at the end of this budget brief.

Budget Overview

The enacted FY 2013-14 Net General Fund Appropriation for the Health and Human Services Subcommittee is $5.0 billion. This is an increase of 8.2 percent from the FY 2013-14 Continuation Budget. The General Fund Appropriation funds 17,571 full-time equivalent positions (FTE).[1] The chart below shows the subcommittee budget by divisions.



[1] Does not reflect positions that may be eliminated as part of management flexibility reserves.

S.L. 2013-360, Appropriations Act of 2013 (S.B. 402), as amended by S.L. 2013-363, Modifications/2013 Appropriations Act (H.B. 112), appropriates $5.0 billion for the 12 Department of Health and Human Services (DHHS) agencies. Legislative adjustments to the FY 2013-14 Continuation Budget for the DHHS agencies increased spending by $377.9 million in FY 2013-14. In FY 2014-15 spending increases by $507.1 million. The Legislative budget process focused primarily on the following major areas:

- Preparing for future Medicaid reform;
- Avoiding future Medicaid budget shortfalls; and
- Finding savings in Medicaid and other DHHS programs to fund required Medicaid budget growth.

This Fiscal Brief provides a summary of the adjusted 2013-15 biennial budget for DHHS.

Preparing for Medicaid Reform

S.L. 2013-360, Appropriations Act of 2013 requires DHHS, in consultation with a Medicaid Reform Advisory Group, to create a detailed plan to reform the

Medicaid program. DHHS is prohibited from implementing Medicaid Reform without legislative approval. The Department's plan will be presented to the General Assembly for consideration by March 17, 2014. The plan should be designed to accomplish the following goals:

1) Create a predictable and sustainable Medicaid program;
2) Increase administrative ease and efficiency for Medicaid providers; and
3) Provide care for the whole person by uniting physical and behavioral health care.

Avoiding Future Medicaid Budget Shortfalls

Budget writers were confronted with a significant budget gap in the State's Medicaid budget for FY 2012-13 due to increased enrollment and utilization, a one-time State reimbursement of federal drug rebate payments, and a miscalculation of federal receipts. To ensure adequate funding through July 2013, the General Assembly passed S.L. 2013-56, Medicaid/2012-13 Additional Appropriations (H.B. 980), authorizing $451 million, and S.L. 2013-184, Title (H.B. 336) authorizing $45 million, for a total of $496 million in additional Medicaid funding. For FY 2012-13, Medicaid is expected to have spent $416 million more (13.4 percent) than was originally appropriated during the 2012 Session.

With the FY 2012-13 Medicaid budget gap covered, the General Assembly's focus in the FY 2013-15 biennial budget for DHHS was providing sufficient continued funding for Medicaid. Most of the 8.2 percent increase in the DHHS budget is dedicated to Medicaid. S.L. 2013-360, Appropriations Act of 2013 includes an additional $392.4 million above the Continuation Budget for Medicaid in FY 2013-14. The additional Medicaid funding covers the structural shortfall from FY 2012-13, projected enrollment and utilization growth, the expected impact of the Affordable Care Act (ACA) on the current Medicaid program, and a variety of program changes. The following chart summarizes the components of the additional Medicaid funding in FY 2013-14:

Structural Shortfall	$272.0 M
Enrollment/Utilization Growth	$191.0 M
ACA Woodwork and DSH Effects	$49.7 M
ACA Health Choice to Medicaid	$22.0 M
Non-Recurring IT	$4.8 M
General Assembly Reductions	($143.5 M)
Non-Recurring Federal Payments	($3.8 M)
TOTAL CHANGE	$392.4 M

Funding for the Division of Medical Assistance (DMA, the division responsible for Medicaid) in FY 2013-14 is $3.46 billion, or 12.8 percent more than the Continuation Budget.

The Appropriations Act includes an estimate of expected total Medicaid costs that projects an additional $463 million in FY 2013-14 and $586 million in FY 2014-15 to account for the structural shortfall in Medicaid funding in FY 2012-13, growth in Medicaid enrollment, and changes in utilization.

The budget accommodates increased projected Medicaid enrollment from the "woodwork" effect of the ACA and reduced federal funding to pay State facilities through the Disproportionate Share Hospital (DSH) program. The ACA "woodwork" effect refers to individuals currently eligible, but not enrolled in, Medicaid, who are expected to enroll in future years as a result of 1) the outreach efforts for the ACA's new Health Insurance Marketplaces, 2) an easier enrollment process, and 3) the requirement that individuals have health insurance after January 1, 2014. By the end of FY 2014-2015, over 40 percent of those currently eligible, but not enrolled, are forecasted to enroll in Medicaid. These two items represent a projected $49.7 million increase in State spending requirements in FY 2013-14.

S.L. 2013-360 also provides funding to implement an ACA requirement that shifts children whose families earn up to 133 percent of the Federal Poverty Level (FPL) from Health Choice to Medicaid. This is projected to increase State Medicaid spending by $22.1 million in FY 2013-14. While there is a partial offset for reduced Health Choice spending, overall State costs are expected to rise as a result of a broader array of benefits and lower copays in Medicaid compared to Health Choice.

Finding Savings for Medicaid Budget Growth

S.L. 2013-360, Appropriations Act of 2013 includes numerous budget changes across divisions that provide savings to offset required Medicaid funding increases.

Significant Medicaid Savings

- **Increased Hospital Assessments** - S.L. 2013-360 converts the method for determining the State's share of hospital assessments to fund service payments to hospitals from a flat amount to a percentage. This change is projected to increase the State's share of the assessments by $52 million in FY 2013-14.

- **Shared Savings Plan** - S.L. 2013-360 includes a Medicaid Shared Savings plan that establishes a system to reimburse selected medical providers based on performance. The plan withholds three percent of claims payments to providers beginning in FY 2013-14; these funds will be used to make performance payments beginning in FY 2014-15. The performance payment structure will be developed by DHHS in consultation with providers. S.L. 2013-360 includes a $26.9 million reduction in State funding in FY 2013-14 as a result of the three percent withhold.

- **Reduced Outpatient Payments** - S.L. 2013-360 reduces hospital outpatient service payments, including emergency services, from 80 percent of cost to 70 percent of cost. However, the hospital assessments referenced above will result in an increasing federal share of payments, which will mean that hospitals only have their payments reduced by about 1/3 of this amount. The change in hospital outpatient payment is projected to reduce State Medicaid spending by $23.1 million in FY 2013-14.

- **Rate Freezes for Providers with Automatic Increases** - S.L. 2013-360 freezes rates for all providers who previously received an automatic increase in their rate (with the exception of nursing homes, prescription drugs, Federally Qualified Health Centers, Medicare Parts B & D premiums, hospice, state operated facilities and third party insurance premiums). Freezing the rates effective on June 30, 2013 for these selected providers is projected to reduce State Medicaid spending by $17.2 million in FY 2013-14.

- **Cost Savings Through Drug Adjustments** – S.L. 2013-360 implements changes in brand-name and generic drug pricing and reduces dispensing fees for brand drugs and all but one tier of generic drugs. These actions reduce the expected spending for drugs by $14.6 million in FY 2013-14.

  The Department is further authorized to implement prior authorization and other utilization restrictions for medications prescribed for mental illness.

Significant Non-Medicaid Savings

Non-Medicaid DHHS agencies are reduced by an average of 3.5 percent in S.L. 2013-360. Most areas of DHHS will have either spending reductions or essentially flat funding. The most notable of the non-Medicaid DHHS savings provisions are discussed below.

- **Child Development Services Agencies (CDSA) Early Intervention** - In FYs 2011-12 and 2012-13, over $17 million was transferred annually from the Division of Public Health (DPH) to DMA for Medicaid budget shortfalls. Over half of the amounts transferred were initially budgeted for the Early Intervention Branch, which provides assessment, treatment, and referral services for children aged zero to three, primarily through its 16 CDSAs. S.L. 2013-360 reduces the Early Intervention budget by $8 million in FY 2013-14 and $10 million in FY 2014-15. DPH is authorized to close up to four of the 16 CDSAs if needed to achieve the reduction. However, S.L. 2013-363 specifies that DPH shall not close the Morganton CDSA and shall keep open the CDSAs with the highest caseloads of children from rural or medically-underserved areas.

- **AIDS Drug Assistance Program (ADAP)** - S.L. 2013-360 reduced State ADAP funding by $8 million in FY 2013-14. Due to increased federal receipts for this program, ADAP pharmaceutical purchases are projected to be $5 million more in FY 2013-14 than in the FY 2012-13 budget.

- **Local Management Entities/Managed Care Organization (LME/MCO) Administration** – S.L. 2013-360 reduced the LME/MCO administration funding formula, saving $15 million in FY 2013-14.

- **Alcohol and Drug Abuse Treatment Centers (ADATC)** – S.L. 2013-360 reduced ADATC funding by 12 percent in FY 2013-14, providing projected savings of nearly $5 million.

Additional DHHS Items

Pre-Kindergarten Education

S.L. 2013-360, Appropriations Act of 2013 adds $12.5 million in funding from lottery receipts to support an additional 2,500 slots for Pre-Kindergarten education, bringing the total number of recurring slots to 27,500.

S.L. 2013-363, Modifications/2013 Appropriations Act extends the deadline by which public school classrooms must be licensed by the Division of Child Development and Early Education (DCDEE) to July 1, 2014.

Smart Start

S.L. 2013-360 continues the focus on improving child care quality by adding three star-rated (out of five stars) child care facilities to the child care facilities that local partnerships work with to improve quality of care. Previously, the focus for improvement was only on one and two star-rated facilities.

The North Carolina Partnership for Children, Inc., and the local partnerships are required to provide contributions through matching a specified percentage of the total amount budgeted by the State for the program in each fiscal year of the biennium. The match requirement for both the North Carolina Partnership for Children, Inc., and the local partnerships increases from the 2012-13 requirement of a 13 percent match to a FY 2013-14 requirement of 14 percent and a FY 2014-15 requirement of 15 percent. This will increase the match requirement by $1.5 million each year, providing more funding for Smart Start.

Child Care Subsidy

S.L. 2013-360 allows county departments of social services to use up to two percent of their child care subsidy allocation for fraud detection and investigation initiatives. Two reports are required on the use of these funds. The first, a progress report, is due no later than May 1, 2014; a follow-up report is due no later than January 1, 2015.

Mental Health/Developmental Disabilities/Substance Abuse Services

S.L. 2013-360 incorporates recommendations from the Legislative Study Commissions established by S.L. 2012-142, the *Mental Health Subcommittee of the Health and Human Services Legislative Oversight Committee* and the *Blue Ribbon Commission on Transitions to Community Living.* Specific actions include:

- Two million dollars to establish a statewide tele-psychiatry program to address critical shortages of qualified mental health professionals. Tele-psychiatry services reduce emergency room wait times, involuntary commitments, and the costs incurred to transport persons to State psychiatric hospitals.

- Authorization to pilot a tiered-rate for State-County Special Assistance to address the needs of adult care and group home residents who are ineligible for Medicaid personal care services. Participating counties will have the flexibility to implement a payment system based upon intensity of need that pays for supervision and medication management, in addition to room and board.

- Authorization to develop and implement a two-tiered rate structure for the three-way contracts between the State, local management entities/managed care organizations (LME/MCOs), and community hospitals. The three-way contracts enable LME/MCOs to purchase short-term, inpatient mental health services in community hospitals. S.L. 2013-360 authorizes a higher three-way contract rate for patients assessed to have higher severity levels of mental health need.

- Expansion funds to purchase technology and other infrastructure for the new Broughton Hospital scheduled to open in FY 2014-15.

- Two funding expansions to transition adults with mental illness or intellectual/developmental disabilities from institutional settings to community-based housing and supports.

- Implementation of the settlement agreement between the State and U.S. Department of Justice to transfer or divert individuals with severe mental illness from assisted living facilities and State psychiatric hospitals; $3.8 million in FY 2013-14 and $9.4 million in FY 2014-15.

- Supervision and medication management services (33 hours per month) for adult group home residents who were ineligible to continue to receive Medicaid personal care services on January 1, 2013; $4.6 million, non-recurring.

These policy changes provide additional funding and direction for two legislative priorities of the FY 2013-15 biennium budget: improving the availability and quality of child care and pre-Kindergarten education services, and incorporating the Legislative Study Commissions' recommendations regarding mental health.

For additional information, please contact:

Health and Human Services Team

Susan Jacobs *susan.jacobs@ncleg.net*
Deborah Landry *deborah.landry@ncleg.net*
Steve Owen *steve.owen@ncleg.net*
M David Rice *david.rice@ncleg.net*
Denise Thomas *denise.thomas@ncleg.net*

Fiscal Research Division
NC General Assembly
300 N. Salisbury St., Room 619
Raleigh, North Carolina 27603-5925
(919) 733-4910
http://www.ncleg.net/fiscalresearch

Actual and Certified Expenditures and Receipts[1] by Agency

Division of Central Management and Support

	Actual FY 2011-12	Actual FY 2012-13	Enacted FY 2013-14	Enacted FY 2014-15
Expenditures	120,188,169	126,934,570	139,160,027	141,675,226
Less: Receipts	63,694,328	65,977,862	65,373,898	65,373,898
Net General Fund Appropriations	$56,493,841	$60,956,708	$73,786,129	$76,301,328
Positions (FTE)	641.8	638.3	632.3	632.3

Division of Aging and Adult Services

	Actual FY 2011-12	Actual FY 2012-13	Enacted FY 2013-14	Enacted FY 2014-15
Expenditures	105,024,104	106,927,440	114,377,939	113,570,929
Less: Receipts	60,755,523	63,151,811	60,235,598	59,228,588
Net General Fund Appropriations	$44,268,581	$43,775,629	$54,142,341	$54,342,341
Positions (FTE)	73.5	73.5	73.5	73.5

Divisions of Blind and Deaf/Hard of Hearing Services

	Actual FY 2011-12	Actual FY 2012-13	Enacted FY 2013-14	Enacted FY 2014-15
Expenditures	29,086,669	29,874,274	33,017,455	33,017,455
Less: Receipts	20,764,306	21,695,658	24,838,837	24,838,837
Net General Fund Appropriations	$8,322,363	$8,178,616	$8,178,618	$8,178,618
Positions (FTE)	316.8	313.8	313.8	313.8

Division of Child Development and Early Education

	Actual FY 2011-12	Actual FY 2012-13	Enacted FY 2013-14	Enacted FY 2014-15
Expenditures	662,294,474	669,099,408	662,982,382	662,982,382
Less: Receipts	399,659,660	411,106,467	408,667,773	408,667,773
Net General Fund Appropriations	$262,634,814	$257,992,941	$254,314,609	$254,314,609
Positions (FTE)	309.8	303.8	303.8	303.8

[1] Receipts are based on the FY 2013-15 Continuation Budget. Total requirements are estimated based on changes to Net General Fund Appropriations and receipts.

Division of Health Services Regulation

	Actual FY 2011-12	Actual FY 2012-13	Enacted FY 2013-14	Enacted FY 2014-15
Expenditures	63,611,042	56,209,731	64,275,318	64,290,740
Less: Receipts	47,663,558	42,344,340	47,879,261	47,879,261
Net General Fund Appropriations	$15,947,484	$13,865,391	$16,396,057	$16,411,479
Positions (FTE)	558.5	555.5	565.5	565.5

Division of Medical Assistance

	Actual FY 2011-12	Actual FY 2012-13	Enacted FY 2013-14	Enacted FY 2014-15
Expenditures	14,241,450,471	12,643,008,323	13,913,667,384	14,471,939,094
Less: Receipts	11,214,489,593	9,125,314,086	10,451,717,265	10,863,820,003
Net General Fund Appropriations	$3,026,960,878	$3,517,694,237	$3,461,950,119	$3,608,119,091
Positions (FTE)	425.5	428.3	428.3	428.3

Division of Mental Health, Developmental Disablilities and Substance Abuse Services

	Actual FY 2011-12	Actual FY 2012-13	Enacted FY 2013-14	Enacted FY 2014-15
Expenditures	1,366,409,130	1,368,256,396	1,388,398,177	1,393,848,563
Less: Receipts	697,027,523	683,863,564	688,862,575	688,862,575
Net General Fund Appropriations	$669,381,607	$684,392,832	$699,535,602	$704,985,988
Positions (FTE)	11,155.9	11,712.2	11,712.2	11,712.2

NC Health Choice

	Actual FY 2011-12	Actual FY 2012-13	Enacted FY 2013-14	Enacted FY 2014-15
Expenditures	336,858,465	325,597,032	322,144,812	311,943,585
Less: Receipts	259,003,262	246,263,499	254,195,652	254,195,652
Net General Fund Appropriations	$77,855,203	$79,333,533	$67,949,160	$57,747,933
Positions (FTE)	5.0	5.0	5.0	5.0

Division of Public Health

	Actual FY 2011-12	Actual FY 2012-13	Enacted FY 2013-14	Enacted FY 2014-15
Expenditures	807,514,836	770,031,338	830,221,628	828,009,128
Less: Receipts	615,511,411	628,755,391	686,067,541	686,067,541
Net General Fund Appropriations	$192,003,425	$141,275,947	$144,154,087	$141,941,587
Positions (FTE)	2,101.8	2,105.8	2,090.8	1,930.8

Division of Social Services

	Actual FY 2011-12	Actual FY 2012-13	Enacted FY 2013-14	Enacted FY 2014-15
Expenditures	1,674,763,277	1,661,798,665	1,621,316,168	1,623,266,168
Less: Receipts	1,489,276,926	1,496,195,456	1,446,707,736	1,446,707,736
Net General Fund Appropriations	$185,486,351	$165,603,209	$174,608,432	$176,558,432
Positions (FTE)	416.0	415.0	415.0	415.0

Division of Vocational Rehabilitation

	Actual FY 2011-12	Actual FY 2012-13	Enacted FY 2013-14	Enacted FY 2014-15
Expenditures	142,794,532	139,578,673	139,673,718	139,673,718
Less: Receipts	106,306,974	106,931,724	100,900,549	100,900,549
Net General Fund Appropriations	$36,487,558	$32,646,949	$38,773,169	$38,773,169
Positions (FTE)	1,031.5	1,030.5	1,030.5	1,030.5

Change in FTE, FY 2013-14

	Vacant	Filled	Receipts	New	Transfers	Net Change
Health and Human Services						
Central Management and Support	-	(6.0)	-	-	-	(6.0)
Aging and Adult Services	-	-	-	-	-	-
Blind and Deaf/Hard of Hearing Services	-	-	-	-	-	-
Child Development and Early Education	-	-	(14.0)	-	-	(14.0)
Health Services Regulation	-	-	-	10.0	-	10.0
Medical Assistance	-	-	-	-	-	-
Mental Health, Dev. Disabilities, & Sub. Abuse Serv.	-	-	-	-	-	-
NC Health Choice	-	-	-	-	-	-
Public Health	(15.0)	-	-	-	-	(15.0)
Social Services	-	-	-	-	-	-
Vocational Rehabilitation	-	-	-	-	-	-
Health and Human Services	**(15.0)**	**(6.0)**	**(14.0)**	**10.0**	**-**	**(25.0)**

Health and Human Services Subcommittee 2014-15 Fiscal Year Budget Highlights

Fiscal Brief October 9, 2014

The North Carolina General Assembly House and Senate Appropriations Subcommittees on Health and Human Services (HHS Subcommittee) develop and recommend the budget for one State agency: The Department of Health and Human Services (DHHS). DHHS comprises 11 divisions, which may be categorized under four broad service areas: health, human services, administration, and support.

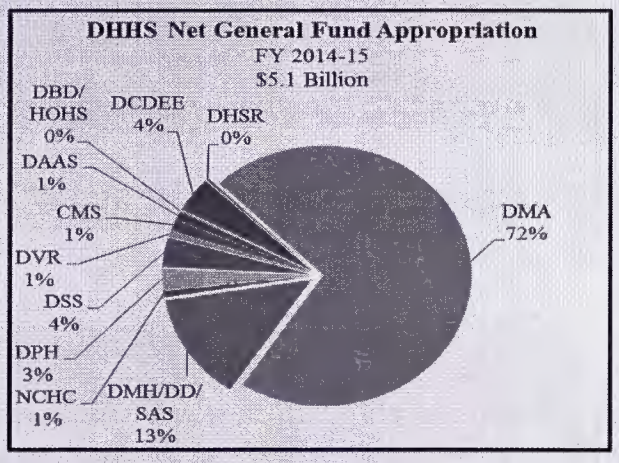
Actual and Enacted Expenditures and Receipts[1]

	Actual FY 2011-12	Actual FY 2012-13	Actual FY 2013-14	Certified[2] FY 2014-15
Expenditures	19,549,995,169	17,896,294,301	18,468,002,712	18,977,591,211
Less: Receipts	14,974,153,064	12,891,308,763	13,574,353,842	13,829,430,163
Net General Fund Appropriations	$4,575,842,105	$5,004,985,538	$4,893,648,870	$5,148,161,048
Positions (FTE)	17,036.1	17,581.7	17,518.4	17,400.7

[1] Division level budget and FTE information is provided at the end of this brief.
[2] Certified budget expenditures and receipts updated February 9, 2015.

Budget Overview

The certified FY 2014-15 net General Fund appropriation for the Department of Health and Human Services is $5.1 billion. This is an increase of 0.2 percent from the FY 2014-15 certified budget. The General Fund Appropriation funds 17,403 full-time equivalent positions (FTE).[3] The chart below shows the budget by division.



[3] Does not reflect positions that may be eliminated as part of management flexibility reserves.

S.L. 2014-100, Appropriations Act of 2014 (S.B. 744), appropriates $5.1 billion for the 11 Department of Health and Human Services (DHHS) divisions. Legislative adjustments to the FY 2014-15 certified budget for the HHS agencies increase spending by $10.5 million. The Legislative budget process focused primarily on the following major areas:

- Reforming Medicaid;
- Estimating the Medicaid budget shortfall;
- Identifying savings to cover the Medicaid budget shortfall;
- Realigning funds for child care subsidy; and
- Strengthening child protective services.

This Fiscal Brief provides a summary of the adjusted FY 2014-15 budget for DHHS.

Medicaid

Reform

Section 12H.1 of S.L. 2014-100 states the intent of the General Assembly to develop a detailed Medicaid reform plan during a Special Session in November 2014. However on August 20, 2014 the General Assembly adjourned sine die and will not return in November for a Special Session.

The Department is required to continue to consult with stakeholder groups, study, and recommend options for a Medicaid reform plan intended to provide greater budget predictability.

S.L. 2014-100 specifically prohibits the Department from:

- Implementing initiatives that will commit the State to any particular Medicaid reform plan;
- Submitting any reform-related State plan, amendments, waivers, or grant applications; and,
- Entering into contracts related to implementing Medicaid reform.

Both the House and the Senate passed versions of H.B. 118, North Carolina Medicaid Modernization; however a final version of the legislation was not enacted.

Estimating the Shortfall

Magnitude of the FY 2013-14 Budget Shortfall

Before determining how much to budget for the Medicaid program in FY 2014-15, an analysis of the FY 2013-14 budget was necessary. However, FY 2013-14 was a year with significant challenges for the Medicaid budget and the State's ability to forecast future budget needs. One of the major goals of the biennial budget passed during the 2013 Session was to avoid future Medicaid shortfalls by providing an appropriate factor for growth. However, despite efforts to avoid a budget shortfall, the General Assembly was again required to identify savings to provide additional funds for the Medicaid program for both FY 2013-14 and FY 2014-15.

The FY 2013-14 estimated shortfall was significantly less than the previous fiscal year. The total estimated Medicaid budget shortfall for FY 2013-14 was $81.7 million. The budget gap was offset by an estimated Health Choice budget surplus of $9.4 million, resulting in a net estimated budget shortfall of $72.3 million for FY 2013-14.

In summary, the net $72.3 million budget shortfall was comprised of the following:

Estimated claims, utilization and growth impact:	
Medicaid[1]	$ 157.1 M
Health Choice[2]	9.4 M
Net claims surplus	$ 166.5 M
Unachieved Reductions and PCS Budget	(76.0 M)
Unbudgeted ACA Implementation Impact	(18.1 M)
Cost Settlements	(8.2 M)
Liabilty for Claims and Enrollment Backlog	(136.5 M)
Projected Budget Shortfall	($72.3 M)

1 Medicaid amount is primarily due to the estimated claims and enrollment backlog.
2 Health Choice amount is due to the transfer of children to Medicaid.

Forecast Impediments

Implementation of two new information technology systems significantly impacted the State's ability to forecast expenditures. NC TRACKS, the new Medicaid claims payment system, was implemented on July 1, 2013. The new eligibility system, NC FAST, was implemented on October 1, 2013. The implementation of these new systems resulted in delayed and limited access to complete, timely and consistent data to analyze spending, trends and the impact of changes; delays in processing applications for Medicaid and Health Choice enrollment; and, delays in processing provider claims for payment.

Limited data resulted in significant uncertainty and negated the Fiscal Research Division's (FRD) ability to produce an accurate Medicaid forecast. Based on overall expenditure data and available national data, FRD instead produced best and worst case scenarios for the General Assembly to consider.

Budget Issues

Unachieved budget reductions also significantly impacted the Medicaid budget. S.L. 2013-360, Appropriations Act of 2013 reduced the Medicaid budget by $147.3 million and the Health Choice budget by $15.6 million. The Fiscal Research Division estimated that the Division of Medical Assistance would not achieve $63.6 million of those reduction items by the end of the 2013-14 fiscal year.

Without access to the appropriate data, it was difficult for FRD and DHHS to accurately assess the overall spending and trends for enrollment and utilization. However, expenditures in the personal care services (PCS) program exceeded the projected budget. PCS is provided to Medicaid recipients at home or in an adult care home. PCS provides assistance with activities of daily living, based on an independent assessment. The State has made numerous changes in the PCS program over the last three years in an effort to control spending. Section 12H.10 of S.L. 2014-100 directs the Department to propose a financial plan to contain the growth of the PCS budget in FY 2015-16 to the same level as FY 2014-15. Additionally the provision authorizes the Joint Legislative Oversight Committee on Health and Human Services to engage a contractor to study the issues related to reforming and redesigning the PCS program, while meeting the State's obligations under the Americans with Disabilities Act.

The Affordable Care Act (ACA) impacted spending in several ways, including:

- The provision that hospitals could determine that individuals are presumptively eligible for Medicaid and process claims until a final determination was made by the State;
- The expectation that individuals previously eligible for Medicaid that had chosen not to enroll, would enroll to avoid penalties;
- All children up to 133 percent of the federal poverty level must be covered under Medicaid, which required the State to shift 71,000 children from Health Choice to Medicaid; and
- The fact that North Carolina was not prepared to apply the new Modified Adjusted Gross Income (MAGI) eligibility criteria for enrollment effective January 1, 2014 which resulted in those individuals scheduled to be recertified remaining on Medicaid rolls for a longer time period in FY 2013-14.

Additional Funds for FY 2014-15

In estimating the amount of funds needed for Medicaid in FY 2014-15, FRD used FY 2013-14 assumptions as a foundation for preparing best and worst case scenarios. A number of factors from FY 2013-14 had to be annualized to prepare the new year's budget, including: increased Medicaid recipients as a result of ACA requirements for previously eligible individuals; the shift of children from Health Choice to Medicaid; the impact of presumptive eligibility; and, the impact of reduction items that began in FY 2013-14. This adjusted base served as a starting point for estimating the FY 2014-15 budget.

The base budget was increased to provide a 1.1 percent increase in enrollment and a 4.2 percent increase in utilization. Adjustments were also made to factor in the impact of a shift in enrollment distribution to more costly program aid categories based on historical trends and the impact of a higher federal match rate.

Contingency Reserve Established

Faced with a lack of reliable expenditure and enrollment data, FRD applied simplified budget methodologies using overall expenditure patterns to create a best and worst case budget estimate for the new fiscal year. Ultimately, the General Assembly adopted the midpoint estimate of $186.4 million for FY 2014-15. The recurring funds will be held in an unappropriated contingency reserve and are not part of the enacted Medicaid budget

Identifying Savings to Cover the Medicaid Shortfall

The General Assembly approved a number of policy changes to offset the costs for the Medicaid program in FY 2014-15 including:

- **Mental Health Drug Management**
  The Department is directed to manage mental health drug benefits to reduce State expenditures by $12 million annually by

adjusting the preferred drug list to maximize supplemental rebates and to impose controls that include prior authorization, utilization review and other restrictions. The effective date for this policy change is January 1, 2015; therefore the anticipated savings for FY 2014-15 is $6 million.

- **Reduce Provider Rates and Weights**
  S.L. 2014-100 reduces fee-for-service rates by one percent for all providers except hospital inpatient, drugs and dispensing fees, nursing homes, non-PCS home care services, private duty nursing, cost based providers and services where rates or rate-setting methodologies are set by the federal government or negotiated contract.

  Hospital inpatient weights will be reduced by 2.2 percent. The effective date of the rate and weight reductions is January 1, 2015 and will produce $7.2 million in savings.

- **Imaging Capitated Contract**
  S.L. 2014-100 directs the Department to achieve $5 million of savings in FY 2014-15 through renegotiation of the contract with its capitated imaging contractor, Medsolutions.

- **Hospital Outpatient Cost Settlements**
  S.L. 2014-100 modifies the payment and settlement for UNC Hospitals and Vidant Medical Center to 70 percent of cost, consistent with all other hospitals in the State. With an effective date of July 1, 2014, this will save the State $10 million in FY 2014-15.

- **Freeze Nursing Home Case Mix**
  S.L. 2014-100 freezes the quarterly case mix adjustments for the direct care component of the nursing home rates effective January 1, 2015. This change will produce $2.2 million in savings.

- **Average Acquisition Cost for Drug Pricing**
  S.L. 2014-100 directs the Department to change their drug pricing methodology so that ingredient cost is based on average acquisition cost. The Department is also required to adjust dispensing fees to generate a combined net savings of $975,000 in FY 2014-15.

- **State Retention of the Hospital Provider Assessment Plan**
  S.L. 2014-100 increases the percentage of financial assessments that will be retained by the State from 25.9 percent to 28.85 percent effective July 1, 2014. This increase will generate $15.1 million.

- **Single Base Rate for All Hospitals**
  S.L. 2014-100 establishes that effective January 1, 2015 a single base payment rate for all inpatient hospital services will be set at the state-wide median. The estimated savings for the State is $10.8 million.

Child Care Subsidy

Income Eligibility

S.L. 2014-100 changes Child Care Subsidy income eligibility effective October 1, 2014 from 75 percent of State Median Income to 200 percent of the Federal Poverty Level (FPL) for children ages 0-5 and special needs children; and to 133 percent FPL for children ages 6-12. Children in foster care, and those receiving child protective or child welfare services, will continue to receive assistance without regard to income. Families currently receiving assistance will have their eligibility determined by the new income standards at their next redetermination after October 1, 2014.

Most families who receive child care subsidy are required to pay a co-payment or a pro-rated co-payment for part-time care. Effective October 1, 2014, all required co-payments will be set at 10 percent of income, and payments for part-time care will no longer be pro-rated. Children in foster care or children who receive child protective or child welfare services will continue to be exempt from making co-payments.

Effective January 1, 2015 the definition of "income unit" for eligibility determination will change to include stepparents and the stepparent's child, if applicable. Additionally a nonparent relative caretaker (for example, a grandparent, aunt, or uncle), and the caretaker's spouse and child, if applicable, will be included in the definition of the "income unit" if the child's parent is not in the home.

Use of Funds

These changes in eligibility result in reductions of $11.4 million. The General Assembly repurposed the funds into the Child Care Subsidy program as follows:

- $6.8 million to increase the child care market rates for three, four and five star center and homes by 25 percent of the difference between the market rates currently in use and the recommended rate from the 2013 Child Care Market Rate study. The rates were last adjusted in 2007.
- $4.6 million to remove 1,000 slots from the child care subsidy waiting list in fiscal year 2014-15. When the eligibility changes are fully implemented, the repurposed funds will reduce the child care waiting list by 4,000 slots.

Allocation Formula Changes

S.L. 2014-100 requires the Division of Child Development and Early Education to update the child care allocation formula utilizing 2010 census data beginning in FY 2014-15. The use of the 2010 data will result in a reduction in funding for some counties and an increase in funding for others.

The change in allocations will be phased in over time. Beginning in FY 2014-15 county allocations will be adjusted by one-third of the impact of the 2010 Census. The next one-third adjustment will occur in FY 2016-17; the final third will be implemented in FY 2018-19. S.L. 2014-100 also requires county allocations to meet the following requirements:

- A county cannot receive less than 90 percent of its FY 2001-2002 allocation.
- For FY 2014-15, a county that did not have a waiting list in FY 2013-14 will not receive an increase in its allocation.
- Beginning in FY 2015-16, a county will not receive an increase if its spending was below 95 percent of its allocation in the previous year.

Child Protective Services (CPS)

S.L. 2014-100 appropriates $13.6 million for the Child Protective Services program; including $7.3 million to reduce CPS investigative workers' assessment caseloads to the State recommended level of 10 cases per worker. The number of CPS investigations in North Carolina has grown from 111,720 in FY 2001-02 to 134,126 in FY 2011-12, an increase of 20 percent. In calendar year 2011, there were 43 counties which exceeded the recommended caseload size. Increases in CPS caseload sizes impact how quickly a county can react to reports of abuse, neglect and dependency.

An additional $4.5 million is appropriated for Child Welfare In-Home Services to maintain the safety of the child while helping the parent/caretaker learn more effective parenting practices.

S.L. 2014-100 provides $750,000 to fund nine positions at the Division of Social Services to enhance the oversight of child welfare services in local county departments of social services. The new positions will improve oversight by monitoring, training and providing technical assistance to counties to ensure that the services provided address safety, permanency, and the well-being of children.

S.L. 2014-100 provides $700,000 in funding for a statewide evaluation of CPS at county departments of social services and the Department of Health and Human Services assessing child protective services performance, caseload sizes, administrative structure, funding adequacy and worker turnover, and providing recommendations to improve each area.

S.L. 2014-100 provides $300,000 to fund the development and implementation of a pilot program designed to enhance coordination of services and

information among local county departments of social service agencies and local law enforcement, court system, Guardian Ad Litem programs and other agencies as determined by the Department of Health and Human Services.

Other Major HHS Items

Office of the Chief Medical Examiner

S.L. 2014-100 appropriates an additional $1 million in funds to the Office of the Chief Medical Examiner (OCME) to address operational deficiencies in the statewide medical examination system. These funds are to be used to hire additional staff to perform autopsies and to train county medical examiners and law enforcement personnel to conduct proper death investigations. S.L. 2014-100, Sec. 12E.6 directs the Department to establish an oversight system, including the development and implementation of uniform protocols, to achieve operational efficiencies and to improve the quality of postmortem medicolegal examinations performed under the authority of OCME.

For additional information, please contact:

Health and Human Services

Susan Jacobs — *susan.jacobs@ncleg.net*
Deborah Landry — *deborah.landry@ncleg.net*
Steve Owen — *steve.owen@ncleg.net*
Denise Thomas — *denise.thomas@ncleg.net*

Fiscal Research Division
NC General Assembly
300 N. Salisbury St., Room 619
Raleigh, North Carolina 27603-5925
(919) 733-4910
http://www.ncleg.net/fiscalresearch

Actual and Certified Expenditures and Receipts by Division/Program

Division of Central Management and Support

	Actual FY 2011-12	Actual FY 2012-13	Actual FY 2013-14	Certified FY 2014-15
Expenditures	120,188,169	125,908,514	144,784,960	152,152,679
Less: Receipts	63,694,328	65,974,192	56,900,810	79,247,879
Net General Fund Appropriations	$56,493,841	$59,934,322	$87,884,150	$72,904,800
Positions (FTE)	641.8	638.3	630.3	632.3

Division of Aging and Adult Services

	Actual FY 2011-12	Actual FY 2012-13	Actual FY 2013-14	Certified FY 2014-15
Expenditures	105,024,104	106,927,441	103,738,221	115,311,763
Less: Receipts	60,755,523	63,151,812	62,679,994	61,838,971
Net General Fund Appropriations	$44,268,581	$43,775,629	$41,058,227	$53,472,792
Positions (FTE)	73.5	73.5	73.5	73.5

Divisions of Blind and Deaf/Hard of Hearing Services

	Actual FY 2011-12	Actual FY 2012-13	Actual FY 2013-14	Certified FY 2014-15
Expenditures	29,086,669	29,874,512	26,858,377	32,639,127
Less: Receipts	20,764,306	21,695,680	20,598,815	24,460,509
Net General Fund Appropriations	$8,322,363	$8,178,832	$6,259,562	$8,178,618
Positions (FTE)	316.8	313.8	313.8	313.8

Division of Child Development and Early Education

	Actual FY 2011-12	Actual FY 2012-13	Actual FY 2013-14	Certified FY 2014-15
Expenditures	662,294,474	669,099,259	656,924,715	667,998,042
Less: Receipts	399,659,660	411,106,467	412,804,790	444,361,688
Net General Fund Appropriations	$262,634,814	$257,992,792	$244,119,926	$223,636,354
Positions (FTE)	309.8	303.8	303.8	302.8

Division of Health Services Regulation

	Actual FY 2011-12	Actual FY 2012-13	Actual FY 2013-14	Certified FY 2014-15
Expenditures	63,611,042	56,213,053	58,357,135	65,399,275
Less: Receipts	47,663,558	42,344,340	43,268,597	49,275,796
Net General Fund Appropriations	$15,947,484	$13,868,713	$15,088,538	$16,123,479
Positions (FTE)	558.5	555.5	565.5	565.5

Division of Medical Assistance

	Actual FY 2011-12	Actual FY 2012-13	Actual FY 2013-14	Certified FY 2014-15
Expenditures	14,241,450,471	12,643,008,323	13,303,105,674	13,769,876,232
Less: Receipts	11,214,489,593	9,125,314,086	9,899,321,179	10,081,328,109
Net General Fund Appropriations	$3,026,960,878	$3,517,694,237	$3,403,784,495	$3,688,548,123
Positions (FTE)	425.5	428.3	428.3	428.3

Division of Mental Health, Developmental Disablilities and Substance Abuse Services

	Actual FY 2011-12	Actual FY 2012-13	Actual FY 2013-14	Certified FY 2014-15
Expenditures	1,366,409,130	1,368,260,023	1,355,447,632	1,364,706,219
Less: Receipts	697,027,523	683,863,564	660,570,003	684,642,473
Net General Fund Appropriations	$669,381,607	$684,396,459	$694,877,629	$680,063,746
Positions (FTE)	11,155.9	11,712.2	11,718.7	11,705.2

NC Health Choice

	Actual FY 2011-12	Actual FY 2012-13	Actual FY 2013-14	Certified FY 2014-15
Expenditures	336,858,465	325,597,032	246,435,066	174,711,677
Less: Receipts	259,003,262	246,263,500	187,777,208	132,777,705
Net General Fund Appropriations	$77,855,203	$79,333,532	$58,657,858	$41,933,972
Positions (FTE)	5.0	5.0	5.0	5.0

Division of Public Health

	Actual FY 2011-12	Actual FY 2012-13	Actual FY 2013-14	Certified FY 2014-15
Expenditures	807,514,836	770,028,806	743,185,225	827,356,675
Less: Receipts	615,511,411	628,755,403	605,988,504	691,020,631
Net General Fund Appropriations	$192,003,425	$141,273,403	$137,196,721	$136,336,044
Positions (FTE)	2,101.8	2,105.8	2,034.0	1,931.8

Division of Social Services

	Actual FY 2011-12	Actual FY 2012-13	Actual FY 2013-14	Certified FY 2014-15
Expenditures	1,674,763,277	1,661,798,665	1,693,405,403	1,668,936,436
Less: Receipts	1,489,276,926	1,495,907,995	1,526,473,418	1,480,171,149
Net General Fund Appropriations	$185,486,351	$165,890,670	$166,931,985	$188,765,287
Positions (FTE)	416.0	415.0	415.0	424.0

Division of Vocational Rehabilitation

	Actual FY 2011-12	Actual FY 2012-13	Actual FY 2013-14	Certified FY 2014-15
Expenditures	142,794,532	139,578,673	135,760,304	138,503,086
Less: Receipts	106,306,974	106,931,724	97,970,524	100,305,253
Net General Fund Appropriations	$36,487,558	$32,646,949	$37,789,780	$38,197,833
Positions (FTE)	1,031.5	1,030.5	1,030.5	1,018.5

Change in FTE, FY 2014-15

	Vacant	Filled	Receipts	New	Transfers	Net Change
Health and Human Services						
Central Management and Support				2.0		2.0
Aging and Adult Services						
Blind and Deaf/Hard of Hearing Services						
Child Development and Early Education	(1.0)					(1.0)
Health Services Regulation						
Medical Assistance						
Disabilities, & Sub. Abuse Serv.	(7.0)					(7.0)
NC Health Choice						
Public Health	(1.0)	(6.0)				(7.0)
Social Services				9.0		9.0
Vocational Rehabilitation	(13.8)	(7.0)				(20.8)
Health and Human Services	**(22.8)**	**(13.0)**	**-**	**11.0**		**(24.8)**

Tuesday, February 10	Room	Time
APPROPRIATIONS, HEALTH AND HUMAN SERVICES (JOINT)	643	8:30 am

Name	County	
Amanda Padden	Orange	Graig R. Meyer
Carrie Ruff	Rutherford	Mike Hager

Committee Sergeants at Arms

NAME OF COMMITTEE APPRROPIATIONS ON HHS

DATE: 2-10-2015 Room: 643

House Sgt-At Arms:

1. Name: REGGIE SILLS
2. Name: MARVIN LEE
3. Name: REY COOKE
4. Name: TERRY McCRAW
5. Name:

Senate Sgt-At Arms:

1. Name: CANTON LEWIS
2. Name: MARCUS KITTS
3. Name:
4. Name:
5. Name:

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HHS — 2-10-2015

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Matt Good	NCPC
Jamaica Pfister	CHS-NC
Frank Hill	PSG
Lexi Morgan	NCRMA
Padraig Gibbons	Capital City
TORRI Bryant	Restore NC
Matt Anderson	CHS NC
TRACY GOLVARD	AHA
Alan Briggs	NC Food Banks
Raquel Begelman	Nurse of the Day
Rob Lamme	PLA

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HHS — 2-10-2015

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kerra Bolton	CITN
John Handley	MF+S
Michelle Frazier	MF+S

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HHS — 2-10-2015

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Hayden Bauguess	FSP
[illegible]	NCNS
[illegible]	NCNS
Joanna Spruill	NLAFP
Daniel Van Lere	Vibrant Health
[illegible]	Carolinas Healthcare
[illegible]	GSU
Erica Nelson	NCHA
Wendy Kelly	Forsyth County
Ryan Blackledge	Cone Health
TJ Bugbee	NP

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HHS — 2-10-2015

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Amanda Horaker	Trautman Sandoc
Allison Waller	Cardinal Innovations
Thomas Moore	TWC
Julia M Adams Schoenrock	ARC, NCARF, NARC, ASNC
Sandy Sands	NP
JOEL MAYNARD	OPM + ASSOC
KEVIN LECOUNT	SEANC
Andy Chase	KMA
Kristen Lester	SSG NC
Christie Cleary	Wakemed
Cindy Hensel	NCHA

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HHS — 2-10-2015

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Hugh Johnson	NCAHC
Alex Mills	KLG
JERRY COHEN	Nelson Mullins
Ben Worthy	Lilly
Bill Rustin	ACP
Mike Johnson	ACP
Carson Hicks	MVA
Madeline Keeter	Cairo Mont Wrath
Scot Laster	SSGNC
Chris McClure	Brooks Pierce
J Peters	CCS

VISITOR REGISTRATION SHEET

APPROPRIATIONS ON HHS — Name of Committee

2-10-2015 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jon Carr	Jordan from Lumpkin

Joint Committee on Appropriations on Health and Human Services
Tuesday, February 11, 2015 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Joint Committee on Appropriations on Health and Human Services met at 8:30 AM on February 11, 2015, in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, William Brisson, Josh Dobson, Beverly Earle, Jean Farmer-Butterfield, Howard Hunter, Verla Insko, Chris Malone, and Gary Pendleton were present, along with 8 Senate members.

Senator Ralph Hise presided.

Senator Hise opened the meeting by welcoming everyone and recognizing the House Sergeants-at-Arms—Ray Cooke, Marvin Lee, Terry McCraw, and Reggie Sills—and the Senate Sergeants-at-Arms—Charles Marsalis and Steve McKaig. He also recognized the two House Pages in attendance—Lydia Noonan of Wilson County and Reaghan Waites of Wake County. There were no Senate Pages.

Senator Hise then recognized Secretary Wos for comments on DHHS Priorities FY 2015-17. Secretary Wos spoke about the reorganization and realignment of the Department; strategic investment in Medicaid reform; enhancement of the IT infrastructure—NCTracks and NC FAST; and a recent hospital ED diversion of patients and the need to provide crisis prevention and intervention at the community level. She discussed the Office of Vital Records and Office of Chief Medical Examiner, and then answered questions from Committee members.

Susan Jacbos, Fiscal Research, concluded her presentation on the Joint Appropriations Committeee on Health and Human Services Overview, and answered questions from Committee members.

The meeting adjourned at 9:59 AM

Senator Ralph Hise
Presiding

Susan Fanning, Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

February 11, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

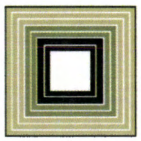
I.	**Welcome & Opening Remarks**	Senator Ralph Hise, Presiding Co-Chair
II.	**DHHS Priorities FY 2015-17**	Dr. Aldona Wos, Secretary DHHS
	Adjourn	

Joint Appropriations Committee on Health and Human Services

Committee Schedule and Budget Overview

Susan Jacobs
Fiscal Research Division

February 10, 2015



FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Joint Appropriations Committee on Health and Human Services

FY 2015-17 Session Strategy: Shifting from "*Paying*" to "*Investing*"

FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Joint Appropriations Committee on Health and Human Services Committee Presentation Plan

Session Strategy:
Shifting from "Paying" to "Investing"

"America spends twice as much on health care than any other nation, but we don't have the healthiest people….research indicates that spending on health care to <u>treat</u> people may actually come at the expense of investing in public health programs meant to keep people from getting sick to start with."

Source: Robert Wood Johnson Foundation "Geographic Variations in Public Health Spending: Correlates and Consequences" – October 2009

Session Strategy:
Shifting from "Paying" to "Investing"

- **North Carolina ranked 14th nationally in overall per capita health care expenditures in 2009.**

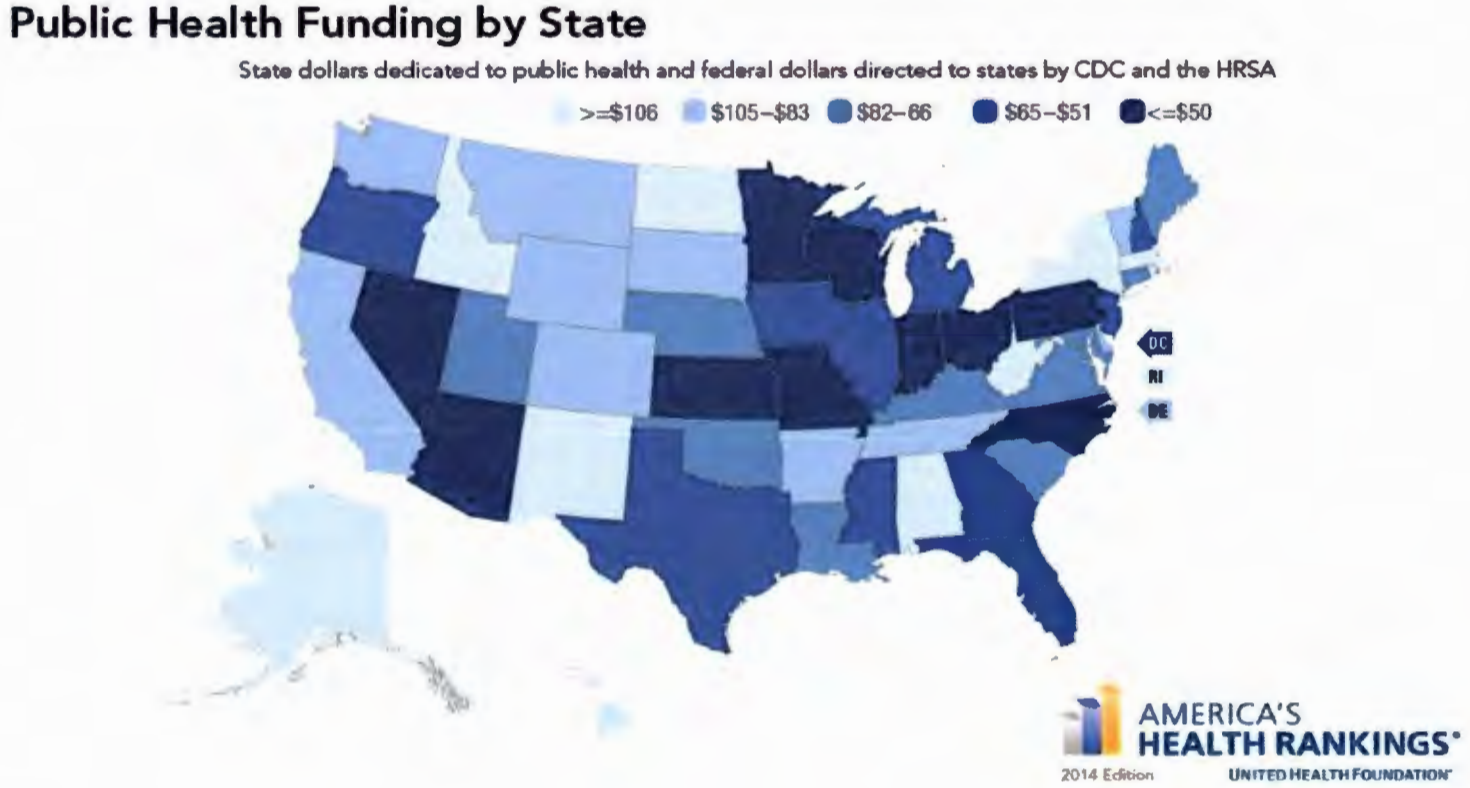
- **North Carolina's spending for public health expenditures was $51 compared to the national average of $94 per capita in 2009.**

- **North Carolina ranked 43rd in the country in public health spending at $50 per capita compared to the national average of $90 in 2014.**

- **North Carolina's overall health outcome ranking in 2014 is 37th in the nation, and was 35th in 2013.**

Source: http://kff.org/other/state-indicator/health-spending-per-capita/
Source: http://americashealthrankings.org/ALL/PH_Spending

Session Strategy:
Shifting from "Paying" to "Investing"



Joint Appropriations Committee on Health and Human Services Committee Presentation Plan

Session Strategy:
Shifting from "*Paying*" to "*Investing*"

Key Question for Any Program:

What outcome will you *require* for the investment you are making? Consider the following:

- **Are resources being targeted for the right purpose/program? Does that purpose "fit" with the overall goal of the agency?**
- **Does the program produce positive, evidence-based outcomes?**
- **Is there an alternative that would yield a better result for the state overall?**
- **Is the program adequately or inadequately funded?**
- **Other committee requirements?**

Where to Start? Focus for Long Session – Children (Birth -5)

Joint Appropriations Committee on Health and Human Services Committee Presentation Plan

Session Strategy:
Shifting from "Paying" to "Investing"

Planned Meeting Topics

- Organizational Meeting/DHHS Overview
- Secretary Wos and DHHS Staff – Goals for FY 2015-17
- Implementation Status of Historical Budget Items and Legislation
- Program Evaluation Division Report – "DHHS Should Integrate Substance Abuse Treatment Facilities into the Community-Based System and Improve Performance Management"
- Program Evaluation Division Report – "Revising State Child Support Incentive System Could Promote Improved Performance of County Program"
- School of Public Health – North Carolina Health Outcome Comparisons (All Populations)
- School of Public Health – North Carolina Health Outcome Comparisons for Children (Ages 0 – 5)
- School of Public Health – North Carolina Health Outcome Comparisons (Birth Weight/Infant Mortality)
- Evidence-Based Policy Making – Pew-MacArthur Results First Initiative
- "How North Carolina Pays Providers" – Fiscal Research Division
- Medical Payments for Pregnant Women and Infants/Cost Analysis of High Risk Deliveries/Preterm Births

Joint Appropriations Committee on Health and Human Services Committee Presentation Plan

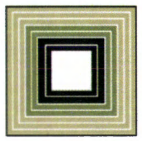
Session Strategy:
Shifting from "Paying" to "Investing"

Planned Meeting Topics

- North Carolina Prenatal/Perinatal Programs and Programs Focused on Reducing Infant Mortality
- North Carolina Public Health Programs for Children (Ages 0 – 5)
- "How Can North Carolina Improve Birth Outcomes Through Evidence-Based Practices" – Guest Speaker
- Proven Successes in Improving the Health of Children – Guest Speaker
- Staff Wrap-Up and Committee Discussion
- North Carolina Family Support Programs for Children (Ages 0 – 5) (Approximately 5 Meetings)
- Staff Wrap-Up and Committee Discussion

Joint Appropriations Committee on Health and Human Services

Budget Overview



FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Department of Health and Human Services

Statutory Authority

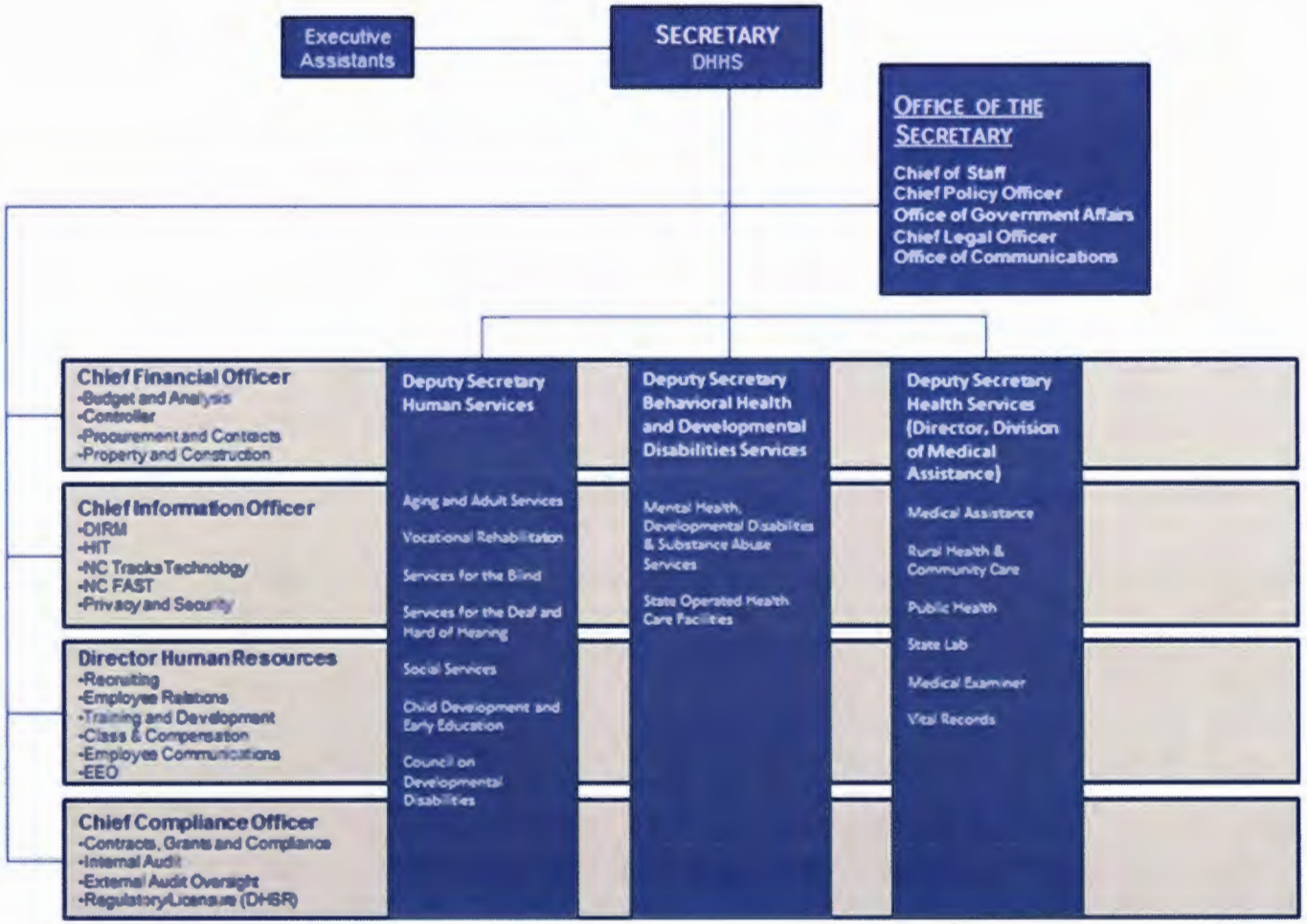
G.S. 143B-137.1. Department of Health and Human Services – duties.

It shall be the duty of the Department to:

- Provide the necessary management, development of policy, and establishment and enforcement of standards for the provisions of services in the fields of public and mental health and rehabilitation.
- With the intent to assist all citizens – as individuals, families, and communities – to achieve and maintain an adequate level of health, social and economic well being, and dignity.
- Whenever possible, the Department shall emphasize preventive measures to avoid or to reduce the need for costly emergency treatments that often result from lack of forethought.
- **The Department shall establish priorities to eliminate those excessive expenses incurred by the State for lack of adequate funding or careful planning of preventive measures.** (1997 443, s. 11A.3.)

Department of Health and Human Services

G.S. 143B-138.1



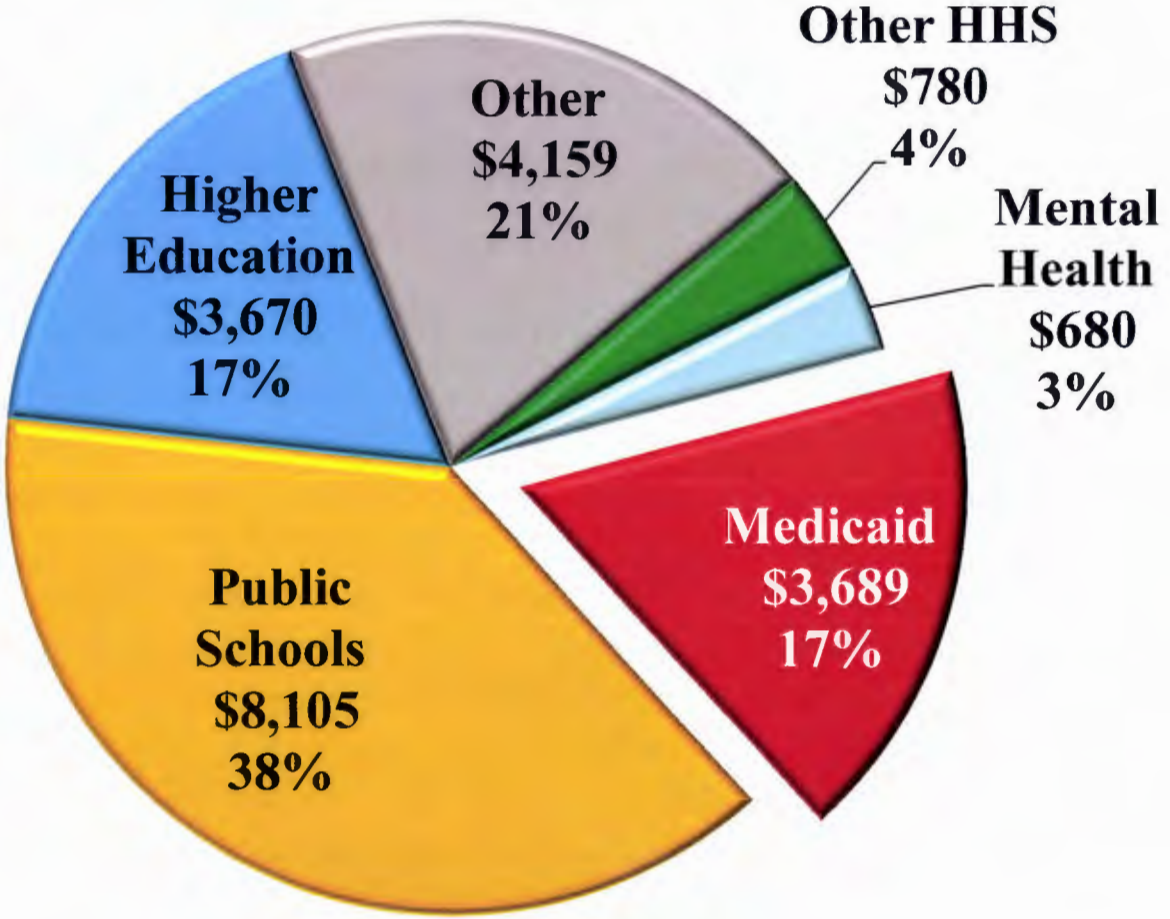
Department of Health and Human Services
2014-15 Certified General Fund Budget

Subcommittee/Area	General Fund Appropriation	% of Total
Education	11,775,270,816	56%
Health & Human Services	**5,148,161,048**	**24%**
Justice & Public Safety	2,366,128,478	11%
Natural & Economic Resources	407,326,212	2%
General Government	427,467,752	2%
Statewide Reserves and Capital	957,755,839	5%
TOTAL	**$21,082,110,145**	**100.00%**

Department of Health and Human Services
2014-15 Certified General Fund Budget

General Fund Appropriations FY 2014-15

Total: $21,082.1 million



Department of Health and Human Services

2014-15 Certified General Fund Budget

Health and Human Services	FY 2014-15	% of Total
Blind and Deaf / Hard of Hearing Services	8,178,618	0.16%
Health Service Regulation	16,123,479	0.31%
Vocational Rehabilitation	38,197,833	0.74%
NC Health Choice	41,933,972	0.81%
Aging and Adult Services	53,472,792	1.04%
Central Management and Support	72,904,800	1.42%
Public Health	136,336,044	2.65%
Social Services	188,765,287	3.67%
Child Development	223,636,354	4.34%
Mental Health, Dev. Disabilities and Sub. Abuse	680,063,746	13.21%
Medical Assistance	3,688,548,123	71.65%
Total Health and Human Services	**5,148,161,048**	**100%**

Department of Health and Human Services

2014-15 Total Certified Budget

Health and Human Services	FY 2014-15	% of Total
Blind and Deaf / Hard of Hearing Services	32,639,127	0.17%
Health Service Regulation	65,399,275	0.34%
Aging and Adult Services	115,311,763	0.61%
Vocational Rehabilitation	138,503,086	0.73%
Central Management and Support	152,152,679	0.80%
NC Health Choice	174,711,677	0.92%
Child Development	667,998,042	3.52%
Public Health	827,356,675	4.36%
Mental Health, Dev. Disabilities and Sub. Abuse	1,364,706,219	7.19%
Social Services	1,668,936,436	8.79%
Medical Assistance	13,769,876,232	72.56%
Total Health and Human Services	**18,977,591,211**	**100%**

Department of Health and Human Services
2013-14 Legislative Budget Adjustments

FY 2013-14	Governor's Continuation Budget	Recurring Adjustments	Nonrecurring Adjustments	Legislative Net Changes	FTE Changes	Revised Appropriation 2013-14	% Change
Central Management and Support	54,028,354	14,840,375	4,917,400	19,757,775	(6.00)	73,786,129	36.57%
Aging and Adult Services	54,443,196	(300,855)	0	(300,855)	0	54,142,341	-0.55%
Blind and Deaf / Hard of Hearing Services	8,178,618	0	0	0	0	8,178,618	0.00%
Child Development	259,254,083	(1,590,625)	(3,348,849)	(4,939,474)	(14.00)	254,314,609	-1.91%
Health Service Regulation	16,761,992	(365,935)	0	(365,935)	10.00	16,396,057	-2.18%
Medical Assistance	3,069,576,810	391,202,327	1,170,982	392,373,309	0	3,461,950,119	12.78%
Mental Health, Dev. Disabilities and Sub. Abuse	706,797,747	(18,660,348)	11,398,203	(7,262,145)	0	699,535,602	-1.03%
NC Health Choice	80,131,026	(12,181,866)	0	(12,181,866)	0	67,949,160	-15.20%
Public Health	156,784,502	(6,605,500)	(6,024,915)	(12,630,415)	(15.00)	144,154,087	-8.06%
Social Services	170,629,904	(847,818)	4,826,346	3,978,528	0	174,608,432	2.33%
Vocational Rehabilitation	39,284,143	(510,974)	0	(510,974)	0	38,773,169	-1.30%
Total Health and Human Services	**4,615,870,375**	**364,978,781**	**12,939,167**	**377,917,948**	**(25.00)**	**4,993,788,323**	**8.19%**

FY 2014-15	Governor's Continuation Budget	Recurring Adjustments	Nonrecurring Adjustments	Legislative Net Changes	FTE Changes	Revised Appropriation 2014-15	% Change
Central Management and Support	54,718,515	20,400,758	1,182,055	21,582,813	(6.00)	76,301,328	39.44%
Aging and Adult Services	54,443,196	(100,855)	0	(100,855)	0	54,342,341	-0.19%
Blind and Deaf / Hard of Hearing Services	8,178,618	0	0	-	0	8,178,618	0.00%
Child Development	259,254,083	(1,590,625)	(3,348,849)	(4,939,474)	(14.00)	254,314,609	-1.91%
Health Service Regulation	16,761,992	(350,513)	0	(350,513)	10.00	16,411,479	-2.09%
Medical Assistance	3,083,576,810	524,542,281	0	524,542,281	0	3,608,119,091	17.01%
Mental Health, Dev. Disabilities and Sub. Abuse	706,797,747	(18,660,348)	16,848,589	(1,811,759)	0	704,985,988	-0.26%
NC Health Choice	80,131,026	(22,383,093)	0	(22,383,093)	0	57,747,933	-27.93%
Public Health	156,784,502	(16,818,000)	1,975,085	(14,842,915)	(175.00)	141,941,587	-9.47%
Social Services	170,629,904	1,102,182	4,826,346	5,928,528	0	176,558,432	3.47%
Vocational Rehabilitation	39,284,143	(510,974)	0	(510,974)	0	38,773,169	-1.30%
Total Health and Human Services	**4,630,560,536**	**485,630,813**	**21,483,226**	**507,114,039**	**(185.00)**	**5,137,674,575**	**10.95%**

Department of Health and Human Services
2014-15 Legislative Budget Adjustments

	Certified Budget	Recurring Adjustments	Nonrecurring Adjustments	Legislative Net Changes	FTE Changes	Revised Appropriation 2014-15	% Change
Central Admin. and Support[1]	76,301,328	(5,396,528)	2,000,000	(3,396,528)	1.00	72,904,800	-4.45%
Aging and Adult Services	54,342,341	(969,549)	100,000	(869,549)	0	53,472,792	-1.60%
Blind and Deaf / Hard of Hearing Services	8,178,618	0	0	0	0	8,178,618	0.00%
Child Development[2]	254,314,609	(1,893,496)	(28,784,759)	(30,678,255)	-1	223,636,354	-12.06%
Health Service Regulation	16,411,479	(288,000)	0	(288,000)	0	16,123,479	-1.75%
Medical Assistance[3]	3,608,119,091	(56,536,746)	136,965,778	80,429,032	0	3,688,548,123	2.23%
Mental Health, Dev. Disabilities and Sub. Abuse	704,985,988	(8,323,653)	(16,598,589)	(24,922,242)	-7	680,063,746	-3.54%
NC Health Choice[4]	57,747,933	(15,813,961)	0	(15,813,961)	0	41,933,972	-27.38%
Public Health	141,941,587	176,620	(5,782,163)	(5,605,543)	(7.00)	136,336,044	-3.95%
Social Services	176,558,432	11,081,105	1,125,750	12,206,855	9.00	188,765,287	6.91%
Vocational Rehabilitation	38,773,169	(575,336)	0	(575,336)	(11.95)	38,197,833	-1.48%
Total Health and Human Services	**5,137,674,575**	**(78,539,544)**	**$ 89,026,017**	**10,486,473**	**(16.95)**	**5,148,161,048**	**0.20%**

1-Department wide reduction of $16 million included in this budget.
2-Federal funds used to offset $33.8 million in general funds.
3-Increase is due to additional funds for FY 13-14 shortfall.
4-Reduction based primarily on moving children from Health Choice to Medicaid.

Questions?

North Carolina General Assembly
Fiscal Research Division
Room 619
Legislative Office Building
Raleigh, NC 27603-5925
(919)-733-4910

http://www.ncleg.net/FiscalResearch/

VISITOR REGISTRATION SHEET

Health & Human Services — 2-11-15

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joey Stansbury	Senator Tucker
Kelly Castillo	NASW-NC
[illegible]	Benchmarks
Annaliese Dolph	DC
Matt Gray	NCPC
Joanna Spruill	NCAFP
Jennifer Gasperini	NCMS
Victoria Bennis	ECU - Guest
Mousumee Panigrahi	UNC Pediatrics
Carol Logan	UNC Med Peds
Scott Lassen	SSG NC

VISITOR REGISTRATION SHEET

Jt. HHS Approps. — February 11, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Bass	Troutman Sanders
Wendy Keely	Focus Carolina
John DelGrosso	Brubaker & Assoc.
Rob Lamme	RLA
John McMullen	MFS
Joyce Peterson	CSS
High Johnson	NCACC
Matthew McConnell	Carolinas Healthcare
Scott Unsworth	NHRMC
J Peters	CSS
Judy Jenkins	Oatsuka

VISITOR REGISTRATION SHEET

Jt. HHS Approps. — February 11, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mike Jones	ACP
Bill Rustad	ACP
Jim Johnson	BSA
Lanier Hodgson	UNC Health Care
Kevin Botha	WTM
Chris McClure	BP
Cherri Grayson	UHG
Cara Tozzie	Gov. Office
[illegible]	CCNC
Doug Mckeon	PSG
TJ Boybee	NP

VISITOR REGISTRATION SHEET

St. HHS Approps. — February 11, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Bode	BSH
Amanda Hbraker	Troutman Sanders
Amy Elle	NCPA
Daniel Van Liere	Valant Health
Trent Womble	DHHS
Kara Weishaar	Smith Anderson
Thomas Moe	FWW
Elizabeth Hodges	NC Peds
Mary Bethune	AARP-NC
Chip Baggett	NCMS
Anna Roberts	Pub Sector Group

VISITOR REGISTRATION SHEET

Jt. HHS Approps. — February 11, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cory Hanna	NCHA
Rick Coulton	Law Offices of Rick Coulton PLLC
C. Suggs	TS
Erica Nelson	NCHA
Fred Walsh	Eastern Seals UCP
Kristen Walker	SSCNC
Evelyn Henderson	CYOR

VISITOR REGISTRATION SHEET

Jt. HHS Approps. — February 11, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tamera Coyne-Beasley MD.	UNC - Chapel Hill
Joel Maynard	GPM

Joint Committee on Appropriations on Health and Human Services
Tuesday, March 3, 2015 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Joint Committee on Appropriations on Health and Human Services met at 8:30 AM on March 3, 2015 in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, William Brisson, Josh Dobson, Chris Malone, Howard Hunter and Gary Pendleton were present, along with 7 Senate members.

Representative William Brisson presided.

Representative Brisson opened the meeting by welcoming everyone and recognizing the House Sergeants-At-Arms: Young Bae, Bill Morris and Jim Moran, and Senate Sergeants-at-Arms: Canton Lewis and Steve Wilson.
He then recognized House Pages: Jacob Byrd from Burke County and Niki Vemulapalli of Cabarrus County; and Senate Pages Wilker Ballantine of New Hanover County and Ann-Hunter Carraway of Wake County.

Representative Brisson then recognized Dr. Anna Schenck of the Public Health Leadership Program & North Carolina Institute for Public Health to give a report on "How Healthy is North Carolina". Representative Brisson then opened the floor for questions by the members.

The meeting adjourned at 9:45 a.m.

Representative William Brisson
Presiding

Julie Ryan, Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

March 3, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Representative William Brisson, Presiding Co-Chair
	Introductions:	
	Sergeant at Arms:	
	House: Young Bae	
	Bill Morris	
	Jim Moran	
	Senate: ~~Kenton~~ Lewis Canton	
	Steve Wilson	
	Introduction of Pages:	
	See Attached -	
II.	**"How Healthy is North Carolina?"**	Dr. Anna Schenck, PhD, MPSH Associate Dean for Practice Professor of the Practice Public Health Leadership Program & NC Institute for Public Health
	Committee Discussion	
	Adjourn	

How healthy is North Carolina?

HHS Joint Appropriations Subcommittee, March 3, 2015

Anna P. Schenck, PhD, MPSH

Associate Dean for Practice

Professor of the Practice

Public Health Leadership Program &
North Carolina institute *for* Public Health

UNC
GILLINGS SCHOOL OF
GLOBAL PUBLIC HEALTH

Mission of the School

to improve public health, promote individual well-being and eliminate health disparities across North Carolina and around the world

Overview

- Present data on key health indicators for NC, compared to US and other southern states

- Identify areas where investments can result in improved health outcomes for North Carolinians

Goals

- Healthy long lives for all North Carolinians
- Healthy communities – healthy state of NC
- Investments in approaches that are effective in helping us achieve the goal of healthy individuals, communities and a healthy state

What does it mean to be healthy?

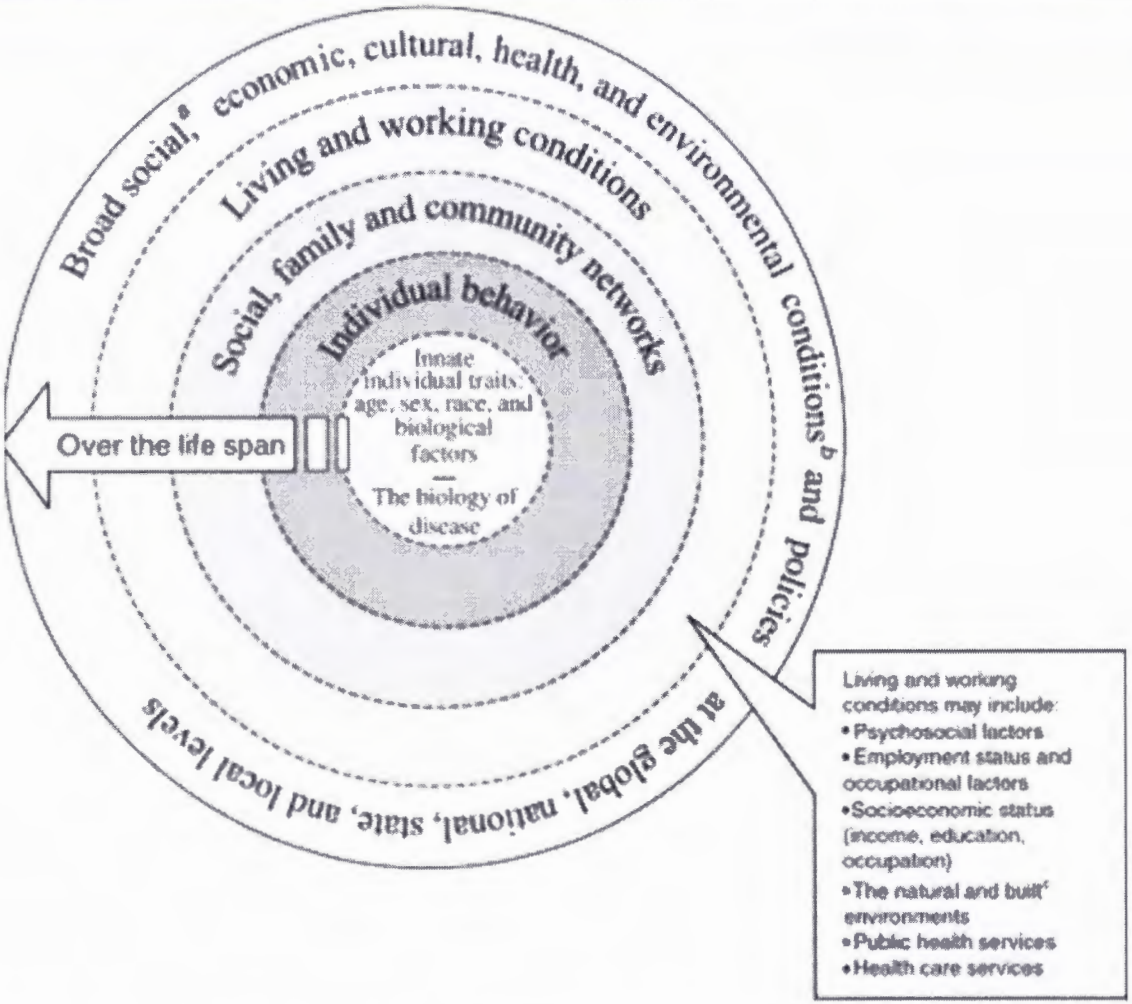
- A common measure used is life expectancy
  - North Carolina ranks 40th among the states in terms of life expectancy (77 years)*
    - An American born in Minnesota or Hawaii can expect to live 3 or 4 years longer than one born in North Carolina
  - Average life expectancy hides important variation*
    - Those born in Watauga and Wake can expect to live 8-9 years longer than those born in Swain or Richmond
    - White females in NC can expect to live 9 years longer than African American males

* Sources: http://www.worldlifeexpectancy.com/usa/north-carolina-life-expectancy and http://healthstats.publichealth.nc.gov/indicator/view_numbers/LifeExp.County.html

- The health of a state, and the health of a community are more than the health of individuals

- What does it take to have a healthy state?

Socio-ecological model of health



Source: Institute of Medicine. (2003). The Future of the Public's Health in the 21st Century. Washington, D.C.: National Academies Press.

Determinants of health

Source: Healthy People 2020

Role of Health Care

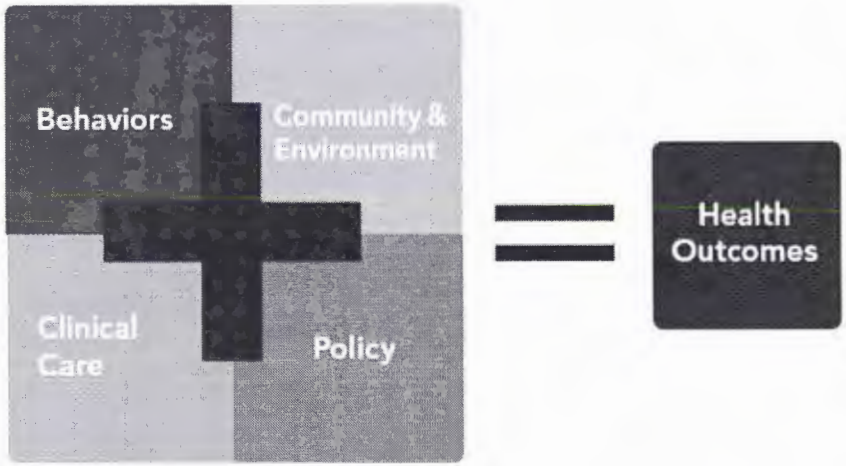
- Clinical care is important but not the primary determinant of health
- As a nation, we spend 17% of our GDP on health
  - 50% more than the next highest country
- We have some of the worst outcomes compared to other developed countries
  - 42 among other developed countries in infant mortality

* Sources: http://www.oecd.org/unitedstates/Briefing-Note-UNITED-STATES-2014.pdf

Health care related spending **crowds out** spending on a number of other areas that would help us achieve better health outcomes

AMERICA'S
HEALTH RANKINGS
UNITED HEALTH FOUNDATION

- 25 years of state-by-state comparisons
- Partnership of United Health Foundation, American Public Health Association and Partnership for Prevention



*Source: United Health Foundation. America's Health Rankings 2014, A call to action for individuals and their communities. Accessed at: www. Americashealthrankings.org.

Comparisons

- North Carolina and six southern neighbors
  - Virginia
  - Tennessee
  - South Carolina
  - Georgia
  - Alabama
  - Florida
- United States
- Data from Americas Health Rankings and County Health Rankings*

* Sources: www.americashealthrankings.org and www.countyhealthrankings.org

rates
diabetes
cancer
obesity
statistics
preterm
death
environmental
cholesterol
infant
pressure
birth
disease
rate
ranking
low
vital
ranking
blood
number
conditions
diseases
weight
morbidity
mortality
tobacco
births
heart
high

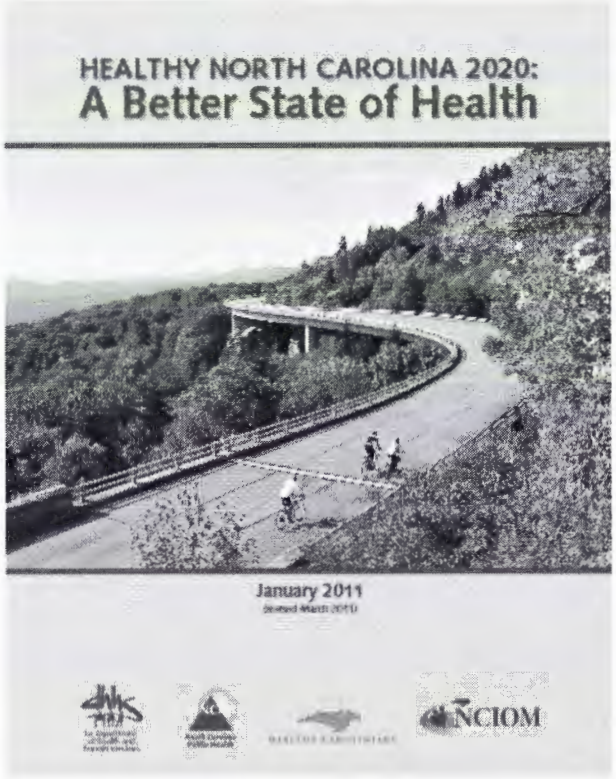
Frameworks

National

Healthy People 2020

http://www.healthypeople.gov/

North Carolina



http://www.publichealth.nc.gov/hnc2020/index.htm

Healthy babies

	Infant Mortality	Low birth weight	Pre-term births
North Carolina	7.3	8.8	12
Alabama	8.6	10	14.6
Florida	**6.3**	8.6	13.7
Georgia	6.6	9.3	12.7
South Carolina	7.5	9.6	13.7
Tennessee	7.3	9.2	12.5
Virginia	6.6	**8.1**	**11.3**
United States	6	8	11.5

Definitions:

Infant mortality rates represent the number of deaths to infants before age 1 per 1000 live births
Low birth weight represents the percent of infants born weighing less than 5.5 pounds.
Preterm births are the percent of babies born before 37 weeks gestation.

Healthy children and youth

	Childhood Immunization	Adolescent Immunization
North Carolina	72	64.9
Alabama	77	65.5
Florida	70	63.8
Georgia	69.8	64
South Carolina	66.5	60.4
Tennessee	68.5	61.2
Virginia	69.2	58.5
United States	70.4	67.1

Definitions:

Childhood immunization represents the Percentage of children aged 19 to 35 months receiving recommended doses of DTaP, polio, MMR, Hib, hepatitis B, varicella, and PCV vaccines.

Adolescent immunization represents the percentage of adolescents aged 13 to 17 years who have received 1 dose of Tdap since the age of 10 years, 1 dose of menigococcal conjugate vaccine, and 3 doses of HPV (females).

Healthy children and youth

	Child Poverty Rate	High School Graduation
North Carolina	26.8	79
Alabama	26.4	75
Florida	19.3	75
Georgia	23.2	70
South Carolina	18.5	72
Tennessee	26.7	83
Virginia	14.5	84
United States	19.9	81

Definition:
Child poverty rate represents the percentage of persons younger than 18 years who live in households at or below the poverty threshold.

Mortality
(rates per 100,000 population)

	Cancer	Cardiovascular Disease	Chronic Respiratory Disease
North Carolina	196.2	252.2	50.6
Alabama	211.5	329.2	63
Florida	**182.7**	**223**	58
Georgia	192.3	273	41.8
South Carolina	203.5	272.2	57.7
Tennessee	213.5	300.6	60.1
Virginia	189.5	241.1	**38.5**
United States	189.9	251.4	47.2

Intervention Pyramid

Morbidity

	High blood pressure	High cholesterol	Diabetes
North Carolina	35.5	41	11.4
Alabama	40.3	44.4	13.8
Florida	34.6	40.3	11.2
Georgia	35	38.1	10.8
South Carolina	38.4	42.6	12.5
Tennessee	38.8	38.7	12.2
Virginia	32.5	38.6	9.8
United States	31.4	38.4	9.6

Definitions:
High blood pressure – the percent of persons who have been told by a health professional they have high blood pressure.
High cholesterol – the percent of person who have had their cholesterol checked and been told it was high (BRFSS).
Diabetes: the percent of person who responded yes they had been told by a doctor that they have diabetes (BRFSS).

Substance abuse and mental health

	Excessive Drinking (%)	Drug Deaths per 100,000	Suicide per 100,000
North Carolina	14.1	12.6	13.2
Alabama	12.3	11.7	15
Florida	17.6	15.2	14.9
Georgia	14.3	10.8	**12**
South Carolina	16.3	13.5	14.2
Tennessee	**10.5**	17.2	15
Virginia	17.2	**8.4**	12.9
United States	18.2	13	12.9

Definitions:

Excessive drinking= binge or heaving drinking. BRFSS. Expressed as a percent of adults.

Drug deaths=deaths due to drug injury of any intent per 100,000 population.

Behaviors/conditions

	Adult Smoking	Youth Smoking	Adult Obesity	Youth Obesity	Adult Physical Inactivity
North Carolina	20.3	15			
Alabama	21.5	18			
Florida	**16.8**	10.8			
Georgia	18.8	12.8			
South Carolina	22	16			
Tennessee	24.3	15.4			
Virginia	19	**11.1**			
United States	19	15.7			

Behaviors/conditions

	Adult Smoking	Youth Smoking	Adult Obesity	Youth Obesity	Adult Physical Inactivity
North Carolina	20.3	15	29.4	12.5	
Alabama	21.5	18	32.4	17.1	
Florida	**16.8**	10.8	**26.4**	11.6	
Georgia	18.8	12.8	30.3	12.7	
South Carolina	22	16	31.7	13.9	
Tennessee	24.3	15.4	33.7	16.9	
Virginia	19	**11.1**	27.2	**12**	
United States	19	15.7	29.4	15.7	

Behaviors/conditions

	Adult Smoking	Youth Smoking	Adult Obesity	Youth Obesity	Adult Physical Inactivity
North Carolina	20.3	15	29.4	12.5	26.6
Alabama	21.5	18	32.4	17.1	31.5
Florida	**16.8**	10.8	**26.4**	11.6	27.7
Georgia	18.8	12.8	30.3	12.7	27.2
South Carolina	22	16	31.7	13.9	26.9
Tennessee	24.3	15.4	33.7	16.9	37.2
Virginia	19	**11.1**	27.2	**12**	**25.5**
United States	19	15.7	29.4	15.7	25.3

Public health funding

	Public Health Funding (per capita)
North Carolina	$49.85
Alabama	$116.50
Florida	$57.98
Georgia	$60.00
South Carolina	$67.71
Tennessee	$83.11
Virginia	$68.04
United States	$90.00

Definition:
State dollars dedicated to public health and federal dollars directed to states by the Centers for Disease Control and Prevention and the Health Resources and Services Administration

What works for Healthy NC?

- Evidence based solutions to these problems exist
- Important to implement solutions with the appropriate "dose"
- Monitoring and evaluating progress is key to success
- Partnerships across all sectors working on the social determinants of health

Processes for Priority Setting

- Considerations
  - Number of people affected
  - Severity
  - Effectiveness of interventions
  - Return on investment
- Tools and processes have been used in many other states and communities

Closing comments

- North Carolina ranks 37 among all 50 states in health
- Improving health outcomes requires partnerships across all sectors
- Evidence about successful programs and policies exists
- Sustained and consistent effort will be needed to improve health outcomes

Acknowledgements

- NC Division of Public Health
- NC State Center for Health Statistics
- NC Department of Health and Human Services

nc department of health and human services

NCPH
North Carolina Public Health

For more information

Contact:

Anna Schenck, PhD, MSPH

Anna.Schenck@unc.edu

SENATE PAGES ATTENDING

COMMITTEE: Joint Approps - Health & Hum. Serv.

DATE: 3/3, TIME: 8:30, ROOM: 643

Pages: Please print legibly.....*or else!!!!!!!!!!!!!!!!*

Page Name	Hometown	Sponsoring Senator
1 Wilker Ballantine	Wilmington	Berger
2 Ann-Hunter Carraway	Wake Forest	Barefoot
3		
4 Niki Vemulapalli	Cabarrus	Pittman
5 JAcob Byrd	Burke	Blackwell
6		
7		
8		
9		

Do not add additional names below the grid.

Pages: Please present this form to either the Committee Clerk at the meeting or a Sgt. at Arms.

Committee Sergeants at Arms

NAME OF COMMITTEE Jt. Comm. App. on HHS

DATE: 03/03/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name: Canton Lewis
2. Name: Steve Wilson
3. Name:
4. Name:
5. Name:

Carlton Lewis
Steve Wilson

Tuesday, March 3	Room	Time
APPROPRIATIONS, HEALTH AND HUMAN SERVICES	643	8:30 am

Name	County	Sponsor
Jacob Byrd	Burke	Hugh Blackwell
Niki Vemulapalli	Cabarrus	Larry G. Pittman

VISITOR REGISTRATION SHEET

Jt. Comm. App. on HHS — 03/03/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michele Rivest	NC Child Care Coalition
Marisa Jarrell	K&L Gates
Rhian Meiwald	Williams Mullen
Megan Klutz	Rep. Ultimire LA
Ken Michel	Brunhuk
Tom Friedman	STP
Colleen Kochanek	NCCEP
Matt Gray	NCK
Chip Kelly	Nelson Mullins
TRACY GOLLAND	AHHC
Whitney Christensen	Ward & Smith, P.A

VISITOR REGISTRATION SHEET

Jt. Comm. App. on HHS — 03/03/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kay Castillo	NASW-NC
NICHOLE KARIM	NAMI NC
Mary Bethea	AARP - NC
RUTH PETERSEN	DPH
Jim MARTIN	TPCB DPH
Danie/Staley	Division of Public Health - DHHS
Eleanor Howell	DHHS/Div. Public Health
Alan Devlin	UNC School of Public Health
Jen Willis	UNC-CH
Maribeth Wooten	DHHS / Div. of Public Health
ALAN DELLAPENNA	DHHS/DPH

VISITOR REGISTRATION SHEET

Jt. Comm. App. on HHS — 03/03/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Trent Womble	DHHS
Wendy Kelly	Focus Carolinas
Robin Huffman	NC Psychiatric Assoc
Ryan Blackledge	CoreHealth
Allison Stewart	Cardinal Innovations
Joanna Spruill	NCAFP
Amanda Honaker	Troutman Sanders
TJ Bugbee	NP
John Handi	MFTs
Curtis McDonald	BMS
Chris Emanuel	C.G. Emanuel Group

VISITOR REGISTRATION SHEET

Jt. Comm. App. on HHS — 03/03/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rob Lamm	RLA
Alex Knapp	PENC
Judy Jenkins	OAPI
Erin Fleck	Senate Staff
Mike James	ACP
Bill Rustin	ACA
Jennifer Goodling	NCMS
Fred Wood	Eastern Seals UCP
Martha McConnell	Carolinas HealthCare
Dan Worthy	Lilly
[illegible]	CSS

VISITOR REGISTRATION SHEET

Jt. Comm. App. on HHS — 03/03/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kara Weisenar	SA
Cory Hand	NCHA
Erika Nelson	NCHA
Chip Boger	NCMS
DAVID BARNES	Electrician
Matt Ellinwood	NCJC
Kristen Laster	SSGNC
Cara Townsend	Governor's Office
Lynda [illegible]	NCALHD
Jim Dolan	BSA
Chuck Stone	SEANC

VISITOR REGISTRATION SHEET

Jt. Comm. App. on HHS — 03/03/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JEFF BACKHART	MWL

VISITOR REGISTRATION SHEET

Jt. Comm. App. on HHS — 03/03/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jason Joyner	New Frame

Joint Committee on Appropriations on Health and Human Services
Wednesday, March 4, 2015 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Appropriations on Health and Human Services met at 8:30 AM on March 4, 2015 in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, William Brisson, Josh Dobson, Chris Malone, Beverly Earle, Howard Hunter and Gary Pendleton were present, along with 8 Senate members.

Senator Louis Pate Presided.

Senator Pate opened the meeting by welcoming everyone and recognizing the House Sergeants-At-Arms: Young Bae, Bill Morris and Jim Moran, and Senate Sergeants-at-Arms: Canton Lewis and Steve Wilson. He then recognized House Pages: Jordan Trivette from Bladen County and Niki Vemulapalli of Cabarrus County; and Senate Page Daria Thomas of Kinston.

Senator Pate recognized Jeff Grimes of the Program Evaluation Division to give a report on "DHHS Should Integrate State Substance Abuse Treatment Facilities into the Community-Based System and Improve Performance Management" (attachment 1). Joyce Jones, Legislative Drafting Division was also recognized to explain "Bill Summary/Joint Legislative Program Evaluation Oversight Committee Recommendations/Publically Funded Substance Abuse Services" (attachment 2).

Senator Pate then opened the floor for questions by the members.

The meeting adjourned at 9:50 a.m.

Louis M Pate Jr.
Senator Louis Pate
Presiding

Edna Pearce
Edna Pearce, Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

March 4, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Senator Louis Pate, Presiding Co-Chair
II.	**"DHHS Should Integrate State Substance Abuse Treatment Facilities into the Community-Based System and Improve Performance Management"**	Jeff Grimes, Program Evaluation Division
	Bill Summary/Joint Legislative Program Evaluation Oversight Committee Recommendations/ Publically Funded Substance Abuse Services	Joyce Jones, Legislative Drafting Division
III.	**Strategies to Increase Child and Adolescent Behavioral Health Inpatient Beds (S. L. 2014-100;Section 12F.3)**	Dave Richard, Deputy Secretary Behavioral Health and Developmental Disability Services, Department of Health and Human Services
	Committee Discussion	
	Adjourn	

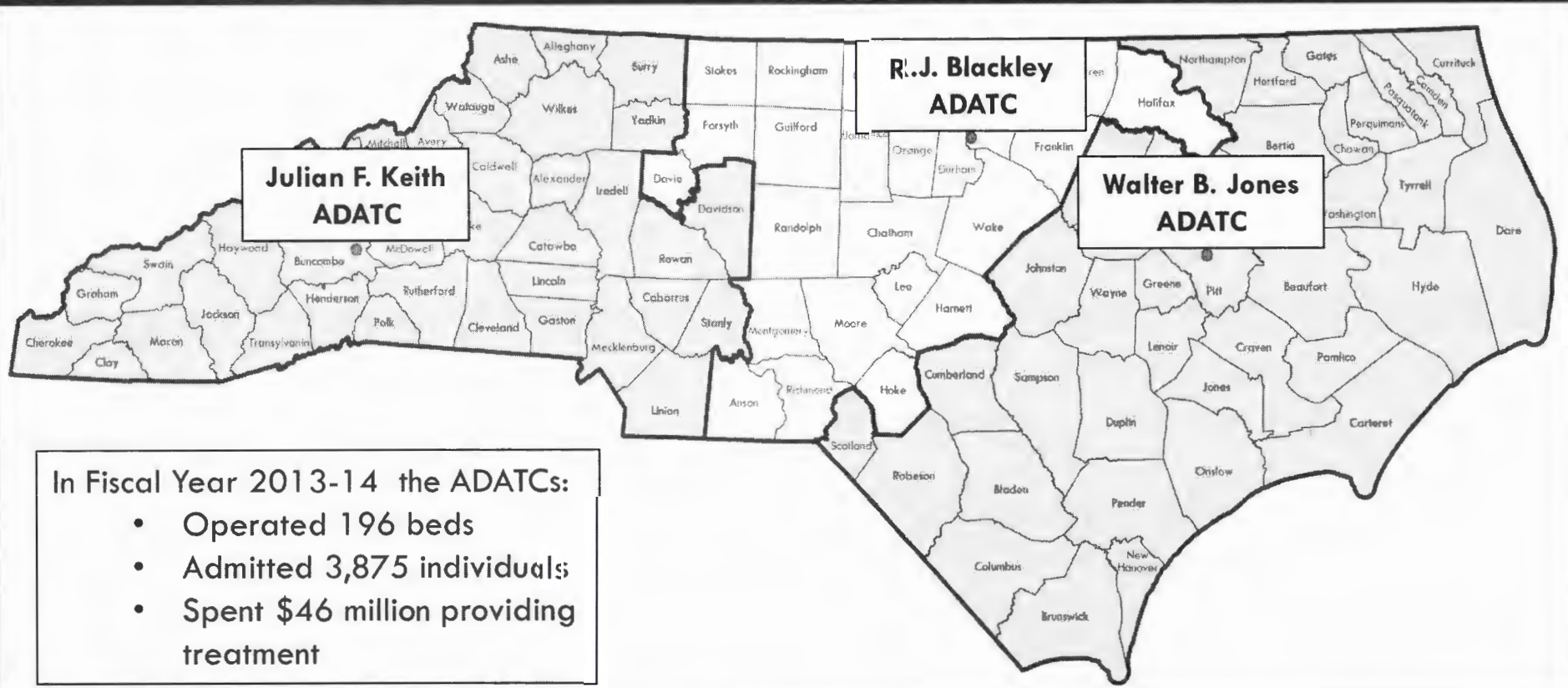
DHHS Should Integrate State Substance Abuse Treatment Facilities into the Community-Based System and Improve Performance Management

A presentation to Joint Appropriations Committee on Health and Human Services

March 4, 2015

Jeff Grimes, Senior Program Evaluator

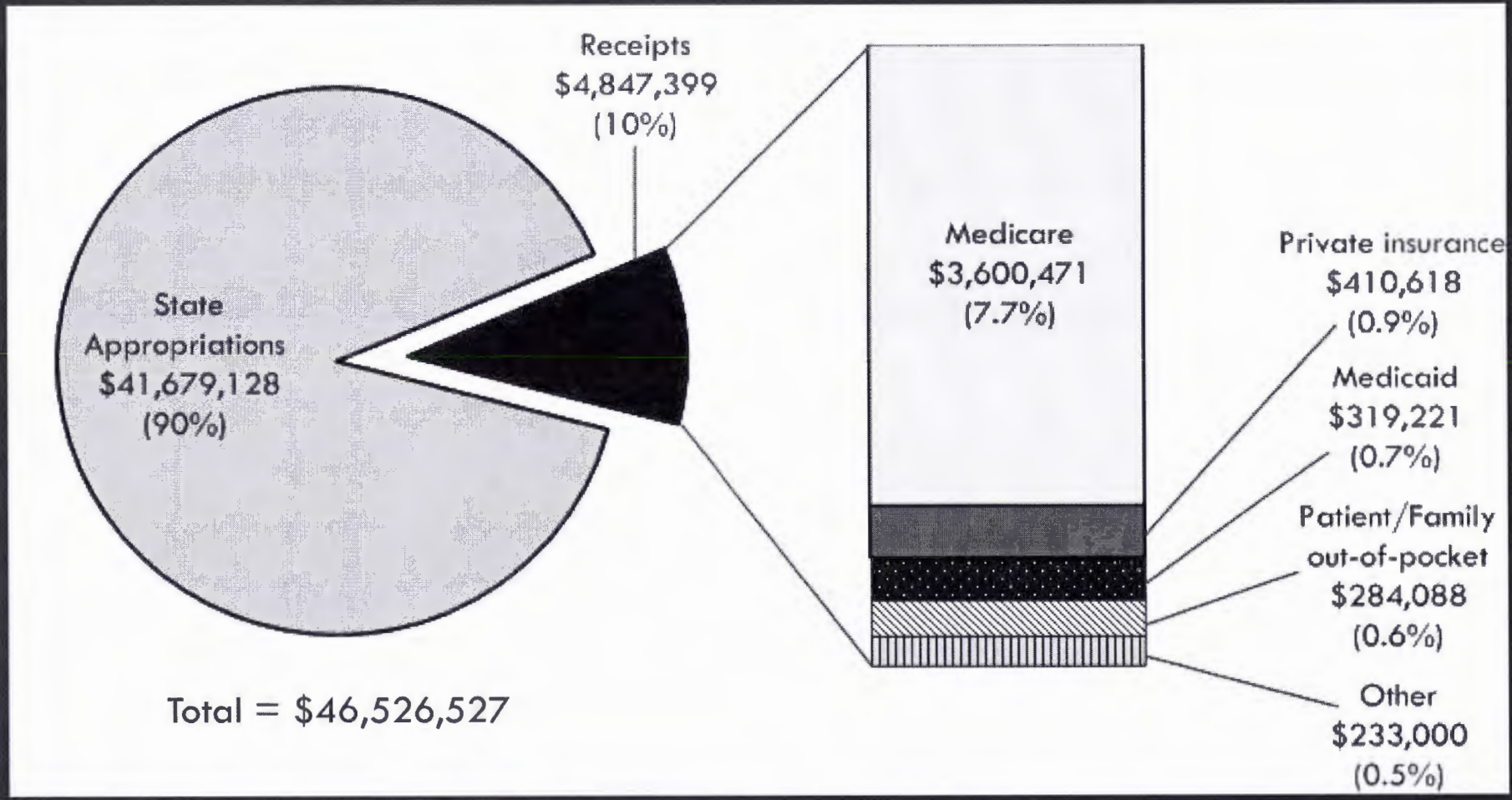
Three Alcohol Drug Abuse Treatment Centers (ADATCs)



In Fiscal Year 2013-14 the ADATCs:

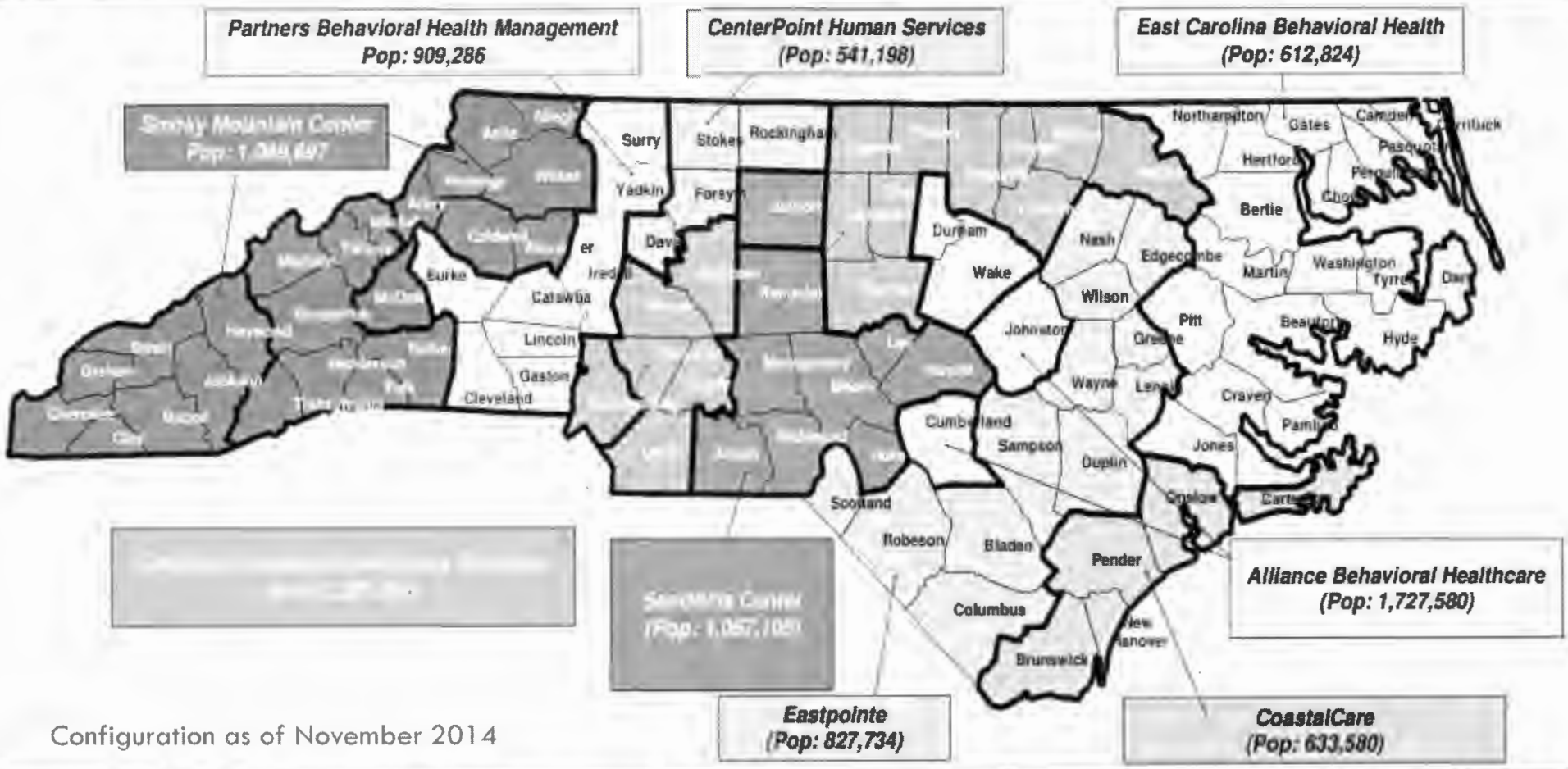
- Operated 196 beds
- Admitted 3,875 individuals
- Spent $46 million providing treatment

State Appropriations Funded 90% of ADATC Operations in Fiscal Year 2013-14



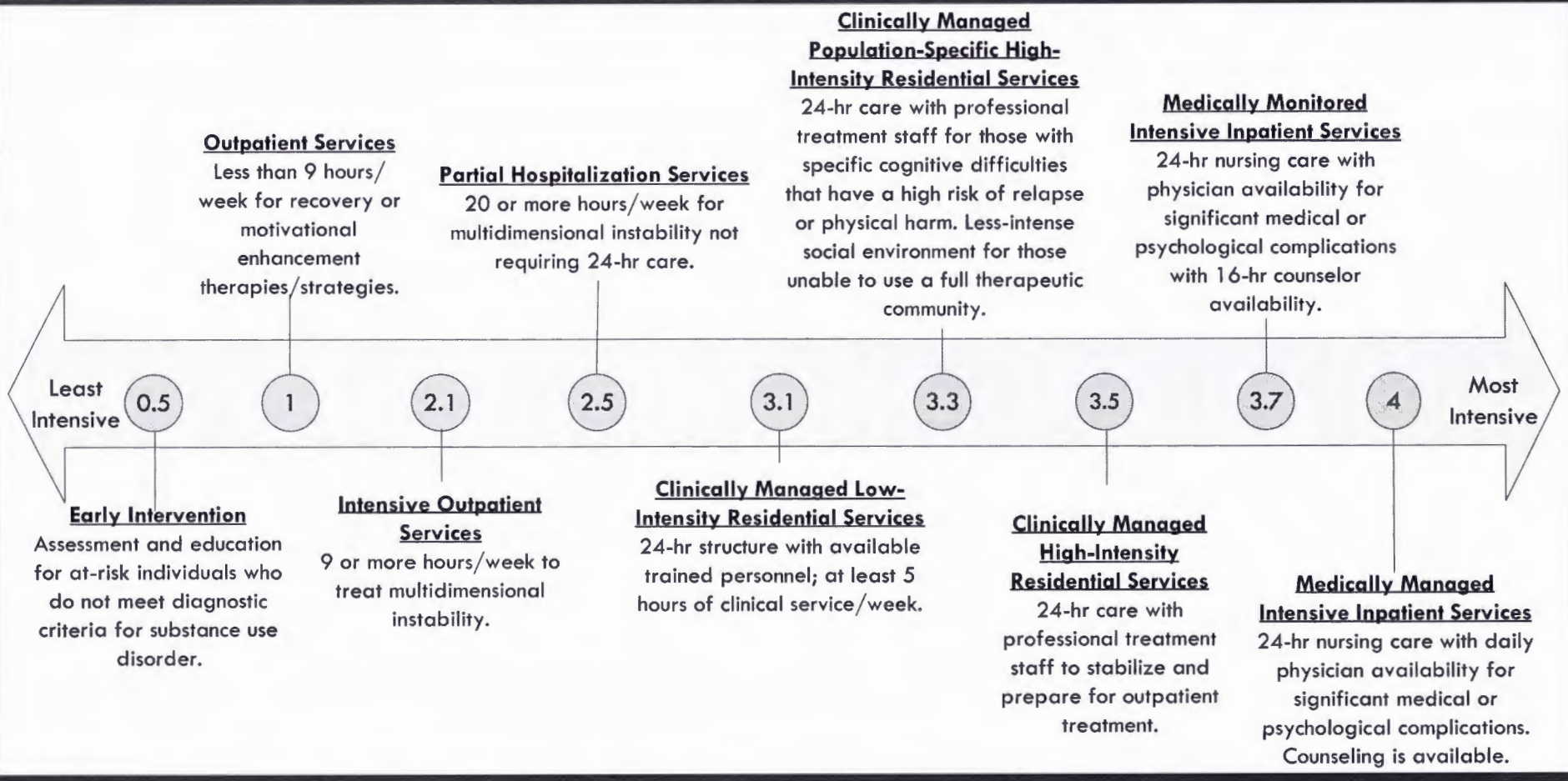
Total = $46,526,527

Community-Based Treatment System
Local Management Entities/Managed Care Organizations (LME/MCOs)



Configuration as of November 2014

American Society of Addiction Medicine (ASAM) Continuum of Care for Substance Abuse Treatment



Report p. 4, Exhibit 1

Finding 1.

The three Alcohol and Drug Abuse Treatment Centers operate with a high degree of autonomy, resulting in operational and treatment differences

ADATC Admissions, Personnel, and Expenditures

ADATC Facility	Annual Admissions	Number of Personnel	2013–14 Expenditures	Average Cost Per Stay
Julian F. Keith	1,203	194	$15,212,660	$12,646
R.J. Blackley	1,291	152	$16,126,312	$12,491
Walter B. Jones	1,381	155	$15,187,556	$10,998
Total	3,875	501	$46,526,527	

Report p. 13, Exhibit 8

Over-Expenditures at ADATCs in Fiscal Year 2013-14

- ADATCs received a $4.9 million reduction in appropriations
- ADATCs overspent appropriations by $5.2 million
- Overexpenditures covered by O'Berry Neuro-Medical Treatment Center and Murdoch Developmental Center

Report p. 15

Finding 2.

Separation of the Alcohol and Drug Abuse Treatment Centers from the community-based system creates operational silos which impose challenges to utilization management, continuity of care, and information management

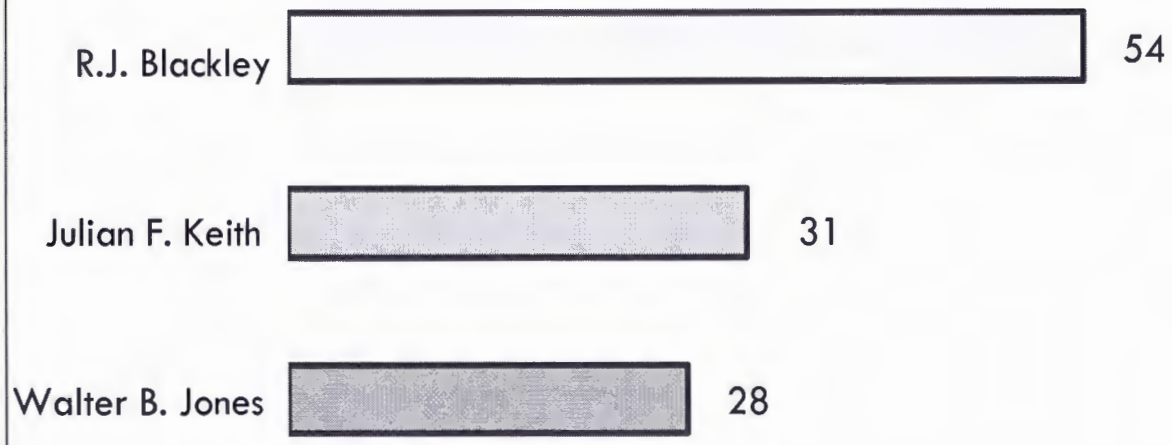
Structural Incentives Promote Overreliance on ADATCs

- LME/MCOs have no financial incentive to manage utilization of ADATCs
- ADATCs have limited incentive to restrict utilization
- LME/MCOs have little incentive to invest in expanded community-based treatment options that would serve as a substitute for ADATC services

Report p. 20

Prolonged Lengths of Stay Cost the State More Than $1.5 Million in Fiscal Years 2012-14

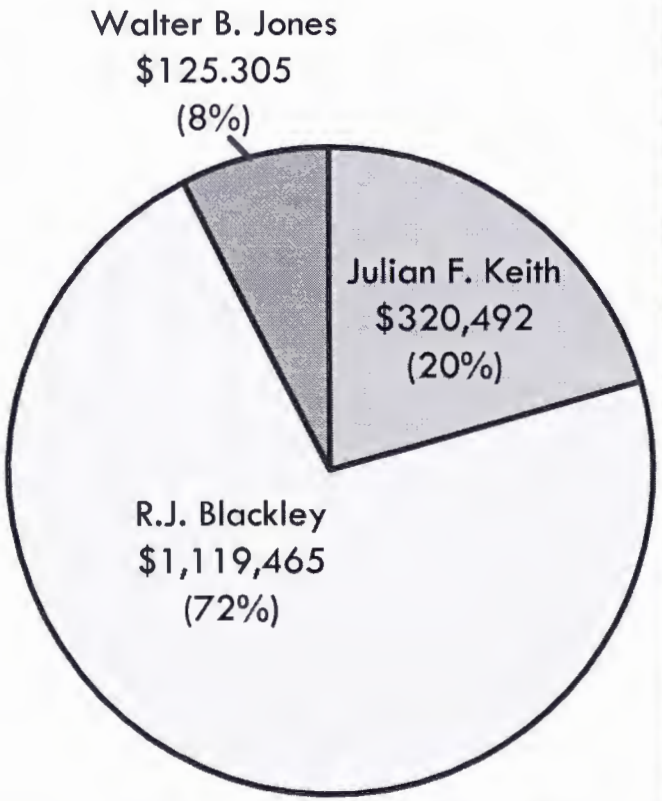
Number of Individuals Who Received Prolonged Treatment



Total = 113 Individuals

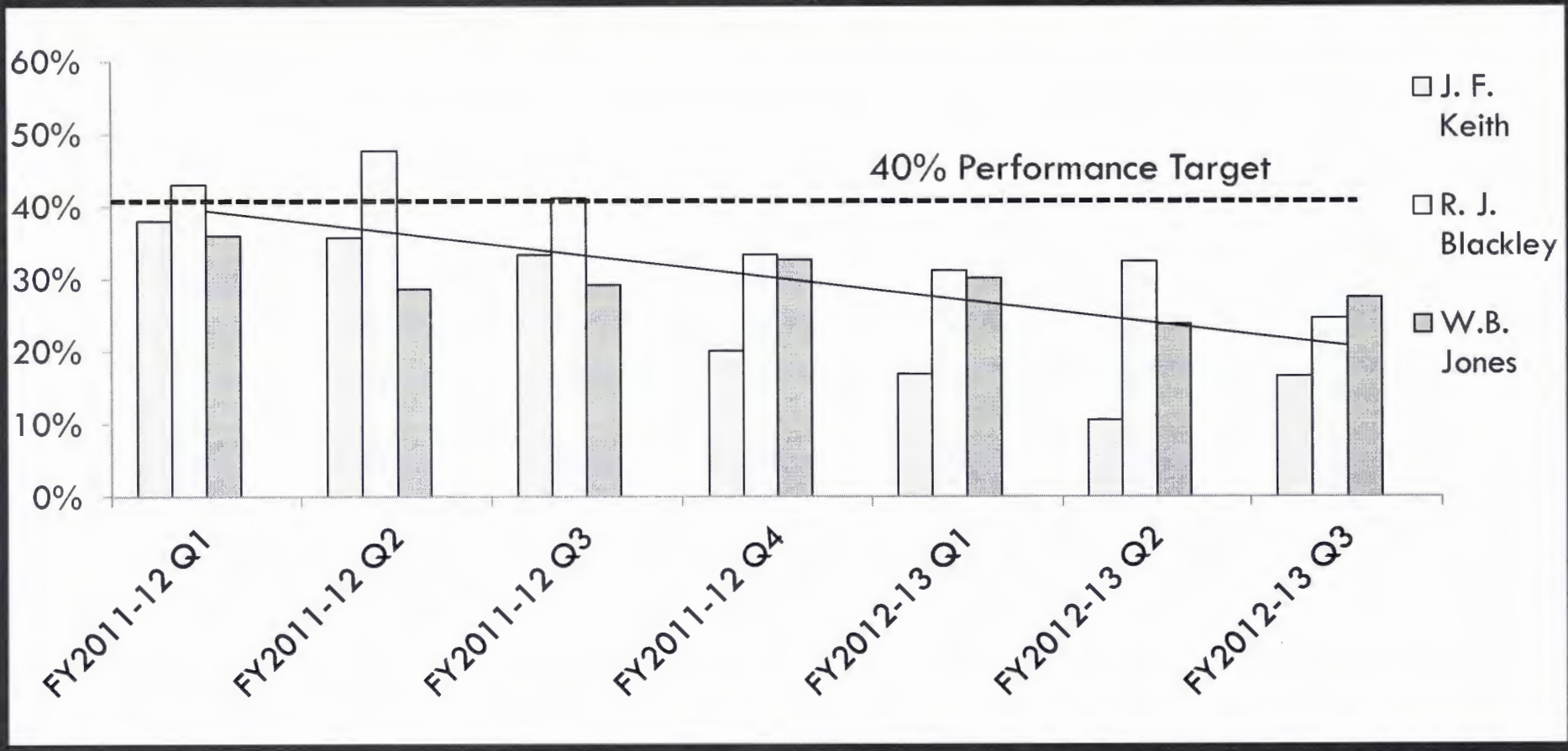
Prolonged Length of Stay = treatment days that exceeded two standard deviations from the mean number of treatment days at each facility

Cost of Prolonged Treatment



Total Cost = $1,565,262

Continuity of Care Among the ADATCs and LME/MCOs Falls Short of the Performance Target



Report pp. 22-23, Exhibit 15

Finding 3.

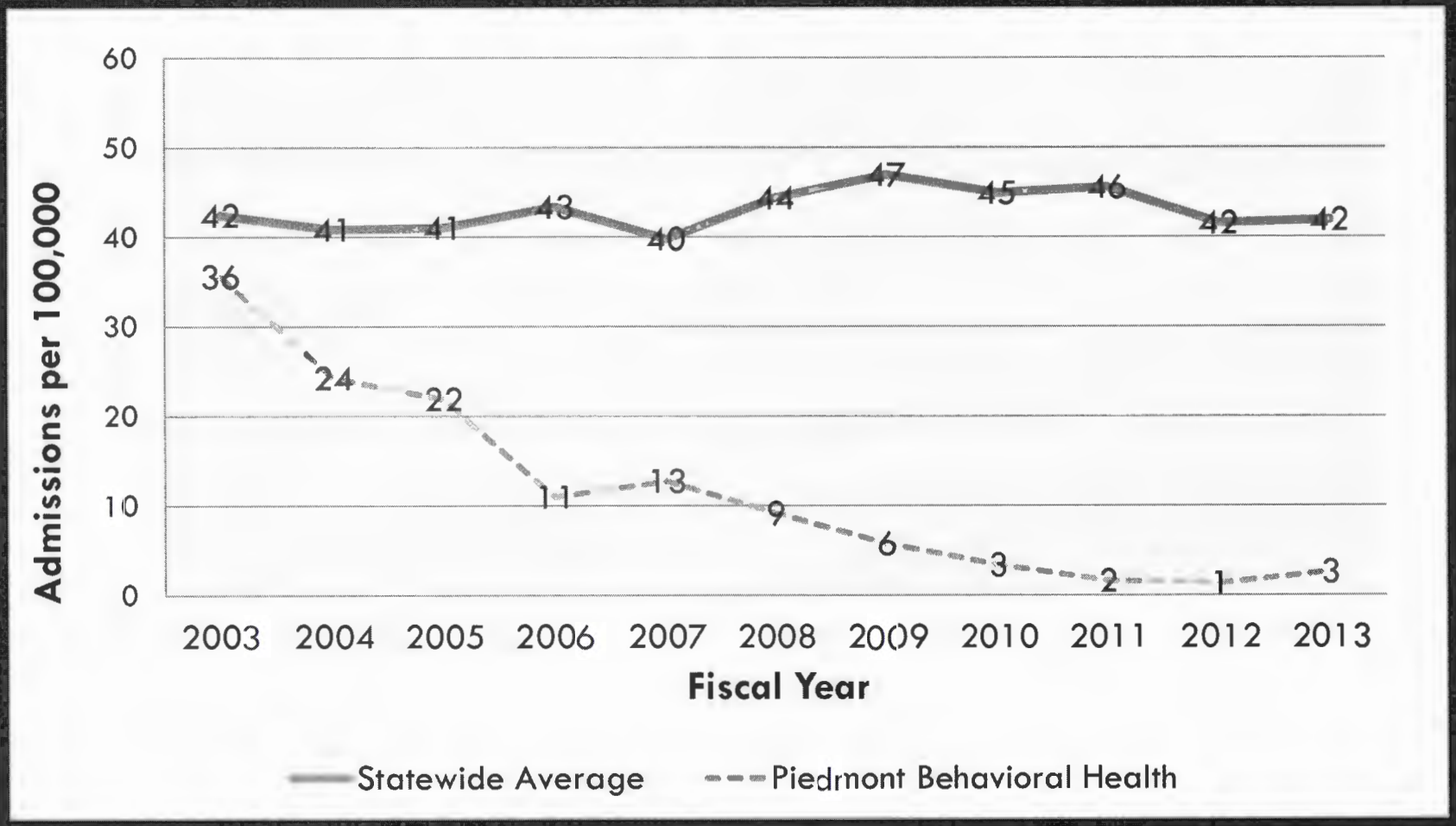
Separation of the Alcohol and Drug Abuse Treatment Centers from the community-based system limits North Carolina's ability to address service gaps and manage cost

The Piedmont Demonstration Project

- In 2003, Piedmont Behavioral Health (PBH) began receiving a share of state institution funding from the psychiatric hospitals and ADATCs in order to expand their provider network in the community
- PBH agreed to pay ADATC when an individual from a PBH county is treated at an ADATC

Report pp. 27-29

Fewer Individuals are Admitted to ADATCs from Piedmont Behavioral Health Counties



Report pp. 26-27, 29-30

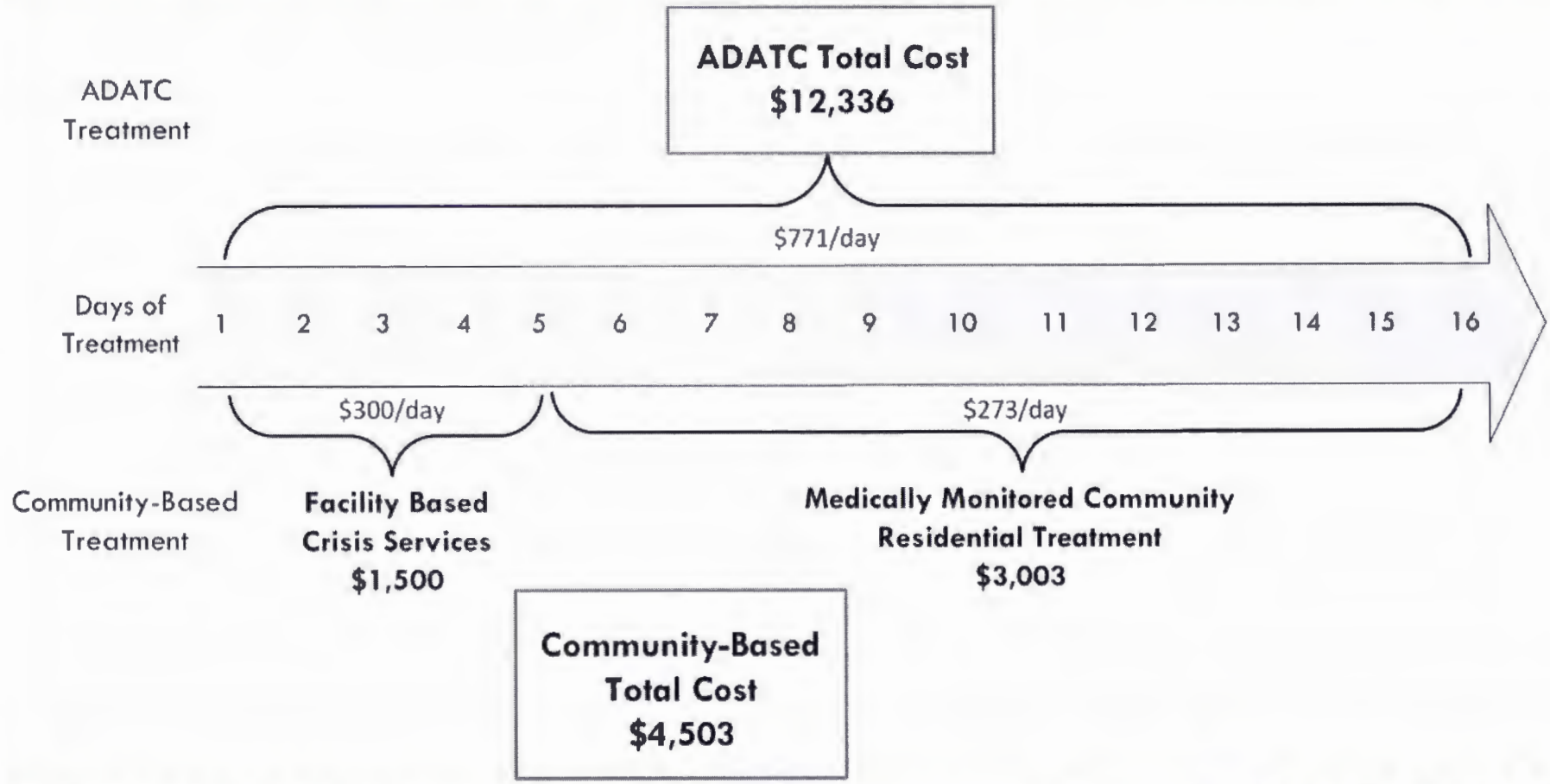
PBH Use of Other Services

- Two crisis/detoxification facilities that serve PBH counties
- Seven hospital detoxification providers
- 300 individuals served at medically monitored community residential treatment facility

Source: Cardinal Innovations Healthcare Solutions, Fiscal Year 2012-13

Report pp. 28-29

Medically Monitored Intensive Inpatient Services Cost Less in the Community-Based System



Report pp. 29-30, Exhibit 19

The Community-Based System Has Service Gaps

- Some LME/MCOs had levels of care for which they did not expend any dollars on services
- If there is a gap in services, individual may be treated at a higher level of care than necessary and at greater cost
- Separation of the ADATCs and community-based system limits the ability of LME/MCOs to address these gaps

Report pp. 31-34

Finding 4.

North Carolina lacks a performance management system that tracks long-term outcomes of public substance abuse treatment

Substance Abuse Treatment Performance Management

- North Carolina does not have reliable encounter-level data due to problems with NCTracks since July 2013
- When encounter-level data was available, performance management emphasized processes and outputs rather than outcomes

Report pp. 31-32, Exhibit 14

Measuring Long-Term Outcomes

Outcome Measure	Indicator
Reductions or abstention from substance use over time	• % of those treated who are no longer using • % of those treated who report reductions in use • % of those treated who report no use
Improvements in personal health over time	• Reductions in emergency room-related costs • Reductions in overall healthcare spending for those who received treatment
Improvements in social functioning over time	• Obtaining employment • Maintaining employment • Reduced reliance on social support programs • Stable living environment
Reductions in threats to public health and safety over time	• Reductions in criminal justice system interactions

Report pp. 31-32, Exhibit 14

Recommendations

Recommendation 1.

The General Assembly should integrate the Alcohol and Drug Abuse Treatment Centers into North Carolina's community-based substance abuse treatment system

The Process

- One year of planning for transition
- Reduce funding to ADATCs in 25% increments over a three-year transition period, while funding to LME/MCOs is increased by a corresponding amount
- By the fourth year, LME/MCOs would receive 100% of state appropriations previously going to ADATCs

Integration Process

- LME/MCOs would be able to use reallocated funding to increase capacity in the community-based system and/or purchase services from ADATCs
- By the end of the transition period, ADATCs would be providers in a LME/MCO network and would be receipt-supported based upon demand for services

Report p. 41

Timeline for Reporting

- Feb 1, 2016—LME/MCOs develop plans on how to use reallocated funding
- April 1, 2016—DHHS submits an ADATC business plan for the transition to the Joint Legislative Oversight Committee on Health and Human Services
- 2016 until 2020—DHHS annually submits report on integration of ADATCs into the community-based system and LME/MCO use of reallocated funding

Report p. 41

Recommendation 2.

The General Assembly should direct DMH/DD/SAS to strengthen its performance management system for substance abuse treatment by improving data collection and tracking long-term outcomes

Direct DMH/DD/SAS to Develop a Plan to Improve Performance Management

Plan should include:

- Specific long-term outcome measures the division will begin tracking
- Steps for incorporating outcomes into performance management system to assess the performance of providers, LME/MCOs, and the system as a whole
- Data elements to improve the process of analyzing gaps in the community-based system
- Timelines

Report pp. 42-43

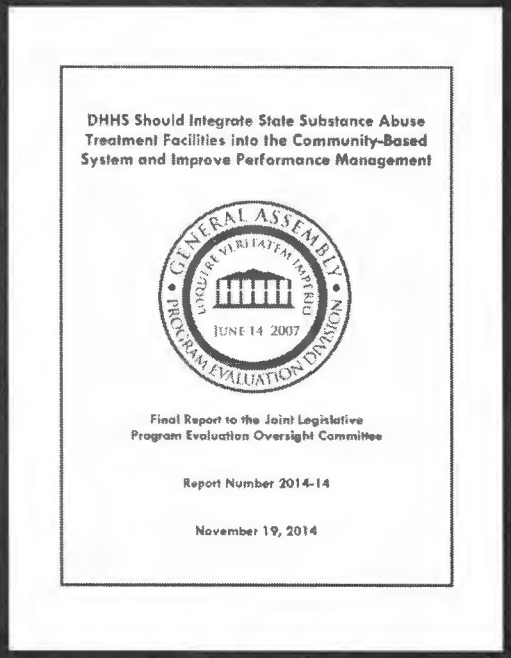
Plan for Improved Performance Management

- DMH/DD/SAS should submit a plan to the Joint Legislative Oversight Committee on Health and Human Services on or before January 15, 2016

Summary

- Separation of the ADATCs from the community-based system limits North Carolina's ability to address service gaps, provide a seamless continuum of care, and manage cost
- DHHS should integrate the ADATCs into the community-based system and improve performance management by tracking long-term outcomes

Report available online at www.ncleg.net/PED/Reports/reports.html


DHHS Should Integrate State Substance Abuse Treatment Facilities into the Community-Based System and Improve Performance Management

GENERAL ASSEMBLY · NORTH CAROLINA · PROGRAM EVALUATION DIVISION · LOQUERE VERITATEM IMPERIO · JUNE 14 2007

Final Report to the Joint Legislative Program Evaluation Oversight Committee

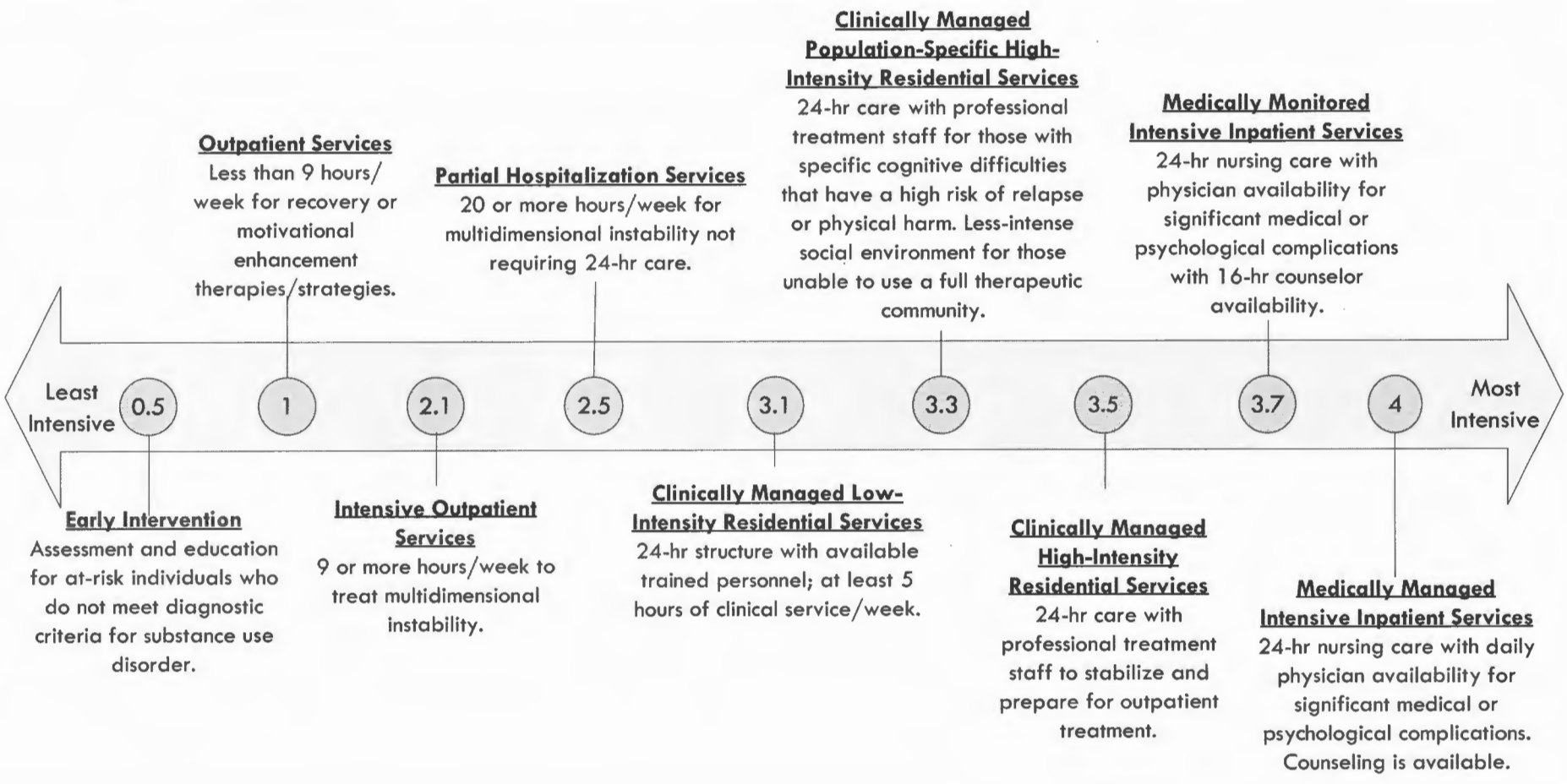
Report Number 2014-14

November 19, 2014

Jeff Grimes

Jeff.grimes@ncleg.net

Exhibit 1. The American Society of Addiction Medicine (ASAM) Continuum of Care for Adult Substance Abuse Treatment



Note: Each level of care is associated with a number with decimals used to express gradations of intensity.

Source: Program Evaluation Division based on the American Society of Addiction Medicine continuum of care.

Exhibit 24: Summary of the Recommended ADATC Integration Process During the Transition Period

Integration Process	Transition Year 1 Fiscal Year 2016–17	Transition Year 2 Fiscal Year 2017–18	Transition Year 3 Fiscal Year 2018–19	Full Integration Fiscal Year 2019–20
ADATC Funding Allocation (% of Fiscal Year 2014–15 State Appropriations)	$ 27,477,710 (75%)	$ 18,318,473 (50%)	$ 9,159,237 (25%)	$ 0 (0%)
LME/MCO Funding Allocation from ADATCs (% of Fiscal Year 2014–15 State Appropriations)	$ 9,159,237 (25%)	$ 18,318,473 (50%)	$ 27,477,710 (75%)	$ 36,636,942 (100%)
LME/MCO Use of Reallocated ADATC Funding	Develop capacity for community-based substance abuse treatment services and/or purchase services from ADATCs →			
LME/MCO Contracts with ADATCs	LME/MCOs determine amount of ADATC services they wish to purchase and contract with DSOHF for services →			
LME/MCO Payment Rate for ADATC Services	25% of the negotiated rate	50% of the negotiated rate	75% of the negotiated rate	100% of the negotiated rate
LME/MCO Prior Authorization Process	ADATCs receive prior authorization from LME/MCOs in order to receive payment for state-funded services →			
ADATC Operations	ADATCs adjust operations based on funding from direct state appropriations and estimated receipts from Medicare, Medicaid, insurance, self-pay, and LME/MCOs. →			ADATC operations are 100% supported by receipts from Medicare, Medicaid, insurance, self-pay, and LME/MCOs.

Note: The Program Evaluation Division used the Fiscal Year 2014–15 authorized budget to estimate the transition period funding allocations for the ADATCs and LME/MCOs.

Source: Program Evaluation Division.

Bill Draft 2015-MGa-8B*: PED Recs/Publicly Funded Substance Abuse Svcs.

2015-2016 General Assembly

Committee:	Joint Legislative Program Evaluation Oversight Committee	**Date:**	February 9, 2015
Introduced by:		**Prepared by:**	Joyce Jones Committee Counsel
Analysis of:	2015-MGa-8B*		

SUMMARY: ***Bill Draft 2015-MGa-8B implements the recommendations of a recent report by the Program Evaluation Division by integrating the State-Operated Alcohol and Drug Abuse Treatment Centers (ADATCs) into the array of publicly funded substance abuse services managed by local management entities/managed care organizations (LME/MCOs); reallocating direct State appropriations for ADATCs to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS) for management by the LME/MCOs; and strengthening the performance management system for substance abuse services.***

CURRENT LAW: North Carolina's public system for adult substance abuse treatment has two primary components: (i) the community-based system managed by nine LME/MCOs that contract with providers throughout the State for an array of substance abuse services, and (ii) the three ADATCS that operate semi-autonomously under the Division of State-Operated Health Care Facilities (DSOHF) to provide inpatient substance abuse services. North Carolina lacks a performance management system that tracks long-term outcomes of public substance abuse treatment.

BILL ANALYSIS:

Section 1 sets forth the definitions that apply throughout the bill draft.

Sections 2 through 6 of the bill draft implement Recommendation 1 of the Report as follows:

Section 2(a) expresses the General Assembly's intent to integrate ADATCs into the array of publicly funded substance abuse services managed by LME/MCOs. **Section 2(b)** directs DHHS to prepare and submit by April 1, 2016, a 3-year transition business plan that includes at least the following five components: (i) the LME/MCOs' projected demand for ADATC services both during the transition period and during the first three fiscal years following full integration; (ii) the projected availability of ADATC services during this same time period; (iii) procedures for making operational adjustments at the ADATCs during the transition period based upon the demand for services and the availability of funding to provide these services; (iv) a methodology for establishing and updating the rates to be paid by LME/MCOs for ADATC services provided to individuals whose care is managed and paid for by the LME/MCOs; and (v) a uniform process for LME/MCOs to give prior authorization for ADATCs to admit and treat individuals for whom the LME/MCOs will be financially responsible. The prior authorization process will allow the LME/MCOs to control whether an individual will be served in the community or as an inpatient by an ADATC.

Section 3(a) expresses the General Assembly's intent to gradually terminate all direct State appropriations for ADATCs and instead reallocate this funding to DMH/DD/SAS for community services in order to allow the LME/MCOs to assume full responsibility for managing all publicly funded substance abuse services, including those delivered through the ADATCs. To this end, **Section 3(a)** terminates all direct State appropriations for ADATCs, effective July 1, 2019, and reallocates these funds to DMH/DD/SAS for management by the LME/MCOs. **This version eliminates former*

Subsection (c) which specified the exact amount of the ADATC reductions and reallocations to DMH/DD/SAS for each fiscal year of the transition period.

To help the LME/MCOs do some advance planning for assumption of this enhanced management responsibility, **Section 3(b)** directs DMH/DD/SAS to estimate by August 1, 2015, the amount of reallocated ADATC funds each LME/MCO will receive for each fiscal year of the transition period. The estimated share for each LME/MCO must be based on the amount appropriated to the ADATCs for the 2015-16 fiscal year and must be proportional to the total population of the LME/MCO catchment area, with the following exception: The estimated fund allocation for Cardinal Innovations Healthcare Solutions (Cardinal) is to be adjusted by an amount sufficient to reflect the ADATC State institution fund allocation received by Cardinal for the original counties under the Piedmont Demonstration Project. **Section 3(b)** further directs DMH/DD/SAS to condition each LME/MCO's receipt of reallocated ADACT funds on the submission of a written transition plan by February 1, 2016, specifying how the LME/MCO plans to use these reallocated ADATC funds to increase its capacity for providing the full continuum of substance abuse services.

Section 4 imposes various requirements on the LME/MCOs to help them plan for and manage utilization and payment for ADATC services; namely, (i) submitting written transition plans to DMH/DD/SAS by February 1, 2016, (ii) sharing with DSOHF by February 1st of each year their projected demand for ADATC services in the upcoming fiscal year, (iii) entering into a contract with DSOHF by April 1st of each year for the ADATC services it intends to utilize during the next fiscal year, and (iv) implementing and enforcing the prior authorization process established by DHHS pursuant to Section 2(b)(5) of this act.

To help the ADATCs become wholly receipt supported, **Section 5** requires the ADATCs to evaluate and adjust their operations during each year of the transition period based upon the projected demand for services and the availability of funding to meet the demand for services from direct State appropriations and estimated receipts from Medicare, Medicaid, insurance, self-pay and the LME/MCOs.

Under **Section 6(a),** DMH/DD/SAS is responsible for monitoring the LME/MCOs and the ADATCs during the transition period to (i) ensure that State expenditures on substance abuse services continue to meet the maintenance of effort requirements of the federal Substance Abuse Prevention and Treatment Block Grant, (ii) keep abreast of efforts by the LME/MCOs to increase capacity for providing substance abuse services to meet the needs of individuals formerly serviced by the ADATCs, and (iii) be informed about the extent to which LME/MCOs are utilizing ADATC services. Under **Section 6(b)**, DHHS must report each October 1st from 2016 through 2020, on the status of fully integrating the ADATCs into the array of publicly funded substance abuse services managed by the LME/MCOs; and on how direct State appropriations reallocated from the ADATCs to the LME/MCOs have been used to purchase substance abuse services.

In accordance with Recommendation 2 of the Report, **Section 7** directs DMH/DD/SAS, in consultation with the LME/MCOs and, as needed, other DHHS Divisions, the North Carolina Court System, and other State Departments, to develop and submit by January 15, 2016, a plan for a stronger performance management system that tracks long-term outcome measures for publicly funded substance abuse services.

EFFECTIVE DATE: The bill draft is effective when it becomes law.

BACKGROUND: The bill draft is based on the Program Evaluation Division report entitled *DHHS Should Integrate State Substance Abuse Treatment Facilities into the Community-Based System and Improve Performance Management*, Report Number 2014-14 (November 19, 2014).

HOUSE BILL 119*

Short Title:	PED Recs/Publicly Funded Substance Abuse Svcs.	(Public)
Sponsors:	Representatives Horn, Hurley, and Saine (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health, if favorable, Appropriations.	

March 2, 2015

A BILL TO BE ENTITLED

AN ACT INTEGRATING STATE-OPERATED ALCOHOL AND DRUG ABUSE TREATMENT CENTERS (ADATCS) INTO THE ARRAY OF PUBLICLY FUNDED SUBSTANCE ABUSE SERVICES MANAGED BY LOCAL MANAGEMENT ENTITIES/MANAGED CARE ORGANIZATIONS, REALLOCATING DIRECT STATE APPROPRIATIONS FOR ADATCS TO THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES FOR MANAGEMENT BY THE LME/MCOS, AND STRENGTHENING THE PERFORMANCE MANAGEMENT SYSTEM FOR PUBLICLY FUNDED SUBSTANCE ABUSE SERVICES, AS RECOMMENDED BY THE JOINT LEGISLATIVE PROGRAM EVALUATION OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

PART I. DEFINITIONS

SECTION 1. As used in this act, the following definitions apply unless the context requires otherwise:

(1) ADATCs. – All of the Alcohol and Drug Treatment Centers under the jurisdiction of the DHHS Secretary, as identified in G.S. 122C-181.

(2) DHHS. – The North Carolina Department of Health and Human Services.

(3) DMH/DD/SAS. – The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the North Carolina Department of Health and Human Services.

(4) DSOHF. – The Division of State-Operated Healthcare Facilities of the North Carolina Department of Health and Human Services.

(5) LME/MCO or Local Management Entity/Managed Care Organization. – As defined in G.S. 122C-3; a local management entity that is under contract with DHHS to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.

(6) Transition period. – The three-year period beginning July 1, 2016, and ending June 30, 2019, during which ADATCs are to be fully integrated into the array of publicly funded substance abuse services managed by the LME/MCOs.

PART II. DHHS TRANSITION BUSINESS PLAN FOR INTEGRATING ADATCS INTO THE ARRAY OF PUBLICLY FUNDED SUBSTANCE ABUSE SERVICES MANAGED BY LME/MCOS.

SECTION 2.(a) It is the intent of the General Assembly to integrate the ADATCs into the array of publicly funded substance abuse services managed by the LME/MCOs over a three-year period, beginning no earlier than July 1, 2016, and ending with full integration by June 30, 2019.

SECTION 2.(b) By April 1, 2016, DHHS shall prepare and submit to the Joint Legislative Oversight Committee on Health and Human Services a three-year transition business plan for integrating all ADATCs into the array of publicly funded substance abuse services managed by the LME/MCOs. The plan shall include at least all of the following components:

(1) The projected demand by LME/MCOs for substance abuse services provided by the ADATCs during (i) each fiscal year of the transition period and (ii) the first three fiscal years subsequent to full integration of the ADATCs into the array of publicly funded substance abuse services managed by the LME/MCOs.

(2) The projected availability of services at all ADATCs during (i) each fiscal year of the transition period and (ii) the first three fiscal years subsequent to full integration of the ADATCs into the array of publicly funded substance abuse services managed by the LME/MCOs.

(3) Procedures for making operational adjustments at each of the ADATCs during the transition period based upon the demand for services and the availability of funding to provide these services. Operational adjustments may include one or any combination of the following:

a. Staffing adjustments.

b. Changes in the use of contract staff.

c. Facility closures.

(4) A methodology for establishing and updating the rates to be paid by LME/MCOs for substance abuse services provided by ADATCs to individuals receiving these services under the management of the LME/MCOs.

(5) A uniform process for LME/MCOs to give prior authorization for ADATCs to admit and treat individuals whose care is managed and paid for by the LME/MCOs. The prior authorization process developed pursuant to this subsection shall be developed by DHHS, in consultation with the LME/MCOs. As part of this process, an ADATC shall provide screening and triage services and notify the appropriate LME/MCO when an individual reliant upon State funds for substance abuse services seeks direct admission to the ADATC. The LME/MCO for the catchment area in which the individual resides shall determine if the individual should be admitted to the ADATC based upon clinical information provided by the ADATC. If the LME/MCO approves admission, the LME/MCO shall be financially responsible for all inpatient substance abuse services rendered by the ADATC to the individual. If the LME/MCO denies admission, the LME/MCO shall be responsible for paying the cost of assessment services performed by the ADATC and for making arrangements for the individual to receive alternative substance abuse services.

PART III. TERMINATION AND REALLOCATION OF DIRECT STATE APPROPRIATIONS FOR ADATCS

SECTION 3.(a) It is the intent of the General Assembly to gradually terminate all direct State appropriations for ADATCs by the beginning of the 2019-2020 fiscal year and instead reallocate this funding to DMH/DD/SAS for community services in order to allow the LME/MCOs to assume responsibility for managing the full array of publicly funded substance abuse services, including those delivered through the ADATCs. To this end and notwithstanding any other provision of law, all direct State appropriations for ADATCs are terminated effective July 1, 2019, and reallocated to DMH/DD/SAS for allocation to the LME/MCOs. The LME/MCOs shall use these reallocated funds to manage and pay for the utilization of substance abuse treatment and services for individuals within their respective catchment areas.

SECTION 3.(b) In order to allow the LME/MCOs to plan in advance how to effectively and efficiently manage these reallocated ADATC funds, DMH/DD/SAS shall do all of the following:

(1) Calculate and notify each LME/MCO by August 1, 2015, of its estimated share of these fund allocations for each fiscal year of the transition period. The estimated share of fund allocations for each LME/MCO shall be:
   a. Based on the total amount of direct State appropriations allocated to the ADATCs for the 2015-2016 fiscal year.
   b. Proportional to the total population of the LME/MCO catchment area, except that the estimated share of allocations for the LME/MCO known as Cardinal Innovations Healthcare Solutions (Cardinal) shall be reduced by an amount sufficient to reflect the ADATC state institution fund allocation received by Cardinal for the original counties under the Piedmont Demonstration Project.

(2) As a condition of receiving its share of reallocated ADATC funds, require each LME/MCO to submit by February 1, 2016, a written transition plan describing how the LME/MCO plans to use these reallocated ADATC funds to (i) build capacity for community-based substance abuse services, (ii) reduce gaps in substance abuse services, (iii) purchase substance abuse services from the ADATCs, or (iv) any combination of these. DMH/DD/SAS shall review the written transition plans to ensure each LME/MCO proposes using these reallocated ADATC funds to purchase substance abuse services.

PART IV. LME/MCO PAYMENT AND UTILIZATION MANAGEMENT FOR ADATC SERVICES

SECTION 4. In order to allow the LME/MCOs to effectively and efficiently manage utilization of, and payment for, ADATC services for individuals within their respective catchment areas, each LME/MCO shall do all of the following:

(1) By February 1, 2016, submit to DMH/DD/SAS a written transition plan describing how it plans to use reallocated ADATC funds to (i) build capacity for community-based substance abuse services, (ii) reduce gaps in substance abuse services, (iii) purchase substance abuse services from the ADATCs, or (iv) any combination of these.

(2) By February 1 of each year, submit to DSOHF its projected demand for ADATC services for the upcoming fiscal year.

(3) By April 1 of each year, enter into a contract with DSOHF for the ADATC services it intends to utilize during the next fiscal year. The contract shall include at least all of the following terms:
   a. The projected amount of substance abuse services to be provided by the ADATCs to individuals within the LME/MCO catchment area.

b. The negotiated rate to be paid by the LME/MCO for substance abuse services provided by the ADATCs to individuals receiving these services under the management of the LME/MCOs. The negotiated rate shall be sufficient to cover one hundred percent (100%) of the actual cost to the ADATCs for providing these services, except that during the transition period the negotiated rate shall be calculated as follows:

1. For fiscal year 2016-2017, LME/MCOs shall pay twenty-five percent (25%) of the facility's per bed day cost for ADATC services provided to individuals under the management of the LME/MCOs.
2. For fiscal year 2017-2018, LME/MCOs shall pay fifty percent (50%) of the per bed day cost for ADATC services provided to individuals under the management of the LME/MCOs.
3. For the 2018-2019 fiscal year, LME/MCOs shall pay seventy-five percent (75%) of the per bed day cost for ADATC services provided to individuals under the management of the LME/MCOs.

c. Any conditions imposed upon the ADATCs for receiving payment from the LME/MCOs for services provided to individuals whose care is managed and paid for by the LME/MCOs, including prior authorization.

(4) Implement and enforce the prior authorization process established by DHHS, in consultation with the LME/MCOs, pursuant to Section 2(b)(5) of this act.

PART V. ADJUSTMENT OF ADATC OPERATIONS

SECTION 5. It is the intent of the General Assembly that at the end of the transition period, each of the ADATCs be wholly receipt-supported. To this end, during the transition period, each of the ADATCs shall annually evaluate and adjust their operations based upon the projected demand for services and the availability of funding to meet the demand for services from direct State appropriations and estimated receipts from Medicare, Medicaid, insurance, self-pay, and the LME/MCOs. These operational adjustments shall be in compliance with the procedures established by DHHS pursuant to Section 2(b)(3) of this act.

PART VI. OVERSIGHT AND REPORTING

SECTION 6.(a) During the transition period, DMH/DD/SAS shall monitor each of the following with respect to integration of the ADATCs into the array of publicly funded substance abuse services managed by the LME/MCOs:

(1) Expenditures by LME/MCOs and by ADATCs to ensure that North Carolina continues to meet the maintenance of effort requirements of the federal Substance Abuse Prevention and Treatment Block Grant.

(2) Efforts by each of the LME/MCOs to increase capacity for substance abuse treatment to ensure the development of community-based services to meet the needs of individuals formerly served by the ADATCs.

(3) Utilization by LME/MCOs of substance abuse services provided by the ADATCs.

SECTION 6.(b) Beginning October 1, 2016, and annually thereafter until October 1, 2020, DHHS shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Program Evaluation Oversight Committee on each of the following:

(1) The status of fully integrating the ADATCs into the array of publicly funded substance abuse services managed by the LME/MCOs.
(2) A breakdown of how direct State appropriations reallocated from the ADATCs to the LME/MCOs have been used to purchase substance abuse services.

PART VII. PLAN FOR STRENGTHENING PERFORMANCE MANAGEMENT FOR THE STATE'S PUBLICLY FUNDED SUBSTANCE ABUSE SERVICES

SECTION 7. By January 15, 2016, DMH/DD/SAS, in consultation with the LME/MCOs, shall develop and submit to the Joint Legislative Oversight Committee on Health and Human Services a plan to strengthen performance management for the State's publicly funded substance abuse services. The Department is encouraged to consult with other Divisions under its jurisdiction, the North Carolina Court System, and other State agencies, including the Departments of Public Safety, Revenue, and Commerce, in order to develop a plan that integrates other data into a performance management system that measures outcomes. The plan shall identify at least all of the following:

(1) Specific long-term outcome measures to be tracked by DMH/DD/SAS.
(2) Challenges with the current information technology system used for Medicaid claim adjudication that may limit the State's ability to implement meaningful performance management, and proposed remedies for either eliminating this limitation in the system or collecting needed data from the LME/MCOs.
(3) Time lines for all steps necessary for DMH/DD/SAS to begin tracking long-term outcome measures.
(4) Data elements, such as patient placement criteria data, that would allow DMH/DD/SAS to improve the process for analyzing service gaps in substance abuse services.
(5) Protocols for using long-term outcomes to (i) assess the effectiveness of treatment modalities and practices, (ii) measure the performance of providers and LME/MCOs in the delivery of substance abuse services, and (iii) hold LME/MCOs accountable for effective and efficient treatment.

PART VIII. EFFECTIVE DATE

SECTION 8. This act is effective when it becomes law.

Committee Sergeants at Arms

NAME OF COMMITTEE Jt Comm. on App. HHS

DATE: 03/04/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: Carlton Lewis
2. Name: Steve Wilson
3. Name: _____
4. Name: _____
5. Name: _____

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on this page

HOUSE PAGES

Wednesday, March 4	**Room**	**Time**
APPROPRIATIONS, HEALTH AND HUMAN SERVICES	643	8:30 am

Name	County	Sponsor
Jordan Trivette	Bladen	William D. Brisson
Niki Vemulapalli	Cabarrus	Larry G. Pittman

~~VIMULAPOLLY~~
VEMULE APOLLY

SENATE PAGES ATTENDING

COMMITTEE: Joint App – Health & Hum. Serv.

DATE: 3/4, TIME: 8:30, ROOM: 643

Pages: Please print legibly.....*or else!!!!!!!!!!!!!!!!*

Page Name	Hometown	Sponsoring Senator
1 Daria Thomas	Kinston	D. Davis
2		
3		
4		
5		
6		
7		
8		
9		

Do not add additional names below the grid.

Pages: Please present this form to either the Committee Clerk at the meeting or a Sgt. at Arms.

VISITOR REGISTRATION SHEET

Jt Comm. on App. HHS — 03/04/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Peyton Mayrant	
Jim Mahon	BSA
TJ Bugbee	NP

VISITOR REGISTRATION SHEET

Jt Comm. on App. HHS — 03/04/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Trent Womble	DHHS
Jessie Goodman	DHHS/DMJR
Ellen Weaver	Ellen
Joanna Spruill	NCAFP
Marian Farrell	K+L Gates
Amanda Horacek	Trautman Sanders
John Handley	MFS
Rob Lamm	RLA
[illegible]	[illegible]
[illegible]	[illegible]
Matt Gross	NCPL

VISITOR REGISTRATION SHEET

Jt Comm. on App. HHS — 03/04/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ann Rodriguez	NC council of Community Programs
Judy Jenkins	OAPI
Allison Stewart	Cardinal Innovations
Bill Rustin	ACP
Josh Ehrich	JDA
Jennifer Gasperini	NCMS
Tricia Bryant	Pastore
Ruian Menard	Williams Mullen
Chris [illegible]	N-N-S.
Christine Craig	Wakemed
J Peters	CSS

VISITOR REGISTRATION SHEET

Jt Comm. on App. HHS — Name of Committee

03/04/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michael Hauser	THCG
Blake Tedder	self
Leah Smith	NC SEG
Colleen Kochanek	NCCEP

House Committee on Appropriations, Health and Human Services
Thursday, March 5, 2015 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Appropriations, Health and Human Services met at 8:30 AM on March 5, 2015 in Room 643 of the Legislative Office Building.

Representative Josh Dobson, presided
Co-Chairs Marilyn Avila, William Brisson, and Chris Malone as well as Representatives Jean Farmer-Butterfield, Verla Insko, Gary Pendleton and Howard Hunter from the House side attended.

On the Senate side, Co-Chairs Ralph Hise, Louis Pate as well as Senators Tamara Barringer, Floyd McKissick, Terry Van Duyn and Andy Wells attended.

Chairman Dobson recognized both House and Senate Sergeant at Arms, as well as both House and Senate pages for the day. (See attached list of names)

Susan Jacobs, staff from the Fiscal Department updated the time outline for the committee.

Dr. Dorothy Cilenti, DrPHD, MPH, MSW Clinical Assistant Professor, Department of Maternal and Child Health UNC Gilling School of Global Public Health made a presentation on "How Healthy are North Carolina's Children?" (See attachment)

After presentation Chairman Dobson open the floor for questions.

The meeting adjourned at 9:50am.

Representative Josh Dobson
Presiding

Caroline Stirling, Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

March 5, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Representative Josh Dobson, Presiding Co-Chair
II.	**"How Healthy are North Carolina's Children?"**	Dr. Dorothy Cilenti, DrPH, MPH, MSW Clinical Assistant Professor Department of Maternal and Child Health UNC Gillings School of Global Public Health
	Committee Discussion	
	Adjourn	

ATTENDANCE

Committee: Appropriations Subcommittee on Health and Human Services

DATES NAMES - **HOUSE**	3/3	3/5	3/6	3/10	3/11	3/12	3/17	3/18	3/19	3/24
Co-Chair Marilyn Avila		✓								
Co-Chair William Brisson		✓								
Co-Chair Josh Dobson		✓								
Co-Chair Chris Malone		✓								
Vice-Chair Jean Farmer-Butterfield		✓								
Vice-Chair Verla Insko		✓								
Vice-Chair Gary Pendleton		✓								
House Committee Members										
Rep. Beverly Earle										
Rep. Howard Hunter		✓								
SENATE										
Co-Chair Ralph Hise		✓								
Co-Chair Louis Pate		✓								
Co-Chair Tommy Tucker										
Senate Committee Members										
Sen. Tamara Barringer		✓								
Sen. Floyd McKissick		✓								
Sen. Gladys Robinson										
Sen. Bob Rucho										
Sen. Terry Van Duyn		✓								
Sen. Andy Wells		✓								
Committee Clerk		CS								

2015 Session

Joint House and Senate Appropriations Subcommittee on Health and Human Services

Presiding Chair and Committee Clerk Schedule

	Tue 3/3	**Wed 3/5**	**Thu 3/6**
Presiding Chair	Rep. Brisson	Sen. Pate	Rep. Dobson
Committee Clerk	Caroline	Edna	Julie
	Tue 3/10	**Wed 3/11**	**Thu 3/12**
Presiding Chair	Sen. Tucker	Rep. Malone	Sen. Hise
Committee Clerk	Joseph	Wanda	Susan Fanning
	Tue 3/17	**Wed 3/18**	**Thu 3/19**
Presiding Chair	Rep. Avila	Sen. Pate	Rep. Brisson
Committee Clerk	Susan Lewis	Edna	Caroline
	Tue 3/24	**Wed 3/25**	**Thu 3/26**
Presiding Chair	Sen. Tucker	Rep. Dobson	Sen. Hise
Committee Clerk	Joseph	Julie	Susan Fanning
	Tue 3/31	**Wed 4/1**	**Thu 4/2**
Presiding Chair	Rep. Malone	Sen. Pate	Rep. Avila
Committee Clerk	Wanda	Edna	Susan Lewis
	Tue 4/7	**Wed 4/8**	**Thu 4/9**
Presiding Chair	Sen. Tucker	Rep. Brisson	Sen. Hise
Committee Clerk	Joseph	Caroline	Susan Fanning
	Tues 4/14	**Wed 4/15**	**Thu 4/16**
Presiding Chair	Rep. Dobson	Sen. Pate	Rep. Malone
Committee Clerk	Julie	Edna	Wanda

How Healthy are North Carolina's Children (0-5)?

HHS Joint Appropriations Subcommittee

March 5, 2015

Dorothy Cilenti, DrPH, MPH, MSW

Clinical Assistant Professor

Department of Maternal and Child Health

UNC
GILLINGS SCHOOL OF
GLOBAL PUBLIC HEALTH

Overview

- Review data on key health and well-being indicators for NC children ages 0-5
  - Economic Indicators
  - Education Indicators
  - Health Indicators
  - Family and Community Indicators
- Identify areas where investments in children's health and well-being may be sustained

Our Goals for North Carolina Children

- Healthy, long lives for all North Carolina's children
- Educational and economic opportunity for all children
- Improved outcomes for all children to assure a vibrant long-term economic and social future for North Carolina

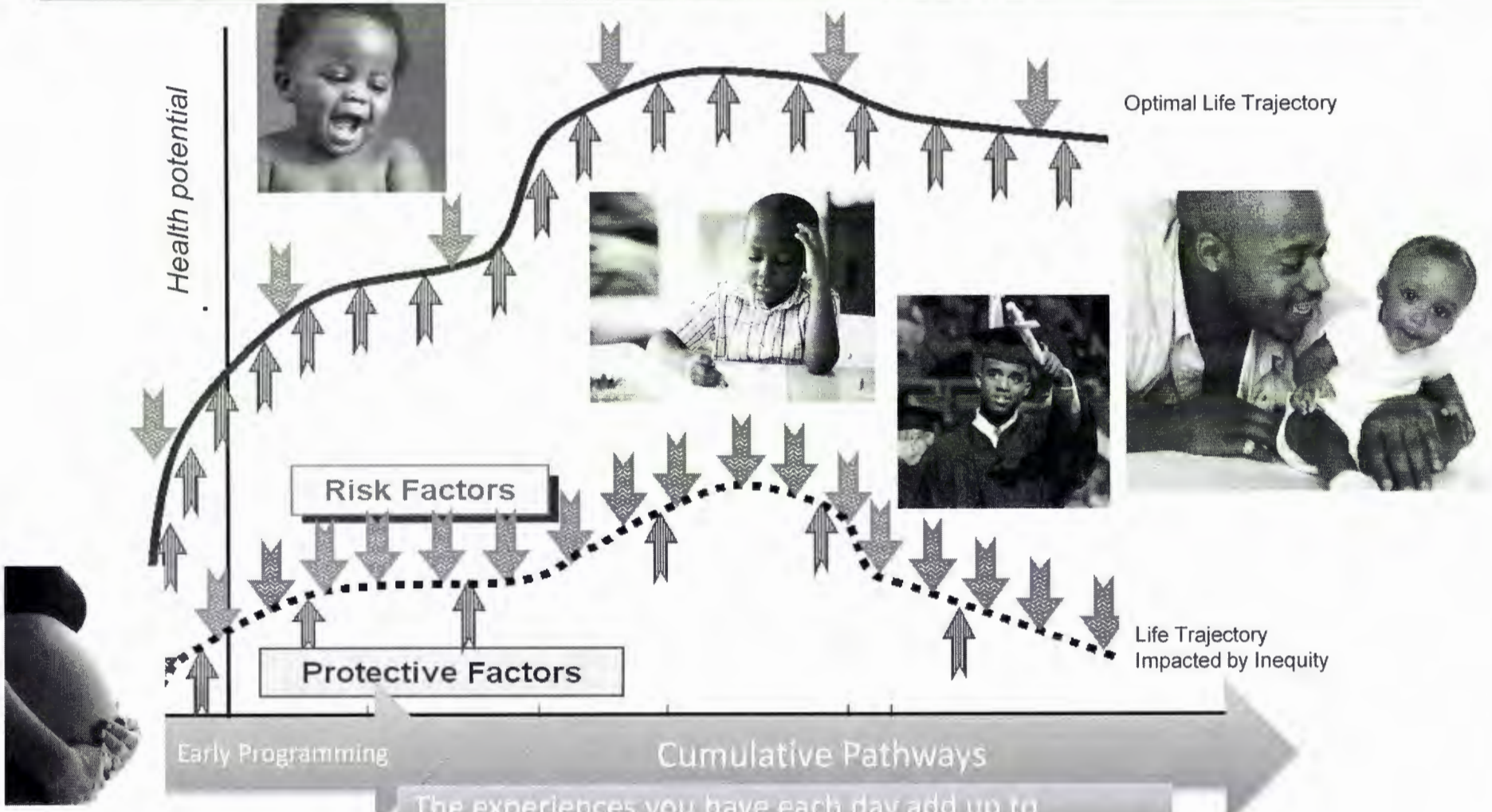
Social Determinants of Health

National Trends in Child Well-Being Since 1990

- Economic Well-Being
  - Gains in the late 1990s unraveled in early 2000s; post recession, the child poverty rate reached 22%
- Education
  - Percentage of 3- and 4- year olds attending preschool increased to 51%
  - Improvements in 4-yr high school graduation rates
- Health
  - Improvements in health and safety contributed to child well-being, largely as a result of increased access to health insurance through Medicaid and the State Children's Health Insurance Program
  - Rates of childhood obesity concerning
- Family and Community
  - Steady decline in percentage of children living with two married parents
  - Reduction in teen pregnancy and teen birth rates
  - Education level of parents has increased

Sources: 2014 Data Book-State Trends in Child Well-Being. Available at www.kidscount.org

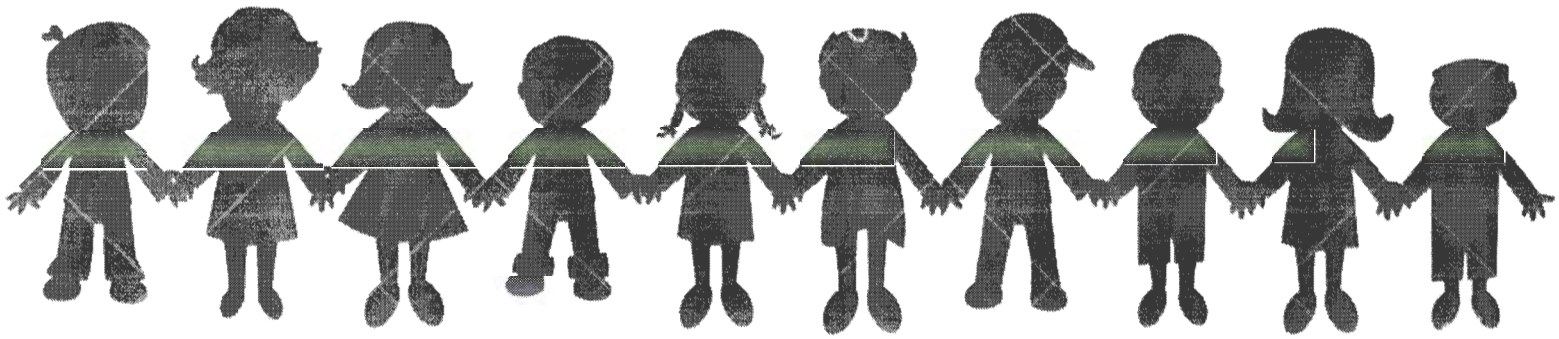
The Life Course Model



Mic[illegible]C. Lu, MD, MPH and Neal Halfon, MD, MPH, "Racial and Ethnic Disparities in Bir[illegible]tcomes: A Life-Course Perspective," Maternal and Child Health Journal 7, no. 1 ([illegible]h 2003): 13–30

Life Expectancy at Birth 2011-2013

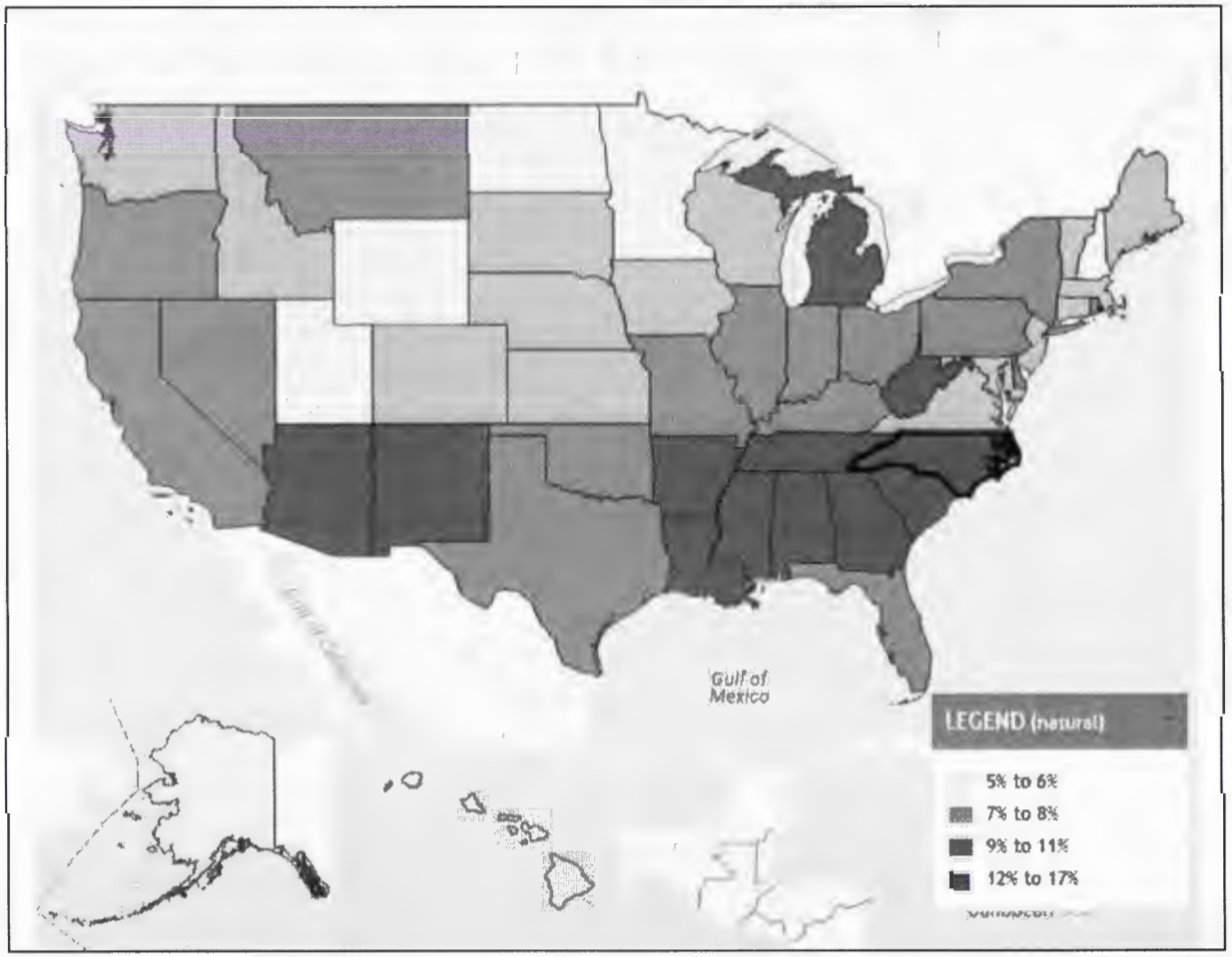
Ten Lowest Counties		Ten Highest Counties	
Swain	73.1	Moore	79.9
Columbus	74.0	Alleghany	80.0
Robeson	74.2	Polk	80.2
Halifax	74.3	Transylvania	80.2
Richmond	74.3	Mecklenburg	80.4
Scotland	74.7	Camden	80.6
Vance	74.8	Wake	81.4
Cleveland	75.0	Chatham	81.6
Anson	75.3	Watauga	81.6
Graham	75.5	Orange	81.7



ECONOMIC INDICATORS

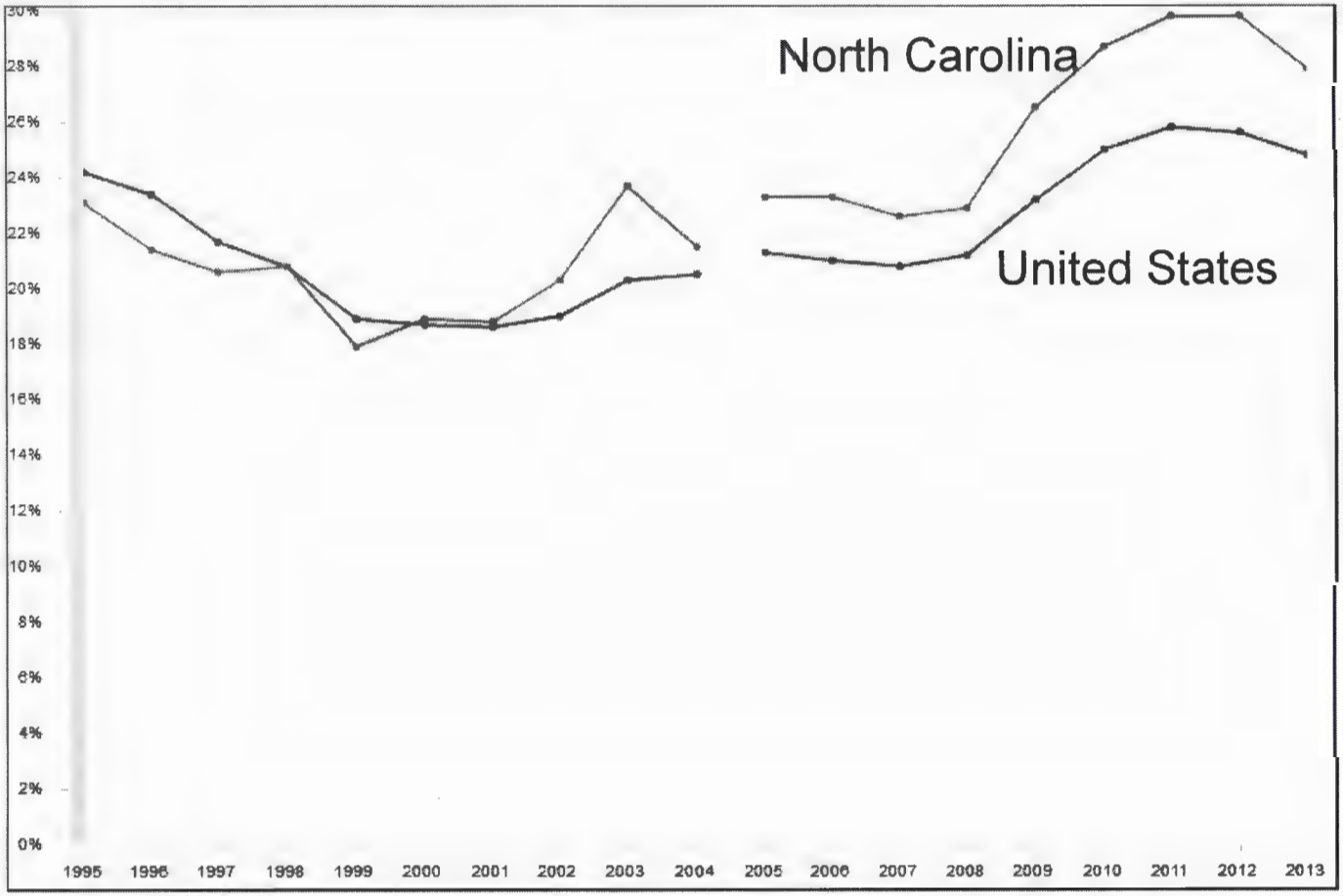
Children in Extreme Poverty

2013 Data



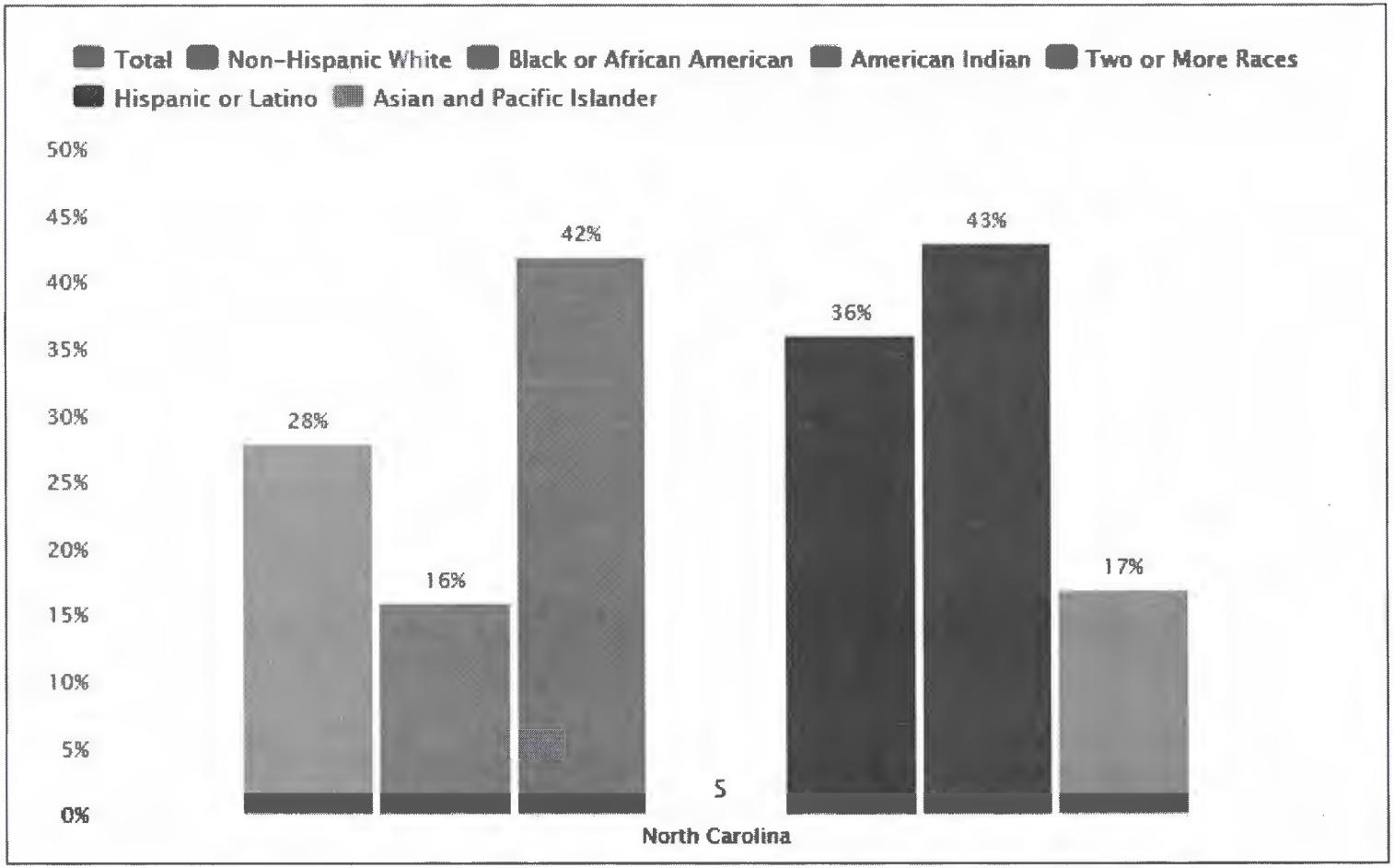
Source: National KIDS Count

Children Under 5 in Poverty
North Carolina vs. United States 1995-2013



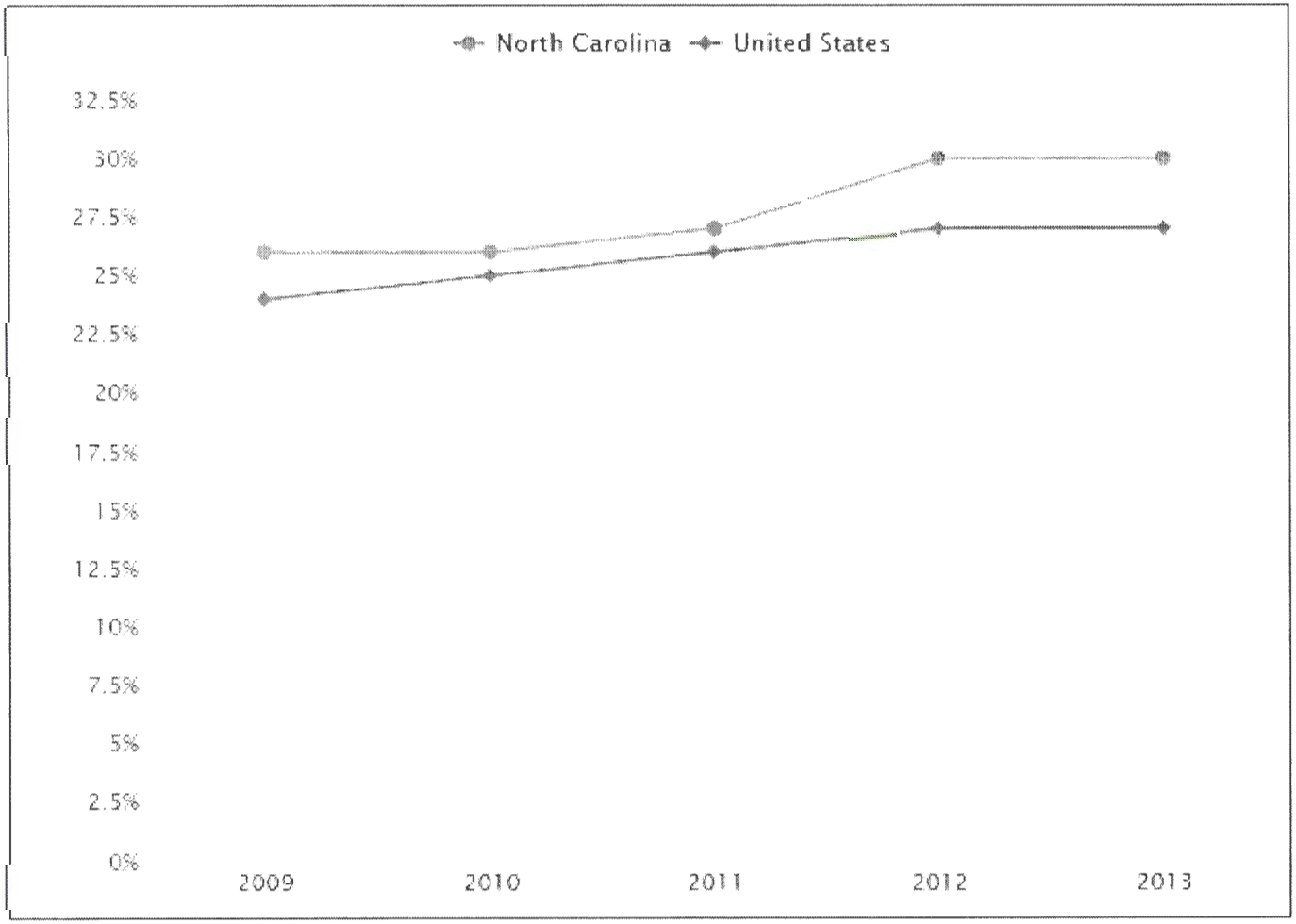
Source: U.S. Census Bureau, Small Area Income and Poverty Estimates

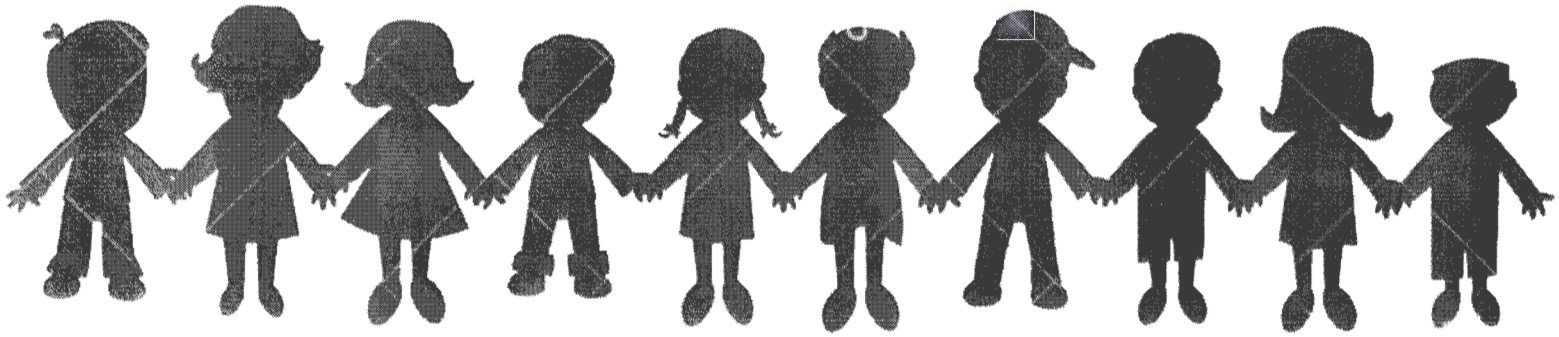
Percent of North Carolina Children in Poverty



Estimates suppressed when the confidence interval around the percentage is greater than or equal to 10 percentage points.

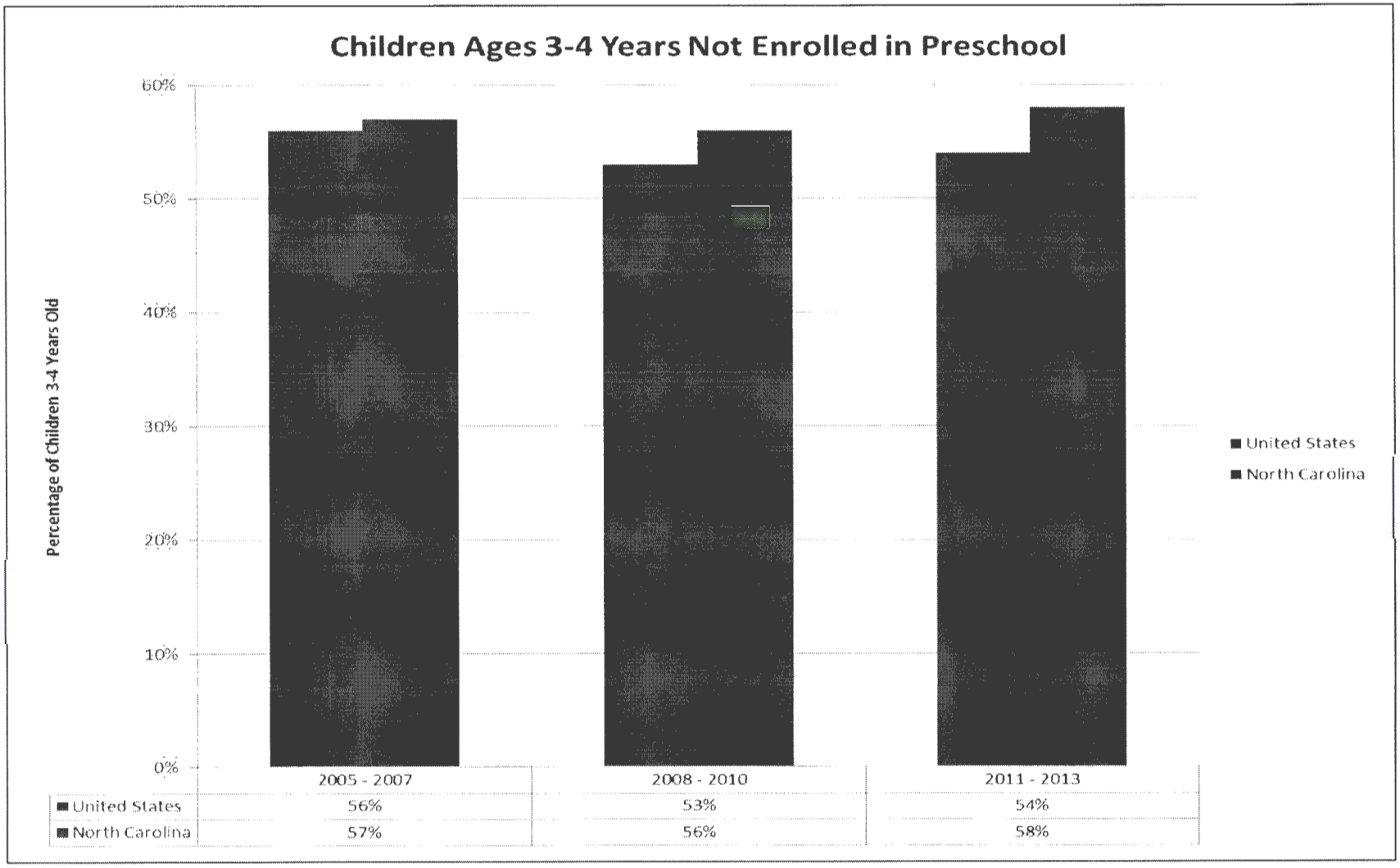
Children in Low-Income Working Families by Age Group





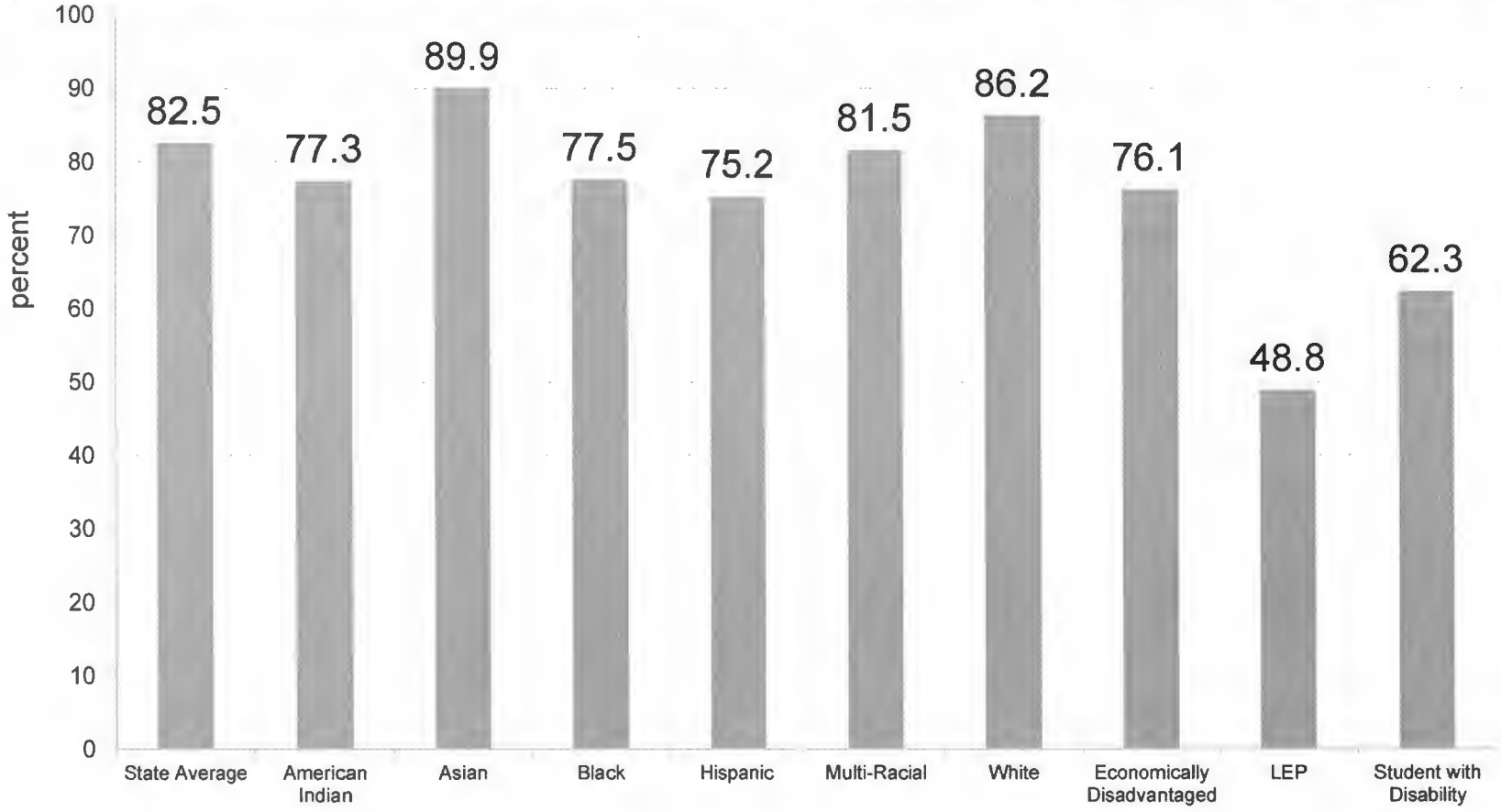
EDUCATION INDICATORS

Children Ages 3-4 Not Enrolled in Preschool

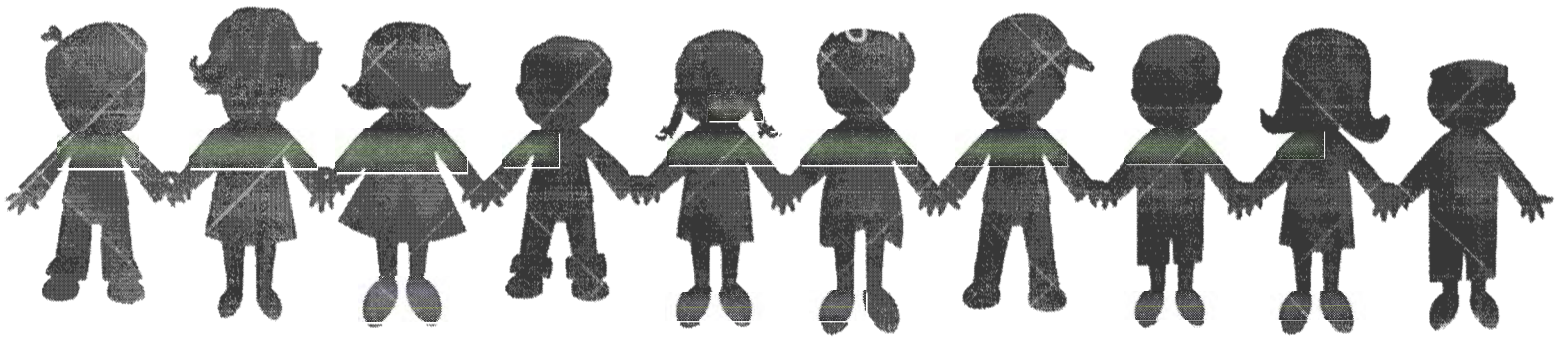


	2005 - 2007	2008 - 2010	2011 - 2013
United States	56%	53%	54%
North Carolina	57%	56%	58%

Four-Year Cohort Graduation Rate by Race/Ethnicity, NC 2012-2013

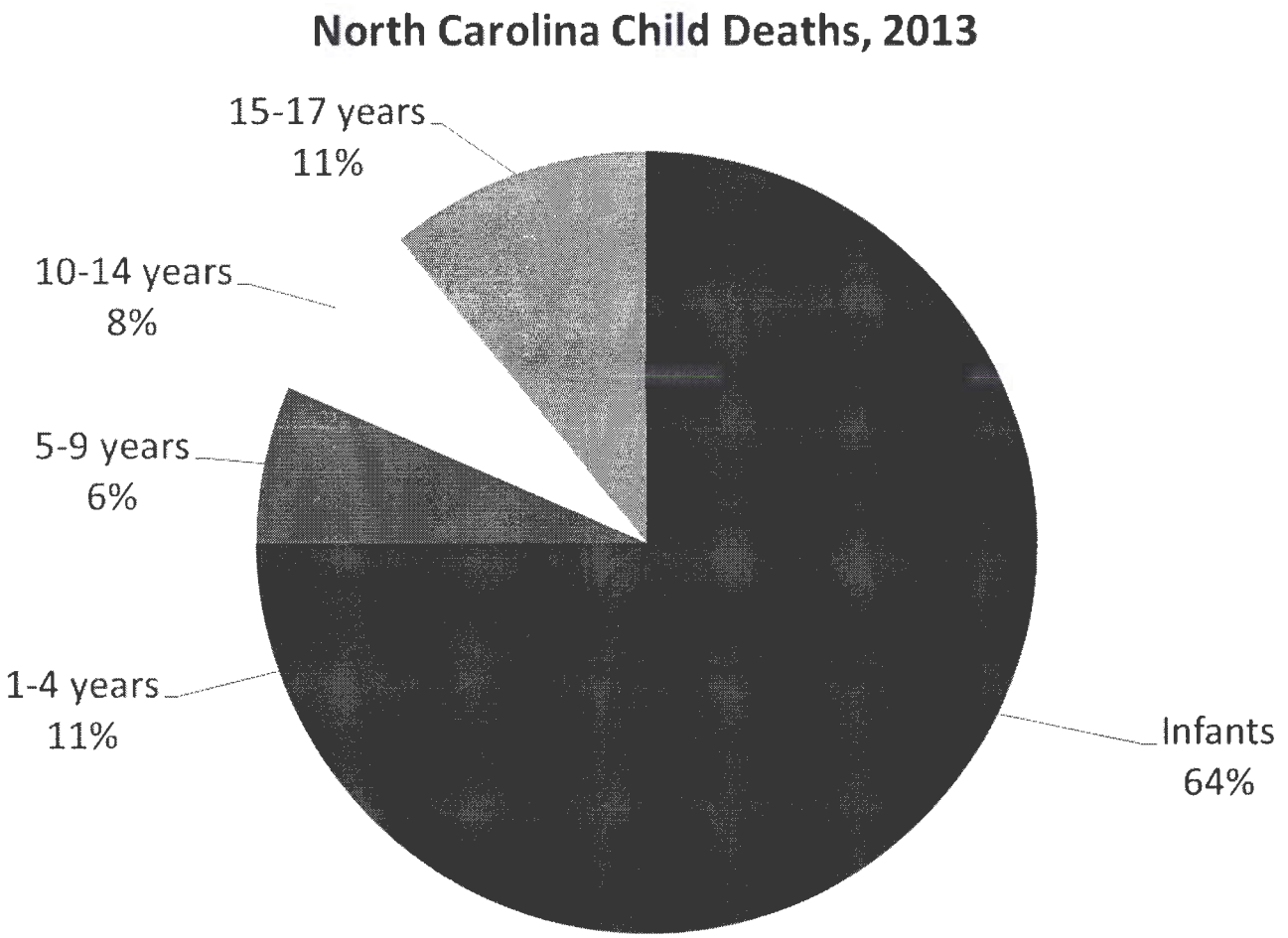


Source: NC Child. KIDS COUNT Data Center



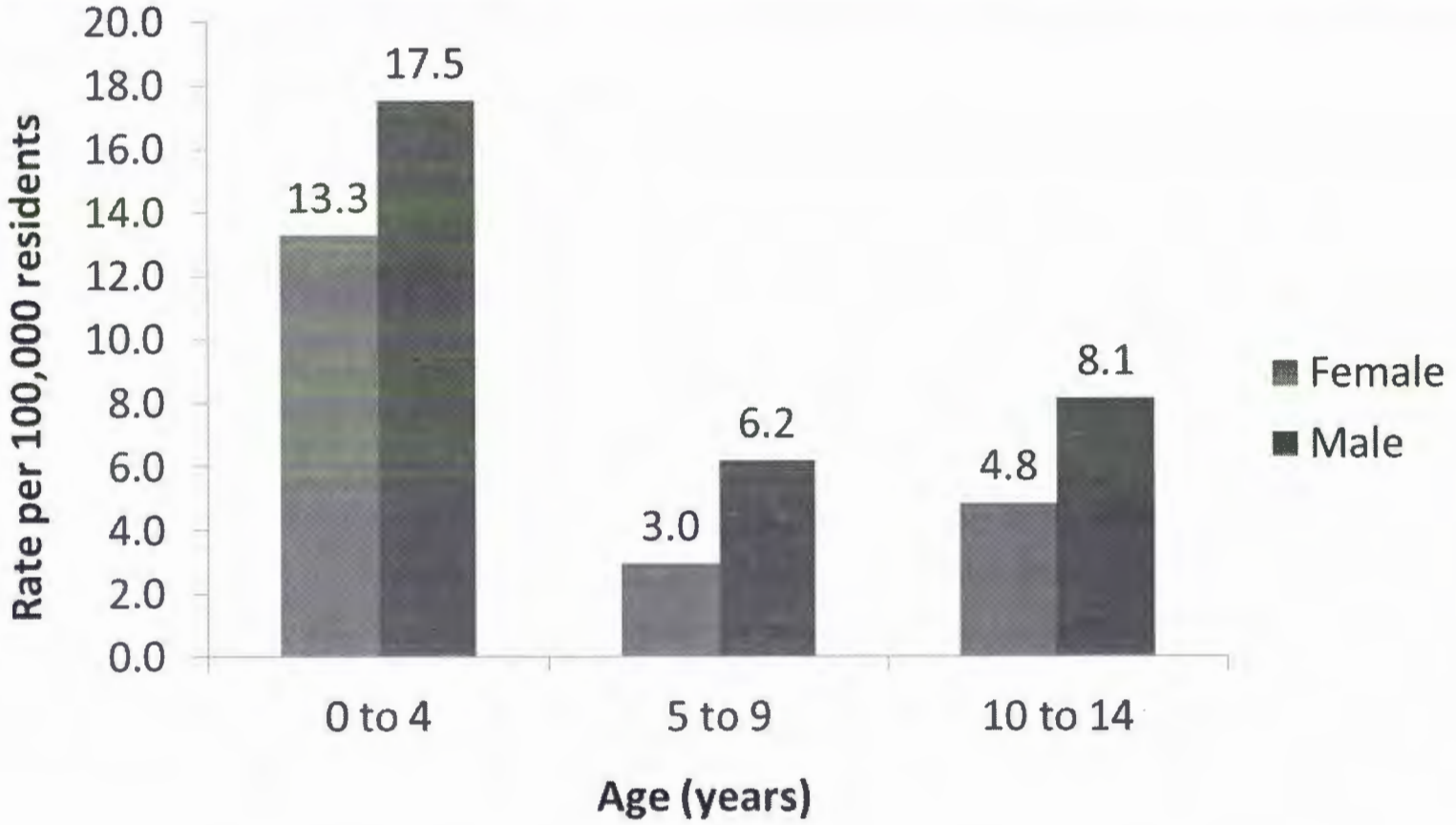
HEALTH INDICATORS

North Carolina Child Deaths, 2013



North Carolina Child Injury Deaths

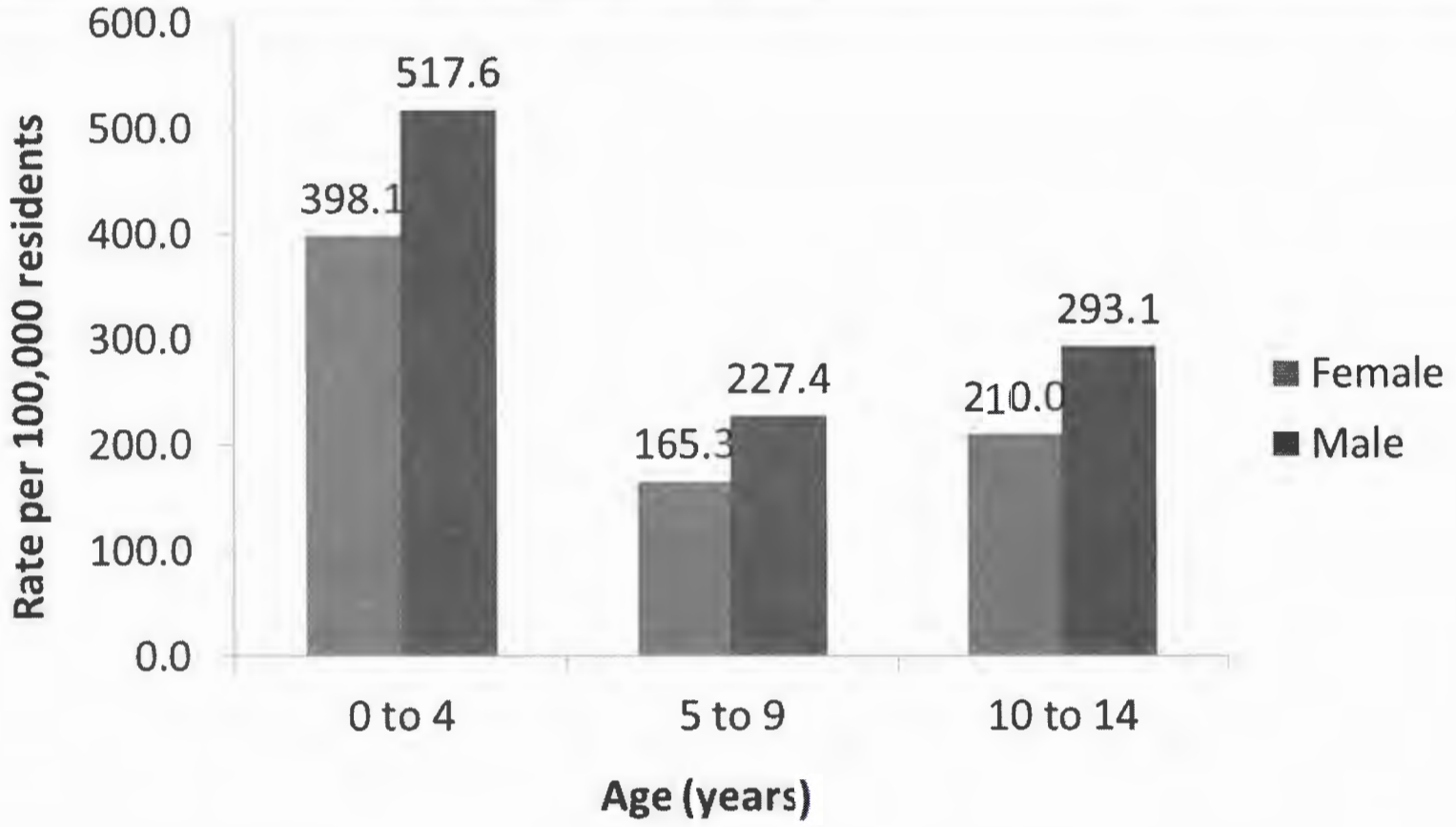
2010-2013 (N=671)



Source: N.C. State Center for Health Statistics, Vital Statistics-Deaths, 2010-2013; Analysis by Injury Epidemiology and Surveillance Unit

North Carolina Injury Hospitalizations

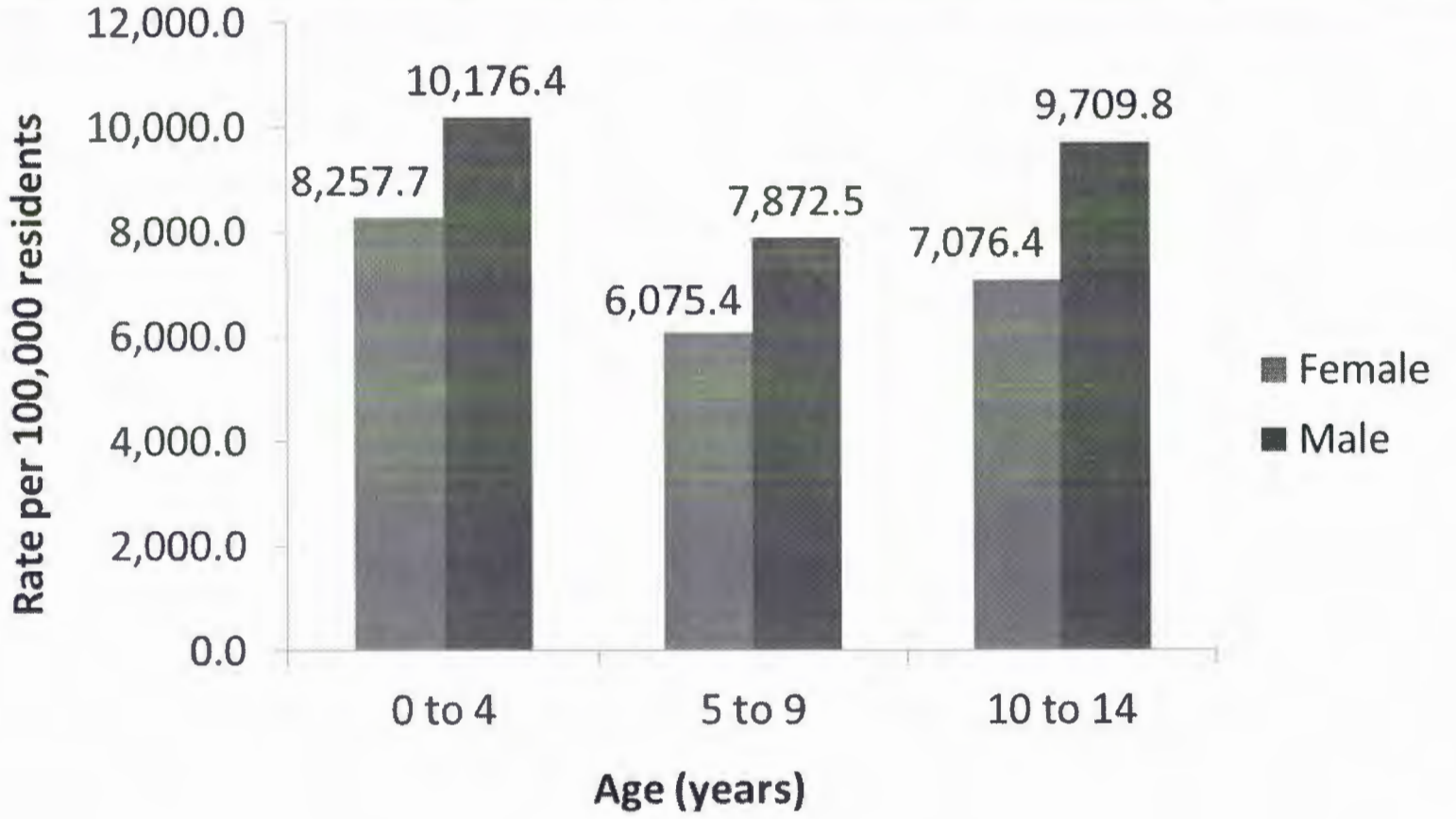
By Age and Sex: 2010-2013 (N=17,268)



Source: N.C. State Center for Health Statistics, Vital Statistics-Hospitalizations, 2010-2012; Analysis by Injury Epidemiology and Surveillance Unit

North Carolina Child Injury Emergency Department Visits

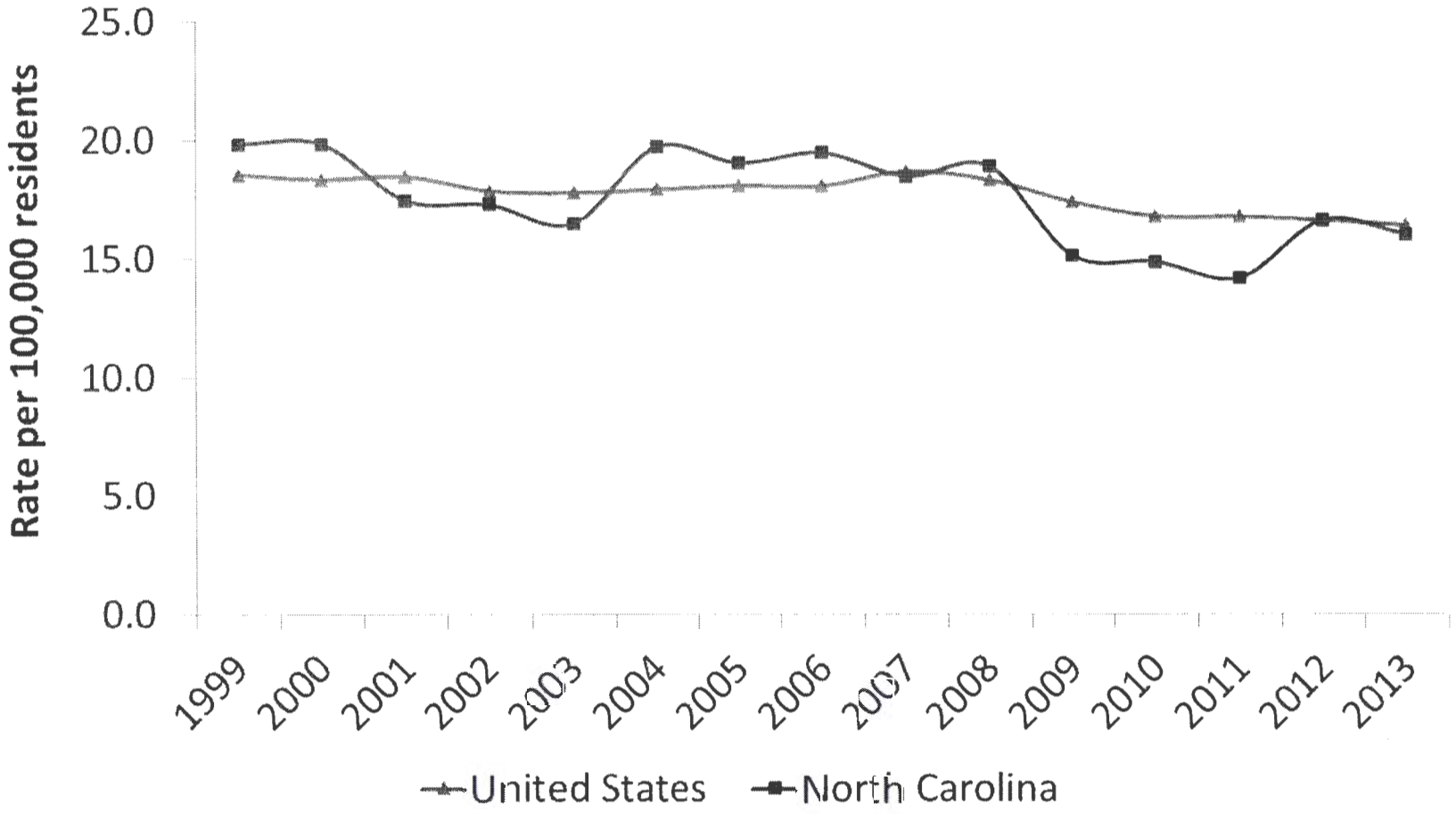
By Age and Sex: 2010-2013 (N=626,149)



Source: NC DETECT, 2010-2013; Analysis by Injury Epidemiology and Surveillance Unit

US and NC Child Injury Death Rates

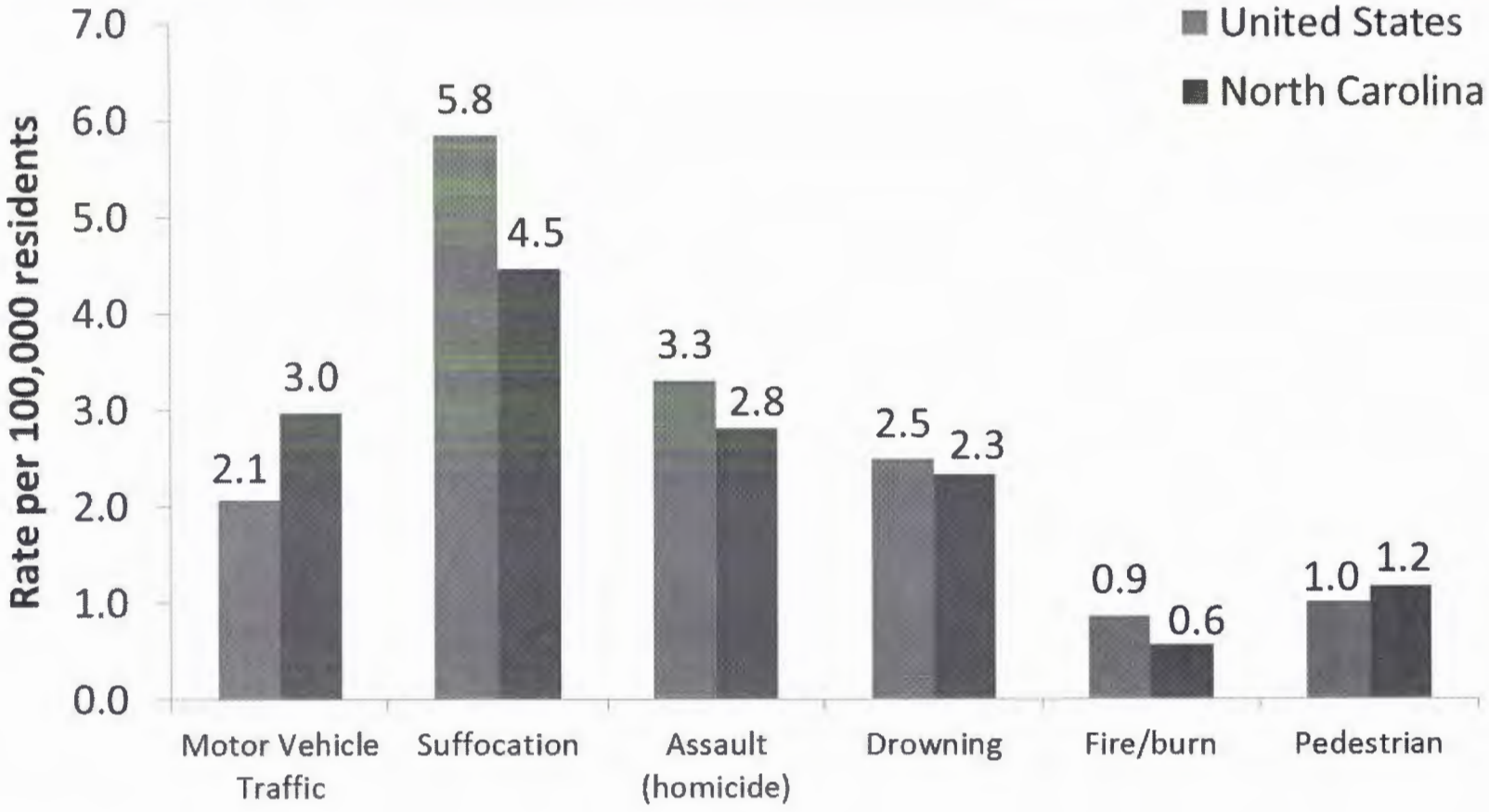
Age 0-4; 1999-2013



Source: CDC WISQARS; Analysis by Injury Epidemiology and Surveillance Unit

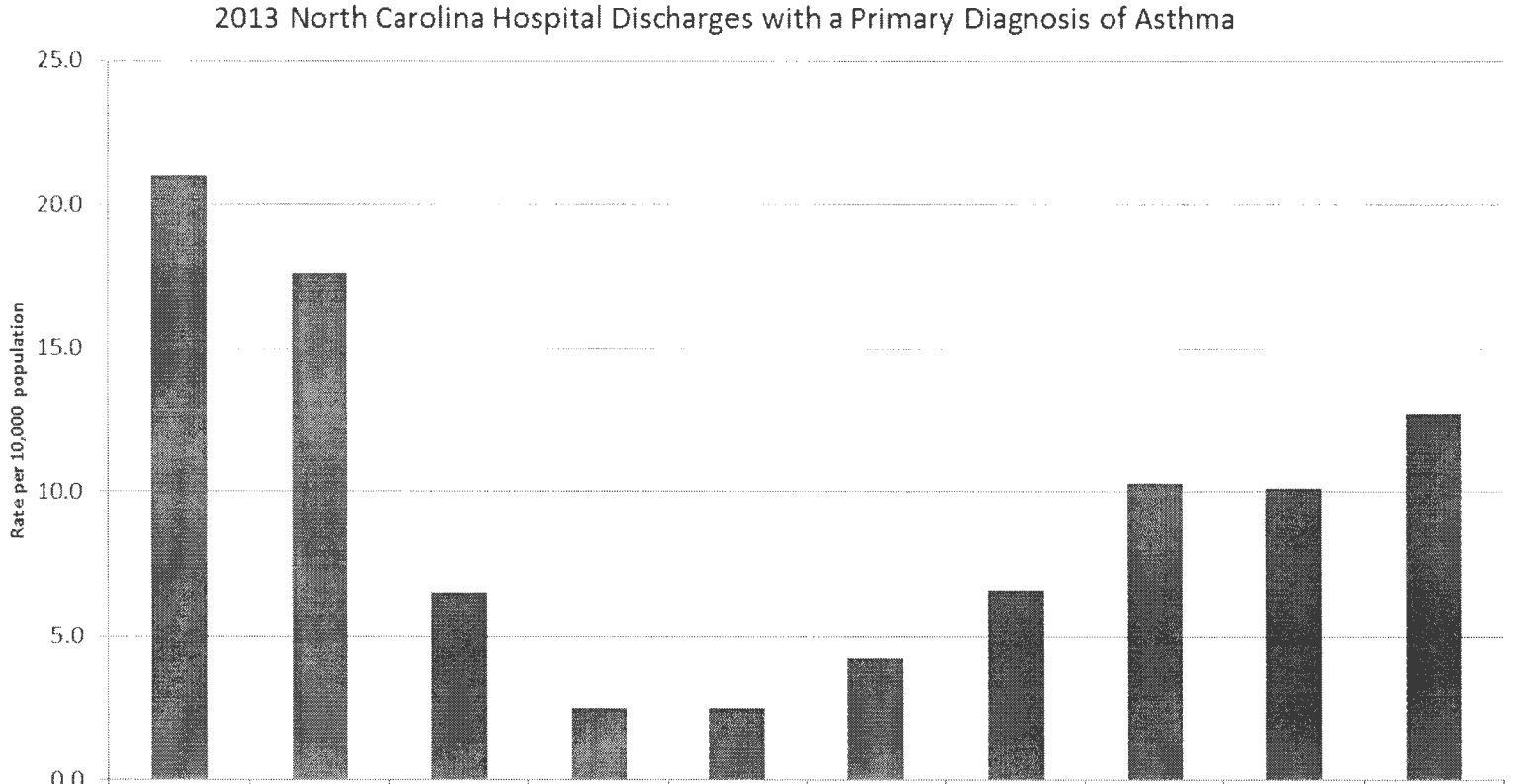
US and NC Child Injury Death Rates

Age 0-4: 2010-2013



Source: CDC WISQARS; Analysis by Injury Epidemiology and Surveillance Unit

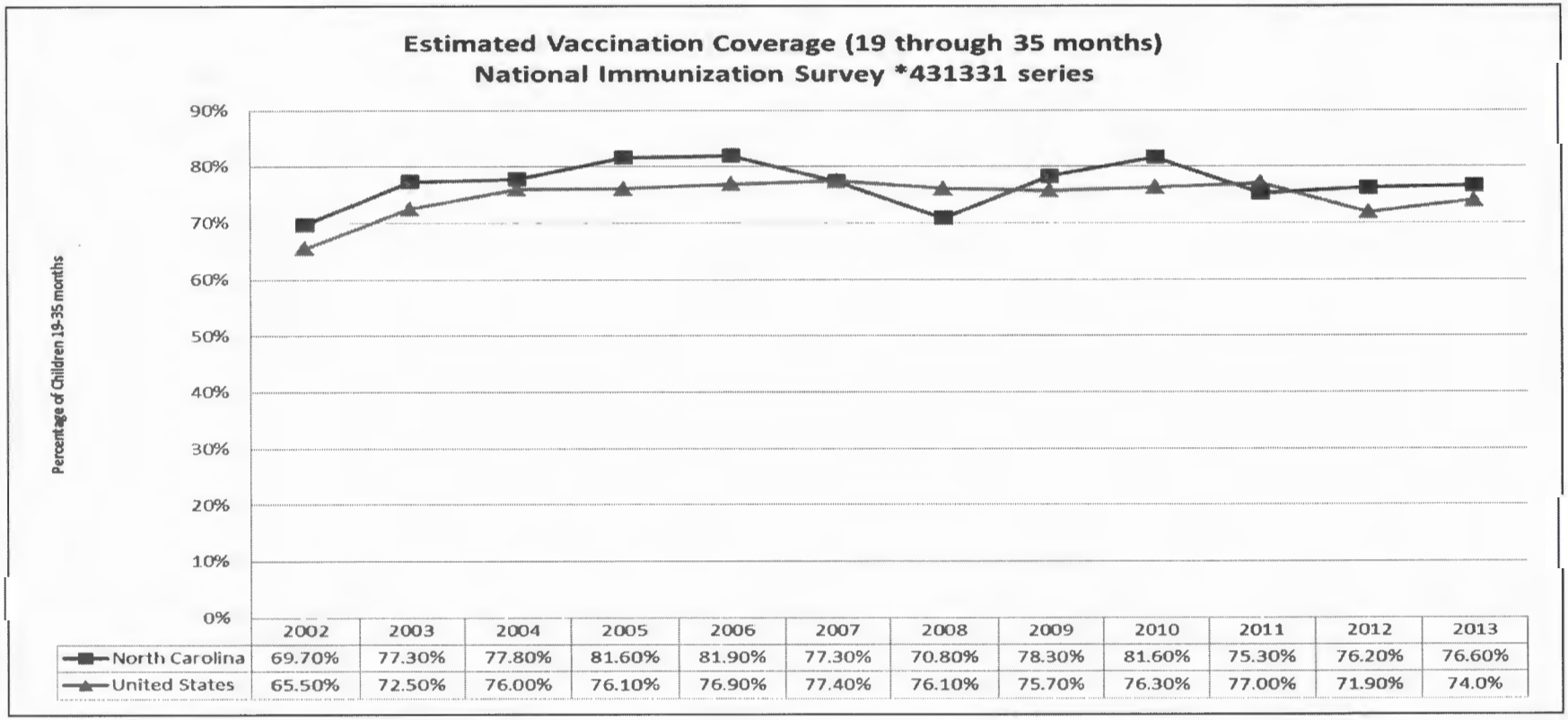
North Carolina Hospital Discharges with Primary Diagnosis of Asthma



	Ages 00-04	Ages 05-09	Ages 10-14	Ages 15-17	Ages 18-24	Ages 25-34	Ages 35-44	Ages 45-54	Ages 55-64	Ages 65+
Discharge Rate	21.0	17.6	6.5	2.5	2.5	4.2	6.6	10.3	10.1	12.7

Note: Provisional North Carolina hospital discharge data - subject to change.
Data includes only NC residents served in NC hospitals. Numbers and rates shown here may be smaller than the actual hospital use for counties that border other states.

Estimated Vaccination Coverage



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
North Carolina	69.70%	77.30%	77.80%	81.60%	81.90%	77.30%	70.80%	78.30%	81.60%	75.30%	76.20%	76.60%
United States	65.50%	72.50%	76.00%	76.10%	76.90%	77.40%	76.10%	75.70%	76.30%	77.00%	71.90%	74.0%

*4 or more doses of DTaP.

*3 or more doses of any poliovirus vaccine.

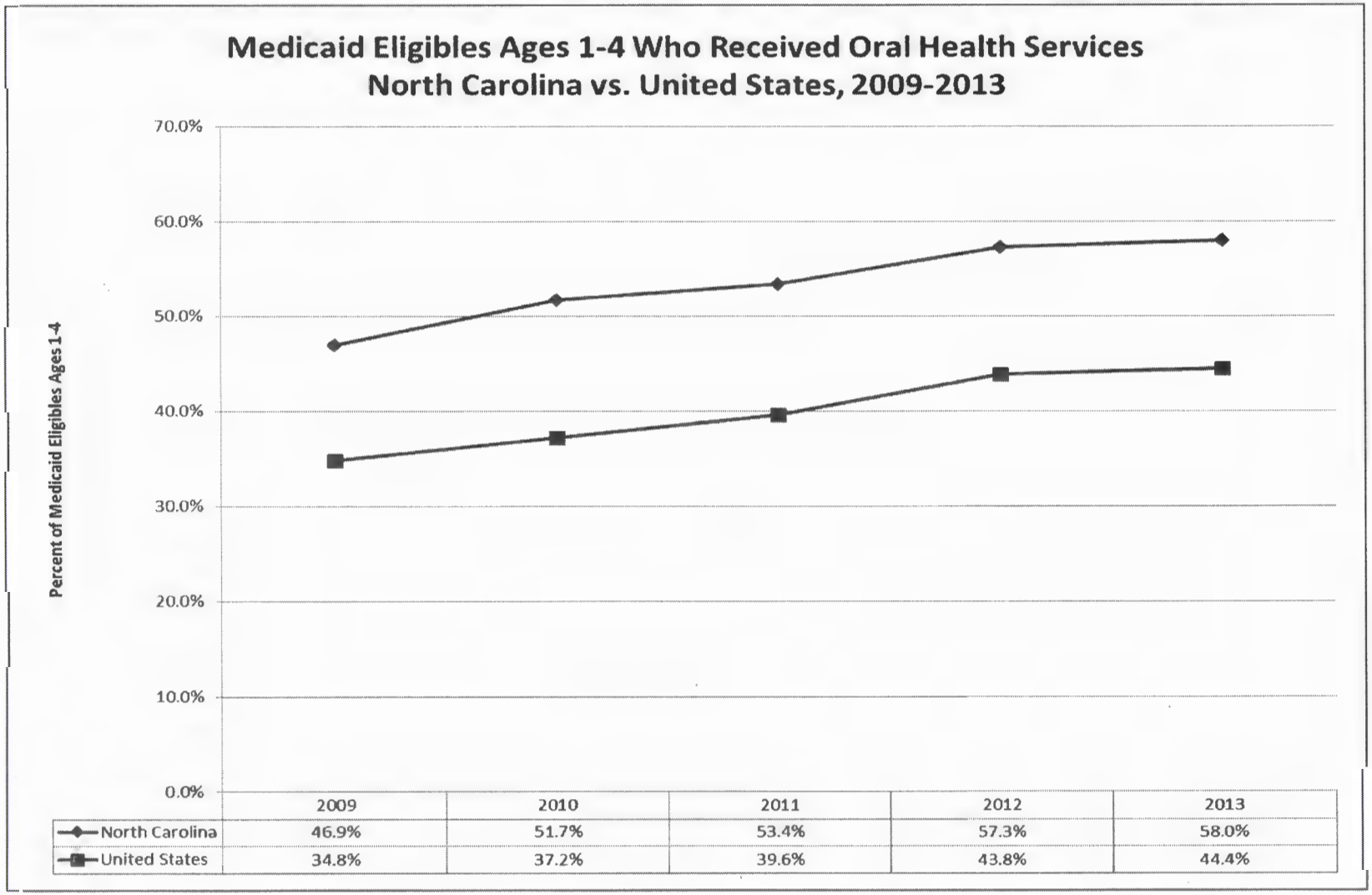
*1 or more doses of measles-mumps-rubella vaccine.

*3 or more doses of Haemophilus influenzae type b (Hib) vaccine.

*3 or more doses of hepatitis B vaccine.

*1 or more doses of varicella at or after child's first birthday, unadjusted for history of varicella illness.

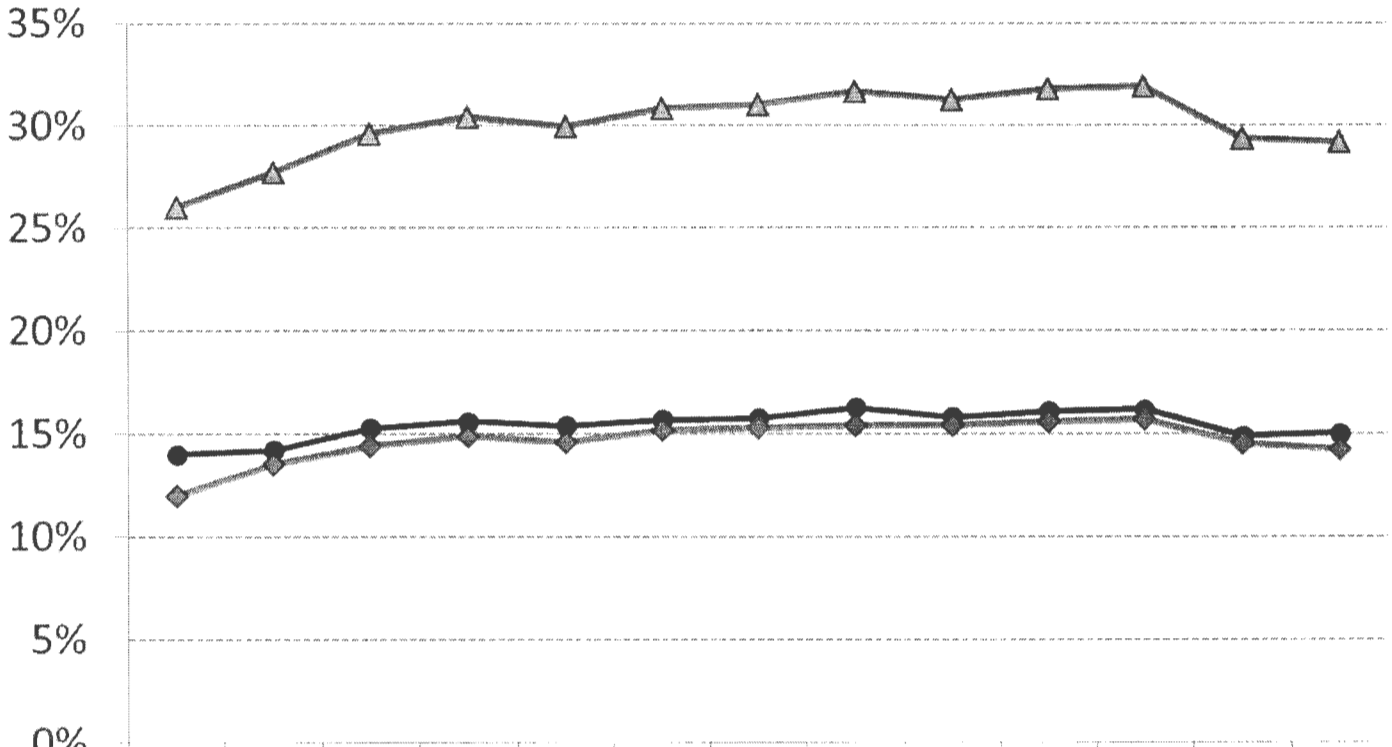
Medicaid Eligibles Ages 1-4 Receiving Oral Health Services



	2009	2010	2011	2012	2013
North Carolina	46.9%	51.7%	53.4%	57.3%	58.0%
United States	34.8%	37.2%	39.6%	43.8%	44.4%

Percentage of Overweight and Obese Children 2-4 Years of Age

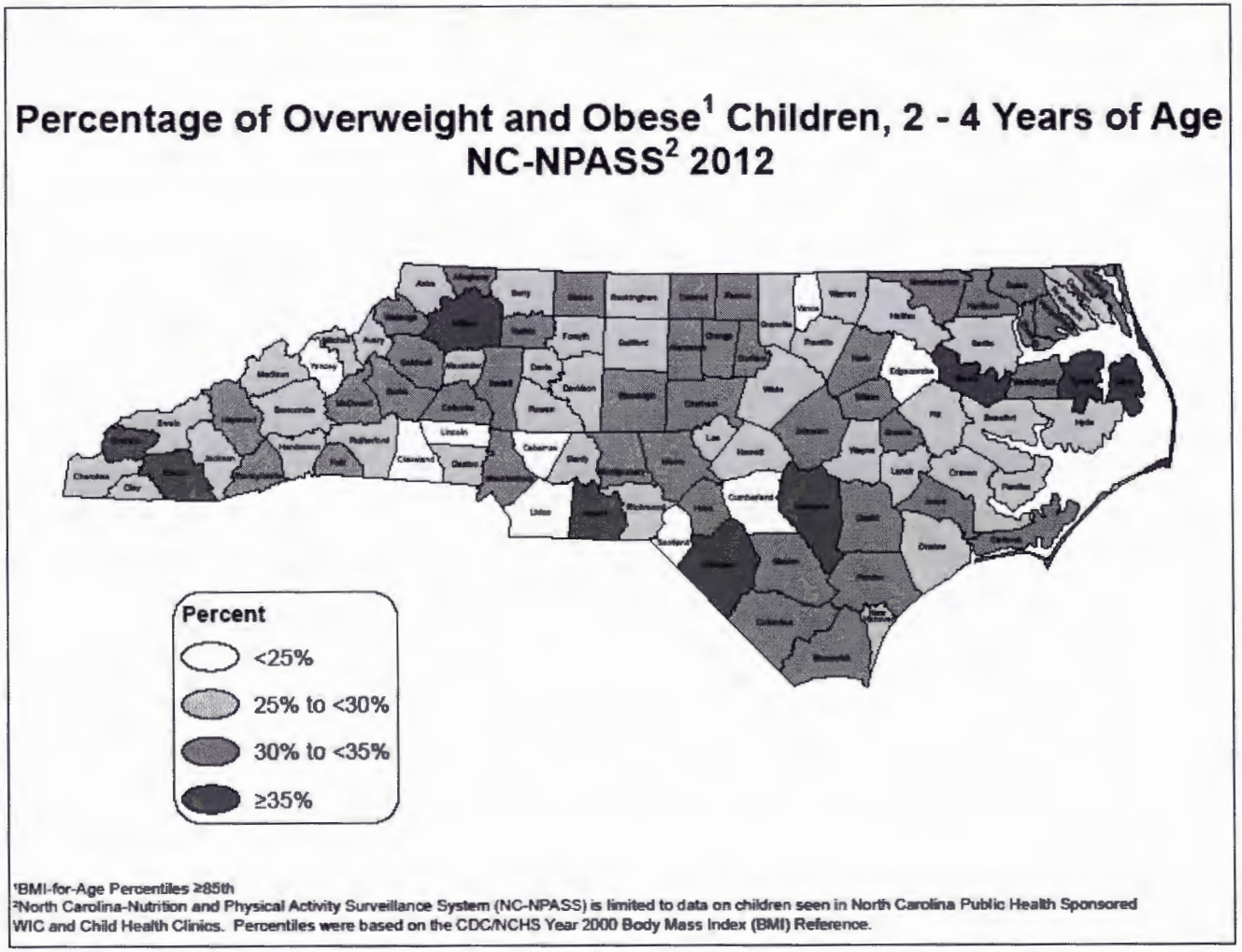
NC-NPASS* 2001 – 2013



	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Overweight and Obese	26.0%	27.7%	29.6%	30.5%	29.9%	30.9%	31.0%	31.7%	31.2%	31.8%	31.9%	29.4%	29.2%
Overweight only	14.0%	14.2%	15.3%	15.6%	15.4%	15.7%	15.8%	16.3%	15.8%	16.1%	16.2%	14.9%	15.0%
Obese only	12.0%	13.5%	14.4%	14.9%	14.6%	15.2%	15.3%	15.4%	15.4%	15.6%	15.7%	14.5%	14.2%

*North Carolina-Nutrition and Physical Activity Surveillance System (NC-NPASS) is limited to data on children seen in North Carolina Public Health Sponsored WIC and Child Health Clinics. Percentiles were based on the CDC/NCHS Year 2000 Body Mass Index (BMI) Reference.

Percentage of Overweight and Obese Children 2-4 Years of Age



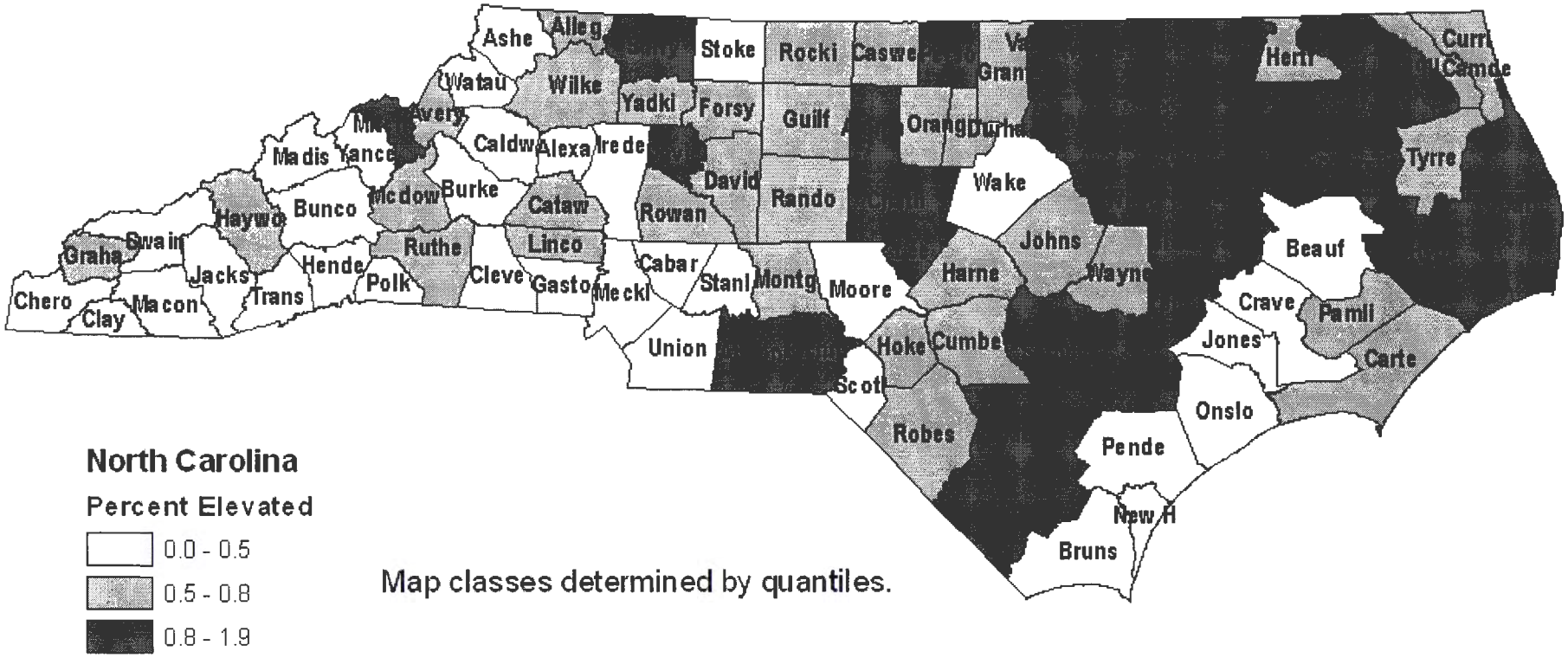
[1]BMI-for-Age Percentiles ≥85th
[2]North Carolina-Nutrition and Physical Activity Surveillance System (NC-NPASS) is limited to data on children seen in North Carolina Public Health Sponsored WIC and Child Health Clinics. Percentiles were based on the CDC/NCHS Year 2000 Body Mass Index (BMI) Reference.

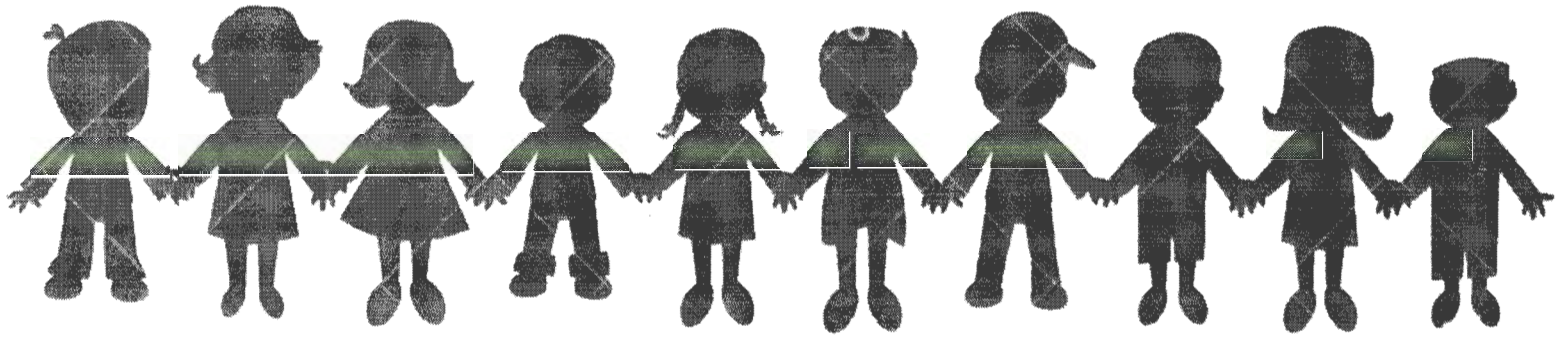
North Carolina Children Tested for Lead Poisoning, 1995-2011

	6 mos to 6 yrs	1 and 2 years		Confirmed 6 mos to 6 yrs	
Year	Number	Number	% tested	10-19	≥20
1995	87,894	44,308	21.9	718	178
⋮					
2001	120,161	82,176	35.1	467	73
2002	120,940	86,218	36.2	466	68
2003	121,717	88,052	37.4	470	38
2004	124,436	92,046	39.1	349	52
2005	128,055	96,547	40.6	302	53
2006	135,555	103,889	42.8	257	38
2007	143,903	112,519	44.9	234	38
2008	152,181	120,993	46.8	182	36
2009	160,563	129,267	49.4	143	38
2010	162,060	132,014	51.3	146	24
2011	156,039	129,558	52.0	105	22

Percent of Elevated Blood Lead Level in Children, 2005-2009

Percent of 1- and 2-Year Old Children with Blood Lead Level >= 10 ug/dL
2005-2009

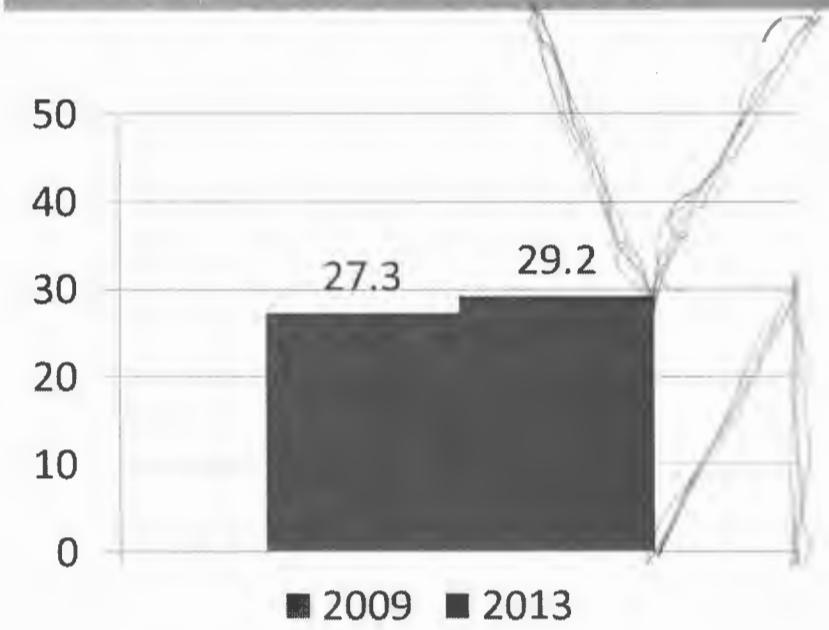




FAMILY AND COMMUNITY INDICATORS

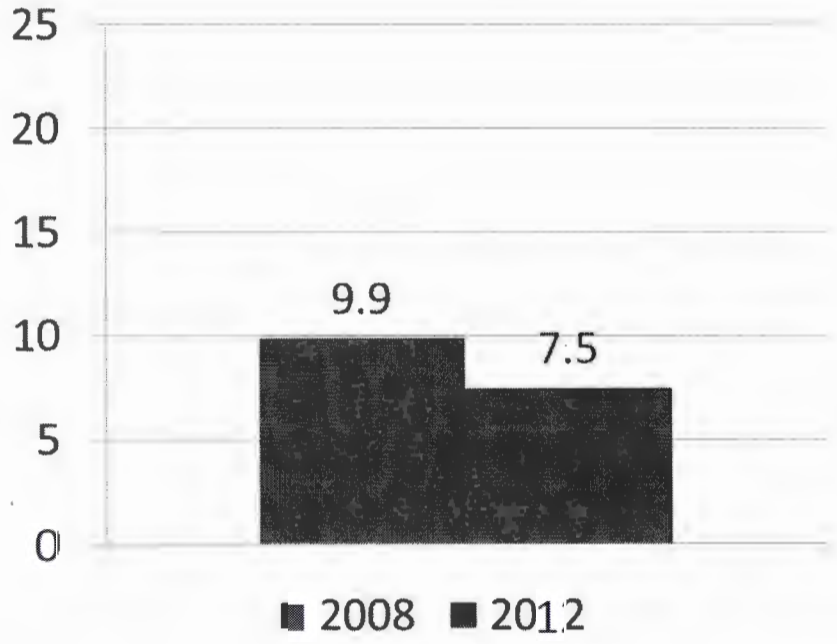
Parents in Household

Percent of NC Children Living in Female-headed Single Parent Households



Source: U.S. Census Bureau, American Community Survey

Number of NC Children with an Incarcerated Parent per 1,000 Resident Children



Source: North Carolina Department of Public Safety

What Works for Healthy Children?

- Evidence based solutions to these problems exist
- Important to implement solutions that fit our context
- Monitoring and evaluating progress is key to success

Processes for Priority Setting

- Considerations
  - Number of people affected
  - Severity
  - Effectiveness of interventions
  - Costs
- Tools and processes have been used in many other states and communities

Closing Comments

- North Carolina ranks 34 among all 50 states in overall child well-being
- Improving health outcomes requires partnerships
- We have examples of successful programs and policies
- Sustained and consistent effort is needed to improve health outcomes

" If we can summon the political will, we certainly have sufficient knowledge to act now and to act boldly so that 25 years from now, our children and our country will be healthier, stronger and better prepared for all of the challenges and opportunities that lie ahead."

Patrick T. McCarthy

President and CEO

The Annie E. Casey Foundation

Acknowledgements

- NC Division of Public Health
- NC State Center for Health Statistics
- NC Department of Health and Human Services

nc department of health and human services

NCPH
North Carolina Public Health

For More Information

Contact:

Dorothy Cilenti, DrPH, MPH, MSW

cilenti@email.unc.edu

UNC
GILLINGS SCHOOL OF
GLOBAL PUBLIC HEALTH

Committee Sergeants at Arms

NAME OF COMMITTEE JT Comm. App. on HHS

DATE: 05/05/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name: Canton Lewis
2. Name: Larry Hancock
3. Name:
4. Name:
5. Name:

Burton Lewis
Larry Hancock

SENATE PAGES ATTENDING

COMMITTEE: Joint: Health & Human Services

DATE: 3/5, TIME: 8:30, ROOM: 643

Pages: Please print legibly.....*or else!!!!!!!!!!!!!!!!*

Page Name	Hometown	Sponsoring Senator
1	~~[illegible] Pinetops~~	~~[illegible]~~
2 Alexis Powell	Greenville	Don Davis
3		
4		
6		
7		
8		
9		

Do not add additional names below the grid.

Pages: Please present this form to either the Committee Clerk at the meeting or a Sgt. at Arms.

Thursday, March 5	Room	Time
APPROPRIATIONS, HEALTH AND HUMAN SERVICES	643	8:30 am

Name	County	Sponsor
Emilyann Marsh	Johnston	Speaker
Jordan Trivette	Bladen	William D. Brisson

VISITOR REGISTRATION SHEET

JT Comm. App. on HHS 03/05/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jon Carr	NC Pediatric Society
Trent Womble	DHHS
Allison Stewart	cardinal Innovations
Ryan Blackledge	Cone Health
Joanna Spruill	NCAFP
TJ Bugbee	NP
Bill Rustin	ACP
Arthur James	ACP
Josh Ehrich	JDA

VISITOR REGISTRATION SHEET

Joint Appropriations Committee Health Human Serv. 3-05-15

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Collins	SEANC

VISITOR REGISTRATION SHEET

Joint Appropriations Committee Health Human Serv. 3-05-15

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sherri George	UHG

VISITOR REGISTRATION SHEET

JT Comm. App. on HHS — 05/05/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ed Stafford	BP
Demetrius Delavich	Senator Robinson
Dirk Culp	[illegible] PLLC
Peter Andersen	DHHS/DPH
Eleanor Howell	DHHS/DPH

Joint Appropriations Committee on Health and Human Services
Wednesday, March 11, 2015 at 8:30 am
Legislative Office Building – Room 643

MINUTES

The Joint Appropriations Committee on Health and Human Services met at 8:30 am on March 11, 2015 in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, William Brisson, Josh Dobson, Chris Malone, Jean Farmer Butterfield, Verla Insko, Gary Pendleton and Howard Hunter were present along with 8 Senate members.

Representative Malone presided.

Representative Malone opened the meeting by welcoming everyone and recognizing the House Sergeants-at-Arms – Young Bae, Bill Morris and Jim Moran – and the Senate Sergeants-at-Arms – Jim Hamilton and Anderson Meadows. He also recognized the pages in attendance. For the House were Abby Martin of Wilson County, Brianna Moore of Rutherford County and Keiara Newsome of Mecklenburg County. For the Senate were Reagan Waites and Rachel Bass – both of Wake County.

Pam Kilpatrick with the Office of State Budget and Management presented the Governor's recommended budget.

The Committee received comments and questions respectively from Senators Hise and Barringer, Representative Avila, Senator Tucker, Representatives Pendleton and Farmer Butterfield, Senator Robinson and Representative Insko.

The meeting adjourned at 9:45 AM.

Representative Chris Malone
Presiding

Joey Stansbury
Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

March 11, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Representative Chris Malone, Presiding Co-Chair
II.	**Governor's Recommended Budget**	Pam Kilpatrick, Office of State Budget and Management
	Committee Discussion	
	Adjourn	

Office of State Budget and Management
Balancing Needs - Improving Government

The Governor's 2015-17 Recommended Budget

for the Department of Health and Human Services

Presented by:

The Office of State Budget and Management

March 11, 2015

DHHS Budget Overview

TOTAL HEALTH AND HUMAN SERVICES GENERAL FUND BUDGETS

	2013-14 Actual	2014-15 Authorized	2015-16 Recommended	% Change	2016-17 Recommended	% Change
Requirements	$18,468,002,559	$18,992,200,857	$19,601,533,472	5.75%	$20,206,607,175	8.94%
Receipts	$13,574,353,755	$13,843,782,988	$14,295,404,925	5.82%	$14,675,807,718	8.58%
GF Appropriation	$4,893,648,804	$5,148,417,869	$5,306,128,547	5.56%	$5,530,799,457	9.92%

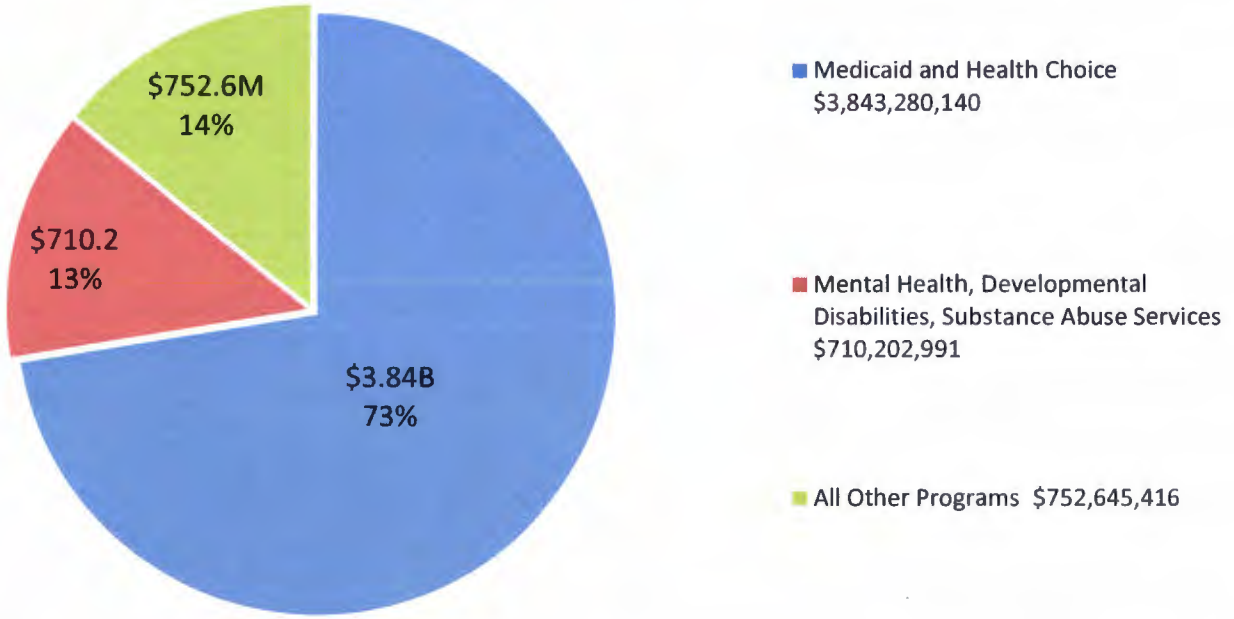
The Governor's recommended budget for DHHS is $10.8B over the biennium

Makes significant investments in access to health care, behavioral health services, supports for families and children, improved public health infrastructure, and technology to support service delivery

Savings are achieved through administrative efficiencies and leveraging federal funds to reduce demand on state appropriations

DHHS State Funding

FY 2015-16 Recommended State General Fund Appropriation is $5.3B, growing to $5.5B in FY 2016-17



Medical Assistance and Mental Health account for 86% of DHHS General Fund appropriations in the recommended budget

DHHS Recommended Budget Highlights

Investments in the Administration's Priorities

- Community mental health services investments - $10.2M / $32M
- State operated health care facilities - $27.9M / $11.6M
- Services to children in foster care and adoption - $4.5M / $10.4M
- Medical Examiner improvements - $335K / $4.2M
- Continue Pre-K expansion from 2014-15 - $5.04M / $5.04M
- Support NC FAST to improve access to services - $5.8M / $13M
- Complete NC TRACKS development – $2.3M / $940K
- Develop Electronic Death Records System – $500K / $1.5M
- Fund Medicaid rebase - $287.5M / $460.6M
- Establish a Medicaid Risk Reserve - $50M / $125M (retained in reserve outside of DHHS)

Savings

- Administrative efficiencies by reducing vacant positions, reducing personal services contracts, and achieving IT savings - $7.5M / $7.5M
- Leveraging receipts to lessen demand on state dollars - $47.4M / $27.8M

DHHS Base Budget

	2014-15 "Worksheet I" Authorized Budget	Recommended Base Budget for 2015-17 Biennium: 2015-16 Adjustments	2015-16 Recommended Base Budget	2016-17 Adjustments	2016-17 Recommended Base Budget
Requirements (Expenditures)	18,992,200,857	(483,259,097)	18,508,941,760	(483,981,599)	18,508,219,258
Receipts	13,843,782,988	(354,767,436)	13,489,015,552	(355,489,936)	13,488,293,052
Net General Fund Appropriation	5,148,417,869	(128,491,661)	5,019,926,208	(128,491,663)	5,019,926,206
Positions (Full Time Equivalent)	17,051	0	17,051	0	17,051

Base Budget Adjustments reduced DHHS state appropriations by $128.5M, or 2.5%.

DHHS Base Budget

DHHS BASE BUDGET CHANGES BY CATEGORY

Annualize Programs and/or Positions	(17,982,420)
Remove Non-Recurring Decreases	42,955,771
Remove Non-Recurring Increases	(153,465,012)
GRAND TOTAL ALL CHANGES	(128,491,661)

Adjustments are made to annualize partially funded programs, remove non-recurring appropriations, adjust federal payroll tax changes, lease increases, and receipt funded programs, reconcile, and provide for base budget changes required by statute.

DHHS Base Budget

		General Fund Impact
	Annualize 2014-15 Enacted Appropriations	
1	Child Protective Services Caseloads	956,656
2	Medicaid- Mental Health Drug Management	(6,000,000)
3	Medicaid - Provider Rate and Hospital DRG Weigh Mix Reduction	(7,190,441)
4	Medicaid - Nursing Home Case Mix Index Adjustment	(2,200,000)
5	Medicaid - Single Base Rate	(10,800,000)
6	Medicaid - Nursing Home Rates	7,330,000
7	Medicaid - Paraguard Rate	(62,000)
8	Medicaid - Rx Dispensing Fee Study	(100,000)
9	Medicaid Non Recurring Rebase Funds FY13-14	(136,503,776)
10	Medicaid - Personal Care Services Study Option Program	(300,000)
11	Health Choice Hospital Single Base Rate	(63,961)
12	Vocational Rehabilitation Position Elimination	(14,674)

DHHS Base Budget

		General Fund Impact
	Remove Enacted Non-Recurring Appropriations	
13	NC FAST	(864,655)
14	Competitive Grants to Non Profits	(317,400)
15	Supplemental Short Term Assistance to Group Homes	(2,000,000)
16	Senior Center Capital funding	(100,000)
17	Block Grant Swap Out	13,982,425
18	TANF for Pre K	19,842,334
19	TANF for Child Care Subsidy	3,348,849
20	Pre-K Non Recurring Expansion	(5,040,000)
21	ADAP Supplemental Rebate Funds	5,782,163
22	Nurse Family Partnership	(675,000)
23	Maternity Homes	(925,085)
24	High Risk Maternity Clinics	(375,000)
25	Federal Funds for County Child Welfare Services	(4,826,346)
26	Child Protective Services Statewide Evaluation	(700,000)
27	Child Protective Services Pilot Program	(300,000)
28	Work First Drug Testing	(125,750)
29	DSS Transfer-Maternity Homes	-
30	NC Child Treatment Program	(250,000)
	TOTAL BASE BUDGET CHANGES	**(128,491,661)**

Community-Based Mental Health Services

Investing in a Comprehensive Array of Prevention, Intervention and Treatment Services

- *Three Way Psychiatric Beds $0 / $10M*
  Increases local-in patient capacity by 30 to approximately 195 beds

- *Behavioral Urgent Care and Facility-Based Crisis Services $0 / $2M*
  Outpatient and residential services for children and adults

- *NC START (Systematic, Therapeutic, Assessment, Respite and Treatment) $0 / $2.3M*
  Adds a fourth START Team for improved statewide coverage and expands services to children

- *TASC (Treatment Alternatives for Safer Communities) $1.9M / $1.9M*
  Reduces average caseload and accommodates increased referrals

Investments in Facility-Based Care

- *New Broughton Hospital $16.6M / $0*

  Restores one-time funding for medical equipment, furniture, and information technology to make hospital patient-ready

- *Inflationary Increases $2.8M / $3.2M*

  Requests funding for core facility and patient care accounts, including utilities, food, and drugs

- *Chronic Budget Shortfall $8.5M / $8.5M*

  Enables financial viability of state facilities by addressing structural gap (coupled with DHHS efficiency measures)

Facility-Based Mental Health Services

Factors contributing to a chronic shortfall (gap between spending and revenues)

- Delayed transitions of patients and staff to Central Region Hospital
- Increased expenditures due to patient acuity, increasing food and medical costs
- Variations in receipts to support facility operations, mix of patients and third party cost recovery

Current Year Outlook

Net liabilities brought forward into 2014-15: $13M

Current Year (2014-15) anticipated shortfall: $20M

Combined debt brought forward and current year shortfall means estimated unfunded liabilities at June 30, 2015 of $33M

Office of the Chief Medical Examiner

Invests in the Office of the Chief Medical Examiner (OCME) $335K / $4.2M

- **Expansion funding will do the following:**
  - Creates 14 new medicolegal death investigator positions: 4 FTE in Y1 and 10 FTE in Y2
  - Funds two forensic pathology fellowships (one at East Carolina University and one at Wake Forest University)
  - Strengthens the medical examiner training program
  - Supports operational costs associated with accreditation by the National Association of Medical Examiners
  - Increases autopsy fees and medical examiner fees

Electronic Death Registration System

Develops and implements an Electronic Death Registration System (EDRS) at the Vital Records Office $475K / $1.5M

- EDRS will improve customer service by doing the following:
  - Providing more accurate and timely access to certified copies of death certificates
  - Reducing turnaround time for death records
  - Increasing security of personal data
  - Enabling timely public health data analytics

- State currently uses an 84-year-old paper-based system for the 83,000 death records processed every year

Investments in Families and Children

Foster Care Caseload Growth $4.5M / $7.5M

Program projects growth in children of 6% and 3% each year of the biennium, respectively, and recurring state funds are recommended to ensure all children and their families receive support.

Adoption Assistance $0 / $2.9M

Continues payments for a growing number of children moving from foster care to permanent placements.

NC Pre K $2.3M / $2.3M

Continues the commitment to high quality early childhood programs by making permanent a one-time expansion in 2014-15 of NC Pre K slots. Funded through increased lottery receipts of $2.7M each year and recurring state funds, the program serves more than 26,800 at-risk four-year-olds.

Investments in Information Technology

The Governor's Recommended Budget continues the state's commitment to the development as well as the operations and maintenance of the NC FAST and NC TRACKS information technology systems to enhance access to services

Recommended Funding for Major IT Development and Implementation

	2015-16	2016-17
NC FAST	$5,803,000	$13,052,000
NC TRACKS	$2,300,000	$940,000

Recommended Funding for Major IT Operations and Maintenance

	2015-16	2016-17
NC FAST[1]	$0	$0
NC TRACKS[2]	$400,000	$400,000

[1] NC FAST O&M is funded through budget grant funds, redirecting budget used to support legacy system, and funding provided during the 2013-15 biennium.

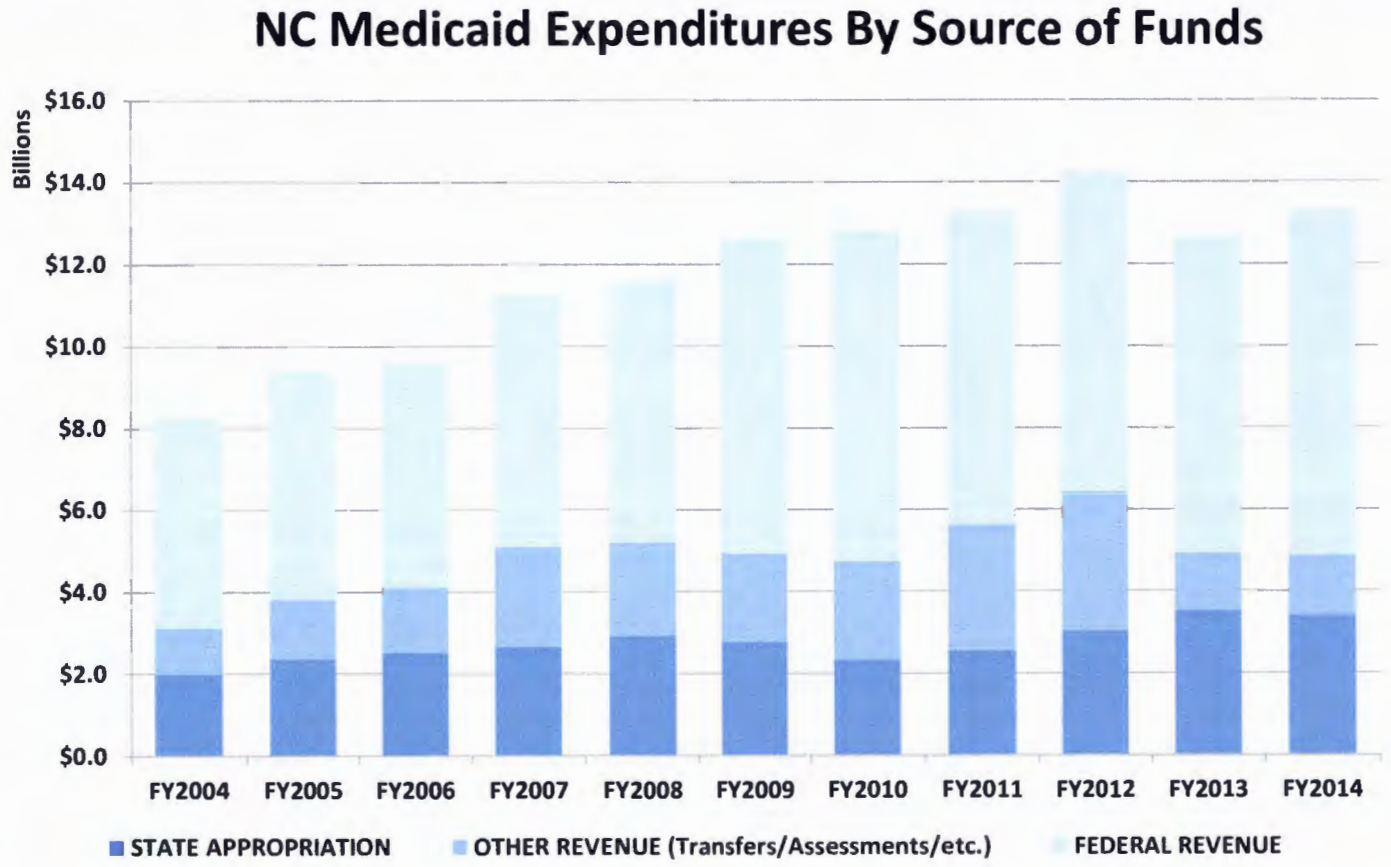
[2] NC TRACKS O&M is supported by redirecting $600,000 in savings realized by implementing the new system in addition to the base budget and the recommended expansion.

Savings in Information Technology

The Governor's Recommended Budget achieves savings through the implementation of NC TRACKS. This is in addition to reduction items related to the implementation of NC TRACKS that were included in Session Law 2013-360 and Session Law 2014-100.

NC TRACKS Savings		
Session Law 2013-360	Division of Medical Assistance	($2,016,771)
Session Law 2014-100	Division of Mental Health	($2,400,000)
2015-17 Governor's Recommended Budget	Division of Medical Assistance	($4,775,749)

Medicaid Expenditure History



Medicaid is funded with federal dollars matched with state appropriations and other state revenues such as provider assessments and drug rebates. Federal funds make up about 2/3 of Medicaid expenditures. Inherent uncertainties in projections for the 2015-17 biennium are mitigated by a recommended risk Medicaid Risk Reserve.

Medicaid Year to Date Through February

MEDICAID BUDGET TO ACTUAL
(In Billions)

	Authorized Budget	Year to Date Actuals	% of Total Budget
Requirements	$ 13.731	$ 8.477	61.7%
Receipts	$ 10.043	$ 6.088	60.6%
Appropriations	$ 3.688	$ 2.389	64.8%

Source: NCAS BD 701 Certified Report (03/09/2015) for the Period Ending February 28, 2015

Total Medicaid expenditures includes all payments - provider payments, cost settlements, supplemental hospital payments, current year and prior year adjustments, and administrative costs, as well as offsetting federal matching funds and all other receipts

Medicaid Checkwrites

$10,870,728,645	Total Checkwrite Budget
$7,488,357,745	Checkwrite Expenditures through March 3
68.9%	Share of Checkwrite Budget Expended

Claims payments made to providers through NC Tracks are referred to as "checkwrites." The checkwrite budget makes up about 79% of the total Medicaid budget.

50 checkwrites scheduled this fiscal year (34 to date and 16 remaining)

4 year average % of budget expended through the first week of March (2011-2014) is 68.8

DMA forecasts Medicaid to end 2015 with a positive cash balance

2015-17 Forecast

- **Prepared by DHHS using new DMA Medicaid Model**
  - Model data base, executive summary of processes and key assumptions
- **Assumptions / Variables**
  - Enrollment, consumption, mix, cost of services
  - Savings achieved/not achieved
- **Medicaid Rebase Recommendation**
  - Recommended rebase is $287.5M in 2015-16 and $460.6M in 2016-17
  - Governor recommends risk reserve of $50M in 2015-16 and additional $125M in 2016-17 *(outside of the Medicaid budget, not included in DHHS totals)*

Medicaid Rebase

	2013-14 Actual	2014-15 Forecast	2015-17 Base Budget	2016-17 Rebase	2015-16 Budget	2016-17 Rebase	2016-17 Budget
Expenditures	$13,303,105,674	$13,628,963,351	$13,277,289,348	$1,022,356,904	**$14,299,646,252**	$1,589,329,992	**$14,866,619,340**
Revenues	$9,899,321,179	$10,057,856,802	$9,744,740,562	$734,866,837	**$10,479,607,399**	$1,128,721,377	**$10,873,461,939**
Appropriation	$3,403,784,495	$3,571,106,549	$3,352,548,786	$287,490,067	**$3,820,038,853**	$460,608,615	**$3,993,157,401**
Year-over-Year Growth		***4.92%***			***6.97%***		***4.53%***
Percent Growth over Base Budget				***8.58%***		***13.74%***	

Major Assumptions:

- Enrollment Growth – higher than historical trends
  - January 2014 through January 2015 = 8.2%
  - January 2015 through June 2015 = 10.2%
  - July 2015 through June 2016 = 4.6%
  - July 2016 through June 2017 = 3.6%

- Utilization and Average Cost per Recipient – forecasted by account, along with additional context

- Governor's Recommendation adjusted DMA's January 31, 2015 forecast:
  - Implemented policies that produced savings to the Medicaid budget
  - Removed non-enrollment driven increases or decreases (funds traditionally not part of rebase)
  - Removed 1% of claims reserve in rebase

Medicaid Reform

The Governor's Recommended Budget supports patient-centered, provider led Medicaid reform to improve the quality of health care for citizens and contain health care costs.

Funding Summary:

- $1,160,611 state appropriations in each year of the 2015-17 biennium
- Governor's recommendation reflects:
  - Expanded state staff of 22 FTE to develop, support and monitor the transition of the Medicaid program from traditional fee-for-service to an accountable care delivery model
  - No contract expansion. Budget recommendation assumes that contract needs for actuarial analysis, ongoing reform consultation, IT system changes and quality measurement can be covered with existing Medicaid contract availability
  - Resulting savings will be incorporated into future budget forecasts

Health Choice Rebase

Expenditures	$246,435,066	$199,337,822	$174,461,506	$24,785,855	**$199,247,361**	$28,497,258	**$202,958,764**
Revenues	$187,777,208	$150,861,620	$132,586,847	$19,262,845	**$151,849,692**	$22,088,046	**$154,674,893**
Appropriation	$58,657,858	$48,476,202	$41,874,659	$5,523,010	**$47,397,669**	$6,409,212	**$48,283,871**
Year-over-Year Growth		***(17.36%)***			***(2.22%)***		***(1.87%)***
Percent Growth over Base Budget				***13.19%***		***15.31%***	

Major Assumptions:

- Governor's Recommendation adjusted DMA's January 31, 2015 forecast:
  - Implemented policies that produced savings to the Health Choice budget
  - Removed non-enrollment driven increases or decreases (funds traditionally not part of rebase)

Conclusion

The Governor's Recommended Budget builds on a significant base budget level of funding for health and human services programs and makes further critical investments in access to health care, behavioral health services, supports for families and children, improved public health infrastructure, and technology to support service delivery.

Thank you.
Questions / Comments

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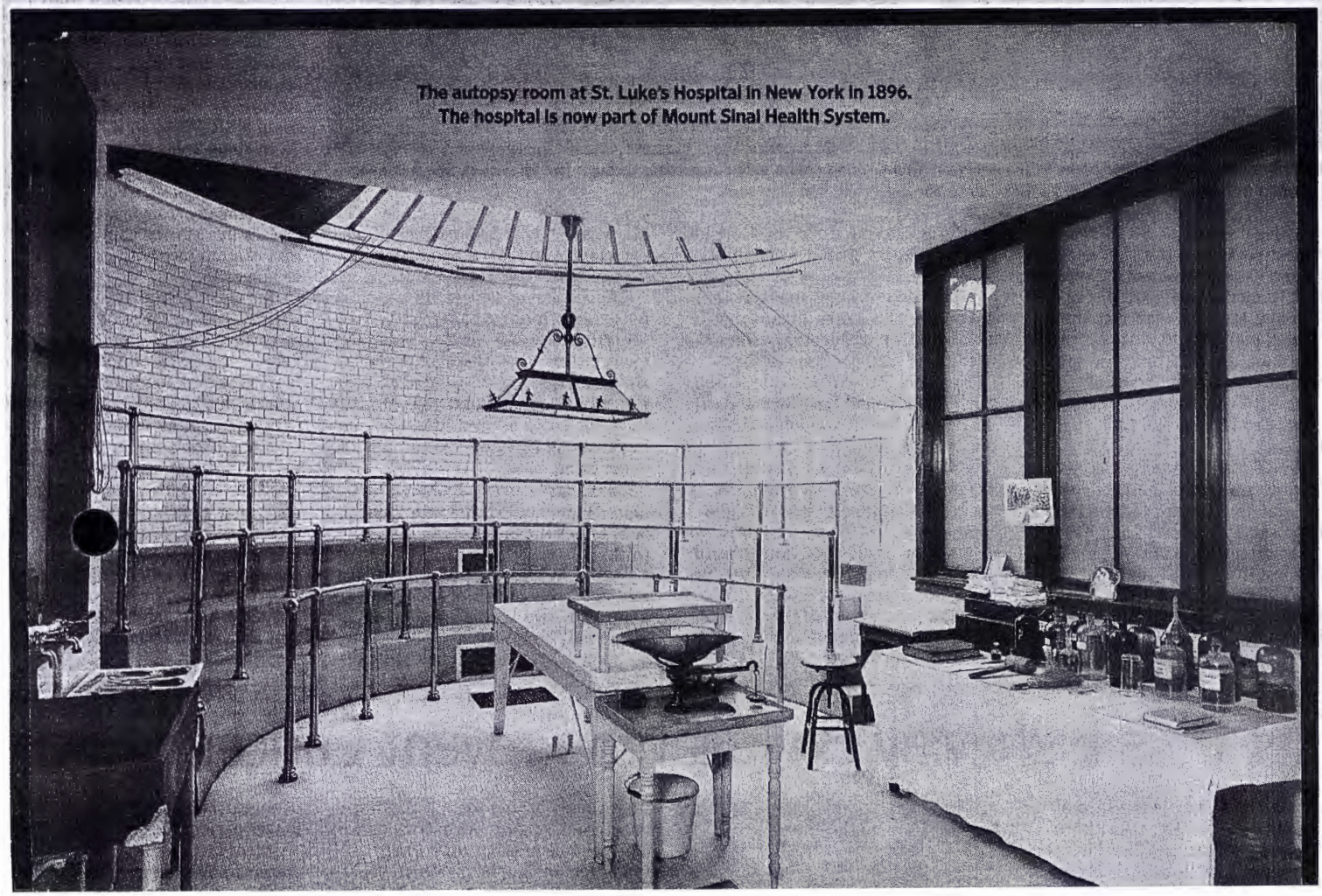
What Autopsies Can Teach



The autopsy room at St. Luke's Hospital in New York in 1896. The hospital is now part of Mount Sinai Health System.

AUTOPSY

Continued from page D1

as ever."

Not every death would benefit from an autopsy, and some families remain opposed to the idea for religious or other reasons. Even when patients themselves leave written requests to have their body autopsied or donated, most states require formal consent from their next of kin.

"People often say they are open to learning more medical information, but they're still afraid of the concept of their loved one being cut open," says Lisa Salberg, chief executive of the Hypertrophic Cardiomyopathy Association, an advocacy group that helps families cope with the disease, which afflicts about 1 in 500 Americans. "But we can learn so much from the people we've lost."

HEALTH JOURNAL

Some teaching hospitals still perform autopsies, in part to help train pathology residents. "If there's something we missed, we'd like to know, and we'd also like to know when we are right," says Barbara Crain, director of the autopsy service at Johns Hopkins Medicine in Baltimore, which offers the postmortem exams to any patient who dies at one of its four affiliated hospitals, at no cost, if the family requests it.

Laura Friend

Sarah Friend, at 10, died two years later. An autopsy found a genetic condition.

Private services and some medical-examiners' offices also perform autopsies for families seekir private autopsy "can help a manage a lot of emotion," s Margolis, director of the Au Center of Chicago, where au services start at $2,500. "If feeling guilty or angry or co may help to hear that the tu very advanced and there wa more anybody could do."

Some researchers hope a forms of postmortem invest could increase interest. The partial autopsies of individu and virtual autopsies, which bodies with MRI or CT scan dissecting them. While such is useful for locating bullets tifying broken bones, it can much as conventional autop cannot definitely determine of death, some pathologists

Mount Sinai Health Syst York City plans to offer "mi invasive" autopsies, which i small instruments to remov tissue samples for further s thologists there hope this w costly and more acceptable lies than traditional open a

Pathologists say some of useful information comes fr

BRIG. GEN. GARY H. PENDLETON
N.C. HOUSE OF REPRESENTATIVES
49TH DISTRICT

610 LEGISLATIVE OFFICE BUILDING
300 N. SALISBURY STREET
RALEIGH, NC 27603-5925

(919) 733-5860
GARY.PENDLETON@NCLEG.NET

Committee Sergeants at Arms

NAME OF COMMITTEE Jt Comm. on App. HHS

DATE: 03/11/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name: Jim Hamilton
2. Name: Anderson Meadows
3. Name:
4. Name:
5. Name:

SENATE PAGES ATTENDING

COMMITTEE: Joint App – Health & Hum. Serv.

DATE: 3-11, TIME: 8:30am ROOM: 643

Pages: Please print legibly.....*or else!!!!!!!!!!!!!!!!*

Page Name	Hometown	Sponsoring Senator
1 Reagan Waites	Raleigh	Chad Barefoot
2 Rachel Bass	Raleigh	John Alexander
3		
5		
6		
7		
8		
9		

Do not add additional names below the grid.

Pages: Please present this form to either the Committee Clerk at the meeting or a Sgt. at Arms.

VISITOR REGISTRATION SHEET

Joint House and Senate Appropriations Subcommittee on Health and Human Services — March 11, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
TRACY COLVARD	AHHC
Cody Hand	NCHA
Ryan Blackledge	CoreHealth
Matthew McConnell	Carolinas HealthCare Syst
[illegible]	CSS
Evelyn Hawthorne	CHOR
[illegible]	[illegible]
Lauren Coffey	Policy
[illegible]	SEANC
Annaliese Dolph	NL
Alan Briggs	NC Food Banks

VISITOR REGISTRATION SHEET

Joint House and Senate Appropriations Subcommittee on Health and Human Services March 11, 2015

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Rhian Merwald	Williams Mullen
Torri Bryant	~~SOF~~
Kay Castillo	NASW-NC
ARUN KUMAR	NC DHHS
Ann Rodriguez	NC Council of Community Programs

VISITOR REGISTRATION SHEET

Joint House and Senate Appropriations Subcommittee on Health and Human Services — March 11, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Amanda Honaker	TS
TJ Bugbee	NP
Trent Womble	DHHS
	ACP
Josh Ehrlich	JDA
Chris McClure	Brooks Pierce
Matt Gross	NCPC
	NCEMA
Lexi Morgan	NCKMA
	ACT

Joint Committee on Appropriations on Health and Human Services
Tuesday, March 17, 2015 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Joint Committee on Appropriations on Health and Human Services met at 8:30 AM on March 17, 2015, in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, William Brisson, Josh Dobson, Beverly Earle, Jean Farmer-Butterfield, Howard Hunter, Verla Insko, Chris Malone, and Gary Pendleton were present, along with 8 Senate members.

Senator Ralph Hise presided.

Senator Hise opened the meeting by welcoming everyone and recognizing the House Sergeants-at-Arms—Young Bae, Jim Moran, and Bill Morris—and the Senate Sergeants-at-Arms—Dale Huff and Marcus Kitts. He also recognized the House Page in attendance—Sierra Cox of Gaston County and and the Senate Page in attendance —Dishanda Brown of Guilford County.

Senator Hise then recognized Gary VanLandingham, Director, Pew-MacArthur Results First Initiative, and Josh Watters, Senior Associate, Pew-MacArthur Results First Initiative who shared a presentation: The Pew-MacArthur Results First Initiative: Invest in Programs That Work. Mr. VanLandingham and Mr. Watters then answered questions from Committee members.

The meeting adjourned at 9:50 AM

Senator Ralph Hise
Presiding

Susan Fanning, Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

March 17, 2015 8:30 a.m.
Legislative Office Building - Room 643

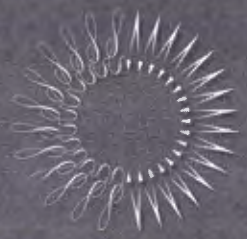
Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Senator Ralph Hise, Presiding Co-Chair
II.	**The Pew - MacArthur Results First Initiative: Invest In Programs That Work**	Gary VanLandingham, Director, Pew-MacArthur Results First Initiative Josh Watters, Senior Associate Pew-MacArthur Results First Initiative

Committee Discussion

Adjourn



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The Pew-MacArthur Results First Initiative:
INVEST IN PROGRAMS THAT WORK

March 17, 2015

The Policy Challenge

- Though policymakers strive to make strategic choices, the process often relies on inertia and anecdote
- Limited data on:
  - What programs are funded
  - What each costs
  - What programs accomplish
  - How they compare
- **Solution: bring systematic evidence into the budget process**

The Results First Approach

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Compare current programs to evidence

Inventory Programs

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PROGRAM INFORMATION	BUDGET	
Program Name	Program Budget (FY13)	% of FY13 Program Budget
Thinking for a Change	$50,000	2%
Vocational Education in Prison	$300,000	16%
Transcendental Meditation	$75,000	4%
Sober Living Environment	$180,000	9%
Adult Boot Camps	$250,000	13%
Veterans Courts	$70,000	4%
All Others	$1,000,000	52%

Compare Inventory to Database of Evidence-Based Programs

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Program Area	Intervention	Blueprints for Healthy Youth Development	California Evidence-Based Clearinghouse for Child Welfare	CrimeSolutions.gov	Promising Practices Network	NREPP
Sexual/Dating Violence	4th R Curriculum			Promising		
Early Childhood Education	Abecedarian Project				Proven	
Mental Health: Adult	Acceptance and Commitment Therapy (ACT)		1: Well-Supported			3.7
General Prevention	All Stars			No Effects		2.2
Juvenile Justice	Functional Family Therapy (FFT)	Model	2: Supported	Effective		
Student Behavior/ Character Education	Good Behavior Game	Promising		Effective		3.2

Assess Level of Funding for Evidence-Based Programs

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PROGRAM INFORMATION	BUDGET		EVIDENCE-BASED
Program Name	**Program Budget (FY13)**	**% of FY13 Program Budget**	**Ratings**
Thinking for a Change	$50,000	2%	Evidence-based
Vocational Education in Prison	$300,000	16%	Evidence-based
Transcendental Meditation	$75,000	4%	Strong beneficial: high rigor
Sober Living Environment	$180,000	9%	Promising
Adult Boot Camps	$250,000	13%	No Effects
Veterans Courts	$70,000	4%	N/A
All Others	$1,000,000	52%	N/A

22%: Highest-rated

9%: Second-highest rated

13%: No Effects

56%: No Evidence

The Results First Approach

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Compare current programs to evidence

Conduct benefit-cost analysis to compare returns on investment

EXAMPLE: Meta-analysis of Functional Family Therapy

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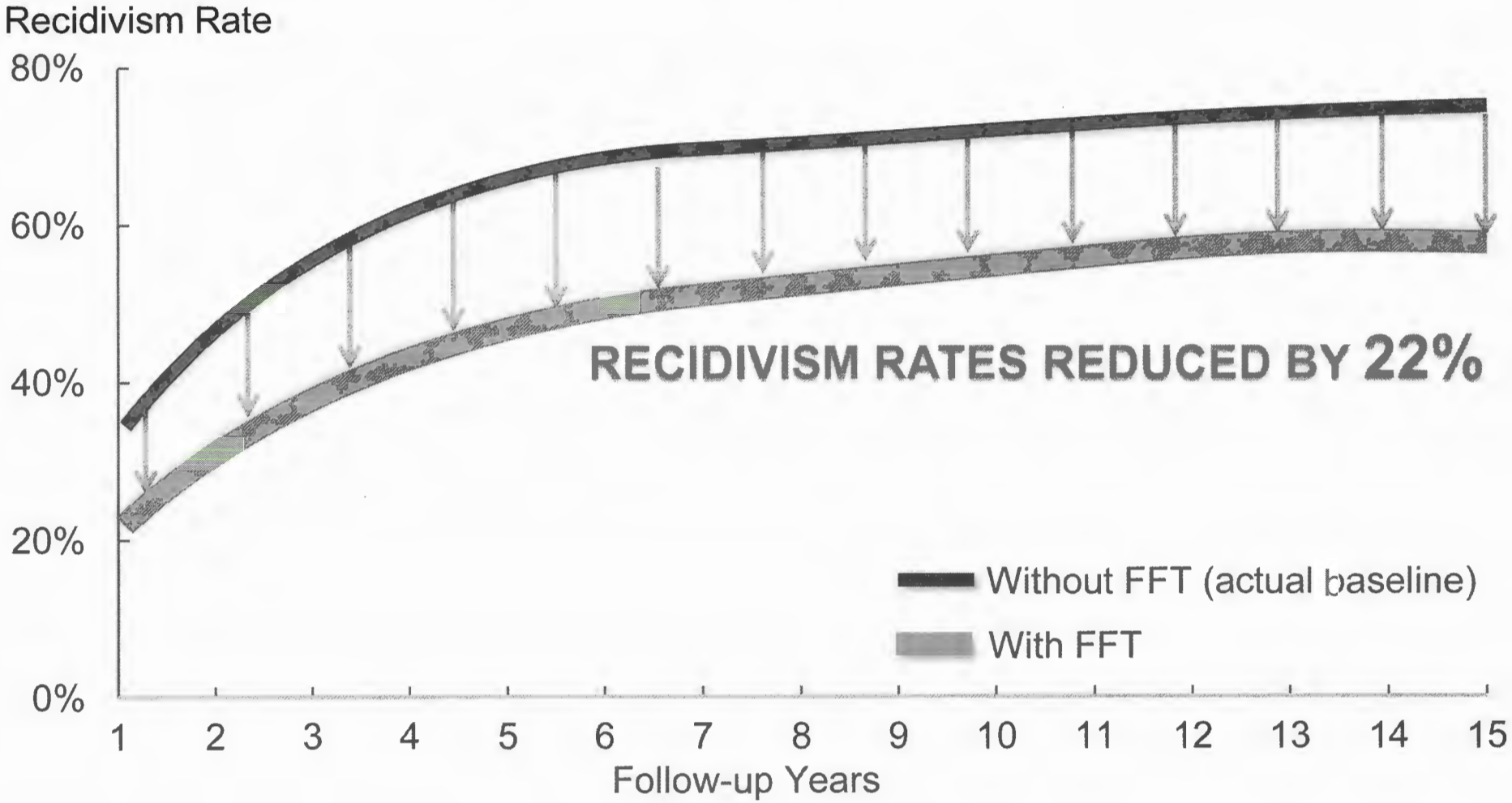

Source: Washington State Institute for Public Policy

Community-Based Functional Family Therapy

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OUTCOMES FROM PARTICIPATION		MAIN SOURCE OF BENEFITS
Reduced crime	**$29,340**	Lower state & victim costs
Increased high school graduation	**$9,530**	Increased earnings
Reduced health care costs	**$398**	Lower public costs
Total Benefits	**$37,587**	
Cost	**$3,333**	
Net Present Value	**$34,254**	
Benefits per Dollar of Cost	**$11.28**	

Source: Washington State Institute for Public Policy

Compare Return on Investment of Programs - "Consumer Reports"

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PUBLIC HEALTH AND PREVENTION	COST	LONG-TERM BENEFITS	BENEFIT/COST RATIO
D.A.R.E. (Drug Abuse Resistance Ed.)	$53	**$1,941**	$36.44
All Stars	$101	**$2,389**	$23.59
Mentoring for Students (School Based)	$1,786	**$33,515**	$18.77
Life skills training	$97	**$1,125**	$11.58
Nurse Family Partnership	$9,842	**$27,174**	$2.77
Parents as Teachers	$2,684	**$2,875**	$1.07
JUVENILE PROGRAMS			
Aggression replacement training	$1,543	**$55,821**	$37.19
Coordination of services	$403	**$6,043**	$16.01
Drug court	$3,154	**$11,539**	$4.66
Scared Straight	$66	**-$12,988**	**-$195.61**

Source: Washington State Institute for Public Policy

The Results First Approach

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- Compare current programs to evidence
- Conduct benefit-cost analysis to compare returns on investment
- Target funds to evidence-based programs
- Goal: Achieve dramatic improvements without increased spending

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Results First Work in States

Participation in Results First

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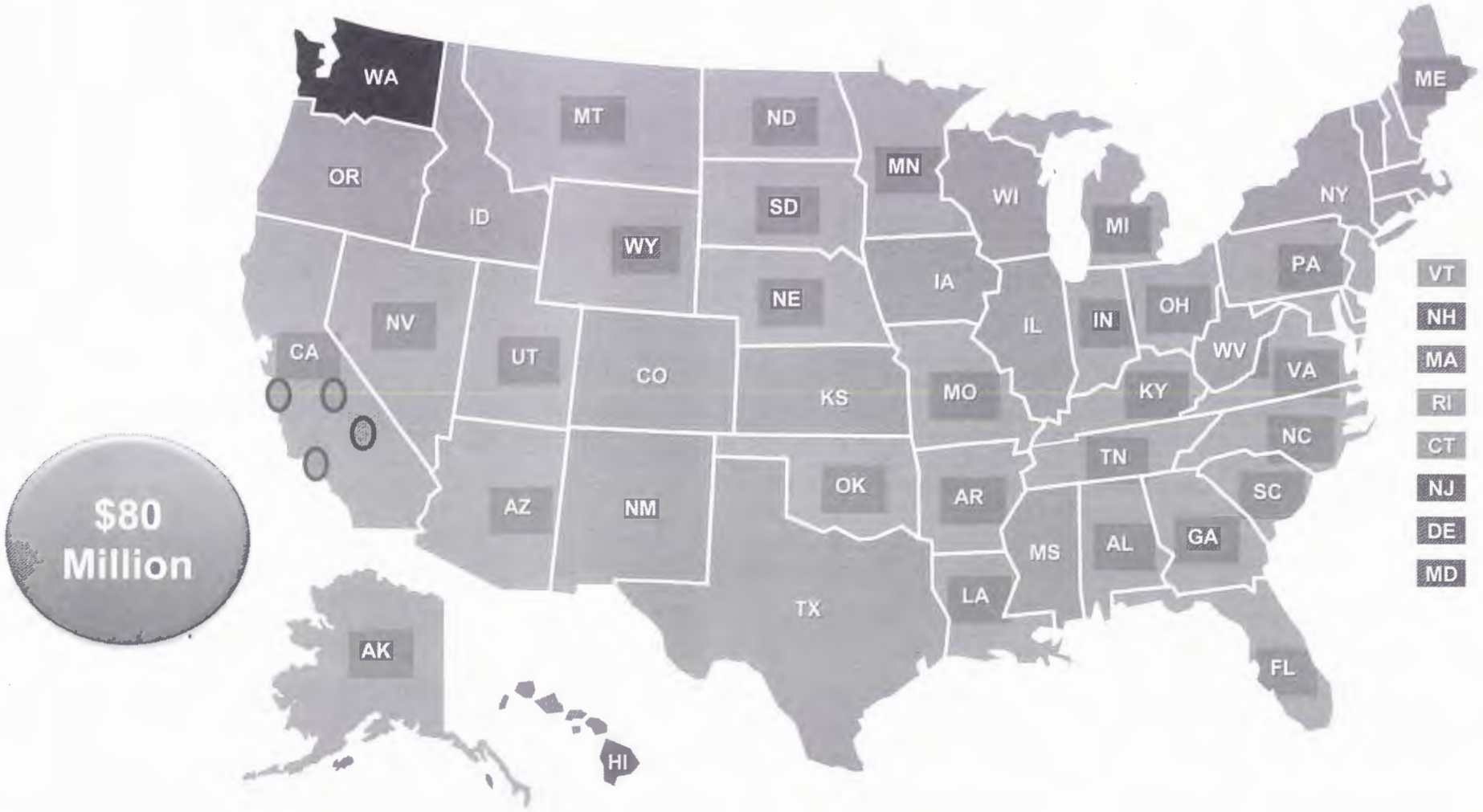


New Mexico

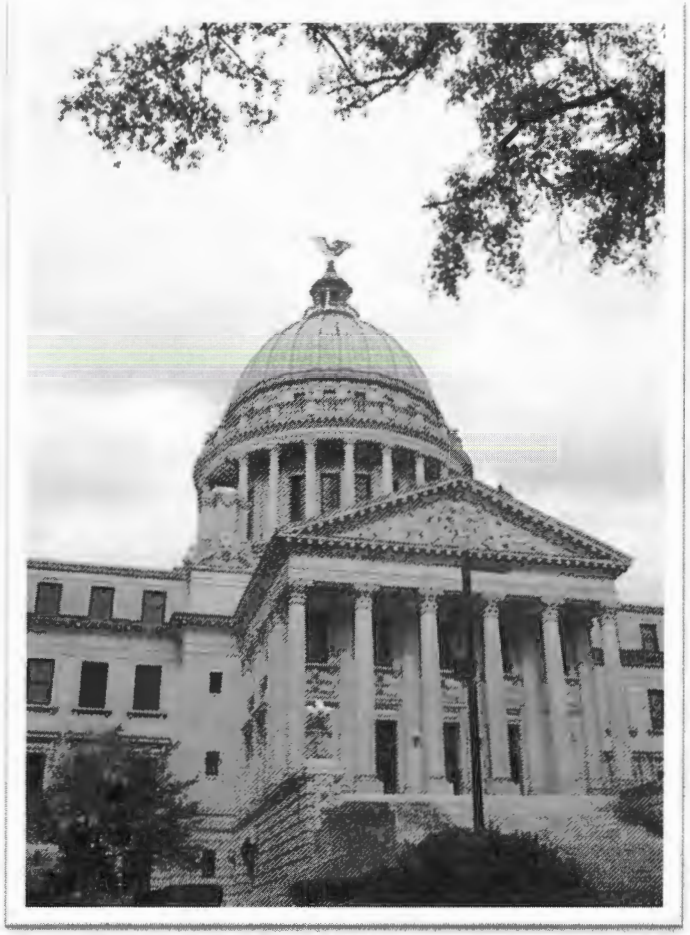
- Implemented in all available policy areas
- Produced Innovative Reports:
  - "Cost of Doing Nothing"
  - Report on Impact of State Budget Cuts
- Used Results First approach to target $49.6M for evidence-based programming in early education, child welfare, and criminal justice

Iowa

- Replaced ineffective domestic violence treatment program with new pilot program
- Expanding *Cognitive Behavioral Therapy* (CBT) and vocational education programs
  - Received federal grant funding to train staff on new CBT programs

Mississippi

- Recently completed analysis of adult criminal justice programs
- Program inventory underway for juvenile justice and K-12 education
- Passed 3 bills in 2014 session to build data infrastructure:
  - Requires data reporting by local courts and enforcement agencies
  - Authorizes access to certain juvenile justice records the purpose of data collection and reporting
  - Requires comprehensive program inventories for 4 pilot agencies
  - Defines evidence-based, research based, and promising programs



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Implementation and Roles

Suggested Model Implementation

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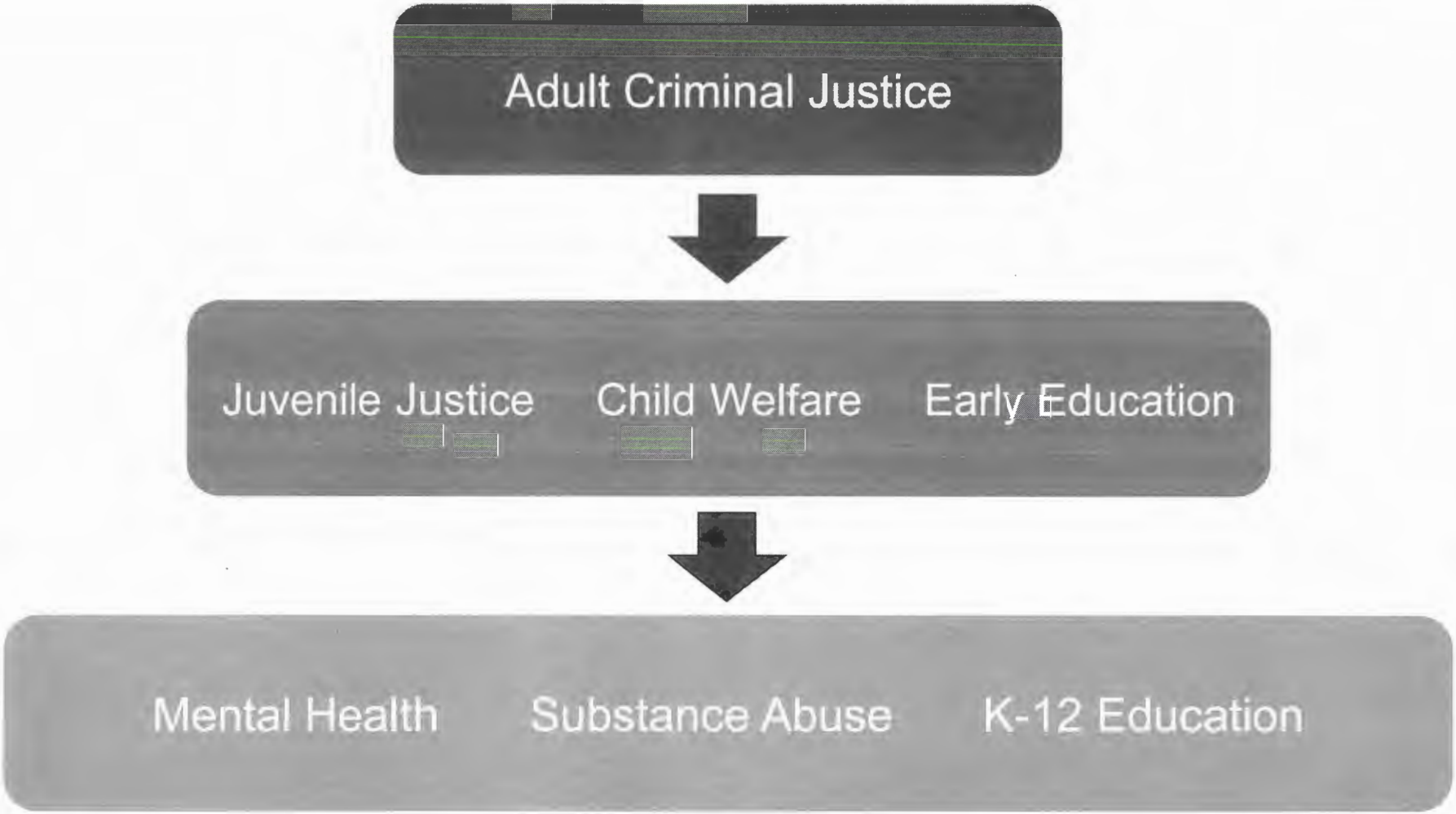

The Role of Partner States

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- Secure leadership support
- Appoint a policy work group
- Establish a staff work group with project manager
- Collaborate with Results First to strengthen the model and build a learning community of states

Services Provided by Results First

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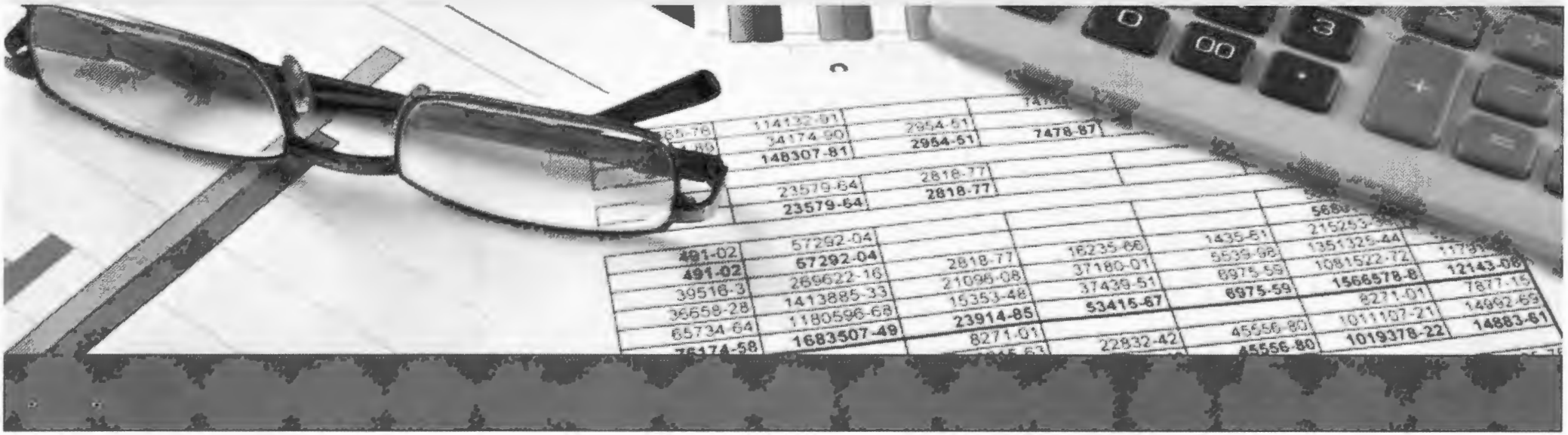
- Provide software
- Train staff in the approach
- Provide ongoing technical assistance
- Help interpret results for policymakers
- Compile and share lessons learned with other participating states
- Expand and update model



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Gary VanLandingham, Director

gvanlandingham@pewtrusts.org

Joshua Watters, Senior Associate

jwatters@pewtrusts.org

www.pewtrusts.org/ResultsFirst

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Legislating Evidence-Based Policymaking

A look at state laws that support data-driven decision-making

Overview

Under increasing pressure to demonstrate effectiveness and do more with less, many governments are expanding their use of evidence-based programs—those shown in rigorous evaluations to be effective. Committing to such proven programs can help governments strengthen efficiency and accountability and achieve better outcomes for residents.

Legislators across the country have enacted laws that promote the use of evidence-based programs and practices. To examine this trend, the Pew-MacArthur Results First Initiative reviewed more than 100 state statutes passed between 2004 and 2014 and identified five different approaches to promoting data-driven program choices:

1. Require agencies to inventory and categorize funded programs by their evidence of effectiveness.
2. Provide incentives for the use of evidence- and research-based programs.
3. Restrict funding of programs shown to be ineffective.
4. Require the use of evidence- or research-based programs.
5. Dedicate funding to evidence- or research-based programs.

This brief examines several of these laws and looks at how state governments have used them to expand the use of evidence-based policymaking.

What Is Evidence-Based Policymaking?

Evidence-based policymaking uses the best available research and data on program results to inform government budget, policy, and management decisions. It focuses on what works—those programs that rigorous evaluations have shown to achieve positive outcomes. By using this approach, governments can:

- **Reduce wasteful spending.** Targeting funding based on evidence of effectiveness enables policymakers to identify and eliminate programs that have failed to deliver expected results, freeing dollars for other uses.
- **Expand successful programs.** Comparing programs allows policymakers to direct funding to those that deliver the highest return on investment.
- **Strengthen accountability.** Focusing on outcomes makes it easier to hold agencies, managers, and providers accountable for results.

Types of laws that support evidence-based programs

Require agencies to inventory and categorize funded programs by their evidence of effectiveness

Governments often lack data on the programs they operate, limiting policymakers' ability to make informed budget decisions. For example, states typically do not have a comprehensive list of the programs that they fund or reliable information on the outcomes those programs produce. To fill this gap, some states have enacted legislation requiring agencies to create an inventory of funded programs and categorize them based on the extent to which they have been proved through rigorous research to be effective. For example:

- In 2012, the **Washington** legislature passed House Bill 2536 to strengthen its mental health, child welfare, and juvenile justice services.[1] The law requires the Department of Social and Health Services, the Washington State Institute for Public Policy, and the University of Washington Evidence-Based Practice Institute to establish criteria for three standards of program effectiveness—evidence-based, research-based, and promising practice[2]—and to compile a list of programs that meet these standards.[3] As part of this process, Washington-based providers can nominate their own programs for consideration.[4] The state's mental health, child welfare, and juvenile justice agencies are required to report on the extent to which their funded programs meet the evidence standards and to identify service gaps.

  The state reports that this process has achieved several benefits. For example, the Department of Social and Health Services was able to identify the number of people served in evidence-based programs, the percentage of total funds directed to those programs, and the number of people who were eligible but did not receive services. In juvenile justice, the department identified eight programs operating throughout the state that met the evidence standards and determined that approximately 67 percent of treatment funds were being spent on those programs.[5]
- **Mississippi** passed H.B. 677 in 2014, establishing four categories for ranking programs—evidence-based, research-based, promising practices, and lacking evidence of effectiveness. It also mandates that the Legislative Budget Office and Joint Committee on Performance Evaluation and Expenditure Review work with the state's corrections, health, education, and transportation agencies to catalogue and categorize all funded programs based on these standards.[6] The state reports that this mandate has helped shift the culture toward evidence-based policymaking.

Leaders in Mississippi noted the importance of the mandate providing clear definitions and standards for the evidence that will be used to categorize programs. These criteria help make the inventory process transparent, avoid confusion among providers, and create options for using the standards in the budget process.

> "Legislative leadership was interested in reinvigorating evidence-based budgeting using cost-benefit analysis. ... [W]e selected four agencies whose budgets could really benefit from a clearer understanding of what programs they administer. We want the program inventory to become a performance management tool for agencies. Every program has to tie back to some state strategic goal and, if it doesn't, let's talk about the rationale for continuing it."
>
> — **Max Arinder**, *executive director of the Mississippi Legislature's Joint Committee on Performance Evaluation and Expenditure Review*

Provide incentives for the use of evidence- and research-based programs

Several states have used grants and other funding strategies to promote implementation of evidence-based programs. For example, Wisconsin, California, and Massachusetts have supported evidence-based interventions through the use of financial incentives:

- The **Wisconsin** Treatment Alternatives and Diversion (TAD) program, enacted in 2005, provides grants to counties to fund alternatives to prosecution and incarceration of nonviolent offenders with histories of alcohol and drug abuse.[7] The grants are awarded to counties through a competitive process that requires recipients to provide services consistent with evidence-based practices. The program is funded through a combination of state and federal funds, with counties required to provide a 25 percent match. Between 2006 and 2014, 36 of the state's 72 counties and tribes received grants.[8] A recent evaluation found that TAD programs helped reduce incarceration by 231,533 days across all participants and that 57 percent of participants had not been convicted of a new crime three years after being discharged from the program.[9]
- **California**'s Community Corrections Performance Incentives Fund Act (Senate Bill 678) of 2009 encourages counties to reduce the number of offenders that county probation programs send to the state prison system. Counties that do so receive a portion of the savings generated by reductions in the state prison population and must reinvest those funds in evidence-based probation programs. Participating counties also must report outcome data quarterly and undergo annual assessments of program effectiveness.[10]

  The program has saved a total of $919.6 million since 2010, of which counties have received $449.5 million in incentive funding to support local evidence-based programs.[11] A 2014 Judicial Council of California report to the Legislature noted that counties have expanded their use of evidence-based programs and practices, including risk and needs assessments, offender supervision, treatment programs, and more effective management strategies.[12] In addition to the substantial savings, the state has reduced probation failures by 23 percent while the overall state crime rate has remained below the 2008 baseline.
- In 2014, **Massachusetts** created a competitive grant program aimed at testing or expanding evidence-based, research-based, or promising practice approaches to reducing recidivism.[13] To be eligible for funding, providers must inventory their current programs and classify each by evidence of its effectiveness, demonstrate efforts to support quality implementation and independent evaluation, and commit to increasing the number of

evidence-based programs they deliver. The state will use a customized cost-benefit model to evaluate the programs and ensure that those selected are implemented with fidelity to their original designs. The $2.6 million program is funded by federal dollars provided through the Edward Byrne Memorial Justice Assistance Grant Program.

Restrict funding of programs shown to be ineffective

Legislators in some states have promoted accountability and reinforced the importance of evidence-based practice by restricting agencies and providers from implementing programs shown in rigorous research to be ineffective or harmful to target populations. Missouri and Ohio have enacted laws that apply such restrictions:

- The **Missouri** Legislature passed S.B. 17 in 2013, creating "Bryce's Law" to provide scholarships for children with autism spectrum disorders, Down syndrome, Angelman syndrome, and cerebral palsy to attend qualified schools.[14] In addition to utilizing specific evidence-based education principles, participating schools are prohibited from using any interventions listed as ineffective by the Missouri Autism Guidelines Initiative's *Autism Spectrum Disorders: Guide to Evidence-Based Interventions*, which is grounded in the findings of six nationally recognized research reviews. The guide specifies that an intervention is ineffective when sufficient evidence finds that it did not yield the intended outcomes.[15]
- In 1993, **Ohio** enacted Ohio Revised Code Section 5139.43, creating the Reasoned and Equitable Community and Local Alternatives to the Incarceration of Minors (RECLAIM) program, which provides funding to counties to implement community-based alternatives for juvenile offenders, including those who would otherwise be committed to detention facilities.[16] In addition to encouraging the use of evidence-based programs, the law was amended in 2007 to state that "moneys in the fund shall not be used to support programs or services that do not comply with federal juvenile justice and delinquency prevention core requirements or to support programs or services that research has shown to be ineffective." Independent evaluations of the program cite substantial savings (as much as $45 for every $1 invested) and reduced juvenile reoffending as major benefits.[17]

Require the use of evidence- or research-based programs

Some legislatures have mandated that certain state agencies implement only those programs that demonstrate at least a minimum standard of effectiveness. Although this approach is feasible only in policy areas that have a robust evidence base on what works, it increases the likelihood that public spending is limited to activities shown to produce positive outcomes. Michigan and Kentucky have passed legislation requiring specific agencies to implement evidence-based programs in key policy areas:

- In 2012, **Michigan** passed Act 291, requiring the state departments of Community Health, Human Services, and Education to allocate funding to those home visiting programs that have strong evidence of effectiveness.[18] The law specifies that two categories of programs are eligible for funding: evidence-based programs—those that are supported by rigorous research and have clear designs and implementation standards—and promising programs. To be eligible for continued funding, promising programs are required to undergo an evaluation of their effectiveness. Because effective implementation plays a critical role in achieving expected outcomes, all programs are required to maintain fidelity with key elements of their designs.
- **Kentucky** passed the Public Safety and Offender Accountability Act in 2011, with the goal of helping control corrections costs. The law seeks to prioritize expensive prison beds for the highest-risk offenders and mandates the use of evidence-based programs for the supervision and treatment of pretrial defendants, inmates, probationers, and parolees.[19] The act provides a definition of "evidence-based" and directs the Department of Corrections to create objective criteria for determining which programs meet the standard. It also phased in a

requirement for using evidence-based programs, with 75 percent of program funding expected to come from prison savings by 2016. In 2014, Kentucky passed a similar requirement for its juvenile justice system.[20]

Since the law passed, the Department of Corrections has expanded its use of evidence-based programs and practices in prisons across Kentucky, investing $13.9 million in fiscal 2012 in education and vocational training, substance abuse treatment, and sex offender treatment interventions that have proved effective.[21]

Dedicate funding to evidence- or research-based programs

Some states have required that specific percentages of appropriated funds be used for programs that meet defined standards of evidence. These mandates are typically phased in over several years to give agencies time to implement and expand evidence-based programs. For example, Oregon and Tennessee have passed laws dedicating funds for evidence-based programs:

- In 2003, **Oregon** passed S.B. 267, which requires five state agencies to gradually increase the amount of funding allocated to evidence-based drug and alcohol treatment, mental health treatment, adult recidivism prevention, and juvenile crime prevention programs.[22] The agencies are required to report the percentage of their total budgets allocated to evidence-based programs every two years. To begin the process, the agencies received guidance from stakeholder groups on developing criteria to identify evidence-based programs. For example, the Oregon Youth Authority and Department of Corrections met with stakeholders to identify the interventions operating in the state that were subject to provisions of the 2003 law and then used the Correctional Program Checklist, a research-based assessment tool used to determine whether those programs included characteristics associated with reducing recidivism.

  Beginning in the 2005-07 biennium, the five agencies were required to demonstrate that at least 25 percent of their funds were used to support evidence-based programs. That increased to 50 percent by the end of the 2007-09 biennium and 75 percent by the end of 2009-11. By 2012, all agencies reported that they had achieved these targets.[23]

- The **Tennessee** Legislature enacted Public Chapter 585 in 2007, requiring the Department of Children's Services (DCS) to restrict the use of state funds to evidence-based juvenile justice prevention and treatment programs.[24] The law requires the department to increase the percentage of funds allocated to evidence-based programs from 25 percent to 75 percent over five years. To qualify for funding, programs must meet state-defined standards for evidence, which include requirements that they have implementation protocols or manuals that specify the nature, quality, and amount of services provided and that they demonstrate positive outcomes in at least two evaluations.

  An advisory panel, consisting of the Tennessee Supreme Court's Administrative Office of the Courts, Tennessee Commission on Children and Youth, and provider representatives named by the DCS commissioner, identified the approaches and practices that met the evidence-based standard and should be used to evaluate programs operating in the state. The Peabody Research Institute at Vanderbilt University conducted an independent evaluation to determine the extent to which the state's juvenile justice programs, including those delivered by private provider organizations, were aligned with these proven approaches and practices and the percentage of funding supporting those programs.

  Lead evaluator Mark Lipsey noted: "The way in which the legislation defined evidence was pivotal. Specifically, the law requires programs to include key elements proven by rigorous research to affect important outcomes; however, providers don't have to necessarily implement national model programs. This allowed locally developed programs where the interventions follow evidence-based design to be included."[25]

In its most recent report, issued in October 2010, the evaluator noted that DCS "appeared to be on a trajectory" to meet the goal of 75 percent of funding supporting evidence-based programs by the end of fiscal 2012.[26]

"The next phase of the work is to move beyond just identifying which programs are evidence-based to looking at how those programs are being implemented to ensure fidelity to design," said Lipsey.

Key considerations

Legislators can play a critical role in expanding the use of evidence-based programs and helping their states achieve better outcomes for residents. When developing legislation that supports the implementation, funding, and oversight of evidence-based programs, policymakers may wish to consider several issues:

- **Create clear standards for evidence.** It is important to provide clear definitions and standards for programs and the evidence needed to qualify for each standard. These criteria make the inventory and categorization process transparent, avoid confusion among providers, and offer options for using standards in the budget process. Policymakers may consider using the definitions and categories adopted by other states or those used by national research clearinghouses.
- **Consider the available evidence base when choosing policy areas for legislation.** In many policy areas, such as adult criminal and juvenile justice and adult and child mental health, a significant body of research exists on the effectiveness of alternative programs. Focusing legislation on areas with a robust evidence base makes it easier to assess existing programs and identify evidence-based options.
- **Require monitoring and outcome reporting.** Research has shown that even the best programs will fail to deliver expected outcomes (and may even cause harm) if they are poorly managed. Legislators may wish to consider requiring agencies to monitor evidence-based programs for compliance with key elements of their implementation models. Policymakers can also mandate that agencies regularly measure and report data on program outcomes, recognizing that some results may take longer to achieve than others.

Although legislation is important, leaders can also use other tools to support evidence-based programs. For example, executive branch policymakers can incorporate specific language into budget guidance and issue executive orders or agency directives. Agency leaders also play an important role in creating monitoring systems to ensure that programs are implemented according to their research-based model and in tracking program outcomes to ensure they achieve expected results.

To learn more about these other approaches, Results First is undertaking a 50-state analysis of efforts to support evidence-based policymaking. The study will explore how states use laws, administrative rules, executive orders, appropriations, budget guidance, and other policies and practices across several policy areas to expand the use and quality of effective, evidence-based programs.

Appendix: Methodology

Results First researchers conducted a LexisNexis search for laws enacted between 2004 and 2014 using the following search terms: evidence-based policymaking (or policy making), evidence-based decision making, evidence-based program(s), evidence-based practice, research-based decision making, research-based practice, research-based program(s). Citations were returned for all state legislation containing one or more of these terms with an excerpt of the relevant line(s) containing the term(s). This preliminary list of laws was supplemented by additional laws identified through other Pew research.

The researchers then reviewed the laws for relevance to this project, identified those laws that exemplify the five legislative approaches profiled in this report, and conducted interviews with individuals familiar with the legislation, including officials from agencies affected by the law or researchers responsible for evaluating and reporting on the law's impact. Results First researchers did not conduct a comprehensive analysis of the extent to which these laws have affected the use of evidence-based programs. Further, although the laws were separated into five primary categories, many include aspects from multiple categories.

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MacArthur Foundation

Contact: Gary VanLandingham, director, Pew-MacArthur Results First Initiative
Email: gvanlandingham@pewtrusts.org
Phone: 202-540-6207

Pew-MacArthur Results First Initiative, a project of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, works with states to implement an innovative cost-benefit analysis approach that helps them invest in policies and programs that are proven to work.

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New Mexico's Evidence-based Approach to Better Governance

A Progress Report on Executing the Results First Approach

Overview

Since partnering with the Pew-MacArthur Results First Initiative in September 2011, New Mexico has become a leader in using sophisticated cost-benefit analysis to inform policy and budget decisions. Building on a strong history of investing in evidence-based programs and measuring their performance, the Results First approach has enabled state policymakers to get a clearer picture of the comparative value of potential taxpayer investments and to direct resources to the most effective programs.

New Mexico's Results First model uses state-specific data to compare the costs and long-term benefits of a range of programs and policies. The state's Legislative Finance Committee, working with the

New Mexico Sentencing Commission and Corrections Department, implemented the model with a focus on public safety programs; as the model grew to include other policy areas, additional state agencies also provided data. Over the past two years, the state has used the Results First approach to:

- Calculate and compare the long-term costs and benefits of portfolios of programs in adult and juvenile justice, child welfare, mental health and substance abuse, and early childhood.
- Help inform legislative funding decisions to direct $49.6 million to evidence-based programs that will deliver high returns for New Mexico residents.
- Shift funds from an offender intervention program determined to be ineffective to an alternative that analysis showed would produce strong public safety outcomes.
- Promote the development of an inventory of the state's recidivism-reduction programs to identify the extent to which they are evidence-based.

This brief documents New Mexico's progress in implementing the Results First approach, highlights its accomplishments in using evidence-based policymaking, identifies challenges facing the state, and illustrates how this work complements other state efforts to use data to deliver better results.

Results First: A Model for Making More Cost-effective Policy Choices

The Results First approach uses a nationally recognized, peer-reviewed model with a three-step process:

- **Use the best national research** to analyze all available studies of similar programs across the country to identify what works, what doesn't, and how effective various programs are in achieving policy goals.
- **Apply state-specific data to the national results** to project the effect different program and policy approaches would have in the state.
- **Compare the costs of each program to its projected benefits** and produce a report that ranks programs by the relative value they would generate for taxpayers. This information enables policymakers to identify the best return on investment of public dollars.

The cost-benefit analysis model was developed by the Washington State Institute for Public Policy in partnership with the Pew-MacArthur Results First Initiative, a project of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation. States and local governments can use the model to assess programs in many public policy areas, including adult criminal and juvenile justice, pre-K through 12th-grade education, general prevention programs for children and adolescents, child welfare, mental health, substance abuse, and public health.

Building the New Mexico Results First model

In 2011, staff of New Mexico's Legislative Finance Committee requested the assistance of the Pew-MacArthur Results First Initiative in implementing the cost-benefit analysis model. The state's goal was to better assess the long-term implications of its budget choices and to identify interventions that would achieve high returns on the investment of taxpayer dollars.

The Legislature assigned responsibility for the effort to the Legislative Finance Committee, which plays several critical roles in the state. As the Legislature's fiscal and management arm, the committee conducts program evaluations and issues performance report cards that assess whether taxpayer expenditures are delivering desired results. It produces an annual statewide policy analysis report on progress in key program areas and develops budget recommendations. Committee staff also regularly makes presentations to legislative committees, agencies, and stakeholder groups. These activities help to equip the Legislature to use the Results First model when making policy and budget decisions. As Kelly Klundt, fiscal analyst for the committee, noted, "It's a year-round educational experience. So when actual session happens, [legislators] have a better understanding of the evidence."

Personnel from Results First traveled to New Mexico in 2011 to train committee staff, led by Director David Abbey and Deputy Director Charles Sallee, on the cost-benefit approach. Results First provided ongoing technical assistance through subsequent site visits, conference calls, and webinars. The committee focused its initial effort on adult criminal justice programs with extensive help from staff of the state's Sentencing Commission and Corrections Department.

To implement the crime component of the Results First model, the committee partnered with the Sentencing Commission, which maintains a collection of independently reviewed criminal and juvenile justice data. Staff from the two offices gathered needed information from various state and federal sources, including the FBI, the U.S. Bureau of Justice Statistics, the state's Department of Public Safety, and its Administrative Office of the Courts. The committee also partnered with the state's Corrections Department to identify and analyze information on programs offered within the prison system and the costs of department services.

Following these successful collaborations, the committee collaborated with New Mexico's departments of Children, Youth, and Families; Public Education; Public Safety; and Health, to expand the model's scope to assess state child welfare, substance abuse and mental health, and early childhood education programs.

Reporting New Mexico's Results First findings

The Legislative Finance Committee has issued five evaluation reports presenting Results First findings on the relative costs and benefits of potential investments in programs for adult criminal justice, child welfare, and early childhood education. As the committee's Sallee stated, "we use evaluations to identify the problem areas in the state and use the Results First model to show how much it is costing and what programs can deliver promising outcomes at higher returns."

Criminal justice

The committee has issued two evaluation reports on New Mexico's adult criminal justice programs since summer 2012, *Reducing Recidivism, Cutting Costs and Improving Public Safety in the Incarceration and Supervision of Adult Offenders* and *Evidence-Based Programs to Reduce Recidivism and Improve Public Safety in Adult Corrections.* These reports used the Results First approach to calculate the cost-benefit ratio of the state's community-based, correctional, and alternative reentry programs.[1] Key findings included:

- More than 75 percent of the state's adult criminal justice programs lacked rigorous evidence of effectiveness.
- Reducing recidivism by 10 percent through investing in evidence-based programs could decrease prison costs by $8.3 million and victimization costs by approximately $40 million.[2]

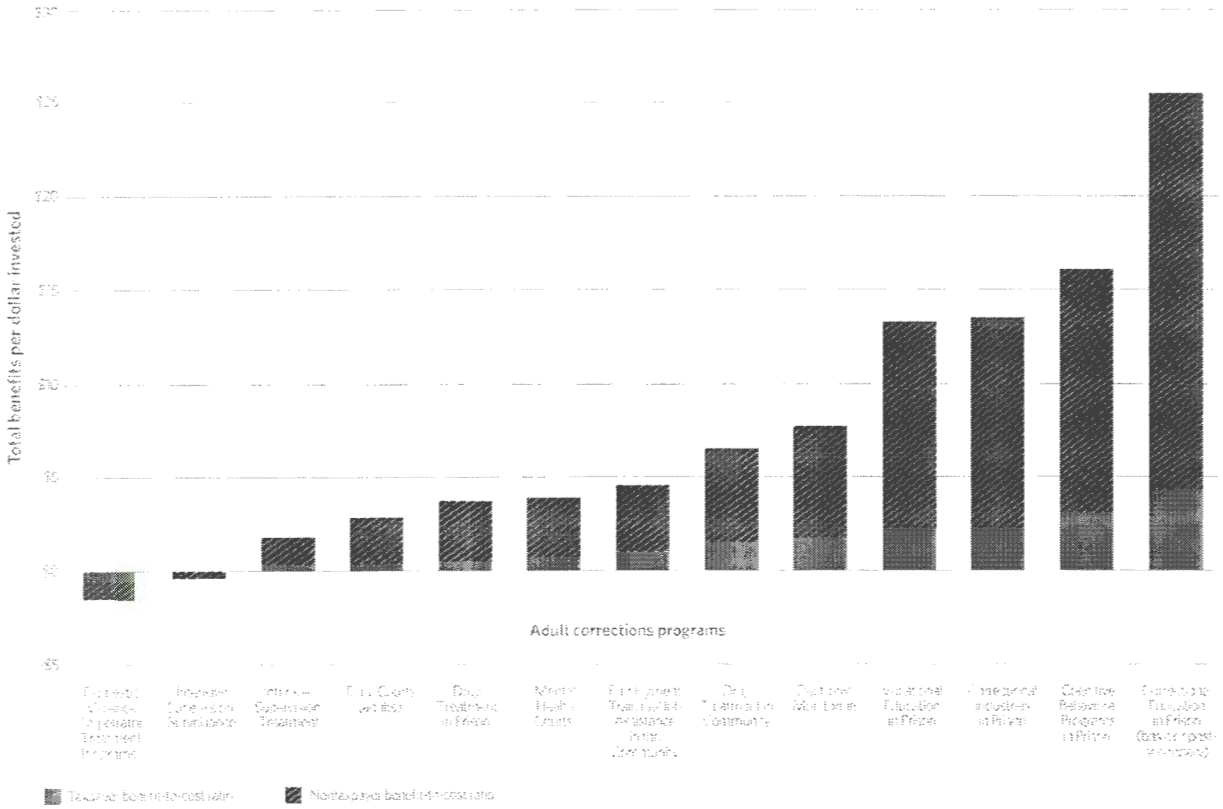
- Investing in evidence-based corrections programs proved to reduce recidivism could yield returns as high as $26 for every $1 invested.
- If current trends hold, offenders released in 2011 will cost taxpayers an estimated $360 million in corrections costs over the next 15 years.[3]

The reports also calculated the impact of budget reductions. In fiscal year 2011, the Corrections Department discontinued two programs shown to reduce recidivism—drug courts and corrections industries—as a part of budget cuts made in response to the Great Recession. Using the Results First model, the committee found that eliminating these programs cost the state $2.8 million in annual taxpayer and crime victim benefits.[4] "Having this information could have helped agencies make better and more informed decisions about what to cut," said Sallee.

Figure 1

New Mexico's Cost-Benefit Analysis Model Compared Cost-Benefit Ratios for Prison Programs

Total benefit-to-cost ratio, by program



Source: New Mexico Legislative Finance Committee, *Evidence-Based Programs to Reduce Recidivism and Improve Public Safety in Adult Corrections* (July 2012), 8, http://www.nmlegis.gov/lcs/lfc/lfcdocs/perfaud%/LFC%20Results%20First%20-%20Evidence-Based%20Programs%20to%20Reduce%20Recidivism%20and%20Improve%20Public%20Safety%20in%20Adult%20Corrections.pdf.

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Child welfare

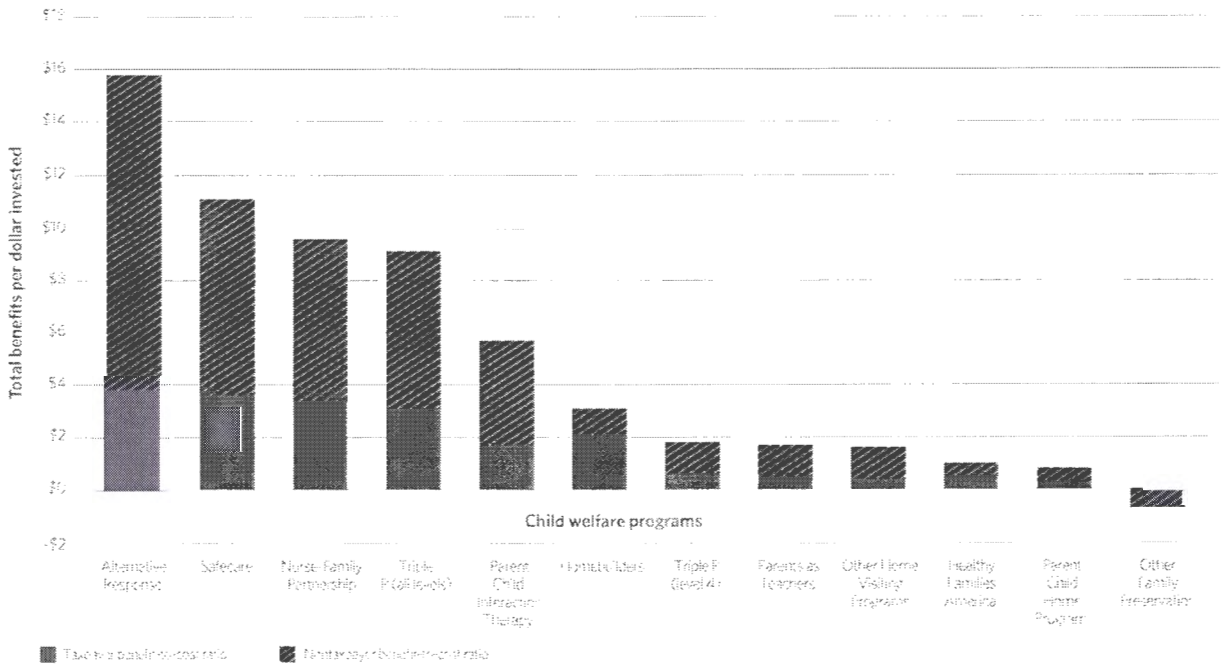
Since 2012, New Mexico's Legislative Finance Committee has released two evaluation reports—*Improving Outcomes for Pregnant Women and Infants Through Medicaid* and *Evidence-Based Programs to Reduce Child Maltreatment*—that used the Results First model to assess the state's child welfare investments and the potential benefits of investing in evidence-based programs to reduce child maltreatment.[5] They found that:

- New Mexico spends about $113 million annually through the Child Protective Services Division responding to child maltreatment (including investigation, in-home services, foster care, adoption, and administrative costs) and that reducing child maltreatment and placement in foster care by 10 percent could save tens of millions of dollars.
- Only 5 in every 1,000 children in the New Mexico child protection system receive preventive services, compared with the national average of 43 per 1,000.

Figure 2

New Mexico's Cost-Benefit Analysis Model Compared Returns for Child Welfare Programs

Total returns on investment, by program



Source: New Mexico Legislative Finance Committee, *Evidence-Based Programs to Reduce Child Maltreatment* (April 2014), 13, http://www.nmlegis.gov/lcs/lfc/lfcdocs/perfaudit/LFC%20Results%20First%20Report%20-%20Evidence-Based%20Programs%20to%20Reduce%20Child%20Maltreatment.pdf.

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- Evidence-based programs could generate returns as high as $15.64 for every $1 invested and reduce child maltreatment and its recurrence by up to 26 percent.
- Foster care placement costs approximately $21,000 per year per child compared with $3,700 for proven in-home services.
- Evidence-based home visiting programs would yield a range of returns of up to $9.70 for every $1 invested.

Table 1

Results First New Mexico Used the Results First Approach to Produce a Consumer Report for Early Childhood Programs

Ranking of New Mexico programs to improve education outcomes

Program	Benefits to participants	Benefits to taxpayers	Other beneficiaries	Other indirect benefits	Total benefits	Costs	Benefit-cost net present value	Benefit-cost ratio	Percent of time net present value is > 0
Nurse-Family Partnership	$9,974	$9,868	$8,946	$0	$28,789	($2,967)	$25,822	$9.70	89%
Head Start	$11,239	$7,167	$7,186	($3,139)	$22,452	($8,564)	$13,888	$2.62	89%
Parents as Teachers	$2,282	$1,282	$997	$0	$4,561	($2,966)	$1,595	$1.54	68%
Other home visiting programs	$2,210	$1,035	$1,173	$0	$4,419	($2,970)	$1,449	$1.49	69%
New Mexico PreK	$1,618	$690	$801	$0	$3,110	($2,900)	$210	$1.07	48%
Model early childhood programs	$15,143	$10,168	$11,050	$0	$36,361	($34,332)	$2,028	$1.06	53%
4-Star	$1,602	$683	$806	$0	$3,092	($6,532)	($3,441)	$0.47	30%
Early Head Start	($602)	$2,844	$132	$0	$2,375	($12,042)	($9,667)	$0.20	28%
5-Star	($351)	($150)	($172)	$0	($673)	($6,864)	$7,537	($0.10)	6%
Even Start	($572)	($244)	($276)	$0	($1,093)	($4,061)	($5,153)	($0.27)	10%
3-Star	($973)	($415)	($479)	$0	($1,868)	($6,120)	($7,988)	($0.31)	17%
2-Star	($1,640)	($699)	($812)	$0	($3,151)	($5,269)	($8,420)	($0.60)	3%
Registered Homes	($3,098)	($1,322)	($1,535)	$0	($5,995)	($2,904)	($8,859)	($2.06)	0%

Source: New Mexico Legislative Finance Committee, *Evidence-Based Early Education Programs to Improve Education Outcomes* (April 2014) 9, http://www.nmlegis.gov/lcs/lfc/lfcdocs/perfaudit/LFC%20Results%20First%20Report%20-%20Evidence-Based%20Early%20Education%20Programs%20to%20Improve%20Education%20Outcomes.pdf.

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Early childhood education

The Legislative Finance Committee also used its Results First model to develop the findings featured in an April 2014 report, *Evidence-Based Early Education Programs to Improve Education Outcomes.*[6] The report used state-specific data to calculate and rank the return on investment that the state would achieve through a range of evidence-based programs designed to improve educational outcomes and found that:

- Only two of the state's six home visiting programs, which can lead to improved school readiness, were evidence-based.
- Evidence-based early education programs yield a range of results, including reducing remediation needs in public and higher education, special education, juvenile rehabilitation, welfare assistance, and juvenile and adult criminal activities.
- In contrast, the state's programs that were not evidence-based demonstrated losses of as much as $2 for every $1 invested.

Using Results First to target funding

New Mexico also used its Results First model analyses to identify opportunities for strategic investments in quality programs, which were included in its legislative budget recommendations for fiscal 2013-14 and 2014-15. Results First data helped inform decisions to target $49.6 million over the two-year period, including:

- $41.9 million to evidence-based early childhood programs. This included $35.8 million directed toward early education ($16.5 million for pre-K, $10 million to the K-3 Plus extended school year program, $6 million toward early literacy programs, $3.3 million to improve the quality of early childhood programs) and $6.1 million targeted to support evidence-based home visiting programs.
- $7.7 million to evidence-based criminal justice programs. These funds included $4.4 million for a new evidence-based drug treatment program to replace one the analysis showed was not delivering the expected return on investment. Targeted funds also included $1.5 million for inmate education, $1.5 million for community resources for job training and mental health, and $300,000 for a corrections industries program that provides training and work experience opportunities for inmates.

Using Results First to improve services

In addition to assisting in the development of the Results First model, the New Mexico Corrections Department is using the approach to gain a better understanding of the programs it operates and to identify opportunities for improvement. In 2012, the department's Office of Recidivism Reduction conducted an inventory of its state-funded adult criminal justice programs and partnered with the Legislative Finance Committee to determine the level of evidence of effectiveness for each. This analysis found that fewer than 10 of the more than 40 programs studied were evidence-based.[7]

> "It's a no-brainer analytical model; we should be using programs that are effective."
>
> **Douglas Carver,** New Mexico Courts, Corrections, and Justice Committee

The study revealed that one of the department's drug abuse prevention programs—Therapeutic Communities—was not operating according to its evidence-based design and as a result was not achieving desired outcomes. The department subsequently replaced the program with an alternative—Residential Drug Abuse Treatment—that the Results First analysis showed would generate a return of $4 in benefits for every $1 invested. "We can't afford to spend money on programs that are not effective. This heightened the need to use our resources to evaluate our local programs that we haven't had outcome evaluations for," said Linda Freeman, deputy director of the New Mexico Sentencing Commission.

Over the next year, the Corrections Department plans to begin using the New Mexico Results First model to support additional management initiatives. After receiving training, agency staff will perform further cost-benefit assessments and identify opportunities for program improvements. The department plans to implement Correctional Offender Management Profiling for Alternative Sanctions, also known as COMPAS, a risk and needs assessment tool, to supplement this approach. Results will be shared with senior staff each quarter to foster discussions on evidence-based programs.

Lessons learned in New Mexico

The Results First approach has had a significant impact on improving the way budget and policy decisions are made in New Mexico, but the effort has not been without challenges. State officials identified five key lessons learned during the first three years.

Building a state's Results First model requires resources and flexibility

New Mexico has sought various data sources to integrate into Results First, but each source requires its own level of preparation for inclusion in the model. Jon Courtney, a program evaluator with the Legislative Finance Committee who has worked on Results First since 2011, emphasized the importance of dedicating sufficient resources to ensure good data are used in the model. "While some data is readily usable, other data requires substantial analysis to make it model-ready," Courtney said.

To ensure the quality of New Mexico's Results First data, the committee designated two program evaluation staff to Results First to coordinate collection with executive agencies, identify external sources (such as federal entities, surveys, and research studies), populate the model, and run cost-benefit analyses. The Corrections Department and Sentencing Commission committed to providing ongoing resources to this effort, such as developing an annual inventory of state-run corrections programs, including costs and participation data, and assisting the Legislative Finance Committee with data analyses. In June 2014, all three entities signed a memorandum of understanding that sets forth their respective responsibilities and the ongoing assistance the Pew-MacArthur Results First Initiative will provide.

Strong interbranch communication is essential

Throughout the implementation process, communication and collaboration between the legislative and executive branches was critical to maximizing the impact of the Results First approach. Regular communication among the Corrections Department, Sentencing Commission, and Legislative Finance Committee was important to clarify the process, identify and address concerns, and build support for the approach among stakeholders.

To support this collaboration, the Legislative Finance Committee briefed agency staff on how the approach was working, discussed the required data, and explained how the results would inform budget and policy decisions.

This was particularly important because evaluations and cost-benefit analyses may identify programs that are not achieving expected results, which could be seen to reflect negatively on agencies and providers. Corrections Department officials and committee staff stressed the importance of presenting findings in ways that helped agencies improve performance and shift resources to more effective programs, rather than placing blame.

To ensure that evidence is used to inform budget and policy decisions, New Mexico's experience shows that it is also important to develop a broad coalition of champions across government. The New Mexico Sentencing Commission's diverse membership of law enforcement officials, criminal defense lawyers, and representatives from citizen interest groups made it a valuable partner in communicating the benefits of the approach and facilitating agency and legislative buy-in.

> "Results First has allowed us to have an ongoing conversation with policymakers about the power of good data to show where we can both save money and reduce recidivism."
>
> **Tony Ortiz,** New Mexico Sentencing Commission

To strengthen this communication and establish additional partnerships, the commission is developing a stakeholder group to collaborate on and advance the Results First approach.

Transitioning to evidence-based programs takes time

Policymakers understandably want to see the results from investments they have made in programs and expect outcomes to be reported on a regular basis. The compressed time periods of legislative sessions create pressure to quickly deliver data that demonstrate program effectiveness and inform budget deliberations, but collecting and analyzing the data needed to show these results often cannot be done on a similarly expedited schedule. Sufficient time must be allotted to ensure a complete and accurate analysis process.

For example, recidivism is a key outcome that is typically measured 36 months after an inmate's release. New Mexico's Corrections Department partnered with PB&J Family Services in 2007 to implement an animal welfare program for rescued dogs—Heeling Hearts—that provides therapeutic and skills training for incarcerated women. The department is currently evaluating the program, but the results, particularly its effect on reducing recidivism, will not be available for several months. David Huerta, former director of recidivism reduction at the department, said, "It's hard to convince legislators or businessmen that we need time to give results."

Identifying evidence-based programs for specific populations can also be difficult. For example, the Corrections Department's priorities include expanding evidence-based interventions for female offenders, but limited information was available to identify effective programs for this population. To help address this gap, the Pew-MacArthur Results First Initiative compiled a database of evidence-based programs identified by several national research clearinghouses, which states can use to increase their menu of available programs. Agencies can also use the database and the Results First model to identify effective programs that meet specific criteria, such as serving certain populations, and then incorporate key elements into their non-evidence-based interventions to improve outcomes.

Information needs to be clear and understandable for policymakers

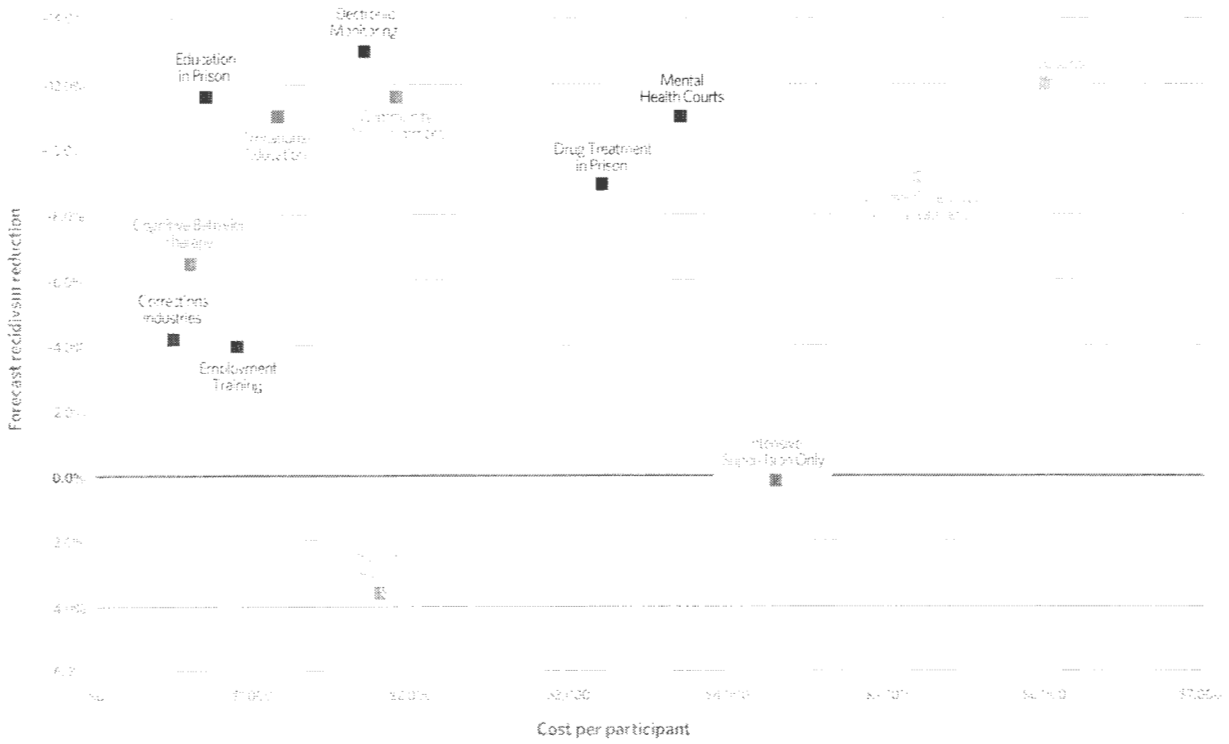
The Legislative Finance Committee designs its reports and presentations to communicate findings in clear, accessible formats, such as graphics depicting program outcomes, costs, and benefits. Staff note that this is essential to gaining policymakers' attention on important issues that might not otherwise be on their radar.

Eric Chenier, a fiscal analyst responsible for making recommendations on the criminal justice budget, noted that policymakers are often focused on education and Medicaid issues, which account for the largest portion of the state's budget. "If it's not those two issues," said Chenier, "it's harder to break through the noise. I think the most important thing is having an edge on everything with the right kind of data such as Results First." With Results First analysis, Chenier could easily illustrate to policymakers the costs and recidivism effects of fiscal 2015 budget recommendations, shown in Figure 3, reproduced from the committee's report.[8]

Figure 3

Results First New Mexico Calculated Prison Program Cost-effectiveness to Inform Budget Recommendations

Programs' costs and anticipated impact on recidivism reduction



Source: New Mexico Legislative Finance Committee, *Supplemental Tables and Graphs*, Vol. 3, (2014) 37, http://www.nmlegis.gov/lcs/lfc/lfcdocs/tbvol3/2015Recommend Vol III.pdf.

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Resources must be dedicated to program implementation and monitoring

It is important for policymakers to recognize that investments in evidence-based interventions will not achieve desired outcomes unless the programs are well managed and implemented with fidelity to their designs. As noted earlier, the Legislative Finance Committee's 2012 report on New Mexico's criminal justice programs found that one of the state's evidence-based programs was not achieving its intended outcome of reducing recidivism due to poor implementation. Accordingly, it is important for states to establish strong program monitoring systems, particularly when, as in New Mexico, private providers deliver many programs. Finding the necessary resources to carry out this oversight can be a challenge for many agencies because funding for monitoring is often not built into provider contracts. New Mexico officials acknowledged the need to establish clear guidelines for fidelity monitoring, and committee staff are discussing this issue with agencies.

Next steps for Results First in New Mexico

New Mexico achieved significant benefits from implementing its Results First cost-benefit model, providing state policymakers and agency leaders with critical information about the effectiveness and return on investment from criminal justice, early education, and child welfare programs. Moving forward, New Mexico plans to:

- Convene a multiagency stakeholder group. The New Mexico Sentencing Commission will organize a stakeholder group consisting of representatives from the Corrections Department, New Mexico Sentencing Commission, and the Legislative Finance Committee to collaborate on and advance the Results First approach.
- Support ongoing criminal justice reforms. In response to presentations by Results First and other groups, New Mexico recently formed a Criminal Justice Reform Subcommittee to explore effective means for reducing crime at lower costs. Results First data will feed into subcommittee deliberations on courses of action.
- Continue to expand the Results First model into additional policy areas. The Legislative Finance Committee plans to continue using the model to inform program evaluations and budget recommendations and to expand its use in budget deliberations in other policy areas such as juvenile justice, behavioral health, and public education.

> "The only way you can really determine if you're getting the value of your resources is to gather information, assess it, and try to determine the outcomes. I think the evidence-based approach that we take will give us the information we need to fund the programs that work."
>
> **Representative Luciano "Lucky" Varela (D)**

Endnotes

1 New Mexico Legislative Finance Committee, *Reducing Recidivism, Cutting Costs and Improving Public Safety in the Incarceration and Supervision of Adult Offenders* (June 2012), http://www.nmlegis.gov/lcs/handouts/BHS%20101812%20NM%20Corrections%20Department%20LFC%20Program%20Evaluation.pdf; New Mexico Legislative Finance Committee, *Evidence-Based Programs to Reduce Recidivism and Improve Public Safety in Adult Corrections* (July 2013), http://www.nmlegis.gov/lcs/lfc/lfcdocs/perfaudit/LFC%20Results%20First%20-%20Evidence-Based%20Programs%20to%20Reduce%20Recidivism%20and%20Improve%20Public%20Safety%20in%20Adult%20Corrections.pdf.

2 New Mexico Legislative Finance Committee, *Evidence-Based Programs to Reduce Recidivism*. This is based on an 18-month average stay of Corrections Department inmates.

3 New Mexico Legislative Finance Committee, *Reducing Recidivism, Cutting Costs*. The report also showed that, based on the state's projections, New Mexico's prison population will exceed current capacity over the next 10 years with half of the 3,440 offenders released in fiscal 2011 expected to return to prison within five years.

4 New Mexico Legislative Finance Committee, *Reducing Recidivism, Cutting Costs*.

5 New Mexico Legislative Finance Committee, *Improving Outcomes for Pregnant Women and Infants Through Medicaid* (September 2012), http://www.nmlegis.gov/lcs/lfc/lfcdocs/perfaudit/Human%20Services%20Department%20-%20Improving%20Outcomes%20for%20Pregnant%20Women%20and%20Infants%20Through%20Medicaid.pdf; New Mexico Legislative Finance Committee, Evidence-Based Programs to Reduce Child Maltreatment (April 2014), http://www.nmlegis.gov/lcs/lfc/lfcdocs/perfaudit/LFC%20Results%20First%20Report%20-%20Evidence-Based%20Programs%20to%20Reduce%20Child%20Maltreatment.pdf.

6 New Mexico Legislative Finance Committee, *Evidence-Based Early Education Programs to Improve Education Outcomes* (April 2014), http://www.nmlegis.gov/lcs/lfc/lfcdocs/perfaudit/LFC%20Results%20First%20Report%20-%20Evidence-Based%20Early%20Education%20Programs%20to%20Improve%20Education%20Outcomes.pdf.

7 New Mexico Legislative Finance Committee, *Reducing Recidivism, Cutting Costs*.

8 New Mexico Legislative Finance Committee, *Supplemental Tables and Graphs, Vol. 3* (2014), http://www.nmlegis.gov/lcs/lfc/lfcdocs/budget/2015RecommendVolIII.pdf.

Contact: Gary VanLandingham, director, Pew-MacArthur Results First Initiative
Email: gvanlandingham@pewtrusts.org
Phone: 202-540-6207

Pew-MacArthur Results First Initiative, a project of The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation, works with states to implement an innovative cost-benefit analysis approach that helps them invest in policies and programs that are proven to work.

VISITOR REGISTRATION SHEET

Joint Committee on Appropriations on Health and Human Services

March 17, 2015

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D. Tommy Tropp	Senior Tar Heel Legislative
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VISITOR REGISTRATION SHEET

Joint Committee on Appropriations on Health and Human Services

March 17, 2015

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Eric Breit	Prevent Child Abuse NC
Judith McDermott	OSBM
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Annaliese Dolph	Dolph Law
Michelle Hughes	NC Child
Tom V. [illegible]	NC CHILD
NICHOLLE KARIM	NAMI NC
Rman menwald	williams mullen
Joe White	OSBM
Jonathan Yeomans	OSBM
[illegible]	OSBM
[illegible]	DST
Mat [illegible]	NCR
Amy Fulk	30 [illegible]
Jennifer Mahan	ASNC
Tom BENN	EDF

09-21-201

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Joint Committee on Appropriations on Health and Human Services

March 17, 2015

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Jennifer Cascarini	NCMS
Mike Lanier	ACP
Chris McClure	BSP
Curtis McDonald	BMS
Josh Ehrich	JDA
Doug Lewis	NCSTA
Trent Womble	DHHS
Mark Ezzell	APNC
Joanna Spinell	NCAFP
[illegible]	[illegible]
[illegible]	MVA
TJ Bugbee	NP
[illegible]	BSA
Erica Nelson	NCHA
Martha McConnell	Carolinas Healthcare
Adam Sholar	DHHS

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Joint Committee on Appropriations on Health and Human Services

March 17, 2015

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Flint Benson	SEANC
John Boyd	Mayland Comm College
J Reeves	CSS
Cody Hand	NCHA
Bill Kuntz	AOC
Johanna Reese	NCACC
Allison Stewart	Cardinal Innovations
John Bode	BCBS
Anna Roberts	Public Sector Group
Judy Jenkins	Otsuka
Edward Robinson	NCPMA
Lexi Morgan	NCPMA
John Galt	NCS
Doug Mistew	PSG
Sally Sanders	NCP
Ed Thurlow	BBP

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VISITOR REGISTRATION SHEET

Joint Committee on Appropriations on Health and Human Services

March 17, 2015

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NAME	FIRM OR AGENCY AND ADDRESS
Nancy Clark	McDowell County Senior Tar Heel Legislature
Rachel Deal	Avery Senior Tar Heel Legislature
Charles Jefferson	Warren County Sr. Tar Heel Legislature
Winfred Christensen	Ward & Smith, P.A.

09-21-201

House Committee on Appropriations, Health and Human Services
Wednesday, March 18, 2015 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Appropriations, Health and Human Services met at 8:30 AM on March 18, 2015 in Room 643 of the Legislative Office Building.

Representative Marilyn Avila, Chair, presided.
Co-Chairs William Brisson, Josh Dobson, Chris Malone as well as Representatives Jean Farmer-Butterfield, Gary Pendleton, Verla Insko, Beverly Earle, and Howard Hunter from the House side attended.

On the Senate side, Co-Chairs Ralph Hise, Louis Pate and Tommy Tucker as well as Senators Tamara Barringer, Floyd McKissick, Terry Van Duyn and Andy Wells attended.

Chairman Avila recognized House and Senate Sergeant at Arms, as well as both the House and Senate pages for the day. (See attached list)

Dr. Dorothy Cilenti, DrPHD, MPH, MSW Clinical Assistant Professor, Department of Maternal and Child Health UNC Gilling School of Global Public Health continued her presentation on "How Healthy are North Carolina's Children?" (See attachment)

The meeting adjourned at 9:45am.

Marilyn Avila
Representative Marilyn Avila, Chair
Presiding

Caroline Stirling
Caroline Stirling, Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

March 18, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Representative Marilyn Avila, Presiding Co-Chair
II.	**"How Healthy are North Carolina's Mothers and Babies?"**	Dr. Dorothy Cilenti, DrPH, MPH, MSW Clinical Assistant Professor Department of Maternal and Child Health UNC Gillings School of Global Public Health
	Committee Discussion	
	Adjourn	

How Healthy are North Carolina's Mothers and Babies?

HHS Joint Appropriations Subcommittee

March 12, 2015

Dorothy Cilenti, DrPH, MPH, MSW

Clinical Assistant Professor

Department of Maternal and Child Health

UNC
GILLINGS SCHOOL OF
GLOBAL PUBLIC HEALTH

Overview

- Present data on key health and well-being indicators for NC pregnant women and infants

- Identify areas where investments in maternal and infant health and well-being may be sustained

Goals

- All babies born with the same chance for a healthy and long life
- Strong families and communities to support parents and infants during the first year of life
- Optimal health for all mothers before pregnancy and after delivery

Socio-Ecological Model

Snapshot of North Carolina Mothers and Babies, 2013

118,983

Total number of births

2,062

Number of low-weight babies

84%

Women ages 18-34 giving birth

58.6%

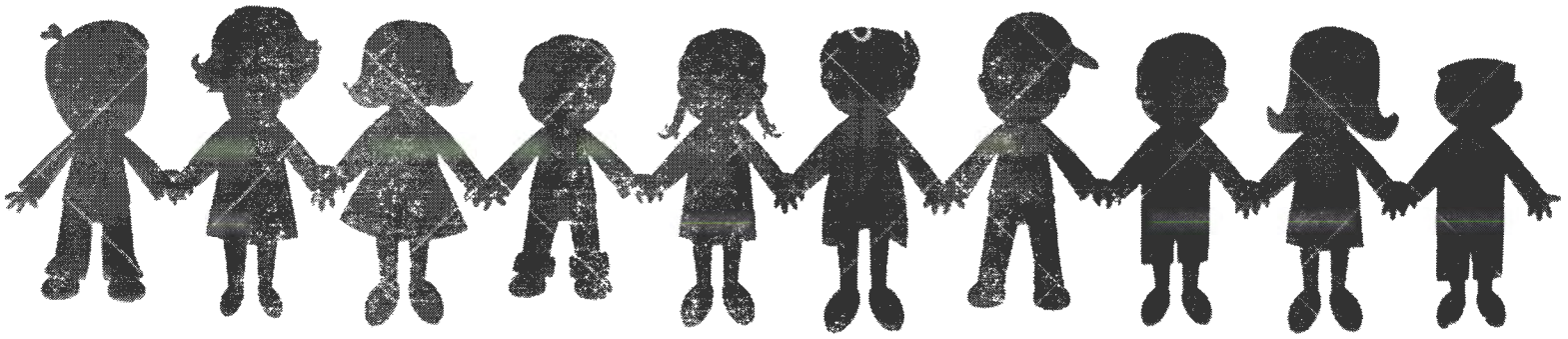
Births to married women

49.6%

Women were obese or overweight before giving birth

20,282

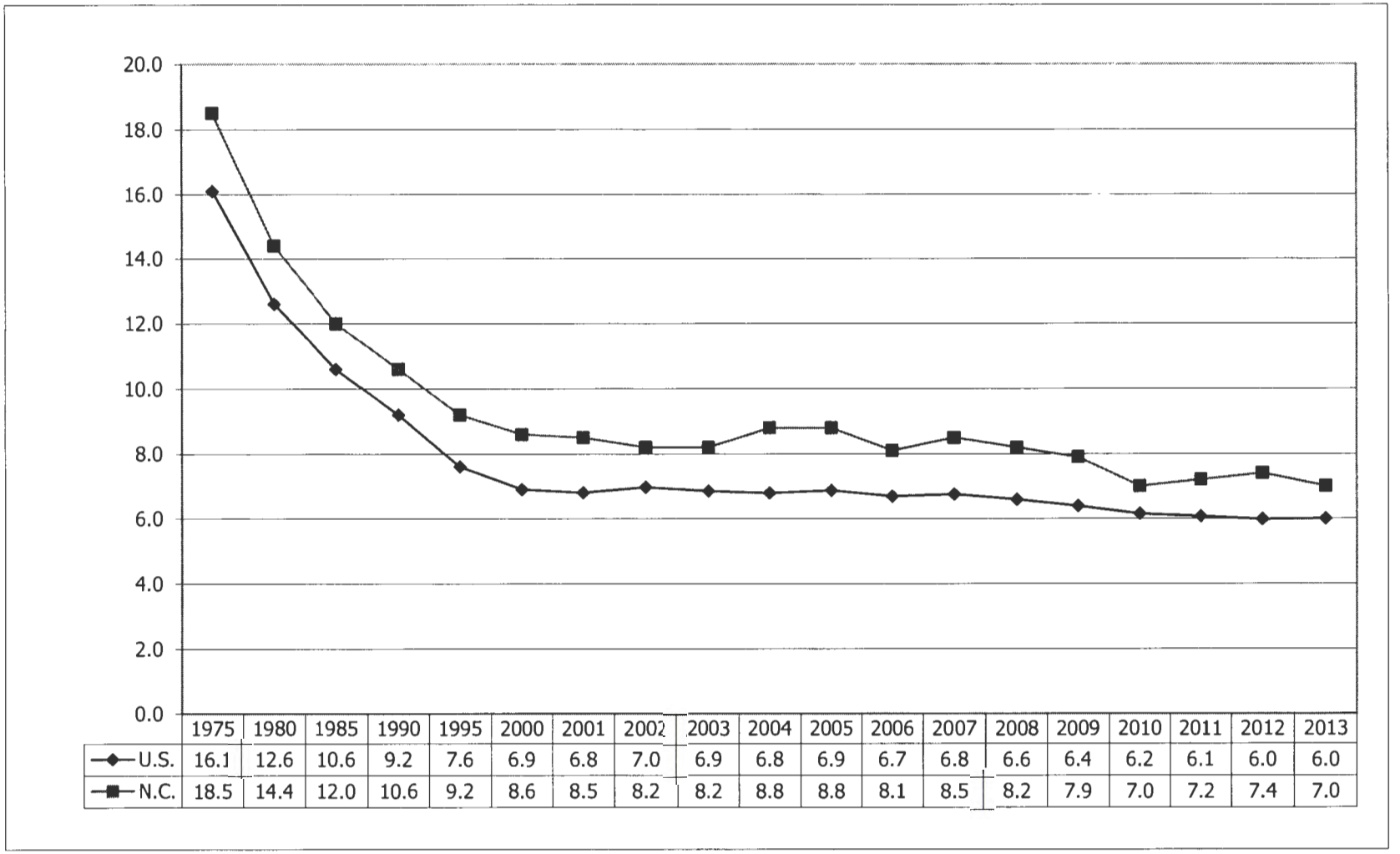
Babies born to mothers with less than a high school education



INFANT MORTALITY

A society's infant mortality rate is considered an important indicator of its health, because infant mortality is associated with socioeconomic status, access to health care, and the health status of women of childbearing age. (Congressional Budget Office, 1992)

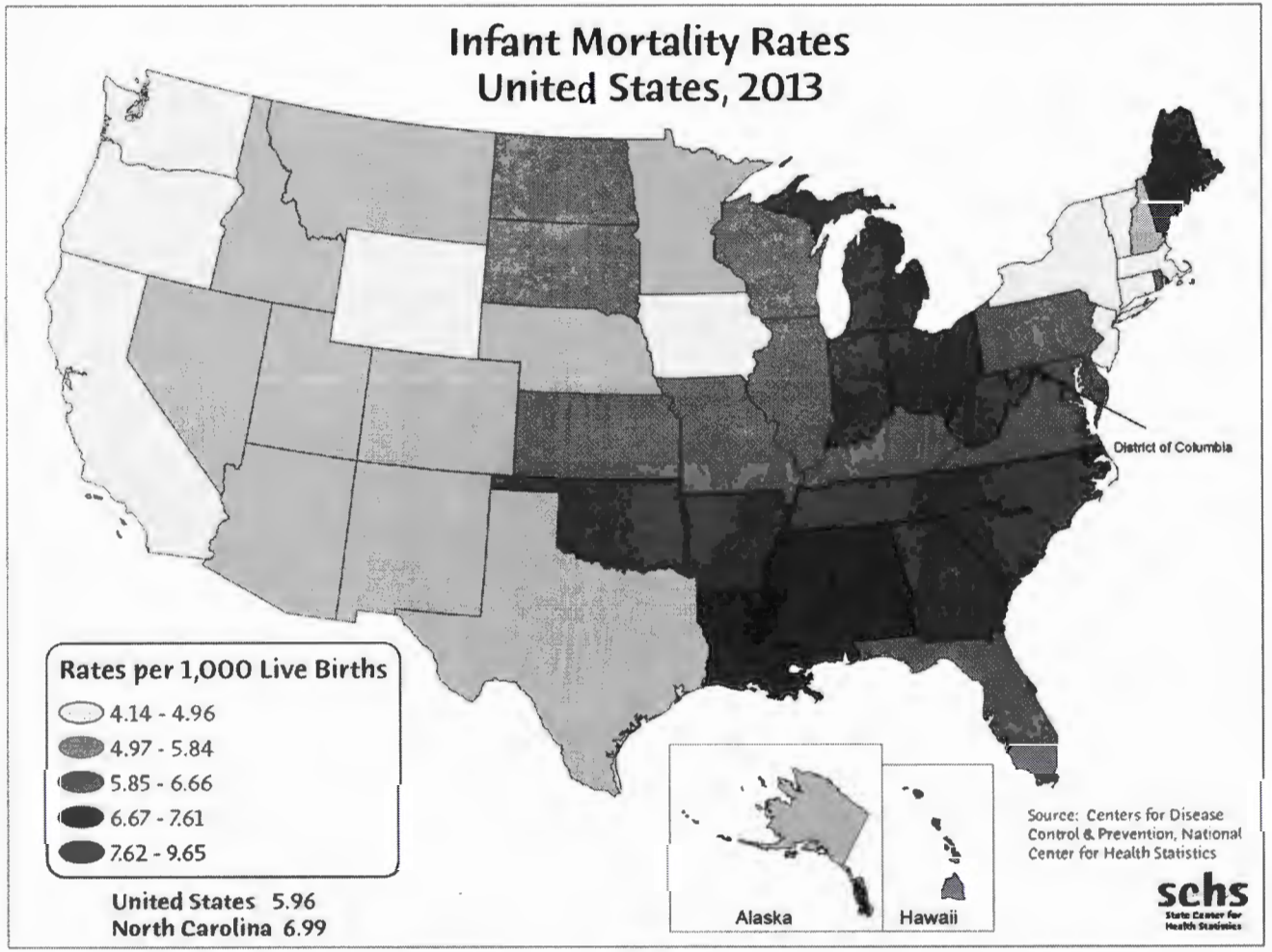
Infant Mortality Rates:1975-2013



	1975	1980	1985	1990	1995	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
U.S.	16.1	12.6	10.6	9.2	7.6	6.9	6.8	7.0	6.9	6.8	6.9	6.7	6.8	6.6	6.4	6.2	6.1	6.0	6.0
N.C.	18.5	14.4	12.0	10.6	9.2	8.6	8.5	8.2	8.2	8.8	8.8	8.1	8.5	8.2	7.9	7.0	7.2	7.4	7.0

Source: State Center for Health Statistics & CDC/National Center for Health Statistics

National Infant Mortality Rates, 2013

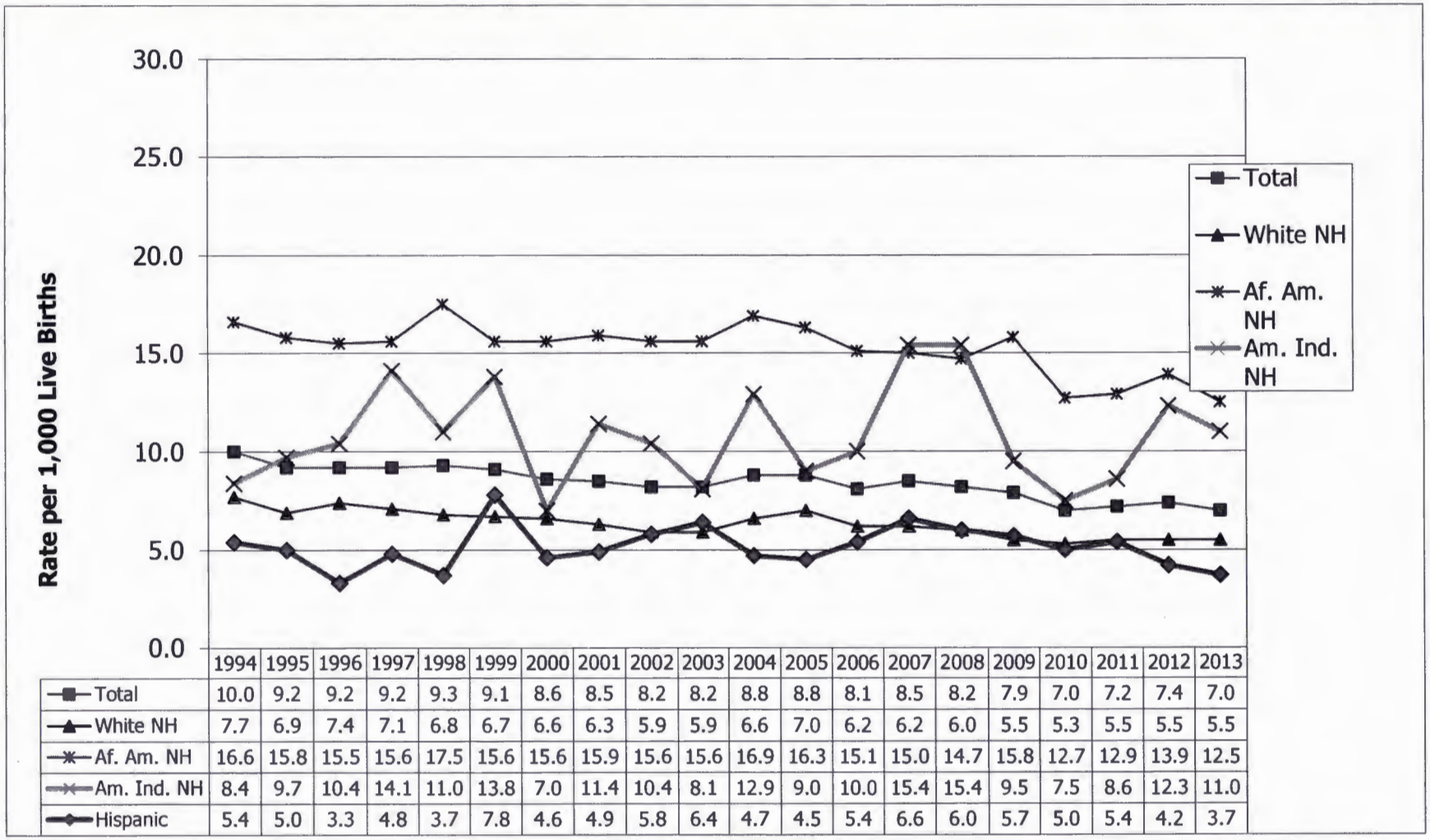


2013 U.S. Infant Mortality Rate Rankings

Rank	State
1	Mississippi
2	Louisiana
3	Alabama
4	Arkansas
5	West Virginia
6	Ohio
7	Indiana
8 (tie)	Maine
	Michigan
10	North Carolina

Source: State Center for Health Statistics & CDC/National Center for Health Statistics

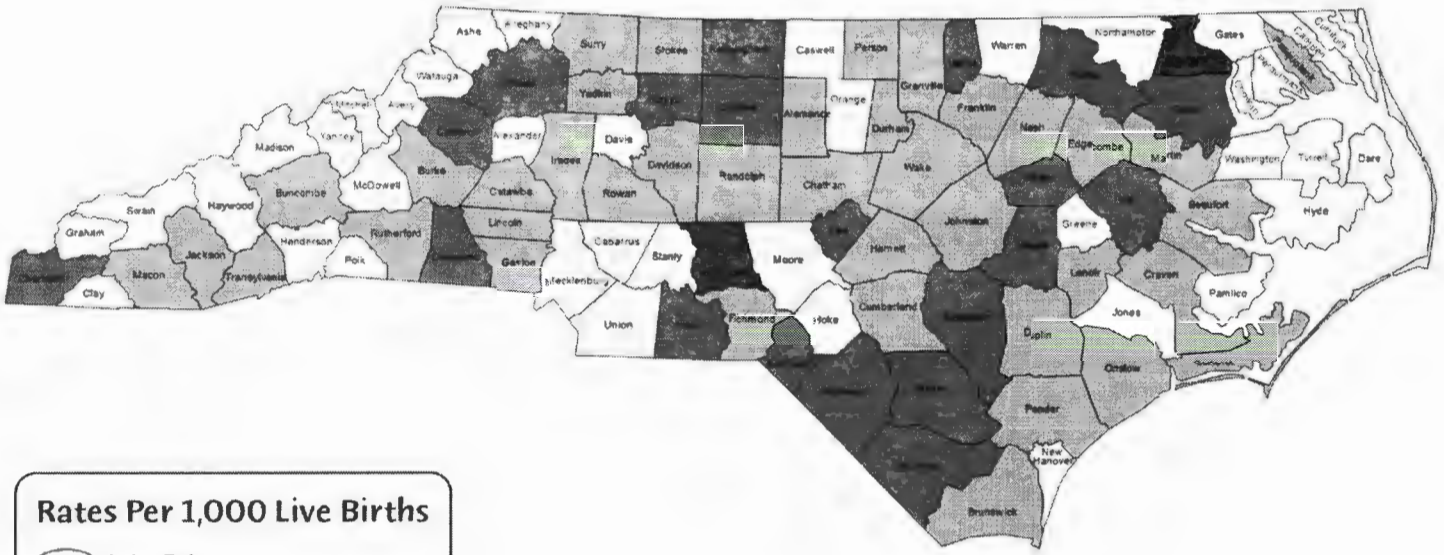
North Carolina Infant Mortality Rates 1994-2013



	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Total	10.0	9.2	9.2	9.2	9.3	9.1	8.6	8.5	8.2	8.2	8.8	8.8	8.1	8.5	8.2	7.9	7.0	7.2	7.4	7.0
White NH	7.7	6.9	7.4	7.1	6.8	6.7	6.6	6.3	5.9	5.9	6.6	7.0	6.2	6.2	6.0	5.5	5.3	5.5	5.5	5.5
Af. Am. NH	16.6	15.8	15.5	15.6	17.5	15.6	15.6	15.9	15.6	15.6	16.9	16.3	15.1	15.0	14.7	15.8	12.7	12.9	13.9	12.5
Am. Ind. NH	8.4	9.7	10.4	14.1	11.0	13.8	7.0	11.4	10.4	8.1	12.9	9.0	10.0	15.4	15.4	9.5	7.5	8.6	12.3	11.0
Hispanic	5.4	5.0	3.3	4.8	3.7	7.8	4.6	4.9	5.8	6.4	4.7	4.5	5.4	6.6	6.0	5.7	5.0	5.4	4.2	3.7

Source: North Carolina State Center for Health Statistics

North Carolina Infant Mortality Rates by County 2009-2013



Rates Per 1,000 Live Births

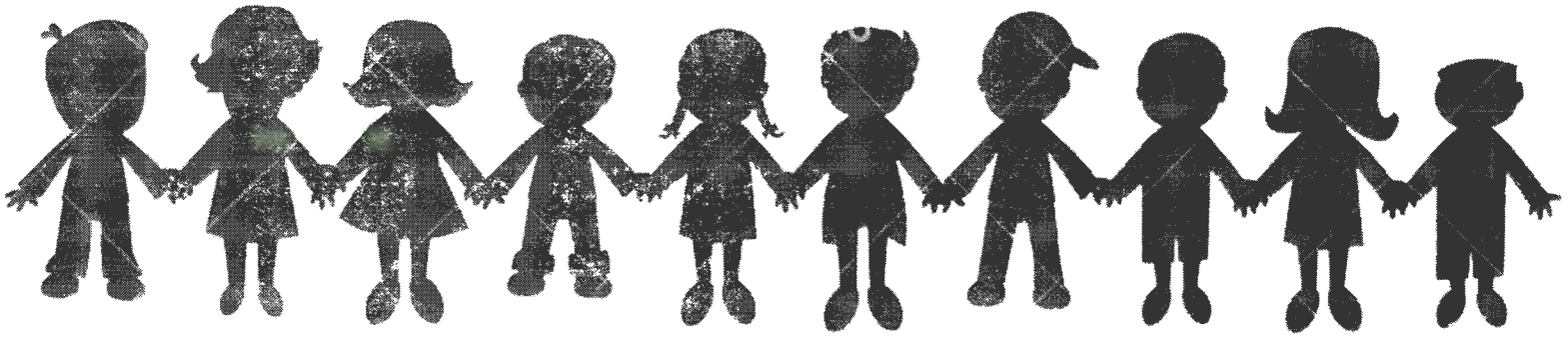
- 1.4 - 5.8
- 5.9 - 8.5
- 8.6 - 12.1
- 12.2 - 18.1
- Suppressed*

* Rates based on less than 10 deaths are unreliable and have been suppressed.

North Carolina Infant Mortality by Perinatal Care Regions

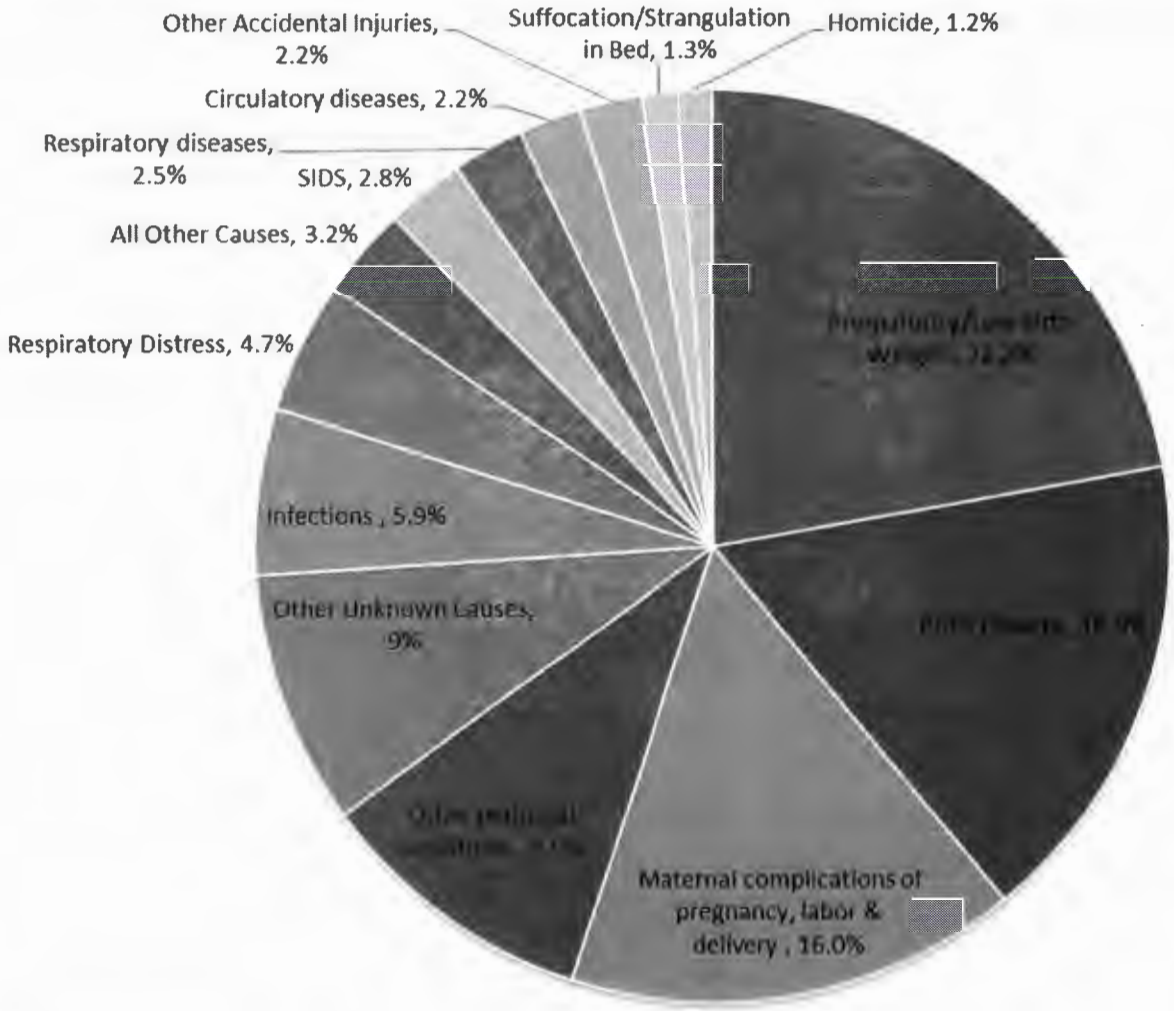
Rates Per 1,000 Live Births

- 6.1
- 6.2 - 6.7
- 6.8 - 7.3
- 7.4 - 7.7
- County Boundary



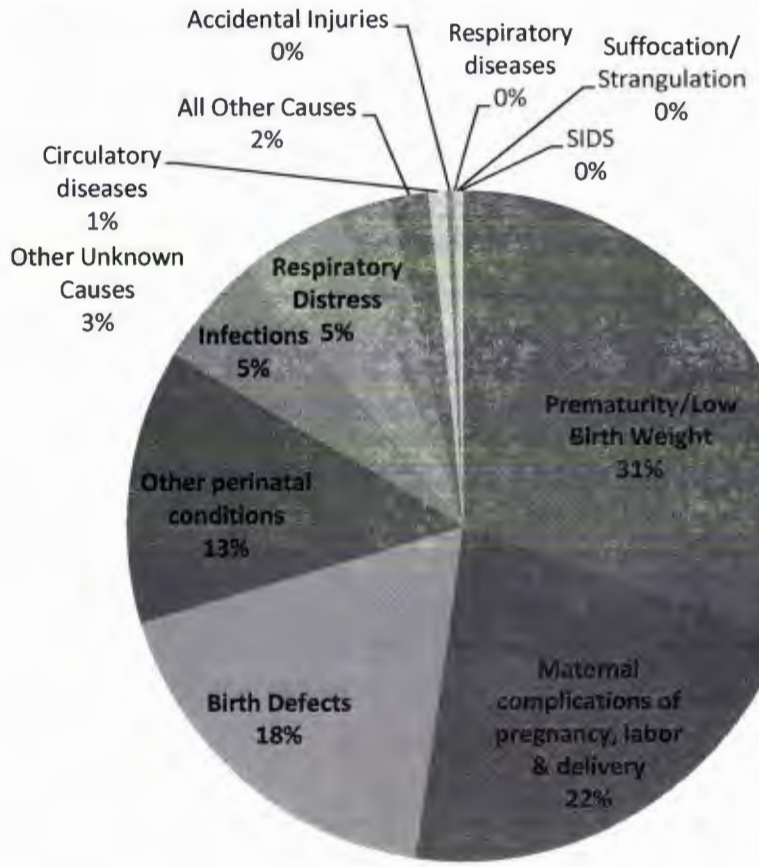
CAUSES OF INFANT MORTALITY AND MORBIDITY

Leading Causes of Infant Death
North Carolina, 2013

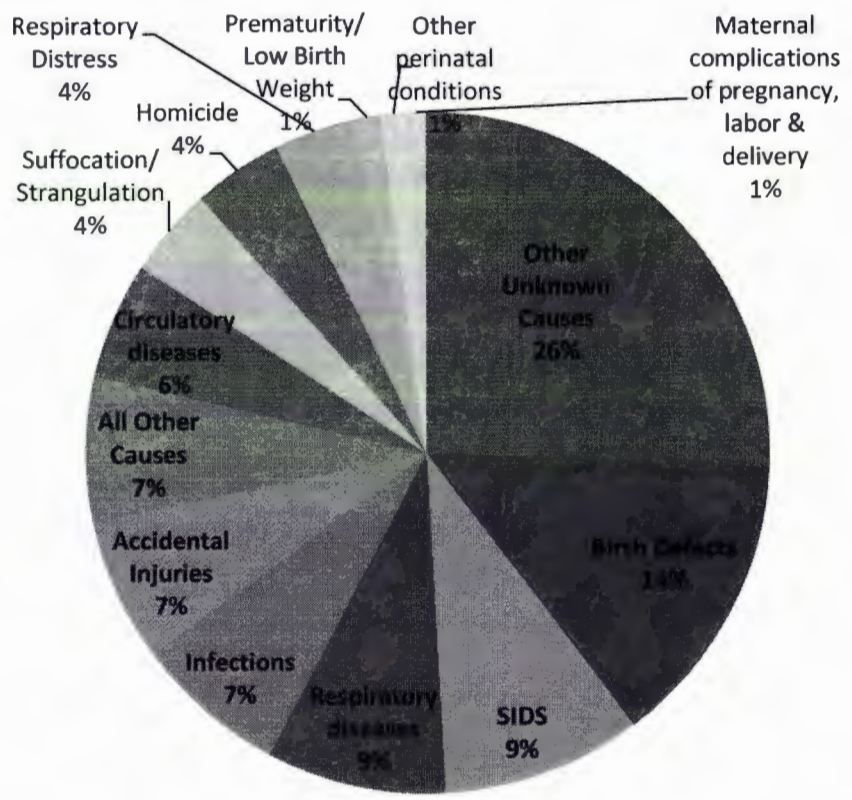


Source: State Center for Health Statistics

Leading Causes of Infant Death
Neonatal vs. Postneonatal, NC Residents 2013



Neonatal



Postneonatal

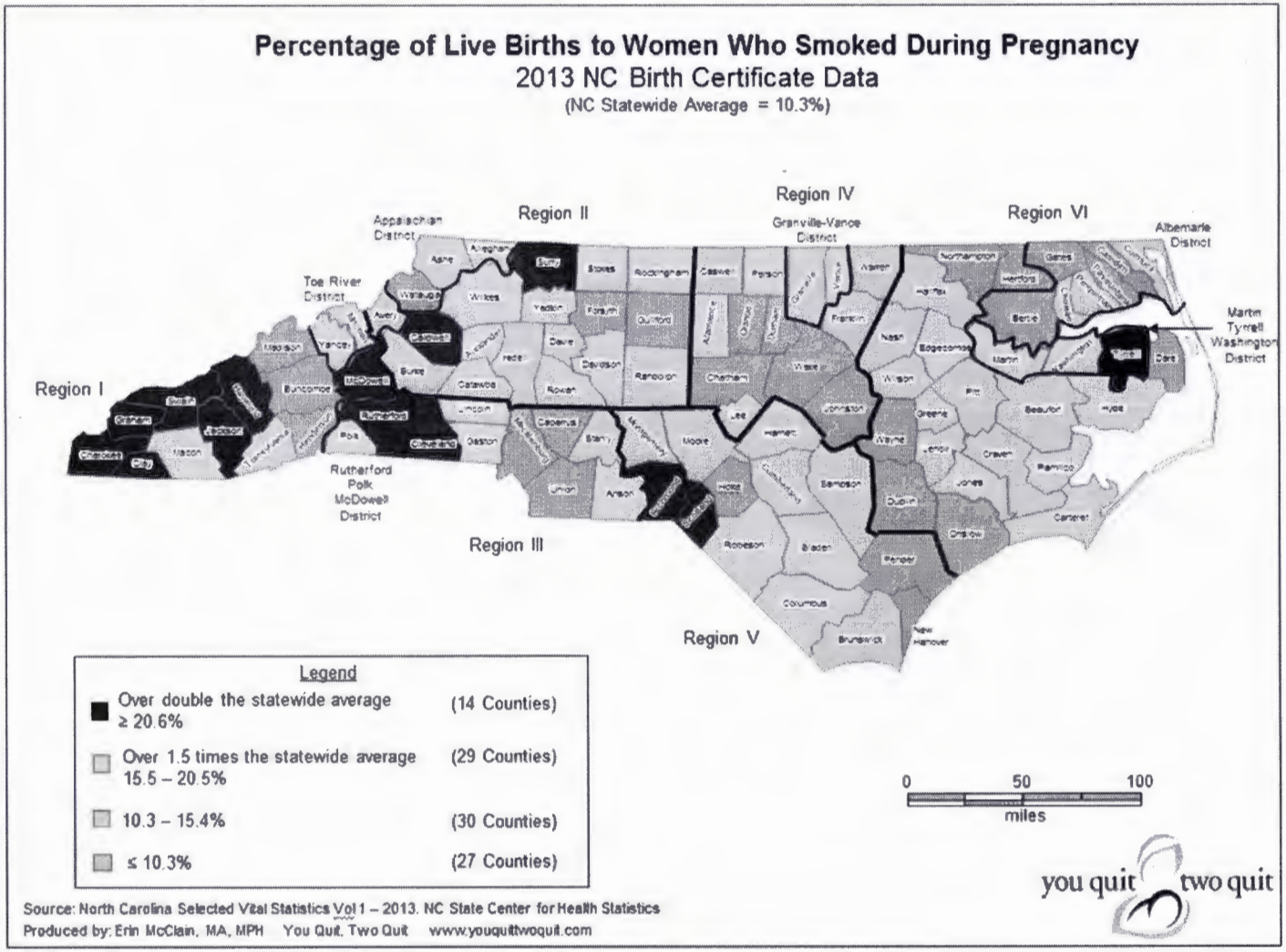
Source: State Center for Health Statistics

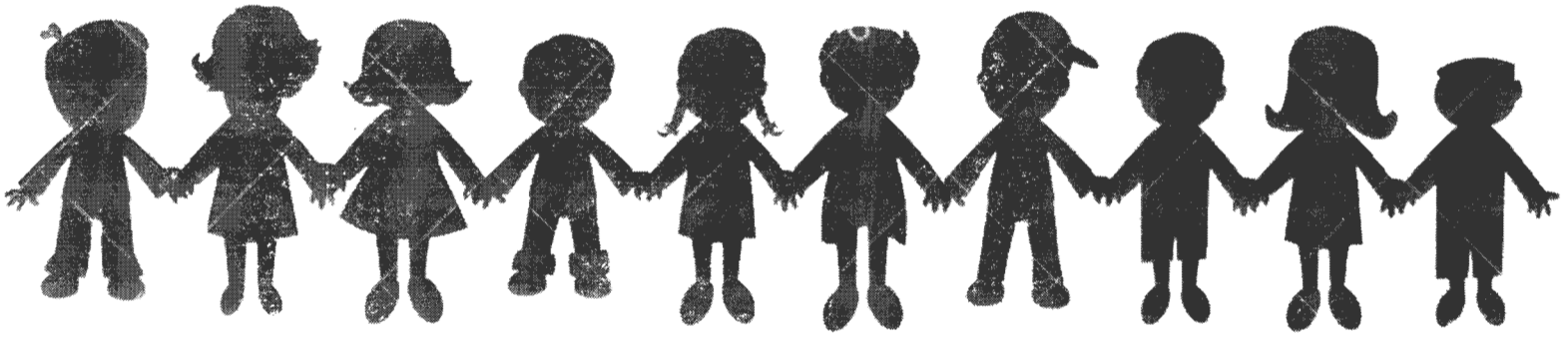
North Carolina Low Birthweight Rates 2009-2013

Modifiable Risk Factors Common to Congenital Conditions

Risk factor	Birth Defects	Preterm Birth	Low Birth Weight	Developm. disability
Nutrition status	X	X	X	
Insufficient folic acid/vitamin	X	X	X	X
Smoking	X	X	X	X
Alcohol use / abuse	X	X	X	X
Illicit drugs	X	X	X	X
Obesity	X	X	X	
Diabetes - gestational	X	X	X	
Infectious diseases	X	X	X	X
Selected medications	X	X	X	X
Psycho-social stressors		X		
Environment and working activity	X	X	X	X

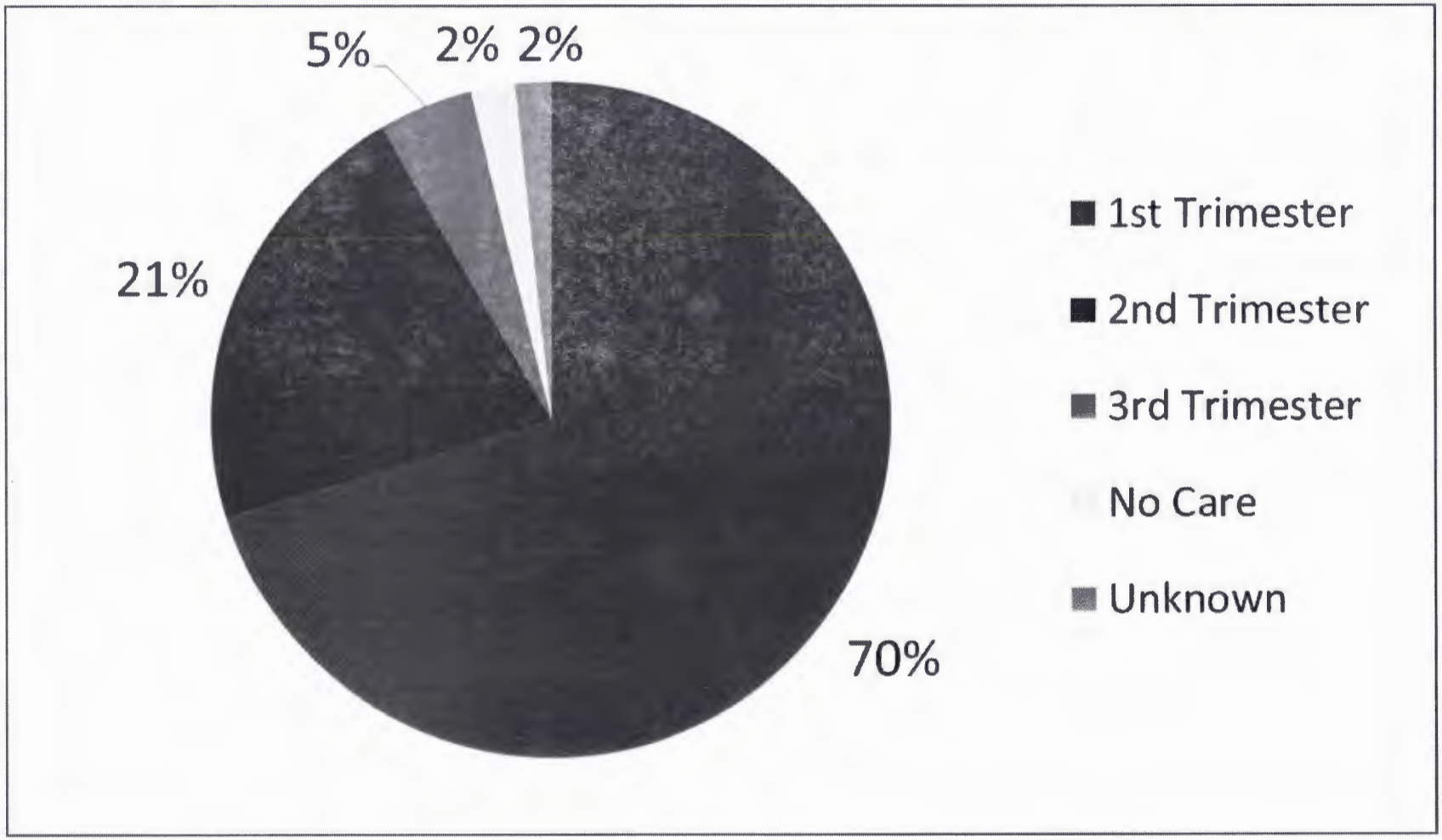
Percentage of Live Births to Women Who Smoked During Pregnancy





PROTECTIVE FACTORS

2013 North Carolina Resident Births: Trimester Prenatal Care Began



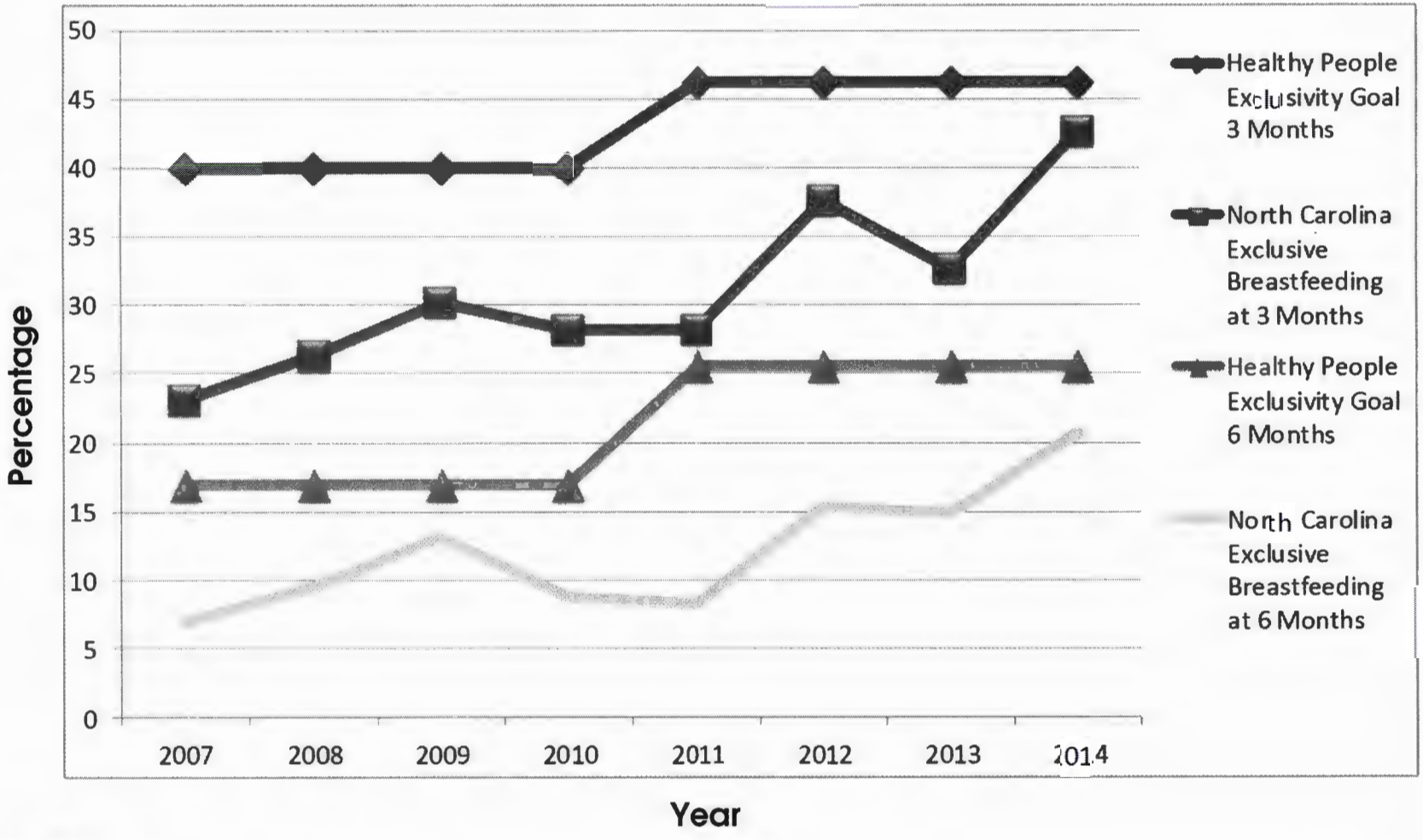
Source: State Center for Health Statistics

Centers for Disease Control and Prevention (CDC) Breastfeeding Report Card

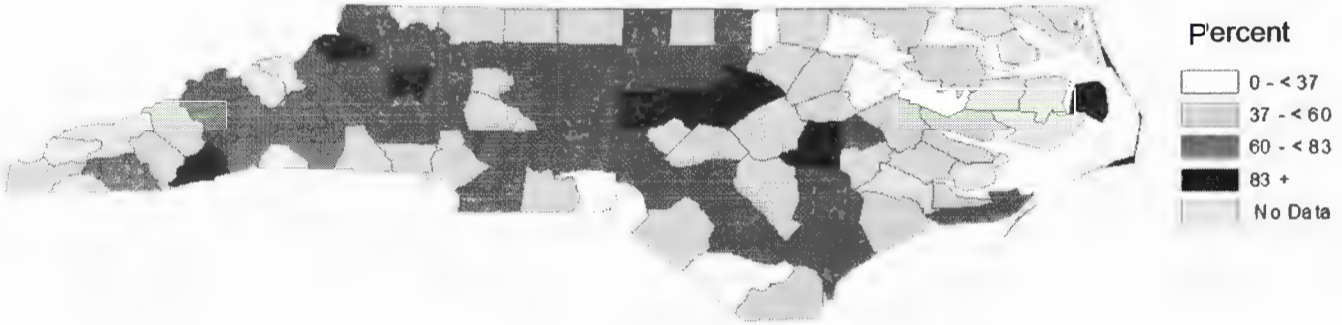
Objective	Healthy People 2020 Goal	Nation 2014 (%)	North Carolina 2010 (%)	North Carolina 2011 (%)	North Carolina 2012 (%)	North Carolina 2013 (%)	North Carolina 2014 (%)
Ever Breastfed	81.9 %	79.2	73.5	67.3	68.2	74.9	**77.2**
Breastfeeding at 6 months	60.6 %	49.4	35.9	37.0	38.3	48.5	**48.3**
Breastfeeding at 12 months	34.1 %	26.7	19.4	19.6	20.8	31.9	**24.5**
Exclusive breastfeeding at 3 months	46.2 %	40.7	28.2	28.1	37.6	32.7	**42.6**
Exclusive breastfeeding at 6 months	25.5 %	18.8	8.7	8.2	15.3	14.8	**20.7**

http://www.cdc.gov/breastfeeding

North Carolina Breastfeeding Trends 2007-2014



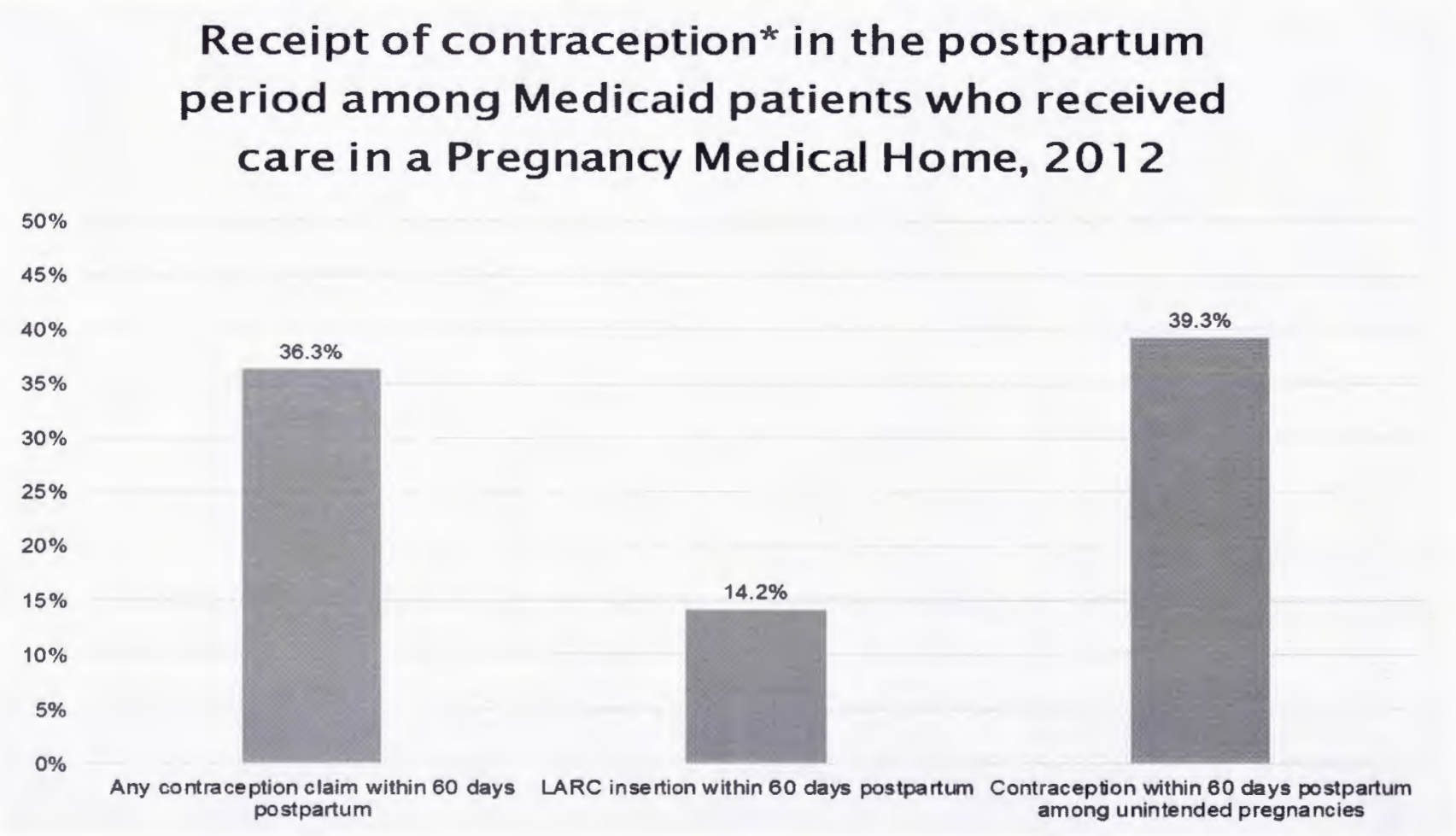
Percentage of Infants Ever Breastfed by County



* *Among infants born during the reporting period.*

2011 NC PedNSS Table 7B

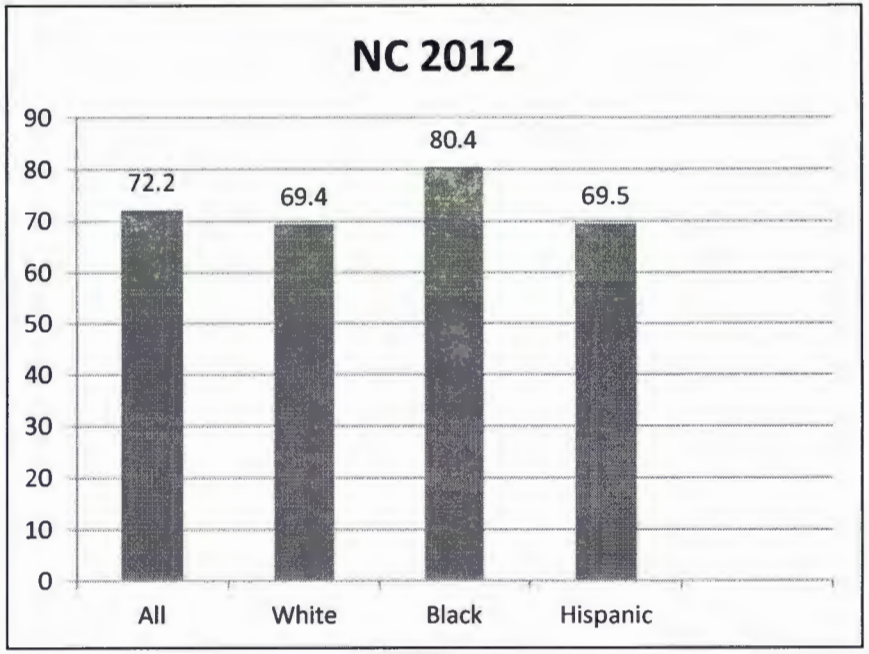
Contraception in the Postpartum Period among Medicaid Patients



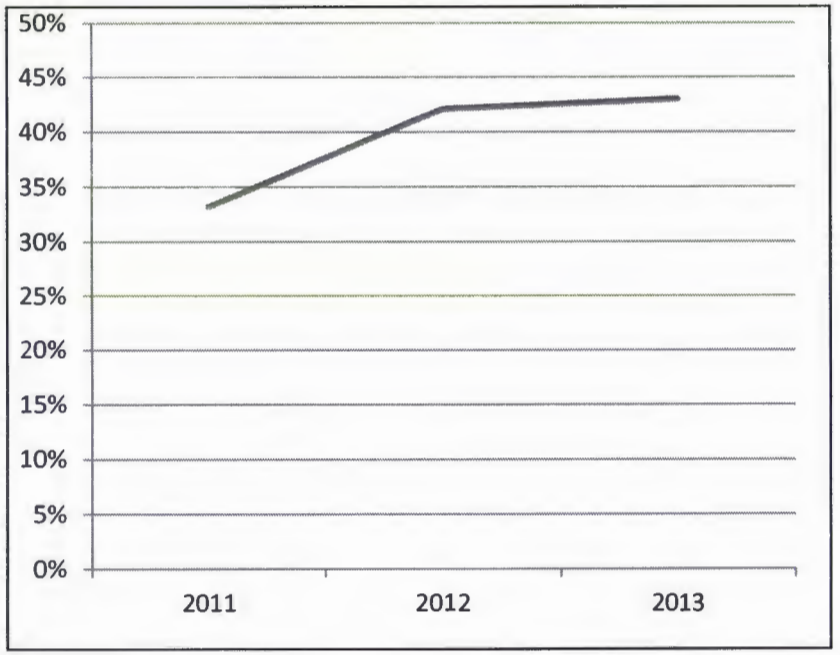
*Based on paid claims for contraceptive methods, excluding any patient with a history of sterilization; LARC methods are only included if there is a paid claim for the insertion of the device.

Women's Preventive Health

Women (18-44) who had a routine checkup in the past year



Women (18-44) who took a multivitamin, prenatal vitamin, or folic acid supplement every day



Source: State Center for Health Statistics/
Behavioral Risk Factor Surveillance System (BRFSS)

What Works for Healthy Mothers and Infants?

- Evidence-based and evidence-informed solutions to these problems exist
- Important to implement solutions that fit our context
- Monitoring and evaluating progress is key to success

Processes for Priority Setting

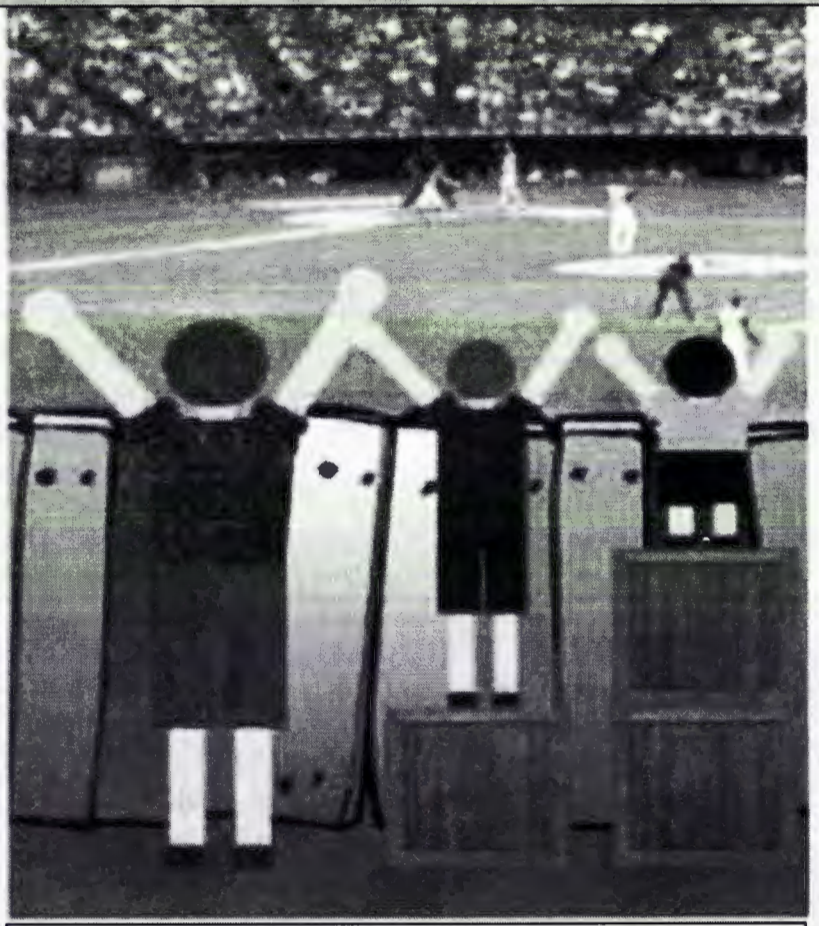
- Considerations
  - Number of people affected
  - Severity
  - Effectiveness of interventions
  - Return on Investment
- Tools and processes have been used in many other states and communities

Closing Comments

- North Carolina ranks 40th among all 50 states in infant mortality
- Improving maternal and infant health outcomes requires partnerships
- We have examples of successful programs and policies
- Sustained and consistent effort will be needed to improve birth outcomes and eliminate disparities

Interventions may need to be different to achieve desired outcomes for all

This is Equality



This is EQUITY

Source: Health Equity Learning Lab Series: From Conceptual Theory to Concrete Practice

Acknowledgements

- NC Department of Health and Human Services' Division of Public Health and State Center for Health Statistics

For More Information

Contact:

Dorothy Cilenti, DrPH, MPH, MSW

cilenti@email.unc.edu

UNC
GILLINGS SCHOOL OF
GLOBAL PUBLIC HEALTH

Committee Sergeants at Arms

NAME OF COMMITTEE Jt. Comm. on App. HHS

DATE: 03/18/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name: DALE HUFF
2. Name: MARCUS KITTS
3. Name:
4. Name:
5. Name:

PAGES ATTENDING

Date: 3-18, 8:30

Committee: Joint: Health & Hum Serv. **Room:** 643

PLEASE PRINT LEGIBILY!!!!!

Page Name	Hometown	Sponsoring Senator
1 Gesche Barg	Charlotte	Rucho
2		
3		
5		
6		
7		
8		
9		

Do not add additional names below the grid.

Pages: Please present this form to either the Committee Clerk at the meeting or a Sgt. at Arms.

Wednesday, March 18	Room	Time
APPROPRIATIONS HEALTH & HUMAN SERVICES (JOINT)	643	8:30 am

Name	County	Sponsor
Kateleigh Johnson	Harnett	David R. Lewis

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 03/18/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Byron Grimmett	Carolina Neurosurgery & Spine 220 Baldwin Ave Charlotte 28204
Jennifer Mahan	NSNC
CHRIS DILLON	WAKE CO
Erica Nelson	NCHA
[illegible]	[illegible]
Mim James	AHP
Maeve Hanlon	GSK
Gary Hunt	NCHA
DAVID BARNES	Electricities

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — Name of Committee

03/18/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Belinda Pettiford	DHHS-Div. of Public Health
Jennifer Willis	UNC-CH
[illegible] Jenkins	OAPI
[illegible]	[illegible]
Jonathan Yeomans	OSBM
Canaan Duce	NCA
Kaya Wanniarachchi	ECBN
Josh Ehrlich	JDA
Ryan Blackledge	Cone Health
Joanna Grull	NCAFP
Sarah Moffat	NCMGMA
Mollie Lynch	NCMGMA (CEMA)
Eric Stowe	NC MGMA

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Jt. Comm. on App. HHS — 03/18/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lexi Morgan	NCRMA
Andy Ellen	NCRMA
Elizabeth Robinson	NCRMA
Thom Mm	Lobbyist
TJ Bugbee	NP
Jim Johnson	BSA
Ken McHan	[illegible]
Trent Womble	DHHS
Rob Hamme	RLA
Kim Renwald	WPR
Ann Rodriguez	NC Council of Community Programs

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Jt. Comm. on App. HHS — 03/18/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Curtis McDonald	BMS
Jay Peters	CSS
Chuck Stone	SEAK
Andy Chase	KMA
Ken Melton	KMA
Sam Sadler	NP
Mark Eggel	APK

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 03/18/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Donna Fogleman	NCMGMA - NC Medical Group Managers Assoc
Sandra Jarrett	NCMGMA -
Fran Sembert	NCMGMA
CAROL PETTIT	NCMGMA
Melissa H. White	NCMGMA
Jeanne Chamberlin	NCMGMA
Jacob Rodman	NCMGMA
Mary Tyrey	NCMS Alliance
Stephen DeBiasi	NCMGMA
Christopher Shireman	NCMGMA
Jennifer Gasperini	NCMS

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 03/18/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Leah Cook	NCMGMA
Matt Gross	NCR
Tom VITAGLIONE	NCCHILD
Demetrius Debatch	Senator Glady Robinson
Lauren Coffey	Gov office Policy
Ashley Perkins	Perkins Law
Austin Pruitt	Perkinson
KARL STEIN	RALEIGH ORTHOPAEDIC CLINIC
Harry Lyda	NWC
Mark McConnell	Carolinas HealthCare Syst
Annalrese Dolph	Dolph LAW

Joint Committee on Appropriations on Health and Human Services
Thursday, March 19, 2015 at 8:30 a.m.
Room 643 of the Legislative Office Building

MINUTES

The Joint Appropriations Committee on Health and Human Services met at 8:30 a.m. on Thursday, March 19, 2015 in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, William Brisson, Chris Malone, Gary Pendleton and Verla Insko were present along with 7 Senate Members.

Senator Louis Pate presided.

Senator Pate opened the meeting by welcoming everyone and recognizing the House Sergeants-at-Arms: Young Bae, James Moran and Bill Morris. Senate Sergeants-at-Arms: Canton Lewis and Marcus Kitts. He then recognized House Page Tonio Sims from Pitt County and Senate Page Nicholas Oddo of Wake County.

Senator Pate recognized Ms. Susan Jacobs of the Fiscal Research Division to give an update on the "Committee Schedule Update" (attachment 1) for the next few weeks. Afterward, Ms. Jacobs turned the meeting over to Mr. Steve Owen of the Fiscal Research Division to give an overview of "Medicaid Provider Payments" (attachment 2). He explained in detail and then opened the floor for questions and answers.

The meeting adjourned at 9:50 a.m.

Senator Louis Pate
Presiding

Edna Pearce, Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

March 19, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Senator Louis Pate, Presiding Co-Chair
II.	**Schedule Update**	Susan Jacobs, Fiscal Research Division
III.	**Overview of Medicaid Provider Payments (Part I)**	Steve Owen, Fiscal Research Division
	Committee Discussion	
	Adjourn	

Joint Appropriations Committee on Health and Human Services

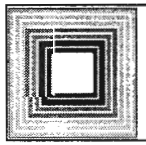
Committee Schedule Update

Susan Jacobs
Fiscal Research Division

March 19, 2015

Joint Appropriations Committee on Health and Human Services

FY 2015-17 Session Strategy: Shifting from "*Paying*" to "*Investing*"



FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Joint Appropriations Committee on Health and Human Services Committee Presentation Plan

Session Strategy:
Shifting from "Paying" to "Investing"

"America spends twice as much on health care than any other nation, but we don't have the healthiest people….research indicates that spending on health care to <u>treat</u> people may actually come at the expense of investing in public health programs meant to keep people from getting sick to start with."

Source: Robert Wood Johnson Foundation "Geographic Variations in Public Health Spending: Correlates and Consequences" – October 2009

Joint Appropriations Committee on Health and Human Services Committee Presentation Plan

Session Strategy:
Shifting from "*Paying*" to "*Investing*"

Key Question for Any Program:

What outcome will you *require* for the investment you are making? Consider the following:

- **Are resources being targeted for the right purpose/program? Does that purpose "fit" with the overall goal of the agency?**
- **Does the program produce positive, evidence-based outcomes?**
- **Is there an alternative that would yield a better result for the state overall?**
- **Is the program adequately or inadequately funded?**
- **Other committee requirements?**

Where to Start? Focus for Long Session – Children (Birth -5)

Joint Appropriations Committee on Health and Human Services Committee Presentation Plan

Session Strategy:
Shifting from "Paying" to "Investing"

Planned Meeting Topics

- ✓ Organizational Meeting/DHHS Overview
- ✓ Secretary Wos and DHHS Staff – Goals for FY 2015-17
- ✓ Implementation Status of Historical Budget Items and Legislation (posted to website)
- ✓ Program Evaluation Division Report – "DHHS Should Integrate Substance Abuse Treatment Facilities into the Community-Based System and Improve Performance Management"
- Program Evaluation Division Report – "Revising State Child Support Incentive System Could Promote Improved Performance of County Program"(Cancelled)
- ✓ School of Public Health – North Carolina Health Outcome Comparisons (All Populations)
- ✓ School of Public Health – North Carolina Health Outcome Comparisons for Children (Ages 0 – 5)
- ✓ School of Public Health – North Carolina Health Outcome Comparisons (Birth Weight/Infant Mortality)
- ✓ Evidence-Based Policy Making – Pew-MacArthur Results First Initiative
- **"How North Carolina Pays Providers" – Fiscal Research Division (3/19 & 3/24)**
- Medical Payments for Pregnant Women and Infants/Cost Analysis of High Risk Deliveries/Preterm Births (3/25)

Joint Appropriations Committee on Health and Human Services Committee Presentation Plan

Session Strategy:
Shifting from "Paying" to "Investing"

Planned Meeting Topics

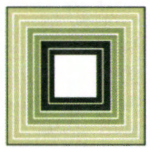
- North Carolina Public Health Programs for Children (Ages 0 – 5) (3/26)
- "How Can North Carolina Improve Birth Outcomes Through Evidence-Based Practices" – (3/31)
- North Carolina Family Support Programs for Children (Ages 0 – 5) (4/1 and 4/2)
- Staff Wrap-Up and Committee Discussion

Health and Human Services
Joint Legislative Oversight Committee

Overview of
Medicaid Provider Payments

Steve Owen,
Fiscal Research Division

March 19, 2015



FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Medicaid Payment Primer

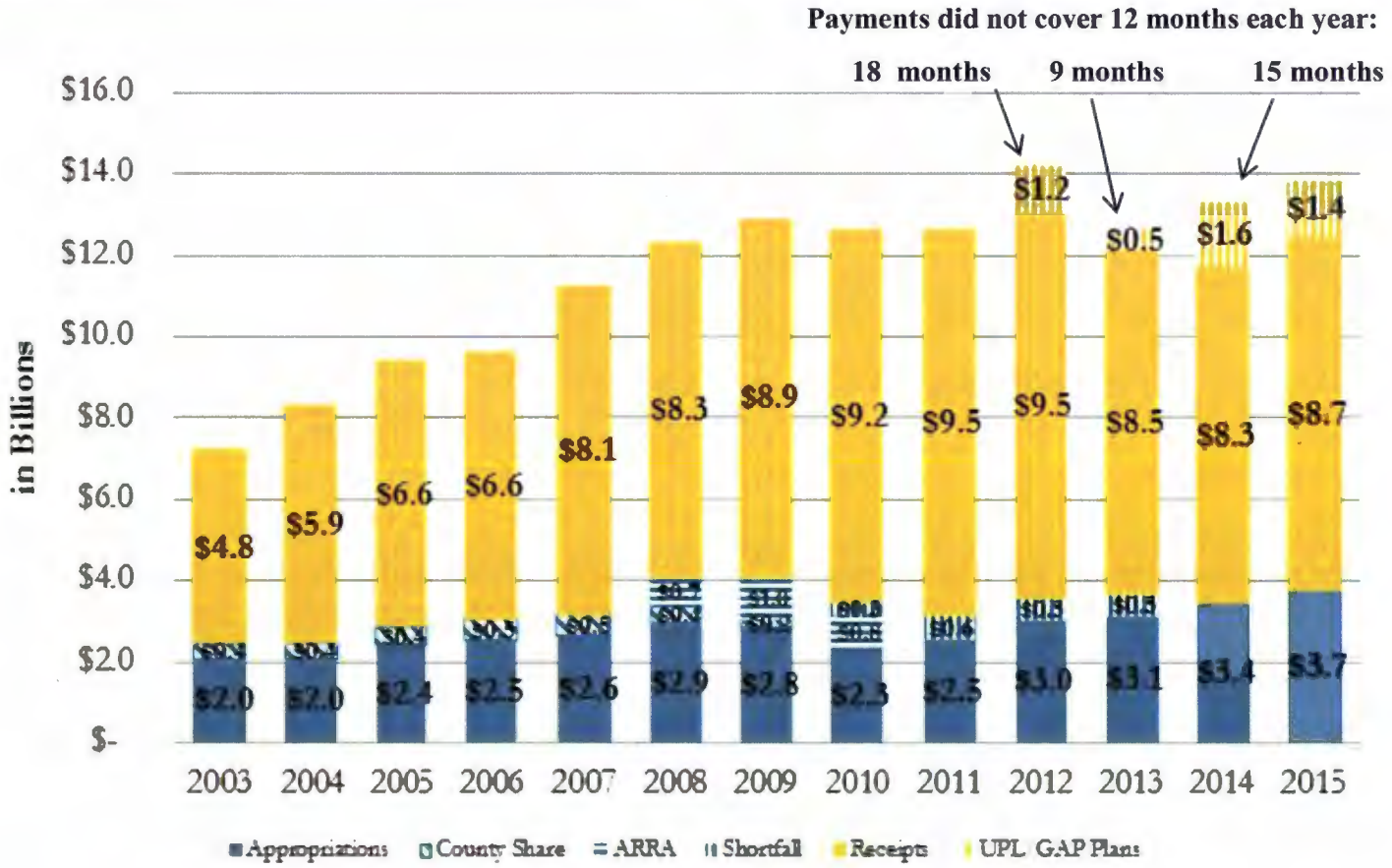
- *Basics of Medicaid Payment and Drivers*
- *Provider Payment Methodologies and Economic Incentives*
- *Health Department Payment Methodology*
- *Skilled Nursing Payment Methodology*
- *Physician Payment Methodology*
- *Drug and Dispensing Fee Methodology*
- *LME/MCO Payment Methodology*
- *Hospital Payment Methodologies*

Presentation on 3/24/15

Source:

Medicaid Spending Trends

Chart reflects total net Medicaid spending including claims, administration, contracts, settlements, program integrity, transfers and other spending



SFY 2014-15 FRD budget does not include the $186 M contingency reserve

Source: NC Office of the State Controller and NCAS BD701 and FRD estimate for SFY 2014-15

Medicaid Payment Primer

- What this is not
  - Presentation of provider payment adequacy
  - Presentation of equitability of provider payments
  - History or discussion of provider payment policies
  - Spending Analysis
- This is intended to be
  - Educational presentation on the methodologies used to pay providers for Medicaid services

Basics of Medicaid Payment and Drivers

- Medicaid Spending Equation =

Enrollment * Utilization * Mix * PRICE * Benefits

- PRICE/Medicaid payments to providers can be comprised of a complex set of methodologies, formulas and processes that have evolved through the years based on federal government practice (Medicare), market forces and North Carolina's need to manage spending on the Medicaid program.

- Like nearly all changes to Medicaid, changes in PRICE require approval by CMS, key considerations by CMS related to the impact of changes include:
  - Recipient access to care
  - Comparability of rates for similar/deemed same services
  - Market rates for similar services
  - Provider cost in delivering service

- DHHS/DMA has staff dedicated and consultants engaged to support the current rate setting and oversight process.

Provider Payment Methodologies

North Carolina utilizes a variety of methodologies to reimburse providers for services.

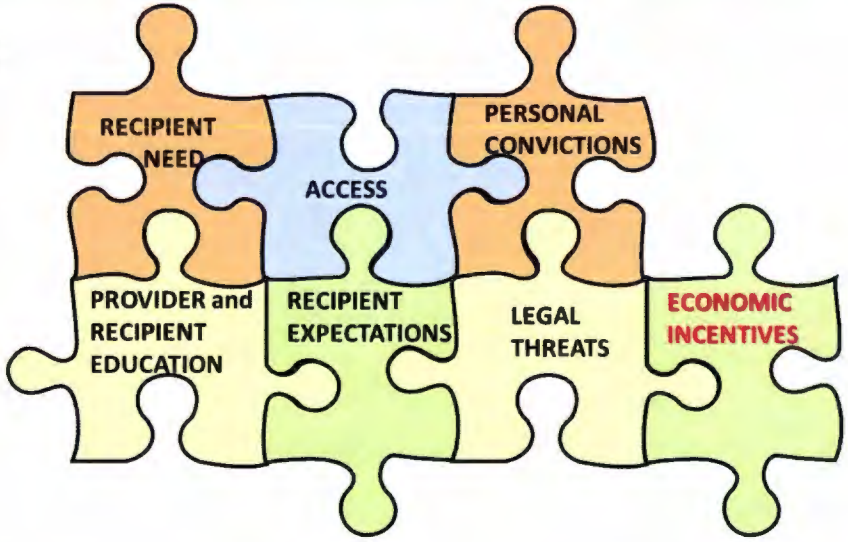
The methodologies in the chart cover the vast majority of providers where the payment is a single rate or amount.

Health Departments, Skilled Nursing, Physicians, Drugs, Behavioral Health and Hospitals which represent 64% of the total spending budget for claims in FY 2014-15, will be discussed in detail.

Method	*NC Providers Impacted*	*Payment Calculation*
Fee Schedule	Laboratory, Dental, Optical, Chiropractic, Podiatrist, Hearing Aids, DME, Therapies, Hospice	**Code * Rate = Payment**
Per Unit Rate	Personal Care Services, Home Health, Ambulance, Dispensing Fees	**Rate * Units = Payment** (Units can be items, hours, minutes, days, visits, encounters, procedures)
Cost	FQHC (or CMS Rate), Rural Health Centers, Health Departments, DMH	**Interim Rate * Billed Charges = Payment** (Additional payment as a settlement after cost report filed to equal cost less interim payments or cost based in the providers invoice)
Indexed Fee	Prescribed drug product	**Current: Brand-WAC by Drug * 1.027 = Payment** **Current: Generic-SMAC by Drug * 1.925 = Payment** **Effective 1/1/15-Average Acquisition Cost = Payment**
Case Rates	Ambulatory Surgery	**Procedure Code = Rate = Payment**
Premium	Medicare Parts A, B and D, HIPP plan	**Recipients Covered * Premium = Payment**
Per Member Per Month	CCNC, PACE and Medsolutions	**Recipients Covered * PMPM Rate = Payment**

Role of Payment Methodologies in Care Delivery

- "Decision Drivers" – it isn't just clinical; health care decisions are comprised of many factors or components, including:



- We start with the assumption that all people want to provide good care that helps people….do no harm…..
- However, payment and economics may provide incentives that may conflict with this premise
- Physical health services are predominately paid by Medicaid under a fee for service (FFS) model
- While Behavioral Health is paid by Medicaid under a capitated model, underlying providers are paid FFS

Fee for Service Payment Model

PRO's

- Emphasis on productivity – encourages delivery of care and maximizing visits.
- Relatively flexible and easily adaptable regardless of the size or organizational structure, type of service provided, place of service provision or geographic location of care.
- Easily understood by providers.
- Supports accountability for patient care processes.
- Reimburses provider for all services rendered

CON's

- Lacks incentives to deliver efficient care.
- Lacks incentives to prevent unnecessary care.
- Can be limited to face to face visits – which may impede activities such as care coordination and telemedicine.
- Economically rewards volume.
- Complexity makes it difficult for patients/recipients to understand billing .
- Because payment is generally limited to one provider for one interaction does little to encourage management of care across the continuum.

Source: Janet Silversmith, Health Policy Director, Minnesota Medical Association – www.minnesotamedicine.com/Past-Issues-2011/February-2011

NC Provider Payment Economic Incentives

Payment methodologies can create incentives that divert focus from outcomes

• Fee Schedule	• Complete coding of all services, volume of services or intensity of codes billable
• Per Unit Rate	• Volume or intensity of justifiable units
• Cost Reimbursement	• Allocation of cost to services with higher Medicaid utilization
• Indexed Fee	• Coding to highest level of service reimbursable, more services
• Case Rates	• Coding to highest level of service reimbursable, more cases
• Premium	• Ensure highest appropriate enrollment category
• Per Member Per Month	• Ensure highest appropriate enrollment category

Health Department Medicaid Payment Methodologies

- Like hospitals, Health Department receipts come from a variety of sources including State and Federal, Local, Grants, Medicaid (claims and settlements), Fees from individuals and commercial payers and Donations. The proportions vary from Health Dept. to Health Dept.
- Medicaid claims payments for service are based on the same fee schedule as any provider of that service.
- Health Departments also receive a unique payment that other providers don't; that is the federal share of the difference between the cost of providing Medicaid billable services and the Medicaid claims payment.

Skilled Nursing Payment Methodologies

- Skilled nursing facilities are paid a per diem rate - that ultimately is unique to each facility.
- The last rebasing of rates to cost occurred in 2009, using 2005 cost reports.
- There are 3 components to per diem rates – Direct Care, Indirect Service and Fair Rental Value

Skilled Nursing Payment Methodologies

- Direct Care

COVERS

- Reimburses the skilled nursing facility for 2 factors a) nursing & aide costs; historically subject to a CMI adjustment quarterly, which was frozen in the FY 2015 budget; & b) nursing supplies, food, activities, social services & ancillary services, which are not subject to CMI adjustment

BASIS FOR PAYMENT

- Base per diem the same for all facilities, CMI adjustment results in a unique rate for each skilled nursing facility.

Skilled Nursing Payment Methodologies

- Indirect Service
  - ***COVERS*** • Reimburses the skilled nursing facility for administration, laundry and linen, housekeeping, operation, maintenance of the plant and indirect cost of ancillary services
  - ***BASIS FOR PAYMENT*** • Same for all facilities; set at state-wide day weighted median rates
- Fair Rental Value
  - ***COVERS*** • Reimburses the skilled nursing facility for capital related costs for building, equipment and leases
  - ***BASIS FOR PAYMENT*** • Unique for each facility, supposed to be updated annually based on national construction cost index per the State Plan

Physician Payment Methodologies

- Physicians are paid based on a percentage of the Medicare fee schedule.
- Evaluation and management (E&M) codes are currently paid at an estimated 78% of Medicare and all other CPT codes are paid an estimated 84% of Medicare after 4/1/14.
- Some other provider fee schedules are a derivative of the physician fee schedule.
- UNC and ECU have a supplemental payment plan that provides an additional payment for the difference between the Medicaid rate and the average commercial rate. The state share of this annual payment is funded by UNC and ECU.

Drug and Dispensing Fee Payment Methodologies

- Pharmacies are paid for product cost based on national or state developed indices.
- Brand drug prices are based on the national wholesale acquisition cost (WAC) and generic prices are calculated by the state on the State Medicaid Average Cost (SMAC) list.
- Brand drugs are paid at 1.027 times WAC for non-specialty drugs and 1.01 times for specialty drugs and generics are paid at 150% of SMAC.
- These indices are updated monthly in the CSC system
- Pharmacies are also paid a dispensing fee based on the individual pharmacy's average generic dispensing percentage.

Drug and Dispensing Fee Payment Methodologies

- Why is there a difference in dispensing fees based on generic dispensing rates
- The product price is not the only consideration**

FY 2014-15 BUDGET		
BRAND DRUGS	$ 1,165	B
GENERIC DRUGS	$ 245	M
DISPENSING FEES	$ 112	M
DRUG REBATES	$ (616)	M

- The overall average generic drug is 17% of the overall average brand drug; therefore encouraging generics reduces cost to the State
- Medicaid receives rebates for drugs; generic rebate % is fixed; whereas the Brand rebate is set by CMS at a minimum %, with no cap.
- Additionally there is a supplemental rebate for NC

Rebates compiled, computed and collected quarterly

REAL EXAMPLE

	Medicaid Rate	Rebate Collected	Net Cost to NC
Brand Drug A	$ 283.22	-198.87	$ 84.35
Generic Equivalent	$ 189.41	-25.01	$ 164.40

QUESTIONS

LME/MCO's and Hospitals on March 24, 2015

Steve Owen – steve.owen@ncleg.net
919-733-4910

3% PHYSICIAN REDUCTION

- **Shared Savings Approved in FY 2013-14 Budget:**

Establishes a **3% withhold** on selective services **effective January 1, 2014**. Services subject to the withhold include inpatient hospital, physician (**excluding primary care physicians until January 1, 2015**), dental, optical services and supplies, podiatry, chiropractors, hearing aids, personal care services, nursing homes, adult care homes and drugs. DHHS will work with providers to develop a **shared savings plan that will be implemented by January 1, 2015 that will include incentives to provide effective and efficient care that results in positive outcomes for Medicaid recipients**. In FY 2013-14 the State share of the amount withheld will be $14.7 million. This represents a total impact of $41.9 million in provider payments, including both the State and federal shares. In FY 2014-15 the State share of the withhold will be $30.6 million, providers will be eligible for shared savings that are projected to total $8.9 million and the impact of the shared savings plan on expenditures is projected to be $15.1 million.

- **3% Withhold/Reduction – effective 1/1/14 all impacted providers, excluding primary care physicians, reduced by 3%. Primary care physicians ACA mandate delayed reduction until 1/1/15.**
- **Savings in State spending from more efficient or effective care and better outcomes to be shared with Providers. DHHS to develop mechanisms for sharing.**
- **Reduced rates to hospitals would result in some increase in assessments under the GAP plan which would result in an increase in the state retention amount.**

ACRONYMS AND DEFINITIONS

- **ACA** – Affordable Care Act:
- **CAP** – Community Alternative Program: waiver program approved by CMS as an alternative to FFS that is tasked with achieving specific objectives, such as avoiding institutionalization.
- **Capitation** – Single monthly payment for a comprehensive array of services, whether the organization assumes risks for utilization, price and consumption.
- **CCNC** – Community Care of North Carolina: 14 networks of primary care providers that at contracted with NCCCN (North Carolina Community Care Network) and Medicaid for care and case management services on a PMPM basis.
- **CMI** – Case mix index: a relative indicator of the complexity of services or resources required to provide services.
- **CMS** – Centers for Medicare and Medicaid Services: federal agency responsible for oversight and approval of Medicaid programs and practices.
- **CPE** – Certified public expenditures: State expenditure of funds by an agency outside of DMA where CMS allows that spending to count as the State share to draw federal funds under Medicaid.
- **CPT** – Current Procedural Terminology: universal listing of codes that describe health services provided by individuals. Codes include a relative value or weight that is used by NC Medicaid and other payers to determine payments to providers.
- **CSC** – Computer Sciences Corporation: organization that DHHS contracted with to develop and operate the Medicaid Management Information System.
- **DHHS** – Department of Health and Human Services: NC Department that oversees DMA.

- **DMA** – Division of Medical Assistance: entity responsible for the operation of the Medicaid program in NC.
- **DME** – Durable medical equipment: equipment and supplies billable to the Medicaid program.
- **DSH** – Disproportionate Share Hospital: federal allotment for uncompensated care payments to hospitals.
- **E&M** – Evaluation and Management Codes: billing codes used by NC Medicaid and other payers to define services provided as part of an office visit.
- **FFS** – Fee for service: basis for payment of most physical health services.
- **FQHC** – Federally Qualified Health Center: federal designation for an organization qualifying for enhanced reimbursement from Medicare and Medicaid. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors.
- **ICF-MR** – Intermediate Care Facility – Mental Retardation: NC facility that provides services if individuals with specific disabilities.
- **IGT** – Intergovernmental transfer: funds transfer between governmental units; that is allowed under CMS regulations.
- **GAP** – Hospital supplemental payment plan: defines methodology for calculating equity and upper payment limit payments to hospitals and the associated assessment to fund the State share.
- **GME** – Graduate Medical Education: payment made to teaching hospitals to cover the additional cost to the hospital or service provided in connection with medical education.
- **LME/MCO** – Local Management Entity/Managed Care Organization: NC organizations that contract with Medicaid for behavioral health services on a capitated basis.

- **MRI** – Medicaid Reimbursement Initiative: plan developed by NC and approved by CMS that defines how NC utilizes the federal DSH allotment and CPE's.
- **PACE** – Program of All Inclusive Care for the Elderly: alternative capitation payment model to FFS for individuals at risk for institutionalization in a skilled nursing facility. Objective is to avoid institutionalization.
- **PMPM** – Per member per month: calculation of the amount of spending per enrollee per month, or a payment that is based on the number of people enrolled rather than specific services provided.
- **SMAC** – State Medicaid Average Costs: NC developed and maintained index of the average cost of generic drugs which is used as a basis for generic drug pricing in NC.
- **WAC** – Wholesale acquisition costs: national index of the wholesale acquisition of cost of drugs. This index is used as a basis for pricing brand drugs in NC.

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 03/19/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Andy Ellen	NCRMP
Mike Caputo	NCOSA
Meghan Cook	OITS
John McMillan	DFHS
Julia Adams Schenck	ASWC, NWRC, ARC
Rob Lamme	RLA
Chip Byrd	NCMS
[illegible]	CSS
DAVID BARNES	Electricities
Michael Houser	THCG

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 03/19/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lexi Morgan	NCRMA
TJ Bugbee	NP
[illegible]	[illegible]
Amanda Horaker	Troutman Sanders
Rhian merwald	WM
Bill Rus[illegible]	[illegible]
Josh Ehrich	IAA
Austin Pruitt	Perkinson
[illegible]	[illegible]
Kristen Laster	SSGNC
Lori Kroll	Novant Health

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 03/19/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
NATHAN LOVELAND	UNC HOSPITALS 101 MANNING DR CHAPEL HILL
Lauren Coffey	Gov office Policy
Pam Kilpatrick	OSBM
JOE LANIER	CARDINAL INNOVATIONS
Mary Bethea	AARP - NC
Ed Shuler	GF
Erica Nelson	NCHA
Chris McClure	Brooks Pierce
Jennifer Gasperini	NCMS
J Peters	CSS
Judy Jenkins	DMPI

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — Name of Committee

03/19/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
KYLE CHERMAK	REP. FORD - NC GA
Madeline Keeter	CaroMont Health
Carson Weiss	NVA

JOINT Committee on Appropriations, Health and Human Services
Wednesday, March 25, 2015 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Joint Committee on Appropriations, Health and Human Services met at 8:30 AM on March 25, 2015 in Room 643 of the Legislative Office Building. Representatives Avila, Dobson, Malone, Insko, Pendleton, Earle, Hunter attended. Senators Hise, Pate, Tucker, Barringer, McKissick, Robinson, Van Duyn and Wells attended.

Representative William Brisson presided.

Sergeants of Arms were Young Bae, Bill Morris, Jim Moran, Steve McKaig, Larry Hancock.
Pages from the Senate were Cassie Phillips, Paige Peterson, Grace Woods,Ashlynn Worthington.
Pages from the House were Morgan Hinton, Dion Hodges, Christian Judkins, Nia Judkins.

Chairman Brisson called the meeting to order at 8:36 a.m.

Steve Owens, Fiscal Research Division, followed up on his presentation from the meeting on March 24, 2015. He took questions from members. He then presented the second part of his presentation on the Overview of Medicaid Provider Payments. (See attached Exhibit 1)
Susan Jacobs, Fiscal Research Division, presented a draft of options for the committee to consider. (See attached Exhibit 2)

Chairman Brisson adjourned the meeting at 9:50 a.m.

Representative Brisson, Presiding

Susan Lewis, Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

March 25, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Representative William Brisson, Presiding Co-Chair
II.	**Overview of Medicaid Provider Payments (Part II)**	Steve Owen, Fiscal Research Division
III.	**Draft Options for Committee Consideration**	Susan Jacobs, Fiscal Research Division
	Committee Discussion	
	Adjourn	

Health and Human Services
Joint Legislative Oversight Committee

Overview of
Medicaid Provider Payments

Steve Owen,
Fiscal Research Division

March 24, 2015

Exhibit 1

FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Medicaid Payment Primer

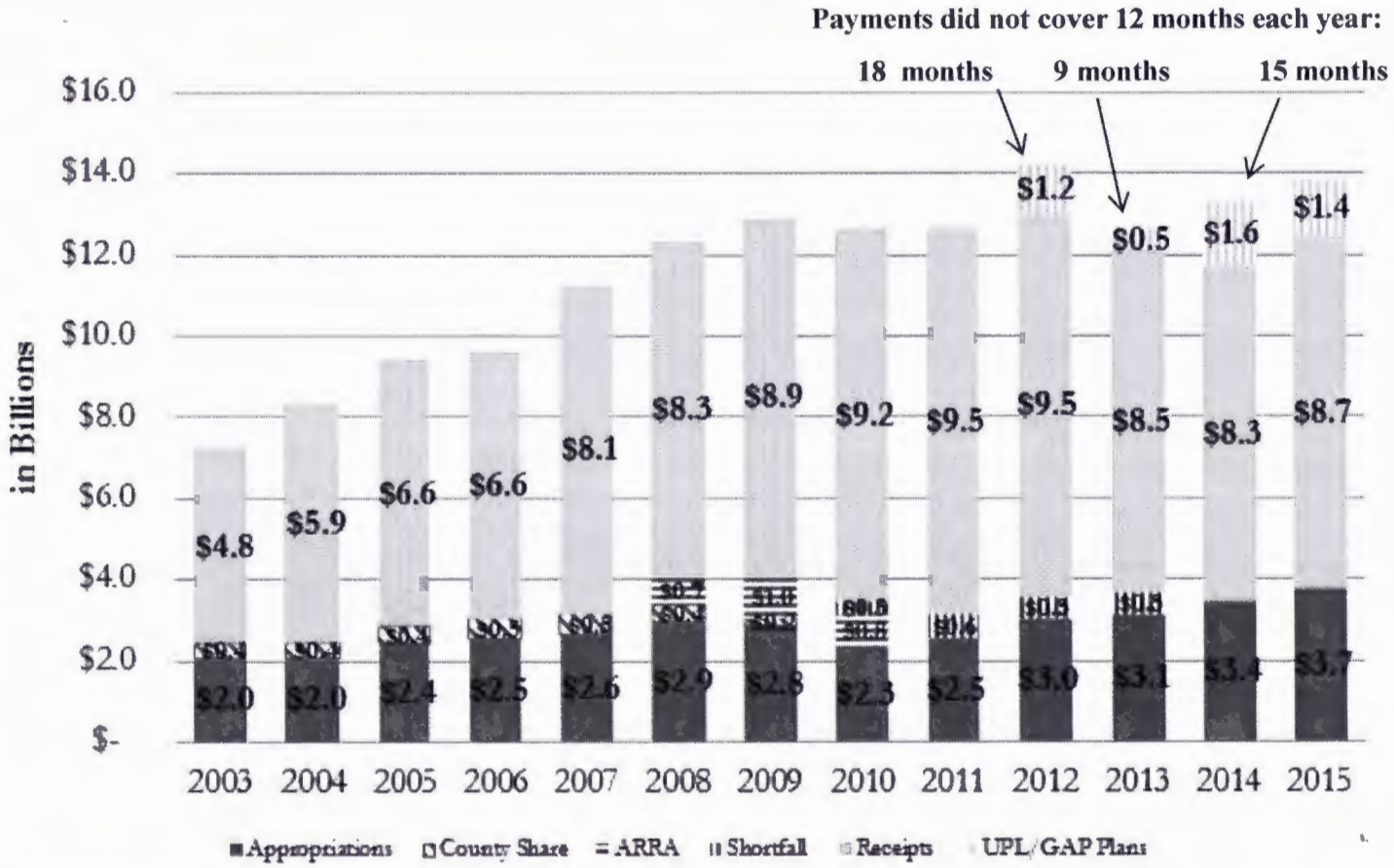
- *Basics of Medicaid Payment and Drivers*
- *Provider Payment Methodologies and Economic Incentives*
- *Health Department Payment Methodology*
- *Skilled Nursing Payment Methodology*
- *Physician Payment Methodology*
- *Drug and Dispensing Fee Methodology*

Presentation on 3/19/15

- *LME/MCO Payment Methodology*
- *Hospital Payment Methodologies*

Medicaid Spending Trends

Chart reflects total net Medicaid spending including claims, administration, contracts, settlements, program integrity, transfers and other spending



SFY 2014-15 FRD budget does not include the $186 M contingency reserve

Source: NC Office of the State Controller and NCAS BD701 and FRD estimate for SFY 2014-15

Medicaid Payment Primer

- What this is not
  - Presentation of provider payment adequacy
  - Presentation of equitability of provider payments
  - History or discussion of provider payment policies
  - Spending Analysis
- This is intended to be
  - Educational presentation on the methodologies used to pay providers for Medicaid services

Basics of Medicaid Payment and Drivers

- Medicaid Spending Equation =

Enrollment * Utilization * Mix * PRICE * Benefits

- PRICE/Medicaid payments to providers can be comprised of a complex set of methodologies, formulas and processes that have evolved through the years based on federal government practice (Medicare), market forces and North Carolina's need to manage spending on the Medicaid program.

- Like nearly all changes to Medicaid, changes in PRICE require approval by CMS, key considerations by CMS related to the impact of changes include:
  - Recipient access to care
  - Comparability of rates for similar/deemed same services
  - Market rates for similar services
  - Provider cost in delivering service

- DHHS/DMA has staff dedicated and consultants engaged to support the current rate setting and oversight process.

LME/MCO Payment Methodologies

- The LME/MCO's contract with DMA for an array of behavioral health services on a capitated basis.
- The capitation rates were originally actuarially established based on historical spending, with an adjustment for trending factors and anticipated lower costs related to utilization management.
- LME/MCO rates include a 2% add-on payment until organizations reserves at a contracted level
- The LME/MCO contract covers services previously paid as FFS that include hospital services (inpatient, outpatient and emergency), physician and non-physician services, CAP services and ICF-MR.
- CMS approves a rate range; DMA must negotiate with the LME/MCO within that approved range.
- One significant exclusion in the calculation of the rates has been drugs, which remain a FFS payment by DMA.

LME/MCO Payment Methodologies

- Future updates to the PMPM or capitated rates should be actuarially based on actual claims experience by the LME/MCO.
- The positive side of this is that the State can realize the benefit of utilization improvements beyond actuarial expectations, the downside is that the state could reclaim all gains, leaving the LME/MCO with the only option to maintain or enhance profits being further reduction in utilization or rates paid to providers.
- An additional concern is that continually relying on historical expenditures as a basis for negotiating rates, may result the only alternative for providers to remain financially viable is to cut needed services.

Hospital Payment Methodologies

- Hospital payments are the most complex of all provider groups, their methodologies include claims payments, cost settlements, uncompensated care, supplemental payments for allowable cost, equity and inpatient upper payment limits (MRI and GAP Plans).

- Hospital payments are funded by federal receipts, provider funding (intergovernmental transfers and assessments) and State appropriations. The State also benefits from an "add on" retention percentage of 28.85% of all assessments paid by hospitals.

- When all payments are considered Hospitals receive 100% of cost outpatient/emergency services and the equivalent of Medicare rates for inpatient services. Understanding the funding for each component is important in understanding the net impact of payments to hospitals – hospitals fund the state share of most supplemental payments above claims.

Hospital Payment Methodologies

DSH Specific Limit = Medicaid Costs + Uninsured Costs

INPATIENT

		100% Medicaid Costs			Unins	Medicare Rates
Public	Federal	Claims - CMS FMAP	MRI Enhanced Payments		DSH	GAP UPL - CMS
	State Share	State Appropriation	Public Hospital IGT		Pub Hosp CPE	Hospital Assessment + State Retention
Non - Public	Federal	Claims - CMS FMAP	MRI Enh Pmts	GAP Equity - CMS FMAP	DSH	GAP UPL - CMS FMAP
	State Share	State Appropriation	Public Hospital CPE	Hospital Assessment + State Retention	Pub Hosp CPE	Hospital Assessment + State Retention
UNC	Federal	Claims - CMS FMAP	Settlement - CMS FMAP		DSH	UNC UPL - CMS
	State Share	State Appropriation	State Appropriation		State Approp	Hospital IGT
ECU	Federal	Claims - CMS FMAP	Settlement - CMS FMAP		DSH	GAP UPL - CMS
	State Share	State Appropriation	State Appropriation		State Approp	Other Hospital Assessment + State Retention
Critical Access	Federal	Claims - CMS FMAP	Settlement - CMS FMAP		DSH	GAP UPL - CMS
	State Share	State Appropriation	State Appropriation		State Approp	Other Hospital Assessment + State Retention

OUTPATIENT

Public	Federal	Claims and Settlement - CMS FMAP	MRI Enhanced Pmts		DSH
	State Share	State Appropriation	Public Hospital IGT		Pub Hosp CPE
Non - Public	Federal	Claims and Settlement - CMS FMAP	MRI Enh	GAP Equity - CMS	DSH
	State Share	State Appropriation	Public Hospital CPE	Hospital Assessment + State Retention	Pub Hosp CPE
UNC	Federal	Claims and Settlement - CMS FMAP	MRI Enhanced Pmts		DSH
	State Share	State Appropriation	Public Hospital IGT		State Approp
ECU	Federal	Claims and Settlement - CMS FMAP	MRI Enhanced Pmts		DSH
	State Share	State Appropriation	Public Hospital IGT		State Approp
Critical Access	Federal	Claims - CMS FMAP	Settlement - CMS FMAP		DSH
	State Share	State Appropriation	State Appropriation		State Approp

FUNDING FOR HOSPITAL PAYMENTS THROUGH MEDICAID

Federal Share Sources

- Traditional federal match at the annually approved rate
- MRI plan enhanced payments, state share funded from public hospital IGT

State Share Sources

- Annual state share of spending appropriated through the budget
- Intergovernmental Transfers (IGT) to fund the state share of supplemental DSH payments
- ECU Certified Public Expenditures (CPE) used to fund the state share of DSH payments
- Assessments on hospitals to fund the state share of GAP plan equity and UPL payments
- Assessment on other hospitals used to fund the state share of GAP plan payments to specific hospitals

NOTES

1) Hospital assessments equal the state share required to match the federal portion of the payment plus the state retention percentage appproved by the General Assembly
2) The relative size of the bars in the table are not a precise measure of the relative size of the payments as they change from year to year based on changes in Medicaid rates and policy, changes in Medicare rates, changes in hospital cost and CMS policy changes.

KEY DEFINITIONS:

1) **Public Hospital or Qualified Public Hospital (QPH) is a North Carolina designation that relates to the county involvement in governance and the ability to use intergovernmental transfers to move funds to the state.**
2) **MRI Plan – a plan approved by CMS that defines how the federal DSH allotment and supplemental enhanced payments are paid to hospitals.**
3) **Hospital GAP Plan – a plan approved by CMS and General Assembly that defines the methodology for payment of supplemental equity and upper payment limit amounts to hospitals, and related funding.**
4) **Critical Access Hospital – CMS designation for certain small rural hospitals meeting criteria that allows additional funding for services as a "safety net" hospital.**
5) **Medicaid Costs – annual report completed by each hospital that calculates the total costs of providing services to Medicaid patients.**
6) **Medicare Rates – amount that Medicare would have paid for inpatient services based on the Medicaid DRG times the Medicare DRG rate.**
7) **Certified Public Expenditures (CPE) - amounts that CMS allows in limited situations to count as state share in drawing federal funds.**

Hospital Payment Methodologies – Outpatient/Emergency Services

Definition – outpatient includes all diagnostic and treatment services for which an overnight stay at the hospital is not required. Emergency services include those services rendered in the hospital emergency room to a patient not admitted to the inpatient units as part of that visit to the hospital

Payment	Method	Funding
• Claims ***Paid weekly as claims are billed to CSC***	• Effective 7/1/14 all hospitals are paid an interim payment of 70% of estimated cost based on the billed charges.	• NC funds the state share
• Settlements ***Paid annually following submission of a cost report by each hospital***	• Annually, based on the hospital's cost report, the hospitals receive or pay back the difference in the claims payment and 70% of actual cost.	• NC funds the state share

Hospital Payment Methodologies – Outpatient/Emergency Services

Payment	Method	Funding
• MRI- Enhanced Payments ***Paid quarterly***	• Qualified Public hospitals are paid the difference between the claim plus settlement and 100% of costs. Non-QPH hospitals receive a portion of the difference in claim plus settlements and 100% of costs.	• QPH hospitals IGT the state share of supplemental payments for public hospitals; CPE's fund non-QPH payments
• Equity Payments ***Paid quarterly***	• Non-QPH hospitals receive the difference between the claims plus settlement plus the enhanced payment and 100% of costs as a supplemental payment.	• Non-QPH hospitals fund the state share through an assessment plus 28.85% for state retention

Hospital Payment Methodologies – Inpatient Services

Definition – inpatient services reflect those services provided by a hospital as part of an admission to the inpatient facilities, generally an overnight stay in a hospital inpatient bed.

Payment	*Method*	*Funding*
• Claims ***Paid weekly when claims are billed to CSC***	• There are 740 diagnostic related groups (DRG's) that NC uses that reflect the service provided on inpatient basis in hospitals. Each DRG has a weight that reflects the relative cost/complexity or intensity of services provided. These weights are multiplied by a "base rate" to determine the amount of the payment. • Hospitals can receive an additional claim payment if the patient stay exceeds standards or costs are outside a specified standard deviation of costs	• NC funds the state share

Hospital Payment Methodologies – Inpatient Services

Payment	***Method***	***Funding***
• Settlement ***Paid annually following submission of cost report***	• UNC and Vidant Medical Center (ECU) receive an annual payment equal to the difference in the DRG payment and 100% of Medicaid costs for inpatient services	• NC funds the state share
• MRI - Enhanced Payments ***Paid quarterly***	• Qualified Public hospitals are paid the difference between the DRG and 100% of costs. Non-QPH hospitals receive a portion of the difference in DRG and 100% of costs.	• QPH hospitals IGT the state share of supplemental payments for public hospitals; CPE's fund non-QPH payments

Hospital Payment Methodologies – Inpatient Services

Payment	*Method*	*Funding*
• Equity Payments ***Paid quarterly***	• Non-QPH hospitals receive the difference between the DRG plus the enhanced payment and 100% of costs as a supplemental payment.	• Non-QPH hospitals fund the state share through an assessment plus 28.85% for state retention
• UPL Payments ***Paid quarterly***	• All hospitals except UNC receive a supplemental payment equivalent to the difference between the DRG plus enhanced payments plus equity payments and Medicare rates. • UNC has their own UPL plan	• Hospitals fund the state share through an assessment plus 28.85% for state retention • UNC IGT's the state share of payments

DSH Specific Limit must be considered for both inpatient and outpatient payments

This presentation highlights that North Carolina Medicaid payment system currently focuses more on how much is paid and who is paid than rather than the outcomes achieved. Can the current Medicaid payment system support an outcomes based program?

QUESTIONS

Steve Owen – steve.owen@ncleg.net
919-733-4910

Appropriations Committee on Health and Human Services

Draft Options for Committee Consideration

Session Goal: Shifting from "*Paying*" to "*Investing*"

Key Question: Does the Committee want to invest in evidence-based programs that will result in better birth outcomes and healthier children? If yes, then *how*?

Two major strategies for the FY 2015-17 Biennium are proposed for your consideration.

1 - Business Strategy: Increasing the Department's capacity to strategically build, evaluate and fund outcome-based programs. Improving this function within DHHS should ultimately result in a better base budget.

- Develop Planning and Evaluation Capacity within DHHS

  - Evaluating performance of agency programs.
  - Establishing standards and evaluation tools necessary to effectively implement pilot projects.
  - Designing a strategic plan for DHHS, and designing/implementing reorganizational plan.
  - Creating and maintaining an accessible inventory of all DHHS programs.
  - Working with DHHS agencies to assure that every program is focused on achieving outcomes.
  - Establishing a formal relationship with the School of Government? Leverage the expertise we have in our University System?

- Improve Contract Development and Administration

  - Developing, administering and monitoring contracts.
  - Assuring that all health-related contracts are outcome-based. Are the payment structures in the current contracts for primary care case management and mental health services based on achieving required health outcomes?

- Expand budget, accounting and forecasting capacity within DHHS

  - Developing and monitoring the agency budgets.
  - Providing technical assistance to DHHS agencies.
  - Analyzing the fiscal impact of proposed legislation.
  - Forecasting.

Key Question: Does the Committee want to invest in evidence-based programs that will result in better birth outcomes and healthier children? If YES, then *where* will the money come from?

2 - Policy Strategy: Investing in evidence-based programs specifically focused on improving the health and wellbeing of young children.

- New Resources (Federal/State/Local or a Combination)

  - ☐ Medicaid Provider Assessments

    - Increase existing assessments (NR)
    - Development new assessments (Physicians, other groups)
    - Reform payment policies to allow UPL plans that can be funded by providers with a state retention.

  - ☐ Require or incentivize increased local participation and accountability?

Exhibit 2

- Reallocation of Resources

    - Medicaid Payment Reform Options – None of the existing payments are based on outcomes.
    - Redesign the Federal Disproportionate Share for Hospitals/Medicaid Reimbursement Initiative plan.
    - LME/MCO 2% Risk Reserve – target funds for critical mental health programs for children or adults.
    - Elimination of state funds for other non-evidence based programs.
    - Tobacco Settlement funds?
    - Renegotiate existing contracts.
    - Budget overrealized receipts for prevention. (NR)

Committee Direction to Staff?

3% Physician Rate Reduction and Retroactive Recoupments

Facts:

1) FY 2013-14 budget was approved with a reduction item entitled "Shared Savings Plan" (Item 76 page G-14) that identified specific providers that would be included in the plan.
2) The shared savings plan had two components:
    a. 3% Withhold or reduction to identified provider's rates effective 1/1/14, with the exception of primary care physicians who were exempted until 1/1/15 as a result of ACA mandates to pay them 100% of Medicare rates until that date.
    b. Shared savings payments to providers to be implemented by 1/1/15, based on a plan collaboratively developed by the Department and providers that created incentives for effective and efficient care that results in positive outcomes for Medicaid recipients. 3% reduction was not intended to fund shared savings payments.
3) FY 2014-15 eliminated the shared savings payments to providers based on the Department's position that it could not identify initiatives under this plan. The 3% withhold/reduction was preserved.

DHHS Actions:

1) Communicated with providers on 3% reduction and effective dates in December 2013, January, September, October and November 2014.
2) State Plan Amendment (SPA) prepared to implement the 3% reduction in rates effective 1/1/14 for all identified providers, with the exception of primary care physicians, whose effective date was 1/1/15. **CMS approved the SPA in June 2014.**
3) All indentified provider's rates, with the exception of physicians, were reduced in FY 2013-14 effective 1/1/14.
4) Implemented a prospective 3% reduction for all physician rates on March 2, 2015 and communicated that the amounts paid above the CMS approved rates would be recouped at some time in the future. For non-primary care physicians monies would be recouped back to 1/1/14 and for primary care physicians back to 1/1/15.

Options:

A	Maintain rate reduction and recover amounts paid above CMS approved rates	*DHHS develop and implement recoupment plan*
B	Maintain rate reduction prospectively and do not retroactively recover amounts paid above CMS approved rates	*1 – DHHS repay federal share of amounts paid above CMS approved rate* *2 – File new SPA with retroactive date - unlikely*
C	Repeal rate reduction prospectively and recover amounts paid above CMS rates	*DHHS file SPA for new rate and develop and implement recoupment plan*
D	Repeal rate reduction prospectively and do not retroactively recover amounts paid above CMS approved rates	*DHHS file SPA for new rate and repay federal share of amounts paid above CMS approved rates or include retroactive effective date, which is unlikely*

Consideration: Implication for 3% reduction already implemented for other providers.

ATTENDANCE

Committee: Appropriations Subcommittee on Health and Human Services

DATES NAMES - **HOUSE**	~~3/3~~ 3/25	3/5	3/6	3/10	3/11	3/12	3/17	3/18	3/19	3/24
Co-Chair Marilyn Avila	✓									
Co-Chair William Brisson	✓									
Co-Chair Josh Dobson	✓									
Co-Chair Chris Malone	✓									
Vice-Chair Jean Farmer-Butterfield										
Vice-Chair Verla Insko	✓									
Vice-Chair Gary Pendleton	✓									
House Committee Members										
Rep. Beverly Earle	✓									
Rep. Howard Hunter	✓									
SENATE										
Co-Chair Ralph Hise	✓									
Co-Chair Louis Pate	✓									
Co-Chair Tommy Tucker	✓									
Senate Committee Members										
Sen. Tamara Barringer	✓									
Sen. Floyd McKissick	✓									
Sen. Gladys Robinson	✓									
Sen. Bob Rucho										
Sen. Terry Van Duyn	✓									
Sen. Andy Wells	✓									
Committee Clerk										

Committee Sergeants at Arms

NAME OF COMMITTEE Jt. Comm. on App. HHS

DATE: 03/25/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name: Steve McKaig
2. Name: Larry Hancock
3. Name:
4. Name:
5. Name:

SENATE PAGES ATTENDING

COMMITTEE: Joint Approps- Health & Human Services **ROOM:** 643 LOB

DATE: 3-25 **TIME:** 8:30

PLEASE PRINT LEGIBILY!!!!!!!!!!!!!....*or else!*

Page Name	Hometown	Sponsoring Senator
1. Cassi Phillips	Spruce Pine	Hise
2. Paige Peterson	Spruce Pine	Hise
3. Grace Ward	Fuquay Varina	Barefoot
4. Ashlynn Worthington	Cary	J. Davis
5.		
6.		
7.		
8.		
9.		
10.		

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

Wednesday, March 25
APPROPRIATIONS
HEALTH & HUMAN
SERVICES (JOINT)

Room
643

Time
8:30 am

Name	County	Sponsor
Morgan Hinton	Wake	Susi H. Hamilton
Dion Hodge	Wake	Yvonne Lewis Holley
Christian Judkins	Wake	Yvonne Lewis Holley
Nia Judkins	Wake	Yvonne Lewis Holley

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Alexis Staton	NC State - Social Work
Lee Kryzenowski	NC State - Social Work
Chichi McAllister	NC state — Social work
Jaimika Paul	NC State University - Social Work
Teyara Hudson	NC state university - social work
Erin Frey	AstraZeneca
Matt Gross	NCR
Ed Sinclair	BJP
Tom VITAGLIONE	NC CHILD
Laura White	DHHS
Kuian Mewald	WM

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Judy Jenkins	OAPI
Kristin Gordon	Perkinson Law Firm
Dodie Renfer	Consler Collaborative Resolutions
NICHOLLE KARIM	NAMI NC
Emily VanderSchaaf	UNC Pediatrics
Jonathan Kotch	Health Care for All NC
Rita Kuwahara	Health Care for All NC
Neal Kitzy	UNC Pediatrics
BILL SHENTON	PO / NEW SPAVILL
Bill Croft	NC Resp Care Board
JOHN COOPER	Cap. Tal City Strategies

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Laura Saye	NC State Uni - Social Work
Lauren Coffey	Policy Gov's office
Sarah Grimsrud	OSBM
Pam Kilpatrick	OSBM

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rob Hardi	MTJS
John DelGrosso	Brubaker Assoc.
Lori Kroll	Novant Health
Lanier Hodgson	UNC Health
MARK PARFITT	UNC HEALTH
Cory Hood	NCHA
Austin Pruitt	Perkinson
Caroline Twiggs	Mars Hill University
TORRI Bryant	Self
Kelly Goodfellow	Alliance Behavioral Healthcare
Ann Rodriguez	NC Council of Community Programs

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jake Elder	JDA
Chris McClure	Brooks Pierce
Fred Boone	Boone & Assoc.
Miriam Schwarz	WCMS
Diane Hankes	AllCare Anesthesia
Robt. C. Henderson MD	Robt C Henderson MD PLLC
Kristen Page	UNC Health Care
Dolly Penn	UNC Health
TJ Boybee	NP
Martha A McConnell	Carolinas HealthCare
Joanne Spruill	NCAPP

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Allison Stewart	cardinal Innovations
Daniel VanLiere	Vidant Health
Lexi Morgan	NCR MA
Joyce Peters	CSS
Scott Laster	SSG NC
Amanda Horaker	Tradmor Sentel
Alan Briggs	NC Food Banks
Chip Bell	NCMS

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 03/25/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Phillip Holt	NCIFA
Cory Brown	DRNC
Lisa Baker	NCOHA
Vicky Wesner	CCCC
J Peters	CSS

Joint Appropriations Committee on Health and Human Services
Tuesday, March 31, 2015 at 8:30 am
Legislative Office Building - Room 643

MINUTES

The Joint Appropriations Committee on Health and Human Services met at 8:30 am on March 31 2015 in room 643 of the Legislative Office Building. Representatives Marilyn Avila, William Brisson, Josh Dobson, Chris Malone, Jean Farmer-Butterfield, Verla Insko and Gary Pendleton, were present along with eight Senate members.

Senator Tucker presided.

Senator Tucker opened the meeting by welcoming everyone and recognizing the House Sergeant-at-Arms - Bill Morris, Jim Moran and Joe Crook - and the Senate Sergeant-at-Arms - Canton Lewis and Marcus Kitts. He also recognized the pages in attendance. For the Senate were Martha Bland of Cumberland County (sponsored by Sen. Meredith), Adelle Patten of Cabarrus County (sponsored by Sen. Berger), Hannah Patten of Cabarrus County (sponsored by Sen. Hartsell), Elijah Ellison of Durham County (sponsored by Sen. Woodard) and Nathan Oakley of Durham County (sponsored by Sen. Woodard).

Senator Tucker then introduced Steve Owen with the Fiscal Research Division who made a presentation on maternity and Medicaid. Questions and comments followed by Representatives Avila, Insko, Pendleton and Malone and Senators Hise, Tucker, McKissick, Robinson and Barringer

The meeting adjourned at 9:35 am.

Senator Tommy Tucker
Presiding

Joey Stansbury
Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

March 31, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Senator Tommy Tucker, Presiding Co-Chair
II.	**Mothers, Babies and Medicaid**	Steve Owen, Fiscal Research Division
	Committee Discussion	
	Adjourn	

Joint Legislative Program Evaluation Oversight Committee

Mothers, Babies and Medicaid

Steve Owen,
Fiscal Research Division

March 26, 2015

Trends and Analysis of Mothers and Babies

This will primarily be a data presentation

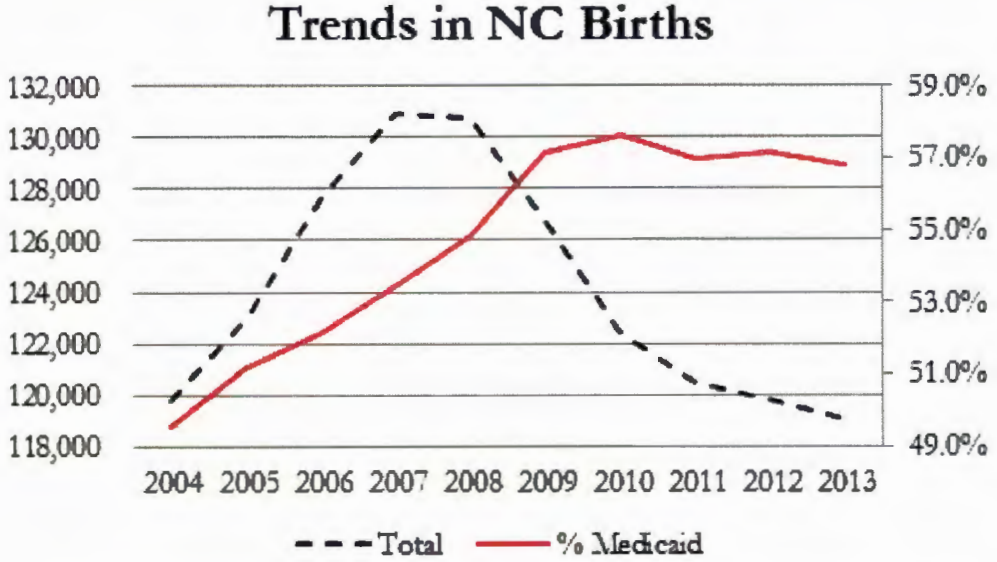
DISCUSSION GUIDE

- Comparative Trends in Births
- Trends in C-Section Rates
- Trends in Infant Birth Weights
- Trends in Spending
- Observations and Next Step

There will be more questions raised than answered

Trends in NC Births

- Percentage of births covered by Medicaid increased from about 50% in 2004 to about 57% in 2010, and continues at 57% of total births through 2013

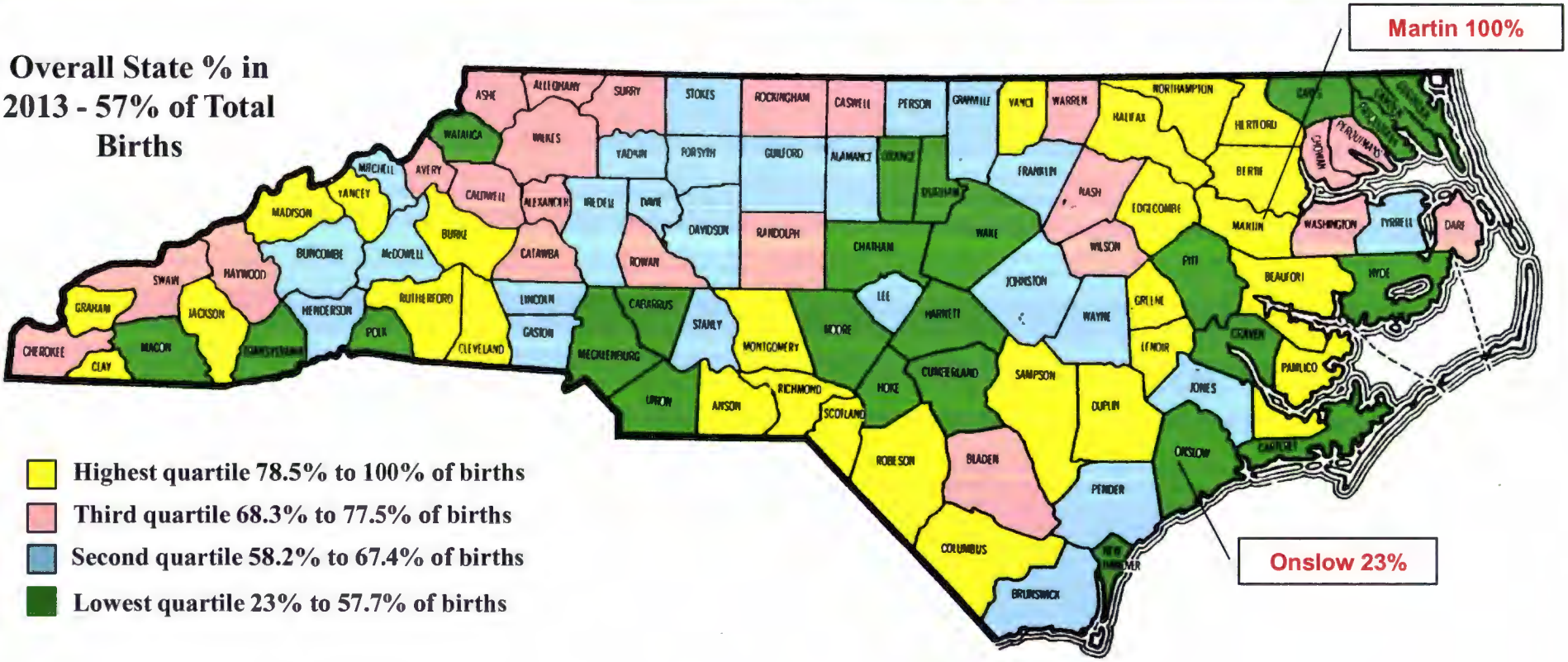


- The growth in the Medicaid percentage of total births is function Medicaid births growing at a rate faster than non-Medicaid births through 2010, then declining at a slower rate through 2013

Source: DHHS Data Warehouses and NC Birth Certificate Data

Medicaid % of NC Births

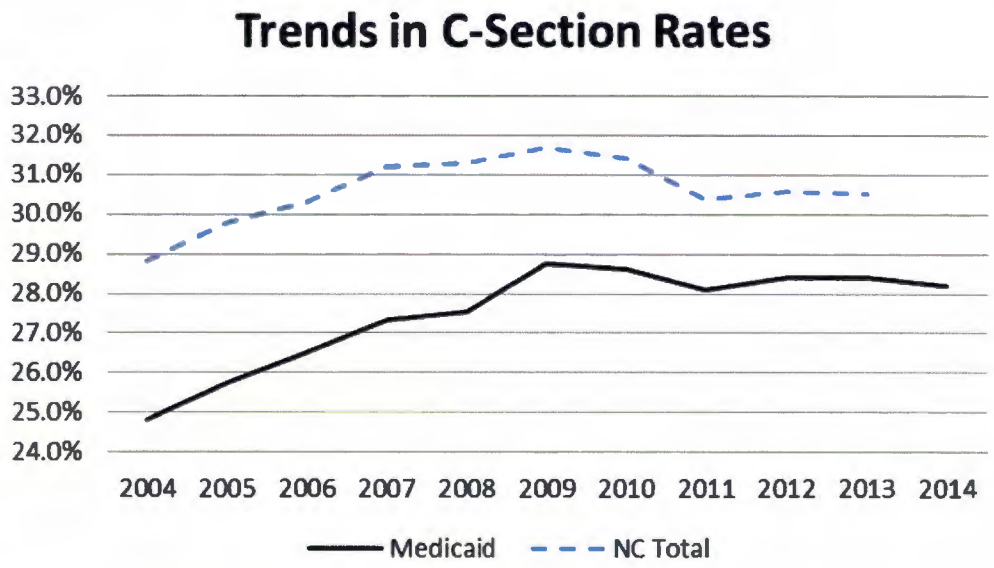
Overall State % in 2013 - 57% of Total Births



Source: DHHS Data Warehouses and NC Birth Certificate Data

Trends in Medicaid C-Section Rate

- Medicaid C-Section rates in NC lower than the rates for the general population
- Medicaid C-Section rates primary driver of State rates because the majority of births paid for by Medicaid

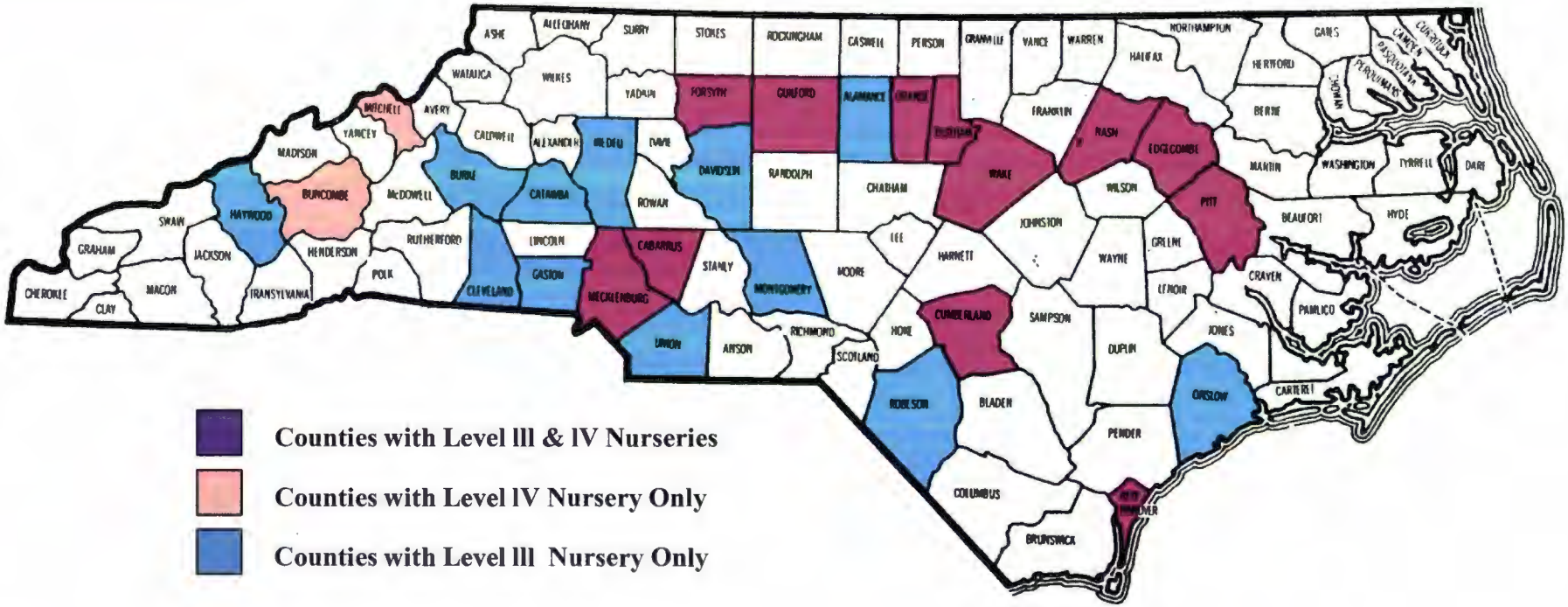


Source: DHHS Data Warehouses and NC Birth Certificate Data

One Unanswered Question:

Data shows a positive trend in recent year's C-section rates…data not available to demonstrate absolutely what among programs implemented within and external to Medicaid has impacted this rate?

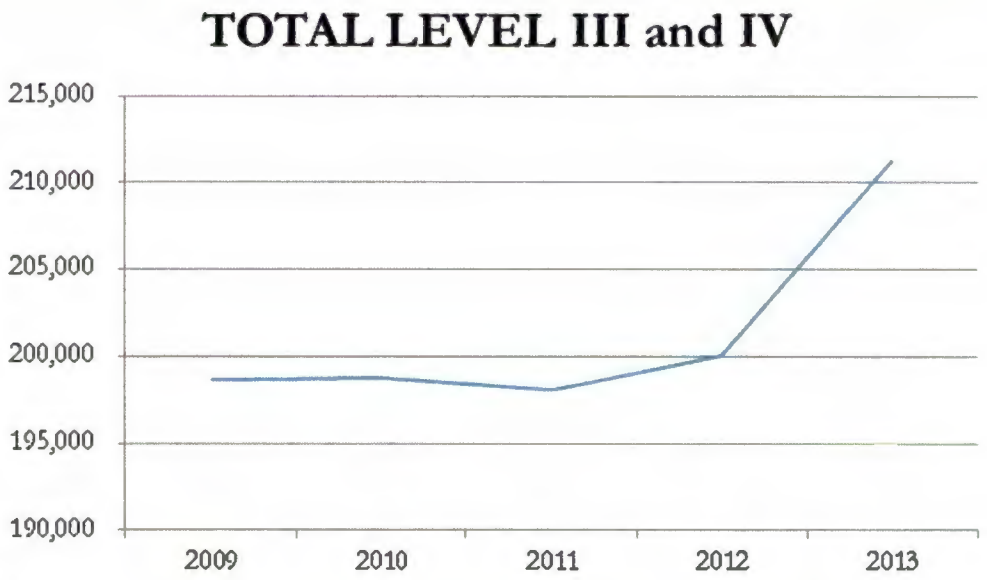
Locations of Higher Levels of Care for Newborns



Source: DHHS Division of Health Services Regulation

Trends in Days Reported for Higher Levels of Care for Newborns

- Level III and IV are the highest level of hospital care offered to newborns in NC
- Days consistently reported by hospitals began to increase in 2012 for all babies

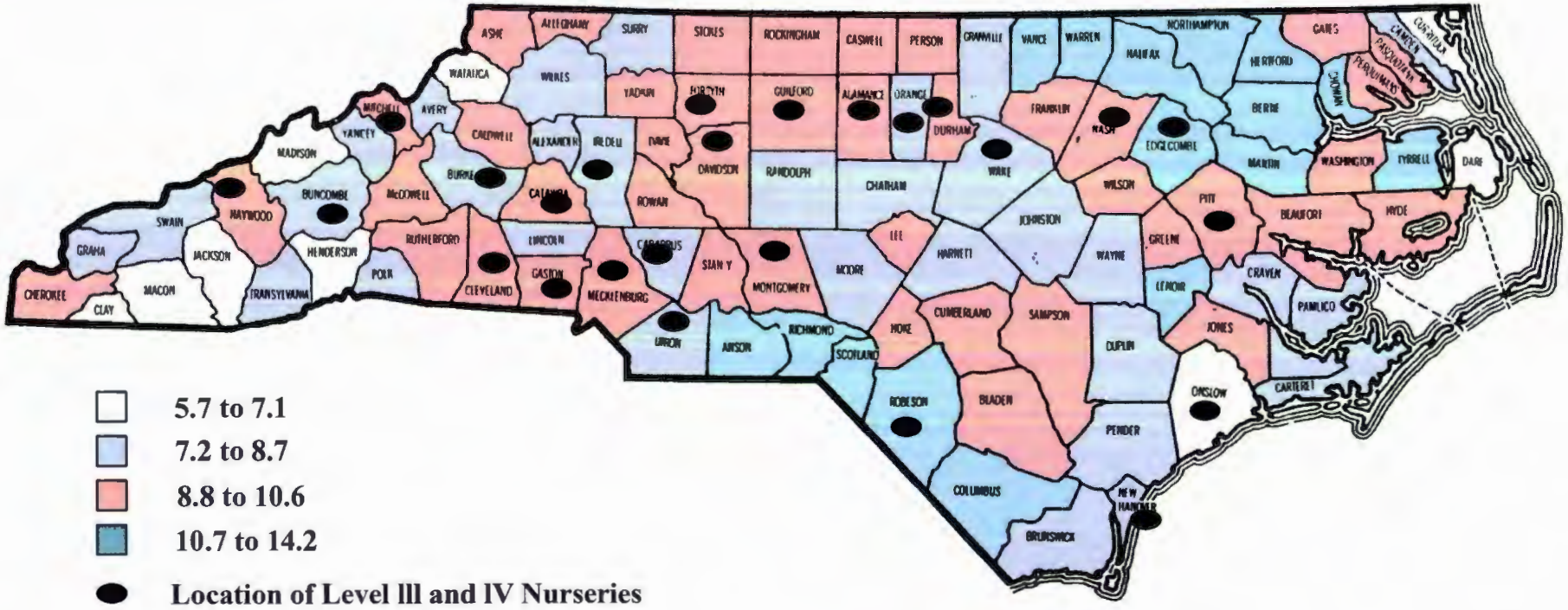


One Unanswered Question:

With improvement in birth weights what is causing increase in Level III and IV days, how much is longer lengths of stay versus increased admissions – why?

Source: DHHS Health Services Regulation

Medicaid Low Birth Weights/1,000 Births

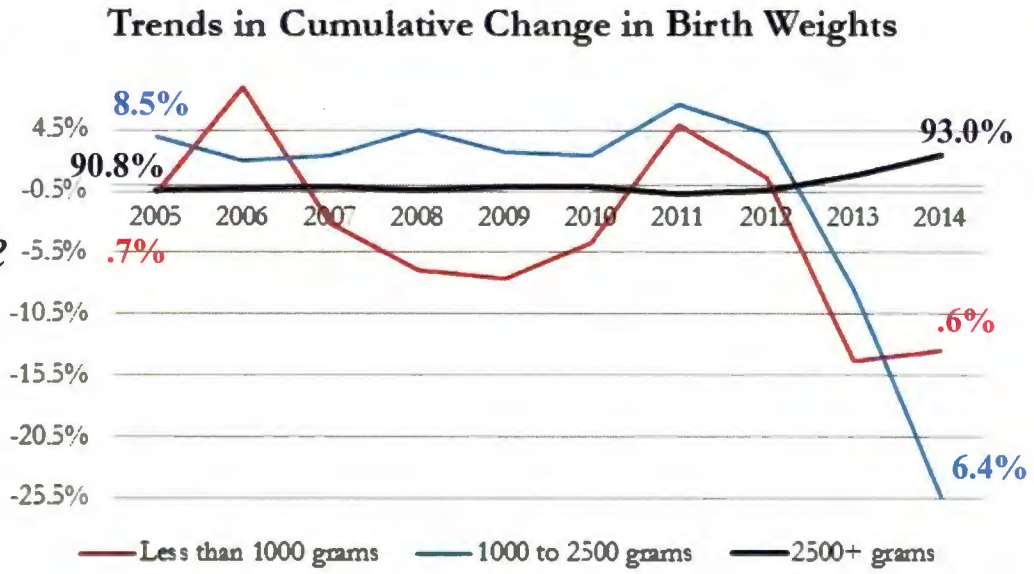


Source: DHHS Division of Health Services Regulation and UNC School of Public Health
Presentations at HHS Appropriations

Trends in Medicaid Infant Birth Weights

- *Birth weights one indicator of infant health*
- *Should be a key determinate in Medicaid spending for children*

	FY 2013-14
Less Than 500 Grams	$ 39,723
500 to 749 Grams	$ 129,632
750 to 999 Grams	$ 123,156
1000 to 1499 Grams	$ 72,550
1500 to 2499 Grams	$ 19,575
2500+ Grams	$ 5,550



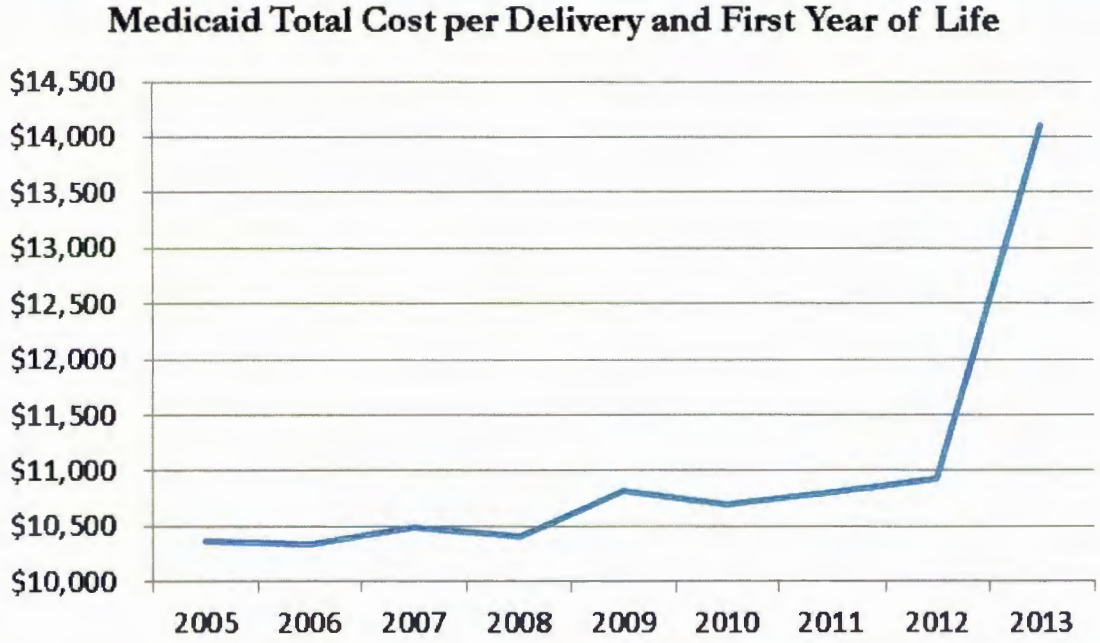
Comparison of Birth Weight Distribution

	2012			2014
	Medicaid	NC	US	Medicaid
Very Low Birth Weight <1500 grams	1.6%	1.7%	1.4%	1.2%
Low Birth Weight < 2500 grams	9.6%	9.0%	8.1%	7.0%

Source: DHHS Data Warehouses and NC Birth Certificate Data

Trends in Medicaid Spending on Births

Absolute costs include the actual payment for the mother's prenatal, delivery payments to CCNC for the Pregnancy Medical Home and the child for the year of life



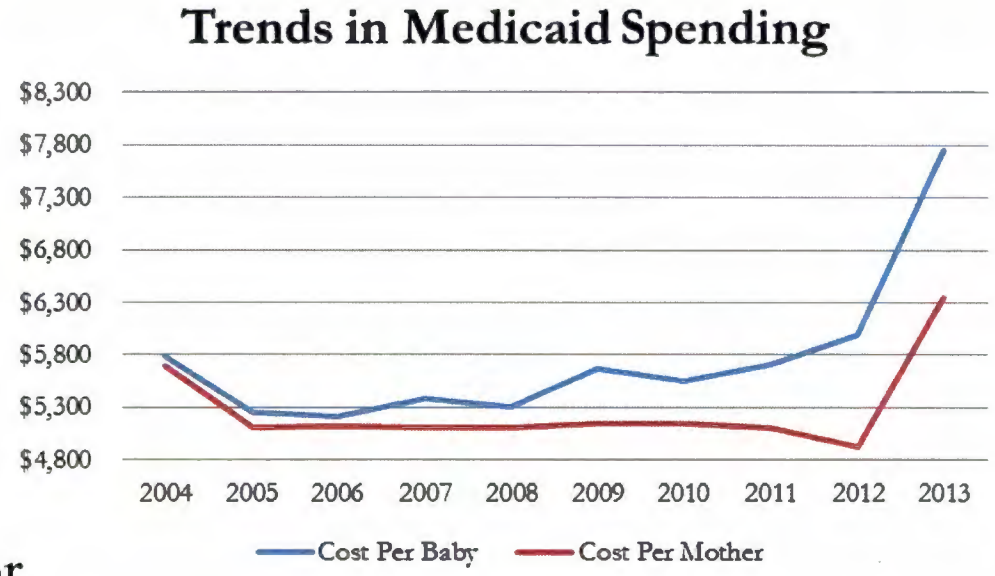
Cost in 2013 includes one case with hospital payments of $2.5 M, but this would only account for an overall increase in the average cost of only $20. The increase in 2013 is primarily a function of payments to hospitals and physicians which increased the average cost by $2,270

One Unanswered Question: ***What is driving change in 2013 hospital and physician spending?***

Source: DHHS Data Warehouses and NC Birth Certificate Data

Trends in Medicaid Spending on Births

- Prior to 2013, C-section rates appear to be positively impacting absolute Medicaid spending for mothers.
- Absolute spending for infants trending upward after 2006 for Medicaid spending in nearly every year.



One Unanswered Question:

How much is utilization, rates, consumption, mix or location of providers contributing to trends in Medicaid spending for mothers and babies?

Source: DHHS Data Warehouses and NC Birth Certificate Data

Location & Mix Create Variations in Medicaid Spending

		Base Rate	Normal Delivery	C-Section w/Comp	Normal Newborn	Full Term Neonate w/Comp	Premature w/Comp
University of North Carolina Hospital		$ 4,531.66	$ 3,116	$ 5,554	$ 914	$ 7,319	$ 18,805
Vidant Medicaid Center		$ 3,741.75	$ 2,573	$ 4,586	$ 755	$ 6,043	$ 15,527
North Carolina Baptist Hospital		$ 3,741.68	$ 2,573	$ 4,586	$ 755	$ 6,043	$ 15,526
Duke University Hospital		$ 3,709.22	$ 2,550	$ 4,546	$ 748	$ 5,991	$ 15,392
Carolinas Medical Center	Other Teaching Hospitals	$ 3,103.68	$ 2,134	$ 3,804	$ 626	$ 5,013	$ 12,879
Durham Regional Hospital	Other Teaching Hospitals	$ 2,875.69	$ 1,977	$ 3,524	$ 580	$ 4,645	$ 11,933
New Hanover Regional Medical Center	Other Teaching Hospitals	$ 2,850.27	$ 1,960	$ 3,493	$ 575	$ 4,603	$ 11,827
WakeMed Raleigh Campus	Other Teaching Hospitals	$ 2,848.92	$ 1,959	$ 3,492	$ 575	$ 4,601	$ 11,822
Mission Hospital	Other Teaching Hospitals	$ 2,811.06	$ 1,933	$ 3,445	$ 567	$ 4,540	$ 11,665
Moses H. Cone Memorial Hospital	Other Teaching Hospitals	$ 2,803.21	$ 1,927	$ 3,436	$ 565	$ 4,527	$ 11,632
Carolinas Medical Center - Northeast	Other Teaching Hospitals	$ 2,796.99	$ 1,923	$ 3,428	$ 564	$ 4,517	$ 11,606
Cape Fear Valley Medical Center	Other Teaching Hospitals	$ 2,763.73	$ 1,900	$ 3,387	$ 557	$ 4,464	$ 11,468
Union Regional Medical Center	Other Teaching Hospitals	$ 2,756.16	$ 1,895	$ 3,378	$ 556	$ 4,451	$ 11,437
Mercy Hospitals	Other Teaching Hospitals	$ 2,747.50	$ 1,889	$ 3,367	$ 554	$ 4,437	$ 11,401
Forsyth Memorial Hospital	Other Teaching Hospitals	$ 2,746.69	$ 1,889	$ 3,366	$ 554	$ 4,436	$ 11,398
ALL OTHER		$ 2,704.50	$ 1,860	$ 3,315	$ 545	$ 4,368	$ 11,223

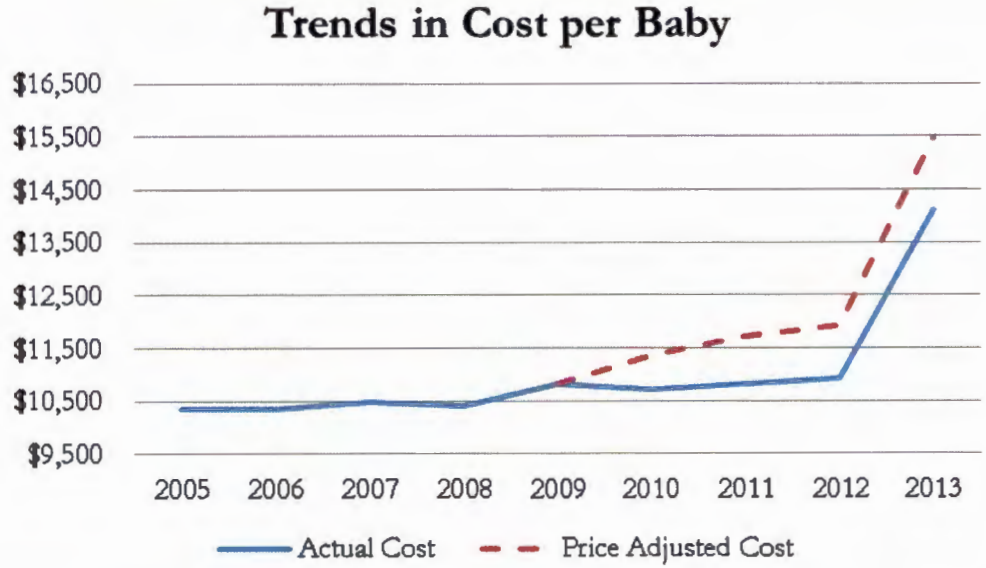
One Unanswered Question: ***How has % of deliveries changed for each of these facilities?***

Source: Division of Medical Assistance

The difference in the hospital rates reflect the graduate medical education addition to base rates for teaching hospitals

Trends in Medicaid Spending on Births

- Rate reductions during the period impacted spending trends
- Price adjusted cost normalizes spending for rate reductions implemented



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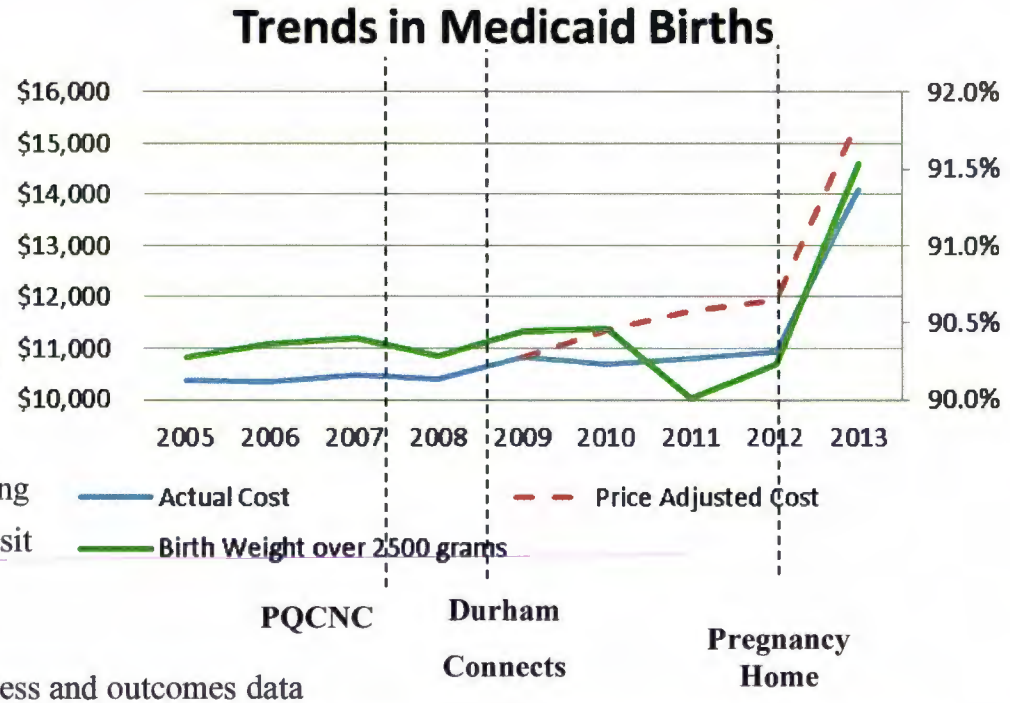
Lowest birth weight babies cost as much on average as 20 times more than a baby born at 2,500 grams or higher

Source: DHHS Data Warehouses and NC Birth Certificate Data

Initiatives for Improving Outcomes

- Durham Connects – in-home post delivery nurse visits for births in Durham County
- PQCNC – focused on a variety of initiatives, education and programs, such as eliminating elective 39 week gestation periods
- Pregnancy Home – initiative through CCNC to lower c-section rate and improve birth weights:
  - $50 incentive to complete standardized risk screening
  - $150 incentive for performing post partum office visit
  - Exemption from PA's for OB ultrasounds
  - Enhanced rate for normal deliveries
  - Care management, care manager and access to process and outcomes data



Actual data is not available to determine the exact factors leading to these changes, there are numerous other actions taken by other Divisions and Agencies/Organizations outside DHHS

One Unanswered Question: *If infant birth weights are increasing, c-section rates are declining – why are average costs per delivery increasing?*

Source: DHHS Data Warehouses and NC Birth Certificate Data

Summary

- The data shows:

  1) Birth weights have improved and reported hospital days for neonates has increased,

  2) C-section rates have started declining, and

  3) Absolute Medicaid spending for prenatal, deliveries, CCNC and the 1st year of an infant's life are mostly flat in total prior to 2013; however, General Assembly actions to lower rates and change policy appear to be the primary factor driving Medicaid spending.

- The data doesn't answer a lot of questions, but rather raises questions about

  a) What is/should the relationship between birth weights & c-section rates and costs & Level III and IV days?

  b) Who is/should be looking at health outcomes for mothers & babies and costs from a system perspective?

  c) What should NC be investing in to improve outcomes and lower costs?

  c) Next steps?

QUESTIONS

Steve Owen – steve.owen@ncleg.net
919-733-4910

SENATE PAGES ATTENDING

COMMITTEE: Joint Approps - Health & Hum Serv, **ROOM:** 643

DATE: 3-31 **TIME:** 8:30

PLEASE PRINT LEGIBILY!!!!!!!!!!!!!....*or else!*

SENATE Page Name	Hometown	Sponsoring Senator
1. Martha Bland	Fayetteville	Senator Meredith
2. Adelle Patten	Concord	Senator Berger
3. Hannah Ross Patten	Concord	Senator Hartsell
4. Elijah Ellison	Durham	Senator Woodard
5. Nathan Oakley	Durham	Senator Woodard
6. House		
7. Alexis Gardner	Cumberland County	Marvin W. Lucas
8. Stewart Haynes	Wilson	Susan Martin
9.		
10.		

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

Committee Sergeants at Arms

NAME OF COMMITTEE Joint Appropriations Committee on HHS

DATE: 3/31/15 Room: 643

House Sgt-At Arms:

1. Name: Bill Morris
2. Name: Jim Moran
3. Name: Joe Crook
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: Canton Lewis
2. Name: Marcus Kitts
3. Name: _____
4. Name: _____
5. Name: _____

Canton Lewis
Marcus Kitts

VISITOR REGISTRATION SHEET

Joint House and Senate Appropriations Subcommittee on Health and Human Services — March 31, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
NICHOLE KARLIN	NAMI NC
Lauren Coffey	Gov's office/Policy
Macon Gardner	GSK
Joann Spruill	NCAFF
Jodi Mayer	GPM; Assoc

VISITOR REGISTRATION SHEET

Joint House and Senate Appropriations Subcommittee on Health and Human Services — March 31, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Amy Hobbs	CCNC
David Collins	SEANC
J Peters	CSS
Jim Johnson	BSA
Annalise Dolph	DL
Eric Burt	PCANC
Hany Zayed	NUC
Elizabeth Roper	NCRMA
Jud Walker	Eastern Seal UCP
Peyton Myers	
Joyce Peters	CSS
TJ Brybee	NP
J Burke	BSC

VISITOR REGISTRATION SHEET

Joint House and Senate Appropriations Subcommittee on Health and Human Services — March 31, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Erica Nelson	NCHA
Ed Knight	
Tom Killian	Nelson Mullins
Barbara	Benchmarks
Michelle Brooks	East Carolina University

VISITOR REGISTRATION SHEET

Joint House and Senate Appropriations Subcommittee on Health and Human Services — March 31, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Julia M Adams-Schenck	ARC, NC, MARC, NCARF
John DeBruins	Brubaker + Assoc.
Jennifer Casperini	NCMS
Amanda Honaker	Trautman Sanders
Ann Rodriguez	NC Council of Comm Programs
Allison Stewart	cardinal Innovations
Trent Womble	DHHS
MARK BENTON	NCCCN
Jennifer Cockman	NCCCN
Day Mckee	PSG
Cory HARD	NCHA

VISITOR REGISTRATION SHEET

Joint House and Senate Appropriations Subcommittee on Health and Human Services — March 31, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Ryan Blacklidge	Cone Health
Lanier Hodgson	UNC Health
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	RLA
Ashley Perkinson	Perkinson Law
[illegible]	EHSR
[illegible]	SEANC
Chris McClure	Brooks Pierce
Ken Melton	K. M. H.
Kay Castillo	NASW-NC

Joint Committee on Appropriations on Health and Human Services
Thursday, April 2, 2015 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Joint Committee on Appropriations on Health and Human Services met at 8:30 AM on April 2, 2015 in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, Chris Malone and Gary Pendleton were present, along with 8 Senate members.

Representative Marilyn Avila presided.

Representative Avila opened the meeting by welcoming everyone and recognizing the House Sergeants-At-Arms: Young Bae, Bill Morris and Jim Moran, and Senate Sergeants-at-Arms: Terry Barnhardt, Jim Hamilton and Dale Huff.
He then recognized House Pages: Asheer McCutchen of Wake County, Dawson Claire McHarg of Wilson County and Matthew Parker of Forsyth County; and Senate Pages Annabelle Webb of Vance County, Kayla Childress of Onslow County, Lily Richardson of Warren County, Alex Epley of Onslow County and Drew West of Buncombe County.

Representative Avila then recognized Denise Thomas from Fiscal Research to give a report on "Maternal and Child Health Services". Representative Avila then opened the floor for questions by the members.

The meeting adjourned at 9:36 a.m.

Marilyn Avila
Representative Marilyn Avila
Presiding

Julie Ryan
Julie Ryan, Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

April 2, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Representative Marilyn Avila, Presiding Co-Chair
II.	**Maternal and Child Health Services**	Denise Thomas, Fiscal Research Division
	Committee Discussion	
	Adjourn	

Table of Counties and EBHV Programs
(MIECHV Funded Programs Shaded)

NC Counties	PAT	NFP	HFA	EHS
ALAMANCE	X			
ALEXANDER				X
ALLEGHANY				
ANSON				X
ASHE			X	
AVERY				
BEAUFORT	X			
BERTIE	X			X
BLADEN				
BRUNSWICK	X			
BUNCOMBE		X		X
BURKE	X		X	X
CABARRUS	X			
CALDWELL				X
CAMDEN	X			
CARTERET				X
CASWELL				X
CATAWBA	X			X
CHATHAM				
CHEROKEE	X	X		
CHOWAN				
CLAY	X			
CLEVELAND		X		
COLUMBUS	X	X		
CRAVEN	X			X
CUMBERLAND				
CURRITUCK	X			
DARE	X			
DAVIDSON	X			
DAVIE	X			
DUPLIN	X			
DURHAM			X	X
EDGECOMBE		X		

NC Counties	PAT	NFP	HFA	EHS
FORSYTH	X	X		
FRANKLIN				
GASTON		X		
GATES	X			
GRAHAM		X		
GRANVILLE	X			
GREENE	X			
GUILFORD	X	X		
HALIFAX	X	X		
HARNETT	X			
HAYWOOD	X	X		
HENDERSON	X			X
HERTFORD		X		X
HOKE	X			
HYDE	X			
IREDELL	X			
JACKSON	X	X		
JOHNSTON	X			
JONES				X
LEE	X			
LENOIR	X			
LINCOLN				
MACON	X	X		
MADISON				
MARTIN	X			
MCDOWELL		X		X
MECKLENBURG	X	X	X	
MITCHELL			X	
MONTGOMERY				
MOORE				
NASH				
NEW HANOVER	X			
NORTHAMPTON	X	X		

NC Counties	PAT	NFP	HFA	EHS
ONSLOW	X			X
ORANGE				X
PAMLICO				X
PASQUOTANK	X			
PENDER				
PERQUIMANS				
PERSON	X			
PITT	X	X		
POLK		X		X
RANDOLPH	X			
RICHMOND				X
ROBESON	X	X	X	
ROCKINGHAM	X	X		
ROWAN	X		X	
RUTHERFORD		X		
SAMPSON	X			X
SCOTLAND				
STANLEY	X			
STOKES				
SURRY	X			
SWAIN	X	X		
TRANSYLVANIA				X
TYRRELL				
UNION				X
VANCE				
WAKE	X	X		X
WARREN				
WASHINGTON				
WATAUGA				
WAYNE	X		X	
WILKES				
WILSON	X			
YADKIN	X			
YANCEY			X	

Maternal and Child Health Services Funded by the NC Department of Health and Human Services

Joint Appropriation Committee on Health and Human Services

April 2, 2015

FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Presentation Outline

- Overview of NC Maternal & Child Health Indicators
- Role of DHHS Operating Divisions
- Description of Specific Programs/Services
- Overview of Evidence-Based Maternal and Child Health Programs
- Summary

NC Maternal and Child Health Indicators

- NC infant mortality rate has declined and is at an all-time low, but it remains significantly higher than the US average. North Carolina ranks 40th among all 50 states in infant mortality
- In 2013, NC had 2,160 fetal and infant deaths
  - Prematurity/Low birth weight, birth defects, maternal conditions and perinatal conditions are contributing factors
  - Maternal complications include pre-existing chronic conditions like asthma, kidney, diabetes, heart disease or alcohol/drug addiction, as well as acute conditions like infections, complications or pregnancy, and post-surgical complications
- Nearly 30% of pregnant women in NC did not receive any prenatal care in the first trimester

  Early prenatal care can identify risk factors and address health concerns before they present a problem for the mother or the infant

NC Maternal and Child Health Indicators

- 10,509 NC babies were born with low or very low birth weight in 2013
  - 8.8% of NC births
- Babies born with a low birth weight (less than 5.5 pounds):
  - have a high probability of delayed development and short- and long-term disabilities
  - are at greater risk of dying within the first year of life.

DHHS Maternal and Child Health Services

- Five divisions administer, fund, or provide healthcare services for pregnant women, postpartum women, and children ages 0 to 5 years:
  - Division of Medical Assistance
  - Division of Mental Health/Developmental Disabilities/Substance Abuse Services
  - Division of Public Health
  - Division of Social Services
  - Division of State Operated Facilities

Division of Medical Assistance Maternal Health

- CCNC Pregnancy Medical Home Program
- CCNC Pregnancy Care Management Program

CCNC Pregnancy Medical Home Program

- Partnership between Community Care of North Carolina (CCNC), the Division of Medical Assistance (DMA) and the Division of Public Health (DPH)
- Goal is to improve the quality of perinatal care given to Medicaid recipients, thereby improving birth outcomes and reducing Medicaid spending
  - Provide coordinated, evidence-based maternity care management for women at risk for poor birth outcomes
- Recruits obstetrics practices to enroll as pregnancy medical home (PMH)
  - Includes eligible local health departments
- 48,057 pregnant women enrolled in Medicaid received PMH services in 2013

CCNC Pregnancy Medical Home Program

- PMH providers agree to:
  - Screen all pregnant Medicaid patients to determine if they have a high priority risk factor
  - Coordinate patient's care with a pregnancy care manager
  - Eliminate elective deliveries performed before 39 weeks of gestation
  - Offer and provide 17P to eligible patients
  - Achieve and maintain cesarean section deliveries at 20% or less
- PMH Providers receive:
  - $50 for completing a risk screening at initial visit
  - $150 for completing a post-partum office visit
  - Enhanced payment rate for normal deliveries – same rate as cesarean
  - A pregnancy care manager assigned to the practice
  - Coordination and support from local CCNC network
  - Exemption from prior approval on ultrasounds

PMH High Priority Risk Factors

- History of preterm birth
- History of low birth weight
- Multiple gestation
- Fetal complications
- Chronic medical conditions which may complicate pregnancy
- Unsafe living environment
- Substance or tobacco use
- Late entry into prenatal care
- Missing two or more prenatal appointments without rescheduling
- Unanticipated hospital utilization
  - Including emergency department visit

Pregnancy Medial Home Program Outcomes

CCNC reports that since the launch of PMH in April 2011

- The rate of **low birth weight** in the Medicaid population has decreased
  - from 11.2% in the year ending March 2012 to 10.53% in the year ending March 2013 and remained at the reduced rate in the year ending March 2014
- The rate of **very low birth weight** in the Medicaid population has decreased
  - from **2.02%** in SFY13 to **1.87%** in SFY14, after being over 2% for the past decade
- The rate of **preterm birth** (deliveries before 37 weeks) has decreased, along with a shift in term births
  - fewer births at 37-38 weeks and more in the 39-41 week range
  - Increased utilization of 17p to prevent recurrent preterm birth
- The **cesarean delivery rate** has decreased slightly
- The rate of **first trimester prenatal care** remains unchanged
- The **postpartum visit rate** increased from 40.9% in 2011 to 46.5% in 2013

CCNC Pregnancy Care Management Program

- Statewide, population-based program that strives for positive and healthy outcomes for pregnant women and their infants
  - Serves Medicaid and non-Medicaid eligible women
- Local health departments receive funding to provide pregnancy care management services in their area
  - Each health department receives a $5.32 PMPM for each female Medicaid enrollee aged 14 to 44 living in its catchment area, regardless of pregnancy status
- Health departments use the payments to provide:
  - Non-clinical, pregnancy care management services
  - Health promotion and prevention activities
- In 2013, 42,070 women received pregnancy care management services

CCNC Pregnancy Care Management

- Pregnancy Care Managers are Registered Nurse or Social workers.
- Duties include:
  - Provide assistance in getting needed services such as medical care, transportation, food, or housing
  - Ensure that woman understands her prenatal care plan
  - Refer women to other programs/services such as childbirth classes, breastfeeding education, family planning, WIC
  - Coordinating across all care providers
  - Making follow-up appointments

Division of Mental Health/Developmental Disabilities/Substance Abuse Services

- NC Perinatal and Maternal Substance Abuse Initiative
- North Carolina Fetal Alcohol Prevention Program
  - MotherToBabyNC

NC Perinatal and Maternal Substance Abuse Initiative

- Provides substance abuse services for pregnant women and women, with dependent children, who have a substance use disorder
- Program Services include:
  - Screening and assessment
  - Case management
  - Outpatient substance abuse and mental health services
  - Parenting skills
  - Transportation
  - Childcare
  - Residential services (or access to these services)
  - Referrals and coordination for primary and preventative health care for the mothers and children
  - Referrals for appropriate developmental, mental health and prevention services for the children
- Residential services only are available Statewide

NC Perinatal and Maternal Substance Abuse Initiative

- FY 2013-14 participants served:
  - Over 1,300 women, entered substance abuse treatment services
    - included 353 pregnant women
  - Approximately 1,250 women received screening, brief intervention, and referral services
    - included 639 pregnant women

- FY 2013-14 Cost: $6,172,016
  - Substance Abuse Prevention and Treatment Block Grant: $2,729,316
  - General Fund: $3,442,700

Perinatal Substance Use Specialist

- The Perinatal Substance Use Specialist provides information, referral and advocacy for pregnant and parenting women who may have a substance use disorder.
  - Contract with a non-profit agency to provide a 1-800 toll free telephone information and referral service

- Provides information, referral and advocacy for pregnant and parenting women who may have a substance use disorder.
  - Services are available to the public and to professionals to
  - Provide support in accessing substance abuse treatment services statewide.

- Provides technical assistance, training and education regarding screening and referrals to local health departments, departments of social services and other agencies in the community who work with this population

Perinatal Substance Use Specialist

- Maintains a capacity management (bed availability) listing of residential substance abuse services for pregnant and parenting women and their children to assist the public and professionals to identify appropriate and available services statewide

- Responsible for publicizing the availability of the NC Perinatal & Maternal Substance Abuse Initiative outpatient and residential services

- 223 women received services in FY 2013-14

- FY 2013-14 Expenditures: $82,779
  - Federal receipts: $37,779
  - General Fund: $45,000

North Carolina Fetal Alcohol Prevention Program

- Targets Fetal Alcohol Spectrum Disorders(FASDs) by providing outreach and education on the dangers of alcohol use during pregnancy
  - Strives to decrease the incidence of preventable birth defects and developmental disabilities
  - provides education to pregnant women, women of child-bearing age, their significant others, and the professionals who work with them
  - Funds the *Mother To Baby North Carolina Pregnancy Exposure Riskline*
- FY 2013-14 expenditures: $71,083
  - Served 285
- Services are available statewide

Division of Public Health Maternal and Child Health Programs

Division of Public Health: Maternal and Child Health Services

- The Division of Public Health (DPH) administers an array of maternal and child health programs and services
- In general, DPH does not provide direct services but instead allocates State, federal, and other receipts to direct service entities, primarily the local health departments, non-profits, private contractors
- Women's and Children's Health Section (WCH)
  - to assure, promote and protect the health and development of families with emphasis on women, infants, children and youth.
  - WCH programs place a major emphasis on the provision of preventive health services beginning in the pre-pregnancy period and extending throughout childhood

Women's and Children's Health Section

- Children and Youth: health promotion, prevention, early identification, treatment and intervention
  - Administers the Home Visiting Programs
- Early Intervention: administers the Infant-Toddler Program which provides supports and services for children, birth to three who have special needs
  - Children's Developmental Services Agencies (CDSA)
- Immunization: oversees the North Carolina Immunization Program (NCIP)
  - provides vaccines - at no charge - for eligible children from birth to 18 years old
  - Distributes vaccines to health care providers at no charge

Women's and Children's Health Section

- Nutrition Services: promotes sound nutrition habits among infants, children, and women in their child-bearing years
  - WIC - provides counseling, referrals, and food assistance to pregnant and postpartum women, infants, and children up to age 5
  - Child and Adult Care Food Program - provides reimbursement for meals and snacks served to eligible children and adults in non-residential child and adult care settings
  - Breastfeeding Promotion and Support - provides technical assistance and resources to promote and support women's decisions to breastfeed their infants
- Women's Health: administers programs and services that protect the health and well-being of infants and of women during their child-bearing years
  - Allocates funding and provides oversight to local health departments and community agencies for an array women's health services, including family planning, prenatal care, flu shots and other immunizations, and maternity care coordination

Maternal Health Program

- WCH oversees and provides funds to local health departments to support multiple maternal health programs/services for low and high risk low-income pregnant women
  - prenatal care
  - pregnancy care management
  - childbirth education
  - skilled nurse home visits
- State and federal funds are allocated to the 85 local health departments to provide the services
  - 66 local health department offer complete prenatal services
- FY 2013-14 DPH allocation to health departments:
  - Federal receipts: $2,377,128
  - General Fund: $3,104,126

  $5,481,254

17P Initiative

- Evidence-based initiative resulting from a partnership of the Division of Public Health, the Division of Medical Assistance, Community Care of North Carolina and the UNC Center for Maternal and Infant Health
- 17P (hydroxyprogesterone) is an intramuscular progesterone treatment administered on a weekly basis to pregnant women with a history of spontaneous preterm birth
  - reduces the risk of recurring pre-term births
  - performance expectation of all practices participating in the CCNC Pregnancy Medical Home program
- Division of Public Health funds a contract with the UNC Center for Maternal and Infant Health to support education and distribution of 17P
- In FY 2013-14, program funds were used to provide 17P to 90 uninsured women, who received an average of 10 injections each

High Risk Maternity Clinics

- High Risk Maternity Clinics are designed to identify and appropriately treat women with high-risk conditions.
  - Clinics provide care to prevent and improve the conditions that cause maternal or infant mortality and morbidity
- WCH provides funding to the State's network of High Risk Maternity Clinics to assure that women with high risk conditions, such as diabetes, receive needed specialized care and support services
  - Funds are provided to 10 local health departments and the ECU High Risk Maternity Clinic
- Local health departments and physicians refer pregnant women with a medically indicated high risk condition to the closest of High Risk Maternity Clinic

Maternal Health Programs

- Medical Nutrition Therapy for Pregnant and Postpartum Women
  - Medicaid reimbursable service that provides intensive nutrition intervention for pregnant women and those who have recently delivered a baby
  - Service is available by referral from local health department maternity clinics
- Women's Health & Tobacco Use Program
  - supports local health department efforts to implement the evidence-based "5As Intervention" (Ask, Advise, Assess, Assist, Arrange) with maternal health and family planning participants
- Health and Behavior Intervention
  - Medicaid reimbursable service to provide assistance to women and their families to address complex lifestyle issues that are likely to affect the health of the mother and her baby
  - Service is offered in some health departments by a licensed clinical social worker
- March of Dimes
  - Under a contractual arrangement, March of Dimes provides preconception and folic acid education for women before pregnancy to reduce birth defects, preterm birth, and infant mortality

Perinatal Quality Collaborative of NC (PQCNC)

- Collaborative of various stakeholders engaged in maternal-infant (perinatal) care in North Carolina
- Statewide organization headquartered in Chapel Hill at the UNC School of Medicine in the Department of Pediatrics
- Identifies opportunities to improve perinatal care and implements time limited statewide quality initiative projects
- PQCNC works with hospitals to focus on four objectives:
  - develop strategies to spread the use of best practice
  - reduce unnecessary variations in care
  - promote partnership with families and patients
  - optimize resources

Maternal Serum Screening

- Screens uninsured pregnant women for risk of having a child with a neural tube birth defect, Down Syndrome, or other chromosome abnormality
- Available statewide
- 2,343 women were screen in FY13-14
- FY 2013-14 Cost: $280,532 General Fund

Newborn Screening Services

- Newborn screening identifies metabolic conditions and critical congenital heart defects that can affect a child's long-term health or survival.
  - Early detection, diagnosis, and intervention can prevent death or disability and enable children to reach their full potential.
- As required by statute, all babies born in North Carolina are tested, using blood collected at birth, for certain genetic, endocrine, and metabolic disorders.
- If screening results are abnormal, the Newborn Screening Program contacts the infant's doctor
  - The infant will be referred for more laboratory testing and, based on the results, may also be referred to a major medical center or a specialist for treatment

Newborn Screening Services

- Treatment centers include, but are not limited to:
  - Carolinas Medical Center, Charlotte
  - Duke University Medical Center, Durham
  - East Carolina University, Greenville
  - Mission Hospital, Asheville
  - University of North Carolina, Chapel Hill
  - Wake Forest University, Winston-Salem
- Available statewide
- Screened 127,893 newborn infants in FY13-14
- FY 2013-14 Cost: $3,103,002 Federal Receipts

Baby Love Program

- Serves pregnant women enrolled in Medicaid for the purpose of promoting a healthy pregnancy and positive birth outcomes

- Provides prenatal and post-partum (up to 60 days after delivery) services
  - Childbirth Education
  - Medical home
  - Referrals to other programs/services such as WIC, dental care, counseling, family planning, etc.

Baby Love Program Home Visiting Services

- Maternal Care Skilled Nurse Home Visit -assess and treat pregnant women who have one or more specific high risk conditions
- Home Visit for Postnatal Assessment and Follow-up Care - provide health, social support, and/or educational services directly to families in their homes
  - Purpose of visit is to follow up on the mother's health; to counsel on family planning and infant care; and to arrange for additional appointments for the infant and mother
  - Must be conducted by a nurse who is not a Pregnancy Care Manager
  - Only one visit is allowed
- Home Visit for Newborn Care and Assessment - deliver health, social support, and/or educational services directly to Medicaid-eligible families
  - Infants ages birth to 60 days who receive Medicaid are eligible for this service

Baby Love Plus

- The Baby Love Plus Program strives to address racial disparities that affect infant mortality, and improve birth outcomes and the health of pregnant and interconceptional women and their families
- Program services include outreach, case management, education, and support services for fathers

- 2,475 women served in FY13-14
  - Counties served: Bertie, Edgecombe, Greene, Martin, Tyrrell, Washington, Pitt, Gates, Halifax, Hertford, Nash, Northampton, Guilford, and Forsyth.

- FY 2013-14 Cost: $1,406,617 General Fund

Healthy Beginnings

- Healthy Beginnings minority infant mortality reduction program provides support to pregnant and interconceptional women and their children by providing case management and support activities that promote best practices in maternal and infant health.
  - Counties served: Forsyth, Gaston, Pitt, and Rowan, Buncombe, Northampton, Hertford, Granville, Vance, Lee, Columbus, and Guilford
    - 650 individuals served in FY13-14
- FY 2013-14 Cost:
  - Federal Receipts: $354,672
  - General Fund: $381,678
    $736,350

Key Measures	FY13-14 Outcomes
Infant Mortality Rate	0
Low Birth Weight Rate	12.5%
% Children Receiving Scheduled Well Child Visit 3-5 Days after Birth	89.4%

Maternal, Infant and Early Childhood Home Visiting

- Evidence-based home visiting programs have been shown to
  - Increase use of prenatal care and improved birth outcomes
  - Prevent child injuries, abuse and neglect, and decrease emergency department visits
  - Improve children's cognitive and emotional development
  - Improve school readiness and performance
- Serve first-time, low income mothers and at-risk families
  - Families receive regular, planned home visits
  - Participation is voluntary and they may choose to leave the program at any time
- Home visitors may be nurses, social workers, early childhood educators, paraprofessionals, trained lay persons

Maternal, Infant and Early Childhood Home Visiting

- Assess the family needs and provide services based on those needs:
  - Teach parenting skills
  - Provide information and guidance on a variety of topics including breastfeeding, nutrition, safe sleep position, well child care, injury prevention, etc.
  - Screen and provide referrals for issues such as postpartum depression, substance abuse, family violence
  - Screen children for developmental delays and facilitate early diagnosis and intervention for autism and other developmental disabilities.
  - Connect families to other appropriate services and resources
- U.S. Department of Health and Human Services recognizes 17 home visiting models that meet the criteria and are considered evidence-based
  - NC uses four models
    - Nurse Family Partnership Program (NFPP)
    - Healthy Families America (HFA)
    - Early Head Start (EHS)
    - Parents As Teacher (PAT)

North Carolina Evidence Based Home Visiting Programs

Counties with Programs funded by NC MIECHV (Maternal, Infant and Early Childhood Home Visiting) Formula Grant to States are Shaded
(March 2015)

Parents as Teachers ★
Nurse-Family Partnership ▲
Healthy Families America □
Early Head Start-Home Visiting ●

Source: Division of Public Health, NC DHHS

FISCAL RESEARCH DIVISION
A Staff Agency of the North Carolina General Assembly

Maternal, Infant and Early Childhood Home Visiting

- FY 2013-14 Expenditures: $4,116,939
  - Federal Receipts: $3,036,738
  - General Fund: $ 1,080,201

- 1,253 clients served in FY13-14

- Home Visiting Program services available in 78 counties

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

- WIC serves pregnant women, postpartum and breastfeeding women, infants, and children less than 5 years of age at nutritional or medical risk and a household income less than 185% of poverty
  - provides nutrition education, breastfeeding promotion and support, nutritious foods, including specialized infant formulas, and referrals to other healthcare services
- Available statewide
- FY 2013-14 Cost: $186,124,080 Federal Receipts
- Average 257,182 participants served per month in FY13-14

Pregnant Women	24,931
Postpartum and Breastfeeding Women	35,911
Infants	62,145
Children ages 1 to 5 years	134,195

WCH Pregnancy Care Management Program

- Separate program, not part of the CCNC initiative
- Provides specialized prenatal and postpartum care management services to low income, uninsured women who are ineligible for Medicaid
- Counties served: Buncombe, Cabarrus, Chatham, Duplin, Durham, Guilford, Henderson, Johnston, Mecklenburg, Montgomery, Moore, New Hanover, Pitt, Sampson, and Wake
  - Served approximately 1,400

- FY 2013-14 Cost: $395,280
  - Federal Receipt: $128,037
  - General Fund: $267,243

Triple P (Positive Parenting Program)

- Triple P is a parenting program that aims to reduce the prevalence of child emotional, behavioral, and mental health problems

- Evidence-based
  - reduce child abuse
  - decrease hospitalizations from child abuse injuries
  - reduce foster care placements

- Parenting knowledge and skills-based training provided as one-on-one counseling, group settings, and online courses

Triple P (Positive Parenting Program)

- Education sessions may address specific family situations
  - Child with a serious behavior problem
  - Child with disabilities
  - Parents going through divorce or separation
  - Healthier, more active life styles

- Program services are available in 32 counties through the local health department

- FY 2013-14 Cost: $2,422,408
  - Federal Receipt: $1,602,409
  - General Fund: $ 819,999

Young Families Connect: Engaging Communities

- Assist existing providers who are serving expectant and/or parenting women and men ages 13 – 24 years.
  - Provides community education/support

- Counties served: Bladen, Onslow, Robeson, Rockingham, and Wayne
  - Served 165 individuals

- FY 2013-14 Cost: $619,384 Federal Receipts

Division of Social Services

Residential Maternity Homes

Residential Maternity Homes

- Maternity homes are facilities which provide residential and other services to adolescents and adult women during pregnancy and after delivery

- Division of Social Services contracts with seven homes to provide room and board services
  - Contract is for residential services only and does not include any other services

- Services are available statewide
  - Served 138 women in FY 2013-2014

- FY13-14 General Fund Expenditures: $1,148,708

Residential Maternity Homes

- Division of Social Services contracts with seven homes, operated by non-profit agencies, to provide room and board services
  - Contract is for residential services only and does not include healthcare services or treatment

- Maternity Home rates compared to other types of residential facilities that receive State reimbursement

Facility Type	Average Daily Rate	Average Monthly Rate	% Maternity Home Rate
Adult Care Homes	$39	$1,182	31%
ACH-SCU	$51	$1,515	39%
Maternity Homes	$129	$3,870	
Nursing Homes	$158	$4,750	123%

Division of State Operated Healthcare Facilities

Walter B. Jones Alcohol and Drug Abuse Treatment Center (ADATC)

Perinatal Services

Walter B. Jones ADATC Perinatal Services

- Walter B. Jones ADATC provides perinatal services for pregnant and post-partum substance abusing women.
  - Women can bring their infant up to 12 months of age
  - Program is available to women from around the State
- Perinatal Services are provided in an inpatient setting
  - no pre-determined length of stay
  - women may choose to remain in treatment until they deliver, and return afterwards with her infant to complete treatment
- Walter B. Jones ADATC can accommodate any number of pregnant women (based on facility capacity), and up to five infants
  - In FY 2013-14 services were provided to 104 pregnant women and 13 post-partum women
- FY 2013-14 Estimated Cost: $2,258,975
  - Estimated Receipts: $189,371
  - General Fund: $2,069,604

Evidenced -Based
Maternal and Child Health Services

Evidence-Based Perinatal Services

- Medical Homes
  - CCNC Pregnancy Medical Home
- 17P
- Home Visiting Programs
  - Nurse Family Partnership Program (NFPP)
  - Healthy Families America (HFA)
  - Early Head Start (EHS)
  - Parents As Teacher (PAT
- Perinatal Quality Collaborative of NC (PQCNC)
- CenteringPregnancy
- Alcohol Screening and Brief Intervention
  - NC Perinatal and Maternal Substance Abuse Initiative

Evidence-Based Services Prevention and Health Promotion for Women and Children

- Breastfeeding Promotion Programs
  - Supplemental Nutrition Program for Women Infants and Children (WIC)
- Tobacco Prevention/Smoking Cessation
  - 5 A's Intervention
  - QuitlineNC
  - You Quit Two Quit
- Community-Wide Campaigns Promoting Use of Folic Acid Supplements
  - March of Dimes Contract
- Group-based Parenting Programs
  - Triple P

Summary

- DHHS offers an array of programs and services that are intended to improve birth outcomes and children's health
- There are evidence-based programs in use
- For many programs, accessible and relevant outcome data is lacking
- There is no one DHHS entity that appears to "in charge"
  - At least 5 DHHS Divisions are funding health and family support services for pregnant women, infants, and young children
  - DPH funds are primarily allocated to local health departments, non-profits, and contract agencies which are responsible for delivering the services

Committee Sergeants at Arms

NAME OF COMMITTEE Appropriations - Health & Human Services

DATE: 4-2-15 **Room:** 643

House Sgt-At Arms:

1. **Name:** _____
2. **Name:** _____
3. **Name:** _____
4. **Name:** _____
5. **Name:** _____

Senate Sgt-At Arms:

1. **Name:** Terry Barnhardt
2. **Name:** Jim Hamilton
3. **Name:** Dale Huff
4. **Name:** _____
5. **Name:** _____

Committee Sergeants at Arms

NAME OF COMMITTEE Jt. Comm. on App HHS

DATE: 04/02/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

Thursday, April 2	**Room**	**Time**
APPROPRIATIONS HEALTH & HUMAN SERVICES (JOINT)	643	8:30 am

Name	County	Sponsor
Asheer McCutchen	Wake	Rosa U. Gill
Dawson Claire McHarg	Wilson	Susan Martin
Matthew Parker	Forsyth	Evelyn Terry

SENATE PAGES ATTENDING

COMMITTEE: ~~Joint Apps.~~ – Health & Hum. Serv. ROOM: 643

DATE: 4-2 TIME: 8:30

PLEASE PRINT <u>LEGIBILY</u>!!!!!!!!!!!!!....*or else!*

Page Name	Hometown	Sponsoring Senator
1. Annabelle Webb	Henderson	Bryant
2. [illegible]	[illegible]	[illegible]
3. Kayla Childres	Jacksonville	Brown
4. Lily Richardson	Warrenton	Bryant
5. Alex Epley	Jacksonville	Brown
6. Drew West	Candler	Apodaca
7.		
8.		
9.		
10.		

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

VISITOR REGISTRATION SHEET

Jt. Comm. on App HHS
Name of Committee

04/02/15
Date

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NAME	FIRM OR AGENCY AND ADDRESS
NICHOLE KARIM	NAMI NC

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Bill Carlton	Law Office/Public Policy
MARK BEANTON	NBCN/NCCCN
John Alexander	NBCN / NCCCN
JOEL MAYNARD	GRM & ASSOC
John Boyd	Maryland Community College
Edwina R. Sluder	" " "
Amy Hobbs	CCNC
Andy Chase	KMA
Pat A. Yancy	APPCNC

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Kara Weishaar	SA
John Bode	B+H
Evelyn Thornton	ETHOR
TJ Bradbee	NP
Ashley Perkinson	Perkinson Law
Bill Rowan	A-R
Ron Worthy	Lilly
Lauren Coffey	Gov office/Policy
M. K. Tomsy	DCP
Stevens	CSS

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Ryan Maxwell	WM
Josh Ehrich	JDA
Chris McClure	Burns Ren
Frank Hill	PSG
Jonathan Yeomans	OSBM
Eric Braat	PCANC
Mah Grays	NCPC
Flint Benson	SEANC
Tom Vitaglione	NCCHILD
Tracy Colvard	AHIHC

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04/02/15 — Date

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NAME	FIRM OR AGENCY AND ADDRESS
Lexi Morgan	NCRMA
[illegible]	[illegible]
Martha Ann McConnell	Carolinas HealthCare
Allison Stewart	Cardinal Innovations
Jennifer Gasperini	NCMS
Amanda Hraker	TSS
Trent Womble	DHHS
Rob Lamm	PLA
Mary Hedrick	GSK
Flo Stein	DMHDDSAS
Lee McKethan	Nelson Mullins

Joint Committee on Appropriations on Health and Human Services
Tuesday, April 14, 2015 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Joint Committee on Appropriations on Health and Human Services met at 8:30 AM on April 14, 2015, in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, William Brisson, Josh Dobson, Jean Farmer-Butterfield, Howard Hunter, Verla Insko, Chris Malone, and Gary Pendleton were present, along with 7 Senate members.

Senator Ralph Hise presided.

Senator Hise opened the meeting by welcoming everyone and recognizing the House Sergeants-at-Arms—Young Bae, Jim Moran, and Bill Morris—and the Senate Sergeants-at-Arms—Dale Huff, Steve McKaig, and Matt Urben. He also recognized the House Pages in attendance—Will Dunn III of Pitt County and Eli Horbnack of Rutherford County; and the Senate Pages in attendance —Luke Evans of Randolph County and Sarah Strickland of Sampson County.

Senator Hise recognized Deborah Landry of Fiscal Research Division who presented agenda item II. – Child Care Subsidy, and then Robb Kindsvatter, Director, Division of Child Development and Early Education, DHHS who presented agenda item III. – Legislative Update Federal CCDF Reauthorization. Ms. Landry and Mr. Kindsvatter then answered questions from Committee members.

The meeting adjourned at 9:50 AM

Senator Ralph Hise
Presiding

Susan Fanning, Committee Clerk

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Tuesday	April 14, 2015	8:30 AM	643 LOB

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

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

April 14, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Senator Ralph Hise, Presiding Co-Chair
II.	**Child Care Subsidy**	Deborah Landry, Fiscal Research Division
III.	**Legislative Update Federal CCDF Reauthorization**	Rob Kindsvatter, Director, Division of Child Development and Early Education, DHHS
	Committee Discussion	
	Adjourn	

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Division of Child Development and Early Education
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Legislative Update
Federal CCDF Reauthorization

Rob Kindsvatter, DCDEE Director
April 14, 2015

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Reauthorization of Child Care Development Fund (CCDF) Block Grant

- Reauthorized federal legislation is The CCDBG (Child Care and Development Block Grant) Act of 2014, amending CCDBG Act of 1990 enacted on November 19, 2014
- Compliance with requirements in the new law will be established through submission and approval of the FY 2016-18 CCDF State Plans (changed from biennial to triennial).
- Some changes can be established through agency, others have to go through legislative or rulemaking process.

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Monitoring of Licensing and Regulatory

- Requires a pre-licensure visit and at least 1 annual unannounced inspection for all child care facilities.
- Ensure that individuals who are hired as licensing inspectors (Child Care Consultants) are qualified and receive training
- Maintain the ratio of licensing inspectors to providers and facilities at a level sufficient to perform inspections on a timely basis
- Must be implemented by November 19, 2016

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Results of Monitoring and Inspection

- State must make public by electronic means (web site) the results of monitoring and inspection reports, including:
  - Major substantiated complaints
  - Number of deaths
  - Serious Injuries
  - Instances of substantiated child abuse
- Implemented by November 2017 or earlier

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Criminal Background Checks

- States must have policies and procedures in place to conduct comprehensive criminal background checks for child care providers and staff
  - NC currently already completing most aspects, will have to add some additional details to existing checks.
- Must be implemented by September 30, 2017

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Child Care Subsidy Changes

- Priority must be given to children of families with very low incomes, including homeless children, and children with special needs.
- Adds foster parent to the definition of 'parent'
- Requires increased partnership with State/public agencies, tribal organizations and faith and community based agencies to increase capacity, supply and quality of care
- Prioritize investments in geographic areas of specific concern or with concentrated poverty

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Child Care Subsidy Changes

- Requires minimum 12 month eligibility period for service
  - Regardless of changes in income, up to 85% of SMI -or-
  - Temporary changes in participation in work, training or education activities
- Requires transition plan and allowances for job search
- States are allowed the option to terminate service if a parent permanently loses employment, but must continue service for at least 3 months after change.
- Purpose of this is to provide continuity of high quality care for children

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Child Care Subsidy Changes

- Additional reporting required on children served, as well as those on waiting lists and denied service
- Must develop and implement strategies to increase supply and quality of care for:
  - Children in underserved areas
  - Infants/Toddlers
  - Children with disabilities
  - Children in care during non-traditional hours
- Requires that redetermination not 'unduly disrupt' parent/guardian's employment

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Child Care Subsidy Changes

- To set payment rates, states must conduct either market rate survey or alternative methodology
- If market rate survey is used, must reflect variations in price of child care by geographic area, type of provider, and age of child
- Alternative methodology can include a cost estimation model
- State is required to set CCDF subsidy payment rates in accordance with the results of the **current** market rate survey or alternative methodology

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Minimum Quality Spending Changes

- **Reauthorization increases the minimum quality spending requirement to 9%, phased in over 5 years.**

(Reference: Section 658G(a)(2))

Federal Fiscal Year	% Quality Set-aside	% Infant and Toddler	Total Quality Set-aside
FFY 2016	7%	--	7%
FFY 2017	7%	3%	10%
FFY 2018	8%	3%	11%
FFY 2019	8%	3%	11%
FFY 2020 (and ongoing)	9%	3%	12%

- **Current minimum is 4% (plus appropriated set asides)**

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Quality Set Aside for Infant and Toddlers

- In addition to overall minimum quality spending:
  - 3% of funds must be used for quality activities that relate to improving the quality of care for infants and toddlers.
  - Begins in 2017 and continues forward

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Quality Activity Requirements

Professional Training Requirements –

- Supporting training/professional development of child care workforce through:
  - Activities that relate to scientifically-based, developmentally appropriate strategies to promote the social, emotional, physical and cognitive development of children.
  - Connecting child care staff to postsecondary training, financial aid, or other resources
  - Special training focus on neurological development, nutrition, physical activity, low-income populations, and children with disabilities
  - Developing strategies to reduce expulsions
  - Engaging families in culturally and linguistically appropriate ways
  - Implementation of the State's early learning and developmental guidelines

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Quality Activity Requirements (TQRIS)

Tiered Quality Rating and Improvement System:

- Support and assess provider quality
- Build on State licensing/regulatory standards
- Improve the quality of different types of providers /services
- Evaluate quality and effectiveness of child care programs
- Improve parents' understanding of early childhood system and ratings
- Provide financial incentives for improved quality

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5 Star Rated License • Prekindergarten • Subsidized Early Education for Kids

Quality Activity Requirements

- Improving the Supply and Quality of Infant/Toddler Care
- Improving health and safety, cognitive and physical development for Infant and toddlers,
- Expanding statewide system of child care resource and referral services
- Facilitating state requirements for inspection, monitoring, training, health and safety, and licensing standards.
- Evaluating and assessing the quality and effectiveness of child care programs.
- Supporting child care providers in the pursuit of accreditation
- Supporting state or local efforts to develop high quality program standards relating to health, mental health, nutrition, physical activity and development.

NORTH CAROLINA DCDEE
Division of Child Development and Early Education
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Reporting Changes

- State must submit the following:
  - Starting FY 2016 annually submit certification describing how funds were used to comply with quality set-aside requirements during preceding fiscal year
  - Amount of funds reserved for quality improvement activities
  - Quality improvement activities, outcomes and expenditures
  - Measures State will use to evaluate progress toward improving quality of child care programs and services

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Implementation Dates

- Raising the minimum quality requirement from 4 to 9%: Phased-in over a 5-year period beginning in FY 2016
- Additional 3% quality set-aside for infants and toddlers: Starting in FY 2017
- Criminal background checks for all child care providers: September 30, 2017
- Monitoring of licensing and regulatory requirements for providers serving CCDF children: November 19, 2016
- Posting results of monitoring and inspection reports on a public website: Earlier of November 19, 2017 or 1 year after implementation of required monitoring policies.
- State compliance with priority for services for underserved populations: September 30, 2016.

NORTH CAROLINA
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Division of Child Development and Early Education
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Questions?

Child Care Subsidy

Deborah Landry
Fiscal Analyst

April 14, 2015
Joint Appropriations Committee on Health and Human Services

Division of Child Development and Early Education

Major Programs

- **Child Care Subsidy** - provides financial assistance to eligible families to support parents' employment or education, child developmental needs, child protective services and child welfare services.
- **Smart Start** – provides planning, funding and services to improve the quality of and access to child care, access to health services for young children and family support services.
- **PreK** - provides high-quality educational experiences to enhance school readiness for eligible four-year-olds.

Program Comparison

	Smart Start	Child Care Subsidy	PreK
Mission	School Readiness	Provide needs based child care assistance	School Readiness
Target Population	Children from birth to age 5	Low income families with children under age 12	At-risk four-year-olds who have not been exposed to a child care setting

Program Comparison

	Smart Start	Child Care Subsidy	PreK
Eligibility	• Varies by activity • Local partnerships have flexibility for some activities	• Age 0 to 5, and Special Needs children, 200% of federal poverty level • Age 6-12, 133% of federal poverty level • Need child care for an eligible activity such as employment, high school or post-secondary education	• Income eligible at 75% of state median income • Eligible without regard to income: some military families; children with Limited English Proficiency, IEP, some health conditions, or educational need identified by screening
Funding and Administration	• Nonprofit organization at state and local levels • Public/private partnership • State and private funding • Local decision-making to address local needs	• Combination of State and Federal funding from Block Grants and the General Fund. • Locally administered program with State level support	• State program with state funding, plus other sources of funding contributed according to local decisions • Standard program; local decision-making about location of pre-k classrooms; all classrooms meet state standards

Child Care Subsidy Evaluation

What Works For Health Database

Expected Beneficial Outcomes

- Increased employment
- Increased earnings
- Increased access to child care

Ratings:

- Evidence Rating: Scientifically Supported
- Impact on Disparities: Likely to Decrease Disparities

Source: http://whatworksforhealth.wisc.edu/index.php

Child Care Subsidy Evaluation

- There is strong evidence that child care subsidies increase employment and earnings for low income families.
- Subsidies have also been shown to increase low income children's enrollment in formal child care settings, which is often higher quality than non-family home-based care.

Source: http://whatworksforhealth.wisc.edu/index.php

Child Care Subsidy Evaluation

Child care subsidies increase employment for single mothers especially those with low income and those without a high school education.

Single mothers who receive subsidies:

- Work more hours
- Have more standard work schedules
- Stay in jobs longer
- Earn more than mothers who do not receive subsidies.

Source: http://whatworksforhealth.wisc.edu/index.php

Child Care Subsidy Evaluation

- Child care subsidies can allow employed parents to access child care centers and center-based preschool programs that they may not have been able to afford without subsidies, and may increase use of center-based care.
- Research indicates that subsidies that move children from informal, non-parental care to more formal care settings can have positive long-term effects on children's future educational attainment and labor market participation.

Source: http://whatworksforhealth.wisc.edu/index.php

Child Care Subsidy Funding

	2012-13	2013-14	2014-15
Requirements	$ 421,104,288	$ 343,260,327	$ 336,530,468
Receipts	$ 312,340,419	$ 302,137,474	$ 309,394,955
Appropriation	$ 108,763,869	$ 41,122,853	$ 27,135,513

- Chart includes administration.
- 2012-13 includes Smart Start Subsidized Child Care. Beginning in 2013-14 Smart Start Subsidized Child Care is budgeted in a separate fund code.
- The change in Requirements from 2013-14 to 2014-15 was due to the elimination of a reserve account.

Source: BD 307 Fiscal Years 2011-15 DHHS - Child Development and Early Education Code: 14420, Fund 1380

Child Care Subsidy Recent Legislative Changes

Child Care Subsidies for Higher Quality Centers and Homes: Session Law 2011-145 Section 10.7(g) - required DCDEE to phase in a new policy in which child care subsidies are paid, to the extent possible, for child care in the higher quality centers and homes only. Subsidy funds are not paid for one- or two-star-rated facilities. The division may allow exemptions in counties where there is an inadequate number of three-, four-, and five-star-rated facilities for nonstar-rated programs, such as religious programs.

Market Rate Increases: S.L. 2014-100 Section12B.5 requires the Department to increase the child care market rates for 3, 4 and 5 star centers and home by 25% of the difference between the current market rates and the market rates recommended in the 2013 Child Care Market Rate Study

Child Care Subsidy Recent Legislative Changes

Child Care Subsidy Eligibility Changes

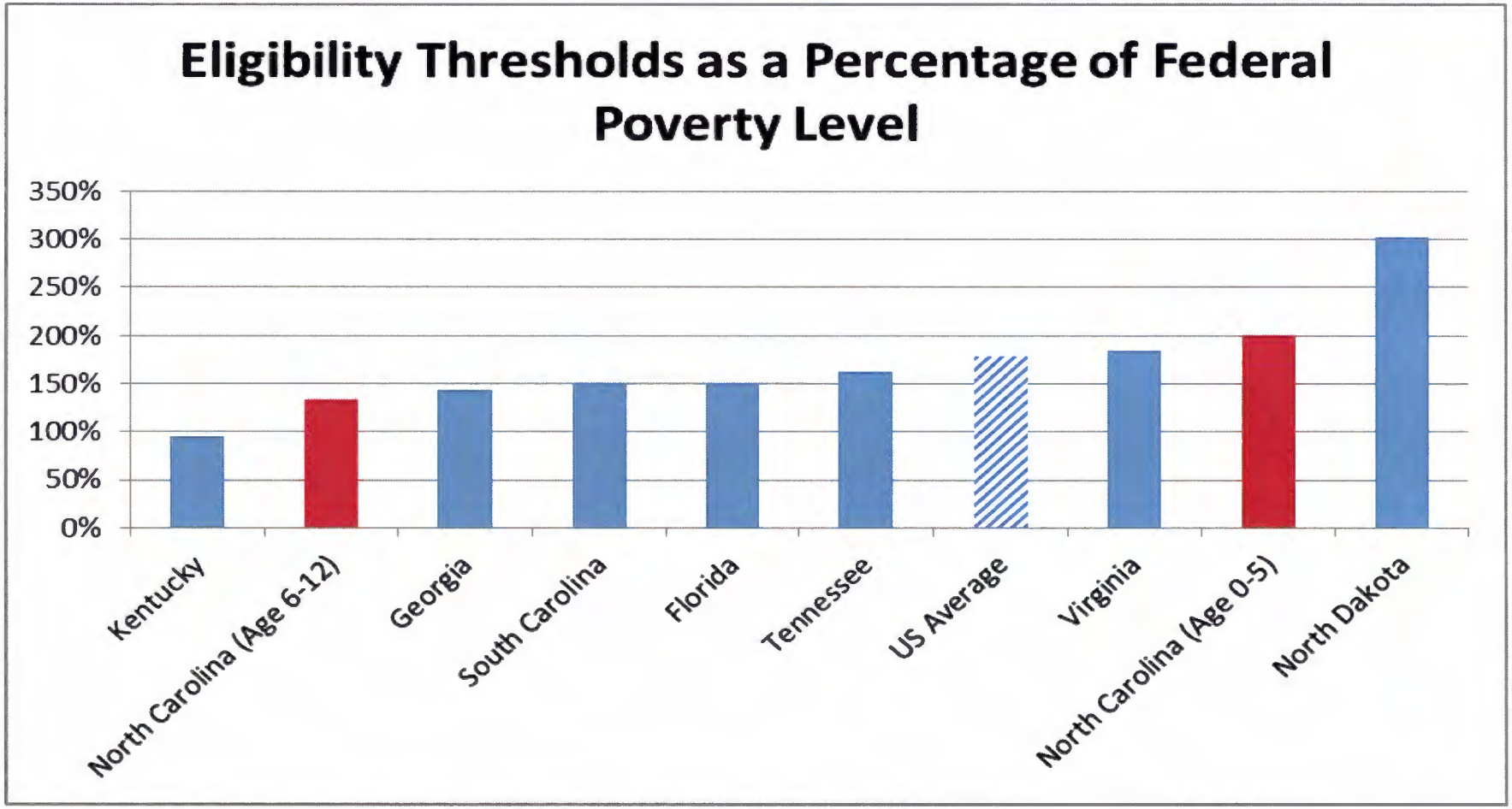
S.L. 2014-100 Section 12B.1 made the following changes:

- Income level from 75% of State Median Income to the Federal Poverty Level. Details are on the next slide.
- Step-parents and nonparent caretaker relative income are now counted.
- Co-payments are no longer prorated for part-time care.

Child Care Subsidy Eligibility

- Children age 0-5 and special needs children in income eligible families with income less than 200% of Federal Poverty Level (FPL) A family of 4 must have income less than $3,975 a month or $47,700 a year.
- Children age 6-12 in eligible families with income less than 133% of FPL. A family of 4 must have income less than $2,643 a month or $31,716 a year.
- Children who need child care services to support child welfare services.
- Children receiving foster care services who are in the custody of a county department of social services.

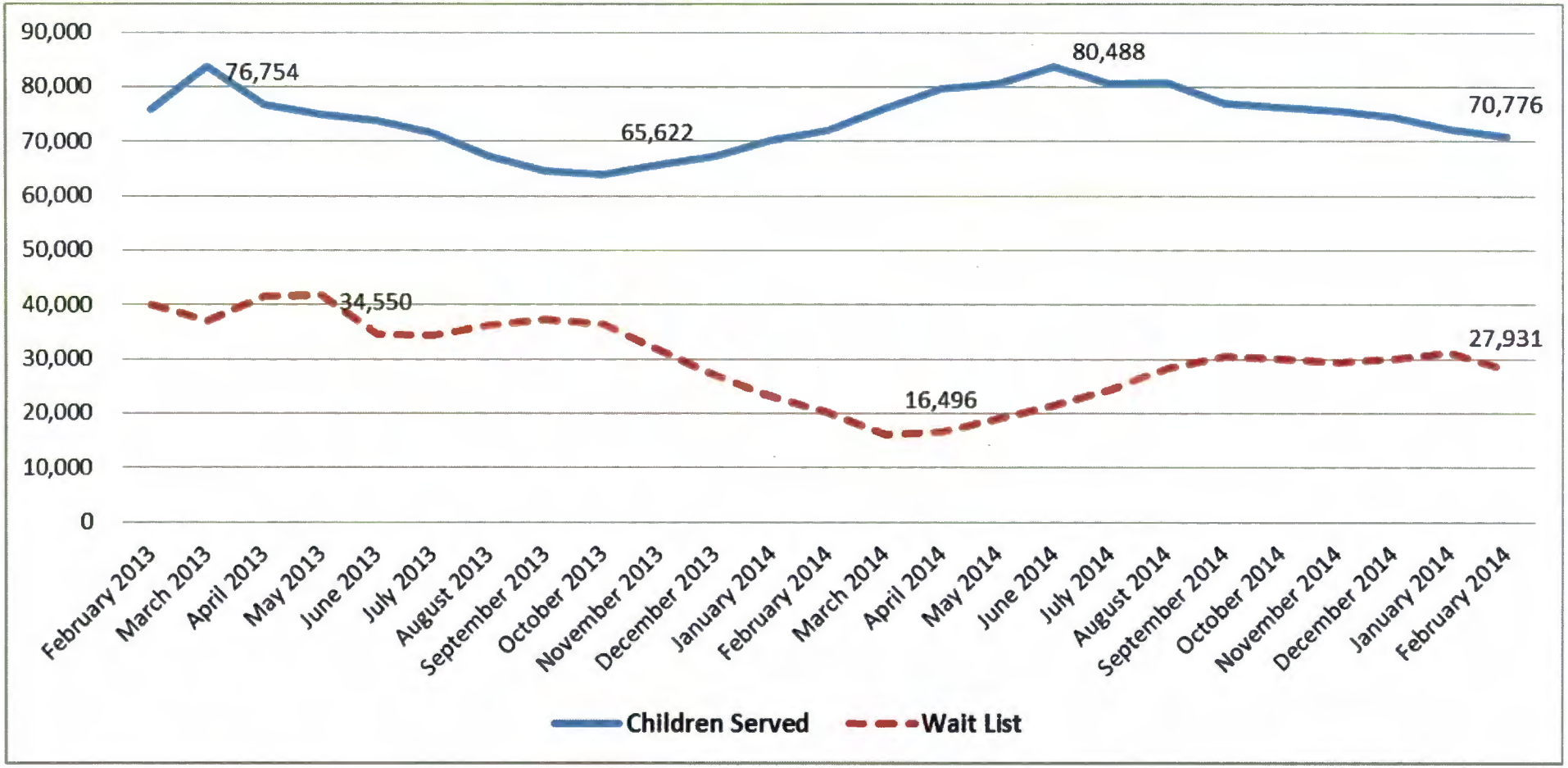
Child Care Subsidy Income Limits



Note: States income limits may be based on federal poverty level or their state median income. States income limits were converted to a federal poverty level equivalent to make this comparison.

Source: The CCDF Policies Database Book of Tables: Key Cross-State Variations in CCDF Policies as of October 1, 2013

Child Care Subsidy Children Served and Wait List



Source: Division of Child Development and Early Education Monthly Statistical Summary, February 2013– July 2013, Subsidy Expenditure Reports August 2013-February 2015

Child Care Subsidy Children Served and Wait List

July through February	Avg. Monthly Children Served	Avg. Monthly Wait List
FY 2010-11	85,296	45,932
FY 2011-12	77,724	46,584
FY 2012-13	76,990	42,833
FY 2013-14	67,809	30,659
FY 2014-15	75,986	28,936

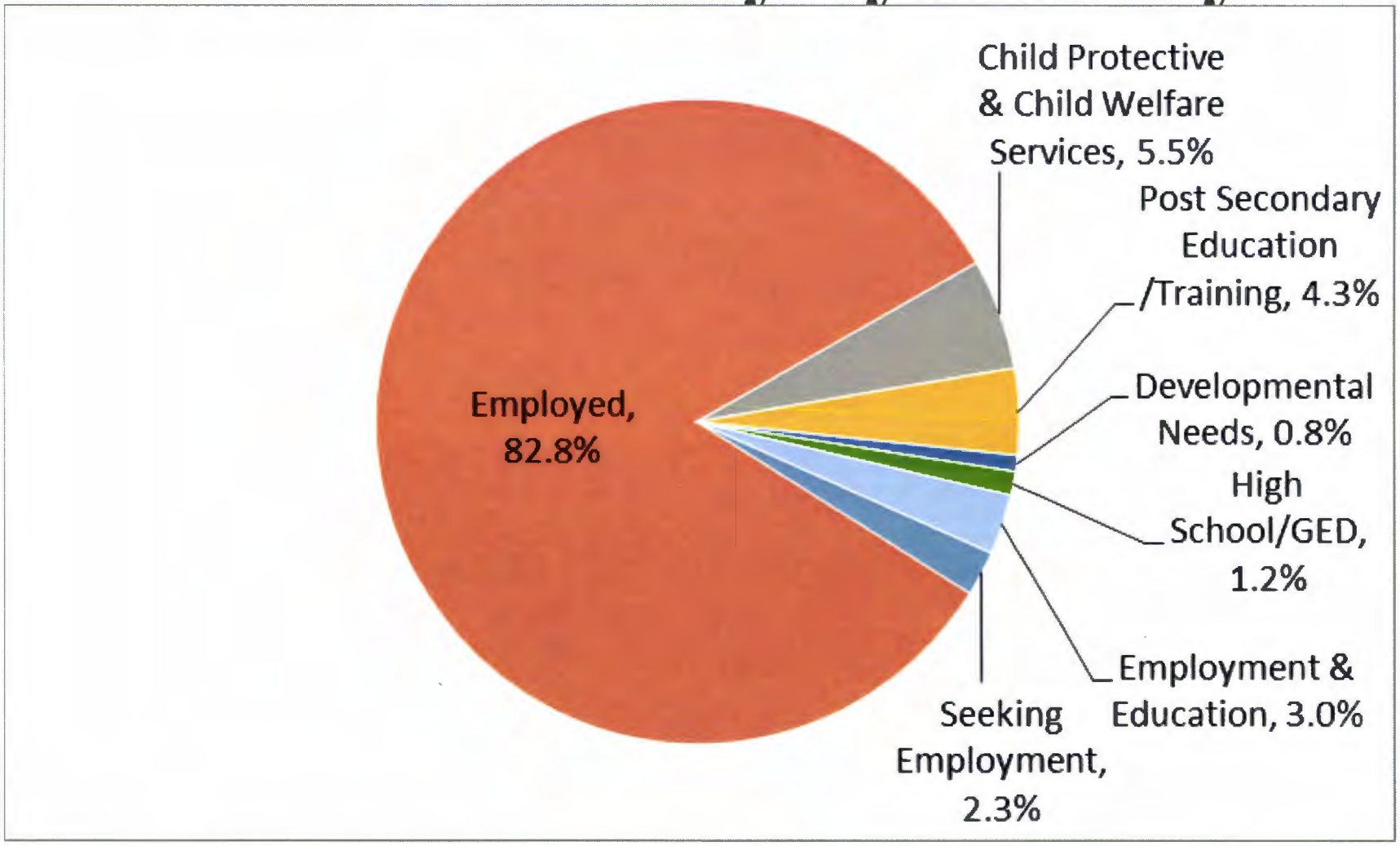
Source: Division of Child Development and Early Education Monthly Statistical Summary, February 2013– July 2013, Subsidy Expenditure Reports August 2013-February 2015

Child Care Subsidy Eligibility

Income eligible families must also be participating in a qualifying activity:

- Employment
- Seeking Employment
- Post Secondary Education
- Developmental Needs of the Child
- High School Education
- Combination of the above

Child Care Subsidy - Reasons Families Receive Subsidy by Activity



Source: Division of Child Development and Early Education, Number of Children Served and Expenditures by Need Co.xlsx

Star Rating System

The Star Rating System was developed to:

- Provide information to parents about the quality of care in child care centers and family child care homes.
- Recognize providers for the higher quality care that they provide.
- Acts as a roadmap for providers to follow as they strive to improve the quality of their care.

Star Rating System

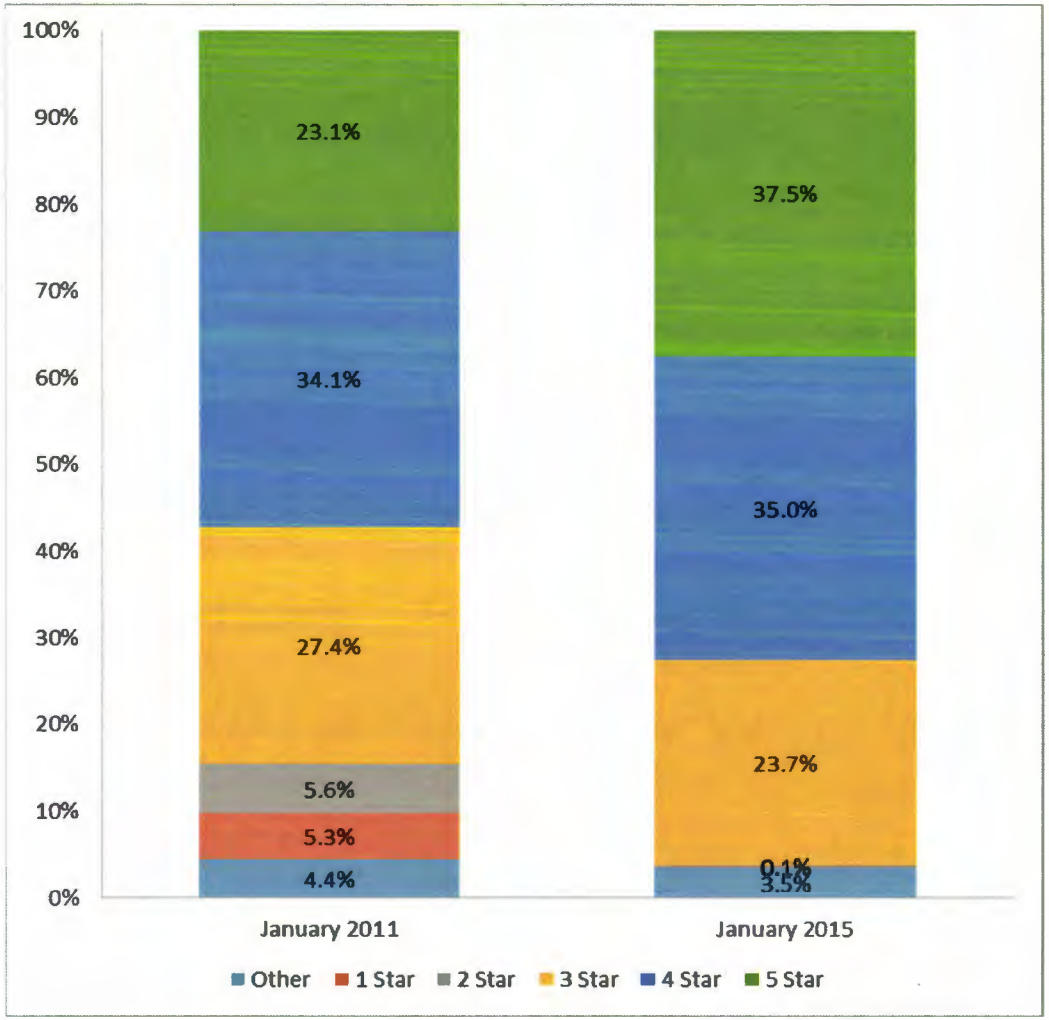
Providers may earn 1 to 5 stars.

A rating of one star means that a child care program meets North Carolina's minimum licensing standards for child care.

All programs earn their star rating based on two components:

- Staff education
- Program Standards

Comparison of Where Children Receiving Subsidy are Served by Star Rating in January 2011 to January 2015

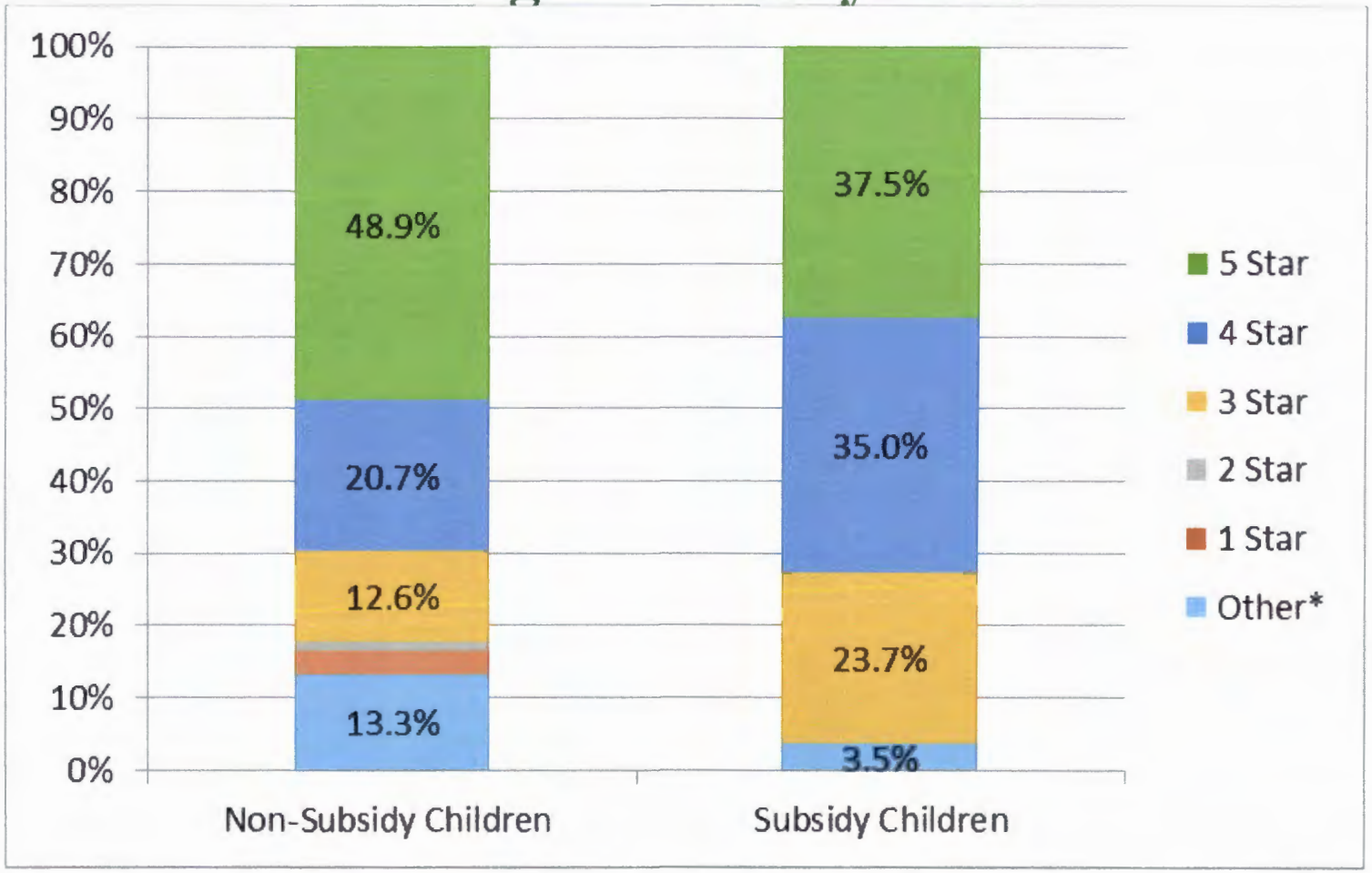


S.L. 2013-360, Appropriations Act of 2013, Section 12.B.3(f) prohibited subsidy funding to be paid for 1 or 2 star rated facilities. Exemptions are allowed in counties where there are an inadequate number of higher rated facilities.

Other includes temporary and provisional licenses and Religious Sponsored Notice of Compliance certificates.

Source: http://ncchildcare.nc.gov/pdf_forms/statistical_detail_report_january_2015.pdf

Comparison of Where Children are Served by Star Rating in January 2015



*Other includes temporary and provisional licenses and Religious Sponsored Notice of Compliance certificates.

Source: http://ncchildcare.nc.gov/pdf_forms/statistical_detail_report_january_2015.pdf and Division of Child Development Number of Children Served and Expenditures by Star Ra .xlsx

Change in Number of 1 to 5 Star Rated Family Child Care Homes over the Past 5 Years

	January 2011	January 2012	January 2013	January 2014	January 2015	Change in Number of Homes	% Change 2011 to 2015
Other*	11	9	15	15	9	(2)	-11%
1 Star	905	723	486	395	352	(553)	-48%
2 Star	692	615	414	286	232	(460)	-58%
3 Star	749	683	775	751	711	(38)	-6%
4 Star	639	642	703	715	693	54	8%
5 Star	412	393	370	331	294	(118)	-24%
Total	3,408	3,065	2,763	2,493	2,291	-1,117	-30%

*Other includes temporary and provisional licenses and Religious Sponsored Notice of Compliance certificates.

Source: Division of Child Development and Early Education Monthly Statistical Summary

Change in Number of 1 to 5 Star Rated Child Care Centers over the Past 5 Years

	January 2011	January 2012	January 2013	January 2014	January 2015	Change in Number of Centers	% Change 2011 to 2015
Other*	561	525	633	602	620	59	9%
1 Star	364	251	134	80	74	(290)	-56%
2 Star	279	183	68	41	32	(247)	-59%
3 Star	1,015	997	1,019	946	905	(110)	-11%
4 Star	1,212	1,170	1,187	1,162	1,123	(89)	-8%
5 Star	1,489	1,650	1,768	1,901	2,007	518	40%
Total	4,920	4,776	4,809	4,732	4,761	-159	-4%

*Other includes temporary and provisional licenses and Religious Sponsored Notice of Compliance certificates.

Source: Division of Child Development and Early Education Monthly Statistical Summary

Questions?

Fiscal Research Division
Room 619, LOB
919-733-4910
www.ncleg.net/fiscalresearch/

VISITOR REGISTRATION SHEET

JT. APPROP. SUB-COMMITTEE ON HEALTH & HUMAN SERVICES
(Committee Name)

April 14 2015
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Matt Gross	NLPL
Kay Castillo	NASW-NC
David Collins	SEANC
TRACY GOLVARD	AHHC
Nancy H. Brown	NCPC Board Chair
Cindy Watkins	NCPC
Paul Kilpatrick	OSBM
Audra McDevitt	OSBM
Wayne Williams	OSBM
Michael Rivest	NC Child Care Coalition
JREES	CSS
Michelle Brooks	East Carolina University
Annaliese Dolph	DL
Kara Mc	Bennett
Meg Miller	KLG
Doug Miskew	PSG

VISITOR REGISTRATION SHEET

JT. APPROP. SUB-COMMITTEE ON HEALTH & HUMAN SERVICES
(Committee Name)

April 14, 2015
Date

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NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Gasperini	NCMS
Joanna Spruill	NCAFP
Kenya Caldwell	NCAFP - MS4
Mawlana Sheridan	NCAFP - MS 4
Ryan Blankenship	Cone Health
Trent Womble	DHHS
Judy Jenkins	Otsuka
Josh Ehrich	JJA
[illegible]	CCS
Austin Truitt	[illegible]
Bob Rucci	[illegible]
Matthew McConnell	Carolinas Healthcare
TJ Bulbree	NP
Curtis McDonald	BMS
Jaye Peters	CSS
John DeBruhl	Brubaker & Assoc.
Allison Cooper	NCOA
Rob Lamme	RCA

09-21-201

VISITOR REGISTRATION SHEET

JT. APPROP. SUB-COMMITTEE ON HEALTH & HUMAN SERVICES
(Committee Name)

April 14, 2015
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	BSA
Lao Rumant	CYPC
Meredith Whitfield	WCU
JOEL MAYNARD	GTM & ASSOC
Andy Chase	KMA
Douglas Holbrook	NCSBA
DANIEL VAN LEAR	VIDANT HEALTH
Tracy Kimbrell	Parker Poe

09-21-201

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JT. APPROP. SUB-COMMITTEE ON HEALTH & HUMAN SERVICES
(Committee Name)

Date

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NAME	FIRM OR AGENCY AND ADDRESS
Dick Catlett	Law Office of Dick Catlett PLLC
Tom Bean	EDF
Patricia A. Yancey	APPCNC
Erica Nelson	NCHA
Blake Tedder	self

VISITOR REGISTRATION SHEET

JT. APPROP. SUB-COMMITTEE ON HEALTH & HUMAN SERVICES
(Committee Name)

April 14, 2015
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS

House Committee on Appropriations, Health and Human Services
Wednesday, April 15, 2015 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The House Committee on Appropriations, Health and Human Services met at 8:30 AM on April 15, 2015 in Room 643 of the Legislative Office Building. Representatives M. Avila, W. Brisson, J. Dobson, C. Malone, J. Farmer-Butterfield, V. Insko, G. Pendleton, B. Earle, H. Howard attended.

Representative Chris Malone, Chair, presided and welcomed everyone to the meeting. He introduced and thanked the Sergeant-at-Arms. He also introduced and welcomed the House and Senate Pages. Please see attachments.

Chairman Malone welcomed and introduced State Auditor, Beth Wood, CPA.
She presented the 2014 Financial Statement Audit of the Department Of Health and Human Services. See attached sheets and book.

Chairman Malone welcomed and introduced Laketha Miller, CPA, Controller for DHHS.
Please see attachments.

The meeting adjourned at 9:50 a.m.

Representative Chris Malone, Chair
Presiding

Wanda Benson, Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

April 15, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Representative Chris Malone, Presiding Co-Chair
II.	**Presentation of 2014 Financial Statement Audit of the Department of Health and Human Services** **Note:** The audit report is posted on the Committee website. The Auditor will distribute hard copies for Committee members at the meeting	State Auditor, Beth Wood, CPA
III.	**DHHS Response**	Laketha Miller, CPA, Controller DHHS
	Committee Discussion	
	Adjourn	

JOINT APPROPRIATIONS COMMITTEE
ON HEALTH AND HUMAN SERVICES

Department of Health and Human Services
Financial Audit Overview

Laketha M. Miller CPA, Controller
Office of the Controller

April 15, 2015

Two clean financial audits validated our results

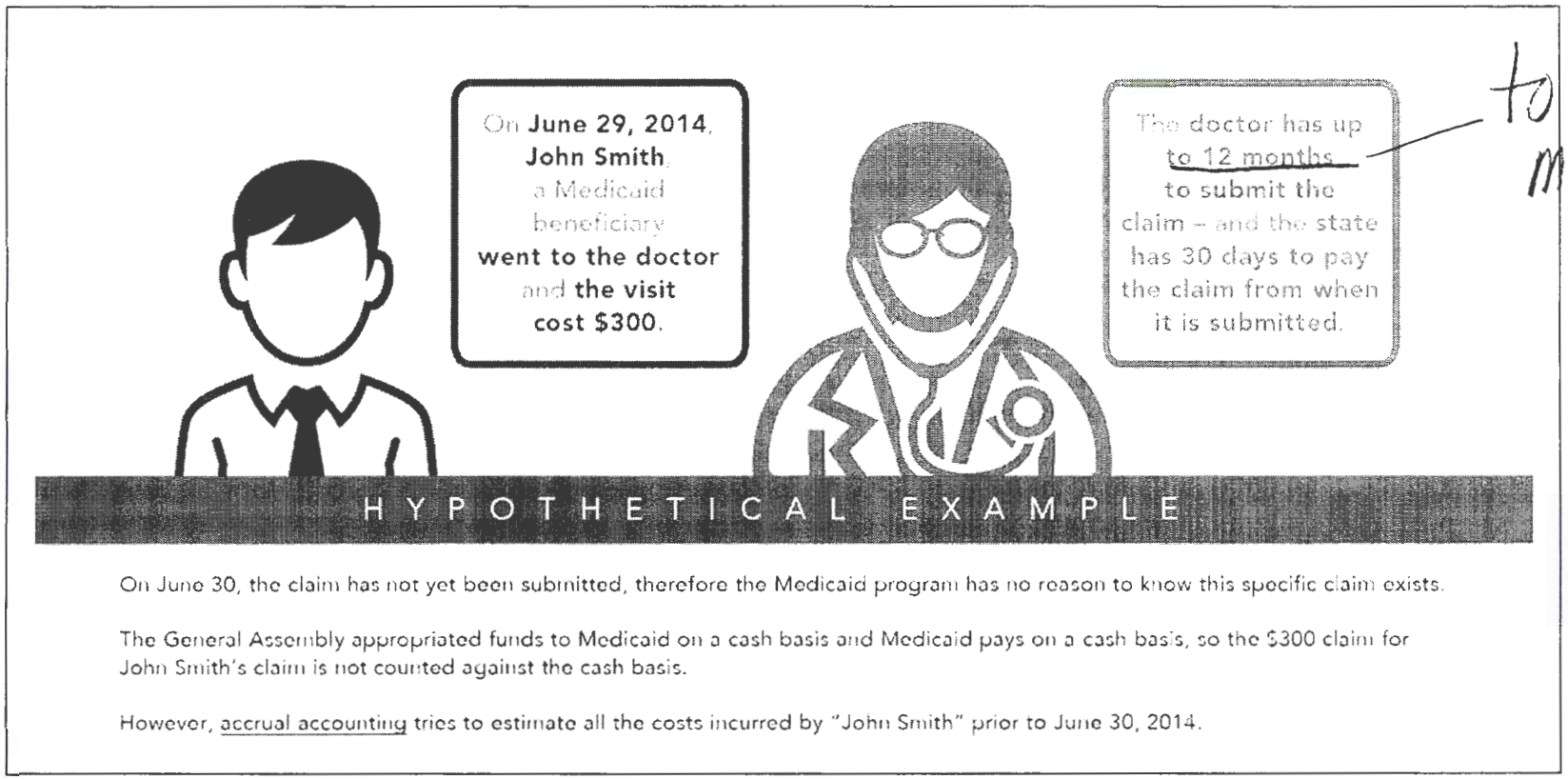
Comprehensive Annual Financial Report Dec. 2014	DHHS Financial Statement Audit April 2015
Annual financial audit of DHHS and other state departments	First detailed financial audit in 20 years
Provides look at overall financial health of all state departments	Provides look at overall financial health of one department

Actual Year End Results - Cash Basis

- Record revenue when received and expenditures when paid
- General Assembly budgets on a cash basis
- State operates on a cash basis
- DHHS ended last fiscal year with a positive cash balance
  - $104M cash not spent by DHHS includes $64M cash not spent on Medicaid (page 38 of April Audit Report)
- $104M reverted to state general fund at the end of the fiscal year see pg 38
- These results were confirmed by both audits

Accrual Basis Accounting

Accruals recognize revenues when earned and expenditures when obligated. As an example...



Year End Results – Accrual Basis

	Medicaid 2014 Financial Statement
Assets	
Cash, Cash Equivalents, and Pooled Cash	$42,369,114
Receivables, net	
Accounts Receivable	84,959,343
Intergovernmental Receivables	800,088,158
	$927,416,615
Liabilities	
Accounts Payable and Accrued Liabilities	
Accounts Payable	$10,167,693
Intergovernmental Payables	159,776,964
Medical Claims Payables	984,582,106
Due to Other State Agencies and Funds	181,191
Due to UNC Hospitals	116,143,907
Other Liabilities	6,589,406
	$1,277,441,267
Total Deferred Inflows of Resources	606
Fund Balance	($350,025,258)

agrees or | or hats on Pg 60. of state auditor's Budget

Source: Page 60 of April Audit Report

Year End Results – Accrual Basis

	Medicaid 2014 Financial Statement
Assets	
Cash, Cash Equivalents, and Pooled Cash	$42,369,114
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Accounts Receivable	84,959,343
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Source: Page 60 of April Audit Report

Year End Results – Accrual Basis

	Medicaid 2014 Financial Statement
Assets	
Cash, Cash Equivalents, and Pooled Cash	$42,369,114
Receivables, net	
Accounts Receivable	84,959,343
State Receivable	0
Intergovernmental Receivables	800,088,158
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Other Liabilities	6,589,406
	$1,277,441,267
Total Deferred Inflows of Resources	606
Fund Balance	($350,025,258)

Our financial statements and the audits correctly do not include the state appropriation required to match the federal share of the estimated Medicaid claims and other Medicaid payables.

If the state appropriations were included...

Source: Page 60 of April Audit Report

Year End Results – Accrual Basis

	Medicaid w/ Required State Appropriations
Assets	
Cash, Cash Equivalents, and Pooled Cash	$42,369,114
Receivables, net	
Accounts Receivable	84,959,343
State Receivable	381,285,238
Intergovernmental Receivables	800,088,158
	$1,308,701,853
Liabilities	
Accounts Payable and Accrued Liabilities	
Accounts Payable	$10,167,693
Intergovernmental Payables	159,776,964
Medical Claims Payables	984,582,106
Due to Other State Agencies and Funds	181,191
Due to UNC Hospitals	116,143,907
Other Liabilities	6,589,406
	$1,277,441,267
Total Deferred Inflows of Resources	606
Fund Balance	$31,259,980

The financial statement includes $800M in Intergovernmental Receivables. This amount represents the federal matching funds for Medicaid claims and other payables; however, to receive the federal funds the state must provide matching funds.

The required state match is $381M. This amount is included in the current fiscal year budget.

Year End Results – Accrual Basis

164
64 converted to Medicaid

	Medicaid 2014 Financial Statement	Medicaid w/ Required State Appropriations
Assets		
Cash, Cash Equivalents, and Pooled Cash	$42,369,114	$42,369,114
Receivables, net		
Accounts Receivable	84,959,343	84,959,343
State Receivable	0	381,285,238
Intergovernmental Receivables	800,088,158	800,088,158
	$927,416,615	$1,308,701,853
Liabilities		
Accounts Payable and Accrued Liabilities		
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	$1,277,441,267	$1,277,441,267
Total Deferred Inflows of Resources	606	606
Fund Balance	($350,025,258)	$31,259,980

Committee Sergeants at Arms

NAME OF COMMITTEE Jt. Comm. on App. HHS

DATE: 4/15/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name: _____
5. Name: _____

Senate Sgt-At Arms:

1. Name: _____
2. Name: _____
3. Name: _____
4. Name: _____
5. Name: _____

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 04/15/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Hamlin	MTS
Trent Womble	DHHS
Doug Lassiter	NCSTA
Austin Pruitt	Parkinson Law
Carson Hui	MVA
Cathy Rossberg	AMERIGROUP
Mike McBrien	Biogen
Matthew McConnell	Cardinal Healthcare Support
Amanda Horacek	TSS
Andy Gallo	NCPIE
Lexi Muniz	NCPIE

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Jt. Comm. on App. HHS — 04/15/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	CSS
[signature]	[illegible]
Lanier Swann Hodgson	UNC Health Care
Joanna Spruill	NCAFP

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 04/15/15

Name of Committee — Date

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Phoebe Landon	Brooks Pierce
JOE LANIER	CARDINAL
Judy Jenkins	Otsuka
Erica Nelson	NCHA
M. Lee Jones	DCP
Ken Melton	K.M.A.
Chip Killian	Nelson Mullins
Mel Wolfe	PhRMA
Doug Miskew	PSG
Rob Lamm	PCA
Lynda Tew	NCACHP

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 04/15/15

Name of Committee — Date

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Judy McDermott	OSBM
Pam Kilpatrick	OSBM
Sarah Grimsrud	OSBM
Kay Castillo	NASW-NC
Kenneth Haywood	BBGH
Mac Baxley	N C Foot & Ankle
Rhian Merwald	Williams Mullen
Matt Gross	NCPK
Flint Benson	SEANC
David Collins	SEANC
TRACY GOLVARD	AHIHC

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — Name of Committee

04/15/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ryan Blackledge	Cone Health
Bill Rustin	AHS
Chris McClure	BP
Annaliese Dolph	DL
Andy Chase	

Joint Committee on Appropriations on Health and Human Services
Thursday, April 16, 2015 at 8:30 a.m.
Room 643 of the Legislative Office Building

MINUTES

The Joint Appropriations Committee on Health and Human Services met at 8:30 a.m. on Thursday, April 16, 2015 in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, Josh Dobson, Chris Malone, Jean Farmer-Butterfield, Beverly Earle, Gary Pendleton and Verla Insko were present along with 8 Senate Members.

Senator Louis Pate presided.

Senator Pate opened the meeting by welcoming everyone and recognizing the House Sergeants-at-Arms: Young Bae, Bill Morris and Joe Austin; Senate Sergeants-at-Arms: Marcus Kitts, Canton Lewis, Giles Jeffreys and Dale Huff. He then recognized House Pages: Chris McCain from Alamance County, Ben Smith from Johnston County and Roman Bilan from Pitt County; Senate Pages: Sarah Strickland of Salemburg and Luke Evans of Asheboro.

Senator Pate recognized Ms. Deborah Landry of the General Assembly Research Division to give a presentation regarding Smart Start and NC Pre-K programs (attachments 1 & 2). She explained in detail and then opened the floor for questions and answers.

Dr. Nancy Brown, Chair of NCPC, Board of Directors, Cindy Watkins, President, NCPC, Inc., and Donna White, Deputy Director, NCPC, Inc. along with Rob Kindsvatter, Director, DHHS DCDEE, and Cynthia Wheeler of DHHS, DCDEE also were in attendance to answer any questions the Committee Members may have.

The meeting adjourned at 9:45 a.m.

Senator Louis Pate
Presiding

Edna Pearce, Committee Clerk

Principal Clerk
Reading Clerk

SENATE
NOTICE OF JOINT COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

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

DAY	DATE	TIME	ROOM
Thursday	April 16, 2015	8:30 AM	643 LOB

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

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

April 16, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.,
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Senator Pate, Presiding Co-Chair
II.	**Smart Start**	Deborah Landry, Fiscal Research Division
III.	**NC Pre-K**	Deborah Landry, Fiscal Research Division
	Committee Discussion	
	Adjourn	

Attachment 1

Smart Start

Deborah Landry
April 16, 2015

Joint Appropriations Committee on Health and Human Services

Program Comparison

	Smart Start	Child Care Subsidy	PreK
Mission	School Readiness	Provide needs based child care assistance	School Readiness
Target Population	Children from birth to age 5	Low income families with children under age 12	At-risk four-year-olds who have not been exposed to a child care setting

Program Comparison

	Smart Start	Child Care Subsidy	PreK
Eligibility	• Varies by activity • Local partnerships have flexibility for some activities	• 75% of state median income • Need child care for an eligible activity such as employment, high school or post-secondary education	• Income eligible at 75% of state median income • Eligible without regard to income: some military families; children with Limited English Proficiency, IEP, some health conditions, or educational need identified by screening
Funding and Administration	• Nonprofit organization at state and local levels • Public/private partnership • State and private funding • Local decision-making to address local needs	• Combination of State and Federal funding from Block Grants and the General Fund. • Locally administered program with State level support	• State program with state funding, plus other sources of funding contributed according to local decisions • Standard program; local decision-making about location of pre-k classrooms; all classrooms meet state standards

Smart Start

Smart Start's Vision

Every child reaches his or her potential and is prepared for success in a global community.

Smart Start's Mission

Advance a high quality, comprehensive, accountable system of care and education for every child beginning with a healthy birth.

Source: http://www.smartstart.org/

Smart Start Evaluation

What Works For Health Database

Expected Beneficial Outcomes

- Increased school readiness
- Increased vaccination
- Increased access to health care
- Increased child care quality

Ratings:

- Evidence Rating: Some Evidence
- Impact on Disparities: Likely to Decrease Disparities

Source: http://whatworksforhealth.wisc.edu/index.php

Smart Start Evaluation

- There is some evidence that Smart Start improves school readiness, especially for disadvantaged children. Additional evidence is needed to confirm effects.
- Children who attend centers participating in Smart Start appear better prepared for kindergarten than children who receive no child care. For low income children, these centers can increase school readiness (e.g., cognitive, language, social, and motor skills) more than other day care centers.

Source: http://whatworksforhealth.wisc.edu/index.php

Smart Start Evaluation

- The quality of centers participating in Smart Start appears to improve over time, especially when centers adopt Smart Start's quality improvement strategies. Centers may increase kids' language, reading, and math skills as quality increases. Through Smart Start's health services, participating children are more likely to receive a DTP vaccination and to have a regular source of care than non-participants.
- Research suggests that Smart Start partnerships work best when communities assess their baseline needs and develop plans locally, but set goals that can be evaluated by both communities and state officials. Communities can expect a multi-year collaborative process before they achieve measurable outcomes.

Source: http://whatworksforhealth.wisc.edu/index.php

Recent Smart Start Evaluation

Impact of North Carolina's Early Childhood Initiatives on Special Education Placements in Third Grade

"We find that access to early childhood programs in North Carolina significantly reduces special education placements in third grade. At 2009 funding levels, the SS reduces placements by 10% and the MAF program by 32%. Together, at these funding levels, the two programs reduce the odds of special education placement by 39%."

Source: Impact of North Carolina's Early Childhood Initiatives on Special Education Placements in Third Grade; Clara G. Muschkin, Helen F. Ladd, Kenneth A. Dodge, *Duke University*

Smart Start Evaluation

Sample of Programs Funded by Smart Start

Program	Description	Evidence Rating	Clearinghouse
Incredible Years	Seeks to prevent and reduce children's, up to age 12, challenging behavior while increasing their social skills by offering parent, teacher, and child training.	Scientifically Supported	What Works for Health
Reach Out and Read	Partners with doctors, nurse practitioners, and other medical professionals to incorporate literacy support into regular well-child visits. From the 6-month checkup through age five, medical providers give children developmentally appropriate books and give parents guidance and encouragement on reading with their children.	Scientifically Supported	What Works for Health
Parents as Teachers (PAT)	Educators visit parents' homes to teach them about early childhood development and promote effective parenting strategies. The program also includes developmental screenings of children, parent group meetings, and a resource network that links families with community resources.	Some Evidence	What Works for Health

Smart Start Evaluation

Sample of Programs Funded by Smart Start

Program	Description	Evidence Rating	Clearinghouse
Nurse-Family Partnership	Voluntary home-visiting program that targets low income, first-time mothers and their babies. Home visits begin during pregnancy and continue through a child's second birthday. The program aims to improve prenatal, birth, and early childhood outcomes.	Scientifically Supported	What Works for Health
The Triple P (Positive Parenting Program)	A system of parenting interventions for families with children ages 0-8,1 which seeks to strengthen parenting skills and prevent dysfunctional parenting, so as to prevent child maltreatment and emotional, behavioral, and developmental problems.	Supported, Promising, Near Top Tier	Results First (Pew Center) reported in 6 of 8 clearinghouses

Smart Start Certified Budget

	State	Child Care Development Fund (CCDF)	Total
FY 2008-09	$ 209.7	$ -	$ 209.7
FY 2009-10	$ 193.7	$ -	$ 193.7
FY 2010-11	$ 188.3	$ -	$ 188.3
FY 2011-12	$ 150.7	$ -	$ 150.7
FY 2012-13	$ 143.6	$ 7.0	$ 150.6
FY 2013-14	$ 140.0	$ 7.0	$ 147.0
FY 2014-15	$ 140.0	$ 7.0	$ 147.0

S.L. 2012-142 replaced $7 million in state funding for $7 million in CCDF block grant funding with no reduction in total funding.

The Department of Health and Human Services allocated $3.6 million of the $5 million non-profit reduction in S.L. 2011-145 to Smart Start. This is reflected in 2013-14.

Note: The total does not include the local match.

Source: BD307 for FY 2008-09 through 2012-13 and BD 701 for FY 2013-14 and 2014-15.

Local Partnership Expenditures

	2009-10	2010-11	2011-12	2012-13	2013-14
Child Care Subsidy	$77.4	$75.5	$66.7	$66.8	$64.8
Health Support	$6.5	$5.9	$2.9	$2.9	$2.8
Program Support	$7.3	$7.4	$6.4	$6.3	$6.4
Administration	$14.2	$13.9	$11.5	$11.5	$11.3
Family Support	$19.3	$19.6	$14.4	$15.7	$16.1
Other Early Childhood Related Activities	$55.9	$54.5	$43.8	$41.6	$40.5
Total	$180.6	$176.8	$145.7	$144.8	$141.9

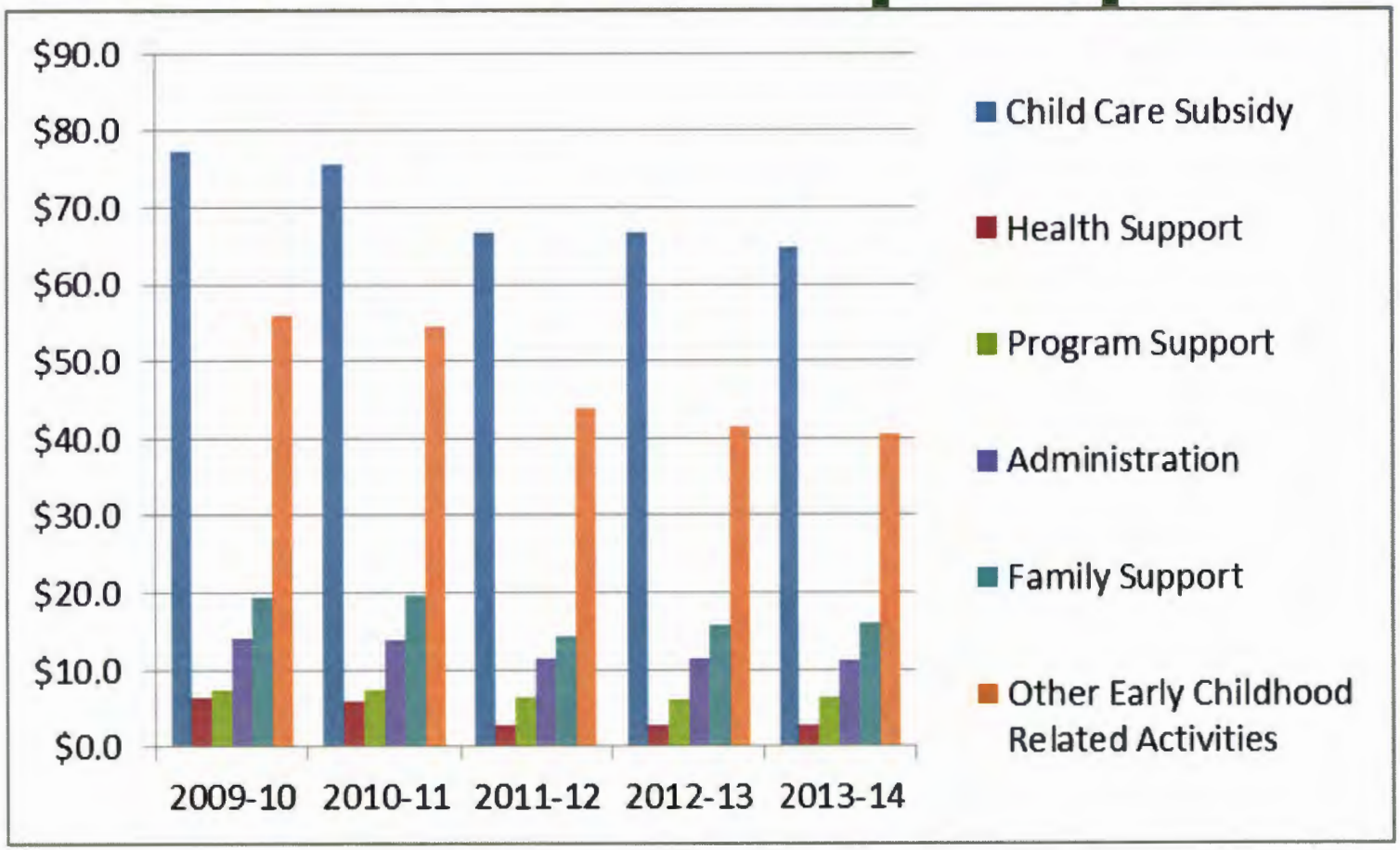
Dollars are in millions.

Program Support includes technical assistance, monitoring of all services , evaluation to ensure appropriate implementation of services and coordination across service providers.

Other Early Childhood Related Activities include but are not limited to working with child care programs to improve and maintain quality, supporting teachers to attend early childhood college courses and providing professional development.

Source: Smart Start Annual Reports 2009-10 through 2013-14

Local Partnership Expenditures



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Source: Smart Start Annual Reports 2009-10 through 2013-14

Smart Start Match Requirements

- Match requirements were increased for FY 2013-14 and 2014-15.

	2011-12	2012-13	2013-14	2014-15
In-Kind	3%	3%	3%	4%
Cash	10%	10%	11%	11%
Total	13%	13%	14%	15%

- In-kind donated resources that are counted toward the total required match can be equal to no more than the percentage listed for the applicable fiscal year.
- Failure to obtain the match by June 30th of each year results in a dollar-for-dollar reduction in the appropriation for the Program for a subsequent fiscal year.

Smart Start Match

	2011-12		2012-13		2013-14		2014-15
	Required	Actual	Required	Actual	Required	Actual	Required
In-Kind	$4.4	$9.0	$4.4	$8.2	$4.4	$8.7	$5.9
Cash	$14.7	$17.0	$14.7	$17.7	$16.2	$20.0	$16.2
Total	$19.1	$26.0	$19.1	$25.9	$20.6	$28.7	$22.1

Note: Dollars shown are in millions.

Source: Smart Start Annual Reports to the General Assembly

Smart Start Services and Number Served

Quality of Care & Access	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-14
Child Care Programs receiving support to improve or maintain the quality of care	2,933	2,804	2,575	2,558	2,229
Children receiving subsidy assistance from Smart Start. (Average monthly)	14,157	13,157	11,351	11,246	11,149
Teachers receiving an education-based salary supplement	10,733	10,019	7,193	6,351	5,797
Teachers participating in Smart Start-funded programs that help them to study early education at the college level	6,011	5,053	4,024	2,911	2,094

Source: Smart Start Annual reports and North Carolina Partnership for Children.
Source for children receiving subsidy assistance: Division of Child Development and Early Education Monthly Child Care Statistical reports.

Smart Start Services and Number Served

Supporting Parents	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-14
Families participating in ongoing parenting programs	*6,099*	*6,189*	*3,930*	*3,684*	*3,283*
Parents receiving assistance through the evidence-based Parents as Teachers program.	*5,718*	*6,257*	*4,146*	*3,723*	*3,235*
Child Health and Nutrition					FY 2013-14
Children with special needs or at-risk for developmental delay receiving Smart Start health-related enhanced services	6,169	6,365	5,850	5,720	4,923
Child Care facilities receiving child health consultation services	3,351	3,318	2,303	2,447	2,333
Children that participated in Shape NC initiatives	Program started in FY 2010-11	483	1,044	946	1,158

Note: Services that are italicized have an evidence based rating or include services that have an evidence based rating.

Source: Smart Start Annual reports and North Carolina Partnership for Children.

Smart Start Services and Number Served

Promoting Early Literacy	FY 2009-2010	FY 2010-2011	FY 2011-2012	FY 2012-2013	FY 2013-14
Parents participating in early literacy programs	16,178	17,685	28,563	47,849	71,664
Classrooms participating in the Raising a Reader program	345	425	373	555	490
Children participating in the Reach Out and Read program	*Program started in FY 2011-12*	*Program started in FY 2011-12*	*9,109*	*20,557*	*37,673*
Medical offices participating in the Reach Out and Reach program	*Program started in FY 2011-12*	*Program started in FY 2011-12*	*39 offices in 20 counties*	*51 offices in 22 counties*	*66 offices in 29 counties*

Note: Services that are italicized have an evidence based rating.

Source: Smart Start Annual reports and North Carolina Partnership for Children.

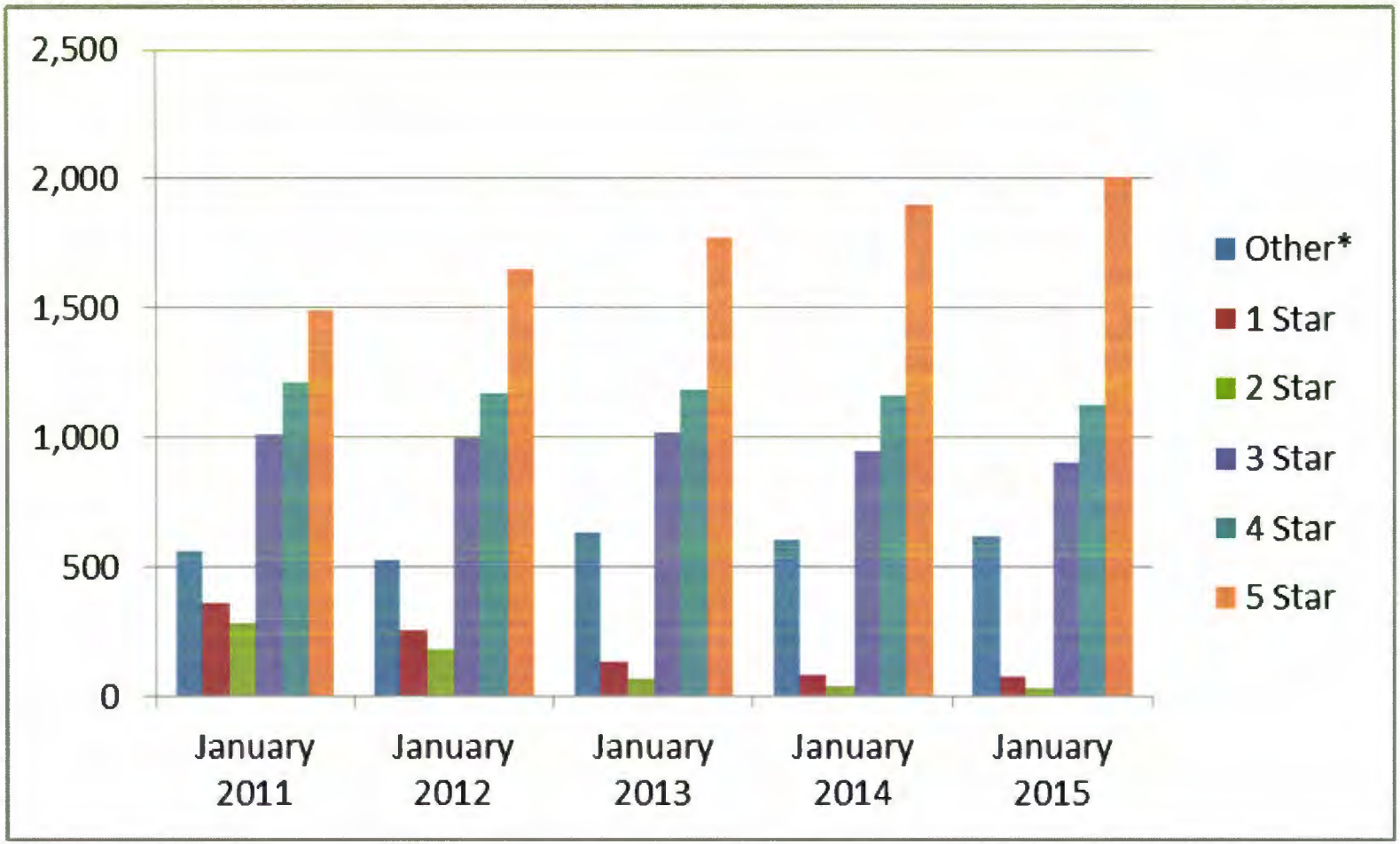
Change in Child Care Centers Star Ratings From 2011 to 2015

	January 2011	January 2012	January 2013	January 2014	January 2015	Change in Number of Centers	% Change 2011 to 2015
Other*	561	525	633	602	620	59	9%
1 Star	364	251	134	80	74	(290)	-56%
2 Star	279	183	68	41	32	(247)	-59%
3 Star	1,015	997	1,019	946	905	(110)	-11%
4 Star	1,212	1,170	1,187	1,162	1,123	(89)	-8%
5 Star	1,489	1,650	1,768	1,901	2,007	518	40%
Total	4,920	4,776	4,809	4,732	4,761	-159	-4%

*Other includes temporary and provisional licenses and Religious Sponsored Notice of Compliance certificates.

Source: Division of Child Development and Early Education Monthly Statistical Summary

Change in Child Care Centers Star Ratings From 2011 to 2015



*Other includes temporary and provisional licenses and Religious Sponsored Notice of Compliance certificates.

Source: Division of Child Development and Early Education Monthly Statistical Summary

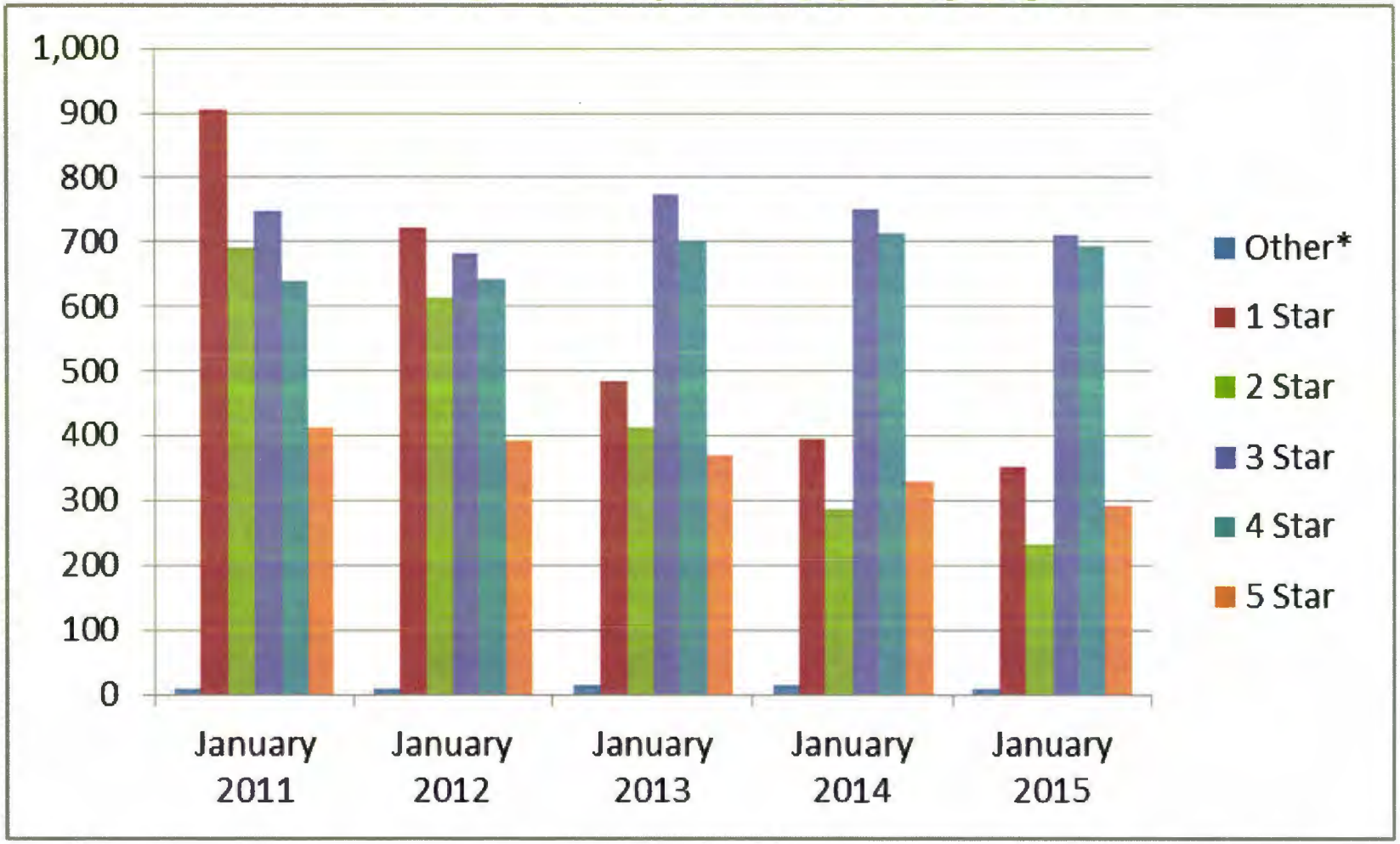
Change in Child Care Home Star Ratings From 2011 to 2015

	January 2011	January 2012	January 2013	January 2014	January 2015	Change in Number of Homes	% Change 2011 to 2015
Other*	11	9	15	15	9	(2)	-11%
1 Star	905	723	486	395	352	(553)	-48%
2 Star	692	615	414	286	232	(460)	-58%
3 Star	749	683	775	751	711	(38)	-6%
4 Star	639	642	703	715	693	54	8%
5 Star	412	393	370	331	294	(118)	-24%
Total	3,408	3,065	2,763	2,493	2,291	-1,117	-30%

*Other includes temporary and provisional licenses and Religious Sponsored Notice of Compliance certificates.

Source: Division of Child Development and Early Education Monthly Statistical Summary

Change Child Care Home Star Ratings From 2011 to 2015



*Other includes temporary and provisional licenses and Religious Sponsored Notice of Compliance certificates.

Source: Division of Child Development and Early Education Monthly Statistical Summary

Questions?

Fiscal Research Division

Room 619, LOB

919-733-4910

www.ncleg.net/fiscalresearch/

Attachment 2

Pre-K

Deborah Landry
April 16, 2015

Joint Appropriations Committee on Health and Human Services

Program Comparison

	Smart Start	Child Care Subsidy	PreK
Mission	School Readiness	Provide needs based child care assistance	School Readiness
Target Population	Children from birth to age 5	Low income families with children under age 12	At-risk four-year-olds who have not been exposed to a child care setting

Program Comparison

	Smart Start	Child Care Subsidy	PreK
Eligibility	• Varies by activity • Local partnerships have flexibility for some activities	• Age 0 to 5, and Special Needs children, 200% of federal poverty level • Age 6-12, 133% of federal poverty level • Need child care for an eligible activity such as employment, high school or post-secondary education	• Income eligible at 75% of state median income • Eligible without regard to income: some military families; children with Limited English Proficiency, IEP, some health conditions, or educational need identified by screening
Funding and Administration	• Nonprofit organization at state and local levels • Public/private partnership • State and private funding • Local decision-making to address local needs	• Combination of State and Federal funding from Block Grants and the General Fund. • Locally administered program with State level support	• State program with state funding, plus other sources of funding contributed according to local decisions • Standard program; local decision-making about location of pre-k classrooms; all classrooms meet state standards

Pre-K

The NC Pre-K Program is designed to provide high-quality educational experiences to enhance school readiness for eligible four-year-old children.

The NC Pre-K Program Requirements are built premise that to be successful academically in school, children need to be prepared in all five of the developmental domains that are critical to children's overall well-being and success in reading and math as they enter school:

- Approaches to play and learning
- Emotional and social development
- Health and Physical Development
- Cognitive development
- Language development and communication

Source: http://ncchildcare.dhhs.state.nc.us/general/mb_ncprek.asp

Pre- K Evaluation

What Works For Health Database

Expected Beneficial Outcomes

- Improved cognitive skills
- Improved social emotional skills
- Increased academic achievement
- Increased earnings
- Reduced child care costs

Ratings:

- Evidence Rating: Scientifically Supported
- Impact on Disparities: Likely to Decrease Disparities

Source: http://whatworksforhealth.wisc.edu/index.php

Pre- K Evaluation

- State-sponsored pre-K programs, whether universal or not, improve children's language, math, and reading skills.
- Explicit academic instruction, low staff-to-student ratios good classroom management, and emotional support can also improve children's cognitive and social outcomes.

Source: http://whatworksforhealth.wisc.edu/index.php

Pre- K Evaluation

The State of Preschool 2013, published by the National Institute for Early Education Research provides information on the pre-K programs operated by the 40 states and Washington D.C. that offer pre-K.

Each program is measured against 10 benchmarks. These are:

Early Learning Standards	Maximum class size
Teacher degree	Staff-child ratio
Teacher specialized training	Screening/referral and support services
Assistant Teacher Degree	Meals
Teacher in-service	Monitoring

North Carolina was one of only 4 states, plus one of Louisiana's three programs, to meet all 10 benchmarks.

Source: Barnett, W.S., Carolan, M.E., Squires, J.H., Clarke Brown, K. (2013). The state of preschool 2013: State preschool yearbook. New Brunswick, NJ: National Institute for Early Education Research

Recent Pre-K Evaluation

Impact of North Carolina's Early Childhood Initiatives on Special Education Placements in Third Grade

"We find that access to early childhood programs in North Carolina significantly reduces special education placements in third grade. At 2009 funding levels, the SS reduces placements by 10% and the MAF program by 32%. Together, at these funding levels, the two programs reduce the odds of special education placement by 39%."

Source: Impact of North Carolina's Early Childhood Initiatives on Special Education Placements in Third Grade; Clara G. Muschkin, Helen F. Ladd, Kenneth A. Dodge, *Duke University*

Pre-K Funding History and Number Served

	State	Lottery	TANF	Total	Number of Funded Slots
FY 2008-09	$ 86.0	$ 84.6	$ -	**$ 170.6**	33,798
FY 2009-10	$ 53.0	$ 84.6	$ 28.0	**$ 165.6**	31,197
FY 2010-11	$ 35.8	$ 79.6	$ 45.0	**$ 160.4**	30,767
FY 2011-12	$ 65.0	$ 63.1	$ -	**$ 128.1**	24,836
FY 2012-13	$ 65.0	$ 63.1	$ -	**$ 128.1**	24,664
FY 2013-14	$ 65.0	$ 75.5	$ -	**$ 140.5**	26,617
FY 2014-15	$ 50.2	$ 75.5	$ 19.8	**$ 145.5**	28,379

One-time funding:

- **In SFY 11-12, a total of $9.1 million in state funding was spent for one-time expansion of NC Pre-K. This added 1,982 slots, bringing the totals to $137.2 million in state funding and 26,818 children served.**
- **In SFY 12-13, a total of $12.4 million in state funding was spent for one-time expansion of NC Pre-K. This added 4,908 partial year slots, bringing the totals to $140.5 million in state funding and 29,572 children served.**

State Pre-K Slot Costs

Facility Type	FY 2012-13	FY 2013-14
Private Child Care - Lead Teacher with Birth-Kindergarten License	$ 650	$ 650
Private Child Care - Lead Teacher with4-Year Degree without Birth-Kindergarten License	$ 600	$ 600
Public Schools	Up to $473	Up to $473
Head Start	Up to $300	Up to $400

Source: Division of Child Development and Early Education

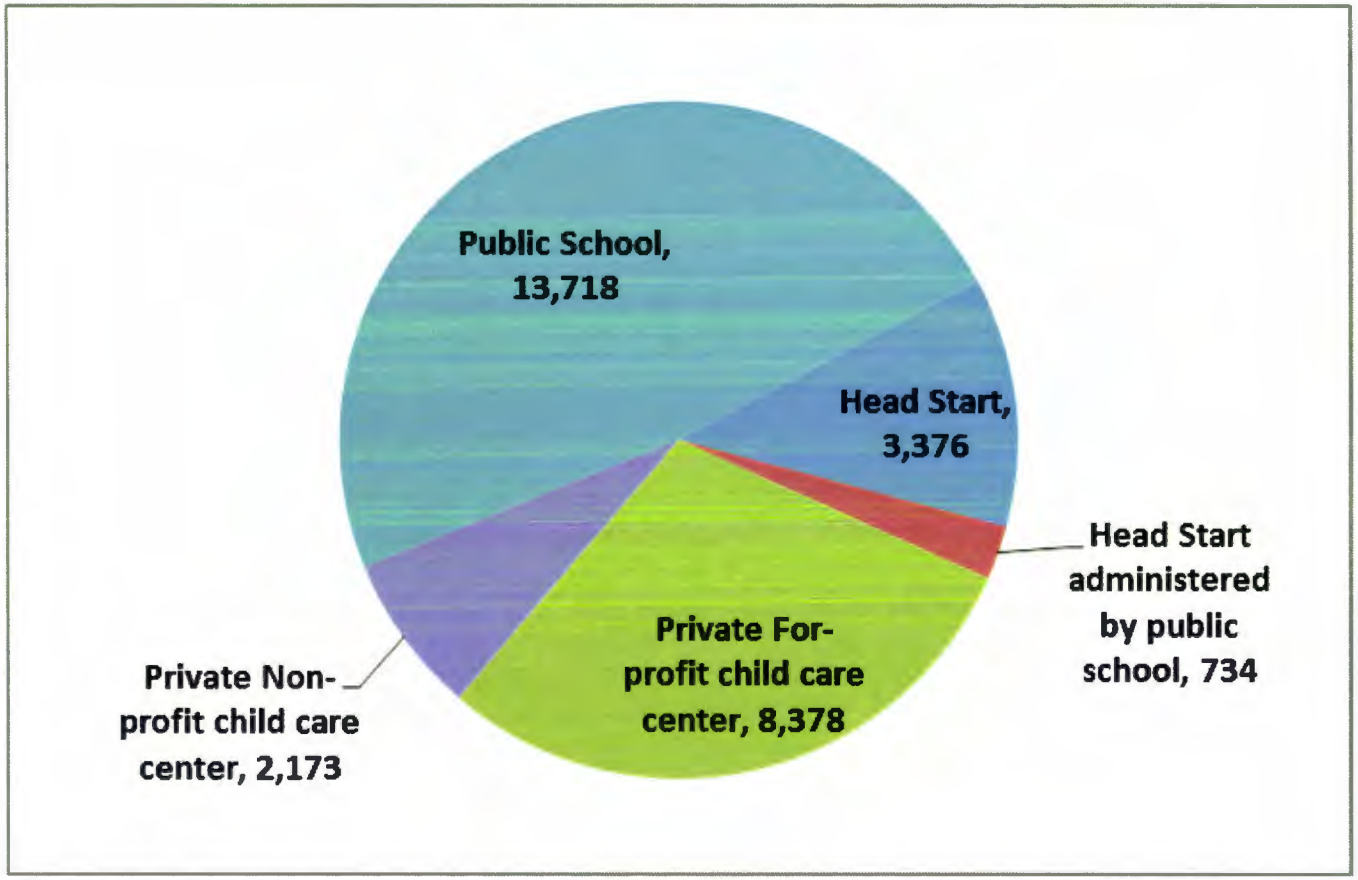
NC Pre-K Program Data for 2014-15

- Sites: 1168
- Classrooms: 1971
- Students Served: 28,379
- Contractors by Type
  - Public School – 41
  - Local Partnership for Children – 45
  - Head Start – 4
  - Other - 1

Source: Division of Child Development and Early Education, NC Pre-K Program Data for 2014-15, February 2, 2015

NC Pre-K Program Data for 2014-15

Students Served by Facility Type



Source: Division of Child Development and Early Education, NC Pre-K Program Data for 2014-15, February 2, 2015

Pre-K Site Selection

- The NC Pre-K Program requires that every county (or region) participating in NC Pre-K must establish and maintain a NC Pre-K Committee.
- The committee must be co-chaired by the school superintendent for the local education agency (LEA) and the board chair (or designee) for the local Smart Start Partnership.
- The committee selects a contractor agency.
- Each Pre-K committee must have a Site Selection Subcommittee.

Source: NC Pre-Kindergarten (NC Pre-K) Program Requirements and Guidance, published by the Division of Child Development and Early Education

Pre-K Site Selection

- S.L. 2012-142 Section 10.1(f) requires DCDEE to establish a standard decision-making process to be used by local NC Pre-K committees in awarding NC Pre-K classroom slots and student selection. DCDEE has implemented a standard site selection application and a site selection rubric which all Site Selection Subcommittees must utilize in awarding Pre-K classrooms.

Source: NC Pre-Kindergarten (NC Pre-K) Program Requirements and Guidance, published by the Division of Child Development and Early Education

Contractor Duties

- Program progress (recruiting, child identification and eligibility, enrollment, and attendance);
- Site updates (child placement; star licensure progress);
- Site staff education levels, staff salaries and progress toward goals (administrators, teachers, assistants);
- Professional development activities;

Source: NC Pre-Kindergarten (NC Pre-K) Program Requirements and Guidance, published by the Division of Child Development and Early Education

Contractor Duties

- Efforts to collaborate with other agencies;
- Strengths and barriers to service delivery;
- Efforts to implement plans related to transportation, transitions, helping families access health insurance and a medical and dental home, helping ensure child health assessments, and consultation from a qualified health professional; and
- Fiscal and budget reports, including funds received and funds paid to subcontractor(s).

Source: NC Pre-Kindergarten (NC Pre-K) Program Requirements and Guidance, published by the Division of Child Development and Early Education

Early Childhood Program Evidence

- Child Care Subsidy – Scientifically Supported
- Smart Start – Some Evidence
- Pre-K - Scientifically Supported

- Scientifically Supported -Strategies with this rating are most likely to make a difference. These strategies have been tested in many robust studies with consistently positive results.
- Some Evidence - Strategies with this rating are likely to work, but further research is needed to confirm effects. These strategies have been tested more than once and results trend positive overall.

Source: http://whatworksforhealth.wisc.edu/index.php

Questions?

Fiscal Research Division

Room 619, LOB

919-733-4910

www.ncleg.net/fiscalresearch/

Committee Sergeants at Arms

NAME OF COMMITTEE House Comm. on Appropr.Health

DATE: 4/16/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Joe Austin
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name: Marcus Kitts
2. Name: Canton Lewis
3. Name: Giles Jeffreys
4. Name: Dale Huff
5. Name:

Thursday, April 16	**Room**	**Time**
APPROPRIATIONS HEALTH & HUMAN SERVICES (JOINT)	643	8:30 am

Name	County	Sponsor
Chris McCain	Alamance	Dennis Riddell
Ben Smith	Johnston	N. Leo Daughtry
Roman Bilan	Pitt	Brian Brown

SENATE PAGES ATTENDING

COMMITTEE: Joint Appro. - Health & Hum. Serv ROOM: 643

DATE: 4-16 TIME: 8:30

PLEASE PRINT LEGIBILY!!!!!!!!!!!!!....*or else!*

Page Name	Hometown	Sponsoring Senator
1. Sarah Strickland	Salemburg	Berger
2. Lyte Evans	Asheboro	Tillman
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

- From NCPC

Dr. Nancy H Brown - Chair, NCPC, Board of Directors

Cindy Watkins - President, NCPC, Inc.

Donna White - Deputy Director, NCPC, Inc.

- DHHS- DCDEE

Rob Kindsvatter, Director, DHHS DCDEE

Cynthia A. Wheeler, DHHS, DCDEE

-

VISITOR REGISTRATION SHEET

JT. APPROP. SUB-COMMITTEE ON HEALTH & HUMAN SERVICES
(Committee Name)

4/16/15
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Demetrius Deloatch	Sen. Robinson
Judith McDevitt	OSBM
Wayne Williams	OSBM
Connie Wilson	Smart Start/Early Childhood
Mah Gray	NCPC
Kay Castillo	NASW-NC
Pam Kilpatrick	OSBM
Erica Nelson	NCHA
Madeline Keeter	CaroMont Health
KEVIN LECOUNT	SEANC
Colleen Kachanek	NCCEA
Andy Chase	KMA
Bill Rustin	AFT
Rab Lamm	TCH
Judy Jenkins	Ots dhhs
J Peters	CSS
Jennifer Mahan	ASNC

VISITOR REGISTRATION SHEET

JT. APPROP. SUB-COMMITTEE ON HEALTH & HUMAN SERVICES
(Committee Name)

4/16/15
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Trent Womble	DHHS
Fred Waddell	ESUCP
Carson Blue	MVA
Josh Lynch	JDA
[illegible]	[illegible]
Amanda Horeake	TSS
[illegible]	ACP
Annalise Ralph	DL
Breeder BLACKwell	Cape Fear Valley
Cathy Thorp	NCHA
Austin Pruitt	Parkinson Law
Tom VITAGLIONE	NC CHILD
Wendy Kelly	Lows Carolina
[illegible]	MH&S
Jim Johnson	BSA
Christine Cruis	WakeMed

09-21-201

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JT. APPROP. SUB-COMMITTEE ON HEALTH & HUMAN SERVICES
(Committee Name)

4/16/15
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Hardin	CTR
Steve Brewer	CTR
Isabel Villa-Davis	NCAH
Michelle Frazier	MFTS
Julie Wh	NCMMC
[illegible]	MWC
[illegible]	BSD
[illegible]	NSS
[illegible]	ETGR

09-21-201

Joint Committee on Appropriations on Health and Human Services
Tuesday, April 21, 2015 at 8:30 AM
Room 643 of the Legislative Office Building

MINUTES

The Joint Committee on Appropriations on Health and Human Services met at 8:30 AM on April 21, 2015 in Room 643 of the Legislative Office Building. Representatives Marilyn Avila, William Brisson, Josh Dobson, Chris Malone, Jean Farmer-Butterfield, Beverly Earle, Verla Insko and Gary Pendleton were present, along with 7 Senate members.

Representative Josh Dobson presided.

Representative Dobson opened the meeting by welcoming everyone and recognizing the House Sergeants-At-Arms: Young Bae, Bill Morris and Jim Moran, and Senate Sergeants-at-Arms: Canton Lewis, Giles Jeffreys and Dale Huff.
He then recognized House Pages: Ethan Mastin from Surry County, Lizzie O'Briant of Randolph County, Davis Privette of Guilford County and Joe Swaim of Randolph County; and Senate Pages Emily Braren of Lee County, Nick Mills of Wake County and Olivia Robenson of Onslow County.

Representative Dobson then recognized Dr. Aldona Wos, Secretary of HHS for comments by the Secretary. Rep. Dobson then recognized Sherry Bradsher, Deputy Secretary of Human Services to speak on Child Welfare Needs. Rep. Dobson next recognized Angela Taylor, Director Office of NC FAST, DHHS to provide an NC FAST Update. Rep. Dobson next recognized Neil Ramgoolam, Client Executive, Curam Software Brand and Richelle Mathieu, Product Specialist, Curam Software Lead to speak on IBM Solutions for Child Welfare. Rep. Dobson recognized the final presenter of the day, David Atkinson, Director Human Services, Carteret County to speak on the Counties Point of View on Child Welfare.

Representative Dobson then opened the floor for questions by the members.

The meeting adjourned at 9:51 a.m.

Representative Josh Dobson
Presiding

Julie Ryan, Committee Clerk

CHAIR'S AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

April 21, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks (8:30 – 8:35)**	Representative Dobson, Presiding Co-Chair
II.	**Secretary's Comments (8:35-8:40)**	Dr. Aldona Wos, Secretary DHHS
III.	**Child Welfare Needs (8:40 – 8:45)**	Sherry Bradsher, Deputy Secretary of Human Services, DHHS
IV.	**NC FAST Update (8:45-9:00)**	Angela Taylor, Director Office of NC FAST, DHHS
V.	**IBM Solution for Child Welfare (9:00 – 9:30)**	Neil Ramgoolam ~~Ronan Rooney~~, Director Programs of Care, IBM Research/Cúram Richelle Mathieu, Cúram Software Lead, Product Specialist
VI.	**Counties Point of View on Child Welfare (9:30 – 9:35)**	David Atkinson, Director Human Services, Carteret County
	Committee Discussion	
	Adjourn	

North Carolina Department of Health & Human Services

NC FAST
North Carolina Families Accessing Services through Technology

NC FAST
Child Welfare and Adult and Family Services

April 21, 2015

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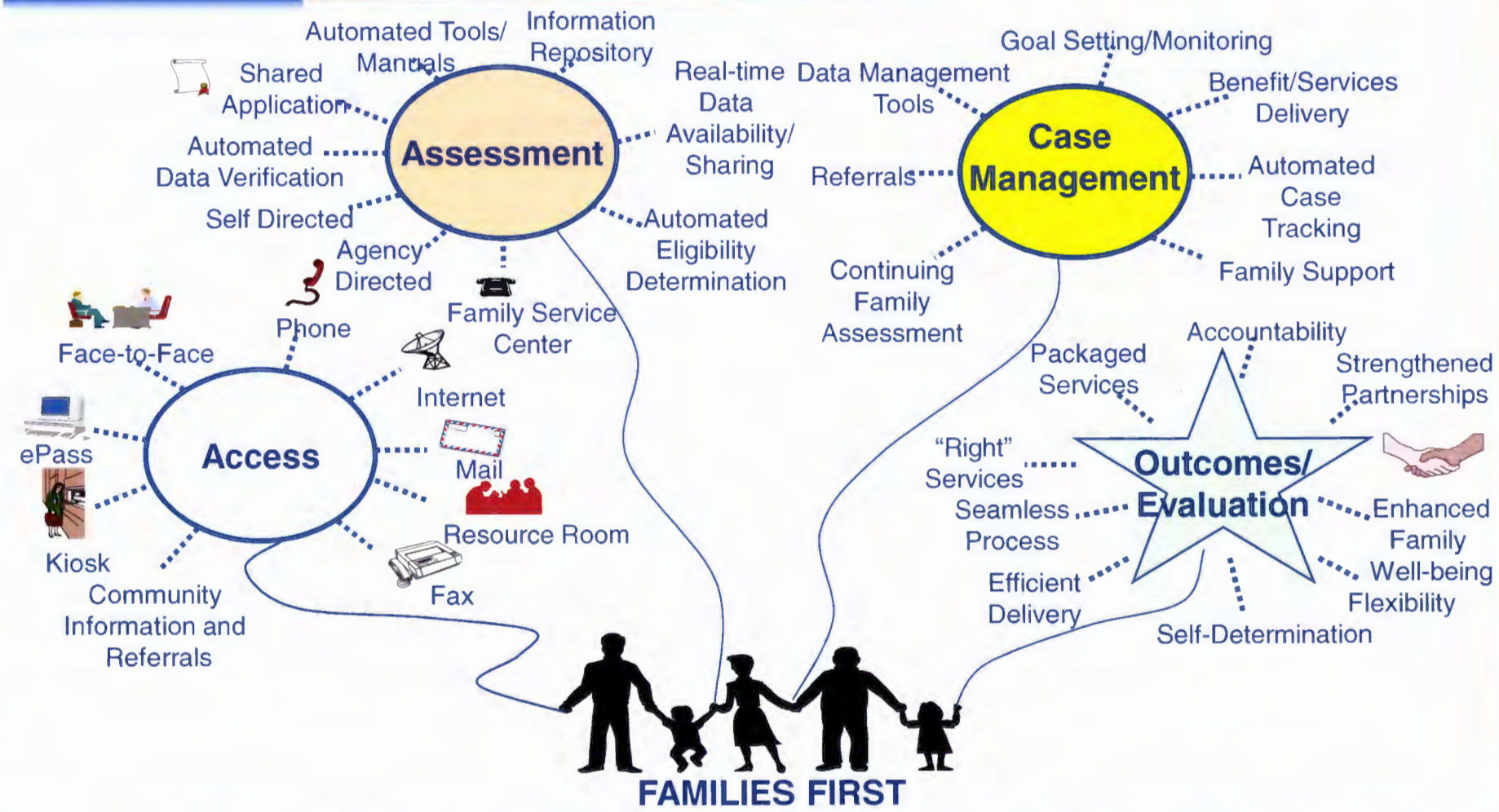
Streamlining Access and Strengthening Families



"Provide family centered services by means of an efficient, seamless service delivery process that provides flexibility for the counties and accountability throughout the system"

What is NC FAST?

- Integrated Case Management business solution that delivers state benefits and services at the county level.
- Competitive procurement decision made in 2008.
- Replaces 19 siloed legacy systems.
- Shares client data across all programs and across counties.
- Applies State and Federal rules and policies, built into the business solution.

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Original NC FAST Timeline

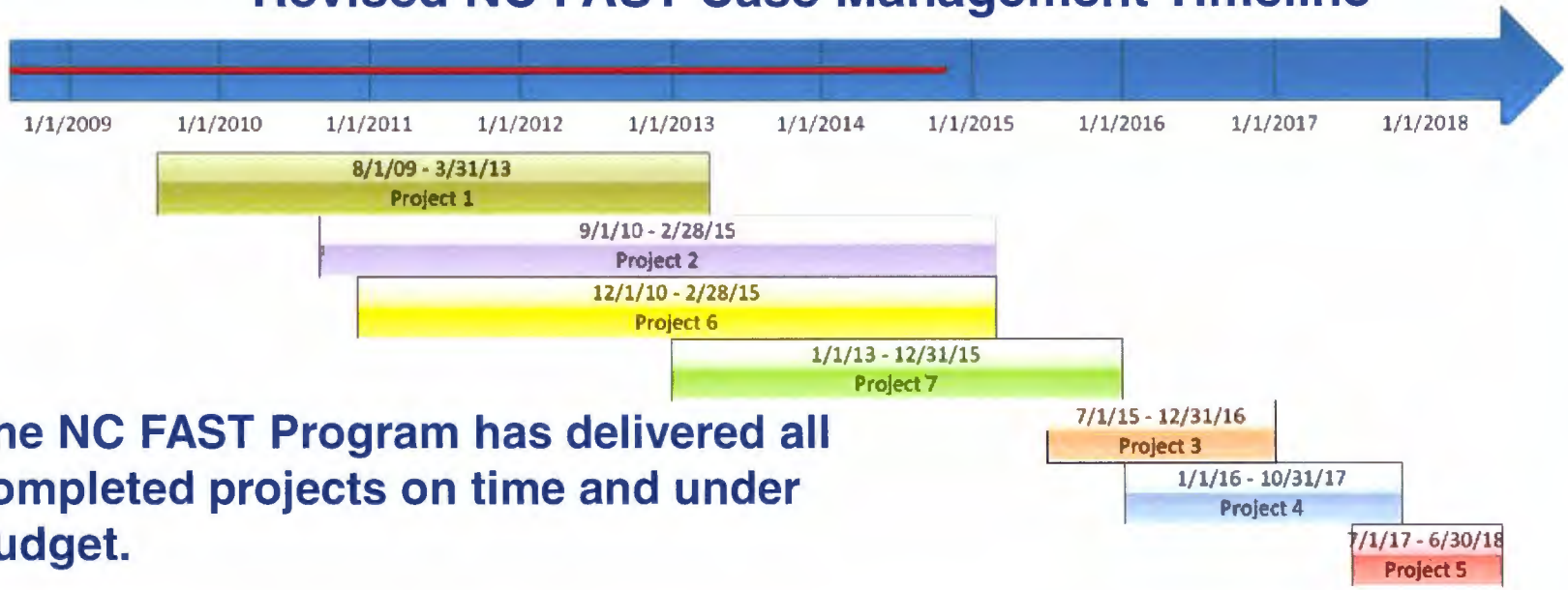
Case Management Timeline as of August 2009

- ***Project 1***: *Global Case Management and Food and Nutrition Services (FSIS)*
- ***Project 2***: *EIS Part 1 (Screening and Intake for Work First (TANF), Medicaid, Special Assistance and Refugee Assistance*
- ***Project 3***: *LIEAP, Child Care and CIP*
- ***Project 4***: *Child Services*
- ***Project 5***: *Aging and Adult Services*
- ***Project 6***: *EIS Part 2 (Eligibility for Work First (TANF), Medicaid, Special Assistance and Refugee Assistance*

- Project 1: Retired the 30+ year-old Food Stamp Information System (FSIS) legacy system.
- Project 2&6: The 30+ year-old Eligibility Information System (EIS) legacy system will be retired.

ACA Impact on NC FAST Timeline

Revised NC FAST Case Management Timeline



The NC FAST Program has delivered all completed projects on time and under budget.

Last Modified 10/24/14

- ***Project 1***: *Global Case Management and Food and Nutrition Services (FSIS)*
- ***Project 2***: *EIS Part 1 (Screening and Intake for Work First (TANF), Medicaid, Special Assistance, Refugee Assistance*
- ***Project 3***: *LIEAP, Child Care and CIP*
- ***Project 4***: *Child Services*
- ***Project 5***: *Aging and Adult Services*
- ***Project 6***: *EIS Part 2 (Eligibility for Work First (TANF), Medicaid, Special Assistance, Refugee Assistance*
- ***Project 7***: *HealthCare.gov Interoperability and Rules (Federally-Facilitated Marketplace)*
- **Note:** Due to the Affordable Care Act (ACA), Project 6 was moved up in the overall timeline and combined with Project 2.
- **Note:** Project 7 was also added in response to Federal changes associated with ACA.

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Benefits of an Integrated Case Management System

- Enables real-time sharing of client and case information across programs and counties.
- Enables families to provide their information only once for eligible programs.
- Provides a Decision Support Model to deliver timely services and protect NC's most vulnerable children and aging adults.
- Supports a truly integrated, cross-functional service delivery approach that moves beyond the current siloed and paper-based systems.
- Leverages existing investments in infrastructure and software technology to continue delivering services for additional programs and interfaces to health services in the future.

Serving North Carolinians

Currently, 2.5M North Carolinians across all 100 counties are receiving benefits through NC FAST.

Actively Delivering Economic Benefits

- Project 1: Food and Nutrition Services benefits
- Project 2/6:
  - Traditional Medicaid program eligibility
  - Work First benefits
  - Special Assistance benefits
  - Refugee Assistance benefits
- Project 7: ACA Modified Adjusted Gross Income Medicaid program eligibility

These projects provide a solid foundation for expansion of NC FAST into protective service programs.

NC FAST Projects

Economic Benefit Project

Project 3 Low Income Energy Assistance Program (LIEAP), Child Care, and Crisis Intervention Program (CIP):

Includes screening, intake, assessment, eligibility determination and benefit delivery for LIEAP, Child Care, and CIP. The initial planning tasks and re-assessment of the original requirements was started in October 2013. The project design, development, and implementation will begin July 2015.

Legacy system replacement

- Subsidized Child Care Reimbursement (SCCR)
- Energy System (CIP and LIEAP)

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NC FAST Projects

Services Project

Project 4 Child Services: Includes screening, intake, licensure, assessments, service planning and provisioning for Child Protective Services, Child Placement and Foster Care, and Adoption Services.

Legacy system replacement

- Child Placement and Payment System (CPPS)
- Central Registry Child Abuse and Neglect (CRCAN)
- Central Registry Fatalities (FAT)
- Multiple Response System (MRS)
- Adoption Index Management System (AIMS)
- Foster Care Facility Licensing System (FCFLS)
- Interstate Compact for the Placement of Children (ICPC)

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NC FAST Projects

Services Project

Project 5 Adult and Family Services: Includes screening, intake, licensure, assessments, service planning and provisioning for Adult Protective Services, Resident Assessments, Guardianship Services, Adult Placement Services for Residential Care and Adult Care Home Case Management.

Legacy system replacement

- Adult Protective Services (APS)
- Disinterested Public Agent Guardians (DPAG)
- ARMS (aging resources management system)
- Special Assistance In-Home
- Services Information System (SIS)
- Daysheets

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Session Law 2011-145

Pursuant to Session Law 2011-145, Section 6A.7.(b) DHHS collaborated with the Office of the State CIO staff to developed a plan and process to evaluate the case management needs in the department to determine where appropriate to utilize the NC FAST enterprise case management solution. This was to adhere to the Session Law requirement for DHHS to implement a single case management system throughout DHHS.

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Support for NC FAST

- Governor's Budget supports the ongoing efforts of NC FAST. The budget includes continued implementation of Project 7- ACA Medicaid, Project 3 – Child Care, Low Income Energy Assistance Program, and Crisis Intervention Program, and Project 4 – Child Services.

	2015-2016			2016-2017		
	Recurring Changes	Non Recurring Changes	Total	Recurring Changes	Non Recurring Changes	Total
Req	$ -	$ 5,803,000	$ 5,803,000	$ -	$ 13,052,000	$ 13,052,000
Rec	$ -	$ -	$ -	$ -	$ -	$ -
Appr	$ -	$ 5,803,000	$ 5,803,000	$ -	$ 13,052,000	$ 13,052,000
Pos	0.000	37.000	37.000	0.000	40.000	40.000

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Integrating Child Welfare and Eligibility Systems

Real Time Shared Data between programs and counties, Enhanced Operational Analytics, Common Data Model, Aligned Business Operations, Interoperability, Elimination of unnecessary complexities with interfaces, Enhanced ability to adapt policies, Improved Outcomes, Promotion of client focused delivery.

Client Benefits from an Integrated System

- **80% of the families in the child welfare system are also receiving some other human services benefit.**
- Workers would no longer need to look up and re-enter data in multiple systems resulting in less required data gathering from the client or family.
- Administering all these services and benefits from one system supports a complete view of a client and family including family composition, location and movement, and participation in all programs.

IBM Cúram Discussion

- IBM Commitment
- IBM Cúram Child Welfare Solution
- NC FAST
- Mobility Demonstration

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Cúram in practical use...

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Mission

To provide care and protection for citizens and families in need and to help them to achieve their social and economic potential

Maximizing the social and economic ROI

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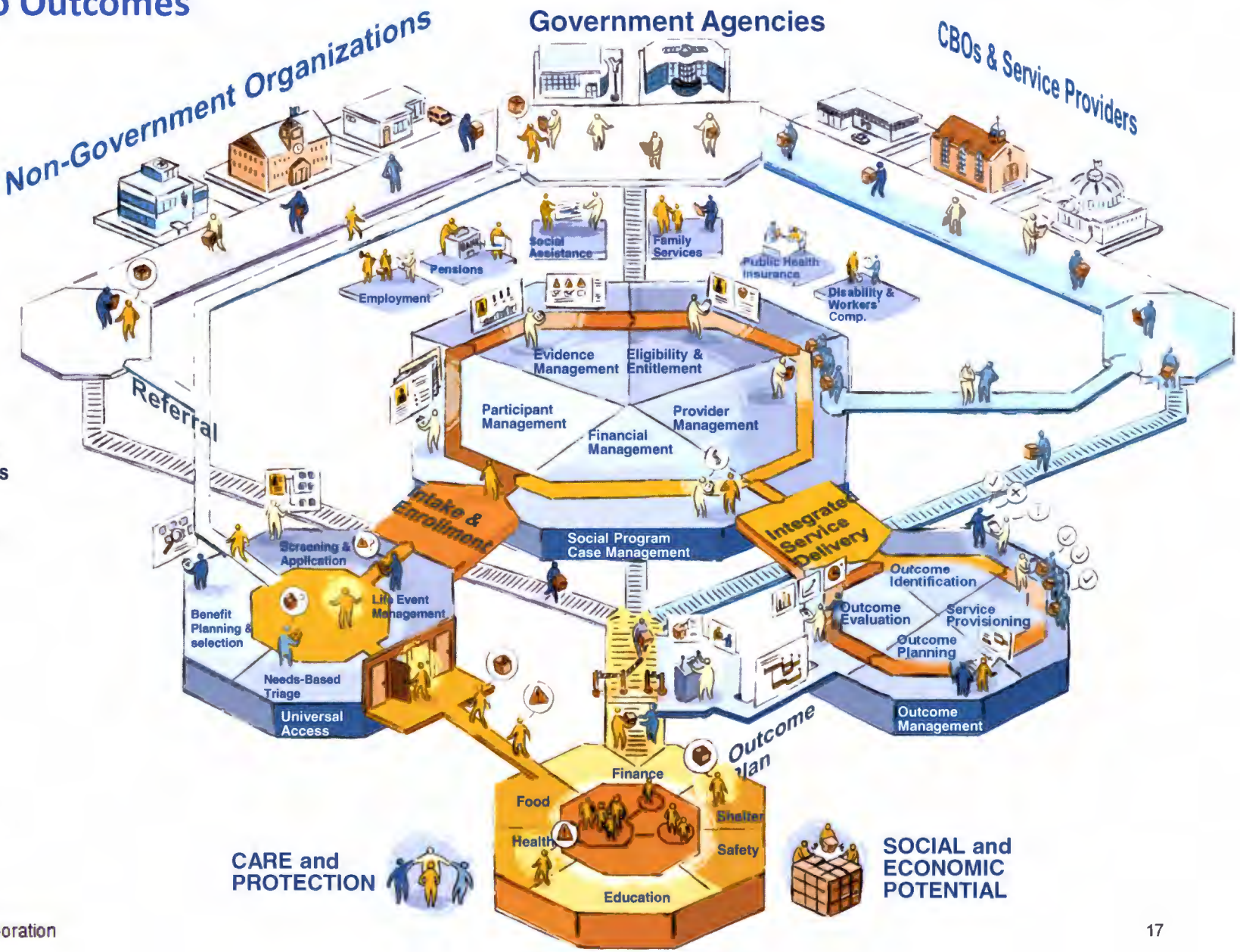
Needs to Outcomes



Non-Government Organizations (NGO)

Government Agencies

Providers

Client

Life Events

Needs

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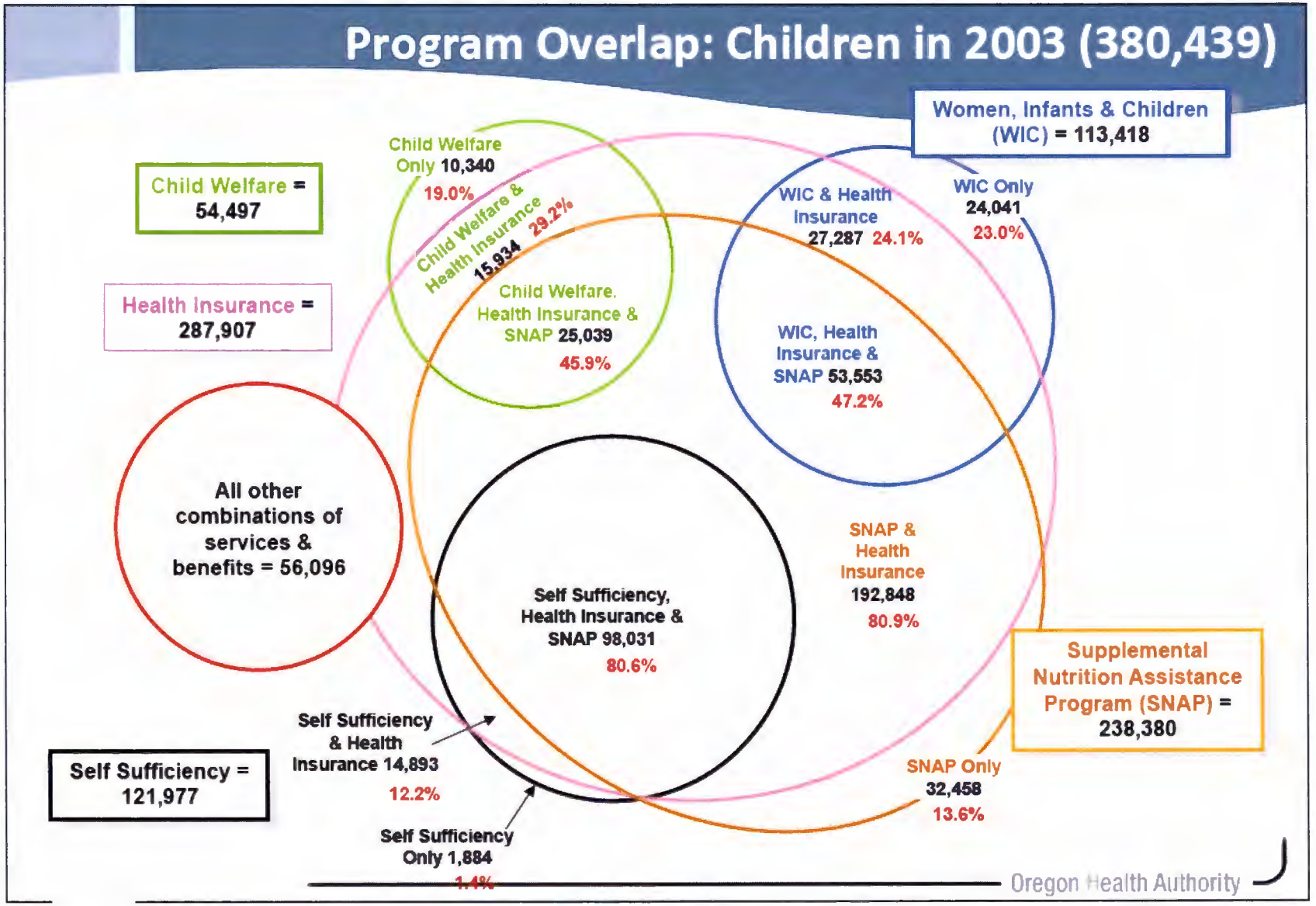

Enhancing MITA to Accommodate Interoperability. R. Howard 8/2010, MMIS Conference 2010

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Improving the Efficacy Of Care

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Person centered care

Applying advanced technology to improve the lives of our most vulnerable citizens while lowering the growing and unsustainable cost of caring for them

by

Enabling Care Teams to do their job better

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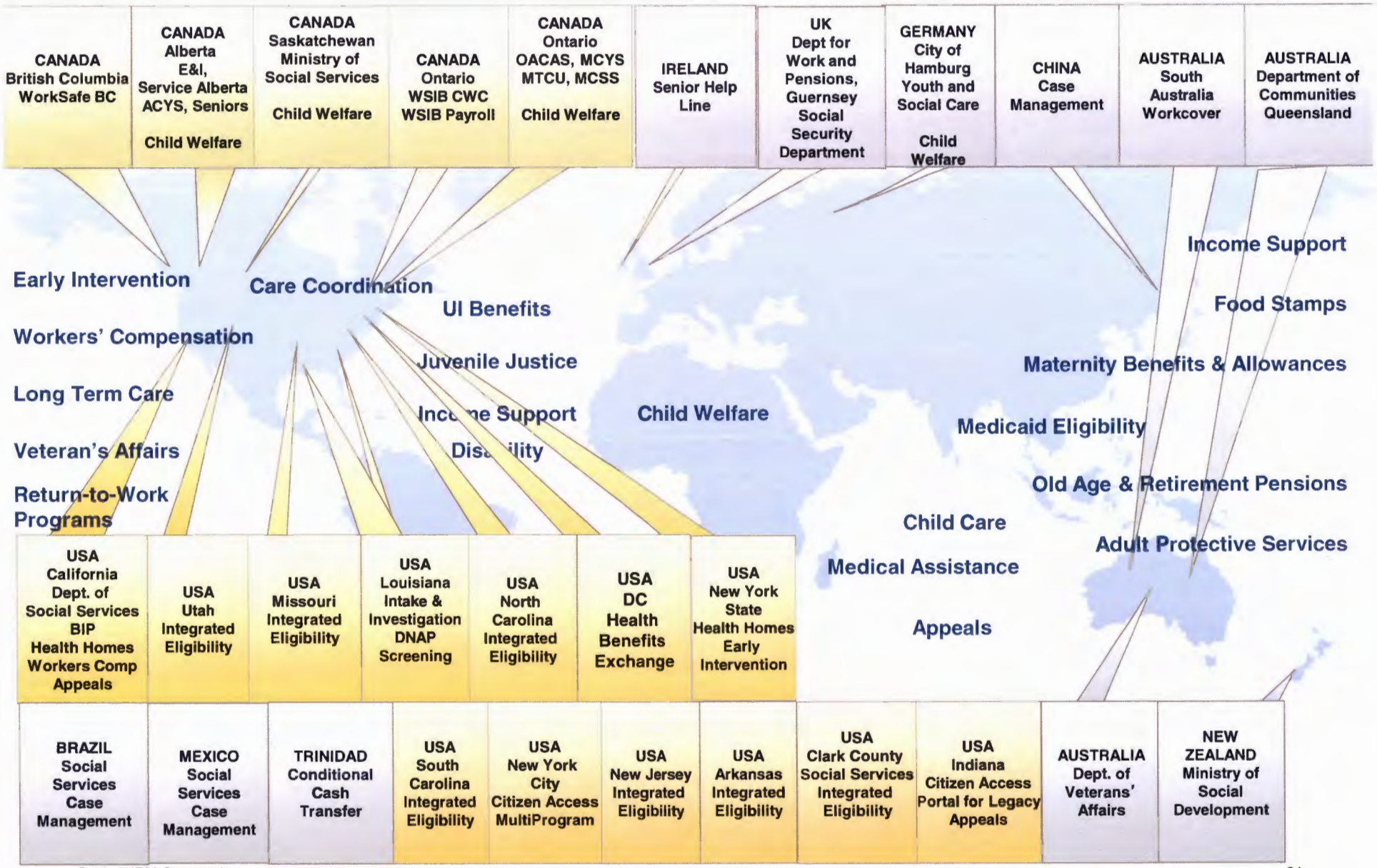
Cúram Global Footprint



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IBM is committed to the success of NCFAST

IBM's Child Welfare solution is designed by US case workers and has been validated against global requirements

IBM has partnered with Children's Research Center

The Child Welfare solution is a foundation to extend platform to support Aging and Adult Services

Collaborative and transformational approach

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Contents

- IBM Commitment
- IBM Cúram Child Welfare Solution
- NC FAST
- Mobility Demonstration

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IBM Cúram for Child Welfare

Providing an out-of-the-box solution capable of supporting state Child Welfare requirements while helping case workers address the safety, permanency and well-being needs of children in their care

- **Designed based on U.S. Child Welfare practices** and verified to be consistent with global child welfare best practices

- **Content Partnership** with industry leader Children's Research Center (CRC) supporting effective case worker decision making

- Design team included **U.S. Child Welfare Case Workers** and industry specialists

Mature Product History

- Released in 2007
- First go-live in 2010

CRC Children's Research Center

Advancing Research...Improving Outcomes

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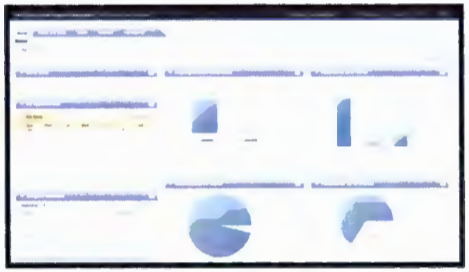
Role-Based Workspaces

Case Worker Workspace



Supervisor Workspace

ePASS Public Portal

Social Program Management Platform

Mobile App

Administrative Workspace

Business Analyst Workspace

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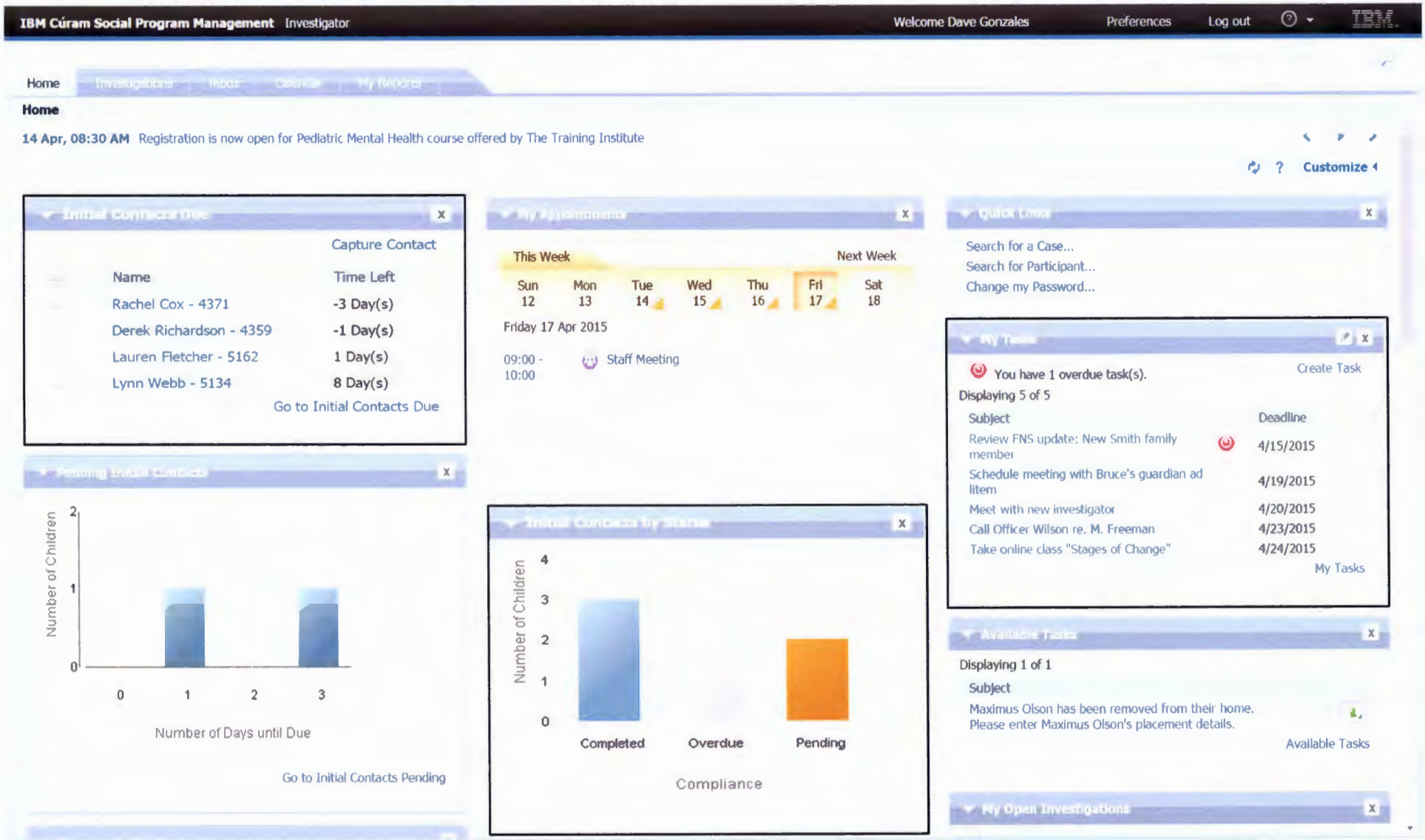
Investigator Workspace



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IBM Cúram for Child Welfare – Functional Summary

Case Management

Intake	Investigation	On-Going Case Mgmt	Adoption	Court/ Legal	Collaborative Case Mgmt
Multi-channel Support	Add/ Manage Allegations	View Allegations	Adoption Subsidy	Legal Actions	Social Enterprise Collaboration
Capture Type & Participant	Override Allegation Disposition	Service Planning/Authorization	Visitation Plan	Agree-ments	Multi-Disciplinary Team (MDT)
Extended Search	Milestones/ Waivers	Inter-jurisdictional Agreements	Prospective Parent Recruitment & Mgt	Legal Status	Case & Participant Index
Record Allegations	Service Referrals	Outcome Management	Adoption Finalization	Petitions and Orders	Meeting Scheduling & Tracking
Screen in/out	Submit/ Recommend	Foster Care IV-E Determination	IV-E Elig. Rules for Adoption Subsidy		
Contact Logs				Hearings	MDT Portal

Placement/ Provider Management

Removals	Service Provider Financials	Foster Care Matching
Days in Care	Placement Request	Services

Structured Decision Making®

Screening Criteria	Response Priority Assessment	Safety Assessment	Family Risk Assessment
Caregiver Strengths and Needs Assessment/ Reassessment	Child Strengths and Needs Assessment/ Reassessment	Family Reunification Assessment	Risk Reassessment

Existing in NCFAST

Core Functionality

Workflow Automation	Correspondence Mgmt	Participant Management
Rules Engine	Notifications	Workload Management
Task Management	Calendaring Functionality	Audit Trails
Security	Web Services	On-line Help

Person Management

Merge & Unmerge Person	Person Details: Indigenous; Medical; Physical; Gang Affiliation	Citizen Context Viewer	Education/ Perform-ance

Performance Management

Caseload Dashboard	Work Queue Mgmt	Reassign Tasks & Cases	Real-time KPI's
Report Templates	Data marts	AFCARS Batch Extracts	

Financial Management

Decision History	Eligibility Determination	Change in Circumstances
Adoption Subsidies	Foster Parent Board Payments	IV-E Eligibility

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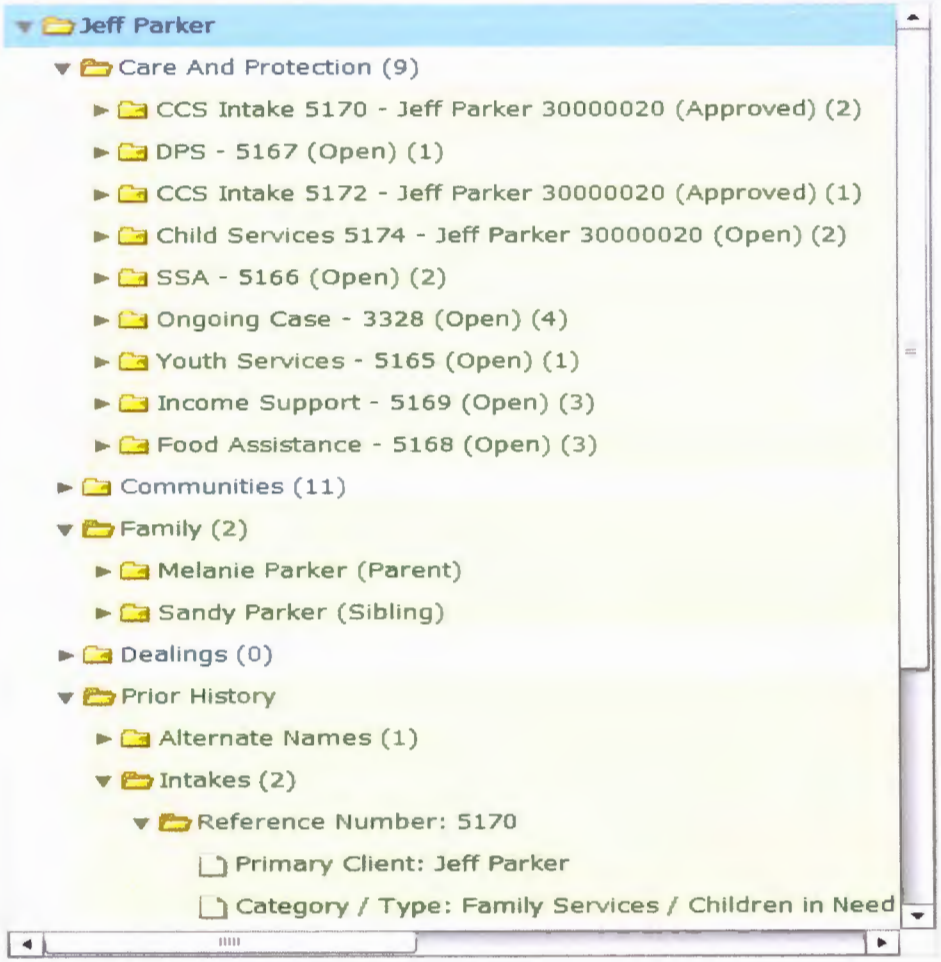
View data from external agencies & other internal agencies

Date of Birth: 4/14/2000

Gender: Male

Address: 304 North Greene Street, Greensboro, North Carolina



Coordination and Communication Tools

- allow team members to collaborate and communicate about the creation, maintenance and status of outcome plans

Family and Case Context

- provides teams with all of the relevant information on existing cases, benefits and services currently being received across multiple programs – from both ***Internal and External Data Sources***

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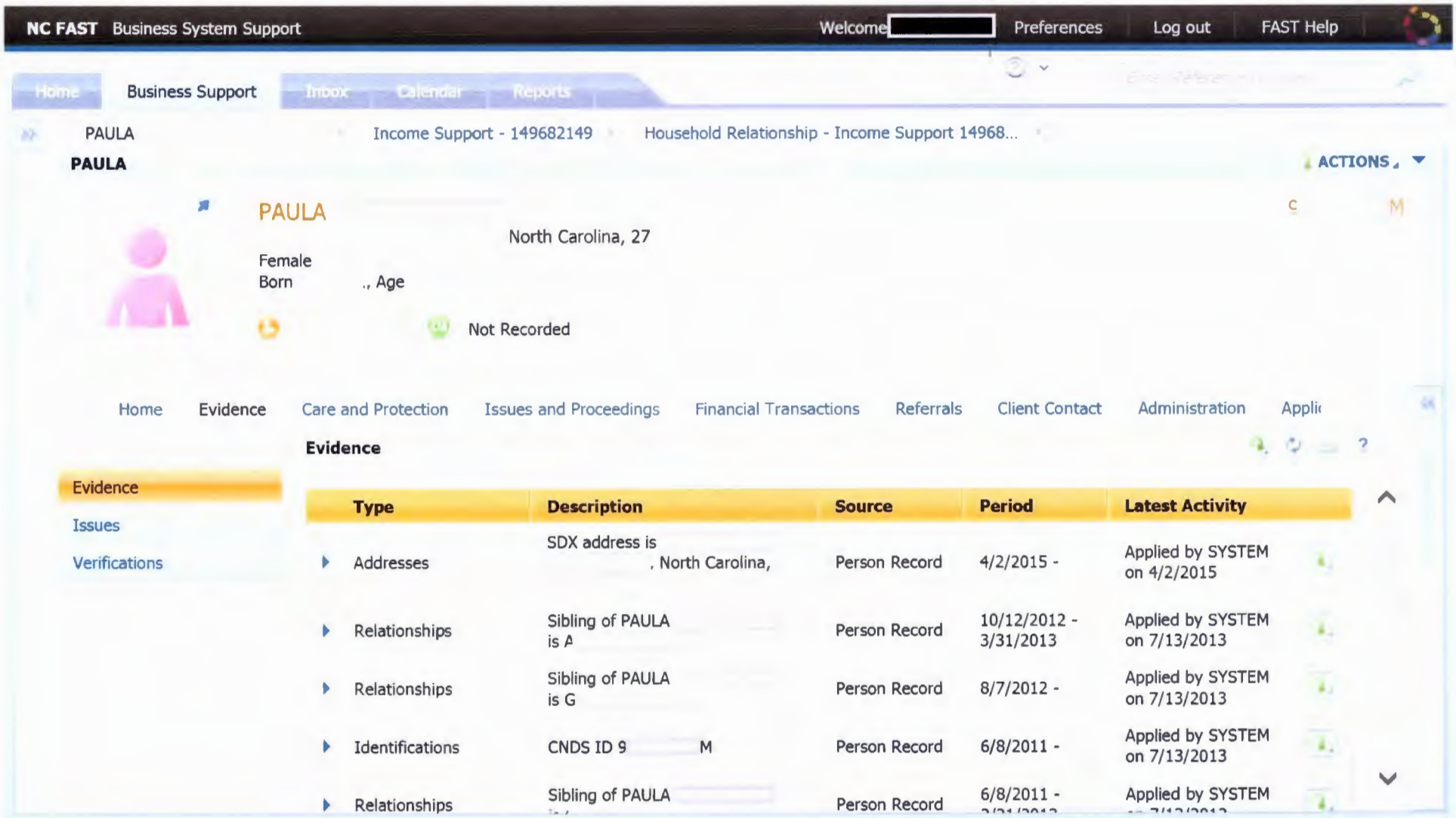
NC FAST Person Evidence



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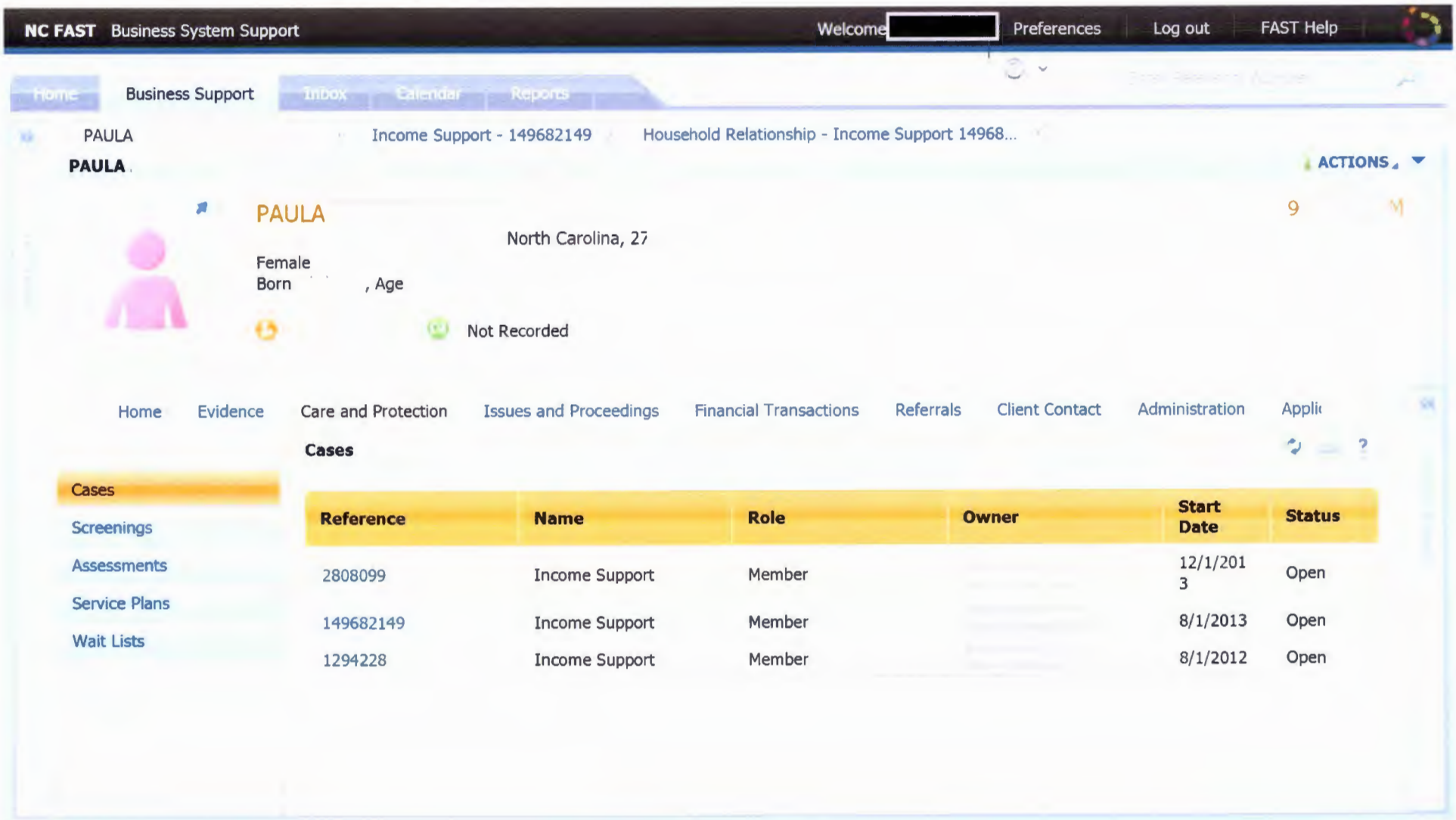
NC FAST Person's Cases



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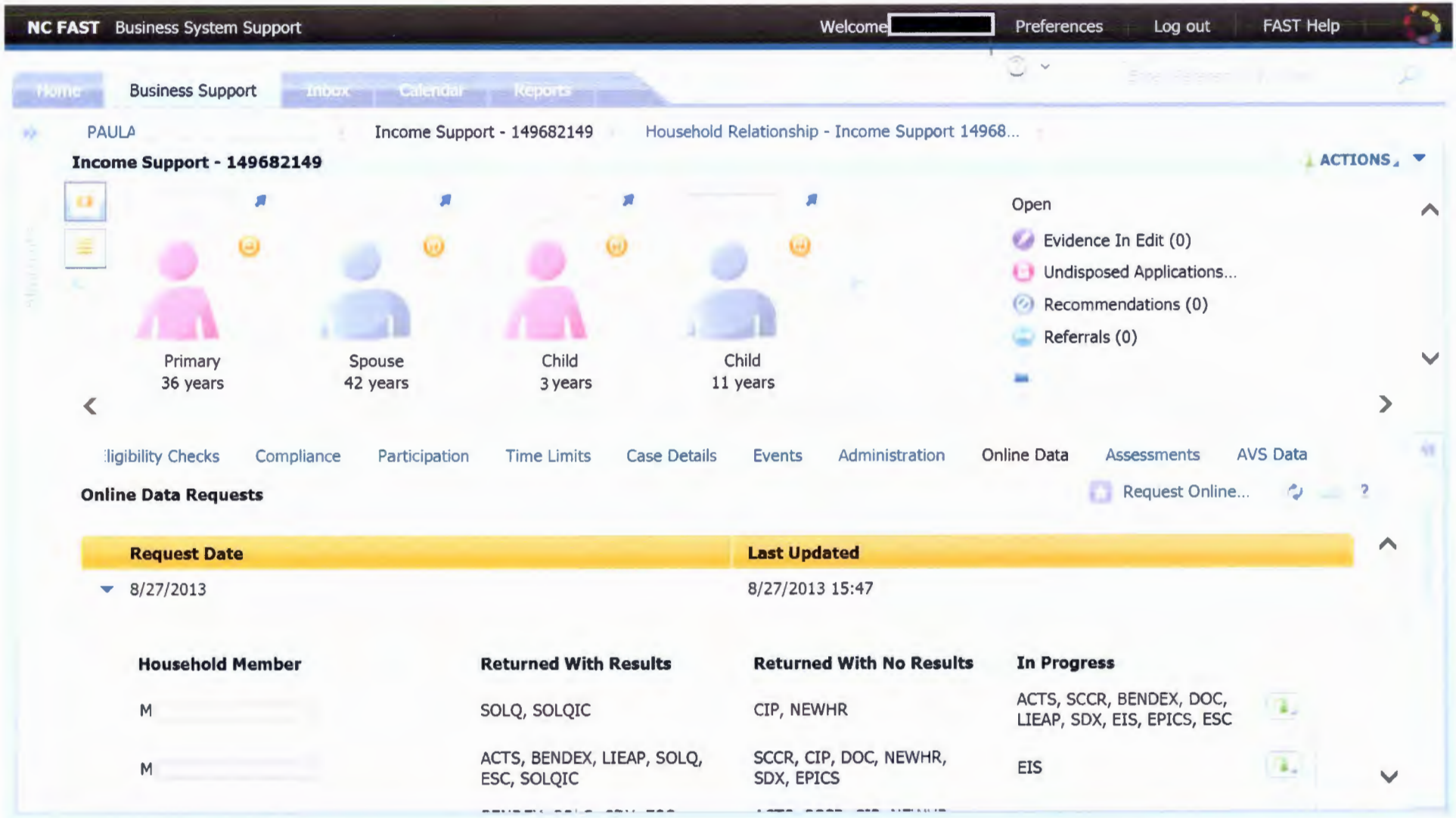
NC FAST On-line Data



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Current Child Services Planning and Analysis Efforts

In order to analyze current Child Services program and system needs, a child welfare committee was established in January 2015 to jointly evaluate necessary system functions, current business processes and system implementation considerations.

Committee Members

- State DSS
- NC FAST
- Buncombe, Carteret, Catawba, Cleveland, Dare, Johnston, Orange, Richmond, Rowan Counties
- IBM
- Accenture

Committee Activities

- Review 4,500 business system functions for accuracy and completeness
- Document current county business processes and system implementation considerations
- Gather lessons learned from other states
- Develop action items for system implementation preparation

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Child Welfare Committee

- Virtual Meetings with States to discuss lessons learned and best practices for Child Welfare:
  - Colorado
  - Ohio
  - Wisconsin
  - Minnesota
  - Pennsylvania
- County Process Reviews
  - Buncombe
  - Moore
  - Gaston
  - Franklin
- County Listening Sessions
  - Surry
  - Harnett
  - Cleveland
  - Onslow
  - Randolph
  - Northampton
  - Cumberland
  - Pitt
  - Henderson
  - Rockingham

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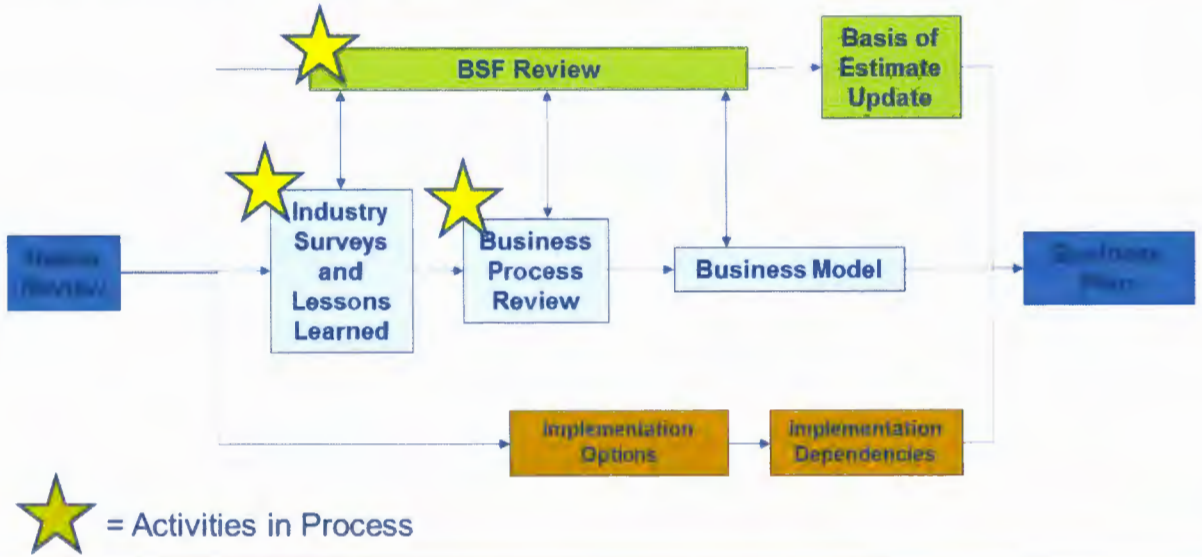
Child Welfare Committee

Note: This effort will feed into the start of Project 4: Child Services in January 2016.

Child Welfare Assessment Activities

The Child Welfare Committee is in process of gathering information for the Business Plan. Currently, members of the group are engaged in BSF reviews, conversations with other states to discuss lessons learned, and visits to counties to document business processes. These activities will help inform the overall business model and implementation approach. The committee is also reviewing workload data gathered by DSS.



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Questions

Implementing one integrated system to administer child welfare as well as economic benefit programs provides better services and outcomes for the clients and families whose well-being depends on these systems the most.

SENATE PAGES ATTENDING

COMMITTEE: Joint App. - Health & Hum Serv. ROOM: 643

DATE: 4-21 TIME: 8:30

PLEASE PRINT LEGIBLY!!!!!!!!!!!!!....*or else!*

Page Name	Hometown	Sponsoring Senator
1. Emily Braren	Sanford	Rabin
2. Nick Mills	Raleigh	Stein
3. Olivia Robertson	Swansboro	Brown
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

Tuesday, April 21	Room	Time
APPROPRIATIONS HEALTH & HUMAN SERVICES (JOINT)	643	8:30 am

Name	County	Sponsor
Ethan Mastin	Surry	Sarah Stevens
Lizzie O'Briant	Randolph	Pat B. Hurley
Davis Privette	Guilford	John Faircloth
Joe Swaim	Randolph	Allen McNeill

Committee Sergeants at Arms

NAME OF COMMITTEE Jt. Comm. on App. HHS

DATE: 04/21/15 Room: 643

House Sgt-At Arms:

1. Name: Young Bae
2. Name: Bill Morris
3. Name: Jim Moran
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name: Giles Jeffreys
2. Name: Canton Lewis
3. Name: Dale Huff
4. Name:
5. Name:

VISITOR REGISTRATION SHEET

Jt. Comm. on App. HHS — 04/21/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	[illegible]
Ed Stulpin	BP
Erica Nelson	NC HA
Rob Lamm	TCCA
TJ Burbee	NP
Joanna Spruill	NCAPP
Curtis McDonald	BMS
Kristen Laster	SS gmc
Chris McClure	BP
Dana Sims	SM
Jennifer Gasperini	NCMS

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Jt. Comm. on App. HHS 04/21/15

Name of Committee Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Matt Gross	NCR
Isaac Gorodetski	Manhattan Institute 52 Vanderbilt Ave NY NY 10017
Jim Copland	"
Becki Gray	Locke Foundation
Andy Chase	KMA
NICHOLE KAREM	NAMI NC
[illegible]	[illegible]
[illegible]	EHGR
Elizabeth Brown[illegible]	Hunt Institute
Vicki Byrd	self

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Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
David Collins	SEANC
Tom Vitaglione	NCCHILD
Jonathan Yeomans	OSBM
Wayne Miller	OSBM
Sarah Grimsrud	OSBM
Judith McDermid	OSBM
Josh Ehrich	JDA
Annalisa Dolph	DL
Chip Kullen	Nelson Mullins
Pam Kilpatrick	OSBM
J Peters	CSS

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VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jonathan Kappler	UNCGA
Drew Mierk	UNCGA
Matt Anderson	CHS NC

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Jt. Comm. on App. HHS — 04/21/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Trent Womble	DHHS
Richard Stevens	SA
Julia Adams Schmick	Arc ASNC MARC
Austin Pruitt	Perkinson Laws
[illegible]	ACF
Scott Lasater	SSG NC
Bain Jones	NCBE
Lexi Morgan	NCFMA
Amanda Honaker	TSS
Mattie McConnell	Carolinas HealthCare
Ryan Blackledge	Cone Health

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Jt. Comm. on App. HHS — 04/21/15

Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
Jose Munarco	GPM & Assoc.

Joint Appropriations Committee on Health and Human Services
Wednesday, April 22, 2015 at 8:30 am
Legislative Office Building - Room 643

MINUTES

The Joint Appropriations Committee on Health and Human Services met at 8:30 am on April 22, 2015 in room 643 of the Legislative Office Building. Representatives Marilyn Avila, Josh Dobson, Chris Malone, Jean Farmer-Butterfield, Verla Insko, Gary Pendleton, Beverly Earle and Howard Hunter were present along with eight Senate members.

Representative Chris Malone presided.

Representative Malone opened the meeting by welcoming everyone and recognizing the House Sergeant-at-Arms - Young Bae, Bill Morris and Jim Moran - and the Senate Sergeants-at-Arms - Giles Jeffreys, Canton Lewis and Dale Huff. He also recognized the attending pages. For the House were Pira Apputhurai of Mecklenburg County (sponsored by Rep. William Brawley), Alina Cardwell of Alamance County (sponsored by Rep. Dennis Riddell), and Alisha Harrison of Wake County (sponsored by Rep. Paul Stam). For the Senate were AJ Swaim III of Wake County (sponsored by Sen. Chad Barefoot), Alec Johnson of Haywood County (sponsored by Sen. Terry Van Duyn) and Langden Rammer of Gaston County (sponsored by Sen. Kathy Harrington).

Representative Malone then introduced Senator Barringer who spoke on foster care legislation and introduced musical recording artist Jimmy Wayne for a musical presentation. Jimmy Wayne sang and spoke on the need for greater support of North Carolina's foster care children. Following Jimmy Wayne, Wayne Black - NC DSS Director and Kevin Kelley NC DHHS Child Welfare Section Chief gave presentations on foster care in North Carolina. This followed with questions by Representatives Insko, Pendleton, Avila and Earle and Senators McKissick and Robinson.

The meeting adjourned at 9:48 am.

Representative Chris Malone
Presiding

Joey Stansbury
Committee Clerk

AGENDA
JOINT APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

April 22, 2015 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Marilyn Avila
Rep. William Brisson
Rep. Josh Dobson
Rep. Chris Malone
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Rep. Jean Farmer-Butterfield, Vice Chair
Rep. Verla Insko, Vice Chair
Rep. Gary Pendleton, Vice Chair
Rep. Beverly Earle
Rep. Howard J. Hunter, III
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Representative Chris Malone, Presiding Co-Chair
II.	**Introduction of Guest Speaker**	Senator Tamara Barringer
III.	**Testimony in Favor of Foster Care Reform**	Guest Speaker – Jimmy Wayne
IV.	**NC Foster Care System**	Wayne Black, Director Division of Social Services, DHHS Kevin Kelley, Section Chief Child Welfare Services, DHHS
V.	**Committee Discussion**	
VI.	**Foster Care Legislation Introduced During the 2015 Session (Handouts Only):**	Senate • S423* Foster Care Family Act , Senators Barringer, Harrington and Tucker (House Companion to this bill – H407) • S424* Fostering Success, Senators Barringer, Harrington and Tucker (House Companion to this bill – H424) • S578 Transition Certain Abuse Investigations/DCDEE , Senator Barringer House • H407* Foster Care Family Act, Representatives Stevens and Glazier (Senate Companion – S423) • H424* Fostering Success, Representatives Stevens and Glazier (Senate Companion – S424) • H580 Ban Smoking in Foster Care Settings/Infants, Representatives Cotham and Adcock • H933 Successful Transition/Foster Care Youth, Representatives Avila, Stevens, Dobson, and Glazier
	Adjourn	

North Carolina DHHS
Division of Social Services

Foster Care Overview

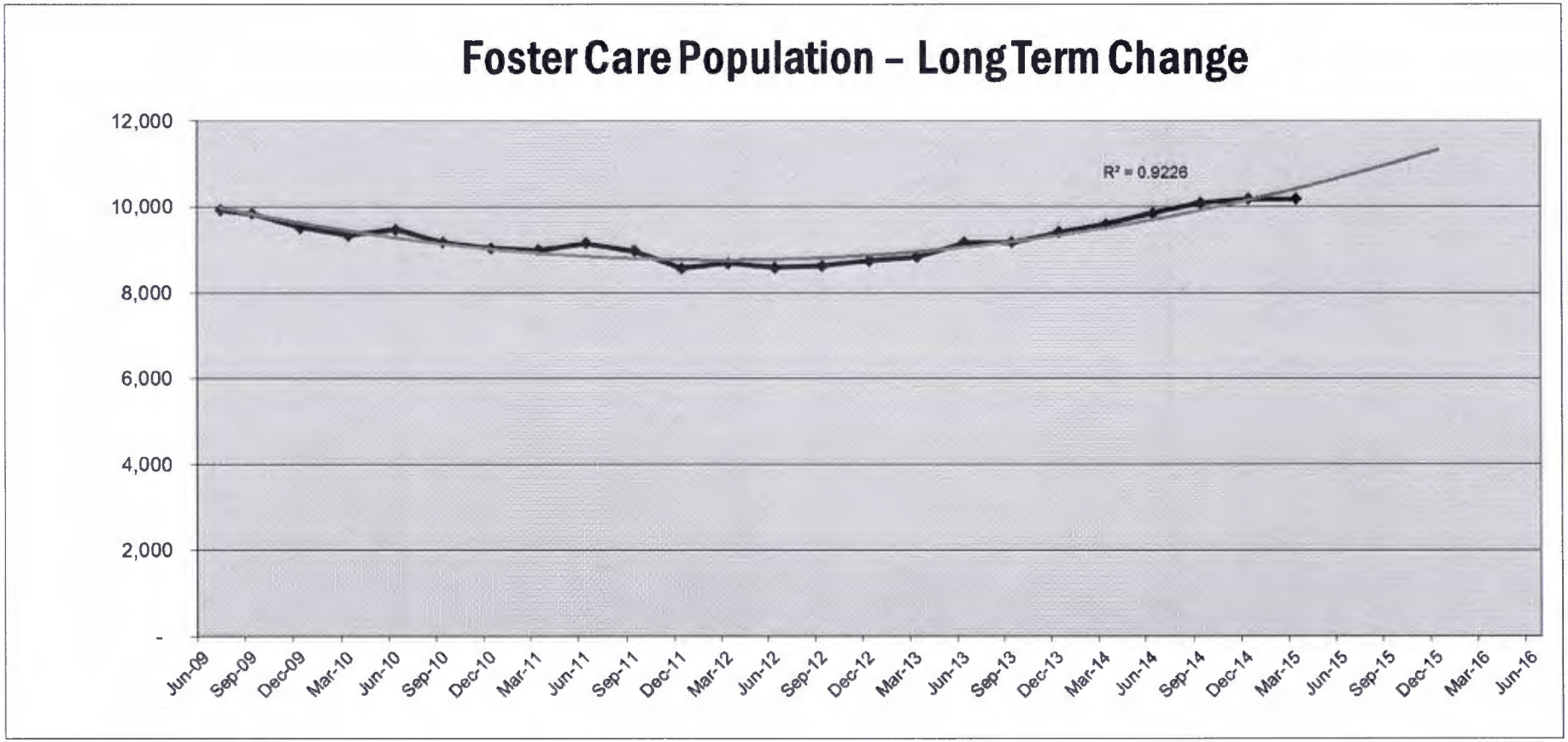
Wayne Black, DSS Director
Kevin Kelley, Child Welfare Section Chief

April 22, 2015

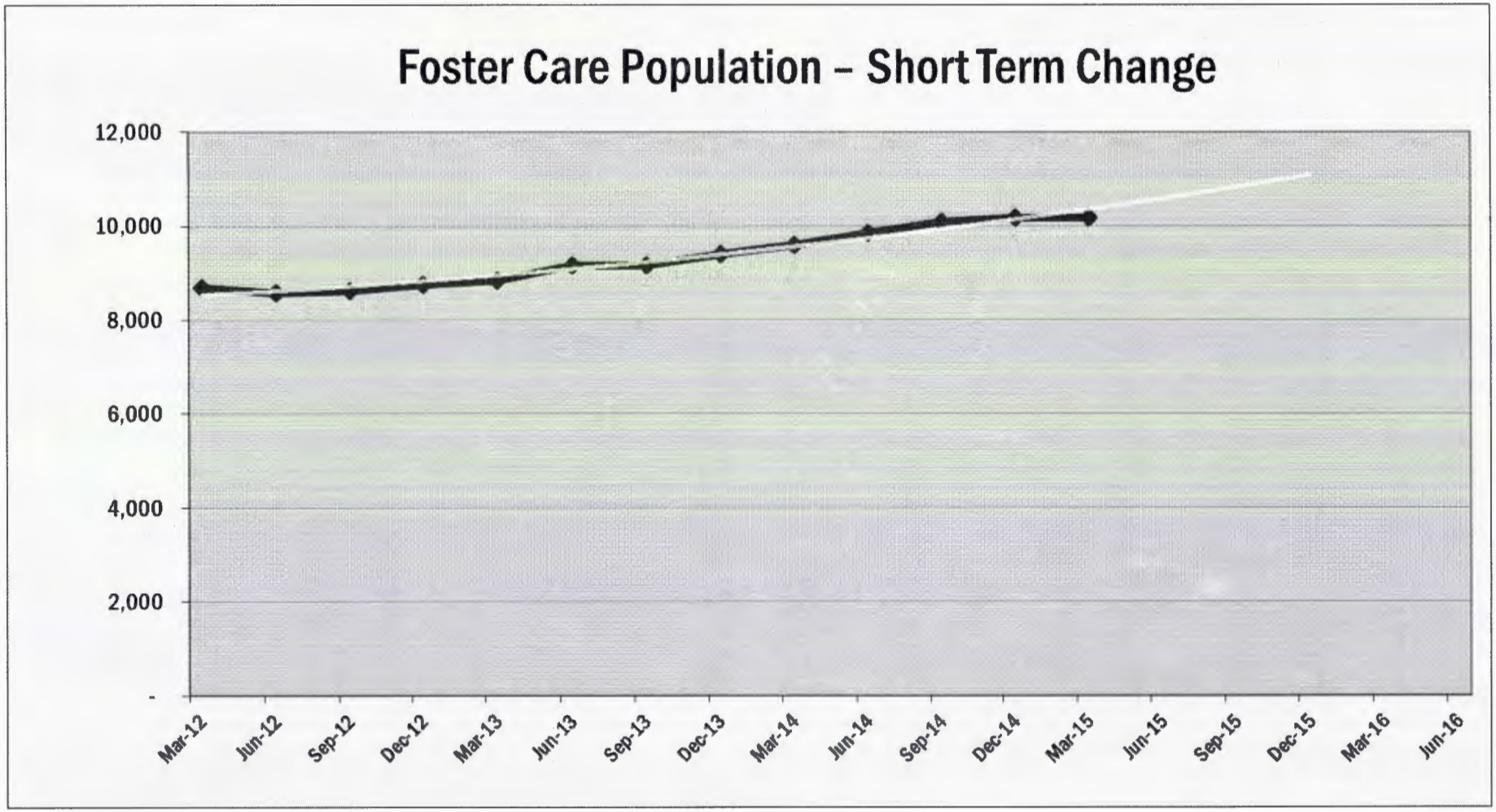
What is Foster Care?

- Foster care means 24-hour substitute care for children placed away from their parents or guardians **and** for whom the State agency has placement and care responsibility. (per US HHS Administration for Children Youth and Families)
  - Legal Status of a child (birth – 18)
  - Court determined (legal option for Voluntary Placement Agreements)
  - Not a placement type (Foster Parent licensure)
  - Not exclusive of Mental Health treatment (therapeutic foster care)
  - Federal oversight and monitoring through title IV-E of the Social Security Act

Caseload Growth: June 2009 - March 2015

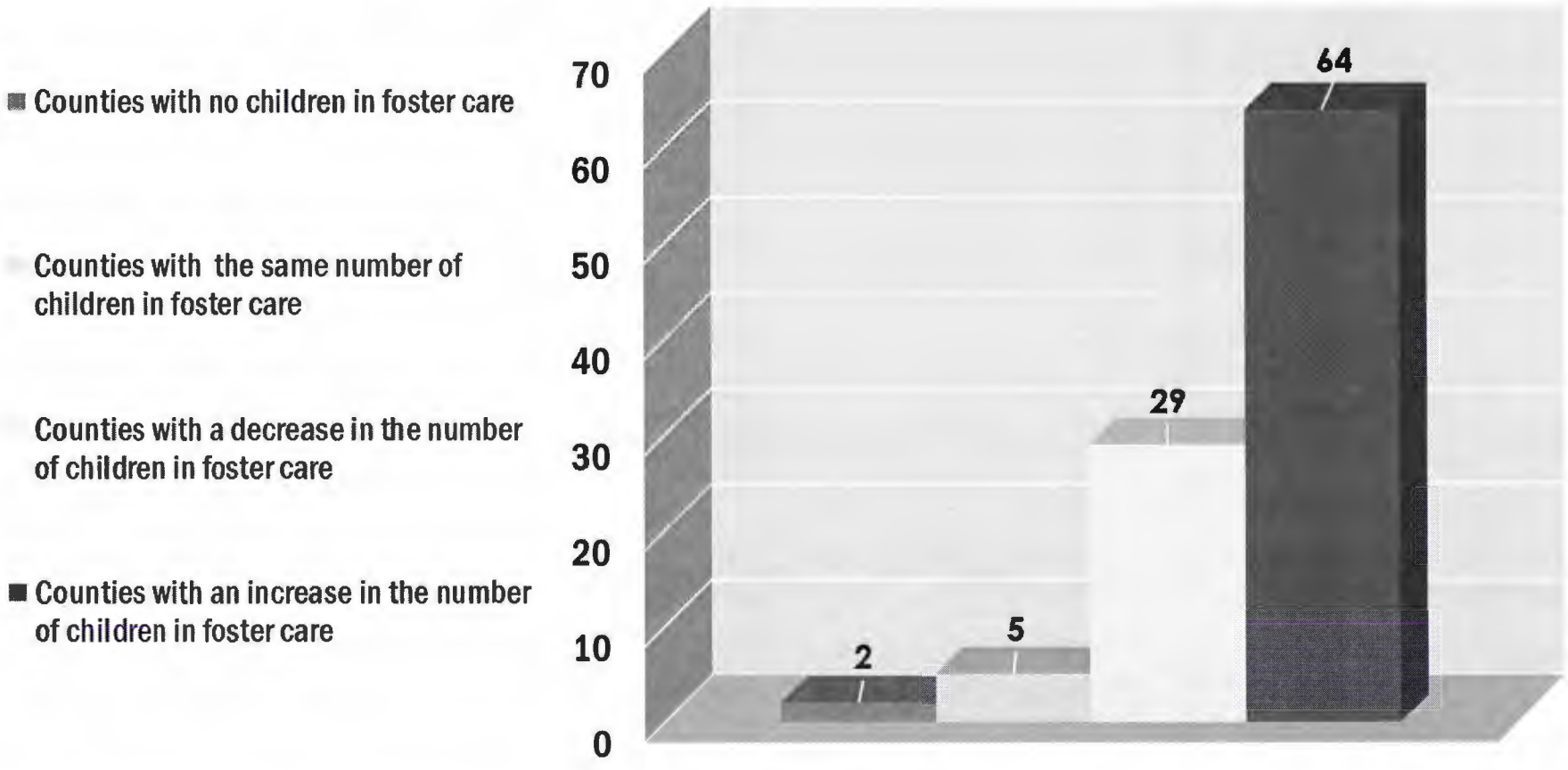


Caseload Growth: March 2012 - March 2015



Growth in the Foster Care Population

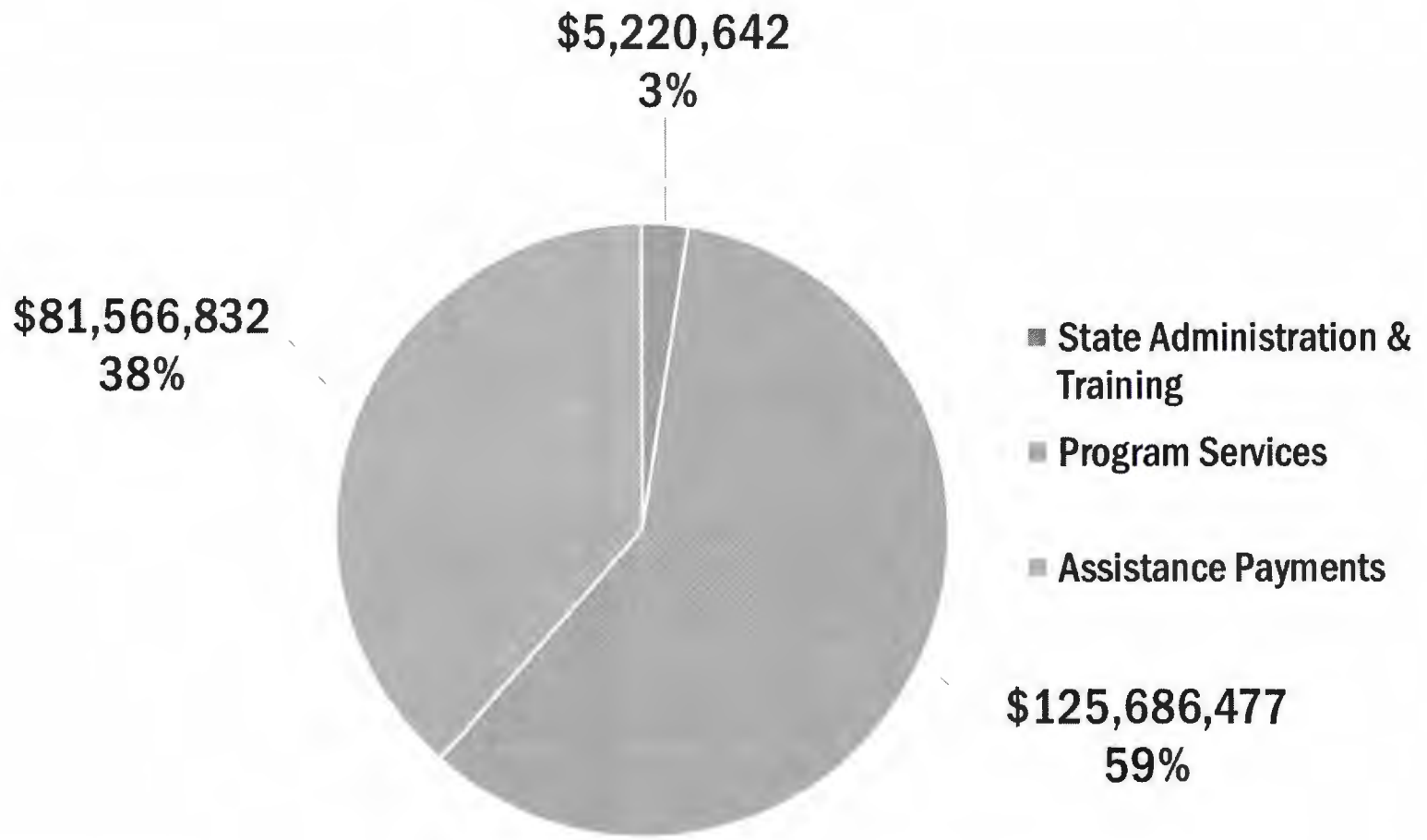
Foster Care Population: January 2013 vs March 2015



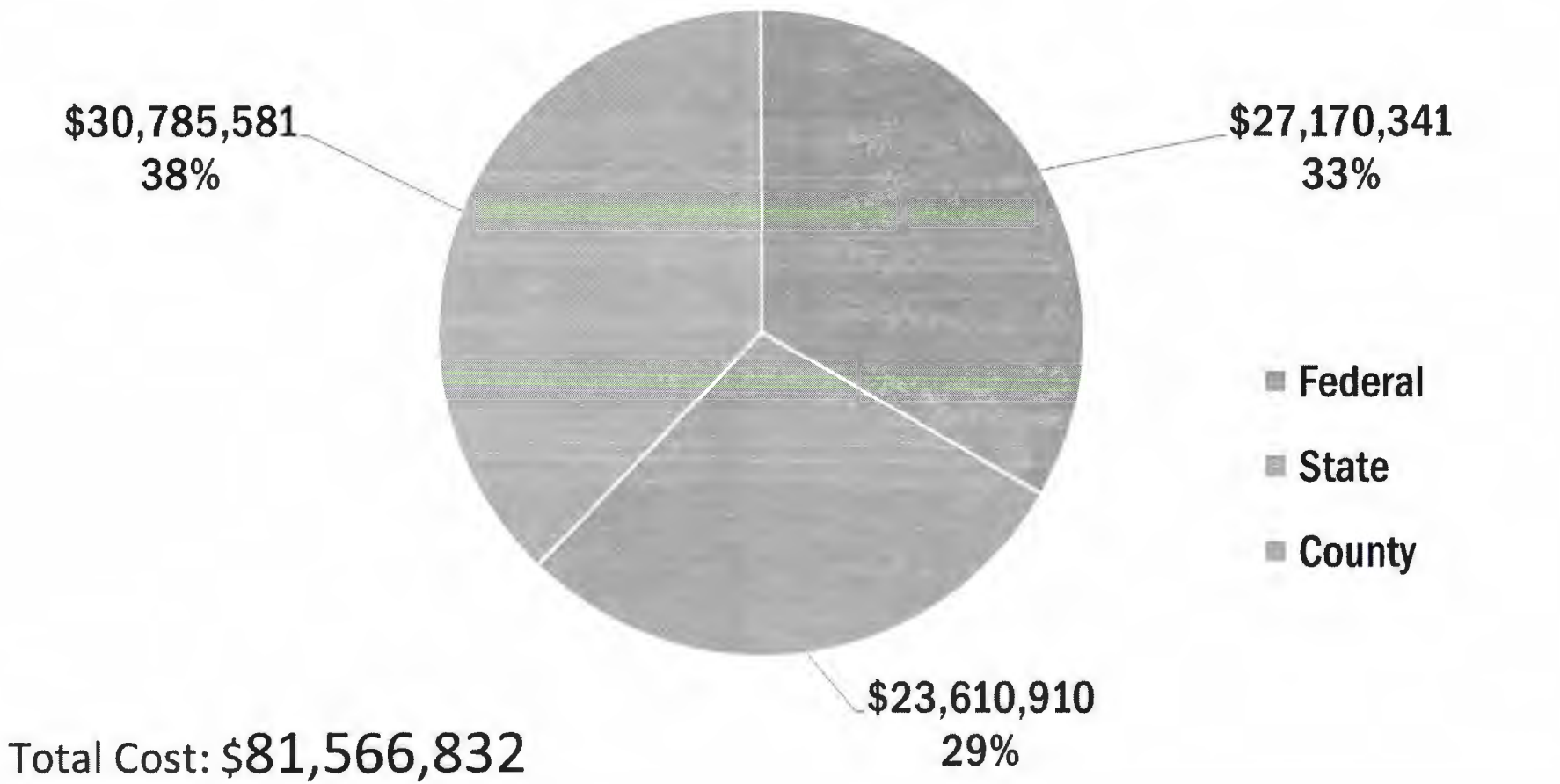
Reasons Cited for Entry Into Foster Care

		2010	2014	Change	% Change
Total Number of Children Entering Care		4,982	5,727	745	15.0%
Reasons for Entering Foster Care					
Number of Children for Whom Reason was Cited	Other	727	756	29	4%
	Incarceration	269	410	141	52%
	Alcoholic (Parent)	468	541	73	16%
	Physical Abuse	467	534	67	14%
	Child's Behavior Problem	560	485	-75	-13%
	Inadequate Housing	580	820	240	41%
	Coping	1,098	1,391	293	27%
	Drug Addict (Parent)	1,348	1,805	457	34%
	Neglect	3,956	4,695	739	19%

Foster Care Expenditures SFY 2013-2014

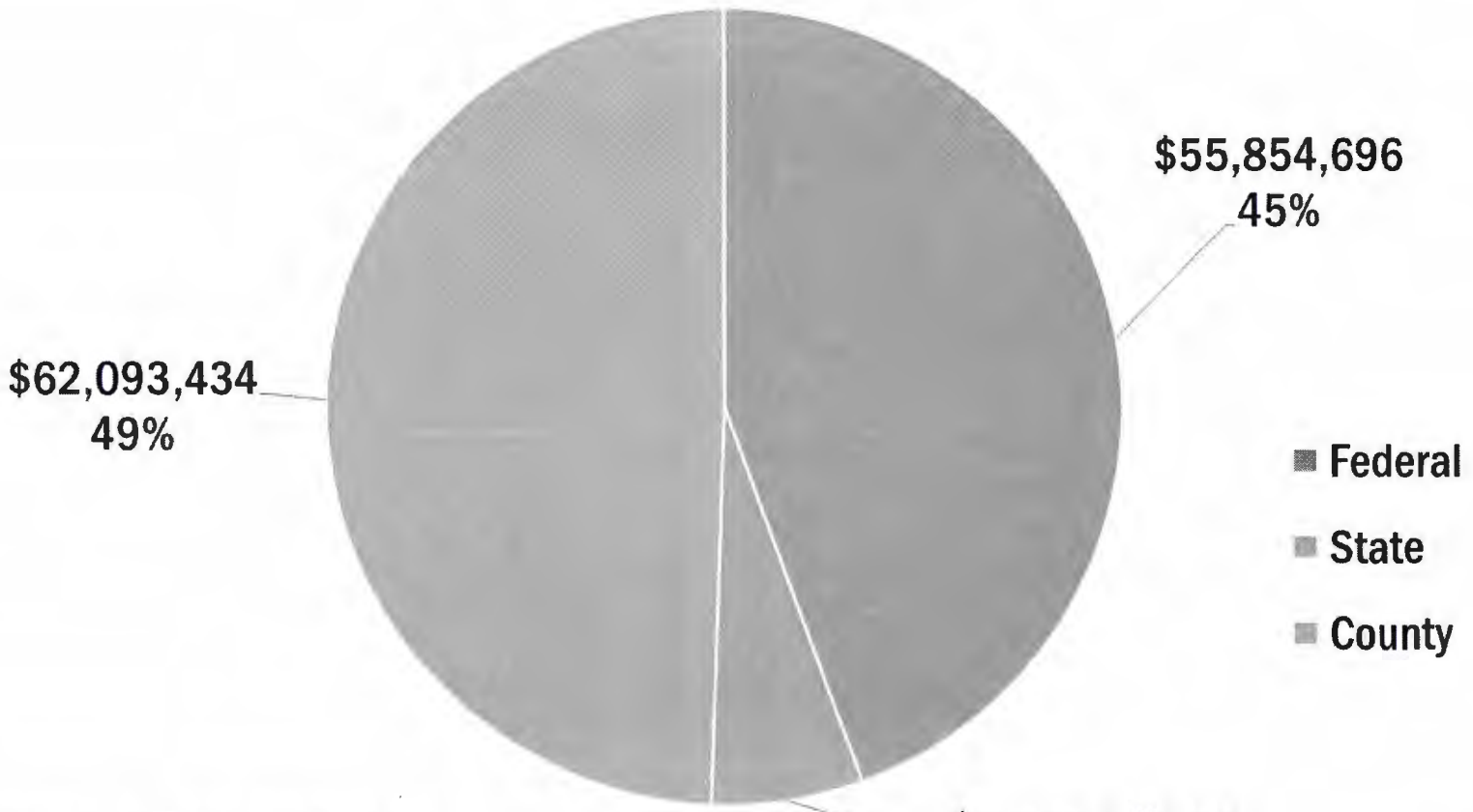


Maintenance - Assistance Payments SFY 2013-14



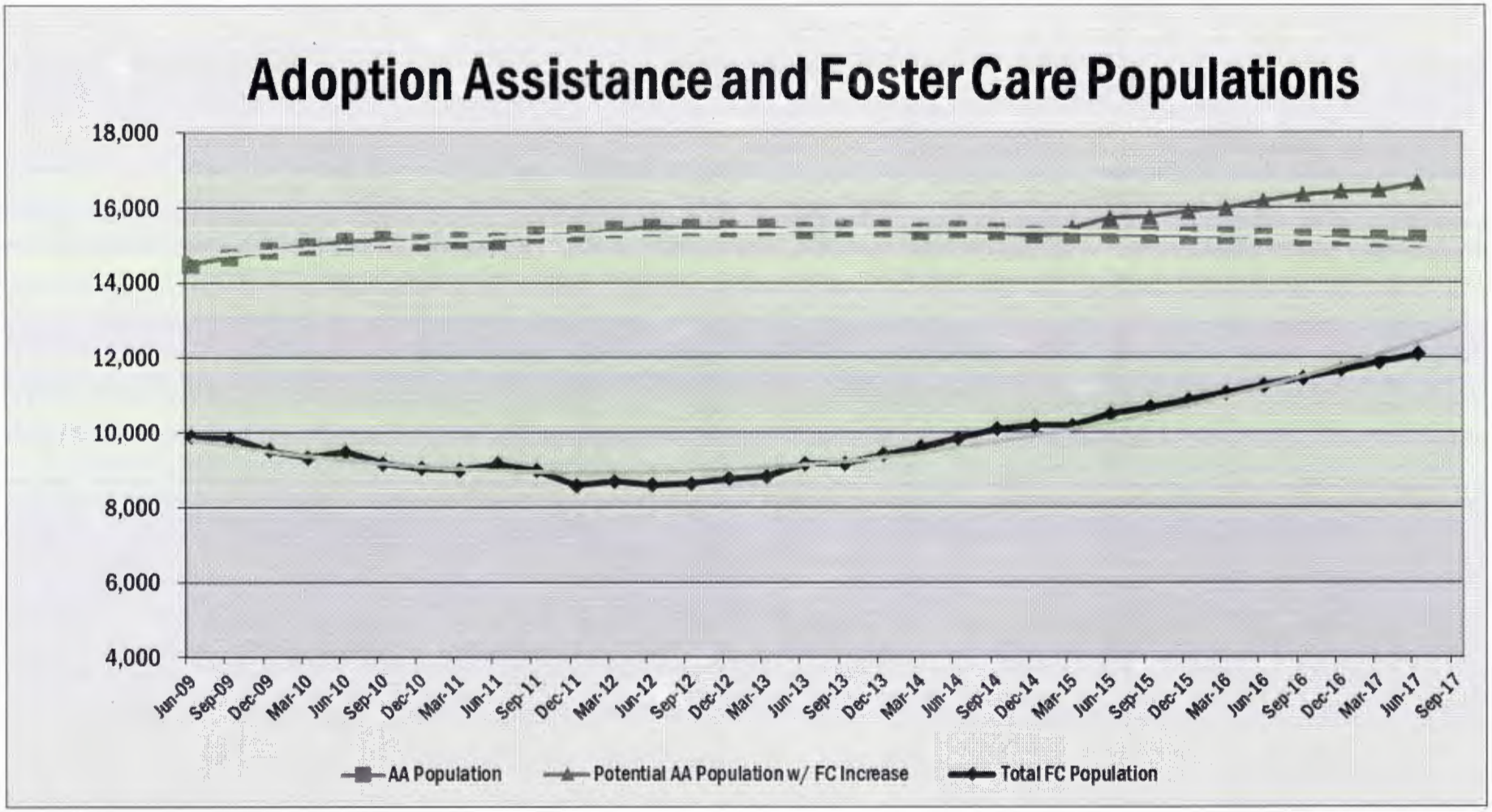
Total Cost: $81,566,832

Foster Care Administration: Program Services SFY 2013-14



Total Cost: $125,686,477

Foster Care and Adoption Assistance



HOUSE BILL 407*
Committee Substitute Favorable 4/15/15

Short Title: Foster Care Family Act. (Public)

Sponsors:

Referred to:

April 1, 2015

A BILL TO BE ENTITLED

AN ACT TO ALIGN STATE LAW WITH FEDERAL LAW BY PROVIDING FOR THE SUPPORT OF HEALTHY DEVELOPMENT OF YOUTH IN FOSTER CARE THROUGH IMPLEMENTATION OF A REASONABLE AND PRUDENT PARENTING STANDARD FOR DECISIONS MADE BY A FOSTER PARENT OR A DESIGNATED OFFICIAL FOR A CHILD CARE INSTITUTION AND REVISING TO THE JUVENILE CODE UNDER THE LAWS PERTAINING TO ABUSE, NEGLECT, AND DEPENDENCY REGARDING JUVENILE PLACEMENT; TO PROVIDE LIABILITY INSURANCE FOR FOSTER PARENTS; TO REDUCE BARRIERS TO OBTAINING A DRIVERS LICENSE FOR FOSTER CHILDREN BY PROVIDING THAT MINORS AGED SIXTEEN AND OVER IN THE CUSTODY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ARE COMPETENT TO CONTRACT FOR AUTOMOBILE INSURANCE, BY SPECIFYING PERSONS OTHER THAN THE FOSTER PARENT WHO MAY SIGN FOR A FOSTER CHILD TO OBTAIN A LEARNER'S PERMIT OR PROVISIONAL DRIVERS LICENSE, AND BY CLARIFYING THAT FOSTER PARENTS DO NOT VIOLATE FINANCIAL RESPONSIBILITY REQUIREMENTS BY ALLOWING FOSTER CHILDREN WITH THEIR OWN INSURANCE COVERAGE TO OPERATE A VEHICLE OWNED BY THE FOSTER PARENT; AND TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY A MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE.

The General Assembly of North Carolina enacts:

PART I. SHORT TITLE

SECTION 1.1. This act shall be known and may be cited as the "Foster Care Family Act."

PART II. REASONABLE AND PRUDENT PARENTING STANDARD IN FOSTER CARE

SECTION 2.1. Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Reasonable and prudent parenting standard.**

(a) The reasonable and prudent parenting standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while encouraging the child's emotional and developmental growth.

(b) Every child care institution shall designate an on-site official who is authorized to apply the reasonable and prudent parenting standard pursuant to this section.

(c) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the Department of Health and Human Services, must use the reasonable and prudent parenting standard when determining whether to allow a child in foster care to participate in extracurricular, enrichment, and social activities.

(d) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services with custody of or placement authority over a child in foster care, or the Department of Health and Human Services, shall not be held liable for an act or omission of the child if the caregiver or county department of social services is acting in accordance with the reasonable and prudent parenting standard under this section.

(e) Unless otherwise ordered by a court with jurisdiction pursuant to G.S. 7B-200, a caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, exercising the reasonable and prudent parenting standard has the authority to provide or withhold permission, without prior approval of the court or a county department of social services, allowing a child in foster care, in the custody of a county department of social services or under the placement authority of a county department of social services through a voluntary placement agreement, to participate in normal childhood activities. Normal childhood activities shall include, but are not limited to, extracurricular, enrichment, and social activities, and may include overnight activities outside the direct supervision of the caregiver for periods of over 24 hours and up to 72 hours.

(f) The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services, or the Department of Health and Human Services, shall not be liable for injuries to the child that occur as a result of the reasonable and prudent parenting standard. The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services or the Department of Health and Human Services, shall be liable for any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in the injury to the child."

SECTION 2.2. G.S. 7B-505(b) reads as rewritten:

"(b) The court shall order the Department to make diligent efforts to notify relatives and any custodial parents of the juvenile's siblings that the juvenile is in nonsecure custody and of any hearings scheduled to occur pursuant to G.S. 7B-506, unless the court finds such notification would be contrary to the best interests of the juvenile. In placing a juvenile in nonsecure custody under this section, the court shall first consider whether a relative of the juvenile is willing and able to provide proper care and supervision of the juvenile in a safe home. If the court finds that the relative is willing and able to provide proper care and supervision in a safe home, then the court shall order placement of the juvenile with the relative unless the court finds that placement with the relative would be contrary to the best interests of the juvenile."

SECTION 2.3. G.S. 7B-800.1(a)(4) reads as rewritten:

"(a) Prior to the adjudicatory hearing, the court shall consider the following:

...

(4) Whether relatives or parents with custody of a sibling of the juvenile have been identified and notified as potential resources for placement or support."

SECTION 2.4. G.S. 7B-901 reads as rewritten:

"**§ 7B-901. Dispositional hearing.**

The dispositional hearing shall take place immediately following the adjudicatory hearing and shall be concluded within 30 days of the conclusion of the adjudicatory hearing. The dispositional hearing may be informal and the court may consider written reports or other evidence concerning the needs of the juvenile. The juvenile and the juvenile's parent, guardian, or custodian shall have the right to present evidence, and they may advise the court concerning the disposition they believe to be in the best interests of the juvenile. The court may consider any evidence, including hearsay evidence as defined in G.S. 8C-1, Rule 801, including testimony or evidence from any person who is not a party, that the court finds to be relevant, reliable, and necessary to determine the needs of the juvenile and the most appropriate disposition. The court may exclude the public from the hearing unless the juvenile moves that the hearing be open, which motion shall be granted.

At the dispositional hearing, the court shall inquire as to the identity and location of any missing parent and whether paternity is at issue. The court shall include findings of the efforts undertaken to locate the missing parent and to serve that parent and efforts undertaken to establish paternity when paternity is an issue. The order may provide for specific efforts in determining the identity and location of any missing parent and specific efforts in establishing paternity. The court shall also inquire about efforts made to identify and notify ~~relatives~~ relatives, including parents with custody of a sibling of the juvenile, as potential resources for placement or support."

SECTION 2.5. Article 9 of Chapter 7B of the General Statutes is amended by adding the following new sections to read:

"**§ 7B-903.1. Juvenile placed in custody of a county department of social services.**

(a) To the extent authorized by federal law, a county department of social services with custody of a juvenile is authorized to make decisions about matters not addressed in this section that are generally made by a juvenile's custodian, including, but not limited to, educational decisions and consenting to the sharing of the juvenile's information. The county department of social services may delegate any part of this authority to the juvenile's parent, foster parent, or another individual.

(b) When a juvenile is in the custody or placement responsibility of a county department of social services, the placement provider may, in accordance with G.S. 131D-10.2A, provide or withhold permission, without prior approval of the court or county department of social services, allowing a juvenile to participate in normal childhood activities. If such authorization is not in the juvenile's best interest, the court shall set forth alternative parameters for approving normal childhood activities.

"**§ 7B-912. Juveniles 14 years of age and older; Another Planned Permanent Living Arrangement.**

(a) In addition to the permanency planning requirements under G.S. 7B-906.1, at every permanency planning hearing for a juvenile in the custody of a county department of social services who has attained the age of 14 years, the court shall inquire and make written findings regarding each of the following:

(1) The services provided to assist the juvenile in making a transition to adulthood.

(2) The steps the county department of social services is taking to ensure that the foster family or other licensed placement provider follows the reasonable and prudent parenting standard as provided in G.S. 131D-10.2A.

(3) Whether the juvenile has regular opportunities to engage in age- or developmentally appropriate activities.

(b) At or before the last scheduled permanency planning hearing, but at least 90 days before a juvenile attains 18 years of age, the court shall (i) inquire as to whether the juvenile has a copy of the juvenile's birth certificate, Social Security card, health insurance information,

drivers license or other identification card, and any educational or medical records the juvenile requests and (ii) determine the person or entity that should assist the juvenile in obtaining these documents before the juvenile attains the age of 18 years.

(c) If the court finds each of the following conditions applies, the court shall approve Another Planned Permanent Living Arrangement (APPLA) as the juvenile's primary permanent plan:

(1) The juvenile is 16 or 17 years old.

(2) The county department of social services has made diligent efforts to place the juvenile permanently with a parent or relative or in a guardianship or adoptive placement.

(3) Compelling reasons exist that it is not in the best interest of the juvenile to be placed permanently with a parent or relative or in a guardianship or adoptive placement.

(4) APPLA is the best permanency plan for the juvenile.

(d) If the court approves APPLA as the juvenile's permanent plan, the court shall, after questioning the juvenile, make written findings addressing the juvenile's desired permanency outcome."

PART III. LIABILITY INSURANCE FOR FOSTER PARENTS

SECTION 3.1. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-43. Development of policy form or endorsement for personal liability insurance for foster parents.**

(a) The Rate Bureau shall develop an optional policy form or endorsement to be filed with the Commissioner for approval no later than May 1, 2016, that provides liability insurance for foster parents licensed under Article 1A of Chapter 131D of the General Statutes to provide foster care in a family foster home or therapeutic foster home. The policy form or endorsement shall provide coverage for acts or omissions of the foster parent while the parent is acting in his or her capacity as a foster parent in a licensed family foster home or therapeutic foster home licensed under Article 1A of Chapter 131D of the General Statutes.

(b) Nothing in this section is intended to require that the liability insurance policy or endorsement required by this section cover an act or omission that results from any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in injury to the child."

PART IV. REDUCE DRIVING BARRIERS FOR FOSTER CHILDREN

SECTION 4.1. Article 1 of Chapter 48A of the General Statutes is amended by adding a new section to read:

"**§ 48A-4. Certain minors competent to contract.**

A minor who is 16 years of age or older and who is in the legal custody of the Department of Health and Human Services, Division of Social Services, shall be qualified and competent to contract for the purchase of an automobile insurance policy with the consent of the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b). The minor shall be responsible for paying the costs of the insurance premiums and shall be liable for damages caused by the minor's negligent operation of a motor vehicle. No State or local government agency, foster parent, or entity providing services to the minor under contract or at the direction of a State or local government agency shall be responsible for paying any insurance premiums or liable for damages of any kind as a result of the operation of a motor vehicle by the minor."

SECTION 4.2. G.S. 20-11(i) reads as rewritten:

"(i) Application. — An application for a permit or license authorized by this section must be signed by both the applicant and another person. That person must be:

(1) The applicant's parent or guardian;
(2) A person approved by the applicant's parent or guardian; or
(3) A person approved by the Division.
(4) With respect to minors in the legal custody of the Department of Health and Human Services, Division of Social Services, any of the following:
a. A guardian ad litem or attorney advocate appointed to advocate for the minor.
b. A case manager or other type of caseworker assigned to work with the minor.
c. If no person listed in sub-subdivision a. or b. of this subdivision is available, the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b)."

SECTION 4.3. G.S. 20-309 is amended by adding a new subsection to read:

"(a2) The owner of a motor vehicle who is a foster parent providing foster care to a person between the ages of 16 and 21 shall not violate the requirements of this Article by allowing the motor vehicle to be operated by the person if the person is covered by a nonowner motor vehicle insurance policy issued by the North Carolina Reinsurance Facility as authorized by G.S. 58-37-35(g)(13). Nothing in this section is intended to prevent a foster parent from including a foster child on the parent's own motor vehicle insurance policy."

PART V. STUDY MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

SECTION 5.1.(a) The Department of Health and Human Services, Division of Medical Assistance, shall design and draft, but not submit, a 1915(c) Medicaid waiver to serve children with Serious Emotional Disturbance (SED) in home and community-based settings. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

SECTION 5.1.(b) The Department shall report the draft waiver, other findings, and any other options or recommendations to best serve children with SED to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015. Specifically, the report shall provide an in-depth analysis of the cost per slot, including an analysis of the estimated number of waiver recipients who would be transitioned from a facility to a home and community-based setting and the estimated number of waiver recipients who would avoid placement in a facility.

PART VI. EFFECTIVE DATE

SECTION 6.1. Parts 2 and 4 of this act become effective October 1, 2015. The remainder of this act is effective when it becomes law.

HOUSE BILL 580

Short Title:	Ban Smoking in Foster Care Setting/Infants.	(Public)
Sponsors:	Representatives Cotham and Adcock (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Health.	

April 6, 2015

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE SOCIAL SERVICES COMMISSION TO ADOPT A POLICY PROHIBITING A FOSTER PARENT FROM SMOKING IN THE PRESENCE OF AN INFANT IN THE FOSTER PARENT'S CARE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-10.5 is amended by adding a new subdivision to read:

"**§ 131D-10.5. Powers and duties of the Commission.**

In addition to other powers and duties prescribed by law, the Commission shall exercise the following powers and duties:

...

(8) Adopt rules establishing a policy to prohibit a foster parent from smoking in the presence of an infant in the foster parent's care pursuant to G.S. 131D-10.7A."

SECTION 2. Article 1A of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-10.7A. Policy prohibiting smoking in the presence of an infant in foster care setting.**

(a) For purposes of this section, the following definitions apply:

(1) *Infant. – A young child less than one year of age.*

(2) Smoking. – As defined in G.S. 143-596(5).

(b) Pursuant to rules adopted by the Commission under G.S. 131D-10.5(8), the Department of Health and Human Services, Division of Social Services, shall enforce a written policy prohibiting a foster parent from smoking in a private residence used to provide licensed foster care to infants. The policy shall further prohibit a foster parent from smoking in the presence of an infant in the foster parent's care while the infant and the foster parent are in a motor vehicle. The policy shall require a foster parent to prohibit others from smoking in the presence of an infant in that foster parent's care."

SECTION 3. This act is effective when it becomes law.

HOUSE BILL 933

Short Title:	Successful Transition/Foster Care Youth.	(Public)
Sponsors:	Representatives Avila, Stevens, Dobson, and Glazier (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Appropriations.	

April 20, 2015

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH AN INITIATIVE FOR THE SUCCESSFUL TRANSITION OF FOSTER CARE YOUTH TO ADULTHOOD.

The General Assembly of North Carolina enacts:

SECTION 1. Article 1A of Chapter 131D of the General Statutes is amended by adding the following new Part to read:

"Part 3. Partnership for Successful Transition of Foster Care Youth to Adulthood.

"**§ 131D-10.9F. Purpose.**

It is the intent of the General Assembly to fund and support transitional living services that demonstrate positive outcomes for youth, attract significant private sector funding, and will lead to the development of evidence-based programs to serve the at-risk population described in this Part.

"**§ 131D-10.9G. Foster Care Transitional Living Initiative Fund.**

(a) There is created the Foster Care Transitional Living Initiative Fund that will support a demonstration project with services provided by Youth Villages to (i) improve outcomes for youth ages 17-21 years who transition from foster care through implementation of outcome-based Transitional Living Services, (ii) identify cost-savings in social services and juvenile and adult correction services associated with the provision of Transitional Living Services to youth aging out of foster care, and (iii) take necessary steps to establish an evidence-based transitional living program available to all youth aging out of foster care. In implementing these goals, the Foster Care Transitional Living Initiative Fund shall support the following strategies:

(1) Transitional Living Services, which is an outcome-based program that follows the Youth Villages Transitional Living Model. Outcomes on more than 7,000 participants have been tracked since the program's inception. The program has been evaluated through an independent Randomized Controlled Trial. Results indicate that Youth Villages Transitional Living Model had positive impacts in a variety of areas, including housing stability, earnings, economic hardship, mental health, and intimate partner violence in comparison to the control population.

(2) Public-Private Partnership, which is a commitment by private-sector funding partners to match one hundred percent (100%) of the funds appropriated to the Foster Care Transitional Living Initiative Fund for the 2015-2017 fiscal biennium for the purposes of providing Transitional Living Services through

the Youth Villages Transitional Living Model to youth aging out of foster care.

(3) Impact Measurement and Evaluation, which are services funded through private partners to provide independent measurement and evaluation of the impact the Youth Villages Transitional Living Model has on the youth served, the foster care system, and on other programs and services provided by the State which are utilized by former foster care youth.

(4) Advancement of Evidence-Based Process, which is the implementation and ongoing evaluation of the Youth Villages Transitional Living Model for the purposes of establishing the first evidence-based transitional living program in the nation. To establish the evidence-based program, additional randomized controlled trials may be conducted to advance the model.

(b) The Social Services Commission shall adopt rules to implement the provisions of this section.

(c) This program shall not constitute an entitlement and is subject to the availability of funds."

SECTION 2. G.S. 131D-10.9A reads as rewritten:

"**§ 131D-10.9A. Permanency Innovation Initiative Oversight Committee created.**

(a) Creation and Membership. – The Permanency Innovation Initiative Oversight Committee is established. The Committee shall be located administratively in the General Assembly. The Committee shall consist of ~~11~~ 12 members serving staggered terms. In making appointments, each appointing authority shall select members who have appropriate experience and knowledge of the issues to be examined by the Committee and shall strive to ensure racial, gender, and geographical diversity among the membership. The initial Committee members shall be appointed on or after July 1, 2013, as follows:

(1) Four members shall be appointed by the General Assembly upon recommendation of the Speaker of the House of Representatives. Of the members appointed under this subdivision, at least one shall be a member of the judiciary who shall serve for a term of two years and at least one shall be a representative from the Children's Home Society of North Carolina who shall serve for a term of three years. One member of the House shall be appointed for a one-year term. The remaining appointee shall serve a one-year term.

(2) Four members shall be appointed by the General Assembly upon the recommendation of the President Pro Tempore of the Senate. Of the members appointed under this subdivision, at least one shall be a representative from the Department of Health and Human Services, Division of Social Services, who shall serve for a term of two years and at least one shall be a representative from The Duke Endowment who shall serve for a term of three years. One member of the Senate shall be appointed for a one-year term. The remaining appointee shall serve a one-year term.

(3) ~~Three~~ Four members shall be appointed by the Governor. Of the members appointed under this subdivision, at least one shall be a representative from a county department of social services who shall serve for a term of three ~~years and~~ years, at least one shall be a representative from the University of North Carolina at Chapel Hill who shall serve for a term of two ~~years.~~ years, and at least one shall be a representative from Youth Villages who shall serve for a term of two years. The remaining member shall serve a one-year term.

(b) Terms. – Upon the expiration of the terms of the initial Committee members, each member shall be appointed for a term of three years and shall serve until a successor is

appointed. No member may serve more than two consecutive full terms. A vacancy shall be filled within 30 days by the authority making the initial appointment.

(c) Purpose and Powers. – The Committee shall:

(1) Design and implement a data tracking methodology to collect and analyze information to gauge the success of the ~~initiative.~~initiative established under this section as well as an initiative for foster care youth transitioning to adulthood in accordance with Part 3 of this Article.

(2) Develop a methodology to identify short- and long-term cost-savings in the provision of foster care and foster care transitional living services and any potential reinvestment strategies.

(3) Oversee program implementation to ensure fidelity to the program models identified under subdivisions (1) and (2) of ~~G.S. 131D-10.9B(a).~~G.S. 131D-10.9B(a) and under subdivisions (1) through (4) of G.S. 131D-10.9G(a).

(4) Study, review, and recommend other policies and services that may positively impact ~~permanency and well-being outcomes.~~permanency, well-being outcomes, and youth aging out of the foster care system.

(d) Reports. – The Committee shall report its analysis and any findings and recommendations to the General Assembly by September 15 of each year.

(e) Organization. – The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Committee. The Committee shall meet at least once a quarter upon the joint call of the cochairs. A quorum of the Committee is seven members. No action may be taken except by a majority vote at a meeting at which a quorum is present.

(f) Funding. – From funds available to the General Assembly, the Legislative Services Commission shall allocate monies to fund the work of the Committee. Members of the Committee shall receive subsistence and travel expenses as provided in G.S. 120-3.1 and G.S. 138-5.

(g) Staff. – 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 Director of Legislative Assistants 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. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Social Services, the sum of one million three hundred thousand dollars ($1,300,000) for the 2015-2016 fiscal year and the sum of one million seven hundred fifty thousand dollars ($1,750,000) for the 2016-2017 fiscal year to be used solely for the Foster Care Transitional Living Initiative Fund for services provided by Youth Villages as established by G.S. 131D-10.9G, enacted under Section 1 of this act.

SECTION 4. This act is effective when it becomes law.

SENATE BILL 578

Short Title:	Transition Certain Abuse Investigations/DCDEE.	(Public)
Sponsors:	Senators Barringer, Hise, and Tucker (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate.	

March 30, 2015

A BILL TO BE ENTITLED

AN ACT TO TRANSITION ABUSE AND NEGLECT INVESTIGATIONS IN CHILD CARE FACILITIES TO THE DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 7B-101(3) reads as rewritten:

"**§ 7B-101. Definitions.**

As used in this Subchapter, unless the context clearly requires otherwise, the following words have the listed meanings:

...

(3) Caretaker. – Any person other than a parent, guardian, or custodian who has responsibility for the health and welfare of a juvenile in a residential setting. A person responsible for a juvenile's health and welfare means a stepparent, foster parent, an adult member of the juvenile's household, an adult relative entrusted with the juvenile's care, any person such as a house parent or cottage parent who has primary responsibility for supervising a juvenile's health and welfare in a residential child care facility or residential educational facility, or any employee or volunteer of a division, institution, or school operated by the Department of Health and Human Services. ~~"Caretaker" also means any person who has the responsibility for the care of a juvenile in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes and includes any person who has the approval of the care provider to assume responsibility for the juveniles under the care of the care provider.~~ Nothing in this subdivision shall be construed to impose a legal duty of support under Chapter 50 or Chapter 110 of the General Statutes. The duty imposed upon a caretaker as defined in this subdivision shall be for the purpose of this Subchapter only.

...."

SECTION 2. G.S. 7B-300 reads as rewritten:

"**§ 7B-300. Protective services.**

The director of the department of social services in each county of the State shall establish protective services for juveniles alleged to be abused, neglected, or dependent.

Protective services shall include the screening of reports, the performance of an assessment using either a family assessment response or an investigative assessment response, casework, or other counseling services to parents, guardians, or other caretakers as provided by the director to help the parents, guardians, or other caretakers and the court to prevent abuse or neglect, to

improve the quality of child care, to be more adequate parents, guardians, or caretakers, and to preserve and stabilize family life.

~~The provisions of this Article shall also apply to child care facilities as defined in G.S. 110-86.~~"

SECTION 3. G.S. 7B-301(a) reads as rewritten:

"(a) Any person or institution who has cause to suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. 7B-101, or has died as the result of maltreatment, shall report the case of that juvenile to the director of the department of social services in the county where the juvenile resides or is found. The report may be made orally, by telephone, or in writing. The report shall include information as is known to the person making it including the name and address of the juvenile; the name and address of the juvenile's parent, guardian, or caretaker; the age of the juvenile; the names and ages of other juveniles in the home; the present whereabouts of the juvenile if not at the home address; the nature and extent of any injury or condition resulting from abuse, neglect, or dependency; and any other information which the person making the report believes might be helpful in establishing the need for protective services or court intervention. If the report is made orally or by telephone, the person making the report shall give the person's name, address, and telephone number. Refusal of the person making the report to give a name shall not preclude the department's assessment of the alleged abuse, neglect, dependency, or death as a result of maltreatment.

~~Upon receipt of any report of sexual abuse of the juvenile in a child care facility, the director shall notify the State Bureau of Investigation within 24 hours or on the next workday. If sexual abuse in a child care facility is not alleged in the initial report, but during the course of the assessment there is reason to suspect that sexual abuse has occurred, the director shall immediately notify the State Bureau of Investigation. Upon notification that sexual abuse may have occurred in a child care facility, the State Bureau of Investigation may form a task force to investigate the report.~~"

SECTION 4. G.S. 7B-302(a) reads as rewritten:

"(a) When a report of abuse, neglect, or dependency is received, the director of the department of social services shall make a prompt and thorough assessment, using either a family assessment response or an investigative assessment response, in order to ascertain the facts of the case, the extent of the abuse or neglect, and the risk of harm to the juvenile, in order to determine whether protective services should be provided or the complaint filed as a petition. When the report alleges abuse, the director shall immediately, but no later than 24 hours after receipt of the report, initiate the assessment. When the report alleges neglect or dependency, the director shall initiate the assessment within 72 hours following receipt of the report. When the report alleges abandonment, the director shall immediately initiate an assessment, take appropriate steps to assume temporary custody of the juvenile, and take appropriate steps to secure an order for nonsecure custody of the juvenile. The assessment and evaluation shall include a visit to the place where the juvenile ~~resides, except when the report alleges abuse or neglect in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes. When a report alleges abuse or neglect in a child care facility as defined in Article 7 of Chapter 110 of the General Statutes, a visit to the place where the juvenile resides is not required.~~ resides. When the report alleges abandonment, the assessment shall include a request from the director to law enforcement officials to investigate through the North Carolina Center for Missing Persons and other national and State resources whether the juvenile is a missing child."

SECTION 5. G.S. 7B-307 reads as rewritten:

"**§ 7B-307. Duty of director to report evidence of abuse, neglect; investigation by local law enforcement; notification of Department of Health and Human ~~Services and State Bureau of Investigation.~~Services.**

(a) If the director finds evidence that a juvenile may have been abused as defined by G.S. 7B-101, the director shall make an immediate oral and subsequent written report of the

findings to the district attorney or the district attorney's designee and the appropriate local law enforcement agency within 48 hours after receipt of the report. The local law enforcement agency shall immediately, but no later than 48 hours after receipt of the information, initiate and coordinate a criminal investigation with the protective services assessment being conducted by the county department of social services. Upon completion of the investigation, the district attorney shall determine whether criminal prosecution is appropriate and may request the director or the director's designee to appear before a magistrate.

If the director receives information that a juvenile may have been physically harmed in violation of any criminal statute by any person other than the juvenile's parent, guardian, custodian, or caretaker, the director shall make an immediate oral and subsequent written report of that information to the district attorney or the district attorney's designee and to the appropriate local law enforcement agency within 48 hours after receipt of the information. The local law enforcement agency shall immediately, but no later than 48 hours after receipt of the information, initiate a criminal investigation. Upon completion of the investigation, the district attorney shall determine whether criminal prosecution is appropriate.

If the report received pursuant to G.S. 7B-301 involves abuse or neglect of a juvenile or child maltreatment, as defined in G.S. 110-105.3, in child care, the director shall notify the Department of Health and Human Services within 24 hours or on the next working day of receipt of the report.

~~(b) If the director finds evidence that a juvenile has been abused or neglected as defined by G.S. 7B-101 in a child care facility, the director shall immediately so notify the Department of Health and Human Services and, in the case of sexual abuse, the State Bureau of Investigation, in such a way as does not violate the law guaranteeing the confidentiality of the records of the department of social services.~~

~~(c) Upon completion of the assessment, the director shall give the Department written notification of the results of the assessment required by G.S. 7B-302. Upon completion of an assessment of sexual abuse in a child care facility, the director shall also make written notification of the results of the assessment to the State Bureau of Investigation.~~

The director of the department of social services shall submit a report of alleged abuse, neglect, or dependency cases or child fatalities that are the result of alleged maltreatment to the central registry under the policies adopted by the Social Services Commission."

SECTION 6. G.S. 110-105 reads as rewritten:

"**§ 110-105. Authority to inspect facilities.**

(a) The Department shall have authority to inspect facilities without notice, when it determines there is cause to believe that an emergency situation exists or there is a complaint alleging a violation of licensure law. When the Department is notified by the county director of social services that the director has received a report of child maltreatment in a child care facility, or when the Department is notified by any other person that alleged child maltreatment has occurred in a facility, the Commission's rules shall provide for an inspection conducted without notice to the child care facility to determine whether the alleged child maltreatment has occurred. The inspection shall be conducted within seven calendar days of receipt of the report. Additional visits shall be conducted, as warranted.

(a1) The Commission shall adopt standards and rules under this subsection which provide for the following types of inspections:

(1) An initial licensing inspection, which shall not occur until the administrator of the facility receives prior notice of the initial inspection visit;

(2) A plan for visits to all facilities, including announced and unannounced visits, which shall be confidential unless a court orders its disclosure;

(3) An inspection that may be conducted without notice, if there is ~~probable~~ cause to believe that an emergency situation exists or there is a complaint alleging a violation of licensure law. ~~When the Department is notified by the~~

~~county director of social services that the director has received a report of child abuse or neglect in a child care facility, or when the Department is notified by any other person that alleged abuse or neglect has occurred in a facility, the Commission's rules shall provide for an inspection conducted without notice to the child care facility to determine whether the alleged abuse or neglect has occurred. This inspection shall be conducted within seven calendar days of receipt of the report, and when circumstances warrant, additional visits shall be conducted.~~

The ~~Secretary or the Secretary's designee,~~Department, upon presenting appropriate credentials to the operator of the child care facility, may perform inspections in accordance with the standards and rules promulgated under this subsection. The ~~Secretary or the Secretary's designee~~Department may inspect any area of a building in which there is reasonable evidence that children are in ~~care.~~care or in which the Department has cause to believe that conditions in that area of a building pose a potential risk to the health, safety, or well-being of children in care.

(b) If an operator refuses to allow the Secretary or the Secretary's designee to inspect the child care facility, the Secretary shall seek an administrative warrant in accordance with G.S. 15-27.2."

SECTION 7. G.S. 110-105.2 is repealed.

SECTION 8. Article 7 of Chapter 110 of the General Statutes is amended by adding the following new sections to read:

"**§ 110-105.3. Child maltreatment.**

(a) The purpose of this section is to assign the authority to investigate instances of child maltreatment in child care facilities to the Department of Health and Human Services, Division of Child Development and Early Education. The General Assembly recognizes that the ability to properly investigate child maltreatment in licensed child care facilities is dependent upon the cooperation of State and local law enforcement agencies, as well as county departments of social services.

(b) The following definitions shall apply in this Article:

(1) Child maltreatment. – Any act or series of acts of commission or omission by a caregiver that results in harm, potential for harm, or threat of harm to a child. Acts of commission include, but are not limited to, physical, sexual, and psychological abuse. Acts of omission include, but are not limited to, failure to provide for the physical, emotional, or medical well-being of a child, and failure to properly supervise children, which results in exposure to potentially harmful environments.

(2) Caregiver. – The operator of a licensed child care facility or religious-sponsored child care facility, a child care provider, as defined in G.S. 110-90.2(a)(2), a volunteer, or any person who has the approval of the provider to assume responsibility for children under the care of the provider.

(3) Child care facilities. – Any of the following:

a. All facilities required to be licensed under this Article.

b. All religious-sponsored facilities operating pursuant to G.S. 110-106 of this Article.

c. All locations where children are being cared for by someone other than their parent or legal guardian that require a license under this Article, but have not been issued a license by the Department.

(c) The Department, local departments of social services, and local law enforcement personnel shall cooperate with the medical community to ensure that reports of child maltreatment in child care facilities are properly investigated.

(d) When a report of child maltreatment is received, the Department shall make a prompt and thorough assessment to ascertain the facts of the case, the extent of the maltreatment, and the risk of harm to children enrolled at the child care facility. When the report alleges maltreatment meeting the definition of abuse or neglect as defined in G.S. 14-318.2 and G.S. 14-318.4, the Department shall contact local law enforcement officials to investigate the report.

(e) During the pendency of an investigation, the Department may issue a protection plan restricting an individual alleged to have maltreated a child from being on the premises of the facility while children are in care. The Department may also suspend activities at a facility under investigation including, but not limited to, transportation, aquatic activities, and field trips.

(f) At any time during the pendency of a child maltreatment investigation, the Department may order immediate corrective action as required to protect the health, safety, or welfare of children in care. If the corrective action does not occur within the period specified in the corrective action order, the Department may take administrative action to protect the health, safety, or welfare of the children at the child care facility.

(g) The Department may, in accordance with G.S. 150B-3(c), summarily suspend the license of a child care facility if the Department determines that emergency action is required to protect the health, safety, or welfare of the children in a child care facility regulated by the Department.

(h) Until an investigation by the Department confirms that child maltreatment did occur in a child care facility, all matters regarding the investigation, including, but not limited to, any complaint, allegation, or inspection or the identity of the reporter, shall be held in strictest confidence by the Department, except under the following circumstances:

(1) The Department shall disclose confidential information to any federal, State, or local government entity or its agent in order to protect a juvenile from child maltreatment, abuse, or neglect. Any confidential information disclosed to any federal, State, or local government entity or its agent pursuant to this subdivision shall remain confidential with the other government entity or its agent and shall only be redisclosed for purposes directly connected with carrying out that entity's mandated responsibilities.

(2) A district court, superior court, or administrative law judge of this State presiding over a civil matter in which the Department is not a party may order the Department to release confidential information. The court may order the release of confidential information after providing the Department with reasonable notice and an opportunity to be heard and then determining that the information is relevant, necessary to the trial of the matter before the court, and unavailable from any other source.

(i) When a report of child maltreatment alleges facts which indicate that a report is required under G.S. 7B-301, the Department shall contact the local department of social services in the county where the juvenile resides or is found, and make the necessary report.

(j) In performing any duties related to the assessment of a report of child maltreatment, the Department may consult with any public or private agencies or individuals, including the available State or local law enforcement officers, probation and parole officers, and the director of any county department of social services who shall assist in the assessment and evaluation of the seriousness of any report of child maltreatment when requested by the Department. The Department or the Department's representatives may make a written demand for any information or reports, whether or not confidential, that may in the Department's opinion be relevant to the assessment of the report. Upon the Department or the Department's representative's request and unless protected by attorney-client privilege, any public or private

agency or individual shall provide access to and copies of this confidential information and the records required by this subsection, to the extent permitted by federal law and regulations.

(k) The North Carolina Child Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section. Rules promulgated subject to this section shall be exempt from the provisions of G.S. 150B-19.1(e) and (f).

"**§ 110-105.4. Duty to report child maltreatment.**

(a) Any person who has cause to suspect that a child in a child care facility has been maltreated, as defined by G.S. 110-105.3, or has died as the result of maltreatment occurring in a child care facility, shall report the case of that child to the Department. The report may be made orally, by telephone, or in writing. The report shall include information as is known to the person making the report, including (i) the name and address of the child care facility where the child was allegedly maltreated, (ii) the name and address of the child's parent, guardian, or caretaker, (iii) the age of the child, (iv) the present whereabouts of the child if not at the home address, (v) the nature and extent of any injury or condition resulting from maltreatment, and (vi) any other information the person making the report believes might assist in the investigation of the report. If the report is made orally or by telephone, the person making the report shall give the person's name, address, and telephone number. Refusal of the person making the report to give a name shall not preclude the Department's assessment of the alleged maltreatment.

(b) Upon receipt of any report of maltreatment involving sexual abuse of the child in a child care facility, the Department shall notify the State Bureau of Investigation within 24 hours or on the next workday. If sexual abuse in a child care facility is not alleged in the initial report, but during the course of the assessment there is reason to suspect that sexual abuse has occurred, the Department shall immediately notify the State Bureau of Investigation. Upon notification that sexual abuse may have occurred in a child care facility, the State Bureau of Investigation may form a task force to investigate the report.

"**§ 110-105.5. Child maltreatment registry.**

(a) The Department shall establish and maintain a registry containing the names of all caregivers who have been confirmed by the Department of having maltreated a child pursuant to G.S. 110-105.3.

(b) The Child Maltreatment Registry shall indicate when a finding is contested and may include a brief statement made by the individual against whom the finding was made.

(c) Individuals who wish to contest findings under subsection (a) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act under Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the Department's intent to place its findings about the person in the Child Maltreatment Registry.

(d) Prior to employment, an operator of a child care facility shall request the Department check the status of a potential employee in the Child Maltreatment Registry, and the Department shall notify the employer of the individual's Registry status.

(e) Individuals whose names are listed on the Registry shall not own, operate, or be employed at any licensed child care facility or religious-sponsored child care facility.

(f) No person shall be liable for providing any information for the Child Maltreatment Registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the Child Maltreatment Registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee. The immunity established by this subsection does not extend to malicious conduct or intentional wrongdoing.

(g) Upon request, a child care facility, as defined in G.S. 110-105.3, is permitted to provide confidential or other identifying information to the Department, including social

security numbers, taxpayer identification numbers, parent's legal surname prior to marriage, and dates of birth, for the purpose of verifying the identity of accused caregiver.

(h) With the exception of the names of individuals listed on the Child Maltreatment Registry, appeal status, and a statement made pursuant to subsection (b) of this section, all other information received by or pertaining to the Child Maltreatment Registry shall be confidential and is not a public record under Chapter 132 of the General Statutes.

(i) The North Carolina Child Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section.

"**§ 110-105.6. Penalties for child maltreatment.**

(a) For purposes of this Article, child maltreatment occurring in child care facilities is a violation of this Article, licensure standards, and licensure laws.

(b) Pursuant to G.S. 110-105.3, when an investigation confirms that child maltreatment did occur in a child care facility, the Department may issue an administrative action up to and including summary suspension and revocation of the facility's child care license.

(c) If the facility is permitted to remain open after an administrative action has been issued, the administrative action shall specify any corrective action to be taken by the operator.

(d) The Department shall make unannounced visits to determine whether the corrective action has occurred. If the corrective action has not occurred, then the Department may take further action against the facility as necessary to protect the health, safety, or welfare of the children at the child care facility.

(e) Administrative actions issued shall include a statement of the reasons for the action, and shall specify corrective action that shall be taken by the operator.

(f) Under the terms of the administrative action, the Department may limit enrollment of new children until satisfied the situation giving rise to the confirmation of child maltreatment no longer exists.

(g) Specific corrective action required by an administrative action authorized by this Article may include the removal of the individual responsible for child maltreatment from child care pending a final determination or appeal of the individual's placement on the Child Maltreatment Registry.

(h) Nothing in this section shall restrict the Department from using any other statutory or administrative remedies available."

SECTION 9. This act is effective when it becomes law.

HOUSE BILL 12
Committee Substitute Favorable 3/16/15
Committee Substitute #2 Favorable 3/25/15

Short Title: Amend Gaston Foster Care Ombudsman Prog. (Local)

Sponsors:

Referred to:

January 29, 2015

A BILL TO BE ENTITLED

AN ACT TO AMEND THE FOSTER CARE OMBUDSMAN PILOT PROGRAM IN GASTON COUNTY.

The General Assembly of North Carolina enacts:

SECTION 1. Section 1(c) of S.L. 2013-111 reads as rewritten:

"**SECTION 1.(c)** The foster care ombudsman shall:

(1) When a juvenile is placed in foster care following a disposition order under G.S. 7B-905, be a party in all actions under ~~G.S. 7B-906 and G.S. 7B-907~~ G.S. 7B-906.1 on behalf of the foster parents and permitted to speak on their behalf. The County ~~shall~~may designate an attorney to assist the ombudsman, if requested by the ombudsman. If requested by the parent or the juvenile, the ombudsman shall be allowed to participate in any meeting or court hearing regarding the juvenile prior to a disposition order.

(2) Determine the facts, the needs of the juvenile, and the available resources within the family, foster community, and community to meet those needs; to facilitate, when appropriate, the settlement of disputed issues; to explore options with the court at the dispositional hearing; to report to the court when the needs of the juvenile are not being met; and to protect and promote the best interests of the juvenile as seen by the foster family.

(3) Have the authority to obtain any information or reports, whether or not confidential, that may in the ombudsman's opinion be relevant to ~~the~~ a case. The ombudsman shall have access to case files regarding any juvenile in the care of the Department if the juvenile is placed with a foster parent at any point. No privilege other than the attorney-client privilege may be invoked to prevent the ombudsman from obtaining such information. The confidentiality of the information or reports shall be respected by the ombudsman, and no disclosure of any information or reports shall be made to anyone except by order of the court or unless otherwise provided by law.

(4) Refer to the social services director and any appropriate law enforcement any cause of suspect that any juvenile is abused, neglected, or dependent, as defined by G.S. 7B-101.

(5) Be a resource and advocate for foster parents.

(6) Provide to the director of social services a periodic report on foster placements within the county, including any recommendations regarding that placement or future placements.

(7) Compile and make available to the Board any data the ombudsman has collected in the course of exercising his or her official duties.

(8) Provide information regarding the role, duties, and functions of foster parents and the ombudsman, and the rights of children in foster care. The ombudsman may assist a pre-adoptive parent or a relative of the juvenile with matters related to that case, if so requested by the pre-adoptive parent or relative.

(9) Comply with any other duties or responsibilities deemed appropriate by the Board."

SECTION 2. Sections 2 and 3 of S.L. 2013-111 are repealed.

SECTION 3. Section 5 of S.L. 2013-111 reads as rewritten:

"**SECTION 5.** This act is effective when it becomes ~~law and expires July 1, 2015.~~law."

SECTION 4. G.S. 7B-906.1 reads as rewritten:

"**§ 7B-906.1. Review and permanency planning hearings.**

...

(b) The director of social services shall make a timely request to the clerk to calendar each hearing at a session of court scheduled for the hearing of juvenile matters. The clerk shall give 15 days' notice of the hearing and its purpose to (i) the parents, (ii) the juvenile if 12 years of age or more, (iii) the guardian, (iv) the person providing care for the juvenile, (v) the custodian or agency with custody, (vi) the guardian ad litem, (vii) the foster care ombudsman, and ~~(vii)~~(viii) any other person or agency the court may specify. The department of social services shall either provide to the clerk the name and address of the person providing care for the juvenile for notice under this subsection or file written documentation with the clerk that the juvenile's current care provider was sent notice of hearing. Nothing in this subsection shall be construed to make the person providing care for the juvenile a party to the proceeding solely based on receiving notice and the right to be heard.

(c) At each hearing, the court shall consider information from the parents, the juvenile, the guardian, any person providing care for the juvenile, the custodian or agency with custody, the guardian ad litem, the foster care ombudsman, and any other person or agency that will aid in the court's review. The court may consider any evidence, including hearsay evidence as defined in G.S. 8C-1, Rule 801, or testimony or evidence from any person that is not a party, that the court finds to be relevant, reliable, and necessary to determine the needs of the juvenile and the most appropriate disposition.

...."

SECTION 5. This act applies to Gaston County only.

SECTION 6. This act is effective when it becomes law.

SENATE BILL 424

Short Title:	Fostering Success.	(Public)
Sponsors:	Senators Barringer, Harrington, Tucker (Primary Sponsors); Bingham, Brock, Bryant, Clark, Cook, Daniel, J. Davis, Ford, Foushee, Hartsell, Hise, J. Jackson, Krawiec, Lee, Lowe, McInnis, Pate, Rabin, Rabon, Robinson, Sanderson, Smith, Smith-Ingram, Soucek, Tarte, Van Duyn, Waddell, and Woodard.	
Referred to:	Rules and Operations of the Senate.	

March 26, 2015

A BILL TO BE ENTITLED

AN ACT TO EXTEND THE PROVISION OF FOSTER CARE TO THE AGE OF 19 YEARS AND MAKE VARIOUS CONFORMING STATUTORY CHANGES; AUTHORIZE THE SOCIAL SERVICES COMMISSION TO ADOPT RULES IMPLEMENTING THE EXPANSION OF FOSTER CARE THROUGH AGE 19; PROVIDE FOR THE EXTENSION OF GUARDIANSHIP SERVICES THROUGH AGE 19; REQUIRE THE SUBMISSION OF A STATE PLAN AMENDMENT TO DRAW-DOWN FEDERAL IV-E FUNDS FOR THE EXPANSION OF FOSTER CARE THROUGH AGE 19; AND APPROPRIATE FUNDS TO IMPLEMENT THE PURPOSES OF THIS ACT.

Whereas, national research documents the long-term benefits to youth of completing high school, including decreased unemployment rates, decreased reliance on public assistance, decreased rates of incarceration, increased lifetime earnings, improved health choices, and better education outcomes of subsequent generations; and

Whereas, these benefits increase even more with any postsecondary education attainment; and

Whereas, national research has demonstrated that the increase in postsecondary educational attainment associated with allowing foster youth to remain in care until they are 21 years old, and the resulting increase in lifetime earnings associated with postsecondary education, mean an estimated two-dollar increase in lifetime earnings for every dollar spent on keeping foster youth in care beyond age 18; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108A-48 reads as rewritten:

"**§ 108A-48. State Foster Care Benefits Program.**

(a) The Department is authorized to establish a State Foster Care Benefits Program with appropriations by the General Assembly for the purpose of providing assistance to children who are placed in foster care facilities by county departments of social services in accordance with the rules and regulations of the Social Services Commission. Such appropriations, together with county contributions for this purpose, shall be expended to provide for the costs of keeping children in foster care facilities.

(b) ~~No benefits provided by this section shall be granted to any individual who has passed his eighteenth birthday unless he is less than 21 years of age and is a full-time student or has been accepted for enrollment as a full-time student for the next school term pursuing a high school diploma or its equivalent; a course of study at the college level; or a course of vocational~~

~~or technical training designed to fit him for gainful employment.~~The Department may continue to provide benefits pursuant to this section to an individual who has attained the age of 18 years and chosen to continue receiving foster care services to 19 years of age if the individual is (i) completing secondary education or a program leading to an equivalent credential, (ii) enrolled in an institution that provides postsecondary or vocational education, (iii) participating in a program or activity designed to promote, or remove barriers to, employment, (iv) employed for at least 80 hours per month, or (v) incapable of completing the educational or employment requirements of this subsection due to a medical condition or disability."

SECTION 2. G.S. 108A-49.1 reads as rewritten:

"**§ 108A-49.1. Foster care and adoption assistance payment rates.**

(a) The maximum rates for State participation in the foster care assistance program are established on a graduated scale as follows:

(1) $475.00 per child per month for children from birth through five years of age.

(2) $581.00 per child per month for children six through 12 years of age.

(3) $634.00 per child per month for children 13 through ~~18~~ 19 years of age.

(b) The maximum rates for the State adoption assistance program are established consistent with the foster care rates as follows:

(1) $475.00 per child per month for children from birth through five years of age.

(2) $581.00 per child per month for children six through 12 years of age.

(3) $634.00 per child per month for children 13 through ~~18~~ 19 years of age.

(c) The maximum rates for the State participation in human immunodeficiency virus (HIV) foster care and adoption assistance are established on a graduated scale as follows:

(1) $800.00 per child per month with indeterminate HIV status.

(2) $1,000 per child per month with confirmed HIV infection, asymptomatic.

(3) $1,200 per child per month with confirmed HIV infection, symptomatic.

(4) $1,600 per child per month when the child is terminally ill with complex care needs.

In addition to providing board payments to foster and adoptive families of HIV-infected children, any additional funds remaining that are appropriated for purposes described in this subsection shall be used to provide medical training in avoiding HIV transmission in the home.

(d) The State and a county participating in foster care and adoption assistance shall each contribute fifty percent (50%) of the nonfederal share of the cost of care for a child placed by a county department of social services or child-placing agency in a family foster home or residential child care facility. A county shall be held harmless from contributing fifty percent (50%) of the nonfederal share of the cost for a child placed in a family foster home or residential child care facility under an agreement with that provider as of October 31, 2008, until the child leaves foster ~~care or~~care, experiences a placement ~~change.~~change, or, if after attaining the age of 18 years, the child chooses to continue receiving foster care or guardianship services to age 19 years as provided by law."

SECTION 3. G.S. 131D-10.2 reads as rewritten:

"**§ 131D-10.2. Definitions.**

For purposes of this Article, unless the context clearly implies otherwise:

...

(3) "Child" means an individual less than ~~18~~ 19 years of age, who has not been emancipated under the provisions of Article 35 of Chapter 7B of the General Statutes.

...

(9a) "Foster Parent" means any individual who is ~~18~~ 19 years of age or older who is licensed by the State to provide foster care.

...."

SECTION 4. Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Foster care through 19 years of age.**

(a) A child placed in foster care who has attained the age of 18 years may continue receiving foster care services to age 19 years as provided by law. A child who initially chooses to opt out of foster care upon attaining the age of 18 years may opt to receive foster care services at a later date up to 19 years of age.

(b) A child who has attained the age of 18 years and chosen to continue receiving foster care services to 19 years of age may continue to receive benefits pursuant to Part 4 of Article 2 of Chapter 108A of the General Statutes upon meeting the requirements under G.S. 108A-48(b)."

SECTION 5. G.S. 131D-10.5 is amended by adding a new subdivision to read:

"**§ 131D-10.5. Powers and duties of the Commission.**

In addition to other powers and duties prescribed by law, the Commission shall exercise the following powers and duties:

(1) Adopt, amend and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this ~~Article;~~Article.

(2) Issue declaratory rulings as may be needed to implement the provisions and purposes of this ~~Article;~~Article.

(3) Adopt rules governing procedures to appeal Department decisions pursuant to this Article granting, denying, suspending or revoking ~~licenses;~~licenses.

(4) Adopt criteria for waiver of licensing rules adopted pursuant to this ~~Article;~~Article.

(5) Adopt rules on documenting the use of physical restraint in residential child-care ~~facilities;~~facilities.

(6) Adopt rules establishing personnel and training requirements related to the use of physical restraints and time-out for staff employed in residential child-care ~~facilities; and~~facilities.

(7) Adopt rules establishing educational requirements, minimum age, relevant experience, and criminal record status for executive directors and staff employed by child placing agencies and residential child care facilities.

(8) Adopt any rules necessary for the expansion of foster care for individuals who have attained the age of 18 years and chosen to continue receiving foster care services to 19 years of age in accordance with G.S. 131D-10.2A."

SECTION 6.(a) The Department of Health and Human Services, Division of Social Services, (Division) shall develop a plan for the expansion of foster care services for individuals who have attained the age of 18 years and opt to continue receiving foster care services to 19 years of age. The Division shall report on the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2015. The Division shall report on the plan as implemented to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2016.

SECTION 6.(b) No later than 60 days after the Department implements the plan for the expansion of foster care services as required under subsection (a) of this section, the Division shall submit a state plan amendment to the U.S. Department of Health and Human Services Administration for Children and Families to make federal payments for foster care and adoption assistance, as applicable, under Title IV-E, available to a person meeting the requirements of G.S. 108A-48(b), as enacted in Section 1 of this act.

SECTION 7. Regarding the provision of foster care services, the Department of Health and Human Services, Division of Social Services, may provide for the financial support of children who are deemed to be (i) in a permanent family placement setting, (ii) eligible for legal guardianship, and (iii) otherwise unlikely to receive permanency. The Division of Social Services shall design the Guardianship Assistance Program (GAP) to include provisions for extending guardianship services for individuals who have attained the age of 18 years and opt to continue to receive guardianship services to age 19 years if the individual is (i) completing secondary education or a program leading to an equivalent credential, (ii) enrolled in an institution that provides postsecondary or vocational education, (iii) participating in a program or activity designed to promote, or remove barriers to, employment, (iv) employed for at least 80 hours per month, or (v) incapable of completing the educational or employment requirements of this section due to a medical condition or disability. The Guardianship Assistance Program rates shall reimburse the legal guardian for room and board and be set at the same rate as the foster care room and board rates in accordance with rates established under G.S. 108A-49.1. The Social Services Board shall adopt rules establishing a Guardianship Assistance Program to implement this section, including defining the phrase "legal guardian" as used in this section.

SECTION 8. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Social Services, the sum of fifty-six thousand forty-two dollars ($56,042) for the 2015-2016 fiscal year to develop the plan for the expansion of foster care services as authorized under Section 6 of this act.

SECTION 9. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Social Services, the sum of one million three hundred twenty-eight thousand four hundred ninety-nine dollars ($1,328,499) for the 2016-2017 fiscal year to implement the plan developed pursuant to Section 6 of this act.

SECTION 10. Section 8 of this act becomes effective October 1, 2015. Section 9 of this act becomes effective July 1, 2016. The remainder of this act becomes effective August 1, 2016.

HOUSE BILL 424*

Short Title:	Fostering Success.	(Public)
Sponsors:	Representatives Stevens and Glazier (Primary Sponsors). *For a complete list of Sponsors, refer to the North Carolina General Assembly Web Site.*	
Referred to:	Judiciary III.	

April 1, 2015

A BILL TO BE ENTITLED

AN ACT TO EXTEND THE PROVISION OF FOSTER CARE TO THE AGE OF NINETEEN YEARS AND MAKE VARIOUS CONFORMING STATUTORY CHANGES; AUTHORIZE THE SOCIAL SERVICES COMMISSION TO ADOPT RULES IMPLEMENTING THE EXPANSION OF FOSTER CARE THROUGH AGE NINETEEN; PROVIDE FOR THE EXTENSION OF GUARDIANSHIP SERVICES THROUGH AGE NINETEEN; REQUIRE THE SUBMISSION OF A STATE PLAN AMENDMENT TO DRAW DOWN FEDERAL IV-E FUNDS FOR THE EXPANSION OF FOSTER CARE THROUGH AGE NINETEEN; AND APPROPRIATE FUNDS TO IMPLEMENT THE PURPOSES OF THIS ACT.

Whereas, national research documents the long-term benefits to youth of completing high school, including decreased unemployment rates, decreased reliance on public assistance, decreased rates of incarceration, increased lifetime earnings, improved health choices, and better education outcomes of subsequent generations; and

Whereas, these benefits increase even more with any postsecondary education attainment; and

Whereas, national research has demonstrated that the increase in postsecondary educational attainment associated with allowing foster youth to remain in care until they are 21 years old, and the resulting increase in lifetime earnings associated with postsecondary education means an estimated two-dollar increase in lifetime earnings for every dollar spent on keeping foster youth in care beyond age 18; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108A-48 reads as rewritten:

"**§ 108A-48. State Foster Care Benefits Program.**

(a) The Department is authorized to establish a State Foster Care Benefits Program with appropriations by the General Assembly for the purpose of providing assistance to children who are placed in foster care facilities by county departments of social services in accordance with the rules and regulations of the Social Services Commission. Such appropriations, together with county contributions for this purpose, shall be expended to provide for the costs of keeping children in foster care facilities.

(b) ~~No benefits provided by this section shall be granted to any individual who has passed his eighteenth birthday unless he is less than 21 years of age and is a full-time student or has been accepted for enrollment as a full-time student for the next school term pursuing a high school diploma or its equivalent; a course of study at the college level; or a course of vocational or technical training designed to fit him for gainful employment.~~ The Department may continue

to provide benefits pursuant to this section to an individual who has attained the age of 18 years and chosen to continue receiving foster care services to 19 years of age if the individual is (i) completing secondary education or a program leading to an equivalent credential, (ii) enrolled in an institution that provides postsecondary or vocational education, (iii) participating in a program or activity designed to promote, or remove barriers to, employment, (iv) employed for at least 80 hours per month, or (v) incapable of completing the educational or employment requirements of this subsection due to a medical condition or disability."

SECTION 2. G.S. 108A-49.1 reads as rewritten:

"**§ 108A-49.1. Foster care and adoption assistance payment rates.**

(a) The maximum rates for State participation in the foster care assistance program are established on a graduated scale as follows:

(1) $475.00 per child per month for children from birth through five years of age.

(2) $581.00 per child per month for children six through 12 years of age.

(3) $634.00 per child per month for children 13 through ~~18~~ 19 years of age.

(b) The maximum rates for the State adoption assistance program are established consistent with the foster care rates as follows:

(1) $475.00 per child per month for children from birth through five years of age.

(2) $581.00 per child per month for children six through 12 years of age.

(3) $634.00 per child per month for children 13 through ~~18~~ 19 years of age.

(c) The maximum rates for the State participation in human immunodeficiency virus (HIV) foster care and adoption assistance are established on a graduated scale as follows:

(1) $800.00 per child per month with indeterminate HIV status.

(2) $1,000 per child per month with confirmed HIV infection, asymptomatic.

(3) $1,200 per child per month with confirmed HIV infection, symptomatic.

(4) $1,600 per child per month when the child is terminally ill with complex care needs.

In addition to providing board payments to foster and adoptive families of HIV-infected children, any additional funds remaining that are appropriated for purposes described in this subsection shall be used to provide medical training in avoiding HIV transmission in the home.

(d) The State and a county participating in foster care and adoption assistance shall each contribute fifty percent (50%) of the nonfederal share of the cost of care for a child placed by a county department of social services or child-placing agency in a family foster home or residential child care facility. A county shall be held harmless from contributing fifty percent (50%) of the nonfederal share of the cost for a child placed in a family foster home or residential child care facility under an agreement with that provider as of October 31, 2008, until the child leaves foster ~~care or~~care, experiences a placement ~~change.~~change, or, if after attaining the age of 18 years, the child chooses to continue receiving foster care or guardianship services to age 19 years as provided by law."

SECTION 3. G.S. 131D-10.2 reads as rewritten:

"**§ 131D-10.2. Definitions.**

For purposes of this Article, unless the context clearly implies otherwise:

...

(3) "Child" means an individual less than ~~18~~ 19 years of age, who has not been emancipated under the provisions of Article 35 of Chapter 7B of the General Statutes.

...

(9a) "Foster Parent" means any individual who is ~~18~~ 19 years of age or older who is licensed by the State to provide foster care.

...."

SECTION 4. Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Foster care through 19 years of age.**

(a) A child placed in foster care who has attained the age of 18 years may continue receiving foster care services to age 19 years as provided by law. A child who initially chooses to opt out of foster care upon attaining the age of 18 years may opt to receive foster care services at a later date up to 19 years of age.

(b) A child who has attained the age of 18 years and chosen to continue receiving foster care services to 19 years of age may continue to receive benefits pursuant to Part 4 of Article 2 of Chapter 108A of the General Statutes upon meeting the requirements under G.S. 108A-48(b)."

SECTION 5. G.S. 131D-10.5 reads as rewritten:

"**§ 131D-10.5. Powers and duties of the Commission.**

In addition to other powers and duties prescribed by law, the Commission shall exercise the following powers and duties:

(1) Adopt, amend and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this ~~Article;~~Article.

(2) Issue declaratory rulings as may be needed to implement the provisions and purposes of this ~~Article;~~Article.

(3) Adopt rules governing procedures to appeal Department decisions pursuant to this Article granting, denying, suspending or revoking ~~licenses;~~licenses.

(4) Adopt criteria for waiver of licensing rules adopted pursuant to this ~~Article;~~Article.

(5) Adopt rules on documenting the use of physical restraint in residential child-care ~~facilities;~~facilities.

(6) Adopt rules establishing personnel and training requirements related to the use of physical restraints and time-out for staff employed in residential child-care ~~facilities; and~~facilities.

(7) Adopt rules establishing educational requirements, minimum age, relevant experience, and criminal record status for executive directors and staff employed by child placing agencies and residential child care facilities.

(8) Adopt any rules necessary for the expansion of foster care for individuals who have attained the age of 18 years and chosen to continue receiving foster care services to 19 years of age in accordance with G.S. 131D-10.2A."

SECTION 6.(a) The Department of Health and Human Services, Division of Social Services, (Division) shall develop a plan for the expansion of foster care services for individuals who have attained the age of 18 years and opt to continue receiving foster care services to 19 years of age. The Division shall report on the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2015. The Division shall report on the plan as implemented to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2016.

SECTION 6.(b) No later than 60 days after the Department implements the plan for the expansion of foster care services as required under subsection (a) of this section, the Division shall submit a state plan amendment to the U.S. Department of Health and Human Services Administration for Children and Families to make federal payments for foster care and adoption assistance, as applicable, under Title IV-E, available to a person meeting the requirements of G.S. 108A-48(b), as enacted in Section 1 of this act.

SECTION 7. Regarding the provision of foster care services, the Department of Health and Human Services, Division of Social Services, may provide for the financial support

of children who are deemed to be (i) in a permanent family placement setting, (ii) eligible for legal guardianship, and (iii) otherwise unlikely to receive permanency. The Division of Social Services shall design the Guardianship Assistance Program (GAP) to include provisions for extending guardianship services for individuals who have attained the age of 18 years and opt to continue to receive guardianship services to age 19 years if the individual is (i) completing secondary education or a program leading to an equivalent credential, (ii) enrolled in an institution that provides postsecondary or vocational education, (iii) participating in a program or activity designed to promote, or remove barriers to, employment, (iv) employed for at least 80 hours per month, or (v) incapable of completing the educational or employment requirements of this section due to a medical condition or disability. The Guardianship Assistance Program rates shall reimburse the legal guardian for room and board and be set at the same rate as the foster care room and board rates in accordance with rates established under G.S. 108A-49.1. The Social Services Board shall adopt rules establishing a Guardianship Assistance Program to implement this section, including defining the phrase "legal guardian" as used in this section.

SECTION 8. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Social Services, the sum of fifty-six thousand forty-two dollars ($56,042) for the 2015-2016 fiscal year to develop the plan for the expansion of foster care services as authorized under Section 6 of this act.

SECTION 9. There is appropriated from the General Fund to the Department of Health and Human Services, Division of Social Services, the sum of one million three hundred twenty-eight thousand four hundred ninety-nine dollars ($1,328,499) for the 2016-2017 fiscal year to implement the plan developed pursuant to Section 6 of this act.

SECTION 10. Section 8 of this act becomes effective October 1, 2015. Section 9 of this act becomes effective July 1, 2016. The remainder of this act becomes effective August 1, 2016.

SENATE BILL 423
Health Care Committee Substitute Adopted 4/15/15

Short Title: Foster Care Family Act. (Public)

Sponsors:

Referred to:

March 26, 2015

A BILL TO BE ENTITLED

AN ACT TO ALIGN STATE LAW WITH FEDERAL LAW BY PROVIDING FOR THE SUPPORT OF HEALTHY DEVELOPMENT OF YOUTH IN FOSTER CARE THROUGH IMPLEMENTATION OF A REASONABLE AND PRUDENT PARENT STANDARD FOR DECISIONS MADE BY A FOSTER PARENT OR A DESIGNATED OFFICIAL FOR A CHILD CARE INSTITUTION AND REVISING TO THE JUVENILE CODE UNDER THE LAWS PERTAINING TO ABUSE, NEGLECT, AND DEPENDENCY REGARDING JUVENILE PLACEMENT; TO PROVIDE LIABILITY INSURANCE FOR FOSTER PARENTS; TO REDUCE BARRIERS TO OBTAINING A DRIVERS LICENSE FOR FOSTER CHILDREN BY PROVIDING THAT MINORS AGED SIXTEEN AND OVER IN THE CUSTODY OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES ARE COMPETENT TO CONTRACT FOR AUTOMOBILE INSURANCE, BY SPECIFYING PERSONS OTHER THAN THE FOSTER PARENT WHO MAY SIGN FOR A FOSTER CHILD TO OBTAIN A LEARNER'S PERMIT OR PROVISIONAL DRIVERS LICENSE, AND BY CLARIFYING THAT FOSTER PARENTS DO NOT VIOLATE FINANCIAL RESPONSIBILITY REQUIREMENTS BY ALLOWING FOSTER CHILDREN WITH THEIR OWN INSURANCE COVERAGE TO OPERATE A VEHICLE OWNED BY THE FOSTER PARENT; AND TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY A MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE.

The General Assembly of North Carolina enacts:

PART I. SHORT TITLE

SECTION 1.1. This act shall be known and may be cited as the "Foster Care Family Act."

PART II. REASONABLE AND PRUDENT PARENTING STANDARD IN FOSTER CARE

SECTION 2.1. Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Reasonable and prudent parenting standard.**

(a) The reasonable and prudent parenting standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while encouraging the child's emotional and developmental growth.

(b) Every child care institution shall designate an on-site official who is authorized to apply the reasonable and prudent parenting standard pursuant to this section.

(c) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the Department of Health and Human Services must use the reasonable and prudent parenting standard when determining whether to allow a child in foster care to participate in extracurricular, enrichment, and social activities.

(d) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services, or the Department of Health and Human Services with custody of or placement authority over a child in foster care shall not be held liable for an act or omission of the child if the caregiver or county department of social services is acting in accordance with the reasonable and prudent parenting standard under this section.

(e) Unless otherwise ordered by a court with jurisdiction pursuant to G.S. 7B-200, a caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, exercising the reasonable and prudent parenting standard has the authority to provide or withhold permission, without prior approval of the court or a county department of social services, allowing a child in foster care, in the custody of a county department of social services or under the placement authority of a county department of social services through a voluntary placement agreement, to participate in normal childhood activities. Normal childhood activities shall include, but are not limited to, extracurricular, enrichment, and social activities, and may include overnight activities outside the direct supervision of the caregiver for periods of over 24 hours and up to 72 hours.

(f) The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services, or the Department of Health and Human Services, shall not be liable for injuries to the child that occur as a result of the reasonable and prudent parenting standard. The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, or the designated official at a child care institution where the child is placed, or the county department of social services or the Department of Health and Human Services, shall be liable for any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in the injury to the child."

SECTION 2.2. G.S. 7B-505(b) reads as rewritten:

"(b) The court shall order the Department to make diligent efforts to notify relatives and any custodial parents of the juvenile's siblings that the juvenile is in nonsecure custody and of any hearings scheduled to occur pursuant to G.S. 7B-506, unless the court finds such notification would be contrary to the best interests of the juvenile. In placing a juvenile in nonsecure custody under this section, the court shall first consider whether a relative of the juvenile is willing and able to provide proper care and supervision of the juvenile in a safe home. If the court finds that the relative is willing and able to provide proper care and supervision in a safe home, then the court shall order placement of the juvenile with the relative unless the court finds that placement with the relative would be contrary to the best interests of the juvenile."

SECTION 2.3. G.S. 7B-800.1(a)(4) reads as rewritten:

"(a) Prior to the adjudicatory hearing, the court shall consider the following:

...

(4) Whether relatives or parents with custody of a sibling of the juvenile have been identified and notified as potential resources for placement or support."

SECTION 2.4. G.S. 7B-901 reads as rewritten:

"**§ 7B-901. Dispositional hearing.**

The dispositional hearing shall take place immediately following the adjudicatory hearing and shall be concluded within 30 days of the conclusion of the adjudicatory hearing. The dispositional hearing may be informal and the court may consider written reports or other evidence concerning the needs of the juvenile. The juvenile and the juvenile's parent, guardian, or custodian shall have the right to present evidence, and they may advise the court concerning the disposition they believe to be in the best interests of the juvenile. The court may consider any evidence, including hearsay evidence as defined in G.S. 8C-1, Rule 801, including testimony or evidence from any person who is not a party, that the court finds to be relevant, reliable, and necessary to determine the needs of the juvenile and the most appropriate disposition. The court may exclude the public from the hearing unless the juvenile moves that the hearing be open, which motion shall be granted.

At the dispositional hearing, the court shall inquire as to the identity and location of any missing parent and whether paternity is at issue. The court shall include findings of the efforts undertaken to locate the missing parent and to serve that parent and efforts undertaken to establish paternity when paternity is an issue. The order may provide for specific efforts in determining the identity and location of any missing parent and specific efforts in establishing paternity. The court shall also inquire about efforts made to identify and notify ~~relatives~~ relatives, including parents with custody of a sibling of the juvenile, as potential resources for placement or support."

SECTION 2.5. Article 9 of Chapter 7B of the General Statutes is amended by adding the following new sections to read:

"**§ 7B-903.1. Juvenile placed in custody of a county department of social services.**

(a) To the extent authorized by federal law, a county department of social services with custody of a juvenile is authorized to make decisions about matters not addressed in this section that are generally made by a juvenile's custodian, including, but not limited to, educational decisions and consenting to the sharing of the juvenile's information. The county department of social services may delegate any part of this authority to the juvenile's parent, foster parent, or another individual.

(b) When a juvenile is in the custody or placement responsibility of a county department of social services, the placement provider may, in accordance with G.S. 131D-10.2A, provide or withhold permission, without prior approval of the court or county department of social services, allowing a juvenile to participate in normal childhood activities. If such authorization is not in the juvenile's best interest, the court shall set forth alternative parameters for approving normal childhood activities.

"**§ 7B-912. Juveniles 14 years of age and older; Another Planned Permanent Living Arrangement.**

(a) In addition to the permanency planning requirements under G.S. 7B-906.1, at every permanency planning hearing for a juvenile in the custody of a county department of social services who has attained the age of 14 years, the court shall inquire and make written findings regarding each of the following:

(1) The services provided to assist the juvenile in making a transition to adulthood.

(2) The steps the county department of social services is taking to ensure that the foster family or other licensed placement provider follows the reasonable and prudent parenting standard as provided in G.S. 131D-10.2A.

(3) Whether the juvenile has regular opportunities to engage in age- or developmentally appropriate activities.

(b) At or before the last scheduled permanency planning hearing, but at least 90 days before a juvenile attains 18 years of age, the court shall (i) inquire as to whether the juvenile has a copy of the juvenile's birth certificate, Social Security card, health insurance information,

drivers license or other identification card, and any educational or medical records the juvenile requests and (ii) determine the person or entity that should assist the juvenile in obtaining these documents before the juvenile attains the age of 18 years.

(c) If the court finds each of the following conditions applies, the court shall approve Another Planned Permanent Living Arrangement (APPLA) as the juvenile's primary permanent plan:

(1) The juvenile is 16 or 17 years old.

(2) The county department of social services has made diligent efforts to place the juvenile permanently with a parent or relative or in a guardianship or adoptive placement.

(3) Compelling reasons exist that it is not in the best interest of the juvenile to be placed permanently with a parent or relative or in a guardianship or adoptive placement.

(4) APPLA is the best permanency plan for the juvenile.

(d) If the court approves APPLA as the juvenile's permanent plan, the court shall, after questioning the juvenile, make written findings addressing the juvenile's desired permanency outcome."

PART III. LIABILITY INSURANCE FOR FOSTER PARENTS

SECTION 3.1. Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-43. Development of policy form or endorsement for personal liability insurance for foster parents.**

(a) The Rate Bureau shall develop an optional policy form or endorsement to be filed with the Commissioner for approval no later than May 1, 2016, that provides liability insurance for foster parents licensed under Article 1A of Chapter 131D of the General Statutes to provide foster care in a family foster home or therapeutic foster home. The policy form or endorsement shall provide coverage for acts or omissions of the foster parent while the parent is acting in his or her capacity as a foster parent in a licensed family foster home or therapeutic foster home licensed under Article 1A of Chapter 131D of the General Statutes.

(b) Nothing in this section is intended to require that the liability insurance policy or endorsement required by this section cover an act or omission that results from any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in injury to the child."

PART IV. REDUCE DRIVING BARRIERS FOR FOSTER CHILDREN

SECTION 4.1. Article 1 of Chapter 48A of the General Statutes is amended by adding a new section to read:

"**§ 48A-4. Certain minors competent to contract.**

A minor who is 16 years of age or older and who is in the legal custody of the Department of Health and Human Services, Division of Social Services, shall be qualified and competent to contract for the purchase of an automobile insurance policy with the consent of the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b). The minor shall be responsible for paying the costs of the insurance premiums and shall be liable for damages caused by the minor's negligent operation of a motor vehicle. No State or local government agency, foster parent, or entity providing services to the minor under contract or at the direction of a State or local government agency shall be responsible for paying any insurance premiums or liable for damages of any kind as a result of the operation of a motor vehicle by the minor."

SECTION 4.2. G.S. 20-11(i) reads as rewritten:

"(i) Application. — An application for a permit or license authorized by this section must be signed by both the applicant and another person. That person must be:

(1) The applicant's parent or guardian;
(2) A person approved by the applicant's parent or guardian; or
(3) A person approved by the Division.
(4) With respect to minors in the legal custody of the Department of Health and Human Services, Division of Social Services, any of the following:
a. A guardian ad litem or attorney advocate appointed to advocate for the minor.
b. A case manager or other type of caseworker assigned to work with the minor.
c. If no person listed in sub-subdivision a. or b. of this subdivision is available, the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b)."

SECTION 4.3. G.S. 20-309 is amended by adding a new subsection to read:

"(a2) The owner of a motor vehicle who is a foster parent providing foster care to a person between the ages of 16 and 21 shall not violate the requirements of this Article by allowing the motor vehicle to be operated by the person if the person is covered by a non-owner motor vehicle insurance policy issued by the North Carolina Reinsurance Facility as authorized by G.S. 58-37-35(g)(13). Nothing in this section is intended to prevent a foster parent from including a foster child on the parent's own motor vehicle insurance policy."

PART V. STUDY MEDICAID WAIVER FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

SECTION 5.1.(a) The Department of Health and Human Services, Division of Medical Assistance, shall design and draft, but not submit, a 1915(c) Medicaid waiver to serve children with Serious Emotional Disturbance (SED) in home and community-based settings. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

SECTION 5.1.(b) The Department shall report the draft waiver, other findings, and any other options or recommendations to best serve children with SED to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015. Specifically, the report shall provide an in-depth analysis of the cost per slot, including an analysis of the estimated number of waiver recipients who would be transitioned from a facility to a home and community-based setting and the estimated number of waiver recipients who would avoid placement in a facility.

PART VI. EFFECTIVE DATE

SECTION 6.1. Parts 2 and 4 of this act become effective October 1, 2015. The remainder of this act is effective when it becomes law.

SENATE PAGES ATTENDING

COMMITTEE: Joint: Health & Hum. Serv. ROOM: 643

DATE: 4-22 TIME: 8:30

PLEASE PRINT LEGIBLY!!!!!!!!!!!!!....*or else!*

	Page Name	Hometown	Sponsoring Senator
1.	A J Swain III	Wendell	Barefoot
2.	Alec Johnson	Canton	Van Duyn
3.	Langden Ramseur	Gastonia	Harrington
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Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

Wednesday, April 21	**Room**	**Time**
APPROPRIATIONS HEALTH & HUMAN SERVICES (JOINT)	643	8:30 am

Name	County	Sponsor
Pira Apputhurai	Mecklenburg	William Brawley
Alina Cardwell	Alamance	Dennis Riddell
Alisha Harrison	Wake	Paul Stam

Committee Sergeants at Arms

NAME OF COMMITTEE Joint Approp: Health & Human Services

DATE: 4-22-15 **Room:** 643

House Sgt-At Arms:

1. **Name:** Young Bae
2. **Name:** Bill Morris
3. **Name:** Jim Moran
4. **Name:**
5. **Name:**

Senate Sgt-At Arms:

1. **Name:** Giles Jaffreys
2. **Name:** Canton Lewis
3. **Name:** Dale Huff
4. **Name:**
5. **Name:**

VISITOR REGISTRATION SHEET

Jt. Comm. on App HHS — Name of Committee

04/22/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
BILL RUSTIN	AZP
Maeve Gaecher	GSC
Melissa Reed	PP
Charlie Reece	PPSAT
Lauren Finn	PPSAT
Michelle Frazier	MF+S
[illegible]	MFS
John DelGiorno	Brubaker & Assoc.
John Gibbons	RHA Howell
Richard Anderson	RHA Howell
Paige Johnson	PPSAT

VISITOR REGISTRATION SHEET

Jt. Comm. on App HHS — Name of Committee

04/22/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carson Thie	NVA
Erica Nelson	NCHA
Adam Sibley	DHHS
Jon Carr	Jordan Rich
Madeline Keeter	CaroMont Health
Julia Santiago	Planned Parenthood
Jola Tucnes	UNC
Jennifer Williamson	UNC, NCMS
Sylvia Groth	UNC ophthalmology, NCMS
Bradley King	UNC ophthalmology, NCMS.
Mike Torres	NCP

VISITOR REGISTRATION SHEET

Jt. Comm. on App HHS — Name of Committee

04/22/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Leslie Kellenberger	Benchmarks
Flint Benson	SEANC
Anna Roberts	PSG
Doug Miskew	PSG
John Bode	B+A
Rob Lahaie	TLA
Richard Stevens	SH
Alexandra Kelly	CHS
Jamaica Pfister	CHS
Matt Anderson	CHS NC
Trent Womble	DHHS

VISITOR REGISTRATION SHEET

Jt. Comm. on App HHS — Name of Committee

04/22/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Heyney Hutaff	N.C.B.A.
Frank Hill	PSG
Allison Stewart	cardinal Innovations
Lexi Morgan	NCPMA
Jennifer Casparro	NCMS
Jackson Stancil	CCS
Tina Waters*	ECBH
Ann Rodriguez	NC Council of Community Programs
Danielle Brinton	Senate Intern
Austin Pruitt	Parkinson Law

VISITOR REGISTRATION SHEET

Jt Comm on APP HHS

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Rustin	NCFPC

VISITOR REGISTRATION SHEET

Jt. Comm. on App HHS — 04/22/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Melissia Arkin	Strategic Behavioral Center
Jennifer Bosk	IRB Marketing
Lauren Zingraff	SAYSO, INC.
Shaquana Mack	Sayso, Inc.
Gabrielle Foushee	Sayso, Inc.
Daniel Ball, BSW	Sayso Inc.
Jason West	Youth Villages
Tara Ward	Youth Villages
Brendan Rice	Foster Care to Success / NC Reach
Matt Gross	NCPC
John Jay	Relias Learning

VISITOR REGISTRATION SHEET

Jt. Comm. on App HHS — 04/22/15

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Molly Daughtry	RHA Health Services Inc 2023-1 S. 17th St. Wilmington, NC 28401
Melanie Shoaff	FesCare [illegible]
Jill Lineberger	RHA Health Servies Inc. 983 Cloverleaf Plaza Kannapolis NC 28059
Tina Stewart	RHA Howell-River Bend 140 Pirates Rd. New Bern, NC 28562
Luanne Davis	RHA Howell Bear Creek 5840 Greenwood Ave. LaGrange, NC 28551

VISITOR REGISTRATION SHEET

Jt. Comm. on App HHS — Name of Committee

04/22/15 — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Mercedes Restucha-Klein	Disability Rights NC
Courtney Coyle	NASW-NC
Kay Castillo	NASW-NC
Mandy Ableidinger	Benchmarks NC
Mike Strickland	NCRR – council
Wayne Wellham	OSBM
Judith Mident	OSBM
Jonathan Yeomans	OSBM
Michelle Brooks	East Carolina University
TRACY GOLVARD	AHEC
Chavi Koneru	NARAL
Hannah Osborne	NHRAL

Senate Appropriations Committee on Health and Human Services
Wednesday, May 27, 2015 at 8:00 am
Legislative Office Building - Room 643

MINUTES

The Senate Appropriations Committee on Health and Human Services met at 8:00 am on May 27, 2015 in room 643 of the Legislative Office Building. Eight NC Senate members attended.

Senator Tucker presided.

Senator Tucker opened the meeting by welcoming everyone and recognizing the Senate Sergeants-at-Arms – Charles Marsalis and Terry Barnhardt. He also recognized the pages in attendance. Senate pages attending were Alexis Givens of Mecklenburg County (sponsored by Sen. Joyce Waddell), Macy Wade Morgan of Beaufort County (sponsored by Sen. Bill Cook), Michyla Greene of Mecklenburg County (sponsored by Sen. Joel Ford), Ellie Klass of Davidson County (sponsored by Sen. Stan Bingham) and Arturo Casal of Stanly County (sponsored by Sen. Tom McInnis).

Susan Jacobs with the Fiscal Research Division presented the NC Senate's target and guidance. She also presented the NC Senate budget process calendar.

Discussion on the presentation by Senators Hise, Pate and Tucker and questions by Senators Robinson and McKissick concerning the process and targets.

The meeting adjourned at 8:27 am.

Tommy Tucker

Senator Tommy Tucker
Presiding

Joey Stansbury
Committee Clerk

AGENDA
SENATE APPROPRIATIONS COMMITTEE ON HEALTH AND HUMAN SERVICES

May 27, 2015 8:00 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Sen. Ralph Hise
Sen. Louis Pate
Sen. Tommy Tucker

Committee Members
Sen. Tamara Barringer
Sen. Floyd McKissick, Jr.
Sen. Gladys Robinson
Sen. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

I.	**Welcome & Opening Remarks**	Senator Tucker, Presiding Co-Chair
II.	**Senate Target and Guidance**	Susan Jacobs, Fiscal Research Division
III.	**Senate Calendar**	Susan Jacobs, Fiscal Research Division
IV.	**Committee Discussion**	
	Adjourn	

Senate Appropriations Committee on Health and Human Services

Spending Targets:

FY 2015-16: $5,270,516,208

FY 2016-17: $5,406,534,821

Guidance for All Subject Area Committees:

Committee Report and Special Provisions

- Evaluate budget programmatically, eliminating programs that aren't needed and providing adequate funding to those that still serve vital functions.
- Recurring money expansion items (funded outside of the Committee spending target) must be funded with recurring reductions.
- Address budget needs for both years of the biennium, minimizing the need for a revised budget in the short session.
- No spending reversions or "shall not revert" language in special provisions or money items.
- Vacant positions are being handled by the Full Chairs. Subcommittees **should not eliminate the funding for vacant positions**.
- If eliminating filled positions, list each position number.
- Consult other subject area committees as necessary.
- Refer certain items to the Full Chairs:
    - Salary-related items, debt service, or other statewide issues
    - Fee increases/decreases
- Worker's Compensation line items should be increased/decreased to reflect an average of FY 2012-13 and FY 2013-14 actuals.
    - Subcommittees must achieve this within their target amounts and should not decrease other accounts that would simply shift a structural budget problem in worker's compensation to another line item.
- All programs receiving funding via a transfer from the Highway Fund will be subject to Continuation Review. Additional information will be provided regarding this process.

Reporting

- Note unresolved or pending items.
- List funding priorities not included in package.

Specific Committee Guidance:

- Medicaid rebase is to be funded within the spending target at the level proposed in the Governor's Recommended Budget less increased FMAP funds resulting from federal PL 113-93.
- Broughton hospital building reserves are to be funded within the spending target in year 1.
- Look into discontinuing funding of primary care case management contracts.
- Discontinue Access NC travel guide (Highway Fund transfer).

Senate 2015 Appropriations Schedule

June 2015						
Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
	1 Senate Budget Process →	**2**	**3**	**4**	**5**	6 →
7	**8**	**9** Senate Approps & Finance	**10** Senate 2nd Reading	**11** Senate 3rd Reading	**12**	13
14	**15** Conference Process →	**16**	**17**	**18**	**19**	20 →
21 Father's Day	**22** Conference Process →	**23**	**24**	**25**	**26**	27 →
28	**29**	**30** Pass Conference Report				

Senate Budget Development
Fiscal Research Division

Senate 2015 Appropriations Schedule

May 2015

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
					1	2
3	4	5 House Budget Process	6 →	7 →	8	9
10 Mother's Day	11	12 House Budget	13 →	14 →	15	16
17	18	19 House Approps	20	21 House 2nd Reading	22 House 3rd Reading	23
24	25 Memorial Day	26 **Senate Budget Process** →	27 →	28 →	29 →	30
31						

Senate Budget Development
Fiscal Research Division

SENATE PAGES ATTENDING

COMMITTEE: ~~Approps.~~ - Health & Human Serv. ROOM: 643

DATE: 5-27 TIME: 8 AM

PLEASE PRINT <u>LEGIBLY</u>!!!!!!!!!!!!!....*or else!*

Page Name	Hometown	Sponsoring Senator
1. Macywade Morgan	Pantego	Cook
2. Alexis Givens	Charlotte	Waddell
3. Ellie P. Ihlass	Lexington	Bingham
4. Arturo Casal	Norwood	McInnis
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Do not add names below the grid.

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

Senate Appropriations Health and Human Services

May 27, 2015

Senate Sgt. At Arms

Charles Marsalis

Terry Barnhardt

Alexis Givens - Senator Waddell (Charlotte)

Macy Wade Morgan - Senator Cook (Pantego)

Michyla Greene - Senator Ford (Charlotte) (Beaufort Co.)

Ellie P. Klass - Senator Bingham - Lexington

VISITOR REGISTRATION SHEET

Senate Appropriations Subcommittee on Health and Human Services — May 27, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Andy Chase	KMA
Wayne Williams	OSBM
Rob LaMure	RLA
Matt Gross	NCR
Emilyn Hawthorne	DHHR/NCACA
Ed [illegible]	BOP
Colleen Kochanek	KCG
Annaliese Ralph	DL
Kevin LeCount	SEANC
Pat A. Yarney	APPCNC
Sarah Preston	ACLU-NC

VISITOR REGISTRATION SHEET

Senate Appropriations Subcommittee on Health and Human Services — May 27, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Derek Schroder, MD	North Carolina Med. Society
Andrew Wilkins	North Carolina Medical Society
Paul Harrison	NC Medical Society
Jennifer Gasperini	NCMS
Alex Klupp	RNC
Alan Briggs	NC Food Banks
Elizabeth Schab	NCPHA
Tom Vitaglione	NC Child

VISITOR REGISTRATION SHEET

Senate Appropriations Subcommittee on Health and Human Services — May 27, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Brian Rusin	ACP
Mike James	↓
Peters	CSS
Amanda Honaker	TSS
W. Ward Jr.	PPAD
[illegible]	WS
Susan Munrad	WM
Michelle Frazier	NFTS
Judy Jenkins	DSMS
Trent Womble	DHHS
Andy Eller	NCPM
Allison Stewart	Cardinal Innovations

VISITOR REGISTRATION SHEET

Senate Appropriations Subcommittee on Health and Human Services — May 27, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Chris McClure	Brooks Bevan
Chip Killian	Nelson Mullins
TJ Burger	NP
Austin Pruitt	Perkinson Law
[illegible]	MTS
John Bode	B x H
[illegible]	[illegible]
Lexi Morgan	NCRMA
Elizabeth Robinson	NCRMA
Andy Ellen	NCRMA
[illegible]	LOL LLC

VISITOR REGISTRATION SHEET

Senate Appropriations Subcommittee on Health and Human Services — May 27, 2015

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY AND ADDRESS
Tonya Horton	TSS
Wendy Kelly	Focus Carolina
Martha McConnell	Carolinas Health Care Sys
Erica Nelson	NC HA
Adam Shaber	DHHS
Ryan Blackledge	Consultealth
Kara Weisbaar	SA
Joyce Peters	CSS
Carson Wise	MVA
Jon Carr	Jordan Price

Senate Appropriations Committee on Health and Human Services
Monday, June 15, 2015 at 4:00 pm
Legislative Office Building - Room 422

MINUTES

The Senate Appropriations Committee on Health and Human Services met at 4:00 pm on June 15, 2015 in room 422 of the Legislative Office Building. Nine NC Senate members attended.

Senator Tucker presided.

Senator Tucker opened the meeting with Senator Pate reviewing the base budget rules. Senator Tucker thanked staff for their assistance with budget preparation and then recognized Senator Hise to present the money report and special provisions for the committee's health and human services budget.

Senators Robinson, McKissick, and Van Duyn raised questions concerning medicaid reform, the Office of Minority Health, personal services contracts, the Wright School, rural hospitals and certificate of need and ADAC.

The meeting adjourned at 5:21 pm.

Senator Tommy Tucker
Presiding

Joey Stansbury
Committee Clerk

Senate
Sen. Ralph Hise, Co-Chair
Sen. Louis Pate, Co-Chair
Sen. Tommy Tucker, Co-Chair
Sen. Tamara Barringer
Sen. Floyd McKissick
Sen. Gladys Robinson
Se. Bob Rucho
Sen. Terry Van Duyn
Sen. Andy Wells

SENATE APPROPRIATIONS SUBCOMMITTEE HEALTH AND HUMAN SERVICES

AGENDA

June 15, 2015
Legislative Office Building – Room 422

4:00 p.m.

I.	**Senator Tommy Tucker, Presiding**	Welcome, Opening Remarks, and Rules Review
II.	**2015 Appropriations Act House Bill 97, Proposed Senate Committee Substitute:** Proposed HHS Committee Report Proposed HHS Special Provisions	Senator Hise

Adjourn

Senate Appropriations/Base Budget Committee

Rules for Considering Amendments

If amendments are offered, then the following rules must be met in order to make the amendment eligible for consideration:

1. Money can only be transferred among items within the same subcommittee section.

2. Amendments where money is being transferred among items within a subcommittee must clearly identify the items/programs that are being increased and decreased.

3. Nonrecurring reductions cannot be made to fund recurring additions.

4. Amendments that spend reversions are not allowed.

5. Amendments that increase or create new management flexibility reserves are not allowed.

6. Amendments that increase spending in the subcommittee budgets are not allowed.

7. Amendments are not allowed where funding for an item comes from statewide reserves.

8. Amendments that adjust funds from compensation increase reserves or other reserves related to salaries and benefits are not allowed.

9. Amendments that adjust funds for workers' compensation are not allowed.

10. Amendments that adjust funds related to vacant positions are not allowed.

11. Since this is a meeting of Full Appropriations, amendments that address finance portions of the bill will not be heard.

12. Amendments must be in writing, the original signed, with 100 copies available for distribution.

13. To be considered, a proposed amendment must have been logged in by the committee clerk in room 643 by 10:00 a.m. on Tuesday, June 16, 2015.

SENATE APPROPRIATIONS COMMITTEE

ON

HEALTH AND HUMAN SERVICES

REPORT
ON THE
CONTINUATION AND EXPANSION BUDGETS

House Bill 97

June 15, 2015

Health and Human Services

GENERAL FUND

	FY 15-16		FY 16-17	
Recommended Base Budget	**$89,605,783**		**$89,605,783**	
Legislative Changes				
(1.0) Division of Central Management and Support				
1 Health Information Exchange (1910) Eliminates recurring funding for the exchange in accordance with S.L. 2015-7.	($2,000,000)	R	($2,000,000)	R
2 Health Net Grants (1372) Eliminates the NC Health Net program and allocates half of the remaining funding to the Community Health Grants program. The Community Health Grant program is increased by 42% to $7.5 million.	($2,250,000)	R	($2,250,000)	R
3 NCTRACKS- System Savings (2413,1122) Decreases funding based on anticipated savings associated with the replacement of Medicaid's claims processing system. Over $60 million remains in the DHHS budget for this purpose.	($4,775,749)	R	($4,775,749)	R
4 Miscellaneous Contractual Services (1120) Reduces funding for contracts in central management. Over $3.1 million remains in the budget for this purpose in central management.	($3,200,000)	NR		
5 NC FAST Required Changes (2411,1122) Provides funds to make the required changes to NC FAST associated with allowing the Eastern Band of the Cherokee to administer their Medicaid and Food and Nutrition Services Programs in accordance with State law.	$360,000 $3,200,000	R NR	$360,000	R
6 NC FAST- Operations and Maintenance (2411, 1122) Provides $9,871,059 in FY 2015-16 and $13,220,665 in FY 2016-17 in additional receipts for ongoing maintenance and operations for the NC FAST system. Three technology support analyst positions will be created and funded with the additional receipts. Total funding for this purpose is $60 million for FY 2015-16 and $47.5 million for FY 2016-17				
7 NC FAST System Development (2411,1122) Provides funding for continued system development including using prior-year earned revenue in the nonrecurring amount of $6,647,849 million in FY 2015-16 and $5,298,178 in FY 2016-17. The total funding for NC FAST is $60 million for FY 2015-16 and $47.5 million for FY 2016-17. Creates 18 positions in FY 2015-16 and 20 positions in FY 2016-17 with the additional receipts.				

	FY 15-16		FY 16-17	
8 Child Welfare Case Management System (1910) Provides nonrecurring funds to purchase a child welfare case management system. The NC FAST system will not be used for child welfare case management. Funding includes prior year earned revenue in the amount of $2,752,151 in FY 2015-16 and $4,101,824 in FY 2016-17. Total funding, including federal funding for the system is $8.5 million in FY 2015-16 and $17.2 million in FY 2016-17.	$5,803,000	NR	$13,052,000	NR
9 NCTRACKS (2413, 1122) Provides recurring funding for the operation and maintenance of NC TRACKS. Additional nonrecurring funding is provided for the development and implementation of 2 projects; ICD-10 which is used to code medical procedures and the Business Process Automated System for the Division of Health Service Regulation. Total funding for this purpose is over $60 million for FY 2015-16 and FY 2016-17.	$400,000 $2,300,000	R NR	$400,000 $940,000	R NR
10 Health Information Exchange (HIE) (1910) Funding is provided to continue efforts towards the implementation of a statewide HIE.	$8,000,000	R	$8,000,000	R
11 Government Data Analytics Center (1910) Funds a contract for the development for new and enhanced health data analytics capability and functionality for the Department.	$300,000 $700,000	R NR	$300,000 $1,000,000	R NR
12 Community Paramedicine Pilot Project Provides funds to implement 3 pilot projects focused on expanding the role of paramedics to allow for community-based initiatives designed to avoid nonemergency use of hospital emergency rooms.	$350,000	NR		
13 Competitive Block Grant- Additional Funds (1910) Provides $350,000 in recurring funds for long-term residential substance abuse services. Designates $350,000 for Big Brothers Big Sisters North Carolina Collaborative in FY 2015-16 and allows non-profits providing mentoring services to compete for the additional funds beginning in FY 2016-17. Total availability for this purpose is increased to $14.2 million for each year of the biennium.	$700,000	R	$700,000	R
14 Competitive Block Grant-Transfer from Division of Public Health (1910) Transfers funds resulting from the elimination of the Office of Minority Health and the Physical Activity and Nutrition Branch in the Division of Public Health. The scope of the block grant is increased to allow non-profits to compete to receive funding for programs proven to reduce health disparities and improve physical health and nutrition across the state. Preventative Health Services block grant funds in the amount of $4,000,754 are also transferred to this competitive block grant. This action provides $7.7 million for health disparities, physical activity, and nutrition grants.	$3,410,420	R	$3,410,420	R
15 Office of the State Auditor - Financial Audit Provides funds for a comprehensive financial audit of DHHS for FY 2014-15 and FY 2015-16. These funds shall be transferred to the Office of the State Auditor to perform the financial audit.	$450,000	R	$450,000	R

	FY 15-16		FY 16-17	
16 Worker's Compensation Adjustment Reserve Provides funding to adjust workers' compensation line items to the average FY 2012-13 and FY 2013-14 actual expenditures estimated to be from net General Fund appropriations. Agencies are directed to further adjust these line items using receipts to reflect the average FY 2012-13 and FY 2013-14 actual expenditures from all fund sources.	$5,148,986	R	$5,148,986	R
17 Contracting Specialist and Certification Program			$175,000	R
Provides nonrecurring funds to contract with the UNC School of Government to design a program for DHHS managers similar to the School's Certified Local Government Purchasing Officer and local purchasing and contracts programs. Recurring funds in FY 2016-17 will fund positions for the Office of State Human Resources (OSHR) dedicated to the oversight and training of the new program at DHHS.	$150,000	NR	$25,000 2.00	NR
18 Community Mental Health Initiatives (1910) Provides funds pursuant to the U.S. Department of Justice settlement agreement to continue to develop and implement housing, support, and other services for people with mental illness. This action increases the settlement budget to $27.5 million in FY 2015-16 and to $35.3 million in FY 2016-17.	$7,848,341	R	$15,597,746	R
19 Justification Review (1910)	($7,572,212)	R	($7,572,212)	R
Requires a justification review as part of a statewide plan to invest in evidence-based programs focused on reducing infant mortality and improving birth outcomes and the health status of children birth to age 5. The following programs will have funds converted to nonrecurring for FY 2015-16 and funds for FY 2016-17 will be contingent upon a statewide plan and report submitted to the Legislative Oversight Committee on Health and Human Services: Programs Subject to Justification Review: Maternal and Child Health Contracts - $2,472,094 High Risk Maternity Clinic - $375,000 Healthy Beginnings (2 contracts) - $396,025 Pregnancy Care Case Management - $300,901 Maternal, Infant and Early Childhood Home Visiting - $425,643 Triple P- Positive Parenting Program - $828,233 NC Perinatal and Maternal Substance Abuse Initiative - $2,729,316 Perinatal Substance Abuse Specialist - $45,000 Programs Receiving Receipts Only (subject to a review and inclusion in the statewide plan): Baby Love Plus - $1,156, 915 (Federal Funds) Young Families Connect - $1,027,528 (Federal Funds)	$7,572,212	NR		
20 Justification Review Reserve (1910) Establishes a recurring reserve for programs subject to a justification review in FY 2015-16. Ongoing funding will be contingent upon a statewide plan submitted to the Legislative Oversight Committee on Health and Human Services.			$7,572,212	R

Senate Appropriations Committee on Health and Human Services	FY 15-16		FY 16-17	
Total Legislative Changes	**$10,019,786**	R	**$25,516,403**	R
	$16,875,212	NR	**$15,017,000**	NR
Total Position Changes			2.00	
Revised Budget	**$116,500,781**		**$130,139,186**	

Health and Human Services

GENERAL FUND

	FY 15-16	FY 16-17
Recommended Base Budget	**$42,845,788**	**$42,845,788**
Legislative Changes		
(2.0) Division of Aging and Adult Services		
21 No Action Taken Takes no action on the Division's FY 2015-17 recommended base budget.		
Total Legislative Changes		
Total Position Changes		
Revised Budget	**$42,845,788**	**$42,845,788**

Health and Human Services

GENERAL FUND

	FY 15-16		FY 16-17	
Recommended Base Budget	**$249,687,727**		**$249,687,727**	
Legislative Changes				
(3.0) Division of Child Development and Early Education				
22 Federal Funding for NC Pre-K (1330) Budgets Temporary Assistance for Needy Families block grant funding on a nonrecurring basis for NC Pre-K.	($16,891,442)	NR	($16,891,442)	NR
23 Cost-Allocate Staff (1110) Budgets federal block grant funds for positions within the Division of Child Development and Early Education. Total availability for this program is not changed.	($507,577)	R	($507,577)	R
24 Child Care Subsidy (1380) Budgets Temporary Assistance for Needy Families (TANF) and TANF Contingency Block grant funds on a nonrecurring basis for child care subsidy. Total availability for this program is not changed.	($5,211,614)	NR	($2,835,482)	NR
25 NC Pre-K (1330) Provides recurring funding for NC Pre-K. Total availability is $141.5 million.	$2,323,599	R	$2,323,599	R
26 Child Care Subsidy Market Rate Increase (1380) Provides funding to increase the Child Care Subsidy market rate, effective September 1, 2015, to the recommended rates based on the 2013 Market Rate study for ages 0,1 and 2 in 3-, 4-, and 5-star centers and homes in Tier 1 and 2 counties. Total availability for FY 2015-16 is increased by 1.3% to $331.6 million and for FY 2016-17 is increased by 1.5% to $332.4 million.	$4,200,000	R	$5,000,000	R
27 North Carolina Early Childhood Integrated Data System (ECIDS) (1163) Provides funding for ECIDS, an integrated system of early childhood education, health, and social service information focused on children ages 0-5 receiving State and federal services. The system is designed to provide information about when and how children are being served and the program services they receive. ECIDS will connect with the Department of Public Instruction's data system to allow analysis of the effects of early childhood programs and services over time.			$699,690	R
28 Early Childhood Education and Development Plan Provides funding for a plan by the Program Evaluation Division to consolidate the NC Pre-K, Smart Start, and Child Care Subsidy programs.	$300,000	NR		

Senate Appropriations Committee on Health and Human Services	FY 15-16		FY 16-17	
Total Legislative Changes	**$6,016,022**	R	**$7,515,712**	R
	($21,803,056)	NR	**($19,726,924)**	NR
Total Position Changes				
Revised Budget	**$233,900,693**		**$237,476,515**	

Health and Human Services

GENERAL FUND

	FY 15-16		FY 16-17	
Recommended Base Budget	**$180,017,803**		**$180,017,803**	
Legislative Changes				
(4.0) Division of Social Services				
29 State-County Special Assistance (1570) Reduces funding for State-County Special Assistance due to a decline in the number of individuals participating in the program. The FY 2015-16 total availability is decreased by 6% leaving $125.8 million. The FY 2016-17 total availability is decreased by 8.6% leaving $122.3 million.	($4,000,000)	R	($5,750,000)	R
30 Personal Services Contracts (1110) Eliminates funding for personal services contracts in the Services Support fund. There is $2.5 million remaining for this purpose across all funds in the division.	($9,540)	R	($9,540)	R
31 Foster Care Caseload Increase (1532) Increases funding for foster care to support the growth in the foster care caseload. Paid placements are expected to increase by 6% in FY 2015-16 and 3% in FY 2016-17. Increases total availability by 6.9% to $192.7 million in FY 2015-16. Increases total availability by 11.7% to $201.2 million in FY 2016-17.	$4,500,000	R	$7,500,000	R
32 Foster Care Expansion to Age 21 (1532) Provides funding to increase the age to 21 for youth in foster care. This item along with the Foster Care Caseload item increases the total availability for FY 2016-17 by 13.8% to $205 million. Social Services Program Coordinator - $58,951	$50,000 1.00	R	$2,000,000 1.00	R
33 Adoption Assistance for Youth Adopted after Age 16 (1531) Provides funds for Adoption Assistance to age 21 for youth adopted after age 16. Federal rules require that if states extend foster care past age 18, they must extend adoption assistance for youth adopted after age 16 to the same age as foster care. This increases the total availability for Adoption Assistance to $105.7 million.			$200,000	R
34 Maternity Homes (1110) Provides recurring funding for maternity homes. Funding remains the same as the FY 2014-15 level of $1.2 million.	$925,000	R	$925,000	R
35 Child Protective Services Pilot- GDAC (1430) Provides funding for a contract with the Government Data Analytics Center to enhance and improve the coordination of services and information among agencies to improve the protection and outcomes for vulnerable children served through Child Welfare Services.	$300,000	NR		

	FY 15-16		FY 16-17	
36 Child Support Enforcement Incentive Payments(1371)				
Budgets federal Child Support Enforcement incentive payments. The Division shall retain up to 15% of annual federal incentive payments it receives to enhance centralized child support services. No less than 85% of the federal incentive payments must be allocated to county child support services programs to improve effectiveness and efficiency.				
Total Legislative Changes	**$1,465,460**	**R**	**$4,865,460**	**R**
	$300,000	**NR**		
Total Position Changes	1.00		1.00	
Revised Budget	**$181,783,263**		**$184,883,263**	

Health and Human Services

GENERAL FUND

	FY 15-16		FY 16-17	
Recommended Base Budget	**$141,283,615**		**$141,283,615**	
Legislative Changes				
(5.0) Division of Public Health				
37 Office of Minority Health (1262) Eliminates the Office of Minority Health and transfers the General Fund appropriation and receipts to the competitive block grant administered by the Division of Central Management and Support. Six positions, 3.38 FTE supported by the General Fund, are eliminated: 60039724 - Public Hlth Prog Consult I, $59,769 60041601 - Public Hlth Prog Consul II, $53,248 60041613 - Public Health Prog Mgr II, $76,031 60041619 - Program Assistant IV, $33,060 60041620 - Public Hlth Pgm Consult II, $66,780 60041600 - PH Program Supervisor II, $26,230	($3,144,108) -3.38	R	($3,144,108) -3.38	R
38 AIDS Drug Assistance Program Receipts (1460) Budgets additional drug rebate receipts and maintains funds available for AIDS pharmaceuticals at $47,844,707.	($6,268,646)	R	($6,268,646)	R
39 Personal Services and University Contracts (1110) Reduces funding for university and personal services contracts. $3,551,989 remains available for this purpose.	($70,072)	R	($70,072)	R
40 QUITLINE Receipts (1271) Budgets additional Medicaid receipts and maintains the Quitline's budget at $1,200,000.	($100,000)	R	($100,000)	R

	FY 15-16		FY 16-17	
41 Physical Activity and Nutrition Branch (1261) Eliminates the Physical Activity and Nutrition Branch, and transfers the General Fund appropriation and receipts to the competitive block grant administered by the Division of Central Management and Support. Six positions, 2.30 FTE supported by the General Fund, are eliminated: 65021006 - Information and Communications Spec II, $55,000 60041098 - Nutrition Prog Consultant, $57,360 60041186 - Public Hlth Prog Supv II, $56,898 60041112 - Public Health Prog Mgr I, $74,931 60041107 - Office Assistant IV, $33,587 60041125 - Office Assistant IV, $36,224	($266,312) -2.30	R	($266,312) -2.30	R
42 Office of Chief Medical Examiner (OCME) - Autopsy Costs (1172) Budgets revenue generated from autopsy fee increase and eliminates the $400 supplement paid for autopsies performed by contractors, a savings of $1,080,000. This is offset by the increased contract rate that OCME will pay for contracted autopsies that are not billed to counties, a cost of $418,500. Total funding after all actions in this report will be $8.6 million in FY 2015-16 and $10.4 million in FY 2016-17.	($661,500)	R	($661,500)	R
43 Office of Chief Medical Examiner - Training (1172) Provides funds to implement mandatory annual training for county medical examiners. Total funding after all actions in this report will be $8.6 million in FY 2015-16 and $10.4 million in FY 2016-17.	$100,000	R	$100,000	R
44 Office of Chief Medical Examiner - Equipment (1172) Provides funds to replace outdated and obsolete equipment. Total funding after all actions in this report will be $8.6 million in FY 2015-16 and $10.4 million in FY 2016-17.	$400,000	NR	$400,000	NR
45 ECU and Wake Forest University Forensic Pathologist Fellowships (1172) Provides funds to support 1 Forensic Pathologist Fellowship each at East Carolina and Wake Forest Universities. The fellows will perform autopsies at the State's regional autopsy centers. Total funding after all actions in this report will be $8.6 million in FY 2015-16 and $10.4 million in FY 2016-17.	$250,000	R	$250,000	R
46 Office of Chief Medical Examiner - Automation (1172) Provides funds to replace and upgrade the Medical Examiner Information System. Total funding after all actions in this report will be $8.6 million in FY 2015-16 and $10.4 million in FY 2016-17.			$2,195,000	NR

	FY 15-16		FY 16-17	
47 Office of Chief Medical Examiner - Transportation (1172) Provides funds to increase the rate paid for transporting bodies for death investigations or to the OCME autopsy centers. Total funding after all actions in this report will be $8.6 million in FY 2015-16 and $10.4 million in FY 2016-17.	$400,000	R	$400,000	R
48 Office of Chief Medical Examiner - Autopsy Fee Receipts (1172) Budgets increased autopsy fee receipts of $1,813,500 annually. Effective July 1, 2015, the autopsy fee will increase from $1,250 to $2,800. The new fee approximates the actual cost to perform an autopsy. Total funding after all actions in this report will be $8.6 million in FY 2015-16 and $10.4 million in FY 2016-17.				
49 State Public Health Laboratory (1174) Budgets funds to provide rabies drugs to indigent persons who have been exposed to rabid animals. This action increases funds available for drug supplies to $280,466.	$110,000	R	$110,000	R
50 Local Health Departments - Improve Birth Outcomes (13A1) Provides funds for a competitive block grant process for county health departments to increase access to prenatal care and improve birth outcomes. This action increases funding for Maternal and Infant Health to $52.8 million.	$2,500,000	R	$2,500,000	R
51 Nurse Family Partnership Program (13A1) Provides funds for home visiting services provided by the Nurse Family Partnership Program. Of the amount provided, $225,000 shall be used to expand existing programs serving rural areas in the western and eastern portions of the State. Total funds available for the program is $1.4 million.	$900,000	R	$900,000	R
52 Perinatal Quality Collaborative of North Carolina (PQCNC) (13A1) Provides funds to sustain PQCNC while it transitions during the FY 2015-17 biennium to become fully receipt-supported effective July 1, 2017. This action maintains funding at $808,172 in FY 2015-16 and $835,000 in FY 2016-17.	$465,000	NR	$635,000	NR
53 Forensic Tests for Alcohol (1151) Eliminates the base budget for the Forensic Tests for Alcohol Branch pending the findings of a continuation review to be completed during FY 2015-16. All programs supported with Highway Fund receipts are subject to a continuation review during FY 2015-16. About 37% of the Branch's budget are Highway Fund receipts. FY 2016-17 funds for this purpose are budgeted in a separate reserve account to be restored if recommended during the 2016 Short Session.	($1,368) $1,368	R NR	($1,368)	R
54 Newborn Screening (1174) Provides funding for equipment and supply purchases needed to expand newborn screening to include severe combined immunodeficiency (SCID) as required by H.B. 698. This action increases funding for newborn screening to $24.4 million in FY 2015-16.	$440,000	NR		

Senate Appropriations Committee on Health and Human Services	FY 15-16		FY 16-17	
55 Poison Control Center Funds (1332) Provides funding for the Carolinas Poison Center 24-hour telephone hotline. This action increases the Children's Health Services budget to $268 million.	$1,000,000	R	$1,000,000	R
Total Legislative Changes	**($5,252,006)**	R	**($5,252,006)**	R
	$1,306,368	NR	**$3,230,000**	NR
Total Position Changes	-5.68		-5.68	
Revised Budget	**$137,337,977**		**$139,261,609**	

Health and Human Services

	GENERAL FUND			
	FY 15-16		FY 16-17	
Recommended Base Budget	**$680,179,847**		**$680,179,847**	

Legislative Changes

(6.0) Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

56 Personal Services Contracts (1110) Reduces funding for personal services contracts. $535,015 remains available for personal and miscellaneous contractual services in each year of the biennium.	($243,886)	R	($243,886)	R
57 Single Stream Funding (1422) Reduces single-stream funding and replaces it with LME/MCO cash balance for both years of the biennium.	($185,604,653)	NR	($185,604,653)	NR
58 Wright School (1546) Eliminates funding and closes the Wright School, effective October 1, 2015.	($2,106,265) -38.66	R	($2,808,353) -38.66	R
59 New Broughton Hospital (1541, 1561) Provides funds for technology infrastructure, furniture, and equipment for the Broughton Hospital replacement facility scheduled to open in December 2016.	$16,598,589	NR		
60 Inflationary Increases for State Facilities (14460) Provides funds to offset inflationary increases in utilities, food, and other costs at the State-operated healthcare facilities. This action increases the total funds available for the facilities to $897,841,574 in FY 2015-16 and $898,180,502 in FY 2016-17.	$2,819,802	R	$3,158,730	R
61 Three-way Psychiatric Beds (1464) Provides funds to increase the number of community hospital beds that may be purchased to provide psychiatric inpatient treatment services. This action increases funding 7% to $40,583,394 and will increase the three-way contract capacity from 165 to 172 beds.	$2,463,750	NR	$2,463,750	NR
62 START Teams (1445,1462) Provides funds to expand START (Systematic, Therapeutic, Assessment, Resources and Treatment) Team services to children and adolescents with intellectual or developmental disabilities and to add respite services for both children and adults. This action increases the total funds available for child and adult NC START services from $2,437,207 to $3,981,207.	$1,544,000	R	$1,544,000	R

Senate Appropriations Committee on Health and Human Services	FY 15-16		FY 16-17	
63 Substance Abuse Services Criminal Offenders - TASC (1463) Provides funds to increase the number of TASC (Treatment Alternatives for Safer Communities) case managers who provide substance abuse assessment and referral services to criminal offenders who are maintained in the community instead of sentenced to prison or those who have been released from prison and are under supervision of a probation officer. This action will increase the TASC budget by 35% from $5,362,122 to $7,222,122.	$1,860,000	R	$1,860,000	R
64 Crisis Bed Registry (1110) Provides funds to develop and operate a psychiatric bed registry to provide real-time information on the number of child, adolescent, and adult beds available at each licensed inpatient facility in the State.	$134,000 $350,000 2.00	R NR	$134,000 2.00	R
65 Alcohol and Drug Abuse Treatment Centers (ADATC) (156D, 156E, 156F) Eliminates the General Fund appropriations and converts the State-operated ADATCs to 100% receipt-supported.	($37,381,817)	R	($37,381,817)	R
66 Substance & Alcohol Abuse Treatment Services (1442, 1463) Provides funding to LME/MCOs to purchase inpatient alcohol and substance abuse treatment services from the State-operated ADATCs. This action increases the budget for LME/MCO alcohol and substance abuse treatment to $77,692,211.	$37,381,817	R	$37,381,817	R
67 Cross-Area Service Programs (1422) Provides funding to support individuals with intellectual/developmental disabilities including residential living, day services, supported employment opportunities, and family support services. This action increases the single stream funding budget to $330,828,240 in FY 2015-16 and to $331,628,240 in FY 2016-17.	$800,000	R	$1,600,000	R
68 Drug Overdose Medications (1463) Provides funds to purchase opioid antagonists as defined in G.S. 90-106.2. This action increases funding for adult community substance abuse services to $34,618,966.	$50,000	NR		
69 Compensation Increase Reserve - HHS State Agency Teachers Provides funds to change the tiers of the salary schedule, to increase starting teacher pay from $33,000 to $35,000 per year, to grant an experience-based step increase for eligible educators earning a year of creditable experience, and to ensure that all educators, assuming no change in credentials, are paid at least their FY 2014-15 compensation.	$141,455	R	$141,455	R
70 NC Controlled Substance Reporting System (1110) Provides funding to strengthen controlled substance monitoring. This action increases the Services Support budget to $14,116,956.	$15,000 $95,070	R NR	$15,000	R

Senate Appropriations Committee on Health and Human Services	FY 15-16		FY 16-17	
Total Legislative Changes	**$4,964,106**	R	**$5,400,946**	R
	($166,047,244)	NR	**($183,140,903)**	NR
Total Position Changes	-36.66		-36.66	
Revised Budget	**$519,096,709**		**$502,439,890**	

Health and Human Services

	GENERAL FUND			
	FY 15-16		FY 16-17	
Recommended Base Budget	**$37,752,132**		**$37,752,132**	
Legislative Changes				
(7.0) Division of Vocational Rehabilitation				
71 Access North Carolina Travel Program Eliminates the Access NC Travel Guide due to the loss of Highway Fund receipts earmarked for this purpose. One position is eliminated: 60054404, Communications Project Manager, $41,729	$0	R	$0	R
Total Legislative Changes	**$0**	R	**$0**	R
Total Position Changes				
Revised Budget	**$37,752,132**		**$37,752,132**	

Health and Human Services

	GENERAL FUND			
	FY 15-16		FY 16-17	
Recommended Base Budget	**$16,022,641**		**$16,022,641**	
Legislative Changes				
(8.0) Division of Health Service Regulation				
72 Certificate Of Need (1102, 1101) Eliminates funding for the cost of Certificate of Need (CON) activities beginning in FY 2015-16 and phases out all CON by 2019. This reduction will leave over $1.6 million in the portion of the Health Service Regulation for CON and Health Planning and over $16 million in the Division budget for all functions.	($560,506)	R	($1,120,013)	R
Total Legislative Changes	**($560,506)**	R	**($1,120,013)**	R
Total Position Changes				
Revised Budget	**$15,462,135**		**$14,902,628**	

Health and Human Services

GENERAL FUND

	FY 15-16		FY 16-17	
Recommended Base Budget	**$3,532,548,786**		**$3,532,548,784**	
Legislative Changes				
(9.0) Division of Medical Assistance				
73 Personal Service Contracts (1101) Reduces funding for personal service contracts. This leaves over $3 million dollars in the Medicaid budget for this and similar spending.	($850,895)	R	($850,895)	R
74 NCTRACKS Certification Increases federal receipts for the Medicaid program for claims adjudication and other functions contracted through Computer Sciences Corporation (CSC) effective 7/1/15 due to federal certification of the system. The NCTRACKS system was certified in April 2015, allowing the Federal Medical Assistance Percentage to increase from 50% to 75% on a recurring basis. This item represents the impact of recovering the difference in Federal Medical Assistance Percentage (FMAP) paid from 7/1/13 for NCTRACKS prior to system certification by Centers for Medicare and Medicaid Services (CMS).	($8,940,545) ($19,600,000)	R NR	($8,566,737)	R
75 Mobile Dental Screenings and Assessments (1310) Eliminates gaps in services created by mobile dental screenings and assessments in both public schools and long term care settings where no referral for subsequent treatment by a qualified Medicaid provider follows service. This represents a .4% reduction in provider payments and will leave over $350 million in budgeted payments for dental providers.	($511,800)	R	($511,800)	R
76 Pharmacy Dispensing Fees (1310) Implements average acquisition cost as a basis for Medicaid payment that will result in lower product cost for drugs for the Medicaid program. The Department will use a survey of pharmacies to determine the average cost of dispensing Medicaid prescriptions and increase the weighted average dispensing fee to no more than $12.00 effective 1/1/16 to ensure pharmacies cover the cost of filling Medicaid prescriptions based on the survey. The Department will maintain a higher dispensing fee for generic and preferred drugs and for brand and non-preferred drugs. This represents a 1.4% reduction in provider payments and leaves over $1.5 billion for payment of prescription drugs.	($4,052,375)	R	($9,005,279)	R

	FY 15-16		FY 16-17	
77 340B Pricing for Specialty Prescription Drugs (1102, 1310) Implements enhanced Medicaid payments to 340B specialty pharmacies to incentivize them to fill prescriptions using their lower cost 340B inventory. The lower cost for the product/drug will be passed on to Medicaid through the claims payment. This is a 0.09% reduction in provider payments and leaves over $1.5 billion for payment of prescription drugs. The first year savings are reduced by the programming cost in NCTRACKS to implement this change.	($67,413)	R	($483,139)	R
78 340B Pharmacy Network Creation (1310) Creates a network of 340B specialty pharmacies and requires those pharmacies to invoice product cost (any medication with a cost of $1,500 per month) at 340B pricing rather than the retail pharmacy rate. This represents a 0.06% reduction in payments to providers and leaves over $1.5 billion for payment of prescription drugs.	($255,900)	R	($341,200)	R
79 Local Management Entity/Managed Care Organization 2% Risk Reserve (1310) Requires the LME/MCO's to transfer operating cash to the risk reserve to meet the 15% risk reserve requirement. This item discontinues funding for the 2% add on to Local Management Entity/Managed Care Organization (LME/MCO) capitation payments for all LME/MCO's meeting reserve requirement after the transfer. The change will be effective 1/1/16. This will leave over $2.5 billion for payments to the LME/MCO's for behavioral health services and administration.	($8,444,580)	R	($17,236,985)	R
80 Hospital Inpatient Base Rates - GME (1310, 1320, 1337) Discontinues the Graduate Medical Education (GME) add-on to inpatient hospital base rates effective 10/15/15. The GME cost will continue to be included in all calculations under the Medicaid Reimbursement Initiative (MRI) and Hospital GAP equity and upper payment limit (UPL) supplemental plans for determining payments and related intergovernmental transfers and provider assessments. This will leave over $850 million in Medicaid claims for inpatient hospital services and increases the budget for supplemental payment to over $900 million for inpatient hospitals.	($12,748,795)	R	($31,127,204)	R
81 Community Care of North Carolina (CCNC) Contract (1311) Discontinues contracts and payments to North Carolina Community Care Networks (NCCCN) effective 1/1/16. Contract payments for care management and pregnancy home will be discontinued, along with pass-through payments to NCCCN for the Health Departments. Health Department pass through payments to NCCCN will be changed to direct payment to Health Departments for services. Per Member Per Month (PMPM) payments that will be discontinued include the Carolina Access payments to physician providers.	($32,475,000)	R	($64,950,000)	R
82 Health Department Care Coordination for Children Payments (1310) Reinstates the Health Department pass through payments included in the NCCCN contract care coordination for children services to a direct payment to Health Departments for services.	$6,475,000	R	$12,950,000	R

Senate Appropriations Committee on Health and Human Services	FY 15-16		FY 16-17	
83 Primary Care and Obstetrician Rates (1310) Increases rates for primary care physicians and obstetricians to be equal to Medicare rates effective 1/1/16.	$25,302,940	R	$50,605,880	R
84 Traumatic Brain Injury Waiver (1101, 1102, 1310) Increases funding for a new service package for Traumatic Brain Injury under a waiver in North Carolina. Costs include both service expenditures and administrative costs.	$2,000,000	R	$2,000,000	R
85 Immunizing Pharmacists (1102) Provides funding for programming NCTRACKS to allow pharmacists to be added as an individual provider for reimbursement for vaccinations.	$500,000	NR		
86 Hospital Outpatient Cost Increase (1310, 1320) Increases funding for the loss of the sales tax exemptions for not for profit hospitals effective 7/1/15. The sales tax paid will become an allowable cost for these hospitals and will increase the settlement for outpatient services. This will increase the total requirements for outpatient services claims/settlement and supplemental equity payments by $4,331,000.	$1,061,096	R	$1,105,662	R
87 Medicaid Reform (1101, 1102) Provides funds for planning and reform of the Medicaid program to shift utilization risk from the State under a capitated model.	$5,000,000	R	$5,000,000	R
88 Reinstate Cost Settlement Per 1993 Agreement (1310, 1320) Increases outpatient cost settlement for Vidant Medical Center to 100% of allowable costs.	$3,400,000	R	$3,400,000	R
89 Private Duty Nursing Rates (1310) Increases rates for private duty nursing services (PDN) by 10% effective 1/1/16.	$1,182,615	R	$2,564,747	R
90 Medicaid Rebase (1310, 1311, 1320, 1331) Provides funds for enrollment and utilization growth for the Medicaid program.	$311,706,719	R	$489,053,809	R
91 State Children's Health Insurance Program Federal Rate (1101, 1102, 1310) Reduces funding on a nonrecurring basis for SCHIP/Health Choice due to a nonrecurring increase in FMAP for 2 years.	($39,631,522)	NR	($55,533,825)	NR
Total Legislative Changes	**$287,781,067**	R	**$433,606,859**	R
	($58,731,522)	NR	**($55,533,825)**	NR
Total Position Changes				
Revised Budget	**$3,761,598,331**		**$3,910,621,818**	

Health and Human Services

	GENERAL FUND			
	FY 15-16		FY 16-17	
Recommended Base Budget	**$41,874,629**		**$41,874,629**	
Legislative Changes				
(10.0) NC Health Choice				
92 SCHIP FMAP Rate Budgets an increase in the Federal Medical Assistance Percentage (FMAP). North Carolina's FMAP is increasing by 23 percentage points effective October 1, 2015. Overall spending is not impacted by the budgeting of these increased receipts.	($34,841,237)	NR	($47,358,284)	NR
93 Cost Settlement of Hospital Outpatient Services (1310, 1320) Increases funding to allow the settlement of hospital outpatient services on the same methodology as Medicaid at 70% of allowable costs effective 7/1/15. This will increase total requirements for outpatient services for the new settlement methodology by $3,100,000.	$816,877	R	$843,834	R
94 Health Choice Rebase Funds the anticipated growth in the Health Choice program. Projects enrollment growth at 2.3% for FY 2015-16 and 1.1% for FY 2016-17. Funds are also provided for increased utilization and claims. Increases total availability in FY 2015-16 by 14.2% to $199.2 million. Increases total availability in FY 2016-17 by 16.2% to $202.8 million.	$5,522,950	R	$6,230,413	R
Total Legislative Changes	**$6,339,827**	R	**$7,074,247**	R
	($34,841,237)	NR	**($47,358,284)**	NR
Total Position Changes				
Revised Budget	**$13,373,219**		**$1,590,592**	

Health and Human Services

	GENERAL FUND			
	FY 15-16		FY 16-17	
Recommended Base Budget	**$8,107,457**		**$8,107,457**	
Legislative Changes				
(11.0) Division of Services for the Blind and Services for the Deaf and Hard of Hearing				
95 Personal Services Contract (1110) Reduces funding for personal services contracts. $65,750 remains available to fund contractual services.	($9,250)	R	($9,250)	R
Total Legislative Changes	**($9,250)**	R	**($9,250)**	R
Total Position Changes				
Revised Budget	**$8,098,207**		**$8,098,207**	

Senate Appropriations Committee on Health and Human Services

Special Provisions for H.B. 97, 2015 Appropriations Act

June 15, 2015

information to the student regarding the consequences that accompany each option and any other relevant information that may be helpful to the student when considering which option to select.

SECTION 11.16.(b) Beginning November 1, 2016, the Board of Governors shall report annually to the Joint Legislative Education Oversight Committee regarding the number of students who graduated from a cooperative innovative high school program with an associate degree and which option was chosen by those students when applying for admission to a constituent institution.

SECTION 11.16.(c) This section applies to the 2016-2017 academic year and each subsequent academic year.

SEAA FUNDS FOR ADMINISTRATION OF SPECIAL EDUCATION SCHOLARSHIP GRANT PROGRAM

SECTION 11.18. Section 5(b) of S.L. 2013-364, as amended by Section 3.2 of S.L. 2013-363, reads as rewritten:

"**SECTION 5.(b)** Of the funds allocated to NCSEAA to be used for the award of scholarship grants to eligible students under subsection (a) of this section, for fiscal year 2013-2014, NCSEAA may retain up to two hundred thousand dollars ($200,000) for administrative costs associated with the scholarship grant program. For fiscal year ~~2014-2015~~ 2015-2016 and subsequent years, NCSEAA may retain up to ~~two percent (2%)~~ four percent (4%) annually for administrative costs associated with the scholarship grant program."

WESTERN GOVERNORS UNIVERSITY CHALLENGE GRANT

SECTION 11.20. Of the funds appropriated in this act to the Board of Governors of The University of North Carolina, the sum of two million dollars ($2,000,000) in nonrecurring funds for the 2015-2016 fiscal year shall be used as a challenge grant to Western Governors University to raise the sum of five million dollars ($5,000,000) in private funds for the 2015-2016 fiscal year to establish a North Carolina campus. The allocation of two million dollars ($2,000,000) under this section is contingent upon receipt by Western Governors University of five million dollars ($5,000,000) in private funds for the purpose of establishing a North Carolina campus.

HUNT INSTITUTE/NO GENERAL FUNDS

SECTION 11.21. Notwithstanding any other provision of law, no monies from the General Fund shall be used for the support of The Hunt Institute which is an affiliate of the University of North Carolina at Chapel Hill.

PART XII. DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBPART XII-A. CENTRAL MANAGEMENT AND SUPPORT

FUNDING FOR PROGRAMS TO IMPROVE CHILDREN'S HEALTH/ESTABLISH COMPETITIVE GRANTS PROCESS

SECTION 12A.2.(a) Findings. – The General Assembly finds that America spends twice as much on health care as any other nation, yet Americans are not the healthiest people in the world. Research indicates that spending on health care to treat people may actually come at the expense of investing in public health programs meant to keep people from getting sick in the first place. The General Assembly further finds that infant mortality rates are an indicator of a state's overall health status. North Carolina currently ranks fortieth in the nation on infant mortality. Implementing statewide policies to invest in evidence-based programs that are scientifically proven to lower infant mortality rates, and improve birth outcomes and the health

of children ages birth to five, will assure that future rankings for North Carolina are among the best in the nation.

SECTION 12A.2.(b) Designation of Lead Agency. – The Secretary of the North Carolina Department of Health and Human Services (Secretary) shall designate a lead agency that is responsible for doing all of the following:

(1) Assuming responsibility for controlling all funding and contracts designed to (i) improve North Carolina's birth outcomes, (ii) improve the overall health status of children in this State from ages birth to five, and (iii) lower this State's infant mortality rates.

(2) Working in consultation with the University of North Carolina Gillings School of Global Public Health to develop a statewide, comprehensive plan to accomplish the goals described in subdivision (1) of this subsection.

(3) Conducting a justification review of all programs and activities funded with State appropriations described in subsection (c) of this section.

SECTION 12A.2.(c) Nonrecurring Allocations. – For the 2015-2016 fiscal year only, the Department of Health and Human Services shall allocate the following designated amounts for the following programs on a nonrecurring basis:

(1)	Maternal and Child Health Contracts	$2,472,094 NR
(2)	High-Risk Maternity Clinic	375,000 NR
(3)	Healthy Beginnings (Two Contracts)	396,025 NR
(4)	Pregnancy Care Case Management	300,901 NR
(5)	Maternal, Infant, and Early Childhood Home Visiting	425,643 NR
(6)	Triple P-Positive Parenting Program	828,233 NR
(7)	NC Perinatal and Maternal Substance Abuse Initiative	2,729,316 NR
(8)	Perinatal Substance Abuse Specialist	45,000 NR

SECTION 12A.2.(d) Statewide Proposal and Justification Review. – By March 1, 2016, the Secretary shall submit the statewide proposal developed pursuant to subsection (b) of this section to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division for consideration during the 2016 Regular Session of the 2015 General Assembly. The statewide proposal shall include at least all of the following:

(1) Details of the statewide plan and identification of the lead agency responsible for assuring the success of the plan.

(2) Justification for continuing, reducing, or eliminating funding for the programs and activities that receive nonrecurring allocations for the 2015-2016 fiscal year.

(3) Recommendations for reallocation of funding from programs and activities that are not evidence-based and that are not producing positive returns on investment consistent with the goals described in subdivision (1) of subsection (b) of this section.

(4) Recommendations for investments in new initiatives that accomplish the goals described in subdivision (1) of subsection (b) of this section.

SECTION 12A.2.(e) Establishment of Competitive Grants Process for Local Health Departments. – It is the intent of the General Assembly that, beginning in the 2016-2017 fiscal year, the Department of Health and Human Services implement a competitive grants process for local health departments based on a county's current health status and the county's detailed proposal to invest in evidence-based programs to achieve the goals described in subdivision (1) of subsection (b) of this section. To that end, the Department shall develop a plan that establishes a competitive grants process to be administered by the Division of Central Management and Support. The Department shall develop a plan that, at a minimum, includes each of the following components:

(1) A request for application (RFA) process to allow local health departments to apply for and receive State funds on a competitive basis.

(2) A requirement that the Secretary prioritize grant awards to those local health departments that are able to leverage non-State funds in addition to the grant award.

(3) A process that awards grants to local health departments dedicated to providing services on a countywide basis and that supports the goals described in subdivision (1) of subsection (b) of this section.

(4) Ensures that funds received by the Department to implement the plan supplement and do not supplant existing funds for health and wellness programs and initiatives.

SECTION 12A.2.(f) Funds for Competitive Grants Process. – Of the funds appropriated in this act to the Department of Health and Human Services, Division of Public Health, the sum of two million five hundred thousand dollars ($2,500,000) in recurring funds for each year of the 2015-2017 fiscal biennium shall be used to establish the competitive grants process for local health departments described in subsection (e) of this section. The Department shall not use more than five percent (5%) of these funds for administrative purposes.

SECTION 12A.2.(g) Evaluation Protocol for Future Program Funding. – The Department shall work with the University of North Carolina Gillings School of Global Public Health (School of Global Public Health) to establish an evaluation protocol for determining program effectiveness and future funding requirements at the local level. By April 1, 2016, the Department, in consultation with the School of Global Public Health, shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services on the request for application process to allow local health departments to apply for and receive State funds on a competitive basis. The report shall include the counties awarded, the amount of the award, the types of programs to be funded, and the evaluation process to be used in determining county performance.

HEALTH INFORMATION TECHNOLOGY

SECTION 12A.4.(a) The Department of Health and Human Services (Department), in cooperation with the State Chief Information Officer (State CIO), shall coordinate health information technology (HIT) policies and programs within the State of North Carolina. The goal of the DHHS CIO in coordinating State HIT policy and programs shall be to avoid duplication of efforts and to ensure that each State agency, public entity, and private entity that undertakes health information technology activities does so within the area of its greatest expertise and technical capability and in a manner that supports coordinated State and national goals, which shall include at least all of the following:

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

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

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

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

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

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

(7) Facilitating health and clinical research.

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

SECTION 12A.4.(b) The Department, in cooperation with the State CIO, shall establish and direct an HIT management structure that is efficient and transparent and that is compatible with the Office of the National Health Coordinator for Information Technology (National Coordinator) governance mechanism. The HIT management structure shall be responsible for all of the following:

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

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

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

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

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

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

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

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

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

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

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

SECTION 12A.4.(c) By no later than January 15, 2016, the Department shall provide a written report on the status of HIT efforts to the Joint Legislative Oversight Committees on Health and Human Services and Information Technology and to the Fiscal Research Division. The report shall be comprehensive and shall include all of the following:

(1) Current status of federal HIT initiatives.

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

(3) Other State information technology initiatives with potential applicability to State HIT efforts.

(4) Efforts to ensure coordination and avoid duplication of HIT efforts within the State.

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

(6) Efforts by the DHHS CIO to coordinate HIT initiatives within the State and any obstacles or impediments to coordination.

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

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

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

FUNDS FOR OVERSIGHT AND ADMINISTRATION OF STATEWIDE HEALTH INFORMATION EXCHANGE NETWORK

SECTION 12A.5.(a) It is the intent of the General Assembly to do all of the following with respect to health information exchange:

(1) Establish a successor HIE Network to which (i) all Medicaid providers shall be connected by July 1, 2017, and (ii) all other entities that receive State funds for the provision of health services shall be connected by January 1, 2018.

(2) Establish (i) a State-controlled Health Information Exchange Authority to oversee and administer the successor HIE Network and (ii) a Health Information Exchange Advisory Board to provide consultation to the Authority on matters pertaining to administration and operation of the HIE Network and on statewide health information exchange, generally.

(3) Have the successor HIE Network gradually become and remain one hundred percent (100%) receipt-supported by establishing reasonable participation fees approved by the General Assembly and by drawing down available matching funds whenever possible.

SECTION 12A.5.(b) In order to achieve the objectives described in subsection (a) of this section, funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, for the 2015-2016 fiscal year and for the 2016-2017 fiscal year to continue efforts toward the implementation of a statewide health information exchange network shall be transferred to the Department of Information Technology. By 30 days after the effective date of this section, the Secretary of the Department of Health and Human Services and the State Chief Information Officer (State CIO) shall enter into a written memorandum of understanding pursuant to which the State CIO will have sole authority to direct the expenditure of these funds until (i) the North Carolina Health Information Exchange Authority (Authority) is established and the State CIO has appointed an Authority Director and (ii) the North Carolina Health Information Exchange Advisory Board (Advisory Board) is established with members appointed pursuant to Article 29B of Chapter 90 of the General Statutes, as enacted by subsection (d) of this section. The State CIO shall use these transferred funds to accomplish the following:

(1) Beginning immediately upon receipt of the transferred funds, facilitate the following:

a. Establishment of the successor HIE Network described in subsection (a) of this section.

b. Termination or assignment to the Authority by December 31, 2015, of any contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

(2) Fund the monthly operational expenses incurred or encumbered by the NC HIE from July 1, 2015, until December 31, 2015. Notwithstanding any other provision of law to the contrary, the total amount of monthly operating expenses paid for with these funds shall not exceed one hundred

seventy-seven thousand dollars ($177,000) per month, or a total of one million sixty-two thousand dollars ($1,062,000) for the six-month period commencing July 1, 2015, and ending December 31, 2015. The State CIO shall terminate payments for these monthly operational expenses upon the earlier of December 31, 2015, or upon the termination or assignment to the Authority of all contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

The State CIO is encouraged to explore all available opportunities for the State to receive federal grant funds and federal matching funds for health information exchange.

SECTION 12A.5.(c) Once the Authority Director has been hired and the Advisory Board has been established with members appointed pursuant to Article 29B of Chapter 90 of the General Statutes, as enacted by subsection (d) of this section, the Authority shall use these funds to do the following:

(1) Fund the operational expenses of the Authority and the Advisory Board.

(2) Establish, oversee, administer, and provide ongoing support of a successor HIE Network to the HIE Network established under Article 29A of Chapter 90 of the General Statutes.

(3) Enter into any contracts necessary for the establishment, administration, and operation of the successor HIE Network.

(4) Facilitate the termination or assignment to the Authority by December 31, 2015, of any contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

(5) Fund the monthly operational expenses incurred or encumbered by the NC HIE from July 1, 2015, until December 31, 2015. Notwithstanding any other provision of law to the contrary, the total amount of monthly operating expenses paid for with these funds shall not exceed one hundred seventy-seven thousand dollars ($177,000) per month, or a total of one million sixty-two thousand dollars ($1,062,000) for the six-month period commencing July 1, 2015, and ending December 31, 2015. The Authority shall terminate payments for these monthly operational expenses upon the earlier of December 31, 2015, or upon the termination or assignment to the Authority of all contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

The Authority is encouraged to explore all available opportunities for the State to receive federal grant funds and federal matching funds for health information exchange.

SECTION 12A.5.(d) Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 29B.

"Statewide Health Information Exchange Act.

"**§ 90-414.1. Title.**

This act shall be known and may be cited as the "Statewide Health Information Exchange Act."

"**§ 90-414.2. Purpose.**

This Article is intended to improve the quality of health care delivery within this State by facilitating and regulating the use of a voluntary, statewide health information exchange network for the secure electronic transmission of individually identifiable health information among health care providers, health plans, and health care clearinghouses in a manner that is

consistent with the Health Insurance Portability and Accountability Act, Privacy Rule and Security Rule, 45 C.F.R. §§ 160, 164.

"**§ 90-414.3. Definitions.**

The following definitions apply in this Article:

(1) Business associate. – As defined in 45 C.F.R. § 160.103.

(2) Business associate contract. – The documentation required by 45 C.F.R. § 164.502(e)(2) that meets the applicable requirements of 45 C.F.R. § 164.504(e).

(3) Covered entity. – Any entity described in 45 C.F.R. § 160.103 or any other facility or practitioner licensed by the State to provide health care services.

(4) Disclose or disclosure. – The release, transfer, provision of access to, or divulging in any other manner an individual's protected health information through the HIE Network.

(5) Emergency medical condition. – A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in (i) placing an individual's health in serious jeopardy, (ii) serious impairment of an individual's bodily functions, or (iii) serious dysfunction of any bodily organ or part of an individual.

(6) GDAC. – The North Carolina Government Data Analytics Center.

(7) Health Benefits Authority. – The Authority established under Article 14 of Chapter 143B of the General Statutes to operate the Medicaid and NC Health Choice programs.

(8) HIE Network. – The voluntary, statewide health information exchange network overseen and administered by the Authority.

(9) HIPAA. – The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended.

(10) Individual. – As defined in 45 C.F.R. § 160.103.

(11) North Carolina Health Information Exchange Authority or Authority. – The entity established pursuant to G.S. 90-414.5.

(12) North Carolina Health Information Exchange Advisory Board or Advisory Board. – The Advisory Board established under G.S. 90-414.6.

(13) Opt out. – An individual's affirmative decision to disallow his or her protected health information maintained by or on behalf of one or more specific covered entities from being disclosed to other covered entities through the HIE Network.

(14) Protected health information. – As defined in 45 C.F.R. § 160.103.

(15) Public health purposes. – The public health activities and purposes described in 45 C.F.R. § 164.512(b).

(16) Qualified organization. – An entity designated by the Authority to contract with covered entities on behalf of the Authority to facilitate the participation of such covered entities in the HIE Network.

(17) Research purposes. – Research that meets the standard described in 45 C.F.R. § 164.512(i).

(18) State CIO. – The State Chief Information Officer.

"**§ 90-414.4. Required participation in HIE Network for some providers.**

(a) The General Assembly makes the following findings:

(1) That controlling escalating health care costs of the Medicaid program and other State-funded health services is of significant importance to the State, its taxpayers, its Medicaid recipients, and other recipients of State-funded health services.

(2) That the Health Benefits Authority needs timely access to claims and clinical information in order to assess performance, improve health care outcomes, pinpoint medical expense trends, identify beneficiary health risks, and evaluate how the State is spending money on Medicaid and other State-funded health services.

(3) That making this clinical information available through the HIE Network will improve care coordination within and across health systems, increase care quality, enable more effective population health management, reduce duplication of medical services, augment syndromic surveillance, allow more accurate measurement of care services and outcomes, increase strategic knowledge about the health of the population, and facilitate health care cost containment.

(b) As a condition of receiving State funds, including Medicaid funds, the following entities shall connect to the HIE Network and submit individual patient demographic and clinical data on services paid for with State funds, including Medicaid funds, based on the findings set forth in subsection (a) of this section and notwithstanding the voluntary nature of the HIE Network under G.S. 90-414.2:

(1) Each hospital, as defined in G.S. 131E-76(3), that has an electronic health record system.

(2) Each Medicaid provider.

(3) Each provider that receives State funds for the provision of health services.

(c) The Authority shall give the Health Benefits Authority real-time access to data and information disclosed through the HIE Network. At the request of the Director of the Fiscal Research, Bill Drafting, Research, or Program Evaluation Divisions of the General Assembly for data and information disclosed through the HIE Network or for a consolidation or analysis of the data and information disclosed through the HIE Network, the Authority shall provide the professional staff of these Divisions with data and information responsive to the Director's request. Prior to providing the General Assembly's staff with any data or information disclosed through the HIE Network or with any compilation or analysis of data or information disclosed through the HIE Network, the Authority shall redact any personal identifying information in a manner consistent with the standards specified for de-identification of health information under the HIPAA Privacy Rule, 45 C.F.R. § 164.15, as amended.

"**§ 90-414.4A. State ownership of data disclosed through HIE Network.**

Any data disclosed through the HIE Network pursuant to G.S. 90-414.4 or any other provision of this Article shall be and will remain the sole property of the State. Any data or product derived from the data disclosed to the HIE Network pursuant to G.S. 90-414.4 or any other provision of this Article, including a consolidation or analysis of the data, shall be and will remain the sole property of the State. The Authority shall not allow proprietary information it receives pursuant to G.S. 90-414.4 or any other provision of this Article to be used by any person or entity for commercial purposes.

"**§ 90-414.5. North Carolina Health Information Exchange Authority.**

(a) Creation. – There is hereby established the North Carolina Health Information Exchange Authority to oversee and administer the HIE Network in accordance with this Article. The Authority shall be located within the Department of Information Technology and shall be under the supervision, direction, and control of the State CIO. The State CIO shall employ an Authority Director and may delegate to the Authority Director all powers and duties associated with the daily operation of the Authority, its staff, and the performance of the powers and duties set forth in subsection (b) of this section. In making this delegation, however, the State CIO maintains the responsibility for the performance of these powers and duties.

(b) Powers and Duties. – The Authority has the following powers and duties:

(1) Oversee and administer the HIE Network in a manner that ensures all of the following:
  a. Compliance with this Article.
  b. Compliance with HIPAA and any rules adopted under HIPAA, including the Privacy Rule and Security Rule.
  c. Compliance with the terms of any business associate contract the Authority or qualified organization enters into with a covered entity participating in the HIE Network.
  d. Notice to the patient by the provider on the initial visit about the HIE Network, including information and education about the right of individuals on a continuing basis to opt out or rescind a decision to opt out.
  e. Opportunity for all individuals to exercise on a continuing basis the right to opt out or rescind a decision to opt out.
  f. Nondiscriminatory treatment by covered entities of individuals who exercise the right to opt out.

(2) Employ staff necessary to carry out the provisions of this Article and determine the compensation, duties, and other terms and conditions of employment of hired staff.

(3) Enter into contracts pertaining to the oversight and administration of the HIE Network, including contracts of a consulting or advisory nature. G.S. 143-64.20 does not apply to this subdivision.

(4) Establish fees approved by the General Assembly for participation in the HIE Network.

(5) Following consultation with the Advisory Board, develop and enter into written participation agreements with covered entities that utilize the HIE Network. The participation agreements shall specify the terms and conditions governing participation in the HIE Network. The agreement shall also require compliance with policies developed by the Authority pursuant to this Article or pursuant to applicable laws of the state of residence for entities located outside of North Carolina. In lieu of entering into a participation agreement directly with covered entities, the Authority may enter into participation agreements with qualified organizations, which in turn enter into participation agreements with covered entities.

(6) Add, remove, disclose, and access protected health information through the HIE Network in accordance with this Article.

(7) Following consultation with the Advisory Board, enter into a business associate contract with each of the covered entities participating in the HIE Network. In lieu of entering into a business associate contract directly with covered entities, the Authority may enter into business associate contracts with qualified organizations, which in turn may enter into business associate contracts with covered entities.

(8) Following consultation with the Advisory Board, grant user rights to the HIE Network to business associates of covered entities participating in the HIE Network (i) at the request of the covered entities and (ii) at the discretion of the Authority upon consideration of the business associates' legitimate need for utilizing the HIE Network and privacy and security concerns.

(9) Facilitate and promote use of the HIE Network by covered entities.

(10) Periodically monitor compliance with this Article by covered entities participating in the HIE Network.

(11) Collect clinical health data from all Medicaid providers and other providers that receive State funds for the provision of health services in order to ensure the efficient delivery of Medicaid and other health services and to improve patient outcomes and measure performance.

(12) Collaborate with the State CIO to ensure that resources available through the GDAC are properly leveraged, assigned, or deployed to support the work of the Authority. The duty to collaborate under this subdivision includes collaboration on data hosting and development, implementation, operation, and maintenance of the HIE Network.

(13) Initiate or direct expansion of existing public-private partnerships within the GDAC as necessary to meet the requirements, duties, and obligations of the Authority. Notwithstanding any other provision of law and subject to the availability of funds, the State CIO, at the request of the Authority, shall assist and facilitate expansion of existing contracts related to the HIE Network, provided that such request is made in writing by the Authority to the State CIO with reference to specific requirements set forth in this Article.

(14) In consultation with the Advisory Board, develop a strategic plan for achieving statewide participation in the HIE Network by all hospitals and health care providers licensed in this State.

(15) In consultation with the Advisory Board, define the following with respect to operation of the HIE Network:

a. Business policy.

b. Protocols for data integrity, data sharing, data security, HIPAA compliance, and business intelligence as defined in G.S. 143B-426.38A. To the extent permitted by HIPAA, protocols for data sharing shall allow for the disclosure of data for academic research.

c. Qualitative and quantitative performance measures.

d. An operational budget and assumptions.

(16) Annually report to the Joint Legislative Oversight Committees on the Health Benefits Authority and Information Technology on the following:

a. The operation of the HIE Network.

b. Any efforts or progress in expanding participation in the HIE Network.

c. Health care trends based on information disclosed through the HIE Network.

"**§ 90-414.6. North Carolina Health Information Exchange Advisory Board.**

(a) Creation and Membership. – There is hereby established the North Carolina Health Information Exchange Advisory Board within the Department of Information Technology. The Advisory Board shall consist of the following nine members:

(1) The following three members appointed by the President Pro Tempore of the Senate:

a. A licensed physician in good standing and actively practicing in this State.

b. A patient representative.

c. An individual with technical expertise in health data analytics.

(2) The following three members appointed by the Speaker of the House of Representatives:

a. A representative of a critical access hospital.

b. A representative of a federally qualified health center.

c. An individual with technical expertise in health information technology.

(3) The following three ex officio, nonvoting members:

a. The State Chief Information Officer or a designee.

b. The Program Manager of GDAC or a designee.

c. The Chief Executive Officer of the Health Benefits Authority or a designee.

(b) Chairperson. – A chairperson shall be elected from among the members. The chairperson shall organize and direct the work of the Advisory Board.

(c) Administrative Support. – The Department of Information Technology shall provide necessary clerical and administrative support to the Advisory Board.

(d) Meetings. – The Advisory Board shall meet at least quarterly and at the call of the chairperson. A majority of the Advisory Board constitutes a quorum for the transaction of business.

(e) Terms. – In order to stagger terms, in making initial appointments, the President Pro Tempore shall designate two of the members appointed under subdivision (1) of subsection (a) of this section to serve for a one-year period from the date of appointment, and the Speaker of the House of Representatives shall designate two members appointed under subdivision (2) of subsection (a) of this section to serve for a one-year period from the date of appointment. The remaining voting members shall serve two-year periods. Future appointees who are voting members shall serve terms of two years, with staggered terms based on this subsection. Voting members may serve up to two consecutive terms, not including the abbreviated two-year terms that establish staggered terms or terms of less than two years that result from the filling of a vacancy. Ex officio, nonvoting members are not subject to these term limits. A vacancy other than by expiration of a term shall be filled by the appointing authority.

(f) Expenses. – Members of the Advisory Board who are State officers or employees shall receive no compensation for serving on the Advisory Board but may be reimbursed for their expenses in accordance with G.S. 138-6. Members of the Advisory Board who are full-time salaried public officers or employees other than State officers or employees shall receive no compensation for serving on the Advisory Board but may be reimbursed for their expenses in accordance with G.S. 138-5(b). All other members of the Advisory Board may receive compensation and reimbursement for expenses in accordance with G.S. 138-5.

(g) Duties. – The Advisory Board shall provide consultation to the Authority with respect to the advancement, administration, and operation of the HIE Network and on matters pertaining to health information exchange, generally. In carrying out its responsibilities, the Advisory Board may form committees of the Advisory Board to examine particular issues related to the advancement, administration, or operation of the HIE Network.

"**§ 90-414.7. Participation by covered entities.**

(a) Each covered entity that elects to participate in the HIE Network shall enter into a business associate contract and a written participation agreement with the Authority or qualified organization prior to disclosing or accessing any protected health information through the HIE Network.

(b) Each covered entity that elects to participate in the HIE Network may authorize its business associates to disclose or access protected health information on behalf of the covered entity through the HIE Network in accordance with this Article and at the discretion of the Authority, as provided in G.S. 90-414.5(b)(8).

(c) Notwithstanding any State law or regulation to the contrary, each covered entity that elects to participate in the HIE Network may disclose an individual's protected health information through the HIE Network (i) to other covered entities for any purpose permitted by HIPAA, unless the individual has exercised the right to opt out, and (ii) in order to facilitate the

provision of emergency medical treatment to the individual, subject to the requirements set forth in G.S. 90-414.8(e).

(d) Any health care provider who relies in good faith upon any information provided through the Authority or through a qualified organization in the health care provider's treatment of a patient shall not incur criminal or civil liability for damages caused by the inaccurate or incomplete nature of this information.

"**§ 90-414.8. Continuing right to opt out; effect of opt out; exception for emergency medical treatment.**

(a) Each individual has the right on a continuing basis to opt out or rescind a decision to opt out.

(b) The Authority or its designee shall enforce an individual's decision to opt out or rescind an opt out prospectively from the date the Authority or its designee receives notice of the individual's decision to opt out or rescind an opt out in the manner prescribed by the Authority. An individual's decision to opt out or rescind an opt out does not affect any disclosures made by the Authority or covered entities through the HIE Network prior to receipt by the Authority or its designee of the individual's notice to opt out or rescind an opt out.

(c) A covered entity may not deny treatment or benefits to an individual because of the individual's decision to opt out. However, nothing in this Article is intended to restrict a treating physician from otherwise appropriately terminating a relationship with a patient in accordance with applicable law and professional ethical standards.

(d) Except as otherwise permitted in subsection (e) of this section and G.S. 90-414.9(a)(3), the protected health information of an individual who has exercised the right to opt out may not be disclosed to covered entities through the HIE Network for any purpose.

(e) The protected health information of an individual who has exercised the right to opt out may be disclosed through the HIE Network in order to facilitate the provision of emergency medical treatment to the individual if all of the following criteria are met:

(1) The reasonably apparent circumstances indicate to the treating health care provider that (i) the individual has an emergency medical condition, (ii) a meaningful discussion with the individual about whether to rescind a previous decision to opt out is impractical due to the nature of the individual's emergency medical condition, and (iii) information available through the HIE Network could assist in the diagnosis or treatment of the individual's emergency medical condition.

(2) The disclosure through the HIE Network is limited to the covered entities providing diagnosis and treatment of the individual's emergency medical condition.

(3) The circumstances and extent of the disclosure through the HIE Network is recorded electronically in a manner that permits the Authority or its designee to periodically audit compliance with this subsection.

"**§ 90-414.9. Construction and applicability.**

(a) Nothing in this Article shall be construed to do any of the following:

(1) Impair any rights conferred upon an individual under HIPAA, including all of the following rights related to an individual's protected health information:

a. The right to receive a notice of privacy practices.

b. The right to request restriction of use and disclosure.

c. The right of access to inspect and obtain copies.

d. The right to request amendment.

e. The right to request confidential forms of communication.

f. The right to receive an accounting of disclosures.

(2) Authorize the disclosure of protected health information through the HIE Network to the extent that the disclosure is restricted by federal laws or regulations, including the federal drug and alcohol confidentiality regulations set forth in 42 C.F.R. Part 2.

(3) Restrict the disclosure of protected health information through the HIE Network for public health purposes or research purposes, so long as disclosure is permitted by both HIPAA and State law.

(4) Prohibit the Authority or any covered entity participating in the HIE Network from maintaining in the Authority's or qualified organization's computer system a copy of the protected health information of an individual who has exercised the right to opt out, as long as the Authority or the qualified organization does not access, use, or disclose the individual's protected health information for any purpose other than for necessary system maintenance or as required by federal or State law.

(b) This Article applies only to disclosures of protected health information made through the HIE Network, including disclosures made within qualified organizations. It does not apply to the use or disclosure of protected health information in any context outside of the HIE Network, including the redisclosure of protected health information obtained through the HIE Network.

"**§ 90-414.10. Penalties and remedies.**

A covered entity that discloses protected health information in violation of this Article is subject to the following:

(1) Any civil penalty or criminal penalty, or both, that may be imposed on the covered entity pursuant to the Health Information Technology for Economic and Clinical Health (HITECH) Act, P.L. 111-5, Div. A, Title XIII, section 13001, as amended, and any regulations adopted under the HITECH Act.

(2) Any civil remedy under the HITECH Act or any regulations adopted under the HITECH Act that is available to the Attorney General or to an individual who has been harmed by a violation of this Article, including damages, penalties, attorneys' fees, and costs.

(3) Disciplinary action by the respective licensing board or regulatory agency with jurisdiction over the covered entity.

(4) Any penalty authorized under Article 2A of Chapter 75 of the General Statutes if the violation of this Article is also a violation of Article 2A of Chapter 75 of the General Statutes.

(5) Any other civil or administrative remedy available to a plaintiff by State or federal law or equity."

SECTION 12A.5.(e) G.S. 126-5 is amended by adding a new subdivision to read:

"**§ 126-5. Employees subject to Chapter; exemptions.**

...

(c1) Except as to the provisions of Articles 6 and 7 of this Chapter, the provisions of this Chapter shall not apply to:

...

(31) Employees of the North Carolina Health Information Exchange Authority."

SECTION 12A.5.(f) Article 29A of Chapter 90 of the General Statutes is repealed.

SECTION 12A.5.(g) Subsections (d) and (e) of this section become effective October 1, 2015. Subsection (f) of this section becomes effective on the date the State Chief Information Officer notifies the Revisor of Statutes that all contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE, as defined in G.S. 90-413.3, and (ii) between the NC HIE and any third parties have been terminated or assigned to the North Carolina Health Information Exchange

Authority established under Article 29B of Chapter 90 of the General Statutes, as enacted by subsection (d) of this section. The remainder of this section becomes effective July 1, 2015.

FUNDS FOR NCTRACKS, THE REPLACEMENT MULTIPAYER MEDICAID MANAGEMENT INFORMATION SYSTEM

SECTION 12A.6. Of the funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, for NCTRACKS, the sum of four hundred thousand dollars ($400,000) for the 2015-2016 fiscal year and the sum of four hundred thousand dollars ($400,000) for the 2016-2017 fiscal year shall be used to operate and maintain NCTRACKS; and the sum of two million three hundred thousand dollars ($2,300,000) in nonrecurring funds for the 2015-2016 fiscal year and the sum of nine hundred forty thousand dollars ($940,000) in nonrecurring funds for the 2016-2017 fiscal year shall be used to develop and implement the ICD-10 Project and the Business Process Automated System for the Division of Health Service Regulation. In addition, overrealized receipts are hereby appropriated to the Department of Health and Human Services, Division of Central Management and Support, up to the amounts necessary to implement this section. In the event it becomes necessary for the Department to utilize these overrealized receipts or any other funds appropriated to the Department to implement this section, the Department shall first (i) obtain prior approval from the Office of State Budget and Management (OSBM) and (ii) consult with the Joint Legislative Oversight Committees on Health and Human Services and Information Technology and the Fiscal Research Division. As part of the consultation required by this section, the Department shall provide the amounts of any overrealized receipts or other funds it intends to use to make up for any shortfall in funding for NCTRACKS and an explanation of the circumstances necessitating the use of overrealized receipts or other funds to make up for the shortfall.

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

SECTION 12A.7.(a) Departmental receipts appropriated in this act in the amount of nine million eight hundred seventy-one thousand fifty-nine dollars ($9,871,059) for the 2015-2016 fiscal year and thirteen million two hundred twenty thousand six hundred sixty-five dollars ($13,220,665) for the 2016-2017 fiscal year shall be used to provide ongoing maintenance and operations for the NC FAST system, including the creation of three full-time equivalent technology support analyst positions.

SECTION 12A.7.(b) Prior year earned revenue appropriated in this act in the amount of six million six hundred forty-seven thousand eight hundred forty-nine dollars ($6,647,849) for the 2015-2016 fiscal year and five million two hundred ninety-eight thousand one hundred seventy-eight dollars ($5,298,178) for the 2016-2017 fiscal year and the cash balance in Budget Code 24410 Fund 2411 for the North Carolina Families Accessing Services through Technology (NC FAST) project shall be used to match federal funds in the 2015-2016 and 2016-2017 fiscal years to expedite the development and implementation of Child Care, Low Income Energy Assistance, Crisis Intervention Programs, Child Services, and NC FAST Federally-Facilitated Marketplace (FFM) Interoperability components of the NC FAST program. The Department shall report any changes in approved federal funding or federal match rates within 30 days after the change to the Joint Legislative Oversight Committees on Health and Human Services and Information Technology and the Fiscal Research Division.

COMPETITIVE GRANTS/NONPROFIT ORGANIZATIONS, HEALTH DISPARITY-RELATED INITIATIVES, AND PHYSICAL HEALTH AND NUTRITION

SECTION 12A.8.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, the following amounts shall be used for the specified purposes:

(1) The sum of ten million three hundred twenty-eight thousand nine hundred eleven dollars ($10,328,911) for each year of the 2015-2017 fiscal biennium and the sum of three million eight hundred fifty-two thousand five hundred dollars ($3,852,500) appropriated in Section 12I.1 of this act in Social Services Block Grant funds for each year of the 2015-2017 fiscal biennium shall be used to allocate funds for nonprofit organizations.

(2) The sum of three million two hundred ninety-nine thousand five hundred seventy-six dollars ($3,299,576), offset by receipts in the amount of one hundred fifty-five thousand four hundred sixty-eight dollars ($155,468) for each year of the 2015-2017 fiscal biennium and the sum of two million seven hundred fifty-six thousand eight hundred fifty-five dollars ($2,756,855) appropriated in Section 12I.1 of this act in Preventive Health Services Block Grant funds for the 2015-2016 fiscal year shall be used to continue the established competitive grants process for health disparity-related initiatives.

(3) The sum of four hundred twenty-six thousand three hundred thirty-three dollars ($426,333), offset by receipts in the amount of one hundred sixty thousand twenty-one dollars ($160,021) for each year of the 2015-2017 fiscal biennium and the sum of one million two hundred forty-three thousand eight hundred ninety-nine dollars ($1,243,899) appropriated in Section 12I.1 of this act in Preventive Health Services Block Grant funds for the 2015-2016 fiscal year shall be used to establish a competitive grants process for physical health and nutrition-related initiatives.

SECTION 12A.8.(b) Nonprofit Organizations. –

(1) The Department shall continue administering a competitive grants process for nonprofit funding. The Department shall administer a plan that, at a minimum, includes each of the following:

a. A request for application (RFA) process to allow nonprofits to apply for and receive State funds on a competitive basis. The Department shall require nonprofits to include in the application, a plan to evaluate the effectiveness, including measurable impact or outcomes, of the activities, services, and programs for which the funds are being requested.

b. A requirement that nonprofits match a minimum of fifteen percent (15%) of the total amount of the grant award.

c. A requirement that the Secretary prioritize grant awards to those nonprofits that are able to leverage non-State funds in addition to the grant award.

d. A process that awards grants to nonprofits that have the capacity to provide services on a statewide basis and that support any of the following State health and wellness initiatives:

1. A program targeting advocacy, support, education, or residential services for persons diagnosed with autism.

2. A system of residential supports for those afflicted with substance abuse addiction.

3. A program of advocacy and supports for individuals with intellectual and developmental disabilities or severe and persistent mental illness, substance abusers, or the elderly.

4. Supports and services to children and adults with developmental disabilities or mental health diagnoses.
5. A food distribution system for needy individuals.
6. The provision and coordination of services for the homeless.
7. The provision of services for individuals aging out of foster care.
8. Programs promoting wellness, physical activity, and health education programming for North Carolinians.
9. The provision of services and screening for blindness.
10. Provision for the delivery of after-school services for apprenticeships or mentoring at-risk youth.
11. The provision of direct services for amyotrophic lateral sclerosis (ALS) and those diagnosed with the disease.
12. A comprehensive smoking prevention and cessation program that screens and treats tobacco use in pregnant women and postpartum mothers.
13. A program providing short-term or long-term residential substance abuse services. For purposes of this sub-subdivision, "long-term" means a minimum of 12 months.

e. Ensures that funds received by the Department to implement the plan supplement and do not supplant existing funds for health and wellness programs and initiatives.

f. Allows grants to be awarded to nonprofits for up to two years.

g. With grants awarded beginning July 1, 2016, a requirement that of the funds provided for competitive grants pursuant to this section, a minimum of five percent (5%) of the grants be awarded to new grant recipients who did not receive grant awards during the previous competitive grants process.

(2) No later than July 1, 2015, and every two years thereafter, as applicable, the Secretary shall announce the recipients of the competitive grant awards and allocate funds to the grant recipients for the respective grant period pursuant to the amounts designated under subdivision (1) of subsection (a) of this section. After awards have been granted, the Secretary shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services on the grant awards that includes at least all of the following:

a. The identity and a brief description of each grantee and each program or initiative offered by the grantee.

b. The amount of funding awarded to each grantee.

c. The number of persons served by each grantee, broken down by program or initiative.

(3) No later than December 1 of each fiscal year, each nonprofit organization receiving funding pursuant to this subsection in the respective fiscal year shall submit to the Division of Central Management and Support a written report of all activities funded by State appropriations. The report shall include the following information about the fiscal year preceding the year in which the report is due:

a. The entity's mission, purpose, and governance structure.

b. A description of the types of programs, services, and activities funded by State appropriations.

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

d. Outcome measures that demonstrate the impact and effectiveness of the programs, services, and activities.

e. A detailed program budget and list of expenditures, including all positions funded, matching expenditures, and funding sources.

(4) For the 2015-2017 fiscal biennium only, from the funds identified in subdivision (1) of subsection (a) of this section, the Department shall allocate the sum of three hundred fifty thousand dollars ($350,000) in each year of the 2015-2017 fiscal biennium to Big Brothers Big Sisters North Carolina Collaborative for the purpose of providing mentoring services. Big Brothers Big Sisters North Carolina Collaborative shall be required to seek future funding through the competitive grants process in accordance with subdivision (1) of this subsection.

SECTION 12A.8.(c) Health Disparity-Related Initiatives. –

(1) Funds identified in subdivision (2) of subsection (a) of this section shall be used to continue the competitive grants process established to close the gap in the health status of African-Americans, Hispanics/Latinos, and American Indians as compared to the health status of white persons. These grants shall continue to focus on the use of measures to eliminate or reduce health disparities among minority populations in this State with respect to heart disease, stroke, diabetes, obesity, asthma, HIV/AIDS, cancer, infant mortality, and low birth weight.

(2) It is the intent of the General Assembly that the Department continue implementing the competitive grants process established for health disparity-related initiatives funding to be administered by the Division of Central Management and Support. The Department shall continue implementing a process that, at a minimum, includes each of the following:

a. A request for application (RFA) process to allow an entity to apply for and receive State funds on a competitive basis. The Department shall require entities to include in the application, a plan to evaluate the effectiveness, including measurable impact or outcomes, of activities, services, and programs for which the funds are being requested.

b. The amount of any grant award is limited to three hundred thousand dollars ($300,000).

c. Only community-based organizations, faith-based organizations, local health departments, and hospitals located in urban and rural areas of the western, eastern, and Piedmont areas of this State are eligible to apply for these grants. No more than four grants shall be awarded to applicants located in any one of the three areas specified in this sub-subdivision.

d. Each eligible applicant shall be required to demonstrate substantial participation and involvement with all other categories of eligible applicants in order to ensure an evidence-based medical home model that will affect change in health and geographic disparities.

e. Eligible applicants shall select one or more of the following chronic illnesses or conditions specific to the applicant's geographic area as the basis for applying for a grant under this subdivision to affect

change in the health status of African-Americans, Hispanics/Latinos, or American Indians:

1. Heart disease.
2. Stroke.
3. Diabetes.
4. Obesity.
5. Asthma.
6. HIV/AIDS.
7. Cancer.
8. Infant mortality.
9. Low birth weight.

f. The minimum duration of the grant period for any grant awarded under this subsection is two years.

g. The maximum duration of the grant period for any grant awarded under this subsection is three years.

h. If approved for a grant award, the grantee (i) shall not use more than eight percent (8%) of the grant funds for overhead costs and (ii) shall be required at the end of the grant period to demonstrate significant gains in addressing one or more of the health disparity focus areas identified in subdivision (1) of this subsection.

i. An independent panel with expertise in the delivery of services to minority populations, health disparities, chronic illnesses and conditions, and HIV/AIDS shall conduct the review of applications for grants. The Department shall establish the independent panel required by this sub-subdivision.

(3) The grants awarded under this subsection shall be awarded in honor of the memory of the following deceased members of the General Assembly: Bernard Allen, Pete Cunningham, John Hall, Robert Holloman, Howard Hunter, Ed Jones, Jeanne Lucas, Vernon Malone, William Martin, and William Wainwright. These funds shall be used for concerted efforts to address large gaps in health status among North Carolinians who are African-American, as well as disparities among other minority populations in North Carolina.

(4) By October 1, 2017, the Department shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on funds appropriated for grants allocated pursuant to this subsection for the 2015-2017 fiscal biennium. The report shall include specific activities undertaken by grantees pursuant to subdivision (1) of this subsection to address large gaps in health status among North Carolinians who are African-American and other minority populations in this State and shall also address all of the following:

a. Which community-based organizations, faith-based organizations, local health departments, and hospitals received grants.

b. The amount of funding awarded to each grantee.

c. Which of the minority populations were served by each grantee.

d. Which community-based organizations, faith-based organizations, local health departments, and hospitals were involved in fulfilling the goals and activities of each grant-in-aid awarded under this section and what activities were planned and implemented by the grantee to fulfill the community focus of grants awarded pursuant to this subsection.

c. How the activities implemented by the grantee fulfilled the goal of reducing health disparities among minority populations and the specific success in reducing particular incidences.

SECTION 12A.8.(d) Physical Health and Nutrition-Related Activities. –

(1) Funds identified in subdivision (3) of subsection (a) of this section shall be used to establish and administer a competitive grants process for programs demonstrated to improve physical health and nutrition across the State.

(2) It is the intent of the General Assembly that, beginning fiscal year 2015-2016, the Department implements a competitive grants process for physical health and nutrition-related initiatives funding. To that end, the Department shall develop a plan that establishes a competitive grants process to be administered by the Division of Central Management and Support. The Department shall develop a plan that, at a minimum, includes each of the following:

a. A request for application (RFA) process to allow an entity to apply for and receive State funds on a competitive basis. The Department shall require entities to include in the application, a plan to evaluate the effectiveness, including measurable impact or outcomes, of activities, services, and programs for which the funds are being requested.

b. A process that awards grants to entities that have the capacity to provide services on a statewide basis and support physical health and nutrition initiatives.

c. Ensures that funds received by the Department to implement the plan supplement and do not supplant existing funds for physical health and nutrition programs and initiatives.

d. Allows grants to be awarded for up to two years.

(3) No later than February 1, 2016, the Secretary of Health and Human Services shall develop a plan for the implementation of the competitive grants process for physical health and nutrition-related initiative funding and shall report to the Joint Legislative Oversight Committee on Health and Human Services on the plan.

(4) No later than March 1, 2016, the Secretary of Health and Human Services shall implement the plan for the competitive grants process.

(5) No later than July 1, 2016, the Secretary shall announce the recipients of the competitive grant awards and allocate funds to the grant recipients for the 2016-2017 fiscal year pursuant to the amounts designated under subdivision (3) of subsection (a) of this section. After awards have been granted, the Secretary shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services on the grant awards that includes at least all of the following:

a. The identity and a brief description of each grantee and each program or initiative offered by the grantee.

b. The amount of funding awarded to each grantee.

c. The number of persons served by each grantee, broken down by program or initiative.

(6) No later than December 1, 2016, each program receiving funding pursuant to subdivision (3) of subsection (a) of this section shall submit to the Division of Central Management and Support a written report of all activities funded by State appropriations. The report shall include the following information about the fiscal year preceding the year in which the report is due:

a. The entity's mission, purpose, and governance structure.
b. A description of the type of program, service, or activity funded by State appropriations.
c. Statistical and demographical information on the number of persons served by the program, service, or activity, including the counties in which services are provided.
d. Outcome measures that demonstrate the impact and effectiveness of the program, service, or activity.
e. A detailed program budget and list of expenditures, including all positions funded and funding sources.
f. The source and amount of any matching funds received by the entity.

COMMUNITY HEALTH GRANT PROGRAM CHANGES

SECTION 12A.9. The Department of Health and Human Services, Office of Rural Health and Community Care, shall repurpose two million two hundred fifty thousand dollars ($2,250,000) in Health Net appropriations to the Community Health Grant Program. The new appropriation for this program is seven million six hundred eighty-seven thousand one hundred sixty-nine dollars ($7,687,169) in recurring funds. To ensure continuity of care, safety-net agencies receiving Health Net funds at the end of the 2014-2015 fiscal year shall be eligible to apply for and receive Community Health Grant funds at their current level of funding for the 2015-2016 and 2016-2017 fiscal years. After the 2016-2017 fiscal year, these agencies must submit an application for funding through the competitive Community Health Grant process. The Community Health Grant Program is available to rural health centers, free clinics, public health departments, school-based health centers, federally qualified health centers, and other nonprofit organizations that provide primary care and preventive health services to low-income populations, including uninsured, underinsured, Medicaid, and Medicare residents across the State.

RURAL HEALTH LOAN REPAYMENT PROGRAMS

SECTION 12A.10.(a) The Department of Health and Human Services, Office of Rural Health and Community Care, shall use funds appropriated in this act for loan repayment to medical, dental, and psychiatric providers practicing in State hospitals or in rural or medically underserved communities in this State to combine the following loan repayment programs in order to achieve efficient and effective management of these programs:

(1) The Physician Loan Repayment Program.
(2) The Psychiatric Loan Repayment Program.
(3) The Loan Repayment Initiative at State Facilities.

SECTION 12A.10.(b) These funds may be used for the following additional purposes:

(1) Continued funding of the State Loan Repayment Program for primary care providers and expansion of State incentives to general surgeons practicing in Critical Access Hospitals (CAHs) located across the State.
(2) Expansion of the State Loan Repayment Program to include eligible providers residing in North Carolina who use telemedicine in rural and underserved areas.

FUNDS FOR COMMUNITY PARAMEDICINE PILOT PROGRAM

SECTION 12A.12.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, for the 2015-2016 fiscal year, the sum of three hundred fifty thousand dollars ($350,000) shall be used to implement a community paramedicine pilot program. The pilot program shall focus on

expanding the role of paramedics to allow for community-based initiatives that result in providing care that avoids nonemergency use of emergency rooms and 911 services and avoids unnecessary admissions into health care facilities.

SECTION 12A.12.(b) The North Carolina Office of Emergency Medical Services (NCOEMS) shall set the education standards and other requirements necessary to qualify as a community paramedic eligible to participate in the pilot program established in subsection (a) of this section. The Department shall consult with the NCOEMS to define the objectives, set standards, and establish the required outcomes for the pilot program.

SECTION 12A.12.(c) The Department of Health and Human Services shall establish up to three program sites to implement the community paramedicine pilot program, one of which shall be New Hanover Regional Emergency Medical Services. For the 2015-2016 fiscal year, the New Hanover Regional Emergency Medical Services program site shall be awarded up to two hundred ten thousand dollars ($210,000), and each of the remaining program sites may be awarded up to seventy thousand dollars ($70,000). In selecting the remaining program sites, the Department may give preference to counties that currently have an established community paramedic program.

SECTION 12A.12.(d) The Department of Health and Human Services shall submit a report to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Committee on Health and Human Services, and the Fiscal Research Division by June 1, 2016, on the progress of the pilot program and shall include an evaluation plan based on the U.S. Department of Health and Human Services, Health Resources and Services Administration Office of Rural Health Policy's Community Paramedicine Evaluation Tool published in March 2012.

SECTION 12A.12.(e) The Department of Health and Human Services shall submit a final report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2016. At a minimum, the final report shall include all of the following:

(1) An updated version of the evaluation plan required by subsection (d) of this section.
(2) An estimate of the cost to expand the program incrementally and statewide.
(3) An estimate of any potential savings of State funds associated with expansion of the program.
(4) If expansion of the program is recommended, a time line for expanding the program.

FUNDS FOR DESIGN AND IMPLEMENTATION OF CONTRACTING SPECIALIST AND CERTIFICATION PROGRAM

SECTION 12A.13. Funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, for the design of a contracting specialist training and certification program for management level personnel within the Department of Health and Human Services (DHHS) shall be used as follows:

(1) For the 2015-2016 fiscal year, the sum of one hundred fifty thousand dollars ($150,000) in nonrecurring funds shall be allocated to the University of North Carolina School of Government (SOG) to design the program for permanent administration by the Office of State Human Resources (OSHR). SOG shall design a program that is similar to its Certified Local Government Purchasing Officer program and local purchasing and contracts program. OSHR, SOG, and the Office of the State Chief Information Officer shall provide assistance on program design and implementation as requested by DHHS, OSHR, or SOG. To the extent practical, DHHS, OSHR, and SOG shall design and develop the program as a prototype for a State

government-wide program. Although designed for personal and professional services contracting, the design may incorporate any applicable best practices for construction and technology contracting.

(2) For the 2016-2017 fiscal year:

a. The sum of twenty-five thousand dollars ($25,000) in nonrecurring funds shall be used to assist both DHHS and OSHR with program implementation.

b. The sum of one hundred seventy-five thousand dollars ($175,000) in recurring funds shall be used for program support and to fund two full-time equivalent positions within OSHR dedicated to oversight of, and training for, this new program.

CHILD WELFARE CASE MANAGEMENT SYSTEM

SECTION 12A.14.(a) Funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, in the amount of five million eight hundred three thousand dollars ($5,803,000) in nonrecurring funds and prior year earned revenue in the amount of two million seven hundred fifty-two thousand one hundred fifty-one dollars ($2,752,151) for the 2015-2016 fiscal year and in the amount of thirteen million fifty-two thousand dollars ($13,052,000) in nonrecurring funds and prior year earned revenue in the amount of four million one hundred one thousand eight hundred twenty-four dollars ($4,101,824) for the 2016-2017 fiscal year shall be used to purchase a child welfare case management system that has demonstrated its ability to provide child welfare case management services in another state within the United States. The Division shall purchase a system that can be integrated with North Carolina Families Accessing Services through Technology (NC FAST) and the work product of the Child Protective Services Pilot Project being conducted in accordance with Section 12C.11 of this act. The Division shall issue a request for proposals (RFP) in selecting a system for purchase. The Department shall not move forward with implementing the child welfare case management system in NC FAST.

SECTION 12A.14.(b) It is the intent of the General Assembly that beginning fiscal year 2016-2017, all Department of Health and Human Services' information technology assets, resources, and personnel transfer to the Department of Information Technology, as created in this act. To that end, the planning, development, and implementation of the child welfare case management system described in this section shall be coordinated with the Department of Information Technology.

SECTION 12A.14.(c) The Department shall report on the results of the RFP to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Information Technology, and the Fiscal Research Division no later than October 1, 2016.

SUBPART XII-B. DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION

NC PRE-K PROGRAM/STANDARDS FOR FOUR- AND FIVE-STAR RATED FACILITIES

SECTION 12B.1.(a) Eligibility. – The Department of Health and Human Services, Division of Child Development and Early Education, shall continue implementing the prekindergarten program (NC Pre-K). The NC Pre-K program shall serve children who are four years of age on or before August 31 of the program year. In determining eligibility, the Division shall establish income eligibility requirements for the program not to exceed seventy-five percent (75%) of the State median income. Up to twenty percent (20%) of children enrolled may have family incomes in excess of seventy-five percent (75%) of median income if those children have other designated risk factors. Furthermore, any age-eligible child who is a

child of either of the following shall be eligible for the program: (i) an active duty member of the Armed Forces of the United States, including the North Carolina National Guard, State military forces, or a reserve component of the Armed Forces who was ordered to active duty by the proper authority within the last 18 months or is expected to be ordered within the next 18 months or (ii) a member of the Armed Forces of the United States, including the North Carolina National Guard, State military forces, or a reserve component of the Armed Forces who was injured or killed while serving on active duty. Eligibility determinations for prekindergarten participants may continue through local education agencies and local North Carolina Partnership for Children, Inc., partnerships.

Other than developmental disabilities or other chronic health issues, the Division shall not consider the health of a child as a factor in determining eligibility for participation in the NC Pre-K program.

SECTION 12B.1.(b) Multiyear Contracts. – The Division of Child Development and Early Education shall require the NC Pre-K contractor to issue multiyear contracts for licensed private child care centers providing NC Pre-K classrooms.

SECTION 12B.1.(c) Programmatic Standards. – All entities operating prekindergarten classrooms shall adhere to all of the policies prescribed by the Division of Child Development and Early Education regarding programmatic standards and classroom requirements.

SECTION 12B.1.(d) NC Pre-K Committees. – Local NC Pre-K committees shall use the standard decision-making process developed by the Division of Child Development and Early Education in awarding prekindergarten classroom slots and student selection.

SECTION 12B.1.(e) Reporting. – The Division of Child Development and Early Education shall submit an annual report no later than March 15 of each year to the Joint Legislative Oversight Committee on Health and Human Services, the Office of State Budget and Management, and the Fiscal Research Division. The report shall include the following:

(1) The number of children participating in the NC Pre-K program by county.

(2) The number of children participating in the NC Pre-K program who have never been served in other early education programs such as child care, public or private preschool, Head Start, Early Head Start, or early intervention programs.

(3) The expected NC Pre-K expenditures for the programs and the source of the local contributions.

(4) The results of an annual evaluation of the NC Pre-K program.

SECTION 12B.1.(f) Audits. – The administration of the NC Pre-K program by local partnerships shall be subject to the financial and compliance audits authorized under G.S. 143B-168.14(b).

CHILD CARE SUBSIDY RATES

SECTION 12B.2.(a) The maximum gross annual income for initial eligibility, adjusted biennially, for subsidized child care services shall be determined based on a percentage of the federal poverty level as follows:

AGE	INCOME PERCENTAGE LEVEL
0 – 5	200%
6 – 12	133%

The eligibility for any child with special needs, including a child who is 13 years of age or older, shall be two hundred percent (200%) of the federal poverty level.

SECTION 12B.2.(b) Effective July 1, 2015, the Department of Health and Human Services, Division of Child Development and Early Education, shall revise its child care subsidy policy to exclude from the policy's definition of "income unit" a nonparent relative

caretaker, and the caretaker's spouse and child, if applicable, when the parent of the child receiving child care subsidy does not live in the home with the child.

SECTION 12B.2.(c) Fees for families who are required to share in the cost of care are established based on ten percent (10%) of gross family income. Co-payments shall not be prorated for part-time care.

SECTION 12B.2.(d) Payments for the purchase of child care services for low-income children shall be in accordance with the following requirements:

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

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

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

(4) No payments shall be made for transportation services or registration fees charged by child care facilities.

(5) Payments for subsidized child care services for postsecondary education shall be limited to a maximum of 20 months of enrollment.

(6) The Department of Health and Human Services shall implement necessary rule changes to restructure services, including, but not limited to, targeting benefits to employment.

SECTION 12B.2.(e) Provisions of payment rates for child care providers in counties that do not have at least 50 children in each age group for center-based and home-based care are as follows:

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

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

SECTION 12B.2.(f) A market rate shall be calculated for child care centers and homes at each rated license level for each county and for each age group or age category of enrollees and shall be representative of fees charged to parents for each age group of enrollees within the county. The Division of Child Development and Early Education shall also calculate a statewide rate and regional market rate for each rated license level for each age category.

SECTION 12B.2.(g) The Division of Child Development and Early Education shall continue implementing policies that improve the quality of child care for subsidized children, including a policy in which child care subsidies are paid, to the extent possible, for child care in the higher-quality centers and homes only. The Division shall define higher-quality, and subsidy funds shall not be paid for one- or two-star-rated facilities. For those counties with an inadequate number of four- and five-star-rated facilities, the Division shall continue a transition period that allows the facilities to continue to receive subsidy funds while the facilities work on the increased star ratings. The Division may allow exemptions in

counties where there is an inadequate number of four- and five-star-rated facilities for non-star-rated programs, such as religious programs.

SECTION 12B.2.(h) 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. Except as authorized by subsection (g) of this section, 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 12B.2.(i) Payment for subsidized child care services provided with Temporary Assistance for Needy Families Block Grant funds shall comply with all regulations and policies issued by the Division of Child Development and Early Education for the subsidized child care program.

SECTION 12B.2.(j) Noncitizen families who reside in this State legally shall be eligible for child care subsidies if all other conditions of eligibility are met. If all other conditions of eligibility are met, noncitizen families who reside in this State illegally shall be eligible for child care subsidies only if at least one of the following conditions is met:

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

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

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

SECTION 12B.2.(k) The Department of Health and Human Services, Division of Child Development and Early Education, shall require all county departments of social services to include on any forms used to determine eligibility for child care subsidy whether the family waiting for subsidy is receiving assistance through the NC Pre-K Program or Head Start.

CHILD CARE SUBSIDY MARKET RATE INCREASES/CERTAIN AGE GROUPS AND COUNTIES

SECTION 12B.2A. Beginning September 1, 2015, the Department of Health and Human Services, Division of Child Development and Early Education, shall increase the child care subsidy market rates to the rates recommended by the 2013 Child Care Market Rate Study from birth through two years of age in three-, four-, and five-star-rated child care centers and homes in tier one and tier two counties. For purposes of this section, tier one and tier two counties shall have the same designations as those established by the N.C. Department of Commerce.

CHILD CARE ALLOCATION FORMULA

SECTION 12B.3.(a) The Department of Health and Human Services shall allocate child care subsidy voucher funds to pay the costs of necessary child care for minor children of needy families. The mandatory thirty-percent (30%) North Carolina Partnership for Children, Inc., subsidy allocation under G.S. 143B-168.15(g) shall constitute the base amount for each county's child care subsidy allocation. The Department of Health and Human Services shall use the following method when allocating federal and State child care funds, not including the

aggregate mandatory thirty-percent (30%) North Carolina Partnership for Children, Inc., subsidy allocation:

(1) Funds shall be allocated to a county based upon the projected cost of serving children under age 11 in families with all parents working who earn less than the applicable federal poverty level percentage set forth in Section 12B.2 of this act.

(2) The Department of Health and Human Services shall allocate to counties all State funds appropriated for child care subsidy and shall not withhold funds during the 2015-2016 and 2016-2017 fiscal years.

SECTION 12B.3.(b) The Department of Health and Human Services may reallocate unused child care subsidy voucher funds in order to meet the child care needs of low-income families. Any reallocation of funds shall be based upon the expenditures of all child care subsidy voucher funding, including North Carolina Partnership for Children, Inc., funds within a county.

SECTION 12B.3.(c) When implementing the formula under subsection (a) of this section, the Department of Health and Human Services, Division of Child Development and Early Education, shall include the market rate increase in the formula process, rather than calculating the increases outside of the formula process. Additionally, the Department shall do the following:

(1) For fiscal year 2015-2016, (i) continue implementing one-third of the change in a county's allocation based on the new Census data; (ii) implement an additional one-third of the change in a county's allocation beginning fiscal year 2016-2017; and (iii) the final one-third change in a county's allocation beginning fiscal year 2018-2019. However, beginning fiscal year 2015-2016, a county's initial allocation shall be the county's expenditure in the previous fiscal year. With the exception of market rate increases consistent with any increases approved by the General Assembly, a county whose spending coefficient is less than ninety-five percent (95%) in the previous fiscal year shall receive its prior year's expenditure as its allocation and shall not receive an increase in its allocation in the following year. A county whose spending coefficient is at least ninety-five percent (95%) in the previous fiscal year shall receive, at a minimum, the amount it expended in the previous fiscal year and may receive additional funding, if available. The Division may waive this requirement and allow an increase if the spending coefficient is below ninety-five percent (95%) due to extraordinary circumstances, such as a State or federal disaster declaration in the affected county. By October 1 of each year, the Division shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division the counties that received a waiver pursuant to this subdivision and the reasons for the waiver.

(2) Effective immediately following the next new Census data release, implement (i) one-third of the change in a county's allocation in the year following the data release; (ii) an additional one-third of the change in a county's allocation beginning two years after the initial change under this subdivision; and (iii) the final one-third change in a county's allocation beginning the following two years thereafter.

CHILD CARE FUNDS MATCHING REQUIREMENTS

SECTION 12B.4. No local matching funds may be required by the Department of Health and Human Services as a condition of any locality's receiving its initial allocation of child care funds appropriated by this act unless federal law requires a match. If the Department

reallocates additional funds above twenty-five thousand dollars ($25,000) to local purchasing agencies beyond their initial allocation, local purchasing agencies must provide a twenty percent (20%) local match to receive the reallocated funds. Matching requirements shall not apply when funds are allocated because of an emergency as defined in G.S. 166A-19.3(6).

CHILD CARE REVOLVING LOAN

SECTION 12B.5. Notwithstanding any law to the contrary, funds budgeted for the Child Care Revolving Loan Fund may be transferred to and invested by the financial institution contracted to operate the Fund. The principal and any income to the Fund may be used to make loans, reduce loan interest to borrowers, serve as collateral for borrowers, pay the contractor's cost of operating the Fund, or pay the Department's cost of administering the program.

ADMINISTRATIVE ALLOWANCE FOR COUNTY DEPARTMENTS OF SOCIAL SERVICES/USE OF SUBSIDY FUNDS FOR FRAUD DETECTION

SECTION 12B.6.(a) The Department of Health and Human Services, Division of Child Development and Early Education, shall fund the allowance that county departments of social services may use for administrative costs at four percent (4%) of the county's total child care subsidy funds allocated in the Child Care and Development Fund Block Grant plan or eighty thousand dollars ($80,000), whichever is greater.

SECTION 12B.6.(b) Each county department of social services may use up to two percent (2%) of child care subsidy funds allocated to the county for fraud detection and investigation initiatives.

SECTION 12B.6.(c) The Division of Child Development and Early Education may adjust the allocations in the Child Care and Development Fund Block Grant under Section 12I.1 of this act according to (i) the final allocations for local departments of social services under subsection (a) of this section and (ii) the funds allocated for fraud detection and investigation initiatives under subsection (b) of this section. The Division shall submit a report on the final adjustments to the allocations of the four percent (4%) administrative costs to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than September 30 of each year.

EARLY CHILDHOOD EDUCATION AND DEVELOPMENT INITIATIVES ENHANCEMENTS

SECTION 12B.7.(a) Policies. – The North Carolina Partnership for Children, Inc., and its Board shall ensure policies focus on the North Carolina Partnership for Children, Inc.'s mission of improving child care quality in North Carolina for children from birth to five years of age. North Carolina Partnership for Children, Inc.-funded activities shall include assisting child care facilities with (i) improving quality, including helping one-, two-, and three-star-rated facilities increase their star ratings and (ii) implementing prekindergarten programs. State funding for local partnerships shall also be used for evidence-based or evidence-informed programs for children from birth to five years of age that do the following:

(1) Increase children's literacy.
(2) Increase the parents' ability to raise healthy, successful children.
(3) Improve children's health.
(4) Assist four- and five-star-rated facilities in improving and maintaining quality.

SECTION 12B.7.(b) Administration. – Beginning fiscal year 2015-2016, administrative costs for central administration shall be equivalent to not more than three and twenty-five hundredths percent (3.25%). Administrative costs shall be equivalent to, on an average statewide basis for all local partnerships, not more than seven and seventy-five hundredths percent (7.75%) of the total statewide allocation to all local partnerships for the

2015-2016 fiscal year and beginning fiscal year 2016-2017, equivalent to not more than seven and five-tenths percent (7.5%) of the total statewide allocation to all local partnerships. For purposes of this subsection, administrative costs shall include costs associated with partnership oversight, business and financial management, general accounting, human resources, budgeting, purchasing, contracting, and information systems management. The North Carolina Partnership for Children, Inc., shall continue using a single statewide contract management system that incorporates features of the required standard fiscal accountability plan described in G.S. 143B-168.12(a)(4). All local partnerships are required to participate in the contract management system and, directed by the North Carolina Partnership for Children, Inc., to collaborate, to the fullest extent possible, with other local partnerships to increase efficiency and effectiveness.

SECTION 12B.7.(c) Salaries. – The salary schedule developed and implemented by the North Carolina Partnership for Children, Inc., shall set the maximum amount of State funds that may be used for the salary of the Executive Director of the North Carolina Partnership for Children, Inc., and the directors of the local partnerships. The North Carolina Partnership for Children, Inc., shall base the schedule on the following criteria:

(1) The population of the area serviced by a local partnership.
(2) The amount of State funds administered.
(3) The amount of total funds administered.
(4) The professional experience of the individual to be compensated.
(5) Any other relevant factors pertaining to salary, as determined by the North Carolina Partnership for Children, Inc.

The salary schedule shall be used only to determine the maximum amount of State funds that may be used for compensation. Nothing in this subsection shall be construed to prohibit a local partnership from using non-State funds to supplement an individual's salary in excess of the amount set by the salary schedule established under this subsection.

SECTION 12B.7.(d) Match Requirements. – The North Carolina Partnership for Children, Inc., and all local partnerships shall, in the aggregate, be required to match one hundred percent (100%) of the total amount budgeted for the program in each fiscal year of the 2015-2017 biennium. Of the funds the North Carolina Partnership for Children, Inc., and the local partnerships are required to match, contributions of cash shall be equal to at least twelve percent (12%) and in-kind donated resources shall be equal to no more than five percent (5%) for a total match requirement of seventeen percent (17%) for the 2015-2016 fiscal year; and contributions of cash shall be equal to at least thirteen percent (13%) and in-kind donated resources shall be equal to no more than six percent (6%) for a total match requirement of nineteen percent (19%) for the 2016-2017 fiscal year. The North Carolina Partnership for Children, Inc., may carry forward any amount in excess of the required match for a fiscal year in order to meet the match requirement of the succeeding fiscal year. Only in-kind contributions that are quantifiable shall be applied to the in-kind match requirement. Volunteer services may be treated as an in-kind contribution for the purpose of the match requirement of this subsection. Volunteer services that qualify as professional services shall be valued at the fair market value of those services. All other volunteer service hours shall be valued at the statewide average wage rate as calculated from data compiled by the Division of Employment Security of the Department of Commerce in the Employment and Wages in North Carolina Annual Report for the most recent period for which data are available. Expenses, including both those paid by cash and in-kind contributions, incurred by other participating non-State entities contracting with the North Carolina Partnership for Children, Inc., or the local partnerships, also may be considered resources available to meet the required private match. In order to qualify to meet the required private match, the expenses shall:

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

(2) If in-kind, other than volunteer services, be quantifiable in accordance with generally accepted accounting principles for nonprofit organizations.
(3) Not include expenses funded by State funds.
(4) Be supplemental to and not supplant preexisting resources for related program activities.
(5) Be incurred as a direct result of the Early Childhood Initiatives Program and be necessary and reasonable for the proper and efficient accomplishment of the Program's objectives.
(6) Be otherwise allowable under federal or State law.
(7) Be required and described in the contractual agreements approved by the North Carolina Partnership for Children, Inc., or the local partnership.
(8) Be reported to the North Carolina Partnership for Children, Inc., or the local partnership by the contractor in the same manner as reimbursable expenses.

Failure to obtain a seventeen-percent (17%) match by June 30 of the 2015-2016 fiscal year and a nineteen-percent (19%) match by June 30 of the 2016-2017 fiscal year shall result in a dollar-for-dollar reduction in the appropriation for the Program for a subsequent fiscal year. The North Carolina Partnership for Children, Inc., shall be responsible for compiling information on the private cash and in-kind contributions into a report that is submitted to the Joint Legislative Oversight Committee on Health and Human Services 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 12B.7.(e) Bidding. – 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 as developed by the Board of Directors of the North Carolina Partnership for Children, Inc.
(2) For amounts greater than five thousand dollars ($5,000), but less than fifteen thousand dollars ($15,000), three written quotes.
(3) For amounts of fifteen thousand dollars ($15,000) or more, but less than forty thousand dollars ($40,000), a request for proposal process.
(4) For amounts of forty thousand dollars ($40,000) or more, a request for proposal process and advertising in a major newspaper.

SECTION 12B.7.(f) Allocations. – The North Carolina Partnership for Children, Inc., shall not reduce the allocation for counties with less than 35,000 in population below the 2012-2013 funding level.

SECTION 12B.7.(g) Performance-Based Evaluation. – The Department of Health and Human Services shall continue to implement the performance-based evaluation system.

SECTION 12B.7.(h) Expenditure Restrictions. – The Department of Health and Human Services and the North Carolina Partnership for Children, Inc., shall ensure that the allocation of funds for Early Childhood Education and Development Initiatives for the 2015-2017 fiscal biennium shall be administered and distributed in the following manner:

(1) Capital expenditures are prohibited for the 2015-2017 fiscal biennium. For the purposes of this section, "capital expenditures" means expenditures for capital improvements as defined in G.S. 143C-1-1(d)(5).
(2) Expenditures of State funds for advertising and promotional activities are prohibited for the 2015-2017 fiscal biennium.

For the 2015-2017 fiscal biennium, local partnerships shall not spend any State funds on marketing campaigns, advertising, or any associated materials. Local partnerships may spend any private funds the local partnerships receive on those activities.

PLAN FOR MERGER OF EARLY EDUCATION AND FAMILY SUPPORT PROGRAMS

SECTION 12B.8. The Joint Legislative Program Evaluation Oversight Committee shall include in the 2015-2017 Work Plan a directive for the Program Evaluation Division to plan a merger of the Child Care Subsidy, NC Prekindergarten (NC Pre-K), and Smart Start programs. The Director of the Program Evaluation Division shall recommend a firm for approval by the Legislative Services Commission to prepare the plan under the supervision of the Program Evaluation Division. The sum of three hundred thousand dollars ($300,000) is hereby appropriated to the Legislative Services Commission from the General Fund for the 2015-2016 fiscal year in nonrecurring funds to pay for the contract. The Program Evaluation Division shall submit the merger plan prepared by the contractor to the Joint Legislative Program Evaluation Oversight Committee, the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Education Oversight Committee, and the Fiscal Research Division no later than March 1, 2016.

U.S. DEPARTMENT OF DEFENSE-CERTIFIED CHILD CARE FACILITIES PARTICIPATION IN STATE-SUBSIDIZED CHILD CARE PROGRAM

SECTION 12B.9.(a) Article 7 of Chapter 110 of the General Statutes is amended by adding a new section to read:

"**§ 110-106.2. Department of Defense-certified child care facilities.**

(a) As used in this section, the phrase "Department of Defense-certified child care facility" shall include child development centers, family child care homes, and school-aged child care facilities operated aboard a military installation under the authorization of the United States Department of Defense (Department of Defense) certified by the Department of Defense.

(b) Procedure Regarding Department of Defense-Certified Child Care Facilities. –

(1) Department of Defense-certified child care facilities shall file with the Department a notice of intent to operate a child care facility in a form determined by the Department of Defense.

(2) As part of its notice, each Department of Defense-certified child care facility shall file a report to the Department indicating that it meets the minimum standards for child care facilities as provided by the Department of Defense.

(3) Department of Defense-certified child care facilities that meet all the requirements of this section shall be exempt from all other requirements of this Article and shall not be subject to licensure.

(4) For purposes of the North Carolina Subsidized Child Care Program, Department of Defense-certified child care facilities shall be reimbursed as follows:

a. Department of Defense-certified child care facilities that are accredited by the National Association for the Education of Young Children (NAEYC) shall be reimbursed at the five-star-rated license rate.

b. All other Department of Defense-certified child care facilities shall be reimbursed at the four-star-rated license rate."

SECTION 12B.9.(b) G.S. 143B-168.15(g) reads as rewritten:

"(g) Not less than thirty percent (30%) of the funds spent in each year of each local partnership's direct services allocation shall be used to expand child care subsidies. To the extent practicable, these funds shall be used to enhance the affordability, availability, and quality of child care services as described in this section. The North Carolina Partnership may increase this percentage requirement up to a maximum of fifty percent (50%) when, based upon a significant local waiting list for subsidized child care, the North Carolina Partnership determines a higher percentage is justified. Local partnerships shall spend an amount for child

care subsidies that provides at least fifty-two million dollars ($52,000,000) for the Temporary Assistance to Needy Families (TANF) maintenance of effort requirement and the Child Care Development Fund and Block Grant match requirement. Funds allocated under this section shall supplement and not supplant any federal or State funds allocated to Department of Defense-certified child care facilities licensed under G.S. 110-106.2."

SECTION 12B.9.(c) Department of Defense-certified child care facilities licensed pursuant to G.S. 110-106.2, as enacted in subsection (a) of this section, may participate in the State-subsidized child care program that provides for the purchase of care in child care facilities for minor children in needy families; provided, that funds allocated from the State-subsidized child care program to Department of Defense-certified child care facilities shall supplement and not supplant funds allocated in accordance with G.S. 143B-168.15(g). Payment rates and fees for military families who choose Department of Defense-certified child care facilities and who are eligible to receive subsidized child care shall be as set forth in Section 12B.2 of this act.

SECTION 12B.9.(d) This section becomes effective January 1, 2016.

SUBPART XII-C. DIVISION OF SOCIAL SERVICES

TANF BENEFIT IMPLEMENTATION

SECTION 12C.1.(a) The General Assembly approves the plan titled "North Carolina Temporary Assistance for Needy Families State Plan FY 2013-2016," prepared by the Department of Health and Human Services and presented to the General Assembly. The North Carolina Temporary Assistance for Needy Families State Plan covers the period October 1, 2013, through September 30, 2016. The Department shall submit the State Plan, as revised in accordance with subsection (b) of this section, to the United States Department of Health and Human Services.

SECTION 12C.1.(b) The counties approved as Electing Counties in the North Carolina Temporary Assistance for Needy Families State Plan FY 2013-2016, as approved by this section, are Beaufort, Caldwell, Catawba, Lenoir, Lincoln, Macon, and Wilson.

SECTION 12C.1.(c) Counties that submitted the letter of intent to remain as an Electing County or to be redesignated as an Electing County and the accompanying county plan for years 2013 through 2016, pursuant to G.S. 108A-27(e), shall operate under the Electing County budget requirements effective July 1, 2015. For programmatic purposes, all counties referred to in this subsection shall remain under their current county designation through September 30, 2016.

SECTION 12C.1.(d) For each year of the 2015-2017 fiscal biennium, Electing Counties shall be held harmless to their Work First Family Assistance allocations for the 2014-2015 fiscal year, provided that remaining funds allocated for Work First Family Assistance and Work First Diversion Assistance are sufficient for payments made by the Department on behalf of Standard Counties pursuant to G.S. 108A-27.11(b).

SECTION 12C.1.(e) In the event that departmental projections of Work First Family Assistance and Work First Diversion Assistance for the 2015-2016 fiscal year or the 2016-2017 fiscal year indicate that remaining funds are insufficient for Work First Family Assistance and Work First Diversion Assistance payments to be made on behalf of Standard Counties, the Department is authorized to deallocate funds, of those allocated to Electing Counties for Work First Family Assistance in excess of the sums set forth in G.S. 108A-27.11, up to the requisite amount for payments in Standard Counties. Prior to deallocation, the Department shall obtain approval by the Office of State Budget and Management. If the Department adjusts the allocation set forth in subsection (d) of this section, then a report shall be made to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

INTENSIVE FAMILY PRESERVATION SERVICES FUNDING AND PERFORMANCE ENHANCEMENTS

SECTION 12C.2.(a) Notwithstanding the provisions of G.S. 143B-150.6, the Intensive Family Preservation Services (IFPS) 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 IFPS shall ensure the application of standardized assessment criteria for determining imminent risk and clear criteria for determining out-of-home placement.

SECTION 12C.2.(b) The Department of Health and Human Services shall require that any program or entity that receives State, federal, or other funding for the purpose of IFPS shall provide information and data that allows for the following:

(1) An established follow-up system with a minimum of six months of follow-up services.

(2) Detailed information on the specific interventions applied, including utilization indicators and performance measurement.

(3) Cost-benefit data.

(4) Data on long-term benefits associated with IFPS. This data shall be obtained by tracking families through the intervention process.

(5) The number of families remaining intact and the associated interventions while in IFPS and 12 months thereafter.

(6) The number and percentage, by race, of children who received IFPS compared to the ratio of their distribution in the general population involved with Child Protective Services.

SECTION 12C.2.(c) The Department shall establish a performance-based funding protocol and shall only provide funding to those programs and entities providing the required information specified in subsection (b) of this section. The amount of funding shall be based on the individual performance of each program.

CHILD CARING INSTITUTIONS

SECTION 12C.3. Until the Social Services Commission adopts rules setting standardized rates for child caring institutions as authorized under G.S. 143B-153(8), the maximum reimbursement for child caring institutions shall not exceed the rate established for the specific child caring institution by the Department of Health and Human Services, Office of the Controller. In determining the maximum reimbursement, the State shall include county and IV-E reimbursements.

USE OF FOSTER CARE BUDGET FOR GUARDIANSHIP ASSISTANCE PROGRAM

SECTION 12C.4. Of the funds available for the provision of foster care services, the Department of Health and Human Services, Division of Social Services, may provide for the financial support of children who are deemed to be (i) in a permanent family placement setting, (ii) eligible for legal guardianship, and (iii) otherwise unlikely to receive permanency. The Division of Social Services shall design the Guardianship Assistance Program (GAP) to include provisions for extending guardianship services for individuals who have attained the age of 18 years and opt to continue to receive guardianship services until reaching 21 years of age if the individual is (i) completing secondary education or a program leading to an equivalent credential, (ii) enrolled in an institution that provides postsecondary or vocational education, (iii) participating in a program or activity designed to promote, or remove barriers to, employment, (iv) employed for at least 80 hours per month, or (v) incapable of completing the educational or employment requirements of this section due to a medical condition or disability. The Guardianship Assistance Program rates shall reimburse the legal guardian for

room and board and be set at the same rate as the foster care room and board rates in accordance with rates established under G.S. 108A-49.1. The Social Services Board shall adopt rules establishing a Guardianship Assistance Program to implement this section, including defining the phrase "legal guardian" as used in this section.

CHILD WELFARE POSTSECONDARY SUPPORT PROGRAM (NC REACH)

SECTION 12C.5.(a) Funds appropriated from the General Fund to the Department of Health and Human Services for the child welfare postsecondary support program shall be used to continue providing assistance with the "cost of attendance" as that term is defined in 20 U.S.C. § 108711 for the educational needs of foster youth aging out of the foster care system and special needs children adopted from foster care after age 12. These funds shall be allocated by the State Education Assistance Authority.

SECTION 12C.5.(b) Of the funds appropriated from the General Fund to the Department of Health and Human Services, the sum of fifty thousand dollars ($50,000) for the 2015-2016 fiscal year and the sum of fifty thousand dollars ($50,000) for the 2016-2017 fiscal year shall be allocated to the North Carolina State Education Assistance Authority (SEAA). The SEAA shall use these funds only to perform administrative functions necessary to manage and distribute scholarship funds under the child welfare postsecondary support program.

SECTION 12C.5.(c) Of the funds appropriated from the General Fund to the Department of Health and Human Services, the sum of three hundred thirty-nine thousand four hundred ninety-three dollars ($339,493) for the 2015-2016 fiscal year and the sum of three hundred thirty-nine thousand four hundred ninety-three dollars ($339,493) for the 2016-2017 fiscal year shall be used to contract with an entity to administer the child welfare postsecondary support program described under subsection (a) of this section, which administration shall include the performance of case management services.

SECTION 12C.5.(d) Funds appropriated to the Department of Health and Human Services for the child welfare postsecondary support program shall be used only for students attending public institutions of higher education in this State.

FEDERAL CHILD SUPPORT INCENTIVE PAYMENTS

SECTION 12C.7.(a) Centralized Services. – The North Carolina Child Support Services Section (NCCSS) of the Department of Health and Human Services, Division of Social Services, shall retain up to fifteen percent (15%) of the annual federal incentive payments it receives from the federal government to enhance centralized child support services. To accomplish this requirement, NCCSS shall do the following:

(1) In consultation with representatives from county child support services programs, identify how federal incentive funding could improve centralized services.

(2) Use federal incentive funds to improve the effectiveness of the State's centralized child support services by supplementing and not supplanting State expenditures for those services.

(3) Develop and implement rules that explain the State process for calculating and distributing federal incentive funding to county child support services programs.

SECTION 12C.7.(b) County Child Support Services Programs. – NCCSS shall allocate no less than eighty-five percent (85%) of the annual federal incentive payments it receives from the federal government to county child support services programs to improve effectiveness and efficiency using the federal performance measures. To that end, NCCSS shall do the following:

(1) In consultation with representatives from county child support services programs, examine the current methodology for distributing federal

incentive funding to the county programs and determine whether an alternative formula would be appropriate. NCCSS shall use its current formula for distributing federal incentive funding until an alternative formula is adopted.

(2) Upon adopting an alternative formula, develop a process to phase-in the alternative formula for distributing federal incentive funding over a four-year period.

SECTION 12C.7.(c) Reporting by County Child Support Services Programs. – NCCSS shall establish guidelines that identify appropriate uses for federal incentive funding. To ensure those guidelines are properly followed, NCCSS shall require county child support services programs to comply with each of the following:

(1) Submit an annual plan describing how federal incentive funding would improve program effectiveness and efficiency as a condition of receiving federal incentive funding.

(2) Report annually on: (i) how federal incentive funding has improved program effectiveness and efficiency and been reinvested into their programs, (ii) provide documentation that the funds were spent according to their annual plans, and (iii) explain any deviations from their plans.

SECTION 12C.7.(d) Plan/Report by NCCSS. – The NCCSS shall develop a plan to implement the requirements of this section. Prior to implementing the plan, NCCSS shall submit a progress report on the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2015.

After implementing the plan, NCCSS shall submit a report on federal child support incentive funding to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1 of each year. The report shall describe how federal incentive funds enhanced centralized child support services to benefit county child support services programs and improved the effectiveness and efficiency of county child support services programs. The report shall further include any changes to the State process the NCCSS used in calculating and distributing federal incentive funding to county child support services programs and any recommendations for further changes.

CHILD PROTECTIVE SERVICES IMPROVEMENT INITIATIVE/REVISE STATEWIDE EVALUATION REPORT DATE

SECTION 12C.8. The Department of Health and Human Services, Division of Social Services, shall report on the findings and recommendations from the comprehensive, statewide evaluation of the State's child protective services system required by Section 12C.1(f) of S.L. 2014-100 to the Joint Legislative Oversight Committee on Health and Human Services on or before March 1, 2016.

FOSTERING SUCCESS/EXTEND FOSTER CARE TO 21 YEARS OF AGE

SECTION 12C.9.(a) G.S. 108A-48 reads as rewritten:

"**§ 108A-48. State Foster Care Benefits Program.**

(a) The Department is authorized to establish a State Foster Care Benefits Program with appropriations by the General Assembly for the purpose of providing assistance to children who are placed in foster care facilities by county departments of social services in accordance with the rules and regulations of the Social Services Commission. Such appropriations, together with county contributions for this purpose, shall be expended to provide for the costs of keeping children in foster care facilities.

~~(b) No benefits provided by this section shall be granted to any individual who has passed his eighteenth birthday unless he is less than 21 years of age and is a full-time student or has been accepted for enrollment as a full-time student for the next school term pursuing a high~~

~~school diploma or its equivalent; a course of study at the college level; or a course of vocational or technical training designed to fit him for gainful employment.~~

(c) The Department may continue to provide benefits pursuant to this section to an individual who has attained the age of 18 years and chosen to continue receiving foster care services until reaching 21 years of age if the individual is (i) completing secondary education or a program leading to an equivalent credential, (ii) enrolled in an institution that provides postsecondary or vocational education, (iii) participating in a program or activity designed to promote, or remove barriers to, employment, (iv) employed for at least 80 hours per month, or (v) incapable of completing the educational or employment requirements of this subsection due to a medical condition or disability.

(d) With monthly supervision and oversight by the director of the county department of social services or a supervising agency, an individual receiving benefits pursuant to subsection (c) of this section may reside outside a foster care facility in a college or university dormitory or other semi-supervised housing arrangement approved by the director of the county department of social services and continue to receive benefits pursuant to this section."

SECTION 12C.9.(b) G.S. 108A-49 is amended by adding a new subsection to read:

"(e) If all other eligibility criteria are met, adoption assistance payments may continue until the beneficiary reaches the age of 21 if the beneficiary was adopted after reaching the age of 16 but prior to reaching the age of 18."

SECTION 12C.9.(c) G.S. 108A-49.1 reads as rewritten:

"**§ 108A-49.1. Foster care and adoption assistance payment rates.**

(a) The maximum rates for State participation in the foster care assistance program are established on a graduated scale as follows:

(1) $475.00 per child per month for children from birth through five years of age.

(2) $581.00 per child per month for children six through 12 years of age.

(3) $634.00 per child per month for children at least 13 ~~through 18~~ but less than 21 years of age.

(b) The maximum rates for the State adoption assistance program are established consistent with the foster care rates as follows:

(1) $475.00 per child per month for children from birth through five years of age.

(2) $581.00 per child per month for children six through 12 years of age.

(3) $634.00 per child per month for children at least 13 ~~through 18~~ but less than 21 years of age.

(c) The maximum rates for the State participation in human immunodeficiency virus (HIV) foster care and adoption assistance are established on a graduated scale as follows:

(1) $800.00 per child per month with indeterminate HIV status.

(2) $1,000 per child per month with confirmed HIV infection, asymptomatic.

(3) $1,200 per child per month with confirmed HIV infection, symptomatic.

(4) $1,600 per child per month when the child is terminally ill with complex care needs.

In addition to providing board payments to foster and adoptive families of HIV-infected children, any additional funds remaining that are appropriated for purposes described in this subsection shall be used to provide medical training in avoiding HIV transmission in the home.

(d) The State and a county participating in foster care and adoption assistance shall each contribute fifty percent (50%) of the nonfederal share of the cost of care for a child placed by a county department of social services or child-placing agency in a family foster home or residential child care facility. A county shall be held harmless from contributing fifty percent (50%) of the nonfederal share of the cost for a child placed in a family foster home or

residential child care facility under an agreement with that provider as of October 31, 2008, until the child leaves foster care or experiences a placement change.

(e) A county shall be held harmless from contributing fifty percent (50%) of the nonfederal share of the cost for an individual receiving benefits pursuant to G.S. 108A-48(c)."

SECTION 12C.9.(d) G.S. 131D-10.2 reads as rewritten:

"**§ 131D-10.2. Definitions.**

For purposes of this Article, unless the context clearly implies otherwise:

...

(3) "Child" means an individual less than ~~18~~ 21 years of age, who has not been emancipated under the provisions of Article 35 of Chapter 7B of the General Statutes.

...

(9a) "Foster Parent" means any individual who is ~~18~~ 21 years of age or older who is licensed by the State to provide foster care.

...."

SECTION 12C.9.(e) Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Foster care until 21 years of age.**

(a) A child placed in foster care who has attained the age of 18 years may continue receiving foster care services until reaching 21 years of age as provided by law. A child who initially chooses to opt out of foster care upon attaining the age of 18 years may opt to receive foster care services at a later date until reaching 21 years of age.

(b) A child who has attained the age of 18 years and chosen to continue receiving foster care services until reaching 21 years of age may continue to receive benefits pursuant to Part 4 of Article 2 of Chapter 108A of the General Statutes upon meeting the requirements under G.S. 108A-48(c)."

SECTION 12C.9.(f) G.S. 131D-10.5 reads as rewritten:

"**§ 131D-10.5. Powers and duties of the Commission.**

In addition to other powers and duties prescribed by law, the Commission shall exercise the following powers and duties:

(1) Adopt, amend and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this ~~Article;~~Article.

(2) Issue declaratory rulings as may be needed to implement the provisions and purposes of this ~~Article;~~Article.

(3) Adopt rules governing procedures to appeal Department decisions pursuant to this Article granting, denying, suspending or revoking ~~licenses;~~licenses.

(4) Adopt criteria for waiver of licensing rules adopted pursuant to this ~~Article;~~Article.

(5) Adopt rules on documenting the use of physical restraint in residential child-care ~~facilities;~~facilities.

(6) Adopt rules establishing personnel and training requirements related to the use of physical restraints and time-out for staff employed in residential child-care ~~facilities; and~~facilities.

(7) Adopt rules establishing educational requirements, minimum age, relevant experience, and criminal record status for executive directors and staff employed by child placing agencies and residential child care facilities.

(8) Adopt any rules necessary for the expansion of foster care for individuals who have attained the age of 18 years and chosen to continue receiving foster care services to 21 years of age in accordance with G.S. 131D-10.2A."

SECTION 12C.9.(g) Article 9 of Chapter 7B of the General Statutes is amended by adding a new section to read:

"**§ 7B-910.1. Review of voluntary foster care placements with young adults.**

(a) The court shall review the placement of a young adult in foster care authorized by G.S. 108A-48(c) when the director of social services and a young adult who was in foster care as a juvenile enter into a voluntary placement agreement. The review hearing shall be held not more than 90 days from the date the agreement was executed, and the court shall make findings from evidence presented at this review hearing with regard to all of the following:

(1) Whether the placement is in the best interest of the young adult in foster care.

(2) The services that have been or should be provided to the young adult in foster care to improve the placement.

(3) The services that have been or should be provided to the young adult in foster care to further the young adult's educational or vocational ambitions, if relevant.

(b) Upon written request of the young adult or the director of social services, the court may schedule additional hearings to monitor the placement and progress toward the young adult's educational or vocational ambitions.

(c) No guardian ad litem under G.S. 7B-601 will be appointed to represent the young adult in the initial or any subsequent hearing.

(d) The clerk shall give written notice of the initial and any subsequent review hearings to the young adult and foster care and the director of social services at least 15 days prior to the date of the hearing."

SECTION 12C.9.(h) G.S. 7B-401.1 is amended by adding a new subsection to read:

"(i) Young Adult in Foster Care. – In proceedings held pursuant to G.S. 7B-910.1, the young adult in foster care and the director of the department of social services are parties."

SECTION 12C.9.(i) The Department of Health and Human Services, Division of Social Services (Division), shall develop a plan for the expansion of foster care services for individuals who have attained the age of 18 years and opt to continue receiving foster care services until reaching 21 years of age. The Division shall report on the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2015. The Division shall report on the plan as implemented to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2016.

SECTION 12C.9.(j) No later than 60 days after the Department implements the plan for the expansion of foster care services as required under subsection (i) of this section, the Division shall submit a State plan amendment to the U.S. Department of Health and Human Services Administration for Children and Families to make federal payments for foster care and adoption assistance, as applicable, under Title IV-E, available to a person meeting the requirements of G.S. 108A-48(c), as enacted in subsection (a) of this section.

SECTION 12C.9.(k) Any agreement entered into pursuant to G.S. 108A-48(b) prior to the effective date of subsection (a) of this section shall remain in full force and effect, and no provision of this section shall be construed to affect or alter such an agreement.

SECTION 12C.9.(l) Subsection (a) of this section becomes effective August 1, 2016, and applies to agreements entered into on or after that date. Subsections (i), (j), and (k) of this section are effective when they become law. The remainder of this section becomes effective August 1, 2016.

REQUIRE TRANSFER OF CERTAIN SERVICES TO EASTERN BAND OF CHEROKEE INDIANS

SECTION 12C.10.(a) G.S. 108A-25 reads as rewritten:

"**§ 108A-25. Creation of programs; assumption by federally recognized tribe of programs.**

...

(e) When any federally recognized Native American tribe within the State assumes responsibility for any social services, Medicaid and NC Health Choice healthcare benefit programs, and ancillary services, including Medicaid administrative and service functions, that are otherwise the responsibility of a county under State law, then, notwithstanding any other provision of law, the county shall be relieved of the legal responsibility related to the tribe's assumption of those services. With respect to a tribe's assumption of any responsibilities for administration of any aspects of the NC Medicaid program, NC Health Choice, and the Supplemental Nutrition Assistance Program (SNAP), the State and the tribe shall execute an agreement to set forth the general terms, definitions, and conditions by which the parties shall operate. Upon the execution of the agreement, to allow the tribe to assume certain duties and responsibilities for the administration of the NC Medicaid program, NC Health Choice, and SNAP, the agreement between the State and the tribe shall require the tribe to accept the oversight authority of the State and the Department of Health and Human Services (Department) in the administration and supervision of these programs. In addition to the other necessary terms and conditions, the agreement shall include the following conditions:

(1) All requirements as prescribed by federal law, as well as the tribe and State's responsibilities in complying with federal law, including, but not limited to, any specific provisions pertaining to accounting and auditing compliance, maintenance of liability insurance, confidentiality, reporting requirements, indemnity, waiver of immunity, or due process.

(2) As the Department is the federally recognized single State agency for the NC Medicaid program, NC Health Choice, and SNAP, provisions stating the Department retains ultimate administrative discretion in the administration and supervision of the program, including, but not limited to, issuance and interpretation of all applicable policies, rules, and regulations regarding application processing, eligibility determinations and redeterminations, and other functions related to the eligibility process.

(3) Provisions by the tribe to ensure that individuals who will be responsible for the tribe's duties and responsibilities under this agreement shall be employed under standards equivalent to current standards for a Merit System of Personnel Administration or any standards later prescribed by the Office of Personnel Management under section 208 of the Intergovernmental Personnel Act of 1970 and shall provide the Department with information for verification of this condition.

(4) Either party may terminate the agreement without cause with at least 30 days' notice prior to the date the terminating party seeks to terminate the agreement. The Department may terminate all or part of the agreement when federal or State funding becomes unavailable for any reason.

(f) With respect to programs federally administered by the Administration for Children and Families (ACF), the Department shall maintain oversight authority for all federal protections to individuals living on federal reservations held in trust by the United States until such time as ACF has approved the Eastern Band of Cherokee Indians to administer these programs."

SECTION 12C.10.(b) G.S. 108A-87(c) reads as rewritten:

"(c) Notwithstanding subsections (a) and (b) of this section, when the Eastern Band of Cherokee Indians assumes responsibility for a program described under G.S. 108A-25(e), the following shall occur:

(1) Nonfederal matching funds designated to Jackson and Swain counties to serve the Eastern Band of Cherokee Indians for that program previously borne by the State shall be allocated directly to the Eastern Band of Cherokee Indians rather than to those ~~counties.~~counties and shall not exceed the amount expended by the State for fiscal year 2014-2015 for programs or services assumed by the Eastern Band of Cherokee Indians, as applicable, plus the growth rate equal to the growth in State-funded nonfederal share for all counties.

(2) Any portion of nonfederal matching funds borne by counties for public assistance and social services programs and related administrative costs shall be borne by the Eastern Band of Cherokee Indians."

SECTION 12C.10.(c) Of the funds appropriated in this act from the General Fund to the Department of Health and Human Services, Division of Social Services, the sum of three hundred sixty thousand dollars ($360,000) in recurring funds for fiscal year 2015-2016 and the sum of three million two hundred thousand dollars ($3,200,000) in nonrecurring funds for fiscal year 2015-2016 shall be deposited in the Department's information technology budget code to be used for ongoing operation and maintenance pursuant to implementing the provisions of this section.

SECTION 12C.10.(d) Approval for the tribe to administer the eligibility process for Medicaid and NC Health Choice is contingent upon federal approval of a state plan amendment and Medicaid waivers by the Centers for Medicare and Medicaid Services (CMS). The Department of Health and Human Services, Division of Medical Assistance, shall make any necessary amendments to its previous SPA 14-001, including amendment of its effective date. The new effective date shall be October 1, 2016. If CMS does not approve the SPA, the counties shall continue serving individuals living on the federal lands held in trust by the United States.

SECTION 12C.10.(e) Within 30 days of CMS approval of the amended SPA 14-001, the Department of Health and Human Services shall submit an Advanced Planning Document Update (APDU) to CMS, the United States Department of Agriculture (USDA), and the Administration for Children and Families (ACF). If CMS, USDA, and ACF do not approve the APDU, the counties shall continue serving individuals living on the federal lands held in trust by the United States.

SECTION 12C.10.(f) Upon CMS, USDA, and ACF approval of the APDU, the Department of Health and Human Services (Department) shall begin functional and detailed design, development, testing, and training of NC FAST, NCTracks, and legacy systems to allow the Eastern Band of Cherokee Indians to assume certain administrative duties consistent with approval given by federal funding partners and any agreements between the Eastern Band of Cherokee Indians and the Department.

SECTION 12C.10.(g) If federal law allows the Eastern Band of Cherokee Indians to assume responsibility for the NC Medicaid program, NC Health Choice, or SNAP, the Eastern Band of Cherokee Indians shall be allowed to assume responsibility for those programs if they choose to assume such responsibility.

CHILD PROTECTIVE SERVICES PILOT PROJECT

SECTION 12C.11.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Social Services, the sum of three hundred thousand dollars ($300,000) shall be used for the continuation of the Child Protective Services Pilot Project established by Section 12C.1(e) of S.L. 2014-100. The Division shall continue to collaborate with the Government Data Analytics Center (GDAC) and shall utilize the funds to support and enhance the Pilot by doing the following:

(1) Developing a dashboard linking the family to the child.

(2) Integrating additional Department of Health and Human Services and other State department data sources to build a more comprehensive view of the child and family, including (i) matching the child to the caretaker; (ii) linking child, family, and address information; and (iii) integrating Criminal Justice Law Enforcement Automated Data Services (CJLEADS) data to determine if the caretaker or someone living in the house is a sex offender or has a criminal history.

(3) Developing a comprehensive profile of a child that includes demographic and caretaker information and indicators or flags of other services, including, but not limited to, prior assessments of the child, eligibility for food and nutrition programs, Medicaid, and subsidized child care.

SECTION 12C.11.(b) The Division of Social Services shall interface the work product from the Child Protective Services Pilot Program with the statewide child welfare case management system operated by the Department of Health and Human Services by utilizing resources and subject matter expertise available through existing public-private partnerships within the GDAC for the purposes of analyzing risk and improving outcomes for children. The Division of Social Services shall submit its findings and recommendations in a final report on the Child Protective Services Pilot Program to the Joint Legislative Oversight Committee on Health and Human Services no later than March 1, 2016.

FOSTER CARE FAMILY ACT

SECTION 12C.12.(a) This section shall be known and may be cited as the "Foster Care Family Act."

SECTION 12C.12.(b) Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Reasonable and prudent parenting standard.**

(a) The reasonable and prudent parenting standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while encouraging the child's emotional and developmental growth.

(b) Every child care institution shall designate an on-site official who is authorized to apply the reasonable and prudent parenting standard pursuant to this section.

(c) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, the designated official at a child care institution where the child is placed, or the county department of social services, must use the reasonable and prudent parenting standard when determining whether to allow a child in foster care to participate in extracurricular, enrichment, and social activities.

(d) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, the designated official at a child care institution where the child is placed, the county department of social services, or the Department of Health and Human Services with custody of or placement authority over a child in foster care shall not be held liable for an act or omission of the child if the caregiver or county department of social services is acting in accordance with the reasonable and prudent parenting standard under this section.

(e) Unless otherwise ordered by a court with jurisdiction pursuant to G.S. 7B-200, a caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, exercising the reasonable and prudent parenting standard has the authority to provide or withhold permission, without prior approval of the court or a county department of social services, allowing a child in foster care, in the custody of a county department of social services, or under the placement authority of a county department of social services through a voluntary placement agreement, to participate in normal childhood activities. Normal childhood activities shall include, but are not limited to, extracurricular, enrichment,

and social activities and may include overnight activities outside the direct supervision of the caregiver for periods of over 24 hours and up to 72 hours.

(f) The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, the designated official at a child care institution where the child is placed, the county department of social services, or the Department of Health and Human Services, shall not be liable for injuries to the child that occur as a result of the reasonable and prudent parenting standard. The burden of proof with respect to a breach of the reasonable and prudent parenting standard shall be by clear and convincing evidence.

(g) The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, the designated official at a child care institution where the child is placed, the county department of social services, or the Department of Health and Human Services, shall be liable for any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in the injury to the child."

SECTION 12C.12.(c) G.S. 7B-505(b) reads as rewritten:

"(b) The court shall order the Department to make diligent efforts to notify relatives and any custodial parents of the juvenile's siblings that the juvenile is in nonsecure custody and of any hearings scheduled to occur pursuant to G.S. 7B-506, unless the court finds such notification would be contrary to the best interests of the juvenile. In placing a juvenile in nonsecure custody under this section, the court shall first consider whether a relative of the juvenile is willing and able to provide proper care and supervision of the juvenile in a safe home. If the court finds that the relative is willing and able to provide proper care and supervision in a safe home, then the court shall order placement of the juvenile with the relative unless the court finds that placement with the relative would be contrary to the best interests of the juvenile."

SECTION 12C.12.(d) G.S. 7B-800.1(a)(4) reads as rewritten:

"(a) Prior to the adjudicatory hearing, the court shall consider the following:

...

(4) Whether relatives or parents with custody of a sibling of the juvenile have been identified and notified as potential resources for placement or support."

SECTION 12C.12.(e) G.S. 7B-901 reads as rewritten:

"**§ 7B-901. Dispositional hearing.**

The dispositional hearing shall take place immediately following the adjudicatory hearing and shall be concluded within 30 days of the conclusion of the adjudicatory hearing. The dispositional hearing may be informal and the court may consider written reports or other evidence concerning the needs of the juvenile. The juvenile and the juvenile's parent, guardian, or custodian shall have the right to present evidence, and they may advise the court concerning the disposition they believe to be in the best interests of the juvenile. The court may consider any evidence, including hearsay evidence as defined in G.S. 8C-1, Rule 801, including testimony or evidence from any person who is not a party, that the court finds to be relevant, reliable, and necessary to determine the needs of the juvenile and the most appropriate disposition. The court may exclude the public from the hearing unless the juvenile moves that the hearing be open, which motion shall be granted.

At the dispositional hearing, the court shall inquire as to the identity and location of any missing parent and whether paternity is at issue. The court shall include findings of the efforts undertaken to locate the missing parent and to serve that parent and efforts undertaken to establish paternity when paternity is an issue. The order may provide for specific efforts in determining the identity and location of any missing parent and specific efforts in establishing paternity. The court shall also inquire about efforts made to identify and notify ~~relatives~~ relatives or parents with custody of a sibling of the juvenile, as potential resources for placement or support."

SECTION 12C.12.(f) Article 9 of Chapter 7B of the General Statutes is amended by adding the following new sections to read:

"**§ 7B-903.1. Juvenile placed in custody of a county department of social services.**

(a) To the extent authorized by federal law, a county department of social services with custody of a juvenile is authorized to make decisions about matters not addressed in this section that are generally made by a juvenile's custodian including, but not limited to, educational decisions and consenting to the sharing of the juvenile's information. The county department of social services may delegate any part of this authority to the juvenile's parent, foster parent, or another individual.

(b) When a juvenile is in the custody or placement responsibility of a county department of social services, the placement provider may, in accordance with G.S. 131D-10.2A, provide or withhold permission, without prior approval of the court or county department of social services, allowing a juvenile to participate in normal childhood activities. If such authorization is not in the juvenile's best interest, the court shall set forth alternative parameters for approving normal childhood activities.

"**§ 7B-912. Juveniles 14 years of age and older; Another Planned Permanent Living Arrangement.**

(a) In addition to the permanency planning requirements under G.S. 7B-906.1, at every permanency planning hearing for a juvenile in the custody of a county department of social services who has attained the age of 14 years, the court shall inquire and make written findings regarding each of the following:

(1) The services provided to assist the juvenile in making a transition to adulthood.

(2) The steps the county department of social services is taking to ensure that the foster family or other licensed placement provider follows the reasonable and prudent parenting standard as provided in G.S. 131D-10.2A.

(3) Whether the juvenile has regular opportunities to engage in age-appropriate or developmentally appropriate activities.

(b) At or before the last scheduled permanency planning hearing, but at least 90 days before a juvenile attains 18 years of age, the court shall (i) inquire as to whether the juvenile has a copy of the juvenile's birth certificate, Social Security card, health insurance information, drivers license or other identification card, and any educational or medical records the juvenile requests and (ii) determine the person or entity that should assist the juvenile in obtaining these documents before the juvenile attains the age of 18 years.

(c) If the court finds each of the following conditions applies, the court shall approve Another Planned Permanent Living Arrangement (APPLA) as the juvenile's primary permanent plan:

(1) The juvenile is 16 or 17 years old.

(2) The county department of social services has made diligent efforts to place the juvenile permanently with a parent or relative or in a guardianship or adoptive placement.

(3) Compelling reasons exist that it is not in the best interest of the juvenile to be placed permanently with a parent or relative or in a guardianship or adoptive placement.

(4) APPLA is the best permanency plan for the juvenile.

(d) If the court approves APPLA as the juvenile's permanent plan, the court shall, after questioning the juvenile, make written findings addressing the juvenile's desired permanency outcome."

SECTION 12C.12.(g) Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-44. Development of policy form or endorsement for personal liability insurance for foster parents.**

(a) The Rate Bureau shall develop an optional policy form or endorsement to be filed with the Commissioner for approval no later than May 1, 2016, that provides liability insurance for foster parents licensed under Article 1A of Chapter 131D of the General Statutes to provide foster care in a family foster home or therapeutic foster home. The policy form or endorsement shall provide coverage for acts or omissions of the foster parent while the parent is acting in his or her capacity as a foster parent in a licensed family foster home or therapeutic foster home licensed under Article 1A of Chapter 131D of the General Statutes.

(b) Nothing in this section is intended to require that the liability insurance policy or endorsement required by this section cover an act or omission that results from any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in injury to the child."

SECTION 12C.12.(h) Article 1 of Chapter 48A of the General Statutes is amended by adding a new section to read:

"**§ 48A-4. Certain minors competent to contract.**

A minor who is 16 years of age or older and who is in the legal custody of the county department of social services shall be qualified and competent to contract for the purchase of an automobile insurance policy with the consent of the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b). The minor shall be responsible for paying the costs of the insurance premiums and shall be liable for damages caused by the minor's negligent operation of a motor vehicle. No State or local government agency, foster parent, or entity providing services to the minor under contract or at the direction of a State or local government agency shall be responsible for paying any insurance premiums or liable for damages of any kind as a result of the operation of a motor vehicle by the minor."

SECTION 12C.12.(i) G.S. 20-11(i) reads as rewritten:

"(i) Application. — An application for a permit or license authorized by this section must be signed by both the applicant and another person. That person must be:

(1) The applicant's parent or guardian;
(2) A person approved by the applicant's parent or guardian; or
(3) A person approved by the Division.
(4) With respect to minors in the legal custody of the county department of social services, any of the following:
  a. A guardian ad litem or attorney advocate appointed to advocate for the minor.
  b. The director or his or her designee or other type of caseworker assigned to work with the minor.
  c. If no person listed in sub-subdivision a. or b. of this subdivision is available, the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b)."

SECTION 12C.12.(j) G.S. 20-309 is amended by adding a new subsection to read:

"(a2) Notwithstanding any other provision of this Chapter, an owner's policy of liability insurance issued to a foster parent or parents, which policy includes an endorsement excluding coverage for one or more foster children residing in the foster parent's or parents' household, may be certified as proof of financial responsibility, provided that each foster child for whom coverage is excluded is insured in an amount equal to or greater than the minimum limits required by G.S. 20-279.21 under some other owner's policy of liability insurance or a named nonowner's policy of liability insurance. The North Carolina Rate Bureau shall establish, with the approval of the Commissioner of Insurance, a named driver exclusion endorsement or endorsements for foster children as described herein."

SECTION 12C.12.(k) G.S. 20-279.21(b) reads as rewritten:

"(b) ~~Such~~ Except as provided in G.S. 20-309(a2), such owner's policy of liability insurance:

...."

SECTION 12C.12.(l) The Department of Health and Human Services, Division of Medical Assistance, shall design and draft, but not submit, a 1915(c) Medicaid waiver to serve children with Serious Emotional Disturbance (SED) in home and community-based settings. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

SECTION 12C.12.(m) The Department shall report, on the draft waiver required by subsection (l) of this section, other findings and any other options or recommendations to best serve children with SED to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015. Specifically, the report shall provide an in-depth analysis of the cost per slot, including an analysis of the estimated number of waiver recipients who would be transitioned from a facility to a home and community-based setting and the estimated number of waiver recipients who would avoid placement in a facility.

SECTION 12C.12.(n) Subsections (b) through (f) and (h) through (k) of this section become effective October 1, 2015. The remainder of this section is effective when this act becomes law.

SUBPART XII-D. DIVISION OF AGING AND ADULT SERVICES

STATE-COUNTY SPECIAL ASSISTANCE RATES

SECTION 12D.1.(a) For each year of the 2015-2017 fiscal biennium, the maximum monthly rate for residents in adult care home facilities shall be one thousand one hundred eighty-two dollars ($1,182) per month per resident.

SECTION 12D.1.(b) For each year of the 2015-2017 fiscal biennium, the maximum monthly rate for residents in Alzheimer's/Dementia special care units shall be one thousand five hundred fifteen dollars ($1,515) per month per resident.

SUBPART XII-E. DIVISION OF PUBLIC HEALTH

FUNDS FOR SCHOOL NURSES

SECTION 12E.1.(a) Funds appropriated in this act for the School Nurse Funding Initiative shall be used to supplement and not supplant other State, local, or federal funds appropriated or allocated for this purpose. Communities shall maintain their current level of effort and funding for school nurses. These funds shall not be used to fund nurses for State agencies. These funds shall be distributed to local health departments according to a formula that includes all of the following:

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

SECTION 12E.1.(b) The Division of Public Health shall ensure that school nurses funded with State funds (i) do not assist in any instructional or administrative duties associated with a school's curriculum and (ii) perform all of the following with respect to school health programs:

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

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

SECTION 12E.2. The Department of Health and Human Services shall work with the Department of Public Safety (DPS) to use DPS funds to purchase pharmaceuticals for the treatment of individuals in the custody of DPS who have been diagnosed with Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome (HIV/AIDS) in a manner that allows these funds to be accounted for as State matching funds in the Department of Health and Human Services drawdown of federal Ryan White funds earmarked for the AIDS Drug Assistance Program (ADAP).

APPOINTMENT, MANDATORY TRAINING, AND REVOCATION OF APPOINTMENT OF COUNTY MEDICAL EXAMINERS

SECTION 12E.4.(a) G.S. 130A-382 reads as rewritten:

"**§ 130A-382. County medical examiners; appointment; term of office; ~~vacancies.~~vacancies; training requirements; revocation for cause.**

(a) The Chief Medical Examiner shall appoint ~~one~~ two or more county medical examiners for each county for a three-year term. In appointing medical examiners for each county, the Chief Medical Examiner shall give preference to physicians licensed to practice medicine in this State but may also appoint licensed physician assistants, nurse practitioners, nurses, ~~coroners,~~ or emergency medical technician paramedics. A medical examiner may serve more than one county. The Chief Medical Examiner may take jurisdiction in any case or appoint another medical examiner to do so.

(b) County medical examiners shall complete annual continuing education training as directed by the Office of the Chief Medical Examiner and based upon established and published guidelines for conducting death investigations. The continuing education training shall include training regarding sudden unexplained death in epilepsy. The Office of the Chief Medical Examiner shall annually update and publish these guidelines on its Internet Web site. Newly appointed county medical examiners shall complete mandatory orientation training as directed by the Office of the Chief Medical Examiner within 90 days of their appointment.

(c) The Chief Medical Examiner may revoke a county medical examiner's appointment for failure to adequately perform the duties of the office after providing the county medical examiner with written notice of the basis for the revocation and an opportunity to respond."

SECTION 12E.4.(b) This section becomes effective January 1, 2016.

INCREASE IN NORTH CAROLINA MEDICAL EXAMINER AUTOPSY FEE

SECTION 12E.5.(a) G.S. 130A-389(a) reads as rewritten:

"(a) If, in the opinion of the medical examiner investigating the case or of the Chief Medical Examiner, it is advisable and in the public interest that an autopsy or other study be made; or, if an autopsy or other study is requested by the district attorney of the county or by any superior court judge, an autopsy or other study shall be made by the Chief Medical Examiner or by a competent pathologist designated by the Chief Medical Examiner. A complete autopsy report of findings and interpretations, prepared on forms designated for the purpose, shall be submitted promptly to the Chief Medical Examiner. Subject to the limitations of G.S. 130A-389.1 relating to photographs and video or audio recordings of an autopsy, a copy of the report shall be furnished to any person upon request. A fee for the autopsy or other study shall be paid by the State. However, if the deceased is a resident of the county in which the death or fatal injury occurred, that county shall pay the fee. The fee shall be ~~one thousand two hundred fifty dollars ($1,250).~~two thousand eight hundred dollars ($2,800)."

SECTION 12E.5.(b) Subsection (a) of this section applies to fees imposed for autopsies performed on or after July 1, 2015.

SECTION 12E.5.(c) Funds appropriated in this act to the Department of Health and Human Services, Division of Public Health, Office of the Chief Medical Examiner, shall not be used to provide a supplement to counties to offset any portion of the autopsy fee authorized in G.S. 130A-389(a), as amended by subsection (a) of this section.

INCREASE IN NORTH CAROLINA MEDICAL EXAMINER FEE

SECTION 12E.6.(a) G.S. 130A-387 reads as rewritten:

"**§ 130A-387. Fees.**

For each investigation and prompt filing of the required report, the medical examiner shall receive a fee paid by the State. However, if the deceased is a resident of the county in which the death or fatal injury occurred, that county shall pay the fee. The fee shall be ~~one hundred dollars ($100.00).~~two hundred fifty dollars ($250.00)."

SECTION 12E.6.(b) Subsection (a) of this section becomes effective July 1, 2015, and applies to fees imposed for investigations and reports filed on or after that date.

INCREASE IN TRANSPORTATION RATE FOR DEATH INVESTIGATIONS AND AUTOPSIES

SECTION 12E.7. Of the funds appropriated in this act to the Department of Health and Human Services, Division of Public Health, Office of the Chief Medical Examiner, the sum of four hundred thousand dollars ($400,000) for the 2015-2016 fiscal year and the sum of four hundred thousand dollars ($400,000) for the 2016-2017 fiscal year shall be used to increase the current base contract rate paid by the Department to transport bodies for death investigations or autopsies to one hundred ninety dollars ($190.00) for the first 40 miles and then one dollar ($1.00) per mile after the first 40 miles.

TRANSFER OF FUNCTIONS OF OFFICE OF MINORITY HEALTH

SECTION 12E.8. The Office of Minority Health of the Department of Health and Human Services is hereby eliminated. The Department of Health and Human Services, Division of Central Management, shall assume responsibility for establishing and administering a competitive grants process in accordance with Section 12A.8(d) of this act for evidence-based programs that are scientifically proven to eliminate or reduce health disparities among minority populations in this State.

TRANSFER OF FUNCTIONS OF PHYSICAL ACTIVITY AND NUTRITION PROGRAM TO DIVISION OF CENTRAL MANAGEMENT AND SUPPORT

SECTION 12E.9. The Physical Activity and Nutrition Program within the Department of Health and Human Services, Division of Public Health, Chronic Disease and

Injury Section, is hereby eliminated. The Department of Health and Human Services, Central Management and Support Division, shall assume responsibility for establishing and administering a competitive grants process in accordance with Section 12A.8(c) of this act for evidence-based programs that are scientifically proven to improve physical health and nutrition across the State.

RENAMING AND TRANSFER OF OFFICE OF RURAL HEALTH AND COMMUNITY CARE TO DIVISION OF PUBLIC HEALTH

SECTION 12E.10.(a) The Office of Rural Health and Community Care is hereby transferred from the Department of Health and Human Services, Division of Central Management and Support, to the Department of Health and Human Services, Division of Public Health, by a Type I transfer, as defined in G.S. 143A-6, and renamed the Rural Health Section.

SECTION 12E.10.(b) Consistent with subsection (a) of this section, the Revisor of Statutes may conform names and titles changed by this section, and may correct statutory references as required by this section, throughout the General Statutes. In making the changes authorized by this section, the Revisor may also adjust subject and verb agreement and the placement of conjunctions.

SUBPART XII-F. DIVISION OF MH/DD/SAS AND STATE OPERATED HEALTHCARE FACILITIES

FUNDS FOR LOCAL INPATIENT PSYCHIATRIC BEDS OR BED DAYS

SECTION 12F.1.(a) Use of Funds. – Of the funds appropriated in Section 2.1 of this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, for crisis services, the sum of forty-three million forty-nine thousand one hundred forty-four dollars ($43,049,144) for the 2015-2016 fiscal year and the sum of forty-three million forty-nine thousand one hundred forty-four dollars ($43,049,144) for the 2016-2017 fiscal year shall be used to purchase additional local inpatient psychiatric beds or bed days not currently funded by or though LME/MCOs. The Department shall continue to implement a two-tiered system of payment for purchasing these local inpatient psychiatric beds or bed days based on acuity level with an enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels, as defined by the Department. The enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels shall not exceed the lowest average cost per patient bed day among the State psychiatric hospitals. In addition, at the discretion of the Secretary of Health and Human Services, existing funds allocated to LME/MCOs for community-based mental health, developmental disabilities, and substance abuse services may be used to purchase additional local inpatient psychiatric beds or bed days. Funds designated in this subsection for the purchase of local inpatient psychiatric beds or bed days shall not be used to supplant other funds appropriated or otherwise available to the Department for the purchase of inpatient psychiatric services through contracts with local hospitals.

SECTION 12F.1.(b) Distribution and Management of Beds or Bed Days. – The Department shall work to ensure that any local inpatient psychiatric beds or bed days purchased in accordance with this section are utilized solely for individuals who are medically indigent, defined as uninsured persons who (i) are financially unable to obtain private insurance coverage as determined by the Department and (ii) are not eligible for government-funded health coverage such as Medicare or Medicaid; and distributed across the State in LME/MCO catchment areas and according to need as determined by the Department. The Department shall ensure that beds or bed days for individuals with higher acuity levels are distributed across the

State in LME catchment areas, including any catchment areas served by managed care organizations, and according to greatest need based on hospital bed utilization data. The Department shall enter into contracts with LME/MCOs and local hospitals for the management of these beds or bed days. The Department shall work to ensure that these contracts are awarded equitably around all regions of the State. LME/MCOs shall manage and control these local inpatient psychiatric beds or bed days, including the determination of the specific local hospital or State psychiatric hospital to which an individual should be admitted pursuant to an involuntary commitment order.

SECTION 12F.1.(c) Funds to Be Held in Statewide Reserve. – Funds appropriated to the Department for the purchase of local inpatient psychiatric beds or bed days shall not be allocated to LME/MCOs but shall be held in a statewide reserve at the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, to pay for services authorized by the LME/MCOs and billed by the hospitals through the LME/MCOs. LME/MCOs shall remit claims for payment to the Department within 15 working days after receipt of a clean claim from the hospital and shall pay the hospital within 30 working days after receipt of payment from the Department.

SECTION 12F.1.(d) Ineffective LME/MCO Management of Beds or Bed Days. – If the Department determines that (i) an LME/MCO is not effectively managing the beds or bed days for which it has responsibility, as evidenced by beds or bed days in the local hospital not being utilized while demand for services at the State psychiatric hospitals has not reduced, or (ii) the LME/MCO has failed to comply with the prompt payment provisions of subsection (c) of this section, the Department may contract with another LME/MCO to manage the beds or bed days or, notwithstanding any other provision of law to the contrary, may pay the hospital directly.

SECTION 12F.1.(e) Reporting by LME/MCOs. – The Department shall establish reporting requirements for LME/MCOs regarding the utilization of these beds or bed days.

SECTION 12F.1.(f) Reporting by Department. – By no later than December 1, 2016, and by no later than December 1, 2017, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on all of the following:

(1) A uniform system for beds or bed days purchased during the preceding fiscal year from (i) funds appropriated in this act that are designated for this purpose in subsection (a) of this section, (ii) existing State appropriations, and (iii) local funds.

(2) Other Department initiatives funded by State appropriations to reduce State psychiatric hospital use.

SINGLE STREAM FUNDING FOR MH/DD/SAS COMMUNITY SERVICES

SECTION 12F.2.(a) For the purpose of mitigating cash flow problems that many LME/MCOs experience at the beginning of each fiscal year relative to single stream funding, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Division), shall distribute not less than one-twelfth of each LME/MCO's continuation allocation at the beginning of the fiscal year and subtract the amount of that distribution from the LME/MCO's total reimbursements for the fiscal year.

SECTION 12F.2.(b) The Division is directed to reduce its allocation for single stream funding by one hundred eighty-five million six hundred four thousand six hundred fifty-three dollars ($185,604,653) in nonrecurring funds for the 2015-2016 fiscal year and by one hundred eighty-five million six hundred four thousand six hundred fifty-three dollars ($185,604,653) for the 2016-2017 fiscal year. The Division is directed to allocate this reduction among the LME/MCOs based on the percentage of the total single stream funding allocated to each LME/MCO for the 2014-2015 fiscal year. During each year of the 2015-2017 fiscal

biennium, each LME/MCO shall use its cash reserves to provide at least the same level of services paid for by single stream funding during the 2014-2015 fiscal year.

FUNDS FOR THE NORTH CAROLINA CHILD TREATMENT PROGRAM

SECTION 12F.3.(a) Recurring 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 2015-2017 fiscal biennium for the North Carolina Child Treatment Program (NC CTP) shall be used for the following purposes:

(1) To continue to provide clinical training and coaching to licensed clinicians on an array of evidence-based treatments and to provide a statewide platform to assure accountability and outcomes.

(2) To maintain and manage a public roster of program graduates, linking high-quality clinicians with children, families, and professionals.

(3) To partner with State, LME/MCO, and private sector leadership to bring effective mental health treatment to children in juvenile justice and mental health facilities.

SECTION 12F.3.(b) All data, including any entered or stored in the State-funded secure database developed for the NC CTP to track individual-level and aggregate-level data with interface capability to work with existing networks within State agencies, is and remains the sole property of the State.

TRAUMATIC BRAIN INJURY FUNDING

SECTION 12F.6. 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 2015-2016 fiscal year, the sum of two million three hundred seventy-three thousand eighty-six dollars ($2,373,086) shall be used exclusively to support traumatic brain injury (TBI) services as follows:

(1) The sum of three hundred fifty-nine thousand two hundred eighteen dollars ($359,218) shall be used to fund contracts with the Brain Injury Association of North Carolina, Carolinas Rehabilitation, or other appropriate service providers.

(2) The sum of seven hundred ninety-six thousand nine hundred thirty-four dollars ($796,934) shall be used to support residential programs across the State that are specifically designed to serve individuals with TBI.

(3) The sum of one million two hundred sixteen thousand nine hundred thirty-four dollars ($1,216,934) shall be used to support requests submitted by individual consumers for assistance with residential support services, home modifications, transportation, and other requests deemed necessary by the consumer's local management entity and primary care physician.

CREATION OF SEPARATE DOROTHEA DIX HOSPITAL PROPERTY FUND WITHIN THE MENTAL HEALTH TRUST FUND

SECTION 12F.6A.(a) G.S. 143C-9-2 is amended by adding a new subsection to read:

"(b1) The Dorothea Dix Hospital Property Fund is established as a separate fund within the Trust Fund. The fund is established to receive the net proceeds from the sale of the Dorothea Dix Hospital property. Moneys in the Dorothea Dix Hospital Property Fund shall be allocated or expended only upon an act of appropriation by the General Assembly and shall not be subject to the limitations of the moneys in the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs as described in subsection (b) of this section."

SECTION 12F.6A.(b) Notwithstanding G.S. 146-30 or any other provision of law, the net proceeds of the sale of the Dorothea Dix Hospital property shall be deposited into the Dorothea Dix Hospital Property Fund established in G.S. 143C-9-2(b1), as enacted by subsection (a) of this section.

JOINT STUDY OF JUSTICE AND PUBLIC SAFETY AND BEHAVIORAL HEALTH

SECTION 12F.10. The Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety shall each appoint a subcommittee to study the intersection of Justice and Public Safety and behavioral health and report their findings and recommendations to their respective Committees. The subcommittees shall meet jointly to study and report on the following issues:

(1) The impact of the Justice Reinvestment Act on the State's behavioral health system, including the following:
   a. The impact of the Justice Reinvestment Act on the demand for community-based behavioral health services available through local management entities/managed care organizations (LME/MCOs).
   b. The change in the number of criminal offenders referred to the Treatment Accountability for Safer Communities (TASC) program since 2010 and other demands on the TASC program that have arisen since that time.
   c. The sources and amounts of funding available to serve this population, as well as any other support or resources that are provided by the Department of Public Safety to the Department of Health and Human Services or the LME/MCOs.
   d. An analysis of the supply and demand for behavioral health providers who serve this population.

(2) The impact of mental illness and substance abuse on county law enforcement agencies, including the following:
   a. The number of people with mental illness and substance abuse issues held in county jails.
   b. The impact on local law enforcement agencies, particularly with respect to their budgets and personnel.

(3) The impact of judicial decisions on the State's behavioral health and social services system, including the following:
   a. The role and impact of family court decisions on the demand for and delivery of county social services.
   b. The role and impact of decisions by drug treatment courts, veterans' mental health courts, and driving while impaired courts.
   c. The impact of judicial decisions on the availability of beds in State-operated psychiatric facilities as a result of involuntary commitment orders and incapacity to proceed decisions.

(4) Any other relevant issues the subcommittees jointly deem appropriate.

LME/MCO USE OF FUNDS TO PURCHASE INPATIENT ALCOHOL AND SUBSTANCE ABUSE TREATMENT SERVICES

SECTION 12F.12.(a) It is the intent of the General Assembly to terminate all direct State appropriations for State-operated alcohol and drug abuse treatment centers (ADATCs) beginning with the 2015-2016 fiscal year and instead appropriate funds to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, for community services in order to allow local management entities/managed care organizations (LME/MCOs) to assume responsibility for

managing the full array of publicly funded substance abuse services, including inpatient services delivered through the ADATCs. To this end and notwithstanding any other provision of law, on the effective date of this section all direct State appropriations for ADATCs are terminated and the ADATCs shall be one hundred percent receipt-supported.

SECTION 12F.12.(b) From funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, to be allocated to LME/MCOs for the purchase of inpatient alcohol and substance abuse treatment services, the LME/MCOs shall use their respective fund allocations for individuals within their respective catchment areas as follows:

(1) During the 2015-2016 fiscal year, a minimum of one hundred percent (100%) of the allocation shall be used exclusively to purchase inpatient alcohol and substance abuse treatment services from the ADATCs.

(2) During the 2016-2017 fiscal year, a minimum of ninety percent (90%) of the allocation shall be used exclusively to purchase inpatient alcohol and substance abuse treatment services from the ADATCs. The LME/MCOs shall use the remaining ten percent (10%) of their respective allocations to purchase inpatient alcohol and substance abuse treatment services from any qualified provider.

SECTION 12F.12.(c) By March 1, 2016, the Department of Health and Human Services shall develop and report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division a plan to allow the ADATCs to remain one hundred percent (100%) receipt-supported. The report shall include an evaluation of (i) other community-based and residential services that could be provided by the ADATCs and (ii) potential funding sources other than payments from the LME/MCOs, including funding available from estimated receipts from Medicare, Medicaid, insurance, and self-pay.

CLOSURE OF WRIGHT SCHOOL

SECTION 12F.13.(a) The Department of Health and Human Services shall not allow any new admissions or readmissions to the Wright School after June 30, 2015. The Department shall, in consultation with local management entities/managed care organizations, develop a plan to transition all students enrolled at the Wright School to other appropriate educational and treatment settings.

SECTION 12F.13.(b) By September 30, 2015, the Department shall permanently cease operations at the Wright School.

SECTION 12F.13.(c) G.S. 122C-181(a)(5)b. is repealed effective October 1, 2015.

REPORT ON MULTIPLICATIVE AUDITING AND MONITORING OF CERTAIN SERVICE PROVIDERS

SECTION 12F.14. No later than December 1, 2015, the Department of Health and Human Services shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the status of multiplicative auditing and monitoring of all provider agencies under the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, that have been nationally accredited through a recognized national accrediting body. The report shall include (i) all group home facilities licensed under Chapter 122C of the General Statutes, (ii) a complete list of all auditing and monitoring activities to which these service providers are subject, and (iii) recommendations on the removal of all unnecessary regulatory duplication to enhance efficiency.

FUNDS FOR DRUG OVERDOSE MEDICATIONS

SECTION 12F.15. 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 2015-2016 fiscal year for the purchase of opioid antagonists as defined in G.S. 90-106.2, shall be used as follows:

(1) Twenty-five thousand dollars ($25,000) shall be used to purchase opioid antagonists to be distributed at no charge to the North Carolina Harm Reduction Coalition to serve individuals at risk of experiencing an opioid-related drug overdose or to the friends and family members of an at-risk individual.

(2) Twenty-five thousand dollars ($25,000) shall be used to purchase opioid antagonists to be distributed at no charge to North Carolina law enforcement agencies.

STRENGTHENING OF CONTROLLED SUBSTANCES MONITORING

STATEWIDE OPIOID PRESCRIBING GUIDELINES

SECTION 12F.16.(a) By July 1, 2016, the following State health officials and health care provider licensing boards shall adopt the North Carolina Medical Board's Policy for the Use of Opiates for the Treatment of Pain:

(1) The Director of the Division of Public Health of the Department of Health and Human Services (DHHS).

(2) The Director of the Division of Medical Assistance, DHHS.

(3) The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS.

(4) The directors of medical, dental, and mental health services within the Department of Public Safety.

(5) North Carolina State Board of Dental Examiners.

(6) North Carolina Board of Nursing.

(7) North Carolina Board of Podiatry Examiners.

CONTINUING EDUCATION REQUIREMENTS

SECTION 12F.16.(b). The following health care provider occupational licensing boards shall require continuing education on the abuse of controlled substances as a condition of license renewal for health care providers who prescribe controlled substances:

(1) North Carolina Board of Dental Examiners.

(2) North Carolina Board of Nursing.

(3) North Carolina Board of Podiatry Examiners.

(4) North Carolina Medical Board.

SECTION 12F.16.(c). In establishing the continuing education standards, the boards listed in subsection (b) of this section shall require that at least one hour of the total required continuing education hours consists of a course designed specifically to address prescribing practices. The course shall include, but not be limited to, instruction on controlled substance prescribing practices and controlled substance prescribing for chronic pain management.

IMPROVE CONTROLLED SUBSTANCES REPORTING SYSTEM ACCESS AND UTILIZATION

SECTION 12F.16.(d). G.S. 90-113.74 reads as rewritten:

"**§ 90-113.74. Confidentiality.**

(a) Prescription information submitted to the Department is privileged and confidential, is not a public record pursuant to G.S. 132-1, is not subject to subpoena or discovery or any other use in civil proceedings, and except as otherwise provided below may only be used (i) for investigative or evidentiary purposes related to violations of State or federal ~~law and~~ law, (ii) for regulatory ~~activities.~~ activities, or (iii) to inform medical records or clinical care. Except as otherwise provided by this section, prescription information shall not be disclosed or disseminated to any person or entity by any person or entity authorized to review prescription information.

...

(c) The Department shall release data in the controlled substances reporting system to the following persons only:

...

(8) Any county medical examiner appointed by the Chief Medical Examiner pursuant to G.S. 130A-382 and the Chief Medical Examiner, for the purpose of investigating the death of an individual.

(9) The federal Drug Enforcement Administration's Office of Diversion Control.

(10) The North Carolina Health Information Exchange Authority (NC HIE Authority), established under Article 29A of this Chapter, through Web-service calls.

...."

SECTION 12F.16.(e). The Department of Health and Human Services shall adopt appropriate policies and procedures documenting and supporting the additional functionality and expanded access added by subsection (d) of this section for the Controlled Substances Reporting System (CSRS) for the entities added to G.S. 90-113.74(c) by subsection (d) of this section and shall amend its contract with the vendor that operates the CSRS to support the additional functionality and expanded access to the CSRS.

IMPROVE CONTROLLED SUBSTANCES REPORTING SYSTEM CONTRACT

SECTION 12F.16.(f). The Department of Health and Human Services (DHHS) shall modify the contract for the Controlled Substances Reporting System (CSRS) to improve performance, establish user access controls, establish data security protocols, and ensure availability of data for advanced analytics. Specifically, the contract shall be modified to include the following:

(1) A connection to the North Carolina Health Information Exchange Authority (NC HIE Authority).

(2) The establishment of interstate connectivity.

(3) Data security protocols that meet or exceed the Federal Information Processing Standards (FIPS) established by the National Institute of Standards and Technology (NIST).

SECTION 12F.16.(g). DHHS shall complete the contract modifications required by subsection (f) of this section by December 31, 2015. DHHS shall report by November 15, 2015, to the Joint Legislative Program Evaluation Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services regarding the progress to modify the contract.

SECTION 12F.16.(h). DHHS shall apply for grant funding from the National Association of Boards of Pharmacy to establish the connection to PMP InterConnect. The Department shall request forty thousand thirty-five dollars ($40,035) to establish the initial interface for PMP InterConnect and thirty thousand dollars ($30,000) for two years of ongoing service, maintenance, and support for PMP InterConnect in order to create interstate

connectivity for the drug monitoring program as required by subdivision (2) of subsection (f) of this section.

SECTION 12F.16.(i). 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 CSRS shall be used as follows:

(1) For the 2015-2016 fiscal year, the sum of forty thousand thirty-five dollars ($40,035) shall be used to connect the CSRS and the NC HIE Authority, as required by subdivision (1) of subsection (f) of this section.

(2) For the 2015-2016 fiscal year and for the 2016-2017 fiscal year, the sum of fifteen thousand dollars ($15,000) shall be used to maintain a connection between the CSRS and the NC HIE Authority, as required by subdivision (1) of subsection (f) of this section.

(3) For the 2015-2016 fiscal year, the sum of forty thousand thirty-five dollars ($40,035) shall be used to establish the initial interface for PMP InterConnect, as required by subdivision (2) of subsection (f) of this section. This amount shall be adjusted or eliminated if DHHS is successful in obtaining grant awards or identifying other allowable receipts for this purpose. If receipts are used for this purpose, this nonrecurring appropriation shall revert to the General Fund.

(4) For the 2015-2016 fiscal year, the sum of fifteen thousand dollars ($15,000) shall be used for the cost of annual service fees for the interstate connection for the drug monitoring program, as required by subdivision (2) of subsection (f) of this section. This amount shall be adjusted or eliminated if DHHS is successful in obtaining grant awards or identifying other allowable receipts for this purpose. If receipts are used for this purpose, this nonrecurring appropriation shall revert to the General Fund.

EXPAND MONITORING CAPACITY

SECTION 12F.16.(j). The North Carolina Controlled Substances Reporting System shall expand its monitoring capacity by establishing data use agreements with the Prescription Behavior Surveillance System. In order to participate, the CSRS shall establish a data use agreement with the Center of Excellence at Brandeis University no later than January 1, 2016.

SECTION 12F.16.(k) Beginning September 1, 2016, and every two years thereafter, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services shall report on its participation with the Prescription Behavior Surveillance System to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety.

MEDICAID LOCK-IN PROGRAM

SECTION 12F.16.(l). The Division of Medical Assistance of the Department of Health and Human Services (DMA) shall take the following steps to improve the effectiveness and efficiency of the Medicaid lock-in program:

(1) Establish written procedures for the operation of the lock-in program, including specifying the responsibilities of DMA and the program contractor.

(2) Establish procedures for the sharing of bulk data with the Controlled Substances Regulatory Branch.

(3) In consultation with the Physicians Advisory Group, extend lock-in duration to two years and revise program eligibility criteria to align the program with the statewide strategic goals for preventing prescription drug abuse. DMA shall report an estimate of the cost-savings from the revisions to the eligibility criteria to the Joint Legislative Program Evaluation Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services within one year of the lock-in program again becoming operational.

(4) Develop a Web site and communication materials to inform lock-in enrollees, prescribers, pharmacists, and emergency room health care providers about the program.

(5) Increase program capacity to ensure that all individuals who meet program criteria are locked in.

(6) Conduct an audit of the lock-in program within six months after the effective date of this act in order to evaluate the effectiveness of program restrictions in preventing overutilization of controlled substances, identify any program vulnerabilities, and address whether there is evidence of any fraud or abuse within the program.

DMA shall report to the Joint Legislative Program Evaluation Oversight Committee by September 30, 2015, on its progress toward implementing all items included in this section.

STATEWIDE STRATEGIC PLAN

SECTION 12F.16.(m). There is hereby created the Prescription Drug Abuse Advisory Committee, to be housed in and staffed by the Department of Health and Human Services (DHHS). The Committee shall develop and, through its members, implement a statewide strategic plan to combat the problem of prescription drug abuse. The Committee shall include representatives from the following, as well as any other persons designated by the Secretary of Health and Human Services:

(1) The Division of Medical Assistance, DHHS.

(2) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS.

(3) The Division of Public Health, DHHS.

(4) The Rural Health Section of the Division of Public Health, DHHS.

(5) The State Bureau of Investigation.

(6) The Attorney General's Office.

(7) The following health care regulatory boards with oversight of prescribers and dispensers of prescription drugs:

a. North Carolina Board of Dental Examiners.

b. North Carolina Board of Nursing.

c. North Carolina Board of Podiatry Examiners.

d. North Carolina Medical Board.

e. North Carolina Board of Pharmacy.

(8) The UNC Injury Prevention Research Center.

(9) The substance abuse treatment community.

(10) Governor's Institute on Substance Abuse, Inc.

(11) The Department of Insurance's drug take-back program.

After developing the strategic plan, the Committee shall be the State's steering committee to monitor achievement of strategic objectives and receive regular reports on progress made toward reducing prescription drug abuse in North Carolina.

(b) In developing the statewide strategic plan to combat the problem of prescription drug abuse, the Prescription Drug Abuse Advisory Committee shall, at a minimum, complete the following steps:

(1) Identify a mission and vision for North Carolina's system to reduce and prevent prescription drug abuse.

(2) Scan the internal and external environment for the system's strengths, weaknesses, opportunities, and challenges (a SWOC analysis).

(3) Compare threats and opportunities to the system's ability to meet challenges and seize opportunities (a GAP analysis).

(4) Identify strategic issues based on SWOC and GAP analyses.

(5) Formulate strategies and resources for addressing these issues.

(c) The strategic plan for reducing prescription drug abuse shall include three to five strategic goals that are outcome-oriented and measureable. Each goal must be connected with objectives supported by the following five mechanisms of the system:

(1) Oversight and regulation of prescribers and dispensers by State health care regulatory boards.

(2) Operation of the Controlled Substances Reporting System.

(3) Operation of the Medicaid lock-in program to review behavior of patients with high use of prescribed controlled substances.

(4) Enforcement of State laws for the misuse and diversion of controlled substances.

(5) Any other appropriate mechanism identified by the Committee.

(d) DHHS, in consultation with the Prescription Drug Abuse Advisory Committee, shall develop and implement a formalized performance management system that connects the goals and objectives identified in the statewide strategic plan to operations of the Controlled Substances Reporting System and Medicaid lock-in program, law enforcement activities, and oversight of prescribers and dispensers. The performance management system must be designed to monitor progress toward achieving goals and objectives and must recommend actions to be taken when performance falls short.

(e) Beginning on December 1, 2016, and annually thereafter, DHHS shall submit an annual report on the performance of North Carolina's system for monitoring prescription drug abuse to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety.

EFFECTIVE DATE

SECTION 12F.16.(n). Subdivision (f)(1) of this section becomes effective upon the establishment of the North Carolina Health Information Exchange Authority pursuant to Section 12A.5 of this act. The remainder of this section is effective when it becomes law.

ELIMINATE PUBLICATION/ACCESS NORTH CAROLINA TRAVEL GUIDE

SECTION 12F.17. G.S. 168-2 is repealed.

SUBPART XII-G. DIVISION OF HEALTH SERVICE REGULATION

MORATORIUM ON SPECIAL CARE UNIT LICENSES

SECTION 12G.2.(a) Section 12G.1(a) of S.L. 2013-360, as amended by Section 12G.5 of S.L. 2014-100, reads as rewritten:

"**SECTION 12G.1.(a)** For the period beginning July 31, 2013, and ending ~~June 30, 2016,~~June 30, 2017, the Department of Health and Human Services, Division of Health Service Regulation (Department), shall not issue any licenses for special care units as defined in

G.S. 131D-4.6 and G.S. 131E-114. This prohibition shall not restrict the Department from doing any of the following:

(1) Issuing a license to a facility that is acquiring an existing special care unit.

(2) Issuing a license for a special care unit in any area of the State upon a determination by the Secretary of the Department of Health and Human Services that increased access to this type of care is necessary in that area during the moratorium imposed by this section.

(3) Processing all completed applications for special care unit licenses received by the Division of Health Service Regulation along with the applicable license fee prior to June 1, 2013.

(4) Issuing a license to a facility that was in possession of a certificate of need as of July 31, 2013, that included authorization to operate special care unit beds."

SECTION 12G.2.(a1) The Department shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services by March 1, 2016, containing at least the following information:

(1) The number of licensed special care units in the State.

(2) The capacity of the currently licensed special care units to serve people in need of their services.

(3) The anticipated growth in the number of people who will need the services of a licensed special care unit.

(4) The number of applications received from special care units seeking licensure as permitted by this section, and the number of those applications that were not approved.

SECTION 12G.2.(b) This section is effective when this act becomes law.

PHASED CERTIFICATE OF NEED REPEAL

SECTION 12G.5.(a) It is the intent of the General Assembly to repeal the certificate of need laws set forth in Article 9 of Chapter 131E of the General Statutes in three phases as set forth in subsections (b) and (c) of this section.

SECTION 12G.5.(b) Phase 1. – Effective January 1, 2016, the certificate of need laws will not apply to the following health service facilities and activities:

(1) The establishment of beds or a change in bed capacity at any of the following health service facilities:
   a. Acute care hospitals.
   b. Inpatient psychiatric hospitals.
   c. Inpatient rehabilitation hospitals.
   d. Kidney disease treatment centers.
   e. ICFMRs.
   f. Chemical dependency treatment facilities.

(2) The offering of any of the following services:
   a. Bone marrow transplantation.
   b. Burn intensive care services.
   c. Open heart surgery services.
   d. Solid organ transplantation.

(3) The acquisition of any of the following equipment:
   a. Gamma knife equipment.
   b. Heart-lung bypass machine.
   c. Lithotripter.

(4) The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility.

SECTION 12G.5.(c) Phase 2. – Effective August 1, 2017, the certificate of need laws will not apply to the establishment of beds or a change in bed capacity at any of the following health service facilities:

(1) Diagnostic centers.
(2) Ambulatory surgical facilities.

SECTION 12G.5.(d) Phase 3. – Effective January 1, 2019, the certificate of need laws will not apply to the following health service facilities and activities:

(1) Nursing homes.
(2) Hospice programs.
(3) Hospice inpatient facilities.
(4) Hospice residential care facilities.
(5) Long-term care hospitals.
(6) The offering of cardiac catheterization services.
(7) The acquisition of any of the following equipment:
  a. Cardiac catheterization equipment.
  b. Linear accelerator.
  c. Magnetic resonance imaging scanner.
  d. Positron emission tomography scanner.
  e. Simulator.

REPEAL CERTIFICATE OF PUBLIC ADVANTAGE LAWS

SECTION 12G.6.(a) Article 1E of Chapter 90 and Article 9A of Chapter 131E of the General Statutes are repealed.

SECTION 12G.6.(b) All existing certificates of public advantage (COPAs) granted pursuant to Article 1E of Chapter 90 and Article 9A of Chapter 131E of the General Statutes, as defined in these Articles, are cancelled effective January 1, 2016. By delaying the effective date of the cancellation of COPAs to January 1, 2016, it is the intent of the General Assembly to provide parties to existing cooperative agreements, as defined in G.S. 90-21.25 and G.S. 131E-192.2, with sufficient time to review their cooperative agreements for compliance with State and federal laws and to take whatever action the parties deem necessary.

SECTION 12G.6.(c) This section is effective when it becomes law.

SUBPART XII-H. DIVISION OF MEDICAL ASSISTANCE (MEDICAID)

MEDICAID ELIGIBILITY

SECTION 12H.2.(a) Families and children who are categorically and medically needy are eligible for Medicaid, subject to the following annual income levels:

Family Size	Categorically Needy Income Level	Medically Needy Income Level
1	$ 5,208	$ 2,904
2	6,828	3,804
3	8,004	4,404
4	8,928	4,800
5	9,888	5,196
6	10,812	5,604
7	11,700	6,000
8	12,432	6,300

The Department of Health and Human Services shall provide Medicaid coverage to 19- and 20-year-olds under this subsection in accordance with federal rules and regulations. Medicaid enrollment of categorically needy families with children shall be continuous for one year without regard to changes in income or assets.

SECTION 12H.2.(b) For the following Medicaid eligibility classifications for which the federal poverty guidelines are used as income limits for eligibility determinations, the income limits will be updated each April 1 immediately following publication of federal poverty guidelines. The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to the following:

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

(2) Pregnant women with incomes equal to or less than one hundred ninety-six percent (196%) of the federal poverty guidelines and without regard to resources. Services to pregnant women eligible under this subsection continue throughout the pregnancy but include only those related to pregnancy and to those other conditions determined by the Department as conditions that may complicate pregnancy.

(3) Infants under the age of one with family incomes equal to or less than two hundred ten percent (210%) of the federal poverty guidelines and without regard to resources.

(4) Children aged one through five with family incomes equal to or less than two hundred ten percent (210%) of the federal poverty guidelines and without regard to resources.

(5) Children aged six through 18 with family incomes equal to or less than one hundred thirty-three percent (133%) of the federal poverty guidelines and without regard to resources.

(6) Workers with disabilities described in G.S. 108A-66A with unearned income equal to or less than one hundred fifty percent (150%) of the federal poverty guidelines.

The Department of Health and Human Services, Division of Medical Assistance, shall also provide family planning services to men and women of childbearing age with family incomes equal to or less than one hundred ninety-five percent (195%) of the federal poverty guidelines and without regard to resources.

SECTION 12H.2.(c) The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to adoptive children with special or rehabilitative needs, regardless of the adoptive family's income.

SECTION 12H.2.(d) The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to "independent foster care adolescents," ages 18, 19, and 20, as defined in section 1905(w)(1) of the Social Security Act (42 U.S.C. § 1396d(w)(1)), without regard to the adolescent's assets, resources, or income levels.

SECTION 12H.2.(e) The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to women who need treatment for breast or cervical cancer and who are defined in 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII).

SECTION 12H.2.(f) G.S. 108A-70.21 reads as rewritten:

"**§ 108A-70.21. Program eligibility; benefits; enrollment fee and other cost-sharing; coverage from private plans; purchase of extended coverage.**

(a) Eligibility. – The Department may enroll eligible children based on availability of funds. Following are eligibility and other requirements for participation in the Program:

(1) Children must:

a. Be between the ages of 6 through 18;

b. Be ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance;
c. Be uninsured;
d. Be in a family whose family income is above one hundred thirty-three percent (133%) ~~through~~ and less than or equal to two hundred eleven percent ~~(200%)~~(211%) of the federal poverty level;
e. Be a resident of this State and eligible under federal law; and
f. Have paid the Program enrollment fee required under this Part.

...

(b) Benefits. – All health benefits changes of the Program shall meet the coverage requirements set forth in this subsection. Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:

(1) No services for long-term care.
(2) No nonemergency medical transportation.
(3) No EPSDT.
(4) Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.

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

(1), (1a) Repealed by Session Laws 2011-145, s. 10.41(b), effective July 1, 2011.
(2) Vision: Scheduled routine eye examinations once every 12 months, eyeglass lenses or contact lenses once every 12 months, routine replacement of eyeglass frames once every 24 months, and optical supplies and solutions when needed. NCHC recipients must obtain optical services, supplies, and solutions from NCHC enrolled, licensed or certified ophthalmologists, optometrists, or opticians. In accordance with G.S. 148-134, NCHC providers must order complete eyeglasses, eyeglass lenses, and ophthalmic frames through Nash Optical Plant. Eyeglass lenses are limited to NCHC-approved single vision, bifocal, trifocal, or other complex lenses necessary for a Plan enrollee's visual welfare. Coverage for oversized lenses and frames, designer frames, photosensitive lenses, tinted contact lenses, blended lenses, progressive multifocal lenses, coated lenses, and laminated lenses is limited to the coverage for single vision, bifocal, trifocal, or other complex lenses provided by this subsection. Eyeglass frames are limited to NCHC-approved frames made of zylonite, metal, or a combination of zylonite and metal. All visual aids covered by this subsection require prior approval. Requests for medically necessary complete eyeglasses, eyeglass lenses, and ophthalmic frames outside of the NCHC-approved selection require prior approval. Requests for medically necessary fabrication of complete eyeglasses or eyeglass lenses outside of Nash Optical Plant require prior approval. Upon prior approval refractions may be covered more often than once every 12 months.
(3) Under the North Carolina Health Choice Program for Children, the co-payment for nonemergency visits to the emergency room for children whose family income is ~~at or below~~ less than or equal to one hundred ~~fifty~~fifty-nine percent ~~(150%)~~(159%) of the federal poverty level is ten dollars ($10.00). The co-payment for children whose family income is ~~between~~ above one hundred ~~fifty-one~~ fifty-nine percent ~~(151%)~~(159%) and

less than or equal to two hundred eleven percent ~~(200%)~~(211%) of the federal poverty level is twenty-five dollars ($25.00).

...

(c) Annual Enrollment Fee. – There shall be no enrollment fee for Program coverage for enrollees whose family income is ~~at or below~~less than or equal to one hundred ~~fifty~~ fifty-nine percent ~~(150%)~~(159%) of the federal poverty level. The enrollment fee for Program coverage for enrollees whose family income is above one hundred ~~fifty~~ fifty-nine percent ~~(150%)~~(159%) ~~through~~and less than or equal to two hundred eleven percent ~~(200%)~~(211%) of the federal poverty level shall be fifty dollars ($50.00) per year per child with a maximum annual enrollment fee of one hundred dollars ($100.00) for two or more children. The enrollment fee shall be collected by the county department of social services and retained to cover the cost of determining eligibility for services under the Program. County departments of social services shall establish procedures for the collection of enrollment fees.

(d) Cost-Sharing. – There shall be no deductibles, copayments, or other cost-sharing charges for families covered under the Program whose family income is ~~at or below~~less than or equal to one hundred ~~fifty~~fifty-nine percent ~~(150%)~~(159%) of the federal poverty level, except that fees for outpatient prescription drugs are applicable and shall be one dollar ($1.00) for each outpatient generic prescription drug, for each outpatient brand-name prescription drug for which there is no generic substitution available, and for each covered over-the-counter medication. The fee for each outpatient brand-name prescription drug for which there is a generic substitution available is three dollars ($3.00). Families covered under the Program whose family income is above one hundred ~~fifty~~ fifty-nine percent ~~(150%)~~(159%) of the federal poverty level shall be responsible for copayments to providers as follows:

(1) Five dollars ($5.00) per child for each visit to a provider, except that there shall be no copayment required for well-baby, well-child, or age-appropriate immunization services;

(2) Five dollars ($5.00) per child for each outpatient hospital visit;

(3) A one dollar ($1.00) fee for each outpatient generic prescription drug, for each outpatient brand-name prescription drug for which there is no generic substitution available, and for each covered over-the-counter medication. The fee for each outpatient brand-name prescription drug for which there is a generic substitution available is ten dollars ($10.00).

(4) Twenty dollars ($20.00) for each emergency room visit unless:

a. The child is admitted to the hospital, or

b. No other reasonable care was available as determined by the Department.

..."

LME/MCO OUT-OF-NETWORK AGREEMENTS

SECTION 12H.3.(a) The Department of Health and Human Services (Department) shall ensure that local management entities/managed care organizations (LME/MCOs) utilize an out-of-network agreement that contains standardized elements developed in consultation with LME/MCOs. The out-of-network agreement shall be a streamlined agreement between a single provider of behavioral health or intellectual/developmental disability (IDD) services and an LME/MCO to ensure access to care in accordance with 42 C.F.R. 438.206(b)(4), reduce administrative burden on the provider, and comply with all requirements of State and federal laws and regulations. Beginning July 1, 2015, LME/MCOs shall use the out-of-network agreement in lieu of a comprehensive provider contract when all of the following conditions are met:

(1) The services requested are medically necessary and cannot be provided by an in-network provider.

(2) The behavioral health or IDD provider's site of service delivery is located outside of the geographical catchment area of the LME/MCO, and the LME/MCO is not accepting applications or the provider does not wish to apply for membership in the LME/MCO closed network.

(3) The behavioral health or IDD provider is not excluded from participation in the Medicaid program, the NC Health Choice program or other State or federal health care program.

(4) The behavioral health or IDD provider is serving no more than two enrollees of the LME/MCO, unless the agreement is for inpatient hospitalization, in which case the LME/MCO may, but shall not be required to, enter into more than five such out-of-network agreements with a single hospital or health system in any 12-month period.

SECTION 12H.3.(b) Medicaid providers providing services pursuant to an out-of-network agreement shall be considered a network provider for purposes of Chapter 108D of the General Statutes only as it relates to enrollee grievances and appeals.

PROVIDER APPLICATION AND RECREDENTIALING FEE

SECTION 12H.4. The Department of Health and Human Services, Division of Medical Assistance, shall charge an application fee of one hundred dollars ($100.00), and the amount federally required, to each provider enrolling in the Medicaid Program for the first time. The fee shall be charged to all providers at recredentialing every three years.

REIMBURSEMENT FOR IMMUNIZING PHARMACIST SERVICES

SECTION 12H.5.(a) Effective January 1, 2016, the Department of Health and Human Services, Division of Medical Assistance (Department), shall provide Medicaid and NC Health Choice reimbursement for the administration of covered vaccinations or immunizations provided by immunizing pharmacists in accordance with G.S. 90-85.15B.

SECTION 12H.5.(b) In order to implement the requirements of subsection (a) of this section, the Department shall enroll immunizing pharmacists as providers.

SECTION 12H.5.(c) The Department shall submit any State plan amendments necessary to accomplish the requirements of this section.

TRAUMATIC BRAIN INJURY MEDICAID WAIVER

SECTION 12H.6.(a) The Department of Health and Human Services, Division of Medical Assistance and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Department), shall submit to the Centers for Medicare and Medicaid Services a request for approval of the 1915(c) waiver for individuals with traumatic brain injury (TBI) that the Department designed pursuant to Section 12H.6 of S.L. 2014-100, which the Joint Legislative Oversight Committee on Health and Human Services recommended as part of its December 2014 report to the General Assembly, and which is further described in the Department's February 1, 2015, report to the General Assembly.

SECTION 12H.6.(b) The Department shall report to the Joint Legislative Oversight Committee on Health and Human Services on the status of the Medicaid TBI waiver request and the plan for implementation no later than December 1, 2015. The Department shall submit an updated report by March 1, 2016. Each report shall include the following:

(1) The number of individuals who are being served under the waiver and the total number of individuals expected to be served.

(2) The expenditures to date and a forecast of future expenditures.

(3) Any recommendations regarding expansion of the waiver.

SECTION 12H.6.(c) Of the funds appropriated to the Department of Health and Human Services, Division of Medical Assistance, two million dollars ($2,000,000) for fiscal

year 2015-2016 and two million dollars ($2,000,000) for fiscal year 2016-2017 shall be used to fund the Medicaid TBI waiver.

STUDY MEDICAID COVERAGE FOR VISUAL AIDS

SECTION 12H.6A. The Department of Health and Human Services, Division of Medical Assistance, in consultation with the Department of Public Safety, shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2015, containing an analysis of the fiscal impact to the State of reinstating Medicaid coverage for visual aids for adults utilizing a contract with the Department of Public Safety for fabrication of the eyeglasses at Nash Optical Plant Optical Laboratory. The report shall also analyze the cost of reinstating Medicaid coverage for routine eye examinations for adults in addition to the coverage for visual aids.

ASSESSMENTS

SECTION 12H.7. G.S. 108A-122(b) reads as rewritten:

"(b) Allowable Cost. – An assessment paid under this Article may be included as allowable costs of a hospital for purposes of any applicable Medicaid reimbursement ~~formula.~~ formula; assessments paid under this Article shall be excluded from cost settlement. An assessment imposed under this Article may not be added as a surtax or assessment on a patient's bill."

LME/MCO TRANSFER OF FUNDS TO RISK RESERVE

SECTION 12H.8.(a) After the local management entities/managed care organizations (LME/MCOs) have allocated funds to cover the reduction in single stream funding required by Section 12F.2 of this act, the Department of Health and Human Services, Division of Medical Assistance, shall require LME/MCOs to transfer funds from their operating cash reserves to their contractually-required risk reserve account in an amount sufficient so that the funds in the risk reserve account equal fifteen percent (15%) of annual premiums. The Department shall not require LME/MCOs to transfer from their operating cash reserves the amount needed to make up the difference between the current month's claims payments and the capitation payment received for the month.

SECTION 12H.8.(b) The Department shall discontinue paying the two percent (2%) added to the administrative payment of an LME/MCO when the amount in the LME/MCO's risk reserve account reaches fifteen percent (15%) of annual premiums.

SECTION 12H.8.(c) The Department shall work with LME/MCOs to consolidate their multiple existing reserve accounts so that each LME/MCO has only one reserve account.

ADMINISTRATIVE HEARINGS FUNDING

SECTION 12H.9. Of the funds appropriated to the Department of Health and Human Services, Division of Medical Assistance, for administrative contracts and interagency transfers, the Department of Health and Human Services (Department) shall transfer the sum of one million dollars ($1,000,000) for the 2015-2016 fiscal year and the sum of one million dollars ($1,000,000) for the 2016-2017 fiscal year to the Office of Administrative Hearings (OAH). These funds shall be allocated by the OAH for mediation services provided for Medicaid applicant and recipient appeals and to contract for other services necessary to conduct the appeals process. OAH shall continue the Memorandum of Agreement (MOA) with the Department for mediation services provided for Medicaid recipient appeals and contracted services necessary to conduct the appeals process. The MOA will facilitate the Department's ability to draw down federal Medicaid funds to support this administrative function. Upon receipt of invoices from OAH for covered services rendered in accordance with the MOA, the Department shall transfer the federal share of Medicaid funds drawn down for this purpose.

ACCOUNTING FOR MEDICAID RECEIVABLES AS NONTAX REVENUE

SECTION 12H.10.(a) Receivables reserved at the end of the 2015-2016 and 2016-2017 fiscal years shall, when received, be accounted for as nontax revenue for each of those fiscal years.

SECTION 12H.10.(b) For the 2015-2016 fiscal year, the Department of Health and Human Services shall deposit from its revenues one hundred thirty-nine million dollars ($139,000,000) with the Department of State Treasurer to be accounted for as nontax revenue. For the 2016-2017 fiscal year, the Department of Health and Human Services shall deposit from its revenues one hundred thirty-nine million dollars ($139,000,000) with the Department of State Treasurer to be accounted for as nontax revenue. These deposits shall represent the return of General Fund appropriations, nonfederal revenue, fund balances, or other resources from State-owned and State-operated hospitals which are used to provide indigent and nonindigent care services. The return from State-owned and State-operated hospitals to DHHS will be made from nonfederal resources in an amount equal to the amount of the payments from the Division of Medical Assistance for uncompensated care. The treatment of any revenue derived from federal programs shall be in accordance with the requirements specified in the Code of Federal Regulations, Title 2, Part 225.

MEDICAID SPECIAL FUND TRANSFER

SECTION 12H.11. Of the funds transferred to the Department of Health and Human Services for Medicaid programs pursuant to G.S. 143C-9-1, there is appropriated from the Medicaid Special Fund to the Department of Health and Human Services the sum of forty-three million dollars ($43,000,000) for the 2015-2016 fiscal year and the sum of forty-three million dollars ($43,000,000) for the 2016-2017 fiscal year. These funds shall be allocated as prescribed by G.S. 143C-9-1(b) for Medicaid programs. Notwithstanding the prescription in G.S. 143C-9-1(b) that these funds not reduce State general revenue funding, these funds shall replace the reduction in general revenue funding effected in this act.

MISCELLANEOUS MEDICAID PROVISIONS

SECTION 12H.12.(a) Volume Purchase Plans and Single Source Procurement. – The Department of Health and Human Services, Division of Medical Assistance, may, subject to the approval of a change in the State Medicaid Plan, contract for services, medical equipment, supplies, and appliances by implementation of volume purchase plans, single source procurement, or other contracting processes in order to improve cost containment.

SECTION 12H.12.(b) Cost Containment Programs. – The Department of Health and Human Services, Division of Medical Assistance, may undertake cost containment programs, including contracting for services, preadmissions to hospitals, and prior approval for certain outpatient surgeries before they may be performed in an inpatient setting.

SECTION 12H.12.(c) Medicaid Identification Cards. – The Department shall issue Medicaid identification cards to recipients on an annual basis with updates as needed.

MISCELLANEOUS HEALTH CHOICE PROVISIONS

SECTION 12H.14.(a) G.S. 108A-70.18(4a) is repealed.

SECTION 12H.14.(b) G.S. 108A-70.20 reads as rewritten:

"**§ 108A-70.20. Program established.**

The Health Insurance Program for Children is established. The Program shall be known as North Carolina Health Choice for Children, and it shall be administered by the Department of Health and Human Services in accordance with this Part and as required under Title XXI and related federal rules and regulations. Administration of ~~Program benefits and~~ claims processing

shall be as ~~provided under Part 5 of Article 3 of Chapter 135 of the General Statutes.~~described in 42 C.F.R. § 447.45(d)(1)."

SECTION 12H.14.(c) Subsections (g) and (h) of G.S. 108A-70.21 are repealed.

SECTION 12H.14.(d) G.S. 108A-70.21(i) reads as rewritten:

"(i) ~~No Lifetime Maximum Benefit Limit. —~~Benefits provided to an enrollee in the Program ~~shall not be subject to a maximum lifetime limit.~~may be subject to lifetime maximum limits set forth in Medicaid and NC Health Choice medical coverage policies adopted pursuant to G.S. 108A-54.2."

SECTION 12H.14.(e) G.S. 108A-70.27(c) is repealed.

REINSTATE COST SETTLEMENT PURSUANT TO 1993 STATE AGREEMENT

SECTION 12H.17. Effective July 1, 2015, the cost settlement for outpatient Medicaid services performed by Vidant Medical Center, which was previously known as Pitt County Memorial Hospital, shall be at one hundred percent (100%) of allowable costs.

COVERED SERVICES AND PAYMENT FOR SERVICES

SECTION 12H.18. Except as otherwise specifically provided in this act or another act passed during the 2015 Regular Session, the authorized State plan services, co-pays, reimbursement rates, and fees shall remain the same as those authorized as of June 30, 2015.

DRUG REIMBURSEMENT USING AVERAGE ACQUISITION COST

SECTION 12H.19.(a) The Department of Health and Human Services, Division of Medical Assistance, (Department) shall adopt an average acquisition cost methodology for brand and generic drug ingredient pricing to be effective beginning on January 1, 2016. The drug ingredient pricing methodology shall be consistent with new federal requirements or, if the new federal requirements have not yet been finalized by July 1, 2015, consistent with the most recent draft federal requirements. In adopting a new drug ingredient pricing methodology, the Department shall also do all of the following:

(1) Raise the average dispensing fee to a weighted average amount that does not exceed twelve dollars ($12.00).

(2) Set actual dispensing fees that maintain a higher dispensing fee for preferred and generic drugs and a lower dispensing fee for brand and nonpreferred drugs.

(3) Ensure that ingredient prices are updated at least monthly.

SECTION 12H.19.(b) In addition to the requirements in subsection (a) of this section, the Department may also set tiered dispensing fees that establish a higher dispensing fee for providers who dispense a lower volume of prescriptions and a lower dispensing fee for providers who dispense a higher volume of prescriptions, as long as the weighted average amount of all the tiered dispensing fees does not exceed twelve dollars ($12.00).

SECTION 12H.19.(c) In order to implement this section, the Department shall either amend the State plan amendment request submitted to the Centers for Medicare and Medicaid Services (CMS) pursuant to Section 12H.8 of S.L. 2014-100 so that it conforms with the requirements of this section or shall withdraw that State plan amendment and submit a new State plan amendment request to CMS that conforms with the requirements of this section, in accordance with the procedures set forth in G.S. 108A-54.1A.

MEDICAID DENTAL SERVICE COST SETTLEMENT

SECTION 12H.20. The Department of Health and Human Services, Division of Medical Assistance, shall submit a State Plan Amendment request to the Centers for Medicare and Medicaid Services to assure that all State-operated dental schools receive the same reimbursement for dental services provided to North Carolina Medicaid beneficiaries.

MOBILE DENTAL PROVIDER ENROLLMENT

SECTION 12H.21. For mobile dental providers seeking enrollment as a Medicaid provider, and upon reenrollment of current Medicaid mobile dental providers, the Department of Health and Human Services, Division of Medicaid Assistance, shall require as a condition of enrollment or reenrollment that the mobile dental provider show proof of a contractual affiliation with dental practice that is not mobile, and the Department shall require the mobile dental provider to use the National Provider Identifier (NPI) of the non-mobile dental practice for purposes of filing claims.

INCREASE RATES FOR PRIVATE DUTY NURSING

SECTION 12H.22. Effective January 1, 2016, the Department of Health and Human Services, Division of Medical Assistance, shall increase by ten percent (10%) the rate paid for private duty nursing services provided pursuant to Clinical Coverage Policy 3G.

RESTRICTING GRADUATE MEDICAL PAYMENTS

SECTION 12H.23.(a) The Department of Health and Human Services shall submit a State Plan Amendment to modify Section 4.19-A of the Medicaid State Plan, such that, effective October 1, 2015, no Medicaid provider may receive reimbursement for Graduate Medical Education (GME) in addition to their DRG Unit Value (Base) rate under the methodology as defined in the current Medicaid State Plan.

SECTION 12H.23.(b) This modification shall be implemented upon approval by the Centers for Medicare and Medicaid Services (CMS).

SECTION 12H.23.(c) The Department of Health and Human Services, Division of Medical Assistance, shall be exempt from the 90-day prior submission requirement in G.S. 108A-54.1A in order to submit the State Plan amendment required to implement this section.

MEDICAID TRANSFORMATION AND REORGANIZATION

SECTION 12H.24.(a) Intent and Goals. – It is the intent of the General Assembly to transform the State's current Medicaid program to a program that provides budget predictability for the taxpayers of this State while ensuring quality care to those in need. The new Medicaid program shall be designed to achieve the following goals:

(1) Ensure budget predictability through shared risk and accountability.

(2) Ensure balanced quality, patient satisfaction, and financial measures.

(3) Ensure efficient and cost-effective administrative systems and structures.

(4) Ensure a sustainable delivery system.

SECTION 12H.24.(b) Structure of Delivery System. – The transformed Medicaid program described in subsection (a) of this section shall be organized according to the following principles and parameters:

(1) The Health Benefits Authority (Authority), created in subsection (h1) of this section, shall have full budget and regulatory authority to manage the State's Medicaid and NC Health Choice programs, except the General Assembly shall determine eligibility categories and income thresholds.

(2) Among its initial tasks, the Authority shall:

a. Determine the structural and financial qualifications required for managed care organizations (MCOs) and provider-led entities (PLEs). The majority of the members of a PLE's governing board shall be composed of providers as defined in G.S. 108C-2 or entities composed of providers.

b. Designate six regions within the State. Regions must be composed of whole counties. Regions do not have to be contiguous, and it is not the intent of the General Assembly to require that every county be included in at least one of the six regions.

(3) The Authority shall enter into contractual relationships with MCOs and PLEs for the delivery of all Medicaid health care items and services. All contracts shall be the result of a request for proposals (RFP) issued by the Authority and the submission of competitive bids by MCOs and PLEs. The governing principles and minimum terms and conditions of the RFPs, bids, and contracts are described in subsection (d) of this section.

(4) The number and nature of the contracts required under subdivision (3) of this subsection shall be as follows:

a. Three contracts between the Authority and any combination of individual MCOs and individual PLEs. Each of these contracts shall provide statewide coverage for all Medicaid health care items and services (statewide contracts).

b. Up to 12 contracts between the Authority and individual PLEs for coverage of specified regions (regional contracts). Regional contracts shall be in addition to the three statewide contracts required under sub-subdivision a. of this subdivision. Each regional contract shall provide coverage throughout the entire region for all Medicaid health care items and services. A PLE may bid on more than one region. The Authority shall have full discretion to enter into one, two, or no regional contracts in any region.

(5) As a result of the contracts entered into by the Authority under subdivision (3) of this subsection, a recipient shall have at least three, but no more than five enrollment choices for the provision of all Medicaid health care items and services. The Authority shall provide for annual open enrollment periods and shall determine the process for assigning recipients who do not select a MCO or PLE during the enrollment period.

SECTION 12H.24.(c) Time Line. – The following milestones for Medicaid transformation shall occur no later than the following dates:

(1) When this act becomes law. -

a. The Health Benefits Authority is created pursuant to subsection (h1) of this section and appointments to the Authority's Board shall be made pursuant to G.S. 143B-1405.

b. The Joint Legislative Oversight Committee on the Health Benefits Authority (LOC-HBA) is created pursuant to subsection (l) of this section to oversee the Medicaid and NC Health Choice programs.

(2) September 1, 2015. – The Department of Health and Human Services (Department) shall establish the Medicaid stabilization team pursuant to subsection (g) of this section.

(3) October 1, 2015. -

a. The Authority is designated as the single state agency for the administration of Medicaid and NC Health Choice.

b. The Department and the Authority shall enter into agreements necessary for the Authority to supervise the Department's administration of the Medicaid and NC Health Choice programs.

(4) February 1, 2016. – The Authority shall submit requests for waivers and State Plan amendments to the Centers for Medicare and Medicaid Services necessary to implement Medicaid transformation.

(5) March 1, 2016. – The Authority shall report recommended statutory changes to the North Carolina General Statutes to the LOC-HBA.
(6) April 1, 2017. – The initial recipient enrollment period begins.
(7) August 1, 2017. – Capitated full-risk contracts begin.

SECTION 12H.24.(d) Requests for Proposals; Bids; Terms & Conditions of Contracts. – The following shall be components of the initial RFPs, responsive bids to the initial RFPs, and the initial contracts that are required under subsection (b) of this section.

(1) An RFP may solicit bids for a statewide contract, a regional contract, or both, and may propose variable contract durations.
(2) RFPs must require at least all of the following:
  a. Full-risk capitation for all Medicaid health care items and services.
  b. Coverage for all program aid categories except the dual eligible categories for which Medicaid only pays Medicare premiums.
  c. All bidders meet solvency requirements established by the Department of Insurance pursuant to subsection (k1) of this section.
  d. All bidders meet the same standards and metrics for risk, outcomes, and quality.
  e. All bidders establish appropriate networks or providers to deliver services.
  f. All bidders subcontract with existing LME/MCOs for behavioral health services for up to three years at a capitation rate that is no less than the most recently negotiated rate for the then current scope of benefits paid to LME/MCOs.
  g. All bidders agree not to limit providers' ability to contract with other MCOs and PLEs.
  h. All bidders must connect to the Health Information Exchange Network or any successor information technology entity or architecture specified by the Authority in order to ensure effective systems and connectivity to support clinical coordination of care, exchange of information, and the availability of data to the Authority to manage the Medicaid and NC Health Choice program for the State.
  i. All bidders ensure that their contracts with providers include value-based payment systems that support the achievement of overall performance, quality, and outcome measures.
(3) All bids must respond to the requirements of subdivision (2) of this subsection and must also include at least all of the following:
  a. For statewide contracts, a description of how the MCO or PLE will ensure access to appropriate care throughout the State.
  b. For regional contracts, a description of how the PLE will ensure access to appropriate care throughout the region.
  c. Proposed competitive medical loss ratios.
  d. Proposed full-risk capitated rates based on Centers for Medicare and Medicaid Services (CMS) actuarial soundness and industry standards as well as risk adjusted rate ranges using claims data from fiscal year 2014-2015. Actuarial calculations must include utilization assumptions consistent with industry and local standards.
  e. Methods to ensure program integrity against provider fraud, waste, and abuse at all levels.
(4) In addition to the requirements of subdivisions (1) through (3) of this subsection, each contract must provide for all of the following:

a. Negotiated full-risk capitated rates, including a portion that is at risk for achievement of quality and outcome measures.
b. Negotiated competitive medical loss ratios.
c. Compliance by the MCO or PLE with all CMS requirements for the Medicaid and NC Health Choice programs.
d. Defined measures and goals for risk adjusted health outcomes, quality of care, patient satisfaction, and cost. Each component must be measured and monitored continually and reported at set intervals as determined by the Authority. Each component shall be subject to specific accountability measures, including penalties. The Authority may use organizations such as National Committee for Quality Assurance (NCQA), Physician Consortium for Performance Improvement (PCPI), Healthcare Effectiveness Data and Information Set (HEDIS), or any others necessary to develop effective measures for outcomes and quality.
e. Acceptance of full responsibility by the MCO or PLE for all grievance and appeals.
f. Ability of the MCO or PLE to exclude providers from networks based on economic or quality standards.
g. Ability of the MCO or PLE to terminate the capitation rate required under sub-subdivision f. of subdivision (2) of this subsection if termination of the rate is mutually agreed to by the LME/MCO.
h. Agreement that covered benefits will not be reduced from the covered services in effect on the date the contract is awarded except in instances where the Authority reduces a covered service for all recipients and for all contracts.

SECTION 12H.24.(e) Monthly Progress Report. – Beginning November 1, 2015, and monthly thereafter until October 1, 2018, the Health Benefits Authority shall report to the LOC-HBA and the Fiscal Research Division on the State's progress toward completing Medicaid transformation. The March 1, 2016, report shall contain proposed changes to the North Carolina General Statutes that are necessary to implement Medicaid transformation.

SECTION 12H.24.(f) Maintain Funding Mechanisms. – In developing the waivers and State Plan amendments necessary to implement this section, the Authority shall work with the Centers for Medicare & Medicaid Services (CMS) to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the extent that the levels of funding may be preserved. If such Medicaid-specific funding cannot be maintained as currently implemented, then the Authority shall advise the LOC-HBA created in subsection (h1) of this section of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation. If such Medicaid-specific funding streams cannot be preserved through the transformation process or if revenue would decrease, it is the intent of the General Assembly to modify such funding streams so that any supplemental payments to providers are more closely aligned to improving health outcomes and achieving overall Medicaid goals.

SECTION 12H.24.(g) DHHS Role in Medicaid Transformation. – During Medicaid transformation, the Department of Health and Human Services, Division of Medical Assistance (Division), shall cooperate with the Authority to ensure a smooth transition of the Medicaid and NC Health Choice programs and shall perform all of the following functions:

(1) The Department and the Authority shall enter into agreements necessary for the Authority to supervise the Department's administration of the Medicaid and NC Health Choice programs until the transformed Medicaid program is completed.

(2) The Department of Health and Human Services, Office of the Secretary, (Office of the Secretary) shall organize a Medicaid stabilization team to do the following:

a. Maintain the Medicaid and NC Health Choice programs until Medicaid transformation has been completed.

b. Work with the Authority during the transition.

c. Develop strategies to successfully complete the requirements of sub-subdivisions a. and b. of this subdivision.

d. Make recommendations to the LOC-HBA on any additional authorization or funding necessary to successfully complete the requirements of sub-subdivisions a. and b. of this subdivision.

e. With assistance from the Office of State Human Resources, conduct interviews and meetings with designated essential employees of the Division to explain the transition process, including options for the employees and the bonus payment system established under this subsection.

f. No later than September 1, 2015, report to the LOC-HBA on the plan to communicate to employees, as required by sub-subdivision e. of this subdivision.

(3) The Office of the Secretary shall identify the key managers, leaders, and decision makers to be part of the stabilization team and, no later than September 1, 2015, shall submit a list of these people and their roles to the Authority and the LOC-HBA.

(4) No later than September 1, 2015, the Secretary of Health and Human Services (Secretary) shall identify and designate "essential positions" throughout the Department without which the Medicaid and NC Health Choice programs could not operate on a day-to-day basis. Such positions designated by the Secretary may include any position, whether subject to or exempt from the State Personnel Act or whether supervisory or nonsupervisory, as long as the position is essential to the operation of Medicaid or NC Health Choice. Because the designation is based on the functions to be performed and because of the nature of the bonuses provided under this subsection, the designation of a position as essential may not be revoked, and the Secretary may designate both open and filled positions.

(5) In order to encourage employees to remain in their positions working on Medicaid and NC Health Choice within the Department, employees serving in positions designated as essential positions under this subsection shall be eligible for the following benefits:

a. Effective August 1, 2015, any employee working in a designated essential position within the Division shall receive a bonus at each pay period that is equal to five percent (5%) of the employee's earnings for that period.

b. Effective August 1, 2015, any employee working in a designated essential position within the Department, but outside of the Division, whose salary is paid with federal Medicaid funds shall also receive a five percent (5%) bonus, paid in the same manner as bonuses are paid under sub-subdivision a. of this subdivision. If such an employee working outside of the Division does not work full-time on Medicaid issues, then the amount of the bonus shall be calculated by first multiplying the employee's earnings for that period by the

percentage of the employee's time spent on Medicaid issues and then multiplying that product by five percent (5%).

c. Any employee who received bonus payments under sub-subdivisions a. or b. of this subdivision who is still employed within the Division or within the Department as of July 31, 2017, or who is employed within the Authority, shall receive a final bonus payment equal to the sum of all the bonus payments that the employee had received since July 1, 2015, under sub-subdivision a. of this subdivision. No employee departing before July 31, 2017, shall be eligible to receive any portion of such a final bonus payment, and no property right is created by this subsection for employees that depart before July 31, 2017.

d. The bonus payments paid under this subsection are made notwithstanding G.S. 126-4(2) or any other provision of law. Notwithstanding G.S. 135-1(7a), bonus payments paid under this subsection shall not count as "compensation" for purposes of the Retirement System for Teachers and State Employees, nor shall the Department of Health and Human Services be required to make payments to the Retirement System based on the amounts paid as bonuses. Additionally, bonus payments paid under this subsection shall not count as "compensation" or "salary" for calculating severance payments under G.S. 126-8.5 or calculating unemployment benefits.

(6) The Department shall not enter into any new contracts, or renew or extend any contracts that existed prior to the effective date of this subsection, related to the Medicaid or NC Health Choice programs without the express prior approval of the Board of the Authority. The Department and the Division shall ensure that any Medicaid-related or NC Health Choice-related State contract entered into after the effective date of this act contains a clause that allows the Department or the Division to terminate the contract without cause upon 30 days' notice. Any contract signed by the Department or the Division after the effective date of this act that lacks such a termination clause shall, nonetheless, be deemed to include such a clause and shall be cancellable without cause upon 30 days' notice.

SECTION 12H.24.(h1) Creation of Health Benefits Authority. – Effective when this act becomes law, the Health Benefits Authority as established in this section shall be a single, unified cabinet-level department. In accordance with the time line set out in subsection (c) of this section, the Health Benefits Authority shall administer and operate all functions, powers, duties, obligations, and services related to the Medicaid and NC Health Choice programs. In accordance with the time line set out in subsection (c) of this section, all functions, powers, duties, obligations, and services vested in the Department of Health and Human Services, Division of Medical Assistance, are vested in the Health Benefits Authority.

SECTION 12H.24.(h2) G.S. 143B-6 reads as rewritten:

"**§ 143B-6. Principal departments.**

In addition to the principal departments enumerated in the Executive Organization Act of 1971, all executive and administrative powers, duties, and functions not including those of the General Assembly and its agencies, the General Court of Justice and the administrative agencies created pursuant to Article IV of the Constitution of North Carolina, and higher education previously vested by law in the several State agencies, are vested in the following principal departments:

...

(12) Health Benefits Authority."

SECTION 12H.24.(h3) Chapter 143B of the General Statutes is amended by adding a new Article to read:

"Article 14.

"Health Benefits Authority.

"**§ 143B-1400. Creation and organization.**

There is hereby established the Health Benefits Authority (Authority) to administer and operate the Medicaid and NC Health Choice programs. The Authority shall be governed by a board, which shall be responsible for ensuring quality health outcomes to eligible recipients at a predictable cost to the taxpayers of this State. The Authority shall be the designated single State agency for the administration and operation of the Medicaid and NC Health Choice programs.

"**§ 143B-1405. Board of the Health Benefits Authority.**

(a) The Board of the Health Benefits Authority shall consist of the following:

(1) Three members appointed by the Governor.

(2) Two members appointed by the General Assembly, on the recommendation of the President Pro Tempore of the Senate.

(3) Two members appointed by the General Assembly, on the recommendation of the Speaker of the House of Representatives.

(4) The Secretary of Health and Human Services or the Secretary's designee, who shall serve as an ex officio nonvoting member of the Board.

(b) Each appointed member of the board shall have expertise from at least one of the following areas:

(1) The administration of large health delivery systems.

(2) Health insurance.

(3) Health actuarial science.

(4) Health economics.

(5) Health law and policy.

In making appointments to the Board under this section, each appointing authority shall consult with the other appointing authorities to ensure adequate representation from all of the areas of expertise listed in this subsection.

(c) The following individuals may not serve on the Board:

(1) An individual who receives or has received Medicaid payments during the six months prior to serving on the Board for providing health care or services to enrollees of the North Carolina Medicaid or NC Health Choice programs.

(2) An individual who is or has been during the six months prior to serving on the Board a registered lobbyist for a provider, or association of providers, receiving payments from the North Carolina Medicaid or NC Health Choice programs, or an employee of such a lobbyist.

(3) An individual who has, within six months of appointment, been an officer or employee of the State.

As used in this subsection, the term "provider" includes any parent, subsidiary, or affiliated legal entity, and the term "provider" has the same meaning as defined under G.S. 108C-2.

(d) Board members appointed under subdivision (1) through (3) of subsection (a) of this section shall serve for a term of four years. The Governor shall have the power to remove any member of the Board from office for misfeasance, malfeasance, or nonfeasance in accordance with the provisions of G.S. 143B-13 of the Executive Organization Act of 1973. Appointing authorities shall fill any vacancies that arise to complete the term of the vacating Board member.

(e) In making the initial appointments, the appointing authorities shall, in order to stagger terms, designate one person appointed under subdivision (1) of subsection (a) of this

section, one person appointed under subdivision (2) of subsection (a) of this section, and one person appointed under subdivision (3) of subsection (a) of this section to serve until June 30, 2017. The remaining four appointees shall serve until June 30, 2019. Future appointees shall serve terms of four years, with staggered terms based on this section. Board members may serve up to two consecutive terms, not including the abbreviated two-year terms that establish staggered terms or terms of less than two years that result from the filling of a vacancy.

(f) The Governor shall designate a chair of the Board from among the appointed voting members of the Board. The Board member designated as the chair shall serve as a chair at the pleasure of the Governor. The chair shall serve on the Governor's Cabinet. If the Governor does not appoint a chair, the Board may select a chair from among its voting members. The Board-selected chair shall serve in that capacity until such time as the Governor appoints a chair.

(g) The Board shall meet at least monthly until August 1, 2017, and at least quarterly thereafter. The Board may also meet at the call of the chair or at the request of a majority of the voting Board members. A majority of the voting Board members constitutes a quorum for conducting business.

(h) The voting members of the Board are State officers and not State employees. No voting member may serve on the Board while employed as a State employee.

(i) The voting members of the Board shall be compensated in an amount sufficient to obtain quality professionals with experience managing large businesses, insurance programs, and health systems. The initial compensation for voting Board members shall be established by the Office of State Human Resources no later than October 1, 2015. Thereafter, the compensation of voting Board members shall be set by the Board under G.S. 143B-1410(3) and shall be comparable to compensation paid to the members of boards operating large health insurance plans but shall not exceed the highest compensation paid to a member of the Council of State. When adjusting members' compensation, the Board shall provide a justification to the Office of State Human Resources based upon a survey of comparable health insurance plans.

"**§ 143B-1410. Powers and duties of the Board of the Health Benefits Authority.**

(a) The Board of the Health Benefits Authority shall have the following powers and duties:

(1) Administer and operate the Medicaid and NC Health Choice programs. None of the powers and duties enumerated in the other subdivisions of this subsection shall be construed to limit the broad grant of authority to administer and operate the Medicaid and NC Health Choice programs.

(2) Employ the Medicaid Director, who shall be responsible for the daily operation of the Authority, and other staff, including legal staff. In hiring staff, the Board may offer employment contracts for a term.

(3) Set compensation for the employees, including performance-based bonuses based on meeting budget or other targets, and for the voting Board members.

(4) Procure office space for the Authority.

(5) Notwithstanding G.S. 143-64.20, enter into contracts for the administration of the Medicaid and NC Health Choice programs, as well as manage such contracts, including contracts of a consulting or advisory nature.

(6) Employ or contract for independent internal auditing staff that report directly to the Board rather than to the Medicaid Director. Notwithstanding subsection (b) of this section, this function may not be delegated.

(7) Pursuant to G.S. 108A-1, supervise the county departments of social services in their administration of eligibility determinations. Pursuant to subdivision (5) of this subsection, the Board may contract with the Department of Health and Human Services or any other appropriate party to perform this task or a portion of this task.

(8) Define and approve the following for the Authority and the programs managed by the Authority:
  a. Business policy.
  b. Strategic plans, including desired health outcomes for the covered populations, which shall do the following:
    1. Be developed at a frequency of no less than every five years with the input of stakeholders.
    2. Identify key opportunities and challenges facing the organization.
    3. Identify the Authority's strengths and weaknesses to address these opportunities and challenges.
    4. Identify key goals for the Authority for this time period, consistent with the reform goals identified by the General Assembly.
    5. Identify output and outcome performance measures to quantify the Authority's progress toward these goals.
    6. Identify strategies to reach these goals.
    7. Be used as a guide for units within the Authority to establish unit-specific operational plans at the same frequency.
  c. Performance management system, including quantitative indicators for goals and objectives, which shall do the following:
    1. Be developed and implemented within the first year of the creation of the Authority, and updated no less than annually thereafter with available data.
    2. Establish quantitative performance measures focusing on the quality and efficiency of service delivery and administration, using a nationally recognized quality improvement effort allowing comparison of North Carolina to other states as those developed by, but not limited to, the federal Medicaid Quality Measurement Program and the Baldridge Quality Program.
    3. Establish measurable objectives for each goal identified in the strategic plan, and performance updated annually.
    4. Establish, for each objective, benchmark activities, including an estimated date of completion, the area for which efforts are attempting a change, a quantitative indicator of success for the area, and quarterly milestones allowing Authority managers and employees to monitor progress throughout the year.
    5. Establish mechanisms for obtaining data necessary for the collection and public distribution of performance information.
  d. Program and policy changes.
  e. Operational budget and assumptions.
(9) Establish and adjust all program components, except for eligibility, of the Medicaid and NC Health Choice programs within the appropriated and allocated budget.
(10) Adopt rules related to the Medicaid and NC Health Choice programs.
(11) Develop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid and NC Health Choice programs within budget.

(12) Approve or disapprove and oversee all expenditures to be charged to or allocated to the Medicaid and NC Health Choice programs by other State departments or agencies.

(13) Develop and present to the Joint Legislative Oversight Committee on the Health Benefits Authority and the Office of State Budget and Management by January 1 of each year, beginning in 2016, the following information for the Medicaid and NC Health Choice programs:

a. A detailed four-year forecast of expected changes to enrollment growth and enrollment mix.

b. What program changes will be made by the Authority in order to stay within the existing budget for the programs based on the next fiscal year's forecasted enrollment growth and enrollment mix.

c. The cost to maintain the current level of services based on the next fiscal year's forecasted enrollment growth and enrollment mix.

(14) Secure and pay for the services of the State Auditor's Office to conduct annual audits of the financial accounts of the Authority.

(15) Publish the Annual Medicaid Report, which shall contain, at a minimum, the following:

a. Details on the Authority's performance over the prior four years on the following:

1. The identified quantitative measures from its strategic plan and performance management system.

2. A comparison of the identified quantitative measures from its strategic plan and performance management system and other states participating in the quality improvement effort.

b. Annual audited financial statements.

(16) Publish in an electronic format, and update on at least a monthly basis, at least the following information about the Medicaid and NC Health Choice programs:

a. Enrollment by program aid category by county.

b. Per member per month spending by category of service.

c. Spending and receipts by fund along with a detailed variance analysis.

d. A comparison of the above figures to the amounts forecasted and budgeted for the corresponding time period.

(b) The Board may delegate any of its powers and duties to the Medicaid Director and other staff of the Authority and, upon adoption of an annual budget, shall delegate to the Medicaid Director its powers and duties pursuant to sub-subdivisions d. and e. of subdivision (8) of subsection (a) of this section. In delegating powers or duties, however, the Board maintains the responsibility for the performance of those powers or duties.

(c) Pursuant to G.S. 108E-2-1, the General Assembly retains the authority to determine the eligibility categories and income thresholds for the Medicaid and NC Health Choice programs.

"**§ 143B-1415. Variations from certain State laws.**

Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Health Benefits Authority, notwithstanding any other provision of law:

(1) Employees of the Authority shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).

(2) The Authority may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).

(3) The Authority's employment contracts offered pursuant to G.S. 143B-1410(a)(2) are not subject to review and approval by the Office of State Human Resources. The Authority's employment of supplementary staff for temporary work is not subject to review and approval by the Office of State Human Resources including the requirements of G.S. 126-6.3.

(4) If the Authority establishes alternative procedures for the review and approval of contracts, then the Authority is exempt from State contract review and approval requirements, but may still choose to utilize the State contract review and approval procedures for particular contracts.

(5) The Board of the Authority may move into a closed session for any of the reasons listed in G.S. 143-318.11, as well as for discussions on the following:

a. Rates, contract amounts, or any other amounts to be paid to any entity, including the amount of any transfers to any other State agency or Division.

b. Audits and investigations.

c. Development of the annual budget forecast report for the General Assembly, as required by G.S. 143B-1410(a)(14).

d. Development of a strategic plan.

e. Any report to be submitted to the General Assembly.

(6) Documents created for, or developed during, a closed session of the Board for one of the reasons specifically listed in the sub-subdivisions of subdivision (5) of this section, as well as any minutes from such a closed session of the Board, that would otherwise become public record by operation of Chapter 132 of the General Statutes, shall not become public record until the item under discussion has been made public through the publishing of the relevant rate or amount, findings from an audit or investigation, the annual budget forecast report, the strategic plan, or a report to the General Assembly.

"**§ 143B-216.1420. Cooling off period for certain Health Benefits Authority employees.**

(a) Ineligible Vendors. – The Board shall not contract for goods or services with a vendor that employs or contracts with a person who is a former State Medicaid or NC Health Choice employee and uses that person in the administration of a contract with the Authority.

(b) Vendor Certification. – The Medicaid Director shall require each vendor submitting a bid or contract to certify that the vendor will not use a former Medicaid or NC Health Choice employee in the administration of a contract with the Authority in violation of the provisions of subsection (a) of this section. Any person who submits a certification required by this subsection knowing the certification to be false shall be guilty of a Class I felony.

(c) A violation of the provisions of this section shall void the contract.

(d) Definitions. – As used in this section, the following terms mean:

(1) Administration of a contract. – Oversight of the performance of a contract, authority to make decisions regarding a contract, interpretation of a contract, or participation in the development of specifications or terms of a contract or in the preparation or award of a contract.

(2) Former Medicaid or NC Health Choice employee. – A person who, for any period within the preceding six months, was employed as an employee or contract employee of the Authority, who in the six months immediately preceding termination of State employment, participated personally in either the award or management of an Authority contract with the vendor, or made regulatory or licensing decisions that directly applied to the vendor.

"**§ 143B-216.1425. Medicaid Reserve Account.**

(a) The Medicaid Reserve Account is established as a nonreverting reserve in the General Fund. The purpose of the Medicaid Reserve Account is to provide for unexpected budgetary shortfalls within the Medicaid and NC Health Choice programs that result from program expenditures in excess of the amount appropriated for the Medicaid and NC Health Choice programs by the General Assembly and which continue to exist after the Health Benefits Authority makes its best efforts to control costs through midyear budget corrections under G.S. 143B-1410(a)(12).

(b) The Medicaid Reserve Account shall have the following minimum and maximum target balances:

(1) Minimum target. – Five percent (5%) of a given fiscal year's General Fund appropriations for capitation payments for both the Medicaid and NC Health Choice programs.

(2) Maximum target. – Twelve percent (12%) of a given fiscal year's General Fund appropriations for capitation payments for both the Medicaid and NC Health Choice programs.

(c) Notwithstanding G.S. 143C-1-2(b), any funds appropriated to the Health Benefits Authority for the Medicaid or NC Health Choice programs and that remain unencumbered at the end of a fiscal year shall, rather than revert to the General Fund, be credited to the Medicaid Reserve Account. Any funds to be deposited in the Medicaid Reserve Account that would cause the fund balance to exceed the maximum target balance for the Medicaid Reserve Account shall instead be credited to the General Fund.

(d) Medicaid Reserve Account funds may be disbursed by the Health Benefits Authority to manage budgetary shortfalls in the Medicaid and NC Health Choice programs only after all of the following occur:

(1) The Board of the Health Benefits Authority certifies that there is a projected Medicaid shortfall in the current fiscal year.

(2) The Health Benefits Authority has already made midyear budget corrections under G.S. 143B-1410(a)(12), but those midyear budget corrections have not achieved the projected budget savings.

(3) The Health Benefits Authority reports to the Joint Legislative Commission on Governmental Operations on its intent to disburse Medicaid Reserve Account funds. The report shall include a detailed analysis of receipts, payments, claims, and transfers, including an identification of and explanation of the recurring and nonrecurring components of the shortfall.

Medicaid Reserve Account funds may be disbursed in accordance with this subsection even if it results in the fund balance falling below the minimum target balance for the Medicaid Reserve Account."

SECTION 12H.24.(i) Board Start-Up. – The following activities shall facilitate the timely commencement of the Health Benefits Authority:

(1) The Board of the Health Benefits Authority may meet prior to October 1, 2015, in order to begin organizing and preparing to govern the Medicaid and NC Health Choice programs. The Board may begin meeting as soon as a majority of the appointments have been made and upon the call of the chair; however, the initial meeting shall be no later than September 1, 2015. The Division of Medical Assistance shall provide administrative support and meeting space to the Board prior to November 1, 2015.

(2) If the Governor does not make initial appointments to the Board by September 1, 2015, the Board members who have been appointed may select a chair from among the appointed members and may conduct the business of the Authority. Actions taken by the Board under this subdivision shall be

official actions of the Board, provided a majority of the appointed Board members are present and approve the action.

(3) In order to set the initial compensation for the voting Board members, the Office of State Human Resources shall survey the compensation paid to the members of comparable large health insurance plans. The Office shall complete the survey no later than September 1, 2015, and set the initial compensation for voting Board members no later than October 1, 2015. A voting Board member shall be eligible to receive compensation beginning on the first business day following the effective date of the member's appointment.

SECTION 12H.24.(j) Transfer of Rules. – Effective October 1, 2015, all rules and policies exempted from rule making related to the Medicaid and NC Health Choice programs shall transfer to the Health Benefits Authority. In its March 1, 2016, report to the Joint Legislative Oversight Committee on the Health Benefits Authority, the Health Benefits Authority shall include recommendations for additional exemptions from the rule-making requirements and contested case provisions in Chapter 150B of the General Statutes.

SECTION 12H.24.(k) Legal Actions. – For any legal action involving the Medicaid or NC Health Choice programs in which the Division of Medical Assistance or the Department of Health and Human Services is named as a party, the Health Benefits Authority may be joined as a party by reason of transfer of interest upon motion of any party pursuant to Rule 25(d) of the North Carolina Rules of Civil Procedure. This subsection shall not be construed to limit any other opportunities for joinder or intervention that are otherwise allowed under the North Carolina Rules of Civil Procedure or elsewhere under law.

SECTION 12H.24.(k1) The Commissioner of Insurance shall establish solvency requirements for MCOs and PLEs that contract with the Health Benefits Authority pursuant to this section. The same requirements shall apply to and may be based on existing requirements for similarly situated regulated entities. The Commissioner shall consult with the Authority in developing the requirements. The Commissioner shall make recommendations, including any statutory changes, to the Joint Legislative Oversight Committee on the Health Benefits Authority by March 1, 2016.

SECTION 12H.24.(l) Legislative Oversight of Medicaid. – Chapter 120 of the General Statutes is amended by adding the following new Article:

"Article 23B.

"Joint Legislative Oversight Committee on the Health Benefits Authority.

"**§ 120-209. Creation and membership of Joint Legislative Oversight Committee on the Health Benefits Authority.**

(a) The Joint Legislative Oversight Committee on the Health Benefits Authority is established. The Committee consists of 14 members as follows:

(1) Seven members of the Senate appointed by the President Pro Tempore of the Senate, at least two of whom are members of the minority party.

(2) Seven members of the House of Representatives appointed by the Speaker of the House of Representatives, at least two of whom are members of the minority party.

(b) Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year except initial appointments begin on the date of appointment. 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.

(c) A member continues to serve until a successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

"**§ 120-209.1. Purpose and powers of Committee.**

(a) The Joint Legislative Oversight Committee on the Health Benefits Authority shall examine budgeting, financing, administrative, and operational issues related to the Medicaid and NC Health Choice programs and to the Health Benefits Authority.

(b) The Committee may make periodic reports to the General Assembly on matters for which it may report to a regular session of the General Assembly.

"**§ 120-209.2. 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 the Health Benefits Authority. The Committee shall meet 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.

(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 Directors of Legislative Assistants 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.

(d) The Committee cochairs may establish subcommittees for the purpose of examining issues relating to its Committee charge.

"**§ 120-209.3. Additional powers.**

The Joint Legislative Oversight Committee on the Health Benefits Authority, while in discharge of official duties, shall have access to any paper or document, and may compel the attendance of any State official or employee before the Committee or secure any evidence under G.S. 120-19. In addition, G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee as if it were a joint committee of the General Assembly.

"**§ 120-209.4. Reports to Committee.**

Whenever the Health Benefits Authority is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees, the Health Benefits Authority shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on the Health Benefits Authority."

SECTION 12H.24.(m) G.S. 120-208.1(a)(2)b. is repealed.

SECTION 12H.24.(n) Recodification; Technical and Conforming Changes. – The Revisor of Statutes shall recodify existing law related to Medicaid and NC Health Choice, including Parts 6, 6A, 7, and 8 of Article 2, Article 5, and Article 7 of Chapter 108A of the General Statutes, as well as Chapters 108C and 108D of the General Statutes, into a new Chapter 108E of the General Statutes to be entitled "Medicaid and NC Health Choice Health Benefit Programs" and to have the following structure:

Article 1. Administration of the Medicaid and NC Health Choice Programs
- Part 1. Establishment of the Medicaid Program
- Part 2. Establishment of the NC Health Choice Program
- Part 3. Administration by County Departments of Social Services

Article 2. Medicaid and NC Health Choice Eligibility
- Part 1. In General
- Part 2. Eligibility for Medicaid
- Part 3. Eligibility for NC Health Choice

Article 3. Medicaid and NC Health Choice Benefits and Cost-Sharing
- Part 1. In General
- Part 2. Medicaid Benefits and Cost-Sharing
- Part 3. NC Health Choice Benefits and Cost-Sharing

Article 4. Medicaid and NC Health Choice Provider Requirements
Part 1. Provider Enrollment
Part 2. Provider Reimbursement and Recovery
Part 3. Hospital Assessment Act
Part 4. Other
Article 5. Third-Party Liability
Part 1. In General
Part 2. Subrogation
Part 3. Insurance
Part 4. Estate Recovery
Article 6. Fraud and Criminal Activity
Article 7. Appeals
Part 1. Eligibility Appeals for Medicaid and NC Health Choice
Part 2. Benefit Appeals for Medicaid
Subpart 1. Generally
Subpart 2. Medicaid Managed Care for Behavioral Health Services Appeals
Part 3. Benefit Reviews for NC Health Choice
Part 4. Provider Appeals

When recodifying, the Revisor is authorized to change all references to the North Carolina Department of Health and Human Services or to the Division of Medical Assistance to instead be references to the Health Benefits Authority. The Revisor may separate subsections of existing statutory sections into new sections and, when necessary to organize relevant law into its proper place in the above structure, may rearrange sentences that currently appear within subsections. The Revisor may modify statutory citations throughout the General Statutes, as appropriate, and may modify any references to statutory Divisions, such as "Chapter," "Article," "Part," "section," or "subsection." Within Articles 4 and 5 of Chapter 108A of the General Statutes, the Revisor of Statutes shall append to each reference to the North Carolina Department of Health and Human Services or to the Secretary of the Department the language "and, with respect to Medicaid and NC Health Choice, the Health Benefits Authority." The Revisor of Statutes may conform names and titles changed by this subsection, and may correct statutory references as required by this subsection, throughout the General Statutes. In making the changes authorized by this subsection, the Revisor may also adjust subject and verb agreement and the placement of conjunctions. The Revisor shall consult with the Department of Health and Human Services and the new Health Benefits Authority on this recodification.

SECTION 12H.24.(o) G.S. 108A-1 reads as rewritten:

"**§ 108A-1. Creation.**

Every county shall have a board of social services or a consolidated human services board created pursuant to G.S. 153A-77(b) which shall establish county policies for the programs established by this Chapter in conformity with the rules and regulations of the Social Services Commission and under the supervision of the Department of Health and Human Services. Provided, however, county policies for the program of medical assistance shall be established in conformity with the rules and regulations of the ~~Department of Health and Human Services~~ Health Benefits Authority."

SECTION 12H.24.(p) G.S. 108A-54.1A reads as rewritten:

"**§ 108A-54.1A. Amendments to Medicaid State Plan and Medicaid Waivers.**

(a) ~~No provision in the Medicaid State Plan or in a Medicaid Waiver may expand or otherwise alter the scope or purpose of the Medicaid program from that authorized by law enacted by the General Assembly. For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.~~ The Authority

is expressly authorized and required to take any and all necessary action to amend the State Plan and waivers in order to keep the program within the certified budget.

~~(b) The Department may submit amendments to the State Plan only as required under any of the following circumstances:~~

~~(1) A law enacted by the General Assembly directs the Department to submit an amendment to the State Plan.~~

~~(2) A law enacted by the General Assembly makes a change to the Medicaid Program that requires approval by the federal government.~~

~~(3) A change in federal law, including regulatory law, or a change in the interpretation of federal law by the federal government requires an amendment to the State Plan.~~

~~(4) A change made by the Department to the Medicaid Program requires an amendment to the State Plan, if the change was within the authority granted to the Department by State law.~~

~~(5) An amendment to the State Plan is required in response to an order of a court of competent jurisdiction.~~

~~(6) An amendment to the State Plan is required to ensure continued federal financial participation.~~

~~(c) Amendments to the State Plan submitted to the federal government for approval shall contain only those changes that are allowed by the authority for submitting an amendment to the State Plan in subsection (b) of this section.~~

(d) No fewer than 10 days prior to submitting an amendment to the State Plan to the federal government, the Department shall post the amendment on its Web site and notify the members of the Joint Legislative Oversight Committee on the Health Benefits Authority and the Fiscal Research Division that the amendment has been posted. This requirement shall not apply to draft or proposed amendments submitted to the federal government for comments but not submitted for approval. ~~The amendment shall remain posted on the Department's Web site at least until the plan has been approved, rejected, or withdrawn. If the authority for submitting the amendment to the State Plan is pursuant to subdivision (3), (4), (5), or (6) of subsection (b) of this section, then, prior to submitting an amendment to the federal government, the Department shall submit to the General Assembly members receiving notice under this subsection and to the Fiscal Research Division an explanation of the amendment, the need for the amendment, and the federal time limits required for implementation of the amendment.~~

~~(e) The Department shall submit an amendment to the State Plan to the federal government by a date sufficient to provide the federal government adequate time to review and approve the amendment so the amendment may be effective by the date required by the directing authority in subsection (b) of this section. Additionally, if a change is made to the Medicaid program by the General Assembly and that change requires an amendment to the State Plan, then the amendment shall be submitted at least 90 days prior to the effective date of the change as provided in the legislation.~~

(f) Any public notice required under 42 C.F.R. 447.205 shall, in addition to any other posting requirements under federal law, be posted on the Department's Web site. Upon posting such a public notice, the Department shall notify the members of the Joint Legislative Oversight Committee on the Health Benefits Authority and the Fiscal Research Division that the public notice has been posted. Public notices shall remain posted on the Department's Web site."

SECTION 12H.24.(q) G.S. 108A-54.2(d) is repealed.

SECTION 12H.24.(r) Part 1 of Article 2 of Chapter 108E of the General Statutes, created by the recodification process described in subsection (n) of this section, shall include the following two new sections:

"**§ 108E-2-1. General Assembly sets eligibility categories.**

Eligibility categories and income thresholds are set by the General Assembly, and the Authority shall not alter the eligibility categories and income thresholds from those authorized by the General Assembly. The Authority is expressly authorized to adopt temporary and permanent rules regarding eligibility requirements and determinations, to the extent that they do not conflict with parameters set by the General Assembly.

"**§ 108E-2-2. Counties determine eligibility.**

Counties determine eligibility in accordance with Chapter 108A of the General Statutes."

SECTION 12H.24.(s) G.S. 126-5 is amended by adding a new subdivision to read:

"**§ 126-5. Employees subject to Chapter; exemptions.**

...

(c1) Except as to the provisions of Articles 6 and 7 of this Chapter, the provisions of this Chapter shall not apply to:

...

(31) Employees of the Health Benefits Authority."

SECTION 12H.24.(t) G.S. 143B-153 reads as rewritten:

"**§ 143B-153. Social Services Commission – creation, powers and duties.**

There is hereby created the Social Services Commission of the Department of Health and Human Services with the power and duty to adopt rules and regulations to be followed in the conduct of the State's social service programs with the power and duty to adopt, amend, and rescind rules and regulations under and not inconsistent with the laws of the State necessary to carry out the provisions and purposes of this Article. Provided, however, the ~~Department of Health and Human Services~~Health Benefits Authority shall have the power and duty to adopt rules and regulations to be followed in the conduct of the State's medical assistance program.

...."

SECTION 12H.24.(u) G.S. 150B-1 reads as rewritten:

"**§ 150B-1. Policy and scope.**

...

(d) Exemptions from Rule Making. – Article 2A of this Chapter does not apply to the following:

...

(9) The ~~Department of Health and Human Services~~ Health Benefits Authority in adopting new or amending existing medical coverage policies for the State Medicaid and NC Health Choice programs pursuant to G.S. 108A-54.2.

...

(20) The ~~Department of Health and Human Services~~ Health Benefits Authority in implementing, operating, or overseeing new 1915(b)/(c) Medicaid Waiver programs or amendments to existing 1915(b)/(c) Medicaid Waiver programs.

...

(22) The ~~Department of Health and Human Services~~ Health Benefits Authority with respect to the content of State Plans, State Plan Amendments, and Waivers approved by the Centers for Medicare and Medicaid Services (CMS) for the North Carolina Medicaid Program and the NC Health Choice program.

...

(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

...

(17) The ~~Department of Health and Human Services~~ Health Benefits Authority with respect to the review of North Carolina Health Choice Program

determinations regarding delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services.

...."

SECTION 12H.24.(v) Appropriation. – Of the funds appropriated from the General Fund to the Department of Health and Human Services, Division of Medical Assistance, the sum of five million dollars ($5,000,000) in recurring funds for the 2015-2016 and the 2016-2017 fiscal years shall be used to accomplish the Medicaid transformation required by this section. These funds shall provide a State match for an estimated five million dollars ($5,000,000) in federal funds beginning in the 2015-2016 fiscal year. Upon request of the Board, but no later than October 1, 2015, the Department shall transfer these funds to the Health Benefits Authority to be used for Medicaid transformation.

SECTION 12H.24.(w) Medicaid Transformation Reserve Fund. – The Medicaid Transformation Reserve Fund is established in the Office of State Budget and Management as a nonreverting reserve in the General Fund. The purpose of the Medicaid Transformation Reserve Fund is to provide funds for converting from a fee-for-services payment system to a capitated payment system. Funds reserved in the Medicaid Transformation Reserve Fund shall be available only upon an appropriation by act of the General Assembly and do not constitute an "appropriation made by law," as that phrase is used in Section 7(1) of Article V of the North Carolina Constitution. The sum of one hundred eighty-five million six hundred four thousand six hundred fifty-three dollars ($185,604,653) in nonrecurring funds for fiscal year 2015-2016 and the sum of one hundred eighty-five million six hundred four thousand six hundred fifty-three dollars ($185,604,653) in nonrecurring funds for fiscal year 2016-2017 are hereby reserved in the Medicaid Transformation Reserve Fund.

SECTION 12H.24.(x) Effective Date. – Subsections (n) through (u) of this section become effective October 1, 2015. The remainder of this section is effective when this act becomes law.

INCREASE RATES TO PRIMARY CARE PHYSICIANS AND DISCONTINUE PRIMARY CARE CASE MANAGEMENT

SECTION 12H.25.(a) Effective January 1, 2016, the current Medicaid and Health Choice primary care case management (PCCM) program is discontinued. The Department of Health and Human Services shall not renew or extend the contract for PCCM services with North Carolina Community Care Networks, Inc. (NCCCN), beyond December 31, 2015.

SECTION 12H.25.(b) The Department of Health and Human Services shall take all actions necessary to discontinue the current Medicaid and Health Choice PCCM program as implemented by NCCCN. As soon as reasonably possible, but no later than October 1, 2015, the Department shall submit to the Centers for Medicare and Medicaid Services (CMS) a Medicaid State plan amendment eliminating the PCCM program. If CMS has not approved the State plan amendment by January 1, 2016, the Department of Health and Human Services nevertheless shall discontinue all payments related to the PCCM program beginning January 1, 2016, unless and until CMS denies the State plan amendment.

SECTION 12H.25.(c) This section shall not be construed to prohibit the Department of Health and Human Services from developing or utilizing contracts for managed care other than PCCM after January 1, 2016.

SECTION 12H.25.(d) Effective January 1, 2016, G.S. 108A-70.21(b) reads as rewritten:

"(b) Benefits. – All health benefits changes of the Program shall meet the coverage requirements set forth in this subsection. Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to

children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:

...

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

~~The Department shall provide services to children enrolled in the NC Health Choice Program through Community Care of North Carolina (CCNC) and shall pay Community Care of North Carolina providers the per member, per month fees as allowed under Medicaid.~~"

SECTION 12H.25.(e) Effective January 1, 2016, the rates paid to primary care physicians shall be one hundred percent (100%) of Medicare rates. For purposes of this section, the term primary care physicians refers to those physicians for whom the Affordable Care Act required payment at one hundred percent (100%) of the Medicare rate until January 1, 2015, and all OB/GYN physicians.

SECTION 12H.25.(f) Upon the discontinuation of the PCCM program, of the funds previously used for the NCCCN contract, the Department shall use six million four hundred seventy-five thousand dollars ($6,475,000) in fiscal year 2015-2016 and twelve million nine hundred fifty thousand dollars ($12,950,000) in fiscal year 2016-2017 to directly fund local health departments' continued services related to the Care Coordination for Children (CC4C) program, which was previously funded through the contract with NCCCN.

NC HEALTH CHOICE COST SETTLEMENT

SECTION 12H.26. Effective July 1, 2015, hospital outpatient services covered by NC Health Choice shall be cost settled at seventy percent (70%) of allowable costs, using the same methodology that is used for Medicaid.

BLOOD GLUCOSE TESTING EQUIPMENT AND SUPPLIES

SECTION 12H.27.(a) Notwithstanding any other provision of law, the Department of Health and Human Services, Division of Medical Assistance, (Department) is authorized to use any reimbursement methodology or arrangement to provide Medicaid coverage for blood glucose testing equipment and supplies, provided that the Department's total requirements, net of rebates, for providing blood glucose testing equipment and supplies does not exceed one million nine hundred thirty-three thousand three hundred fifty-seven dollars ($1,933,357) in fiscal year 2015-2016 and two million twenty thousand nine hundred seventy-four dollars ($2,020,974) in fiscal year 2016-2017.

SECTION 12H.27.(b) Any state plan amendment submitted to implement this section shall not be subject to the 90-day prior submission requirement of G.S. 108A-54.1A(e).

MEDICAID CONTINGENCY RESERVE

SECTION 12H.28.(a) Funds in the Medicaid Contingency Reserve established by Section 12H.38 of S.L. 2014-100 shall be used only for budget shortfalls in the Medicaid Program that occur during the 2015-2016 fiscal year. These funds shall be available for expenditure only upon an appropriation by act of the General Assembly.

SECTION 12H.28.(b) It is the intent of the General Assembly to appropriate funds from the Medicaid Contingency Reserve only if:

(1) The Director of the Budget, after the State Controller has verified that receipts are being used appropriately, has found that additional funds are needed to cover a shortfall in the Medicaid budget for the State fiscal year.

(2) The Department of Health and Human Services or the Health Benefits Authority created in Section 12H.24 of this act has submitted a State plan amendment to the Centers for Medicare and Medicaid Services to delink eligibility for Medicaid from eligibility for State-County Special Assistance,

to be effective 90 days after the date of submission of the State plan amendment. At least 45 days prior to submitting that State plan amendment, the Department of Health and Human Services or the Health Benefits Authority must have submitted a draft of that plan to the Joint Legislative Oversight Committee on the Health Benefits Authority and, if the General Assembly was not in session, must have consulted with the Committee on that draft.

(3) The Director of the Budget has reported immediately to the Fiscal Research Division on the amount of the shortfall found in accordance with subdivision (1) of this subsection. This report shall include an analysis of the causes of the shortfall, such as (i) unanticipated enrollment and mix of enrollment, (ii) unanticipated growth or utilization within particular service areas, (iii) errors in the data or analysis used to project the Medicaid budget, (iv) the failure of the program to achieve budgeted savings, (v) other factors and market trends that have impacted the price of or spending for services, (vi) variations in receipts from prior years or from assumptions used to prepare the Medicaid budget for the current fiscal year, or (vii) other factors. The report shall also include data in an electronic format that is adequate for the Fiscal Research Division to confirm the amount of the shortfall and its causes.

SECTION 12H.28.(c) Effective 90 days after the State plan amendment is submitted to the Centers for Medicare and Medicaid Services (CMS) or when CMS approves the State plan amendment, whichever occurs later, eligibility for Medicaid coverage is delinked from eligibility for State-County Special Assistance and recipients of State-County Special Assistance no longer automatically qualify for Medicaid coverage solely because of their receipt of State-County Special Assistance.

SECTION 12H.28.(d) Nothing in this section shall be construed to limit the authority of the Governor to carry out his duties under the Constitution.

SUBPART XII-I. DHHS BLOCK GRANTS

DHHS BLOCK GRANTS

SECTION 12I.1.(a) Except as otherwise provided, appropriations from federal block grant funds are made for each year of the fiscal biennium ending June 30, 2017, according to the following schedule:

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) FUNDS		FY 2015-2016	FY 2016-2017
Local Program Expenditures			
Division of Social Services			
01.	Work First Family Assistance	$57,167,454	$57,167,454
02.	Work First County Block Grants	80,093,566	78,073,437
03.	Work First Electing Counties	2,378,213	2,378,213
04.	Adoption Services – Special Children Adoption Fund	2,026,877	2,026,877

05.	Child Protective Services – Child Welfare Workers for Local DSS	9,412,391	9,412,391
06.	Child Welfare Collaborative	632,416	632,416
	Division of Child Development and Early Education		
07.	Subsidized Child Care Program	35,248,910	37,419,801
08.	Swap Child Care Subsidy	6,352,644	6,352,644
09.	Pre-K Swap Out	16,829,306	12,333,981
	Division of Public Health		
10.	Teen Pregnancy Prevention Initiatives	2,950,000	2,950,000
	DHHS Administration		
11.	Division of Social Services	2,482,260	2,482,260
12.	Office of the Secretary	34,042	34,042
13.	Eligibility Systems – Operations and Maintenance	2,738,926	4,206,640
14.	NC FAST Implementation	1,313,384	1,865,799
	Transfers to Other Block Grants		
	Division of Child Development and Early Education		
15.	Transfer to the Child Care and Development Fund	71,773,001	71,773,001
	Division of Social Services		
16.	Transfer to Social Services Block Grant for Child Protective Services – Training	1,300,000	1,300,000
17.	Transfer to Social Services Block Grant for Child Protective Services	5,040,000	5,040,000
18.	Transfer to Social Services Block Grant for County Departments of Social Services for Children's Services	4,148,001	4,148,001
19.	Transfer to Social Services Block Grant – Foster Care Services	1,385,152	1,385,152

TOTAL TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) FUNDS		**$303,306,543**	**$300,982,109**
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) EMERGENCY CONTINGENCY FUNDS			
Local Program Expenditures			
Division of Child Development and Early Education			
01.	Subsidized Child Care	29,033,340	28,600,000
02.	Subsidized Child Care Swap Out	4,547,023	0
TOTAL TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) EMERGENCY CONTINGENCY FUNDS		**$33,580,363**	**$28,600,000**
SOCIAL SERVICES BLOCK GRANT			
Local Program Expenditures			
Divisions of Social Services and Aging and Adult Services			
01.	County Departments of Social Services (Transfer From TANF $4,148,001)	$27,427,015	$27,165,668
02.	Child Protective Services (Transfer From TANF)	5,040,000	5,040,000
03.	State In-Home Services Fund	2,382,970	1,943,950
04.	Adult Protective Services	1,245,363	1,245,363
05.	State Adult Day Care Fund	1,994,084	1,994,084
06.	Child Protective Services/CPS Investigative Services – Child Medical Evaluation Program	563,868	563,868
07.	Special Children Adoption Incentive Fund	462,600	462,600
08.	Child Protective Services – Child Welfare Training for Counties (Transfer From TANF)	1,300,000	1,300,000
09.	Home and Community Care Block Grant (HCCBG)	1,696,888	1,696,888
10.	Child Advocacy Centers	375,000	375,000

11.	Guardianship	3,978,360	3,978,360
12.	Foster Care Services (Transfer From TANF)	1,385,152	1,385,152
	Division of Central Management and Support		
13.	DHHS Competitive Block Grants for Nonprofits	3,852,500	3,852,500
14.	NC FAST – Operations and Maintenance	712,324	939,315
	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services		
15.	Mental Health Services – Adult and Child/Developmental Disabilities Program/ Substance Abuse Services – Adult	4,030,730	4,030,730
	DHHS Program Expenditures		
	Division of Services for the Blind		
16.	Independent Living Program	3,361,323	3,361,323
	Division of Health Service Regulation		
17.	Adult Care Licensure Program	381,087	381,087
18.	Mental Health Licensure and Certification Program	190,284	190,284
	DHHS Administration		
19.	Division of Aging and Adult Services	577,745	577,745
20.	Division of Social Services	559,109	559,109
21.	Office of the Secretary/Controller's Office	127,731	127,731
22.	Division of Child Development and Early Education	13,878	13,878
23.	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	27,446	27,446
24.	Division of Health Service Regulation	118,946	118,946
TOTAL SOCIAL SERVICES BLOCK GRANT		**$61,804,403**	**$61,331,027**
LOW-INCOME ENERGY ASSISTANCE BLOCK GRANT			

Local Program Expenditures			
Division of Social Services			
01.	Low-Income Energy Assistance Program (LIEAP)	$40,244,534	$39,303,674
02.	Crisis Intervention Program (CIP)	40,244,534	39,303,674
Local Administration			
Division of Social Services			
03.	County DSS Administration	6,454,961	6,454,961
DHHS Administration			
04.	Office of the Secretary/DIRM	412,488	412,488
05.	Office of the Secretary/Controller's Office	18,378	18,378
06.	NC FAST Development	1,075,319	3,381,373
Transfers to Other State Agencies			
Department of Environment and Natural Resources (DENR)			
07.	Weatherization Program	11,847,017	11,570,050
08.	Heating Air Repair and Replacement Program (HARRP)	6,303,514	6,156,147
09.	Local Residential Energy Efficiency Service Providers – Weatherization	475,046	475,046
10.	Local Residential Energy Efficiency Service Providers – HARRP	252,761	252,761
11.	DENR – Weatherization Administration	475,046	475,046
12.	DENR – HARRP Administration	252,760	252,760
Department of Administration			
13.	N.C. Commission on Indian Affairs	87,736	87,736
TOTAL LOW-INCOME ENERGY ASSISTANCE BLOCK GRANT		**$108,144,094**	**$108,144,094**

CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT			
Local Program Expenditures			
Division of Child Development and Early Education			
01.	Child Care Services (Smart Start $7,000,000)	$154,678,008	$152,370,856
02.	Electronic Tracking System	801,240	401,492
03.	Transfer from TANF Block Grant for Child Care Subsidies	71,773,001	71,773,001
04.	Quality and Availability Initiatives (TEACH Program $3,800,000)	26,514,964	26,019,987
DHHS Administration			
Division of Child Development and Early Education			
05.	DCDEE Administrative Expenses	9,049,505	9,049,505
Division of Social Services			
06.	Local Subsidized Child Care Services Support	15,930,279	15,930,279
07.	NC FAST Development	186,404	586,152
Division of Central Administration			
08.	DHHS Central Administration – DIRM Technical Services	775,000	775,000
09.	Central Regional Maintenance	202,000	202,000
10.	Child Care Health Consultation Contracts	62,205	62,205
TOTAL CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT		**$279,972,606**	**$277,170,477**
MENTAL HEALTH SERVICES BLOCK GRANT			
Local Program Expenditures			
01.	Mental Health Services – Child	$3,619,833	$3,619,833
02.	Administration	200,000	200,000
03.	Mental Health Services – Adult/Child	11,755,152	11,755,152

04.	Crisis Solutions Initiative – Critical Time Intervention	750,000	750,000
05.	Mental Health Services – First Psychotic Symptom Treatment	643,491	643,491
TOTAL MENTAL HEALTH SERVICES BLOCK GRANT		**$16,968,476**	**$16,968,476**

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

Local Program Expenditures

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

01.	Substance Abuse – HIV and IV Drug	$3,919,723	$3,919,723
02.	Substance Abuse Prevention	8,669,284	8,669,284
03.	Substance Abuse Services – Treatment for Children/Adults	29,519,883	29,519,883
04.	Crisis Solutions Initiatives – Walk-In Crisis Centers	420,000	420,000
05.	Crisis Solutions Initiatives – Collegiate Wellness/Addiction Recovery	1,085,000	1,085,000
06.	Crisis Solutions Initiatives – Community Paramedic Mobile Crisis Management	60,000	60,000
07.	Crisis Solutions Initiatives – Innovative Technologies	41,000	41,000
08.	Crisis Solutions Initiatives – Veteran's Crisis	250,000	250,000
09.	Administration	454,000	454,000

Division of Public Health

10.	HIV Testing for Individuals in Substance Abuse Treatment	765,949	765,949
TOTAL SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT		**$45,184,839**	**$45,184,839**

MATERNAL AND CHILD HEALTH BLOCK GRANT

Local Program Expenditures

Division of Public Health			
01.	Children's Health Services (Safe Sleep Campaign $45,000; Prevent Blindness $560,837; Community-Based Sickle Cell Centers $100,000)	$7,574,703	$7,574,703
02.	Women's Health (March of Dimes $350,000; Teen Pregnancy Prevention Initiatives $650,000; 17P Project $52,000; Nurse-Family Partnership $509,018)	6,520,148	6,520,148
03.	Oral Health	44,901	44,901
04.	Evidence-Based Programs in Counties With Highest Infant Mortality Rates	1,575,000	1,575,000
DHHS Program Expenditures			
Division of Public Health			
05.	Children's Health Services	1,342,928	1,342,928
06.	Women's Health – Maternal Health	107,714	107,714
07.	State Center for Health Statistics	158,583	158,583
08.	Health Promotion – Injury and Violence Prevention	87,271	87,271
DHHS Administration			
Division of Public Health			
09.	Division of Public Health Administration	552,571	552,571
TOTAL MATERNAL AND CHILD HEALTH BLOCK GRANT		**$17,963,819**	**$17,963,819**
PREVENTIVE HEALTH SERVICES BLOCK GRANT			
Local Program Expenditures			
01.	Physical Activity and Prevention	$2,034,060	$2,034,060
02.	Injury and Violence Prevention (Services to Rape Victims – Set-Aside)	173,476	173,476
03.	Community-Focused Eliminating Health		

	Disparities Initiative Grants	2,756,855	0
DHHS Program Expenditures			
Division of Public Health			
04.	HIV/STD Prevention and Community Planning	145,819	145,819
05.	Oral Health Preventive Services	320,074	451,809
06.	Laboratory Services – Testing, Training, and Consultation	21,012	21,012
07.	Injury and Violence Prevention (Services to Rape Victims – Set-Aside)	192,315	192,315
08.	State Laboratory Services – Testing, Training, and Consultation	199,634	199,634
09.	Heart Disease and Stroke Prevention	273,772	405,507
10.	Performance Improvement and Accountability	839,736	971,471
11.	Physical Activity and Nutrition	68,073	68,073
12.	State Center for Health Statistics	107,291	107,291
DHHS Administration			
Division of Public Health			
13.	Division of Public Health	172,820	172,820
14.	Division of Public Health – Physical Activity and Nutrition Branch	1,243,899	0
TOTAL PREVENTIVE HEALTH SERVICES BLOCK GRANT		**$8,548,836**	**$4,943,288**
COMMUNITY SERVICES BLOCK GRANT			
Local Program Expenditures			
Office of Economic Opportunity			
01.	Community Action Agencies	$24,047,065	$24,047,065
02.	Limited Purpose Agencies	1,335,948	1,335,948

DHHS Administration			
03.	Office of Economic Opportunity	1,335,948	1,335,948
TOTAL COMMUNITY SERVICES BLOCK GRANT		**$26,718,961**	**$26,718,961**

GENERAL PROVISIONS

SECTION 12I.1.(b) Information to Be Included in Block Grant Plans. – The Department of Health and Human Services shall submit a separate plan for each Block Grant received and administered by the Department, and each plan shall include the following:

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

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

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

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

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

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

SECTION 12I.1.(c) Changes in Federal Fund Availability. – If the Congress of the United States increases the federal fund availability for any of the Block Grants or contingency funds and other grants related to existing Block Grants administered by the Department of Health and Human Services from the amounts appropriated in this section, the Department shall allocate the increase proportionally across the program and activity appropriations identified for that Block Grant in this section. In allocating an increase in federal fund availability, the Office of State Budget and Management shall not approve funding for new programs or activities not appropriated in this section.

If the Congress of the United States decreases the federal fund availability for any of the Block Grants or contingency funds and other grants related to existing Block Grants administered by the Department of Health and Human Services from the amounts appropriated in this section, the Department shall develop a plan to adjust the Block Grants based on reduced federal funding.

Notwithstanding the provisions of this subsection, for fiscal years 2015-2016 and 2016-2017, increases in the federal fund availability for the Temporary Assistance to Needy Families (TANF) Block Grant shall be used only for the North Carolina Child Care Subsidy program to pay for child care in four- or five-star-rated facilities for four-year-old children and shall not be used to supplant State funds.

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

SECTION 12I.1.(d) Except as otherwise provided, appropriations from federal Block Grant funds are made for each year of the fiscal biennium ending June 30, 2017, according to the schedule enacted for State fiscal years 2015-2016 and 2016-2017 or until a new schedule is enacted by the General Assembly.

SECTION 12I.1.(e) All changes to the budgeted allocations to the Block Grants or contingency funds and other grants related to existing Block Grants administered by the

Department of Health and Human Services that are not specifically addressed in this section shall be approved by the Office of State Budget and Management, and the Office of State Budget and Management shall consult with the Joint Legislative Oversight Committee on Health and Human Services for review prior to implementing the changes. The report shall include an itemized listing of affected programs, including associated changes in budgeted allocations. All changes to the budgeted allocations to the Block Grants shall be reported immediately to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division. This subsection does not apply to Block Grant changes caused by legislative salary increases and benefit adjustments.

SECTION 12I.1.(f) Except as otherwise provided, the Department of Health and Human Services shall have flexibility to transfer funding between the Temporary Assistance for Needy Families (TANF) Block Grant and the TANF Emergency Contingency Funds Block Grant so long as the total allocation for the line items within those block grants remains the same.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) FUNDS

SECTION 12I.1.(g) The sum of eighty million ninety-three thousand five hundred sixty-six dollars ($80,093,566) for the 2015-2016 fiscal year and the sum of seventy-eight million seventy-three thousand four hundred thirty-seven dollars ($78,073,437) for the 2016-2017 fiscal year appropriated in this section in TANF funds to the Department of Health and Human Services, Division of Social Services, shall be used for Work First County Block Grants. The Division shall certify these funds in the appropriate State-level services based on prior year actual expenditures. The Division has the authority to realign the authorized budget for these funds among the State-level services based on current year actual expenditures.

SECTION 12I.1.(h) The sum of nine million four hundred twelve thousand three hundred ninety-one dollars ($9,412,391) appropriated in this section to the Department of Health and Human Services, Division of Social Services, in TANF funds for each year of the 2015-2017 fiscal biennium for child welfare improvements shall be allocated to the county departments of social services for hiring or contracting staff to investigate and provide services in Child Protective Services cases; to provide foster care and support services; to recruit, train, license, and support prospective foster and adoptive families; and to provide interstate and post-adoption services for eligible families.

Counties shall maintain their level of expenditures in local funds for Child Protective Services workers. Of the Block Grant funds appropriated for Child Protective Services workers, the total expenditures from State and local funds for fiscal years 2015-2016 and 2016-2017 shall not be less than the total expended from State and local funds for the 2012-2013 fiscal year.

SECTION 12I.1.(i) The sum of two million twenty-six thousand eight hundred seventy-seven dollars ($2,026,877) appropriated in this section in TANF funds to the Department of Health and Human Services, Special Children Adoption Fund, for each year of the 2015-2017 fiscal biennium shall be used in accordance with G.S. 108A-50.2. The Division of Social Services, in consultation with the North Carolina Association of County Directors of Social Services and representatives of licensed private adoption agencies, shall develop guidelines for the awarding of funds to licensed public and private adoption agencies upon the adoption of children described in G.S. 108A-50 and in foster care. Payments received from the Special Children Adoption Fund by participating agencies shall be used exclusively to enhance the adoption services program. No local match shall be required as a condition for receipt of these funds.

SOCIAL SERVICES BLOCK GRANT

SECTION 12I.1.(j) The sum of twenty-seven million four hundred twenty-seven thousand fifteen dollars ($27,427,015) for the 2015-2016 fiscal year and the sum of twenty-seven million one hundred sixty-five thousand six hundred sixty-eight dollars ($27,165,668) for the 2016-2017 fiscal year appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Division of Social Services, shall be used for county block grants. The Division shall certify these funds in the appropriate State-level services based on prior year actual expenditures. The Division has the authority to realign the authorized budget for these funds among the State-level services based on current year actual expenditures.

SECTION 12I.1.(k) The sum of one million three hundred thousand dollars ($1,300,000) appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Division of Social Services, for each year of the 2015-2017 fiscal biennium shall be used to support various child welfare training projects as follows:

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

(2) Provide training for residential child caring facilities.

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

SECTION 12I.1.(l) The Department of Health and Human Services is authorized, subject to the approval of the Office of State Budget and Management, to transfer Social Services Block Grant funding allocated for departmental administration between divisions that have received administrative allocations from the Social Services Block Grant.

SECTION 12I.1.(m) Social Services Block Grant funds appropriated for the Special Children Adoption Incentive Fund will require a fifty-percent (50%) local match.

SECTION 12I.1.(n) The sum of five million forty thousand dollars ($5,040,000) appropriated in this section in the Social Services Block Grant for each year of the 2015-2017 fiscal biennium shall be allocated to the Department of Health and Human Services, Division of Social Services. The Division shall allocate these funds to local departments of social services to replace the loss of Child Protective Services State funds that are currently used by county governments to pay for Child Protective Services staff at the local level. These funds shall be used to maintain the number of Child Protective Services workers throughout the State. These Social Services Block Grant funds shall be used to pay for salaries and related expenses only and are exempt from 10A NCAC 71R .0201(3) requiring a local match of twenty-five percent (25%).

SECTION 12I.1.(o) The sum of three million eight hundred fifty-two thousand five hundred dollars ($3,852,500) appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Division of Central Management and Support, shall be used for DHHS competitive block grants pursuant to Section 12A.8 of this act for each year of the 2015-2017 fiscal biennium. These funds are exempt from the provisions of 10A NCAC 71R .0201(3).

SECTION 12I.1.(p) The sum of three hundred seventy-five thousand dollars ($375,000) appropriated in this section in the Social Services Block Grant for each year of the 2015-2017 fiscal biennium to the Department of Health and Human Services, Division of Social Services, shall be used to continue support for the Child Advocacy Centers, and the funds are exempt from the provisions of 10A NCAC 71R .0201(3).

SECTION 12I.1.(q) The sum of three million nine hundred seventy-eight thousand three hundred sixty dollars ($3,978,360) for each year of the 2015-2017 fiscal biennium appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Divisions of Social Services and Aging and Adult Services, shall be used for guardianship services pursuant to Chapter 35A of the General Statutes. The Department may expend funds appropriated in this section to support (i) existing corporate guardianship contracts during the 2015-2016 and 2016-2017 fiscal years and (ii) guardianship contracts

transferred to the State from local management entities or managed care organizations during the 2015-2016 and 2016-2017 fiscal years.

LOW-INCOME ENERGY ASSISTANCE BLOCK GRANT

SECTION 12I.1.(r) Additional emergency contingency funds received may be allocated for Energy Assistance Payments or Crisis Intervention Payments without prior consultation with the Joint Legislative Oversight Committee on Health and Human Services. Additional funds received shall be reported to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division upon notification of the award. The Department of Health and Human Services shall not allocate funds for any activities, including increasing administration, other than assistance payments, without prior consultation with the Joint Legislative Oversight Committee on Health and Human Services.

SECTION 12I.1.(s) The sum of forty million two hundred forty-four thousand five hundred thirty-four dollars ($40,244,534) for the 2015-2016 fiscal year and the sum of thirty-nine million three hundred three thousand six hundred seventy-four dollars ($39,303,674) for the 2016-2017 fiscal year appropriated in this section in the Low-Income Energy Assistance Block Grant to the Department of Health and Human Services, Division of Social Services, shall be used for Energy Assistance Payments for the households of (i) elderly persons age 60 and above with income up to one hundred thirty percent (130%) of the federal poverty level and (ii) disabled persons eligible for services funded through the Division of Aging and Adult Services.

County departments of social services shall submit to the Division of Social Services an outreach plan for targeting households with 60-year-old household members no later than August 1 of each year. The outreach plan shall comply with the following:

(1) Ensure that eligible households are made aware of the available assistance, with particular attention paid to the elderly population age 60 and above and disabled persons receiving services through the Division of Aging and Adult Services.

(2) Include efforts by the county department of social services to contact other State and local governmental entities and community-based organizations to (i) offer the opportunity to provide outreach and (ii) receive applications for energy assistance.

(3) Be approved by the local board of social services or human services board prior to submission.

CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT

SECTION 12I.1.(t) 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 12I.1.(u) If funds appropriated through the Child Care and Development Fund Block Grant for any program cannot be obligated or spent in that program within the obligation or liquidation periods allowed by the federal grants, the Department may move funds to child care subsidies, unless otherwise prohibited by federal requirements of the grant, in order to use the federal funds fully.

MENTAL HEALTH SERVICES BLOCK GRANT

SECTION 12I.1.(v) The sum of six hundred forty-three thousand four hundred ninety-one dollars ($643,491) appropriated in this section in the Mental Health Services Block Grant to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for each year of the 2015-2017 fiscal biennium is allocated for Mental Health Services – First Psychotic Symptom Treatment.

The Division shall report on (i) the specific evidence-based treatment and services provided, (ii) the number of persons treated, and (iii) the measured outcomes or impact on the participants served. The Division shall report to the House of Representatives Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division no later than December 31, 2016.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

SECTION 12I.1.(w) The sum of two hundred fifty thousand dollars ($250,000) appropriated in this section in the Substance Abuse Prevention and Treatment Block Grant to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for each year of the 2015-2017 fiscal biennium shall be allocated to the Department of Administration, Division of Veterans Affairs, to establish a call-in center to assist veterans in locating service benefits and crisis services. The call-in center shall be staffed by certified veteran peers within the Division of Veterans Affairs and trained by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

MATERNAL AND CHILD HEALTH BLOCK GRANT

SECTION 12I.1.(x) 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 2015-2016 fiscal year or the 2016-2017 fiscal year, then those funds shall be transferred to the State Board of Education to be administered by the Department of Public Instruction. The Department of Public Instruction shall use the funds to establish an abstinence until marriage education program and shall delegate to one or more persons the responsibility of implementing the program and G.S. 115C-81(e1)(4) and (4a). The Department of Public Instruction shall carefully and strictly follow federal guidelines in implementing and administering the abstinence education grant funds.

SECTION 12I.1.(y) The Department of Health and Human Services shall ensure that there will be follow-up testing in the Newborn Screening Program.

SECTION 12I.1.(z) The sum of one million five hundred seventy-five thousand dollars ($1,575,000) appropriated in this section in the Maternal and Child Health Block Grant to the Department of Health and Human Services, Division of Public Health, for each year of the 2015-2017 fiscal biennium shall be used for evidence-based programs in counties with highest infant mortality rates. The Division shall report on (i) the counties selected to receive the allocation, (ii) the specific evidenced-based services provided, (iii) the number of women served, and (iv) any impact on the counties' infant mortality rate. The Division shall report its findings to the House of Representatives Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division no later than December 31, 2016.

SECTION 12I.1.(aa) The sum of one hundred thousand dollars ($100,000) allocated in this section in the Maternal and Child Health Block Grant to the Department of Health and Human Services, Division of Public Health, for each year of the 2015-2017 fiscal biennium for community-based sickle cell centers shall not be used to supplant existing State or federal funds.

PART XIII. DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

TVA SETTLEMENT FUNDS

SECTION 13.2. In fiscal year 2015-2016, The Department of Agriculture and Consumer Services shall apply for two million two hundred forty thousand dollars ($2,240,000) from the Tennessee Valley Authority Settlement Agreement in compliance with the

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate

Committee On Appropriations

On

Health and Human Services

June 15, 2015

Room 422, LOB

4:00 PM

Senate Sergeant at Arms:

MARCUS KITTS

JIM HAMILTON

VISITOR REGISTRATION SHEET

SENATE APPROPRIATIONS HHS

(Committee Name)

6-15-15

Date

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Allison Stewart	Cardinal
Ryan Blackledge	Core Health
Leah Parsons	Gov's office
Adam Shelar	DHHS
Kerra Bolton	Wake Tech Media
Ruran Menald	UNC
Julia Adams-Schenwick	Arc, ASNC, MARC, NCARF
Tracy Kimbrell	Parker Poe
Erica Nelson	NCHA
Daniel Rain	Troutman Sanders
Ken Melton	K.M.H.
ANDY WALSH	SMITH ANDERSON
David Collins	SEANC
Jim Slate	DHHS
Trent Womble	DHHS
Marjorie Donaldson	DHHS

09-22-2012

Christin Danchi Rep. Stam

VISITOR REGISTRATION SHEET

(Committee Name)

Date

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