2017-2018

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

MEMBERS & STAFF

House Members	Senate Members
Representative Josh Dobson, Cochair	Senator Louis Pate, Cochair
Representative Donny Lambeth, Cochair	Senator Dan Bishop
Representative William Brisson	Senator David L. Curtis
Representative Carla D. Cunningham	Senator Jim Davis
Representative Nelson Dollar	Senator Valerie P. Foushee
Representative Beverly M. Earle	Senator Ralph Hise
Representative Jean Farmer-Butterfield	Senator Joyce Krawiec
Representative Bert Jones	Senator Gladys A. Robinson
Representative Chris Malone	Senator Jeff Tarte
Representative Gregory F. Murphy, MD	Senator Tommy Tucker
Representative Donna McDowell White	Senator Mike Woodard
Representative Gale Adcock, Advisory	Senator Tamara Barringer, Advisory
	Senator Michael V. Lee, Advisory

Committee Clerks	
Julie Ryan	DeAnne Mangum
Pan Briles	

Committee Staff	
Fiscal Research Division:	
Deborah Landry	Steve Owen
Denise Thomas	
Legislative Drafting Division:	
Lisa Wilks	Amy Jo Johnson
Joyce Jones	
Legislative Analysis Division:	
Theresa Matula	Jason Moran-Bates
Jennifer Hillman	Susan Barham

MINUTES
JOINT LEGISLATIVE OVERSIGHT COMMITTEE
HEALTH & HUMAN SERVICES

Tuesday, October 10, 2017
9:00 a.m.
Legislative Office Building, Room 643

ATTENDEES:

Chairmen: Pate, Dobson and Lambeth

House Members: **Brisson, Cummingham, Dollar, Earle, Malone, White and Adcock**
Senate Members: **Bishop, Krawiec, Tucker, Barringer**

I. Welcome and Opening Remarks

Chair, Donny Lambeth presided and called the meeting to order at 9:12 a.m.

Representative Lambeth introduced Sergeant-at-Arms Staff assisting with the meeting. Senator Pate welcomed members and guests.

II. Comments from the Secretary

North Carolina Secretary of Health and Human Services, Mandy Cohen, introduced members of her team: Susan Perry-Manning, Deputy Secretary for Human Services; Sam Gibbs, Deputy Secretary for Technology & Operations; Dave Richard, Deputy Secretary for Medical Assistance; and, Michael Becketts, Assistant Secretary for Human Services.

Secretary Cohen shared her concern of the opioid crisis and how the department would focus on effectively addressing the problem. Opioid overdose caused 1300 deaths in North Carolina during 2016.

III. Overview of the Committee's Purpose

Lisa Wilks, Legislative Drafting Division, reviewed Article 23A of the North Carolina General Statutes that establishes the Joint Legislative Oversight Committee on Health and Human Services.

IV. 2017 Session Resource Materials – Budget and Fiscal Highlights, Conference Committee Report Highlights, and Substantive Enacted HHS Legislation

Theresa Matula, Legislative Analysis Division, provided resource materials for members of the committee: 2017 Budget and Fiscal Policy Highlights; Conference Committee Report Selected Highlights for Health and Human Services; and, 2017 Substantive Enacted Legislation Pertaining to Health and Human Services.

V. Subcommittee Appointments

Chairman Lambeth announced the following subcommittee appointments:

Medical Education and Residency Programs Subcommittee

Senator Louis Pate, Cochair
Senator Jeff Tarte
Senator Mike Woodard

Representative Donny Lambeth, Cochair
Representative Gregory F. Murphy, MD
Representative Jean Farmer-Butterfield

Behavioral Health Subcommittee

Senator Tommy Tucker, Cochair
Senator Dan Bishop
Senator Gladys Robinson

Representative Chris Malone, Cochair
Representative Burt Jones
Representatve William Brisson

Aging Subcommittee

Senator Joyce Krawiec, Cochair
Senator David Lewis
Senator Valerie Foushee

Representative Josh Dobson, Cochair
Representative Donna McDowell-White
Representative Beverly Earle

Meeting dates and times will be announced at a future time.

VI. Child Welfare Updates

Implementation of the Federal Program Improvement Plan (S.L. 2017-57, Sec. 11C.7)

Susan Perry-Manning, Deputy Secretary for Human Services, provided an overview of key legislation at both the Federal and State levels. The top priority is prevention services that ensure a safe permanent home for children as quickly as possible. During the 2016-17 fiscal year, 11,205 youth were placed in foster care – an increase over the previous year of 688 youth. The increase is due to a variety of issues that include parental opioid use and parental mental health.

Michael Becketts, Assistant Secretary, highlighted the Child and Family Services Review. The Federal performance review conducted in 2015 included a sample of child welfare cases from ten counties. North Carolina was rated on seven outcome measures that focused on child and family well-being and seven systemic factors that focused on staff training, monitoring and quality assurance, and availability and provision of appropriate services.

Mr. Becketts reported that, because North Carolina failed to meet expectations in each of the 14 CFSR areas, NCCFS was placed on a two-year Federal Program Improvement Plan designed to improve statewide performance. Implementation began January 2017 and will run through December 2018.

New leadership in DHHS Division of Social Services and Child Welfare is focusing on outcomes and will measure progress quarterly. Mr. Becketts stated that the department is continuing implementation of NC FAST Child Welfare module to ensure accountability and improve performance.

NC FAST Implementation of the Child Welfare Case Management System
Deputy Secretary for Technology and Operations, Sam Gibbs, provided an up-to-date of the NC FAST management system. Statewide implementation with enhancements is scheduled for June 2018. Mr. Gibbs indicated that additional funding is needed for on-site support to assist county child welfare staff incorporate the use of NC FAST.

Planning for Implementation of Rylan's Law/Family/Child Protection and Accountability Act (S.L. 2017-41)
Mr. Becketts reviewed the provisions of the Family-Child Protection and Accountability Act. The creation of a regional supervision structure of county social services departments will recommend any regulatory or legislative changes necessary to improve collaboration between counties and identify potential benefits and challenges for transitioning North Carolina from county-administered to a regionally-administered system.

The Act also requires a reform of the existing social services system that focuses on mutual accountability and corrective action. Also included will be the establishment of a Child Well-being Transformation Council and the implementation of specific policy and regulatory changes to improve the well-being of children and youth in foster care. Among the changes will be a driver's license pilot project to promote independence.

Mr. Becketts indicated that the timeline which began July 1, 2017 is very aggressive with full implementation by September 2020. Mr. Becketts reported that progress to date included an RFP issued on September 29th, 2017 for the third-party organization. Additionally, the Working Group held its first meeting on October 3rd.

Chairman Pate and Senators Barringer and Tucker expressed concerns regarding the NC FAST system and cited incidences of horrific child abuse and neglect. Representative Dollar spoke to the urgency of identifying and correcting current procedures.

VII. NC Pre-K Update on Slots

Susan Perry-Manning reported that Pre-K administrators in all North Carolina counties were offered an opportunity to request additional slots. A total of 4,896 slots were requested. Each of the fifty-six counties that requested expansion received additional slots. As a result, an additional 1,655 children are now being served.

Representative Dobson expressed concern regarding capacity to manage increased enrollment. Ms. Perry-Manning responded that capacity is a concern and that business partners are helping. She stated that licensed teachers and transportation are also concerns.

Representatives Earle, Dollar, Cunningham and Senator Pate responded to the report.

VIII. Overview of Interim Investigative Report of Cardinal Innovations Healthcare Solutions

Deputy Secretary Dave Richard provided a copy of the Special Investigations of Cardinal Innovations Healthcare Solutions conducted by the North Carolina Office of the Internal Auditor-Health and Human Services. The interim investigation determined that several items warrant attention which include:

- The employment contract of the CEO that provides severance payments for a broad range of reasons;
- Length of time severance payments are to be made;
- Employment contracts with six other executives and four key employees that also include severance provisions;
- Payment of severance payments for reasons other than termination of employment
- Salary and bonuses of CEO that are more than three times higher than those of the CEOs at the State's six other LME/MCOs;
- Additional compensation that is three times higher than the maximum allowable for the position established by the NC Office of State Human Resources; and,
- Cardinal's average bonus during FY 2016 that ranged from 156% to 311% higher than the other two LME/MCOs who pay bonuses.

Cardinal receives funding from the Division of Medical Assistance (DMA) and the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS). During the State's fiscal years 2015 and 2016, Cardinal received $567 million and $587 million respectively from DMA and payments of $86 million and $88 million respectively from DMHDDSAS.

The following committee members responded to the report: Senators Tucker, Barringer, Krawiec, Bishop and Chairman Pate; and, Representatives Dollar, Cunningham, Earle, and White.

Deputy Secretary Richard informed the committee that concerns would be layed out at a Board meeting in November. "Our goal is to provide oversite and operate within the law," he said.

IX. Adjournment

The Joint Legislative Oversight Committee on Health and Human Services adjourned at 11:55 a.m. Representative Lambeth announced that the next meeting is scheduled for Tuesday, November 14, 2017.

Representative Donny Lambeth, Chair

Panthea Briles, Committee Clerk

Attachment: Agenda
Handouts

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

October 10, 2017 9:00 a.m.
Legislative Office Building - Room 643

Committee Cochairs
Rep. Josh Dobson
Rep. Donny Lambeth
Sen. Louis Pate

Legislative Members
Rep. William D. Brisson
Rep. Carla D. Cunningham
Rep. Nelson Dollar
Rep. Beverly M. Earle
Rep. Jean Farmer-Butterfield
Rep. Bert Jones
Rep. Chris Malone
Rep. Gregory F. Murphy, MD
Rep. Donna McDowell White
Sen. Dan Bishop
Sen. David L. Curtis
Sen. Jim Davis
Sen. Valerie P. Foushee
Sen. Ralph Hise
Sen. Joyce Krawiec
Sen. Gladys A. Robinson
[illegible]n. Jeff Tarte
[illegible]. Tommy Tucker
Sen. Mike Woodard

Advisory Members
Rep. Gale Adcock
Sen. Tamara Barringer
Sen. Michael V. Lee

I.	**Welcome & Opening Remarks**	**Representative Donny Lambeth** Presiding Cochair
II.	**Comments from the Secretary**	**Mandy Cohen, MD**, Secretary, Department of Health & Human Services (DHHS)
III.	**Overview of the Committee's Purpose (Article 23A, Chapter 120)**	**Lisa Wilks,** Committee Staff
IV.	**2017 Session Resource Materials - Budget and Fiscal Highlights, Conference Committee Report Highlights, & Substantive Enacted HHS Legislation**	**Theresa Matula,** Committee Staff
V.	**Subcommittee Appointments**	**Representative Donny Lambeth** Presiding Cochair
VI.	**Child Welfare Updates:**	
	• **Implementation of the Federal Program Improvement Plan (S.L. 2017-57, Sec. 11C.7)**	**Susan Perry-Manning** , Deputy Secretary for Human Services & **Michael Becketts**, Assistant Secretary for Human Services, DHHS
	• **NC FAST Implementation of the Child Welfare Case Management System**	**Sam Gibbs**, Deputy Secretary for Technology and Operations & **Michael Becketts**, Assistant Secretary for Human Services, DHHS
	• **Planning for Implementation of Rylan's Law/Family/Child Protection and Accountability Act (S.L. 2017-41)**	**Michael Becketts**, Assistant Secretary for Human Services, DHHS
VII.	**NC Pre-K Update on Slots**	**Susan Perry-Manning** , Deputy Secretary for Human Services, DHHS
VIII.	**Overview of Interim Investigative Report of Cardinal Innovations Healthcare Solutions**	**Dave Richard,** Deputy Secretary for Medical Assistance, DHHS
IX.	**Adjourn** **Next Meeting: November 14, 2017**	

Article 23A.

Joint Legislative Oversight Committee on Health and Human Services.

§ 120-208. Creation and membership of Joint Legislative Oversight Committee on Health and Human Services.

(a) The Joint Legislative Oversight Committee on Health and Human Services is established. The Committee consists of 22 members as follows:

(1) Eleven members of the Senate appointed by the President Pro Tempore of the Senate, at least three of whom are members of the minority party; and

(2) Eleven members of the House of Representatives appointed by the Speaker of the House of Representatives, at least three 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. 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. (2011-291, s. 1.6(c).)

§ 120-208.1. Purpose and powers of Committee.

(a) The Joint Legislative Oversight Committee on Health and Human Services shall examine, on a continuing basis, the systemwide issues affecting the development, budgeting, financing, administration, and delivery of health and human services, including issues relating to the governance, accountability, and quality of health and human services delivered to individuals and families in this State. The Committee shall make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of effectiveness and efficiency in system administration at the State and local levels. In conducting its examination, the Committee shall do all of the following:

(1) Study the budgets, programs, and policies of each Division within the Department of Health and Human Services, to determine ways in which the General Assembly may encourage improvement in the budgeting and delivery of health and human services provided to North Carolinians;

(2) Examine, in particular, issues relating to services provided by the following Divisions within the Department of Health and Human Services:

a. Aging and Adult Services.

b. Repealed by Session Laws 2015-245, s. 16, effective September 23, 2015.

c. Mental Health, Developmental Disabilities, and Substance Abuse Services.

d. Public Health.

e. Social Services;

(3) Study other states' health and human services initiatives, in order to provide an ongoing commentary to the General Assembly on these initiatives and to

make recommendations for implementing similar initiatives in North Carolina; and

(4) Study any other health and human services matters that the Committee considers necessary to fulfill its mandate.

(b) The Committee may make interim reports to the General Assembly on matters for which it may report to a regular session of the General Assembly. A report to the General Assembly may contain any legislation needed to implement a recommendation of the Committee. (2011-291, s. 1.6(c); 2015-245, s. 16.)

§ 120-208.2. 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 Health and Human Services. The Committee shall meet at least once per quarter, except while the General Assembly is in regular session, and may meet at other times upon the joint call of the cochairs.

(b) A quorum of the Committee is 10 members. No action may be taken except by a majority vote at a meeting at which a quorum is present. While in the discharge of its official duties, the Committee has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4.

(c) Members of the Committee receive subsistence and travel expenses as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Supervisors of Clerks of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee.

(d) The Committee cochairs may establish subcommittees for the purpose of examining issues relating to services provided by particular Divisions within the Department of Health and Human Services. (2011-291, s. 1.6(c).)

§ 120-208.3. Additional powers.

The Joint Legislative Oversight Committee on Health and Human Services, 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. (2011-291, s. 1.6(c).)

§ 120-208.4. Reports to the Committee.

(a) Whenever a Division within the Department of Health and Human Services is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees on matters affecting that Division, the Department shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on Health and Human Services.

(b) Beginning no later than November 1, 2012, and annually thereafter, the Department of Health and Human Services shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the use of lapsed salary

funds by each Division within the Department. For each Division, the report shall include the following information about the preceding State fiscal year:

(1) The total amount of lapsed salary funds.

(2) The number of full-time equivalent positions comprising the lapsed salary funds.

(3) The Fund Code for each full-time equivalent position included in the number reported pursuant to subdivision (2) of this section.

(4) The purposes for which the Department expended lapsed salary funds. (2011-291, s. 1.6(c); 2012-142, s. 10.20; 2013-360, s. 12A.11.)

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Fiscal Research Division

Budget Development

NC 2017 Legislative Session
Budget and Fiscal Policy Highlights

Budget Brief

September 27, 2017

Introduction

During the 2017 session, the General Assembly enacted a State budget for FY 2017-18 that provides $23 billion in net General Fund appropriations and makes significant statutory policy changes. The FY 2017-18 budget represents a 3.5% increase over the base operating budget. Session Law 2017-57 (S.B. 257), the 2017 Appropriations Act, provides salary increases for educators and State employees, increasing the ongoing monthly benefit for retirees, and additional funds for the Savings Reserve, the Repairs and Renovations Reserve, and disaster relief efforts. The legislation also includes reductions to the Individual and Corporate Income Tax rates and enacts the Juvenile Justice Reinvestment Act. More specifically, the major components of the Appropriations Act include:

- Lowered the Individual Income and Corporate Income tax rates, increased the standard deduction for Individual Income, reduced the Franchise tax on S-corporations, created various exemptions to the Sales and Use tax, repealed the Mill Machinery tax, and extended the Renewable Energy tax credit for projects claiming refunds by 1/1/2018.
- $181 million to provide a $1,000 salary increase to most State-funded employees.
- $102 million to increase the salaries for teachers and instructional support personnel.
- $35.4 million to increase the salaries for Principals and Assistant Principals.
- $44 million to provide a 1.0% cost-of-living adjustment for State retirees.
- Establishment of a Pay-As-You-Go Capital and Infrastructure Fund effective July 1, 2019.
- Enactment of the Juvenile Justice Reinvestment Act by increasing the age range for juvenile court jurisdiction from under-16-years old to under-18-years old.
- Creation of a new Needs-Based Public School Capital Fund with $30 million from Education Lottery proceeds.
- An additional $100 million for disaster recovery, supplementing, the $200 million appropriated in S.L. 2016-124, Disaster Recovery Act of 2016.
- An additional $364 million for the Savings Reserve, and $125 million for repairs and renovations.
- Left remaining a $499.3 million unappropriated balance in the General Fund for the first year of the fiscal biennium.

General Fund Availability, Revenue, and Tax Changes

The total amount of funds available in the General Fund for FY 2017-18, excluding State agency receipts, is $23.5 billion (See Appendix A). The $23.5 billion in availability consists of: the beginning unreserved fund balance, forecasted General Fund revenues, and adjustments for enacted tax law changes.

Beginning Unreserved General Fund Balance

The projected unreserved fund balance at the end of FY 2016-17 was $961 million:

- $109 million in unappropriated funds from the FY 2016-17 budget, adjusted for appropriations made in the Disaster Recovery Act;
- $271 million in reversions (i.e., appropriated but unexpended funds); and
- $581 million in over collected revenue.

From this balance, $263 million was earmarked and another $101 million restored to the Savings Reserve to offset Disaster Recovery Act appropriations made in December 2016, bringing the Reserve's balance to $1.8 billion. The General Assembly also earmarked $125 million for repairs and renovations, resulting in a beginning unreserved fund balance of $471 million in funds available for other purposes in FY 2017-18.

General Fund Revenue

The single largest source of projected State General Fund availability is tax revenue, which the Fiscal Research Division (FRD) and the Office of State Budget and Management (OSBM) estimate through a consensus revenue forecasting process. The joint estimate was projected to be $23.2 billion for FY 2017-18, before tax law changes.

Tax Law Changes

The Appropriations Act includes adjustments to the Individual Income Tax, Corporate Income Tax, Franchise Tax, and Sales and Use Tax.

Individual Income Tax. The Appropriations Act reduces the Individual Income tax rate from 5.499% to 5.25% effective for the 2019 tax year. The Standard Deduction is increased from $17,500 to $20,000 beginning in 2019 and the standard deduction for head of household filers is changed from 80% to 75% of the amount for married filing jointly taxpayers. The child care tax credit is repealed and replaced with a deduction for child care expenses, effective for the 2018 tax year. These changes to personal income tax will reduce revenue by $782.9 million in FY 2019-20, the first full year of implementation.

Corporate Income Tax. In 2015, the General Assembly reduced the corporate income tax rate from 5% to 4% and provided for a further decrease to 3% if a General Fund revenue target was met. That rate reduction trigger was met, and the rate dropped to 3% in 2017. The Appropriations Act further reduces the corporate income tax, to 2.5%, effective for the 2019 tax year. This change will reduce availability by $130.9 million in FY 2019-20, the first full year of implementation.

Franchise Tax. The Appropriations Act reduces the franchise tax rate for S corporations by applying a flat $200 on the first $1 million of the entity's tax base, applicable to the calculation of franchise tax reported by the entity on 2018 and later corporate income tax returns. This change reduces availability by approximately $20 million annually beginning in FY 2018-19.

Sales and Use Tax. The Appropriations Act exempts from sales tax distribution equipment, and accessories, or repair parts for distribution equipment, sold to a large fulfillment facility, effective July 1, 2017.

Renewable Energy Tax Credit. The Appropriations Act allows certain biomass resource-related projects to claim the renewable energy tax credit if it had a certain minimum level of completion prior to January 1, 2016, and it was placed in service prior to May 5, 2017.

Other Taxes. Other changes to State tax laws include:

- Sales tax exemptions include:
    - Distribution equipment, and accessories, attachments, or repair parts for distribution equipment, sold to a large fulfillment facility, effective July 1, 2017.
    - **Mill machinery** and certain other manufacturing and industrial equipment (replaces the current 1%/$80 privilege tax applicable), effective July 1, 2018.
    - Repair or replacement parts for a ready mix concrete mill, regardless of whether the mill is freestanding or affixed to a motor vehicle, effective July 1, 2018.
    - Certain expenses associated with transformative investment opportunities, which require a business to invest at least $4 billion and create at least 5,000 jobs.

General Fund Appropriations and Budgetary Actions

The budget enacted by the General Assembly provides $23 billion in net General Fund appropriations in FY 2017-18, and includes salary increases and benefit changes for State employees, and various adjustments to State agency budgets.

Salary and Benefit Changes

Salary Increases for Most State-funded Employees. The net General Fund budget includes approximately $12 billion, excluding agency receipts and other sources of funds, in FY 2017-18 to support the salaries of over 248,600 full-time equivalent (FTE) State-funded positions in State agencies, the University of North Carolina (UNC) system, community colleges, and Local Education Agencies (LEAs). Notable compensation increases provided in the Appropriations Act include:

- $181 million to provide a $1,000 salary increase to most State employees and non-certified personnel in LEAs,
- $102 million to increase salaries for teachers and instructional support personnel paid according to the teacher salary schedule (see Appendix B),
- $18.4 million to complete the third and final phase of Correctional Officer custody-based salary increases, and,
- $35.4 million to increase salaries for School-Based Administrators (Principals/Assistant Principals).

LEA Performance-Based Pay. The Appropriations Act overhauls the principal salary schedule by replacing the prior schedule based on experience and number of supervised positions with a schedule based on school size and school growth (see Appendix C). The new schedule sets principal salaries higher, on average, than the previous salary schedule, with early career principals receiving the largest increases. A principal can receive a salary increase above the base salary for the respective school size by meeting (10% increase) or exceeding (20% increase) the Education Value Added Assessment System (EVAAS) growth expectations in 2 of 3 years.

In addition to the new principal salary schedule, principals are eligible to receive bonuses based on their supervised school's growth. Principals in the top 50% of the State in school growth will receive a bonus ranging from $1,000 to $5,000 depending on school-growth ranking. Principals supervising a school that is not exceeding growth expectations

and subsequently receives an exceeded growth evaluation will receive an additional bonus of $5,000 (the bonus increases to $10,000 if the school is a grade D or F as measured under G.S. 115C-83.15(d)).

Sections 8.8D and 8.8E of the Appropriations Act create a $25.3 million nonrecurring bonus program for FY 2017-18 to provide reading performance bonuses to teachers from grades 4 through 8, and math performance bonuses to teachers in grades 4 and 5 based on EVAAS growth scores. For each subject, teachers in the top 25% of the State or within their LEA will receive a $2,150 bonus.

Retirement Systems. The Appropriations Act funds each of the State-supported retirement systems at the actuarially determined employer contribution (ADEC) or higher, reflecting all impacts of 2017 legislation. The employer contribution rate for the Teachers and State Employees' Retirement System (TSERS) is increased to 10.78% of an employee's pay for FY 2017-18. The additional net appropriations for this increase are $81 million in FY 2017-18. TSERS, which is the largest of the retirement systems, has 305,000 contributing members, 200,000 beneficiaries, and pays retirement benefits of $4.2 billion annually to retirees of State agencies, departments, institutions, universities, local public schools, and community colleges.

The Appropriations Act also provides a 1.0% cost-of-living adjustment (COLA) to retirees of TSERS, the Consolidated Judicial Retirement System, and the Legislative Retirement System at a recurring cost of $44 million and makes probation/parole officers eligible for certain law-enforcement retirement benefits at a recurring cost of $2 million. These additional costs are included in the contribution increase amounts.

State Health Plan (SHP). The SHP administers health benefit coverage for 715,000 active State agency, department, institution, university, local public school, and community college employees; eligible retired employees; certain dependents of active and retired employees; active and retired employees of selected local governments; and certain fire and rescue squad and National Guard members. Total funding requirements for the SHP from all sources for FY 2017-18 is projected to be approximately $3.5 billion. 2017 premiums for the SHP are shown in Appendix D.

The Appropriations Act includes an additional $80 million to increase SHP employer premiums by 4% in January 2018, which includes increased contributions to cover retirees in the SHP.

Section 35.21 of the Appropriations Act amends Article 3B of Chapter 135 of the General Statutes to require that future retirees earn contributory retirement service in a State retirement system prior to January 1, 2021, and do not withdraw that service, among other requirements, in order to be eligible for coverage in the SHP as a retiree under the amended law. That section also establishes a committee to study State employee compensation and benefits and requires report of its findings by February 1, 2019.

Budget Adjustments by Appropriations Committee Area

The chart below shows the total base and enacted agency budgets for each appropriations committee for the 2017-18 fiscal year.

Budget Comparison by Appropriations Committee
FY 2017-18 Base vs. 2017-18 Enacted[1] Budgets ($ millions)

Committee/Area	FY 2017-18 Base	FY 2017-18 Enacted	% Change
Education[2]	12,609.1	13,109.1	4.0%
Health and Human Services	5,273.9	5,253.3	(0.4%)
Justice and Public Safety	2,623.9	2,701.9	3.0%
Agriculture and Natural and Economic Resources	541.9	587.8	8.5%
General Government	384.4	409.6	6.6%
Debt Service, Reserves, IT and Capital	761.5	919.0	20.7%
Total Net General Fund Appropriations	**$22,194.7**	**$22,980.7**	**3.5%**

[1]-As amended by S.L. 2017-197, Budget Technical Corrections.

[2]-Enrollment growth funds appropriated in Statewide Reserves have been included in Education Committee totals for comparison purposes.

Education. Major budget and policy changes in Education include:

- Providing an additional $6.3 million in each year of the biennium to serve a greater percentage of school-age children with disabilities. School districts will receive $4,254 for each child identified with disabilities up to a 12.75% of the school district's average daily membership (ADM). In previous fiscal years, a school district's funding was capped at 12.5% of ADM.

- Prohibiting school districts from transferring funds out of four public school allotments. Beginning in 2017-18, school districts are prohibited from transferring funds out of the Children with Disabilities or Limited English Proficiency allotments. In FY 2018-19, two additional allotments are subject to the prohibition: Academically or Intellectually Gifted and Textbooks and Digital Resources.

- Creating the Joint Legislative Task Force on Education Finance Reform consisting of 18 legislators (9 from each chamber) to study various weighted student formula funding models and develop a new funding model for elementary and secondary public schools.

An expanded summary of legislative actions impacting agency budgets and public policy under the purview of the Education Appropriations Committees can be found here.

Justice and Public Safety. The Juvenile Justice Reinvestment Act, Section 16D.4 of the Appropriations Act, increases the age range for juvenile court jurisdiction from under-16-years-old to under-18-years-old. Class A through Class G felony offenses must be tried in adult court, while Class H and Class I felonies and all misdemeanors are tried in juvenile court unless they are transferred to adult court.

While some portions of the Juvenile Justice Reinvestment Act have already taken effect, the primary policy change of increasing the age of jurisdiction for H-I felonies and all misdemeanors has an effective date of December 1, 2019. The budget contains $519,600 in the first year of the biennium and $478,000 in the second year for the planning phases of implementation, along with $13.2 million in capital funding for a new Youth Development Center. However, the bulk of the Act's costs will be closer to the effective date.

Fiscal Research, in a fiscal note for a similar bill considered in the 2017 Regular Session, estimated that the Department of Public Safety (DPS), Indigent Defense Services (IDS), and the Administrative Office of the Courts (AOC) would begin incurring costs in FY 2019-20, while full costs would not be incurred until FY 2020-21. If this implementation timeline holds, Fiscal Research estimates the Act will cost all impacted agencies a total of $28.5 million (261 FTE) in FY 2019-20 and $40.8 million (411.5 FTE) in FY 2020-21. Future years will likely track with FY 2020-21 expenditures, with adjustments for inflation and changes in the juvenile delinquent population.

A Juvenile Jurisdiction Advisory Committee is established to develop and present cost estimates and a plan for implementation, including potential extension of juvenile jurisdiction in other offenses, to the General Assembly.

A more detailed summary of budget actions in Justice and Public Safety can be found here.

Other Significant Budget Policy:

Savings Reserve Changes

Session Law 2017-5, Strengthen Savings Reserve, made major changes to the State's primary means for addressing revenue shortfalls during an economic downturn or an unforeseen event. Prior to this law's passage, Chapter 143C, the State Budget Act had: 1) required that 25% of the State's unreserved fund balance be transferred to the Savings Reserve at the end of each fiscal year and, 2) set a goal to maintain a balance in the Savings Reserve equal to or greater than 8% of the prior year's General Fund operating budget.

Effective October 1, 2017, S.L. 2017-5 replaces the requirements set in G.S. 143C-4-2, and institutes a new savings target for the Savings Reserve, "...sufficient to cover 2 years of need for 9 out of 10 scenarios involving a decline in General Fund revenue from one fiscal year to the next fiscal year." The new law also eliminates the 25% unreserved fund balance transfer directive, and instead requires the General Assembly to include in each Current Operations Appropriations Act a transfer into the Savings Reserve of at least 15% of each fiscal year's estimated growth in State tax revenues that are deposited in the General Fund.

The act establishes the following the parameters for use of the Savings Reserve:

- Upon a majority vote of each chamber in the General Assembly and in an amount totaling no more than 7.5% of the State's prior year operating budget, the Reserve may be used to address revenue declines; operating budget shortfalls; costs imposed by a court and, for addressing an emergency as defined in G.S. 166A-19.3.

- Upon a two-thirds vote of each chamber in the General Assembly, the amount of funds drawn from the Reserve may exceed the 7.5% cap and be used for the purposes enumerated above.

- Upon a two-thirds vote of each chamber of the General Assembly, the Reserve may be used in an amount determined by and for purposes deemed appropriate at the discretion of the General Assembly.

With S.L. 2017-5 not becoming effective until October 1, 2017, the General Assembly was subject to the prior Savings Reserve requirements in developing the FY 2017-19 Appropriations Act. The 2017 Appropriations Act earmarks $263 million of the unreserved fund balance to the Savings Reserve, bringing the total in the Reserve to just under $1.84 billion, or about 8.2% of the prior year net General Fund operating budget, the largest total since inception of the Reserve. The budget also accounts for an estimated $72 million transfer into the Savings Reserve in FY 2018-19 due to projected growth in tax revenues.

Pay-As-You-Go Capital and Infrastructure Fund

The Appropriations Act establishes the Pay-As-You-Go Capital and Infrastructure Fund (Fund) on July 1, 2019. G.S.143C-4-3, the State's Repairs and Renovations Reserve, is repealed July 1, 2019 and replaced by a new section G.S. 143C-4-3.1, establishing a recurring funding source to address the ongoing capital and infrastructure needs of the State.

The Fund will consist of 4% of net State tax revenues that are deposited in the General Fund, one-fourth of the year end unreserved fund balance, appropriations by the General Assembly, interest and investment earnings, and any other funds as authorized by the General Assembly. The Fund will pay the State's debt service obligations and be used for new State agency and university capital projects and repairs and renovations of State-owned buildings. The Fund will be administered by the Office of State Budget and Management and be available for expenditure only upon appropriation by the General Assembly. The Governor's Recommended State Budget is required to include a transfer of 4% of the estimated net tax revenues that are deposited in the General Fund.

Lottery Allocations to Needs-Based Public School Capital Fund

Section 5.3 of the Appropriations Act adjusts allocations within the Education Lottery Fund (ELF) based on growing revenue from the State lottery and creates a new Needs-Based Public School Capital Fund (NBPSCF), which will receive $30 million in FY 2017-18, and $75 million in FY 2018-19. Section 5.3 also establishes a statutory appropriation dedicating all future ELF revenue growth, over and above the amounts appropriated in Session Law 2017-57 (after ensuring that a minimum balance of $25 million remains in the Lottery Reserve Fund) to the NBPSCF. The NBPSCF is projected to receive $360.3 million in net lottery proceeds over the next 5 fiscal years.

The NBPSCF will be administered by the Superintendent of Public Instruction and will provide public school construction grants to tier 1 and tier 2 counties as determined under G.S. 143B-437.08. Grants awards are capped at $10 million to $15 million depending on tier designation and may be used only for new capital projects. The chart below shows all appropriations from the Education Lottery Fund for the fiscal biennium.

Education Lottery Fund (ELF) Appropriations

Program	FY 2017-18	FY 2018-19
Noninstructional Support Personnel	383,888,897	385,914,455
Prekindergarten Program	78,252,110	78,252,110
Public School Building Capital Fund	100,000,000	100,000,000
Needs-Based Public School Capital Fund	30,000,000	75,000,000
Scholarships for Needy Students	30,450,000	30,450,000
UNC Need-Based Financial Aid	10,744,733	10,744,733
LEA Transportation	43,277,192	1,386,090
TOTAL ELF Appropriations	**$676,612,932**	**$681,747,388**

Disaster Recovery Relief

In mid-December 2016, the General Assembly convened a special session enacting S.L. 2016-124, Disaster Recovery Act of 2016, which transferred and appropriated $100.9 million from the Savings Reserve to the General Fund. The legislation also appropriated $100 million from the FY 2016-17 unappropriated General Fund balance for a combined total of over $200 million for State disaster recovery relief. Of that $200 million, $76.2 million was allocated to the State Emergency Response and Disaster Relief Fund to be spent on matching federal programs and future emergencies. The balances of the funds were designated for damage caused by Hurricane Mathew and wildfires in the western part

of the State. The Act also required that the Governor's Recommended State Budget for FY2017-18 include a recommendation to replenish the $100.9 million back to the Savings Reserve.

During the 2017 regular session, the General Assembly appropriated an additional $99.6 million in disaster relief funding to supplement its earlier efforts. In a separate act, Session Law 2017-119, Disaster Recovery Act of 2017 allocated the additional recovery funds to various State agencies and expanded the types of disaster covered and the uses of the funds. Allocations included an additional $22.3 million to the State Emergency Response and Disaster Relief Fund to match federal disaster assistance programs.

Additional summaries of selected budget and policy changes in other Appropriations Committees including Health and Human Services, Agriculture and Natural and Economic Resources, General Government and other areas can be found at the following links or at www.ncleg.net/fiscalresearch/fiscal_briefs/fiscal_briefs.html:

- Education
- Health and Human Services
- Agriculture and Natural and Economic Resources
- Justice and Public Safety
- General Government
- Transportation
- Information Technology
- Capital

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Appendices

Appendix A: Revised General Fund Availability Statement

General Fund Availability Statement[1]

		Fiscal Year 2017-18	Fiscal Year 2018-19
1	Unappropriated Balance	208,607,416	499,303,328
2	Disaster Recovery Appropriations (S.L. 2016-124)	(200,928,370)	0
3	Transfer From Savings Reserve	100,928,370	0
4	Revised Unappropriated Balance	108,607,416	499,303,328
5			
6	Over Collections FY 2016-17	580,600,000	0
7	Reversions FY 2016-17	271,000,000	0
8	Replenish Savings Reserve (S.L. 2016-124)	(100,928,370)	0
9	Earmarkings of Year End Fund Balance:		
10	Savings Reserve	(263,000,000)	0
11	Repairs and Renovations	(125,000,000)	0
12	**Beginning Unreserved Fund Balance**	**471,279,046**	**499,303,328**
13			
14	**Revenues Based on Existing Tax Structure**	**22,303,700,000**	**23,299,200,000**
15			
16	**Non-tax Revenues**		
17	Investment Income	60,100,000	60,600,000
18	Judicial Fees	240,900,000	240,500,000
19	Disproportionate Share	164,700,000	149,600,000
20	Insurance	75,500,000	75,500,000
21	Master Settlement Agreement (MSA)	127,200,000	127,200,000
22	Other Non-Tax Revenues	180,600,000	182,900,000
23	**Subtotal Non-tax Revenues**	**849,000,000**	**836,300,000**
24			
25			
26	**Total General Fund Availability**	**23,623,979,046**	**24,634,803,328**
27			
28	**Adjustments to Availability: 2017 Session**		
29	Tax Law Changes	(6,900,000)	(521,800,000)
30	Transfer of Taxes from Short-Term Lease or Rental of Motor Vehicles to Highway Fund	(10,000,000)	(10,000,000)
31	Transfer to Savings Reserve (S.L. 2017-5)	0	(72,090,000)
32	Transfer Additional MSA funds to Golden L.E.A.F.	(7,500,000)	(7,500,000)
33	Transfer to Medicaid Transformation Reserve	(75,000,000)	0
34	Transfer from Contingency and Emergency Fund	7,000,000	0
35	Transfer from Department of Insurance	3,655,405	4,026,728
36	Transfer from the Department of the State Treasurer	(5,453,230)	(5,434,773)
37	**Subtotal Adjustments to Availability: 2017 Session**	**(94,197,825)**	**(612,798,045)**
38			
39	**Revised General Fund Availability**	**23,529,781,221**	**24,022,005,283**
40			
41	Less General Fund Net Appropriations	(23,030,477,893)	(23,652,171,951)
42			
43	**Unappropriated Balance Remaining**	**499,303,328**	**369,833,332**

[1]As amended by S.L. 2017-197, Budget Technical Corrections.

Appendix B: Monthly FY 2017-18 and Intended FY 2018-19 "A" Teacher Salary Schedule

Years of Experience	FY 2017-18	Intended FY 2018-19
0	$3,500	$3,500
1	$3,600	$3,600
2	$3,630	$3,700
3	$3,730	$3,800
4	$3,730	$3,900
5	$3,830	$4,000
6	$3,830	$4,100
7	$3,930	$4,200
8	$3,930	$4,300
9	$4,055	$4,400
10	$4,055	$4,500
11	$4,205	$4,600
12	$4,205	$4,700
13	$4,355	$4,800
14	$4,355	$4,900
15	$4,555	$5,000
16	$4,630	$5,000
17	$4,730	$5,000
18	$4,730	$5,000
19	$4,830	$5,000
20	$4,830	$5,000
21	$4,930	$5,000
22	$4,930	$5,000
23	$5,000	$5,000
24	$5,000	$5,000
25+	$5,130	$5,130

Appendix C: Annual FY 2017-18 Principal Salary Schedule

Average Daily Membership	Base	Met Growth	Exceeded Growth
0-400	$61,751	$67,926	$74,101
401-700	$64,839	$71,322	$77,806
701-1,000	$67,926	$74,719	$81,511
1,001-1,300	$71,014	$78,115	$85,216
1,301+	$74,101	$81,511	$88,921

Note: Placement on "Base", "Met Growth", or "Exceeded Growth" section of the schedule based on the highest EVAAS growth evaluation in 2 of the 3 most recent school years.

Appendix D: Employee/Retiree Monthly Premiums Effective January 1, 2017[1]

Coverage Type	Traditional 70/30 Plan	Enhanced 80/20 Plan[2]	Consumer Directed[2]
Non-Medicare Active Employee/Retiree			
Employee/Retiree Only	$0.00	$15.04	$0.00
Employee/Retiree + Child(ren)	$218.14	$305.18	$196.32
Employee/Retiree + Spouse	$562.10	$683.52	$505.90
Employee/Retiree + Family	$598.70	$723.76	$538.82

Medicare Primary for Both Employee/Retiree and Dependent(s)	Traditional 70/30 Plan	Base Medicare Advantage
Employee/Retiree Only	$0.00	$0.00
Employee/Retiree + Child(ren)	$155.20	$124.80
Employee/Retiree + Spouse	$408.08	$124.80
Employee/Retiree + Family	$444.66	$249.60

[1] Employer premium is $479.48 per month ($372.56 for Medicare Primary).

[2] Premiums for Enhanced 80/20 and Consumer Directed Health Plan (CDHP) assume member completes three wellness activities: smoking attestation; primary care physician selection and Patient Centered Medical Home video viewing; and a health assessment. Premiums for Traditional 70/30 assume member completed smoking attestation.

Conference Committee Report
Session Law 2017-57 (S. B. 257), 2017 Appropriations Act
Selected Highlights for Health and Human Services

The Conference Budget for Health and Human Services in FY 2017-18 includes net appropriations of $5.3 billion, which is $20.6 million, 0.4%, less than the base budget for FY 2017-16. The FY 2018-19 net appropriations is $5.4 billion, which is $116.4 million above the base budget for FY 2017-18, a 2.2% increase.

The following selected Department of Health and Human Services (DHHS) highlights may be found in **Section G** of the 2017 Conference Committee Report (page and item numbers noted); selected special provisions may be found in **Part XI** of S.B. 257 (section references are noted):

Division of Central Management and Support

Committee Report Items

- Reduces funding for contracts and purchased services on a department-wide basis by $3.2 million recurring. **(Page G-7, Item #4)**
- Provides $7.5 million recurring to double the grant funding for community health centers, rural health centers, free clinics, and other health safety net providers. **(G-7, #6)**
- Provides one-time funding of $3 million to the Cape Fear Valley Medical Center to offset actual lost Medicare payments for admissions to the Center prior to October 1, 2017, that are attributed to the Center's reclassification by the federal Centers for Medicare and Medicaid Services (CMS) as a rural hospital or rural referral center or any other change approved by CMS. **(G-8, #9)**
- Provides funding for continued development of NC FAST including the Child Welfare case management system. ($8.9 million in 2017-19 and $11.9 million in 2018-19 on a nonrecurring basis in both years) **(G-9, #13)**
- Supports the ongoing operation, development and enhancement of the Controlled Substances Reporting System to automate reports, generate and deploy advanced analytics to improve prescribing practices and to identify unusual prescribing patterns. Provides funding for 6 positions, 4 in Central Management for operation and maintenance of the system and 2 in the Division of Mental Health, Developmental Disability and Substance Abuse Services for analytics. ($1.8 million recurring each year of the biennium) **(G-11, #18 & #19)**

Provisions from S.B. 257

- Community Health Program Changes –authorizes the use of State and federal funding to provide safety net health care providers ongoing training and technical assistance related to health information technology, electronic health records, and connecting to the State's health information exchange network. **(Sec. 11A.8)**
- Provides $4.7 million in the DHHS Competitive Grants for Boys and Girls Clubs, Big Brothers Big Sisters, and Triangle Residential Options for Substance Abusers (TROSA). **(Sec. 11A.14)**

Division of Aging and Adult Services

Provisions from S.B. 257

- Recommendation to Appoint a Subcommittee on Aging states that the cochairs for the Joint Legislative Oversight Committee on Health and Human Services (JLOC HHS) may consider appointing a subcommittee on aging to examine the states delivery of services for older adults in order to (1) determine their needs and (2) make recommendations on how to address those needs. **(Sec. 11D.3)**

Division of Child Development and Early Education (DCDEE)

Committee Report Items

- Provides $9 million in FY 2017-18 and $18.3 million in FY 2018-19 to reduce the North Carolina Pre-K (NC Pre-K) waitlist by 75% by FY 2018-19. Funding is comprised of federal block grant funds and general fund appropriation. NC Pre-K slots will be increased by 1,725 in FY 2017-18 and 3,525 in FY 2018-19 over the number of FY 2016-17 slots. The total number of slots will be approximately 28,725 in FY 2017-18 and 30,525 in FY 2018-19. This will reduce the current waiting list of 4,700 by 75% by FY 2018-19. (Current number of NC Pre-K slots is 27,000) **(G- 29, #42)**

NC Pre-K Conference Budget

	2007-18	2018-19
Requirements	$9,000,000	$18,300,000
Receipts	$6,000,000	$12,200,000
Appropriations	$3,000,000	$6,100,000
Current slots (2016-17)	27,000	27,000
New Slots	1,725	3,325
Total Slots	28,725	30,525

The waitlist for FY 2016-17 was 4,700. In FY 2018-19, the 3,525 slots are 75% of the waitlist of 4,700.

- Child Care Subsidy market rate increase provides $13 million in FY 2017-18 and $17 million in FY 2018-19 to increase the market rate effective October 1, 2017 for infants through 2 year olds in 3-, 4-, and 5-star centers and homes in Tier 3 counties to the recommended market rate. Also effective October 1, 2017 the market rate is increased for school-aged children in 3-, 4-, and 5-star centers and homes in Tier 1 and 2 counties to the recommended market rate. **(G-29, #43)**
- Smart Start Reading Initiative increases access to Dolly Parton's imagination Library an early literacy program that mails age-appropriate books to register children on a monthly basis. Once fully implemented access to the program will be statewide. ($3.5 million in FY 2017-18 and $7 million in FY 2018-19) **(G-30, #47)**

Provisions from S.B. 257

- Child Care Allocation Formula allows the DCDEE to withhold up to 2% of available funds from the allocation formula for preventing the termination of services and for repayment of any federal funds identified by counties as overpayments. The Division must allocate any funds withheld before the end of the fiscal year if the funds are not needed for these purposes. The Division must set aside 4% of the subsidy allocation for vulnerable populations which include special needs and homeless children. Counties with a spending coefficient above 100% must submit a plan for managing their allocation before receiving any reallocated funds. **(Sec. 11B.5)**

Division of Social Services

Committee Report Items

- Funds resources to implement the Child Welfare Federal Program Improvement Plan required under the federal Child and Family Services Review. Provides $8.7 million in FY 2017-18 and $9.5 million for enhancements to the Child Welfare system including training for local child welfare workers and supervisors. Expands both In-Home and post permanency support services to improve the safety and outcomes of children involved in the Child Welfare system. **(G-38, #54)**
- Provides nonrecurring funding to implement the Family/Child Protection & Accountability Act to reform the State child welfare system, improve State oversight, and develop a plan for the regionalization of county departments of social services. ($161,439 in FY 2017-18 and $3.2 million in FY 2018-19) **(G-38, #55)**
- Continues the provision of temporary assistance for facilities that serve special assistance recipients. Counties and the State will each provide 50% of the funding. Facilities will receive $34 per month for each resident who receives

Special Assistance. ($5 million nonrecurring in each year of the biennium) **(G-38, #56)**

Provisions from S.B. 257

- Social Services Block Grant provides $3 million nonrecurring in each year of the biennium to assist counties in the implementation of the Child Welfare case management system in NC FAST. **(Sec. 11L.1.k)**

Division of Public Health

Committee Report Items

- Provides $2 million recurring to expand Nurse Family Partnership Program home visiting services. **(G-50, #83)**
- Provides $500,000 recurring to expand 2 smoking cessation programs: QuitlineNC and You Quit Two Quit. **(G-50, #84)**
- Provides $500,000 nonrecurring for tobacco prevention activities targeted to youth and people of childbearing age. **(G-50, #85)**
- Provides $1 million recurring and $2 million nonrecurring to address the structural budget deficit at the State Laboratory of Public Health. **(G-51, #86)**
- Provides $600,000 for Hepatitis C and other communicable disease testing and treatment. **(G-51, #87)**

Provisions from S.B. 257

- Implements the Federal Elevated Blood Level Standard in North Carolina to lower the level of lead detected in children and pregnant women that requires immediate action to remove sources of lead from their environment. This action makes the State's blood lead level consistent with the federal Centers for Disease Control and Prevention. **(Sec. 11E.6)**
- Authorizes the use of Modified Adjusted Income (MAGI) to determine income eligibility for the AIDS Drug Assistance Program, raising the income eligibility level for uninsured persons with AIDS/HIV to receive AIDS drug assistance. **(Sec. 11E.9)**
- Authorizes and provides $2.2 million in federal block grant funding to establish the 3-year *Every Week Counts Demonstration Project* to reduce pre-term births and improve birth outcomes in Robeson and Columbus Counties. These counties have the highest number of preterm births in the State. **(Sec. 11E.12)**

Division of Mental Health, Developmental Disabilities and Substance Abuse Services

Committee Report Items

- Behavioral health funding consolidates several changes on a recurring and nonrecurring basis in both years of the biennium as reflected in total below: **(G-60, #105)**

	FY 2017-18	**FY 2018-19**
Recurring	($9.7) million	($1.9) million
Nonrecurring	($43.4) million	($44.6) million

The components of the changes are reflected below:

	FY 2017-18		FY 2018-19	
	Recurring	Nonrecurring	Recurring	Nonrecurring
Single Stream	($31.5) M	($55.5)M	($36.0) M	($54.6) M
3-Way Beds	$2.5 M		$2.5 M	
Disability Rights Settlement	$6.2 M	$26 K	$6.3 M	
DOJ Settlement	$8.9 M		$17.0 M	
Expand DD Slots	$4.1 M		$8.3 M	
Group Home Funding		$5.0 M		$5.0 M
Community Substance Abuse Services		$5.0 M		$5.0 M
Case Management System		$2.0 M		

- Provides nonrecurring funds for Broughton Hospital of $2.5 million in each year to fund potential litigation and other costs related to delays in hospital construction, other costs related to minor equipment to be installed during construction and transition to the new hospital and funds a study of potential uses for the old Broughton Hospital facilities. **(G-61, #107)**
- Drug overdose medication provides recurring funding of $100,000 to purchase opioid antagonists. **(G-62, #110)**

Provisions from S.B. 257

- Defines the Single Stream Funding reduction amount for each Local Management Entity/Managed Care Organization (LME/MCO) for both recurring and nonrecurring reductions. The provision directs the Secretary to provide any recommended changes in these amounts to the JLOC HHS by March 1, 2018 and directs the Department on July 1, 2017 to begin a quarterly financial review of all LME/MCOs to identify vulnerable LME/MCOs. The solvency standards that will

be included in the DHHS Behavioral Health Strategic Plan required by January 1, 2018 will be the basis for determining LME/MCOs at risk of failing within a 2-year period that will require corrective action plans and monthly reporting. The first report to the JLOC HHS identifying any LME/MCOs at risk of failing is required by 10/1/17.

The provision states it is the intent of the General Assembly that LME/MCOs maintain utilization at the same level as 2015.

The provision allows up to $30 million nonrecurring to be restored in the event the Office of State Budget and Management (OSBM) certifies a surplus in Medicaid spending. **(Sec. 11F.2)**

- Modifies the percentage requirement for LME/MCO purchase of inpatient Alcohol and Substance Use Disorder Treatment Services (ADATC) beds from state operated facilities in FY 2017-18. **(Sec. 11F.4)**
- Directs the funding of psychiatric and facility based crisis beds using sale of Dorothea Dix Property funds in the amount of $17M to increase inpatient behavioral health bed capacity for adults at 5 selected hospitals/centers and $2M for competitive grants to establish up to two new facility-based crisis facilities for children and adolescents. **(Sec. 11F.5)**
- Requires the Department to study the Statewide Expansion of the Wright School and to submit a report by March 1, 2018 with options and recommendation for feasibility, cost and obstacles to establishing additional facilities for the treatment to children, 20 ages six to 12, with serious emotional and behavioral disorders and (ii) support their families 21 and communities in building the capacity to meet their children's special needs at home, at 22 school, and within their local communities. **(Sec. 11F.12)**
- Describes the use of the SAMHSA two year grant totaling $30 million to address North Carolinas Opioid Crisis and reporting requirements for the use of the funds and outcomes on November 1st in 2018 and 2019. **(Sec. 11F.14)**
- Provides nonrecurring funding for Group Homes in the amount of $5 million each year to provide temporary, short-term financial assistance in the form of a monthly payment to group homes on behalf of each resident who meets all of the criteria defined in the provision. **(Sec. 11F.18A)**

Division of Medical Assistance

Committee Report Items

- Medicaid Rebase increases base budget in both years of the biennium to reflect the impact of enrollment and utilization trends as reflected below: **(G-88, #134)**

	FY 2017-18	**FY 2018-19**
Recurring	$66.7 million	$177.4 million
Nonrecurring	($63.0) million	($64.8) million

- Reduces budget to reflect LME/MCO intergovernmental transfer to help fund the State's cost for behavioral health services totaling $17.7 million in FY 2017-18 and $18.0 million in FY 2018-19. **(G-88, #135)**
- Increase rates for Medicaid personal care services effective 1/1/18 to an effective rate per hour of $15.60 for a total cost in FY 2017-18 of $1.3 million and in FY 2018-19 of $2.7 million. **(G-88, #137)**
- Graduate Medical Education reimbursement funded at $30 million nonrecurring in each year. **(G-89, #139)**
- Management flexibility reduction of $15 million nonrecurring in each year with the Department's authority. **(G-89, #140)**
- Provides $1.4 million in FY 2017-18 and $1.5 million in FY 2018-19 to extend the clinical policy allowing retroactive authorization of personal care services from 10 days to 30 days. **(G-89, #141)**

Provisions from S.B. 257

- Plan to establish Medicaid coverage for ambulance transports to alternative appropriate care locations directs the Department to develop a plan to implement coverage for ambulance transports for individuals in behavioral health crisis to alternative locations, such as behavioral crisis centers, rather than hospital emergency departments. The Department is to submit a report no later than 12/1/17 with details on the implementation plan. **(Sec. 11H.14A)**
- Prepayment Claims Review Modifications allows DHHS to keep providers on prepayment review for up to 24 months (currently 12) and would require providers to submit a certain volume of claims during the review period in order to meet the standards for successful completion of the program. Clarifies certain aspects of provider terminations and appeals resulting from prepayment review. **(Sec. 11H.19)**

NC Health Choice

Committee Report Items

- Adjusts the base budget to reflect spending target in both years of the biennium as reflected below **(G-96, #145)**:

	FY 2017-18	**FY 2018-19**
Nonrecurring	($44.6) million	($46.9) million
Recurring	$1.5 million	$3.9 million

Agenda Item IV-C

2017

Substantive Enacted Legislation Pertaining to Health and Human Services

September 2017

Legislative Analysis Division, North Carolina General Assembly

2017 Substantive Enacted Legislation
Pertaining to Health and Human Services

This document provides summaries of substantive legislation pertaining to health and human services enacted during the 2017 Session of the General Assembly. In an effort to facilitate use, the summaries of Enacted Legislation have been categorized under subheadings, and then arranged in numerical order by Session Law under each subheading.

The brief summaries contained in this document represent work products from the following Legislative Analysis Division staff members: Susan Barham, Jennifer Hillman, Theresa Matula, Jason Moran-Bates, and Gus Willis. A more thorough summary of most bills may be found on the NCGA website: http://www.ncleg.net/Legislation/Legislation.html

Subheadings:

To facilitate use, each subheading below is hyperlinked to that section of the document.

DEPARTMENT OF HEALTH AND HUMAN SERVICES – GENERALLY

CHILDREN

MEDICAID & HEALTH CHOICE

MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/SUBSTANCE ABUSE SERVICES

PUBLIC HEALTH

PROVIDERS, FACILITIES & LICENSURE

OLDER & DISABLED ADULTS

SUMMARIES

DEPARTMENT OF HEALTH AND HUMAN SERVICES – GENERALLY

DHHS Coordination of Health Information Technology (S.L. 2017-57, Sec. 11A.1/ S257 – 2017 Appropriations Act)

Sec. 11A.1 of S.L. 2017-57 (SB 257) adds a new section (G.S. 143B-139.4D) to Article 3 of Chapter 143B to require the Department of Health and Human Services, in cooperation with the State Chief Information Officer, to coordinate health information technology policies and programs for the State. The Department's Chief Information Officer is responsible for avoiding duplication of efforts and for ensuring that each State agency, public entity, and private entity that undertakes health information technology activities uses great expertise and technical capability in a manner that supports State and national goals and includes specified responsibilities. Additionally, the Department, in cooperation with the Department of Information Technology, is required to establish and direct a health information technology management structure that is efficient, transparent, and compatible with the Office of the National Health Coordinator for Information Technology governance mechanism. Specific responsibilities are listed for the health information technology management structure.

This section became effective July 1, 2017.

Health Information Exchange Requirements and Study (S.L. 2017-57, Sec. 11A.5/ S257 – 2017 Appropriations Act)

Sec. 11A.5 of S.L. 2017-57 (SB 257) amends Session Laws and statutes pertaining to the Health Information Exchange (HIE) to specify when certain providers and entities must be connected to the HIE Network and to require a study of the State Health Plan related to the feasibility and appropriateness of providers and entities connecting to submit data.

Providers and Entities Connected to the HIE Network - Sec 12A.5(a)(1) of S.L. 2015-241 is amended to require specified providers and entities to be connected to the HIE network with regard to services rendered to Medicaid and other State-funded health care program beneficiaries and services paid for with Medicaid or other State-funded health care funds. The changes in the Session Law are also included as G.S. 90-414.4(a1) and require the following:

- By June 1, 2018, the following Medicaid service providers must be connected: Hospitals, Physicians, Physician Assistants, and Nurse Practitioners. (G.S. 90-414(a1)(1))
- By June 1, 2019, all other providers of Medicaid and State-funded health care services, except Prepaid Health Plans and local management entities/managed care organizations (LME/MCO) as detailed below, must submit demographic and clinical data. (G.S. 90-414(a1)(2))
- In accordance with S.L. 2015-245, Prepaid Health Plans must submit encounter and claims data by the commencement date of a capitated contract with the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services. By June 1, 2020, LME/MCOs must submit encounter and claims data. (G.S. 90-414(a1)(3))

The Department of Information Technology (DIT), in consultation with the Department of Health and Human Services (DHHS), may establish a process to grant limited extensions of time to providers and entities that demonstrate and on-going good faith effort to establish connection and begin data submission. Both Departments must review and decide on an extension request within 30 days. The process must include a presentation by the provider or entity on an expected time line for connection. No extension may be granted to: (i) a provider or entity that fails to provide information to both DIT and DHHS, or (ii) that would result in connecting to the HIE Network later than June 1, 2020. The statute is also amended to allow an exemption for providers for patient records that are subject to certain disclosure restrictions.

Sec. 11A.5(c)-(f) amend various statutory provisions related to the Health Information Exchange. Section 11A.5(g) requires DHHS to include as one of the terms and conditions of any contract it enters into, on or after the effective date, with a local management entity/managed care organization (LME/MCO) or Prepaid Health Plan (PHP), a requirement that the LME/MCO or PHP must comply with the provisions of G.S. 90-414.4.

State Health Plan Study - Sec. 11A.5(h) requires DHHS, DIT, and the Division in the Department of State Treasurer responsible for the State Health Plan for Teachers and State Employees, to conduct a joint study of:

- The feasibility and appropriateness of providers and entities, other than those specified in G.S. 90-414.4(a1)(1), connecting with and submitting demographic and clinical data through the HIE Network.
- The feasibility and appropriateness of providers and entities, other than those specified in G.S. 90-414.4(3), connecting with and submitting encounter and claims data through the HIE Network.

The study must examine at least six specified topics and a joint report must be submitted to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Information Technology by April 1, 2018.

This section became effective July 1, 2017.

Controlled Substances Reporting System Improvements (S.L. 2017-57, Sec. 11A.6/ S257 – 2017 Appropriations Act)

Sec. 11A.6 of S.L. 2017-57 (SB 257) appropriates $1.2 million dollars in recurring funds to the Department of Health and Human Services (DHHS), Division of Central Management and Support, for use in developing and implementing software via existing public-private partnerships with the Government Data and Analytics Center (GDAC) for the performance of advanced analytics within the Controlled Substances Reporting System (CSRS). Specifically, the funds are to be used to enhance reports authorized by statute, enhance the Department's ability to provide data to persons or entities authorized to receive information, aggregate relevant data sources, and enhance the Department's ability to generate and deploy advanced analytics to improve opioid prescribing practices, identify unusual prescribing patterns, and detect behavior indicative of misuse, addiction, or criminal activity.

DHHS must execute any contractual agreements and interagency data sharing agreements necessary to complete these improvements by December 1, 2017. To the extent allowable under federal and State laws and regulations, the Department of Information Technology must coordinate with DHHS to develop an interface between the CSRS and the Health Information Exchange (HIE) Network and leverage interfaces already developed

between the HIE Network and health care entities as a method of providing CSRS data, reports, and analytic outputs to health care practitioners and dispensers.

This section became effective June 28, 2017.

Data Analytics and Performance Enhancements (S.L. 2017-57, Sec. 11A.7/ S257 – 2017 Appropriations Act)

Sec 11A.7 of S.L. 2017-57 (SB 257) provides that any enhancement of the State's data analytics capabilities utilizing funds appropriated by the act to the Department of Health and Human Services, Division of Central Management and Support, are subject to applicable State laws requiring the analytics to be developed and implemented in collaboration with the Government Data Analytics Center.

This section became effective July 1, 2017.

Community Health Grant Program Changes (S.L. 2017-57, Sec. 11A.8/ S257 – 2017 Appropriations Act)

Sec. 11A.8 of S.L. 2017-57 (SB 257), as amended by Sec. 3.2 of S.L. 2017-197, increases funding for Community Health Grants by $7.5 million dollars annually. Each individual grant cannot exceed $150,000. The Office of Rural Health must create standard quality and outcome metrics for grant recipients and require grant recipients to report on their outcomes beginning July 1, 2018. This section requires that the funding must be used for the following purposes:

- Establishing four positions to support administration of the Community Health Grant Program. This section limits funding for positions to $200,000 in recurring funds.
- Providing $200,000 in recurring funds for administrative costs.
- Providing limitations specifying that grants must be awarded to community and rural health centers, local health departments, and school-based centers that: (1) provide primary and preventative services to uninsured or medically indigent populations, and (2) serve as a medical home increasing access to primary and preventative care, creating and integrating new services including dental, pharmacy, and behavioral health services, and increasing capacity and quality of care by replacing facilities, equipment, or technologies.
- Establishing a Primary Care Advisory Committee to develop a process for grading applications.

This section became effective July 1, 2017.

Rural Health Loan Repayment Programs (S.L. 2017-57, Sec. 11A.9/ S257 – 2017 Appropriations Act)

Sec. 11A.9 of S.L. 2017-57 (SB 257) requires the Office of Rural Health to combine loan repayment programs for physicians, psychiatrists, and those working at state facilities. The funds may be used to: (1) continue funding the State Loan Repayment Program for primary care providers, (2) expand State incentives for general surgeons in Critical Access Hospitals, and (3) include eligible providers who use telemedicine in rural and underserved areas.

This section became effective July 1, 2017.

Reduction of Funds for Purchased Services (S.L. 2017-57, Sec. 11A.10/ S257 – 2017 Appropriations Act)

Sec. 11A.10 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services (DHHS) to reduce spending for purchased services and prohibits DHHS from reducing any funding that impacts direct services or funding that supports the 2012 settlement agreement between the U.S. Department of Justice and the State of North Carolina related to the Americans with Disabilities Act.

This section became effective July 1, 2017.

Office of Program Evaluation Reporting and Accountability (S.L. 2017-57, Sec. 11A.11/ S257 – 2017 Appropriations Act)

Sec. 11A.11 of S.L. 2017-57 (SB 257) prohibits the Department of Health and Human Services (DHHS) from using any funds appropriated for the Office of Program Evaluation Reporting and Accountability (OPERA) for any purpose other than to establish and administer the OPERA. This section also requires DHHS to report to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2017, on the establishment of the OPERA including expenditures for the 2015-2016 fiscal year, steps taken to establish the OPERA, an organizational chart, a list of current and ongoing assessments and evaluations, and an explanation of any obstacles to establishing and operating the OPERA as required by law.

This section became effective July 1, 2017.

Contracting Specialist and Certification Program (S.L. 2017-57, Sec. 11A.12/ S257 – 2017 Appropriations Act)

Sec. 11A.12 of S.L. 2017-57 (SB 257) pertains to a provision in the 2016 budget bill (S.L. 2016-94) requiring the UNC School of Government, in collaboration with the Department of Health and Human Services (DHHS), to prepare a proposal for implementing and administering a contracting specialist training program for management-level personnel within DHHS. This section requires DHHS to submit the proposal to the Joint Legislative Oversight Committee on Health and Human Services by September 1, 2017, and specifies that the proposal must include a detailed description of the proposed program curriculum and cost estimates for implementation and administration of the program.

This section became effective June 28, 2017.

Competitive Grants/Nonprofit Organizations (S.L. 2017-57, Sec. 11A.14/ S257 – 2017 Appropriations Act)

Sec. 11A.14 of S.L. 2017-57 (SB 257) allocates funding for nonprofit organizations that provide services with State dollars. This section sets out the procedures and the requirements for organizations to receive funding. Funds awarded pursuant to this section, but not disbursed or encumbered at the end of each fiscal year, must remain available for expenditure and will not revert. This section specifically awards funds to Big Brothers Big Sisters, TROSA, and the Boys and Girls Clubs for dropout prevention programs.

Additionally, this section repeals the statute that authorizes the Secretary of Health and Human Services to receive requests for grants-in-aid from non-State agencies.

This section became effective July 1, 2017.

Final Report - Eastern Band of Cherokee Indians Assumption of Services (S.L. 2017-57, Sec. 11C.10/ S257 – 2017 Appropriations Act)

Sec. 11C.10 of S.L. 2017-57 (SB 257) repeals a provision in the 2015 budget bill (S.L. 2015-241) requiring the Department of Health and Human Services, Division of Social Services, to submit ongoing quarterly reports on the assumption of certain services by the Eastern Band of Cherokee Indians. This section instead requires the Division to submit a final report to the Joint Legislative Oversight Committee on Health and Human Services when implementation of the assumption of services is complete.

This section became effective July 1, 2017.

Ombudsman Changes - DHHS Study (S.L. 2017-103/ H248)

S.L. 2017-103 (HB 248) makes changes to the adult care home and nursing home community advisory committees and to the duties of the Office of the State Long-Term Care Ombudsman Program to conform to federal changes.

The act also requires the Department of Health and Human Services to study Public Law 113-51, HIV Organ Policy Equity (HOPE) Act, and the Final Safeguards and Research Criteria publication by the US Department of Health and Human Services and the National Institutes of Health, to determine any necessary public health safeguards, regulations, and statutory changes. The Department is required to submit findings and recommendations on any necessary changes related to the HOPE Act and the corresponding safeguards to the Joint Legislative Oversight Committee on Health and Human Services on or before January 1, 2018.

This act became effective July 12, 2017.

DHHS Recommend Telemedicine Policy - PSYPACT (S.L. 2017-133/ H 283)

S.L. 2017-133 (HB 283) requires the Department of Health and Human Services to: (1) study and recommend a telemedicine policy for the State, and (2) study the Psychology Interjurisdictional Compact (PSYPACT) and its impact on the delivery of psychology services via the telehealth model. On or before October 1, 2017, the Department is required to report findings and recommendations on a telemedicine policy and on PSYPACT to the Joint Legislative Oversight Committee on Health and Human Services.

The act became effective July 20, 2017.

CHILDREN

Rylan's Law/Family/Child Protection & Accountability Act (S.L. 2017-41/H630)

S.L. 2017-41 (HB 630) does the following:

- establishes social services regional supervision and collaboration;
- reforms the State child welfare system;
- improves accountability and state oversight of the child welfare system;
- requires written agreements, corrective action, and state intervention with social services departments;

- creates regional social services departments;
- establishes a child well-being transformation council to improve coordination, collaboration, and communication among child-serving agencies;
- establishes a pilot program to help youth in substitute care obtain drivers licenses;
- establishes a pilot program to authorize a waiver of the employment requirement for foster parents with children receiving intensive alternative family treatment;
- reduces the time a parent has to appeal from a termination of parental rights order;
- reduces the time for foster care licensure approval; and
- requires child protective service observation before physical custody of a child may be returned to a parent, guardian, custodian or caretaker from whom the child was removed.

This act has various effective dates. Please refer to the full summary at http://www.ncleg.net/ for greater detail.

NC Pre-K Programs/Standards for Four- and Five-Star Rated Facilities (S.L. 2017-57, Sec. 11B.1/ S257 – 2017 Appropriations Act)

Sec. 11B.1 of S.L. 2017-57 (SB 257) outlines eligibility, multiyear contracts, building standards, programmatic standards, NC Pre-K Committees, reporting, and audits for NC Pre-K.

- The Department of Health and Human Services (DHHS), Division of Child Development and Early Education (DCDEE), must continue implementing the NC Pre-K program and serving children who are four years of age on or before August 31 of the program year. The DCDEE shall establish income eligibility not to exceed 75% of the State median income, although up to 20% of the children enrolled may have family incomes in excess of income eligibility threshold if they have other designated risk factors. Children of military personnel are eligible for participation. Eligibility determinations may continue to be made by local education agencies and local NC Partnership for Children, Inc., partnerships. The DCDEE is not allowed to consider the health of a child as a factor for eligibility other than developmental disabilities or other chronic health issues.
- The DCDEE must require the NC Pre-K contractor to issue multiyear contracts for licensed private child care centers providing NC Pre-K classrooms.
- Except as provided in G.S. 110-91(4), private child care facilities and public schools operating NC pre-K classrooms must meet the building standards for preschool students required in G.S. 115C-521.1 and must adhere to all of the policies prescribed by the DCDEE regarding programmatic standards and classroom requirements.
- Local NC Pre-K committees must use the standard decision-making process developed by the DCDEE in awarding NC Pre-K classroom slots and selecting students.
- The DCDEE must report to the Joint Legislative Oversight Committee on Health and Human Services, the Office of State Budget and Management, and the Fiscal Research Division by March 15 of each year.
- NC Pre-K program administration by local partnerships is subject to financial and compliance audits.

This section became effective July 1, 2017.

State Agency Continued Collaboration on Early Childhood Education/ Transition from Preschool to Kindergarten (S.L. 2017-57, Sec. 11B.2/ S257 – 2017 Appropriations Act)

Sec. 11B.2 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services (DHHS), in consultation with the Department of Public Instruction (DPI), and others, to continue to collaborate on an ongoing basis in the development and implementation of a statewide vision and a comprehensive approach to early childhood education, birth through third grade, creating cross agency accountability with a comprehensive set of data indicators, including consideration of the NC Pathways to Grade-Level Reading. DHHS and DPI must submit a follow up report on the statewide vision to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee on or before January 1, 2018, and make subsequent annual reports as needed.

DHHS and DPI must also continue developing a standardized program to transition children from preschool to kindergarten and identify specified minimum methods and recommendations. DHHS must report on the development of the transition program by January 1, 2018 to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee.

This section became effective July 1, 2017.

Codify Certain Child Care Subsidy Provisions (S.L. 2017-57, Sec. 11B.6/ S257 – 2017 Appropriations Act)

Sec. 11B.6 of S.L. 2017-57 (SB 257) codifies child care subsidy provisions in Part 10C, Article 3, Chapter 143B of the General Statutes. The sections provide for the following: child care funds matching requirements, child care revolving loan, and an administrative allowance to county departments of social services for use in detecting fraud.

This section became effective July 1, 2017.

Child Care Subsidy Recipients to Cooperate with Child Support Services/ Demonstration Project (S.L. 2017-57, Sec. 11B.7/ S257 – 2017 Appropriations Act)

Sec. 11B.7 of S.L. 2017-57 (SB 257) requires a one-year statewide demonstration project in accordance with S.L. 2015-51 requiring a custodial parent or other relative or person with primary custody of a child receiving child care subsidy payments to cooperate with the county child support service program as a condition of receiving child care subsidy payments.

- The Department of Health and Human Services (DHHS), Division of Child Development and Early Education (DCDEE) and Division of Social Services (DSS) are required to implement the project beginning January 1, 2018, or 30 days from the date the US Department of Health and Human Services, Office of Child Care, approves the Child Care and Development Fund (CCDF) plan, whichever is later.
- The DCDEE and DSS must conduct the demonstration project in at least three counties, but no more than six, that represent three regions of the State in both urban and rural settings. In selecting counties, DCDEE and DSS must: (1) consider the various methods counties employ in receiving and processing child care subsidy applications and (2) compare data from the counties that participate in the demonstration project to counties to similarly sized and situated that do not participate.

- Components of the project and factors for evaluating the project are outlined in the section.
- The DCDEE and DSS are required to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than March 1, 2019, or if the plan is approved after January 1, 2018, no later than three months from the date the demonstration project is completed, whichever is later.

This section became effective July 1, 2017.

Smart Start Early Literacy Initiative/ Dolly Parton Imagination Library (S.L. 2017-57, Sec. 11B.9/ S257 – 2017 Appropriations Act

Sec. 11B.9 of S.L. 2017-57 (SB 257) expands access to Dolly Parton's Imagination Library, an early literacy program that mails books on a monthly basis to children registered for the program. This section allows the North Carolina Partnership for Children to use up to two percent of the funding for program evaluation. The North Carolina Partnership for Children must report by March 1, 2018 to the Joint Legislative Oversight Committee on Health and Human Services on the success of the program.

This section became effective July 1, 2017.

Intensive Family Preservation Services Funding and Performance Enhancements (S.L. 2017-57, Sec. 11C.2/ S257 - 2017 Appropriations Act)

Sec. 11C.2 of S.L. 2017-57 (SB 257) requires the Intensive Family Preservation Services Program (IFPS) to provide services to children and families in cases of abuse, neglect and dependency where a child is at imminent risk of removal from the home. The IFPS program must be implemented statewide on a regional basis. This section sets out data collection and reporting requirements that the Department of Health and Human Services must require from that any program that receives funding for the purpose of IFPS.

This section became effective July 1, 2017.

Federal Child Support Incentive Payments (S.L. 2017-57, Sec. 11C.6 / S 257 – 2017 Appropriations Act)

Sec. 11C.6 of S.L. 2017-57 (SB 257) requires the North Carolina Child Support Services Section (NCCSS) of the Department of Health and Human Services to retain up to 15% of the annual federal incentive payments NCCSS receives from the federal government to enhance centralized child support services by: (1) consulting with county child support programs, (2) supplementing State expenditures with federal incentive payments for centralized child support services, and (3) developing rules for calculating and distributing the funds. NCCSS must allocate no less than 85% of federal incentive funds to the county child support services programs to improve effectiveness and efficiency of county child support services.

This section directs NCCSS to require the county child support services programs to submit an annual plan describing how federal incentive funding improves program effectiveness and efficiency and to report annually on the plan. NCCSS must report with any recommendations to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1 of each year.

This section became effective July 1, 2017.

Child Welfare System Changes (SL 2017-57, Sec. 11C-7/ S257 - 2017 Appropriations Act)

Sec. 11C.7 of S.L. 2017-57 (SB 257) directs the Division of Social Services (DSS), Department of Health and Human Services (DHHS), to implement the requirements of the federal Program Improvement Plan (Plan) to bring North Carolina into compliance with national standards for child welfare policy and practices and to report on the implementation and outcomes of the Plan to the Joint Legislative Oversight Committee on Health and Human Services semiannually on February 1 and August 1 until February 1, 2019.

This section also requires DSS and the county departments of social services to develop a model of oversight for the statewide strategic plan for child welfare services while supporting a county's abilities to meet performance standards outlined in the plan. Of the funds appropriated to DSS in each year of the 2017-2019 biennium for the child welfare program improvement plan, $60,000 in each fiscal year must be used by DSS, in collaboration with the North Carolina State Commission on Indian Affairs, to: i) recruit foster parents, ii) increase the number of foster homes for children who are members of a State-recognized tribe, and (iii) provide training for staff county departments of social services to ensure culturally appropriate service for children who are members of a State-recognized tribe.

Finally, this section directs DSS to continue toward the completion of the child welfare component of the North Carolina Families Accessing Services through Technology (NC FAST) system. It is the intent of the General Assembly that the child welfare component of the NC FAST system be operational by December 31, 2017. The Division must report on the child welfare component of the NC FAST system to the Joint Legislative Oversight Committee on Health and Human Services quarterly through April 1, 2019. Elements that must be included in the report are specified.

This section became effective July 1, 2017.

Successful Transition from Foster Care and Youth Permanency Innovation Initiative Technical Change (S.L. 2017-57, Sec. 11C.9/ S257)

Sec. 11C.9 of S.L. 2017-57 (SB 257) creates the Foster Care Transitional Living Initiative Fund to support a demonstration project by Youth Villages that provides transitional services for youth aging out of foster care. The goals of the demonstration project include: (1) improving outcomes for youth that transition from foster care through implementation of Transitional Living Services, (2) identifying cost savings in services provided to youth aging out of foster care, and (3) establishing an evidenced-based transitional living program available for all youth aging out of foster care.

This section also amends the purpose and powers of the Permanency Innovation Initiative Oversight Committee to broaden the committee's look at initiatives and oversight for programs that support foster care youth transitioning to adulthood.

This section became effective July 1, 2017.

Eckerd Kids and Caring for Children Angel Watch Program – Report on Use of Additional Funds (SL 2017-57, Sec. 11C.14/ S 257- 2017 Appropriations Act)

Sec. 11C.14 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services, Division of Social Services, to report on the use of additional funds provided by the 2017 Appropriations Act in continued support of the Eckerd Kids and Caring for Children's Angel Watch program. This foster care program serves children ages 0 to 10, who are not in the custody of a county department of social services and whose families are temporarily unable to care for them due to a crisis. The report must include the following:

- The number of families and children served by the program, including the counties in which the services are provided.
- The number of children who enter foster care within six months after their family participates in the program.
- A comparison of children with similar needs that do not participate in the program and the number of those children who enter into foster care.
- Any other matters deemed relevant.

On or before December 1, 2018, the Division is required to submit a report to the House and Senate Appropriations Committees on Health and Human Services and the Fiscal Research Division.

This section became effective July 1, 2017.

Funds for the North Carolina Child Treatment Program (S.L. 2017-57, Sec. 11F.1/ S257 – 2017 Appropriations Act)

Sec. 11F.1 of S.L. 2017-57 (SB 257) mandates that funds appropriated to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the North Carolina Child Treatment Program be used exclusively for the following purposes:

- 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 measurable outcomes;
- To maintain and manage a public roster of program graduates, linking high-quality clinicians with children, families, and professionals; and
- To partner with leadership within the State, local management entities/managed care organizations as defined in G.S. 122C-3, and the private sector to bring effective mental health treatment to children in juvenile justice and mental health facilities.

This section became effective July 1, 2017.

MEDICAID & HEALTH CHOICE

Health Analytics Program (S.L. 2017-57, Sec. 11A.4/ S257 – 2017 Appropriations Act)

Sec. 11A.4 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services to continue coordinating with the Government Data Analytics Center (GDAC) to develop and operationalize the Health Analytics Program for Medicaid claims analytics and population health management authorized by Sec. 12A.17 of S.L. 2015-241, as amended by Sec. 12A.7 of S.L. 2016-9, and in compliance with G.S. 143B-1385(c)(2)f. The purpose of the Health Analytics Program is apply analytics to Medicaid data in an effort to maximize health care savings and efficiencies, optimize positive health outcomes, and assist in the transition to the transformed North Carolina Medicaid and Health Choice programs.

This section became effective July 1, 2017.

Increase Access to Public Benefits for Older Dual Eligible Seniors (S.L. 2017-57, Sec. 11C.8/ S257 – 2017 Appropriations Act)

Refer to the Older and Disabled Adults section of this document for a summary of this item.

Medicaid Eligibility (S.L. 2017-57, Sec. 11H.1/ S257 – 2017 Appropriations Act)

Sec. 11H.1 of S.L. 2017-57 (SB 257) sets forth the same Medicaid eligibility income categories and thresholds as in the 2015 budget bill (S.L. 2015-241).

This section became effective July 1, 2017.

Medicaid Annual Report (S.L. 2017-57, Sec. 11H.2/ S257 – 2017 Appropriations Act)

Sec. 11H.2 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services, Division of Medical Assistance, to continue publishing the Medicaid Annual Report and accompanying tables on its website by December 31, following the end of each fiscal year.

This section became effective July 1, 2017.

Provider Application and Recredentialing Fee (S.L. 2017-57, Sec. 11H.3/ S257 – 2017 Appropriations Act)

Sec. 11H.3 of S.L. 2017-57 (SB 257) codifies the existing Medicaid provider application fee of $100, in addition to the federal required amount, which the Department of Health and Human Services, Division of Medical Assistance, must charge all Medicaid providers upon initial enrollment and at recredentialing every five years.

This section became effective July 1, 2017.

Volume Purchase Plans and Single-Source Procurement (S.L. 2017-57, Sec. 11H.6/ S257 – 2017 Appropriations Act)

Sec. 11H.6 of S.L. 2017-57 (SB 257) allows the Department of Health and Human Services, Division of Medical Assistance, to utilize volume purchase plans, single source procurement, or other contracting processes in order to improve cost containment.

This section became effective July 1, 2017.

Annual Issuance of Medicaid Identification Cards (S.L. 2017-57, Sec. 11H.7/ S257 – 2017 Appropriations Act)

Sec. 11H.7 of S.L. 2017-57 (SB 257) continues the requirement that the Department of Health and Human Services (DHHS) must issue Medicaid identification cards on an annual basis and requires DHHS to update its rules in accordance with this requirement.

This section became effective July 1, 2017.

Increase Personal Care Services Rate (S.L. 2017-57, Sec. 11H.12/ S257 – 2017 Appropriations Act)

Sec. 11H.12 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services, Division of Medical Assistance, to increase the rate paid for Medicaid personal care services and for in-home aide, respite care in-home aide, and personal care assistance services that are provided under the Community Alternatives Program for Children (CAP-C) waiver. The rate for these services is increased to $3.90 per 15-minute billing unit, which is equivalent to $15.76 per hour.

This section became effective July 1, 2017, and requires the rate increase begin January 1, 2018.

Retroactive Personal Care Services Payment (S.L. 2017-57, Sec. 11H.12A/ S257 – 2017 Appropriations Act)

Sec. 11H.12A of S.L. 2017-57 (SB 257) pertains to Medicaid reimbursement for personal care services provided to a Medicaid recipient before prior approval for the services has been requested. Before this provision, Medicaid policy has allowed prior approval for personal care services to be effective retroactively up to 10 days prior to the date prior approval was requested. This section extends the prior approval retroactive effective period to up to 30 days prior to the date prior approval was requested, which allows providers to receive Medicaid reimbursement for personal care services provided up to 30 days prior to requesting prior approval for the services.

This section became effective August 1, 2017, and applies to personal care services requests received on or after that date.

Graduate Medical Education Medicaid Reimbursement (S.L. 2017-57, Sec. 11H.13/ S257 – 2017 Appropriations Act)

Sec. 11H.13 of S.L. 2017-57 (SB 257) pertains to Medicaid reimbursement to hospitals for graduate medical education costs. A provision in the 2015 budget bill (S.L. 2015-241) imposed certain prohibitions on Medicaid reimbursement for graduate medical education costs.

This section directs that for the period July 1, 2017, through June 30, 2019, the Department of Health and Human Services, Division of Medical Assistance is not required to implement the prohibitions on reimbursement for graduate medical education that were required by the 2015 budget bill. This section states the General Assembly's intent to provide funding to continue the reimbursement for graduate medical education beyond the 2017-2019 fiscal biennium as part of the Medicaid transformation required by legislation passed in 2015. This section requires the Division of Medical Assistance to report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by January 1, 2018, on Medicaid spending for graduate medical education as well as other Medicaid spending.

This section became effective July 1, 2017.

Plan to Implement Coverage for Home Visits for Pregnant Women and Families with Young Children (S.L. 2017-57, Sec. 11H.14/ S257 – 2017 Appropriations Act)

Sec. 11H.14 of S.L. 2017-57 (SB 257) states the General Assembly's intent to provide Medicaid coverage for home visits consistent with the Nurse-Family Partnership model. This section requires the Department of Health and Human Services (DHHS) to develop a plan to implement this coverage and report the plan to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by November 1, 2017. The report must state whether DHHS intends to add this coverage pursuant to the authority granted under G.S. 108A-54(e) or whether additional appropriations are needed to implement the coverage.

This section became effective July 1, 2017.

Plan to Establish Medicaid Coverage for Ambulance Transports to Alternative Appropriate Care Locations (S.L. 2017-57, Sec. 11H.14A/ S257 – 2017 Appropriations Act)

Sec. 11H.14A of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services (DHHS) to develop a plan for adding Medicaid coverage for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics, or other alternative appropriate care locations, instead of hospital emergency departments. DHHS must report its plan to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by December 1, 2017, and the report must state whether DHHS intends to add this coverage pursuant to the authority granted under G.S. 108A-54(e) or whether additional appropriations are needed to implement this coverage.

This section became effective July 1, 2017.

NC Tracks Enhancements to Prevent and Detect Fraud, Waste, and Abuse (S.L. 2017-57, Sec. 11H.15/ S257 – 2017 Appropriations Act)

Sec. 11H.15 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services to enhance the capability of the NC Tracks Medicaid Management Information System (MMIS) to detect and prevent fraud, waste, and abuse prior to the payment of claims. The new capability must be implemented using existing MMIS contracts no later than 150 days after the effective date of this section.

This section became effective June 28, 2017.

Medicaid Transformation Clarifying Changes (S.L. 2017-57, Sec. 11H.17/ S257 – 2017 Appropriations Act)

Sec. 11H.17 of S.L. 2017-57 (SB 257) clarifies language in the 2015 Medicaid transformation legislation that that exempts certain services provided or billed by Local Education Agencies and Child Developmental Services Agencies from being reimbursed through the capitated contracts with Prepaid Health Plans that are required as part of Medicaid transformation. Instead of being covered by Prepaid Health Plans, these exempted services will continue to be reimbursed as they are under the current system.

This section became effective July 1, 2017.

Prepayment Claims Review Modifications (S.L. 2017-57, Sec. 11H.19/ S257 – 2017 Appropriations Act)

Sec. 11H.19 of S.L. 2017-57 (SB 257) amends the statute governing the Medicaid prepayment claims review process, which allows the Department of Health and Human Services (DHHS) to require certain Medicaid providers to submit documentation related to billed claims for review before the provider can receive Medicaid reimbursement for the claims. Changes to the prepayment review process made in this section include:

- DHHS may keep providers on prepayment review for up to 24 months (increased from 12 months).
- Providers must submit a certain volume of claims during the review period in order to meet the standards for successful completion of the prepayment review program.
- If claims for services that were provided with the timeframe that the provider was on prepayment review are submitted after prepayment review has ended, those claims may still be subject to review prior to payment.
- Certain aspects of provider terminations and appeals resulting from prepayment review are clarified.

This section becomes effective October 1, 2017, and applies to providers who are placed on prepayment review on or after that date and to written notices provided to providers on or after that date.

Medicaid Eligibility Monitoring (S.L. 2017-57, Sec. 11H.20/ S257 – 2017 Appropriations Act)

Sec. 11H.20 of S.L. 2017-57 (SB 257) creates a new statute that requires the Department of Health and Human Services (DHHS) to review certain information for all Medicaid recipients quarterly to determine whether the recipient has had a change in circumstances that may make the recipient no longer eligible for Medicaid. Under the statute, DHHS must share the information about the change in circumstances with the relevant county departments of social services (DSS), and the statute provides a process that the county DSS must follow with regard to redetermining eligibility for recipients who are identified during the DHHS review.

This section specifies that DHHS may contract with vendors or enter into memoranda of understanding with other agencies to assist with this review.

The statute created by this section will become effective January 1, 2018. The remainder of the section became effective June 28, 2017.

Medicaid Eligibility Determination Timeliness Reporting (S.L. 2017-57, Sec. 11H.21/ S257 – 2017 Appropriations Act)

Sec. 11H.21 of S.L. 2017-57 (SB 257) codifies a requirement that the Department of Health and Human Services report annually to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice with certain data related to the timeliness of Medicaid eligibility determinations made by the county departments of social services. This reporting was initially required in the 2016 budget bill (S.L. 2016-94) for two years, and this section continues the reporting requirement on an ongoing basis.

This section became effective July 1, 2017.

Support Improvement in the Accuracy of Medicaid Eligibility Determinations (S.L. 2017-57, Sec. 11H.22/ S257 – 2017 Appropriations Act)

Sec. 11H.22 of S.L. 2017-57 (SB 257) enacts various provisions related to the accuracy of Medicaid eligibility determinations made by county departments of social services, including the following:

- It clarifies in statute that the Department of Health and Human Services (DHHS) administers the Medicaid program and delegates Medicaid eligibility determinations to the county departments of social services.
- It requires DHHS to report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by November 1, 2017, on progress made in response to the State Auditor's January 2017 Performance Audit regarding the accuracy of county Medicaid eligibility determinations.
- It creates a new set of statutes that require DHHS to annually audit all county departments of social services' Medicaid eligibility determinations based on standards for accuracy and quality assurance set by DHHS in consultation with the State Auditor and adopted in rule. For counties not meeting these standards, the statutes require a corrective action plan and allow DHHS to assume responsibility for determining eligibility if the plan is not completed.
- It requires DHHS to collaborate with the State Auditor to develop a plan of implementation of the annual audits required by statute and to report that plan to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2018.
- It codifies in statute the counties' financial responsibility for eligibility determination errors that are attributable to the county, which was previously established in an administrative rule.
- It requires DHHS to develop a NC FAST training and certification program that all county caseworkers must complete every three years. DHHS must report on the implementation of this program to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2018.

This section became effective June 28, 2017. The statute regarding the counties' financial responsibility for certain Medicaid eligibility determination errors applies to errors identified on or after June 28, 2017.

Medicaid Subrogation Rights Conforming Changes (S.L. 2017-57, Sec. 11H.23/ S257 – 2017 Appropriations Act)

Sec. 11H.23 of S.L. 2017-57 (SB 257) pertains to the Medicaid program's subrogation to a Medicaid beneficiary's right to recover from a third party in cases of personal injury or wrongful death, meaning that the Medicaid program may receive a share of a Medicaid beneficiary's recovery when Medicaid paid for services provided as a result of the injury. Medicaid subrogation is required by federal law, and changes to this federal law are scheduled to become effective October 1, 2017. The changes to federal law will require changes to the North Carolina Medicaid subrogation statute. This section amends the current North Carolina statute pertaining to Medicaid subrogation only if the changes to federal law take effect as planned on October 1, 2017. The changes to the North Carolina statute pertain to the amount of the lien that the Medicaid program has on the Medicaid beneficiary's recovery from a third party.

This section became effective July 1, 2017, and the changes required by the section will become effective if federal law changes take effect on October 1, 2017.

MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/ SUBSTANCE ABUSE SERVICES

Strengthen Opioid Misuse Prevention (STOP) Act (S.L. 2017-74/ H 243)

S.L. 2017-74 (HB 243) makes the following changes to the laws governing the prescribing of controlled substances:

- Extends the statewide standing order for opioid antagonists to allow practitioners to prescribe an opioid antagonist to any governmental or nongovernmental agency (effective July 1, 2017).
- Designates certain Schedule II and III drugs as "targeted controlled substances and makes changes to the laws governing the prescribing of those targeted controlled substances to:
  - Require a physician assistant or nurse practitioners employed by pain clinics to personally consult with their supervising physician prior to prescribing the targeted controlled substance if the use of the targeted controlled substance will exceed 30 days (effective July 1, 2017).
  - Require electronic prescriptions for all targeted controlled substances not meeting certain exceptions (effective January 1, 2020).
  - Limit prescriptions for targeted controlled substances upon initial consultations for acute pain to no more than a five-day supply, unless the prescription is for post-operative acute pain relief immediately following a surgical procedure, in which case

the practitioner may not prescribe more than a 7-day supply (effective January 1, 2018).

- Require hospice and palliative care providers who prescribe a targeted controlled substance to provide oral and written information to the patient and the patient's family regarding the proper disposal of the targeted controlled substance (effective January 1, 2017).

➢ Clarifies the allowable funds for syringe exchange programs.

➢ Makes changes to the statutes governing the Controlled Substance Reporting System (CSRS) database including:

- Requiring dispensers to report information required by statute to the CSRS database no later than the close of the next business day after the prescription is delivered (effective September 1, 2017).
- Imposing a civil penalty upon dispensers for failing to report the information required within a reasonable time of being informed by DHHS that the required information is missing or incomplete (effective September 1, 2017).
- Allowing the Department to notify practitioners and their respective licensing boards of prescribing behavior that (i) increases the risk of diversion of controlled substances, (ii) increases the risk of harm to the patient, or (iii) is an outlier among other practitioner behavior (effective July 1, 2017).
- Requiring administrators of hospital emergency departments and acute care facilities to provide the Department with an annual list of delegates who are authorized to receive data on behalf of providers within the hospital (effective July 1, 2017).
- Requiring dispensers to demonstrate to the satisfaction of the NC Board of Pharmacy that they are registered for access to the CSRS database within 30 days of initial or renewal licensure (effective June 29, 2017; applies to acts committed 30 days after State Chief Information Officer notifies the Revisor of Statutes that (i) upgrades to the CSRS database have been completed and (ii) the upgraded database is fully operational and connected to the statewide health information exchange).
- Requiring practitioners to review the patient's preceding 12 month history in the CSRS database prior to initially prescribing a targeted controlled substance to a patient and again every 3 months afterward that the targeted controlled substance remains a part of the patient's medical care (effective June 29, 2017) applies to acts committed 30 days after State Chief Information Officer notifies the Revisor of Statutes that (i) upgrades to the CSRS database have been completed and (ii) the upgraded database is fully operational and connected to the statewide health information exchange).
- Requiring dispensers to review the patient's preceding 12 month history in the CSRS database prior to dispensing a targeted controlled substance and document the review under certain circumstances (effective June 29, 2017) applies to acts committed 30 days after State Chief Information Officer notifies the Revisor of Statutes that (i) upgrades to the CSRS database have been completed and (ii) the upgraded database is fully operational and connected to the statewide health information exchange).

- Creating a CSRS Fund for the operation of the CSRS database (effective September 1, 2017).
- Requiring an annual report from the Department on data reported to the CSRS database (effective September 1, 2017).

➢ Amends language in the 2015 budget to facilitate the interstate connectivity of the CSRS database (effective July 1, 2017).

Single-Stream Funding for DMH/DD/SAS Community Services (S.L. 2017-57, Sec. 11F.2/ S257 – 2017 Appropriations Act)

Sec. 11F.2 of S.L. 2017-57 (SB 257), as amended by Sec. 4(a) of S.L. 2017-206, directs the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services (DHHS) to make single-stream funding payments to local management entities/managed care organizations (LME/MCOs) for behavioral health services on the third working day of each month of the year. This section also reduces the total amount of single-stream funding available to the Division in each year of the biennium compared to past budgets and directs the Division to allocate the reduction in funding among the LME/MCOs according to a prescribed schedule. By March 1, 2018, the Secretary of the Department of Health and Human Services may submit to the Joint Legislative Oversight Committee on Health and Human Services a proposal for any adjustments to the allocation of the recurring LME/MCO reductions. In the event of a Medicaid budget surplus in either year of the biennium, then the amount of the surplus, not to exceed $30 million in each year, may be used to offset the single-stream funding reductions required by this section.

This section also requires the following:

➢ LME/MCOs must offer the same level of service utilization as during the 2014-2015 fiscal year across the LME/MCO's catchment area.

➢ DHHS must establish an annual maintenance of effort (MOE) spending requirement for all mental health and substance abuse services, which the LME/MCOs must meet using State appropriations, in order to meet MOE requirements for federal block grant awards.

➢ DHHS must report certain financial information for all LME/MCOs monthly to the Joint Legislative Oversight Committee on Health and Human Services.

➢ Each quarter, beginning July 1, 2017, the Secretary of DHHS must evaluate all LME/MCOs relative to solvency standards developed by DHHS. If the Secretary determines that an LME/MCO is at risk of failing financially within two years, then a plan of corrective action for the LME/MCO must be created and implemented. By October 1, 2017, the Secretary of DHHS must submit a report to the Joint Legislative Oversight Committee on Health and Human Services on any LME/MCO that has been determined to be at risk of failing financially in accordance with this section.

This section became effective July 1, 2017.

Funds for Local Inpatient Psychiatric Beds or Bed Days (S.L. 2017-57, Sec. 11F.3/ S257 – 2017 Appropriations Act)

Sec. 11F.3 of S.L. 2017-57 (SB 257) continues a requirement that the Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities, and

Substance Abuse Services, use certain funds to purchase additional new or existing local inpatient psychiatric beds or bed days not currently funded through the local management entities/managed care organizations (LME/MCOs) for individuals who are medically indigent. This section allows DHHS to use up to ten percent (10%) of this funding to pay for facility-based crisis services and nonhospital detoxification services to any individual in need of the services regardless of whether the individual is medically indigent.

This section requires DHHS to report to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2018, and December 1, 2019, on the use of these funds.

This section became effective July 1, 2017.

Use of Funds to Purchase Inpatient Alcohol and Substance Use Disorder Treatment Services (S.L. 2017-57, Sec. 11F.4/ S257 – 2017 Appropriations Act)

Sec. 11F.4 of S.L. 2017-57 (SB 257) amends language pertaining to the use of funds for the purchase of inpatient alcohol and substance abuse treatment services from the 2015 budget to require that a minimum of 86% of the allotted funds be used exclusively to purchase inpatient alcohol and substance abuse treatment services from the Alcohol Drug Abuse Treatment Centers (ADATCs) in order to increase the availability of services through the ADATCs to individuals in need of opioid treatment. The LME/MCOs are required to use any remaining allocations to purchase inpatient alcohol and substance abuse treatment services from any qualified provider.

This section became effective July 1, 2017.

Use of Dorothea Dix Hospital Property Funds for the Purchase of Additional Psychiatric and Facility-Based Crisis Beds (S.L. 2017-57, Sec. 11F.5/ S257 – 2017 Appropriations Act)

Sec. 11F.5 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to utilize certain funds appropriated from the Dorothea Dix Hospital Property Fund to pay for renovation or building costs for constructing new licensed inpatient behavioral health beds or for converting existing inpatient acute care beds into licensed inpatient behavioral health beds. Certain portions of these funds must be used for beds at Caldwell/University of North Carolina Health Care in Caldwell County, Cape Fear Valley Medical Center in Cumberland County, Mission Health System in Buncombe County, Good Hope Hospital in Harnett County, and the Dix Crisis Intervention Center in Onslow County. Facilities that receive this funding are exempt from certificate of need review for establishing or expanding behavioral health services, including outpatient therapy services and substance use disorder services, as well as for replacing or relocating a behavioral health facility or for changing inpatient bed capacity. Facilities receiving this funding also must reserve fifty percent (50%) of the beds constructed or converted with these funds either for purchase by DHHS or for certain patients referred by local management entity/managed care organizations (LME/MCOs). DHHS must report to the Joint Legislative Oversight Committee on Health and Human Services annually beginning November 1, 2018, on the additional beds created by this funding and must submit by December 1, 2020, a plan for funding the operating costs of these beds from a source other than the Dorothea Dix Hospital Property Fund.

This section also provides funding to the Division to be used to award competitive grants for establishing up to two new facility-based crisis centers for children and adolescents.

This section became effective July 1, 2017.

Funds for Case Management Pilot Program (S.L. 2017-57, Sec. 11F.5A/ S257 – 2017 Appropriations Act)

Sec. 11F.5A of S.L. 2017-57 (SB 257) requires $2 million in nonrecurring funds for the 2017-18 fiscal year appropriated to the Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), to be allocated for the development and establishment of a two-year pilot program at a hospital in Wake County to support a hospital-based, comprehensive community case management program. DMH/DD/SAS, in consultation with LME/MCOs responsible for the management and provision of mental health, developmental disabilities, and substance abuse disorder services in Wake County under the 1915(b)(c) Medicaid Waiver must oversee the development and establishment of the pilot program to ensure it is designed to reduce avoidable emergency department readmissions and emergency department boarding times among individuals with behavioral health needs.

By December 1, 2020, DHHS must submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division, evaluating the effectiveness of the pilot program in reducing avoidable emergency department readmissions and emergency department boarding times among individuals with behavioral health needs.

This section became effective July 1, 2017.

Additions to the Strategic Plan for Improvement of Behavioral Health Services (S.L. 2017-57, Sec. 11F.6/ S257 – 2017 Appropriations Act)

Sec. 11F.6 of S.L. 2017-57 (SB 257) amends a provision in the 2016 budget bill (S.L. 2016-94) that directs the Department of Health and Human Services (DHHS) to develop and submit a statewide strategic plan for behavioral health services. This section adds a requirement that DHHS consider past and current studies and reports in development of the strategic plan. This section also directs DHHS to consider issues pertaining to the delivery of services for people with intellectual and developmental disabilities, which the 2016 budget bill previously had directed the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to study, in development of the strategic plan.

This section became effective July 1, 2017.

Mental Health/Substance Use Disorder Central Assessment and Navigation System Pilot Program (S.L. 2017-57, Sec. 11F.7/ S257 – 2017 Appropriations Act)

Sec. 11F.7 of S.L. 2017-57 (SB 257) establishes a two-year pilot program to focus on assessing and navigating individuals seeking mental health or substance use disorder services, or both, to appropriate community-based services or other community resources in order to reduce the utilization of hospital emergency department services for mental health and substance use disorder services. The pilot must be overseen by the Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), in consultation with the LME/MCO responsible for the

management and provision of mental health, developmental disabilities, and substance use disorder services in New Hanover County under the 1915(b)(c) Medicaid Waiver and is funded through $250,000 in nonrecurring funds for each of the 2017-18 and 2018-19 fiscal years.

The pilot is to be conducted at New Hanover Regional Medical Center (NHRMC) and at Wellness City, operated by Recovery Innovations, Inc., by a 3-person, centralized team consisting of the following individuals:

- A master's level, fully licensed clinician to perform comprehensive clinical assessments of NHRMC patients and other New Hanover County residents exhibiting symptoms of mental illness or substance use disorder who are referred to the pilot program.
- A qualified professional to assist patients, particularly those with a completed comprehensive clinical assessment, with identifying and accessing appropriate community-based services or other community resources.
- A North Carolina certified peer support specialist, with specialized training and personal experience in successfully managing his or her own serious mental illness or substance use disorder, to provide peer support services, including encouraging patients to take personal responsibility for managing their condition, assisting patients in establishing meaningful roles in society, and providing patients with transportation to and from appointments.

The LME/MCO responsible for the management and provision of mental health, developmental disabilities, and substance abuse services in New Hanover County, in collaboration with NHRMC and Recovery Innovations, Inc. must submit an interim report to DMH/DD/SAS by July 1, 2018, and to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2018. A final report must be provided to DMH/DD/SAS by July 1, 2019 and to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2019.

This section became effective July 1, 2017.

Traumatic Brain Injury Pilot Program (S.L. 2017-57, Sec. 11F.9/ S257 – 2017 Appropriations Act)

Sec. 11F.9 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to allocate $150,000 in nonrecurring funds in fiscal year 2017-18 and $300,000 in nonrecurring funds in fiscal year 2018-19 to develop and implement a traumatic brain injury pilot program designed to increase compliance with internationally approved evidence-based treatment guidelines for traumatic brain injury.

DHHS must establish up to three program implementation sites in trauma hospitals. Each program site will receive up to one hundred thousand dollars ($100,000) for the development and implementation of an interactive quality assessment and quality assurance clinical decision support tool. DHHS must contract with a private entity to assist participating trauma hospitals in implementing this tool.

By February 1, 2018, DHHS must submit a progress report on the development and implementation of the pilot program authorized by this section to the Joint Legislative Oversight

Committee on Health and Human Services and the Fiscal Research Division, with a final report being submitted no later than January 7, 2019.

This section became effective July 1, 2017.

Expansion and Renaming of Prescription Drug Abuse Advisory Committee (S.L. 2017-57, Sec. 11F.10/ S257 – 2017 Appropriations Act)

Sec. 11F.10 of S.L. 2017-57 (SB 257) codifies language creating the Prescription Drug Abuse Advisory Committee in the 2015 budget, renames the Committee the Opioid and Prescription Drug Abuse Advisory Committee, expands the committee to require representatives from the Divisions of Adult Correction and Juvenile Justice, Department of Public Safety, and requires the Fiscal Research Division receive a copy of the Department's annual reports in addition to the Joint Legislative Oversight Committees on Health and Human Services and Justice and Public Safety.

This section became effective July 1, 2017.

Funds to Address North Carolina's Opioid Crisis (S.L. 2017-57, Sec. 11F.14A/ S257 – 2017 Appropriations Act)

Sec. 11F.14A of S.L. 2017-57 (SB 257) requires funds awarded to the Department of Health and Human Services (DHHS) from the federal Substance Abuse and Mental Health Services Administration, Grant Number 1H79TI080257-01 Revised, pursuant to the Notice of Award dated April 26, 2017, to address North Carolina's opioid crisis to be used as follows:

- At least 80% of any such funds used during each fiscal year of the 2017-19 fiscal biennium must be used to increase access to treatment and recovery services for individuals with an opioid use disorder.
- Up to 15% of any such funds used during each fiscal year of the 2017-19 fiscal biennium may be used to increase access to opioid use prevention services.
- Up to 5% of any such funds used during each fiscal year of the 2017-19 fiscal biennium may be spent on administrative costs associated with implementing the above grant award.

DHHS must, at a minimum, achieve the following outcomes as a result of any funds spent:

- Increase the number of individuals receiving opioid use disorder treatment by 9% during each fiscal year of the 2017-19 biennium.
- Increase the capacity of Mediation-Assisted Treatment services by 5% during each year of the 2017-19 fiscal biennium.

DHHS must report specified data to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2018 and again by November 1, 2019 on the use of the funds.

This section became effective July 1, 2017.

Repeal of LME/MCO Clinical Integration Activities Report (S.L. 2017-57, Sec. 11F.16/ S257 – 2017 Appropriations Act)

Sec. 11F.16 of S.L. 2017-57 (SB 257) repeals a provision in the 2013 budget bill (S.L. 2013-360) requiring the Department of Health and Human Services to report semiannually to the Joint Legislative Oversight Committee on Health and Human Services on the progress, outcomes, and savings associated with clinical integration activities conducted by the local management entities/managed care organizations (LME/MCOs) and Community Care of North Carolina (CCNC).

This section became effective July 1, 2017.

Supplemental Short-Term Assistance for Group Homes (S.L. 2017-57, Sec. 11F.18A/ S257 – 2017 Appropriations Act)

Sec. 11F.18A of S.L. 2017-57 (SB 257) reinstates short-term State funding for group home residents who were eligible for Medicaid personal care services prior to January 1, 2013, who lost their eligibility for the services after that date, and who have continuously resided in a group home since December 31, 2012. The funding must be used to provide necessary supervision and medication management for these residents. This short-term funding was originally established in the 2013 budget bill (S.L. 2013-360) but ended on June 30, 2015. This section authorizes funding to continue through June 30, 2019.

This section became effective July 1, 2017.

Expand North Carolina Innovations Waiver Slots (S.L. 2017-57, Sec. 11H.11/ S257 – 2017 Appropriations Act)

Sec. 11H.11 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services, Division of Medical Assistance, to make an additional 400 slots available under the NC Innovations waiver beginning January 1, 2018.

This section became effective July 1, 2017.

PROVIDERS, FACILITIES & LICENSURE

Occupational Therapy Choice of Provider (S.L. 2017-24/H 208)

S.L. 2017-24 (HB 208) amends G.S. 58-50-30 to allow insureds to receive insurance-covered occupational therapy from the licensed occupational therapist of their choice.

The act becomes effective October 1, 2017, and applies to health benefits contracts issued, renewed, or amended on or after that date.

Enact Physical Therapy Licensure Compact (S.L. 2017-28/ H 57)

S.L. 2017-28 (HB 57) makes North Carolina a member of the Physical Therapy Licensure Compact. Membership in the compact allows physical therapists who hold licenses in good standing in another Compact state to practice physical therapy in North Carolina. Likewise, physical therapists holding a valid license in North Carolina are able to practice physical therapy

in another Compact member state. The Compact became effective April 25, 2017. The act also amends G.S. 93B-15.1 to prohibit occupational licensing boards (OLBs), as defined in G.S. 93B-1, from charging fees as a pre-requisite to issuing licenses to military-trained applicants and spouses of military members who are licensed in good standing in another state.

The provisions of the act pertaining to the Physical Therapy Licensure Compact will become effective October 1, 2017. The provisions of the act pertaining to OLBs became effective July 1, 2017.

Required Experience for DMH/DD/SAS QPs (S.L. 2017-32/ H 478)

S.L. 2017-32 (HB 478) requires the Department of Health and Human Services (DHHS) to amend the qualifications for Qualified Professionals in the mental health, developmental disabilities, and substance abuse services (DMH/DD/SAS) system of care to count all years of full-time DMH/DD/SAS experience toward the required number of years' experience, regardless of when the experience was obtained.

This act became effective June 8, 201; however, any changes to clinical coverage policies and any changes to rules adopted by DHHS relating to the qualifications of Qualified Professionals required in the act are not effective until DHHS has received CMS approval of the State Plan amendment required by this act.

Graduate Medical Funding for Cape Fear Valley Medical Center (S.L. 2017-57, Sec. 11A.13/ S257 – 2017 Appropriations Act)

Sec. 11A.13 of S.L. 2017-57 (HB 257) directs the Department of Health and Human Services, Division of Central Management and Support, to allocate up to $3 million dollars in recurring funds to be used to for graduate medical education to support the establishment of residency programs at the Cape Fear Medical Center (Center) affiliated with Campbell University School of Medicine.

The recurring amount of funds allocated to the Center will not exceed the lesser of: (1) the total amount of actual lost Medicare payments attributed to the Center's reclassification as a rural hospital prior to October 1, 2017, or (2) any other charge approved by CMS, up to a maximum of $3 million dollars.

No funds will be paid to the Center until the Office of State Budget and Management (OSMB) certifies: (1) the amount of actual lost Medicare payments, (2) that the Center has maintained approval from the Centers for Medicare and Medicaid Services (CMS) for reclassification as a rural hospital or rural referral center, and (3) the Center has maintained approval from the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for residency programs with at least 130 additional residency slots.

The Center must report on its progress in establishing residency programs to the House Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division no later than April 1, 2018.

Any funds not obligated to, or encumbered by, the Center by June 30, 2018, must revert to the General Fund.

This section became effective July 1, 2017.

Study Continuing Education for Health Care Providers Licensed to Prescribe Controlled Substances (S.L. 2017-57, Sec. 11F.11/ S257 – 2017 Appropriations Act)

Sec. 11F.11 of S.L. 2017-57 (SB 257) encourages the North Carolina Area Health Education Centers Program to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by December 1, 2017 on the feasibility of providing a continuing education course for health care providers licensed to prescribe controlled substances in the State. The course would include instruction on at least all of the following:

- Controlled substance prescribing practices.
- Controlled substance prescribing for chronic pain management.
- Misuse and abuse of controlled substances.

This section became effective June 28, 2017.

Study on Statewide Expansion of the Wright School (S.L. 2017-57, Sec. 11F.12/ S257 – 2017 Appropriations Act)

Sec. 11F.12 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services to study and report to the Joint Legislative Oversight Committee on Health and Human Services on the feasibility and cost of, and any obstacles to, establishing additional State-operated facilities throughout the State to: (1) provide statewide access to best practice, cost-effective, residential mental health treatment to children, ages six to 12, with serious emotional and behavioral disorders and (2) support their families and communities by building the capacity to meet their children's special needs at home, at school, and within their local communities.

This section became effective July 1, 2017.

Facilities Included Under Single Hospital License (S.L. 2017-57, Sec. 11G.2/ S257 – 2017 Appropriations Act)

Sec. 11G.2 of S.L. 2017-57 (SB 257) amends G.S. 131E-77(e1) to remove "premises, buildings, outpatient clinics, and other locations" from the definition of what a hospital license issued by the Department of Health and Human Services may cover.

This section became effective June 28, 2017.

Moratorium on Special Care Unit Licenses (S.L. 2017-57, Sec. 11G.3/ S257 – 2017 Appropriations Act)

Refer to the Older & Disabled Adults section of this document for a summary of this item.

Joint Oversight Subcommittees on Medical Education and Residency Programs (S.L. 2017-57, Sec. 11J.2 / S257 – 2017 Appropriations Act)

Sec. 11J.2 of S.L. 2017-57 (SB 257) requires the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee to appoint subcommittees to jointly examine the use of State funds to support medical education

and medical residency programs. The subcommittees may seek input from other states, stakeholders, and national experts on medical education programs, medical residency programs, and health care.

By February 1, 2018, the Department of Health and Human Services and the University of North Carolina must provide the subcommittees the following information: (1) the identity, location, and number of positions available in medical education programs and medical residency programs, broken down by geographic area; (2) the specific amount of State funds or the nature of any other support provided by the State to medical education programs and medical residency programs, broken down by program; (3) the number of graduates of medical education programs and medical residency programs who are currently practicing in North Carolina, broken down by specialty areas in which North Carolina is experiencing a shortage; (4) the number of program graduates who practiced in North Carolina for at least five years after graduation; and (5) any other information requested by the subcommittees.

The subcommittees shall jointly develop a proposal for a statewide plan to support medical education programs and medical residency programs within North Carolina. Each subcommittee shall submit a report to its respective oversight committee on or before March 15, 2018, at which time each subcommittee will terminate.

This section became effective June 28, 2017.

Authorization for Chiropractic Preceptorships (S.L. 2017-57, Sec. 11J.3/ S257 – 2017 Appropriations Act)

Sec. 11J.3 of S.L. 2017-57 (SB 257) amends Article 8 of Chapter 90 of the General Statutes to establish a chiropractic preceptorship program where chiropractic students may observe licensed chiropractors and perform the duties of a certified chiropractic assistant while under the supervision of a licensed chiropractor.

This section became effective June 28, 2017.

The Pharmacy Patient Fair Practices Act (S.L. 2017-116/H 466)

S.L. 2017-116 (HB 466) permits pharmacists to discuss lower-cost alternative drugs with, and sell lower-cost alternative drugs to, consumers. It prohibits pharmacy benefits managers from using contract terms to prevent pharmacies from providing store-direct delivery services. Pharmacy benefits managers are also prohibited from charging insureds a co-pay that exceeds the total submitted charges by a network pharmacy. Finally, it allows pharmacy benefits managers to charge pharmacies a fee for costs related to claim adjudication only if the fee was set out in a contract or reported on the remittance advice of the claim.

This act will become effective October 1, 2017, and apply to all contracts entered into, renewed, or amended on or after that date.

Establish New Nurse Licensure Compact (S.L. 2017-140/ H 550)

S.L. 2017-140 (HB 550) enacts and makes North Carolina a member state in the new nurse licensure compact. It also repeals the current nurse licensure compact and replaces it with the new version.

This act will become effective the earlier of December 31, 2018, or the enactment of the new compact by the 26th state. The Board must report to the Revisor of Statutes when 26 states have enacted the compact.

Require Criminal Background Checks for Pharmacist Licensure (S.L. 2017-144/ S 104)

S.L. 2017-144 (SB 104) makes a number of technical changes to G.S. 90-85.15, which governs applications and requirements for licensure as a pharmacist, and mandates that the Board of Pharmacy require applicants for a pharmacy license to provide the Board with a criminal history report, at the applicant's expense, from a reporting service designated by the Board.

This act becomes effective January 1, 2018.

Reduce Cost and Regulatory Burden on Hospital Construction (S.L. 2017-174/S 42)

S.L. 2017-174 (SB 42) directs the North Carolina Medical Care Commission to adopt the recommendations of the American Society of Healthcare Engineers Facility Guidelines Institute.

This act became effective July 21, 2017, and applies to any licensee or prospective applicant who seeks to make specified types of alterations or additions to its hospital facilities, or to construct new hospital facilities, that submit plans and specifications to the Department of Health and Human Services on or after January 1, 2016.

Dental Plans Provider Contracts and Transparency (S.L. 2017-205/H 140)

S.L. 2017-205 (HB 140) makes entities that write stand-alone dental insurance subject to the disclosure and notification provisions for fee schedules, reimbursement policies, and claim submission policies contained in the health plans fee schedules. It clarifies that "household property" for the purposes of single interest credit property insurance includes household furniture, furnishings, appliances, and other personal property of a debtor, not including an automobile. It also requires credit insurance rate standards to be set every third year beginning January 1, 2018.

This bill was vetoed by the Governor on July 27, 2017. The veto was overridden on August 30, 2017. This act becomes effective October 1, 2017.

Change Membership of Medical Board (S.L. 2017/H 770)

Sec. 5 of S.L. 2017-206 (HB 770) amends the membership of the North Carolina Medical Board by changing the entities that appoint the public members. Previously the Governor appointed three public members. Under this act the Governor appoints one public member and the General Assembly appoints two public members. For the two public members appointed by the General Assembly, one member is upon the recommendation of the Speaker of the House of Representatives and one is upon the recommendation of the President Pro Tempore of the Senate. Additionally, new language is inserted to prohibit a public member from being a health care provider or the spouse of a health care provider.

This section became effective August 30, 2017, and applies to vacancies occurring after June 30, 2017.

PUBLIC HEALTH

Funds for School Nurses (S.L. 2017-57, Sec 11E.1/S257 – 2017 Appropriations Act)

Sec. 11E.1 of S.L. 2017-57 (SB 257) adds a new section (G.S. 130A-4.3) to Part 1, of Article 1, of Chapter 130A of the General Statutes directing the Department of Health and Human Services (DHHS) to distribute funds appropriated for the School Nurse Funding Initiative to local health departments according to a formula that includes: (1) school nurse-to-student ratio, (2) the percentage of students eligible for free or reduced-price meals, (3) the 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) the percentage of students with chronic illnesses, and (8) the percentage of county population consisting of minority persons. These funds must supplement and not supplant other state, local, or federal funds appropriated for the same purpose.

The new statute also requires the Division of Public Health (DPH) to ensure that school nurses funded pursuant to the section: (1) serve as the coordinator of the health services program, (2) provide health education to students, staff, and parents, (3) identify health and safety concerns in the 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, (8) provide health education and counseling, and (9) be available to assist the county health department during a public health emergency. Additionally DPH must ensure school nurses funded with the funds to not assist in any instructional or administrative duties associated with a school's curriculum.

This section became effective July 1, 2017.

Budget Deficit in State Laboratory of Public Health (S.L. 2017-57, Sec 11E.2/S257 – 2017 Appropriations Act)

Sec. 11E.2 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services, Division of Public Health, to review the current fee schedule for medical and environmental services provided by the State Laboratory of Public Health and report any recommended strategies for addressing its structural budget deficit no later than March 1, 2018.

This section became effective on June 28, 2017.

Local Health Departments Competitive Grant Process (S.L. 2017-57, Sec 11E.3/S257 – 2017 Appropriations Act)

Sec. 11E.3 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services (DHHS), Division of Public Health, to use funds appropriated in each biennium to administer a competitive grant process for local health departments based on maternal and infant health indicators, with the goals of improving North Carolina birth outcomes, improving the overall health status of children five and younger, and lowering North Carolina's infant mortality rate.

The plan for administering the competitive grant process must include the following components: (1) a request for application 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 guarantee that funds received by the Department to implement the plan supplement and do not supplant existing funds for maternal and child health initiatives, and (4) an award of grants to local health departments for up to two years.

No later than July 1 of each year, the Secretary of DHHS must announce the recipients of the competitive grant awards and allocate funds to the grant recipients. After awards have been granted, the Secretary must submit a report to the Joint Legislative Oversight Committee on Health and Human Services that includes the identity and a brief description of each grantee, each program or initiative offered by the grantee, the amount of funding awarded to each grantee, and the number of persons served by each grantee.

No later than December 1 of each fiscal year, each local health department receiving funding pursuant to this section must submit to the Division of Central Management and Support, a written report of all activities funded by State appropriations.

This section became effective July 1, 2017.

Evidence-Based Diabetes Program (S.L. 2017-57, Sec 11E.5/S257 – 2017 Appropriations Act)

Sec. 11E.5 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services (DHHS) to administer an evidence-based diabetes prevention program targeting minority populations in consultation with the Chronic Disease and Injury Prevention Section. The program should be modeled after the program recommended by the National Institute of Diabetes and Digestive and Kidney Diseases. DHHS must report on the program to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2017, and annually thereafter.

This section became effective July 1, 2017.

Implementation of Federal Elevated Blood Level Standard (S.L. 2017-57, Sec 11E.6/S257 – 2017 Appropriations Act)

Sec. 11E.6 of S.L. 2017-57 (SB 257) amends Part 4 of Article 5 of Chapter 130A of the General Statutes to change the definition of "confirmed lead poisoning" to mean a blood lead concentration of 10 micrograms per deciliter and the definition of "elevated blood lead level" to mean a blood lead concentration of five micrograms per deciliter. Sec. 11E.5 also amends Part 4 of Article 5 of Chapter 130A of the General Statutes to confirm that the lead poisoning statutes apply to pregnant women in addition to children.

This section became effective July 1, 2017.

AIDS Drug Assistance Program (S.L. 2017-57, Sec 11E.7/S257 – 2017 Appropriations Act)

Sec. 11E.7 of S.L. 2017-57 (SB 257) amends Part 1 of Article 1 of Chapter 130A by adding a new section (G.S. 130A-4.4) to require the Department of Health and Human Services to work with the Department of Public Safety (DPS) and use DPS funds to purchase drugs to treat AIDS for individuals in the custody of DPS. The funds must be used in a way that allows

them to be accounted for as State matching funds in the federal AIDS Drug Assistance Program.

This section became effective July 1, 2017.

Implementation of Cost-neutral Premium Assistance Program Within AIDS Drug Assistance Program (ADAP) - (S.L. 2017-57, Sec 11E.8/S257 – 2017 Appropriations Act)

Sec. 11E.8 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services (DHHS), Division of Public Health, to continue to implement within the NC ADAP a health insurance premium assistance program that:

- Is cost neutral or achieves savings;
- Utilizes federal funds from Part B of the Ryan White HIV/AIDS Program and ADAP funds to provide individual ADAP participants or subsets of ADAP participants with premium and cost-sharing assistance for the purchase or maintenance of private health insurance coverage, including premiums, co-payments, and deductibles; and
- Meets the requirements of Section 12E.1 of S.L. 2016-94.

DHHS must submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on implementation of the health insurance premium assistance program that must include at least all of the following components:

- A detailed explanation of the program design;
- A demonstration of cost neutrality, which must include a comparison of the cost of providing prescription drugs to eligible beneficiaries through the new health insurance premium program and the existing ADAP program;
- Information on health outcomes of program participants; and
- Any obstacles to program implementation.

This section became effective July 1, 2017.

Eating Disorder Study (S.L. 2017-57, Sec 11E.11/S257 – 2017 Appropriations Act)

Sec. 11E.11 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services, Division of Public Health, to study eating disorders in North Carolina and issue a report on its findings to the Joint Legislative Oversight Committee on Health and Human Services by November 1, 2017.

This section became effective June 28, 2017.

Every Week Counts Demonstration Project (S.L. 2017-57, Sec 11E.12/S257 – 2017 Appropriations Act)

Sec. 11E.12 of S.L. 2017-57 (SB 257) establishes a demonstration project, at least three years long, to study the extent home-based prenatal care reduces preterm birth and whether women pregnant with multiple children who are at risk of preterm birth can benefit from 17 Alpha-Hydroxyprogesterone Caproate (17P) therapy. This section provides that $2.2 million dollars in non-recurring funds from the federal Maternal and Child Health Black Grant are

allocated to the Department of Health and Human Services (DHHS) for the 2017-18 and 2018-19 fiscal years to conduct this demonstration project in Robeson and Columbus counties.

The project must consist of the following components: (1) an Every Week Counts enrollment visit including an early ultrasound assessment and a complete medical examination; (2) women enrolled in Every Week Counts will receive home visits during pregnancy that combine a home-based prenatal care model with social interventions; (3) women enrolled in Every Week Counts will receive home visits during the first two years of their child's life. In these monthly visits, the child's health, growth, and development will be tracked, and the mother will be provided with information on nutritional, health, and developmental needs; (4) there must be a randomized clinical trial of 17P within Every Week Counts in a population of women enriched for preterm birth susceptibility.

Six months after the conclusion of the project, the University of North Carolina at Chapel Hill (UNC) must submit a final report on the project to DHHS. No later than three months after receiving the report from UNC, DHHS must submit a report to the Joint Legislative Oversight Committee on Health and Human Services including an estimate of the cost to expand the program incrementally and statewide, an estimate of any potential savings of State funds associated with expansion of the program, and a timeline for expanding the program statewide if expansion is recommended. The demonstration program will end when UNC submits its report to DHHS.

This section became effective July 1, 2017.

Funds for Pregnancy Care Initiatives (S.L. 2017-57, Sec 11E.13/S257 – 2017 Appropriations Act)

Sec. 11E.13 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services (DHHS) to allocate $1.3 million in nonrecurring funds for each of the 2017-18 and 2018-19 fiscal years to the Carolina Pregnancy Care Fellowship for use as follows: (1) $800,000 to provide grants to purchase durable medical equipment for clinics that apply to the Carolina Pregnancy Care Fellowship for that equipment; (2) $170,000 to provide grants for training on the use of durable medical equipment; (3) $30,000 may be used by Carolina Pregnancy Care Fellowship for administrative purposes related to those grants; (4) $300,000 must be transferred to the Human Coalition, a nonprofit organization, to develop and implement a two-year continuum of care pilot program to assist women experiencing crisis pregnancies to carry their pregnancies to full term.

The program implemented by the Human Coalition must use care coordinators and nursing staff in close collaboration. By November 1, 2017, and periodically thereafter, the Human Coalition must report to DHHS on this program, and DHHS must report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the program by April 1, 2018. DHHS must issue a final report on the program to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than April 1, 2019, and the program will expire on June 30, 2019.

This section became effective July 1, 2017.

Communicable Disease Testing (S.L. 2017-57, Sec 11F.18/S257 – 2017 Appropriations Act)

Sec. 11E.14 of S.L. 2017-57 provides that of the funds appropriated to the State Laboratory of Public Health, Division of Public Health, Department of Health and Human Services, the sum of $300,000 in recurring funds, and $300,000 in nonrecurring funds, for each fiscal year must be used for the purposes listed below.

- To provide testing for Hepatitis C and other priority communicable diseases identified by the Division of Public Health.
- To provide individuals who test positive for Hepatitis C and other priority communicable diseases with access to treatment options.

This section became effective July 1, 2017.

Study on Site-Of-Use Solutions for Safe Disposal of Prescription Drugs (S.L. 2017-57, Sec 11F.18/S257 – 2017 Appropriations Act)

Sec. 11F.18 of S.L. 2017-57 (SB 257) requires the Department of Health of Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to study and submit a report to the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division, on simple site-of-use solutions for the safe disposal of prescription drugs.

This section became effective July 1, 2017.

Funds to Continue Community Paramedicine Pilot Program (S.L. 2017-57, Sec 11G.1/S257 – 2017 Appropriations Act)

Sec. 11G.1 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services, Division of Health Services Regulation, to allocate $350,000 in nonrecurring funds for each of the 2017-18 and 2018-19 fiscal years to continue the community paramedicine pilot program authorized in Section 12A.12 of S.L. 2015-241, as amended by Section 12A.3 of S.L. 2016-94. The funds must be distributed as follows: (1) $210,000 to the New Hanover Regional Emergency Medical Services site; (2) $70,000 to the McDowell County Emergency Medical Services site; and (3) $70,000 to the Wake County Emergency Medical Services site.

By November 1, 2019, the Department of Health and Human Services must submit an updated report on the community paramedicine pilot program to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

This section became effective July 1, 2017.

Update Rabies Control Laws (S.L. 2017-106/S 74)

S.L. 2017-106 (SB 74) requires local health directors to use the guidelines issued by the National Association of State Public Health Veterinarians when deciding the proper control measures for a dog, cat, or ferret that has been exposed to rabies.

This act becomes effective October 1, 2017.

OLDER & DISABLED ADULTS

Development and Use of Funds for Alzheimer's Registry (S.L. 2017-57, Sec 11A.5A/ S257 – 2017 Appropriations Act)

Section 3.1 of S.L. 2017-197 amends PART XI of S.L. 2017-57 to add a section (11A.5A) to require that support for the development of an Alzheimer's Registry be accomplished through the Bryan Alzheimer's Disease Research Center at Duke University Medical Center. This section is notwithstanding anything to the contrary in the Joint Conference Committee Report on the Base, Capital, and Expansion Budgets for S.L. 2017-57, and pertains to funds appropriated for the Alzheimer's Registry to the Department of Health and Human Services, Division of Central Management and Support, for each fiscal year of the 2017-2019 fiscal biennium.

This section became effective July 1, 2017.

Increase Access to Public Benefits for Older Dual Eligible Seniors (S.L. 2017-57, Sec. 11C.8/ S257 – 2017 Appropriations Act)

Sec. 11C.8 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services (DHHS), Division of Social Services (DSS), continue implementing an evidence-based pilot program to increase access to public benefits for seniors aged 65 and older who are dually enrolled in Medicare and Medicaid to: (i) improve the health and independence of seniors and (ii) reduce health care costs. DSS must continue to partner with a not-for-profit firm to engage in a data-driven campaign to identify individuals, conduct an outreach program to enroll individuals in SNAP, provide application assistance, evaluate project effectiveness, and make recommendations on policy options. Any nonrecurring funds from 2016-17 fiscal year will not revert but will remain available for continued pilot implementation along with any private or nonprofit funding. If funding and capacity is available, DSS may expand the pilot. DSS must report to the Office of the Governor and the Joint Legislative Oversight Committee on Health and Human Services on the progress in the pilot program by February 1 following each year the pilot program is in place.

This section became effective July 1, 2017.

Temporary Financial Assistance for Facilities Licensed to Accept State-County Special Assistance (S.L. 2017-57, Sec. 11C.13/ S257 – 2017 Appropriations Act)

Sec. 11C.13 of S.L. 2017-57 (SB 257) outlines the criteria for the payment of temporary financial assistance on behalf of a resident and recipient of State-County Special Assistance in the form of a monthly payment to facilities licensed to accept State-County Special Assistance payments. Counties must pay 50% of the cost of providing the monthly payment. The Department of Health and Human Services (DHHS), Division of Social Services (DSS), must make the payments to facilities in accordance with the following requirements:

- The monthly payment is $34.00 per month per resident who is a State-County Special Assistance recipient.
- The payments must only be used to offset the cost of serving the residents who are recipients of State-County Special Assistance.

- DSS must make the payments only from July 1, 2017, until June 30, 2019, and only to the extent that sufficient State and county funds allocated for this purpose are available.
- DSS must not make payments under this section on behalf of a resident whose eligibility determination for State-County Special Assistance is pending.
- DSS must terminate all monthly payments under this section on the earlier of June 30, 2019, or upon depletion of the funds allocated and is not required to provide temporary assistance beyond this period.

This section does not obligate the General Assembly to appropriate funds for the purpose of this section, and is not an entitlement to provide funds for this purpose to a facility, resident of a facility, or other individual.

This section became effective July 1, 2017, and expires June 30, 2019.

State-County Special Assistance (S.L. 2017-57, Sec. 11D.1/ S257 – 2017 Appropriations Act)

Sec. 11D.1 of S.L. 2017-57 (SB 257) establishes the 2017-2019 fiscal biennium maximum monthly rate for State-County Special Assistance recipients who are residents in adult care home facilities at $1,182 per month per resident, and the maximum monthly rate for residents in Alzheimer's/Dementia special care units at $1,515 per month per resident.

This section became effective July 1, 2017.

Authorization for Secretary of DHHS to Raise the Maximum Number of State-County Special Assistance In-Home Payments (S.L. 2017-57, Sec. 11D.1A/ S257 – 2017 Appropriations Act)

Sec. 11D.1A of S.L. 2017-57 (SB 257) authorizes the Secretary of the Department of Health and Human Services, within existing appropriations, to waive the 15% cap on the number of Special Assistance in-home payments. This section is notwithstanding G.S. 108A-47.1 which authorizes the payments be made for up to 15% of the caseload for all State-County Special Assistance.

This section became effective July 1, 2017, and expires June 30, 2019.

Alignment of State and Federal Aging Plan Reporting Deadlines (S.L. 2017-57, Sec. 11D.2/ S257 – 2017 Appropriations Act)

Sec. 11D.2 of S.L. 2017-57 (SB 257) amends G.S. 143B-181.1A to change the date, from March 1 to July 1 of every other odd-numbered year, that the Department of Health and Human Services, Division of Aging and Adult Services, is required to submit a plan for serving older adults in the State.

This section became effective July 1, 2017

Recommendation to Appoint a Subcommittee on Aging (S.L. 2017-57, Sec. 11D.3/ S257 – 2017 Appropriations Act)

Sec 11D.3 of S.L. 2017-57 (SB 257) encourages the cochairs of the Joint Legislative Oversight Committee on Health and Human Services to consider appointing a subcommittee to

examine the State's delivery of services for older adults to: (1) determine their service needs, and to (2) make recommendations to the Committee on how to address those needs. The subcommittee is encouraged to seek input from a variety of stakeholders and interest groups, including the Division of Aging and Adult Services and the Division of Social Services in the Department of Health and Human Services; the North Carolina Coalition on Aging; the North Carolina Senior Tarheel Legislature; and the Governor's Advisory Council on Aging. If the subcommittee is appointed it must submit an interim report on or before March 1, 2018, and a final report on or before November 1, 2018.

This section became effective July 1, 2017.

Moratorium on Special Care Unit Licenses (S.L. 2017-57, Sec. 11G.3/ S257 – 2017 Appropriations Act)

Sec. 11G.3 of S.L. 2017-57 (SB 257) prohibits the Department of Health and Human Services (DHHS), Division of Health Service Regulation, from issuing licenses for special care units, except in specified situations, from the period beginning July 1, 2017, and ending June 30, 2019. The section also requires DHHS to submit a report to the Joint Legislative Oversight Committee on Health and Human Services by March 1, 2019. The report must contain the following:

- The number of licensed special care units in the State.
- The capacity of the currently licensed special care units to serve people in need of their services.
- The anticipated growth in the number of people needing special care unit services.
- The number of applications received from special care units seeking licensure as permitted by this section, and the number of applications that were not approved.

This section became effective July 1, 2017.

Increase Personal Care Services Rate (S.L. 2017-57, Sec. 11H.12/ S257 – 2017 Appropriations Act)

Refer to the Medicaid & Health Choice section of this document for a summary of this item.

Retroactive Personal Care Services Payment (S.L. 2017-57, Sec. 11H.12A/ S257 – 2017 Appropriations Act)

Refer to the Medicaid & Health Choice section of this document for a summary of this item.

Study Program of All-Inclusive Care for the Elderly (PACE) (S.L. 2017-57, Sec. 11H.25/ S257 – 2017 Appropriations Act)

Sec. 11H.25 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services (DHHS), Division of Medical Assistance, to study the efficacy of the Program of All-Inclusive Care for the Elderly (PACE). DHHS must engage a variety of stakeholders, PACE organizations, PACE consumers, and the general public, and the study must consist of the following:

- An evaluation of the existing program, including an update on the report required by Sec. 12H.3 of S.L. 2014-100, structures of PACE organizations, and clinical outcome and quality measures.
- A statewide assessment of anticipated long-term care needs over the next 10 years, by county.
- A review of PACE experiences in other states with an analysis of costs and quality.
- An evaluation of State regulations on PACE providers, including any that could be eliminated.
- An assessment of the role of PACE in the continuum of care and the opportunities to apply the PACE model to additional populations under the PACE Innovations Act of 2015, P.L. 114-85.

No later than March 1, 2018, DHHS must submit a report to the Joint Legislative Oversight Committee on Health and Human Services on the information above and recommendations to provide the highest quality programs at a low cost and to keep aging individuals in their homes.

This section became effective July 1, 2017.

Ombudsman Changes/DHHS Study (S.L. 2017-103/ H248)

Refer to the Department of Health and Human Services-Generally section of this document for a summary of this item.

Improve Adult Care Home Regulation (S.L. 2017-184/H657)

S.L. 2017-184 (HB 657) makes the following changes pertaining to adult care homes: exempts from certificate of need review the acquisition of certain unlicensed adult care homes; implements an informal dispute resolution process for certain inspection findings; changes the training requirements for personal care aides; makes changes to the star rating program; and requires the Department of Health and Human Services to study the Star Rated Certificate Program and report on progress to the Joint Legislative Oversight Committee on Health and Human Services by February 1, 2018, with a final report by October 1, 2018.

This act becomes effective October 1, 2017, with the following exceptions which became effective July 25, 2017: Section 4 requiring the Division of Health Service Regulation, Department of Health and Human Services, and county Departments of Social Services to establish procedures to implement an Informal Dispute Resolution, Section 6 requiring the Star-Rated Certificate study, and Section 7 pertaining to the certificate of need exemption.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

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SENATE BILL 582
House Committee Substitute Favorable 6/28/17
Third Edition Engrossed 6/28/17
Proposed Conference Committee Substitute S582-CCSML-4 [v.1]
10/04/2017 05:50:00 PM

Short Title: Budget & Agency Technical Corrections. (Public)

Sponsors:

Referred to:

April 4, 2017

A BILL TO BE ENTITLED

AN ACT (I) TO MAKE TECHNICAL, CLARIFYING, AND OTHER MODIFICATIONS TO THE CURRENT OPERATIONS APPROPRIATIONS ACT OF 2017 AND TO RELATED LEGISLATION AND (II) TO MAKE AGENCY TECHNICAL CORRECTIONS.

The General Assembly of North Carolina enacts:

PART I. GENERAL PROVISIONS

SECTION 1.1. Section 5.3(e) of S.L. 2017-57 reads as rewritten:

"**SECTION 5.3.(e)** Grant funds awarded under this section shall be subject to a matching requirement from the recipient county as follows:

(1) For a county designated as a development tier one area, the grant shall not exceed three dollars ($3.00) in grant funds for every one dollar ($1.00) provided by the county. Grant funds awarded to a tier one county shall not exceed fifteen million dollars ($15,000,000).

(2) For a county designated as a development tier two area, the grant shall not exceed one dollar ($1.00) for every one dollar ($1.00) in grant funds provided by the county. Grant funds awarded to a tier two county shall not exceed ten million dollars ($10,000,000).

Grant funds shall be used for the construction of new ~~capital projects~~school buildings only. Grant funds shall not be used for real property acquisition or for operational lease agreements. Notwithstanding subdivision (2) of this subsection, grant funds shall only be awarded to development tier one counties until the 2020-2021 fiscal year. Grant funds shall not be awarded to any county that has received over eight million seven hundred fifty thousand dollars ($8,750,000) in funds from the Public School Building Capital Fund from the 2012-2013 fiscal year to the 2016-2017 fiscal year."

SECTION 1.2. Section 3 of S.L. 2017-119 reads as rewritten:

"**SECTION 3.** Implementation. – The following actions and policy shall be taken to implement this section:

...

(7) All the following shall apply to the funds allocated to the Lumber River Council of Government as provided in sub-subdivision (1)b. of Section 1 of this act:

a. The Housing Finance Agency (HFA) shall coordinate with the Lumber River Council of Government (COG) to create a 30- to ~~35-unit~~36-unit

multifamily affordable housing complex (housing complex) within the Fair Bluff Town limits. All funds allocated to the COG under this act shall be used solely for the development, management, maintenance, and preservation of the housing complex. When filling units in the affordable housing complex, priority shall be given to low-income residents of Fair Bluff affected by the flooding and damage caused by Hurricane Matthew.

...."

SECTION 1.3. Section 3 of S.L. 2017-137 reads as rewritten:

"**SECTION 3.** ~~This~~ Section 2.5 of this act becomes effective January 1, 2018. The remainder of this act becomes effective October 1, ~~2017. Section~~2017, and Section 1 applies to ~~plans prepared for acquisitions~~ policies issued or renewed on or after ~~the effective~~ that date."

SECTION 1.4. The Department of Administration shall study the utilization of buildings by State agencies in the downtown Raleigh area and report its findings to the Joint Legislative Committee on Governmental Operations no later than April 1, 2018.

PART II. EDUCATION

SECTION 2.1. G.S. 115D-5(x), as enacted by Section 7.22(g) of S.L. 2017-57, reads as rewritten:

"(x) In addition to the evaluation of cooperative innovative high schools by the State Board of Education pursuant to G.S. 115C-238.55, the State Board of Community Colleges, in conjunction with the State Board of Education and the Board of Governors of The University of North Carolina, shall evaluate the success of students participating in the Career and College Promise Program, including the College Transfer pathway and the Career and Technical Education pathway. Success shall be measured by high school retention rates, high school completion rates, high school dropout rates, certification and associate degree completion, admission to four-year institutions, postgraduation employment in career or study-related fields, and employer satisfaction of employees who participated in the programs. The Boards shall jointly report by ~~January~~March 15 of each year to the Joint Legislative Education Oversight Committee."

SECTION 2.2. G.S. 115C-64.17(c), as enacted by Section 7.23F(b) of S.L. 2017-57, reads as rewritten:

"(c) Selection of Recipients. – For the 2017-2018 fiscal year, the Commission shall accept applications for a grant until November ~~1~~,30, 2017. For subsequent fiscal years that funds are made available for the Program, the Commission shall accept applications for a grant until August 1 of each year. The Commission shall select recipients in a manner that considers diversity among the pool of applicants, including geographic location, location of industries in the area in which a local school administrative unit is located, and the size of the student population served by the unit, in order to award funds to the extent possible to grant recipients that represent different regions and characteristics of the State. The Commission shall recommend recipients of the grants to the State Board of Education. The State Board, upon consultation with the Superintendent of Public Instruction, shall approve the recipients of grant awards."

SECTION 2.3.(a) Section 8.2(b) of S.L. 2017-57 reads as rewritten:

"**SECTION 8.2.(b)** This section applies to teachers entering the profession in the 2017-2018 fiscal ~~year.~~year who were hired prior to the effective date of Section 8.2A of this act."

SECTION 2.3.(b) S.L. 2017-57 is amended by adding a new section to read:

"**SUPPORT FOR LATER-HIRED HIGHLY QUALIFIED NC TEACHING GRADUATES**

"**SECTION 8.2A.(a)** For purposes of this section, a "highly qualified graduate" or "graduate" is an individual entering the teaching profession and hired on or after the effective

date of this section who has graduated from an approved educator preparation program located in North Carolina with both of the following criteria:

(1) A grade point average of 3.75 or higher on a 4.0 scale, or its equivalent.

(2) A score of the following or higher on an edTPA assessment or an equivalent score on a nationally normed and valid pedagogy assessment used to determine clinical practice performance:

a. A score of 42 for the World Languages and Classical Languages edTPA assessment.

b. A score of 57 for the Elementary Education edTPA assessment.

c. A score of 48 for all other edTPA assessments.

Notwithstanding Section 8.1(a) of this act, a highly qualified graduate who is employed by a local board of education shall receive a salary supplement each month at the highest level for which the graduate qualifies, as follows:

(1) A graduate accepts initial employment at a school identified as low-performing by the State Board of Education pursuant to G.S. 115C-105.37 shall receive a salary supplement during the graduate's first three years of employment as a teacher, without a break in service, equivalent to the difference between the State-funded salary of the graduate and the State-funded salary of a similarly situated teacher with three years of experience on the "A" Teachers salary schedule, as long as the graduate (i) remains teaching at the same school or (ii) accepts subsequent employment at another low-performing school or local school administrative unit identified as low-performing.

(2) A graduate licensed and employed to teach in the areas of special education, science, technology, engineering, or mathematics shall receive a salary supplement during the graduate's first two years of employment as a teacher, without a break in service, equivalent to the difference between the State-funded salary of the graduate and the State-funded salary of a similarly situated teacher with two years of experience on the "A" Teachers salary schedule, as long as the graduate continues teaching in one of those areas.

(3) All other graduates shall receive a salary supplement during the graduate's first year of employment as a teacher, without a break in service, equivalent to the difference between the State-funded salary of the graduate and the State-funded salary of a similarly situated teacher with one year of experience on the "A" Teachers salary schedule.

"**SECTION 8.2A.(b)** This section is effective when it becomes law and applies to teachers entering the profession in the 2017-2018 fiscal year hired on or after that date."

SECTION 2.4.(a) Section 8.3(c) of S.L. 2017-57 reads as rewritten:

"**SECTION 8.3.(c)** A principal compensated in accordance with this section for the 2017-2018 fiscal year shall receive an amount equal to the greater of the following:

(1) The applicable amount determined pursuant to subsection (a) of this section.

(2) For principals who were eligible for longevity in the 2016-2017 fiscal year, the sum of the following:

a. The salary the principal received in the 2016-2017 fiscal year pursuant to Section 9.1 or Section 9.2 of S.L. 2016-94.

b. The longevity that the principal would have received as provided for State employees under the North Carolina Human Resources Act for the 2016-2017 fiscal year based on the principal's current years of service.

(3) For principals who were not eligible for longevity in the 2016-2017 ~~school~~ fiscal year, the salary the principal received in the 2016-2017 fiscal year pursuant to Section 9.1 or Section 9.2 of S.L. 2016-94."

SECTION 2.4.(b) Section 8.5(e) of S.L. 2017-57 reads as rewritten:

"**SECTION 8.5.(e)** An assistant principal compensated in accordance with this section for the 2017-2018 fiscal year shall receive an amount equal to the greater of the following:

(1) The applicable amount determined pursuant to subsections (a) through (c) of this section.

(2) For assistant principals who were eligible for longevity in the 2016-2017 fiscal year, the sum of the following:

a. The salary the assistant principal received in the 2016-2017 fiscal year pursuant to Section 9.1 or Section 9.2 of S.L. 2016-94.

b. The longevity that the assistant principal would have received as provided for State employees under the North Carolina Human Resources Act for the 2016-2017 fiscal year based on the assistant principal's current years of service.

(3) For assistant principals who were not eligible for longevity in the 2016-2017 fiscal year, the salary the assistant principal received in the 2016-2017 fiscal year pursuant to Section 9.1 or Section 9.2 of S.L. 2016-94."

SECTION 2.4.(c) This section is effective when it becomes law and applies retroactively to July 1, 2017.

PART III. HEALTH AND HUMAN SERVICES

SECTION 3.1. Section 12F.1 of S.L. 2016-94 reads as rewritten:

"**SECTION 12F.1.(a)** Definitions. – As used in this section, the following terms have the following meanings:

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

(2) FQHC. – A federally qualified health center located in this State.

(3) Prescriber. – Anyone authorized to prescribe drugs pursuant to the laws of this State.

(4) Program participant. – An individual who (i) has been clinically assessed and diagnosed with opioid addiction, (ii) is selected by an FQHC to participate in the pilot program authorized by this section, and (iii) as part of the pilot program, receives the nonnarcotic, nonaddictive, extended-release, injectable formulation of opioid antagonist approved by the United States Food and Drug Administration for the prevention of relapse to opioid dependence.

~~(5) Randomized control group member. – An individual who (i) has been clinically assessed and diagnosed with opioid addiction, (ii) is selected by a FQHC to participate in the pilot program authorized by this section, and (iii) as part of the pilot program, does not receive the nonnarcotic, nonaddictive, extended-release, injectable formulation of opioid antagonist approved by the United States Food and Drug Administration for the prevention of relapse to opioid dependence.~~

"**SECTION 12F.1.(b)** Pilot Program. – The Department shall oversee the administration of a three-year pilot program to be conducted by designated FQHCs to address North Carolina's growing opioid addiction and overdose crisis. The goal of the pilot program is to study the effectiveness of combining behavioral therapy with the utilization of a nonnarcotic, nonaddictive, extended-release, injectable formulation of opioid antagonist approved by the United States Food and Drug Administration for the prevention of relapse to opioid dependence. In conducting the pilot program, selected FQHCs may collaborate with the Department, the North Carolina

Institute of Medicine (NCIOM), and any other qualified entity or State agency that may be of assistance in accomplishing the objectives of the pilot program. Prior to the initiation of this pilot program, the Department shall, in collaboration with the NCIOM or any other qualified entity, determine the number of program participants ~~and randomized control group members~~ needed to participate in the pilot program in order to ensure sufficient statistical significance to support any conclusions about the effectiveness of the pilot program.

"**SECTION 12F.1.(c)** Selection of Participating FQHCs. – Not later than 30 days after the effective date of this section, the Department shall select a minimum of three and not more than five FQHCs located in different areas of the State to participate in the pilot program authorized by this section, giving first priority to FQHCs that have received supplemental grant funds from the United States Department of Health and Human Services, Health Resources and Services Administration, for substance abuse service expansion with a focus on medication-assisted treatment in opioid use disorders.

"**SECTION 12F.1.(d)** Selection of Program Participants. – Not later than 60 days after the effective date of this section, the Department shall develop, in collaboration with the NCIOM or any other qualified entity, a methodology for selecting program participants ~~and randomized control group members~~ at each FQHC. Only individuals who have been clinically assessed and diagnosed with opioid addiction may be selected and treated as program ~~participants and randomized control group members.~~participants. Individuals who have been referred from local criminal justice agencies may be selected as program ~~participants and randomized control group members.~~participants.

"**SECTION 12F.1.(e)** Treatment Standards. – As a condition of participating in the pilot program authorized by this section, each FQHC shall sign a written participation agreement provided by the Department that requires the FQHC to adhere to at least all of the following treatment standards for the duration of its participation in the pilot program:

(1) Treatment may be provided to program participants ~~and randomized control group members~~ only by a treatment provider who is affiliated with a participating FQHC.

(2) Only individuals who have been clinically assessed and diagnosed with opioid addiction may be selected and treated as program ~~participants and randomized control group members.~~participants.

(3) Treatment providers at participating FQHCs shall do all of the following:

a. Provide treatment based on an integrated service delivery model that consists of the coordination of care between a prescriber and an addiction services provider.

b. Conduct any necessary additional professional, comprehensive substance use disorder and mental health diagnostic assessments of individuals under consideration for selection as pilot program participants to determine if they would benefit from substance use disorder treatment and monitoring.

c. Determine, based on the assessments described in sub-subdivision b. of this subdivision, the treatment needs of the program participants served by the treatment provider.

d. Develop individualized treatment goals and objectives for each program participant.

e. Provide program participants with access to medication-assisted treatment utilizing a nonnarcotic, nonaddictive, extended-release, injectable formulation of opioid antagonist.

f. In addition to medication-assisted treatment, provide program participants with other types of therapies, including behavioral therapies, outpatient programs, and community support, for opioid use

disorder and any other disorders that are determined by the treatment provider to be co-occurring disorders.

g. In the case of medication-assisted treatment provided under the pilot program, a drug may be used only if it has been approved by the United States Food and Drug Administration for use in combination with behavioral therapy for the prevention of relapse to opioid dependence.

h. Comply with all applicable federal opioid treatment standards.

i. Monitor the progress of program participants ~~and randomized control group members~~ through the use of regular drug testing, including urinalysis.

"**SECTION 12F.1.(f)** FQHC Reports. – No later than 60 days after the effective date of this section, the Department shall, in collaboration with the NCIOM or any other qualified entity, develop a standardized methodology for the collection of information on program participants ~~and randomized control group members~~ at each FQHC. As a condition of participating in the pilot program authorized by this section, each selected FQHC must agree to follow this standardized methodology for (i) collecting information on program participants ~~and randomized control group members~~ and (ii) annually reporting that information to the Department, in the format prescribed by the Department. The annual report shall include at least all of the following information, in the format prescribed by the Department:

(1) For each program ~~participant and randomized control group member,~~participant, that individual's age, sex, and length of treatment. This information shall be reported to the Department in a manner that does not disclose personally identifying information about program ~~participants and randomized control group members.~~participants.

(2) The total number of program participants ~~and the total number of randomized control group members~~ who successfully transitioned to opioid abstinence for a minimum of 30 days, 60 days, 90 days, six months, 12 months, and 18 months.

~~(3) A comparison of program participants to the randomized control group members.~~

~~(4)~~(3) The amount of State appropriations expended on a per program participant basis at each participating FQHC.

"**SECTION 12F.1.(g)** Evaluation of Pilot Program. – By November 1, 2020, the Department shall conduct and submit to the Joint Legislative Oversight Committee on Health and Human Services a comprehensive evaluation of the effectiveness of this pilot program in addressing North Carolina's growing opioid addiction and overdose crisis. The Department may contract with an institution of higher education or other qualified entity with expertise in evaluating programs similar to the pilot program authorized by this section. The comprehensive evaluation shall include whether this pilot program was successful as measured by at least all of the following:

(1) The total number of program participants who successfully transitioned to opioid abstinence for a minimum of 30 days, 60 days, 90 days, six months, 12 months, and 18 months.

~~(2) A comparison of the program participants to the randomized control group members.~~

~~(3)~~(2) A cost-benefit analysis of the pilot program.

"**SECTION 12F.1.(h)** Expiration. – The pilot program conducted at each selected FQHC shall expire no later than three years after the date of its commencement at that particular FQHC.

"**SECTION 12F.1.(i)** Funds in the amount of five hundred thousand dollars ($500,000) from the federal Substance Abuse Prevention and Treatment Block Grant shall be allocated to the Department of Health and Human Services, Division of Mental Health, Developmental

Disabilities, and Substance Abuse Services, for the 2016-2017 fiscal year. These funds shall be allocated to the FQHCs selected to participate in the pilot program authorized by this section on a per program participant basis to offset the cost of the following services:

(1) Medication dispensed to program participants.
(2) Provider fees for services rendered to program participants.
(3) Up to 14 days of detoxification services.
(4) Behavioral therapy for program participants.
(5) Drug testing and monitoring of program participants.

"**SECTION 12F.1.(j)** Subsection (i) of this section becomes effective July 1, 2016. The remainder of this section is effective when it becomes law."

SECTION 3.2.(a) G.S. 147-86.70(b)(1) reads as rewritten:

"(b) Definitions. – The following definitions apply in this section:

(1) ABLE account. – An account established and owned by an eligible individual and maintained under this Article. A parent, guardian, ~~guardian~~ or agent under a power of attorney may act on behalf of an account owner."

SECTION 3.2.(b) G.S. 147-86.71 reads as rewritten:

"**§ 147-86.71. ABLE Program.**

…

(b) Accounts. – The following provisions apply to an ABLE account:

(1) An account owner or contributor may establish an account by making an initial contribution to the ABLE Program Trust, signing an application form approved by the Board or its designee, and naming the designated beneficiary. If the contributor is not the account owner, the account owner or the account owner's parent, guardian, trustee, or agent shall also sign the application form."

…

(d) Limitations. – The Board, in administering the ABLE Program Trust, shall ensure each of the following:

…

(9) A ~~trustee~~ parent, trustee, or guardian appointed as a signatory of an ABLE account does not have or acquire any beneficial interest in the account and administers the account for the benefit of the designated beneficiary."

SECTION 3.3. Section 11F.9 of S.L. 2017-57 reads as rewritten:

"**SECTION 11F.9.(a)** ~~Of the funds appropriated to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of one hundred fifty thousand dollars ($150,000) in nonrecurring funds for the 2017-2018 fiscal year and the sum of three hundred thousand dollars ($300,000) in nonrecurring funds for the 2018-2019 fiscal year shall be used to develop and implement an adult and pediatric traumatic brain injury pilot program.~~ The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall establish an adult and pediatric traumatic brain injury pilot program, to be conducted at not less than three and not more than five trauma hospitals licensed in this State. The purpose of the pilot program is to increase compliance with internationally approved evidence-based treatment guidelines for severe adult and pediatric traumatic brain injury in order to reduce patient mortality, improve patient level of recovery, and reduce long-term care costs.

"~~**SECTION 11F.9.(b)** The Department of Health and Human Services shall establish up to three program sites to implement the adult and pediatric traumatic brain injury pilot program authorized by this section, all of which shall be trauma hospitals. Each program site shall be awarded up to one hundred thousand dollars ($100,000) for the development and implementation of an interactive quality assessment and quality assurance clinical decision support tool to~~

~~provide real-time, evidence-based medical care guidance for intensive care unit patients with severe adult or pediatric traumatic brain injury.~~

"**SECTION 11F.9.~~(c)~~(b)** ~~The Department of Health and Human Services shall contract with a private entity to assist participating trauma hospitals in implementing the tool described in subsection (b) of this section.~~ Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the sum of one hundred fifty thousand dollars ($150,000) in nonrecurring funds for the 2017-2018 fiscal year and the sum of three hundred thousand dollars ($300,000) in nonrecurring funds for the 2018-2019 fiscal year shall be used to enter into a contract with an independent entity to operate the pilot program authorized by this section. In so doing, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall select an independent entity that has (i) developed software for an interactive quality assessment and quality assurance clinical decision support tool that provides real-time, evidence-based medical care guidance for intensive care unit patients with severe adult or pediatric traumatic brain injury and (ii) prior experience assisting trauma hospitals in other states in implementing this software. In consideration for payments made to the independent entity under the contract, the independent entity shall assume responsibility for all of the following:

(1) Initiating and operating the pilot program, including the selection of not less than three and not more than five trauma hospitals licensed in this State to serve as pilot program sites.

(2) Assisting participating trauma hospitals in implementing the software developed by the independent entity for use as an interactive quality assessment and quality assurance clinical decision support tool to provide real-time, evidence-based medical care guidance for intensive care unit patients with severe adult or pediatric traumatic brain injury. In providing such implementation assistance, the ~~private~~ independent entity shall utilize the treatment guidelines and practice recommendations that have been peer reviewed and approved by the American Association of Neurological Surgeons and are recognized as the current standard of care for individuals with severe traumatic brain injury.

"**SECTION 11F.9.~~(d)~~(c)** By February 1, 2018, the Department of Health and Human Services shall submit a progress report on the development and implementation of the pilot program authorized by this section to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

"**SECTION 11F.9.~~(e)~~(d)** By January 7, 2019, the Department of Health and Human Services shall submit a final report of the pilot program authorized by this section to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division. At a minimum, the final report shall include all of the following:

(1) The number and outcome of patients served at each program site, broken down by patient age and county of origin.

(2) A breakdown of expenditures at each program site by type of service.

(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."

SECTION 3.4. Part XI of S.L. 2017-57 is amended by adding a new section to read:

"**FUNDS FOR THE TOWN OF BOLTON**

"**SECTION 11D.3A.** Notwithstanding any other provision of law or descriptive language to the contrary in the Committee Report described in Section 39.2 of this act, nonrecurring funds

appropriated in this act to the Department of Health and Human Services, Division of Aging and Adult Services, for the 2017-2018 fiscal year, for allocation to the Bolton Senior Center shall instead be allocated to the Town of Bolton."

PART IV. AGRICULTURE AND NATURAL AND ECONOMIC RESOURCES

SECTION 4.1. Section 15.9A of S.L. 2017-57 reads as rewritten:

"**SECTION 15.9A.** The funds appropriated in this act to the Department of Commerce as a grant-in-aid to the Town of Haw River shall be used to provide grants, loans, or both for a historic mill renovation project. In addition to the provisions governing reporting, oversight, and administration of grant funds contained in G.S. 143C-6-23, the Town of Haw River shall enter into an agreement with any ~~subgrantee~~ entity receiving ~~funds.~~funds (recipient). The agreement shall contain, at a minimum, (i) a provision that funds received under the agreement may be used only for mill rehabilitation purposes, (ii) a provision allowing the Town of Haw River to inspect all records of the ~~subgrantee~~ recipient that may be used to confirm compliance with the agreement, (iii) a provision establishing methods for determining compliance with the agreement, and (iv) a provision requiring recapture or repayment of all ~~grant~~ funds if the ~~subgrantee~~ recipient fails to comply with the terms of the agreement. In the event of a violation of the agreement, the Town of Haw River shall take action to ~~recapture all grant~~recoup all funds. The Town may retain up to twenty percent (20%) of the funds described in this section for the historic mill renovation project for infrastructure improvements necessary for and directly related to the project. For purposes of this section, the phrase "infrastructure improvements" is defined as street improvements, site improvements, including site utilities, sidewalks, parking, hardscape products, costs for demolition, engineering, and architecture, and fixtures for any spaces in the historic mill renovation project leased and used by the Town. The Commerce Finance Center shall, in cooperation with the Town of Haw River, conduct an annual review of the mill restoration project and shall submit a report to the Joint Legislative Oversight Committee on Agriculture and Natural and Economic Resources and the Fiscal Research Division on April 1 each year beginning April 1, 2021, until project completion."

SECTION 4.2. Section 13.22 of S.L. 2017-57, as amended by Section 4.2 of S.L. 2017-197, reads as rewritten:

"**SECTION 13.22.(a)** The following allocations are made from funds appropriated by this act to the Division of Water Infrastructure of the Department of Environmental Quality for water and sewer infrastructure grants:

...

(4) The sum of one hundred thousand dollars ($100,000) for the 2017-2018 fiscal year to Davidson County ~~for the Wil-Cox bridge sewer expansion.~~to be allocated as follows:

a. Fifty thousand dollars ($50,000) for a sewer project.

b. Notwithstanding any other provision of this section or Chapter 159G of the General Statutes to the contrary, fifty thousand dollars ($50,000) for preservation and restoration work on the Wil-Cox bridge.

...."

SECTION 4.3. Section 15.14B(c) of S.L. 2014-100 reads as rewritten:

"**SECTION 15.14B.(c)** This section becomes effective January 1, ~~2015, and expires July 1, 2020.~~2015. The Secretary shall not award a grant for any qualifying expenses for which a taxpayer receives a tax credit under G.S. 105-130.47 or G.S. 105-151.29."

SECTION 4.4. Section 10.24 of S.L. 2017-57 reads as rewritten:

"...

"**SECTION 10.24.(e)** The Committee shall develop a business plan for the Food Processing Research Center at the North Carolina Research Campus (Center) to implement. The business plan required by this subsection shall include processes for designing and marketing the Center.

Of the funds appropriated in this act to North Carolina State University for the Center, the University shall allocate not more than the sum of one hundred thousand dollars ($100,000) in nonrecurring funds for the 2017-2018 fiscal year to the Committee to cover costs incurred by the Committee in developing a business plan required under this subsection. The business plan required under this subsection shall ensure all of the following:

(1) The financial stability for the Center, including sources and uses for funds to operate the facility and maintain equipment for the Center.

(2) The creation and implementation of revenue models that can be used to support the expenses of the facility with the goal of positioning the facility to ultimately cease to need State funds for continued operations.

(3) The creation and implementation of policies that protect the State's investment in the initiative and provide for a return to the taxpayers by increasing job opportunities, private sector investment, and increased markets for value-added agricultural products.

(4) Any other provision the Committee deems necessary to carry out the intent and accomplish the goals established in this section.

Upon completion of the business plan required under this subsection, the Committee shall submit the business plan to the University.

"**SECTION 10.24.(f)** No less than 30 days prior to expending or encumbering any other funds provided in this act to the University for the Center, the University shall submit the business plan required under subsection (e) of this section to the Joint Legislative Commission on Government Operations. The business plan required under subsection (e) of this section is binding, and the University shall not deviate from the plan without having the plan amended by the Committee, which may adopt amendments by a majority vote.

...."

SECTION 4.5.(a) Of the funds appropriated in S.L. 2017-57 to the Wildlife Resources Commission, an additional fifty thousand dollars ($50,000) in recurring funds is allocated to the Outdoor Heritage Advisory Council to provide support for the operation of the Council, including the salaries and benefits of Council personnel.

SECTION 4.5.(b) Part 36 of Article 7 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"**§ 143B-344.62. Outdoor Heritage Advisory Council – executive director; staff.**

The Council may, subject to appropriations or other funds that accrue to it, employ an executive director to carry out the day-to-day responsibilities and business of the Council. The executive director shall serve at the pleasure of the Council. The executive director, also subject to appropriations or other funds that accrue to the Council, may hire additional staff and consultants to assist in the discharge of the executive director's responsibilities, as determined by the Council."

SECTION 4.6.(a) G.S. 97-2(2) reads as rewritten:

"(2) Employee. – The term "employee" means every person engaged in an employment under any appointment or contract of hire or apprenticeship, express or implied, oral or written, including aliens, and also minors, whether lawfully or unlawfully employed, but excluding persons whose employment is both casual and not in the course of the trade, business, profession, or occupation of his employer, and as relating to those so employed by the State, the term "employee" shall include all officers and employees of the State, including such as are elected by the people, or by the General Assembly, or appointed by the Governor to serve on a per diem, part-time or fee basis, either with or without the confirmation of the Senate; as relating to municipal corporations and political subdivisions of the State, the term "employee" shall include all officers and employees thereof, including such as are elected by

the people. The term "employee" shall include members of the North Carolina National Guard while on State active duty under orders of the Governor and members of the North Carolina State Defense Militia while on State active duty under orders of the Governor. The term "employee" shall include deputy sheriffs and all persons acting in the capacity of deputy sheriffs, whether appointed by the sheriff or by the governing body of the county and whether serving on a fee basis or on a salary basis, or whether deputy sheriffs serving upon a full-time basis or a part-time basis, and including deputy sheriffs appointed to serve in an emergency, but as to those so appointed, only during the continuation of the emergency. The sheriff shall furnish to the board of county commissioners a complete list of all deputy sheriffs named or appointed by him immediately after their appointment and notify the board of commissioners of any changes made therein promptly after such changes are made. Any reference to an employee who has been injured shall, when the employee is dead, include also the employee's legal representative, dependents, and other persons to whom compensation may be payable: Provided, further, that any employee, as herein defined, of a municipality, county, or of the State of North Carolina, while engaged in the discharge of the employee's official duty outside the jurisdictional or territorial limits of the municipality, county, or the State of North Carolina and while acting pursuant to authorization or instruction from any superior officer, shall have the same rights under this Article as if such duty or activity were performed within the territorial boundary limits of their employer.

Except as otherwise provided herein, every executive officer elected or appointed and empowered in accordance with the charter and bylaws of a corporation shall be considered as an employee of such corporation under this Article.

Any such executive officer of a corporation may, notwithstanding any other provision of this Article, be exempt from the coverage of the corporation's insurance contract by such corporation's specifically excluding such executive officer in such contract of insurance, and the exclusion to remove such executive officer from the coverage shall continue for the period such contract of insurance is in effect, and during such period such executive officers thus exempted from the coverage of the insurance contract shall not be employees of such corporation under this Article.

All county agricultural extension service employees who do not receive official federal appointments as employees of the United States Department of Agriculture and who are field faculty members with professional rank as designated in the memorandum of understanding between the North Carolina Agricultural Extension Service, North Carolina State University, A & T State University, and the boards of county commissioners shall be deemed to be employees of the State of North Carolina. All other county agricultural extension service employees paid from State or county funds shall be deemed to be employees of the county board of commissioners in the county in which the employee is employed for purposes of workers' compensation.

The term "employee" shall also include members of the Civil Air Patrol currently certified pursuant to G.S. 143B-1031(a) when performing duties in the course and scope of a State-approved mission pursuant to Subpart C of Part 5 of Article 13 of Chapter 143B of the General Statutes.

"Employee" shall not include any person performing voluntary service as a ski patrolman who receives no compensation for such services other than

meals or lodging or the use of ski tow or ski lift facilities or any combination thereof.

"Employee" shall not include any person elected or appointed and empowered as an executive officer, director, or committee member under the charter, articles, or bylaws of a nonprofit corporation subject to Chapter 47A, 47C, 47F, 55A, or 59B of the General Statutes, or any organization exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code, who performs only voluntary service for the nonprofit corporation, provided that the person receives no remuneration for the voluntary service other than reasonable reimbursement for expenses incurred in connection with the voluntary service. When a nonprofit corporation as described herein employs one or more persons who do receive remuneration other than reasonable reimbursement for expenses, then any volunteer officers, directors, or committee members excluded from the definition of "employee" by operation of this paragraph shall be counted as employees for the sole purpose of determining the number of persons regularly employed in the same business or establishment pursuant to G.S. 97-2(1). Other than for the limited purpose of determining the number of persons regularly employed in the same business or establishment, such volunteer nonprofit officers, directors, or committee members shall not be "employees" under the Act. Nothing herein shall prohibit a nonprofit corporation as described herein from voluntarily electing to provide for workers' compensation benefits in the manner provided in G.S. 97-93 for volunteer officers, directors, or committee members excluded from the definition of "employee" by operation of this paragraph. This paragraph shall not apply to any volunteer firefighter, volunteer member of an organized rescue squad, an authorized pickup firefighter when that individual is engaged in emergency fire suppression activities for the North Carolina Forest Service, a duly appointed and sworn member of an auxiliary police department organized pursuant to G.S. 160A-282, or a senior member of the State Civil Air Patrol functioning under Subpart C of Part 5 of Article 13 of Chapter 143B of the General Statutes, even if such person is elected or appointed and empowered as an executive officer, director, or committee member under the charter, articles, or bylaws of a nonprofit corporation as described herein.

Any sole proprietor or partner of a business or any member of a limited liability company may elect to be included as an employee under the workers' compensation coverage of such business if he is actively engaged in the operation of the business and if the insurer is notified of his election to be so included. Any such sole proprietor or partner or member of a limited liability company shall, upon such election, be entitled to employee benefits and be subject to employee responsibilities prescribed in this Article.

"Employee" shall include an authorized pickup firefighter of the North Carolina Forest Service of the Department of Agriculture and Consumer Services when that individual is engaged in emergency fire suppression activities for the North Carolina Forest Service. As used in this section, "authorized pickup firefighter" means an individual who has completed required fire suppression training as a wildland firefighter and who is available as needed by the North Carolina Forest Service for emergency fire suppression activities, including immediate dispatch to wildfires and standby for initial attack on fires during periods of high fire danger.

~~It shall be a rebuttable presumption that the term "employee" shall not include any person performing services in the sale of newspapers or magazines to ultimate consumers under an arrangement whereby the newspapers or magazines are to be sold by that person at a fixed price and the person's compensation is based on the retention of the excess of the fixed price over the amount at which the newspapers or magazines are charged to the person.~~"

SECTION 4.6.(b) This section becomes effective January 1, 2018.

SECTION 4.7.(a) Section 15.8(a) of S.L. 2017-57, as amended by Section 4.8(a) of S.L. 2017-197, reads as rewritten:

"**SECTION 15.8.(a)** Of the funds appropriated in this act to the Rural Economic Development Division of the Department of Commerce, the sum of five million ~~eight~~ seven hundred seventy-five thousand dollars ~~($5,875,000)~~($5,775,000) in nonrecurring funds for the 2017-2018 fiscal year shall be used to provide grants-in-aid for downtown revitalization projects for each of the following counties and municipalities in the following amounts:

...

(7) One hundred thousand dollars ($100,000) each to the City of Archdale, the City of Asheboro, the Village of Clemmons, the unincorporated community of Cliffside in Rutherford County, the Town of Emerald Isle, the City of Hendersonville, the City of Kannapolis, the Town of Kernersville, the City of Lumberton, the Town of Oakboro, the Town of Old Fort, the Town of Pembroke, the City of Randleman, the City of Roxboro, the City of Trinity, and the Town of ~~Troy, and the Town of Yadkinville.~~Troy.

...."

SECTION 4.7.(b) Section 15.8 of S.L. 2017-57 is amended by adding new subsections to read:

"**SECTION 15.8.(f)** Of the funds appropriated in this act to the Rural Economic Development Division of the Department of Commerce, the sum of twenty-five thousand dollars ($25,000) in nonrecurring funds for the 2017-2018 fiscal year shall be used to provide a grant-in-aid to the Town of Dover to be used for parks and recreation projects.

"**SECTION 15.8.(g)** Notwithstanding G.S. 143B-472.127, of the funds appropriated in this act to the Rural Economic Development Division of the Department of Commerce, the sum of seventy-five thousand dollars ($75,000) in nonrecurring funds for the 2017-2018 fiscal year shall be used to provide a grant-in-aid to Lincoln County for the Voice Interoperability Plan for Emergency Responders network."

SECTION 4.8.(a) G.S. 143B-293.2(a1) reads as rewritten:

"(a1) Members Selection. – The North Carolina Oil and Gas Commission shall consist of nine members appointed as follows:

...

(3) One appointed by the General Assembly upon recommendation of the Speaker of the House of Representatives in conformance with G.S. 120-121, who is a ~~representative~~member of a nongovernmental conservation interest.

...

(5) One appointed by the General Assembly upon recommendation of the President Pro Tempore of the Senate in conformance with G.S. 120-121, who is a ~~representative~~member of a nongovernmental conservation interest.

...."

SECTION 4.8.(b) This section applies to appointments made on or after the effective date of this act.

SECTION 4.9. Section 14.19 of S.L. 2017-57 reads as rewritten:

"**SECTION 14.19.** Of the funds appropriated by this act to the Division of North Carolina Aquariums in the North Carolina Department of Natural and Cultural Resources, the sum of three hundred thousand dollars ($300,000) in nonrecurring funds for the 2017-2018 fiscal year is allocated for planning and permitting of Blake Farms satellite aquarium area in Scotts Hill, North Carolina, and the Division is authorized to expend funds ~~for this purpose.~~to engage architects and other program consultants to (i) collaborate with Blake Farms to design and permit the building housing the satellite aquarium area; and (ii) produce schematic, design, and final construction documents for the satellite aquarium area."

SECTION 4.10.(a) Section 37.2(e) of S.L. 2016-94, as amended by Section 36.3(g) of S.L. 2017-57, reads as rewritten:

"**SECTION 37.2.(e)** Notwithstanding any provision of law to the contrary, funds appropriated for a water resources development project shall be used to provide no more than fifty percent (50%) of the nonfederal portion of funds for the project. This subsection applies to funds appropriated in this act and to funds appropriated prior to the 2015-2017 fiscal biennium that are unencumbered and proposed for reallocation to provide the nonfederal portion of funds for water resources development projects. The limitation on fund usage contained in this subsection applies only to projects in which a local government or local governments participate. This subsection shall not apply to, and there shall be no local match required for, any of the following, notwithstanding any other provision of law:

(1) The Environmental Quality Incentives Program. Furthermore, Section 36.3(e) of S.L. 2013-360, Section 36.2(e) of S.L. 2014-100, and Section 31.3(e) of S.L. 2015-241 shall not apply to funds made available as part of the Environmental Quality Incentives Program in any fiscal year. ~~Any~~ Funds appropriated during the 2015-2017 biennium, and any remaining balance of funds appropriated prior to the 2015-2017 fiscal biennium for Environmental Quality Incentives Program projects shall be paid out to each of the original grantees for the full grant award amount, except that the Secretary may retain ten percent (10%) of the State share of funding until the Natural Resources Conservation Service of the United States Department of Agriculture has provided a final practice approval for the project.

...."

SECTION 4.10.(b) G.S. 143-215.72(d) reads as rewritten:

"(d) The following procedures apply only to grants for the purpose set forth in G.S. 143-215.71(8):

(1) A nongovernmental entity managing, administering, or executing the grant on behalf of a unit of local government may apply as a co-applicant for the grant and may be included as a responsible party on any required resolution issued by the unit of local government.

(2) ~~The~~ Upon request signed by the grant applicant and co-applicant, the Department ~~may~~ shall make periodic payments to the co-applicant for its share of nonfederal costs of a project prior to receipt of a final practice approval from the Natural Resources Conservation Service if the grantee has submitted a certified reimbursement request or invoice."

PART V. JUSTICE AND PUBLIC SAFETY

SECTION 5.1. G.S. 97-13 is amended by adding a new subsection to read:

"(c1) Certain Inmates. – Notwithstanding the thirty dollars ($30.00) per week limit in subsection (c) of this section, the average weekly wage of inmates employed pursuant to the Prison Industry Enhancement Program shall be calculated pursuant to G.S. 97-2(5)."

SECTION 5.2.(a) G.S. 114-2(1) reads as rewritten:

"(1) To defend all actions in the appellate division in which the State shall be interested, or a party, and to appear for the State in any other court or tribunal in any cause or matter, civil or criminal, in which the State may be a party or interested. The duty to represent the State in criminal appeals shall not be delegated to any district attorney's office or any other entity."

SECTION 5.2.(b) G.S. 7A-61 reads as rewritten:

"**§ 7A-61. Duties of district attorney.**

The district attorney shall prepare the trial dockets, prosecute in a timely manner in the name of the State all criminal actions and infractions requiring prosecution in the superior and district courts of ~~his~~the district attorney's prosecutorial ~~district,~~district and advise the officers of justice in ~~his~~the district attorney's district.~~district, and perform such duties related to appeals to the Appellate Division from his district as the Attorney General may require. Effective January 1, 1971, the~~ The district attorney shall also represent the State in juvenile cases in the superior and district courts in which the juvenile is represented by an attorney. The district attorney shall provide to the Attorney General any case files, records and additional information necessary for the Attorney General to conduct appeals to the Appellate Division for cases from the district attorney's prosecutorial district. The Attorney General shall not delegate to the district attorney, or any other entity, the duty to represent the State in criminal and juvenile appeals. Each district attorney shall devote his full time to the duties of his office and shall not engage in the private practice of law."

SECTION 5.2.(c) This section is effective July 1, 2017. It shall be the obligation of the Attorney General to work with each District Attorney to ensure that all criminal appeals delegated on or after July 1, 2017, to a District Attorney's office shall be properly returned to the Attorney General's office. Notwithstanding the previous two sentences, actions taken by the office of a District Attorney related to a criminal appeal delegated to that office on or after July 1, 2017, shall be deemed to have been taken with full legal authority to act on behalf of the State.

SECTION 5.3. Part XVII of S.L. 2017-57 is amended by adding a new section to read:

"**DWI MISDEMEANOR CLARIFICATIONS/EXPERT TESTIMONY REVISIONS**

"**SECTION 17.8.(a)** G.S. 15-1 reads as rewritten:

"**§ 15-1. Statute of limitations for misdemeanors.**

The crimes of deceit and malicious mischief, and the crime of petit larceny where the value of the property does not exceed five dollars ($5.00), and all misdemeanors except malicious misdemeanors, shall be ~~presented or found by the grand jury~~ charged within two years after the commission of the same, and not afterwards: Provided, that if any ~~indictment found within that time~~ pleading shall be defective, so that no judgment can be given thereon, another prosecution may be instituted for the same offense, within one year after the first shall have been abandoned by the State.""

"**SECTION 17.8.(b)** G.S. 8C-1, Rule 702(a1), reads as rewritten:

"**Rule 702. Testimony by experts.**

...

(a1) ~~A witness, qualified under subsection (a) of this section and with proper foundation,~~ Notwithstanding any other provision of law, a witness may give expert testimony solely on the issue of impairment and not on the issue of specific alcohol concentration level relating to the following:

(1) The results of a Horizontal Gaze Nystagmus (HGN) Test when the test is administered in accordance with the person's training by a person who has successfully completed training in HGN.

(2) Whether a person was under the influence of one or more impairing substances, and the category of such impairing substance or ~~substances. A witness who has received training and~~ substances, if the witness holds a

current certification as a Drug Recognition Expert, issued by the State Department of Health and Human ~~Services, shall be qualified to give the testimony under this subdivision.~~Services."

"**SECTION 17.8.(c)** Subsection (a) of this section becomes effective December 1, 2017, and applies to offenses committed on or after that date. The remainder of the section is effective when it becomes law.""

PART VI. TRANSPORTATION

SECTION 6.1. Section 34.28A(b) of S.L. 2017-57 reads as rewritten:

"**SECTION 34.28A.(b)** Submission of Analysis. – The Departments shall jointly submit the findings of the analysis required under subsection (a) of this section, including any legislative recommendations, to the Joint Legislative Transportation Oversight Committee and the Joint Legislative Oversight Committee on Agriculture and Natural and Economic Resources by ~~February~~April 1, 2018."

SECTION 6.2. Section 34.29 of S.L. 2017-57 reads as rewritten:

"**SECTION 34.29.** The Department of Transportation shall study the use of its new dredge vessel, the Dredge Manteo. As part of this study, the Department shall include (i) an approximation of the annual cost to the State to operate and maintain the dredge vessel and (ii) a plan to allow use of the dredge vessel by other State departments and agencies. The Department shall report its findings, including any recommended legislation, to the Joint Legislative Transportation Oversight Committee by ~~December 1, 2017.~~April 1, 2018."

PART VII. FINANCE

SECTION 7.1.(a) G.S. 105-244.4(a), as enacted by S.L. 2017-204, reads as rewritten:

"(a) Reduction – The Secretary may reduce an assessment against a taxpayer who requests relief for State and local sales and use taxes in the amount as provided in this section and waive any penalties imposed as part of the assessment when the assessment is the result of an audit of the taxpayer by the Department and all of the following apply:

...

(5) The taxpayer meets one of the following:

a. The taxpayer received a proposed assessment dated on or before August 15, 2017, did not file a request for review, paid the tax due, and files a written request with the Secretary ~~no later than 120 days following the receipt of a proposed assessment~~ on or before December 29, 2017, to request the amount of sales or use taxes be reduced as provided in this section citing the specific reasons therefor.

b. The taxpayer received a proposed assessment dated on or before September 30, 2017, timely filed a request for review, and files a written request with the Secretary on or before December 29, 2017, to request the amount of sales or use taxes be reduced as provided in this section citing the specific reasons therefor. The Department does not need to take further action on the taxpayer's request for review unless the taxpayer states in writing, when filing a request for reduction under this section, that the reduction does not resolve the taxpayer's objection to the proposed assessment and that the taxpayer wishes to continue the Departmental review.

c. ~~A~~ The taxpayer ~~who does not agree with a proposed assessment must also file~~ receives a proposed assessment after September 30, 2017, and timely files a request for review ~~within 120 days of the date of the notice of proposed assessment~~ as provided in G.S. 105-241.11 ~~in order~~

~~for a request to reduce the amount of tax as allowed by this section to be considered by the Secretary.~~and files a written request with the Secretary no later than 45 days from the date of the notice of the proposed assessment to request the amount of sales or use taxes be reduced as provided in this section citing the specific reasons therefor."

SECTION 7.1.(b) This section becomes effective August 11, 2017.

SECTION 7.2.(a) Section 38.8(a) of S.L. 2017-57 reads as rewritten:

"**SECTION 38.8.(a)** Article 5F of Chapter 105 of the General Statutes, G.S. 105-164.13(5a), and ~~G.S. 105-163.13(57a)~~G.S. 105-164.13(57a) are repealed."

SECTION 7.2.(b) This section is effective when it becomes law and applies retroactively to sales made on or after July 1, 2017.

PART VIII. AGENCY TECHNICAL CORRECTIONS

SECTION 8.1. G.S. 18B-1114.1, as amended by Section 18 of S.L. 2017-87 and by Section 19 of S.L. 2017-108, reads as rewritten:

"**§ 18B-1114.1. Authorization of winery special event permit.**

(a) Authorization. – The holder of an unfortified winery permit, a limited winery permit, a viticulture/enology course authorization, or a wine producer permit may obtain a winery special permit allowing the winery or wine producer to give free tastings of its wine, and to sell its wine by the glass or in closed containers, at trade shows, conventions, shopping malls, wine festivals, street festivals, holiday festivals, agricultural festivals, farmers markets, balloon races, local fund-raisers, ~~farmers markets,~~ and other similar events approved by the Commission.

(b) Limitation. – A winery special event permit is valid only in a jurisdiction that has approved the establishment of ABC stores or has approved the sale of unfortified wine."

SECTION 8.2. G.S. 28A-2B-2 reads as rewritten:

"**§ 28A-2B-2. Venue.**

The venue for a petition under G.S. 28A-2B-1 is the county of this State in which the petitioner whose will or codicil is the subject of the petition ~~is domiciled.~~resides."

SECTION 8.3. G.S. 28A-21-2, as amended by Section 10 of S.L. 2017-158, reads as rewritten:

"**§ 28A-21-2. Final accounts.**

(a) Unless the time for filing the final account has been extended by the clerk of superior court, the personal representative or collector must file the final account for settlement within one year after qualifying or within six months after receiving a State estate or inheritance tax release, or in the time period for filing an annual account pursuant to G.S. 28A-21-1, whichever is later. ~~If no estate or inheritance tax return was required to be filed for the estate, the personal representative or collector shall so certify in the final account filed with the clerk of superior court. Such certification shall list the amount and value of all of the decedent's property, and with respect to real estate, its particular location within or outside the State, including any property transferred by the decedent over which the decedent had retained any interest, or any property transferred within three years prior to the date of the decedent's death, and after being filed and accepted by the clerk of superior court shall be prima facie evidence that such property is free of any State inheritance or State estate tax liability. The personal representative or collector shall produce vouchers for all payments or verified proof for all payments in lieu of vouchers. With the approval of the clerk of superior court, such account may be filed voluntarily at any time. In all cases, the accounting shall be reviewed, audited and recorded by the clerk of superior court in the manner prescribed in G.S. 28A-21-1.~~

(a1) If no estate or inheritance tax return was required to be filed for the estate, the personal representative or collector shall so certify in the final account filed with the clerk of superior court. Such certification shall list the amount and value of all of the decedent's property and, with

respect to real estate, its particular location within or outside the State, including any property transferred by the decedent over which the decedent had retained any interest, or any property transferred within three years prior to the date of the decedent's death, and, after being filed and accepted by the clerk of superior court, shall be prima facie evidence that such property is free from any State inheritance or State estate tax liability. This subsection only applies to estates of decedents who died before January 1, 2013.

(a2) The personal representative or collector shall produce vouchers for all payments or verified proof for all payments in lieu of vouchers. With the approval of the clerk of superior court, such account may be filed voluntarily at any time. In all cases, the accounting shall be reviewed, audited, and recorded by the clerk of superior court in the manner prescribed by G.S. 28A-21-1.

(b) Except as provided in subsection (a), after the date specified in the general notice to creditors as provided for in G.S. 28A-14-1, if all of the debts and other claims against the estate of the decedent duly presented and legally owing have been paid in the case of a solvent estate or satisfied pro rata according to applicable statutes in the case of an insolvent estate, the personal representative or collector may file the personal representative's or collector's final account to be reviewed, audited and recorded by the clerk of superior court. Nothing in this subsection shall be construed as limiting the right of the surviving spouse or minor children to file for allowances under G.S. 30-15 through 30-18 and the right of a surviving spouse to file for property rights under G.S. 29-30."

SECTION 8.4.(a) G.S. 31D-5-505, as recodified by Section 13(b) of S.L. 2017-102, reads as rewritten:

"**§ 31D-5-505. Requisites of release ~~or limitation~~ as against creditors and purchasers for value.**

No release ~~or limitation~~ of a power of appointment after March 8, 1943, which is made by the owner of the legal title to real property in this State shall be valid as against creditors and purchasers for a valuable consideration until an instrument in writing setting forth the release ~~or limitation~~ is executed and acknowledged in the manner required for a deed and recorded in the county where the real property is."

SECTION 8.4.(b) The Revisor of Statutes shall cause to be printed all explanatory comments of the drafters of this section, as the Revisor may deem appropriate.

SECTION 8.5.(a) G.S. 36C-5-505 reads as rewritten:

"**§ 36C-5-505. Creditor's claim against settlor.**

...

(c) Subject to the Uniform Voidable Transactions Act, Article 3A of Chapter 39 of the General Statutes, for purposes of this section, property contributed to the following trusts is not considered to have been contributed by the settlor and a person who would otherwise be treated as a settlor or a deemed settlor of the following trusts may not be treated as a settlor:

(1) If the settlor is a beneficiary after the death of the settlor's spouse:

a. An irrevocable inter vivos marital trust that is treated as a general power of appointment trust described in section 2523(e) of the Internal Revenue Code.

b. An irrevocable inter vivos marital trust that is treated as a qualified terminable interest trust under section 2523(f) of the Internal Revenue Code.

c. An irrevocable inter vivos trust of which the settlor's spouse is a beneficiary during the spouse's lifetime but which does not qualify for the federal gift tax marital deduction, and during the lifetime of the settlor's spouse (i) the settlor's spouse is the only beneficiary or (ii) the settlor's spouse and ~~the settlor's issue~~ any issue of the settlor or the settlor's spouse, or both, are the only beneficiaries.

d. Another trust, to the extent that the property of the other trust is attributable to property passing from a trust described in sub-subdivisions a., b., and c. of this subdivision.

For purposes of this subdivision, notwithstanding the provisions of G.S. 36C-1-103(3), the settlor is a beneficiary whether so named under the initial trust instrument or through the exercise of a limited or general power of appointment.

(2) An irrevocable inter vivos trust for the benefit of a person if the settlor is the person's spouse, regardless of whether or when that person was a settlor of an irrevocable inter vivos trust for the benefit of the person's spouse.

For purposes of this subsection, the "settlor's spouse" refers to the person to whom the settlor was married at the time the irrevocable inter vivos trust was created, notwithstanding a subsequent dissolution of the marriage."

SECTION 8.5.(b) The Revisor of Statutes shall cause to be printed all explanatory comments of the drafters of this section, as the Revisor may deem appropriate.

SECTION 8.6. G.S. 42A-37(a) reads as rewritten:

"(a) Any member of the Armed Forces of the United States who executes a vacation rental agreement and subsequently receives (i) an order for deployment with a military unit for a period overlapping with the rental period or (ii) permanent change of station orders requiring the member to relocate on a date prior to the beginning of the lease term may terminate the member's vacation rental agreement by providing the landlord or landlord's agent with a written notice of termination within 10 calendar days of receipt of the order. The notice must be accompanied by either a copy of the official military orders or a written verification signed by the member's commanding officer. Termination of a lease pursuant to this subsection is effective immediately upon receipt of the notice by the landlord or landlord's agent. All monies paid by the terminating member, with the exception of nonrefundable fees paid to third parties as described in ~~G.S. 42-16(a),~~ G.S. 42A-16, in connection with the vacation rental agreement shall be refunded to the member within 30 days of termination of the agreement."

SECTION 8.7.(a) G.S. 57D-1-03, as amended by Section 4 of S.L. 2017-90, reads as rewritten:

"**§ 57D-1-03. Definitions.**

~~In this Chapter unless otherwise specifically provided:~~ Unless otherwise specifically provided, the following definitions apply in this Chapter:

…

~~(33b)~~(32b) Service-disabled veteran-owned small business. – A business that satisfies both of the following requirements:

a. The business's net annual receipts do not exceed one million dollars ($1,000,000).

b. One or more service-disabled veterans own more than fifty percent (50%) of the business."

SECTION 8.7.(b) This section becomes effective January 1, 2018.

SECTION 8.8.(a) G.S. 90-92(a) reads as rewritten:

"(a) This schedule includes the controlled substances listed or to be listed by whatever official name, common or usual name, chemical name, or trade name designated. In determining that a substance comes within this schedule, the Commission shall find: a low potential for abuse relative to the substances listed in Schedule III of this Article; currently accepted medical use in the United States; and limited physical or pyschological dependence relative to the substances listed in Schedule III of this Article. The following controlled substances are included in this schedule:

…

(5) Narcotic Drugs. – Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing limited quantities of any of the following narcotic drugs, or any salts thereof:

a. Not more than 1 milligram of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit.

b. Buprenorphine.

c. 2-[(dimethylamino)methyl]-1-(3-methoxyphenyl)cyclohexanol, its salts, optical and geometric isomers, and salts of these isomers (including tramadol)."

SECTION 8.8.(b) The sub-subdivision c. added to G.S. 90-92(a)(5) by Section 6 of S.L. 2017-115 is repealed.

SECTION 8.8.(c) This section becomes effective December 1, 2017, and subsection (a) of this section applies to offenses committed on or after that date.

SECTION 8.9.(a) G.S. 135-7(g)(2), as enacted by Section 5(a) of S.L. 2017-129, reads as rewritten:

"(2) Funding of the LEIA. – In the event that the General Assembly creates or modifies any provision for the retirement of, or payment of retirement benefits to, public officers or public employees that has a cost savings as measured by actuarial note required by Article 15 of Chapter 120 of the General Statutes, the Board of Trustees may direct up to one hundredth percent (0.01%) of the required contributions to fund the LEIA. These funds must be deposited in a separate fund from the fund into which regular employer contributions are deposited for the Retirement System. The Board of ~~Trustee~~ Trustees shall not direct any employer contributions into the LEIA after November 1, 2021."

SECTION 8.9.(b) This section becomes effective October 1, 2017.

SECTION 8.10. G.S. 143-47.7 reads as rewritten:

"**§ 143-47.7. Notice and record of appointment required.**

(a) Within 30 days after acceptance of appointment by a person appointed to public office, the appointing authority shall file written notice of the appointment with the Governor, the Secretary of State, the Legislative Library, ~~the State Library,~~ the State Ethics Commission, and the State Controller. For the purposes of this section, a copy of the letter from the appointing authority, a copy of the properly executed notice of appointment as set forth in subsection (c) of this section, or a copy of the properly executed Commission of Appointment shall be sufficient to be filed if the copy contains the information required in subsection (b) of this section.

(b) The notice required by this Article shall contain the following information:

(1) The name and office of the appointing authority;

(2) The public office to which the appointment is made;

(3) The name and address of the appointee;

(4) The county of residence of the appointee;

(5) The citation to the law or other authority authorizing the appointment;

(6) The specific statutory qualification for the public office to which the appointment is made, if applicable;

(7) The name of the person the appointee replaces, if applicable;

(8) The date the term of the appointment begins; and

(9) The date the term of the appointment ends.

(c) The following form may be used to comply with the requirements of this section:

"NOTICE OF APPOINTMENT

Notice is given that _____ is hereby appointed to the following
Name

public office:

Public Office: _____

Citation to Law or Other Authority Authorizing the Appointment:

_____

Specific Statutory Qualification for the Public Office, if Applicable:

_____

Address of the Appointee: _____

_____

_____

County of Residence of the Appointee: _____

Date Term of Appointment Begins: _____

Date Term of Appointment Ends: _____

Name of Person the Appointee Replaces, if applicable:

_____

_____ _____

Date of Appointment Signature

_____

Office of Appointing Authority

Distribution:

Governor

Secretary of State

Legislative Library

~~State Library~~

State Ethics Commission

State Controller""

SECTION 8.11. G.S. 143-138(b4)(2a), as enacted by Section 8(b) of S.L. 2017-108 and Section 8(a) of S.L. 2017-130, reads as rewritten:

"(2a) A "therapeutic equine facility" is an equine facility as described in ~~sub-subdivision a. of subdivision (1) of this subsection~~ sub-subdivision (1)a. of this subsection operated by an organization exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code that provides therapeutic equine-related activities for persons who are physically, intellectually, or emotionally challenged."

SECTION 8.12. G.S. 143B-68 reads as rewritten:

"**§ 143B-68. Public Librarian Certification Commission – members; selection; quorum; compensation.**

The Public Librarian Certification Commission of the Department of Natural and Cultural Resources shall consist of five members as follows: (i) ~~the chairman of the North Carolina Association of Library Trustees, (ii)~~ the chairman of the public libraries section of the North Carolina Library Association, ~~(iii) an individual~~ (ii) two individuals named by the Governor upon the nomination of the North Carolina Library Association, ~~(iv)~~ (iii) the dean of a State or regionally accredited graduate school of librarianship in North Carolina appointed by the Governor and ~~(v)~~ (iv) one member at large appointed by the Governor.

The members shall serve four-year terms or while holding the appropriate ~~chairmanships.~~chairmanship. Any appointment to fill a vacancy created by the resignation, dismissal, death or disability of a member shall be for the balance of the unexpired term.

The Governor shall have the power to remove any member of the Commission from office for misfeasance, malfeasance, and nonfeasance according to the provisions of G.S. 143B-13 of the Executive Organization Act of 1973.

The members of the Commission shall receive per diem, and necessary travel expenses in accordance with the provisions of G.S. 138-5.

A majority of the Commission shall constitute a quorum for the transaction of business.

All clerical and other services required by the Commission shall be supplied by the Secretary of the Department through the regular staff of the Department."

SECTION 8.13. Part XII of S.L. 2006-248 is repealed.

SECTION 8.14. Section 6A.19(e) of S.L. 2011-145 is repealed.

PART IX. EFFECTIVE DATE

SECTION 9. Except as otherwise provided, this act is effective when it becomes law.

Committee Cochairs
Rep. Josh Dobson
Rep. Donny Lambeth
Sen. Louis Pate

Legislative Members
Rep. William D. Brisson
Rep. Carla D. Cunningham
Rep. Nelson Dollar
Rep. Beverly M. Earle
Rep. Jean Farmer-Butterfield
Rep. Bert Jones
Rep. Chris Malone
Rep. Gregory F. Murphy, MD
Rep. Donna McDowell White
Sen. Dan Bishop
Sen. David L. Curtis
Sen. Jim Davis
Sen. Valerie P. Foushee
Sen. Ralph Hise
Sen. Joyce Krawiec
Sen. Gladys A. Robinson
Sen. Jeff Tarte
Sen. Tommy Tucker
Sen. Mike Woodard

Ad[illegible]y Members
Re[illegible]e Adcock

October 10, 2017

Members of the Joint Legislative Oversight Committee on Health and Human Services:

G.S. 120-208.2(d) authorizes the Committee cochairs to establish subcommittees of the Joint Legislative Oversight Committee on Health and Human Services to examine issues pertaining to services provided by Divisions of the Department of Health and Human Services. This letter provides member appointments for three subcommittees authorized by S.L. 2017-57 and S.L. 2016-94.

Session Law 2017-57, Section 11J.2, directs this Committee and the Joint Legislative Education Oversight Committee to each appoint a subcommittee to jointly examine the use of State funds to support medical education and medical residency programs. In conducting the study, the subcommittees must examine at least all of the following:

(1) The health care needs of the State's residents and the State's goals in meeting those health care needs through the support and funding of medical education and medical residency programs located within the State.
(2) The short-term and long-term benefits to the State for allocating State funds to medical education and medical residency programs located within the State.
(3) Recommended changes and improvements to the State's current policies with respect to allocating State funds and providing other support to medical education programs and medical residency programs located within the State.
(4) Development of an evaluation protocol to be used by the State in determining (i) the particular medical education programs and medical residency programs to support with State funds and (ii) the amount of State funds to allocate to these programs.
(5) Any other relevant issues the subcommittees deem appropriate.

The subcommittee members listed below are appointed to work with members of the Joint Legislative Education Oversight Committee subcommittee.

Medical Education and Residency Programs Subcommittee,
Joint Legislative Oversight Committee on Health and Human Services

Senate Members	House Members
Senator Louis Pate, Cochair	Representative Donny Lambeth, Cochair
Senator Jeff Tarte	Representative Gregory F. Murphy, MD
Senator Mike Woodard	Representative Jean Farmer-Butterfield

Session Law 2016-94, Section 12F.10, as amended by S.L. 2017-57, Section 11F.6, directs this Committee and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to each establish a subcommittee on Behavioral Health Services. The two subcommittees are directed to meet jointly to do the following:

(1) Oversee the Department's development of the strategic plan required by subsection (b) of Section 12F.10 of S.L. 2016-94.
(2) Review the strategic plan developed by the Department in accordance with subsection (b), including a review of all performance-related goals and measures for the delivery of mental health, developmental disabilities, substance abuse, and traumatic brain injury services.
(3) Review consolidated monthly, quarterly, and annual reports and analyses of behavioral health services funded by Medicaid and State-only appropriations.

The subcommittee members listed below are appointed to work with the members of the Joint Legislative Education Oversight Committee subcommittee.

Behavioral Health Subcommittee,
Joint Legislative Oversight Committee on Health and Human Services

Senate Members	House Members
Senator Tommy Tucker, Cochair	Representative Chris Malone, Cochair
Senator Dan Bishop	Representative Bert Jones
Senator Gladys Robinson	Representative William Brisson

Session Law 2017-57, Section 11D.3, provides that cochairs for this Committee may consider appointing a subcommittee on aging to examine the State's delivery of services for older adults in order to (i) determine their service needs and to (ii) make recommendations to the Oversight Committee on how to address those needs.

The subcommittee members listed below are appointed to this subcommittee.

Aging Subcommittee

Senate Members	House Members
Senator Joyce Krawiec, Cochair	Representative Josh Dobson, Cochair
Senator David Curtis	Representative Donna McDowell White
Senator Valerie Foushee	Representative Beverly Earle

All three subcommittees will need to present their subcommittee report, including any recommendations, to the Joint Legislative Oversight Committee on Health and Human Services one meeting prior to the final meeting in the 2017-18 interim. The Cochairs and Committee staff will keep the subcommittees apprised of this date.

Sincerely,

Representative Josh Dobson, Cochair

Senator Louis Pate, Cochair

Representative Donny Lambeth, Cochair

Joint Legislative Oversight Committee on Health and Human Services
2017-18 Interim Subcommittees

Medical Education and Residency Programs Subcommittee, Joint Legislative Oversight Committee on Health and Human Services*

Senate Members	House Members
Senator Louis Pate, Cochair	Representative Donny Lambeth, Cochair
Senator Jeff Tarte	Representative Gregory F. Murphy, MD
Senator Mike Woodard	Representative Jean Farmer-Butterfield
Staff	
Jason Moran-Bates, Legislative Analysis	Theresa Matula, Legislative Analysis
Denise Thomas, Fiscal	Steve Owen, Fiscal
Amy Jo Johnson, Legislative Drafting	
Clerk	
Pan Briles	Julie Ryan
DeAnne Mangum	

Authorization: S.L. 2017-57, Section 11J.2. *This is a joint study with the Joint Legislative Education Oversight Committee.

Behavioral Health Subcommittee, Joint Legislative Oversight Committee on Health and Human Services*

Senate Members	House Members
Senator Tommy Tucker, Cochair	Representative Chris Malone, Cochair
Senator Dan Bishop	Representative Bert Jones
Senator Gladys A. Robinson	Representative William Brisson
Staff	
Jennifer Hillman, Legislative Analysis	Joyce Jones, Legislative Drafting
Susan Barham, Legislative Analysis	Steve Owen, Fiscal
Clerk	
DeAnne Mangum	Pan Briles
Julie Ryan	

Authorization: S.L. 2016-94, Section 12F.10, as amended by Section 11F.6 of S.L. 2017-57. *This is a joint study with the Joint Legislative Oversight Committee on Medicaid and Health Choice.

Aging Subcommittee

Senate Members	House Members
Senator Joyce Krawiec, Cochair	Representative Josh Dobson, Cochair
Senator David L. Curtis	Representative Donna McDowell White
Senator Valerie P. Foushee	Representative Beverly M. Earle
Staff	
Theresa Matula, Legislative Analysis	Deborah Landry, Fiscal
Lisa Wilks, Legislative Drafting	
Clerk	
Julie Ryan	DeAnne Mangum
Pan Briles	

Authorization: S.L. 2017-57, Section 11D.3

S.L. 2017-57

...

CHILD WELFARE SYSTEM CHANGES

SECTION 11C.7.(a) Federal Improvement Plan Implementation. – The Department of Health and Human Services, Division of Social Services, shall continue implementing the requirements of the federal Program Improvement Plan to bring our State into compliance with national standards for child welfare policy and practices. The Division shall collaborate with county departments of social services to develop a model of oversight that supports program outcomes and a county's ability to meet performance standards as outlined in the Program Improvement Plan. Oversight may include support for continuous quality improvement, staff training, and data analysis.

Of the funds appropriated to the Division in each year of the 2017-2019 fiscal biennium for the child welfare program improvement plan, the sum of sixty thousand dollars ($60,000) recurring in each year of the 2017-2019 fiscal biennium shall be used by the Division, in collaboration with the North Carolina State Commission on Indian Affairs within the Department of Administration, for North Carolina State-recognized tribes to assist in (i) recruiting foster parents, (ii) increasing the number of foster homes for children who are members of a North Carolina State-recognized tribe, and (iii) providing training for staff of county departments of social services to ensure culturally appropriate services for children who are members of a North Carolina State-recognized tribe.

The Division shall report on the implementation and outcomes of the Program Improvement Plan to the Joint Legislative Oversight Committee on Health and Human Services. The report shall be submitted semiannually on February 1 and August 1 of each year, with a final report on February 1, 2019.

SECTION 11C.7.(b) Child Welfare/NC FAST. – The Department of Health and Human Services, Division of Social Services, shall continue toward completion of the child welfare component of the North Carolina Families Accessing Services Through Technology (NC FAST) system to (i) bring the State into compliance with the Statewide Information System systematic factor of the Child and Family Services Review (CFSR) and (ii) ensure that data quality meets federal standards and adequate information is collected and available to counties to assist in tracking children and outcomes across counties.

It is the intent of the General Assembly that the child welfare component of the NC FAST system be operational by December 31, 2017. To that end, the Department of Health and Human Services, Division of Social Services, shall report on the development, implementation, and outcomes of the child welfare component of the NC FAST system to the Joint Legislative Oversight Committee on Health and Human Services quarterly through April 1, 2019. The report shall include, at a minimum, each of the following:

(1) The current time line for development and implementation of the child welfare component to NC FAST.
(2) Any adjustments and justifications for adjustments to the time line.
(3) Progress on the development and implementation of the system.
(4) Address any identified issues in developing or implementing the child welfare component to NC FAST and solutions to address those issues.
(5) The level of county participation and involvement in each phase of the project.
(6) Any budget and expenditure reports, including overall project budget and expenditures, and current fiscal year budget and expenditures.

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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

SESSION LAW 2017-41
HOUSE BILL 630

AN ACT TO ESTABLISH SOCIAL SERVICES REGIONAL SUPERVISION AND COLLABORATION; REFORM THE CHILD WELFARE SYSTEM IN THIS STATE; IMPROVE ACCOUNTABILITY AND STATE OVERSIGHT OF THE CHILD WELFARE SYSTEM; REQUIRE WRITTEN AGREEMENTS, CORRECTIVE ACTION, AND STATE INTERVENTION WITH SOCIAL SERVICES DEPARTMENTS; CREATE REGIONAL SOCIAL SERVICE DEPARTMENTS; ESTABLISH A CHILD WELL-BEING TRANSFORMATION COUNCIL; ESTABLISH A DRIVERS LICENSE PILOT PROJECT; ESTABLISH A PILOT PROGRAM TO AUTHORIZE A WAIVER OF THE EMPLOYMENT REQUIREMENT FOR FOSTER PARENTS OF CHILDREN RECEIVING INTENSIVE ALTERNATIVE FAMILY TREATMENT; REDUCE THE TIME FRAME A PARENT HAS TO APPEAL FROM A TERMINATION OF PARENTAL RIGHTS ORDER; REDUCE THE TIME FRAME FOR LICENSURE APPROVAL REGARDING FOSTER CARE; AND REQUIRE CHILD PROTECTIVE SERVICE OBSERVATION BEFORE PHYSICAL CUSTODY OF CHILD MAY BE RETURNED.

Whereas, the children and families involved in North Carolina's child welfare system are among our most vulnerable children and most fragile families; and

Whereas, the recent federal Child and Family Services Review (CFSR) and the North Carolina Statewide Child Protective Services Evaluation of the State's Child Protective Services (CPS) program identified troubling gaps and flaws in North Carolina's child welfare system that are allowing too many of those vulnerable children and fragile families to fall through the cracks; and

Whereas, transforming the child welfare system to better ensure the safety, permanency, and well-being of children and families is the right thing to do; and

Whereas, county social services agencies are facing significant resource and administration challenges in areas other than child welfare, such as public assistance and adult services; and

Whereas, a recent audit by the North Carolina State Auditor of Medicaid eligibility determinations by county departments of social services concluded that most of the county departments reviewed in the audit did not consistently meet standards for timeliness and accuracy; and

Whereas, a recent report by the Program Evaluation Division reached similar conclusions regarding county administration of Medicaid eligibility determinations; and

Whereas, North Carolina's Aging Services Plan and a recent report on Alzheimer's and related dementias by the North Carolina Institute of Medicine emphasize the tremendous growth of the aging population and anticipate relying heavily on social services agencies to support the needs of this population; and

Whereas, it has been challenging for the State to effectively supervise administration of complex social services programs in 100 counties and it would be more efficient and effective for the State to supervise fewer local agencies; and



(6) Two county social services directors, one of whom shall be appointed by the President Pro Tempore of the Senate and one of whom shall be appointed by the Speaker of the House of Representatives.
(7) One representative from the North Carolina Association of Social Services Attorneys (NCASSA), appointed by the President of the NCASSA.
(8) One representative from the Association of North Carolina County Social Services Directors, appointed by the President of the Association.

SECTION 1.2.(c) Ad Hoc Subcommittees. – The cochairs may, at their discretion, establish ad hoc subcommittees involving experts and representatives of stakeholder organizations to provide information and offer recommendations related to their areas of expertise and interest. Experts and organizations may include:

(1) Social Services Commission.
(2) North Carolina Association of County Boards of Social Services.
(3) Guardian ad Litem Program.
(4) Office of Indigent Defense Services.
(5) North Carolina Partnership for Children, Inc.
(6) Disability Rights of North Carolina.
(7) Benchmarks NC.
(8) North Carolina Association of Local Health Directors.
(9) North Carolina Council of Community Programs.
(10) North Carolina Emergency Management Association.
(11) North Carolina Child Support Council.
(12) North Carolina Pediatric Society.
(13) AARP North Carolina.
(14) County commissioners representing jurisdictions that have diverse geographic, socioeconomic, and demographic characteristics.
(15) Directors and administrators of consolidated human services agencies.
(16) Other experts or stakeholders identified by the cochairs.

SECTION 1.2.(d) Duties. – The Working Group shall develop recommendations for the regional supervision and collaboration plan required by Section 1.1 of this act. The Working Group shall divide its work into two stages, the first to address regional supervision and the second to address interagency collaboration and regionalization.

(1) Stage One. – The Working Group shall convene its first meeting no later than October 6, 2017. During the first stage, the Working Group shall develop recommendations regarding:
    a. The size, number, and location of the regions. Recommendations shall take into consideration (i) the need for regions to maintain direct, local connections with the jurisdictions they serve; (ii) alignment with other regional organizations that intersect with the work of social services, as appropriate; and (iii) awareness of the cultural differences and similarities between regions.
    b. The allocation of responsibility between the central, regional, and local officials in supervising and administering the social services programs and services.
    c. Methods for holding the regional offices accountable for performance and responsiveness.
    d. Requirements for the regional offices to share information about local departmental performance with the relevant board or boards of county commissioners, county or regional board of social services, or consolidated human services board.

(4) Develop a plan for collection, analysis, and effective use of data by the social services system.

(5) Create a Social Services System Transparency and Wellness Dashboard (Dashboard) as provided in subsection (c) of this section.

(6) Develop a plan for consistent, standardized continuous quality improvement (CQI) for social services at the State, regional, and county levels.

(7) Review policies and procedures to support and accelerate system reform, focusing on sustainable change that will improve outcomes for children and families.

(8) Provide ongoing evaluation and oversight of the Department's implementation of social services system reform.

(9) Develop a child welfare reform plan as specified in subsection (b) of this section.

(10) Comply with all applicable reporting and implementation requirements specified in subsection (d) of this section.

In developing and implementing the social services system reform plan, the organization shall engage the services of national technical advisors with broad expertise and experience in implementing large-scale, systemic social services reform. The national technical advisors may have specialized expertise in certain areas of social services, such as child welfare, adult services, public assistance, or child support enforcement.

SECTION 2.1.(b) Child Welfare Reform. – The contract with the third-party organization required by subsection (a) of this section shall also require the organization to develop a child welfare reform plan that, at a minimum, makes recommendations regarding:

(1) Child Protective Services (CPS), including the system for receiving reports and investigating allegations of child abuse, neglect, or dependency.

(2) Preventive and in-home services that provide struggling families with needed supports and treatment to prevent removal of the children from the home.

(3) Child fatality oversight, including a review of the existing structure, communication, and effectiveness of the Community Child Protection Teams, the Child Fatality Prevention Team, and use of Citizen Review Panels. Oversight shall also include identification of systemic problems in the child welfare system that may increase risk of harm or death to a child and implementation of timely and appropriate systemic reforms following a child fatality.

(4) Placement of children in foster care and other out-of-home settings.

(5) Services provided to children, youth, and parents involved with child welfare to achieve reunification of families.

(6) Efforts to achieve permanency for children either through reunification with family, legal guardianship or custody, or adoption.

(7) Provision of health care, mental health, and educational services to children and families involved with the child welfare system.

(8) Services provided to older youth in foster care and to those who have aged out of foster care.

(9) Strategies to ensure well-trained and adequately compensated staff to improve performance and reduce turnover.

(10) Practice and implementation, including:

a. Ensuring a statewide, trauma-informed, culturally competent, family-centered practice framework.

provision of accurate federal reporting and improved case management, continuous quality improvement (CQI), and overall improved outcomes for children and families. The data from the Dashboard shall be readily available on the Department's Web site. For purposes of this subsection, the term "Dashboard" means a standard set of performance and outcome metrics that indicate how effectively the components of the social services system are working.

SECTION 2.1.(e) The following reporting and implementation requirements shall occur:

(1) The Office of State Budget and Management (OSBM) shall report to the Joint Legislative Oversight Committee on Health and Human Services (Committee) upon hiring an organization as required by subsection (a) of this section to develop the social services reform plan pursuant to this section.

(2) OSBM shall include in the contract clear direction that time is of the essence and failure to perform within the required time line constitutes breach of contract. OSBM shall also include a provision in the contract authorizing it to terminate the contract without financial penalty to the State if OSBM, in consultation with the Committee, determines that progress on development of the child welfare reform plan is unsatisfactory.

(3) The organization shall submit a preliminary report to the Committee no later than 180 days after the contract is finalized. The preliminary report shall set forth the progress made on developing the reform plan and the objectives for the subsequent 180 days. After that preliminary report is submitted, the organization shall submit bimonthly reports to Committee on the progress of development and implementation of the child welfare reform plan.

(4) The Department shall submit preliminary recommendations to the Committee no later than October 1, 2018, regarding legislative changes necessary to implement the reform plan developed by the organization. After the preliminary report is submitted, the Department may submit additional reports to the Committee identifying additional legislative changes that are necessary to implement the reform plan as it is further developed and implemented.

SECTION 2.2. This part becomes effective July 1, 2017.

PART III. LOCAL DSS WRITTEN AGREEMENTS; CORRECTIVE ACTION; STATE INTERVENTION

SECTION 3.1.(a) G.S. 108A-74 reads as rewritten:

"**§ 108A-74. County departments required to enter into annual written agreement for all social services programs other than medical assistance; County department failure to provide child welfare services; State intervention in or control of child welfare service delivery.**

(a) Notwithstanding any other provision of law to the contrary, the Secretary of Health and Human Services may take action in accordance with this section to ensure the delivery of child welfare services in accordance with State laws and applicable rules. As used in this section, the terms:

(1) "County department of social services" also means the consolidated human services agency, whichever applies;

(2) "County director of social services" also means the human services director, whichever applies; and

(3) "County board of social services" also means the consolidated human services board, whichever applies.

county director of social services, and after providing them with an opportunity to be heard, shall withhold funding for the particular service or services in question and shall ensure the provision of these services through contracts with public or private agencies or by direct operation by the Department of Health and Human Services.

(d) In the event that the Secretary assumes control of service delivery pursuant to subsection (c) of this section, the county director of social services shall be divested of all service delivery powers conferred upon the director by G.S. 108A-14 and other applicable State law as the powers pertain to the services in question. Upon assumption of control of service delivery, the Secretary may assign any of the powers and duties of the county director of social services to the Director of the Division of Social Services of the Department of Health and Human Services or to a contractor as the Secretary deems necessary and appropriate to continue the provision of the services in the county.

(e) In the event the Secretary takes action under this section, the Department of Health and Human Services shall, in conjunction with the county board of commissioners, the county board of social services, and the county director of social services develop and implement a corrective plan of action. The Department of Health and Human Services shall also keep the chair of the county board of commissioners, the chair of the county board of social services, and the county director of social services informed of any ongoing concerns or problems with the delivery of the services in question.

(f) Upon the Secretary taking action pursuant to subsection (c) of this section, county funding of the services in question shall continue and at no time during the period of time that the Secretary is taking action shall a county withdraw funds previously obligated or appropriated for the services. Upon the Secretary's assumption of the control of service delivery, the county shall also pay the nonfederal share of any additional cost that may be incurred to operate the services in question at the level necessary to comply fully with State law and Social Services Commission rules.

(g) During the period of time that the Secretary is taking action pursuant to subsection (c) of this section, the Department of Health and Human Services shall work with the county board of commissioners, the county board of social services, and the county director of social services, to enable service delivery to be returned to the county if and when the Secretary has determined that services can be provided by the county in accordance with State law and applicable rules."

SECTION 3.1.(b) This section becomes effective upon ratification and applies to written agreements required pursuant to G.S. 108A-74(a1) for fiscal years 2018-2019 and 2019-2020.

SECTION 3.2.(a) Effective March 1, 2020, G.S. 108A-74 reads as rewritten:

"**§ 108A-74. ~~County~~ Local departments required to enter into annual written agreement for all social services programs other than medical assistance; ~~County~~ Local department failure to ~~provide child welfare services;~~comply with the written agreement or applicable law; corrective action; State intervention in or control of ~~child welfare~~ service delivery.**

(a) Notwithstanding any other provision of law to the contrary, the Secretary ~~of Health and Human Services~~ may take action in accordance with this section to ensure the delivery of child welfare services in accordance with State laws and applicable rules. As used in this section, the ~~terms:~~following definitions shall apply:

(1) ~~"County department of social services" also means the~~ Department of social services. – The department responsible for administration of the social services and programs of public assistance in a county. It includes a county department of social services, a consolidated human services agency, ~~department~~ or a regional social services department, whichever ~~applies;~~ applies.

performance requirements or comply with the terms of the agreement or applicable law.

(a3) If a department of social services fails to comply with the terms of the written agreement or applicable law for three consecutive months or for five months within any consecutive 12-month period, the Secretary and the department of social services shall enter into a joint corrective action plan within 60 working days. The Secretary may also require a corrective action plan more quickly in urgent circumstances, regardless of whether the circumstances are directly related to a mandated performance requirement specified in the written agreement.

(a4) The corrective action plan shall include each of the following components:

(1) The duration of the joint corrective action plan, not to exceed 12 months. If the Secretary determines that the department of social services has not shown measurable progress within six months, the Secretary may summarily conclude that the department of social services has failed to successfully complete the joint corrective plan and may proceed with steps necessary to temporarily assume administrative responsibilities of the department of social services. If the Secretary determines the department of social services has shown measurable progress within six months, the Secretary may extend the joint corrective action plan by six months, but in no case shall a joint corrective action plan exceed 18 months.

(2) The performance requirements for the department of social services that constitute successful completion of the joint corrective action plan.

(3) A schedule and plan for providing updates to the social services board regarding the department's progress implementing the corrective action plan.

(4) An acknowledgement that failure to successfully complete the joint corrective action plan shall result in temporary assumption of all or part of the department of social services administration.

(b) If the Secretary ~~of Health and Human Services~~ determines that a ~~county~~ department of social services ~~is not providing child protective services, foster care services, or adoption services in accordance with State law and with applicable rules adopted by the Social Services Commission, or fails to demonstrate reasonable efforts to do so,~~ has failed to successfully complete the joint corrective action plan, then the ~~Secretary, after providing written notification of intent to the county director of social services, to the chair of the county board of commissioners, and to the chair of the county board of social services, and after providing them with an opportunity to be heard, may intervene in the particular service or services in question. Intervention includes, but is not limited to, the following activities:~~Secretary shall give the board of county commissioners, the department of social services, the county manager, and the board of social services at least 30 days' notice that the Secretary, through the appropriate regional social services office, intends to temporarily assume all or part of the department's socials services administration in accordance with subsection (c) of this section. In a regional department of social services, notice shall be provided to boards of county commissioners and county managers for all counties served by the region.

~~(1) Sending staff of the Department of Health and Human Services to the county department of social services to provide technical assistance and to monitor the services being provided;~~

~~(2) Establishing a corrective plan of action to correct inappropriate policies and procedures; and~~

~~(3) Advising county personnel as to appropriate policies and procedures.~~

~~If within 60 days of completion of the intervention activities, the Secretary finds that the county department of social services is not providing in accordance with State laws and applicable rules the particular service or services for which intervention was initiated, or has~~

restored to the department of social services, the Secretary shall notify the board of county commissioners, the department of social services, the county manager, and the board of social services that the temporary assumption of program administration will be terminated and the effective date of the termination. Upon termination, the department of social services shall resume its full authority to administer the program or programs that were assumed.

~~(d) In the event that the Secretary assumes control of service delivery pursuant to subsection (c) of this section, the county director of social services shall be divested of all service delivery powers conferred upon the director by G.S. 108A-14 and other applicable State law as the powers pertain to the services in question. Upon assumption of control of service delivery, the Secretary may assign any of the powers and duties of the county director of social services to the Director of the Division of Social Services of the Department of Health and Human Services or to a contractor as the Secretary deems necessary and appropriate to continue the provision of the services in the county.~~

~~(e) In the event the Secretary takes action under this section, the Department of Health and Human Services shall, in conjunction with the county board of commissioners, the county board of social services, and the county director of social services develop and implement a corrective plan of action. The Department of Health and Human Services shall also keep the chair of the county board of commissioners, the chair of the county board of social services, and the county director of social services informed of any ongoing concerns or problems with the delivery of the services in question.~~

~~(f) Upon the Secretary taking action pursuant to subsection (c) of this section, county funding of the services in question shall continue and at no time during the period of time that the Secretary is taking action shall a county withdraw funds previously obligated or appropriated for the services. Upon the Secretary's assumption of the control of service delivery, the county shall also pay the nonfederal share of any additional cost that may be incurred to operate the services in question at the level necessary to comply fully with State law and Social Services Commission rules.~~

~~(g) During the period of time that the Secretary is taking action pursuant to subsection (c) of this section, the Department of Health and Human Services shall work with the county board of commissioners, the county board of social services, and the county director of social services, to enable service delivery to be returned to the county if and when the Secretary has determined that services can be provided by the county in accordance with State law and applicable rules.~~"

SECTION 3.2.(b) This section becomes effective March 1, 2020, and is effective for all written agreements required pursuant to G.S. 108A-74 entered into on or after that date.

SECTION 3.3. The Department shall report to the Joint Legislative Oversight Committee on Health and Human Services (Committee) by August 1 of every year regarding oversight of the local administration of social services programs other than medical assistance.

(1) The reports shall include, at a minimum:
   a. A copy of the template for the written agreement required by G.S. 108A-74(a1).
   b. An evaluation of the implementation of the requirement for a written agreement.
   c. A summary of any oversight action taken by the Department pursuant to the agreement or G.S. 108A-74, including a list of any federal or State funds that were withheld as a result of the State's oversight.

(2) Beginning August 1, 2021, the reports required in this section shall also include:

members to fill any remaining vacancies. The composition of the board shall reasonably reflect the population makeup of the entire region and provide equitable region-wide representation. All members shall be residents of the region.

(d) Except as provided in this subsection, members of a regional board of social services shall serve terms of three years. Two of the original members shall serve terms of one year, and two of the original members shall serve terms of two years. No member shall serve more than three consecutive three-year terms. County commissioner members shall serve only as long as the member is a county commissioner.

(e) Whenever a county shall join or withdraw from an existing regional social services department, the regional board of social services shall be dissolved and a new board shall be appointed as provided in subsection (c) of this section.

(f) Vacancies shall be filled by the appointing authority for any unexpired portion of a term.

(g) A chairperson shall be elected annually by a regional board of social services. The regional social services director shall serve as secretary to the board.

(h) A majority of the actual membership, excluding vacancies, shall constitute a quorum.

(i) Upon being given written notice and an opportunity to respond, a member may be removed from office by the regional board of social services for any of the following:

(1) Commission of a felony or other crime involving moral turpitude.

(2) Violation of a State law governing conflict of interest.

(3) Violation of a written policy adopted by the county board of commissioners of each county in the region.

(4) Habitual failure to attend meetings.

(5) Conduct that tends to bring the office into disrepute.

(j) A member may receive a per diem in an amount established by the county commissioner members of the regional board of social services. Reimbursement for subsistence and travel shall be in accordance with a policy set by the county commissioner members of the regional board of social services.

(k) The board shall meet at least quarterly. The chairperson or three of the members may call a special meeting.

(l) A regional board of social services is authorized to provide liability insurance for the members of the board and the employees of the regional social services department. A regional board of social services is also authorized to contract for the services of an attorney to represent the board, the regional social services department, and its employees, as appropriate. The purchase of liability insurance pursuant to this subsection waives both the regional board of social services' and the regional social services department's governmental immunity, to the extent of insurance coverage, for any act or omission occurring in the exercise of a governmental function. By entering into a liability insurance contract with the regional board of social services, an insurer waives any defense based upon the governmental immunity of the regional board of social services or the regional social services department.

"**§ 108A-15.3C. Dissolution of a regional social services department.**

(a) Whenever the board of commissioners of each county constituting a regional social services department determines that the department is not operating in the best interests of the respective counties, they may direct that the regional social services department be dissolved.

(b) Whenever a board of commissioners of a county which is a member of a regional social services department determines that the department is not operating in the best interests of that county, it may withdraw from the regional social services department.

(c) Dissolution of a regional social services department or withdrawal from the regional social services department by a county shall be effective only at the end of the fiscal year in which the action of dissolution or withdrawal transpired.

or was present when the report required by G.S. 7B-301 was received. Notwithstanding G.S. 153A-257, the absence of a juvenile from the juvenile's home pursuant to a protection plan during an assessment or the provision of case management services by a department of social services shall not change the original venue if it subsequently becomes necessary to file a juvenile petition."

SECTION 4.5. G.S. 143B-153 is amended by adding a new subdivision to read:

"**§ 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 shall have the power and duty to adopt rules and regulations to be followed in the conduct of the State's medical assistance program.

...

(9) The Commission shall adopt rules governing the obligations of counties to contribute financially to regional social services departments in accordance with G.S. 108A-15.3A(e)."

SECTION 4.6. Sections 4.1, 4.2, 4.3, and 4.4 become effective March 1, 2019. Section 4.5 becomes effective upon ratification.

PART V. CHILD WELL-BEING TRANSFORMATION COUNCIL

SECTION 5.1. Chapter 143 of the General Statutes is amended by adding a new Article to read:

"Article 82.

"Child Well-Being Transformation Council.

"**§ 143-775. Child Well-Being Transformation Council established; membership; qualifications; vacancies.**

(a) Purpose; Findings. – The welfare of North Carolina's children is a priority. There are many public and private agencies and organizations across the State involved with promoting the welfare of children and protecting them from harm, such as those involving child care, education, health care, social services, and juvenile justice. Though these agencies and organizations provide important services, they often fail to collaborate, coordinate, and communicate about those services. A more systematic and coordinated approach to services will help ensure that the State achieves the best possible outcomes for children. Therefore, the General Assembly finds that it is essential that a single body serve as a means for coordination, collaboration, and communication among agencies and organizations involved in providing public services to children.

(b) Creation and Membership. – There is established the North Carolina Child Well-Being Transformation Council (Council). The Council shall be located administratively in the General Assembly. The Council shall consist of 17 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 Council and shall strive to ensure members are appointed who represent the geographical, political, gender, and racial diversity of this State. The initial Council members shall be appointed on or after July 1, 2018, as follows:

(1) 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, one shall be a member of the Senate who shall serve for a term of two years, one shall be a representative from the Administrative Office of the Courts who shall serve for a term of

(a) Upon its establishment, the Council shall direct its initial focus on the following initiatives:

(1) Mapping the network of child-serving agencies and organizations in the State.

(2) Cataloging examples of failures in coordination, collaboration, and communication in the context of child welfare.

(3) Reviewing the work of bodies similar to the Council operating in other states to identify promising practices and focus areas for the Council's work.

(b) Beginning March 1, 2020, the Council shall:

(1) Monitor changes in the social services and child welfare system associated with reform and regional supervision.

(2) Identify gaps in coordination, collaboration, and communication related to all publicly funded child serving programs.

(3) Recommend changes in law, policy, or practice necessary to remedy gaps or problems impacting coordination, collaboration, and communication among publicly funded child-serving agencies.

(c) The Council shall submit a report to the chairs of the Senate Appropriations Committee on Health and Human Services, the chairs of the House of Representatives Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division by June 30 of each year. The report shall include a summary of the Council's work for the previous year, any findings and recommendations for change, and a work plan for the upcoming year.

(d) The Council is authorized to accept gifts or grants from other sources to support administration of the Council."

SECTION 5.2. This part becomes effective July 1, 2017.

PART VI. DRIVERS LICENSE PILOT PROJECT

SECTION 6.1.(a) The General Assembly recognizes that not having a drivers license is a barrier to education, employment, health care, and other community-based activities for older youth in foster care, as defined in G.S. 131D-10.2(9), working toward independence. One of the biggest barriers to accessing a drivers license for such youth is the ability to obtain insurance. Therefore, to assist in this effort, the Department of Health and Human Services, Division of Social Services, shall establish a two-year pilot program that shall reimburse, on a first-come, first-served basis, youth and caregivers' costs associated with drivers license education, drivers license fees, insurance costs, and any other costs associated with obtaining a drivers license. The Division shall take appropriate steps to ensure proper advertising of the pilot program.

SECTION 6.1.(b) The Division of Social Services shall report on the pilot project to the Joint Legislative Oversight Committee on Health and Human Services by March 1, 2018.

SECTION 6.2. This part becomes effective July 1, 2017.

PART VII. PILOT WAIVER FOR IAFT FOSTER PARENTS

SECTION 7.(a) The General Assembly has determined that in an effort to maximize funding, local management entities/managed care organizations (LME/MCOs) are utilizing Intensive Alternative Family Treatment (IAFT), which is a means of cost-effective, specialized foster care treatment service that is being used for many youth who would have previously been treated in Medicaid congregate care, such as psychiatric residential treatment facilities. The General Assembly finds that these higher-need youth are often (i) suspended or expelled from school or day programs and (ii) require multiple appointments on a weekly basis to address needs, such as therapy, medication management, and school individual education plans (IEPs). Further, in accordance with rules, foster parents are required to maintain outside

1. Has preserved the right to appeal the order in writing within 30 days after entry and service of the order.
2. A termination of parental rights petition or motion has not been filed within 65 days of entry and service of the order.
3. A notice of appeal of the order eliminating reunification is filed within 30 days after entry and service of the expiration of the 65 days.

b. A party who is a guardian or custodian with whom reunification is not a permanent plan.

~~(6) Any order that terminates parental rights or denies a petition or motion to terminate parental rights.~~

(a1) In a juvenile matter under this Subchapter, appeal of a final order of the court shall be made directly to the Supreme Court in the following juvenile matters:

(1) Any order that terminates parental rights or denies a petition or motion to terminate parental rights.

(2) An order eliminating reunification as a permanent plan under G.S. 7B-906.2(b), if all of the following conditions are satisfied:

a. The right to appeal the order eliminating reunification has been preserved in writing within 30 days of entry and service of the order.

b. A motion or petition to terminate the parent's rights is filed within 65 days of entry and service of the order eliminating reunification and both of the following occur:

1. The motion or petition to terminate rights is heard and granted.
2. The order terminating parental rights is appealed in a proper and timely manner.

c. A separate notice of appeal of the order eliminating reunification is filed within 30 days after entry and service of a termination of parental rights order.

(a2) In an appeal filed pursuant to subdivision (a1)(2) of this section, the Supreme Court shall review the order eliminating reunification together with an appeal of the order terminating parental rights. If the order eliminating reunification is vacated or reversed, the order terminating parental rights shall be vacated.

(b) Notice of appeal and notice to preserve the right to appeal shall be given in writing by a proper party as defined in G.S. 7B-1002 and shall be made within 30 days after entry and service of the order in accordance with G.S. 1A-1, Rule 58.

(c) Notice of appeal shall be signed by both the appealing party and counsel for the appealing party, if any. In the case of an appeal by a juvenile, notice of appeal shall be signed by the guardian ad litem attorney advocate."

SECTION 8.(b) This section becomes effective January 1, 2019, and applies to appeals filed on or after that date.

PART IX. TIME FRAME FOR LICENSURE APPROVAL/FOSTER CARE

SECTION 9.1. G.S. 131D-10.3 is amended by adding a new subsection to read:

"**§ 131D-10.3. Licensure required.**

...

(d1) Notwithstanding any other provision of law, the Department shall grant or deny a license to provide foster care or therapeutic foster care within three months from the date of application.

...."

PART XI. EFFECTIVE DATE

SECTION 11. Except as otherwise provided, this act is effective when it becomes law.

In the General Assembly read three times and ratified this the 15th day of June, 2017.

s/ Philip E. Berger
President Pro Tempore of the Senate

s/ Tim Moore
Speaker of the House of Representatives

s/ Roy Cooper
Governor

Approved 5:05 p.m. this 21st day of June, 2017

JOINT LEGISLATIVE COMMITTEE
ON HEALTH AND HUMAN SERVICES

Child Welfare Updates

Susan Perry-Manning, Deputy Secretary for Human Services

Michael Becketts, Assistant Secretary for Human Services

Sam Gibbs, Deputy Secretary for Technology and Operations

Oct. 10, 2017

Overview

- Implementation of the Federal Program Improvement Plan
- NC FAST Implementation of the Child Welfare Case Management System
- Planning for Implementation of the Family-Child Protection and Accountability Act/Rylan's Law

JOINT LEGISLATIVE COMMITTEE
ON HEALTH AND HUMAN SERVICES

Implementation of the Federal Program Improvement Plan

S.L. 2017-57, Sec. 11C.7

Susan Perry-Manning, Deputy Secretary for Human Services

Michael Becketts, Assistant Secretary for Human Services

Oct. 10, 2017

Child Welfare Overview – Key Legislation

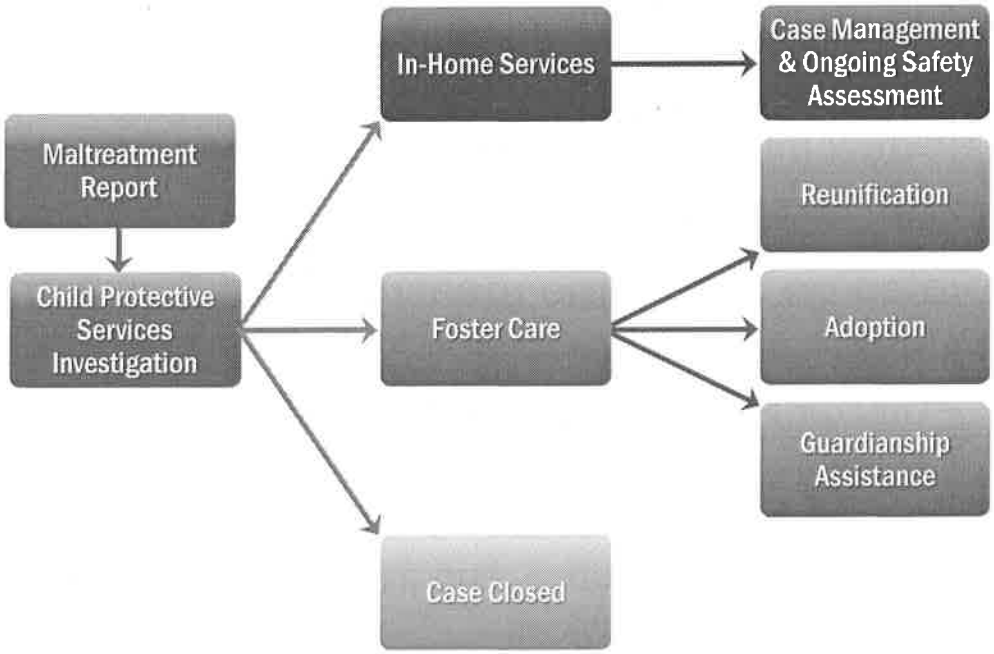
- Federal Legislation
  - Child Abuse Prevention and Treatment Act – 1974
  - Adoption and Safe Families Act – 1996
  - Fostering Connections to Success and Increasing Adoptions Act – 2008
- Major State Legislation
  - Fostering Success Act - 2015
  - Foster Care Family Act – 2015
  - Family-Child Protection & Accountability Act 2017/Rylan's Law

Scope of the Child Welfare System

All child welfare agencies in the U.S. have four core mandates from federal laws and regulations:

1. Respond to reports of child maltreatment
2. Serve families in their homes and help them overcome difficulties and keep their children safe
3. Provide alternative, safe living environments when children cannot be maintained safely in their homes
4. Provide a safe, permanent home for children as quickly as possible

Flow of Child Welfare Services

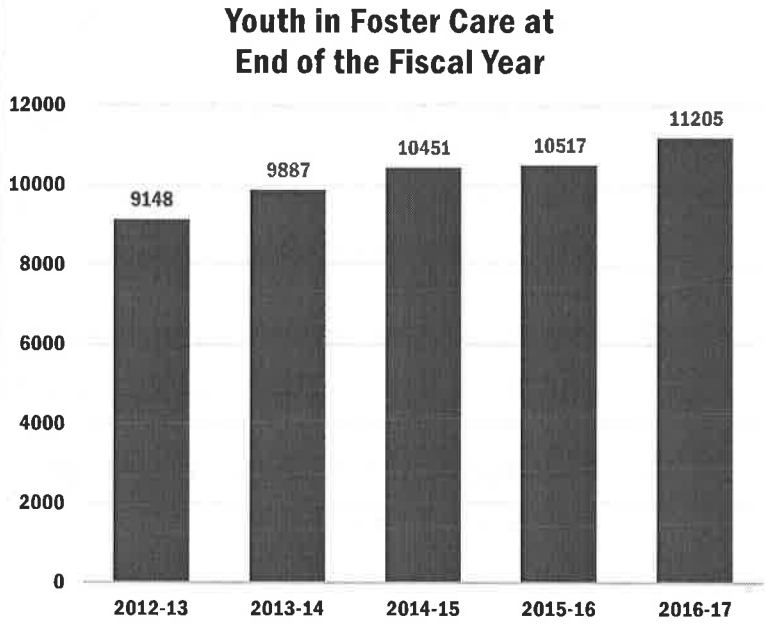


Child Welfare Overview – Foster Care

Children are placed in foster care when safety at home cannot be assured

Increase is due to a variety of issues including

- Parental opioid use
- Parental mental health
  - — Impacts the severity of child neglect and abuse



Child and Family Services Review (CFSR)

- Federal performance review of child welfare services conducted in 2015
- Review included a sample of child welfare cases from 10 counties
- Rated on 7 outcome measures and 7 systemic actors
  - – Outcome measures focus on child and family well-being
  - – Systemic factors focus on staff training, monitoring and quality assurance, and availability and provision of appropriate services

CFSR: Program Improvement Plan

- North Carolina failed to meet expectations in each of 14 CFSR areas requiring a federal Program Improvement Plan (PIP)
- DHHS, county DSS departments, stakeholders and ACF worked together to develop PIP
- PIP is a 2-year plan that began January 2017 and will conclude December 2018
- PIP is designed to improve statewide performance

PIP: Progress & Next Steps

- Met all PIP activities to-date within agreed upon timeframes
- Appointed new leadership in DHHS Division of Social Services and Child Welfare Section
- Working to revise PIP to focus on outcomes and measure progress quarterly
- Incorporating PIP activities into broader child welfare reform effort
- Continuing implementation of NC FAST Child Welfare module to ensure accountability and improve performance

JOINT LEGISLATIVE COMMITTEE
ON HEALTH AND HUMAN SERVICES

NC FAST Implementation of Child Welfare Case Management

Sam Gibbs, Deputy Secretary for Technology and Operations

Oct. 10, 2017

NC FAST Overview

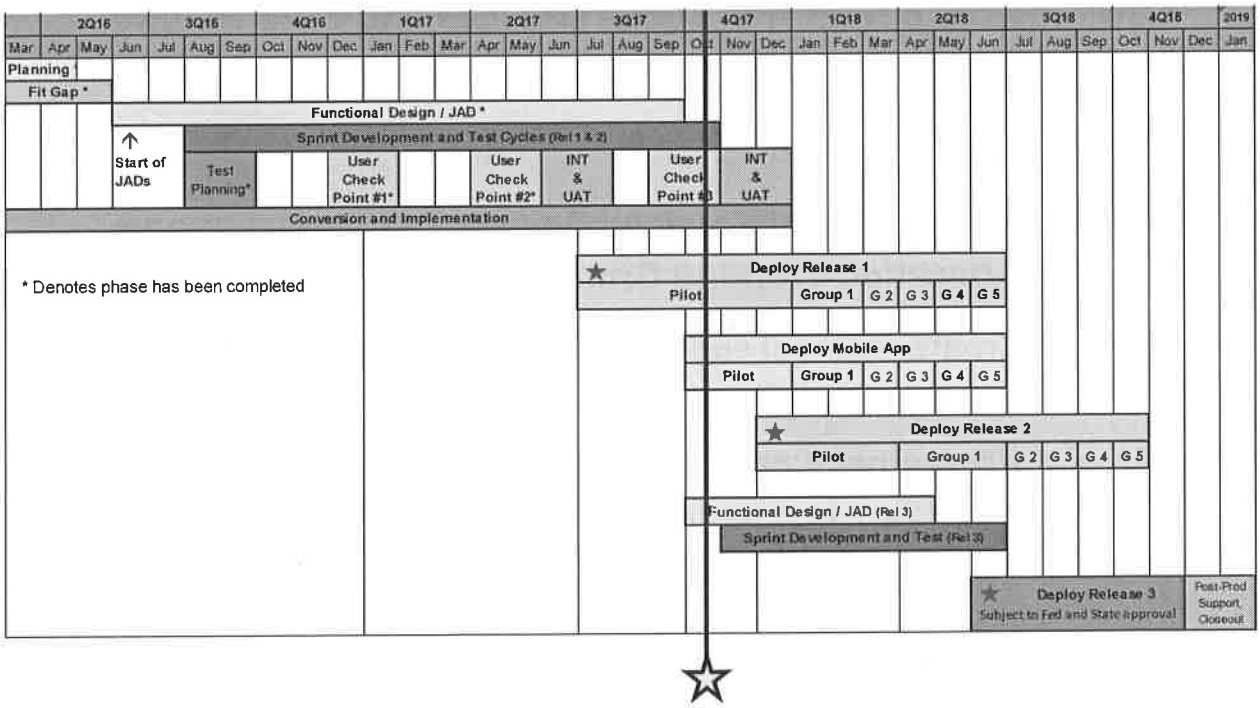
North Carolina Families Accessing Services through Technology (NC FAST)

- Developed as a tool to improve eligibility determination and service delivery for:
  - Food and Nutrition Services, Medicaid, Work First, Child Care Subsidy, Child Welfare, etc.
- Benefits include real-time sharing of client and case information across programs and counties and support for an integrated, cross-functional service delivery approach

NC FAST Child Welfare Update

- On schedule for final completion in December 2018
- August 2017: 5 pilot counties began using Release 1 functionality
- 1,200 intakes entered in system; almost 700 family and investigative assessments
- 25 system enhancements identified as high priority items by pilot counties
- January 2018: Go-live for additional counties to provide time to deploy high priority enhancements
- June 2018 (extended from April): Completion of statewide implementation with enhancements
- Mobility functionality pilots: Allows case workers to input information in field via iPads
- As previously requested, additional funding needed for on-site support to help county child welfare staff incorporate use of NC FAST to streamline and improve how they do their work

Current NC FAST Child Welfare Timeline



JOINT LEGISLATIVE COMMITTEE
ON HEALTH AND HUMAN SERVICES

Family-Child Protection and Accountability Act

S.L. 2017-41

Michael Becketts, Assistant Secretary for Human Services

Oct. 10, 2017

Family-Child Protection and Accountability Act Overview

Law requires a reform of social services and child welfare system

Provisions of Act include:

1. Convene a Social Services Regional Supervision and Collaboration Working Group to:
   - Create regional supervision structure of county social services departments
   - Recommend any regulatory or legislative changes necessary to improve collaboration between counties in administration of social services
   - Identify potential benefits and challenges for transitioning state from county-administered to regionally administered system

Family-Child Protection and Accountability Act Overview

2. Reform State supervision and accountability of the existing social services system
    - Issue a Request for Proposals by 9/30/2017
    - Contract with an expert, third-party organization to work with DHHS to develop a recommended reform plan for social services and child welfare

3. Establish written agreements between county DSS and DHHS for all social services programs, except medical assistance
    - Focus on mutual accountability and corrective action
    - Includes performance and administrative measures

Family-Child Protection and Accountability Act Overview

4. Establish a Child Well-being Transformation Council

5. Implement specific policy and regulatory changes to improve the well-being of children and youth in foster care
    - Implement a driver's license pilot project for foster youth
    - Pilot an intensive family treatment program for foster youth
    - Establish 90-day timeframe for processing foster home applications
    - Change policy regarding termination of parental rights
    - Change procedures related to returning physical custody to parents

Key Milestones

	DATE	MILESTONE
2017	07/01	Rylan's Law went into effect
	09/29	RFP for third-party organization issued
	10/03	Working group convened by the School of Government
2018	02/15	Contract award for third-party organization
	04/15	Working group 1st report to NCGA
	07/01	Written agreements between DHHS and DSS effective
	10/01	Reform legislation recommendations to JLOC by DHHS
	11/15	DHHS regional supervision plan due
2019	01/01	TPR statute effective
	02/01	Working group 2nd report due to JLOC
2020	03/01	Regional supervision implemented
	09/02	Project end

Progress To-Date

- DHHS meeting timeframe for processing foster home applications
- DHHS/AOC issued guidance to counties and courts regarding changes in procedure for returning physical custody to parents
- RFP for the third-party organization issued on 9/29/2017
- Working Group's first meeting held 10/3/17
- DHHS-DSS written agreements under development with input requested from each county social services Director

JOINT LEGISLATIVE COMMITTEE
ON HEALTH AND HUMAN SERVICES

NC Pre-K Update on Slots

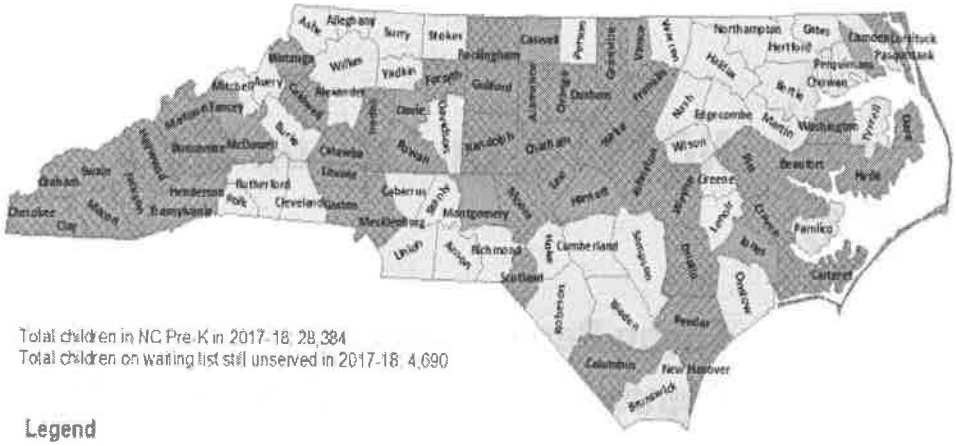
Susan Perry-Manning
Deputy Secretary for Human Services

Oct. 10, 2017

2017-18 NC Pre-K Expansion Activities

- All county NC Pre-K Administrators offered opportunity to request additional slots
- Counties reported waiting lists totaling 6,345
- Requests made to serve an additional 4,896 children
- All counties requesting expansion received slots
- Able to serve 1,655 additional children

2017-18 NC Pre-K
Children Served and Unmet Need



Total children in NC Pre-K in 2017-18: 28,384
Total children on waiting list still unserved in 2017-18: 4,690

Legend

- Counties with children in NC Pre-K: 100
- Counties Requesting and receiving pre-k expansion: 58
- Counties receiving NC Pre-K expansion with children on waiting list still unserved: 49
- Counties receiving NC Pre-K expansion with 50% or more of children on waiting list still unserved: 36





Office of the Internal Auditor
HEALTH AND HUMAN SERVICES

Special Investigations

Cardinal Innovations Healthcare Solutions

INTERIM INVESTIGATIVE REPORT AND INTERIM FOLLOW-UP ASSESSMENT (OSA PER-2017-4445)

October 2, 2017

Office of the Internal Auditor
INVESTIGATIONS CASE # 5017-03

Fieldwork Completed: August 10, 2017
Release Date: October 2, 2017
Case Number: 5017-03

EXECUTIVE SUMMARY

The Office of the Internal Auditor (OIA), Special Investigations Unit, performed this investigation at the request of Department of Health and Human Services' (DHHS) Secretary Mandy Cohen. This request included the following objectives:

1. Continue to investigate the findings and recommendations identified in the North Carolina Office of the State Auditor (OSA) performance audit report PER-2017-4445 of Cardinal Innovations Healthcare Solutions (Cardinal), related to State law, regarding Local Management Entity/Managed Care Organization (LME/MCO) functions.

2. Evaluate Cardinal's compliance with the contract and funding from the Division of Medical Assistance (DMA), and allocation letters and agreements with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS).

DHHS wishes to acknowledge the significant work of the Office of the State Auditor in conducting a performance audit of Cardinal Innovations Healthcare Solutions to evaluate whether Cardinal is 1) operating within its statutory mission, and 2) a good steward of State and Federal resources. DHHS takes very seriously the findings of the State Auditor. After receiving the report from the State Auditor, DHHS communicated with the Cardinal Board of Directors, and this Interim Investigative Report and Interim Follow-up Assessment is based on, and in follow-up to, the State Auditor's Performance Audit Report dated May 2017.

Based on investigative procedures performed, OIA determined the following items warrant the attention of the Cardinal Board of Directors and DHHS management:

1. The employment contract with Cardinal's CEO provides severance payments for a broad range of reasons, whereas the other three LME/MCOs with severance arrangements with their CEO limit the reasons to termination of employment without just cause.

   Specifically, Cardinal's CEO is eligible for severance if:
   a. Cardinal ceases to be an independent entity;
   b. an unaffiliated third party becomes responsible for the day-to-day operations of Cardinal;
   c. a majority of the Board is replaced within a 12-month period without the endorsement of the Board; or
   d. statutory or regulatory changes occur that materially alter Cardinal's services, revenues, governance, or employment practices.

2. The employment contract with Cardinal's CEO provides for severance payments to be made for up to 36 months but not less than 24 months, which is two to four times greater than the period of time provided in the employment contracts of any of the other three LME/MCOs with severance arrangements with their CEOs. The other three LME/MCOs with severance agreements with their

CEOs limit their severance periods to 12 months or less. (Three LME/MCOs do not have severance arrangements with their CEOs).

3. The employment contracts with Cardinal's six other executives and four key employees include severance provisions. No other LME/MCO has a severance arrangement with an employee other than their CEO.

   Cardinal's employment contracts with its six other executives and four key employees require severance payments to be made for reasons other than their termination of employment, including:
   a. Cardinal ceasing to be an independent entity;
   b. an unaffiliated third party becomes responsible for the day-to-day operations of Cardinal;
   c. the termination or resignation of the CEO (if employee reports directly to the CEO); or
   d. statutory or regulatory changes that materially alter Cardinal's services, revenues, governance, or employment practices.

   These employment contracts require severance payments to be made for a period of up to 36 months but not less than 24 months.

4. Cardinal's contracts requiring payment of severance to the CEO and 10 other employees for reasons other than termination of employment without cause, poses a substantial risk and may not be in the best interest of Cardinal, beneficiaries, and/or the State to the extent that they–
   a. jeopardize the ongoing operations of Cardinal and potentially interrupt services to beneficiaries if the CEO is terminated or resigns and all or key members of the executive leadership or other employees with severance arrangements leave Cardinal;
   b. increase the financial impact on Cardinal of terminating the employment of the CEO or due to the CEO's resignation;
   c. insulate the CEO and employees from current or future legal changes in the organization and/or its operation despite it being a quasi-governmental entity; or
   d. provide for excessive severance payments to be made.

5. The salary and bonus opportunities for Cardinal's CEO are more than three times higher than those of the CEOs at the State's six other LME/MCOs. Additionally, compensation for Cardinal's CEO is three times higher than the maximum allowable for the position established by the North Carolina Office of State Human Resources (OSHR).

6. Only three of the seven LME/MCOs pay bonuses to employees, and Cardinal's average bonus from FY 2016 is 156% to 311% higher than the other two LME/MCOs who pay bonuses.

Further, as described in more detail below, DHHS continues its investigation of Cardinal, and continues to seek responses from Cardinal's leadership and Board regarding a number of outstanding requests for information and action.

INTRODUCTION

Background

Within available resources, it is the obligation of the State and local government to provide mental health, developmental disability and substance abuse services through a delivery system designed to meet the needs of clients and to maximize their quality of life. State and local governments are tasked with developing and maintaining a unified system of services centered in area authorities. The furnishing of services to implement this obligation requires the cooperation and financial assistance of counties, the State and the Federal government.

DHHS is responsible for providing for the coordination of public mental health, developmental disability and substance abuse services between area authorities and State facilities. DHHS is also responsible for enforcing the provisions of North Carolina General Statutes, Chapter 122C, which is the Mental Health, Developmental Disabilities and Substance Abuse Act of 1985.

DHHS must monitor the fiscal and administrative practices of area authorities to ensure that the programs are accountable to the State for the management and use of Federal and State funds allocated for mental health, developmental disability, and substance abuse services. DHHS must ensure that the practices of area authorities are consistent with professionally accepted accounting and management principles.

Cardinal is an area authority, or Local Management Entity/Managed Care Organization (LME/MCO) created by North Carolina General Statute 122C. Cardinal is responsible for management and oversight of the public system of mental health, developmental disability, and substance abuse services at the community level in 20 counties across North Carolina. A primary function of an LME/MCO is the financial management and accountability for the use of State and local funds for the delivery of publicly funded services.

Cardinal is the largest of the State's seven LME/MCOs, serving more than 850,000 Medicaid-enrolled members and providing services to all residents across 20 counties. Cardinal contracts with DHHS's Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) to provide for the management and oversight of the public system of mental health, developmental disabilities, and substance abuse services at the community level. Cardinal contracts with DHHS's Division of Medical Assistance (DMA) to operate the managed behavioral healthcare services under the Medicaid waiver through a network of licensed practitioners and provider agencies. The contract between DMA and Cardinal requires Cardinal to "comply with all laws, ordinances, codes, rules, regulations and licensing requirements that are applicable to the conduct of its business, including those of Federal, State and local agencies having jurisdiction and/or authority." If Cardinal substantially fails to comply with the requirements of any applicable State or Federal law, statute, rule or regulation, and fails to take appropriate action to immediately correct the problem, DMA would have grounds to terminate the contract.

Cardinal's most significant funding is provided by DMA. Funding from Medicaid totaled $567 million and $587 million for State fiscal years 2015 and 2016, respectively. Cardinal also received funding from DMHDDSAS with payments of $86 million and $88 million for State fiscal years 2015 and 2016, respectively. Cardinal is governed by an area board consisting of 13 members, whose primary responsibilities include strategic planning, budgets, and hiring and evaluation of the CEO. Cardinal's

current CEO has been in position since July 1, 2015 and was Cardinal's Executive Vice President and General Counsel prior to holding this position.

Scope / Methodology

The scope of our investigation focused on the supporting documentation required to achieve the stated objectives. Our examination was conducted in accordance with standard investigative techniques, which include, but are not limited to, examination of books and records, voluntary interviews with appropriate personnel, and other such evidence-gathering procedures as necessary under the circumstances.

Investigators

Jeff Minor, Senior Audit Manager, DHHS Office of the Internal Auditor
Michelle Blackwelder, Senior Auditor, DHHS Office of the Internal Auditor

Subject Matter Experts

Christal Kelly, Associate Director of Provider Reimbursement, DMA
Alfred Greco, Financial Manager, DMA
Deb Goda, Behavioral Health Unit Manager, DMA
Renee Rader, Waiver Contract Manager, DMA
Dennis Farley, Team Lead for Financial Audit, DMH
Mabel McGlothen, Team Lead for LME/MCO Systems Performance, DMH

Procedures

As part of the examination, OIA and subject matter experts took the following actions:

- Examination of contracts/agreements between Cardinal and DHHS.
- Review of minutes of Cardinal Board Meetings
- Communication with the NC OSHR
- Interviews with the following individuals:
    - Chuck Hollowell, General Counsel, Cardinal
    - Steve Martin, Deputy General Counsel, Cardinal

INVESTIGATIVE RESULTS

1. The employment contract with Cardinal's CEO provides severance payments for a broad range of reasons, whereas the other three LME/MCOs with severance agreements with their CEO limit the reasons to termination of employment without just cause. Specifically, Cardinal's CEO is eligible for severance if Cardinal ceases to be an independent entity; an unaffiliated third party becomes responsible for the day-to-day operations of Cardinal; a majority of the Board is replaced within a 12-month period without the endorsement of the Board; or statutory or regulatory changes occur that materially alter Cardinal's services, revenues, governance, or employment practices.

CEO's Severance Agreement

The employment contract for the current CEO is for the three-year period of July 1, 2016 through June 30, 2019. A severance clause is included in the agreement, in which the CEO would receive severance of varying length, depending on the circumstances of departure. The longest severance period was for a period of up to 36 months, if there was a change in control within Cardinal. The agreement included four scenarios which would satisfy the change of control provision:

1. The Company, pursuant to an agreement or by operation of law, in one or a series of related transactions, ceases to exist as an independent entity;
2. The entry of the Company into a contractual arrangement in which an unaffiliated third party effectively becomes the manager of the day-to-day operations of the Company;
3. A majority of the directors of the Board are replaced during any 12-month period by directors whose appointment or election is not endorsed by a majority of the Board before the date of appointment or election; or
4. Any statutory or regulatory change that materially alters the Company's services, revenues, governance, or employment practices.

As noted in the table below, only four of the seven LME/MCOs have a severance arrangement with their CEO, and only Cardinal has such arrangements with other employees. The other LME/MCOs with severance arrangements limit severance payments to those situations in which the CEO's employment is terminated without cause, whereas Cardinal's arrangements include other reasons, i.e., Cardinal ceasing to be an independent entity, an unaffiliated third party becomes responsible for the day-to-day operations of Cardinal, a majority of the Board being replaced within 12 months without the endorsement of the Board (CEO only) or the termination or resignation of the CEO (if a direct report to the CEO), or statutory or regulatory changes that materially alter Cardinal's services, revenues, governance, or employment practices.

Severance Agreements by LME/MCO			
LME/MCO	Employees Eligible	Severance Length	Severance Terms
Alliance	CEO	6 months	Severance equal to six months of base compensation for termination without just cause, or if employee terminates for good reason (e.g. material reduction in annual base compensation; Alliance's failure to comply with a material term of employee contract). Health insurance coverage also provided for severance period.
Cardinal	CEO, all six other executives and four key employees	24-36 months	Severance equal to 24-36 months, if there is a change in control (e.g. For CEO: majority of Board replaced during any 12-month period by directors whose appointment/election is not endorsed by majority of Board; company ceases to exist as an independent entity; unaffiliated party effectively becomes manager of day-to-day operations of Company; any statutory or regulatory change that materially alters the Company's services, revenues, governance or employment practices); For other employees, all above apply, except board changeover; however, additional severance clause triggered for the seven employees who report to the CEO, if the CEO is terminated or resigns. Severance includes up to 18 months of COBRA health insurance coverage.
Eastpointe	CEO	12 months	Severance equal to one year of annual salary, and health insurance coverage, if Board elects to discontinue employment without just cause (e.g. reclassification of executive's title or duties resulting from a merger or other reorganization, unless post-merger title/duties is consistent with that of Executive Vice President, and total compensation is not reduced.)
Partners BH	N/A	N/A	N/A
Sandhills	N/A	N/A	N/A
Trillium	N/A	N/A	N/A
Vaya	CEO	0-12 months	Severance equal to one month for each full year of CEO's employment if terminated without just cause, 12-month maximum. Health insurance coverage also provided, up to the point of new coverage or expiration of severance period.

2. The employment contract with Cardinal's CEO provides for severance payments to be made for up to 36 months but not less than 24 months, which is two to four times (or more) greater than the period of time provided in the employment contracts of any of the other three LME/MCOs with severance arrangements with their CEOs. The other three LME/MCOs with severance agreements with their CEOs limit their severance periods to 12 months or less. Three LME/MCOs do not have severance agreements with their CEOs.

As noted in the table above, only four of the seven LME/MCOs have a severance arrangement with their CEOs. Of the other three LME/MCOs with severance arrangements, the period during which severance payments are made after termination of the CEO's employment without cause ranges from one month to twelve months. The period during which Cardinal may pay severance ranges from 24 to 36 months. The other three LME/MCOs with severance agreements with their CEOs limit their severance periods to 12 months or less. Three LME/MCOs do not have severance arrangements with their CEOs.

3. The employment contracts with Cardinal's six other executives and four key employees include severance provisions. No other LME/MCO has a severance arrangement with an employee other than their CEO.

Cardinal's employment contracts with its six other executives and four key employees require severance payments to be made for reasons other than their termination of employment, including:

a. **Cardinal ceasing to be an independent entity;**
b. **an unaffiliated third party becomes responsible for the day-to-day operations of Cardinal;**

c. the termination or resignation of the CEO (if employee reports directly to the CEO); or
d. statutory or regulatory changes that materially alter Cardinal's services, revenues, governance, or employment practices.

These employment contracts require severance payments to be made for a period of up to 36 months but not less than 24 months.

As noted in the table on the previous page, only Cardinal has severance arrangements with other employees. The arrangements provide for severance to be paid for reasons other than the employee's termination of employment without just cause. The period during which Cardinal may pay severance ranges from 24 to 36 months.

On July 24, 2017, OIA interviewed Cardinal's General Counsel and Deputy General Counsel about the severance packages. Cardinal's General Counsel stated that the executive employment agreements were prepared by outside counsel, Nelson Mullins Riley & Scarborough, LLP. According to the General Counsel, the independent counsel has significant experience in labor and employment issues. According to Cardinal's Deputy General Counsel, the June 30, 2019 end date on the employment agreements was chosen because it was the day before the projected go-live date for the pre-paid health plan (PHP) contracts under the Medicaid Reform legislation passed in September 2015. The agreements were intended to retain executive and other key personnel at Cardinal through the critical deadline.

4. Cardinal's contracts requiring payment of severance to the CEO and 10 other employees for reasons other than termination of employment without cause poses a substantial risk and may not be in the best interest of Cardinal, beneficiaries, and/or the State to the extent that it –

a. jeopardizes the ongoing operations of Cardinal and potentially interrupts services to beneficiaries if the CEO is terminated or resigns and all or key members of the executive leadership of other employees with severance arrangements leave Cardinal;
b. increases the financial impact on Cardinal of terminating the employment of the CEO or the CEO's resignation;
c. insulates the CEO and employees from current or future legal changes in the organization and/or its operation despite it being a quasi-governmental entity; or
d. provides for excessive severance payments to be made.

To the extent that the severance arrangements with the six executives and four key employees permit the executive or employee to begin receiving severance benefits upon the termination or resignation of the CEO, it may create a conflict of interest by aligning these executives and employees' interests more closely with the CEO than the ongoing operation of Cardinal, and result in a potential interruption in its operations and ensuring that services are provided to beneficiaries. The potential financial and operational impact may influence the Board's decision making with regard to terminating the employment of the CEO or taking an action that may result in his resignation.

In addition to the unusually broad severance protections afforded to Cardinal's CEO, other executives, and key employees, the length of Cardinal's severance provisions, when combined with other severance provisions not offered at other LME/MCOs, could present significant financial and operational risks. For example, one contract term provides employees their "base salary for a period of 24 months, or for the remaining term of the agreement, whichever is longer." Given this provision, Cardinal could be compelled to pay each of the seven employees who report directly to the Chief Executive Officer (CEO) 24 months of their base pay, if the CEO resigns the day before the contracts expire on June 30, 2019. If such an event were to occur, Cardinal would be obligated to pay more than $3.5 million in severance to the seven employees who report to the CEO, for the 24 months of base pay beyond the employment contract period.

Finally, Cardinal is an LME/MCO created by North Carolina General Statute 122C. As a quasi-governmental entity, its services, revenues, governance, and employment practices are prescribed by statute. To the extent that Cardinal's severance arrangements may insulate its CEO, executives, and key employees from changes to those statutes, they are inconsistent with public policy.

5. The salary and bonus opportunities for Cardinal's CEO are more than three times higher than those of the CEOs at the State's six other LME/MCOs. Additionally, compensation for Cardinal's CEO is three times higher than the maximum allowable for the position established by the North Carolina Office of State Human Resources.

In FY2016, the base salary for Cardinal's CEO was $517,526, and when combined with his bonus of $100,000, he received $617,526 in total compensation that year. OIA obtained the CEO salary and bonus information from each of the other six LME/MCOs. That information is detailed below for all seven LME/MCOs:

Salary and Bonus of LME/MCO CEOs (FY16)			
LME / MCO	CEO Salary	CEO Bonus	Total
Alliance	$177,500	-	$177,500
Cardinal	$517,526	$100,000	$617,526
Eastpointe	$175,000	-	$175,000
Partners BH	$166,294	$15,000	$181,294
Sandhills	$177,288	-	$177,288
Trillium	$190,272	-	$190,272
Vaya	$217,155	-	$217,155

OIA also requested and received from OSHR the maximum salary range for the Area Director/CEO position for the LME/MCOs, which is reflected in the table below.

Area Director/CEO Salary Range		
Year	Minimum	Maximum
2015	$107,843	$190,612
2016	$109,461	$193,471
2017	$110,461	$194,471

Of the seven LME/MCOs operating in the State, two, Cardinal and Vaya, have exceeded the maximum of the range. While Vaya exceeded the maximum amount by $23,684, Cardinal exceeded the maximum of the range for base salary by $324,055 and by $424,055 total by paying the CEO $617,526 in FY 2016, which is more than three times the maximum of OSHR's allowable range of $193,471.

Cardinal's response in OSA's May 2017 report stated that its Board of Directors complied with the statutory guidelines in setting its CEO's salary, and that "OSHR has not established any salary range for the LME/MCO Area Directors." Cardinal also said that it submitted its salary plan to OSHR each year, as required, and that OSHR's acceptance of its annual salary plan serves as acceptance of any salary adjustments made.

OIA sought guidance from OSHR regarding the salary established for Cardinal's CEO. On August 7, 2017, OSHR's Deputy Director, provided the following response:

> *"We (OSHR) can find no proof of Cardinal sending in a request, or supporting documentation, for a salary increase for the CEO per NCGS 122C-121. Cardinal has submitted an annual pay plan to this office. However, the pay plan should not be used to circumvent the requirements of NCGS 122C-121 as the pay plan does not contain the required information per NCGS 122C-121. Unless Cardinal had submitted a request and supporting documentation for a salary increase per NCGS 122C-121, we would not be reviewing for such. Absent any written approval from the State Human Resources Director, nothing has been approved."*

OSHR also stated that it agreed with OSA's finding and recommendations regarding Cardinal's CEO pay issues in its May 2017 report. As a result of one of OSA's recommendations, OSHR's Deputy Director said OSHR has requested CEO salary rates and supporting documentation from all LME/MCO entities, and that all seven LME/MCOs had submitted CEO salary information. The Deputy Director also said that OSHR has adjusted the Area Director/CEO salary range to reflect the legislative increases awarded since 2010, plus a 5% salary exception, which will be communicated to the LME/MCOs. "Please note that even with the new adjusted salary range, the Cardinal CEO will still be above the maximum rate allowed. The State Human Resources Director has not approved any salary above the adjusted Area Director/CEO salary range maximum."

On August 10, 2017, OSHR sent a letter to Cardinal. The letter stated the new maximum of salary range of the Area Director/CEO position is $194,471, although OSHR is willing to approve 5% above the new maximum of the range as an exception, which is $204,195. The OSHR letter then states, "Based on the information you submitted, the salary of your Area Director/CEO is above this new rate and therefore, out of compliance. Please work to adjust the Area Director/CEO salary accordingly and notify us of how you have remedied this situation. In the future, please ensure that any salary adjustment complies with the provisions of G.S. 122C-121 – the Mental Health, Disabilities, and Substance Abuse Act of 1985." OSHR sent a similar letter to Vaya Health.

6. Only three of the seven LME/MCOs pay bonuses to employees, and Cardinal's average bonus is 156% and 311% higher than the other LME/MCOs who pay bonuses.

In its May 2017 report, OSA determined Cardinal paid about $1.9 million in FY15 employee bonuses and $2.4 million in FY16 employee bonuses. The average bonus per employee was about $3,000 in FY15 and $4,000 in FY16. The bonuses were coded to Cardinal's administrative portion of Medicaid funding source in both years. OIA, with the assistance of DHHS subject matter experts, requested and received bonus information from each of the six other LME/MCOs, which OIA reviewed and is presented in the chart below.

Average Bonus of LME/MCO Employees (FY17)			
LME / MCO	Total Bonus to Employees	Number of Employees	Average Bonus
Alliance	N/A	527	N/A
Cardinal*	$2,432,420	618	$3,936
Eastpointe	N/A	315	N/A
Partners BHM	$1,148,576	454	$ 2,530
Sandhills	N/A	289	N/A
Trillium	N/A	417	N/A
VAYA	$611,971	483	$1,267

*Cardinal bonus information is from FY16.

Bonus information received from each of the LME/MCOs indicate only three of the seven LME/MCOs offer bonuses to employees, and of the three that did, Cardinal average bonus of $3,936 per employee is three times higher than Vaya's average employee bonus of $1,267, and also exceeds the $2,530 average bonus per employee at Partners Behavioral Health Management.

RECOMMENDATIONS

1. The Cardinal Board should carefully review its current severance arrangements with its CEO, other executives and key employees to ascertain whether it can sustain its operations and fulfill its statutory, regulatory and contractual obligations without adversely impacting services to beneficiaries, if these employees exercise the rights afforded to them.

2. The Cardinal Board and management should implement procedures and align its operations with other LME/MCOs and State laws to ensure its spending, including compensation and potential severance obligations, are appropriate for a local government entity. In particular, the Cardinal Board may offer severance benefits as an incentive for an Area Director/CEO to accept its offer of employment at its discretion in accordance with NCGS122C-121 (a2); however, the Cardinal Board should align the terms of its severance arrangements with the other LME/MCOs in the State.

3. In accordance with NCGS122C-121 (a1), the Cardinal Board and management should adjust its CEO's salary to comply with allowable salary range established by OSHR.

MATTERS REQUIRING ADDITIONAL ACTION

DHHS continues to address a number of outstanding items.
First, Cardinal must provide information to DHHS on whether it has addressed, or plans to address, a number of items from Secretary Cohen's June 12 letter to the Board.

a) **Issue:** Policy changes that will be enacted to address any excessive spending on Cardinal Innovations Healthcare board meetings and trainings.
Action Needed: Cardinal's Board of Directors' Governance Committee approved motion on 2/17/17 to recommend to full Board that FY 2018 Board meetings and trainings be held at Cardinal's corporate headquarters in Charlotte. During the 2/17 - 2/18/17 Board meeting, Cardinal's General Counsel, provided an update on the proposed Board of Directors Meeting Schedule for FY 2018 that included this location. However, the Board minutes reviewed do not include more specific details on spending on future board meetings and trainings, and Cardinal has not provided any documentation that supports actual changes to its policies and procedures. Cardinal must make appropriate changes and provide documentation.

b) **Issue:** Personnel policy changes that will bring Cardinal Innovations Healthcare salary and compensation package in line with accepted public entity packages and current law.
Action Needed: On 5/30/17, OSHR sent a memo to all LME/MCOs requesting information on CEO salaries above $187,354 and support for the ranges. Cardinal responded to the request with an Executive Market Compensation Survey by Willis Towers Watson requested back in 2016. On 8/10/17, NC OSHR sent a letter to Cardinal outlining a new maximum of $194,471 for the CEO, effective immediately, with a 5% maximum exception of $204,195 permitted. OSHR requested Cardinal adjust the CEO's salary to comply with this maximum. Cardinal has not responded to this letter nor addressed this matter. Cardinal must come into compliance with the OSHR guidance.

c) **Issue:** Changes to travel policy that will bring Cardinal Innovations Healthcare in line with North Carolina Public Agency policies.
Action Needed: DHHS has informally learned that Cardinal's executive team internally decided to stop using charter flights as a travel practice and the last charter flight occurred November 2015. The Ad Hoc Committee of the Board concurred with this decision on June 13, 2017, although Cardinal has not provided any documentation that supports any actual changes to its policies or procedures regarding charter flights or aligning its travel policies with North Carolina Public Agency policies. Cardinal must make appropriate changes and provide documentation.

d) **Issue:** Any disciplinary action taken by Cardinal's Board concerning CEO actions.
Action Needed: At the 6/23 - 6/24/17 meeting of the Cardinal Board of Directors, the Ad Hoc Committee of the Board discussed correspondence between Cardinal's Chairman of the Board of Directors and Secretary Cohen with the full Board. The Board agreed to respond with full board concurrence regarding Ad Hoc Committee's actions. Cardinal must provide additional information.

In addition, DHHS will continue to review Cardinal's response to the OSA report. Cardinal has not identified a specific corrective action plan related to the OSA findings. DMA and DMHDDSAS will request a corrective action plan from Cardinal for their review and approval and revise its allocation letters, contracts, and polices to specifically address OSA's findings.

Finally, DHHS intends to identify and review compensation packages in collaboration with OSHR for additional highly-compensated employees at Cardinal.

Cardinal's Response:

September 8, 2017

The Honorable Mandy Cohen, MD, MPH
Secretary
Department of Health and Human Services
State of North Carolina
2001 Mail Service Center
Raleigh, NC 27699-2001

Dear Secretary Cohen:

Thank you for the opportunity to review and comment on the draft interim report regarding the Department of Health and Human Services (DHHS) investigation of Cardinal Innovations Healthcare. We recognize that DHHS has raised important questions about our employment practices, and we agree that these questions need to be resolved.

In the report, DHHS raises several questions regarding Cardinal Innovations' employment practices, and compares Cardinal's practices to those of the other six LME/MCOs. In contrast to the other LME/MCOs, Cardinal received approval from the state to leave the state personnel system more than 20 years ago. As a result, Cardinal's employees are not part of the state pay scale, do not receive state benefits, and are not part of the state retirement program. We adopted market-based employment practices to attract and retain well-qualified staff so that we can continue to deliver high-quality outcomes for members and maintain their service continuity while the State completes its efforts to reform the Medicaid program.

Despite this important distinction, we look forward to working through the appropriate channels to resolve these issues.

Sincerely,

Lucy U. Drake, Chairman
Board of Directors

cc: Richard Topping, CEO, Cardinal Innovations Healthcare
Mark Payne, Interim Audit Director, NCDHHS

Cardinal Innovations HEALTHCARE

OIA's Response

The Office of the Internal Auditor (OIA), Special Investigations Unit, of the Department of Health and Human Services (DHHS) provides this additional explanation in light of Cardinal Innovations Healthcare Solutions' (Cardinal) response dated September 8, 2017 to OIA's Interim Investigative Report and Interim Follow-up Assessment (OSA PER-2017-4445). While we appreciate that Cardinal agrees that DHHS OIA's Report has raised important questions about Cardinal's employment practices, the response does not describe planned corrective actions.

Cardinal's response states, in relevant part, "[i]n contrast to the other LME/MCOs, Cardinal received approval from the state to leave the state personnel system more than 20 years ago. As a result, Cardinal's employees are not part of the state pay scale, do not receive state benefits, and are not part of the state retirement program."

OIA sought additional guidance from the Office of State Human Resources (OSHR) regarding Cardinal's response. Per OSHR, Cardinal's response is in reference to G.S. 126-11(a1) that provides for the State Human Resources Commission to approve "substantial equivalency" of a personnel system for all employees of the area mental health authority, established by it with approval of each of the boards of commissioners of the counties which comprise it, making its personnel system exempt from aspects of the state personnel system. OSHR noted that six of seven LME/MCOs in North Carolina have received approval for "substantial equivalency" in Recruitment, Selection, and Advancement (25 NCAC 01I.2401) and Classification/ Compensation (25 NCAC 01I.2402), in accordance with G.S. 126-11(a1). As such, it does not appear that Cardinal stands "in contrast" to other LME/MCOs in its exemptions from the state personnel system.

Although Cardinal (as Piedmont Behavioral Health) may have received approval as a "substantially equivalent" area mental health authority in 1993, and a review may have been undertaken in 2003 and 2008 by OSHR, it does not appear that Cardinal has complied with 25 NCAC 01I.2408, which outlines the criteria required for ongoing expectations to maintain the "substantially equivalent" designation. This criteria states, in part:

Ongoing Expectations:

> In order that the Office of State Human Resources shall have access to the information and materials necessary to an informed judgment of whether an exempted, local personnel system remains substantially equivalent, local jurisdictions desiring to maintain exempted systems shall comply with the following requirements:
>
> (1) Recertification. Recertification of the commitment by a Board of County Commissioners of authority to maintain a system or portion of a system of personnel administration in accordance with the Basic Requirements for a Substantially Equivalent Personnel System may be necessary, at the discretion of the State Human Resources Commission, in the following instances:
>
> (a) Upon significant change in the membership of the Board of Commissioners or Area Authority.
>
> (b) Upon passage of significant new legislation or policy which will apply to the local system or system portion.

(c) Upon major reorganization, restructuring, or downsizing of the personnel system of the county or Area Authority.

(3) Filling of System Documentation. Each jurisdiction which has been granted a substantially equivalent personnel system exemption by the State Human Resources Commission shall annually, or upon substantial interim change, file with the Office of State Human Resources:

(a) All personnel policies currently pertaining to exempt portions of the local system, which have been adopted by the Board of County Commissioners, County Manager, Area Authority, or Area Director.

(b) Documentation which in material and substance fully illustrates the design, method, and process currently being employed in the administration of exempted portions of the local personnel system. If there has been no substantial change in personnel policies or technical method within an annual period, the County Manager or Personnel Director shall so certify in a letter to the Local Government Coordinator, Substantially Equivalent Systems, Office of State Human Resources.

(c) Jurisdictions with exempted systems shall cooperatively respond to related requests by the Office of State Human Resources for additional information which is deemed essential to a complete and accurate understanding of the design and process of a local system.

More specifically, Piedmont Behavioral Health became Cardinal Innovations Healthcare Solutions effective July 1, 2012. As stated in Cardinal's 2011-2012 annual report, "On July 1, 2012, we [Cardinal] transitioned from five to 15 counties. The PBH name was retired, and we left behind a Board that has served us well for the past 37 years." OSHR has no record of receiving the requisite recertification from Cardinal. See, Recommendation 3 in OIA's Report.

Cardinal's response additionally states, in relevant part, "We adopted market-based employment practices to attract and retain well-qualified staff..."

Per OSHR, the staff compensation must be in compliance with 25 NCAC 01I.2401 and 25 NCAC 01I.2402, in accordance with G.S. 126-11(a1). An entity is exempt from state rules relevant to approved personnel system portions "for all employees of the area mental health authority. . ." when any entity is approved for as "substantially equivalent" per G.S. 126-11(a1). Cardinal's contracts requiring payment of severance to ten other employees (in addition to the CEO) appears to be contrary to this statute and OSHR's approval of Cardinal's personnel system as a "substantially equivalent" mental health authority in that this arrangement was not provided to all employees. See, Recommendation 3 in OIA's Report.

Although Cardinal's CEO salary is not subject to "substantial equivalency" requirements of G.S. 126-11(a1), it is governed by G.S. 122C-121. G.S. 122C-121(a1) states, in relevant part -

(a1) The area board shall establish the area director's salary under Article 3 of Chapter 126 of the General Statutes. Notwithstanding G.S. 126-9(b), an area director may be paid a salary that is in excess of the salary ranges established by the State Human Resources Commission. **Any salary that is higher than the maximum of the applicable salary range shall be supported by documentation of comparable salaries in comparable operations within the region and shall also include the specific amount the board proposes to pay the director. The area board shall not authorize any salary adjustment that is above the normal allowable salary**

range without obtaining prior approval from the Director of the Office of State Human Resources. [emphasis added]

As noted in OIA's Report, the salary and bonus opportunities for Cardinal's CEO are more than three times higher than the maximum allowable for the position established by OSHR and more than three times higher than those of the CEOs in the State's six other LME/MCOs. In light of the fact that the Cardinal CEO is paid a salary that is in excess of the salary ranges established by OSHR, and no evidence has been provided that the Director of OSHR gave prior approval to Cardinal CEO's salary range, the reported comparable salaries in comparable operations (i.e., LME/MCOs) is relevant and supports Recommendation 3 that Cardinal's Board should adjust its CEO's salary to comply with allocable salary ranges established by OSHR.

And, although G.S. 122C-121(a2) permits the Cardinal Board to, in its discretion, offer severance benefits to an applicant for the position of director as an incentive for the applicant to accept an offer of employment, the comparable severance benefits offered by comparable operations (i.e., other LME/MCOs) is relevant and supports Recommendation 3.

Finally, Cardinal's response notes that its employees do not receive state benefits and are not part of the state retirement program. In point of fact, other LME/MCO employees have local or "substantially equivalent" benefits and are not part of the Teachers and State Employees Retirement System.

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Health and Human Services

10-10-17

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Ryan Minto	UHG
	NCAHP
	CSS
Jeff Horton	NCALTCF
Sarah Balls	Brodeur, NSSC.
mary Mallow	OSP
Paul M. Buck	Beacon Health Options
Dodie Benfer	CCR
Kari Barsness	Gateway
Ann Rodriguez	NC Council of Comm Programs
Brian Perkins	Alliance BHC
Sara Wilson	Alliance BHC
Emily Ziegler	UNC REX
	Bone Assoc.

10-10-17

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Health and Human Services

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

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Tommy Severs	MMC
Charmaine Fuller Cooper	AARP
Mike McBrierty	Biogen
Barbara Foley	MAXIMUS
	MLC
Ken Melton	K.M.A.
	NMRS
Richard Edwards	CBC
Judith McDermott	OSBM
Sarah McQuillan	KCANC
FRANK HILL	PSG
Rick Irby	TBI Advocate
Jeannie Irby	TBI Advocate
Pier Protz	TBI Advocate, BIANC
CAROL ORNITZ	TBI Advocate, BIANC
JONATHAN YOUNG	OSBM

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Committee on Health and Human Services

10-10-17

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE ASSISTANT

NAME	FIRM OR AGENCY AND ADDRESS
Kevin Rich	OSBM
Mary Bethel	NC Coalition on Aging
Jamaica Pfister	Childrens Home Society
Matt Gross	NC Child
Nwanne Agada	NC Child
Lyneka Judkins	Liberty Healthcare, Raliegh
DENISE Hobson	Liberty Healthcare of NC
John Nash	The Arc of NC
James Whaley	Rep. Cynthia Ball
Elizabeth Hudgins	NCPeds
Deb Clary	NCSP
Jean Andersen	BIAC
Betsy McCorkle	KGANC
Ed Judge	BP
Franklin Freeman	NHC
Katy Burgamy	BP
Kara McCann	Benchmarks

VISITOR REGISTRATION SHEET

JL Oversight Comm: on HHS — 10/10/17

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JEFF BARNHART	McGUIREWOODS
CS Hall Jr	CSX
Rob Lemmie	PLA
TJ Bybee	NP
Johnathan Garza	Real Facts NC
Cory Dunn	DRNC
Wendy Kelly	Focus Cuba

VISITOR REGISTRATION SHEET

JT Oversight Comm. on HHS — 10/10/17

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chris McClure	BP
Nate Denny	DH
Lisa Haire	NC DMH/DDSAS
Christine Craig	WakeMed
Marilyn Avila	Self
Ashley Ellen	NCRA
Phoebe Yandon	MMC
Ashley Perkins	Perkins Law

MINUTES
JOINT LEGISLATIVE OVERSIGHT COMMITTEE
HEALTH & HUMAN SERVICES

Tuesday, November 14, 2017 9:00 a.m.
Legislative Office Building – Room 544

ATTENDEES:
Chairmen: Pate, Dobson, and Lambeth

House Members: Brisson, Cunningham, Dollar, Earle, Jones, Malone, Murphy, White, and Adcock
Senate Members: Curtis, Davis, Foushee, Hise, and Krawiec

Comments from the Secretary

Dr. Mandy Cohen, Secretary of the Division of Health and Human Services, was recognized. She briefly reviewed issues addressed at the Committee's previous meeting and then provided a quick update on North Carolinians' search for affordable health insurance. She explained the NC Tracks Enhancement plan to prevent and detect fraud, waste and abuse. A copy of her presentation is attached.

Telemedicine Study and Recommendations

Dr. Maggie Sauer, Direction of the Office of Rural Health, was recognized. She provided highlights of the report with the main focus on a proposal to use, support and promote technology to provide "whole person" care in rural areas. She pointed out infrastructure issues, federal policies that need to be reviewed, and insurance billing issues. The Committee then advised staff to draft legislation regarding telemedicine and asked the Department to submit waiver language suggestions. A copy of the report and Dr. Sauer's presentation is attached.

DHHS Strategic Plan to Address the North Carolina Opioid Crisis

Dr. Cohen was recognized. She stated that three people die each day from opioid overdose in North Carolina and that 50% of overdose patients seen in emergency rooms are uninsured. Dr. Susan Kansagra, Section Chief of the Chronic Disease and Injury Section, was recognized to explain a prevention plan. There are a large number of organizations working together to develop a strategic plan of prevention, interventional treatment, a reduced flow of drugs, and a wider access to treatment and care. By making naloxone widely available and linking overdose survivors to care, there have been over 8,000 reversals reported to date. The plan is to measure the plan's impact and revising strategies on based on results. A copy of Dr. Kansagra's presentation is attached.

Controlled Substances Reporting System (CSRS) Update

Charles Carter, Chief Operating Officer for Technology and Operations, was recognized. He explained that the Department is in the process of looking for a new CSRS vendor with a goal of upgrading functionality and increasing productivity of current treatment programs. The vendor will be able to channel through multiple portals to get a full spectrum of data, develop a multistate data exchange platform, train users on the new platform and develop a user friendly streamlined portal. A copy of Mr. Carter's presentation is attached.

Report on Use of the Dorothea Dix Hospital Property Fund to increase Licensed Inpatient Behavioral Health Beds

Steve Owen, committee staff, was recognized to review the funding intent to increase beds statewide; and improve mental health care for children and adolescences with advanced crisis centers. Mark Benton, Deputy Secretary for Health Services was recognized. He outlined the spending on $20 million for the construction of facility based crisis beds for children and adolescents, and for the conversion/construction of licensed short-term, inpatient behavioral health beds. A copy of Mr. Owen's information, Mr. Benton's presentation, and the report is attached.

Traumatic Brain Injury (TBI)

Dave Richard, Deputy Secretary for Medical Assistance, was recognized. He provided an update on the Adult and Pediatric Traumatic Brain Injury Program. The Programs' goals are to increase compliance with internationally approved treatment guidelines, focus on the population with severe TBI and offer the program at three to five trauma hospitals across the State. It is estimated that about 200,000 citizens suffer from TBI. A copy of Mr. Richard's presentation is attached.

The meeting adjourned at 11:26 a.m.

Senator Louis Pate, Presiding

DeAnne Mangum, Committee Assistant

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

November 14, 2017 9:00 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Josh Dobson
Rep. Donny Lambeth
Sen. Louis Pate

Legislative Members
Rep. William D. Brisson
Rep. Carla D. Cunningham
Rep. Nelson Dollar
Rep. Beverly M. Earle
Rep. Jean Farmer-Butterfield
Rep. Bert Jones
Rep. Chris Malone
Rep. Gregory F. Murphy, MD
Rep. Donna McDowell White
Sen. Dan Bishop
Sen. David L. Curtis
Sen. Jim Davis
Sen. Valerie P. Foushee
Sen. Ralph Hise
Sen. Joyce Krawiec
Sen. Gladys A. Robinson
Sen. Jeff Tarte
Sen. Tommy Tucker
Sen. Mike Woodard

Advisory Members
Rep. Gale Adcock
Sen. Tamara Barringer
Sen. Michael V. Lee

I.	Welcome & Opening Remarks	Senator Louis Pate Presiding Co-chair
II.	Comments from the Secretary • *NC Tracks Enhancements to Prevent and Detect Fraud, Waste, and Abuse (S.L. 2017-57, Sec. 11H.15)*	Mandy Cohen, MD, Secretary Department of Health and Human Services
III.	Telemedicine Study and Recommendations	Maggie Sauer, Director Office of Rural Health Department of Health and Human Services
IV.	DHHS Strategic Plan to Address the North Carolina Opioid Crisis	Mandy Cohen, MD, Secretary Department of Health and Human Services Susan Kansagra, Section Chief Chronic Disease and Injury Section DHHS Division of Public Health
V.	Controlled Substances Reporting System (CSRS) Update	Charles Carter, Chief Operating Officer for Technology and Operations DHHS Information Technology Division
VI.	Report on Use of the Dorothea Dix Hospital Property Fund to Increase Licensed Inpatient Behavioral Health Beds	Steve Owen, Committee Staff Mark Benton, Deputy Secretary for Health Services DHHS
VII.	Traumatic Brain Injury	Mark Benton, Deputy Secretary for Health Services DHHS Dave Richard, Deputy Secretary for Medical Assistance DHHS Division of Medical Assistance
VIII.	Adjourn Next Meeting: December 12, 2017	

JOINT LEGISLATIVE COMMITTEE
ON HEALTH AND HUMAN SERVICES

NCTracks Enhancement to Prevent and Detect Fraud, Waste and Abuse

Dr. Mandy Cohen
Department of Health and Human Services

Nov. 14, 2017

NCTracks Enhancement to Prevent and Detect Fraud, Waste and Abuse

- Enhancement goal: Identify scenarios that can be evaluated for action during claims adjudication
- Current identified scenarios addressed in this effort:
  - Providers with bankruptcies, judgments or liens
  - Providers with expired licenses
  - Providers identified as sex offenders
  - Deceased providers/recipients
  - Incarcerated recipients
  - Recipients living outside of North Carolina

Status

- Provider monitoring workflow is in place and reporting capabilities are being enhanced, implemented by the end of November.

JOINT LEGISLATIVE COMMITTEE
ON HEALTH AND HUMAN SERVICES

Telemedicine Study and Recommendations S.L. 2017-133

Maggie Sauer
Department of Health and Human Services

Nov. 14, 2017

SL 2017-133 Report Recommendations

DHHS firmly believes that telemedicine can improve the health of our population if we respond effectively to two opportunities:

1) 1115 Medicaid Waiver
2) Broadband Infrastructure

To Effectively Respond to these Opportunities:

(1) Adopt a Uniform Definition of the Term Telemedicine

- Adopt the Health Resources & Services Administration (HRSA)'s definition of telehealth and telemedicine.

(2) Describe the scope of services that can be covered by telemedicine

- Support the development of telemedicine programs that:
  - Increase access to care
  - Uphold the standard of care
  - Improve patient satisfaction
  - Reduce costs
  - Engage practitioners to provide care at the top of their licenses.

(3) Determine acceptable communication and data transfer speeds necessary to ensure the privacy of health information and appropriate for insurance reimbursement

- North Carolina Office of Broadband Infrastructure 2017 Broadband Report recommendations should be enacted as quickly
- Eligible providers and institutions should **participate in NC HealthConnex**
- Covered entities and business associates must follow all federal and state regulations to secure protected health information

SL 2017-133 Report Recommendations

(4) Informed Consent Standards

- Adopt the American Telemedicine Association's standards for informed consent

(5) Online Prescribing Standards

- Telemedicine practitioners must abide by all federal regulations for E-Prescribing
  - Ryan Haight Online Pharmacy Consumer Protection Act
  - Controlled Substances Act

(6) Telemedicine provider licensing standards

- Adopt the American Telemedicine Association's standards for informed consent

(7) Private payer telemedicine reimbursement standards

- Further study and stakeholder input are needed

(8) Psychology Interjurisdictional Compact (PSYPACT)

- DHHS supports the position of the North Carolina Psychological Association, that North Carolina should create legislation to participate in PSYPACT

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

October 1, 2017

SENT VIA ELECTRONIC MAIL

The Honorable Louis Pate, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 311, Legislative Office Building
Raleigh, NC 27603

The Honorable Josh Dobson, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 301N, Legislative Office Building
Raleigh, NC 27603

The Honorable Donny Lambeth, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 303, Legislative Office Building
Raleigh, NC 27603

Dear Chairmen:

Session Law 2017-133, Section 2, requires the Department of Health and Human Services, to submit a report to the Joint Legislative Oversight Committee on Health and Human Services containing findings and recommendations, a proposed telemedicine policy and a recommendation on the PSYPACT. This report is due no later than October 1, 2017. Pursuant to the provisions of law, the Department is pleased to submit the attached report.

Should you have any questions about this report, please contact Maggie Sauer, Director for the Office of Rural Health, at Maggie.Sauer@dhhs.nc.gov or 919-527-6440.

Sincerely,

Mandy Cohen, MD, MPH
Secretary

cc:
Maggie Sauer
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Ben Popkin
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Report on Telemedicine Study and Recommendations

SL 2017-133, Section 2

Report to the

Joint Legislative Oversight Committee on Health and Human Services

By

North Carolina Department of Health and Human Services

October 1, 2017

Executive Summary

Background and Overview

Background: In Session Law 2017-133, the North Carolina General Assembly (NCGA) directed the North Carolina Department of Health and Human Services (DHHS) to conduct a study and provide recommendations on a telemedicine policy for the State. DHHS welcomed the opportunity to embark on this important work which has the potential to improve the quality of life for North Carolinians.

DHHS has completed an extensive survey of the information requested in S.L. 2017-133 and is pleased to report that standards exist in many of the areas. As requested by the NCGA, a summary of the recommendations and rationale can be found on pages six through nine for the following items:

- Definition of the term telemedicine
- The scope of services that can be covered by telemedicine
- Acceptable communication and data transfer speeds necessary to ensure privacy of health information and appropriate for insurance reimbursement
- Informed consent standards
- Online prescribing standards
- Telemedicine provider licensing standards
- Private payer telemedicine reimbursement standards
- Psychology Interjurisdictional Compact (PSYPACT)

While North Carolina has made progress advancing the use of telemedicine, there remains much work to do. DHHS is ready to partner with the NCGA to take action to make the necessary changes that will maximize the use of telemedicine.

In the past two decades, DHHS has helped lead the adoption of telemedicine statewide. In 1999, the Division of Medical Assistance enacted a Medicaid policy to reimburse telemedicine programs for their services. This policy continues to be adapted to fit the changing landscape.[1] With the support of the NCGA, the Office of Rural Health has collaborated with East Carolina University Center for Telepsychiatry and e-Behavioral Health since 2013 to administer the North Carolina Statewide Telepsychiatry Program, currently operating in 43 hospitals.[2]

DHHS recommends that North Carolina adopt an aggressive statewide telemedicine policy that will improve health for all people by increasing access to high quality care. The opportunities range from improving health outcomes for those with chronic conditions, to gaining and maintaining independence for those who are aging or have a disability, to improving access to care in rural areas.

Technology is evolving quickly and our ability to assist our most vulnerable citizens through creative uses of this tool has vastly increased. Capitalizing on this opportunity requires intentional thought and planning, as well as

[1] Please see pg. 23 for more information.

[2] Please see pg. 15 for more information.

creating unique and innovative partnerships across State Government. DHHS firmly believes that telemedicine can improve the health of our population if we respond effectively to the two opportunities outlined below:

Opportunity #1: 1115 Medicaid Waiver
Opportunity #2: Broadband Infrastructure

Opportunity 1: 1115 Medicaid Waiver

Presently, the Waiver describes telemedicine as a tool to reach our most vulnerable citizens, particularly those in rural areas. As the State moves to a managed care environment, **Medicaid Managed Care Organizations (MCOs) should be required to ensure access to high quality, patient-centered care by incorporating telemedicine into their payment models.**

DHHS is considering innovative strategies to meet the needs of rural and underserved communities who do not have adequate access to physicians and other healthcare providers. The focus is not only treat illness, but provide an opportunity for improved health. The 1115 Waiver is designed to encourage whole-person care and adequate workforce is an essential core component to our success in that objective. **North Carolina can improve access to the healthcare workforce by participating in Interstate Licensure Compacts such as PSYPACT and increasing incentives for providers to use telemedicine to reach patients in underserved areas.**

Opportunity 2: Broadband Infrastructure

The North Carolina Office of Broadband Infrastructure 2017 Broadband Report recommendations should be enacted as quickly as possible to support patients' ability to communicate and exchange information between their home or community environment and their healthcare provider/entity.[3] Enacting these recommendations will enable individuals to connect in their homes by computer, smart device, or home monitoring systems.

Telemedicine tools may create a vehicle to engage patients with their primary care provider to increase continuity of care without the burden of travel or time away from work, school, or family. Though broadband is in every county, residents and businesses struggle to access adequate service for some telemedicine modalities. DHHS will partner with other state agencies and philanthropic groups to identify solutions to address this problem.

Next Steps

Additional work is required to achieve optimal use of these resources. DHHS is ready to continue our work with the NCGA to further outline telemedicine strategies and actions to support our most vulnerable citizens and increase the health of North Carolinians. S.L. 2017-133 is an opportunity to gather the collective resources across DHHS, Departments of Commerce, Insurance, and Information Technology, along with other stakeholders to adequately address these prospects.

To that end, DHHS recommends the establishment of a Legislative Subcommittee to engage our collective state efforts and those of other stakeholders to build a comprehensive telemedicine implementation plan. DHHS looks forward to engaging with this Subcommittee to develop a roadmap for this plan.

[3] Please see pg. 25 for more information.

Table of Contents

Executive Summary **2**

I. S.L. 2017-133, Section 1-2 Requirements and Responses **6**

II. Overview **9**

III. Background **10**

A. Telemedicine Definitions 10

B. Populations Served 11

C. Forms of Telemedicine 11

D. Metrics 12

IV. Scope of Services **12**

A. Primary Care Services 13

B. Chronic Disease Management and Care Coordination 14

C. Behavioral Health Services 15

D. Emergency Services 16

E. Specialty Care Services 16

V. Patient Privacy and Safety **18**

A. HIPAA Compliance 18

B. Informed Consent 18

C. Quality of Care 19

VI. Provider Standards **20**

A. Licensing and Credentialing 20

B. Drug Prescription Standards 20

C. Interstate Licensure Compacts 21

D. PSYPACT 21

VII. Payment Standards **22**

A. Centers for Medicare & Medicaid Services (CMS) 22

B. North Carolina Medicaid Program 23
C. Private Payment Policies 23
VIII. The Road to Adoption 26
A. Best Practices in Broadband Internet 26
B. Best Practices in Reimbursement 28
C. Best Practices in Workforce and Licensing 30
D. Supporting the Telemedicine Workforce in Rural Communities 32
IX. Appendix 33
A. Figure 1: North Carolina Primary Care Health Professional Shortage Areas 33
B. Figure 2: North Carolina Mental Health Professional Shortage Areas 34
C. Figure 3: North Carolina Dental Health Professional Shortage Areas 35

I. S.L. 2017-133, Section 1-2 Requirements and Responses

The following document provides some context for review of current practices and future considerations for the creation of a more robust telemedicine infrastructure for the State which builds upon the current infrastructure and proposed Medicaid policy emphasizing the quadruple aim as defined by better experience of care, per capita cost containment and funding stability, better health, and improved provider engagement and support.

To achieve this vision, DHHS provides the following responses and recommendations for each area requested by NCGA:

(1) **A definition of the term telemedicine**

- **a.** Adopt the Health Resources & Services Administration (HRSA)'s definition of telehealth and telemedicine as "the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications." The Centers for Medicare & Medicaid Services have incorporated this definition.[4]
- **b.** DHHS agrees with the opinion of the American Telemedicine Association, that the terms "telehealth" and "telemedicine" may be used interchangeably.[5]

(2) **The scope of services that can be covered by telemedicine**

- **a.** Support the development of telemedicine programs that increase access to care, uphold the standard of care, improve patient satisfaction, reduce costs, and engage practitioners to provide care at the top of their licenses. Telemedicine is not a service in itself; it is a modality for providing the service. As the capabilities of technology continue to evolve, so will the scope of telemedicine programs.[6]
- **b.** Adopt best practices as suggested by the National Quality Forum (NQF) and the Agency for Healthcare Research and Quality (AHRQ) to ensure patients have access to the highest quality and continuity of care.[7]

(3) **Acceptable communication and data transfer speeds necessary to ensure the privacy of health information and appropriate for insurance reimbursement**

- **a.** Covered entities and business associates must follow all federal and state regulations to secure protected health information (PHI), including those set forth by Health Insurance Portability and Accountability Act (HIPAA), HIPAA Privacy and Security Rules, the Health Information Technology for Economic and Clinical Health (HITECH) Act, and the Office of Civil Rights. Covered entities and business associates must conduct risk analyses and install administrative, physical, and technical safeguards to ensure the protection of PHI.[8]

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[4] Please see pg. 10 for more information.

[5] Ibid.

[6] Please see pg. 9 for more information.

[7] Please see pg. 19 for more information.

[8] Please see pg. 18 for more information.

b. The North Carolina Office of Broadband Infrastructure 2017 Broadband Report recommendations should be enacted as quickly as possible to support patients' ability to communicate and exchange information directly between their home or community environment and their healthcare provider/entity.[9]

c. Recognize that a high-speed broadband internet connection is essential for the provision of telemedicine services, which take many forms. Telemedicine programs using Live Video Conferencing require a high-speed broadband internet connection with a minimum bandwidth of 1Mbps (megabits per second) download speed and 384 Kbps (kilobits per second) upload speed. Having sufficient bandwidth helps to ensure a clear, uninterrupted picture during the video conference.[10]

d. Eligible providers and institutions should participate in NC HealthConnex, the statewide Health Information Exchange (HIE), to enhance interoperability of electronic health records and share data securely.[11]

(4) **Informed consent standards**

a. Adopt the recommendations set forth by the American Telemedicine Association that informed consent contain the following:

i. "Inform the patients of their rights when receiving telemedicine, including the right to stop or refuse treatment.

ii. Tell patients their own responsibilities when receiving telemedicine treatment.

iii. Have a formal complaint or grievance process to resolve any potential ethical concerns or issues that might come up as a result of telecare.

iv. Describe the potential benefits, constraints, and risks (like privacy and security) of telemedicine.

v. Inform patients of what will happen in the case of technology or equipment failures during telemedicine sessions, and state a contingency plan."[12]

b. Consult patients and involved family members before services are rendered to them over telemedicine. Patients and involved family members should feel comfortable using the technology.[13]

c. Obtain informed consent before services are rendered. Informed consent can be verbal or written, and ideally will include both by discussing the service with the patient, then letting the patient review and sign a consent form written in their preferred language.[14]

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[9] Please see pg. 25 for more information.

[10] Ibid.

[11] Please see pg. 27 for more information.

[12] Please see pg. 18 for more information.

[13] Ibid.

[14] Ibid.

(5) **Online prescribing standards**

a. Telemedicine practitioners must abide by all federal regulations for E-Prescribing, including those specified under the Controlled Substances Act and the Ryan Haight Online Pharmacy Consumer Protection Act.[15]

(6) **Telemedicine provider licensing standards**

a. Provider licensing standards regarding telemedicine should promote and support a patient-centered model of care, enhancing access to quality care and continuity of care. Further study is needed to outline specific care guidelines with input from provider/consumer stakeholders and regulating entities.[16]

b. Consistent with the language in the 1115 Waiver submitted by DHHS, a standardized and centralized credentialing process should be developed and adopted for all providers, to include those who practice telemedicine, to ensure parity across care delivery models."[17]

c. Further study is needed to consider the impact of participation in the Interstate Medical Licensure Compact as formulated by the Federation of State Medical Boards.[18]

(7) **Private payer telemedicine reimbursement standards**

a. Further study and stakeholder input are needed to consider reimbursement standards for private payers. DHHS should further examine the standards of other states and the results of those standards on cost and access.[19]

(8) **Psychology Interjurisdictional Compact (PSYPACT)**

a. DHHS supports the position of the North Carolina Psychological Association, that North Carolina should create legislation to participate in PSYPACT as this will help to address behavioral health workforce issues.[20]

b. Participation in PSYPACT should be contingent upon upholding patient-centered models and data reporting for continuity of care, such as participating in NC HealthConnex.[21]

In addition to the recommendations above, DHHS requests that the NCGA convene a Legislative Subcommittee to further study telemedicine issues and the opportunities it presents for NC. The Subcommittee should consist of a diverse group of telehealth leaders as identified by NCGA, to include the Departments of Insurance, Commerce, and Information Technology, provider licensing boards, commercial payers, and rural providers. The vision of the

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[15] Please see pg. 20 for more information.

[16] Ibid.

[17] Ibid.

[18] Please see pg. 21 for more information.

[19] Please see pg. 22 for more information.

[20] Please see pg. 21 for more information.

[21] Ibid.

Subcommittee will be to ensure that the citizens of North Carolina receive the highest quality, most accessible quality care possible regardless of where they live, work, and play.

II. Overview

In Session Law 2017-133, the North Carolina General Assembly (NCGA) directed the North Carolina Department of Health and Human Services (DHHS) to conduct a study and provide recommendations on a telemedicine policy for the State. The following document provides some context for review of current practices and future considerations for the creation of a more robust telemedicine infrastructure for the State which builds upon the current infrastructure and proposed Medicaid policy emphasizing the quadruple aim of improved outcomes, lower cost of care, improved patient experience, and improved clinician experience.

North Carolina continues to emphasize the needs of underserved, rural and aging citizens. Our rural communities have a higher number of community members who are aging, have higher incidence of chronic disease and die earlier[22] due, in part, to the lack of access to quality, whole-person healthcare. Our citizenry is unique and works in a variety of industries throughout North Carolina, including farming, fishing, logging and other small businesses and minimum wage jobs. A robust telemedicine infrastructure could provide significant benefits to the State, including the following:

- Overall improved access to primary and specialty care
- Improved healthcare costs if individuals are able to participate in a regular healthcare routine rather than higher cost care caused by untreated chronic conditions or preventable healthcare emergency
- Improved access to behavioral health services integrated into primary care settings
- Improved access to community-based behavioral health services to decrease the likelihood of emergency events and hospitalizations
- Improved access to substance abuse support services and management to assist in identifying and treating individuals and their affected families
- Support of individuals in their homes and communities rather than traveling long distances, improving work attendance, avoiding loss of income due to childcare and lost time at work, and transportation costs
- Increased engagement of rural providers with their colleagues thus improving quality care for their patients and decreasing provider isolation and improving retention in the communities that need services the most
- Support of older adults and individuals with disabilities to gain and continue independence

The current 1115 Medicaid waiver encourages managed care organizations to plan creatively to provide increased access to care for persons in rural and underserved communities. It does not however, prescribe the type, measurement or other requirements of telemedicine services, leaving that to the General Assembly to further define with additional stakeholder engagement. It does represent a tremendous opportunity for our State to be

[22] 2017 County Health Rankings. (2017). Retrieved September 13, 2017, from http://www.countyhealthrankings.org/sites/default/files/state/downloads/CHR2017_NC.pdf

forward thinking in the application of telemedicine to address the health challenges of some of our most vulnerable citizens.

This document does not provide a complete analysis of what is needed, but does suggest some initial steps to begin a more thorough analysis of the issues at hand. DHHS recommends including additional stakeholder engagement across our state to ensure these strategies:

- Follow standard of care quality guidelines that are equal to or better than in-office care,
- Adhere to patient medical home standards, and
- Provide continuity of care

Furthermore, these recommendations in no way suggest telemedicine as a strategy to replace 1:1 patient engagement with primary care physicians and other healthcare providers. It does suggest that North Carolina explore innovative ways to ensure that people receive quality access to care, at the right place, the right time and with the best outcomes for the most effective cost.

III. Background

Many telemedicine and telehealth programs have been created across North Carolina in recent years. As telehealth and telemedicine use continues to grow statewide, it will be increasingly important to create standards that uphold the quality of care and protect patient privacy, yet encourage the growth of telemedicine programs that lead to lower cost, higher quality care, and improved health outcomes for North Carolinians.

A. Telemedicine Definitions

- The **Health Resources & Services Administration (HRSA)** defines telehealth as "the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications."[23]
- The **American Telemedicine Association** states that telehealth and telemedicine are used interchangeably and refer to "the use of remote health care technology to deliver clinical services."[24]
- The **Centers for Medicare & Medicaid Services (CMS)** use HRSA's definition for telehealth, but also provide additional guidance regarding places of service and the distant site practitioners who can be reimbursed for the service. An originating site is defined as "the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs." The distant site is where the consulting practitioner is located. Practitioners paid under Medicare include physicians, nurse practitioners, physician assistants, nurse-midwives, and more.[25]

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[23] Telehealth Programs. (n.d.). Retrieved August 15, 2017, from https://www.hrsa.gov/ruralhealth/telehealth/

[24] FAQs. (n.d.). Retrieved August 15, 2017, from http://www.americantelemed.org/about/telehealth-faqs-

[25] Telehealth Services. (2016). Retrieved August 16, 2017, from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

B. Populations Served

When the forms of telemedicine are explained, concerns are often raised over which populations can benefit from services and whether telemedicine is accessible for all populations. These are decisions that program planners and clinicians make on a daily basis with in-person programs, and similar considerations must apply to telemedicine programs. **Section IV** of this document lists an assortment of telemedicine programs serving a diverse group of populations in our State.

Telemedicine presents a unique opportunity to expand access to care and provide direct support to populations in need. For example, many areas of North Carolina are designated Health Professional Shortage Areas (HPSAs), which demonstrate the need for greater access to care in the areas of primary care, mental health, and oral health. Maps of these HPSAs are provided in the **Appendix** of this document. Practitioners located in urban settings can overcome the rural workforce shortages by providing consults to rural residents over great distances. In addition, the Long Term Services and Supports (LTSS) population may gain access to monitoring programs that could aid them in their daily lives and help them remain independent in their communities with their families for longer periods and with greater independence than is presently possible.

C. Forms of Telemedicine

As technology continues to evolve, so will the ways in which people use it. Currently, the most common forms of telemedicine are (1) Video Conferencing, (2) Store and Forward, (3) Remote Patient Monitoring, and (4) mHealth or Mobile Health.

- **Video Conferencing**
  - Uses "two-way interactive audio-video technology to connect users when a live, face-to-face interaction is necessary"
  - Similar to Apple's FaceTime or Microsoft's Skype
  - Uses computer screens and microphones to allow face-to-face interaction over live video
  - Allows peripherals (e.g., electronic stethoscopes, otoscopes, and electrocardiograms (EKGs))
  - Used for direct patient care, consultations between providers, and patient education.[26]
- **Store and Forward**
  - "Allows for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through secure email transmission"[5]
  - Clinicians can analyze tests or exams at a later time, after the patient visit has concluded.
  - Creates flexibility with provider scheduling
  - Reduces patient wait times for specialty services
  - Often used for radiology, pathology, dermatology, and ophthalmology service[27]
- **Remote Patient Monitoring**
  - Collects patient vital signs and relevant chronic disease metrics (such as glucose levels) for transmission to care coordinators, who can contact the patient for follow-up if needed

[26] Video Conferencing. (n.d.). Retrieved August 15, 2017, from http://www.cchpca.org/what-is-telehealth/video-conferencing

[27] Store and Forward. (n.d.). Retrieved August 15, 2017, from http://www.cchpca.org/store-and-forward

- Patients use medical devices with an internet connection in their home to transmit data securely and automatically
- Identifies health issues early on
- Used for chronic disease management[28]

- **mHealth (also known as Mobile Health)**
  - Uses "devices such as smart phones and portable monitoring sensors that transmit information to providers, as well as dedicated application software (apps), which are downloaded onto devices"
  - Growing with the popularity of wearables, such as fitness trackers, pedometers, and heartbeat sensors
  - Includes reminders and automated data collection
  - Transmits information to providers
  - Assists in virtual care and Remote Patient Monitoring
  - Used for chronic disease management[29]
- **In-home monitoring and support devices**
  - In-home monitoring and support devices can be placed in the homes of older adults and individuals with disabilities to help them gain and continue their independence. Living at home with support and/or supporting caregivers in the home to ensure/continue independence as long and fully is possible with new technologies. It is important to consider that technology evolves, non-traditional forms of telemedicine may emerge.

D. Metrics

In the same way program planners and clinicians must consider how a given program can serve populations, they must also consider the targeted outcomes for patients served. Because the use of telemedicine is new and has not been implemented broadly, there is little standardization for this mode of treatment. Organizations like the National Quality Forum and AHRQ are creating metrics for consideration. It is important that while deploying services through telemedicine, the standard of care is upheld and performance metrics are tracked. North Carolina has an enormous opportunity to be in the forefront of this work. Telemedicine services are at their highest value when they provide better patient outcomes and experience, while also reducing the overall cost of care. Please see **Section V** of this document for continued discussion on quality of care.

IV. Scope of Services

There are a variety of programs currently using telemedicine across North Carolina and nationwide. DHHS conducted an environmental scan of telemedicine services as outlined below. This list is not comprehensive. Examples are based on availability of information and are not meant to reflect endorsement or promotion of individual programs.

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[28] Remote Patient Monitoring. (n.d.). Retrieved August 15, 2017, from http://www.cchpca.org/remote-patient-monitoring

[29] Mobile Health. (n.d.). Retrieved August 15, 2017, from http://www.cchpca.org/mobile-health

A. Primary Care Services

- General Primary Care Services- Several health systems in North Carolina, including Cone Health and Carolinas HealthCare System, have developed smart phone apps that allow patients and employees to connect with a PCP within minutes.
    - During the videoconference, the PCP can diagnose and provide treatment for low acuity conditions. This is done using smart devices (smart phones, tablets, etc.) to create Live Video Conferencing sessions between patients and primary care providers.

- PCPs School-Based Health- Health-e-Schools is a program administered by the Center for Rural Health Innovation. The program serves public schools located in McDowell, Mitchell, and Yancey counties by connecting students and faculty with access to a PCP. The service is effective in diagnosing low acuity conditions, and PCPs can help to assess whether a patient's condition necessitates a visit to a higher level of care. This program expands access to care and helps keep children from missing school due to travel to primary care offices.[30]
    - Live Video Conferencing carts are equipped with specialized medical equipment, including electrical stethoscopes and otoscopes, to enable a PCP at the distant site to assess a patient's condition as if the service were being provided in-person. However, the PCP is unable to palpate or feel an area of the patient's body.

- Primary Care Consultation and Education- Telemedicine is also used for provider education or consultation. The Extension for Community Healthcare Outcomes (ECHO) Model was created to provide knowledge and support to PCPs to manage patients with complex conditions.
    - PCPs may participate in grand rounds over Live Video Conferencing with interdisciplinary groups of specialists
    - PCPs procure the specialists' advice on specific cases and gain knowledge to treat these cases
    - PCPs are assigned specialist mentors and engage in continuous learning.[31]
    - The ECHO model has expanded internationally and is sometimes targeted to specific conditions
    - The University of North Carolina has launched an initiative using the ECHO model to enable PCPs to provide Medication Assisted Treatment (MAT) to patients suffering from opioid addiction. Leaders of the initiative hope to increase the number of MAT providers in the state to combat the accidental overdose rate.[32]
    - Outside of the ECHO Model, other health systems have utilized their automatic systems to support PCPs. For example, Mission Health is encouraging PCPs to employ Office-

[30] Center for Rural Health Innovation: MY Health-e-Schools. (n.d.). Retrieved August 23, 2017, from http://crhi.org/MY-Health-e-Schools/index.html

[31] About ECHO | Project Echo. (n.d.). Retrieved August 24, 2017, from https://echo.unm.edu/about-echo/

[32] UNC-Chapel Hill. (2017). UNC-Chapel Hill initiative will combat opioid use disorders and overdose deaths. Retrieved August 24, 2017, from http://uncnews.unc.edu/2017/02/15/unc-chapel-hill-initiative-will-combat-opioid-use-disorders-overdose-deaths/

Based Opioid Treatment (OBOT) in their practices. Mission Health has modified its electronic health record to attach drug screenings and confirm patient's involvement in treatment. These efforts, in turn, help PCPs to feel supported and encouraged that they are following OBOT policies.[33]

B. Chronic Disease Management and Care Coordination

Patients with chronic diseases need regular monitoring and access to primary care, but transportation issues, provider shortages, and limited financial resources are common barriers to this care.

- Remote Patient Monitoring- When a PCP refers a patient to the program, registered nurses install a telehealth kiosk in the patient's home and train the patient on use of the kiosk. The patient is given medical supplies including a weight scale, blood pressure monitor, glucose meter, and peak flow meter. The patient then monitors the readings and uses the kiosk to input the data and answer questions about their current health. The kiosk transmits the data to the patient's electronic health record, which the nurses read each day to monitor the readings and determine any abnormalities. This allows the nurses and PCP to respond with interventions, if needed, to help the patient manage their chronic diseases.[34]
    - In 2006, Roanoke-Chowan Community Health Center launched the Patient Provider Telehealth Network to target improved outcomes for patients with cardiovascular disease, diabetes, or hypertension.

- Enabling Technology- Individuals with disabilities can gain and continue independence using in-home support devices, which can assist them in their daily routines and alert caregivers of warning signs.
    - Services like *Simply*Home install systems customized to fit the need of the individual so that they can use the technology to remember to turn off the stove, lock their doors, administrate their medication at the appropriate time, and call for help when needed.[35]

- Diabetic Care -The prevalence of diabetes in North Carolina continues to increase, with at least 1 in 10 adults in North Carolina living with the chronic disease.[36] Patients with diabetes can also develop a disease called diabetic retinopathy (DR), one of the leading causes of blindness in adults. Patients require annual comprehensive eye exams to prevent further damage, but because of workforce shortages in rural areas, patients may need to travel great distances to get an exam. Through teleophthalmology, images of the patient's eyes can be sent through Store and Forward technology to a specialist for later viewing.

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[33] Hartye, J., & Boice, D. (2017). Phone Interview on May 17, 2017.

[34] Schwartz, K., & Britton, B. (2011). Use of Telehealth to Improve Chronic Disease Management. NCMJ, 72(3), 216-218.

[35] How It Works – SimplyHome. (n.d.). Retrieved September 13, 2017, from https://www.simply-home.com/how-it-works

[36] Type 2 Diabetes in North Carolina (2017). Retrieved August 24, 2017, from http://www.diabetesnc.com/downloads/0617/CCCPH_FactSheet_Diabetes_FINAL_May2017.pdf

- Indian Health Service-Joslin Vision Network Teleophthalmology Program has implemented this service into primary care offices so that patients can have images taken during their regular diabetes management appointments. The program has increased the annual DR screening rate by 50%, resulting in a 51% increase in laser treatments to prevent severe vision loss. After conducting over 70,000 retinal exams, the program has been successful in decreasing diabetes-related vision loss for its patients. The program has also reported being "less costly and more effective than a live eye examination for detecting DR and preventing vision loss."[37]

C. Behavioral Health Services

Many primary care offices have seen the benefit of integrating behavioral health services, but behavioral health workforce shortages may prevent them from recruiting a behavioral health professional (BHP). In addition, if a large health system owns many primary care offices, it may be more efficient to place the BHP at a central location and serve several sites via telemedicine.

- Carolinas HealthCare System has created behavioral health services in their primary care offices using telehealth. The PCP and patient are located on-site, each patient room is equipped with Live Video Conferencing equipment so that the PCP and patient can speak with the BHP. The BHP can provide the patient with **education, a psychological assessment, crisis intervention, etc. via telemedicine.** This service helps to support PCPs, expands access to behavioral health care for patients, and reduces stigma since behavioral health and primary services are co-located.[38]

- **Telepsychiatry** is an emerging solution to address higher acuity behavioral health services and workforce shortages. In 2013 the North Carolina General Assembly created a model for statewide telepsychiatry services. As defined in North Carolina Session Law 2013-360:

  Telepsychiatry is "the delivery of acute mental health or substance abuse care, including diagnosis or treatment, by means of two-way real-time interactive audio and video by a consulting provider at a consultant site to an individual patient at a referring site."

  This legislation created the **North Carolina Statewide Telepsychiatry Program**, administered by the North Carolina Office of Rural Health and the East Carolina University Center for Telepsychiatry and e-Behavioral Health, which provides access to behavioral health professionals for individuals presenting to hospital emergency departments (EDs) with behavioral health crises. Mobile carts are equipped with screens, cameras, and microphones, patients can have two-way interactions with providers through Live Video Conferencing. After providing over 25,000

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[37] Teleophthalmology | Indian Health Service (IHS). (n.d.). Retrieved August 24, 2017, from https://www.ihs.gov/teleophthalmology/

[38] Castro, M., & Sparks, W. (2016). Utilizing Emerging Virtual Care Methods to Improve Access to Care. Presentation, Raleigh, NC.

telepsychiatry assessments, NC-STeP has achieved 25% reductions in median length of stay for telepsychiatry patients and cumulative estimated cost savings of $15,066,000.[39]

- Telepsychiatry has become an effective solution not only for emergency departments, but also in community-based settings. **Community Behavioral Health** providers continue to use and expand telepsychiatry to provide support to individuals across North Carolina. Organizations like Daymark Recovery Services use telepsychiatry to extend the availability of clinical services to individuals who otherwise would not have access to the services.

D. Emergency Services

Sometimes it can be unclear to patients whether a particular issue is worth a visit to a hospital ED. RelyMD, created by a group of emergency medicine physicians in North Carolina, is a service allowing patients to use their smart devices for immediate Live Video Conferencing with an emergency medicine physician. After assessing the patient, the physician can recommend a referral. This service helps to divert unnecessary visits to hospital EDs and can give guidance for first aid after an accident.[40]

- In 2016, Wake County EMS partnered with RelyMD to launch a pilot program targeted toward reducing unnecessary ED admissions. When paramedics arrive at a requested location, they can connect the patient with the emergency medicine physician to ascertain whether the issue necessitates ambulance transportation to an ED. However, if after assessing the patient the physician determines that an ED visit is not necessary, the physician can assist the patient and paramedic in creating alternate plans, such as education or follow-up. After providing 20 consults and assisting with alternate arrangements, this pilot program diverted 18 unnecessary ED visits.[41]

E. Specialty Care Services

- Neurology -When a patient is suffering from symptoms of stroke, the time to diagnosis and treatment is critical. However, there is a limited number of stroke centers in North Carolina.
  - Wake Forest Baptist Health launched its Telestroke Network to provide rural hospitals with access to trained specialists. Hospitals in the network are equipped with mobile carts, which are used to conduct an assessment via Live Video Conferencing among the patient, onsite practitioner, and distant provider. The care team uses the information from the assessment to help diagnose the patient's condition and create a plan of action. This service helps to eliminate the disparity in stroke care between rural hospitals and tertiary care centers.[42]

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[39] Home | NC-STeP. (n.d.). Retrieved August 15, 2017, from http://www.ecu.edu/cs-dhs/ncstep/

[40] How Does RelyMD Work? (n.d.). Retrieved August 24, 2017, from https://relymd.com/how-does-relymd-work/

[41] How Wake County EMS Cut Emergency Transfers by 90%. (n.d.). Retrieved August 28, 2017, from https://relymd.com/wake-county-ems-case-study/

[42] Wake Forest Baptist Telestroke Network. (n.d.). Retrieved August 24, 2017, from http://www.wakehealth.edu/Referring-Physicians/Neurosciences/Telestroke/Telestroke-Network.htm

- Specialty Services for Children with Special Needs – In 2003, The University of North Carolina Department of Physical Medicine and Rehabilitation created the TelAbility program to help provide care to children with disabilities. TelAbility allows children and their families to access specialists and care coordinators at community-based settings, such as primary care offices, through Live Video Conferencing. The program is interdisciplinary and care involves physicians, physical therapists, occupational therapists, speech-language pathologists, and many more types of practitioners. By helping children with disabilities and their families to engage in appointments close to home, the program aims to increase patient compliance and alleviate transportation burdens.[43]

- Supports for Persons Needing Assistance to Remain in a Community or Home-Based Setting-In-home monitoring and support devices can be placed in the homes of older adults and individuals with disabilities to help them gain and continue their independence. *Simply Home*, a North Carolina based company, provides assistive technology solutions promoting the independence, community integration, and self-determination of senior adults and people with disabilities. Their remote support systems blend the latest in technology and natural support to provide a safety net for people who want to live independently.

F. Dentistry

According to a recent study, North Carolina ranks 47th in the nation in dentists per capita.[44] This workforce shortage results in many patients receiving limited or no dental care at all.

- California Model - University of the Pacific in California has created a new model, the Virtual Dental Home (VDH), to expand access to oral health services. This model allows registered dental hygienists in alternative practice (RDHAP), registered dental hygienists working in public health programs (RDH) and registered dental assistants in extended functions (RDAEF) to provide basic dental services in community-based settings. Records from the visit are transmitted to a dentist for review, and the dentist can instruct the dental hygienist or assistant on appropriate responses such as, conducting risk assessments, providing preventive services, and interim therapeutic restorations (ITRs). If further follow-up from a dentist is needed, the patient is referred for treatment at the dentist's office. This service is most effective with children and elders, as they are most susceptible to diseases from neglect of oral health.[45]

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[43] TelAbility / Home. (n.d.). Retrieved August 28, 2017, from http://www.telability.org/index.pl

[44] Fraher, E., McGee, V., Hom, J., & Gaul, K. (2012). We're Not Keeping Up With the Joneses: North Carolina Has Fewer Dentists per Capita Than Neighboring (and Most Other) States. Retrieved August 24 2017, from http://nciom.org/wp-content/uploads/2012/03/NCMJ_73206-web.pdf

[45] About Virtual Dental Home. (n.d.). Retrieved August 24, 2017, from http://dental.pacific.edu/departments-and-groups/pacific-center-for-special-care/innovations-center/virtual-dental-home-system-of-care/about-virtual-dental-home

V. Patient Privacy and Safety

As Health Information Technology continues to develop, it becomes increasingly important that all processes, workflows, equipment, and data systems are built around upholding patient privacy and safety. Several important considerations are provided below.

A. HIPAA Compliance

Covered entities and businesses must adhere to all applicable laws and regulations regarding patient privacy and safety. This can include, but is not limited to:

- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- HIPAA Privacy and Security Rules
- Health Information Technology for Economic and Clinical Health (HITECH) Act
- Regulations set forth by the Office of Civil Rights (OCR)

Telemedicine providers must give special attention to the HIPAA Security Rule, as it addresses the safeguards for securing protected health information (PHI) that is stored electronically. Covered entities and business associates should conduct risk analyses and install administrative, physical, and technical safeguards to ensure the protection of PHI.[46]

B. Informed Consent

An important component of quality care is patient and family engagement (PFE). Just as patients should be involved in decision-making about their exams and procedures, they should also be consulted before services are rendered to them over telemedicine. Patients and involved family members should feel comfortable using the technology and informed consent should be obtained before services are rendered. Informed consent can be verbal or written, and if possible, include both by discussing the service with the patient, then letting him or her review and sign a consent form written in the patient's preferred language. DHHS concurs with the American Telemedicine Association's recommendations that informed consent contain the following:

- "Inform patients of their rights when receiving telemedicine, including the right to stop or refuse treatment.
- Tell patients their own responsibilities when receiving telemedicine treatment.
- Have a formal complaint or grievance process to resolve any potential ethical concerns or issues that might come up as a result of telecare.
- Describe the potential benefits, constraints, and risks (like privacy and security) of telemedicine.

[46] Summary of the HIPAA Security Rule. (n.d.). Retrieved August 16, 2017, from https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html

- Inform patients of what will happen in the case of technology or equipment failures during telemedicine sessions, and state a contingency plan."[47]

C. Quality of Care

Quality outcomes should be tracked to ensure quality of care through telemedicine. The National Quality Forum (NQF) is developing a framework to support creation of quality and performance metrics, which is now accepting comment for its draft reports.[48] In addition, the Agency for Healthcare Research and Quality (AHRQ) has created a series of roadmaps and toolkits that establish guidelines for telemedicine programs.[49] Administrators of telemedicine programs must monitor performance metrics to ensure quality of care and facilitate quality improvement activities to optimize workflow and preventerror.

To demonstrate value of care, payers will likely require tracking certain metrics as a condition of payment. For example, Cherokee Health Systems in Tennessee provides telebehavioral health services to their population and has an agreement with TennCare (Tennessee's Medicaid Program) to track the following metrics for patients with a behavioral health diagnosis:

- 7-day and 30-day psychiatric hospital readmission rate
- Selective serotonin re-uptake inhibitor (SSRI) adherence for depression management
- Follow-up after psychiatric hospitalization within 7 and 30 days
- Initiation and engagement of alcohol and drug treatment
- Use of multiple concurrent antipsychotics in children/adolescents
- Body mass index (BMI) and weight composite metric
- Comprehensive diabetes care (eye exam, blood pressure, nephropathy, HbA1c testing, and HbA1c poor control)
- Well child visits (age 7-11 years) and adolescent well-care visits (age 12-21 years)
- All-cause hospital readmissions
- Emergency department visits
- Total inpatient hospital admissions
- Mental Health inpatient utilization
- Rate of inpatient psychiatric admissions[50]

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[47] Telemedicine & Informed Consent: Done the Right Way. (n.d.). Retrieved September 06, 2017, from http://blog.evisit.com/telemedicine-informed-patient-consent-done-right-way

[48] NQF: Telehealth Framework to Support Measure Development 2016-2017. (n.d.). Retrieved August 22, 2017, from http://www.qualityforum.org/Telehealth_2016-2017.aspx

[49] Telemedicine | AHRQ Information Exchange. (n.d.). Retrieved August 22, 2017, from https://innovations.ahrq.gov/qualitytools/term/203

[50] Personal email communication from Parinda Khatri, Director of Integrated Care, Cherokee Health Systems, to Brian Cooper, North Carolina Office of Rural Health, received 08/09/2017 at 8:58 p.m.

VI. Provider Standards

Ensuring patients' access to quality care in a manner that promotes continuity of care and practices supporting the Patient Centered Medical Home (PCMH) model is paramount. The Patient-Centered Medical Home is a model of care that puts patients at the forefront of care. PCMHs build better relationships between people and their clinical care teams.

- **Fragmented care results in poorer care.** Higher rates of fragmentation are associated with higher costs, lower quality and higher rates of preventable hospitalizations.[1]
- **Integrated care produces better outcomes.** Communicating information for shared patient populations results in better care.[2]
- **Payers are increasingly supporting PCMH.** Because the PCMH model can help patients avoid costly complications, public and commercial payers are increasingly rewarding the PCMH model of care.[3]

A. Licensing and Credentialing

Telemedicine creates new considerations for licensing agencies. In its position statement on telemedicine, the North Carolina Medical Board (NCMB) states that telemedicine "is a potentially useful tool that, if employed appropriately, can provide important benefits to patients...however, licensees practicing via telemedicine will be held to the same standard of care as licensees employing more traditional in-person medical care." NCMB also comments on the importance of staff training, technologies used in examination, the licensee-patient relationship, prescribing, and medical records.[51]

Facilities and health care organizations must also reconsider their credentialing practices when working with telemedicine practitioners. For example, many hospitals may still have their credentialing by-laws written as if all practitioners were providing services in-person; therefore, some rules may be modified as appropriate to allow for greater telemedicine adoption at the facility. For instance, it may be unnecessary for a hospital to require immunization records in its credentialing application for telemedicine practitioners.

B. Drug Prescription Standards

E-Prescribing is defined by CMS as:

> "a prescriber's ability to electronically send an accurate, error-free and understandable prescription directly to a pharmacy from the point-of-care."[52]

Telemedicine practitioners can prescribe drugs at a distance via the practice of E-Prescribing. NCMB allows for e-prescribing drugs via telemedicine consults, in compliance with federal and state laws, however:

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[51] Telemedicine. (2014). North Carolina Medical Board. Retrieved August 22, 2017, from https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/telemedicine

[52] E-Prescribing – Centers for Medicare & Medicaid Services. (n.d.). Retrieved August 22, 2017, from https://www.cms.gov/Medicare/E-Health/Eprescribing/index.html?redirect=/eprescribing

- "prescribing controlled substances for the treatment of pain by means of telemedicine is not consistent with the standard of care."[53]
- The 2008 Ryan Haight Online Pharmacy Consumer Protection Act adds clarification on e-prescribing and maintaining compliance under the Controlled Substances Act.[54]

C. Interstate Licensure Compacts

Since telemedicine allows practitioners to provide services over distances, consideration must be given as to whether practitioners can render services across state lines. NCMB states:

> "any licensee using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina."[55]

- National efforts have been going on for several years to encourage the practice of telemedicine services across state lines.
- In 2013, the Federation of State Medical Boards worked with several stakeholders to create the framework for an Interstate Medical Licensure Compact (IMLC), which would allow qualified physicians to be "eligible for expedited licensure in all states participating in the Compact."[56]
- There are now 22 states participating in the Compact, of which North Carolina is not a member. States nearby to North Carolina participating in the IMLC include West Virginia, Tennessee, Alabama, Mississippi, and Pennsylvania.[57]

D. PSYPACT

To promote a Psychology Interjurisdictional Compact (PSYPACT), the Association of State and Provincial Psychology Boards created model language in February 2015 for state legislatures to consider. If passed by seven states, PSYPACT would become effective, allowing psychologists to apply for "Interjurisdictional Practice Certificates" or "E-Passports" from participating states. These credentials would permit psychologists to provide telepsychology services or to temporarily practice psychology in states different from their home state. If

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[53] Telemedicine. (2014). North Carolina Medical Board. Retrieved August 22, 2017, from https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/telemedicine

[54] Online Prescribing | Center for Connected Health Policy. (n.d.). Retrieved August 22, 2017, from http://www.cchpca.org/online-prescribing-0

[55] Telemedicine. (2014). North Carolina Medical Board. Retrieved August 22, 2017, from https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/telemedicine

[56] Understanding the Medical Licensure Compact | Federation of State Medical Boards. (n.d.). Retrieved August 22, 2017, from http://www.fsmb.org/policy/advocacy-policy/interstate-model-proposed-medical-lic

[57] Interstate Medical Licensure Compact. (n.d.). Retrieved August 22, 2017, from http://www.imlcc.org/

PSYPACT became effective, a Commission would be created to provide additional guidance and regulation for the compact.[58]

The North Carolina Psychological Association (NCPA) reached out to DHHS for comment regarding PSYPACT. Leaders of NCPA felt that their members would be in support of PSYPACT, as the Compact would provide flexibility for psychologists to provide services over state lines. DHHS agrees with this recommendation, as PSYPACT has the potential to address behavioral health workforce shortages.

VII. Payment Standards

Telemedicine programs must be sustainable in order to keep functioning. Most payers appear to have a telemedicine policy of some sort, but each one has its own stipulations for payment. In addition, some telemedicine programs are provided directly to the consumer and rely on collecting payments on a cash basis up-front, before the service is rendered. As overall healthcare reimbursement models move from traditional fee-for-service to value-based and capitated models, payment standards by payer can also adapt.

A. Centers for Medicare & Medicaid Services (CMS)

Outside of demonstration areas like Alaska and Hawaii, CMS only reimburses Live Video Conferencing visits. CMS also places particular requirements on the location of the originating site and the type of distant site practitioner. Below are the requirements:

- Authorized originating sites include offices of physicians, hospitals, rural health clinics, federally qualified health centers, hospital-based renal dialysis centers, skilled nursing facilities, and community mental health centers. These sites must be located in a county outside of a Metropolitan Statistical Area (MSA) or a Health Professional Shortage Area (HPSA) located in a rural census tract.
- Eligible distant site practitioners include physicians, nurse practitioners, physician assistants, and more.[59]
- Professional services provided via telehealth are reimbursed under Medicare at the appropriate amount designated under the Medicare Physician Fee Schedule (PFS), with one exception. Telehealth services provided by a provider located in a Critical Access Hospital (CAH) who has reassigned billing rights to a CAH that elected the "Optional Billing Method" under Medicare and the payment amount is 80% of the Medicare PFS for telehealth services.
- Originating sites are eligible for reimbursement of an originating site facility fee for telehealth services, paid as a separately billable Part B payment.

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[58] PSYPACT Factsheet. (n.d.). Retrieved August 24, 2017, from http://www.cchpca.org/sites/default/files/resources/PSYPACT%20Factsheet.pdf

[59] Telehealth Services. (2016). Retrieved August 16, 2017, from https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

On July 13, 2017, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2018.

- CMS is currently soliciting public comments and recommendations from practitioners and stakeholders on specific changes in Medicare Telehealth Services to **reduce the administrative burden of practitioners by eliminating the required telehealth modifier for professional claims and to cover five additional procedure codes including Health Risk Assessment and Care Planning for Chronic Care Management.**[60]

B. North Carolina Medicaid Program

In common with the telemedicine policies of CMS, the North Carolina Medicaid Program only reimburses Live Video Conferencing Visits and places requirements on eligible providers and originating sites. Below are the requirements currently in effect:

- For general telemedicine services, eligible clinicians include physicians, nurse practitioners, nurse midwives, and physician's assistants.
    - For telepsychiatry services, additional clinicians can bill for the service, including advanced practice psychiatric nurse practitioners, advanced practice psychiatric clinical nurse specialists, licensed psychologists, licensed clinical social workers, and community diagnostic assessment agencies.
- Originating sites that can bill for services include offices of the clinicians described above and hospitals, federally qualified health centers, rural health clinics, local health departments, and local management entities.[61]

C. Private Payment Policies

1. **Blue Cross Blue Shield of North Carolina's (BCBSNC)** position is that telehealth "is a potentially useful tool that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and the reduced cost of patient care." BCBSNC will reimburse for telehealth services only "if all the following conditions are met:
    - The patient is present at the time of service;
    - All services provided are medically appropriate and necessary;
    - A service provided to a member located in North Carolina is rendered by a provider licensed to practice independently in the state of North Carolina;

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[60] Department of Health and Human Services, Centers for Medicare & Medicaid Services, Fact Sheet: Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2018. (2017). Retrieved August 31, 2017, from https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-07-13-2.html

[61] Medicaid and Health Choice Clinical Coverage Policy No: 1H. (2015). Retrieved August 22, 2017, from https://files.nc.gov/ncdma/documents/files/1H.pdf

- The encounter satisfies the elements of the patient-provider relationship, as determined by the relevant healthcare regulatory board of the state where the patient is physically located;
- The service takes place via an interactive audio and video telecommunications system. Interactive telecommunications systems must be multi-media communication that, at a minimum, includes audio and video equipment permitting real-time consultation among the patient, consulting practitioner, and referring practitioner (as appropriate);
- The service is conducted over a secured channel with provisions described in Policy Guidelines;
- A permanent record of online communications relevant to the ongoing medical care and follow-up of the patient is maintained as part of the patient's medical record;
- The extent of any evaluation and management services (E/M) provided over the Telemedicine technology includes at least a problem focused history and straight forward medical decision making, as defined by the current version of the Current Procedural Terminology (CPT) manual."

However, BCBSNC will not reimburse the following:

- Telemedicine that occurs the same day as a face to face visit, when performed by the same provider and for the same condition.
- Services performed via asynchronous communications systems, except for online medical evaluations.
- Services performed via telephonic (audio only) consultations. (See Section "Benefits Application" regarding availability of member benefits for telephonic services.)
- Triage to assess the appropriate place of service and/or appropriate provider type.
- Patient communications incidental to E/M, counseling, or medical services covered by this policy, including, but not limited to:
    - Reporting of test results
    - Provision of educational materials
- Administrative matters, including but not limited to, scheduling, registration, updating billing information, reminders, requests for medication refills or referrals, ordering of diagnostic studies, and medical history intake completed by the patient.
- New and established outpatient E/M and outpatient consultation E/M services performed without an intervening provider present with the patient, except as reimbursed under online medical evaluations.
- Online medical evaluations occurring more than once within 7 days for the same episode of care and rendered by the same health care provider.
- Online medical evaluations that occur within 7 days after a face-to-face evaluation and management service performed by the same provider for the same condition, whether provider requested or unsolicited patient follow-up.

In addition, the policy contains guidelines around security and confidentiality, licensing, billing, coding, prescription of controlled substances, etc.[62]

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[62] Blue Cross Blue Shield of North Carolina. (2016). Corporate Reimbursement Policy Telehealth (pp. 1-7). Retrieved from https://www.bcbsnc.com/assets/services/public/pdfs/medicalpolicy/telehealth.pdf

2. **Cigna** states that telehealth services "encompass the delivery of health-related services and information through telecommunications technologies to improve a patient's clinical health status. Telehealth includes a growing variety of applications and services using two-way video, smart phones, wireless devices, and other forms of video telecommunications technology. Telehealth is not a medical specialty in itself but a healthcare delivery modality, which is expected to increase access and decrease the cost of delivering care." Assuming that medically necessity standards are met, Cigna has additional expectations, including:
    - "To provide a safe telehealth environment, providers are expected to follow the same professional judgment and ethical principles as they would in "face-to-face" visits, including when and how they choose to employ these technologies. Providers are expected to consider the patient's condition, circumstances, available resources, and their own comfort level and expertise when using telehealth.
    - Providers need to be aware of all relevant state and federal laws related to the use of telehealth to include those that govern prescribing and the establishment of a doctor-patient relationship. In addition, providers need to be aware of relevant practice guidelines developed by the specialty societies as they relate to both in-person and telehealth practices, [ensuring] that they are appropriately licensed to provide services in each state where patients are physically located at the time of treatment.
    - Following every visit, the provider is expected to document and communicate the outcome of the encounter to the patient's primary care provider or other specialty providers using secure methods (e.g., fax, secure email, transmit to EMR), as well as to the patient, unless the patient has not given consent for that communication.
    - Telephonic sessions are not considered to be medically necessary or appropriate as a substitute for face-to-face or video therapy visits. Without a face to face (or video) examination, a phone call alone does not allow for a proper exam and the legally/medically proper physician-patient relationship."[63]
3. **UnitedHealthcare's** telemedicine policy adopts the originating sites and authorized practitioners from the CMS policy. In addition, UnitedHealthcare "will reimburse for Telehealth services which are recognized by CMS when reported with modifier GT (Interactive Telecommunications)."[64]
4. **NC Deparment of Insurance** As the regulating agency of the insurance industry in our state, DOI believes the following issues should be considered as it may relate to the commercial market :
    - Telemedicine regulation in the delivery of Medicaid benefits should not be directly imposed on the commercial insurance community
    - A state telehealth/telemedicine policy needs to be fluid enough to evolve with innovation.
    - A telehealth/telemedicine policy needs to encourage market competition and allow carriers the flexibility to realize efficiencies.

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[63] Cigna. (2017). CIGNA Standards AND Guidelines/Medical Necessity Criteria For Treatment of Mental Health and Substance Use Disorders (pp. 51-52). Retrieved from https://cignaforhcp.cigna.com/public/content/pdf/resourceLibrary/behavioral/2017_CBH_SGandMNC-Final.pdf

[64] UnitedHealthcare. (2017). Telemedicine Policy (pp. 1-3). Retrieved from https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesHtml/ReimbursementPolicies/Telemedicine-2017.pdf

Specific caution should be given when considering private payor requirements for Medicaid services potentially shifting to regulation of the commercial market and will require additional review.

VIII. The Road to Adoption

A. Best Practices in Broadband Internet

1. IT Infrastructure for Telemedicine Programs

Depending on the form of telemedicine used in services, telemedicine programs must have an information technology (IT) infrastructure that can properly support the need for data collection, storage, and transmission. This infrastructure often involves a combination of broadband internet connection, electronic health records, and health information exchange (HIE) systems.

To provide necessary speeds to transfer data, the internet connection supporting a telemedicine program needs to have sufficient bandwidth, which is the capacity for data transfer.

> ***For a telemedicine program using Live Video Conferencing, the University of Arkansas for Medical Services recommends a broadband internet connection with a minimum bandwidth of 1 Mbps (megabits per second) download speed and 384 Kbps (kilobits per second) upload speed.[65] Having sufficient bandwidth helps to ensure a clear, uninterrupted picture during the video conference. This bandwidth recommendation is in line with the Federal Communications Commission (FCC)'s guidelines for broadband speed.[66]***

Since telemedicine transmits data electronically, electronic health records (EHRs) are necessary to facilitate the capture of documentation and automate data collection. This is especially important in telemedicine because the consulting practitioner is not located in the same place as the patient.

- EHR products need to be able to share information between originating sites and distant sites without issues.
- Some EHR products are interoperable, meaning that they use similar protocols for messaging and processing information that enable them to share information seamlessly.[67]

The diverse array of EHR products is not always interoperable. In these cases, EHRs must exchange data through protocols approved by the Office of National Coordinator for Health Information Technology (ONC-HIT).

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[65] Hall-Barrow, Julie. (n.d.). Telemedicine Toolbox. Retrieved August 16, 2017, from http://www.uams.edu/saves/Telemedicine%20Toolbox.pdf

[66] Broadband Speed Guide. (n.d.). Retrieved September 6, 2017, from https://www.fcc.gov/reports-research/guides/broadband-speed-guide

[67] What is EHR Interoperability and why is it important? (n.d.). Retrieved August 16, 2017, from https://www.healthit.gov/providers-professionals/faqs/what-ehr-interoperability-and-why-it-important

- One method of information exchange is to set up a central repository for clinical data, which can then transmit the information to many EHRs when needed. This system is a Health Information Exchange (HIE).[68]
- **NC General Statute 90-414.7** created a statewide HIE for virtually all providers in North Carolina to connect to one another. Known as NCHealthConnex, the system is now connected to over 800 facilities with more in process.[69]

As an example, a telemedicine program using Live Video Conferencing would require equipment (such as a screen, camera, microphone, etc.) for both the originating site and distant site. The equipment would need:

- HIPAA-compliant software using appropriate safeguards, such as data encryption.
- Broadband internet connection with a minimum speed of 1 Mbps download, 384 Kbps upload to ensure a clear, uninterrupted picture during the video conference.
- To ensure the originating and distant sites have access to inputting and receiving documentation of the visit, they would need to either:
    - Be connected to the same or interoperable electronic health record (EHR) systems or
    - Have a system in place to transmit data securely using protocols approved by the Office of National Coordinator for Health Information Technology (ONC-HIT). An example of the latter would be NC HealthConnex, North Carolina's statewide HIE.

2. *IT Infrastructure to Support Direct Patient Access and Support Direct Patient Access and Participation*

A high-speed broadband internet connection is required to transmit data, live video, and image files from one location to another. To provide telemedicine services to patients in hospitals, outpatient clinics, community anchor points (e.g. public libraries and schools), and in their own homes, all of these locations must have access to a high-speed internet connection.

- There are more than 400,000 households in North Carolina without access to high-speed internet.
- The North Carolina Office of Broadband Infrastructure released a 2017 Broadband Plan with the goal for "every North Carolinian to have affordable access to broadband service." The plan made several recommendations to accomplish this goal, including:
    - "Incentivize investment in next-generation, future-proof infrastructure and reduce barriers to deployment
    - Create community-based adoption and utilization programs and initiatives
    - Close the 'homework gap' for K-12 students without access at home
    - Facilitate integration of broadband into economic development strategies

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[68] Official Information about Health Information Exchange (HIE). (n.d.). Retrieved August 22, 2017, from https://www.healthit.gov/HIE

[69] NC Health Information Exchange Authority. (n.d.). Retrieved August 22, 2017, from https://hiea.nc.gov/

- Recognize and leverage the influence telehealth technologies have on household broadband adoption and use
- Enhance public safety and first responder connectivity, by continuing the pursuit of a state-wide, interoperable data network and the Next-Generation 911 Initiative."[70]

B. Best Practices in Reimbursement

States have the option to determine whether to cover telehealth services, what types of telehealth and which specific procedures to cover, where in the state it can be covered, how it is provided, what types of practitioners may be reimbursed as long as they are qualified as Medicaid providers according to Medicaid regulations, and how much to reimburse for specific telehealth services as long as the payments do not exceed federal upper limits for reimbursement.

- Under Medicaid, "states may reimburse the physician or other licensed practitioner at the distant site and reimburse a facility fee to the originating site.
- States can also reimburse any additional costs such as technical support, transmission charges, and equipment. These add-on costs can be incorporated into the fee-for-service rates or separately reimbursed as an administrative cost by the state. If they are separately billed and reimbursed, the costs must be linked to a covered Medicaid service."[71]

As of April 2017, 48 states and the District of Columbia have some form of reimbursement for telehealth under their Medicaid program. Only Massachusetts and Rhode Island do not have definitive reimbursement policies for Medicaid coverage of telehealth services.[72]

- Although there has been some increase in the past year in states covering Store and Forward and Remote Patient Monitoring, utilization and reimbursement for Live Video Conferencing is far more widespread across state Medicaid programs.
- Medicaid programs in eight states (Alaska, Arizona, Illinois, Minnesota, Mississippi, Missouri, Virginia and Washington) reimburse for all three telehealth delivery methods.

While Medicaid coverage for specific services delivered via telehealth varies from state to state, many state Medicaid programs follow the example of Medicare regarding reimbursement and provider parity.

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[70] Connecting North Carolina: State Broadband Plan. (2017). https://ncbroadband.gov/wp-content//uploads/2017/02/NC-Broadband-Plan_2017_Online_FINAL_PNGs3www.pdf

[71] Department of Health and Human Services, Centers for Medicare & Medicaid Services, Medicaid.Gov Website, Medicaid Benefits: Telemedicine. (n.d.). Retrieved September 1, 2017, from https://www.medicaid.gov/medicaid/benefits/telemed/index.html

[72] State Telehealth Laws and Reimbursement Policies, A Complete Scan of the 50 States and District of Columbia, Center for Connected Health Policy, The National Telehealth Policy Resource Center. (April 2017). Retrieved August 30, 2017, from http://www.cchpca.org/sites/default/files/resources/50%20STATE%20PDF%20FILE%20APRIL%202017%20FINAL%20PASSWORD%20PROTECT.pdf

- Generally, Medicaid programs reimburse for services provided via telehealth at the same rates as those delivered in-person.
- Staff at the Center for Connected Health Policy was contacted and report that they are "unaware of any state that pays for telemedicine services at a different rate than in-person services."[73]

Blue Cross Blue Shield, Aetna, Cigna and other private payers are not required under federal law to provide coverage for any type of telemedicine.

Some states have passed laws that affect private payers' telehealth reimbursement policies. "As of September 2016, 32 states have passed private payer parity laws,"[74] but just a few states require payment parity, that the telemedicine encounter be reimbursed at the same rate as an in-person encounter.

- States' private payer parity laws have many coverage limitations, such as only reimbursing for live video encounters. Some also include the caveat that telemedicine must be covered but is subject to the terms and conditions of the contract between the enrollee and payer.
- No two private payer parity laws are the same
- Some states only require parity of benefits, while others require parity of reimbursement at the same level as in-person care[75]

The Center for Connected Health Policy is conducting a study to assess and describe telehealth private payer parity laws, assess the relative impact the laws have had on private and public payers, and develop recommendations for improving private payer parity laws.

- Before 2010, only eight states had private payer parity laws. Since 2010, 25 states have passed private payer parity laws. "While such legislation has gained momentum and popularity, there has not been any comprehensive analysis of the impact of these laws related to the expanded use and payment for telehealth services.
- Many of the private payer parity laws fail to address the impact on its Medicaid program, and whether these requirements extend to private payers that serve Medicaid patients." [76]

Federal legislation is also pending to address these issues. "Congress is reconsidering a nationwide telehealth coverage bill, named the Medicare Telehealth Parity Act of 2017[77], designed to introduce an incremental, though

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[73] Personal email communication from Christine Colouro, Program Associate II, Center for Connected Health Policy, to Glenn Field, North Carolina Office of Rural Health, received 08/28/2017 at 5:32 p.m.

[74] Ibid.

[75] Telehealth Resource Centers, Reimbursement: Private Payer Law. (n.d.). Retrieved September 1, 2017, from https://www.telehealthresourcecenter.org/toolbox-module/private-payer-law

[76] Assessing the Impact of Telehealth Private Payer Laws across States, Center for Connected Health Policy, The National Telehealth Policy Resource Center. (n.d.). Retrieved September 1, 2017, from http://www.cchpca.org/assessing-impact-telehealth-private-payer-laws-across-states

[77] H.R.2550 - Medicare Telehealth Parity Act of 2017 (2017). Retrieved September 5, 2017, from https://www.congress.gov/bill/115th-congress/house-bill/2550/text/ih?overview=closed&format=xml

significant, expansion of coverage for telehealth services under the Medicare program." The bipartisan Act is sponsored by Representative Mike Thompson (D-CA), with seven co-sponsors to date (four Republican, three Democrat). If enacted, the Act would modernize the way Medicare reimburses telehealth services by expanding the number of qualifying geographic locations and expanding coverage of telehealth services under Medicare incrementally in three phases. Key provisions of the proposed Act include:

- Expanding qualifying originating sites to include all federally qualified health centers and all rural health clinics;
- Qualifying geographic location also includes counties in Metropolitan Statistical Areas with populations fewer than 50,000;
- Expanding telehealth coverage to include services provided by certified diabetes educators, respiratory therapists, audiologists, occupational therapists, speech language therapists, and physical therapists;
- Expanding qualifying originating sites to include a home telehealth site, and the qualifying originating geographic location include counties in Metropolitan Statistical Areas with populations of 50,000-100,000;
- Expanding qualifying originating geographic locations to include counties in Metropolitan Statistical Areas with populations above 100,000;
- Medicare coverage of remote patient monitoring services (RPM) for covered chronic care conditions, and home dialysis services for those with end stage renal disease;
- Authorizes the Centers for Medicare & Medicaid Services to develop and implement new payment methods for these telehealth services.

"The introduction of the Medicare Telehealth Parity Act of 2017, coupled with other telehealth related bills and the creation of the Congressional Telehealth Caucus, represents continued progress towards expanded telehealth coverage and hopefully portends increasing support for and understanding of telehealth benefits among federal lawmakers."[78]

C. Best Practices in Workforce and Licensing

As discussed in **Section VI** of this document, many states are participating in the Interstate Medical Licensure Compact (IMLC). Developed by the Federation of State Medical Boards (FSMB) the IMLC is designed to provide an expedited process with fewer administrative burdens for qualified physicians seeking licensure in multiple states.

- The IMLC will help to increase "access to health care for patients in underserved or rural areas and allowing them to more easily connect with medical experts through the use of telemedicine technologies."[79]

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[78] Lacktman, Nathaniel M. Ferrante, Thomas S. "Is Telemedicine Change Coming to Congress? The Medicare Telehealth Parity Act of 2017 Among Several New Federal Bills." (2017). Retrieved September 1, 2017, from https://www.healthcarelawtoday.com/2017/07/10/is-telemedicine-change-coming-to-congress-the-medicare-telehealth-parity-act-of-2017-among-several-new-federal-bills/

[79] Interstate Medical Licensure Compact Homepage, The IMLC. (n.d.). Retrieved August 29, 2017, from https://imlcc.org/

- The Compact also strengthens public safety by facilitating participating states' ability to share investigative and disciplinary information. Regulatory authority will remain with the participating state medical boards, rather than being delegated to the Compact or any entity administering the Compact.
- Participation in the IMLC is voluntary for both physicians and state boards of medicine licensure.
- States participating in the Compact can act as a primary state for licensure and source of verification for background checks through the Compact. "Under this agreement licensed physicians can qualify to practice medicine across state lines within the Compact if they meet the agreed upon eligibility requirements.
- Approximately 80% of physicians meet the criteria for licensure through the IMLC." [80]
- Updates on states with compact legislation pending, member states issuing licenses, and member states issuing licenses and Letters of Qualification for expedited licensure can be tracked state-by-state in the interactive map at The Interstate Medical Licensure Compact website at https://imlcc.org/.

State Medical Boards may also create separate licenses for telemedicine providers. The first telemedicine license was issued in Tennessee in 1998. However, effective on October 31, 2016, the Tennessee Medical Board discontinued issuing new telemedicine licenses.

- Those holding a Tennessee telemedicine license have the option to convert it to a full Tennessee medical license without cost if he or she submits an application to the Board by October 31, 2018.
- The Tennessee Medical Board also revised its telemedicine rules to more clearly reflect modern day telemedicine.
- The revised rules emphasize that telemedicine is the practice of medicine and prohibit tele-medicine providers from being held to a stricter standard of care. Pursuant to Tenn. Code Ann. § 63-1-155(c)(1)(A), "A healthcare provider who delivers services through the use of telehealth shall be held to the same standard of professional practice as a similar licensee of the same practice area of specialty that is providing the same healthcare services through in-person encounters."[81]

Several pieces of federal legislation are also pending to help address workforce issues and encourage the adoption of telemedicine:

- **The CONNECT Act (S. 1016 – CONNECT for Health Act of 2017)** -Expands access to telehealth by making a series of exceptions to the restrictions around telehealth currently in Medicare, including the originating site, geographic, provider, and service restrictions for ACOs, waivers, mental health services, Medicare Advantage and bundled and global payments.
    - It allows for the reimbursement for remote patient monitoring services when they are in combination with chronic or transitional care management services.

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[80] Zimmerschied, Caleb. "Cross-state Licensing Process Now Live in 8 States," AMA Wire, May 8, 2017. Retrieved August 31, 2017, from https://wire.ama-assn.org/life-career/cross-state-licensing-process-now-live-8-states.

[81] Revised Telemedicine Rules Assigned Effective Date of October 31, 2016, Tennessee Department of Health Board of Medical Examiners Annual Newsletter. (2016). Retrieved August 30, 2017, from https://www.tn.gov/assets/entities/health/attachments/Fall_2016_Newsletter.pdf (Accessed 08/30/2017)

- Additional sections eliminate some of the geographic or originating site restrictions on FQHCs, facilities operated by Indian Health Services, stroke care and ESRD services.[82]

- **H.R. 1152 – Care Veterans Deserve Act of 2017-** Allows a licensed healthcare professional to practice using telemedicine in any state under the VA program.[83]
- **H.R. 2123 – VETS Act of 2017-** Allows health care professionals who are employed by, or have contracts with the Department of Veterans Affairs to be able to treat VA patients in any state using telemedicine, even if neither the provider nor the patient is physically located in a facility owned by the federal government.[84]
- **H.R. 3360 – Telehealth Enhancement Act of 2017-**Adds urban critical access hospitals, sole community hospitals, home telehealth sites, and counties with fewer than 25,000 people as eligible for Medicare payments for telemedicine.[85]

D. Supporting the Telemedicine Workforce in Rural Communities

North Carolina State Loan Repayment-To help increase access to care in rural and underserved communities, the North Carolina Office of Rural Health (NC ORH) administers a State Loan Repayment Program (SLRP) for eligible providers who choose to work in designated areas of the state.

- **In Session Law 2017-57**, the NCGA, defined "expansion of the State Loan Repayment Program to include eligible providers residing in North Carolina who use telemedicine in rural and underserved areas."[86]
    - This expansion allows the state to incentivize providers who commit a portion, or all of, their time to serving rural and underserved areas through telemedicine services.
    - This incentive may support the sustainability of telemedicine programs by decreasing workforce turnover.

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[82] S.1016 - CONNECT for Health Act of 2017 (2017). Retrieved September 5, 2017, from https://www.congress.gov/bill/115th-congress/senate-bill/1016

[83] H.R. 1152 – Care Veterans Deserve Act of 2017. (2017). Retrieved September 5, 2017, from https://www.congress.gov/bill/115th-congress/house-bill/1152

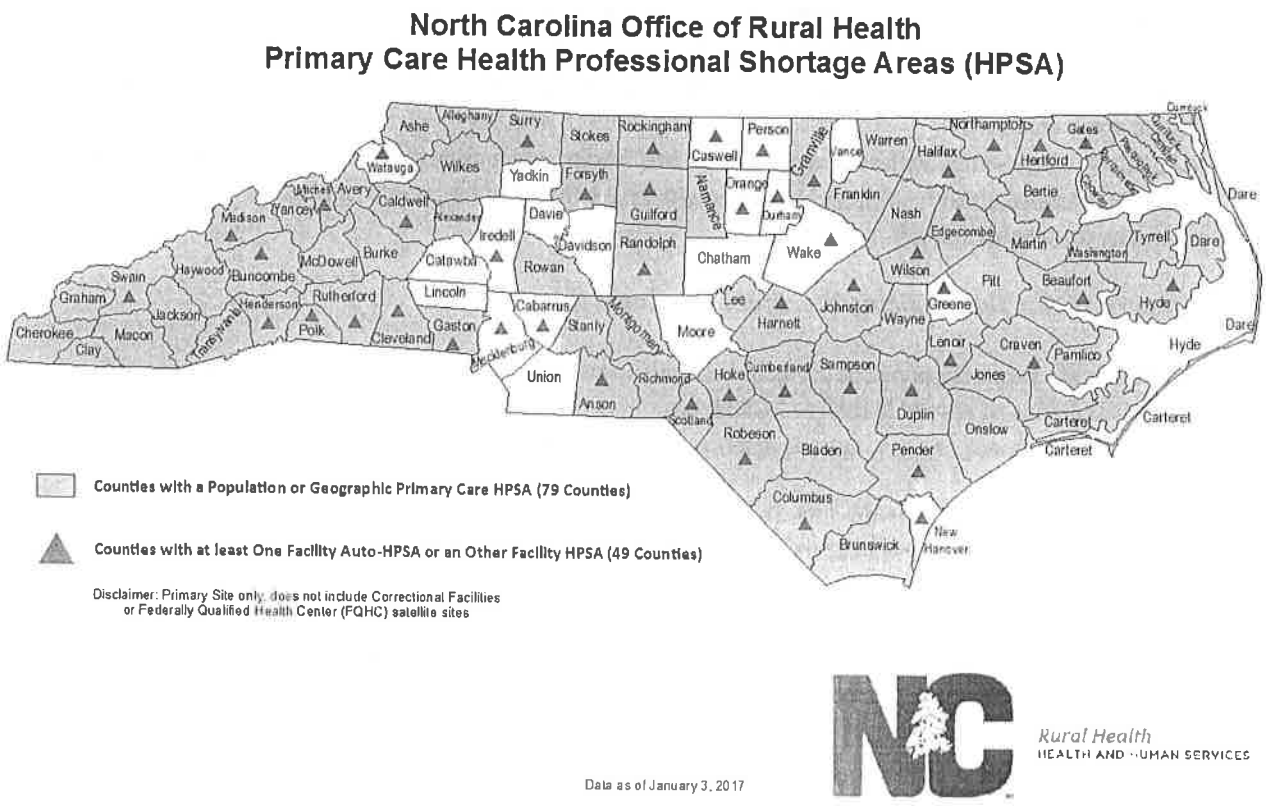
[84] H.R. 2123 – VETS Act of 2017. (2017). Retrieved September 5, 2017, from https://www.congress.gov/bill/115th-congress/house-bill/2123

[85] H.R. 3360 – Telehealth Enhancement Act of 2017. (2017). Retrieved September 5, 2017, from https://www.congress.gov/bill/115th-congress/house-bill/2123

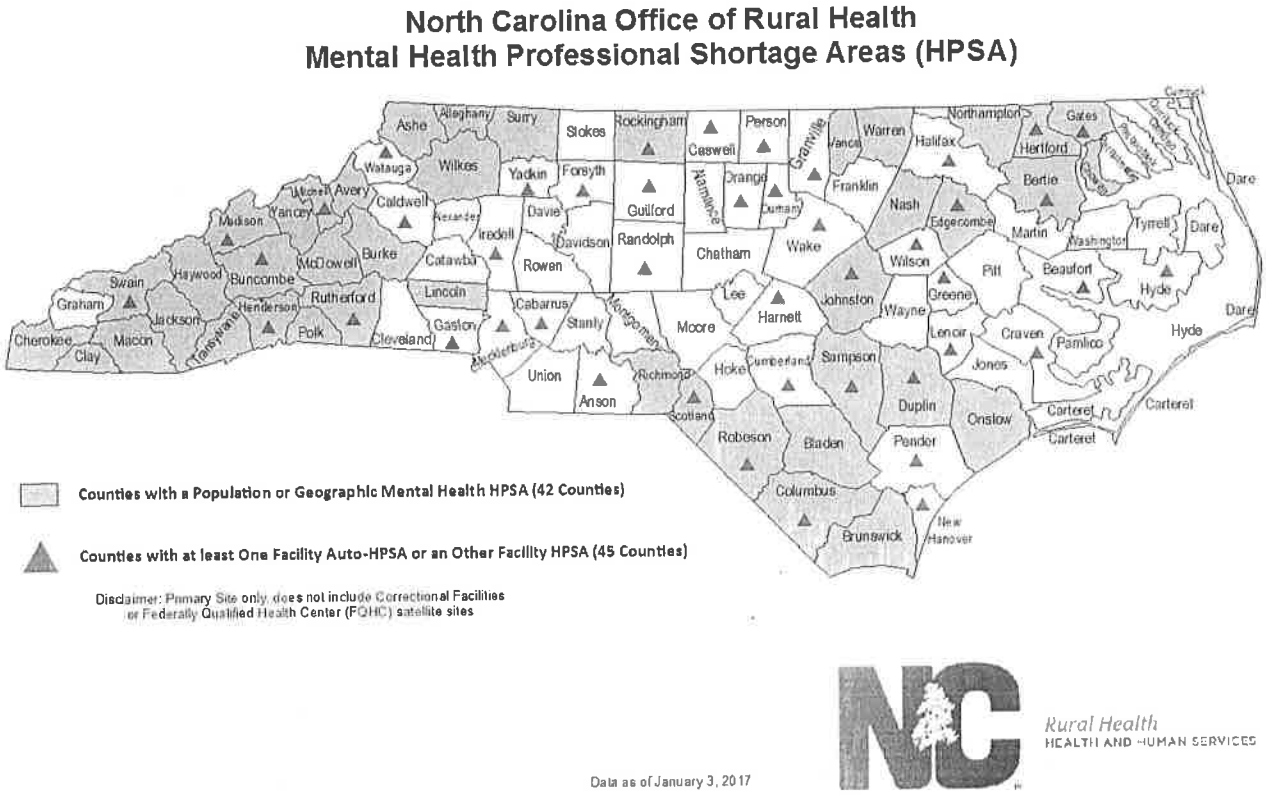
[86] North Carolina Session Law 2017-57 (2017). Sec 11A.9.

IX. Appendix

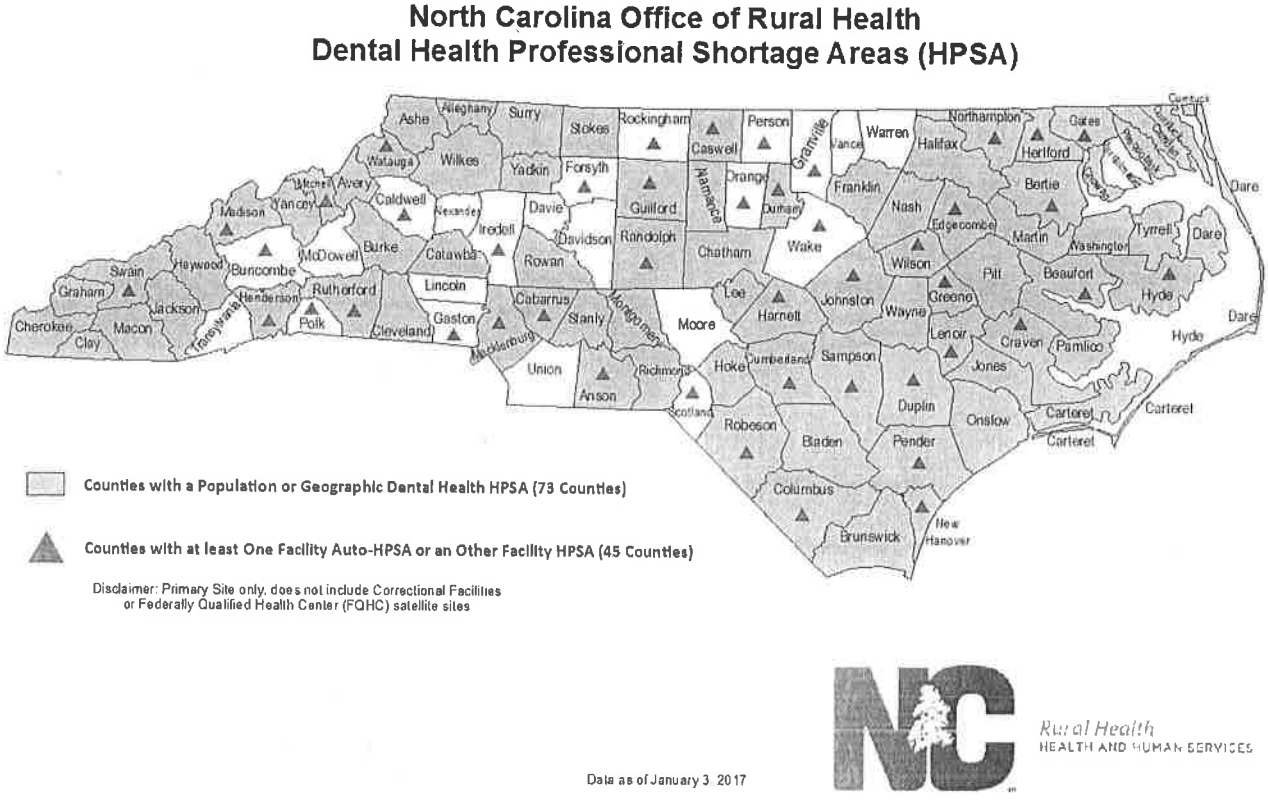
A. Figure 1: North Carolina Primary Care Health Professional Shortage Areas



B. *Figure 2: North Carolina Mental Health Professional Shortage Areas*



C. *Figure 3: North Carolina Dental Health Professional Shortage Areas*



JOINT LEGISLATIVE COMMITTEE
ON HEALTH AND HUMAN SERVICES

The Opioid Epidemic: The State of the State

Dr. Mandy Cohen, Dr. Susan Kansagra
Department of Health and Human Services

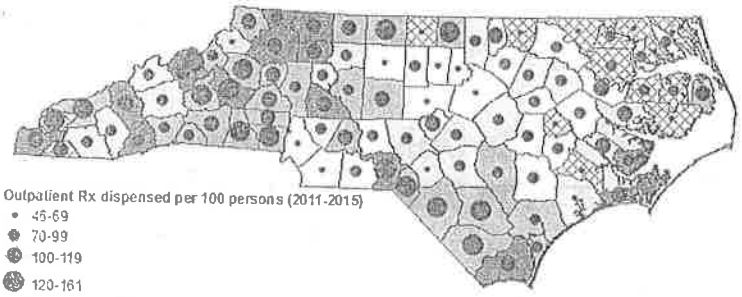
Nov. 14, 2017

3 PEOPLE DIE EACH DAY FROM OPIOID OVERDOSE IN NC

Source: Average daily deaths using N.C. State Center for Health Statistics, Vital Statistics-Deaths, 2015-2016.

Rates of Unintentional/Undetermined Prescription Opioid Overdose Deaths & Outpatient Opioid Analgesic Prescriptions Dispensed

North Carolina Residents, 2011-2015



Average mortality rate: 6.4 per 100,000 persons

Average dispensing rate: 82.9 Rx per 100 persons

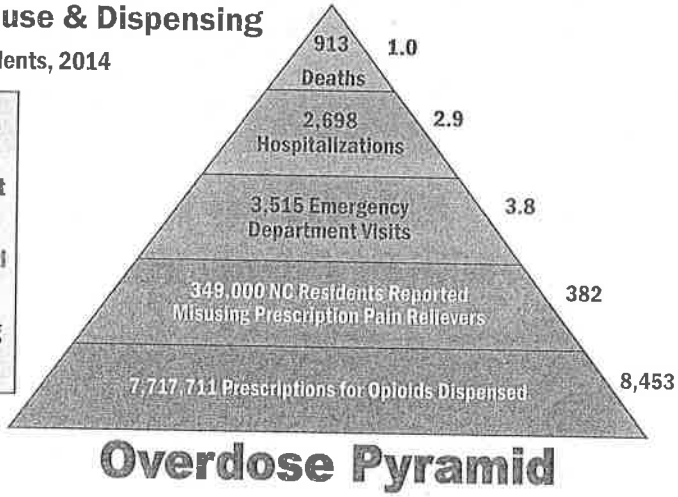
Source: Deaths- N.C. State Center for Health Statistics, Vital Statistics, 2011-2015, Overdose: (X40-X44 & Y10-Y14) and commonly prescribed opioid T-codes (T40.2 and T40.3)/Population-National Center for Health Statistics, 2011-2015/Opioid Dispensing- Controlled Substance Reporting System, NC Division of Mental Health, 2011-2015
Analysis: Injury and Epidemiology Surveillance Unit

North Carolina Injury & Violence PREVENTION Branch

Opioid Deaths, Hospitalizations, ED Visits, Misuse & Dispensing

North Carolina Residents, 2014

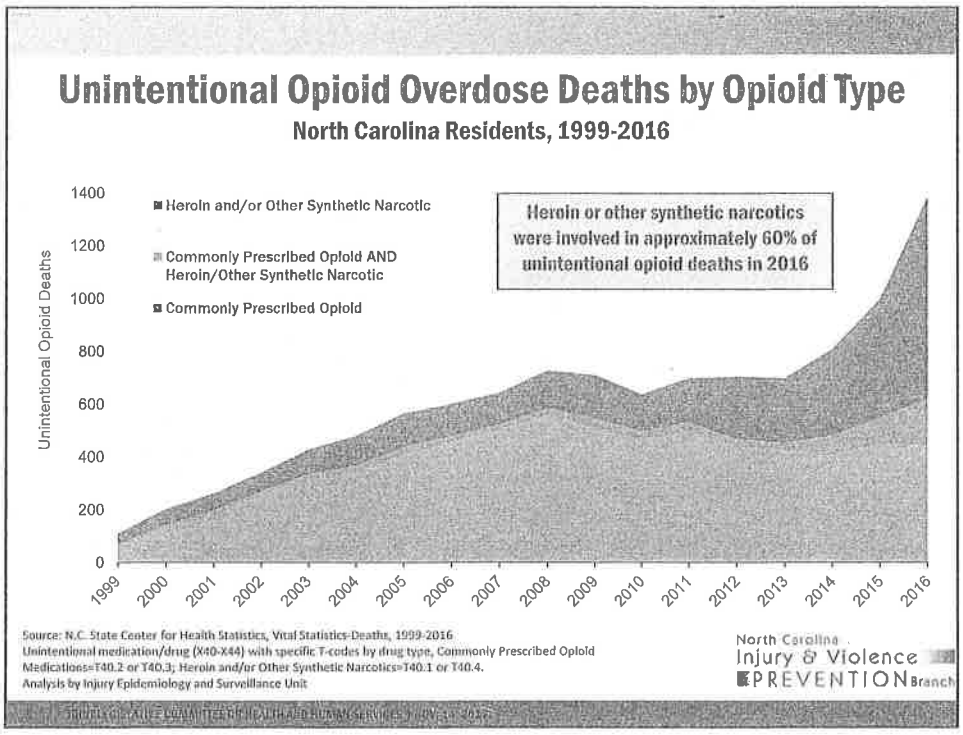
In 2014, for every 1 opioid overdose death, there were just under 3 hospitalizations and nearly 4 ED visits due to medication or drug overdose.

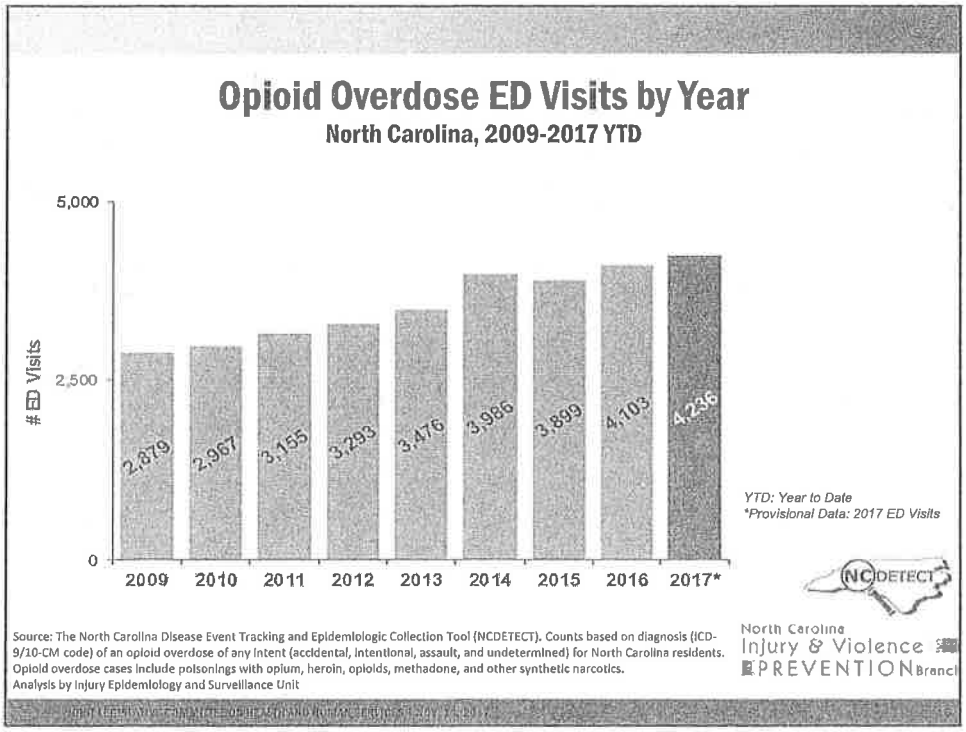


Overdose Pyramid

Source: Deaths-N.C. State Center for Health Statistics, Vital Statistics, 2014/ Hospitalizations-N.C. State Center for Health Statistics, Vital Statistics, 2014/ED-NC DETECT, 2014/ Misuse-NSDUH 2013-2014/Prescriptions-CSRS, 2014/
Analysis by Injury Epidemiology and Surveillance Unit

North Carolina Injury & Violence PREVENTION Branch


Unintentional Opioid Overdose Deaths by Opioid Type
North Carolina Residents, 1999-2016
Heroin and/or Other Synthetic Narcotic
Commonly Prescribed Opioid AND Heroin/Other Synthetic Narcotic
Commonly Prescribed Opioid
Heroin or other synthetic narcotics were involved in approximately 60% of unintentional opioid deaths in 2016
Unintentional Opioid Deaths
1400
1200
1000
800
600
400
200
0
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
Source: N.C. State Center for Health Statistics, Vital Statistics-Deaths, 1999-2016
Unintentional medication/drug (X40-X44) with specific T-codes by drug type, Commonly Prescribed Opioid Medications=T40.2 or T40.3; Heroin and/or Other Synthetic Narcotics=T40.1 or T40.4.
Analysis by Injury Epidemiology and Surveillance Unit
North Carolina
Injury & Violence
PREVENTION Branch


Opioid Overdose ED Visits by Year
North Carolina, 2009-2017 YTD
ED Visits
5,000
2,500
0
2,879
2,967
3,155
3,293
3,476
3,986
3,899
4,103
4,296
2009
2010
2011
2012
2013
2014
2015
2016
2017*
YTD: Year to Date
*Provisional Data: 2017 ED Visits
NCDETECT
Source: The North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NCDETECT). Counts based on diagnosis (ICD-9/10-CM code) of an opioid overdose of any intent (accidental, intentional, assault, and undetermined) for North Carolina residents. Opioid overdose cases include poisonings with opium, heroin, opioids, methadone, and other synthetic narcotics.
Analysis by Injury Epidemiology and Surveillance Unit
North Carolina
Injury & Violence
PREVENTION Branch

Opioid Overdose ED Visits by Insurance Coverage
2017 YTD

Insurance Coverage	
Private Insurance	14%
Medicaid/Medicare	27%
Uninsured/Self-pay	50%
Other/Unknown	9%

Data Source: The North Carolina Disease Event Tracking and Epidemiologic Collection Tool (NCDETECT). Counts based on diagnosis (ICD-9/10-CM code) of an opioid overdose of any intent (accidental, intentional, assault, and undetermined) for North Carolina residents. Opioid overdose cases include poisonings with opium, heroin, opioids, methadone, and other synthetic narcotics.

N.C.'s Response Coordination

Many organizations* across NC are addressing the opioid overdose epidemic.



*Logos not all inclusive

JOINT LEGISLATIVE COMMITTEE ON HEALTH AND HUMAN SERVICES | NOV. 14, 2017

North Carolina Injury & Violence PREVENTION Branch

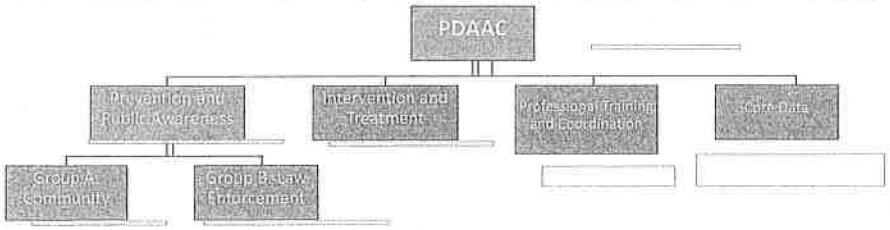
9

Opioid and Prescription Drug Abuse Advisory Committee

Mandated Coordination of State Response to the Opioid Epidemic

2015 Session Law 241 mandates

State strategic plan • DHHS creates PDAAC • Annual report to General Assembly



- Meets quarterly
- 5 work groups & action plans
- 150+ participate
- State agencies, partner organizations working on the opioid epidemic

NC Opioid Action Plan Strategies

- Reduce oversupply of prescription opioids
- Reduce diversion of prescription drugs and flow of illicit drugs
- Increase community awareness and prevention
- Make naloxone widely available and link overdose survivors to care
- Expand access to treatment and recovery oriented systems of care
- Measure our impact and revise strategies based on results

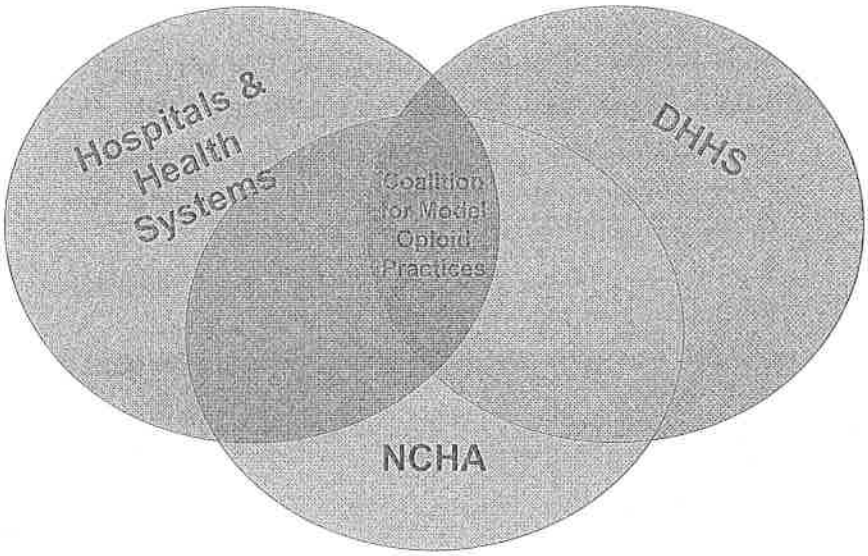
https://www.ncdhhs.gov/opioids

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https://www.ncdhhs.gov/opioids

Coalition for Model Opioid Practices



STOP Act - Prescriber Provisions

- Limits **first-time** prescriptions of targeted controlled substances for **acute pain** to **≤5 days**
- Prescriptions following a surgical procedure limited to **≤7 days**
- Allows follow-up prescriptions as needed for pain
- Limit does not apply to controlled substances to be wholly administered in a:
  - hospital, nursing home, hospice facility, or residential care facility
- Dispensers not liable for dispensing a prescription that violates this limit

Effective January 1, 2018

Payers Council

- Will bring together public and private payers to identify, align, and implement policies that:
  - –Support providers in judicious prescribing of opioids;
  - –Promote safer and more comprehensive alternatives to pain management;
  - –Improve access to naloxone, substance use disorder treatment and recovery supports; and
  - –Engage and empower patients in the management of their health.
- First meeting in December

Medicaid pharmacy benefit changes

- In August, implemented prior approval for opioid analgesic doses which:
  - –Exceed 120 mg of morphine equivalents per day
  - –Are greater than a 14-day supply of any opioid, or,
  - –Are non-preferred opioids on the NC Medicaid Preferred Drug List (PDL)

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https://www.ncdhhs.gov/opioids

New Partnership

HIDTA (High Intensity Drug Traffic Area)

- Coalitions funded by White House Drug Coordinating Office and CDC/DEA
- In NC, has created public safety/public health collaboration
- Providing new reports using ED data to move from passive to active outbreak surveillance



North Carolina Injury & Violence PREVENTION Branch

Synthetic Opioid Control Act (SB-347 / HB 464)

- Synthetic Opioid & Other Dangerous Drug Control Act lists all known fentanyl derivatives as controlled substances and by creating a new "catch-all" provision describing the chemical backbone structure of the fentanyl molecule in order to capture any future fentanyl derivative that may be encountered here.
- Various other changes to update and modernize controlled substance act, at request of law enforcement.

NC Opioid Action Plan Strategies

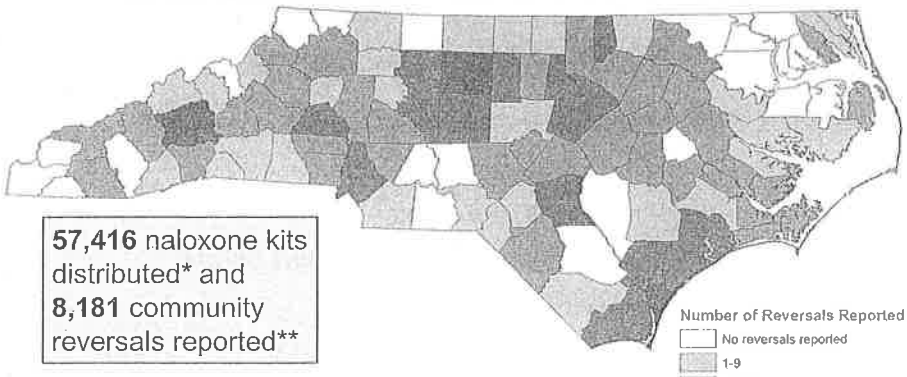
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https://www.ncdhhs.gov/opioids

Naloxone Distribution

- DHHS purchased and distributed nearly 40,000 units of naloxone in October.
- Distribution via opioid treatment programs, NC Harm Reduction Coalition, EMS agencies/first responders, and other community partners

2013 Good Samaritan/Naloxone Access Law
Opioid Overdose Reversals with Naloxone Reported to the North Carolina Harm Reduction Coalition, 8/1/2013-9/30/2017



57,416 naloxone kits distributed* and **8,181** community reversals reported**

*87 kits distributed in an unknown location in North Carolina and 14 kits distributed to individuals living in states outside of North Carolina; includes 4,577 kits distributed to Law Enforcement Agencies

**21 reversals in an unknown location in North Carolina and 134 reversals using NCHRC kits in other states reported to NCHRC

Source: North Carolina Harm Reduction Coalition (NCHRC), October 2017
Analysis by Injury Epidemiology and Surveillance Unit

North Carolina Injury & Violence PREVENTION Branch

NC Opioid Action Plan Strategies

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https://www.ncdhhs.gov/opioids

Opioid STR Grant Funding

- $2,728,727 in CURES grant expenditures from 07/01/17 -10/24/17 through the LME/MCOs
- Types of services provided include:
  - non-hospital medical detox
  - individual and group therapies
  - opioid treatment (medication administration)
  - intensive outpatient treatment
  - group/supervised living (supportive, recovery housing)
  - recovery supports

ECHO Project Pilot

- DHHS funding UNC to offer for providers:
  - Free DATA – 2000 training
  - Weekly case-based learning ECHO clinic
  - In office support for providers interested in training and strategy support for medical assistants, nurses, and office staff in their practices.
  - One to one provider case consultation
- Working on an expansion of access to the ECHO clinic, DATA-2000 training, and CME credits to providers in all 100 counties.

Medicaid pharmacy benefit changes

- In November, prior authorization removed for suboxone film.
  - –Suboxone is a prescription drug used for Medication-Assisted Treatment (MAT)
  - –Allows quicker access for patients who are ready to commit to treatment

NC Opioid Action Plan Strategies

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- Measure our impact and revise strategies based on results

https://www.ncdhhs.gov/opioids

North Carolina has achieved some successes...

AND has more work to do.

JOINT LEGISLATIVE COMMITTEE
ON HEALTH AND HUMAN SERVICES

Controlled Substance Reporting System

Charles Carter
Department of Health and Human Services

Nov. 14, 2017

Future State

- Upgraded CSRS Functionality:
  - Immediate interstate connectivity for two-way controlled substance data exchange with the majority of states and territories
  - Electronic Health Record (EHR) integration with all NC providers at no cost to the providers
  - New capabilities consistent with HIE/GDAC advanced analytics roadmap in alignment with opioid addiction programs
  - Deployment of industry standard solution which reduces implementation complexity

Steps to Achieve Future State

- CSRS vendor contract extension
- Execute MOU with the National Association of Boards of Pharmacy (NABP) for interstate connectivity
- Procure vendor that fully meets CSRS goals established by the General Assembly
- Develop process to integrate all provider's EHR to new platform
- Train dispensers and providers on new platform

DOROTHEA DIX HOSPITAL PROPERTY FUNDS - PROVISION SUMMARY

Intent of General Assembly	To increase inpatient behavioral health bed capacity in rural areas of the State with the highest need	
	To increase the number of facility-based crisis centers in North Carolina for children and adolescents	
	S.L. 2016-94, Sec 12F.4	**S.L. 2017-57, Sec 11F.5**
Funding	IP beds construction or conversion - $18 million NR; SFY 16-17	IP beds construction or conversion - $17 million NR; SFY 17-18
	Child/Adolescent facility based crisis - $2 million NR, SFY 16-17	Child/Adolescent facility based crisis - $2 million NR; SFY 17-18
Allocation of Funding		
Inpatient Beds	DHHS awards at least 1 hospital in each of three State regions to receive funds	Up to $4 million - UNC Caldwell
		Up to $4 million - Cape Fear Valley Medical Center
		Up to $4 million - Mission Health System
		Up to $3 million - Good Hope Hospital
		Up to $2 million - Onslow County Dix Crisis Intervention Center
Facility Based Crisis	Competitive Bid - up to two new facility-based crisis centers for children and adolescents	Competitive Bid - up to two new facility-based crisis centers for children and adolescents
Naming of Beds	Named in honor of Dorothea Dix	Named in honor of Dorothea Dix
Certificate of Need	Exempt	Exempt
Stipulations	1) 50% reserved for State to purchase under three way bed program or for LME/MCO referrals	1) 50% reserved for State to purchase under three way bed program or for LME/MCO referrals
	2) Any qualifying rural county in a county that adjoins a county with a population of at least 60,000 must have at least 18 short-term inpatient behavioral health beds licensed and operational within 3 years	
Reporting	By 11/1/17 begin annual report on number and location of beds brought into operation as a result of these funds	By 11/1/18 begin annual report on number and location of beds brought into operation as a result of these funds
	By 12/1/20 the Department shall submit a proposal for funding the recurring costs of the additional beds from a source other than the Dorothea Dix Fund	By 12/1/20 the Department shall submit a proposal for funding the recurring costs of the additional beds from a source other than the Dorothea Dix Fund
Unspent or Unencombered Funds	Not Specified	SFY 2016-17: remain in Dorothea Dix Hospital Property Fund
		SFY 2017-18: remain in Dorothea Dix Hospital Property Fund

	June 2016	June 2017	September 2017
Cash Balance in Dorothea Dix Hospital Property Fund	**$50,207,650**	**$50,725,634**	**$50,887,781**
Unappropriated Balance	**$50,207,650**	**$30,725,634**	**$11,887,781**

NOTE: Funding is non-recurring for each budget year

Prepared by Fiscal Research Division - 11/14/17

JOINT LEGISLATIVE COMMITTEE
ON HEALTH AND HUMAN SERVICES

Use of the Dorothea Dix Hospital Property Fund to Increase Licensed Inpatient Behavioral Health Beds

S.L. 2016-94, Section 11F.4(a)(e)

Mark Benton
Department of Health and Human Services

Nov. 14, 2017

S.L. 2016-94, Section 11F.4(a), (e): $2M + $18M

- $2M allocated from the Dorothea Dix Hospital Property Fund for the construction of Facility Based Crisis Beds for Children/Adolescents
  - Competitive statewide bidding process; two awardees
  - Awards have been given & contracts have been executed

1.	Family Preservation	16 beds	$1M	Buncombe County
	• *Target opening March 2018*			
2.	KidsPeace	16 beds	$1M	Wake County
	• *Target opening March 2019*			

- $18M allocated from the Dorothea Dix Hospital Property Fund for the conversion/construction of licensed short-term, inpatient Behavioral Health Beds
  - Competitive bidding process in three State regions – Eastern, Central, & Western; one awardee per region
  - Awards have been given & contracts in development for all awardees; expected contract executions in early 2018

1.	Southeastern Regional Medical Center	10 beds	$1.4M	Robeson County
2.	Duke LifePoint - Maria Parham Health	33 beds	$10M	Franklin County
3.	Charles A. Cannon, Jr. Memorial Hosp.	27 beds	$6.5M	Avery County

Use of Dorothea Dix Hospital Property Funds to Increase Short-Term, Inpatient Behavioral Health Bed Capacity in Rural Areas of the State with the Highest Need

Session Law 2016-94, Section 12F.4.(d)

Report to the

Joint Legislative Oversight Committee on Health and Human

and

The Fiscal Research Division

By

North Carolina Department of Health and Human Services

November 1, 2017

Background

SECTION 12F.4.(d) *Beginning November 1, 2017, the Department of Health and Human Services shall annually report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the number and location of additional licensed short-term, inpatient behavioral health beds brought into operation with funds allocated under subsection (a) of this section.*

Session Law 2016-94, Section 12F.4.(d), requires the North Carolina Department of Health and Human Services (DHHS) to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the use of Dorothea Dix Hospital Property Funds to increase short-term, inpatient behavioral health bed capacity in rural areas of the state with the highest need.

Introduction

Session Law 2016-94, Section 12F.4.(a) stated that "it is the intent of the General Assembly to increase short-term, inpatient behavioral health bed capacity in rural areas of the State with the highest need." http://www.ncga.state.nc.us/Sessions/2015/Bills/House/PDF/H1030v8.pdf

The legislation required in Section 12.F.4.(b) that:

> As a condition of receiving these funds, each selected rural hospital shall reserve at least fifty percent (50%) of the constructed or converted beds for (i). purchase by the Department under the State-administered, three-way contract and (ii) referrals by local management entities/managed care organizations (LME-MCOs) of individuals who are indigent or Medicaid recipients.

DHHS posted a Request for Applications (RFA) in December 2016, and re-posted it in February 2017 and June 2017, pursuant to the legislative requirements above.

Four eligible applications were submitted in response to the first posting, and one eligible application was submitted after each of the second and third postings of the RFA. The applications all proposed to convert or construct new psychiatric/Substance Use beds in the following rural counties:

- Avery
- Franklin
- Harnett
- Robeson
- Swain

Of the six eligible applications, three were selected for awards. The following table list the hospitals that were selected, the award amounts, the number of proposed beds, and the location of future inpatient care in the proposed beds. The table also includes the corresponding Local Management Entity – Managed Care Organization (LME-MCO) for each hospital that will be

responsible for referrals of persons who are indigent or have Medicaid, and for care coordination of persons who will be discharged from the hospital beds.

Table 1.: Award Amounts and Beds

LME-MCO	Hospital Applicant	Award Amount	Number/Type of Proposed Beds	Location of Proposed Beds
Cardinal Innovations Solutions	DLP Maria Parham, Inc.	$10,103,500.00	33 beds (adult)	Franklin County, Louisburg, NC (old Franklin Regional Medical Center facility)
Eastpointe Human Services	Southeastern Regional Medical Center	$1,393,014.00	10 beds (adult)	Robeson County, Lumberton, NC
Vaya Health	Charles A. Cannon, Jr. Memorial Hospital	$6,503,478.00	27 beds (adults and child/adolescent)	Avery County, Linville, NC
Total		$17,999,992.00	70 beds	

Contracts

DHHS is currently developing contracts with the three hospitals that were selected for awards. The contracts are anticipated to be ready for implementation during the first half of State Fiscal Year 2018.

JOINT LEGISLATIVE COMMITTEE
ON HEALTH AND HUMAN SERVICES

Adult and Pediatric Traumatic Brain Injury Pilot Program

S.L. 2017-57, Section 11F.9

Dave Richard and Mark Benton
Department of Health and Human Services

Nov. 14, 2017

Adult and Pediatric TBI Pilot Program

- Purpose is to increase compliance with internationally approved evidence-based treatment guidelines.
- Goals include:
  - Reduction in patient mortality
  - Improve patient level of recovery
  - Reduce long-term care costs
- Will focus on adult and pediatric populations with severe classification of TBI. (Individuals with Glasgow Coma Scales of 3 to 8)
- Will occur at 3 to 5 trauma hospitals licensed by the state.
- DMH/DD/SAS and DMA are collaborating on the implementation of this pilot program.
  - An RFA is in the process of development to identify a contractor for the pilot implementation.

TBI Overview and Statistics

- Centers for Disease Control and Prevention (CDC) estimates the prevalence rate of TBI to be 2% of the population. This equates to approximately 200,000 North Carolinians.
- There are 113,852 consumers who had a TBI diagnosis in at least one of seven diagnosis code positions using applicable ICD-9 codes, based on paid claims for any Medicaid-funded service or non-Medicaid-funded (DMH/DD/SAS) mental health service paid through the NCTracks system after July 1, 2013 for services beginning on or before September 30, 2015.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Joint Legislative Oversight Committee on Health and Human Services

November 14, 2017 9:00 AM Rm. 643

House Sgt-at-Arms

Young Bae

Terry McCraw

Jim Moran

Senate Sgt-at-Arms

Frances Patterson

Billy Fritscher

VISITOR SIGN-IN

Joint Legislative Oversight Committee on Health and Human Services

11/14/2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
Randy Parrett	Oracle
Marilyn Avila	self
Anita Bachmann	UHC
Rob Lamm	RLA
John Bode	BSA
Daniel Barnum	Troutman Sanders
Jon Carr	Jordan Price
TJ Bugbee	NP
Dany Misleh	PSG
John Thompson	TPC
Kari Barsness	Gateway Health
Thomas Moore	CGA
Sue Ann Forrest	NCMS

VISITOR SIGN-IN

Joint Legislative Oversight Committee on Health and Human Services

11/14/2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
Lindsey Dowling	FSP
Carson Hicks	MVA
Ryan Blankenship	Cone HealthD
Katie Mills	CFVH
Breeden Blackwell	CFVH
Christine Craig	WakeMed
Daniel VanLaere	Vidant Health
Rick Zechini	WM
Tracy Kimbrell	Parker Poe
Ed Turlington	BP
Sara Wilson	Alliance BHC
Brian Perkins	Alliance BHC

VISITOR SIGN-IN

Joint Legislative Oversight Committee on Health and Human Services

11/14/2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
Pier Protz	Brain Injury Assn. of NC
Yvonne Copeland	CCME - Carolina Center Medical Excellence
Carol Burroughs	DIT - GDAC
Jean Anderson	Brain Injury Assn NC
Katye Tobe	SML
Paul M. Duck	Beacon Health Options
April Byrd	LME Interbranch (Beacon)
Laura Caldwell	Feeding the Carolinas
Harry	MWC
	CSX
JEFF BARNHART	MWC
Jarrett Burr	BCC

VISITOR SIGN-IN

Joint Legislative Oversight Committee on Health and Human Services

11/14/2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
Richard Edwards	Community Based Care
Jerry Villemain	NC Brain Injury Advisory Council
CAROL ORNITZ	BIANC Board
DAVID POWERS	PS, LLC
Frank Hill	PSG
Jill Elliott	Liberty Healthcare
Denise Hobson	Liberty Healthcare
Kara Weishaar	SA
David Green	Focus Carolinas
Brian Cooper	NC Office of Rural Health
Brad Christoph	Campbell University Medical Student
Matt Gross	NC Child
Sarah Wolfe	MWC

VISITOR SIGN-IN

Joint Legislative Oversight Committee on Health and Human Services

11/14/2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
J Ryans	CSS
H Watkins	The Arc of NC
Amanda Donovan	KTS
[illegible]	SAANHN
Robyn Smith Brown	NCANS
[illegible]	NC Peds
Bodie Reifer	CCR
Chris McClure	BP

VISITOR SIGN-IN

Joint Legislative Oversight Committee on Health and Human Services

11/14/2017

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
Diane Hamrick	Reach Out Extended
Carla Obioha	Care 4 Carolina
Shelly Perkins	Perkins Law
Lexi Arthur	NCF

NORTH CAROLINA GENERAL ASSEMBLY

Raleigh, North Carolina 27601

MEMORANDUM

TO: Members, Joint Legislative Oversight Committee on Health and Human Services
FROM: Sen. Joyce Krawiec, Co-Chair
Rep. Josh Dobson, Co-Chair
Rep. Donny Lambeth, Co-Chair

SUBJECT: Meeting Notice

The **Joint Legislative Oversight Committee on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	LOCATION
Tuesday	December 12, 2017	8:30 AM	643 LOB

Rep. Dobson will Chair

Parking for non-legislative meeting attendees is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. You can view a map of downtown by visiting http://www.ncleg.gov/graphics/downtownmap.pdf.

If you are unable to attend or have any questions concerning this meeting, please contact Julie Ryan at Dobsonla@ncleg.net.

cc: Committee Record _X_
Interested Parties _X_

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

December 12, 2017 8:30 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Josh Dobson
Rep. Donny Lambeth
Sen. Louis Pate

Legislative Members
Rep. William D. Brisson
Rep. Carla D. Cunningham
Rep. Nelson Dollar
Rep. Beverly M. Earle
Rep. Jean Farmer-Butterfield
Rep. Bert Jones
Rep. Chris Malone
Rep. Gregory F. Murphy, MD
Rep. Donna McDowell White
Sen. Dan Bishop
Sen. David L. Curtis
Sen. Jim Davis
Sen. Valerie P. Foushee
Sen. Ralph Hise
Sen. Joyce Krawiec
Sen. Gladys A. Robinson
Sen. Jeff Tarte
Sen. Tommy Tucker
Sen. Mike Woodard

Advisory Members
Rep. Gale Adcock
Sen. Tamara Barringer
Sen. Michael V. Lee

I.	Welcome & Opening Remarks	Representative Josh Dobson Presiding Co-chair
II.	Comments from the Secretary	Mandy Cohen, MD, Secretary Department of Health and Human Services
III.	Report on Contracting Specialist & Certification Program	Denise Thomas, Committee Staff Patti Bowers, Director DHHS Office of Procurement, Contracts & Grants
IV.	North Carolina Families Accessing Services Through Technology (NC FAST) Update	Angela Taylor, Director NC FAST, DHHS Susan Perry-Manning, Deputy Secretary for Human Services DHHS
V.	Other IT Project Updates • NCTRACKS • Health Information Exchange (HIE) • Health Information Technology (HIT) • DHH Data Collection & Services Management Information System • Women, Infants & Children (WIC)/EBT • Electronic Death Records • Medical Examiner Information System	Sam Gibbs, Deputy Secretary for Technology & Operations DHHS Information Technology Division Danny Staley, Director DHHS Division of Public Health
VI.	Discussion on Cardinal Innovations	Mandy Cohen, MD, Secretary Department of Health and Human Services Dave Richard, Deputy Secretary for Medical Assistance DHHS Division of Medical Assistance

Adjourn
Next Meeting: January 16, 2018

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES
December 12, 2017
Room 643 of the Legislative Office Building

The Joint Legislative Oversight Committee on Health and Human Services met on Tuesday, December 12, 2017 at 8:30 AM. The meeting was held in Room 643 of the Legislative Office Building. Members present were: Representatives Adcock, Brisson, Cunningham, Dobson, Dollar, Earle, Farmer-Butterfield, Fisher, Jones, Lambeth, Malone, Murphy and White and members of the Senate.

Committee Sergeants at Arms:
House: Terry, McCraw, David Leighton and Jim Moran
Senate: Billy Fritscher and Becky Myrick

Representative Dobson presided.

Representative Dobson welcomed the committee and provided opening remarks on the agenda for the committee.

Representative Dobson recognized Dr. Mandy Cohen, Secretary of the Department of Health and Human Services to provide an update on Cardinal Innovations. (See attached presentation)

Representative Dobson recognized Denise Thomas, Committee Staff, to summarize for the committee the Session Laws regarding Contracting Specialist and Certification Programs. (See attached handout on S.L. 2015-241, S.L. 2016-94 and S.L. 2017-57)

Representative Dobson recognized Patti Bowers, Director DHHS Office of Procurement, Contracts and Grants to provide a summary to the committee on these programs. (See attached handout).

Representative Dobson recognized Angela Taylor, Director of NC FAST, DHHS and Susan Perry-Manning, Deputy Secretary for Human Services DHHS to provide an update on the North Carolina Families Accessing Services Through Technology (NC FAST) program.
(See attached presentation)

Representative Dobson recognized Sam Gibbs, Deputy Secretary for Technology & Operations, DHHS Information Technology and Danny Staley, Director, Division of Public Health to provide the committee updates on IT projects at DHHS. (See attached presentation)

Representative Dobson facilitated a discussion with the committee and Dr. Mandy Cohen, MD, Secretary, Department of Health and Human Services and Dave Richard, Deputy Secretary for Medical Assistance, DHHS Division of Medical Assistance, on Cardinal Innovations.

There being no further business, the meeting adjourned at 11:28 AM.

Representative Josh Dobson
Presiding

Julie Ryan, Committee Clerk

ATTENDANCE

JLOC ON HEALTH & HUMAN SERVICES

2017-2018 SESSION

DATES	12-12-17														
DOBSON, Josh **Co-Chair**	✓														
LAMBETH, Donny **Co-Chair**	✓														
PATE, Louis **Co-Chair**	✓														
Representatives															
BRISSON, William	✓														
CUNNINGHAM, Carla	✓														
DOLLAR, Nelson	✓														
EARLE, Beverly	✓														
FARMER-BUTTERFIELD, Jean	✓														
JONES, Bert	✓														
MALONE, Chris	✓														
MURPHY, Greg	✓														
WHITE, Donna	✓														
Advisory Member															
ADCOCK, Gayle	✓														
FISHER, Susan	✓														
Senators															
BISHOP, Dan	✓														
CURTIS, David	✓														
DAVIS, Jim	✓														
FOUSHEE, Valerie	✓														
HISE, Ralph	✓														
KRAWIEC, Joyce	✓														
ROBINSON, Gladys	✓														
TARTE, Jeff	✓														

12-12-17

TUCKER, Tommy	✓														
WOODARD, Mike															
Advisory Members															
BARRINGER, Tamara	✓														
LEE, Michael	✓														
Staff Members															
LANDRY, Deborah															
MATULA, Theresa															
THOMAS, Denise															
WILKS, Lisa															

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON HEALTH AND HUMAN SERVICES

DHHS Update: Cardinal Innovations

Dr. Mandy Cohen, Dave Richard
Department of Health and Human Services

December 12, 2017

Actions To Date

- On November 27, DHHS announced after consultation with JLOC:
  - Temporary takeover of all LME functions at Cardinal
  - Revocation of approval for board structure, requiring board be reconstituted by December 15
  - Expectation that Cardinal pay back $3.8 million from administrative funds, based on salary paid
- On November 29, DHHS obtained a temporary restraining order (TRO) against the former CEO and former board members to prevent them from interfering in DHHS's management of Cardinal.

Appointment of New Board

- County Commissioners have primary responsibility for appointing new board members
- Board must have 11 to 21 members in 13 distinct categories
  - This includes 3 members appointed from Cardinal's Consumer & Family Advisory Committee (CFAC)
- DHHS worked with NC Association of County Commissioners on streamlined process:
  - Each county has appointed a member to a nominating committee
  - Individuals were able to nominate themselves or others to serve on the Cardinal board by providing a package of information to the nominating committee.
  - The nominating committee will meet this week and recommend a slate for the new board.
- To ensure stability for the organization, new board will be appointed by December 15

Next Steps

- DHHS staff remain on-site to oversee activities and help stabilize Cardinal
- New board must be formally appointed and trained in order to assume oversight responsibilities for the organization.
- Cardinal, working with DHHS, must develop a detailed corrective action plan in response to audits by Office of the State Auditor and the DHHS Office of Internal Audit.
- Key staff vacancies must be filled

S.L. 2015-241:

STUDY DESIGN AND IMPLEMENTATION OF CONTRACTING SPECIALIST AND CERTIFICATION PROGRAM

SECTION 12A.13. The Joint Legislative Oversight Committee on Health and Human Services shall study and make recommendations regarding the design of a contracting specialist training and certification program for management level personnel within the Department of Health and Human Services (DHHS) similar to the Certified Local Government Purchasing Officer program and local purchasing and contracts program of the University of North Carolina School of Government.

S.L 2016-94:

CONTRACTING SPECIALIST TRAINING PROGRAM

SECTION 12A.4.(a) The School of Government at the University of North Carolina at Chapel Hill (SOG), in collaboration with the Director of Procurement, Contracts and Grants for the Department of Health and Human Services, shall prepare a proposal for the design of a contracting specialist training program for management level personnel within the Department that is based on both national standards and the Certified Local Government Purchasing Officer Program administered by the SOG. By August 1, 2016, the SOG and the Department shall submit the proposal prepared pursuant to this subsection to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

SECTION 12A.4.(b) The SOG, in collaboration with the Director of Procurement, Contracts and Grants for the Department of Health and Human Services, shall prepare a proposal for the implementation and administration of the contracting specialist training program for management level personnel within the Department. The proposal shall include budget estimates for program implementation and administration based on the requirements of the program design. The SOG and the Department shall submit the proposal prepared pursuant to this subsection, including budget estimates for program implementation and administration, to the House Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division for consideration during the 2017 Regular Session.

SECTION 12A.4.(c) This section is effective when it becomes law.

S.L. 2017-57

CONTRACTING SPECIALIST AND CERTIFICATION PROGRAM

SECTION 11A.12.(a) By September 1, 2017, the Department of Health and Human Services shall submit to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division the proposal prepared pursuant to Section 12A.4 of S.L. 2016-

94 by the School of Government at the University of North Carolina at Chapel Hill, in collaboration with the Director of Procurement, Contracts and Grants for the Department of Health and Human Services, for the implementation and administration of a contracting specialist training program for management level personnel within the Department. The proposal shall include a detailed description of the proposed program curriculum along with budget estimates for program implementation and administration based on the requirements of the program design.

SECTION 11A.12.(b) This section is effective when this act becomes law.

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON HEALTH AND HUMAN SERVICES

Contracting Specialist & Certification Program

S.L. 2017-57 Sec. 11A.12

Patti Bowers
Department of Health and Human Services

December 12, 2017

Contracting Specialist and Certification Program

Examples of formal national and state Contract Management training programs include:

- National Contract Management Association (NCMA)
- Carolinas Association of Governmental Purchasing
- Certified Local Government Purchasing (CLGPO) certification administered by UNC-CH School of Government (SOG)
- Washington State Department of Enterprise Services (DES)
- Florida Certified Contract Manager Program

DHHS presents three options for consideration:

- DHHS in-house training.
- Partner with UNC SOG
- Partner with Dept. of Administration (DOA)–Purchase & Contract

Implementation Options and Recommendation

1. DHHS in-house training
   - Contract with third party for curriculum design - $100,000 one-time cost
   - Two FTEs to deliver training on an ongoing basis - $165,395 recurring salary, benefits, etc.
   - No additional cost to deliver training
2. Partner with UNC SOG
   - Curriculum and instructional design - $90,000 one-time
   - Two FTEs to deliver training on an ongoing basis - $184,348 recurring salary, benefits, etc.
   - $1,125 per participant
3. Partner with Department of Administration (DOA)–Purchase & Contract
   - 1 FTE Curriculum designer – $82,697 recurring salary, benefits, etc.
   - 2 FTEs to deliver training on an ongoing basis - $165,395 recurring salary, benefits, etc.

Recommendation is DHHS in-house training

Accomplishments to date

- Newly hired staff with requisite skill set
- Process improvement initiatives
  - DHHS Office of Procurement, Contracts & Grants restructuring
  - Division of State Operated Healthcare Facilities procurement realignment
  - Strategic Sourcing
- DOA Training Modules completed by DHHS staff statewide
  - Five modules attended by 104 staff members in 2015
  - Six modules attended by 194 staff members in 2016
  - Eight modules attended by 155 staff members in 2017[1]

[1] As of December 6, 2017

DHHS Contracts FY 2017-18

Item #	Budget Code	DHHS Contract #	Division/Office	Contractor	Type of Contractor	Brief Description of Contract (including goods/services purchased)	Contract Start Date	Contract End Date	SFY 2017-18 Contract Funding ($)					Contract Total Amount ($)
									Federal	State	Local	Other	Total	
8	14410	36130	Central Management and Support - NC Council on Developmental Disabilities	Jill E. Hinton	Individual	Jill Hinton will be a part-time and contractual Policy Analyst that will draw lessons from the best available data, research, and practical experiences to inform and advance the Council's mission.The work of the public policy analyst will inform state programmatic, fiscal and budget policy discussions and contribute to sound decisions that improve the well-being of individuals with intellectual and other developmental disabilities, communities, and North Carolina as a whole.The Public Policy Analyst is responsible for developing and leading the Council's efforts to track emergent policy issues and trends related to individuals with intellectual and other developmental disabilities. The Public Policy Analyst must coordinate and collaborate with NCCDD staff in developing and managing a significant body of information.	07/01/2017	06/30/2018	$30,000.00	$0.00	$0.00	$0.00	$30,000.00	$30,000.00
9	14410	34642	Central Management and Support - NC Council on Developmental Disabilities	National Disability Institute, Inc.	Non-Profit	Through contracting with the National Disability Institute, the purpose of this initiative is to continue to encourage and support the partnership of the public and private sectors in spreading financial awareness to people with I/DD and their families. Information must be disseminated to raise community expectations with stakeholders, consumers, families, and provider networks. Moreover, the initiative must consist of training agencies and/or qualified individuals to conduct financial literacy training to help support financial stability and independence and provide asset-building opportunities for persons with disabilities. Training components should include financial education and asset-building elements such as: budgeting, credit, credit repair, checking and savings accounts, free tax preparation, employment, retirement, public benefit programs, and disability-related income. In addition, the training must include information on raising the expectations of the community for people with I/DD to have the potential to accumulate assets. In NCCDD's new Five-Year Plan for FFY 2017-2021, Goal 1 states, "By 2021, increase financial security through asset development for individuals with intellectual and other developmental disabilities (I/DD)," and Objective A states, "Increase financial asset development and security for individuals with I/DD by increasing their knowledge, developing financial plans, and implementing the plan's goals."	10/01/2016	06/30/2018	$78,750.00	$0.00	$0.00	$26,250.00	$105,000.00	$180,000.00
10	14410	34700	Central Management and Support - NC Council on Developmental Disabilities	North Carolina Department of Health and Human Services, Division of Aging and Adult Services	DHHS	The North Carolina Council on Developmental Disabilities has established goals and objectives to address the needs for individuals, families, and decision makers to learn more about guardianship, alternatives, and supporting policies and practices to have the least restrictive options. The work of this initiative will work to support the goals of the Council's Five Year Plan. This initiative will meet the guidelines outlines in Goal 2 of the Five Year Plan as stated: Goal 2: By 2021, Increase community living for individuals with intellectual and other developmental disabilities (IDD). Objective 2.3: The Council will fund training, consultation and technical assistance to support the development of policies and practices, relative to guardianship and alternatives to guardianship so that more individuals with I/DD will have healthy relationships and positive community connections that will support personal choice and decision making.	01/01/2017	12/31/2017	$37,500.00	$0.00	$0.00	$12,500.00	$50,000.00	$100,000.00

DHHS Contracts FY 2017-18

III -2 SAMPLE

Item #	Budget Code	DHHS Contract #	Division/Office	Contractor	Type of Contractor	Brief Description of Contract (including goods/services purchased)	Contract Start Date	Contract End Date	SFY 2017-18 Contract Funding ($)					Contract Total Amount ($)
									Federal	State	Local	Other	Total	
1	14410	23354	Central Management and Support - DHHS Information Technology Division	Accenture, L.L.C.	For-Profit	Contract with an Integrator for the Global Case Management plus Food and Nutrition Services project and the EIS Part 1 project under NC FAST. Other program functionality from in-scope program areas will be added as needed for individual projects.	08/30/2010	01/31/2019	$24,213,331.00	$7,299,656.00	$0.00	$0.00	$31,512,987.00	$230,900,633.00
2	14410	20338	Central Management and Support - DHHS Information Technology Division	Curam Software, Inc.	For-Profit	To purchase an automated case management system. This system will include functionality from existing legacy systems for in-scope program areas that are managed by multiple DHHS partner divisions, and other functionality as needed.	12/23/2008	12/22/2019	$16,229,304.00	$8,851,068.00	$0.00	$0.00	$25,080,372.00	$141,220,010.00
3	14410	20953	Central Management and Support - DHHS Information Technology Division	Libera, Inc.	For-Profit	Procurement and Installation of a Case Management System for the Division of Services for the Blind, the Division of Services for the Deaf and Hard of Hearing and the Division of Vocational Rehabilitation.	10/19/2010	12/31/2020	$2,351,921.00	$0.00	$0.00	$0.00	$2,351,921.00	$8,869,076.00
4	14410	35997	Central Management and Support - DHHS Information Technology Division	North Carolina Department of Information Technology	Other State Agency	The purpose of this Request for Quote is to procure software maintenance and support for the Chancellor EDI transaction and clearinghouse software (hereinafter referenced to as ("Software"), and for the implementation of an Enhancement to the Software to activate existing functionality. This Software is currently hosted at the North Carolina Department of Information Technology Data Center and Quality Systems Inc.("Vendor"), which owns the software, is the only Vendor that can provide support.	09/19/2017	09/18/2018	$0.00	$20,663.00	$0.00	$0.00	$20,663.00	$24,795.00
5	14410	21192	Central Management and Support - DHHS Information Technology Division	Quadramed Affinity Corporation	For-Profit	tracking clients along with their medical record information and for billing clients and third party payers for services they receive at the fourteen facilities operating under the DMH/DD/SAS and the Controllers` Office.	06/15/1998	07/31/2018	$0.00	$1,965,590.00	$0.00	$0.00	$1,965,590.00	$13,660,864.00
6	14410	36131	Central Management and Support - NC Council on Developmental Disabilities	Erika Hagensen Kammer	Individual	Erika Hagensen Kammer will be a part-time and contractual Policy Analyst that will draw lessons from the best available data, research, and practical experiences to inform and advance the Council's mission.The work of the public policy analyst will inform state programmatic, fiscal and budget policy discussions and contribute to sound decisions that improve the well-being of individuals with intellectual and other developmental disabilities, communities, and North Carolina as a whole.The Public Policy Analyst is responsible for developing and leading the Council's efforts to track emergent policy issues and trends related to individuals with intellectual and other developmental disabilities. The Public Policy Analyst must coordinate and collaborate with NCCDD staff in developing and managing a significant body of information.	07/01/2017	06/30/2018	$30,000.00	$0.00	$0.00	$0.00	$30,000.00	$30,000.00
7	14410	34710	Central Management and Support - NC Council on Developmental Disabilities	First In Families of North Carolina	Non-Profit	The NCCDD intends for the selected contractor, First in Families, to utilize these funds to identify siblings of people with an intellectual or other developmental disability to be sibling leaders in North Carolina and assist them in establishing a comprehensive support network to address the diverse needs that their peers face. The contractor will be responsible for the following: Working with siblings to build networking opportunities to address isolation.Facilitate information sharing and education for siblings to understand their brother or sister's needs and alternatives to guardianship.Promote future planning discussions.Empower siblings to make systemic change and be strong advocates.Promote elements of independent living and self-determination. The NCCDD is seeking out creative solutions towards addressing the needs of siblings that will encompass assessing the level of sibling support across North Carolina in local communities that already exists, outreach efforts to rural populations and diverse sibling demographics, input from stakeholders, and sustainable options. While support needs for siblings differ depending on their stage of life, the NCCDD initially intends for FIF to focus on adult siblings. With the focus on adult siblings, the NCCDD aims to identify sibling leaders, role models, and advocates who can eventually guide the sibling movement in North Carolina.	10/01/2016	09/30/2017	$12,500.00	$0.00	$0.00	$4,166.75	$16,666.75	$66,667.00

Prepared by DHHS

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

September 15, 2017

SENT VIA ELECTRONIC MAIL

The Honorable Louis Pate, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 311, Legislative Office Building
Raleigh, NC 27603

The Honorable Josh Dobson, Chair
Joint Legislative Oversight Committee on
Health and Human Services
North Carolina General Assembly
Room 301N, Legislative Office Building
Raleigh, NC 27603

Dear Chairmen:

Session Law 2017-57, Section 11A.12.(a) requires the Department of Health and Human Services to submit the proposal prepared pursuant to Section 12A.4 of S.L. 2016-94 by the School of Government at the University of North Carolina at Chapel Hill, in collaboration with the Director of Procurement, Contracts and Grants for the Department of Health and Human Services, for the implementation and administration of a contracting specialist training program for management level personnel within the Department no later than September 1, 2017.

On September 1 2017, the Department advised the Committee that, due to substantial collaborations with the UNC School of Government, the report would be delayed no later than 15 days. Pursuant to that notice, the Department is pleased to submit the attached report.

Please direct all questions concerning this report to Patti Bowers, Director of Procurement, Contracts and Grants, at 919-855-4080 or Patti.Bowers@dhhs.nc.gov.

Sincerely,

Mark T. Benton

for Mandy Cohen, MD, MPH
Secretary

cc: Rod Davis, Joyce Jones, Pam Kilpatrick, reports@ncleg.net, Ben Popkin, Susan Jacobs, Patti Bowers, Mark Benton, Theresa Matula, Marjorie Donaldson, LT McCrimmon, Susan Perry-Manning, Kolt Ulm, Leah Burns, Denise Thomas, Christen Linke Young

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER
GOVERNOR

MANDY COHEN, MD, MPH
SECRETARY

September 15, 2017

SENT VIA ELECTRONIC MAIL

Mark Trogdon, Director
Fiscal Research Division
Suite 619, Legislative Office Building
Raleigh, NC 27603

Dear Director Trogdon:

Session Law 2017-57, Section 11A.12.(a) requires the Department of Health and Human Services to submit the proposal prepared pursuant to Section 12A.4 of S.L. 2016-94 by the School of Government at the University of North Carolina at Chapel Hill, in collaboration with the Director of Procurement, Contracts and Grants for the Department of Health and Human Services, for the implementation and administration of a contracting specialist training program for management level personnel within the Department no later than September 1, 2017.

On September 1 2017, the Department advised the Committee that, due to substantial collaborations with the UNC School of Government, the report would be delayed no later than 15 days. Pursuant to that notice, the Department is pleased to submit the attached report.

Please direct all questions concerning this report to Patti Bowers, Director of Procurement, Contracts and Grants, at 919-855-4080 or Patti.Bowers@dhhs.nc.gov.

Sincerely,

Mark T. Benton

for Mandy Cohen, MD, MPH
Secretary

cc:

Rod Davis	Ben Popkin	Theresa Matula	Kolt Ulm
Joyce Jones	Susan Jacobs	Marjorie Donaldson	Leah Burns
Pam Kilpatrick	Patti Bowers	LT McCrimmon	Denise Thomas
reports@ncleg.net	Mark Benton	Susan Perry-Manning	Christen Linke Young

Contracting Specialist and Certification Program

Session Law 2017-57, Section 11A.12.(a)



Report to

The Joint Legislative Oversight Committee on

Health and Human Services

By

North Carolina
Department of Health and Human Services

and

UNC School of Government

September 15, 2017

Reporting Requirement

Section 11A.12.(a) of S.L. 2017-57 requires by September 1, 2017, the Department of Health and Human Services to "submit to the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division the proposal prepared pursuant to Section 12A.4 of S.L. 2016-94 by the School of Government at the University of North Carolina at Chapel Hill (SOG), in collaboration with the Director of Procurement, Contracts and Grants for the Department of Health and Human Services, for the implementation and administration of a contracting specialist training program for management level personnel within the Department. The proposal shall include a detailed description of the proposed program curriculum along with budget estimates for program implementation and administration based on the requirements of the program design."

Overview

Per Session Law 2016-94, Section 12A.4.(a), the original proposal submitted on August 1, 2016 for the design of a contracting specialist training program for management level personnel within the Department that is based on national standards and the Certified Local Government Purchasing Officer Program administered by the SOG is attached in Appendix A.

This proposal further details the resources, including budget estimates, necessary for program implementation and administration as required in Section 12A.4.(b).

While procurement and contracting training and certification is available from the SOG and the Department of Administration, Division of Purchase and Contract, no formal training exists for North Carolina government contract managers and administrators that addresses the multiple stages of contracting, especially for post-award contract administration:



As presented in the previous report, Contract Management and Contract Administration within DHHS is decentralized, meaning that most pre-solicitation and post-award procurement and contracting activities take place primarily at the division level as opposed to through a centralized office. The DHHS Office of Procurement, Contracts and Grants (OPCG) provides oversight during the solicitation, evaluation and award phase for the department's procurement and contracting activities. Within DHHS' 30 divisions, two categories of personnel are primarily responsible for procurement and contract management functions: contract managers and contract administrators. **Contract Managers** ensure legal procurement requirements are followed and facilitate division procurement requests with the DHHS Procurement Office and the Department of Administration Division of Purchasing and Contract. **Contract Administrators** manage the contract once it has been awarded and act as the point of contact with vendors and contractors. On the procurement continuum, Contract Managers are involved with the contract at the pre-award phase, and Contract Administrators are involved with the contract at the post-award phase.

DHHS, on average, has responsibility for **1,862** active or current contracts. The resources required for the pre-award phase or acquisition planning, award phase or source selection, and post-award phase or contract administration include **6** Department Contract Administrators, **768** Division Contract Administrators, **91** Division Contract Managers and an additional **418** individuals assigned contract administration duties. OPCG has a total of **7** positions that support and provide oversight of the contracting process for services. An additional **4** positions handle the purchase of goods. At a minimum, **1,294** individuals would require some degree of contracting specialist training.

Competencies and Skills

The competencies and technical skills necessary in each of these roles is reflected in the Contract Leadership Competency Model developed by Dr. John Wilkinson. In 2010, Dr. Wilkinson created the Contract Leadership Competency Model. This model was designed to show how the hard skills of Contract Management must be balanced with the mix of the soft skills of Leadership to achieve superior results. The Model also shows that while there is a process involved with Contract Management (Acquisition Planning, Source Selection, and Contract Administration), the competencies of Leadership (Character and Competence) must be applied throughout the process to earn the reputation as a Trusted Business Advisor and Complex Problem Solver.[1]

The technical skills necessary for each phase of the contracting cycle include:

- Acquisition Planning
  - Contract Law
  - Contracting Methods
  - Contract Types
  - Competition
  - Market Research
- Source Selection
  - Offer
  - Negotiation
  - Acceptance
  - Consideration
  - Protests
- Contract Administration
  - Contract Performance
  - Modifications
  - Disputes
  - Termination
  - Closeout

The leadership skills necessary across all phases of the contracting cycle include:

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[1] Wilkinson, John. Contract Leadership Competency Model. http://www.thinc-llc.biz/contact-leadership-competency-model.php

- Competence
  - Communication
  - Action Oriented
  - Collaboration
  - Creativity
  - Knowledge Capture
- Character
  - Integrity
  - Vision
  - Courage
  - Compassion
  - Optimism

Current Training Options, National Standards, the Certified Local Government Purchasing Officer Program and Other State Training Programs

Appendix B describes the current training opportunities available to NC procurement and contracting professionals. Most of the training provided is directed toward individuals involved in the award or source selection phase. Other than commercially available training in all three phases of the contracting cycle, no other source exists that meets the intent of the Contracting Specialist Training Program envisioned in S.L. 2016-94.

Appendix C provides the costs associated with the current training available. It would be cost prohibitive for **1,294** individuals involved in the contracting process to participate in anything but the free training currently available from the Department of Administration, Division of Purchase and Contract. The Contract Administration and Monitoring class, while valuable, focuses on post-award contract administration, without the benefit of the pre-award and award phases which are critical and often determine the success of a contract through implementation of a program or service.

There are many formal Contract Management training programs available, however the **National Contract Management Association (NCMA)** is a professional organization for contract management professionals in the public and private sectors.

NCMA recently published *The Contract Management Standard™*, Appendix D, to describe the nature of contract management in terms of the contract management processes created through the integration and interaction of job tasks and competencies, and the purposes they serve. The common and repeated use of this standard will improve productivity, increase efficiency, and reduce costs. *The Contract Management Standard* is a doctrinal publication serves as the foundation of the *Contract Management Body of Knowledge®, Fifth Edition*.[2]

The intent of the *Contract Management Standard™* is to:

1. Define and standardize the term of "contract management."

[2] Contract Management Body of Knowledge (CMBOK), 5th ed., National Contract Management Association (2017)

2. Present and define the processes involved in all phases of the contract lifecycle (pre-award, award, and post-award).
3. Develop and fortify contract management practices, policies, and processes.
4. Inspire critical thinking and learning to bring efficiency to the contract management profession.
5. Be a living document, with a formal change process.[3]

The framework for DHHS' Contracting Specialist Program should be based on the principles of a nationally recognized professional organization such as NCMA.

The **Carolinas Association of Governmental Purchasing** offers a voluntary certification program (CLGPO) for government purchasing officers. Its purposes are to:

- Provide a greater service to taxpayers through more efficient purchasing.
- Recognize achievement of an established level of competency and proficiency among purchasing officials.
- Provide continuing professional development of purchasing officials and enhance their professional image.

The Certified Local Government Purchasing Officer (CLGPO) certification is administered by the **UNC School of Government** with an examination offered every year in February or March on the day before the annual Local Government Purchasing School (CAGP Spring Conference).

Requirements and applications for CLGPO certification, recertification, and lifetime certification can be found at the UNC School of Government.[4] While the CLGPO program is open to state government procurement officials, the program historically has served and been utilized by local governments. Thus, the courses offered at the UNC SOG required for CLGPO certification focus on the laws governing local government procurement and do not address the laws, administrative regulations, and procedures specific to state agencies. For the same reasons, the CLGPO examination tests applicants' knowledge on the laws applicable to local government procurement.

A similar program could be developed for the DHHS Contracting Specialist Training Program; however, if such a program were to be administered by the UNC SOG, it would need resources to develop the curriculum and hire trainers to provide training and administer the program, including developing and administering a certification examination. It is estimated that the program would consist of three two-day classes addressing the pre-award, award and post-award phases of the contract lifecycle, an examination review session and a certification examination. Costs associated with the classes would be in line with those outlined in Appendix C and average approximately $950 per person. Additional costs for curriculum development, training personnel, and examination administration are detailed under Option 2 on page 6 of this report.

The **Washington State Department of Enterprise Services (DES)** requires training for all employees who manage, monitor, or serve, as subject matter experts on contracts will teach the approach to manage

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[3] Contract Management Standard™, Final Edition, Version 1.0, National Contract Management Association (2017)
[4] Carolinas Association of Governmental Purchasers (CAPG). CLGPO Certification.
https://www.cagponline.org/chapters/nigp-cagp/certifications.cfm

contractors, ensure compliance to the statement of work, and ensure contractor performance. This on-line course is provided in four modules at no cost:

- Module 1 (1 hour)
  - Contract Management Overview
    - Define Contract Management
    - The Basics of a Contract
    - Purchasing Approaches, Pricing Models and Risk
    - Contracting Tools to Guide You
- Module 2 (36 minutes)
  - Contract Management Phases and Functions
    - Three Phases of Contract Management
    - The importance of pre-award planning
    - Award Activities: Contract execution and why it matters
    - Post-Award activities
- Module 3 (34 minutes)
  - Essentials of Contract Management
    - The Contract is signed, now what
    - Essential elements of contract monitoring
    - How to implement contract management
- Module 4 (35 minutes)
  - Contract Changes, Disputes, Appeals
    - When things don't go as planned
    - When the agency and contractor disagree
    - Best practices and lessons learned

The (DES) oversees the Washington State Training and Certification Program for the procurement of goods and services. As people join state agencies or transfer to new jobs within the state, they need the training appropriate to their new jobs. There is a 90-day window to take the training. No agency employee may execute or manage a contract unless they have met the new training requirements.[5]

An online approach may be feasible for the DHHS Contracting Specialist Training Program; however, it would be extremely difficult to monitor the outcome and effectiveness of the training. Given the complexity of many DHHS contracts, instructor-led training would provide the following benefits, which would ultimately impact the successful execution of contracts:

- Learning from experts.
- Opportunities for instructor-learner and learner-learner interactions.
- Peer learning and network-building.
- The ability to ask questions and receive immediate feedback.
- Adaptability—the ability of instructors to tailor courses to learners' needs, even on the fly.
- Focus and attention—learning is not constantly interrupted by ringing phones, emails, etc.

[5] Washington State Department of Enterprise Services. Procurement Training and Development. http://des.wa.gov/about/projects-initiatives/procurement-reform/procurement-training-and-development

The **Florida Certified Contract Manager Program** is managed by the **Department of Management Services** and requires, in accordance with Florida Statutes, "Each contract manager who is responsible for contracts in excess of $100,000 annually must complete training in contract management and become a certified contract manager." Certification requires successful completion of eight online training modules, a two-day instructor-led training, and a final assessment, with a minimum score of 80%.[6]

These examples are provided to demonstrate the variety of options available for implementing a DHHS Contracting Specialist Training Program that meets the intent of S.L. 2016-94.

DHHS Contracting Specialist Training Program Implementation Options

Option 1

DHHS has many diverse and complex contracts managed and administered by a variety of individuals with varying degrees of contracting experience. To implement a successful Contracting Specialist Training Program, both programmatic and contracting subject matter expertise is essential. To that end, Option 1 is to contract with a third party with NCMA and Contract Management Standard™ experience to design the curriculum. DHHS would hire two FTEs to provide instructor-led training to DHHS employees.

Budget requirements for implementing this option include:

Curriculum Design by Third Party Contractor	$100,000 (Not to exceed/non-recurring)
2 FTEs to deliver training on an ongoing basis	$165,395 (recurring salary, benefits, etc.)
Total	$265,395

The training for this option would be structured in terms of the Contract Management Standard™ competencies (see page 3 of the attachment). This would mean four, 4-6 hour sessions delivered Monday – Thursday or Tuesday – Friday on an ongoing basis. The four sessions would include Guiding Principles, Pre-Award, Award, and Post-Award.

Option 2

This option would include partnering with UNC SOG to develop the curriculum based on the Contract Management Standard, and UNC SOG would deliver the training and administer the certification examination in the same manner they do for the CLGPO certification. Requirements to implement this option would include additional resources at UNC SOG as well as costs for delivering the training.

Budget requirements for implementing this option include:

Curriculum Design by UNC SOG	TBD
2 EPA non-faculty FTEs to deliver training on an ongoing basis	$ 170,000 (recurring salary, benefits, etc.)
Costs for three two-day classes • Pre-Award Phase • Award Phase	$950 per person

[6] Florida Department of Management Services. Florida Certified Contract Manager. http://www.dms.myflorida.com/business_operations/state_purchasing/public_procurement_professional_development/florida_certified_contract_manager

• Post-Award Phase	
One-day Examination Review Session	$100 per person
Certification Examination	$75 per person

Option 3

DOA P&C has developed a robust Procurement Training Program in recent years. The program includes a one-day NC Contract Administration and Monitoring course that covers post-award subjects. This option would include partnering with DOA P&C to develop curriculum to add pre-award and award phase training.

Budget requirements for implementing this option include:

Curriculum Design by Third Party Contractor	$100,000 (Not to exceed/non-recurring)
2 FTEs to deliver training on an ongoing basis	$165,395 (recurring salary, benefits, etc.)
Total	$248,092

Of the options outlined above, the most cost effective is ***Option 1***. This option would be the most efficient method for delivering training to the large and diverse number of DHHS employees engaged in the various phases of contracting. In addition, it would afford the trainers as well as trainees the opportunity to engage with subject matter experts across the department in a setting unique to DHHS. Another benefit of this option would be the on-going availability of in-house subject-matter experts to advise DHHS contracting personnel on an as-needed basis. While a training program provides attendees with basic knowledge and skills, no curriculum can anticipate or address all potential questions and challenges faced by contracting personnel in any organization, especially one with the diversity and complexity of contracting operations as DHHS. The availability of in-house subject-matter experts to provide on-going advice and consultation will greatly enhance the ability of DHHS contracting personnel to effectively employ their training and perform their contract management and administration functions.

Options 2 and 3 would take longer to implement, cost more, limit the opportunity to customize the curriculum to meet DHHS' unique needs for training, and not provide the availability of on-going advice and consultation from in-house subject-matter experts.

We welcome any feedback that you, the members of your committee, or your committee staff wish to offer.

APPENDIX A

Contracting Specialist Training Program

Session Law 2016-94, Section 12A.4.(a)

Report to
The Joint Legislative Oversight Committee on
Health and Human Services
By
North Carolina
Department of Health and Human Services
and

UNC School of Government

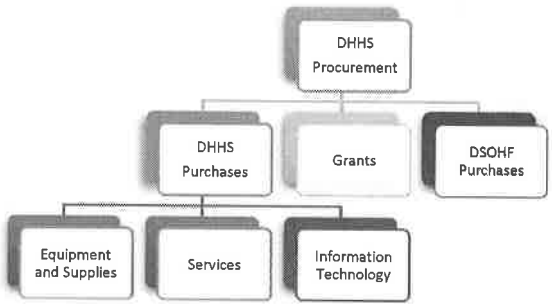
August 1, 2016

Reporting Requirement

Section 12A.4.(a) of the 2016 Appropriations Act (S.L. 2016-94) requires the UNC School of Government and the Department of Health and Human Services to "prepare a proposal for the design of a contracting specialist training program for management level personnel within the Department that is based on both national standards and the Certified Local Government Purchasing Officer Program administered by the SOG," and to report to the Joint Legislative Oversight Committee on Health and Human Services by August 1, 2016.

Overview

The Department of Health and Human Services (DHHS) procures a wide variety of goods and services which, for purposes of this report, fall into four basic categories: (1) Information Technology (2) Equipment, Supplies (3) Services, and (4) Grant Contracts. Information technology procurement is governed by statutory requirements separate and apart from other departmental procurement which, by law, involves interaction with, oversight and approval by and, ultimately, transition to the Department of Information Technology.[7] For these reasons, this report focuses on training for DHHS personnel who manage contracts other than those for information technology.



Methodology

In developing a proposal for the design of a contracting specialist training program for DHHS personnel responsible for contract management, two important categories of information must be identified before the curriculum of a training program can be developed and implementation strategies outlined.

First, the roles and responsibilities of these personnel must be defined. Second, the professional competencies needed to effectively perform these roles and responsibilities must be identified. Thereafter, curriculum for a training program and program implementation options can be developed. This report focused on defining the roles and responsibilities of DHHS contract management personnel and the competencies they need. Sec. 12A.4(b). of 2016-94 requires the School of Government and DHHS to prepare a proposal for implementation and administration of the training program. This report will be submitted to the House and Senate Appropriations Committees on Health and Human Services and Fiscal Research Division for consideration during the 2017 Regular Session.

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[7] G.S. Chapter 143B, Article 15.j

Roles and Responsibilities – DHHS Contract Managers and Administrators

Contract Management and Administration within DHHS is decentralized, meaning that most pre-award and post-award procurement and contracting activities take place primarily at the division level as opposed to through a centralized office. DHHS is divided into 30 divisions and oversees 14 State Operated Healthcare Facilities (developmental centers, neuro-medical treatment centers, psychiatric hospitals, alcohol and drug abuse treatment centers, and two residential programs for children). Because of the diverse and complex array of programs and services delivered by DHHS, its procurement and contracting ranges from highly sophisticated Medicaid service contracts, medical equipment and pharmaceuticals to routine office equipment and supplies.

The DHHS Office of Procurement and Contract Services (DHHS Procurement Office) provides oversight during the solicitation, evaluation and award phase for the department's procurement and contracting activities, and develops policies and procedures for departmental procurement, including general contracting requirements, contract administration and monitoring, specific solicitations under the Request for Applications (RFAs), Request for Information (RFIs), and Request for Proposals (RFPs) methods, and personal service contracts.[8] The DHHS Procurement Office also approves a number of categories of departmental contracts, including those that propose modifications to the DHHS general terms and conditions; sole source contracts; operations and program-related contracts of $200,000 or more; contracts with other state agencies and local governments; contracts with institutions of higher education; RFP contracts of $10,000 or more, and all consulting contracts.[9]

Within DHHS' 30 divisions, two categories of personnel are primarily responsible for procurement and contract management functions: contract managers and contract administrators. **Contract managers** ensure legal procurement requirements are followed and facilitate division procurement requests with the DHHS Procurement Office and the Department of Administration Division of Purchasing and Contract. **Contract administrators** manage the contract once it has been awarded and act as the point of contact with vendors and contractors. On the procurement continuum, contract managers are involved with the contract at the pre-award phase, and contract administrators are involved with the contract at the post-award phase.

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[8] These policies and procedures can be obtained at https://www2.ncdhhs.gov/info/olm/manuals/dhs/pol-70/man/.

[9] DHHS Policies and Procedures Section VII: Procurement and Contract Services; Chapter 2, Contract Administration, Page 6 (2008).



Professional Competencies

Contract managers (those involved in the pre-award phase) must be proficient in a variety of knowledge, skills and competencies, including:

- competitive bidding requirements (which in many instances requires compliance with both state law and federal regulations)
- departmental policies and procedures for contract approval
- departmental terms and conditions requirements
- contract negotiation
- standards of conduct (including conflicts of interest)

Contract administrators (those involved in the post-award phase) must be proficient in a variety of knowledge, skills and competencies, including:

- applicable state and federal laws and departmental policies
- contract management principles and techniques
- project management
- performance evaluation and quality assurance
- subcontract and supplier management
- monitoring of compliance with terms and conditions
- contract interpretation, modification, and dispute resolution
- close-out and termination
- standards of conduct (including conflicts of interest)

The range and extent of contract administration activities will vary depending on the type of contract, complexity, and cost. A contract administrator may need assistance from other personnel with technical expertise in a specific subject matter to fully manage the contract through its duration.

Because the focus of the Joint Legislative Oversight Committee on Health and Human Services has been on the post-award phase of departmental contracting, our efforts moving forward will be targeted toward those personnel who perform this function – contract administrators.

Potential Training Requirements

Although we have not advanced to the second part of this endeavor (that required by Sec. 12A.4.(b)), we believe it helpful to outline the certification program developed by the National Contract Management Association (NCMA) to give a framework for future discussions.

The NCMA, founded in 1959, is a professional organization for contract management professionals in the public and private sectors. NCMA offers five certification programs, including one applicable to state government contract managers – the Certified Professional Contracts Manager (CPCM). CPCM certification requires an undergraduate degree, 120 Continuing Professional Education (CPE) hours, at least five years' experience in the contract management (or related) field, and passage of the CPCM certification examination.

The competencies identified by NCMA for post-award contract managers are:[10]

A. Contract Management
   a. Using effective communications
   b. Attending a post-award kick-off meeting
   c. Conducting periodic status review meetings
   d. Preparing written status reports
   e. Observing and monitoring performance
   f. Documenting performance
B. Quality Assurance
   a. Quality assurance tools
   b. Acceptance testing
   c. Contract manager's role in quality assurance
C. Subcontract Management
D. Contract Changes and Modifications
   a. Bilateral and unilateral changes
   b. Uniform Commercial Code (UCC) contract modifications
   c. Federal Acquisition Regulation (FAR) contract modifications
E. Transportation
F. Contract Interpretation and Disputes
   a. Contract interpretation
   b. Alternative dispute resolution
G. Contract Closeout
H. Contract Termination and Excusable Delay
   a. Termination for Default
   b. Excusable Delay/*Force Majeure*
   c. Contract cancellation

Some of the topics listed above may not be directly applicable to DHHS contract managers. Phase two of this endeavor will involve developing the curriculum – training topics, content, and hours

[10] Contract Management Body of Knowledge (CMBOK), 4th ed., National Contract Management Association (2013).

of classroom instruction – that is best tailored to the competencies for this specific group of personnel. Nonetheless, the NCMA outline of competencies does provide a list of the general categories of topics likely to be included (where applicable) in a DHHS contract administrator training curriculum

Other sources of training curriculum specific to contract management include those offered by the National Institute of Governmental Procurement (NIGP), International Association for Contract and Commercial Management, and even undergraduate and graduate online degrees in contract management. In addition, the N.C. Division of Purchasing and Contract has developed training classes in contract management. Finally, the UNC School of Government offers local government procurement courses that include sessions on contract management.

Conclusion

We will initiate the second phase of this endeavor after submission of this report. We welcome any feedback that you, the members of your committee, or your committee staff wish to offer.

Appendix B – Training Opportunities Currently Available

The University of North Carolina School of Government (SOG) offers the following Local Government Purchasing and Contracting Courses:

- **Basic Principles of Local Government Purchasing**

  This 4-day course is designed for new local government purchasing officials and covers basic principles and legal requirements for local government purchasing. This course is offered annually for $525

  Topics include the following:

  - Competitive bidding requirements for purchasing and construction contracting
  - Purchasing ethics and conflicts of interest
  - Practical skills such as vendor relations, developing specifications, and bid solicitations
  - Purchasing policies and electronic bidding
  - Decision analysis, motivational strategies, and effective communication
  - Local government law overview, including open meetings and public records laws
  - Budgeting and fiscal control
  - Surplus property disposal
  - Tips for success from experienced local government purchasing professionals

- **Contracting for Construction and Design Services**

  This 2 ½ day course addresses topics of interest to those involved in construction contracts or in the procurement of the services of engineers and architects. Topics include bidding procedures; construction methods; minority participation and reporting requirements; legal aspects of construction contracts; contract administration; and selection of design services. A panel will address recommended practices in construction, including Joint AIA/AGC Committee recommendations. This course is offered annually for $400.

- **Intermediate Purchasing Seminar**

  This three-day seminar will sharpen participants' purchasing skills and deepen their understanding of the legal and practical aspects of public purchasing.

  This course is intended for officials with two or more years of experience in local governmental purchasing, and will cover bidding and property disposal, capital leasing, performance management and benchmarking, insurance and risk management, electronic bidding and contract management, effective communications, ethics and conflicts of interest, and practical skills training, including handling difficult bids. This course is offered annually for $425.

- **Introduction to Local Government Finance**

  This 4-day introductory course provides basic instruction in local government and public authority finance and financial management. Areas of instruction include the basic legal authority and requirements governing local government revenues, budgeting processes, cash management,

purchasing and contracting, expenditure control, conflicts of interest, fund accounting and financial reporting. The course also provides an overview of the state and local economic issues that inform strategic budgeting decisions. This course is offered annually for $575.

Certified Local Government Purchasing Officer Program

The Carolinas Association of Governmental Purchasing offers a voluntary certification program (CLGPO) for government purchasing officers. Its purposes are to:

- Provide a greater service to taxpayers through more efficient purchasing.
- Recognize achievement of an established level of competency and proficiency among purchasing officials.
- Provide continuing professional development of purchasing officials and enhance their professional image.

To be eligible for certification, an applicant must have at least 3 years' experience as a governmental purchasing professional, be a member of CAGP, complete 4 core courses offered by the School of Government, earn 22 points through activities such as training, conference attendance, service to CAGP, and higher education, and pass a certification examination administered by the School of Government. Once certified, purchasers are eligible for recertification every 5 years, and may also seek lifetime certification.

The Certified Local Government Purchasing Officer (CLGPO) certification is administered by the UNC School of Government with an examination offered every year in February or March on the day before the annual Local Government Purchasing School (CAGP Spring Conference).

Requirements and applications for certification, recertification, and lifetime certification can be found at the UNC School of Government.

The NC Department of Administration (DOA), Division of Purchase & Contract (P&C) offers valuable in-person and online training opportunities to employees of state agencies, community colleges, universities, and Vendors interested in doing business with the state of North Carolina.

The following courses are offered by the DOA P&C at no cost:

- **NC Contract Administration & Monitoring**

  This instructor-led course includes the following topics: contract administration principles, terminology, roles and responsibilities of contract administrators, problem-solving, and best practices for individuals responsible for managing, administering, or managing contracts. This 1-day course is offered monthly.

Recommended Prerequisites relevant to employees involved in contract administration and monitoring:

- **NC Procurement**
  This instructor-led course provides a comprehensive overview of the procurement process for purchasing goods and services not related to information technology. The content of this course

includes the following topics: basic principles of procurement, common terminology, governing regulations, delegation of authority, ethics, acquisition methods, procurement planning, developing specifications and scope of work, developing solicitations, solicitation documentation, competitive bidding, evaluation, terms and conditions, negotiation, resolution of protests and disputes, and best practices. This 3-day course is offered monthly.

- **Specification Writing**

  This instructor-led course explains the purpose of specification writing to obtain a commodity or service that will satisfy a particular need at an economical cost. In this course, participants will discuss how writing a specification relates to the sections of the Invitation for Bid (IFB), identify key components of a specification that makes it nonrestrictive and promotes competition, explore each type of specification, and determine when each type of specification is used for a particular need. This 1-day course is offered monthly.

- **Solicitation Documents & the Law: Explaining Legal Terms and Conditions in IFBs and RFPs**

  This instructor-led course includes a review of the legal significance of the organization and content of the state's Invitation for Bids (IFB) and Request for Proposals (RFP) templates. This course will focus on explaining why the sometimes obscure and puzzling provisions in the solicitation document are important for creating an effective and enforceable contract. This 1-day course is offered quarterly.

- **Request for Proposal (RFP) Development & Evaluation**

  This instructor-led course is an in-depth study of Request for Proposals (RFP). This course is designed to help with planning an RFP, using standard solicitation documents, managing the RFP process and evaluating offers for purchases not related to information technology. This 2-day course is offered monthly.

- **Determining Cost**

  This instructor-led course explains the basic elements of total cost of ownership (TCO) financial analysis for public procurement. This course is designed for the procurement professional who is faced with supporting acquisition decisions for various goods and services. Through case-based scenarios, discover all of the obvious costs and all of the hidden costs of ownership across the full lifecycle of the acquisition. This 6.5-hour course is offered quarterly.

National Institute of Governmental Purchasers (NIGP) courses offered through DOA P&C at a reduced cost:

- **Contract Administration in the Public Sector**

  This class provides a framework for examining contract administration by focusing on essential elements of the discipline. The intent is for participants to develop a strong understanding of the complexities of contract administration and recognize the importance of planning, monitoring, and providing proactive insight and oversight of contract performance. Practical examples,

discussion, group exercises and case studies will be used throughout the course. This 3-day course is offered occasionally at a cost of $700 per student.

For further information regarding DOA P&C training please visit: http://ncdoa.s3.amazonaws.com/s3fs-public/pandc/OnlineTrainingMaterials/2017_course_catalog_final.pdf.

The Department of Information Technology, IT Strategic Sourcing Office offers the following IT Procurement Training classes quarterly:

- **IT Procurement Rules Review**

  This 7-hour class provides a review of Title 9, Chapter 6, of the North Carolina Administrative Code, the rules that govern purchase of information technology goods and services. The rules, which were amended effective September 1, 2013, are mandatory for use by Executive state agencies and recommended for use by other government entities when procuring IT goods and services. This class is designed for new purchasing staff, but will also serve as a refresher for seasoned purchasers.

- **Introduction to IT Procurement**

  This 6-hour class provides an overview of information technology purchasing under the procurement rules. Topics include how to develop, write and review invitations for Bids, conduct pre-bid conferences and bid openings, and evaluate bids. This class is designed for new purchasing officers.

- **The RFP Process**

  This 7-hour class provides information about writing, reviewing, and evaluating Request for Proposals and managing contracts. We will also discuss how to plan evaluation and scoring methodologies for the RFP. This class is designed for anyone involved in writing, reviewing, or evaluating RFPs or managing IT contracts.

In addition to IT Procurement Training the NC Department of Information Technology Enterprise Project Management Office offers a certification prep class to aid state project managers in their preparation for the Project Management Institute's (PMI) global standard Project Management Professional certification.

Classes are held in the spring (April/May) and fall (October/November) and are FREE for State employees (a typical PMP prep boot camp can cost more than $3,000).

Twelve (12) classes cover the following areas:

- 10 Project Management Knowledge Areas
- Professional Responsibility
- Final Exam Comprehensive Review

This comprehensive program requires a significant commitment of time and energy for students to succeed. Our pass rate (90%+) is in line with industry-leading vendors who provide PMP prep services.

Aside from the highly valued benefit of achieving certification, many of our students have developed key networking opportunities within the program that have yielded professional benefits beyond the classroom.

NIGP offers the following contracting courses for learning how to identify and define terms, concepts and principles of the contract administration process to ensure proper mechanisms are in place to enhance performance. Contract Administration in the Public Sector, Introduction to Public Procurement, Legal Aspects of Public Procurement and Strategic Procurement Planning in the Public Sector are the contracting courses that align with the Contract Administration Domain for the Universal Public Procurement Certification Council (UPPCC) Body of Knowledge (BOK). The UPPCC is an independent entity formed to govern and administer the Certified Public Procurement Officer (CPPO) and Certified Professional Public Buyer (CPPB) certification programs. Contract Administration is one of six domains for which NIGP provides coursework that are acceptable for obtaining public procurement certification. The others are Procurement Administration, Sourcing, Negotiation, Supply Management and Strategic Procurement Planning.

- **Contract Administration in the Public Sector**

  This class provides a framework for examining contract administration by focusing on essential elements of the discipline. The intent is for the student to develop a strong understanding of the complexities of contract administration and recognize the importance of planning, monitoring, and proactive insight into and oversight of contract performance. Practical examples, discussion, group exercises and case studies will be used throughout the course. This 3-day course is offered periodically at locations across the country at a cost of $915 per student. A 9-week online course is also offered at a cost of $945.

Upon successful completion of this course participants will be able to:

  - Identify and define terms, concepts and principles of the contract administration process
  - Identify contract risk and plan appropriate mitigation
  - Develop the CAP and PAP for a given case study
  - Recommend an appropriate remedy when given a contractual problem or issue
  - Apply a process to handle a performance problem
  - Describe and apply dispute resolution methods
  - Closeout a contract including conducting a contract analysis
  - Describe how contract administration can be continually improved to enhance contract performance in accordance with the commonly accepted practices of the profession

- **Introduction to Public Procurement**

  The work of public procurement is no longer a clerical function performed independently by various people throughout different agencies or departments within a government entity. This

class provides an overview of the ever-changing profession by identifying fundamental concepts that affect procurement in the public sector. Practical examples, discussion, group exercises and case studies will be used throughout the course. This 3-day course is offered periodically at locations across the country at a cost of $915 per student.

Upon successful completion of this course participants will be able to:

- Describe the roles, organization and functions of public procurement
- Explain the steps in the procurement cycle and the stakeholder relationships inherent in each step
- Demonstrate how public procurement adds value to the delivery of public services
- Describe the cultural, social, political, economic and legal environments that impact public procurement
- Demonstrate the importance of ethics and professionalism in public procurement

- **Legal Aspects of Public Procurement**

Designed to be an educational exploration of the legal elements of public procurement, this course will provide a foundation of the principles and general concepts of the law as it applies to public procurement. Course content will address issues such as the Uniform Commercial Code (U.C.C.), the Model Procurement Code, Sale of Goods Act and the legal implications surrounding solicitations, contracting, and post-award issues. Attention will be given to the ethical issues facing the profession relevant to the law. This course will focus on actual procurement situations with relevant procurement implications using practical examples, discussion, group exercises, and case studies throughout the course. This 3-day course is offered periodically at locations across the country at a cost of $915. An 8-week online course is offered at a cost of $945.

Upon successful completion of this course participants will be able to:

- Identify and define public purchasing legal terms, concepts and principles.
- Apply basic legal concepts and principles to practical public procurement situations
- Describe how the three categories of law — the common law of contracts, statutory law and administrative law — apply to public purchasing.
- Describe how the laws establish the rights and obligations of all parties.
- Distinguish between ethical and legal requirements and apply the appropriate actions and conduct.
- Describe the role of the public professional in the application of procurement and contract law in accordance with the commonly accepted practices of the profession.

- **Strategic Procurement Planning in the Public Sector**

The direction of public sector organizations has generated increased demand for strategic procurement planning and participation by procurement professionals in the actual implementation of many projects—particularly out-sourcing, privatization, and public-private

partnerships. This course provides practical tools and approaches that can be used by the procurement practitioner to contribute to an organization's strategic mission. These include the development of strategic plans, the strategic role of procurement in the budget process, pricing strategies and value-adding analysis techniques, the tools and analytics of strategic sourcing, client satisfaction strategies, and talent management. Practical examples, discussion, group exercises, and case studies will be used throughout the course. This 3-day course is offered periodically at locations across the country at a cost of $890. An 8-week online course is offered at a cost of $945.

Upon successful completion of this course participants will be able to:

- Describe the value-added role of procurement in the organizational strategic planning process.
- Develop a strategic procurement plan for an organization.
- Describe the various budget processes and the ways that the procurement function can add value to each process.
- Describe the steps in the strategic sourcing process.

- Evaluate, select, and apply the tools and processes available for a comprehensive procurement plan.
- Use analysis tools to identify opportunities for strategic sourcing.
- Use tools to manage client expectations and engagements to create positive outcomes.
- Use activity analysis and tracking tools to determine the staffing required to support organizational success

Additional courses available from NIGP include:

- **Contracting for Public Sector Services**

Faced with the challenge of identifying best value, can the public procurement professional successfully engage partners to achieve efficiency, effectiveness, and the social goals of the community? Call it privatization, outsourcing, competitive tendering, or alternative service delivery, contracting for public sector services dominates contract spending at all levels of government in countries around the world. This course examines the process beginning from the decision whether to "make or buy" through the special considerations of the services RFP, the contract award, and contract administration. Practical examples, discussion, group exercises, and cases studies will be used throughout the course. A 6-week online course is offered at a cost of $720.

Upon successful completion of this course participants will be able to:

- Identify advantages and disadvantages of contracting for services.
- Conduct a make-or-buy decision based on a scenario or case study.
- Determine variables that impact public/private competition.

- Develop performance measures for a Scope of Work (SOW).
- Develop proposal evaluation criteria.
- Analyze options available to an agency in a protest.
- Create a transition plan.

- **Developing and Managing Requests for Proposals**

  This course is uniquely designed to prepare procurement professionals to use the Request for Proposals (RFP) process to its maximum potential. The class agenda will identify the process, offer a key understanding of the elements of the proposal, and ascertain ways in which the document can be used to its full capability. Pitfalls and success stories will make the class relevant and applicable when planning to incorporate this type of solicitation into the government process. Practical examples, discussion, group exercises, and case studies will be used throughout the course. This 3-day course is offered periodically at locations across the country at a cost of $915 per student. An 8-week online course is offered at a cost of $945.

Upon successful completion of this course participants will be able to:

- Select the best solicitation process for a given procurement
- Describe the RFP planning and development process
- Describe the Evaluation Team roles and responsibilities
- Identify and describe the different types of evaluation methodologies and their associated application
- Describe proposal handling processes
- Prepare to conduct a negotiation
- Describe how to customize terms and conditions in a contract to meet the needs of the procurement
- Identify and describe how to manage post award issues in accordance with the commonly accepted practices of the profession.

- **Effective Contract Writing**

  Many purchasing professionals are required to organize, write and interpret contracts. This session is designed to cover the structure and meaning of enforceable contracts. Contracts have a logical sequence and specific contract provisions. By learning the basics and rules for improvement, the principles become manageable. The seminar will offer tips and tricks on the language that can be used when writing contracts for any entity. This 2-day course is offered periodically at locations across the country at a cost of $915 per student.

Upon successful completion of this course participants will be able to:

- Define what a contract is
- List the format of a Contract

- Discuss Specific Contract Provisions

- **How to Buy Performance Results**

  An agreement should be more than the purchase of goods and services — it should ensure that the best results are achieved by the end user. Performance results can be embedded into a contract that articulates the desired outcomes and produces improved results. This course aims to explain the difference between the purchasing of goods and services versus the purchasing of performance results and how this crucial difference can be used to develop tools and techniques to improve contracts and supplier performance. This 1-day course is offered periodically at locations across the country at a cost of $915 per student.

Upon successful completion of this course participants will be able to:

- Develop an appropriate mission statement for a purchase
- Develop and structure a statement of work designed for performance results.
- Develop a contract written for performance results.
- Develop results-based metrics for a contract.

- **Risk Management in Public Sector Contracts**

  Risk is a critical consideration in the contracting and procurement process. A thoughtful and proactive approach toward risk, as it relates to specific procurement actions, contributes to the success of contract performance. Risk is directly related to the successful achievement of targeted goals and objectives. The emphasis of this course is on developing a solid understanding of the complexities of risk management. The course content recognizes the importance of planning, monitoring, and proactive insight and oversight into risk areas related to the contract's stated performance outputs and outcomes. Practical examples, discussion, group exercises, and case studies will be used throughout the course. This 2-day course is offered periodically at locations across the country at a cost of $710 per student. A 6-week online course is offered at a cost of $584.

Upon successful completion of this course participants will be able to:

- Identify the components of the risk management process.
- Describe each phase of the four-phase process model for managing risk.
- Assess types and levels of risk associated with a procurement project.
- Identify risk management tools and associate these tools with different types of risk.
- Utilize a risk management plan to identify, assess, and handle procurement-related risks.
- Integrate risk management practices into contract administration.

- **Sourcing in the Public Sector**

This course provides the participant with a comprehensive overview of the sourcing process within the public sector. Essential elements, including pre-sourcing planning, needs assessment, specifications, scope of work, deliverables, procurement strategies, value analysis, and internal control processes, are explored. Determining the appropriate sourcing method, preparing the relevant sourcing invitation document, managing the acquisition process, evaluation of response submissions, and contract awards will also be covered. In addition, the course will examine trends, technology developments, and the effects of both on the processes. Practical examples, discussion, group exercises and case studies will be used throughout the course. This 3-day course is offered periodically at locations across the country at a cost of $890. A

Upon successful completion of this course participants will be able to:

- Describe the stages in the solicitation process (from cradle to grave)
- Define various methods of competitive and non-competitive procurement including risk and benefits of each.
- Identify when prequalification is appropriate and the methods of prequalifying suppliers and products.
- Prepare and issue procurement documents including types of specifications, terms and conditions and bid/proposal forms.
- Describe the process of receiving, opening and analyzing bids, methods for award and award strategies.
- Identify and select responsive and responsible suppliers.
- Identify trends and technologies and their impact on sourcing in the public sector.

For further information regarding NIGP training and certification, please visit: http://www.nigp.org/grow-professionally.

The National Contract Management Association (NCMA) offers a variety of virtual and in-person educational events and certifications. E-Courses are available on a variety of topics including:

- Ethics
- Negotiations
- Contract Administration
- Contract Modifications and Options
- Contract Types
- Performance Based Contracting

These are one (1) hour courses and are $70 each and Webinars on a variety of topics are $189.

NCMA Education Partners offer certificate programs that range in coursework and cost. For example, one partner offers a 3-course package costs $5995, while another a Procurement and Contract Management Certificate for $15,000.

The application fee for the Certified Professional Contract Manager Certification is $375 and the cost for the exam is $125. The CPCM certification is most appropriate for contracting professionals who have mastered most the contract management competencies in the Contract Management Body of Knowledge (CMBOK), have extensive business education and training, and have a minimum of 5 years of experience. Study guides are available to assist in preparing for the certification exam.

For further information regarding NCMA training and certification, please visit: http://www.ncmahq.org/learn-and-advance/certification.

Appendix C – Costs Associated with Training Opportunities Currently Available

The following table provides a summary of training resources currently available to DHHS employees. Detailed information regarding these offerings can be found in Appendix B.

Training Provider	Course Title	Unit Cost	Total Cost
UNC SOG	Basic Principles of Local Government Purchasing	$525	
	Contracting for Construction and Design Services	$400	
	Intermediate Purchasing Seminar	$425	
	Introduction to Local Government Finance	$575	
CLGPO Certification – administered by CAGP's CLGPO Committee		Free	Free
NC DOA P&C	NC Contract Administration and Monitoring (Post Award)	Free	Free
	NC Procurement	Free	Free
	Specification Writing	Free	Free
	Solicitation Documents and the Law: Explaining Legal Terms and Conditions in IFBs and RFPs	Free	Free
	Request for Proposal (RFP) Development and Evaluation	Free	Free
	Determining Cost	Free	Free
	NIGP Contract Administration in the Public Sector	$700	
NC DIT	IT Procurement Rules Review	Free	Free
	Introduction to IT Procurement	Free	Free
	The RFP Process	Free	Free
National Institute for Governmental Purchasers (NIGP)	Contract Administration in the Public Sector	$945	

	Introduction to Public Procurement	$915	
	Legal Aspects of Public Procurement	$915	
	Strategic Planning in the Public Sector	$945	
	Contracting for Public Sector Services	$720	
	Developing and Managing Requests for Proposals	$915	
	Effective Contract Writing	$915	
	How to Buy Performance Results	$915	
	Risk Management in Public Sector Contracts	$710	
	Sourcing in the Public Sector	$890	
National Contract Management Association (NCMA)	E-Courses (topics including ethics, negotiations, contract administration, contract modifications and options, contract types, performance based contracting)	$70 per topic	

Appendix D – The Contract Management Standard



The Contract Management Standard™

Final Edition

Purpose of the Contract Management Standard

The purpose of the *Contract Management Standard* is to describe the nature of contract management in terms of the contract management processes created through the integration and interaction of job tasks and competencies, and the purposes they serve. The common and repeated use of this standard will improve productivity, increase efficiency, and reduce costs.

A standard is "a document established by consensus that provides rules, guidelines, or characteristics for activities or their results."[1] Compliance with this definition is shown in **FIGURE 1**.

FIGURE 1. Requirements of a Standard

Requirement	Compliance
"document"	This document is published by the National Contract Management Association.
"established by consensus"	Consensus was established through a job task analysis survey and working groups comprised of materially affected and interested parties. This process included a survey of contract managers, expert drafting, peer review, and a formal public comment validation.
"provides rules"	See "Contract Life Cycle" for the domains, competencies, and job tasks inherent to each life cycle phase.
"provide guidelines"	See "Guiding Principles" for the principles relevant to all buyers and sellers throughout all phases of contract management.
"provide characteristics for activities"	See "Competency" and "Job Tasks" for the characteristics of the activities (also referred to as "processes").
"provide their results"	See "Domains" for the expected outcomes of contract management job tasks.

Definitions

Terms related to contract management are defined in the NCMA *Contract Management Body of Knowledge*. The following terms, with their basic definitions, are provided for easy reference:

Contract management–the actions of a contract manager to develop solicitations, develop offers, form contracts, perform contracts, and close contracts.

Contract manager–the authorized representative or agent for a contracting party.

Contract–a mutually binding legal relationship obligating the seller to furnish supplies or services and the buyer to provide consideration for them.

Structure of the Contract Management Standard

The *Contract Management Standard* is comprised of five components (see **FIGURE 2**):

1 | *Guiding Principles*–For contract management, these principles apply to all contract managers in all phases of the contract life cycle.

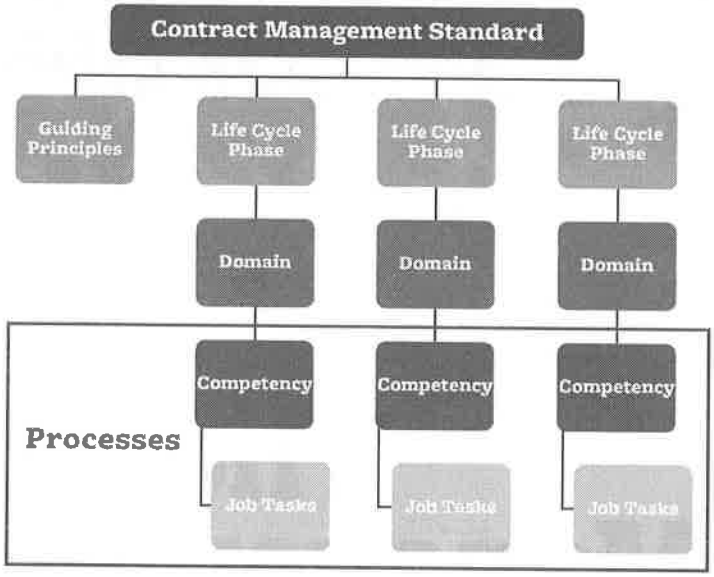
2 | *Contract Life Cycle Phases*–The phases of a contract: pre-award, award, and post-award.

3 | *Domains*–The areas within a contract life cycle phase that produce significant contract management outcomes.

4 | *Competencies*–The processes utilized to produce the expected contract management outcomes of the domains. These processes involve the ability to perform multiple job tasks, both simultaneously and sequentially, while achieving meaningful results.

5 | *Job Tasks*–The tasks performed on a routine basis by contract managers. Contract managers systematically process the job tasks to achieve the expected results of the competencies.

FIGURE 2. Component Structure of the *Contract Management Standard*



The *Contract Management Standard* is established as presented in **FIGURE 3** on page 3.

1.0 Guiding Principles

Guiding Principles for contract management are applicable throughout all phases of the contract life cycle in all contract management circumstances, irrespective of changes in priorities, strategies, requirements, or resources (e.g. personnel, money, equipment, time). (See **FIGURE 4** on page 3.)

FIGURE 3. The Contract Management Standard

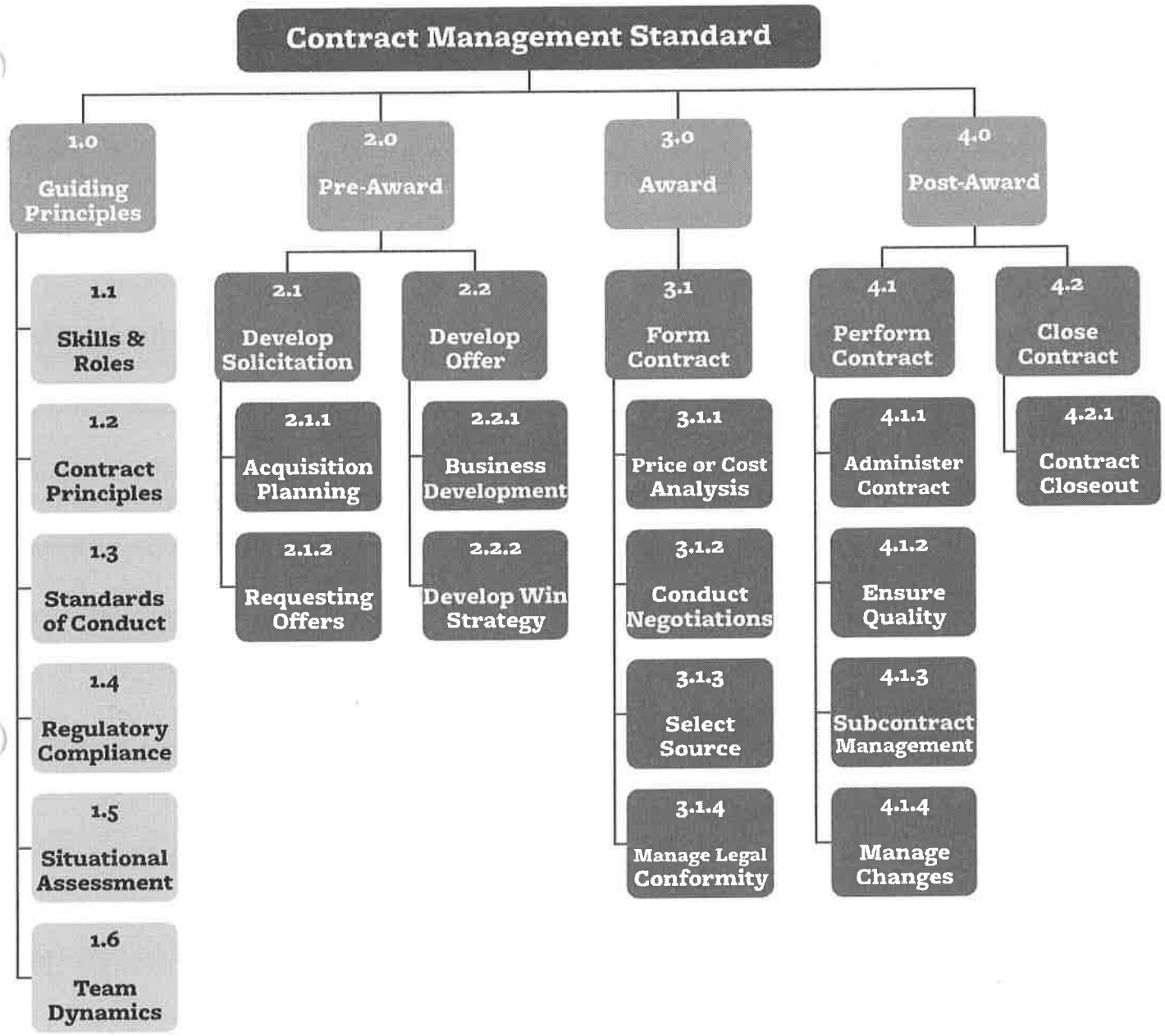
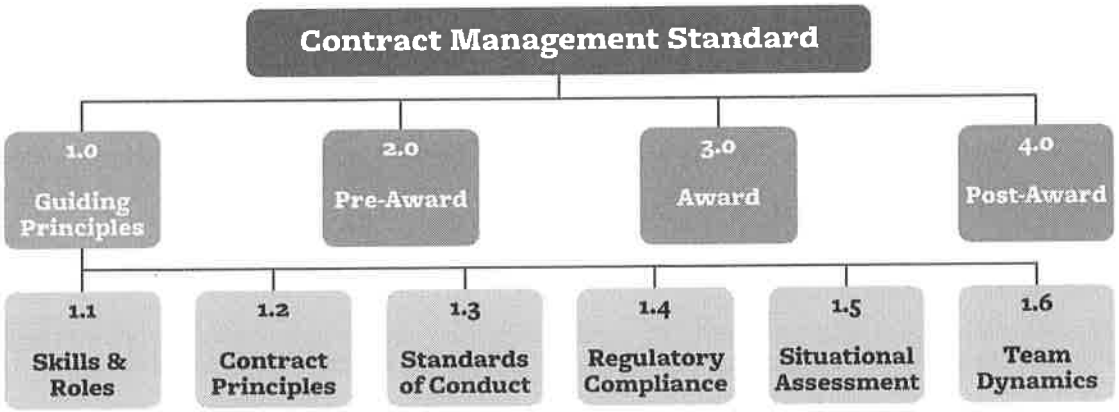


FIGURE 4. The *Guiding Principles* of Contract Management



1.1 Skills and Roles

Contract management is the process of managing contracts throughout the contract life cycle while ensuring customer satisfaction. This includes the management of contract elements such as negotiations, changes, requirement interpretations, deliverables, contract terms and conditions, and risk management.

In terms of the responsibilities assigned to a contract manager, contract management has a very broad perspective. The job scope ranges from the skills of managing, organizing, and planning to the negotiating of complex contracts. Contract management demands general business skill and acumen in such areas as change management, collaboration, communication, critical thinking, customer orientation, influencing others, knowledge management, leadership, problem solving, and results orientation. In addition, it requires specialized skill and acumen in such areas as financial management, project management, risk management, and supply chain management.

Contract managers fall into two primary functions–the buyer and the seller.

Buyer: The contracted party with the requirement for goods and/or services to be fulfilled by one or more sellers.

Seller: The contracted party tasked with fulfilling the buyer's requirement for goods and/or services.

The buyer and the seller satisfy requirements through effective management of the contract. This skill requires the contract manager to focus on the problem as stated and process the available information and knowledge to achieve an actionable solution. This process is highlighted by identifying risks and facilitating the mitigation of the risks. Though many solutions may not lead to the most desired outcome, the contract manager should strive to minimize the influence of personal biases, maximize the likelihood of an accurate result, and facilitate communication among affected parties.

Successful contract managers are those who can develop and execute actionable business strategies. To serve in this role requires higher education, professional training, and occupational experience to help guide the customer and other stakeholders through the contract life cycle phases. Contract managers must have effective analytical, problem-solving, and communication skills–and must be adaptable to a changing business environment. Contract managers must understand the regulatory environment in order to legally implement innovative solutions and must manage risk while satisfying contract requirements and obligations.

The size and complexity of the contract will influence the constraints on which the contract manager needs to focus and require effective application and management of appropriate contract management processes. While constraints may negatively impact behavior in some areas, they should encourage creative problem-solving and critical thinking skills while performing within ethical and regulatory boundaries.

1.2 Contract Principles

Contract principles are the fundamentals of contracting that all contract managers must understand and apply. Simply put, a contract results from:

- Offer,
- Acceptance,
- Consideration, and
- The intent to create a legal relationship.

For a contract to be valid, both parties must indicate that they agree to the terms. For a contract to be binding, it must be for a legal purpose and can only be made by parties who are competent.

Contract principles fall into two major categories:

General contracting concepts–These include such notions as principal and agency, types of authority, essential elements of a contract, market research, competition, fair and reasonable prices, and ethics; and

Terms and conditions to address specific contract matters–These include such things as inspection and acceptance, title transfer, force majeure, risk of loss, repudiation, warranties, payment terms, contract changes, and termination.

1.3 Standards of Conduct

Standards of conduct help to define the ethical behavior expected of all contract managers and their organizations. Standards of conduct are intended to create trust and confidence in the integrity of the contract management process. The standards require contract managers to conduct themselves in such a manner as to bring credit upon the profession. Contract managers conduct all business in good faith while:

- Being transparent in making appropriate disclosures,
- Adequately protecting competitive information, and
- Avoiding actual or apparent conflicts of interest.

This ethical behavior not only applies to collaboration with other professionals, but it also applies to the technical aspects involved throughout the contract life cycle phases. All contract managers should abide by the letter and spirit of the standards of conduct.

1.4 Regulatory Compliance

At its core, the contract management profession is about the knowledge and application of laws, codes, and regulations. Contracts are legal documents that represent an agreement between the parties whose terms and conditions are legally binding and enforceable in courts of law and other administrative bodies. As such, it is important for contract managers to have a working knowledge of the laws, codes, regulations, and other sources of guidance that define, to a large extent, the environment in which the contract manager operates.

1.5 Situational Assessment

Applying knowledge through lessons learned to the management of current and future contracts is a crucial ability in contract management. Successful contract managers do the following:

- Know how to capture, document, and share knowledge;
- Know how to shape requirements to align with their organization's vision, mission, and strategic goals;
- Are aware of how seemingly independent contract actions impact each other now and in the future;
- Understand product and systems life cycle principles;
- Apply effective market research techniques to collect, analyze, and implement market intelligence;
- Identify opportunities for process improvement and optimization; and
- Negotiate meaningful contract terms and conditions while meeting customer needs.

1.6 Team Dynamics

The contract management team combines the functional disciplines of buyers and sellers for the common purpose of satisfying the customer need. While buyer and seller teams may work independently in the pre-award phase, the relationship becomes formal upon contract award and continues until the contract is closed. Members of the contract management team are expected to add value by performing their functions and knowing their roles throughout the contract life cycle phases.

To be successful, each member must have a working knowledge of all roles involved on the team. These roles can include, for example, engineering, estimating, finance, legal, logistics, pricing, project management, requirement development, supply chain management, etc. Becoming familiar with the other roles on the team will enable each role to complement one another, and to allow for identification of gaps or overlaps in responsibilities.

The contract management team must be able to:

- Conduct meaningful collaboration in order to make accurate and timely decisions while solving complex contracting problems and forming an effective contract relationship,
- Identify opportunities for process improvement and optimization, and
- Collect and record lessons learned.

Contract Life Cycle Phases

Contracts have a distinct beginning and end, and the contract life cycle defines these parameters. The contract life cycle generally consists of three contract phases, as seen in **FIGURE 5**: pre-award, award, and post-award.

Contract management processes performed by contract managers generally fall into five domains within the three contract life cycle phases. **FIGURE 6** illustrates how the domains relate to the life cycle phases.

FIGURE 7 on page 6 illustrates the domains and their outcomes. Each contract life cycle phase and domain has specific competencies and job tasks that together are called "processes."

FIGURE 5. The Phases of the Contract Life Cycle

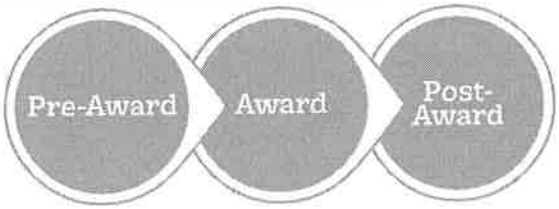
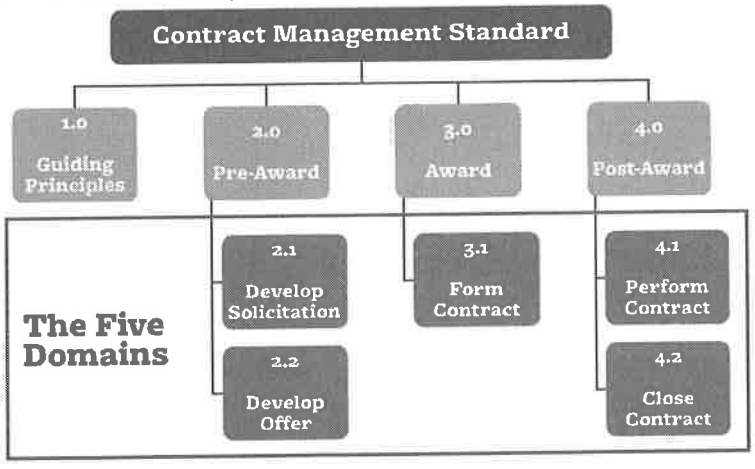


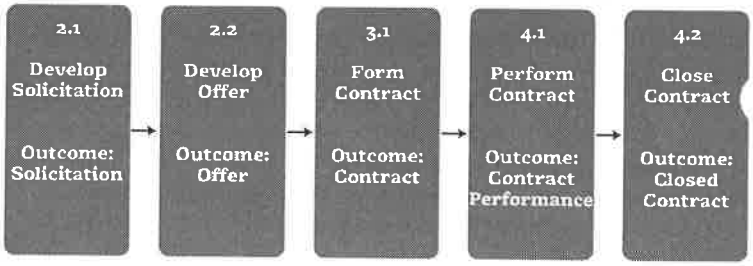
FIGURE 6. Contract Life Cycle Phases with Associated Domains



2.0 Pre-Award Life Cycle Phase

Pre-Award is the first phase of the contract life cycle. The pre-award process for the buyer includes assisting in defining the customer requirements for products or services, and then developing a comprehensive acquisition plan to fulfill those requirements in a timely manner at a reasonable price. This includes developing and executing an overall strategy for the purchase, which is accomplished through researching the marketplace, developing contracting strategies, preparing solicitations, and requesting offers.

FIGURE 7. Contract Management Domains and Their Outcomes



The pre-award process for the seller includes developing and executing a strategy for obtaining the award for a contract, including pre-sales activities, market strategies, and responding to the procurement.

There are two domains within the pre-award life cycle phase:

- *Develop Solicitation*–The buyer job tasks and competencies for this domain produce the acquisition plan and the solicitation.
- *Develop Offer*–The seller job tasks and competencies for this domain produce the business development plan and the offer.

2.1 Develop Solicitation

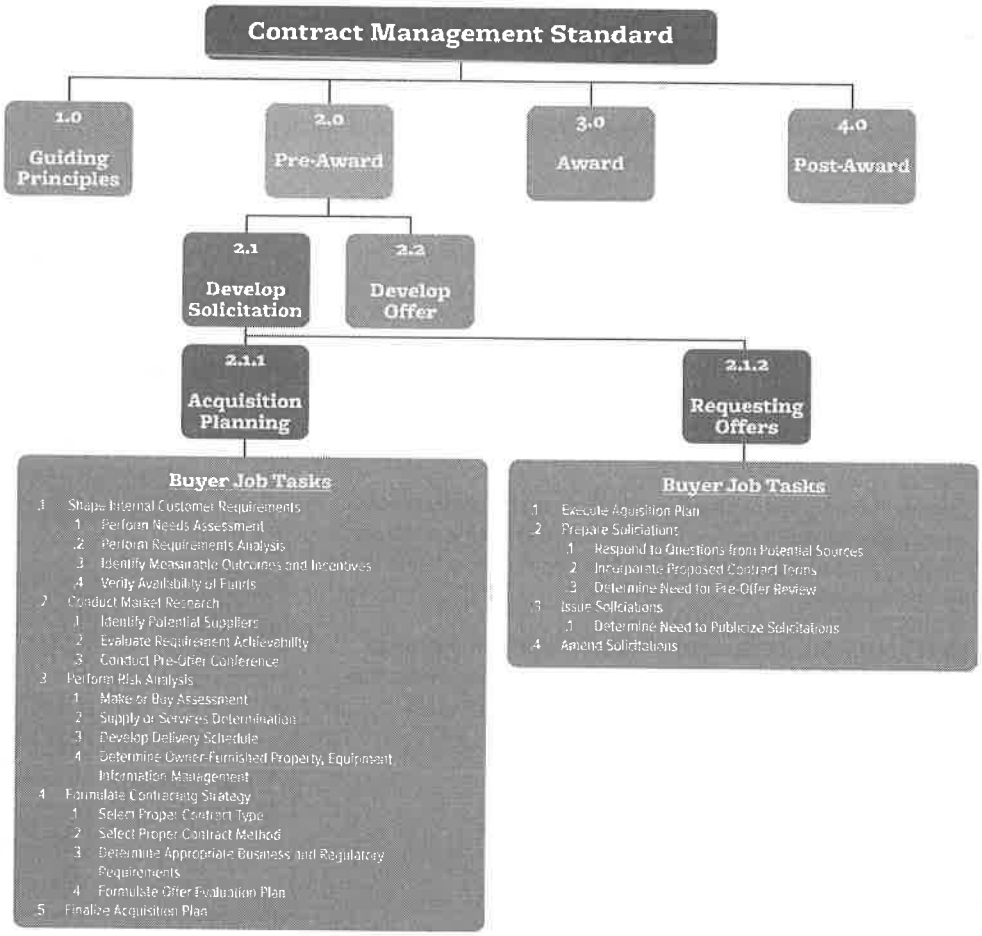
Develop Solicitation is primarily the domain of the buyer. (See **FIGURE 8.**) It is the process of describing all the elements of the customer requirements (technical, business, regulatory, etc.) to the sellers. The value added by this process is the accurate presentation of the customer requirement through a solicitation in order to create a viable contract that can be performed.

» 2.1.1 Acquisition Planning

Acquisition Planning is the process by which efforts of all personnel responsible for an acquisition are coordinated and integrated through a comprehensive plan for fulfilling the customer need in a timely manner at a reasonable cost. It includes developing the overall strategy for managing the acquisition. The value added through acquisition planning is in developing a plan that includes such elements as:

- Assisting in defining the buyer's requirements,
- Conducting relevant market research,
- Performing meaningful risk analysis, and
- Formulating the contracting strategy.

FIGURE 8. Competencies and Tasks for the *Develop Solicitation* Domain



» 2.1.2 Requesting Offers

Requesting Offers is the process of implementing the acquisition plan by soliciting responses from contractors in order to fulfill a customer need. The value added of requesting offers is producing a clear and concise solicitation that effectively communicates all the buyer's requirements and enables the sellers to provide comprehensive, responsive proposals.

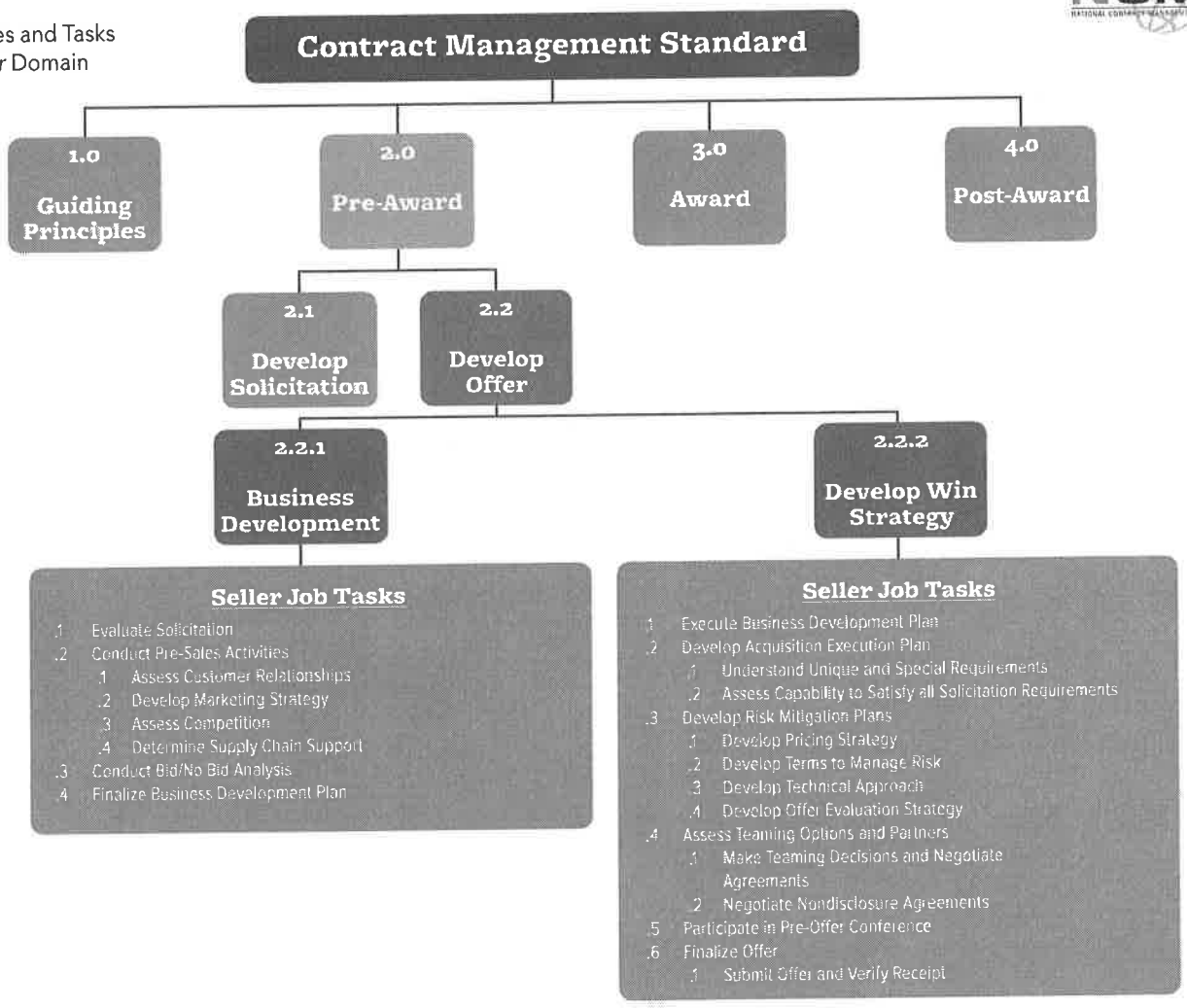
2.2 Develop Offer

Develop Offer is primarily the domain of the seller. It is the process of:

- Developing foundational business practices and strategies to compete in the marketplace, and
- Responding to solicitations with the intent of winning contracts and meeting performance requirements.

The value added by this process is to provide the buyer with a comprehensive solution to the buyer's requirements that

FIGURE 9. Competencies and Tasks for the *Develop Offer* Domain



enhances the seller's competitive position in the marketplace while delivering customer value. (See **FIGURE 9.**)

» *2.2.1 Business Development*

Business Development is the process of:

- Organizing pre-sales activities to develop customer relations and market strategy, and
- Assessing competition.

The value added in business development is to understand the customer's near- and long-term requirements and determine the organization's ability to successfully respond to a solicitation.

» *2.2.2 Develop Win Strategy*

Develop Win Strategy is the organization's ability to execute the business development plan as it assembles an offer to win business. The value added in developing a win strategy is in exploiting and increasing organizational strengths and efficiencies in order to enhance marketplace positioning.

3.0 Award Life Cycle Phase

The second contract life cycle phase is *Award*. The award process involves all the work by both the buyer and seller that produces an awarded contract. Some contracts are very simple and others are exceedingly complex, but the majority fall somewhere in between. There is one domain in the award phase: *Form Contract*. The job tasks and competencies of the *Form Contract* domain produce the contract. (See **FIGURE 10** on page 8.)

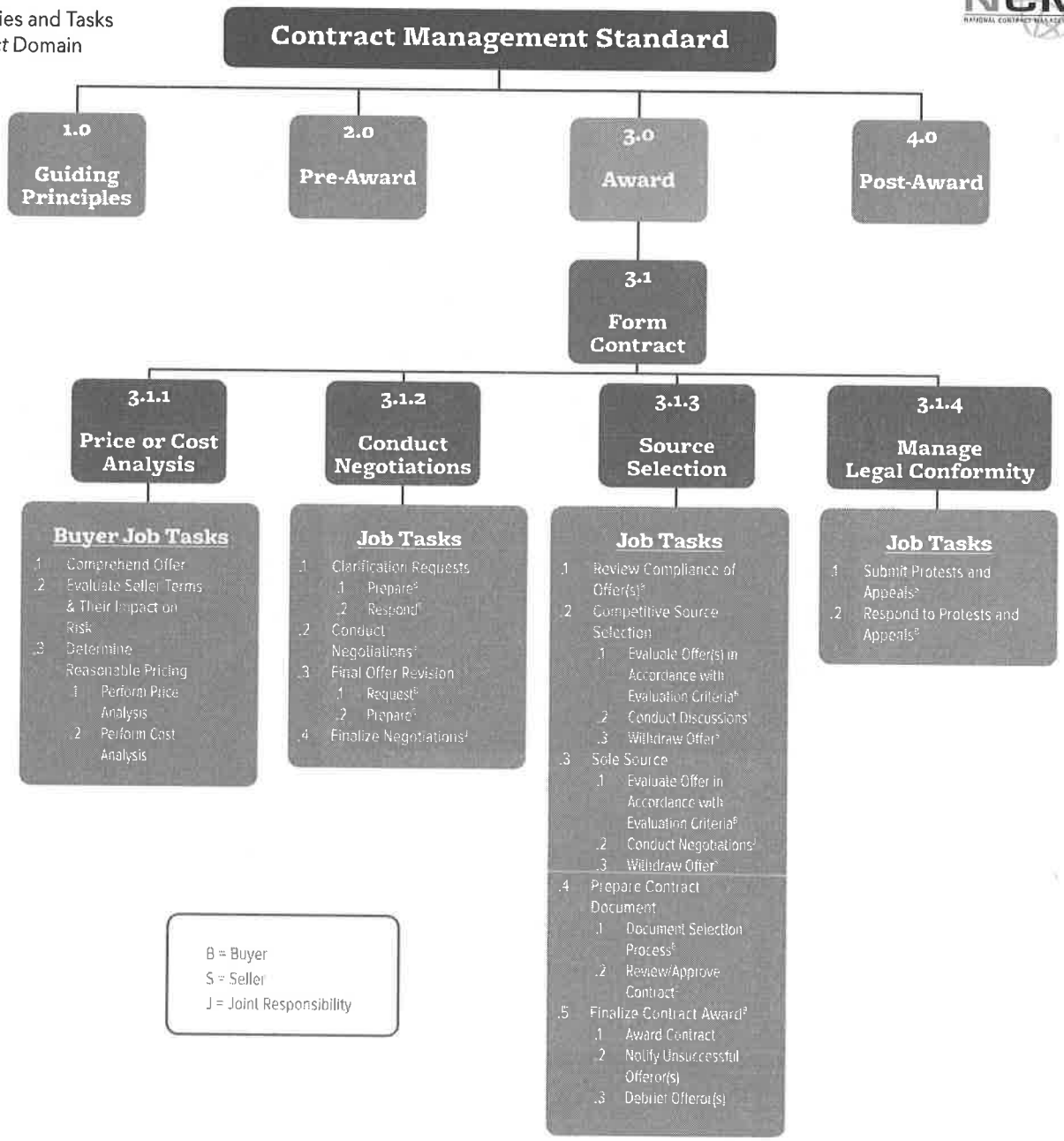
For this transitional phase, buyer job tasks include:

- Evaluating offers,
- Conducting negotiations,
- Selecting the source,
- Awarding the contract(s),
- Debriefing offerors, and
- Addressing mistakes in offers and seller challenges to the selection process.

For the seller, job tasks include:

- Clarifying offers,
- Participating in negotiations, and
- Preparing final offers.

FIGURE 10. Competencies and Tasks for the *Form Contract* Domain



3.1 Form Contract

Form Contract is the process of:

- Determining reasonable cost and pricing,
- Conducting negotiations,
- Selecting the source, and
- Managing challenges and disagreements.

The value added by this process is to mitigate or eliminate contract performance risk by selecting the best source and negotiating prices and terms and conditions.

» *3.1.1 Price or Cost Analysis*

Price Analysis is the process of examining and evaluating an offeror's proposed price without evaluation of the separate detailed cost elements and proposed profit of the offeror's price proposal. The value added by this process is the buyer's ability to evaluate an offer by comparing it with indicators of reasonableness, such as:

- Historical prices paid,
- Published prices,
- Competitive analysis,
- Comparative analysis, and
- Market data.

Cost Analysis is the process of reviewing and evaluating any separate cost elements and profit or fee in an offeror's proposal–and of the judgmental factors applied in projecting from the data to the estimated costs–to determine the degree to which the offeror's proposed costs represent the cost of contract performance should cost

assuming reasonable economy and efficiency. The value added by this process is the buyer's ability to ascertain a fair and reasonable price and/or determine the realism of the price in preparation for contract negotiations, discussions, and for reducing risk in contract performance.

» 3.1.2 Conduct Negotiations

Conduct Negotiations is the process of communicating between buyer and seller regarding all aspects of the offer and its terms, and often involves clarifying requirements and parties requesting changes or consideration of an alternate approach that may be consistent with the solicitation requirements. The value added by this process is where both parties work to find common ground or offer compromises among their differences in quantity, price, delivery, quality, or other factors.

» 3.1.3 Source Selection

Source Selection is the process of analyzing submitted offers in accordance with the solicitation evaluation criteria to select the source that has the highest probability of satisfactory contract performance. The value added by this process is in mitigating buyer risk by selecting the offeror most likely to satisfactorily perform the contract.

» 3.1.4 Manage Legal Conformity

Manage Legal Conformity is the process of resolving conflict between potential and actual contracted parties. The value added by this process is the ability to resolve issues related to the solicitation or source selection process through informal and formal means.

4.0 Post-Award Life Cycle Phase

Once the Award phase is completed, the Post-Award contract life cycle phase begins. This involves all of the contract management functions known as "contract administration." The contract administration functions will vary greatly depending on the complexity of the contract. Both the buyer and seller are actively involved in contract administration to ensure satisfactory performance and to bring the contract to a successful conclusion.

Buyer job tasks include:

- Addressing any issues arising during contract performance that might increase performance risk,
- Executing contract modifications,
- Monitoring compliance of contract terms,
- Making payment(s), and
- Closing out the contract.

Seller job tasks include:

- Contract performance,
- Invoicing,
- Engaging in subcontracting activities,
- Managing contract changes, and
- Bringing the contract to a successful conclusion.

There are two domains within the post-award phase:

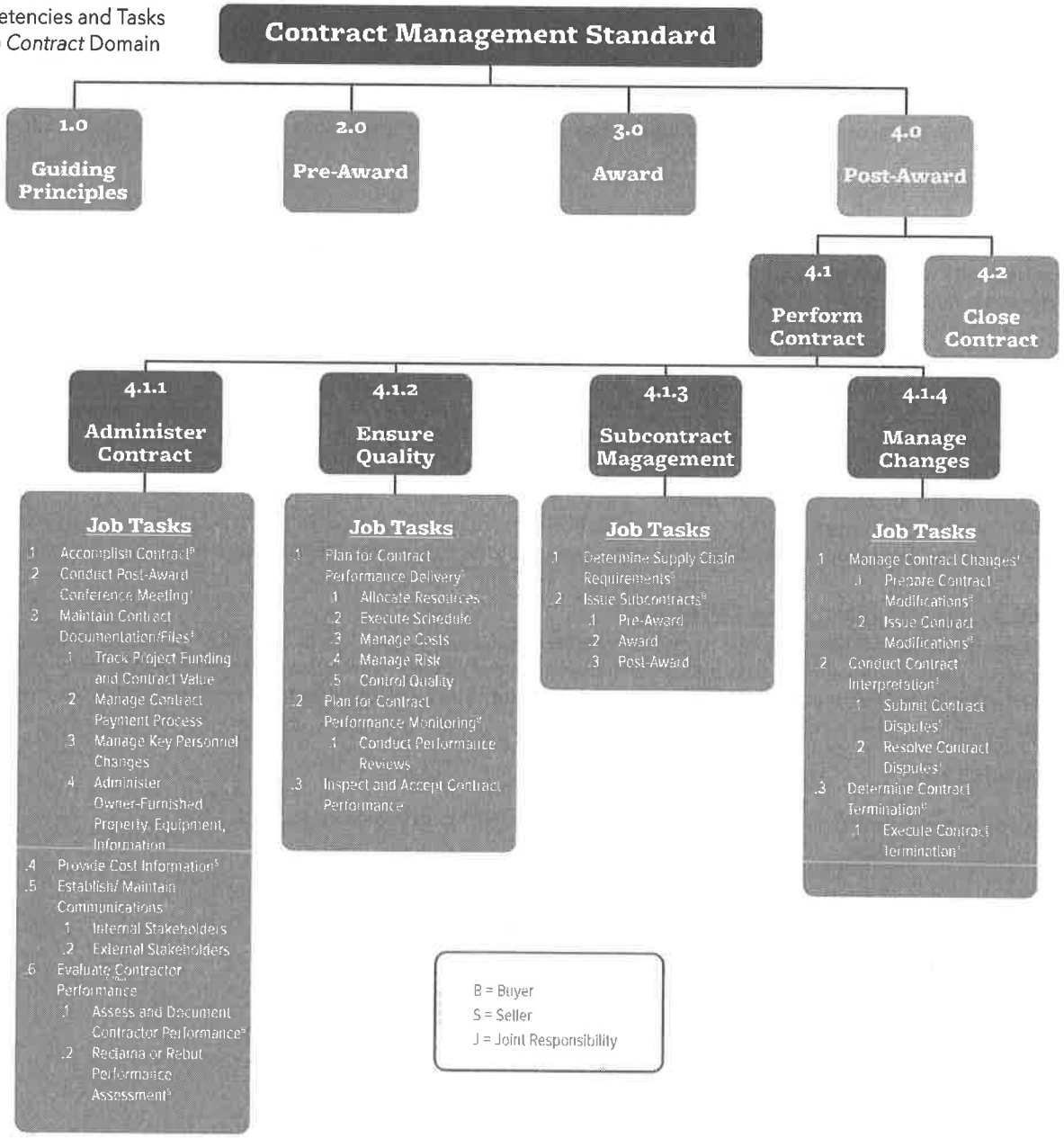
- *Perform Contract*–The job tasks and competencies for this domain produce the contract performance.
- *Close Contract*–The job tasks and competency for this domain produce the closed contract.

4.1 Perform Contract

Perform Contract is the process of establishing and maintaining communications, and tracking and documenting contract performance. The value added by this process is:

- Monitoring risk and assessing its impact on contract performance, and
- Ensuring compliance with contractual terms and conditions during contract performance up to contract closeout or termination. (See **FIGURE 11.**)

FIGURE 11. Competencies and Tasks for the *Perform Contract* Domain



» *4.1.1 Administer Contract*

Administer Contract is the process of:

- Establishing expectations,
- Maintaining communication channels,
- Processing contract documentation,
- Conducting post-award performance reviews, and
- Assessing contract performance.

The value added by this process is in managing risk and increasing the likelihood of satisfactory contract execution.

» *4.1.2 Ensure Quality*

Ensure Quality is the process of:

- Planning for contract performance delivery and monitoring, and
- Inspecting and accepting contract performance.

The value added by this process is to ensure the delivered product or service meets the terms and conditions of the contract.

» *4.1.3 Subcontract Management*

Subcontract Management is the process of contract management of subcontracts, with the prime contractor being responsible for the performance of its supply chain. The value added by this process is in having a single point-of-contact responsible for:

- Subcontract award,
- Technical and financial performance,
- Monitoring performance, and
- Payment to the subcontractors and suppliers for the work accom plished under subcontract terms.

» 4.1.4 Manage Changes

Manage Changes is the process of:

- Initiating, considering, negotiating, and issuing contract modifications; and
- Maintaining configuration control of the contract and subsequent contract performance.

The value added by this process is to allow flexibility in making necessary contract changes while protecting the integrity of the contract.

4.2 Close Contract

The *Close Contract* domain is the domain of both the buyer and seller. It is the process of:

- Verifying all the requirements of the contract are satisfied,
- Settling unresolved matters, and
- Reconciling the contract to make final payment.

The value added by this process is in determining the buyer and seller contract obligations have all been satisfied. (See **FIGURE 12.**)

» 4.2.1 Contract Closeout

Contract Closeout is the process of ensuring:

- All performance has been accomplished,
- Final payment has been made, and
- The contract has been reconciled.

The value added by this process is in the completion, delivery, and acceptance of the contract requirement(s) in accordance with the terms and conditions of the contract.

ENDNOTE

1. https://ansi.org/about_ansi/faqs/faqs.aspx?menuid=1.

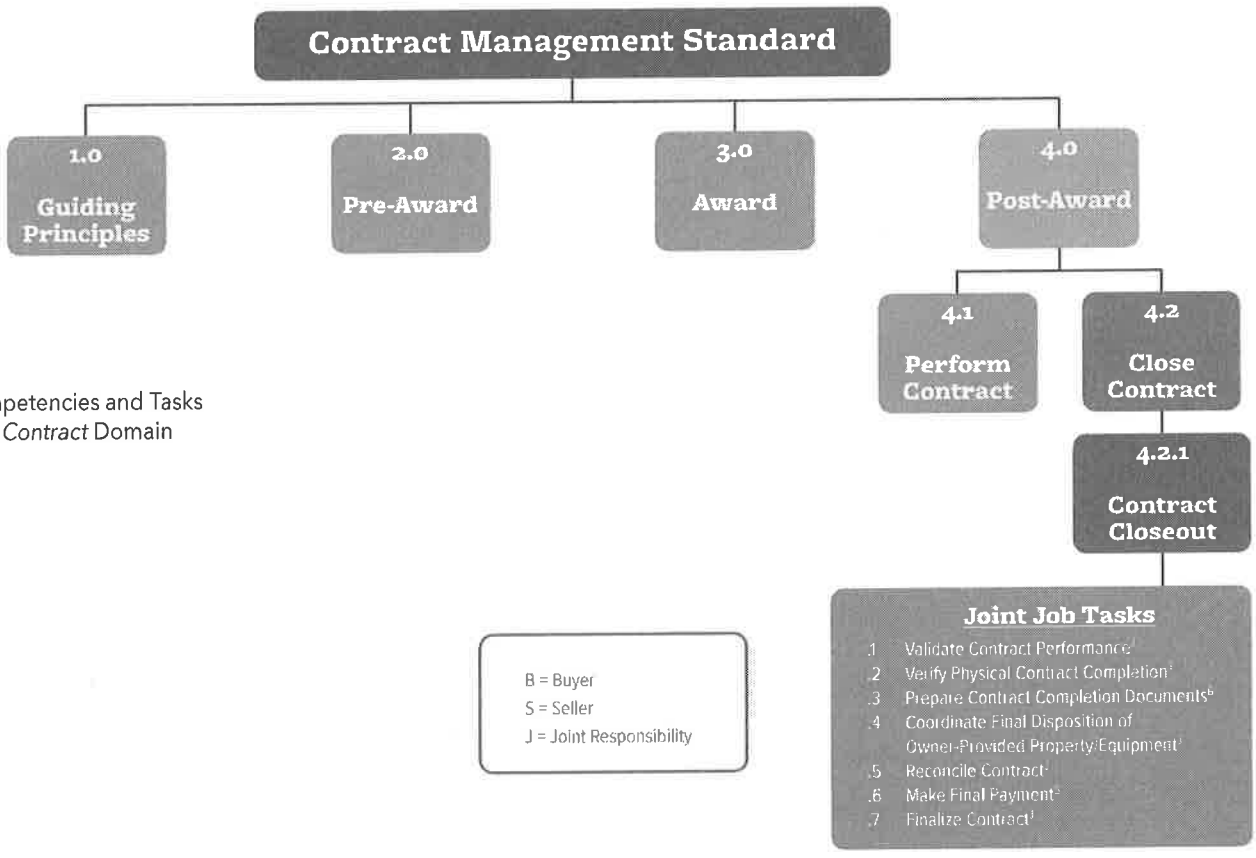


FIGURE 12. Competencies and Tasks for the *Close Contract* Domain

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ON HEALTH AND HUMAN SERVICES

North Carolina Families Accessing Services through Technology (NC FAST) Update

Susan Perry-Manning and Angela Taylor
Department of Health and Human Services

December 12, 2017

What is NC FAST ?

North Carolina Families Accessing Services through Technology

- Software solution to deliver state benefits and services at the county level for all 100 NC local DSS's
- Counties now manage case information for Medicaid eligibility, Food and Nutrition Services, Child Care, and Energy programs in one system
- Replaces 20 legacy systems upon full transition
- Shares client data across all benefitting programs
- Applies federal rules, built into the system
- Collects data for individual eligibility and case management and program, county, and state level outputs and performance measures
- 90% business process change management, 10% technology

NC FAST Guiding Principles

- Partner with and add value to system users and stakeholders – front line staff, managers, administrators, and policymakers
- Support accurate and timely administration of programs to assure compliance and integrity
- Focus on quality service delivery, efficiency and accountability
- Share ownership of problems and solutions with DHHS program and IT staff and county DSS's

NC FAST Projects

Completed Projects

- Global Case Management and Food and Nutrition Services
  - Full implementation to all 100 counties was completed in March 2013.
- Medicaid, Work First, Special Assistance, and Refugee Assistance
  - Full implementation to all 100 counties was completed in November 2014.
- Federally-Facilitated Marketplace Interoperability
  - Full implementation to all 100 counties was completed in June 2016.

In-Process Projects

- Subsidized Child Care Assistance, Crisis Intervention and Low Income Energy Assistance
- Child Welfare Services
- Medicaid Self Service and Enterprise Program Integrity
- Document Management System Enhancement

Adult Services has not been initiated at this time

NC FAST Metrics

- 6,500 users daily in all 100 counties
- 4,430 individuals have accessed one or more of 44 online training modules

Program	Applications Processed in SFY2017	Applications Processed in SFY2018 (to date)
Food and Nutrition Services (FNS)	554K	229K
Supplemental Nutrition Assistance Program (SNAP)	5K	2K
Medicaid	627K	245K
Cash Assistance	31K	14K
Special Assistance	11K	4K
Refugee Cash Assistance	1K	75

Program	Number of Applications Processed since Go-Live
Child Care	59K
Energy Programs (Low Income Energy Assistance Program (LIEAP) and Crisis Intervention Program (CIP)	87K

SOURCE: NC FAST System Data as of Nov. 30, 2017

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON HEALTH AND HUMAN SERVICES

DHHS IT Project Updates

Sam Gibbs and Danny Staley
Department of Health and Human Services

December 12, 2017

NCTracks

Multi-payer claims payment system supporting NC Medicaid and Divisions of Public Health, Mental Health/Developmental Disabilities/Substance Abuse Services and Office of Rural Health.

- **Operations**
  - Pays to over 1.8 million beneficiaries and 90,000+ providers
  - Claims Processing
    - Medical, behavioral health, dental, pharmacy and related claims for services rendered
    - System enhancements and defect repairs have reduced pending claims by 60%[1]

Fiscal Year	Number of Claims Processed (Millions)	PAID AMOUNT (Billion)
SFY 2016	225 Million	$11.2 Billion
SFY 2017	229 Million	$11.4 Billion

  - Application System Activities
    - Automated interfaces to Lexis-Nexis, NC Medical Board and SBI
    - Accelerated resolution rate of system defects resulting in 50 reduction of open defects[1]
  - Provider Services
    - Automated and operational process improvements have resulted in 50% reduction in inventory of Provider applications, reverifications and changes[2]
    - Application processing time reduced from 109 to 54 days[2]
    - Change request processing time from 75 to 34 days[2]
    - ~ 92,700 Active Providers as of October 2017

[1] Over last 24 months [2] Over last 12 months

NCTracks

Current Initiatives

- March 2017 received approval from CMS for Planning Advanced Planning Document (PAPD) to address Medicaid Enterprise System (MES) replacement
- Identifying changes required to NCTracks to support Medicaid Reform
- Aligning Medicaid Reform technology-related activities to with MES replacement activities to support Medicaid Reform goals and long-term Medicaid Enterprise System requirements (e.g., MITA Modularity)

MITA: Medicaid Information Technology Architecture

Health Information Exchange

The Health Information Exchange Authority (HIEA) is a led by the Department of Information Technology to provide services to assist in the electronic exchange of health information between health care entities.

- Continue to maintain strong partnership with the NC HIEA
  - Joint meetings and collaboration on key initiatives
- Collaboration on DHHS & HIEA Roadmap
  - Developing framework for discovery
  - Establishing governance team for continued development
- Partnering in identifying potential new value propositions
  - Exploring services within DHHS
  - Engaging private health care stakeholders
- Participating with HIEA team in legislative study
  - April 1, 2018 Feasibility Study
  - Extension Process

Health Information Technology

- Establishing presence in the NC digital health community
  - Building relationships with public and private entities
  - Participation in NC State ASSIST DoD workshop
  - Modernizing website
  - New email: NCHealthIT@dhhs.nc.gov
- Pursing opportunities for enterprise collaboration and solution development:
  - Division of State Operated Healthcare Facilities evaluation of electronic health record solutions
  - Division of Public Health - Immunization Registry Team and HIEA onboarding and services optimization
  - Division of Vocational Rehabilitation Services to explore HIEA use case for eligibility determination
- Meaningful Use Electronic Health Record Incentive Program
  - SFY18 - $3,405,005 issued in Federal incentive payments to date

Division of Services for the Deaf and the Hard of Hearing (DSDHH)

- Services Management System replaces several legacy systems
  - Posting of Request for Proposal: First Quarter 2018
  - Web-based with accessible mobile technology
  - Designed to maximize operational, service delivery and reporting efficiencies
  - Services tracked to clients and agencies, processes applications and invoices for assistive equipment and sign language interpreting services, manages resource inventories
  - Collaborative effort with DIT on business requirements and procurement documentation
  - Target Implementation Date: First Quarter 2019

eWIC Project

- **Project Purpose**

  Ensure compliance with the Healthy, Hunger-Free Kids Act of 2010 requiring all Supplemental Nutrition Program for Women, Infants and Children (WIC) State Agencies to implement Electronic Benefits Transfer by October 1, 2020, transitioning WIC benefits from paper vouchers to a debit style card

- **Current Status**
  - Project 100% federally funded
  - Pilot in progress in 7 counties (Bladen, Brunswick, Columbus, Duplin, New Hanover, Onslow, and Pender)
    October 4, 2017-December 31, 2017
    - Over 8,500 eWIC cards issued to families
    - Over $350,000 in WIC purchases redeemed by 127 WIC-approved vendors
  - Statewide Rollout anticipated January 22, 2018 to May 11, 2018
  - Project on schedule with all major milestones met



Electronic Death Registration System (EDRS)

- **Project Purpose**

  Replace current paper-based death registration process to meet today's industry standards, and provide accurate and timely registration/issuance of death records and death data reporting to local, state, and federal partners

- **Current Status**

  Anticipate vendor award by December 28, 2017

Medical Examiner Information System (MEIS)

- **Project Purpose**

  Replace 15-year outdated, obsolete and unsupported technology currently in use for the statewide medical examiner system

- **Current Status**

  RFP projected to be posted by December 29, 2017

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M. Watson	SAM
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Fred Bone	Bone Assoc.
J Peters	CSS
J [illegible]	NCALTCF
Jenny Villafane	Carolinas Healthcare system
Kruti Patel	Carolinas Healthcare System
Brandt Bettilyon	Carolinas Healthcare System
Holly Watkins	The Arc of NC

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[illegible]	Vidant Health
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Christin Cran	WakeMed
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Andy Munn	MVA

Committee Sergeants at Arms

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2. Name: David Leighton
3. Name: Jim Moran
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name: Billy Fritscher
2. Name: Becky Myrick
3. Name:
4. Name:
5. Name:

MINUTES
JOINT LEGISLATIVE OVERSIGHT COMMITTEE
HEALTH & HUMAN SERVICES

Tuesday, January 16, 2018
9:00 a.m.
Legislative Office Building, Room 643

ATTENDEES:

Chairmen:	**Pate, Dobson and Lambeth**
House Members:	**Cummingham, Dollar, Earle, Farmer-Butterfield, Malone, Murphy, White and Adcock, Fisher**
Senate Members:	**Curtis, Davis, Foushee, Hise, Krawiec, Tarte, Tucker, Barringer**

I. Welcome and Opening Remarks

Chair, Donny Lambeth presided and called the meeting to order at 9:10 a.m.

Representative Lambeth introduced Sergeant-at-Arms Staff assisting with the meeting and Jessica Boney, new member of the committee staff and attorney in Legislative Analysis.. He also welcomed members and guests.

II. Comments from the Secretary

North Carolina Secretary of Health and Human Services, Mandy Cohen, introduced DHHS staff presenting at today's meeting: Rod Davis, Chief Financial Officer; Mark Benton, Deputy Secretary for Health Services; Sam Gibbs, Deputy Secretary for Technology & Operations; and, Dave Richard, Deputy Secretary for Medical Assistance.

A. Update on Cardinal Innovations

Secretary Cohen provided an update regarding Cardinal Innovations. She reported that Cardinal is now operating under a new structure outlined by statute. Secretary Cohen stated that she is pleased with the progress being made. She complimented staff on its work to ensure a smoothe transition during restructure. Current operations of Cardinal Innovations Healthcare includes: 1) Meeting day-to-day obligations; 2) Having State on-site and regular calls with leadership; 3) Finalizing Corrective Action Plan; and, 4) Finalizing the process for allocating $3.8 million from administrative funds.

In response to Senator Pate's inquiry regarding authority over rules and regulations, Secretary Cohen responded that it was bound by statute. Representative Dollar requested clarification regarding the Consumer and Family Advocate Committee to which Secretary Cohen responded that the committee is comprised of 20 voting members; three of which are consumer family advocates from the CFA Committee.

The Secetary expressed confidence in the Board moving forward. She added that the Board is going through significant training and that several members served on the previous Board.

Senator Krawiec commended the department on the work it has accomplished and inquired if taxpayers will recover funds that were in violation of statute. Secretary Cohen responsed that attorneys are looking at what our legal options are.

Representative Earle questioned the reappointment of previous Board members and offered that term limits were set forth in statute stating that enough qualified persons are available within the state to fill seats without reappointment to the Board. Representative Cunningham inquired when the Corrective Action Plan would be ready for the Committee's review. Secretary Cohen responded stating that Board members were appointed by County Commissioners and agreed to look into term limits. She informed the Committee that the Action Plan would be available within the next several weeks.

B. Update on Influenza Data in North Carolina

Secretary Cohen reported on the current status of North Carolina influenza. As of January 6th, 26 flu-related deaths have been reported in North Carolina. Most occurred in persons aged 65 or older. Data indicate cases of the influenza are on the rise and will only get worse. Secretary Cohen reviewed the benefits of the vaccine and stated that DHHS has been proactive in promoting vaccination against the flu, conducting influenza surveillance, and providing guidance to clinicians to control outbreaks.

Representative Fisher observed that North Carolina was one of the last states to reach the threshold of being noticed for having the flu. She asked if an epidemiologist could follow up on the conjecture that temperature, etc. affect the probability of contracting the flu.

Representative Murphy applauded the efforts of DHHS and staff in addressing needs. He inquired if the 10% efficacy rate was accurate. In response, Secretary Cohen stated that North Carolina is seeing a virulent strain that is very intense. She encouraged everyone to become vaccinated. In response to a question from Chairman Lambeth regarding a shortage of the vaccine, Secretary Cohen stated no; however, some areas are experiencing a shortage of IV bags, etc.

Senator Tarte inquired about the timeline of payment to physicians working with the State to address the epidemic. Dave Richard, Deputy Secretary, responded that payment would be made prior to the end of the fiscal year. Chairman Lambeth asked the timeline for reports. In response, Secretary Cohen stated that several reports are outstanding and should be resdy soon. She agreed to notify the chairs if any require further action by the committee.

III. Office of Program Evaluation Reporting and Accountability (OPERA) Report

(S.L. 2017-57, Sec. 11A.11)

History of Legislative Actions Related to the DHHS Office of Program Evaluation Reporting and Accountability

Denise Thomas, Committee staff, reviewed Session Law 2015-241 that established the creation of the Office of Program Evaluation Reporting and Accountability (OPERA) within the Department of Health and Human Services. She reported that the purpose of OPERA is to: 1) Address a shortage of data preventing effectiveness of the DHHS programs; and, 2) Evaluate DHHS programs using evidence-based methodologies. As of the 2017 Session, DHHS has not established an office or hired a director. Funds for the establishment of OPERA was a part of the 2017 Appropriations Bill.

Rod Davis, DHHS Chief Financial Officer, provided a summary of OPERA actions to date as required by S.L. 2017-57, Sec. 11A.11. He reported that the three positions established in the statute remain vacant. Mr. Davis informed the committee that qualifications established in statute made recruiting for the position difficult. He further reported that no evaluations or assessments had been made under the office of OPERA.

Mr. Davis reviewed tenents of the Department's web-based system that can/or has the capability of including duties outlined in OPERA's requirement for a web-based system. He offered alternative recommendations for the Committee's consideration.

Senator Hise, along with Chairman Dobson, Senator Tucker, Representative Dollar and Representative Cunnungham. expressed frustration. Chairman Dobson stating, "Statute is not a suggestion. You are required to follow statutes in place." He offered his assistance in identifying/finding good candidates. Chairman Lambeth and Senator Krawiec inquired about the salary structure for positions.

Senator Tucker added that this statute is in place for a reason adding that "numbers and data hold people accountable. The Senator further asked the status on implementing a fraud program with Medicaid payments? Mr. Davis responded that a vendor has been identified to ensure that NC Tracks will be in place by spring. Mr. Davis will provide an update if the system is not operational by April 30th.

Representaive Dollar asked if there is a specific work product that is directly in line with data requested. He asked for a list or summary of ativities for the committee to evaluate.

Senator Barringer informed the Committee that the new system implemented in New Hanover County is working well and a good product. She asked if a plan was in place to implement the New Hanover pilot program around the state.

Secretary Cohen responded that the Department's intent is not just to change technology but to build infrastructure and set priorities.

Chairman Lambeth asked the Secretary to share the Director's job description and salary information with committee members. "We may know someone suitable," he said.

IV. Update on Cherry and Broughton Hospitals

Mark Benton reported that Cherry Hospital, located on its new campus, had a bed capacity of 294, an increase of 97 beds from its former location. A total of 158 clinical positions are needed to open the remaining 51 beds. They include: 5 psychiatrists; 64 registered nurses; 52 Healthcare technicians; and 37 other support staff. Each of these positions are funded in the current budget.

Broughton Hospital has a bed capacity of 382, an additional bed capacity of 85 above its current location. Mr. Benton informed the committee that funding for the additional positions is not available; equipment, and furniture are not fully funded. From an original contract value of $129.8 million, the balance as of November 30, 2017 is $11.0 million. Mr. Benton provided a summary of construction timelines, the takeover agreement between DHHS and Travelers, and a summary of construction delays.

Mr. Benton added that DHHS would continue to provide updates on these efforts.

Chairman Dobson informed the Committee that he took a tour of Broughton and was pleased with the progress being made. He inquired as to how far the additional beds at both Cherry and Broughton have taken us. Mr. Benton responded that it is more about getting the patients properly discharged and back into the community -- "a full circle mindset," he said.

Chairman Lambeth inquired of the cost associated with reworking and extending the contract. In response, Mr. Benton stated that some of the *fixes* were reworked by the contractor as a part of the original contract at no additional cost.

Senator Tucker asked about the cost per bed at each of the facilities. Mr. Benton responded that the budget per year is between $1 and $1.5 million. Senator Tucker requested further clarification regarding cost of construction per bed as the amount reported seemed excessive. Mr. Benton will investigate and provide an update.

V. Health Information Exchange Update

Christie Burris, Executive Director, provided an overview of the North Carolina Health Information Exchange Authority (NC HIEA). Its technology partner is SAS Institute. She informed the Committee that a Feasibility Study is under way with a target completion date of

February 28 or early March. Ms. Burris reviewed the current state of the exchange and value-added features. She reported that upon completion, the HIE will have approximately 98% of North Carolina's healthcare providers connected by June 1, 2020 that will allow access to data from other states through connections to national healthcare data networks.

Sam Gibbs , Deputy Secretary for Technology and Operations reviewed DIT's initiatives to date that include: 1) Strong partnership with NC HIEA; 2) Collaboration on DHHS & HIEA Roadmap; 3) Partnership in identifying potential new value propositions; and, 4) Participation with HIEA team in a Legislative Study.

Senator Hise asked if current deadlines were realistic and if the legislature should take more action to make the transfer run smoothly? He also inquired if NC Connex has the capability of getting all the information possible on patients, not just those on Medicaid.

Considering cyber security, Representative Murphy asked if patients must sign a release of information form in order for HIE to have their information. Mr. Gibbs replied that North Carolina is an opt-out state; therefore, all patients are automatically opted into system until they "opt out."

As a follow-up, Representative Murphy asked if small, rural healthcare providers will be charged to use Electronic Healthcare Records. Mr. Gibbs responded that funds are being allocated back to the providers to help with cost. He added it becomes quite costly considering not only the purchase but also time and resources to train doctors on its use. He stated that DHHS has no control over fees by EHR vendors but added that DHHS is working on transparency with its provider community. DHHS and hosted an EHR vendor day to discuss requirements and convey the message that HIEA is part of the vision of the State to drive managed, holistic care.

Reprentative Dollar asked that Mr. Gibbs address his concern of a state agency having access to medical records of private-pay persons. Mr. Gibbs stated that information is coming into the system in two ways. 1) At the micro-level, de-identified data from all players will help North Carolina move to managed care; and, 2) by looking at whole-patient care – we can determine consistency in health insurance coverage and visibility of patient records that will allow physicians to improve health outcomes.

In a follow-up question, Representative Dollar inquired about cost to providers. Mr. Gibbs responded that, keeping in mind concern for smaller physician practices, cost can vary from five thousand dollars to millions of dollars.

"Millions of dollars isn't practical for smaller providers, which include smaller specialty doctor offices, smaller pharmacies, small dentist practices, etc. It needs to be cost effective," Representative Dollar stated. He also inquired if behavioral health could be integrated into the system before 2020.

Ms. Burris responded that the hope is to have behavioral health integrated by 2020.

Senator Tarte expressed concern that North Carolinians are not aware that their clinical information is now owned by the State. "It is troublesome that patients have the option to opt out, but do not know they never had the option of *opting in*," he said.

Chairman Lambeth asked if any action needs to be taken during the upcoming Session to keep implementation on track. Mr. Gibbs replied that there may be recommendations coming to assist in that the process.

VI. LME/MCO Performance Standards and Accomplishments

Steve Owen, Fiscal Research Division, provided an overview of the objectives of the performance summaries and reviewed definitations of the operational measures: Utilization; Readmissions: ER Revisits; and Authorization Denials. His presentation included percent of change in demographics from 2014 to 2017. Medicaid-covered individuals have increased from an average of 1,2 million in 2014 to 1.5 million in the current fiscal year. Uninsured lives have declined from 1.34 million in 2014 in the current fiscal year to 1.12 million in the current year.

Mr. Owen reported that the percentage of Medicaid population accessing Substance Abuse Disoder in SFY 2017-18 was 27.6% higher than during the SFY 20 4-15. Percentage of uninsured population accessing SUD services is up by 5.6% since SFY 2014-15. Per-person spending is higher for SUD than for Mental Health. Mr. Owen stated that increased utilization of SUD services could impact availability of LME/MCO funds for uninsured Mental Health or developmental disabilities or increasing waiting lists.

Data were also provided on Inpatient and Emergency visits, Medicaid and Uninsured Readmissions, Medicaid Clinical Denials and Uninsured Clinical Denials.

Secretary Cohen asked committee members to keep in mind: When is variance wanted and needed.

Mark Benton shared comparative data on the LME/MCO funding streams for Medicaid patients to Single Stream/Uninsured patients. He informed the committee that LME/MCO contracts were amended to include financial consequences for failing to meet expected standards.

Dave Richard discussed DHHS's oversight of LME/MCOs and stated that Medicaid can access the uninsured.

Senator Tarte suggested having urgent care on-site giving the ability to redirect the patient based on need. He asked if hospitals were statutorily restricted from having an urgent care on-site. Secretary Cohen responded that some emergency rooms have triage to address the patient's needs more efficiently. She added that the department is working to better inform communities that emergency rooms are not the only options available and stressed the importance of consulting with legal counsel to make certain the message is conveyed properly.

Senator Hise addressed the growth in fund balance despite cuts. He expressed his frustration after hearing from constituents that monies should be going toward services to build capacity within the community. Mr. Richard responded that Secretary Cohen has been clear on reinvestments—investments that off-set higher cost of services. Mr. Richard added that the Department welcomes the conversation and recognizes that the system was designed for reinvestment purposes.

Senator Tucker referenced the construction of new buildings in West End and Wilkes County. Secretary Cohen acknowledged the importance of timelines to ensure that funds are spent wisely and avoid unintended outcomes of constructing a new facility for the purpose of depleting reserve funds.

Representative Dollar requested additional comments regarding fund balance and steps to ensure reinvestment. Secretary Cohen acknowledged reinvesting is a complicated issue based on factors such as: Drivers; Identification of LME/MCOs making money; Medical loss ratio; and, available cash. "Money gets tied up in many different ways," she said.

In the interest of time, Chairman Lambeth closed the discussion. "Very little new information has been heard today. Let's resolve some of the issues we have been talking about so that we may move forward."

VII. LME/MCO Approaches to Addressing the Opioid Crisis

Brian Ingraham, CEO of Vaya Health, presented an informative report on the status of the Opiod Epidemic in North Carolina and how the State is addressing the crisis. A startling static is that there are 83 painkiller prescriptions per 100 North Carolinians. In 2016, approximately 675.3 million Opiod pills were dispensed in North Carolina; 94.8 million in Vaya catchment counties. The number of drug poisoning deaths in North Carolina during this same time period was 1965; 1518 involved opiates and 552 involved herion only.

To address the crisis, the Western North Carolina Substance Use Alliance was formed. The Alliance has developed a comprehensive community substance use strategic plan: Phase I to address the crisis and Phase II to monitor and implement the plan.

Goals of the Alliance include: 1) Increasing collaboration among agencies and stakeholders; 2) Leveraging resources to maximize efforts; 3) Reducing unnecessary duplication; and, 4) Establishing intervention priorities.

In order to reduce the prevalence of alcohol and drug misuse, members focus on four key areas: 1) Expanding medication assisted treatment; 2) Enhancing substance use treatmen for pregnant women; 3) Strengthening the continuum of treatment and crisis services for adults; and, 4) Strengthening the continuum of treatment and prevention services for children and adolescents.

Mr. Ingraham stated that the Alliance is using Medication Assisted Treatment Expansion (MAT), along with specialized MAT programs and Outreach and engagement, to combat the epidemic. MAT and other substance abuse services have been made available through DHHS Cures grant funding. Vaya has spent approximately $800 thousand to date; 52% of this funding went toward MAT services.

Mr. Ingraham also reported that DHHS has funded a pilot program with Vaya to expand the use of Vivitrol. Additionally, the Waynesville Police Department is participating in Law Enforcement AssistedDiversion (LEAD), a collaborative project with Vaya and the NC Harm Reduction Coalition. This program will include fundig for MAT for approximately 60 LEAD clients. MindKare Kiosks, NC Harm Reduction/WNC Aids Project Overdose Prevention and Outreach are other initiatives to combat substance abuse.

Mr. Ingraham informed the committee that Vaya is supporting three primary prevention providers to implement the Cures Program focused on decreasing the non-medical use of prescription drugs to include Opiods. More than one thousand lock boxes have been distributed in 23 counties to safely secure prescription medications and prescription medication take-back efforts have removed over four tons of pills from communities.

Mr Ingraham was pleased to report that Vaya was the first in the country to purchase a large quantity of NARCAN nasal spray for distribution. To date, 127 confirmed overdose reversals has been recorded. Vaya has received an additional 5400 NARCAN kits Mr. Ingraham estimates these kits will result in approximately 500 overdose reversals.

Senator Davis asked if documentation was being made when a single patient uses NARCAN. He stated the importance of action data to determine how many doses are required for patients to be properly treated.

Senator Krawiec inquired about the higher cost of NARCAN nasal spray. Mr. Ingrham acknowledged that NARCAN nasal spray is more expensive to purchase but administration of the drug is much easier than injection. He added that high-volume purchases do drive down costs.

Rep. Cunningham inquired about trends in other drugs. Mr. Ingraham replied that the number of prescriptions and pills is being reduced but replaced by other drugs. He stated that North Carolina is a state that allows for open prescription of Naloxone.

VIII. Adjournment

Chair Lambeth delayed the presentation: Status of Strategic Plan for the Improvement of Behavioral Health Services until the February meeting.

Representative Lambeth announced the next meeting of JLOC-HHS is scheduled for Tuesday, February 13, 2018. The meeting adjourned at 12:34 p.m.

Representative Donny Lambeth, Chair

Panthea Briles, Committee Clerk

Attachment: Agenda
Handouts

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

January 16, 2018 9:00 a.m.
Legislative Office Building - Room 643

Committee Cochairs
Rep. Josh Dobson
Rep. Donny Lambeth
Sen. Louis Pate

Legislative Members
Rep. William D. Brisson
Rep. Carla D. Cunningham
Rep. Nelson Dollar
Rep. Beverly M. Earle
Rep. Jean Farmer-Butterfield
Rep. Bert Jones
Rep. Chris Malone
Rep. Gregory F. Murphy, MD
Rep. Donna McDowell White
Sen. Dan Bishop
Sen. David L. Curtis
Sen. Jim Davis
Sen. Valerie P. Foushee
Sen. Ralph Hise
Sen. Joyce Krawiec
Sen. Gladys A. Robinson
Sen. Jeff Tarte
Sen. Tommy Tucker
Sen. Mike Woodard

Advisory Members
Rep. Gale Adcock
Rep. Susan Fisher
Sen. Tamara Barringer
Sen. Michael V. Lee

I.	**Welcome & Opening Remarks**	**Representative Donny Lambeth**, Presiding Cochair
II.	**Comments from the Secretary** a. **Update on Cardinal Innovations** b. **Update on Influenza Data in NC** c. **Other**	**Mandy Cohen, MD**, Secretary, Department of Health & Human Services (DHHS)
III.	**Office of Program Evaluation Reporting and Accountability (OPERA) Report** (S.L. 2017-57, Sec 11A.11)	**Denise Thomas,** Committee Staff **Rod Davis**, Chief Financial Officer, DHHS
IV.	**Update on Cherry and Broughton Hospitals**	**Mark Benton**, Deputy Secretary for Health Services, DHHS
V.	**Health Information Exchange Update** (Chapter 90, Article 29B, as amended by S.L. 2017-57, Sec. 11A.5 (b-(f); S.L. 2015-241, Sec. 12A.5(a)(1), as amended by S.L. 2017-57, Section 11A.5(a); and S.L. 2017-57, Sec. 11A.5(g-i))	**Christie Burris**, Director, N.C. Health Information Exchange Authority (NC HIEA), Government Data Analytics Center (GDAC), Department of Information Technology
	DHHS Collaboration and Partnership Efforts	**Sam Gibbs,** Deputy Secretary for Technology and Operations, DHHS
VI.	**LME/MCO Performance Standards and Accomplishments**	**Steve Owen**, Committee Staff **Mark Benton**, Deputy Secretary for Health Services, DHHS **Dave Richard**, Deputy Secretary, Division of Medical Assistance, DHHS
VII.	**LME/MCO Approaches to Addressing the Opioid Crisis**	**Brian Ingraham,** CEO, Vaya Health
VIII.	**Status of Strategic Plan for the Improvement of Behavioral Health Services** (S.L. 2016-94, Sec. 12F.10(b), as amended by S.L. 2017-57, Sec 11F.6)	**Mark Benton**, Deputy Secretary for Health Services, DHHS **Dave Richard**, Deputy Secretary, Division of Medical Assistance, DHHS
IX.	**Adjourn** **Next Meeting: February 13, 2018**	

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON HEALTH AND HUMAN SERVICES

DHHS Updates

Mandy Cohen, MD, MPH
Department of Health and Human Services

January 16, 2018

Cardinal Innovations Healthcare Board Selection

- New Board –
  Nominated by County Commissioner process
- Board Members –
  Includes all legislatively mandated categories including the 3 CFAC representatives
- Training –
  DHHS and Cardinal staff conducted initial training January 6
- Next Steps –
  Additional training/preparation for Board to assume responsibility

Cardinal Innovations Healthcare Operations

- Meeting day-to-day obligations
- State onsite and regular calls with leadership
- Corrective Action Plan is being finalized
- Process for allocating $3.8 million from administrative funds is being finalized

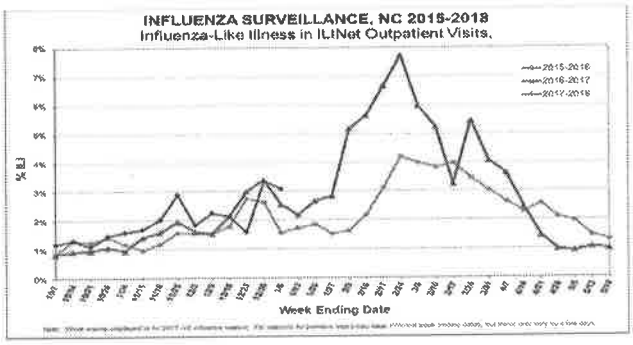
Influenza: Annual Impacts Nationwide

- Major health burden
  - 140,000–710,000 hospitalizations
  - 12,000–56,000 deaths
- $10 billion in direct medical costs
  $87 billion total economic burden
- Potential to cause deadly pandemics

Source: https://www.cdc.gov/flu/about/disease/burden.htm

2017–18 NC Influenza Season: Update

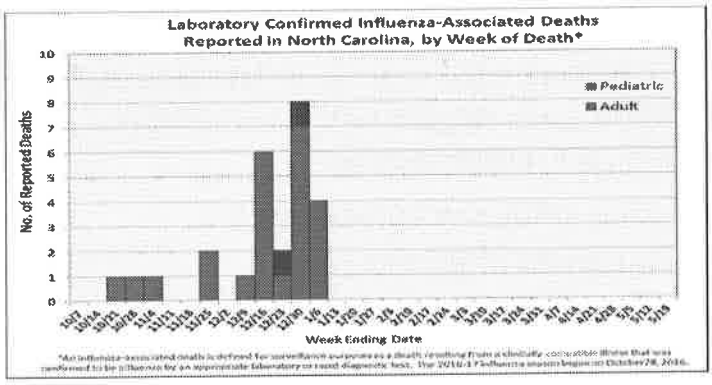
- Activity increasing



- Influenza A (H3N2) viruses predominating
  - Associated with more severe illness in those ≥65 or <5 years of age

SOURCE: www.flu.nc.gov

NC Influenza-Associated Deaths: 2017–18 Season



- 26 deaths reported through January 6, 2018
- Most in persons ≥ 65 years of age
- Reporting lags behind other measures of flu activity

SOURCE: www.flu.nc.gov

Flu Vaccine Benefits

- Best way to prevent flu illness and complications
- Prevents millions of illnesses and tens of thousands of hospitalizations each year
- Can significantly reduce a child's risk of dying from influenza
- Protects people around you, including those who are more vulnerable to serious flu illness
- May make illness milder if you do get sick

Source: https://www.cdc.gov/flu/protect/keyfacts.htm

2017–18 NC Influenza Season: DHHS Actions

- Promoting vaccination against flu
  - Meet the Shot Dodgers campaign launched 2017
  - >358,000 doses shipped by N.C. Immunization Program; still receiving orders
- Conducting influenza surveillance
  - Weekly updates at www.flu.nc.gov
- Providing guidance to clinicians, facilities
  - Antiviral treatment recommendations
  - Control of outbreaks

HISTORY OF LEGISLATIVE ACTIONS RELATED TO THE DHHS OFFICE OF PROGRAM EVALUATION REPORTING AND ACCOUNTABILITY

SESSION LAW 2015-241

CREATION OF OFFICE OF PROGRAM EVALUATION REPORTING AND ACCOUNTABILITY WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

SECTION 12A.3.(a) Article 3 of Chapter 143B of the General Statutes is amended by adding a new Part to read:

"Part 31A. Office of Program Evaluation Reporting and Accountability.

"**§ 143B-216.52. Department of Health and Human Services; Office of Program Evaluation Reporting and Accountability.**

The Office of Program Evaluation Reporting and Accountability (OPERA) is hereby established within the Department of Health and Human Services. Employees of the OPERA shall be subject to the North Carolina Human Resources Act only as provided in G.S. 126-5(c1)(31).

"**§ 143B-216.53. Appointment, qualifications, and removal of OPERA Director.**

(a) The Secretary of Health and Human Services shall appoint a Director of OPERA, who shall perform the duties of the position independently. The Director shall report directly to the Secretary and shall not report to any other deputy, division director, or staff member of the Department.

(b) The Director must have a minimum of 10 years of experience in program evaluation equivalent to the duties of the office, including at least three years of experience at the management level.

(c) The Director may only be removed by the Secretary of Health and Human Services effective 30 days after written notification to the Speaker of the House of Representatives, the President Pro Tempore of the Senate, the State Auditor, and the Director of the Fiscal Research Division of the Legislative Services Office. The notification must itemize the causes and particulars justifying the Director's removal.

"**§ 143B-216.54. Duties of the Office of Program Evaluation Reporting and Accountability.**

The Office of Program Evaluation Reporting and Accountability has the following duties:

(1) To assess the evidentiary basis of all Department programs as recommended by Evidence-Based Policymaking: A Guide for Effective Government, a project of the Results First Initiative of the Pew Charitable Trusts and the John D. and Katherine T. MacArthur Foundation.

(2) To identify and evaluate any Department program when directed by the General Assembly, the Secretary, or as deemed necessary by the Director.

(3) To develop an Internet Web site containing an inventory of departmental programs consisting of the program name and a link to a program profile. For each program, the profile must contain, at a minimum, all of the following:

a. Legal authority for the program.

b. Program performance for the past five fiscal years and year to date for the current fiscal year.

1. Outcome. – The verifiable quantitative effects or results attributable to the program compared to a performance standard.

2. Output. – The verifiable number of units of services or

activities compared to a standard.

3. Efficiency. – The verifiable total direct and indirect cost per output and per outcome compared to a standard.

4. Performance standard. – A quantitative indicator based upon best practices, generally recognized standards, or comparisons with relevant programs in other states or regions for gauging achievement of efficiency, output, and outcomes.

5. Benchmarks. – A broad societal indicator used for gauging ultimate outcomes of the program, such as U.S. Census data.

c. Funding by source for the current and previous five fiscal years.

d. Listing of filled and vacant employee positions as specified by the Office of State Budget and Management.

e. Listing of contracts during the previous fiscal year and of the current fiscal year to date with individuals and firms and the actual and authorized cost, funding source, and purposes of those contracts.

f. Categorization by evidence of effectiveness as determined by the Office.

g. Potential return on investment of each program.

h. Findings and recommendations from internal and external State or federal audits, Office program assessments, and program evaluations.

(4) To assure that the Office Internet Web site allows users to list all of the following:

a. Programs that exceeded, met, or did not meet performance standards for efficiency, outputs, and outcomes for the immediate preceding fiscal year.

b. Programs by category of evidence of effectiveness.

c. Programs by potential return on investment.

d. Programs listed in a manner determined useful by the Office.

(5) To cooperate with and respond promptly to requests for program-level data and information from the Office of State Budget and Management, the Fiscal Research and Program Evaluation Divisions of the Legislative Services Office, and the State Auditor.

"**§ 143B-216.55. Powers of the Office of Program Evaluation Reporting and Accountability.**

The Office of Program Evaluation Reporting and Accountability is authorized, primarily for the purpose of assessing accurate return on investment, to do all of the following:

(1) Have unfettered access to any data or record maintained by the Department and to assure its confidentiality when required by State or federal law.

(2) Interview any Department employee or independent contractor without others present.

(3) Conduct announced or unannounced inspections of departmental-owned or departmental-leased facilities."

SECTION 12A.3.(b) G.S. 126-5(c1) 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 Office of Program Evaluation Reporting and Accountability of the Department of Health and Human Services."

SESSION LAW 2016-94

QUALIFICATIONS OF DIRECTOR OF OFFICE OF PROGRAM EVALUATION, REPORTING, AND ACCOUNTABILITY

SECTION 12A.9. G.S. 143B-216.55(b) reads as rewritten:

"(b) The Director must have ~~a minimum of 10 years of~~ experience in program evaluation equivalent to the duties of the office, including at least three years of experience at the management ~~level.~~level that demonstrates increasing levels of responsibility within the field of program evaluation."

SESSION LAW 2017-57

OFFICE OF PROGRAM EVALUATION REPORTING AND ACCOUNTABILITY

SECTION 11A.11.(a) The Department of Health and Human Services shall not use any funds appropriated in this act for the Office of Program Evaluation Reporting and Accountability for any purpose other than to establish and administer that Office and to implement the provisions of Part 31A of Article 3 of Chapter 143B of the General Statutes.

SECTION 11A.11.(b) By December 1, 2017, 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 establishment and operation of the Office of Program Evaluation Reporting and Accountability. The report shall include at least all of the following:

(1) A breakdown of all expenditures from the funds appropriated to the Department since the 2015-2016 fiscal year for the establishment and administration of the Office.

(2) All steps taken by the Department to establish the Office pursuant to Part 31A of Article 3 of Chapter 143B of the General Statutes.

(3) An organizational chart of the Office that includes all employees.

(4) A list of all assessments and evaluations conducted or in progress by the Office.

(5) An explanation of any obstacles to establishment and operation of the Office or fulfillment by the Office of any of the duties prescribed in G.S. 143B-216.56.

OFFICE OF PROGRAM EVALUATION REPORTING AND ACCOUNTABILITY

Session Law 2017-57, Section 11A.11

Report to

The Joint Legislative Oversight Committee on

Health and Human Services

and

Fiscal Research Division

By

North Carolina
Department of Health and Human Services

December 1, 2017

Reporting Requirements

Session Law 2017-57, Section 11A.11 requires the Department of Health and Human Services to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the establishment and operation of the Office of Program Evaluation Reporting and Accountability. The report shall include at least all of the following:

(1) A breakdown of all expenditures from the funds appropriated to the Department since the 2015-2016 fiscal year for the establishment and administration of the Office.
(2) All steps taken by the Department to establish the Office pursuant to Part 31A of Article 3 of Chapter 143B of the General Statutes.
(3) An organizational chart of the Office that includes all employees.
(4) A list of all assessments and evaluations conducted or in progress by the Office.
(5) An explanation of any obstacles to establishment and operation of the Office or fulfillment by the Office of any of the duties prescribed in G.S. 143B-216.56.

Summary of Actions

The General Assembly appropriated $500,000 in the SFY 2015-17 biennium to establish the office. The Department established the following three (3) positions for the office:

- Director
- Lead Evaluator
- Administrative Assistant

No individuals have been hired into the positions. Further, there has been no expenditure of funds appropriated to the Department since the 2015-2016 fiscal year for the establishment and administration of the Office.[1]

Recruitment by the DHHS Leadership team and Human Resources has been conducted for the Director's position since the 2015-16 year. It was determined that the qualifications initially set in legislation for this position made it difficult to recruit. The qualifications for the position were slightly modified in SL 2016-94. Several individuals have been interviewed since the position was created but none determined to be a successful candidate.

There have been no assessments or evaluations done under the auspices of this office.

In addition, the Department proposed during the 2017 legislative long session, to - incorporate the Office of Program Evaluation Reporting and Accountability (OPERA) into the Division of Budget and Analysis. Alternatively, consideration of this proposal is recommended.

By incorporating or aligning OPERA Unit with the Division of Budget and Analysis (B&A) -Program Performance Analysis Section, DHHS can optimize its work and responsiveness to key decision-makers

[1] In SFY 2016-17, under the authority of GS 143B-12, the Department was directed to transfer positions and operational funds for the NC Department of Military and Veteran Affairs. As a result, the salary reserve balance of the fund and other funds across DHHS were reduced to meet this requirement from the State.

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON HEALTH AND HUMAN SERVICES

LME/MCO Performance Standards and Accomplishments

Dave Richard & Mark Benton
Department of Health and Human Services

January 16, 2018

LME/MCO Funding Streams (SFY ending June 30, 2017)

Medicaid		Single Stream/Uninsured	
Population	1.8 Million	Uninsured Population	1.2+ Million*
Total Expenditures	$2.629 Billion	Total Expenditures	$361.2 Million*
Spending per Capita	$1,407	Spending per Capita	$297

Service Array

Inpatient, Outpatient, Crisis, Community Based Supports, Enhanced Services, Support Services and Innovation Waiver Services

Service Array

Same, less Innovation Waiver Services plus Residential/Housing, Supported Employment

*Nearly $85M spent on Medicaid recipients

LME/MCO Performance Measures w/Penalties

In order to provide greater focus on specific measures the LME/MCO contracts were amended in July 2017 to include financial consequences for failing to meet expected standards

The performance measures include:

- Follow-up within Seven Days after Discharge from a Hospital (including Facility-based Crisis Services) or Detox Service for the Mental Health and Substance Use Disorder populations. (DMH/DD/SAS & Medicaid)
  - Performance Standard: 40%
  - Potential Penalty: $100,000 (Medicaid) per month & $50,000 (DMH/DD/SAS) per month
- Number of Transitions to Community Living Initiative (TCLI) population members transitioned into supportive housing. (DMH/DD/SAS)
  - Performance Standard: 100% of annual housing slots allotted to LME/MCO by DHHS
  - Potential Penalty: $600,000 annually ($300,000 for SFY18)
- Medical Care Coordination for Individuals with Intellectual/Developmental Disabilities (I/DD) who are on the Medicaid Innovations Waiver. (Medicaid)
  - Performance Standard: 90%
  - Potential Penalty: $100,000 per month

DHHS Oversight of LME/MCOs

MONTHLY

Financial

- Medicaid: YTD Net Value, Defensive Interval, Medical Loss Ratio, Dollar Value of Encounter Claims
- DMH/DD/SAS: Expenditures of SSF, Block Grants (MHBG, SABG, SSBG, Opioid-STR), 3-Way Bed, and calculations of MOE and TCLI

Quality – Combined Medicaid and DMH/DD/SAS Reporting

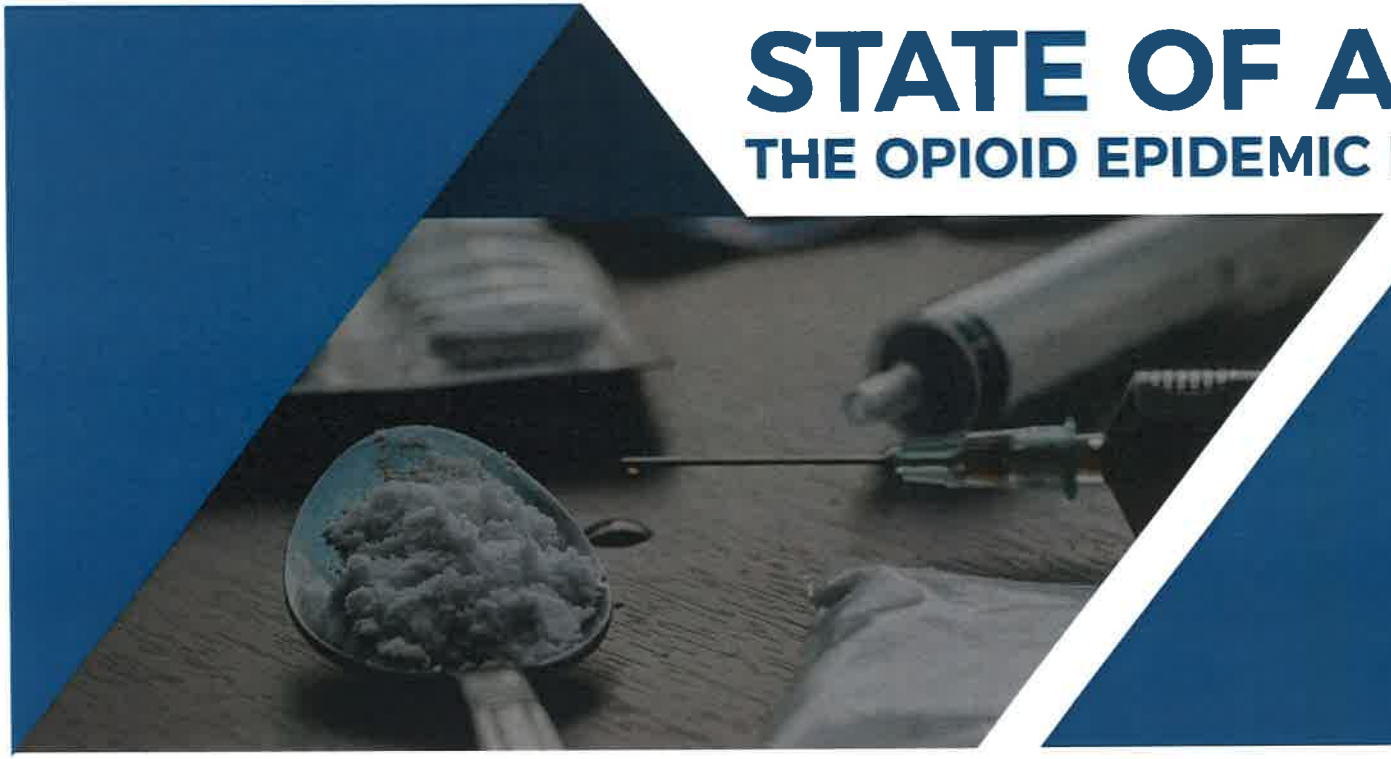
- Call Center Performance, IDD Wait List, Consumer Safety Incidents, TCLI, Claims/Encounter Processing (timely filing and denials), Persons Served, Community Psychiatric Hospital Admissions, Care Coordination, Emergency Department Utilization, Care Coordination, Authorizations Requests, Complaints/Grievances, Program Integrity Investigations Results
- Calls with LME/MCO CEOs

QUARTERLY

- Interagency Monitoring Team reviews (Medicaid and DMH/DD/SAS)
- DMH/DD/SAS: Quarterly calls with LME/MCOs regarding expenditures of SSF, Block Grants, MOE, and 2014-2015 service level targets

ANNUALLY

- External Quality Review (EQR on site reviews; some activity is semi-annual)
- On-Site Audit for Clinical Review and Sub-recipient Monitoring of Block Grants Spending
- Financial Settlement Audit for non-Medicaid state funds

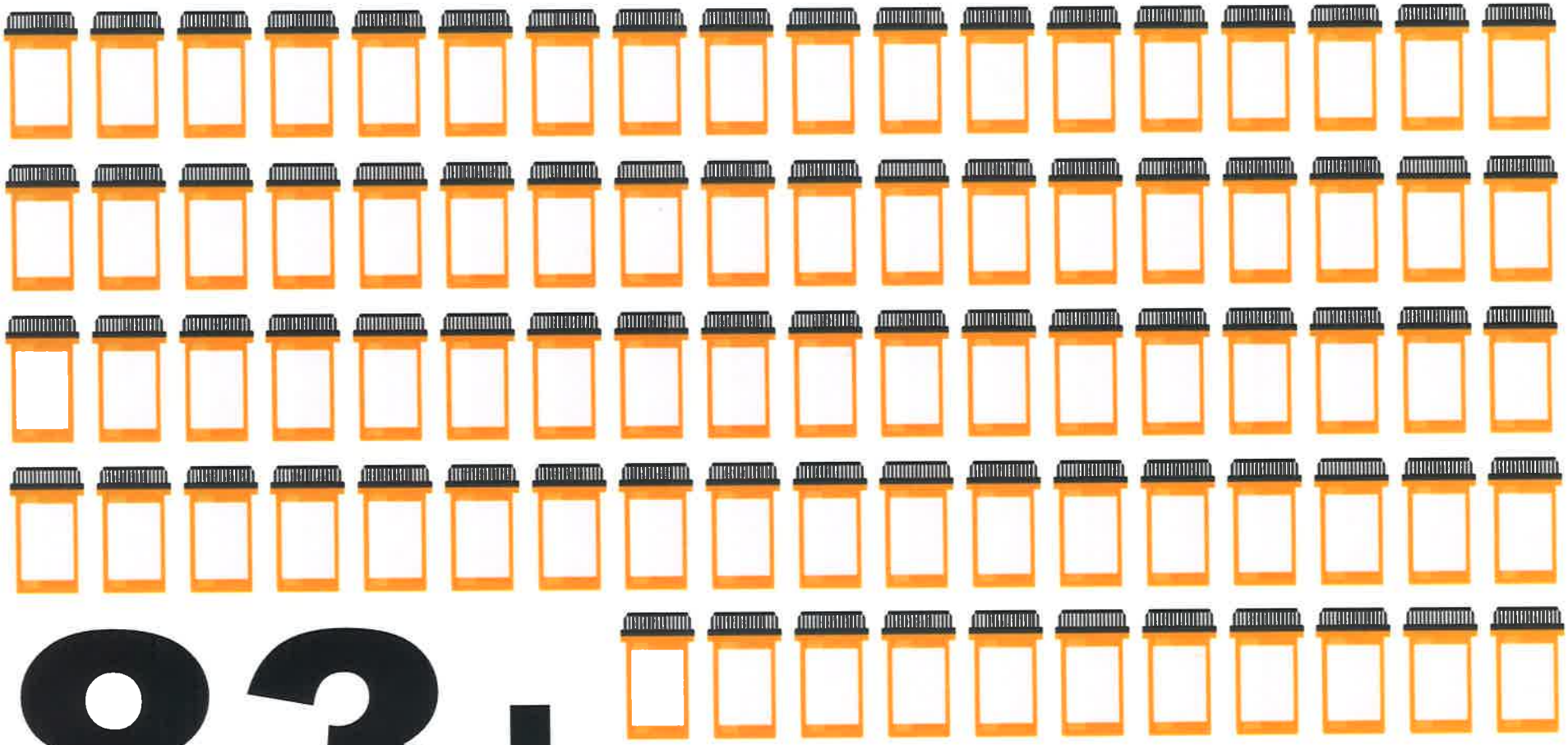


STATE OF ADDICTION:
THE OPIOID EPIDEMIC IN NORTH CAROLINA

Joint Legislative Oversight Committee on Health and Human Services

LME/MCO Approaches to Addressing the Opioid Crisis
Presented by Brian Ingraham, CEO
January 16, 2018

VAYAHEALTH



83↓

Painkiller prescriptions per 100 North Carolinians

Source: CDC US Prescribing Rate Maps (2016)



675,315,375↓

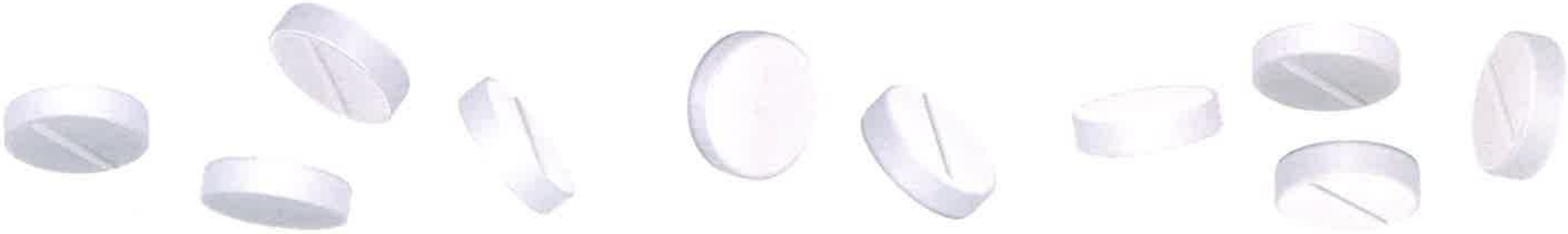
Opioid pills dispensed in North Carolina in 2016

SOURCE: NC Division of Mental Health, Developmental Disabilities and Substance Use Services Controlled Substance Reporting System

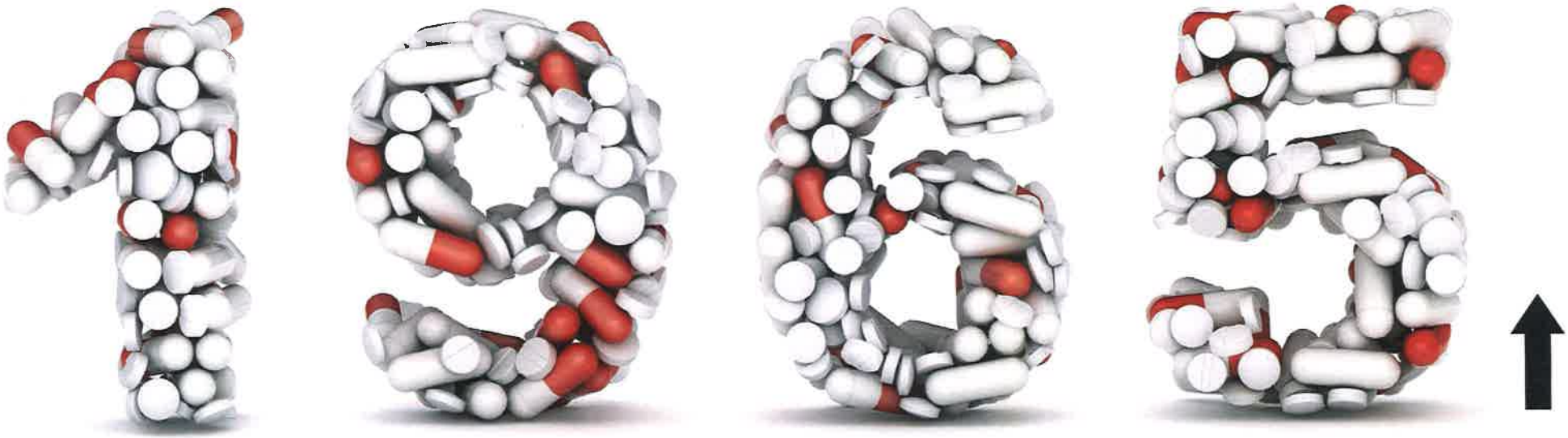


94,881,114↓

Opioid pills dispensed in Vaya catchment counties in 2016



SOURCE: NC Division of Mental Health, Developmental Disabilities and Substance Use Services Controlled Substance Reporting System



Number of drug poisoning deaths in North Carolina in 2016

1518 ***involving opiates**** ↑ **552** ***involving heroin only*** ↑

*Includes all opioid pills, carfentanyl, fentanyl and heroin

SOURCES: NC DHHS Injury and Violence Prevention Branch and North Carolina Office of the Chief Medical Examiner Report – Fentanyl and Heroin-Related Deaths in North Carolina: 2016

What can be done?



There is no silver bullet

What is Vaya doing to combat the crisis?



WNC SUBSTANCE USE ALLIANCE

Steering Committee includes representatives from:

- Vaya Health
- Mission Health
- MAHEC
- Buncombe County Government
- Henderson County Government
- Duke Life Point
- High Country Community Health
- Project Lazarus
- RHA
- October Road
- Cherokee Indian Hospital Authority
- Local criminal justice system



WESTERN NORTH CAROLINA SUBSTANCE USE ALLIANCE

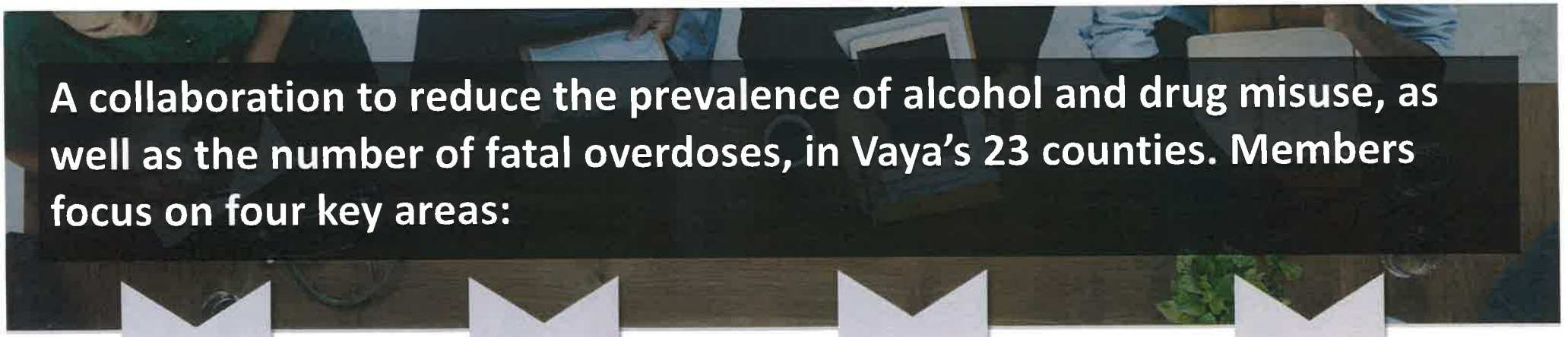
- Formed to organize resources and leverage existing efforts and work across the 23 counties using a collective impact framework
- Work guided by both the 2016 report of the N.C. Governor's Task Force on Mental Health and Substance Use and the first-ever Surgeon General's Report on Alcohol, Drugs, and Health
- Tasked with formulating a comprehensive community substance use strategic plan (Phase One) and the monitoring and implementation of the plan (Phase Two)



Goals of the Alliance

- Increase collaboration across agencies and stakeholders to coordinate efforts addressing the problems associated with substance use
- Leverage resources to maximize efforts across the Vaya Health 23-county catchment area
- Reduce unnecessary duplication of efforts to address substance use
- Establish intervention priorities for the region that will result in positive outcomes and increase sustainability for all populations, regardless of payment source

WNC Substance Use Alliance



A collaboration to reduce the prevalence of alcohol and drug misuse, as well as the number of fatal overdoses, in Vaya's 23 counties. Members focus on four key areas:

- Expanding Medication Assisted Treatment
- Enhancing substance use treatment for pregnant women
- Strengthening the continuum of treatment and crisis services for adults
- Strengthening the continuum of treatment & prevention services for children & adolescents

Nine Priorities of the Alliance

1. Implement a local plan, in conjunction with County Leadership Forums, aligned with the State's Opioid Action Plan to address the opioid crisis
2. Increase access to treatment services and supports (e.g. housing, employment services) through expansion of services and reduction of barriers to service areas
3. Conduct community education and awareness campaigns regarding opioid use and other substance misuse and recovery in order to reduce stigma
4. Increase effective engagement across all SUD populations
5. Increase engagement and access to services in a timely manner for pregnant or child rearing individuals
6. Increase number of providers/organizations providing integrated primary care and behavioral health models or whole person care for all populations and increase community awareness of locations to access integrated care
7. Continue expansion and development of peer support and family peer support models for substance use and co-occurring disorders
8. Maximize funding sources for service delivery
9. Develop and utilize a data framework to capture county-specific level data points/ indicators with reporting enabled across systems and agencies, to plan, implement and assess collective impact initiatives

What are we doing to combat the epidemic?



- Medication Assisted Treatment (MAT) Expansion
  - MAT: Evidence-based best practice involving the use of medications paired with counseling and therapy
- Specialized MAT programs
- Outreach and engagement

MAT Expansion



Using DHHS Cures grant funding, MAT and other substance use services have been made available to an additional 400 uninsured individuals by increasing access throughout our region

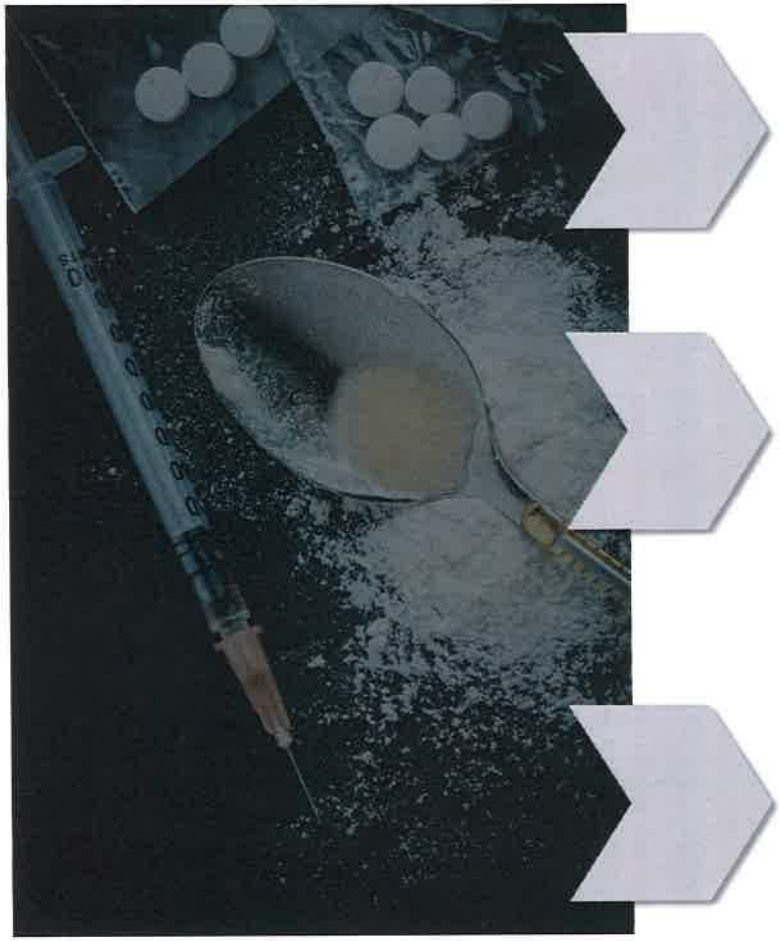
- Vaya was allocated $898,867 and has spent approximately $800,000 to date
- 52% of this funding went to MAT services

Specialized MAT Programs



- DHHS has funded a pilot project with Vaya to expand the use of Vivitrol in FQHC sites
- The Waynesville Police Department is participating in Law Enforcement Assisted Diversion (LEAD), a collaborative project with Vaya and the NC Harm Reduction Coalition
  - Program will include funding for MAT for approximately 60 LEAD clients

Outreach and Engagement



MindKare Kiosks in all 23 Vaya counties offer individuals opportunities to take substance use screenings and contact Vaya for connection to treatment

NC Harm Reduction/WNC Aids Project Overdose Prevention and Outreach using Peers, targets individuals who experienced an opioid reversal and engages individuals at needle exchange sites across the catchment area

Vaya and WNCAP to implement HIV and Hep C testing in targeted areas

Prevention Efforts

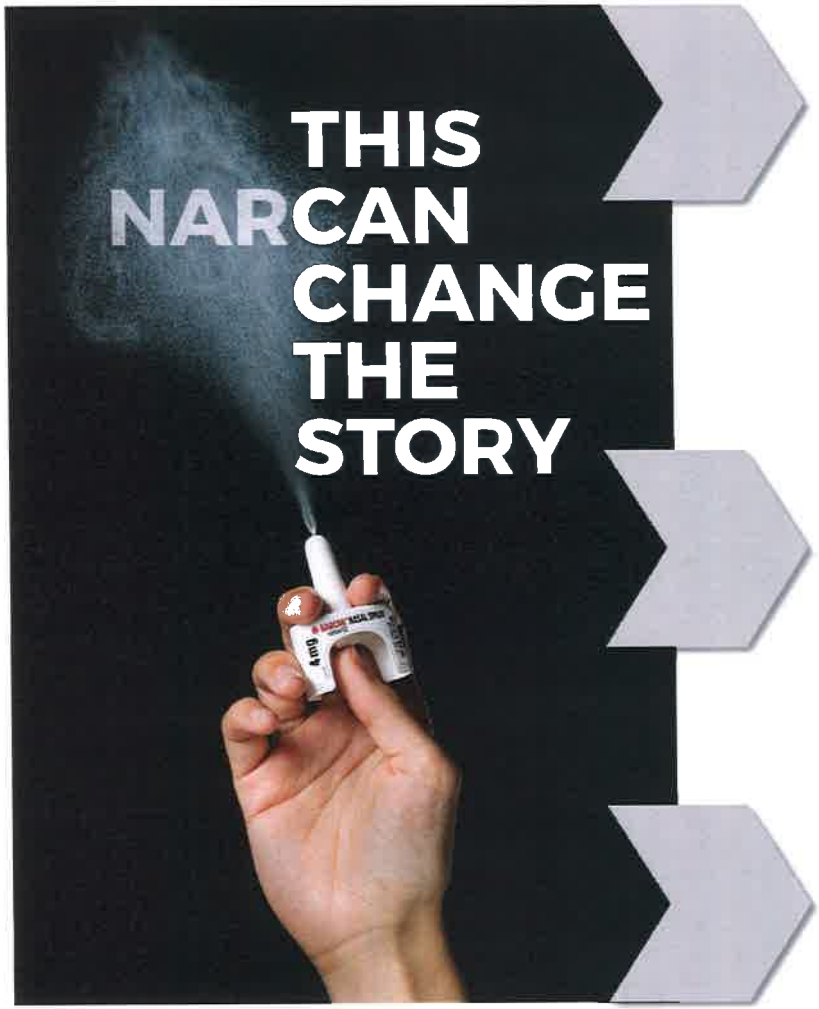


Vaya is currently supporting three primary prevention providers and their mentor communities to implement the Cures program in Ashe, Avery, Haywood, Mitchell and Transylvania counties

- Focus on decreasing the non-medical use of prescription drugs, including opioids

Over 1,000 lock boxes have been distributed throughout our 23 counties to safely secure prescription medications

Prescription medication take-back efforts have removed over four tons of pills from communities



Using community reinvestment funds in 2016, Vaya was the first in the country to purchase a large quantity of NARCAN nasal spray for distribution

- 127 confirmed overdose reversals

With the assistance of DHHS, Vaya received an additional 5,400 NARCAN kits

- Based on current trends, we expect these kits will result in approximately 500 overdose reversals

Vaya used the NARCAN kit making to spearhead an awareness campaign


NARC

February 22,

Follow-up to Joint Legislative Oversight Committee on HHS Questions
Date: Jan. 16, 2018

1. Rep. Earle – How long had previous Cardinal board members that have been reappointed served? Is there any board member that has served out term limit yet?

   Cardinal's prior alternative board structure did not have fixed terms, so no members served to the end of term nor were any "reappointed."

2. Rep. Cunningham - When Cardinal submits and the Department approves their corrective action plan (CAP), will a copy be shared with members of the JLOC?

   A copy of the corrective action plan was sent to members on January 29. It is also posted on the DHHS website.

3. Rep. Fisher – NC is one of the last states to reach the threshold for the flu. Why are we later, thoughts on that?

   The timing of the flu season in NC has been similar to surrounding states. Factors contributing to the timing of flu activity are not well understood but the Division of Public Health conducts detailed monitoring and reports results beginning in October of each year.

4. Senator Tarte – What were the numbers for flu deaths last year?

   219 flu-associated deaths were reported during the 2016-2017 season

5. Senator Tarte – What is the total amount due for physician reimbursement for immunizations?

   Federal law included a temporary increase in reimbursement for vaccine administration, paid for with entirely federal funds. The Division of Medical Assistance estimates the additional payout for reprocessing two vaccine administration codes to be approximately $10 – $12 million, 100% federal match. The reprocessing of the claims is scheduled to begin in April 2018.

6. Senator Krawiec & Rep Lambeth – What is the job description and salary for the Director of OPERA's position?

   The budgeted salary for the position is $175,000. Please see the attached word document (Opera Director.docx) for the job description.

7. Senator Tucker - If the anticipated start date for the Medicaid fraud/abuse pilot is later than April 30, 2018, what is that estimated start date?

   We anticipate starting prior to April 30; likely at the end of April.

8. Rep. Dollar – Is there work product related to the OPERA functions that can be shared? What has been done. A list or summary of activities would be helpful.

   In the course of doing business as required of the Division of Budget and Analysis, staff performs many of the same analysis that OPERA requires. This list includes:

   - Analyzing and evaluating (on a quantitative or qualitative basis) the effectiveness of service/program and supporting operations in meeting established goals and objectives.
     - Ongoing Contract Analysis: Analysis of types of contracts, purpose, funding sources redundancy, etc. as 90% of DHHS funds go out to local entities in the form of contracts and allocations.
     - Grants: Establishment of new direction and process for seeking and applying for public and private grants which was created to identify grantor requirements, proposed division uses and the linkage of grant activities to DHHS services, contracts and results. This has been used over the past two years to assess the impact of over 200 grants used for the achievement of the Department's goals, service objectives, priorities, and to create a Department-wide database of grant funded activities.
   - Advising on potential changes/direction to improve the efficiency of service/program and administrative operations.
   - Researching and investigating new or improved practices programs or operations.
   - Analyzing new or proposed legislation or regulations to determine impact on program operations and management
   - Developing new or modified administrative program policies, regulations, goals, or objectives.
   - Identifying and /or developing data required for use in the management and direction of programs.
   - Analysis of the Department's workforce programs and ongoing data analysis in regard to the State's Common Follow Up System.

   A primary focus has been to provide objective, accurate, analysis with respect to planning and evaluation of fiscal/budget, legislative and measurable service

performance in order to assess the effectiveness and to enhance the efficiency of DHHS programs/services. For this to be successful and to build the capacity to conduct/perform more specific evaluation, DHHS has worked on establishing a performance culture by abandoning the old culture of the siloed operational approach and moved to a collaborative and results focused approach that would lead to enhanced service delivery and cost efficiencies. Several important steps were as follows:

- The budgets for the multiple divisions within DHHS and over 260 services were completely reformed to accomplish a broad service oriented approach rather than a divisional approach. In other words, if it was prevention services for children, those service budgets would have the same fund coding across the Department and could be easily identified.

- DHHS Open Window was created and implemented to be key web-based performance management tool and inventory of service oriented searchable website rather than individual divisional websites making it a simple matter to identify needed services no matter where they may be located in the Department. The website provides comprehensive information on resources, budget information, target populations performance measures, and other information to be transparent and accountable to decision-makers while obtaining the information needed to evaluate progress and work towards continuous quality improvement by effectively using data; and developing and conducting regular analysis including scorecards to inform Department management decision making on recommendations to improve DHHS services/service delivery; and resource planning.

- Following table demonstrates the alignment of Open Window with OPERA requirements for a program inventory and other data necessary to support program evaluation.

OPERA Requirements	DHHS Performance Management System	Notes
Inventory of Departmental Programs	✓	Data can by accessed multiple ways such as by Division, by the performance goal and objective area under which it is aligned, or by name
	✓	
Legal Authority	✓	
Program Performance -5 years	✓	DHHS finalized its service structure in 2010. Although the development of effective measures has been ongoing, with the input of SFY 2015 data, will have 5 yrs. of data
Outcomes	✓	
Outputs	✓	
Efficiency	✓	
Benchmarks	✓	Used by some; plan to review/incorporate more broadly as appropriate
Performance Standard		Capacity to add to specifically address and report on exists
Funding By Source for Current Year	✓	
Funding By Source -last 5 Years	✓	DHHS restructured the budgets for the multiple divisions within DHHS in 2010 to reflect a broad service oriented approach rather than a divisional approach which allows us to measure effectively based on alignment to performance goals and objectives. In other words, if it is prevention services for children, those service budgets have the same coding across the Department and could be easily identified. We automated the financial component of the DHHS system with the state's accounting system (NCAS) to ensure accurate data. Prior to that, it was a more manual process
List of Filled Positions List of vacant Employees	In Development	System currently reflects the number of positions for each service. Other specificity can be added.
Findings and recommendations from internal and external State or federal audits, Office program assessments, and program evaluations	✓	Data can be uploaded per service/program; questions and other information gathered regarding it; recommendations may be reflected in new or changing measures and outcomes.
List of Contracts during the previous fiscal year and of the current fiscal year to date with individuals and firms and the actual and authorized cost, funding source, and purposes of those contracts.	✓	DHHS system contains all identified elements and more with the exception of contract expenditures. Can be developed. Tells Contracts are linked to the DHHS service (s) for which the contract provides part of or all of the required service delivery.

9. Senator Barringer – Requested more information on the Duke Endowment Pilot Program in New Hanover county.

   The business analytics collaboration between New Hanover County and SAS is funded by the Duke Endowment and is specific to that county. DHHS is not involved in this project. However, NCFAST is currently sending client data to North Carolina Government Data Analytics Center to support the Center Child Welfare ASSIST program, which provides access to some outside sources of data that are similar to those accessed in New Hanover County.

10. Senator Tucker – What is the cost of construction per bed at Cherry and Broughton hospital? What will be done with old Cherry hospital?

    New Cherry Hospital cost per bed is $306K (more favorable bid market)

New Broughton Hospital cost per bed is $342K (less favorable bid market)

Our psychiatric hospitals include the following which are not typically included in standard office space:

1. Primary care units for housing patients
2. Extensive fire alarm and security systems to provide a "defend in place" approach to dealing with patients and other building occupants during emergencies
3. Commercial Kitchen
4. Cafeteria and dining rooms
5. Nurse stations
6. Physical therapy area
7. Activity rooms
8. Group rooms
9. Pharmacy
10. Lab
11. Dental clinic
12. Gymnasium
13. Exterior courtyards with basketball courts and security fencing
14. Medical unit outfitted with acute care hospital equipment
15. Radiology Department
16. Building technology and automation specific to hospital/psychiatric hospitals including nurse call system, duress system, etc.
17. Safety considerations unique to psychiatric hospitals such as anti-ligature mechanisms throughout patient use areas, automatic locking doors in patient areas, etc.

11. Senator Tucker - What's the status of the buildings that comprise the former Cherry Hospital complex – are they being used (if so, for what purpose) and, if not, are there any future use plans under consideration?

Cherry Hospital continues to use some of the buildings on the old campus including Royster, Conference Center, Warehouse and a few maintenance shops. The electrical and mechanical systems in Royster were damaged during Hurricane Matthew and are currently being repaired. When Cherry can use the Royster building again, likely this spring, the space will be used primarily for offices, but also for record storage, training space, and dorm space for students and during adverse weather. The Conference Center will continue to be used for large trainings, meetings and will also be available for use by other DHHS (or other State) agencies that need similar space. The Warehouse and maintenance shops continue to be used as they were previously.

The Therapeutic Center has been leased to a local community organization to be used as a Community Center. It was also flooded and damaged during Hurricane Matthew and the Community Center has not yet opened.

The primary patient care buildings on the old campus, the U-buildings, are in need of extensive renovation and repair. For example, repeated break down of elevators limited areas in which patients could be safely served prior to the move. The original boiler and chiller systems serving the buildings were also well past the life expectancy of each system and at risk of catastrophic failure leaving the buildings without heat/cooling/hot water. The electrical systems serving these buildings were also in need of replacement due to age and condition. The existing boiler and chiller systems were destroyed by Hurricane Matthew. Therefore, any reuse of these buildings would require not only the repair/replacement of the elevator and electrical systems, but would also require a complete replacement of the boiler and chiller systems serving the buildings. The buildings have been without any power and conditioning since Hurricane Matthew in Sept. 2016. DHHS continues to evaluate options.

12. Senator Tarte - Are there any statutes/regulations which prevent a hospital having an urgent care center on site?

    42 C.F.R. 489.24 defines a "dedicated emergency department," which are subject to EMTALA requirements=. An urgent care center owned or operated by a hospital may be determined to be a "dedicated emergency department" and subject to EMTALA requirements, but will not always be designated as such. The federal regulations don't prohibit a hospital from having an urgent care center on site, but the urgent care center may be subject to EMTALA regulations – the determination under federal rules is based on all relevant facts and circumstances.

13. Senator Krawiec - What is the difference in the per unit cost of naloxone that is administered nasally or via an injection.

    The cost of a two-unit dose (4 ml total) of nasal naloxone is $75. The cost of naloxone administered by syringe averages $30 per 2 ml, while the cost of the auto-inject naloxone (similar to an epi pen) averages $3,750 per injector. These prices are based on costs for individuals and do not reflect potentially lower costs available to bulk purchasers. Of note, nasal naloxone is approved by the FDA for community-based (for the non-medically trained) use. It also offers the highest

available dosage strength, and with the increased use of fentanyl and carfentanyl, a higher dosage of naloxone is often required to reverse an overdose. If using an injectable (needle), this could require multiple vials and multiple injections. We have experienced a greater reluctance to use the injectables, particularly from law enforcement and community groups, and concern from communities regarding the potential for more used syringes requiring proper disposal.

Approved Classification	
Effective Date	
Analyst	
FLSA Status	

OFFICE OF STATE HUMAN RESOURCES
POSITION DESCRIPTION FORM

Name of Employee N/A	Present University or Beacon Position Number / Proposed Number 65024086
Present Classification Title / Salary Grade or Flat Rate	Proposed Classification Title / Salary Grade or Banded Level
Usual Working Title of Position Office of Program Evaluation, Director	Department, University, Agency or Commission Department of Health and Human Services
Institution / Division Office of Program Evaluation, DHHS	Section / Unit N/A
Street Address, City and County 803 Biggs Drive, Raleigh, NC 27603	Location of Workplace, Building and Room Number Clark Building , Dorothea Dix Campus
Name of Immediate Supervisor	Supervisor's Position Title and Number DHHS Secretary (60037780)
Work Schedule *(i.e. Monday-Friday, rotating shifts, etc.)* Monday - Friday	Work Hours *(i.e. 8:00 am-5:00 pm, etc.)* 8:00 a.m. – 5:00 p.m.

Primary Purpose of the Organizational Unit

Per Session Law 2015-241 the Office of Program Evaluation Reporting and Accountability (OPERA) was established by within the Department of Health and Human Services. Duties of this office include the following responsibilities:

(1) To assess the evidentiary basis of all Department programs as recommended by Evidence-Based Policymaking: A Guide for Effective Government, a project of the Results First Initiative of the Pew Charitable Trusts and the John D. and Katherine T. MacArthur Foundation.

(2) To identify and evaluate any Department program when directed by the General Assembly, the Secretary, or as deemed necessary by the Director.

(3) To develop an Internet Web site containing an inventory of departmental programs consisting of the program name and a link to a program profile which includes details about each program as specified by legislation.

(4) To assure that the Office Internet Web site allows users to examine: programs that exceeded, met; or did not meet performance standards for efficiency, outputs, and outcomes for the immediate preceding fiscal year; programs by category of evidence of effectiveness; programs by potential return on investment; programs listed in a manner determined useful by the Office.

(5) To respond to requests for program-level data and information from the Office of State Budget and Management, the Fiscal Research and Program Evaluation Divisions of the Legislative Services Office, and the State Auditor.

Changes in Responsibilities and/or Organizational Relationship Since the Position Was Last Classified **N/A**	
%	**Description of Work:** *Describe the purpose of the job, and the major functions in which the employee participates or for which the employee is responsible. In the small left-hand column, indicate the percent of time the employee spends in each functional element. The percentage amounts should add up to 100%. In addition, please place an asterisk (*) next to each essential duty/function.*
25%	**Planning and Organization** – Position directs the Office of Program Evaluation through planning, organizing and by working directly with the Secretary, key leaders of DHHS management, DHHS performance management, policy, and business/budget staff to set evaluation outcome goals. In collaboration with the Secretary, key leaders and executive management and partners, develops, implements and monitors an evaluation plan addressing logic models, strategic and program evaluation questions, data collection methods, analysis and reporting. This position is responsible for assuring evaluation of programs when directed by the General Assembly, the Secretary, or as deemed necessary by the Director. The position will have the support of and supervise one professional and one administrative support staff to carry out the responsibilities of this Office.
25%	**Program Management** This position supports services/programs by using data to evaluate and make recommendations for improvement or other result as necessary; will integrate relevant information as needed from multiple sources to form a comprehensive perspective; adapts or redesigns work activities to meet Departmental needs. To accomplish this, this position will seek and use others' input regarding critical actions, timelines, sequencing, scope, methodology expected outcomes and priorities. Maintains links and collaborates where possible with other external data collection, evaluation and systems changes efforts; develops relationships with other agencies and providers to assure access and links with other data systems.
25%	**Business Administration** - This position will evaluate resources, develop plans accordingly, and use quantitative and qualitative analytical skills to study performance impact and outcome of the Department's services/programs including performance measurement, financing, operational procedures and return on investment; develops and prepares internal reports of status, progress and outcomes of evaluation activities. The position will also work with other managers to assure that coordination occurs with all DHHS partners to bring focus to priority issues and to develop solutions. Position also assures that partner agencies are informed regarding the potential impact of decisions made.
25%	**Professional Knowledge** –Ability to analyze complicated program and/or budget data and to form conclusions for lay-audiences with varying knowledge of evaluation, budget, program and fiscal policies. This position requires a wide-range of knowledge in addition to the technical skills necessary to conduct effective program evaluation including: Demonstrated ability to work with diverse personalities and professional backgrounds; experience working with public, private, and nonprofit organizational structures; ability to think strategically, remaining focused on goals and objectives; Highly proficient and knowledgeable in the use of current computer analytic software and tools; high level of organization and attention to detail; ability to multi-task, meet deadlines and be persistent, and solve problems as they arise. Strong oral and written communication skills.

Competencies, Knowledge, Skills and Abilities Required in this Position

- Knowledge and experience of using evaluation and community-based research to inform program development
- Knowledge and experience of program evaluation principles, theories, concepts and practices
- Demonstrated expertise in successfully designing and carrying out quantitative and qualitative research and evaluation processes
- Ability to analyze information, summarize findings and present them in ways easily understandable to decision-makers
- Demonstrated ability in designing and manipulating data using a computer database
- Experience developing, and maintaining longitudinal data management systems
- Understanding of statistical principles and methods for data analysis
- Experience working with governing bodies
- Demonstrated managerial experience in planning, directing and organizing the work of professional staff.
- Considerable knowledge of health and/or human services programs either through professional work experience in professional health and/or human services work and/or experience associated with the management of health and/or human services programs
- Considerable knowledge of state and federal laws affecting these programs with subsequent impact and consequence on performance outcomes/results, budgeting and fiscal analysis.
- Ability to work independently without close technical or administration supervision.

Education and Experience Required

What educational background is needed to perform these duties and responsibilities? What kind of work experience is needed?

Master's degree in relevant field and professional experience in program evaluation equivalent to the duties of the office, including at least three years of experience at the management level that demonstrates increasing levels of responsibility within the field of program evaluation.

License or Certification Required by Statute or Regulation: *Is a license or certificate required? What kind and type?*

N/A

Employee's Signature/Title	Date		Supervisor's Signature/Title	Date

ATTENDANCE

JLOC ON HEALTH & HUMAN SERVICES

2017-2018 SESSION

DATES	01-16-18														
DOBSON, Josh Co-Chair	✓														
LAMBETH, Donny Co-Chair	✓														
PATE, Louis Co-Chair	✓														
Representatives															
BRISSON, William															
CUNNINGHAM, Carla	✓														
DOLLAR, Nelson	✓														
EARLE, Beverly	✓														
FARMER-BUTTERFIELD, Jean	✓														
JONES, Bert															
MALONE, Chris	✓														
MURPHY, Greg	✓														
WHITE, Donna	✓														
Advisory Member															
ADCOCK, Gayle	✓														
FISHER, Susan	✓														
Senators															
BISHOP, Dan															
CURTIS, David	✓														
DAVIS, Jim	✓														
FOUSHEE, Valerie	✓														
HISE, Ralph	✓														
KRAWIEC, Joyce	✓														
ROBINSON, Gladys															
TARTE, Jeff	✓														

01-16-18

TUCKER, Tommy	✓														
WOODARD, Mike															
Advisory Members															
BARRINGER, Tamara	✓														
LEE, Michael															
Staff Members															
LANDRY, Deborah	✓														
MATULA, Theresa	✓														
THOMAS, Denise	✓														
WILKS, Lisa	✓														

VISITOR REGISTRATION SHEET

Health & Human Svcs. Jt. Leg. Oversight — 01/16/2018 — Room 643

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joyce Peters	CSS
[illegible]	DHB
Scott Laster	KGANC
Nian Sarks, DC	Least Invasive Fast
Randy Parrott	Oracle

VISITOR REGISTRATION SHEET

Health & Human Svcs. Jt. Leg. Oversight | 01/16/2018 | Room 643

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jean Andersen	Brain Injury Council
[illegible]	CSS
[illegible]	[illegible]
Bill Holmes	DIT
TJ Bugbee	NP
Julia Adams-Scheurich	Oak City GR
Jennifer Mahan	ASNC

VISITOR REGISTRATION SHEET

Health & Human Svcs. Jt. Leg. Oversight — 01/16/2018 — Room 643

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bob Robinson	Alliance Behavioral Healthcare
Brian Perkins	Alliance BHC
Sara Wilson	Alliance BHC
Robyn Smith Brown	NC Academy of Nutrition & Dietetics
Katherine Restrepo	John Locke Found.
Lexi Arthur	JLF
Ann Rodriguez	i2i Center for Integrative Health
Deborah Owens	NCRHLA
Tommy Sewe	MWC
DAVE MARCHIORI	ARCHER / WESTERN
James Whalen	Rep. Cynthia Ball

VISITOR REGISTRATION SHEET

Health & Human Svcs. Jt. Leg. Oversight | 01/16/2018 | Room 643

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Hugh Johnson	NCAJC
Dub Clary	NCSP
Jon Yeomans	DSSN
Mary Bethea	NC COA
Jesse Goodwin	DHHS/DHSR
TRACY GILYARD	AHHC
Logan Martin	Benchmarks
Mike Leighs	NCPC
Kelly Vogel	Amerigroup
Rachel Beach	Ph Law
Franklin Freeman	MWC

VISITOR REGISTRATION SHEET

Health & Human Svcs. Jt. Leg. Oversight | 01/16/2018 | Room 643

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Katye Tobe	SML
Greg Griggs	NCAFP
Martha Brode	Raleigh NC
CHET STROYNY	3M HIS
Gerry Tracy	3M HIS
CS Hollis	CSH
Lyla Parkinson	Parkinson Law
Ed Turlp	BPO
Caroline Hale	NASW-NC
Kay Castillo	NASW-NC
AMES SIMMONS	EQUALITY NC

VISITOR REGISTRATION SHEET

Health & Human Svcs. Jt. Leg. Oversight — 01/16/2018 — Room 643

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
M. Watson	SAMHSA GMG
Jeff Barnhart	MWC
Mitch Armstrong	Smith Anderson
Joe Lanier	Troutman
Laurie Stickney	Community Partnerships, Inc.
Dodie Reifer	CCR
Doug Miskew	PSG
[illegible]	Dewitt Strategy Group
Paul M. Duck	Beacon Health Options
April Boyd	Bennett Lawrence & Smith

VISITOR REGISTRATION SHEET

Health & Human Svcs. Jt. Leg. Oversight — 01/16/2018 — Room 643

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Phoebe Landon	MWC
Kirsten Mundt	WR
[illegible]	CCMC
Yvonne Copeland	Cardinas Centers for Medical Excellence
Regina Goodie Crawford	EMS MC / NCAEMSA
Pier Protz	Brain Injury Advisory Council
Carol Beatty	NC Brain Injury Area Board Member
Jeannie Darby	TBI Advocate, A/C CFAC BI Committee
Jenny Gadd	Alberta Professional Services 3107 S. Elm-Eugene St. GSO
Derek Mitchell	"
DAVID POWERS	POWERS STRATEGIES, LLC

VISITOR REGISTRATION SHEET

Health & Human Svcs. Jt. Leg. Oversight — 01/16/2018 — Room 643

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Thamy Mace	CGA
Ryan Blackledge	Cone Health
Kaitlyn Hunsberger	Cone Health
Sarah McQuillan	KGA
Cody HAND	NCHA
Matt McConnell	Carolinas HealthCare System
Kruti Patel	Carolinas HealthCare System
Sarah Smith	RD
Rob Lamm	RLA
Trail Baird	SHIFT NC
Harry Kaplan	[illegible]

VISITOR REGISTRATION SHEET

Health & Human Svcs. Jt. Leg. Oversight | 01/16/2018 | Room 643

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bradford Snoeda	NCDOT
Carson Thio	NVA
Sue Ann Farrest	NCMS
Chip Bg	NCMS
Elizabeth Robinson	NCRMA
Kory Kiger	NCRMA
Andy Ellen	NCRMA
Dana Sapsa	SA
Kara Weslar	SA

MINUTES
JOINT LEGISLATIVE OVERSIGHT COMMITTEE
HEALTH & HUMAN SERVICES

Wednesday, February 28, 2018 9:00 a.m.
Legislative Office Building – Room 643

ATTENDEES:
Chairmen: Pate, Dobson, Lambeth

House Members: Brisson, Cunningham, Dollar, Earle, Farmer-Butterfield, Jones, Malone, White, Adcock, and Fisher
Senate Members: Davis, Foushee, Hise, Krawiec, Tarte, and Tucker

Welcome and Opening Remarks

Senator Pate presided as Chair and introduced Mark Collins, a new fiscal analyst with the Fiscal Research Division. A copy of his experience is attached.

Comments from the Secretary

Dr. Mandy Cohen, Secretary of the Department of Health and Human Services, was recognized. She provided a brief update on Cardinal Innovations. The full transition will be complete by the end of January and $3.8 million has been committed to fund community investment activities. The Board of Directors is engaged in recommendations with final approval by DHHS. Then Secretary Cohen moved on to an update on the flu season. This season had a higher peak than previous seasons and a second, lower peak is expected later. There have been a total of 200 deaths, predominantly in people over the age of 65. The vaccine was only 36% effective this year and she underscored the need for better vaccines and the need for everyone to be vaccinated. A copy of Secretary Cohen's presentation is attached.

Local Health Department Issues

Introduction

Dennis Joyner, President of the NC Association of Local Health Directors, Union County Health Department, was recognized. He pointed out that there are 85 local health departments covering all 100 counties. They have three public health core functions: 1. assessment (monitor/diagnose), 2. policy development (partnership/educate), and 3. assurance (provide care/public health workforce). Local health departments provided care for over 500,000 citizens statewide, while providing over 1.3 million services to those patients.

Communicable Disease Response

Dr. John Morrow, Pitt County Health Director, was recognized. He pointed out that local health departments have been assigned to manage communicable diseases on the local level and these cases have increased tenfold over ten years. Their nurses are responsible for complex communicable disease investigations as required by law. He provided a 2017 chart of communicable disease by county. He stated that though outbreaks are increasing, funding has not. He requested increased funding, increased resources and an improved ability to communicate about threats within their jurisdictions.

Budget Pressures

Lisa Macon Harrison, Local Public Health Director for Granville Vance District Health Department, was recognized. She said that each clinic has different needs and budgets. About 22% of her clinic's budget is from State and federal dollars. The rest is funded by private health insurance, fees from environmental services, grants (33%), and Medicaid. Needs are challenging, deep and wide as local health departments provide food, lodging and institutional sanitation inspections, individual on-site water supply inspections, communicable disease control, and vital records registration. North Carolina ranks 44 out 50 state in public health per capita spending.

A copy of their joint power point is attached.

DHHS Jail Oversight

Steve Lewis, Section Chief, Construction Section, DHHS Division of Health Service Regulation, was recognized. He quickly reviewed General Statutes involving jail oversight; and briefly provided inmate death statistics and remedies. He explained the proposed changes to modernize the rules involving prison supervision rounds, special watch (suicide prevention), and the limited assignment of other duties to offices on supervision rounds. A copy of his power point presentation is attached.

Study Inmate Health Information Exchange Software (Session Law 2017-57, Section 16C311A)

Joe Prater, Deputy Secretary of Administration for the Department of Public Safety, was recognized. He outlined the history of prison inmate health information programs and technology. He reiterated that this was just information on prisons, not jails. He said that continuity of care is a primary standard. The State has a comprehensive health information exchanges and is doing a good job meeting current and future demands. Other programs might be duplicative, so the Department of Public Safety, DHHS and the Department of Information Technology are recommended to work together to transfer pertinent health information on all inmates. Bob Brison, Chief for Information Technology for the Department of Public Safety, was recognized to answer questions on communication capability compliance with regards to federal guidelines and the ability to share data with other agencies on the State and federal level. A copy of Mr. Prater's handout is attached.

Due to time constraints the remaining portion of the agenda was moved to the next meeting.

The meeting adjourned at 12:05 p.m.

Louis M Pate

Senator Louis Pate, Presiding

DeAnne Mangum

DeAnne Mangum, Committee Assistant

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

February 28, 2017 9:00 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Josh Dobson
Rep. Donny Lambeth
Sen. Louis Pate

Legislative Members
Rep. William D. Brisson
Rep. Carla D. Cunningham
Rep. Nelson Dollar
Rep. Beverly M. Earle
Rep. Jean Farmer-Butterfield
Rep. Bert Jones
Rep. Chris Malone
Rep. Gregory F. Murphy, MD
Rep. Donna McDowell White
Sen. Dan Bishop
Sen. David L. Curtis
Sen. Jim Davis
Sen. Valerie P. Foushee
Sen. Ralph Hise
Sen. Joyce Krawiec
Sen. Gladys A. Robinson
Sen. Jeff Tarte
Sen. Tommy Tucker
Sen. Mike Woodard

isory Members
p. Gale Adcock
Rep. Susan Fisher
Sen. Tamara Barringer
Sen. Michael V. Lee

I.	Welcome & Opening Remarks	Senator Louis Pate Presiding Co-chair
II.	Comments from the Secretary	Mandy Cohen, MD, Secretary Department of Health and Human Services
	• Cardinal Update • Flu Update	
III.	Local Health Department Issues	
	• Introduction	Dennis Joyner, President of the NC Association of Local Health Directors, Union County Health Department
	• Communicable Disease Response	John Morrow, MD, MPH Pitt County Health Director
	• Budget Pressures	Lisa Macon Harrison, Director, Granville-Vance Health District
IV.	DHHS Jail Oversight	Steve Lewis, Section Chief, Construction Section, DHHS Division of Health Service Regulation
V.	Study Inmate Health Information Exchange Software (Session Law 2017-57, Section 16C.11A)	Joe Prater, Deputy Secretary of Administration for the Department of Public Safety
VI.	Child Welfare Update	
	• Program Improvement Plan	Susan Perry-Manning, Deputy Secretary for Human Services
	• NC FAST	Sam Gibbs, Deputy Secretary for Technology and Operations
VII.	Adjourn Next Meeting: March 13, 2018	

Mark Collins

Mark comes to the Fiscal Research Division with 18 years of experience as an analyst.

For the past 5 years he has worked as a Financial Analyst with the Department of State Treasurer, State Health Plan Division.

Prior to that, Mark worked as a Fiscal and Policy Analyst for the Maryland General Assembly for 13 years.

Mark has a Bachelor's Degree in Criminology from the University of Maryland and a Master's Degree in Human Organization Science from Villanova University.

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON HEALTH AND HUMAN SERVICES

DHHS Updates

Mandy Cohen, MD, MPH
Department of Health and Human Services

February 28, 2018

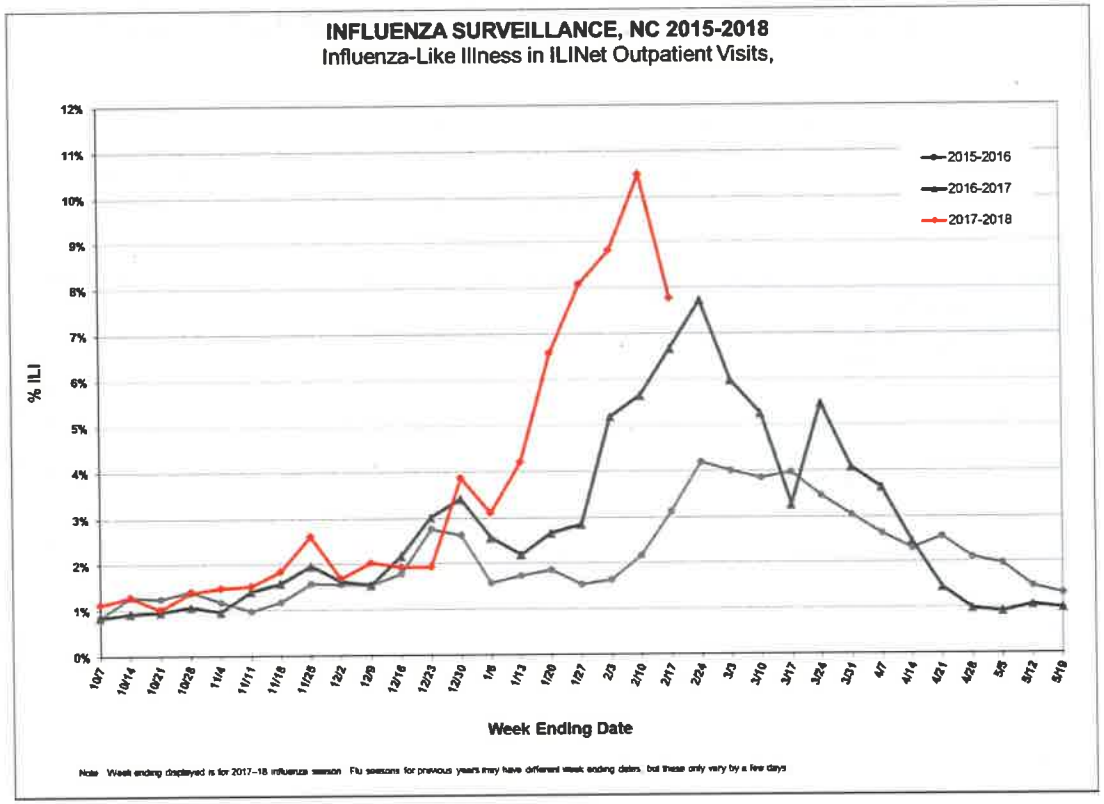
Cardinal Innovations Update

At the end of January 2018:

- DHHS transitioned leadership and governance to new board
- Corrective Action Plan adopted by board
- Committed $3.8 Million from administrative allocation and other existing resources to fund community investment activities this fiscal year
  - High impact initiatives that will positively affect members and their communities over the next 12 months
    - Capital, equipment and/or programmatic needs
  - Transparent process
  - Board of Directors engagement in recommendations
  - Final oversight and approval by DHHS
- Cardinal retained outside counsel
- Court granted DHHS' motion for Preliminary Injunction against former Cardinal Board Members & Leadership

2017–18 NC Influenza Season: Update

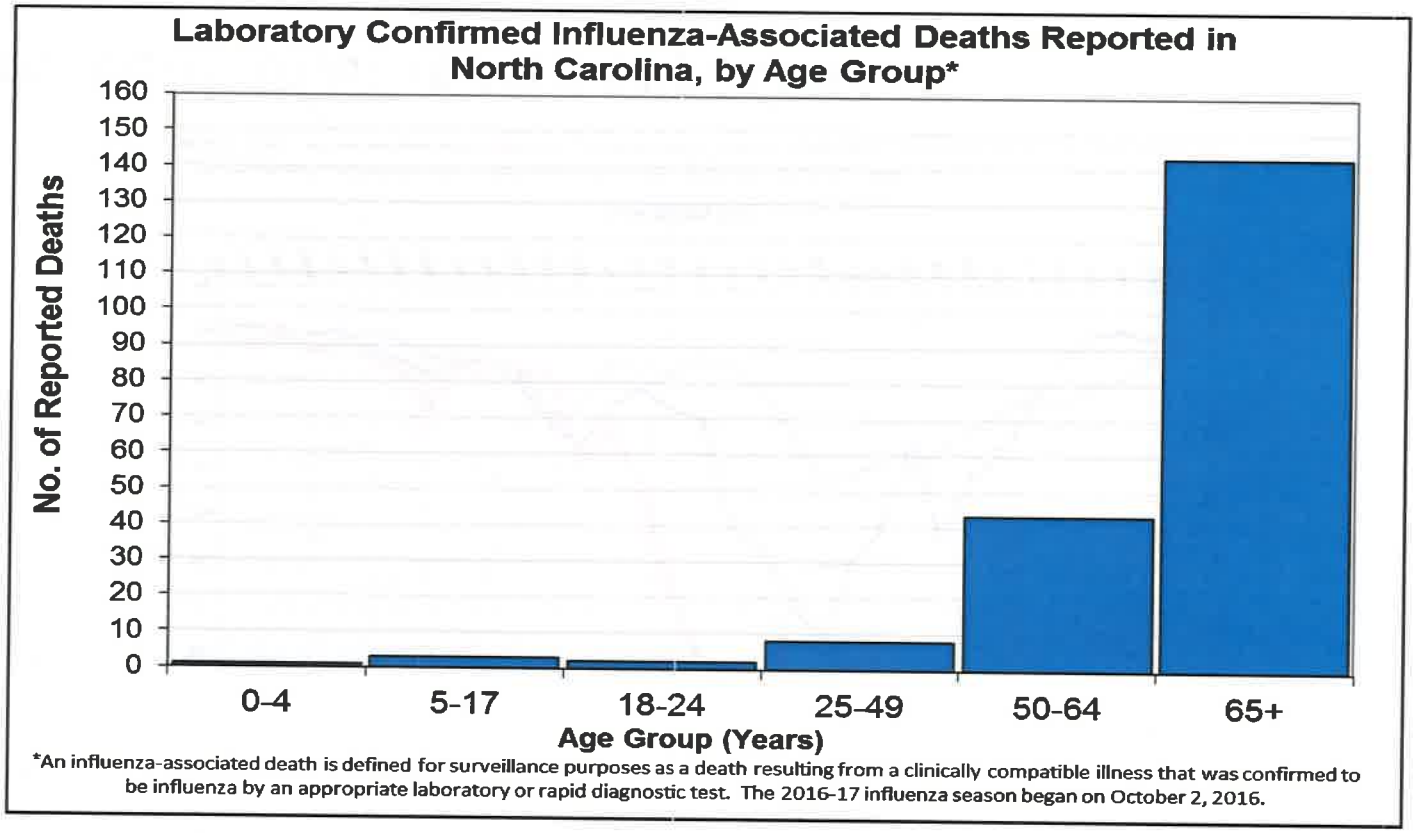
- Activity peaked during week ending February 10



- Higher peak than recent seasons
- Influenza A (H3N2) viruses predominating

SOURCE: www.flu.nc.gov

NC Influenza-Associated Deaths: 2017–18 Season



- Most deaths in persons ≥ 65 years of age
- Reporting lags behind other measures of flu activity
- Total deaths 200

SOURCE: www.flu.nc.gov

Flu Vaccine Effectiveness: Interim Estimates

- Overall effectiveness at 36%
  - Lower against H3N2, higher against other flu viruses
  - 59% effective for children 6 months–8 years
  - Similar to 2016-17 flu season (39% effective)
- Reduced risk of getting sick and having to go to the doctor for flu by about one-third
  - Best available way to prevent influenza illness and complications
  - Underscores need for better vaccines

Flu Messages

- Not too late to get vaccinated
  - High levels of flu expected for coming weeks
  - Flu B tends to increase in spring
- If you think you have the flu, call your doctor
  - Prescription antiviral drugs are important second line of defense
  - Especially important for those at high risk for complications
- Remember common sense prevention actions
  - Hand hygiene, respiratory etiquette
  - Stay home from school/work when sick

NC Electronic Disease Surveillance System

NC EDSS EVENT ID# _____

North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

PERTUSSIS (WHOOPING COUGH)

Confidential Communicable Disease Report—Part 2

NC DISEASE CODE: 47

REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate *(mm/dd/yyyy)* / /
						SSN

NC EDSS LAB RESULTS Verify if lab results for this event are in NC EDSS. If not present, enter results.

Was laboratory testing for pertussis done? ☐ Yes ☐ No ☐ Unknown

	Date Specimen Collected (month/day/year)	Result	Is case laboratory-confirmed? ☐ Yes ☐ No
Culture	/ /		Result Code P Positive N Negative I Indeterminate E Pending X Not Done S Parapertussis
DFA	/ /		
PCR	/ /		
Serology (1st specimen)	/ /		
Serology (2nd specimen)	/ /		

Note: Serology is based on either single sample or combined result from acute and convalescent samples.

NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U
If yes, symptom onset date (mm/dd/yyyy): __/__/____
CHECK ALL THAT APPLY:
Encephalopathy ☐Y ☐N ☐U
Seizures/convulsions ☐Y ☐N ☐U
If yes, specify
☐ New onset
☐ Exacerbation of underlying seizure disorder
☐ Other, specify: _____
☐ Unknown
Cough ☐Y ☐N ☐U
Onset date (mm/dd/yyyy): ____/____/____
Was patient still coughing at final interview? ☐Y ☐N ☐U
Final interview date (mm/dd/yyyy): ____/____/____ (at least two weeks after cough onset)
Duration of cough at final interview: _____ days
This must be at least 14 days of cough.
Paroxysmal cough ☐Y ☐N ☐U
Whoop ☐Y ☐N ☐U
Post-tussive vomiting ☐Y ☐N ☐U
Apnea ☐Y ☐N ☐U
Chest x-ray ☐Y ☐N ☐U
If yes, Chest x-ray abnormal? ☐Y ☐N ☐U
Pneumonia ☐Y ☐N ☐U
If yes, confirmed by x-ray or CT ☐Y ☐N ☐U
Other symptoms, signs, clinical findings, or complications consistent with this illness? ☐Y ☐N ☐U
If yes, specify: _____

TREATMENT
Did patient take an antibiotic as treatment for this illness? ☐Y ☐N ☐U
If yes, specify antibiotic name: _____
Dose _____
Date antibiotic began ____/____/____
Date antibiotic ended ____/____/____
Were antibiotics taken before culture specimen collected? ☐Y ☐N ☐U
Specify culture site(s): _____
Was antibiotic prophylaxis given prior to illness onset? ☐Y ☐N ☐U
Did the patient require mechanical ventilation? ☐Y ☐N ☐U
Date started (mm/dd/yyyy): ____/____/____
Was patient hospitalized for this illness >24 hours? ☐Y ☐N ☐U
Hospital name: _____
City, State: _____
Hospital contact name: _____
Telephone: (____) _____ - _____
Admit date (mm/dd/yyyy): ____/____/____
Discharge date (mm/dd/yyyy): ____/____/____
Restrictions to movement or freedom of action? ☐Y ☐N
Check all that apply:
☐ Work ☐ Sexual behavior
☐ Child care ☐ Blood and body fluid
☐ School ☐ Other, specify
_____

Date control measures issued: ____/____/____
Date control measures ended: ____/____/____
Was patient compliant with control measures? ☐Y ☐N
Does patient know anyone else with similar symptom(s) who had the same or similar travel history? ☐Y ☐N ☐U
If yes, list person(s) and contact information:

Does the patient know anyone else with similar symptoms? ☐Y ☐N ☐U
If yes, specify name and relationship to person(s)

Is the patient part of an outbreak of this disease? ☐Y ☐N

VACCINE
Has patient ever received pertussis-containing vaccine? ☐Y ☐N ☐U
Vaccine #1:
Date of vaccination (mm/dd/yyyy): ____/____/____
Vaccine type: _____
Manufacturer: _____
Product/trade name: _____
Lot number: _____
Vaccine #2:
Date of vaccination (mm/dd/yyyy): ____/____/____
Vaccine type: _____
Manufacturer: _____
Product/trade name: _____

(CONTINUED)

Diseases and Conditions Reportable in North Carolina

Physicians must report these diseases and conditions to the county local health department, according to the **North Carolina Administrative Code: 10A NCAC 41A.0101 Reportable Diseases and Conditions** (see below). Contact information for local health departments can be accessed at ***www.ncalhd.org/directors***. If you are unable to contact your local health department, call the 24/7 pager for N.C. Communicable Disease Branch ***(919) 733-3419.***

For diseases and conditions required to be reported within 24 hours, the initial report shall be made by telephone to the local health department, and the written disease report be made within 7 days. The reporting rules and disease report forms can be accessed at: ***http://epi.publichealth.nc.gov/cd/report.html***

Diseases in *BOLD ITALICS* should be reported immediately to local health department.

Reportable to Local Health Department Within 24 Hours

DISEASE/CONDITION

A-G

ANTHRAX
BOTULISM, FOODBORNE
BOTULISM, INTESTINAL (INFANT)
BOTULISM, WOUND
Campylobacter infection
Chancroid
Chikungunya
Cholera
Cryptosporidiosis
Cyclosporiasis
Diphtheria
E.coli infection, shiga toxin-producing
Foodborne disease: Clostridium perfringens
Foodborne: staphylococcal
Foodborne disease: other/unknown
Foodborne poisoning: ciguatera
Foodborne poisoning: mushroom
Foodborne poisoning: scombroid fish
Gonorrhea
Granuloma inguinale

H-N

Haemophilus influenzae, invasive disease
Hemolytic-uremic syndrome (HUS)
HEMORRHAGIC FEVER VIRUS INFECTION
Hepatitis A
Hepatitis B, acute
HIV/AIDS
HIV
AIDS
Influenza virus infection causing death
Listeriosis
Measles (rubeola)
Meningococcal disease, invasive
Middle East respiratory syndrome (MERS)
Monkeypox
NOVEL INFLUENZA VIRUS INFECTION

O-U

Ophthalmia neonatorum
Pertussis (Whooping Cough)
PLAGUE
Poliomyelitis, paralytic
Rabies, human
Rubella
Salmonellosis
S. aureus with reduced susceptibility to vancomycin
SARS coronavirus infection
Shigellosis
SMALLPOX
Syphilis
primary
secondary
early latent
late latent
late with clinical manifestations
congenital
Tuberculosis
TULAREMIA
Typhoid Fever, acute

V-Z

Vaccinia
Vibrio infection, other than cholera & vulnificus
Vibrio vulnificus
Zika

Reportable to Local Health Department Within 7 Days

DISEASE/CONDITION

A-G

Brucellosis
Chlamydial infection—laboratory confirmed
Creutzfeldt-Jakob Disease
Dengue
Ehrlichiosis, HGA (human granulocytic anaplasmosis)
Ehrlichiosis, HME (human monocytic or e. chaffeensis)
Ehrlichiosis, unspecified
Encephalitis, arboviral, WNV
Encephalitis, arboviral, LAC
Encephalitis, arboviral, EEE
Encephalitis, arboviral, other

H-N

Hantavirus infection
Hepatitis B, carriage
Hepatitis B, perinatally acquired
Hepatitis C, acute
Legionellosis
Leprosy
Leptospirosis
Lyme disease
Lymphogranuloma venereum
Malaria
Meningitis, pneumococcal
Mumps
Non-gonococcal urethritis

O-Z

Pelvic inflammatory disease
Psittacosis
Q fever
Rocky Mountain Spotted Fever
Rubella, congenital syndrome
Streptococcal infection, Group A, Invasive
Tetanus
Toxic shock syndrome, non-streptococcal
Toxic shock syndrome, streptococcal
Trichinosis
Typhoid, carriage (Salmonella typhi)
Yellow fever

You may be contacted by the local health department for additional information about this case. Medical record information relevant to the investigation and/or control of a communicable disease is exempt from the HIPAA Privacy Rule (see 45 CFR 164.512(a)) and is permitted as an exception to confidentiality of records in NC State Law GS § 130 A-130.

North Carolina General Statute:

§130A-135. Physicians to report.

A physician licensed to practice medicine who has reason to suspect that a person about whom the physician has been consulted professionally has a communicable disease or communicable condition declared by the Commission to be reported, shall report information required by the Commission to the local health director of the county or district in which the physician is consulted.

North Carolina Administrative Code:

10A NCAC 41A.0101 Reportable Diseases and Conditions

(a) The following named diseases and conditions are declared to be dangerous to the public health and are hereby made reportable within the time period specified after the disease or condition is reasonably suspected to exist:

North Carolina's Local Health Departments

Dennis Joyner, MPH
President, NCALHD

Union County Public Health Director

February 28, 2018

NCALHD
North Carolina Association of Local Health Directors

- There are 85 Local Health Departments representing all 100 counties in NC

- Working in conjunction with the NC Division of Public Health, local health departments seek to promote and contribute to the highest possible level of health for the people of NC.

- Three Core Functions of Public Health
  - Assessment – (monitor / diagnose)
  - Policy Development – (partnership / educate)
  - Assurance – (provide care / public health workforce)

Common public health focus areas include:

- **Community Health Assessment**
- **Communicable Disease Control**
- **Environmental Health**
- **Public Health Preparedness**
- **Family Planning**
- **Maternal & Child Health Promotion**
- **Chronic Disease Prevention**

Primary Care in Local Health Departments

- 51 - Adult Primary Care
- 72 - Child Primary Care
- 50 - Both Adult & Child Primary Care

Dental Clinics in Local Health Departments

- 39 – Adult and/or Children

In 2016, Local Health Departments provided care for 500,000 unduplicated patients in our clinics.

- 40% Medicaid
- 47% Uninsured
- Over 3.1 million services provided

Communicable Disease Funding at the Local Level

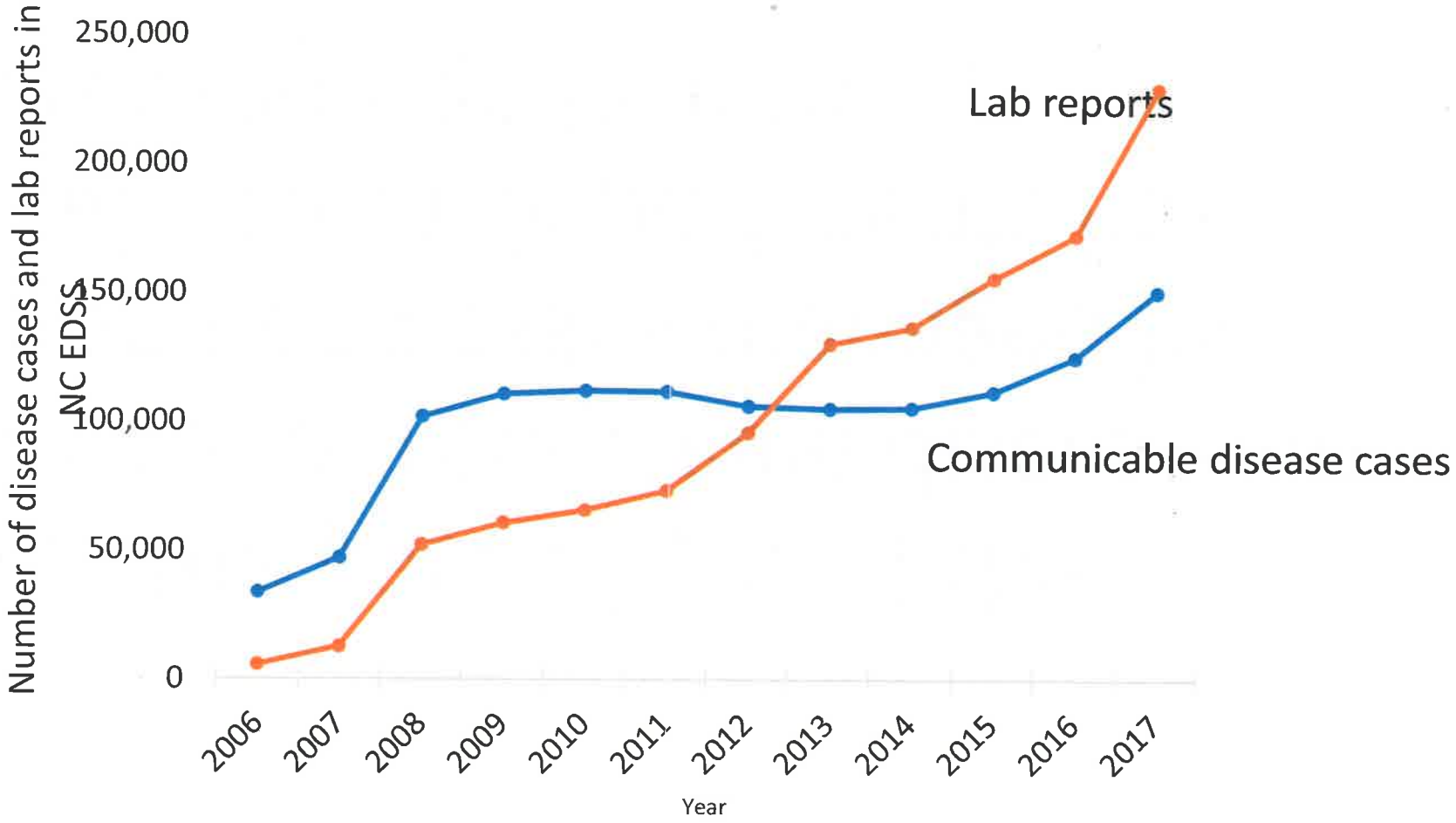
John Morrow, MD, MPH
Pitt County Public Health
February 2018

NCALHD
North Carolina Association of Local Health Directors

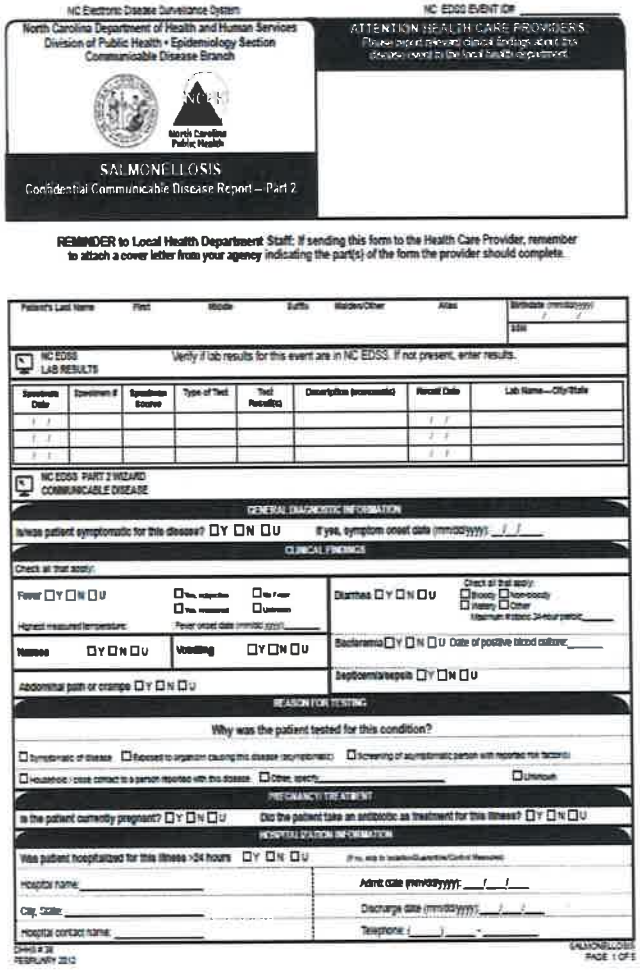
Over the past 10 years, the number of reportable disease lab reports and cases managed by Local Health Departments has increased significantly.

NCALHD
North Carolina Association of Local Health Directors

The number of communicable disease cases has doubled and the number of laboratory reports Public Health Nurses must review has increased 10-fold over the past 10 years



Communicable disease nurses are responsible for complex disease investigation requirements



NC Electronic Disease Surveillance System — NC EDSS EVENT ID#: _____

North Carolina Department of Health and Human Services
Division of Public Health • Epidemiology Section
Communicable Disease Branch

ATTENTION HEALTH CARE PROVIDERS:
Please report reportable clinical findings about this disease/condition to the local health department.

North Carolina Public Health

SALMONELLOSIS
Confidential Communicable Disease Report – Part 2

REMINDER to Local Health Department Staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

Patient's Last Name | First | Middle | Suffix | Maiden/Other | Alias | Birthdate (mm/dd/yyyy) | SSN

NC EDSS LAB RESULTS — Verify if lab results for this event are in NC EDSS. If not present, enter results.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name—City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE

GENERAL DIAGNOSTIC INFORMATION

Is/was patient symptomatic for this disease? ☐Y ☐N ☐U If yes, symptom onset date (mm/dd/yyyy): __/__/____

CLINICAL FINDINGS

Check all that apply:

Fever ☐Y ☐N ☐U — ☐Yes, subjective ☐Yes, measured ☐No Fever ☐Unknown
Highest measured temperature: Fever onset date (mm/dd/yyyy): _____

Diarrhea ☐Y ☐N ☐U — Check all that apply: ☐Bloody ☐Non-bloody ☐Watery ☐Other
Maximum # stools/ 24-hour period: _____

Nausea ☐Y ☐N ☐U | Vomiting ☐Y ☐N ☐U

Bacteremia ☐Y ☐N ☐U Date of positive blood culture: _____

Abdominal pain or cramps ☐Y ☐N ☐U

Septicemia/sepsis ☐Y ☐N ☐U

REASON FOR TESTING

Why was the patient tested for this condition?

☐Symptomatic of disease ☐Exposed to organism causing this disease (asymptomatic) ☐Screening of asymptomatic person with reported risk factor(s)
☐Household / close contact to a person reported with this disease ☐Other, specify: _____ ☐Unknown

PREGNANCY/TREATMENT

Is the patient currently pregnant? ☐Y ☐N ☐U Did the patient take an antibiotic as treatment for this illness? ☐Y ☐N ☐U

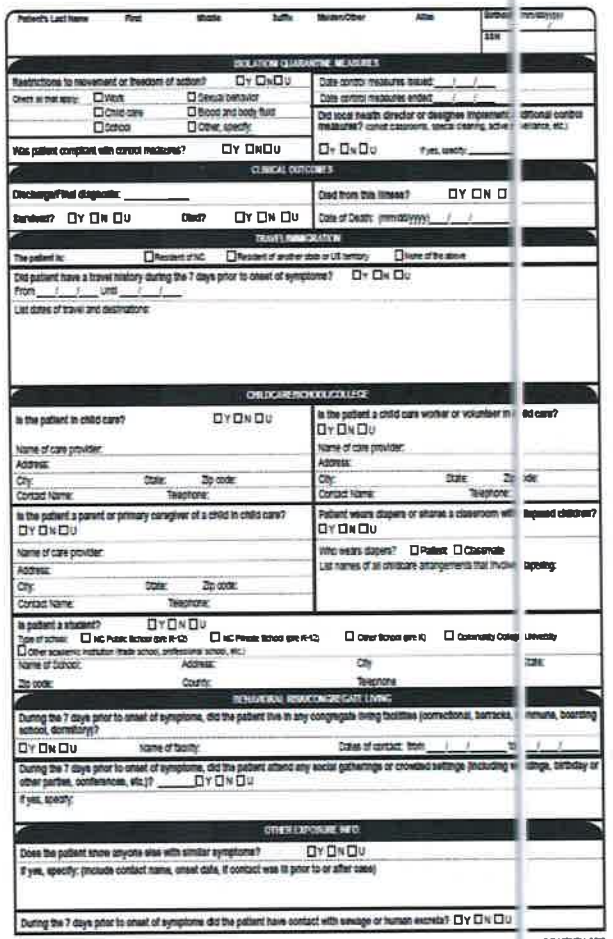
HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours ☐Y ☐N ☐U (If yes, skip to Isolation/Quarantine/Control Measures)

Hospital name: _____ | Admit date (mm/dd/yyyy): __/__/____
City, State: _____ | Discharge date (mm/dd/yyyy): __/__/____
Hospital contact name: _____ | Telephone: (___) ___-____

DHHS # 38
FEBRUARY 2012

SALMONELLOSIS
PAGE 1 OF 5



Patient's Last Name | First | Middle | Suffix | Maiden/Other | Alias | Birthdate (mm/dd/yyyy) | SSN

ISOLATION/QUARANTINE MEASURES

Restrictions to movement or freedom of action? ☐Y ☐N ☐U
Check all that apply: ☐Work ☐Child care ☐School ☐Sexual behavior ☐Blood and body fluid ☐Other, specify:
Was patient compliant with control measures? ☐Y ☐N ☐U
Date control measures issued: __/__/____
Date control measures ended: __/__/____
Did local health director or designee implement additional control measures? (cohort classrooms, special cleaning, active surveillance, etc.) ☐Y ☐N ☐U If yes, specify: _____

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____
Survived? ☐Y ☐N ☐U Died? ☐Y ☐N ☐U
Died from this illness? ☐Y ☐N ☐
Date of Death: (mm/dd/yyyy) __/__/____

TRAVEL INFORMATION

The patient is: ☐Resident of NC ☐Resident of another state or US territory ☐None of the above
Did patient have a travel history during the 7 days prior to onset of symptoms? ☐Y ☐N ☐U
From __/__/____ Until __/__/____
List dates of travel and destinations:

CHILDCARE/SCHOOL/COLLEGE

Is the patient in child care? ☐Y ☐N ☐U
Name of care provider:
Address:
City: State: Zip code:
Contact Name: Telephone:

Is the patient a child care worker or volunteer in child care? ☐Y ☐N ☐U
Name of care provider:
Address:
City: State: Zip code:
Contact Name: Telephone:

Is the patient a parent or primary caregiver of a child in child care? ☐Y ☐N ☐U
Name of care provider:
Address:
City: State: Zip code:
Contact Name: Telephone:

Patient wears diapers or attends a classroom with diapered children? ☐Y ☐N ☐U
Who wears diapers? ☐Patient ☐Classmate
List names of all childcare arrangements that involve diapering:

Is patient a student? ☐Y ☐N ☐U
Type of school: ☐NC Public School (pre K-12) ☐NC Private School (pre K-12) ☐Other School (pre K) ☐Community College ☐University
☐Other academic institution (trade school, professional school, etc.)
Name of School: Address: City: State:
Zip code: County: Telephone

RESIDENTIAL/CONGREGATE LIVING

During the 7 days prior to onset of symptoms, did the patient live in any congregate living facilities (correctional, barracks, dormitory, communa, boarding school, dormitory)? ☐Y ☐N ☐U Name of facility: Dates of contact: from __/__/____ to __/__/____

During the 7 days prior to onset of symptoms, did the patient attend any social gatherings or crowded settings (including lounge, birthday or other parties, conferences, etc.)? ☐Y ☐N ☐U
If yes, specify:

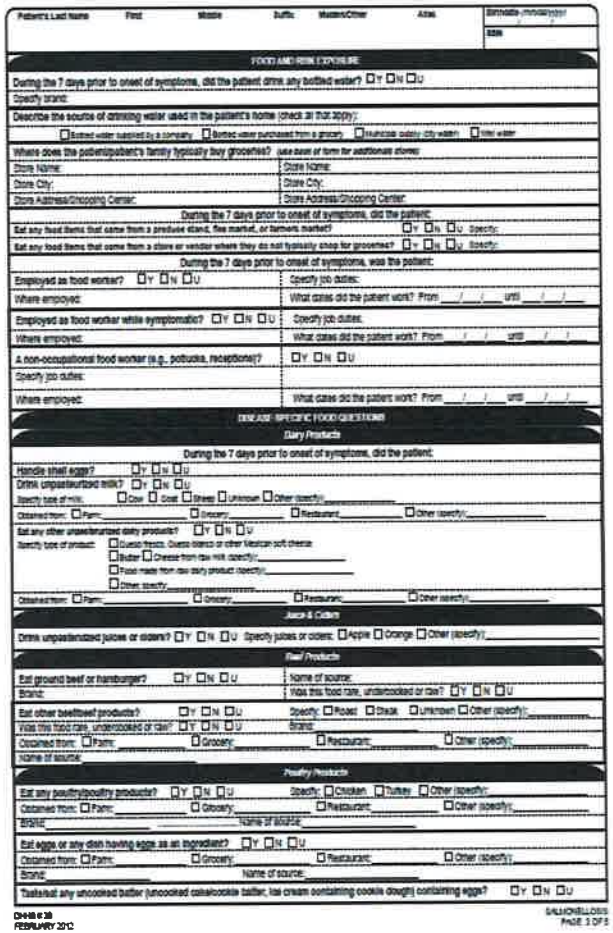
OTHER EXPOSURE INFO.

Does the patient know anyone else with similar symptoms? ☐Y ☐N ☐U
If yes, specify: (include contact name, onset date, if contact was ill prior to or after case)

During the 7 days prior to onset of symptoms did the patient have contact with sewage or human excreta? ☐Y ☐N ☐U

DHHS # 38
FEBRUARY 2012

SALMONELLOSIS
PAGE 2 OF 5



Patient's Last Name | First | Middle | Suffix | Maiden/Other | Alias | Birthdate (mm/dd/yyyy) | SSN

FOOD AND RISK EXPOSURE

During the 7 days prior to onset of symptoms, did the patient drink any bottled water? ☐Y ☐N ☐U
Specify brand:
Describe the source of drinking water used in the patient's home (check all that apply):
☐Bottled water supplied by a company ☐Bottled water purchased from a grocery ☐Municipal public city water ☐Well water
Where does the patient/patient's family typically buy groceries? (use back or form for additional stores)
Store Name: | Store Name:
Store City: | Store City:
Store Address/Shopping Center: | Store Address/Shopping Center:

During the 7 days prior to onset of symptoms, did the patient:
Eat any food items that came from a produce stand, flea market, or farmers market? ☐Y ☐N ☐U Specify:
Eat any food items that came from a store or vendor where they do not typically shop for groceries? ☐Y ☐N ☐U Specify:

During the 7 days prior to onset of symptoms, was the patient:
Employed as food worker? ☐Y ☐N ☐U | Specify job duties:
Where employed: | What dates did the patient work? From __/__/____ until __/__/____
Employed as food worker while symptomatic? ☐Y ☐N ☐U | Specify job duties:
Where employed: | What dates did the patient work? From __/__/____ until __/__/____
A non-occupational food worker (e.g., potlucks, receptions)? ☐Y ☐N ☐U
Specify job duties:
Where employed: | What dates did the patient work? From __/__/____ until __/__/____

DISEASE-SPECIFIC FOOD QUESTIONS

Dairy Products

During the 7 days prior to onset of symptoms, did the patient:
Handle shell eggs? ☐Y ☐N ☐U
Drink unpasteurized milk? ☐Y ☐N ☐U
Specify type of milk: ☐Cow ☐Goat ☐Sheep ☐Unknown ☐Other (specify):
Obtained from: ☐Farm: _____ ☐Grocery: _____ ☐Restaurant: _____ ☐Other (specify): _____
Eat any other unpasteurized dairy products? ☐Y ☐N ☐U
Specify type of product: ☐Queso fresco, Queso blanco or other Mexican soft cheese ☐Butter ☐Cheese from raw milk (specify): _____ ☐Food made from raw dairy product (specify): _____ ☐Other (specify): _____
Obtained from: ☐Farm: _____ ☐Grocery: _____ ☐Restaurant: _____ ☐Other (specify): _____

Juice & Cider

Drink unpasteurized juices or ciders? ☐Y ☐N ☐U Specify juices or ciders: ☐Apple ☐Orange ☐Other (specify): _____

Beef Products

Eat ground beef or hamburger? ☐Y ☐N ☐U | Name of source:
Brand: | Was this food rare, undercooked or raw? ☐Y ☐N ☐U
Eat other beef/beef products? ☐Y ☐N ☐U Specify: ☐Roast ☐Steak ☐Unknown ☐Other (specify): _____
Was this food rare, undercooked or raw? ☐Y ☐N ☐U | Brand:
Obtained from: ☐Farm: _____ ☐Grocery: _____ ☐Restaurant: _____ ☐Other (specify): _____
Name of source: _____

Poultry Products

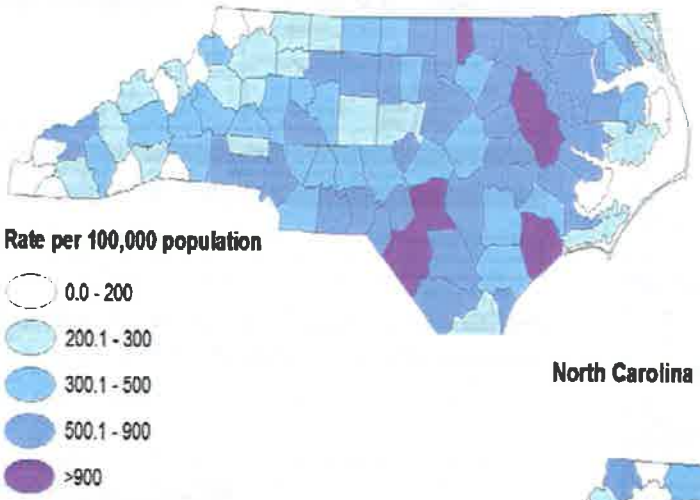
Eat any poultry/poultry products? ☐Y ☐N ☐U Specify: ☐Chicken ☐Turkey ☐Other (specify): _____
Obtained from: ☐Farm: _____ ☐Grocery: _____ ☐Restaurant: _____ ☐Other (specify): _____
Brand: _____ Name of source: _____
Eat eggs or any dish having eggs as an ingredient? ☐Y ☐N ☐U
Obtained from: ☐Farm: _____ ☐Grocery: _____ ☐Restaurant: _____ ☐Other (specify): _____
Brand: _____ Name of source: _____
Taste/eat any uncooked batter (uncooked cake/cookie batter, ice cream containing cookie dough) containing eggs? ☐Y ☐N ☐U

DHHS # 38
FEBRUARY 2012

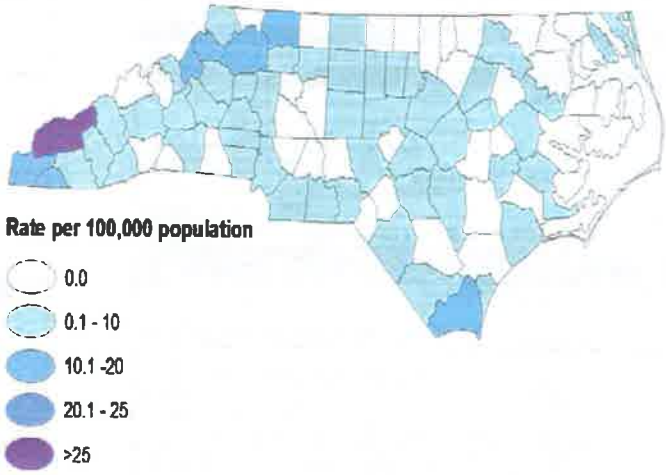
SALMONELLOSIS
PAGE 3 OF 5

Public Health manages communicable diseases every day

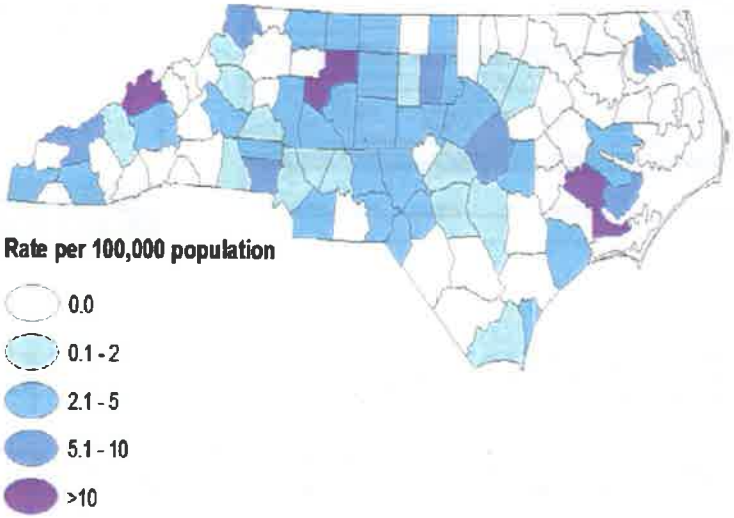
North Carolina Newly Diagnosed Chlamydia Rates, 2016



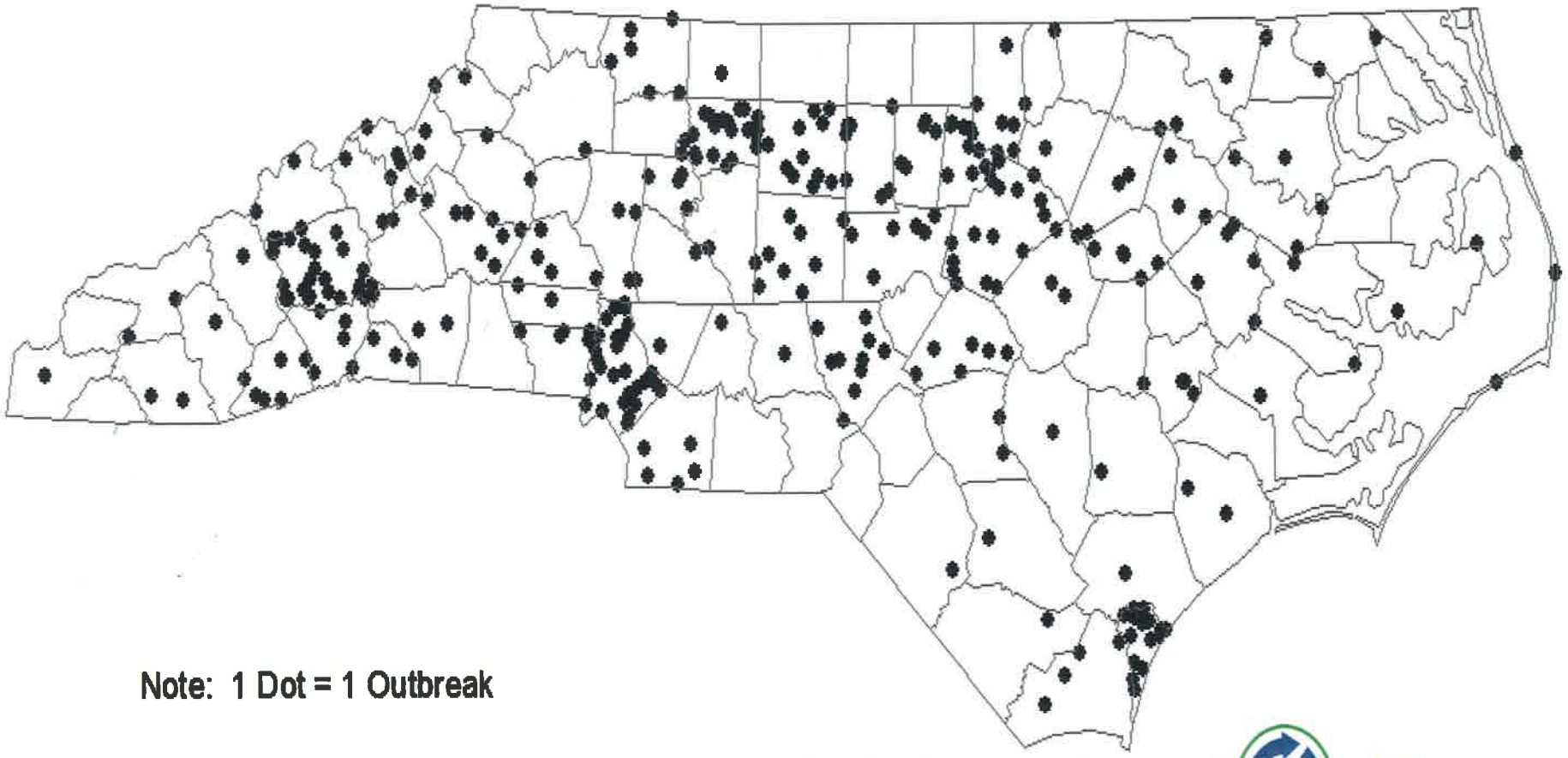
North Carolina Newly Diagnosed Acute Hepatitis C Rates, 2016



North Carolina Pertussis Rates, 2016



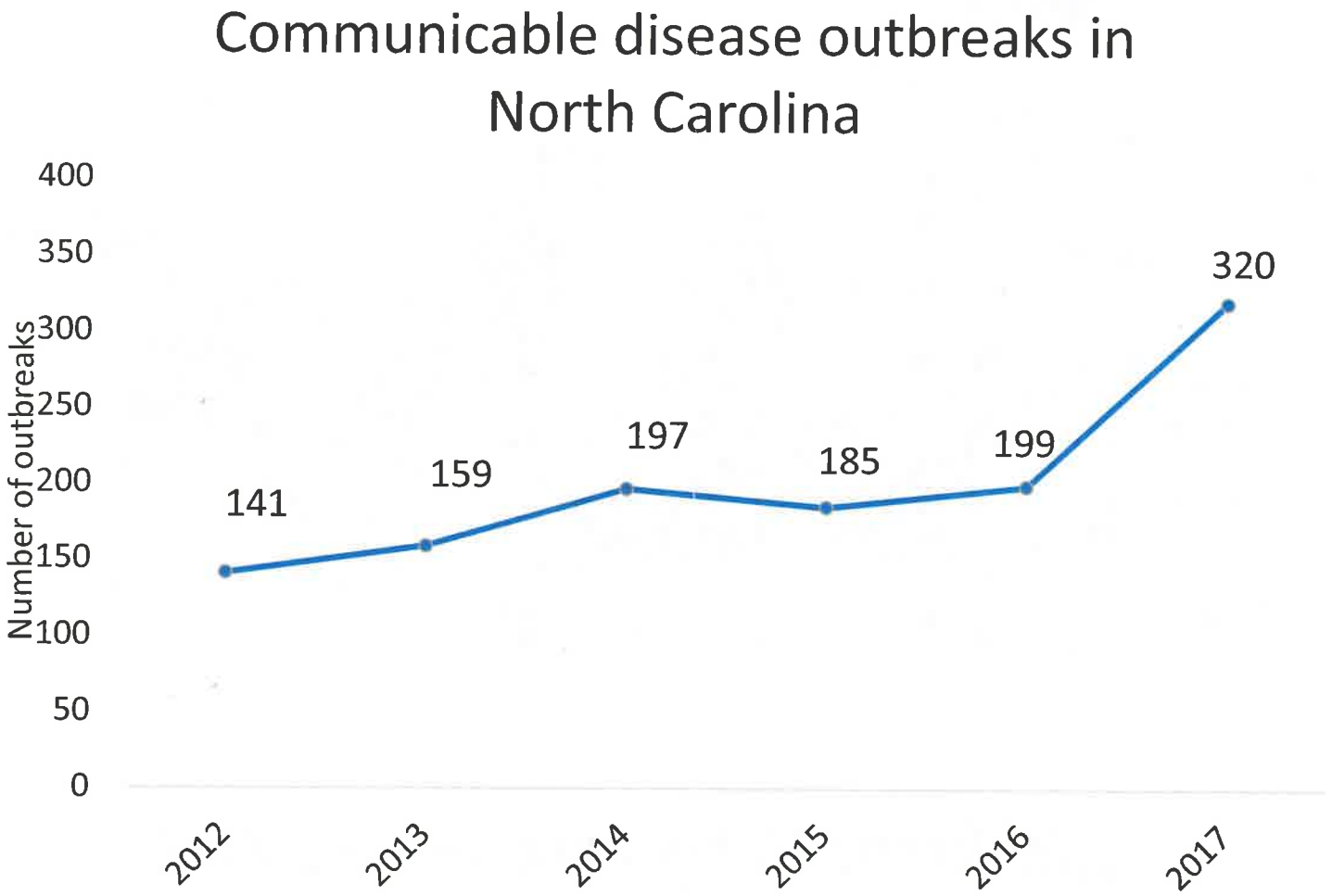
North Carolina Outbreaks By County, 2017



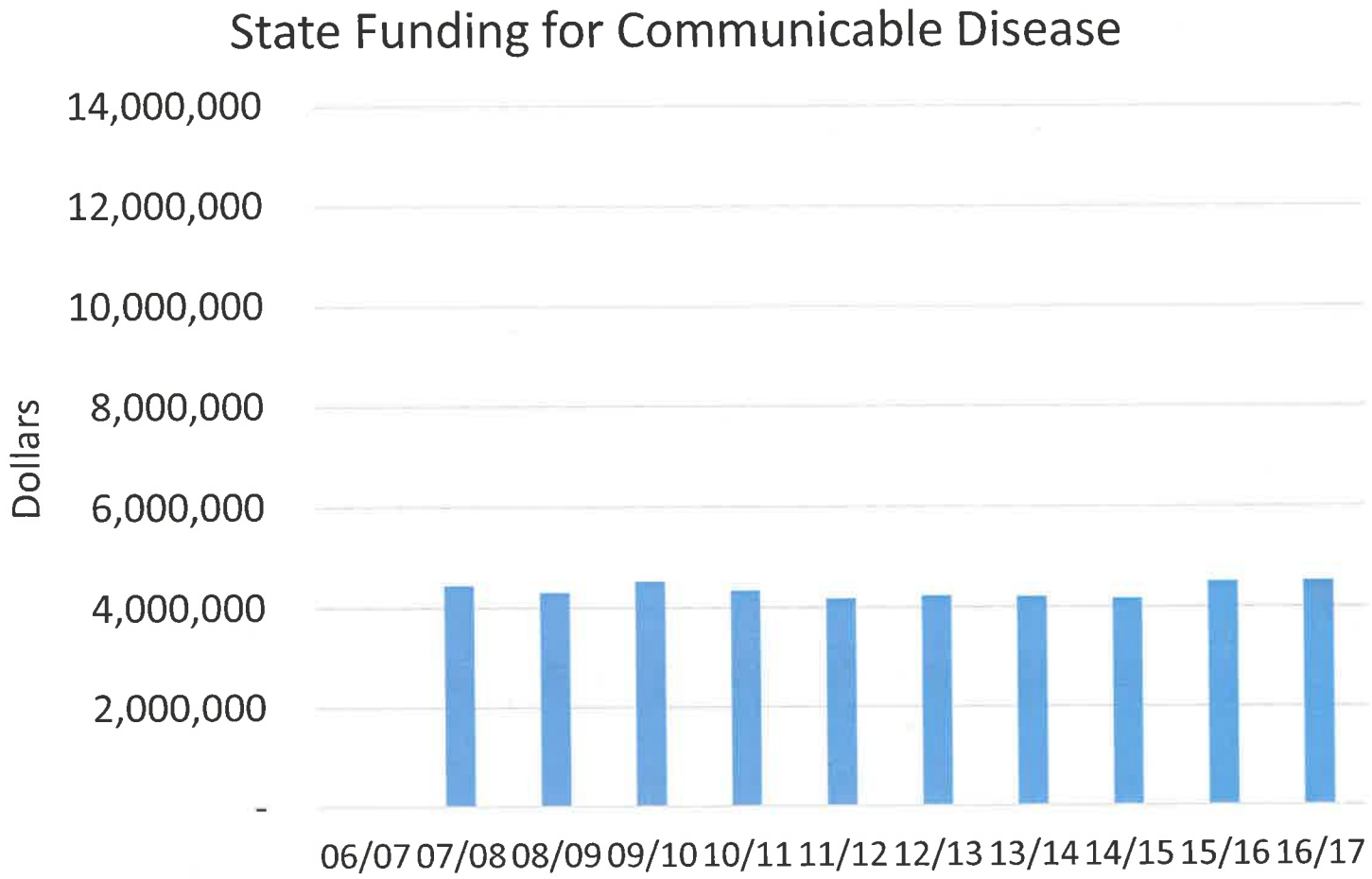
Note: 1 Dot = 1 Outbreak

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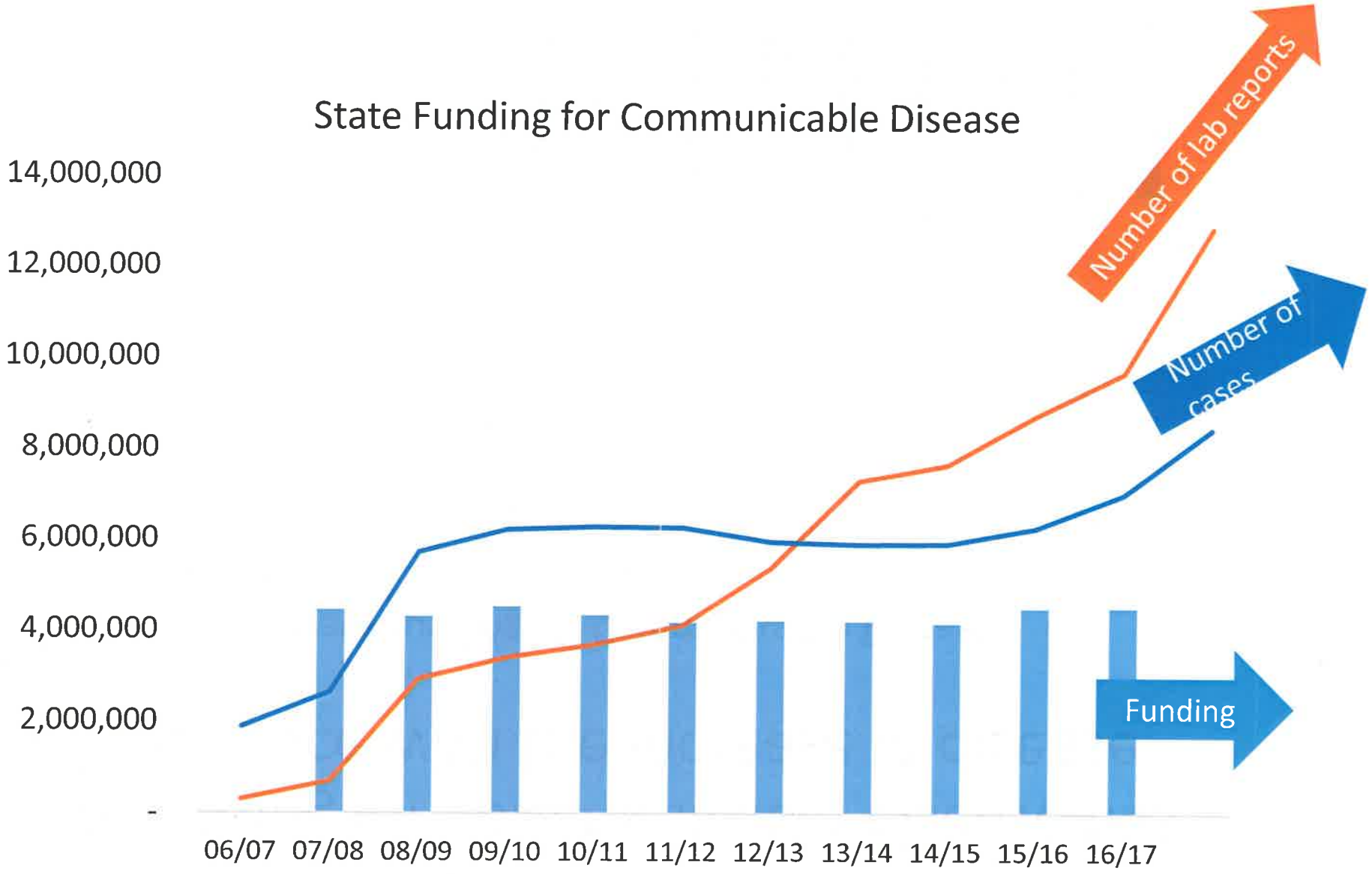
Outbreaks are also increasing

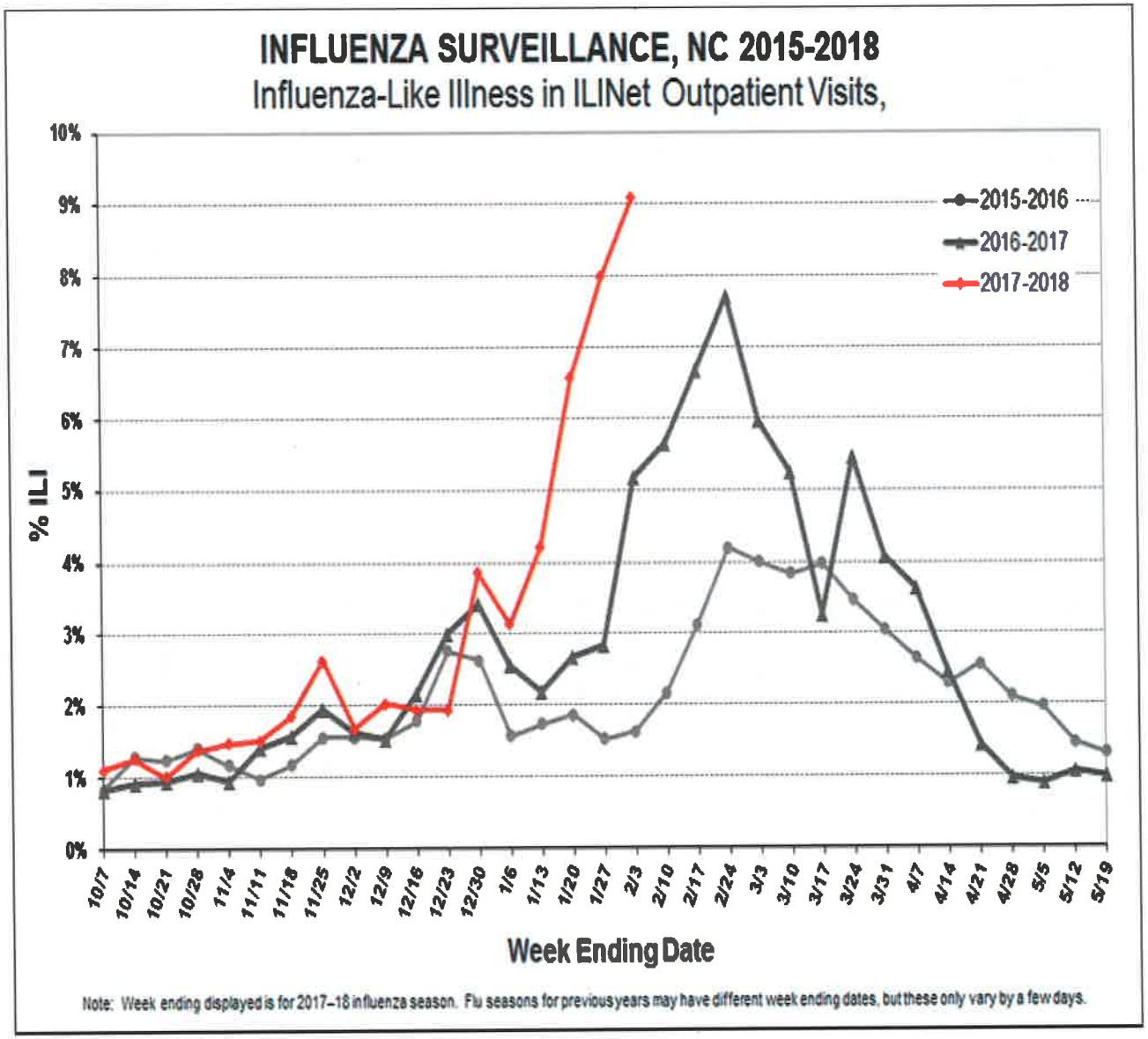


State funding for communicable disease has not kept pace with the increase in disease.



State funding for communicable disease has not kept pace with the increase in disease.




INFLUENZA SURVEILLANCE, NC 2015-2018
Influenza-Like Illness in ILINet Outpatient Visits,
% ILI
10%
9%
8%
7%
6%
5%
4%
3%
2%
1%
0%
2015-2016
2016-2017
2017-2018
10/7
10/14
10/21
10/28
11/4
11/11
11/18
11/25
12/2
12/9
12/16
12/23
12/30
1/6
1/13
1/20
1/27
2/3
2/10
2/17
2/24
3/3
3/10
3/17
3/24
3/31
4/7
4/14
4/21
4/28
5/5
5/12
5/19
Week Ending Date
Note: Week ending displayed is for 2017–18 influenza season. Flu seasons for previous years may have different week ending dates, but these only vary by a few days.

Questions ?

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NCALHD Legislative Priority

- Increase funding to Local Public Health to Address Rapidly Emerging Infectious Disease (e.g. ZIKA, Hepatitis C, Escherichia coli (E. coli) O121 or E. coli O26, Antibiotic Resistant Infections, , Coronavirus (MERS), Meningitis, Drug Resistant Tuberculosis, Influenza, etc.).
- In light of recent national and international concern around communicable disease outbreaks, it is imperative that local health departments have a minimum set of resources available to perform local communicable disease control and community and public health surveillance activities, and to communicate clearly about disease threats within their jurisdictions.
- Support for the basic core functions of local public health departments is waning, along with infrastructure funding, impacting local public health ability to accomplish mandated services. Local control of communicable diseases is a well-recognized core public health function here in NC and nationally, a role comparable to the public safety mission of law enforcement.

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Budget Pressures for North Carolina's Local Health Departments

NCALHD
North Carolina Association of Local Health Directors

Lisa Macon Harrison, MPH
Local Public Health Director
Granville Vance District Health Department

February 28, 2018







Public health works every day to promote and protect health, and prevent disease. Overall, Local Health Departments are the only community entities concerned with **protecting the health of the entire community...**advocating for and promoting health in its broadest form.

Required local public health services include:

Provide:	Provide/contract/certify:
Food, lodging & institutional sanitation	Adult health
Individual on-site water supply	Home health
Sanitary sewage collection, treatment & disposal	Dental public health
Communicable disease control	HIV/STD
Vital records registration	Maternal health
	Child health
	Family planning
*These required services do not even touch on the basic Community Health Assessment or Health Education and Health Promotion needs within a community. Moving forward, the work of the LHD as a community health strategist for public health 3.0 will require addressing determinants of health and connecting partners.	Public health laboratory

A Resilient Public Health System is more than just the sum of its parts, but to date, in the US, we have funded mainly just parts.



"... the vast majority of government health spending in the United States is for individual illness care and treatment for disease; a far smaller and inadequate proportion is provided, ineffectively, to support governmental public health's efforts to improve population health. **The current financing system for health in the United States is profoundly misaligned."**

—National Academy of Sciences

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Piecing it together well relies on a strong foundation

Funding for public health today is cobbled together at federal, state and local levels with a diverse and ephemeral stream of program-oriented dollars attached to expectations and deliverables that form, in one way of looking at it, a game of Jenga.





Example: Maternal & Child Health Block Grant

The Title V Maternal and Child Health Services Block Grant to States Program ("MCH Block Grant") is a formula grant under which funds are awarded to 59 states and jurisdictions upon their submission of an acceptable plan that addresses the health services needs within a state for the target population of mothers, infants and children, which includes children with special health care needs (CSHCN), and their families. **Through the MCH Block Grant, each state and jurisdiction supports and promotes the development and coordination of systems of care for the MCH population**, which are family-centered, evidence-based, community-based and culturally appropriate.

In FY11-12, The NC General Assembly (NCGA) began to carve out Maternal & Child Health Block Grant money for specific programs removing critical support for the local public health system.

- Since 2011, the number of programs and amount of money set aside by the NCGA has increased to **39% of the entire MCHBG in 2017.**

- **Because of the redirection of these funds for public health , Local Health Departments will take a $2.2M reduction in 2018**
  - This impacts LHDs ability to offer medical services as a safety-net provider and removes critical programs for maternal and child health.
  - County by county, these carve-outs may mean the reduction of services including successful programs that improve pregnancy outcomes, reduction in programs that have led to the lower teen pregnancy rates as well as essential prenatal care services.
  - As a result of the cuts, local county governments are left to make difficult decisions to either supplant the funds lost by these reductions made to the federal grant or lay off staff and reduce or eliminate programs.

Today, the demands on the public health system are greater than ever. Health of a community drives the economy. Poor community health translates into a reduction in community growth, loss of existing or future industry, and ultimately reduced tax revenue.

Each level of government has different but important responsibilities for protecting the public's health. **Unpredictable and steadily decreasing federal and state funds puts our local public health system at risk.**



NC Ranks #44 out of the 50 states in Public Health per capita state spending

North Carolina has consistently fallen in the bottom portion of the rankings that list per capita funding for public health by state. The 2016 TFAH report puts **NC at # 44 out of 50** states for state public health funding levels **which reflects a $14.30 investment per person**.

The median for comparison is $35.77 in South Dakota ranked on the list at #25. If we were to move up in the rankings and reach only for that midline, we would pass Georgia (at #39), Louisiana (#38), Florida (#37) and South Carolina (#36) along the way – and we don't like to be ranked behind our southern brethren very much.

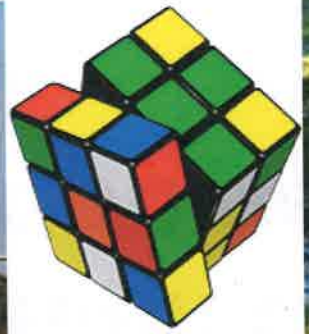


-Trust for America's Health (2016)

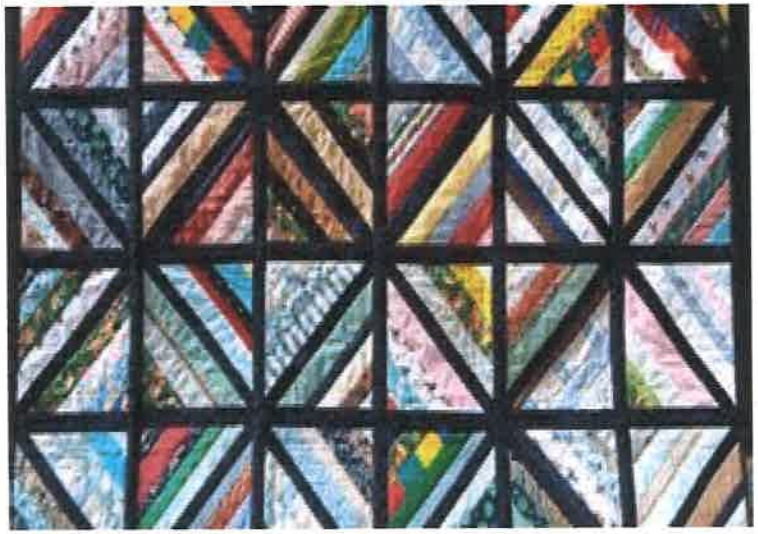
Visual Interpretation of LHD Budgets in NC

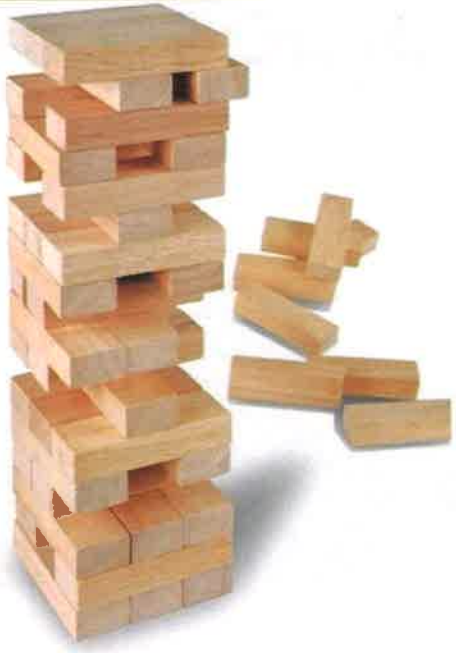


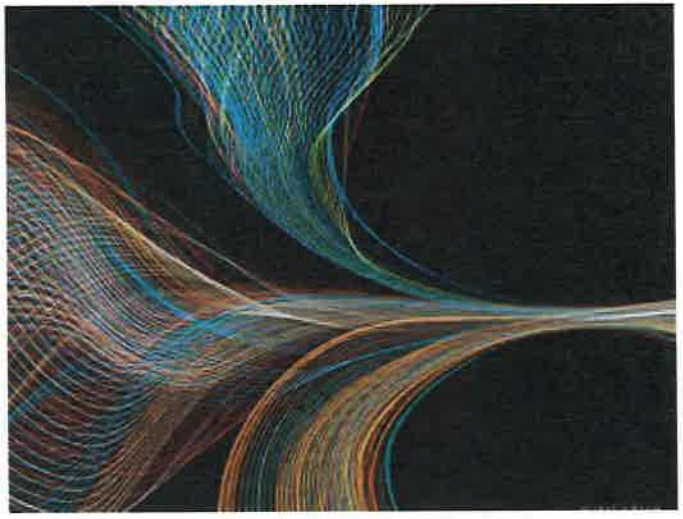


















"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend." *-Benjamin Disraeli*



NCALHD

North Carolina Association of Local Health Directors

Closing Remarks

Dennis Joyner, President, NCALHD
Union County Health Director

Dennis.Joyner@unioncountync.gov

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of Local Health Directors

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON HEALTH AND HUMAN SERVICES

DHHS Oversight of Jail Death Reporting

Steven C. Lewis
Department of Health and Human Services

February 28, 2018

Local Confinement Facility G.S. 153A-217(5)

- A "'local confinement facility' includes a county or city jail, a local lockup, a regional or district jail, a juvenile detention facility, a detention facility for adults operated by a local government, and any other facility operated by a local government for confinement of people awaiting trial or serving sentences, except that it shall not include a county satellite jail/work release unit governed by Part 3 of Article 10 of Chapter 153A."

DHSR Oversight of Jail Death Reporting

- How does the oversight process function?
  - DHSR's oversight authority is set forth in G.S. Chapter 153A, Article 10, Part 2.

- What kind of oversight responsibilities does DHSR have?
  - DHSR conducts routine inspections to determine a jail's compliance with minimum standards, twice annually.

- What role does DHSR play in responding to an inmate death or suicide?
  - DHSR conducts compliance reviews of all reported inmate deaths that occur in a jail. DHSR also undertakes a compliance review when it learns of an "out-of-custody" death where there may be questions regarding the in-custody care and supervision of the inmate.

G.S. 153A-221. Minimum Standards

- Secretary of Health and Human Services shall develop and publish minimum standards for the operation of local confinement facilities (jails). The standards shall provide for:
  - Secure and safe physical facilities
  - Jail design and sanitation
  - Supervision of inmates
  - Medical and mental health care for inmates
  - Personal hygiene and comfort of inmates
  - Provision of food to inmates
  - Any other provisions that may be necessary for the safekeeping, care, and welfare of inmates
- These standards are set forth in the regulations found in 10A NCAC Subchapter 14J.

DHSR Construction Section, Jails and Detention Unit

- The Jails and Detention Unit is funded by 100% State Appropriations in the amount of $168K
- This funding does not cover the full costs/expenses of the unit; the Construction Section provides other resources to ensure this unit can meet its responsibilities.

Other Relevant General Statutes

- G.S. 153A-220 Jail and detention service
  - Requires DHHS personnel to provide technical assistance to jails and review plans of new jail construction.
- G.S. 153A-222 Inspections of local confinement facilities
  - Requires DHHS personnel to inspect jails not less than twice per year.
- G.S. 153A-225 Medical care of prisoners
  - Requires a governing body to adopt a plan for the medical care of inmates.
  - Requires jail administrator to notify medical examiner and coroner immediately if an inmate dies in a local confinement facility and to submit a written report to DHHS within 5 days of the date of death.
- G.S. 162-22 Custody of jail
  - Sheriff has the care and custody of the jail in his/her county.

Jails and Detention Unit Roles & Responsibilities

- DHSR's Jails and Detention Unit has an important role in surveying/inspecting jails/local confinement facilities to ensure compliance with applicable regulations.
- The ultimate responsibility for safety of individuals confined in their facilities, as provided by G.S. 162-22, is with the Sheriff.
- At the local level it is the Sheriff, Jail Administrator, Local Health Director and the County Commissioners who are responsible for the daily operations and safety of all individuals confined in their local confinement facilities.

Jails and Detention Unit Roles & Responsibilities

- Each confinement facility is required to develop a plan for providing medical care for inmates. G.S. 153A-225(a)(4) ...The unit shall develop the plan
  - In consultation with appropriate local officials and organizations, including the sheriff, the county physician, the local or district health director, and the local medical society.
  - The plan must be approved by the local or district health director after consultation with the area mental health, developmental disabilities, and substance abuse authority, if it is adequate to protect the health and welfare of the prisoners.
  - ...the plan must be adopted by the governing body.

Capacities and Ages of Confinement Facilities

- There are 110 jails and 3 district jails serving multiple counties.
- Vary in size and configuration:
  - Graham/Hyde Counties and Farmville have capacity of 8 inmates
  - Mecklenburg Central has capacity of 1,904 inmates
- Oldest jail in Orange County, built in 1925
- Newest jail in Bladen County, opened in 2017

Jail Inmate Deaths and Average Daily Population

Deaths	2015	2016	2017
In Custody	35	20	35
Out-of-Custody	5	6	3
Total	40	26	38
Suicide*	20	12	7
Natural*	11	11	20
Other*	9	3	11
Average Daily Population	18,456	18,576	**

* As provided to DHSR per "Report of Inmate Death" as reported by the jail G.S.153A-225

**Pending

Role in Compliance Reviews of Inmate Deaths

- Pursuant to G.S. 153A-225, jailers are required to report inmate deaths to DHSR when the death occurs in the jail ("in-custody").
- Jails may submit death reports when the inmate death is "out-of-custody," but are not legally required to do so.
- The Construction Section conducts compliance reviews of all "in-custody" inmate deaths that are reported.
- While not required, it is the practice of the Construction Section to conduct a compliance review when it learns of an "out-of-custody" death where there may be questions regarding in-custody care and supervision of the inmate.

Revisions to 10A NCAC Subchapter 14J

- Process to revise the regulations that pertain to jails and local confinement facilities began August 13, 2015
- 33 rules proposed for re-adoption with changes
- 20 related to jail operations
- 13 related to jail design and construction
- Expected re-adoption effective date is December 1, 2018

Proposed Changes to Modernize Rule

10A NCAC 14J.0601

Existing Rule	Proposed Changes
Supervision rounds (twice per hour in-person check of inmates in general population)	Added rule language that requires rounds to be conducted no more than 35 minutes apart.
Special watch (four times per hour in-person check of inmate on suicide watch)	Added rule language that requires rounds to be conducted no more than 20 minutes apart.
Officers assigned to supervision rounds shall not be assigned "other duties."	Added rule language listing these "other duties," such as delivering food to inmates, transporting inmates to court and escorting inmates to medical appointments.

NORTH CAROLINA
DEPARTMENT OF PUBLIC SAFETY
PREVENT. PROTECT. PREPARE

Inmate Health Information Exchange

Department of Public Safety
Division of Adult Correction and Juvenile Justice

Joint Legislative Oversight Committee on Health and Human Services
February 28, 2018

Presentation

- Overview of Session Law 2017-57, Section 16C.11A
- Background/Context - Overview of correctional health care
- State's health information exchange
- Q & A

Overview of legislative study and report

- Pursuant to Session Law 2017-57, Section 16C.11A:

"The Department of Public Safety, in collaboration with the Department of Health and Human Services, shall study the feasibility of the State acquiring and implementing an inmate health information exchange program…"

  - With the intent of the inmate health information exchange system to:
    - Allow for the secure and effective transfer of pertinent medical information on an inmate; and
    - Minimize or eliminate the need for the replication of tests on inmates

- In this report:
  - "Inmate" is defined as individual incarcerated in the state's prisons system
  - Adult inmate health care/health services referred to as "correctional health care"

Overview of state's adult inmate health care

- G.S. 148-19 establishes "health services" for Division of Adult Correction (DAC)
- Mandates standards for health services to inmates
  - Establishes the following:
    - Outside medical facilities may be used if necessary
    - Department of Public Safety (DPS) shall seek cooperation with other agencies
    - A connection created between DPS/DAC, Department of Health and Human Services (DHHS), and other state agencies for necessary assistance in the provision of inmate health care
    - That each inmate shall receive examinations after admission and that inmates' work and other assignments shall be made with due regard to their physical and mental condition
    - That the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall adopt standards for the delivery of mental health and mental retardation services to inmates by DPS/DAC

Overview of state's adult inmate health care

- System-wide adult inmate healthcare includes:
  - Medical
  - Psychiatry
  - Behavioral health, including Substance Abuse (Alcoholism & Chemical Dependency Programs- ACDP)
  - Dental
  - Pharmacy
  - 2 on-site health care facilities (Central Prison and North Carolina Correctional Center for Women)

- For FY 16-17:
  - Total expenditures of $329.7M
  - Total FTEs of 2,232

- Current total inmate population (02/05/18) = 36,399

Background/Context
State DPS/DAC Perspective

- **118%**
  - % increase over the last 10 years of inmates age 55+
- **60%**
  - % increase over the last 10 years of inmates diagnosed with chronic illnesses
- **65%**
  - % increase over the last 10 years of inmates diagnosed with mental illness
- **95%**
  - % of inmates expected to return to society after incarceration
  - = approximately 24,000/year
  - = "major public safety and public health player"
  - = need to focus on "continuum of care"

Background/Context
National Perspective

- **According to a recent Pew Charitable Trusts study:**

"Prison health care sits at the intersection of pressing state priorities. From protecting public safety to fighting disease and promoting physical and behavioral health, and from fine-tuning budgets that trim waste to investing in cost-effective programming with long-term payoffs, the health care that prisons provide to incarcerated individuals and the care that prisons facilitate post-release is a critical linchpin with far-reaching implications."

"Well-run, forward-thinking prison health care systems are vital to state aims of providing care to incarcerated individuals, protecting communities, strengthening public health, and spending money wisely. Likewise, poorly performing systems threaten to make states less safe, less healthy, and less fiscally prudent. Put simply: The stakes extend far beyond the confines of prison gates."

Background/Context
National Perspective

- Continuum or continuity of services is not a new concept in criminal justice reform with reentry/transition efforts in terms of jobs, transportation, housing, etc.
- Correctional health care viewed in past in isolation – now needs to be well-connected with reentry and transition
- "Public safety is public health; public health is public safety."
  - Richard Carmona, U.S. Surgeon General, 2002 - 2006

Need for technology

- The cost, scope and complexity of today's inmate health care system demands the support of technology that is robust, comprehensive, and broadly interoperable.
- DPS/DAC has recently developed and is implementing an internal electronic health record (EHR) system, state-wide.
- This EHR is also capable of integrating with a viable state-wide health information exchange (HIE) system.
- The State of North Carolina has invested in such a system - the NC Health Information Exchange Network.

Health Information Exchange in NC

- In 2015, the General Assembly of North Carolina established a state-managed Health Information Exchange Authority (NC HIEA) to oversee and administer the N.C. Health Information Exchange Network (NCGS 90-414.7). The cost, scope and complexity of today's inmate health care system demands the support of technology that is robust, comprehensive, and broadly interoperable.

- The NC HIEA operates North Carolina's state-designated health information exchange, NC HealthConnex, a secure, standardized electronic system in which providers can share important patient health information. DPS/DAC has recently developed and is implementing an internal electronic health record (EHR) system, state-wide.

- State law requires that all health care providers that receive State funds connect to NC HealthConnex by certain dates in 2018 and 2019 in order to continue to receive payments for services provided (NCGS 90-414.4).

- General fund appropriations for the NC HIE have been authorized by the North Carolina General Assembly as follows:
  - $9 million, recurring;
  - an additional $3 million, non-recurring, for fiscal year 2017-2018 to support an upgrade of the health information exchange system; and
  - no fees to connect to NC HealthConnex charged by state – may be charged by providers' electronic health record vendors.

Conclusions/Recommendations

- The State of North Carolina already has a comprehensive, enterprise-level HIE in production - NC HealthConnex – for which substantial investments of state funds have been made.
- The Department of Public Safety and Department of Health and Human Services believe the NC HealthConnex system represents a viable health information system which will allow for the secure and effective transfer of pertinent health information on inmates.
- The Department of Public Safety and Department of Health and Human Services believe that a less comprehensive system, such as one which would, for example, only connect jails and prisons with detainee/inmate health information, is duplicative in nature and falls short of the current correctional health care demands.
- The Department of Public Safety and Department of Health and Human Services recommend, therefore, that the Department of Public Safety work collaboratively with the Department of Health and Human Services and the Department of Information Technology's (DIT) Government Data Analytics Center (GDAC) to utilize the NC HealthConnex health information exchange system for the secure and effective transfer of pertinent health information on inmates.

Questions?

Committee Sergeants at Arms

NAME OF COMMITTEE Jt. Leg. Oversight Health & Human Svcs.

DATE: 02/28/2018 Room: 643

House Sgt-At Arms:

1. Name: Terry McCraw
2. Name: Bill Bass
3. Name: Jim Moran
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name: Billy Fritscher
2. Name: John Enloe
3. Name:
4. Name:
5. Name:

Updated #1: DUE TO WEATHER CONDITIONS MEETING WILL NOW START AT 10:00AM

NORTH CAROLINA GENERAL ASSEMBLY

Raleigh, North Carolina 27601

MEMORANDUM

TO: Members, Joint Legislative Oversight Committee on Health and Human Services
FROM: Rep. Josh Dobson, Co-Chair
Rep. Donny Lambeth, Co-Chair
Sen. Joyce Krawiec, Co-Chair

SUBJECT: Meeting Notice

The **Joint Legislative Oversight Committee on Health and Human Services** will meet at the following time:

DAY	DATE	TIME	LOCATION
Tuesday	March 13, 2018	10:00 AM	643 LOB

Rep. Dobson will Chair

Parking for non-legislative meeting attendees is available in the visitor parking deck #75 located on Salisbury Street across from the Legislative Office Building. Parking is also available in the parking lot across Jones Street from the State Library/Archives. You can view a map of downtown by visiting http://www.ncleg.gov/graphics/downtownmap.pdf.

If you are unable to attend or have any questions concerning this meeting, please contact Julie Ryan at Dobsonla@ncleg.net.

cc: Committee Record _X_
Interested Parties _X_

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

March 13, 2018 9:00 a.m.
Legislative Office Building - Room 643

Committee Co-Chairs
Rep. Josh Dobson
Rep. Donny Lambeth
Sen. Louis Pate

Legislative Members
Rep. William D. Brisson
Rep. Carla D. Cunningham
Rep. Nelson Dollar
Rep. Beverly M. Earle
Rep. Jean Farmer-Butterfield
Rep. Bert Jones
Rep. Chris Malone
Rep. Gregory F. Murphy, MD
Rep. Donna McDowell White
Sen. Dan Bishop
Sen. David L. Curtis
Sen. Jim Davis
Sen. Valerie P. Foushee
Sen. Ralph Hise
Sen. Joyce Krawiec
Sen. Gladys A. Robinson
Sen. Jeff Tarte
Sen. Tommy Tucker
Sen. Mike Woodard

Advisory Members
Rep. Gale Adcock
Rep. Susan Fisher
Sen. Tamara Barringer
Sen. Michael V. Lee

I.	Welcome & Opening Remarks	Representative Josh Dobson Presiding Co-chair
II.	Comments from the Secretary	Mandy Cohen, MD, Secretary Department of Health and Human Services
III.	Mental Health Issues in Jails	Eddie Caldwell, Executive Vice President and General Counsel, North Carolina Sheriffs' Association
IV.	Child Welfare Update	
	• Program Improvement Plan	Susan Perry-Manning, Deputy Secretary for Human Services
	• NC FAST	Sam Gibbs, Deputy Secretary for Technology and Operations
		Susan Perry-Manning, Deputy Secretary for Human Services
V.	Subcommittee Reports	
	• Aging Subcommittee	Deborah Landry, Committee Staff
	• GME Joint Subcommittee	Jason Moran-Bates, Committee Staff
VI.	Draft Recommendations from JLOC-HHS to the 2018 Session	Theresa Matula, Committee Staff
	Adjourn Next Meeting: April 10, 2018	

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES
March 13, 2018
Room 643 of the Legislative Office Building

The Joint Legislative Oversight Committee on Health and Human Services met on Tuesday, March 13, 2018 at 10:00 AM. The meeting was held in Room 643 of the Legislative Office Building. Members present were: Representatives Adcock, Brisson, Dobson, Dollar, Earle, Jones, Lambeth, Malone, Murphy and White. Members of the Senate were also present.

Representative Josh Dobson presided.

Committee Sergeants at Arms:
House: Terry McCraw, Dean Marshbourne and John Gilbert
Senate: Terry Edmondson and Charles Marsalis

Representative Dobson welcomed the committee and provided opening remarks.

Representative Dobson recognized Dr. Mandy Cohen, MD, Secretary, Department of Health and Human Services to provide an update on the 2017-2018 NC Influenza Season. (See attached presentation)

Representative Dobson recognized Eddie Caldwell, Executive Vice President and General Counsel, North Carolina Sheriffs' Association to provide an update on the mental health services in county jails. (See attached presentation)

Representative Dobson recognized Susan Perry-Manning, Deputy Secretary for Human Services to provide an update on the implementation of the Federal Program Improvement Plan. (See attached presentation)

Representative Dobson recognized Susan Perry-Manning, Deputy Secretary for Human Services and Sam Gibbs, Deputy Secretary for Technology and Operations to provide an update on NC FAST Implementation of Child Welfare. (See attached presentation)

Representative Dobson recognized Deborah Landry, Committee Staff, to present the subcommittee report for the Aging Subcommittee (See attached report)

Representative Dobson recognized Jason Moran-Bates, Committee Staff to present the subcommittee report for the Joint Subcommittee on Medical Education and Medical Residency Programs. (See attached report)

Representative Dobson recognized Theresa Matula, Committee Staff, to present the Draft Recommendations from the Joint Legislative Oversight Committee on Health and Human Services to the 2018 Session for consideration by the committee. (See attached presentation)

Representative Dobson recognized Chairman Lambeth.
Chairman Lambeth moved that the Joint Legislative Oversight Committee on Health and Human Services approve the draft recommendations as presented and direct staff to prepare a report, including any corresponding bill drafts, for presentation at an upcoming meeting, which will be our next meeting in April.

Represented Dobson: Members, you have heard the motion, all in favor signify by saying Aye. Any opposed. The Ayes have it; motion carries.

Representative Dobson thanked the members and Secretary Cohen and her staff for presenting.

There being no further business, the meeting adjourned at 11:52 AM.

Representative Josh Dobson
Presiding

Julie Ryan, Committee Clerk

ATTENDANCE

JLOC ON HEALTH & HUMAN SERVICES

2017-2018 SESSION

DATES	03-13-18														
DOBSON, Josh **Co-Chair**	✓														
LAMBETH, Donny **Co-Chair**	✓														
PATE, Louis **Co-Chair**	✓														
Representatives															
BRISSON, William	✓														
CUNNINGHAM, Carla															
DOLLAR, Nelson	✓														
EARLE, Beverly	✓														
FARMER-BUTTERFIELD, Jean															
JONES, Bert	✓														
MALONE, Chris	✓														
MURPHY, Greg	✓														
WHITE, Donna	✓														
Advisory Member															
ADCOCK, Gayle	✓														
FISHER, Susan															
Senators															
BISHOP, Dan	✓														
CURTIS, David	✓														
DAVIS, Jim	✓														
FOUSHEE, Valerie															
HISE, Ralph	✓														
KRAWIEC, Joyce	✓														
ROBINSON, Gladys															
TARTE, Jeff															

DATES	02-28-18														
TUCKER, Tommy	✓														
WOODARD, Mike															
Advisory Members															
BARRINGER, Tamara	✓														
LEE, Michael	✓														
Staff Members															
LANDRY, Deborah															
MATULA, Theresa															
THOMAS, Denise															
WILKS, Lisa															

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON HEALTH AND HUMAN SERVICES

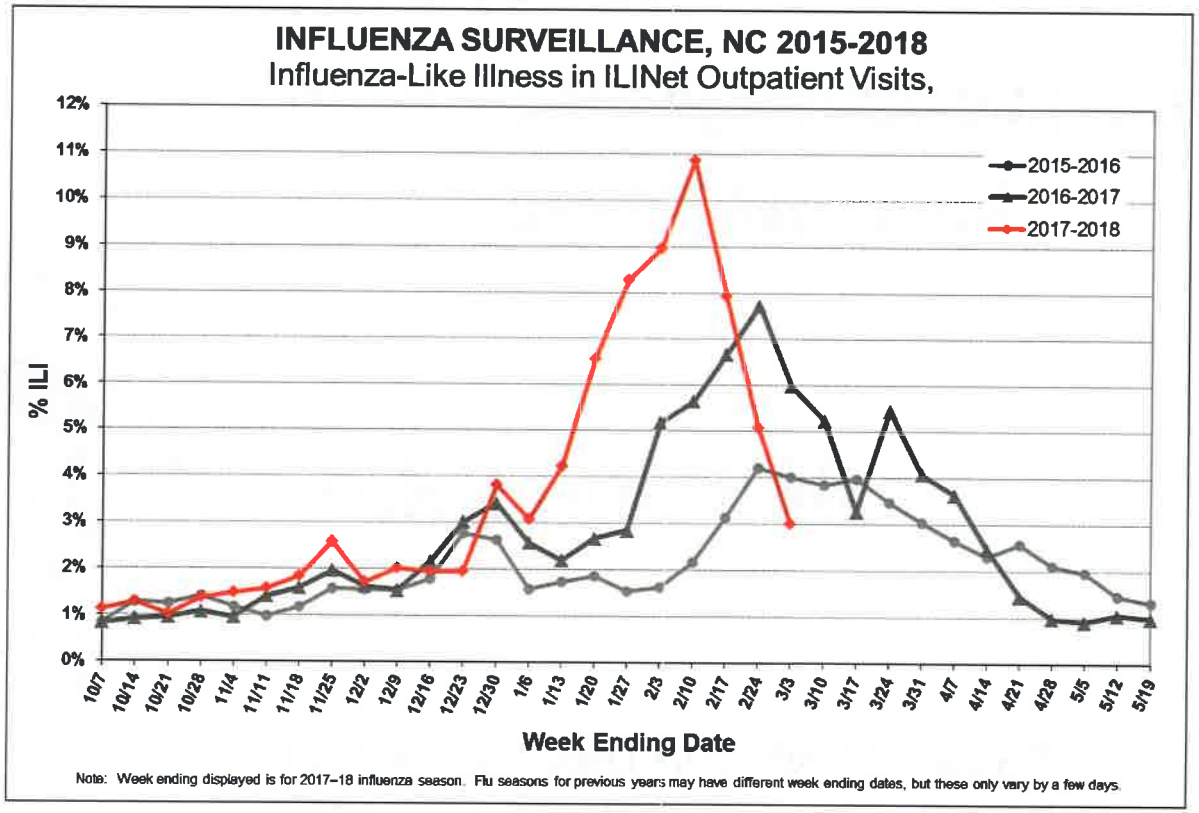
DHHS Updates

Mandy Cohen, MD, MPH
Department of Health and Human Services

March 13, 2018

2017–18 NC Influenza Season: Update

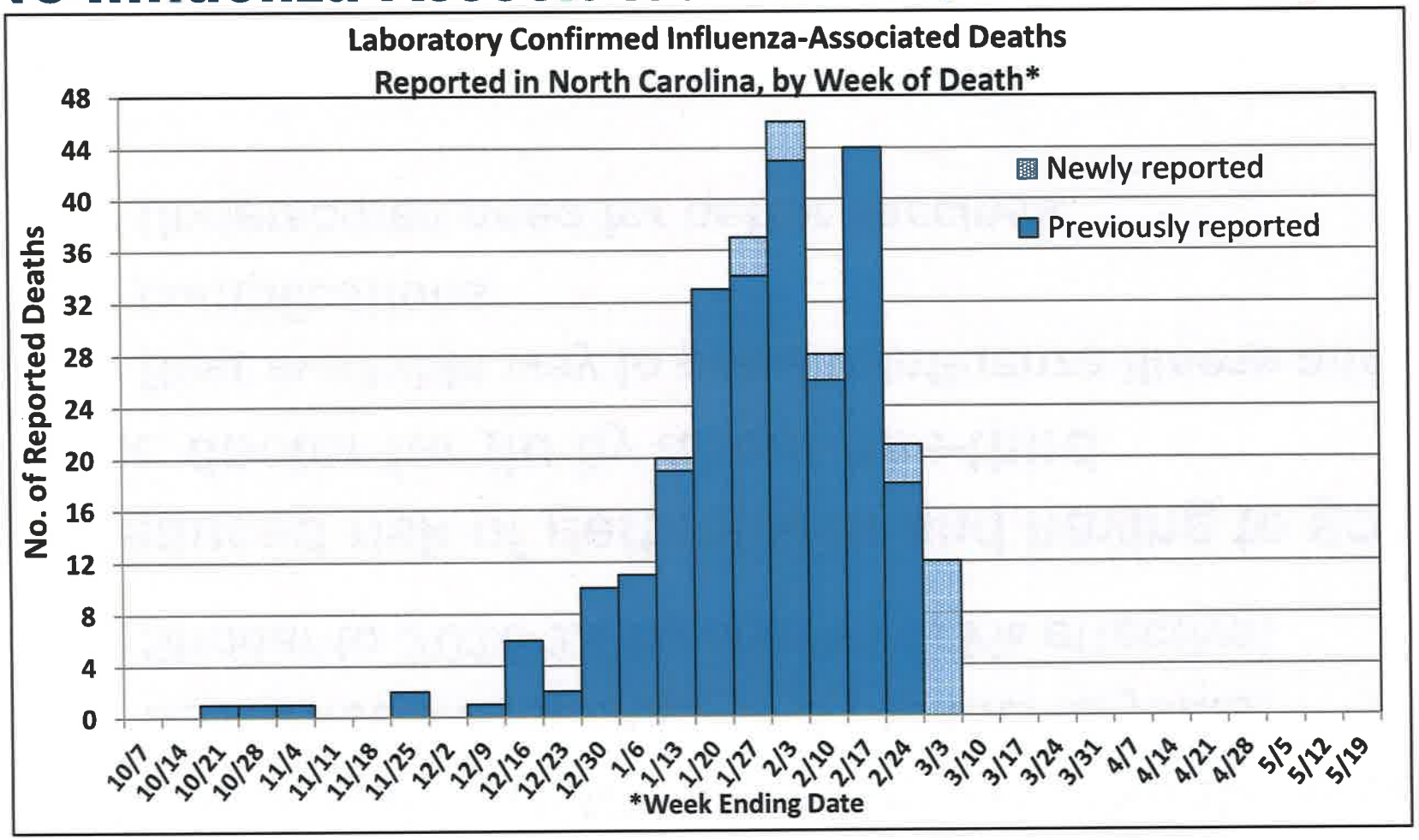
- Activity peaked during week ending February 24



- Higher peak than recent seasons
- Influenza B infections still circulating

SOURCE: www.flu.nc.gov

NC Influenza-Associated Deaths: 2017–18 Season



- Most deaths in persons ≥ 65 years of age
- Reporting lags behind other measures of flu activity
- Total deaths 276

SOURCE: www.flu.nc.gov

Flu Vaccine Effectiveness: Interim Estimates

- Overall effectiveness at 36%
  - Lower against H3N2, higher against other flu viruses
  - 59% effective for children 6 months–8 years
  - Similar to 2016-17 flu season (39% effective)
- Reduced risk of getting sick and having to go to the doctor for flu by about one-third
  - Best available way to prevent influenza illness and complications
  - Underscores need for better vaccines

Flu Messages

- Not too late to get vaccinated
  - High levels of flu expected for coming weeks
  - Flu B tends to increase in spring
- If you think you have the flu, call your doctor
  - Prescription antiviral drugs are important second line of defense
  - Especially important for those at high risk for complications
- Remember common sense prevention actions
  - Hand hygiene, respiratory etiquette
  - Stay home from school/work when sick

Mental Health Services in County Jails

Eddie Caldwell
Executive Vice President and General Counsel
North Carolina Sheriffs' Association

March 13, 2018

Mental Health Services in County Jails

Presentation to the Joint Legislative Oversight Committee on Health and Human Services

March 13, 2018

Mental Health Services in County Jails

- Today's Presentation is an Overview

- Experts with Details are:
  - Sheriffs, Jail Administrators, and Detention Officers
  - Steve Lewis and staff, DHHS Construction Section
  - Bob Kurtz, Ph.D., DHHS, Division of MH/DD/SA

Mental Health Services in County Jails

- G.S. § 162-22, Custody of Jail

"The sheriff shall have the care and custody of the jail in his county; and shall be, or appoint, the keeper thereof."

Mental Health Services in County Jails

Topics for Today's Presentation

- Training Requirements
  - Detention Officers
  - Medical Care Providers
- An Overview of Medical Care in Jails
- Process for Screening Prisoners
- Mental Health Services Provided by the Jails
  - Using Jail Staff
  - Via Contracts with Health Care Providers
- Coordination upon Prisoner's Release between Jail and LME

Training Requirements

- Detention Officers
  - Certified by the NC Sheriffs' Education and Training Standards Commission

  - Detention Officer Certification Course
    - Minimum of 174 Hours of Training
    - Curriculum Developed by the North Carolina Justice Academy
    - Taught by Certified Instructors
    - Delivered by Sheriffs' Offices, the NC Justice Academy and Various Community Colleges

Training Requirements

- Medical Care Providers:

  County Jails or their health care providers utilize staff certified by the appropriate State licensing agency, such as the nursing board, medical board, etc.

G.S. § 153A-225, Medical Care of Prisoners

- Board of County Commissioners must adopt "a plan for providing medical care for prisoners" which shall:
  - Be designed to protect the health and welfare of the prisoners
  - Be designed to avoid the spread of contagious disease
  - Provide for medical supervision and emergency medical care to the extent necessary for prisoners' health and welfare
  - Provide for detection, examination and treatment of prisoners who are infected with tuberculosis or venereal disease

G.S. § 153A-225, Medical Care of Prisoners

- Payment of hospital and medical care provider bills is almost always the responsibility of the county.
- Rarely does a prisoner have valid medical insurance.
- Medicaid is not available to MOST prisoners. Generally, prisoners that are males under 65 don't qualify for Medicaid.
- NCSA and others have programs that "scrub" the bills for errors and for charges in excess of the statutory maximum.

G.S. § 153A-225, Medical Care of Prisoners

- Medical Care Plan is developed in consultation with:
  - Sheriff
  - County Physician
  - Local or District Health Director
  - Local Medical Society

G.S. § 153A-225, Medical Care of Prisoners

- Medical Care Plan must be adequate to protect the health and welfare of the prisoners, and must be approved by:
  - Local or District Health Director after consultation with area mental health, developmental disabilities and substance abuse authority
  - Board of County Commissioners

10A NCAC 14J .1001

- Medical plan shall be reviewed annually

- Medical plan shall include policies and procedures that address:

(1) Health screening of inmates upon admission;
(2) Handling routine medical care;
(3) The handling of inmates with chronic illnesses or known communicable diseases or conditions;

10A NCAC 14J .1001 (continued)

- Medical plan shall include policies and procedures that address:

(4) Administration, dispensing and control of prescription and non-prescription medications;

(5) Handling emergency medical problems, including but not limited to emergencies involving dental care, chemical dependency, pregnancy and mental health;

(6) Maintenance and confidentiality of medical records; and

(7) Privacy during medical examinations and conferences with qualified medical personnel.

10A NCAC 14J .1001 (continued)

- Inmates must be provided an opportunity each day to communicate their health complaints to a health professional or to an officer.

- Qualified medical personnel shall be available to evaluate the medical needs of inmates.

- A written record shall be maintained of the request for medical care and the action taken.

Process for Screening Prisoners

- Questionnaire is administered to prisoners admitted into jail and the prisoners answers are documented
- "Brief Jail Mental Health Screen"
- Eight Questions
- Prisoner is referred for further mental health evaluation:
  - If prisoner's answer is YES to certain questions, or
  - If detention officer feels "it is necessary for any other reason"

Process for Screening Prisoners

- During screening, the Detention Officer should note the following:
  - Language Barrier
  - Difficulty understanding questions
  - Under the influence of drugs/alcohol
  - Non-cooperative
  - Other comments/impressions

Mental Health Services Provided by the Jails

- Health Services in jails are provided by:
  - Third party company that specializes in jail health care
    - [two companies serve approximately two-thirds of the jails]
  - Local health department
  - Local private physician

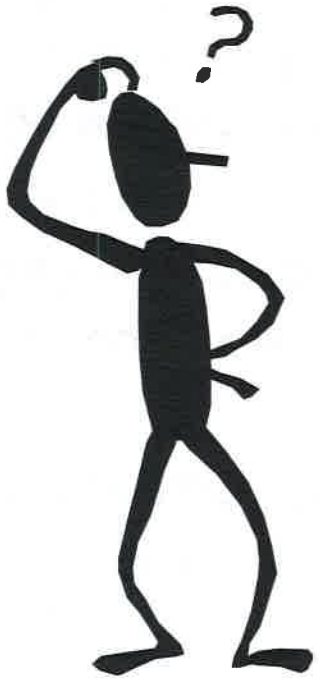
Mental Health Services Provided by the Jails

- Varies among the individual jails
- Provided by the jail's health care provider
- Use of telemedicine
- In coordination with the LME, utilizing local providers
  - For prisoners in jail and those on pre-trial release
- Central Prison Hospital (for safekeepers)
- Involuntary Commitment (IVC) to State Mental Hospitals
- Prisoners found incompetent to stand trial to State Mental Hospitals

Coordination upon Prisoner's Release between Jail and LME

- Degree of coordination varies widely. Some examples of feedback from jail administrators about the role of the LME is:
  - No coordination with LME
  - LME very seldom coordinates with the jail upon prisoners' release
  - Don't have a LME
  - Have a contract with Daymark Recovery Services to provide an employee onsite in the jail to find resources and help for prisoners about to be released
  - No coordination with LME, but jail staff work with providers in the area to connect prisoners to available services

Questions?





Eddie Caldwell
Executive Vice President and General Counsel
North Carolina Sheriffs' Association

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ecaldwell@ncsheriffs.net

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON HEALTH AND HUMAN SERVICES

Implementation of the Federal Program Improvement Plan

Susan Perry-Manning
Department of Health and Human Services

March 13, 2018

Child and Family Services Review (CFSR)

- Program Improvement Plan (PIP) required based on outcome of 2015 federal performance review of child welfare services
- Rated on seven outcome measures and seven systemic factors

CFSR Outcome Measures

- 105 cases from 10 counties sampled out of 10,000 across the state

CFSR OUTCOME MEASURES
1. Children are protected from abuse and neglect.
2. Children are safely maintained in their homes when possible and appropriate.
3. Children have permanency and stability in their living situations.
4. Continuity of family relationships and connections is preserved for children.
5. Families have enhanced capacity to provide for their children's needs.
6. Children receive appropriate services to meet their educational needs.
7. Children receive adequate services to meet their physical and mental health needs.

CFSR Systemic Factors

- Systemic factors were reviewed by using:
  - Case reviews
  - Interviews with partners
  - Focus groups with stakeholders

CFSR SYSTEMIC FACTORS
1. Statewide Information System
2. Case Review System
3. Quality Assurance System
4. Staff and Provider Training
5. Service Array and Resource Development
6. Agency Responsiveness to the Community
7. Foster and Adoptive Parent Licensing, Recruitment and Retention

Program Improvement Plan (PIP)

- Required because NC failed to meet each of the 14 CFSR areas
- Designed to improve statewide performance
- DSS stakeholders and federal partners involved in development
- Effective January 1, 2017 through December 31, 2018
- Contains 5 goals, 14 strategies, 75 activities
- 10 pilot counties participating:
  - Buncombe, Craven, Cumberland, Durham, Hoke, Mecklenburg, Pitt, Scotland, Wake, Wilson
- All strategies will be complete by December 2018

Goal 1: Improve outcomes for child safety, permanency and well-being

Strategy 1: Strengthen and clarify child welfare policies and practices

- Redesigned Child Welfare Policy Manual
  - Included revisions to policies in key areas of Child Protective Services (CPS) Intake, CPS Assessments, CPS In-Home Services, & Permanency Planning
  - Rolled out statewide by July 2018

Strategy 2: Enhance the training system to support application of revised child welfare policies and practices

- Curricula for pre-service and ongoing training under revision to incorporate policy changes
- Training for all counties to be completed by May 2018

Strategy 3: Strengthen the capacity of county DSS's through supervisor academy

- 3 new courses for supervisors designed – facilitated by UNC or Methodist College
- 2 of 4 training cohorts completed, 1 in progress, 1 beginning September

Goal 1: Improve outcomes for child safety, permanency and well-being

Strategy 4: Implement a technical assistance model

- Researched technical assistance models
- Worked with Capacity Building Center for States to develop 3-tier technical assistance approach from basic to intensive
- Engaging national consultant through the Child Protection and Accountability Act (HB630) legislation to finalize new technical assistance model

Strategy 5: County-level family engagement committees & state-level family advisory council

- Established Family Advisory Council – State DSS
- Piloting Local Family Engagement Committees
  - Durham
  - Forsyth
  - Richmond

Goal 2: Improve the outcomes through statewide quality assurance system

Strategy 1: Operationalize state quality assurance system through use of federal On Site Review Instrument (OSRI)

- Established process with federal Children's Bureau for state level review of county cases using OSRI tool
- 10 pilot counties actively using OSRI tool to review cases at county level for continuous quality improvement
- Interactive on-demand course developed regarding OSRI and case review process
- Working with Director's Association to refine OSRI Quarterly Report that will provide a snapshot of state and county level performance and opportunities for additional support and improvement

Goal 3: Improve the permanency outcomes through collaboration with the judicial system

Strategy 1: Plan with judicial system to address permanency issues through the identification of shared outcomes

- Convened forum on February 23 for county DSS and court partners to build partnership and plan to address factors that increase the time children spend in foster care
- Developed permanency report card, "Permanency Performance Profile" for each court jurisdiction to measure timeliness to permanency

Strategy 2: Provide targeted engagement with county DSS & courts to court jurisdictions that are not achieving expected outcomes.

Strategy 3: Implement Guardianship Assistance Program

- Completed March 2017
- Education and Promotion Toolkit in development

Goal 4: Strengthen cross-system service provision

Strategy 1: Establish agreements between county DSS & LME/MCOs

- The NCIOM and DHHS convened regional leadership summits between September 2017 and October 2018 (referred to as Bridging Local Systems)
- 30 3-hour regional leadership summit meetings in 14 counties across North Carolina.
  - 337 unique participants attended from all 7 LME/MCOs and 88 of the 100 county DSS agencies in North Carolina
- Key themes centered on needs for:
  - Ongoing cross-system communication and collaboration
  - Alignment of North Carolina's Behavioral Health and Social Services System
  - Addressing the service needs of child-welfare involved families
  - Strengthening the training and development of our workforce

Goal 4: Strengthen cross-system service provision

Strategy 2: Strengthen recruitment of foster & adoptive parents

- Provided counties with template recruitment and retention plan
- County plans submitted to NC DSS annually to address:
  - Recruit/maintain a pool of ethnically and racially diverse families
  - Capacity and ability to use data to inform and monitor efforts
  - Excellent customer service provided to prospective, current, and former foster, adoptive, and kinship families
- NC DSS to provide technical assistance, education, and resources specific to plans
  - Ensuring counties meeting plan goals
  - Compliance with Multi-Ethnic Placement Act (MEPA) requirements
  - Providing targeted support to counties based on plan progress

Goal 4: Strengthen cross-system service provision

Strategy 3: Strengthen stakeholder understanding of federal plans

- Develop training for stakeholders regarding the Child and Family Services Plan (CFSP) and Annual Progress and Services Report (APSR) to increase stakeholder participation when plan updates are needed
  - CFSP is a five-year plan designed to integrate all of the programs that service children and families into a continuum of services from prevention to protection to permanency
  - The APSR is submitted each year as an interim review for the CFSP
  - Stakeholder understanding of these key plans help ensure NC DSS engages in ongoing consultation regarding major concerns of child welfare programming as outlined in the CFSR systemic factor *Agency Responsiveness to the Community*

Goal 5: Enhance the statewide data quality, collection and dissemination of information

Strategy 1: Strengthen statewide information system – NC FAST Child Welfare System

- Pilot with five counties
- Refining system to ensure it provides a framework for policy compliance and expected practice
- Currently updating system to include modified Program Improvement Plan policies – to be completed June 2018
- Working to ensure data quality, build reports, and ultimately create data dashboard

Key Accomplishments

- PIP activities progressing within agreed upon timeframes
  - Working closely with Children's Bureau to align expectations with requirements
  - Revised leadership council to include county as well as state initiative
  - Added an additional Supervisor Academy
- Implemented improved Corrective Action Plan process
  - Defined support and monitoring
  - Clear accountability
- Designed report to track performance in all PIP areas
  - Will be used to identify needed supports to improve county performance
  - Identified areas for training and technical assistance to-date:
    - Improved documentation
    - Frequency of Social Worker contacts
- Strengthened Child Fatality review process
  - New protocol to conduct preliminary review of fatalities involving foster children and child in active in-home services cases within 7 days of a fatality

Next Steps

- Monitoring PIP Progress
  - Children's Bureau evaluating on a rolling 6 month basis
  - Baseline performance goals established by the Children's Bureau
- Align PIP work with activities from HB630

JOINT LEGISLATIVE OVERSIGHT COMMITTEE
ON HEALTH AND HUMAN SERVICES

NC FAST Implementation of Child Welfare Update

Susan Perry-Manning and Sam Gibbs
Department of Health and Human Services

March 13, 2018

Child Welfare Services Overview

- NC FAST Child Welfare System, when fully implemented, will integrate child protection, child foster care/placement, adoption services and:
  - Provide counties with the ability to view family history across the state to inform decisions
  - Drive consistency of service delivery and compliance with policy
  - Automate and streamline foster care revenues
  - Aggregate county and state level data for monitoring and outcomes tracking

Child Welfare Services Overview

- Deployed with multiple releases
  - Release 1:
    - CPS Intake, CPS Assessments, CPS In-Home Services, Legal Services, Title IV-E Eligibility, Financials, Federal Reporting
  - Release 2:
    - Adoptions, Provider Management, LINKS, Foster Home Licensure, Guardianship Assistance Program (GAP)
  - Release 3:
    - PIP Policy Changes and Federal requirements to interface with other systems such as Administrative Office of Courts
- Designed with pilot and staggered roll out to allow defect fixes and enhancements to be scheduled into production

Progress

- 5 Pilot Counties
  - Franklin, Guilford, Richmond, Rockingham, Sampson
- Pilot counties went live on August 7, 2017
- Pilots are using system daily
  - Data as of March 4, 2018
    - 4743 Intakes
    - 2655 Assessments
    - 921 Ongoing Cases
      - 257 In-Home Services
      - 664 Foster Care Cases
    - 50 Foster Care Cases for Ages 18-21

Current Status

- Pilot process has identified a variety of defects and enhancements to be addressed that will improve functionality
- Critical issues are items that, if not corrected, do not allow staff to do their work within the system itself and for which there is no reasonable work around within the system
- DHHS has committed to address critical issues before rolling out to additional counties
- Concerns raised by DSS Directors include:
  - NC FAST System availability: Issue resolved
  - DSS Directors' ability to monitor/assess work: Reports will be available in mid-March release
  - County foster care financials defects: To be completed in mid-March release
  - Economic services should not have access to child welfare information: Issue resolved

Current Status

DSS Directors' concerns:

- PIP policy changes have not been incorporated: Scheduled for Release 3 in June (not critical for next release)
- Help desk response rate: Ongoing improvements underway; adding new staff with both child welfare content expertise and IT knowledge; and retraining existing team
- Social worker training: Additional training needed for the implementation of child welfare practice within the NC FAST environment

Other Issues Identified:

- Business processes in NC FAST may not be consistent with current policies: Some issues resolved; ongoing
- Increased workload to pilot new system: Mitigating impact through onsite support and additional training; system will drive some standardization of practice and require changes in business processes

NC FAST Child Welfare Challenges

- Moving to a statewide, integrated case management system has a major impact on the way social workers document their cases, access information, and complete their required activities
- Child Welfare operates differently across counties making change management difficult
- Concurrent implementation process during federal Program Improvement Plan
- 24X7 high availability access to allow Child Welfare workers full functionality at all times

Current Status

- DHHS leadership met with DSS directors to hear their concerns and review critical issues and agreed that critical issues needed resolution before the next roll out
- Established weekly DHHS leadership meetings to review NC FAST Child Welfare System status in detail – working every technical, program, policy and staffing issue through to resolution

Current Status

- Created multidisciplinary teams of DHHS and county DSS staff to resolve management reports, training needs, and foster care financials
- Improved communications with county leadership and staff
- Adjusted roll out schedule to address fixes and county readiness

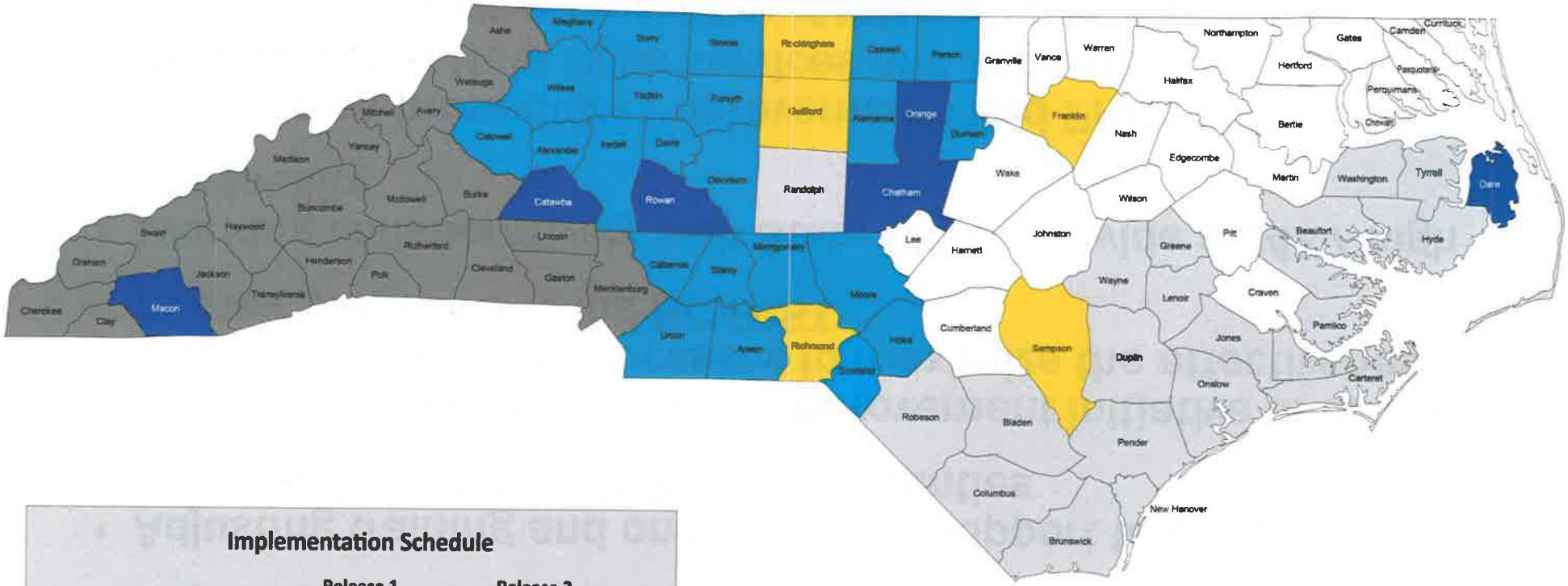
Lessons Learned

- 2016 business requirements for Child Welfare System were inadequate resulting in the need for more development work during roll out
- Additional cross-training within DHHS technical and program staff needed
- Additional on-the-ground support needed to support implementation
- Ongoing county input at both leadership and direct services level essential

Next Steps

- Releasing fixes based on priority needs
- New release of Cúram software in April which includes improved user interface
- Adjusting training and on-the-ground support to ensure adequate preparation for roll-out counties
- Initiating a Business Process Improvement initiative to assist county in improving processes to maximize the effectiveness of their programs using NC FAST
- Working collaboratively with State CIO to provide a 24X7 high availability
- Working on immediate improvements and Proof of Concept to provide better Help Desk services and support:
  - Using the cognitive capabilities of IBM Watson to provide Help Desk staff with an intelligent tool to provide improved predictability
  - Faster resolutions of end-user Help Desk tickets and reported issues

Revised Rollout Schedule



Implementation Schedule

	Release 1	Release 2
Pilot	August 7, 2017	February 26, 2018
Expanded Pilot	March 26, 2018	March 26, 2018
Group 2	June 25, 2018	June 25, 2018
Group 3	August 20, 2018	August 20, 2018
Group 4	September 24, 2018	September 24, 2018
Group 5	November 26, 2018	November 26, 2018

NORTH CAROLINA GENERAL ASSEMBLY

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

SUBCOMMITTEE ON AGING

Cochairs:
Representative Josh Dobson
Senator Joyce Krawiec

INTERIM SUBCOMMITTEE REPORT TO THE FULL COMMITTEE

FEBRUARY 2018

TABLE OF CONTENTS

TRANSMITTAL LETTER 3

SUBCOMMITTEE MEMBERSHIP 4

SUBCOMMITTEE AUTHORIZATION 5

SUBCOMMITTEE PROCEEDINGS 6

FINDINGS AND RECOMMENDATION 9

TRANSMITTAL LETTER

[Back to Top]

February 12, 2018

Members of the Joint Legislative Oversight Committee on Health and Human Services:

The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Aging, respectfully submits the following interim report in accordance with S.L. 2017-57, Section 11D.3.

Representative Josh Dobson
Cochair

Senator Joyce Krawiec
Cochair

SUBCOMMITTEE MEMBERSHIP

[Back to Top]

Senate Members	House Members
Senator Joyce Krawiec, Cochair	**Representative Josh Dobson, Cochair**
Senator David Curtis	**Representative Donna McDowell White**
Senator Valerie P. Foushee	**Representative Beverly M. Earle**

Subcommittee Staff:	
DeAnne Mangum, Senate Clerk	Julie Ryan, House Clerk
	Pan Briles, House Clerk
Deborah Landry, Fiscal Research	Theresa Matula, Legislative Analysis
Lisa Wilks, Legislative Drafting	

SUBCOMMITTEE AUTHORIZATION

[Back to Top]

The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Aging, was created pursuant to S.L. 2017-57, Section 11D.3. The authorizing legislation allows the cochairs of the Joint Legislative Oversight Committee on Health and Human Services to appoint a subcommittee on aging to examine the State's delivery of services for older adults in order to (i) determine their service needs and to (ii) make recommendations to the Oversight Committee on how to address those needs. If appointed, the subcommittee is required to submit an interim report of its findings and recommendations, including any proposed legislation, to the Joint Legislative Oversight Committee on Health and Human Services on or before March 1, 2018, and a final report of its findings and recommendations, including any proposed legislation, on or before November 1, 2018, at which time it will terminate. The authorizing legislation is provided below.

S.L. 2017-57, SECTION 11D.3: RECOMMENDATION TO APPOINT A SUBCOMMITTEE ON AGING

SECTION 11D.3.(a) Pursuant to the authority in G.S. 120-208.2(d), the cochairs for the Joint Legislative Oversight Committee on Health and Human Services may consider appointing a subcommittee on aging to examine the State's delivery of services for older adults in order to (i) determine their service needs and to (ii) make recommendations to the Oversight Committee on how to address those needs. North Carolina currently ranks ninth in the nation for the size of the age 60 and older population and tenth in the nation for the age 85 and older population. From 2015 to 2035, the age 65 and older population is projected to increase sixty-seven percent (67%) and the age 85 and older population is projected to increase one hundred two percent (102%). By 2019, North Carolina will have more people that are 60 years of age and older than children age zero to 17. It is recommended that the subcommittee examine the range of programs and services for older adults throughout the continuum of care. The subcommittee is encouraged to seek input from a variety of stakeholders and interest groups, including the Division of Aging and Adult Services and the Division of Social Services, Department of Health and Human Services; the North Carolina Coalition on Aging; the North Carolina Senior Tarheel Legislature, and the Governor's Advisory Council on Aging.

SECTION 11D.3.(b) If a subcommittee on aging is appointed, the subcommittee shall submit an interim report of its findings and recommendations, including any proposed legislation, to the Joint Legislative Oversight Committee on Health and Human Services on or before March 1, 2018, and shall submit a final report of its findings and recommendations, including any proposed legislation, on or before November 1, 2018, at which time it shall terminate unless reappointed by the cochairs of the Oversight Committee under the authority granted in G.S. 120-208.2(d).

The Cochairs for the Joint Legislative Oversight Committee on Health and Human Services appointed members to the Subcommittee on Aging during a Committee meeting on October 10, 2017.

SUBCOMMITTEE PROCEEDINGS

[Back to Top]

The Subcommittee met three times between November 17, 2017, and February 12, 2018. This section of the report provides an overview of the topics and presenters for each subcommittee meeting. Detailed minutes and copies of handouts from each meeting are on file in the Legislative Library. Handouts from the meetings are also available at the Joint Legislative Oversight Committee website.

Overview of Topics and Presenters

November 17, 2017

- Welcome & Opening Remarks
  Representative Josh Dobson, Presiding Cochair

- Subcommittee Charge
  Lisa Wilks, Subcommittee Staff

- Division of Aging and Adult Services Budget Overview
  Deborah Landry, Subcommittee Staff

- Division of Aging and Adult Services and Aging Population Overview
  Michael A. Becketts, Assistant Secretary for Human Services, Department of Health and Human Services (DHHS)

  Joyce Massey-Smith, Adult Services Section Chief, Aging and Adult Services, DHHS

- Subcommittee Discussion

December 13, 2017

- Welcome & Opening Remarks
  Senator Joyce Krawiec, Presiding Cochair

- Presentations by Associations and Entities
  - Public Consulting Group (PCG)
    Kevin Hutchinson, Public Consulting Group
    Rob Finlayson, Pulselight

- NC Coalition on Aging
  Mary Bethel, President
- AARP of NC
  Doug Dickerson, State Director
- North Carolina Senior Tar Heel Legislature
  J. Dwight Cartner, Speaker
- Alzheimer's Association
  Scott Herrick, State Director of Public Policy, Eastern & Western Carolina Chapters
- NC PACE Association
  Linda Shaw, Executive Director, NC PACE Association
  Renee Rizzuti, Executive Director, PACE of the Southern Piedmont

- Presentations by Area Agencies on Aging (AAA) and Senior Centers
  - High Country Area Agency on Aging
    Julie Wiggins, Director
  - Piedmont Triad Regional Council Area Agency on Aging
    Bob Cleveland, Aging Program Planner- Davidson/ Guilford/Surry
  - Moore County Senior Enrichment Center
    Terri Prots, Director, Moore County Department of Aging
  - Roy B. Culler, Jr. Senior Center in High Point
    Calvin Vaughn, Director

February 12, 2018 Meeting

- Welcome & Opening Remarks
  Representative Josh Dobson, Presiding Cochair

- Association for Home and Hospice Care of NC
  Tracy Colvard, Vice President of Government Relations and Public Policy

- North Carolina Health Care Facilities Association
  Adam Sholar, President and CEO

- NC Association of Long Term Care Facilities
  Jeff Horton, Executive Director

- Adult Day Care/Day Health
  Teresa Johnson Troup, NCADSA
  Mark Bumgarner, M.S., Executive Director Adult Life Programs
  Michael A. Boles, Jr., Director of Adult Day Services, Resources for Seniors, Inc.

- Adult Protective Services
  Karen Harrington, Director, Catawba County Department of Social Services

- Project C.A.R.E. (Caregiver Alternatives to Running on Empty)
  Dawn Gartman, Project C.A.R.E Director, Division of Aging and Adult Services.

- Report Presentation
  Theresa Matula, Subcommittee Staff

FINDINGS AND RECOMMENDATION

[Back to Top]

FINDINGS: CONTINUATION OF THE SUBCOMMITTEE ON AGING

The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Aging, was appointed pursuant to S.L. 2017-57, Section 11D.3. The purpose of the Subcommittee was to examine the State's delivery of services for older adults in order to (i) determine their service needs and to (ii) make recommendations to the Oversight Committee on how to address those needs. Additionally, the enacted legislation encouraged the Subcommittee to seek input from a variety of stakeholders and interest groups, including the Division of Aging and Adult Services and the Division of Social Services, Department of Health and Human Services; the North Carolina Coalition on Aging; the North Carolina Senior Tar Heel Legislature; and the Governor's Advisory Council on Aging.

The Subcommittee met three times and heard from 23 presenters on a range of programs and services for older adults in North Carolina. During its first meeting, the Subcommittee heard a presentation on the amount of money the State spends to support services for older adults, and it heard from the Division of Aging and Adult Services, Department of Health and Human Services (DHHS) on the current and projected population of older adults in North Carolina. During the second meeting the Subcommittee heard from the following: Public Consulting Group (PCG); NC Coalition on Aging; AARP of NC; North Carolina Senior Tar Heel Legislature; Alzheimer's Association; NC PACE Association; two Area Agencies on Aging; and two Senior Centers. During the third meeting, the Subcommittee heard from the Association for Home and Hospice Care of NC; North Carolina Health Care Facilities Association; NC Association of Long Term Care Facilities; Adult Day Care/Day Health; a county Department of Social Services on Adult Protective Services; and heard a presentation on Project C.A.R.E.

The authorizing legislation provided that if the subcommittee is appointed, it is required to submit an interim report of its findings and recommendations, including any proposed legislation, to the Joint Legislative Oversight Committee on Health and Human Services on or before March 1, 2018, and to submit a final report of its findings and recommendations, including any proposed legislation, on or before November 1, 2018, at which time it shall terminate unless reappointed by the cochairs of the Oversight Committee under the authority granted in G.S. 120-208.2(d). Due to winter weather issues, sessions of the NC General Assembly, and scheduling conflicts, the subcommittee was not able to schedule more than three meetings prior to the March reporting requirement. The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Aging, finds that continued study of the State's delivery of services for older adults is necessary and requests that the Cochairs of the Joint Legislative Oversight Committee on Health and Human Services allow the Subcommittee on Aging to continue its work during

the interim period following the 2018 Regular Session of the 2017 North Carolina General Assembly.

RECOMMENDATION: CONTINUATION OF THE SUBCOMMITTEE ON AGING

The Joint Legislative Oversight Committee on Health and Human Services, Subcommittee on Aging, recommends that Cochairs of the Joint Legislative Oversight Committee on Health and Human Services allow the Subcommittee on Aging to continue its study of the State's delivery of services for older adults during the interim period following the 2018 Regular Session of the 2017 North Carolina General Assembly.

NORTH CAROLINA GENERAL ASSEMBLY

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

&

JOINT LEGISLATIVE EDUCATION OVERSIGHT COMMITTEE

JOINT SUBCOMMITTEE ON MEDICAL EDUCATION AND MEDICAL RESIDENCY PROGRAMS

Cochairs:
Representative John Fraley
Representative Donny Lambeth
Senator David Curtis
Senator Louis Pate

FINAL REPORT
TO EACH
FULL COMMITTEE

MARCH 2018

TABLE OF CONTENTS

TRANSMITTAL LETTER 3

JOINT SUBCOMMITTEE MEMBERSHIP 4

JOINT SUBCOMMITTEE AUTHORIZATION 5

JOINT SUBCOMMITTEE PROCEEDINGS 7

FINDINGS AND RECOMMENDATION 9

PROPOSED LEGISLATION 13

TRANSMITTAL LETTER

March 1, 2018

To Members of the Joint Legislative Oversight Committee on Health and Human Services and Members of Joint Legislative Education Oversight Committee:

The Joint Subcommittee on Medical Education and Medical Residency Programs respectfully submits the following final report in accordance with the joint study conducted pursuant to S.L. 2017-57, Section 11J.2.

Representative John Fraley
Cochair

Senator David Curtis
Cochair

Representative Donny Lambeth
Cochair

Senator Louis Pate
Cochair

JOINT SUBCOMMITTEE MEMBERSHIP

S.L. 2017-57, Section 11J.2, required the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee to each appoint a subcommittee to jointly examine the use of State funds to support medical education and medical residency programs. Below are the members appointed from each of the Oversight Committees.

Medical Education and Residency Programs Subcommittee, Joint Legislative Oversight Committee on Health and Human Services

Senate Members	House Members
Senator Louis Pate, Cochair	Representative Donny Lambeth, Cochair
Senator Jeff Tarte	Representative Gregory F. Murphy, MD.
Senator Mike Woodard	Representative Jean Farmer-Butterfield
Staff	
Jason Moran-Bates, Legislative Analysis	Theresa Matula, Legislative Analysis
Denise Thomas, Fiscal	Steve Owen, Fiscal
Amy Jo Johnson, Legislative Drafting	

Medical Education and Residency Programs Subcommittee, Joint Legislative Education Oversight Committee

Senate Members	House Members
Senator David Curtis, Cochair	Representative John Fraley, Cochair
Senator Joyce Krawiec	Representative David Lewis
Senator Ronald Rabin	Representative Larry Strickland
Staff	
Samantha Yarborough, Legislative Analysis	Drupti Chauhan, Legislative Analysis
Leslie Karkanawi, Legislative Drafting	Lisa Fox, Fiscal

JOINT SUBCOMMITTEE AUTHORIZATION

The Joint Subcommittee on Medical Education and Medical Residency Programs was created pursuant to S.L. 2017-57, Section 11J.2 which directed the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee to each appoint a subcommittee to jointly examine the use of State funds to support medical education and medical residency programs. The authorizing language from S.L. 2017-57, Section 11J.2, which became effective June 28, 2017, is provided below.

JOINT SUBCOMMITTEE ON MEDICAL EDUCATION AND MEDICAL RESIDENCY PROGRAMS

SECTION 11J.2.(a) The Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee shall each appoint a subcommittee to jointly examine the use of State funds to support medical education and medical residency programs. In conducting the study, the subcommittees shall examine at least all of the following:

(1) The health care needs of the State's residents and the State's goals in meeting those health care needs through the support and funding of medical education and medical residency programs located within the State.

(2) The short-term and long-term benefits to the State for allocating State funds to medical education and medical residency programs located within the State.

(3) Recommended changes and improvements to the State's current policies with respect to allocating State funds and providing other support to medical education programs and medical residency programs located within the State.

(4) Development of an evaluation protocol to be used by the State in determining (i) the particular medical education programs and medical residency programs to support with State funds and (ii) the amount of State funds to allocate to these programs.

(5) Any other relevant issues the subcommittees deem appropriate.

SECTION 11J.2.(b) The subcommittees may seek input from other states, stakeholders, and national experts on medical education programs, medical residency programs, and health care as it deems necessary.

SECTION 11J.2.(c) By February 1, 2018, the Department of Health and Human Services and The University of North Carolina shall provide the subcommittee

the following information regarding State funds and other support provided by the State to medical education programs and medical residency programs located in North Carolina:

(1) The identity, location, and number of positions available in these medical education programs and medical residency programs, broken down by geographic area.

(2) The specific amount of State funds or the nature of any other support provided by the State to medical education programs and medical residency programs, broken down by program.

(3) The number of graduates of medical education programs and medical residency programs who are currently practicing in North Carolina, broken down by specialty areas in which North Carolina is experiencing a shortage, including:

a. Anesthesiology.
b. Neurology.
c. Neurosurgery.
c. Obstetrics/Gynecology.
d. Primary Care.
e. Psychiatry.
f. Surgery.
g. Urology.
h. Any other specialty areas determined by the Department of Health and Human Services or The University of North Carolina to be experiencing a shortage.

(4) The number of program graduates who practiced in North Carolina for at least five years after graduation.

(5) Any other information requested by the subcommittees.

SECTION 11J.2.(d) The subcommittees shall jointly develop a proposal for a statewide plan to support medical education programs and medical residency programs within North Carolina in a manner that maximizes the State's financial and other support of these programs and addresses the short-term and long-term health care needs of the State's residents. Each subcommittee shall submit a report to its respective oversight committee on or before March 15, 2018, at which time each subcommittee shall terminate.

SECTION 11J.2.(e) This section is effective when this act becomes law.

JOINT SUBCOMMITTEE PROCEEDINGS

This section of the report provides a brief overview of the topics and presenters. Detailed minutes and copies of handouts from each meeting are on file in the legislative library. Handouts from the meetings are also available at the Handouts from the meetings are also available at the Joint Legislative Oversight Committee on Health and Human Services website and the Joint Legislative Education Oversight Committee website.

Overview of Topics and Presenters

February 12, 2018

- Welcome & Opening Remarks
  Senator Louis Pate, Presiding Co-chair
- Committee Charge
  Jason Moran-Bates, Subcommittee Staff, Legislative Analysis Division
- Overview of Graduate Medical Education Funding
  Steve Owen, Subcommittee Staff, Fiscal Research Division
  Lisa Fox, Subcommittee Staff, Fiscal Research Division
- Report on S.L. 2017-57, Sec. 11J.2(c)
  Maggie Sauer, Office of Rural Health, DHHS
  Dr. Erin Fraher, Cecil B. Sheps Center for Health Services Research
- Improving the Return on Investment in Graduate Medical Education: Towards a Statewide Solution
  Dr. Warren Newton, North Carolina Area Health Education Centers Program
  Dr. Joseph Pino, South East Area Health Education Center
- Current State of Medical Education and Residency and Suggestions to Address North Carolina's Health Care Needs
  Dr. Julie Byerley, University of North Carolina School of Medicine
  Dr. Catherine Kuhn, Duke University School of Medicine
  Dr. Mark Stacy, East Carolina University Brody School of Medicine
  Dr. Michael Waldrum, Vidant Health
  Dr. John Kauffman, Campbell University School of Osteopathic Medicine

March 1, 2018

- Welcome & Opening Remarks
  Representative Donny Lambeth, Presiding Co-chair
- Loan Repayments for Providers in Rural Areas
  Maggie Sauer, Office of Rural Health, DHHS
- Cape Fear Valley Health Center Graduate Medical Education Program
  Michael Nagowski, Chief Financial Officer
- Wake Forest Baptist Graduate Medical Education Program
  Dr. Richard Lord
- Presentation of Draft Subcommittee Report
  Jason Moran-Bates, Subcommittee Staff, Legislative Analysis Division

JOINT SUBCOMMITTEE FINDINGS AND RECOMMENDATIONS

S.L. 2017-57, Section 11J.2, requires the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee to each appoint a subcommittee to "jointly examine the use of State funds to support medical education and medical residency programs." S.L. 2017-57, Section 11J.2(d), tasked the two subcommittees with jointly developing a proposal for "a statewide plan to support medical education programs and medical residency programs within North Carolina in a manner that maximizes the State's financial and other support of these programs and addresses the short-term and long-term health care needs of the State's residents." The provision requires each subcommittee to report to its respective oversight committee on or before March 15, 2018. Half of the Joint Subcommittee was named in October, 2017, but the other half of the Joint Subcommittee was not named until January, 2017. Since the two subcommittees were required to work jointly, the work of the Joint Subcommittee was delayed.

The first meeting of the Joint Subcommittee on Medical Education and Medical Residency Programs was held on February 12, 2018. During that meeting, the Subcommittee members heard a presentation on an overview of graduate medical education funding provided by Subcommittee staff. S.L. 2017-57, Section 11J.2(c) required the Department of Health and Human Services and The University of North Carolina to provide the following information: (1) the identity, location, and number of positions available in medical education and medical residency programs by geographic area; (2) the specific amount of State funds or the nature of any other support provided by the State to medical education and medical residency programs by program; (3) the number of graduates of medical education and medical residency programs who are currently practicing in North Carolina by specialty area in which the State is experiencing a shortage; (4) the number of program graduates who practiced in North Carolina for at least five years after graduation; and (5) any other information requested. In response, the Joint Subcommittee received information from the Office of Rural Health, Department of Health and Human Services, and the Cecil B. Sheps Center for Health Services Research. Among other issues, the Sheps Center presentation focused on the need for transparency and accountability in determining which residency programs are addressing the shortage of physicians in rural areas.

The Joint Subcommittee also heard from the North Carolina Area Health Education Centers Program on improving the return on investment in graduate medical education. The presentation focused on prioritizing rural graduate medical education expansion; targeting the right specialties and settings; having a comprehensive solution; collecting data to track outcomes; paying for performance for education; and transparency and public leadership.

Additionally, the Joint Subcommittee heard from the following on the current state of medical education and residency programs, including suggestions to address the State's health care needs: University of North Carolina School of Medicine; Duke University School of Medicine; Brody School of Medicine at East Carolina University and Vidant Health; and Campbell University School of Osteopathic Medicine.

During the second meeting, on March 1, 2018, the Joint Subcommittee heard a presentation from the Wake Forest School of Medicine. The Subcommittee also heard a presentation on the loan repayment programs available to medical providers practicing in rural North Carolina.

Given the brevity of the Subcommittee's work and the importance of this issue, the Joint Subcommittee on Medical Education and Residency Programs submits the findings and recommendations outlined below.

FINDING 1: CONTINUED STUDY AND DEVELOPMENT OF A PLAN TO SUPPORT MEDICAL EDUCATION AND MEDICAL RESIDENCY PROGRAMS IN A MANNER THAT ADDRESSES THE HEALTH CARE NEEDS OF THE STATE.

S.L. 2017-57, Section 11J.2(d), required a subcommittee appointed by the Joint Legislative Oversight Committee on Health and Human Services and a subcommittee appointed by the Joint Legislative Education Oversight Committee to jointly "develop a proposal for a statewide plan to support medical education programs and medical residency programs within North Carolina in a manner that maximizes the State's financial and other support of these programs and addresses the short-term and long-term health care needs of the State's residents." The authorizing legislation required a report to the respective Oversight Committees by March 15, 2018. Due to a late start, the Joint Subcommittee on Medical Education and Medical Residency Programs was only able to hold two meetings prior to the reporting date.

The Joint Subcommittee finds that there is continued interest in examining ways to support medical education and medical residency programs with a goal of addressing the short-term and long-term health care needs of the State's residents. The Joint Subcommittee also finds that it is important for any subcommittee appointed to be in a position to begin work as soon as possible. However, the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee may find it necessary to prioritize their interim work and both Committees may not be in a position to appoint a subcommittee to work jointly. Therefore, the respective Oversight Committees may wish to encourage the General Assembly to enact legislation for continued study with a mechanism allowing flexibility for two appointed subcommittees to work jointly, or for one or more appointed subcommittees to work independently. Additionally, in order to devote sufficient time to these complex and important topics, the Joint Subcommittee finds that it would be beneficial for the study to take place over two interim periods with a final reporting deadline of March 1, 2020.

RECOMMENDATION 1: CONTINUED STUDY AND DEVELOPMENT OF A PLAN TO SUPPORT MEDICAL EDUCATION AND MEDICAL RESIDENCY PROGRAMS IN A MANNER THAT ADDRESSES THE HEALTH CARE NEEDS OF THE STATE.

The Joint Subcommittee on Medical Education and Medical Residency Programs recommends that the Joint Legislative Oversight Committee on Health and Human Services, and the Joint Legislative Education Oversight Committee, encourage the General Assembly to enact legislation allowing continued study and development of a plan to support medical education and medical residency programs in a manner that addresses the health care needs of the State.

FINDING 2: DEVELOPMENT OF MEASURABLE OBJECTIVES TO BE USED WHEN FUNDING MEDICAL EDUCATION AND RESIDENCY PROGRAMS.

S.L. 2017-57, Section 11J.2, requires the two subcommittees to jointly "develop a proposal for a statewide plan to support medical education programs and medical residency programs within North Carolina in a manner that maximizes the State's financial and other support of these programs and addresses the short-term and long-term health care needs of the State's residents." The Joint Subcommittee received good information this interim, but more information is needed to identify specific measurable objectives, along with specified timeframes for achievement, which will be used by the State when funding medical education and residency programs that address healthcare needs throughout the State, particularly increased health care access in rural areas, and to provide the Department of Health and Human Services direction in designing programs to support those objectives.

The Joint Subcommittee on Medical Education and Medical Residency Programs heard a variety of presentations regarding medical education and residency programs. The presentations highlighted the need for transparency with regard to the funding related to medical residency programs, the data needed to track residents throughout their career, and the lack of one specific entity in the State to gather this information. Presentations also pointed out that the variety of medical schools in the State have differing goals and objectives. The Subcommittee finds that the State does not appear to have a specific set of objectives for medical education and residency programs.

At this time, there was not enough data before the Subcommittee to make specific recommendations on a statewide plan to support medical education programs and medical residency programs. The Joint Subcommittee finds that more information is needed and should be provided by the Department of Health and Human Services in collaboration with the Cecil G. Sheps Center for Health Services Research, the North Carolina Area Health Education Centers, the North Carolina Institute of Medicine, the University of North Carolina at Chapel Hill School of Medicine, and the Brody School of Medicine at East Carolina University.

RECOMMENDATION 2: DEVELOPMENT OF MEASURABLE OBJECTIVES TO BE USED WHEN FUNDING MEDICAL EDUCATION AND RESIDENCY PROGRAMS.

The Joint Subcommittee on Medical Education and Medical Residency Programs recommends that the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee encourage the General Assembly to enact legislation requiring the Department of Health and Human Services to gather and report information to facilitate the development of measurable objectives, along with specified timeframes for achievement, which will be used by the State when funding medical education and residency programs addressing the health care needs of residents throughout the State and to provide the Department of Health and Human Services direction in designing programs to support those objectives.

JOINT SUBCOMMITTEE PROPOSED LEGISLATION

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2017

U D

BILL DRAFT 2017-SHz-3 [v.6] (02/09)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
02/20/2018 12:08:27 PM

Short Title: Medical Education & Residency Study. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO STUDY MEDICAL EDUCATION AND MEDICAL RESIDENCY PROGRAMS, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES AND THE JOINT LEGISLATIVE EDUCATION OVERSIGHT COMMITTEE.

Whereas, S.L. 2017-57, Section 11J.2, authorized the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee to each appoint a subcommittee to jointly examine the use of State funds to support medical education and medical residency programs; and

Whereas, the Joint Subcommittee on Medical Education and Medical Residency Programs, appointed by the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee, was not able to conduct a thorough examination of medical education and residency programs and to develop a plan to support them in a manner that addresses the health care needs of the State prior to the March 15, 2018, reporting deadline; and

Whereas, there is continued interest in examining ways to support medical education and medical residency programs with a goal of addressing the short-term and long-term health care needs of the State's residents; and

Whereas, the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee may find it necessary to prioritize their interim work and both Committees may not be in a position to appoint a subcommittee to work jointly; and

Whereas, the intent of the act is to create a mechanism allowing flexibility for two appointed subcommittees to work jointly, or for one or more appointed subcommittees to work independently; and

Whereas, the Joint Subcommittee on Medical Education and Medical Residency Programs identified data and information that will be needed to inform the work of future subcommittees in order to more thoroughly examine medical education and residency programs in order to identify objectives for those programs throughout the State and to provide direction to the Department of Health and Human Services in designing programs to that meet the needs of the State; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee may each appoint a subcommittee to study medical education and medical residency programs. If appointed, the subcommittees may consult each other and may elect to meet jointly, but each subcommittee is authorized to work independently and report to its respective oversight committee.

SECTION 2.(a) The medical education and medical residency study may include examination of the following:

(1) The health care needs of the State's residents and the State's goals in meeting those health care needs through the support and funding of medical education and medical residency programs located within the State.

(2) The short-term and long-term benefits to the State for allocating State funds to medical education and medical residency programs located within the State.

(3) Recommended changes and improvements to the State's current policies with respect to allocating State funds and providing other support to medical education programs and medical residency programs located within the State.

(4) Development of an evaluation protocol to be used by the State in determining (i) the particular medical education programs and medical residency programs to support with State funds and (ii) the amount of State funds to allocate to these programs.

(5) Any other relevant issues deemed appropriate.

SECTION 2.(b) The study may include input from other states, stakeholders, and national experts on medical education programs, medical residency programs, and health care, as deemed necessary.

SECTION 2.(c) The study may examine the reports provided by the Department of Health and Human Services and The University of North Carolina in accordance with S.L. 2017-57, Section 11J.2.(c), and the report provided by the Department of Health and Human Services in accordance with Section 3 of this act.

SECTION 3. No later than August 1, 2019, the Department of Health and Human Services shall submit to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Education Oversight Committee, and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, a report on medical education and residency programs. This report shall be developed in collaboration with the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, the North Carolina Area Health Education Centers, the North Carolina Institute of Medicine, the University of North Carolina at Chapel Hill School of Medicine, and the Brody School of Medicine at East Carolina University. The report shall be used to facilitate the development of measurable objectives, along with specified timeframes for achievement, which will be used by the State when funding medical education and residency programs addressing the health care needs throughout the State, particularly increased health care access in rural areas. The report shall contain the following information:

(1) Detailed information about North Carolina medical school student slots, residency slots, and intern slots, including the number of slots for each medical school and residency program and how these slots have changed over time. This information shall include the slot caps set by Medicare and other agencies, the methodology used to establish those slot caps, information on how the slot caps have changed over time, and how changes to the slot caps

may be accomplished in the future. This information shall also include an assessment of the effect of the slot caps on each medical school and residency program in North Carolina.

(2) Suggested overall objectives for the medical education and residency programs in the State, including identified outcomes and goals to meet the needs of rural areas.

(3) Total funding for the North Carolina Area Health Education Centers for the past three fiscal years, the primary purposes of the funding, and outcomes that have been achieved relative to those purposes.

(4) Total funding for the University of North Carolina at Chapel Hill School of Medicine and the Brody School of Medicine at East Carolina University for the past three fiscal years. This shall include an analysis of the cost of operating each school of medicine compared to the total funding for each school of medicine.

(5) The total reimbursement paid to hospitals related to Graduate Medical Education (GME) through the Medicaid program, including all of the following methodologies: receipts, claims payments, cost settlements, enhanced payments, and equity supplemental payments. This shall include an analysis of the funding source for this reimbursement, including how much of the funding is provided by the State, by hospitals, and by the federal government.

(6) A detailed explanation of all Medicaid GME reimbursement methodologies that the Department of Health and Human Services intends to use, or is using, under the transformed North Carolina Medicaid and North Carolina Health Choice programs as described in S.L. 2015-245, as amended by Section 2 of S.L. 2016-121, Section 11H.17 of S.L. 2017-57, and Section 4 of 2017-186. This explanation shall include a rationale for any changes made to the Medicaid GME reimbursement methodology, outcomes to be achieved by these changes, and methods by which to measure these outcomes.

(7) Strategies, outside of the publically-funded programs, used by hospitals and communities to attract and retain health care providers to rural areas.

(8) Any recommendations regarding a body to compile and oversee the State's medical education and residency programs data, including whether this additional oversight body is necessary. If an oversight body is recommended, this recommendation shall also include the composition of that body, the recommended agency to house the body, the duties of the body, the specific information the body is to oversee, the mechanism by which the body will collect the data, and any funding needs for the body.

(9) An analysis of how other states have modified or developed funding to meet the need in rural areas regarding the recruitment and retention of health care providers, including the use of Medicaid funding, loan forgiveness, and loan repayment. This analysis should include the processes by which other states have identified the need for health care providers by specialty or location and the outcomes achieved.

(10) Any limitations or parameters set by other entities that may restrict the State's ability to modify programs that support the State's objectives, including (i)

Medicaid reimbursement for GME, (ii) loan forgiveness, (iii) loan repayment, or (iv) other sources of funding.

SECTION 4. A subcommittee authorized by this act and appointed shall develop a proposal for a statewide plan to support medical education programs and medical residency programs within North Carolina in a manner that maximizes the impact of financial and other support provided by the State for these programs and addresses the short-term and long-term health care needs of the State's residents, particularly increased health care access in rural areas. A subcommittee authorized by this act and appointed, may provide an interim report to its respective oversight committee by November 1, 2018, and shall report to its respective oversight committee on or before March 1, 2020, at which time a subcommittee authorized by this act shall terminate.

SECTION 5. This act is effective when it becomes law.

Draft Recommendations for Consideration by the Joint Legislative Oversight Committee on Health and Human Services (JLOC-HHS)

3/12/2018

AGING	BACKGROUND
RECOMMENDATION 1: CONTINUATION OF THE SUBCOMMITTEE ON AGING. The Joint Legislative Oversight Committee on Health and Human Services recommends that Cochairs of the Joint Legislative Oversight Committee on Health and Human Services allow the Subcommittee on Aging to continue its study of the State's delivery of services for older adults during the interim period following the 2018 Regular Session of the 2017 North Carolina General Assembly.	S.L. 2017-57, Sec. 11D.3 allowed the JLOC-HHS to appoint a subcommittee on aging. This is a recommendation from the Subcommittee on Aging. The interim report was presented to the JLOC-HHS on March 13, 2018.
MEDICAL EDUCATION & MEDICAL RESIDENCY	**BACKGROUND**
RECOMMENDATION 2: CONTINUED STUDY AND DEVELOPMENT OF A PLAN TO SUPPORT MEDICAL EDUCATION AND MEDICAL RESIDENCY PROGRAMS IN A MANNER THAT ADDRESSES THE HEALTH CARE NEEDS OF THE STATE. The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation allowing continued study and development of a plan to support medical education and medical residency programs in a manner that addresses the health care needs of the State.	S.L. 2017-57, Sec. 11J.2, required the JLOC-HHS and the Joint Legislative Education Oversight Committee to each appoint a subcommittee to jointly examine the use of State funds to support medical education and medical residency programs. This is a recommendation from the Joint Subcommittee on Medical Education and Medical Residency. The report was presented to the JLOC-HHS on March 13, 2018.
RECOMMENDATION 3: DEVELOPMENT OF MEASURABLE OBJECTIVES TO BE USED WHEN FUNDING MEDICAL EDUCATION AND RESIDENCY PROGRAMS. The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation requiring the Department of Health and Human Services to gather and report information to facilitate the development of measurable objectives, along with specified timeframes for achievement, which will	Same background as referenced above.

be used by the State when funding medical education and residency programs addressing the health care needs of residents throughout the State and to provide the Department of Health and Human Services direction in designing programs to support those objectives.	
TELEMEDICINE	**BACKGROUND**
RECOMMENDATION 4: IMPLEMENTATION OF A STATUTORY FRAMEWORK FOR TELEMEDICINE IN NORTH CAROLINA AND FURTHER STUDY OF ISSUES RELATED TO TELEMEDICINE. The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation (i) establishing the framework for the practice of telemedicine in the state of North Carolina to include definitions, the provision of services by providers licensed under Chapter 90 of the General Statutes, informed consent standards, guidelines for handling protected health information, and a standard of care; and (ii) directing the Department of Health and Human Services to conduct studies on reimbursement of telemedicine by private health benefit plans, a program to ensure all North Carolina residents have access to broadband internet sufficient to support telemedicine, metrics and other data to be used in assessing the quality of care provided by telemedicine, and licensing standards for individuals providing healthcare through telemedicine.	S.L. 2017-133, Sec. 2 required the Department of Health and Human Services (DHHS) to submit a report containing findings, recommendations, and a proposed telemedicine policy, to the JLOC-HHS. It further provided that based on the Department's report, the Committee must consider making a recommendation to the 2017 General Assembly during the 2018 Regular Session. DHHS presented a report to the JLOC-HHS on October10, 2017.
PSYPACT	**BACKGROUND**
RECOMMENDATION 5: NORTH CAROLINA PARTICIPATION IN THE PSYCHOLOGY INTERJURISDICTIONAL COMPACT (PSYPACT). The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation allowing North Carolina to participate in the Psychology Interjurisdictional Compact (PSYPACT) and to require the Department of Health and Human Services and the North Carolina Psychology Board to foster continuity of care by exploring the participation of PSYPACT participants in NC HealthConnex health information exchange.	S.L. 2017-133, Sec. 2 required the Department of Health and Human Services (DHHS) to submit a report containing findings and a recommendation on the PSYPACT to the JLOC-HHS. It further provided that based on the Department's report, the Committee must consider making a recommendation to the 2017 General Assembly during the 2018 Regular Session. DHHS presented a report to the JLOC-HHS on October10, 2017.

HEALTH ISSUES IN LOCAL CONFINEMENT FACILITIES	BACKGROUND
RECOMMENDATION 6: HEALTH ISSUES IN LOCAL CONFINEMENT FACILITIES. The Joint Legislative Oversight Committee on Health and Human Services encourages the General Assembly to enact legislation to (i) clarify that the death of a prisoner in the custody of a local confinement facility shall be reported regardless of the physical location of the prisoner; (ii) to require the Secretary of the Department of Health and Human Services to undertake a study to improve prisoner health screening to determine when a prisoner has been prescribed life-saving prescription medications and to ensure the timely administration of those prescription medications; and (iii) to encourage the Department of Public Safety, the Department of Health and Human Services, and the Department of Information Technology's Government Data Analytics Center, to pursue State prisons becoming full participants in the NC HealthConnex health information exchange and to explore participation of local confinement facilities in the NC HealthConnex health information exchange.	The JLOC-HHS heard presentations on this issue from the Division of Health Service Regulation, DHHS, and the Department of Public Safety on February 28, 2018.

DRAFT

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Comm on Health and Human Services — Mar 13 2018

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
AMES SIMMONS	EQUALITY NC
John Nash	The Arc of NC
Natalie Batten	Accenture
Dodie Rorfu	CCR
DAVID POWERS	POWERS STRATEGIES LLC
Lindsey Dowling	FSP
Brian Perkins	Alliance BHC
Sara Wilson	Alliance BHC
Jamaica Pfister	Children's Home Society of NC
Breeder	CFVH
Blackwell	

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Comm on Health and Human Services — Mar 13 2018

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Doug Misken	PSG
Chris McClure	BP
Michelle Frazier	SML
Denton Delsatch	TS
Darryl Childers	Governor's Office
Rhaegan Jackson	Focus Carolina
Ryan Menard	WM
David Collins	Waste Pro
[illegible]	[illegible]
Doug Lassiter	NCSTA
Kay Kiger	NCRMA

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Comm on Health and Human Services — Mar 13 2018

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sue Ann Forrest	NCMS
Amanda Donovan	KTS
Carson Dunn	MVA
Kari Barsness	Gateway Health
TJ Bugbee	NP
[illegible]	MP
Ryan Blackledge	Core Health
Jon Carr	Jordan Price Law Firm
Kara Weishaar	SA
Dana Simpson	SA
[illegible]	NCMS

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Comm on Health and Human Services — Mar 13 2018

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JOEL MAYNARD	GPM ; ASSOC
Fred Bonn	Bonn : Assoc
JOE LANIER	TROUTMAN
Andy Ellen	NCAHA
A. Chase	KMA
Rachel Bedi	Kplaw
LT MCGinnon	DHHS
Mark Fleming	BCBS NC
Mary Bethea	NCCOA
Khadrana Blade	ALSO

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Comm on Health and Human Services — Mar 13 2018

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
CS Hollis	CSH
Jal Lara	CHA
PAIGE WORSHAM	NCACC
Maeve Gard	GSK
Zane Stilwell	TSG
Lanier Hodges	UNC HCSR
Geraldine Hall	PTA
Pamela Shipp	Monarch
Tracy Kimbrell	Parker Poe
Jennifer Mahan	ASNC

~~Speaker~~

~~VISITOR REGISTRATION SHEET~~

Joint Legislative Oversight Comm on Health and Human Services — Mar 13 2018

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Gina Bocchetti	League of Women Voters
Sarah Wolfe	MWC
Mark Molinaro	IBM
Emma Shelby	Policy Group
Donna Fayko	NCACDSS / Rowan County
Sarah Bradshaw	Sampson Co. DSS / NCACDSS
Nicki Perry	Franklin Co DSS / NCACDSS
Felissa Fennell	Rockingham Co HHS / NCACDSS
Robby Hall	NCACDSS / Richmond County
Heather Skeen	NCACDSS / Guilford
[illegible]	NCACDSS

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Comm on Health and Human Services — Mar 13 2018

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	CSS
J Jenkins	OAPI
M. Downs	Shire
David Ferrell	NP
Michael Leighs	NC PC
Jean Andersen	Blank, Cardinal IH.
CAROL ORNITZ	BRAIN INJURY ASSN BOARD
Myra Thompson	Guilford County Social Services
Brenda Jackson	Cumberland County Social Services
Susan Osborne	Alamance Co DSS
[signature]	Alamance Co. DSS

VISITOR REGISTRATION SHEET

Joint Legislative Oversight Comm on Health and Human Services — Mar 13 2018

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dick Carlton	Ken Ag & RR Ctr
John Cooper	CONNECT C

SPEAKER REGISTRATION SHEET

H. Logs. Oversight on Health & Human Svcs. 03/13/2018

Name of Committee | Date

SPEAKERS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Donna Fayko	Rowan Co DSS/NCACDSS
Sarah Bradshaw	Sampson Co. DSS

Committee Sergeants at Arms

NAME OF COMMITTEE Joint Legislative Oversight Comm on Health and Human Services

DATE: Mar 13 2018 Room: 643

House Sgt-At Arms:

1. Name: Terry McCraw
2. Name: Dean Marshbourne
3. Name: John Gilbert
4. Name:
5. Name:

Senate Sgt-At Arms:

1. Name: Terry Edmondson
2. Name: Charles Marsalis
3. Name:
4. Name:
5. Name:

MINUTES
JOINT LEGISLATIVE OVERSIGHT COMMITTEE
HEALTH & HUMAN SERVICES

Tuesday, April 10, 2018
9:00 a.m.
Legislative Office Building, Room 643

ATTENDEES:

Chairmen:	**Dobson and Lambeth**
House Members:	**Dollar, Earle, Farmer-Butterfield, Malone, Murphy, White, Adcock, Fisher**
Senate Members:	**Bishop, Curtis, Krawiec, Tarte, Tucker, Woodward, Barringer, Lee**

I. Welcome and Opening Remarks

Chair, Donny Lambeth presided and called the meeting to order at 9:10 a.m.

Chairman Lambeth introduced Sergeant-at-Arms Staff assisting with the meeting and welcomed members and guests.

II. Comments from the Secretary

- North Carolina Secretary of Health and Human Services, Mandy Cohen, began by announcing that April is a month of celebration as it recognizes much of the great work that is going on across the state. It is: Minority Health Month; Public Health Month; Child Abuse Prevention Awareness Month; Week of the Young Child; and, Mental Health Awareness Month.

  Secretary Cohen, provided an update of the 2017-18 influenza season. She reported that activity peaked the week ending February 10th, higher than recent seasons and a total of 342 deaths were recorded. She stated that most deaths occurred in persons 65 years-of-age and older. She reminded those in attendance that Flu B is continuing to circulate and offered precautionary advice such as: contact your doctor and continue common sense prevention actions such as hand hygiene and respiratory etiquette. She asked everyone to call their doctor and to stay at home when sick.

  Secretary Cohen addressed actions involving the Department of Social Services in Cherokee County. She informed the committee that DHHS had learned that the county had been using Custody and Visitation Agreements (CVAs). Secretary Cohen reported that DHHS began working with Cherokee County to facilitate child placement for the children affected by this placement.

She explained that the use of CVAs circumvents required court system involvement which is not according to policies or procedures. DHHS determined that child welfare services were not being provided in accordance with the law, rules and policy by the Cherokee Department of Social Services which posed a substantial threat to the safety and well-being of children.

Due to its findings, DHHS assumed temporary, direct operation of Cherokee County's DSS Child Welfare Services on March 19th. She stated that this is the first time DHHS has taken control of a county's child welfare services. "It was narrowed to just those child welfare services. It has been a very collaborative effort throughout the process," she stated.

Secretary Cohen reviewed the steps that have been taken:

- DHHS informed Cherokee County leadership prior to initiating action to assume temporary responsibility of child welfare services;
- County leadership expressed support for action and DHHS has been working closely with County leadership throughout the process;
- DHHS provided Cherokee County leadership with an initial assessment of Child Welfare Services on March 30th;
- DHHS will work with county leadership to develop a plan to return administration of Child Welfare Services to Cherokee DSS upon completion of agreed upon steps for training, staffing, and oversight; and,
- DHHS is committed to continued partnership and collaboration with Cherokee County Leadership

Representative Stevens asked if its custody/visitation agreements are consistant with an extension of temporary placement agreements. The Secretary responded that the concern in this circumstance is that the CVAs did not involve the court system; they were privately negotiated agreements between the parties.

Julie Cronin general counsel for the Department of Health and Human Services, responded, "The custody/visitation agreements largely pre-dated the temporary parental safety agreement policy that came into play effective August 2016. What is being noted during DHHS's investigation is that many of these agreements that pre-dated the TPSA policy, it seems was molded into that policy and continued through the implementation of that policy. Although there is cloning, they are separate and distinct."

In follow-up, Representative Stevens added that her understanding is that the TPSAs predated 2016. She continued that she likes the concept of the TPSAs even though there is no legal basis for them and stated her concern that TPSAs will make families rush everything into court. Representative Stevens expressed her desire to have further discussion.

Representative Dobson asked several questions regarding the Cherokee County issue:

1) How long had the county been inappropriately following this practice?

   Secretary Cohen responded that it dated back to 2009.

2) How did this practice fall through the cracks?

   Given its oversight and regulatory roll, the Department is trying to understand how this happened and has begun looking at procedures at the State level. The Department is also looking at improvement to ensure it has the tools necessary to assist counties that have veered from policy and provide corrective action plans to get them back on track.

   "We are reviewing our own internal policy," she stated. "The manner in which we were conducting our review, the situation did not come to light. This is the reason we need to think about how we conduct our oversight differently," she concluded.

3) Representative Dobson further asked if it would be fair to say that DHHS is currently working on changes that need to be made across the state to ensure that situations such as this do not fall through the cracks in other counties.

   In response, Secretary Cohen stated that DHHS had been in contact with all 99 other counties and working in partnership with them specifically about any use of TPSAs in identifying and addressing any points of ownerability. She added that the Department is also reviewing its own policy and oversight and how it considers not only identifying issues but also putting together a corrective action plan to which counties are accountable.

   Representative Dobson requested a copy for committee members of the Department's concrete recommendations once they are in place.

In response to Representative Dobson's question, Senator Barringer called the committee's attention to the report that would be presented later in the meeting. She stated that the Cherokee County incident is another example of 100 counties and 100 different ways of doing things and the tremendous need for DHHS to provide guidance and oversight. She stated that, "It's not just a legal matter. The outcome of skipping the step of having legal oversight has resulted in children being placed in families that have the same problems as the birth family. . .mental health issues, alleged drug issues, no home studies done. Children are being placed in jeopardy. Additionally, because a legal procedure was not followed, children who have been in stable homes for a long period of time may be in jeopardy of being deflected. We must have a system across this State that supports our families and our children in every county. Children deserve a family not a system," she concluded. They deserve care not just a system. And that is what we are doing in the Child and Family Accountability and Protection Act, " she concluded.

Senator Barringer asked of Michael Becketts the status of the investigations into children's deaths that the Department received prior to the new administration.

Mr. Becketts responded that the Department is well on its way to being relatively current in its infant fatality reviews. He reported that the Department has scheduled every backlogged fatality review to occur before June 30th, 2018. Mr. Becketts is hopeful that reports of each review will be ready before the end of July. "This will allow the Department to facilitate fatality reviews within three-to-four months of a child's fatality.

Senator Barringer commended Mr. Becketts for the work he is doing. She stated that she would like for the Department to have a much tighter timeframe for reporting. "This information is critical for our families and our children," she said.

Senator Barringer added that the national expert under the RFP was selected and requested a report of the progress being made as it dovetails with reports being heard later in the meeting.

Mr. Becketts informed the committee that the Center for Support of Families was selected as the vendor to do the examination of the Social Services and Child Welfare System. The contract was awarded on March 7th and the Center has been actively engaged and involved with the Department of Health and Human Services collecting data and information around System's operation. The first review meeting with the Office of State Budget & Management was held on April 9th. His expectation is that the Social Services and Child Welfare System will have monthly check points on its progress. He expressed confidence that the Social Services and Child Welfare System is moving forward at the expected pace.

Senator Barringer acknowledged that, based on information received, the State is on schedule with the established timeline that is critical for effective oversight. "If we do not have data, if we do not have a reliable data system, the other work will not matter because we cannot have accountability. We must get the data system in order," she reiterated.

Senator Tucker inquired about the status of the Child Protective Services System that is being developed by IBM and Cúram. He expressed concern that the State failed Federal inspection and asked if the State, like Ontario, had options such as suing IBM for not delivering on time.

Secretary Cohen acknowledged her shared frustration with the software product Cúram. She informed the committee that DHHS had been working collaboratively with county partners who have done a tremendous job in transitioning to the new data system while continuing the work of Child Protective Services.

She offered that Cúram is redesigning business processes and how workers are now using their time with the new collection system for information in place. Once up and running, we will have the ability to collect and share information in a standardized way across all counties.

Secretary Cohen reported that the data system is on tract for rollout by the end of this calendar year making the product more user friendly and easier to navigate. An update to Cúram is expected during May. "We all agree (the new system) is important and implementation is top priority for us." she said.

In follow-up, Senator Tucker asked if DHHS counsel has read the contract and provided a summary of recourse on the product should it not work and/or if it were not up and running by the end of the calendar year and are penalties in place for not delivering on time. Secretary Cohen stated that she would have DHHS counsel review the contract and provide follow-up. She added that DHHS is meeting with Cúram's senior team to ensure they understand the urgency of the work and its importance as well as Cúram's need for responsiveness.

In conclusion, Senator Tucker shared that, from a business standpoint, the State has not written solid contracts with penalties in the past resulting in the State losing millions of dollars.

Representative Cunningham asked the status of Mecklenburg County's Corrective Action Plan.

Secretary Cohen responded that DHHS had been on-site and was concerned about its findings. She reported that the Department had provided a corrective action plan; and, to date, the County is following that plan. "DHHS has future opportunities to make certain Mecklenburg County is continuing to adhere to those policies," she reported.

- Regarding birthing centers, Secretary Cohen informed the committee that DHHS has no regulatory authority over free-standing birthing centers. North Carolina does not require licensing of birthing centers. She stated that, due to the number of deaths over a short period of time, DHHS sent a letter to Baby & Co on April 6th asking for an on-site review of its Cary location and had not received a response. If Baby & Co allow the review, DHHS will send its regulatory team just as it would a hospital and conduct an inspection of its policies and procedures as well as look at patient records in the service of understanding what may have happened related to the deaths of these infants.

  Secretary Cohen reiterated that DHHS is limited in its authority but hopeful Baby & Co will cooperate with this voluntary request.

  Representative Dollar thanked Secretary Cohen for responding to both the public concern as well as the letter he sent previously regarding steps the Department had taken. He offered his commitment to closing the regulatory loop-hole to ensure that all of our healthcare facilities are appropriately regulated and overseen and that the State has an opportunity to investigate when tragedies occur.

  Representative Murphy commented that DHHS's involvement in the regulatory process should be mandatory. He expressed his desire to work with his colleagues and DHHS to close the loop on this topic.

  Senator Woodward stated that Baby & Co is a very personal issue for him as it involves his constituents. Comparing situations, he asked what role the Department has when a child dies in a hospital setting or what regulatory review occurs.

  Secretary Cohen responded that the Department shares concern in the safety and welfare of infants and newborns. She recognized committee member, Senator Tamara Barringer, as a champion around child fatality to ensure that the Department is doing everything possible to learn lessons so that tragedies do not recur. "That goes for a hospital setting or a home or any birth place," she said.

  Chairman Lambeth asked if DHHS had an inventory of all birthing centers operating in North Carolina and the number of births in each of those centers?

Given its lack of authority over birthing centers, Secretary Cohen responded that she did not know of the department's tracking of the centers but would report back any findings.

Representative Dollar inquired about a presentation entitled: SUD 1115 Waiver. "Is that a part of the current 1115 Waiver Amendment that was submitted in November or is this something separate from that," he asked.

Secretary Cohen responded that it was a part of the 1115 Waiver Amendment in order to increase DHHS's ability to respond to the Opioid crisis. "It is something that CMS has scoped out with a number of other states and we modeled it after New Jersey's," she concluded.

III. Social Services Regional Supervision and Collaboration Working Group Report (S.L. 2017-41 (HB 630) Sec.1.2 (e))

Senator Tamara Barringer provided background information regarding the Social Services Regional Supervision and Collaboration Working Group Report that was established under the Child Protection and Accountability Act of 2017. Senator Barringer publicly thanked members of the committee who served diligently and members of UNC School of Government who facilitated the process. The charge of the work group was to develop recommendations for improving state supervision of the county-administered social services system through the use of a new system of regional state offices. She praised the work group which was comprised of volunteers from across the State representing various governmental bodies at the state, district and local levels.

Representative Sarah Stevens added that the Child Welfare Group, which starts up this summer, will be the next step to ensuring that all policies are put in place. "This is the structure to do it; this is the structure to send it down to local agencies; however, this is just the first step," she said. The second step will be looking at those policies and making sure they are consistent, making sure they are based in law and passing laws necessary to make certain policies are carried out correctly.

Representative Stevens expressed her appreciation to all groups involved and asked for continued support as the structure is put into place.

Aimee Wall, with UNC School of Government, reviewed the history and provided an overview of S.L. 2017-41, that establishes Social Services Regional Supervision and Collaboration Working Group (SSWG) and directs the SSWG to develop recommendations for improving state supervision of the county-administered social services system through the use of a new system of regional state offices.

The State One Report is the first of a larger Reform Plan that includes: 1) High-quality and consistent service provision across all counties; 2) Accountability to ensure that all local agencies are providing high-quality services; and, 3) Transparency of local agency performance and outcomes.

Ms. Wall informed the committee that North Carolina operates under a State-Supervised, County-Administered System. She explained that the State is taking the lead to define the shape of its system and overseeing county administration. Ms. Wall described North Carolina's system as a "realatively unusual" model. The majority of states have state-administered systems. She explained that those states have county presence but different in that the state takes the lead in its administration.

She depicted the Reform Plan as the center of a perfectly designed puzzle that brings together: Child Well-Being Council; Contracts/Corrective Action between counties and the State; Regional Departments; and, the Social Services Working Group. The State will contract with an outside organization to evaluate the role of the State and the new strategic direction for the social services system. The child welfare reform will have a more detailed reform plan to include specific requirements. The Report Card and NC FAST data will be used in the evaluation process. Contracts between counties and state will address performance requirements and administrative responsibilities. Noncompliance may result in the withholding of state or federal funds. Following full implementation in 2020, performance requirements will be tied to the Dashboard and other reliable data. Noncompliance will result in a Corrective Action Plan.

After March 2019, new authority will be granted for the counties to create regional Social Services Agencies or new legal entities, e.g., *public authorities*, designed to provide some or all of the social services that are provided to individuals in the program. Multiple county social services agencies will be permitted but may be limited to certain services. Counties will be required to contribute financially to the regional departments; the Social Services Commission will adopt contribution rules.

A new group, The Child Well-Being Transformation Council, will focus on improving coordination, collaboration and communication among agencies and organizations that provide public services to children. Initially, the Council will be charged with identifying relevant agencies/organizations; identifying problems in collaboration and communication within the child welfare system; and, research the role of similar councils in other states. By March 2020, the Council should be prepared to recommend changes necessary to remedy identified gaps.

The final piece of the puzzle was the establishment of the Social Services Regional Supervision and Collaboration Working Group (SSWG). Ms. Wall reviewed the recommendations of the working group.

Recommendations were reported in six general categories:

1) Goals – She noted that it is not just about oversight and enforcement.
A. Support; B. Technical Assistance; C. Responsiveness; C. Trust; and, D. Relationship/ Partnership with the State and the counties.

2) Functions –
A. Compliance; B. Fiscal monitoring; C. Support to county administration; D. Integrated data systems; E. Interagency coordination; F. Policy guidance and technical assistance; G. Quality improvement; H. Staffing standards and support; and, H. Training.

3) Staffing – Types of staffing through the regional offices
A. High-quality, experienced, reliable; B. Expertise available in all social services; C. Resource allocations; D. Movement of some central office staff to regional offices; and, E. Model includes: director, administrative staff, general technical assistance, and program consultants

Ms. Wall added that the working group feels strongly that regions and the central office must have flexibility to allocate resources differently from region-to-region. She stated that the working group expects that, once DHHS deliberates on the plan and the recommendations, it may choose to reallocate central office staff to regional office functions and have that conversation with the outside contractor who was engaged to do a comprehensive review of the State agency – how it is staffed and how it is meeting needs.

4) Regions – Ms. Wall stated that North Carolina has a strong regional presence. A regional staff is in place for the majority of programs and is working to provide technical assistance and support on a regular basis. The emphasis is to create a systematic and organized way of concentrating expertise in regional offices that cover the entire scope of service.

Ms. Wall reminded the committee that regional offices have been an evolution as the State previously had regional offices that were disbanned in the early 2000. Since that time more program-by-program regional support was implemented.

The working group did not recommend an individual map but agreed that five-to-seven regions should be established. The report indicates that the working group did not recommend an individual map. Instead, the working group identified guidelines for the development of a regional map. They include: A) Avoid splitting counties between regions; B) Create a region of contiguous counties; C) Preserve Judicial districts; D) Establish regions of comparable geographic size and population served; E) Maintain natural networks; and, F) Concentrate regional expertise for serving military and American Indian communities.

5) Local Supervision/Local Oversight

Ms. Wall reported that the working group discussed the full life cycle of a social services agency and the players who were involved. It identified several options for increasing involvement from local elected officials as well as the county manager and county social services board in overseeing the county administration.

6) Other

In the essence of time, Ms. Wall did not review details of the category but encouraged members to look over this section of the report. "They are not unimportant," she concluded. Those topics include: A) Consistency across regions; B) Accountability of regional offices; C) Physical space for regional offices; D) Studies; and, E) Ongoing system oversight.

Stage Two of the Social Services Working Group charge is to look at the county-administered system more closely to determine: A) How the counties are cooperating with one another; and, B) What are the barriers to that inter-county coordination, cooperation and service. She reminded the committee that specific areas are identified in the legislation. Ms. Wall stated that she foresees a rich conversation considering the encore group has built a good repore with one another and represents deep experience.

The second part of Stage Two poses the questions, "What would a regionally-administered system look like?" Ms. Wall emphasized the term *administered* considering what is currently in place is a State-supervised, county-administered system. She asked: What if we turned that on its head and it was a State-supervised, regionally-administered system. Instead of all the counties having the option of creating regional departments, what if they were mandated to create regional departments and *new public authorities* were the bodies that were delivering services. So instead of counties doing it, it's regions.

Ms. Wall informed committee members that the Working Group will have this conversation; they will not be required to propose legislation or otherwise make specific recommentatons. The language in the legislation is: "create a vision; talk about a vision; what would that look like." The expectation is that they will have a high-level discussion of this idea in order to identify the potential benefits and challenges associated with their transition.

Within the process, the Working Group expects to fully engage with several of the ad hoc subcommittees that were identified in the legislation. "There are a lot of stakeholders," she concluded.

Ms. Wall reported that maps for pubic comments were provided and lots of comments were received from stakeholders. Informational gatherings will be held in order to have more active stakeholder engagement and group conversations to gather information on these fundamental issues. She announced that the first meeting is scheduled for May 2nd and additional informational gatherings will be held during the summer months.

Chairman Lambeth called on Senator Barringer who recognized her Senate colleagues, Senators Krawiec and Harrington, who also worked on this effort and publicly thanked them for their support. Senator Barringer recommended to committee members that they take a look at the Appendices with the maps. She is hopeful to stay on tract and identified the data system as a potential holdup.

Senator Tucker expressed his pleasure in the forward progress being made. He inquired about the lack of control by County Commissioners over the DHHS director and the health director, as they are State employees. "What different structure will this plan offer in that situation. In most incidences, County Commissioners do not even realize that they are liable for incidences such as these. What changes with that scenario are currently in place," he asked.

Ms. Wall responded that a lot of conversation centered around the disconnect felt by County Commissioners regarding their authority to govern social services agencies. She identified several options under State law:

1) A law passed in 2012 that allowed County Commissioners to abolish the Social Services Board and assume the powers and duties either of the Social Services Board or consolidated Human Services Board. She reported that quite a few counties (28) have done some form of change.

   The SSWG Report builds on that legislation and includes some opportunities for change to the law that would increase the involvement of County Commissioners. She called attention to the section of the report that is colored with red and green notations having to do with local authority.

   Green refers to what a county currently may do without additional legislative authority to make changes in getting County Commissioners more involved and increasing the work of the Social Services Governing Board in having more notice and more conversations between the State agencies and the County Commissioners. Things that could happen without legislation on a voluntary basis. If mandated, legislation would be required.

   Notations in red would also increase local involvement and oversight and would require legislation. Ms. Wall recommended that section of the report that identifies the Working Group's ideas.

As follow-up, Senator Tucker called attention to the "integrated data system" mentioned in pages 1 – 15 of the report. He asked that Ms. Wall identify that system. She replied that that term was used to refer to the idea of NC FAST and the *Dream System* that will be coming. The expectation that integrated data, reliable data, transparent data is an essential part of supervision.

Senator Tucker referred to a situation in Union County and the lack of an MOU prevented County officials from going in and doing anything at the local DSS. He added that is how it has been for years. DHHS was *hands off* and that is why we have a hundred different ways of running departments because of lack of direction from the State. He commended Secretary Cohen for allowing the State to move forward.

"How do we respond to people who say, 'this is another piece of beauraceacy, this is just another layer?" He referred to his conversation with Senator Barringer about repurposing some staff. Will there be a reduction in county services. How is this not just another layer for us to fund without being affective?"

In response, Ms. Wall stated that the vision of the Working Group is that the Regional Office will be a means of getting closer to the ground, getting it closer to the counties so that they may respond more quickly in a more systemic, organized way.

Representative Fisher appreciated the fact that these recommendations are still optional for counties and regions to come together around the plan. She asked if any discussion took place in the Working Group about the need for extra funding to implement the plan.

Ms. Wall responded that the Working Group did not have a robust conversation about the issue of additional funding. For regional departments, there will be a significant financial lift, especially on the front end to get the plan up and running. Ms. Wall called attention to the Social Services Working Group's website listed in the report that includes: All materials from all meetings; the webcasts are recorded and posted; and also an email address for the Social Services Working Group. "All emails are posted on-line and made available to the group. If you have thoughts, anywhere along the line, I encourage you to send them in. The Group will welcome them," she said.

Representative Farmer-Butterfield asked for a description of how the regional system currently exists. Ms. Wall's response was that it varies from program to program. Representative Farmer-Butterfield further asked if there had been any feedback from local DSS about regionalization. What expectations do you have from them? Ms. Wall was not aware of any surveys or official data gathering on levels of interest. Ms. Wall did say that a lot of concern was expressed during the time the legislature was considering a version of the bill that would have mandated regional departments of social services.

As follow-up, the Representative inquired about the possibility of doing both. "The Regional State Offices are not empowered to provide services. They do, however, have the authority to temporarily assume administration if there are on-going compliance problems or an urgent situation arises," she responded.

Representative White expressed concern for those counties that are doing a good job and have County Commissioner support. She inquired, "If we go to Stage Two, a mandatory regional center, how would that impact local support agencies such as the sheriff departments, aging department, public health department, all of these departments are aware of each other's clients and pull together to provide resources needed. "These local agencies feel they would loose their connectivity," she said.

Ms. Wall reiterated that it's not just the county DSS but a wide network of private providers and community groups but also other groups that support the community. It's a large web but we are focused strictly on one small piece.

Representative Cunningham asked if there was a set timeframe for corrective action to take place. "The report and current bodies of law include some timeframes. The Corrective Action Plan does include some tight timeframes," Ms. Wall replied.

Representative Cunningham cited page 25. "Extended Non-Compliance; is that new? Ms. Wall responded that it is currently not in law. The group did discuss to increase local oversight.

Representative Cunningham expressed concern about keeping everyone *in line* with so much flexibility, no structure and lack of structure.

Senator Barringer responded that the goal is, with proper oversight and the relationship between DHHS, Regional Offices, and counties, they will know each other and be able to work with a flexible system. All regions are different and all situations are different. The committee wanted to make certain that when a critical need arises, the need may be addressed immediately. If the need is a more long-term process-type situation, that the county will have time to react.

Senator Barringer closed by thanking committee members for their feedback and stating that the committee is making tough recommendations and tough decisions that are affecting the lives of children. "We are listening," she concluded.

Chairman Lambeth encouraged committee members, after reading the report and hearing the presentation, to re-read the report and provide additional feedback.

IV. Presentation of Draft Committee Report

Chairman Lambeth thanked committee staff for the tremendous amount of support they have provided to committee members over the past several months.

He called upon Theresa Matula to present the draft committee report that corresponds to the recommendations that the committee approved at its March 13th, 2018 meeting. Members received the report via email the previous week. She provided a recap of the committee's work during the Interim and read the recommendations of the committee contained in the report:

Recommendation 1: Continuation of the Subcommittee on Aging

Recommendation 2: Continued Study and Development of a Plan to Support Medical Education and Medical Residency Programs in a manner that addresses the healthcare needs of the State

Recommendation 3: Development of the Measurable Objectives to be used when funding Medical Education and Residency Programs

Recommendation 4: Implementation of a Statutory Framework for Telemedicine in North Carolina and Study of Issues Related to Telemedicine

Recommendation 5: North Carolina Participation in the Psychology Interjurisdictional Compact (PSYPACT)

Recommendation 6: Health Issues in Local Confinement Facilities

V. Committee Discussion/Vote on Draft

Senator Tucker asked if an appropriation would be required to implement PSYPACT and Telemedicine recommendaitons. Ms. Matula responded that no appropriation was required. The Telemedicine bill puts a structure in place and requires further study of issues related to Telemedicine. The PSYPACT would simply allow psychologists in other states to provide services to North Carolina residents if they are not licensed in North Carolina.

Chairman Lambeth provided clarification regarding the potential of additional appropriation funding for medical education. There are areas in which the GA provides funding for medical education. There was a lot of fact-finding into where we are investing resources. "Quite frankly, we ran out of time," he said. The question for the committee is: With more time, can we look at those resources and ask is there a better way to reallocate or reinvest those resources in other areas?