NORTH CAROLINA GENERAL ASSEMBLY

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES

REPORT TO THE 2014 SESSION OF THE 2013 GENERAL ASSEMBLY OF NORTH CAROLINA

APRIL 2014

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April 17, 2014

To: Lieutenant Governor Dan Forest, President of the Senate
Senator Philip E. Berger, President Pro Tempore of the Senate
Representative Thom Tillis, Speaker of the House of Representatives
Members of the 2014 Regular Session of the 2013 General Assembly

Pursuant to Article 23A of Chapter 120 of the North Carolina General Statutes, the Joint Legislative Oversight Committee on Health and Human Services has been meeting to examine the systemwide issues affecting the development, budgeting, financing, administration and delivery of health and human services. Accordingly, the Committee respectfully submits the following report on issues studied during the 2013-2014 interim.

Respectfully,

Senator Ralph Hise, Jr,
Co-Chair

Representative Justin Burr
Co-Chair

Representative Mark Hollo
Co-Chair

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COMMITTEE MEMBERSHIP

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EXECUTIVE SUMMARY OF RECOMMENDATIONS

The following is an executive summary of the recommendations from the Joint Legislative Oversight Committee on Health and Human Services. These recommendations, and the findings upon which they are based, can be found under the Committee Findings and Recommendations section of this report. These recommendations have been arranged by topic and many of them represent the work of three subcommittees.

Midwives

MIDWIVES RECOMMENDATION: SUPPORT THE INTRODUCTION OF THE UPDATE/MODERNIZE MIDWIFERY PRACTICE ACT BY THE GENERAL ASSEMBLY.
The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Midwives Subcommittee and supports allowing introduction of the bill [2013-LUz-137] recommended by this Subcommittee in order to facilitate further discussion and debate on this topic during the 2014 Session.

Public Guardianship

PUBLIC GUARDIANSHIP RECOMMENDATION 1: FURTHER STUDY OF PUBLIC GUARDIANSHIP - APPOINTMENT OF A SUBCOMMITTEE
The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and in accordance with the authority granted in G.S. 120-208.2(d), the Committee cochairs will consider appointing a subcommittee during the 2014-15 interim for continued study of public guardianship issues.

PUBLIC GUARDIANSHIP RECOMMENDATION 2: OVERSIGHT/STATUS REPORTS
The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and recommends enactment of legislation [2013-SHz-9] by the General Assembly to amend the requirements contained in the North Carolina General Statutes relating to the contents of the status reports that must be filed by guardians with the clerk of superior court and to require all general guardians and guardians of the person to file a status report.

PUBLIC GUARDIANSHIP RECOMMENDATION 3: OVERSIGHT/COMPLAINT INVESTIGATION
The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and recommends enactment of legislation [2013-MGz-142] by the General Assembly to direct the Division of Aging and Adult Services, Department of Health and Human Services, to collaborate with the Administrative Office of the Courts to develop a plan ensuring that a protective services investigator incorporate a face-to-face observation with the ward and/or an interview with the ward as part of the complaint investigation process and report findings and recommendations to the Oversight Committee on or before October 1, 2014.

PUBLIC GUARDIANSHIP RECOMMENDATION 4: CONFLICTS OF INTEREST - GENERALLY
The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and in accordance with the authority granted in G.S. 120-

208.2(d), the Committee cochairs will consider appointing a subcommittee during the 2014-15 interim to study potential conflicts of interest between guardians, wards, and service providers.

PUBLIC GUARDIANSHIP RECOMMENDATION 5: CONFLICT OF INTEREST - CHILD WELFARE CASES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and recommends enactment of legislation [2013-MGz-142] by the General Assembly to direct the Division of Social Services, Department of Health and Human Services, to study the issue of conflicts of interest in child welfare cases, and report findings and recommendations to the Oversight Committee on or before October 1, 2014.

PUBLIC GUARDIANSHIP RECOMMENDATION 6: CONFLICT OF INTEREST - REPRESENTATIVE PAYEE

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and in accordance with the authority granted in G.S. 120-208.2(d), the Committee cochairs will consider appointing a subcommittee during the 2014-15 interim to study the issue relating to guardians being designated as representative payee of a ward's disability benefits as well as of other public funds.

PUBLIC GUARDIANSHIP RECOMMENDATION 7A: GUARDIAN AS PAID SERVICE PROVIDER

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and recommends enactment of legislation [2013-MGz-142] by the General Assembly to direct the Department of Health and Human Services to continue utilizing safeguards already in place regarding guardians as paid service providers, and to direct the Divisions of Aging and Adult Services and Social Services, Department of Health and Human Services, to consult with the clerks of superior court, the LME/MCOs, the North Carolina Bar Association Section on Elder Law, and any other interested groups, to develop a transition plan for situations when a parent/caregiver is no longer able to provide care or to serve as a guardian, with the specific goal of formulating a plan that will avoid the necessity of making an individual a ward of the State. The Department shall report findings and recommendations to the Oversight Committee on or before October 1, 2014.

PUBLIC GUARDIANSHIP RECOMMENDATION 7B: OVERSIGHT/UTILIZATION OF CARE COORDINATION SERVICES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and recommends enactment of legislation [2013-MGz-142] by the General Assembly to direct the Department of Health and Human Services to study whether utilization of care coordination services would provide needed oversight to safeguard against conflicts of interest when guardians serve as paid providers and report findings and recommendations to the Oversight Committee on or before October 1, 2014.

Mental Health

MENTAL HEALTH RECOMMENDATIONS 1A AND 1B: FURTHER STUDY BY A MENTAL HEALTH SUBCOMMITTEE AND EXPANSION OF THE SUBCOMMITTEE'S CHARGE TO INCLUDE CONSIDERATION OF ISSUES RELATED TO THE NEEDS OF PERSONS WITH TRAUMATIC BRAIN INJURY

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and in accordance with the authority granted in G.S. 120-208.2(d), the Committee cochairs will consider appointing a subcommittee during the 2014-15 interim for continued study of the State's behavioral health needs, including an examination of the treatment and service needs of persons with traumatic brain injury.

MENTAL HEALTH RECOMMENDATION 2: DHHS SHOULD IMPROVE COMMUNICATION AND COORDINATION AMONG THE DIVISIONS THAT HAVE A ROLE IN THE DELIVERY OF STATE AND FEDERALLY-FUNDED BEHAVIORAL HEALTH SERVICES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to develop a strategy to improve communication and coordination among the Department's divisions that are responsible for the administration of funds or programs related to behavioral health services, especially regarding the use of public and private facilities, and to report findings and recommendations to the Oversight Committee on or before November 1, 2014. The strategy shall include a process to address shortages and deficiencies identified in the annual State Medical Facilities Plan.

MENTAL HEALTH RECOMMENDATION 3A: INCREASE OUTPATIENT, CRISIS STABILIZATION, AND TREATMENT OPTIONS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to work with the LME/MCOs to increase community-based outpatient crisis and emergency services treatment programs which allow individuals in crisis to be stabilized and treated in settings other than emergency departments and State-operated psychiatric hospitals, and to report findings and recommendations to the Oversight Committee on or before November 1, 2014.

MENTAL HEALTH RECOMMENDATION 3B: APPROPRIATE FUNDS TO INCREASE FACILITY- BASED CRISIS SERVICES FOR CHILDREN, ADOLESCENTS, AND ADULTS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the General Assembly appropriate additional community services funds to be used by the LME/MCOs to establish facility-based crisis units.

MENTAL HEALTH RECOMMENDATION 3C: APPROPRIATE FUNDING TO PILOT A BEHAVIORAL HEALTH OBSERVATION UNIT

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the General Assembly appropriate funds to pilot a 12-bed behavioral health observation unit. The purpose of the unit is to stabilize persons who are in crisis and to determine the need for further treatment or hospitalization.

MENTAL HEALTH RECOMMENDATION 3D: DHHS SHOULD DEVELOP PLAN FOR A COMPREHENSIVE ARRAY OF OUTPATIENT TREATMENT, CRISIS PREVENTION, AND INTERVENTION SERVICES THAT ARE AVAILABLE STATEWIDE

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to develop a plan to ensure that a comprehensive array of outpatient treatment, crisis prevention, and intervention services are available and accessible to children, adolescents, and adults in every LME/MCO, and to report findings and recommendations to the Oversight Committee on or before November 1, 2014. The plan developed by the Department shall ensure that an adequate number of crisis stabilization units are available in each LME/MCO.

MENTAL HEALTH RECOMMENDATION 4A: DHHS ASSESS NEED AND RECOMMEND OPTIONS TO INCREASE PSYCHIATRIC AND SUBSTANCE ABUSE INPATIENT SERVICES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to study the need for and recommend options to increase the inventory of psychiatric and substance abuse inpatient services, including additional State-operated facilities, community hospital beds, U.S. Veterans Administration beds, and community-based services that decrease the need for inpatient treatment, and to report findings and recommendations to the Oversight Committee on or before November 1, 2014.

MENTAL HEALTH RECOMMENDATION 4B: DEVELOP AND IMPLEMENT INCENTIVES TO INCREASE THE INVENTORY OF LICENSED INPATIENT PSYCHIATRIC SERVICES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to develop a plan to incentivize hospitals and other entities to apply for licenses for new inpatient behavioral health services and/or to begin operating existing beds that are currently licensed but unstaffed, and to report findings and recommendations to the Oversight Committee on or before November 1, 2014.

MENTAL HEALTH RECOMMENDATION 4C: PROGRAM EVALUATION DIVISION STUDY AND MAKE RECOMMENDATION TO IMPROVE THE CERTIFICATE OF NEED PROCESS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the Program Evaluation Division (PED), NCGA, study the Certificate of Need (CON) process to determine if it is a barrier to increasing the availability of inpatient psychiatric and substance abuse treatment services in the State. The study shall include a review of the impact of CON regulations prohibiting the transfer of licensed inpatient psychiatric beds across county lines. As part of the review, PED shall seek the input of the Department of Health and Human Services, the NC Hospital Association, and other inpatient service providers, to develop recommendations for streamlining the CON process. The Program Evaluation Division shall report its findings and recommendations no later than April 1, 2015.

MENTAL HEALTH RECOMMENDATION 4D: DHHS STUDY AND MAKE RECOMMENDATIONS ON THE FEASIBILITY OF USING EXISTING CHERRY HOSPITAL BUILDINGS TO PROVIDE COMMUNITY AND FACILITY-BASED SERVICES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the

General Assembly to direct the Department of Health and Human Services (DHHS) to study and make recommendations on the use of the existing Cherry Hospital buildings after patients and operations are relocated to the replacement facility. As part of the study, DHHS shall assess the condition and develop an inventory of every building located on the existing Cherry Hospital campus. The study shall include an examination of the feasibility of using the existing Cherry Hospital facility to provide community and facility-based behavioral health services, including additional child and adolescent inpatient beds, and to report findings and recommendations to the Oversight Committee on or before November 1, 2014.

MENTAL HEALTH RECOMMENDATION 5A: EXPAND AND TARGET THREE-WAY CONTRACT FUNDING TO INCREASE THE NUMBER OF LICENSED CHILD/ADOLESCENT PSYCHIATRIC BEDS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the General Assembly appropriate expansion funding for the three-way contracts that will be targeted specifically to increase the number of licensed child/adolescent psychiatric beds in areas of the State that have the greatest need for these beds.

MENTAL HEALTH RECOMMENDATION 5B: DHHS TO DEVELOP A STRATEGY TO INCREASE CHILD/ADOLESCENT INPATIENT PSYCHIATRIC BEDS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to collaborate with the relevant stakeholders to develop a comprehensive strategy to address the dearth of licensed child/adolescent inpatient psychiatric beds throughout the State and to report findings and recommendations to the Oversight Committee, and to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services, on or before March 1, 2015. The strategy shall ensure that an adequate inventory of child and adolescent beds are available in the catchment areas of each LME/MCO. The plan shall include the development and implementation of a child/adolescent psychiatric bed registry to provide real-time information on the number of beds available at each licensed inpatient facility in the State.

MENTAL HEALTH RECOMMENDATION 5C: DHHS SHOULD TRACK AND SEPARATELY REPORT ON THE INVENTORY OF CHILD BEDS AND ADOLESCENT BEDS SEPARATELY

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Division of Health Service Regulation, Department of Health and Human Services, to begin tracking and providing separate reports no later than January 1, 2015, on the inventory of inpatient behavioral health beds for children ages six through 12 and for adolescents over age 12.

MENTAL HEALTH RECOMMENDATION 5D: PROGRAM EVALUATION DIVISION STUDY AND MAKE RECOMMENDATION TO IMPROVE THE CERTIFICATE OF NEED PROCESS FOR CHILD AND ADOLESCENT INPATIENT PSYCHIATRIC BEDS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the Program Evaluation Division (PED), NCGA, review the Certificate of Need (CON) process to determine if it is a barrier to increasing the

availability of child and adolescent inpatient psychiatric beds in the State. As part of the review, PED shall seek the input of the Department of Health and Human Services, the NC Hospital Association, and other inpatient service providers to develop recommendations for streamlining the CON process and providing incentives to increase CON applications for child and adolescent psychiatric beds. The Program Evaluation Division shall report its findings and recommendations no later than April 1, 2015.

MENTAL HEALTH RECOMMENDATION 6A: ESTABLISH A LEGISLATIVE STUDY COMMITTEE TO EXAMINE THE IMPACT OF JUDICIAL ACTIONS ON THE STATE PSYCHIATRIC HOSPITALS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and in accordance with the authority granted in G.S. 120-208.2(d), the Committee cochairs will consider appointing a subcommittee during the 2014-15 interim for continued study of how judicial actions impact the inventory of available beds at State operated psychiatric hospitals.

MENTAL HEALTH RECOMMENDATION 6B: PROGRAM EVALUATION DIVISION STUDY THE IMPACT OF INVOLUNTARY COMMITMENTS AND INCAPACITY TO PROCEED ORDERS ON THE STATE PSYCHIATRIC HOSPITALS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the Program Evaluation Division (PED), NCGA, study the impact of judicial actions on admissions to the State-operated psychiatric hospitals and report its findings and recommendations no later than April 1, 2015.

MENTAL HEALTH RECOMMENDATION 7A: APPROPRIATE FUNDS TO EXPAND THE STATE TELESPSYCHIATRY PROGRAM TO PRIMARY CARE SETTINGS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the General Assembly appropriate funds to expand State-funded telepsychiatry services to primary care settings.

MENTAL HEALTH RECOMMENDATION 7B: APPROPRIATE FUNDS TO ESTABLISH ADDICTION PSYCHIATRY RESIDENCIES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the General Assembly appropriate funds to establish two addiction psychiatry residency fellowships. The fellowships will prepare two psychiatrists per year as subspecialists in addiction medicine to meet an expanding need for prevention, direct patient care, teaching and research into recognition, diagnosis, and treatment of substance use disorders.

MENTAL HEALTH RECOMMENDATION 7C: FULLY IMPLEMENT THE 2008 MENTAL HEALTH COMMISSION WORKFORCE DEVELOPMENT PLAN

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to report to the Oversight Committee on the status of the implementation of the 2008 Mental Health Commission Workforce Development Plan no later than November 1, 2014.

MENTAL HEALTH RECOMMENDATION 8: DHHS SHOULD DEVELOP MEANINGFUL OUTCOME MEASURES ON THE IMPACT OF TREATMENT AND SERVICES PROVIDED BY ALCOHOL AND DRUG ABUSE TREATMENT CENTERS (ADATC)

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to develop meaningful outcome measures of the impact of ADATC treatment on an individual's substance use following discharge and to report to the Oversight Committee, and to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services on or before March 1, 2015.

Medicaid

MEDICAID RECOMMENDATION 1: STATE PLAN AMENDMENTS

The Joint Legislative Oversight Committee on Health and Human Services recommends enactment of legislation [2013-MEz-100] by the General Assembly to specify additional procedures related to notice and submission of State Plan Amendments and waivers.

Child Protective Services

CHILD PROTECTIVE SERVICES RECOMMENDATION 1: ADEQUATE FUNDING FOR CHILD PROTECTIVE SERVICES

The Joint Legislative Oversight Committee on Health and Human Services recommends that funding be identified to provide adequate resources for local county departments of social services to provide Child Protective Services to protect abused, neglected and dependent children and youth.

CHILD PROTECTIVE SERVICES RECOMMENDATION 2: CONDUCT A STATEWIDE EVALUATION AND PILOT PROJECT FOR CHILD PROTECTIVE SERVICES

The Joint Legislative Oversight Committee on Health and Human Services recommends that a comprehensive independent statewide evaluation be conducted of Child Protective Services performance, caseload sizes, administrative structure, funding, worker turnover, and monitoring and oversight. The evaluation should include recommendations for improvements in Child Protective Services. Further, it is recommended that a pilot program, including an evaluation, be conducted that is designed to enhance coordination of services and information sharing among local county departments of social services, local law enforcement, the court system, Guardian Ad Litem programs, and other agencies as determined appropriate by the Department of Health and Human Services.

COMMITTEE PROCEEDINGS

The Joint Legislative Oversight Committee met eight (8) times between October 2013 and April 2014. This section of the report provides a brief overview of topics and presenters for each meeting and a summary of the proceedings for each meeting. Detailed minutes and handouts from each meeting are available in the Legislative Library. Agendas and handouts for each meeting are available at the following link:
http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=144

Overview of Topics and Presenters

October 8, 2013 – Morning Meeting
(The morning meeting was a joint meeting with the Joint Legislative Oversight Committee on Information Technology.)

- **North Carolina Tracks**
  - Project History - Larry Yates, Program Evaluation Division, NCGA
  - Medicaid Provider Panel (Various Providers)
  - NC Tracks Vendor - Mike Gaffney, Computer Sciences Corporation (CSC)
  - Department of Health and Human Services - Dr. Aldona Wos, Secretary, DHHS
- **North Carolina Families Accessing Services Through Technology (NC FAST)**
  - Project History - Deborah Landry, Fiscal Research Division, NCGA
  - NC FAST Vendors - Buffie Rodri, Accenture; Rick Helfer, IBM
  - Department of Health and Human Services - Dr. Aldona Wos, Secretary, DHHS

October 8, 2013 – Afternoon Meeting

- **Committee Charge, Subcommittee Authorization, Staff Support** - Theresa Matula, Research Division, NCGA
- **2013 Session: Legislative Overview**
  - 2013 Appropriations Act (S.L. 2013-360) – Medicaid Items - Steve Owen, Fiscal Research Division & Ryan Blackledge, Legislative Drafting Division, NCGA
  - Safeguard Qualified Individuals- Medicaid PCS (S.L. 2013-306) - Theresa Matula, Research Division, NCGA
  - Warrant Status/Drug Screening Public Assistance (S.L. 2013-417) - Amy Jo Johnson, Research Division, NCGA
- **Department of Health and Human Services (DHHS) Budget Update** - Pam Kilpatrick, Assistant State Budget Officer, Office of State Budget and Management (OSBM)
- **Medicaid Reform: Status Update** (S. L. 2013-360, Section 12H.1)- Dr. Aldona Wos, Secretary, DHHS
- **DHHS Update on Select Topics:**
  - Employee Salaries and Contracts
  - Implementation of Medicaid Budget Adjustments (Status of State Plan Amendments)
  - Personal Care Services (S.L. 2013-306)
  - Drug Screening Public Assistance (S.L. 2013-417)
  - Non-Emergency Medical Transportation
  - Status Update: Local Management Entity/Managed Care Organization
  - Departmental Reorganization
  - Additional Comments

November 19, 2013

- **Medicaid Budget Update** - Susan Jacobs and Steve Owen, Fiscal Research Division, and Jennifer Hillman, Research Division, NCGA; and Pam Kilpatrick, Assistant State Budget Officer, OSBM
- **Status of Medicaid State Plan Amendments (SPAs)** - Sandy Terrell, Acting Director, Division of Medical Assistance, DHHS
  Personal Care Services (PCS) Update
  Medicaid Presumptive Eligibility Follow-Up on NC Tracks - Joe Cooper, Chief Information Officer (CIO), DHHS
- **Overview of Medicaid Reform Approaches Across the US** - Bob Atlas, Consultant, DHHS
- **US DOJ Agreement Implementation** - Jessica Bradley Keith, Special Advisor on ADA, DHHS
  - Status of Housing Slots
- **2013 Enacted Mental Health Legislation Overview** - Jan Paul, Research Division, NCGA
- **Mental Health Topics** - Dr. Aldona Wos, Secretary, DHHS, and Dave Richard, Director, MH/DD/SAS, DHHS
  - New Mental Health Initiative
  - LME/MCO Overview
  - Status of Meck LINK
- **DHHS Update on Select Topics** - Dr. Aldona Wos, Secretary, DHHS; Joe Cooper, CIO, DHHS; and Sherry Bradsher, Deputy Secretary of Human Services, DHHS
  - Health Information Exchange Status
  - Impact of Federal Shutdown
- **Subcommittee Appointments**
  - Certified Nurse Midwives (S.L. 2013-360, Section 12I.2)
  - Impact of 1915(b)(c) Medicaid Waiver and Other Mental Health System Reforms on Guardianship (S.L. 2013-258, Section 3)
  - Oversight of CSC Contract Performance & NC Tracks Implementation
  - Mental Health

December 10, 2013

- **Budget Implementation Updates**
  - Department of Health and Human Services (DHHS) Contingency Plan for Expiration of Federal Continuing Resolution/Potential Shutdown in January 2014 - Art Pope, State Budget Director, OSBM; and Sherry Bradsher, Deputy Secretary of Human Services, DHHS
  - Medicaid Budget & Claims Payment Update - Steve Owen, Fiscal Research Division, NCGA
  - DHHS Budget Update - Pam Kilpatrick, Asst. State Budget Officer, OSBM
  - Pre-K Impacts Due to Sequester Impact on Head Start - Rob Kindsvatter, Director, Division of Child Development & Early Education
- **Medicaid-Related Updates** - Sandy Terrell, Acting Director, Division of Medical Assistance (DMA), DHHS
  - Shared Savings Plan Update (S.L. 2013-360, Section 12H.18(a))
  - Medicaid Cost Containment Activities (S.L. 2013-360, Section 12H.26)
  - Medicaid Reform Update (S.L. 2013-360, Section 12H.1)

- Status of Budget-Directed Medicaid State Plan Amendments
- **Health Information Technology Updates** - Joe Cooper, CIO, DHHS
  - NC Tracks Follow-Up; Costs Associated with Full Implementation of NC Tracks (S.L. 2013-360, Section 12A.4(g)(2))
  - Plan for Elimination of the Office of Medicaid Management Information System Services (S.L. 2013-360, Section 12A.4(g)(3))
  - Health Information Exchange Status (S.L. 2013-363, Section 4.18)
- **Impact of Pashby and Bowditch Cases on Personal Care Services (PCS)**
  - Summary and Status of Cases - Iain Stauffer, Special Deputy Attorney General, NC Department of Justice
  - Budget Impact of Cases - Sandy Terrell, Acting Director, DMA, DHHS
- **Mental Health-Related Updates** - Dave Richard, Director, DMH/DD/SAS, DHHS and Dr. Robin Cummings, M.D., Deputy Secretary, DHHS
  - New Policy on Mental Health Treatment for Adopted Children on Medicaid
  - Three-Way Contracts & Implementation of Two-Tiered System of Payment for Purchasing Inpatient Psychiatric Beds (S.L. 2013-360, Section 12A.2B(a))
  - Plan for Statewide Telepsychiatry Program

January 14, 2014

- **Remarks**- Dr. Aldona Wos, Secretary, DHHS
- **Budget Updates**
  - Trends in Medicaid Spending and Data - Susan Jacobs and Steve Owen, Fiscal Research Division, NCGA
  - DHHS Budget Update - Rod Davis, Chief Financial Officer, DHHS
  - Medicaid Budget Update/Implementation of Reductions - Sandy Terrell, Acting Director, Division of Medical Assistance, DHHS
- **Accountable Care Organizations** - Bob Atlas, Consultant, DHHS
- **Child Protective Services**
  - Background Checks/Criminal History - Wayne Black, Director, Division of Social Services (DSS), DHHS
  - State Oversight of County Programs - Wayne Black, Director, DSS, DHHS
  - Historical Funding and Trend Analysis - Deborah Landry, Fiscal Research Division
- **Managing Emergency Closures of Residential Facilities** - Dennis Streets, Director, Division of Aging and Adult Services, DHHS

February 11, 2014

- **Medicaid Budget Update** - Pam Kilpatrick, Assistant State Budget Officer, OSBM; and Rod Davis, CFO, DHHS
- **Child Protective Services Programs in Other States** - Deborah Landry, Fiscal Research Division, NCGA
- **Pre-K and Smart Start** - Deborah Landry, Fiscal Research Division, NCGA
  - Focus of Child Development and Early Education - Rob Kindsvatter, Director, Division of Child Development & Early Education, DHHS
  - NC Pre-K Pilot Program Status (S.L. 2013-360, Sec 12B.1(f)) - Rob Kindsvatter, Director, Division of Child Development & Early Education, DHHS
  - NC Partnership for Children - Dr. Nancy H. Brown, Chair, The North Carolina Partnership for Children Board

- **Medicaid Eligibility Extension Related to MAGI** - Ryan Blackledge, Legislative Drafting Division, NCGA; and Sandy Terrell, Acting Director, DMA, DHHS
- **ACO Models & Savings – Other States -** David Rice, Fiscal Research Division, NCGA
- **Medicaid Shared Savings Plan Update -** Sandy Terrell, Acting Director, DMA, DHHS
- **Update on Status of Broughton and Cherry Hospital Construction Projects -** Luke Hoff, Director, Property & Construction Division, DHHS
- **Health Information Exchange (HIE) Status Report -** Chris Scarboro, President, NC Health Information Exchange
- **Implementation of Transparency Provisions** (S.L. 2013-382) - Drexdal Pratt, Director, Division of Health Service Regulation, DHHS
- **Status of Staffing at DHHS -** Mark Gogal, Director, Human Resources, DHHS
  - Ideas to Address Staffing Concerns and Update on Medicaid Director Search - Dr. Aldona Wos, Secretary, DHHS
- **Status of Nonprofit Organizations/Establishment of Competitive Grant Process** (S.L. 2013-360, Sec 12A.2(e)) - Sherrie Settle, Associate Director, Contracts, Grants and Compliance, DHHS

March 12, 2014

- **Secretary's Comments -** Dr. Aldona Wos, Secretary, Department of Health and Human Services (DHHS)
- **Subcommittee Reports**
  - Certified Nurse Midwives Subcommittee (S.L. 2013-360, Section 12I.2) - Barbara Riley, Research Division and Lisa Wilks, Legislative Drafting Division, NCGA
  - Impact of Mental Health Reforms on Public Guardianship Subcommittee (S.L. 2013-258, Section 3) – Jan Paul, Research Division, NCGA
  - Mental Health Subcommittee - Denise Thomas, Fiscal Research Division, NCGA
- **Division of Public Health Updates**
  - Review of Revised Statewide Oral Health Strategic Plan (S.L. 2013-360, Section 12E.2(c) - Danny Staley, Deputy Director & Chief Operating Officer, Division of Public Health (DPH), DHHS
  - Update on Implementation of Reductions to Children's Developmental Services Agencies (S.L. 2013-360, Section 12E.4) - Dr. Kevin Ryan, Chief, Women's & Children's Health Section, DPH, DHHS
- **Information Technology Updates** - Joe Cooper, Chief Information Officer, DHHS
  - NC Tracks Follow-up
  - Review of Detailed Plan for MH/DD/SAS Health Care Information System Project (S.L. 2013-360, Section 12F.5)
- **LME/MCO Consolidation Update** - Dave Richard, Director, Division of Mental Health, Developmental Disabilities & Substance Abuse Services, DHHS
- **Medicaid-Related Updates** – Dr. Robin Cummings, Deputy Secretary of Health Services, DHHS
  - Organizational Structure/Oversight of Division of Medical Assistance
  - Review of Contracts Supporting NC Medicaid Operations (Alvarez & Marsal; Navigant Healthcare)
  - Update on Medicaid Eligibility Extension Related to MAGI
  - Update on Development of New Regional Base Rates for Hospitals (S.L. 2013-360, Sec. 12H.20(b))

- Update on Implementation of Behavioral Health Clinical Integration Activities with CCNC (S.L. 2013-360, Section 12F.4A(e))

March 26, 2014

- **Comments from the DHHS Secretary -** Dr. Aldona Wos, Secretary, DHHS
- **Medicaid Budget Status/Forecast for FY 14/15 –** Rod Davis, CFO, DHHS and Pam Kilpatrick, Assistant State Budget Officer, OSBM
- **Required Budget Reductions** - Susan Jacobs, Fiscal Research, NCGA
- **Status of Required Budget Reductions -** Rick Brennan, CFO, DMA, DHHS
- **Medicaid Budget Model** - Steve Owen, Fiscal Research, NCGA
- **Medicaid Shared Savings Plan Report** (S.L. 2013-360, Sec. 12H.18 (a)-(c)) - Rick Brennan, CFO, DMA, DHHS
- **Medicaid Reform Report** (S.L. 2013-360, Sec. 12H.1) - Dr. Robin Cummings, Deputy Secretary for Health Services and Medicaid Transformation, DHHS; Bob Atlas, Consultant, DHHS; Mardy Peal, Senior Advisor to the Secretary, DHHS
- **Medicaid Reform: Plan for Analysis/Key Questions and Potential Areas of Concern -** Susan Jacobs and Steve Owen, Fiscal Research, NCGA

April 17, 2014

- **Comments from the DHHS Secretary -** Dr. Aldona Wos, Secretary, DHHS
- **Medicaid Budget Update –** Rod Davis, CFO, DHHS
- **Medicaid Data Analytics –** Joe Cooper, CIO, DHHS
- **NCTracks Update –** Joe Cooper, CIO, DHHS
- **NC FAST Update –** Joe Cooper, CIO, DHHS
- **Potential Savings Through the Purchase of Insurance** (S.L. 2013-360, Sec. 12H.12) – Sandy Terrell, Acting Director, Division of Medical Assistance, DHHS
- **Child Protective Services** – Deborah Landry, Fiscal Research Division, NCGA
- **Consolidation of Local Departments of Social Services and Local Divisions of Public Health**– Jan Paul, Research Division, NCGA; and Sherry Bradsher, Deputy Secretary of Human Services, DHHS
- **Presentation of Committee Report to NCGA** – Theresa Matula, Research Division, NCGA, and Committee Staff

Summary of Committee Proceedings

October 8, 2013

On the morning of October 8, 2013, the Joint Legislative Oversight Committee on Health and Human Services held a joint meeting with the Joint Legislative Oversight Committee on Information Technology to discuss issues related to the North Carolina Tracks (NCTracks) and the North Carolina Families Accessing Services through Technology (NC FAST) programs. The following information is a summary of presentations during the jointly held meeting.

Morning Meeting

NCTracks

Larry Yates, Program Evaluation Division, presented the history of North Carolina's Medicaid Management Information System (MMIS) from 1972 when the federal government required the states to operate a MMIS, through the current implementation of NCTracks. NCTracks went live on July 1, 2013.

Next, the Committees heard from a panel of Medicaid providers on various problems they have encountered with NCTracks. The panel included: Sandra Jarrett, Practice Manager of Salisbury Orthopedic Associates and Chair of the Medicaid Committee for NC Medical Group Managers Association; Susan Fountain, Onslow Radiology Center; Kimberly Lynn, Operations Manager of Carolina Apothecary and Chair of the NC Association of Home Medical Equipment; Lisa Arnold, Nurse and Practice Manager of Triangle Physicians for Women; and Sandra Williams, Chief Financial Officer of Cape Fear Valley Health System.

Mike Gaffney, Vice-President and General Manager of Computer Sciences Corporation (CSC) highlighted some of the successes of NCTracks, some of the benefits that NCTracks provides to the State and providers that were not available on the earlier system, and the progress to correct the remaining issues.

Joe Cooper, Chief Information Officer, DHHS, provided an overview of the NCTracks project, key issues still being addressed and a timeline for their resolution, the rationale for going ahead with implementation on July 1, 2013, improvement in the assistance given providers by the regional call centers, trends in the percentage of claims paid, and the training offered to providers before the implementation. He also explained how NCTracks is the first multi-payer solution in the country and should increase the effectiveness of identifying fraud and abuse.

NC FAST

Deborah Landry, Fiscal Research Division, NCGA, explained how North Carolina Families Accessing Services through Technology (NC FAST) is a program designed to improve the way that DHHS and county departments of social services conduct their business. NC FAST provides automated tools that allows workers to determine eligibility and track cases, helps to share information and coordinate services, and provides comprehensive data for evaluating program outcomes. The case management function will help determine client eligibility and services for programs including: Food and Nutrition Services, Work First, and Medicaid.

The Committees next heard from the vendors working on NC FAST. Buffie Rodri, Managing Director of Accenture, explained that the vision was to create a consolidated application that could capture all the benefit information at one time and determine eligibility across all programs. Accenture is working with DHHS staff on implementation of NC FAST. Rick Helfer, IBM team leader, explained how IBM is providing the underlying software for the project.

Wayne Black, Director of the Division of Social Services, DHHS, and Anthony Vellucci, Director of NC FAST, DHHS, updated the Committees on the progress to fully implement NC FAST. Mr. Black reviewed the status of the various projects in the NC FAST program, remaining challenges, and how DHHS has been using State NC FAST staff to help the counties process backlog cases. Mr. Vellucci reported that 96 counties were processing new applications at their normal rate and 82 counties were processing recertifications at their normal rate.

A period of public comment followed and then the joint meeting was adjourned.

Afternoon Meeting

The Committee reconvened in the afternoon and Theresa Matula, Research Division, NCGA, presented the following information: (1) the Committee charge, (2) authorization for a subcommittee to study allowing certified nurse-midwives greater flexibility in the practice of midwifery, (3) authorization for a subcommittee to examine the impact of the 1915(b)/(c) Medicaid Waiver and other mental health reforms on public guardianship services, and (4) a list of the staff from the Research Division, Bill Drafting Division, and Fiscal Research Division who will be supporting the work of the Committee.

The next item on the agenda was a review of the major Medicaid provisions in the 2013 Appropriations Act. Steve Owen, Fiscal Research Division, NCGA, reported on the major money items, including: budget change components, hospital changes, rate freezes for services subject to automatic adjustments, cost savings through drug adjustments, and shared savings plan. Ryan Blackledge, Legislative Drafting Division, NCGA, reported on the creation of the Medicaid Reform Advisory Group directed to consult with the Division of Medical Assistance, DHHS, in the creation of a detailed plan for significant reforms to the State's Medicaid Program. The budget provision states that no steps shall be taken to implement the Medicaid reform plan until the General Assembly authorizes the change. Mr. Blackledge also reported on the changes made in the State Plan Amendments (SPAs) process and additional Medicaid changes including that the State Plan now has the force and effect of rules, changes to post-payment review and recovery audit contracts and that CCNC must set and pay per member per month payments to providers.

Next, was an overview of two bills enacted during the 2013 Session: Safeguard Qualified Individuals- Medicaid PCS (S.L. 2013-306) and Warrant Status/Drug Screening Public Assistance (S.L. 2013-417). Theresa Matula, Research Division, NCGA, reviewed the provisions of the first bill, Safeguard Qualified Individuals- Medicaid Personal Care Services (PCS) (S.L. 2013-306), that would allow eligible Medicaid recipients to receive up to 130 hours per month of PCS instead of the current maximum of 80 hours per month. The Department of Health and Human Services is directed to apply for a Medicaid State Plan Amendment (SPA) necessary to implement the Act. The law also requires the Department to reduce the PCS rates in order to fund the additional service hours and remain within the budgeted amount of funds for PCS. Amy Jo Johnson, Research Division, NCGA, reviewed the second bill Warrant Status/Drug Screening Public Assistance (S.L. 2013-417). The first part of the bill would require a county department of social services to verify whether an applicant for, or recipient of, Temporary Assistance to Needy Families (TANF) or Food and Nutrition Services (FNS) benefits is a fleeing felon or a probation or parole violator. The eligibility of a member of the individual's household for those benefits would not be affected. The second part of the bill requires drug screening and testing for applicants for or recipients of Work First Program assistance when there is reasonable suspicion to believe that the individual is illegally using controlled substances.

Pam Kilpatrick, Assistant State Budget Officer, Office of State Budget and Management, reviewed the Medicaid budget and expenditures as of September 30, 2013. Medicaid total spending is ahead

of target and it's too early to evaluate actual Medicaid performance to help in forecasting future appropriation needs. Some of the variables to consider for forecasting future Medicaid appropriation needs include: impact of delayed provider payments because of NCTracks problems, changes resulting from implementation of the federal Affordable Care Act (ACA), budget savings resulting from waivers in the Medicaid State Plan Amendments (SPAs), and "normal" variables such as enrollment volume, utilization and mix of services consumed, and how the actual activity tracks the forecast. Ms. Kilpatrick concluded her presentation with information about the impact of the federal shutdown on the mandatory federal programs, Temporary Aid to Needy Families (TANF), Social Services Block Grant (SSBG), and Child Care Development Fund (CCDF) block grants and the discretionary Women, Infants and Children (WIC) program. Congress failed to enact a budget or a continuing resolution for federal FY 2014. According to OSBM guidance, federally funded programs could not incur obligation after September 30th in the absence of federal cash on hand or funding from a prior fiscal period. State departments could not spend any State monies on programs which are 100% federally funded or increase State funding of partially funded federal programs.

Department of Health and Human Services Secretary, Dr. Aldona Wos, reported on the status of Medicaid reform. She noted that DHHS would propose a Medicaid reform plan by March 17, 2014, as mandated by the General Assembly, to strengthen Medicaid operations and improve the ability to forecast Medicaid costs to the State. The plan would be designed to meet the needs of both Medicaid providers and recipients by taking into account the unique healthcare needs of the State's diverse population and the geography of the State. DHHS has conducted nearly 100 hours of meetings with stakeholders across the State and plans to continue to reach out to stakeholders and national experts in the area of Medicaid reform for their input.

The final agenda item was an update by DHHS on various topics. The first presentation was on departmental reorganization. Secretary Wos reported that the Departmental reorganization was undertaken to increase accountability, eliminate duplication, and streamline services. Mark Payne, Chief of Staff, reviewed the current Department organizational chart and discussed the composition of the Secretary's senior leadership team. Mark Gogal, Director of Human Resources, gave an overview of the DHHS workforce. He noted that there are about 18,000 positions in DHHS, 16,500 are filled and 1,500 are vacant. Positions are assigned a job title with a corresponding salary range using the Office of State Human Resources (OSHR) classification and salary plan. Salaries for filling open positions are determined based on the position's responsibilities and critical skills needed, the individual's qualifications, education, competencies, and relevant experience, and in accordance with the existing OSHR salary administration guidelines and procedures. Personal Services Contracts are used to bring in people with needed expertise for a limited period of time when no talent is readily available inside the department. Personal Services Contracts must comply with previously existing policy and procedures.

Dave Richard, Director of Mental Health, Developmental Disability and Substance Abuse Services, DHHS, explained that all 100 counties have completed the transition to the managed care services for Medicaid behavioral health services as of April 1, 2013. DHHS has identified several areas for improvement, including oversight, contracts and finances. DHHS has instituted monthly performance report cards for each Local Management Entity/Managed Care Organization (LME/MCO) to look at the numbers of people served, authorizations for services, rate of admissions to community psychiatric hospitals, number of claims and percent processed, and number of complaints. There is also a monthly report card to examine the financial viability of each LME/MCO. A contract may be terminated if standards are not met for 3 consecutive months.

Dr. Robin Cummings, Deputy Secretary, DHHS, updated the Committee on the new Statewide Telepsychiatry Program. The goal of the program is to improve access to mental health professionals and improve quality of care in underserved areas. A two-year contract was finalized with East Carolina University to operate the program. Currently, 18 hospitals are participating in the program and 43 additional hospitals are on a waiting list to participate.

Sandy Terrell, Acting Medicaid Director, DHHS, explained that in 2013 the General Assembly authorized up to 50 additional hours of Medicaid Personal Care Services (PCS) for qualified individuals and the Department was directed to reduce the rate for PCS in order to fund the additional service hours and still remain within budgeted amounts. The Department has been monitoring expenditures and utilization patterns to determine if the rate for PCS may be modified. The rate for PCS submitted to CMS on October 1, 2013, was $13.12, which is below the first quarter rate of $15.52. She said that the budget would be monitored to see if there was an opportunity to increase the rate and still stay within the budget.

Wayne Black, Director of the Division of Social Services, DHHS, gave an update on the drug screening for public assistance initiative. He stated that the Department is looking at the types of drugs that might be tested, the testing methods that might be available, and the policies/procedures used in other states with similar programs. The Department is also working with the counties to get thorough cost information and a better understanding of how the law can be implemented.

Sandy Terrell, Acting Medicaid Director, DHHS, reported on the implementation of the Medicaid budget adjustments and the status of State Plan Amendments (SPAs). She explained the process for getting approval of a SPA by the Center for Medicare and Medicaid Services (CMS). The Department will submit over 90 SPAs this fiscal year. In comparison, DHHS has submitted an average of 25 SPAs per year to CMS over the last five years.

Dennis Streets, Director of the Division of Adult and Aging Services, DHHS, provided information on non-emergency medical transportation. In 2012, the General Assembly directed the Department to study the merits of a statewide brokerage model for managing non-emergency medical transportation (NEMT). The Department determined that a brokerage model would not produce savings so the current operating model at the county level was left in place. The next steps are to share best practices for operational efficiencies, evaluate county expenditure data for cost savings, and improve customer service.

November 19, 2013

The meeting began with several presentations that provided an update on the status of the Medicaid budget. Susan Jacobs, Fiscal Research Division, NCGA, explained that complete claims data is not available because of the problems with NCTracks. The lack of complete claims data makes it difficult to forecast where the Medicaid budget will stand at the end of the fiscal year (FY). Fiscal Research staff are continually looking at the risk factors, what information is unknown, and what needs to be monitored in order to do more than just talk about where they think the Medicaid budget is right now. Overall, the Medicaid budget is within the approved budget for the first four months of FY 2013-14, but this assumes no unreported or unrecognized liabilities and the reasonableness of the estimates of unprocessed claims and unrecorded NCTracks costs. Steve Owen, Fiscal Research Division, NCGA, reviewed the budget risks and areas that need focused monitoring. The drivers of the Medicaid budget, enrollment, the mix of the enrollment, utilization, and policy decisions, affect the expenditures for Medicaid. Jennifer Hillman, Research Division, NCGA, provided information about Medicaid presumptive eligibility under the Affordable Care Act (ACA) and its effect on the Medicaid budget. Beginning January 1, 2014, the ACA will require states

to expand the categories of beneficiaries covered by presumptive eligibility and qualified hospitals may elect to make presumptive eligibility determinations.

Next, Mr. Owen presented information on Medicaid administrative costs in North Carolina and how they compare to administrative costs in other state programs of similar size. He said that in an "apples to apples" comparison of total administrative cost, North Carolina's percentage of administrative to total service cost are among the lowest.

Pam Kilpatrick, Assistant State Budget Officer, Office of State Budget and Management, reviewed the Medicaid budget and expenditures as of October 31, 2013. Medicaid total spending through October is ahead of target. The normal variables of the trends in consumption, utilization, mix of services and enrollment will continue to unfold throughout the year. Budget savings will be impacted by the timing and success of SPAs and DHHS implementation, implementation of the ACA, and the impact of problems with getting accurate data from NCTracks.

A series of presentations followed that were designed to update the Committee on select Medicaid topics. Sandy Terrell, Acting Medicaid Director, reported that all SPAs with an effective date of July 1, 2013 have been submitted and all SPAs with an effective date of October 1, 2013 are near completion. SPAs with an effective date in 2014, will be submitted on or before March 31, 2014. There are some concerns that achieving the savings linked with State Plan changes may be a challenge.

Sabrina Lee, Assistant Director for Long Term Care and Facility Services, gave an update on the recent Personal Care Services (PCS) program changes, including the change in the 2013 Session that authorized up to 50 additional hours of PCS for persons who meet additional eligibility criteria. She reported that the Independent Assessment Contractor has begun processing requests from physicians for additional PCS hours. Public comment on a proposed revision to clinical coverage policy 3L was mostly concerned with the reimbursement rate reduction.

Carolyn McClanahan, Chief of Eligibility Services, Division of Medical Services, DHHS, provided information on how DHHS is working to implement procedures and policies around presumptive eligibility determinations for hospitals contained in the provisions of the Affordable Care Act (ACA). Beginning January 1, 2014, qualified hospitals may opt to do presumptive eligibility for Medicaid. She described the training that DHHS has been providing to hospital personnel. Additional training and follow-up sessions will continue through the end of the year.

Joe Cooper, Chief Information Officer (CIO), DHHS, provided an update on the progress since the last Committee meeting of fully implementing NCTracks. He stated that 11 regional provider help centers were offered across the State including: Fayetteville, Winston-Salem, Charlotte, and Raleigh. Computer Services Corporation (CSC) reached more than 1,000 providers through on-line and in-person training. More regional provider help centers will continue across the State and customer service at the help centers has improved. He also identified the top issues that CSC must address, including reducing the remaining backlogs and resolving data issues in the data warehouse.

Bob Atlas, DHHS consultant, provided an overview of Medicaid reform models being tried across the country. He pointed out that North Carolina Medicaid costs are 14% above the US average and there seems to be an opportunity to get some savings. He reviewed classic cost containment measures enacted by other legislatures but also warned that they can have adverse impacts. Health cost risks can be transferred so that the State is not solely responsible for costs but they can be shared with providers. He pointed out how many Southeastern states are shifting their Medicaid spending to capitation and that managed care needs to be considered in North Carolina. Mardy

Peal, Senior Advisor to the Secretary, DHHS, reviewed the progress of the Medicaid Reform Advisory Group that is scheduled to report a plan to reform Medicaid by March 17, 2014.

Jessica Keith, Special Advisor on ADA, DHHS, gave an update on the Transitions to Community Living Initiative to transition 3,000 people with serious mental illness to a living arrangement of their choice and to ensure that appropriate supports exist for full community integration. The Department has been partnering with the LME/MCOs to work on the Transitions to Community Living Initiative and 163 individuals were in supportive housing by November 8, 2013.

Jan Paul, Research Division, NCGA, reviewed relevant legislation enacted by the General Assembly that relates specifically to LME/MCOs from the 2011 Session, the 2012 Session, and the 2013 Session.

Dave Richard, Director of Mental Health, Developmental Disability and Substance Abuse Services, DHHS, presented the new Mental Health Crisis Solutions Initiative. Because the State currently lacks an effective crisis intervention continuum that emphasizes prevention and early intervention, emergency response and stabilization services, the Initiative will focus on expanding across the State the existing strategies that work so the right services are in the right place at the right time. He mentioned that the responsibility for crisis intervention and treatment extends beyond the Department and it is important to build partnerships with other key partners. A Crisis Solutions Coalition would be created to cooperate in finding solutions to help people in crisis. Key partners include law enforcement, the criminal justice system, hospitals, EMS, community health centers, LME/MCOs, behavioral health providers, and advocacy organizations.

Mr. Richard then presented an update on LME/MCOs. He reported that all 10 LME/MCOs are online and the Department is working with the LME/MCO partners to look at future consolidations to provide a sustainable system that supports people with mental illness, developmental disabilities, and substance abuse disorders and provides cost efficiency. He also gave an update on Meck LINK working with Cardinal Innovations to develop a merged organization.

The next agenda item was a DHHS update on select topics. Joe Cooper, Chief Information Officer (CIO), reported on the status of the Health Information Exchange (NC HIE). The NC HIE was established in 2010, but was found to be unsuccessful in 2012. NC HIE merged with the NC Community Care Networks in early 2013. DHHS is in conversation with the NC HIE regarding the utilization and sharing of data in the NC HIE network.

Sherry Bradsher, Deputy Secretary of Human Services, DHHS, reported on the impact of the federal shutdown. She stated that 2,259 DHHS employees were subject to furloughs. The federal shutdown began on October 1, 2013, and all services were resumed on October 17, 2013. She highlighted the major grants and services that were impacted by the shutdown. She said that the Department would have to look at how to make sure in the future that critical staff positions and services were funded.

The membership of the four subcommittees was announced before the meeting was adjourned.

December 10, 2013

The first agenda item was a presentation on the DHHS contingency plan for the potential federal government shutdown in January 2014. Art Pope, State Budget Director, Office of State Budget and Management (OSBM), explained that the October 2013 federal government shutdown was caused when Congress failed to enact a budget for federal Fiscal Year (FY) 2014. Unless Congress acts before January 15, 2014, the federal government will shut down again. After the October 2013 shutdown, states received guidance from Congress that they will be reimbursed for any State funds

spent during a federal shutdown. It would take a Special Session of the General Assembly for State funds to be expended for these programs because the OSBM does not have authority to spend State funds from the Savings Reserve Account without an act of appropriation by the General Assembly.

Pam Kilpatrick, Assistant State Budget Director, OSBM, followed the State Budget Director with additional information about the October 2013 federal shutdown and the possibility of another federal shutdown in January 2014.

Sherry Bradsher, Deputy Secretary for Human Services, DHHS explained the steps that the Department is taking in the event of a potential future federal shutdown to mitigate the impact to services. The contingency plan is looking at three critical areas of readiness for a potential shutdown: communications, timing, and protocols.

Steve Owen, Fiscal Research Division, NCGA, presented an update on the Medicaid budget and claims payments. He reported that there is currently not enough clean claims data from NCTracks to prepare an accurate forecast for FY 2013-14. Medicaid enrollment data is critical to being able to monitor expenditures and prepare a forecast. Beginning November 1, 2013, all counties were processing new Medicaid applications through NC FAST. Fiscal Research is working with DHHS to determine the most accurate source of enrollment data. Mr. Owen also discussed the factors that will impact Medicaid expenditures during the remainder of the year.

Ms. Kilpatrick reviewed the Medicaid budget and expenditures through November 30, 2013. Some of the variables impacting the Medicaid budget are: NCTracks inability to reflect "pended claims", errors in expenditure data, and impact of the ACA.

The next agenda item was regarding the impact on Pre-K impacts from the federal sequestration reductions to Head Start. Rob Kindsvatter, Director, Division of Child Development & Early Education, DHHS, reported that Head Start serves more than 3,700 at-risk 4-year-olds (14%) of the total number of at-risk 4-year-olds. In FY 13-14, federal sequestration reduced Head Start federal funding by 5.27% causing more children to go to private child care and public school slots. He reported that the impact of the Head Start sequestration reductions was that 318 Pre-K slots could not be added.

A series of presentations followed that were designed to update the Committee on select Medicaid topics. Sandy Terrell, Acting Medicaid Director, reported on the Shared Savings Plan. DHHS is engaging stakeholders in discussions about the formation of the plan. Ms. Terrell then reported on Medicaid cost containment activities, including identifying opportunities for savings in optional services, exploring stricter eligibility criteria by monitoring hospital compliance with the new presumptive eligibility changes, and reviewing possible prior authorization requirements for certain drugs. Next, she reviewed the status of budget-directed Medicaid SPAs. She explained that CMS had been asking for additional information and DHHS was working to get the SPAs approved as quickly as possible in order to achieve the budget savings for the State. Mardy Peal, Senior Advisor to the Secretary, DHHS, ended this segment of the agenda by presenting an update on the work of the Medicaid Reform Advisory Group. A new business model is needed that will treat the whole person with the right care, in the right place, at the right time. The new system must incentivize providers to care for patients in a cost-effective and outcome-oriented manner with the costs being shared between the State and providers.

The next series of presentations were health information technology updates. Joe Cooper, Chief Information Officer, began with NCTracks. He reviewed the costs of operation and maintenance, costs of implementation, system improvements, customer service performance, dollar amount of claims paid and priority issues still needing resolution. Mr. Cooper explained that the Office of

Medicaid Management Information Systems (OMMIS), DHHS, is expected to close down by June 30, 2014 because of the implementation of NCTracks. Lastly, he reviewed the status of the requirement for hospitals to transmit Medicaid data via the NC Health Information Exchange. In addition to the DHHS and CCNC, hospitals will now be included in the discussions on this issue.

The impact of the Pashby and Bowditch cases on Personal Care Services (PCS) was the focus of the next two presentations. Iain Stauffer, Special Deputy Attorney General, NC Department of Justice, reported on the current status of the cases; and Sandy Terrell, Acting Medicaid Director, reported on the budget impact of the cases.

Dr. Courtney Cantrell, Policy Advisor for Integrated Care, DMH/DD/SAS, DHHS, began the first of a series of mental health-related updates with information about the new policy on mental health treatment for adopted children on Medicaid. Dave Richard, Director of DMH/DD/SAS, reported on three-way contracts and the implementation of a two-tiered system of payment for purchasing inpatient psychiatric beds. Dr. Robin Cummings, Deputy Secretary for Health Services, provided information on the implementation plan for a statewide telepsychiatry program. The program will ensure that persons with acute mental health or substance abuse problems that present at an Emergency Department will get timely specialized psychiatric treatment.

January 14, 2014

Susan Jacobs and Steve Owen, Fiscal Research Division, NCGA, updated the Committee on trends in Medicaid spending. The purpose of the presentation was to give the Committee members an understanding of historical Medicaid data and how to use that historical data appropriately. Based on per member per month (PMPM) data, NC seems to have instituted more effective measures to control increases in spending than other states since 2008. NC has declined overall by 11.6% on PMPM since 2008 while the US PMPM has increased overall by 6% for the same period.

Rod Davis, Chief Financial Officer, reviewed the DHHS budget as of November 30, 2013. He provided the actual expenditures as a percentage of the total appropriation expended by each division and outlined the following Medicaid budget risk factors: beneficiary increase, presumptive eligibility, flu season, SPA approval, vendor implementation, and unpaid claims backlog.

Sandy Terrell, Acting Medicaid Director, DHHS, presented an update on the Medicaid budget and the implementation of budget reductions. She reported that DHHS anticipates having all the SPAs with rate freezes approved by next month but there is still some concern about whether all of the savings can be obtained.

The next presenter, Bob Atlas, Consultant, DHHS, reported on the definition of Accountable Care Organizations (ACOs) and how they differ from Managed Care Organizations (MCOs). He discussed implementation in states that are starting to use ACOs in Medicaid. Some Medicare ACOs already exist in NC and more are emerging.

A series of presentations on Child Protective Services followed. Wayne Black, Director of the Division of Social Services, DHHS, explained the oversight and supervision requirements for natural parents, foster parents, adoptive parents, guardianship and custodians. Mr. Black also reviewed how the State has oversight of county department of social services and how a board of commissioners may adopt rules, regulations or ordinances requiring any applicant for employment to be subject to a State and federal criminal record check. Deborah Landry, Fiscal Research Division, NCGA, reported on the historical funding and trend analysis of Child Protective Services. Her presentation covered protective services expenditures and funding, protective services worker turnover rates, and investigation rate trends.

Dennis Streets, Director of the Division of Aging and Adult Services, DHHS, provided information about the procedures established by DHHS to manage emergency closures of adult residential facilities. In 2013, DHHS was faced with several cases where an adult residential facility suddenly closed and the owner/operator failed to take responsibility for planning the closure and the disposition of the residents. Secretary Wos established a work group to assure a well-planned and coordinated response to any emergency closures of adult residential facilities in the future.

February 11, 2014

The meeting began with two presentations that updated the Committee on the Medicaid budget. Pam Kilpatrick, Assistant State Budge Officer, OSBM, reviewed the Medicaid budget and expenditures through December 31, 2013. Because OSBM still doesn't have accurate data, they are relying on comparative analysis trends so the Medicaid picture is uncertain at the mid-year mark. She expects that in the second half of FY 2013-14, the adequacy of State funding for Medicaid will become clearer when DHHS can forecast revenues and expenditures, update OSBM on savings measures, ACA impacts, and when NCTracks is providing data with a higher degree of accuracy.

Rod Davis, Chief Financial Officer, DHHS, reviewed the budget as of December 31, 2013. He said that they were on target with Medicaid requirements but most of the unknown variables began January 1, 2014, including a beneficiary increase, presumptive eligibility, SPA approval, vendor implementation, and unpaid claims backlog.

Deborah Landry, Fiscal Research Division, NCGA, reported on Child Protective Services (CPS) programs in other states. She provided data on the various organizational structures of child welfare systems across the country, education and training of cps workers, and the increase in the number of cps investigations. She stated that more data is needed for a complete statewide evaluation of the administrative structure, performance, funding of CPS services and caseload sizes for CPS workers.

The next series of presentations were on child development and early education. Deborah Landry, Fiscal Research Division, NCGA, discussed the trends in appropriations, local match requirements, and services by number served for Smart Start from FY 2008-09 - forward. She then discussed the cost of Pre-K slots, funding history, number of slots, and other Pre-K program data. Rob Kindsvatter, Director of DCDEE, DHHS, reported on the progress of getting all NC Pre-K public schools licensed by July 1, 2014, classroom payment pilot study, standardized site selection, and evaluating long-term effects of participation in the program. He concluded his report with information on an improved criminal records check process for day care workers and increasing access to high quality child care. Dr. Nancy Brown, Chair of the NC Partnership for Children Board (NCPC), discussed brain development and the importance of early learning for children. She explained the relationship between the NCPC and the local Smart Start partnerships as they work together to improve early child care, early education, and child health and nutrition.

The next two presentations addressed a Medicaid eligibility extension waiver related to Modified Adjusted Gross Income (MAGI). Ryan Blackledge, Legislative Drafting Division, NCGA, described the new standard under the ACA for calculating financial eligibility for certain Medicaid recipients. He addressed the requirements for re-determining Medicaid eligibility, the impact of delaying redetermination, any legal problems with the process used by DHHS to get a waiver, and any fiscal impacts due to the waiver. Sandy Terrell, Acting Medicaid Director, apologized that DHHS had not performed an adequate fiscal review of the impact of the waiver's impact and that the required public and legislative notice wasn't given.

David Rice, Fiscal Research Division, NCGA, reviewed the Medicaid Accountable Care Organization (ACO) models used in Oregon, Colorado, and Utah. He pointed out that ACOs require some level of upfront costs and it is uncertain whether ACOs actually do result in Medicaid savings.

Sandy Terrell, Acting Medicaid Director, DHHS, presented a report on Shared Savings methodology to the Committee. She went over the timeline of activities that includes implementation of a Shared Savings Plan on July 1, 2014 and payments to providers beginning on January 1, 2015. She discussed the challenges to developing the plan. DHHS will continue to seek critical input from providers in the development of the plan.

Luke Hoff, Director of the Property & Construction Division, DHHS, presented an update on the status of construction at Broughton Hospital and Cherry Hospital. He reviewed the budget and the schedule for substantial completion, final acceptance, and start of patient move-in for both projects.

Chris Scarboro, President, NC Health Information Exchange (NC HIE), reviewed the progress on the NC HIE's work to facilitate the sharing of data with DHHS for patient care paid for with Medicaid funds. He explained that an agreement between NC HIE and DHHS must be executed regarding the utilization and sharing of the data in the NC HIE network before implementation.

Drexdal Pratt, Director of Health Service Regulation, DHHS, reported on the progress of implementing the transparency provisions of S.L. 2013-382. He reported that the fair billing part of the law will be implemented in May of 2014. DHHS intends for the rest of the law to be implemented by November 1, 2014.

Mark Gogal, Director of Human Resources, DHHS, updated the Committee on the status of vacancies and turnovers, challenges in filling certain positions, current actions to address vacancies, and additional steps needed to fill difficult to recruit positions including the possibility of salary administration flexibility for specialized job classifications within the Divisions of Medical Assistance and Information Technology. He highlighted the high turnover rates in the Divisions of Medical Assistance, Information Technology, Health Service Regulation, and State Operated Healthcare Facilities.

Sherrie Settle, Associate Director of Contracts, Grants and Compliance, DHHS, reported on the progress of developing and implementing a competitive grants process for funding nonprofits dedicated to providing services statewide to support 13 health and wellness initiatives. She reviewed the three funding strategies and the timeline for awarding the grants.

March 12, 2014

The meeting started with presentations of three subcommittee reports. The report from the Certified Nurse Midwives Subcommittee was presented by Amy Jo Johnson, Research Division, NCGA, and Lisa Wilks, Legislative Drafting Division, NCGA. The report from the Impact of Mental Health Reforms on Public Guardianship Subcommittee was presented by Jan Paul, Research Division, NCGA. The report from the Mental Health Subcommittee was presented by Denise Thomas, Fiscal Research Division, NCGA. The Committee briefly discussed the findings and recommendations contained in the subcommittee reports.

Danny Staley, Deputy Director & Chief Operating Officer, Division of Public Health, DHHS, gave an update on a revised statewide oral health strategic plan. He discussed the reorganization of the Division of Public Health, Oral Health Section; surveillance; community water fluoridation programs; sealant promotion and utilization; and oral care for the frail elderly in long-term care facilities.

Dr. Kevin Ryan, Chief of the Women's and Children's Health Section, Division of Public Health, DHHS, presented an update on the implementation of reductions to the Children's Developmental Services Agencies (CDSA). The new plan is designed to downsize the number of positions in State CDSAs without eliminating services or produce significant service disruptions to families.

Next, Joe Cooper, Chief Information Officer, DHHS, gave an update on the status of correcting key program functions in NCTracks; a comparison of claims processing statistics between the old MMIS system and NCTracks; customer service improvements; and the status on receiving certification from CMS. Next, he reviewed the goals, costs, and benefits of the plan for the MH/DD/SAS Health Care Information System Project.

Dave Richard, Director of DMH/DD/SAS, DHHS, presented an update on LME/CMO consolidation. Beginning April 1, Cardinal Innovations Healthcare Solutions will manage the 1915 (b)/(c) waiver in Mecklenburg County. He explained how future mergers are a part of Medicaid reform and should lead to higher quality LME/MCOs that produce administrative consistency, service flexibility, and healthier outcomes for consumers.

The last series of presentations were Medicaid-related updates. Dr. Robin G. Cummings, Deputy Secretary of Health Services and Medicaid Transformation and Acting State Health Director, DHHS, discussed the organizational structure and oversight of the Division of Medical Assistance. Rod Davis, Chief Financial Officer, DHHS, reviewed two contracts intended to support and improve North Carolina Medicaid operations. Sandy Terrell, Acting Medicaid Director, gave an update on the DHHS effort to obtain a relaxation from federal requirements, effective April 1, 2014, to begin processing Medicaid recertifications under the modified adjusted gross income (MAGI) rules. This action would reduce the amount of manual data entry needed and mitigate the Medicaid recertification backlog faced by the counties.

Ms. Terrell also updated the Committee on the progress of replacing the existing base rates for individual hospitals with new regional base rates for all hospitals within a given region. She pointed out that future implementation will require collaboration between DHHS and the NC Hospital Association and any changes to current base rates will require a SPA and changes to NCTracks.

Finally, Courtney Cantrell, Policy Advisor for Integrated Care, DMH/DD/SAS, DHHS, updated the Committee on implementation of behavioral health clinical integration activities with Community Care of North Carolina (CCNC).

March 26, 2014

The first two presentations were on the status of the Medicaid budget and a forecast for the FY 2014-15. Pam Kilpatrick, Assistant State Budget Officer, OSBM, reviewed the Medicaid budget status and expenditures for FY 2013-14 through February 2014. She explained that the factors complicating OSBM's interpretation of the year to date Medicaid numbers are the backlog in processing new Medicaid applications, the potential claims backlog, and the impact of the savings measures enacted in the 2013 budget. She said that the Department of Health and Human Services' best estimate for 2013-14 is a $120 million to $140 million shortfall. Rod Davis, Chief Financial Officer, DHHS, presented the methodology used to prepare the Medicaid forecast for FY 2013-14, enrollment trends, and improved financial management practices. He explained that Department is in the process of designing and implementing an improved forecast and budget process.

Susan Jacobs, Fiscal Research Division, NCGA, reported on the required budget reductions for Medicaid. She explained that there is no Medicaid forecast, only a preliminary estimate for the current fiscal year Medicaid status (a net shortfall of $69 million to $131 million), and the potential

impact on FY 2014-15 ($126 million to $257 million). A significant portion of the estimated shortfall is associated with budget reductions based specifically on legislatively required policy changes that have not been implemented.

Rick Brennon, Chief Financial Officer for DMA, DHHS, discussed the status of the required Medicaid budget reductions. He gave an overview of the implementation of the reductions through the submission of SPAs and more details about key reductions.

Steve Owen, Fiscal Research Division, discussed the importance of preparing a Medicaid budget model. Because Medicaid is an entitlement program it has to be paid for and a budget model helps ensure accuracy. He reviewed the numerous methods that the State has utilized during the last decade to reduce Medicaid expenditures. He shared the best and worst case scenarios for Medicaid appropriations trends predicted by the budget model.

Sandy Terrell, Acting Medicaid Director, discussed the serious challenges to implement the Shared Savings Plan. Some of those challenges include that considerable investment will be required for implementation, the amount budgeted by the General Assembly to share may not be sufficient to incent providers, and shared savings is a competing priority in light of upcoming reform efforts.

Mardy Peal, Senior Advisor, DHHS, Courtney Cantrell, Acting Director for MH/DD/SAS, and Bob Atlas, consultant, DHHS, presented the Medicaid Reform Plan. Medicaid reform aims to make budgeting more predictable, flatten the cost growth trend, and improve the health outcomes of the beneficiaries through the use of ACOs beginning in July 2015. If the ACOs do not meet yearly benchmarks in the areas of access, cost, and quality, the Department will take corrective action. Managed care was considered as the model for reform but was found not to be a viable alternative.

The meeting ended with a presentation by Susan Jacobs, Fiscal Research Division, and Steve Owen, Fiscal Research Division, on key questions and of concern in the following areas: compliance with the budget special provision; provider participation; system structure; payment model; and savings computation.

April 17, 2014

During the meeting on April 17, 2014, the Committee heard opening comments from Dr. Aldona Wos, Secretary of DHHS. Then the Committee received information from Rod Davis, Chief Financial Officer, DHHS, on the status of the Medicaid budget and the forecast for the 2014-2015 Fiscal Year.

Mr. Joe Cooper, Chief Information Officer, DHHS, presented information on Medicaid Data Analytics, and updates on NCTracks and NC FAST. Next Sandy Terrell, Acting Division Director, Division of Medical Assistance, DHHS presented the report required by S.L. 2013-360, Sec. 12H.12 on potential savings through the purchase of insurance.

The Committee then received information from Deborah Landry, Fiscal Research Division, NCGA, on child protective services; and heard a presentation on the consolidation of local departments of social services and local departments of public health. Finally, the Committee was presented with a draft report from the Committee to the 2014 Session of the North Carolina General Assembly. Committee staff reviewed the report and Committee discussion followed.

SUBCOMMITTEE MEMBERSHIP

During the 2013-14 Interim, four subcommittees of the Joint Legislative Oversight Committee on Health and Human Services were appointed. The Oversight of CSC Contract Performance and NC Tracks Implementation Subcommittee did not meet during the interim. The Midwives Subcommittee, Public Guardianship Subcommittee, and the Mental Health Subcommittee presented reports to the Joint Legislative Oversight Committee on March 12, 2014. Minutes for the Subcommittee meetings are on file in the Legislative Library. Handouts and agendas are available online at the following link:
http://www.ncleg.net/gascripts/DocumentSites/browseDocSite.asp?nID=144&sFolderName=\HHS Subcommittees by Interim\2013-14 HHS Subcommittees.

Midwives Subcommittee

S.L. 2013-360 (SB 402), Section 12I.2, directed the Joint Legislative Oversight Committee on Health and Human Services to appoint a subcommittee to study whether certified nurse-midwives should be given more flexibility in the practice of midwifery. In conducting the study, the subcommittee was directed to consider whether a certified nurse-midwife should be allowed to practice midwifery in collaboration with, rather than under the supervision of, a physician licensed to practice medicine under Article 1 of Chapter 90 of the General Statutes who is actively engaged in the practice of obstetrics.

Below is a list of the Members and staff of the Midwives Subcommittee.

Senate Members	House Members
Senator Louis Pate, Chair	Representative Sarah Stevens, Chair
Senator Jeff Tarte	Representative Marilyn Avila
Senator Mike Woodard	Representative Michael Wray
Staff	
Barbara Riley, Research Division	Amy Jo Johnson, Research Division
Lisa Wilks, Legislative Drafting Division	Sara Kamprath, Research Division
David Rice, Fiscal Research Division	Susan Jacobs, Fiscal Research Division

Public Guardianship Subcommittee

S.L. 2013-258 (HB 543), Section 3., required the Joint Legislative Oversight Committee on Health and Human Services to appoint a subcommittee to examine the impact of the 1915(b)/(c) Medicaid Waiver and other mental health system reforms on public guardianship services, including guardianship roles, responsibilities, and procedures and the effect on existing relationships between guardians and wards.

Below is a list of the Members and staff of the Public Guardianship Subcommittee.

Senate Members	House Members
Senator Tamara Barringer, Chair	Representative Bert Jones, Chair
Senator Shirley Randleman	Representative Nelson Dollar
Senator Gladys Robinson	Representative Beverly Earle
Staff:	
Jan Paul, Research Division	Jennifer Hillman, Research Division
Joyce Jones, Legislative Drafting Division	Theresa Matula, Research Division
Denise Thomas, Fiscal Research Division	Deborah Landry, Fiscal Research Division

Mental Health Subcommittee

On January 14, 2014, pursuant to G.S. 120-208.2(d), the Mental Health Subcommittee was created. The Mental Health Subcommittee was directed to study the following issues:

(1) The State's progress in reforming the mental health system, with particular focus on the deinstitutionalization process and identifying the appropriate resources for mental health needs.
(2) Existing local supports for community health needs and the possible need for additional investments by the State.
(3) The appropriate capacity in State facilities and the need for additional investments by the State for those individuals with the most severe mental health needs. This may include a review of the current capacity, the growth in need for acute beds, staffing issues, and salary flexibility.
(4) The continuum of care for the State's mental health system, including the various points of entry.
(5) The State's mental health, alcohol and substance abuse disorder statutes related to civil commitments and their alignment with the statewide behavioral health crisis services delivery system.

Below is a list of the Members and staff of the Mental Health Subcommittee.

Senate Members	House Members
Senator Fletcher Hartsell, Jr., Chair	Representative Susan Martin, Chair
Senator Tommy Tucker	Representative Donny Lambeth
Senator Louis Pate	Representative Carl Ford
Senator Earline Parmon	Representative William Brisson
Staff:	
Jan Paul, Research Division	Barbara Riley, Research Division
Jennifer Hillman, Research Division	Susan Barham, Research Division
Patsy Pierce, Research Division	
Joyce Jones, Legislative Drafting Division	Ryan Blackledge, Legislative Drafting Division
Denise Thomas, Fiscal Research Division	Steve Owen, Fiscal Research Division
David Rice, Fiscal Research Division	

Oversight of CSC Contract Performance and NC Tracks Implementation Subcommittee

On January 14, 2014, pursuant to G.S. 120-208.2(d), the Oversight of CSC Contract Performance and NC Tracks Implementation Subcommittee was created. The Subcommittee was created to study the North Carolina Department of Health and Human Services (DHHS) program and planning for the design, development, and implementation of the NCTracks system (replacement Medicaid Management Information System). The Subcommittee was directed to study the following:

(1) The current status of the NCTracks system, to include system defects and required functionality that is not yet implemented.
(2) The system design, development, and implementation process, to include procedural and systemic issues identified during the process.
(3) All costs associated with system design, development, and implementation.
(4) Vendors' performance during the design, development and implementation of the system.
(5) The DHHS and the program vendor plan to resolve remaining issues associated with the program.

(6) The DHHS and program vendor timeline for completion of a fully functional NCTracks system.
(7) DHHS progress toward resolving unpaid Medicaid claims.

Below a list of the Members and staff of the Oversight of CSC Contract Performance and NC Tracks Implementation Subcommittee.

Senate Members	**House Members**
Senator Jeff Tarte, Chair	Representative Marilyn Avila, Chair
Senator Ralph Hise	Representative Jason Saine
Senator Tommy Tucker	Representative Tom Murry
Senator Don Davis	Representative Jim Fulghum, MD
Staff:	
Susan Jacobs, Fiscal Research Division	Steve Owen, Fiscal Research Division
Deborah Landry, Fiscal Research Division	Karlynn O'Shaughnessy, Fiscal Research Division
Ryan Blackledge, Legislative Drafting Division	Joyce Jones, Legislative Drafting Division
Jennifer Hillman, Research Division	

The Oversight of CSC Contract Performance and NC Tracks Implementation Subcommittee did not meet during the interim.

COMMITTEE FINDINGS AND RECOMMENDATIONS

Findings and Recommendations from the Joint Legislative Oversight Committee on Health and Human Services are provided in this section. The findings and recommendations have been categorized by topic.

Midwives

The findings below were reported from the Midwives Subcommittee to the Joint Legislative Oversight Committee on Health and Human Services on March 12, 2014. The corresponding recommendation is from the Joint Legislative Oversight Committee on Health and Human Services.

MIDWIVES FINDING 1: CERTIFIED NURSE MIDWIVES: CURRENT SUPERVISION REQUIREMENTS.

In North Carolina, Certified Nurse Midwives (CNM), under the supervision of a physician actively engaged in the practice of obstetrics, provide prenatal, intrapartum, postpartum, newborn, and Interconceptual care. A CNM is authorized to write prescriptions for drugs in accordance with the same conditions applicable to a nurse practitioner.

In North Carolina, a CNM must provide evidence of the arrangement for physician supervision. Under the rules developed by the Joint Subcommittee of the North Carolina Medical Board and the Board of Nursing, the evidence required is a written document detailing the nature and extent of the supervision and a delineation of the procedures to be adopted and followed by the CNM and the supervising physician, including clinical practice guidelines for the delivery of health care services, ongoing communication, and periodic and joint evaluation of services rendered.

MIDWIVES FINDING 2: CERTIFIED NURSE MIDWIVES: EDUCATION AND TRAINING

Certified Nurse Midwives (CNM) are highly educated, experienced, and trained in the practice of midwifery and taught to practice in consultation and collaboration with physicians and other health care providers.

A CNM is a registered nurse who has obtained a graduate degree and has completed a midwifery education program accredited by the Accreditation Commission for Midwifery Education. CNMs must pass a national certification exam administered by the American Midwifery Certification Board. To maintain certification, a CNM must be recertified every 5 years and complete continuing education requirements.

Certified Nurse Midwives are taught to practice within the health care system that provides for consultation, collaboration, or referral to a physician or other health care provider as indicated by the health status of the woman or newborn.

In addition to fundamental courses covering reproductive physiology, pharmacology, physical assessment, and others, midwifery education and training includes specific courses on patient safety and quality assurance of patient safety, advanced life support for obstetrics, and certification in advanced fetal monitoring.

MIDWIVES FINDING 3: INCREASE SUPPLY OF OBSTETRICAL HEALTH CARE PROVIDERS IN UNDERSERVED AREAS.

North Carolina needs to expand the number of obstetrical health care providers in the State, especially in underserved areas.

Data from the Cecil G. Sheps Center for Health Services Research, UNC-CH, shows that 24 counties in the State have no obstetrical care provider, either physician or CNMs. There has been a slight decline in the number of physicians providing deliveries in the past 10 years. This decline is due to a significant decrease in the number of family physicians doing deliveries and providing prenatal care. 47 counties in North Carolina do not have a CNM.

East Carolina University's School of Nursing offers the only midwifery education program in the State. 78% of the graduates of that program have chosen to practice in North Carolina.

MIDWIVES FINDING 4: CERTIFIED NURSE MIDWIVES: IMPACT OF PHYSICIAN SUPERVISION REQUIREMENT

North Carolina's requirement of physician supervision places some unnecessary restrictions on CNM practice and can result in well-qualified CNMs choosing to practice in other states.

The physician supervision requirement for CNMs has, in some cases, prevented CNMs from practicing in the State. Some CNMs have been unable to find a supervisory physician despite diligent efforts to secure an agreement. Others have had their practice abruptly closed as a result of the physician unexpectedly terminating the supervisory agreement. The abrupt closure of a CNM practice can present difficulties to patients who are forced to find alternative obstetrical care mid-way through a pregnancy.

MIDWIVES FINDING 5: CERTIFIED NURSE MIDWIVES: OTHER STATES ALLOW INDEPENDENT PRACTICE

Currently, 26 states require a written collaborative or supervisory agreement with a physician. Of the 24 states that allow independent practice, Vermont, Maine, Colorado, and Nevada require practice under a written agreement for a period of time before the CNM may practice independently.

MIDWIVES FINDING 6: CERTIFIED NURSE MIDWIVES: ALTERNATIVE TO WRITTEN PRACTICE AGREEMENT WITH ADDITIONAL EXPERIENCE REQUIREMENTS

With the addition of an experience requirement, CNMs in North Carolina should be allowed to practice in collaboration with physicians and other health care providers without the need for a written practice agreement.

While CNMs receive thorough and extensive education and training in nurse-midwifery education programs, there is a necessity for hands-on experience gained through actual practice. Just as medical doctors are expected to complete an internship program after medical school, CNMs and their patients would also benefit from a similar period of supervised experience. A 24-month, 2,400 hours transition to practice period under the supervision of a physician or an experienced CNM would enhance the quality of care provided by CNMs to their North Carolina patients.

MIDWIVES FINDING 7: CERTIFIED NURSE MIDWIVES: GRACE PERIOD AFTER UNEXPECTED TERMINATION OF WRITTEN PRACTICE AGREEMENT

Certified Nurse Midwives practicing pursuant to a written practice agreement should have a grace period after an unexpected termination of the agreement in which to obtain a practice agreement with another physician or experienced CNM.

Unexpected termination of required supervisory agreements can be disruptive for both the CNM whose practice is closed and for the patients who suddenly find themselves without an obstetrical health care provider. A grace period of up to 90 days would provide a CNM with adequate time to find a new supervisory physician or CNM, or in the case that the CNM decides to close the practice, time for patients to transition to a new provider.

MIDWIVES RECOMMENDATION: SUPPORT THE INTRODUCTION OF THE UPDATE/MODERNIZE MIDWIFERY PRACTICE ACT BY THE GENERAL ASSEMBLY.
The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Midwives Subcommittee and supports allowing introduction of the bill [2013-LUz-137] recommended by this Subcommittee in order to facilitate further discussion and debate on this topic during the 2014 Session.

Public Guardianship

The findings below were reported from the Public Guardianship Subcommittee to the Joint Legislative Oversight Committee on Health and Human Services. The corresponding recommendations are from the Joint Legislative Oversight Committee on Health and Human Services.

PUBLIC GUARDIANSHIP FINDING 1: FURTHER STUDY OF PUBLIC GUARDIANSHIP - APPOINTMENT OF A SUBCOMMITTEE
Guardianship limits the personal autonomy and legal rights of an incompetent ward. However, guardianship also may protect a ward or the ward's property. Limiting the rights of an individual through the appointment of a guardian should not be undertaken unless it is clear that guardianship will give the ward a fuller capacity for exercising his or her rights. The law must balance the competing interests of autonomy and protection by establishing the procedures for the appointment of an appropriate guardian, and providing guidelines or rules relating to potential conflicts of interest, the provision of necessary services, the safeguarding of the ward's personal resources as well as of public resources, the protection of the ward from abuse, neglect, exploitation, and to ensure adequate and appropriate oversight.

The Subcommittee heard presentations indicating that the number of guardianships is increasing as Baby Boomers advance in age. Where there are no individuals able to serve, increased burdens are placed on public guardians, and study should be made with regard to developing a more robust system of disinterested public guardians, as well as making transition plans for wards whose family member or other individual guardian may become unable to continue providing guardianship services.

Previously, the clerk could appoint LMEs and other entities as guardians. Under the recent change in the law allowing for the appointment only of a department of social services as disinterested public agent, cases that formerly went to other entities as disinterested public agent now go to DSS. As such, DSS agencies may need additional resources to handle the guardianship demands placed on the agency. There are corporations that serve as guardians, contracting with DSS to provide guardianship services in order to relieve DSS of its increasing caseload, but those corporations must be paid for their services under the contracts, and sources of funding must be identified.

The Subcommittee on Public Guardianship has had insufficient time and opportunity to explore and examine all of the important issues and information affecting the provision of guardianship services. Specifically, the Subcommittee would like to have explored other options, including the possibility

of the creation of an Office of Public Guardianship. Therefore, the Subcommittee believes the interests of the citizens of the State would be well-served by allowing a committee to continue this important work.

PUBLIC GUARDIANSHIP RECOMMENDATION 1: FURTHER STUDY OF PUBLIC GUARDIANSHIP - APPOINTMENT OF A SUBCOMMITTEE

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and in accordance with the authority granted in G.S. 120-208.2(d), the Committee cochairs will consider appointing a subcommittee during the 2014-15 interim for continued study of public guardianship issues.

PUBLIC GUARDIANSHIP FINDING 2: OVERSIGHT/STATUS REPORTS

G.S. 35A-1202 defines status reports and G.S. 35A-1242 defines the status report for incompetent wards. Presentations by the Department of Health and Human Services, Division of Aging and Adult Services (DAAS), on behalf of the Public Guardianship Ad Hoc Workgroup recommended that G.S. 35A-1202(14) and G.S. 35A-1242 be modified to require additional information be included in status reports.

The Subcommittee agrees that greater oversight is needed of public guardians of the person and public general guardians. It is important that more detailed information regarding the ward be available for review by the clerk.

PUBLIC GUARDIANSHIP RECOMMENDATION 2: OVERSIGHT/STATUS REPORTS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and recommends enactment of legislation [2013-SHz-9] by the General Assembly to amend the requirements contained in the North Carolina General Statutes relating to the contents of the status reports that must be filed by guardians with the clerk of superior court and to require all general guardians and guardians of the person to file a status report.

PUBLIC GUARDIANSHIP FINDING 3: OVERSIGHT/COMPLAINT INVESTIGATION

During the March 5th meeting, the Subcommittee heard a presentation by the Division of Aging and Adult Services, Department of Health and Human Services. A portion of the presentation focused on the complaint investigation and resolution process with a county Department of Social Services (DSS). The following three points were made:

- Any citizen-initiated concerns, including those passed through legislative (State and Congressional) and executive branches are investigated by the Division of Aging and Adult Services field-based staff.
- Interviews are conducted with DSS staff, family members, and others involved in the ward's care.
- On-site visits are made as needed to ensure the ward's needs are appropriately addressed.

Individuals served by a publicly funded guardian generally are vulnerable individuals with complex needs. In many cases, guardians can be supportive and serve to maximize a ward's potential and quality of life. It was reported to the Subcommittee that there may have been cases in which public guardians have been non-responsive, impeded employment and housing opportunities, and obstructed appropriate restoration of competency or modification of guardianship. In cases where the clerk or the DSS receives a report of abuse, neglect or exploitation of a ward, it is important that appropriate protection and advocacy services be provided. The ward should be offered an opportunity to provide information to an investigator and to participate as fully as possible in all decisions that affect him or her. The DSS should have specific protocols and policies to govern

guardians, including responsiveness, personal contact with the ward, and a person-centered plan, and should develop plans for each guardian in order to ensure that the ward's needs are met and that the guardianship plan is regularly monitored.

PUBLIC GUARDIANSHIP RECOMMENDATION 3: OVERSIGHT/COMPLAINT INVESTIGATION

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and recommends enactment of legislation [2013-MGz-142] by the General Assembly to direct the Division of Aging and Adult Services, Department of Health and Human Services, to collaborate with the Administrative Office of the Courts to develop a plan ensuring that a protective services investigator incorporate a face-to-face observation with the ward and/or an interview with the ward as part of the complaint investigation process and report findings and recommendations to the Oversight Committee on or before October 1, 2014.

PUBLIC GUARDIANSHIP FINDING 4: CONFLICTS OF INTEREST - GENERALLY

Changes to State guardianship laws made as a result of the 1915(b)/(c) Medicaid Waiver limit the clerk of superior court when appointing a disinterested public agent as guardian to the appointment only of the director or assistant director of a county department of social services. Clerks of superior court no longer have the authority to appoint an area mental health agency or other human services agency as a disinterested public agent. National Guardianship Association standards provide that the guardian shall avoid all conflicts of interest and self-dealing, or the appearance of such, when addressing the needs of the person under guardianship. Such conflicts may be based on moral, ethical, and/or financial reasons and can arise, for example, when the guardian directly provides housing, medical, legal, or other direct services to the ward and is not a family guardian approved by the court to provide specified direct services that are in the best interest of the ward. Guardians should be educated as to what constitutes a conflict of interest and self-dealing and why they should be avoided. Under current State law, if a disinterested public agent believes that his role or the role of his agency in relation to the ward is such that his service as guardian would constitute a conflict of interest, or if he knows of any other reason that his service as guardian may not be in the ward's best interest, the disinterested public agent is required to bring such matter to the attention of the clerk and seek the appointment of a different guardian.

Virtually all presenters who addressed the issue of parents and relatives as both guardians and paid service providers agreed that the clerk of superior court should continue to have the discretion, based on full information and a determination as to the ward's best interest, to appoint the person who will take the best care of the ward**.**

PUBLIC GUARDIANSHIP RECOMMENDATION 4: CONFLICTS OF INTEREST - GENERALLY

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and in accordance with the authority granted in G.S. 120-208.2(d), the Committee cochairs will consider appointing a subcommittee during the 2014-15 interim to study potential conflicts of interest between guardians, wards, and service providers.

PUBLIC GUARDIANSHIP FINDING 5: CONFLICT OF INTEREST – CHILD WELFARE CASES

The Subcommittee heard from presenters that the potential for a conflict of interest arises when a county Department of Social Services has been appointed as guardian for both a child who is the subject of a report of abuse, neglect or dependency that must be investigated by Child Protective Services as well as for the parent or legal guardian of that child.

PUBLIC GUARDIANSHIP RECOMMENDATION 5: CONFLICT OF INTEREST - CHILD WELFARE CASES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and recommends enactment of legislation [2013-MGz-142] by the General Assembly to direct the Division of Social Services, Department of Health and Human Services, to study the issue of conflicts of interest in child welfare cases, and report findings and recommendations to the Oversight Committee on or before October 1, 2014.

PUBLIC GUARDIANSHIP FINDING 6: CONFLICT OF INTEREST – REPRESENTATIVE PAYEE

Although it is unusual for individuals requiring public guardianship services to have significant financial resources, there are wards whose guardians are individuals, corporations, or disinterested public agents who have assets to be safeguarded and whose financial affairs must be properly managed. Many wards may be receiving Social Security, SSI or other disability benefits. The Subcommittee was informed that there is a potential conflict of interest as well as opportunity for abuse and exploitation when a guardian seeks to be designated as representative payee of the ward's Social Security or SSI benefits or is the payee of other public monies. The issues relating to these financial conflicts of interest warrant further examination and study.

PUBLIC GUARDIANSHIP RECOMMENDATION 6: STUDY CONFLICT OF INTEREST IN REPRESENTATIVE PAYEE SITUATIONS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and in accordance with the authority granted in G.S. 120-208.2(d), the Committee cochairs will consider appointing a subcommittee during the 2014-15 interim to study the issue relating to guardians being designated as representative payee of a ward's disability benefits as well as of other public funds.

PUBLIC GUARDIANSHIP FINDING 7: GUARDIAN AS PAID SERVICE PROVIDER AND OVERSIGHT/UTILIZATION OF CARE COORDINATION SERVICES

Clerks, through their judicial role, make a determination as to who is best able to act in the best interest of ward. Clerks use a variety of means by which to gather information to assist them with their decision, including conducting criminal background checks, conducting interviews, reviewing medical records, and examining family dynamics. Clerks need to continue to be allowed discretion to make those decisions appropriately and based on full information, in order to choose whomever they believe is going to take the best care of the ward. Clerks of court are currently working with their local Departments of Social Services to ensure that all private guardianship possibilities are exhausted before appointing a public guardian.

A guardian has tremendous power and authority, whether compensated or not. There is a need to focus on the interplay between the personal decision-making responsibilities of a ward who receives a great number of public service dollars. As a practical matter, any amount of compensation a guardian receives for providing guardianship services is significantly less than the amount of dollars that may be needed for the ward on the service side. In some jurisdictions, there may be a trend to disallow a guardian who is making decisions as to what services are needed and appropriate for the ward to also be a paid provider of those services. Recent case law in the State stands for the proposition that it is not in the best interests of the ward and that there exists an actual or potential conflict of interest when an entity is both providing services and acting as guardian.

On the other hand, there was consensus among the presenters that no one can better serve as guardian than a family member who cares about the ward and has perhaps spent a great deal of his or her life providing for the ward's care. The presenters agreed that not only is any movement towards appointing disinterested third parties and away from private individuals as guardians concerning, but also in some situations where a parent or relative cannot work outside the home because of the needs of their ward, it may be in the ward's best interest for that parent or relative to serve both as the guardian and a paid provider of services. In fact, in situations where, because of the nature of the ward's disability, they need full-time, around-the-clock care, it might be in the ward's best interest for the parent to be a guardian who receives a monthly stipend as well as a paid service provider, and it might be less expensive for the State.

Conflicts of interest are more likely to arise where money is changing hands and there is no familial or moral obligation towards the ward on the part of the guardian. Clerks, through their judicial role, are charged with the legal responsibility of making a determination as to what is in the best interests of the ward, and thereby need discretion to choose whomever they believe is going to be the best person to serve as guardian and to act in the best interest of the ward. Parents and other relatives, as permitted under current law, should continue to be both guardians and paid providers when appropriate, if adequate oversight is present. However, a plan should be in place for an alternate guardianship arrangement in the event an individual guardian of the person becomes unwilling or unable to serve, and such plan should explore all possible alternatives to prevent the appointment of a public guardian in order to ensure the best interests of the ward as well as to safeguard the resources of the State. In addition, a plan should be in place for provision of services by an alternative provider.

PUBLIC GUARDIANSHIP RECOMMENDATION 7A: GUARDIAN AS PAID SERVICE PROVIDER

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and recommends enactment of legislation [2013-MGz-142] by the General Assembly to direct the Department of Health and Human Services to continue utilizing safeguards already in place regarding guardians as paid service providers, and to direct the Divisions of Aging and Adult Services and Social Services, Department of Health and Human Services, to consult with the clerks of superior court, the LME/MCOs, the North Carolina Bar Association Section on Elder Law, and any other interested groups, to develop a transition plan for situations when a parent/caregiver is no longer able to provide care or to serve as a guardian, with the specific goal of formulating a plan that will avoid the necessity of making an individual a ward of the State. The Department shall report findings and recommendations to the Oversight Committee on or before October 1, 2014.

PUBLIC GUARDIANSHIP RECOMMENDATION 7B: OVERSIGHT/UTILIZATION OF CARE COORDINATION SERVICES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Public Guardianship Subcommittee and recommends enactment of legislation [2013-MGz-142] by the General Assembly to direct the Department of Health and Human Services to study whether utilization of care coordination services would provide needed oversight to safeguard against conflicts of interest when guardians serve as paid providers and report findings and recommendations to the Oversight Committee on or before October 1, 2014.

Mental Health

The findings below were reported from the Mental Health Subcommittee to the Joint Legislative Oversight Committee on Health and Human Services. The corresponding recommendations are from the Joint Legislative Oversight Committee on Health and Human Services.

MENTAL HEALTH FINDING 1: MENTAL HEALTH SUBCOMMITTEE TO CONTINUE EXAMINATION OF THE STATE'S BEHAVIORAL HEALTH ISSUES AND NEEDS

As indicated by the vast amount and variety of presentations listed in the proceedings section above, the State's behavioral health needs are complex, and encompass services for persons with mental illness, intellectual/developmental disabilities, and substance abuse disorders. There is an ongoing need for an array of services in both community-based and residential settings. The Subcommittee met three times during the 2013-14 interim and did not have sufficient time to deliberate and fully address all of the issues. The Subcommittee needs more time to gather information, identify options, and develop recommendations to increase access to effective, evidenced based behavioral health programs and services.

MENTAL HEALTH RECOMMENDATIONS 1A AND 1B: FURTHER STUDY BY A MENTAL HEALTH SUBCOMMITTEE AND EXPANSION OF THE SUBCOMMITTEE'S CHARGE TO INCLUDE CONSIDERATION OF ISSUES RELATED TO THE NEEDS OF PERSONS WITH TRAUMATIC BRAIN INJURY

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and in accordance with the authority granted in G.S. 120-208.2(d), the Committee cochairs will consider appointing a subcommittee during the 2014-15 interim for continued study of the State's behavioral health needs, including an examination of the treatment and service needs of persons with traumatic brain injury.

MENTAL HEALTH FINDING 2: INSUFFICIENT COLLABORATION AND COORDINATION AMONG THE VARIOUS DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) DIVISIONS

The Department of Health and Human Services has six separate operating divisions that have a significant impact on the State's behavioral health system:

- Division of Aging and Adult Services (DAAS) – administers services and programs for adults with disabilities, a significant number of whom have behavioral health needs.
- Division of Health Services Regulation (DHSR) – certifies and monitors medical, mental health, and adult care facilities.
- Division of Medical Assistance (DMA) – administers the NC Medicaid Program which pays for most of the State-funded behavioral health services.
- Division of Mental Health/Developmental Disabilities/Substance Abuse Services (DMH/DD/SAS) – administers State-funded mental health, developmental disability, and substance abuse services programs.
- Division of Public Health (DPH) – administers an array of services, in partnership with the 85 local health departments, to promote healthcare, including community- based risk reduction and disease prevention, promoting healthy lifestyles, and promoting the availability and accessibility of quality health care services.

- Division of State-Operated Healthcare Facilities (DSOHF) – manages 14 State operated health care facilities that provide residential treatment for adults and children with mental illness, developmental disabilities and substance abuse disorders.

While DMH/DD/SAS is the lead agency for management of behavioral health services, testimony and committee discussion indicated that each of these five divisions play a significant role in the delivery of State funded behavioral health services. However, it appears that more communication and coordination among the divisions is needed. For example, DHSR produces an annual *State Medical Facilities Plan* which provides an inventory of medical facilities and services, including mental health, developmental disabilities and substance abuse; inpatient psychiatric services, and intermediate care facilities for individuals with intellectual disabilities. In addition to the inventory, the plan addresses the adequacy of services, indicating gaps and shortages. However, it appears that there is no follow up coordination between DHSR and DMH/DD/SAS to develop a strategy to address the needs identified by the plan.

MENTAL HEALTH RECOMMENDATION 2: DHHS SHOULD IMPROVE COMMUNICATION AND COORDINATION AMONG THE DIVISIONS THAT HAVE A ROLE IN THE DELIVERY OF STATE AND FEDERALLY-FUNDED BEHAVIORAL HEALTH SERVICES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to develop a strategy to improve communication and coordination among the Department's divisions that are responsible for the administration of funds or programs related to behavioral health services, especially regarding the use of public and private facilities, and to report findings and recommendations to the Oversight Committee on or before November 1, 2014. The strategy shall include a process to address shortages and deficiencies identified in the annual State Medical Facilities Plan.

MENTAL HEALTH FINDING 3: COMMUNITY-BASED CRISIS SERVICE PROGRAMS ARE COST-EFFECTIVE ALTERNATIVES TO EMERGENCY DEPARTMENTS AND LONG-TERM HOSPITALIZATION

Community-based crisis stabilization services are an alternative to the use of local hospital emergency departments or inpatient services in State-operated facilities. These services include psychiatric outpatient clinics, 24-hour crisis walk-in clinics, psychiatric urgent care units, facility-based crisis treatment, 23-hour observation, and non-hospital detoxification. In many counties, these types of service are limited or non-existent.

MENTAL HEALTH RECOMMENDATION 3A: INCREASE OUTPATIENT, CRISIS STABILIZATION, AND TREATMENT OPTIONS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to work with the LME/MCOs to increase community-based outpatient crisis and emergency services treatment programs which allow individuals in crisis to be stabilized and treated in settings other than emergency departments and State-operated psychiatric hospitals, and to report findings and recommendations to the Oversight Committee on or before November 1, 2014.

MENTAL HEALTH RECOMMENDATION 3B: APPROPRIATE FUNDS TO INCREASE FACILITY- BASED CRISIS SERVICES FOR CHILDREN, ADOLESCENTS, AND ADULTS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the General Assembly appropriate additional community services funds to be used by the LME/MCOs to establish facility-based crisis units.

MENTAL HEALTH RECOMMENDATION 3C: APPROPRIATE FUNDING TO PILOT A BEHAVIORAL HEALTH OBSERVATION UNIT

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the General Assembly appropriate funds to pilot a 12-bed behavioral health observation unit. The purpose of the unit is to stabilize persons who are in crisis and to determine the need for further treatment or hospitalization.

MENTAL HEALTH RECOMMENDATION 3D: DHHS SHOULD DEVELOP PLAN FOR A COMPREHENSIVE ARRAY OF OUTPATIENT TREATMENT, CRISIS PREVENTION, AND INTERVENTION SERVICES THAT ARE AVAILABLE STATEWIDE

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to develop a plan to ensure that a comprehensive array of outpatient treatment, crisis prevention, and intervention services are available and accessible to children, adolescents, and adults in every LME/MCO, and to report findings and recommendations to the Oversight Committee on or before November 1, 2014. The plan developed by the Department shall ensure that an adequate number of crisis stabilization units are available in each LME/MCO..

MENTAL HEALTH FINDING 4: THERE IS AN INSUFFICIENT INVENTORY OF LICENSED ADULT PSYCHIATRIC INPATIENT BEDS

North Carolina has a shortage of inpatient psychiatric and substance abuse treatment beds. North Carolina has 21.4 adult inpatient psychiatric beds per 100,000 persons, a total of 2,040 State operated and community hospital beds. The Subcommittee heard testimony which indicated that national experts recommend 22 – 50 beds per 100,000. An additional 52 beds are needed to reach 22 per 100,000 while an additional 2,714 beds would be needed to achieve 50 beds per 100,000. The January 2013 Joint Legislative Health and Human Services Oversight Committee Report to the 2013 General Assembly included recommendations to determine the cost of increasing the number of beds in State psychiatric hospitals and to investigate the possibility of placing a new psychiatric facility in the south central region of the State.

MENTAL HEALTH RECOMMENDATION 4A: DHHS ASSESS NEED AND RECOMMEND OPTIONS TO INCREASE PSYCHIATRIC AND SUBSTANCE ABUSE INPATIENT SERVICES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to study the need for and recommend options to increase the inventory of psychiatric and substance abuse inpatient services, including additional State-operated facilities, community hospital beds, U.S. Veterans Administration beds, and community-based services that decrease the need for inpatient treatment, and to report findings and recommendations to the Oversight Committee on or before November 1, 2014.

MENTAL HEALTH RECOMMENDATION 4B: DEVELOP AND IMPLEMENT INCENTIVES TO INCREASE THE INVENTORY OF LICENSED INPATIENT PSYCHIATRIC SERVICES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to develop a plan to incentivize hospitals and other entities to apply for licenses for new inpatient behavioral health services and/or to begin operating existing beds that are currently licensed but unstaffed, and to report findings and recommendations to the Oversight Committee on or before November 1, 2014.

MENTAL HEALTH RECOMMENDATION 4C: PROGRAM EVALUATION DIVISION STUDY AND MAKE RECOMMENDATION TO IMPROVE THE CERTIFICATE OF NEED PROCESS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the Program Evaluation Division (PED), NCGA, study the Certificate of Need (CON) process to determine if it is a barrier to increasing the availability of inpatient psychiatric and substance abuse treatment services in the State. The study shall include a review of the impact of CON regulations prohibiting the transfer of licensed inpatient psychiatric beds across county lines. As part of the review, PED shall seek the input of the Department of Health and Human Services, the NC Hospital Association, and other inpatient service providers, to develop recommendations for streamlining the CON process. The Program Evaluation Division shall report its findings and recommendations no later than April 1, 2015.

MENTAL HEALTH RECOMMENDATION 4D: DHHS STUDY AND MAKE RECOMMENDATIONS ON THE FEASIBILITY OF USING EXISTING CHERRY HOSPITAL BUILDINGS TO PROVIDE COMMUNITY AND FACILITY-BASED SERVICES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services (DHHS) to study and make recommendations on the use of the existing Cherry Hospital buildings after patients and operations are relocated to the replacement facility. As part of the study, DHHS shall assess the condition and develop an inventory of every building located on the existing Cherry Hospital campus. The study shall include an examination of the feasibility of using the existing Cherry Hospital facility to provide community and facility-based behavioral health services, including additional child and adolescent inpatient beds, and to report findings and recommendations to the Oversight Committee on or before November 1, 2014.

MENTAL HEALTH FINDING 5: INSUFFICIENT INVENTORY OF LICENSED CHILD/ADOLESCENT PSYCHIATRIC INPATIENT BEDS

The 2014 Annual Medical Facilities Plan indicates that there are 291 licensed non-State operated child/adolescent beds in North Carolina. However, three LME/MCOs (ECBH, Eastpointe, and Smoky Mountain) have no licensed child/adolescent inpatient psychiatric services available within their catchment areas. For example, there are no beds in a catchment area covering 31 counties in eastern North Carolina served by two LME/MCOs. Other LME/MCOs have beds available to them but the inventory is not sufficient to meet the need within their catchment areas. Children and adolescents who reside in these areas and need inpatient psychiatric treatment must leave their communities to access these services. DHSR estimates that 72 child/adolescent beds are needed statewide. However, for the past two fiscal years, DHSR has not received any Certificate of Need (CON) applications for child/adolescent inpatient psychiatric beds.

MENTAL HEALTH RECOMMENDATION 5A: EXPAND AND TARGET THREE-WAY CONTRACT FUNDING TO INCREASE THE NUMBER OF LICENSED CHILD/ADOLESCENT PSYCHIATRIC BEDS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the General Assembly appropriate expansion funding for the three-way contracts that will be targeted specifically to increase the number of licensed child/adolescent psychiatric beds in areas of the State that have the greatest need for these beds.

MENTAL HEALTH RECOMMENDATION 5B: DHHS TO DEVELOP A STRATEGY TO INCREASE CHILD/ADOLESCENT INPATIENT PSYCHIATRIC BEDS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to collaborate with the relevant stakeholders to develop a comprehensive strategy to address the dearth of licensed child/adolescent inpatient psychiatric beds throughout the State and to report findings and recommendations to the Oversight Committee, and to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services, on or before March 1, 2015. The strategy shall ensure that an adequate inventory of child and adolescent beds are available in the catchment areas of each LME/MCO. The plan shall include the development and implementation of a child/adolescent psychiatric bed registry to provide real-time information on the number of beds available at each licensed inpatient facility in the State.

MENTAL HEALTH RECOMMENDATION 5C: DHHS SHOULD TRACK AND SEPARATELY REPORT ON THE INVENTORY OF CHILD BEDS AND ADOLESCENT BEDS SEPARATELY

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Division of Health Service Regulation, Department of Health and Human Services, to begin tracking and providing separate reports no later than January 1, 2015, on the inventory of inpatient behavioral health beds for children ages six through 12 and for adolescents over age 12.

MENTAL HEALTH RECOMMENDATION 5D: PROGRAM EVALUATION DIVISION STUDY AND MAKE RECOMMENDATION TO IMPROVE THE CERTIFICATE OF NEED PROCESS FOR CHILD AND ADOLESCENT INPATIENT PSYCHIATRIC BEDS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the Program Evaluation Division (PED), NCGA, review the Certificate of Need (CON) process to determine if it is a barrier to increasing the availability of child and adolescent inpatient psychiatric beds in the State. As part of the review, PED shall seek the input of the Department of Health and Human Services, the NC Hospital Association, and other inpatient service providers to develop recommendations for streamlining the CON process and providing incentives to increase CON applications for child and adolescent psychiatric beds. The Program Evaluation Division shall report its findings and recommendations no later than April 1, 2015.

MENTAL HEALTH FINDING 6: JUDICIAL ACTIONS AFFECT THE AVAILABILITY OF BEDS IN THE STATE OPERATED PSYCHIATRIC HOSPITALS

When a person suffering a behavioral health crisis is arrested and taken before a magistrate, the magistrate may issue an involuntary commitment order. LME/MCOs and providers report that in many cases, these orders are inappropriate and the best treatment option is community-based. However, providers must comply with the judgments. The courts may also determine that an individual's mental health status renders the individual incapable of proceeding to trial. The incapacity to proceed orders, in turn, affect the availability of State hospital beds for persons who are being held at hospital emergency departments while awaiting admission to one of the State psychiatric hospitals.

MENTAL HEALTH RECOMMENDATION 6A: ESTABLISH A LEGISLATIVE STUDY COMMITTEE TO EXAMINE THE IMPACT OF JUDICIAL ACTIONS ON THE STATE PSYCHIATRIC HOSPITALS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and in accordance with the authority granted in G.S. 120-208.2(d), the Committee cochairs will consider appointing a subcommittee during the 2014-15 interim for continued study of how judicial actions impact the inventory of available beds at State operated psychiatric hospitals.

MENTAL HEALTH RECOMMENDATION 6B: PROGRAM EVALUATION DIVISION STUDY THE IMPACT OF INVOLUNTARY COMMITMENTS AND INCAPACITY TO PROCEED ORDERS ON THE STATE PSYCHIATRIC HOSPITALS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the Program Evaluation Division (PED), NCGA, study the impact of judicial actions on admissions to the State-operated psychiatric hospitals and report its findings and recommendations no later than April 1, 2015.

MENTAL HEALTH FINDING 7: THERE IS AN INSUFFICIENT BEHAVIORAL HEALTH WORKFORCE TO MEET CURRENT AND FUTURE SERVICE DEMAND

There is a shortage of psychiatrists and other licensed behavioral health providers throughout the State, particularly in rural areas. Options to address these shortages include increasing psychiatrist employment and retention incentives and expanding telepsychiatry to primary care settings such as clinics, health departments, and private primary care providers.

MENTAL HEALTH RECOMMENDATION 7A: APPROPRIATE FUNDS TO EXPAND THE STATE TELESPSYCHIATRY PROGRAM TO PRIMARY CARE SETTINGS

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the General Assembly appropriate funds to expand State-funded telepsychiatry services to primary care settings.

MENTAL HEALTH RECOMMENDATION 7B: APPROPRIATE FUNDS TO ESTABLISH ADDICTION PSYCHIATRY RESIDENCIES

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends the General Assembly appropriate funds to establish two addiction psychiatry residency fellowships. The fellowships will prepare two psychiatrists per year as subspecialists in addiction medicine to meet an expanding need for prevention, direct patient care, teaching and research into recognition, diagnosis, and treatment of substance use disorders.

MENTAL HEALTH RECOMMENDATION 7C: FULLY IMPLEMENT THE 2008 MENTAL HEALTH COMMISSION WORKFORCE DEVELOPMENT PLAN

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to report to the Oversight Committee on the status of the implementation of the 2008 Mental Health Commission Workforce Development Plan no later than November 1, 2014.

MENTAL HEALTH FINDING 8: INADEQUATE OUTCOME DATA AVAILABLE FOR THE STATE OPERATED ALCOHOL AND DRUG ABUSE TREATMENT CENTERS (ADATC)

The Department of Health and Human Services (DHHS) operates three ADATCs, which are licensed inpatient psychiatric hospitals that provide medical detoxification, medical treatment, and intensive counseling services to persons addicted to drugs or alcohol. The annual cost of the three ADATCs is $40 million in General Fund appropriations. Most of the individuals served by the ADATCs are indigent, unemployed, and uninsured, so the ADATCs collect minimal revenue to offset the State's cost. However, DHHS is unable to assess the ADATCs' long-term impact on individuals' alcohol or drug use once they are discharged back into their communities.

MENTAL HEALTH RECOMMENDATION 8: DHHS SHOULD DEVELOP MEANINGFUL OUTCOME MEASURES ON THE IMPACT OF TREATMENT AND SERVICES PROVIDED BY ALCOHOL AND DRUG ABUSE TREATMENT CENTERS (ADATC)

The Joint Legislative Oversight Committee on Health and Human Services appreciates the work of the Mental Health Subcommittee and recommends enactment of legislation [2013-MGz-141] by the General Assembly to direct the Department of Health and Human Services to develop meaningful outcome measures of the impact of ADATC treatment on an individual's substance use following discharge and to report to the Oversight Committee, and to the House of Representatives Appropriations Subcommittee on Health and Human Services and the Senate Appropriations Committee on Health and Human Services on or before March 1, 2015.

Medicaid

MEDICAID FINDING 1: STATE PLAN AMENDMENTS

The Joint Legislative Oversight Committee on Health and Human Services finds that the Department of Health and Human Services (DHHS) routinely submits State Plan Amendments (SPAs) to the Centers for Medicare & Medicaid Services (CMS) up to three months after the effective date of the required change to the Medicaid program. Although technically compliant with federal law, this practice requires DHHS to choose between: (1) delaying implementation and attempting to retroactively implement the provision, or (2) implementing the provision without CMS approval and without the opportunity for public review and comment on the State Plan Amendment. The practice of implementing provisions without CMS approval could jeopardize federal funding if CMS rejects or alters the SPA upon review.

The Committee also finds that, without publication or notice to the General Assembly, on August 8, 2013, DHHS submitted a request to CMS for a waiver to automatically extend eligibility renewals by three months for certain Medicaid beneficiaries, resulting in unanticipated expenditures. The General Assembly was not formally notified of the waiver until January 2014. Following appropriate processes for the notice and submission of State Plan Amendments and waivers is critical to achieving budgeted savings and in apprising the General Assembly of circumstances affecting the budget with sufficient time to react.

MEDICAID RECOMMENDATION 1: STATE PLAN AMENDMENTS
The Joint Legislative Oversight Committee on Health and Human Services recommends enactment of legislation [2013-MEz-100] by the General Assembly to specify additional procedures related to notice and submission of State Plan Amendments and waivers.

Child Protective Services

CHILD PROTECTIVE SERVICES FINDING 1: ADEQUATE FUNDING FOR CHILD PROTECTIVE SERVICES
Child Protective Services is funded by federal, state, and county funds. Federal funds are comprised of the Temporary Assistance for Needy Families (TANF) block grant, Title IV-E, and Social Services Block Grant (SSBG) funds. Two issues are significantly impacting child protective services: the loss of federal funding for fiscal year 2013-14, and the caseload for child protective services.

Loss of Federal Funds - Local county departments of social services have lost a significant amount of federal funding for child protective services. The Committee heard information indicating that counties have lost over $23 million in federal funding in fiscal year 2013-14. This loss includes $4.5 million in TANF block grant funding for protective services workers in local county department of social services, $3.8 million of TANF county block grant funds ($6.8 million was reduced from the county block grant, counties spend approximately 60% of their county block grant funds on Child Protective Services), and $14.6 million in Title IV-E funding. The Governor requested and the legislature approved $4.8 million in non-recurring state funding for county departments of social services. With these added non-recurring funds the net loss of funding was $18.1 million.

Child Protective Services Caseload Data - The Child Protective Service (CPS) policy from the Division of Social Services recommends that average CPS caseloads be no greater than 10 families at any time for workers performing CPS assessments, and 10 families at any time for staff providing in-home services. The Committee heard that the population of children under 18 has grown by 10.5% from June 2002 to June 2012, and that the number of Child Protective Services Investigations has grown by 20% from fiscal year 2002 to fiscal year 2012. The Committee also heard that 57 counties are within the recommended caseload size. Of the remaining 43 counties, 21 have a caseload size of over 15 cases per worker. Further, in 9 of those 21 counties there is an average caseload size of over 20 cases per worker. Additionally, the Committee learned that the average time to begin an investigation once a county is notified of suspected abuse, neglect or dependency has been rising from 44.6 hours to begin an investigation in 2008 to 48.8 hours to begin an investigation in 2011.

Due to the loss of federal funding for fiscal year 2013-14, and the caseload for child protective services, the Committee believes that additional funding is needed to replace lost federal funding; to provide additional child protective services workers at the county departments of social services in an effort to reduce caseloads to the recommended standard and to restore Child Welfare field staff for the Division of Social Services; and to provide enhanced oversight of county departments of social services.

CHILD PROTECTIVE SERVICES RECOMMENDATION 1: ADEQUATE FUNDING FOR CHILD PROTECTIVE SERVICES
The Joint Legislative Oversight Committee on Health and Human Services recommends that funding be identified to provide adequate resources for local county departments of social services to provide Child Protective Services to protect abused, neglected and dependent children and youth.

CHILD PROTECTIVE SERVICES FINDING 2: CONDUCT A STATEWIDE EVALUATION AND PILOT PROJECT FOR CHILD PROTECTIVE SERVICES

The Committee heard that accurate staffing data regarding child protective service workers at the local county departments of social services is not currently available. Counties are surveyed every year, however not all counties respond to the survey. The Committee also heard that application and adherence to child protective services policies appears to vary among counties. The implementation of a structured interview process has reduced the variation in Child Protective Services investigation rates; however the rate of findings continues to vary across counties. As discussed in Finding 1 above, counties vary in their compliance with Child Protective Services caseload sizes.

The following outlines the review process and quality initiative that impact the Division of Social Services' delivery of services to children and youth. The Administration for Children & Families, US Department of Health and Human Services, has two bureaus: the Children's Bureau, and the Family & Youth Services Bureau. The Children's Bureau periodically conducts Child and Family Services Reviews (CFSRs) to ensure that state child welfare systems conform to federal child welfare requirements, to determine processes and outcomes for children and families engaged in child welfare services, and to assist states in achieving positive outcomes for children and families. A state must develop a Program Improvement Plan in response to areas that were determined to need improvement. The Division of Social Services reported that formal reviews of county departments of social services were most recently completed in 2001 and 2007. North Carolina also has a quality and accountability achievement initiative, REAP: Reaching for Excellence and Accountability in Practice. The REAP Mission Statement is as follows, "The North Carolina Division of Social Services and County Departments of Social Services, in collaboration with our community partners, will share accountability for reaching core achievements for children, youth and families. We will adopt a quality-improvement approach to child welfare that is data-driven, results-oriented, and tailored to the specific strengths and needs of each community. This approach encompasses the use of best practices, technical assistance, and training to continuously improve outcomes for children, youth, and families in our state." The Division reported that REAP is the Continuous Quality Improvement system for NC Child Welfare, however, there are currently only 17 counties participating in REAP. As a result, there is not current statewide data available on the performance of county departments of social services with regard to child protective services.

The State needs a comprehensive evaluation of child protective services performance, caseload sizes, administrative structure, funding, employee turnover, monitoring, and oversight. There may also be an opportunity for greater coordination among the entities who serve children involved with the child protective services system. The Committee makes the recommendation below, but is not recommending a particular bill draft at this time.

CHILD PROTECTIVE SERVICES RECOMMENDATION 2: CONDUCT A STATEWIDE EVALUATION AND PILOT PROJECT FOR CHILD PROTECTIVE SERVICES

The Joint Legislative Oversight Committee on Health and Human Services recommends that a comprehensive independent statewide evaluation be conducted of Child Protective Services performance, caseload sizes, administrative structure, funding, worker turnover, and monitoring and oversight. The evaluation should include recommendations for improvements in Child Protective Services. Further, it is recommended that a pilot program, including an evaluation, be conducted that is designed to enhance coordination of services and information sharing among local county departments of social services, local law enforcement, the court system, Guardian Ad Litem programs, and other agencies as determined appropriate by the Department of Health and Human Services.

PROPOSED LEGISLATION

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

U **D**

BILL DRAFT 2013-LUz-137 [v.7] (03/04)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/7/2014 3:19:12 PM

Short Title:	Update/Modernize Midwifery Practice Act.	(Public)
Sponsors:	(Primary Sponsor).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO UPDATE AND MODERNIZE THE MIDWIFERY PRACTICE ACT, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

Whereas, certified nurse-midwives are advanced practice registered nurses who are formally educated with current requirements for graduate level education and have achieved certification by the American Midwifery Certification Board; and

Whereas, North Carolina ranks 44th in the nation in infant mortality and 37th in maternal mortality; and

Whereas, women in North Carolina face disparities in access to prenatal health care services as half of North Carolina counties have three or fewer obstetricians, 31 counties have no obstetricians, and 46 counties have no certified nurse-midwives; and

Whereas, women in North Carolina face disparities in primary health care services as 78 counties are designated as health professional shortage areas by the Health Resources and Services Administration; and

Whereas, the American Congress of Obstetricians and Gynecologists projects a workforce shortage of obstetricians/gynecologists and recommends certified nurse-midwives as part of the solution; and

Whereas, care by certified nurse-midwives within a health care system has been shown to produce high quality outcomes at lower costs; and

Whereas, access to care by certified nurse-midwives has specifically been shown to decrease rates of neonatal and infant mortality, low birth weight, medical intervention, and caesarean section; and

Whereas, the requirement to practice under the supervision of a physician creates an undue restriction on the practice of certified nurse-midwives and inappropriate liability for the physician; and

Whereas, 24 states and the District of Columbia allow certified nurse-midwives to practice independently, without a collaborative or supervisory practice agreement with a physician; and

Whereas, the Institute of Medicine has found access to care from certified nurse-midwives has improved primary health care services for women in rural and inner city areas and recommends removing scope-of-practice barriers, such as the requirement of

physician supervision, and allowing certified nurse-midwives to practice to the full extent of their education and training; and

Whereas, the American College of Obstetricians and Gynecologists and the American College of Nurse-Midwives have jointly stated that obstetricians/gynecologists and certified nurse-midwives "are experts in their respective fields of practice and are educated, trained, and licensed, independent providers" and that obstetricians/gynecologists and certified nurse-midwives "should have access to a system of care that fosters collaboration among licensed, independent providers"; and

Whereas, the Federal Trade Commission has found that removing restrictions on the practice of advanced practice registered nurses such as certified nurse-midwives "has the potential to benefit consumers by expanding choices for patients, containing costs, and improving access"; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 1 of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-18.7. Limitations on nurse-midwives.**

(a) Any certified nurse-midwife approved under the provisions of Article 10A of this Chapter to provide midwifery care may use the title "certified nurse-midwife." Any other person who uses the title in any form or holds himself or herself out to be a certified nurse-midwife or to be so approved shall be deemed to be in violation of this Article.

(b) A certified nurse-midwife is authorized to write prescriptions for drugs if all of the following conditions are met:

(1) The certified nurse-midwife has current approval from the joint subcommittee established under G.S. 90-178.4.

(2) The joint subcommittee as established under G.S. 90-178.4 has assigned an identification number to the certified nurse-midwife that appears on the written prescription.

(3) The joint subcommittee as established under G.S. 90-178.4 has provided to the certified nurse-midwife written instructions about indications and contraindications for prescribing drugs and a written policy for periodic review of the drugs prescribed.

(c) The joint subcommittee of the North Carolina Medical Board and the Board of Nursing, established under G.S. 90-178.4, shall adopt rules governing the approval of individual certified nurse-midwives to write prescriptions with any limitations the joint subcommittee deems is in the best interest of patient health and safety, consistent with the rules established for nurse practitioners under G.S. 90-18.2(b)(1)."

SECTION 2. G.S. 90-178.2 reads as rewritten:

"**§ 90-178.2. Definitions.**

~~As used in this Article:~~The following definitions apply in this Article:

(1) Certified nurse-midwife. – A nurse licensed and registered under Article 9A of this Chapter who has completed a midwifery education program accredited by the Accreditation Commission for Midwifery Education, passed a national certification examination administered by the American Midwifery Certification Board, and has received the professional designation of 'Certified Nurse-Midwife' (CNM). Certified nurse-midwives practice in accordance with the Core Competencies for Basic Midwifery Practice, the Standards for the Practice of Midwifery, the Philosophy of the

American College of Nurse-Midwives (ACNM), and the Code of Ethics promulgated by the ACNM.

(1a) Collaborating provider. – A physician licensed to practice medicine under Article 1 of this Chapter for a minimum of four years and who is or has engaged in the practice of obstetrics or a certified nurse-midwife who has been approved to practice midwifery under this Article for a minimum of four years.

(1b) Collaborative provider agreement. – A formal, written agreement between a collaborating provider and a certified nurse-midwife with less than 24 months and 2,400 hours of practice as a certified nurse-midwife to provide consultation and collaborative assistance or guidance.

(2) "Interconceptional care" includes but is not limited to:

~~a. Family planning;~~

~~b.~~a. Screening for cancer of the breast and reproductive tract;

~~c.~~b. Screening for and management of minor infections of the reproductive organs;

c. Gynecologic care, including family planning, perimenopause, and postmenopause care; and

(3) ~~"Intrapartum care" includes but~~Intrapartum care. – Care that focuses on the facilitation of the physiologic birth process and includes but is not limited ~~to:~~to the following:

a. ~~Attending women in uncomplicated labor;~~Confirmation and assessment of labor and its progress.

b. ~~Assisting with spontaneous delivery of infants in vertex presentation from 37 to 42 weeks gestation;~~Identification of normal and deviations from normal and appropriate interventions, including management of complications, abnormal intrapartum events, and emergencies.

b1. Management of spontaneous vaginal birth and appropriate third-stage management, including the use of uterotonics.

c. Performing ~~amniotomy;~~amniotomy.

d. Administering local ~~anesthesia;~~anesthesia.

e. Performing episiotomy and ~~repair; and~~repair.

f. Repairing lacerations associated with childbirth.

(4) "~~Midwifery" means the~~Midwifery. – The act of providing prenatal, intrapartum, postpartum, newborn and interconceptional care. The term does not include the practice of medicine by a physician licensed to practice medicine when engaged in the practice of medicine as defined by law, the performance of medical acts by a physician assistant or nurse practitioner when performed in accordance with the rules of the North Carolina Medical Board, the practice of nursing by a registered nurse engaged in the practice of nursing as defined by ~~law, or the rendering of childbirth assistance in an emergency situation.~~law, or the performance of abortion, as defined in G.S. 90-21.6.

(5) ~~"Newborn care" includes~~Newborn care. – Care that focuses on the newborn and includes, but is not limited ~~to:~~to, the following:

a. Routine assistance to the newborn to establish respiration and maintain thermal ~~stability;~~stability.

b. Routine physical assessment including APGAR ~~scoring;~~scoring.
c. Vitamin K ~~administration; and~~administration.
d. Eye prophylaxis for opthalmia neonatorum.
e. Methods to facilitate newborn adaptation to extrauterine life, including stabilization, resuscitation, and emergency management as indicated.

(6) ~~"Postpartum care"includes~~Postpartum care. – Care that focuses on management strategies and therapeutics to facilitate a healthy puerperium and includes, but is not limited ~~to:~~to, the following:
a. Management of the normal third stage of ~~labor;~~labor.
b. Administration of ~~pitocin and methergine~~uterotonics after delivery of the infant when ~~indicated; and~~indicated.
c. Six weeks postpartum evaluation exam and initiation of family planning.
d. Management of deviations from normal and appropriate interventions, including management of complications and emergencies.

(7) ~~"Prenatal care" includes~~Prenatal care. – Care that focuses on promotion of normal pregnancy using management strategies and therapeutics as indicated and includes, but is not limited ~~to:~~to, the following:
a. ~~Historical and physical assessment;~~Obtaining history with ongoing physical assessment of mother and fetus.
b. Obtaining and assessing the results of routine laboratory ~~tests; and~~tests.
b1. Confirmation and dating of pregnancy.
c. Supervising the use of prescription and nonprescription medications, such as prenatal vitamins, folic acid, ~~iron, and nonprescription medicines.~~and iron."

SECTION 3. G.S. 90-178.3 reads as rewritten:

"**§ 90-178.3. Regulation of midwifery.**

(a) No person shall practice or offer to practice or hold oneself out to practice midwifery unless approved ~~pursuant to~~ under this Article.

(b) A ~~person~~ certified nurse-midwife approved ~~pursuant to~~ under this Article may practice midwifery in a hospital or non-hospital ~~setting and~~setting. The certified nurse-midwife shall ~~practice under the supervision of a physician licensed to practice medicine who is actively engaged in the practice of obstetrics.~~consult, collaborate with, or refer to other providers licensed under this Article, if indicated by the health status of the patient. A ~~registered nurse~~certified nurse-midwife approved ~~pursuant to~~ under this Article is authorized to write prescriptions for drugs in accordance with ~~the same conditions applicable to a nurse practitioner under G.S. 90-18.2(b).~~G.S. 90-18.7(b).

(b1) A certified nurse-midwife with less than 24 months and 2,400 hours of practice as a certified nurse-midwife shall: (i) have a collaborative provider agreement with a collaborating provider and (ii) maintain signed and dated copies of the collaborative provider agreement as required by practice guidelines and any rules adopted by the joint subcommittee of the North Carolina Medical Board and the Board of Nursing. If a collaborative provider agreement is terminated before the certified nurse-midwife acquires the level of experience required for approval under this Article, the certified nurse-midwife shall have 90 days from the date the agreement is terminated to enter into a collaborative provider agreement with a new

collaborating provider. During the 90-day period, the certified nurse-midwife may continue to practice midwifery as defined under this Article.

(c) Graduate nurse midwife applicant status may be granted by the joint subcommittee in accordance with G.S. 90-178.4."

SECTION 4. G.S. 90-178.4(a) reads as rewritten:

"(a) The joint subcommittee of the North Carolina Medical Board and the Board of Nursing created ~~pursuant to~~ under G.S. 90-18.2 shall administer the provisions of this Article and the rules adopted ~~pursuant to~~ under this Article; Provided, however, that actions of the joint subcommittee ~~pursuant to~~ under this Article shall not require approval by the North Carolina Medical Board and the Board of Nursing. For purposes of this Article, the joint subcommittee shall be enlarged by ~~four~~ seven additional members, including ~~two certified midwives~~ five nurse-midwives appointed upon the recommendation of the North Carolina Affiliate of the American College of Nurse-Midwives and two ~~obstetricians~~ physicians actively engaged in the practice of obstetrics who have had working experience with ~~midwives.~~certified nurse-midwives."

SECTION 5. G.S. 90-178.4 is amended by adding the following new subsections to read:

"(a1) Any certified nurse-midwife who attends a planned birth outside of a hospital setting shall obtain a signed informed consent agreement from the certified nurse-midwife's patient that shall include:

(1) Information about the risks associated with a planned birth outside of the hospital.

(2) A clear assumption of those risks by the patient.

(3) An agreement by the patient to consent to transfer to a health care facility when and if deemed necessary by the certified nurse-midwife.

(4) If the certified nurse-midwife is not covered under a policy of liability insurance, a clear disclosure to that effect.

(a2) Any certified nurse-midwife who attends a planned birth outside of a hospital setting shall provide to each patient a detailed, written plan for emergent and nonemergent transfer, which shall include:

(1) The name of and distance to the nearest health care facility licensed under Chapter 122C or 131E of the General Statutes that has at least one operating room.

(2) The procedures for transfer, including mode(s) of transportation and method(s) for notifying the relevant health care facility of impending transfer."

SECTION 6. G.S. 90-178.4(b) reads as rewritten:

"(b) The joint subcommittee shall adopt rules ~~pursuant to~~ under this Article to establish each of the following:

(1) A fee which shall cover application and initial approval up to a maximum of one hundred dollars ~~($100.00);~~($100.00).

(2) An annual renewal fee to be paid by January 1 of each year by persons approved ~~pursuant to~~under this Article up to a maximum of fifty dollars ~~($50.00);~~($50.00).

(3) A reinstatement fee for a lapsed approval up to a maximum of five dollars ~~($5.00);~~($5.00).

(4) The form and contents of the applications which shall include information related to the applicant's education and certification by the ~~American College of Nurse-Midwives; and~~American Midwifery Certification Board.

(5) The procedure for establishing ~~physician supervision~~collaborative provider agreements as required by this Article."

SECTION 7. G.S. 90-178.5 reads as rewritten:

"**§ 90-178.5. Qualifications for ~~approval.~~approval; independent practice.**

(a) In order to be approved by the joint subcommittee ~~pursuant to~~ under this Article, a person ~~shall:~~shall comply with each of the following:

(1) Complete an application on a form furnished by the joint ~~subcommittee;~~subcommittee.

(2) Submit evidence of certification by the ~~American College of Nurse-Midwives;~~American Midwifery Certification Board.

(3) Submit evidence of ~~arrangements for physician supervision; and~~a collaborative provider agreement as required by G.S. 90-178.3(b1).

(4) Pay the fee for application and approval.

(b) Upon submitting to the joint subcommittee evidence of completing 24 months and 2,400 hours of practice as a certified nurse-midwife pursuant to a collaborative provider agreement, a certified nurse-midwife is authorized to practice midwifery independently in accordance with this Article."

SECTION 8. G.S. 90-178.7 reads as rewritten:

"**§ 90-178.7. Enforcement.**

(a) The joint subcommittee may apply to the Superior Court of Wake County to restrain any violation of this Article.

(b) ~~Any person who violates G.S. 90-178.3(a) shall be guilty of a Class 3 misdemeanor.~~No person shall perform any act constituting the practice of midwifery, as defined in this Article, or any of the branches thereof, unless the person shall have been first approved under this Article. Any person who practices midwifery without being duly approved and registered, as provided in this Article, shall not be allowed to maintain any action to collect any fee for such services. Any person so practicing without being duly approved shall be guilty of a Class 3 misdemeanor. Any person so practicing without being duly approved under this Article and who is falsely representing himself or herself in a manner as being approved under this Article or any Article of this Chapter shall be guilty of a Class I felony."

SECTION 9. Article 10A of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-178.8. Limit vicarious liability.**

(a) No physician or physician assistant, including the physician assistant's employing or supervising physician, licensed under Article 1 of this Chapter or nurse licensed under Article 9A of this Chapter, shall be held liable for any civil damages as a result of the medical care or treatment provided by the physician, physician assistant, or nurse when:

(1) The physician, physician assistant, or nurse is providing medical care or treatment to a woman or infant in an emergency situation; and

(2) The emergency situation arises during the delivery or birth of the infant as a consequence of the care provided by a certified nurse-midwife approved under this Article who attends a planned birth outside of a hospital setting.

However, the physician, physician assistant, or nurse shall remain liable for his or her own independent acts of negligence.

(b) No health care facility licensed under Chapter 122C or 131E of the General Statutes shall be held liable for civil damages as a result of the medical care or treatment provided by the facility when:

(1) The facility is providing medical care or treatment to a woman or infant in an emergency situation; and

(2) The emergency situation arises during the delivery or birth of the infant as a consequence of the care provided by a certified nurse-midwife approved under this Article who attends a planned birth outside of a hospital setting.

However, the health care facility shall remain liable for its own independent acts of negligence.

(c) Nothing in this section shall be construed to limit liability when the civil damages to this section are the result of gross negligence or willful or wanton misconduct."

SECTION 10. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

U **D**

BILL DRAFT 2013-SHz-9 [v.2] (03/06)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/7/2014 3:01:52 PM

Short Title:	Status Reports Filed by Guardians.	(Public)
Sponsors:	(Primary Sponsor).	
Referred to:		

A BILL TO BE ENTITLED

AN ACT TO AMEND THE REQUIRED CONTENTS OF A STATUS REPORT FILED BY A PUBLIC GUARDIAN, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 35A-1202 reads as rewritten:

"**§ 35A-1202. Definitions.**

When used in this Subchapter, unless a contrary intent is indicated or the context requires otherwise:

…

(10) "Guardian of the person" means a guardian appointed solely for the purpose of performing duties relating to the care, custody, and control of a ward.

…

(14) "Status report" means the report required by G.S. 35A-1242 to be filed by the general guardian or guardian of the person. ~~A status report shall include a report of a recent medical and dental examination of the ward by one or more physicians or dentists, a report on the guardian's performance of the duties set forth in this Chapter and in the clerk's order appointing the guardian, and a report on the ward's condition, needs, and development. The clerk may direct that the report contain other or different information. The report may also contain, without limitation, reports of mental health or mental retardation professionals, psychologists, social workers, persons in loco parentis, a member of a multidisciplinary evaluation team, a designated agency, a disinterested public agent or agency, a guardian ad litem, a guardian of the estate, an interim guardian, a successor guardian, an officer, official, employee or agent of the Department of Health and Human Services, or any other interested persons including, if applicable to the ward's situation, group home parents or supervisors, employers, members of the staff of a treatment facility, or foster parents.~~

(15) "Ward" means a person who has been adjudicated incompetent or an adult or minor for whom a guardian has been appointed by a court of competent jurisdiction."

SECTION 2. G.S. 35A-1242 reads as rewritten:

"**§ 35A-1242. Status reports for incompetent wards.**

(a) Any corporation or disinterested public agent that is guardian of the person for an incompetent person, within six months after being appointed, shall file an initial status report with ~~the designated agency, if there is one, or with~~ the clerk. The initial status report shall also be submitted to the designated agency, if there is one. Such guardian shall file a second status report with the ~~designated agency or the~~ clerk one year after being appointed, and subsequent reports annually thereafter. The clerk may order any other guardian of the person to file status reports. If a guardian required by this section to file a status report is employed by the designated agency, the guardian shall file any required status report with both the designated agency and the clerk.

(a1) Each status report shall include the items outlined below.

(1) A report of recent medical and dental examinations of the ward by one or more physicians and dentists.

(2) A report on the guardian's performance of the duties set forth in this Chapter and in the clerk's order appointing the guardian.

(3) A report on the ward's residence, education, employment, and rehabilitation or habilitation.

(4) A report of the guardian's efforts to restore competency.

(5) A report of the guardian's efforts to seek alternatives to guardianship.

(6) If the guardians in a disinterested public agent or corporation, a report of the efforts to identify alternative guardians.

(7) The guardian's recommendations for implementing a more limited guardianship, preserving for the ward the opportunity to exercise rights that are within ward's comprehension and judgment.

(8) Any additional reports or information required by the clerk.

(a2) The guardian may include in the status report additional information pertaining to the ward's best interests.

(b) Each status report shall be filed under the guardian's oath or affirmation that the report is complete and accurate so far as he is informed and can determine.

(b1) The clerk shall make status reports submitted by disinterested public agents or corporations available to Director, or the Director's designee, of the Division of Aging and Adult Services, Department of Health and Human Services. The Director, or the Director's designee, shall review the status reports in connection with its regular program of oversight for these categories of guardians.

(c) A clerk ~~or designated agency~~ that receives a status report shall not make the status report available to anyone other than the guardian, the ward, the court, or State or local human ~~resource~~ services agencies providing services to the ward.

(d) The clerk, on his or her own motion, or any interested party may file a motion in the cause pursuant to G.S. 35A-1207 with the clerk in the county where the guardianship is docketed to request modification of the order appointing the guardian or guardians or for consideration of any matters contained in the status report."

SECTION 3. This act becomes effective October 1, 2014.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

U **D**

BILL DRAFT 2013-MGz-142 [v.4] (04/08)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/10/2014 3:03:16 PM

Short Title:	Improve Oversight of Public Guardianship.	(Public)
Sponsors:		
Referred to:		

A BILL TO BE ENTITLED

AN ACT REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EXAMINE WAYS TO IMPROVE THE INTEGRITY, EFFICIENCY AND OVERSIGHT OF THE PUBLIC GUARDIANSHIP SYSTEM, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Aging and Adult Services, shall collaborate with the Administrative Office of the Courts to develop a plan regarding the Department's evaluation of complaints pertaining to wards under the care of publicly funded guardians in order to ensure that, in addition to current requirements, the complaint process also incorporates a face-to-face observation of the ward, an interview with the ward, or both. The plan shall include a requirement that an individual with experience in understanding the unique needs and abilities of the ward be assigned to conduct the observation or interview.

SECTION 2. The Department of Health and Human Services, Division of Social Services, shall study the issue of conflicts of interest in child welfare cases as related to public guardianship. In conducting the study, the Department shall consider the following regarding addressing potential conflicts of interest:

(1) Creating internal firewalls to prevent information sharing and influence among staff members involved with the conflicting cases.
(2) Creating a formal or an informal "buddy system" allowing a county with a conflict to refer a case to a neighboring county.
(3) Referring the guardianship to a corporate guardian until the child welfare case is resolved.
(4) Having the Department assume responsibility for either the guardianship or the child welfare case.
(5) Recommending legislation to permit the clerk the option to appoint a public agency or official, other than the director of social services, to serve as a disinterested public agent in exceptional circumstances only.
(6) Any other issues specific to this matter the Department deems appropriate.

SECTION 3. The Department of Health and Human Services shall continue utilizing existing safeguards regarding guardians as paid service providers. In addition, the

Division of Aging and Adult Services of the Department of Health and Human Services shall consult with the clerks of superior court, local management entities that have been approved as managed care organizations, the North Carolina Bar Association Section on Elder Law, and any other interested groups, to develop a model plan for transitioning a ward to an alternative guardianship arrangement when an individual guardian of the person becomes unable or unwilling to serve. The model plan shall focus on ways to prevent the appointment of a public guardian.

SECTION 4. The Department of Health and Human Services shall continue to study whether utilization of care coordination services would provide needed oversight to safeguard against conflicts of interest when guardians serve as paid providers.

SECTION 5. The Department shall submit a final report of its findings and recommendations for each of the issues described in sections 1 through 4 of this act to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than October 1, 2014.

SECTION 6. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

U **D**

BILL DRAFT 2013-MGz-141 [v.10] (04/07)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/10/2014 12:26:00 PM

Short Title: Strategies for Improving MH-DD-SAS. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP AND REPORT ON STRATEGIES AND RECOMMENDATIONS FOR IMPROVING THE DELIVERY OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services ("Department") shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2014, that includes all of the following components:

(1) A strategy for improving communication and coordination among all divisions within the Department that administer funds or programs related to the delivery of behavioral health services, especially regarding the most appropriate and efficient uses of public and private inpatient behavioral health services. The Department shall include as part of its strategy a process to address shortages and deficiencies identified in the annual State Medical Facilities Plan.

(2) A plan developed in collaboration with local management entities that have been approved to operate as managed care organizations ("LME/MCOs") to increase access to, and availability of, community-based outpatient crisis and emergency services for the stabilization and treatment of individuals experiencing mental health, developmental disability, or substance abuse crises in settings other than local hospital emergency departments and State-operated psychiatric hospitals.

(3) A plan to ensure that a comprehensive array of outpatient treatment and crisis prevention and intervention services are available and accessible to children, adolescents, and adults in every LME/MCO catchment area. The plan shall ensure that an adequate number of crisis stabilization units are available in each LME/MCO catchment area.

(4) Findings and recommendations for increasing the inventory of inpatient psychiatric and substance abuse services within the State. In developing its findings and recommendations, the Department shall examine the advantages and disadvantages of increasing this inventory of services through (i) additional State-operated facilities, (ii) community hospital beds, (iii) United States Veterans Administration beds, and (iv) community-based services that decrease the need for inpatient treatment.

(5) A plan for offering hospitals and other entities incentives to apply for licenses to begin offering new inpatient behavioral health services, or to begin operating existing licensed beds that are currently unstaffed, or both.

(6) Recommendations on the use of the existing Cherry Hospital buildings after patients and operations are relocated to the replacement facility. In developing its findings and recommendations, the Department shall conduct a study that includes development of an inventory and assessment of the condition of every building located on the existing Cherry Hospital campus. The study shall include an examination of the feasibility of using the existing Cherry Hospital facility to provide community-based and facility-based behavioral health services, including additional child and adolescent inpatient beds.

(7) A method by which the Division of Health Service Regulation can begin tracking and separately reporting no later than January 1, 2015, on the inventory of inpatient behavioral health beds for children ages six through 12 and for adolescents over age 12.

(8) A status update on the implementation of each component of the 2008 Mental Health Commission Workforce Development Plan.

SECTION 2. The Department shall submit a report to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division by March 1, 2015, that includes all of the following components:

(1) A comprehensive strategy, developed in collaboration with stakeholders deemed relevant by the Department, to address the dearth of licensed child and adolescent inpatient psychiatric beds throughout the State. The strategy shall:

a. Ensure that an adequate inventory of child and adolescent beds are available in each LME/MCO catchment area.

b. Include the development and implementation of a child and adolescent psychiatric bed registry to provide real-time information on the number of beds available at each licensed inpatient facility in the State.

(2) Recommendations for meaningful outcome measures to be implemented by State-operated alcohol and drug abuse treatment centers to assess the impact of inpatient treatment on an individual's substance use following discharge from a State-operated alcohol and drug abuse treatment center. The recommendations shall include a proposed timeline for implementation of these outcome measures.

SECTION 3. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2013

S **D**

BILL DRAFT 2013-MEz-100* [v.7] (03/27)

(THIS IS A DRAFT AND IS NOT READY FOR INTRODUCTION)
4/15/2014 1:22:54 PM

Short Title: State Plan Amendments/ Submission and Notice. (Public)

Sponsors:

Referred to:

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ADDITIONAL PUBLIC POSTING AND NOTICE OF STATE PLAN AMENDMENTS AND TO REQUIRE SUBMISSION OF A STATE PLAN AMENDMENT TO THE FEDERAL GOVERNMENT PRIOR TO THE EFFECTIVE DATE OF THE STATE PLAN AMENDMENT, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 108A-54.1A reads as rewritten:

"**§ 108A-54.1A. Amendments to Medicaid State Plan and Medicaid Waivers.**

…

(d) No fewer than 10 days prior to submitting an amendment to the State Plan to the federal government, the Department shall post the amendment on its Web site and notify the members of the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division that the amendment has been posted. This requirement shall not apply to draft or proposed amendments submitted to the federal government for comments but not submitted for approval. The amendment shall remain posted on the Department's Web site at least until the plan has been approved, rejected, or withdrawn. If the authority for submitting the amendment to the State Plan is pursuant to subdivision (3), (4), (5), or (6) of subsection (b) of this section, then, prior to submitting an amendment to the federal government, the Department shall submit to the General Assembly members receiving notice under this subsection and to the Fiscal Research Division an explanation of the amendment, the need for the amendment, and the federal time limits required for implementation of the amendment.

(e) The Department shall submit an amendment to the State Plan to the federal government by a date sufficient to provide the federal government adequate time to review and approve the amendment so the amendment may be effective by the date required by the directing authority in subsection (b) of this section. Additionally, if a change is made to the Medicaid program by the General Assembly and that change requires an amendment to the State Plan, then the amendment shall be submitted at least 90 days prior to the effective date of the change as provided in the legislation.

(e) The Department shall submit an amendment to the State Plan to the federal government ~~by a date sufficient to provide the federal government adequate time to review and approve the amendment so the amendment may be effective by the date required by the~~

~~directing authority in subsection (b) of this section.~~ at least 90 days prior to the effective date of the amendment, regardless of any later submission date allowed under federal law.

(f) Any public notice required under 42 CFR 447.205 shall, in addition to any other posting requirements under federal law, be posted on the Department's Web site. Upon posting such a public notice, the Department shall notify the members of the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division that the public notice has been posted. Public notices shall remain posted on the Department's website."

SECTION 2.(a) G.S. 108A-55(c) reads as rewritten:

"(c) The Department shall reimburse providers of services, equipment, or supplies under the Medical Assistance Program in the following amounts:

(1) The amount approved by the ~~Health Care Financing Administration~~ Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services, if ~~that Administration~~ CMS approves an exact reimbursement ~~amount;~~ amount.

(2) The amount determined by application of a method approved by the ~~Health Care Financing Administration~~ Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services, if ~~that Administration~~ CMS approves the method by which a reimbursement amount is determined, and not the exact amount.

The Department shall establish the methods by which reimbursement amounts are determined in accordance with Chapter 150B of the General Statutes. A change in a reimbursement amount becomes effective as of the date for which the change is approved by the ~~Health Care Financing Administration~~ Centers for Medicare & Medicaid Services (CMS) of the United States Department of Health and Human Services. ~~The Department shall report to the Fiscal Research Division of the Legislative Services Office and to the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Human Resources or the Joint Legislative Oversight Committee on Health and Human Services on any change in a reimbursement amount at the same time as it sends out public notice of this change prior to presentation to the Health Care Financing Administration.~~"

SECTION 2.(b) By repealing language in subsection (a) of this section related to giving to the General Assembly notice of a public notice, it is not the intent of the General Assembly to remove the required notice of the changes to reimbursement amounts for services, equipment, or supplies. Rather, it is the intent that those notices be given pursuant to G.S. 108A-54.1A(f), rather than pursuant to both G.S. 108A-54.1A(f) and G.S. 108A-55(c).

SECTION 3. This act becomes effective July 1, 2014, and the amendment to G.S. 108A-54.1A(e) applies to State Plan Amendments with effective dates on or after September 1, 2014.