

# **Clarifying County and State Responsibilities**

**Final Report of the 2001-02 NCACC Functional and Fiscal Task Force**

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**June, 2003**

# Clarifying County and State Responsibilities

## Findings and Recommendations of the 2001-02 NCACC Functional and Fiscal Task Force

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NCACC President David Plyler appointed a task force to examine county and state fiscal responsibilities, with initial attention to human services and public education, in order to determine whether those relationships and responsibilities are appropriate and sound. The task force, co-chaired by Dr. Breeden Blackwell, Cumberland County Commissioner, and Dr. John Thuss, Jr., Caldwell County Commissioner, included county commissioners, county managers, a county social services director and General Assembly members. To ensure executive branch understanding of county issues, Ann Lichtner, Governor Easley's Director of Intergovernmental Relations, participated in task force discussions.

During its first nine months of deliberation, task force members developed, debated and modified numerous recommendations for realignment of county responsibilities vis a vis the state. In deciding how best to provide public services, the task force considered its key question is how to assign responsibility to units of local government and state agencies for administration, finance, and decision-making. That is, in the case of each public service, who should provide it, who should pay for it, and who should make decisions about it? After much information gathering and discussion, the committee makes its principal findings in the following two main areas of concern:

**Medicaid. Counties should be relieved of the responsibility for paying Medicaid program costs. Counties should continue to administer the program according to federal and state regulations and pay the current 50 percent administrative costs.**

In most states, the state government administers the Medicaid program and fully funds the nonfederal share of Medicaid costs. In North Carolina, counties serve as agents of the state in determining eligibility for qualifying citizens, but they do so according to strict federal and state regulations. Counties pay 50 percent of the local cost to administer the Medicaid program, while the federal government pays the other 50 percent. NC counties are also mandated to pay 15 percent of the nonfederal program costs or about 5.7 percent of the total costs for medical services provided.

The task force found that it is inappropriate for counties to pay for Medicaid program costs, for the following reasons:

- Because the program must be provided uniformly throughout the state, the federal and state governments make all the decisions about the program. The federal and state governments decide who will be eligible, which services will be provided, and how much will be paid to medical care service providers. Counties make none of the decisions that determine Medicaid program costs, and therefore they have no control over their share of such costs.
- Poorer counties have relatively more poor people eligible for the Medicaid program. Poorer counties also have lower tax bases and lower incomes, making Medicaid program costs more burdensome for them.
- Exploding increases in Medicaid costs have greatly reduced the ability of counties to support other programs for which counties have appropriate administrative and program cost responsibilities, such as: EMS, law enforcement, jail and court facilities, public works projects, economic development, senior services, social services, public health programs, library services, public schools, and other functions and services.

**Public education. The General Assembly should act to fulfill its responsibilities under existing laws by providing from state revenues the resources needed for the standard course of study that must be made available in every public school throughout the state. Counties should continue to be responsible for building and maintaining capital facilities.**

Since 1868 North Carolina's constitution has made the General Assembly responsible for providing a "general and uniform" system of public schools. In 1933 the state accepted responsibility for paying all the operating expenses of the public schools for an eight-month term. In subsequent decades, as counties increasingly supplemented state operating funds, the responsibilities of the states and counties became unclear. In 1984, in an effort to improve public schools, the General Assembly enacted into law a requirement that a "standard course of study" be devised that would define an adequate, minimum education program to be provided in all public schools. One provision of the law (General Statutes, Chapter 115C) established the state's responsibility, as follows:

"To insure a quality education for every child in North Carolina, and to assure that the necessary resources are provided, it is the policy of the State of North Carolina to provide from State revenue sources the instructional expenses for current operations of the public school system as defined in the standard course of study."

## **Medicaid**

### **Why Should Counties Be Relieved of Medicaid Service Costs?**

The task force believed that its primary recommendations should be firmly grounded on guiding principles to answer appropriately who should provide a service, who should pay for a service, and who should make decisions about a service. The following findings clearly enunciate that county funding in Medicaid services is inappropriate, given the minimal discretion counties have in influencing Medicaid policies, the disproportionate burden Medicaid has on poorer counties, and the growing inability of counties to meet other critical service demands in light of Medicaid cost escalation.

### **County Responsibilities for Medicaid Costs**

The basic purpose of county government in North Carolina is to serve as an agent of the state government in administering certain statewide services that must be offered at the local level. In this role counties administer three main categories of statewide services on behalf the state government – public education, public health and social services programs. Medicaid is just one of the many social services programs that counties administer on behalf the state. These programs are financed mainly by the federal and state governments, though in North Carolina the state requires that counties pay for administrative costs and certain other costs of these programs.

This paper addresses some of the increasingly serious issues that have arisen as a result of the expansion in the Medicaid program and the dramatic escalation in costs of the program. Because these issues have implications not just for the Medicaid program but for all other services provided by counties, it is important to reassess responsibilities for the Medicaid program in terms of basic principles that should govern the assignment of state and local responsibilities for such state programs.

### **Current responsibilities for the Medicaid program.**

Medicaid is a federal program that provides medical services to poor people. State governments are responsible for administering the program, for determining who will be eligible, for deciding which medical services will be covered, for setting fees that will be paid to medical providers, and for paying costs not covered by the federal government.

There are two types of costs in Medicaid – program costs and administrative costs. Program costs are comprised of the payments made to medical service providers, such as doctors and hospitals, to cover specific services rendered to eligible recipients. Administrative costs include the costs of managing the statewide program, determining eligibility of individuals who apply for services, paying providers and performing other functions required by the program.

The federal government pays a share of program costs that varies according to the states' per capita income. States must pay the balance of program costs, which is called “the non-federal share.” Currently in North Carolina the non-federal share of program costs is about 38 percent of total program costs.

In most states responsibility for the Medicaid program rests solely with state agencies, and therefore state governments pay for all administrative costs and all the non-federal share of program costs. In some other states counties or other local government units have responsibility for administering the program at the local level, but they are not required to pay a portion of the non-federal share of program costs. North Carolina is one of a few states that require local governments to pay part of the non-federal share of program costs.

Based on a task force-sponsored research project, 17 states out of 41 respondents required some participation in Medicaid costs by their counties – 13 for administrative costs and 15 for services costs. However, only 2 states – North Carolina and New York – required counties to participate in all of the Medicaid services costs presented in the survey.

North Dakota and Montana have recently eliminated county participation in Medicaid. North Dakota counties agreed to pay 100 percent of administrative costs without federal reimbursement, while the state claims the federal reimbursement to offset program costs. North Dakota has adopted this model – counties fully fund administrative costs while the state fully funds the programs' services costs and claims federal reimbursement for the counties' administrative costs – for all economic programs. The state does require continued county

participation in elderly and juvenile in-home services. Montana counties ceded motor vehicle registration and gaming revenues to the state for its assumption of Medicaid program costs. (More study findings can be found in Appendix F.)

In North Carolina, county governments are required to bear the cost of local administration and also to pay 15 percent of the non-federal share of program costs (which amounts to about 5.7 percent of total program costs). The financial burden of these responsibilities on counties is becoming substantially greater every year. Currently the county share of non-federal program costs is about \$350 million per year, and is expected to increase to about \$450 million in 2002-03. Medicaid costs have been growing at about 15 percent per year. In addition, the counties' administrative costs amount to about \$57 million each year.

### **Assigning responsibilities for the Medicaid program**

The basic decisions that the General Assembly must make in assigning responsibility for various public programs involve three questions: Who should administer the program? Who should pay for the program? Who should make decisions about the program?

#### **Who should administer Medicaid?**

County governments have proven that they can efficiently and effectively administer programs at the local level on behalf of the state. They have done so not only for Medicaid services but also for public schools, public health, and social services programs. Counties already determine eligibility of individuals for social services programs such as the food stamp program and the Temporary Assistance for Needy Families (TANF) program. It would be needless and wasteful, then, for the state to establish local or regional offices and hire state employees to determine eligibility of individuals. Thus it seems appropriate that the state has assigned to counties the responsibility for determining Medicaid eligibility according to rules established by the state.

All other administrative functions of Medicaid must be performed by state agencies because the program must be uniform across the state. Thus the state government is responsible for overall management of the program, for establishing statewide rules for determining who will be eligible to receive services, for deciding what services will be covered by the program, and for setting fees that will be paid to medical service providers for the various services rendered.

#### **Who should pay for Medicaid costs?**

Paying for services that are strictly local in nature. As a general principle, it is best to leave responsibility for paying for a public service at the local level if the service in question is of concern only to local residents. For these kinds of services the local community, through their elected officials, must decide how much of the service they want and are willing to pay for through local taxes and fees. For example, North Carolina makes local governments responsible for deciding the size of the local police force, the number of firefighters who will be employed, and the size and scope of recreation programs. The local community is expected to bear the cost of the level of service it chooses for these programs. If the cost of providing a service rises, local officials must reassess the level of service. If they are not willing to pay the increased costs of a given service level, they can reduce the service level or try to provide the service more efficiently.

This principle does not apply in the case of Medicaid. The program is not just of concern to local residents. It is a federal and state program intended to provide services to needy people that otherwise would not be provided by local governments. The state requires that counties administer the program locally, which mainly involves determining eligibility of local residents according to state-set rules. Other than supervising county employees who do that, counties have no discretion as to the level of service or how services will be provided. Program costs can increase because the state changes eligibility rules, increases the types of services covered, or increases the fees that will be paid to providers. County officials have no control over, and no say in, these kinds of decisions. When costs rise for any of these reasons, counties must pay their proportionate share of the costs by increasing taxes or by reducing spending on other services funded through the county budget.

Paying for services that are statewide in nature. Individual communities determine the level of services they want for local services such as police, fire protection and recreation programs. Statewide services, such as highways and roads, corrections and the court system, must be provided uniformly across the state. If counties

are to administer a service, the state sets uniform standards and provides financing to compensate for disparities in the counties' ability to pay.

The state public school system is an example of a service that must be provided uniformly, at least to a degree. North Carolina's constitution requires the General Assembly provide for a "general and uniform" system of public schools. Because there are great disparities in the ability of counties to finance schools, financing schools cannot be left to counties. Instead, the state defines a basic education program and pays the operating expenses for that program in all the schools (local units may supplement the state program, and are responsible for building and maintaining school facilities).

The Medicaid program must also be provided uniformly across the state. A uniform services level is set by the state when it defines who is eligible, what medical services are covered, and how much will be paid by the state to medical care providers. Although the state does not require counties to pay all costs of the program, it makes counties responsible for a set proportion of total program costs, an amount that is determined by decisions made by the state.

There are several consequences of making counties responsible for a proportion of program costs. First, poorer counties will tend to have relatively more poor people who qualify for Medicaid services, so their costs will be relatively higher than those of richer counties. Second, because of their lower property tax bases, the burden of taxes needed to pay for the local share will be higher in the poorer counties. Third, because of political resistance to increasing property tax rates, which exists in all counties, forcing counties to increase spending for a program over which they have no control will have the result of reducing the ability of counties to pay for those services over which they have some discretion. For example, forcing counties to increase their spending on Medicaid as program costs increase means that counties will have less ability to add to the state level of spending for public schools and for fulfilling their responsibilities for building and maintaining school facilities. Their ability to finance other county programs, including those the state requires them to provide, will be similarly reduced.

### **Who will make decisions about Medicaid?**

Two principles are relevant to this question. First, if we want to provide a service throughout the state in a uniform manner, the state will have to make decisions about how the service will be provided. If uniformity is not important, we can allow local officials to make the decisions about service levels and how a service will be provided. Second, because local circumstances and local needs vary, and because local officials are usually in the best position to manage a program provided at the local level, it is often best to give local officials at least some discretion and flexibility in deciding how a program is administered.

In the case of Medicaid, the program must necessarily be provided in a uniform manner throughout the state, and therefore the main decisions must be made by the state. The state sets uniform rules for eligibility, establishes the list of medical services that will be covered, and sets the fees that will be paid to providers. Counties have no authority or discretion in these matters. The only decisions made by counties have to do with supervising and providing facilities for employees who determine eligibility.

### **Summary and conclusion**

This analysis suggests that it is appropriate for the state to require counties to administer the Medicaid program at the local level, which mainly involves determining who is eligible for Medicaid services according to state-set rules. Counties already determine eligibility for other social services programs, and they can do so effectively for Medicaid as well. Counties must pay for these administrative costs, and apparently have no objection to doing so.

The remaining unresolved issue is whether counties should be responsible for paying a proportion of the non-federal share of program costs, or whether those costs should be borne by all taxpayers of the state through the state tax system. This analysis suggests three main reasons, aside from the substantial amount of the county share, why counties should not be responsible for program costs:

First, poorer counties have less ability to pay for program costs because of lower per capita income and low property tax bases, and because they are likely to have relatively more lower-income people eligible for the program.

Second, counties have no control over the factors that are causing large increases in program costs. Medicaid costs at both the state and local level depend mainly on three factors: the rules for determining who will be eligible to receive services and the services that they are entitled to receive; the number of people who qualify for services (which can change as eligibility rules change but also if economic weakness reduces incomes and thereby makes more people eligible); and the level of fees paid to medical care providers (though fees are set by the state, they must inevitably increase as medical costs increase). If the state wants to change the rules and fees that govern program costs, it should be responsible for paying for the resulting cost increases.

Third, the escalating burden of Medicaid costs on counties is reducing their ability to finance other needed services, many of which they provide in their role as agents of the state government.

Thereby, the task force finds the following:

**Counties should be relieved of the responsibility for paying Medicaid program costs. Counties should continue to administer the program according to federal and state regulations and pay the current 50 percent administrative costs.**

## **Public Education**

### **Responsibility for Financing Public Schools**

Since 1868, North Carolina's Constitution has made the General Assembly responsible for "providing a general and uniform" system of public schools. The 1868 Constitution required that public schools be provided in every county for a minimum term of four months. Since then the idea that a minimum level of education program should be provided in all the schools has been the basis for North Carolina's approach to financing schools. The history of public schools in North Carolina has mainly involved the struggle to achieve the goal of providing a specified minimum education program in all schools, despite great differences in the ability of the counties to finance schools, and, once that goal is met, to set the goal higher.

For a long time that minimum program was defined merely by the length of school term to be achieved. Even the four-month term could not be met until 1900, when the state began to provide regular state support. In 1901, the state supplied special grants to those counties that did not have sufficient resources to provide the minimum term. Once that goal was met, the constitution was changed to require a six-month term in all schools. That goal was not met until 1931, when the General Assembly committed the state to paying all the operating expenses for the six-month term.

In 1933 the General Assembly extended the length of the term to eight months. Existing local taxes for school support were abolished, but counties were authorized to supplement state funds if they chose to do so, and counties remained responsible for building and maintaining school facilities.

After 1933 the General Assembly added new school resources to the education program it financed, including free textbooks, bus transportation, the 12th grade, kindergarten, teaching assistants, and many other resources. But there was no way to determine what the state was responsible for – state spending depended solely on what the General Assembly chose to appropriate, and if that was not enough the counties had to supply the additional needs, if they could afford to do so. It became increasingly unclear what was a state responsibility and what was a county responsibility.

In 1984, in response to a national report on public education titled "A Nation at Risk," North Carolina began a new effort to improve the public schools. A blue-ribbon commission recommended a major initiative to provide needed resources in all schools by defining a standard course of study that should be made available to every child in the state. To insure that the resources called for by this new minimum education program would be available, the state was to be responsible for paying for them.

This program was enacted into law in 1984 as the Basic Education Program. Those laws are still in effect, and in fact constitute the state's school finance system. The State Board of Education is still charged with implementing the basic education program within funds appropriated for that purpose. The law still mandates that the standard course of study shall describe the "education program to be offered to every child in the public schools." The laws call for a minimum, but by no means minimal, standard course of study that includes instruction in "arts, communication skills, physical education and personal health and safety, mathematics, media and computer skills, science, second languages, social studies, and vocational and technical education." [GS 115C-81(a1)]

The law also established state responsibility for providing the resources needed for the standard course of study, while counties are responsible for facilities:

"To insure a quality education for every child in North Carolina, and to assure that the necessary resources are provided, it is the policy of the State of North Carolina to provide from State revenue sources the instructional expenses for current operations of the public school system as defined in the standard course of study. ... It is the policy of the State of North Carolina that the facilities requirements for public education system will be met by county governments." [GS 115C-408(b)]

The Basic Education Program, which was to cost several billion dollars and to provide 25,000 additional teachers and support staff, was to be phased in over an eight-year period. The program provided many additional services over the next several years, many of which had not been available before in poorer counties,

and the state was on target to implement the plan fully when the fiscal crisis of the early 1990s interfered. As a result the subsequent annual phases of the program were not fully financed.

After the fiscal crisis ended, the original impetus for the program was forgotten and the state turned its attention to various new initiatives. The result is that today the state is not fulfilling its responsibility under the policy established in law to provide all the resources needed to make the standard course of study available in all schools. It is up to each county to provide those unfunded resources, and many of them do not have the means to do so.

North Carolina long ago met its goal of providing a minimum education program as defined by the constitutionally mandated school term – the bold measures taken by the state in 1931 and 1933 guarantee that all schools can meet the current constitutional requirement of a nine-month school term. The Basic Education Program took the state school finance system created then and added a new dimension and a new goal – to guarantee that every school is able to provide the education program needed by its children. The General Assembly recognized in its policy established in law that only by having the state pay for the resources needed can that goal be achieved everywhere in the state. Unfortunately, the state has so far failed to meet the goal it set in 1985, and consequently the standard course of study is not available to every child in the state.

The committee therefore finds as follows:

**The General Assembly should act to fulfill its responsibilities under existing laws by providing from state revenues the resources needed for the standard course of study that must be made available in every public school throughout the state. Counties should continue to be responsible for building and maintaining capital facilities.**

The committee recommends that the General Assembly review and re-evaluate the standard course of study, taking into account the North Carolina Supreme Court ruling in the Leandro case that the state is responsible for providing a “sound basic education” to all children in the state. Based on that revaluation, the General Assembly should develop a multi-year plan to provide the resources needed to make the revised standard course of study available to all children in the state.

## **Other Findings and Recommendations of the Task Force**

During its discussions and deliberations, the task force developed a number of other recommendations for consideration by the NCACC Board and Association membership. Several of these would serve as interim measures as the two main findings are addressed; others would better clarify current county human services and educational responsibilities.

### **Medicaid Interim Measures**

- **Cap county payment of Medicaid at 2001-02 levels**

This interim measure would immediately relieve counties of escalating, uncontrollable costs caused by eligibility changes, increased Medicaid eligibility, and medical cost inflation. It would also provide relief to all counties and would substantially reduce the counties' Medicaid burden over time. While this measure would postpone the state's budget impact, the current state budget crisis may limit quick action.

- **Advocate tier approach for county share—e.g. Tier 1 counties pay 1 percent, Tier 2 pay 2 percent**

This interim measure would help low-wealth counties substantially, while providing some immediate relief to all counties. Again, the state budget crisis may limit action since the tier approach would cost the state approximately \$124 million the first year. Task force members also expressed concern over the tier structure itself, in that it fluctuates from year to year and may not represent a true ability to pay.

- **Consider assuming other appropriate state expenditures**

This measure could be more attractive to the state than the others as cited, given that some state expenditures would be reduced. An example of a program that might be appropriate for county assumption is the sedimentation and erosion control service. Task force members did caution that any legislative or administrative authority enabling a "trade" should allow county flexibility in establishing and operating the program. There were also concerns expressed about the low-wealth counties' inability to pay.

- **Allow state to retain proceeds from newly authorized half-cent sales tax as revenue trade for Medicaid services cost**

Rockingham County offered up this proposal for consideration since this trade would spread an economic gain to more counties than adoption of the sales tax, would eliminate the disproportionate burden on poorer counties, and would shield county boards from having to enact a tax to replace state-shared local revenues.

### **Consideration for Other Medicaid Changes**

- **Tighten Medicaid client eligibility requirements and/or services provided**
- **Suspend Medicaid program expansion and cap services and client eligibility as allowed under law**
- **Provide better automation for Medicaid to contain costs and minimize fraud**

The task force suggests that the NCACC human resources steering committee and the DHHS managers' advisory committee examine these considerations in greater depth.

### **Recommendations for Other Services Changes or Implementation of Best Practices**

- **Reduce or eliminate state health program mandates**

While the state provides very few state dollars to support public health, it promulgates excessive state requirements that may not address local needs.

The task force recommends that local health directors be surveyed to identify specific problem areas.

- **Eliminate state limitations on fee schedules that support locally-funded services**

State limitations on fee schedules inhibit cost recovery of services, particularly for environmental health programs.

The task force recommends that a study be undertaken to determine fee schedule components, limits on county flexibility to increase fees, etc. From this study, counties could be authorized to develop a fee schedule to support programs' actual costs

- **Address disparity in maintenance of effort requirements in TANF program**

Federal regulations require an 80 percent maintenance of effort for the state's welfare reform program – WorkFirst – but the state plan requires “standard” counties to maintain county funding at 100 percent. County TANF appropriations of \$98 million exceed the MOE by roughly \$19.7 million.

The task force recommends that NCACC investigate with NC-DHHS a possible reduction in the counties' TANF MOE.

- **Seek measures to reduce social services administrative expenses through streamlined systems or better automation**

Since the state does not share in social services administrative expenses, there is no statewide incentive to reduce paper process through streamlined systems or better automation. Task force members noted that some counties want to lead in automation efforts but need system connectivity to eliminate duplicate data entry, while other counties lack technical expertise for automation. County automation is also hampered by federal requirements for “statewideness.”

The state has begun the NCFAST automation initiative, whose first task is to review, coordinate and streamline divisional policies. Case management, intake, eligibility determination, etc. are to be automated through departmental initiatives. Worker training, technical assistance and access to personal computers may be the county's responsibility.

The task force recommends that NCACC staff work with the NC-DHHS through the HAPP Council to enable counties with automated systems to connect seamlessly to state systems. For those counties without automation in place, the state should provide desktop functionality for basic human services. The task force further encourages movement on HAPP Council efforts to develop a connectivity model for county/state systems integration and asks that the NCFAST initiative maintain appropriate county involvement to meet caseworker needs.

- **Seek measures to facilitate greater county involvement in setting human services policies, procedures and administrative processes**

State human services agencies issue conflicting or confusing policies with little input or clarification from counties. The state requires excessive uniformity for human services programs. Counties should have more latitude in responding to local needs and environment. To encourage local flexibility, the state should consider using block grants in lieu of categorical grants.

The task force recommends using the DHHS county managers' advisory committee to identify specific areas for improvement. It asks that the advisory committee recommend and submit process changes to the NC-DHHS for resolution. The advisory committee should submit recommended policy changes to the NCACC human resources steering committee for its consideration.

- **Address service gaps resulting from closing of regional DHHS personnel offices**

The recent closing of regional DHHS personnel offices may result in cost shifting to counties and reduce needed technical assistance in personnel matters.

The task force recommends that the NCACC support and assist the state personnel office's effort to address regional personnel changes and to streamline review and approval processes.

- **Ensure county access to human services program data and performance**

While the NC-DHHS has initiated sophisticated data warehouse for access to client and program data, task force members noted lack of access to human services data.

The task force recommends that NC-DHHS inventory its data resources to share with the managers' advisory committee. From that list, the managers can help identify "missing" data needs and work with the department to make these available. It is further recommended that the department publish county data via online resources.

- **Adapt single audit process if needed to ensure federal monitoring requirements can be met without duplicative audit efforts**

Task force members expressed concern that NC-DHHS is resuming multiple financial and program audits. It recommends that the NCACC support efforts of the managers' advisory committee to minimize duplicative audits and meet with the Local Government Commission to ensure that single-audit requirements and instructions to auditing community capture program monitoring information.

- **Retain ceiling on number of charters allowed statewide and provide for better state oversight and accountability of charter schools**
- **Limit school board initiated mediation to specific statutory requirements for county financing**
- **Encourage board of commissioners and local board of education to meet regularly**

## **Appendix A. NCACC County/State Financial Resources/Functional Responsibility Task Force Membership**

### **Co-chairs:**

Dr. Breeden Blackwell                      Cumberland County

Dr. John Thuss, Jr.                              Caldwell County

### **Members:**

Dr. Delilah Blanks                              Bladen County Commissioner

Joe Carpenter                                      Gaston County Commissioner

Becky Carney                                      Mecklenburg County Commissioner

Frank Emory                                        Wilson County Commissioner

Johnnie Ray Farmer                              Hertford County Commissioner

Herb Greene                                        Caldwell County Commissioner

Mark West                                         Macon County Commissioner

Gloria Whisenhunt                                Forsyth County Commissioner

Mark Payne                                        Johnston County, Attorney

Tom Lundy                                         Catawba County Manager

Graham Pervier                                  Forsyth County Manager

Tom Robinson                                      Rockingham County Manager

Al Wentzy                                         Northampton County, Social Services Director

Walter Dalton – represented by  
Clare Marie Weddle                                Rutherford County Attorney and State Senator

Bill Owens                                         Representative, 1st District

Dennis Magovern                                 Forsyth County, Special Asst. to Manager

### **IOG Staff:**

Dr. Don Liner                                        Economist, Institute of Government

### **NCACC Staff:**

Rebecca Troutman                                 Research and IT Director

Ed Regan    Deputy Director

James Blackburn                                 General Counsel

### **Executive Branch Representative:**

Ann Lichtner                                        Director of Intergovernmental Relations, Governor Easley's Office

## **Appendix B. Evolution of County/State Functional & Fiscal Relationships**

NCACC President David Plyler's task force on county/state functional/fiscal relations held its first meeting Oct. 3, 2001, with Dr. Breeden Blackwell, Cumberland County Commissioner and Dr. John Thuss, Jr., Caldwell County Commissioner, serving as co-chairs (see September 2001 issue of *CountyLines* for full committee membership). The task force first considered its charge by President Plyler, reaching consensus after a much-spirited debate over the breadth of its initial activities. NCACC Executive Director Ron Aycock then reviewed the Association's current policy on intergovernmental relations (posted at [ncacc.org](http://ncacc.org)) to provide an organizational framework for the task force's assignments.

To help task force members understand our current structure of county/state fiscal relations, Dr. Don Liner, Economist with the Institute of Government, provided an overview on the historical give-and-take of financing and administering local services. Following is an excerpt of his comments.

### **Intergovernmental Fiscal Relations – A brief history**

Don Liner, Institute of Government

(Summary of remarks)

In deciding how best to provide public services to North Carolinians, the key question is how to assign responsibility to units of local government and state agencies for administration, finance and decision-making. That is, in the case of each public service, who should provide it, who should pay for it, and who should make decisions about it?

There are two important aspects of North Carolina's approach to these questions. First, North Carolina has placed much responsibility with county governments which, acting as agents of the state government, provide certain services, such as public schools and social services and public health programs, that must be administered locally throughout the state.

Second, because of disparities in the ability of counties to finance public services and out of a desire to achieve some uniformity in provision of public services, North Carolina has shifted much of the responsibility for financing the major county functions to the state government.

#### ***The evolution of the role of counties in North Carolina***

As local areas were settled during the colonial era, the colonial assembly established county governments there to provide law enforcement, courts and other public services. Counties acted essentially as political subdivisions of the colonial government. County officials were not elected by the people, but rather were appointed by the assembly or the governor.

After the Civil War, when Southern states were forced to revise their constitutions, elements of the Pennsylvania form of government were adopted. County commissioners were to be elected by the people, and counties were subdivided into townships that were to provide some local services.

This system lasted only a few years, and it was not until the 1890s, and in a few counties not until after 1900, that county commissioners became elected officials again. Townships never regained their role as units of local government.

Thus, traditionally and historically, the primary role of the county has been to serve as an agent of state government responsible for providing certain services that must be provided to all people in the state, including those who live within the boundaries of municipalities

But counties have a second role. In their primary role as agents of state government, they must provide public schools and social services and public health programs according to state standards and mandates. But counties may choose to provide additional services, such as recreation programs and countywide library systems, if people in the county want to have them and are willing to pay for them.

#### ***Centralization of financial responsibility***

Before 1900 the responsibility for administering and financing public services rested almost entirely with local government. The state government provided few services. It provided the highest court and a central prison for long-term prisoners. It operated mental hospitals and schools for the blind and deaf, and provided financial support to orphanages and three universities. There were no state highways. Counties administered and financed public schools – there were no state appropriations for public schools. The primary state revenue source was the property tax. In fact, more than 90 percent of all tax revenues, both local and state, came from the property tax.

This situation began to change about 1900 because the state wanted to improve the public schools. The 1868 constitution had required the General Assembly to provide a “general and uniform” school system, but the General Assembly required each county to administer and finance the schools from their own resources. At that time 57 of the 97 counties that existed were too poor to provide schools for the constitutionally required term of four months even if they levied the maximum property tax rate allowed by law.

The General Assembly began to support public schools directly by making two appropriations of equal amount. The first appropriation was distributed to all schools according to school enrollment. The second appropriation, called the equalizing fund, was distributed only to the counties that could not provide the constitutionally mandated school term. This was the first major state school equalization fund in the United States.

Another major step was taken in 1921. First, the General Assembly adopted a policy of eliminating the state’s use of the property tax and establishing a separate state tax system. The personal and corporate income taxes were enacted. Second, the General Assembly acted to establish a state highway system – a “great system of roads” connecting all 100 county seats – by enacting a gasoline tax, borrowing large amounts of money for highway construction, and taking over responsibility for 5,000 miles of county roads. During the 1920s the state paved those roads to modern standards and also took over responsibility for an additional 5,000 miles of county roads. North Carolina came to be called “the Good Roads State.”

The most important change in fiscal responsibilities came about in 1931 and 1933 as a result of the fiscal problems caused by the Great Depression. In 1931 the following measures were taken by the General Assembly:

- The state took over responsibility for paying the operating expenses for the six-month school term required by the constitution.
- The state assumed administrative and financial responsibility for all county roads outside municipal boundaries, and for all prisoners sentenced to more than 60 days.
- The Local Government Commission was created to help local governments deal with their fiscal problems and to regulate local fiscal practices.

The General Assembly carried the fiscal revolution a step further by taking the following measures two years later:

- The state accepted responsibility for paying the operating expenses of the public schools for an equal eight-month school term throughout the state.
- The state accepted responsibility for all prisoners sentenced to 30 days or more.
- The state enacted the retail sales tax as a way to pay for the increased state responsibilities.

The measures taken in 1931 and 1933 amounted to a fiscal revolution. Financial responsibility for the major county functions – schools, roads, and prisons – were assumed by the state, and the state took over administrative responsibility for roads and prisons (except jails). Whereas the property tax had accounted for two-thirds of state and local tax revenue, after these measures were taken the property tax accounted for only one-third of state and local tax revenue.

The centralization of financial responsibility has continued since 1933. The state share of the cost of financing social services programs created during the 1930s and later was assumed largely by the state. During the 1960s the state assumed responsibility for both administering and financing the court system. Also during the 1960s

the state bore the main financial responsibility for financing the community college system. A further step was taken in 1985 when the state, through the Basic Education Plan, accepted responsibility for paying the expenses needed to provide a standard course of study in all public schools (however, the state did not completely fulfill that responsibility).

### ***Summary***

Counties were established in the colonial era as administrative subdivisions of the central government. They continue to play that role as agents of the state government responsible for providing schools, social services programs, and public health programs. Today, however, counties are governed by elected officials and therefore play an additional role as local government units that can respond to demands for services in addition to those mandated by the state.

Since 1900 major changes have been made in the assignment of responsibility for administering and financing public services. The state has assumed both administrative and financial responsibility for highways and roads, corrections (except jails), and the judicial system.

Perhaps the biggest change has been the centralization of financial responsibility at the state level. The basic problem in having public services administered at the local level is disparity in the ability of counties to finance them. The disparity in the ability of counties to finance public schools led to the initial efforts around 1900 to have the state play a larger role in financing schools and led to a major increase in state responsibility during the 1930s. The state now is responsible for the basic expenses of the public school system and pays for most of the state and local share of the costs of social services program. Altogether, state revenues account for more than 70 percent of all tax revenues collected by state and local governments in North Carolina.

Dr. Liner followed his remarks with recommendations to the task force to examine existing and new public services in light of guiding principles to help answer what unit government is best suited to administer, finance, and make decisions about those services. For example, if uniformity is required, state financing would be the best mechanism since local financing with unequal funding capacity will necessarily lead to disparities. The task force agreed to devote one meeting to an enunciation of those principles.

The task force emphasized the need to educate all county and state officials on the organizational structure and financing of county services, and how structure and financing of these services have changed over time, either consciously or inadvertently. Also of importance to the task force is the need for counties to speak with one voice, the need to address county/state relations as a partnership rather than an “us versus them” mentality, and the need to recognize the critical nature of the services under consideration.

## **Appendix C. Evolution of County/State Social Services and Medicaid Functional & Fiscal Relationships**

President David Plyler's task force on county/state functional/fiscal relations continued its examination of critical county services at its last two meetings of 2001, with the November meeting focusing on social services, particularly Medicaid, and the December meeting reviewing the counties' role in mental health and health services. This article reports on the findings of the November meeting.

John Saxon with the Institute of Government led off our November meeting to describe the evolution of county social services vis a vis the state. Please find below a summary of his remarks:

### **The Fiscal Impact of Medicaid on North Carolina Counties**

**John L. Saxon\***

Medicaid is a public assistance program that pays for health care for certain groups of low-income persons (children, pregnant women, disabled persons and senior citizens). Medicaid was established in 1965 when Congress enacted Title XIX of the Social Security Act.

Although federal law does not require North Carolina or other states to establish a Medicaid program, the federal government provides significant federal funding (about \$116 billion in federal fiscal year [FFY] 2000) to those that do. Federal law requires participating states to administer their Medicaid programs on a uniform statewide basis, to provide Medicaid to certain groups of low-income persons, and to provide certain medical services to Medicaid recipients. States, however, are free to design their own Medicaid programs within these federal guidelines, and may cover non-mandatory groups and choose to provide non-mandated services. States also largely establish their own payment rates for medical services. Each state's Medicaid program, therefore, is different.

In most states, a state health or social services agency administers Medicaid. In North Carolina (and several other states, including New York and California), it is administered by state and county agencies. In North Carolina, the state DHHS Division of Medical Assistance is responsible for administering Medicaid at the state level (and, through a private contractor, for processing claims and making payments to medical providers), while county departments of social services administer Medicaid locally (processing applications and determining eligibility).

The federal government pays the largest share of Medicaid costs – at least 50 percent of each state's Medicaid services costs plus half of each state's administrative costs. The federal government's share of Medicaid services costs is called the federal medical assistance percentage (FMAP); the state's share is called the non-federal share. Each state's FMAP is based on its per capita income. As a state's per capita income rises relative to national per capita income, its FMAP declines – requiring the state to pay an increased share of Medicaid costs. North Carolina's FMAP is currently 62.46 percent.

In most states, the state pays the entire non-federal share of Medicaid costs. (Although counties in these states are not required to pay part of the cost of their state Medicaid programs, they may be required to pay for prisons, roads, or other government services for which North Carolina counties have no fiscal responsibility.)

The federal Medicaid statute, however, allows states to require counties to pay part of the non-federal share. (Federal law requires states to pay at least 40 percent of the non-federal share of Medicaid costs from state revenues; North Carolina law [GS 108A-54] requires the state to pay *at least* 50 percent of the non-federal share of Medicaid costs.)

Several states (including North Carolina, Arizona, Florida, Iowa, Nevada, New Hampshire, New Mexico and New York) currently require counties to pay part of the non-federal share of Medicaid medical services.

New York requires counties to pay 20 percent of the non-federal share (about 10 percent of the total cost) for Medicaid long-term care services for county residents and 50 percent of the non-federal share (about 25 percent

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\* *Mr. Saxon is a Professor of Public Law and Government at the UNC-CH Institute of Government. His areas of responsibility include social welfare law and policy, elder law, and child support enforcement.*

to the total cost) for other Medicaid services. In Arizona, counties are required to pay about 10 percent of the total cost of Medicaid services; Iowa counties pay about four percent of the cost of Iowa's Medicaid program.

Approximately 10 states (including North Carolina, Colorado, Minnesota and Ohio) require counties to pay all or part of the non-federal share of the cost of administering Medicaid locally.

In North Carolina, state law currently requires counties to pay 15 percent of the non-federal share of Medicaid services provided to county residents (now about 5.7 percent of the total) plus 100 percent of the non-federal share of local administrative costs. State revenues pay the remaining 85 percent of the non-federal share for Medicaid services.

In state fiscal year (SFY) 1999, North Carolina counties spent approximately \$226 million in local funds for Medicaid services and administration – about 4.5 percent of the statewide total cost (\$4.9 billion). Federal funding provided \$3 billion for Medicaid (61 percent of the total), while state General Fund appropriations of \$1.3 billion (26 percent) and other state revenues (\$417 million or 8.5 percent of total) covered the remaining costs.

Although state law requires counties to pay a portion of the state's Medicaid services costs, counties have little control over their Medicaid spending. Instead, county Medicaid spending is driven by factors that counties can't control – federal and state policies expanding Medicaid eligibility and services; increases in the number of county residents covered by Medicaid (especially elderly and disabled recipients); county poverty rates; increased health care costs; increased utilization of health care; and decreases in North Carolina's FMAP.

During the 1990s, county-funded Medicaid spending in North Carolina almost tripled – from about \$86 million in SFY 1990 to \$226 million in SFY 1999 (a 163 percent increase, not adjusting for inflation). During the same period, total combined spending by all counties increased by 115 percent. Each of North Carolina's 100 counties, however, is different with respect to its resources and needs, and fiscal responsibility for Medicaid therefore impacts different counties to different extents.

In Bertie, Halifax, Hertford, Edgecombe, Northampton, and 10 other counties, between one-quarter and one-third of all county residents are Medicaid recipients, while less than one-eighth of county residents in 18 other counties receive Medicaid. County per capita Medicaid spending also varies significantly from county to county (from a high of \$58.44 per capita in Bertie County to a low of \$14.69 per capita in Wake County).

More importantly, Medicaid disproportionately impacts counties that have limited property tax bases combined with high rates of poverty, Medicaid eligibility and Medicaid spending. In SFY 1999, Bertie County was required to spend \$1.2 million in county funds for Medicaid services for county residents – almost 8 percent of the county's \$15.5 million budget and approximately 17 cents per \$100 of the county's \$701 million property tax base. County spending for Medicaid represented more than 10 cents per \$100 of the property tax base in about one-quarter of North Carolina's counties (primarily economically distressed Tier 1 and 2 counties) compared to about five cents or less per \$100 in 28 other counties.

Several bills regarding the fiscal responsibility of counties for Medicaid were introduced during the General Assembly's 2001 legislative session. House Bill 1082 and Senate Bill 923 would have required the state to pay 100 percent of the non-federal share of Medicaid services. House Bill 65 would have reduced the fiscal responsibility of Tier 1, 2, 3, and 4 counties from 15 percent to 3, 6, 9, and 12 percent of the non-federal share of Medicaid services provided to county residents. (North Carolina counties are classified as Tier 1, 2, 3, 4, or 5 counties under the Bill Lee Economic Development Act; Tier 1 counties are the most economically distressed.) House Bill 317 (and Senate Bills 580, 691 and 844) would have reduced the fiscal responsibility of all counties for Medicaid from 5.7 percent to 1 percent of the non-federal share for Tier 1 counties, 2 percent for Tier 2 counties, 3 percent for Tier 3 counties, 4 percent for Tier 4 counties, and 5 percent for Tier 5 counties. None of these bills, however, was reported favorably.

There is, however, some legal precedent for adjusting or mitigating the counties' fiscal responsibility for state public assistance programs.

First, until 1997 the state provided several million dollars per year to counties through a public assistance equalization fund (GS 108A-92). These state funds (which were intended to partially offset the fiscal impact on

economically distressed counties of state requirements regarding county funding of public assistance programs) were distributed using a formula that considered each county's per capita property taxes and sales tax collections, number of Medicaid and other public assistance recipients per capita, and per capita county spending for Medicaid and other public assistance programs.

Second, the General Assembly enacted legislation in 2001 (S.L. 2001-385) requiring the state Department of Health and Human Services to study the feasibility of reducing the counties' financial responsibility for assistance payments to low-income, elderly or disabled residents of adult-care homes from 50 to 25 percent.

Given the recent significant increases in the cost of North Carolina's Medicaid program combined with the impact of the current economic recession on state and county budgets, the fiscal responsibility of North Carolina counties for Medicaid will almost certainly remain a major fiscal and policy issue during the coming year, and one that NCACC's task force on county-state financial resources and functional responsibilities will continue to study.

Following John's comments, Dan Hudgins, DSS Director in Durham County, highlighted for the task force the programmatic changes in Medicaid since its inception in North Carolina. Dan noted that several allocation formulae have been adjusted over time, requiring higher county match rates – e.g. transportation and at-risk case management (counties provide full non-federal share funding), and intermediate-care facilities for mental health (ICF/MR) clients (the state used to fund full non-federal share but counties now pay normal match). Dan also expressed concern over the lack of state funding to support Medicaid administrative costs, which in turn provides little state incentive to reduce manual administrative processes. Finally, Dan provided his top Medicaid challenges (ICF/MR) cost shifting, a growing Latino/Hispanic population ineligible for Medicaid but still needing services, simplification/automation needs, and Medicaid being used as a major funding source for other county human services.

Al Wentzy, Northhampton DSS Director, echoed Dan's concerns and suggested that the National Association of Counties be engaged in the Medicaid issue. Mr. Wentzy then spoke to his county's specific budget problems with Medicaid, coming from a small, rural area with a high number of Medicaid eligibles. Mr. Wentzy said that 23 cents of his county's tax rate of 88 cents is used to cover county Medicaid costs alone.

The task force was fortunate to have NC-DHHS Deputy Secretary Lanier Cansler and Division of Medical Assistance Director Nina Yeager provide the department's perspective on Medicaid. Mr. Cansler noted that the state was facing a \$100 million shortfall in its Medicaid appropriation for 2001-02, requiring an additional \$18 million in county funding. He also addressed the limit on the community alternatives program – a Medicaid service to avoid long-term placement in lieu of home services.

Ms. Yeager distributed a number of Medicaid financial and program statistics to the task force, saying that other states were also facing large increases in Medicaid spending. One graph depicted a large increase in the number of eligibles for this fiscal year (up 9.3 percent), resulting from the economic recession. Another table showed major expenditure increases in drug costs (up 22.9 percent from last year and now the single largest spending category and greater than long-term care, consuming 17 percent of total expenditures), physician care (up 22.7 percent and reflecting 10.3 percent of the total), and hospital outpatient (up 25.6 percent and reflecting 6.1 percent of the total). Ms. Yeager then discussed a number of departmental and legislative cost containment initiatives, many of which are targeted at Medicaid prescription drug costs.

The task force's final presenter was Ms. Patrice Roesler, NCACC Director of Intergovernmental Programs, who reviewed the Association's advocacy efforts to phase out the counties' share of Medicaid program expenditures – an Association legislative goal. Ms. Roesler highlighted House Bill 317, which would reduce each county's share to equal its economic development tier designation, and discussed the role of the budget bill for Medicaid – the annual budget bill outlines funding and eligibility requirements. Ms. Roesler noted Association efforts to have the counties' funding requirements for Medicaid be part of the study bill, in order to bring more in-depth legislative analysis to county concerns. (The author is happy to report that these efforts were successful). Ms. Roesler opined that the General Assembly needs to establish a long-range plan to manage the Medicaid crisis. She also cautioned that county Medicaid relief would necessarily require counties to reach consensus on

assumption of like costs for currently state-funded services or identification of additional revenue sources that could more appropriately pay for Medicaid since the property tax is not a suitable fit.

## **Appendix D. Evolution of County/State Mental Health and Health Functional & Fiscal Relationships**

President David Plyler's task force on county/state functional/fiscal relations spent its December meeting examining the counties' role in mental health and health services. Gaston County Commissioner Joe Carpenter hosted the task force in a beautiful and unique setting – the Stowe Botanical Gardens, a large and diverse complex supported by a private non-profit foundation.

The task force heard from several local health and mental health directors, as well as a state health representative, who described how human services responsibilities evolved in North Carolina.

Jim Kirkpatrick, mental health consultant and former Wake County mental health director, began our December meeting by providing an overview of county mental health responsibilities. Jim emphasized to task force members that the state faced a whole new set of changes and challenges in mental health, given the current system restructuring, and said that county commissioners are vital players under the new structure.

Jim noted that the history of national mental health care began when the country began. Our ancestors also grappled with difficult questions regarding caring for the mentally ill, namely “as a rational society, how do you deal with those whose illness causes them to be irrational?”

For the first 150 years of our state's history, counties were responsible by default for the mentally ill, who were often housed in county jails and poorhouses. Given the very meager resources available, generally the conditions in these institutions were unsatisfactory. In the early to mid 1800s, national mental health reforms began espousing that a routine, benign living environment would help cure mental illness. One such reformer, Dorothea Dix, traveled from state to state to see how the mentally ill were being cared for. She collected horror stories of the deplorable conditions and then composed memorials, or speeches, to address the states' general assemblies, in an effort to arouse public sympathy and guilt.

North Carolina's general assembly, in response to Ms. Dix, began appropriating to build and operate a state hospital for the mentally ill, and thus assumed funding and administrative control for public mental health services.

Further mental health research in the early 1900s showed that prevention and early intervention within the community should precede institutionalization. This prompted a number of the more affluent North Carolina cities to establish mental hygiene facilities, funded by community chests. In the mid 1900s, three major impetuses accelerated community mental health treatment:

- World War II created a growing awareness and a lessening of public stigma of mental health in that 12 percent of those enlisting in military service were denied enrollment due to mental capacity limitations, and many of those that served were later found to have mental health problems.
- New psychiatric drugs were introduced, and for the first time, chemicals were used to combat and ameliorate symptoms, thus enabling the mentally ill to live in their communities.
- It was shown that long-term institutionalization created its own mental health issues—patient dependence grew while their independence foundered, making life-long commitment increasingly more likely.

In response to these changes, the federal government began funding community mental health clinics and encouraged a dual system of funding from states and local governments. National studies called on more funding for community programs and use of state hospitals as sites for intensive treatment only. Despite a shift towards community mental health services, North Carolina continued to grow its institutional programs, although federal funds were drawn down to build local programs. Accompanying these federal funds was an increasing array of federal rules and regulation regarding program and service operations.

In 1977 North Carolina enacted its current mental health organizational model, which called for replacing optional local mental health authorities serving one county with area mental health authorities serving one or more counties by designated catchments areas. Today 37-seven authorities exist, with 14 of those organized as a single county entity.

Mr. Kirkpatrick noted that this combined responsibility for cost and control of mental health service delivery has posed a number of problems in the past, namely cost-shifting such as substituting Medicaid for state match

funds and function-shifting such as the repeated efforts at de-institutionalization. He asserted that state service reductions have not shown a corresponding shift to funding community services.

Jim also cautioned that service gaps are widening throughout the state, evidenced in part by a growing homeless population, who often suffer from mental illness and substance abuse. He also advocated that any state and local contracts contain mutual obligations and mutual sanctions for default, unlike the memoranda of understanding of old that stipulated local obligations and sanctions only. Jim ended his comments by re-emphasizing the need for county commissioners to become more involved with mental health services – he found in his tenure with Wake County that the county’s mental health program absolutely needed the support, the commitment, and the protection of the county’s board of commissioners.

Tom McDevitt, co-director of the Smoky Mountain area authority, next reviewed the evolution of area program financing, with a special emphasis on Medicaid funding in mental health, which now represents 48 percent of the system’s \$1.7 billion costs. *(Author’s note: counties contribute in direct appropriations \$107 million to area authorities, not including the county Medicaid match.)*

Tom first outlined the cost-finding process associated with Medicaid funding of mental health services, which could require authority reimbursement payback if the rate-setting component misses its mark. Tom then addressed past program funding drivers with federal block grants driving service delivery and funding in the 1970s. In comparison, an increase in state dollars drove delivery in the early 1980s until several lawsuits redirected and greatly increased state dollar requirements for categorical expenditures such as the Willie M and Thomas S programs. Finally Medicaid began impacting service delivery throughout the 1990s as the state sought non-state dollars to support community programs – prior to Willie M few Medicaid dollars were found in area authorities.

Tom noted that area authorities were not against maximizing Medicaid, but they were concerned that few state dollars were available for services for the non-Medicaid client. He also mentioned that the recent enrollment of non-profits to bill for Medicaid has been accompanied by escalating Medicaid costs in mental health. Finally, he commented on the state’s plan for mental health restructuring and cautioned that limits on area authority service provision could result in decreased service access.

Dennis Harrington, NC-DHHS Division of Health Services administrator and former county health director, led off the task force’s discussion of county health services by reviewing the public role in health—assessing the environment, addressing health problems through policies and procedures, and providing direct health services if no other providers are available. Dennis saw the state’s role as a funding conduit for both state and federal dollars. He also noted that the state provides technical assistance, monitors service provision and use of funds, and provides some direct services such as lab services. Mr. Harrington did stress that public health funds mainly come from counties, with lesser amounts from federal sources, and very few dollars from state appropriations. Intergovernmental funds come down as either categorical grants (\$83 million in state and federal funds with 15 percent in state funds alone) or state non-categorical grants through population allocations and district incentives (\$5.3 million). Dennis mentioned that local health departments are seeing more uninsured clients with Medicaid clients accessing private sector services. In terms of future health impacts, he believed that more out of state citizens without adequate insurance would locate in North Carolina, that there would necessarily be more emphasis on public health’s response to bio-terrorism, and that new service approaches would need to be considered – namely more consolidated health districts. Finally Dennis cautioned that HIPAA (Health Insurance Portability and Accountability Act) would pose major demands on local health departments and that health information technology drastically needs upgrading.

Task force members questioned state requirements for county health funding, and Dennis responded that while the state requires a number of services to be provided locally, state funding is only available as the budget allows. Task force members then questioned the need for detailed state program requirements given the few state dollars used to support health programs.

Wayne Raynor, Harnett County Health Director, next provided an overview of public health from a local perspective. Wayne noted that the public health practice could be seen as a “quiet miracle,” in that, without fanfare, it has been largely responsible for eradicating a number of communicable diseases such as tuberculosis,

small pox, and measles, which killed hundreds of thousands of children and adults. Wayne then outlined a number of other challenges that remain. For example, the infant mortality rate in North Carolina in 1988 was the highest in the nation (now at 45<sup>th</sup>). One in four children in North Carolina start school with unattended dental problems. Teen pregnancy and teen smoking continue at alarming rates. North Carolina faces a health disparities gap – infant mortality, cardiovascular disease, heart disease and stroke strike minorities at more than twice the rate of whites. Shrinking public health dollars limit local public health’s ability to meet the needs of a growing diverse population, and no substantial increases in state continuation funding have occurred in 25 years. Other newer challenges include West Nile Virus, bioterrorism, drug resistant diseases like tuberculosis and some sexually transmitted diseases, lack of information technology, compliance with HIPAA, and the pressing demand for mandated translation services.

Mr. Raynor cautioned that too many health dollars have been targeted to the curative approach instead of preventive measures. As an example, in 1998, 33,963 low birth weight babies were born in North Carolina. Total hospital charges exceeded \$296 million, averaging \$8,700 per problem birth or 11 times that of a baby born without major medical problems. In addition, school-age children who were low birth weight babies are more likely to experience learning disabilities, attention disorders, developmental impairments and breathing problems. Preventing a very low weight birth can save \$59,700 in medical expenses in the first year. Data compiled during 2001 (of about 65 counties) indicate that at least an additional \$7 million is needed in local health departments to meet the needs of a growing number of uninsured prenatal clients.

Environmental health has its own challenges. While local health departments operate a number of environmental health programs to enforce state rules and regulations, local governments receive less than two percent of funding to do so from state sources. One medium size county with a total annual environmental health budget of \$502,000 receives \$8,000 (1.6 percent) in state funds. Wayne noted that an additional \$15 million is needed to provide core public health services such as communicable disease control, on-site sewage and wastewater disposal, lead poisoning prevention, chronic disease control, laboratory support, health promotion and risk-reduction programs.

## **Appendix E. Evolution of County/State Public Education Functional & Fiscal Relationships**

President David Plyler's task force on county/state functional/fiscal relations spent its February and March meetings examining the counties' role in public school funding, as well as hearing updates on state activities regarding funding structures and Medicaid. The task force first heard from Dan Gerlach, Governor Easley's Senior Policy Advisor for Fiscal Affairs, who outlined two new gubernatorial commissions charged with examining the state's tax structure and efficiency measures. After good-naturedly fielding a number of criticisms from task force members about the governor's seizure of local revenues, Dan discussed the purpose and timeframe of the two commissions. The Tax Structure Commission will examine opportunities for tax simplification, taking into account the new economy, while not jeopardizing the long-term condition of NC citizens. The Efficiency Commission will look at disparate economic development efforts and the need for their consolidation, including the Bill Lee Act and workforce development programs. The commission will also consider the state's condition of its capital facilities and bond capacity, personnel systems and information technology services. Both commissions are necessarily examining Medicaid, given its impacts on state and county budgets. Dan noted that his commissions would be anxious in considering the task force's recommendations – both commissions have county representation, Mary Ann Black, Durham County Chair, and Graham Pervier, Forsyth County Manager. Both commissions envision short-term strategies to be recommended for the upcoming short legislative session, with more in-depth recommendations to be considered during the next long session.

North Carolina counties and the state have expressed interest in knowing how many other states require their counties to contribute to Medicaid costs and what those specific requirements are. A number of advocacy and research groups report data show differing requirements. To help understand what other counties fund in Medicaid spending, Catawba County Manager and task force member Tom Lundy worked with the UNC-Chapel Hill MPA program to organize a survey research project using graduate students. Tom, in his role as ICMA regional board member, agreed to identify county managers in other states to poll, and the author agreed to work with the other state county associations to have them respond to the survey. The graduate students, Emily Wilson, Allison Bollay, and Stephanie Schmitt, have their research project plan currently underway, with a report of their findings due in May, 2002.

The task force next heard from Dr. Don Liner, Institute of Government Economist and public school funding expert, who described how county responsibilities for public school funding evolved in North Carolina. The state created its first statewide system of public school financing beginning in 1839 (the second state to do so nationally). In this system, local communities provided the schoolhouses and paid \$20 of the \$60 of teachers' salaries with the state funding the rest. Justices of the Peace appointed local boards of county superintendents to oversee public schools, and by the mid-1840s, all counties had established a public school system. While few other states implemented statewide systems until the late 1800s, North Carolina's system did languish during the Civil War.

During Reconstruction, the "Carpetbagger Constitution" mandated that the General Assembly support a "general and uniform system of free public schools." The authorizing act established a statewide uniform course of study, created the state board of education and abolished local superintendent boards, with oversight and control of local schools transferred to boards of county commissioners. The act also provided for elected school committees for each township, with responsibilities similar to those of our current school boards. Funding was a decisive issue at that time as well, with insufficient state funding requiring county funding supplements through county school taxes.

With the turn of the century, Gov. Charles B. Aycock spearheaded much greater state financial support of public schools and greater equity between black and white systems to ensure literacy. The General Assembly also began equalization funding for counties not able to fully support their educational requirements despite taxing at the highest property tax rate allowed. This was the first major equalizing grants program nationally. Throughout the teens and twenties, North Carolina enacted a number of progressive efforts to spur school attendance, literacy and state funding support

During the Great Depression, a number of North Carolina counties faced bankruptcy, schools were closing and teachers were going unpaid. This heralded in a tumultuous change in public school financing that largely exists today. The General Assembly accepted full responsibility for operating schools and allocated state resources based on the number of teachers. To pay for its educational funding commitments, the legislature enacted a three-percent sales tax. The state abolished all local school taxes but did permit counties to enact supplemental school taxes. Counties remained responsible for public school facilities.

In 1984, the state considered an equalizing grant program like those found in other states but instead examined what a basic education program should look like. The resulting BEP, enacted in 1984, provided that the state fund all the operating resources needed for a basic course of study for every student, and added billions to state education support for teachers, librarians, psychologists, media specialists and other instructional positions. In all 25,000 additional school positions were to be funded.

BEP funding was to have been phased in over an eight-year period, but it fell victim to the state's fiscal crisis in 1990. As the state's finances improved, other educational initiatives such as Senate Bill 2, ABCs and moving to an average national teachers' salary schedule drained resources from the BEP.

Dr. Liner then reviewed a number of statistical charts, comparing North Carolina's school funding system externally with that of other states, and internally with sources of school funds. According to Don's data, North Carolina ranked 46th in local share of state and local revenues for schools. When queried by task force members, he noted that most states allow school districts to set property tax rates but that many of these states did not have a history of strong county government. For total current spending, state resources support 68 percent of costs, while local dollars contribute 24 percent. While state spending dominates instructional spending, local spending dominates administration and school facilities spending. When comparing how total spending varies with per capita income, Don showed how North Carolina does not have the great disparities that have led to court-ordered school funding changes in other states. He also noted that regional high schools could alleviate some of the problems found in smaller, poorer counties.

Johnston County Chair J.H. Langdon, NCACC Public Education Steering Committee chair, and NCACC Deputy Director Ed Regan provided a follow up to Don's historical overview of educational funding by noting some specific items under consideration by the Public Education Steering Committee. Commissioner Langdon told task force members that his committee was investigating the lack of clarity of current funding arrangements – what the state is responsible for, the impact of charter schools, and school facility ownership issues. Several task force members questioned the efficacy of the current funding system – they were concerned that the system was one of conflict, not one focusing on education. A discussion ensued of the advantages and disadvantages of local school boards having taxing authority – some noted that taxing authority may lead to replacing school board members who focus on education with those who are only interested in minimizing property tax rates. Capital financing capability was also mentioned as problematic, in that counties would compete with taxing school boards for bond funding of public facilities.

Regan reviewed the statutory requirements of county school funding (see table below) and noted that while the general mandate found in G.S. 115C-426(B) was the only vague funding requirement, it was usually the focus of the school/county funding disputes that went to mediation. Consequently, the public education steering committee was considering language to define more clearly when mediation might be used such as restricting its use to those specific statutory requirements for county funding. Ed also provided an overview of county/school funding formulae in place, noting that 12 counties have formal funding arrangements – e.g. based on changes in student population, inflation, county revenue growth, while Scotland County is legislatively required to spend at a certain per pupil level.

The task force next considered a number of recommendations to re-align current public education funding responsibilities.

**SUMMARY OF STATUTORY MANDATES FOR SCHOOL FINANCING**

**I. Specific Statutory Requirements for County Funding**

<u>Activity of Function</u>	<u>Statutory Reference</u>
A. School Facilities, Furniture, Apparatus	115C-521
B. Buildings for Bus and Vehicle Storage	115C-249
C. Initial Purchase of School Buses	115C-249
D. School Maintenance and Repairs	115C-524
E. Instructional Supplies, Reference Books	115C-522(c)
F. Library, Science, and Classroom Equipment	115C-522(c)
G. Water Supply and Sanitary Facilities	115C-522(c)
H. School Property Insurance	115C-534

**II. Specific Statutory Requirements for School Board to Fund From Local Sources (These do not specify county appropriation)**

A. School Board Members Compensation and Expenses	115C-38
B. Superintendent's Office: Furniture, Equipment, Supplies	115C-277
C. School Finance Officer and Fiscal Services	115C-435*
D. Annual Independent Audit	115C-447

\*NOTE: State now provides annual allotment for school finance officers.

**III. General Mandates in the School Budget and Fiscal Control Act**

A. In defining the Local Current Expense Fund the law states that:

“The Local Current Expense Fund shall include (county) appropriations, sufficient, when added to appropriations from the State Public School Fund, for the current operating expense of the public school system in conformity with the education goals and policies of the state and the local board of education, within the financial resources and consistent with the fiscal policies of the board of county commissioners”. (G.S. 115C-426(B))

B. The local Board of Education may appeal the commissioners' budget decision “If the board of education determines that the amounts appropriated by the county commissioners are not sufficient to support a system of free public schools”. (G.S. 115C-431)

## **Appendix F. Medicaid Funding Study – National Practices**

Task force member Tom Lundy, Catawba County manager, arranged for graduate students from the UNC-Chapel Hill Masters of Public Administration program, to conduct a national survey to determine what states require county participation in Medicaid. Alison Beloin, Stephanie Schmitt and Emily Williamson surveyed all state associations and selected county managers and made the following findings.

### **Executive Summary**

In order to determine how North Carolina's Medicaid model compares with other states, this research study surveyed representatives in all states with operational county governments, and sought to identify:

1. Which states require county governments to pay a portion of the non-federal share of Medicaid costs?
2. If the state requires county governments to participate, how do those requirements differ from North Carolina's requirements?
3. What other services are county governments in other states required to fund?

Of the 41 states that responded, 17 reported that counties finance some portion of Medicaid in that state. These states were analyzed by types of Medicaid services provided, funding structures, region of the country, per capita income, population, economic indicators and form of county government. North Carolina and New York are the only states that responded where counties paid for all 13 choices of Medicaid services. No causal relationships were uncovered between the other factors and whether or not a state requires its counties to pay for Medicaid.

As a state whose counties are required to pay for Medicaid, North Carolina is in the minority nationwide. It is one of 11 responding states that require counties to pay for both Medicaid administrative costs and services costs. Two states (Colorado and Wisconsin) require counties to fund only administration costs. Four states (Arizona, Florida, Iowa, and Michigan) require counties to pay only for some type of Medicaid service.

Six states have eliminated county funding for either administrative costs or Medicaid services costs at some point since Medicaid's inception. North Dakota (1997) and Montana (2001) are two states that have passed legislation in the last five years specific to this and may prove to be useful case studies for North Carolina.

For the most part, the project team determined that no pattern exists across all states regarding the general services provided by county governments. The only differences worth noting are counties that do not have to fund Medicaid are more likely to pay for some administrative costs and most transportation costs. This is unlike North Carolina counties, which do not finance all these services. Counties that pay for Medicaid costs are also more likely to pay for other human services. Payment for these services is required in North Carolina as well.