2011 Overview of Enacted Legislation Relating to Health and Human Services
Presented to HHS Oversight Committee
September 20, 2011

LICENSURE, INSPECTION, REGULATION

Streamline Oversight of Service Providers by the Department of Health and Human Services

S.L. 2011-253 (HB 618) directs the Secretary of the Department of Health and Human Services to prepare a rate setting memorandum on changes in service definition, policy, rule, or provider requirements proposed by DHHS, to establish a new task force to evaluate the North Carolina Treatment Outcomes Program Performance System (NC-TOPPS), to allow private sector development of an Internet-based data archive for provider records, and to annually review policy changes made by national accrediting bodies to avoid duplication of agency level policies and procedures.

This act became effective June 23, 2011. (SP)

Department of Health and Human Services Penalties and Remedies Revision

S.L. 2011-249 (HB 397) amends the provisions for the imposition of administrative penalties on nursing care facilities, adult care facilities, and facilities providing services to the mentally ill, developmentally disabled and substance abusers. Violations at these facilities will be classified and processed as follows:

Type A1 violations. Violations by a facility of State or federal laws or regulations that result in death or serious physical harm, abuse, neglect or exploitation.

The person making the finding of violation must:

- Orally and immediately inform the facility of the Type A1 violation and the specific findings.
- Require a written plan of protection for the abatement of the violation in order to protect clients from further risk of harm.
- Within 15 working days of the investigation, send a report of the findings to the facility.
- Require a plan of correction from the facility describing the steps the facility will take to achieve and maintain compliance.

For a Type A1 violation the Department must impose a civil penalty. For facilities serving 6 or fewer persons, the fines must be not less than $500 nor more than $10,000. Facilities serving 7 or more may be assessed not less than $1,000 nor more than $20,000. Failure to correct a Type A1 will result in the assessment of a penalty of $1000 for each day the violation continues beyond the time specified for correction.

Type A2 violations. Violations by a facility of the laws and regulations that results in a substantial risk of death, serious physical harm, abuse, neglect, or exploitation.

The person making the finding of Type A2 violation must follow the same procedure as for a Type A1 violation. The Department may or may not assess a penalty taking into consideration the compliance history, preventative measures, and response to previous violations by the facility. Failure to correct a Type A2 violation will result the assessment of a civil penalty of up to $1,000 for each day the deficiency continues beyond the time specified for correction.

Type B Violation. A Type B violation is one that is detrimental to the health, safety, or wellbeing of a resident, but which does not result in substantial risk that death or serious physical harm, abuse, neglect, or exploitation will occur.

The person making the finding of a violation must follow the same procedure as for a Type A1 or A2 violation.

Repeat Violations. The Department must impose a civil penalty 3x the amount earlier assessed when a facility under the same management or ownership has received a citation for violating the same specific provisions of the law or regulations during the previous 12 months for which the appeal rights are exhausted and penalty payment is expected or has occurred.

Factors to be considered in determining amount of initial penalty.

- Substantial risk that serious physical harm, abuse, neglect, or exploitation will occur.
- Serious physical harm, abuse, neglect, or exploitation, without substantial risk of death did occur.
- Serious physical harm, abuse, neglect, or exploitation, with substantial risk of death did occur.
- A client died.
- A client died and there is substantial risk to others of serious physical harm, abuse, neglect, or exploitation.
- A client died, and there is substantial risk for further client death.
- The reasonable diligence of the facility to comply with State and federal law and regulations.
- Efforts to correct violations.
- Number and type of violations within the previous 36 months.
- Number of clients put at risk by the violation.

Staff Training in Lieu of Penalty. In lieu of assessing all or part of a penalty, the Secretary may order a facility to provide staff training that is specific to the violation, approved by the Department.

In addition, the act directs the Department to impose a $50/day penalty for failure to allow an authorized representative to inspect the premises and records of the facility. For facilities serving the mentally ill, developmentally disabled, or substance abusers, any penalty imposed will commence on the date of the letter of notification of the penalty amount. For adult care facilities and nursing homes, any penalty imposed commences the date the violation was identified.

This act became effective June 23, 2011. (SP)

Nursing Homes/Food Service Inspections

S.L. 2011-226 (HB 622) reduces the frequency of food service inspections of nursing homes or beds licensed under Part 1 of Article 6 of Chapter 131E (Nursing Home Licensure Act) or Part 1 of Article 5 of Chapter 131E (Hospital Licensure Act) if the facility:

- Is certified by the Centers for Medicare and Medicaid Services.
- Has obtained a grade "A" sanitation at its last food service inspection.

The act authorizes the county to perform additional food service inspections in response to a complaint or in the interest of public safety

This act becomes effective October 1, 2011. (SP)

Revise Laws on Adult Care Homes

S.L. 2011-258 (HB 808) amends the law on inspection and monitoring of adult care homes and allows an informal dispute resolution procedure for adult care homes disputing inspection deficiencies. This act allows the annual inspection of an adult care home to be waived if the adult care home has achieved the highest rating in accordance with rules adopted by the NC Medical Care Commission. However, adult care homes that have annual inspections waived must be inspected at least once every two years by the Division of Health Service Regulation, Department of Health and Human Services. Additionally the act requires the Division to offer each adult care home the opportunity to informally resolve disputed findings from inspections conducted by the Division.

This act becomes effective October 1, 2011. (TM)

Discharge of Adult Care Home Residents

S.L. 2011-272 (HB 677) establishes procedures for the discharge of adult care home residents and provides for an appeals process for those discharge decisions. Written notice must be given to the proper individuals 30 days prior to the discharge and include specific information. If a discharge location is not known or is not appropriate for the resident, an adult care home resident discharge team will be convened to assist with placement of the resident. A resident may appeal the discharge notice to the Hearing Unit. While under appeal, the resident will remain in the facility, unless one of the following exceptions apply:

- The discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.
- The safety of other individuals in the facility is endangered.
- The health of other individuals in the facility is endangered.

This act becomes effective October 1, 2011. (AJ)

Exclusions from Licensure: Home Services

S.L. 2011-201 (HB 509) provides that three or more hours of day services or up to 24 hours of residential services can be provided to up to three adults, at least two of whom are mentally ill, developmentally disabled or a substance abuser, in a home which they either rent or own together, without being licensed by the Secretary of the Department of Health and Human Services. Persons with disabilities could not be required to move into an institutional setting if they changed services or service providers or discontinued services.

This act became effective June 14, 2011. (JP)

MENTAL HEALTH

Additional Section 1915 Medicaid Waiver Sites

S.L. 2011-102 (SB 316) repeals a provision of the 2010 Appropriations act which directed an expansion of the capitated 1915 (b)/(c) Medicaid waiver as a demonstration program, but limited the expansion to an additional two LMEs and conditioned further expansion and any expansion of the PBH (formerly Piedmont Behavioral Health) beyond its existing catchment area until after an evaluation and subsequent report to the General Assembly.

The act authorizes a State facility to disclose confidential information for the purposes of collecting certain payments due to the facility and replaces the term "budgetary surplus" with the term "fund balance" as the provision relates to distribution by pro-rata share upon the dissolution of an area authority for mental health, developmental disabilities, and substance abuse services.

This act became effective June 2, 2011. (SP)

Statewide Expansion of 1915(b)/(c) Waiver

S.L. 2011-264 (HB 916) directs the Department of Health and Human Services to restructure the management responsibilities for the delivery of services for individuals with mental illness, intellectual and developmental disabilities, and substance abuse disorders by expanding operation of a 1915(b)/(c) Medicaid Waiver statewide.

System change. - The act directs the Department of Health and Human Services (DHHS) to establish a system to deliver public services statewide to persons with mental illness, intellectual and developmental disabilities, and substance abuse disorders by expanding the 1915(b)/(c) Medicaid Waiver program. DHHS would complete restructuring of management responsibilities for all public resources for MH/DD/SAS programs by July 1, 2013, by:

- Becoming accountable for developing and managing a local system that provides easy access to care, makes available and delivers required services, and provides continuity of care;
- Adhering to the Piedmont Behavioral Health (PBH) system model;
- Within catchment areas, designating a single Local Management Entity (LME), either by merger or interlocal agreements (with one lead LME) to be responsible for all aspects of Waiver management;
- Employing specified managed care strategies, including care coordination and utilization management, to control costs while ensuring that consumers receive medically necessary care;
- Phasing out the current CAP-MR/DD and utilization management functions currently performed by other contractors;
- Designing the Innovations waiver to serve a greater number of qualified individuals within funding limits;
- Requiring 1915(b)/(c) Waiver-approved LMEs to maintain a community presence; implement a feedback and information exchange process to communicate with consumers, providers and others; create systems for communication and care coordination with other organized systems, such as local social service agencies, hospitals, schools, and other community agencies; and comply with specific operational requirements.

LMEs to operate 1915(b)/(c) waivers. - The act directs DHHS by August 1, 2011, to select LMEs which meet the minimum Waiver operations criteria according to the requirements of the RFA 2011-261 issued on April 1, 2011. The act further directs DHHS to cause LMEs that fail to meet minimum operational requirements by January 1, 2013 to merge or align an approved LME, and provides that under an interlocal agreement, a single LME would be responsible for all Waiver operations and contract requirements.

Local government limited liability. - Under the act, county governments are not financially liable for cost overruns associated with the area authority's or single/multi-county program's Waiver operation beyond that entity's risk reserve and Medicaid fund balance amounts.

Services for persons with Intellectual and Developmental Disability (IDD). - Targeted Case Management (TCM) is a service available statewide that assists individuals with intellectual and developmental disabilities in gaining access to needed services described in the State Medicaid Plan, as well as needed medical, social, educational, and other services. During the first year of Waiver operations, LMEs are directed to contract with previously approved TCM providers under the CAP-MR/DD Waiver to provide Community Guide service. A Section 1915(i) Option allows states to offer Home- and Community-Based Services (HCBS), and allows states to offer HCBS under a Medicaid state plan to individuals who are Medicaid-eligible. It limits eligibility to individuals with incomes up to 150 percent of poverty who, but for the program services, would need an institutional level of care. NC Innovations is a means of funding services and supports for people with mental retardation and other related developmental disabilities who are at risk for institutional care in an Intermediate Care Facility for Individuals with Mental Retardation (ICF-MR). Innovations also provides funding for people to return to their homes and communities from ICF-MRs. The act directs DHHS to assess by December 31, 2011, the feasibility of adding habilitation services through the 1915(i) Option for Medicaid enrollees with intellectual and developmental disabilities (IDD) who are not enrolled in the Innovations Waiver and are not residing in an ICF-MR. The act further directs DHHS to consider impacts on ICF-MR facilities and evaluate and minimize possible inconsistencies between the certificate of need requirements and the viability and success of 1915(b)/(c) Waiver programs, and to discontinue for non-waiver LMEs the Supports Intensity Scale pilot program authorized in the 2010 Appropriations Act.

Managed Care Systems. - The act directs DHHS to adopt written policies to align objectives of the 1915(b)/(c) Waiver and the care of eligible consumers with other managed care systems, including Community Care of North Carolina.

Reinvestment of Projected Savings. - The act directs future General Assemblies to consider reinvesting 15% or more of the projected savings from operating the Waiver to increase the number of consumers served by the Innovations Waiver or to expand services for persons with intellectual and developmental disabilities.

Reporting requirements. -The act directs DHHS, in coordination with other specified agencies, to submit a strategic plan for implementing this act to a legislative oversight committee, by October 1, 2011, and to submit periodic status reports to the General Assembly as to the progress of the restructuring and expansion authorized in Section 1 of the act.

LME catchment population. - By July 1, 2012 the minimum population of an area authority or county program must be at least 300,000. The Department will reduce administrative funding of LMEs which do not comply with the minimum population to a rate consistent with catchments of 300,000. By July 1, 2013 the minimum population of an area authority or county program must be at least 500,000. The Department will reassign management responsibilities for State and federal pass-through funding from LMEs which do not comply with the minimum population requirements. Further, the act provides that the dissolution of an area authority not meeting minimum population requirements is effective at any time during the fiscal year.

Rules not subject to the APA. - The act exempts the Department from the rule making under Article 2A of Chapter 150B in implementing, operating, or overseeing new or amending existing Waiver programs.

This act became effective June 23, 2011. (JP)

Enact First Evaluation Program

S.L. 2011-346 (SB 437) authorizes the Secretary of the Department of Health and Human Services to allow appropriately trained licensed clinical social workers, master's level psychiatric nurses, or master's level certified clinical addictions specialists to conduct initial (first-level) examinations for involuntary commitment of individuals with mental illness, in a manner consistent with the First Evaluation Pilot Program.

This act becomes effective October 1, 2011. (SP)

Facilitate Transfer State Psychiatric Hospital Beds to Community Facilities

S.L. 2011-275 (SB 578) authorizes the Secretary to transfer beds without the written memorandum agreement between the LME and the facility submitting the proposal if the entity/facility proposing to operate the beds:

- Submits an application to the Certificate of Need Section within DHHS.
- Commits to serve the type of short-term patients normally placed at the state psychiatric hospital.
- Is hospital authority created pursuant to G.S. 131E-17.
- Is located in a single county area authority.

This act became effective June 23, 2011 and expires December 31, 2011. (SP)

RECORDS AND REPORTING REQUIREMENTS

Facilitate Statewide Health Information Exchange

S.L. 2011-337 (SB 375) creates the North Carolina Health Information Exchange to provide a uniform and regulated method of sharing individually identifiable health information among health care providers, health plans, health care clearinghouses through the use of a voluntary statewide health information exchange network.

Requirements of the NC HIE- The act requires the NC HIE to satisfy multiple requirements prior to the disclosure of any protected health information through the network including:

- Ensuring compliance with HIPAA, compliance with the terms of business associate contracts entered into by the NC HIE or "qualified organizations" with covered entities, and with the provisions of new Article 29A.

- Proper notice to the public relating to the purpose of the network including information about the right to on a continual basis opt out or rescind a previous decision not to participate in the network.
- Ensuring non-discriminatory treatment by providers for individuals who have exercised the right not to particpate.

NC HIE also must facilitate and promote use of the HIE Network by entering into written participation agreements and business associate contracts with covered entities and as appropriate granting user rights to certain business associates of covered entities.

Requirements of Participants (covered entities) - Participating covered entities and authorized business associates shall enter into a written participation agreement and a business associate contract prior to disclosing or accessing any protected health information. Information disclosed on the Network is not limited by conflicting State disclosure laws, but only by the parameters of HIPAA. Further, except for emergency treatment, there shall be no disclosure of any protected health information of an individual who has exercised the right to opt out of the Network. Health care providers relying in good faith on information obtained through the Network shall not incur criminal or civil liability for damages caused by inaccurate or incomplete data.

Opt out Provision- This section governs an individual's right to prevent his or her protected health information from being disclosed through the Network. This right is continuous and allows an individual to rescind a previous decision to opt out. There is an emergency treatment exception provided if all of the following criteria are met:

- Circumstances indicate to the treating health care provider that there is (i) an emergency condition; (ii) it would be impractical to have a meaningful discussion about rescinding a previous decision to opt out; (iii) the information accessed could assist the diagnosis or treatment of the emergency medical condition.
- Disclosure is limited to individuals providing diagnosis and treatment of the medical condition.
- The circumstance and extent of the disclosure is recorded for future audit compliance purposes.

A covered entity may not deny treatment or benefits to an individual because of a decision to opt out.

Penalties and remedies- A covered entity that violates the provisions of Article 29A is subject to the following:

- Civil or criminal penalties available under HITECH Act.
- Civil remedies under HITECH Act that is available to the Attorney General including damages, penalties, attorney's fees, and costs.
- Disciplinary action by the respective licensing board or regulatory agency.
- Any penalty under Article 2A of Chapter 75 of the General Statutes (Identity Theft Protection Act)
- Any civil or administrative remedy available by law or equity.

This act becomes effective October 1, 2011. (SP)

Conform Medical Record Laws

S.L. 2011-314 (SB 607) amends multiple statutes governing the use of confidential medical information under the Pharmacy Practice Act, Mental Health law, Public Health law, and within Adult Care Homes and the Home Health Care setting to authorize disclosure for purposes permitted by HIPAA.

This act becomes effective January 1, 2012. (SP)

Model Health Care-Associated Infections Law

S.L. 2011-386 (HB 809) directs the Department of Health and Human Services (Department) to establish a statewide surveillance and reporting system for health care-associated infections (HAI). The act authorizes the Commission for Public Health to adopt rules to implement a statewide HAI reporting system. The rules must specify uniform standards including, at a minimum, a preference for electronic surveillance and a requirement of electronic reporting.

All 124 hospitals licensed by the Division of Health Service Regulation are subject to the statewide surveillance and reporting system. In addition the hospitals are responsible for the surveillance

and reporting of HAI data to the Department using the National Healthcare Safety Network (NHSN) managed by the Centers for Disease Control and Prevention (CDC). The act also authorizes the Department to release HAI data collected that does not contain personal identifying information, but only if the Department considers the release of the data as reliable and necessary to protect the public's health.

The act directs the Department to annually report to the General Assembly on its activities related to HAI beginning December 31, 2011.

This act became effective June 27, 2011. (SB)

Protect Adult Care Home Residents

S.L. 2011-99 (HB 474) requires the development of guidelines for reporting outbreaks of communicable diseases in adult care homes to local health departments and requires that the Division of Health Services Regulation review an adult care home's compliance with infection prevention requirements as part of the Division's annual inspection. Changes to adult care home prevention requirements will be made as of January 1, 2012, and include the following:

- Implementation of a written infection control policy.
- Compliance with the facilities infection control policy.
- Updates of the infection control policy.
- Designation of an on-site staff member to direction the facility's infection control activities and insure all staff has proper training.

Additionally, changes were made to the training and competency evaluation requirements for adult care home medication aides. The Department of Health and Human Services is responsible for developing a mandatory, annual course for adult care home supervisors on federal Centers for Disease Control and Prevention guidelines by December 1, 2011.

This act became effective May 31, 2011. (AJ)

MEDICAID

Medicaid and Health Choice Provider Requirements

S.L. 2011-399 (SB 496) adds Chapter 108C to the General Statutes, which applies to all providers enrolled in Medicaid and North Carolina Health Choice. The act outlines the provider screening requirements and categorical risk provider types as required by federal law. Criminal history records checks are required for providers in accordance with the federal law. New applicants for provider enrollment are required to submit an attestation that the provider does not owe any final overpayments, assessments, or fines to Medicaid or Health Choice in North Carolina or any other state and is compliant with federal law. New applicants must also attend trainings regarding Medicaid billing and fraud. The Department is authorized to establish a registry of billing agents, clearinghouses, and alternate payees that submit claims on behalf of providers as required by federal law.

The Department of Health and Human Services has the authority to suspend payments to providers pursuant to the federal law, as well as any provider who owes a final overpayment, assessment, or fine to the Department but has not entered into a payment plan with the Department or any provider who has had its participation in Medicaid or Health Choice suspended or terminated. Audits are authorized and provider cooperation required. The act outlines a process for requiring a provider to undergo prepayment claims review should there exist grounds for such a requirement. Provider appeals are addressed and are considered a contested case subject to Chapter 150B of the General Statutes.

This act also expressly authorizes the Department to adopt temporary and permanent rules with regards to Medicaid and NC Health Choice, as well as for changing medical policy pertaining to the Medicaid.

The portion of the act related to the registry of billing agents, clearinghouses, and alternate payees, as well as the portion of the act pertaining to adopting rules regarding medical policy will become

effective on January 1, 2012. The remainder of the act became law effective July 25, 2011, and applies to audits instituted on or after that date and to final overpayments, assessments, or fines due on or after that date. (AJ)

Hospital Medicaid Assessment/Payment Program

S.L. 2011-11 (SB 32) imposes two different Medicaid-related assessments on hospitals: an equity assessment and an upper pay limit assessment. The quarterly assessments are calculated annually as a percentage of total hospital costs by the Secretary of Health and Human Services. The proceeds of the assessments are used to make quarterly distributions to the hospitals as well as a quarterly transfer to the General Fund. The bill directs DHHS to file a State plan amendment with the Centers for Medicare & Medicaid Services to implement the hospital assessments and payments by March 31, 2011.

This act became effective March 25, 2011. (AJ)

Modify FMAP Cuts

S.L. 2011-23 (SB 58) modifies the federal medical assistance percentages cuts in the 2010-2011 state budget by eliminating a reduction in Medicaid provider rates and eliminating a reduction in retirement system contributions to backfill federal medical assistance percentages funds.

This act became effective March 31, 2011. (AJ)

Medicaid Billing by Local Health Departments

S.L. 2011-90 (SB 245) authorizes local health departments, district health departments, and consolidated human service agencies to bill Medicaid through an approved clearinghouse or through the Health Information System (HIS). Entities are entitled to the same negotiated rates as other entities classified as public health entities regardless of billing method chosen. The Division of Public Health will provide aggregate data requirements for Medicaid cost study reimbursement on behalf of entities choosing to bill through an approved clearinghouse; however the entities will be required to submit aggregate data information to the Division of Public Health for this purpose.

This act became effective May 26, 2011. Local health departments, district health departments, and consolidated human services agencies may rebill outside of the HIS system any unpaid Medicaid claims submitted to HIS between the time period of July 1, 2010, and May 26, 2011. (AJ)

PILOTS AND STUDIES

Smart Card Biometrics Against Medicaid Fraud

S.L. 2011-117 (SB 307) establishes the North Carolina Smart Card Pilot Program to replace the current Medicaid assistance cards with Smart Cards. Smart Cards are able to store a variety of digital information on a card the size of a typical credit card. The Pilot Program is designed to do the following:

- Authenticate recipients at the onset and completion of each point of transaction.
- Deny ineligible persons at the point of transaction.
- Authenticate providers at the point of transaction.
- Secure and protect the personal identity and information of recipients.
- Reduce the total amount of medical assistance expenditures by reducing average cost per recipient.

The Pilot Program will last from six to twelve months and will not be expanded unless the Department of Health and Human Services data indicates the program can be expanded through program savings. The act outlines minimum criteria that must be established for the program to be considered a success. By June 30, 2012, the Department must submit a written report to the Governor, to the Speaker of the House of Representative, to the President Pro Tempore of the Senate, to the Chairs of the

Senate and House Appropriations Committees, and to the Fiscal Research Division on the implementation and success of the pilot program.

This act became effective June 13, 2011. (AJ)

Authorize Overnight Respite Pilot

S.L. 2011-104 (SB 512) requires the Department of Health and Human Services to conduct a pilot program to assess the provision of overnight respite services in adult day care programs. The pilot must include a minimum of two and maximum of four stable and successful certified adult day care programs. Adult day care programs selected to participate in the pilot are exempt from specified licensure requirements, but are subject to Division of Health Service Regulation-enforced rules to ensure the health and safety of adult day care overnight respite participants. The Division is required to inspect facilities before allowing the provision of overnight respite services, to monitor visits, and to investigate complaints. Additionally, the Division is authorized to terminate the pilot program or suspend admission at any time if noncompliance with regulations results either in death or serious physical harm or a substantial risk of death or serious physical harm.

The Department is required to annually report to the Program Evaluation Division on the status of the pilot program. The Program Evaluation Division must report to the General Assembly on the feasibility of continuing to provide overnight respite services in adult day care programs on or before October 1, 2014

The act became effective June 2, 2011, adult day care programs participating in the pilot must be selected and have received an initial inspection by January 1, 2012, and the act is repealed June 1, 2015. (TM)

Pilot Release of Inmates to Adult Care Homes

S.L. 2011-389 (HB 678) directs the Department of Health and Human Services (Department) to establish a pilot program addressing needs of inmates in need of personal care services and medication management who are terminally ill or permanently and totally disabled and do not pose a significant safety risk or who have received a medical release from the Department of Corrections (DOC). The Department must select one adult care home in the State to participate in the pilot program. That adult care home would be prohibited from having or admitting any residents other than the selected inmates. The Department would have the discretion to waive any rules relating to inspection and licensing of facilities necessary to protect public health and safety. The Department and DOC is be required to report cost/benefit findings and recommendations to the Joint Legislative Corrections, Crime Control, and Juvenile Justice oversight Committee not later than 18 months after the participating home admits its first resident.

This act became effective June 28, 2011. (SP)