2013

Substantive Legislation: Health and Human Services

October 2013

Research Division, North Carolina General Assembly

2013 Substantive Legislation: Health and Human Services

This document provides summaries of substantive health and human services legislation enacted during the 2013 Regular Session of the 2013 General Assembly. In an effort to facilitate use the summaries of Enacted Legislation have been categorized under subheadings, and then arranged in numerical order by Session Law under each subheading.

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For a document containing all substantive legislation for the 2013 session, please refer to the *Summaries of Substantive Ratified Legislation 2013* produced by the Research Division.

Enacted Legislation

Child Development & Early Education

NC Pre-K

S.L. 2013-360, Sec. 12.B.1 (SB 402, Sec. 12.B.1), as amended by S.L. 2013-363, Secs. 4.2 and 4.3, directs the Division of Child Development and Early Education's (DCDEE) to continue to implement the NC Pre-K program for four-year old children whose parent's income does not exceed 75% of the State Median Income (SMI). Up to 20% of the children in the program may come from families whose income is above 75% SMI, if the children have a designated risk factor. Developmental disabilities or chronic health issues are the only designated health risk factors to be considered for program eligibility. Four-year old children whose parent is on active military duty, or who was injured or killed while on active duty, are also eligible for NC Pre-K. In addition, DCDEE is directed to (i) issue multi-year contracts to licensed private child care centers to provide NC Pre-K classrooms, and (ii) establish a standard decision making process for awarding NC Pre-K slots. All NC Pre-K classrooms in public schools must be licensed by July 1, 2014. All NC Pre-K programs must adhere to DCDEE standards and participate in the Subsidized Early Education for Kids (SEEK) accounting system. DCDEE is directed to implement a pilot program looking at a per classroom funding model for the NC Pre-K program, and report to several committees of the General Assembly and to the Fiscal Research Division, on the outcomes of the pilot program. DCDEE is also required to report annually on the implementation statistics and outcomes of the NC Pre-K program. Conforming statutory changes are made to the expiration dates of terms of members of the Child Care Commission, specifying terms ending in 2015 and 2016. The terms of all current members of the Child Care Commission expired on July 1, 2013 and new members will be appointed by October 1, 2013.

This provision became effective July 1, 2013. (PLP)

Administrative Allowance for County Departments of Social Services - Use of Subsidy Funds for Fraud Detection

S.L. 2013-360, Sec. 12B.7 (SB 402, Sec. 12.B.7), as amended by S.L. 2013-363, Sec. 4.7, directs DCDEE to fund the allowance that county departments of social services can use for administrative costs at 4% of the county's total subsidy funds allocated in the Child Care and Development Fund Block Grant plan or $80,000, whichever is greater. Each county department of social services may use up to 2% of child care subsidy funds for fraud detection and investigation initiatives. DCDEE will submit a progress report on the amount allocated and the use of child care subsidy funds to the Joint Legislative Oversight Committee on Health and Human Services and to Fiscal Research by May 1, 2014 and a follow-up report must be submitted by January 1, 2015. DCDEE may adjust the allocations stipulated in the Budget under the Child Care and Development Fund Block Grant and submit a report on these adjustments to the Joint Legislative Oversight Committee on Health and Human Services and to Fiscal Research by September 30, 2013.

This act became effective July 1, 2013. (PLP)

Children's Developmental Services Agencies

S.L. 2013-360, Sec. 12E.4 (SB 402, Sec. 12E.4) allows the Department of Health and Human Services (Department) to close up to four Children's Developmental Services Agencies (CDSAs). The Department may not close the CDSA in Morganton or any of the CDSAs with high

rural or underserved caseloads. If the Department choses to close a CDSA, that information should be submitted to the Joint Legislative Oversight Committee on Health and Human Services and to the Fiscal Research Division by March 1, 2014.

This section became effective July 1, 2013. (PLP)

Health and Human Services- Departmental/Administrative, Technology, & Related Issues

Small Group Health Insurance Technical Changes

S.L. 2013-357 (HB 649) makes changes to the Small Employer Group Health Coverage Reform Act as a response to various changes to the insurance market that will take effect due to changes in federal regulations and the federal Affordable Care Act (ACA). No small employer carrier will be required to issue the current basic or standard health benefit plans and any plans that are not grandfathered plans, as defined by the ACA, will be terminated on the next anniversary date on or after January 1, 2014, following specified procedures. Changes taking effect January 1, 2014, and January 1, 2016, conform the definition of small employer to the definition found in the ACA. The rating factors for nongrandfathered small group health benefit plans and are limited to the following factors:

- Age, except that the rate may not vary by more than 3:1 for adults.
- Whether the plan covers an individual or a family.
- Geographic rating areas.
- Tobaccos use, except that the rate may not vary by more than 1.20:1.

S.L. 2013-357 (HB 649) also prohibits an insurer from offering stop loss health insurance policies to small employers if the policy contains any specified provisions, effective October 1, 2013. The Department of Insurance is directed to adopt rules pertaining to insurers and third party administrators who administer health benefit plans with stop loss coverage. Additionally, the Department of Insurance is directed to adopt rules to implement the changes to small employer group health coverage.

Except as noted within the summary, this act became effective July 25, 2013. (AJJ)

Department Flexibility to Achieve Departmental Priorities and Enhance Fiscal Oversight and Accountability

S.L. 2013-360, Sec. 12A.1 (SB 402, Sec. 12A.1) authorizes the Secretary of the Department of Health and Human Services to reorganize positions and related operational costs (i) upon a demonstration by the Department of cost-effectiveness and (ii) after approval by the Office of State Budget and Management (OSBM). The Department must identify the positions and the strategies to be implemented to achieve efficiencies.

The Secretary, with prior approval of OSBM, may also realign up to 32 existing positions to expand the ability of the Department's Office of Internal Audit to conduct independent reviews and analyses of various functions and services within the Department.

No later than June 30, 2014, the Department must identify the positions involved and the strategies implemented to achieve efficiencies, to expand internal audit capacity, or both in a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

This section became effective July 1, 2013. (SK)

Funding for Nonprofit Organizations - Establish Competitive Grants Process

S.L. 2013-360, Sec. 12A.2 (SB 402, Sec. 12A.2) describes the intent of the General Assembly that the Department of Health and Human Services (Department) implement a competitive grants process for nonprofit funding (competitive grants process) beginning with fiscal year 2014-2015. The section sets forth the required elements of the competitive grants process that is to be administered by the Division of Central Management and Support. No later than February 1, 2014, the Secretary must develop a plan for the implementation of the competitive grants process and must report to the Joint Legislative Oversight Committee on Health and Human Services on the plan. No later than March 1, 2014, the Secretary must implement the competitive grants process. No later than July 1, 2014, the Secretary must announce the recipients of the competitive grants process awards and allocate funds to the grant recipients for the 2014-2015 fiscal year. After the awards have been granted, the Secretary must submit a report to the Joint Legislative Oversight Committee on Health and Human Services that includes:

- The identity and a brief description of each grantee and each program or initiative offered by the grantee.
- The amount of funding to each grantee.
- The number of persons served by each grantee, broken down by program or initiative.

This section became effective July 1, 2013. (SK)

Health Information Technology

S.L. 2013-360, Sec. 12A.3 (SB 402, Sec. 12A.3) directs the Department of Health and Human Services (Department) to coordinate health information technology (HIT) policies programs within the State to ensure the coordination of all public and private HIT efforts. The Department must also establish a HIT management structure that is efficient, transparent, and compatible with the Office of the National Health Coordinator for Information Technology governance mechanism. The Department must report no later than January 15, 2015 on the status of federal and State HIT efforts to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

This section became effective July 1, 2013. (SK)

Fraud Detection through North Carolina Accountability and Compliance Technology System

S.L. 2013-360, Sec. 12A.5 (SB 402, Sec. 12A.5) directs the Department of Health and Human Services (Department) to work with the Governmental Data Analytics Center to develop an integration plan to leverage the North Carolina Financial Accountability and Compliance Technology System (NC FACTS), the State's enterprise-level fraud detection system. The plan must include the integration of the following systems: NC Tracks, the North Carolina Child Treatment Program (NC CTP), North Carolina Families Accessing Services through Technology (NC FAST). No later than April 1, 2014, the Department must report on a plan to integrate the systems listed above to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Information Technology.

This section became effective July 1, 2013. (SB)

Funding for North Carolina Families Accessing Services through Technology (NC FAST); Report on Eligibility Determinations for the Exchange

S.L. 2013-360, Sec. 12A.6 (SB 402, Sec. 12A.6) requires that the funds appropriated for the North Carolina Families Accessing Services through Technology (NC FAST) project must be used to match federal funds in years 2013-2014 and 2014-2015 to accelerate the development and the implementation of the Eligibility Information System (EIS), Child Care, Low Income Energy Assistance, Crisis Intervention Programs, and Child Service components of the NC FAST project.

This section also directs the Department of Health and Human Services (Department) to report on the performance of the NC FAST project in providing eligibility determinations for Medicaid Applicants on the federally facilitated Health Benefit Exchange (HBE). The Department must submit a report three months after open enrollment begins for the HBE to the Joint Legislative Commission on Governmental Operations, the Joint Legislative Oversight Committee on Health and Human Services, and the Joint Legislative Oversight Committee on Information Technology.

This section became effective July 1, 2013. (SB)

Modifications to Commission for the Blind

S.L. 2013-360, Sec. 12A.14 (SB 402, Sec. 12A.14) repeals the Professional Advisory Committee established in Part 8 of Article 3 of Chapter 143B of the General Statutes. In addition this section amends G.S. 143B-158 by increasing the membership of the Commission for the Blind from 13 to 19 members to include: (i) two licensed physicians nominated by the North Carolina Medical Society whose practice is limited to ophthalmology, (ii) two optometrists nominated by the North Carolina State Optometric Society, and (iii) two opticians nominated by the North Carolina Opticians Association.

This section became effective July 1, 2013. (SB)

Codify Work First Family Assistance Eligibility and Payment Levels

S.L. 2013-360, Sec. 12C.8 (SB 402, Sec. 12C.8) codifies that the maximum net family income eligibility standards for Work First Family Assistance are the same as for the categorically needy under the Medicaid Program.

This section became effective July 1, 2014. (JPP)

Increase Permit Fees Certain Food and Lodging Establishments

S.L. 2013-360, Sec. 12E.1 (SB 402, Sec. 12E.1) adds a definition of "temporary food establishment" to the statutes regulating food and lodging facilities. The section establishes fees for temporary food establishments and limited food establishments of $75 per permit issued. All the fees collected from the issuance of these permits must be used by local health departments for local food, lodging, and institution sanitation programs and activities. The section also increases permit fees for food and lodging facilities, except for temporary food establishments, limited food establishments, and other facilities exempt by statute from these permit fees, from $75 to $120. Temporary food establishments and limited food establishments are added to the facilities that are exempt from late payment fees. The section repeals the amendments to G.S.

130A-248(d) providing for a larger share of the receipts from food and lodging facility permit fees to go to local health departments. 33 1/3% of the permit fees collected may be used to support State health programs and activities.

This section became effective August 1, 2013 and applies to food and lodging permits effective or reassessed on or after that date. (BR)

North Carolina Medical Examiner Autopsy Fees

S.L. 2013-360, Sec. 12E.8 (SB 402, Sec. 12E.8) increases autopsy fees paid by the State or county for autopsies requested by a medical examiner or the Chief Medical Examiner, from $1,000 to $2,000.

This section became effective August 1, 2013 and applies to autopsies performed on or after that date. (BR)

Certificate of Need Exemption for Replacement of Previously Approved Equipment and Facilities Located on the Main Campus of a Licensed Health Service Facility

S.L. 2013-360, Sec. 12G.3 (SB 402, Sec. 12G.3), as amended by S.L. 2013-363, Sec. 4.6, exempts from certificate of need review any replacement equipment that meets specific conditions. S.L. 2013-360, Sec. 12G.3 (SB 402, Sec. 12G.3), also exempts from certificate of need review any capital expenditure exceeding $2 million dollars that meets specific conditions.

This section became effective July 1, 2013 and applies to replacement equipment purchased, and capital expenditures incurred, on or after that date. (AJJ)

Administrative Hearing Funding - Contingency Fees to Audit Contractors

S.L. 2013-360, Sec. 12H.16.(b) (SB 402, Sec. 12H.16.(b)) prohibits the Department of Health and Human Services from paying contingency fees to program integrity recovery contractors in excess of the State share of amounts actually recovered.

This section became effective July 1, 2013. (JLH)

Codify Provider Performance Bonds

S.L. 2013-360, Sec. 12H.17 (SB 402, Sec. 12H.17) codifies a provision that has appeared in past Appropriations Acts allowing the Department of Health and Human Services to require performance bonds of up to $100,000 from providers based on certain risk conditions.

This section became effective July 1, 2013. (JLH)

Community Care of North Carolina to Set and Pay Per Member Per Month Payments on Performance Basis to Encourage Better Care Management

S.L. 2013-360, Sec. 12H.22 (SB 402, Sec. 12H.22) requires the Department of Health and Human Services to contract with Community Care Networks, Inc., to administer and distribute the funds currently allocated to per member per month payments for Community Care of North Carolina primary care providers, if specific criteria are met. Funds will be allocated to primary care providers on a care management performance basis using specified criteria

developed by Community Care Networks. Performance-based payments will begin July 1, 2014. The Department of Health and Human Services will consult with the Joint Legislative Oversight Committee on Health and Human Services on the performance-based payment proposal.

This section became effective July 1, 2013. (AJJ)

Specify Board Selection for the North Carolina Institute of Medicine

S.L. 2013-363, Sec 4.1 (HB 112, Sec 4.1) amends S.L. 2013-360 to add Section 12I.1. The new section amends the law pertaining to the North Carolina Institute of Medicine (NC IOM) to clarify that the NC IOM is governed by a Board of Directors. The Board will consist of: seven individuals appointed by the General Assembly on the recommendation of the Speaker of the House of Representatives, seven individuals appointed by the General Assembly on the recommendation of the President Pro Tempore of the Senate, and seven individuals appointed by the Governor. The Board members should be distinguished and influential leaders from the major health professions, the hospital industry, the health insurance industry, State and county government and other political units, education, business and industry, the universities, and the university medical centers. A term on the Board is for four years and no individual may serve more than two consecutive terms. These provisions amending the law for the NC IOM become effective January 1, 2014.

In order to provide for a staggering of terms, three of the appointments made by the Speaker of the House of Representatives and three of those made by the President Pro Tempore of the Senate will serve two-year terms, four of the appointments made by the Governor will be for two-year terms.

Except as otherwise noted, this section became effective July 1, 2013, the appointments enacted by this section begin on January 1, 2014 and the members serving on July 1, 2013 continue to serve until January 1, 2014. (TM)

Amend Laws Pertaining to the Department of Health and Human Services

S.L. 2013-378 (HB 399), as amended by S.L. 2013-363, Sec. 4.12(a), makes changes to statutes pertaining to child abuse, neglect and dependency, Medicaid, and public health, as requested by the Department of Health and Human Services.

Laws Pertaining to Child Abuse, Neglect, and Dependency. - The act requires court orders placing a juvenile in the custody or responsibility of a county department of social services to include case specific findings as to the reasonable efforts made by the department to either prevent or eliminate the need for placement of the juvenile. The act adds requirements consistent with eligibility requirements under the Child Abuse Prevention and Treatment Reauthorization Act of 2010 for grants for child abuse/neglect prevention and treatment programs, giving courts the option to not pursue reunification when a parent is found to have sexually abused a child or a parent is listed on a sex offender registry.

Laws Pertaining to Medicaid. - The Department of Health and Human Services (Department) is granted all rights available to estate creditors, including the right to qualify as Personal Representative or Collector of an estate. Every personal representative and collector is required to give notice to the Division of Medical Assistance as a known creditor when an estate is opened, if the decedent was receiving medical assistance at the time of death. The Department is a sixth-class creditor for purposes of determining the order of claims against the decedent's estate. Judgments in favor of other sixth-class creditors docketed and in force before the Department seeks recovery for medical assistance would be paid prior to recovery by the Department. The act requires that trustees of revocable trusts who know the person who

established the trust was receiving medical assistance give notice to the Division of Medicaid Assistance within 90 days of the death of the person.

Pursuant to federal regulation, all Medicaid and Health Choice providers must be screened according to one of three risk levels: limited, moderate, and high. S.L. 2013-378 adds additional providers to the already established categories.

Laws Pertaining to Public Health. - The potential maximum penalty for violations of the Department's Lead-Based Paint Program is increased to $5,000 per day for each day a violation continues.

The act creates one standard time limit of ten days for filing a certificate of live birth with the local county registrar.

All health care providers and facilities are required to report each diagnosis of cancer or benign brain or central nervous system tumors. Cancer registry reporting is required be done electronically by October 1, 2014, in a format prescribed by the National Program of Cancer Registries.

Laws Pertaining to Mental Health, Developmental Disabilities, and Substance Abuse. – Section 10 of the act extends the deadline by which a surviving mental health, developmental disabilities, and substance abuse area authority must meet the area board governance requirements if the Secretary approves a merger or realignment of two area authorities and either approves or directs the dissolution of one of them. Section 10 became effective July 29, 2013. A technical change in Section 11 clarifies that the area authority requirement supersedes the authority of a county to operate a consolidated human services agency. Section 11 becomes effective April 1, 2014.

This act becomes effective October 1, 2013, except as noted for the changes to the laws pertaining to mental health, developmental disabilities, and substance abuse. (AJJ)

Warrant Status - Drug Screen Public Assist

S.L. 2013-417 (HB 392) contains two separate parts, in addition to the effective date: Share Arrest Warrant Status of Applicants for Public Assistance and Drug Screening and Testing for Work First Program Assistance.

Share Arrest Warrant Status of Applicants for Public Assistance: The act requires a county Department of Social Services (DSS) to notify an applicant for, or recipient of, Temporary Assistance for Needy Families (TANF) or Food and Nutrition Services (FNS) benefits that confidential information from the individual's record may be released if there exists an outstanding warrant for arrest against the individual. DSS is required to verify whether an applicant is fleeing to avoid prosecution, custody, or confinement after conviction for a felony or violating a condition of probation or parole, by ensuring that the criminal history of an applicant, or of a recipient at the time of benefits renewal, is checked in a manner and to the extent permitted by allocated county and State resources and federal law. The Social Services Commission must adopt rules relating to the sharing of information between county departments of social services and local law enforcement agencies. The Department of Health and Human Services (Department) is required to promote cooperation among State and local agencies to perform these functions. Each county DSS is required to report to the Department, and the Department is required to report to the General Assembly, on the number of individuals denied services under these provisions.

County DSSs will not grant TANF and FNS benefits if the DSS receives information that the applicant/recipient is subject to arrest on an outstanding warrant for a parole or probation violation or for a felony charge. The benefits eligibility of members of the individual's household will not be affected.

The county department of social services must provide to the DOJ, along with the request, any information required by the DOJ and a form signed by the individual to be checked consenting to the check of the criminal record and to the use of any necessary identifying

information required by the State or National Repositories. DOJ may charge a reasonable fee and, with specified exceptions, DSS must keep confidential all information obtained.

Drug Screening and Testing for Work First Program Assistance: The Department is required to administer a drug test to screen each applicant for or recipient of Work First benefits whom the Department reasonably suspects is engaged in the illegal use of controlled substances. Dependent children under age 18 and child-only cases are exempt. The Department must provide notice of drug testing to each applicant or recipient advising that test results are confidential and will not be released to law enforcement. An individual who tests positive for controlled substances must be provided with information regarding substance abuse treatment.

A person who tests positive is ineligible to receive Work First Program assistance for a period of one year from the date of the positive drug test, and may reapply after one year; a person who has a subsequent positive drug test is ineligible for a period of three years from the date of the subsequent drug test. However, a person is eligible to reapply after 30 days with documentation of successful completion of or current satisfactory participation in a substance abuse treatment program offered by an area mental health authority and licensed by the Department. The applicant who reapplies after completion of a treatment program is required to pass a drug test, and would be responsible for the cost of the test. A person may only reapply one time based on completion of a substance abuse treatment program. Additionally, an individual is eligible to reapply after 30 days with documentation that a substance abuse program is not appropriate for the individual and that individual has passed a subsequent drug test, which is paid for by that individual.

Reasonable suspicion that an individual is engaged in the illegal use of controlled substances may be established only by utilizing the following methods:

- Criminal record check that discloses a conviction, arrest, or outstanding warrant relating to illegal controlled substances within three years prior to the date the record check is conducted.
- A determination by a Qualified Professional in Substance Abuse or a physician certified by the American Society of Addiction Medicine that an individual is addicted to illegal substances.
- A screening tool relating to the abuse of illegal controlled substances that yields a result indicating that the individual may be engaged in the illegal use of controlled substances.
- Other screening methods as determined by the Social Services Commission.

The Social Services Commission must adopt rules implementing both portions of the act. Rules for the implementation of drug testing must be adopted no later than February 1, 2014. The Department is required to report to the General Assembly no later than April 1, 2014, on the implementation of drug testing each applicant for or recipient of Work First benefits whom the Department reasonably suspects is engaged in the illegal use of controlled substances.

Section 4, pertaining to statutory changes related to drug screening and testing for Work First Program applicants and recipients, becomes effective August 1, 2014. The remainder of the act became effective October 1, 2013. (AJJ)

Hospitals and Pharmacies

Expand Pharmacists' Immunizing Authority

S.L. 2013-246 (HB 832) creates a new section of the Pharmacy Practice Act authorizing a pharmacist to administer adult vaccines or immunizations enumerated in the statute. An immunizing pharmacist may also administer a flu vaccine to persons at least 14 years old. The act requires that the administration of drugs by an immunizing pharmacist must be in accordance with rules adopted by each of the Boards of Pharmacy and Nursing, and the NC Medical Board.

Representatives of the North Carolina Academy of Family Physicians, the North Carolina Medical Society, the North Carolina Pediatric Society, the North Carolina Association of Community Pharmacists, the North Carolina Association of Pharmacists, and the North Carolina Retail Merchants Association are to collaborate to recommend a minimum standard screening questionnaire and safety procedures for vaccines and immunizations administered by immunizing pharmacists. If the parties cannot reach agreement by October 1, 2013, the Immunization Branch of the Department of Health and Human Services must develop the questionnaire and standards.

Sections 1 through 5 of the act become effective October 1, 2013. The remainder of the act became effective July 3, 2013. (BR)

Modify Hospital Assessments by Changing Amount Retained by State to a Percentage

S.L. 2013-360, Sec. 12H.19 (SB 402, Sec. 12H.19) changes the amount of money that the State collects and keeps from hospital provider assessments from a flat $43M to a variable 25.9% of total collections. This section maintains the collection of assessment amounts from providers acquired by the University of North Carolina (UNC) providers, although UNC remains exempt from assessments. As a result of this section, an additional change to the Hospital Provider Assessment Act is made in S.L. 2013-397, Sec. 10 (SB 553, Sec. 10).

This section became effective July 1, 2013. (JLH)

Amend Pharmacy Laws

S.L. 2013-379 (HB 675) amends the North Carolina Pharmacy Practice Act to provide for the registration of two categories of pharmacy technicians, "certified pharmacy technicians" and "non-certified pharmacy technicians", and makes changes to the laws regarding registration, training, and grounds for disciplinary action of pharmacy technicians. The act expands the audit rights of pharmacies whose records are being audited by a managed care company, insurance company, third party payer, or other entity representing a responsible party. Under the provisions of the act, a pharmacy must be subject to recoupment of the reimbursement for the dispensed product of a prescription in those cases where there was fraud, dispensing in excess of the benefit design, prescriptions not filled in accordance with the prescriber's order, or actual overpayment to the pharmacy. Recoupment of funds must not occur until after the latter of the deadline for appeals or the final internal disposition of the audit. The act also amends the Controlled Substances Act to provide that a written prescription for a Schedule II drug must not be good for more than 6 months.

This act becomes effective October 1, 2013. Section 2, pertaining to pharmacy technicians, and Section 5, pertaining to the dispensing of Schedule II substances, apply to acts occurring on or after that date. Section 3, pertaining to pharmacy rights during an audit, and Section 4, pertaining to pharmacy audit recoupments, apply to audits commencing on or after that date. (BR)

Health Cost Transparency

S.L. 2013-382, Part X (HB 834, Part X) creates the Health Care Cost Reduction and Transparency Act of 2013. The act creates new reporting requirements for hospitals on pricing for the 100 most common in patient diagnostic related groups (DRG) in each hospital. The act also creates similar reporting requirements for hospital outpatient departments and ambulatory surgical facilities (ASF). These facilities must report on the 20 most common surgical procedures and the 20 most common imaging procedures, along with the appropriate CPT and HCPCS codes, performed in each setting. The North Carolina Department of Health and Human Services must

publish this information reported by the hospitals and ASF on its internet website available to the public. The Medical Care Commission is charged with adopting rules identifying the DRG, surgical procedures and imaging procedures on which the facilities will report. In addition, non-profit hospitals and ASF must provide public access to their financial assistance policies and annual financial assistance costs. Disclosure by hospitals of their pricing for the 100 most common DRG begins with the quarter ending June 30, 2014. Reporting by hospitals and ASF on the 20 most common surgical procedures and 20 most common imaging procedures begins with the quarter ending September 30, 2014.

Sections 10.4 and 10.5 of this Part, pertaining to confidentiality of competitive health care information and confidentiality of health care contracts, become effective January 1, 2014. The remainder of this Part became effective August 21, 2013. (BR)

Certain Changes - Payments Prohibited

S.L. 2013-382, Part XI (HB 834, Sec. Part XI), as amended by S.L. 2013-393, Sec. 1, makes it unlawful for any provider of health care services to charge or accept payment for any health care procedure or component of a health care procedure that was not performed or supplied. If a procedure requires the informed consent of a patient, the charge for any component of the procedure performed prior to consent being given must not exceed the actual cost to the provider if the patient elects not to consent to the procedure.

This Part becomes effective December 1, 2013 and applies to health care procedures and services rendered on or after that date. (BR)

Hospital Debt Collections

S.L. 2013-382, Part XII (HB 834, Part XII) prohibits the UNC Health Care System and its affiliates, and other schools of medicine, clinical programs, facilities, and medical practices affiliated with one of the constituent institutions of UNC that provides medical care to the general public, from utilizing setoff debt collection procedures to collect outstanding debts from tax refunds and lottery winnings of debtors.

This Part becomes effective January 1, 2014 and applies to tax refunds determined by the Department of Revenue on or after that date. (BR)

Fair Health Care Facility Billing and Collections Practices

S.L. 2013-382, Part XIII (HB 834, Part XIII) as amended by S.L. 2013-393, Sec. 2 (SB 473, Sec. 2) establishes fair billing and collections practices for hospitals and ambulatory surgical facilities (ASF's). Fair practices include requirements that bills must be written so as to be comprehensible to the ordinary lay person, notice be provided before a bill is sent to collections, and prompt refunds provided by facilities in the event of overpayment. These practices also prohibit a lien for a debt owed a hospital or ASF from attaching to a debtor's principal residence held by spouses as tenants by the entireties or that was held as tenants by the entireties prior to the death of either spouse where the tenancy terminated as a result of the death of either spouse. If the principal residence is located on land in excess of five acres, a lien cannot attach to the principle residence and five acres surrounding the house. Execution on, or forced sale of, the primary residence of a custodial parent or parents to collect an unpaid bill for a debt owed for care provided to a minor is prohibited until the minor leaves the home or reaches the age of majority, whichever comes first.

This Part becomes effective October 1, 2013 and applies to billings and collections practices occurring on or after that date. (BR)

Required Participation in the North Carolina Health Information Exchange

S.L. 2013-382, Part XIV (HB 834, Part XIV), as amended by S.L. 2013-363, Sec. 4.18, requires hospitals that have electronic health records systems to connect to the North Carolina Health Information Exchange network and submit data on services paid for with Medicaid funds. The NC Health Information Exchange (NC HIE) must give the Department of Health and Human Services (Department) real-time access to data and information contained in the NC HIE.

The changes enacted to the required participation in NC HIE for some providers by Section 4.18(a) of S.L. 2013-363, become effective upon the satisfaction of both of the following conditions: (1) the Department and the NC HIE must execute an agreement regarding the utilization and sharing of data and information contained in the HIE Network, which must be in a manner that complies with the Health Information Portability and Accountability Act of 1996 (HIPAA), P.L. 104-191, as amended, the rules adopted under HIPAA, and other applicable federal laws; and (2) the Department and the NC HIE must jointly submit a report to the Joint Legislative Oversight Committees on Information Technology and Health and Human Services on the agreement. The Part becomes effective January 1, 2014. (BR)

Wind Up High Risk Health Insurance Pool

S.L. 2013-410, Sec. 28.5 (HB 92, Sec. 28.5) adds a new section to Part 6 of Article 50 of Chapter 58, North Carolina Health Insurance Risk Pool, to sunset the Pool's insurance operations effective January 1, 2014 and requires all invoices for medical, pharmacy, and other services and all appeals and grievances to be submitted no later than 90 days after this date to be handled in the regular course of business by the Pool. On or before September 1, 2013, the Pool is required to submit to the Commissioner of Insurance for approval a plan for dissolution to address specific issues. All actions by or against the Pool must be filed on or before one year following the sunset of insurance operations. After dissolution, the Pool's liability for insurance benefits, invoices, and all other matters shall be limited to funding held in reserve.

Statutory provisions governing the Pool are repealed effective January 1, 2017.

Except as specifically provided, these sections became effective August 23, 2013. (TH)

Long Term Care & Licensed Facilities

Temporary Funding - Group Homes and Special Care Units

S.L. 2013-4 (HB 5) authorizes the Department of Health and Human Services to provide temporary financial assistance in the form of monthly payments on behalf of residents meeting certain qualifications and residing in group homes, special care units, and adult care homes.

Temporary Assistance to Group Homes - Section 1(b) of the act authorizes the Department to provide temporary monthly payments to group homes on behalf of a resident who was eligible for Medicaid-covered personal care services (PCS) prior to January 1, 2013, but due changes in the eligibility criteria for Medicaid PCS the resident was determined to be ineligible for PCS on or after January 1, 2013. For purposes of this act, group homes are defined as any facility that (i) is licensed by the State pursuant to the law, (ii) meets the definition of a supervised living facility, and (iii) and serves adults whose primary diagnosis is mental illness or a developmental disability but may also have other diagnoses. The following are limitations on the temporary short-term payments to group homes on behalf of qualifying residents:

- The amount of the monthly payments must not exceed $694 per resident for a period not exceeding three months. At the expiration of the three-month period, the monthly

payment per resident will be reduced by 25% and will not exceed $520.50 per month per resident.

- The Department is authorized to make the monthly payments between February 1, 2013 and June 30, 2013.
- The Department is authorized to make the monthly payments to the extent that appropriated funds are available.
- Monthly payments are not allowed on behalf of a resident during the pendency of a Medicaid recipient appeal by, or on behalf of, the resident.
- On June 30, 2013, or upon the depletion of the authorized funds, the Department must terminate all monthly payments authorized by this section of the act.

Temporary Assistance to Special Care Units - Section 1(c) of the act authorizes the Department to provide temporary supplemental monthly payments to licensed special care units (SCU) on behalf of a resident who was eligible for PCS prior to January 1, 2013, and is determined to be eligible for PCS on or after January 1, 2013. The following limitations apply to the supplemental payments to licensed SCUs on behalf of qualifying residents:

- The amount of the monthly payments must not exceed $268 per month for each resident who qualifies for PCS on or after January 1, 2013.
- A SCU receiving supplemental monthly payments authorized by this section of the act must not use the payments to cover any portion of the cost of providing services for which the resident receives Medicaid coverage. The payments can only be used for the continued provision of special care services for which the resident does not otherwise receive Medicaid coverage.
- The Department is authorized to make the supplemental monthly payments between March 1, 2013 and June 30, 2013.
- The Department is authorized to make the supplemental monthly payments to the extent appropriated funds are available.
- Supplemental monthly payments to SCUs are not allowed on behalf of a resident during the pendency of a Medicaid recipient appeal by, or on behalf of, the resident.
- On June 30, 2013, or upon the depletion of the authorized funds, the Department must terminate all monthly payments authorized by this section of the act.

Clarification of Temporary Assistance for Adult Care Homes - The funds to implement this act were authorized by Section 10.23A(f) of S.L. 2012-142, as amended by Section 3.6 of S.L. 2012-145. Section 1(d) of this act clarifies that the temporary, short term financial assistance authorized in Section 10.23A(f) of S.L. 2012-142, as amended, is provided to an adult care home on behalf of a resident who (i) was eligible for PCS prior to January 1, 2013; (ii) completed an independent assessment process, regardless of whether it was completed prior to December 31, 2012; and (iii) is determined to be ineligible for PCS on or after January 1, 2013, due to Medicaid PCS eligibility changes.

Section 2 of the act specifies that the Department is not required to provide temporary, short-term financial assistance to adult care homes, group homes, or special care units beyond June 30, 2013, or upon depletion of the appropriated funds. Section 3 of the act states the intent of the General Assembly not to appropriate State funds for the 2013-2014 and 2014-2015 fiscal years for the purpose of providing further temporary financial assistance to group homes, special care units, and adult care homes.

Section 1 of the act became effective March 6, 2013 and expired June 30, 2013. The remainder of the act became effective March 6, 2013. (TM)

Testing For Long Term Care Applicants and Employees

S.L. 2013-167 (SB 542) requires drug testing for employees of adult care homes, and nursing homes. An offer of employment in an adult care home or nursing home must be conditioned on the applicant's consent to an examination and screening for controlled substances conducted. An adult care home and a nursing home may require random testing for controlled

substances. The results of the examination and screening are confidential and are not public records. The adult care homes and nursing homes are required to pay the cost of the examination and screening, except in the case of examinee-requested retests. The reasonable expenses associated with the retests of confirmed positive results are to be paid by the examinee.

This act becomes effective October 1, 2013. (AJJ)

Safeguard Qualified Individuals - Medicaid PCS

S.L. 2013-306 (HB 492). See the Enacted Legislation section, Medicaid subheading, in this document.

Supplemental Short-Term Assistance for Group Homes

S.L. 2013-360, Sec. 12A.2A (SB 402, Sec. 12A.2A) allows the Department of Health and Human Services to use up to $4,600,000 in nonrecurring funds to provide temporary, short-term financial assistance on a monthly basis to group homes on behalf of each resident that was (i) eligible for Medicaid PCS prior to January 1, 2013, but was determined ineligible for PCS on or after January 1, 2013 due to changes in eligibility criteria, and (ii) has continuously resided in a group home since December 31, 2012.

The Department must use an existing mechanism to administer the funds in the least restrictive manner that ensures compliance with the requirements and timely and accurate payments to group homes. The monthly payments are subject to the following limitations and requirements.

- The maximum assistance per month is $464.30 for each resident meeting all the criteria.
- A group home can only use the payments to provide necessary supervision and medication management.
- Payments begin July 1, 2013 and end June 30, 2014, or upon depletion of funding, whichever is earlier.
- Payments are made only to the extent that sufficient funds are available.
- Monthly payments may not be made on behalf of a resident during the pendency of appeal
- Each group home receiving payments must submit to the Department a list of all funding sources for the operational costs of the group home for the preceding two ears in accordance with the schedule and format prescribed by the Department.

By April 1, 2014, the Department must submit the following to the Joint Legislative Oversight Committee on Health and Human Services:

- A plan for a long-term solution for individuals who reside, and would like to continue to reside, in group homes and as a result of an independent assessment have been determined to need only supervision and/or medication management.
- A list of funding sources for each group home that receives assistance pursuant to this section.

This section became effective January 1, 2013 and expires June 30, 2014. (TM)

Tiered State-County Special Assistance Pilot

S.L. 2013-360, Sec. 12D.2 (SB 402, Sec. 12D.2) requires the Department of Health and Human Services to establish a pilot program to implement a tiered rate structure within the State-County Special Assistance (SA) program for individuals residing in group homes, in-home living arrangements, and assisted living residences. The Department must select four to six counties for participation in the pilot program, at least two of the counties must be rural and at

least two must be urban. The purpose of the pilot program is to determine the best way to implement a statewide block grant for the program; and to test the feasibility and effectiveness of implementing a tiered rate structure to address program participants' intensity of need, including medication management. The pilot program must be implemented during the 2013-2014 fiscal year; implemented in collaboration with the local departments of social services in the selected counties; operate for at least 12 months; and comply with any agreements in effect between the State and the US government. The selected counties will receive a State General Fund allocation as a block grant to be equally matched with county general funds. The General Fund allocation provided to each participating county will be calculated based on the average annual SA expenditures for that county during the 2011-2013 fiscal biennium and adjusted for the amount of projected annual growth in the number of SA recipients in that county during the 2013-15 fiscal biennium. The funds may be used to pay for room, board, personal care services, and medication management, for individuals eligible to receive SA, and subject to the following limitations:

- The funds must not be used to cover any portion of the cost of providing services for which an individual receives Medicaid coverage.
- The pilot program must comply with all federal and State requirements governing the existing State-County Special Assistance program, except that the maximum monthly rates provided in Section 12D.3 of S.L. 2013-360, do not apply to the pilot program.
- The tiered rate structure must be based on intensity of need, and an individual's placement within a tier must be based on an independent assessment of the individual's need for room, board, and assistance with activities of daily living, including medication management.

By February 1, 2014, the Department is required to submit to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division, a progress report on the implementation and operation of the pilot program, including any obstacles to implementation.

By February 1, 2015, the Department is required to submit a final report on the results of the pilot program and any recommendations based on the results. At a minimum, the report must include information from all participating counties on the following:

- The amount of the tiered rates implemented as part of the pilot program.
- The cost methodology for determining these tiered rates.
- The number of individuals participating in the pilot program while residing in a group home.
- The number of individuals participating in the pilot program while residing in an in-home living arrangement.
- The number of individuals participating in the pilot program while residing in an assisted living residence, broken down by facility type.
- A comparison of the number of recipients of State-County SA prior to and during the pilot program, broken down by county and living arrangement.
- Any other information the Department deems relevant for determining the best way to implement a block grant statewide for the State-County SA program.

This section became effective July 1, 2013. (TM)

Three-Year Moratorium on Special Care Unit Licenses

S.L. 2013-360, Sec. 12G.1(a) (SB 402, Sec. 12G.1(a)) prohibits the Division of Health Service Regulation, Department of Health and Human Services, from issuing licenses for special care units (SCU) between July 31, 2013 and July 1, 2016. However, the Department is allowed to issue a license to: a facility that is acquiring an existing SCU, a SCU in an area of the State where the Secretary has determined that increased access to this type of care is necessary, and a SCU for which the Division received a completed application and license fee prior to June 1, 2013.

Also see the Studies section in this document.

This section became effective July 1, 2013. (TM)

Medicaid & Health Choice

No N.C. Exchange/No Medicaid Expansion

S.L. 2013-5 (SB 4) reserves for the General Assembly the authority to determine any State interaction with the federally facilitated Health Benefit Exchange under the Affordable Care Act. Any department, agency, or institution of the State is prohibiting from taking actions towards the formation of a state-based exchange or entering into any contracts or committing any resources to a "partnership" exchange model unless authorized to do so. Statutes to the contrary are repealed. The Department of Insurance is required to cease expenditures funded by exchange-related federal grants. The Department of Health and Human Services is directed to expand NC FAST (North Carolina Families Accessing Services through Technology) technology to provide Medicaid eligibility determinations for the federally facilitated exchange.

North Carolina will not participate in the Medicaid expansion. No department, agency, or institution may attempt to expand the Medicaid eligibility criteria unless directed to do so by the General Assembly.

This act became effective March 6, 2013. (AJJ)

Prohibit Co-pay Waiver - Medicaid Providers

S.L. 2013-145 (SB 137) prohibits waiver of the collection of copayments owed by a recipient of medical assistance, as required by the Medicaid or Health Choice program, with the intent to induce recipients to purchase, lease, or order items or services from the provider, if a provider has obtained a pharmacy permit. The act of waiving a co-payment by these certain providers is prohibited regardless of the amount waived. A provider is not in violation if any of the following applies:

- The waiver is authorized under Medicaid or Health Choice.
- The provider determines that collection of the co-payment would create a substantial financial hardship for the recipient, provided that the waiver of co-payments is not a regular business practice of the provider.
- The provider has made a good faith effort to collect the co-payment.
- The provider is a healthcare facility regulated pursuant to Chapter 131E (hospitals and health care facilities, such as long-term care facilities) or Chapter 122C (facilities for the treatment of mental illness, developmental disabilities, and substance abuse) of the General Statutes.

If a provider is found to be in violation of the prohibited waiver of co-payments, the Department of Health and Human Services must suspend or terminate the provider's participation in the Medicaid and Health Choice programs.

The act becomes effective October 1, 2013, and applies to acts committed on or after that date. (AJJ)

Modify Medicaid Subrogation Statute

S.L. 2013-274 (HB 982) allows a Medicaid beneficiary to challenge the amount of reimbursement that the beneficiary is statutorily presumed to owe to the State out of any recovery against a third-party responsible for causing injury or death to the beneficiary. To rebut the presumption, the beneficiary would be required to prove in superior court by clear and convincing evidence that the amount owed is less than the amount presumed under the statute. The act permits the beneficiary and the Department of Health and Human Services to reach agreement on the amount owed at any time.

This act became effective July 18, 2013, and applies to Medicaid claims that arise on or after that date and to Medicaid claims arising prior to that date for which the Department has not been paid in full. For Medicaid claims that arose prior to the effective date of the act for which the Department has not been paid in full, the medical assistance beneficiary must have 90 days from the effective date within which to apply to the court as pursuant to G.S. 108A-57(a2). (BR)

Safeguard Qualified Individuals - Medicaid PCS

S.L. 2013-306 (HB 492) creates an opportunity for a Medicaid recipient to obtain up to 130 hours per month of Medicaid Personal Care Services (PCS) in accordance with an assessment and care plan and provided that the individual meets certain criteria. The maximum number of hours allowed under current law is 80 hours. To qualify for up to 50 additional hours of PCS, the recipient must meet all of the following criteria:

- Qualify for Medicaid PCS as specified in the current law.
- Require an increased level of supervision.
- Require caregivers with training or experience in caring for individuals who have a degenerative disease, characterized by irreversible memory dysfunction, that attacks the brain and results in impaired memory, thinking, and behavior, including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.
- Require a physical environment, regardless of setting, that includes modifications and safety measures to safeguard the recipient because of the recipient's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.
- Has a history of safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.
- Has a physician's attestation that the individual meets the above criteria.

Based on the physician attestation, the individual must receive an independent assessment to determine the number of hours of PCS that are needed. The assessment must be conducted by a trained professional who is qualified to assess, and has experience in assessing, the needs of individuals with needs for the safeguards indicated in the above bullets. In response to the assessment, a plan of care must be developed by the service provider and approved by the Department of Health and Human Services (Department), Division of Medical Assistance.

The Department is directed to reduce the rate for PCS in order to fund the additional service hours authorized by the act and in order to remain within the budgeted amount of funds for PCS.

On or before August 15, 2013, the Department is required to submit a Medicaid State Plan Amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) to implement this act. The SPA must include an effective date of July 1, 2013, or as soon after that date as allowed by CMS.

On or before August 1, 2013, the Department must make an interim report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division including: (i) an estimate of the number of Medicaid recipients that would be eligible for Medicaid Personal Care Services under this act, (ii) an estimate of the number of PCS hours potential recipients would need broken out in increments of 10 hours between 80 and 130 hours, (iii) a copy of the draft Medicaid State Plan Amendment (SPA), (iv) an estimated time line for approval of the SPA and a projected implementation date, and (v) the rate reductions necessary to implement the act. On or before November 1, 2013, the Department is required to report to the Oversight Committee on the implementation of the act.

The section of the act containing PCS changes, becomes effective upon approval of the SPA by CMS. The Department must provide notice of SPA approval by posting the effective date of the change on its Web site. The remainder of the act became effective July 18, 2013. (TM)

Funds for Replacement Medicaid Management Information System - Implementation of Replacement MMIS

S.L. 2013-360, Sec. 12A.4 (SB 402, Sec. 12A.4), as amended by S.L. 2013-363, Sec. 4.11, authorizes the Department of Health and Human Services to utilize prior year earned revenue received for the replacement Medicaid Management Information System (MMIS), which is commonly referred to as NC Tracks. If the Department does not receive prior year earned revenues in the amounts authorized or funds are insufficient to advance the project, the Department may, with prior approval from the Office of State Budget and Management, utilize over realized receipts and funds appropriated to the Department to achieve the level of funding specified for replacement MMIS.

The Department must develop plans to ensure the timely and effective implementation of enhancements to the system. The replacement MMIS must have the capability to fully implement the administration of NC Health Choice, Ticket to Work, CAP Children's Program, all relevant Medicaid waivers, and the Medicare 646 waiver as it applies to Medicaid eligibles. The Office of the State Chief Information Officer (SCIO) and the Office of Information Technology must work with the Department to ensure timely and effective implementation of the replacement MMIS and enhancements. The Department is directed to consult with the Office of the SCIO concerning the retention of private counsel to negotiate and review contract amendments associated with the replacement MMIS.

Any changes in the implementation schedule must be immediately reported to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Information Technology, the Office of State Budget and Management and the Fiscal Research Division. The Department is also required to submit a number of reports to these entities including progress reports on the full implementation of the replacement MMIS, a plan for the elimination of the Office of Medicaid Management Information Systems Services including the transfer of its remaining operations to other divisions within the Department, and a preliminary report of the Departments plan to achieve system certification.

The Department must complete the Reporting and Analytics Project solution simultaneously with the implementation of the replacement MMIS. Prior written approval from the Office of State Personnel must be required for each specific instance of overtime or compensatory time related to the replacement MMIS after August 1, 2013.

The Department must plan and implement system modifications necessary to enable entities under contract with it to perform Medicaid claim adjudication in the replacement MMIS. These system modifications must be implemented by the earlier of January 1, 2015, or prior to renewing any contract currently in effect with an entity required to perform Medicaid claim adjudication in the replacement MMIS. Upon implementation of the system modifications, all Medicaid claims adjudication must be performed by the replacement MMIS. The Department may require entities under contract with the Department to contract directly with the State's Medicaid fiscal agent to provide technical support for Medicaid claim adjudication performed by the replacement MMIS for these entities. The Department may charge these entities a fee not to exceed the amount necessary to cover the full operating cost of Medicaid claim adjudication performed by the replacement MMIS for these entities. This subsection becomes effective January 1, 2015.

Except as otherwise noted, this section became effective July 1, 2013. (BR)

Detailed Medicaid Reform Proposal to be Prepared by the Department of Health and Human Services - Medicaid Reform Advisory Group Established

S.L. 2013-360, Sec. 12H.1 (SB 402, Sec. 12H.1) establishes the North Carolina Medicaid Reform Advisory Group to advise the Department of Health and Human Services (Department) in the development of a plan to reform Medicaid. There are 5 members: a Representative appointed by the Speaker of the House, a Senator appointed by the President Pro Tempore of the Senate, and three persons appointed by the Governor. The Department is directed to work with the Advisory Group to create a detailed Medicaid reform plan, but is not authorized to implement the plan. The Department must submit the plan to the General Assembly no later than March 17, 2014, and the report must contain the following:

- The details of the reform plan.
- The Department's methodology for selecting the reform plan over alternatives.
- Forecasts of the reform plan's potential to slow the growth of the costs of the Medicaid Program.
- The reform plan's impact, as compared to the existing Medicaid Program, on both providers and recipients in specified areas.
- If regional demonstration projects, pilot projects, or similar projects will be used to test a proposal, how the Department will ensure that the test methodology is scientifically valid and consistent with social science research methods.
- How financial risks will be allocated under the reform plan.
- The mechanisms through which the Department and any contractors would be held accountable for the implementation and performance of the plan.
- Short-term costs to implement the plan and expected long-term savings in future years.
- A realistic time line for implementation.
- Draft Medicaid State Plan Amendments, Medicaid waivers, amendments to State law, or other changes necessary to legally allow the Department to implement its reform plan.
- Any other detailed information that would assist the General Assembly in evaluating the strength of the reform plan.

Any legislation based upon the Department's reform proposal will be eligible for consideration when the 2013 General Assembly reconvenes in 2014, and the requirement pertaining to the order of appropriations bills does not apply to such legislation.

This section became effective July 1, 2013. (AJJ)

Clarify State Plan Amendment Procedures

S.L. 2013-360, Sec. 12H.2 (SB 402, Sec. 12H.2), as amended by S.L. 2013-363, Sec. 4.14, specifies procedures for when and how the Department of Health and Human Services may submit Medicaid State Plan Amendments. Subsection (c) specifies that supplemental payments up to the average commercial rate may be paid only to eligible medical professional providers who were receiving these supplemental payments as of May 22, 2013.

This section became effective July 26, 2013. (JLH)

Codify Medicaid as a Secondary Payor

S.L. 2013-360, Sec. 12H.4 (SB 402, Sec. 12H.4) amends G.S. 108A-55 to add language that has appeared in past Appropriations Acts providing that Medicaid pays for services only after other liable third parties have paid for services. This section further clarifies that for certain

recipients the Department of Health and Human Services pays the lesser of the Medicaid Allowable Amount or an amount up to the actual coinsurance or deductible or both of the primary payor.

This section became effective July 1, 2013. (JLH)

Codify Changes to Medical Policy

S.L. 2013-360, Sec. 12H.6 (SB 402, Sec. 12H.6) combines the two statutes governing the adoption of medical coverage policies for the Medicaid and Health Choice programs and makes the law that is applicable to Health Choice consistent with the law that has been applicable to Medicaid.

This section also codifies the requirement, which has appeared in previous Appropriation Acts, stating that before the Department of Health and Human Services may implement medical policy changes that exceed certain thresholds, the Office of State Budget and Management must prepare a fiscal analysis of the proposed change. This section reduces the thresholds to $500,000 in total annual requirements for Medicaid or $50,000 in total annual requirements for NC Health Choice, as compared to $3,000,000 in total annual requirements for Medicaid or $1,000,000 in total annual requirements for NC Health Choice last fiscal year.

This section also shortens the time periods for notice and comment to 30 days for an initial posting and 10 days for a subsequent posting, when the change to medical coverage policy is required by an act of the General Assembly.

This section became effective July 26, 2013. (JLH)

Clarify Rule Making

S.L. 2013-360, Sec. 12H.9 (SB 402, Sec. 12H.9) gives the Medicaid State Plan and Waivers the force of administrative rules and codifies the Department of Health and Human Services' rule-making authority.

This section became effective July 1, 2013. (JLH)

Medicaid Eligibility - Adjustment to Health Choice Eligibility

S.L. 2013-360, Sec. 12H.10 (SB 402, Sec. 12H.10) expands Medicaid eligibility to include coverage of children aged 6-18 with incomes from 101% to 133% of the federal poverty level beginning on January 1, 2014, as required by Affordable Care Act. This section also eliminates NC Health Choice eligibility for those children effective January 1, 2014.

This section became effective July 1, 2013. (JLH)

Modifications to Existing Covered Services

S.L. 2013-360, Sec. 12H.13 (SB 402, Sec. 12H.13), as amended by S.L. 2013-363, Secs. 4.4, 4.13, and 4.17, adjusts the covered services and payments for covered services under Medicaid and NC Health Choice, including:

- Eliminates inflationary rate increases with the exception of Federally Qualified Health Centers, Rural Health Centers, critical access hospitals, State Operated Services, Hospice, Part B and D Premiums, third party and Health Management Organization premiums, drugs, Managed Care Organization capitation payments, and nursing home direct care services case mix index, effective July 1, 2013;
- Increases copays to the maximum allowed by the Centers for Medicare and Medicaid Services as of June 30, 2013, effective November 1, 2013;
- Requires prior authorization for visits in excess of 10 per recipient per fiscal year for professional services provided by physicians, nurse practitioners, nurse

midwives, physician assistants, clinics, and health departments (currently required for visits in excess of 22). This requirement does not apply to chronic conditions and is effective January 1, 2014;
- Limits adult rehabilitation home visits for set up and training to three within a 12-month period, effective January 1, 2014;
- Reduces the percentage of allowable costs for hospital outpatients from 80% to 70%, effective January 1, 2014;
- Changes reimbursement for drugs so that specialty drug prices based on Wholesale Acquisition Cost (WAC) will be paid at 101% of WAC, nonspecialty drugs based on WAC pricing will be paid at 102.7% of WAC, and drug prices based on the State Medicaid Average Cost (SMAC) will be paid at 150% of SMAC, effective January 1, 2014;
- Changes dispensing fees based upon a tiered chart, effective January 1, 2014; and
- Allows the Department of Health and Human Services (Department) to require prior authorization and other restrictions on mental health drugs, but prohibits the Department from requiring prior authorization for mental health drugs on the Preferred Drug List, effective July 1, 2013.

This section became effective July 1, 2013. (JLH)

Shared Savings Plan with Providers

S.L. 2013-360, Sec. 12H.18 (SB 402, Sec. 12H.18) directs the Department of Health and Human Services (Department) to withhold 3% of payments for specified services rendered to Medicaid and Health Choice recipients on or after January 1, 2014, for the 2013-2015 fiscal biennium. The Department must consult with affected providers to develop a shared savings plan to provide incentives for effective and efficient care to be implemented by July 1, 2014. Payments made to a particular provider group will come from funds withheld from that group and funds withheld for drugs will be used to develop, with Community Care of North Carolina, a program for Medicaid and Health Choice recipients based on the ChecKmeds NC Program. The Department must report to the Joint Legislative Oversight Committee on Health and Human Services no later than March 1, 2014.

This section became effective July 1, 2013. (AJJ)

Modify Medicaid Rate Methodologies

S.L. 2013-360, Sec. 12H.20 (SB 402, Sec. 12H.20) reduces hospital base rates for hospitals that were acquired after December 31, 2011 to ensure that the base rates do not exceed rates that would have been paid if the provider had not been acquired. This section also replaces existing individual base rates for all hospitals with regional base rates.

This section became effective July 1, 2013. (JLH)

Continue A+KIDS Registry and ASAP Initiative

S.L. 2013-360, Sec. 12H.28 (SB 402, Sec. 12H.28), Section 12H.28, directs Community Care of North Carolina (CCNC) and the Division of Medical Assistance to continue to monitor the prescription and administration of atypical or off-label antipsychotic medications to Medicaid recipients under the age of 18 through the A+KIDS Registry and the ASAP initiative. CCNC and the Department of Health and Human Services must report to the Joint Legislative Oversight Committee on Health and Human Services by April 1, 2014 on the effectiveness of these programs.

This act became effective July 1, 2013. (PLP)

Inmate Costs - Court Appointment - Notaries

S.L. 2013-387, Sec 3 (SB 321, Sec. 3) directs the Department of Health and Human Services to work with the counties to prepare for the ability to utilize Medicaid coverage for inpatient hospital care of prisoners. The Department of Justice is to provide technical assistance.

This section became effective September 1, 2013. (JPP)

Mental Health/Developmental Disabilities/Substance Abuse Services

Temporary Funding - Group Homes and Special Care Units

S.L. 2013-4 (HB 5). See the Enacted Legislation section, Long Term/Licensed Facility Care subheading, in this document.

Incapacity to Proceed Amendments

S.L. 2013-18 (SB 45) amends laws pertaining to a criminal defendant's incapacity to proceed. The act authorizes a court to appoint one or more impartial medical experts to examine a defendant charged with a misdemeanor or felony and return a written report describing the defendant's mental health. A defendant charged with a felony may be ordered to a State facility for the mentally ill for observation and treatment. The act provides specific time periods within which examination reports must be submitted to the court.

The court may call any expert appointed to evaluate a defendant to testify at the capacity hearing. The court is required to make findings of fact to support its determination of the defendant's capacity to proceed. Parties may stipulate that the defendant is capable to proceed, but they may not stipulate that the defendant lacks capacity to proceed.

The act also amends laws governing the return of a defendant for trial upon gaining capacity. Effective April 3, 2013, the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services is directed to develop and adopt rules requiring forensic evaluators to meet specified requirements, and to adopt guidelines for treatment of persons involuntarily committed following a determination of incapacity to proceed. The rules and guidelines are to be in place by December 1, 2013.

The statutory provisions of this act become effective December 1, 2013, and apply to offenses committed on or after that date. (BC)

Effective Operation of 1915(b)/(c) Waiver

S.L. 2013-85 (SB 208) outlines actions required of the Secretary of the Department of Health and Human Services (Department) with regard to Local Management Entities/Managed Care Organizations (LME/MCOs) under contract to operate under the Section 1915(b)/(c) Medicaid Waiver. It provides that for all LME/MCOs, the Secretary must certify every six months whether or not the LME/MCO is in compliance with the following three major statutory requirements:

- The LME/MCO has made adequate provision against the risk of insolvency with respect to capitation payments for Medicaid enrollees.
- The LME/MCO is making timely provider payments.

- The LME/MCO is exchanging billing, payment, and transaction information with the Department and providers in a manner that complies with applicable federal standards.

The act prescribes the actions the Secretary must take when an LME/MCO does not receive a compliance certification, including transferring management responsibilities, operations and contracts of a noncompliant LME/MCO to a compliant LME/MCO, and also specifies what must occur if an LME/MCO is not in compliance with other contractual provisions.

This act also eliminates the authority of a county to provide mental health, developmental disabilities, and substance abuse services through operation of a county program, establishes a county commissioner advisory board, and makes certain provisions relating to structure of area boards.

Section 4(a) of the act relating to certain governance requirements becomes effective January 1, 2014. The remainder of the act became effective June 12, 2013. (JPP)

Drug Revise Controlled Substances Reporting

S.L. 2013-152 (SB 222) makes various changes to the North Carolina Controlled Substances Reporting Act, including the following:

- Removes the current exemption given to physicians registered as dispensers of controlled substances, and exempts licensed veterinarians from reporting information into the Controlled Substances Reporting System.
- Requires dispensers to report information about prescriptions no later than three business days after the day when the prescription was delivered.
- Makes changes to the access and confidentiality requirements.
- Increases the civil penalty for improperly releasing, obtaining, or attempting to obtain information from the system or for violating a rule.

This act became effective June 19, 2013. (JPP)

Guardianship Roles of MH/DD/SA Providers

S.L. 2013-258 (HB 543) amends the qualifications for corporations and individuals appointed as guardians. The act prohibits a corporation from being appointed as a guardian for any individual to whom it provides mental health, developmental disabilities, or substance abuse services for compensation as part of a contract or other arrangement with a local management entity (LME). The act also clarifies that individuals who contract with or are employed by an entity that contracts with an LME for the delivery of mental health, developmental disabilities and substance abuse (MH/DD/SA) services may not serve as a guardian for a ward for whom the individual or entity is providing these services, unless the individual is a parent of the ward; a member of the ward's immediate family; a licensed family foster care provider or a licensed therapeutic foster care provider under contract with a LME for the delivery of MH/DD/SA services and is serving as a guardian as of January 1, 2013; or biologically unrelated and was serving on March 1, 2013, as a guardian without compensation for guardianship services.

Also see the Studies section in this document.

This act became effective July 10, 2013. (TM)

Involuntary Commitment Custody Orders

S.L. 2013-308 (HB 635) amends the statute for authorizing involuntary inpatient commitments to provide that (i) the clerk or magistrate may transmit the custody order to the physician or psychologist, or a designee, by fax or email if a person is physically present at a 24-hour facility; (ii) a physician or psychologist at the facility recommends that the person be

involuntarily committed; and (iii) a clerk or magistrate finds probable cause to believe the person meets the commitment criteria.

Upon receiving the custody order, the physician, psychologist or designee is required to do the following:

- Notify the respondent that the respondent has neither committed a crime nor is under arrest, but is being taken into custody for safety and treatment reasons.
- Take the respondent into custody.
- Complete and sign the custody order and return it to the clerk or magistrate via facsimile or email.
- Mail the original custody order to the clerk or magistrate within five days of the facsimile or email return.

The act also provides an exception to the statute requiring a law enforcement officer or other person to take a person into custody when that person is already in custody at the 24-hour facility.

This act becomes effective October 1, 2013. (KQ)

Severance and Relocation for Area Directors

S.L. 2013-339 (SB 223) allows an area mental health, developmental disabilities, and substance abuse board to offer severance benefits, relocation expenses, or both, when making an offer of employment to a candidate for the area director position.

This act became effective July, 23, 2013. (AJJ)

Supplemental Short-Term Assistance for Group Homes

S.L. 2013-360, Sec. 12A.2A (SB 402, Sec. 12A.2A). See the Enacted Legislation section, Long Term /Licensed Facility Care subheading, in this document.

Establish Statewide Telepsychiatry Program

S.L. 2013-360, Sec. 12A.2B (SB 402, Sec. 12A.2B) directs various agencies, by August 15, 2013, to submit to the General Assembly a plan to implement a statewide telepsychiatry program to be administered by the ECU Center for Telepsychiatry under a contract between the Department of Health and Human Services and ECU. The administration and oversight of the program will be overseen by the North Carolina Office of Rural Health and Community Care.

This section became effective July 1, 2013. (JPP)

Funds for Local Inpatient Psychiatric Beds or Bed Days

S.L. 2013-360, Sec. 12F.2 (SB 402, Sec. 12F.2) allocates funds to purchase additional local inpatient psychiatric beds or bed days not currently funded by or through Local Management Entities/Managed Care Organizations (LME/MCOs). The Department of Health and Human Services (Department) is to develop and implement a two-tiered system of payment for purchasing these local inpatient psychiatric beds or bed days based on acuity level, with an enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels, as defined by the Department. This section addresses distribution and management of beds or bed days and reporting requirements for LME/MCOs and the Department.

This section became effective July 1, 2013. (JPP)

Behavioral Health Clinical Integration and Performance Monitoring

S.L. 2013-360, Sec. 12F.4A (SB 402, Sec. 12F.4A) directs the Department of Health and Human Services to require local management entities to implement clinical integration activities with Community Care of North Carolina through Total Care, and to report to the General Assembly on progress, outcomes, and savings associated with the implementation of the activities.

This section became effective July 1, 2013. (JPP)

MH/DD/SAS Health Care Information System

S.L. 2013-360, Sec. 12F.5 (SB 402, Sec. 12F.5) prohibits the Department of Health and Human Services from taking further action or expending any funds appropriated or available to it to develop and implement the health care information system for State facilities operated by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, until specified conditions are met.

This section became effective July 1, 2013. (JPP)

Study Ways to Improve Outcomes and Efficiencies in Alcohol and Drug Abuse Treatment Programs

S.L. 2013-360, Sec. 12F.7(c) (SB 402, Sec. 12F.7(c)), as amended by S.L. 2013-363, Sec. 4.16, reduces the total amount of funds appropriated to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for alcohol and drug abuse treatment centers by twelve percent (12%). If the Department can implement the reduction in a manner that (i) reduces the per bed cost variability across the three centers and (ii) does not result in the closure of any of the three centers, the Department not required to achieve this reduction by reducing the budget for each of the three existing alcohol and drug abuse treatment centers by twelve percent (12%).

Also see the Studies section in this document.

This section became effective July 1, 2013. (SB)

LME/MCO Enrollee Grievances and Appeals

S.L. 2013-397 (SB 553) creates a new chapter of the General Statutes, establishing grievance and appeal procedures for local management entity/managed care organization (LME/MCO) Medicaid behavioral health enrollees.

This act also requires the Department of Health and Human Services to:

- Establish a supportive housing program for individuals transitioning from institutional settings to integrated community-based settings.
- Clarify how funds appropriated to the Department for the establishment and operation of this program are to be used.
- Create a community living housing fund within the Housing Finance Agency to integrated individuals with disabilities into community-based supported housing.

The act also modifies the State's share in the hospital provider assessment tax.

The portion of the act relating to Medicaid managed care grievances and appeals became effective August 23, 2013, and applies to grievances and managed care actions filed on or after that date. The section pertaining to the use of funds appropriated to the Department of Health and Human Services for the 2013-2015 fiscal biennium to develop and implement housing, support, and other services for people with mental illness under the Department of Justice

settlement agreement becomes effective October 1, 2013. The provision regarding the hospital provider assessment tax became effective July 1, 2013. The remainder of the act became effective August 23, 2013. (JPP)

Disposition of DMH/DD/SAS Records

S.L. 2013-413, Sec. 9 (HB 74, Sec. 9) directs the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to amend its procedures to provide that if a Medicaid service has been eliminated by the State, the provider must retain records for three years after the last date of service, unless a longer period is required under federal law. After the expiration of that time period, records may be destroyed or transferred to a State agency or designated contractor.

This section became effective August 23, 2013. (AJJ)

Public Health

Develop Rules for Release of Path Materials

S.L. 2013-43 (SB 240) requires the Department of Health and Human Services and the North Carolina Medical Board to collaborate to adopt rules governing requests for and release of pathological materials made to clinical laboratories within their respective jurisdictions.

This act became effective May 8, 2013. (JPP)

Designate Primary Stroke Centers

S.L. 2013-44 (SB 456) directs the Department of Health and Human Services (Department) to designate a hospital as a primary stroke center if that hospital is certified as a primary stroke center by the Joint Commission or other nationally recognized accrediting body. Each designated hospital is required to make efforts to coordinate the provision of stroke care with other hospitals licensed in this State through a formal written agreement addressing the transportation of acute stroke patients to primary stroke centers and acceptance by primary stroke centers of acute stroke patients initially treated at hospitals not capable of providing appropriate stroke care. A hospital is prohibited from advertising or holding the hospital out to the public as a primary stroke center if the hospital is not certified as such.

The Department is required to maintain a list of hospitals designated as primary stroke centers and post this list on its website. The Department is required to send the list to the medical director of each licensed emergency medical services provider in the State annually.

This act becomes effective October 1, 2013. (AJJ)

Require Pulse Oximetry Newborn Screening

S.L. 2013-45 (SB 98) includes, as a requirement of the Newborn Screening Program, pulse oximetry screening for each baby born in North Carolina. Rules adopted by the Commission for Public Health for oximetry screening must include follow-up protocols to ensure early treatment for identified infants, including the use of telemedicine technologies, as well as a system to track the process and outcomes of newborn screening using pulse oximetry, linked to the Birth Defects Monitoring Program.

This act became effective May 8, 2013. (AJJ)

Encourage Volunteer Care in Free Clinics

S.L. 2013-49 (SB 83) amends the definition of "free clinic" in G.S. 90-21.16(c) by removing the qualification that a free clinic maintain liability insurance. The act provides that in order for a volunteer medical or health service provider to receive the protection from liability provided under G.S. 90-21.16(a), a free clinic must provide, prior to the delivery of health services, a written notice to the patient, for the patient to keep, of the limited liability of volunteer medical or health care providers. The act also amends G.S. 90-21.16(d) regarding referrals of low-income patients to physicians for free services by changing the term "physician" to "medical or health care provider" to make the terminology consistent throughout the statute.

This act becomes effective October 1, 2013 and applies to claims that arise on or after that date. (BR)

Pertussis Education and Awareness

S.L. 2013-161 (SB 486) amends the Hospital Licensure Act to require each hospital to provide information to parents of newborns delivered at the hospital regarding pertussis disease and the availability of the tetanus-diphtheria and pertussis (Tdap) vaccine.

This act becomes effective October 1, 2013. (JPP)

Collaboration Among State Diabetes Programs

S.L. 2013-192 (SB 336) requires the Division of Medical Assistance, Department of Health and Human Services (Department); the Diabetes Prevention and Control Branch, Division of Public Health, the Department; and the State Health Plan Division within the Department of the State Treasurer; to collectively report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on each entity's plans to reduce the incidence of diabetes, to improve diabetes care, and to control complications from diabetes, for the populations each entity serves.

This act became effective June 26, 2013. (TM)

Chronic Care Coordination Act

S.L. 2013-207 (HB 459) requires the Divisions of Public Health and Medical Assistance, Department of Health and Human Services, and the State Health Plan for Teachers and State Employees Division, Department of State Treasurer, to collaborate to reduce the incidence of chronic disease and improve chronic care coordination. Specific requirements include: identifying goals and benchmarks for the reduction of chronic disease; developing wellness and prevention plans; and submitting annual reports to the Senate Appropriations Committee on Health and Human Services, the House Appropriations Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division.

This act became effective June 26, 2013. (TM)

Health Curriculum/Preterm Birth

S.L. 2013-307 (SB 132) requires that the reproductive health and safety education program, provided by each local school administrative unit starting in the seventh grade, must include instruction about the preventable risks of preterm birth in subsequent pregnancies. The Department of Public Instruction (DPI) must ensure that charter schools annually provide students, in grades 7 through 12, information on the preventable risks for preterm birth in

subsequent pregnancies. The Division of Nonpublic Education must ensure that information on the preventable risks for preterm birth in subsequent pregnancies is available to private schools, qualified nonpublic schools and home schools. The preventable risks of preterm birth include induced abortion, smoking, alcohol consumption, the use of illicit drugs, and inadequate prenatal care.

The Division of Public Health, Department of Health and Human Services, must provide sample educational materials to DPI and the Division of Nonpublic Education with the most current information about the preventable causes of preterm birth within 60 days of the effective date of this act and annually thereafter.

This act became effective July 18, 2013 and applies beginning with the 2013-2014 school year. (SK)

Breast Density Notification and Awareness

S.L. 2013-321 (HB 467) requires all health care facilities performing mammography examinations to include information in the mammography report that identifies the patient's individual breast density classification. If the facility determines that a patient has heterogeneously or extremely dense breasts they must also include a notice containing language prescribed in the act. Patients may also be directed to informative material about breast density.

This act becomes effective January 1, 2014. (TM)

Cancer Coordination Reporting

S.L. 2013-360, Sec. 12A.9 (SB 402, Sec. 12A.9) amends the reporting requirements in G.S. 130A-33.51(b) to require the Advisory Committee on Cancer Coordination and Control to submit a written report annually to the Secretary of Health and Human Services.

This section became effective July 1, 2013. (SB)

Modifications to Oral Health Strategy

S.L. 2013-360, Sec. 12E.2 (SB 402, Sec. 12E.2) encourages local health departments to increase access to direct clinical care and preventive oral health services in the dental clinics they sponsor. The section directs the Secretary of Health and Human Services to eliminate at least 15 full-time equivalent positions within the Oral Health Section of the Division of Public Health to achieve a savings of at least $637,500 for fiscal year 2013 -2014, and at least $850,000 for fiscal year 2014-2015. By February 1, 2014, the Department must submit a revised statewide oral health strategic plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

This section became effective July 1, 2013. (BR)

AIDS Drug Assistance Program

S.L. 2013-360, Sec. 12E.5 (SB 402, Sec. 12E.5) directs the Department of Health and Human Services (DHHS) to work with the Department of Public Safety (DPS) to use DPS funds to purchase pharmaceuticals for the treatment of individuals in the custody of DPS who have been diagnosed with Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome and to do so in a manner that allows the funds to be accounted for as State matching funds in the drawdown of federal Ryan White funds. By no later than April 1, 2014, and by no later than April 1, 2014, DHHS and DPS must submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on alternative options for individuals who are eligible to receive services under the AIDS Drug Assistance Program.

This section became effective July 1, 2013. (AJJ)

Community-Focused Eliminating Health Disparities Initiative

S.L. 2013-360, Sec. 12E.6 (SB 402, Sec. 12E.6) provides that funds appropriated to the Department of Health and Human Services, Division of Public Health, Community-Focused Eliminating Health Disparities Initiative must be used to provide a maximum of 12 grants-in-aid to close the gap in the health status of African-Americans, Hispanics/Latinos, and American Indians as compared to the health status of white persons. Grants-in–aid are limited to no more than $300,000 and must have a maximum duration of 3 years. The Department must submit a report on the funds appropriated to the Initiative to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2013.

This section became effective July 1, 2013. (BR)

Strategies for Improving Men's Health

S.L. 2013-360, Sec. 12E.7 (SB 402, Sec. 12E.7) directs the Division of Public Health, Department of Health and Human Services to work to expand the State's attention and focus on the prevention of disease and improvement in the quality of life for men over their entire lifespan and to develop strategies to achieve these goals.

This section became effective July 1, 2013. (BR)

Health and Safety Law Changes

S.L. 2013-366 (SB 353) makes changes to the laws on health and safety as outlined below.

Section 1 of the act clarifies that any health care provider who objects on moral, ethical, or religious grounds to abortion is not required to participate in abortion-related procedures and is not liable for damages or subject to disciplinary action for refusing to do so. This section also adds "health care providers" to the list that includes hospitals and other health care institutions, which are not required to perform an abortion or provide abortion services. Section 1 became effective August 28, 2013.

Section 3 of the act makes it a crime for a person to, knowingly or recklessly, perform, or attempt to perform, an abortion upon a woman with knowledge, or an objective reason to know, that a significant factor in the woman's seeking the abortion is related to the sex of the unborn child. A person committing such an act is liable for damages, including punitive damages and injunctive relief. A claim for damages or injunctive relief barring future acts may be brought by specified parties.

If a person knowingly or recklessly violates the terms of court ordered injunctive relief that person is subject to civil contempt and fined $10,000 for the first violation, $50,000 for the second violation, and $100,000 for the third, and any subsequent, violation. A fine is not assessed against the woman upon whom an abortion is performed or attempted. In any proceeding or civil action brought under the act, the court may preserve the woman's anonymity if the court makes specific findings.

Section 3 is effective October 1, 2013, and applies to violations occurring on or after that date.

Section 4 of the act amends the Women's Right to Know Act and requires that the physician performing a surgical abortion be physically present during the entire abortion procedure. When a drug or chemical is given for the purposes of inducing an abortion, the physician prescribing, dispensing or otherwise providing the drug or chemical must be present when the first drug or chemical is administered. The Department of Health and Human Services (Department) must make resources available on its Web site to a woman who has received information that an unborn child may have a disability or serious abnormality.

Section 4 also requires the Department to amend its rules pertaining to clinics certified to be suitable facilities for the performance of abortions. The Department is authorized to apply any requirement for ambulatory surgery centers to the standards applicable to clinics. In amending the rules, the rules are required to address the following: on site recovery phase of patient care at the clinic, protection of patient privacy, quality assurance, and receipt of necessary medical attention for patients with complications. The Department must report to the Joint Legislative Oversight Committee on Health and Human Services no later than January 1, 2014, on its progress amending the rules. The Department must conduct a study regarding the resources to adequately enforce regulations for certified abortion clinics. The Department will report its findings and recommendations by April 1, 2014, to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division. Section 4 is effective October 1, 2013.

Each section of the act becomes effective as noted above. (AJJ)

Amend Private Club Definition

S.L. 2013-413, Sec. 7 (HB 74, Sec. 7) expands the definition of "private club" as it applies to the regulation of food and lodging facilities by the Commission for Public Health to include an establishment that is organized and operated solely for a social, recreational, patriotic, or fraternal purpose and that is not open to the general public, but is open only to the members of the organization and their bona fide guests.

This section became effective August 23, 2013. (AJJ)

Let Bed and Breakfasts Offer Three Meals a Day

S.L. 2013-413, Sec. 11 (HB 74, Sec. 11) creates a new definition of "bed and breakfast home" under the statutes regulating food and lodging facilities. The Commission for Public Health will adopt rules governing the sanitation of the bed and breakfast homes in a manner that is least restrictive so as to protect the public and not unreasonably interfere with the operation of the bed and breakfast homes.

This section becomes effective October 1, 2013. (AJJ)

Carbon Monoxide Detectors

S.L. 2013-413, Sec. 19 (HB 74, Sec. 19), requires all hotels, motels, and other lodging establishments to have carbon monoxide detectors in every enclosed space having a fossil fuel burning heater, appliance, or fireplace, and in any enclosed space that shares a common wall, floor, or ceiling with an enclosed space having a fossil fuel burning heater, appliance, or fireplace.

Existing hotels will be required to have battery powered or hard-wired carbon monoxide detectors installed by October 1, 2013 in order to obtain or renew a permit to operate as a lodging establishment. After October 1, 2014, existing hotels will be required to have hard-wired carbon monoxide detectors to obtain or renew a permit.

This section amends the law governing the North Carolina State Building Code to require new and renovated lodging establishments to have hard-wired carbon monoxide detectors. New and renovated lodging establishments will be subject to the same provisions as existing lodging establishments in order to obtain or renew a permit to operate as a lodging establishment.

This section became effective August 23, 2013, except that the requirements for existing hotels to have battery powered or hard-wired carbon monoxide detectors become effective October 1, 2013 and expire October 1, 2014, and the requirements for existing hotels to have hard-wired carbon monoxide detectors become effective October 1, 2014. (PL)

Smoking Ban Rules

S.L. 2013-413, Sec. 23 (HB 74, Sec. 23) directions the Commission for Public Health to amend and clarify its rules regarding the prohibition on smoking in restaurants and bars, specifically as the rules pertain to the definition of "enclosed area", no later than January 1, 2014. The Commission for Public Health must report on its progress to the Joint Legislative Oversight Committee on Health and Human Services no later than November 1, 2013.

This section became effective August 23, 2013. (AJJ)

Studies

New/Independent Studies/Commissions

A Family for Every Child - Provision of Foster Care

S.L. 2013-360, Sec. 12C.10 (SB 402, Sec. 12C.10) establishes the Permanency Innovation Initiative Oversight Committee (Committee) consisting of eleven members appointed by the General Assembly upon the recommendation of the Speaker of the House of Representatives, by the General Assembly upon the recommendation of the President Pro Tempore of the Senate, and the Governor.

The Committee is charged to:

- Design and implement a data tracking methodology to collect and analyze information to gauge the success of the initiative.
- Develop a methodology to identify short- and long-term cost-savings in the provision of foster care and any potential reinvestment strategies.
- Oversee program implementation to ensure fidelity to program models.
- Study, review, and recommend other policies and services that may positively impact permanency and well-being outcomes.

Reporting requirements include an annual report to the General Assembly by September 15, including any findings and recommendations.

The Permanency Innovation Initiative Fund is created to support a demonstration project by the Children's Home Society. The purpose of the demonstration project is to (i) improve permanency outcomes for children living in foster care through reunification with parents, providing placement or guardianship with other relatives, or adoption, (ii), improve engagement with biological relative of children in or at risk of entering foster care, and (iii) reduce the costs associated with maintaining children in foster care.

The program is subject to the availability of funds and doesn't constitute an entitlement. The Social Services Commission must adopt rules to implement this section.

This section became effective July 1, 2013. (SK)

Medicaid Reform Advisory Group Established

S.L. 2013-360, Sec. 12H.1 (SB 402, Sec. 12H.1) establishes a North Carolina Medicaid Reform Advisory Group to advise the Department of Health and Human Services in the development of a plan to reform Medicaid. The Group consists of five members: a Representative appointed by the Speaker of the House, a Senator appointed by the President Pro Tempore of the Senate, and three persons appointed by the Governor. The Department is directed to work with the Advisory Group to create a detailed plan, but is not authorized to implement the plan, regarding Medicaid reform. Legislation based on the Department's reform proposal and

recommended by the Advisory Group is eligible for consideration when the 2013 General Assembly reconvenes in 2014. The Advisory Group terminates on July 1, 2014.

Also see the Enacted Legislation section of this document.

This section became effective July 1, 2013 (TM)

Referrals to Existing Commissions/Committees

Guardianship Roles of MHDDSA Providers

S.L. 2013-258 (HB 543) requires the Joint Legislative Oversight Committee on Health and Human Services to appoint a subcommittee to examine the impact of the 1915(b)/(c) Medicaid Waiver and other mental health system reforms on public guardianship services, including guardianship roles, responsibilities and procedures, and the effect on existing relationships between guardians and wards. The subcommittee is required to report its findings and recommendations to the Committee on or before May 9, 2014, at which time it will terminate.

Also see the Enacted Legislation section of this document.

This act became effective July 10, 2013. (TM)

Study Ways to Improve Outcomes and Efficiencies in Alcohol and Drug Abuse Treatment Programs

S.L. 2013-360, Sec. 12F.7(b) (SB 402, Sec. 12F.7(b)) requires the Joint Legislative Program Evaluation Oversight Committee consider including a study of the most effective and efficient ways to operate the inpatient treatment at the alcohol and drug abuse treatment centers in the 2014 Work Plan for the Program Evaluation Division of the General Assembly.

Notwithstanding any provision of this act, the total amount of funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for alcohol and drug abuse treatment centers is reduced by twelve percent (12%). The Department is not required to achieve this reduction by reducing the budget for each of the three existing alcohol and drug abuse treatment centers by twelve percent (12%) as long as the Department implements the reduction in a manner that (i) reduces the per bed cost variability across the three centers and (ii) does not result in the closure of any of the three centers."

Also see the Enacted Legislation section in this document.

This section became effective July 1, 2013. (SB)

Allow Certified Nurse Midwives Greater Flexibility in Practice of Midwifery Study

S.L. 2013-360, Sec. 12I.2 (SB 402, Sec. 12I.2) directs the Joint Legislative Oversight Committee on Health and Human Services (LOC) to appoint a subcommittee to study whether certified nurse-midwives should be given more flexibility in the practice of midwifery. The subcommittee must consider whether a certified nurse-midwife should be allowed to practice midwifery in collaboration with, rather than under the supervision of, a licensed physician. The subcommittee must report its findings and recommendations to the LOC on or before April 1, 2014 at which time the subcommittee will terminate.

This section became effective July 1, 2013. (BR)

Referrals to Departments, Agencies, Etc.

Study Use of Unique Student Identifier - Child Care Subsidy

S.L. 2013-360, Sec. 12B.8 (SB 402, Sec. 12.B.8), directs DCDEE and the Department of Public Instruction to study assigning a unique identifier to monitor the educational performance of children who have received child care subsidies. The report on the results of the study is due no later than April 1, 2014 to the Education, Health, and Information Technology oversight committees and to Fiscal Research Division.

This act became effective July 1, 2013. (PLP)

Division of Social Services Study - Procedures for Reporting Child Abuse

S.L. 2013-360, Sec. 12C.7 (SB 402, Sec. 12C.7) directs the Department of Health and Human Services, Division of Social Services, to study the policies and procedures in place for reporting child abuse and to report to the General Assembly no later than April 1, 2014.

This section became effective July 1, 2013. (JP)

Study Ways to Improve Outcomes and Efficiencies in Alcohol and Drug Abuse Treatment Programs

S.L. 2013-360, Sec. 12F.7(a) (SB 402, Sec. 12F.7(a)) requires the Department of Health and Human Services (Department) to study ways to improve outcomes and reduce costs related to inpatient treatment at the alcohol and drug abuse treatment centers operated by the Division of State-Operated Healthcare Facilities.

The Department must report no later than April 1, 2014 to the Joint Legislative Oversight Committee on Health and Human Services.

Also see the Enacted Legislation section of this document.

This section became effective July 1, 2013. (SB)

Review of Current Special Care Unit Staffing

S.L. 2013-360, Sec. 12G.1(b) (SB 402, Sec. 12G.1(b)) requires the Department of Health and Human Services to review laws pertaining to special care unit (SCU) staff ratios and other staffing requirements. A report of the review to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division must be made by April 1, 2014, and include the following: a comparison of staff ratios and staffing requirements for SCUs in North Carolina and bordering states; the rationale and justification for establishing the existing SCU staff ratios and requirements; and recommendations for changes to existing staff ratios and requirements based on the Department's findings.

Also see the Enacted Legislation section of this document.

This section became effective July 1, 2013. (TM)

Study Potential Savings through the Purchase of Insurance

S.L. 2013-360, Sec. 12H.12 (SB 402, Sec. 12H.12) directs the Department of Health and Human Services to study opportunities for savings in overall State funding by purchasing health insurance for persons served by departmental programs, including Medicaid. The Department of

Health and Human Services will report its findings to the Joint Legislative Oversight Committee on Health and Human Services no later than April 1, 2013.

This section became effective July 1, 2013. (AJJ)