2015

Substantive Enacted Legislation Pertaining to Health and Human Services

January 2016

Research Division, North Carolina General Assembly

2015 Substantive Legislation:

Health and Human Services

This document provides summaries of substantive health and human services legislation enacted during the 2015 Regular Session of the 2015 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.

SUBHEADINGS:

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

A more thorough summary of most bills may be found on the NCGA website:
http://www.ncleg.net/

SUMMARIES

DEPARTMENT OF HEALTH AND HUMAN SERVICES - GENERALLY

Creation of Office of Program Evaluation Reporting and Accountability within the Department of Health and Human Services (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12A.3)

Sec. 12A.3 of S.L. 2015-241 creates the Office of Program Evaluation Reporting and Accountability (OPERA) within the Department of Health and Human Services (DHHS) to review DHHS programs by: (i) accessing any data or record maintained by DHHS and to assure its confidentiality when required by State or federal law; (ii) interviewing any DHHS employee or independent contractor without others present; and (iii) conducting announced or unannounced inspections of departmental-owned or departmental-leased facilities.

This section became effective July 1, 2015.

Study Design and Implementation of Contracting Specialist and Certification Program (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12A.13)

Sec. 12A.13 of S.L. 2015-241 directs the Joint Legislative Oversight Committee on Health and Human Services to study and make recommendations about a contracting specialist training and certification program for management level personnel within the Department of Health and Human Services.

This section became effective July 1, 2015.

Health Information Technology (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12A.4)

Sec. 12A.4 of S.L. 2015-241 directs the Department of Health and Human Services (DHHS) and the State Chief Information Officer (State CIO) to coordinate health information technology (HIT) in order to avoid duplication of efforts and in support of State and national goals. DHHS, in cooperation with the Department of Information Technology, must establish and direct a HIT management structure. DHHS must provide a comprehensive report on the status of HIT efforts to the Joint Legislative Committee on Health and Human Services, the Joint Legislative Oversight Committee on Information Technology, and the Fiscal Research Division no later than January 15, 2016.

This section became effective July 1, 2015.

Competitive Grants/Nonprofit Organizations (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12A.8)

Sec. 12A.8 of S.L. 2015-241 requires the Department of Health and Human Services (DHHS), Division of Central Management and Support to use certain Social Services Block Grant funds to allocate funds for nonprofit organizations. In addition, this section directs the Secretary of DHHS

to announce the recipients of the competitive grant awards no later than July 1 of each year and submit a report to the Joint Legislative Oversight Committee on Health and Human Services on the grant awards. No later than December 1 of each year each nonprofit must submit to the Division of Central Management and Support a written report of all activities funded by State appropriations.

This section became effective July 1, 2015.

Status Report on Implementation of ICD-10 (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12A.6(b))

Section 12A.6(b) of S.L. 2015-241 requires the Department of Health and Human Services (Department) to submit a monthly report beginning on November 15, 2015, to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the status of the implementation of the International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10). The Department must continue to submit the report by the 15th of each month until three consecutive months have passed in which the Department did not issue any hardship advances and until the new Department of Information Technology can assume this function. Thereafter, the Department of Information Technology must submit this report upon the request of the Joint Legislative Oversight Committee on Health and Human Services.

This section became effective July 1, 2015.

Funds for Development of Health Analytics Pilot Program (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12A.17)

Sec. 12A.17 of S.L. 2015-241 appropriates funds for the 2015-2016 fiscal year and the 2016-2017 fiscal year to the Department of Health and Human Services (Department), Division of Central Management and Support, for the development and implementation of a pilot program for Medicaid claims analytics and population health management. The Department must coordinate with the Government Data Analytics Center (GDAC) to develop the pilot program and to provide access to data sources for the program.

By November 30, 2015, the Department must execute all contracts and interagency data-sharing agreements necessary for the development and implementation of the pilot program. By January 15, 2016, the Department and GDAC must provide a progress report to the General Assembly and must make a final report to the General Assembly on their findings and recommendations on the pilot program by May 31, 2016.

This section became effective July 1, 2015.

Require Transfer of Certain Services to Eastern Band of Cherokee Indians (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12C.10)

Sec. 12C.10 of S.L. 2015-241, as amended by Sec. 4.2 of S.L. 2015-268, transfers responsibility for the provision of certain services to the Eastern Band of Cherokee Indians (EBCI). The changes in this section include:

- Amends the law regarding the assumption of programs by a federally recognized tribe and the relief of a county's legal responsibility related to the tribe's assumption of those services. The new language provides that the State and the tribe will execute an agreement providing the general terms, definitions, and conditions by which the parties must operate for administration of any aspects of the NC Medicaid program, NC Health

Choice, and the Supplemental Nutrition Assistance Program (SNAP). In addition to necessary terms and conditions, the agreement must include five specified conditions.

- Amends the law to provide that when the EBCI assumes responsibility for a program nonfederal matching funds and State funds for State programs will be allocated to the EBCI and will not exceed the amount expended by the State for fiscal year 2014-2015 for programs or services plus the growth rate equal to the growth in State-funded nonfederal share for all counties. The EBCI is not prohibited by this section from providing further nonfederal matching funds to maximize their receipt of federal funds.
- Provides that approval for the EBCI to administer the eligibility process for Medicaid and NC Health Choice is contingent upon federal approval of State Plan amendments and Medicaid waivers by the Centers for Medicare & Medicaid Services (CMS). The State Plan amendments and Medicaid waivers submitted must have an effective date of October 1, 2016. Within 30 days of CMS approval of the State Plan amendments and Medicaid waivers, the Department of Health and Human Services (DHHS) must submit an Advanced Planning Document Update (APDU) to CMS, the United States Department of Agriculture (USDA), and the Administration of Children and Families (ACF). If CMS, USDA, and ACF do not approve the APDU, the counties will continue serving individuals living on the federal lands.
- Requires Jackson County and Swain County Departments' of Social Services to provide NC Medicaid, NC Health Choice, and SNAP eligibility workers on-site at Qualla Boundary five days a week (unless amended by agreement) until the transfer of eligibility determination responsibilities is complete.
- Directs DHHS to begin design, development, testing, and training of NC FAST, NCTracks, and legacy systems to allow the EBCI to assume certain administrative duties consistent with approval by federal funding partners.
- Directs DHHS, in collaboration with the EBCI, to draft a project plan to meet the October 1, 2016, effective date and report to the Joint Legislative Oversight Committee on Health and Human Services (HHS Oversight Committee) by January 1, 2016.
- Requires DHHS to report quarterly on the implementation of this section to the HHS Oversight Committee beginning October 1, 2015, and continue until implementation is complete.

This section became effective July 1, 2015.

Dorothea Dix Hospital Property Fund and Plan for Use of Funds (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12F.7)

Sec. 12F.7 of S.L. 2015-241 establishes a fund to receive the net proceeds of the sale of the Dorothea Dix Hospital property and requires the Department of Health and Human Services (DHHS) to submit a plan to use the funds to produce 150 new behavioral health inpatient beds and recommendations to increase the availability of community-based behavioral health treatment and services to the Joint Legislative Oversight Committee on Health and Human Services no later than April 1, 2016.

This section became effective July 1, 2015.

Plan for Relocating all Department of Health and Human Services Office to One Location (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 31.10)

Sec. 31.10 of S.L. 2015-241 directs the Department of Health and Human Services (DHHS), in consultation with the Department of Administration, to develop a plan for relocating the administrative personnel and resources of DHHS that are located on the Dorothea Dix campus and on other property leased or owned by the State in the Greater Triangle area

(consisting of Durham, Orange, Johnston, and Wake Counties) to a single site available to the State. The plan must not include relocation of personnel or resources whose primary responsibilities include the provision of services directly to the public in the Greater Triangle area.

DHHS must report the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by the earlier of October 1, 2016, or six months prior to the date on which the Department is required to move some or all of its personnel and resources from the Dorothea Dix campus under the terms of an agreement between the State and the City of Raleigh.

This section also prohibits DHHS and the Department of Administration from entering into any lease or other agreement to move the personnel or resources of DHHS that currently reside on the Dorothea Dix campus or on other property leased or owned by the State in the Greater Triangle area to another site until specifically authorized to do so by the General Assembly.

This section became effective on July 1, 2015.

CHILD CARE & CHILD DEVELOPMENT

Custodial Parent/Party Cooperate with Child Support (SL 2015-51/ S114)

S.L. 2015-51 requires the Division of Child Development and Early Education and the Division of Social Services in the Department of Health and Human Services to develop a plan to require a person with primary custody of a child receiving child care subsidy payments to cooperate with county child support services as a condition of receiving the subsidy payments. The Divisions are required to submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

This act became effective July 1, 2015.

Transition Certain Abuse Investigations/Division of Child Development and Early Education (SL 2015-123/ S578)

S.L. 2015-123 transitions abuse and neglect investigations in child care facilities to the Division of Child Development and Early Education within the Department of Health and Human Services.

This act becomes effective January 1, 2016.

NC Pre-K Programs/Standards for Four and Five-Star Rated Facilities (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12B.1)

Sec. 12B.1 of S.L. 2015-241 directs the Department of Health and Human Services (DHHS) and the Division of Child Development and Early Education (DCDEE) to continue implementation of the NC Pre-K program to serve four year olds. The Division must establish income eligibility requirements not exceeding 75% of the State median income. Other eligibility requirements for participation include:

- Up to 20% of children enrolled in NC Pre-K may have family incomes above 75% of the State median income if those children have certain risk factors.
- Children of a military parent ordered to active duty within the last 18 months or will be on active duty within the following 18 months.
- Children of a parent in the United States Armed Forces or North Carolina National Guard (or reserves) injured or killed while on active duty.

- Children with developmental disabilities or chronic health issues, other health issues cannot be a factor in determining eligibility.

Eligibility determinations must be made through Local Education Agencies (LEAs) and the North Carolina Partnership for Children, Inc. partnerships for participation in NC Pre-K. NC Pre-K committees must use the standard decision- making process developed by DCDEE to award classroom slots in the student selection process.

DCDEE must require the NC Pre-K contractor to issue a multi-year contract for licensed private childcare centers providing NC Pre-K classrooms. All NC Pre-K providers must follow standards and requirements prescribed by DCDEE. An annual report must be submitted no later than March 15, to the Joint Legislative Oversight Committee on Health and Human Services, the Office of State Budget and Management, and the Fiscal Research Division.

This section became effective July 1, 2015.

Child Care Subsidy Rates (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12B.2)

Section 12B.2 of S.L. 2015-241 does all of the following:

- Sets requirements for payments for the purchase of child care services for low-income children and directs the Department of Health and Human Services (DHHS) to make any necessary rule changes to restructure services.
- Provides for payment rates for child care providers in counties that do not have at least 50 children in each age group for center-based and home-based care.
- Directs the Division of Child Development and Early Education (DCDEE) in DHHS to calculate a market rate for child care centers and homes at each rated license level for each county and each age group as well as calculate a statewide rate and regional market rate for each rated license level for each age category.
- Directs the DCDEE to continue implementing policies that improve the quality of child care for subsidized children, including a policy in which child care subsidies are paid, to the extent possible, for child care in the higher quality centers and homes only.
- Provides that licensed child care facilities and religious-sponsored child care facilities may participate in the program that provides for the purchase of care in child care facilities for minor children of needy families and that child care facilities must meet any additional applicable requirements of federal law or regulations.
- Provides that noncitizen families who reside in this State legally must be eligible for child care subsidies if all other conditions of eligibility are met and is one of the following: (i) the child is receiving child protective services or foster care services; (ii) the child is developmentally delayed or at risk of being developmentally delayed; or (iii) the child is a citizen of the United States.
- Directs the DCDEE to require all county departments of social services to include on any forms used to determine eligibility for child care subsidy whether the family waiting for subsidy is receiving assistance through the NC Pre-K Program or Head Start.

This section became effective July 1, 2015.

Early Childhood Education and Development Initiatives Enhancements (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12B.7)

Sec. 12B.7 of S.L. 2015-241 directs the North Carolina Partnership for Children, Inc. (Partnership), and it's Board to ensure policies focus on the Partnership's mission of improving child care for children from birth to five years old. The Partnership's activities must include assisting child care facilities with (i) improving quality, including increasing star ratings of

facilities and (ii) implementing prekindergarten programs. This section authorizes State funding for local partnerships that use evidence-based or evidence-informed programs that increase children's literacy, the parent's ability to raise healthy successful children, improve children's health, and assist 4- and 5-star rated facilities in improving and maintaining quality.

This section limits administrative costs for all local partnerships to an average of 8% of the total statewide allocation and the Partnership must continue to use a single statewide contract management system that incorporates the features of the standard fiscal accountability plan articulated by statute. In addition, this section prescribes the conditions and criteria for the salary schedule and the amount of State funds that the Partnership may use for the salaries of the Executive Director and the directors of the local partnerships. Nothing prohibits a local partnership from using non-State funds to supplement an individual's salary in excess of the amount set by the schedule.

The Partnership and all local partnerships, in the aggregate, must match 100% of the total amount budgeted for the program in each fiscal year of the 2015-2017 biennium. Failure to match certain amounts will result in a dollar-for-dollar reduction in the appropriation in the subsequent fiscal year. The Partnership must submit a report to the Joint Legislative Oversight Committee on Health and Human Services on the private and in-kind contributions.

This section requires the Partnership and all local partnerships to use certain competitive bidding practices in contracting goods and services and provides that the Partnership may not reduce the allocation with less than 35,000 in population below the 2012-2013 funding level.

Lastly, this section prohibits the Department of Health and Human Services' and the Partnership's use of allocated funds for Early Childhood Education and Development Initiatives for the 2015-2017 fiscal biennium for certain capital improvement expenditures and funding advertising and promotional activities.

This section became effective July 1, 2015.

Statewide Early Education and Family Support Programs (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12B.8)

Section 12B.8 of S.L. 2015-241 directs the Joint Legislative Oversight Committee on Health and Human Services to appoint a subcommittee to study early childhood and family support programs including the: (i) Childcare Subsidy Program, (ii) NC Pre-K, and (iii) Smart Start.

The subcommittee studying the program must consider the:

- Purposes, outcomes, and effectiveness of each program.
- Flexibility needed to meet the needs of children in counties across the State.
- Potential to streamline administration across programs.
- Other relevant issues the subcommittee may deem appropriate.

The subcommittee may seek input from other states, stakeholders, or experts on early childhood and family support programs. The subcommittee must develop a proposal on how to meet county and regional needs and make a report on the proposed plan to the Joint Legislative Oversight Committee on Health and Human Services on or before April 1, 2016.

This section became effective July 1, 2015.

U.S. Department of Defense-Certified Child Care Facilities Participation in State-Subsidized Child Care Program (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12B.9)

Sec. 12B.9 of S.L. 2015-241 amends the law pertaining to Child Care Facilities to allow the U.S. Department of Defense certified child care facilities to participate in the State-subsidized child care program. Department of Defense certified child care facilities include: (i) developmental centers, (ii) family child care homes, and (iii) school-age child care facilities operated on a military installation by the Department of Defense certified by the Department of Defense.

Procedures regarding operating a State-subsidized Department of Defense-certified child care facility include:

- Filing a notice of intent to operate form with the Department of Defense.
- Submitting a report indicating that minimum child care standards for child care facilities have been met as provided by the Department of Defense.

Childcare facilities meeting all requirements of this provision are exempt from State licensure requirements. Child care facilities seeking State subsidies will be reimbursed as a five-star facility if they are accredited by the National Association for the Education of Young Children (NAEYC). All other Department of Defense-certified facilities will be reimbursed as a four-star rated facility. Allocated funds must supplement and not supplant federal or State funds allocated to Department of Defense-certified child care facilities.

This section became effective January 1, 2016.

CHILD HEALTH, MATERNAL HEALTH & ELDER HEALTH

Jim Fulghum Teen Skin Cancer Prevention Act (SL 2015-21/ H158)

S.L. 2015-21 prohibits persons under 18 years of age from using tanning equipment.

This act became effective May 21, 2015.

Maternal Mortality Review Committee (SL 2015-62/ H465 - Women and Children's Protection Act of 2015, Sec. 6)

Sec. 6 of S.L. 2015-62 establishes the Maternal Mortality Review Committee within the Department of Health and Human Services.

This section becomes effective December 1, 2015.

Abortion Changes (SL 2015-62/ H465 - Women and Children's Protection Act of 2015, Sec. 7)

Sec. 7 of S.L. 2015-62 makes a number of changes to North Carolina's abortion laws, please see the full summary of this section online for greater detail.

The substantive provisions in Sec. 7(a) become effective January 1, 2016, and apply to abortions performed or attempted on or after that date. The remainder of this section became effective October 1, 2015, and applies to abortions performed or attempted on or after that date.

Clarify Protections/Exploitation of Elders (S.L. 2015-182/ H 397)

S.L. 2015-182 clarifies the procedures to be followed when a defendant is convicted for exploitation of an older adult or disabled adult and seized assets are used to satisfy the defendant's restitution obligation as ordered by the court. The act specifies the procedures for

serving the order, freezing or seizing the assets, and satisfying the order of restitution if the defendant pleads guilty or no contest to the criminal charges.

This act became effective October 1, 2015 and applies to offenses committed on or after that date.

Amend School Health Assessment Requirement (S.L. 2015-222/HB13)

S.L. 2015-222 requires each child entering the public schools for the first time to submit proof of a health assessment to the school principal within 30 calendar days of the child's first day of attendance. The health assessment results must be submitted on a statewide standardized health assessment transmittal form developed by the Department of Health and Human Services (DHHS) and the Department of Public Instruction (DPI) and the form must only include those items specifically listed in the act. Information provided on the form is not a public record. If the health assessment transmittal form is not presented on or before the child's first day of attendance, the principal will issue a deficiency notice indicating that the form must be submitted within the specified timeframe or the child will not be permitted to attend school. Local board of education policies must state that absences due to failure to submit the health assessment are not suspensions and a student absent due to the lack of a health assessment form must have the opportunity to: take a textbook and school-furnished digital device home, receive missed assignments upon request, and take missed exams. DHHS and DPI must develop a health assessment transmittal form for the 2016-2017 school year and report on or before December 1, 2015, to the Joint Legislative Oversight Committee on Health and Human Services and Joint Legislative Oversight Committee on Education.

This act became effective August 18, 2015, and applies to children enrolling in the public schools for the first time beginning with the 2016-2017 school year.

Clarify Reasonable Health Insurance/Long-Term Care Ombudsman (SL 2015-220/ H308)

S.L. 2015-220 amends laws pertaining to medical support and health insurance coverage relating to child support in order to align State law and federal guidelines. The act also modifies the Long-Term Care Ombudsman Program to conform to federal requirements.

The provisions of this act pertaining to support and coverage relating to child support became effective August 18, 2015, and apply to orders issued or agreements entered into on or after that date. The remainder of this act becomes effective July 1, 2016.

Improve Maternal and Child Health/Establish Competitive Grants Process (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12E.11)

Sec. 12E.11 of S.L. 2015-241 designates the Department of Health and Human Services, Division of Public Health (DPH) as the lead agency to:

- Assume responsibility for controlling all funding and contracts designed to (i) improve North Carolina's birth outcomes, (ii) improve the overall health status of children in this State from ages birth to five, and (iii) lower this State's infant mortality rates.
- Develop a comprehensive plan in consultation with the University of North Carolina Gillings School of Global Public Health.
- Conduct a continuation review of all maternal and child health-related programs in consultation with the Department of Health and Human Services, Office of Program Evaluation Reporting and Accountability (OPERA).
- Establish a competitive grants process for local health departments based on the county's proposal to invest in evidence-based programs and on maternal and infant health indicators.

- Evaluate the protocol for future program funding in consultation with the School of Global Public Health.
- Submit a report on the competitive grants process, in consultation with the School of Global Public Health, to the Joint Legislative Oversight Committee on Health and Human Services no later than April 1, 2016.

This section became effective July 1, 2015.

End Marketing/Sale Unborn Children Body Parts (SL 2015-265/ H297)

S.L. 2015-265 prohibits the sale of the remains of an unborn child resulting from an abortion, or of any aborted material. The act also prohibits the Department of Health and Human Services from allocating funds to support contracts with any abortion providers that provide family planning services, pregnancy prevention activities, or adolescent parenting programs under the Teen Pregnancy Prevention Initiatives.

This act became effective October 1, 2015, and the provisions prohibiting the sale of the remains of an unborn child apply to offenses committed on or after that date.

CHILD PROTECTIVE SERVICES & FOSTER CARE

Amend Certain Requirements/Permanency Innovation Commission (S.L. 2015-95/ S366)

S.L. 2015-95 amends the reporting and meeting requirements of the Permanency Innovation Initiative Oversight Committee. The act reduces the frequency of meetings the Committee must hold from quarterly to at least twice a year, directs the Committee to report to the chairs of the Senate and House Appropriations Subcommittees on Health and Human Services and the Fiscal Research Division, and moves the reporting date from September 15 to February 15 each year.

This act became effective June 19, 2015.

Foster Family Care Act (S.L. 2015-135/ S423)

S.L. 2015-135 modifies laws concerning foster care families by:

- Effective October 1, 2015, creating a reasonable and prudent parent standard in foster care.
- Providing liability insurance for foster parents.
- Effective October 1, 2015, reducing the barriers to obtain a driver's license by foster children.
- Directing the Department of Health and Human Services to study a Medicaid waiver for children with serious emotional disturbance and to report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015.

Except as otherwise provided, this act became effective July 2, 2015.

Successful Transition/Foster Care Youth (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12C.6)

Sec. 12C.6 of S.L. 2015-241 creates the Foster Care Transitional Living Initiative Fund (Fund) to support a demonstration project provided by Youth Villages to:

- Improve outcomes for youth ages 17-21 years who transition from foster care through implementation of outcome-based Transitional Living Services.

- Identify cost savings in social services and juvenile and adult correction services associated with the provision of Transitional Living Services to youth aging out of foster care.
- Take necessary steps to establish an evidence-based transitional living program available to all youth aging out of foster care.

In addition this section sets out strategies that the Fund must support concerning transitional living services, public-private partnership, impact measurement and evaluation, and advancement of the evidence-based process.

The statute creating the Permanency Innovation Initiative Oversight Committee (Committee) is amended to increase the membership of the Committee by one to include a member who represents Youth Villages and who is appointed by the Governor. This section also expands the Committee's duties to include activities related to foster care youth transitioning to adulthood.

This section became effective July 1, 2015.

Child Protective Services Improvement Initiative/Revise Statewide Evaluation Report Date (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12C.8)

Sec. 12C.8 of S.L. 2015-241 requires the Department of Health and Human Services, Division of Social Services to report on the comprehensive, statewide evaluation of the State's child protective services system to the Legislative Oversight Committee on Health and Human Services on or before March 1, 2016.

This section became effective July 1, 2015.

Fostering Success/Extend Foster Care to 21 Years of Age (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12C.9)

Sec. 12C.9 of S.L. 2015-241 does the following:

- Extends foster care benefits to a person until the age of 21 who meets one of the following requirements: (1) is completing high school or a GED, (2) is enrolled in a college or vocational program, (3) is participating in an employment program, (4) is employed for at least 80 hours per month, (5) or is unable to complete one of the above requirements due to a medical condition or disability. This subsection becomes effective January 1, 2017 and applies to agreements entered into on or after that date.
- Provides that an individual over age 18 receiving benefits may be approved to reside in a college dormitory or other semi-supervised housing. This subsection becomes effective January 1, 2017 and applies to agreements entered into on or after that date.
- Extends adoption assistance benefits to age 21 for juveniles adopted after age 16 but prior to age 18 as required by federal law.
- Makes conforming changes to the foster care facility statues to reflect the increase in benefits to age 21.
- Authorizes the Social Services Commission to adopt rules to implement the increase in benefits to age 21.
- Amends the juvenile code statutes to create a review of voluntary foster care placements with young adults.
- Requires the Department of Health and Human Services (DHHS) to develop a plan for the expansion of foster care benefits to age 21 and report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by March 1, 2016 on plan development and again by March 1, 2017 on plan implementation. DHHS

must submit a State Plan amendment no later than 30 days after implementation to the US Department of Health and Human Services Administration for Children and Families. This subsection became effective September 18, 2015.

The remaining subsections become effective January 1, 2017.

Child Protective Services Pilot Project (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12C.11)

Sec. 12C.11 of S.L. 2015-241 authorizes the Department of Health and Human Services, Division of Social Services (DSS), to continue the implementation of the Child Protective Services Pilot Project by collaborating with the Government Data Analytics Center (GDAC) to enhance the project. In order to analyze risk and improve outcomes for children, this section also requires that DSS interface the work product from the pilot project with the statewide child welfare case management system by utilizing resources available through existing public-private partnerships within GDAC. Lastly, DSS must submit a final report on the pilot project to the Legislative Oversight Committee on Health and Human Services no later than March 1, 2016.

This section became effective July 1, 2015.

CONTROLLED SUBSTANCES

Controlled Substances/NBOMe & Other Drugs (SL 2015-162/H341)

S.L. 2015-162 adds a number of drugs to the list of controlled substances in Schedules I, II, and VI of the North Carolina Controlled Substances Act.

The act became effective December 1, 2015, and applies to offenses committed on or after that date.

Amend Cannabidiol (CBD) Oil Statute (SL 2015-154/ H766)

S.L. 15-154, as amended by Sec. 48.5 of S.L. 2015-264, does the following:

- Permits hemp extract to be used as an alternative treatment for intractable epilepsy without participation in a pilot study.
- Amends the limited exception to the North Carolina Controlled Substances Act for the use, possession, and administration of hemp extract.
- Amends and repeals certain provisions of the North Carolina Epilepsy Alternative Treatment Act including who qualifies as a "caregiver" and the registration requirements.

The exception to the North Carolina Controlled Substances Act became effective August 1, 2015, and applies to offenses committed on or after that date. The remainder of this act became effective July 16, 2015.

Statewide Opioid Prescribing Guidelines (SL 2015-241/H97 - 2015 Appropriations Act, Sec. 12F.16(a))

Sec. 12F.16.(a) of S.L. 2015-241 directs the following State health officials and health care provider licensing boards to adopt, by July 1, 2016, the North Carolina Medical Board's Policy for the Use of Opiates for the Treatment of Pain:

- The Director of the Division of Public Health of the Department of Health and Human Services (DHHS).
- The Director of the Division of Medical Assistance, DHHS.

- The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS.
- The directors of medical, dental, and mental health services within the Department of Public Safety.
- North Carolina State Board of Dental Examiners.
- North Carolina Board of Nursing.
- North Carolina Board of Podiatry Examiners.

This subsection became effective September 18, 2015.

Requiring Continuing Education on Abuse of Controlled Substances for Health Care Providers Who Prescribe Controlled Substances (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12F.16(b)-(c))

Ses. 12F.16.(b) and (c) of S.L. 2015-241 direct the following health care provider occupational licensing boards to require continuing education on the abuse of controlled substances as a condition of license renewal:

- North Carolina Board of Dental Examiners.
- North Carolina Board of Nursing.
- North Carolina Board of Podiatry Examiners.
- North Carolina Medical Board.

In establishing the continuing education standards, these boards must require that at least one hour of the total required continuing education hours consists of a course designed specifically to address prescribing practices that includes instruction on controlled substance prescribing and prescribing for chronic pain management.

These subsections became effective September 18, 2015.

Improve Controlled Substances Reporting System Access and Utilization (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12F.16(d)-(e))

Sec. 12F.16.(d) and (e) of S.L. 2015-241 amend the laws regarding confidentiality of information submitted to the Department of Health and Human Services' (DHHS) Controlled Substance Reporting System (CSRS) in order to allow for information within CSRS to be utilized to inform medical records or clinical care and allow DHHS to release data within CSRS to the federal Drug Enforcement Administration's Office of Diversion Control and the North Carolina Health Information Exchange Authority (NC HIE Authority). DHHS must adopt appropriate policies and procedures documenting and supporting this expanded access of the CSRS.

These subsections became effective September 18, 2015.

Improve Controlled Substances Reporting System Contract (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12F.16(f)-(h))

Sec. 12F.16.(f) through (h) of S.L. 2015-241 direct the Department of Health and Human Services (DHHS) to modify the contract for the Controlled Substances Reporting System (CSRS) to improve performance, establish user access controls, establish data security protocols, and ensure availability of data for advanced analytics. Specifically, the contract must

be modified to include the following:

- A connection to the HIE Network administered by the North Carolina Health Information Exchange Authority (NC HIE Authority) (effective upon the establishment of the HIE Network pursuant to 12A.5 of this act).
- The establishment of interstate connectivity.
- Data security protocols that meet or exceed the Federal Information Processing Standards (FIPS) established by the National Institute of Standards and Technology (NIST).

DHHS must complete the above contract modifications by December 31, 2015, and report by November 15, 2015, to the Joint Legislative Program Evaluation Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services on its progress towards modifying the contract. In furtherance of the directive to establish interstate connectivity of the CSRS, DHHS must apply for grant funding from the National Association of Boards of Pharmacy to establish an initial connection to PMP InterConnect, and additional monies for two years of ongoing service, maintenance, and support for PMP InterConnect.

Except as otherwise specified, these subsections became effective September 18, 2015.

Expand Monitoring Capacity of Controlled Substances Reporting System (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12F.16(j)-(k))

Sec. 12F.16(j) and (k) of S.L. 2015-241 direct the North Carolina Controlled Substances Reporting System to expand its monitoring capacity by establishing data use agreements with the Prescription Behavior Surveillance System. The CSRS must establish a data use agreement with the Center of Excellence at Brandeis University by January 1, 2016.

Beginning September 1, 2016, and every two years thereafter, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services must report on its participation with the Prescription Behavior Surveillance System to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety.

These subsections became effective September 18, 2015.

Statewide Strategic Plan – Prescription Drug Abuse Advisory Committee (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12F.16(m)-(q))

Sec. 12F.16.(m)-(q) of S.L. 2015-241 create the Prescription Drug Abuse Advisory Committee (Committee), housed in and staffed by the Department of Health and Human Services (DHHS). The committee is directed to develop and implement a statewide strategic plan to combat the problem of prescription drug abuse. In addition to any persons designated by the Secretary of Health and Human Services, the Committee must include representatives from the following:

- The Division of Medical Assistance, DHHS.
- The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS.
- The Division of Public Health, DHHS.
- The Rural Health Section of the Division of Public Health, DHHS.
- The State Bureau of Investigation.
- The Attorney General's Office.
- The following health care regulatory boards with oversight of prescribers and dispensers of prescription drugs: (i) North Carolina Board of Dental Examiners; (ii) North Carolina Board of

Nursing; (iii) North Carolina Board of Podiatry Examiners; (iv) North Carolina Medical Board; and (v) North Carolina Board of Pharmacy.
- The UNC Injury Prevention Research Center.
- The substance abuse treatment community.
- Governor's Institute on Substance Abuse, Inc.
- The Department of Insurance's drug take-back program.

After the PDAAC develops the strategic plan, it becomes the State's steering committee to monitor achievement of strategic objectives and receive regular reports on progress made toward reducing prescription drug abuse in North Carolina.

In developing the strategic plan, the PDAAC must complete, at minimum, the following steps:
- Identify a mission and vision for North Carolina's system to reduce and prevent prescription drug abuse.
- Scan the internal and external environment for the system's strengths, weaknesses, opportunities, and challenges (a SWOC analysis).
- Compare threats and opportunities to the system's ability to meet challenges and seize opportunities (a GAP analysis).
- Identify strategic issues based on SWOC and GAP analyses.
- Formulate strategies and resources for addressing these issues.

The strategic plan for reducing prescription drug abuse must further include three to five strategic goals that are outcome-oriented and measurable. Each of these goals must be connected with objectives supported by the following five mechanisms of the system:
- Oversight and regulation of prescribers and dispensers by State health care regulatory boards.
- Operation of the Controlled Substances Reporting System (CSRS).
- Operation of the Medicaid lock-in program to review behavior of patients with high use of prescribed controlled substances.
- Enforcement of State laws for the misuse and diversion of controlled substances.
- Any other appropriate mechanism identified by the Committee.

In consultation with the PDAAC, DHHS is required to develop and implement a formalized performance management system that connects the goals and objectives identified in the statewide strategic plan to operations of the CSRS and Medicaid lock-in program, law enforcement activities, and oversight of prescribers and dispensers. This performance management system must be designed to monitor progress toward achieving goals and objectives and must recommend actions to be taken when performance falls short.

Beginning on December 1, 2016 and annually thereafter, DHHS is required to submit a report on the performance of North Carolina's system for monitoring prescription drug abuse to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety.

These subsections became effective September 18, 2015.

Pilot Project/Used Needle Disposal (SL 2015-284/ H712)

S.L. 2015-284 requires the State Bureau of Investigation (SBI), in consultation and collaboration with the NC Harm Reduction Coalition, to establish and implement a used needle and hypodermic syringe disposal pilot program by December 1, 2015. Initially the pilot will operate in two counties, but the SBI may select up to four counties if the pilot is successful. The SBI is required to report to the chairs of the Joint Legislative Oversight Committees on Health and

Human Services and the chairs of the Joint Legislative Oversight Committee on Justice and Public Safety regarding the status of the pilot.

The act also amends the law pertaining to possession of drug paraphernalia to provide that a person will not be charged for residual amounts of a controlled substance contained in a needle or sharp object if prior to searching a person, a person's premises, or a person's vehicle, the person has advised the officer of the needle or sharp object.

The section of the act pertaining to the pilot program became effective October 22, 2015. The section of the act pertaining to charges for residual amounts of a controlled substance became effective December 1, 2015.

DISEASES

Right to Try Act for Terminally Ill Patients (SL 2015-137/ H652)

S.L. 2015-137 establishes a process by which eligible patients who are terminally ill may obtain access to investigational drugs, biological products, and devices so long as various requirements are met.

This act became effective October 1, 2015.

Establish Advisory Council on Rare Diseases (SL 2015-199/ H823)

S.L. 2015-199 establishes the Advisory Council on Rare Diseases housed within the School of Medicine of the University of North Carolina at Chapel Hill. The Advisory Council is tasked with studying, advising, and reporting annually to the Governor, the Secretary of Health and Human Services, and the General Assembly on research, diagnosis, treatment, and education relating to rare diseases.

This act became effective August 1, 2015.

The William C. Lindley, Jr. SUDEP Law (SL 2015-211/ H814)

S.L. 2015-211 requires the Chief Medical Examiner to appoint two or more county medical examiners for each county; removes coroners from the list of those that may be appointed as medical examiners; requires county medical examiners to complete continuing education training, including sudden unexpected death in epilepsy (SUDEP) training; requires newly appointed county medical examiners to complete mandatory orientation training; and allows the Chief Medical Examiner to revoke a county medical examiner's appointment for failure to adequately perform the duties of the office.

This act became effective January 1, 2016.

Baby Carlie Nugent Bill (SL 2015-272/ H698)

S.L. 2015-272 requires the Commission for Public Health to adopt rules to implement a screening test for severe combined immunodeficiency (SCID) and other T-Cell lymphopenias detectable as a result of SCID.

This act became effective October 19, 2015.

Diabetes Education (SL 2015-273/ S694 Reegan's Rule/Enforce Pharmacy Benefits Management, Sec. 1)

Sec. 1 of S.L. 2015-273 adds a new public health chronic disease law to encourage physicians, physician assistants, and certified nurse practitioners to inform parents of Type I diabetes warning signs and symptoms during well-child care visits.

This section of the act becomes effective December 1, 2015.

(Effective October 1, 2015, Sec. 12E.12 of S.L. 2015-241 increased from $19.00 to $24.00 the fee that is used to offset the cost of the Newborn Screening Program. The Joint Conference Committee Report reflects an appropriation for equipment and purchases related to the testing.)

HEALTH CARE FACILITIES & HEALTH CARE LICENSING

Extend Overnight Respite Pilot Program (SL 2015-52/ S291)

S.L. 2015-52 extends until June 30, 2017, the Adult Day Care Overnight Respite Pilot Program authorized by S.L. 2011-104. In order to provide a more comprehensive evaluation of the provision of overnight respite in an adult day care setting, the act requires the Department of Health and Human Services to work with the NC General Assembly's Program Evaluation Division to collect additional information. The Program Evaluation Division is required to provide an interim report on the criteria specified in the act on or before December 1, 2015, and a final report on or before October 1, 2016, to the Joint Legislative Program Evaluation Oversight Committee and to the Joint Legislative Oversight Committee on Health and Human Services.

The act became effective June 4, 2015.

(Note: Also see Licensure of Overnight Respite Facilities (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12G.3.)

Amend Composition of North Carolina Medical Board (SL 2015-213/ H724)

S.L. 2015-213 revises the membership of the North Carolina Medical Board to provide that at least one physician assistant and at least one nurse practitioner must serve as members of the Board.

This act became effective August 11, 2015.

Health Care Cost Reduction and Transparency Act Revisions (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12A.15)

Sec. 12A.15 of S.L. 2015-241 amends the law (G.S. 131E-214.13) pertaining to the Health Care Cost Reduction and Transparency Act of 2013 as follows:

- Changes the reporting frequency from quarterly to annually, and delays reporting until September 30, 2015, for each hospital to report to the Department of Health and Human Services (DHHS) on the 100 most frequently reported admissions by diagnostic related group (DRG) for inpatients.
- Changes the reporting frequency from quarterly to annually, and delays reporting until September 30, 2015, for each hospital and ambulatory surgical facility to report to DHHS the total costs for the 20 most common surgical procedures and the 20 most common imaging procedures by volume, performed in hospital outpatient settings or in ambulatory surgical facilities.

- Delays from January 1, 2015, to March 1, 2016, the date that the Medical Care Commission must adopt rules and requires the Commission to adopt rules to establish and define no fewer than 10 measures for licensed hospital and licensed ambulatory surgical facilities.

This section also amends the law (G.S. 131E-214.14) on disclosure of charity care policy and costs to specify that DHHS must post, in one location and in a manner that is searchable on the DHHS internet Web site, all of the information submitted pertaining to a hospital's or ambulatory surgical facility's financial assistance policy and annual financial assistance costs.

This section became effective July 1, 2015.

Moratorium on Special Care Unit Licenses (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12G.2)

Sec. 12G.2 of S.L. 2015-241 amends Sec. 12G.1(a) of S.L. 2013-360, as amended by Sec. 12G.5 of S.L. 2014-100, to extend the moratorium on special care unit licenses to June 30, 2017. The section prohibits the Department of Health and Human Services (DHHS), Division of Health Service Regulation, from issuing licenses for special care units except in specified situations.

The section also requires the DHHS to submit a report to the Joint Legislative Oversight Committee on Health and Human Services by March 1, 2016. The report must contain the following:

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

The section became effective September 18, 2015.

Licensure of Overnight Respite Facilities (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12G.3)

Sec. 12G.3 of S.L. 2015-241 (i) creates a law pertaining to licensure for overnight respite, (ii) allows an adult day care program to provide overnight respite services in accordance with the new law, (iii) requires a fee for adult day care overnight respite facilities, (iv) requires the Department of Health and Human Services (DHHS) to add adult day care overnight respite as a service under the Home and Community Care Block Grant (HCCBG), and (v) requires DHHS to take action to amend the Innovations waiver and Community Alternatives Program for Disabled Adults (CAP/DA) waiver to allow the use of these new overnight respite facilities.

The overnight respite pilot authorized by S.L. 2011-104, and amended by S.L. 2015-52, is repealed on the earlier of June 30, 2017, or the date the overnight respite licensure process is fully operational.

This section became effective July 1, 2015, and directs DHHS to report to the Revisor of Statutes the date on which overnight respite licensure is implemented and fully operational.

Legacy Medical Care Facility/Certificate of Need Exempt (SL 2015-288/ S698)

S.L. 2015-288 does the following: (1) provides for certain exemptions under the Certificate of Need Law; (2) amends the requirements for a municipality or hospital authority to approve the sale or lease of a public hospital; (3) effective January 1, 2018, repeals North Carolina's

Certificate of Public Advantage laws; and (4) gives a hospital authority the power to engage in health care activities outside the State.

Except as otherwise provided, this act became effective October 29, 2015.

HEALTH INFORMATION EXCHANGE

Health Information Exchange Amendments (SL 2015-7/ S14 Academic Standards/Rules Review/Coal Ash/Funds, Sec. 11)

Sec. 11 of S.L. 2015-7 does the following: (i) amends a provision in the Appropriations Act of 2014 that pertains to the allocation and use of funds for the North Carolina Health Information Exchange (HIE); (ii) directs the Department of Health and Human Services (DHHS) to process payments for allowable expenses that were encumbered before February 1, 2015, by July 1, 2015; (iii) allocates nonrecurring funds to the Division of Central Management and Support within DHHS for the NC HIE and to the Office of the State Chief Information Officer to conduct an assessment of the existing functionality, structure, and operation of the HIE Network; (iv) directs DHHS to report to the General Assembly on all State funds used on or behalf of the HIE and on the HIE Network assessment by May 1, 2015, and June 1, 2015, respectively; and (v) states the intent of the General Assembly to continue efforts towards implementation of a statewide HIE.

This section became effective April 13, 2015.

Funds for Oversight and Administration of Statewide Health Information Exchange Network (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12A.5, as amended)

Section 12A.5 of S.L. 2015-241, as amended by Sec. 86.5 of S.L. 2015-246, creates a mechanism by which the State can establish and connect to a successor Health Information Exchange (HIE) Network for all Medicaid providers and all other entities that receive State funds for the provision of health services by June 1, 2018. In addition, this section establishes the North Carolina HIE Authority (Authority) to oversee and administer the successor HIE Network.

To accomplish these objectives, the State Chief Information Officer (CIO) must enter into a memorandum of understanding with the Secretary of the Department of Health and Human Services (DHHS) that provides the CIO with the sole authority over the HIE until both the Authority and Advisory Board to the Authority are established. Existing HIE contracts must be terminated or assigned to the Authority by February 29, 2016.

Effective October 1, 2015, this section creates a new Article 29B, (Statewide Health Information Exchange Act) in Chapter 90 of the General Statutes intended to improve the quality of health care delivery in the State by facilitating and regulating the use of a voluntary, statewide HIE network for the secure electronic transmission of individually identifiable health information among health care providers, health plans, and health care clearinghouses that is consistent with HIPAA. Despite the voluntary nature of the network, the Article requires: (i) each hospital that has an electronic health record system; (ii) each Medicaid provider; (iii) each provider that receives State funds for the provision of health services; (iv) and each local management entity/managed care organization (LME/MCO) to submit, at least twice daily by way of the HIE Network, demographic and clinical information pertaining to services rendered to Medicaid and other State-funded health care programs.

The Article articulates conditions by which State agencies and the Legislature may gain access to HIE Network data, provides that any data pertaining to services rendered to beneficiaries under the HIE Network is and remains the sole property of the State and must not allow data to

be disclosed for commercial purposes or for any other purposes not otherwise provided under the provision.

This section also creates the North Carolina HIE Authority (Authority), located within the Department of Information Technology and under the direction and control of the State CIO, with broad powers and duties to oversee and administer the HIE Network. The Authority is directed to consult with the North Carolina HIE Advisory Board (Advisory Board) to set guiding principles for the development, implementation, and operation of the HIE Network. The Authority is empowered to establish fees for participation in the HIE Network.

The 11-member Advisory Board is located within the Department of Information Technology, and is tasked with providing consultation to the Authority with respect to the advancement, administration, and operation of the HIE Network and on matters pertaining to health information technology and exchange.

Covered entities (as that term is defined in the Code of Federal Regulations) that participate in the HIE Network must enter into a HIPAA compliant agreement and a written participation agreement with the Authority prior to submitting data to the HIE Network. Participating covered entities may disclose an individual's protected health information through the HIE Network to other covered entities for any purpose provided by HIPAA, unless the individual has exercised the right to opt out, which is available to the individual on a continuing basis. Covered entities that are required to submit demographic and clinical information through the successor HIE Network must not submit such information through the successor HIE Network until the Authority establishes a date for covered entities to begin submitting the information through the HIE Network or other secure electronic means.

This section establishes penalties, actions, and remedies for covered entities that disclose protected information in violation of the Article.

Also effective October 1, 2015, this section provides that, with the exception of the laws governing equal employment and compensation opportunity and privacy of State employee personnel records, the State Human Resources Act does not apply to employees of the NC HIE Authority.

Effective on the date the State CIO notifies the Revisor of Statutes that all contracts pertaining to the prior HIE Network between the State and between any third parties have been terminated or assigned to the successor HIE Network created pursuant to this section, the HIE Network established in 2011, is repealed.

Except as otherwise provided, the remainder of this section became effective July 1, 2015.

MEDICAID AND HEALTH CHOICE

Audit of County Departments of Social Services' Administration of Medicaid Program (SL 2015-7/ S14 Academic Standards/Rules Review/Coal Ash/Funds, Sec. 11.5)

Section 11.5 of S.L. 2015-7 requires the State Auditor to conduct a performance audit of county departments of social services' administration of the North Carolina Medicaid program. The audit must include the examination of at least all of the following:

- The accuracy of Medicaid application eligibility determinations.
- The timeliness of Medicaid application determinations.
- The accuracy of Medicaid re-enrollment eligibility determinations.
- The timeliness of Medicaid re-enrollment eligibility determinations.
- The accuracy of presumptive Medicaid application determinations.

- The timeliness of presumptive Medicaid application determinations.
- The controls and oversight county departments of social services have in place to ensure accurate and timely processing of Medicaid applications and re-enrollment.

The State Auditor is required to submit a preliminary report to the Joint Legislative Oversight Committee on Health and Human Services and to the Fiscal Research Division by June 1, 2015, and to complete the performance audit by February 1, 2016.

This section became effective April 13, 2015.

Health Choice Technical Revisions (SL 2015-96/ S487)

S.L. 2015-96 amends various obsolete statutes governing the Health Insurance Program for Children (North Carolina Health Choice), as recommended by the Department of Health and Human Services.

This act became effective June 19, 2015.

Medicaid Lock-In Program (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12F.16(l))

Sec. 12F.16(l) of S.L. 2015-241, as amended by Sec. 4.4 of S.L. 2015-268, requires the Division of Medical Assistance (DMA) of the Department of Health and Human Services to take various steps to improve the effectiveness and efficiency of the Medicaid lock-in program. DMA must establish written procedures for operation of the program and the sharing of bulk data, extend the lock-in duration to two years and revise program eligibility criteria to align the program with the statewide strategic goals for preventing prescription drug abuse, develop a Web site and communication materials, and increase program capacity. DMA must also conduct an audit of the program by January 1, 2016, and must submit a progress report to the Joint Legislative Program Evaluation Oversight Committee by September 30, 2016.

This section became effective July 1, 2015.

Medicaid Eligibility (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.2)

Sec. 12H.2 of S.L. 2015-241 sets the eligibility categories and income thresholds for the Medicaid and NC Health Choice programs. The increases to the income thresholds compared to the previous budget do not reflect an expansion of eligibility for the programs but rather reflect a conversion of the prior income thresholds to account for the new Modified Adjusted Gross Income (MAGI) methodology for counting income implemented in 2014 as required by the Affordable Care Act.

This section became effective July 1, 2015.

Provider Application and Recredentialing Fee (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.4)

Sec. 12H.4 of S.L. 2015-241, as amended by Sec. 87.5 of S.L. 2015-264, requires the Department of Health and Human Services, Division of Medical Assistance to charge a $100 application fee, in addition to the federally required amount, to each provider enrolling in the Medicaid Program for the first time. The fee is to be charged to all providers at recredentialing every five years.

This section is effective July 1, 2015.

Reimbursement for Immunizing Pharmacist Services (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.5)

Sec. 12H.5 of S.L. 2015-241 provides that, effective January 1, 2016, the Division of Medical Assistance in the Department of Health and Human Services must provide Medicaid and NC Health Choice reimbursement for the administration of covered vaccinations or immunizations provided by immunizing pharmacists in accordance with the laws pertaining to such pharmacists. In addition, this section provides that any State Plan amendments required to implement this provision are not subject to the 90-day prior submission requirement under the law governing amendments to Medicaid State Plan and Medicaid waivers, but instead must be submitted by January 1, 2016.

Except as otherwise provided, this section became effective July 1, 2015.

Study Medicaid Coverage for Visual Aids (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.6A)

Sec. 12H.6A of S.L. 2015-241 requires the Division of Medical Assistance, Department of Health and Human Services, in consultation with the Department of Public Safety, to submit a report to the General Assembly by March 1, 2016, analyzing the fiscal impact to the State of reinstating Medicaid coverage for visual aids under a contract with the Department of Public Safety for fabrication of the eyeglasses at Nash Optical Plant Optical Laboratory.

This section became effective July 1, 2015.

Assessments (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.7)

Sec. 12H.7 of S.L. 2015-241 clarifies that assessments paid by hospitals under the Hospital Provider Assessment Act are not allowable costs for purposes of reimbursement through cost settlement, in accordance with existing language in the Medicaid State Plan.

This section became effective July 1, 2015.

Administrative Hearings Funding (SL 2015- 241/ H97 - 2015 Appropriations Act, Sec. 12H.9)

Sec. 12H.9 of S.L. 2015-241 directs the transfer of $2 million over the next two fiscal years from the Division of Medical Assistance in the Department of Health and Human Services (DHHS) to the Office of Administrative Hearings (OAH). This money must be allocated by OAH for mediation services provided for Medicaid applicant and recipient appeals and to contract for other services necessary to conduct the appeals process. OAH must continue the Memorandum of Agreement with DHHS for provision of these services and the MOA will facilitate DHHS's ability to draw down federal Medicaid funds to support this administrative function.

This section became effective July 1, 2015.

Requiring LME/MCOs to Make Intergovernmental Transfers (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.8)

Sec. 12H.8 of S.L. 2015-241 requires the LME/MCOs to make intergovernmental transfers to the Division of Medical Assistance, Department of Health and Human Services in an aggregate amount of $17,236,985 in each year of the 2015-2017 fiscal biennium. The amount of the intergovernmental transfer that an individual LME/MCO is required to make in each

fiscal year is $17,236,985 multiplied by the individual LME/MCO's percentage of the total Medicaid cash on hand of all of the LME/MCOs in the State.

This section became effective July 1, 2015.

Miscellaneous Health Choice Provisions (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.14)

Sec. 12H.14 of S.L. 2015-241 makes the following changes to the NC Health Choice for Children program:

- Repeals the statute which allows an enrollee in the program who loses eligibility due to an increase in family income above 200% of the federal poverty level and up to and including 225% of the federal poverty level to purchase at full premium cost continued coverage under the program for up to one year.
- Repeals the statute which provides that no State or federal funds can be used to cover or offset the cost of purchased continued coverage.
- Amends the statutes to provide that enrollees in the program may now be subject to a lifetime maximum benefit limit set forth in Medicaid and NC Health Choice medical coverage policies under the procedures for changing a medical policy set forth in statute.
- Provides that any State plan amendments required to implement this section are not subject to the 90-day prior submission requirements under current law.

This section became effective September 18, 2015.

Reinstate Cost Settlement Pursuant to 1993 State Agreement (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.17)

Sec. 12H.17 of S.L. 2015-241, as amended by Sec. 4.7 of S.L. 2015-268, provides that effective October 1, 2015, the cost settlement for outpatient Medicaid services performed by Vidant Medical Center, previously known as Pitt County Memorial Hospital, must be at 100% of allowable costs, and any State Plan amendments required to implement this section are not subject to the 90-day prior submission requirement under current law.

This section became effective July 1, 2015.

Drug Reimbursement Using Average Acquisition Cost (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.19)

Sec. 12H.19 of S.L. 2015-241 delays the effective date that the Medicaid program must utilize the average acquisition cost methodology for drug reimbursement. The effective date is delayed from January 1, 2015 to January 1, 2016.

This section also raises the average dispensing fee for drugs that are reimbursed using the average acquisition cost methodology to a weighted average fee of no more than $12.40 per prescription and requires actual dispensing fees to be lower for generic and preferred drugs and higher for brand and nonpreferred drugs.

This section became effective July 1, 2015.

Medicaid Dental Service Cost Settlement (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.20)

Sec. 12H.20 of S.L. 2015-241 requires the Department of Health and Human Services, Division of Medical Assistance, to submit a State Plan amendment request to the Centers for Medicare and Medicaid Services to ensure that all State-operated dental schools receive

the same reimbursement for dental services provided to North Carolina Medicaid beneficiaries. The State Plan amendment required by this section is not subject to the 90-day submission requirement under current law.

This section became effective July 1, 2015.

Mobile Dental Provider Enrollment (SL 2015- 241/ H97 - 2015 Appropriations Act, Sec. 12H.21)

Sec. 12H.21 of S.L. 2015-241 provides that the Department of Health and Human Services, Division of Medicaid Assistance, must require that as a condition of enrollment or reenrollment mobile dental providers show proof of a contractual affiliation with a dental practice that is not mobile and use the National Provider Identifier of the nonmobile dental practice for filing claims.

This section became effective September 18, 2015.

Increase Rates for Private Duty Nursing (SL 2015-241/H97 - 2015 Appropriations Act, Sec. 12H.22)

Sec. 12H.22 of S.L. 2015-241 requires the Department of Health and Human Services, Division of Medical Assistance, to increase the rate paid for private duty nursing services by 10%, effective January 1, 2016. Any State Plan amendments required to implement this section are not subject to the 90-day prior submission requirement under current law but must be submitted by January 1, 2016.

This section became effective July 1, 2015.

Restricting Graduate Medical Payments (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.23)

Sec. 12H.23 of S.L. 2015-241, as amended by Sec. 88 of S.L. 2015-264, discontinues Medicaid reimbursement for graduate medical education as an add-on to claims payments for Medicaid inpatient hospital services in order to establish a single statewide base rate for those services.

This section became effective July 1, 2015.

Medicaid Contingency Reserve (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.28)

Sec. 12H.28 of S.L. 2015-241 directs that funds reserved in the Medicaid Contingency Reserve in the 2014 budget shall be used only in the event of a Medicaid budget shortfall during the 2015-2016 fiscal year. This section states the General Assembly's intent to appropriate the funds only if the Director of the State Budget has (i) identified a Medicaid budget shortfall after the State Controller has verified that receipts are being used appropriately and (ii) submitted a report to the Fiscal Research Division containing the amount of the shortfall and an analysis.

This section became effective July 1, 2015.

Medicaid Transformation Fund (SL 2015- 241/ H97 - 2015 Appropriations Act, Sec. 12H.29)

Sec. 12H.29 of S.L. 2015-241 establishes the Medicaid Transformation Fund as a special fund in the Office of State Budget and Management for the purpose of providing funds to

convert the Medicaid payment system from a fee-for-service system to a capitated payment system.

This section became effective July 1, 2015.

Amend Cost Settlement of Local Health Departments (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.30)

Sec. 12H.30 of S.L. 2015-241, as amended by Sec. 89 of S.L. 2015-264, requires the Department of Health and Human Services, Division of Medical Assistance, to submit a Medicaid State Plan amendment request to the Centers for Medicare and Medicaid Services to amend the annual cost settlement methodology for local health departments to maximize identification of allowable Medicaid costs and to assure that North Carolina is receiving the maximum federal reimbursement for local health departments' treatment of Medicaid-eligible patients consistent with Medicare reimbursement principles.

This section became effective October 1, 2015.

Medicaid Transformation and Reorganization (SL 2015-245/ H372)

S.L. 2015-245 requires transformation of the Medicaid and NC Health Choice programs in the following ways:

- Requires transition of the current Medicaid and NC Health Choice service delivery system to capitated contracts with Prepaid Health Plans (PHPs).
- Creates a new Division of Health Benefits (DHB) within the Department of Health and Human Services (DHHS) to plan and implement transformation of the programs.
- Creates a new Joint Legislative Oversight Committee on Medicaid and NC Health Choice (Medicaid Oversight Committee) to oversee the programs and the transformation process and outlines specific dates for DHHS to report to the Committee.

Key components of the transition to capitated contracts with PHPs include the following:

- The entities eligible for a PHP contract are provider-led entities (PLEs) and commercial plans (CPs). Both PLEs and CPs must meet solvency criteria developed by the Department of Insurance to be eligible for a capitated PHP contract.
- PHPs will receive capitated per-member per-month payments to provide all covered services for their enrolled beneficiaries.
- Geographical coverage of PHPs will include statewide and regional plans. Statewide contracts will be awarded to 3 PHPs, and up to 10 regional contracts may be awarded to PLEs in 6 regions, which will be defined by the new Division of Health Benefits and will cover the entire State.
- Populations covered by the PHPs will include all Medicaid and Health Choice beneficiaries, except beneficiaries who are dually eligible for Medicare and Medicaid.
- Services covered by the PHPs will include all services, except for dental services, and except that local management entities/managed care organizations (LME/MCO) services will be provided through existing arrangements during the first 4 years of capitated PHP contracts. The primary care case management function provided by Community Care of North Carolina (CCNC) will transition to PHPs.
- The timeline for implementation requires that capitated payments under PHP contracts will begin 18 months after approval of the plan by the federal government, with submission of documents to the federal government required by June 1, 2016.

The new law pertaining to the appointment process and term of office for the Director of the Division of Health Benefits becomes effective January 1, 2021; the effective date of the new law

requiring a cooling- off period for certain DHHS employees is November 1, 2015; and the remainder of the act became effective September 23, 2015.

MENTAL HEALTH/ SUBSTANCE USE/ DEVELOPMENTAL DISABILITIES

Burt's Law (SL 2015-36/ S445)

S.L. 2015-36 enhances protections for clients of facilities whose primary purpose is to provide services for the care, treatment, habilitation, and rehabilitation of individuals with mental illness, developmental disabilities, or substance abuse disorders.

This act increases punishments for client abuse, exploitation, or neglect; imposes a reporting requirement on employees and volunteers who witness a sexual offense or offense against morality perpetrated against a client; and makes the failure to report these violations a Class A1 or Class 1 misdemeanor.

Also, this act adds a requirement that the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services (the Commission) establish standardized procedures to train and keep records of the measures used to comply with the employee and volunteer reporting requirements in G.S. 122C-66.

The section of the act pertaining to the duties of the Commission became effective May 26, 2015. The remainder of this act became effective December 1, 2015, and applies to offenses committed on or after that date.

Achieving a Better Life Experience Act (SL 2015-203/ H556)

S.L. 2015-203 authorizes the establishment of the Achieving a Better Life Experience (ABLE) Trust Fund, administered by the ABLE Board of Trustees, to assist and encourage the contribution of private funds to accounts from which specified expenses may be paid for individuals with disabilities.

This act became effective August 11, 2015.

Expand Community Living Housing Fund Uses (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 25A.1)

Section 25A.1 of S.L. 2015-241 amends the law pertaining to the Community Living Housing Fund to allow the Housing Finance Agency to use monies in the Fund to recruit property owners who are willing to rent targeted units to individuals with disabilities.

This section became effective July 1, 2015.

Department of Health and Human Services Reporting on Initiatives to Reduce State Psychiatric Hospital Use (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12F.1(f))

Sec. 12F.1.(f) of S.L. 2015-241 directs the Department of Health and Human Services (DHHS) to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by December 1, 2016, and December 1, 2017, on the following:

- A uniform system for beds or bed days purchased during the preceding fiscal year from (i) funds appropriated in the budget designated for this purpose; (ii) existing State

appropriations; and (iii) local funds.

- Other DHHS initiatives funded by State appropriations to reduce State psychiatric hospital use.

This subsection became effective July 1, 2015.

Single Stream Funding for MH/DD/SAS Community Services (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12F.2, as amended)

Sec. 12F.2 of S.L. 2015-241, as amended by Sec. 4.8 of S.L. 2015-268, directs the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), to reduce its allocation for single stream funding in fiscal year 2015-2016 and fiscal year 2016-2017. This section directs DMH/DD/SAS to allocate this reduction among the local management entities/managed care organizations (LME/MCOs) based on the individual LME/MCO's percentage of the total cash on hand of all of the LME/MCOs in the State. This section requires each LME/MCO to provide at least the same level of services paid for by single stream funding during the 2014-2015 fiscal year during each year of the biennium.

In the event of a Medicaid budget surplus in either year of the biennium, then the amount of the surplus, not to exceed $30,000,000 in each year, may be used to offset these reductions.

This section also contains monthly reporting requirements and a requirement that the Department establish a maintenance of effort (MOE) spending requirement for all mental health and substance abuse services which must be maintained using non-federal, State appropriations on an annual basis in order to meet MOE requirements for federal block grant awards. LME/MCOs shall ensure the MOE spending requirement is met using State appropriations.

This section became effective July 1, 2015.

Community Paramedic Mobile Crisis Management Pilot Program (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12F.8)

Sec. 12F.8 of S.L. 2015-241 directs the Department of Health and Human Services (DHHS) to develop an evaluation plan for the Department's community paramedic mobile crisis management pilot program based on a U.S. Department of Health and Human Services evaluation tool. By November 1, 2016, DHHS must submit its final report to the Joint Legislative Oversight Committee on Health and Human Services that includes: (i) an updated version of the evaluation plan; (ii) an estimate of the cost to expand the program incrementally; (iii) an estimate of any potential savings of State funds associated with expansion of the program; and (iv) if expansion of the program is recommended, a time line for expanding the program.

This section became effective July 1, 2015.

Joint Study of Justice and Public Safety and Behavioral Health (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12F.10)

Sec. 12F.10 of S.L. 2015-241 requires the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety to each appoint a subcommittee to study the intersection of Justice and Public Safety and behavioral health. The subcommittees must meet jointly to study and report on: (i) the impact of the Justice Reinvestment Act on the State's behavioral health system; (ii) the impact of mental illness and substance abuse on county law enforcement agencies; (iii) the impact of

judicial decisions on the State's behavioral health and social services system; and (iv) any other issues the subcommittees jointly deem appropriate. Each subcommittee must submit a report of its findings and recommendations to its respective committee.

This section became effective July 1, 2015.

LME/MCO Use of Funds to Purchase Inpatient Alcohol and Substance Abuse Treatment Services - Report (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12F.12)

Sec. 12F.12 of S.L. 2015-241 establishes the intent of the General Assembly to terminate all direct State appropriations for State-operated alcohol and drug abuse treatment centers (ADATCs) beginning with the 2015-2016 fiscal year and to appropriate funds to the Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. This change allows local management entities/managed care organizations (LME/MCOs) to assume responsibility for publicly funded substance abuse services, including inpatient services through the ADATCs. The section specifies the use of funds appropriated to the DHHS for the 2015-2016 fiscal year, the 2016-2017 fiscal year, and beyond.

DHHS must develop and report on a plan to allow the ADATCs to remain 100% receipt supported. The report must include an evaluation of (i) other community-based and residential services that could be provided by the ADATCs and (ii) potential funding sources. The report must be provided to the Joint Legislative Oversight Committee on Health and Human Services by March 1, 2016.

This section became effective October 1, 2015. On October 1, 2015, all direct State appropriations for ADATCs were terminated and the ADATCs are 100% receipt-supported.

Report on Multiplicative Auditing and Monitoring of Certain Service Providers (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12F.14)

Sec. 12F.14 of S.L. 2015-241 requires the Department of Health and Human Services to report by December 1, 2015, to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the status of multiplicative auditing and monitoring of specified provider agencies. The report must include all provider agencies under the Division of Mental Health, Developmental Disabilities and Substance Abuse Services that have been nationally accredited through a recognized national accrediting body and must include the following: (i) all group home facilities licensed under statute, (ii) a complete list of all auditing and monitoring activities to which the services providers are subject, and (iii) recommendations on the removal of all unnecessary regulatory duplication to enhance efficiency.

This section became effective July 1, 2015.

Standardized LME/MCO Out-of-Network Agreements (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.3)

Sec. 12H.3 of S.L. 2015-241 requires the Department of Health and Human Services (DHHS) to ensure that LME/MCOs utilize an out-of-network agreement that contains standardized elements developed in consultation with LME/MCOs. The out-of-network agreement is to be a streamlined agreement between a single provider of behavioral health or intellectual/ developmental disability (IDD) services and an LME/MCO to ensure access to care in accordance with State and federal laws and regulations and reduce administrative burden on the provider.

Beginning November 1, 2015, LME/MCOs are required to use the out-of-network agreement in lieu of a comprehensive provider contract when all of the following conditions are met:

- The services requested are medically necessary and cannot be provided by an in-network provider.
- The behavioral health or IDD provider's site of service delivery is located outside of the geographical catchment area of the LME/MCO, and the LME/MCO is not accepting applications or the provider does not wish to apply for membership in the LME/MCO closed network.
- The behavioral health or IDD provider is not excluded from participation in the Medicaid program, the NC Health Choice program, or other State or federal health care program.
- The behavioral health or IDD provider is serving no more than two enrollees of the LME/MCO, unless the agreement is for inpatient hospitalization, in which case the LME/MCO may, but is not required to enter into more than five such out-of-network agreements with a single hospital or health system in any 12-month period.

This section became effective July 1, 2015.

Traumatic Brain Injury Medicaid Waiver (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12H.6)

Sec. 12H.6 of S.L. 2015-241 directs the Divisions of Medical Assistance and Mental Health, Developmental Disabilities, and Substance Abuse Services within the Department of Health and Human Services (DHHS) to submit a request to the Centers for Medicare and Medicaid Services for approval of the 1915(c) waiver for individuals with traumatic brain injury (TBI) that DHHS designed and which the Joint Legislative Oversight Committee on Health and Human Services (HHS Oversight) recommended in its 2014 report to the General Assembly. DHHS must report to HHS Oversight on the status of the Medicaid TBI waiver request and the plan for implementation on both December 1, 2015, and March 1, 2016. The reports must include: (i) the number of individuals served under the waiver and the total number of individuals expected to be served; (ii) the expenditures to date and a forecast of future expenditures; and (iii) any recommendations regarding expansion of the waiver. This section provides that the waiver and State Plan amendments required to implement this waiver are not subject to the 90- day prior submission requirement under the law governing amendments to Medicaid State Plan and Medicaid waivers.

This section became effective July 1, 2015.

Expansion of Pilot Study on Use of Electronic Supervision Devices at Facilities for Children and Adolescents Who Have Primary Diagnosis of Mental Illness (SL 2015-264/ S119 - GSC Technical Corrections 2015, Sec. 91.4.(a)-(b))

Sec. 91.4.(a) and (b) of S.L. 2015-264 expand the pilot program established by the Department of Health and Human Services, Division of Health Service Regulation to study the use of electronic supervision devices as an alternative means of supervision during sleep hours at facilities for children and adolescents who have a primary diagnosis of mental illness and/or emotional disturbance to residential treatment staff secure facilities that are currently owned or operated with the facility currently authorized to waive the requirements, rules, or regulations setting minimum overnight staffing requirements.

These sections became effective October 1, 2015 and expire on June 30, 2016.

Eliminate Publication/Access North Carolina Travel Guide (SL 2015-264/ S119 - GSC Technical Corrections 2015, Sec. 87)

Sec. 87 of S.L. 2015-264 repeals Sec 12F.17 of S.L. 2015-241 and amends the law on right of access to and use of public places by persons with disabilities (G.S. 168-2). Instead of repealing the entire statute, this section amends the statute to remove the requirement that the Department of Health and Human Services develop, print, and promote the publication ACCESS NORTH CAROLINA and the requirement that the Department of Commerce promote the publication and identify travel attractions that should be included in the publication.

This section became effective October 1, 2015.

Status for Providers of MH/DD/SA Services Who Are Nationally Accredited (SL 2015-286/ H765 - Regulatory Reform Act of 2015, Sec. 3.7)

Sec. 3.7 of S.L. 2015-286 amends G.S. 122C-81 to allow the Secretary of the Department of Health and Human Services, in accordance with rules adopted by the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services, to exempt a provider that is nationally accredited and in good standing with the national accrediting agency from undergoing any routine monitoring that is duplicative of the oversight by the national accrediting agency.

This section became effective October 22, 2015.

PUBLIC HEALTH, RURAL HEALTH & COMMUNITY HEALTH

Clarifying the Good Samaritan Law (S.L. 2015-94/S154)

S.L. 2015-94 does the following:

- Imposes additional statutory requirements that must be met before a person can receive immunity from criminal prosecution when seeking medical attention for someone suffering from a drug- or alcohol- related overdose.
- Prohibits arresting a person or revoking a person's pretrial release, probation, parole or post-release based on an offense for which that person is entitled to statutory immunity.
- Grants immunity from civil liability to law enforcement officers who, in good faith, arrest or charge persons later found to be entitled to statutory immunity.
- Provides that nothing in G.S. 90-96.2 bars admission of evidence of crimes by a person not entitled to immunity, limits seizure of evidence or contraband otherwise permitted by law, limits a law enforcement officer's authority to detain or take into custody a person during an arrest for or investigation of offenses other than those for which limited immunity is provided in G.S. 90-96.2, or limits a probation offer's authority to conduct drug testing on persons on pretrial release, probation, or parole.
- Amends the statutes governing the treatment of overdose with opioid antagonist to authorize pharmacists to dispense an opiate antagonist prescribed to a person at risk of experiencing an opiate-related overdose or to a family member, friend, or other person in a position to assist that person, and to grant pharmacists immunity from civil and criminal liability for dispensing an opiate antagonist pursuant to this authority.

This act became effective August 1, 2015, and applies to offenses committed on or after that date.

Food Stand Seating and Outdoor Food Service (SL 2015-104/ S7)

S.L. 2015-104 allows (i) effective October 1, 2015, a food stand to provide tables and seats for eight or fewer customers to use while eating or drinking on the premises and (ii) pushcarts or mobile food units to prepare and serve food on the premises provided they are based from a permitted commissary or restaurant that is located on the premises of a facility containing at least 3,000 permanent seats.

Except as otherwise provided, this act became effective June 24, 2015.

Regulate the Sale of E-Liquid Containers (SL 2015-141/ S 286)

S.L. 2015-141 creates a new statute to: (i) make it unlawful to sell e-liquid containers without child-resistant packaging; (ii) prohibit the sale of an e-liquid product containing nicotine unless the packaging states that the product contains nicotine; (iii) provide that violation of each of the foregoing prohibitions is a Class A1 misdemeanor; (iv) and provide that any person, firm, or corporation would be liable for damages as a result of selling e-liquid containers without child-resistant packaging and any required labeling. The new statute defines the following terms: 'child-resistant packaging;' 'e-liquid;' 'e-liquid container;' and 'vapor product.'

This act becomes effective December 1, 2015, and applies to offenses committed on or after that date.

Amend Septic Tank Requirements (S.L. 2015-147/H705)

S.L. 2015-147 both (i) broadens the types of septic tank systems that may serve as a replacement system in the case of failure of the original system to include innovative and accepted systems that are approved by rule and subject to certain conditions, and (ii) directs the Commission for Public Health to amend discrete rules for sand lined trench systems and the daily design flow for Saprolite systems.

This act became effective July 13, 2015.

HVAC Condensate and Wastewater (SL 2015-207/ H538 - Water and Sewer Service Related Changes, Sec. 6)

Sec. 6 of S.L. 2015-207 amends the public health laws to require public or community wastewater systems to provide for the collection of liquid condensate from residential heating and cooling systems.

This section became effective August 11, 2015.

Funds for Community Paramedicine Pilot Program (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12A.12)

Sec. 12A.12 of S.L. 2015-241 directs the Division of Central Management and Support of the Department of Health and Human Services (DHHS) to implement a community paramedicine pilot program that focuses on providing care that avoids (1) nonemergency use of emergency rooms and 911 services and (2) unnecessary admissions to health care facilities. The North Carolina Office of Emergency Medical Services must set the standards and eligibility requirements for community paramedic programs to participate in the pilot. DHHS will establish up to three program sites to implement the community paramedicine pilot program, one of which is the New Hanover Regional Emergency Medical Services. DHHS must submit

a final report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2016.

This section became effective July 1, 2015.

Rural Health Loan Repayment Programs and Renaming of Office of Rural Health and Community Care (SL 2015-241/ H97 - 2015 Appropriations Act, Sec. 12A.10 and 12A.16)

Sec. 12A.16 of S.L. 2015-241 renames the Office of Rural Health and Community Care, within the Division of Central Management and Support of the Department of Health and Human Services to the Office of Rural Health. Sec. 12A.10 of S.L. 2015-241 authorizes the Office of Rural Health to use funds appropriated in the act for loan repayment to medical, dental, and psychiatric providers practicing in State hospitals or in a rural or medically underserved community to combine with the Physician or Psychiatric Loan Repayment Programs or the Loan Repayment Initiative at State Facilities in order to achieve efficient and effective management of these programs.

These sections became effective July 1, 2015.

Report on Community-Focused Eliminating Health Disparities Initiative (CFEHDI) (SL 2015-241/ H97 - 2015 Appropriations Act, Sec.12E.3(d))

Sec. 12E.3(d) of S.L. 2015-241 requires the Department of Health and Human Services to submit a report on the Community-Focused Eliminating Health Disparities Initiative (CFEHDI) to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2017. The report must include specific activities undertaken by grantees to address large gaps in health status among North Carolinians who are African-American and other minority populations. The report must include the following:

- The entities that received CFEHDI grants-in-aid.
- The amount of funding awarded to each grantee.
- The minority populations served by each grantee.
- Which entities were involved in fulfilling the goals and activities of each grant-in-aid awarded and what activities were planned and implemented to fulfill the community focus of the CFEHDI program.
- How activities implemented by the grantee fulfilled the goal of reducing health disparities and the specific success in reducing particular incidences.

Infant mortality and low birth weight were added as chronic illnesses or conditions under the CFEHDI in Section 12F.3. Other illnesses and conditions under the CFEHDI are as follows: heart disease, stroke, diabetes, obesity, asthma, HIV/AIDS, and cancer.

This section became effective July 1, 2015.

Local Public Health Maintenance of Effort Monies (SL 2015-246/ H44 - Local Government Regulatory Reform 2015, Sec 2.5)

Sec. 2.5 of S.L. 2015-246 repeals the statute that requires that in order for a local health department to be eligible to receive State and federal public health funding from the Division of Public Health in the Department of Health and Human Services, the county or counties comprising the local health department must maintain operating appropriations to local health departments from local property tax receipts at levels equal to amounts appropriated in State fiscal year 2010-2011.

This section becomes effective July 1, 2016.

Local Review of Prototype Franchise Food Establishments (SL 2015-246/ H44 - Local Government Regulatory Reform 2015, Sec. 10)

Sec. 10 of S.L. 2015-246 provides that if the Department of Health and Human Services has reviewed and approved the plan for a prototype franchised or chain food establishment that approved plan may be used in any county of the State without further approval.

Upon request of the owner or operator, the local health department may review and suggest revisions, but any proposed revisions could not be used as a condition of receiving any permit from the local health department, county, or city in which the facility is to be located.

This section became effective September 23, 2015.

Clarify That When A New Permit or Transitional Permit Is Issued, Any Previous Permit For That Same Establishment In That Location Becomes Void (SL 2015-286/ H765 - Regulatory Reform Act of 2015, Sec. 3.8)

Sec. 3.8 of S.L. 2015-286 amends the public health law on the regulation of food and lodging establishments. Existing law requires that when ownership of an establishment is transferred or the establishment is leased, the new owner or lessee must apply for a new permit and may apply for a transitional permit. The changes in this section provide that upon issuance of a new permit or a transitional permit for the same establishment, any previously issued permit for an establishment in that location becomes void. The section does not prohibit issuing more than one owner or lessee a permit for the same location if (i) more than one establishment is operated in the same physical location and (ii) each establishment satisfies all of the rules and requirements provided by law. A "transitional permit" is defined as a permit issued upon the transfer of ownership or lease of an existing food establishment to allow the correction of construction and equipment problems that do not represent an immediate threat to the public health.

This section became effective October 22, 2015.

On-site Wastewater Amendments and Clarifications (SL 2015-286/H765 – Regulatory Reform Act of 2015, Sec. 4.14)

Sec. 4.14 of S.L. 2015-286 amends the statutes governing on-site wastewater systems to:

- Provide for an "engineered option permit" by which a licensed professional engineer may prepare signed and sealed drawings, specifications, plans, and reports for the design, construction, operation, and maintenance of an on-site wastewater system without requiring the oversight or approval of a local health department, and make conforming changes. The engineered option permit may not be utilized until such time as rules adopted by the Commission for Public Health (Commission) become effective.
- Authorize licensed soil scientists and licensed professional geologists to evaluate soil conditions and site conditions for proposed on-site wastewater systems.
- Require permitted systems with a design flow of less than 1,500 gallons per day to be operated by a certified Subsurface Water Pollution Control System Operator and authorize the Commission to establish standards, in addition to the requirement for a certified Subsurface Water Pollution Control System Operator, for systems with a design flow of 1,500 gallons or more per day.
- Direct the Commission, in consultation with stakeholders, to study and report on minimum on-site wastewater system inspection frequency as established in the Administrative Code

to evaluate the feasibility and desirability of eliminating duplicative inspections of on-site wastewater systems.
- Direct the Commission, in consultation with stakeholders, to study and report on the period of validity for improvement permits and authorizations for wastewater system construction and evaluate the costs and benefits of a range of periods of validity.
- Provide that any improvement permit or authorization for wastewater system construction that is in effect on October 22, 2015, which is scheduled to expire on or before July 1, 2016 will remain in effect until July 1, 2016.

This section became effective October 22, 2015. The Commission must adopt temporary rules for implementing the provisions that make statutory amendments by June 1, 2016, and adopt permanent rules for implementing the provisions that make statutory amendments by January 1, 2017.

Amend Approval of On-Site Wastewater Systems (SL 2015-286/H765 – Regulatory Reform Act of 2015, Sec. 4.15)

Sec. 4.15 of S.L. 2015-286 amends the statute pertaining to the approval of on-site wastewater systems technologies as follows:

- Renames "controlled demonstration system" as a "provisional wastewater system" and provides that a provisional system includes any system or component that is acceptable to the Department of Health and Human Services (DHHS) or has been approved by a nationally recognized certification body for at least one year.
- Repeals the law on "experimental systems."
- Amends the processes by which a wastewater system achieves either provisional or innovative wastewater system status.
- Repeals the law authorizing DHHS to form a technical advisory committee (I & E Committee) comprised of specialists who have training and expertise related to on-site subsurface wastewater systems to assist in evaluating applications for approval.
- Repeals the five-year warranty required for certain nitrification trenches for innovative or accepted wastewater systems handling untreated effluent.
- Makes conforming changes to the fee schedule for DHHS review or modification of wastewater systems.

This section also:

- Directs the Commission for Public Health (Commission) to review and amend rules to implement the changes described above.
- Directs the Commission to report, beginning January 1, 2016, and every quarter thereafter until all rules are adopted, on its progress in adopting and amending rules pursuant to the on-site wastewater provisions of this act to HHS Oversight and the Environmental Review Commission (ERC).
- Directs the Commission, in consultation with DHHS, local health departments, and industry stakeholders, to study the costs and benefits of requiring treatment standards above those that are established by nationally recognized standards, and report its findings and recommendations to HHS Oversight and the ERC on or before March 1, 2016.

This section became effective October 22, 2015.

Emergency Medical Service Personnel Technical Changes (SL 2015-290/ H327)

S.L. 2015-290 makes technical and conforming changes to the statutes governing the regulation of emergency medical personnel services to reflect new national standards and directs the North Carolina Medical Care Commission to amend its applicable rules consistent with the changes in the law.

The act became effective October 29, 2015.

PRESCRIPTION DRUGS

Allow Substitution of Biosimilars (SL 2015-27/ H195)

S.L. 2015-27 amends the North Carolina Pharmacy Practice Act by doing the following:

- Provides definitions for biological and interchangeable products.
- Allows for the substitution of an interchangeable biological product for a prescribed drug product.
- Requires communication between a pharmacist and prescriber under certain circumstances when a biological product is dispensed.
- Requires the Board of Pharmacy to maintain a list of biological products determined by the FDA
  to be interchangeable with a specific biological product.
- Extends the liability protection a pharmacist currently has for substituting a generic drug product for a prescribed drug product to the substitution of an interchangeable drug product for a prescribed drug product.

This act became effective October 1, 2015. The provisions of the act that require communication between a pharmacist and prescriber when a biological product is dispensed expire on October 1, 2020.

Create Permit Exemptions/Home Renal Products (SL 2015-28/ H437)

S.L. 2015-28 amends the North Carolina Pharmacy Practice Act to create a pharmacy permit exemption for dispensing and delivery of dialysate or drugs necessary to perform home renal dialysis; to allow pharmacies to ship medications for home use by patients with renal failure to dialysis facilities; and to create an exemption from device and medical equipment permits for home renal products.

This act became effective October 1, 2015.