2017

Substantive Enacted Legislation Pertaining to Health and Human Services

September 2017

Legislative Analysis Division, North Carolina General Assembly

2017 Substantive Enacted Legislation
Pertaining to Health and Human Services

This document provides summaries of substantive legislation pertaining to health and human services enacted during the 2017 Session of the 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.

The brief summaries contained in this document represent work products from the following Legislative Analysis Division staff members: Susan Barham, Jennifer Hillman, Theresa Matula, Jason Moran-Bates, and Gus Willis. A more thorough summary of most bills may be found on the NCGA website: http://www.ncleg.net/Legislation/Legislation.html

Subheadings:

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

SUMMARIES

DEPARTMENT OF HEALTH AND HUMAN SERVICES – GENERALLY

DHHS Coordination of Health Information Technology (S.L. 2017-57, Sec. 11A.1/ S257 – 2017 Appropriations Act)

Sec. 11A.1 of S.L. 2017-57 (SB 257) adds a new section (G.S. 143B-139.4D) to Article 3 of Chapter 143B to require the Department of Health and Human Services, in cooperation with the State Chief Information Officer, to coordinate health information technology policies and programs for the State. The Department's Chief Information Officer is responsible for avoiding duplication of efforts and for ensuring that each State agency, public entity, and private entity that undertakes health information technology activities uses great expertise and technical capability in a manner that supports State and national goals and includes specified responsibilities. Additionally, the Department, in cooperation with the Department of Information Technology, is required to establish and direct a health information technology management structure that is efficient, transparent, and compatible with the Office of the National Health Coordinator for Information Technology governance mechanism. Specific responsibilities are listed for the health information technology management structure.

This section became effective July 1, 2017.

Health Information Exchange Requirements and Study (S.L. 2017-57, Sec. 11A.5/ S257 – 2017 Appropriations Act)

Sec. 11A.5 of S.L. 2017-57 (SB 257) amends Session Laws and statutes pertaining to the Health Information Exchange (HIE) to specify when certain providers and entities must be connected to the HIE Network and to require a study of the State Health Plan related to the feasibility and appropriateness of providers and entities connecting to submit data.

Providers and Entities Connected to the HIE Network - Sec 12A.5(a)(1) of S.L. 2015-241 is amended to require specified providers and entities to be connected to the HIE network with regard to services rendered to Medicaid and other State-funded health care program beneficiaries and services paid for with Medicaid or other State-funded health care funds. The changes in the Session Law are also included as G.S. 90-414.4(a1) and require the following:

- By June 1, 2018, the following Medicaid service providers must be connected: Hospitals, Physicians, Physician Assistants, and Nurse Practitioners. (G.S. 90-414(a1)(1))
- By June 1, 2019, all other providers of Medicaid and State-funded health care services, except Prepaid Health Plans and local management entities/managed care organizations (LME/MCO) as detailed below, must submit demographic and clinical data. (G.S. 90-414(a1)(2))
- In accordance with S.L. 2015-245, Prepaid Health Plans must submit encounter and claims data by the commencement date of a capitated contract with the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services. By June 1, 2020, LME/MCOs must submit encounter and claims data. (G.S. 90-414(a1)(3))

The Department of Information Technology (DIT), in consultation with the Department of Health and Human Services (DHHS), may establish a process to grant limited extensions of time to providers and entities that demonstrate and on-going good faith effort to establish connection and begin data submission. Both Departments must review and decide on an extension request within 30 days. The process must include a presentation by the provider or entity on an expected time line for connection. No extension may be granted to: (i) a provider or entity that fails to provide information to both DIT and DHHS, or (ii) that would result in connecting to the HIE Network later than June 1, 2020. The statute is also amended to allow an exemption for providers for patient records that are subject to certain disclosure restrictions.

Sec. 11A.5(c)-(f) amend various statutory provisions related to the Health Information Exchange. Section 11A.5(g) requires DHHS to include as one of the terms and conditions of any contract it enters into, on or after the effective date, with a local management entity/managed care organization (LME/MCO) or Prepaid Health Plan (PHP), a requirement that the LME/MCO or PHP must comply with the provisions of G.S. 90-414.4.

State Health Plan Study - Sec. 11A.5(h) requires DHHS, DIT, and the Division in the Department of State Treasurer responsible for the State Health Plan for Teachers and State Employees, to conduct a joint study of:

- The feasibility and appropriateness of providers and entities, other than those specified in G.S. 90-414.4(a1)(1), connecting with and submitting demographic and clinical data through the HIE Network.
- The feasibility and appropriateness of providers and entities, other than those specified in G.S. 90-414.4(3), connecting with and submitting encounter and claims data through the HIE Network.

The study must examine at least six specified topics and a joint report must be submitted to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Information Technology by April 1, 2018.

This section became effective July 1, 2017.

Controlled Substances Reporting System Improvements (S.L. 2017-57, Sec. 11A.6/ S257 – 2017 Appropriations Act)

Sec. 11A.6 of S.L. 2017-57 (SB 257) appropriates $1.2 million dollars in recurring funds to the Department of Health and Human Services (DHHS), Division of Central Management and Support, for use in developing and implementing software via existing public-private partnerships with the Government Data and Analytics Center (GDAC) for the performance of advanced analytics within the Controlled Substances Reporting System (CSRS). Specifically, the funds are to be used to enhance reports authorized by statute, enhance the Department's ability to provide data to persons or entities authorized to receive information, aggregate relevant data sources, and enhance the Department's ability to generate and deploy advanced analytics to improve opioid prescribing practices, identify unusual prescribing patterns, and detect behavior indicative of misuse, addiction, or criminal activity.

DHHS must execute any contractual agreements and interagency data sharing agreements necessary to complete these improvements by December 1, 2017. To the extent allowable under federal and State laws and regulations, the Department of Information Technology must coordinate with DHHS to develop an interface between the CSRS and the Health Information Exchange (HIE) Network and leverage interfaces already developed

between the HIE Network and health care entities as a method of providing CSRS data, reports, and analytic outputs to health care practitioners and dispensers.

This section became effective June 28, 2017.

Data Analytics and Performance Enhancements (S.L. 2017-57, Sec. 11A.7/ S257 – 2017 Appropriations Act)

Sec 11A.7 of S.L. 2017-57 (SB 257) provides that any enhancement of the State's data analytics capabilities utilizing funds appropriated by the act to the Department of Health and Human Services, Division of Central Management and Support, are subject to applicable State laws requiring the analytics to be developed and implemented in collaboration with the Government Data Analytics Center.

This section became effective July 1, 2017.

Community Health Grant Program Changes (S.L. 2017-57, Sec. 11A.8/ S257 – 2017 Appropriations Act)

Sec. 11A.8 of S.L. 2017-57 (SB 257), as amended by Sec. 3.2 of S.L. 2017-197, increases funding for Community Health Grants by $7.5 million dollars annually. Each individual grant cannot exceed $150,000. The Office of Rural Health must create standard quality and outcome metrics for grant recipients and require grant recipients to report on their outcomes beginning July 1, 2018. This section requires that the funding must be used for the following purposes:

- Establishing four positions to support administration of the Community Health Grant Program. This section limits funding for positions to $200,000 in recurring funds.
- Providing $200,000 in recurring funds for administrative costs.
- Providing limitations specifying that grants must be awarded to community and rural health centers, local health departments, and school-based centers that: (1) provide primary and preventative services to uninsured or medically indigent populations, and (2) serve as a medical home increasing access to primary and preventative care, creating and integrating new services including dental, pharmacy, and behavioral health services, and increasing capacity and quality of care by replacing facilities, equipment, or technologies.
- Establishing a Primary Care Advisory Committee to develop a process for grading applications.

This section became effective July 1, 2017.

Rural Health Loan Repayment Programs (S.L. 2017-57, Sec. 11A.9/ S257 – 2017 Appropriations Act)

Sec. 11A.9 of S.L. 2017-57 (SB 257) requires the Office of Rural Health to combine loan repayment programs for physicians, psychiatrists, and those working at state facilities. The funds may be used to: (1) continue funding the State Loan Repayment Program for primary care providers, (2) expand State incentives for general surgeons in Critical Access Hospitals, and (3) include eligible providers who use telemedicine in rural and underserved areas.

This section became effective July 1, 2017.

Reduction of Funds for Purchased Services (S.L. 2017-57, Sec. 11A.10/ S257 – 2017 Appropriations Act)

Sec. 11A.10 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services (DHHS) to reduce spending for purchased services and prohibits DHHS from reducing any funding that impacts direct services or funding that supports the 2012 settlement agreement between the U.S. Department of Justice and the State of North Carolina related to the Americans with Disabilities Act.

This section became effective July 1, 2017.

Office of Program Evaluation Reporting and Accountability (S.L. 2017-57, Sec. 11A.11/ S257 – 2017 Appropriations Act)

Sec. 11A.11 of S.L. 2017-57 (SB 257) prohibits the Department of Health and Human Services (DHHS) from using any funds appropriated for the Office of Program Evaluation Reporting and Accountability (OPERA) for any purpose other than to establish and administer the OPERA. This section also requires DHHS to report to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2017, on the establishment of the OPERA including expenditures for the 2015-2016 fiscal year, steps taken to establish the OPERA, an organizational chart, a list of current and ongoing assessments and evaluations, and an explanation of any obstacles to establishing and operating the OPERA as required by law.

This section became effective July 1, 2017.

Contracting Specialist and Certification Program (S.L. 2017-57, Sec. 11A.12/ S257 – 2017 Appropriations Act)

Sec. 11A.12 of S.L. 2017-57 (SB 257) pertains to a provision in the 2016 budget bill (S.L. 2016-94) requiring the UNC School of Government, in collaboration with the Department of Health and Human Services (DHHS), to prepare a proposal for implementing and administering a contracting specialist training program for management-level personnel within DHHS. This section requires DHHS to submit the proposal to the Joint Legislative Oversight Committee on Health and Human Services by September 1, 2017, and specifies that the proposal must include a detailed description of the proposed program curriculum and cost estimates for implementation and administration of the program.

This section became effective June 28, 2017.

Competitive Grants/Nonprofit Organizations (S.L. 2017-57, Sec. 11A.14/ S257 – 2017 Appropriations Act)

Sec. 11A.14 of S.L. 2017-57 (SB 257) allocates funding for nonprofit organizations that provide services with State dollars. This section sets out the procedures and the requirements for organizations to receive funding. Funds awarded pursuant to this section, but not disbursed or encumbered at the end of each fiscal year, must remain available for expenditure and will not revert. This section specifically awards funds to Big Brothers Big Sisters, TROSA, and the Boys and Girls Clubs for dropout prevention programs.

Additionally, this section repeals the statute that authorizes the Secretary of Health and Human Services to receive requests for grants-in-aid from non-State agencies.

This section became effective July 1, 2017.

Final Report - Eastern Band of Cherokee Indians Assumption of Services (S.L. 2017-57, Sec. 11C.10/ S257 – 2017 Appropriations Act)

Sec. 11C.10 of S.L. 2017-57 (SB 257) repeals a provision in the 2015 budget bill (S.L. 2015-241) requiring the Department of Health and Human Services, Division of Social Services, to submit ongoing quarterly reports on the assumption of certain services by the Eastern Band of Cherokee Indians. This section instead requires the Division to submit a final report to the Joint Legislative Oversight Committee on Health and Human Services when implementation of the assumption of services is complete.

This section became effective July 1, 2017.

Ombudsman Changes - DHHS Study (S.L. 2017-103/ H248)

S.L. 2017-103 (HB 248) makes changes to the adult care home and nursing home community advisory committees and to the duties of the Office of the State Long-Term Care Ombudsman Program to conform to federal changes.

The act also requires the Department of Health and Human Services to study Public Law 113-51, HIV Organ Policy Equity (HOPE) Act, and the Final Safeguards and Research Criteria publication by the US Department of Health and Human Services and the National Institutes of Health, to determine any necessary public health safeguards, regulations, and statutory changes. The Department is required to submit findings and recommendations on any necessary changes related to the HOPE Act and the corresponding safeguards to the Joint Legislative Oversight Committee on Health and Human Services on or before January 1, 2018.

This act became effective July 12, 2017.

DHHS Recommend Telemedicine Policy - PSYPACT (S.L. 2017-133/ H 283)

S.L. 2017-133 (HB 283) requires the Department of Health and Human Services to: (1) study and recommend a telemedicine policy for the State, and (2) study the Psychology Interjurisdictional Compact (PSYPACT) and its impact on the delivery of psychology services via the telehealth model. On or before October 1, 2017, the Department is required to report findings and recommendations on a telemedicine policy and on PSYPACT to the Joint Legislative Oversight Committee on Health and Human Services.

The act became effective July 20, 2017.

CHILDREN

Rylan's Law/Family/Child Protection & Accountability Act (S.L. 2017-41/H630)

S.L. 2017-41 (HB 630) does the following:

- establishes social services regional supervision and collaboration;
- reforms the State child welfare system;
- improves accountability and state oversight of the child welfare system;
- requires written agreements, corrective action, and state intervention with social services departments;

- creates regional social services departments;
- establishes a child well-being transformation council to improve coordination, collaboration, and communication among child-serving agencies;
- establishes a pilot program to help youth in substitute care obtain drivers licenses;
- establishes a pilot program to authorize a waiver of the employment requirement for foster parents with children receiving intensive alternative family treatment;
- reduces the time a parent has to appeal from a termination of parental rights order;
- reduces the time for foster care licensure approval; and
- requires child protective service observation before physical custody of a child may be returned to a parent, guardian, custodian or caretaker from whom the child was removed.

This act has various effective dates. Please refer to the full summary at http://www.ncleg.net/ for greater detail.

NC Pre-K Programs/Standards for Four- and Five-Star Rated Facilities (S.L. 2017-57, Sec. 11B.1/ S257 – 2017 Appropriations Act)

Sec. 11B.1 of S.L. 2017-57 (SB 257) outlines eligibility, multiyear contracts, building standards, programmatic standards, NC Pre-K Committees, reporting, and audits for NC Pre-K.

- The Department of Health and Human Services (DHHS), Division of Child Development and Early Education (DCDEE), must continue implementing the NC Pre-K program and serving children who are four years of age on or before August 31 of the program year. The DCDEE shall establish income eligibility not to exceed 75% of the State median income, although up to 20% of the children enrolled may have family incomes in excess of income eligibility threshold if they have other designated risk factors. Children of military personnel are eligible for participation. Eligibility determinations may continue to be made by local education agencies and local NC Partnership for Children, Inc., partnerships. The DCDEE is not allowed to consider the health of a child as a factor for eligibility other than developmental disabilities or other chronic health issues.
- The DCDEE must require the NC Pre-K contractor to issue multiyear contracts for licensed private child care centers providing NC Pre-K classrooms.
- Except as provided in G.S. 110-91(4), private child care facilities and public schools operating NC pre-K classrooms must meet the building standards for preschool students required in G.S. 115C-521.1 and must adhere to all of the policies prescribed by the DCDEE regarding programmatic standards and classroom requirements.
- Local NC Pre-K committees must use the standard decision-making process developed by the DCDEE in awarding NC Pre-K classroom slots and selecting students.
- The DCDEE must report to the Joint Legislative Oversight Committee on Health and Human Services, the Office of State Budget and Management, and the Fiscal Research Division by March 15 of each year.
- NC Pre-K program administration by local partnerships is subject to financial and compliance audits.

This section became effective July 1, 2017.

State Agency Continued Collaboration on Early Childhood Education/ Transition from Preschool to Kindergarten (S.L. 2017-57, Sec. 11B.2/ S257 – 2017 Appropriations Act)

Sec. 11B.2 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services (DHHS), in consultation with the Department of Public Instruction (DPI), and others, to continue to collaborate on an ongoing basis in the development and implementation of a statewide vision and a comprehensive approach to early childhood education, birth through third grade, creating cross agency accountability with a comprehensive set of data indicators, including consideration of the NC Pathways to Grade-Level Reading. DHHS and DPI must submit a follow up report on the statewide vision to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee on or before January 1, 2018, and make subsequent annual reports as needed.

DHHS and DPI must also continue developing a standardized program to transition children from preschool to kindergarten and identify specified minimum methods and recommendations. DHHS must report on the development of the transition program by January 1, 2018 to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee.

This section became effective July 1, 2017.

Codify Certain Child Care Subsidy Provisions (S.L. 2017-57, Sec. 11B.6/ S257 – 2017 Appropriations Act)

Sec. 11B.6 of S.L. 2017-57 (SB 257) codifies child care subsidy provisions in Part 10C, Article 3, Chapter 143B of the General Statutes. The sections provide for the following: child care funds matching requirements, child care revolving loan, and an administrative allowance to county departments of social services for use in detecting fraud.

This section became effective July 1, 2017.

Child Care Subsidy Recipients to Cooperate with Child Support Services/ Demonstration Project (S.L. 2017-57, Sec. 11B.7/ S257 – 2017 Appropriations Act)

Sec. 11B.7 of S.L. 2017-57 (SB 257) requires a one-year statewide demonstration project in accordance with S.L. 2015-51 requiring a custodial parent or other relative or person with primary custody of a child receiving child care subsidy payments to cooperate with the county child support service program as a condition of receiving child care subsidy payments.

- The Department of Health and Human Services (DHHS), Division of Child Development and Early Education (DCDEE) and Division of Social Services (DSS) are required to implement the project beginning January 1, 2018, or 30 days from the date the US Department of Health and Human Services, Office of Child Care, approves the Child Care and Development Fund (CCDF) plan, whichever is later.
- The DCDEE and DSS must conduct the demonstration project in at least three counties, but no more than six, that represent three regions of the State in both urban and rural settings. In selecting counties, DCDEE and DSS must: (1) consider the various methods counties employ in receiving and processing child care subsidy applications and (2) compare data from the counties that participate in the demonstration project to counties to similarly sized and situated that do not participate.

- Components of the project and factors for evaluating the project are outlined in the section.
- The DCDEE and DSS are required to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than March 1, 2019, or if the plan is approved after January 1, 2018, no later than three months from the date the demonstration project is completed, whichever is later.

  This section became effective July 1, 2017.

Smart Start Early Literacy Initiative/ Dolly Parton Imagination Library (S.L. 2017-57, Sec. 11B.9/ S257 – 2017 Appropriations Act

Sec. 11B.9 of S.L. 2017-57 (SB 257) expands access to Dolly Parton's Imagination Library, an early literacy program that mails books on a monthly basis to children registered for the program. This section allows the North Carolina Partnership for Children to use up to two percent of the funding for program evaluation. The North Carolina Partnership for Children must report by March 1, 2018 to the Joint Legislative Oversight Committee on Health and Human Services on the success of the program.

This section became effective July 1, 2017.

Intensive Family Preservation Services Funding and Performance Enhancements (S.L. 2017-57, Sec. 11C.2/ S257 - 2017 Appropriations Act)

Sec. 11C.2 of S.L. 2017-57 (SB 257) requires the Intensive Family Preservation Services Program (IFPS) to provide services to children and families in cases of abuse, neglect and dependency where a child is at imminent risk of removal from the home. The IFPS program must be implemented statewide on a regional basis. This section sets out data collection and reporting requirements that the Department of Health and Human Services must require from that any program that receives funding for the purpose of IFPS.

This section became effective July 1, 2017.

Federal Child Support Incentive Payments (S.L. 2017-57, Sec. 11C.6 / S 257 – 2017 Appropriations Act)

Sec. 11C.6 of S.L. 2017-57 (SB 257) requires the North Carolina Child Support Services Section (NCCSS) of the Department of Health and Human Services to retain up to 15% of the annual federal incentive payments NCCSS receives from the federal government to enhance centralized child support services by: (1) consulting with county child support programs, (2) supplementing State expenditures with federal incentive payments for centralized child support services, and (3) developing rules for calculating and distributing the funds. NCCSS must allocate no less than 85% of federal incentive funds to the county child support services programs to improve effectiveness and efficiency of county child support services.

This section directs NCCSS to require the county child support services programs to submit an annual plan describing how federal incentive funding improves program effectiveness and efficiency and to report annually on the plan. NCCSS must report with any recommendations to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1 of each year.

This section became effective July 1, 2017.

Child Welfare System Changes (SL 2017-57, Sec. 11C-7/ S257 - 2017 Appropriations Act)

Sec. 11C.7 of S.L. 2017-57 (SB 257) directs the Division of Social Services (DSS), Department of Health and Human Services (DHHS), to implement the requirements of the federal Program Improvement Plan (Plan) to bring North Carolina into compliance with national standards for child welfare policy and practices and to report on the implementation and outcomes of the Plan to the Joint Legislative Oversight Committee on Health and Human Services semiannually on February 1 and August 1 until February 1, 2019.

This section also requires DSS and the county departments of social services to develop a model of oversight for the statewide strategic plan for child welfare services while supporting a county's abilities to meet performance standards outlined in the plan. Of the funds appropriated to DSS in each year of the 2017-2019 biennium for the child welfare program improvement plan, $60,000 in each fiscal year must be used by DSS, in collaboration with the North Carolina State Commission on Indian Affairs, to: i) recruit foster parents, ii) increase the number of foster homes for children who are members of a State-recognized tribe, and (iii) provide training for staff county departments of social services to ensure culturally appropriate service for children who are members of a State-recognized tribe.

Finally, this section directs DSS to continue toward the completion of the child welfare component of the North Carolina Families Accessing Services through Technology (NC FAST) system. It is the intent of the General Assembly that the child welfare component of the NC FAST system be operational by December 31, 2017. The Division must report on the child welfare component of the NC FAST system to the Joint Legislative Oversight Committee on Health and Human Services quarterly through April 1, 2019. Elements that must be included in the report are specified.

This section became effective July 1, 2017.

Successful Transition from Foster Care and Youth Permanency Innovation Initiative Technical Change (S.L. 2017-57, Sec. 11C.9/ S257)

Sec. 11C.9 of S.L. 2017-57 (SB 257) creates the Foster Care Transitional Living Initiative Fund to support a demonstration project by Youth Villages that provides transitional services for youth aging out of foster care. The goals of the demonstration project include: (1) improving outcomes for youth that transition from foster care through implementation of Transitional Living Services, (2) identifying cost savings in services provided to youth aging out of foster care, and (3) establishing an evidenced-based transitional living program available for all youth aging out of foster care.

This section also amends the purpose and powers of the Permanency Innovation Initiative Oversight Committee to broaden the committee's look at initiatives and oversight for programs that support foster care youth transitioning to adulthood.

This section became effective July 1, 2017.

Eckerd Kids and Caring for Children Angel Watch Program – Report on Use of Additional Funds (SL 2017-57, Sec. 11C.14/ S 257- 2017 Appropriations Act)

Sec. 11C.14 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services, Division of Social Services, to report on the use of additional funds provided by the 2017 Appropriations Act in continued support of the Eckerd Kids and Caring for Children's Angel Watch program. This foster care program serves children ages 0 to 10, who are not in the custody of a county department of social services and whose families are temporarily unable to care for them due to a crisis. The report must include the following:

- The number of families and children served by the program, including the counties in which the services are provided.
- The number of children who enter foster care within six months after their family participates in the program.
- A comparison of children with similar needs that do not participate in the program and the number of those children who enter into foster care.
- Any other matters deemed relevant.

On or before December 1, 2018, the Division is required to submit a report to the House and Senate Appropriations Committees on Health and Human Services and the Fiscal Research Division.

This section became effective July 1, 2017.

Funds for the North Carolina Child Treatment Program (S.L. 2017-57, Sec. 11F.1/ S257 – 2017 Appropriations Act)

Sec. 11F.1 of S.L. 2017-57 (SB 257) mandates that funds appropriated to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the North Carolina Child Treatment Program be used exclusively for the following purposes:

- To continue to provide clinical training and coaching to licensed clinicians on an array of evidence-based treatments and to provide a statewide platform to assure accountability and measurable outcomes;
- To maintain and manage a public roster of program graduates, linking high-quality clinicians with children, families, and professionals; and
- To partner with leadership within the State, local management entities/managed care organizations as defined in G.S. 122C-3, and the private sector to bring effective mental health treatment to children in juvenile justice and mental health facilities.

This section became effective July 1, 2017.

MEDICAID & HEALTH CHOICE

Health Analytics Program (S.L. 2017-57, Sec. 11A.4/ S257 – 2017 Appropriations Act)

Sec. 11A.4 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services to continue coordinating with the Government Data Analytics Center (GDAC) to develop and operationalize the Health Analytics Program for Medicaid claims analytics and population health management authorized by Sec. 12A.17 of S.L. 2015-241, as amended by Sec. 12A.7 of S.L. 2016-9, and in compliance with G.S. 143B-1385(c)(2)f. The purpose of the Health Analytics Program is apply analytics to Medicaid data in an effort to maximize health care savings and efficiencies, optimize positive health outcomes, and assist in the transition to the transformed North Carolina Medicaid and Health Choice programs.

This section became effective July 1, 2017.

Increase Access to Public Benefits for Older Dual Eligible Seniors (S.L. 2017-57, Sec. 11C.8/ S257 – 2017 Appropriations Act)

Refer to the Older and Disabled Adults section of this document for a summary of this item.

Medicaid Eligibility (S.L. 2017-57, Sec. 11H.1/ S257 – 2017 Appropriations Act)

Sec. 11H.1 of S.L. 2017-57 (SB 257) sets forth the same Medicaid eligibility income categories and thresholds as in the 2015 budget bill (S.L. 2015-241).

This section became effective July 1, 2017.

Medicaid Annual Report (S.L. 2017-57, Sec. 11H.2/ S257 – 2017 Appropriations Act)

Sec. 11H.2 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services, Division of Medical Assistance, to continue publishing the Medicaid Annual Report and accompanying tables on its website by December 31, following the end of each fiscal year.

This section became effective July 1, 2017.

Provider Application and Recredentialing Fee (S.L. 2017-57, Sec. 11H.3/ S257 – 2017 Appropriations Act)

Sec. 11H.3 of S.L. 2017-57 (SB 257) codifies the existing Medicaid provider application fee of $100, in addition to the federal required amount, which the Department of Health and Human Services, Division of Medical Assistance, must charge all Medicaid providers upon initial enrollment and at recredentialing every five years.

This section became effective July 1, 2017.

Volume Purchase Plans and Single-Source Procurement (S.L. 2017-57, Sec. 11H.6/ S257 – 2017 Appropriations Act)

Sec. 11H.6 of S.L. 2017-57 (SB 257) allows the Department of Health and Human Services, Division of Medical Assistance, to utilize volume purchase plans, single source procurement, or other contracting processes in order to improve cost containment.

This section became effective July 1, 2017.

Annual Issuance of Medicaid Identification Cards (S.L. 2017-57, Sec. 11H.7/ S257 – 2017 Appropriations Act)

Sec. 11H.7 of S.L. 2017-57 (SB 257) continues the requirement that the Department of Health and Human Services (DHHS) must issue Medicaid identification cards on an annual basis and requires DHHS to update its rules in accordance with this requirement.

This section became effective July 1, 2017.

Increase Personal Care Services Rate (S.L. 2017-57, Sec. 11H.12/ S257 – 2017 Appropriations Act)

Sec. 11H.12 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services, Division of Medical Assistance, to increase the rate paid for Medicaid personal care services and for in-home aide, respite care in-home aide, and personal care assistance services that are provided under the Community Alternatives Program for Children (CAP-C) waiver. The rate for these services is increased to $3.90 per 15-minute billing unit, which is equivalent to $15.76 per hour.

This section became effective July 1, 2017, and requires the rate increase begin January 1, 2018.

Retroactive Personal Care Services Payment (S.L. 2017-57, Sec. 11H.12A/ S257 – 2017 Appropriations Act)

Sec. 11H.12A of S.L. 2017-57 (SB 257) pertains to Medicaid reimbursement for personal care services provided to a Medicaid recipient before prior approval for the services has been requested. Before this provision, Medicaid policy has allowed prior approval for personal care services to be effective retroactively up to 10 days prior to the date prior approval was requested. This section extends the prior approval retroactive effective period to up to 30 days prior to the date prior approval was requested, which allows providers to receive Medicaid reimbursement for personal care services provided up to 30 days prior to requesting prior approval for the services.

This section became effective August 1, 2017, and applies to personal care services requests received on or after that date.

Graduate Medical Education Medicaid Reimbursement (S.L. 2017-57, Sec. 11H.13/ S257 – 2017 Appropriations Act)

Sec. 11H.13 of S.L. 2017-57 (SB 257) pertains to Medicaid reimbursement to hospitals for graduate medical education costs. A provision in the 2015 budget bill (S.L. 2015-241) imposed certain prohibitions on Medicaid reimbursement for graduate medical education costs.

This section directs that for the period July 1, 2017, through June 30, 2019, the Department of Health and Human Services, Division of Medical Assistance is not required to implement the prohibitions on reimbursement for graduate medical education that were required by the 2015 budget bill. This section states the General Assembly's intent to provide funding to continue the reimbursement for graduate medical education beyond the 2017-2019 fiscal biennium as part of the Medicaid transformation required by legislation passed in 2015. This section requires the Division of Medical Assistance to report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by January 1, 2018, on Medicaid spending for graduate medical education as well as other Medicaid spending.

This section became effective July 1, 2017.

Plan to Implement Coverage for Home Visits for Pregnant Women and Families with Young Children (S.L. 2017-57, Sec. 11H.14/ S257 – 2017 Appropriations Act)

Sec. 11H.14 of S.L. 2017-57 (SB 257) states the General Assembly's intent to provide Medicaid coverage for home visits consistent with the Nurse-Family Partnership model. This section requires the Department of Health and Human Services (DHHS) to develop a plan to implement this coverage and report the plan to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by November 1, 2017. The report must state whether DHHS intends to add this coverage pursuant to the authority granted under G.S. 108A-54(e) or whether additional appropriations are needed to implement the coverage.

This section became effective July 1, 2017.

Plan to Establish Medicaid Coverage for Ambulance Transports to Alternative Appropriate Care Locations (S.L. 2017-57, Sec. 11H.14A/ S257 – 2017 Appropriations Act)

Sec. 11H.14A of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services (DHHS) to develop a plan for adding Medicaid coverage for ambulance transports of Medicaid recipients in behavioral health crisis to behavioral health clinics, or other alternative appropriate care locations, instead of hospital emergency departments. DHHS must report its plan to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by December 1, 2017, and the report must state whether DHHS intends to add this coverage pursuant to the authority granted under G.S. 108A-54(e) or whether additional appropriations are needed to implement this coverage.

This section became effective July 1, 2017.

NC Tracks Enhancements to Prevent and Detect Fraud, Waste, and Abuse (S.L. 2017-57, Sec. 11H.15/ S257 – 2017 Appropriations Act)

Sec. 11H.15 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services to enhance the capability of the NC Tracks Medicaid Management Information System (MMIS) to detect and prevent fraud, waste, and abuse prior to the payment of claims. The new capability must be implemented using existing MMIS contracts no later than 150 days after the effective date of this section.

This section became effective June 28, 2017.

Medicaid Transformation Clarifying Changes (S.L. 2017-57, Sec. 11H.17/ S257 – 2017 Appropriations Act)

Sec. 11H.17 of S.L. 2017-57 (SB 257) clarifies language in the 2015 Medicaid transformation legislation that that exempts certain services provided or billed by Local Education Agencies and Child Developmental Services Agencies from being reimbursed through the capitated contracts with Prepaid Health Plans that are required as part of Medicaid transformation. Instead of being covered by Prepaid Health Plans, these exempted services will continue to be reimbursed as they are under the current system.

This section became effective July 1, 2017.

Prepayment Claims Review Modifications (S.L. 2017-57, Sec. 11H.19/ S257 – 2017 Appropriations Act)

Sec. 11H.19 of S.L. 2017-57 (SB 257) amends the statute governing the Medicaid prepayment claims review process, which allows the Department of Health and Human Services (DHHS) to require certain Medicaid providers to submit documentation related to billed claims for review before the provider can receive Medicaid reimbursement for the claims. Changes to the prepayment review process made in this section include:

- DHHS may keep providers on prepayment review for up to 24 months (increased from 12 months).
- Providers must submit a certain volume of claims during the review period in order to meet the standards for successful completion of the prepayment review program.
- If claims for services that were provided with the timeframe that the provider was on prepayment review are submitted after prepayment review has ended, those claims may still be subject to review prior to payment.
- Certain aspects of provider terminations and appeals resulting from prepayment review are clarified.

This section becomes effective October 1, 2017, and applies to providers who are placed on prepayment review on or after that date and to written notices provided to providers on or after that date.

Medicaid Eligibility Monitoring (S.L. 2017-57, Sec. 11H.20/ S257 – 2017 Appropriations Act)

Sec. 11H.20 of S.L. 2017-57 (SB 257) creates a new statute that requires the Department of Health and Human Services (DHHS) to review certain information for all Medicaid recipients quarterly to determine whether the recipient has had a change in circumstances that may make the recipient no longer eligible for Medicaid. Under the statute, DHHS must share the information about the change in circumstances with the relevant county departments of social services (DSS), and the statute provides a process that the county DSS must follow with regard to redetermining eligibility for recipients who are identified during the DHHS review.

This section specifies that DHHS may contract with vendors or enter into memoranda of understanding with other agencies to assist with this review.

The statute created by this section will become effective January 1, 2018. The remainder of the section became effective June 28, 2017.

Medicaid Eligibility Determination Timeliness Reporting (S.L. 2017-57, Sec. 11H.21/ S257 – 2017 Appropriations Act)

Sec. 11H.21 of S.L. 2017-57 (SB 257) codifies a requirement that the Department of Health and Human Services report annually to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice with certain data related to the timeliness of Medicaid eligibility determinations made by the county departments of social services. This reporting was initially required in the 2016 budget bill (S.L. 2016-94) for two years, and this section continues the reporting requirement on an ongoing basis.

This section became effective July 1, 2017.

Support Improvement in the Accuracy of Medicaid Eligibility Determinations (S.L. 2017-57, Sec. 11H.22/ S257 – 2017 Appropriations Act)

Sec. 11H.22 of S.L. 2017-57 (SB 257) enacts various provisions related to the accuracy of Medicaid eligibility determinations made by county departments of social services, including the following:

- It clarifies in statute that the Department of Health and Human Services (DHHS) administers the Medicaid program and delegates Medicaid eligibility determinations to the county departments of social services.
- It requires DHHS to report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by November 1, 2017, on progress made in response to the State Auditor's January 2017 Performance Audit regarding the accuracy of county Medicaid eligibility determinations.
- It creates a new set of statutes that require DHHS to annually audit all county departments of social services' Medicaid eligibility determinations based on standards for accuracy and quality assurance set by DHHS in consultation with the State Auditor and adopted in rule. For counties not meeting these standards, the statutes require a corrective action plan and allow DHHS to assume responsibility for determining eligibility if the plan is not completed.
- It requires DHHS to collaborate with the State Auditor to develop a plan of implementation of the annual audits required by statute and to report that plan to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2018.
- It codifies in statute the counties' financial responsibility for eligibility determination errors that are attributable to the county, which was previously established in an administrative rule.
- It requires DHHS to develop a NC FAST training and certification program that all county caseworkers must complete every three years. DHHS must report on the implementation of this program to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2018.

This section became effective June 28, 2017. The statute regarding the counties' financial responsibility for certain Medicaid eligibility determination errors applies to errors identified on or after June 28, 2017.

Medicaid Subrogation Rights Conforming Changes (S.L. 2017-57, Sec. 11H.23/ S257 – 2017 Appropriations Act)

Sec. 11H.23 of S.L. 2017-57 (SB 257) pertains to the Medicaid program's subrogation to a Medicaid beneficiary's right to recover from a third party in cases of personal injury or wrongful death, meaning that the Medicaid program may receive a share of a Medicaid beneficiary's recovery when Medicaid paid for services provided as a result of the injury. Medicaid subrogation is required by federal law, and changes to this federal law are scheduled to become effective October 1, 2017. The changes to federal law will require changes to the North Carolina Medicaid subrogation statute. This section amends the current North Carolina statute pertaining to Medicaid subrogation only if the changes to federal law take effect as planned on October 1, 2017. The changes to the North Carolina statute pertain to the amount of the lien that the Medicaid program has on the Medicaid beneficiary's recovery from a third party.

This section became effective July 1, 2017, and the changes required by the section will become effective if federal law changes take effect on October 1, 2017.

MENTAL HEALTH/DEVELOPMENTAL DISABILITIES/ SUBSTANCE ABUSE SERVICES

Strengthen Opioid Misuse Prevention (STOP) Act (S.L. 2017-74/ H 243)

S.L. 2017-74 (HB 243) makes the following changes to the laws governing the prescribing of controlled substances:

- Extends the statewide standing order for opioid antagonists to allow practitioners to prescribe an opioid antagonist to any governmental or nongovernmental agency (effective July 1, 2017).
- Designates certain Schedule II and III drugs as "targeted controlled substances and makes changes to the laws governing the prescribing of those targeted controlled substances to:
  - Require a physician assistant or nurse practitioners employed by pain clinics to personally consult with their supervising physician prior to prescribing the targeted controlled substance if the use of the targeted controlled substance will exceed 30 days (effective July 1, 2017).
  - Require electronic prescriptions for all targeted controlled substances not meeting certain exceptions (effective January 1, 2020).
  - Limit prescriptions for targeted controlled substances upon initial consultations for acute pain to no more than a five-day supply, unless the prescription is for post-operative acute pain relief immediately following a surgical procedure, in which case

the practitioner may not prescribe more than a 7-day supply (effective January 1, 2018).

- Require hospice and palliative care providers who prescribe a targeted controlled substance to provide oral and written information to the patient and the patient's family regarding the proper disposal of the targeted controlled substance (effective January 1, 2017).

- Clarifies the allowable funds for syringe exchange programs.
- Makes changes to the statutes governing the Controlled Substance Reporting System (CSRS) database including:
  - Requiring dispensers to report information required by statute to the CSRS database no later than the close of the next business day after the prescription is delivered (effective September 1, 2017).
  - Imposing a civil penalty upon dispensers for failing to report the information required within a reasonable time of being informed by DHHS that the required information is missing or incomplete (effective September 1, 2017).
  - Allowing the Department to notify practitioners and their respective licensing boards of prescribing behavior that (i) increases the risk of diversion of controlled substances, (ii) increases the risk of harm to the patient, or (iii) is an outlier among other practitioner behavior (effective July 1, 2017).
  - Requiring administrators of hospital emergency departments and acute care facilities to provide the Department with an annual list of delegates who are authorized to receive data on behalf of providers within the hospital (effective July 1, 2017).
  - Requiring dispensers to demonstrate to the satisfaction of the NC Board of Pharmacy that they are registered for access to the CSRS database within 30 days of initial or renewal licensure (effective June 29, 2017; applies to acts committed 30 days after State Chief Information Officer notifies the Revisor of Statutes that (i) upgrades to the CSRS database have been completed and (ii) the upgraded database is fully operational and connected to the statewide health information exchange).
  - Requiring practitioners to review the patient's preceding 12 month history in the CSRS database prior to initially prescribing a targeted controlled substance to a patient and again every 3 months afterward that the targeted controlled substance remains a part of the patient's medical care (effective June 29, 2017) applies to acts committed 30 days after State Chief Information Officer notifies the Revisor of Statutes that (i) upgrades to the CSRS database have been completed and (ii) the upgraded database is fully operational and connected to the statewide health information exchange).
  - Requiring dispensers to review the patient's preceding 12 month history in the CSRS database prior to dispensing a targeted controlled substance and document the review under certain circumstances (effective June 29, 2017) applies to acts committed 30 days after State Chief Information Officer notifies the Revisor of Statutes that (i) upgrades to the CSRS database have been completed and (ii) the upgraded database is fully operational and connected to the statewide health information exchange).

- Creating a CSRS Fund for the operation of the CSRS database (effective September 1, 2017).
- Requiring an annual report from the Department on data reported to the CSRS database (effective September 1, 2017).

➢ Amends language in the 2015 budget to facilitate the interstate connectivity of the CSRS database (effective July 1, 2017).

Single-Stream Funding for DMH/DD/SAS Community Services (S.L. 2017-57, Sec. 11F.2/ S257 – 2017 Appropriations Act)

Sec. 11F.2 of S.L. 2017-57 (SB 257), as amended by Sec. 4(a) of S.L. 2017-206, directs the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services (DHHS) to make single-stream funding payments to local management entities/managed care organizations (LME/MCOs) for behavioral health services on the third working day of each month of the year. This section also reduces the total amount of single-stream funding available to the Division in each year of the biennium compared to past budgets and directs the Division to allocate the reduction in funding among the LME/MCOs according to a prescribed schedule. By March 1, 2018, the Secretary of the Department of Health and Human Services may submit to the Joint Legislative Oversight Committee on Health and Human Services a proposal for any adjustments to the allocation of the recurring LME/MCO reductions. In the event of a Medicaid budget surplus in either year of the biennium, then the amount of the surplus, not to exceed $30 million in each year, may be used to offset the single-stream funding reductions required by this section.

This section also requires the following:

➢ LME/MCOs must offer the same level of service utilization as during the 2014-2015 fiscal year across the LME/MCO's catchment area.

➢ DHHS must establish an annual maintenance of effort (MOE) spending requirement for all mental health and substance abuse services, which the LME/MCOs must meet using State appropriations, in order to meet MOE requirements for federal block grant awards.

➢ DHHS must report certain financial information for all LME/MCOs monthly to the Joint Legislative Oversight Committee on Health and Human Services.

➢ Each quarter, beginning July 1, 2017, the Secretary of DHHS must evaluate all LME/MCOs relative to solvency standards developed by DHHS. If the Secretary determines that an LME/MCO is at risk of failing financially within two years, then a plan of corrective action for the LME/MCO must be created and implemented. By October 1, 2017, the Secretary of DHHS must submit a report to the Joint Legislative Oversight Committee on Health and Human Services on any LME/MCO that has been determined to be at risk of failing financially in accordance with this section.

This section became effective July 1, 2017.

Funds for Local Inpatient Psychiatric Beds or Bed Days (S.L. 2017-57, Sec. 11F.3/ S257 – 2017 Appropriations Act)

Sec. 11F.3 of S.L. 2017-57 (SB 257) continues a requirement that the Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities, and

Substance Abuse Services, use certain funds to purchase additional new or existing local inpatient psychiatric beds or bed days not currently funded through the local management entities/managed care organizations (LME/MCOs) for individuals who are medically indigent. This section allows DHHS to use up to ten percent (10%) of this funding to pay for facility-based crisis services and nonhospital detoxification services to any individual in need of the services regardless of whether the individual is medically indigent.

This section requires DHHS to report to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2018, and December 1, 2019, on the use of these funds.

This section became effective July 1, 2017.

Use of Funds to Purchase Inpatient Alcohol and Substance Use Disorder Treatment Services (S.L. 2017-57, Sec. 11F.4/ S257 – 2017 Appropriations Act)

Sec. 11F.4 of S.L. 2017-57 (SB 257) amends language pertaining to the use of funds for the purchase of inpatient alcohol and substance abuse treatment services from the 2015 budget to require that a minimum of 86% of the allotted funds be used exclusively to purchase inpatient alcohol and substance abuse treatment services from the Alcohol Drug Abuse Treatment Centers (ADATCs) in order to increase the availability of services through the ADATCs to individuals in need of opioid treatment. The LME/MCOs are required to use any remaining allocations to purchase inpatient alcohol and substance abuse treatment services from any qualified provider.

This section became effective July 1, 2017.

Use of Dorothea Dix Hospital Property Funds for the Purchase of Additional Psychiatric and Facility-Based Crisis Beds (S.L. 2017-57, Sec. 11F.5/ S257 – 2017 Appropriations Act)

Sec. 11F.5 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to utilize certain funds appropriated from the Dorothea Dix Hospital Property Fund to pay for renovation or building costs for constructing new licensed inpatient behavioral health beds or for converting existing inpatient acute care beds into licensed inpatient behavioral health beds. Certain portions of these funds must be used for beds at Caldwell/University of North Carolina Health Care in Caldwell County, Cape Fear Valley Medical Center in Cumberland County, Mission Health System in Buncombe County, Good Hope Hospital in Harnett County, and the Dix Crisis Intervention Center in Onslow County. Facilities that receive this funding are exempt from certificate of need review for establishing or expanding behavioral health services, including outpatient therapy services and substance use disorder services, as well as for replacing or relocating a behavioral health facility or for changing inpatient bed capacity. Facilities receiving this funding also must reserve fifty percent (50%) of the beds constructed or converted with these funds either for purchase by DHHS or for certain patients referred by local management entity/managed care organizations (LME/MCOs). DHHS must report to the Joint Legislative Oversight Committee on Health and Human Services annually beginning November 1, 2018, on the additional beds created by this funding and must submit by December 1, 2020, a plan for funding the operating costs of these beds from a source other than the Dorothea Dix Hospital Property Fund.

This section also provides funding to the Division to be used to award competitive grants for establishing up to two new facility-based crisis centers for children and adolescents.

This section became effective July 1, 2017.

Funds for Case Management Pilot Program (S.L. 2017-57, Sec. 11F.5A/ S257 – 2017 Appropriations Act)

Sec. 11F.5A of S.L. 2017-57 (SB 257) requires $2 million in nonrecurring funds for the 2017-18 fiscal year appropriated to the Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), to be allocated for the development and establishment of a two-year pilot program at a hospital in Wake County to support a hospital-based, comprehensive community case management program. DMH/DD/SAS, in consultation with LME/MCOs responsible for the management and provision of mental health, developmental disabilities, and substance abuse disorder services in Wake County under the 1915(b)(c) Medicaid Waiver must oversee the development and establishment of the pilot program to ensure it is designed to reduce avoidable emergency department readmissions and emergency department boarding times among individuals with behavioral health needs.

By December 1, 2020, DHHS must submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division, evaluating the effectiveness of the pilot program in reducing avoidable emergency department readmissions and emergency department boarding times among individuals with behavioral health needs.

This section became effective July 1, 2017.

Additions to the Strategic Plan for Improvement of Behavioral Health Services (S.L. 2017-57, Sec. 11F.6/ S257 – 2017 Appropriations Act)

Sec. 11F.6 of S.L. 2017-57 (SB 257) amends a provision in the 2016 budget bill (S.L. 2016-94) that directs the Department of Health and Human Services (DHHS) to develop and submit a statewide strategic plan for behavioral health services. This section adds a requirement that DHHS consider past and current studies and reports in development of the strategic plan. This section also directs DHHS to consider issues pertaining to the delivery of services for people with intellectual and developmental disabilities, which the 2016 budget bill previously had directed the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to study, in development of the strategic plan.

This section became effective July 1, 2017.

Mental Health/Substance Use Disorder Central Assessment and Navigation System Pilot Program (S.L. 2017-57, Sec. 11F.7/ S257 – 2017 Appropriations Act)

Sec. 11F.7 of S.L. 2017-57 (SB 257) establishes a two-year pilot program to focus on assessing and navigating individuals seeking mental health or substance use disorder services, or both, to appropriate community-based services or other community resources in order to reduce the utilization of hospital emergency department services for mental health and substance use disorder services. The pilot must be overseen by the Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), in consultation with the LME/MCO responsible for the

management and provision of mental health, developmental disabilities, and substance use disorder services in New Hanover County under the 1915(b)(c) Medicaid Waiver and is funded through $250,000 in nonrecurring funds for each of the 2017-18 and 2018-19 fiscal years.

The pilot is to be conducted at New Hanover Regional Medical Center (NHRMC) and at Wellness City, operated by Recovery Innovations, Inc., by a 3-person, centralized team consisting of the following individuals:

- A master's level, fully licensed clinician to perform comprehensive clinical assessments of NHRMC patients and other New Hanover County residents exhibiting symptoms of mental illness or substance use disorder who are referred to the pilot program.
- A qualified professional to assist patients, particularly those with a completed comprehensive clinical assessment, with identifying and accessing appropriate community-based services or other community resources.
- A North Carolina certified peer support specialist, with specialized training and personal experience in successfully managing his or her own serious mental illness or substance use disorder, to provide peer support services, including encouraging patients to take personal responsibility for managing their condition, assisting patients in establishing meaningful roles in society, and providing patients with transportation to and from appointments.

The LME/MCO responsible for the management and provision of mental health, developmental disabilities, and substance abuse services in New Hanover County, in collaboration with NHRMC and Recovery Innovations, Inc. must submit an interim report to DMH/DD/SAS by July 1, 2018, and to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2018. A final report must be provided to DMH/DD/SAS by July 1, 2019 and to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2019.

This section became effective July 1, 2017.

Traumatic Brain Injury Pilot Program (S.L. 2017-57, Sec. 11F.9/ S257 – 2017 Appropriations Act)

Sec. 11F.9 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to allocate $150,000 in nonrecurring funds in fiscal year 2017-18 and $300,000 in nonrecurring funds in fiscal year 2018-19 to develop and implement a traumatic brain injury pilot program designed to increase compliance with internationally approved evidence-based treatment guidelines for traumatic brain injury.

DHHS must establish up to three program implementation sites in trauma hospitals. Each program site will receive up to one hundred thousand dollars ($100,000) for the development and implementation of an interactive quality assessment and quality assurance clinical decision support tool. DHHS must contract with a private entity to assist participating trauma hospitals in implementing this tool.

By February 1, 2018, DHHS must submit a progress report on the development and implementation of the pilot program authorized by this section to the Joint Legislative Oversight

Committee on Health and Human Services and the Fiscal Research Division, with a final report being submitted no later than January 7, 2019.

This section became effective July 1, 2017.

Expansion and Renaming of Prescription Drug Abuse Advisory Committee (S.L. 2017-57, Sec. 11F.10/ S257 – 2017 Appropriations Act)

Sec. 11F.10 of S.L. 2017-57 (SB 257) codifies language creating the Prescription Drug Abuse Advisory Committee in the 2015 budget, renames the Committee the Opioid and Prescription Drug Abuse Advisory Committee, expands the committee to require representatives from the Divisions of Adult Correction and Juvenile Justice, Department of Public Safety, and requires the Fiscal Research Division receive a copy of the Department's annual reports in addition to the Joint Legislative Oversight Committees on Health and Human Services and Justice and Public Safety.

This section became effective July 1, 2017.

Funds to Address North Carolina's Opioid Crisis (S.L. 2017-57, Sec. 11F.14A/ S257 – 2017 Appropriations Act)

Sec. 11F.14A of S.L. 2017-57 (SB 257) requires funds awarded to the Department of Health and Human Services (DHHS) from the federal Substance Abuse and Mental Health Services Administration, Grant Number 1H79TI080257-01 Revised, pursuant to the Notice of Award dated April 26, 2017, to address North Carolina's opioid crisis to be used as follows:

- At least 80% of any such funds used during each fiscal year of the 2017-19 fiscal biennium must be used to increase access to treatment and recovery services for individuals with an opioid use disorder.
- Up to 15% of any such funds used during each fiscal year of the 2017-19 fiscal biennium may be used to increase access to opioid use prevention services.
- Up to 5% of any such funds used during each fiscal year of the 2017-19 fiscal biennium may be spent on administrative costs associated with implementing the above grant award.

DHHS must, at a minimum, achieve the following outcomes as a result of any funds spent:

- Increase the number of individuals receiving opioid use disorder treatment by 9% during each fiscal year of the 2017-19 biennium.
- Increase the capacity of Mediation-Assisted Treatment services by 5% during each year of the 2017-19 fiscal biennium.

DHHS must report specified data to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2018 and again by November 1, 2019 on the use of the funds.

This section became effective July 1, 2017.

Repeal of LME/MCO Clinical Integration Activities Report (S.L. 2017-57, Sec. 11F.16/ S257 – 2017 Appropriations Act)

Sec. 11F.16 of S.L. 2017-57 (SB 257) repeals a provision in the 2013 budget bill (S.L. 2013-360) requiring the Department of Health and Human Services to report semiannually to the Joint Legislative Oversight Committee on Health and Human Services on the progress, outcomes, and savings associated with clinical integration activities conducted by the local management entities/managed care organizations (LME/MCOs) and Community Care of North Carolina (CCNC).

This section became effective July 1, 2017.

Supplemental Short-Term Assistance for Group Homes (S.L. 2017-57, Sec. 11F.18A/ S257 – 2017 Appropriations Act)

Sec. 11F.18A of S.L. 2017-57 (SB 257) reinstates short-term State funding for group home residents who were eligible for Medicaid personal care services prior to January 1, 2013, who lost their eligibility for the services after that date, and who have continuously resided in a group home since December 31, 2012. The funding must be used to provide necessary supervision and medication management for these residents. This short-term funding was originally established in the 2013 budget bill (S.L. 2013-360) but ended on June 30, 2015. This section authorizes funding to continue through June 30, 2019.

This section became effective July 1, 2017.

Expand North Carolina Innovations Waiver Slots (S.L. 2017-57, Sec. 11H.11/ S257 – 2017 Appropriations Act)

Sec. 11H.11 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services, Division of Medical Assistance, to make an additional 400 slots available under the NC Innovations waiver beginning January 1, 2018.

This section became effective July 1, 2017.

PROVIDERS, FACILITIES & LICENSURE

Occupational Therapy Choice of Provider (S.L. 2017-24/H 208)

S.L. 2017-24 (HB 208) amends G.S. 58-50-30 to allow insureds to receive insurance-covered occupational therapy from the licensed occupational therapist of their choice.

The act becomes effective October 1, 2017, and applies to health benefits contracts issued, renewed, or amended on or after that date.

Enact Physical Therapy Licensure Compact (S.L. 2017-28/ H 57)

S.L. 2017-28 (HB 57) makes North Carolina a member of the Physical Therapy Licensure Compact. Membership in the compact allows physical therapists who hold licenses in good standing in another Compact state to practice physical therapy in North Carolina. Likewise, physical therapists holding a valid license in North Carolina are able to practice physical therapy

in another Compact member state. The Compact became effective April 25, 2017. The act also amends G.S. 93B-15.1 to prohibit occupational licensing boards (OLBs), as defined in G.S. 93B-1, from charging fees as a pre-requisite to issuing licenses to military-trained applicants and spouses of military members who are licensed in good standing in another state.

The provisions of the act pertaining to the Physical Therapy Licensure Compact will become effective October 1, 2017. The provisions of the act pertaining to OLBs became effective July 1, 2017.

Required Experience for DMH/DD/SAS QPs (S.L. 2017-32/ H 478)

S.L. 2017-32 (HB 478) requires the Department of Health and Human Services (DHHS) to amend the qualifications for Qualified Professionals in the mental health, developmental disabilities, and substance abuse services (DMH/DD/SAS) system of care to count all years of full-time DMH/DD/SAS experience toward the required number of years' experience, regardless of when the experience was obtained.

This act became effective June 8, 201; however, any changes to clinical coverage policies and any changes to rules adopted by DHHS relating to the qualifications of Qualified Professionals required in the act are not effective until DHHS has received CMS approval of the State Plan amendment required by this act.

Graduate Medical Funding for Cape Fear Valley Medical Center (S.L. 2017-57, Sec. 11A.13/ S257 – 2017 Appropriations Act)

Sec. 11A.13 of S.L. 2017-57 (HB 257) directs the Department of Health and Human Services, Division of Central Management and Support, to allocate up to $3 million dollars in recurring funds to be used to for graduate medical education to support the establishment of residency programs at the Cape Fear Medical Center (Center) affiliated with Campbell University School of Medicine.

The recurring amount of funds allocated to the Center will not exceed the lesser of: (1) the total amount of actual lost Medicare payments attributed to the Center's reclassification as a rural hospital prior to October 1, 2017, or (2) any other charge approved by CMS, up to a maximum of $3 million dollars.

No funds will be paid to the Center until the Office of State Budget and Management (OSMB) certifies: (1) the amount of actual lost Medicare payments, (2) that the Center has maintained approval from the Centers for Medicare and Medicaid Services (CMS) for reclassification as a rural hospital or rural referral center, and (3) the Center has maintained approval from the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for residency programs with at least 130 additional residency slots.

The Center must report on its progress in establishing residency programs to the House Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division no later than April 1, 2018.

Any funds not obligated to, or encumbered by, the Center by June 30, 2018, must revert to the General Fund.

This section became effective July 1, 2017.

Study Continuing Education for Health Care Providers Licensed to Prescribe Controlled Substances (S.L. 2017-57, Sec. 11F.11/ S257 – 2017 Appropriations Act)

Sec. 11F.11 of S.L. 2017-57 (SB 257) encourages the North Carolina Area Health Education Centers Program to report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by December 1, 2017 on the feasibility of providing a continuing education course for health care providers licensed to prescribe controlled substances in the State. The course would include instruction on at least all of the following:

- Controlled substance prescribing practices.
- Controlled substance prescribing for chronic pain management.
- Misuse and abuse of controlled substances.

This section became effective June 28, 2017.

Study on Statewide Expansion of the Wright School (S.L. 2017-57, Sec. 11F.12/ S257 – 2017 Appropriations Act)

Sec. 11F.12 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services to study and report to the Joint Legislative Oversight Committee on Health and Human Services on the feasibility and cost of, and any obstacles to, establishing additional State-operated facilities throughout the State to: (1) provide statewide access to best practice, cost-effective, residential mental health treatment to children, ages six to 12, with serious emotional and behavioral disorders and (2) support their families and communities by building the capacity to meet their children's special needs at home, at school, and within their local communities.

This section became effective July 1, 2017.

Facilities Included Under Single Hospital License (S.L. 2017-57, Sec. 11G.2/ S257 – 2017 Appropriations Act)

Sec. 11G.2 of S.L. 2017-57 (SB 257) amends G.S. 131E-77(e1) to remove "premises, buildings, outpatient clinics, and other locations" from the definition of what a hospital license issued by the Department of Health and Human Services may cover.

This section became effective June 28, 2017.

Moratorium on Special Care Unit Licenses (S.L. 2017-57, Sec. 11G.3/ S257 – 2017 Appropriations Act)

Refer to the Older & Disabled Adults section of this document for a summary of this item.

Joint Oversight Subcommittees on Medical Education and Residency Programs (S.L. 2017-57, Sec. 11J.2 / S257 – 2017 Appropriations Act)

Sec. 11J.2 of S.L. 2017-57 (SB 257) requires the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee to appoint subcommittees to jointly examine the use of State funds to support medical education

and medical residency programs. The subcommittees may seek input from other states, stakeholders, and national experts on medical education programs, medical residency programs, and health care.

By February 1, 2018, the Department of Health and Human Services and the University of North Carolina must provide the subcommittees the following information: (1) the identity, location, and number of positions available in medical education programs and medical residency programs, broken down by geographic area; (2) the specific amount of State funds or the nature of any other support provided by the State to medical education programs and medical residency programs, broken down by program; (3) the number of graduates of medical education programs and medical residency programs who are currently practicing in North Carolina, broken down by specialty areas in which North Carolina is experiencing a shortage; (4) the number of program graduates who practiced in North Carolina for at least five years after graduation; and (5) any other information requested by the subcommittees.

The subcommittees shall jointly develop a proposal for a statewide plan to support medical education programs and medical residency programs within North Carolina. Each subcommittee shall submit a report to its respective oversight committee on or before March 15, 2018, at which time each subcommittee will terminate.

This section became effective June 28, 2017.

Authorization for Chiropractic Preceptorships (S.L. 2017-57, Sec. 11J.3/ S257 – 2017 Appropriations Act)

Sec. 11J.3 of S.L. 2017-57 (SB 257) amends Article 8 of Chapter 90 of the General Statutes to establish a chiropractic preceptorship program where chiropractic students may observe licensed chiropractors and perform the duties of a certified chiropractic assistant while under the supervision of a licensed chiropractor.

This section became effective June 28, 2017.

The Pharmacy Patient Fair Practices Act (S.L. 2017-116/H 466)

S.L. 2017-116 (HB 466) permits pharmacists to discuss lower-cost alternative drugs with, and sell lower-cost alternative drugs to, consumers. It prohibits pharmacy benefits managers from using contract terms to prevent pharmacies from providing store-direct delivery services. Pharmacy benefits managers are also prohibited from charging insureds a co-pay that exceeds the total submitted charges by a network pharmacy. Finally, it allows pharmacy benefits managers to charge pharmacies a fee for costs related to claim adjudication only if the fee was set out in a contract or reported on the remittance advice of the claim.

This act will become effective October 1, 2017, and apply to all contracts entered into, renewed, or amended on or after that date.

Establish New Nurse Licensure Compact (S.L. 2017-140/ H 550)

S.L. 2017-140 (HB 550) enacts and makes North Carolina a member state in the new nurse licensure compact. It also repeals the current nurse licensure compact and replaces it with the new version.

This act will become effective the earlier of December 31, 2018, or the enactment of the new compact by the 26th state. The Board must report to the Revisor of Statutes when 26 states have enacted the compact.

Require Criminal Background Checks for Pharmacist Licensure (S.L. 2017-144/ S 104)

S.L. 2017-144 (SB 104) makes a number of technical changes to G.S. 90-85.15, which governs applications and requirements for licensure as a pharmacist, and mandates that the Board of Pharmacy require applicants for a pharmacy license to provide the Board with a criminal history report, at the applicant's expense, from a reporting service designated by the Board.

This act becomes effective January 1, 2018.

Reduce Cost and Regulatory Burden on Hospital Construction (S.L. 2017-174/S 42)

S.L. 2017-174 (SB 42) directs the North Carolina Medical Care Commission to adopt the recommendations of the American Society of Healthcare Engineers Facility Guidelines Institute.

This act became effective July 21, 2017, and applies to any licensee or prospective applicant who seeks to make specified types of alterations or additions to its hospital facilities, or to construct new hospital facilities, that submit plans and specifications to the Department of Health and Human Services on or after January 1, 2016.

Dental Plans Provider Contracts and Transparency (S.L. 2017-205/H 140)

S.L. 2017-205 (HB 140) makes entities that write stand-alone dental insurance subject to the disclosure and notification provisions for fee schedules, reimbursement policies, and claim submission policies contained in the health plans fee schedules. It clarifies that "household property" for the purposes of single interest credit property insurance includes household furniture, furnishings, appliances, and other personal property of a debtor, not including an automobile. It also requires credit insurance rate standards to be set every third year beginning January 1, 2018.

This bill was vetoed by the Governor on July 27, 2017. The veto was overridden on August 30, 2017. This act becomes effective October 1, 2017.

Change Membership of Medical Board (S.L. 2017/H 770)

Sec. 5 of S.L. 2017-206 (HB 770) amends the membership of the North Carolina Medical Board by changing the entities that appoint the public members. Previously the Governor appointed three public members. Under this act the Governor appoints one public member and the General Assembly appoints two public members. For the two public members appointed by the General Assembly, one member is upon the recommendation of the Speaker of the House of Representatives and one is upon the recommendation of the President Pro Tempore of the Senate. Additionally, new language is inserted to prohibit a public member from being a health care provider or the spouse of a health care provider.

This section became effective August 30, 2017, and applies to vacancies occurring after June 30, 2017.

PUBLIC HEALTH

Funds for School Nurses (S.L. 2017-57, Sec 11E.1/S257 – 2017 Appropriations Act)

Sec. 11E.1 of S.L. 2017-57 (SB 257) adds a new section (G.S. 130A-4.3) to Part 1, of Article 1, of Chapter 130A of the General Statutes directing the Department of Health and Human Services (DHHS) to distribute funds appropriated for the School Nurse Funding Initiative to local health departments according to a formula that includes: (1) school nurse-to-student ratio, (2) the percentage of students eligible for free or reduced-price meals, (3) the percentage of children in poverty, (4) per capita income, (5) eligibility as a low-wealth county, (6) mortality rates for children between one and 19 years of age, (7) the percentage of students with chronic illnesses, and (8) the percentage of county population consisting of minority persons. These funds must supplement and not supplant other state, local, or federal funds appropriated for the same purpose.

The new statute also requires the Division of Public Health (DPH) to ensure that school nurses funded pursuant to the section: (1) serve as the coordinator of the health services program, (2) provide health education to students, staff, and parents, (3) identify health and safety concerns in the school environment, (4) support healthy food services programs, (5) promote healthy physical education, sports policies, and practices, (6) provide health counseling, assess mental health needs, provide interventions, and refer students to appropriate school staff or community agencies, (7) promote community involvement in assuring a healthy school, (8) provide health education and counseling, and (9) be available to assist the county health department during a public health emergency. Additionally DPH must ensure school nurses funded with the funds to not assist in any instructional or administrative duties associated with a school's curriculum.

This section became effective July 1, 2017.

Budget Deficit in State Laboratory of Public Health (S.L. 2017-57, Sec 11E.2/S257 – 2017 Appropriations Act)

Sec. 11E.2 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services, Division of Public Health, to review the current fee schedule for medical and environmental services provided by the State Laboratory of Public Health and report any recommended strategies for addressing its structural budget deficit no later than March 1, 2018.

This section became effective on June 28, 2017.

Local Health Departments Competitive Grant Process (S.L. 2017-57, Sec 11E.3/S257 – 2017 Appropriations Act)

Sec. 11E.3 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services (DHHS), Division of Public Health, to use funds appropriated in each biennium to administer a competitive grant process for local health departments based on maternal and infant health indicators, with the goals of improving North Carolina birth outcomes, improving the overall health status of children five and younger, and lowering North Carolina's infant mortality rate.

The plan for administering the competitive grant process must include the following components: (1) a request for application process to allow local health departments to apply for

and receive State funds on a competitive basis, (2) a requirement that the Secretary prioritize grant awards to those local health departments that are able to leverage non-State funds in addition to the grant award, (3) a guarantee that funds received by the Department to implement the plan supplement and do not supplant existing funds for maternal and child health initiatives, and (4) an award of grants to local health departments for up to two years.

No later than July 1 of each year, the Secretary of DHHS must announce the recipients of the competitive grant awards and allocate funds to the grant recipients. After awards have been granted, the Secretary must submit a report to the Joint Legislative Oversight Committee on Health and Human Services that includes the identity and a brief description of each grantee, each program or initiative offered by the grantee, the amount of funding awarded to each grantee, and the number of persons served by each grantee.

No later than December 1 of each fiscal year, each local health department receiving funding pursuant to this section 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, 2017.

Evidence-Based Diabetes Program (S.L. 2017-57, Sec 11E.5/S257 – 2017 Appropriations Act)

Sec. 11E.5 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services (DHHS) to administer an evidence-based diabetes prevention program targeting minority populations in consultation with the Chronic Disease and Injury Prevention Section. The program should be modeled after the program recommended by the National Institute of Diabetes and Digestive and Kidney Diseases. DHHS must report on the program to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2017, and annually thereafter.

This section became effective July 1, 2017.

Implementation of Federal Elevated Blood Level Standard (S.L. 2017-57, Sec 11E.6/S257 – 2017 Appropriations Act)

Sec. 11E.6 of S.L. 2017-57 (SB 257) amends Part 4 of Article 5 of Chapter 130A of the General Statutes to change the definition of "confirmed lead poisoning" to mean a blood lead concentration of 10 micrograms per deciliter and the definition of "elevated blood lead level" to mean a blood lead concentration of five micrograms per deciliter. Sec. 11E.5 also amends Part 4 of Article 5 of Chapter 130A of the General Statutes to confirm that the lead poisoning statutes apply to pregnant women in addition to children.

This section became effective July 1, 2017.

AIDS Drug Assistance Program (S.L. 2017-57, Sec 11E.7/S257 – 2017 Appropriations Act)

Sec. 11E.7 of S.L. 2017-57 (SB 257) amends Part 1 of Article 1 of Chapter 130A by adding a new section (G.S. 130A-4.4) to require the Department of Health and Human Services to work with the Department of Public Safety (DPS) and use DPS funds to purchase drugs to treat AIDS for individuals in the custody of DPS. The funds must be used in a way that allows

them to be accounted for as State matching funds in the federal AIDS Drug Assistance Program.

This section became effective July 1, 2017.

Implementation of Cost-neutral Premium Assistance Program Within AIDS Drug Assistance Program (ADAP) - (S.L. 2017-57, Sec 11E.8/S257 – 2017 Appropriations Act)

Sec. 11E.8 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services (DHHS), Division of Public Health, to continue to implement within the NC ADAP a health insurance premium assistance program that:

- Is cost neutral or achieves savings;
- Utilizes federal funds from Part B of the Ryan White HIV/AIDS Program and ADAP funds to provide individual ADAP participants or subsets of ADAP participants with premium and cost-sharing assistance for the purchase or maintenance of private health insurance coverage, including premiums, co-payments, and deductibles; and
- Meets the requirements of Section 12E.1 of S.L. 2016-94.

DHHS must submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on implementation of the health insurance premium assistance program that must include at least all of the following components:

- A detailed explanation of the program design;
- A demonstration of cost neutrality, which must include a comparison of the cost of providing prescription drugs to eligible beneficiaries through the new health insurance premium program and the existing ADAP program;
- Information on health outcomes of program participants; and
- Any obstacles to program implementation.

This section became effective July 1, 2017.

Eating Disorder Study (S.L. 2017-57, Sec 11E.11/S257 – 2017 Appropriations Act)

Sec. 11E.11 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services, Division of Public Health, to study eating disorders in North Carolina and issue a report on its findings to the Joint Legislative Oversight Committee on Health and Human Services by November 1, 2017.

This section became effective June 28, 2017.

Every Week Counts Demonstration Project (S.L. 2017-57, Sec 11E.12/S257 – 2017 Appropriations Act)

Sec. 11E.12 of S.L. 2017-57 (SB 257) establishes a demonstration project, at least three years long, to study the extent home-based prenatal care reduces preterm birth and whether women pregnant with multiple children who are at risk of preterm birth can benefit from 17 Alpha-Hydroxyprogesterone Caproate (17P) therapy. This section provides that $2.2 million dollars in non-recurring funds from the federal Maternal and Child Health Black Grant are

allocated to the Department of Health and Human Services (DHHS) for the 2017-18 and 2018-19 fiscal years to conduct this demonstration project in Robeson and Columbus counties.

The project must consist of the following components: (1) an Every Week Counts enrollment visit including an early ultrasound assessment and a complete medical examination; (2) women enrolled in Every Week Counts will receive home visits during pregnancy that combine a home-based prenatal care model with social interventions; (3) women enrolled in Every Week Counts will receive home visits during the first two years of their child's life. In these monthly visits, the child's health, growth, and development will be tracked, and the mother will be provided with information on nutritional, health, and developmental needs; (4) there must be a randomized clinical trial of 17P within Every Week Counts in a population of women enriched for preterm birth susceptibility.

Six months after the conclusion of the project, the University of North Carolina at Chapel Hill (UNC) must submit a final report on the project to DHHS. No later than three months after receiving the report from UNC, DHHS must submit a report to the Joint Legislative Oversight Committee on Health and Human Services including an estimate of the cost to expand the program incrementally and statewide, an estimate of any potential savings of State funds associated with expansion of the program, and a timeline for expanding the program statewide if expansion is recommended. The demonstration program will end when UNC submits its report to DHHS.

This section became effective July 1, 2017.

Funds for Pregnancy Care Initiatives (S.L. 2017-57, Sec 11E.13/S257 – 2017 Appropriations Act)

Sec. 11E.13 of S.L. 2017-57 (SB 257) directs the Department of Health and Human Services (DHHS) to allocate $1.3 million in nonrecurring funds for each of the 2017-18 and 2018-19 fiscal years to the Carolina Pregnancy Care Fellowship for use as follows: (1) $800,000 to provide grants to purchase durable medical equipment for clinics that apply to the Carolina Pregnancy Care Fellowship for that equipment; (2) $170,000 to provide grants for training on the use of durable medical equipment; (3) $30,000 may be used by Carolina Pregnancy Care Fellowship for administrative purposes related to those grants; (4) $300,000 must be transferred to the Human Coalition, a nonprofit organization, to develop and implement a two-year continuum of care pilot program to assist women experiencing crisis pregnancies to carry their pregnancies to full term.

The program implemented by the Human Coalition must use care coordinators and nursing staff in close collaboration. By November 1, 2017, and periodically thereafter, the Human Coalition must report to DHHS on this program, and DHHS must report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the program by April 1, 2018. DHHS must issue a final report on the program to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than April 1, 2019, and the program will expire on June 30, 2019.

This section became effective July 1, 2017.

Communicable Disease Testing (S.L. 2017-57, Sec 11F.18/S257 – 2017 Appropriations Act)

Sec. 11E.14 of S.L. 2017-57 provides that of the funds appropriated to the State Laboratory of Public Health, Division of Public Health, Department of Health and Human Services, the sum of $300,000 in recurring funds, and $300,000 in nonrecurring funds, for each fiscal year must be used for the purposes listed below.

- To provide testing for Hepatitis C and other priority communicable diseases identified by the Division of Public Health.
- To provide individuals who test positive for Hepatitis C and other priority communicable diseases with access to treatment options.

This section became effective July 1, 2017.

Study on Site-Of-Use Solutions for Safe Disposal of Prescription Drugs (S.L. 2017-57, Sec 11F.18/S257 – 2017 Appropriations Act)

Sec. 11F.18 of S.L. 2017-57 (SB 257) requires the Department of Health of Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, to study and submit a report to the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division, on simple site-of-use solutions for the safe disposal of prescription drugs.

This section became effective July 1, 2017.

Funds to Continue Community Paramedicine Pilot Program (S.L. 2017-57, Sec 11G.1/S257 – 2017 Appropriations Act)

Sec. 11G.1 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services, Division of Health Services Regulation, to allocate $350,000 in nonrecurring funds for each of the 2017-18 and 2018-19 fiscal years to continue the community paramedicine pilot program authorized in Section 12A.12 of S.L. 2015-241, as amended by Section 12A.3 of S.L. 2016-94. The funds must be distributed as follows: (1) $210,000 to the New Hanover Regional Emergency Medical Services site; (2) $70,000 to the McDowell County Emergency Medical Services site; and (3) $70,000 to the Wake County Emergency Medical Services site.

By November 1, 2019, the Department of Health and Human Services must submit an updated report on the community paramedicine pilot program to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

This section became effective July 1, 2017.

Update Rabies Control Laws (S.L. 2017-106/S 74)

S.L. 2017-106 (SB 74) requires local health directors to use the guidelines issued by the National Association of State Public Health Veterinarians when deciding the proper control measures for a dog, cat, or ferret that has been exposed to rabies.

This act becomes effective October 1, 2017.

OLDER & DISABLED ADULTS

Development and Use of Funds for Alzheimer's Registry (S.L. 2017-57, Sec 11A.5A/ S257 – 2017 Appropriations Act)

Section 3.1 of S.L. 2017-197 amends PART XI of S.L. 2017-57 to add a section (11A.5A) to require that support for the development of an Alzheimer's Registry be accomplished through the Bryan Alzheimer's Disease Research Center at Duke University Medical Center. This section is notwithstanding anything to the contrary in the Joint Conference Committee Report on the Base, Capital, and Expansion Budgets for S.L. 2017-57, and pertains to funds appropriated for the Alzheimer's Registry to the Department of Health and Human Services, Division of Central Management and Support, for each fiscal year of the 2017-2019 fiscal biennium.

This section became effective July 1, 2017.

Increase Access to Public Benefits for Older Dual Eligible Seniors (S.L. 2017-57, Sec. 11C.8/ S257 – 2017 Appropriations Act)

Sec. 11C.8 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services (DHHS), Division of Social Services (DSS), continue implementing an evidence-based pilot program to increase access to public benefits for seniors aged 65 and older who are dually enrolled in Medicare and Medicaid to: (i) improve the health and independence of seniors and (ii) reduce health care costs. DSS must continue to partner with a not-for-profit firm to engage in a data-driven campaign to identify individuals, conduct an outreach program to enroll individuals in SNAP, provide application assistance, evaluate project effectiveness, and make recommendations on policy options. Any nonrecurring funds from 2016-17 fiscal year will not revert but will remain available for continued pilot implementation along with any private or nonprofit funding. If funding and capacity is available, DSS may expand the pilot. DSS must report to the Office of the Governor and the Joint Legislative Oversight Committee on Health and Human Services on the progress in the pilot program by February 1 following each year the pilot program is in place.

This section became effective July 1, 2017.

Temporary Financial Assistance for Facilities Licensed to Accept State-County Special Assistance (S.L. 2017-57, Sec. 11C.13/ S257 – 2017 Appropriations Act)

Sec. 11C.13 of S.L. 2017-57 (SB 257) outlines the criteria for the payment of temporary financial assistance on behalf of a resident and recipient of State-County Special Assistance in the form of a monthly payment to facilities licensed to accept State-County Special Assistance payments. Counties must pay 50% of the cost of providing the monthly payment. The Department of Health and Human Services (DHHS), Division of Social Services (DSS), must make the payments to facilities in accordance with the following requirements:

- The monthly payment is $34.00 per month per resident who is a State-County Special Assistance recipient.
- The payments must only be used to offset the cost of serving the residents who are recipients of State-County Special Assistance.

- DSS must make the payments only from July 1, 2017, until June 30, 2019, and only to the extent that sufficient State and county funds allocated for this purpose are available.
- DSS must not make payments under this section on behalf of a resident whose eligibility determination for State-County Special Assistance is pending.
- DSS must terminate all monthly payments under this section on the earlier of June 30, 2019, or upon depletion of the funds allocated and is not required to provide temporary assistance beyond this period.

This section does not obligate the General Assembly to appropriate funds for the purpose of this section, and is not an entitlement to provide funds for this purpose to a facility, resident of a facility, or other individual.

This section became effective July 1, 2017, and expires June 30, 2019.

State-County Special Assistance (S.L. 2017-57, Sec. 11D.1/ S257 – 2017 Appropriations Act)

Sec. 11D.1 of S.L. 2017-57 (SB 257) establishes the 2017-2019 fiscal biennium maximum monthly rate for State-County Special Assistance recipients who are residents in adult care home facilities at $1,182 per month per resident, and the maximum monthly rate for residents in Alzheimer's/Dementia special care units at $1,515 per month per resident.

This section became effective July 1, 2017.

Authorization for Secretary of DHHS to Raise the Maximum Number of State-County Special Assistance In-Home Payments (S.L. 2017-57, Sec. 11D.1A/ S257 – 2017 Appropriations Act)

Sec. 11D.1A of S.L. 2017-57 (SB 257) authorizes the Secretary of the Department of Health and Human Services, within existing appropriations, to waive the 15% cap on the number of Special Assistance in-home payments. This section is notwithstanding G.S. 108A-47.1 which authorizes the payments be made for up to 15% of the caseload for all State-County Special Assistance.

This section became effective July 1, 2017, and expires June 30, 2019.

Alignment of State and Federal Aging Plan Reporting Deadlines (S.L. 2017-57, Sec. 11D.2/ S257 – 2017 Appropriations Act)

Sec. 11D.2 of S.L. 2017-57 (SB 257) amends G.S. 143B-181.1A to change the date, from March 1 to July 1 of every other odd-numbered year, that the Department of Health and Human Services, Division of Aging and Adult Services, is required to submit a plan for serving older adults in the State.

This section became effective July 1, 2017

Recommendation to Appoint a Subcommittee on Aging (S.L. 2017-57, Sec. 11D.3/ S257 – 2017 Appropriations Act)

Sec 11D.3 of S.L. 2017-57 (SB 257) encourages the cochairs of the Joint Legislative Oversight Committee on Health and Human Services to consider appointing a subcommittee to

examine the State's delivery of services for older adults to: (1) determine their service needs, and to (2) make recommendations to the Committee on how to address those needs. The subcommittee is encouraged to seek input from a variety of stakeholders and interest groups, including the Division of Aging and Adult Services and the Division of Social Services in the Department of Health and Human Services; the North Carolina Coalition on Aging; the North Carolina Senior Tarheel Legislature; and the Governor's Advisory Council on Aging. If the subcommittee is appointed it must submit an interim report on or before March 1, 2018, and a final report on or before November 1, 2018.

This section became effective July 1, 2017.

Moratorium on Special Care Unit Licenses (S.L. 2017-57, Sec. 11G.3/ S257 – 2017 Appropriations Act)

Sec. 11G.3 of S.L. 2017-57 (SB 257) 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, from the period beginning July 1, 2017, and ending June 30, 2019. The section also requires DHHS to submit a report to the Joint Legislative Oversight Committee on Health and Human Services by March 1, 2019. 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.

This section became effective July 1, 2017.

Increase Personal Care Services Rate (S.L. 2017-57, Sec. 11H.12/ S257 – 2017 Appropriations Act)

Refer to the Medicaid & Health Choice section of this document for a summary of this item.

Retroactive Personal Care Services Payment (S.L. 2017-57, Sec. 11H.12A/ S257 – 2017 Appropriations Act)

Refer to the Medicaid & Health Choice section of this document for a summary of this item.

Study Program of All-Inclusive Care for the Elderly (PACE) (S.L. 2017-57, Sec. 11H.25/ S257 – 2017 Appropriations Act)

Sec. 11H.25 of S.L. 2017-57 (SB 257) requires the Department of Health and Human Services (DHHS), Division of Medical Assistance, to study the efficacy of the Program of All-Inclusive Care for the Elderly (PACE). DHHS must engage a variety of stakeholders, PACE organizations, PACE consumers, and the general public, and the study must consist of the following:

- An evaluation of the existing program, including an update on the report required by Sec. 12H.3 of S.L. 2014-100, structures of PACE organizations, and clinical outcome and quality measures.
- A statewide assessment of anticipated long-term care needs over the next 10 years, by county.
- A review of PACE experiences in other states with an analysis of costs and quality.
- An evaluation of State regulations on PACE providers, including any that could be eliminated.
- An assessment of the role of PACE in the continuum of care and the opportunities to apply the PACE model to additional populations under the PACE Innovations Act of 2015, P.L. 114-85.

No later than March 1, 2018, DHHS must submit a report to the Joint Legislative Oversight Committee on Health and Human Services on the information above and recommendations to provide the highest quality programs at a low cost and to keep aging individuals in their homes.

This section became effective July 1, 2017.

Ombudsman Changes/DHHS Study (S.L. 2017-103/ H248)

Refer to the Department of Health and Human Services-Generally section of this document for a summary of this item.

Improve Adult Care Home Regulation (S.L. 2017-184/H657)

S.L. 2017-184 (HB 657) makes the following changes pertaining to adult care homes: exempts from certificate of need review the acquisition of certain unlicensed adult care homes; implements an informal dispute resolution process for certain inspection findings; changes the training requirements for personal care aides; makes changes to the star rating program; and requires the Department of Health and Human Services to study the Star Rated Certificate Program and report on progress to the Joint Legislative Oversight Committee on Health and Human Services by February 1, 2018, with a final report by October 1, 2018.

This act becomes effective October 1, 2017, with the following exceptions which became effective July 25, 2017: Section 4 requiring the Division of Health Service Regulation, Department of Health and Human Services, and county Departments of Social Services to establish procedures to implement an Informal Dispute Resolution, Section 6 requiring the Star-Rated Certificate study, and Section 7 pertaining to the certificate of need exemption.