Senate Appropriations Committee on Health and Human Services

Special Provisions for H.B. 97, 2015 Appropriations Act

June 15, 2015

information to the student regarding the consequences that accompany each option and any other relevant information that may be helpful to the student when considering which option to select.

SECTION 11.16.(b) Beginning November 1, 2016, the Board of Governors shall report annually to the Joint Legislative Education Oversight Committee regarding the number of students who graduated from a cooperative innovative high school program with an associate degree and which option was chosen by those students when applying for admission to a constituent institution.

SECTION 11.16.(c) This section applies to the 2016-2017 academic year and each subsequent academic year.

SEAA FUNDS FOR ADMINISTRATION OF SPECIAL EDUCATION SCHOLARSHIP GRANT PROGRAM

SECTION 11.18. Section 5(b) of S.L. 2013-364, as amended by Section 3.2 of S.L. 2013-363, reads as rewritten:

"**SECTION 5.(b)** Of the funds allocated to NCSEAA to be used for the award of scholarship grants to eligible students under subsection (a) of this section, for fiscal year 2013-2014, NCSEAA may retain up to two hundred thousand dollars ($200,000) for administrative costs associated with the scholarship grant program. For fiscal year ~~2014-2015~~ 2015-2016 and subsequent years, NCSEAA may retain up to ~~two percent (2%)~~ four percent (4%) annually for administrative costs associated with the scholarship grant program."

WESTERN GOVERNORS UNIVERSITY CHALLENGE GRANT

SECTION 11.20. Of the funds appropriated in this act to the Board of Governors of The University of North Carolina, the sum of two million dollars ($2,000,000) in nonrecurring funds for the 2015-2016 fiscal year shall be used as a challenge grant to Western Governors University to raise the sum of five million dollars ($5,000,000) in private funds for the 2015-2016 fiscal year to establish a North Carolina campus. The allocation of two million dollars ($2,000,000) under this section is contingent upon receipt by Western Governors University of five million dollars ($5,000,000) in private funds for the purpose of establishing a North Carolina campus.

HUNT INSTITUTE/NO GENERAL FUNDS

SECTION 11.21. Notwithstanding any other provision of law, no monies from the General Fund shall be used for the support of The Hunt Institute which is an affiliate of the University of North Carolina at Chapel Hill.

PART XII. DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBPART XII-A. CENTRAL MANAGEMENT AND SUPPORT

FUNDING FOR PROGRAMS TO IMPROVE CHILDREN'S HEALTH/ESTABLISH COMPETITIVE GRANTS PROCESS

SECTION 12A.2.(a) Findings. – The General Assembly finds that America spends twice as much on health care as any other nation, yet Americans are not the healthiest people in the world. Research indicates that spending on health care to treat people may actually come at the expense of investing in public health programs meant to keep people from getting sick in the first place. The General Assembly further finds that infant mortality rates are an indicator of a state's overall health status. North Carolina currently ranks fortieth in the nation on infant mortality. Implementing statewide policies to invest in evidence-based programs that are scientifically proven to lower infant mortality rates, and improve birth outcomes and the health

of children ages birth to five, will assure that future rankings for North Carolina are among the best in the nation.

SECTION 12A.2.(b) Designation of Lead Agency. – The Secretary of the North Carolina Department of Health and Human Services (Secretary) shall designate a lead agency that is responsible for doing all of the following:

(1) Assuming responsibility for controlling all funding and contracts designed to (i) improve North Carolina's birth outcomes, (ii) improve the overall health status of children in this State from ages birth to five, and (iii) lower this State's infant mortality rates.

(2) Working in consultation with the University of North Carolina Gillings School of Global Public Health to develop a statewide, comprehensive plan to accomplish the goals described in subdivision (1) of this subsection.

(3) Conducting a justification review of all programs and activities funded with State appropriations described in subsection (c) of this section.

SECTION 12A.2.(c) Nonrecurring Allocations. – For the 2015-2016 fiscal year only, the Department of Health and Human Services shall allocate the following designated amounts for the following programs on a nonrecurring basis:

(1)	Maternal and Child Health Contracts	$2,472,094 NR
(2)	High-Risk Maternity Clinic	375,000 NR
(3)	Healthy Beginnings (Two Contracts)	396,025 NR
(4)	Pregnancy Care Case Management	300,901 NR
(5)	Maternal, Infant, and Early Childhood Home Visiting	425,643 NR
(6)	Triple P-Positive Parenting Program	828,233 NR
(7)	NC Perinatal and Maternal Substance Abuse Initiative	2,729,316 NR
(8)	Perinatal Substance Abuse Specialist	45,000 NR

SECTION 12A.2.(d) Statewide Proposal and Justification Review. – By March 1, 2016, the Secretary shall submit the statewide proposal developed pursuant to subsection (b) of this section to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division for consideration during the 2016 Regular Session of the 2015 General Assembly. The statewide proposal shall include at least all of the following:

(1) Details of the statewide plan and identification of the lead agency responsible for assuring the success of the plan.

(2) Justification for continuing, reducing, or eliminating funding for the programs and activities that receive nonrecurring allocations for the 2015-2016 fiscal year.

(3) Recommendations for reallocation of funding from programs and activities that are not evidence-based and that are not producing positive returns on investment consistent with the goals described in subdivision (1) of subsection (b) of this section.

(4) Recommendations for investments in new initiatives that accomplish the goals described in subdivision (1) of subsection (b) of this section.

SECTION 12A.2.(e) Establishment of Competitive Grants Process for Local Health Departments. – It is the intent of the General Assembly that, beginning in the 2016-2017 fiscal year, the Department of Health and Human Services implement a competitive grants process for local health departments based on a county's current health status and the county's detailed proposal to invest in evidence-based programs to achieve the goals described in subdivision (1) of subsection (b) of this section. To that end, the Department shall develop a plan that establishes a competitive grants process to be administered by the Division of Central Management and Support. The Department shall develop a plan that, at a minimum, includes each of the following components:

(1) A request for application (RFA) 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 process that awards grants to local health departments dedicated to providing services on a countywide basis and that supports the goals described in subdivision (1) of subsection (b) of this section.
(4) Ensures that funds received by the Department to implement the plan supplement and do not supplant existing funds for health and wellness programs and initiatives.

SECTION 12A.2.(f) Funds for Competitive Grants Process. – Of the funds appropriated in this act to the Department of Health and Human Services, Division of Public Health, the sum of two million five hundred thousand dollars ($2,500,000) in recurring funds for each year of the 2015-2017 fiscal biennium shall be used to establish the competitive grants process for local health departments described in subsection (e) of this section. The Department shall not use more than five percent (5%) of these funds for administrative purposes.

SECTION 12A.2.(g) Evaluation Protocol for Future Program Funding. – The Department shall work with the University of North Carolina Gillings School of Global Public Health (School of Global Public Health) to establish an evaluation protocol for determining program effectiveness and future funding requirements at the local level. By April 1, 2016, the Department, in consultation with the School of Global Public Health, shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services on the request for application process to allow local health departments to apply for and receive State funds on a competitive basis. The report shall include the counties awarded, the amount of the award, the types of programs to be funded, and the evaluation process to be used in determining county performance.

HEALTH INFORMATION TECHNOLOGY

SECTION 12A.4.(a) The Department of Health and Human Services (Department), in cooperation with the State Chief Information Officer (State CIO), shall coordinate health information technology (HIT) policies and programs within the State of North Carolina. The goal of the DHHS CIO in coordinating State HIT policy and programs shall be to avoid duplication of efforts and to ensure that each State agency, public entity, and private entity that undertakes health information technology activities does so within the area of its greatest expertise and technical capability and in a manner that supports coordinated State and national goals, which shall include at least all of the following:

(1) Ensuring that patient health information is secure and protected, in accordance with applicable law.
(2) Improving health care quality, reducing medical errors, reducing health disparities, and advancing the delivery of patient-centered medical care.
(3) Providing appropriate information to guide medical decisions at the time and place of care.
(4) Ensuring meaningful public input into HIT infrastructure development.
(5) Improving the coordination of information among hospitals, laboratories, physicians' offices, and other entities through an effective infrastructure for the secure and authorized exchange of health care information.
(6) Improving public health services and facilitating early identification and rapid response to public health threats and emergencies, including bioterrorist events and infectious disease outbreaks.
(7) Facilitating health and clinical research.

(8) Promoting early detection, prevention, and management of chronic diseases.

SECTION 12A.4.(b) The Department, in cooperation with the State CIO, shall establish and direct an HIT management structure that is efficient and transparent and that is compatible with the Office of the National Health Coordinator for Information Technology (National Coordinator) governance mechanism. The HIT management structure shall be responsible for all of the following:

(1) Developing a State plan for implementing and ensuring compliance with national HIT standards and for the most efficient, effective, and widespread adoption of HIT.

(2) Ensuring that (i) specific populations are effectively integrated into the State plan, including aging populations, populations requiring mental health services, and populations utilizing the public health system, and (ii) unserved and underserved populations receive priority consideration for HIT support.

(3) Identifying all HIT stakeholders and soliciting feedback and participation from each stakeholder in the development of the State plan.

(4) Ensuring that existing HIT capabilities are considered and incorporated into the State plan.

(5) Identifying and eliminating conflicting HIT efforts where necessary.

(6) Identifying available resources for the implementation, operation, and maintenance of health information technology, including identifying resources and available opportunities for North Carolina institutions of higher education.

(7) Ensuring that potential State plan participants are aware of HIT policies and programs and the opportunity for improved health information technology.

(8) Monitoring HIT efforts and initiatives in other states and replicating successful efforts and initiatives in North Carolina.

(9) Monitoring the development of the National Coordinator's strategic plan and ensuring that all stakeholders are aware of and in compliance with its requirements.

(10) Monitoring the progress and recommendations of the HIT Policy and Standards Committee and ensuring that all stakeholders remain informed of the Committee's recommendations.

(11) Monitoring all studies and reports provided to the United States Congress and reporting to the Joint Legislative Oversight Committee on Information Technology and the Fiscal Research Division on the impact of report recommendations on State efforts to implement coordinated HIT.

SECTION 12A.4.(c) By no later than January 15, 2016, the Department shall provide a written report on the status of HIT efforts to the Joint Legislative Oversight Committees on Health and Human Services and Information Technology and to the Fiscal Research Division. The report shall be comprehensive and shall include all of the following:

(1) Current status of federal HIT initiatives.

(2) Current status of State HIT efforts and initiatives among both public and private entities.

(3) Other State information technology initiatives with potential applicability to State HIT efforts.

(4) Efforts to ensure coordination and avoid duplication of HIT efforts within the State.

(5) A breakdown of current public and private funding sources and dollar amounts for State HIT initiatives.

(6) Efforts by the DHHS CIO to coordinate HIT initiatives within the State and any obstacles or impediments to coordination.

(7) HIT research efforts being conducted within the State and sources of funding for research efforts.

(8) Opportunities for stakeholders to participate in HIT funding and other efforts and initiatives during the next quarter.

(9) Issues associated with the implementation of HIT in North Carolina and recommended solutions to these issues.

FUNDS FOR OVERSIGHT AND ADMINISTRATION OF STATEWIDE HEALTH INFORMATION EXCHANGE NETWORK

SECTION 12A.5.(a) It is the intent of the General Assembly to do all of the following with respect to health information exchange:

(1) Establish a successor HIE Network to which (i) all Medicaid providers shall be connected by July 1, 2017, and (ii) all other entities that receive State funds for the provision of health services shall be connected by January 1, 2018.

(2) Establish (i) a State-controlled Health Information Exchange Authority to oversee and administer the successor HIE Network and (ii) a Health Information Exchange Advisory Board to provide consultation to the Authority on matters pertaining to administration and operation of the HIE Network and on statewide health information exchange, generally.

(3) Have the successor HIE Network gradually become and remain one hundred percent (100%) receipt-supported by establishing reasonable participation fees approved by the General Assembly and by drawing down available matching funds whenever possible.

SECTION 12A.5.(b) In order to achieve the objectives described in subsection (a) of this section, funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, for the 2015-2016 fiscal year and for the 2016-2017 fiscal year to continue efforts toward the implementation of a statewide health information exchange network shall be transferred to the Department of Information Technology. By 30 days after the effective date of this section, the Secretary of the Department of Health and Human Services and the State Chief Information Officer (State CIO) shall enter into a written memorandum of understanding pursuant to which the State CIO will have sole authority to direct the expenditure of these funds until (i) the North Carolina Health Information Exchange Authority (Authority) is established and the State CIO has appointed an Authority Director and (ii) the North Carolina Health Information Exchange Advisory Board (Advisory Board) is established with members appointed pursuant to Article 29B of Chapter 90 of the General Statutes, as enacted by subsection (d) of this section. The State CIO shall use these transferred funds to accomplish the following:

(1) Beginning immediately upon receipt of the transferred funds, facilitate the following:

a. Establishment of the successor HIE Network described in subsection (a) of this section.

b. Termination or assignment to the Authority by December 31, 2015, of any contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

(2) Fund the monthly operational expenses incurred or encumbered by the NC HIE from July 1, 2015, until December 31, 2015. Notwithstanding any other provision of law to the contrary, the total amount of monthly operating expenses paid for with these funds shall not exceed one hundred

seventy-seven thousand dollars ($177,000) per month, or a total of one million sixty-two thousand dollars ($1,062,000) for the six-month period commencing July 1, 2015, and ending December 31, 2015. The State CIO shall terminate payments for these monthly operational expenses upon the earlier of December 31, 2015, or upon the termination or assignment to the Authority of all contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

The State CIO is encouraged to explore all available opportunities for the State to receive federal grant funds and federal matching funds for health information exchange.

SECTION 12A.5.(c) Once the Authority Director has been hired and the Advisory Board has been established with members appointed pursuant to Article 29B of Chapter 90 of the General Statutes, as enacted by subsection (d) of this section, the Authority shall use these funds to do the following:

(1) Fund the operational expenses of the Authority and the Advisory Board.

(2) Establish, oversee, administer, and provide ongoing support of a successor HIE Network to the HIE Network established under Article 29A of Chapter 90 of the General Statutes.

(3) Enter into any contracts necessary for the establishment, administration, and operation of the successor HIE Network.

(4) Facilitate the termination or assignment to the Authority by December 31, 2015, of any contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

(5) Fund the monthly operational expenses incurred or encumbered by the NC HIE from July 1, 2015, until December 31, 2015. Notwithstanding any other provision of law to the contrary, the total amount of monthly operating expenses paid for with these funds shall not exceed one hundred seventy-seven thousand dollars ($177,000) per month, or a total of one million sixty-two thousand dollars ($1,062,000) for the six-month period commencing July 1, 2015, and ending December 31, 2015. The Authority shall terminate payments for these monthly operational expenses upon the earlier of December 31, 2015, or upon the termination or assignment to the Authority of all contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE and (ii) between the NC HIE and any third parties.

The Authority is encouraged to explore all available opportunities for the State to receive federal grant funds and federal matching funds for health information exchange.

SECTION 12A.5.(d) Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 29B.

"Statewide Health Information Exchange Act.

"**§ 90-414.1. Title.**

This act shall be known and may be cited as the "Statewide Health Information Exchange Act."

"**§ 90-414.2. Purpose.**

This Article is intended to improve the quality of health care delivery within this State by facilitating and regulating the use of a voluntary, statewide health information exchange network for the secure electronic transmission of individually identifiable health information among health care providers, health plans, and health care clearinghouses in a manner that is

consistent with the Health Insurance Portability and Accountability Act, Privacy Rule and Security Rule, 45 C.F.R. §§ 160, 164.

"**§ 90-414.3. Definitions.**

The following definitions apply in this Article:

(1) Business associate. – As defined in 45 C.F.R. § 160.103.

(2) Business associate contract. – The documentation required by 45 C.F.R. § 164.502(e)(2) that meets the applicable requirements of 45 C.F.R. § 164.504(e).

(3) Covered entity. – Any entity described in 45 C.F.R. § 160.103 or any other facility or practitioner licensed by the State to provide health care services.

(4) Disclose or disclosure. – The release, transfer, provision of access to, or divulging in any other manner an individual's protected health information through the HIE Network.

(5) Emergency medical condition. – A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in (i) placing an individual's health in serious jeopardy, (ii) serious impairment of an individual's bodily functions, or (iii) serious dysfunction of any bodily organ or part of an individual.

(6) GDAC. – The North Carolina Government Data Analytics Center.

(7) Health Benefits Authority. – The Authority established under Article 14 of Chapter 143B of the General Statutes to operate the Medicaid and NC Health Choice programs.

(8) HIE Network. – The voluntary, statewide health information exchange network overseen and administered by the Authority.

(9) HIPAA. – The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended.

(10) Individual. – As defined in 45 C.F.R. § 160.103.

(11) North Carolina Health Information Exchange Authority or Authority. – The entity established pursuant to G.S. 90-414.5.

(12) North Carolina Health Information Exchange Advisory Board or Advisory Board. – The Advisory Board established under G.S. 90-414.6.

(13) Opt out. – An individual's affirmative decision to disallow his or her protected health information maintained by or on behalf of one or more specific covered entities from being disclosed to other covered entities through the HIE Network.

(14) Protected health information. – As defined in 45 C.F.R. § 160.103.

(15) Public health purposes. – The public health activities and purposes described in 45 C.F.R. § 164.512(b).

(16) Qualified organization. – An entity designated by the Authority to contract with covered entities on behalf of the Authority to facilitate the participation of such covered entities in the HIE Network.

(17) Research purposes. – Research that meets the standard described in 45 C.F.R. § 164.512(i).

(18) State CIO. – The State Chief Information Officer.

"**§ 90-414.4. Required participation in HIE Network for some providers.**

(a) The General Assembly makes the following findings:

(1) That controlling escalating health care costs of the Medicaid program and other State-funded health services is of significant importance to the State, its taxpayers, its Medicaid recipients, and other recipients of State-funded health services.

(2) That the Health Benefits Authority needs timely access to claims and clinical information in order to assess performance, improve health care outcomes, pinpoint medical expense trends, identify beneficiary health risks, and evaluate how the State is spending money on Medicaid and other State-funded health services.

(3) That making this clinical information available through the HIE Network will improve care coordination within and across health systems, increase care quality, enable more effective population health management, reduce duplication of medical services, augment syndromic surveillance, allow more accurate measurement of care services and outcomes, increase strategic knowledge about the health of the population, and facilitate health care cost containment.

(b) As a condition of receiving State funds, including Medicaid funds, the following entities shall connect to the HIE Network and submit individual patient demographic and clinical data on services paid for with State funds, including Medicaid funds, based on the findings set forth in subsection (a) of this section and notwithstanding the voluntary nature of the HIE Network under G.S. 90-414.2:

(1) Each hospital, as defined in G.S. 131E-76(3), that has an electronic health record system.

(2) Each Medicaid provider.

(3) Each provider that receives State funds for the provision of health services.

(c) The Authority shall give the Health Benefits Authority real-time access to data and information disclosed through the HIE Network. At the request of the Director of the Fiscal Research, Bill Drafting, Research, or Program Evaluation Divisions of the General Assembly for data and information disclosed through the HIE Network or for a consolidation or analysis of the data and information disclosed through the HIE Network, the Authority shall provide the professional staff of these Divisions with data and information responsive to the Director's request. Prior to providing the General Assembly's staff with any data or information disclosed through the HIE Network or with any compilation or analysis of data or information disclosed through the HIE Network, the Authority shall redact any personal identifying information in a manner consistent with the standards specified for de-identification of health information under the HIPAA Privacy Rule, 45 C.F.R. § 164.15, as amended.

"**§ 90-414.4A. State ownership of data disclosed through HIE Network.**

Any data disclosed through the HIE Network pursuant to G.S. 90-414.4 or any other provision of this Article shall be and will remain the sole property of the State. Any data or product derived from the data disclosed to the HIE Network pursuant to G.S. 90-414.4 or any other provision of this Article, including a consolidation or analysis of the data, shall be and will remain the sole property of the State. The Authority shall not allow proprietary information it receives pursuant to G.S. 90-414.4 or any other provision of this Article to be used by any person or entity for commercial purposes.

"**§ 90-414.5. North Carolina Health Information Exchange Authority.**

(a) Creation. – There is hereby established the North Carolina Health Information Exchange Authority to oversee and administer the HIE Network in accordance with this Article. The Authority shall be located within the Department of Information Technology and shall be under the supervision, direction, and control of the State CIO. The State CIO shall employ an Authority Director and may delegate to the Authority Director all powers and duties associated with the daily operation of the Authority, its staff, and the performance of the powers and duties set forth in subsection (b) of this section. In making this delegation, however, the State CIO maintains the responsibility for the performance of these powers and duties.

(b) Powers and Duties. – The Authority has the following powers and duties:

(1) Oversee and administer the HIE Network in a manner that ensures all of the following:
  a. Compliance with this Article.
  b. Compliance with HIPAA and any rules adopted under HIPAA, including the Privacy Rule and Security Rule.
  c. Compliance with the terms of any business associate contract the Authority or qualified organization enters into with a covered entity participating in the HIE Network.
  d. Notice to the patient by the provider on the initial visit about the HIE Network, including information and education about the right of individuals on a continuing basis to opt out or rescind a decision to opt out.
  e. Opportunity for all individuals to exercise on a continuing basis the right to opt out or rescind a decision to opt out.
  f. Nondiscriminatory treatment by covered entities of individuals who exercise the right to opt out.

(2) Employ staff necessary to carry out the provisions of this Article and determine the compensation, duties, and other terms and conditions of employment of hired staff.

(3) Enter into contracts pertaining to the oversight and administration of the HIE Network, including contracts of a consulting or advisory nature. G.S. 143-64.20 does not apply to this subdivision.

(4) Establish fees approved by the General Assembly for participation in the HIE Network.

(5) Following consultation with the Advisory Board, develop and enter into written participation agreements with covered entities that utilize the HIE Network. The participation agreements shall specify the terms and conditions governing participation in the HIE Network. The agreement shall also require compliance with policies developed by the Authority pursuant to this Article or pursuant to applicable laws of the state of residence for entities located outside of North Carolina. In lieu of entering into a participation agreement directly with covered entities, the Authority may enter into participation agreements with qualified organizations, which in turn enter into participation agreements with covered entities.

(6) Add, remove, disclose, and access protected health information through the HIE Network in accordance with this Article.

(7) Following consultation with the Advisory Board, enter into a business associate contract with each of the covered entities participating in the HIE Network. In lieu of entering into a business associate contract directly with covered entities, the Authority may enter into business associate contracts with qualified organizations, which in turn may enter into business associate contracts with covered entities.

(8) Following consultation with the Advisory Board, grant user rights to the HIE Network to business associates of covered entities participating in the HIE Network (i) at the request of the covered entities and (ii) at the discretion of the Authority upon consideration of the business associates' legitimate need for utilizing the HIE Network and privacy and security concerns.

(9) Facilitate and promote use of the HIE Network by covered entities.

(10) Periodically monitor compliance with this Article by covered entities participating in the HIE Network.

(11) Collect clinical health data from all Medicaid providers and other providers that receive State funds for the provision of health services in order to ensure the efficient delivery of Medicaid and other health services and to improve patient outcomes and measure performance.

(12) Collaborate with the State CIO to ensure that resources available through the GDAC are properly leveraged, assigned, or deployed to support the work of the Authority. The duty to collaborate under this subdivision includes collaboration on data hosting and development, implementation, operation, and maintenance of the HIE Network.

(13) Initiate or direct expansion of existing public-private partnerships within the GDAC as necessary to meet the requirements, duties, and obligations of the Authority. Notwithstanding any other provision of law and subject to the availability of funds, the State CIO, at the request of the Authority, shall assist and facilitate expansion of existing contracts related to the HIE Network, provided that such request is made in writing by the Authority to the State CIO with reference to specific requirements set forth in this Article.

(14) In consultation with the Advisory Board, develop a strategic plan for achieving statewide participation in the HIE Network by all hospitals and health care providers licensed in this State.

(15) In consultation with the Advisory Board, define the following with respect to operation of the HIE Network:

a. Business policy.

b. Protocols for data integrity, data sharing, data security, HIPAA compliance, and business intelligence as defined in G.S. 143B-426.38A. To the extent permitted by HIPAA, protocols for data sharing shall allow for the disclosure of data for academic research.

c. Qualitative and quantitative performance measures.

d. An operational budget and assumptions.

(16) Annually report to the Joint Legislative Oversight Committees on the Health Benefits Authority and Information Technology on the following:

a. The operation of the HIE Network.

b. Any efforts or progress in expanding participation in the HIE Network.

c. Health care trends based on information disclosed through the HIE Network.

"**§ 90-414.6. North Carolina Health Information Exchange Advisory Board.**

(a) Creation and Membership. – There is hereby established the North Carolina Health Information Exchange Advisory Board within the Department of Information Technology. The Advisory Board shall consist of the following nine members:

(1) The following three members appointed by the President Pro Tempore of the Senate:

a. A licensed physician in good standing and actively practicing in this State.

b. A patient representative.

c. An individual with technical expertise in health data analytics.

(2) The following three members appointed by the Speaker of the House of Representatives:

a. A representative of a critical access hospital.

b. A representative of a federally qualified health center.

c. An individual with technical expertise in health information technology.

(3) The following three ex officio, nonvoting members:

a. The State Chief Information Officer or a designee.

b. The Program Manager of GDAC or a designee.

c. The Chief Executive Officer of the Health Benefits Authority or a designee.

(b) Chairperson. – A chairperson shall be elected from among the members. The chairperson shall organize and direct the work of the Advisory Board.

(c) Administrative Support. – The Department of Information Technology shall provide necessary clerical and administrative support to the Advisory Board.

(d) Meetings. – The Advisory Board shall meet at least quarterly and at the call of the chairperson. A majority of the Advisory Board constitutes a quorum for the transaction of business.

(e) Terms. – In order to stagger terms, in making initial appointments, the President Pro Tempore shall designate two of the members appointed under subdivision (1) of subsection (a) of this section to serve for a one-year period from the date of appointment, and the Speaker of the House of Representatives shall designate two members appointed under subdivision (2) of subsection (a) of this section to serve for a one-year period from the date of appointment. The remaining voting members shall serve two-year periods. Future appointees who are voting members shall serve terms of two years, with staggered terms based on this subsection. Voting members may serve up to two consecutive terms, not including the abbreviated two-year terms that establish staggered terms or terms of less than two years that result from the filling of a vacancy. Ex officio, nonvoting members are not subject to these term limits. A vacancy other than by expiration of a term shall be filled by the appointing authority.

(f) Expenses. – Members of the Advisory Board who are State officers or employees shall receive no compensation for serving on the Advisory Board but may be reimbursed for their expenses in accordance with G.S. 138-6. Members of the Advisory Board who are full-time salaried public officers or employees other than State officers or employees shall receive no compensation for serving on the Advisory Board but may be reimbursed for their expenses in accordance with G.S. 138-5(b). All other members of the Advisory Board may receive compensation and reimbursement for expenses in accordance with G.S. 138-5.

(g) Duties. – The Advisory Board shall provide consultation to the Authority with respect to the advancement, administration, and operation of the HIE Network and on matters pertaining to health information exchange, generally. In carrying out its responsibilities, the Advisory Board may form committees of the Advisory Board to examine particular issues related to the advancement, administration, or operation of the HIE Network.

"**§ 90-414.7. Participation by covered entities.**

(a) Each covered entity that elects to participate in the HIE Network shall enter into a business associate contract and a written participation agreement with the Authority or qualified organization prior to disclosing or accessing any protected health information through the HIE Network.

(b) Each covered entity that elects to participate in the HIE Network may authorize its business associates to disclose or access protected health information on behalf of the covered entity through the HIE Network in accordance with this Article and at the discretion of the Authority, as provided in G.S. 90-414.5(b)(8).

(c) Notwithstanding any State law or regulation to the contrary, each covered entity that elects to participate in the HIE Network may disclose an individual's protected health information through the HIE Network (i) to other covered entities for any purpose permitted by HIPAA, unless the individual has exercised the right to opt out, and (ii) in order to facilitate the

provision of emergency medical treatment to the individual, subject to the requirements set forth in G.S. 90-414.8(e).

(d) Any health care provider who relies in good faith upon any information provided through the Authority or through a qualified organization in the health care provider's treatment of a patient shall not incur criminal or civil liability for damages caused by the inaccurate or incomplete nature of this information.

"**§ 90-414.8. Continuing right to opt out; effect of opt out; exception for emergency medical treatment.**

(a) Each individual has the right on a continuing basis to opt out or rescind a decision to opt out.

(b) The Authority or its designee shall enforce an individual's decision to opt out or rescind an opt out prospectively from the date the Authority or its designee receives notice of the individual's decision to opt out or rescind an opt out in the manner prescribed by the Authority. An individual's decision to opt out or rescind an opt out does not affect any disclosures made by the Authority or covered entities through the HIE Network prior to receipt by the Authority or its designee of the individual's notice to opt out or rescind an opt out.

(c) A covered entity may not deny treatment or benefits to an individual because of the individual's decision to opt out. However, nothing in this Article is intended to restrict a treating physician from otherwise appropriately terminating a relationship with a patient in accordance with applicable law and professional ethical standards.

(d) Except as otherwise permitted in subsection (e) of this section and G.S. 90-414.9(a)(3), the protected health information of an individual who has exercised the right to opt out may not be disclosed to covered entities through the HIE Network for any purpose.

(e) The protected health information of an individual who has exercised the right to opt out may be disclosed through the HIE Network in order to facilitate the provision of emergency medical treatment to the individual if all of the following criteria are met:

(1) The reasonably apparent circumstances indicate to the treating health care provider that (i) the individual has an emergency medical condition, (ii) a meaningful discussion with the individual about whether to rescind a previous decision to opt out is impractical due to the nature of the individual's emergency medical condition, and (iii) information available through the HIE Network could assist in the diagnosis or treatment of the individual's emergency medical condition.

(2) The disclosure through the HIE Network is limited to the covered entities providing diagnosis and treatment of the individual's emergency medical condition.

(3) The circumstances and extent of the disclosure through the HIE Network is recorded electronically in a manner that permits the Authority or its designee to periodically audit compliance with this subsection.

"**§ 90-414.9. Construction and applicability.**

(a) Nothing in this Article shall be construed to do any of the following:

(1) Impair any rights conferred upon an individual under HIPAA, including all of the following rights related to an individual's protected health information:

a. The right to receive a notice of privacy practices.

b. The right to request restriction of use and disclosure.

c. The right of access to inspect and obtain copies.

d. The right to request amendment.

e. The right to request confidential forms of communication.

f. The right to receive an accounting of disclosures.

(2) Authorize the disclosure of protected health information through the HIE Network to the extent that the disclosure is restricted by federal laws or regulations, including the federal drug and alcohol confidentiality regulations set forth in 42 C.F.R. Part 2.

(3) Restrict the disclosure of protected health information through the HIE Network for public health purposes or research purposes, so long as disclosure is permitted by both HIPAA and State law.

(4) Prohibit the Authority or any covered entity participating in the HIE Network from maintaining in the Authority's or qualified organization's computer system a copy of the protected health information of an individual who has exercised the right to opt out, as long as the Authority or the qualified organization does not access, use, or disclose the individual's protected health information for any purpose other than for necessary system maintenance or as required by federal or State law.

(b) This Article applies only to disclosures of protected health information made through the HIE Network, including disclosures made within qualified organizations. It does not apply to the use or disclosure of protected health information in any context outside of the HIE Network, including the redisclosure of protected health information obtained through the HIE Network.

"**§ 90-414.10. Penalties and remedies.**

A covered entity that discloses protected health information in violation of this Article is subject to the following:

(1) Any civil penalty or criminal penalty, or both, that may be imposed on the covered entity pursuant to the Health Information Technology for Economic and Clinical Health (HITECH) Act, P.L. 111-5, Div. A, Title XIII, section 13001, as amended, and any regulations adopted under the HITECH Act.

(2) Any civil remedy under the HITECH Act or any regulations adopted under the HITECH Act that is available to the Attorney General or to an individual who has been harmed by a violation of this Article, including damages, penalties, attorneys' fees, and costs.

(3) Disciplinary action by the respective licensing board or regulatory agency with jurisdiction over the covered entity.

(4) Any penalty authorized under Article 2A of Chapter 75 of the General Statutes if the violation of this Article is also a violation of Article 2A of Chapter 75 of the General Statutes.

(5) Any other civil or administrative remedy available to a plaintiff by State or federal law or equity."

SECTION 12A.5.(e) G.S. 126-5 is amended by adding a new subdivision to read:

"**§ 126-5. Employees subject to Chapter; exemptions.**

…

(c1) Except as to the provisions of Articles 6 and 7 of this Chapter, the provisions of this Chapter shall not apply to:

…

(31) Employees of the North Carolina Health Information Exchange Authority."

SECTION 12A.5.(f) Article 29A of Chapter 90 of the General Statutes is repealed.

SECTION 12A.5.(g) Subsections (d) and (e) of this section become effective October 1, 2015. Subsection (f) of this section becomes effective on the date the State Chief Information Officer notifies the Revisor of Statutes that all contracts pertaining to the HIE Network established under Article 29A of Chapter 90 of the General Statutes (i) between the State and the NC HIE, as defined in G.S. 90-413.3, and (ii) between the NC HIE and any third parties have been terminated or assigned to the North Carolina Health Information Exchange

Authority established under Article 29B of Chapter 90 of the General Statutes, as enacted by subsection (d) of this section. The remainder of this section becomes effective July 1, 2015.

FUNDS FOR NCTRACKS, THE REPLACEMENT MULTIPAYER MEDICAID MANAGEMENT INFORMATION SYSTEM

SECTION 12A.6. Of the funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, for NCTRACKS, the sum of four hundred thousand dollars ($400,000) for the 2015-2016 fiscal year and the sum of four hundred thousand dollars ($400,000) for the 2016-2017 fiscal year shall be used to operate and maintain NCTRACKS; and the sum of two million three hundred thousand dollars ($2,300,000) in nonrecurring funds for the 2015-2016 fiscal year and the sum of nine hundred forty thousand dollars ($940,000) in nonrecurring funds for the 2016-2017 fiscal year shall be used to develop and implement the ICD-10 Project and the Business Process Automated System for the Division of Health Service Regulation. In addition, overrealized receipts are hereby appropriated to the Department of Health and Human Services, Division of Central Management and Support, up to the amounts necessary to implement this section. In the event it becomes necessary for the Department to utilize these overrealized receipts or any other funds appropriated to the Department to implement this section, the Department shall first (i) obtain prior approval from the Office of State Budget and Management (OSBM) and (ii) consult with the Joint Legislative Oversight Committees on Health and Human Services and Information Technology and the Fiscal Research Division. As part of the consultation required by this section, the Department shall provide the amounts of any overrealized receipts or other funds it intends to use to make up for any shortfall in funding for NCTRACKS and an explanation of the circumstances necessitating the use of overrealized receipts or other funds to make up for the shortfall.

FUNDS FOR NORTH CAROLINA FAMILIES ACCESSING SERVICES THROUGH TECHNOLOGY (NC FAST)

SECTION 12A.7.(a) Departmental receipts appropriated in this act in the amount of nine million eight hundred seventy-one thousand fifty-nine dollars ($9,871,059) for the 2015-2016 fiscal year and thirteen million two hundred twenty thousand six hundred sixty-five dollars ($13,220,665) for the 2016-2017 fiscal year shall be used to provide ongoing maintenance and operations for the NC FAST system, including the creation of three full-time equivalent technology support analyst positions.

SECTION 12A.7.(b) Prior year earned revenue appropriated in this act in the amount of six million six hundred forty-seven thousand eight hundred forty-nine dollars ($6,647,849) for the 2015-2016 fiscal year and five million two hundred ninety-eight thousand one hundred seventy-eight dollars ($5,298,178) for the 2016-2017 fiscal year and the cash balance in Budget Code 24410 Fund 2411 for the North Carolina Families Accessing Services through Technology (NC FAST) project shall be used to match federal funds in the 2015-2016 and 2016-2017 fiscal years to expedite the development and implementation of Child Care, Low Income Energy Assistance, Crisis Intervention Programs, Child Services, and NC FAST Federally-Facilitated Marketplace (FFM) Interoperability components of the NC FAST program. The Department shall report any changes in approved federal funding or federal match rates within 30 days after the change to the Joint Legislative Oversight Committees on Health and Human Services and Information Technology and the Fiscal Research Division.

COMPETITIVE GRANTS/NONPROFIT ORGANIZATIONS, HEALTH DISPARITY-RELATED INITIATIVES, AND PHYSICAL HEALTH AND NUTRITION

SECTION 12A.8.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, the following amounts shall be used for the specified purposes:

(1) The sum of ten million three hundred twenty-eight thousand nine hundred eleven dollars ($10,328,911) for each year of the 2015-2017 fiscal biennium and the sum of three million eight hundred fifty-two thousand five hundred dollars ($3,852,500) appropriated in Section 12I.1 of this act in Social Services Block Grant funds for each year of the 2015-2017 fiscal biennium shall be used to allocate funds for nonprofit organizations.

(2) The sum of three million two hundred ninety-nine thousand five hundred seventy-six dollars ($3,299,576), offset by receipts in the amount of one hundred fifty-five thousand four hundred sixty-eight dollars ($155,468) for each year of the 2015-2017 fiscal biennium and the sum of two million seven hundred fifty-six thousand eight hundred fifty-five dollars ($2,756,855) appropriated in Section 12I.1 of this act in Preventive Health Services Block Grant funds for the 2015-2016 fiscal year shall be used to continue the established competitive grants process for health disparity-related initiatives.

(3) The sum of four hundred twenty-six thousand three hundred thirty-three dollars ($426,333), offset by receipts in the amount of one hundred sixty thousand twenty-one dollars ($160,021) for each year of the 2015-2017 fiscal biennium and the sum of one million two hundred forty-three thousand eight hundred ninety-nine dollars ($1,243,899) appropriated in Section 12I.1 of this act in Preventive Health Services Block Grant funds for the 2015-2016 fiscal year shall be used to establish a competitive grants process for physical health and nutrition-related initiatives.

SECTION 12A.8.(b) Nonprofit Organizations. –

(1) The Department shall continue administering a competitive grants process for nonprofit funding. The Department shall administer a plan that, at a minimum, includes each of the following:

a. A request for application (RFA) process to allow nonprofits to apply for and receive State funds on a competitive basis. The Department shall require nonprofits to include in the application, a plan to evaluate the effectiveness, including measurable impact or outcomes, of the activities, services, and programs for which the funds are being requested.

b. A requirement that nonprofits match a minimum of fifteen percent (15%) of the total amount of the grant award.

c. A requirement that the Secretary prioritize grant awards to those nonprofits that are able to leverage non-State funds in addition to the grant award.

d. A process that awards grants to nonprofits that have the capacity to provide services on a statewide basis and that support any of the following State health and wellness initiatives:

1. A program targeting advocacy, support, education, or residential services for persons diagnosed with autism.

2. A system of residential supports for those afflicted with substance abuse addiction.

3. A program of advocacy and supports for individuals with intellectual and developmental disabilities or severe and persistent mental illness, substance abusers, or the elderly.

4. Supports and services to children and adults with developmental disabilities or mental health diagnoses.
5. A food distribution system for needy individuals.
6. The provision and coordination of services for the homeless.
7. The provision of services for individuals aging out of foster care.
8. Programs promoting wellness, physical activity, and health education programming for North Carolinians.
9. The provision of services and screening for blindness.
10. Provision for the delivery of after-school services for apprenticeships or mentoring at-risk youth.
11. The provision of direct services for amyotrophic lateral sclerosis (ALS) and those diagnosed with the disease.
12. A comprehensive smoking prevention and cessation program that screens and treats tobacco use in pregnant women and postpartum mothers.
13. A program providing short-term or long-term residential substance abuse services. For purposes of this sub-subdivision, "long-term" means a minimum of 12 months.

e. Ensures that funds received by the Department to implement the plan supplement and do not supplant existing funds for health and wellness programs and initiatives.
f. Allows grants to be awarded to nonprofits for up to two years.
g. With grants awarded beginning July 1, 2016, a requirement that of the funds provided for competitive grants pursuant to this section, a minimum of five percent (5%) of the grants be awarded to new grant recipients who did not receive grant awards during the previous competitive grants process.

(2) No later than July 1, 2015, and every two years thereafter, as applicable, the Secretary shall announce the recipients of the competitive grant awards and allocate funds to the grant recipients for the respective grant period pursuant to the amounts designated under subdivision (1) of subsection (a) of this section. After awards have been granted, the Secretary shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services on the grant awards that includes at least all of the following:
a. The identity and a brief description of each grantee and each program or initiative offered by the grantee.
b. The amount of funding awarded to each grantee.
c. The number of persons served by each grantee, broken down by program or initiative.

(3) No later than December 1 of each fiscal year, each nonprofit organization receiving funding pursuant to this subsection in the respective fiscal year shall submit to the Division of Central Management and Support a written report of all activities funded by State appropriations. The report shall include the following information about the fiscal year preceding the year in which the report is due:
a. The entity's mission, purpose, and governance structure.
b. A description of the types of programs, services, and activities funded by State appropriations.

c. Statistical and demographical information on the number of persons served by these programs, services, and activities, including the counties in which services are provided.
d. Outcome measures that demonstrate the impact and effectiveness of the programs, services, and activities.
e. A detailed program budget and list of expenditures, including all positions funded, matching expenditures, and funding sources.

(4) For the 2015-2017 fiscal biennium only, from the funds identified in subdivision (1) of subsection (a) of this section, the Department shall allocate the sum of three hundred fifty thousand dollars ($350,000) in each year of the 2015-2017 fiscal biennium to Big Brothers Big Sisters North Carolina Collaborative for the purpose of providing mentoring services. Big Brothers Big Sisters North Carolina Collaborative shall be required to seek future funding through the competitive grants process in accordance with subdivision (1) of this subsection.

SECTION 12A.8.(c) Health Disparity-Related Initiatives. –

(1) Funds identified in subdivision (2) of subsection (a) of this section shall be used to continue the competitive grants process established to close the gap in the health status of African-Americans, Hispanics/Latinos, and American Indians as compared to the health status of white persons. These grants shall continue to focus on the use of measures to eliminate or reduce health disparities among minority populations in this State with respect to heart disease, stroke, diabetes, obesity, asthma, HIV/AIDS, cancer, infant mortality, and low birth weight.

(2) It is the intent of the General Assembly that the Department continue implementing the competitive grants process established for health disparity-related initiatives funding to be administered by the Division of Central Management and Support. The Department shall continue implementing a process that, at a minimum, includes each of the following:
a. A request for application (RFA) process to allow an entity to apply for and receive State funds on a competitive basis. The Department shall require entities to include in the application, a plan to evaluate the effectiveness, including measurable impact or outcomes, of activities, services, and programs for which the funds are being requested.
b. The amount of any grant award is limited to three hundred thousand dollars ($300,000).
c. Only community-based organizations, faith-based organizations, local health departments, and hospitals located in urban and rural areas of the western, eastern, and Piedmont areas of this State are eligible to apply for these grants. No more than four grants shall be awarded to applicants located in any one of the three areas specified in this sub-subdivision.
d. Each eligible applicant shall be required to demonstrate substantial participation and involvement with all other categories of eligible applicants in order to ensure an evidence-based medical home model that will affect change in health and geographic disparities.
e. Eligible applicants shall select one or more of the following chronic illnesses or conditions specific to the applicant's geographic area as the basis for applying for a grant under this subdivision to affect

change in the health status of African-Americans, Hispanics/Latinos, or American Indians:

1. Heart disease.
2. Stroke.
3. Diabetes.
4. Obesity.
5. Asthma.
6. HIV/AIDS.
7. Cancer.
8. Infant mortality.
9. Low birth weight.

f. The minimum duration of the grant period for any grant awarded under this subsection is two years.

g. The maximum duration of the grant period for any grant awarded under this subsection is three years.

h. If approved for a grant award, the grantee (i) shall not use more than eight percent (8%) of the grant funds for overhead costs and (ii) shall be required at the end of the grant period to demonstrate significant gains in addressing one or more of the health disparity focus areas identified in subdivision (1) of this subsection.

i. An independent panel with expertise in the delivery of services to minority populations, health disparities, chronic illnesses and conditions, and HIV/AIDS shall conduct the review of applications for grants. The Department shall establish the independent panel required by this sub-subdivision.

(3) The grants awarded under this subsection shall be awarded in honor of the memory of the following deceased members of the General Assembly: Bernard Allen, Pete Cunningham, John Hall, Robert Holloman, Howard Hunter, Ed Jones, Jeanne Lucas, Vernon Malone, William Martin, and William Wainwright. These funds shall be used for concerted efforts to address large gaps in health status among North Carolinians who are African-American, as well as disparities among other minority populations in North Carolina.

(4) By October 1, 2017, the Department shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on funds appropriated for grants allocated pursuant to this subsection for the 2015-2017 fiscal biennium. The report shall include specific activities undertaken by grantees pursuant to subdivision (1) of this subsection to address large gaps in health status among North Carolinians who are African-American and other minority populations in this State and shall also address all of the following:

a. Which community-based organizations, faith-based organizations, local health departments, and hospitals received grants.

b. The amount of funding awarded to each grantee.

c. Which of the minority populations were served by each grantee.

d. Which community-based organizations, faith-based organizations, local health departments, and hospitals were involved in fulfilling the goals and activities of each grant-in-aid awarded under this section and what activities were planned and implemented by the grantee to fulfill the community focus of grants awarded pursuant to this subsection.

e. How the activities implemented by the grantee fulfilled the goal of reducing health disparities among minority populations and the specific success in reducing particular incidences.

SECTION 12A.8.(d) Physical Health and Nutrition-Related Activities. –

(1) Funds identified in subdivision (3) of subsection (a) of this section shall be used to establish and administer a competitive grants process for programs demonstrated to improve physical health and nutrition across the State.

(2) It is the intent of the General Assembly that, beginning fiscal year 2015-2016, the Department implements a competitive grants process for physical health and nutrition-related initiatives funding. To that end, the Department shall develop a plan that establishes a competitive grants process to be administered by the Division of Central Management and Support. The Department shall develop a plan that, at a minimum, includes each of the following:

a. A request for application (RFA) process to allow an entity to apply for and receive State funds on a competitive basis. The Department shall require entities to include in the application, a plan to evaluate the effectiveness, including measurable impact or outcomes, of activities, services, and programs for which the funds are being requested.

b. A process that awards grants to entities that have the capacity to provide services on a statewide basis and support physical health and nutrition initiatives.

c. Ensures that funds received by the Department to implement the plan supplement and do not supplant existing funds for physical health and nutrition programs and initiatives.

d. Allows grants to be awarded for up to two years.

(3) No later than February 1, 2016, the Secretary of Health and Human Services shall develop a plan for the implementation of the competitive grants process for physical health and nutrition-related initiative funding and shall report to the Joint Legislative Oversight Committee on Health and Human Services on the plan.

(4) No later than March 1, 2016, the Secretary of Health and Human Services shall implement the plan for the competitive grants process.

(5) No later than July 1, 2016, the Secretary shall announce the recipients of the competitive grant awards and allocate funds to the grant recipients for the 2016-2017 fiscal year pursuant to the amounts designated under subdivision (3) of subsection (a) of this section. After awards have been granted, the Secretary shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services on the grant awards that includes at least all of the following:

a. The identity and a brief description of each grantee and each program or initiative offered by the grantee.

b. The amount of funding awarded to each grantee.

c. The number of persons served by each grantee, broken down by program or initiative.

(6) No later than December 1, 2016, each program receiving funding pursuant to subdivision (3) of subsection (a) of this section shall submit to the Division of Central Management and Support a written report of all activities funded by State appropriations. The report shall include the following information about the fiscal year preceding the year in which the report is due:

a. The entity's mission, purpose, and governance structure.
b. A description of the type of program, service, or activity funded by State appropriations.
c. Statistical and demographical information on the number of persons served by the program, service, or activity, including the counties in which services are provided.
d. Outcome measures that demonstrate the impact and effectiveness of the program, service, or activity.
e. A detailed program budget and list of expenditures, including all positions funded and funding sources.
f. The source and amount of any matching funds received by the entity.

COMMUNITY HEALTH GRANT PROGRAM CHANGES

SECTION 12A.9. The Department of Health and Human Services, Office of Rural Health and Community Care, shall repurpose two million two hundred fifty thousand dollars ($2,250,000) in Health Net appropriations to the Community Health Grant Program. The new appropriation for this program is seven million six hundred eighty-seven thousand one hundred sixty-nine dollars ($7,687,169) in recurring funds. To ensure continuity of care, safety-net agencies receiving Health Net funds at the end of the 2014-2015 fiscal year shall be eligible to apply for and receive Community Health Grant funds at their current level of funding for the 2015-2016 and 2016-2017 fiscal years. After the 2016-2017 fiscal year, these agencies must submit an application for funding through the competitive Community Health Grant process. The Community Health Grant Program is available to rural health centers, free clinics, public health departments, school-based health centers, federally qualified health centers, and other nonprofit organizations that provide primary care and preventive health services to low-income populations, including uninsured, underinsured, Medicaid, and Medicare residents across the State.

RURAL HEALTH LOAN REPAYMENT PROGRAMS

SECTION 12A.10.(a) The Department of Health and Human Services, Office of Rural Health and Community Care, shall use funds appropriated in this act for loan repayment to medical, dental, and psychiatric providers practicing in State hospitals or in rural or medically underserved communities in this State to combine the following loan repayment programs in order to achieve efficient and effective management of these programs:

(1) The Physician Loan Repayment Program.
(2) The Psychiatric Loan Repayment Program.
(3) The Loan Repayment Initiative at State Facilities.

SECTION 12A.10.(b) These funds may be used for the following additional purposes:

(1) Continued funding of the State Loan Repayment Program for primary care providers and expansion of State incentives to general surgeons practicing in Critical Access Hospitals (CAHs) located across the State.
(2) Expansion of the State Loan Repayment Program to include eligible providers residing in North Carolina who use telemedicine in rural and underserved areas.

FUNDS FOR COMMUNITY PARAMEDICINE PILOT PROGRAM

SECTION 12A.12.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, for the 2015-2016 fiscal year, the sum of three hundred fifty thousand dollars ($350,000) shall be used to implement a community paramedicine pilot program. The pilot program shall focus on

expanding the role of paramedics to allow for community-based initiatives that result in providing care that avoids nonemergency use of emergency rooms and 911 services and avoids unnecessary admissions into health care facilities.

SECTION 12A.12.(b) The North Carolina Office of Emergency Medical Services (NCOEMS) shall set the education standards and other requirements necessary to qualify as a community paramedic eligible to participate in the pilot program established in subsection (a) of this section. The Department shall consult with the NCOEMS to define the objectives, set standards, and establish the required outcomes for the pilot program.

SECTION 12A.12.(c) The Department of Health and Human Services shall establish up to three program sites to implement the community paramedicine pilot program, one of which shall be New Hanover Regional Emergency Medical Services. For the 2015-2016 fiscal year, the New Hanover Regional Emergency Medical Services program site shall be awarded up to two hundred ten thousand dollars ($210,000), and each of the remaining program sites may be awarded up to seventy thousand dollars ($70,000). In selecting the remaining program sites, the Department may give preference to counties that currently have an established community paramedic program.

SECTION 12A.12.(d) The Department of Health and Human Services shall submit a report to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Committee on Health and Human Services, and the Fiscal Research Division by June 1, 2016, on the progress of the pilot program and shall include an evaluation plan based on the U.S. Department of Health and Human Services, Health Resources and Services Administration Office of Rural Health Policy's Community Paramedicine Evaluation Tool published in March 2012.

SECTION 12A.12.(e) The Department of Health and Human Services shall submit a final report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2016. At a minimum, the final report shall include all of the following:

(1) An updated version of the evaluation plan required by subsection (d) of this section.
(2) An estimate of the cost to expand the program incrementally and statewide.
(3) An estimate of any potential savings of State funds associated with expansion of the program.
(4) If expansion of the program is recommended, a time line for expanding the program.

FUNDS FOR DESIGN AND IMPLEMENTATION OF CONTRACTING SPECIALIST AND CERTIFICATION PROGRAM

SECTION 12A.13. Funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, for the design of a contracting specialist training and certification program for management level personnel within the Department of Health and Human Services (DHHS) shall be used as follows:

(1) For the 2015-2016 fiscal year, the sum of one hundred fifty thousand dollars ($150,000) in nonrecurring funds shall be allocated to the University of North Carolina School of Government (SOG) to design the program for permanent administration by the Office of State Human Resources (OSHR). SOG shall design a program that is similar to its Certified Local Government Purchasing Officer program and local purchasing and contracts program. OSHR, SOG, and the Office of the State Chief Information Officer shall provide assistance on program design and implementation as requested by DHHS, OSHR, or SOG. To the extent practical, DHHS, OSHR, and SOG shall design and develop the program as a prototype for a State

government-wide program. Although designed for personal and professional services contracting, the design may incorporate any applicable best practices for construction and technology contracting.

(2) For the 2016-2017 fiscal year:

a. The sum of twenty-five thousand dollars ($25,000) in nonrecurring funds shall be used to assist both DHHS and OSHR with program implementation.

b. The sum of one hundred seventy-five thousand dollars ($175,000) in recurring funds shall be used for program support and to fund two full-time equivalent positions within OSHR dedicated to oversight of, and training for, this new program.

CHILD WELFARE CASE MANAGEMENT SYSTEM

SECTION 12A.14.(a) Funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, in the amount of five million eight hundred three thousand dollars ($5,803,000) in nonrecurring funds and prior year earned revenue in the amount of two million seven hundred fifty-two thousand one hundred fifty-one dollars ($2,752,151) for the 2015-2016 fiscal year and in the amount of thirteen million fifty-two thousand dollars ($13,052,000) in nonrecurring funds and prior year earned revenue in the amount of four million one hundred one thousand eight hundred twenty-four dollars ($4,101,824) for the 2016-2017 fiscal year shall be used to purchase a child welfare case management system that has demonstrated its ability to provide child welfare case management services in another state within the United States. The Division shall purchase a system that can be integrated with North Carolina Families Accessing Services through Technology (NC FAST) and the work product of the Child Protective Services Pilot Project being conducted in accordance with Section 12C.11 of this act. The Division shall issue a request for proposals (RFP) in selecting a system for purchase. The Department shall not move forward with implementing the child welfare case management system in NC FAST.

SECTION 12A.14.(b) It is the intent of the General Assembly that beginning fiscal year 2016-2017, all Department of Health and Human Services' information technology assets, resources, and personnel transfer to the Department of Information Technology, as created in this act. To that end, the planning, development, and implementation of the child welfare case management system described in this section shall be coordinated with the Department of Information Technology.

SECTION 12A.14.(c) The Department shall report on the results of the RFP to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Information Technology, and the Fiscal Research Division no later than October 1, 2016.

SUBPART XII-B. DIVISION OF CHILD DEVELOPMENT AND EARLY EDUCATION

NC PRE-K PROGRAM/STANDARDS FOR FOUR- AND FIVE-STAR RATED FACILITIES

SECTION 12B.1.(a) Eligibility. – The Department of Health and Human Services, Division of Child Development and Early Education, shall continue implementing the prekindergarten program (NC Pre-K). The NC Pre-K program shall serve children who are four years of age on or before August 31 of the program year. In determining eligibility, the Division shall establish income eligibility requirements for the program not to exceed seventy-five percent (75%) of the State median income. Up to twenty percent (20%) of children enrolled may have family incomes in excess of seventy-five percent (75%) of median income if those children have other designated risk factors. Furthermore, any age-eligible child who is a

child of either of the following shall be eligible for the program: (i) an active duty member of the Armed Forces of the United States, including the North Carolina National Guard, State military forces, or a reserve component of the Armed Forces who was ordered to active duty by the proper authority within the last 18 months or is expected to be ordered within the next 18 months or (ii) a member of the Armed Forces of the United States, including the North Carolina National Guard, State military forces, or a reserve component of the Armed Forces who was injured or killed while serving on active duty. Eligibility determinations for prekindergarten participants may continue through local education agencies and local North Carolina Partnership for Children, Inc., partnerships.

Other than developmental disabilities or other chronic health issues, the Division shall not consider the health of a child as a factor in determining eligibility for participation in the NC Pre-K program.

SECTION 12B.1.(b) Multiyear Contracts. – The Division of Child Development and Early Education shall require the NC Pre-K contractor to issue multiyear contracts for licensed private child care centers providing NC Pre-K classrooms.

SECTION 12B.1.(c) Programmatic Standards. – All entities operating prekindergarten classrooms shall adhere to all of the policies prescribed by the Division of Child Development and Early Education regarding programmatic standards and classroom requirements.

SECTION 12B.1.(d) NC Pre-K Committees. – Local NC Pre-K committees shall use the standard decision-making process developed by the Division of Child Development and Early Education in awarding prekindergarten classroom slots and student selection.

SECTION 12B.1.(e) Reporting. – The Division of Child Development and Early Education shall submit an annual report no later than March 15 of each year to the Joint Legislative Oversight Committee on Health and Human Services, the Office of State Budget and Management, and the Fiscal Research Division. The report shall include the following:

(1) The number of children participating in the NC Pre-K program by county.

(2) The number of children participating in the NC Pre-K program who have never been served in other early education programs such as child care, public or private preschool, Head Start, Early Head Start, or early intervention programs.

(3) The expected NC Pre-K expenditures for the programs and the source of the local contributions.

(4) The results of an annual evaluation of the NC Pre-K program.

SECTION 12B.1.(f) Audits. – The administration of the NC Pre-K program by local partnerships shall be subject to the financial and compliance audits authorized under G.S. 143B-168.14(b).

CHILD CARE SUBSIDY RATES

SECTION 12B.2.(a) The maximum gross annual income for initial eligibility, adjusted biennially, for subsidized child care services shall be determined based on a percentage of the federal poverty level as follows:

AGE	INCOME PERCENTAGE LEVEL
0 – 5	200%
6 – 12	133%

The eligibility for any child with special needs, including a child who is 13 years of age or older, shall be two hundred percent (200%) of the federal poverty level.

SECTION 12B.2.(b) Effective July 1, 2015, the Department of Health and Human Services, Division of Child Development and Early Education, shall revise its child care subsidy policy to exclude from the policy's definition of "income unit" a nonparent relative

caretaker, and the caretaker's spouse and child, if applicable, when the parent of the child receiving child care subsidy does not live in the home with the child.

SECTION 12B.2.(c) Fees for families who are required to share in the cost of care are established based on ten percent (10%) of gross family income. Co-payments shall not be prorated for part-time care.

SECTION 12B.2.(d) Payments for the purchase of child care services for low-income children shall be in accordance with the following requirements:

(1) Religious-sponsored child care facilities operating pursuant to G.S. 110-106 and licensed child care centers and homes that meet the minimum licensing standards that are participating in the subsidized child care program shall be paid the one-star county market rate or the rate they charge privately paying parents, whichever is lower, unless prohibited by subsection (g) of this section.

(2) Licensed child care centers and homes with two or more stars shall receive the market rate for that rated license level for that age group or the rate they charge privately paying parents, whichever is lower, unless prohibited by subsection (g) of this section.

(3) Nonlicensed homes shall receive fifty percent (50%) of the county market rate or the rate they charge privately paying parents, whichever is lower.

(4) No payments shall be made for transportation services or registration fees charged by child care facilities.

(5) Payments for subsidized child care services for postsecondary education shall be limited to a maximum of 20 months of enrollment.

(6) The Department of Health and Human Services shall implement necessary rule changes to restructure services, including, but not limited to, targeting benefits to employment.

SECTION 12B.2.(e) Provisions of payment rates for child care providers in counties that do not have at least 50 children in each age group for center-based and home-based care are as follows:

(1) Except as applicable in subdivision (2) of this subsection, payment rates shall be set at the statewide or regional market rate for licensed child care centers and homes.

(2) If it can be demonstrated that the application of the statewide or regional market rate to a county with fewer than 50 children in each age group is lower than the county market rate and would inhibit the ability of the county to purchase child care for low-income children, then the county market rate may be applied.

SECTION 12B.2.(f) A market rate shall be calculated for child care centers and homes at each rated license level for each county and for each age group or age category of enrollees and shall be representative of fees charged to parents for each age group of enrollees within the county. The Division of Child Development and Early Education shall also calculate a statewide rate and regional market rate for each rated license level for each age category.

SECTION 12B.2.(g) The Division of Child Development and Early Education shall continue implementing policies that improve the quality of child care for subsidized children, including a policy in which child care subsidies are paid, to the extent possible, for child care in the higher-quality centers and homes only. The Division shall define higher-quality, and subsidy funds shall not be paid for one- or two-star-rated facilities. For those counties with an inadequate number of four- and five-star-rated facilities, the Division shall continue a transition period that allows the facilities to continue to receive subsidy funds while the facilities work on the increased star ratings. The Division may allow exemptions in

counties where there is an inadequate number of four- and five-star-rated facilities for non-star-rated programs, such as religious programs.

SECTION 12B.2.(h) Facilities licensed pursuant to Article 7 of Chapter 110 of the General Statutes and facilities operated pursuant to G.S. 110-106 may participate in the program that provides for the purchase of care in child care facilities for minor children of needy families. Except as authorized by subsection (g) of this section, no separate licensing requirements shall be used to select facilities to participate. In addition, child care facilities shall be required to meet any additional applicable requirements of federal law or regulations. Child care arrangements exempt from State regulation pursuant to Article 7 of Chapter 110 of the General Statutes shall meet the requirements established by other State law and by the Social Services Commission.

County departments of social services or other local contracting agencies shall not use a provider's failure to comply with requirements in addition to those specified in this subsection as a condition for reducing the provider's subsidized child care rate.

SECTION 12B.2.(i) Payment for subsidized child care services provided with Temporary Assistance for Needy Families Block Grant funds shall comply with all regulations and policies issued by the Division of Child Development and Early Education for the subsidized child care program.

SECTION 12B.2.(j) Noncitizen families who reside in this State legally shall be eligible for child care subsidies if all other conditions of eligibility are met. If all other conditions of eligibility are met, noncitizen families who reside in this State illegally shall be eligible for child care subsidies only if at least one of the following conditions is met:

(1) The child for whom a child care subsidy is sought is receiving child protective services or foster care services.

(2) The child for whom a child care subsidy is sought is developmentally delayed or at risk of being developmentally delayed.

(3) The child for whom a child care subsidy is sought is a citizen of the United States.

SECTION 12B.2.(k) The Department of Health and Human Services, Division of Child Development and Early Education, shall require all county departments of social services to include on any forms used to determine eligibility for child care subsidy whether the family waiting for subsidy is receiving assistance through the NC Pre-K Program or Head Start.

CHILD CARE SUBSIDY MARKET RATE INCREASES/CERTAIN AGE GROUPS AND COUNTIES

SECTION 12B.2A. Beginning September 1, 2015, the Department of Health and Human Services, Division of Child Development and Early Education, shall increase the child care subsidy market rates to the rates recommended by the 2013 Child Care Market Rate Study from birth through two years of age in three-, four-, and five-star-rated child care centers and homes in tier one and tier two counties. For purposes of this section, tier one and tier two counties shall have the same designations as those established by the N.C. Department of Commerce.

CHILD CARE ALLOCATION FORMULA

SECTION 12B.3.(a) The Department of Health and Human Services shall allocate child care subsidy voucher funds to pay the costs of necessary child care for minor children of needy families. The mandatory thirty-percent (30%) North Carolina Partnership for Children, Inc., subsidy allocation under G.S. 143B-168.15(g) shall constitute the base amount for each county's child care subsidy allocation. The Department of Health and Human Services shall use the following method when allocating federal and State child care funds, not including the

aggregate mandatory thirty-percent (30%) North Carolina Partnership for Children, Inc., subsidy allocation:

(1) Funds shall be allocated to a county based upon the projected cost of serving children under age 11 in families with all parents working who earn less than the applicable federal poverty level percentage set forth in Section 12B.2 of this act.

(2) The Department of Health and Human Services shall allocate to counties all State funds appropriated for child care subsidy and shall not withhold funds during the 2015-2016 and 2016-2017 fiscal years.

SECTION 12B.3.(b) The Department of Health and Human Services may reallocate unused child care subsidy voucher funds in order to meet the child care needs of low-income families. Any reallocation of funds shall be based upon the expenditures of all child care subsidy voucher funding, including North Carolina Partnership for Children, Inc., funds within a county.

SECTION 12B.3.(c) When implementing the formula under subsection (a) of this section, the Department of Health and Human Services, Division of Child Development and Early Education, shall include the market rate increase in the formula process, rather than calculating the increases outside of the formula process. Additionally, the Department shall do the following:

(1) For fiscal year 2015-2016, (i) continue implementing one-third of the change in a county's allocation based on the new Census data; (ii) implement an additional one-third of the change in a county's allocation beginning fiscal year 2016-2017; and (iii) the final one-third change in a county's allocation beginning fiscal year 2018-2019. However, beginning fiscal year 2015-2016, a county's initial allocation shall be the county's expenditure in the previous fiscal year. With the exception of market rate increases consistent with any increases approved by the General Assembly, a county whose spending coefficient is less than ninety-five percent (95%) in the previous fiscal year shall receive its prior year's expenditure as its allocation and shall not receive an increase in its allocation in the following year. A county whose spending coefficient is at least ninety-five percent (95%) in the previous fiscal year shall receive, at a minimum, the amount it expended in the previous fiscal year and may receive additional funding, if available. The Division may waive this requirement and allow an increase if the spending coefficient is below ninety-five percent (95%) due to extraordinary circumstances, such as a State or federal disaster declaration in the affected county. By October 1 of each year, the Division shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division the counties that received a waiver pursuant to this subdivision and the reasons for the waiver.

(2) Effective immediately following the next new Census data release, implement (i) one-third of the change in a county's allocation in the year following the data release; (ii) an additional one-third of the change in a county's allocation beginning two years after the initial change under this subdivision; and (iii) the final one-third change in a county's allocation beginning the following two years thereafter.

CHILD CARE FUNDS MATCHING REQUIREMENTS

SECTION 12B.4. No local matching funds may be required by the Department of Health and Human Services as a condition of any locality's receiving its initial allocation of child care funds appropriated by this act unless federal law requires a match. If the Department

reallocates additional funds above twenty-five thousand dollars ($25,000) to local purchasing agencies beyond their initial allocation, local purchasing agencies must provide a twenty percent (20%) local match to receive the reallocated funds. Matching requirements shall not apply when funds are allocated because of an emergency as defined in G.S. 166A-19.3(6).

CHILD CARE REVOLVING LOAN

SECTION 12B.5. Notwithstanding any law to the contrary, funds budgeted for the Child Care Revolving Loan Fund may be transferred to and invested by the financial institution contracted to operate the Fund. The principal and any income to the Fund may be used to make loans, reduce loan interest to borrowers, serve as collateral for borrowers, pay the contractor's cost of operating the Fund, or pay the Department's cost of administering the program.

ADMINISTRATIVE ALLOWANCE FOR COUNTY DEPARTMENTS OF SOCIAL SERVICES/USE OF SUBSIDY FUNDS FOR FRAUD DETECTION

SECTION 12B.6.(a) The Department of Health and Human Services, Division of Child Development and Early Education, shall fund the allowance that county departments of social services may use for administrative costs at four percent (4%) of the county's total child care subsidy funds allocated in the Child Care and Development Fund Block Grant plan or eighty thousand dollars ($80,000), whichever is greater.

SECTION 12B.6.(b) Each county department of social services may use up to two percent (2%) of child care subsidy funds allocated to the county for fraud detection and investigation initiatives.

SECTION 12B.6.(c) The Division of Child Development and Early Education may adjust the allocations in the Child Care and Development Fund Block Grant under Section 12I.1 of this act according to (i) the final allocations for local departments of social services under subsection (a) of this section and (ii) the funds allocated for fraud detection and investigation initiatives under subsection (b) of this section. The Division shall submit a report on the final adjustments to the allocations of the four percent (4%) administrative costs to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than September 30 of each year.

EARLY CHILDHOOD EDUCATION AND DEVELOPMENT INITIATIVES ENHANCEMENTS

SECTION 12B.7.(a) Policies. – The North Carolina Partnership for Children, Inc., and its Board shall ensure policies focus on the North Carolina Partnership for Children, Inc.'s mission of improving child care quality in North Carolina for children from birth to five years of age. North Carolina Partnership for Children, Inc.-funded activities shall include assisting child care facilities with (i) improving quality, including helping one-, two-, and three-star-rated facilities increase their star ratings and (ii) implementing prekindergarten programs. State funding for local partnerships shall also be used for evidence-based or evidence-informed programs for children from birth to five years of age that do the following:

(1) Increase children's literacy.
(2) Increase the parents' ability to raise healthy, successful children.
(3) Improve children's health.
(4) Assist four- and five-star-rated facilities in improving and maintaining quality.

SECTION 12B.7.(b) Administration. – Beginning fiscal year 2015-2016, administrative costs for central administration shall be equivalent to not more than three and twenty-five hundredths percent (3.25%). Administrative costs shall be equivalent to, on an average statewide basis for all local partnerships, not more than seven and seventy-five hundredths percent (7.75%) of the total statewide allocation to all local partnerships for the

2015-2016 fiscal year and beginning fiscal year 2016-2017, equivalent to not more than seven and five-tenths percent (7.5%) of the total statewide allocation to all local partnerships. For purposes of this subsection, administrative costs shall include costs associated with partnership oversight, business and financial management, general accounting, human resources, budgeting, purchasing, contracting, and information systems management. The North Carolina Partnership for Children, Inc., shall continue using a single statewide contract management system that incorporates features of the required standard fiscal accountability plan described in G.S. 143B-168.12(a)(4). All local partnerships are required to participate in the contract management system and, directed by the North Carolina Partnership for Children, Inc., to collaborate, to the fullest extent possible, with other local partnerships to increase efficiency and effectiveness.

SECTION 12B.7.(c) Salaries. – The salary schedule developed and implemented by the North Carolina Partnership for Children, Inc., shall set the maximum amount of State funds that may be used for the salary of the Executive Director of the North Carolina Partnership for Children, Inc., and the directors of the local partnerships. The North Carolina Partnership for Children, Inc., shall base the schedule on the following criteria:

(1) The population of the area serviced by a local partnership.
(2) The amount of State funds administered.
(3) The amount of total funds administered.
(4) The professional experience of the individual to be compensated.
(5) Any other relevant factors pertaining to salary, as determined by the North Carolina Partnership for Children, Inc.

The salary schedule shall be used only to determine the maximum amount of State funds that may be used for compensation. Nothing in this subsection shall be construed to prohibit a local partnership from using non-State funds to supplement an individual's salary in excess of the amount set by the salary schedule established under this subsection.

SECTION 12B.7.(d) Match Requirements. – The North Carolina Partnership for Children, Inc., and all local partnerships shall, in the aggregate, be required to match one hundred percent (100%) of the total amount budgeted for the program in each fiscal year of the 2015-2017 biennium. Of the funds the North Carolina Partnership for Children, Inc., and the local partnerships are required to match, contributions of cash shall be equal to at least twelve percent (12%) and in-kind donated resources shall be equal to no more than five percent (5%) for a total match requirement of seventeen percent (17%) for the 2015-2016 fiscal year; and contributions of cash shall be equal to at least thirteen percent (13%) and in-kind donated resources shall be equal to no more than six percent (6%) for a total match requirement of nineteen percent (19%) for the 2016-2017 fiscal year. The North Carolina Partnership for Children, Inc., may carry forward any amount in excess of the required match for a fiscal year in order to meet the match requirement of the succeeding fiscal year. Only in-kind contributions that are quantifiable shall be applied to the in-kind match requirement. Volunteer services may be treated as an in-kind contribution for the purpose of the match requirement of this subsection. Volunteer services that qualify as professional services shall be valued at the fair market value of those services. All other volunteer service hours shall be valued at the statewide average wage rate as calculated from data compiled by the Division of Employment Security of the Department of Commerce in the Employment and Wages in North Carolina Annual Report for the most recent period for which data are available. Expenses, including both those paid by cash and in-kind contributions, incurred by other participating non-State entities contracting with the North Carolina Partnership for Children, Inc., or the local partnerships, also may be considered resources available to meet the required private match. In order to qualify to meet the required private match, the expenses shall:

(1) Be verifiable from the contractor's records.

(2) If in-kind, other than volunteer services, be quantifiable in accordance with generally accepted accounting principles for nonprofit organizations.
(3) Not include expenses funded by State funds.
(4) Be supplemental to and not supplant preexisting resources for related program activities.
(5) Be incurred as a direct result of the Early Childhood Initiatives Program and be necessary and reasonable for the proper and efficient accomplishment of the Program's objectives.
(6) Be otherwise allowable under federal or State law.
(7) Be required and described in the contractual agreements approved by the North Carolina Partnership for Children, Inc., or the local partnership.
(8) Be reported to the North Carolina Partnership for Children, Inc., or the local partnership by the contractor in the same manner as reimbursable expenses.

Failure to obtain a seventeen-percent (17%) match by June 30 of the 2015-2016 fiscal year and a nineteen-percent (19%) match by June 30 of the 2016-2017 fiscal year shall result in a dollar-for-dollar reduction in the appropriation for the Program for a subsequent fiscal year. The North Carolina Partnership for Children, Inc., shall be responsible for compiling information on the private cash and in-kind contributions into a report that is submitted to the Joint Legislative Oversight Committee on Health and Human Services in a format that allows verification by the Department of Revenue. The same match requirements shall apply to any expansion funds appropriated by the General Assembly.

SECTION 12B.7.(e) Bidding. – The North Carolina Partnership for Children, Inc., and all local partnerships shall use competitive bidding practices in contracting for goods and services on contract amounts as follows:

(1) For amounts of five thousand dollars ($5,000) or less, the procedures specified by a written policy as developed by the Board of Directors of the North Carolina Partnership for Children, Inc.
(2) For amounts greater than five thousand dollars ($5,000), but less than fifteen thousand dollars ($15,000), three written quotes.
(3) For amounts of fifteen thousand dollars ($15,000) or more, but less than forty thousand dollars ($40,000), a request for proposal process.
(4) For amounts of forty thousand dollars ($40,000) or more, a request for proposal process and advertising in a major newspaper.

SECTION 12B.7.(f) Allocations. – The North Carolina Partnership for Children, Inc., shall not reduce the allocation for counties with less than 35,000 in population below the 2012-2013 funding level.

SECTION 12B.7.(g) Performance-Based Evaluation. – The Department of Health and Human Services shall continue to implement the performance-based evaluation system.

SECTION 12B.7.(h) Expenditure Restrictions. – The Department of Health and Human Services and the North Carolina Partnership for Children, Inc., shall ensure that the allocation of funds for Early Childhood Education and Development Initiatives for the 2015-2017 fiscal biennium shall be administered and distributed in the following manner:

(1) Capital expenditures are prohibited for the 2015-2017 fiscal biennium. For the purposes of this section, "capital expenditures" means expenditures for capital improvements as defined in G.S. 143C-1-1(d)(5).
(2) Expenditures of State funds for advertising and promotional activities are prohibited for the 2015-2017 fiscal biennium.

For the 2015-2017 fiscal biennium, local partnerships shall not spend any State funds on marketing campaigns, advertising, or any associated materials. Local partnerships may spend any private funds the local partnerships receive on those activities.

PLAN FOR MERGER OF EARLY EDUCATION AND FAMILY SUPPORT PROGRAMS

SECTION 12B.8. The Joint Legislative Program Evaluation Oversight Committee shall include in the 2015-2017 Work Plan a directive for the Program Evaluation Division to plan a merger of the Child Care Subsidy, NC Prekindergarten (NC Pre-K), and Smart Start programs. The Director of the Program Evaluation Division shall recommend a firm for approval by the Legislative Services Commission to prepare the plan under the supervision of the Program Evaluation Division. The sum of three hundred thousand dollars ($300,000) is hereby appropriated to the Legislative Services Commission from the General Fund for the 2015-2016 fiscal year in nonrecurring funds to pay for the contract. The Program Evaluation Division shall submit the merger plan prepared by the contractor to the Joint Legislative Program Evaluation Oversight Committee, the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Education Oversight Committee, and the Fiscal Research Division no later than March 1, 2016.

U.S. DEPARTMENT OF DEFENSE-CERTIFIED CHILD CARE FACILITIES PARTICIPATION IN STATE-SUBSIDIZED CHILD CARE PROGRAM

SECTION 12B.9.(a) Article 7 of Chapter 110 of the General Statutes is amended by adding a new section to read:

"**§ 110-106.2. Department of Defense-certified child care facilities.**

(a) As used in this section, the phrase "Department of Defense-certified child care facility" shall include child development centers, family child care homes, and school-aged child care facilities operated aboard a military installation under the authorization of the United States Department of Defense (Department of Defense) certified by the Department of Defense.

(b) Procedure Regarding Department of Defense-Certified Child Care Facilities. –

(1) Department of Defense-certified child care facilities shall file with the Department a notice of intent to operate a child care facility in a form determined by the Department of Defense.

(2) As part of its notice, each Department of Defense-certified child care facility shall file a report to the Department indicating that it meets the minimum standards for child care facilities as provided by the Department of Defense.

(3) Department of Defense-certified child care facilities that meet all the requirements of this section shall be exempt from all other requirements of this Article and shall not be subject to licensure.

(4) For purposes of the North Carolina Subsidized Child Care Program, Department of Defense-certified child care facilities shall be reimbursed as follows:

a. Department of Defense-certified child care facilities that are accredited by the National Association for the Education of Young Children (NAEYC) shall be reimbursed at the five-star-rated license rate.

b. All other Department of Defense-certified child care facilities shall be reimbursed at the four-star-rated license rate."

SECTION 12B.9.(b) G.S. 143B-168.15(g) reads as rewritten:

"(g) Not less than thirty percent (30%) of the funds spent in each year of each local partnership's direct services allocation shall be used to expand child care subsidies. To the extent practicable, these funds shall be used to enhance the affordability, availability, and quality of child care services as described in this section. The North Carolina Partnership may increase this percentage requirement up to a maximum of fifty percent (50%) when, based upon a significant local waiting list for subsidized child care, the North Carolina Partnership determines a higher percentage is justified. Local partnerships shall spend an amount for child

care subsidies that provides at least fifty-two million dollars ($52,000,000) for the Temporary Assistance to Needy Families (TANF) maintenance of effort requirement and the Child Care Development Fund and Block Grant match requirement. Funds allocated under this section shall supplement and not supplant any federal or State funds allocated to Department of Defense-certified child care facilities licensed under G.S. 110-106.2."

SECTION 12B.9.(c) Department of Defense-certified child care facilities licensed pursuant to G.S. 110-106.2, as enacted in subsection (a) of this section, may participate in the State-subsidized child care program that provides for the purchase of care in child care facilities for minor children in needy families; provided, that funds allocated from the State-subsidized child care program to Department of Defense-certified child care facilities shall supplement and not supplant funds allocated in accordance with G.S. 143B-168.15(g). Payment rates and fees for military families who choose Department of Defense-certified child care facilities and who are eligible to receive subsidized child care shall be as set forth in Section 12B.2 of this act.

SECTION 12B.9.(d) This section becomes effective January 1, 2016.

SUBPART XII-C. DIVISION OF SOCIAL SERVICES

TANF BENEFIT IMPLEMENTATION

SECTION 12C.1.(a) The General Assembly approves the plan titled "North Carolina Temporary Assistance for Needy Families State Plan FY 2013-2016," prepared by the Department of Health and Human Services and presented to the General Assembly. The North Carolina Temporary Assistance for Needy Families State Plan covers the period October 1, 2013, through September 30, 2016. The Department shall submit the State Plan, as revised in accordance with subsection (b) of this section, to the United States Department of Health and Human Services.

SECTION 12C.1.(b) The counties approved as Electing Counties in the North Carolina Temporary Assistance for Needy Families State Plan FY 2013-2016, as approved by this section, are Beaufort, Caldwell, Catawba, Lenoir, Lincoln, Macon, and Wilson.

SECTION 12C.1.(c) Counties that submitted the letter of intent to remain as an Electing County or to be redesignated as an Electing County and the accompanying county plan for years 2013 through 2016, pursuant to G.S. 108A-27(e), shall operate under the Electing County budget requirements effective July 1, 2015. For programmatic purposes, all counties referred to in this subsection shall remain under their current county designation through September 30, 2016.

SECTION 12C.1.(d) For each year of the 2015-2017 fiscal biennium, Electing Counties shall be held harmless to their Work First Family Assistance allocations for the 2014-2015 fiscal year, provided that remaining funds allocated for Work First Family Assistance and Work First Diversion Assistance are sufficient for payments made by the Department on behalf of Standard Counties pursuant to G.S. 108A-27.11(b).

SECTION 12C.1.(e) In the event that departmental projections of Work First Family Assistance and Work First Diversion Assistance for the 2015-2016 fiscal year or the 2016-2017 fiscal year indicate that remaining funds are insufficient for Work First Family Assistance and Work First Diversion Assistance payments to be made on behalf of Standard Counties, the Department is authorized to deallocate funds, of those allocated to Electing Counties for Work First Family Assistance in excess of the sums set forth in G.S. 108A-27.11, up to the requisite amount for payments in Standard Counties. Prior to deallocation, the Department shall obtain approval by the Office of State Budget and Management. If the Department adjusts the allocation set forth in subsection (d) of this section, then a report shall be made to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

INTENSIVE FAMILY PRESERVATION SERVICES FUNDING AND PERFORMANCE ENHANCEMENTS

SECTION 12C.2.(a) Notwithstanding the provisions of G.S. 143B-150.6, the Intensive Family Preservation Services (IFPS) Program shall provide intensive services to children and families in cases of abuse, neglect, and dependency where a child is at imminent risk of removal from the home and to children and families in cases of abuse where a child is not at imminent risk of removal. The Program shall be developed and implemented statewide on a regional basis. The IFPS shall ensure the application of standardized assessment criteria for determining imminent risk and clear criteria for determining out-of-home placement.

SECTION 12C.2.(b) The Department of Health and Human Services shall require that any program or entity that receives State, federal, or other funding for the purpose of IFPS shall provide information and data that allows for the following:

(1) An established follow-up system with a minimum of six months of follow-up services.

(2) Detailed information on the specific interventions applied, including utilization indicators and performance measurement.

(3) Cost-benefit data.

(4) Data on long-term benefits associated with IFPS. This data shall be obtained by tracking families through the intervention process.

(5) The number of families remaining intact and the associated interventions while in IFPS and 12 months thereafter.

(6) The number and percentage, by race, of children who received IFPS compared to the ratio of their distribution in the general population involved with Child Protective Services.

SECTION 12C.2.(c) The Department shall establish a performance-based funding protocol and shall only provide funding to those programs and entities providing the required information specified in subsection (b) of this section. The amount of funding shall be based on the individual performance of each program.

CHILD CARING INSTITUTIONS

SECTION 12C.3. Until the Social Services Commission adopts rules setting standardized rates for child caring institutions as authorized under G.S. 143B-153(8), the maximum reimbursement for child caring institutions shall not exceed the rate established for the specific child caring institution by the Department of Health and Human Services, Office of the Controller. In determining the maximum reimbursement, the State shall include county and IV-E reimbursements.

USE OF FOSTER CARE BUDGET FOR GUARDIANSHIP ASSISTANCE PROGRAM

SECTION 12C.4. Of the funds available for the provision of foster care services, the Department of Health and Human Services, Division of Social Services, may provide for the financial support of children who are deemed to be (i) in a permanent family placement setting, (ii) eligible for legal guardianship, and (iii) otherwise unlikely to receive permanency. The Division of Social Services shall design the Guardianship Assistance Program (GAP) to include provisions for extending guardianship services for individuals who have attained the age of 18 years and opt to continue to receive guardianship services until reaching 21 years of age if the individual is (i) completing secondary education or a program leading to an equivalent credential, (ii) enrolled in an institution that provides postsecondary or vocational education, (iii) participating in a program or activity designed to promote, or remove barriers to, employment, (iv) employed for at least 80 hours per month, or (v) incapable of completing the educational or employment requirements of this section due to a medical condition or disability. The Guardianship Assistance Program rates shall reimburse the legal guardian for

room and board and be set at the same rate as the foster care room and board rates in accordance with rates established under G.S. 108A-49.1. The Social Services Board shall adopt rules establishing a Guardianship Assistance Program to implement this section, including defining the phrase "legal guardian" as used in this section.

CHILD WELFARE POSTSECONDARY SUPPORT PROGRAM (NC REACH)

SECTION 12C.5.(a) Funds appropriated from the General Fund to the Department of Health and Human Services for the child welfare postsecondary support program shall be used to continue providing assistance with the "cost of attendance" as that term is defined in 20 U.S.C. § 108711 for the educational needs of foster youth aging out of the foster care system and special needs children adopted from foster care after age 12. These funds shall be allocated by the State Education Assistance Authority.

SECTION 12C.5.(b) Of the funds appropriated from the General Fund to the Department of Health and Human Services, the sum of fifty thousand dollars ($50,000) for the 2015-2016 fiscal year and the sum of fifty thousand dollars ($50,000) for the 2016-2017 fiscal year shall be allocated to the North Carolina State Education Assistance Authority (SEAA). The SEAA shall use these funds only to perform administrative functions necessary to manage and distribute scholarship funds under the child welfare postsecondary support program.

SECTION 12C.5.(c) Of the funds appropriated from the General Fund to the Department of Health and Human Services, the sum of three hundred thirty-nine thousand four hundred ninety-three dollars ($339,493) for the 2015-2016 fiscal year and the sum of three hundred thirty-nine thousand four hundred ninety-three dollars ($339,493) for the 2016-2017 fiscal year shall be used to contract with an entity to administer the child welfare postsecondary support program described under subsection (a) of this section, which administration shall include the performance of case management services.

SECTION 12C.5.(d) Funds appropriated to the Department of Health and Human Services for the child welfare postsecondary support program shall be used only for students attending public institutions of higher education in this State.

FEDERAL CHILD SUPPORT INCENTIVE PAYMENTS

SECTION 12C.7.(a) Centralized Services. – The North Carolina Child Support Services Section (NCCSS) of the Department of Health and Human Services, Division of Social Services, shall retain up to fifteen percent (15%) of the annual federal incentive payments it receives from the federal government to enhance centralized child support services. To accomplish this requirement, NCCSS shall do the following:

(1) In consultation with representatives from county child support services programs, identify how federal incentive funding could improve centralized services.

(2) Use federal incentive funds to improve the effectiveness of the State's centralized child support services by supplementing and not supplanting State expenditures for those services.

(3) Develop and implement rules that explain the State process for calculating and distributing federal incentive funding to county child support services programs.

SECTION 12C.7.(b) County Child Support Services Programs. – NCCSS shall allocate no less than eighty-five percent (85%) of the annual federal incentive payments it receives from the federal government to county child support services programs to improve effectiveness and efficiency using the federal performance measures. To that end, NCCSS shall do the following:

(1) In consultation with representatives from county child support services programs, examine the current methodology for distributing federal

incentive funding to the county programs and determine whether an alternative formula would be appropriate. NCCSS shall use its current formula for distributing federal incentive funding until an alternative formula is adopted.

(2) Upon adopting an alternative formula, develop a process to phase-in the alternative formula for distributing federal incentive funding over a four-year period.

SECTION 12C.7.(c) Reporting by County Child Support Services Programs. – NCCSS shall establish guidelines that identify appropriate uses for federal incentive funding. To ensure those guidelines are properly followed, NCCSS shall require county child support services programs to comply with each of the following:

(1) Submit an annual plan describing how federal incentive funding would improve program effectiveness and efficiency as a condition of receiving federal incentive funding.

(2) Report annually on: (i) how federal incentive funding has improved program effectiveness and efficiency and been reinvested into their programs, (ii) provide documentation that the funds were spent according to their annual plans, and (iii) explain any deviations from their plans.

SECTION 12C.7.(d) Plan/Report by NCCSS. – The NCCSS shall develop a plan to implement the requirements of this section. Prior to implementing the plan, NCCSS shall submit a progress report on the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2015.

After implementing the plan, NCCSS shall submit a report on federal child support incentive funding to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1 of each year. The report shall describe how federal incentive funds enhanced centralized child support services to benefit county child support services programs and improved the effectiveness and efficiency of county child support services programs. The report shall further include any changes to the State process the NCCSS used in calculating and distributing federal incentive funding to county child support services programs and any recommendations for further changes.

CHILD PROTECTIVE SERVICES IMPROVEMENT INITIATIVE/REVISE STATEWIDE EVALUATION REPORT DATE

SECTION 12C.8. The Department of Health and Human Services, Division of Social Services, shall report on the findings and recommendations from the comprehensive, statewide evaluation of the State's child protective services system required by Section 12C.1(f) of S.L. 2014-100 to the Joint Legislative Oversight Committee on Health and Human Services on or before March 1, 2016.

FOSTERING SUCCESS/EXTEND FOSTER CARE TO 21 YEARS OF AGE

SECTION 12C.9.(a) G.S. 108A-48 reads as rewritten:

"**§ 108A-48. State Foster Care Benefits Program.**

(a) The Department is authorized to establish a State Foster Care Benefits Program with appropriations by the General Assembly for the purpose of providing assistance to children who are placed in foster care facilities by county departments of social services in accordance with the rules and regulations of the Social Services Commission. Such appropriations, together with county contributions for this purpose, shall be expended to provide for the costs of keeping children in foster care facilities.

~~(b) No benefits provided by this section shall be granted to any individual who has passed his eighteenth birthday unless he is less than 21 years of age and is a full-time student or has been accepted for enrollment as a full-time student for the next school term pursuing a high~~

~~school diploma or its equivalent; a course of study at the college level; or a course of vocational or technical training designed to fit him for gainful employment.~~

(c) The Department may continue to provide benefits pursuant to this section to an individual who has attained the age of 18 years and chosen to continue receiving foster care services until reaching 21 years of age if the individual is (i) completing secondary education or a program leading to an equivalent credential, (ii) enrolled in an institution that provides postsecondary or vocational education, (iii) participating in a program or activity designed to promote, or remove barriers to, employment, (iv) employed for at least 80 hours per month, or (v) incapable of completing the educational or employment requirements of this subsection due to a medical condition or disability.

(d) With monthly supervision and oversight by the director of the county department of social services or a supervising agency, an individual receiving benefits pursuant to subsection (c) of this section may reside outside a foster care facility in a college or university dormitory or other semi-supervised housing arrangement approved by the director of the county department of social services and continue to receive benefits pursuant to this section."

SECTION 12C.9.(b) G.S. 108A-49 is amended by adding a new subsection to read:

"(e) If all other eligibility criteria are met, adoption assistance payments may continue until the beneficiary reaches the age of 21 if the beneficiary was adopted after reaching the age of 16 but prior to reaching the age of 18."

SECTION 12C.9.(c) G.S. 108A-49.1 reads as rewritten:

"**§ 108A-49.1. Foster care and adoption assistance payment rates.**

(a) The maximum rates for State participation in the foster care assistance program are established on a graduated scale as follows:

(1) $475.00 per child per month for children from birth through five years of age.

(2) $581.00 per child per month for children six through 12 years of age.

(3) $634.00 per child per month for children at least 13 ~~through 18~~ but less than 21 years of age.

(b) The maximum rates for the State adoption assistance program are established consistent with the foster care rates as follows:

(1) $475.00 per child per month for children from birth through five years of age.

(2) $581.00 per child per month for children six through 12 years of age.

(3) $634.00 per child per month for children at least 13 ~~through 18~~ but less than 21 years of age.

(c) The maximum rates for the State participation in human immunodeficiency virus (HIV) foster care and adoption assistance are established on a graduated scale as follows:

(1) $800.00 per child per month with indeterminate HIV status.

(2) $1,000 per child per month with confirmed HIV infection, asymptomatic.

(3) $1,200 per child per month with confirmed HIV infection, symptomatic.

(4) $1,600 per child per month when the child is terminally ill with complex care needs.

In addition to providing board payments to foster and adoptive families of HIV-infected children, any additional funds remaining that are appropriated for purposes described in this subsection shall be used to provide medical training in avoiding HIV transmission in the home.

(d) The State and a county participating in foster care and adoption assistance shall each contribute fifty percent (50%) of the nonfederal share of the cost of care for a child placed by a county department of social services or child-placing agency in a family foster home or residential child care facility. A county shall be held harmless from contributing fifty percent (50%) of the nonfederal share of the cost for a child placed in a family foster home or

residential child care facility under an agreement with that provider as of October 31, 2008, until the child leaves foster care or experiences a placement change.

(e) A county shall be held harmless from contributing fifty percent (50%) of the nonfederal share of the cost for an individual receiving benefits pursuant to G.S. 108A-48(c)."

SECTION 12C.9.(d) G.S. 131D-10.2 reads as rewritten:

"**§ 131D-10.2. Definitions.**

For purposes of this Article, unless the context clearly implies otherwise:

…

(3) "Child" means an individual less than ~~18~~ 21 years of age, who has not been emancipated under the provisions of Article 35 of Chapter 7B of the General Statutes.

…

(9a) "Foster Parent" means any individual who is ~~18~~ 21 years of age or older who is licensed by the State to provide foster care.

…."

SECTION 12C.9.(e) Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Foster care until 21 years of age.**

(a) A child placed in foster care who has attained the age of 18 years may continue receiving foster care services until reaching 21 years of age as provided by law. A child who initially chooses to opt out of foster care upon attaining the age of 18 years may opt to receive foster care services at a later date until reaching 21 years of age.

(b) A child who has attained the age of 18 years and chosen to continue receiving foster care services until reaching 21 years of age may continue to receive benefits pursuant to Part 4 of Article 2 of Chapter 108A of the General Statutes upon meeting the requirements under G.S. 108A-48(c)."

SECTION 12C.9.(f) G.S. 131D-10.5 reads as rewritten:

"**§ 131D-10.5. Powers and duties of the Commission.**

In addition to other powers and duties prescribed by law, the Commission shall exercise the following powers and duties:

(1) Adopt, amend and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this ~~Article;~~Article.

(2) Issue declaratory rulings as may be needed to implement the provisions and purposes of this ~~Article;~~Article.

(3) Adopt rules governing procedures to appeal Department decisions pursuant to this Article granting, denying, suspending or revoking ~~licenses;~~licenses.

(4) Adopt criteria for waiver of licensing rules adopted pursuant to this ~~Article;~~Article.

(5) Adopt rules on documenting the use of physical restraint in residential child-care ~~facilities;~~facilities.

(6) Adopt rules establishing personnel and training requirements related to the use of physical restraints and time-out for staff employed in residential child-care ~~facilities; and~~facilities.

(7) Adopt rules establishing educational requirements, minimum age, relevant experience, and criminal record status for executive directors and staff employed by child placing agencies and residential child care facilities.

(8) Adopt any rules necessary for the expansion of foster care for individuals who have attained the age of 18 years and chosen to continue receiving foster care services to 21 years of age in accordance with G.S. 131D-10.2A."

SECTION 12C.9.(g) Article 9 of Chapter 7B of the General Statutes is amended by adding a new section to read:

"**§ 7B-910.1. Review of voluntary foster care placements with young adults.**

(a) The court shall review the placement of a young adult in foster care authorized by G.S. 108A-48(c) when the director of social services and a young adult who was in foster care as a juvenile enter into a voluntary placement agreement. The review hearing shall be held not more than 90 days from the date the agreement was executed, and the court shall make findings from evidence presented at this review hearing with regard to all of the following:

(1) Whether the placement is in the best interest of the young adult in foster care.

(2) The services that have been or should be provided to the young adult in foster care to improve the placement.

(3) The services that have been or should be provided to the young adult in foster care to further the young adult's educational or vocational ambitions, if relevant.

(b) Upon written request of the young adult or the director of social services, the court may schedule additional hearings to monitor the placement and progress toward the young adult's educational or vocational ambitions.

(c) No guardian ad litem under G.S. 7B-601 will be appointed to represent the young adult in the initial or any subsequent hearing.

(d) The clerk shall give written notice of the initial and any subsequent review hearings to the young adult and foster care and the director of social services at least 15 days prior to the date of the hearing."

SECTION 12C.9.(h) G.S. 7B-401.1 is amended by adding a new subsection to read:

"(i) Young Adult in Foster Care. – In proceedings held pursuant to G.S. 7B-910.1, the young adult in foster care and the director of the department of social services are parties."

SECTION 12C.9.(i) The Department of Health and Human Services, Division of Social Services (Division), shall develop a plan for the expansion of foster care services for individuals who have attained the age of 18 years and opt to continue receiving foster care services until reaching 21 years of age. The Division shall report on the plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2015. The Division shall report on the plan as implemented to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by November 1, 2016.

SECTION 12C.9.(j) No later than 60 days after the Department implements the plan for the expansion of foster care services as required under subsection (i) of this section, the Division shall submit a State plan amendment to the U.S. Department of Health and Human Services Administration for Children and Families to make federal payments for foster care and adoption assistance, as applicable, under Title IV-E, available to a person meeting the requirements of G.S. 108A-48(c), as enacted in subsection (a) of this section.

SECTION 12C.9.(k) Any agreement entered into pursuant to G.S. 108A-48(b) prior to the effective date of subsection (a) of this section shall remain in full force and effect, and no provision of this section shall be construed to affect or alter such an agreement.

SECTION 12C.9.(l) Subsection (a) of this section becomes effective August 1, 2016, and applies to agreements entered into on or after that date. Subsections (i), (j), and (k) of this section are effective when they become law. The remainder of this section becomes effective August 1, 2016.

REQUIRE TRANSFER OF CERTAIN SERVICES TO EASTERN BAND OF CHEROKEE INDIANS

SECTION 12C.10.(a) G.S. 108A-25 reads as rewritten:

"**§ 108A-25. Creation of programs; assumption by federally recognized tribe of programs.**

…

(e) When any federally recognized Native American tribe within the State assumes responsibility for any social services, Medicaid and NC Health Choice healthcare benefit programs, and ancillary services, including Medicaid administrative and service functions, that are otherwise the responsibility of a county under State law, then, notwithstanding any other provision of law, the county shall be relieved of the legal responsibility related to the tribe's assumption of those services. With respect to a tribe's assumption of any responsibilities for administration of any aspects of the NC Medicaid program, NC Health Choice, and the Supplemental Nutrition Assistance Program (SNAP), the State and the tribe shall execute an agreement to set forth the general terms, definitions, and conditions by which the parties shall operate. Upon the execution of the agreement, to allow the tribe to assume certain duties and responsibilities for the administration of the NC Medicaid program, NC Health Choice, and SNAP, the agreement between the State and the tribe shall require the tribe to accept the oversight authority of the State and the Department of Health and Human Services (Department) in the administration and supervision of these programs. In addition to the other necessary terms and conditions, the agreement shall include the following conditions:

(1) All requirements as prescribed by federal law, as well as the tribe and State's responsibilities in complying with federal law, including, but not limited to, any specific provisions pertaining to accounting and auditing compliance, maintenance of liability insurance, confidentiality, reporting requirements, indemnity, waiver of immunity, or due process.

(2) As the Department is the federally recognized single State agency for the NC Medicaid program, NC Health Choice, and SNAP, provisions stating the Department retains ultimate administrative discretion in the administration and supervision of the program, including, but not limited to, issuance and interpretation of all applicable policies, rules, and regulations regarding application processing, eligibility determinations and redeterminations, and other functions related to the eligibility process.

(3) Provisions by the tribe to ensure that individuals who will be responsible for the tribe's duties and responsibilities under this agreement shall be employed under standards equivalent to current standards for a Merit System of Personnel Administration or any standards later prescribed by the Office of Personnel Management under section 208 of the Intergovernmental Personnel Act of 1970 and shall provide the Department with information for verification of this condition.

(4) Either party may terminate the agreement without cause with at least 30 days' notice prior to the date the terminating party seeks to terminate the agreement. The Department may terminate all or part of the agreement when federal or State funding becomes unavailable for any reason.

(f) With respect to programs federally administered by the Administration for Children and Families (ACF), the Department shall maintain oversight authority for all federal protections to individuals living on federal reservations held in trust by the United States until such time as ACF has approved the Eastern Band of Cherokee Indians to administer these programs."

SECTION 12C.10.(b) G.S. 108A-87(c) reads as rewritten:

"(c) Notwithstanding subsections (a) and (b) of this section, when the Eastern Band of Cherokee Indians assumes responsibility for a program described under G.S. 108A-25(e), the following shall occur:

(1) Nonfederal matching funds designated to Jackson and Swain counties to serve the Eastern Band of Cherokee Indians for that program previously borne by the State shall be allocated directly to the Eastern Band of Cherokee Indians rather than to those ~~counties.~~counties and shall not exceed the amount expended by the State for fiscal year 2014-2015 for programs or services assumed by the Eastern Band of Cherokee Indians, as applicable, plus the growth rate equal to the growth in State-funded nonfederal share for all counties.

(2) Any portion of nonfederal matching funds borne by counties for public assistance and social services programs and related administrative costs shall be borne by the Eastern Band of Cherokee Indians."

SECTION 12C.10.(c) Of the funds appropriated in this act from the General Fund to the Department of Health and Human Services, Division of Social Services, the sum of three hundred sixty thousand dollars ($360,000) in recurring funds for fiscal year 2015-2016 and the sum of three million two hundred thousand dollars ($3,200,000) in nonrecurring funds for fiscal year 2015-2016 shall be deposited in the Department's information technology budget code to be used for ongoing operation and maintenance pursuant to implementing the provisions of this section.

SECTION 12C.10.(d) Approval for the tribe to administer the eligibility process for Medicaid and NC Health Choice is contingent upon federal approval of a state plan amendment and Medicaid waivers by the Centers for Medicare and Medicaid Services (CMS). The Department of Health and Human Services, Division of Medical Assistance, shall make any necessary amendments to its previous SPA 14-001, including amendment of its effective date. The new effective date shall be October 1, 2016. If CMS does not approve the SPA, the counties shall continue serving individuals living on the federal lands held in trust by the United States.

SECTION 12C.10.(e) Within 30 days of CMS approval of the amended SPA 14-001, the Department of Health and Human Services shall submit an Advanced Planning Document Update (APDU) to CMS, the United States Department of Agriculture (USDA), and the Administration for Children and Families (ACF). If CMS, USDA, and ACF do not approve the APDU, the counties shall continue serving individuals living on the federal lands held in trust by the United States.

SECTION 12C.10.(f) Upon CMS, USDA, and ACF approval of the APDU, the Department of Health and Human Services (Department) shall begin functional and detailed design, development, testing, and training of NC FAST, NCTracks, and legacy systems to allow the Eastern Band of Cherokee Indians to assume certain administrative duties consistent with approval given by federal funding partners and any agreements between the Eastern Band of Cherokee Indians and the Department.

SECTION 12C.10.(g) If federal law allows the Eastern Band of Cherokee Indians to assume responsibility for the NC Medicaid program, NC Health Choice, or SNAP, the Eastern Band of Cherokee Indians shall be allowed to assume responsibility for those programs if they choose to assume such responsibility.

CHILD PROTECTIVE SERVICES PILOT PROJECT

SECTION 12C.11.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Social Services, the sum of three hundred thousand dollars ($300,000) shall be used for the continuation of the Child Protective Services Pilot Project established by Section 12C.1(e) of S.L. 2014-100. The Division shall continue to collaborate with the Government Data Analytics Center (GDAC) and shall utilize the funds to support and enhance the Pilot by doing the following:

(1) Developing a dashboard linking the family to the child.

(2) Integrating additional Department of Health and Human Services and other State department data sources to build a more comprehensive view of the child and family, including (i) matching the child to the caretaker; (ii) linking child, family, and address information; and (iii) integrating Criminal Justice Law Enforcement Automated Data Services (CJLEADS) data to determine if the caretaker or someone living in the house is a sex offender or has a criminal history.

(3) Developing a comprehensive profile of a child that includes demographic and caretaker information and indicators or flags of other services, including, but not limited to, prior assessments of the child, eligibility for food and nutrition programs, Medicaid, and subsidized child care.

SECTION 12C.11.(b) The Division of Social Services shall interface the work product from the Child Protective Services Pilot Program with the statewide child welfare case management system operated by the Department of Health and Human Services by utilizing resources and subject matter expertise available through existing public-private partnerships within the GDAC for the purposes of analyzing risk and improving outcomes for children. The Division of Social Services shall submit its findings and recommendations in a final report on the Child Protective Services Pilot Program to the Joint Legislative Oversight Committee on Health and Human Services no later than March 1, 2016.

FOSTER CARE FAMILY ACT

SECTION 12C.12.(a) This section shall be known and may be cited as the "Foster Care Family Act."

SECTION 12C.12.(b) Part 1 of Article 1A of Chapter 131D of the General Statutes is amended by adding a new section to read:

"**§ 131D-10.2A. Reasonable and prudent parenting standard.**

(a) The reasonable and prudent parenting standard is characterized by careful and sensible parental decisions that maintain a child's health, safety, and best interests while encouraging the child's emotional and developmental growth.

(b) Every child care institution shall designate an on-site official who is authorized to apply the reasonable and prudent parenting standard pursuant to this section.

(c) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, the designated official at a child care institution where the child is placed, or the county department of social services, must use the reasonable and prudent parenting standard when determining whether to allow a child in foster care to participate in extracurricular, enrichment, and social activities.

(d) A caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, the designated official at a child care institution where the child is placed, the county department of social services, or the Department of Health and Human Services with custody of or placement authority over a child in foster care shall not be held liable for an act or omission of the child if the caregiver or county department of social services is acting in accordance with the reasonable and prudent parenting standard under this section.

(e) Unless otherwise ordered by a court with jurisdiction pursuant to G.S. 7B-200, a caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, exercising the reasonable and prudent parenting standard has the authority to provide or withhold permission, without prior approval of the court or a county department of social services, allowing a child in foster care, in the custody of a county department of social services, or under the placement authority of a county department of social services through a voluntary placement agreement, to participate in normal childhood activities. Normal childhood activities shall include, but are not limited to, extracurricular, enrichment,

and social activities and may include overnight activities outside the direct supervision of the caregiver for periods of over 24 hours and up to 72 hours.

(f) The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, the designated official at a child care institution where the child is placed, the county department of social services, or the Department of Health and Human Services, shall not be liable for injuries to the child that occur as a result of the reasonable and prudent parenting standard. The burden of proof with respect to a breach of the reasonable and prudent parenting standard shall be by clear and convincing evidence.

(g) The caregiver, including the child's foster parent, whether the child is in a family foster home or a therapeutic foster home, the designated official at a child care institution where the child is placed, the county department of social services, or the Department of Health and Human Services, shall be liable for any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in the injury to the child."

SECTION 12C.12.(c) G.S. 7B-505(b) reads as rewritten:

"(b) The court shall order the Department to make diligent efforts to notify relatives and any custodial parents of the juvenile's siblings that the juvenile is in nonsecure custody and of any hearings scheduled to occur pursuant to G.S. 7B-506, unless the court finds such notification would be contrary to the best interests of the juvenile. In placing a juvenile in nonsecure custody under this section, the court shall first consider whether a relative of the juvenile is willing and able to provide proper care and supervision of the juvenile in a safe home. If the court finds that the relative is willing and able to provide proper care and supervision in a safe home, then the court shall order placement of the juvenile with the relative unless the court finds that placement with the relative would be contrary to the best interests of the juvenile."

SECTION 12C.12.(d) G.S. 7B-800.1(a)(4) reads as rewritten:

"(a) Prior to the adjudicatory hearing, the court shall consider the following:

…

(4) Whether relatives or parents with custody of a sibling of the juvenile have been identified and notified as potential resources for placement or support."

SECTION 12C.12.(e) G.S. 7B-901 reads as rewritten:

"**§ 7B-901. Dispositional hearing.**

The dispositional hearing shall take place immediately following the adjudicatory hearing and shall be concluded within 30 days of the conclusion of the adjudicatory hearing. The dispositional hearing may be informal and the court may consider written reports or other evidence concerning the needs of the juvenile. The juvenile and the juvenile's parent, guardian, or custodian shall have the right to present evidence, and they may advise the court concerning the disposition they believe to be in the best interests of the juvenile. The court may consider any evidence, including hearsay evidence as defined in G.S. 8C-1, Rule 801, including testimony or evidence from any person who is not a party, that the court finds to be relevant, reliable, and necessary to determine the needs of the juvenile and the most appropriate disposition. The court may exclude the public from the hearing unless the juvenile moves that the hearing be open, which motion shall be granted.

At the dispositional hearing, the court shall inquire as to the identity and location of any missing parent and whether paternity is at issue. The court shall include findings of the efforts undertaken to locate the missing parent and to serve that parent and efforts undertaken to establish paternity when paternity is an issue. The order may provide for specific efforts in determining the identity and location of any missing parent and specific efforts in establishing paternity. The court shall also inquire about efforts made to identify and notify ~~relatives~~ relatives or parents with custody of a sibling of the juvenile, as potential resources for placement or support."

SECTION 12C.12.(f) Article 9 of Chapter 7B of the General Statutes is amended by adding the following new sections to read:

"**§ 7B-903.1. Juvenile placed in custody of a county department of social services.**

(a) To the extent authorized by federal law, a county department of social services with custody of a juvenile is authorized to make decisions about matters not addressed in this section that are generally made by a juvenile's custodian including, but not limited to, educational decisions and consenting to the sharing of the juvenile's information. The county department of social services may delegate any part of this authority to the juvenile's parent, foster parent, or another individual.

(b) When a juvenile is in the custody or placement responsibility of a county department of social services, the placement provider may, in accordance with G.S. 131D-10.2A, provide or withhold permission, without prior approval of the court or county department of social services, allowing a juvenile to participate in normal childhood activities. If such authorization is not in the juvenile's best interest, the court shall set forth alternative parameters for approving normal childhood activities.

"**§ 7B-912. Juveniles 14 years of age and older; Another Planned Permanent Living Arrangement.**

(a) In addition to the permanency planning requirements under G.S. 7B-906.1, at every permanency planning hearing for a juvenile in the custody of a county department of social services who has attained the age of 14 years, the court shall inquire and make written findings regarding each of the following:

(1) The services provided to assist the juvenile in making a transition to adulthood.

(2) The steps the county department of social services is taking to ensure that the foster family or other licensed placement provider follows the reasonable and prudent parenting standard as provided in G.S. 131D-10.2A.

(3) Whether the juvenile has regular opportunities to engage in age-appropriate or developmentally appropriate activities.

(b) At or before the last scheduled permanency planning hearing, but at least 90 days before a juvenile attains 18 years of age, the court shall (i) inquire as to whether the juvenile has a copy of the juvenile's birth certificate, Social Security card, health insurance information, drivers license or other identification card, and any educational or medical records the juvenile requests and (ii) determine the person or entity that should assist the juvenile in obtaining these documents before the juvenile attains the age of 18 years.

(c) If the court finds each of the following conditions applies, the court shall approve Another Planned Permanent Living Arrangement (APPLA) as the juvenile's primary permanent plan:

(1) The juvenile is 16 or 17 years old.

(2) The county department of social services has made diligent efforts to place the juvenile permanently with a parent or relative or in a guardianship or adoptive placement.

(3) Compelling reasons exist that it is not in the best interest of the juvenile to be placed permanently with a parent or relative or in a guardianship or adoptive placement.

(4) APPLA is the best permanency plan for the juvenile.

(d) If the court approves APPLA as the juvenile's permanent plan, the court shall, after questioning the juvenile, make written findings addressing the juvenile's desired permanency outcome."

SECTION 12C.12.(g) Article 36 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-36-44. Development of policy form or endorsement for personal liability insurance for foster parents.**

(a) The Rate Bureau shall develop an optional policy form or endorsement to be filed with the Commissioner for approval no later than May 1, 2016, that provides liability insurance for foster parents licensed under Article 1A of Chapter 131D of the General Statutes to provide foster care in a family foster home or therapeutic foster home. The policy form or endorsement shall provide coverage for acts or omissions of the foster parent while the parent is acting in his or her capacity as a foster parent in a licensed family foster home or therapeutic foster home licensed under Article 1A of Chapter 131D of the General Statutes.

(b) Nothing in this section is intended to require that the liability insurance policy or endorsement required by this section cover an act or omission that results from any action or inaction of gross negligence, willful and wanton conduct, or intentional wrongdoing that results in injury to the child."

SECTION 12C.12.(h) Article 1 of Chapter 48A of the General Statutes is amended by adding a new section to read:

"**§ 48A-4. Certain minors competent to contract.**

A minor who is 16 years of age or older and who is in the legal custody of the county department of social services shall be qualified and competent to contract for the purchase of an automobile insurance policy with the consent of the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b). The minor shall be responsible for paying the costs of the insurance premiums and shall be liable for damages caused by the minor's negligent operation of a motor vehicle. No State or local government agency, foster parent, or entity providing services to the minor under contract or at the direction of a State or local government agency shall be responsible for paying any insurance premiums or liable for damages of any kind as a result of the operation of a motor vehicle by the minor."

SECTION 12C.12.(i) G.S. 20-11(i) reads as rewritten:

"(i) Application. — An application for a permit or license authorized by this section must be signed by both the applicant and another person. That person must be:

(1) The applicant's parent or guardian;
(2) A person approved by the applicant's parent or guardian; or
(3) A person approved by the Division.
(4) With respect to minors in the legal custody of the county department of social services, any of the following:
  a. A guardian ad litem or attorney advocate appointed to advocate for the minor.
  b. The director or his or her designee or other type of caseworker assigned to work with the minor.
  c. If no person listed in sub-subdivision a. or b. of this subdivision is available, the court with continuing jurisdiction over the minor's placement under G.S. 7B-1000(b)."

SECTION 12C.12.(j) G.S. 20-309 is amended by adding a new subsection to read:

"(a2) Notwithstanding any other provision of this Chapter, an owner's policy of liability insurance issued to a foster parent or parents, which policy includes an endorsement excluding coverage for one or more foster children residing in the foster parent's or parents' household, may be certified as proof of financial responsibility, provided that each foster child for whom coverage is excluded is insured in an amount equal to or greater than the minimum limits required by G.S. 20-279.21 under some other owner's policy of liability insurance or a named nonowner's policy of liability insurance. The North Carolina Rate Bureau shall establish, with the approval of the Commissioner of Insurance, a named driver exclusion endorsement or endorsements for foster children as described herein."

SECTION 12C.12.(k) G.S. 20-279.21(b) reads as rewritten:

"(b) ~~Such~~ Except as provided in G.S. 20-309(a2), such owner's policy of liability insurance:

…."

SECTION 12C.12.(l) The Department of Health and Human Services, Division of Medical Assistance, shall design and draft, but not submit, a 1915(c) Medicaid waiver to serve children with Serious Emotional Disturbance (SED) in home and community-based settings. The Department may submit drafts of the waiver to the Centers for Medicare and Medicaid Services (CMS) to solicit feedback but shall not submit the waiver for CMS approval until authorized by the General Assembly.

SECTION 12C.12.(m) The Department shall report, on the draft waiver required by subsection (l) of this section, other findings and any other options or recommendations to best serve children with SED to the Joint Legislative Oversight Committee on Health and Human Services by December 1, 2015. Specifically, the report shall provide an in-depth analysis of the cost per slot, including an analysis of the estimated number of waiver recipients who would be transitioned from a facility to a home and community-based setting and the estimated number of waiver recipients who would avoid placement in a facility.

SECTION 12C.12.(n) Subsections (b) through (f) and (h) through (k) of this section become effective October 1, 2015. The remainder of this section is effective when this act becomes law.

SUBPART XII-D. DIVISION OF AGING AND ADULT SERVICES

STATE-COUNTY SPECIAL ASSISTANCE RATES

SECTION 12D.1.(a) For each year of the 2015-2017 fiscal biennium, the maximum monthly rate for residents in adult care home facilities shall be one thousand one hundred eighty-two dollars ($1,182) per month per resident.

SECTION 12D.1.(b) For each year of the 2015-2017 fiscal biennium, the maximum monthly rate for residents in Alzheimer's/Dementia special care units shall be one thousand five hundred fifteen dollars ($1,515) per month per resident.

SUBPART XII-E. DIVISION OF PUBLIC HEALTH

FUNDS FOR SCHOOL NURSES

SECTION 12E.1.(a) Funds appropriated in this act for the School Nurse Funding Initiative shall be used to supplement and not supplant other State, local, or federal funds appropriated or allocated for this purpose. Communities shall maintain their current level of effort and funding for school nurses. These funds shall not be used to fund nurses for State agencies. These funds shall be distributed to local health departments according to a formula that includes all of the following:

(1) School nurse-to-student ratio.
(2) Percentage of students eligible for free or reduced-price meals.
(3) 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) Percentage of students with chronic illnesses.
(8) Percentage of county population consisting of minority persons.

SECTION 12E.1.(b) The Division of Public Health shall ensure that school nurses funded with State funds (i) do not assist in any instructional or administrative duties associated with a school's curriculum and (ii) perform all of the following with respect to school health programs:

(1) Serve as the coordinator of the health services program and provide nursing care.
(2) Provide health education to students, staff, and parents.
(3) Identify health and safety concerns in the school environment and promote a nurturing 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 and serve as school liaison to a health advisory committee.
(8) Provide health education and counseling and promote healthy activities and a healthy environment for school staff.
(9) Be available to assist the county health department during a public health emergency.

AIDS DRUG ASSISTANCE PROGRAM (ADAP)

SECTION 12E.2. The Department of Health and Human Services shall work with the Department of Public Safety (DPS) to use DPS funds to purchase pharmaceuticals for the treatment of individuals in the custody of DPS who have been diagnosed with Human Immunodeficiency Virus or Acquired Immune Deficiency Syndrome (HIV/AIDS) in a manner that allows these funds to be accounted for as State matching funds in the Department of Health and Human Services drawdown of federal Ryan White funds earmarked for the AIDS Drug Assistance Program (ADAP).

APPOINTMENT, MANDATORY TRAINING, AND REVOCATION OF APPOINTMENT OF COUNTY MEDICAL EXAMINERS

SECTION 12E.4.(a) G.S. 130A-382 reads as rewritten:

"**§ 130A-382. County medical examiners; appointment; term of office; ~~vacancies.~~vacancies; training requirements; revocation for cause.**

(a) The Chief Medical Examiner shall appoint ~~one~~ two or more county medical examiners for each county for a three-year term. In appointing medical examiners for each county, the Chief Medical Examiner shall give preference to physicians licensed to practice medicine in this State but may also appoint licensed physician assistants, nurse practitioners, nurses, ~~coroners,~~ or emergency medical technician paramedics. A medical examiner may serve more than one county. The Chief Medical Examiner may take jurisdiction in any case or appoint another medical examiner to do so.

(b) County medical examiners shall complete annual continuing education training as directed by the Office of the Chief Medical Examiner and based upon established and published guidelines for conducting death investigations. The continuing education training shall include training regarding sudden unexplained death in epilepsy. The Office of the Chief Medical Examiner shall annually update and publish these guidelines on its Internet Web site. Newly appointed county medical examiners shall complete mandatory orientation training as directed by the Office of the Chief Medical Examiner within 90 days of their appointment.

(c) The Chief Medical Examiner may revoke a county medical examiner's appointment for failure to adequately perform the duties of the office after providing the county medical examiner with written notice of the basis for the revocation and an opportunity to respond."

SECTION 12E.4.(b) This section becomes effective January 1, 2016.

INCREASE IN NORTH CAROLINA MEDICAL EXAMINER AUTOPSY FEE

SECTION 12E.5.(a) G.S. 130A-389(a) reads as rewritten:

"(a) If, in the opinion of the medical examiner investigating the case or of the Chief Medical Examiner, it is advisable and in the public interest that an autopsy or other study be made; or, if an autopsy or other study is requested by the district attorney of the county or by any superior court judge, an autopsy or other study shall be made by the Chief Medical Examiner or by a competent pathologist designated by the Chief Medical Examiner. A complete autopsy report of findings and interpretations, prepared on forms designated for the purpose, shall be submitted promptly to the Chief Medical Examiner. Subject to the limitations of G.S. 130A-389.1 relating to photographs and video or audio recordings of an autopsy, a copy of the report shall be furnished to any person upon request. A fee for the autopsy or other study shall be paid by the State. However, if the deceased is a resident of the county in which the death or fatal injury occurred, that county shall pay the fee. The fee shall be ~~one thousand two hundred fifty dollars ($1,250).~~two thousand eight hundred dollars ($2,800)."

SECTION 12E.5.(b) Subsection (a) of this section applies to fees imposed for autopsies performed on or after July 1, 2015.

SECTION 12E.5.(c) Funds appropriated in this act to the Department of Health and Human Services, Division of Public Health, Office of the Chief Medical Examiner, shall not be used to provide a supplement to counties to offset any portion of the autopsy fee authorized in G.S. 130A-389(a), as amended by subsection (a) of this section.

INCREASE IN NORTH CAROLINA MEDICAL EXAMINER FEE

SECTION 12E.6.(a) G.S. 130A-387 reads as rewritten:

"**§ 130A-387. Fees.**

For each investigation and prompt filing of the required report, the medical examiner shall receive a fee paid by the State. However, if the deceased is a resident of the county in which the death or fatal injury occurred, that county shall pay the fee. The fee shall be ~~one hundred dollars ($100.00).~~two hundred fifty dollars ($250.00)."

SECTION 12E.6.(b) Subsection (a) of this section becomes effective July 1, 2015, and applies to fees imposed for investigations and reports filed on or after that date.

INCREASE IN TRANSPORTATION RATE FOR DEATH INVESTIGATIONS AND AUTOPSIES

SECTION 12E.7. Of the funds appropriated in this act to the Department of Health and Human Services, Division of Public Health, Office of the Chief Medical Examiner, the sum of four hundred thousand dollars ($400,000) for the 2015-2016 fiscal year and the sum of four hundred thousand dollars ($400,000) for the 2016-2017 fiscal year shall be used to increase the current base contract rate paid by the Department to transport bodies for death investigations or autopsies to one hundred ninety dollars ($190.00) for the first 40 miles and then one dollar ($1.00) per mile after the first 40 miles.

TRANSFER OF FUNCTIONS OF OFFICE OF MINORITY HEALTH

SECTION 12E.8. The Office of Minority Health of the Department of Health and Human Services is hereby eliminated. The Department of Health and Human Services, Division of Central Management, shall assume responsibility for establishing and administering a competitive grants process in accordance with Section 12A.8(d) of this act for evidence-based programs that are scientifically proven to eliminate or reduce health disparities among minority populations in this State.

TRANSFER OF FUNCTIONS OF PHYSICAL ACTIVITY AND NUTRITION PROGRAM TO DIVISION OF CENTRAL MANAGEMENT AND SUPPORT

SECTION 12E.9. The Physical Activity and Nutrition Program within the Department of Health and Human Services, Division of Public Health, Chronic Disease and

Injury Section, is hereby eliminated. The Department of Health and Human Services, Central Management and Support Division, shall assume responsibility for establishing and administering a competitive grants process in accordance with Section 12A.8(c) of this act for evidence-based programs that are scientifically proven to improve physical health and nutrition across the State.

RENAMING AND TRANSFER OF OFFICE OF RURAL HEALTH AND COMMUNITY CARE TO DIVISION OF PUBLIC HEALTH

SECTION 12E.10.(a) The Office of Rural Health and Community Care is hereby transferred from the Department of Health and Human Services, Division of Central Management and Support, to the Department of Health and Human Services, Division of Public Health, by a Type I transfer, as defined in G.S. 143A-6, and renamed the Rural Health Section.

SECTION 12E.10.(b) Consistent with subsection (a) of this section, the Revisor of Statutes may conform names and titles changed by this section, and may correct statutory references as required by this section, throughout the General Statutes. In making the changes authorized by this section, the Revisor may also adjust subject and verb agreement and the placement of conjunctions.

SUBPART XII-F. DIVISION OF MH/DD/SAS AND STATE OPERATED HEALTHCARE FACILITIES

FUNDS FOR LOCAL INPATIENT PSYCHIATRIC BEDS OR BED DAYS

SECTION 12F.1.(a) Use of Funds. – Of the funds appropriated in Section 2.1 of this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, for crisis services, the sum of forty-three million forty-nine thousand one hundred forty-four dollars ($43,049,144) for the 2015-2016 fiscal year and the sum of forty-three million forty-nine thousand one hundred forty-four dollars ($43,049,144) for the 2016-2017 fiscal year shall be used to purchase additional local inpatient psychiatric beds or bed days not currently funded by or though LME/MCOs. The Department shall continue to implement a two-tiered system of payment for purchasing these local inpatient psychiatric beds or bed days based on acuity level with an enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels, as defined by the Department. The enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels shall not exceed the lowest average cost per patient bed day among the State psychiatric hospitals. In addition, at the discretion of the Secretary of Health and Human Services, existing funds allocated to LME/MCOs for community-based mental health, developmental disabilities, and substance abuse services may be used to purchase additional local inpatient psychiatric beds or bed days. Funds designated in this subsection for the purchase of local inpatient psychiatric beds or bed days shall not be used to supplant other funds appropriated or otherwise available to the Department for the purchase of inpatient psychiatric services through contracts with local hospitals.

SECTION 12F.1.(b) Distribution and Management of Beds or Bed Days. – The Department shall work to ensure that any local inpatient psychiatric beds or bed days purchased in accordance with this section are utilized solely for individuals who are medically indigent, defined as uninsured persons who (i) are financially unable to obtain private insurance coverage as determined by the Department and (ii) are not eligible for government-funded health coverage such as Medicare or Medicaid; and distributed across the State in LME/MCO catchment areas and according to need as determined by the Department. The Department shall ensure that beds or bed days for individuals with higher acuity levels are distributed across the

State in LME catchment areas, including any catchment areas served by managed care organizations, and according to greatest need based on hospital bed utilization data. The Department shall enter into contracts with LME/MCOs and local hospitals for the management of these beds or bed days. The Department shall work to ensure that these contracts are awarded equitably around all regions of the State. LME/MCOs shall manage and control these local inpatient psychiatric beds or bed days, including the determination of the specific local hospital or State psychiatric hospital to which an individual should be admitted pursuant to an involuntary commitment order.

SECTION 12F.1.(c) Funds to Be Held in Statewide Reserve. – Funds appropriated to the Department for the purchase of local inpatient psychiatric beds or bed days shall not be allocated to LME/MCOs but shall be held in a statewide reserve at the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, to pay for services authorized by the LME/MCOs and billed by the hospitals through the LME/MCOs. LME/MCOs shall remit claims for payment to the Department within 15 working days after receipt of a clean claim from the hospital and shall pay the hospital within 30 working days after receipt of payment from the Department.

SECTION 12F.1.(d) Ineffective LME/MCO Management of Beds or Bed Days. – If the Department determines that (i) an LME/MCO is not effectively managing the beds or bed days for which it has responsibility, as evidenced by beds or bed days in the local hospital not being utilized while demand for services at the State psychiatric hospitals has not reduced, or (ii) the LME/MCO has failed to comply with the prompt payment provisions of subsection (c) of this section, the Department may contract with another LME/MCO to manage the beds or bed days or, notwithstanding any other provision of law to the contrary, may pay the hospital directly.

SECTION 12F.1.(e) Reporting by LME/MCOs. – The Department shall establish reporting requirements for LME/MCOs regarding the utilization of these beds or bed days.

SECTION 12F.1.(f) Reporting by Department. – By no later than December 1, 2016, and by no later than December 1, 2017, the Department shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on all of the following:

(1) A uniform system for beds or bed days purchased during the preceding fiscal year from (i) funds appropriated in this act that are designated for this purpose in subsection (a) of this section, (ii) existing State appropriations, and (iii) local funds.

(2) Other Department initiatives funded by State appropriations to reduce State psychiatric hospital use.

SINGLE STREAM FUNDING FOR MH/DD/SAS COMMUNITY SERVICES

SECTION 12F.2.(a) For the purpose of mitigating cash flow problems that many LME/MCOs experience at the beginning of each fiscal year relative to single stream funding, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Division), shall distribute not less than one-twelfth of each LME/MCO's continuation allocation at the beginning of the fiscal year and subtract the amount of that distribution from the LME/MCO's total reimbursements for the fiscal year.

SECTION 12F.2.(b) The Division is directed to reduce its allocation for single stream funding by one hundred eighty-five million six hundred four thousand six hundred fifty-three dollars ($185,604,653) in nonrecurring funds for the 2015-2016 fiscal year and by one hundred eighty-five million six hundred four thousand six hundred fifty-three dollars ($185,604,653) for the 2016-2017 fiscal year. The Division is directed to allocate this reduction among the LME/MCOs based on the percentage of the total single stream funding allocated to each LME/MCO for the 2014-2015 fiscal year. During each year of the 2015-2017 fiscal

biennium, each LME/MCO shall use its cash reserves to provide at least the same level of services paid for by single stream funding during the 2014-2015 fiscal year.

FUNDS FOR THE NORTH CAROLINA CHILD TREATMENT PROGRAM

SECTION 12F.3.(a) Recurring funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the 2015-2017 fiscal biennium for the North Carolina Child Treatment Program (NC CTP) shall be used for the following purposes:

(1) 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 outcomes.

(2) To maintain and manage a public roster of program graduates, linking high-quality clinicians with children, families, and professionals.

(3) To partner with State, LME/MCO, and private sector leadership to bring effective mental health treatment to children in juvenile justice and mental health facilities.

SECTION 12F.3.(b) All data, including any entered or stored in the State-funded secure database developed for the NC CTP to track individual-level and aggregate-level data with interface capability to work with existing networks within State agencies, is and remains the sole property of the State.

TRAUMATIC BRAIN INJURY FUNDING

SECTION 12F.6. Of the funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the 2015-2016 fiscal year, the sum of two million three hundred seventy-three thousand eighty-six dollars ($2,373,086) shall be used exclusively to support traumatic brain injury (TBI) services as follows:

(1) The sum of three hundred fifty-nine thousand two hundred eighteen dollars ($359,218) shall be used to fund contracts with the Brain Injury Association of North Carolina, Carolinas Rehabilitation, or other appropriate service providers.

(2) The sum of seven hundred ninety-six thousand nine hundred thirty-four dollars ($796,934) shall be used to support residential programs across the State that are specifically designed to serve individuals with TBI.

(3) The sum of one million two hundred sixteen thousand nine hundred thirty-four dollars ($1,216,934) shall be used to support requests submitted by individual consumers for assistance with residential support services, home modifications, transportation, and other requests deemed necessary by the consumer's local management entity and primary care physician.

CREATION OF SEPARATE DOROTHEA DIX HOSPITAL PROPERTY FUND WITHIN THE MENTAL HEALTH TRUST FUND

SECTION 12F.6A.(a) G.S. 143C-9-2 is amended by adding a new subsection to read:

"(b1) The Dorothea Dix Hospital Property Fund is established as a separate fund within the Trust Fund. The fund is established to receive the net proceeds from the sale of the Dorothea Dix Hospital property. Moneys in the Dorothea Dix Hospital Property Fund shall be allocated or expended only upon an act of appropriation by the General Assembly and shall not be subject to the limitations of the moneys in the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs as described in subsection (b) of this section."

SECTION 12F.6A.(b) Notwithstanding G.S. 146-30 or any other provision of law, the net proceeds of the sale of the Dorothea Dix Hospital property shall be deposited into the Dorothea Dix Hospital Property Fund established in G.S. 143C-9-2(b1), as enacted by subsection (a) of this section.

JOINT STUDY OF JUSTICE AND PUBLIC SAFETY AND BEHAVIORAL HEALTH

SECTION 12F.10. The Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety shall each appoint a subcommittee to study the intersection of Justice and Public Safety and behavioral health and report their findings and recommendations to their respective Committees. The subcommittees shall meet jointly to study and report on the following issues:

(1) The impact of the Justice Reinvestment Act on the State's behavioral health system, including the following:
   a. The impact of the Justice Reinvestment Act on the demand for community-based behavioral health services available through local management entities/managed care organizations (LME/MCOs).
   b. The change in the number of criminal offenders referred to the Treatment Accountability for Safer Communities (TASC) program since 2010 and other demands on the TASC program that have arisen since that time.
   c. The sources and amounts of funding available to serve this population, as well as any other support or resources that are provided by the Department of Public Safety to the Department of Health and Human Services or the LME/MCOs.
   d. An analysis of the supply and demand for behavioral health providers who serve this population.

(2) The impact of mental illness and substance abuse on county law enforcement agencies, including the following:
   a. The number of people with mental illness and substance abuse issues held in county jails.
   b. The impact on local law enforcement agencies, particularly with respect to their budgets and personnel.

(3) The impact of judicial decisions on the State's behavioral health and social services system, including the following:
   a. The role and impact of family court decisions on the demand for and delivery of county social services.
   b. The role and impact of decisions by drug treatment courts, veterans' mental health courts, and driving while impaired courts.
   c. The impact of judicial decisions on the availability of beds in State-operated psychiatric facilities as a result of involuntary commitment orders and incapacity to proceed decisions.

(4) Any other relevant issues the subcommittees jointly deem appropriate.

LME/MCO USE OF FUNDS TO PURCHASE INPATIENT ALCOHOL AND SUBSTANCE ABUSE TREATMENT SERVICES

SECTION 12F.12.(a) It is the intent of the General Assembly to terminate all direct State appropriations for State-operated alcohol and drug abuse treatment centers (ADATCs) beginning with the 2015-2016 fiscal year and instead appropriate funds to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, for community services in order to allow local management entities/managed care organizations (LME/MCOs) to assume responsibility for

managing the full array of publicly funded substance abuse services, including inpatient services delivered through the ADATCs. To this end and notwithstanding any other provision of law, on the effective date of this section all direct State appropriations for ADATCs are terminated and the ADATCs shall be one hundred percent receipt-supported.

SECTION 12F.12.(b) From funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, to be allocated to LME/MCOs for the purchase of inpatient alcohol and substance abuse treatment services, the LME/MCOs shall use their respective fund allocations for individuals within their respective catchment areas as follows:

(1) During the 2015-2016 fiscal year, a minimum of one hundred percent (100%) of the allocation shall be used exclusively to purchase inpatient alcohol and substance abuse treatment services from the ADATCs.

(2) During the 2016-2017 fiscal year, a minimum of ninety percent (90%) of the allocation shall be used exclusively to purchase inpatient alcohol and substance abuse treatment services from the ADATCs. The LME/MCOs shall use the remaining ten percent (10%) of their respective allocations to purchase inpatient alcohol and substance abuse treatment services from any qualified provider.

SECTION 12F.12.(c) By March 1, 2016, the Department of Health and Human Services shall develop and report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division a plan to allow the ADATCs to remain one hundred percent (100%) receipt-supported. The report shall include an evaluation of (i) other community-based and residential services that could be provided by the ADATCs and (ii) potential funding sources other than payments from the LME/MCOs, including funding available from estimated receipts from Medicare, Medicaid, insurance, and self-pay.

CLOSURE OF WRIGHT SCHOOL

SECTION 12F.13.(a) The Department of Health and Human Services shall not allow any new admissions or readmissions to the Wright School after June 30, 2015. The Department shall, in consultation with local management entities/managed care organizations, develop a plan to transition all students enrolled at the Wright School to other appropriate educational and treatment settings.

SECTION 12F.13.(b) By September 30, 2015, the Department shall permanently cease operations at the Wright School.

SECTION 12F.13.(c) G.S. 122C-181(a)(5)b. is repealed effective October 1, 2015.

REPORT ON MULTIPLICATIVE AUDITING AND MONITORING OF CERTAIN SERVICE PROVIDERS

SECTION 12F.14. No later than December 1, 2015, the Department of Health and Human Services shall report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the status of multiplicative auditing and monitoring of all provider agencies under the Division of Mental Health, Developmental Disabilities and Substance Abuse Services, that have been nationally accredited through a recognized national accrediting body. The report shall include (i) all group home facilities licensed under Chapter 122C of the General Statutes, (ii) a complete list of all auditing and monitoring activities to which these service providers are subject, and (iii) recommendations on the removal of all unnecessary regulatory duplication to enhance efficiency.

FUNDS FOR DRUG OVERDOSE MEDICATIONS

SECTION 12F.15. Funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse

Services, for the 2015-2016 fiscal year for the purchase of opioid antagonists as defined in G.S. 90-106.2, shall be used as follows:

(1) Twenty-five thousand dollars ($25,000) shall be used to purchase opioid antagonists to be distributed at no charge to the North Carolina Harm Reduction Coalition to serve individuals at risk of experiencing an opioid-related drug overdose or to the friends and family members of an at-risk individual.

(2) Twenty-five thousand dollars ($25,000) shall be used to purchase opioid antagonists to be distributed at no charge to North Carolina law enforcement agencies.

STRENGTHENING OF CONTROLLED SUBSTANCES MONITORING

STATEWIDE OPIOID PRESCRIBING GUIDELINES

SECTION 12F.16.(a) By July 1, 2016, the following State health officials and health care provider licensing boards shall adopt the North Carolina Medical Board's Policy for the Use of Opiates for the Treatment of Pain:

(1) The Director of the Division of Public Health of the Department of Health and Human Services (DHHS).

(2) The Director of the Division of Medical Assistance, DHHS.

(3) The Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS.

(4) The directors of medical, dental, and mental health services within the Department of Public Safety.

(5) North Carolina State Board of Dental Examiners.

(6) North Carolina Board of Nursing.

(7) North Carolina Board of Podiatry Examiners.

CONTINUING EDUCATION REQUIREMENTS

SECTION 12F.16.(b). The following health care provider occupational licensing boards shall require continuing education on the abuse of controlled substances as a condition of license renewal for health care providers who prescribe controlled substances:

(1) North Carolina Board of Dental Examiners.

(2) North Carolina Board of Nursing.

(3) North Carolina Board of Podiatry Examiners.

(4) North Carolina Medical Board.

SECTION 12F.16.(c). In establishing the continuing education standards, the boards listed in subsection (b) of this section shall require that at least one hour of the total required continuing education hours consists of a course designed specifically to address prescribing practices. The course shall include, but not be limited to, instruction on controlled substance prescribing practices and controlled substance prescribing for chronic pain management.

IMPROVE CONTROLLED SUBSTANCES REPORTING SYSTEM ACCESS AND UTILIZATION

SECTION 12F.16.(d). G.S. 90-113.74 reads as rewritten:

"**§ 90-113.74. Confidentiality.**

(a) Prescription information submitted to the Department is privileged and confidential, is not a public record pursuant to G.S. 132-1, is not subject to subpoena or discovery or any other use in civil proceedings, and except as otherwise provided below may only be used (i) for investigative or evidentiary purposes related to violations of State or federal ~~law and~~ law, (ii) for regulatory ~~activities.~~ activities, or (iii) to inform medical records or clinical care. Except as otherwise provided by this section, prescription information shall not be disclosed or disseminated to any person or entity by any person or entity authorized to review prescription information.

…

(c) The Department shall release data in the controlled substances reporting system to the following persons only:

…

(8) Any county medical examiner appointed by the Chief Medical Examiner pursuant to G.S. 130A-382 and the Chief Medical Examiner, for the purpose of investigating the death of an individual.

(9) The federal Drug Enforcement Administration's Office of Diversion Control.

(10) The North Carolina Health Information Exchange Authority (NC HIE Authority), established under Article 29A of this Chapter, through Web-service calls.

…."

SECTION 12F.16.(e). The Department of Health and Human Services shall adopt appropriate policies and procedures documenting and supporting the additional functionality and expanded access added by subsection (d) of this section for the Controlled Substances Reporting System (CSRS) for the entities added to G.S. 90-113.74(c) by subsection (d) of this section and shall amend its contract with the vendor that operates the CSRS to support the additional functionality and expanded access to the CSRS.

IMPROVE CONTROLLED SUBSTANCES REPORTING SYSTEM CONTRACT

SECTION 12F.16.(f). The Department of Health and Human Services (DHHS) shall modify the contract for the Controlled Substances Reporting System (CSRS) to improve performance, establish user access controls, establish data security protocols, and ensure availability of data for advanced analytics. Specifically, the contract shall be modified to include the following:

(1) A connection to the North Carolina Health Information Exchange Authority (NC HIE Authority).

(2) The establishment of interstate connectivity.

(3) Data security protocols that meet or exceed the Federal Information Processing Standards (FIPS) established by the National Institute of Standards and Technology (NIST).

SECTION 12F.16.(g). DHHS shall complete the contract modifications required by subsection (f) of this section by December 31, 2015. DHHS shall report by November 15, 2015, to the Joint Legislative Program Evaluation Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services regarding the progress to modify the contract.

SECTION 12F.16.(h). DHHS shall apply for grant funding from the National Association of Boards of Pharmacy to establish the connection to PMP InterConnect. The Department shall request forty thousand thirty-five dollars ($40,035) to establish the initial interface for PMP InterConnect and thirty thousand dollars ($30,000) for two years of ongoing service, maintenance, and support for PMP InterConnect in order to create interstate

connectivity for the drug monitoring program as required by subdivision (2) of subsection (f) of this section.

SECTION 12F.16.(i). Funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for the CSRS shall be used as follows:

(1) For the 2015-2016 fiscal year, the sum of forty thousand thirty-five dollars ($40,035) shall be used to connect the CSRS and the NC HIE Authority, as required by subdivision (1) of subsection (f) of this section.

(2) For the 2015-2016 fiscal year and for the 2016-2017 fiscal year, the sum of fifteen thousand dollars ($15,000) shall be used to maintain a connection between the CSRS and the NC HIE Authority, as required by subdivision (1) of subsection (f) of this section.

(3) For the 2015-2016 fiscal year, the sum of forty thousand thirty-five dollars ($40,035) shall be used to establish the initial interface for PMP InterConnect, as required by subdivision (2) of subsection (f) of this section. This amount shall be adjusted or eliminated if DHHS is successful in obtaining grant awards or identifying other allowable receipts for this purpose. If receipts are used for this purpose, this nonrecurring appropriation shall revert to the General Fund.

(4) For the 2015-2016 fiscal year, the sum of fifteen thousand dollars ($15,000) shall be used for the cost of annual service fees for the interstate connection for the drug monitoring program, as required by subdivision (2) of subsection (f) of this section. This amount shall be adjusted or eliminated if DHHS is successful in obtaining grant awards or identifying other allowable receipts for this purpose. If receipts are used for this purpose, this nonrecurring appropriation shall revert to the General Fund.

EXPAND MONITORING CAPACITY

SECTION 12F.16.(j). The North Carolina Controlled Substances Reporting System shall expand its monitoring capacity by establishing data use agreements with the Prescription Behavior Surveillance System. In order to participate, the CSRS shall establish a data use agreement with the Center of Excellence at Brandeis University no later than January 1, 2016.

SECTION 12F.16.(k) Beginning September 1, 2016, and every two years thereafter, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services shall report on its participation with the Prescription Behavior Surveillance System to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety.

MEDICAID LOCK-IN PROGRAM

SECTION 12F.16.(l). The Division of Medical Assistance of the Department of Health and Human Services (DMA) shall take the following steps to improve the effectiveness and efficiency of the Medicaid lock-in program:

(1) Establish written procedures for the operation of the lock-in program, including specifying the responsibilities of DMA and the program contractor.

(2) Establish procedures for the sharing of bulk data with the Controlled Substances Regulatory Branch.

(3) In consultation with the Physicians Advisory Group, extend lock-in duration to two years and revise program eligibility criteria to align the program with the statewide strategic goals for preventing prescription drug abuse. DMA shall report an estimate of the cost-savings from the revisions to the eligibility criteria to the Joint Legislative Program Evaluation Oversight Committee and the Joint Legislative Oversight Committee on Health and Human Services within one year of the lock-in program again becoming operational.

(4) Develop a Web site and communication materials to inform lock-in enrollees, prescribers, pharmacists, and emergency room health care providers about the program.

(5) Increase program capacity to ensure that all individuals who meet program criteria are locked in.

(6) Conduct an audit of the lock-in program within six months after the effective date of this act in order to evaluate the effectiveness of program restrictions in preventing overutilization of controlled substances, identify any program vulnerabilities, and address whether there is evidence of any fraud or abuse within the program.

DMA shall report to the Joint Legislative Program Evaluation Oversight Committee by September 30, 2015, on its progress toward implementing all items included in this section.

STATEWIDE STRATEGIC PLAN

SECTION 12F.16.(m). There is hereby created the Prescription Drug Abuse Advisory Committee, to be housed in and staffed by the Department of Health and Human Services (DHHS). The Committee shall develop and, through its members, implement a statewide strategic plan to combat the problem of prescription drug abuse. The Committee shall include representatives from the following, as well as any other persons designated by the Secretary of Health and Human Services:

(1) The Division of Medical Assistance, DHHS.

(2) The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, DHHS.

(3) The Division of Public Health, DHHS.

(4) The Rural Health Section of the Division of Public Health, DHHS.

(5) The State Bureau of Investigation.

(6) The Attorney General's Office.

(7) The following health care regulatory boards with oversight of prescribers and dispensers of prescription drugs:

a. North Carolina Board of Dental Examiners.

b. North Carolina Board of Nursing.

c. North Carolina Board of Podiatry Examiners.

d. North Carolina Medical Board.

e. North Carolina Board of Pharmacy.

(8) The UNC Injury Prevention Research Center.

(9) The substance abuse treatment community.

(10) Governor's Institute on Substance Abuse, Inc.

(11) The Department of Insurance's drug take-back program.

After developing the strategic plan, the Committee shall be the State's steering committee to monitor achievement of strategic objectives and receive regular reports on progress made toward reducing prescription drug abuse in North Carolina.

(b) In developing the statewide strategic plan to combat the problem of prescription drug abuse, the Prescription Drug Abuse Advisory Committee shall, at a minimum, complete the following steps:

(1) Identify a mission and vision for North Carolina's system to reduce and prevent prescription drug abuse.

(2) Scan the internal and external environment for the system's strengths, weaknesses, opportunities, and challenges (a SWOC analysis).

(3) Compare threats and opportunities to the system's ability to meet challenges and seize opportunities (a GAP analysis).

(4) Identify strategic issues based on SWOC and GAP analyses.

(5) Formulate strategies and resources for addressing these issues.

(c) The strategic plan for reducing prescription drug abuse shall include three to five strategic goals that are outcome-oriented and measureable. Each goal must be connected with objectives supported by the following five mechanisms of the system:

(1) Oversight and regulation of prescribers and dispensers by State health care regulatory boards.

(2) Operation of the Controlled Substances Reporting System.

(3) Operation of the Medicaid lock-in program to review behavior of patients with high use of prescribed controlled substances.

(4) Enforcement of State laws for the misuse and diversion of controlled substances.

(5) Any other appropriate mechanism identified by the Committee.

(d) DHHS, in consultation with the Prescription Drug Abuse Advisory Committee, shall develop and implement a formalized performance management system that connects the goals and objectives identified in the statewide strategic plan to operations of the Controlled Substances Reporting System and Medicaid lock-in program, law enforcement activities, and oversight of prescribers and dispensers. The performance management system must be designed to monitor progress toward achieving goals and objectives and must recommend actions to be taken when performance falls short.

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

EFFECTIVE DATE

SECTION 12F.16.(n). Subdivision (f)(1) of this section becomes effective upon the establishment of the North Carolina Health Information Exchange Authority pursuant to Section 12A.5 of this act. The remainder of this section is effective when it becomes law.

ELIMINATE PUBLICATION/ACCESS NORTH CAROLINA TRAVEL GUIDE

SECTION 12F.17. G.S. 168-2 is repealed.

SUBPART XII-G. DIVISION OF HEALTH SERVICE REGULATION

MORATORIUM ON SPECIAL CARE UNIT LICENSES

SECTION 12G.2.(a) Section 12G.1(a) of S.L. 2013-360, as amended by Section 12G.5 of S.L. 2014-100, reads as rewritten:

"**SECTION 12G.1.(a)** For the period beginning July 31, 2013, and ending ~~June 30, 2016,~~June 30, 2017, the Department of Health and Human Services, Division of Health Service Regulation (Department), shall not issue any licenses for special care units as defined in

G.S. 131D-4.6 and G.S. 131E-114. This prohibition shall not restrict the Department from doing any of the following:

(1) Issuing a license to a facility that is acquiring an existing special care unit.

(2) Issuing a license for a special care unit in any area of the State upon a determination by the Secretary of the Department of Health and Human Services that increased access to this type of care is necessary in that area during the moratorium imposed by this section.

(3) Processing all completed applications for special care unit licenses received by the Division of Health Service Regulation along with the applicable license fee prior to June 1, 2013.

(4) Issuing a license to a facility that was in possession of a certificate of need as of July 31, 2013, that included authorization to operate special care unit beds."

SECTION 12G.2.(a1) The Department shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services by March 1, 2016, containing at least the following information:

(1) The number of licensed special care units in the State.

(2) The capacity of the currently licensed special care units to serve people in need of their services.

(3) The anticipated growth in the number of people who will need the services of a licensed special care unit.

(4) The number of applications received from special care units seeking licensure as permitted by this section, and the number of those applications that were not approved.

SECTION 12G.2.(b) This section is effective when this act becomes law.

PHASED CERTIFICATE OF NEED REPEAL

SECTION 12G.5.(a) It is the intent of the General Assembly to repeal the certificate of need laws set forth in Article 9 of Chapter 131E of the General Statutes in three phases as set forth in subsections (b) and (c) of this section.

SECTION 12G.5.(b) Phase 1. – Effective January 1, 2016, the certificate of need laws will not apply to the following health service facilities and activities:

(1) The establishment of beds or a change in bed capacity at any of the following health service facilities:
   a. Acute care hospitals.
   b. Inpatient psychiatric hospitals.
   c. Inpatient rehabilitation hospitals.
   d. Kidney disease treatment centers.
   e. ICFMRs.
   f. Chemical dependency treatment facilities.

(2) The offering of any of the following services:
   a. Bone marrow transplantation.
   b. Burn intensive care services.
   c. Open heart surgery services.
   d. Solid organ transplantation.

(3) The acquisition of any of the following equipment:
   a. Gamma knife equipment.
   b. Heart-lung bypass machine.
   c. Lithotripter.

(4) The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility.

SECTION 12G.5.(c) Phase 2. – Effective August 1, 2017, the certificate of need laws will not apply to the establishment of beds or a change in bed capacity at any of the following health service facilities:

(1) Diagnostic centers.
(2) Ambulatory surgical facilities.

SECTION 12G.5.(d) Phase 3. – Effective January 1, 2019, the certificate of need laws will not apply to the following health service facilities and activities:

(1) Nursing homes.
(2) Hospice programs.
(3) Hospice inpatient facilities.
(4) Hospice residential care facilities.
(5) Long-term care hospitals.
(6) The offering of cardiac catheterization services.
(7) The acquisition of any of the following equipment:
  a. Cardiac catheterization equipment.
  b. Linear accelerator.
  c. Magnetic resonance imaging scanner.
  d. Positron emission tomography scanner.
  e. Simulator.

REPEAL CERTIFICATE OF PUBLIC ADVANTAGE LAWS

SECTION 12G.6.(a) Article 1E of Chapter 90 and Article 9A of Chapter 131E of the General Statutes are repealed.

SECTION 12G.6.(b) All existing certificates of public advantage (COPAs) granted pursuant to Article 1E of Chapter 90 and Article 9A of Chapter 131E of the General Statutes, as defined in these Articles, are cancelled effective January 1, 2016. By delaying the effective date of the cancellation of COPAs to January 1, 2016, it is the intent of the General Assembly to provide parties to existing cooperative agreements, as defined in G.S. 90-21.25 and G.S. 131E-192.2, with sufficient time to review their cooperative agreements for compliance with State and federal laws and to take whatever action the parties deem necessary.

SECTION 12G.6.(c) This section is effective when it becomes law.

SUBPART XII-H. DIVISION OF MEDICAL ASSISTANCE (MEDICAID)

MEDICAID ELIGIBILITY

SECTION 12H.2.(a) Families and children who are categorically and medically needy are eligible for Medicaid, subject to the following annual income levels:

Family Size	Categorically Needy Income Level	Medically Needy Income Level
1	$ 5,208	$ 2,904
2	6,828	3,804
3	8,004	4,404
4	8,928	4,800
5	9,888	5,196
6	10,812	5,604
7	11,700	6,000
8	12,432	6,300

The Department of Health and Human Services shall provide Medicaid coverage to 19- and 20-year-olds under this subsection in accordance with federal rules and regulations. Medicaid enrollment of categorically needy families with children shall be continuous for one year without regard to changes in income or assets.

SECTION 12H.2.(b) For the following Medicaid eligibility classifications for which the federal poverty guidelines are used as income limits for eligibility determinations, the income limits will be updated each April 1 immediately following publication of federal poverty guidelines. The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to the following:

(1) All elderly, blind, and disabled people who have incomes equal to or less than one hundred percent (100%) of the federal poverty guidelines.

(2) Pregnant women with incomes equal to or less than one hundred ninety-six percent (196%) of the federal poverty guidelines and without regard to resources. Services to pregnant women eligible under this subsection continue throughout the pregnancy but include only those related to pregnancy and to those other conditions determined by the Department as conditions that may complicate pregnancy.

(3) Infants under the age of one with family incomes equal to or less than two hundred ten percent (210%) of the federal poverty guidelines and without regard to resources.

(4) Children aged one through five with family incomes equal to or less than two hundred ten percent (210%) of the federal poverty guidelines and without regard to resources.

(5) Children aged six through 18 with family incomes equal to or less than one hundred thirty-three percent (133%) of the federal poverty guidelines and without regard to resources.

(6) Workers with disabilities described in G.S. 108A-66A with unearned income equal to or less than one hundred fifty percent (150%) of the federal poverty guidelines.

The Department of Health and Human Services, Division of Medical Assistance, shall also provide family planning services to men and women of childbearing age with family incomes equal to or less than one hundred ninety-five percent (195%) of the federal poverty guidelines and without regard to resources.

SECTION 12H.2.(c) The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to adoptive children with special or rehabilitative needs, regardless of the adoptive family's income.

SECTION 12H.2.(d) The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to "independent foster care adolescents," ages 18, 19, and 20, as defined in section 1905(w)(1) of the Social Security Act (42 U.S.C. § 1396d(w)(1)), without regard to the adolescent's assets, resources, or income levels.

SECTION 12H.2.(e) The Department of Health and Human Services, Division of Medical Assistance, shall provide Medicaid coverage to women who need treatment for breast or cervical cancer and who are defined in 42 U.S.C. § 1396a(a)(10)(A)(ii)(XVIII).

SECTION 12H.2.(f) G.S. 108A-70.21 reads as rewritten:

"**§ 108A-70.21. Program eligibility; benefits; enrollment fee and other cost-sharing; coverage from private plans; purchase of extended coverage.**

(a) Eligibility. – The Department may enroll eligible children based on availability of funds. Following are eligibility and other requirements for participation in the Program:

(1) Children must:

a. Be between the ages of 6 through 18;

b. Be ineligible for Medicaid, Medicare, or other federal government-sponsored health insurance;
c. Be uninsured;
d. Be in a family whose family income is above one hundred thirty-three percent (133%) ~~through~~ and less than or equal to two hundred eleven percent ~~(200%)~~(211%) of the federal poverty level;
e. Be a resident of this State and eligible under federal law; and
f. Have paid the Program enrollment fee required under this Part.

...

(b) Benefits. – All health benefits changes of the Program shall meet the coverage requirements set forth in this subsection. Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:

(1) No services for long-term care.
(2) No nonemergency medical transportation.
(3) No EPSDT.
(4) Dental services shall be provided on a restricted basis in accordance with criteria adopted by the Department to implement this subsection.

In addition to the benefits provided under the North Carolina Medicaid Program, the following services and supplies are covered under the Health Insurance Program for Children established under this Part:

(1), (1a) Repealed by Session Laws 2011-145, s. 10.41(b), effective July 1, 2011.
(2) Vision: Scheduled routine eye examinations once every 12 months, eyeglass lenses or contact lenses once every 12 months, routine replacement of eyeglass frames once every 24 months, and optical supplies and solutions when needed. NCHC recipients must obtain optical services, supplies, and solutions from NCHC enrolled, licensed or certified ophthalmologists, optometrists, or opticians. In accordance with G.S. 148-134, NCHC providers must order complete eyeglasses, eyeglass lenses, and ophthalmic frames through Nash Optical Plant. Eyeglass lenses are limited to NCHC-approved single vision, bifocal, trifocal, or other complex lenses necessary for a Plan enrollee's visual welfare. Coverage for oversized lenses and frames, designer frames, photosensitive lenses, tinted contact lenses, blended lenses, progressive multifocal lenses, coated lenses, and laminated lenses is limited to the coverage for single vision, bifocal, trifocal, or other complex lenses provided by this subsection. Eyeglass frames are limited to NCHC-approved frames made of zylonite, metal, or a combination of zylonite and metal. All visual aids covered by this subsection require prior approval. Requests for medically necessary complete eyeglasses, eyeglass lenses, and ophthalmic frames outside of the NCHC-approved selection require prior approval. Requests for medically necessary fabrication of complete eyeglasses or eyeglass lenses outside of Nash Optical Plant require prior approval. Upon prior approval refractions may be covered more often than once every 12 months.
(3) Under the North Carolina Health Choice Program for Children, the co-payment for nonemergency visits to the emergency room for children whose family income is ~~at or below~~ less than or equal to one hundred ~~fifty~~fifty-nine percent ~~(150%)~~(159%) of the federal poverty level is ten dollars ($10.00). The co-payment for children whose family income is ~~between~~ above one hundred ~~fifty one~~ fifty-nine percent ~~(151%)~~(159%) and

less than or equal to two hundred eleven percent ~~(200%)~~(211%) of the federal poverty level is twenty-five dollars ($25.00).

...

(c) Annual Enrollment Fee. – There shall be no enrollment fee for Program coverage for enrollees whose family income is ~~at or below~~less than or equal to one hundred ~~fifty~~ fifty-nine percent ~~(150%)~~(159%) of the federal poverty level. The enrollment fee for Program coverage for enrollees whose family income is above one hundred ~~fifty~~ fifty-nine percent ~~(150%)~~(159%) ~~through~~and less than or equal to two hundred eleven percent ~~(200%)~~(211%) of the federal poverty level shall be fifty dollars ($50.00) per year per child with a maximum annual enrollment fee of one hundred dollars ($100.00) for two or more children. The enrollment fee shall be collected by the county department of social services and retained to cover the cost of determining eligibility for services under the Program. County departments of social services shall establish procedures for the collection of enrollment fees.

(d) Cost-Sharing. – There shall be no deductibles, copayments, or other cost-sharing charges for families covered under the Program whose family income is ~~at or below~~less than or equal to one hundred ~~fifty~~fifty-nine percent ~~(150%)~~(159%) of the federal poverty level, except that fees for outpatient prescription drugs are applicable and shall be one dollar ($1.00) for each outpatient generic prescription drug, for each outpatient brand-name prescription drug for which there is no generic substitution available, and for each covered over-the-counter medication. The fee for each outpatient brand-name prescription drug for which there is a generic substitution available is three dollars ($3.00). Families covered under the Program whose family income is above one hundred ~~fifty~~ fifty-nine percent ~~(150%)~~(159%) of the federal poverty level shall be responsible for copayments to providers as follows:

(1) Five dollars ($5.00) per child for each visit to a provider, except that there shall be no copayment required for well-baby, well-child, or age-appropriate immunization services;

(2) Five dollars ($5.00) per child for each outpatient hospital visit;

(3) A one dollar ($1.00) fee for each outpatient generic prescription drug, for each outpatient brand-name prescription drug for which there is no generic substitution available, and for each covered over-the-counter medication. The fee for each outpatient brand-name prescription drug for which there is a generic substitution available is ten dollars ($10.00).

(4) Twenty dollars ($20.00) for each emergency room visit unless:

a. The child is admitted to the hospital, or

b. No other reasonable care was available as determined by the Department.

…"

LME/MCO OUT-OF-NETWORK AGREEMENTS

SECTION 12H.3.(a) The Department of Health and Human Services (Department) shall ensure that local management entities/managed care organizations (LME/MCOs) utilize an out-of-network agreement that contains standardized elements developed in consultation with LME/MCOs. The out-of-network agreement shall be a streamlined agreement between a single provider of behavioral health or intellectual/developmental disability (IDD) services and an LME/MCO to ensure access to care in accordance with 42 C.F.R. 438.206(b)(4), reduce administrative burden on the provider, and comply with all requirements of State and federal laws and regulations. Beginning July 1, 2015, LME/MCOs shall use the out-of-network agreement in lieu of a comprehensive provider contract when all of the following conditions are met:

(1) The services requested are medically necessary and cannot be provided by an in-network provider.

(2) The behavioral health or IDD provider's site of service delivery is located outside of the geographical catchment area of the LME/MCO, and the LME/MCO is not accepting applications or the provider does not wish to apply for membership in the LME/MCO closed network.

(3) The behavioral health or IDD provider is not excluded from participation in the Medicaid program, the NC Health Choice program or other State or federal health care program.

(4) The behavioral health or IDD provider is serving no more than two enrollees of the LME/MCO, unless the agreement is for inpatient hospitalization, in which case the LME/MCO may, but shall not be required to, enter into more than five such out-of-network agreements with a single hospital or health system in any 12-month period.

SECTION 12H.3.(b) Medicaid providers providing services pursuant to an out-of-network agreement shall be considered a network provider for purposes of Chapter 108D of the General Statutes only as it relates to enrollee grievances and appeals.

PROVIDER APPLICATION AND RECREDENTIALING FEE

SECTION 12H.4. The Department of Health and Human Services, Division of Medical Assistance, shall charge an application fee of one hundred dollars ($100.00), and the amount federally required, to each provider enrolling in the Medicaid Program for the first time. The fee shall be charged to all providers at recredentialing every three years.

REIMBURSEMENT FOR IMMUNIZING PHARMACIST SERVICES

SECTION 12H.5.(a) Effective January 1, 2016, the Department of Health and Human Services, Division of Medical Assistance (Department), shall provide Medicaid and NC Health Choice reimbursement for the administration of covered vaccinations or immunizations provided by immunizing pharmacists in accordance with G.S. 90-85.15B.

SECTION 12H.5.(b) In order to implement the requirements of subsection (a) of this section, the Department shall enroll immunizing pharmacists as providers.

SECTION 12H.5.(c) The Department shall submit any State plan amendments necessary to accomplish the requirements of this section.

TRAUMATIC BRAIN INJURY MEDICAID WAIVER

SECTION 12H.6.(a) The Department of Health and Human Services, Division of Medical Assistance and Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (Department), shall submit to the Centers for Medicare and Medicaid Services a request for approval of the 1915(c) waiver for individuals with traumatic brain injury (TBI) that the Department designed pursuant to Section 12H.6 of S.L. 2014-100, which the Joint Legislative Oversight Committee on Health and Human Services recommended as part of its December 2014 report to the General Assembly, and which is further described in the Department's February 1, 2015, report to the General Assembly.

SECTION 12H.6.(b) The Department shall report to the Joint Legislative Oversight Committee on Health and Human Services on the status of the Medicaid TBI waiver request and the plan for implementation no later than December 1, 2015. The Department shall submit an updated report by March 1, 2016. Each report shall include the following:

(1) The number of individuals who are being served under the waiver and the total number of individuals expected to be served.

(2) The expenditures to date and a forecast of future expenditures.

(3) Any recommendations regarding expansion of the waiver.

SECTION 12H.6.(c) Of the funds appropriated to the Department of Health and Human Services, Division of Medical Assistance, two million dollars ($2,000,000) for fiscal

year 2015-2016 and two million dollars ($2,000,000) for fiscal year 2016-2017 shall be used to fund the Medicaid TBI waiver.

STUDY MEDICAID COVERAGE FOR VISUAL AIDS

SECTION 12H.6A. The Department of Health and Human Services, Division of Medical Assistance, in consultation with the Department of Public Safety, shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division by October 1, 2015, containing an analysis of the fiscal impact to the State of reinstating Medicaid coverage for visual aids for adults utilizing a contract with the Department of Public Safety for fabrication of the eyeglasses at Nash Optical Plant Optical Laboratory. The report shall also analyze the cost of reinstating Medicaid coverage for routine eye examinations for adults in addition to the coverage for visual aids.

ASSESSMENTS

SECTION 12H.7. G.S. 108A-122(b) reads as rewritten:

"(b) Allowable Cost. – An assessment paid under this Article may be included as allowable costs of a hospital for purposes of any applicable Medicaid reimbursement ~~formula.~~ formula; assessments paid under this Article shall be excluded from cost settlement. An assessment imposed under this Article may not be added as a surtax or assessment on a patient's bill."

LME/MCO TRANSFER OF FUNDS TO RISK RESERVE

SECTION 12H.8.(a) After the local management entities/managed care organizations (LME/MCOs) have allocated funds to cover the reduction in single stream funding required by Section 12F.2 of this act, the Department of Health and Human Services, Division of Medical Assistance, shall require LME/MCOs to transfer funds from their operating cash reserves to their contractually-required risk reserve account in an amount sufficient so that the funds in the risk reserve account equal fifteen percent (15%) of annual premiums. The Department shall not require LME/MCOs to transfer from their operating cash reserves the amount needed to make up the difference between the current month's claims payments and the capitation payment received for the month.

SECTION 12H.8.(b) The Department shall discontinue paying the two percent (2%) added to the administrative payment of an LME/MCO when the amount in the LME/MCO's risk reserve account reaches fifteen percent (15%) of annual premiums.

SECTION 12H.8.(c) The Department shall work with LME/MCOs to consolidate their multiple existing reserve accounts so that each LME/MCO has only one reserve account.

ADMINISTRATIVE HEARINGS FUNDING

SECTION 12H.9. Of the funds appropriated to the Department of Health and Human Services, Division of Medical Assistance, for administrative contracts and interagency transfers, the Department of Health and Human Services (Department) shall transfer the sum of one million dollars ($1,000,000) for the 2015-2016 fiscal year and the sum of one million dollars ($1,000,000) for the 2016-2017 fiscal year to the Office of Administrative Hearings (OAH). These funds shall be allocated by the OAH for mediation services provided for Medicaid applicant and recipient appeals and to contract for other services necessary to conduct the appeals process. OAH shall continue the Memorandum of Agreement (MOA) with the Department for mediation services provided for Medicaid recipient appeals and contracted services necessary to conduct the appeals process. The MOA will facilitate the Department's ability to draw down federal Medicaid funds to support this administrative function. Upon receipt of invoices from OAH for covered services rendered in accordance with the MOA, the Department shall transfer the federal share of Medicaid funds drawn down for this purpose.

ACCOUNTING FOR MEDICAID RECEIVABLES AS NONTAX REVENUE

SECTION 12H.10.(a) Receivables reserved at the end of the 2015-2016 and 2016-2017 fiscal years shall, when received, be accounted for as nontax revenue for each of those fiscal years.

SECTION 12H.10.(b) For the 2015-2016 fiscal year, the Department of Health and Human Services shall deposit from its revenues one hundred thirty-nine million dollars ($139,000,000) with the Department of State Treasurer to be accounted for as nontax revenue. For the 2016-2017 fiscal year, the Department of Health and Human Services shall deposit from its revenues one hundred thirty-nine million dollars ($139,000,000) with the Department of State Treasurer to be accounted for as nontax revenue. These deposits shall represent the return of General Fund appropriations, nonfederal revenue, fund balances, or other resources from State-owned and State-operated hospitals which are used to provide indigent and nonindigent care services. The return from State-owned and State-operated hospitals to DHHS will be made from nonfederal resources in an amount equal to the amount of the payments from the Division of Medical Assistance for uncompensated care. The treatment of any revenue derived from federal programs shall be in accordance with the requirements specified in the Code of Federal Regulations, Title 2, Part 225.

MEDICAID SPECIAL FUND TRANSFER

SECTION 12H.11. Of the funds transferred to the Department of Health and Human Services for Medicaid programs pursuant to G.S. 143C-9-1, there is appropriated from the Medicaid Special Fund to the Department of Health and Human Services the sum of forty-three million dollars ($43,000,000) for the 2015-2016 fiscal year and the sum of forty-three million dollars ($43,000,000) for the 2016-2017 fiscal year. These funds shall be allocated as prescribed by G.S. 143C-9-1(b) for Medicaid programs. Notwithstanding the prescription in G.S. 143C-9-1(b) that these funds not reduce State general revenue funding, these funds shall replace the reduction in general revenue funding effected in this act.

MISCELLANEOUS MEDICAID PROVISIONS

SECTION 12H.12.(a) Volume Purchase Plans and Single Source Procurement. – The Department of Health and Human Services, Division of Medical Assistance, may, subject to the approval of a change in the State Medicaid Plan, contract for services, medical equipment, supplies, and appliances by implementation of volume purchase plans, single source procurement, or other contracting processes in order to improve cost containment.

SECTION 12H.12.(b) Cost Containment Programs. – The Department of Health and Human Services, Division of Medical Assistance, may undertake cost containment programs, including contracting for services, preadmissions to hospitals, and prior approval for certain outpatient surgeries before they may be performed in an inpatient setting.

SECTION 12H.12.(c) Medicaid Identification Cards. – The Department shall issue Medicaid identification cards to recipients on an annual basis with updates as needed.

MISCELLANEOUS HEALTH CHOICE PROVISIONS

SECTION 12H.14.(a) G.S. 108A-70.18(4a) is repealed.

SECTION 12H.14.(b) G.S. 108A-70.20 reads as rewritten:

"**§ 108A-70.20. Program established.**

The Health Insurance Program for Children is established. The Program shall be known as North Carolina Health Choice for Children, and it shall be administered by the Department of Health and Human Services in accordance with this Part and as required under Title XXI and related federal rules and regulations. Administration of ~~Program benefits and~~ claims processing

shall be as ~~provided under Part 5 of Article 3 of Chapter 135 of the General Statutes.~~described in 42 C.F.R. § 447.45(d)(1)."

SECTION 12H.14.(c) Subsections (g) and (h) of G.S. 108A-70.21 are repealed.

SECTION 12H.14.(d) G.S. 108A-70.21(i) reads as rewritten:

"(i) ~~No Lifetime Maximum Benefit Limit. –~~ Benefits provided to an enrollee in the Program ~~shall not be subject to a maximum lifetime limit.~~may be subject to lifetime maximum limits set forth in Medicaid and NC Health Choice medical coverage policies adopted pursuant to G.S. 108A-54.2."

SECTION 12H.14.(e) G.S. 108A-70.27(c) is repealed.

REINSTATE COST SETTLEMENT PURSUANT TO 1993 STATE AGREEMENT

SECTION 12H.17. Effective July 1, 2015, the cost settlement for outpatient Medicaid services performed by Vidant Medical Center, which was previously known as Pitt County Memorial Hospital, shall be at one hundred percent (100%) of allowable costs.

COVERED SERVICES AND PAYMENT FOR SERVICES

SECTION 12H.18. Except as otherwise specifically provided in this act or another act passed during the 2015 Regular Session, the authorized State plan services, co-pays, reimbursement rates, and fees shall remain the same as those authorized as of June 30, 2015.

DRUG REIMBURSEMENT USING AVERAGE ACQUISITION COST

SECTION 12H.19.(a) The Department of Health and Human Services, Division of Medical Assistance, (Department) shall adopt an average acquisition cost methodology for brand and generic drug ingredient pricing to be effective beginning on January 1, 2016. The drug ingredient pricing methodology shall be consistent with new federal requirements or, if the new federal requirements have not yet been finalized by July 1, 2015, consistent with the most recent draft federal requirements. In adopting a new drug ingredient pricing methodology, the Department shall also do all of the following:

(1) Raise the average dispensing fee to a weighted average amount that does not exceed twelve dollars ($12.00).

(2) Set actual dispensing fees that maintain a higher dispensing fee for preferred and generic drugs and a lower dispensing fee for brand and nonpreferred drugs.

(3) Ensure that ingredient prices are updated at least monthly.

SECTION 12H.19.(b) In addition to the requirements in subsection (a) of this section, the Department may also set tiered dispensing fees that establish a higher dispensing fee for providers who dispense a lower volume of prescriptions and a lower dispensing fee for providers who dispense a higher volume of prescriptions, as long as the weighted average amount of all the tiered dispensing fees does not exceed twelve dollars ($12.00).

SECTION 12H.19.(c) In order to implement this section, the Department shall either amend the State plan amendment request submitted to the Centers for Medicare and Medicaid Services (CMS) pursuant to Section 12H.8 of S.L. 2014-100 so that it conforms with the requirements of this section or shall withdraw that State plan amendment and submit a new State plan amendment request to CMS that conforms with the requirements of this section, in accordance with the procedures set forth in G.S. 108A-54.1A.

MEDICAID DENTAL SERVICE COST SETTLEMENT

SECTION 12H.20. The Department of Health and Human Services, Division of Medical Assistance, shall submit a State Plan Amendment request to the Centers for Medicare and Medicaid Services to assure that all State-operated dental schools receive the same reimbursement for dental services provided to North Carolina Medicaid beneficiaries.

MOBILE DENTAL PROVIDER ENROLLMENT

SECTION 12H.21. For mobile dental providers seeking enrollment as a Medicaid provider, and upon reenrollment of current Medicaid mobile dental providers, the Department of Health and Human Services, Division of Medicaid Assistance, shall require as a condition of enrollment or reenrollment that the mobile dental provider show proof of a contractual affiliation with dental practice that is not mobile, and the Department shall require the mobile dental provider to use the National Provider Identifier (NPI) of the non-mobile dental practice for purposes of filing claims.

INCREASE RATES FOR PRIVATE DUTY NURSING

SECTION 12H.22. Effective January 1, 2016, the Department of Health and Human Services, Division of Medical Assistance, shall increase by ten percent (10%) the rate paid for private duty nursing services provided pursuant to Clinical Coverage Policy 3G.

RESTRICTING GRADUATE MEDICAL PAYMENTS

SECTION 12H.23.(a) The Department of Health and Human Services shall submit a State Plan Amendment to modify Section 4.19-A of the Medicaid State Plan, such that, effective October 1, 2015, no Medicaid provider may receive reimbursement for Graduate Medical Education (GME) in addition to their DRG Unit Value (Base) rate under the methodology as defined in the current Medicaid State Plan.

SECTION 12H.23.(b) This modification shall be implemented upon approval by the Centers for Medicare and Medicaid Services (CMS).

SECTION 12H.23.(c) The Department of Health and Human Services, Division of Medical Assistance, shall be exempt from the 90-day prior submission requirement in G.S. 108A-54.1A in order to submit the State Plan amendment required to implement this section.

MEDICAID TRANSFORMATION AND REORGANIZATION

SECTION 12H.24.(a) Intent and Goals. – It is the intent of the General Assembly to transform the State's current Medicaid program to a program that provides budget predictability for the taxpayers of this State while ensuring quality care to those in need. The new Medicaid program shall be designed to achieve the following goals:

(1) Ensure budget predictability through shared risk and accountability.
(2) Ensure balanced quality, patient satisfaction, and financial measures.
(3) Ensure efficient and cost-effective administrative systems and structures.
(4) Ensure a sustainable delivery system.

SECTION 12H.24.(b) Structure of Delivery System. – The transformed Medicaid program described in subsection (a) of this section shall be organized according to the following principles and parameters:

(1) The Health Benefits Authority (Authority), created in subsection (h1) of this section, shall have full budget and regulatory authority to manage the State's Medicaid and NC Health Choice programs, except the General Assembly shall determine eligibility categories and income thresholds.
(2) Among its initial tasks, the Authority shall:
    a. Determine the structural and financial qualifications required for managed care organizations (MCOs) and provider-led entities (PLEs). The majority of the members of a PLE's governing board shall be composed of providers as defined in G.S. 108C-2 or entities composed of providers.

b. Designate six regions within the State. Regions must be composed of whole counties. Regions do not have to be contiguous, and it is not the intent of the General Assembly to require that every county be included in at least one of the six regions.

(3) The Authority shall enter into contractual relationships with MCOs and PLEs for the delivery of all Medicaid health care items and services. All contracts shall be the result of a request for proposals (RFP) issued by the Authority and the submission of competitive bids by MCOs and PLEs. The governing principles and minimum terms and conditions of the RFPs, bids, and contracts are described in subsection (d) of this section.

(4) The number and nature of the contracts required under subdivision (3) of this subsection shall be as follows:

a. Three contracts between the Authority and any combination of individual MCOs and individual PLEs. Each of these contracts shall provide statewide coverage for all Medicaid health care items and services (statewide contracts).

b. Up to 12 contracts between the Authority and individual PLEs for coverage of specified regions (regional contracts). Regional contracts shall be in addition to the three statewide contracts required under sub-subdivision a. of this subdivision. Each regional contract shall provide coverage throughout the entire region for all Medicaid health care items and services. A PLE may bid on more than one region. The Authority shall have full discretion to enter into one, two, or no regional contracts in any region.

(5) As a result of the contracts entered into by the Authority under subdivision (3) of this subsection, a recipient shall have at least three, but no more than five enrollment choices for the provision of all Medicaid health care items and services. The Authority shall provide for annual open enrollment periods and shall determine the process for assigning recipients who do not select a MCO or PLE during the enrollment period.

SECTION 12H.24.(c) Time Line. – The following milestones for Medicaid transformation shall occur no later than the following dates:

(1) When this act becomes law. -

a. The Health Benefits Authority is created pursuant to subsection (h1) of this section and appointments to the Authority's Board shall be made pursuant to G.S. 143B-1405.

b. The Joint Legislative Oversight Committee on the Health Benefits Authority (LOC-HBA) is created pursuant to subsection (l) of this section to oversee the Medicaid and NC Health Choice programs.

(2) September 1, 2015. – The Department of Health and Human Services (Department) shall establish the Medicaid stabilization team pursuant to subsection (g) of this section.

(3) October 1, 2015. -

a. The Authority is designated as the single state agency for the administration of Medicaid and NC Health Choice.

b. The Department and the Authority shall enter into agreements necessary for the Authority to supervise the Department's administration of the Medicaid and NC Health Choice programs.

(4) February 1, 2016. – The Authority shall submit requests for waivers and State Plan amendments to the Centers for Medicare and Medicaid Services necessary to implement Medicaid transformation.

(5) March 1, 2016. – The Authority shall report recommended statutory changes to the North Carolina General Statutes to the LOC-HBA.
(6) April 1, 2017. – The initial recipient enrollment period begins.
(7) August 1, 2017. – Capitated full-risk contracts begin.

SECTION 12H.24.(d) Requests for Proposals; Bids; Terms & Conditions of Contracts. – The following shall be components of the initial RFPs, responsive bids to the initial RFPs, and the initial contracts that are required under subsection (b) of this section.

(1) An RFP may solicit bids for a statewide contract, a regional contract, or both, and may propose variable contract durations.
(2) RFPs must require at least all of the following:
a. Full-risk capitation for all Medicaid health care items and services.
b. Coverage for all program aid categories except the dual eligible categories for which Medicaid only pays Medicare premiums.
c. All bidders meet solvency requirements established by the Department of Insurance pursuant to subsection (k1) of this section.
d. All bidders meet the same standards and metrics for risk, outcomes, and quality.
e. All bidders establish appropriate networks or providers to deliver services.
f. All bidders subcontract with existing LME/MCOs for behavioral health services for up to three years at a capitation rate that is no less than the most recently negotiated rate for the then current scope of benefits paid to LME/MCOs.
g. All bidders agree not to limit providers' ability to contract with other MCOs and PLEs.
h. All bidders must connect to the Health Information Exchange Network or any successor information technology entity or architecture specified by the Authority in order to ensure effective systems and connectivity to support clinical coordination of care, exchange of information, and the availability of data to the Authority to manage the Medicaid and NC Health Choice program for the State.
i. All bidders ensure that their contracts with providers include value-based payment systems that support the achievement of overall performance, quality, and outcome measures.
(3) All bids must respond to the requirements of subdivision (2) of this subsection and must also include at least all of the following:
a. For statewide contracts, a description of how the MCO or PLE will ensure access to appropriate care throughout the State.
b. For regional contracts, a description of how the PLE will ensure access to appropriate care throughout the region.
c. Proposed competitive medical loss ratios.
d. Proposed full-risk capitated rates based on Centers for Medicare and Medicaid Services (CMS) actuarial soundness and industry standards as well as risk adjusted rate ranges using claims data from fiscal year 2014-2015. Actuarial calculations must include utilization assumptions consistent with industry and local standards.
e. Methods to ensure program integrity against provider fraud, waste, and abuse at all levels.
(4) In addition to the requirements of subdivisions (1) through (3) of this subsection, each contract must provide for all of the following:

a. Negotiated full-risk capitated rates, including a portion that is at risk for achievement of quality and outcome measures.
b. Negotiated competitive medical loss ratios.
c. Compliance by the MCO or PLE with all CMS requirements for the Medicaid and NC Health Choice programs.
d. Defined measures and goals for risk adjusted health outcomes, quality of care, patient satisfaction, and cost. Each component must be measured and monitored continually and reported at set intervals as determined by the Authority. Each component shall be subject to specific accountability measures, including penalties. The Authority may use organizations such as National Committee for Quality Assurance (NCQA), Physician Consortium for Performance Improvement (PCPI), Healthcare Effectiveness Data and Information Set (HEDIS), or any others necessary to develop effective measures for outcomes and quality.
e. Acceptance of full responsibility by the MCO or PLE for all grievance and appeals.
f. Ability of the MCO or PLE to exclude providers from networks based on economic or quality standards.
g. Ability of the MCO or PLE to terminate the capitation rate required under sub-subdivision f. of subdivision (2) of this subsection if termination of the rate is mutually agreed to by the LME/MCO.
h. Agreement that covered benefits will not be reduced from the covered services in effect on the date the contract is awarded except in instances where the Authority reduces a covered service for all recipients and for all contracts.

SECTION 12H.24.(e) Monthly Progress Report. – Beginning November 1, 2015, and monthly thereafter until October 1, 2018, the Health Benefits Authority shall report to the LOC-HBA and the Fiscal Research Division on the State's progress toward completing Medicaid transformation. The March 1, 2016, report shall contain proposed changes to the North Carolina General Statutes that are necessary to implement Medicaid transformation.

SECTION 12H.24.(f) Maintain Funding Mechanisms. – In developing the waivers and State Plan amendments necessary to implement this section, the Authority shall work with the Centers for Medicare & Medicaid Services (CMS) to attempt to preserve existing levels of funding generated from Medicaid-specific funding streams, such as assessments, to the extent that the levels of funding may be preserved. If such Medicaid-specific funding cannot be maintained as currently implemented, then the Authority shall advise the LOC-HBA created in subsection (h1) of this section of any modifications necessary to maintain as much revenue as possible within the context of Medicaid transformation. If such Medicaid-specific funding streams cannot be preserved through the transformation process or if revenue would decrease, it is the intent of the General Assembly to modify such funding streams so that any supplemental payments to providers are more closely aligned to improving health outcomes and achieving overall Medicaid goals.

SECTION 12H.24.(g) DHHS Role in Medicaid Transformation. – During Medicaid transformation, the Department of Health and Human Services, Division of Medical Assistance (Division), shall cooperate with the Authority to ensure a smooth transition of the Medicaid and NC Health Choice programs and shall perform all of the following functions:

(1) The Department and the Authority shall enter into agreements necessary for the Authority to supervise the Department's administration of the Medicaid and NC Health Choice programs until the transformed Medicaid program is completed.

(2) The Department of Health and Human Services, Office of the Secretary, (Office of the Secretary) shall organize a Medicaid stabilization team to do the following:
a. Maintain the Medicaid and NC Health Choice programs until Medicaid transformation has been completed.
b. Work with the Authority during the transition.
c. Develop strategies to successfully complete the requirements of sub-subdivisions a. and b. of this subdivision.
d. Make recommendations to the LOC-HBA on any additional authorization or funding necessary to successfully complete the requirements of sub-subdivisions a. and b. of this subdivision.
e. With assistance from the Office of State Human Resources, conduct interviews and meetings with designated essential employees of the Division to explain the transition process, including options for the employees and the bonus payment system established under this subsection.
f. No later than September 1, 2015, report to the LOC-HBA on the plan to communicate to employees, as required by sub-subdivision e. of this subdivision.

(3) The Office of the Secretary shall identify the key managers, leaders, and decision makers to be part of the stabilization team and, no later than September 1, 2015, shall submit a list of these people and their roles to the Authority and the LOC-HBA.

(4) No later than September 1, 2015, the Secretary of Health and Human Services (Secretary) shall identify and designate "essential positions" throughout the Department without which the Medicaid and NC Health Choice programs could not operate on a day-to-day basis. Such positions designated by the Secretary may include any position, whether subject to or exempt from the State Personnel Act or whether supervisory or nonsupervisory, as long as the position is essential to the operation of Medicaid or NC Health Choice. Because the designation is based on the functions to be performed and because of the nature of the bonuses provided under this subsection, the designation of a position as essential may not be revoked, and the Secretary may designate both open and filled positions.

(5) In order to encourage employees to remain in their positions working on Medicaid and NC Health Choice within the Department, employees serving in positions designated as essential positions under this subsection shall be eligible for the following benefits:
a. Effective August 1, 2015, any employee working in a designated essential position within the Division shall receive a bonus at each pay period that is equal to five percent (5%) of the employee's earnings for that period.
b. Effective August 1, 2015, any employee working in a designated essential position within the Department, but outside of the Division, whose salary is paid with federal Medicaid funds shall also receive a five percent (5%) bonus, paid in the same manner as bonuses are paid under sub-subdivision a. of this subdivision. If such an employee working outside of the Division does not work full-time on Medicaid issues, then the amount of the bonus shall be calculated by first multiplying the employee's earnings for that period by the

percentage of the employee's time spent on Medicaid issues and then multiplying that product by five percent (5%).

c. Any employee who received bonus payments under sub-subdivisions a. or b. of this subdivision who is still employed within the Division or within the Department as of July 31, 2017, or who is employed within the Authority, shall receive a final bonus payment equal to the sum of all the bonus payments that the employee had received since July 1, 2015, under sub-subdivision a. of this subdivision. No employee departing before July 31, 2017, shall be eligible to receive any portion of such a final bonus payment, and no property right is created by this subsection for employees that depart before July 31, 2017.

d. The bonus payments paid under this subsection are made notwithstanding G.S. 126-4(2) or any other provision of law. Notwithstanding G.S. 135-1(7a), bonus payments paid under this subsection shall not count as "compensation" for purposes of the Retirement System for Teachers and State Employees, nor shall the Department of Health and Human Services be required to make payments to the Retirement System based on the amounts paid as bonuses. Additionally, bonus payments paid under this subsection shall not count as "compensation" or "salary" for calculating severance payments under G.S. 126-8.5 or calculating unemployment benefits.

(6) The Department shall not enter into any new contracts, or renew or extend any contracts that existed prior to the effective date of this subsection, related to the Medicaid or NC Health Choice programs without the express prior approval of the Board of the Authority. The Department and the Division shall ensure that any Medicaid-related or NC Health Choice-related State contract entered into after the effective date of this act contains a clause that allows the Department or the Division to terminate the contract without cause upon 30 days' notice. Any contract signed by the Department or the Division after the effective date of this act that lacks such a termination clause shall, nonetheless, be deemed to include such a clause and shall be cancellable without cause upon 30 days' notice.

SECTION 12H.24.(h1) Creation of Health Benefits Authority. – Effective when this act becomes law, the Health Benefits Authority as established in this section shall be a single, unified cabinet-level department. In accordance with the time line set out in subsection (c) of this section, the Health Benefits Authority shall administer and operate all functions, powers, duties, obligations, and services related to the Medicaid and NC Health Choice programs. In accordance with the time line set out in subsection (c) of this section, all functions, powers, duties, obligations, and services vested in the Department of Health and Human Services, Division of Medical Assistance, are vested in the Health Benefits Authority.

SECTION 12H.24.(h2) G.S. 143B-6 reads as rewritten:

"**§ 143B-6. Principal departments.**

In addition to the principal departments enumerated in the Executive Organization Act of 1971, all executive and administrative powers, duties, and functions not including those of the General Assembly and its agencies, the General Court of Justice and the administrative agencies created pursuant to Article IV of the Constitution of North Carolina, and higher education previously vested by law in the several State agencies, are vested in the following principal departments:

…

(12) Health Benefits Authority."

SECTION 12H.24.(h3) Chapter 143B of the General Statutes is amended by adding a new Article to read:

"Article 14.

"Health Benefits Authority.

"**§ 143B-1400. Creation and organization.**

There is hereby established the Health Benefits Authority (Authority) to administer and operate the Medicaid and NC Health Choice programs. The Authority shall be governed by a board, which shall be responsible for ensuring quality health outcomes to eligible recipients at a predictable cost to the taxpayers of this State. The Authority shall be the designated single State agency for the administration and operation of the Medicaid and NC Health Choice programs.

"**§ 143B-1405. Board of the Health Benefits Authority.**

(a) The Board of the Health Benefits Authority shall consist of the following:

(1) Three members appointed by the Governor.

(2) Two members appointed by the General Assembly, on the recommendation of the President Pro Tempore of the Senate.

(3) Two members appointed by the General Assembly, on the recommendation of the Speaker of the House of Representatives.

(4) The Secretary of Health and Human Services or the Secretary's designee, who shall serve as an ex officio nonvoting member of the Board.

(b) Each appointed member of the board shall have expertise from at least one of the following areas:

(1) The administration of large health delivery systems.

(2) Health insurance.

(3) Health actuarial science.

(4) Health economics.

(5) Health law and policy.

In making appointments to the Board under this section, each appointing authority shall consult with the other appointing authorities to ensure adequate representation from all of the areas of expertise listed in this subsection.

(c) The following individuals may not serve on the Board:

(1) An individual who receives or has received Medicaid payments during the six months prior to serving on the Board for providing health care or services to enrollees of the North Carolina Medicaid or NC Health Choice programs.

(2) An individual who is or has been during the six months prior to serving on the Board a registered lobbyist for a provider, or association of providers, receiving payments from the North Carolina Medicaid or NC Health Choice programs, or an employee of such a lobbyist.

(3) An individual who has, within six months of appointment, been an officer or employee of the State.

As used in this subsection, the term "provider" includes any parent, subsidiary, or affiliated legal entity, and the term "provider" has the same meaning as defined under G.S. 108C-2.

(d) Board members appointed under subdivision (1) through (3) of subsection (a) of this section shall serve for a term of four years. The Governor shall have the power to remove any member of the Board from office for misfeasance, malfeasance, or nonfeasance in accordance with the provisions of G.S. 143B-13 of the Executive Organization Act of 1973. Appointing authorities shall fill any vacancies that arise to complete the term of the vacating Board member.

(e) In making the initial appointments, the appointing authorities shall, in order to stagger terms, designate one person appointed under subdivision (1) of subsection (a) of this

section, one person appointed under subdivision (2) of subsection (a) of this section, and one person appointed under subdivision (3) of subsection (a) of this section to serve until June 30, 2017. The remaining four appointees shall serve until June 30, 2019. Future appointees shall serve terms of four years, with staggered terms based on this section. Board members may serve up to two consecutive terms, not including the abbreviated two-year terms that establish staggered terms or terms of less than two years that result from the filling of a vacancy.

(f) The Governor shall designate a chair of the Board from among the appointed voting members of the Board. The Board member designated as the chair shall serve as a chair at the pleasure of the Governor. The chair shall serve on the Governor's Cabinet. If the Governor does not appoint a chair, the Board may select a chair from among its voting members. The Board-selected chair shall serve in that capacity until such time as the Governor appoints a chair.

(g) The Board shall meet at least monthly until August 1, 2017, and at least quarterly thereafter. The Board may also meet at the call of the chair or at the request of a majority of the voting Board members. A majority of the voting Board members constitutes a quorum for conducting business.

(h) The voting members of the Board are State officers and not State employees. No voting member may serve on the Board while employed as a State employee.

(i) The voting members of the Board shall be compensated in an amount sufficient to obtain quality professionals with experience managing large businesses, insurance programs, and health systems. The initial compensation for voting Board members shall be established by the Office of State Human Resources no later than October 1, 2015. Thereafter, the compensation of voting Board members shall be set by the Board under G.S. 143B-1410(3) and shall be comparable to compensation paid to the members of boards operating large health insurance plans but shall not exceed the highest compensation paid to a member of the Council of State. When adjusting members' compensation, the Board shall provide a justification to the Office of State Human Resources based upon a survey of comparable health insurance plans.

"**§ 143B-1410. Powers and duties of the Board of the Health Benefits Authority.**

(a) The Board of the Health Benefits Authority shall have the following powers and duties:

(1) Administer and operate the Medicaid and NC Health Choice programs. None of the powers and duties enumerated in the other subdivisions of this subsection shall be construed to limit the broad grant of authority to administer and operate the Medicaid and NC Health Choice programs.

(2) Employ the Medicaid Director, who shall be responsible for the daily operation of the Authority, and other staff, including legal staff. In hiring staff, the Board may offer employment contracts for a term.

(3) Set compensation for the employees, including performance-based bonuses based on meeting budget or other targets, and for the voting Board members.

(4) Procure office space for the Authority.

(5) Notwithstanding G.S. 143-64.20, enter into contracts for the administration of the Medicaid and NC Health Choice programs, as well as manage such contracts, including contracts of a consulting or advisory nature.

(6) Employ or contract for independent internal auditing staff that report directly to the Board rather than to the Medicaid Director. Notwithstanding subsection (b) of this section, this function may not be delegated.

(7) Pursuant to G.S. 108A-1, supervise the county departments of social services in their administration of eligibility determinations. Pursuant to subdivision (5) of this subsection, the Board may contract with the Department of Health and Human Services or any other appropriate party to perform this task or a portion of this task.

(8) Define and approve the following for the Authority and the programs managed by the Authority:
a. Business policy.
b. Strategic plans, including desired health outcomes for the covered populations, which shall do the following:
1. Be developed at a frequency of no less than every five years with the input of stakeholders.
2. Identify key opportunities and challenges facing the organization.
3. Identify the Authority's strengths and weaknesses to address these opportunities and challenges.
4. Identify key goals for the Authority for this time period, consistent with the reform goals identified by the General Assembly.
5. Identify output and outcome performance measures to quantify the Authority's progress toward these goals.
6. Identify strategies to reach these goals.
7. Be used as a guide for units within the Authority to establish unit-specific operational plans at the same frequency.
c. Performance management system, including quantitative indicators for goals and objectives, which shall do the following:
1. Be developed and implemented within the first year of the creation of the Authority, and updated no less than annually thereafter with available data.
2. Establish quantitative performance measures focusing on the quality and efficiency of service delivery and administration, using a nationally recognized quality improvement effort allowing comparison of North Carolina to other states as those developed by, but not limited to, the federal Medicaid Quality Measurement Program and the Baldridge Quality Program.
3. Establish measurable objectives for each goal identified in the strategic plan, and performance updated annually.
4. Establish, for each objective, benchmark activities, including an estimated date of completion, the area for which efforts are attempting a change, a quantitative indicator of success for the area, and quarterly milestones allowing Authority managers and employees to monitor progress throughout the year.
5. Establish mechanisms for obtaining data necessary for the collection and public distribution of performance information.
d. Program and policy changes.
e. Operational budget and assumptions.
(9) Establish and adjust all program components, except for eligibility, of the Medicaid and NC Health Choice programs within the appropriated and allocated budget.
(10) Adopt rules related to the Medicaid and NC Health Choice programs.
(11) Develop midyear budget correction plans and strategies and then take midyear budget corrective actions necessary to keep the Medicaid and NC Health Choice programs within budget.

(12) Approve or disapprove and oversee all expenditures to be charged to or allocated to the Medicaid and NC Health Choice programs by other State departments or agencies.

(13) Develop and present to the Joint Legislative Oversight Committee on the Health Benefits Authority and the Office of State Budget and Management by January 1 of each year, beginning in 2016, the following information for the Medicaid and NC Health Choice programs:

a. A detailed four-year forecast of expected changes to enrollment growth and enrollment mix.

b. What program changes will be made by the Authority in order to stay within the existing budget for the programs based on the next fiscal year's forecasted enrollment growth and enrollment mix.

c. The cost to maintain the current level of services based on the next fiscal year's forecasted enrollment growth and enrollment mix.

(14) Secure and pay for the services of the State Auditor's Office to conduct annual audits of the financial accounts of the Authority.

(15) Publish the Annual Medicaid Report, which shall contain, at a minimum, the following:

a. Details on the Authority's performance over the prior four years on the following:

1. The identified quantitative measures from its strategic plan and performance management system.

2. A comparison of the identified quantitative measures from its strategic plan and performance management system and other states participating in the quality improvement effort.

b. Annual audited financial statements.

(16) Publish in an electronic format, and update on at least a monthly basis, at least the following information about the Medicaid and NC Health Choice programs:

a. Enrollment by program aid category by county.

b. Per member per month spending by category of service.

c. Spending and receipts by fund along with a detailed variance analysis.

d. A comparison of the above figures to the amounts forecasted and budgeted for the corresponding time period.

(b) The Board may delegate any of its powers and duties to the Medicaid Director and other staff of the Authority and, upon adoption of an annual budget, shall delegate to the Medicaid Director its powers and duties pursuant to sub-subdivisions d. and e. of subdivision (8) of subsection (a) of this section. In delegating powers or duties, however, the Board maintains the responsibility for the performance of those powers or duties.

(c) Pursuant to G.S. 108E-2-1, the General Assembly retains the authority to determine the eligibility categories and income thresholds for the Medicaid and NC Health Choice programs.

"**§ 143B-1415. Variations from certain State laws.**

Although generally subject to the laws of this State, the following exemptions, limitations, and modifications apply to the Health Benefits Authority, notwithstanding any other provision of law:

(1) Employees of the Authority shall not be subject to the North Carolina Human Resources Act, except as provided in G.S. 126-5(c1)(31).

(2) The Authority may retain private legal counsel and is not subject to G.S. 114-2.3 or G.S. 147-17(a) through (c).

(3) The Authority's employment contracts offered pursuant to G.S. 143B-1410(a)(2) are not subject to review and approval by the Office of State Human Resources. The Authority's employment of supplementary staff for temporary work is not subject to review and approval by the Office of State Human Resources including the requirements of G.S. 126-6.3.

(4) If the Authority establishes alternative procedures for the review and approval of contracts, then the Authority is exempt from State contract review and approval requirements, but may still choose to utilize the State contract review and approval procedures for particular contracts.

(5) The Board of the Authority may move into a closed session for any of the reasons listed in G.S. 143-318.11, as well as for discussions on the following:

a. Rates, contract amounts, or any other amounts to be paid to any entity, including the amount of any transfers to any other State agency or Division.

b. Audits and investigations.

c. Development of the annual budget forecast report for the General Assembly, as required by G.S. 143B-1410(a)(14).

d. Development of a strategic plan.

e. Any report to be submitted to the General Assembly.

(6) Documents created for, or developed during, a closed session of the Board for one of the reasons specifically listed in the sub-subdivisions of subdivision (5) of this section, as well as any minutes from such a closed session of the Board, that would otherwise become public record by operation of Chapter 132 of the General Statutes, shall not become public record until the item under discussion has been made public through the publishing of the relevant rate or amount, findings from an audit or investigation, the annual budget forecast report, the strategic plan, or a report to the General Assembly.

"**§ 143B-216.1420. Cooling off period for certain Health Benefits Authority employees.**

(a) Ineligible Vendors. – The Board shall not contract for goods or services with a vendor that employs or contracts with a person who is a former State Medicaid or NC Health Choice employee and uses that person in the administration of a contract with the Authority.

(b) Vendor Certification. – The Medicaid Director shall require each vendor submitting a bid or contract to certify that the vendor will not use a former Medicaid or NC Health Choice employee in the administration of a contract with the Authority in violation of the provisions of subsection (a) of this section. Any person who submits a certification required by this subsection knowing the certification to be false shall be guilty of a Class I felony.

(c) A violation of the provisions of this section shall void the contract.

(d) Definitions. – As used in this section, the following terms mean:

(1) Administration of a contract. – Oversight of the performance of a contract, authority to make decisions regarding a contract, interpretation of a contract, or participation in the development of specifications or terms of a contract or in the preparation or award of a contract.

(2) Former Medicaid or NC Health Choice employee. – A person who, for any period within the preceding six months, was employed as an employee or contract employee of the Authority, who in the six months immediately preceding termination of State employment, participated personally in either the award or management of an Authority contract with the vendor, or made regulatory or licensing decisions that directly applied to the vendor.

"**§ 143B-216.1425. Medicaid Reserve Account.**

(a) The Medicaid Reserve Account is established as a nonreverting reserve in the General Fund. The purpose of the Medicaid Reserve Account is to provide for unexpected budgetary shortfalls within the Medicaid and NC Health Choice programs that result from program expenditures in excess of the amount appropriated for the Medicaid and NC Health Choice programs by the General Assembly and which continue to exist after the Health Benefits Authority makes its best efforts to control costs through midyear budget corrections under G.S. 143B-1410(a)(12).

(b) The Medicaid Reserve Account shall have the following minimum and maximum target balances:

(1) Minimum target. – Five percent (5%) of a given fiscal year's General Fund appropriations for capitation payments for both the Medicaid and NC Health Choice programs.

(2) Maximum target. – Twelve percent (12%) of a given fiscal year's General Fund appropriations for capitation payments for both the Medicaid and NC Health Choice programs.

(c) Notwithstanding G.S. 143C-1-2(b), any funds appropriated to the Health Benefits Authority for the Medicaid or NC Health Choice programs and that remain unencumbered at the end of a fiscal year shall, rather than revert to the General Fund, be credited to the Medicaid Reserve Account. Any funds to be deposited in the Medicaid Reserve Account that would cause the fund balance to exceed the maximum target balance for the Medicaid Reserve Account shall instead be credited to the General Fund.

(d) Medicaid Reserve Account funds may be disbursed by the Health Benefits Authority to manage budgetary shortfalls in the Medicaid and NC Health Choice programs only after all of the following occur:

(1) The Board of the Health Benefits Authority certifies that there is a projected Medicaid shortfall in the current fiscal year.

(2) The Health Benefits Authority has already made midyear budget corrections under G.S. 143B-1410(a)(12), but those midyear budget corrections have not achieved the projected budget savings.

(3) The Health Benefits Authority reports to the Joint Legislative Commission on Governmental Operations on its intent to disburse Medicaid Reserve Account funds. The report shall include a detailed analysis of receipts, payments, claims, and transfers, including an identification of and explanation of the recurring and nonrecurring components of the shortfall.

Medicaid Reserve Account funds may be disbursed in accordance with this subsection even if it results in the fund balance falling below the minimum target balance for the Medicaid Reserve Account."

SECTION 12H.24.(i) Board Start-Up. – The following activities shall facilitate the timely commencement of the Health Benefits Authority:

(1) The Board of the Health Benefits Authority may meet prior to October 1, 2015, in order to begin organizing and preparing to govern the Medicaid and NC Health Choice programs. The Board may begin meeting as soon as a majority of the appointments have been made and upon the call of the chair; however, the initial meeting shall be no later than September 1, 2015. The Division of Medical Assistance shall provide administrative support and meeting space to the Board prior to November 1, 2015.

(2) If the Governor does not make initial appointments to the Board by September 1, 2015, the Board members who have been appointed may select a chair from among the appointed members and may conduct the business of the Authority. Actions taken by the Board under this subdivision shall be

official actions of the Board, provided a majority of the appointed Board members are present and approve the action.

(3) In order to set the initial compensation for the voting Board members, the Office of State Human Resources shall survey the compensation paid to the members of comparable large health insurance plans. The Office shall complete the survey no later than September 1, 2015, and set the initial compensation for voting Board members no later than October 1, 2015. A voting Board member shall be eligible to receive compensation beginning on the first business day following the effective date of the member's appointment.

SECTION 12H.24.(j) Transfer of Rules. – Effective October 1, 2015, all rules and policies exempted from rule making related to the Medicaid and NC Health Choice programs shall transfer to the Health Benefits Authority. In its March 1, 2016, report to the Joint Legislative Oversight Committee on the Health Benefits Authority, the Health Benefits Authority shall include recommendations for additional exemptions from the rule-making requirements and contested case provisions in Chapter 150B of the General Statutes.

SECTION 12H.24.(k) Legal Actions. – For any legal action involving the Medicaid or NC Health Choice programs in which the Division of Medical Assistance or the Department of Health and Human Services is named as a party, the Health Benefits Authority may be joined as a party by reason of transfer of interest upon motion of any party pursuant to Rule 25(d) of the North Carolina Rules of Civil Procedure. This subsection shall not be construed to limit any other opportunities for joinder or intervention that are otherwise allowed under the North Carolina Rules of Civil Procedure or elsewhere under law.

SECTION 12H.24.(k1) The Commissioner of Insurance shall establish solvency requirements for MCOs and PLEs that contract with the Health Benefits Authority pursuant to this section. The same requirements shall apply to and may be based on existing requirements for similarly situated regulated entities. The Commissioner shall consult with the Authority in developing the requirements. The Commissioner shall make recommendations, including any statutory changes, to the Joint Legislative Oversight Committee on the Health Benefits Authority by March 1, 2016.

SECTION 12H.24.(l) Legislative Oversight of Medicaid. – Chapter 120 of the General Statutes is amended by adding the following new Article:

"Article 23B.

"Joint Legislative Oversight Committee on the Health Benefits Authority.

"**§ 120-209. Creation and membership of Joint Legislative Oversight Committee on the Health Benefits Authority.**

(a) The Joint Legislative Oversight Committee on the Health Benefits Authority is established. The Committee consists of 14 members as follows:

(1) Seven members of the Senate appointed by the President Pro Tempore of the Senate, at least two of whom are members of the minority party.

(2) Seven members of the House of Representatives appointed by the Speaker of the House of Representatives, at least two of whom are members of the minority party.

(b) Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year except initial appointments begin on the date of appointment. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

(c) A member continues to serve until a successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

"**§ 120-209.1. Purpose and powers of Committee.**

(a) The Joint Legislative Oversight Committee on the Health Benefits Authority shall examine budgeting, financing, administrative, and operational issues related to the Medicaid and NC Health Choice programs and to the Health Benefits Authority.

(b) The Committee may make periodic reports to the General Assembly on matters for which it may report to a regular session of the General Assembly.

"**§ 120-209.2. Organization of Committee.**

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on the Health Benefits Authority. The Committee shall meet upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present.

(c) Members of the Committee receive subsistence and travel expenses, as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Directors of Legislative Assistants of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee.

(d) The Committee cochairs may establish subcommittees for the purpose of examining issues relating to its Committee charge.

"**§ 120-209.3. Additional powers.**

The Joint Legislative Oversight Committee on the Health Benefits Authority, while in discharge of official duties, shall have access to any paper or document, and may compel the attendance of any State official or employee before the Committee or secure any evidence under G.S. 120-19. In addition, G.S. 120-19.1 through G.S. 120-19.4 shall apply to the proceedings of the Committee as if it were a joint committee of the General Assembly.

"**§ 120-209.4. Reports to Committee.**

Whenever the Health Benefits Authority is required by law to report to the General Assembly or to any of its permanent, study, or oversight committees or subcommittees, the Health Benefits Authority shall transmit a copy of the report to the cochairs of the Joint Legislative Oversight Committee on the Health Benefits Authority."

SECTION 12H.24.(m) G.S. 120-208.1(a)(2)b. is repealed.

SECTION 12H.24.(n) Recodification; Technical and Conforming Changes. – The Revisor of Statutes shall recodify existing law related to Medicaid and NC Health Choice, including Parts 6, 6A, 7, and 8 of Article 2, Article 5, and Article 7 of Chapter 108A of the General Statutes, as well as Chapters 108C and 108D of the General Statutes, into a new Chapter 108E of the General Statutes to be entitled "Medicaid and NC Health Choice Health Benefit Programs" and to have the following structure:

Article 1. Administration of the Medicaid and NC Health Choice Programs
- Part 1. Establishment of the Medicaid Program
- Part 2. Establishment of the NC Health Choice Program
- Part 3. Administration by County Departments of Social Services

Article 2. Medicaid and NC Health Choice Eligibility
- Part 1. In General
- Part 2. Eligibility for Medicaid
- Part 3. Eligibility for NC Health Choice

Article 3. Medicaid and NC Health Choice Benefits and Cost-Sharing
- Part 1. In General
- Part 2. Medicaid Benefits and Cost-Sharing
- Part 3. NC Health Choice Benefits and Cost-Sharing

Article 4. Medicaid and NC Health Choice Provider Requirements
Part 1. Provider Enrollment
Part 2. Provider Reimbursement and Recovery
Part 3. Hospital Assessment Act
Part 4. Other
Article 5. Third-Party Liability
Part 1. In General
Part 2. Subrogation
Part 3. Insurance
Part 4. Estate Recovery
Article 6. Fraud and Criminal Activity
Article 7. Appeals
Part 1. Eligibility Appeals for Medicaid and NC Health Choice
Part 2. Benefit Appeals for Medicaid
Subpart 1. Generally
Subpart 2. Medicaid Managed Care for Behavioral Health Services Appeals
Part 3. Benefit Reviews for NC Health Choice
Part 4. Provider Appeals

When recodifying, the Revisor is authorized to change all references to the North Carolina Department of Health and Human Services or to the Division of Medical Assistance to instead be references to the Health Benefits Authority. The Revisor may separate subsections of existing statutory sections into new sections and, when necessary to organize relevant law into its proper place in the above structure, may rearrange sentences that currently appear within subsections. The Revisor may modify statutory citations throughout the General Statutes, as appropriate, and may modify any references to statutory Divisions, such as "Chapter," "Article," "Part," "section," or "subsection." Within Articles 4 and 5 of Chapter 108A of the General Statutes, the Revisor of Statutes shall append to each reference to the North Carolina Department of Health and Human Services or to the Secretary of the Department the language "and, with respect to Medicaid and NC Health Choice, the Health Benefits Authority." The Revisor of Statutes may conform names and titles changed by this subsection, and may correct statutory references as required by this subsection, throughout the General Statutes. In making the changes authorized by this subsection, the Revisor may also adjust subject and verb agreement and the placement of conjunctions. The Revisor shall consult with the Department of Health and Human Services and the new Health Benefits Authority on this recodification.

SECTION 12H.24.(o) G.S. 108A-1 reads as rewritten:

"**§ 108A-1. Creation.**

Every county shall have a board of social services or a consolidated human services board created pursuant to G.S. 153A-77(b) which shall establish county policies for the programs established by this Chapter in conformity with the rules and regulations of the Social Services Commission and under the supervision of the Department of Health and Human Services. Provided, however, county policies for the program of medical assistance shall be established in conformity with the rules and regulations of the ~~Department of Health and Human Services~~ Health Benefits Authority."

SECTION 12H.24.(p) G.S. 108A-54.1A reads as rewritten:

"**§ 108A-54.1A. Amendments to Medicaid State Plan and Medicaid Waivers.**

(a) ~~No provision in the Medicaid State Plan or in a Medicaid Waiver may expand or otherwise alter the scope or purpose of the Medicaid program from that authorized by law enacted by the General Assembly. For purposes of this section, the term "amendments to the State Plan" includes State Plan amendments, Waivers, and Waiver amendments.~~The Authority

is expressly authorized and required to take any and all necessary action to amend the State Plan and waivers in order to keep the program within the certified budget.

~~(b) The Department may submit amendments to the State Plan only as required under any of the following circumstances:~~

~~(1) A law enacted by the General Assembly directs the Department to submit an amendment to the State Plan.~~

~~(2) A law enacted by the General Assembly makes a change to the Medicaid Program that requires approval by the federal government.~~

~~(3) A change in federal law, including regulatory law, or a change in the interpretation of federal law by the federal government requires an amendment to the State Plan.~~

~~(4) A change made by the Department to the Medicaid Program requires an amendment to the State Plan, if the change was within the authority granted to the Department by State law.~~

~~(5) An amendment to the State Plan is required in response to an order of a court of competent jurisdiction.~~

~~(6) An amendment to the State Plan is required to ensure continued federal financial participation.~~

~~(c) Amendments to the State Plan submitted to the federal government for approval shall contain only those changes that are allowed by the authority for submitting an amendment to the State Plan in subsection (b) of this section.~~

(d) No fewer than 10 days prior to submitting an amendment to the State Plan to the federal government, the Department shall post the amendment on its Web site and notify the members of the Joint Legislative Oversight Committee on the Health Benefits Authority and the Fiscal Research Division that the amendment has been posted. This requirement shall not apply to draft or proposed amendments submitted to the federal government for comments but not submitted for approval. ~~The amendment shall remain posted on the Department's Web site at least until the plan has been approved, rejected, or withdrawn. If the authority for submitting the amendment to the State Plan is pursuant to subdivision (3), (4), (5), or (6) of subsection (b) of this section, then, prior to submitting an amendment to the federal government, the Department shall submit to the General Assembly members receiving notice under this subsection and to the Fiscal Research Division an explanation of the amendment, the need for the amendment, and the federal time limits required for implementation of the amendment.~~

~~(e) The Department shall submit an amendment to the State Plan to the federal government by a date sufficient to provide the federal government adequate time to review and approve the amendment so the amendment may be effective by the date required by the directing authority in subsection (b) of this section. Additionally, if a change is made to the Medicaid program by the General Assembly and that change requires an amendment to the State Plan, then the amendment shall be submitted at least 90 days prior to the effective date of the change as provided in the legislation.~~

(f) Any public notice required under 42 C.F.R. 447.205 shall, in addition to any other posting requirements under federal law, be posted on the Department's Web site. Upon posting such a public notice, the Department shall notify the members of the Joint Legislative Oversight Committee on the Health Benefits Authority and the Fiscal Research Division that the public notice has been posted. Public notices shall remain posted on the Department's Web site."

SECTION 12H.24.(q) G.S. 108A-54.2(d) is repealed.

SECTION 12H.24.(r) Part 1 of Article 2 of Chapter 108E of the General Statutes, created by the recodification process described in subsection (n) of this section, shall include the following two new sections:

"**§ 108E-2-1. General Assembly sets eligibility categories.**

Eligibility categories and income thresholds are set by the General Assembly, and the Authority shall not alter the eligibility categories and income thresholds from those authorized by the General Assembly. The Authority is expressly authorized to adopt temporary and permanent rules regarding eligibility requirements and determinations, to the extent that they do not conflict with parameters set by the General Assembly.

"**§ 108E-2-2. Counties determine eligibility.**

Counties determine eligibility in accordance with Chapter 108A of the General Statutes."

SECTION 12H.24.(s) G.S. 126-5 is amended by adding a new subdivision to read:

"**§ 126-5. Employees subject to Chapter; exemptions.**

…

(c1) Except as to the provisions of Articles 6 and 7 of this Chapter, the provisions of this Chapter shall not apply to:

…

(31) Employees of the Health Benefits Authority."

SECTION 12H.24.(t) G.S. 143B-153 reads as rewritten:

"**§ 143B-153. Social Services Commission – creation, powers and duties.**

There is hereby created the Social Services Commission of the Department of Health and Human Services with the power and duty to adopt rules and regulations to be followed in the conduct of the State's social service programs with the power and duty to adopt, amend, and rescind rules and regulations under and not inconsistent with the laws of the State necessary to carry out the provisions and purposes of this Article. Provided, however, the ~~Department of Health and Human Services~~Health Benefits Authority shall have the power and duty to adopt rules and regulations to be followed in the conduct of the State's medical assistance program.

…."

SECTION 12H.24.(u) G.S. 150B-1 reads as rewritten:

"**§ 150B-1. Policy and scope.**

…

(d) Exemptions from Rule Making. – Article 2A of this Chapter does not apply to the following:

…

(9) The ~~Department of Health and Human Services~~ Health Benefits Authority in adopting new or amending existing medical coverage policies for the State Medicaid and NC Health Choice programs pursuant to G.S. 108A-54.2.

…

(20) The ~~Department of Health and Human Services~~ Health Benefits Authority in implementing, operating, or overseeing new 1915(b)/(c) Medicaid Waiver programs or amendments to existing 1915(b)/(c) Medicaid Waiver programs.

…

(22) The ~~Department of Health and Human Services~~ Health Benefits Authority with respect to the content of State Plans, State Plan Amendments, and Waivers approved by the Centers for Medicare and Medicaid Services (CMS) for the North Carolina Medicaid Program and the NC Health Choice program.

…

(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

…

(17) The ~~Department of Health and Human Services~~ Health Benefits Authority with respect to the review of North Carolina Health Choice Program

determinations regarding delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services.

…."

SECTION 12H.24.(v) Appropriation. – Of the funds appropriated from the General Fund to the Department of Health and Human Services, Division of Medical Assistance, the sum of five million dollars ($5,000,000) in recurring funds for the 2015-2016 and the 2016-2017 fiscal years shall be used to accomplish the Medicaid transformation required by this section. These funds shall provide a State match for an estimated five million dollars ($5,000,000) in federal funds beginning in the 2015-2016 fiscal year. Upon request of the Board, but no later than October 1, 2015, the Department shall transfer these funds to the Health Benefits Authority to be used for Medicaid transformation.

SECTION 12H.24.(w) Medicaid Transformation Reserve Fund. – The Medicaid Transformation Reserve Fund is established in the Office of State Budget and Management as a nonreverting reserve in the General Fund. The purpose of the Medicaid Transformation Reserve Fund is to provide funds for converting from a fee-for-services payment system to a capitated payment system. Funds reserved in the Medicaid Transformation Reserve Fund shall be available only upon an appropriation by act of the General Assembly and do not constitute an "appropriation made by law," as that phrase is used in Section 7(1) of Article V of the North Carolina Constitution. The sum of one hundred eighty-five million six hundred four thousand six hundred fifty-three dollars ($185,604,653) in nonrecurring funds for fiscal year 2015-2016 and the sum of one hundred eighty-five million six hundred four thousand six hundred fifty-three dollars ($185,604,653) in nonrecurring funds for fiscal year 2016-2017 are hereby reserved in the Medicaid Transformation Reserve Fund.

SECTION 12H.24.(x) Effective Date. – Subsections (n) through (u) of this section become effective October 1, 2015. The remainder of this section is effective when this act becomes law.

INCREASE RATES TO PRIMARY CARE PHYSICIANS AND DISCONTINUE PRIMARY CARE CASE MANAGEMENT

SECTION 12H.25.(a) Effective January 1, 2016, the current Medicaid and Health Choice primary care case management (PCCM) program is discontinued. The Department of Health and Human Services shall not renew or extend the contract for PCCM services with North Carolina Community Care Networks, Inc. (NCCCN), beyond December 31, 2015.

SECTION 12H.25.(b) The Department of Health and Human Services shall take all actions necessary to discontinue the current Medicaid and Health Choice PCCM program as implemented by NCCCN. As soon as reasonably possible, but no later than October 1, 2015, the Department shall submit to the Centers for Medicare and Medicaid Services (CMS) a Medicaid State plan amendment eliminating the PCCM program. If CMS has not approved the State plan amendment by January 1, 2016, the Department of Health and Human Services nevertheless shall discontinue all payments related to the PCCM program beginning January 1, 2016, unless and until CMS denies the State plan amendment.

SECTION 12H.25.(c) This section shall not be construed to prohibit the Department of Health and Human Services from developing or utilizing contracts for managed care other than PCCM after January 1, 2016.

SECTION 12H.25.(d) Effective January 1, 2016, G.S. 108A-70.21(b) reads as rewritten:

"(b) Benefits. – All health benefits changes of the Program shall meet the coverage requirements set forth in this subsection. Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to

children eligible under the Program shall be equivalent to coverage provided for dependents under North Carolina Medicaid Program except for the following:

…

No benefits are to be provided for services and materials under this subsection that do not meet the standards accepted by the American Dental Association.

~~The Department shall provide services to children enrolled in the NC Health Choice Program through Community Care of North Carolina (CCNC) and shall pay Community Care of North Carolina providers the per member, per month fees as allowed under Medicaid.~~"

SECTION 12H.25.(e) Effective January 1, 2016, the rates paid to primary care physicians shall be one hundred percent (100%) of Medicare rates. For purposes of this section, the term primary care physicians refers to those physicians for whom the Affordable Care Act required payment at one hundred percent (100%) of the Medicare rate until January 1, 2015, and all OB/GYN physicians.

SECTION 12H.25.(f) Upon the discontinuation of the PCCM program, of the funds previously used for the NCCCN contract, the Department shall use six million four hundred seventy-five thousand dollars ($6,475,000) in fiscal year 2015-2016 and twelve million nine hundred fifty thousand dollars ($12,950,000) in fiscal year 2016-2017 to directly fund local health departments' continued services related to the Care Coordination for Children (CC4C) program, which was previously funded through the contract with NCCCN.

NC HEALTH CHOICE COST SETTLEMENT

SECTION 12H.26. Effective July 1, 2015, hospital outpatient services covered by NC Health Choice shall be cost settled at seventy percent (70%) of allowable costs, using the same methodology that is used for Medicaid.

BLOOD GLUCOSE TESTING EQUIPMENT AND SUPPLIES

SECTION 12H.27.(a) Notwithstanding any other provision of law, the Department of Health and Human Services, Division of Medical Assistance, (Department) is authorized to use any reimbursement methodology or arrangement to provide Medicaid coverage for blood glucose testing equipment and supplies, provided that the Department's total requirements, net of rebates, for providing blood glucose testing equipment and supplies does not exceed one million nine hundred thirty-three thousand three hundred fifty-seven dollars ($1,933,357) in fiscal year 2015-2016 and two million twenty thousand nine hundred seventy-four dollars ($2,020,974) in fiscal year 2016-2017.

SECTION 12H.27.(b) Any state plan amendment submitted to implement this section shall not be subject to the 90-day prior submission requirement of G.S. 108A-54.1A(e).

MEDICAID CONTINGENCY RESERVE

SECTION 12H.28.(a) Funds in the Medicaid Contingency Reserve established by Section 12H.38 of S.L. 2014-100 shall be used only for budget shortfalls in the Medicaid Program that occur during the 2015-2016 fiscal year. These funds shall be available for expenditure only upon an appropriation by act of the General Assembly.

SECTION 12H.28.(b) It is the intent of the General Assembly to appropriate funds from the Medicaid Contingency Reserve only if:

(1) The Director of the Budget, after the State Controller has verified that receipts are being used appropriately, has found that additional funds are needed to cover a shortfall in the Medicaid budget for the State fiscal year.

(2) The Department of Health and Human Services or the Health Benefits Authority created in Section 12H.24 of this act has submitted a State plan amendment to the Centers for Medicare and Medicaid Services to delink eligibility for Medicaid from eligibility for State-County Special Assistance,

to be effective 90 days after the date of submission of the State plan amendment. At least 45 days prior to submitting that State plan amendment, the Department of Health and Human Services or the Health Benefits Authority must have submitted a draft of that plan to the Joint Legislative Oversight Committee on the Health Benefits Authority and, if the General Assembly was not in session, must have consulted with the Committee on that draft.

(3) The Director of the Budget has reported immediately to the Fiscal Research Division on the amount of the shortfall found in accordance with subdivision (1) of this subsection. This report shall include an analysis of the causes of the shortfall, such as (i) unanticipated enrollment and mix of enrollment, (ii) unanticipated growth or utilization within particular service areas, (iii) errors in the data or analysis used to project the Medicaid budget, (iv) the failure of the program to achieve budgeted savings, (v) other factors and market trends that have impacted the price of or spending for services, (vi) variations in receipts from prior years or from assumptions used to prepare the Medicaid budget for the current fiscal year, or (vii) other factors. The report shall also include data in an electronic format that is adequate for the Fiscal Research Division to confirm the amount of the shortfall and its causes.

SECTION 12H.28.(c) Effective 90 days after the State plan amendment is submitted to the Centers for Medicare and Medicaid Services (CMS) or when CMS approves the State plan amendment, whichever occurs later, eligibility for Medicaid coverage is delinked from eligibility for State-County Special Assistance and recipients of State-County Special Assistance no longer automatically qualify for Medicaid coverage solely because of their receipt of State-County Special Assistance.

SECTION 12H.28.(d) Nothing in this section shall be construed to limit the authority of the Governor to carry out his duties under the Constitution.

SUBPART XII-I. DHHS BLOCK GRANTS

DHHS BLOCK GRANTS

SECTION 12I.1.(a) Except as otherwise provided, appropriations from federal block grant funds are made for each year of the fiscal biennium ending June 30, 2017, according to the following schedule:

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) FUNDS		**FY 2015-2016**	**FY 2016-2017**
Local Program Expenditures			
Division of Social Services			
01.	Work First Family Assistance	$57,167,454	$57,167,454
02.	Work First County Block Grants	80,093,566	78,073,437
03.	Work First Electing Counties	2,378,213	2,378,213
04.	Adoption Services – Special Children Adoption Fund	2,026,877	2,026,877

05.	Child Protective Services – Child Welfare Workers for Local DSS	9,412,391	9,412,391
06.	Child Welfare Collaborative	632,416	632,416
	Division of Child Development and Early Education		
07.	Subsidized Child Care Program	35,248,910	37,419,801
08.	Swap Child Care Subsidy	6,352,644	6,352,644
09.	Pre-K Swap Out	16,829,306	12,333,981
	Division of Public Health		
10.	Teen Pregnancy Prevention Initiatives	2,950,000	2,950,000
DHHS Administration			
11.	Division of Social Services	2,482,260	2,482,260
12.	Office of the Secretary	34,042	34,042
13.	Eligibility Systems – Operations and Maintenance	2,738,926	4,206,640
14.	NC FAST Implementation	1,313,384	1,865,799
Transfers to Other Block Grants			
	Division of Child Development and Early Education		
15.	Transfer to the Child Care and Development Fund	71,773,001	71,773,001
	Division of Social Services		
16.	Transfer to Social Services Block Grant for Child Protective Services – Training	1,300,000	1,300,000
17.	Transfer to Social Services Block Grant for Child Protective Services	5,040,000	5,040,000
18.	Transfer to Social Services Block Grant for County Departments of Social Services for Children's Services	4,148,001	4,148,001
19.	Transfer to Social Services Block Grant – Foster Care Services	1,385,152	1,385,152

TOTAL TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) FUNDS		**$303,306,543**	**$300,982,109**
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) EMERGENCY CONTINGENCY FUNDS			
Local Program Expenditures			
Division of Child Development and Early Education			
01.	Subsidized Child Care	29,033,340	28,600,000
02.	Subsidized Child Care Swap Out	4,547,023	0
TOTAL TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) EMERGENCY CONTINGENCY FUNDS		**$33,580,363**	**$28,600,000**
SOCIAL SERVICES BLOCK GRANT			
Local Program Expenditures			
Divisions of Social Services and Aging and Adult Services			
01.	County Departments of Social Services (Transfer From TANF $4,148,001)	$27,427,015	$27,165,668
02.	Child Protective Services (Transfer From TANF)	5,040,000	5,040,000
03.	State In-Home Services Fund	2,382,970	1,943,950
04.	Adult Protective Services	1,245,363	1,245,363
05.	State Adult Day Care Fund	1,994,084	1,994,084
06.	Child Protective Services/CPS Investigative Services – Child Medical Evaluation Program	563,868	563,868
07.	Special Children Adoption Incentive Fund	462,600	462,600
08.	Child Protective Services – Child Welfare Training for Counties (Transfer From TANF)	1,300,000	1,300,000
09.	Home and Community Care Block Grant (HCCBG)	1,696,888	1,696,888
10.	Child Advocacy Centers	375,000	375,000

11.	Guardianship	3,978,360	3,978,360
12.	Foster Care Services (Transfer From TANF)	1,385,152	1,385,152
	Division of Central Management and Support		
13.	DHHS Competitive Block Grants for Nonprofits	3,852,500	3,852,500
14.	NC FAST – Operations and Maintenance	712,324	939,315
	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services		
15.	Mental Health Services – Adult and Child/Developmental Disabilities Program/ Substance Abuse Services – Adult	4,030,730	4,030,730
	DHHS Program Expenditures		
	Division of Services for the Blind		
16.	Independent Living Program	3,361,323	3,361,323
	Division of Health Service Regulation		
17.	Adult Care Licensure Program	381,087	381,087
18.	Mental Health Licensure and Certification Program	190,284	190,284
	DHHS Administration		
19.	Division of Aging and Adult Services	577,745	577,745
20.	Division of Social Services	559,109	559,109
21.	Office of the Secretary/Controller's Office	127,731	127,731
22.	Division of Child Development and Early Education	13,878	13,878
23.	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	27,446	27,446
24.	Division of Health Service Regulation	118,946	118,946
TOTAL SOCIAL SERVICES BLOCK GRANT		**$61,804,403**	**$61,331,027**

LOW-INCOME ENERGY ASSISTANCE BLOCK GRANT

Local Program Expenditures			
Division of Social Services			
01.	Low-Income Energy Assistance Program (LIEAP)	$40,244,534	$39,303,674
02.	Crisis Intervention Program (CIP)	40,244,534	39,303,674
Local Administration			
Division of Social Services			
03.	County DSS Administration	6,454,961	6,454,961
DHHS Administration			
04.	Office of the Secretary/DIRM	412,488	412,488
05.	Office of the Secretary/Controller's Office	18,378	18,378
06.	NC FAST Development	1,075,319	3,381,373
Transfers to Other State Agencies			
Department of Environment and Natural Resources (DENR)			
07.	Weatherization Program	11,847,017	11,570,050
08.	Heating Air Repair and Replacement Program (HARRP)	6,303,514	6,156,147
09.	Local Residential Energy Efficiency Service Providers – Weatherization	475,046	475,046
10.	Local Residential Energy Efficiency Service Providers – HARRP	252,761	252,761
11.	DENR – Weatherization Administration	475,046	475,046
12.	DENR – HARRP Administration	252,760	252,760
Department of Administration			
13.	N.C. Commission on Indian Affairs	87,736	87,736
TOTAL LOW-INCOME ENERGY ASSISTANCE BLOCK GRANT		**$108,144,094**	**$108,144,094**

CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT			
Local Program Expenditures			
Division of Child Development and Early Education			
01.	Child Care Services (Smart Start $7,000,000)	$154,678,008	$152,370,856
02.	Electronic Tracking System	801,240	401,492
03.	Transfer from TANF Block Grant for Child Care Subsidies	71,773,001	71,773,001
04.	Quality and Availability Initiatives (TEACH Program $3,800,000)	26,514,964	26,019,987
DHHS Administration			
Division of Child Development and Early Education			
05.	DCDEE Administrative Expenses	9,049,505	9,049,505
Division of Social Services			
06.	Local Subsidized Child Care Services Support	15,930,279	15,930,279
07.	NC FAST Development	186,404	586,152
Division of Central Administration			
08.	DHHS Central Administration – DIRM Technical Services	775,000	775,000
09.	Central Regional Maintenance	202,000	202,000
10.	Child Care Health Consultation Contracts	62,205	62,205
TOTAL CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT		**$279,972,606**	**$277,170,477**
MENTAL HEALTH SERVICES BLOCK GRANT			
Local Program Expenditures			
01.	Mental Health Services – Child	$3,619,833	$3,619,833
02.	Administration	200,000	200,000
03.	Mental Health Services – Adult/Child	11,755,152	11,755,152

04.	Crisis Solutions Initiative – Critical Time Intervention	750,000	750,000
05.	Mental Health Services – First Psychotic Symptom Treatment	643,491	643,491
TOTAL MENTAL HEALTH SERVICES BLOCK GRANT		**$16,968,476**	**$16,968,476**

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

Local Program Expenditures

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

01.	Substance Abuse – HIV and IV Drug	$3,919,723	$3,919,723
02.	Substance Abuse Prevention	8,669,284	8,669,284
03.	Substance Abuse Services – Treatment for Children/Adults	29,519,883	29,519,883
04.	Crisis Solutions Initiatives – Walk-In Crisis Centers	420,000	420,000
05.	Crisis Solutions Initiatives – Collegiate Wellness/Addiction Recovery	1,085,000	1,085,000
06.	Crisis Solutions Initiatives – Community Paramedic Mobile Crisis Management	60,000	60,000
07.	Crisis Solutions Initiatives – Innovative Technologies	41,000	41,000
08.	Crisis Solutions Initiatives – Veteran's Crisis	250,000	250,000
09.	Administration	454,000	454,000

Division of Public Health

10.	HIV Testing for Individuals in Substance Abuse Treatment	765,949	765,949
TOTAL SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT		**$45,184,839**	**$45,184,839**

MATERNAL AND CHILD HEALTH BLOCK GRANT

Local Program Expenditures

Division of Public Health			
01.	Children's Health Services (Safe Sleep Campaign $45,000; Prevent Blindness $560,837; Community-Based Sickle Cell Centers $100,000)	$7,574,703	$7,574,703
02.	Women's Health (March of Dimes $350,000; Teen Pregnancy Prevention Initiatives $650,000; 17P Project $52,000; Nurse-Family Partnership $509,018)	6,520,148	6,520,148
03.	Oral Health	44,901	44,901
04.	Evidence-Based Programs in Counties With Highest Infant Mortality Rates	1,575,000	1,575,000
DHHS Program Expenditures			
Division of Public Health			
05.	Children's Health Services	1,342,928	1,342,928
06.	Women's Health – Maternal Health	107,714	107,714
07.	State Center for Health Statistics	158,583	158,583
08.	Health Promotion – Injury and Violence Prevention	87,271	87,271
DHHS Administration			
Division of Public Health			
09.	Division of Public Health Administration	552,571	552,571
TOTAL MATERNAL AND CHILD HEALTH BLOCK GRANT		**$17,963,819**	**$17,963,819**
PREVENTIVE HEALTH SERVICES BLOCK GRANT			
Local Program Expenditures			
01.	Physical Activity and Prevention	$2,034,060	$2,034,060
02.	Injury and Violence Prevention (Services to Rape Victims – Set-Aside)	173,476	173,476
03.	Community-Focused Eliminating Health		

Disparities Initiative Grants	2,756,855	0
DHHS Program Expenditures		
Division of Public Health		
04. HIV/STD Prevention and Community Planning	145,819	145,819
05. Oral Health Preventive Services	320,074	451,809
06. Laboratory Services – Testing, Training, and Consultation	21,012	21,012
07. Injury and Violence Prevention (Services to Rape Victims – Set-Aside)	192,315	192,315
08. State Laboratory Services – Testing, Training, and Consultation	199,634	199,634
09. Heart Disease and Stroke Prevention	273,772	405,507
10. Performance Improvement and Accountability	839,736	971,471
11. Physical Activity and Nutrition	68,073	68,073
12. State Center for Health Statistics	107,291	107,291
DHHS Administration		
Division of Public Health		
13. Division of Public Health	172,820	172,820
14. Division of Public Health – Physical Activity and Nutrition Branch	1,243,899	0
TOTAL PREVENTIVE HEALTH SERVICES BLOCK GRANT	**$8,548,836**	**$4,943,288**
COMMUNITY SERVICES BLOCK GRANT		
Local Program Expenditures		
Office of Economic Opportunity		
01. Community Action Agencies	$24,047,065	$24,047,065
02. Limited Purpose Agencies	1,335,948	1,335,948

DHHS Administration			
03.	Office of Economic Opportunity	1,335,948	1,335,948
TOTAL COMMUNITY SERVICES BLOCK GRANT		**$26,718,961**	**$26,718,961**

GENERAL PROVISIONS

SECTION 12I.1.(b) Information to Be Included in Block Grant Plans. – The Department of Health and Human Services shall submit a separate plan for each Block Grant received and administered by the Department, and each plan shall include the following:

(1) A delineation of the proposed allocations by program or activity, including State and federal match requirements.
(2) A delineation of the proposed State and local administrative expenditures.
(3) An identification of all new positions to be established through the Block Grant, including permanent, temporary, and time-limited positions.
(4) A comparison of the proposed allocations by program or activity with two prior years' program and activity budgets and two prior years' actual program or activity expenditures.
(5) A projection of current year expenditures by program or activity.
(6) A projection of federal Block Grant funds available, including unspent federal funds from the current and prior fiscal years.

SECTION 12I.1.(c) Changes in Federal Fund Availability. – If the Congress of the United States increases the federal fund availability for any of the Block Grants or contingency funds and other grants related to existing Block Grants administered by the Department of Health and Human Services from the amounts appropriated in this section, the Department shall allocate the increase proportionally across the program and activity appropriations identified for that Block Grant in this section. In allocating an increase in federal fund availability, the Office of State Budget and Management shall not approve funding for new programs or activities not appropriated in this section.

If the Congress of the United States decreases the federal fund availability for any of the Block Grants or contingency funds and other grants related to existing Block Grants administered by the Department of Health and Human Services from the amounts appropriated in this section, the Department shall develop a plan to adjust the Block Grants based on reduced federal funding.

Notwithstanding the provisions of this subsection, for fiscal years 2015-2016 and 2016-2017, increases in the federal fund availability for the Temporary Assistance to Needy Families (TANF) Block Grant shall be used only for the North Carolina Child Care Subsidy program to pay for child care in four- or five-star-rated facilities for four-year-old children and shall not be used to supplant State funds.

Prior to allocating the change in federal fund availability, the proposed allocation must be approved by the Office of State Budget and Management. If the Department adjusts the allocation of any Block Grant due to changes in federal fund availability, then a report shall be made to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division.

SECTION 12I.1.(d) Except as otherwise provided, appropriations from federal Block Grant funds are made for each year of the fiscal biennium ending June 30, 2017, according to the schedule enacted for State fiscal years 2015-2016 and 2016-2017 or until a new schedule is enacted by the General Assembly.

SECTION 12I.1.(e) All changes to the budgeted allocations to the Block Grants or contingency funds and other grants related to existing Block Grants administered by the

Department of Health and Human Services that are not specifically addressed in this section shall be approved by the Office of State Budget and Management, and the Office of State Budget and Management shall consult with the Joint Legislative Oversight Committee on Health and Human Services for review prior to implementing the changes. The report shall include an itemized listing of affected programs, including associated changes in budgeted allocations. All changes to the budgeted allocations to the Block Grants shall be reported immediately to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division. This subsection does not apply to Block Grant changes caused by legislative salary increases and benefit adjustments.

SECTION 12I.1.(f) Except as otherwise provided, the Department of Health and Human Services shall have flexibility to transfer funding between the Temporary Assistance for Needy Families (TANF) Block Grant and the TANF Emergency Contingency Funds Block Grant so long as the total allocation for the line items within those block grants remains the same.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) FUNDS

SECTION 12I.1.(g) The sum of eighty million ninety-three thousand five hundred sixty-six dollars ($80,093,566) for the 2015-2016 fiscal year and the sum of seventy-eight million seventy-three thousand four hundred thirty-seven dollars ($78,073,437) for the 2016-2017 fiscal year appropriated in this section in TANF funds to the Department of Health and Human Services, Division of Social Services, shall be used for Work First County Block Grants. The Division shall certify these funds in the appropriate State-level services based on prior year actual expenditures. The Division has the authority to realign the authorized budget for these funds among the State-level services based on current year actual expenditures.

SECTION 12I.1.(h) The sum of nine million four hundred twelve thousand three hundred ninety-one dollars ($9,412,391) appropriated in this section to the Department of Health and Human Services, Division of Social Services, in TANF funds for each year of the 2015-2017 fiscal biennium for child welfare improvements shall be allocated to the county departments of social services for hiring or contracting staff to investigate and provide services in Child Protective Services cases; to provide foster care and support services; to recruit, train, license, and support prospective foster and adoptive families; and to provide interstate and post-adoption services for eligible families.

Counties shall maintain their level of expenditures in local funds for Child Protective Services workers. Of the Block Grant funds appropriated for Child Protective Services workers, the total expenditures from State and local funds for fiscal years 2015-2016 and 2016-2017 shall not be less than the total expended from State and local funds for the 2012-2013 fiscal year.

SECTION 12I.1.(i) The sum of two million twenty-six thousand eight hundred seventy-seven dollars ($2,026,877) appropriated in this section in TANF funds to the Department of Health and Human Services, Special Children Adoption Fund, for each year of the 2015-2017 fiscal biennium shall be used in accordance with G.S. 108A-50.2. The Division of Social Services, in consultation with the North Carolina Association of County Directors of Social Services and representatives of licensed private adoption agencies, shall develop guidelines for the awarding of funds to licensed public and private adoption agencies upon the adoption of children described in G.S. 108A-50 and in foster care. Payments received from the Special Children Adoption Fund by participating agencies shall be used exclusively to enhance the adoption services program. No local match shall be required as a condition for receipt of these funds.

SOCIAL SERVICES BLOCK GRANT

SECTION 12I.1.(j) The sum of twenty-seven million four hundred twenty-seven thousand fifteen dollars ($27,427,015) for the 2015-2016 fiscal year and the sum of twenty-seven million one hundred sixty-five thousand six hundred sixty-eight dollars ($27,165,668) for the 2016-2017 fiscal year appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Division of Social Services, shall be used for county block grants. The Division shall certify these funds in the appropriate State-level services based on prior year actual expenditures. The Division has the authority to realign the authorized budget for these funds among the State-level services based on current year actual expenditures.

SECTION 12I.1.(k) The sum of one million three hundred thousand dollars ($1,300,000) appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Division of Social Services, for each year of the 2015-2017 fiscal biennium shall be used to support various child welfare training projects as follows:

(1) Provide a regional training center in southeastern North Carolina.

(2) Provide training for residential child caring facilities.

(3) Provide for various other child welfare training initiatives.

SECTION 12I.1.(l) The Department of Health and Human Services is authorized, subject to the approval of the Office of State Budget and Management, to transfer Social Services Block Grant funding allocated for departmental administration between divisions that have received administrative allocations from the Social Services Block Grant.

SECTION 12I.1.(m) Social Services Block Grant funds appropriated for the Special Children Adoption Incentive Fund will require a fifty-percent (50%) local match.

SECTION 12I.1.(n) The sum of five million forty thousand dollars ($5,040,000) appropriated in this section in the Social Services Block Grant for each year of the 2015-2017 fiscal biennium shall be allocated to the Department of Health and Human Services, Division of Social Services. The Division shall allocate these funds to local departments of social services to replace the loss of Child Protective Services State funds that are currently used by county governments to pay for Child Protective Services staff at the local level. These funds shall be used to maintain the number of Child Protective Services workers throughout the State. These Social Services Block Grant funds shall be used to pay for salaries and related expenses only and are exempt from 10A NCAC 71R .0201(3) requiring a local match of twenty-five percent (25%).

SECTION 12I.1.(o) The sum of three million eight hundred fifty-two thousand five hundred dollars ($3,852,500) appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Division of Central Management and Support, shall be used for DHHS competitive block grants pursuant to Section 12A.8 of this act for each year of the 2015-2017 fiscal biennium. These funds are exempt from the provisions of 10A NCAC 71R .0201(3).

SECTION 12I.1.(p) The sum of three hundred seventy-five thousand dollars ($375,000) appropriated in this section in the Social Services Block Grant for each year of the 2015-2017 fiscal biennium to the Department of Health and Human Services, Division of Social Services, shall be used to continue support for the Child Advocacy Centers, and the funds are exempt from the provisions of 10A NCAC 71R .0201(3).

SECTION 12I.1.(q) The sum of three million nine hundred seventy-eight thousand three hundred sixty dollars ($3,978,360) for each year of the 2015-2017 fiscal biennium appropriated in this section in the Social Services Block Grant to the Department of Health and Human Services, Divisions of Social Services and Aging and Adult Services, shall be used for guardianship services pursuant to Chapter 35A of the General Statutes. The Department may expend funds appropriated in this section to support (i) existing corporate guardianship contracts during the 2015-2016 and 2016-2017 fiscal years and (ii) guardianship contracts

transferred to the State from local management entities or managed care organizations during the 2015-2016 and 2016-2017 fiscal years.

LOW-INCOME ENERGY ASSISTANCE BLOCK GRANT

SECTION 12I.1.(r) Additional emergency contingency funds received may be allocated for Energy Assistance Payments or Crisis Intervention Payments without prior consultation with the Joint Legislative Oversight Committee on Health and Human Services. Additional funds received shall be reported to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division upon notification of the award. The Department of Health and Human Services shall not allocate funds for any activities, including increasing administration, other than assistance payments, without prior consultation with the Joint Legislative Oversight Committee on Health and Human Services.

SECTION 12I.1.(s) The sum of forty million two hundred forty-four thousand five hundred thirty-four dollars ($40,244,534) for the 2015-2016 fiscal year and the sum of thirty-nine million three hundred three thousand six hundred seventy-four dollars ($39,303,674) for the 2016-2017 fiscal year appropriated in this section in the Low-Income Energy Assistance Block Grant to the Department of Health and Human Services, Division of Social Services, shall be used for Energy Assistance Payments for the households of (i) elderly persons age 60 and above with income up to one hundred thirty percent (130%) of the federal poverty level and (ii) disabled persons eligible for services funded through the Division of Aging and Adult Services.

County departments of social services shall submit to the Division of Social Services an outreach plan for targeting households with 60-year-old household members no later than August 1 of each year. The outreach plan shall comply with the following:

(1) Ensure that eligible households are made aware of the available assistance, with particular attention paid to the elderly population age 60 and above and disabled persons receiving services through the Division of Aging and Adult Services.

(2) Include efforts by the county department of social services to contact other State and local governmental entities and community-based organizations to (i) offer the opportunity to provide outreach and (ii) receive applications for energy assistance.

(3) Be approved by the local board of social services or human services board prior to submission.

CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT

SECTION 12I.1.(t) Payment for subsidized child care services provided with federal TANF funds shall comply with all regulations and policies issued by the Division of Child Development for the subsidized child care program.

SECTION 12I.1.(u) If funds appropriated through the Child Care and Development Fund Block Grant for any program cannot be obligated or spent in that program within the obligation or liquidation periods allowed by the federal grants, the Department may move funds to child care subsidies, unless otherwise prohibited by federal requirements of the grant, in order to use the federal funds fully.

MENTAL HEALTH SERVICES BLOCK GRANT

SECTION 12I.1.(v) The sum of six hundred forty-three thousand four hundred ninety-one dollars ($643,491) appropriated in this section in the Mental Health Services Block Grant to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for each year of the 2015-2017 fiscal biennium is allocated for Mental Health Services – First Psychotic Symptom Treatment.

The Division shall report on (i) the specific evidence-based treatment and services provided, (ii) the number of persons treated, and (iii) the measured outcomes or impact on the participants served. The Division shall report to the House of Representatives Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division no later than December 31, 2016.

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

SECTION 12I.1.(w) The sum of two hundred fifty thousand dollars ($250,000) appropriated in this section in the Substance Abuse Prevention and Treatment Block Grant to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for each year of the 2015-2017 fiscal biennium shall be allocated to the Department of Administration, Division of Veterans Affairs, to establish a call-in center to assist veterans in locating service benefits and crisis services. The call-in center shall be staffed by certified veteran peers within the Division of Veterans Affairs and trained by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

MATERNAL AND CHILD HEALTH BLOCK GRANT

SECTION 12I.1.(x) If federal funds are received under the Maternal and Child Health Block Grant for abstinence education, pursuant to section 912 of Public Law 104-193 (42 U.S.C. § 710), for the 2015-2016 fiscal year or the 2016-2017 fiscal year, then those funds shall be transferred to the State Board of Education to be administered by the Department of Public Instruction. The Department of Public Instruction shall use the funds to establish an abstinence until marriage education program and shall delegate to one or more persons the responsibility of implementing the program and G.S. 115C-81(e1)(4) and (4a). The Department of Public Instruction shall carefully and strictly follow federal guidelines in implementing and administering the abstinence education grant funds.

SECTION 12I.1.(y) The Department of Health and Human Services shall ensure that there will be follow-up testing in the Newborn Screening Program.

SECTION 12I.1.(z) The sum of one million five hundred seventy-five thousand dollars ($1,575,000) appropriated in this section in the Maternal and Child Health Block Grant to the Department of Health and Human Services, Division of Public Health, for each year of the 2015-2017 fiscal biennium shall be used for evidence-based programs in counties with highest infant mortality rates. The Division shall report on (i) the counties selected to receive the allocation, (ii) the specific evidenced-based services provided, (iii) the number of women served, and (iv) any impact on the counties' infant mortality rate. The Division shall report its findings to the House of Representatives Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division no later than December 31, 2016.

SECTION 12I.1.(aa) The sum of one hundred thousand dollars ($100,000) allocated in this section in the Maternal and Child Health Block Grant to the Department of Health and Human Services, Division of Public Health, for each year of the 2015-2017 fiscal biennium for community-based sickle cell centers shall not be used to supplant existing State or federal funds.

PART XIII. DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

TVA SETTLEMENT FUNDS

SECTION 13.2. In fiscal year 2015-2016, The Department of Agriculture and Consumer Services shall apply for two million two hundred forty thousand dollars ($2,240,000) from the Tennessee Valley Authority Settlement Agreement in compliance with the