SENATE APPROPRIATIONS ON HEALTH AND HUMAN SERVICES

SENATE BILL 402
NORTH CAROLINA GENERAL ASSEMBLY

MAY 20, 2013

accomplishments and prior State fiscal year itemized expenditures and fund sources. The annual report shall include a report of royalty revenues generated from the Subject Projects.

(2) Provide to the Fiscal Research Division a copy of the Institute's annual audited financial statement within 30 days of issuance of the statement.

SECTION 11.12.(e) Remaining allotments after September 1 shall not be released to the Institute if the reporting requirements provided in subsection (d) of this section are not satisfied.

SECTION 11.12.(f) No more than one hundred twenty thousand dollars ($120,000) in State funds shall be used for the annual salary of any one employee of the Institute. For purposes of this subsection, the term "State funds" means funds appropriated by the State to the Institute and interest earned on those funds.

SECTION 11.12.(g) No State funds shall be used by the Institute (i) to hire or facilitate the hiring of a lobbyist or any person performing the duties or activities of a lobbyist, without regard to the person's title; or (ii) to facilitate any lobbying efforts.

UNC/STRATEGIC PLAN FUNDS

SECTION 11.13. Of the funds appropriated by this act to the Board of Governors of The University of North Carolina for the 2013-2015 fiscal biennium, the Board of Governors may spend a sum of up to fifteen million dollars ($15,000,000) for the 2013-2014 fiscal year and a sum of up to fifteen million dollars ($15,000,000) for the 2014-2015 fiscal year to implement provisions of The University of North Carolina Strategic Plan as set out in the report "Our Time, Our Future: The University of North Carolina Compact with North Carolina."

PART XII. DEPARTMENT OF HEALTH AND HUMAN SERVICES

SUBPART XII-A. CENTRAL MANAGEMENT AND SUPPORT

DEPARTMENT FLEXIBILITY TO ACHIEVE DEPARTMENTAL PRIORITIES AND ENHANCE FISCAL OVERSIGHT AND ACCOUNTABILITY.

SECTION 12A.1.(a) Notwithstanding any other provision of law and consistent with the intent of G.S. 143B-10, the Secretary of the Department of Health and Human Services may reorganize positions and related operational costs within the Department (i) upon a demonstration by the Department of cost-effectiveness and (ii) after approval by the Office of State Budget and Management (OSBM) of a written proposal submitted by the Department to OSBM. Proposals submitted to OSBM under this section shall, at a minimum, identify the positions involved and the strategies to be implemented in order to achieve efficiencies.

SECTION 12A.1.(b) Notwithstanding G.S. 143C-6-4 and in order to enhance fiscal oversight and accountability, the Secretary of the Department of Health and Human Services may realign existing resources to expand its internal audit capacity. The Secretary may, with the approval of OSBM, identify up to 32 existing positions for this purpose. The expanded Office of Internal Audit shall provide the Department's management personnel with independent reviews and analyses of various functions and services within the Department, including operational audits, performance audits, compliance audits, financial audits, and other special reviews. Any realignment of resources and positions pursuant to this subsection is subject to the prior approval of OSBM.

SECTION 12A.1.(c) By no later than June 30, 2014, the Department shall report any actions undertaken pursuant to this section to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division. The report shall, at a minimum, identify the positions involved and the strategies implemented to achieve efficiencies, to expand internal audit capacity, or both.

COMPETITIVE GRANTS PROCESS FOR NONPROFIT FUNDING

SECTION 12A.2.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Office of the Secretary, the sum of nine million five hundred twenty-nine thousand one hundred thirty-four dollars ($9,529,134) for the 2013-2014 fiscal year and the sum of five million two hundred seventy-three thousand eight hundred thirty-five dollars ($5,273,835) appropriated in Section 12J.1 of this act for the 2013-2014 fiscal year shall be used to implement a request for application (RFA) process to allow non-State entities to apply for and receive State funds on a competitive basis.

SECTION 12A.2.(b) The Office of the Secretary shall administer grants awarded to non-State entities pursuant to this section and shall require non-State entities to match ten percent (10%) of the total amount of the grant. The Office of the Secretary shall prioritize grant awards to those non-State entities that are able to leverage non-State funds in addition to the grant award.

SECTION 12A.2.(c) Grants shall be awarded to non-State entities dedicated to providing services statewide and supporting 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 comprehensive program of education, advocacy, and support related to brain injury and those affected by brain injury.
(3) A system of residential supports for those afflicted with substance abuse addiction.
(4) A program of advocacy and supports for individuals with intellectual and developmental disabilities or severe and persistent mental illness, substance abusers, or the elderly.
(5) Supports and services to children and adults with developmental disabilities or mental health diagnoses.
(6) A food distribution system for needy individuals.
(7) The provision and coordination of services for the homeless.
(8) The provision of maternity and high-risk pregnancy services.
(9) The provision of services for individuals aging out of foster care.
(10) Programs promoting wellness, physical activity, and health education programming for North Carolinians.
(11) A program focused on enhancing vision screening through the State's public school system.
(12) Provision for the delivery of after-school services for at-risk youth.
(13) The provision of direct services for amyotrophic lateral sclerosis (ALS) and those diagnosed with the disease.

SECTION 12A.2.(d) The Department shall submit a written report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the use of these funds no later than April 1, 2014. The report shall include at least all of the following:

(1) The identity and a brief description of each grantee and each program or initiative offered by the grantee.
(2) The amount of funding awarded to each grantee.
(3) The number of persons served by each grantee, broken down by program or initiative.

SECTION 12A.2.(e) Funds received by the Department of Health and Human Services pursuant to this section shall supplement and not supplant existing funds for health and wellness programs and initiatives.

HEALTH INFORMATION TECHNOLOGY

SECTION 12A.3.(a) The Department of Health and Human Services, in cooperation with the State Chief Information Officer, shall coordinate health information technology (HIT) policies and programs within the State of North Carolina. The Department's goal 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.3.(b) The Department of Health and Human Services 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.3.(c) Section 10.24(c) of S.L. 2011-145 reads as rewritten:

"**SECTION 10.24.(c)** ~~Beginning October 1, 2011, the Department of Health and Human Services shall provide quarterly written reports~~By no later than January 15, 2015, the Department of Health and Human Services shall provide a written report on the status of HIT efforts to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division. The ~~reports due each January 1 and July 1 shall consist of updates to substantial initiatives or challenges that have occurred since the most recent comprehensive report. The reports due each October 1 and April 1~~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) A breakdown of current public and private funding sources and dollar amounts for State HIT initiatives.

(4) Department efforts to coordinate HIT initiatives within the State and any obstacles or impediments to coordination.

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

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

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

FUNDS FOR REPLACEMENT MEDICAID MANAGEMENT INFORMATION SYSTEM/IMPLEMENTATION OF REPLACEMENT MMIS

SECTION 12A.4.(a) The Secretary of the Department of Health and Human Services may utilize prior year earned revenue received for the replacement MMIS in the amount of nine million six hundred fifty-eight thousand one hundred fifty-two dollars ($9,658,152) for the 2013-2014 fiscal year and in the amount of one million six hundred sixty-six thousand six hundred twenty-five dollars ($1,666,625) for the 2014-2015 fiscal year. In the event the Department does not receive prior year earned revenues in the amounts authorized by this section, or funds are insufficient to advance the project, the Department may, with prior approval from the Office of State Budget and Management (OSBM), utilize overrealized receipts and funds appropriated to the Department to achieve the level of funding specified in this section for the replacement MMIS.

SECTION 12A.4.(b) The Department shall make full development of the replacement MMIS a top priority. During development and implementation of the replacement MMIS, the Department shall develop plans to ensure the timely and effective implementation of enhancements to the system to provide the following capabilities:

(1) Receiving and tracking premiums or other payments required by law.

(2) Compatibility with the Health Information System.

SECTION 12A.4.(c) The Department shall make every effort to expedite the implementation of the enhancements. The replacement MMIS shall have the capability to fully implement the administration of NC Health Choice, Ticket to Work, CAP Children's Program, all relevant Medicaid waivers, and the Medicare 646 waiver as it applies to Medicaid eligibles.

SECTION 12A.4.(d) The Office of the State Chief Information Officer (SCIO) and the Office of Information Technology Services (ITS) shall work in cooperation with the Department to ensure the timely and effective implementation of the replacement MMIS and any enhancements. The SCIO shall ensure that the replacement MMIS meets all State requirements for project management and shall immediately report any failure to meet these requirements to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Information Technology, the Fiscal Research Division, and the Office of State Budget and Management. The SCIO shall also immediately report if any replacement MMIS project, or portion of a project, is listed as red in the project portfolio management tool.

SECTION 12A.4.(e) Notwithstanding G.S. 114-2.3, the Department shall consult with the Office of the SCIO concerning the retention of private counsel for the replacement MMIS, and as directed by the Office of the SCIO, retain private counsel with expertise in pertinent information technology and computer law to negotiate and review contract amendments associated with the replacement MMIS. The private counsel engaged by the Department shall review the replacement MMIS contract amendments between the Department and the vendors to ensure that the requirements of subsection (c) of this section are met in their entirety and that the terms of the contract amendments are in the State's best interest.

SECTION 12A.4.(f) The Department shall immediately report any changes to the replacement MMIS implementation schedules to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Information Technology, the Fiscal Research Division, and the Office of State Budget and Management, with a full explanation of the reason for the change and any associated costs.

SECTION 12A.4.(g) The Department shall provide the following reports on the replacement MMIS by the dates specified in this subsection to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Information Technology, the Fiscal Research Division, and the Office of State Budget and Management:

(1) By no later than August 1, 2013, a progress report on full implementation of the replacement MMIS, which shall include at least all of the following:

a. An updated estimate of the costs associated with operating and maintaining the system during the 2013-2014 fiscal year and during the 2014-2015 fiscal year, with an explanation for any changes from previous submissions.

b. Any issues encountered following the "go-live" date of July 1, 2013, how each issue was resolved, any cost associated with the resolution of each issue, and the source of funding for the associated cost.

c. Any system requirements for manual workarounds, any cost associated with these system requirements, the source of funding used to pay for the associated cost, the time line for implementing an automated solution for each manual workaround, the cost associated with transitioning to each automated solution, and the source of funding for each identified cost.

d. A comparison of timeliness and accuracy of payments for legacy system and replacement system transactions, using the same criteria for both.

e. Required capabilities that are not available in the replacement MMIS on the "go-live" date of July 1, 2013, with a date for the implementation of each, as well as any cost associated with implementation.

(2) By no later than September 1, 2013, a plan for the elimination of the Office of Medicaid Management Information System Services (OMMISS) and the transfer of its remaining operations to other Divisions within the Department of Health and Human Services. This plan shall include at least all of the following:

a. The specific operations to be transferred to other Divisions within the Department, the specific Division to which each operation will be transferred, the State personnel that will be impacted by each transfer, costs associated with each transfer, and sources of funding to enable the identified Divisions to assume these transferred operations.

b. Any State personnel costs that will result from the dissolution of OMMISS, including the costs of any severance payments and any compensatory time earned during the course of the project, broken down by employee; and any identified sources of funding to pay for these personnel costs.

c. A plan for transitioning out of the space currently leased by the State for OMMISS, costs associated with this transition, and any savings that will result from the transition.

(3) By no later than October 1, 2013, a preliminary report on the Department's plan for achieving system certification, which shall include at least all of the following:

a. A description of the process.

b. A detailed time line.

c. Any issues that could impact the timing of system certification and plans to mitigate identified issues.

d. Any costs associated with system certification.

e. Any identified funding sources to pay for costs associated with system certification.

SECTION 12A.4.(h) The Department shall complete the Reporting and Analytics Project solution simultaneously with the implementation of the replacement MMIS.

SECTION 12A.4.(i) Notwithstanding any other provision of law and to the extent permitted by federal law, the Department shall not approve any overtime or compensatory time related to the replacement MMIS after the replacement MMIS "go-live" date of July 1, 2013, without the prior written approval of the Office of State Personnel for each specific instance of overtime or compensatory time.

SECTION 12A.4.(j) Beginning when the replacement MMIS is fully implemented, the Department shall require all Medicaid claim adjudication to be performed by the replacement MMIS, including all Medicaid claim adjudication performed by entities under contract with the Department. The Department may charge entities under contract with the Department a fee not to exceed the amount necessary to cover the full operating cost of Medicaid claim adjudication performed by the replacement MMIS.

FRAUD DETECTION THROUGH NORTH CAROLINA ACCOUNTABILITY AND COMPLIANCE TECHNOLOGY SYSTEM

SECTION 12A.5. The Department of Health and Human Services shall integrate with and leverage the State's enterprise-level fraud detection system operated by the North

Carolina Financial Accountability and Compliance Technology System (NC FACTS) in an effort to detect and prevent potential fraud, waste, and improper payments. Integration shall involve the following information technology systems:

(1) Medicaid Management Information System (MMIS).
(2) North Carolina Child Treatment Program (NC CTP) State-funded secure database.
(3) North Carolina Families Accessing Services through Technology (NC FAST).

FUNDING FOR NORTH CAROLINA FAMILIES ACCESSING SERVICES THROUGH TECHNOLOGY (NC FAST); REPORT ON ELIGIBILITY DETERMINATIONS FOR THE EXCHANGE

SECTION 12A.6.(a) Funds appropriated in this act in the amount of eight hundred sixty-four thousand six hundred fifty-five dollars ($864,655) for State fiscal year 2014-2015 along with 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 fiscal years 2013-2014 and 2014-2015 to expedite the development and implementation of the Eligibility Information System (EIS), Child Care, Low Income Energy Assistance, and Crisis Intervention Programs, and Child Service components of the NC FAST project.

SECTION 12A.6.(b) The Department of Health and Human Services shall report on NC FAST's performance in providing eligibility determinations for Medicaid applicants on the federally facilitated Health Benefit Exchange, a required function of NC FAST directed by Section 2 of S.L. 2013-5. The report shall contain a description of the following:

(1) Funding sources, funding amounts, and expenditures for the project beginning in fiscal year 2012-2013 through the time of the report.
(2) Any challenges with the eligibility determination project and how NC FAST solved those challenges.
(3) The number of eligibility determinations performed for applicants on the federally facilitated Health Benefit Exchange, including an analysis of on what days and for how many persons eligibility determinations were performed as well as how many applicants were determined to be eligible.

The Department shall submit a report to the Joint Legislative Commission on Governmental Operations, the Joint Legislative Oversight Committee on Health and Human Services, and the Joint Legislative Oversight Committee on Information Technology three months after open enrollment begins for the federally facilitated Health Benefit Exchange.

LIABILITY INSURANCE

SECTION 12A.7. Article 31 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-31-26. Medical liability insurance for certain physicians and dentists.**

(a) The Secretary of the Department of Health and Human Services and the Secretary of the Department of Public Safety may provide medical liability insurance not to exceed one million dollars ($1,000,000) per incident on behalf of employees of these Departments who are licensed to practice medicine or dentistry; on behalf of all licensed physicians who are faculty members of The University of North Carolina who perform work on a contractual basis for the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services for incidents that occur in Division programs; and on behalf of physicians in all residency training programs from The University of North Carolina who are in training at institutions operated by the Department of Health and Human Services. This coverage may include commercial insurance or self-insurance and shall cover these individuals for their acts or omissions only

while they are engaged in providing medical and dental services pursuant to their State employment or training.

(b) The coverage provided pursuant to this section shall not cover any individual for any act or omission that the individual knows or reasonably should know constitutes a violation of the applicable criminal laws of any state or the United States, or that arises out of any sexual, fraudulent, criminal, or malicious act or out of any act amounting to willful or wanton negligence.

(c) The coverage provided pursuant to this section shall not require any additional appropriations and, except as provided in subsection (a) of this section, shall not apply to any individual providing contractual service to the Department of Health and Human Services or the Department of Public Safety."

ELIMINATE UNNECESSARY AND REDUNDANT REPORTS

SECTION 12A.8.(a) Eliminate Outcomes Evaluation Study on the Effectiveness of Substance Abuse Services Provided to Person Convicted of DWI. – G.S. 122C-142.1(j) is repealed.

SECTION 12A.8.(b) Eliminate Evaluation of Efficiency and Effectiveness of Family Resource Center Grant Program. – G.S. 143B-152.15(b) is repealed.

SECTION 12A.8.(c) Eliminate Annual Report on Progress of MH/DD/SAS State Plan. – G.S. 122C-102(c) is repealed.

SECTION 12A.8.(d) Eliminate Annual Report on North Carolina State Plan on Healthcare Associated Infections. – G.S. 130A-150(e) is repealed.

SECTION 12A.8.(e) Eliminate Annual Report on The Health Insurance Program for Children. – G.S. 108A-70.27(b) is repealed.

SECTION 12A.8.(f) Eliminate Annual Report by State Child Fatality Review Team. – G.S. 143B-150.20(h) is repealed.

SECTION 12A.8.(g) Forgiveness of Late Reports. – Notwithstanding any other provision of law, unless otherwise required in this act, the Department of Health and Human Services is not required to submit any report due on or before January 6, 2013, to the General Assembly; to any committee, commission, subcommittee, task force, or division of the General Assembly; or to any other department, unit, or subdivision of State government, if the Department has not already submitted the report prior to July 1, 2013. This subsection shall not be construed to eliminate any reports due from the Department after January 6, 2013, except as otherwise provided by law.

CANCER COORDINATION REPORTING

SECTION 12A.9. G.S. 130A-33.51(b) reads as rewritten:

"(b) The Committee shall submit a written report not later than May 1, 1994, and not later than October 1 of each subsequent year, to ~~the Governor and to the Joint Legislative Commission on Governmental Operations.~~ the Secretary. The report shall address the progress in implementation of a cancer control program. The report shall include an accounting of funds expended and anticipated funding needs for full implementation of recommended programs."

MEETINGS OF CANCER COORDINATION COMMITTEE

SECTION 12A.10. G.S. 130A-33.50(b) reads as rewritten:

"(b) The Committee shall have up to 34 members, including the Secretary of the Department or the Secretary's designee. The members of the Committee shall elect a chair and vice-chair from among the Committee membership. The Committee shall meet not more than twice a year at the call of the chair. Six of the members shall be legislators, three of whom shall be appointed by the Speaker of the House of Representatives, and three of whom shall be appointed by the President Pro Tempore of the Senate. Four of the members shall be cancer

survivors, two of whom shall be appointed by the Speaker of the House of Representatives, and two of whom shall be appointed by the President Pro Tempore of the Senate. The remainder of the members shall be appointed by the Governor as follows:

(1) One member from the Department of Environment and Natural Resources;
(2) Three members, one from each of the following: the Department, the Department of Public Instruction, and the North Carolina Community College System;
(3) Four members representing the cancer control programs at North Carolina medical schools, one from each of the following: the University of North Carolina at Chapel Hill School of Medicine, the Bowman Gray School of Medicine, the Duke University School of Medicine, and the East Carolina University School of Medicine;
(4) One member who is an oncology nurse representing the North Carolina Nurses Association;
(5) One member representing the Cancer Committee of the North Carolina Medical Society;
(6) One member representing the Old North State Medical Society;
(7) One member representing the American Cancer Society, North Carolina Division, Inc.;
(8) One member representing the North Carolina Hospital Association;
(9) One member representing the North Carolina Association of Local Health Directors;
(10) One member who is a primary care physician licensed to practice medicine in North Carolina;
(11) One member representing the American College of Surgeons;
(12) One member representing the North Carolina Oncology Society;
(13) One member representing the Association of North Carolina Cancer Registrars;
(14) One member representing the Medical Directors of the North Carolina Association of Health Plans; and
(15) Up to four additional members at large.

Except for the Secretary, the members shall be appointed for staggered four-year terms and until their successors are appointed and qualify. The Governor may remove any member of the Committee from office in accordance with the provisions of G.S. 143B-13. Members may succeed themselves for one term and may be appointed again after being off the Committee for one term."

LAPSED SALARY FUNDS REPORT

SECTION 12A.11. Section 10.20 of S.L. 2012-142 is repealed.

PRISON REPORT

SECTION 12A.12. G.S. 148-19(d) reads as rewritten:

"(d) The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall adopt standards for the delivery of mental health and mental retardation services to inmates in the custody of the Division of Adult Correction of the Department of Public Safety. The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall give the Secretary of Public Safety an opportunity to review and comment on proposed standards prior to promulgation of such standards; however, final authority to determine such standards remains with the Commission. The Secretary of the Department of Health and Human Services shall designate an agency or agencies within the Department of Health and Human Services to monitor the implementation by the Division of Adult Correction

of the Department of Public Safety of these standards and of substance abuse standards adopted by the Division of Adult Correction of the Department of Public Safety. ~~The Secretary of Health and Human Services shall send a written report on the progress which the Division of Adult Correction of the Department of Public Safety has made on the implementation of such standards to the Governor, the Lieutenant Governor, and the Speaker of the House. Such reports shall be made on an annual basis beginning January 1, 1978.~~"

MODIFICATIONS TO JUSTUS-WARREN TASK FORCE

SECTION 12A.13. G.S. 143B-216.60 reads as rewritten:

"**§ 143B-216.60. The Justus-Warren Heart Disease and Stroke Prevention Task Force.**

…

(e) The Task Force shall meet ~~at least quarterly or more frequently~~ not more than twice annually at the call of the Chair.

~~(f) The Task Force Chair may establish committees for the purpose of making special studies pursuant to its duties, and may appoint non-Task Force members to serve on each committee as resource persons. Resource persons shall be voting members of the committees and shall receive subsistence and travel expenses in accordance with G.S. 138-5 and G.S. 138-6. Committees may meet with the frequency needed to accomplish the purposes of this section.~~

…."

MODIFICATIONS TO COMMISSION FOR THE BLIND

SECTION 12A.14.(a) Eliminate Professional Advisory Committee. – Part 8 of Article 3 of Chapter 143B of the General Statutes is repealed.

SECTION 12A.14.(b) G.S. 143B-158 reads as rewritten:

"**§ 143B-158. Commission for the Blind.**

(a) The Commission for the Blind of the Department of Health and Human Services shall consist of ~~13~~19 members as follows:

(1) One representative of the Statewide Independent Living Council.

(2) One representative of a parent training and information center established pursuant to section 631(c) of the Individuals with Disabilities Education Act, 20 U.S.C. § 1431(c).

(3) One representative of the State's Client Assistance Program.

(4) One vocational rehabilitation counselor who has knowledge of and experience in vocational rehabilitation services for the blind. A vocational rehabilitation counselor appointed pursuant to this subdivision shall serve as a nonvoting member of the Commission if the counselor is an employee of the Department of Health and Human Services.

(5) One representative of community rehabilitation program services providers.

(6) One current or former applicant for, or recipient of, vocational rehabilitation services.

(7) One representative of a disability advocacy group representing individuals who are blind.

(8) One parent, family member, guardian, advocate, or authorized representative of an individual who is blind, has multiple disabilities, and either has difficulty representing himself or herself or who is unable, due to disabilities, to represent himself or herself.

(9) One representative of business, industry, and labor.

(10) One representative of the directors of projects carried out under section 121 of the Rehabilitation Act of 1973, 29 U.S.C. § 741, as amended, if there are any of these projects in the State.

(11) One representative of the Department of Public Instruction.
(12) One representative of the Commission on Workforce Development.
(12a) Two licensed physicians nominated by the North Carolina Medical Society whose practice is limited to ophthalmology.
(12b) Two optometrists nominated by the North Carolina State Optometric Society.
(12c) Two opticians nominated by the North Carolina Opticians Association.
(13) The Director of the Division of Services for the Blind shall serve as an ex officio, nonvoting member.

(b) The members of the Commission for the Blind shall be appointed by the Governor. The Governor shall appoint members after soliciting recommendations from representatives of organizations representing a broad range of individuals who have disabilities and organizations interested in those individuals. In making appointments to the Commission, the Governor shall consider, to the greatest extent practicable, the extent to which minority populations are represented on the Commission.

(c) ~~A~~ Except for individuals appointed to the Commission under subdivisions (12a), (12b), and (12c) of subsection (a) of this section, a majority of Commission members shall be persons who are blind, as defined in ~~G.S. 111-11. A majority of Commission members shall be persons who are~~ G.S. 111-11 and who are not employed by the Division of Services for the Blind.

(d) The Commission for the Blind shall select a Chairperson from among its members.

(e) The term of office of members of the Commission is three years. The term of members appointed under subdivisions (1), (2), (3), ~~and (4)~~ (4), and (12a) of subsection (a) of this section shall expire on June 30 of years evenly divisible by three. The term of members appointed under subdivisions (5), (6), (7), ~~and (8)~~ (8), and (12b) of subsection (a) of this section shall expire on June 30 of years that follow by one year those years that are evenly divisible by three. The term of members appointed under subdivisions (9), (10), (11), ~~and (12)~~ (12), and (12c) of subsection (a) of this section shall expire on June 30 of years that precede by one year those years that are evenly divisible by three.

(f) No individual may be appointed to more than two consecutive three-year terms. Upon the expiration of a term, a member shall continue to serve until a successor is appointed, as provided by G.S. 128-7. An appointment to fill a vacancy shall be for the unexpired balance of the term.

(g) A member of the Commission shall not vote on any issue before the Commission that would have a significant and predictable effect on the member's financial interest. The Governor shall have the power to remove any member of the Commission from office for misfeasance, malfeasance, or nonfeasance in accordance with the provisions of G.S. 143B-13 of the Executive Organization Act of 1973.

(h) The members of the Commission shall receive per diem and necessary travel and subsistence expenses in accordance with the provisions of G.S. 138-5.

(i) A majority of the Commission shall constitute a quorum for the transaction of business.

(j) All clerical and other services required by the Commission shall be supplied by the Secretary of Health and Human Services."

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

NC PRE-K

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. – The Division of Child Development and Early Education shall establish a standard decision-making process to be used by local NC Pre-K committees in awarding prekindergarten classroom slots and student selection.

SECTION 12B.1.(e) SEEK. – All prekindergarten classrooms shall be required to participate in the Subsidized Early Education for Kids (SEEK) accounting system to streamline the payment function for these classrooms with a goal of eliminating duplicative systems and streamlining the accounting and payment processes among the subsidy reimbursement systems. Prekindergarten funds transferred may be used to add these programs to SEEK.

SECTION 12B.1.(f) Pilot Program. – The Division of Child Development and Early Education shall create a pilot program that provides funding for NC Pre-K classrooms on a per classroom basis. The pilot program shall include three different NC Pre-K contractual regions that are geographically diverse. The local NC Pre-K administrator shall contract with the provider for operation of a classroom established pursuant to the pilot program. The Division shall provide a report on the status of the pilot program to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division no later than January 31, 2014. The report shall include the following:

(1) The number of students served.
(2) The amount of funds paid for each classroom.
(3) The amount of funds paid per student.
(4) The attendance information on students in the pilot program as compared to those students in a classroom having a traditional funding structure.
(5) Information on the number of students and students' families using the Subsidized Early Education for Kids (SEEK) system.
(6) A cost comparison of the classroom pilots to the average cost per student through the per student funding methodology.

SECTION 12B.1.(g) 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 Commission on Governmental Operations, 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.

COUNTY DEPARTMENTS OF SOCIAL SERVICES TO ADMINISTER CHILD CARE SUBSIDY

SECTION 12B.2.(a) It is the intent of the General Assembly to streamline services at the local level. To that end, only a county department of social services shall administer child care subsidy funds. Any child care subsidy funds previously administered by a local North Carolina Partnership for Children, Inc., partnership shall be administered by the county department of social services. Expenditures for child care subsidy, including North Carolina Partnership for Children, Inc., child care subsidy funds, for fiscal years 2013-2014 and 2014-2015 shall not be less than the expenditures for child care subsidy for the 2012-2013 fiscal year. Any administrative savings the Department of Health and Human Services, Division of Child Development and Early Education, can identify based on the administration of child care subsidy by county departments of social services shall be allocated to child care subsidy.

SECTION 12B.2.(b) The Department of Health and Human Services, Division of Child Development and Early Education, shall report on the implementation of the requirements of subsection (a) of this section to the Joint Legislative Committee on Health and Human Services and the Fiscal Research Division no later than April 1, 2014.

CHILD CARE SUBSIDY RATES

SECTION 12B.3.(a) The maximum gross annual income for initial eligibility, adjusted biennially, for subsidized child care services shall be seventy-five percent (75%) of the State median income, adjusted for family size.

SECTION 12B.3.(b) Fees for families who are required to share in the cost of care shall be established based on a percent of gross family income and adjusted for family size. Fees shall be determined as follows:

FAMILY SIZE	PERCENT OF GROSS FAMILY INCOME
1-3	10%
4-5	9%
6 or more	8%

SECTION 12B.3.(c) 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 (f) 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 (f) 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.3.(d) 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.3.(e) 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.3.(f) 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 nonstar rated programs, such as religious programs.

SECTION 12B.3.(g) 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 (f) 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.3.(h) Payment for subsidized child care services provided with Work First Block Grant funds shall comply with all regulations and policies issued by the Division of Child Development for the subsidized child care program.

SECTION 12B.3.(i) 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.3.(j) 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 ALLOCATION FORMULA

SECTION 12B.4.(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 seventy-five percent (75%) of the State median income.

(2) No county's allocation shall be less than ninety percent (90%) of its State fiscal year 2001-2002 initial child care subsidy allocation.

(3) For fiscal years 2013-2014 and 2014-2015, the Division of Child Development and Early Education shall base the formula identified in subdivision (1) of this subsection on the same data source used for the 2012-2013 fiscal year.

(4) 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 2013-2014 and 2014-2015 fiscal years.

SECTION 12B.4.(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.

CHILD CARE FUNDS MATCHING REQUIREMENTS

SECTION 12B.5. 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 a disaster as defined in G.S. 166A-19.3(6).

CHILD CARE REVOLVING LOAN

SECTION 12B.6. 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.7.(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 Development Fund Block Grant plan or eighty thousand dollars ($80,000), whichever is greater.

SECTION 12B.7.(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.

STUDY USE OF UNIQUE STUDENT IDENTIFIER/CHILD CARE SUBSIDY

SECTION 12B.8.(a) In coordination with the Department of Public Instruction (DPI), the Department of Health and Human Services, Division of Child Development and Early Education (DCDEE), shall study assigning a unique student identifier to monitor, throughout their education, the performance levels of children receiving child care subsidies. The study shall be designed to provide data on the efficacy of child care facilities participating in the child care subsidy program or the North Carolina Partnership for Children, Inc. The study shall define the requirements for the following:

(1) Establishing the unique identifier.
(2) Collecting, maintaining, and analyzing data.
(3) Recommending a solution that will allow for the cost-effective acquisition and maintenance of data from child care facilities.
(4) Recommending an interface with DPI applications that monitors and analyzes student performance.
(5) Estimating the cost for developing an interface and implementing the requirements identified in the study.

SECTION 12B.8.(b) DCDEE shall report the results of the study to the Joint Legislative Committee on Health and Human Services, the Joint Legislative Education Oversight Committee, the Joint Legislative Oversight Committee on Information Technology, and the Fiscal Research Division no later than April 1, 2014.

EARLY CHILDHOOD EDUCATION AND DEVELOPMENT INITIATIVES ENHANCEMENTS/SALARY SCHEDULE/MATCH REQUIREMENT ADJUSTMENTS

SECTION 12B.9.(a) Policies. – The North Carolina Partnership for Children, Inc., and its Board shall establish policies that focus the North Carolina Partnership for Children, Inc.'s mission on 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.9.(b) Administration. – Administrative costs shall be equivalent to, on an average statewide basis for all local partnerships, not more than eight percent (8%) 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 develop 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 shall be required to participate in the contract management system and shall be 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.9.(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.9.(d) Match Requirements. – It is the intent of the General Assembly to continue to increase the percentage of the match of cash and in-kind contributions required of the North Carolina Partnership for Children, Inc., and the local partnerships. 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 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 eleven percent (11%), and in-kind donated resources shall be equal to no more than three percent (3%) for a total match requirement of fourteen percent (14%) for the 2013-2014 fiscal year; and contributions of cash shall be equal to at least eleven percent (11%), and in-kind donated resources shall be equal to no more than four percent (4%) for a total match requirement of fifteen percent (15%) for the 2014-2015 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 Employment Security Commission 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 fourteen percent (14%) match by June 30 of the 2013-2014 fiscal year and a fifteen percent (15%) match by June 30 of the 2014-2015 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 Commission on Governmental Operations 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.9.(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 to be 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.9.(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.9.(g) Performance-Based Evaluation. – The Department of Health and Human Services shall continue to implement the performance-based evaluation system.

SECTION 12B.9.(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 State fiscal years 2013-2014 and 2014-2015 shall be administered and distributed in the following manner:

(1) Capital expenditures are prohibited for fiscal years 2013-2014 and 2014-2015. 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 fiscal years 2013-2014 and 2014-2015.

For fiscal years 2013-2014 and 2014-2015, 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.

SUBPART XII-C. DIVISION OF SOCIAL SERVICES

REVISE DATES/TANF BENEFIT IMPLEMENTATION

SECTION 12C.1.(a) The General Assembly approves the plan titled "North Carolina Temporary Assistance for Needy Families State Plan 2012-2015," 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, 2012, through September 30, 2015. The Department shall submit the State Plan, as revised in accordance with subsection (b) of this section and as amended by this act or any other act of the 2013 General Assembly, 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 2012-2015, 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 2012 through 2015 pursuant to G.S. 108A-27(e) shall operate under the Electing County budget requirements effective July 1, 2012. For programmatic purposes, all counties referred to in this subsection shall remain under their current county designation through September 30, 2015.

SECTION 12C.1.(d) For the 2013-2014 fiscal year, Electing Counties shall be held harmless to their Work First Family Assistance allocations for the 2012-2013 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 2013-2014 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 Commission on Governmental Operations, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations 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) in such a manner that no additional expenses are incurred beyond the funds budgeted for foster care. 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) Of the funds appropriated from the General Fund to the Department of Health and Human Services, the sum of five hundred forty-seven thousand two hundred forty-five dollars ($547,245) for the 2013-2014 fiscal year and six hundred ten thousand eight hundred seventeen dollars ($610,817) for the 2014-2015 fiscal year shall be used to expand support for the child welfare postsecondary support program 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 by providing assistance with the "cost of attendance" as that term is defined in 20 U.S.C. § 108711. 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 2013-2014 fiscal year and the sum of fifty thousand dollars ($50,000) for the 2014-2015 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 2013-2014 fiscal year and the sum of three hundred thirty-nine thousand four hundred ninety-three dollars ($339,493) for the 2014-2015 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.

REQUIRE DRUG TESTING/WORK FIRST PROGRAM ASSISTANCE

SECTION 12C.6.(a) G.S. 108A-29.1 reads as rewritten:

"**§ 108A-29.1. ~~Substance abuse treatment required; drug~~ Drug testing required for Work First Program applicants and recipients.**

(a) ~~Each applicant or current recipient of Work First Program benefits, determined by a Qualified Professional in Substance Abuse (QPSA) or by a physician certified by the American Society of Addiction Medicine (ASAM) to be addicted to alcohol or drugs and to be in need of professional substance abuse treatment services shall be required, as part of the person's MRA and as a condition to receiving Work First Program benefits, to participate satisfactorily in an individualized plan of treatment in an appropriate treatment program. As a mandatory program component of participation in an addiction treatment program, each applicant or current recipient shall be required to submit to an approved, reliable, and professionally administered regimen of testing for presence of alcohol or drugs, without advance notice, during and after participation, in accordance with the addiction treatment program's individualized plan of treatment, follow-up, and continuing care services for the applicant or current recipient.~~The Department shall require a drug test to screen each applicant for or recipient of Work First Program assistance. The cost of the drug testing is the responsibility of the individual tested. The Department shall provide notice of drug testing to each applicant or recipient. The notice shall advise the applicant or recipient that drug testing will be conducted as a condition of receiving Work First Program assistance, and that the results of the drug tests will remain confidential and will not be released to law enforcement. The applicant or recipient shall be advised that the required drug testing may be avoided if the applicant or recipient does not apply for Work First Program assistance. Dependent children under the age of 18 are exempt from the requirements of this section. The Department shall require the following:

(1) That for two-parent households, both parents comply with the drug testing requirement.

(2) That any teen parent who is emancipated pursuant to Article 35 of Chapter 7B of the General Statutes comply with the drug testing requirement.

(3) That each applicant or recipient be advised before testing that he or she may inform the agent administering the test of any prescription or over-the-counter medication he or she is taking.

(4) That each applicant or recipient being tested sign a written acknowledgement that he or she has received and understood the notice and advice provided under this subsection.

(5) That each applicant or recipient who fails a drug test understands that he or she has the right to take one or more additional tests.

(b) ~~An applicant or current recipient who fails to comply with any requirement imposed pursuant to this section shall not be eligible for benefits or shall be subject to the termination of benefits, but shall be considered to be receiving benefits for purposes of determining eligibility for medical assistance.~~For an applicant or current recipient who tests negative for controlled substances, the Department shall increase the amount of the initial Work First Program assistance by the amount paid by the applicant or recipient for the drug testing. An applicant or recipient who tests positive for controlled substances as a result of a drug test required under this section is ineligible to receive Work First Program assistance for one year from the date of the positive drug test, except as provided in subsection (b1) of this section. The individual may reapply after one year. However, if the individual has any subsequent positive drug tests, the individual shall be ineligible for benefits for three years from the date of the subsequent positive drug test unless the individual reapplies pursuant to subsection (b1) of this section.

(b1) An applicant or recipient deemed ineligible may reapply for Work First Program assistance if the individual can document the successful completion of a substance abuse treatment program offered by a provider under subsection (e) of this section and licensed by the Department. The applicant or recipient who reapplies for Work First Program assistance after completion of a substance abuse program shall pass a drug test. The cost of any drug testing and substance abuse program provided under this subsection shall be the responsibility of the applicant or recipient being tested and receiving treatment. An applicant or recipient who reapplies for Work First Program assistance pursuant to this subsection may reapply one time only.

(c) The children of any applicant or current recipient shall remain eligible for benefits, and these benefits shall be paid to a protective payee pursuant to G.S. 108A-38.

(d) ~~An applicant or current recipient shall not be regarded as failing to comply with the requirements of this section if an appropriate drug or alcohol treatment program is unavailable.~~The Social Services Commission shall adopt rules pertaining to the testing of applicants and recipients under this section.

(e) Area mental health authorities organized pursuant to Article 4 of Chapter 122C of the General Statutes shall be responsible for administering the provisions of this section.

~~(f) The requirements of this section may be waived or modified as necessary in the case of individual applicants or recipients to the degree necessary to comply with Medicaid eligibility provisions.~~"

SECTION 12C.6.(b) The Department of Health and Human Services, Division of Social Services, shall report to the Joint Legislative Committee on Health and Human Services and the Fiscal Research Division no later than April 1, 2014, on the implementation of this section.

SECTION 12C.6.(c) This section becomes effective November 1, 2013.

DSS STUDY/PROCEDURES FOR REPORTING CHILD ABUSE

SECTION 12C.7.(a) The Department of Health and Human Services, Division of Social Services, shall study the policies and procedures in place for reporting child abuse. In conducting the study, the Division shall review the following:

(1) Reports of child abuse in child care facilities.
(2) How reports of child abuse are received.
(3) The number of inaccurate reports of child abuse the Division receives annually.
(4) The number of children the Division has placed in child protective services pursuant to a report of child abuse.
(5) The reasons a child is placed in child protective services pursuant to a report of child abuse.
(6) The procedures the Division follows after determining child abuse has occurred as well as the procedures the Division follows after determining child abuse has not occurred.
(7) The number of reports the Division has determined to be false and a summary of actions taken in response to false reports.
(8) Procedures and actions the Division follows in removing or redacting reports or other information made available to the public regarding an individual accused of child abuse or a child care facility where the alleged abuse occurred when there is a determination that no abuse has occurred.
(9) Any recommendations the Division has for improving the process for reporting instances of child abuse.

SECTION 12C.7.(b) The Division of Social Services shall report the results of the study and any recommendations to the Joint Legislative Committee on Health and Human Services and the Fiscal Research Division no later than April 1, 2014.

CODIFY WORK FIRST FAMILY ASSISTANCE ELIGIBILITY AND PAYMENT LEVELS

SECTION 12C.8. Part 2 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read as follows:

"**§ 108A-27A. Income eligibility and payment level for Work First Family Assistance.**

The maximum net family annual income eligibility standards for Work First Family Assistance are the same standards of need for eligibility for the categorically needy under the Medicaid Program, as provided in the eligibility table found in G.S. 108-54.6(a). The payment level for Work First Family Assistance shall be fifty percent (50%) of the standard of need."

SUBPART XII-D. DIVISION OF AGING AND ADULT SERVICES

STATEWIDE IMPLEMENTATION OF PROJECT C.A.R.E.

SECTION 12D.1.(a) Funds appropriated in this act to the Department of Health and Human Services, Division of Aging & Adult Services, for the 2013-2015 fiscal biennium for the Caregiver Alternatives to Running On Empty project (Project C.A.R.E.) shall be used to support Alzheimer's-related activities consistent with the goals of Project C.A.R.E. in all 100 counties. By no later than December 31, 2013, the Department shall submit a report on the progress of statewide implementation of Project C.A.R.E. to the Joint Legislative Oversight Committee on Health and Human Services, the Fiscal Research Division, and the Governor's Advisory Council on Aging.

SECTION 12D.1.(b) Section 10.35B of S.L. 2010-31 is repealed.

TIERED STATE-COUNTY SPECIAL ASSISTANCE PILOT

SECTION 12D.2.(a) It is the intent of the General Assembly to create a State-County Special Assistance program that allows counties greater flexibility in serving individual needs within their communities and greater control over how county funds are used to support this program in light of the fact that counties are required to pay for fifty percent (50%) of the costs of this program. To that end, the General Assembly directs the Department of Health and Human Services to establish a pilot program in accordance with subsection (b) of this section.

SECTION 12D.2.(b) The Department of Health and Human Services, Division of Aging and Adult Services, shall establish a pilot program to implement a tiered rate structure within the State-County Special Assistance program for individuals residing in group homes, in-home living arrangements, and assisted living residences as defined in G.S. 131D-2.1. The purposes of the pilot program are to (i) determine the best way to implement a block grant for this program statewide and (ii) test the feasibility and effectiveness of implementing a tiered rate structure to address program participants' intensity of need, including medication management. The Department shall select a minimum of four and a maximum of six counties to participate in the pilot program, at least two of which shall be rural counties and at least two of which shall be urban counties. The pilot program shall be implemented during the 2013-2014 fiscal year for at least a 12-month period.

SECTION 12D.2.(c) The Department shall implement the pilot program in collaboration with the local departments of social services in the counties selected for participation. As part of the pilot program, the selected counties shall receive a State General Fund allocation as a block grant to be equally matched with county general funds. The General Fund allocation provided to each county participating in the pilot program shall be calculated based upon the average annual Special Assistance expenditures for that county during the 2011-2013 fiscal biennium, adjusted for the amount of projected annual growth in the number of Special Assistance recipients in that county during the 2013-2015 fiscal biennium. These funds may be used to pay for room, board, and personal care services, including medication management, for individuals eligible to receive State-County Special Assistance, subject to the following limitations and requirements:

(1) These funds shall not be used to cover any portion of the cost of providing services for which an individual receives Medicaid coverage.

(2) The pilot program shall comply with all federal and State requirements governing the existing State-County Special Assistance program.

(3) The tiered rate structure shall be based upon intensity of need, and an individual's placement within a tier shall be based upon an independent assessment of the individual's need for room, board, and assistance with activities of daily living, including medication management.

SECTION 12D.2.(d) By no later than February 1, 2014, the Department shall submit a progress report on the implementation and operation of the pilot program, including any obstacles to implementation; and by no later than February 1, 2015, the Department shall submit a final report on the results of the pilot program, along with any recommendations based on these results, to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division. The report due by February 1, 2015, shall include information from all participating counties on at least all of the following:

(1) The amount of the tiered rates implemented as part of the pilot program.

(2) The cost methodology for determining these tiered rates.

(3) The number of individuals participating in the pilot program while residing in a group home.

(4) The number of individuals participating in the pilot program while residing in an in-home living arrangement.

(5) The number of individuals participating in the pilot program while residing in an assisted living residence as defined by G.S. 131D-2.1, broken down by facility type.

(6) A comparison of the number of recipients of State-County Special Assistance prior to and during the pilot program, broken down by county and living arrangement.

(7) Any other information the Department deems relevant for determining the best way to implement a block grant statewide for the State-County Special Assistance program.

SECTION 12D.2(e). As used in this section, the term "group home" means any facility that (i) is licensed under Chapter 122C of the General Statutes, (ii) meets the definition of a supervised living facility under 10A NCAC 27G .5601, and (iii) serves adults whose primary diagnosis is mental illness or a developmental disability but may also have other diagnoses.

SUBPART XII-E. DIVISION OF PUBLIC HEALTH

INCREASE PERMIT FEES FOR CERTAIN FOOD AND LODGING ESTABLISHMENTS

SECTION 12E.1.(a) G.S. 130A-247 is amended by adding a new subdivision to read:

"(8) "Temporary food establishment" means an establishment not otherwise exempted from this part pursuant to G.S. 130A-250 that (i) prepares or serves food, (ii) operates for a period of time not to exceed 21 days in one location, and (iii) is affiliated with and endorsed by a transitory fair, carnival, circus, festival, or public exhibition."

SECTION 12E.1.(b) G.S. 130A-248(d) reads as rewritten:

"(d) The Department shall charge each establishment subject to this section, except nutrition programs for the elderly administered by the Division of Aging and Adult Services of the Department of Health and Human Services, establishments that prepare and sell meat food products or poultry products, temporary food establishments, limited food services establishments, and public school cafeterias, a fee of ~~seventy-five~~one hundred twenty dollars ~~($75.00)~~($120.00) for each permit issued. This fee shall be reassessed annually for permits that do not expire. The Commission shall adopt rules to implement this subsection. Fees collected under this subsection shall be used for State and local food, lodging, and institution sanitation programs and activities. No more than ~~thirty-three and one-third percent (33 1/3%) of the fees~~fifty dollars ($50.00) of each fee collected under this subsection may be used to support State health programs and activities."

SECTION 12E.1.(c) G.S. 130A-248(d1) reads as rewritten:

"(d1) The Department shall charge a twenty-five dollar ($25.00) late payment fee to any establishment subject to this section, except nutrition programs for the elderly administered by the Division of Aging of the Department of Health and Human Services, establishments that prepare and sell meat food products or poultry products, temporary food establishments, limited food services establishments, and public school cafeterias, that fails to pay the fee required by subsection (d) of this section within 45 days after billing by the Department. The Department may, in accordance with G.S. 130A-23, suspend the permit of an establishment that fails to pay the required fee within 60 days after billing by the Department. The Department shall charge a reinstatement fee of one hundred fifty dollars ($150.00) to any establishment that requests reinstatement of its permit after the permit has been suspended. The Commission shall adopt rules to implement this subsection.

The clear proceeds of civil penalties collected pursuant to this subsection shall be remitted to the Civil Penalty and Forfeiture Fund in accordance with G.S. 115C-457.2."

SECTION 12E.1.(d) G.S. 130A-248 is amended by adding a new subsection to read:

"(d2) A local health department shall charge each temporary food establishment and each limited food services establishment a fee of seventy-five dollars ($75.00) for each permit issued. A local health department shall use all fees collected under this subsection for local food, lodging, and institution sanitation programs and activities."

SECTION 12E.1.(e) Subsections (a) through (d) of this section become effective on July 1, 2013, and apply to food and lodging permits effective or reassessed on or after July 1, 2013.

SECTION 12E.1.(f) Section 31.11A of S.L. 2011-145, as amended by Section 61A of S.L. 2011-391 and Section 10.15 of S.L. 2012-142, is repealed.

MODIFICATIONS TO ORAL HEALTH STRATEGY

SECTION 12E.2.(a) It is the intent of the General Assembly to redirect the resources of the Oral Health Section within the Department of Health and Human Services, Division of Public Health, to provide direct clinical care in dental clinics operated or sponsored by local health departments.

SECTION 12E.2.(b) Effective October 1, 2013, the Secretary of Health and Human Services shall eliminate 39 full-time equivalent dental hygienist positions, two full-time equivalent dental equipment technician positions, and seven full-time equivalent administrative positions within the Oral Health Section of the Division of Public Health. The Secretary shall reallocate the funds that become available as a result of eliminating the 39 full-time equivalent dental hygienist positions and the two full-time equivalent dental equipment technician positions in the form of grants-in-aid to local health departments that operate or sponsor dental clinics. The local health departments shall use these grants-in-aid for the sole purpose of hiring dental hygienists or dental assistants to provide direct clinical care in the dental clinics operated or sponsored by the local health departments.

SECTION 12E.2.(c) By no later than February 1, 2014, the Department shall submit a revised statewide oral health strategic plan to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division. The plan shall include at least all of the following:

(1) Recommendations for reorganizing the Department's Oral Health Section.
(2) Strategies for reducing oral diseases through prevention, education, and health promotion services.
(3) Strategies for monitoring public oral health.
(4) Strategies for increasing access to dental care.

FUNDS FOR SCHOOL NURSES

SECTION 12E.3.(a) All 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 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.3.(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.

SECTION 12E.3.(c) Section 6.9(b) of S.L. 2011-145, as amended by Section 6.2 of S.L. 2012-142, is repealed.

CHILDREN'S DEVELOPMENTAL SERVICE AGENCIES

SECTION 12E.4. In order to reduce the amount of State funds appropriated for the Children's Developmental Service Agencies (CDSAs) program, the Department of Health and Human Services, Division of Public Health, shall close four CDSAs, effective July 1, 2014. The Department shall retain the CDSAs with the highest caseloads of children residing in rural and medically underserved areas. By no later than March 1, 2014, the Department shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division identifying the four CDSAs selected for closure in accordance with this section.

AIDS DRUG ASSISTANCE PROGRAM

SECTION 12E.5.(a) 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).

SECTION 12E.5.(b) By no later than April 1, 2014, and by no later than April 1, 2015, the Department of Health and Human Services, Division of Public Health, shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on all of the following:

(1) Use of the funds appropriated to support ADAP for the preceding fiscal year.
(2) Steps taken by DHHS to reduce the waiting list for ADAP.
(3) Alternative options for serving individuals diagnosed with HIV/AIDS who are eligible to receive services under ADAP, including the State Medicaid

program and the federally facilitated Health Benefit Exchange that will operate in this State.

COMMUNITY-FOCUSED ELIMINATING HEALTH DISPARITIES INITIATIVE

SECTION 12E.6.(a) Funds appropriated in this act to the Department of Health and Human Services, Division of Public Health, for the Community-Focused Eliminating Health Disparities Initiative (CFEHDI) shall be used to provide a maximum of 12 grants-in-aid to close the gap in the health status of African-Americans, Hispanics/Latinos, and American Indians as compared to the health status of white persons. These grants-in-aid shall 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, and cancer. The Office of Minority Health shall coordinate and implement the grants-in-aid program authorized by this section.

SECTION 12E.6.(b) In implementing the grants-in-aid program authorized by subsection (a) of this section, the Department shall ensure all of the following:

(1) The amount of any grant-in-aid is limited to three hundred thousand dollars ($300,000).

(2) Only community-based organizations, faith-based organizations, local health departments, hospitals, and CCNC networks located in urban and rural areas of the western, eastern, and Piedmont areas of this State are eligible to apply for these grants-in-aid. No more than four grants-in-aid shall be awarded to applicants located in any one of the three areas specified in this subdivision.

(3) 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.

(4) 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-in-aid under this section to affect change in the health status of African-Americans, Hispanics/Latinos, or American Indians:
   a. Heart Disease.
   b. Stroke.
   c. Diabetes.
   d. Obesity.
   e. Asthma.
   f. HIV/AIDS.
   g. Cancer.

(5) The minimum duration of the grant period for any grant-in-aid is two years.

(6) The maximum duration of the grant period for any grant-in-aid is three years.

(7) If approved for a grant-in-aid, 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 subsection (a) of this section.

(8) 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-in-aid. The Department shall establish the independent panel required by this section.

SECTION 12E.6.(c) The grants-in-aid awarded under this section 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.

SECTION 12E.6.(d) Section 10.21(d) of S.L. 2011-145 reads as rewritten:

"**SECTION 10.21.(d)** By ~~October 1, 2012, and annually thereafter,~~October 1, 2013, the Department shall submit a report to ~~the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services,~~ the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on funds appropriated to the CFEHDI. The report shall include specific activities undertaken pursuant to subsection (a) of this section 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:

(1) Which community-based organizations, faith-based organizations, local health departments, hospitals, and CCNC networks received CFEHDI grants-in-aid.

(2) The amount of funding awarded to each grantee.

(3) Which of the minority populations were served by each grantee.

(4) Which community-based organizations, faith-based organizations, local health departments, hospitals, and CCNC networks 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 the CFEHDI program.

(5) 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."

STRATEGIES FOR IMPROVING MEN'S HEALTH

SECTION 12E.7. Article 7 of Chapter 130A of the General Statutes is amended by adding a new Part to read:

"Part 5A. Men's Health.

"**§ 130A-223.1. Department to establish strategies for improving men's health.**

The Department of Health and Human Services, Division of Public Health, Chronic Disease and Injury Prevention Section, shall work to expand the State's attention and focus on the prevention of disease and improvement in the quality of life for men over their entire lifespan. The Department shall develop strategies for achieving these goals, which shall include, but not be limited to, all of the following:

(1) Developing a strategic plan to improve health care services.

(2) Building public health awareness.

(3) Developing initiatives within existing programs.

(4) Pursuing federal and State funding for the screening, early detection, and treatment of prostate cancer and other diseases affecting men's health."

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

ESTABLISH STATEWIDE TELEPSYCHIATRY PROGRAM

SECTION 12F.1.(a) By no later than October 1, 2013, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall develop and submit a plan for implementation of a statewide telepsychiatry program to the Joint Legislative Oversight Committee on Health and Human

Services and the Fiscal Research Division. The plan shall be substantially similar to the Albemarle Hospital Foundation telepsychiatry program currently operating in 12 hospitals in eastern North Carolina and include at least all of the following:

(1) Specific steps to be taken by the Department, within a specified time period, to establish and administer the program statewide.

(2) Program costs and rates of payment for telepsychiatry services.

(3) Recommendations for addressing liability issues related to participation in telepsychiatry.

SECTION 12F.1.(b) Chapter 122C of the General Statutes is amended by adding a new Article to read:

"Article 1B.

"Statewide Telepsychiatry Program.

"**§ 122C-20.5. Department to establish statewide telepsychiatry program.**

(a) The following definitions apply in this section:

(1) Consultant site. – The site at which the consulting provider is physically located at the time the consulting provider delivers the acute mental health or substance abuse care by means of telepsychiatry.

(2) Referring site. – A hospital licensed under Chapter 131E of the General Statutes at which a patient experiencing an acute mental health or substance abuse crisis is physically located.

(3) Telepsychiatry. – The delivery of acute mental health or substance abuse care, including diagnosis or treatment, by means of two-way real-time interactive audio or video by a consulting provider at a consultant site to an individual patient at a referring site. The term does not include the standard use of telephones, facsimile transmissions, unsecured electronic mail, or a combination of these in the course of care.

(4) Consulting provider. – A physician or other health care provider licensed in this State to provide acute mental health or substance abuse care.

(b) By no later than January 1, 2014, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall establish a statewide telepsychiatry program that allows referring sites to utilize consulting providers at a consultant site to provide timely psychiatric assessment and rapid initiation of treatment for patients at the referring site experiencing an acute mental health or substance abuse crisis.

(c) The Commission shall adopt rules necessary to implement this section. The rules shall specify at least all of the following:

(1) Requirements to ensure the health and safety of patients.

(2) Participation and equipment requirements for consultant sites, consulting providers, and referring sites.

(3) Rates of payment for telepsychiatry services.

(d) The Department shall periodically evaluate the effectiveness of the statewide telepsychiatry program."

SECTION 12F.1.(c) G.S. 143B-147(a)(1) is amended by adding a new sub-subdivision to read:

"(1) To adopt rules regarding the

…

g. Statewide telepsychiatry program established pursuant to G.S. 122C-20.5."

SECTION 12F.1.(d) 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 2013-2015 fiscal biennium for the statewide telepsychiatry program shall be used for the following purposes:

(1) To establish and administer the statewide telepsychiatry program authorized in G.S. 122C-20.5.
(2) To purchase needed telepsychiatry equipment for State-owned and State-operated hospitals participating in the statewide telepsychiatry program.
(3) To contract with an outside vendor for management of the statewide telepsychiatry program.

FUNDS FOR LOCAL INPATIENT PSYCHIATRIC BEDS OR BED DAYS

SECTION 12F.2.(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 thirty-eight million one hundred twenty-one thousand six hundred forty-four dollars ($38,121,644) for the 2013-2014 fiscal year and the sum of thirty-eight million one hundred twenty-one thousand six hundred forty-four dollars ($38,121,644) for the 2014-2015 fiscal year shall be used to purchase additional local inpatient psychiatric beds or bed days not currently funded by or though LME/MCOs. 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.2.(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 distributed across the State in LME/MCO catchment areas and according to need as determined by the Department. 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.2.(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.2.(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.2.(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.2.(f) Reporting by Department. – By no later than March 1, 2014, 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 fiscal year ending June 30, 2013, 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.

SECTION 12F.2.(g) Repeal of Hospital Utilization Pilot. – Sections 10.49(s1) through 10.49(s5) of S.L. 2007-323 are repealed.

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 2013-2015 fiscal biennium for the North Carolina Child Treatment Program (NC CTP) shall be used for the following purposes:

(1) To provide clinical training and coaching to licensed Medicaid 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) Nonrecurring 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 2013-2015 fiscal biennium for the North Carolina Child Treatment Program (NC CTP) shall be used to pay for the cost of developing a secure database for the NC CTP to track individual-level and aggregate-level data with interface capability to work with existing networks within State agencies. The database shall be the property of the State and shall be hosted on State infrastructure. Any data or product that is part of, or derived from, this database shall be and will remain the sole property of the State.

SINGLE STREAM FUNDING FOR MH/DD/SAS COMMUNITY SERVICES

SECTION 12F.4.(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, 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.4.(b) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall periodically review and, as deemed necessary by the Department, update the set of standardized covered benefits developed and implemented by the Department pursuant to Section 10.11(b) of S.L. 2011-145 for recipients of LME/MCO community service funds; provided, however, the Department shall not implement any updates that increase the overall cost of these standardized covered benefits.

MH/DD/SAS HEALTH CARE INFORMATION SYSTEM PROJECT

SECTION 12F.5. The Department of Health and Human Services shall not take any further action or expend any funds appropriated or available to the Department to develop and implement the health care information system for State facilities operated by the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. By no later than March 1, 2014, the Department shall submit a detailed plan of this system to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Information Technology, and the Fiscal Research Division. The plan shall include an explanation of at least all of the following:

(1) The process the Department used to select the Veterans Health Information Systems and Technology Architecture (VisTA), whether or not the selection process was competitive, and if not, why it was not.
(2) Requirements for vendor services to support system implementation and operation and the costs associated with this support.
(3) Governance structure for the system.
(4) Modules to be implemented in each facility and the reason for each.
(5) Assignment of responsibility for system maintenance, codes fixes, application upgrades, and hardware upgrades.
(6) Whether the application and database will be implemented at each facility or centrally managed by the Department and the reasons for the decision.
(7) Identification of additional hardware that will be required to support a statewide rollout and the location at which the Department plans to host it.
(8) Assignment of responsibility for backup and recovery.
(9) If there will be redundant failover between facilities.
(10) Plans, time lines, and costs for implementing any other modules currently offered by the United State Department of Veterans Affairs.
(11) A process for ensuring that the system software is upgraded whenever the United States Department of Veterans Affairs upgrades its system.
(12) Technology constraints for VisTA and State-supported facilities and how they will be addressed, by facility.
(13) Facility on-boarding plan for the State psychiatric hospitals and other State facilities operated by the Division.
(14) Costs and sources of funding for planning, development, and implementation at each facility and five years of costs and sources of funding for operations and maintenance at each facility.
(15) Any other costs associated with system planning, development, implementation, operation, and maintenance.
(16) Any issues associated with the planning, development, and implementation, identified by the Department, the Office of the State Chief Information Officer, the Office of Information Technology Services, or the Office of State Budget and Management, with a solution for each identified issue.

LME/MCO FUNDS FOR SUBSTANCE ABUSE SERVICES

SECTION 12F.6.(a) LME/MCOs shall use a portion of their allocated funds for substance abuse treatment services to support prevention and education activities at a level at least equivalent to the 2012-2013 fiscal year.

SECTION 12F.6.(b) In providing treatment and services for adult offenders and increasing the number of Treatment Accountability for Safer Communities (TASC) case managers, local management entities shall consult with TASC to improve offender access to substance abuse treatment and match evidence-based interventions to individual needs at each stage of substance abuse treatment. Special emphasis should be placed on intermediate

punishment offenders, community punishment offenders at risk for revocation, and Department of Correction releases who have completed substance abuse treatment while in custody.

The Department shall allocate up to three hundred thousand dollars ($300,000) 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, to provide substance abuse services for adult offenders and to increase the number of TASC case managers. These funds shall be allocated to TASC before funds are allocated to LMEs for mental health services, substance abuse services, and crisis services.

CLOSE STATE-OPERATED ALCOHOL & DRUG ABUSE TREATMENT CENTERS

SECTION 12F.7.(a) The Department of Health and Human Services shall not allow any new admissions or readmissions to State-operated alcohol and drug abuse treatment centers (ADATCs) after June 30, 2013.

SECTION 12F.7.(b) By no later than September 30, 2013, the Department shall permanently cease operations at all State-operated ADATCs and close these facilities.

SECTION 12F.7.(c) The sum of ten million dollars ($10,000,000) appropriated in this act for the 2013-2014 fiscal year and the sum of twenty million dollars ($20,000,000) appropriated in this act for the 2014-2015 fiscal year from the savings achieved as a result of closing the State-operated ADACTs shall be used to increase the allocations provided to the LME/MCOs. LME/MCOs shall use these funds to provide community-based and residential alcohol and substance abuse treatment services. LME/MCOs shall not use these funds to supplant other State, local, or block grant funds provided for this purpose.

SEVERANCE & RELOCATION FOR AREA DIRECTORS

SECTION 12F.8. G.S. 122C-121(a2) reads as rewritten:

"(a2) The area board shall not provide the director with any benefits that are not also provided by the area board to all permanent employees of the area ~~program.~~program, except that the area board may, in its discretion, offer severance benefits, relocation expenses, or both to an applicant for the position of director as an incentive for the applicant to accept an offer of employment. The director shall be reimbursed only for allowable employment-related expenses at the same rate and in the same manner as other employees of the area program."

SUBPART XII-G. DIVISION OF HEALTH SERVICE REGULATION

THREE-YEAR MORATORIUM ON SPECIAL CARE UNIT LICENSES

SECTION 12G.1. For the period beginning July 1, 2013, and ending July 1, 2016, the Department of Health and Human Services, Division of Health Service Regulation, 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 three-year 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.

ELIMINATE COMPREHENSIVE REPORT ON MEDICATION-RELATED ERRORS IN NURSING HOMES

SECTION 12G.2.(a) G.S. 131E-128.1(e) reads as rewritten:

"(e) Confidentiality. – The meetings or proceedings of the advisory committee, the records and materials it produces, and the materials it considers, including analyses and reports pertaining to medication-related error reporting under G.S. 131E-128.2 ~~and G.S. 131E-128.5~~ and pharmacy reports on drug defects and adverse reactions under G.S. 131E-128.4, shall be confidential and not be considered public records within the meaning of G.S. 132-1. The meetings or proceedings and records and materials also shall not be subject to discovery or introduction into evidence in any civil action against a nursing home or a provider of professional health services resulting from matters that are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall testify in any civil action as to any evidence or other matters produced or presented during the meetings or proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. Notwithstanding the foregoing:

(1) Information, documents, or records otherwise available, including any deficiencies found in the course of an inspection conducted under G.S. 131E-105, shall not be immune from discovery or use in a civil action merely because they were presented during meetings or proceedings of the advisory committee. A member of the advisory committee or a person who testifies before the committee may testify in a civil action but cannot be asked about that person's testimony before the committee or any opinion formed as a result of the committee meetings or proceedings.

(2) Information that is confidential and not subject to discovery or use in civil actions under this subsection may be released to a professional standards review organization that performs any accreditation or certification function. Information released to the professional standards review organization shall be limited to information reasonably necessary and relevant to the standards review organization's determination to grant or continue accreditation or certification. Information released to the standards review organization retains its confidentiality and is not subject to discovery or use in any civil action as provided under this subsection. The standards review organization shall keep the information confidential subject to this subsection.

(3) Information that is confidential and not subject to discovery or use in civil actions under this subsection may be released to the Department of Health and Human Services pursuant to its investigative authority under G.S. 131E-105. Information released to the Department shall be limited to information reasonably necessary and relevant to the Department's investigation of compliance with Part 1 of Article 6 of this Chapter. Information released to the Department retains its confidentiality and is not subject to discovery or use in any civil action as provided in this subsection. The Department shall keep the information confidential subject to this subsection.

(4) Information that is confidential and is not subject to discovery or use in civil actions under this subsection may be released to an occupational licensing board having jurisdiction over the license of an individual involved in an incident that is under review or investigation by the advisory committee. Information released to the occupational licensing board shall be limited to information reasonably necessary and relevant to an investigation being conducted by the licensing board pertaining to the individual's involvement in the incident under review by the advisory committee. Information released to an occupational licensing board retains its confidentiality and is not subject to discovery or use in any civil action as provided in this

subsection. The occupational licensing board shall keep the information confidential subject to this subsection."

SECTION 12G.2.(b) G.S. 131E-128.1(g) reads as rewritten:

"(g) Penalty. – The Department may take adverse action against the license of a nursing home upon a finding that the nursing home has failed to comply with this section, G.S. 131E-128.2, 131E-128.3, ~~131E-128.4, or 131E-128.5.~~or 131E-128.4."

SECTION 12G.2.(c) G.S. 131E-128.5 is repealed.

CERTIFICATE OF NEED EXEMPTION FOR REPLACEMENT EQUIPMENT & REPLACEMENT FACILITIES ON THE MAIN CAMPUS OF A CON-APPROVED HEALTH SERVICE FACILITY

SECTION 12G.3.(a) G.S. 131E-184 is amended by adding a new subsection to read:

"(f) The Department shall exempt from certificate of need review the purchase of any replacement equipment that exceeds the two million dollar ($2,000,000) threshold set forth in G.S. 131E-176(22) and any capital expenditure that exceeds the two million dollar ($2,000,000) threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

(1) For replacement equipment, if the replacement equipment is to be used on the main campus of a licensed health service facility that has already obtained certificate of need approval.

(2) For a capital expenditure, if the sole purpose of the capital expenditure is to replace an existing health service facility on the main campus of a licensed health service facility that has already obtained certificate of need approval and the capital expenditure does not result in (i) a change in bed capacity as defined in G.S. 131E-176(5) or (ii) the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.

(3) The licensed health service facility proposing to purchase the replacement equipment or incur the capital expenditure shall provide prior written notice to the Department, along with supporting documentation to demonstrate that it meets the exemption criteria of this subsection."

SECTION 12G.3.(b) This section applies to replacement equipment purchased and capital expenditures incurred on or after July 1, 2013.

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

DETAILED MEDICAID REFORM PROPOSAL TO BE PREPARED BY DEPARTMENT OF HEALTH AND HUMAN SERVICES

SECTION 12H.1.(a) The Department of Health and Human Services, Division of Medical Assistance, (Department) shall create a detailed plan for, but not implement, significant reforms to the State's Medicaid Program that shall accomplish the following:

(1) Create a predictable and sustainable Medicaid program for North Carolina taxpayers.

(2) Increase administrative ease and efficiency for North Carolina Medicaid providers.

(3) Provide care for the whole person by uniting physical and behavioral health care.

SECTION 12H.1.(b) The Department shall submit its detailed proposal of how to reform the State's Medicaid Program to the General Assembly. The report shall contain the following:

(1) The details of the reform plan, including how the plan would accomplish the goals set out in subsection (a) of this section.
(2) The Department's methodology for selecting the reform plan over alternatives.
(3) Forecasts of the reform plan's potential to slow the growth of the costs of the Medicaid Program, including the assumptions and methodology used for the forecast, as well as an explanation of how the Department's forecast methodology has been improved to produce more accurate forecasting than in prior years.
(4) The reform plan's impact, as compared to the existing Medicaid Program, on both providers and recipients in areas such as enrollment within the Medicaid system, access to services, quality of care, and payment methodologies, and any other areas of comparison to help the General Assembly evaluate the reform plan.
(5) If regional demonstration projects, pilot projects, or similar projects will be used to test a proposal, how the Department will ensure that the test methodology is scientifically valid and consistent with social science research methods.
(6) How financial risks will be allocated under the reform plan.
(7) The mechanisms through which the Department and any contractors under the reform plan would be held accountable for the implementation and performance of the plan.
(8) Short-term costs to implement the plan and expected long-term savings in future years from slowing the growth of costs.
(9) A realistic time line for implementation.
(10) Draft Medicaid State Plan Amendments, Medicaid waivers, amendments to State law, or other changes necessary to legally allow the Department to implement its reform plan.
(11) Any other detailed information that would assist the General Assembly in evaluating the strength of the reform plan and the plan's ability to accomplish the goals set out in subsection (a) of this section.

SECTION 12H.1.(c) The Department is encouraged to and may submit draft Medicaid State Plan amendments, draft waiver applications, or other documents to the federal government to solicit feedback on the Department's proposal prior to reporting to the General Assembly. The Department shall not, however, submit any documents to the federal government to implement the reform plan without legislation authorizing the Department to implement the Department's reform plan.

SECTION 12H.1.(d) The Department shall submit its reform plan to the General Assembly no later than March 17, 2014, but is encouraged to submit its plan as early as it responsibly can.

CLARIFY STATE PLAN AMENDMENT PROCEDURES; REPEAL UNAUTHORIZED STATE PLAN AMENDMENT

SECTION 12H.2.(a) Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read as follows:

"**§ 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.

(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, 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 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 Health and Human Services 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. If the authority for submitting the amendment to the State Plan is pursuant to subdivision (3), (4), or (5) 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."

SECTION 12H.2.(b) G.S. 108A-70.25 reads as rewritten:

"**§ 108A-70.25. State Plan for Health Insurance Program for Children.**

~~The Department shall develop and submit a State Plan to implement "The Health Insurance Program for Children" authorized under this Part to the federal government as application for federal funds under Title XXI. The State Plan submitted under this Part shall be developed by the Department only as authorized by and in accordance with this Part. No provision in the State Plan submitted under this Part may expand or otherwise alter the scope or purpose of the Program from that authorized under this Part. The Department shall include in the State Plan submitted only those items required by this Part and required by the federal government to qualify for federal funds under Title XXI and necessary to secure the State's federal fund allotment for the applicable fiscal period. Except as otherwise provided in this section, the Department shall not amend the State Plan nor submit any amendments thereto to the federal government for review or approval without the specific approval of the General Assembly. In the event federal law requires that an amendment be made to the State Plan and further requires that the amendment be submitted or implemented within a time period when the General Assembly is not and will not be in session to approve the amendment, then the Department may submit the amendment to the federal government for review and approval without the approval of the General Assembly. Prior to submitting an amendment to the federal government without General Assembly approval as authorized in this section, the Department shall report the proposed amendment to the Joint Legislative Oversight Committee on Health and Human~~

~~Services and to members of the Joint Appropriations Subcommittee on Health and Human Services. The report shall include an explanation of the amendment, the necessity therefor, and the federal time limits required for implementation of the amendment.~~

(a) The NC Health Choice program shall be administered and operated in accordance with this Part and the NC Health Choice State Plan, as periodically amended by the Department of Health and Human Services and approved by the federal government.

(b) The requirements in G.S. 108A-54.1A shall apply to NC Health Choice State Plan amendments in the same manner in which they apply to Medicaid State Plan amendments."

SECTION 12H.2.(c) The Department of Health and Human Services shall take any and all action necessary to remove from the Medicaid State Plan the amendment that begins on Attachment 4.19-B, Section 5, Page 2, and pertains to supplemental payments that increase reimbursement to the average commercial rate for certain eligible medical professional providers.

CODIFY GENERAL POLICIES

SECTION 12H.3. G.S. 108A-54 reads as rewritten:

"**§ 108A-54. Authorization of Medical Assistance Program.**

(a) The Department is authorized to establish a Medicaid Program in accordance with Title XIX of the federal Social Security Act. The Department may adopt rules to implement the Program. The State is responsible for the nonfederal share of the costs of medical services provided under the Program. In addition, the State shall pay one hundred percent (100%) of the federal Medicare Part D clawback payments under the Medicare Modernization Act of 2004, P.L. 108-173, as amended. A county is responsible for the county's cost of administering the Program in that county.

…

(c) The Medicaid Program shall be administered and operated in accordance with this Part and the North Carolina Medicaid State Plan and Waivers, as periodically amended by the Department of Health and Human Services in accordance with G.S. 108A-54.1A and approved by the federal government.

(d) The Department shall not take any actions that the Department determines would jeopardize the State's qualification to receive federal funds through the Medicaid Program."

CODIFY MEDICAID AS SECONDARY PAYOR

SECTION 12H.4. G.S. 108A-55 is amended by adding a new subsection to read as follows:

"**§ 108A-55. Payments.**

…

(e) Medicaid is a secondary payor of claims. The Department shall apply Medicaid medical policy to recipients who have primary insurance other than Medicare, Medicare Advantage, and Medicaid. For recipients who have primary insurance other than Medicare, Medicare Advantage, or Medicaid, the Department shall pay an amount up to the actual coinsurance or deductible or both, in accordance with the State Plan, as approved by the Department of Health and Human Services. The Department may disregard application of this policy in cases where application of the policy would adversely affect patient care."

CODIFY COUNTIES SHARING IN FRAUD RECOVERY

SECTION 12H.5. Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read as follows:

"**§ 108A-64.1. Incentives to counties to recover fraudulent Medicaid expenditures.**

The Department of Health and Human Services, Division of Medical Assistance, shall provide incentives to counties that successfully recover fraudulently spent Medicaid funds by

sharing State savings with counties responsible for the recovery of the fraudulently spent funds."

CODIFY CHANGES TO MEDICAL POLICY

SECTION 12H.6.(a) G.S. 108A-54.2 reads as rewritten:

"**§ 108A-54.2. Procedures for changing medical policy.**

(a) The Department shall adopt rules to develop, amend, and adopt medical coverage policy for Medicaid and NC Health Choice in accordance with this section.

(b) Medical coverage policy is defined as those policies, definitions, or guidelines utilized to evaluate, treat, or support the health or developmental conditions of a recipient so as to determine eligibility, authorization or continued authorization, medical necessity, course of treatment and supports, clinical outcomes, and clinical supports treatment practices for a covered procedure, product, or service. Medical coverage policy is subject to the following:

(1) During the development of new medical coverage policy or amendment to existing medical coverage policy, the Department shall consult with and seek the advice of the Physician Advisory Group and other organizations the Secretary deems appropriate. The Secretary shall also consult with and seek the advice of officials of the professional societies or associations representing providers who are affected by the new medical coverage policy or amendments to existing medical coverage policy.

(2) At least 45 days prior to the adoption of new or amended medical coverage policy, the Department shall:

a. Publish the proposed new or amended medical coverage policy on the Department's Web site;

b. Notify all Medicaid and NC Health Choice providers of the proposed, new, or amended policy; and

c. Upon request, provide persons copies of the proposed medical coverage policy.

(3) During the 45-day period immediately following publication of the proposed new or amended medical coverage policy, the Department shall accept oral and written comments on the proposed new or amended policy.

(4) If, following the comment period, the proposed new or amended medical coverage policy is modified, then the Department shall, at least 15 days prior to its adoption:

a. Notify all Medicaid and NC Health Choice providers of the proposed policy;

b. Upon request, provide persons notice of amendments to the proposed policy; and

c. Accept additional oral or written comments during this 15-day period.

(c) If the adoption of new or amended medical coverage policies is necessitated by an act of the General Assembly or a change in federal law, then the 45- and 15-day time periods specified in subsection (b) of this section shall instead be 30- and 10-day time periods.

(d) Unless directed to do so by the General Assembly, the Department shall not change medical policy affecting the amount, sufficiency, duration, and scope of health care services and who may provide services until the Division of Medical Assistance has prepared a five-year fiscal analysis documenting the increased cost of the proposed change in medical policy and submitted it for departmental review. Changes to medical policy affecting the amount, sufficiency, duration, and scope of health care services and who may provide services are subject to the following:

(1) If the fiscal impact indicated by the fiscal analysis for any proposed medical policy change exceeds five hundred thousand dollars ($500,000) in total requirements for Medicaid or fifty thousand dollars ($50,000) in total requirements for NC Health Choice for a given fiscal year, then the Department shall submit the proposed medical policy change to the fiscal analysis to the Office of State Budget and Management and the Fiscal Research Division. The Department shall not implement the proposed medical policy change unless the source of State funding is identified and approved by the Office of State Budget and Management.

(2) If the medical policy change meets the requirement thresholds specified in subdivision (1) of this subsection but is required for compliance with federal law, then the Department shall submit the proposed medical policy or policy interpretation change with the five-year fiscal analysis to the Office of State Budget and Management prior to implementing the change.

The Department shall annually report, by November 1 of each year, all medical policy changes with total requirements of less than the amount specified in subdivision (1) of this subsection to the Office of State Budget and Management and the Fiscal Research Division of the Legislative Services Commission."

SECTION 12H.6.(b) G.S. 108A-54.3 is repealed.

CODIFY PREEXISTING PROVIDER APPLICATION FEE

SECTION 12H.7. G.S. 108C-9 is amended by adding a new subsection to read as follows:

"**§ 108C-9. Provider enrollment criteria.**

…

(e) 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."

CODIFY ELECTRONIC TRANSACTION REQUIREMENTS FOR PROVIDERS

SECTION 12H.8. Chapter 108C of the General Statutes is amended by adding a new section to read as follows:

"**§ 108C-13. Electronic transactions.**

(a) Providers shall follow the Department's established procedures for securing electronic payments, and the Department shall not provide routine provider payments by check. Medicaid providers shall file claims electronically, except that nonelectronic claims submission may be required when it is in the best interest of the Department.

(b) Providers shall submit Preadmission Screening and Annual Resident Reviews (PASARR) through the Department's Web-based tool or through a vendor with interface capability to submit data into the Web-based PASARR.

(c) Providers shall submit requests for prior authorizations electronically via Web site. Providers shall access their authorizations via online portals rather than receiving hard copies by mail. Providers shall receive copies of adverse decisions electronically, although recipients shall receive adverse decisions via certified mail.

(d) Providers shall submit their provider enrollment applications online. The Department shall accept electronic signatures rather than require receipt of signed hard copies."

CODIFY RULE MAKING, TEMPORARY AND EXCEPTIONS

SECTION 12H.9.(a) G.S. 108A-54(b) is recodified as G.S. 108A-54.1B(a).

SECTION 12H.9.(b) G.S. 108A-54.1B, as created by subsection (a) of this section, reads as rewritten:

"**§ 108A-54.1B. Adoption of rules; exceptions.**

(a) The Department is expressly authorized to adopt temporary and permanent rules to implement or define the federal laws and regulations, the North Carolina State Plan of Medical Assistance, and the North Carolina State Plan of the Health Insurance Program for Children, the terms and conditions of eligibility for applicants and recipients of the Medical Assistance Program and the Health Insurance Program for Children, audits and program integrity, the services, goods, supplies, or merchandise made available to recipients of the Medical Assistance Program and the Health Insurance Program for Children, and reimbursement for the services, goods, supplies, or merchandise made available to recipients of the Medical Assistance Program and the Health Insurance Program for Children.

(b) Prior to filing a temporary rule authorized under G.S. 150B-21.1(a)(17) with the Rules Review Commission and the Office of Administrative Hearings, the Department shall consult with the Office of State Budget and Management on the possible fiscal impact of the temporary rule and its effect on State appropriations and local governments.

(c) Rule-making authority granted under this section for particular circumstances or programs is in addition to any other rule-making authority granted to the Department under Chapter 150B of the General Statutes.

(d) 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 shall have the force and effect of rules adopted pursuant to Article 2A of Chapter 150B of the General Statutes."

SECTION 12H.9.(c) G.S. 150B-1(d) is amended by adding a new subdivision to read as follows:

"(d) Exemptions from Rule Making. – Article 2A of this Chapter does not apply to the following:

…

(22) The Department of Health and Human Services 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."

SECTION 12H.9.(d) G.S. 150B-21.1(a) is amended by adding a new subdivision to read as follows:

"(a) Adoption. – An agency may adopt a temporary rule when it finds that adherence to the notice and hearing requirements of G.S. 150B-21.2 would be contrary to the public interest and that the immediate adoption of the rule is required by one or more of the following:

…

(17) To maximize receipt of federal funds for the Medicaid or NC Health Choice programs within existing State appropriations, to reduce Medicaid or NC Health Choice expenditures, and to reduce Medicaid and NC Health Choice fraud and abuse."

CODIFY ELIGIBILITY

SECTION 12H.10.(a) Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read as follows:

"**§ 108A-54.6. Eligibility.**

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

Family	Categorically Needy	Medically Needy

Size	Income Level	Income Level
1	$ 4,344	$ 2,900
2	5,664	3,800
3	6,528	4,400
4	7,128	4,800
5	7,776	5,200
6	8,376	5,600
7	8,952	6,000
8	9,256	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.

(b) Persons eligible for the following programs shall be eligible for Medicaid:

(1) Work First Family Assistance.

(2) Supplemental Social Security Income (SSI).

(3) State/County Special Assistance.

(c) 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 eighty-five percent (185%) 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 percent (200%) 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 percent (200%) 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 percent (100%) 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 eighty-five percent (185%) of the federal poverty guidelines and without regard to resources.

(d) 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.

(e) 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.

(f) 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.10.(b) G.S. 108A-54.1 is recodified as G.S. 108A-66.1. G.S. 108A-66.1(a), as recodified by this subsection, reads as rewritten:

"(a) Title. – This ~~act~~ section may be cited as the Health Coverage for Workers With Disabilities Act. The Department shall implement a Medicaid buy-in eligibility category as permitted under P.L. 106-170, Ticket to Work and Work Incentives Improvement Act of 1999. The Department shall establish rules, policies, and procedures to implement this act in accordance with this section."

SECTION 12H.10.(c) Effective January 1, 2014, G.S. 108A-54.6(c)(5), as enacted by this section, reads as rewritten:

"(5) Children aged six through 18 with family incomes equal to or less than ~~one hundred percent (100%)~~ one hundred thirty-three percent (133%) of the federal poverty guidelines and without regard to resources."

SECTION 12H.10.(d) Effective January 1, 2014, G.S. 108A-70.21(a)(1)d. 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 percent (100%)~~ one hundred thirty-three percent (133%) through two hundred percent (200%) 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.

…."

NC HEALTH CHOICE TEMPORARY EXTENDED COVERAGE

SECTION 12H.11. An enrollee in the NC Health Choice program who loses eligibility due to reaching the age of 19 on or after June 1, 2013, may purchase at full premium cost continued coverage under the NC Health Choice program until the end of the month following the date on which the Secretary of the United States Department of Health and Human Services determines that the North Carolina federally facilitated Health Benefits Exchange is fully operational. The benefits, co-payments, and other conditions of enrollment under the NC Health Choice program applicable to extended coverage purchased in accordance with this section shall be the same as those applicable to an NC Health Choice enrollee who has not yet reached the age of 19.

INSURANCE PREMIUMS FOR PREGNANT WOMEN

SECTION 12H.12.(a) G.S. 108A-54.6(c)(2), as enacted by Section 12H.10 of this act, reads as rewritten:

"(2) Pregnant women with incomes equal to or less than ~~one hundred eighty-five percent (185%)~~one hundred thirty-three percent (133%) 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."

SECTION 12H.12.(b) Article 2 of Chapter 108A of the General Statutes is amended by adding a new Part to read as follows:

"Part 10. Insurance Premiums for Pregnant Women.

"**§ 108A-70.35. Definitions.**

In this Part, the following definitions apply:

(1) Federal poverty guidelines. – The federal poverty guidelines established by the United States Department of Health and Human Services, as periodically revised.

(2) Household income. – As defined under 26 U.S.C. § 5000A(c)(4)(B).

(3) Medicaid. – The State Medical Assistance Program established under Part 6 of this Article.

(4) Minimum essential coverage. – As defined under 26 U.S.C. § 5000A(f)(1).

(5) Program. – The Insurance Premiums for Pregnant Women program established in this Part.

(6) Uninsured. – Without minimum essential coverage.

"**§ 108A-70.36. Purpose; no entitlement.**

The purpose of this Part is to help uninsured, lower-income pregnant women who are residents of this State acquire health insurance through premium assistance. Premium assistance shall be paid from State funds appropriated. Nothing in this Part shall be construed as obligating the General Assembly to appropriate funds for this purpose or as entitling any person to receive premium assistance under this Part.

"**§ 108A-70.37. Program established.**

The Insurance Premiums for Pregnant Women program is established. The program shall be administered by the Department of Health and Human Services in accordance with this Part.

"**§ 108A-70.38. Program eligibility.**

In order to participate in the program, an individual must meet all of the following requirements:

(1) Be a resident of the State.

(2) Be lawfully present in the United States.

(3) Not be on active punishment, as that term is defined under G.S. 15A-1340.11.

(4) Have a medically verified pregnancy.

(5) Not have minimum essential coverage, excluding coverage purchased using funding from the program.

(6) Have household income of no more than one hundred eighty-five percent (185%) of the federal poverty guidelines.

(7) Qualify for a premium assistance credit under 26 U.S.C. § 36B.

"**§ 108A-70.39. Program benefits.**

(a) An individual who qualifies under G.S. 108A-70.38 shall be eligible for premium assistance from the State to help the individual purchase coverage under a health benefit plan during the period of the pregnancy through the end of the second calendar month following the pregnancy.

(b) The amount of the premium assistance shall be the amount necessary to purchase insurance coverage up to the amount provided in 26 U.S.C. § 36B(b)(2)(B)(ii).

(c) The Department of Health and Human Services shall remit the amount of the premium assistance to a qualified individual's insurer on behalf of the qualified individual.

(d) A qualified individual who participates in the program shall remain responsible for the other costs of the health benefit plan in which they are enrolled, including any cost-sharing."

SECTION 12H.12.(c) This section becomes effective January 1, 2014, and applies to pregnancies medically verified on or after that date.

MODIFICATIONS TO EXISTING COVERED SERVICES AND PAYMENT FOR SERVICES

SECTION 12H.13.(a) Except as otherwise provided in this act, the allowable State plan services, co-pays, reimbursement rates, and fees shall remain the same as those effective June 30, 2013. Except as otherwise provided in this act and to the extent allowable under federal law, the adjustments made in this section apply to both the Medicaid Program and the NC Health Choice program.

SECTION 12H.13.(b) Effective July 1, 2013, any rates that contain an inflationary or increase factor shall not increase above the rate in effect on June 30, 2013, unless the rate is otherwise increased by the General Assembly. Hospital outpatient services' percentage of cost shall be adjusted to compensate for expected inflation that hospitals would be eligible for, and cost settlement will only be up to that percentage. Nursing direct care services shall not receive case mix index increases after June 30, 2013, until reinstated. The following rates are excluded from this subsection: Federally Qualified Health Centers, Rural Health Centers, State-Operated services, Hospice, Part B and D Premiums, third-party and HMO premiums, drugs, and MCO capitation payments.

SECTION 12H.13.(c) Effective November 1, 2013, nominal co-pays are increased to the maximum amount allowed by the Centers for Medicare and Medicaid Services (CMS). The Department of Health and Human Services, Division of Medical Assistance, shall monitor changes to federal law and increase the nominal co-pays whenever allowed under federal law.

SECTION 12H.13.(d) Effective January 1, 2014, the following changes are made to allowable State plan services:

(1) Of the 22 visits allowed per recipient per fiscal year for professional services provided by physicians, nurse practitioners, nurse midwives, physician assistants, clinics, and health departments, prior authorization is required for visits in excess of 10 within a year. This limitation and prior authorization requirement does not apply to chronic conditions.

(2) Adult private duty nursing (PDN) is limited to four hundred thirty-two dollars ($432.00) per day.

(3) Adult rehabilitation home visits for set-up and training are limited to three within a 12-month period.

(4) Prior authorization is required for all mental health drugs. A 72-hour emergency supply may be provided if a beneficiary is waiting for acknowledgment of the prior authorization request.

SECTION 12H.13.(e) Effective January 1, 2014, the percentage of allowable costs for hospital outpatients is reduced from eighty percent (80%) to seventy percent (70%).

SECTION 12H.13.(f) Effective January 1, 2014, nonemergency services provided in an emergency room shall be reimbursed based on a single fee. The Department of Health and Human Services, Division of Medical Assistance, shall establish such a fee. This fee may not be cost-settled.

SECTION 12H.13.(g) Effective January 1, 2014, the following changes are made to drug reimbursements:

(1) Reimbursement rates for prescribed drugs are based on an invoice cost that will be established through quarterly surveys to determine the actual cost of

drugs to pharmacies. The Department of Health and Human Services, Division of Medical Assistance, shall conduct such quarterly surveys.

(2) Dispensing fees are to be increased to an average payment of nine dollars and eighty-seven cents ($9.87) for all drugs, with the incentive differential for dispensing generic and preferred drugs remaining at two dollars ($2.00).

ADDITIONAL PERSONAL CARE SERVICES FOR QUALIFIED INDIVIDUALS

SECTION 12H.14.(a) Section 10.9F(c) of S.L. 2012-142, as amended by Section 70 of S.L. 2012-194, reads as rewritten:

"**SECTION 10.9F.(c)** A Medicaid recipient who meets each of the following criteria is eligible for up to 80 hours of personal care services:

(1) The recipient has a medical condition, disability, or cognitive impairment and demonstrates unmet needs for, at a minimum, (i) three of the five qualifying activities of daily living (ADLs) with limited hands-on assistance; (ii) two ADLs, one of which requires extensive assistance; or (iii) two ADLs, one of which requires assistance at the full dependence level.

(2) The recipient (i) resides in a private living arrangement, a residential facility licensed by the State of North Carolina as an adult care home, or a combination home as defined in G.S. 131E-101(1a); or (ii) resides in a group home licensed under Chapter 122C or the General ~~Statues~~ Statutes and under 10A NCAC 27G .5601 as a supervised living facility for two or more adults whose primary diagnosis is mental illness, a developmental disability, or substance abuse dependency, and is eligible to receive personal care services under the Medicaid State Plan.

The five qualifying ADLs are eating, dressing, bathing, toileting, and mobility. For Medicaid recipients meeting the criteria above, ~~Personal~~ personal care services shall be available ~~for up to 80 hours per month~~ in accordance with an assessment conducted under subsection (d) of this section and a plan of care developed by the service provider and approved by the Department of Health and Human Services, Division of Medical Assistance, or its designee.

(3) A Medicaid recipient who meets the eligibility criteria provided in subdivisions (1) and (2) of this subsection and all of the criteria provided below is eligible for up to 50 additional hours of Medicaid Personal Care Services per month for a total of up to 130 hours per month in accordance with an assessment and a plan of care.

a. The recipient requires an increased level of supervision.

b. The recipient requires caregivers with training or experience in caring for individuals who have a degenerative disease characterized by irreversible memory dysfunction that attacks the brain and results in impaired memory, thinking, and behavior including gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.

c. Regardless of setting, the recipient requires a physical environment that includes modifications and safety measures to safeguard the recipient because of the recipient's gradual memory loss, impaired judgment, disorientation, personality change, difficulty in learning, and the loss of language skills.

d. The recipient exhibits safety concerns related to inappropriate wandering, ingestion, aggressive behavior, and an increased incidence of falls.

Physician attestation. – A recipient must have a physician's attestation that the recipient meets each of the criteria in sub-subdivisions a. through d. of subdivision (3) of this subsection. A recipient is not required to have a new attestation if he or she is identified by the Department of Health and Human Services, Division of Medical Assistance, as having on record a physician's attestation that meets the requirements of this subdivision. A recipient is required to have a new attestation if one cannot be identified by the Division of Medical Assistance or if the one identified does not meet the requirements of this subdivision.

Independent assessment. – Based on the physician's attestation, the Medicaid recipient must receive an independent assessment conducted by a trained professional who is qualified to assess and has experience assessing individuals with the needs for additional safeguards identified by this subdivision. The independent assessment shall be conducted in accordance with subsection (d) of this section and shall determine the number of hours of personal care services needed by the individual. In response to the assessment, a plan of care shall be developed by the service provider and approved by the Department of Health and Human Services, Division of Medical Assistance, or its designee.

Personal care services shall not include nonmedical transportation; financial management; non-hands-on assistance such as cueing, prompting, guiding, coaching, or babysitting; and household chores not directly related to the qualifying ADLs."

SECTION 12H.14.(b) The Department shall reduce the rate for personal care services in order to fund the additional service hours authorized under this section within the budgeted amount of funds for personal care services.

SECTION 12H.14.(c) On or before August 1, 2013, and on or before November 1, 2013, the Department of Health and Human Services shall report on the implementation of this section to the Joint Legislative Oversight Committee on Health and Human Services.

MODIFY MEDICAID SUBROGATION STATUTE IN RESPONSE TO WOS V. E.M.A.

SECTION 12H.15.(a) G.S. 108A-57 reads as rewritten:

"**§ 108A-57. Subrogation rights; withholding of information a misdemeanor.**

(a) Notwithstanding any other provisions of the law, to the extent of payments under this Part, the ~~State, or the county providing medical assistance benefits,~~ State shall be subrogated to all rights of recovery, contractual or otherwise, of the beneficiary of this assistance, or of the beneficiary's personal representative, heirs, or the administrator or executor of the estate, against any person. ~~The county attorney, or an attorney retained by the county or the State or both, or an attorney retained by the beneficiary of the assistance if this attorney has actual notice of payments made under this Part shall enforce this section.~~ A personal injury or wrongful death claim brought by a medical assistance beneficiary against a third party shall include a claim for all medical assistance payments for health care items or services furnished to the medical assistance beneficiary as a result of the injury, hereinafter referred to as the "Medicaid claim." Any personal injury or wrongful death claim brought by a medical assistance beneficiary against a third party that does not state the Medicaid claim shall be deemed to include the Medicaid claim.

(a1) If the amount of the Medicaid claim does not exceed one-third of the medical assistance beneficiary's gross recovery, it is presumed that the gross recovery includes compensation for the full amount of the Medicaid claim. If the amount of the Medicaid claim exceeds one-third of the medical assistance beneficiary's gross recovery, it is presumed that one-third of the gross recovery represents compensation for the Medicaid claim.

(a2) A medical assistance beneficiary may dispute the presumptions established in subsection (a1) of this section by applying to the court in which the medical assistance beneficiary's claim against the third party is pending, or if there is none, then to a court of competent jurisdiction, for a determination of the portion of the beneficiary's gross recovery that represents compensation for the Medicaid claim. An application under this subsection shall be filed with the court and served on the Department pursuant to the Rules of Civil Procedure no later than 30 days after the date that the settlement agreement is executed by all parties and, if required, approved by the court, or in cases in which judgment has been entered, no later than 30 days after the date of entry of judgment. The court shall hold an evidentiary hearing no sooner than 30 days after the date the action was filed. All of the following shall apply to the court's determination under this subsection:

(1) The medical assistance beneficiary has the burden of proving by clear and convincing evidence that the portion of the beneficiary's gross recovery that represents compensation for the Medicaid claim is less than the portion presumed under subsection (a1) of this section.

(2) The presumption under subsection (a1) of this section is not rebutted solely by the fact that the medical assistance beneficiary was not able to recover the full amount of all claims.

(3) The court may consider any factors the court deems just and reasonable in determining the portion of the recovery that represents compensation for the Medicaid claim.

(4) The court may determine based upon a preponderance of the evidence that the portion of the recovery that represents compensation for the Medicaid claim is greater than the portion presumed under subsection (a1) of this section.

(a3) ~~Any~~Within 30 days of receipt of the proceeds of a settlement or judgment related to a claim described in subsection (a) of this section, the medical assistance beneficiary or any attorney retained by the beneficiary shall notify the Department of the receipt of the proceeds. The medical assistance beneficiary or any attorney retained by the beneficiary ~~of the assistance~~ shall, out of the proceeds obtained by or on behalf of the beneficiary by settlement with, judgment against, or otherwise from a third party by reason of injury or death, distribute to the Department the amount of assistance paid by the Department on behalf of or to the beneficiary, as prorated with the claims of all others having medical subrogation rights or medical liens against the amount received or recovered, but the amount paid to the Department shall not exceed ~~one-third of the gross amount obtained or recovered.~~the portion presumptively determined under subsection (a1) of this section or the portion judicially determined under subsection (a2) of this section. Unless an action has been commenced pursuant to subsection (a2) of this section, the amount shall be paid to the Department within 30 days of the beneficiary's receipt of the proceeds.

(a4) The United States and the State of North Carolina shall be entitled to shares in each net recovery by the Department under this section. Their shares shall be promptly paid under this section and their proportionate parts of such sum shall be determined in accordance with the matching formulas in use during the period for which assistance was paid to the recipient.

(b) It is a Class 1 misdemeanor for any person seeking or having obtained assistance under this Part for himself or another to willfully fail to disclose to the county department of social services or its attorney the identity of any person or organization against whom the recipient of assistance has a right of recovery, contractual or otherwise.

(c) This section applies to the administration of and claims payments made by the Department of Health and Human Services under the NC Health Choice Program established under Part 8 of this Article.

(d) As required to ensure compliance with this section, the Department may apply to the court in which the medical assistance beneficiary's claim against the third party is pending, or if there is none, then to a court of competent jurisdiction for enforcement of this section."

SECTION 12H.15.(b) This section is effective when it becomes law and applies to claims brought by a medical assistance beneficiary against a third party in which either a settlement agreement is executed by all parties or a judgment is entered against the third party on or after the effective date of this section. For claims in which the Medicaid claim has not been satisfied and as to which, prior to the effective date of this section, either (i) a settlement agreement has been executed by all parties or (ii) judgment has been entered against the third party, the medical assistance beneficiary shall have 90 days from the effective date of this section within which to apply to the court pursuant to G.S. 108A-57(c).

ADMINISTRATIVE HEARINGS FUNDING AND PROCEDURE MODIFICATION

SECTION 12H.16.(a) The Department of Health and Human Services (Department) shall transfer the sum of one million dollars ($1,000,000) for the 2013-2014 fiscal year, and the sum of one million dollars ($1,000,000) for the 2014-2015 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.

SECTION 12H.16.(b) G.S. 108C-12(d) is repealed.

SECTION 12H.16.(c) G.S. 108C-5 reads as rewritten:

"**§ 108C-5. Payment suspension and audits utilizing extrapolation.**

(a) The Department may suspend payments to a provider in accordance with the requirements and procedures set forth in 42 C.F.R. § 455.23.

(b) In addition to the procedures for suspending payment set forth at 42 C.F.R. § 455.23, the Department may also suspend payment to any provider that (i) owes a final overpayment, assessment, or fine to the Department and has not entered into an approved payment plan with the Department or (ii) has had its participation in the Medicaid or Health Choice programs suspended or terminated by the Department. For purposes of this section, a suspension or termination of participation does not become final until all administrative appeal rights have been exhausted and shall not include any agency decision that is being contested at the Department or the Office of Administrative Hearings or in Superior Court provided that the Superior Court has entered a stay pursuant to the provisions of G.S. 150B-48.

(b1) The Department shall withhold payment to any North Carolina Medicaid provider or Health Choice provider for whom the Division of Medical Assistance, or its vendor, has identified an overpayment in a written notice to the provider. Withholding shall begin on the 31st day after the day the notice of overpayment is mailed and shall continue during the pendency of any appeal until the overpayment becomes a final overpayment. For purposes of this subsection, withholding during any month shall not exceed the amount of any interest required by law plus nine percent (9%) of the sum of the total overpayment amount identified in the notice of overpayment and any penalty required by law. If the Department subsequently reduces the identified overpayment in writing, withholding during any subsequent month shall not exceed the amount of any interest required by law plus nine percent (9%) of the sum of the total reduced identified overpayment and any penalty required by law. Total withholdings shall not exceed the total amount of the overpayment plus any penalty and interest charges required

by law. If the total amount withheld exceeds the final overpayment plus interest and penalty required by law, the Department shall pay the provider the amount withheld in excess of the final overpayment plus penalty and interest. Upon request by the provider and for good cause shown, the Department is authorized to approve a payment plan for a provider to pay an overpayment, pursuant to subsection (g) of this section. Absent a showing of good cause for repayment to be made over a period of more than one year, the Department shall take all necessary and appropriate action to recover overpayments within 365 days of the date the notice of overpayment was mailed to the provider.

(c) For providers who owe a final overpayment, assessment, or fine to the Department, the payment suspension shall begin the thirty-first day after the overpayment, assessment, or fine becomes final. The payment suspension shall not exceed the amount owed to the Department, including any applicable penalty and interest charges.

(d) Providers whose participation in the Medicaid or Health Choice programs has been suspended or terminated shall have all payments suspended beginning on the thirty-first day after the suspension or termination becomes final.

(e) The Department shall consult with the N.C. Departments of Treasury and Revenue and other State departments and agencies to determine if a provider owes debts or fines to the State. The Department may collect any of these debts owed to the State subsequent to consideration by the Department of the financial impact upon the provider and the impact upon access to the services provided by the provider.

(f) When issuing payment suspensions and withholdings in accordance with this Chapter, the Department may suspend or withhold payment to all providers which share the same IRS Employee Identification Number or corporate parent as the provider or provider site location which owes the final overpayment, overpayment, assessment, or fine. The Department shall give 30 days advance written notice to all providers which share the same IRS Employee Identification Number or corporate parent as the provider or provider site location of the intention of the Department to implement a payment ~~suspension.~~suspension or withholding.

(g) The Department is authorized to approve a payment plan for a provider to pay a final overpayment, overpayment, assessment, or fine including interest and any penalty. The payment plan can include a term of up to 24 months. The Department shall establish in rule the conditions of such provider payment plans. Nothing in this subsection shall prevent the provider and the Department from mutually agreeing to modifications of a payment plan.

(h) All payments suspended or withheld in accordance with this Chapter shall be applied toward any final overpayment, assessment, or fine owed to the Department.

…."

SECTION 12H.16.(d) Chapter 108C of the General Statutes is amended by adding a new section to read as follows:

"**§ 108C-5.1. Post-payment review and recovery audit contracts.**

The Department shall not pay contingent fees pursuant to any contract with an entity conducting Medicaid post-payment reviews or Recovery Audit Contractor (RAC) audits before all appeal rights have been exhausted. Any contingent fee for Medicaid post-payment reviews or RAC audits shall be calculated as a percentage of the amount of the final overpayment, as defined in G.S. 108C-2(5). The State share of the contingent fee paid for Medicaid post-payment reviews or RAC audits shall not exceed the State share of the amount actually recovered by the Department and applied to the final overpayment."

SECTION 12H.16.(e) Subsection (d) of this section applies only to contracts entered into or amended on or after the effective date of subsection (d).

SECTION 12H.16.(f) G.S. 1A-1 is amended by adding a new Article to read as follows:

"Article 9.

"Extraordinary Writs.

"**Rule 90. Certiorari.**

(a) Scope of the Writ; Review of the Judgments, Decisions, and Orders of the Office of Administrative Hearings. – The writ of certiorari may be issued in appropriate circumstances by the Superior Court to permit review of the judgments, decisions, and orders of the Office of Administrative Hearings when no right of appeal from an interlocutory order exists.

(b) Petition for Writ; to Which Superior Court Addressed. – Application for the writ of certiorari shall be made by filing a petition therefor with the clerk of the superior court division to which appeal of right might lie from a final decision of the Office of Administrative Hearings in the contested case for which issuance of the writ is sought.

(c) Same; Filing and Service; Content. – The petition shall be filed without unreasonable delay and shall be accompanied by proof of service upon all other parties. The petition shall contain a statement of the facts necessary to an understanding of the issues presented by the application, a statement of the reasons why the writ should issue, and certified copies of the judgment, decision, order, or opinion or parts of the record which may be essential to an understanding of the matters set forth in the petition. The petition shall be verified by counsel or the petitioner. Upon receipt of the prescribed docket fee, the clerk will docket the petition.

(d) Response; Determination by Court. – Within 10 days after service of the petition any party may file a response thereto with supporting affidavits or certified portions of the record not filed with the petition. Filing shall be accompanied by proof of service upon all other parties. The court for good cause shown may shorten the time for filing a response. Determination will be made on the basis of the petition, the response, and any supporting papers. No briefs or oral argument will be received or allowed unless ordered by the court upon its own initiative.

"**Rule 91. Mandamus and Prohibition.**

(a) Petition for Writ; to Which Superior Court Addressed. – Applications for the writs of mandamus or prohibition directed to an administrative law judge shall be made by filing a petition therefor with the clerk of the superior court division to which appeal of right might lie from a final decision entered in the contested case for which issuance of the writ is sought.

(b) Same; Filing and Service; Content. – The petition shall be filed without unreasonable delay after the action by the Office of Administrative Hearings sought to be prohibited or compelled has been undertaken, or has occurred, or has been refused, and shall be accompanied by proof of service on the respondent administrative law judge or administrative law judges and on all other parties to the action. The petition shall contain a statement of the facts necessary to an understanding of the issues presented by the application, a statement of the issues presented and of the relief sought, a statement of the reasons why the writ should issue, and certified copies of any order or opinion or parts of the record that may be essential to an understanding of the matters set forth in the petition. The petition shall be verified by counsel or the petitioner. Upon receipt of the prescribed docket fee, the clerk shall docket the petition.

(c) Response; Determination by Court. – Within 10 days after service of the petition the respondent or any party may file a response thereto with supporting affidavits or certified portions of the record not filed with the petition. Filing shall be accompanied by proof of service upon all other parties. The court for good cause shown may shorten the time for filing a response. Determination will be made on the basis of the petition, the response, and any supporting papers. No briefs or oral argument will be received or allowed unless ordered by the court upon its own initiative.

"**Rule 92. Supersedeas.**

(a) Pending Review of Office of Administrative Hearings Judgments, Decisions, and Orders. – Application may be made to the appropriate superior court for a writ of supersedeas to stay the execution or enforcement of any judgment, decision, order, or other determination of

the Office of Administrative Hearings which is not automatically stayed by the taking of appeal when an appeal has been taken or a petition for mandamus, prohibition, or certiorari has been filed to obtain review of the judgment, decision, order, or other determination and (i) a stay order or entry has been sought by the applicant by deposit of security or by motion at the Office of Administrative Hearings and such order or entry has been denied or vacated by the trial tribunal or (ii) extraordinary circumstances make it impracticable to obtain a stay by deposit of security or by application to the Office of Administrative Hearings for a stay order.

(b) Petition; Filing and Service; Content. – The petition shall be filed with the clerk of the superior court division to which appeal of right might lie from a final decision of the Office of Administrative Hearings in the contested case for which issuance of the writ is sought. The petitions shall be accompanied by proof of service upon all other parties. The petition shall be verified by counsel or the petitioner. Upon receipt of the required docket fee, the clerk will docket the petition. For stays of the judgments of the Office of Administrative Hearings, the petition shall contain a statement that a stay has been sought in the Office of Administrative Hearings and denied or vacated or shall contain facts showing that it was impracticable there to seek a stay. For stays of any judgment, the petition shall contain (i) a statement of any facts necessary to an understanding of the basis upon which the writ is sought and (ii) a statement of reasons why the writ should issue in justice to the applicant. The petition may be accompanied by affidavits and by any certified portions of the record pertinent to its consideration. It may be included in a petition to the superior court for certiorari, mandamus, or prohibition.

(c) Response; Determination by Court. – Within 10 days after service of the petition, any party may file a response thereto with supporting affidavits or certified portions of the record not filed with the petition. Filing shall be accompanied by proof of service upon all other parties. The court for good cause shown may shorten the time for filing a response. Determination will be made on the basis of the petition, the response, and any supporting papers. No briefs or oral argument will be received or allowed unless ordered by the court upon its own initiative.

(d) Temporary Stay. – Upon the filing of a petition for supersedeas, the applicant may apply, either within the petition or by separate paper, for an order temporarily staying enforcement or execution of the judgment, decision, order, or other determination pending decision by the court upon the petition for supersedeas. If application is made by separate paper, it shall be filed and served in the manner provided for the petition for supersedeas in Rule 92(b). The court for good cause shown in such a petition for temporary stay may issue such an order ex parte."

SECTION 12H.16.(g) Article 4 of Chapter 150B of the General Statutes is amended by adding a new section to read:

"**§ 150B-53. Writs.**

Any party to a contested case may petition for writs of certiorari, mandamus, prohibition, or supersedeas in the manner prescribed in Rules 90, 91, and 92 of the North Carolina Rules of Civil Procedure."

CODIFY PROVIDER PERFORMANCE BONDS

SECTION 12H.17.(a) Chapter 108C of the General Statutes is amended by adding a new section to read as follows:

"**§ 108C-14. Provider performance bonds.**

(a) Subject to the provisions of this section, the Department may require Medicaid-enrolled providers to purchase a performance bond in an amount not to exceed one hundred thousand dollars ($100,000) naming as beneficiary the Department of Health and Human Services, Division of Medical Assistance, or provide to the Department a validly executed letter of credit or other financial instrument issued by a financial institution or agency honoring a demand for payment in an equivalent amount. The Department may require the

purchase of a performance bond or the submission of an executed letter of credit or financial instrument as a condition of initial enrollment, reenrollment, recredentialing, or reinstatement if any of the following are true:

(1) The provider fails to demonstrate financial viability.
(2) The Department determines there is significant potential for fraud and abuse.
(3) The Department otherwise finds it is in the best interest of the Medicaid program to do so.

The Department shall specify the circumstances under which a performance bond or executed letter of credit will be required.

(b) The Department may waive or limit the requirements of subsection (a) of this section for individual Medicaid-enrolled providers or for one or more classes of Medicaid-enrolled providers based on the following:

(1) The provider's or provider class's dollar amount of monthly billings to Medicaid.
(2) The length of time an individual provider has been licensed, endorsed, certified, or accredited in this State to provide services.
(3) The length of time an individual provider has been enrolled to provide Medicaid services in this State.
(4) The provider's demonstrated ability to ensure adequate record keeping, staffing, and services.
(5) The need to ensure adequate access to care.

In waiving or limiting requirements of this section, the Department shall take into consideration the potential fiscal impact of the waiver or limitation on the State Medicaid Program. The Department shall provide to the affected provider written notice of the findings upon which its action is based and shall include the performance bond requirements and the conditions under which a waiver or limitation apply."

SECTION 12H.17.(b) The Department may adopt temporary rules in accordance with G.S. 150B-21.1 as necessary to implement G.S. 108C-14, as enacted by this section.

SHARED SAVINGS PLAN WITH PROVIDERS

SECTION 12H.18.(a) The Department of Health and Human Services shall consult with providers affected by subsection (b) of this section to develop a shared savings plan that the Department shall implement by July 1, 2014, with provider payments beginning January 1, 2015. The shared savings plan shall provide incentives to provide effective and efficient care that results in positive outcomes for Medicaid recipients. Payments under the shared savings plan shall be paid from funds withheld under subsection (b) of this section.

SECTION 12H.18.(b) During the 2013-2015 fiscal biennium, the Department of Health and Human Services shall withhold four percent (4%) of payments for the following services rendered on or after July 1, 2013:

(1) Inpatient hospital.
(2) Physician, excluding primary care until January 1, 2015.
(3) Dental.
(4) Optical services and supplies.
(5) Podiatry.
(6) Chiropractors.
(7) Hearing aids.
(8) Personal care services.
(9) Nursing homes.
(10) Adult care homes.
(11) Drugs.

Funds from payments withheld under this section that are budgeted to be shared with providers shall not revert to the General Fund.

SECTION 12H.18.(c) The Department of Health and Human Services shall report to the Joint Legislative Oversight Committee on Health and Human Services on the development of the shared savings program established by this section no later than March 1, 2014.

MODIFY HOSPITAL PROVIDER ASSESSMENTS BY CHANGING AMOUNT RETAINED BY STATE TO A PERCENTAGE

SECTION 12H.19.(a) G.S. 108A-121(8) reads as rewritten:

"(8) State's annual Medicaid payment. – ~~Forty-three million dollars ($43,000,000).~~ For an assessment collected under this Article, an amount equal to fifteen and six-tenths percent (15.6%) of the total amount collected under the assessment."

SECTION 12H.19.(b) G.S. 108A-124 reads as rewritten:

"**§ 108A-124. Use of assessment proceeds.**

(a) Use. – The proceeds of the assessments imposed under this Article and all corresponding matching federal funds must be used to make the State annual Medicaid payment to the State and the Medicaid equity payments and UPL payments to hospitals.

(b) Quarterly Payments. – Within seven business days ~~of~~ following the due date for each quarterly assessment imposed under G.S. 108A-123, the Secretary must do the following:

~~(1) Transfer to the State Controller twenty-five percent (25%) of the State's annual Medicaid payment amount.~~

~~(2)~~(1) Pay to each hospital that has paid its equity assessment for the respective quarter twenty-five percent (25%) of its Medicaid equity payment amount. A hospital's Medicaid equity payment amount is the sum of the hospital's Medicaid inpatient and outpatient deficits after calculating all other Medicaid payments, excluding disproportionate share hospital payments and the UPL payment remitted to the hospital under subdivision ~~(3)~~(2) of this subsection.

~~(3)~~(2) Pay to the primary affiliated teaching hospital for the East Carolina University Brody School of Medicine, to the critical access hospitals, and to each hospital that has paid its UPL assessment for the respective quarter twenty-five percent (25%) of its UPL payment amount, as determined under subsection (c) of this section.

…."

SECTION 12H.19.(c) Article 7 of Chapter 108A is amended by adding a new section to read as follows:

"**§ 108A-128. Payment for providers formerly subject to this Article.**

If a hospital provider (i) is exempt from both the equity and UPL assessments under this Article, (ii) makes an intergovernmental transfer (IGT) to the Department of Health and Human Services to be used to draw down matching federal funds, and (iii) has acquired, merged, leased, or managed another provider on or after March 25, 2011, then the hospital provider shall transfer to the State an additional amount, which shall be retained by the State. The additional amount shall be fifteen and six tenths percent (15.6%) of the amount of funds that (i) would be transferred to the State through such an IGT and (ii) are to be used to match additional federal funds that the hospital provider is able to receive because of the acquired, merged, leased, or managed provider."

MODIFY MEDICAID RATE METHODOLOGIES FOR RECENTLY ACQUIRED PROVIDERS; CREATE REGIONAL BASE RATES FOR HOSPITALS

SECTION 12H.20.(a) The Department of Health and Human Services shall modify Medicaid rate methodologies to ensure that rates paid to hospital or physician providers that were acquired, merged, leased, or managed after December 31, 2011, do not exceed rates that would have been paid if the provider had not been acquired, merged, leased, or managed.

SECTION 12H.20.(b) The Department of Health and Human Services, Division of Medical Assistance, shall replace the existing base rates for individual hospitals with new regional base rates for all hospitals within a given region. The Department shall consult with hospitals to define the regions and to identify appropriate regional differences in order to establish regional base rates. The new regional base rates shall do the following:

(1) Maintain the same statewide total for the base rates for all hospitals as before the base rate revision, after first adjusting the statewide total based on the changes to rates made by subsection (a) of this section.

(2) Ensure the sustainability of small rural hospitals, ensuring access to care.

COMMUNITY CARE OF NORTH CAROLINA COST-EFFECTIVENESS AND OUTCOMES STUDY; CONTINUED REPORTING

SECTION 12H.21.(a) As recommended by the Office of the State Auditor in the January 2013 performance audit of the Medicaid Program, the Department of Health and Human Services shall engage medical researchers to perform a scientifically valid study based upon actual data to determine whether the Community Care of North Carolina (CCNC) model saves money and improves health outcomes. This study shall begin during fiscal year 2013-2014 and shall, if possible, be completed by the end of that fiscal year.

SECTION 12H.21.(b) During fiscal year 2014-2015, the Department of Health and Human Services shall submit a report from a qualified entity with proven experience in conducting actuarial and health care studies on the Medicaid cost-savings achieved by the CCNC networks, which shall include children, adults, and the aged, blind, and disabled, to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION 12H.21.(c) North Carolina Community Care Networks, Inc. (NCCCN), shall report quarterly to the Department and to the Office of State Budget and Management (OSBM) on the development of the statewide Enhanced Primary Care Case Management System and its defined goals and deliverables as agreed upon in the contract. NCCCN shall submit biannual reports to the Secretary of Health and Human Services, OSBM, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division on the progress and results of implementing the quantitative, analytical, utilization, quality, cost containment, and access goals and deliverables set out in the contract. NCCCN shall conduct its own analysis of the CCNC system to identify any variations from the development plan for the Enhanced Primary Care Case Management System and its defined goals and deliverables set out in the contract between the Department of Health and Human Services, Division of Medical Assistance (DMA), and NCCCN. Upon identifying any variations, NCCCN shall develop and implement a plan to address the variations. NCCCN shall report the plan to DMA within 30 days after taking any action to implement the plan.

COMMUNITY CARE OF NORTH CAROLINA TO SET AND PAY PER MEMBER PER MONTH PAYMENTS ON PERFORMANCE BASIS TO ENCOURAGE BETTER CARE MANAGEMENT

SECTION 12H.22.(a) The Department of Health and Human Services shall contract with Community Care Networks, Inc. (NCCCN), to administer and distribute the funds currently allocated to per member per month (PMPM) payments for Community Care of North

Carolina (CCNC) primary care providers. NCCCN shall distribute one hundred percent (100%) of the funds allocated to PMPM payments to primary care providers on a care management performance basis using criteria developed by NCCCN. In developing its pay for performance model, NCCCN shall (i) ensure an adequate statewide network of participating CCNC primary care providers and (ii) adopt a payment level of zero dollars ($0.00) for providers who do not satisfactorily participate in CCNC care management initiatives. Performance-based payments shall begin on July 1, 2014.

SECTION 12H.22.(b) PMPM payments from the Department to CCNC primary care providers shall continue until the implementation of the performance-based payment system.

SECTION 12H.22.(c) The Department shall consult with the Joint Legislative Oversight Committee on Health and Human Services on the performance-based payment proposal from NCCCN to incentivize better care management from primary care providers. If the Department submits a report and requests a meeting for the consultation, but the Oversight Committee does not hear the consultation within 90 days of the request, then the consultation requirement shall be deemed waived by the Oversight Committee. The report submitted for consultation shall include the following:

(1) Measureable elements that will be used to differentiate care management performance-based payments from the existing PMPM payments.

(2) A comparison of the performance plan to other measures such as the Healthcare Effectiveness Data and Information Set (HEDIS) or other national performance or quality measures.

(3) The specific structure of when payments would be made.

(4) An impact calculation of prospective payments under the performance-based payment plan and the current PMPM rates.

SECTION 12H.22.(d) Subsection (a) of this section is contingent upon both of the following:

(1) The Department's successful renegotiation of and modification to the existing contract or entering into a new contract with NCCCN to administer and distribute performance-based payments, as provided in subsection (a) of this section.

(2) The consultation required under subsection (c) of this section or an implied waiver of the consultation requirement, as provided in subsection (c) of this section.

GOVERNANCE OF ENTITIES TO MANAGE CARE AND CONTROL COSTS STATEWIDE

SECTION 12H.23.(a) The General Assembly finds that the internal governance of entities contracting with the State to provide centralized care coordination, cost containment, or management of care on a Statewide basis for the Medicaid program is of significant importance to the State, its taxpayers, and its Medicaid recipients, especially given the considerable amount of public funds expended on such contracts. The General Assembly further finds that the public has a profound interest in ensuring the quality of the entities' internal governance and, therefore, it is appropriate that the public should have an influence in the entities' internal governance.

SECTION 12H.23.(b) Based on the legislative findings of subsection (a) of this section, the Department of Health and Human Services shall not enter into a new contract with an entity to provide cost containment or management of care on a statewide basis for the Medicaid program unless the entity adheres to the following governance provisions related to the entity's governing board:

(1) The board shall contain individuals with experience in health care, including the following:
a. A health actuary.
b. Someone with expertise in health information technology, informatics, or provider performance measurement.
c. Two representatives of the provider community.
d. A representative of the health insurance industry.
(2) The board shall provide for public voting members to be appointed as follows:
a. Two persons appointed by the General Assembly on the recommendation of the President Pro Tempore of the Senate.
b. Two persons appointed by the General Assembly on the recommendation of the Speaker of the House of Representatives.
c. Two persons appointed by the Governor.
(3) No more than two members on the board may directly benefit from any per member per month (PMPM) payments or incentive payments that are distributed or administered by the entity.
(4) No more than twenty-five percent (25%) of the members of the board may be providers or come from the provider community.
(5) No member of the board, or immediate family of a member of the board, may be a registered lobbyist or be employed by an entity that lobbies on behalf of a health care provider association.
(6) The board size may not exceed twice the number of persons to be appointed under subdivision (2) of this section plus one.

SECTION 12H.23.(c) Subsection (b) of this section shall not apply to existing contracts or renewals under existing contracts when the renewal is at the option of one party.

ACCOUNTING FOR MEDICAID RECEIVABLES AS NONTAX REVENUE

SECTION 12H.24.(a) Receivables reserved at the end of the 2013-2014 and 2014-2015 fiscal years shall, when received, be accounted for as nontax revenue for each of those fiscal years.

SECTION 12H.24.(b) For the 2013-2014 fiscal year, the Department of Health and Human Services shall deposit from its revenues one hundred ten million dollars ($110,000,000) with the Department of State Treasurer to be accounted for as nontax revenue. For the 2014-2015 fiscal year, the Department of Health and Human Services shall deposit from its revenues one hundred nine million dollars ($109,000,000) 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 non-indigent 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.25. 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 2013-2014 fiscal year and the sum of forty-three million dollars ($43,000,000) for the 2014-2015 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.

MEDICAID COST CONTAINMENT ACTIVITIES

SECTION 12H.26.(a) The Department of Health and Human Services may use up to five million dollars ($5,000,000) in the 2013-2014 fiscal year and up to five million dollars ($5,000,000) in the 2014-2015 fiscal year in Medicaid funds budgeted for program services to support the cost of administrative activities when cost-effectiveness and savings are demonstrated. The funds shall be used to support activities that will contain the cost of the Medicaid Program, including contracting for services, hiring additional staff, funding pilot programs, Health Information Exchange and Health Information Technology (HIE/HIT) administrative activities, or providing grants through the Office of Rural Health and Community Care to plan, develop, and implement cost containment programs.

Medicaid cost containment activities may include prospective reimbursement methods, incentive-based reimbursement methods, service limits, prior authorization of services, periodic medical necessity reviews, revised medical necessity criteria, service provision in the least costly settings, plastic magnetic-stripped Medicaid identification cards for issuance to Medicaid enrollees, fraud detection software or other fraud detection activities, technology that improves clinical decision making, credit balance recovery and data mining services, and other cost containment activities. Funds may be expended under this section only after the Office of State Budget and Management has approved a proposal for the expenditure submitted by the Department. Proposals for expenditure of funds under this section shall include the cost of implementing the cost containment activity and documentation of the amount of savings expected to be realized from the cost containment activity.

SECTION 12H.26.(b) The Department shall report annually on the expenditures under this section to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division. The report shall include the methods used to achieve savings and the amount saved by these methods. The report is due to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division not later than December 1 of each year for the activities of the previous State fiscal year.

MISCELLANEOUS MEDICAID PROVISIONS

SECTION 12H.27.(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.27.(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.27.(c) Posting of Notices on Web Site. – For any public notice of change required pursuant to the provisions of 42 C.F.R. § 447.205, the Department shall, no later than seven business days after the date of publication, publish the same notice on its Web site on the same Web page as it publishes State Plan amendments, and the notice shall remain on the Web site continuously for 90 days.

SECTION 12H.27.(d) Medicaid Identification Cards. – The Department shall issue Medicaid identification cards to recipients on an annual basis with updates as needed.

SUBPART XII-I. MISCELLANEOUS

SPECIFY BOARD SELECTION FOR THE NORTH CAROLINA INSTITUTE OF MEDICINE

SECTION 12I.1.(a) G.S. 90-470 reads as rewritten:

"**§ 90-470. Institute of Medicine.**

(a) The persons appointed under the provisions of this section are declared to be a body politic and corporate under the name and style of the North Carolina Institute of Medicine, and by that name may sue and be sued, make and use a corporate seal and alter the same at pleasure, contract and be contracted with, and shall have and enjoy all the rights and privileges necessary for the purposes of this section. The corporation shall have perpetual succession.

(b) The purposes for which the corporation is organized are to:

(1) Be concerned with the health of the people of North Carolina;

(2) Monitor and study health matters;

(3) Respond authoritatively when found advisable;

(4) Respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions.

~~The 18 initial members of the North Carolina Institute of Medicine shall be appointed by the Governor.~~

(c) The North Carolina Institute of Medicine shall be governed by a Board of Directors. The ~~initial members are authorized, prior to expanding the membership,~~ Board of Directors is authorized to establish and amend bylaws, to procure facilities, employ a director and staff, to solicit, receive and administer funds in the name of the North Carolina Institute of Medicine, and carry out other activities necessary to fulfill the purposes of this section.

(d) The ~~members~~ Board of Directors shall select ~~with the approval of the Governor~~ additional ~~members,~~ members of the North Carolina Institute of Medicine, so that the total membership will not exceed a number determined by the Board of Directors in its bylaws. The membership should be distinguished and influential leaders from the major health professions, the hospital industry, the health insurance industry, State and county government and other political units, education, business and industry, the universities, and the university medical centers.

(e) The North Carolina Institute of Medicine may receive and administer funds from private sources, foundations, State and county governments, federal agencies, and professional organizations.

(f) The director and staff of the North Carolina Institute of Medicine should be chosen from those well established in the field of health promotion and medical care.

~~For the purposes of Chapter 55A of the General Statutes, the members appointed under this section shall be considered the initial board of directors.~~

(g) The North Carolina Institute of Medicine is declared to be under the patronage and control of the State.

(h) The General Assembly reserves the right to alter, amend, or repeal this ~~section.~~ Article."

SECTION 12I.1.(b) Article 31 of Chapter 90 is amended by adding a new section to read as follows:

"**§ 90-471. Board of Directors of the Institute of Medicine.**

(a) The Board of Directors of the North Carolina Institute of Medicine shall be appointed as follows:

(1) Seven individuals appointed by the General Assembly on the recommendation of the Speaker of the House of Representatives.

(2) Seven individuals appointed by the General Assembly on the recommendation of the President Pro Tempore of the Senate.

(3) Seven individuals appointed by the Governor.

(b) The members of the Board of Directors should be distinguished and influential leaders from the major health professions, the hospital industry, the health insurance industry, State and county government and other political units, education, business and industry, the universities, and the university medical centers.

(c) Terms on the Board of Directors shall be for four years, and no individual may serve more than two consecutive terms."

SECTION 12I.1.(c) For the appointments under G.S. 90-471, as enacted by this section, with terms to begin on January 1, 2014, the appointing authorities shall designate certain appointees to serve initial two-year terms as follows:

(1) Of those appointments on the recommendation of the Speaker of the House of Representatives, three shall be designated for two-year terms.

(2) Of those appointments on the recommendation of the President Pro Tempore of the Senate, three shall be designated for two-year terms.

(3) Of those appointments by the Governor, four shall be designated for two-year terms.

A two-year term under this subsection shall count as a term for purposes of the two consecutive term limit provided in G.S. 90-471(c), as enacted by this section.

SECTION 12I.1.(d) The members of the Board of Directors serving as of the effective date of this act may continue to serve until January 1, 2014.

SECTION 12I.1.(e) Subsections (a) and (b) of this section become effective January 1, 2014.

SUBPART XII-J. DHHS BLOCK GRANTS

DHHS BLOCK GRANTS

SECTION 12J.1.(a) Except as otherwise provided, appropriations from federal block grant funds are made for each year of the fiscal biennium ending June 30, 2015, according to the following schedule:

TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) FUNDS

Local Program Expenditures

Division of Social Services

01.	Work First Family Assistance	$ 60,285,413
02.	Work First County Block Grants	82,485,495
03.	Work First Electing Counties	2,352,521
04.	Adoption Services – Special Children's Adoption Fund	2,026,877
05.	Child Protective Services – Child Welfare Workers for Local DSS	9,412,391
06.	Child Welfare Collaborative	632,416

Division of Child Development		
07.	Subsidized Child Care Program	52,060,846
08.	Swap Child Care Subsidy	6,352,644
Division of Public Health		
09.	Teen Pregnancy Initiatives	2,500,000
DHHS Administration		
10.	Division of Social Services	2,482,260
11.	Office of the Secretary	34,042
Transfers to Other Block Grants		
Division of Child Development		
12.	Transfer to the Child Care and Development Fund	71,773,001
13.	Transfer to Social Services Block Grant for Child Protective Services – Child Welfare Training in Counties	1,300,000
14.	Transfer to Social Services Block Grant for Child Protective Services	5,040,000
15.	Transfer to Social Services Block Grant for County Departments of Social Services for Children's Services	4,148,001
TOTAL TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) FUNDS		**$ 302,885,907**
TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) EMERGENCY CONTINGENCY FUNDS		
Local Program Expenditures		
Division of Social Services		
01.	Work First County Block Grants	$ 5,580,925
02.	Work First Electing Counties	25,692
03.	Subsidized Child Care	6,549,469
TOTAL TEMPORARY ASSISTANCE TO NEEDY FAMILIES (TANF) EMERGENCY CONTINGENCY FUNDS		**$ 12,156,086**

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)	$ 29,422,137
02.	Child Protective Services (Transfer from TANF)	5,040,000
03.	State In-Home Services Fund	1,943,950
04.	Adult Protective Services	1,245,363
05.	State Adult Day Care Fund	1,994,084
06.	Child Protective Services/CPS Investigative Services – Child Medical Evaluation Program (Carousel Center for Abused Children $134,592)	563,868
07.	Special Children Adoption Incentive Fund	462,600
08.	Child Protective Services – Child Welfare Training for Counties (Transfer from TANF)	1,300,000
09.	Home and Community Care Block Grant (HCCBG)	1,696,888
10.	Child Advocacy Centers	375,000
11.	Guardianship	3,978,360
12.	UNC Cares Contract	229,376
13.	Foster Care Services	1,385,152

Division of Central Management and Support

14.	DHHS Competitive Block Grants for Nonprofits (2013-2014 Fiscal Year Only)	3,852,500

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

DHHS Program Expenditures

Division of Services for the Blind

16.	Independent Living Program	3,361,323

Division of Health Service Regulation		
17.	Adult Care Licensure Program	381,087
18.	Mental Health Licensure and Certification Program	190,284
DHHS Administration		
19.	Division of Aging and Adult Services	577,745
20.	Division of Social Services	559,109
21.	Office of the Secretary/Controller's Office	127,731
22.	Division of Child Development	13,878
23.	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services	27,446
24.	Division of Health Service Regulation	118,946
TOTAL SOCIAL SERVICES BLOCK GRANT		**$ 62,877,557**

LOW-INCOME HOME ENERGY ASSISTANCE BLOCK GRANT

Local Program Expenditures		
Division of Social Services		
01.	Low-Income Energy Assistance Program (LIEAP)	$ 50,799,293
02.	Crisis Intervention Program (CIP)	33,866,195
Local Administration		
Division of Social Services		
03.	County DSS Administration	6,757,731
DHHS Administration		
04.	Office of the Secretary/DIRM	412,488
05.	Office of the Secretary/Controller's Office	18,378
Transfers to Other State Agencies		
Department of Commerce		
06.	Weatherization Program	15,024,936

07.	Heating Air Repair and Replacement Program (HARRP)	7,193,873
08.	Local Residential Energy Efficiency Service Providers – Weatherization	37,257
09.	Local Residential Energy Efficiency Service Providers – HARRP	338,352
10.	Department of Commerce Administration – Weatherization	37,257
11.	Department of Commerce Administration – HARRP	338,352
	Department of Administration	
12.	N.C. Commission on Indian Affairs	87,736
TOTAL LOW-INCOME HOME ENERGY ASSISTANCE BLOCK GRANT		**$ 114,911,848**

CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT

Local Program Expenditures

	Division of Child Development	
01.	Child Care Services (Smart Start $7,000,000)	$ 158,328,747
02.	Electronic Tracking System	3,000,000
03.	Transfer from TANF Block Grant for Child Care Subsidies	71,773,001
04.	Quality and Availability Initiatives (TEACH Program $3,800,000)	22,500,000

DHHS Administration

	Division of Child Development	
05.	DCDEE Administrative Expenses	6,000,000
06.	Local Subsidized Child Care Services Support	13,274,413
	Division of Central Administration	
07.	DHHS Central Administration – DIRM	

	Technical Services	775,000
TOTAL CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT		**$ 275,651,161**
MENTAL HEALTH SERVICES BLOCK GRANT		
Local Program Expenditures		
01.	Mental Health Services – Adult	$ 10,717,607
02.	Mental Health Services – Child	5,121,991
03.	Administration	200,000
TOTAL MENTAL HEALTH SERVICES BLOCK GRANT		**$ 16,039,598**
SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT		
Local Program Expenditures		
Division of Mental Health, Developmental Disabilities, and Substance Abuse Services		
01.	Substance Abuse Services – Adult	$ 14,960,371
02.	Substance Abuse Treatment Alternative for Women	6,050,300
03.	Substance Abuse – HIV and IV Drug	3,919,723
04.	Substance Abuse Prevention – Child	7,186,857
05.	Substance Abuse Services – Child	4,190,500
06.	Administration	454,000
Division of Public Health		
07.	Risk Reduction Projects	575,654
08.	Aid-to-Counties	190,295
TOTAL SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT		**$ 37,527,700**
MATERNAL AND CHILD HEALTH BLOCK GRANT		
Local Program Expenditures		
Division of Public Health		
01.	Children's Health Services	$ 8,042,531

02. Women's Health (March of Dimes $350,000; Teen Pregnancy Prevention Initiatives $650,000; Perinatal Quality Collaborative $350,000; 17P Project $47,000; Maternity Homes $925,085; Carolina Pregnancy Care Fellowship $250,000)	8,532,935
03. Local Health Departments/Oral Health Services	44,901
Division of Central Management and Support	
04. DHHS Competitive Block Grants for Nonprofits (2013-2014 Fiscal Year Only)	89,374
DHHS Program Expenditures	
Division of Public Health	
05. Children's Health Services	1,301,504
06. Women's Health – Maternal Health	105,419
07. State Center for Health Statistics	164,487
DHHS Administration	
Division of Public Health	
08. Division of Public Health Administration	573,108
TOTAL MATERNAL AND CHILD HEALTH BLOCK GRANT	**$ 18,854,259**
PREVENTIVE HEALTH SERVICES BLOCK GRANT	
Local Program Expenditures	
01. DHHS Competitive Block Grants for Nonprofits (2013-2014 Fiscal Year Only)	1,331,961
02. Injury and Violence Prevention (Services to Rape Victims – Set-Aside)	169,730
DHHS Program Expenditures	
Division of Public Health	
03. HIV/STD Prevention and Community Planning (Transfer from Social Services Block Grant)	145,819

04.	Oral Health Preventive Services	46,302
05.	Laboratory Services – Testing, Training, and Consultation	10,980
06.	Injury and Violence Prevention (Services to Rape Victims – Set-Aside)	199,634
07.	Heart Disease and Stroke Prevention	162,249
08.	Performance Improvement and Accountability	213,971
09.	Physical Activity and Nutrition	38,000
10.	State Center for Health Statistics	61,406
TOTAL PREVENTIVE HEALTH SERVICES BLOCK GRANT		**$ 2,380,052**

COMMUNITY SERVICES BLOCK GRANT

Local Program Expenditures

Office of Economic Opportunity

01.	Community Action Agencies	$ 22,402,724
02.	Limited Purpose Agencies	1,244,596

DHHS Administration

03.	Office of Economic Opportunity	1,244,596
TOTAL COMMUNITY SERVICES BLOCK GRANT		**$ 24,891,916**

GENERAL PROVISIONS

SECTION 12J.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 12J.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 2013-2014 and 2014-2015, increases in the federal fund availability for the Temporary Assistance to Needy Families (TANF) Block Grant shall be used 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.

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, the Joint Legislative Commission on Governmental Operations, and the Fiscal Research Division.

SECTION 12J.1.(d) Except as otherwise provided, appropriations from federal Block Grant funds are made for each year of the fiscal biennium ending June 30, 2015, according to the schedule enacted for State fiscal years 2013-2014 and 2014-2015 or until a new schedule is enacted by the General Assembly.

SECTION 12J.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 Commission on Governmental Operations 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.

TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF) FUNDS

SECTION 12J.1.(f) The sum of eighty-two million four hundred eighty-five thousand four hundred ninety-five dollars ($82,485,495) appropriated in this section in TANF funds to the Department of Health and Human Services, Division of Social Services, for each year of the 2013-2015 fiscal biennium 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 12J.1.(g) The sum of two million four hundred eighty-two thousand two hundred sixty dollars ($2,482,260) appropriated in this section in TANF funds to the Department of Health and Human Services, Division of Social Services, for each year of the 2013-2015 fiscal biennium shall be used to support administration of TANF-funded programs.

SECTION 12J.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 2013-2015 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 2013-2014 and 2014-2015 shall not be less than the total expended from State and local funds for the 2012-2013 fiscal year.

SECTION 12J.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 2013-2015 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.

SECTION 12J.1.(j) The sum of six hundred thirty-two thousand four hundred sixteen dollars ($632,416) appropriated in this section to the Department of Health and Human Services in TANF funds for each year of the 2013-2015 fiscal biennium shall be used to continue support for the Child Welfare Collaborative.

SECTION 12J.1.(k) The Department of Health and Human Services, Division of Social Services, shall use funds appropriated in the Temporary Assistance to Needy Families (TANF) Block Grant and allocated for Work First Family Assistance for each year of the 2013-2015 fiscal biennium to implement Section 12C.6 of this act.

SOCIAL SERVICES BLOCK GRANT

SECTION 12J.1.(l) The sum of twenty-nine million four hundred twenty-two thousand one hundred thirty-seven dollars ($29,422,137) 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 2013-2015 fiscal biennium 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 12J.1.(m) 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 2013-2015 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 12J.1.(n) 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 12J.1.(o) Social Services Block Grant funds appropriated for the Special Children's Adoption Incentive Fund will require a fifty percent (50%) local match.

SECTION 12J.1.(p) 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 2013-2015

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 government 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 12J.1.(q) 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.2 of this act for the 2013-2014 fiscal year only. These funds are exempt from the provisions of 10A NCAC 71R .0201(3).

SECTION 12J.1.(r) 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 2013-2015 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 are exempt from the provisions of 10A NCAC 71R .0201(3).

SECTION 12J.1.(s) Social Services Block Grant funds allocated each year of the 2013-2015 fiscal biennium for child medical evaluations and the Carousel Center for Abused Children are exempt from the provisions of 10A NCAC 71R .0201(3).

SECTION 12J.1.(t) The sum of three million nine hundred seventy-eight thousand three hundred sixty dollars ($3,978,360) appropriated in this section in the Social Services Block Grant for each year of the 2013-2015 fiscal biennium 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 2013-2014 and 2014-2015 fiscal years and (ii) guardianship contracts transferred to the State from local management entities or managed care organizations during the 2013-2014 and 2014-2015 fiscal years.

LOW-INCOME HOME ENERGY ASSISTANCE BLOCK GRANT

SECTION 12J.1.(u) Additional emergency contingency funds received may be allocated for Energy Assistance Payments or Crisis Intervention Payments without prior consultation with the Joint Legislative Commission on Governmental Operations. Additional funds received shall be reported to the Joint Legislative Commission on Governmental Operations 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 Commission on Governmental Operations.

SECTION 12J.1.(v) The sum of fifty million seven hundred ninety-nine thousand two hundred ninety-three dollars ($50,799,293) appropriated in this section in the Low-Income Home Energy Assistance Block Grant for each year of the 2013-2015 fiscal biennium 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.

CHILD CARE AND DEVELOPMENT FUND BLOCK GRANT

SECTION 12J.1.(w) 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 12J.1.(x) 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.

MATERNAL AND CHILD HEALTH BLOCK GRANT

SECTION 12J.1.(y) 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 2013-2014 fiscal year or the 2014-2015 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 12J.1.(z) The Department of Health and Human Services shall ensure that there will be follow-up testing in the Newborn Screening Program.

SECTION 12J.1.(aa) The sum of eighty-nine thousand three hundred seventy-four dollars ($89,374) appropriated in this section in the Maternal and Child Health 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.2 of this act for the 2013-2014 fiscal year only.

PREVENTIVE HEALTH SERVICES BLOCK GRANT

SECTION 12J.1.(bb) The sum of one million three hundred thirty-one thousand nine hundred sixty-one dollars ($1,331,961) appropriated in this section in the Preventive Health 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.2 of this act for the 2013-2014 fiscal year only.

PART XIII. DEPARTMENT OF AGRICULTURE AND CONSUMER SERVICES

INCREASE CERTAIN AGRONOMIC TESTING FEES

SECTION 13.1.(a) G.S. 106-22 reads as rewritten:

"**§ 106-22. Joint duties of Commissioner and Board.**

The Commissioner of Agriculture, by and with the consent and advice of the Board of Agriculture shall:

…

(17) Agronomic Testing. – Provide agronomic testing services and charge reasonable fees for plant analysis, nematode testing, in-State soil testing during peak season, out-of-state soil testing, and expedited soil testing. The Board shall charge at least four dollars ($4.00) for plant analysis, at least two dollars ($2.00) for nematode testing, at least four dollars ($4.00) for in-State soil testing during peak season, at least five dollars ($5.00) for out-of-state soil testing, and at least ~~one hundred dollars ($100.00)~~two hundred dollars