**FUNDS APPROPRIATED TO IMPLEMENT RECOMMENDATIONS OF THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON HEALTH AND HUMAN SERVICES REGARDING BEHAVIORAL HEALTH CRISIS SERVICES**

**SECTION 12F.5.(a)** The following definitions apply in this section:

(1) Facility-Based Crisis Center. – A 24-hour residential facility licensed under 10A NCAC 27G .5000 to provide facility-based crisis service as described in 10A NCAC 27G .5001.

(2) Secretary. – The Secretary of the North Carolina Department of Health and Human Services.

(3) Behavioral Health Urgent Care Center. – An outpatient facility that provides walk-in crisis assessment, referral, and treatment by licensed behavioral health professionals with prescriptive authority to individuals with an urgent or emergent need for mental health, intellectual or developmental disabilities, or substance abuse services.

**SECTION 12F.5.(b)** From funds appropriated in this act to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, for community services for the 2014-2015 fiscal year, the Division shall use two million two hundred thousand dollars ($2,200,000) in recurring funds to accomplish the following:

(1) To increase the number of co-located or operationally linked behavioral health urgent care centers and facility-based crisis centers.

(2) To increase the number of facility-based crisis centers designated by the Secretary as facilities for the custody and treatment of involuntary clients pursuant to G.S. 122C-252 and 10A NCAC 26C .0101. The Department shall give priority to areas of the State experiencing a shortage of these types of facilities.

(3) To provide reimbursement for services provided by facility-based crisis centers.

(4) To establish facility-based crisis centers for children and adolescents.

**SUBPART XII-G. DIVISION OF HEALTH SERVICE REGULATION**

**TECHNICAL CORRECTION TO CERTIFICATE OF NEED EXEMPTION FOR REPLACEMENT OF PREVIOUSLY APPROVED EQUIPMENT**

**SECTION 12G.1.(a)** G.S. 131E-184(f) reads as rewritten:

"(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)~~ G.S. 131E-176(22a) if all of the following conditions are met:

(1) The equipment being replaced is located on the main campus.

(2) The Department has previously issued a certificate of need for the equipment being replaced. This subdivision does not apply if a certificate of need was not required at the time the equipment being replaced was initially purchased by the licensed health service facility.

(3) The licensed health service facility proposing to purchase the replacement equipment 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.1.(b)** This section is effective when it becomes law.

****~~H~~EALTH CARE COST REDUCTION AND TRANSPARENCY ACT REVISIONS**

**SECTION 12G.2.** G.S. 131E-214.13 reads as rewritten:

"**§ 131E-214.13. Disclosure of prices for most frequently reported DRGs, CPTs, and HCPCSs.**

(a) The following definitions apply in this Article:

(1) Ambulatory surgical facility. – A facility licensed under Part 4 of Article 6 of this Chapter.

(2) Commission. – The North Carolina Medical Care Commission.

(3) Health insurer. – ~~As defined in G.S. 108A-55.4, provided that "health insurer" shall not include self-insured plans and group health plans as~~

~~defined in section 607(1) of the Employee Retirement Income Security Act of 1974.~~An entity that writes a health benefit plan and is one of the following:

a. An insurance company under Article 3 of Chapter 58 of the General Statutes.

b. A service corporation under Article 65 of Chapter 58 of the General Statutes.

c. A health maintenance organization under Article 67 of Chapter 58 of the General Statutes.

d. A third-party administrator of one or more group health plans, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1167(1)).

(4) Hospital. – A medical care facility licensed under Article 5 of this Chapter or under Article 2 of Chapter 122C of the General Statutes.

(5) Public or private third party. – Includes the State, the federal government, employers, health insurers, third-party administrators, and managed care organizations.

(b) Beginning with the quarter ending June 30, 2014, and quarterly thereafter, each hospital shall provide to the Department of Health and Human Services, utilizing electronic health records software, the following information about the 100 most frequently reported admissions by DRG for inpatients as established by the ~~Commission:~~Department:

(1) The amount that will be charged to a patient for each DRG if all charges are paid in full without a public or private third party paying for any portion of the charges.

(2) The average negotiated settlement on the amount that will be charged to a patient required to be provided in subdivision (1) of this subsection.

(3) The amount of Medicaid reimbursement for each DRG, including claims and pro rata supplemental payments.

(4) The amount of Medicare reimbursement for each DRG.

(5) For each of the five largest health insurers providing payment to the hospital on behalf of insureds and teachers and State employees, the range and the average of the amount of payment made for each DRG. Prior to providing this information to the Department, each hospital shall redact the names of the health insurers and any other information that would otherwise identify the health insurers.

A hospital shall not be required to report the information required by this subsection for any of the 100 most frequently reported admissions where the reporting of that information reasonably could lead to the identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

(c) The Commission shall adopt rules on or before ~~March 1, 2014,~~January 1, 2015, to ensure that subsection (b) of this section is properly implemented and that hospitals report this information to the Department in a uniform manner. The rules shall include all of the following:

(1) The method by which the Department shall determine the 100 most frequently reported DRGs for inpatients for which hospitals must provide the data set out in subsection (b) of this section.

(2) Specific categories by which hospitals shall be grouped for the purpose of disclosing this information to the public on the Department's Internet Web site.

(d) Beginning with the quarter ending September 30, 2014, and quarterly thereafter, each hospital and ambulatory surgical facility shall provide to the Department, utilizing electronic health records software, information on the total costs for the 20 most common surgical procedures and the 20 most common imaging procedures, by volume, performed in hospital outpatient settings or in ambulatory surgical facilities, along with the related CPT and HCPCS codes. Hospitals and ambulatory surgical facilities shall report this information in the same manner as required by subdivisions (b)(1) through (5) of this section, provided that hospitals and ambulatory surgical facilities shall not be required to report the information required by this subsection where the reporting of that information reasonably could lead to the

identification of the person or persons admitted to the hospital in violation of the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) or other federal law.

(e) The Commission shall adopt rules on or before ~~June 1, 2014~~,January 1, 2015, to ensure that subsection (d) of this section is properly implemented and that hospitals and ambulatory surgical facilities report this information to the Department in a uniform manner. The rules shall include the ~~list of~~ method by which the Department shall determine the 20 most common surgical procedures and the 20 most common imaging ~~procedures, by volume, performed in a hospital outpatient setting and those performed in an ambulatory surgical facility, along with the related CPT and HCPCS codes.~~procedures for which the hospitals must provide the data set out in subsection (d) of this section.

(e1) The Commission shall adopt rules to establish quality measures identical to those established by the Joint Commission for each of the following:

a. Primary cesarean section rate, uncomplicated (TJC PC-02)
b. Early elective delivery rate (TJC PC-01)
c. C. difficile infection SIR (NHSN)
d. Multidrug resistant organisms (NHSN)
e. Surgical site infection SRI for colon surgeries (NSHN)
f. Post op sepsis rate (PSI13)
g. Thrombolytic therapy for acute ischemic stroke patients (STK-4)
h. Stroke education (STK-8)
i. Venous thrombolism prophylaxis (VTE-1)
j. Venous thrombolism discharge instructions (VTE-5)

(f) Upon request of a patient for a particular DRG, imaging procedure, or surgery procedure reported in this section, a hospital or ambulatory surgical facility shall provide the information required by subsection (b) or subsection (d) of this section to the patient in writing, either electronically or by mail, within three business days after receiving the request.

(g) G.S. 150B-21.3 does not apply to rules adopted under subsections (c) and (e) of this section. A rule adopted under subsections (c) and (e) of this section becomes effective on the last day of the month following the month in which the rule is approved by the Commission."

**STUDY CONCERNING EXPANSION OF HEALTH CARE COST REDUCTION AND TRANSPARENCY ACT TO ADDITIONAL HEALTH CARE PROVIDERS**

**SECTION 12G.3.** By December 1, 2014, the Department of Health and Human Services shall study and submit a written report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division summarizing its recommendations for extending North Carolina's Health Care Cost Reduction and Transparency Act of 2013 (the Act) to additional health care providers. The report shall identify all of the following:

(1) Recommended categories of additional health care providers that should be subject to the requirements of the Act.
(2) Recommended data to be collected for the purpose of transparency from each category of identified health care providers.
(3) Recommended exemptions, if any, from certain requirements of the Act for each category of identified health care providers.
(4) Recommended effective dates for the applicability of the Act to each category of identified health care providers.

**MORATORIUM ON HOME CARE AGENCY LICENSES FOR IN-HOME AIDE SERVICES**

**SECTION 12G.4.(a)** For the period commencing on the effective date of this section, and ending June 30, 2016, and notwithstanding the provisions of the Home Care Agency Licensure Act set forth in Part 3 of Article 6 of Chapter 131E of the General Statutes or any rules adopted pursuant to that Part, the Department of Health and Human Services shall not issue any licenses for home care agencies as defined in G.S. 131E-136(2) that intend to offer in-home aide services. This prohibition does not apply to companion and sitter services and shall not restrict the Department from doing any of the following:

(1) Issuing a license to a certified home health agency as defined in G.S. 131E-176(12) that intends to offer in-home aide services.