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

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

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

STUDY DESIGN AND IMPLEMENTATION OF CONTRACTING SPECIALIST AND CERTIFICATION PROGRAM

SECTION 12A.13. The Joint Legislative Oversight Committee on Health and Human Services shall study and make recommendations regarding the design of a contracting specialist training and certification program for management level personnel within the Department of Health and Human Services (DHHS) similar to the Certified Local Government Purchasing Officer program and local purchasing and contracts program of the University of North Carolina School of Government.

HEALTH CARE COST REDUCTION AND TRANSPARENCY ACT REVISIONS

SECTION 12A.15.(a) 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. – 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,~~ reporting period ending September 30, 2015, and ~~quarterly~~ annually 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 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 ~~January 1, 2015,~~ March 1, 2016, 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,~~ reporting period ending September 30, 2015, and ~~quarterly~~ annually 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 ~~January 1, 2015,~~ March 1, 2016, 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 method by which the Department shall determine the 20 most common surgical procedures and the 20 most common imaging procedures for which the hospitals and ambulatory surgical facilities must provide the data set out in subsection (d) of this section.

(e1) The Commission shall adopt rules to establish and define no fewer than 10 quality measures ~~identical to those established by the Joint Commission for each of the following:~~ for licensed hospitals and licensed ambulatory surgical facilities.

~~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 Rules Review Commission."

SECTION 12A.15.(b) G.S. 131E-214.14 reads as rewritten:

"**§ 131E-214.14. Disclosure of charity care policy and costs.**

(a) Requirements. – A hospital or ambulatory surgical facility required to file Schedule H, federal form 990, under the Code must provide the public access to its financial assistance policy and its annual financial assistance costs reported on its Schedule H, federal form 990. The information must be submitted annually to the Department in the time, manner, and format required by the Department. The Department must post all of the information submitted pursuant to this subsection on its internet Web ~~site.~~site in one location and in a manner that is searchable. The posting requirement shall not be satisfied by posting links to internet Web sites. The information must also be displayed in a conspicuous place in the organization's place of business.

...."

RENAMING OF OFFICE OF RURAL HEALTH AND COMMUNITY CARE

SECTION 12A.16.(a) The Office of Rural Health and Community Care within the Department of Health and Human Services, Division of Central Management and Support, is hereby renamed the Office of Rural Health.

SECTION 12A.16.(b) Consistent with subsection (a) of this section, the Revisor of Statutes may conform names and titles changed by this section and may correct statutory references as required by this section throughout the General Statutes. In making the changes authorized by this section, the Revisor may also adjust subject and verb agreement and the placement of conjunctions.

FUNDS FOR DEVELOPMENT OF HEALTH ANALYTICS PILOT PROGRAM

SECTION 12A.17.(a) Of the funds appropriated in this act to the Department of Health and Human Services, Division of Central Management and Support, the sum of seven hundred fifty thousand dollars ($750,000) in nonrecurring funds for the 2015-2016 fiscal year and the sum of two hundred fifty thousand dollars ($250,000) in recurring funds for the 2015-2016 fiscal year and the 2016-2017 fiscal year shall be used for the development and implementation of a pilot program for Medicaid claims analytics and population health management.

SECTION 12A.17.(b) The Department shall coordinate with the Government Data Analytics Center (GDAC) to develop the pilot program and to provide access to needed data sources, including Medicaid claims data, for the pilot program. The pilot program shall utilize the subject matter expertise and technology available through existing GDAC public-private partnerships in order to apply analytics in a manner that would maximize health care savings and efficiencies to the State and optimize positive impacts on health outcomes.

SECTION 12A.17.(c) By November 30, 2015, the Department shall execute all contractual agreements and interagency data-sharing agreements necessary for development and implementation of the pilot program authorized by this section.

SECTION 12A.17.(d) By January 15, 2016, the Department and GDAC shall provide a progress report on the pilot program authorized by this section to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Committee on Health and Human Services, and the Fiscal Research Division. By May 31, 2016, the Department and GDAC shall make a final report of their findings and recommendations on the pilot program authorized by this section to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Information Technology, and the Fiscal Research Division.