

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

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

- 5 (1) Facility-Based Crisis Center. – A 24-hour residential facility licensed under
 6 10A NCAC 27G .5000 to provide facility-based crisis service as described in
 7 10A NCAC 27G .5001.
 8 (2) Secretary. – The Secretary of the North Carolina Department of Health and
 9 Human Services.
 10 (3) Behavioral Health Urgent Care Center. – An outpatient facility that provides
 11 walk-in crisis assessment, referral, and treatment by licensed behavioral
 12 health professionals with prescriptive authority to individuals with an urgent
 13 or emergent need for mental health, intellectual or developmental
 14 disabilities, or substance abuse services.

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

- 20 (1) To increase the number of co-located or operationally linked behavioral
 21 health urgent care centers and facility-based crisis centers.
 22 (2) To increase the number of facility-based crisis centers designated by the
 23 Secretary as facilities for the custody and treatment of involuntary clients
 24 pursuant to G.S. 122C-252 and 10A NCAC 26C .0101. The Department
 25 shall give priority to areas of the State experiencing a shortage of these types
 26 of facilities.
 27 (3) To provide reimbursement for services provided by facility-based crisis
 28 centers.
 29 (4) To establish facility-based crisis centers for children and adolescents.

30
 31 **SUBPART XII-G. DIVISION OF HEALTH SERVICE REGULATION**

32
 33 **TECHNICAL CORRECTION TO CERTIFICATE OF NEED EXEMPTION FOR**
 34 **REPLACEMENT OF PREVIOUSLY APPROVED EQUIPMENT**

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

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

- 39 (1) The equipment being replaced is located on the main campus.
 40 (2) The Department has previously issued a certificate of need for the equipment
 41 being replaced. This subdivision does not apply if a certificate of need was
 42 not required at the time the equipment being replaced was initially purchased
 43 by the licensed health service facility.
 44 (3) The licensed health service facility proposing to purchase the replacement
 45 equipment shall provide prior written notice to the Department, along with
 46 supporting documentation to demonstrate that it meets the exemption criteria
 47 of this subsection."

48 **SECTION 12G.1.(b)** This section is effective when it becomes law.

49
 50 ****HEALTH CARE COST REDUCTION AND TRANSPARENCY ACT REVISIONS**

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

52 **"§ 131E-214.13.** Disclosure of prices for most frequently reported DRGs, CPTs, and
 53 HCPCSs.

54 (a) The following definitions apply in this Article:

- 55 (1) Ambulatory surgical facility. – A facility licensed under Part 4 of Article 6
 56 of this Chapter.
 57 (2) Commission. – The North Carolina Medical Care Commission.
 58 (3) Health insurer. – ~~As defined in G.S. 108A 55.4, provided that "health~~
 59 ~~insurer" shall not include self-insured plans and group health plans as~~

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

- 4 a. An insurance company under Article 3 of Chapter 58 of the General
 5 Statutes.
 6 b. A service corporation under Article 65 of Chapter 58 of the General
 7 Statutes.
 8 c. A health maintenance organization under Article 67 of Chapter 58 of
 9 the General Statutes.
 10 d. A third-party administrator of one or more group health plans, as
 11 defined in section 607(1) of the Employee Retirement Income
 12 Security Act of 1974 (29 U.S.C. § 1167(1)).

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

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

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

- 22 (1) The amount that will be charged to a patient for each DRG if all charges are
 23 paid in full without a public or private third party paying for any portion of
 24 the charges.
 25 (2) The average negotiated settlement on the amount that will be charged to a
 26 patient required to be provided in subdivision (1) of this subsection.
 27 (3) The amount of Medicaid reimbursement for each DRG, including claims and
 28 pro rata supplemental payments.
 29 (4) The amount of Medicare reimbursement for each DRG.
 30 (5) For each of the five largest health insurers providing payment to the hospital
 31 on behalf of insureds and teachers and State employees, the range and the
 32 average of the amount of payment made for each DRG. Prior to providing
 33 this information to the Department, each hospital shall redact the names of
 34 the health insurers and any other information that would otherwise identify
 35 the health insurers.

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

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

- 45 (1) The method by which the Department shall determine the 100 most
 46 frequently reported DRGs for inpatients for which hospitals must provide the
 47 data set out in subsection (b) of this section.
 48 (2) Specific categories by which hospitals shall be grouped for the purpose of
 49 disclosing this information to the public on the Department's Internet Web
 50 site.

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

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

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

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

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

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

27 (g) G.S. 150B-21.3 does not apply to rules adopted under subsections (c) and (e) of this
28 section. A rule adopted under subsections (c) and (e) of this section becomes effective on the
29 last day of the month following the month in which the rule is approved by the Commission."
30

31 STUDY CONCERNING EXPANSION OF HEALTH CARE COST REDUCTION AND 32 TRANSPARENCY ACT TO ADDITIONAL HEALTH CARE PROVIDERS

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

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

47 MORATORIUM ON HOME CARE AGENCY LICENSES FOR IN-HOME AIDE 48 SERVICES

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

- 56 (1) Issuing a license to a certified home health agency as defined in
57 G.S. 131E-176(12) that intends to offer in-home aide services.
58