



## INTRODUCTION

When the General Assembly adjourned “sine die” near midnight on July 1<sup>st</sup>, it was the end to one of the most contentious biennium sessions in recent memory. The 2015 “long” session was the longest in a decade, lasting almost into October, and featured several high-profile battles between the House, Senate and Governor. While the 2016 “short” session (second year of the biennium) adjourned earlier than any in recent memory and did not feature the same kind of drawn out battles we witnessed last year, it was not without moments of significant drama. Despite an insistence from leaders in both chambers that major, controversial issues would have to wait until the next long session (a pledge which was upheld much more than insiders expected back in April), conflicts still managed to erupt and derail major priorities for each chamber. As we detailed in the previous report, bills that were important to two Senate leaders were shot down by the House on the final day of session, and the resulting breakdown between the chambers stranded several high-profile pieces of legislation – including a regulatory reform package that had taken weeks to negotiate; an anti-immigration measure opposed by law enforcement but seemingly destined to pass; and a trio of Constitutional amendments that would have appeared on the November ballot, including one to cap state income tax levels.

Of course, the biggest conflict of the session happened mostly behind closed doors and centered on the backlash to House Bill 2 (a controversial bill passed in March that, aimed at repealing an ordinance Charlotte passed earlier that month that would have expanded protections, but that also effectively precludes all State and local protections for LGBT citizens). Despite strong and continued backlash from major businesses and threats from sports leagues, legislative leaders and Gov. McCrory defended the law publicly, and a “compromise” bill to change some parts of the law that was proposed by some moderate House Republicans fell apart in the final days of session. While the proposal was not a full repeal, it reflected what its authors determined could pass the House and Senate. Despite this attempt at careful balancing, the proposal was rejected both by conservative members who fully support HB2, and Democrats who saw it as a grossly insufficient response.



## NORTH CAROLINA COLLEGE OF EMERGENCY PHYSICIANS



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One change to HB2 was passed in the final hours of session, a restoration of the right of individuals to sue over workplace discrimination in State courts, but with a shortened statute of limitations on these claims from three years to one year. In the days since the legislature adjourned speculation has been rampant about the impact of leaving HB2 in place. We soon got our answer with the NBA's announcement that it was pulling the 2017 All-Star Game from Charlotte in response seen as the most high-profile so far, but certainly not the last repercussion. Expect to hear more about HB2 as the fall campaigns heat up, with Gov. McCrory accusing Attorney General (and Gubernatorial challenger) Roy Cooper of conspiring with "media and sports elites" to create a scandal out of a "common sense" bill. From recent polling, however, HB2 remains very unpopular overall, with many voters holding the Governor and legislative leaders accountable.

The months ahead will see some limited legislative activity as interim Oversight and study committees are formed and begin to meet, however most political energy and attention will be focused on the upcoming election. All 170 legislative members are technically up for reelection, however many races are uncontested and several more are being held in districts that heavily favor one party over the other. There are a number of truly competitive races, however, and while not enough to allow Democrats to regain control of the State House or Senate, certainly enough to change the dynamic within the caucuses if enough Republican seats are flipped. Emboldened by the blowback from House Bill 2 and a historical (though slight) advantage in Presidential election years, Democrats are bullish on their chances to pick up enough seats to become a stronger and more relevant minority party next session. Those hopes do rely, however, on Attorney General Roy Cooper successfully challenging incumbent Gov. McCrory in a race that is statistically tied and will be the focus of a tremendous amount of campaign spending. Other races for less high-profile but certainly significant offices such as Attorney General, Commissioner of Labor, State Supreme Court and Lt. Governor are also expected to be close. With North Carolina seen as a crucial swing state in the Presidential race - particularly for Republican chances - and a U.S. Senate race also on the ballot, our state will be ground zero for a historic amount of political activity, advertising and, almost certainly, acrimony. While the Presidential race will dominate the headlines, those of us who deal with state-level policymaking understand just how impactful the outcomes of each of these races can be. We will keep you posted on the outcome of each race and how they are expected to impact the political context for next session. With several high-profile legislators retiring this session and several more in tough re-election fights this fall, things may be quite different on Jones St. in 2017. In fact, we may look back on 2016 with nostalgia for how brief, and relatively peaceful, it turned out to be.

As we look back over the last year we are ever mindful of the trust and confidence you have placed in us to represent you at the North Carolina General Assembly. We are proud of the work that we do for you and look forward to another session of working together.

## **LEGISLATION ENACTED**

HOUSE BILL 169, Restore State Claim for Wrongful Discharge. This bill was the vehicle used to provide a slight modification to House Bill 2 (also known as the bathroom bill). After all the pressure to repeal House Bill 2 and the rumors that various draft bills were in the works to modify House Bill 2, they really did very little to change the provisions and the problems that many groups and businesses have with the legislation. This bill was one of the regulatory reform bills that was being negotiated in conference and they stripped all of those provisions and right before the end of the session they ran this bill. The bill repeals a section of House Bill 2 that had

repealed the state tort claim for wrongful discharge requiring all discrimination claims to be filed in the Federal Courts). The legislation establishes a right of action for employment discrimination “on account of race, religion, color, national origin, age, biological sex or handicap by employers which regularly employ 15 or more employees”, and establishes a one-year statute of limitations. NOTE: Prior to the passage of House Bill 2, employment discrimination actions could be brought within three years, so this legislation does not fully restore the right of action repealed by House Bill 2. **Effective: July 1, 2016.**

HOUSE BILL 287, Amend Insurance Laws, provides that the provisions of Chapter 58 (Insurance) of the NC General Statutes do not apply to any accountable care organization approved by the Centers for Medicare and Medicaid Services (CMS) to participate in Medicare programs. This exemption would be limited to the activities performed by the Accountable Care Organization pursuant to its agreement with CMS for participation in Medicare programs (Medicare is regulated under Federal Law). The **North Carolina College of Emergency Physicians** was consulted regarding this provision and after some research we determined the provision would not have any negative effects. **Effective: June 30, 2016.**

HOUSE BILL 630, Drinking Water Protect'n/Coal Ash Cleanup, was drafted as a compromise between the legislature and Gov. McCrory on what has been one of the most contentious issues of the past two years: how to deal with the waste ash from coal-fired energy plants, and which branch of government controls those decisions. Earlier in the session the General Assembly passed legislation to reconstitute the Coal Ash Management Commission. The Commission was created by legislation passed in 2014 and became the source of a lawsuit (McCrory v Berger) in which the State Supreme Court ruled for the Governor, finding that the legislature had unconstitutionally assigned itself disproportionate control of the Commission. While the legislation passed earlier in the session ceded a majority of appointments to the Commission to the Governor, he vetoed the bill saying it was “not good for the environment or for the rule of law in North Carolina”. While the bill passed with sufficient support for an override of the Governor’s veto, Senate leadership announced they would not hold an override vote and would instead work with the Governor to develop alternative legislation. That compromise language landed in House Bill 630, and the bill:

- repeals all provisions related to the Coal Ash Management Commission in the General Statutes and transfers all of its responsibilities to the Department of Environmental Quality (DEQ);
- requires a coal ash impoundment owner (read: Duke Energy) to provide permanent alternative water supplies for residents in areas surrounding coal ash surface impoundments;
- allows reconsideration of risk classifications for coal ash surface impoundments based on fulfillment of certain criteria; and
- modifies appointments and other provisions governing the Mining Commission and the Oil and Gas Commission.

Earlier this year, DEQ rated all 14 sites in the state as either intermediate or high risk, which under the state's 2014 Coal Ash Management Act would require them to be excavated. Duke claimed that the cost would be prohibitive and would likely be passed on to ratepayers. Under the compromise language in House Bill 630, Duke is required to excavate coal ash ponds at seven sites (the excavation of these ponds is already required by court order). The other seven sites can be capped in place as long as Duke provides permanent alternative water sources to households within a half-mile of the ponds (or more if testing shows contamination) by Oct. 15, 2018 and satisfies other criteria detailed in the bill. While the bill passed with strong support, Rep. Chuck McGrady (who authored the bill that Gov. McCrory vetoed) voted against the

measure, expressing concern that the 7 largest coal ash ponds in the state could be capped in place. Environmental groups blasted the bill, saying it allowed Duke to continue polluting while simply piping in water for residents. **Effective: July 14, 2016.**

HOUSE BILL 728, Amend Various Licensing Board Laws/Fees, amend laws and fees pertaining to various occupational licensing boards, including provisions to:

- provide that no member may serve more than two complete consecutive three-year terms in a lifetime on the North Carolina Medical Board;
- allow the Board to provide confidential and nonpublic licensing and investigative information in its possession to the Review Panel (which reviews all applicants for physician positions and the physician assistant or nurse practitioner position on the Board);
- provide that all applications, records, papers, files, reports, and all investigative and licensing information received by the Review Panel from the Board and other documents received or gathered by the Review Panel, its members, employees, agents, and consultants as a result of soliciting, receiving, and reviewing applications and making recommendations are not public records. This information is privileged, confidential, and not subject to discovery, subpoena, or other means of legal compulsion for release to any person other than to the Review Panel, the Board, and their employees, agents, or consultants, except as provided;
- require the Review Panel to publish on its website the names and practice addresses of all applicants within 10 days after the application deadline, and the names and practice addresses of the nominees recommended to the Governor within 10 days after notifying the Governor of those recommendations and not less than 30 days prior to the expiration of the open position on the Board;
- require the Review Panel to meet in closed session to review applications; interview applicants; review and discuss information received from the Board; and discuss, debate, and vote on recommendations to the Governor;
- amend the information physicians and physician assistants are required to report to the Board to require them to provide a current, active e-mail address, which is not considered a public record, and which may be used or made available by the Board to disseminate or solicit information affecting public health or the practice of medicine;
- prohibit the Board from denying an application for licensure or annual registration based solely on the applicant's or licensee's failure to become board certified;
- increase the annual registration fee from \$175 to \$250, and remove the requirement that a retired limited volunteer licensee pay an annual registration fee;
- amend the provisions regarding hearing before disciplinary action to provide that, once charges have been issued, the parties may engage in discovery as provided in the North Carolina Rules of Civil Procedure, and require the Board to provide the respondent or his/her counsel with all exculpatory evidence in its possession, except for information that: (1) is subject to attorney-client privilege; (2) would identify an anonymous complainant; or (3) is related to advisory opinions, recommendations, or deliberations by the Board, its staff, and its consultants that will not be entered into evidence; and
- rename the Peer Review provisions as the Health Program for Medical Professionals.

The legislation enacts new provisions regarding the Health Program for Medical Professionals, and allows the Board to enter into an agreement with the North Carolina Medical Society, the North Carolina Academy of Physician Assistants, and the North Carolina Physicians Health Program to identify, review, and evaluate the ability of licensees who have been referred to the North Carolina Physicians Health Program (Program) to function in their professional capacity,

and coordinate regimens for treatment and rehabilitation. The agreement must include guidelines for the following:

- the assessment, referral, monitoring, support, and education of licensees of the Board by reason of a physical or mental illness, a substance abuse-related disorder, or professional sexual misconduct;
- procedures for the Board to refer licensees to the Program;
- criteria for the Program to report licensees to the Board;
- a procedure by which licensees may obtain review of recommendations for assessment or treatment by the Program;
- periodic reporting of statistical information by the Program to the Board, the North Carolina Medical Society, and the North Carolina Academy of Physician Assistants; and
- maintaining the confidentiality of nonpublic information.

The North Carolina Physicians Health Program must report immediately to the Board detailed information about any licensee of the Board who meets any of the following criteria:

- constitutes an imminent danger to patient care by reason of a physical or mental illness, a substance abuse-related disorder, professional sexual misconduct, or any other reason; or
- refuses to submit to an assessment as ordered by the Board, has entered into a monitoring contract and fails to comply with the terms of the Program's monitoring contract, or is still unsafe to practice medicine after treatment.

Information acquired, created, or used in good faith by the Program is privileged, confidential, and not subject to discovery, subpoena, or other means of legal compulsion for release to any person other than to the Board, the North Carolina Physicians Health Program, or their employees or consultants. No person who participates in good faith in the Program will be required to disclose in a civil case the fact of participation or any information acquired or opinions, recommendations, or evaluations acquired or developed solely during the course of participating in the program. Upon the written request of a licensee, the Program will provide the licensee or his or her legal counsel with a copy of a written assessment prepared as part of the licensee's participation in the program, and the licensee would be entitled to a copy of any written assessment created by an alcohol or chemical dependency treatment facility at the recommendation of the Program, to the extent permitted by State and federal laws and regulations. Any information furnished to a licensee is inadmissible and not subject to discovery in any civil proceeding. However, this provision may not be construed to make information, documents, or records otherwise available for discovery or use in a civil action immune from discovery or use in a civil action merely because the information, documents, or records were included as part of the Program's assessment of the licensee or were the subject of information furnished to the licensee. **Effective: This law has not yet been signed into law by the Governor; however, we expect it to be signed over the weekend. If signed, the law will be effective October 1, 2016.**

HOUSE BILL 972, Law Enforcement Recordings/No Public Record. This has been controversial legislation that has been worked on by a variety of groups over the last several years in regards to law enforcement body and car cameras and the videos that result. There were groups that were adamantly opposed to this law since the release of videos is still controlled primarily by law enforcement and the presumption is that the video is protected so that citizens and others would be required to get a Court Order for the information if law enforcement would not release. Those groups felt that the presumption should be that the video is a public record that should be release except for videos that would meet several categories as explained below.

Another provision was added to this bill in the final week of session that would allow a needle exchange program. This provision was in a separate bill that was not moving and was added to this bill in an attempt to have them both approved before the end of session. The legislation includes the following provisions:

- define “recording” as a visual, audio, or visual and audio recording captured by a body-worn camera, a dashboard camera, or any other video or audio recording device operated by or on behalf of a law enforcement agency or law enforcement agency personnel when carrying out law enforcement responsibilities;
- provide that recordings are not public or personnel records;
- allow recordings in the custody of a law enforcement agency to be disclosed only as provided;
- require a person requesting disclosure of a recording to make a written request to the head of the custodial law enforcement agency that states the date and approximate time of the activity captured in the recording or otherwise identifies the activity with reasonable particularity sufficient to identify the recording to which the request refers;
- allow the head of the custodial law enforcement agency to only disclose a recording to the following:
  - a person whose image or voice is in the recording;
  - a personal representative of an adult person whose image or voice is in the recording, if the adult person has consented to the disclosure;
  - a personal representative of a minor or of an adult person under lawful guardianship whose image or voice is in the recording;
  - a personal representative of a deceased person whose image or voice is in the recording; or
  - a personal representative of an adult person who is incapacitated and unable to provide consent to disclosure;
- require the law enforcement agency, when disclosing the recording, to disclose only those portions of the recording that are relevant to the person's request, and prohibit a person who receives disclosure from recording or copying the recording;
- include specific factors the custodial law enforcement agency may consider in determining if a recording is disclosed;
- provide that, if a law enforcement agency denies disclosure, or has failed to provide disclosure more than three business days after the request for disclosure, the person seeking disclosure may apply to the superior court in any county where any portion of the recording was made for a review of the denial of disclosure. The court may conduct a review of the recording, and order the disclosure of the recording only if the court finds that the law enforcement agency abused its discretion in denying the request for disclosure. The court may only order disclosure of those portions of the recording that are relevant to the person's request, and the person who receives disclosure may not record or copy the recording. An order issued pursuant to this section may not order the release of the recording;
- allow certain persons authorized to receive disclosure, or the custodial law enforcement agency, to petition the superior court in any county where any portion of the recording was made for an order releasing the recording to a person authorized to receive disclosure;
- provide that recordings in the custody of a law enforcement agency may only be released pursuant to court order. Any custodial law enforcement agency or any person requesting release of a recording may file an action in the superior court in any county where any portion of the recording was made for an order releasing the recording. The request for

release must state the date and approximate time of the activity captured in the recording, or otherwise identify the activity with reasonable particularity sufficient to identify the recording to which the action refers. The court may conduct a review of the recording. In determining whether to order the release of all or a portion of the recording, in addition to any other standards the court deems relevant, the court shall consider the applicability of all of the following standards:

- release is necessary to advance a compelling public interest;
- the recording contains information that is otherwise confidential or exempt from disclosure or release under State or federal law;
- the person requesting release is seeking to obtain evidence to determine legal issues in a current or potential court proceeding;
- release would reveal information regarding a person that is of a highly sensitive personal nature;
- release may harm the reputation or jeopardize the safety of a person;
- release would create a serious threat to the fair, impartial, and orderly administration of justice;
- confidentiality is necessary to protect either an active or inactive internal or criminal investigation or potential internal or criminal investigation;
- there is good cause shown to release all portions of a recording;
- require the court to release only those portions of the recording that are relevant to the person's request, and allow the court to place any conditions or restrictions on the release of the recording that the court, in its discretion, deems appropriate.

In addition, the legislation authorizes any governmental or nongovernmental organization, including a local or district health department or an organization that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors, may establish and operate a needle and hypodermic syringe exchange program. The legislation will:

- require the objectives of the program be to: (1) reduce the spread of HIV, AIDS, viral hepatitis, and other bloodborne diseases in this State; (2) reduce needle stick injuries to law enforcement officers and other emergency personnel; and (3) encourage individuals who inject drugs to enroll in evidence-based treatment.
- require programs to offer all of the following:
  - disposal of used needles and hypodermic syringes;
  - needles, hypodermic syringes, and other injection supplies at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused. No public funds may be used to purchase needles, hypodermic syringes, or other injection supplies;
  - reasonable and adequate security of program sites, equipment, and personnel. Written plans for security must be provided to the police and sheriff's offices with jurisdiction in the program location and updated annually;
  - educational materials on all of the following:
    - overdose prevention;
    - the prevention of HIV, AIDS, and viral hepatitis transmission;
    - drug abuse prevention;
    - treatment for mental illness, including treatment referrals;
    - treatment for substance abuse, including referrals for medication assisted treatment;

- access to naloxone kits that contain naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of a drug overdose, or referrals to programs that provide access to naloxone hydrochloride; and
- for each individual requesting services, personal consultations from a program employee or volunteer concerning mental health or addiction treatment as appropriate;
- provide that no employee, volunteer, or participant of a program established pursuant to this section shall be charged with or prosecuted for possession of: (1) needles, hypodermic syringes, or other injection supplies obtained from or returned to a program; or (2) residual amounts of a controlled substance contained in a used needle, used hypodermic syringe, or used injection supplies obtained from or returned to a program;
- provide that this limited immunity will apply only if the person claiming immunity provides written verification that a needle, syringe, or other injection supplies were obtained from a needle and hypodermic syringe exchange program;
- provide that, in addition to any other applicable immunity or limitation on civil liability, a law enforcement officer who, acting on good faith, arrests or charges a person who is thereafter determined to be entitled to immunity from prosecution under this section will not be subject to civil liability for the arrest or filing of charges;
- require the governmental or nongovernmental organization, prior to commencing operations of such a program, to report to the North Carolina Department of Health and Human Services, Division of Public Health, (1) the legal name of the organization or agency operating the program; (2) the areas and populations to be served by the program; and (3) the methods by which each program will meet the required program offerings;
- require the program to report the following information to the North Carolina Department of Health and Human Services, Division of Public Health:
  - the number of individuals served by the program;
  - the number of needles, hypodermic syringes, and needle injection supplies dispensed by the program and returned to the program;
  - the number of naloxone kits distributed by the program; and
  - the number and type of treatment referrals provided to individuals served by the program, including a separate report of the number of individuals referred to programs that provide access to naloxone hydrochloride.

**Effective: The recording provisions are effective October 1, 2016, and apply to all requests made on or after that date for the disclosure or release of a recording. The remaining provisions are effective July 11, 2016.**

HOUSE BILL 1044, Law Enforcement Omnibus Bill, establishes a Blue Alert System within the North Carolina Center for Missing Persons to aid in the apprehension of a suspect who kills or inflicts serious bodily injury on a law enforcement officer by providing a statewide system for the rapid dissemination of information regarding the suspect. In addition, the legislation amends the purpose of the Silver Alert System to provide a statewide system for the rapid dissemination of information regarding a missing person or missing child who is believed to be suffering from dementia, Alzheimer's disease, or a disability that requires them to be protected from potential abuse or other physical harm, neglect, or exploitation. **Effective: July 11, 2016.**

SENATE BILL 481, Fund Small Businesses/Publish DOR Rulings, enacts the North Carolina Providing Access to Capital for Entrepreneurs and Small Business Act (NC PACES) to allow NC investors to buy equity or debt offerings from NC issuers if the transaction meets requirements for registration, disclosure, reporting, offering limit and investment limit. The filing

fee for an exemption notice is \$150 and would be used by the Securities Division of the NC Department of Secretary of State to administer and enforce the NC PACES Act.

The legislation also requires public disclosure of written determinations made by the Department of Revenue. A written determination applies the tax law to a specific set of existing facts furnished by a particular taxpayer, and is applicable only to the individual taxpayer addressed and as such has no precedential value except to the taxpayer to whom the determination is issued. The text of a written determination must be published on the Department's website within 90 days of the date the determination is provided to the taxpayer, and the following information will be redacted before the written determination is published:

- the names, addresses, and other identifying details of the taxpayer to whom the written determination pertains and of any other person referenced in the written determination;
- information specifically exempted from disclosure by State or federal law; and
- trade secrets and commercial or financial information obtained from a person that is privileged or confidential.

The Secretary of Revenue is not liable for failure to make redactions unless he or she fails to make the redactions in intentional and willful disregard of the statute, has agreed to redact the information, or has been ordered by a court to make the redaction. The publication requirement does not include disclosure of background file documents. **Effective: July 22, 2016.**

SENATE BILL 482, LLC Clarifications & Emp. Invention Ownership, makes technical and clarifying changes to the Limited Liability Company Act, and further defines an employer's and employee's rights to inventions invented by the employee, including:

- making technical and clarifying changes to a provision of the Limited Liability Act concerning operating agreements;
- providing that the conversion of a charitable or religious corporation to an LLC is permitted if the sole member of the surviving entity is a charitable or religious corporation;
- providing that an employer's ownership of an employee's invention, discovery, or development that has or becomes vested in the employer by contract or by operation of law is not subject to revocation or rescission in the event of a dispute between the employer and employee concerning payment of compensation or benefits to the employee, subject to any contrary provision in the employee's written employment agreement. This provision does not apply where the employee proves that the employer acquired ownership of the employee's invention, discovery, or development fraudulently; and
- allowing the employer to require that full title to certain patents and inventions be in the United States, if required by a contract between the employer and the United States or its agencies.

**Effective: This law has not yet been signed into law by the Governor; however, we expect it to be signed over the weekend. If signed, the law will be effective October 1, 2016.**

SENATE BILL 734, Statewide Standing Order/Opioid Antagonist, authorizes the State Health Director to prescribe an opioid antagonist by means of a statewide standing order with immunity from civil and criminal liability for such action. The law already includes immunity for providers who prescribe an opioid antagonist. **Effective: June 20, 2016.**

SENATE BILL 838, Medicaid Transformation Modifications, requires further reporting from the Department of Health and Human Services related to transformation of the Medicaid and NC

Health Choice Programs and modifies certain provisions of the Medicaid transformation legislation. The legislation includes provisions to:

- require the Department of Health and Human Services (DHHS) to report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division by October 1, 2016, on the following:
    - the status of the 1115 waiver submission to the Centers for Medicare and Medicaid Services (CMS), as well as any other submissions to CMS related to the transition of Medicaid and NC Health Choice from fee for service to capitation, and specifically address the timeliness of the submission or submissions to CMS, responses received from CMS, and strategies necessary to ensure approval of a waiver for Medicaid transformation.
    - a detailed Work Plan for the implementation of the transformation of Medicaid and NC Health Choice programs. The Work Plan shall provide sufficient detail to allow the Joint Legislative Oversight Committee on Medicaid and NC Health Choice to monitor progress and identify challenges and impediments to the implementation of the transformation of Medicaid and NC Health Choice programs. The detailed Work Plan must identify key milestones, tasks, and events necessary to the transition of the programs. For each milestone, task, and event, the Work Plan must specify the expected completion dates and identify the individual who is assigned responsibility for accomplishing or ensuring the accomplishment of the milestone, task, or event;
    - a sufficiently detailed description of any developments or changes during the planning process to enable the General Assembly to address any barriers to successful implementation of the Medicaid and NC Health Choice transformation;
  - update and replace *DHHS through the Division of Health Benefits* with *DHHS* to reflect that DHHS only is responsible for the planning and implementation of the Medicaid transformation;
  - amend the definition of a “provider-led entity” or PLE as an entity that meets all of the following criteria:
    - a majority of the entity's ownership is held by an individual or entity that has as its primary business purpose the ownership or operation of one or more *capitated contracts described in subdivision (3) of this section* or Medicaid and NC Health Choice providers;
    - a majority of the entity's governing body is composed of *individuals who (i) are licensed in the State as physicians, physician assistants, nurse practitioners, or psychologists and (ii) have experience treating beneficiaries of the North Carolina Medicaid program*; and
    - holds a PHP license issued by the Department of Insurance;
  - provide that the following services will not be covered by the capitated PHP contracts:
    - behavioral health services for Medicaid recipients currently covered by the local management entities/managed care organizations (LME/MCOs) for four years after the date capitated contracts begin;
    - dental services;
    - services provided through the Program of All-Inclusive Care for the Elderly;
    - audiology, speech therapy, occupational therapy, physical therapy, nursing, and psychological services prescribed in an Individualized Education Program (IEP) and performed by schools or individuals contracted with Local Education Agencies;
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- services provided directly by a Children's Developmental Services Agency (CDSA) or by a provider under contract with a CDSA if the service is authorized through the CDSA and is included on the child's Individualized Family Service Plan; and
  - services for Medicaid program applicants during the period of time prior to eligibility determination;
- amend the provisions regarding populations covered by PHPs to add six new classes of individuals that are not covered:
  - qualified aliens subject to the five-year bar for means-tested public assistance under 8 U.S.C. § 1613 who qualify for emergency services under 8 U.S.C. § 1611;
  - undocumented aliens who qualify for emergency services under 8 U.S.C. § 1611;
  - medically needy Medicaid recipients;
  - members of federally recognized tribes. Members of federally recognized tribes shall have the option to enroll voluntarily in PHPs;
  - presumptively eligible recipients, during the period of presumptive eligibility;
  - recipients who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program;
- allow up to 12 (instead of 10) contracts between the Division of Health Benefits and PLEs for coverage of regions;
- add State Veterans Homes to the list of those designated as essential providers;
- authorize DHHS to seek approval from CMS through the 1115 waiver to allow parents to retain Medicaid eligibility while their child is being served temporarily by the foster care program. It is the intent of the General Assembly to expand Medicaid eligibility to cover this population upon implementation of the 1115 waiver, if CMS approves this coverage in the waiver;
- require DHHS to remain the Medicaid single State–agency and to be responsible for implementing the required Medicaid transformation and to administer and operate all functions, powers, duties, obligations, and services related to the transformed Medicaid and NC Health Choice programs;
- allow the Secretary of DHHS to appoint a Director of the Division of Health Benefits prior to the effective date;
- provide that, upon the elimination of the Division of Medical Assistance, the Division of Health Benefits will be vested with all functions, powers, duties, obligations, and services previously vested in the Division of Medical Assistance;
- provide that DHHS will continue to administer and operate the Medicaid and NC Health Choice programs through the Division of Medical Assistance until the Division of Medical Assistance is eliminated at which time all functions, powers, duties, obligations, and services vested in the Division of Medical Assistance are vested in the Division of Health Benefits;
- add new provisions regarding the cooling-off period for certain Department employees to define a former employee as a person who, for any period within the preceding six months, was employed as an employee or contract employee of DHHS and personally participated in any of the following: (1) the award of a contract to the vendor; (2) an audit, decision, investigation, or other action affecting the vendor; or (3) regulatory or licensing decisions that applied to the vendor;
- authorize DHHS, notwithstanding any statute that requires a reduction within the Division of Medical Assistance, to establish, maintain, or adjust all Medicaid program components, except for eligibility categories and income thresholds, within the

appropriated and allocated budget for the Medicaid program, provided that the total Medicaid expenditures, net of agency receipts, do not exceed the authorized budget for the Medicaid program; and

- provide that, if DHHS intends to maintain any program components as authorized, then no later than 60 calendar days after Senate Bill 838 becomes law, DHHS must request that the Office of State Budget and Management (OSBM) certify that there are sufficient recurring Medicaid funds to maintain the program component. Within 30 calendar days after receiving DHHS's request, OSBM must respond to the request. If OSBM does not certify by the end of the 30-day period that there are sufficient recurring Medicaid funds to maintain the program component, then DHHS will implement the reduction required.

**Effective: This law has not yet been signed into law by the Governor; however, we expect it to be signed over the weekend. If signed, most of the provisions will be effective retroactively to June 1, 2016.**

SENATE BILL 898, 2016 PPT Appointments Bill, appoints persons to various public offices upon the recommendation of the speaker of the House of Representatives, the President Pro Tempore of the Senate, and the Minority Leader of the Senate as follows:

- Keith Holtsclaw of Mitchell County and Dr. Penney Burlingame Deal of Onslow County appointed to the North Carolina Institute of Medicine Board of Directors for terms to expire on December 31, 2017 (in order to stagger terms of board members);
- Joshua T. Brown of Durham County, Jeffrey H. Ledford of Cleveland County, Charles D. Greene of Forsyth County and Eric S. Cramer of Wake County are appointed to the 911 Board for terms effective January 1, 2017, and expiring on December 31, 2020;
- Dr. Brian B. Sheitman of Wake County and Robin Todd-Hall of Caldwell County are appointed to the North Carolina Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services for terms expiring on June 30, 2019;
- Craig Fitzgerald of Wake County is appointed to the North Carolina Brain Injury Advisory Council for a term effective October 1, 2016, and expiring on September 30, 2020;
- Tammy B. Owens of Wake County, Joe M. Cabaleiro of Wake County, Michael Tramber of Forsyth County, and Cathy L. Swanson of Caldwell County are appointed to the License to Give Trust Fund for terms effective January 1, 2017, and expiring on December 31, 2018.

**Effective: July 1, 2016, except as other provided.**

SENATE BILL 903, Adjournment, adjourned the 2015 regular session “sine die.” **Effective: July 1, 2016.** NOTE: This is the earliest adjournment of a session in many years, though the 2016 “short” session did convene in late April rather than the normal late May start, due to the State’s primary election being moved from early May to March. By adjourning "sine die," they have completed this session and generally they would only come back into session because of a special session called by the Governor or to override a Governor’s veto.

## STATE BUDGET

The following are highlights from the final Health and Human Services budget adopted by the North Carolina General Assembly during the 2016 short session. One significant budget item is support for the Governor’s Task Force on Mental Health and Substance Use. The total funding support for Task Force recommendations is \$20 million, \$10 million in recurring funds and an additional \$10 million in nonrecurring funds, but there are no specifics included in the budget

about how this funding will be spent. The budget also includes \$500,000 in funding for a Medication-Assisted Opioid Use Disorder Pilot Program.

In addition, the budget directs \$18 million from the Dorothea Dix Property Fund for the purpose of expanding inpatient capacity in rural areas near counties with limited inpatient capacity relative to their needs. These funds will be used for construction of new beds or renovation of existing beds to form new inpatient psychiatric units. Another \$2 million from the Dorothea Dix Property Fund will be used to establish two facility-based crisis centers for children.

There is funding in the budget for improvements to the Controlled Substance Reporting System (CSRS) and a requirement that prescribers register for access to CSRS. The Senate budget's language requiring mandatory use of CSRS each time a patient is prescribed a controlled substance was removed as well as the penalty language that would have directed the North Carolina Medical Board to punish prescribers who violate the provision. The HHS budget:

- **Medicaid Timeliness Fund.** Provides \$143,215 in recurring funds for three business system analyst positions to interpret Medicaid data by combining and analyzing diverse types of data to extract actionable data discoveries and new trend analytics. These positions will develop performance standards for county departments of social services (DSS) offices, monitor the data to measure performance and provide guidance to county DSS offices on how to improve the timeliness and accuracy of Medicaid eligibility determinations.
- **NC MedAssist Program.** Provides \$200,000 in nonrecurring funds for the NC MedAssist Program, a pharmacy program that provides access to prescription medications, patient support, advocacy and related services to indigent and uninsured North Carolina residents. Revised net appropriation is \$2.7 million
- **Graduate Medical Education.** Provides \$7,700,000 in recurring funds to support the establishment of a residency program at Cape Fear Valley Hospital. This appropriation replaces an anticipated loss of Medicaid revenue as a result of the hospital's future reclassification as a rural hospital by the Centers for Medicare and Medicaid Services. Cape Fear Valley Hospital is affiliated with Campbell University Medical School.
- **Health Analytics Pilot.** Provides \$1,250,000 in nonrecurring funds to integrate new data sources (such as patient level Healthcare Effectiveness Data and Information Set quality measures); automate reporting and analytic capabilities; integrate a tool to construct and analyze claims as clinical episodes of care to fit into reform and help the State move to value-based purchasing arrangements.
- **Data Analytics.** Provides \$1,918,824 in nonrecurring funds to continue the State's investment in its data analytics capabilities.
- **Child Fatality Review.** Provides \$59,150 in recurring funds to provide for 3 additional positions to ensure timely review of child fatalities. These positions will also develop the system capacity to effectively utilize the results and implement the recommendations as a result of the reviews.

- **Zika Prevention and Detection.** Provides \$477,500 in recurring funds to develop infrastructure to detect, prevent, control and respond to the Zika virus.
- **You Quit Two Quit Smoking Cessation Program.** Provides \$250,000 in nonrecurring funds for You Quit Two Quit smoking cessation program.
- **Cherry Hospital Operating Costs.** Reduces funding previously appropriated to meet Cherry Hospital's expanded bed capacity. Due to construction and other delays, the replacement facility is now scheduled to open in September 2016. Only 25 of the 100 additional beds will be available at that time. The revised net appropriation for Cherry Hospital is \$73.7 million.
- **Controlled Substance Reporting System (CSRS).** Provides \$375,000 in recurring funds and \$1,253,400 in nonrecurring funds to develop software and upgrade the Controlled Substance Reporting System (CSRS). Part of the funding will be used to upgrade the CSRS database to meet the most current architecture standards of the American Society for Automation in Pharmacy and Prescription Monitoring Information Exchange. Another portion of the funds will be used to develop and implement software for the performance of advanced analytics within the CSRS. The budget also requires all prescribers to register for the CSRS. **The budget DOES NOT include a requirement that all prescribers check the CSRS system prior to any prescriptions and the North Carolina College of Emergency Physicians worked with legislators to make sure this provision and the penalty provisions were removed from the final budget.**
- **Controlled Substances Reporting System Improvements.** States that it is the intent of the General Assembly to improve the security, functionality, and interface capabilities of the Controlled Substances Reporting System (CSRS), thereby improving the system's data management and advanced analytics capabilities. Toward that end, funds appropriated to the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMH/DD/SAS), for the 2016-2017 fiscal year for the CSRS shall be used as follows:
  - (1) Six hundred thousand dollars (\$600,000) in nonrecurring funds to upgrade the CSRS database to meet the most current architecture standards of the American Society for Automation in Pharmacy and Prescription Monitoring Information Exchange (PMIX). The upgrade must be designed to facilitate connectivity with controlled substances reporting systems in surrounding states and the statewide health information exchange network in this State, while protecting the privacy of patient information stored in the system in a manner consistent with federal and State laws. The upgraded database will be hosted within the Department of Information Technology.
  - (2) Three hundred seventy-five thousand dollars (\$375,000) in recurring funds and six hundred fifty-three thousand four hundred dollars (\$653,400) in nonrecurring funds shall be used to pay for contractual hours to develop and implement software for the performance of advanced analytics within the CSRS in order to achieve the purposes specified in G.S. 90-113.71 and, more specifically, to accomplish at least all of the following:

- a. To enhance and automate reports solicited by persons or entities authorized under G.S. 90-113.74.
- b. To enhance the Department's ability to provide data to persons or entities authorized to receive information under G.S. 90-113.74.
- c. To aggregate data sources, including those available through the Government Data Analytics Center (GDAC), relevant to the identification of unusual prescribing patterns or behavior indicative of abuse, addiction, or criminal activity.

The budget provides that in improving the CSRS, the DMH/DD/SAS shall utilize subject matter expertise and technology available through existing GDAC public-private partnerships. Upon development and implementation of the advanced analytics software for the CSRS, the DMH/DD/SAS must coordinate with the Division of Public Health and any other appropriate division within the Department of Health and Human Services to ensure that advanced analytics are performed in a manner that achieves the purposes specified in G.S. 90-113.71.

By December 1, 2016, the Department must execute all contractual agreements and interagency data sharing agreements necessary to complete the improvements to the CSRS.

- **Mandatory Prescriber Registration for Access to CSRS.** Provides that within 30 days after obtaining an initial or renewal license that confers the authority to prescribe a controlled substance for the purpose of providing medical care for a patient, the licensee must demonstrate to the satisfaction of the licensing board that he or she is registered for access to the controlled substances reporting system. A violation of this section may constitute cause for the licensing board having jurisdiction over the licensee to suspend or revoke the license.
- **Governor's Task Force Recommendations.** Reserves \$10,000,000 in recurring and \$10,000,000 in nonrecurring funds to implement the recommendations of the Governor's Task Force on Mental Health and Substance Use. The budget does not provide specifics about how these funds would be sent.
- **Child Facility-Based Crisis Centers.** Provides \$2,000,000 in nonrecurring funds to the Department of Health and Human Services for start-up costs to establish up to 2 new child facility-based crisis centers.
- **Inpatient Behavioral Health Beds.** Transfers \$18 million in nonrecurring funds to the Department of Health and Human Services for the purpose of expanding inpatient capacity in rural areas near counties with limited inpatient capacity relative to their needs through constructing new beds or renovating existing beds to form new inpatient psychiatric units. Beds constructed or converted with these funds shall be named in honor of Dorothea Dix.
- **Medicaid Rebase.** Provides for reduction of \$310,524,345 in recurring and \$8,056,927 nonrecurring in Medicaid rebase (which is the adjustment of Medicaid funding).

- **Pilot Program for Medicaid Claims Analytics and Population Health Management.** Provides continued funding to develop a pilot program for Medicaid claims analytics and population health management. This section provides that the Department of Health and Human Services must coordinate with the Government Data Analytics Center to develop a pilot program and to provide access to needed data sources, including Medicaid claims data, Medicaid beneficiary files, and local management entity/managed care organization (LME/MCO) data for the pilot program. By May 31, 2017, the Department and GDAC will make a final report of their findings and recommendations on the pilot program to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Information Technology and the Fiscal Research Division.
- **AIDS Drug Assistance Program.** Requires the Division of Public Health to create within the North Carolina AIDS Drug Assistance Program (ADAP) a health insurance premium assistance program that utilizes federal funds from Part B of the Ryan White HIV/AIDS Program and ADAP funds to provide eligible beneficiaries with premium and cost-sharing assistance for the purchase or maintenance of private health insurance coverage, including premiums, co-payments, and deductibles.
- **Repurposing of Health Disparities Initiative Grants Program Funds.** Provides for a discontinuation of Community-Focused Eliminating Health Disparities Initiative Grants program and repurposes funds to the Chronic Disease and Injury Section to establish an evidence-based Diabetes Prevention Program (DPP).
- **Opioid Addiction Pilot Program.** Requires the Department of Health and Human Services to oversee the administration of a three-year pilot program to be conducted by designated federally qualified health centers (FQHCs) to address NC's growing opioid addiction and overdose crisis. The goal of the pilot program is to study the effectiveness of combining behavioral therapy with the utilization of a nonnarcotic, nonaddictive, extended-release, injectable formulation of opioid antagonist approved by the US Food and Drug Administration for the prevention of relapse to opioid dependence. By November 1, 2020 the Department must conduct and submit to the Joint Legislative Oversight Committee on HHS a comprehensive evaluation of the effectiveness of this pilot program.
- **Dorothea Dix Funds.** Directs the use of Dorothea Dix Hospital Property Funds with a special focus on increased short-term, inpatient behavioral health bed capacity in rural areas of the State with the highest needs. The budget provides for \$18,000,000 from the Dix funds to pay for any renovation or building costs associated with the construction of new licensed short-term, inpatient behavioral health beds and/or the conversion of existing inpatient acute care beds into licensed short-term, inpatient behavioral health beds. The budget directs the DHHS Secretary to select hospitals in the three State regions for institutional services. As a condition of receiving these funds, each selected rural hospital must reserve at least fifty percent (50%) of the constructed or converted beds for (i) purchase by the Department under the State-administered, three-way contract and (ii) referrals by local management entities/managed care organizations (LME/MCOs) of individuals who are indigent or Medicaid recipients. Any hospital unit or other location with short-term, inpatient behavioral health beds constructed or converted with these funds will be named in honor of Dorothea Dix.

The budget provides that notwithstanding the State Medical Facilities Plan, or any other provision of law to the contrary, these additional short-term, inpatient behavioral health beds shall be exempt from certificate of need review. Beginning November 1, 2017, the Department of Health and Human Services shall annually report to the Joint Legislative Oversight Committee on Health and Human Services and the Fiscal Research Division on the number and location of additional licensed short-term, inpatient behavioral health beds brought into operation with funds allocated under subsection (a) of this section. By December 1, 2020, the Department must submit a report that includes a proposal for funding the recurring operating costs of these additional beds from a source or sources other than the Dorothea Dix Hospital Property Funds, including the identification of potential new funding sources.

The budget also allocates \$2,000,000 of the Dix Funds to increase the number of facility-based crisis centers in North Carolina for children and adolescents. The funds will be used to award grants on a competitive basis for the establishment of up to two new facility-based crisis centers in the State for children and adolescents.

- **Traumatic Brain Injury Fund.** Provides over \$2 million to the Traumatic Brain Injury Fund. The funds will be used for contracts with appropriate service providers; to support residential programs that are specifically designed to serve individuals with TBI; and to support requests submitted by individual consumers for assistance with residential support services, home modifications, transportation, and other requests deemed necessary by the consumer's local management entity and primary care physician.
- **Psychiatric Beds.** Requires the Division of Mental Health, Developmental Disabilities, and Substances Abuse Services to use \$40,583,394 for the 2016-2017 fiscal year to purchase additional new or existing local inpatient psychiatric beds or bed days not currently funded by or through LME/MCOs. The Department must also continue to implement a two-tiered system of payment for purchasing these local inpatient psychiatric beds or bed days based on acuity level with an enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels, as defined by the Department. The enhanced rate of payment for inpatient psychiatric beds or bed days for individuals with higher acuity levels shall not exceed the lowest average cost per patient bed day among the State psychiatric hospitals.

In addition, at the discretion of the Secretary of Health and Human Services, existing funds allocated to LME/MCOs for community-based mental health, developmental disabilities, and substance abuse services may be used to purchase additional local inpatient psychiatric beds or bed days. Funds designated 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.

- **Strategic Plan for Improvement of Behavioral Health Services.** Requires the Department of Health and Human Services to develop and submit to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division a strategic statewide plan to improve the efficiency and effectiveness of State-funded behavioral health services. The plan must include the following elements:

- (1) Identification of the Division that will (i) assume lead responsibility for the organization and delivery of publicly funded behavioral health services and (ii) define the current and future roles and responsibilities of local management entities/managed care organizations (LME/MCOs) with respect to the organization and delivery of publicly funded behavioral health services.
  - (2) A process for ensuring that all State contracts with behavioral health providers and managed care organizations responsible for managing Medicaid behavioral health services (including LME/MCOs) contain goals for overall behavioral health services, along with specific measurable outcomes for all publicly funded mental health, developmental disabilities, substance abuse, and traumatic brain injury services.
  - (3) A statewide needs assessment for mental health, developmental disabilities, substance abuse, and traumatic brain injury services by county and type of service, broken down by the source of funding. The needs assessment must include a defined service continuum to address identified needs for targeted populations.
  - (4) Specific solvency standards to be incorporated into State contracts with LME/MCOs that define appropriate cash balances, predictors for sustainability, and measures for performance that the LME/MCOs will monitor and report to the Department on a monthly, quarterly, and annual basis.
  - (5) Any other component the Department deems necessary to achieve the goal of improving the effective and efficient delivery and coordination of publicly funded behavioral health services across the State.
- **Creation of Behavioral Health Services Subcommittee.** Creates a legislative subcommittee on Behavioral Health Services to do the following:
    - (1) Oversee the Department's development of a behavioral health strategic plan.
    - (2) Review the strategic plan developed by the Department.
    - (3) Review consolidated monthly, quarterly, and annual reports and analyses of behavioral health services funded by Medicaid and State-only appropriations.

The subcommittees will jointly make recommendations about the areas of oversight and review. In conducting the required oversight and review, the subcommittees may seek input from other states, stakeholders, and national experts as they deem necessary in conducting their examination and developing their recommendations.

- **Facilities Included Under Single Hospital License.** Provides that any license issued by the Department shall include only facilities, premises, buildings, outpatient clinics, and other locations (i) operated by the hospital within a single county and (ii) operated by the hospital in an immediately adjoining county; provided, however, that facilities, premises, buildings, outpatient clinics, and other locations operated by a hospital in an immediately adjoining county shall only be included within the same hospital license if the applicant hospital demonstrates all of the following to the satisfaction of the Department: (1) There

was previously only one hospital licensed by the Department and providing inpatient services in the immediately adjoining county; and (2) The licensed inpatient hospital in the immediately adjoining county closed or otherwise ceased providing services to patients no more than three years prior to the date the applicant hospital first applied to license a facility, premises, building, outpatient clinic, or location in such immediately adjoining county. If the Department approves an applicant hospital's request to include within its hospital licensure an initial facility, premises, building, outpatient clinic, or other location in an immediately adjoining county, then any other designated facilities, premises, buildings, outpatient clinics, or other locations thereafter developed and operated by the applicant in such immediately adjoining county in accordance with applicable law may also be included within and covered by the license issued to the applicant by the Department. (This provision was included specifically to allow Franklin County to have an Emergency Department owned and/or operated by a hospital in an adjoining County).

- **Medicaid and Health Choice Provider Screening.** Revises the list of providers designated as “high” categorical risk as follows:

The following provider types are hereby designated as "high" categorical risk:

...

- (10) Providers that were excluded, or whose owners, operators, or managing employees were excluded, by the U.S. Department of Health and Human Services Office of Inspector ~~General~~ General, the Medicare program, or another state's Medicaid ~~program~~ or Children's Health Insurance Program within the previous 10 years.
- **Contract to Recover Overpayments and Reporting on Prepayment Fraud.** Provides that no later than October 1, 2016, the Department of Health and Human Services, Division of Medical Assistance, shall issue a request for proposals (RFP) to recover Medicaid and NC Health Choice overpayments to providers when the total amount owed to the State by the provider is less than one hundred fifty dollars (\$150.00). The RFP shall specify that payment under the contract shall be made only in the form of a contingency fee. The contingency fee shall be set at a percentage of the State share of the final overpayment, as defined in G.S. 108C-2(5), that is recovered. No later than October 1, 2016, the Department of Health and Human Services, Division of Medical Assistance, shall report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on a strategy for identifying and addressing prepayment fraud.
  - **Medicaid Graduate Medical Education Payments.** States that it is the intent of the General Assembly to explore all possible funding options to maintain or expand reimbursement for Graduate Medical Education.
  - **Evaluate Medicaid and NC Health Choice Behavioral Health Provider Classification.** Provides that the Department of Health and Human Services, Division of Medical Assistance (Department), in collaboration with statewide behavioral health stakeholders, shall evaluate the classification of agencies providing behavioral health services, other than Critical Access Behavioral Health Agencies (CABHAs), as high categorical risk provider types in accordance with G.S. 108C-3(g)(2) and propose an evaluation tool to be used to classify the categorical risk of different categories of behavioral health agencies. The Department shall consider current federal and State law

and include any recommended legislative changes. By December 1, 2016, the Department shall report its findings and recommendations to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice.

- **Report of Medicaid Eligibility Determination Timeliness.** Requires the Department of Health and Human Services, Division of Medical Assistance (DHHS), to submit a report annually for the 2015-2016 and 2016-2017 fiscal year to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Joint Legislative Oversight Committee on Health and Human Services, and the Fiscal Research Division containing the following information:

- (1) The annual statewide percentage of Medicaid applications processed in a timely manner for the fiscal year.
- (2) The statewide average number of days to process Medicaid applications for each month in the fiscal year.
- (3) The annual percentage of Medicaid applications processed in a timely manner by each county department of social services for the fiscal year.
- (4) The average number of days to process Medicaid applications for each month for each county department of social services.
- (5) The number of months during the fiscal year that each county department of social services met the timely processing standards in Part 10 of Article 2 of Chapter 108A of the General Statutes.
- (6) The number of months during the fiscal year that each county department of social services failed to meet the timely processing standards in Part 10 of Article 2 of Chapter 108A of the General Statutes.
- (7) A description of all corrective action activities conducted by DHHS and county departments of social services in accordance with G.S. 108A-70.36.
- (8) A description of how DHHS plans to assist county departments of social services in meeting timely processing standards for Medicaid applications, for every county in which the performance metrics for processing Medicaid applications in a timely manner do not show significant improvement compared to the previous fiscal year. The report for the 2016-2017 fiscal year must be submitted by November 1, 2017.

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