GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H **D**

HOUSE BILL 1037
PROPOSED COMMITTEE SUBSTITUTE H1037-PCS30551-BP-17

Short Title: COVID-19 Health Care Working Group Policy Rec. (Public)

Sponsors:

Referred to:

April 28, 2020

A BILL TO BE ENTITLED

AN ACT EXPANDING THE STATE'S CAPACITY TO TAKE PUBLIC HEALTH AND SAFETY MEASURES TO ADDRESS THE COVID-19 EMERGENCY, AS RECOMMENDED BY THE HEALTH CARE WORKING GROUP OF THE HOUSE SELECT COMMITTEE ON COVID-19.

The General Assembly of North Carolina enacts:

PART I. DEFINITIONS

SECTION 1.1.(a) Unless the context clearly indicates otherwise, the following definitions apply in this act:

(1) CDC. – The federal Centers for Disease Control and Prevention.

(2) COVID-19. – Coronavirus disease 2019.

(3) COVID-19 diagnostic test. – A test the federal Food and Drug Administration has authorized for emergency use or approved to detect the presence of the severe acute respiratory syndrome coronavirus 2.

(4) COVID-19 emergency. – The period beginning March 10, 2020, and ending on the date the Governor signs an executive order rescinding Executive Order No. 116, Declaration of a State of Emergency to Coordinate Response and Protective Actions to Prevent the Spread of COVID-19.

(5) COVID-19 antibody test. – A serological blood test the federal Food and Drug Administration has authorized for emergency use or approved to measure the amount of antibodies or proteins present in the blood when the body is responding to an infection caused by the severe acute respiratory syndrome coronavirus 2.

SECTION 1.1.(b) This section is effective when it becomes law.

PART II. AFFIRMATIONS OF ACTIONS TAKEN IN RESPONSE TO COVID-19

SECTION 2.1.(a) The North Carolina General Assembly supports the various actions taken by the Governor pursuant to Executive Order No. 116, Declaration of a State of Emergency to Coordinate Response and Protective Actions to Prevent the Spread of COVID-19, and under Executive Order No. 130, Meeting North Carolina's Health and Human Services Needs, actions taken by the Department of Health and Human Services in response to the COVID-19 emergency, and those taken by the North Carolina Medical Board, the North Carolina Board of Nursing, other health care provider licensing boards, and the State's teaching institutions for health care providers and their efforts to address the workforce supply challenges presented

by the COVID-19 emergency. Further, the General Assembly supports each of the following initiatives, including, but not limited to:

(1) As COVID-19 antibody tests become available in the State, encouraging all persons authorized under State law to administer such tests to give priority to frontline care providers, including emergency medical services personnel, firefighters, rescue squad workers, law enforcement officers, licensed health care providers, long-term care providers, child care providers, and other persons essential to the provision of medical care, dental care, long-term care, or child care.

(2) Pursuing any federally available waiver or program allowance regarding child welfare, including, but not limited to, waivers regarding virtual visitation for children in foster care, temporary suspension of relicensing requirements for foster parents, and the continuation of payments for youth in foster care ages 18-21 years, regardless of education or employment requirements.

(3) Providing ongoing flexibility to teaching institutions to ensure students seeking degrees in health care professions can complete necessary clinical hours.

SECTION 2.1.(b) This section is effective when it becomes law.

PART III. INCREASED ACCESS TO MEDICAL SUPPLIES NECESSARY TO RESPOND TO COVID-19 AND FUTURE PUBLIC HEALTH EMERGENCIES

STATE PLAN FOR A STRATEGIC STATE STOCKPILE OF PERSONAL PROTECTIVE EQUIPMENT AND TESTING SUPPLIES FOR PUBLIC HEALTH EMERGENCIES

SECTION 3.1.(a) As used in this section, the following terms have the following meanings:

(1) Acute care providers. – Includes hospitals, free-standing emergency departments, urgent care centers, and dialysis centers.

(2) First responders. – Includes local health departments, law enforcement, fire departments, search and rescue personnel, and emergency medical services providers.

(3) Health care providers. – As defined in G.S. 90-21.50.

(4) Long-term care providers. – Includes skilled nursing facilities, intermediate care facilities as defined in G.S. 131A-3, adult care homes licensed under G.S. 131D-2.4, group homes, home health agencies, and palliative and hospice care providers.

(5) Non-health care entities. – Includes child care providers, local departments of social services, hotels and motels used for isolation and quarantine, shelters, and correctional facilities.

SECTION 3.1.(b) By July 1, 2020, the Division of Public Health (DPH) and the Division of Health Service Regulation (DHSR) within the Department of Health and Human Services, in conjunction with the North Carolina Division of Emergency Management within the Department of Public Safety, shall develop and submit to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Oversight Committee on Justice and Public Safety a plan for creating and maintaining a Strategic State Stockpile of personal protective equipment (PPE) and testing supplies. It is the intent of the General Assembly that the Strategic State Stockpile would be accessible by both public and private acute care providers, first responders, health care providers, long-term care providers, and non-health care entities located within the State for the purposes of addressing the COVID-19 pandemic and future public health emergencies.

SECTION 3.1.(c) The plan shall include at least all of the following components:

(1) Recommendations about which agency will serve as the lead agency to oversee the Strategic State Stockpile described in this section, with (i) a description of the roles of DPH, DHSR, and the Division of Emergency Management and (ii) an explanation of how these entities will collaborate to create and maintain the Strategic State Stockpile.

(2) Recommendations for improvements to the State's existing procurement, allocation, and distribution process for PPE.

(3) Recommendations about what persons or entities should have access to the Strategic State Stockpile.

(4) Recommendations on how to increase within the State the manufacture of PPE that meets CDC guidelines for infection control, including consideration of (i) incentives for in-State private manufacturers and vendors that agree to produce and make PPE available to the Strategic State Stockpile and (ii) the feasibility of Correction Enterprises producing PPE for the Strategic State Stockpile.

(5) Recommendations about procuring testing supplies that meet applicable federal standards.

(6) Identification of available locations for maintaining the Strategic State Stockpile.

(7) Recommendations about the source, type, quality, and quantity of PPE and testing supplies the State should maintain as part of the Strategic State Stockpile, including a process for ongoing evaluation by individuals with expertise in emergency response, infection control, and environmental safety.

(8) A mechanism for managing the inventory of PPE and testing supplies purchased for the Strategic State Stockpile.

(9) An estimated five-year budget, including nonrecurring and recurring costs, for creating and maintaining the Strategic State Stockpile.

(10) Any other components deemed appropriate by DPH and DHSR, in conjunction with the Division of Emergency Management.

SECTION 3.1.(d) This section is effective when it becomes law.

PRIORITY CONSIDERATION OF NORTH CAROLINA-BASED COMPANIES WHEN ADDRESSING PUBLIC HEALTH EMERGENCIES

SECTION 3.2.(a) During a public health emergency, the Department of Health and Human Services and the North Carolina Division of Emergency Management within the Department of Public Safety shall first consider North Carolina-based companies that can provide mobile response units with capabilities to reach rural areas of the State. Operations that shall be considered include patient testing or sample collections, feeding operations, triage facilities, and other operations where it is necessary to deliver mobile services to individuals.

SECTION 3.2.(b) This section is effective when it becomes law.

PART IV. SUPPORT FOR HEALTH CARE PROVIDERS TO RESPOND TO COVID-19

DENTAL BOARD FLEXIBILITY DURING DISASTERS AND EMERGENCIES

SECTION 4.1.(a) Article 2 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-28.5. Disasters and emergencies.**

If the Governor declares a state of emergency or a county or municipality enacts ordinances under G.S. 153A-121, 160A-174, 166A-19.31, or Article 22 of Chapter 130A of the General Statutes, the North Carolina Board of Dental Examiners may waive the requirements of this

Article and Article 16 of this Chapter to permit the provision of dental and dental hygiene services to the public during the state of emergency."

SECTION 4.1.(b) This section is effective when it becomes law.

AUTHORIZATION FOR DENTISTS TO ADMINISTER COVID-19 TESTS

SECTION 4.2.(a) G.S. 90-29(b) is amended by adding a new subdivision to read:

"(14) The administration by dentists of diagnostic tests and antibody tests for coronavirus disease 2019 to patients only if such tests have been approved or authorized for emergency use by the United States Food and Drug Administration."

SECTION 4.2.(b) This section is effective when it becomes law.

AUTHORIZATION PROCESS FOR IMMUNIZING PHARMACISTS TO ADMINISTER COVID-19 IMMUNIZATIONS/VACCINATIONS

SECTION 4.3.(a) In the event the Centers for Disease Control and Prevention recommends an immunization or vaccination for COVID-19 at a time when the General Assembly is not in regular session, any person may petition the State Health Director, in writing, to authorize immunizing pharmacists, as defined in G.S. 90-85.3, to administer the recommended immunization or vaccination for COVID-19 by means of a statewide standing order. The State Health Director shall, within 30 days after receiving such petition, consult with the following entities in evaluating the petition and respond by either approving or denying the petition: Representatives of the North Carolina Academy of Family Physicians, the North Carolina Medical Society, the North Carolina Pediatric Society, the North Carolina Association of Community Pharmacists, the North Carolina Association of Pharmacists, and the North Carolina Retail Merchants Association.

SECTION 4.3.(b) Following the consultation provided in subsection (a) of this section, if the State Health Director approves the petition, the State Health Director may issue a statewide standing order authorizing the administration of an immunization or vaccination of COVID-19 by immunizing pharmacists. If the State Health Director issues a statewide standing order, it shall expire upon the adjournment of the next regular session of the General Assembly.

SECTION 4.3.(c) If the State Health Director approves the petition as provided in subsection (a) of this section, the State Health Director shall, within 10 days after approval, consult with the entities listed in subsection (a) of this section to develop and submit to the North Carolina Board of Medicine, the North Carolina Board of Nursing, the North Carolina Board of Pharmacy, and the Joint Legislative Oversight Committee on Health and Human Services a minimum standard screening questionnaire and safety procedures for written protocols for the administration of the recommended immunization or vaccination for COVID-19 by immunizing pharmacists. In the event that the questionnaire and recommended standards are not developed and submitted within the 10-day period as provided in this subsection, then the Immunization Branch of the Department of Health and Human Services, Division of Public Health, shall develop the questionnaire and recommended standards within the next 10 days and submit them to the North Carolina Board of Medicine, the North Carolina Board of Nursing, the North Carolina Board of Pharmacy, and the Joint Legislative Oversight Committee on Health and Human Services. At a minimum, immunizing pharmacists who administer the recommended immunization or vaccination for COVID-19 shall be required to comply with all the requirements of G.S. 90-85.15B.

SECTION 4.3.(d) All of the following individuals shall be immune from any civil or criminal liability for actions authorized by this section as follows:

(1) The State Health Director acting pursuant to this section.

(2) Any pharmacist who administers a COVID-19 immunization or vaccine pursuant to a statewide standing order issued under this section.

SECTION 4.3.(e) This section is effective when it becomes law.

PRESCRIPTION IDENTIFICATION REQUIREMENTS

SECTION 4.4.(a) Notwithstanding any other provision of law to the contrary, for the duration of the COVID-19 emergency, pharmacists licensed in this State under Article 4A of Chapter 90 of the General Statutes may confirm the identity of any individual seeking dispensation of a prescription by the visual inspection of any form of government-issued photo identification. If the individual seeking dispensation is a known customer, the pharmacist may confirm the individual's identity by referencing existing records, including the controlled substances reporting system. A pharmacist shall review information in the controlled substances reporting system pertaining to the patient for the 12-month period preceding the initial prescription before filling a prescription for a Schedule II controlled substance.

SECTION 4.4.(b) Before delivering a mail-order prescription, a courier shall confirm the identity of the recipient through the visual inspection of any form of government-issued photo identification.

SECTION 4.4.(c) This section is effective when it becomes law and expires 60 days after Executive Order No. 116 is rescinded, or December 31, 2020, whichever is earlier.

TEMPORARY FLEXIBILITY FOR QUALITY IMPROVEMENT PLANS

SECTION 4.5.(a) For purposes of this section, the following definitions apply:

(1) Quality improvement plan rules. – The rules regulating the quality improvement process for physician assistants and nurse practitioners found in 21 NCAC 32S .0213, 21 NCAC 32M .0110, and 21 NCAC 36 .0810.

(2) Application fee rules. – The portions of rules found in 21 NCAC 32S .0204, 21 NCAC 32M .0115, and 21 NCAC 36 .0813 that require the payment of an application fee.

(3) Annual review rules. – The portions of rules requiring the annual review or renewal of a practice arrangement between a physician and a physician assistant or nurse practitioner found in 21 NCAC 32S .0201, 21 NCAC 32M .0110, and 21 NCAC 36 .0806.

SECTION 4.5.(b) Notwithstanding any other provision of law to the contrary, neither the North Carolina Medical Board nor the North Carolina Board of Nursing shall enforce any provision of the quality improvement plan rules to the extent they require any of the following:

(1) Quality improvement process meetings between a physician and a physician assistant or nurse practitioner, provided that the physician assistant or nurse practitioner was practicing within the scope of his or her license prior to February 1, 2020, and continues to practice within the scope of his or her license while this section is effective.

(2) Monthly quality improvement process meetings between a physician and a physician assistant or nurse practitioner during the first six months of the practice arrangement between the physician and the physician assistant or nurse practitioner physician assistant, nurse practitioner, or certified nurse midwife.

SECTION 4.5.(c) Notwithstanding any other provision of law to the contrary, neither the North Carolina Medical Board nor the North Carolina Board of Nursing shall enforce any provision of the quality improvement plan rules or the application fee rules to the extent they require any individual to fill out an application or pay a fee, provided that individual is providing volunteer health care services within the scope of his or her license in response to the COVID-19 pandemic state of emergency declared by the Governor of North Carolina on March 10, 2020.

SECTION 4.5.(d) Notwithstanding any other provision of law to the contrary, neither the North Carolina Medical Board nor the North Carolina Board of Nursing shall enforce any provision of the annual review rules.

SECTION 4.5.(e) This section is effective when it becomes law and expires 60 days after Executive Order No. 116 is rescinded, or December 31, 2020, whichever is earlier.

PANDEMIC HEALTH CARE WORKFORCE STUDY

SECTION 4.6.(a) The mission of the North Carolina Area Health Education Center (NC AHEC) is to meet the State's health and health workforce needs and to provide education programs and services that bridge academic institutions and communities to improve the health of the people of North Carolina, with a focus on underserved populations. Consistent with that mission, the North Carolina General Assembly directs the NC AHEC program to conduct a study of the issues that impact health care delivery and the health care workforce during a pandemic. The study shall focus on the impact of the COVID-19 pandemic, issues that need to be addressed in the aftermath of this pandemic, and plans that should be implemented in the event of a future health crisis.

SECTION 4.6.(b) The study shall include input from universities, colleges, and community colleges that educate health care providers; health care provider licensing boards; the Department of Health and Human Services; the Department of Public Safety; and geographically disbursed rural and urban hospitals, ambulatory surgical centers, primary care practices, specialty care practices, correctional facilities, group homes, home care agencies, nursing homes, adult care homes, and other residential care facilities.

SECTION 4.6.(c) The study shall include, but is not limited to, examination of, and reporting on, the issues outlined below:

(1) Adequacy of the health care workforce supply to respond to a pandemic in the following settings: acute care, ambulatory, primary care, nursing homes, adult care homes, other residential care facilities, correctional facilities, and in-home care.

(2) Adequacy of the health care workforce supply to address the COVID-19 surge; the ability to redirect the existing workforce supply to meet staffing demands, including the identification of any barriers; and recommendations to eliminate barriers and readily deploy staffing in a future health crisis.

(3) Adequacy of the health care workforce training, by setting, and the need for additional training or cross-training of health care providers.

(4) Impact of the COVID-19 pandemic on communities with preexisting workforce shortages.

(5) Impact of personal protective equipment (PPE) availability on the health care workforce, by setting.

(6) Sufficiency of support mechanisms for the health care workforce, including the availability of child care, transportation, mental health and resilience support services, and other support items.

(7) Impact of postponing or eliminating nonessential services and procedures on the health care workforce.

(8) Impact of postponing or eliminating nonessential services and procedures on hospitals, particularly rural hospitals.

(9) Interruptions in the delivery of routine health care during the COVID-19 pandemic and the impact to citizens, primary and specialty care practices, and the health care workforce employed in these practices.

(10) Impact of the COVID-19 pandemic on the delivery of behavioral health services.

(11) Ability of telehealth options to deliver routine and emergent health and behavioral health services to patients.
(12) Impact of telehealth on hospitals during the COVID-19 pandemic.
(13) Support necessary to resume health care delivery to pre-pandemic levels.
(14) Ability of the health care workforce and health care delivery structure to respond to the needs of minority populations, individuals with health disparities, and individuals and communities with increased health risks, during a pandemic.
(15) Impact of the COVID-19 pandemic, including concerns surrounding PPE availability, on current health sciences students and implications for future students contemplating a career in health sciences.

SECTION 4.6.(d) The NC AHEC shall report findings and recommendations to the House Select Committee on COVID-19, Health Care Working Group, on or before November 15, 2020. The report shall include a summary section to provide a high-level debriefing to the State's leaders, health care providers, and others, on successes and priority items to address as the State moves forward.

SECTION 4.6.(e) Due to the evolving nature of the COVID-19 pandemic, the NC AHEC has authority to report subsequent study findings and recommendations, as appropriate, to the Joint House Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Joint Legislative Oversight Committee on Health and Human Services.

SECTION 4.6.(f) This section is effective when it becomes law.

HEALTH CARE LIABILITY PROTECTION FOR EMERGENCY OR DISASTER TREATMENT

SECTION 4.7.(a) Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 1L.

"Emergency or Disaster Treatment Protection Act.

"**§ 90-21.130. Short title.**

This Article shall be known and may be cited as the Emergency or Disaster Treatment Protection Act.

"**§ 90-21.131. Purpose.**

It is the purpose of this section to promote the public health, safety, and welfare of all citizens by broadly protecting the health care facilities and health care providers in this State from liability that may result from treatment of individuals during the COVID-19 public health emergency under conditions resulting from circumstances associated with the COVID-19 public health emergency. A public health emergency that occurs on a statewide basis requires an enormous response from state, federal, and local governments working in concert with private and public health care providers in the community. The rendering of treatment to patients during such a public health emergency is a matter of vital State concern affecting the public health, safety, and welfare of all citizens.

"**§ 90-21.132. Definitions.**

The following definitions apply in this Article:

(1) COVID-19. – Coronavirus disease 2019.
(2) COVID-19 emergency declaration. – Executive Order No. 116 issued March 10, 2020, by Governor Roy A. Cooper, including any amendments issued by executive order, subject to extensions under Chapter 166A of the General Statutes.
(3) COVID-19 emergency rule. – Any executive order, declaration, directive, request, or other state or federal authorization, policy statement, rule making,

or regulation that waives, suspends, or modifies applicable State or federal law regarding scope of practice, including modifications authorizing health care providers licensed in another state to practice in this State, or the delivery of care, including those regarding the facility space in which care is delivered and which equipment is used during the COVID-19 emergency declaration.

(4) Damages. – Economic or noneconomic losses for harm to an individual.

(5) Harm. – Physical and nonphysical contact that results in injury to or death of an individual.

(6) Health care facility. – Any entity licensed pursuant to Chapter 122C, 131D, or 131E of the General Statutes or Article 64 of Chapter 58 of the General Statutes.

(7) Health care provider. –

a. An individual who is licensed, certified, or otherwise authorized under Chapter 90 or 90B of the General Statutes to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.

b. A health care facility where health care services are provided to patients, residents, or others to whom such services are provided as allowed by law.

c. Individuals licensed under Chapter 90 of the General Statutes or practicing under a waiver in accordance with G.S. 90-12.5.

d. Any emergency medical services personnel as defined in G.S. 131E-155(7).

e. Any individual providing health care services within the scope of authority permitted by a COVID-19 emergency rule.

f. Any individual who is employed as a health care facility administrator, executive, supervisor, board member, trustee, or other person in a managerial position or comparable role at a health care facility.

g. An agent or employee of a health care facility that is licensed, certified, or otherwise authorized to provide health care services.

h. An officer or director of a health care facility.

i. An agent or employee of a health care provider who is licensed, certified, or otherwise authorized to provide health care services.

(8) Health care service. – Treatment, clinical direction, supervision, management, administrative or corporate service, provided by a health care facility or a health care provider during the period of the COVID-19 emergency declaration, regardless of the location in this State where the service is rendered:

a. To provide testing, diagnosis, or treatment of a health condition, illness, injury, or disease related to a confirmed or suspected case of COVID-19.

b. To dispense drugs, medical devices, medical appliances, or medical goods for the treatment of a health condition, illness, injury, or disease related to a confirmed or suspected case of COVID-19.

c. To provide care to any other individual who presents or otherwise seeks care at or from a health care facility or to a health care provider during the period of the COVID-19 emergency declaration.

(9) Volunteer organization. – Any medical organization, company, or institution that has made its facility or facilities available to support the State's response and activities under the COVID-19 emergency declaration and in accordance with any applicable COVID-19 emergency rule.

"**§ 90-21.133. Immunity.**

(a) Notwithstanding any law to the contrary, except as provided in subsection (b) of this section, any health care facility, health care provider, or entity that has legal responsibility for the acts or omissions of a health care provider shall have immunity from any civil liability for any harm or damages alleged to have been sustained as a result of an act or omission in the course of arranging for or providing health care services only if all of the following apply:

(1) The health care facility, health care provider, or entity is arranging for or providing health care services during the period of the COVID-19 emergency declaration, including, but not limited to, the arrangement or provision of those services pursuant to a COVID-19 emergency rule.

(2) The arrangement or provision of health care services is impacted, directly or indirectly:

a. By a health care facility, health care provider, or entity's decisions or activities in response to or as a result of the COVID-19 epidemic; or

b. By the decisions or activities, in response to or as a result of the COVID-19 epidemic, of a health care facility or entity where a health care provider provides health care services.

(3) The health care facility, health care provider, or entity is arranging for or providing health care services in good faith.

(b) The immunity from any civil liability provided in subsection (a) of this section shall not apply if the harm or damages were caused by an act or omission constituting gross negligence, reckless misconduct, or intentional infliction of harm by the health care facility or health care provider providing health care services; provided that the acts, omissions, or decisions resulting from a resource or staffing shortage shall not be considered to be gross negligence, reckless misconduct, or intentional infliction of harm.

(c) Notwithstanding any law to the contrary, a volunteer organization shall have immunity from any civil liability for any harm or damages occurring in or at its facility or facilities arising from the State's response and activities under the COVID-19 emergency declaration and in accordance with any applicable COVID-19 emergency rule, unless it is established that such harm or damages were caused by the gross negligence, reckless misconduct, or intentional infliction of harm by the volunteer organization.

"**§ 90-21.134. Severability.**

This Article shall be liberally construed to effectuate its public health emergency purpose as outlined in G.S. 90-121.131. The provisions of this Article are severable. If any part of this Article is declared to be invalid by a court, the invalidity does not affect other parts of this Article that can be given effect without the invalid provision."

SECTION 4.7.(b) This section is effective when it becomes law and applies to acts or omissions occurring during the time of Executive Order No. 116 issued on March 10, 2020, by Governor Roy A. Cooper, and any subsequent time period during which a state of emergency is declared to be in effect during calendar year 2020 by the Governor in response to COVID-19.

AUTHORIZATION FOR PHARMACISTS TO ADMINISTER COVID-19 TESTS

SECTION 4.8.(a) G.S. 90-85.3A is amended by adding a new subsection to read:

"(e) The administration by pharmacists of diagnostic tests and antibody tests for coronavirus disease 2019 to patients only if such tests have been approved or authorized for emergency use by the United States Food and Drug Administration."

SECTION 4.8.(b) This section is effective when it becomes law.

DISPENSE AND USE OF CONTROLLED SUBSTANCES TEMPORARILY AT ADDITIONAL PLACES OF BUSINESS

SECTION 4.9.(a) Notwithstanding any provision of law to the contrary, for the duration of the COVID-19 emergency, a hospital, nursing home, or clinic holding a valid State registration for controlled substances under Article 5 of Chapter 90 of the General Statutes may temporarily dispense or use controlled substances at additional places of business by completing the registration process developed by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services of the North Carolina Department of Health and Human Services, and providing all information required pursuant to said emergency registration process for any overflow facility or satellite facility that may be established temporarily by the hospital, nursing home, or clinic registrant in response to the COVID-19 emergency, and no registration fee shall be required in connection with any such emergency registration.

SECTION 4.9.(b) This section is effective when it becomes law and expires 60 days after Executive Order No. 116 is rescinded, or December 31, 2020, whichever is earlier.

PRE-PROCEDURE COVID-19 TEST RESULT REPORTING

SECTION 4.10.(a) All healthcare providers, as defined under G.S. 130A-476(g), shall receive and report the results, both positive and negative, of any COVID-19 diagnostic test or COVID-19 antibody test performed on an individual prior to any nonemergency surgery or procedure to the Commission for Public Health (Commission) and to the Division of Public Health. The Department of Health and Human Services shall report pre-procedure test result data on a county-by-county basis and update it daily on its Web site.

SECTION 4.10.(b) This section is effective when it becomes law.

PART V. INCREASED FLEXIBILITY FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO RESPOND TO COVID-19

EXTENSION OF TIME FOR ESTABLISHING CONNECTIVITY TO THE STATE'S HEALTH INFORMATION EXCHANGE NETWORK KNOWN AS HEALTHCONNEX

SECTION 5.1.(a) G.S. 90-414.4(a1)(2) reads as rewritten:

"(2) Except as provided in subdivisions (3), (4), and (5) of this subsection, all other providers of Medicaid and State-funded health care services shall begin submitting demographic and clinical data by ~~June 1, 2020.~~October 1, 2021."

SECTION 5.1.(b) G.S. 90-414(a2) reads as rewritten:

"(a2) Extensions of Time for Establishing Connection to the HIE Network. – The Department of Information Technology, in consultation with the Department of Health and Human Services and the State Health Plan for Teachers and State Employees, may establish a process to grant limited extensions of the time for providers and entities to connect to the HIE Network and begin submitting data as required by this section upon the request of a provider or entity that demonstrates an ongoing good-faith effort to take necessary steps to establish such connection and begin data submission as required by this section. The process for granting an extension of time must include a presentation by the provider or entity to the Department of Information Technology, the Department of Health and Human Services, and the State Health Plan for Teachers and State Employees on the expected time line for connecting to the HIE Network and commencing data submission as required by this section. Neither the Department of Information Technology, the Department of Health and Human Services, nor the State Health Plan for Teachers and State Employees shall grant an extension of time (i) to any provider or entity that fails to provide this information to both Departments, and the State Health Plan for Teachers and State Employees, (ii) that would result in the provider or entity connecting to the HIE Network and commencing data submission as required by this section later than ~~June 1, 2020,~~ October 1, 2021, or (iii) that would result in any provider or entity specified in subdivisions (4) and (5) of subsection (a1) of this section connecting to the HIE Network and commencing data submission as required by this section later than June 1, 2022. The Department of

Information Technology shall consult with the Department of Health and Human Services and the State Health Plan for Teachers and State Employees to review and decide upon a request for an extension of time under this section within 30 days after receiving a request for an extension."

SECTION 5.1.(c) This section is effective when it becomes law.

TEMPORARY WAIVER OF THREE-YEAR FINGERPRINTING REQUIREMENT/CHILD CARE PROVIDERS/ADOPTIONS/FOSTER CARE

SECTION 5.2.(a) Notwithstanding G.S. 110-90.2(b), the Department of Health and Human Services, Division of Child Development and Early Education, shall temporarily waive the requirement that current child care providers complete a fingerprint-based criminal history check every three years.

SECTION 5.2.(b) In accordance with federal guidance, all available State and federal name-based criminal background checks for prospective employees seeking employment in licensed child care shall be completed. Prospective employees will be issued a provisional qualification status. In situations where only State and federal name-based checks were completed, fingerprint-based criminal history checks shall be completed within 60 days of Executive Order No. 116 being rescinded, in compliance with State law and rules. If fingerprint-based checks are not completed within 60 days of Executive Order No. 116 being rescinded, the prospective employee will be disqualified until a fingerprint-based check is completed.

SECTION 5.2.(c) Notwithstanding any provision of law or rules to the contrary, the Department of Health and Human Services, Division of Social Services, shall temporarily waive any requirement to complete a fingerprint-based criminal history check pertaining to adoptions, foster care, or child care institutions. However, in accordance with federal guidance, all available name-based criminal background checks for prospective foster parents, adoptive parents, legal guardians, and adults working in child care institutions shall be completed, and, in situations where only name-based checks were completed, fingerprint-based criminal history checks shall be completed within 60 days of Executive Order No. 116 being rescinded, in compliance with State law and rules.

SECTION 5.2.(d) This section is effective when it becomes law and expires 60 days after Executive Order No. 116 is rescinded, or December 31, 2020, whichever is earlier.

PROVIDE MEDICAID COVERAGE FOR COVID-19 TESTING TO UNINSURED INDIVIDUALS IN NORTH CAROLINA DURING THE NATIONWIDE PUBLIC HEALTH EMERGENCY

SECTION 5.3.(a) The Department of Health and Human Services, Division of Health Benefits (DHB), is authorized to provide the Medicaid coverage described in 42 U.S.C.A. § 1396a(a)(10)(A)(ii)(XXIII), which covers COVID-19 testing for certain uninsured individuals during the period in which there is a declared nationwide public health emergency as a result of the 2019 novel coronavirus. DHB is authorized to provide this medical assistance retroactively to the earliest date allowable.

SECTION 5.3.(b) This section is effective when it becomes law.

TEMPORARY MEDICAID COVERAGE FOR THE PREVENTION, TESTING, AND TREATMENT OF COVID-19

SECTION 5.4.(a) The Department of Health and Human Services, Division of Health Benefits (DHB), is authorized to provide temporary, targeted Medicaid coverage to individuals with incomes up to two hundred percent (200%) of the federal poverty level, as requested by the Secretary of the Department of Health and Human Services in the 1115 waiver application submitted to the Centers for Medicare and Medicaid Services (CMS) on March 27, 2020. If CMS grants approval for different coverage or a different population than requested in

that 1115 waiver application, DHB may implement the approved temporary coverage, provided that all the following criteria are met:

(1) The coverage is only provided for a limited time period related to the declared nationwide public health emergency as a result of the 2019 novel coronavirus.

(2) The coverage is not provided for services other than services for the prevention, testing, or treatment of COVID-19.

(3) The income level to qualify for the coverage does not exceed two hundred percent (200%) of the federal poverty level.

SECTION 5.4.(b) The Department of Health and Human Services, Division of Health Benefits, is authorized to provide this Medicaid coverage retroactively to the earliest date allowable.

SECTION 5.4.(c) This section is effective when it becomes law.

SUPPORT RECEIPT OF ENHANCED FEDERAL MEDICAID FUNDING

SECTION 5.5.(a) It is the intent of the General Assembly that North Carolina adhere to all federal requirements for obtaining enhanced federal Medicaid funding, as provided under the Families First Coronavirus Response Act (FFCRA), Public Law 116-127, as amended, for the period required under the FFCRA and during which there is a declared nationwide public health emergency as a result of the 2019 novel coronavirus. Accordingly, the Department of Health and Human Services, Division of Health Benefits, shall adhere to and implement all federal law and regulation necessary for receipt of this enhanced federal Medicaid funding, notwithstanding any State law to the contrary. Further, federal law and regulation applicable to the North Carolina Medicaid program or NC Health Choice program shall supersede and preempt any State law or rule to the contrary during the period in which there is a declared nationwide public health emergency as a result of the 2019 novel coronavirus.

SECTION 5.5.(b) This section is effective when it becomes law.

DISABLED ADULT CHILD PASSALONG ELIGIBILITY/MEDICAID

SECTION 5.6.(a) Effective no later than June 1, 2020, the eligibility requirements for the Disabled Adult Child Passalong authorized under section 1634 of the Social Security Act for the Medicaid program shall consist of only the following four requirements:

(1) The adult is currently entitled to and receives federal Retirement, Survivors, and Disability Insurance (RSDI) benefits as a disabled adult child on a parent's record due to the retirement, death, or disability of a parent.

(2) The adult is blind or has a disability that began before age 22.

(3) The adult would currently be eligible for Supplemental Security Income (SSI) or State-County Special Assistance if the current RSDI benefit is disregarded.

(4) For eligibility that is based on former receipt of State-County Special Assistance and not SSI, the adult must currently reside in an adult care home.

SECTION 5.6.(b) This section is effective when it becomes law.

MODIFICATION OF FACILITY INSPECTIONS AND TRAINING TO ADDRESS INFECTION CONTROL MEASURES FOR COVID-19

SECTION 5.7.(a) Notwithstanding any provision of Article 2 of Chapter 122C, Articles 1 and 3 of Chapter 131D, and Chapter 131E of the General Statutes, or any other provision of law to the contrary, the Department of Health and Human Services, Division of Health Service Regulation, and as applicable, local departments of social services, shall suspend all annual and biennial inspections and regular monitoring requirements for licensed facilities under Article 2 of Chapter 122C of the General Statutes, and Articles 1 and 3 of Chapter 131D of the General Statutes, and Articles 5, 6, and 10 of Chapter 131E of the General Statutes, and provisions within any rules adopted under these chapters that pertain to the Department or DHSR

monitoring, inspection, or investigative requirements, except (i) as DHSR deems necessary to avoid serious injury, harm, impairment, or death to employees, residents, or patients of these facilities or (ii) as directed by the Centers for Medicare and Medicaid Services.

SECTION 5.7.(b) DHSR shall review the compliance history of all facilities licensed under Article 2 of Chapter 122C of the General Statutes and Article 1 of Chapter 131D of the General Statutes that were determined to be in violation, assessed penalties, or placed on probation within the six-month period preceding the beginning of the COVID-19 emergency, for noncompliance with rules or statutes or Centers for Disease Control and Prevention guidelines regarding infection control or the proper use of personal protective equipment. DHSR shall require employees of these facilities to undergo immediate training designated by DHSR about infection control and the proper use of personal protective equipment. The training required by this section may be conducted online, by video conference, or in such manner as DHSR determines appropriate under the circumstances.

SECTION 5.7.(c) This section is effective when it becomes law and expires 60 days after Executive Order No. 116 is rescinded, or December 31, 2020, whichever is earlier.

ALLOW TEMPORARY WAIVER OF 72-HOUR PRE-SERVICE TRAINING REQUIREMENT/CHILD WELFARE STAFF

SECTION 5.8.(a) Notwithstanding G.S. 131D-10.6A(b)(1), the Department of Health and Human Services, Division of Social Services, is authorized to temporarily waive the 72-hour requirement of preservice training before child welfare services staff assumes direct client contact responsibilities. The Division is authorized to identify and use web-based training as an acceptable equivalent in meeting preservice training requirements.

SECTION 5.8.(b) This section is effective when it becomes law and expires 60 days after Executive Order No. 116 is rescinded, or December 31, 2020, whichever is earlier.

PART VI. INCREASED ACCESS TO HEALTH CARE THROUGH TELEHEALTH TO RESPOND TO COVID-19

EXPANDED USE OF TELEHEALTH TO CONDUCT FIRST AND SECOND INVOLUNTARY COMMITMENT EXAMINATIONS DURING THE COVID-19 EMERGENCY

SECTION 6.1.(a) The following words have the following meanings in this section:

(1) Commitment examiner. – As defined in G.S. 122C-3.

(2) Telehealth. – The use of two-way, real-time interactive audio and video where the respondent and commitment examiner can hear and see each other.

(3) Qualified professional. – As defined in G.S. 122C-3.

SECTION 6.1.(b) Notwithstanding any provision of Chapter 122C of the General Statutes or any other provision of law to the contrary, the first examination of a respondent required by G.S. 122C-263 to determine whether the respondent will be involuntarily committed due to mental illness or by G.S. 122C-283(a) to determine whether the respondent will be involuntarily committed due to substance use disorder may be conducted either in the physical face-to-face presence of the commitment examiner or utilizing telehealth equipment and procedures. A commitment examiner who examines a respondent by means of telehealth must be satisfied to a reasonable medical certainty that the determinations made in accordance with G.S. 122C-283(d) would not be different if the examination had been conducted in the physical presence of the commitment examiner. A commitment examiner who is not so satisfied must note that the examination was not satisfactorily accomplished, and the respondent must be taken for a face-to-face examination in the physical presence of a person authorized to perform examinations under G.S. 122C-283.

SECTION 6.1.(c) Notwithstanding any provision of Chapter 122C of the General Statutes or any other provision of law to the contrary, the second examination of a respondent required by G.S. 122C-266(a) to determine whether the respondent will be involuntarily committed due to mental illness or required by G.S. 122C-285(a) to determine if the respondent will be involuntarily committed due to substance use disorder may be conducted either in the physical face-to-face presence of a physician or utilizing telehealth equipment and procedures, provided that the following conditions are met:

(1) In the case of involuntary commitment due to mental illness, the physician who examines the respondent by means of telehealth must be satisfied to a reasonable medical certainty that the determinations made in accordance with subdivisions (a)(1) through (a)(3) of G.S. 122C-266 would not be different if the examination had been done in the physical presence of the examining physician. An examining physician who is not so satisfied must note that the examination was not satisfactorily accomplished, and the respondent must be taken for a face-to-face examination in the physical presence of a physician.

(2) In the case of involuntary commitment due to substance use disorder, the physician who examines the respondent by means of telehealth must be satisfied to a reasonable medical certainty that the determinations made in accordance with G.S. 122C-285(a) would not be different if the examination had been done in the physical presence of the commitment examiner. An examining physician who is not so satisfied must note that the examination was not satisfactorily accomplished, and the respondent must be taken for a face-to-face examination in the physical presence of a qualified professional, as defined in G.S. 122C-3; provided that, if the initial commitment examination was performed by a qualified professional, then this face-to-face examination shall be in the presence of a physician.

SECTION 6.1.(d) This section is effective when it becomes law and expires 60 days after Executive Order No. 116 is rescinded, or December 31, 2020, whichever is earlier.

HEALTH BENEFIT PLAN COVERAGE OF TELEHEALTH

SECTION 6.2.(a) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-310. Telehealth during the COVID-19 emergency.**

(a) For the purposes of this section, the following definitions shall apply:

(1) Health benefit plan. – As defined in G.S. 58-3-167.

(2) Telehealth. – The delivery of health care, including mental and behavioral health care, through real-time, two-way audio/visual delivery.

(3) Virtual health care. – The delivery of health care, including mental and behavioral health care, through audio-only delivery or electronic-only delivery, both synchronous and asynchronous. This term shall include health care delivered over the telephone and electronic patient visits, including health care delivered through an electronic provider portal or electronic patient portal.

(b) This section shall apply to the following time periods:

(1) March 10, 2020, through the date Executive Order No. 116, Declaration of a State of Emergency to Coordinate Response and Protective Actions to Prevent the Spread of COVID-19, expires or is rescinded.

(2) The period of any subsequent state of emergency declared in the 2020 calendar year by the Governor of North Carolina in response to COVID-19 through 30 days after that subsequent state of emergency expires or is rescinded.

(c) All of the following shall apply to all health benefit plans offered in this State:

(1) Health benefit plans shall provide coverage and reimbursement for virtual health care, including mental and behavioral health care.

(2) Health benefit plans shall provide reimbursement for provider-to-provider consultations that are conducted using virtual health care if the health benefit plan would provide reimbursement for the consult had it taken place in-person, face-to-face.

(3) No health benefit plan may require prior authorization for telehealth services or virtual health care services.

(4) No health benefit plan may put limits on the originating site or the distant site for telehealth services or virtual health care services.

(5) Health benefit plans shall cover and reimburse physical therapy, occupational therapy, and speech therapy when delivered through telehealth.

(6) A health benefit plan may require a deductible, a co-payment, or coinsurance for a covered health care service delivered by telehealth by a preferred or contracted provider to a covered individual. The amount of the deductible, co-payment, or coinsurance may not exceed the amount of the deductible, co-payment, or coinsurance required had the covered health care service been provided in-person, face-to-face.

(7) A health benefit plan shall reimburse providers for a covered health care service delivered by telehealth at a level no less than the reimbursement for that service had it been provided in-person, face-to-face."

SECTION 6.2.(b) Effective when this section becomes law, the provisions of G.S. 58-50-310, as enacted under subsection (a) of this section, shall apply to the State Health Plan for Teachers and State Employees.

SECTION 6.2.(c) This section is effective when it becomes law and expires December 31, 2020.

INCREASED ACCESS TO TELEHEALTH UNDER THE MEDICARE PROGRAM

SECTION 6.3. The General Assembly urges the federal Centers for Medicaid and Medicare Services to provide reimbursement for health care delivered through audio-only communication, such as over the telephone, under the Medicare program in order to reduce barriers and increase access to health care for older adults.

PART VII. SEVERABILITY

SECTION 7.1. If any provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of this act as a whole or any part other than the part declared unconstitutional or invalid.

PART VIII. EFFECTIVE DATE

SECTION 8.1. Except as otherwise provided, this act is effective when it becomes law.