GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2021

H **D**

HOUSE BILL 149
Committee Substitute Favorable 5/5/21
PROPOSED SENATE COMMITTEE SUBSTITUTE H149-PCS30552-BCxfr-65

Short Title: Expanding Access to Healthcare. (Public)

Sponsors:

Referred to:

February 25, 2021

A BILL TO BE ENTITLED

AN ACT EXPANDING ACCESS TO HEALTHCARE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

PART I. MEDICAID

NC HEALTH WORKS

SECTION 1.1.(a) Section 3 of S.L. 2013-5 is repealed.

SECTION 1.1.(b) G.S. 108A-54.3A is amended by adding a new subdivision to read:

"(24) Individuals described in section 1902(a)(10)(A)(i)(VIII) of the Social Security Act who are in compliance with work requirements established in the State Plan and in rule. Coverage for individuals under this subdivision is available through an Alternative Benefit Plan that is established by the Department consistent with federal requirements, unless that individual is exempt from mandatory enrollment in an Alternative Benefit Plan under 42 C.F.R. § 440.315."

SECTION 1.1.(c) This section is effective six months after the date this act becomes effective or on the date that the work requirements developed under Part II of this act become effective, whichever is later.

SECTION 1.2.(a) Part 6 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-54.3B. Nonfederal share of NC Health Works costs.**

(a) As used in this section, the following definitions apply:

(1) "Cost" means all expenses incurred by the State and counties that are eligible for Medicaid federal financial participation.

(2) "NC Health Works" means the provision of Medicaid coverage to the individuals described in G.S. 108A-54.3A(24).

(b) It is the intent of the General Assembly to fully fund the nonfederal share of the cost of NC Health Works through a combination of the following sources:

(1) Increases in revenue from the gross premiums tax under G.S. 105-228.5 due to NC Health Works.

(2) Increases in intergovernmental transfers due to NC Health Works.

(3) Excluding any State retention, the hospital health advancement assessment under Part 3 of Article 7B of Chapter 108A of the General Statutes.

(4) Savings to the State attributable to NC Health Works that correspond to State General Fund budget reductions to other State programs.

(c) By October 1 of each year, beginning in 2024, the Department shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Office of State Budget and Management, and the Fiscal Research Division containing all of the following information with supporting calculations:

(1) The total nonfederal share of the cost of NC Health Works for the preceding State fiscal year and the total funding available from the sources described in subsection (b) of this section.

(2) The projected total nonfederal share of the cost of NC Health Works for the current State fiscal year and the total projected funding available from the sources described in subsection (b) of this section.

The Department shall submit detailed data supporting these calculations to the Fiscal Research Division.

(d) If, for any fiscal year, the nonfederal share of the cost of NC Health Works cannot be fully funded through the sources described in subsection (b) of this section, then Medicaid coverage for the individuals described in G.S. 108A-54.3A(24) shall be discontinued as expeditiously as possible. Upon a determination by the Secretary that the nonfederal share of the cost of NC Health Works exceeds the funding from the sources described in subsection (b) of this section, the Secretary shall promptly do all of the following:

(1) Notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Office of State Budget and Management, and the Fiscal Research Division of the determination and post this notice on the Department's website. The notice must include the proposed effective date of the discontinuation of coverage.

(2) Submit all documents to the Centers for Medicare and Medicaid Services necessary to discontinue Medicaid coverage for the individuals described in G.S. 108A-54.3A(24).

"**§ 108A-54.3C. NC Health Works federal financial participation.**

If the federal medical assistance percentage for Medicaid coverage provided to the individuals described in G.S. 108A-54.3A(24) falls below ninety percent (90%), then Medicaid coverage for these individuals shall be discontinued as expeditiously as possible but no earlier than the date the lower federal medical assistance percentage takes effect. Upon receipt of information indicating that the federal medical assistance percentage will be lower than ninety percent (90%), the Secretary shall promptly do all of the following:

(1) Notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, the Office of State Budget and Management, and the Fiscal Research Division of the determination and post this notice on the Department's website. The notice must include the proposed effective date of the discontinuation of coverage.

(2) Submit all documents to the Centers for Medicare and Medicaid Services necessary to discontinue Medicaid coverage for the individuals described in G.S. 108A-54.3A(24)."

SECTION 1.2.(b) This section is effective six months after the date this act becomes effective or on the date that the work requirements developed under Part II of this act become effective, whichever is later.

ARPA TEMPORARY SAVINGS FUND

SECTION 1.3. The ARPA Temporary Savings Fund is established as a nonreverting special fund in the Department of Health and Human Services, Division of Health Benefits (DHB). The ARPA Temporary Savings Fund shall consist of any savings realized by DHB as a

result of federal receipts arising from the enhanced federal medical assistance percentage (FMAP) available to the State under section 9814 of the American Rescue Plan Act of 2021, P.L. 117-2 (ARPA). Upon receipt by DHB of any federal receipts arising from that enhanced FMAP, DHB is directed to deposit the savings associated with those receipts into the ARPA Temporary Savings Fund. Funds in the ARPA Temporary Savings Fund may be allocated or expended only upon an act of appropriation by the General Assembly.

HOSPITAL HEALTH ADVANCEMENT ASSESSMENTS

SECTION 1.5.(a) Each hospital licensed in North Carolina, except for critical access hospitals and State-owned and State-operated hospitals, is subject to an assessment of forty-four thousandths percent (0.044%) of its hospital costs, as defined in G.S. 108A-145.3, for the State fiscal quarter beginning October 1, 2022. This hospital assessment shall be imposed by the Department of Health and Human Services in accordance with the procedures for hospital assessments under Part 1 of Article 7B of Chapter 108A of the General Statutes. From the proceeds of this assessment, the Department of Health and Human Services shall use the sum of two million dollars ($2,000,000), and all corresponding matching federal funds, to reimburse county departments of social services for additional costs incurred by the county in preparation to implement Section 1.1 of this act.

SECTION 1.5.(b) Subsection (a) of this section becomes effective October 1, 2022, and expires December 31, 2022.

SECTION 1.5.(c) Each hospital licensed in North Carolina, except for critical access hospitals and State-owned and State-operated hospitals, is subject to an assessment of five hundred thirty-nine thousandths percent (0.539%) of its hospital costs, as defined in G.S. 108A-145.3, for the State fiscal quarter beginning January 1, 2023, and the State fiscal quarter beginning April 1, 2023. This hospital assessment shall be imposed by the Department of Health and Human Services (DHHS) in accordance with the procedures for hospital assessments under Part 1 of Article 7B of Chapter 108A of the General Statutes. From the proceeds of this assessment, DHHS shall use the sum of two million dollars ($2,000,000) per applicable quarter, and all corresponding matching federal funds, to reimburse county departments of social services for additional costs incurred by the county to implement Section 1.1 of this act.

SECTION 1.5.(d) Subsection (c) of this section becomes effective January 1, 2023, or on the effective date of the Medicaid coverage described in Section 1.1 of this act, whichever is later, and expires June 30, 2023. If the effective date occurs after March 31, 2023, then no assessment shall be imposed for the State fiscal quarter beginning January 1, 2023, and no payments shall be made to the county departments of social services for that quarter.

SECTION 1.6.(a) G.S. 108A-145.3 reads as rewritten:

"**§ 108A-145.3. Definitions.**

The following definitions apply in this Article:

…

(4a) Consumer Price Index. – The most recent Consumer Price Index for All Urban Consumers for the South Region published by the Bureau of Labor Statistics of the United States Department of Labor available on March 1 of the previous State fiscal year.

…

(12b) Newly eligible individual. – As defined in 42 C.F.R. § 433.204.

(12c) Nonfederal share for newly eligible individuals. – One minus the percentage specified in 42 U.S.C. § 1396d(y)(1), expressed as a decimal.

…."

SECTION 1.6.(b) Article 7B of Chapter 108A of the General Statutes, as enacted by Section 2 of S.L. 2021-61, is amended by adding a new Part to read:

"Part 3. Hospital Health Advancement Assessment.

"**§ 108A-147.1. Hospital health advancement assessment.**

(a) The hospital health advancement assessment imposed under this Part shall apply to all hospitals licensed in North Carolina, except that all of the following hospitals are exempt:

(1) Critical access hospitals.

(2) State-owned and State-operated hospitals.

(b) The hospital health advancement assessment shall be assessed as a percentage of each nonexempt hospital's hospital costs. The assessment percentage shall be calculated quarterly by the Department of Health and Human Services in accordance with this Part. The percentage for each quarter shall equal the hospital health advancement assessment collection amount under G.S. 108A-147.3 divided by the total hospital costs for all nonexempt hospitals holding a license on the first day of the assessment quarter.

"**§ 108A-147.3. Hospital health advancement assessment collection amount.**

The hospital health advancement assessment collection amount is an amount of money that is calculated by adding all of the following:

(1) The service cost component under G.S. 108A-147.5.

(2) The administration component under G.S. 108A-147.7.

(3) The State retention component under G.S. 108A-147.9.

"**§ 108A-147.5. Service cost component.**

The service cost component is an amount of money that is the net service expenditures calculated under this section multiplied by the nonfederal share for newly eligible individuals. Net service expenditures are calculated from the data reported to CMS on Form CMS-64 for the preceding quarter. Net service expenditures are the service expenditures attributable to newly eligible individuals after subtracting each of the following:

(1) The rebates attributable to newly eligible individuals.

(2) The expenditures under the graduate medical education methodology in the Medicaid State Plan that are attributable to newly eligible individuals.

"**§ 108A-147.7. Administration component.**

(a) The administration component is an amount of money that consists of a State administration subcomponent and a county administration subcomponent.

(b) The State administration subcomponent is three million three hundred thousand dollars ($3,300,000) for each quarter of the 2023-2024 State fiscal year. For each subsequent State fiscal year, the State administration subcomponent shall be increased over the prior year's quarterly amount by the Consumer Price Index.

(c) The county administration subcomponent is two million dollars ($2,000,000) for each quarter of the 2023-2024 State fiscal year, three million seven hundred thousand dollars ($3,700,000) for each quarter of the 2024-2025 State fiscal year, and three million nine hundred thousand dollars ($3,900,000) for each quarter of the 2025-2026 State fiscal year. For each State fiscal year after the 2025-2026 State fiscal year, the county administration subcomponent shall be increased over the prior year's quarterly amount by the Consumer Price Index.

(d) The administration component is calculated by adding together the State administration subcomponent and the county administration subcomponent.

"**§ 108A-147.9. State retention component.**

The State retention component is thirty-seven million five hundred thousand dollars ($37,500,000) for each quarter of the 2023-2024 State fiscal year. For each subsequent State fiscal year, the State retention component shall be increased over the prior year's quarterly amount by the market basket percentage.

"**§ 108A-147.11. Use of funds.**

The Department shall use the proceeds of the hospital health advancement assessment that are attributable to the county administration subcomponent of the administration component in G.S. 108A-147.7, and all corresponding matching federal funds, to reimburse county

departments of social services for additional costs incurred by the county in determining eligibility for newly eligible individuals."

SECTION 1.6.(c) Notwithstanding G.S. 108A-147.1, as enacted in subsection (b) of this section, for the assessment quarter beginning July 1, 2023, the hospital health advancement assessment shall be five hundred fifty-five thousandths percent (0.555%) of total hospital costs for all hospitals that are not exempt from the hospital health advancement assessment.

SECTION 1.6.(d) Notwithstanding G.S. 108A-147.1, as enacted in subsection (b) of this section, for the assessment quarter beginning October 1, 2023, the Department of Health and Human Services shall determine the hospital health advancement assessment percentage by, first, either increasing or reducing the hospital health advancement assessment collection amount under G.S. 108A-147.3 by the reconciliation component under subsection (e) of this section and then dividing by the total hospital costs of all hospitals that are not exempt from the hospital health advancement assessment.

SECTION 1.6.(e) The reconciliation component is a positive or a negative number that results from subtracting ninety-three million eight hundred twenty-four thousand dollars ($93,824,000) from the actual amount of the service cost component under G.S. 108A-147.5 for the assessment quarter beginning July 1, 2023. If the reconciliation component is a positive number, then the hospital health advancement assessment collection amount shall be increased by the reconciliation component in accordance with this section. If the reconciliation component is a negative number, then the hospital health advancement assessment collection amount shall be reduced by the reconciliation component in accordance with this section.

SECTION 1.6.(f) This section becomes effective July 1, 2023.

SECTION 1.7.(a) G.S. 108A-145.3(16) reads as rewritten:

"(16) Paid capitation. – The total amount of the capitation payments made by the Department to all prepaid health plans for a particular rating group (i) attributable to the base capitation rate in the applicable Medicaid managed care capitation rate ~~certification and~~ certification, (ii) not attributable to newly eligible individuals, and (iii) adjusted by the Department as a result of retroactively implementing any base capitation rate adjustment that is approved by CMS or allowed under Part 438 of Subchapter C of Chapter IV of Title 42 of the Code of Federal Regulations."

SECTION 1.7.(b) G.S. 108A-146.9(a) reads as rewritten:

"(a) The fee-for-service component is an amount of money that is a portion of all the Medicaid fee-for-service payments made to acute care hospitals during the previous data collection period for claims with a date of service on or after July 1, ~~2021.~~ 2021, excluding claims attributable to newly eligible individuals. The fee-for-service component consists of a subcomponent pertaining to claims for which there is no third-party coverage and a subcomponent pertaining to claims for which there is third-party coverage."

SECTION 1.7.(c) G.S. 108A-146.12 reads as rewritten:

"**§ 108A-146.12. Postpartum coverage component.**

(a) The postpartum coverage component is twelve million five hundred thousand dollars ($12,500,000) for each quarter of the 2021-2022 State fiscal year.

(b) The postpartum coverage component is four million five hundred thousand dollars ($4,500,000) for each quarter of the 2023-2024 State fiscal year. For each subsequent State fiscal year, the postpartum coverage component shall be increased over the prior year's quarterly amount by the Medicare Economic Index."

SECTION 1.7.(d) G.S. 108A-146.13(a)(2) reads as rewritten:

"(2) The postpartum subcomponent applies to the assessments under this Part only during the period of April 1, 2022, through March 31, 2027, and is two million nine hundred sixty-two thousand five hundred dollars ($2,962,500) for each quarter of the 2021-2022 State fiscal year. For each quarter of the 2023-2024

State fiscal year, the postpartum subcomponent is one million sixty-five thousand dollars ($1,065,000). For each subsequent State fiscal year, the postpartum subcomponent shall be increased over the prior year's quarterly amount by the Medicare Economic Index."

SECTION 1.7.(e) Section 9D.13A(e) of S.L. 2021-180 is repealed.

SECTION 1.7.(f) Section 9D.14 of S.L. 2021-180 is repealed.

SECTION 1.7.(g) This section becomes effective July 1, 2023.

SECTION 1.8. It is the intent of the General Assembly to consult with stakeholders and the Division of Health Benefits of the Department of Health and Human Services prior to its 2023 Regular Session in order to consider any necessary refinements to the hospital health advancement assessment enacted by Section 1.6 of this act.

HEALTHCARE ACCESS AND STABILIZATION PROGRAM

SECTION 1.10.(a) The Department of Health and Human Services (DHHS) shall consult with stakeholders to develop a submission to the Centers for Medicare and Medicaid Services (CMS) to request approval for increased Medicaid reimbursements to hospitals. The nonfederal share of the requested increased Medicaid reimbursements shall be funded entirely from increased hospital assessment receipts. The submission shall request the highest increase in reimbursement to hospitals that can be funded entirely through increased hospital assessment receipts that are in addition to the receipts for NC Health Works resulting from the approach taken in the Hospital Health Advancement Assessment in this Part.

SECTION 1.10.(b) DHHS shall submit the request developed under subsection (a) of this section to CMS no later than October 1, 2022. If CMS does not approve the initial submission, DHHS shall continue to work with stakeholders to develop a submission that meets requirements for approval by CMS. In the event of an approval by CMS, the increased Medicaid reimbursement to hospitals shall not be effective until the enactment by the General Assembly of legislation that increases the hospital assessment to entirely fund the nonfederal share of the increased reimbursements to hospitals.

SECTION 1.10.(c) No later than February 1, 2023, DHHS shall submit a report to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division with all of the following information:

(1) A copy of the submission to CMS made in accordance with subsection (a) of this section.

(2) A description of the status of the approval of the submission.

(3) Proposed legislative language authorizing the increase in the hospital assessment necessary to effectuate the increased reimbursement to hospitals.

If DHHS receives approval from CMS of any submission under this section after submitting this report, DHHS shall notify the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division of that approval within 14 days of receipt. Within 30 days of receipt of that approval, DHHS shall update and resubmit the report required by this subsection.

PART II. WORK REQUIREMENTS FOR CERTAIN NC HEALTH WORKS BENEFICIARIES

ESTABLISH WORK REQUIREMENTS FOR CERTAIN NC HEALTH WORKS BENEFICIARIES

SECTION 2.(a) Certain individuals eligible for Medicaid under G.S. 108A-54.3A(24), as enacted by Section 1.1 of this act, shall be subject to work requirements as a contingency to participation in NC Health Works. The Department of Health and Human Services (DHHS) shall develop work requirements as a contingency to participation in NC Health

Works that are aligned with the work requirements for Able-Bodied Adults Without Dependents (ABAWDs) policy under the Supplemental Nutrition Assistance Program. All recipients qualifying under G.S. 108A-54.3A(24) shall be subject to the work requirements, except that only the following individuals shall be exempt from the requirements:

(1) Individuals who have been certified as unfit for employment for physical or mental health reasons.
(2) Individuals with a physical, intellectual, or developmental disability that significantly impairs the individual's ability to perform one or more activities of daily living.
(3) Individuals actively participating in a substance abuse treatment and rehabilitation program.
(4) Individuals who are the parent or caretaker of a dependent child under 1 year of age.
(5) Individuals who are a parent or caretaker that provides care for a dependent child with a serious medical condition or disability, to be defined by DHHS.
(6) Individuals who are receiving unemployment compensation and complying with the work requirements that are part of the federal-State unemployment compensation system.
(7) Presumptively eligible recipients, during the period of presumptive eligibility.
(8) Recipients who participate in the North Carolina Health Insurance Premium Payment (NC HIPP) program.
(9) Individuals who are inmates of prisons.

SECTION 2.(b) On or before October 1, 2022, DHHS shall submit to the Centers for Medicare and Medicaid Services (CMS) any State Plan amendments or any waivers necessary to implement work requirements as a contingency to participation in NC Health Works under G.S. 108A-54.3A(24), as enacted by Section 1.1 of this act. DHHS shall request an effective date that is six months from the effective date of this act.

SECTION 2.(c) This Part is effective when it becomes law. The work requirements developed under this Part shall become effective only upon the approval by CMS of the request submitted in accordance with this Part and on either (i) the effective date of the approved work requirements or (ii) six months after the date this act becomes effective, whichever is later. Upon receipt of the approval of the request required by this Part, the Secretary of the Department of Health and Human Services shall notify the Revisor of Statutes of the effective date of the work requirements approved in the request.

PART III. CERTIFICATE OF NEED REFORM

SECTION 3.1. G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

The following definitions apply in this Article:

…

(7b) Expedited review. – The status given to an application's review process when the applicant petitions for the review and the Department approves the request based on findings that all of the following are met:

a. The review is not competitive.
b. The proposed capital expenditure is less than five million dollars ($5,000,000).
~~c. A request for a public hearing is not received within the time frame defined in G.S. 131E-185.~~
d. The agency has not determined that a public hearing is in the public interest.

…

(9b) Health service facility. – A hospital; long-term care hospital; psychiatric facility; rehabilitation facility; nursing home facility; adult care home; kidney disease treatment center, including freestanding hemodialysis units; intermediate care facility for individuals with intellectual disabilities; home health agency office; ~~chemical dependency treatment facility;~~ diagnostic center; hospice ~~office,~~ office; hospice inpatient ~~facility,~~ facility; and hospice residential care ~~facility; and ambulatory surgical~~ facility.

(9c) Health service facility bed. – A bed licensed for use in a health service facility in the categories of (i) acute care beds; (ii) ~~psychiatric beds; (iii)~~ rehabilitation beds; ~~(iv)~~ (iii) nursing home beds; ~~(v)~~ (iv) intermediate care beds for individuals with intellectual disabilities; ~~(vi) chemical dependency treatment beds; (vii)~~ (v) hospice inpatient facility beds; ~~(viii)~~ (vi) hospice residential care facility beds; ~~(ix)~~ (vii) adult care home beds; and ~~(x)~~ (viii) long-term care hospital beds.

…

(16) New institutional health services. – Any of the following:

…

f1. The acquisition by purchase, donation, lease, transfer, or comparable arrangement of any of the following equipment by or on behalf of any person:

1. Air ambulance.
2. Repealed by Session Laws 2005-325, s. 1, effective for hospices and hospice offices December 31, 2005.
3. Cardiac catheterization equipment.
4. Gamma knife.
5. Heart-lung bypass machine.

5a. Linear accelerator.

6. Lithotriptor.

~~7. Magnetic resonance imaging scanner.~~

8. Positron emission tomography scanner.
9. Simulator.

…

~~r. The conversion of a specialty ambulatory surgical program to a multispecialty ambulatory surgical program or the addition of a specialty to a specialty ambulatory surgical program.~~

…

(22a) Related entity. – A legal entity that is directly or indirectly related to an applicant for a certificate of need by any level of common ownership, control, or governance without regard to the extent, scope, size, or overlap of such common ownership, control, or governance.

(22b) Replacement equipment. – Equipment that costs less than ~~two~~ four million dollars ~~($2,000,000)~~ ($4,000,000) and is purchased for the sole purpose of replacing comparable medical equipment currently in use which will be sold or otherwise disposed of when replaced. In determining whether the replacement equipment costs less than ~~two~~ four million dollars ~~($2,000,000),~~ ($4,000,000), the costs of equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the replacement equipment shall be included. The capital expenditure for the equipment shall be deemed to be the fair market value of the equipment or the cost of the equipment, whichever is greater. Beginning September 30, 2022, and on

September 30 each year thereafter, the replacement equipment cost threshold specified in this subdivision shall be adjusted using the Medical Care Index component of the Consumer Price Index published by the U.S. Department of Labor for the 12-month period preceding the previous September 1.

…."

SECTION 3.2. G.S. 131E-178(a) reads as rewritten:

"(a) No person shall offer or develop a new institutional health service without first obtaining a certificate of need from the ~~Department; provided, however, no person who provides gastrointestinal endoscopy procedures in one or more gastrointestinal endoscopy rooms located in a nonlicensed setting, shall be required to obtain a certificate of need to license that setting as an ambulatory surgical facility with the existing number of gastrointestinal endoscopy rooms, provided that:~~Department.

~~(1) The license application is postmarked for delivery to the Division of Health Service Regulation by December 31, 2006;~~

~~(2) The applicant verifies, by affidavit submitted to the Division of Health Service Regulation within 60 days of the effective date of this act, that the facility is in operation as of the effective date of this act or that the completed application for the building permit for the facility was submitted by the effective date of this act;~~

~~(3) The facility has been accredited by The Accreditation Association for Ambulatory Health Care, The Joint Commission on Accreditation of Healthcare Organizations, or The American Association for Accreditation of Ambulatory Surgical Facilities by the time the license application is postmarked for delivery to the Division of Health Service Regulation of the Department; and~~

~~(4) The license application includes a commitment and plan for serving indigent and medically underserved populations.~~

~~All other persons proposing to obtain a license to establish an ambulatory surgical facility for the provision of gastrointestinal endoscopy procedures shall be required to obtain a certificate of need. The annual State Medical Facilities Plan shall not include policies or need determinations that limit the number of gastrointestinal endoscopy rooms that may be approved.~~"

SECTION 3.3. G.S. 131E-182(a) reads as rewritten:

"(a) The Department in its rules shall establish schedules for submission and review of completed applications. The schedules shall provide that only applications for similar proposals in the same service area that are subject to the determinative limitations of need in the State Medical Facilities Plan pursuant to subdivision (1) of subsection (a) of G.S. 131E-183 will be reviewed together."

SECTION 3.4.(a) G.S. 131E-183 reads as rewritten:

"**§ 131E-183. Review criteria.**

(a) The Department shall review all applications utilizing the criteria outlined in this subsection and shall determine that an application is either consistent with or not in conflict with these criteria before a certificate of need for the proposed project shall be issued.

(1) ~~The proposed project~~ Proposed projects for air ambulances, emergency rooms, adult care homes, nursing home facilities, intermediate care facilities for individuals with intellectual disabilities, linear accelerators, gamma knives, positron emission tomography scanners, or any combination of these shall be consistent with applicable policies and need determinations in the State Medical Facilities Plan, the need determination of which constitutes a determinative limitation on the provision of any ~~health service, health service facility, health service facility beds, dialysis stations, operating rooms, or~~

~~home health offices~~ such services that may be approved. All other projects are exempt from and not subject to any applicable policies or need determinations in the State Medical Facilities Plan.

…

(3) The applicant shall identify the population to be served by the proposed project, and shall demonstrate ~~the need that this population has for the services proposed, and~~ the extent to which all residents of the area, and, in particular, low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups are likely to have access to the services proposed.

(3a) In the case of a reduction or elimination of a service, including the relocation of a facility or a service, the applicant shall demonstrate ~~that the needs of the population presently served will be met adequately by the proposed relocation or by alternative arrangements, and~~ the effect of the reduction, elimination or relocation of the service on the ability of low income persons, racial and ethnic minorities, women, handicapped persons, and other underserved groups and the elderly to obtain needed health care.

…

~~(6) The applicant shall demonstrate that the proposed project will not result in unnecessary duplication of existing or approved health service capabilities or facilities.~~

…

~~(9) An applicant proposing to provide a substantial portion of the project's services to individuals not residing in the health service area in which the project is located, or in adjacent health service areas, shall document the special needs and circumstances that warrant service to these individuals.~~

…

(13) The applicant shall demonstrate the contribution of the proposed service in meeting the health-related needs of the elderly and of members of medically underserved groups, such as medically indigent or low income persons, Medicaid and Medicare recipients, racial and ethnic minorities, women, and handicapped persons, which have traditionally experienced difficulties in obtaining equal access to the proposed services, particularly those needs identified in the State Health Plan as deserving of priority. For the purpose of determining the extent to which the proposed service will be accessible, the applicant shall ~~show:~~show all of the following:

a. The extent to which medically underserved populations currently use the applicant's existing services in comparison to the percentage of the population in the applicant's service area which is medically ~~underserved;~~underserved.

b. Its past performance in meeting its obligation, if any, under any applicable regulations requiring provision of uncompensated care, community service, or access by minorities and handicapped persons to programs receiving federal assistance, including the existence of any civil rights access complaints against the ~~applicant;~~applicant.

c. That the elderly and the medically underserved groups identified in this subdivision will be served by the applicant's proposed services and the extent to which each of these groups is expected to utilize the proposed ~~services; and~~services.

d. That the applicant offers a range of means by which a person will have access to its services. Examples of a range of means are outpatient

services, admission by house staff, and admission by personal physicians.

e. The applicant's past performance in meeting projections or other information incorporated into prior approved certificate of need applications filed by the applicant or a related entity during the six-year calendar period preceding an application for a proposed project. The Department shall use this information to assess the criteria specified in subdivision (3) of this subsection and sub-subdivision c. of this subdivision.

…

(20) An applicant already involved in the provision of health services shall provide evidence ~~that~~ of the quality of care the applicant has ~~been~~ provided in the past. This subdivision applies regardless of the geographical location of the applicant's existing health services operations.

…

(d) For each health service for which a certificate of need is required, the Department shall adopt rules specifying the metrics and criteria that will be used to assess the quality of care the applicant has provided in the past, consistent with subdivision (20) of subsection (a) of this section."

SECTION 3.4.(b) By January 1, 2023, the Department shall adopt the rules required by subsection (d) of G.S. 131E-183, as enacted by this act, specifying the metrics and criteria to be used to assess the quality of care a certificate of need applicant has provided in the past. Any applications filed with the Department prior to the effective date of these rules shall not be subject to the metrics and criteria specified in said rules.

SECTION 3.5. G.S. 131E-184 reads as rewritten:

"**§ 131E-184. Exemptions from review.**

…

(c) The Department shall exempt from certificate of need review any conversion of existing acute care beds to psychiatric ~~beds provided all of the following are true:~~beds.

~~(1) The hospital proposing the conversion has executed a contract with the Department's Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, one or more of the area mental health, developmental disabilities, and substance abuse authorities, or a combination thereof to provide psychiatric beds to patients referred by the contracting agency or agencies.~~

~~(2) The total number of beds to be converted shall not be more than twice the number of beds for which the contract pursuant to subdivision (1) of this subsection shall provide.~~

~~(d) In accordance with, and subject to the limitations of G.S. 148-19.1, the Department shall exempt from certificate of need review the construction and operation of a new chemical dependency or substance abuse facility for the purpose of providing inpatient chemical dependency or substance abuse services solely to inmates of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety. If an inpatient chemical dependency or substance abuse facility provides services both to inmates of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety and to members of the general public, only the portion of the facility that serves inmates shall be exempt from certificate of need review.~~

(e) The Department shall exempt from certificate of need review a capital expenditure that exceeds the ~~two million dollar ($2,000,000)~~ monetary threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

(1) The proposed capital expenditure would meet all of the following requirements:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding any of the following existing facilities:
1. Nursing home facility.
2. Adult care home facility.
3. Intermediate care facility for individuals with intellectual disabilities.
b. Not result in a change in bed capacity, as defined in G.S. 131E-176(5), or the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.

(2) The entity proposing to incur the capital expenditure provides prior written notice to the Department, which notice includes documentation that demonstrates that the proposed capital expenditure would be used for one or more of the following purposes:
a. Conversion of semiprivate resident rooms to private rooms.
b. Providing innovative, homelike residential dining spaces, such as cafes, kitchenettes, or private dining areas to accommodate residents and their families or visitors.
c. Renovating, replacing, or expanding residential living or common areas to improve the quality of life of residents.

(f) The Department shall exempt from certificate of need review the purchase of any replacement equipment that exceeds the ~~two million dollar ($2,000,000)~~ monetary threshold set forth in G.S. 131E-176(22a) if all of the following conditions are met:
(1) The equipment being replaced is located on the main campus.
(2) The Department has previously issued a certificate of need for the equipment being replaced. This subdivision does not apply if a certificate of need was not required at the time the equipment being replaced was initially purchased by the licensed health service facility.
(3) The licensed health service facility proposing to purchase the replacement equipment shall provide prior written notice to the Department, along with supporting documentation to demonstrate that it meets the exemption criteria of this subsection.

(g) The Department shall exempt from certificate of need review any capital expenditure that exceeds the ~~two million dollar ($2,000,000)~~ monetary threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:
(1) The sole purpose of the capital expenditure is to renovate, replace on the same site, or expand the entirety or a portion of an existing health service facility that is located on the main campus.
(2) The capital expenditure does not result in (i) a change in bed capacity as defined in G.S. 131E-176(5) or (ii) the addition of a health service facility or any other new institutional health service other than that allowed in G.S. 131E-176(16)b.
(3) The licensed health service facility proposing to incur the capital expenditure shall provide prior written notice to the Department, along with supporting documentation to demonstrate that it meets the exemption criteria of this subsection.

…

(i) The Department shall exempt from certificate of need review the replacement, renovation, or relocation of an institutional health service or a health service facility for which a certificate of need has already been issued, provided that the replacement, renovation, or relocation of the institutional health service or health service facility is to another site within the same service area.

(j) The Department shall exempt from certificate of need review the development, acquisition, construction, expansion, or replacement of a health service facility that obtained certificate of need approval prior to October 1, 2022, as a chemical dependency treatment facility or an ambulatory surgical facility."

SECTION 3.6. G.S. 131E-185 reads as rewritten:

"**§ 131E-185. Review process.**

(a) Repealed by Session Laws 1987, c. 511, s. 1.

(a1) Except as provided in subsection (c) of this section, there shall be a time limit of 90 days for review of the applications, beginning on the day established by rule as the day on which applications for the particular service in the service area shall begin review.

~~(1) Any person may file written comments and exhibits concerning a proposal under review with the Department, not later than 30 days after the date on which the application begins review. These written comments may include:~~

~~a. Facts relating to the service area proposed in the application;~~

~~b. Facts relating to the representations made by the applicant in its application, and its ability to perform or fulfill the representations made;~~

~~c. Discussion and argument regarding whether, in light of the material contained in the application and other relevant factual material, the application complies with relevant review criteria, plans, and standards.~~

(2) ~~No more than 20 days from the conclusion of the written comment period, the~~ The Department shall ensure that a public hearing is conducted within the 45-day period after the date on which the application begins review upon a determination by the agency that a hearing is in the public interest. The public hearing shall be conducted at a place within the appropriate service ~~area if one or more of the following circumstances apply; the review to be conducted is competitive; the proponent proposes to spend five million dollars ($5,000,000) or more; a written request for a public hearing is received before the end of the written comment period from an affected party as defined in G.S. 131E-188(c); or the agency determines that a hearing is in the public interest.~~ area. At such public hearing oral arguments may be made regarding the application or applications under review; and this public hearing shall include the following:

a. An opportunity for the proponent of each application under review to ~~respond to the written comments submitted to the Department about its application;~~comment on the applications under review.

b. An opportunity for any person, except one of the proponents, to comment on the applications under ~~review;~~review.

c. An opportunity for a representative of the Department, or such other person or persons who are designated by the Department to conduct the hearing, to question each proponent of applications under review with regard to the contents of the ~~application;~~application.

The Department shall maintain a recording of any required public hearing on an application until such time as the Department's final decision is issued, or until a final agency decision is issued pursuant to a contested case hearing, whichever is later; and any person may submit a written synopsis or verbatim statement that contains the oral presentation made at the hearing.

(3) The Department may contract or make arrangements with a person or persons located within each service area for the conduct of such public hearings as

may be necessary. The Department shall publish, in each service area, notice of the contracts that it executes for the conduct of those hearings.

(4) Within 15 days from the beginning of the review of an application or applications proposing the same service within the same service area, the Department shall publish notice of ~~the deadline for receipt of written comments, of~~ the time and place scheduled for the public hearing regarding the application or applications under review, and of the name and address of the person or agency that will preside.

(5) The Department shall maintain ~~all written comments submitted to it during the written comment stage and~~ any written submissions received at the public hearing as part of the Department's file respecting each application or group of applications under review by it. The ~~application, written comments,~~ application, written submissions received at the public hearing, and public hearing comments, together with all documents that the Department used in arriving at its decision, from whatever source, and any documents that reflect or set out the Department's final analysis of the application or applications under review, shall constitute the Department's record for the application or applications under review.

(a2) When an expedited review has been approved by the Department, no public hearing shall be held. The Department may contact the applicant and request additional or clarifying information, amendments to, or substitutions for portions of the application. The Department may negotiate conditions to be imposed on the certificate of need with the applicant.

(b) Repealed by Session Laws 1991 (Reg. Sess., 1992), c. 900, s. 137(a).

(c) The Department may extend the review period for a period not to exceed 60 days and provide notice of such extension to all applicants. For expedited reviews, the Department may extend the review period only if it has requested additional substantive information from the applicant."

SECTION 3.7. G.S. 131E-188 reads as rewritten:

"**§ 131E-188. Administrative and judicial review.**

(a) After a decision of the Department to issue, deny or withdraw a certificate of ~~need or exemption or to issue a certificate of need pursuant to a settlement agreement with an applicant to the extent permitted by law,~~ need, any affected ~~person,~~ applicant, as defined in subsection (c) of this section, shall be entitled to a contested case hearing under Article 3 of Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department makes its decision. When a petition is filed, the Department shall send notification of the petition to the proponent of each application that was reviewed with the application for a certificate of need that is the subject of the petition. Any affected ~~person~~ applicant shall be entitled to intervene in a contested case.

A contested case shall be conducted in accordance with the following timetable:

(1) An administrative law judge or a hearing officer, as appropriate, shall be assigned within 15 days after a petition is filed.

(2) The parties shall complete discovery within ~~90~~ 60 days after ~~the assignment of the administrative law judge or hearing officer.~~a petition is filed.

(3) The hearing at which sworn testimony is taken and evidence is presented shall be held within ~~45~~ 30 days after the end of the discovery ~~period.~~period and shall not last more than five days.

(3a) No witness shall be allowed to testify as an expert witness and offer opinion testimony based on scientific, technical, or other specialized knowledge unless that witness is properly qualified by the court pursuant to G.S. 8C-1, Rule 702.

(4) The administrative law judge or hearing officer shall make a final decision within 75 days after the hearing.

(5) Repealed by Session Laws 2011-398, s. 46, as amended by Session Laws 2011-326, s. 23, effective January 1, 2012, and applicable to contested cases commenced on or after that date.

The administrative law judge or hearing officer assigned to a case may extend the deadlines in subdivisions (2) through (4) so long as the administrative law judge or hearing officer makes a final decision in the case within 270 days after the petition is filed.

(a1) On or before the date of filing a petition for a contested case hearing on the approval of an applicant for a certificate of need, the petitioner shall deposit a bond with the clerk of superior court where the new institutional health service that is the subject of the petition is proposed to be located. The bond shall be secured by cash or its equivalent in an amount equal to five percent (5%) of the cost of the proposed new institutional health service that is the subject of the petition, but may not be less than five thousand dollars ($5,000) and may not exceed fifty thousand dollars ($50,000). A petitioner who received approval for a certificate of need and is contesting only a condition in the certificate is not required to file a bond under this subsection.

The applicant who received approval for the new institutional health service that is the subject of the petition may bring an action against a bond filed under this subsection in the superior court of the county where the bond was filed. ~~Upon finding that the petition for a contested case was frivolous or filed to delay the applicant,~~ If a petition for a contested case hearing is dismissed or denied, or the court otherwise rules in favor of the respondent, the court ~~may~~ shall award the applicant ~~part or~~ all of the bond filed under this subsection. At the conclusion of the contested case, if the court ~~does not find that the petition for a contested case was frivolous or filed to delay the applicant,~~ rules in favor of the petitioner, the petitioner shall be entitled to the return of the bond deposited with the superior court upon demonstrating to the clerk of superior court where the bond was filed that the contested case hearing is concluded.

(b) Any affected ~~person~~ applicant who was a party in a contested case hearing shall be entitled to judicial review of all or any portion of any final decision in the following manner. The appeal shall be to the Court of Appeals as provided in G.S. 7A-29(a). The procedure for the appeal shall be as provided by the rules of appellate procedure. The appeal of the final decision shall be taken within 30 days ~~of the~~ after receipt of the written notice of final decision, and notice of appeal shall be filed with the Office of Administrative Hearings and served on the Department and all other affected ~~persons~~ applicants who were parties to the contested hearing.

(b1) Before filing an appeal of a final decision granting a certificate of need, the affected ~~person~~ applicant shall deposit a bond with the Clerk of the Court of Appeals. The bond requirements of this subsection shall not apply to any appeal filed by the Department.

(1) The bond shall be secured by cash or its equivalent in an amount equal to five percent (5%) of the cost of the proposed new institutional health service that is the subject of the appeal, but may not be less than five thousand dollars ($5,000) and may not exceed fifty thousand dollars ($50,000); provided that the applicant who received approval of the certificate of need may petition the Court of Appeals for a higher bond amount for the payment of such costs and damages as may be awarded pursuant to subdivision (2) of this subsection. This amount shall be determined by the Court in its discretion, not to exceed three hundred thousand dollars ($300,000). A holder of a certificate of need who is appealing only a condition in the certificate is not required to file a bond under this subsection.

(2) If the Court of Appeals finds that the appeal was frivolous or filed to delay the applicant, the court shall remand the case to the superior court of the county where a bond was filed for the contested case hearing on the certificate of need. The superior court may award the holder of the certificate of need part or all of the bond. The court shall award the holder of the certificate of need reasonable attorney fees and costs incurred in the appeal to the Court of

Appeals. If the Court of Appeals does not find that the appeal was frivolous or filed to delay the applicant and does not remand the case to superior court for a possible award of all or part of the bond to the holder of the certificate of need, the person originally filing the bond shall be entitled to a return of the bond.

(c) ~~The term "affected persons" includes: the applicant; any individual residing within the service area or the geographic area served or to be served by the applicant; any individual who regularly uses health service facilities within that geographic area or the service area; any person who provides services, similar to the services under review, to individuals residing within the service area or the geographic area proposed to be served by the applicant; any person who, prior to receipt by the agency of the proposal being reviewed, has provided written notice to the agency of an intention to provide similar services in the future to individuals residing within the service area or the geographic area to be served by the applicant; third party payers who reimburse health service facilities for services in the service area in which the project is proposed to be located; and any agency which establishes rates for health service facilities or HMOs located in the service area in which the project is proposed to be located.~~The term "affected applicants" includes only those persons who submitted applications that (i) were scheduled to begin review in the same review period proposing the same new institutional health service in the same service area and (ii) were part of a competitive review involving the application that is the subject of the petition or appeal."

SECTION 3.8. G.S. 148-19.1 reads as rewritten:

"**§ 148-19.1. Exemption from ~~licensure and certificate of need.~~licensure.**

~~(a)~~ Inpatient chemical dependency or substance abuse facilities that provide services exclusively to inmates of the Department of Adult Correction or offenders under the supervision of the Division of Community Supervision and Reentry of the Department of Adult Correction shall be exempt from licensure by the Department of Health and Human Services under Chapter 122C of the General Statutes. If an inpatient chemical dependency or substance abuse facility provides services both to inmates or offenders under supervision and to members of the general public, the portion of the facility that serves inmates or offenders under supervision shall be exempt from licensure.

~~(b) Any person who contracts to provide inpatient chemical dependency or substance abuse services to inmates of the Department of Adult Correction or to offenders under the supervision of the Division of Community Supervision and Reentry of the Department of Adult Correction may construct and operate a new chemical dependency or substance abuse facility for that purpose without first obtaining a certificate of need from the Department of Health and Human Services pursuant to Article 9 of Chapter 131E of the General Statutes. However, a new facility or addition developed for that purpose without a certificate of need shall not be licensed pursuant to Chapter 122C of the General Statutes and shall not admit anyone other than inmates unless the owner or operator first obtains a certificate of need.~~"

SECTION 3.9. If any section or provision of this Part is declared unconstitutional or invalid by the courts, it does not affect the validity of this Part as a whole or any section or provision other than the part so declared to be unconstitutional or invalid.

SECTION 3.10. Section 3.4(b) of this Part is effective when it becomes law. Section 3.8 of this Part becomes effective January 1, 2023. The remainder of this Part becomes effective October 1, 2022.

PART IV. MODERNIZING NURSING REGULATIONS

SECTION 4.1. G.S. 90-171.20 reads as rewritten:

"**§ 90-171.20. Definitions.**

As used in this Article, unless the context requires otherwise:

(1) Advanced assessment. – The taking by an advanced practice registered nurse of the history, physical, and psychological assessment of a patient's signs, symptoms, pathophysiologic status, and psychosocial variations in the determination of differential diagnoses and treatment.

(1a) Advanced practice registered nurse or APRN. – An individual licensed by the Board as an advanced practice registered nurse within one of the following four roles:

a. Nurse practitioner or NP.

b. Certified nurse midwife or CNM.

c. Clinical nurse specialist or CNS.

d. Certified registered nurse anesthetist or CRNA.

(1b) ~~"Board" means the~~ Board. – The North Carolina Board of Nursing.

(2) ~~"Health care provider" means any~~ Health care provider. – Any licensed health care professional and any agent or employee of any health care institution, health care insurer, health care professional school, or a member of any allied health profession. For purposes of this Article, a person enrolled in a program that prepares the person to be a licensed health care professional or an allied health professional shall be deemed a health care provider.

(3) ~~"License" means a~~ License. – A permit issued by the Board to practice nursing as an advanced practice registered nurse, as a registered ~~nurse~~ nurse, or as a licensed practical nurse, including a renewal or reinstatement thereof.

(3a) ~~"Licensee" means any~~ Licensee. – Any person issued a license by the Board, whether the license is active or inactive, including an inactive license by means of surrender.

(4) ~~"Nursing" is a~~ Nursing. – A dynamic discipline which includes the assessing, caring, counseling, teaching, referring and implementing of prescribed treatment in the maintenance of health, prevention and management of illness, injury, disability or the achievement of a dignified death. It is ministering to; assisting; and sustained, vigilant, and continuous care of those acutely or chronically ill; supervising patients during convalescence and rehabilitation; the supportive and restorative care given to maintain the optimum health level of individuals, groups, and communities; the supervision, teaching, and evaluation of those who perform or are preparing to perform these functions; and the administration of nursing programs and nursing services. For purposes of this Article, the administration of required lethal substances or any assistance whatsoever rendered with an execution under Article 19 of Chapter 15 of the General Statutes does not constitute nursing.

(5) ~~"Nursing program" means any~~ Nursing program. – Any educational program in North Carolina offering to prepare persons to meet the educational requirements for licensure under this ~~Article.~~Article as a registered nurse or a licensed practical nurse.

(6) ~~"Person" means an~~ Person. – An individual, corporation, partnership, association, unit of government, or other legal entity.

(6a) Population focus. – With respect to APRN practice, includes one of the following areas of focus:

a. The family or the individual across the life span.

b. Adult/gerontology.

c. Neonatal.

d. Pediatrics.

e. Women's health or gender-related issues.

f. Psychiatric mental health.

(6b) Practice of nursing as an advanced practice registered nurse or APRN. – In addition to the RN scope of practice and within the APRN role and population foci, also consists of the following six components:

a. Conducting an advanced assessment.
b. Delegating and assigning therapeutic measures to assistive personnel.
c. Performing other acts that require education and training consistent with professional standards and commensurate with the APRN's education, certification, demonstrated competencies, and experience.
d. Complying with the requirements of this Article and rendering quality advanced nursing care.
e. Recognizing limits of knowledge and experience.
f. Planning for the management of situations beyond the APRN's expertise.

(6c) Practice of nursing as a certified nurse midwife or CNM. – In addition to the RN scope of practice and APRN role and population foci, also consists of the following four components:

a. The management, diagnosis, and treatment of primary sexual and reproductive health care, including primary, preconception, gynecologic/reproductive/sexual health, antepartum, intrapartum, neonatal, and post-pregnancy care.
b. Ordering, performing, supervising, and interpreting diagnostic studies.
c. Prescribing pharmacologic and nonpharmacologic therapies.
d. Consulting with or referring to other health care providers as warranted by the needs of the patient.

(6d) Practice of nursing as a certified registered nurse anesthetist or CRNA. – In addition to the RN scope of practice and APRN role and population foci, also consists of the following three components:

a. Selecting, ordering, procuring, prescribing, and administering drugs and therapeutic devices to facilitate diagnostic, therapeutic, and surgical procedures.
b. Ordering, prescribing, performing, supervising, and interpreting diagnostic studies, procedures, and interventions.
c. Consulting with or referring to other health care providers as warranted by the needs of the patient.

(6e) Practice of nursing as a clinical nurse specialist or CNS. – In addition to the RN scope of practice and APRN role and population foci, also consists of the following eight components:

a. The diagnosis and treatment of health and illness states.
b. Disease management.
c. Prescribing pharmacologic and nonpharmacologic therapies.
d. Ordering, performing, supervising, and interpreting diagnostic studies.
e. Preventing of illness and risk behaviors.
f. Nursing care for individuals, families, and communities.
g. Integrating care across the continuum to improve patient outcomes.
h. Consulting with or referring to other health care providers as warranted by the needs of the patient.

(6f) Practice of nursing as a nurse practitioner or NP. – In addition to the RN scope of practice and APRN role and population foci, also consists of the following six components:

a. Health promotion, disease prevention, health education, and counseling.

b. Providing health assessment and screening activities.
c. Diagnosing, treating, and facilitating patients' management of their acute and chronic illnesses and diseases.
d. Ordering, performing, supervising, and interpreting diagnostic studies.
e. Prescribing pharmacologic and nonpharmacologic therapies.
f. Consulting with or referring to other health care providers as warranted by the needs of the patient.

(7) ~~The "practice of nursing by a registered nurse" consists~~ Practice of nursing by a registered nurse. – Consists of the following 10 components:
a. Assessing the patient's physical and mental health, including the patient's reaction to illnesses and treatment regimens.
b. Recording and reporting the results of the nursing assessment.
c. Planning, initiating, delivering, and evaluating appropriate nursing acts.
d. Teaching, assigning, delegating to or supervising other personnel in implementing the treatment regimen.
e. Collaborating with other health care providers in determining the appropriate health care for a ~~patient but, subject to the provisions of G.S. 90-18.2, not prescribing a medical treatment regimen or making a medical diagnosis, except under supervision of a licensed physician.~~patient.
f. Implementing the treatment and pharmaceutical regimen prescribed or ordered by any person authorized by State law to prescribe or order the regimen.
g. Providing teaching and counseling about the patient's health.
h. Reporting and recording the plan for care, nursing care given, and the patient's response to that care.
i. Supervising, teaching, and evaluating those who perform or are preparing to perform nursing functions and administering nursing programs and nursing services.
j. Providing for the maintenance of safe and effective nursing care, whether rendered directly or indirectly.

(8) ~~The "practice of nursing by a licensed practical nurse" consists~~ Practice of nursing by a licensed practical nurse. – Consists of the following seven components:
a. Participating in the assessment of the patient's physical and mental health, including the patient's reaction to illnesses and treatment regimens.
b. Recording and reporting the results of the nursing assessment.
c. Participating in implementing the health care plan developed by the registered nurse and/or prescribed by any person authorized by State law to prescribe such a plan, by performing tasks assigned or delegated by and performed under the supervision or under orders or directions of a registered nurse, physician licensed to practice medicine, dentist, or other person authorized by State law to provide the supervision.
c1. Assigning or delegating nursing interventions to other qualified personnel under the supervision of the registered nurse.
d. Participating in the teaching and counseling of patients as assigned by a registered nurse, physician, or other qualified professional licensed to practice in North Carolina.

e. Reporting and recording the nursing care rendered and the patient's response to that care.
f. Maintaining safe and effective nursing care, whether rendered directly or indirectly."

SECTION 4.2. G.S. 90-18(c) reads as rewritten:

"(c) The following shall not constitute practicing medicine or surgery as defined in this Article:

…

~~(7) The practice of midwifery as defined in G.S. 90-178.2.~~

…

(14) The practice of nursing by ~~a~~ an advanced practice registered nurse ~~engaged in the practice of nursing and the performance of acts otherwise constituting medical practice by a registered nurse when performed in accordance with rules and regulations developed by a joint subcommittee of the North Carolina Medical Board and the Board of Nursing and adopted by both boards.~~as defined in Article 9A of this Chapter.

…."

SECTION 4.3.(a) G.S. 90-18.2 is repealed.

SECTION 4.3.(b) G.S. 90-2(a) reads as rewritten:

"(a) There is established the North Carolina Medical Board to regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina. The Board shall consist of 13 members:

…

(2) Five members shall all be appointed by the Governor as follows:

…

d. One shall be a nurse practitioner ~~as defined in G.S. 90-18.2~~ as recommended by the Review Panel pursuant to G.S. 90-3.

…."

SECTION 4.3.(c) G.S. 90-18.3(a) reads as rewritten:

"(a) Whenever a statute or State agency rule requires that a medical or physical examination shall be conducted by a physician, the examination may be conducted and the form signed by a nurse practitioner or a physician assistant, and a physician need not be present. Nothing in this section shall otherwise change the scope of practice of a nurse practitioner or a physician assistant, as defined by G.S. 90-18.1 and ~~G.S. 90-18.2,~~ G.S. 90-171.20, respectively."

SECTION 4.3.(d) G.S. 90-85.24(a) reads as rewritten:

"(a) The Board of Pharmacy shall be entitled to charge and collect not more than the following fees:

…

(13) For annual registration as a dispensing nurse ~~practitioner under G.S. 90-18.2,~~ practitioner, seventy-five dollars ($75.00);

…."

SECTION 4.3.(e) G.S. 90-85.34A reads as rewritten:

"**§ 90-85.34A. Public health pharmacy practice.**

…

(c) This section does not affect the practice of nurse practitioners ~~pursuant to G.S. 90-18.2~~ or of physician assistants pursuant to G.S. 90-18.1."

SECTION 4.4. G.S. 90-29(b) reads as rewritten:

"(b) A person shall be deemed to be practicing dentistry in this State who does, undertakes or attempts to do, or claims the ability to do any one or more of the following acts or things which, for the purposes of this Article, constitute the practice of dentistry:

…

(6) Administers an anesthetic of any kind in the treatment of dental or oral diseases or physical conditions, or in preparation for or incident to any operation within the oral cavity; provided, however, that this subsection shall not apply to a ~~lawfully qualified~~ certified registered nurse anesthetist who administers such ~~anesthetic under the supervision and direction of a licensed dentist or physician,~~ anesthetic, or to a registered dental hygienist qualified to administer local anesthetics.

…."

SECTION 4.5. G.S. 90-171.23(b) reads as rewritten:

"(b) Duties, powers. The Board is empowered to:

…

(14) ~~Appoint and maintain a subcommittee of the Board to work jointly with the subcommittee of the North Carolina Medical Board to develop rules and regulations to govern the performance of medical acts by registered nurses and to determine reasonable fees to accompany an application for approval or renewal of such approval as provided in G.S. 90-8.2. The fees and rules developed by this subcommittee shall govern the performance of medical acts by registered nurses and shall become effective when they have been adopted by both Boards.~~Grant prescribing, ordering, dispensing, and furnishing authority to holders of the advanced practice registered nurse license pursuant to G.S. 90-171.20.

…."

SECTION 4.6. G.S. 90-171.27(b) reads as rewritten:

"**§ 90-171.27. Expenses payable from fees collected by Board.**

…

(b) The schedule of fees shall not exceed the following rates:

Application for license as advanced practice registered nurse	$100.00
Renewal of license to practice as advanced practice registered nurse (two-year period)	100.00
Reinstatement of lapsed license to practice as advanced practice registered nurse and renewal fee	180.00
Application for examination leading to ~~certificate and~~ license as registered nurse	~~$~~75.00
Application for ~~certificate and~~ license as registered nurse by endorsement	150.00
Application for each re-examination leading to ~~certificate and~~ license as registered nurse	75.00
Renewal of license to practice as registered nurse (two-year period)	100.00
Reinstatement of lapsed license to practice as a registered nurse and renewal fee	180.00
Application for examination leading to ~~certificate and~~ license as licensed practical nurse by examination	75.00
Application for ~~certificate and~~ license as licensed practical nurse by endorsement	150.00
Application for each re-examination leading to ~~certificate and~~ license as licensed practical nurse	75.00
Renewal of license to practice as a licensed practical nurse (two-year period)	100.00
Reinstatement of lapsed license to practice as a licensed practical nurse and renewal fee	180.00

Application fee for retired registered nurse status or retired licensed practical nurse status 50.00
Reinstatement of retired registered nurse to practice as a registered nurse or a retired licensed practical nurse to practice as a licensed practical nurse (two-year period) 100.00
Reasonable charge for duplication services and materials.

A fee for an item listed in this schedule shall not increase from one year to the next by more than twenty percent (20%)."

SECTION 4.7.(a) Article 9A of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-171.36B. Advanced practice registered nurse licensure.**

(a) No advanced practice registered nurse shall practice as an advanced practice registered nurse unless the nurse is licensed by the Board under this section.

(b) An applicant for a license to practice as an APRN shall apply to the Board in a format prescribed by the Board and pay a fee in an amount determined under G.S. 90-171.27.

(c) The Board shall adopt rules, not inconsistent with this Article, which identify the criteria which must be met by an applicant in order to be issued a license.

"**§ 90-171.36C. Advanced practice registered nurse licensure; grandfathering exceptions.**

(a) The Board shall issue an APRN license to any person recognized by the Board as an APRN or approved to practice as an APRN in this State on December 31, 2021.

(b) An advanced practice registered nurse licensed under this section shall maintain all practice privileges provided to licensed advanced practice registered nurses under this Chapter.

"**§ 90-171.36D. Advanced practice registered nurse licensure renewal; reinstatement.**

(a) An applicant for renewal of an APRN license issued under this Article shall apply for licensure renewal according to the frequency and schedule established by the Board and pay the required fee.

(b) Failure to renew the APRN license before the expiration date shall result in automatic forfeiture of the right to practice nursing as an APRN in North Carolina until such time as the license has been reinstated.

(c) An APRN licensee who has allowed his or her license to lapse by failure to renew may apply for reinstatement in a manner prescribed by the Board and pay the required fee.

(d) The Board shall adopt rules, not inconsistent with this Article, which identify the criteria which must be met by an applicant for APRN license renewal or reinstatement."

SECTION 4.7.(b) G.S. 90-171.37(b) is repealed.

SECTION 4.8. G.S. 90-171.43 reads as rewritten:

"**§ 90-171.43. License required.**

(a) No person shall practice or offer to practice as ~~a~~ an advanced practice registered nurse, registered ~~nurse~~ nurse, or licensed practical nurse, or use the word "nurse" as a title for herself or himself, or use an abbreviation to indicate that the person is ~~a~~ an advanced practice registered nurse, registered ~~nurse~~ nurse, or licensed practical nurse, unless the person is currently licensed as ~~a~~ an advanced practice registered nurse, registered ~~nurse~~ nurse, or licensed practical nurse as provided by this Article. If the word "nurse" is part of a longer title, such as "nurse's aide", a person who is entitled to use that title shall use the entire title and may not abbreviate the title to "nurse". This Article shall not, however, be construed to prohibit or limit the following:

(1) The performance by any person of any act for which that person holds a license issued pursuant to North Carolina ~~law;~~law.
(2) The clinical practice by students enrolled in approved nursing programs, continuing education programs, or refresher courses under the supervision of qualified ~~faculty;~~faculty.
(3) The performance of nursing performed by persons who hold a temporary license issued pursuant to ~~G.S. 90-171.33;~~G.S. 90-171.33.

(4) The delegation to any person, including a member of the patient's family, by a physician licensed to practice medicine in North Carolina, a licensed dentist or registered nurse of those patient-care services which are routine, repetitive, limited in scope that do not require the professional judgment of a registered nurse or licensed practical ~~nurse;~~nurse.

(5) Assistance by any person in the case of emergency.

Any person permitted to practice nursing without a license as provided in subdivision ~~[(a)]~~(2) (a)(2) or ~~[(a)](3)~~ (a)(3) of this section shall be held to the same standard of care as any licensed nurse.

(a1) The abbreviations for the APRN designation of a certified nurse midwife, a clinical nurse specialist, a certified registered nurse anesthetist, and a nurse practitioner shall be APRN, plus the role title, i.e., CNM, CNS, CRNA, and NP.

(a2) It shall be unlawful for any person to use the title "APRN" or "APRN" plus their respective role titles, the role title alone, authorized abbreviations, or any other title that would lead a person to believe the individual is an APRN, unless permitted by this act.

…."

SECTION 4.9. G.S. 90-171.43A reads as rewritten:

"**§ 90-171.43A. Mandatory employer verification of licensure status.**

(a) Before hiring an advanced practice registered nurse, a registered ~~nurse~~ nurse, or a licensed practical nurse in North Carolina, a health care facility shall verify that the applicant has a current, valid license to practice nursing pursuant to G.S. 90-171.43.

(b) For purposes of this section, "health care facility" means:

(1) Facilities described in G.S. 131E-256(b).

(2) Public health departments, physicians' offices, ambulatory care facilities, and rural health clinics."

SECTION 4.10. G.S. 90-171.44 reads as rewritten:

"**§ 90-171.44. Prohibited acts.**

It shall be a violation of this Article, and subject to action under G.S. 90-171.37, for any person to:

(1) Sell, fraudulently obtain, or fraudulently furnish any nursing diploma or aid or abet therein.

(2) Practice nursing under cover of any fraudulently obtained license.

(3) Practice nursing without a license. This subdivision shall not be construed to prohibit any licensed registered nurse who has successfully completed a program established under G.S. 90-171.38(b) from conducting medical examinations or performing procedures to collect evidence from the victims of offenses described in that subsection.

(3a) Refer to himself or herself as an advanced practice registered nurse; or refer to himself or herself as any of the four roles of advanced practice registered nurses, a registered nurse, or a licensed practical nurse; or use the abbreviations "APRN," "CNM," "CNS," "CRNA," "NP," "RN," and "LPN."

(4) Conduct a nursing program or a refresher course for activation of a license, that is not approved by the Board.

(5) Employ unlicensed persons to practice nursing."

SECTION 4.11.(a) Article 10A of Chapter 90 of the General Statutes is repealed.

SECTION 4.11.(b) G.S. 90-21.11 reads as rewritten:

"**§ 90-21.11. Definitions.**

The following definitions apply in this Article:

(1) Health care provider. – Without limitation, any of the following:

a. A person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed, or is otherwise registered or certified to engage in

the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, ~~midwifery,~~ osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, or psychology.

…."

SECTION 4.12.(a) No later than 30 calendar days after this act becomes law, the Governor shall submit to the Centers for Medicare and Medicaid Services an "opt-out" letter requesting an exemption under 42 C.F.R. § 482.52(c) that allows hospitals, ambulatory surgical centers, critical access hospitals, and rural hospitals in this State the maximum flexibility to obtain Medicare reimbursement for anesthesia services in a manner that best serves each facility and the patients and communities the facility serves.

SECTION 4.12.(b) This section is effective when it becomes law.

SECTION 4.13.(a) The North Carolina Board of Nursing, the North Carolina Medical Board, and the North Carolina State Board of Dental Examiners shall adopt rules to implement the provisions of this Part.

SECTION 4.13.(b) This section is effective when it becomes law.

SECTION 4.14. Except as otherwise provided, this Part becomes effective October 1, 2022.

PART V. HEALTH INSURANCE REFORMS

MEDICAL BILLING TRANSPARENCY

SECTION 5.1.(a) Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-295. Contract requirements for limitations on billing by in-network health service facilities.**

(a) The following definitions apply in this section:

(1) Health care provider. – Any individual licensed, registered, or certified under Chapter 90 of the General Statutes, or under the laws of another state, to provide health care services in the ordinary care of business or practice, as a profession, or in an approved education or training program in any of the following:

a. Anesthesia or anesthesiology.

b. Emergency services, as defined under G.S. 58-3-190(g).

c. Pathology.

d. Radiology.

e. Rendering assistance to a physician performing any of the services listed in this subdivision.

(2) Health service facility. – As defined in G.S. 131E-176(9b) and including any office location.

(3) Out-of-network provider. – A health care provider that has not entered into a contract or agreement with an insurer to participate in one of the insurer's provider networks for the provision of health care services at a pre-negotiated rate.

(b) All contracts or agreements for participation as an in-network health service facility between an insurer offering health benefit plans in this State and a health service facility at which there are out-of-network providers who may be part of the provision of services to an insured while receiving care at the health service facility shall require that the in-network health service facility give at least 72 hours' advanced written notification to an insured that has scheduled an

appointment at that health service facility of the provision of any services by an out-of-network provider to the insured while at that health service facility. If there are not at least 72 hours between the scheduling of the appointment and the appointment, then the in-network health service facility is required to give written notice to the insured on the day the appointment is scheduled. In the case of emergency services, the health service facility is required to give written notice to the insured as soon as reasonably possible. The written notice required by this subsection shall include all of the following:

(1) All of the health care providers that will be rendering services to the insured that are not participating as in-network health care providers in the applicable insurer's network.

(2) The estimated cost to the insured of the services being rendered by the out-of-network providers identified in subdivision (1) of this subsection.

(c) If any provision of this section conflicts with the federal Consolidated Appropriations Act, 2021, P.L. 116-260, and any amendments to that act or regulations promulgated pursuant to that act, then the provisions of P.L. 116-260 will be applied."

SECTION 5.1.(b) This section becomes effective January 1, 2023, and applies to contracts entered into, amended, or renewed on or after that date.

ACCESS TO TELEHEALTH

SECTION 5.2.(a) Part 7 of Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-305. Coverage for telehealth services.**

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

(1) Health care provider. – As defined in G.S. 58-50-61.

(2) Health care services. – As defined in G.S. 58-50-61, with the exception of any services related to an abortion, including a medication abortion, except in the case of a medical emergency, as defined in G.S. 90-21.81(5).

(3) Reserved for future codification purposes.

(4) Telehealth. – As defined in G.S. 90-21.19A, except that the following shall not be considered telehealth unless specifically agreed upon, in writing, by the insurer and the health care provider or contained in reimbursement policies of the insurer for the relevant health benefit plan:

a. Administrative functions, including, but not limited to, scheduling, billing, conducting surveys or questionnaires, providing reminders, or conveying test results.

b. Emails, text messages, or correspondence through an online patient portal, or any combination of those, in which evaluation, management, or medical decision making by a qualified health care provider does not occur.

c. Triage functions.

d. Health care provider-to-health care provider consultations.

e. Therapy, or other patient sessions, provided by unlicensed peers or health coaches.

f. Remote patient monitoring.

g. Audio-only formats, except as defined by audio-only service codes contained within current year American Medical Association Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code sets.

h. Services where current technology requires hands-on physical evaluation or manipulation by a qualified health care provider,

including infusions, injections, biopsies, anesthesia, incisions, and surgery, and other similar services.

i. Facility fees or facility services.

j. Any other function that does not involve medical decision making from a health care provider.

(b) An insurer may not exclude from coverage a health care service or procedure delivered by a health care provider to an insured through telehealth solely because the health care service or procedure is not provided through an in-person, face-to-face consultation.

(c) An insurer is not required to provide coverage for any out-of-network services provided via telehealth.

(d) An insurer may exclude from coverage a health care service delivered by a contracted, or an in-network, health care provider to an insured that is provided solely as a telehealth service without any in-person, face-to-face component if any of the following apply:

(1) The billing code submitted to the insurer does not accurately describe the health care service for which the health care provider is billing.

(2) The health care provider has not agreed to share claims data or clinical data through the NC Health Information Exchange, established under Article 29B of Chapter 90 of the General Statutes, or as otherwise required by the insurer.

(3) The health care service provided is the subject of a utilization management program, or other applicable cost-containment or quality management program, of the insurer.

(4) The health care service is not provided by the patient's designated primary care provider or designated medical home.

(5) The health care provider has not obtained informed consent from the patient, as required under G.S. 90-21.19A.

(6) The insurer determines that the receipt of the health care services through telehealth would impact quality of care or safety of its insureds."

SECTION 5.2.(b) G.S. 58-50-280 reads as rewritten:

"**§ 58-50-280. Contract amendments.**

(a) A health benefit plan or insurer shall send any proposed contract amendment to the notice contact of a health care provider pursuant to G.S. 58-50-275. The proposed amendment shall be dated, labeled "Amendment," signed by the health benefit plan or insurer, and include an effective date for the proposed amendment.

(b) A health care provider receiving a proposed amendment shall be given at least 60 days from the date of receipt to object to the proposed amendment. The proposed amendment shall be effective upon the health care provider failing to object in writing within 60 days.

(c) If a health care provider objects to a proposed amendment, then the ~~proposed amendment is not effective and the initiating health benefit plan or insurer shall be~~ provider is entitled to terminate the contract upon 60 days written notice to the ~~health care provider.~~insurer issuing the health benefit plan.

(d) Nothing in this Part prohibits a health care provider and insurer from negotiating contract terms that provide for mutual consent to an amendment, a process for reaching mutual consent, or alternative notice contacts."

SECTION 5.2.(c) Article 1B of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-21.19A. Telehealth consumer protections.**

(a) The following definitions apply in this section:

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

(2) Health services facility. – As defined in G.S. 131E-176, and including any office location.

(3), (4) Reserved for future codification purposes.

(5) Telehealth. – The use of telecommunications technology to provide health care services to individuals who are not physically present with the health care provider.

(b) Specific informed consent shall be required when health care services are provided through telehealth to individuals who are insured under a health benefit plan. The required informed consent includes all of the following:

(1) Confirmation of the identity of the individual to whom the health care services are provided.

(2) Verification and authentication of the individual's personal health history.

(3) Disclosure of the health care provider's identity, applicable credentials, and contact information, including a current phone number and mailing address of the health care provider's practice.

(4) Disclosure of the delivery model and treatment methods to be utilized, including any limitations of the use of telehealth to provide those health care services. The health care provider is required to document an acknowledgement by the individual, or other authorized party, of the risks and limitations associated with the use of telehealth for the provision of the relevant health care services.

(5) Provision of informed consent that would be applicable if the delivery of the health care services were made in person.

(6) An explanation that it is the role of the health care provider to determine whether the condition being diagnosed or treated is appropriate for a telehealth encounter and advise the individual that the individual is entitled to request an in-person encounter in lieu of a telehealth visit.

(7) If applicable or required for an in-person encounter, provision of the contact information for the North Carolina Medicaid Board, or other applicable licensing board, and a description of, or a website link to, the patient complaint process for the Board.

(c) Prior to the provision of a health care service through telehealth, the health care provider rendering the health care service shall clearly identify all of the following:

(1) The billing entity and the location, phone number, and regulator of the billing entity.

(2) Name and location of the health care provider delivering the telehealth service, if different from the initial disclosure.

(3) The service or procedure being provided.

(4) The estimated cost of care. Estimates of the cost of care shall be based on the health benefit plan under which the individual is insured, if applicable.

(5) The network status of the health care provider based on the health benefit plan under which the individual is insured, if applicable.

(d) All health care providers rendering health care services through telehealth shall comply with all of the following requirements:

(1) Documentation of all informed consent shall be made in the patient's medical history for each telehealth service.

(2) No fee may be applied to patients, insurers, other health care providers, or health care facilities for sharing patient medical records for telehealth services. A health care provider or health care facility shall transfer, free of charge, the patient's medical records to any health care provider or health care facility identified by the patient.

(3) Electronic documentation and storage of patient medical records in accordance with all applicable State and federal privacy laws.

(4) Creation of a saved recording of all patient telehealth encounters, in accordance with all applicable State and federal privacy laws.

(e) Health care providers and health care facilities are prohibited from engaging in any balancing billing related to any health care service provided through telehealth."

SECTION 5.2.(d) This section becomes effective October 1, 2022, and applies to insurance contracts entered into, renewed, or amended on or after that date, or to health care services provided on or after that date, as applicable.

PART VI. EFFECTIVE DATE

SECTION 6. Except as otherwise provided, this act is effective when it becomes law.