2019-2020

SENATE
HEALTH CARE

MINUTES

Bill Index
SENATE COMMITTEE ON HEALTH CARE
Volume I
2019-20120 Long Session

SB 86	**Small Business Healthcare Act.** Senators Bishop, Krawiec, Edwards	March 6 & 7, 2019
SB 168	**Expand Allowable Medical Uses of CBD Oil** Senators McKissick, Hise	March 13, 2019
SB 210	**Organ & Tissue Donation/Heart Heroes** Senators Krawiec, McKissick, Horner	March 20, 2019
SB 212	**Suspend Child Welfare/Aging Components/NC FAST** Senators Krawiec, Hise	March 20, 2019
SB 361	**Health Care Expansion Act of 2019** Senators Krawiec, Bishop, Hise	April 10, May 2, & *June 5 & 12, 2019
SB 537	**Establish New Payment Methodology/ACHs** Senators Hise, Krawiec, Bishop	April 17, 2019
SB 302	**Update Svc & Care Plan Req's/ACH Residents** Senators Hise, Bishop, Krawiec	April 17, 2019
SB 118	**PED/Safekeeper Health Care Cost Recov. Pract.** Senators B. Jackson, Krawiec, Ballard	April 17 & 18, 2019
SB 444	**Allow Use of Oyster Shells As Serving Dishes** Senator McInnis	April 18, 2019
SB 252	**Dental Bill of Rights** Senator J. Davis	May 1 & 2, 2019
SB 574	**Modify Physical Therapy Definition** Senators, J. Davis, Krawiec, Woodard	May 1, 2019
SB 551	**Child Support Cooperation Act of 2019** Senators Krawiec, Hise, Bishop	May 1, 2019
SB 161	**Enact the North Carolina Caregivers Act** Senators Krawiec and Bishop	May 2, 2019
HB 388	**Immunizing Pharmacists** Representatives White, Dobson, Cunningham, Sasser	May 22, 2019

HB 656 Medicaid Changes for Transformation May 22, 2019
Representatives Lambeth, Dobson, Murphy, Sasser

HB 70 Delay NC HealthConnex for Certain Providers May 22 & * May 23, 2019
Representatives Dobson, White, Murphy, Lambeth

***Bill also found in Volume II of the Senate Health Care Committee 2019-2020 Long** Session*

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NORTH CAROLINA GENERAL ASSEMBLY

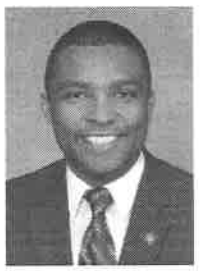
SENATE HEALTH CARE
2019 – 2020 SESSION

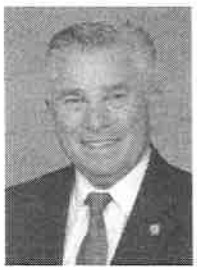

Sen. Dan Bishop
Chair


Sen. Joyce Krawiec
Chair


Sen. Deanna Ballard


Sen. Jim Burgin


Sen. Don Davis


Sen. Jim Davis


Sen. Carl Ford


Sen. Valerie Foushee


Sen. Ralph Hise


Sen. Rick Horner


Sen. Jim Perry


Sen. Gladys Robinson


Sen. Vickie Sawyer


Sen. Terry Van Duyn


Sen. Mike Woodard

Senate Committee on Health Care
Tuesday, February 19, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on February 19, 2019 in Room 643 of the Legislative Office Building. Fifteen members were present.

Representative Murphy, Chair, presided.

The House Health Care Chairs allowed the Senate Health Care Committee to attend their first committee meeting. This was an informational meeting and it was agreed by the chairs that this information would be helpful to both committee's members.

These minutes are being filed to document that the Senate Health Committee convened.

Rep. Murphy welcomed everyone who attended and allowed the members to introduce themselves. He then introduced the special guests:

State Health Plan:
Dale Folwell, CPA, NC State Treasurer
Dee Jones
Andrew Norton
Caroline Smart

Providers:
Dr. Michael Waldrum, NCHA Board Chair and CEO of Vidant Health
Dr. David Zaas, CEO Duke Raleigh Hospital
Dr. Roxie Wells, NCHA
Dr. Terry Aiken, NCHA

Dale Folwell was introduced to give a twenty minute presentation. See enclosed documents. He was followed by a twenty minute presentation from Dr. Michael Waldrum. Rep. Murphy then opened the floor for the house and senate members to ask questions. These questions were responded to by Dale Folwell and Dr. Michel Waldrum.

The meeting adjourned at 12:00 PM.

Senator Joyce Krawiec Non-presiding Chair

Debbie Lown, Committee Clerk

House Committee on Health
Tuesday, February 19, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Presentations

Dale Folwell, CPA, NC State Treasurer, and Dr. Michael Waldrum, NCHA Board Chair and CEO of Vidant Health will present on the proposed State Health Plan Pricing Model. Treasurer Folwell will present first followed by Dr. Waldrum. The Chair will then take questions from the committee.

Other Business

Adjournment

North Carolina
State Health Plan
FOR TEACHERS AND STATE EMPLOYEES

A Division of the Department of State Treasurer

Dale R. Folwell, CPA

STATE TREASURER OF NORTH CAROLINA
DALE R. FOLWELL, CPA



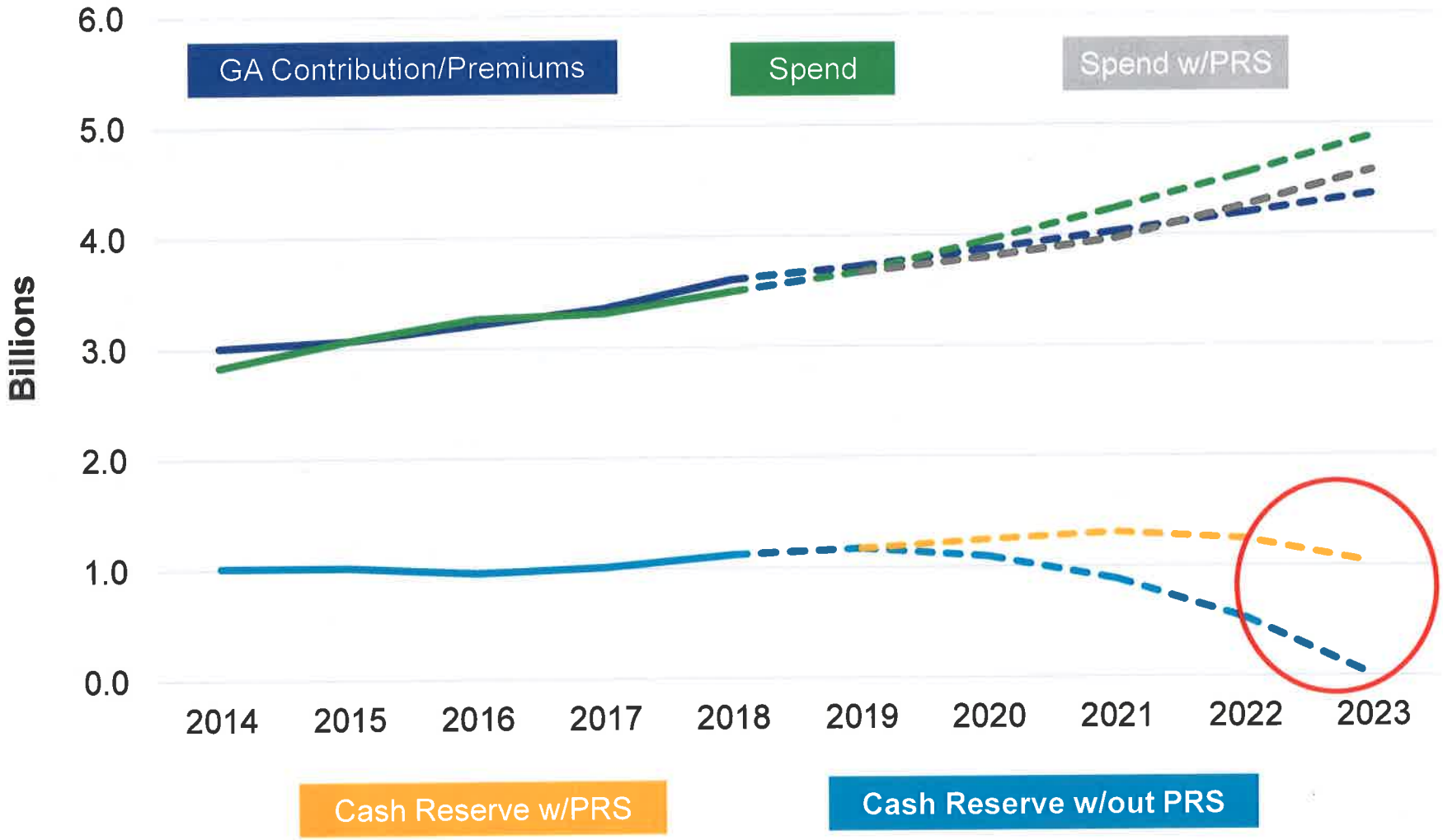
North Carolina State Health Plan Update

February 19, 2019

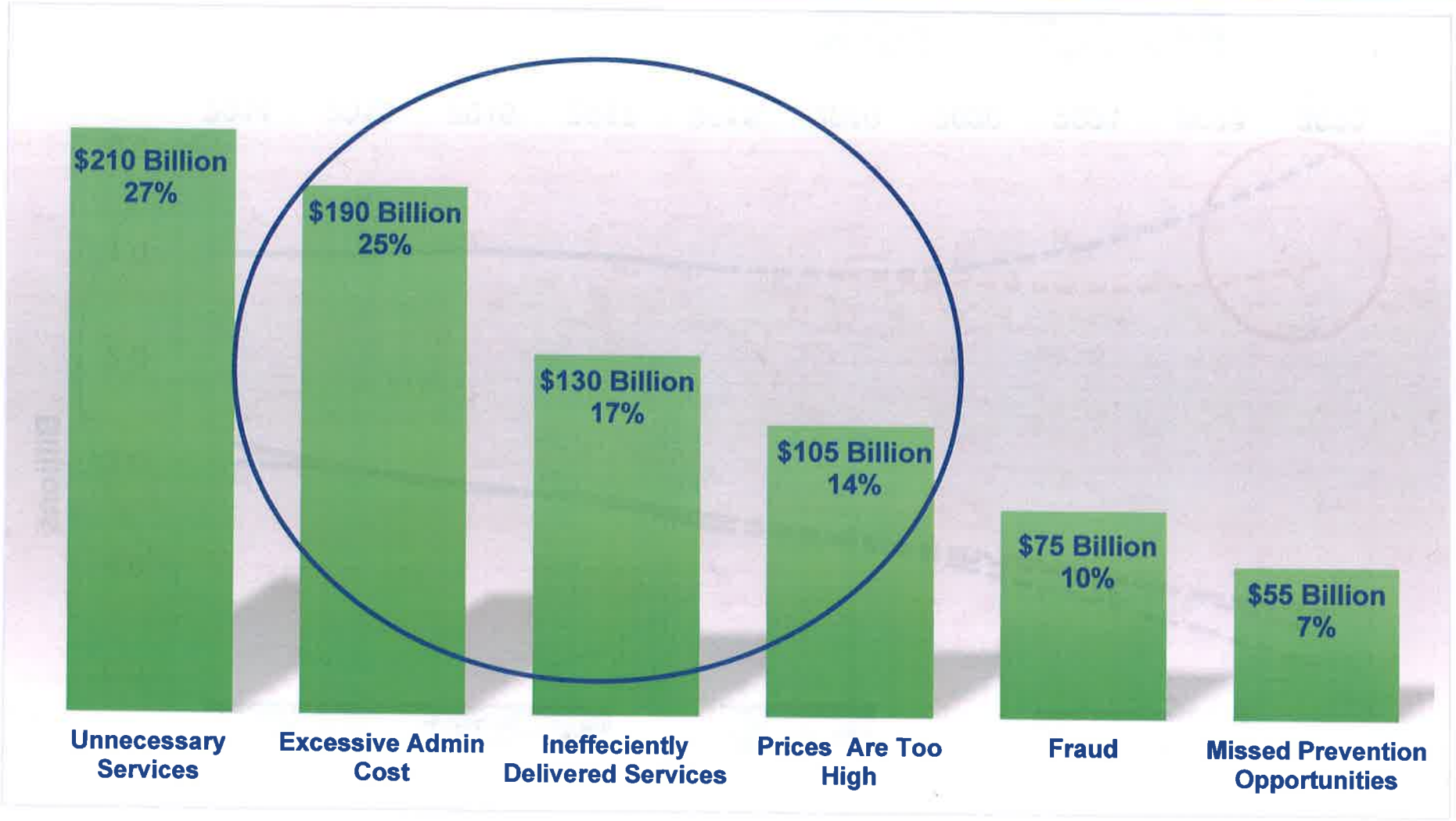
Projected Trended Expense



Financial Projection

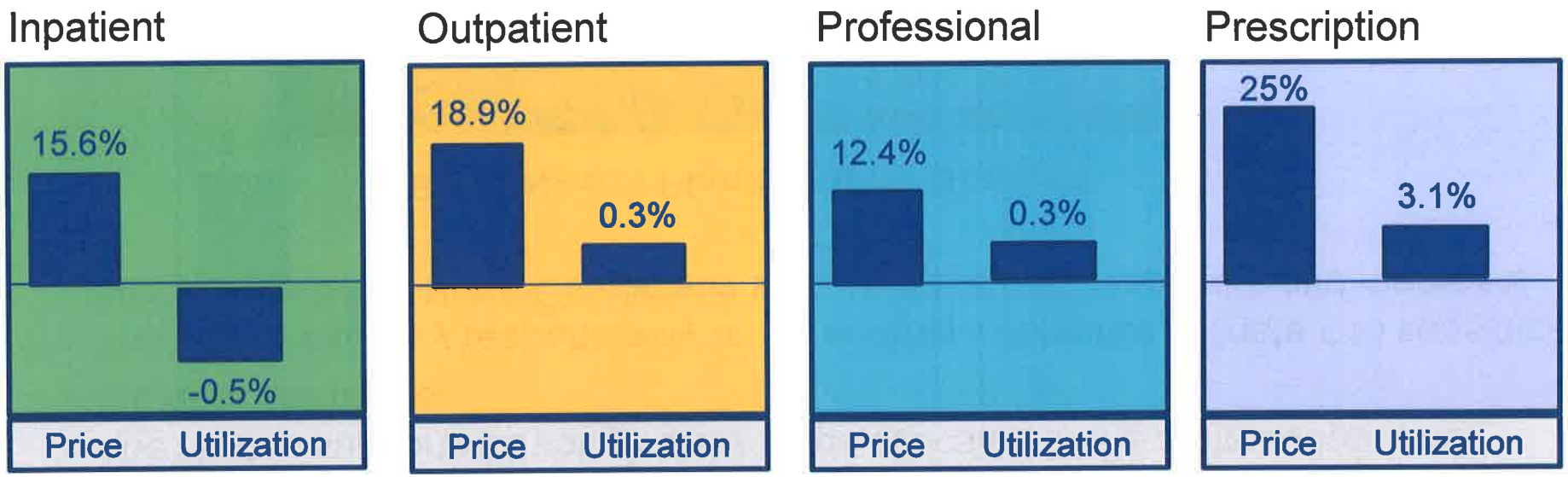


Sources of Inefficiencies in Health Care



Source: The Institute of Medicine, Working Group 2011

Health Care Spending Increasing Trend (2013-2017)



"The value to us of Rex is, it allows us a larger scale and more sophisticated abilities to purchase in bulk, for example, all of the things that hospitals and organizations like us need. We are able to get a much better master contract with Blue Cross and the other private insurers than we would if we were a smaller, Chapel Hill-only entity."

-William Roper MD, Former CEO of UNC Health Care, 2012

Source: Health Care Cost Institute, 2017 Health Care Cost and Utilization Report

Statutory Requirements & Responsibilities

- **§ 135-48.30. Powers and Duties of the State Treasurer.**
- The Department of State Treasurer and the Board of Trustees shall be charged with a fiduciary responsibility for managing all aspects of the Plan, including the receipt, maintenance, investment, and disposition of all Plan assets.
  - As a government payer of health care in North Carolina, providing a sustainable health benefit for more than 720,000 members is essential to avoid being unable to pay claims, which occurred in the 2008 fiscal year loss.
  - The Plan is supported through state funds allocated in the state budget and member premiums.
  - The Plan's fiduciary responsibility to its members does not obligate it to subsidize health care for all North Carolinians as it would impact taxpayers and members.

State Health Plan Funding Sources



Source: 2017-2018 State Health Plan Financial Report.

NCHA
North Carolina Healthcare Association

State Health Plan

- Joint Health Committee

February 19, 2019

Mike Waldrum, MD, MSc, MBA
Chief Executive Officer, Vidant Health
Chairman, North Carolina Healthcare Association (NCHA) Board of Trustees

Uniting hospitals, health systems and care providers for healthier communities

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Vidant Roanoke-Chowan Hospital



"We are taking care of team members and their families as they are taking care of patients and families."

Lisa Rushing, Women's & Children's Unit Nurse Manager

NCHA

State Health Plan Proposal

- Reference Based Pricing
  - Average reduction to providers is 15%
  - Overall, it's an annual $400+ million reduction in reimbursement to hospitals and providers
- Impact
  - Costs will be shifted to businesses
  - Hospital consolidation and closures
  - Decreased access to services
  - Inability to recruit top talent
  - Disproportionately impacts rural communities where there is higher government payment and uninsured patients

NCHA

North Carolina is Not Montana

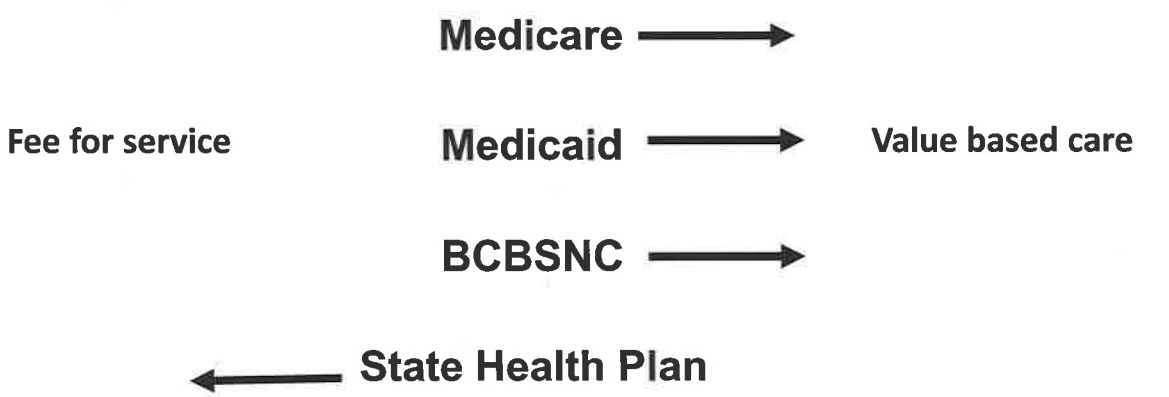
Statistics	Montana	North Carolina
Population	1,062,305 [1]	10,383,620 [1]
State Health Plan Beneficiaries	33,000 [2]	720,000 [3]
Critical Access Hospitals	48 of 53 [4]	20 of 126 [5]
At High Risk Hospitals or Financially Distressed	0 [6]	8 [6]

Montana: "The reference price is based on Medicare rates and is generally an average of 234 percent of those rates" [7]

1. Quick Facts – North Carolina; Montana (2018, July 1). Retrieved from: https://www.census.gov/quickfacts/fact/table/nc,mt/PST045218
2. About-HCBD (2019, February 15). Retrieved from: http://benefits.mt.gov/Resources/About-HCBD
3. Who We Are (2019, February 15). Retrieved from: https://www.shpnc.org/about-us/who-we-are
4. RHIhub (2019, February 18). Retrieved from: https://www.ruralhealthinfo.org/states/montana
5. NC Rural Hospital Program (2019 February 18). Retrieved from: https://www.ncdhhs.gov/divisions/office-rural-health/office-rural-health-programs/north-carolina-rural-hospital-program
6. Sheps Center (2017, December) Retrieved from: https://www.shepscenter.unc.edu/download/15784/
7. Becker's Hospital Review (2018, June) Retrieved from https://www.beckershospitalreview.com/finance/how-montana-cut-healthcare-costs-with-reference-based-pricing.html

NCHA

Value Based Care vs. Fee for Service



Concerns

- Medicaid Transformation
- State Health Plan Proposal

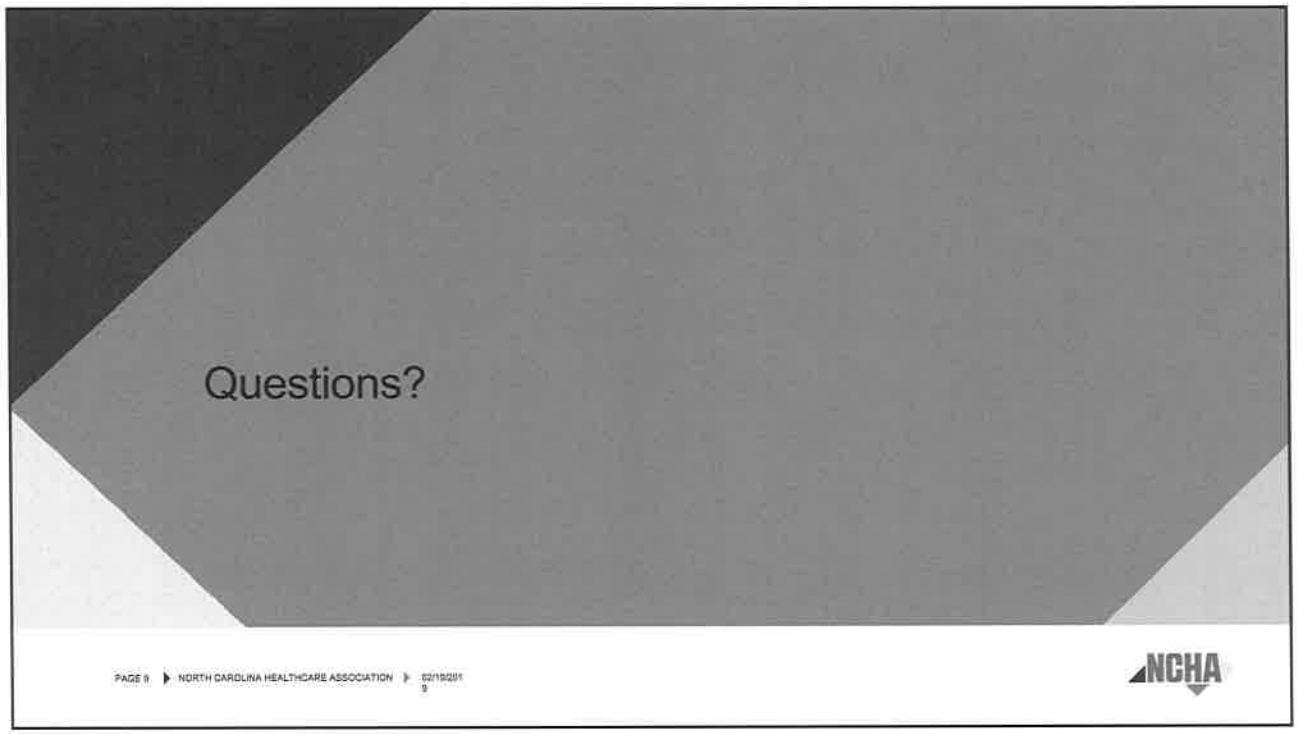
Moving Forward

North Carolina Hospitals stand ready to partner with the State Health Plan and State Employees to build a smarter health plan that promotes health and manages costs

One Team



"We've all worked in hurricane conditions and understand what they are going through," Kaili Nixon said. *"We're all nurses who want to take care of each other. We're one team."*


Questions?
PAGE 9 ▶ NORTH CAROLINA HEALTHCARE ASSOCIATION ▶ 02/19/2019
NCHA

HOSPITALS give BACK

North Carolina hospitals are the heart of our communities.

IN 2017, NC HOSPITALS & HEALTH SYSTEMS REACHED OUTSIDE OF OUR HOSPITAL WALLS TO PROVIDE

$30 MILLION
SUBSIDIZED HEALTH SERVICES
Neonatal intensive care, addiction recovery, trauma services

$286 MILLION
HEALTH PROFESSIONS ED & TRAINING
Scholarships, internship support

$23 MILLION
HEALTH-RELATED RESEARCH COSTS
Investing in new technologies and companies

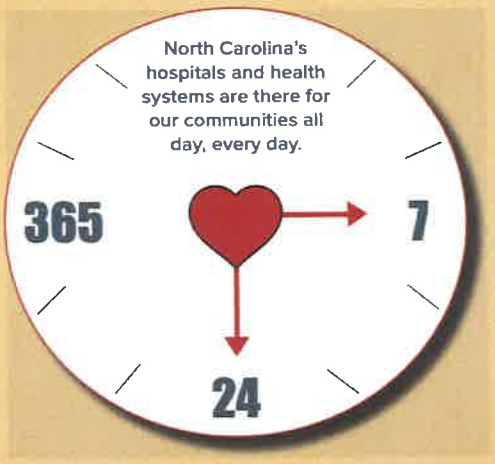
$21 MILLION
COMMUNITY-BUILDING ACTIVITIES
Initiatives to protect or improve the community's health & safety

$144 MILLION
COMMUNITY HEALTH IMPROVEMENT SERVICES
Partnering in community development

$68 MILLION
IN-KIND DONATIONS
Donations of food, equipment, supplies, meeting space & staff hours

Hospitals provide essential services that often go unreimbursed. In 2017, these included:





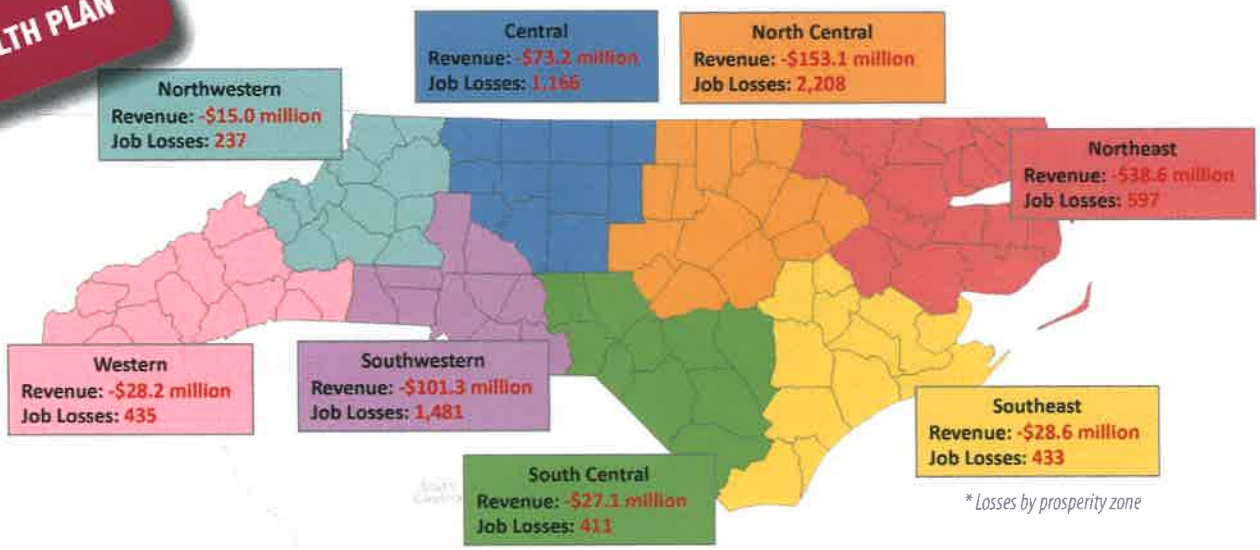
NCHA North Carolina Healthcare Association

Community benefits from North Carolina's hospitals and health systems totaled $4.572 billion in 2017.

THE ECONOMIC IMPACT

OF PROPOSED POLICY CHANGES ON NORTH CAROLINA'S HOSPITALS AND HEALTH SYSTEMS

STATE HEALTH PLAN



*Losses by prosperity zone

The current State Health Plan proposal would reduce hospital revenues by **$465 million,** which translates to an estimated **7,000 jobs lost** statewide.[1]

Estimated losses due to proposed State Health Plan changes will have the following impact on counties by tier:

TIER 1	TIER 2	TIER 3
$52.6M	$136.4M	$276M
815 JOBS	2,132 JOBS	4,019 JOBS

Proposed State Health Plan changes are not focused on healthier North Carolinians

5 NC hospitals have closed in the past 9 years. 8 more are at high risk of financial distress.

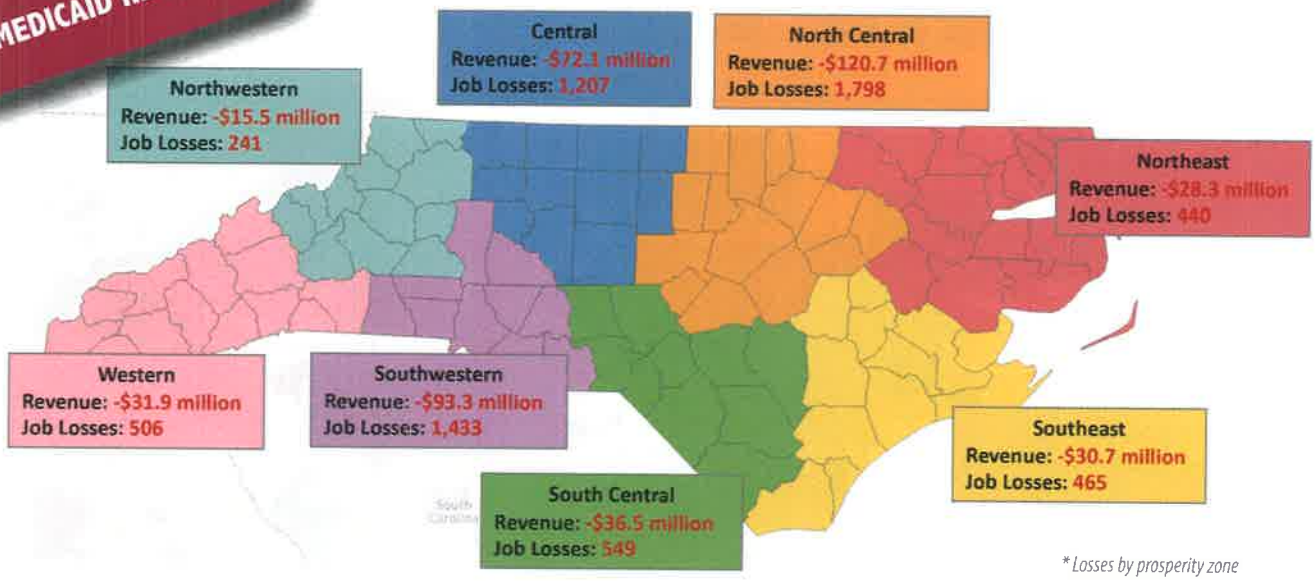
Workforce shortages persist

North Carolina's population is aging and growing

Hospitals must make infrastructure investments to replace older facilities and meet demand

	WORSE	BETTER
Proposed Legislative Change	Percentage of hospitals that currently operate with negative margins that will remain negative as a result of proposed changes	Percentage of hospitals that will move from negative to positive margins as a result of proposed changes
State Health Plan	24%	0%
Medicaid Reform	31%	0%

MEDICAID REFORM



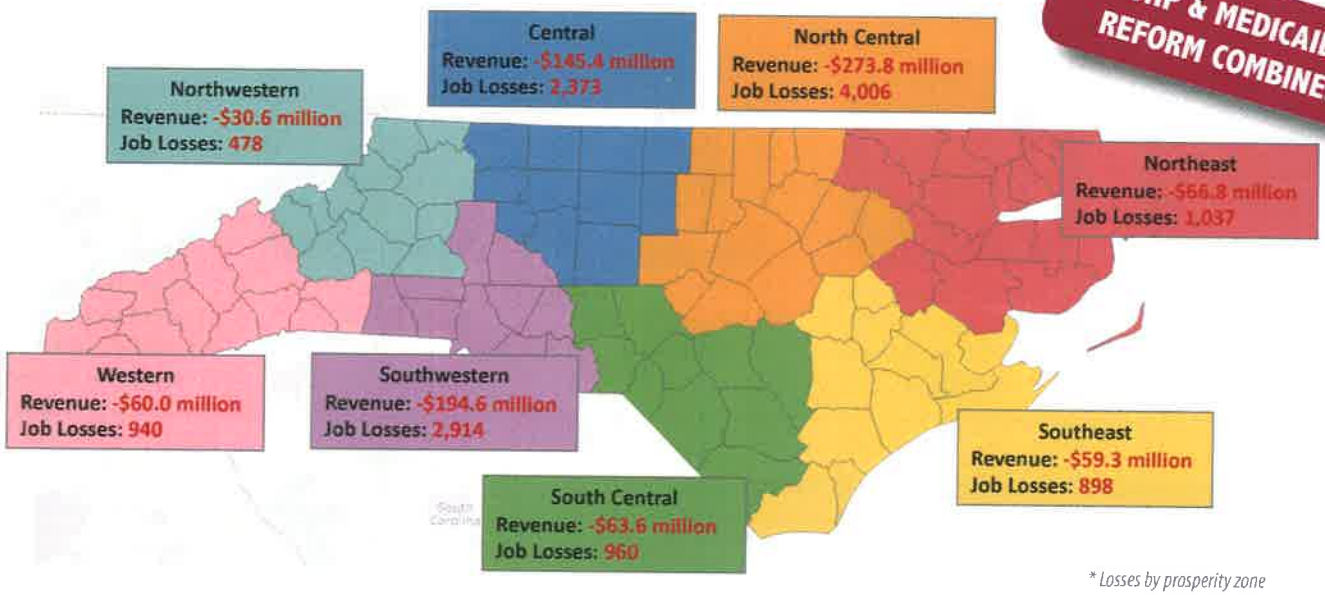
** Losses by prosperity zone*

The current proposal for Medicaid reform would reduce hospital revenues by **$429 million,** which translates to an estimated **6,600 jobs lost** statewide.[1]

Strong health systems = strong hospitals

Rural and urban hospitals are interdependent

SHP & MEDICAID REFORM COMBINED



** Losses by prosperity zone*

Combined impact of SHP proposal and Medicaid Reform would reduce hospital revenues by **$894 million** with an estimated **13,600 jobs lost** statewide. [1]

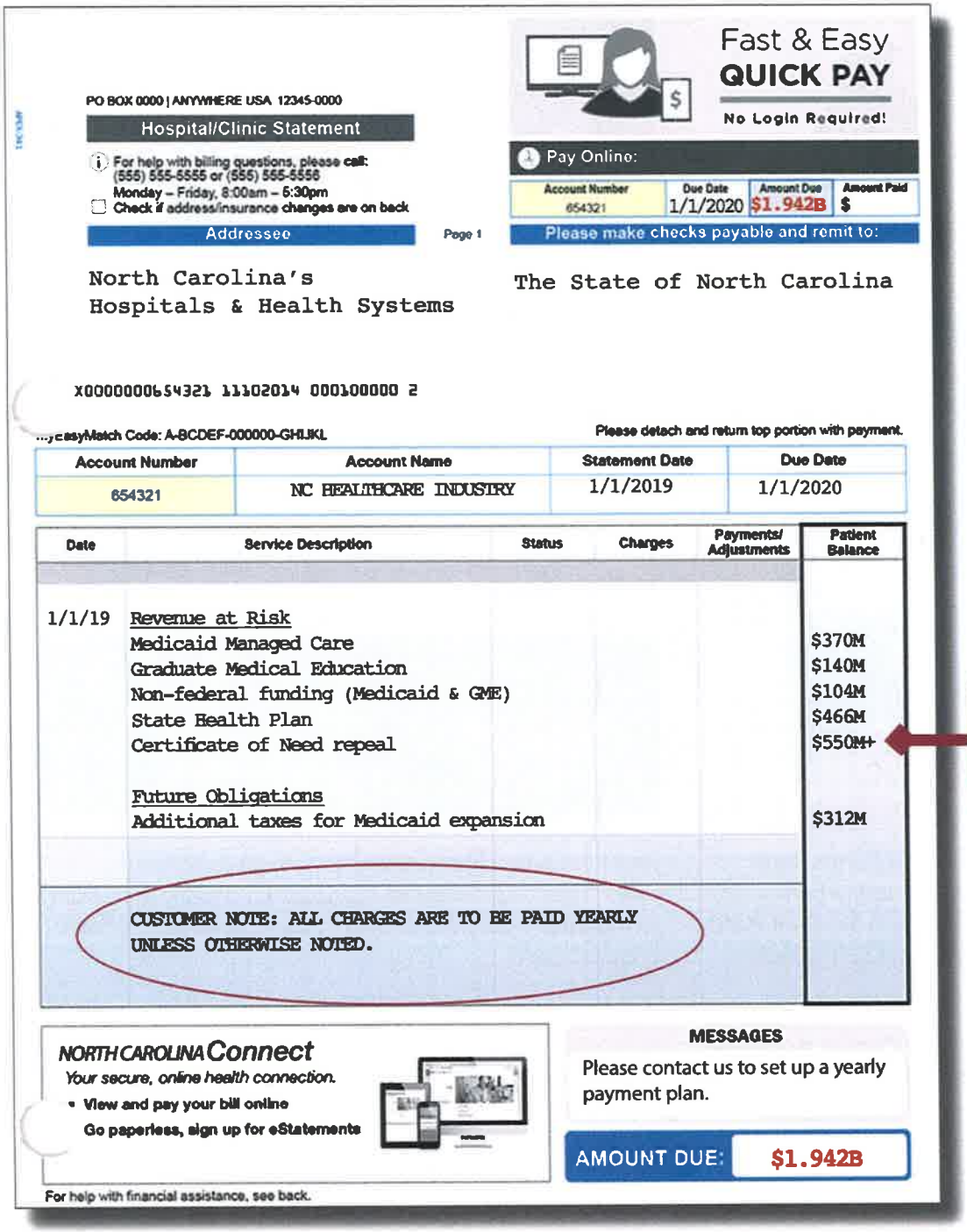
Source: NCHA economic impact analysis using IMPLAN software, February 2019. Jobs include direct, indirect and induced impacts. State Health Plan revenue impacts from NC hospitals and health systems. Medicaid financial analysis developed by Technical Data Working Team on behalf of MRI/GAP Technical Advisory Committee. Information obtained from 2018 MRI/GAP plan and Medicaid Managed Care Rate Book (SFY 2020) issued by the Division of Health and Human Services

NORTH CAROLINA'S HOSPITALS AND HEALTH SYSTEMS...

PICKING UP THE ENTIRE TAB?

North Carolina's hospitals and health systems support expanding access to affordable health insurance coverage for all North Carolinians. NCHA members understand that better access to affordable health care will significantly improve the lives of the people in our state.

However, North Carolina's hospital industry cannot carry the financial load all on its own.



PO BOX 0000 | ANYWHERE USA 12345-0000

Hospital/Clinic Statement

For help with billing questions, please call: (555) 555-5555 or (555) 555-5556
Monday – Friday, 8:00am – 5:30pm
Check if address/insurance changes are on back

Addressee

Page 1

Fast & Easy
QUICK PAY
No Login Required!

Pay Online:

Account Number	Due Date	Amount Due	Amount Paid
654321	1/1/2020	$1.942B	$

Please make checks payable and remit to:

North Carolina's
Hospitals & Health Systems

The State of North Carolina

X00000006 54321 11102014 000100000 2

...yEasyMatch Code: A-BCDEF-000000-GHIJKL

Please detach and return top portion with payment.

Account Number	Account Name	Statement Date	Due Date
654321	NC HEALTHCARE INDUSTRY	1/1/2019	1/1/2020

Date	Service Description	Status	Charges	Payments/ Adjustments	Patient Balance
1/1/19	Revenue at Risk				
	Medicaid Managed Care				$370M
	Graduate Medical Education				$140M
	Non-federal funding (Medicaid & GME)				$104M
	State Health Plan				$466M
	Certificate of Need repeal				$550M+
	Future Obligations				
	Additional taxes for Medicaid expansion				$312M

CUSTOMER NOTE: ALL CHARGES ARE TO BE PAID YEARLY UNLESS OTHERWISE NOTED.

NORTH CAROLINA Connect
Your secure, online health connection.
- View and pay your bill online
- Go paperless, sign up for eStatements

MESSAGES
Please contact us to set up a yearly payment plan.

AMOUNT DUE: $1.942B

For help with financial assistance, see back.

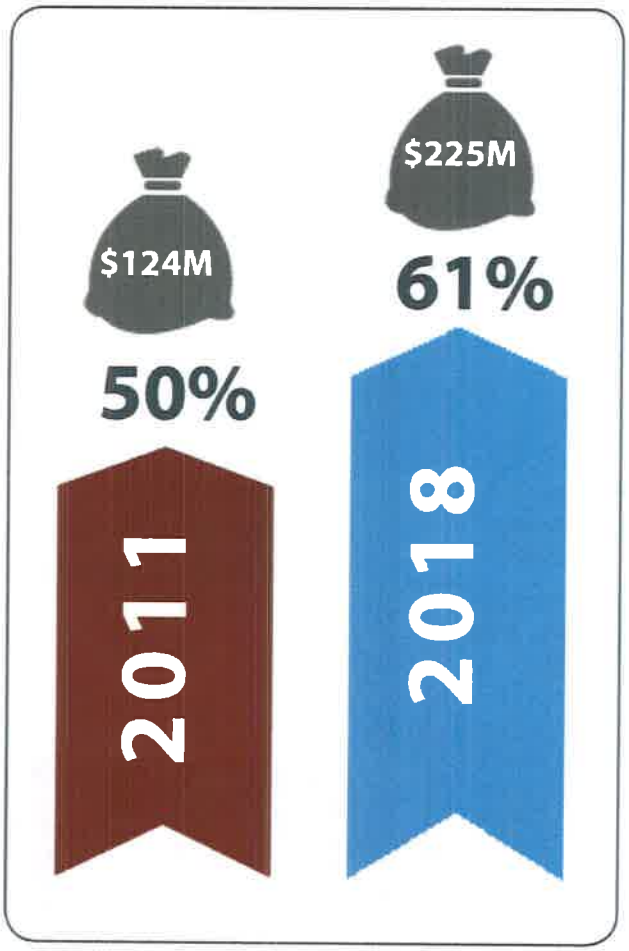
In the ten years after Texas repealed CON, 55 rural hospitals closed

With increased demands from NC DHHS to support Medicaid transformation, and calls from the state treasurer to slash rates paid to providers for its 700,000 State Health Plan enrollees, the financial demands on the state's hospitals will put pressure on the industry to cut services and possibly close facilities.

Source: North Carolina Healthcare Association Financial Analysis

Over the past 25 years, North Carolina hospitals have worked collaboratively with state government entities to ensure that North Carolina has one of the strongest safety nets for Medicaid and uninsured patients.

North Carolina hospitals generate approximately $1.65 billion of reimbursement by voluntarily generating approximately $820 million of non-federal funding to partially offset losses incurred by treating Medicaid and uninsured patients as part of the MRI/GAP program. Since the inception of this program in 2011, the North Carolina General Assembly has continued to shift responsibility for funding hospital reimbursement to North Carolina hospitals.



North Carolina hospitals' share of the non-federal funding has increased from approximately 50% in 2012 to 61% in 2018, including an increase in General Fund revenue from $124 million in 2012 to $225 million in 2018.

With the shift to Medicaid Managed Care, the Division of Health Benefit's actuarial estimates project approximately $370 million (13.4%) in decreased hospital reimbursements, including approximately $183 million in reimbursements funded by hospitals to offset the administrative costs and profits of MCOs. DHB is proposing that hospitals pay approximately $60 million in non-federal funding to ensure that the MCOs' administrative costs and profits are supported by someone other than the General Assembly.

In addition to DHB's expectation that hospitals willing incur $370 million in additional losses on Medicaid patients, hospitals are also expected to continue to assume the state's responsibility to pay for its most vulnerable citizens by providing an additional $312 million in General Fund revenue to support Medicaid expansion, which will help to support approximately $375 million in additional MCO profit.

Why are hospitals expected to provide 70% of the savings in managed care, and 100% of non-federal funding, to pay for Medicaid expansion when the industry represents 25% of the global spend?

The State of North Carolina is establishing an unsustainable model that will dramatically affect Medicaid beneficiaries' access to care in North Carolina.

Since 2012, the biggest benefactor of the MRI/GAP program and hospital supplemental payments has been the North Carolina General Assembly and the Division of Health Benefits. Beginning in 2019, MCOs will also be a benefactor of the more than $800 million (proposed $1.1 billion) in non-federal funding provided by hospitals.

Why are hospitals expected to sacrifice for everyone else to experience only up-side benefit?

At a time when North Carolina's corporate income tax rates have decreased to 3% of profit, DHB is proposing to increase hospital taxes to approximately 5% of total hospital cost.

Who really has "skin in the game," as so many parties benefit by increasing Medicaid losses incurred by hospitals while continuing to expect higher tax revenue from hospitals?

Senate Committee on Health Care
Thursday, February 21, 2019 at 15 minutes after session
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 15 minutes after session on February 21, 2019 in Room 643 of the Legislative Office Building. Ten members were present.

Senator Joyce Krawiec, Chair, presided.

Michael Cartwright from Salisbury, and Clay Williams from Raleigh served as pages.

This meeting was an informational meeting on the practice of Naturopathic Medicine in North Carolina. Senator Krawiec welcomed all who attended and introduced the scheduled presenters.

Walker Wilson, Assistant Secretary for Policy, from the Department of Health and Human Services shared the recommendations from a working group on the Appropriate Oversight and Regulation of the Practice of Naturopathic Medicine in NC (S.L. 2018-24). She also answered questions from the members.

Dr. Amy Hawkins, ND, Chairperson for the NC Association of Naturopathic Physicians gave an overview of Naturopathic Medicine in North Carolina. Sen. Krawiec introduced Dr. Susan DeLaney, ND, a Naturopathic Physician and Dr. Arthur Apolinario, MD, MPH, FAAFP. Questions from the members were answered by Dr. Hawkins, Dr. DeLaney, and Dr. Apolinario.

The meeting adjourned at 11:51.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

Senate Committee on Health Care
Thursday, February 21, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Informational Meeting on the Practice of Naturopathic Medicine in North Carolina

Presentations:

Walker Wilson, Assistant Secretary for Policy, DHHS
Recommendations for Appropriate Oversight and Regulation of the Practice of Naturopathic Medicine in NC (S.L. 2018-24),

Dr. Amy Hawkins, ND
Naturopathic Medicine in NC

Questions from the Committee Members

Senate Health Care Committee

Recommendations for Appropriate Oversight and Regulation of the Practice of Naturopathic Medicine in North Carolina

Walker Wilson
Assistant Secretary for Policy, NC DHHS

February 21, 2019

Agenda

- Overview
- Charge of Work Group per HB 277
- Recommendations
  - Approved Program of Study and Requirements for License
  - Scope of Practice
  - Licensure and Regulatory Oversight
  - Fees

Overview

- Naturopathic medicine is a distinct healthcare profession that encompasses modern, traditional, scientific, and empirical methods of diagnosis, treatment, and prevention
- Naturopathic Doctors combine their specialty knowledge of natural therapies with the rigors of modern science, focusing on prevention and treatment of acute and chronic disease through optimal diet, healthy lifestyle, and the utilization of natural therapies

Regulation of Practice

- Regulation of practice of Naturopathic medicine varies from state to state

States and jurisdictions that license Naturopathic Doctors	Alaska, Arizona, California, Connecticut, Hawaii, Kansas, Maine, Maryland, Massachusetts, Montana, New Hampshire, North Dakota, Oregon, Rhode Island, Utah, Vermont, Washington State, Washington DC, Puerto Rico, and the Virgin Islands
States that register Naturopathic Doctors as an alternative to licensure but essentially equivalent	Colorado, Minnesota, and Pennsylvania
States that prohibit the practice of Naturopathic medicine	South Carolina and Tennessee

HB 277 Directed DHHS to Convene a Work Group

SECTION 1.(a) ..."On or before September 15, 2018, the Secretary of the Department of Health and Human Services, or the Secretary's designee, **shall convene a work group to study the delivery of naturopathic medicine in North Carolina.** The work group shall be comprised of the following individuals: two naturopathic doctors, selected by the North Carolina Association of Naturopathic Physicians; one medical doctor, who has knowledge of the practice of naturopathic medicine, selected by the North Carolina Medical Society; the chairperson of the North Carolina Medical Board, or the chairperson's designee; and the Secretary of the Department of Health and Human Services, or the Secretary's designee.

SECTION 1.(b) The work group shall develop recommendations necessary to provide appropriate oversight and regulation of naturopathic medicine in the State of North Carolina. The work group's recommendations shall include at least the following:

(1) Identification of an approved program of study of naturopathic medicine that provides graduate-level, full-time didactic and supervised clinical training in naturopathic medicine and is accredited by the Council on Naturopathic Medical Education or an equivalent federally recognized accrediting body for the naturopathic medical profession. The program must be offered by an institution of higher education and lead to a degree as a Doctor of Naturopathic Medicine, or equivalent.

(2) A scope of practice for naturopathic doctors, including the extent of their responsibilities as licensed health care professionals; the extent of their ability to diagnose and treat individuals in accordance with the method, thought, and practice of naturopathic medicine and use of diagnostic techniques and therapies; and their prescriptive authority.

(3) Whether the practice of naturopathic medicine should constitute the practice of medicine or surgery as defined in Chapter 90 of the General Statutes.

SECTION 1.(c) The work group shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services on or before January 15, 2019. The report shall include findings and recommendations on the topics outlined in this section and other issues necessary to provide for the appropriate oversight and regulation of the practice of naturopathic medicine in North Carolina. Additionally, the report shall also include recommendations on appropriate fees for application, examination, certification, renewals, and late renewals, as appropriate, to cover the costs associated with oversight."

Work Group Members

- Comprised of five members as required in Session Law 2018-24, HB 277

Dr. Arthur Apolinario, MD, MPH, FAAFP	Appointed by and represented the North Carolina Medical Society and currently serves on the NCMS Board of Directors
Shawn Parker, JD, MPA	Designee of NCMB President Timothy Lietz, MD and current NCMB Board Member
Dr. Amy Hawkins, ND	Appointed by and represented the North Carolina Association of Naturopathic Physicians and currently serves as its current President
Dr. Susan Delaney, ND,	Appointed by and represented the North Carolina Association of Naturopathic Physicians and currently serves as its Legislative Chair
Walker Wilson, MPH	Designated by Secretary Mandy Cohen, MD to serve on behalf of DHHS and as the work group Chairperson

Recommendations for Approved Program of Study and Requirements for License

- Qualification for licensure include completion of an approved program of study
  - Graduate level, full-time didactic and supervised clinical training in naturopathic medicine that is accredited, or has achieved candidacy status for accreditation, by the Council on Naturopathic Medical Education or an equivalent federally recognized accrediting body for the Naturopathic medical profession

Recommendations for Approved Program of Study and Requirements for License

- Qualification for licensure include completion of an approved program of study
  - A program that is offered by an institution of higher education that is accredited by a regional or national institutional accrediting body recognized by the Secretary of the United States Department of Education
  - If the program is offered in the United States, a program that awards the degree of Doctor of Naturopathy or Doctor of Naturopathic Medicine

Recommendations for Approved Program of Study and Requirements for License

- Requirements to be licensed as a Naturopathic Doctor in North Carolina
  - Good moral and ethical character
  - Graduate of an approved program of Naturopathic medicine as defined in prior slides
  - Successfully passed the Naturopathic Physicians Licensing Examination (NPLEX) or
  - Successfully passed a competency-based state or Canadian province naturopathic licensing examination administered prior to the existence of NPLEX

Recommendations for Approved Program of Study and Requirements for License

- Requirements to be licensed as a Naturopathic Doctor in North Carolina
  - Provide satisfactory criminal background report as provided by the State Bureau of Investigations.
  - Completion and submission to the regulatory board of a board-approved written attestation that states the applicant for licensure has collaboration and consultation agreement with a physician licensed by North Carolina Medical Board.

Recommendations for Scope of Practice

- Naturopathic Doctor may employ the following therapies, modalities, procedures, or remedies consistent with Naturopathic education and training:
  - Dispense, administer, order, and advise the use of natural remedies derived from or substantially similar in molecular structure or function to natural sources for preventive and therapeutic purposes, including food, extracts of food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, homeopathic remedies prepared according to the Homeopathic Pharmacopoeia of the United States, and all dietary supplements and nonprescription drugs as defined by the federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 301, et seq.

Recommendations for Scope of Practice

- Order and perform physical examinations and physiological function tests
- Order, perform, and interpret laboratory tests
- Order diagnostic imaging, such as X-ray, MRI, CT scan
  - Scope excludes electrocardiograms, echocardiograms, electroencephalograms, and nuclear imaging
- Perform hot or cold hydrotherapy, naturopathic physical medicine, electromagnetic therapy, and therapeutic exercise

Recommendations for Scope of Practice

- Perform health education and health counseling, including dietary and lifestyle counseling
- Utilize routes of administration for substances, including oral, nasal, auricular, ocular, rectal, vaginal, and transdermal
- Perform care incidental to superficial lacerations and abrasions, including the application of topical and local anesthetics and antimicrobials

Recommendations for Scope of Practice

- Naturopathic Doctor may not perform any of the following functions unless otherwise licensed by this State to do so:
  - Prescribe, dispense, or administer any prescription drug or controlled substance, except as authorized by this Article
  - Use general or spinal anesthetics
  - Perform surgical procedures
  - Administer ionizing radioactive substances for therapeutic purposes
  - Child delivery
  - Diagnose and treat cancer

Recommendations as to whether the Practice of Naturopathic Medicine Constitutes the Practice of Medicine or Surgery per Chapter 90 of the General Statutes

- Include the licensed practice of Naturopathic medicine within the statutory exceptions to the practice of medicine or surgery found in N.C.G.S. 90-18(c)

Recommendations on Licensure and Regulatory Oversight

- Option 1*: Provided by independent North Carolina Naturopathic Medicine Licensing Board
- Option 2: Provided by a North Carolina Board of Healing Arts
- Option 3: Provided by the North Carolina Medical Board assisted by a North Carolina Naturopathic Doctors Licensure Advisory Committee serving within and reporting to the NCMB

***Work Group recommendation**

Recommendations on Fees to Cover Cost Associated with Oversight

- Application and examination $200.00
- License $300.00
- License Renewal $350.00
- Reinstatement $1,000.00
- Reasonable charges for duplication services and material
- Criminal history record check fee equal to the amount imposed by the Department of Justice to conduct the criminal history check requested by the Board

Recommendations for Appropriate Oversight and Regulation of the Practice of Naturopathic Medicine in North Carolina

Session Law 2018-24, House Bill 277

Report to

Joint Legislative Oversight Committee on Health and Human Services

and

The Fiscal Research Division

by
North Carolina Department of Health and Human Services

January 15, 2019

Response to Legislative Request

This report is in response to the General Assembly's provision included in House Bill 277, S.L. 2018-24, which reads:

SECTION 1.(a) Naturopathic medicine is a distinct health care profession that affects the public health, safety, and welfare of the State's residents. Certification of professionals practicing naturopathic medicine will aid in protecting citizens from deception, fraud, and damage to their health status. On or before September 15, 2018, the Secretary of the Department of Health and Human Services, or the Secretary's designee, shall convene a work group to study the delivery of naturopathic medicine in North Carolina. The work group shall be comprised of the following individuals: two naturopathic doctors, selected by the North Carolina Association of Naturopathic Physicians; one medical doctor, who has knowledge of the practice of naturopathic medicine, selected by the North Carolina Medical Society; the chairperson of the North Carolina Medical Board, or the chairperson's designee; and the Secretary of the Department of Health and Human Services, or the Secretary's designee.

SECTION 1.(b) The work group shall develop recommendations necessary to provide appropriate oversight and regulation of naturopathic medicine in the State of North Carolina. The work group's recommendations shall include at least the following:

(1) Identification of an approved program of study of naturopathic medicine that provides graduate-level, full-time didactic and supervised clinical training in naturopathic medicine and is accredited by the Council on Naturopathic Medical Education or an equivalent federally recognized accrediting body for the naturopathic medical profession. The program must be offered by an institution of higher education and lead to a degree as a Doctor of Naturopathic Medicine, or equivalent.

(2) A scope of practice for naturopathic doctors, including the extent of their responsibilities as licensed health care professionals; the extent of their ability to diagnose and treat individuals in accordance with the method, thought, and practice of naturopathic medicine and use of diagnostic techniques and therapies; and their prescriptive authority.

(3) Whether the practice of naturopathic medicine should constitute the practice of medicine or surgery as defined in Chapter 90 of the General Statutes.

SECTION 1.(c) The work group shall report findings and recommendations to the Joint Legislative Oversight Committee on Health and Human Services on or before January 15, 2019. The report shall include findings and recommendations on the topics outlined in this section and other issues necessary to provide for the appropriate oversight and regulation of the practice of naturopathic medicine in North Carolina. Additionally, the report shall also include recommendations on appropriate fees for application, examination, certification, renewals, and late renewals, as appropriate, to cover the costs associated with oversight.

Executive Summary

The work group developed and agreed to the following recommendations. First, the work group recommends that Naturopathic Doctors with a Doctor of Naturopathy (ND) or Doctor of Naturopathic Medicine (NMD) degree through formal study, should be licensed either under their own board or as the first practice area of a combined board of allied/complimentary

practices. Second, Naturopathic Doctors should meet the minimum requirements of education enumerated herein, including training in accredited programs and passing post-graduate board examinations. Third, licensees should be qualified to independently perform a defined scope of practice, which should not be construed as the practice of medicine. Finally, it is the work group's recommendation that only persons licensed as Naturopathic Doctors in North Carolina may use the titles "Naturopathic Doctor," "Doctor of Naturopathic Medicine," "Doctor of Naturopathy," "Naturopathic Medicine," "Naturopath," "Licensed Naturopathic Doctor," or the abbreviations "N.D.", "ND," or any other titles, words, letters, abbreviations, or insignia indicating or implying that the individual is a licensed Naturopathic doctor unless the individual has been licensed as a Naturopathic Doctor. The work group believes that these recommendations for appropriate oversight and regulation of the practice of naturopathic medicine will ultimately promote public health and safety for the people of North Carolina.

Background

Naturopathic medicine is a distinct healthcare profession that encompasses modern, traditional, scientific, and empirical methods of diagnosis, treatment, and prevention. Naturopathic Doctors combine their specialty knowledge of natural therapies with the rigors of modern science, focusing on prevention and treatment of acute and chronic disease through optimal diet, healthy lifestyle, and the utilization of natural therapies. There are six fundamental principles of naturopathic medicine: 1) the healing power of nature; 2) identify and treat the causes; 3) first do no harm; 4) doctor as teacher; 5) treat the whole person; and 6) prevention. Naturopathic medicine is a specialty. Naturopathic Doctors provide optimal care and improve health outcomes when Naturopathic medicine is included in as a healthcare option and integrated into the healthcare system.

Regulation of the practice of Naturopathic medicine varies from state to state in the United States and from province to province in Canada.

States and jurisdictions that license Naturopathic Doctors	Alaska, Arizona, California, Connecticut, Hawaii, Kansas, Maine, Maryland, Massachusetts, Montana, New Hampshire, North Dakota, Oregon, Rhode Island, Utah, Vermont, Washington State, Washington DC, Puerto Rico, and the Virgin Islands
States that register Naturopathic Doctors as an alternative to licensure but essentially equivalent	Colorado, Minnesota, and Pennsylvania
States that prohibit the practice of Naturopathic medicine	South Carolina and Tennessee

Public safety is the most important aspect of licensure of Naturopathic Doctors and regulation of Naturopathic medicine. For health and safety purposes, it is imperative that the public be able to distinguish between Naturopathic Doctors and laypersons who complete an online or non-clinical training program. Licensed Naturopathic Doctors have attended Council on Naturopathic

Medical Education (CNME) accredited four-year Naturopathic medical schools and earned a Doctor of Naturopathy (ND) or Doctor of Naturopathic Medicine (NMD) doctoral-level professional degree. Laypersons may have earned a diploma, distance-learning diploma, or distance-learning degree in "naturopathy" from a non-accredited institution and have no requirement for formal, supervised clinical Naturopathic medical training. Additionally, in states without regulation of Naturopathic medicine and licensure or registration of Naturopathic Doctors, there is no title protection for Naturopathic Doctors. Therefore, in those states, a Naturopathic Doctor, who earned a doctoral degree (ND or NMD) from a CNME-accredited naturopathic medical school and a layperson not licensed to practice Naturopathic medicine with an online diploma from a non-accredited institution can both use "ND" or "NMD" as initials after their name. In states with licensure or registration of Naturopathic Doctors and regulation of Naturopathic medicine, there is title protection for the use of "NMD" or "ND" after a person's name. The national standard is that these titles are restricted to Naturopathic Doctors who have earned an NMD or ND degree from a CNME-accredited Naturopathic medical school.

Public Health and Safety

In states where Naturopathic Doctors are licensed, the practice of Naturopathic Medicine is regulated and individuals without formal CNME accredited training cannot claim to be a Naturopathic Doctor. In these states, the events of harm from those attempting to practice without proper credentials are rare. In response to inquiries conducted by the NCANP, regulatory authorities in Maine, Oregon, and Arizona have responded that there are no known incidences or complaints of individuals making such claims in those states.

Naturopathic Medicine is an unregulated healthcare profession in North Carolina, and as such, the state is attracting large numbers of individuals without clinical, hands-on training claiming to be Naturopathic Doctors. Because these individuals lack formal, supervised training, they jeopardize patients' health and safety and have already negatively impacted public health in the state. North Carolinians who seek natural and integrative medicine are being subjected to fraud, abuse, harm and even death because there is no regulation of Naturopathic Medicine in North Carolina. There have been two known deaths in the state resulting from treatment by individuals claiming to be Naturopathic Doctors but possessing no formal Naturopathic medical education and training.

In 1999, an 8-year-old type 1 diabetic girl was harmed by an individual who held himself out to be a Naturopathic Doctor but was unqualified and not trained in Naturopathic medicine. He told the child's mother that the young girl was not diabetic, but rather had a viral infection and her "system could be cleansed" to make her well. The mother was instructed to stop giving her daughter insulin, and the 8-year-old tragically died at Mission Hospital in Buncombe County several days later in a diabetic coma. Fortunately, the individual was prosecuted and given a 12- to 15-month prison sentence; however, he later returned to practice in Henderson County until his death. The tragic and senseless death of this young girl is a clear example of the importance of regulation of a health care profession.

Licensure of Naturopathic Doctors by North Carolina law would have deterred this individual from practicing Naturopathic medicine with no formal training. The child's parents would have been able to see that he was not licensed by any regulatory authority and making a false claim to having clinical, professionally recognized training in Naturopathic medicine; and an oversight regulatory authority could have intervened and kept the individual from "practicing medicine," then likely this tragedy would have been prevented.

The second known death was in 2012 of a 43-year-old mother of two children who died from treatment for breast cancer by an herb store owner who practiced as a Naturopathic Doctor but had no formal, accredited training from a CNME recognized program. The individual convinced the patient to forgo conventional cancer treatment and to use his herbs and "miracle water" instead. Because he claimed to be a "Doctor," the woman trusted his advice. As there is no regulatory authority overseeing the practice of Naturopathic Medicine in North Carolina, there was no oversight of the claims being made by the herb store owner and the woman's family had no recourse rights through a regulatory Board.

The North Carolina Association of Naturopathic Physicians estimates there are 85 to 100 individuals without formal, accredited Naturopathic medical training practicing in North Carolina as "naturopathic providers." These individuals often claim to be "licensed" by the State of North Carolina through an entity identified as the "North Carolina Board of Naturopathic Examiners." In addition, many of these individuals carry "licenses" provided by the "American Naturopathic Medical Association," a private credentialing company located in Nevada. Neither the "North Carolina Board of Naturopathic Examiners" nor the "American Naturopathic Medical Association" has been granted regulatory authority by any state or the federal government.

Today there are approximately 40 Naturopathic Doctors practicing in North Carolina who are graduates of 4-year, in-residence, full-time, nationally and regionally accredited Naturopathic medical schools recognized by the US Department of Education. These doctors have passed rigorous post-doctoral board examinations administered by the North American Board of Naturopathic Examiners (NABNE) and all but one of those providers hold valid Naturopathic medical licenses from one of the 23 states and/or jurisdictions that currently regulate the practice of Naturopathic Medicine. However, without a regulatory authority in North Carolina and without a license to practice Naturopathic Medicine in this state, these doctors cannot practice to the full extent of their education and training. Without licensure Naturopathic Doctors are prevented from ordering blood labs, PAP smears, x-rays, ultrasounds, and many other diagnostic tests which are important for a full assessment of the patient's health. These tests are often critical to make a proper diagnosis for their presenting condition. Additionally, without licensure there is often barriers to work within the medical community as an integrated team for the optimal benefit of all patients.

The lack of regulation and licensure of Naturopathic Medicine in North Carolina allows untrained individuals to potentially harm the public and simultaneously prevents Naturopathic Doctors with formal medical training from fully utilizing their training which can improve the public health of North Carolina. It is the position of the work group that the passage of licensure

legislation will benefit the citizens of North Carolina by allowing them to enjoy the full benefit of healthcare options provided by qualified Naturopathic Doctors while also being protected from risk of the harm inflicted by individuals not qualified to provide such care. There was agreement among work group members that licensure based upon national standards of education and board examination and regulated by a duly sanctioned board is indeed an effective deterrent.

Work Group Members

The work group was comprised of five members:

Dr. Arthur Apolinario, MD, MPH, FAAFP	Appointed by and represented the North Carolina Medical Society and currently serves on the NCMS Board of Directors
Shawn Parker, JD, MPA	Designee of NCMB President Timothy Lietz, MD and current NCMB Board Member
Dr. Amy Hawkins, ND	Appointed by and represented the North Carolina Association of Naturopathic Physicians and currently serves as its current President
Dr. Susan Delaney, ND,	Appointed by and represented the North Carolina Association of Naturopathic Physicians and currently serves as its Legislative Chair
Walker Wilson, MPH	Designated by Secretary Mandy Cohen, MD to serve on behalf of DHHS and as the work group Chairperson

The work group convened September 4, 2018 and held two additional meetings on October 16, 2018 and November 27, 2018, and one conference call on December 18, 2018.

Recommendations for Approved Program of Study and Requirements for Licensure

The current lack of regulation of naturopathy in North Carolina may be creating consumer confusion and risk to public health in the state of North Carolina. The work group believes the public needs to be able to distinguish between the education and training of a provider who has obtained a doctoral degree from an accredited Naturopathic medical program and someone who has not. Without being able to make such distinctions, individuals may seek healthcare from a layperson not licensed to be a Naturopathic Doctor.

Therefore, the work group recommends a qualification for licensure include completion of an approved program of study that meets all the following conditions:

1. A program that provides graduate-level, full-time didactic and supervised clinical training in naturopathic medicine that is accredited, or has achieved candidacy status for accreditation, by the Council on Naturopathic Medical Education (CNME) or an equivalent federally recognized accrediting body for the Naturopathic medical profession. If the program existed prior to the existence of the CNME, the program must have (i) provided graduate-level, full-time didactic and supervised clinical training in naturopathic

medicine for a duration of not less than 132 weeks and required completion within a period of not less than 35 months, (ii) be recognized as a reputable program by, and in good standing with, CNME, and (iii) if the program is still in existence, be currently accredited, or have achieved candidacy status for accreditation, by the CNME or an equivalent federally recognized accrediting body for the naturopathic medical profession.

2. A program that is offered by an institution of higher education that is accredited by a regional or national institutional accrediting body recognized by the Secretary of the United States Department of Education.
3. If the program is offered in the United States, a program that awards the degree of Doctor of Naturopathy or Doctor of Naturopathic Medicine. If the program is offered in Canada, a program that awards the degree or diploma of Doctor of Naturopathy or Doctor of Naturopathic Medicine and is offered by an institution of higher education that has provincial approval for participation in government-funded student aid programs.

Additionally, the work group recommends the following requirements to be licensed as a Naturopathic Doctor in North Carolina:

1. Good moral and ethical character.
2. Graduate of an approved program of Naturopathic medicine as defined above.
3. Meet one, or both, of the following two conditions:
    a. Has successfully passed the Naturopathic Physicians Licensing Examination (NPLEX), a competency-based national naturopathic licensing examination administered by the North American Board of Naturopathic Examiners or an equivalent successor agency.
    b. Has successfully passed a competency-based state or Canadian province naturopathic licensing examination administered prior to the existence of NPLEX.
4. Provide a satisfactory criminal background report as provided by the State Bureau of Investigations. If the applicant has been a resident of this State for less than five years, the applicant shall provide a satisfactory criminal background report from both the State and National Repositories of Criminal Histories.
5. Completion and submission to the regulatory board of a board-approved written attestation that states the applicant for licensure has a collaboration and consultation agreement with a physician licensed by NCMB. The work group's recommendation is not to be construed as a requirement for supervision of Naturopathic Doctors by any other healthcare professional.

Recommendations for Scope of Practice

Public health and safety are the most important considerations of the scope of practice in any jurisdiction. Like all healthcare providers, having an appropriate scope of practice that accurately reflects the extent and degree of training allows for the delivery of safe and effective care.

The work group recommends a Naturopathic Doctor be a licensed healthcare provider having the same responsibilities as other licensed or registered healthcare providers regarding public health laws, reportable diseases and conditions, communicable disease control and prevention, and the recording of vital statistics. In diagnosing and treating an individual, the work group

recommends that a Naturopathic Doctor may employ the following therapies, modalities, procedures, or remedies consistent with Naturopathic education and training:

1. Dispense, administer, order, and advise the use of natural remedies derived from or substantially similar in molecular structure or function to natural sources for preventive and therapeutic purposes, including food, extracts of food, nutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, homeopathic remedies prepared according to the Homeopathic Pharmacopoeia of the United States, and all dietary supplements and nonprescription drugs as defined by the federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 301, et seq.

   The work group further recommends creation of a Naturopathic Doctors Formulary Council within the regulatory board that is tasked with ongoing development and recommendation to the regulatory board a formulary for use by Naturopathic Doctors. The Council should be comprised of two licensed Naturopathic Doctors, two licensed physicians one pharmacist, and one consumer. The work group's intention with this recommendation is to ensure that Naturopathic Doctors are not restricted if a natural remedy or a remedy derived from or substantially similar in molecular structure or function to natural sources becomes a prescription drug. These substances are currently allowed within the scope of practice and should be protected within the future scope of practice for Naturopathic Doctors.
2. Order and perform physical examinations and physiological function tests.
3. Order, perform, and interpret laboratory tests, including performing waived tests as defined by the United States Food and Drug Administration Clinical Laboratory Improvement Amendments of 1998 (CLIA), including obtaining specimens to assess and treat disease.
4. Order diagnostic imaging, including X-ray, MRI, CT scan, ultrasound, mammogram, and bone densitometry. Scope excludes electrocardiograms, echocardiograms, electroencephalograms, and nuclear imaging.
5. Perform hot or cold hydrotherapy, naturopathic physical medicine, electromagnetic therapy, and therapeutic exercise.
6. Perform health education and health counseling, including dietary and lifestyle counseling.
7. Utilize routes of administration for substances, including oral, nasal, auricular, ocular, rectal, vaginal, and transdermal.
8. Perform care incidental to superficial lacerations and abrasions, including the application of topical and local anesthetics and antimicrobials.

The work group also recommends that a Naturopathic Doctor may not perform any of the following functions unless otherwise licensed by this State to do so:

1. Prescribe, dispense, or administer any prescription drug or controlled substance, except as authorized by this Article.
2. Use general or spinal anesthetics.
3. Perform surgical procedures.
4. Administer ionizing radioactive substances for therapeutic purposes.
5. Child delivery.

6. Diagnose and treat cancer. Prohibition does not apply to adjunctive/complementary care of patients who have previously been or are currently diagnosed with cancer.

Recommendations as to whether the Practice of Naturopathic Medicine Constitutes the Practice of Medicine or Surgery per Chapter 90 of the General Statues

The work group reviewed and discussed the statutory definition of medicine and believe the modalities, procedures, and remedies employed by a licensed Naturopathic Doctor in his or her performance within the scope of practice described above could be construed to be the practice of medicine or surgery as defined in Article 1 of Chapter 90. As such, the work group recommends including the licensed practice of Naturopathic medicine within the statutory exceptions to the practice of medicine or surgery found in North Carolina General Statute 90-18(c).

Recommendations on Licensure and Regulatory Oversight

The work group strongly recommends regulation of Naturopathic Medicine and licensure of Naturopathic Doctors in North Carolina. The work group acknowledges that licensure legislation has been introduced in every legislative session for over 18 years without enactment and wishes to communicate consensus that licensure is in the best interest of public health in North Carolina.

The work group reviewed and discussed three options for regulatory oversight of Naturopathic medicine in North Carolina and recommends Option 1 below.

Option 1: Regulatory oversight provided by an independent North Carolina Naturopathic Medicine Licensing Board.

In this model of regulatory oversight, an independent Naturopathic licensing board would be created which would be self-governing and self-sustaining. This regulatory structure is used for most of the healthcare professions in North Carolina. Currently, this regulatory structure is used in 12 jurisdictions: Arizona, California, Connecticut, Hawaii, Massachusetts, New Hampshire, Oregon, Rhode Island, Utah, Washington, Puerto Rico, and the US Virgin Islands.

Due to the large number of existing licensing boards in North Carolina, the work group acknowledges that creation of a new professional licensing board possibly would not be a favorable option to some members of the North Carolina General Assembly. However, the work group recognizes the need for passage of licensure legislation and recommends an independent licensing board, the well-established successful model in 12 jurisdictions and the model for other healthcare professions in North Carolina. The work group also acknowledges that the small numbers of Naturopathic Doctors that would be eligible for licensure in North Carolina may generate concerns regarding the sustainability of an independent board. It is the work group's opinion that the fees outlined in the section covering fees will allow an independent board to be self-sustaining. The group's opinion recognizes that licensure will attract new Naturopathic Doctors to the state and the number of licensees will grow. Note: For these reasons, the work group recommends an independent Naturopathic licensing board and views this structure as the most direct route to regulation and licensure of Naturopathic Doctors in North Carolina.

Option 2: Regulatory oversight provided by a North Carolina Board of Healing Arts.

In this model of regulatory oversight, North Carolina State Board of Healing Arts would be created which would be self-governing and self-sustaining. This Board would initially provide regulatory oversight and licensure for Naturopathic medicine and Naturopathic Doctors. However, in the future, the Board of Healing Arts could provide a regulatory home for other licensed allied/complementary healthcare professions in North Carolina. Currently, this regulatory structure is used in Kansas, Maine, Montana, and North Dakota. The work group recognizes the benefits of autonomy, appropriate professional oversight, and shared resources with an independent Board of Healing Arts and recommends this regulatory structure as a secondary option.

The work group acknowledges that this regulatory structure may be more amenable to overall legislative goals of reducing the number of professional licensing boards in North Carolina. The work group also recommends that each allied healthcare profession regulated by the Board of Healing Arts have its own Advisory Committee, which reports to the Board on matters pertaining to that allied healthcare profession.

Option 3: Regulatory oversight provided by the North Carolina Medical Board (NCMB) assisted by a North Carolina Naturopathic Doctors Licensure Advisory Committee serving within and reporting to the North Carolina Medical Board.

In this model of regulatory oversight, the Advisory Committee would conduct the business of regulating providers and issuing licenses to Naturopathic Doctors who meet the criteria for licensure in North Carolina. The Advisory Committee would report to the NCMB and no action taken by the Committee would be effective unless approved by the NCMB. Currently, this structure of regulation is used in 4 jurisdictions: Maryland, Minnesota, Pennsylvania, and the District of Columbia.

This option provides the primary benefit of regulation under an already established Board. The work group does not recommend this option if Naturopathic medicine is limited to the scope of practice outlined in this report, and collaborative agreements are formed with physicians licensed by the NCMB. Given this, it is not necessary for the regulatory oversight of Naturopathic Doctors to be under the North Carolina Medical Board, and oversight by its own board, or a Healing Arts Board would still be adequate to provide for the safety of our citizens and the maintenance of professionalism within the group.

Recommendations on Fees to Cover Cost Associated with Oversight

As a basis for determining fees to cover cost associated with oversight, the work group reviewed current fees under all healthcare professional licensing boards in North Carolina. It is the work group's recommendation that fees should be comparable to other licensing boards and recommends the following reasonable fees for licensure of Naturopathic Doctors.

1. Application and examination $200.00
2. License $300.00
3. License renewal $350.00
4. Late renewal $200.00
5. Reinstatement $1,000.00
6. Reasonable charges for duplication services and material.
7. Criminal history record check fee equal to the amount imposed by the Department of Justice to conduct the criminal history record check requested by the Board.

NCANP
north carolina association of naturopathic physicians

NATUROPATHIC MEDICINE & NATUROPATHIC DOCTORS

PRESENTATION TO THE
SENATE HEALTH CARE COMMITTEE
FEBRUARY 21, 2019

NCANP

Dr. Amy Hawkins, ND
Naturopathic Family Wellness – Wrightsville Beach, NC



NCANP

NCANP– MEMBERS & PURPOSE

- Nonprofit formed in 1987
- Members of the state professional organization of Naturopathic Doctors in North Carolina are graduates of 4-year, in-residence, accredited Naturopathic medical schools and maintain licensure in a state, district, territory, or Canadian province that regulates the practice of Naturopathic Medicine
- One of 43 official state affiliates of the American Association of Naturopathic Physicians (AANP) and bound by the national standards that recognize Naturopathic Doctors in the United States

NCANP

NCANP– MEMBERS & PURPOSE CONTINUED

- Fosters and supports Naturopathic Doctors in North Carolina
- Serves the Naturopathic profession through leadership, continuing education, and professional development
- Serves the community by working to expand access to safe and effective Naturopathic care
- Functions as an educational and referral resource for individuals seeking licensed Naturopathic Doctors in North Carolina

NCANP

NATUROPATHIC MEDICINE & NATUROPATHIC DOCTORS (NDs)

Naturopathic Doctors are general practice healthcare practitioners who combine expert knowledge of natural therapies with the advances of modern medicine, providing safe and effective care for all ages. NDs are specialists in integrative medicine, focusing on prevention and treatment of acute and chronic disease through the use of optimal diet, healthy lifestyle habits, and natural therapies.

NCANP

A BRIEF HISTORY OF NATUROPATHIC MEDICINE

- As a distinct health care profession, Naturopathic Medicine is over 100 years old.
- Roots of Naturopathic Medicine can be traced to German physician Dr. Benedict Lust who used this term to describe medical practice that incorporated natural therapies including diet, herbal medicine, hydrotherapy, homeopathy, exercise, manipulative therapies, and counseling.
- The first school of Naturopathic Medicine was founded in New York City by Dr. Lust, and graduated its first class in 1902.
- By the 1920s, Naturopathic medical conventions attracted more than 10,000 practitioners and there were over 20 naturopathic medical schools.
- Washington State became the first state to license Naturopathic Doctors in 1919, followed by Connecticut in 1920 and Hawaii in 1925.
- With the rise of pharmaceutical therapies, Naturopathic medicine experienced a decline in the 1940s and 1950s and many Naturopathic medical programs closed. To keep Naturopathic Medicine alive, National University of Naturopathic Medicine was founded in Portland, Oregon.
- The profession has experienced a resurgence in the past two decades as a health–conscious public has sought alternative and complementary healthcare with a focus on preventive medicine and natural therapies.

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THE PRINCIPLES OF NATUROPATHIC MEDICINE

- **The Healing Power of Nature (Vis Medicatrix Naturae):** Naturopathic Doctors act to identify and remove obstacles to healing and recovery, and to facilitate and augment this inherent self-healing process.
- **Identify and Treat the Causes (Tolle Causam):** Naturopathic Doctors seek to identify and remove the underlying causes of illness.
- **First Do No Harm (Primum Non Nocere):** Naturopathic Doctors follow three guidelines to avoid harming the patient:
  - Utilize methods and medicinal substances which minimize the risk of harmful side effects, using the least force necessary to diagnose and treat;
  - Avoid when possible the harmful suppression of symptoms; and
  - Acknowledge, respect, and work with individuals' natural healing process.
- **Doctor as Teacher (Docere):** Naturopathic Doctors educate their patients and encourage self-responsibility for health. They also recognize and employ the therapeutic potential of the doctor-patient relationship.
- **Treat the Whole Person:** Naturopathic Doctors treat each patient by taking into account individual physical, mental, emotional, genetic, environmental, social, spiritual, and other factors.
- **Prevention:** Naturopathic Doctors emphasize the prevention of disease by assessing risk factors, heredity and susceptibility to disease, and by making appropriate interventions in partnership with their patients to prevent illness.

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CANADIAN COLLEGE OF NATUROPATHIC MEDICINE



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EDUCATION & TRAINING

- Prerequisites for admission include completion of a bachelor's degree (or higher) and standard premedical coursework
- Completion of a 4-year, full-time, in-residence, federally accredited Naturopathic medical program leading to the Doctor of Naturopathic Medicine (ND) degree
- Coursework covers all the same basic & clinical sciences required in standard medical programs
- Additional training in clinical nutrition, botanical medicine, homeopathy, Naturopathic physical medicine, and other natural modalities
- Required preceptor shadowing throughout 4 years of training – minimum 132 hours
- Supervised clinical rotations providing direct patient care during the 3rd and 4th years of study at university/college outpatient teaching clinics – minimum 1200 hours
  - Students serve as a "secondary" clinicians during 3rd year and "primary" clinicians during 4th year of study
  - Opportunity to complete a portion of supervised clinical rotations off-site at low income community health clinics, specialty clinics, etc.

(NOTE: See Naturopathic Medical Education Comparative Curricula Chart)

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NATUROPATHIC DOCTOR EDUCATION & TRAINING ACCREDITATION

Naturopathic medical schools and programs are nationally and regionally accredited by the:

- Council for Naturopathic Medical Education (CNME)
- U.S. Department of Education
- Council for Higher Education Accreditation (CHEA)

CNME

Note: The Council for Naturopathic Medical Education (CNME) is recognized and approved by the U.S. Department of Education as the national accrediting agency for Naturopathic medical programs. The regional accrediting agencies that accredit Naturopathic medical schools and programs are recognized and approved by both the U.S. Department of Education and the Council for Higher Education Accreditation (CHEA).

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ACCREDITED NATUROPATHIC MEDICAL SCHOOLS & PROGRAMS

United States

- Bastyr University in Kenmore, Washington
- Bastyr University – California Campus in San Diego, California
- National University of Health Sciences in Lombard, Illinois
- National University of Natural Medicine in Portland, Oregon
- University of Bridgeport – College of Naturopathic Medicine in Bridgeport, Connecticut
- Southwest College of Naturopathic Medicine in Tempe, Arizona

Canada

- Boucher Institute of Naturopathic Medicine in New Westminster, British Columbia
- Canadian College of Naturopathic Medicine in Toronto, Ontario



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REQUIREMENTS FOR LICENSURE

Licensure to practice as a Naturopathic Doctor requires:

- Graduation from an accredited 4-year, full-time, in-residence Naturopathic medical program
- Passage of NPLEX* Part I (Biomedical Science) and Part II (Core Clinical Science) board examinations
- NPLEX Part I is taken after the 2nd year of study and NPLEX Part 2 is taken after graduation
- Passage of state-specific jurisprudence examinations
- In some jurisdictions, passage of NPLEX Part II Clinical Elective Examinations and/or a state/province-administered clinical board examination is an additional requirement
- Annual continuing education based on a state's licensure requirements (typically 20 – 50 hours per year)

**The Naturopathic Physicians Licensing Examination (NPLEX) is administered by the North American Board of Naturopathic Examiners (NABNE)*

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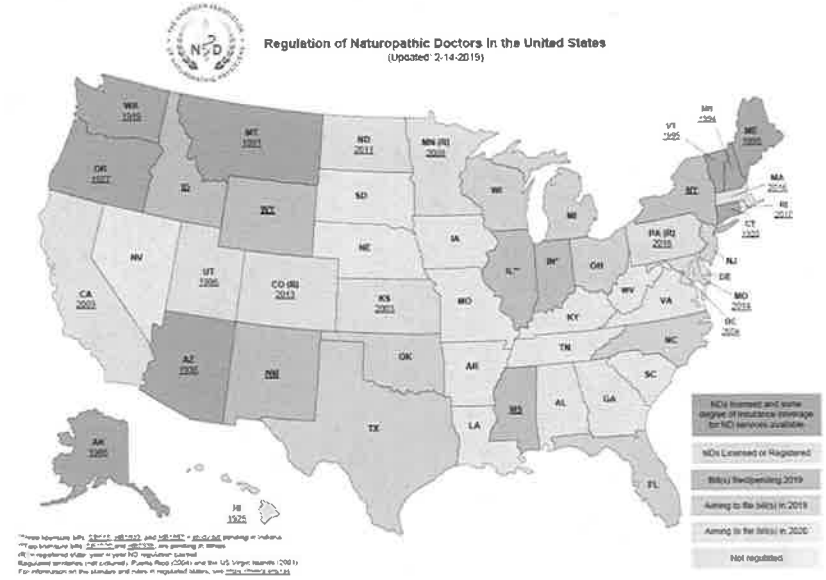
CURRENT REGULATION OF NATUROPATHIC DOCTORS

States	States	States	Districts & Territories
Alaska	Maine	Oregon	District of Columbia
Arizona	Maryland	Pennsylvania	Puerto Rico
California	Massachusetts	**Rhode Island**	US Virgin Islands
Colorado	Minnesota	Utah	
Connecticut	**Montana**	Vermont	
Hawaii	New Hampshire	Washington	
Kansas	**North Dakota**		

Naturopathic Doctors (NDs) are currently licensed or registered in 20 states, the District of Columbia, and the United States territories of Puerto Rico and the U.S. Virgin Islands. **Rhode Island** is the most recent state to license Naturopathic Doctors.

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MAP - Regulation of Naturopathic Doctors in the United States



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WHO OVERSEES REGULATION OF NATUROPATHIC DOCTORS?

- **NDs are regulated by an autonomous naturopathic medicine board** in ten states – Arizona, California, Connecticut, Hawaii, Massachusetts*, New Hampshire, Oregon, Rhode Island, Utah*, and Washington* – and in the two US territories Puerto Rico and the US Virgin Islands*
- **NDs are regulated by the state medical and/or osteopathic board** in three states -- Maryland, Minnesota, Pennsylvania – and in one additional jurisdiction -- the District of Columbia.
- **NDs are regulated by the state office of occupational licensing, professional regulation, or commerce** in three states – Alaska, Colorado, and Vermont
- **NDs are regulated by an alternative/complementary/allied health professional board** in the remaining four states – Kansas, Maine, Montana, North Dakota

*NOTE: In Utah, NDs have their own board; however, the Utah Naturopathic Medicine Board is under the Department of Professional Licensing, which oversees all licensed professions in Utah. Similarly, in Washington State, NDs have their own board; however, the Board of Naturopathy is under the Washington State Department of Health, which oversees all licensed healthcare professions in Washington. The Massachusetts Naturopathic Board and the US Virgin Islands Naturopathic Board are both housed within their respective Departments of Health.

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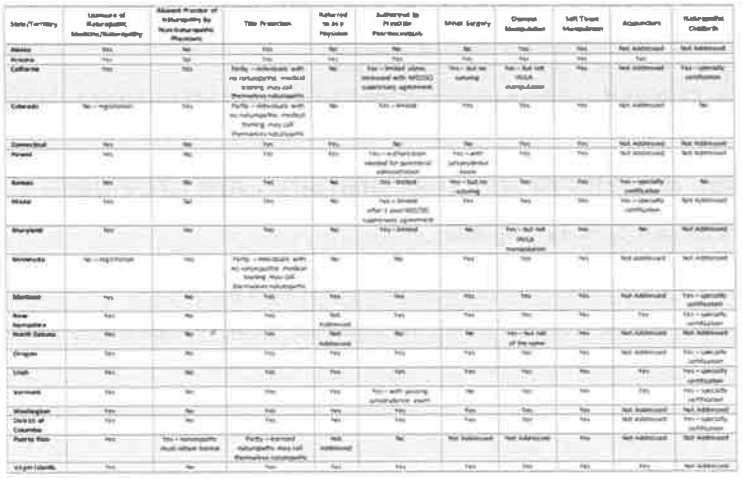
nunm NATIONAL UNIVERSITY OF Natural Medicine



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SCOPE OF PRACTICE VARIES BY JURISDICTION

Naturopathic Medicine
Scope of Practice by State



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SCOPE OF PRACTICE

In every jurisdiction, scope of practice includes the following consistent with Naturopathic medical education and training:

- Prevent, Diagnose, and Treat Health Conditions
- Order Laboratory Testing
- Order Diagnostic Imaging
- Perform Physical Examination
- Utilize Natural Therapies

Additional scope of practice varies based upon state/district/territory

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SCOPE OF PRACTICE: PRIMARY CARE

- 7 states define Naturopathic Medicine as primary health care in their definition of Naturopathic Medicine:
  - California, Colorado, Minnesota, Montana, New Hampshire, North Dakota, Utah
- Naturopathic doctors practice as primary care providers in 3 states:
  - Oregon, Vermont, Washington
- De facto, the case can be made for 6 more states:
  - Arizona, California, Connecticut, Montana, New Hampshire, Utah

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SCOPE OF PRACTICE: PHARMACEUTICAL RX

- NDs have prescription rights in 10 jurisdictions
  - Arizona, California, District of Columbia, Hawaii, Maine, Montana, New Hampshire, Oregon, Utah, Vermont, Washington, and the US Virgin Islands
- Breadth of formulary depends on state law
  - Broadest formularies to be found in Arizona, California, Hawaii, New Hampshire, Oregon, Utah, Vermont, Washington
  - California permits restricted formulary for autonomous practice, but requires collaborative agreement with MD/DO for broad formulary
  - Maine requires 1 year of collaboration with an MD/DO for access to full formulary
  - Vermont is expanding to an open formulary, but does not yet have one

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SCOPE OF PRACTICE: IV THERAPY

- Allowed in 9 states: Arizona, California, Hawaii, Kansas Montana, New Hampshire, Oregon, Utah, Washington
- Some states require special certification
- Kansas requires establishment of a protocol with an MD
- Colorado still has to determine formulary

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SCOPE OF PRACTICE: MINOR SURGERY

- Removal of foreign bodies and care of superficial tissues:
  - Alaska, California, District of Columbia, Kansas, New Hampshire
- "Minor surgery" or "Minor office procedures"
  - Arizona, Colorado, Hawaii, Maine, Minnesota, Montana, Oregon, Utah, Washington, and the US Virgin Islands

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SCOPE OF PRACTICE: CHILD DELIVERY

- 6 jurisdictions permit NDs to attend childbirth:
  - Arizona, California, District of Columbia, Montana, New Hampshire, Oregon, Utah, Vermont
- Most states require special certification
- Some states require collaboration with OB/GYNs

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NATUROPATHIC MEDICINE SPECIALTIES

- While most NDs continue to practice general Naturopathic Medicine, some choose to specialize in one area such as gastroenterology or sports medicine or one population such as pediatrics or women's health
- Others choose to specialize by modality such as botanical medicine, homeopathy, or therapeutic nutrition
- Specialty societies currently include: oncology, environmental medicine, pediatrics, gastroenterology, endocrinology, midwifery, homeopathy, and psychology

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HOW NDs WORK & COLLABORATE WITHIN HEALTHCARE

- Approximately 8000 Naturopathic Doctors in the US
- Approximately 6000 licensed Naturopathic Doctors in the US
- Approximately 40 licensable Naturopathic Doctors in North Carolina
- Most NDs work in solo or group private practice outpatient settings
- NDs work, refer, and collaborate with MDs, DOs, NPs, DCs, LAcs
- In licensed states, NDs work in community health centers, patient-centered medical homes in the states of Oregon and Vermont, and in limited hospital settings

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WHERE NDs WORK AND COLLABORATE

- Naturopathic Doctors work within public health organizations including:
  - National Center for Complementary and Alternative Health at the National Institutes of Health
  - South Texas Veterans Healthcare System
- Naturopathic Doctors are employed at over 28 medical centers of excellence including:
  - Cancer Treatment Centers of America
  - Columbia University, Herbert Irving Comprehensive Cancer Center
  - George Washington Center for Integrative Medicine
  - University of Kansas Medical Center
  - Providence Integrative Medicine Program
  - Shawnee Mission Health
  - University Hospitals, Connor Integrative Health Network
  - University of California Irvine, Susan Samueli Center for Integrative Medicine
  - University of Wisconsin Integrative Health Clinic
  - Cedars-Sinai, Los Angeles
  - Fred Hutchinson Cancer Research Center
  - HealthPoint Washington
  - Oregon Health Sciences University
  - Raby Institute for Integrative Medicine at Northwestern
  - New York University School of Medicine
  - University of Arizona Center for Integrative Medicine
  - University of Washington Medical Center – Roosevelt
  - University of Pittsburgh Medical Center for Integrative Medicine
- Naturopathic Doctors participate in research at medical centers and universities including:
  - Arizona State Diabetes Diabetes Collaborative Arizona State University
  - Kaiser-Permanente
  - Emory University
  - University of Arizona
  - University of Florida
  - University of Minnesota
  - University of Washington
  - Columbia University
  - Mayo Clinic, Scottsdale, AZ
  - Phoenix Veterans Affairs
  - University of Connecticut
  - University of Michigan
  - University of North Carolina Chapel Hill
  - Yale University and Yale-Griffin Hospital

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OPTIMAL PATIENT OUTCOMES

Licensed Naturopathic Doctors have been shown in peer reviewed medical studies to have significant health benefits. Health outcomes studies which have examined the addition of Naturopathic care to conventional care have found that:

- 19% of patients had fewer hospitalizations
- 50% had a reduction in prescription medications needed
- 42% reduced need for office visits
- Risk of cardiovascular event was reduced by 33%, and decrease in death risk due to cardiovascular event by 50%
- Increase of 9.4 "perfect health days" over 6 month period and decrease in work absenteeism for patients with chronic low back pain
- 30% increase in patients achieving blood pressure control in patients with high blood pressure

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NATUROPATHIC DOCTORS SAFETY RECORD

- Oregon has licensed Naturopathic Doctors since 1924. With approximately 1,100 licensed Naturopathic Doctors practicing in the state, Oregon had reported a total of 12 disciplinary actions as of 2016.
- A review of cases contained in Jury Verdicts Northwest's database from 2005 to 2016 showed NO cases against licensed Naturopathic Doctors.
- A review of data from the US Dept of Health & Human Services National Practitioner Databank from 2005 to 2016 showed NO cases against licensed Naturopathic Doctors in California.

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EFFORTS TO REGULATE NATUROPATHIC DOCTORS & NATUROPATHIC MEDICINE IN NORTH CAROLINA

- **FIRST NATUROPATHIC LICENSING BILL WAS INTRODUCED IN 2000 AFTER THE 1999 DEATH OF A CHILD IN BUNCOMBE COUNTY**
- **BILLS HAVE BEEN INTRODUCED IN EVERY LONG SESSION OF THE NC GENERAL ASSEMBLY SINCE THE INITIAL BILL**
- **JOINT LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS - (2011-2012) ***
- **LEGISLATIVE COMMITTEE ON NEW LICENSING BOARDS - (2009-2010) ***
- **JOINT SELECT STUDY COMMITTEE ON NATUROPATHIC LICENSING - February 1, 2005***

**Each of the licensing committees recommended licensure of Naturopathic Doctors in North Carolina.*

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WHY REGULATE NATUROPATHIC DOCTORS?

- Patient safety - ensuring safe, effective healthcare
- Provide consumers with a way of distinguishing between medically trained Naturopathic Doctors and non-medically trained individuals
- Allow Naturopathic Doctors to utilize their education and training within a defined scope of practice
- Research supports optimal patient outcomes and decreased health costs

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NUMBER OF NDs PRE- AND POST-LICENSURE (Selected States)

State	Year Regulated	# of NDs in First Year of Regulation	# of NDs in 2016/2017
ARIZONA	1935	UNKNOWN	883
CALIFORNIA	2003	129	870
COLORADO	2013	84	121
DISTRICT OF COLUMBIA	2004	7	49
NEW HAMPSHIRE	1994	11	88
OREGON	1927	20	1,100
VERMONT	1995	10	337
WASHINGTON	1919	17	1,300

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THANK YOU

We look forward to working together with members of the NC General Assembly and the medical community to secure the regulation of Naturopathic Medicine in North Carolina. Licensure will allow Naturopathic Doctors to fully utilize their education and training; collaborating with other healthcare providers as an integrated team to ensure access to safe and effective integrative care for the benefit of the people of North Carolina.



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Curriculum Comparison for UNC-CH School of Medicine's MD Program and Bastyr University's Doctorate of Naturopathic Medicine

First Year

UNC School of Medicine MD Degree

Title	Subject	Contact Hours
Molecules to Cells	• Biochemistry • Pharmacology • Genetics • Molecular Biology	162 hours
Structure and Development	• Anatomy • Embryology	272 hours
Integrative Function and its Cellular Basis	• Integrative Physiology • Histology	162 hours
Host Defense and Molecular Pathogens	• Microbiology • Pathology • Immunology	150 hours
Clinical Skill Development	• Interview • Physical Exam • Diagnostic Reasoning	187 hours
Medicine in Society	• Relationship between society and medical institutions	37.4 hours
		971 hours

Bastyr University Doctorate of Naturopathic Medicine

Title	Contact Hours
Biochemistry 1-3	132 hours
Pharmacology	55 hours
Anatomy 1-3	330 hours
Embryology	33 hours
Solving Problems in Physiology 1-3	330 hours
Histology	88 hours
Pathology 1 –3	144 hours
Infectious Disease	55 hours
Immunology	44 hours
Physical Clinical Diagnosis 1-3	236.5 hours
Naturopathic Medicine in Historical Context	55 hours
Naturopathic Medicine in Global Context	55 hours
	1557.5 hours

Totals for both schools are **contact instructional hours**. UNC hours taken from daily schedules available at: https://www.med.unc.edu/md/curriculum/calendars. Bastyr hours taken from course catalogue available at: http://www.bastyr.edu/sites/default/files/images/pdfs/course-catalog/full_catalog_11-12.pdf. At Bastyr 1 lecture credit hour equals 11 contact hours, 1 clinical credit equals 11 contact hours, and 1one laboratory credit hour equals 22 contact hours. Subjects of study are organized in the order of how they appear in UNC's program. Hours for clerkships are from sample schedules available at: http://www.med.unc.edu/md/curriculum/course-clerkship-information/course-catalog/year-3-course-descriptions/year-3-course-descriptions. (Accessed 8/15/2012).

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Curriculum Comparison for UNC-CH School of Medicine's MD Program and Bastyr University's Doctorate of Naturopathic Medicine

Second Year

UNC School of Medicine
MD Degree

Title	Contact Hours
Tools for Diagnosis and Therapy	32 hours
Hematology/Oncology	41 hours
Cardiovascular System	43 hours
Respiratory System	50 hours
Gastrointestinal System	46 hours
Urinary Renal System	47 hours
Brain and Behavior	97 hours
Endocrine System and Nutrition	47 hours
Reproductive Medicine Genetics	52.5
Musculoskeletal System/Dermatology	51 hours
Clinical Skills Integration	216 hours
Humanities and Social Science	52 hours
Clinical Epidemiology	32.5

807 hours

Bastyr University Doctorate of Naturopathic Medicine

Title	Contact Hours
Diagnostic Imaging	33 hours
Rheumatology	16.5
Oncology	22 hours
Cardiology	33 hours
Pulmonary Medicine	16.5 hours
EENT	22
Gastroenterology	22 hours
Urology	16.5 hours
Geriatrics	22
Neuroscience	77 hours
Psychological Assessment	22 hours
Endocrinology	33 hours
Macro and Micronutrients	33 hours
Genetics	22
Orthopedics	22 hours
Dermatology	22 hours
Clinical Laboratory Diagnosis 1-3	264 hours
Public Health	16.5
Clinical Ecology	22
Environmental Medicine	16.5

775.5 hours

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Curriculum Comparison for UNC-CH School of Medicine's MD Program and Bastyr University's Doctorate of Naturopathic Medicine

Third Year

UNC School of Medicine
MD Degree

Transition to Clinic		32
Family Medicine		240
Obstetrics and Gynecology		240
Neurology/Intro to Acute Care		160
Inpatient Medicine/Intro to Acute Care		360
Pediatrics		240
Psychiatry		240
Outpatient Medicine		360
Surgery		360
		2192

Hours for clerkships are from sample schedules available at: http://www.med.unc.edu/md/curriculum/course-clerkship-information/course-catalog/year-3-course-descriptions/year-3-course-descriptions. (Accessed 8/15/2012)

Bastyr University Doctorate of Naturopathic Medicine

Clinic Entry		22
Charting and Coding		11
Family Medicine		22
Naturopathic Clinical Theory		55
Shift 1-3		132
Normal Maternity		33
Gynecology		33
Shift 4-5		88
Neurology		22
Addictions and Disorders		22
Shift 6-7		88
Basic Life Support, CPR AED, pediatric		10 hour
Case Management 1-2		110
Diet and Nutrient Therapy 1-2		66
Food, Dietary Systems, Nutritional Assessment		66
Pediatrics 1-2		44
Healing Systems		11
Shift 8-11		176
Naturopathic Counseling 1-3		88
Counseling Shift 12		44
Minor Office Procedures		33
Medical Procedures		33
Radiographic Interpretation 1-2		55
Laboratory Shift 13		44
Botanical Medicine 1-5		123.5
Botanical Medicine Clinical Dispensary		44
		1475.5

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Curriculum Comparison for UNC-CH School of Medicine's MD Program and Bastyr University's Doctorate of Naturopathic Medicine

Fourth Year

UNC School of Medicine MD Degree

Advanced Practice Selective	160
AHEC Internship Selective	160
Critical Care	160
Science of Medicine	160
Electives	160
Electives	160
Electives	160
Capstone	35

1155 hours

Bastyr University Doctorate of Naturopathic Medicine

Title	Contact Hours
Advanced Naturopathic Therapeutics 1-2	44
Preceptorship 1	44
Shift 14	44
Shift 15	44
Shift 16	44
Preceptorship 2	44
Shift 17	44
Shift 18	44
Preceptorship 3	44
Critical Evaluation of the Medical Literature	22
Ethics	11
Jurisprudence	11
Professional Writing/Speaking	11
Business operations / Goal setting	22
Fundamentals of Research Design	22
TCM	33
Physiotherapy/Hydrotherapy	44
Physical Medicine shift 1-2	44
Myofacial Analysis	66
Therapeutic Manipulation 1-4	121
Sports Medicine and Therapeutic Exercise	22
Physical Medicine Shift 3-4	44
Homeopathy 1-3	88
Electives	154

1122 hours

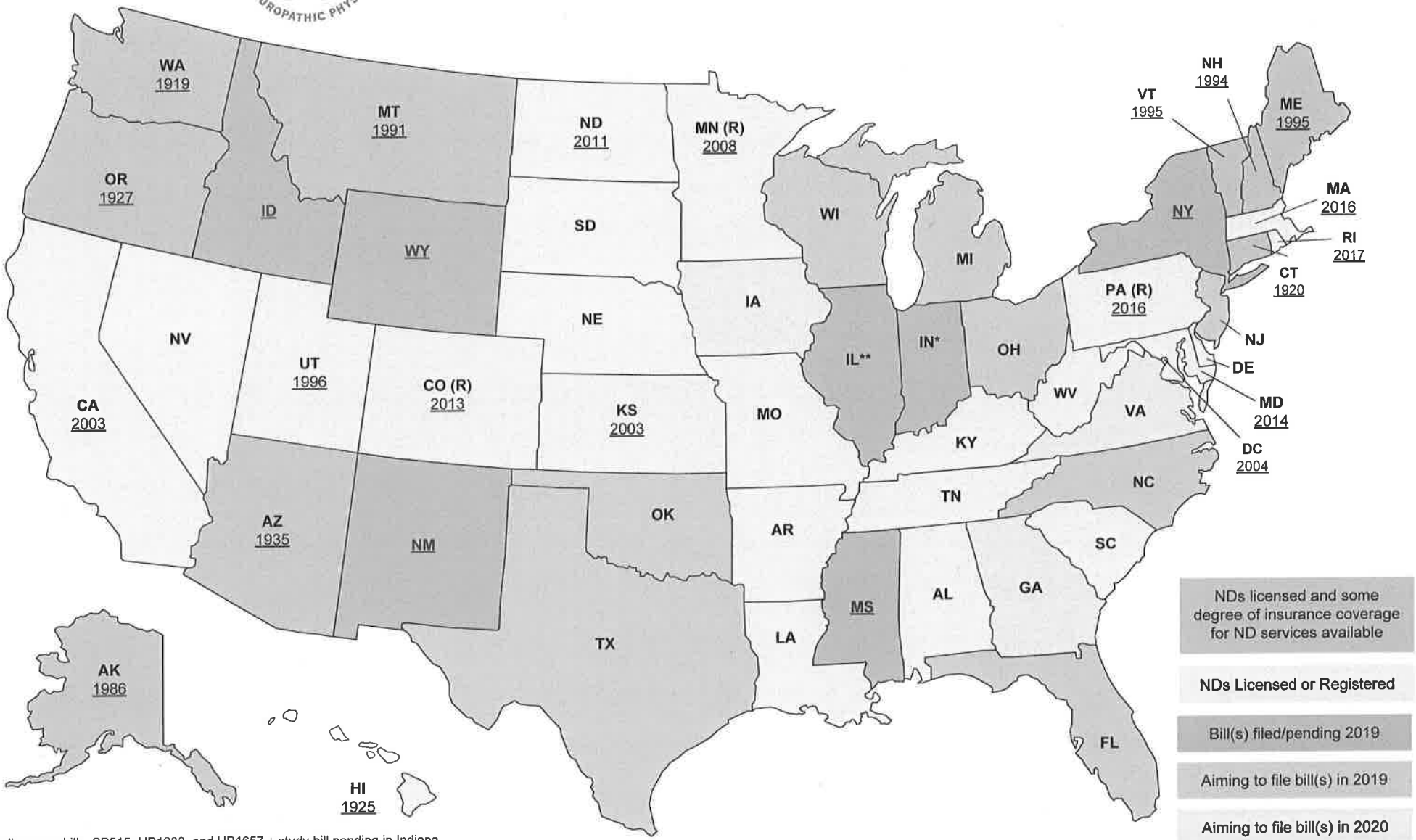
UNC MD Total 5125 hrs

Overall difference in contact hours: 194.5 hours.

Bastyr ND Total 4930.5 hrs

Regulation of Naturopathic Doctors in the United States

(Updated: 2-14-2019)



*Three licensure bills, SB515, HB1633, and HB1657 + study bill pending in Indiana.
**Two licensure bills, SB1220 and HB2338, are pending in Illinois.
(R) = registered state; year = year ND regulation passed.
Regulated territories (not pictured): Puerto Rico (2004) and the US Virgin Islands (2001).
For information on the statutes and rules in regulated states, see https://fnmra.org/ras.

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

February 21, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dana Sapa	SA
Scott McCulloch	RAA
[illegible]	CSS
LT McCrimmon	DHHS
Chandler Crawford	SA
Kara Weishaar	SA
Jackson Stancil	JSC
Sarah [illegible]	ICA
Brendan Riley	NCDC
Emma Shelby	TPG
Sue Ann Tomes	NCMS
Susie Farrell	FSP
Laura Gunter	NCSIO
JOEL MAYNARD	GPM; ADOL
Andy Ennenbach	NMSS
Christine Wesson	ACS CAN

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

February 21, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Reese Holland	Clinton Medical Clinic
Ken Melton	K.M.A.
[illegible] Robinson	Parkinson Ln
Stephen Kouba	KMA
Cary Chambers	Rep Fisher
Evelyn Contre	NC Medical Board
Maisha Evans	DRNC
[illegible]	SEANC
Rosha Fortson	SEANC
Flint Benson	SEANC
Jimmy DAVIS	SEANC
Padraig Gibbons	Connect C
Sarah Wolfe	MWC
Ardis Watkins	SEANC

09-21-201

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 643 LOB

DATE: 2-21 **TIME:** 15 mins. after session

PLEASE PRINT LEGIBLY....*or else!!!!!*

	Page Name	Hometown	Sponsoring Senator
1.	Michael Cartwright	Salisbury	Berger
2.	~~Ashleigh Fretts~~	~~Charlotte~~	~~Waddell~~
3.	Clay Williams	Raleigh	Chaudhuri
4.			
5.			
6.			
7.			
8.			

Notes: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee

On

HEALTH CARE

February 21, 2019 – 11:00 AM

(15 minutes after session)

Room 643

Senate Sergeant at Arms:

BILLY FRITSCHER

LINDA MATTHEWS

CHARLES MARSALIS

SHEREE HEDRICK

FRANK URBEN

Senate Committee on Health Care
Wednesday, March 6, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on March 6, 2019 in Room 643 of the Legislative Office Building. Fourteen members were present.

Senator Joyce Krawiec, Chair, presided.

SB 86 Small Business Healthcare Act. (Senators Bishop, Krawiec, Edwards)

Sen. Krawiec reminded the members that SB 86 was for discussion only. Sen. Bishop moved to accept the Proposed Committee Substitute (PCS) before the committee and it was seconded by Sen. Woodard. The motion carried. Sen Edward was recognized to speak on the PCS. Questions from the members where responded to by: Jason Moran-Bates/Legislative Analysis Division, Sen. Bishop, Robert D. Croom/Attorney for the North Carolina Department of Insurance (NCDOI), and Sen. Edwards. Sen. Krawiec permitted comments from the audience. They were as follows: Leah Burns/Government Relations Director for NC Healthcare Association, and Mark Zimmerman/NC Realtors.

The meeting adjourned at 10:55 AM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

Senate Committee on Health Care
Wednesday, March 6, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 86	Small Business Healthcare Act.	Senator Bishop Senator Krawiec Senator Edwards

FOR DISCUSSION ONLY

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S D

SENATE BILL 86
PROPOSED COMMITTEE SUBSTITUTE S86-CSBC-7 [v.5]
03/05/2019 04:36:33 PM

Short Title: Small Business Healthcare Act. (Public)

Sponsors:

Referred to:

February 20, 2019

A BILL TO BE ENTITLED

AN ACT TO CREATE GREATER OPPORTUNITIES FOR SMALL EMPLOYERS TO PROVIDE EMPLOYEES ACCESS TO HEALTH INSURANCE.

Whereas, Association Health Plans are regulated by multiple consumer protection provisions contained in the Employee Retirement Income Security Act (ERISA), including provisions under the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, and the Genetic Information Nondiscrimination Act; and

Whereas, under ERISA, the State has been regulating self-insured Association Health Plans in such a way that, in addition to the federal consumer protections that apply to the fully insured Association Health Plans, fully protects the citizens of this State; and

Whereas, new federal Department of Labor regulations regarding Association Health Plans allow for states to provide greater opportunities for small businesses and self-employed individuals to access health benefit plans, while still providing health insurance consumers with the coverage protections established by the foregoing legislation and other provisions of federal law; Now, therefore,

The General Assembly of North Carolina enacts:

PART I. MORE OPPORTUNITIES FOR SMALL EMPLOYERS AND SOLE PROPRIETORS TO ACCESS SELF-INSURED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS/ASSOCIATION HEALTH PLANS.

SECTION 1.(a) G.S. 58-49-40(a) reads as rewritten:

"(a) ~~To meet the requirements for issuance of a license and to maintain a~~ To qualify for licensure as a MEWA, a MEWA must ~~be:~~meet all of the following requirements:

(1) ~~Nonprofit:~~Be a nonprofit.

(2) ~~Established by a trade association, industry association, or professional association of employers or professionals~~Be established by a group of employers under an association that (i) has a constitution or ~~bylaws and that~~bylaws, (ii) has been organized and maintained in good faith for a continuous period of ~~five years for purposes other than that of obtaining or providing insurance;~~at least two years, and (iii) has at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees.

(3) ~~Operated~~ Be operated pursuant to a trust agreement by a board of trustees that has complete fiscal control over the MEWA and that is responsible for all

operations of the MEWA. Except as provided in this subdivision, the trustees must be owners, partners, officers, directors, or employees of one or more employers in the MEWA. With the Commissioner's approval, a person who is not such an owner, partner, officer, director, or employee may serve as a trustee if that person possesses the expertise required for such service. A trustee may not be an owner, officer or employee of the administrator or service company of the MEWA. The trustees have the authority to approve applications of association members for participation in the MEWA and to contract with an authorized administrator or service company to administer the operations of the ~~MEWA;~~MEWA.

(4) ~~Neither~~ Be neither offered nor advertised to the public ~~generally; and~~generally.

(5) ~~Operated~~ Be operated in accordance with sound actuarial principles.

(6) Have a commonality of interest as described in subsection (h) of this section.

(7) Have at least 500 covered lives."

SECTION 1.(b) G.S. 58-49-40 is amended by adding one new subsection to read:

"(h) A MEWA will be treated as having a commonality of interest if either of the following is true:

(1) It is established by a group of employers under an association in the same trade, industry, line of business, or profession.

(2) It is established by employers under an association in the same region or metropolitan area, provided that region or area is contiguous to the State and includes the State."

SECTION 1.(c) G.S. 58-49-30 is amended by adding a new subsection to read:

"(f) As used in this section, the term "employer" shall include sole proprietors and self-employed workers."

SECTION 1.(d) G.S. 58-49-50 is amended by adding a new subdivision to read:

"(10a) A copy of the most recent M-1 form as filed with the United States Department of Labor."

PART II. REGULATIONS IMPACTING FULLY INSURED ASSOCIATION HEALTH PLANS.

SECTION 2.(a) G.S. 58-51-80(b)(1) reads as rewritten:

"(b) No policy or contract of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this State unless the group of persons ~~thereby~~ insured by the policy or contract conforms to ~~the requirements of the following subdivisions:~~all of the following requirements:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, or by a principal or two or more principals in the same industry or kind of business, which employer, principal, or trustee shall be deemed the policyholder, covering, except as hereinafter provided, only employees, or agents, of any class or classes thereof determined by conditions pertaining to employment, or agency, for amounts of insurance based upon some plan which will preclude individual selection. The premium may be paid by the employer, by the employer and the employees jointly, or by the employee; and where the relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents, jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis. For the

purposes of this subdivision, the term "employer" includes a multiple employer welfare arrangement that has at least 500 covered lives and is classified by the United States Department of Labor as a bona fide group or association under at least one of the following:

a. The requirements set forth in section 3(5) of the Employee Retirement Income Security Act of 1974 and implementing regulations, including 29 C.F.R. Part 2510.

b. Any United States Department of Labor advisory opinion addressing circumstances in which the United States Department of Labor will consider a person as able to act directly or indirectly in the interest of direct employers in sponsoring an employee welfare benefit plan."

SECTION 2.(b) G.S. 58-51-80(b)(1a) reads as rewritten:

"(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least ~~five~~ two years; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members, other than associate members, have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

…."

SECTION 2.(c) G.S. 58-68-25(a) reads as rewritten:

"**§ 58-68-25. Definitions; excepted benefits; employer size rule.**

(a) Definitions. – ~~In addition to other definitions throughout this Article, the~~ The following definitions ~~and their cognates~~ apply in this Article:

(1) ~~"Bona~~ Bona fide ~~association".~~ association. – With respect to health insurance coverage offered in this State, an association ~~that:~~meeting all of the following requirements:

a. Has been actively in existence for at least five years.

b. Has been formed and maintained in good faith for purposes other than obtaining insurance.

c. Does not condition membership in the association on any health status-related factor relating to an ~~individual (including~~ individual, including an employee of an employer or a dependent of an ~~employee).~~employee.

d. Makes health insurance coverage offered through the association available to all members and individuals eligible for coverage through a member regardless of any health status-related factor relating to the ~~members (or individuals eligible for coverage through a member).~~members or eligible individuals.

e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

f. Meets the additional requirements as may be imposed under State law.

(2) ~~"COBRA~~ COBRA continuation ~~provision".~~ provision. – Any of the following:

a. Section 4980B of the Internal Revenue Code of 1986, other than subdivision (f)(1) of the section insofar as it relates to pediatric vaccines.
b. Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of the Act.
c. Requirements for certain group health plans for certain State and local employees under Title XXII of the Public Health Service ~~Act (42 U.S.C.S. § 300bb, et seq.,) as requirements for certain group health plans for certain State and local employees.~~Act.
d. Article 53 of this ~~Chapter or the~~ Chapter.
e. The health insurance continuation law of another state.

(3) ~~"Employee".~~ Employee. – ~~The meaning given the term under~~ As defined in section 3(6) of the Employee Retirement Income Security Act of 1974.

(4) ~~"Employer".~~ Employer. – ~~The meaning given the term under~~ As defined in section 3(5) of the Employee Retirement Income Security Act of ~~1974, except that the term shall include only employers of two or more employees.~~1974.

(4a) ~~"Group~~ Group health insurance ~~coverage".~~ coverage. – Health insurance coverage offered in connection with a group health plan.

(4b) ~~"Group~~ Group health ~~plan".~~ plan. – ~~The meaning given the term under~~ As defined in 45 C.F.R. § 146.145(a).

(4c) ~~"Group market."~~ Group market. – The market for health insurance coverage offered in connection with a group health plan.

(5) ~~"Health~~ Health insurance ~~coverage" or "coverage" or "health insurance plan" or "plan".~~ coverage, health insurance plan, coverage, or plan. – Benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under any accident and health insurance policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, written by a health insurer. Health insurance coverage includes group health insurance coverage and individual health insurance coverage.

(6) ~~"Health insurer".~~ Health insurer. – An insurance company subject to this Chapter, a hospital or medical service corporation subject to Article 65 of this Chapter, a health maintenance organization subject to Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 49 of this Chapter, that offers and issues health insurance coverage.

(7) ~~"Health~~ Health status-related ~~factor".~~ factor. – Any of the factors described in G.S. 58-68-35(a)(1).

(8) ~~"Individual~~ Individual health insurance ~~coverage".~~ coverage. – Health insurance coverage offered to individuals in the individual market, but not short-term limited duration insurance.

(9) ~~"Individual market".~~ Individual market. – The market for health insurance coverage offered to individuals.

(10) ~~"Large employer".~~ Large employer. – An employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least ~~two employees~~ one employee on the first day of the health insurance plan year.

(11) ~~"Large~~ Large group ~~market".~~ market. – The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a large employer.

(12) ~~"Medical care".~~ Medical care. – Amounts paid ~~for:~~for any of the following:

a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or ~~amounts paid~~ for the purpose of affecting any structure or function of the body.
b. ~~Amounts paid for transportation~~ Transportation primarily for and essential to medical care ~~referred to in~~ under sub-subdivision a. of this subdivision.
c. ~~Amounts paid for insurance~~ Insurance covering medical care ~~referred to in~~ under sub-subdivisions a. and b. of this subdivision.

(13) ~~"Network plan".~~ Network plan. – Health insurance coverage of a health insurer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of health care providers under contract with the health insurer.

(14) ~~"Participant".~~ Participant. – ~~The meaning given the term~~ As defined under section 3(7) of the Employee Retirement Income Security Act of 1974.

(15) ~~"Placed for adoption".~~ Placed for adoption. – The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation.

(16) ~~"Small employer".~~ Small employer. – ~~The meaning given to the term in G.S. 58-50-110(22).~~ As defined in G.S. 58-50-110(22).

(17) ~~"Small~~ Small group ~~market".~~ market. – The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a small employer."

PART III. ALLOW MORE SMALL EMPLOYERS TO PURCHASE STOP-LOSS COVERAGE.

SECTION 3. G.S. 58-50-130(a)(5) reads as rewritten:

"(5) No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers who employ fewer than ~~26~~ 12 eligible employees that does not comply with the underwriting, rating, and other applicable standards in this Act. An insurer shall not issue a stop loss health insurance policy to any person, firm, corporation, partnership, or association defined as a small employer that does any of the following:
a. Provides direct coverage of health expenses payable to an individual.
b. Has an annual attachment point for claims incurred per individual that is lower than twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.
c. Has an annual aggregate attachment point lower than the greater of one of the following:
1. One hundred twenty percent (120%) of expected claims.
2. Twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All

Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.

Nothing in this subsection prohibits an insurer from providing additional incentives to small employers with benefits promoting a medical home or benefits that provide health care screenings, are focused on outcomes and key performance indicators, or are reimbursed on an outcomes basis rather than a fee-for-service basis."

PART IV. EFFECTIVE DATE

SECTION 4. This act is effective October 1, 2019, and applies to contracts entered into, amended, or renewed on or after that date, and to licenses issued or renewed on or after that date.

SENATE BILL 86:
Small Business Healthcare Act.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	March 5, 2019
Introduced by:	Sens. Bishop, Krawiec, Edwards	**Prepared by:**	Jason Moran-Bates
Analysis of:	PCS to First Edition S86-CSBC-7		Staff Attorney

OVERVIEW: The Proposed Committee Substitute to Senate Bill 86 would allow business associations to obtain group health insurance for their members in accordance with newly-issued federal rules. It would also allow insurers to sell stop loss insurance to employers with twelve or more employees. The PCS makes a few technical changes to the original bill. It also requires an association to have at least 500 covered lives before it can obtain self-funded or fully-insured group health insurance plans.

CURRENT LAW: Under current law, in order to be licensed for the purposes of obtaining group health insurance, a Multiple Employer Welfare Arrangement (MEWA) must be: (1) a non-profit organization, (2) established by a business association that has been in existence for at least five years for purposes other than obtaining insurance, (3) run by a board of trustees with complete fiscal control over the association, (4) not offered to the public generally, and (5) run on sound actuarial principles.

In order to obtain a fully-insured association health plan (AHP), a business association must be in existence for at least five years. Currently, the term "employer" does not necessarily include MEWAs for purposes of obtaining a fully-insured health plan. Under current law, MEWAs do not have to meet any size requirements before being able to obtain self-funded group health insurance. Associations cannot obtain group health insurance unless they are made up of 500 persons.

Insurers may not provide stop loss insurance to an employer with fewer than 26 employees.

BILL ANALYSIS:

Part I of the PCS to Senate Bill 86 would amend G.S. 58-49-40 to codify in North Carolina law the new federal regulations for AHPs as they pertain to MEWAs.

Section 1.(a) would allow associations that had been in existence for two years, rather than five, to obtain licensure as a MEWA. It would also require MEWAs to have one substantial business purpose other than offering insurance, have a commonality of interest, and to consist of at least 500 covered lives.

Section 1.(b) would define "commonality of interest" to mean either: (1) established by employers in the same trade, industry, line of business, or profession; or (2) established by employers in the same region or metropolitan area of the State.

Section 1.(c) would allow sole proprietors and self-employed workers to participate in a MEWA.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Part II of the PCS to Senate Bill 86 would amend G.S. 58-51-80 to codify in North Carolina law the new federal regulations for association health plans as they pertain to fully-insured AHPs.

Section 2.(a) would define the term "employer" in 58-51-80(b)(1) to include a MEWA that has at least 500 covered lives and meets the new federal requirements for business associations.

Section 2.(b) would amend G.S. 58-51-80(b)(1a) to allow associations that had been in existence for two years, rather than five, to obtain group health insurance.

Section 2.(c) would amend G.S.58-68-25(a) to require bona fide associations to offer insurance coverage to all individuals eligible for coverage through a member of the association. It also would make conforming changes to G.S. 58-68-25(a).

Part III of the PCS would amend G.S. 58-50-130(a)(5) to allow insurers to provide stop loss insurance to small employers with 12 or more employees.

EFFECTIVE DATE: This act would be effective October 1, 2019, and apply to contracts entered into, amended, or renewed on or after that date and licenses issued or renewed on or after that date.

BACKGROUND: An Association Health Plan (AHP) is a group health insurance plan offered to a business association. The members of the business association are usually individual employers. AHPs can be fully funded, or they can be self-insured. A business association that obtains a self-insured AHP is generally referred to as a Multiple Employer Welfare Arrangement (MEWA). Because AHPs are group health insurance, they are regulated—for the most part—by the Employee Retirement Income Security Act (ERISA).

Prior to 2018, the federal Department of Labor had several requirements a business association had to meet before it could obtain an AHP. First, the individual employer members of the association had to have a commonality of interest, usually defined as a "close economic or representational nexus" with the association. Second, the association had to exist for a bona fide purpose other than offering insurance. Third, the employer members of the association had to have employees; they could not be sole proprietorships.

In late 2018, the Department of Labor changed the requirements. Under the new rules, a commonality of interest will exist if the employer members of the association are either (1) in the same trade, industry, profession, or line of business, or (2) in the same geographic area. The new rules permit the association to obtain an AHP if it has a substantial business purpose other than offering insurance, even if the principal purpose of the association is offering benefits. The employee requirement was dropped entirely; sole proprietors can now join business associations and obtain AHPs.

SENATE BILL 86

Short Title:	Small Business Healthcare Act.	(Public)
Sponsors:	Senators Bishop, Krawiec, Edwards (Primary Sponsors); Ballard, Brown, Burgin, Daniel, J. Davis, Ford, Hise, Johnson, McInnis, Newton, Perry, and Steinburg.	
Referred to:	Rules and Operations of the Senate	

February 20, 2019

A BILL TO BE ENTITLED

AN ACT TO CREATE GREATER OPPORTUNITIES FOR SMALL EMPLOYERS TO PROVIDE EMPLOYEES ACCESS TO HEALTH INSURANCE.

Whereas, Association Health Plans are regulated by multiple consumer protection provisions contained in the Employee Retirement Income Security Act (ERISA), including provisions under the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, and the Genetic Information Nondiscrimination Act; and

Whereas, under ERISA, the State has been regulating self-insured Association Health Plans in such a way that, in addition to the federal consumer protections that apply to the fully insured Association Health Plans, fully protects the citizens of this State; and

Whereas, new federal Department of Labor regulations regarding Association Health Plans allow for states to provide greater opportunities for small businesses and self-employed individuals to access health benefit plans, while still providing health insurance consumers with the coverage protections established by the foregoing legislation and other provisions of federal law; Now, therefore,

The General Assembly of North Carolina enacts:

PART I. MORE OPPORTUNITIES FOR SMALL EMPLOYERS AND SOLE PROPRIETORS TO ACCESS SELF-INSURED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS/ASSOCIATION HEALTH PLANS.

SECTION 1.(a) G.S. 58-49-40(a) reads as rewritten:

"(a) ~~To meet the requirements for issuance of a license and to maintain a~~ To qualify for licensure as a MEWA, a MEWA must ~~be:~~meet all of the following requirements:

(1) ~~Nonprofit;~~Be a nonprofit.

(2) ~~Established by a trade association, industry association, or professional association of employers or professionals that has~~ Have a constitution or bylaws and ~~that has~~ have been organized and maintained in good faith for a continuous period of ~~five~~ at least two years for purposes other than that of obtaining or providing ~~insurance;~~insurance.

(3) ~~Operated~~ Be operated pursuant to a trust agreement by a board of trustees that has complete fiscal control over the MEWA and that is responsible for all operations of the MEWA. Except as provided in this subdivision, the trustees must be owners, partners, officers, directors, or employees of one or more

employers in the MEWA. With the Commissioner's approval, a person who is not such an owner, partner, officer, director, or employee may serve as a trustee if that person possesses the expertise required for such service. A trustee may not be an owner, officer or employee of the administrator or service company of the MEWA. The trustees have the authority to approve applications of association members for participation in the MEWA and to contract with an authorized administrator or service company to administer the operations of the ~~MEWA;~~MEWA.

(3a) Have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees.

(3b) Have a commonality of interest as described in subsection (h) of this section.

(4) ~~Neither~~ Be neither offered nor advertised to the public ~~generally; and~~generally.

(5) ~~Operated~~ Be operated in accordance with sound actuarial principles."

SECTION 1.(b) G.S. 58-49-40 is amended by adding one new subsection to read:

"(h) A MEWA will be treated as having a commonality of interest if either of the following is true:

(1) It is established by employers in the same trade, industry, line of business, or profession.

(2) It is established by employers in the same region or metropolitan area, provided that region or area is contiguous to the State and includes the State."

SECTION 1.(c) G.S. 58-49-30 is amended by adding a new subsection to read:

"(f) As used in this section, the term "employer" shall include sole proprietors and self-employed workers."

SECTION 1.(d) G.S. 58-49-50 is amended by adding a new subdivision to read:

"(10a) A copy of the most recent M-1 form as filed with the United States Department of Labor."

PART II. REGULATIONS IMPACTING FULLY INSURED ASSOCIATION HEALTH PLANS.

SECTION 2.(a) G.S. 58-51-80(b)(1) reads as rewritten:

"(b) No policy or contract of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this State unless the group of persons ~~thereby~~ insured by the policy or contract conforms to ~~the requirements of the following subdivisions:~~all of the following requirements:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, or by a principal or two or more principals in the same industry or kind of business, which employer, principal, or trustee shall be deemed the policyholder, covering, except as hereinafter provided, only employees, or agents, of any class or classes thereof determined by conditions pertaining to employment, or agency, for amounts of insurance based upon some plan which will preclude individual selection. The premium may be paid by the employer, by the employer and the employees jointly, or by the employee; and where the relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents, jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis. For the purposes of this subdivision, the term "employer" includes a multiple

employer welfare arrangement that is classified by the United States Department of Labor as a bona fide group or association under at least one of the following:

a. The requirements set forth in section 3(5) of the Employee Retirement Income Security Act of 1974.

b. Any United States Department of Labor advisory opinion addressing circumstances in which the United States Department of Labor will consider a person as able to act directly or indirectly in the interest of direct employers in sponsoring an employee welfare benefit plan."

SECTION 2.(b) G.S. 58-51-80(b)(1a) reads as rewritten:

"(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least ~~five~~ two years; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members, other than associate members, have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

…."

SECTION 2.(c) G.S. 58-68-25(a) reads as rewritten:

"**§ 58-68-25. Definitions; excepted benefits; employer size rule.**

(a) Definitions. – ~~In addition to other definitions throughout this Article, the~~ The following definitions ~~and their cognates~~ apply in this Article:

(1) ~~"Bona~~ Bona fide ~~association".~~ association. – With respect to health insurance coverage offered in this State, an association ~~that:~~meeting all of the following requirements:

a. Has been actively in existence for at least five years.

b. Has been formed and maintained in good faith for purposes other than obtaining insurance.

c. Does not condition membership in the association on any health status-related factor relating to an ~~individual (including~~ individual, including an employee of an employer or a dependent of an ~~employee).~~employee.

d. Makes health insurance coverage offered through the association available to all members and individuals eligible for coverage through a member regardless of any health status-related factor relating to the ~~members (or individuals eligible for coverage through a member).~~members or eligible individuals.

e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

f. Meets the additional requirements as may be imposed under State law.

(2) ~~"COBRA~~ COBRA continuation ~~provision".~~ provision. – Any of the following:

a. Section 4980B of the Internal Revenue Code of 1986, other than subdivision (f)(1) of the section insofar as it relates to pediatric vaccines.

b. Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of the Act.

c. Requirements for certain group health plans for certain State and local employees under Title XXII of the Public Health Service ~~Act (42 U.S.C.S. § 300bb, et seq.,) as requirements for certain group health plans for certain State and local employees.~~Act.

d. Article 53 of this ~~Chapter or the~~ Chapter.

e. The health insurance continuation law of another state.

(3) ~~"Employee".~~ Employee. – ~~The meaning given the term under~~ As defined in section 3(6) of the Employee Retirement Income Security Act of 1974.

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(4b) ~~"Group~~ Group health ~~plan".~~ plan. – ~~The meaning given the term under~~ As defined in 45 C.F.R. § 146.145(a).

(4c) ~~"Group market."~~ Group market. – The market for health insurance coverage offered in connection with a group health plan.

(5) ~~"Health~~ Health insurance ~~coverage" or "coverage" or "health insurance plan" or "plan".~~ coverage, health insurance plan, coverage, or plan. – Benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under any accident and health insurance policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, written by a health insurer. Health insurance coverage includes group health insurance coverage and individual health insurance coverage.

(6) ~~"Health insurer".~~ Health insurer. – An insurance company subject to this Chapter, a hospital or medical service corporation subject to Article 65 of this Chapter, a health maintenance organization subject to Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 49 of this Chapter, that offers and issues health insurance coverage.

(7) ~~"Health~~ Health status-related ~~factor".~~ factor. – Any of the factors described in G.S. 58-68-35(a)(1).

(8) ~~"Individual~~ Individual health insurance ~~coverage".~~ coverage. – Health insurance coverage offered to individuals in the individual market, but not short-term limited duration insurance.

(9) ~~"Individual market".~~ Individual market. – The market for health insurance coverage offered to individuals.

(10) ~~"Large employer".~~ Large employer. – An employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least ~~two employees~~ one employee on the first day of the health insurance plan year.

(11) ~~"Large~~ Large group ~~market".~~ market. – The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a large employer.

(12) ~~"Medical care".~~ Medical care. – Amounts paid ~~for:~~for any of the following:

a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or ~~amounts paid~~ for the purpose of affecting any structure or function of the body.

b. ~~Amounts paid for transportation~~ Transportation primarily for and essential to medical care ~~referred to in~~ under sub-subdivision a. of this subdivision.

c. ~~Amounts paid for insurance~~ Insurance covering medical care ~~referred to in~~ under sub-subdivisions a. and b. of this subdivision.

(13) ~~"Network plan".~~ Network plan. – Health insurance coverage of a health insurer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of health care providers under contract with the health insurer.

(14) ~~"Participant".~~ Participant. – ~~The meaning given the term~~ As defined under section 3(7) of the Employee Retirement Income Security Act of 1974.

(15) ~~"Placed for adoption".~~ Placed for adoption. – The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation.

(16) ~~"Small employer".~~ Small employer. – ~~The meaning given to the term in G.S. 58-50-110(22).~~ As defined in G.S. 58-50-110(22).

(17) ~~"Small~~ Small group ~~market".~~ market. – The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a small employer."

PART III. ALLOW MORE SMALL EMPLOYERS TO PURCHASE STOP-LOSS COVERAGE.

SECTION 3. G.S. 58-50-130(a)(5) reads as rewritten:

"(5) No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers who employ fewer than ~~26~~ 12 eligible employees that does not comply with the underwriting, rating, and other applicable standards in this Act. An insurer shall not issue a stop loss health insurance policy to any person, firm, corporation, partnership, or association defined as a small employer that does any of the following:

a. Provides direct coverage of health expenses payable to an individual.

b. Has an annual attachment point for claims incurred per individual that is lower than twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.

c. Has an annual aggregate attachment point lower than the greater of one of the following:

1. One hundred twenty percent (120%) of expected claims.

2. Twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be

the index as of July of the year preceding the change divided by the index as of July 2012.

Nothing in this subsection prohibits an insurer from providing additional incentives to small employers with benefits promoting a medical home or benefits that provide health care screenings, are focused on outcomes and key performance indicators, or are reimbursed on an outcomes basis rather than a fee-for-service basis."

PART IV. EFFECTIVE DATE

SECTION 4. This act is effective October 1, 2019, and applies to contracts entered into, amended, or renewed on or after that date, and to licenses issued or renewed on or after that date.

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

March 6, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	RAHC, NCMA-AHAs NCPSA
Henry M Lancaster III	LGA
David Heinen	NC Center for Nonprofits
Andy Chase	KMA
CS Hollis	CSKI
Jack Lane	CSKI
Megan Powell	NCPA
Lisa Riegel	AARP
Matt Gross	DHHS
Ken Melton	K.M.A.
Mark Fleming	BCBSNC
Sarah [illegible]	NHA
Ukan Anderson	BPS
Tom Stellsch-dt	ALG
[illegible] Peterson	Pediatric Advocacy
[illegible]	NMRS

09-21-201

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

March 6, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Catherine Moore	NC Board of Nursing
Debra Parkinson	Parkinson Law
Robert Croom	NCDOI
TED HAMBY	NC DOI
Cassidy Roberton	AMGA
AMES SIMMONS	EQUALITY NC
Rosha Fortson	SEANC
Padraig Gibbons	Connect C
Sarah Patterson	WM
April Byrd	CONNECT SMITH/SUNOVION
ANTHONY SEVERONI	SUNOVION
Johnson Beasley	Blue Cross NC
	CSS
Peg O'Connell	March of Dimes
Tiffany Gladney	NC Rural Center

09-21-201

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

March 6, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lynn Puma	158 Clover Bank Rd Mooresville, NC 28115
Kirby Consier	Novartis / Alexion
Rob May	Novartis / Alexion
Dan Sipe	SG
Scott Lampe	HHS
Bob Rucho	BCBS
Margo Metegar	NCKLA
Isabel Villa-Garcia	NCKLA

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

March 6, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susie Farrell	FSA
Leah Bevins	NCHA
Sarah McQuillan	KGANC
[illegible]	Pharm. Assoc.
Seth Palmer	NCR
CADY THOMAS	FPA
MARK ZIMMERMAN	NCR
Jeff Horton	NCSLA
[illegible]	CCS
[illegible]	CCS
Matt Rousculp	GSK
Maeve Grace	GSK
Bre Hager	CapeMont
Marissa Turner	TSS
Daniel Blum	Troutman
Davida Summerlin	Gov. Office
Lexi Allen	AAmn & Co.

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

March 6, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Hughes Waren	NC Assoc of Heath Underwriters Wilmington
Joe Stewart	11 ANC /HEALTH
Ashley Elle	NCPWH
Kara Weishaar	SA
Heather Robinson	NCPWH
Kacy Kiser	NPWH
Christine Cruc	WakeMed
Amanda Donoven	KTS
Peyton Myers	
Paul Sherman	NCAB
Steven Sawyer	Medical Mutual
Alyssa Boone	NCMS
Tim Moore	CCA
Richard Simpson	NCMS
Sue Ann Forest	NCMS
JERRY SCHILL	NC Fisheries Assn
Teresa Edwards	Senator Edwards office

09-21-201

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 643 LOB

DATE: 3-6 **TIME:** 10 AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

Page Name	Hometown	Sponsoring Senator
1. Ayonna Washington	Forest City	Hise
2. Jake Willis	Cherryville	Harrington
3. Nora Flynn-McIver	Asheville	Van Duyn
4. Kennedy Young	Asheville	Van Duyn
5.		
6.		
7.		
8.		

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee

On Health Care

March 6, 2019

Room 643 LOB

10:00 AM

Senate Sergeant at Arms:

Terry Barnhardt

Chris Moore

Senate Committee on Health Care
Thursday, March 7, 2019 at 10:00 AM
Room 544 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on March 07, 2019, in Room 544 of the Legislative Office Building. Eleven members were present.

Senator Dan Bishop, Chair, presided.

Jake Willis sponsored by Sen. Harrington, Nora Flynn-McIver sponsored by Sen. Van Duyn, and Ayonna Washington sponsored by Sen. Hise served as pages.

SB 86 - Small Business Healthcare Act

Sen. Bishop recognized Sen. Krawiec for a motion. Sen. Krawiec moved to amend the bill. Sen. Woodard moved to approve the amendment and the motion carried. Questions from Sen. Davis were answered by Jason Moran-Bates from the Legislative Analysis Division.

Sen. Hise motioned for a favorable report on the proposed committee substitute as amended, rolled into a new proposed committee substitute, unfavorable to the original bill with a serial referral to Rules. The motion carried.

The meeting adjourned at 10:07 AM.

Senator Dan Bishop, Chair
Presiding

John Wynne, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Thursday, March 07, 2019

Senator Bishop,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

SB **86** Small Business Healthcare Act.

Draft Number:	S86-PCS45094-BC-8
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Dan Bishop will handle SB 86



Senate Committee on Health Care
Thursday, March 7, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 86	Small Business Healthcare Act.	Senator Bishop Senator Krawiec Senator Edwards

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S D

SENATE BILL 86
PROPOSED COMMITTEE SUBSTITUTE S86-CSBC-7 [v.5]
03/05/2019 04:36:33 PM

Short Title: Small Business Healthcare Act. (Public)

Sponsors:

Referred to:

February 20, 2019

A BILL TO BE ENTITLED

AN ACT TO CREATE GREATER OPPORTUNITIES FOR SMALL EMPLOYERS TO PROVIDE EMPLOYEES ACCESS TO HEALTH INSURANCE.

Whereas, Association Health Plans are regulated by multiple consumer protection provisions contained in the Employee Retirement Income Security Act (ERISA), including provisions under the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, and the Genetic Information Nondiscrimination Act; and

Whereas, under ERISA, the State has been regulating self-insured Association Health Plans in such a way that, in addition to the federal consumer protections that apply to the fully insured Association Health Plans, fully protects the citizens of this State; and

Whereas, new federal Department of Labor regulations regarding Association Health Plans allow for states to provide greater opportunities for small businesses and self-employed individuals to access health benefit plans, while still providing health insurance consumers with the coverage protections established by the foregoing legislation and other provisions of federal law; Now, therefore,

The General Assembly of North Carolina enacts:

PART I. MORE OPPORTUNITIES FOR SMALL EMPLOYERS AND SOLE PROPRIETORS TO ACCESS SELF-INSURED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS/ASSOCIATION HEALTH PLANS.

SECTION 1.(a) G.S. 58-49-40(a) reads as rewritten:

"(a) ~~To meet the requirements for issuance of a license and to maintain a~~ To qualify for licensure as a MEWA, a MEWA must ~~be:~~meet all of the following requirements:

(1) ~~Nonprofit;~~Be a nonprofit.

(2) ~~Established by a trade association, industry association, or professional association of employers or professionals~~Be established by a group of employers under an association that (i) has a constitution or ~~bylaws and that~~bylaws, (ii) has been organized and maintained in good faith for a continuous period of ~~five years for purposes other than that of obtaining or providing insurance;~~at least two years, and (iii) has at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees.

(3) ~~Operated~~ Be operated pursuant to a trust agreement by a board of trustees that has complete fiscal control over the MEWA and that is responsible for all

operations of the MEWA. Except as provided in this subdivision, the trustees must be owners, partners, officers, directors, or employees of one or more employers in the MEWA. With the Commissioner's approval, a person who is not such an owner, partner, officer, director, or employee may serve as a trustee if that person possesses the expertise required for such service. A trustee may not be an owner, officer or employee of the administrator or service company of the MEWA. The trustees have the authority to approve applications of association members for participation in the MEWA and to contract with an authorized administrator or service company to administer the operations of the ~~MEWA;~~MEWA.

(4) ~~Neither~~ Be neither offered nor advertised to the public ~~generally; and~~generally.

(5) ~~Operated~~ Be operated in accordance with sound actuarial principles.

(6) Have a commonality of interest as described in subsection (h) of this section.

(7) Have at least 500 covered lives."

SECTION 1.(b) G.S. 58-49-40 is amended by adding one new subsection to read:

"(h) A MEWA will be treated as having a commonality of interest if either of the following is true:

(1) It is established by a group of employers under an association in the same trade, industry, line of business, or profession.

(2) It is established by employers under an association in the same region or metropolitan area, provided that region or area is contiguous to the State and includes the State."

SECTION 1.(c) G.S. 58-49-30 is amended by adding a new subsection to read:

"(f) As used in this section, the term "employer" shall include sole proprietors and self-employed workers."

SECTION 1.(d) G.S. 58-49-50 is amended by adding a new subdivision to read:

"(10a) A copy of the most recent M-1 form as filed with the United States Department of Labor."

PART II. REGULATIONS IMPACTING FULLY INSURED ASSOCIATION HEALTH PLANS.

SECTION 2.(a) G.S. 58-51-80(b)(1) reads as rewritten:

"(b) No policy or contract of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this State unless the group of persons ~~thereby~~ insured by the policy or contract conforms to ~~the requirements of the following subdivisions:~~all of the following requirements:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, or by a principal or two or more principals in the same industry or kind of business, which employer, principal, or trustee shall be deemed the policyholder, covering, except as hereinafter provided, only employees, or agents, of any class or classes thereof determined by conditions pertaining to employment, or agency, for amounts of insurance based upon some plan which will preclude individual selection. The premium may be paid by the employer, by the employer and the employees jointly, or by the employee; and where the relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents, jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis. For the

purposes of this subdivision, the term "employer" includes a multiple employer welfare arrangement that has at least 500 covered lives and is classified by the United States Department of Labor as a bona fide group or association under at least one of the following:

a. The requirements set forth in section 3(5) of the Employee Retirement Income Security Act of 1974 and implementing regulations, including 29 C.F.R. Part 2510.

b. Any United States Department of Labor advisory opinion addressing circumstances in which the United States Department of Labor will consider a person as able to act directly or indirectly in the interest of direct employers in sponsoring an employee welfare benefit plan."

SECTION 2.(b) G.S. 58-51-80(b)(1a) reads as rewritten:

"(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least ~~five~~ two years; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members, other than associate members, have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

...."

SECTION 2.(c) G.S. 58-68-25(a) reads as rewritten:

"**§ 58-68-25. Definitions; excepted benefits; employer size rule.**

(a) Definitions. – ~~In addition to other definitions throughout this Article, the~~ The following definitions ~~and their cognates~~ apply in this Article:

(1) ~~"Bona~~ Bona fide ~~association".~~ association. – With respect to health insurance coverage offered in this State, an association ~~that:~~meeting all of the following requirements:

a. Has been actively in existence for at least five years.

b. Has been formed and maintained in good faith for purposes other than obtaining insurance.

c. Does not condition membership in the association on any health status-related factor relating to an ~~individual (including~~ individual, including an employee of an employer or a dependent of an ~~employee).~~employee.

d. Makes health insurance coverage offered through the association available to all members and individuals eligible for coverage through a member regardless of any health status-related factor relating to the ~~members (or individuals eligible for coverage through a member).~~members or eligible individuals.

e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

f. Meets the additional requirements as may be imposed under State law.

(2) ~~"COBRA~~ COBRA continuation ~~provision".~~ provision. – Any of the following:

a. Section 4980B of the Internal Revenue Code of 1986, other than subdivision (f)(1) of the section insofar as it relates to pediatric vaccines.

b. Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of the Act.

c. Requirements for certain group health plans for certain State and local employees under Title XXII of the Public Health Service ~~Act (42 U.S.C.S. § 300bb, et seq.,) as requirements for certain group health plans for certain State and local employees.~~Act.

d. Article 53 of this ~~Chapter or the~~ Chapter.

e. The health insurance continuation law of another state.

(3) ~~"Employee".~~ Employee. – ~~The meaning given the term under~~ As defined in section 3(6) of the Employee Retirement Income Security Act of 1974.

(4) ~~"Employer".~~ Employer. – ~~The meaning given the term under~~ As defined in section 3(5) of the Employee Retirement Income Security Act of ~~1974, except that the term shall include only employers of two or more employees.~~1974.

(4a) ~~"Group~~ Group health insurance ~~coverage".~~ coverage. – Health insurance coverage offered in connection with a group health plan.

(4b) ~~"Group~~ Group health ~~plan".~~ plan. – ~~The meaning given the term under~~ As defined in 45 C.F.R. § 146.145(a).

(4c) ~~"Group market."~~ Group market. – The market for health insurance coverage offered in connection with a group health plan.

(5) ~~"Health~~ Health insurance ~~coverage" or "coverage" or "health insurance plan" or "plan".~~ coverage, health insurance plan, coverage, or plan. – Benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under any accident and health insurance policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, written by a health insurer. Health insurance coverage includes group health insurance coverage and individual health insurance coverage.

(6) ~~"Health insurer".~~ Health insurer. – An insurance company subject to this Chapter, a hospital or medical service corporation subject to Article 65 of this Chapter, a health maintenance organization subject to Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 49 of this Chapter, that offers and issues health insurance coverage.

(7) ~~"Health~~ Health status-related ~~factor".~~ factor. – Any of the factors described in G.S. 58-68-35(a)(1).

(8) ~~"Individual~~ Individual health insurance ~~coverage".~~ coverage. – Health insurance coverage offered to individuals in the individual market, but not short-term limited duration insurance.

(9) ~~"Individual market".~~ Individual market. – The market for health insurance coverage offered to individuals.

(10) ~~"Large employer".~~ Large employer. – An employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least ~~two employees~~ one employee on the first day of the health insurance plan year.

(11) ~~"Large~~ Large group ~~market".~~ market. – The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a large employer.

(12) ~~"Medical care".~~ Medical care. – Amounts paid ~~for:~~for any of the following:

a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or ~~amounts paid~~ for the purpose of affecting any structure or function of the body.
b. ~~Amounts paid for transportation~~ Transportation primarily for and essential to medical care ~~referred to in~~ under sub-subdivision a. of this subdivision.
c. ~~Amounts paid for insurance~~ Insurance covering medical care ~~referred to in~~ under sub-subdivisions a. and b. of this subdivision.

(13) ~~"Network plan".~~ Network plan. – Health insurance coverage of a health insurer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of health care providers under contract with the health insurer.

(14) ~~"Participant".~~ Participant. – ~~The meaning given the term~~ As defined under section 3(7) of the Employee Retirement Income Security Act of 1974.

(15) ~~"Placed for adoption".~~ Placed for adoption. – The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation.

(16) ~~"Small employer".~~ Small employer. – ~~The meaning given to the term in G.S. 58-50-110(22).~~ As defined in G.S. 58-50-110(22).

(17) ~~"Small~~ Small group ~~market".~~ market. – The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a small employer."

PART III. ALLOW MORE SMALL EMPLOYERS TO PURCHASE STOP-LOSS COVERAGE.

SECTION 3. G.S. 58-50-130(a)(5) reads as rewritten:

"(5) No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers who employ fewer than ~~26~~ 12 eligible employees that does not comply with the underwriting, rating, and other applicable standards in this Act. An insurer shall not issue a stop loss health insurance policy to any person, firm, corporation, partnership, or association defined as a small employer that does any of the following:
a. Provides direct coverage of health expenses payable to an individual.
b. Has an annual attachment point for claims incurred per individual that is lower than twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.
c. Has an annual aggregate attachment point lower than the greater of one of the following:
1. One hundred twenty percent (120%) of expected claims.
2. Twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All

Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.

Nothing in this subsection prohibits an insurer from providing additional incentives to small employers with benefits promoting a medical home or benefits that provide health care screenings, are focused on outcomes and key performance indicators, or are reimbursed on an outcomes basis rather than a fee-for-service basis."

PART IV. EFFECTIVE DATE

SECTION 4. This act is effective October 1, 2019, and applies to contracts entered into, amended, or renewed on or after that date, and to licenses issued or renewed on or after that date.

SENATE BILL 86:
Small Business Healthcare Act.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	March 5, 2019
Introduced by:	Sens. Bishop, Krawiec, Edwards	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	PCS to First Edition S86-CSBC-7		

OVERVIEW: The Proposed Committee Substitute to Senate Bill 86 would allow business associations to obtain group health insurance for their members in accordance with newly-issued federal rules. It would also allow insurers to sell stop loss insurance to employers with twelve or more employees. The PCS makes a few technical changes to the original bill. It also requires an association to have at least 500 covered lives before it can obtain self-funded or fully-insured group health insurance plans.

CURRENT LAW: Under current law, in order to be licensed for the purposes of obtaining group health insurance, a Multiple Employer Welfare Arrangement (MEWA) must be: (1) a non-profit organization, (2) established by a business association that has been in existence for at least five years for purposes other than obtaining insurance, (3) run by a board of trustees with complete fiscal control over the association, (4) not offered to the public generally, and (5) run on sound actuarial principles.

In order to obtain a fully-insured association health plan (AHP), a business association must be in existence for at least five years. Currently, the term "employer" does not necessarily include MEWAs for purposes of obtaining a fully-insured health plan. Under current law, MEWAs do not have to meet any size requirements before being able to obtain self-funded group health insurance. Associations cannot obtain group health insurance unless they are made up of 500 persons.

Insurers may not provide stop loss insurance to an employer with fewer than 26 employees.

BILL ANALYSIS:

Part I of the PCS to Senate Bill 86 would amend G.S. 58-49-40 to codify in North Carolina law the new federal regulations for AHPs as they pertain to MEWAs.

Section 1.(a) would allow associations that had been in existence for two years, rather than five, to obtain licensure as a MEWA. It would also require MEWAs to have one substantial business purpose other than offering insurance, have a commonality of interest, and to consist of at least 500 covered lives.

Section 1.(b) would define "commonality of interest" to mean either: (1) established by employers in the same trade, industry, line of business, or profession; or (2) established by employers in the same region or metropolitan area of the State.

Section 1.(c) would allow sole proprietors and self-employed workers to participate in a MEWA.

Part II of the PCS to Senate Bill 86 would amend G.S. 58-51-80 to codify in North Carolina law the new federal regulations for association health plans as they pertain to fully-insured AHPs.

Section 2.(a) would define the term "employer" in 58-51-80(b)(1) to include a MEWA that has at least 500 covered lives and meets the new federal requirements for business associations.

Section 2.(b) would amend G.S. 58-51-80(b)(1a) to allow associations that had been in existence for two years, rather than five, to obtain group health insurance.

Section 2.(c) would amend G.S.58-68-25(a) to require bona fide associations to offer insurance coverage to all individuals eligible for coverage through a member of the association. It also would make conforming changes to G.S. 58-68-25(a).

Part III of the PCS would amend G.S. 58-50-130(a)(5) to allow insurers to provide stop loss insurance to small employers with 12 or more employees.

EFFECTIVE DATE: This act would be effective October 1, 2019, and apply to contracts entered into, amended, or renewed on or after that date and licenses issued or renewed on or after that date.

BACKGROUND: An Association Health Plan (AHP) is a group health insurance plan offered to a business association. The members of the business association are usually individual employers. AHPs can be fully funded, or they can be self-insured. A business association that obtains a self-insured AHP is generally referred to as a Multiple Employer Welfare Arrangement (MEWA). Because AHPs are group health insurance, they are regulated—for the most part—by the Employee Retirement Income Security Act (ERISA).

Prior to 2018, the federal Department of Labor had several requirements a business association had to meet before it could obtain an AHP. First, the individual employer members of the association had to have a commonality of interest, usually defined as a "close economic or representational nexus" with the association. Second, the association had to exist for a bona fide purpose other than offering insurance. Third, the employer members of the association had to have employees; they could not be sole proprietorships.

In late 2018, the Department of Labor changed the requirements. Under the new rules, a commonality of interest will exist if the employer members of the association are either (1) in the same trade, industry, profession, or line of business, or (2) in the same geographic area. The new rules permit the association to obtain an AHP if it has a substantial business purpose other than offering insurance, even if the principal purpose of the association is offering benefits. The employee requirement was dropped entirely; sole proprietors can now join business associations and obtain AHPs.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

SENATE BILL 86

Short Title:	Small Business Healthcare Act.	(Public)
Sponsors:	Senators Bishop, Krawiec, Edwards (Primary Sponsors); Ballard, Brown, Burgin, Daniel, J. Davis, Ford, Hise, Johnson, McInnis, Newton, Perry, and Steinburg.	
Referred to:	Rules and Operations of the Senate	

February 20, 2019

A BILL TO BE ENTITLED

AN ACT TO CREATE GREATER OPPORTUNITIES FOR SMALL EMPLOYERS TO PROVIDE EMPLOYEES ACCESS TO HEALTH INSURANCE.

Whereas, Association Health Plans are regulated by multiple consumer protection provisions contained in the Employee Retirement Income Security Act (ERISA), including provisions under the Health Insurance Portability and Accountability Act (HIPAA), the Affordable Care Act, the Mental Health Parity and Addiction Equity Act, the Newborns' and Mothers' Health Protection Act, the Women's Health and Cancer Rights Act, and the Genetic Information Nondiscrimination Act; and

Whereas, under ERISA, the State has been regulating self-insured Association Health Plans in such a way that, in addition to the federal consumer protections that apply to the fully insured Association Health Plans, fully protects the citizens of this State; and

Whereas, new federal Department of Labor regulations regarding Association Health Plans allow for states to provide greater opportunities for small businesses and self-employed individuals to access health benefit plans, while still providing health insurance consumers with the coverage protections established by the foregoing legislation and other provisions of federal law; Now, therefore,

The General Assembly of North Carolina enacts:

PART I. MORE OPPORTUNITIES FOR SMALL EMPLOYERS AND SOLE PROPRIETORS TO ACCESS SELF-INSURED MULTIPLE EMPLOYER WELFARE ARRANGEMENTS/ASSOCIATION HEALTH PLANS.

SECTION 1.(a) G.S. 58-49-40(a) reads as rewritten:

"(a) ~~To meet the requirements for issuance of a license and to maintain a~~ To qualify for licensure as a MEWA, a MEWA must ~~be:~~meet all of the following requirements:

(1) ~~Nonprofit:~~Be a nonprofit.

(2) ~~Established by a trade association, industry association, or professional association of employers or professionals that has~~ Have a constitution or bylaws and ~~that has~~ have been organized and maintained in good faith for a continuous period of ~~five~~ at least two years for purposes other than that of obtaining or providing ~~insurance;~~insurance.

(3) ~~Operated~~ Be operated pursuant to a trust agreement by a board of trustees that has complete fiscal control over the MEWA and that is responsible for all operations of the MEWA. Except as provided in this subdivision, the trustees must be owners, partners, officers, directors, or employees of one or more

employers in the MEWA. With the Commissioner's approval, a person who is not such an owner, partner, officer, director, or employee may serve as a trustee if that person possesses the expertise required for such service. A trustee may not be an owner, officer or employee of the administrator or service company of the MEWA. The trustees have the authority to approve applications of association members for participation in the MEWA and to contract with an authorized administrator or service company to administer the operations of the ~~MEWA;~~MEWA.

(3a) Have at least one substantial business purpose unrelated to offering and providing health coverage or other employee benefits to its employer members and their employees.

(3b) Have a commonality of interest as described in subsection (h) of this section.

(4) ~~Neither~~ Be neither offered nor advertised to the public ~~generally; and~~generally.

(5) ~~Operated~~ Be operated in accordance with sound actuarial principles."

SECTION 1.(b) G.S. 58-49-40 is amended by adding one new subsection to read:

"(h) A MEWA will be treated as having a commonality of interest if either of the following is true:

(1) It is established by employers in the same trade, industry, line of business, or profession.

(2) It is established by employers in the same region or metropolitan area, provided that region or area is contiguous to the State and includes the State."

SECTION 1.(c) G.S. 58-49-30 is amended by adding a new subsection to read:

"(f) As used in this section, the term "employer" shall include sole proprietors and self-employed workers."

SECTION 1.(d) G.S. 58-49-50 is amended by adding a new subdivision to read:

"(10a) A copy of the most recent M-1 form as filed with the United States Department of Labor."

PART II. REGULATIONS IMPACTING FULLY INSURED ASSOCIATION HEALTH PLANS.

SECTION 2.(a) G.S. 58-51-80(b)(1) reads as rewritten:

"(b) No policy or contract of group accident, group health or group accident and health insurance shall be delivered or issued for delivery in this State unless the group of persons ~~thereby~~ insured by the policy or contract conforms to ~~the requirements of the following subdivisions:~~all of the following requirements:

(1) Under a policy issued to an employer, principal, or to the trustee of a fund established by an employer or two or more employers in the same industry or kind of business, or by a principal or two or more principals in the same industry or kind of business, which employer, principal, or trustee shall be deemed the policyholder, covering, except as hereinafter provided, only employees, or agents, of any class or classes thereof determined by conditions pertaining to employment, or agency, for amounts of insurance based upon some plan which will preclude individual selection. The premium may be paid by the employer, by the employer and the employees jointly, or by the employee; and where the relationship of principal and agent exists, the premium may be paid by the principal, by the principal and agents, jointly, or by the agents. If the premium is paid by the employer and the employees jointly, or by the principal and agents jointly, or by the employees, or by the agents, the group shall be structured on an actuarially sound basis. For the purposes of this subdivision, the term "employer" includes a multiple

employer welfare arrangement that is classified by the United States Department of Labor as a bona fide group or association under at least one of the following:

a. The requirements set forth in section 3(5) of the Employee Retirement Income Security Act of 1974.

b. Any United States Department of Labor advisory opinion addressing circumstances in which the United States Department of Labor will consider a person as able to act directly or indirectly in the interest of direct employers in sponsoring an employee welfare benefit plan."

SECTION 2.(b) G.S. 58-51-80(b)(1a) reads as rewritten:

"(1a) Under a policy issued to an association or to a trust or to the trustee or trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum of 500 persons and shall have been organized and maintained in good faith for purposes other than that of obtaining insurance; shall have been in active existence for at least ~~five~~ two years; and shall have a constitution and bylaws that provide that (i) the association or associations hold regular meetings not less than annually to further purposes of the members; (ii) except for credit unions, the association or associations collect dues or solicit contributions from members; and (iii) the members, other than associate members, have voting privileges and representation on the governing board and committees. The policy is subject to the following requirements:

...."

SECTION 2.(c) G.S. 58-68-25(a) reads as rewritten:

"**§ 58-68-25. Definitions; excepted benefits; employer size rule.**

(a) Definitions. – ~~In addition to other definitions throughout this Article, the~~ The following definitions ~~and their cognates~~ apply in this Article:

(1) ~~"Bona~~ Bona fide ~~association".~~ association. – With respect to health insurance coverage offered in this State, an association ~~that:~~meeting all of the following requirements:

a. Has been actively in existence for at least five years.

b. Has been formed and maintained in good faith for purposes other than obtaining insurance.

c. Does not condition membership in the association on any health status-related factor relating to an ~~individual (including~~ individual, including an employee of an employer or a dependent of an ~~employee).~~employee.

d. Makes health insurance coverage offered through the association available to all members and individuals eligible for coverage through a member regardless of any health status-related factor relating to the ~~members (or individuals eligible for coverage through a member).~~members or eligible individuals.

e. Does not make health insurance coverage offered through the association available other than in connection with a member of the association.

f. Meets the additional requirements as may be imposed under State law.

(2) ~~"COBRA~~ COBRA continuation ~~provision".~~ provision. – Any of the following:

a. Section 4980B of the Internal Revenue Code of 1986, other than subdivision (f)(1) of the section insofar as it relates to pediatric vaccines.

b. Part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, other than section 609 of the Act.
c. Requirements for certain group health plans for certain State and local employees under Title XXII of the Public Health Service ~~Act (42 U.S.C.S. § 300bb, et seq.,) as requirements for certain group health plans for certain State and local employees.~~Act.
d. Article 53 of this ~~Chapter or the~~ Chapter.
e. The health insurance continuation law of another state.

(3) ~~"Employee".~~ Employee. – ~~The meaning given the term under~~ As defined in section 3(6) of the Employee Retirement Income Security Act of 1974.

(4) ~~"Employer".~~ Employer. – ~~The meaning given the term under~~ As defined in section 3(5) of the Employee Retirement Income Security Act of ~~1974, except that the term shall include only employers of two or more employees.~~1974.

(4a) ~~"Group~~ Group health insurance ~~coverage".~~ coverage. – Health insurance coverage offered in connection with a group health plan.

(4b) ~~"Group~~ Group health ~~plan".~~ plan. – ~~The meaning given the term under~~ As defined in 45 C.F.R. § 146.145(a).

(4c) ~~"Group market."~~ Group market. – The market for health insurance coverage offered in connection with a group health plan.

(5) ~~"Health~~ Health insurance ~~coverage" or "coverage" or "health insurance plan" or "plan".~~ coverage, health insurance plan, coverage, or plan. – Benefits consisting of medical care, provided directly through insurance or otherwise and including items and services paid for as medical care, under any accident and health insurance policy or certificate, hospital or medical service plan contract, or health maintenance organization contract, written by a health insurer. Health insurance coverage includes group health insurance coverage and individual health insurance coverage.

(6) ~~"Health insurer".~~ Health insurer. – An insurance company subject to this Chapter, a hospital or medical service corporation subject to Article 65 of this Chapter, a health maintenance organization subject to Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 49 of this Chapter, that offers and issues health insurance coverage.

(7) ~~"Health~~ Health status-related ~~factor".~~ factor. – Any of the factors described in G.S. 58-68-35(a)(1).

(8) ~~"Individual~~ Individual health insurance ~~coverage".~~ coverage. – Health insurance coverage offered to individuals in the individual market, but not short-term limited duration insurance.

(9) ~~"Individual market".~~ Individual market. – The market for health insurance coverage offered to individuals.

(10) ~~"Large employer".~~ Large employer. – An employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least ~~two employees~~ one employee on the first day of the health insurance plan year.

(11) ~~"Large~~ Large group ~~market".~~ market. – The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a large employer.

(12) ~~"Medical care".~~ Medical care. – Amounts paid ~~for:~~for any of the following:
a. The diagnosis, cure, mitigation, treatment, or prevention of disease, or ~~amounts paid~~ for the purpose of affecting any structure or function of the body.

b. ~~Amounts paid for transportation~~ Transportation primarily for and essential to medical care ~~referred to in~~ under sub-subdivision a. of this subdivision.

c. ~~Amounts paid for insurance~~ Insurance covering medical care ~~referred to in~~ under sub-subdivisions a. and b. of this subdivision.

(13) ~~"Network plan".~~ Network plan. – Health insurance coverage of a health insurer under which the financing and delivery of medical care (including items and services paid for as medical care) are provided, in whole or in part, through a defined set of health care providers under contract with the health insurer.

(14) ~~"Participant".~~ Participant. – ~~The meaning given the term~~ As defined under section 3(7) of the Employee Retirement Income Security Act of 1974.

(15) ~~"Placed for adoption".~~ Placed for adoption. – The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adoption of the child. The child's placement with the person terminates upon the termination of the legal obligation.

(16) ~~"Small employer".~~ Small employer. – ~~The meaning given to the term in G.S. 58-50-110(22).~~ As defined in G.S. 58-50-110(22).

(17) ~~"Small~~ Small group ~~market".~~ market. – The health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health insurance plan maintained by a small employer."

PART III. ALLOW MORE SMALL EMPLOYERS TO PURCHASE STOP-LOSS COVERAGE.

SECTION 3. G.S. 58-50-130(a)(5) reads as rewritten:

"(5) No small employer carrier, insurer, subsidiary of an insurer, or controlled individual of an insurance holding company shall provide stop loss, catastrophic, or reinsurance coverage to small employers who employ fewer than ~~26~~ 12 eligible employees that does not comply with the underwriting, rating, and other applicable standards in this Act. An insurer shall not issue a stop loss health insurance policy to any person, firm, corporation, partnership, or association defined as a small employer that does any of the following:

a. Provides direct coverage of health expenses payable to an individual.

b. Has an annual attachment point for claims incurred per individual that is lower than twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be the index as of July of the year preceding the change divided by the index as of July 2012.

c. Has an annual aggregate attachment point lower than the greater of one of the following:

1. One hundred twenty percent (120%) of expected claims.

2. Twenty thousand dollars ($20,000) for plan years beginning in 2013. For subsequent policy years, the amount shall be indexed using the Consumer Price Index for Medical Services for All Urban Consumers for the South Region and shall be rounded to the nearest whole thousand dollars. The index factor shall be

the index as of July of the year preceding the change divided by the index as of July 2012.

Nothing in this subsection prohibits an insurer from providing additional incentives to small employers with benefits promoting a medical home or benefits that provide health care screenings, are focused on outcomes and key performance indicators, or are reimbursed on an outcomes basis rather than a fee-for-service basis."

PART IV. EFFECTIVE DATE

SECTION 4. This act is effective October 1, 2019, and applies to contracts entered into, amended, or renewed on or after that date, and to licenses issued or renewed on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 86

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S86-ABC-3 [v.3]

Amends Title [NO]
First Edition

Date _____,2019

Senator Krawiec

moves to amend the proposed committee substitute on page 2, line 16, by rewriting the line to read:

""**SECTION 1.(b)** G.S. 58-49-40 is amended by adding two new subsections to read:";

and on page 2, lines 23-24 by inserting a line between the lines to read:

"(i) For purposes of this section, a newly-created association shall be deemed to have been organized and maintained for as long as its newest constituent association has been in existence.";

and on page 3, line 24, by rewriting the line to read:

"and ~~committees. The policy~~committees. For purposes of this section, a newly-created association shall be deemed to have been organized and maintained for as long as its newest constituent association has been in existence. Any policy issued is subject to the following requirements:"."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

S86-ABC-3-V-3

NAME OF MEETING: SENATE COMMITTEE ON HEALTH CARE

DATE: March 7, 2019 10:00 AM Room 643

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Doug Lassiter	NCSBA
Hannah Teague	VISTA Strategies
Kate Apodaca	Vista
Susie Farrell	FL
Cathy Thomas	TPA
Isabel Villa Garcia	NCRLA
Wendy Kelly	Focus Public Affairs
Kara Weisbaker	SA
Sarah	Duke
Nathan Deberdt	Parker Poe
Andy Ellen	NCRMA
Steven Sawyer	Medical Mutual
Chris Boyd	NCMS
Sue Ann Forrest	NCMS
Paul Sherman	NCFB
John Lafferty	NCAOA
Kary Kiss	NCRMA
Dana Martinez	Raleigh Chamber
Padraig Gilsenan	Comcast

NAME OF MEETING: SENATE COMMITTEE ON HEALTH CARE

DATE: March 7, 2019 10:00 AM Room 643

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
	AFIB
Peyton Mayo	
	NMRS
Joe Stewart	NANC / NCAHH
Bo Heath	MWC
Sarah Wolfe	MWC
Fred Bone	Bone Assoc.
Teresa W Edwards	McDonald's
Sallie James	Governor's Office
Hugh Johnson	NCA
Maddie McClendon	Senate Intern
Cassidy Robertson	AMGA
Brooks Rainey Pearson	SELC
James Bordon	SELC
Mc Mullen Ashley	SELC
Hailey Lohr	SELC
Kathryn Magoon	SELC

NAME OF MEETING: SENATE COMMITTEE ON HEALTH CARE

DATE: March 7, 2019 10:00 AM Room 643

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Bob Mays	DOI
Robert Croom	NCDOI
TED HAMBY	NCDOI
LT McCrimmon	DHHS
Debra Dew	NC Chamber

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 643

DATE: 3-7 **TIME:** 10 AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

	Page Name	Hometown	Sponsoring Senator
1.	Jake Willis	Cherryville	Harrington
2.	Nora Flynn-McIver	Asheville	VanDuyn
3.	Ayonna Washington	Forest City	Hise
4.			
5.			
6.			
7.			
8.			

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee

ON

Health Care

March 7, 2019

10:00 AM Room 643

Senate Sergeant at Arms:

TOM BURROUGHS

LINDA MATTHEWS

Senate Committee on Health Care
Wednesday, March 13, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on March 13, 2019 in Room 643 of the Legislative Office Building. Twelve members were present.

Senator Joyce Krawiec, Chair, presided.

Eleanor McNamme from Car, Madison Aloia from Trenton, and Carter Askins from Jacksonville served as pages.

SB 168 Expand Allowable Medical Uses of CBD Oil. (Senators McKissick, Hise)
Sen. Krawiec introduced Sen. McKissick to introduce the bill before the committee. Questions from the members were responded to by Sen. McKissick. Sen. Robinson moved for a favorable report and it carried.

The meeting adjourned at 10:12 AM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Wednesday, March 13, 2019

Senator Krawiec,
submits the following with recommendations as to passage:

FAVORABLE

SB **168** Expand Allowable Medical Uses of CBD Oil.

Draft Number:	None
Sequential Referral:	Judiciary
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Floyd B. McKissick, Jr. will handle SB 168

CMR92-V-1

Senate Committee on Health Care
Wednesday, March 13, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 168	Expand Allowable Medical Uses of CBD Oil.	Senator McKissick Senator Hise

SENATE BILL 168:
Expand Allowable Medical Uses of CBD Oil.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Judiciary. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	March 11, 2019
Introduced by:	Sens. McKissick, Hise	**Prepared by:**	Jessica Boney Staff Attorney
Analysis of:	First Edition		

OVERVIEW: The act would amend the North Carolina Controlled Substances Act and the Epilepsy Alternative Treatment Act to expand the permissible uses for hemp extract to include treatment for autism, multiple sclerosis, Chrohn's disease, and Mitochondrial disease, in addition to the already allowable treatment of intractable epilepsy.

BILL ANALYSIS:

Section 1 amends the North Carolina Controlled Substances Act to allow the possession or use of hemp extract to treat autism, multiple sclerosis, Crohn's disease, or Mitochondrial disease.

Section 2 amends the Epilepsy Alternative Treatment Act by doing the following:

- Renaming the title of the Act, expanding the purpose of the Act, and making conforming changes to the stated General Assembly findings.
- Expanding the definition of caregiver to include a nurse employed by a home health agency licensed under Part 3 of Article 6 of Chapter 131E of the General Statutes or other caregiver.
- Adding to the neurologist's signed statement a caregiver must possess the following information:
  - The patient suffers from autism, multiple sclerosis, Crohn's disease, or Mitochondrial disease.
  - The patient's condition has not responded to three or more treatment options overseen by the neurologist or by a physician with whom the neurologist has consulted about the patient's condition.
- Allowing the neurologist's signed statement to state the patient has been examined and is under the care of a physician who has consulted with the neurologist about the patient's condition. Current law requires the neurologist's signed statement to state the patient has been examined and is under the care of the neurologist.
- Removing the definition of Intractable Epilepsy and adding a definition for Physician.
- Expanding the definition of Patient to an individual that has been diagnosed with autism, multiple sclerosis, Crohn's disease, or Mitochondrial disease.
- Amending the information required in the Alternative Treatment database to include the name, address and hospital affiliation of any physician with whom the neurologist consults about the patient's condition in recommending hemp extract as an alternative treatment.

EFFECTIVE DATE: The act would become effective December 1, 2019.

Karen Cochrane-Brown
Director

S168-SMBP-3 E1 -V-4

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

SENATE BILL 168

Short Title:	Expand Allowable Medical Uses of CBD Oil.	(Public)
Sponsors:	Senators McKissick and Hise (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

February 28, 2019

A BILL TO BE ENTITLED

AN ACT AMENDING THE EXEMPTION FOR USE OR POSSESSION OF CANNABIDIOL AND EXPANDING THE PERMISSIBLE USE OF CANNABIDIOL AS AN ALTERNATIVE TREATMENT TO CHRONIC CONDITIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-94.1(b) reads as rewritten:

"(b) Notwithstanding any other provision of this Chapter, an individual may possess or use hemp extract, and is not subject to the penalties described in this Chapter, if the individual satisfies all of the following criteria:

(1) Possesses or uses the hemp extract only to treat intractable epilepsy, ~~as defined in G.S. 90-113.101.~~autism, multiple sclerosis, Crohn's disease, or Mitochondrial disease.

(2) Possesses, in close proximity to the hemp extract, a certificate of analysis that indicates the hemp extract's ingredients, including its percentages of tetrahydrocannabinol and cannabidiol by weight.

(3) Is a caregiver, as defined in G.S. 90-113.101."

SECTION 2. Article 5G of Chapter 90 of the General Statutes reads as rewritten:

"Article 5G.

"~~Epilepsy~~ Alternative Treatment Act.

"**§ 90-113.100. Short title.**

(a) This act may be cited as the "North Carolina ~~Epilepsy~~ Alternative Treatment Act."

(b) The purpose of this act is to permit the use of hemp extract as an alternative treatment for intractable ~~epilepsy.~~epilepsy, autism, multiple sclerosis, Crohn's disease, and Mitochondrial disease.

(c) The General Assembly finds that there are ~~children~~ individuals in this State suffering from intractable ~~epilepsy~~ epilepsy, autism, multiple sclerosis, Crohn's disease, and Mitochondrial disease for which currently available treatment options have been ineffective. Hemp extract shows promise in treating ~~children with intractable epilepsy.~~these chronic conditions.

"**§ 90-113.101. Definitions.**

The following definitions apply in this Article:

(1) Caregiver. – An individual that is at least 18 years of age and a resident of North Carolina who is a parent, legal guardian, ~~or custodian~~ custodian, nurse employed by a home health agency licensed under Part 3 of Article 6 of Chapter 131E of the General Statutes, or other caregiver of a patient and is registered with the Department of Health and Human and Services under

G.S. 90-113.102 who possesses a written statement dated and signed by a neurologist that states all of the following:

a. The patient has been examined and is under the care of the ~~neurologist.~~neurologist or has been examined and is under the care of a physician who has consulted with the neurologist about the patient's condition.

b. The patient suffers from intractable ~~epilepsy.~~epilepsy, autism, multiple sclerosis, Crohn's disease, or Mitochondrial disease.

c. The patient may benefit from treatment with hemp extract.

d. The patient's condition has not responded to three or more treatment options overseen by the neurologist or by a physician with whom the neurologist has consulted about the patient's condition.

(2) Repealed by Session Laws 2015-154, s. 3, effective July 16, 2015.

(3) Database. – The ~~Intractable Epilepsy~~ Alternative Treatment database, established by the Department of Health and Human Services pursuant to this Article.

(4) Department. – The Department of Health and Human Services.

(5) Hemp Extract. – An extract from a cannabis plant, as defined in G.S. 90-94.1(a).

~~(6) Intractable Epilepsy. – A seizure disorder that, as determined by a neurologist, does not respond to three or more treatment options overseen by the neurologist.~~

(7) Neurologist. – An individual who is licensed under Article 1 of Chapter 90 of the General Statutes, who is board certified in neurology, and is affiliated with the neurology department at one or more hospitals licensed in this State.

(8) Patient. – A person who has been diagnosed ~~by a neurologist~~ with intractable ~~epilepsy.~~epilepsy, autism, multiple sclerosis, Crohn's disease, or Mitochondrial disease by a neurologist or by a physician with whom the neurologist has consulted about the patient's condition.

(8a) Physician. – An individual who is licensed under Article 1 of Chapter 90 of the General Statutes who is board certified and is affiliated with one or more hospitals licensed in this State.

(9) Repealed by Session Laws 2015-154, s. 3, effective July 16, 2015.

"**§ 90-113.102. ~~Intractable Epilepsy~~ Alternative Treatment database; departmental duties.**

(a) The Department shall create a secure and electronic ~~Intractable Epilepsy~~ Alternative Treatment database registry for the registration of neurologists, caregivers, and patients as provided by this Article. All caregivers shall be required to register with the Department. Law enforcement agencies are authorized to contact the Department to confirm a caregiver's registration. The database shall consist of the following information to be provided by the caregivers at the time of registration:

(1) The name and address of the caregiver.

(2) The name and address of the caregiver's patient.

(3) Repealed by Session Laws 2015-154, s. 4, effective July 16, 2015.

(4) The name, address, and hospital affiliation of the neurologist recommending hemp extract as an alternative treatment ~~for intractable epilepsy~~ for the ~~patient.~~patient, and the name, address, and hospital affiliation of any physician with whom the neurologist consults about the patient's condition in making the recommendation.

(b) Repealed by Session Laws 2015-154, s. 4, effective July 16, 2015.

(c) If at any time following registration, the name, address, or hospital affiliation of the patient's neurologist or physician changes, the caregiver shall notify the Department and provide

the Department with the patient's new neurologist's or physician's name, address, and hospital affiliation."

SECTION 3. This act becomes effective December 1, 2019.

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 643

DATE: 3-13 **TIME:** 10 AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

Page Name	Hometown	Sponsoring Senator
1. Eleanor McNamee	Cary	Nickel
2. Madison Aloia	Trenton	Brown
3. Carter Askins	Jacksonville	Brown
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NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee

On

Health Care

March 13, 2019

Room 643 LOB

10:00 AM

Senate Sergeant at Arms:

BILLY FRITSCHER

JIM HAMILTON

ARCHIE SMITH

Senate Committee On Health Care

March 13, 2019 – Room 643 LOB – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
[illegible]	APS
Alyssa Habermann	Duke
[illegible]	WBT
Sarah Bales	Brubaker Hasso.
Patricia Gibbons	Connect C
Calley Mangum	NCFPC
[illegible]	NCFPC
Kaori Barkness	BPS
Anthony Gilardi	S.G.S.
Julia Adams Scheurich	Oak City GR
[illegible]	SEANC
Andy Chase	KMA
Elizabeth [illegible]	Walkwest
Ken Melton	K.M.A.
Pam [illegible]	Monarch
[illegible]	FL
Ryan Menwald	SBE
[illegible]	NCDA&CS
Jeremy Evans	NCDA&CS
John Lanier	NCDA

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

March 13, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Josh Lanier	CSH
Susan Forest	NCMS
Kory Kay	NCRMA
LTM McCrimmon	DHHS
Amanda Falkenbury	DOT
Lisa Martin	Cap Ad
Emma Shelby	TPO
Abby Childress	Parent of child using CBD
Sarah McQuillan	Kaufman Gov Affairs
Pat Roberts	Sr Tar Heel Leg / Transylvania County
Sherrie L. Perry	Senior Tar Heel Leg. / Madison Co
Jan Lounsbury	Senior Tar Heel Leg / Madison Co.
Garrett Pender	Root Bioscience
Lance Blondell	CBDMD
[illegible]	CBX
Hyun Namkoong	NCJC
Brendan Riley	NCDC

09-21-201

Senate Committee on Health Care
Thursday, March 20, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on March 20, 2019, in Room 643 of the Legislative Office Building. Six members were present.

Sen. Bishop, Chair, presided.

Ahmad Whitaker sponsored by Sen. Blue, Anaya Truss-Williams sponsored by Sen. Waddell, Wyatt Sullivan sponsored by Sen. Sanderson, and Harrison Burnette sponsored by Sen. T. Alexander served as pages.

SB 210 - Organ & Tissue Donation/Heart Heroes

Sen. Krawiec was recognized to explain the bill. Sen. D. Davis moved for a favorable report with a referral to Transportation and then to Rules. The motion carried.

SB 212 - Suspend Child Welfare/Aging Component/NC FAST

Sen. Krawiec was recognized to explain the bill and to send forward an amendment. Sen. Krawiec explained the amendment and took questions from members. Sen. D. Davis moved for a favorable motion on the amendment. The motion carried. Sen. Perry moved for a favorable report on the amended bill, rolled into a new proposed committee substitute. The motion carried and was serially referred to Rules.

The meeting adjourned at 10:14 AM.

Senator Dan Bishop, Chair
Presiding

John Wynne, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Wednesday, March 20, 2019

Senator Bishop,
submits the following with recommendations as to passage:

FAVORABLE

SB **210** Organ & Tissue Donation/Heart Heroes.

Draft Number:	None
Sequential Referral:	Transportation
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Joyce Krawiec will handle SB 210



NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Wednesday, March 20, 2019

Senator Bishop,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

SB **212** Suspend Child Welfare/Aging Component/NC FAST.

Draft Number:	S212-PCS35136-SH-3
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Joyce Krawiec will handle SB 212



Senate Committee on Health Care
Wednesday, March 20, 2019 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 210	Organ & Tissue Donation/Heart Heroes	Senator Krawiec Senator McKissick Senator Horner
SB 212	Suspend Child Welfare/Aging Component/NC FAST	Senator Krawiec Senator Hise

Adjournment

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S **1**

SENATE BILL 210*

Short Title:	Organ & Tissue Donation/Heart Heroes.	(Public)
Sponsors:	Senators Krawiec, McKissick, and Horner (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

March 11, 2019

A BILL TO BE ENTITLED

AN ACT AMENDING THE REVISED UNIFORM ANATOMICAL GIFT ACT TO INCLUDE TISSUE DONATION AS PART OF THE DRIVERS LICENSE DONOR AUTHORIZATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-412.7(a) reads as rewritten:

"(a) A donor may make an anatomical gift by any of the following methods:

(1) By authorizing that a statement or symbol be imprinted on the donor's drivers license or identification card indicating that the donor has made an anatomical gift. Anatomical gifts made by this method shall not include a donation of ~~tissue or~~ the donor's body.

(2) In a will.

(3) During a terminal illness or injury of the donor, by any form of communication addressed to at least two adults, at least one of whom is a disinterested witness.

(4) As provided in subsection (b) of this section."

SECTION 2. This act becomes effective October 1, 2019.

SENATE BILL 210:
Organ & Tissue Donation/Heart Heroes.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Transportation. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	March 18, 2019
Introduced by:	Sens. Krawiec, McKissick, Horner	**Prepared by:**	Jessica Boney Staff Attorney
Analysis of:	First Edition		

OVERVIEW: Senate Bill 210 would amend the Revised Uniform Anatomical Gift Act (UAGA). The act would allow donors to authorize tissue donation through a symbol imprinted on a driver's license or an identification card. The act would become effective October 1, 2019.

CURRENT LAW: Part 3A of Article 16 of Chapter 130A of the General Statutes contains the UAGA and does the following:

- Allows a donor to make an anatomical gift by authorizing the placement of a symbol on the donor's driver's license or identification card. An anatomical gift given in this manor does not include tissue. § 130A-412.7(a).
- Defines "anatomical gift" as a donation of all or part of a human body to take effect after the donor's death for the purpose of transplantation, therapy, research, or education. § 130A-412.4 (3).
- Defines "drivers license" as a license or permit issued by the North Carolina Department of Transportation, Division of Motor Vehicles (DMV), to operate a vehicle, whether or not conditions are attached to the license or permit. § 130A-412.4(10).
- Defines "identification card" as an identification card issued by the DMV. § 130A-412.4(14).
- Defines "tissue" as a portion of the human body other than an organ or an eye. The term does not include blood unless the blood is donated for the purpose of research or education. § 130A-412.4(30).

BILL ANALYSIS: The act would modify the UAGA to include tissue as an anatomical gift that may be given by authorizing the placement of a symbol on the donor's driver's license or identification card.

EFFECTIVE DATE: The act would become effective October 1, 2019.

BACKGROUND: Tissue donation is currently authorized by various methods, such as a registering online with Donate Life N.C. Tissues that may be donated include skin, bones, heart valves, tendons and veins. As of 2017, 54.5% of North Carolinians have registered as an organ donor at the DMV. The National Conference of Commissioners on Uniform State Laws promulgated the first version of the UAGA in 1968 and has offered two major revisions to the Act since then, first in 1987 and then 2006. Every state has adopted at least one of version of the UAGA.

Karen Cochrane-Brown
Director

S210-SMBP-5 E1 -V-3

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S D

SENATE BILL 212
PROPOSED COMMITTEE SUBSTITUTE S212-PCS35136-SH-3

Short Title: Suspend Child Welfare/Aging Component/NC FAST. (Public)

Sponsors:

Referred to:

March 12, 2019

A BILL TO BE ENTITLED

AN ACT REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO POSTPONE DEPLOYMENT OF THE NORTH CAROLINA FAMILIES ACCESSING SERVICES THROUGH TECHNOLOGY (NC FAST) SYSTEM AS RELATED TO CASE-MANAGEMENT FUNCTIONALITY FOR THE CHILD WELFARE SYSTEM AND AGING AND ADULT SERVICES' PROGRAMS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Social Services, shall postpone deployment of the North Carolina Families Accessing Services through Technology (NC FAST) system as it relates to case-management functionality for the child welfare system and aging and adult services' programs. The Division shall not deploy the child welfare case-management component of the NC FAST system statewide prior to October 1, 2019, but shall instead continue to develop and improve case-management functionality for the child welfare component of NC FAST only in those counties that participated in the initial pilot program prior to January 1, 2019.

SECTION 2. All counties other than the counties that participated in the pilot program prior to January 1, 2019, may elect to utilize the Intake and Assessment functionality of the NC FAST system.

SECTION 3. This act is effective when it becomes law.

SENATE BILL 212:
Child Welfare/Aging Component/NC FAST.

2019-2020 General Assembly

Committee:	Senate Rules and Operations of the Senate	**Date:**	March 21, 2019
Introduced by:	Sens. Krawiec, Hise	**Prepared by:**	Theresa Matula
Analysis of:	Second Edition		Committee Staff

OVERVIEW: Senate Bill 212 requires the Division of Social Services, Department of Health and Human Services, to postpone deployment of the case-management functionality for the child welfare system and aging and adult services' programs in NC FAST (Families Accessing Services through Technology); prohibits the Division from deploying the child welfare case management component of NC FAST statewide prior to October 1, 2019; requires the Division to continue to develop and improve case-management functionality for the child welfare component only in those counties that participated in the initial pilot program prior to January 1, 2019; and allows counties, other than those that participated in the pilot prior to January 2019, to elect to utilize the Intake and Assessment functionality of the NC FAST system.

[As introduced, this bill was identical to H320, as introduced by Rep. Stevens, which is currently in an unknown committee.]

BILL ANALYSIS: Senate Bill 212 requires the Division of Social Services, Department of Health and Human Services, to postpone deployment of the case-management functionality for the child welfare system and aging and adult services' programs in NC FAST (Families Accessing Services through Technology).

The Division is also prohibited from deploying the child welfare case management component of NC FAST statewide prior to October 1, 2019, and must continue to develop and improve case-management functionality for the child welfare component only in those counties that participated in the initial pilot program prior to January 1, 2019. Counties, other than those in the pilot program prior to January 1, 2019, may elect to utilize the Intake and Assessment functionality of the NC FAST system

EFFECTIVE DATE: This bill would become effective when it becomes law.

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

SENATE BILL 212*

Short Title:	Suspend Child Welfare/Aging Component/NC FAST.	(Public)
Sponsors:	Senators Krawiec and Hise (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

March 12, 2019

A BILL TO BE ENTITLED

AN ACT REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO SUSPEND DEVELOPMENT OF THE NORTH CAROLINA FAMILIES ACCESSING SERVICES THROUGH TECHNOLOGY (NC FAST) SYSTEM AS RELATED TO CASE-MANAGEMENT FUNCTIONALITY FOR THE CHILD WELFARE SYSTEM AND AGING AND ADULT SERVICES' PROGRAMS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Social Services, shall suspend development of the North Carolina Families Accessing Services Through Technology (NC FAST) system as it relates to case-management functionality for the child welfare system and aging and adult services' programs. The Division shall not expand the child welfare case management component of the NC FAST system statewide, but shall instead continue to develop and improve case-management functionality for the child welfare component of NC FAST only in those counties that participated in the initial pilot program prior to January 1, 2019.

SECTION 2. This act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 212*

AMENDMENT NO. _____
(to be filled in by Principal Clerk)

S212-ABP-3 [v.1]

Amends Title [YES]
First Edition

Date 3/20 ,2019

Senator Krawiec

moves to amend the bill on page 1, line 3, by deleting "SUSPEND DEVELOPMENT" and substituting "POSTPONE DEPLOYMENT";

and on page 1, line 9, by deleting "suspend development" and substituting "postpone deployment";

and on page 1, lines 11 – 12, by rewriting the lines to read:
"welfare system and aging and adult services' programs. The Division shall not deploy the child welfare case management component of the NC FAST system statewide prior to October 1, 2019, but shall instead";

and on page 1, lines 15-16, by adding a new line between the line to read:
"**SECTION 2.** All counties other than the counties that participated in the pilot program prior to January 1, 2019, may elect to utilize the Intake and Assessment functionality of the NC FAST system.";

and on page 1, line 16, by deleting "**SECTION 2.**" and substituting "**SECTION 3.**".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

S212-ABP-3-V-1

Senate Committee on Health Care

March 20, 2019 – Room 643 – 10:00 PM

VISITORS

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Lauren Shea	Orange County DSS
Whitney Moore	Orange County DSS
Bernard M. Lee	Orange Co DSS
Melissa McDonald	Orange DSS
Nancy Cole	Orange DSS
Crystal Mitchell	Orange Co DSS
Deans Eaton	NCDOT
Patricia Gibbons	Connect 1
Kristy Preston	Surry County DSS
Tammy Schrenker	Wayne Co DSS
Sarah Bradshaw	Simpson Co. DSS
BRIAN CLAPIER	CHAPIN HALL AT UNIVERSITY OF CHICAGO
Michael Kelly	Kerr-Tar Reg. COG
Cindy McFarland	TSMS
Joyce Peters	CSS
Vicky Mozingo	Pediatrics
Emily Adams	NCPAA
Sally Paille'	NCAPA

Senate Committee on Health Care

March 20, 2019 – Room 643 – 10:00 PM

VISITORS

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NAME	FIRM OR AGENCY
[illegible]	Campbell PA
Deanna Reichert	Campbell PA
Bethany Flinchum	Campbell PA
Allison Blaylock	Campbell PA
Breanna Brabender	Campbell PA
Andy [illegible]	MVA
Erin Hendrickson	PCG
Lisa Cauley	DNNS/DSS
Susan Osborne	DHHS
Michael Beckett	DHHS/DSS
Tara Myers	DHHS
Susan Perry-Manley	DHHS

Senate Committee on Health Care

March 20, 2019 – Room 643 – 10:00 PM

VISITORS

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NAME	FIRM OR AGENCY
Susie Farrell	FSP
Dodie Reefer	Nelson Mullins
B Young	[illegible]
Kara Weishaar	SA
[illegible]	[illegible]
Brian Perkins	Alliance Health
Rob Thompson	NC Child
Leigh Jackson	DIT
Cassidy Robertson	AMGA
Sarah McMillan	KGANC
Jamaira Pfister	CHS
Sallie James	Governor's Office
JACK COZORT	NSS Raleigh
Maggie Cupp	NSS
Holly Perkins	Parker Poe
Kelly Kennedy	Carolina Donor Services
Kate Apodaca	Vista
Sue Ford	NCMS
Chip Baggett	NCMS

Senate Committee on Health Care

March 20, 2019 – Room 643 – 10:00 PM

VISITORS

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NAME	FIRM OR AGENCY
Lanier Hodgson	UNCHCS
Christina Craig	Wakemed
Daniel VanLieve D	Vidant Health
Peyton Mayo	
	NCRA
JEFF BARNHART	MWC

Senate Pages Attending

COMMITTEE: Health Care ROOM: 643

DATE: 3-20 TIME: 10 AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

Page Name	Hometown	Sponsoring Senator
1. Ahmad Whitaker	Raleigh	Blue
2. Anaya Truss-Williams	Charlotte	Waddell
3. Wyatt Sullivan	Raleigh	Sanderson
4. Harrison Burnette	Shelby	T. Alexander
5.		
6.		
7.		
8.		

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

Senate Committee on Health Care
Wednesday, April 10, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on April 10, 2019, in Room 643 of the Legislative Office Building. Thirteen members were present.

Senator Dan Bishop, Chair, presided.

Kennedy Cason sponsored by Sen. Waddell served as a page.

SB 361 - Health Care Expansion Act of 2019 (Senators Krawiec, Hise, Bishop) - FOR DISCUSSION ONLY

Sen. Bishop recognized Sens. Krawiec and Hise to explain the bill. Sen. Bishop then recognized Theresa Matula from the Legislative Analysis Division to clarify some of its provisions. Sen. Bishop then recognized Sen. Hise to further explain the bill.

Sen. Bishop then put the bill to the committee for discussion. Questions from members were answered by Sen. Hise.

The meeting adjourned at 10:25 AM.

Senator Dan Bishop, Chair
Presiding

John Wynne, Committee Clerk

Senate Committee on Health Care
Wednesday, April 10, 2019 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 361	Health Care Expansion Act of 2019	Senator Krawiec Senator Bishop Senator Hise

Adjournment

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S D

SENATE BILL 361
PROPOSED COMMITTEE SUBSTITUTE S361-PCS45303-BCf-41

Short Title: Health Care Expansion Act of 2019. (Public)

Sponsors:

Referred to:

March 27, 2019

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS REFORMS THAT WILL INCREASE ACCESS TO HEALTH CARE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

PART I. REFORM NORTH CAROLINA'S CERTIFICATE OF NEED LAWS

SECTION 1.(a) G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

...

(2) "Bed capacity" means space used exclusively for inpatient ~~care,~~ care at a health service facility, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage. ~~The term "bed capacity" also refers to the number of dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~

...

(5) "Change in bed capacity" means (i) any relocation of health service facility ~~beds, or dialysis stations~~ beds from one licensed facility or campus to another, or (ii) any redistribution of health service facility bed capacity among the categories of health service facility bed as defined in G.S. 131E-176(9c), or (iii) any increase in the number of health service facility ~~beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~beds.

...

(9a) "Health service" means an organized, interrelated medical, diagnostic, therapeutic, ~~and/or~~ or rehabilitative ~~activity~~ activity, or any combination of these, that is integral to the prevention of disease or the clinical management of a sick, injured, or disabled person. "Health service" does not include administrative and other activities that are not integral to clinical ~~management.~~management, or any activities performed at a facility that does not meet the definition of a health service facility.

(9b) "Health service facility" means 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 the mentally retarded;~~ home health agency office; ~~chemical dependency treatment facility; diagnostic center;~~ hospice office, hospice inpatient facility, or hospice residential care ~~facility; and ambulatory surgical~~ facility. The term "health service facility" does not include a licensable facility, as defined in G.S. 122C-3(14)b.

(9c) "Health service facility bed" means 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) intermediate care beds for the mentally retarded; (vi) chemical dependency treatment beds; (vii)~~ (iv) hospice inpatient facility beds; ~~(viii)~~ (v) hospice residential care facility beds; ~~(ix)~~ (vi) adult care home beds; and ~~(x)~~ (vii) long-term care hospital beds.

...

(14a) ~~"Intermediate care facility for the mentally retarded"~~ "Intermediate care facility for individuals with intellectual disabilities" means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for persons with ~~mental retardation,~~ intellectual disabilities, autism, cerebral palsy, epilepsy or related conditions.

...

(16) "New institutional health services" means any of the following:

...

d. The offering of ~~dialysis services or~~ home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.

...

~~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.~~

...

~~u. The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.~~

~~v. The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is reflected on the health service facility's license in effect as of January 1, 2005.~~

...."

SECTION 1.(b) G.S. 131E-177 reads as rewritten:

"**§ 131E-177. Department of Health and Human Services is designated State Health Planning and Development Agency; powers and duties.**

The Department of Health and Human Services is designated as the State Health Planning and Development Agency for the State of North Carolina, and is empowered to exercise the following powers and duties:

(1) To establish standards and criteria or plans required to carry out the provisions and purposes of this Article and to adopt rules pursuant to Chapter 150B of the General Statutes, to carry out the purposes and provisions of this ~~Article;~~Article.

(2) Adopt, amend, and repeal such rules and regulations, consistent with the laws of this State, as may be required by the federal government for grants-in-aid for health service facilities and health planning which may be made available by the federal government. This section shall be liberally construed in order that the State and its citizens may benefit from such ~~grants-in-aid;~~grants-in-aid.

(3) Define, by rule, procedures for submission of periodic reports by persons or health service facilities subject to agency review under this ~~Article;~~Article.

(4) ~~Develop~~ With respect to health service facilities planning, all of the following:

a. Develop policy, criteria, and standards for health service facilities ~~planning; shall conduct~~ planning.

b. Conduct statewide registration and inventories of and make determinations of need for health service facilities, health services as specified in G.S. 131E-176(16)f., and equipment as specified in G.S. 131E-176(16)f1., which shall include consideration of adequate geographic location of equipment and ~~services; and develop~~ services.

c. Develop a State Medical Facilities ~~Plan;~~Plan, provided, however, that the State Medical Facilities Plan shall not include policies or need determinations that limit the number of operating rooms or gastrointestinal endoscopy rooms.

(5) Implement, by rule, criteria for project ~~review;~~review.

(6) Have the power to grant, deny, or withdraw a certificate of need and to impose such sanctions as are provided for by this ~~Article;~~Article.

(7) Solicit, accept, hold and administer on behalf of the State any grants or devises of money, securities or property to the Department for use by the Department in the administration of this ~~Article; and~~Article.

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

(9) Collect fees for submitting applications for certificates of need.

(10) The authority to review all records in any recording medium of any person or health service facility subject to agency review under this Article which pertain to construction and acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records the Department deems to be reasonably necessary to determine compliance with this Article.

The Secretary of Health and Human Services shall have final decision-making authority with regard to all functions described in this section."

SECTION 1.(c) 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:~~

~~(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.~~Department."

SECTION 1.(d) G.S. 131E-181 reads as rewritten:

"**§ 131E-181. Nature of certificate of need.**

…

(d) A recipient of a certificate of need shall complete the project authorized by the certificate of need within two years after the decision to issue the certificate of need becomes final. If the recipient does not complete the project authorized by the certificate of need within this two-year time period, the certificate of need for the authorized project expires the day after the two-year time period ends. A project authorized by a certificate of need is complete when the health service or the health service facility for which the certificate of need was issued is licensed and certified and is in material compliance with the representations made in the certificate of need application.

(e) The Department shall withdraw a certificate of need issued to any recipient that ceases operating the health service or health service facility included in that certificate of need for more than one year."

SECTION 1.(e) G.S. 131E-183(a)(1) reads as rewritten:

"(1) The proposed project 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 that may be approved."

SECTION 1.(f) G.S. 131E-184(c) reads as rewritten:

"(c) The Department shall exempt from certificate of need review any conversion of existing acute care beds to psychiatric ~~beds provided:~~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 and/or one or more of the Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities to provide psychiatric beds to patients referred by the contracting agency or agencies; and~~

~~(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.~~"

SECTION 1.(g) G.S. 131E-184(e)(1) reads as rewritten:

"(1) The proposed capital expenditure would:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding an existing:

1. Nursing home facility, or

2. Adult care home ~~facility, or~~facility; and

~~3. Intermediate care facility for the mentally retarded; and~~

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."

SECTION 1.(h) G.S. 131E-184 is amended by adding new subsections to read:

"(i) The Department shall exempt from certificate of need review the development, acquisition, construction, expansion, or replacement of a health service facility or health service that obtained certificate of need approval prior to October 1, 2019, as an ambulatory surgical facility, including an ambulatory surgical facility with one or more operating rooms or gastrointestinal endoscopy procedure rooms; a diagnostic center; kidney disease treatment center, including freestanding dialysis units; chemical dependency treatment facility; intermediate care facility for individuals with intellectual disabilities; psychiatric hospital; or any other licensable facility, as defined in G.S. 122C-3(14)b.

(j) The Department shall exempt from certificate of need review the establishment of a home health agency by a continuing care retirement community licensed under Article 64 of Chapter 58 of the General Statutes to provide home health services to one or more residents of a continuing care retirement community who have entered into a contract with the continuing care retirement community to receive continuing care services with lodging. A continuing care retirement community that seeks to provide home health services to individuals who do not reside at the continuing care retirement community pursuant to a contract to receive continuing care services with lodging shall be required to obtain a certificate of need as a home health agency prior to developing or offering home health services to any individual not a resident of the continuing care retirement community under a contract to receive continuing care services with lodging. As used in this subsection, the terms "continuing care" and "lodging" are as defined in G.S. 58-64-1. Nothing in this subsection shall be construed to exempt from the State's home health agency licensure and certification requirements a continuing care retirement community that has been exempted from certificate of need review for the provision of home health services to one or more residents pursuant to this subsection."

SECTION 1.(i) G.S. 131E-184(j), as enacted by this section, applies to continuing care retirement communities engaged in the direct provision of home health services on or after October 1, 2019.

SECTION 1.(j) G.S. 131E-186(a) reads as rewritten:

"(a) Within the prescribed time limits in G.S. 131E-185, the Department shall issue a decision to "approve," "approve with conditions," or "deny," an application for a new institutional health service. ~~Approvals involving new or expanded nursing care or intermediate care for the mentally retarded bed capacity shall include a condition that specifies the earliest possible date the new institutional health service may be certified for participation in the Medicaid program. The date shall be set far enough in advance to allow the Department to identify funds to pay for care in the new or expanded facility in its existing Medicaid budget or to include these funds in its State Medicaid budget request for the year in which Medicaid certification is expected.~~"

SECTION 1.(k) 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, any ~~affected person, as defined in subsection (c) of this section,~~

~~shall be~~ proponent of an application that was reviewed with the application for that certificate of need is 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 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 days after the assignment of the administrative law judge or hearing officer.

(3) The hearing at which sworn testimony is taken and evidence is presented shall be held within 45 days after the end of the discovery period.

(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.

...

(b) Any ~~affected~~ person 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 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 who were parties to the contested hearing. The Court of Appeals, in an action for judicial review brought under this section, shall award all costs of such action, including reasonable attorney's fees to the prevailing party. For the purpose of this subsection, reasonable attorney's fees include attorney's fees incurred during the administrative review portion of the contested case arising under Article 3 of Chapter 150B of the General Statutes.

(b1) Before filing an appeal of a final decision granting a certificate of need, the ~~affected person~~ appellant 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).~~ five hundred thousand dollars ($500,000). 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.

...

~~(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.~~"

SECTION 1.(*l*) G.S. 131E-147 is amended by adding a new subsection to read:

"(f) The Department shall not issue or renew a license to operate an ambulatory surgical facility developed, acquired, or replaced on or after October 1, 2019, unless the application includes all of the following:

(1) A commitment that the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least four percent (4%) of the total revenue collected for all surgical cases performed in the facility or proposed facility.

(2) For each year of operation, a commitment to report to the Department the total number of cases by each of the following payer categories:

a. Self-pay surgical cases.
b. Medicaid surgical cases.
c. Medicare surgical cases.
d. Commercial insurance surgical cases.
e. Managed care surgical cases.
f. Other surgical cases.

(3) A commitment to report utilization and payment data for services provided by the ambulatory surgical facility to the statewide data processor, as required by G.S. 131E-214.2."

SECTION 1.(m) G.S. 131E-175(11) and (12) are repealed.

SECTION 1.(n) This section becomes effective October 1, 2019.

PART II. PSYCHOLOGY INTERJURISDICTIONAL LICENSURE COMPACT

SECTION 2.(a) Article 18A of Chapter 90 of the General Statutes, G.S. 90-270.1 through G.S. 90-270.22, is recodified as Article 18G of Chapter 90 of the General Statutes, G.S. 90-270.135 through G.S. 90-270.159.

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

"Article 18H.

"Psychology Interjurisdictional Licensure Compact.

"**§ 90-270.160. Purpose.**

This Compact is designed to achieve the following purposes and objectives:

(1) Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology.

(2) Enhance the states' ability to protect the public's health and safety, especially client/patient safety.

(3) Encourage the cooperation of Compact States in the areas of psychology licensure and regulation.

(4) Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history.

(5) Promote compliance with the laws governing psychological practice in each Compact State.

(6) Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

"**§ 90-270.161. Definitions.**

(1) Adverse action. – Any action taken by a State Psychology Regulatory Authority which finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

(2) Association of State and Provincial Psychology Boards (ASPPB). – The recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

(3) Authority to Practice Interjurisdictional Telepsychology. – A licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

(4) Bylaws. – Those Bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to G.S. 90-270.169 for its governance or for directing and controlling its actions and conduct.

(5) Client/patient. – The recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services.

(6) Commissioner. – The voting representative appointed by each State Psychology Regulatory Authority pursuant to G.S. 90-270.169.

(7) Compact State. – A state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to G.S. 90-270.172(c) or been terminated pursuant to G.S. 90-270.171(b).

(8) Confidentiality. – The principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

(9) Coordinated Licensure Information System or Coordinated Database. – An integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(10) Day. – Any part of a day in which psychological work is performed.

(11) Distant State. – The Compact State where a psychologist is physically present (not through the use of telecommunications technologies) to provide temporary in-person, face-to-face psychological services.

(12) E.Passport. – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

(13) Executive Board. – A group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

(14) Home State. – A Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authority to Practice Interjurisdictional Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the

psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

(15) Identity History Summary. – A summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

(16) In-person, face-to-face. – Interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

(17) Interjurisdictional Practice Certificate (IPC). – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily and verification of one's qualifications for such practice.

(18) License. – Authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

(19) Non-Compact State. – Any State which is not at the time a Compact State.

(20) Psychologist. – An individual licensed for the independent practice of psychology.

(21) Psychology Interjurisdictional Compact Commission (Commission). – The national administration of which all Compact States are members.

(22) Receiving State. – A Compact State where the client/patient is physically located when the telepsychological services are delivered.

(23) Rule. – A written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to G.S. 90-270.170 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal, or suspension of an existing rule.

(24) Significant investigatory information. –

a. Investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

b. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

(25) State. – A state, commonwealth, territory, or possession of the United States or the District of Columbia.

(26) State Psychology Regulatory Authority. – The Board, office, or other agency with the legislative mandate to license and regulate the practice of psychology.

(27) Telepsychology. – The provision of psychological services using telecommunication technologies.

(28) Temporary Authorization to Practice. – A licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

(29) Temporary in-person, face-to-face practice. – Where a psychologist is physically present (not through the use of telecommunications technologies) in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

"**§ 90-270.162. Home State licensure.**

(a) The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

(b) A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(c) Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(d) Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

(e) A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

(1) Currently requires the psychologist to hold an active E.Passport;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

(f) A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

(1) Currently requires the psychologist to hold an active IPC;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

"**§ 90-270.163. Compact privilege to practice telepsychology.**

(a) Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice telepsychology in other Compact States

(Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

(b) To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:
  a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or
  b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:
  a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;
  b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;
  c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;
  d. The program must consist of an integrated, organized sequence of study;
  e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;
  f. The designated director of the program must be a psychologist and a member of the core faculty;
  g. The program must have an identifiable body of students who are matriculated in that program for a degree;
  h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;
  i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master's degree;
  j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;

(4) Have no history of adverse action that violate the Rules of the Commission;

(5) Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;

(6) Possess a current, active E.Passport;

(7) Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background, and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

(8) Meet other criteria as defined by the Rules of the Commission.

(c) The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

(d) A psychologist practicing in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State is restricted, suspended, or otherwise limited, the E.Passport shall be revoked and, therefore, the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

"**§ 90-270.164. Compact Temporary Authorization to Practice.**

(a) Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

(b) To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;

(4) No history of adverse action that violates the Rules of the Commission;

(5) No criminal record history that violates the Rules of the Commission;

(6) Possess a current, active IPC;

(7) Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

(8) Meet other criteria as defined by the Rules of the Commission.

(c) A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

(d) A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State is restricted, suspended, or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

"**§ 90-270.165. Conditions of telepsychology practice in a Receiving State.**

A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

(1) The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State.

(2) Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

"**§ 90-270.166. Adverse actions.**

(a) A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

(b) A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

(c) If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

(1) All Home State disciplinary orders which impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

(2) In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

(3) Other actions may be imposed as determined by the Rules promulgated by the Commission.

(d) A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

(e) A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice which occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

(f) Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

(g) No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection (c) of this section.

"**§ 90-270.167. Additional authorities invested in a Compact State's Psychology Regulatory Authority.**

In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

(1) Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a Compact State's Psychology Regulatory Authority for the attendance and testimony of witnesses and/or the production of evidence from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

(2) Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

(3) During the course of any investigation, a psychologist may not change his/her Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his/her Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission.

All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal, and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

"**§ 90-270.168. Coordinated Licensure Information System.**

(a) The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

(b) Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

(1) Identifying information;
(2) Licensure data;
(3) Significant investigatory information;
(4) Adverse actions against a psychologist's license;
(5) An indicator that a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;
(6) Nonconfidential information related to alternative program participation information;
(7) Any denial of application for licensure and the reasons for such denial; and
(8) Other information which may facilitate the administration of this Compact, as determined by the Rules of the Commission.

(c) The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

(d) Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

(e) Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

"**§ 90-270.169. Establishment of the Psychology Interjurisdictional Compact Commission.**

(a) The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

(1) The Commission is a body politic and an instrumentality of the Compact States.
(2) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.
(3) Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting, and Meetings. –

(1) The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary, or similar executive;
b. Current member of the State Psychology Regulatory Authority of a Compact State; or
c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

(2) Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

(3) Each Commissioner shall be entitled to one vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

(4) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

(5) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rule-making provisions in G.S. 90-270.170.

(6) The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:
a. Noncompliance of a Compact State with its obligations under the Compact;
b. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;
c. Current, threatened, or reasonably anticipated litigation against the Commission;
d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;
e. Accusation against any person of a crime or formally censuring any person;
f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;
g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
h. Disclosure of investigatory records compiled for law enforcement purposes;
i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or
j. Matters specifically exempted from disclosure by federal and state statute.

(7) If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of

actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

(c) The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including, but not limited to:

(1) Establishing the fiscal year of the Commission;

(2) Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

(3) Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;

(4) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

(6) Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;

(7) Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

(8) The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto with the appropriate agency or officer in each of the Compact States;

(9) The Commission shall maintain its financial records in accordance with the Bylaws; and

(10) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(d) The Commission shall have the following powers:

(1) The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all Compact States;

(2) To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

(3) To purchase and maintain insurance and bonds;
(4) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compact State;
(5) To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;
(6) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of the same, provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;
(7) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the Commission shall strive to avoid any appearance of impropriety;
(8) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;
(9) To establish a budget and make expenditures;
(10) To borrow money;
(11) To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;
(12) To provide and receive information from, and to cooperate with, law enforcement agencies;
(13) To adopt and use an official seal; and
(14) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice, and telepsychology practice.

(e) The Executive Board. – The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact.
(1) The Executive Board shall be comprised of six members:
a. Five voting members who are elected from the current membership of the Commission by the Commission.
b. One ex officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.
(2) The ex officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.
(3) The Commission may remove any member of the Executive Board as provided in Bylaws.
(4) The Executive Board shall meet at least annually.
(5) The Executive Board shall have the following duties and responsibilities:
a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, or fees paid by Compact States such as annual dues and any other applicable fees;
b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;
d. Maintain financial records on behalf of the Commission;
e. Monitor Compact compliance of member states and provide compliance reports to the Commission;
f. Establish additional committees as necessary; and
g. Other duties as provided in Rules or Bylaws.

(f) Financing of the Commission. –

(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.

(2) The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(3) The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

(4) The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State.

(5) The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

(g) Qualified Immunity, Defense, and Indemnification. –

(1) The members, officers, Executive Director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(2) The Commission shall defend any member, officer, Executive Director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(3) The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

"**§ 90-270.170. Rule making.**

(a) The Commission shall exercise its rule-making powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

(c) Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

(d) Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rule Making:

(1) On the Web site of the Commission; and

(2) On the Web site of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

(e) The Notice of Proposed Rule Making shall include:

(1) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

(f) Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(g) The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

(1) At least 25 persons who submit comments independently of each other;

(2) A governmental subdivision or agency; or

(3) A duly appointed person in an association that has at least 25 members.

(h) If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

(1) All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.

(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(3) No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not

preclude the Commission from making a transcript or recording of the hearing if it so chooses.

(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

(j) The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rule-making record and the full text of the rule.

(k) If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

(*l*) Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rule-making procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety, or welfare;

(2) Prevent a loss of Commission or Compact State funds;

(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

(4) Protect public health and safety.

(m) The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the Web site of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

"**§ 90-270.171. Oversight, dispute resolution, and enforcement.**

(a) Oversight. –

(1) The executive, legislative, and judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

(2) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

(3) The Commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

(b) Default, Technical Assistance, and Termination. –

(1) If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:
a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default, and/or any other action to be taken by the Commission; and
b. Provide remedial training and specific technical assistance regarding the default.
(2) If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States and all rights, privileges, and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.
(3) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.
(4) A Compact State which has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.
(5) The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.
(6) The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the State of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution. –
(1) Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States.
(2) The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the Commission.

(d) Enforcement. –
(1) The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.
(2) By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.
(3) The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

"**§ 90-270.172. Date of implementation of the Psychology Interjurisdictional Compact Commission and associated rules, withdrawal, and amendments.**

(a) The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rule-making powers necessary to the implementation and administration of the Compact.

(b) Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

(c) Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

(1) A Compact State's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

(d) Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

(e) This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

"**§ 90-270.173. Construction and severability.**

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States."

SECTION 2.(c) Subsections (a) and (b) of this section become effective when at least seven states have enacted the Psychology Interjurisdictional Compact (PSYPACT) set forth in subsection (b) of this section. The North Carolina Psychology Board shall report to the Revisor of Statutes when the PSYPACT set forth in subsection (b) of this section has been enacted by seven member states.

PART III. ALLOW LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT FIRST-LEVEL EXAMINATIONS FOR INVOLUNTARY COMMITMENT AND CREATE FEES

SECTION 3.(a) G.S. 122C-263.1(a) reads as rewritten:

"**§ 122C-263.1. Secretary's authority to certify commitment examiners; training of certified commitment examiners performing first examinations; LME/MCO responsibilities.**

(a) Physicians and eligible psychologists are qualified to perform the commitment examinations required under G.S. 122C-263(c) and G.S. 122C-283(c). The Secretary of Health and Human Services may individually certify to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 other health, mental health, and substance abuse professionals whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment as follows:

(1) The Secretary has received a request:

a. To certify a licensed clinical social worker, a master's or higher level degree nurse practitioner, a licensed professional counsellor, a licensed marriage and family therapist, or a physician's assistant to

conduct the first examinations described in G.S. 122C-263(c) and G.S. 122C-283(c).

b. To certify a master's level licensed clinical addictions specialist to conduct the first examination described in G.S. 122C-283(c).

...

(5) In no event shall the certification of a licensed clinical social worker, master's or higher level degree nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or master's level certified clinical addictions specialist under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or the master's level certified clinical addictions specialist.

...."

SECTION 3.(b) G.S. 90-270.54 reads as rewritten:

"**§ 90-270.54. Requirements for licensure as a marriage and family therapist.**

...

(a1) The Board shall issue a license to conduct first examinations pursuant to G.S. 122C-263.1 to applicants who meet the criteria for licensure in subsection (a) of this subsection and who pay a one-time, ten dollar ($10.00) fee.

...."

SECTION 3.(c) G.S. 90-270.57 reads as rewritten:

"**§ 90-270.57. Fees.**

(a) In order to fund the Board's activities under this Article, the Board may charge and collect fees not exceeding the following:

...

(10) Application to perform first examinations pursuant to G.S. 122C-263.1 10.00.

In addition to the examination fee provided in subdivision (1) of this subsection, the Board may charge and collect from each applicant for license examination the cost of processing test results and the cost of test materials.

(b) The Board may establish fees for the actual cost of (i) document duplication services, (ii) materials, and (iii) returned bank items as allowed by law. All fees listed in subsection (a) of this section shall be nonrefundable."

SECTION 3.(d) This section is effective October 1, 2019. Sections 3(b) and 3(c) apply to applications submitted on or after that date.

PART IV. ELIMINATE REDUNDANCY IN ADULT CARE HOME INSPECTIONS

SECTION 4. G.S. 131D-2.11(a) reads as rewritten:

"(a) State Inspection and Monitoring. – The Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. All facilities licensed under this Article and adult care units in nursing homes are subject to inspections at all times by the Secretary. Except as provided in subsection (a1) of this section, the Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis. Beginning July 1, 2012, the Division of Health Service Regulation shall include as part of its inspection of all adult care homes a review of the facility's compliance with G.S. 131D-4.4A(b) and safe practices for injections and any other procedures during which bleeding typically occurs. In addition, the Department shall ensure that adult care homes are inspected every two years to determine compliance with physical plant and life-safety requirements.

If the annual inspection of an adult care home is conducted separately from the inspection required every two years to determine compliance with physical plant and life-safety requirements, the Division of Health Service Regulation shall not cite, as part of the annual inspection, any violation of law that overlaps with an area addressed by the physical plant and life-safety inspection, unless failure to address the violation during the annual inspection would pose a risk to resident health or safety. Nothing in this section prevents a licensing inspector from referring a concern about physical plant and life-safety requirements to the section within the Division of Health Service Regulation that conducts physical plant and life-safety inspections."

PART V. SEVERABILITY CLAUSE AND EFFECTIVE DATE

SECTION 5.(a) If any section or 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 to be unconstitutional or invalid.

SECTION 5.(b) Except as otherwise provided, this act is effective when it becomes law.

SENATE BILL 361:
Health Care Expansion Act of 2019.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 9, 2019
Introduced by:	Sens. Krawiec, Bishop, Hise	**Prepared by:**	Jessica Boney Theresa Matula Jason Moran-Bates Committee Staff
Analysis of:	First Edition		

OVERVIEW: Senate Bill 361 would increase innovation waiver slots, including an appropriation; repeal Certificate of Need (CON) Laws; enact the Psychology Interjurisdictional Licensure Compact (PSYPACT); allow marriage and family therapist to conduct the first-level exam for involuntary commitment; make changes to the Program for All-Inclusive Care for the Elderly (PACE) Program; and eliminate redundancy in adult care home inspections.

BILL ANALYSIS: Senate Bill 361 would make the changes outlined below.

PART I. INCREASE INNOVATION WAIVER SLOTS would increase innovation waiver slots by a maximum of 1,000 slots available on January 1, 2020 and a maximum of 1,000 slots available January 1, 2021. It would appropriate from the General Fund $10,250,000 in recurring funds for the 2019-2020 fiscal year and $30,750,000 in recurring funds for the 2020-2021 fiscal year to fund these additional slots.

PART II. REPEAL CERTIFICATE OF NEED LAWS would repeal North Carolina's Certificate of Need laws, which are found in Article 9 of Chapter 131E. It would also make changes to statutes in Chapters 6, 58, 113A, 122C, 130A, 131E, 143B, 148, and 150B to conform them to Certificate of Need repeal.

PART III. PSYCHOLOGY INTERJURISDICTIONAL LICENSURE COMPACT (PSYPACT)

Section 3(a) would recodify the current Psychology Practice Act, Article 18A of Chapter 90 of the General Statutes, as Article 18H of Chapter 90 of the General Statutes. **Section 3(b)** of the bill would enact the PSYPACT.

G.S. 90-270.160 would set forth the purpose of the PSYPACT.

G.S. 90-270.161 would establish definitions for the PSYPACT.

G.S. 09-270.162 would:

- Establish a psychologist's home state as the state in which the psychologist is licensed or physically present when practicing.
- Allow a psychologist to provide services, via telepsychology, to clients in other compact states, if those states:
    - Require the psychologist to hold an E.Passport.

  - Investigate complaints against psychologists.
  - Notify the PSYPACT Commission about adverse actions taken against psychologists.
  - Comply with the by-laws of the Commission.
  - Perform criminal background checks on psychologists.
- Allow a psychologist to provide face-to-face services in a compact state if that state:
  - Requires psychologists to hold a current Interjurisdictional Practice Certificate (IPC).
  - Investigates complaints against psychologists.
  - Notifies the PSYPACT Commission about adverse actions taken against psychologists.
  - Complies with the by-laws of the Commission.
  - Performs criminal background checks on psychologists.

G.S. 90-270.163 would allow a psychologist to practice telepsychology with clients in other compact states, provided that the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid E.Passport, and makes certain attestations.

Psychologists practicing under G.S. 90-270.163 would be subject to their home state's licensing authorities, and be subject to the compact state's rules regarding scope of practice.

G.S. 90-270.164 would allow a psychologist to practice psychology face-to-face with clients in compact states, provided the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid IPC, and makes certain attestations.

Psychologists practicing under G.S. 90-270.164 would be subject to the authority, law, and scope of practice of the compact state in which they are practicing.

G.S. 90-270.165 would allow a psychologist to practice telepsychology with patients in other compact states only when the psychologist initiates the session from the home state in which the psychologist is licensed.

G.S. 90-270.166 would allow home states, compact states in which a psychologist treats patients face-to-face, and states in which a psychologist practices via telepsychiatry to take adverse actions against the psychologist's license.

G.S. 90-270.167 would allow the regulatory authority in the compact states the power to:

- Issue subpoenas.
- Issue cease-and-desist orders.
- Prevent psychologists under investigation from changing their home state licensures.

G.S. 90-270.168 would allow the Commission to maintain a database containing the following data on licensed psychologists, which must be submitted by each compact state:

- Identifying information.
- Licensure data.
- Significant investigatory information.
- Information on adverse actions taken by the regulatory authority.

G.S. 90-270.169 would create the Psychology Interjurisdictional Compact Commission. Membership in the Commission would consist of one voting member from each compact state. All meetings of the Commission must be public unless employment, discipline, litigation, contract negotiation, or adverse action investigation are being discussed. The Commission would have all the powers necessary to administer and carry out the business of the PSYPACT.

The Commission may be financed by accepting gifts and levying assessments on member states.

Commission members would be immune from suit for their official actions.

G.S. 90-270.170 would give the Commission power to make rules for the compact. These rules would not affect the rules of practice established by the regulatory authorities of the member states. Rules may be approved by a majority vote of Commission members, and any rule rejected by the legislatures of a majority of member states would no longer have any effect.

G.S. 90-270.171 would establish oversight, default, and conflict resolution provisions for the PSYPACT.

- All branches of government of all member states must enforce the PSYPACT's purpose and intent.
- If a state is in default under the terms of the PSYPACT and refuses to cure that default, the Commission may terminate the state's membership in the PSYPACT.
- By a majority vote of members, the Commission may initiate legal action to enforce compliance with the rules of the PSYPACT.
- The Commission will attempt to resolve any dispute between member and non-member states.

G.S. 90-270.172 would:

- Make the PSYPACT effective on the date the seventh member state enacts it.
- Allow member states to leave the PSYPACT by repealing the act enacting it.
- Prevent the Commission from prohibiting any other licensure agreements between member states, so any reciprocity agreements between member states would still remain in effect.
- Allow member states to amend the PSYPACT; however, amendments would not take effect until the legislatures of all the member states enacted them.

G.S. 90-270.173 would require the PSYPACT to be construed liberally, and if any portions of the PSYPACT are struck down by a court, the remaining provisions would remain in effect.

PART IV. ALLOW LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT FIRST-LEVEL EXAM FOR INVOLUNTARY COMMITMENT would amend G.S. 122C-263.1 to permit licensed marriage and family therapists to conduct first examinations in involuntary commitment proceedings.

PART V. PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) REGULATORY CHANGES would amend statutes pertaining to adult care homes, assisted living facilities, multiunit assisted housing with services (MAHS), and adult day care. **Section 5(a)** amends the licensure requirements for a home care agency to exempt an entity from licensure if they are providing home care services to a PACE program participant if the organization has a valid PACE agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits, Department of Health and Human Services.

Section 5(b) amends the definitions of an adult care home, assisted living residence, and multiunit assisted housing with services (MAHS), to allow services from a PACE organization with a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits, Department of Health and Human Services. **Sections 5(c) – (e)** make conforming changes to adult care home statutes to allow the incorporation of PACE. **Section 5(f)** amends the statutes that pertain to the certification of adult day care programs to exempt adult day care programs with PACE program participants from certification if the organization has a valid PACE agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits, Department of Health and Human Services.

PART VI. ELIMINATE REDUNDANCY IN ADULT CARE HOME INSPECTIONS would amend the statute pertaining to inspections, monitoring, and review of adult care homes. The amendment would provide that if the annual inspection of an adult care home is conducted separately from the physical plant and life-safety requirements inspection required every two years, the Division of Health Service Regulation, DHHS, is prohibited from citing a violation of law that overlaps with a physical plant and life-safety inspection area in the annual inspection unless failure to address poses a risk to resident health or safety.

PART VII contains a severability clause.

EFFECTIVE DATE: Except as provided below, the bill would become effective when it becomes law:

- PART II would be effective January 1, 2020. Subsection (a) of Part II would be apply to contested cases arising on or after January 1, 2020.
- PART III would be effective when at least seven states have enacted the PSYPACT set forth in Part III.
- PART IV would be effective October 1, 2019.
- PART V pertaining to changes associated with the PACE program would become effective October 1, 2019.

BACKGROUND:

PART II: Any new institutional health service, as defined in G.S. 131A-176(16), must undergo Certificate of Need review before it is offered. The process requires an application to the department of Health and Human Services, Division of Health Service Regulation. After the application is submitted, there is a public comment and hearing process before the Division approves or disapproves the application. In making a determination, the Division considers the needs identified in the State Medical Facilities Plan.

PART III: The PSYPACT is a multi-jurisdictional psychology compact. As of April 9, 2019, it has been enacted by seven states (Arizona, Nevada, Utah, Colorado, Nebraska, Missouri and Illinois). Though Illinois has enacted PSYPACT legislation, it does not become effective until January 1st, 2020, and therefore does not count as the seventh state needed to make PSYPACT operational. PSYPACT legislation is currently being considered in District of Columbia, Georgia, New Hampshire, Oklahoma, Pennsylvania, Rhode Island and Texas. It has been endorsed by the psychology licensing boards in seven states (New Mexico, Texas, Georgia, Ohio, Wisconsin, Virginia and Rhode Island). PSYPACT was recommended by the Joint Legislative Oversight Committee on Health and Human Services to the 2018 Session of the 2017 General Assembly of North Carolina.

PART IV: G.S. 122C-263(c) requires that a commitment examiner conduct an examination of a respondent within 24 hours of the respondent being presented for involuntary commitment. This examination can be conducted in person or by using telemedicine procedures. After examining the respondent, the commitment examiner can recommend outpatient treatment, treatment at a 24-hour facility prior to a court hearing on commitment, or a termination of the commitment proceedings.

PART V: Medicaid and Health Choice Clinical Coverage Policy 3B provides the following description of PACE: "The Program of All-Inclusive Care for the Elderly (PACE) is a unique model of managed care service delivery for the frail elderly living in the community. Most PACE participants are dually eligible for Medicare and Medicaid benefits, and all are certified eligible for nursing facility level of care according to the standards established by the state Medicaid agency. The PACE program uses monthly capitated payments from Medicare and NC Medicaid (Medicaid) to provide an integrated and comprehensive medical and social service delivery system for elderly individuals who choose to receive services in the least restrictive community-based setting of care. PACE uses an interdisciplinary team to provide services at the PACE Center and to case manage the services, and supports provided to PACE participants by providers in the PACE network. The PACE program is located in the community and contains a certified adult day health program. Services are provided on site and supplemented by in-home and referral to other services according to each participant's needs."

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

SENATE BILL 361

Short Title:	Health Care Expansion Act of 2019.	(Public)
Sponsors:	Senators Krawiec, Bishop, and Hise (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

March 27, 2019

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS REFORMS THAT WILL INCREASE ACCESS TO HEALTH CARE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

PART I. INCREASE INNOVATIONS WAIVER SLOTS

SECTION 1.(a) The Department of Health and Human Services, Division of Health Benefits, shall amend the North Carolina Innovations waiver to increase the number of slots available under the waiver by a maximum of 1,000 slots to be made available on January 1, 2020, and by a maximum of 1,000 slots to be made available on January 1, 2021.

SECTION 1.(b) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Health Benefits, the sum of ten million two hundred fifty thousand dollars ($10,250,000) in recurring funds for the 2019-2020 fiscal year and the sum of thirty million seven hundred fifty thousand dollars ($30,750,000) in recurring funds for the 2020-2021 fiscal year to be used to fund these additional slots.

PART II. REPEAL OF NORTH CAROLINA'S CERTIFICATE OF NEED LAWS

SECTION 2.(a) G.S. 6-19.1(a) reads as rewritten:

"(a) In any civil action, other than an adjudication for the purpose of establishing or fixing a rate, or a disciplinary action by a licensing board, brought by the State or brought by a party who is contesting State action pursuant to G.S. 150B-43 or any other appropriate provisions of law, unless the prevailing party is the State, the court may, in its discretion, allow the prevailing party to recover reasonable attorney's fees, including attorney's fees applicable to the administrative review portion of the case, in contested cases arising under Article 3 of Chapter 150B, to be taxed as court costs against the appropriate agency if:

(1) The court finds that the agency acted without substantial justification in pressing its claim against the party; and

(2) The court finds that there are no special circumstances that would make the award of attorney's fees unjust. The party shall petition for the attorney's fees within 30 days following final disposition of the case. The petition shall be supported by an affidavit setting forth the basis for the request.

~~Nothing in this section shall be deemed to authorize the assessment of attorney's fees for the administrative review portion of the case in contested cases arising under Article 9 of Chapter 131E of the General Statutes.~~

Nothing in this section grants permission to bring an action against an agency otherwise immune from suit or gives a right to bring an action to a party who otherwise lacks standing to bring the action.

Any attorney's fees assessed against an agency under this section shall be charged against the operating expenses of the agency and shall not be reimbursed from any other source."

SECTION 2.(b) G.S. 58-50-61(a) reads as rewritten:

"(a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:

...

(8) "Health care provider" means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes or the laws of another state to provide health care services in the ordinary care of business or practice or a profession or in an approved education or training program; a health care facility as defined in ~~G.S. 131E-176(9b)~~ this section or the laws of another state to operate as a health care facility; or a pharmacy.

...

(9a) "Health service facility" means 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, hospice inpatient facility, or hospice residential care facility; or ambulatory surgical facility.

...."

SECTION 2.(c) G.S. 58-55-35(a) reads as rewritten:

"(a) Whenever long-term care insurance provides coverage for the facilities, services, or physical or mental conditions listed below, unless otherwise defined in the policy and certificate, and approved by the Commissioner, such facilities, services, or conditions are defined as follows:

...

(10) "Hospice" ~~shall be defined in accordance with the terms of G.S. 131E-176(13a).~~means any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.

(11) "Intermediate care facility for ~~the mentally retarded" shall be defined in accordance with the terms of G.S. 131E-176(14a).~~individuals with intellectual disabilities" means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for individuals with intellectual disabilities, autism, cerebral palsy, epilepsy, or related conditions.

...."

SECTION 2.(d) G.S. 113A-12(3)e. reads as rewritten:

"e. A health care facility financed pursuant to Chapter 131A of the General ~~Statutes or receiving a certificate of need under Article 9 of Chapter 131E of the General~~ Statutes."

SECTION 2.(e) G.S. 122C-23.1(e) reads as rewritten:

"(e) As used in this section, "residential treatment facility" means a "residential facility" as defined in and licensed under this ~~Chapter, but not subject to Certificate of Need requirements under Article 9 of Chapter 131E of the General Statutes.~~Chapter."

SECTION 2.(f) G.S. 131E-13(a)(1) reads as rewritten:

"(1) The corporation shall continue to provide the same or similar clinical hospital services to its patients in medical-surgery, obstetrics, pediatrics, outpatient and emergency treatment, including emergency services for the indigent, that the hospital facility provided prior to the lease, sale, or conveyance. These services may be terminated only as prescribed ~~by Certificate of Need Law prescribed in Article 9 of Chapter 131E of the General Statutes, or, if Certificate of Need Law is inapplicable,~~ by review procedure designed to guarantee public participation pursuant to rules adopted by the Secretary of the Department of Health and Human Services."

SECTION 2.(g) G.S. 131E-136(4) reads as rewritten:

"(4) "Home health agency" means a home care agency which is certified to receive Medicare and Medicaid reimbursement for providing nursing care, therapy, medical social services, and home health aide services on a part-time, intermittent ~~basis as set out in G.S. 131E-176(12), and is thereby also subject to Article 9 of Chapter 131E.~~basis."

SECTION 2.(h) 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 Division of Adult Correction of the Department of Public Safety 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 of the Division of Adult Correction of the Department of Public Safety and to members of the general public, the portion of the facility that serves inmates shall be exempt from licensure.

~~(b) Any person who contracts to provide inpatient chemical dependency or substance abuse services to inmates of the Division of Adult Correction of the Department of Public Safety 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 2.(i) Article 9 of Chapter 131E of the General Statutes, G.S. 130A-45.02(i), 143B-1292, 150B-2(8a)k., and 150B-21.1(6) are repealed.

SECTION 2.(j) This section becomes effective January 1, 2020. Subsection (a) of this section applies to contested cases arising on or after January 1, 2020.

PART III. PSYCHOLOGY INTERJURISDICTIONAL LICENSURE COMPACT

SECTION 3.(a) Article 18A of Chapter 90 of the General Statutes, G.S. 90-270.1 through G.S. 90-270.22, is recodified as Article 18G of Chapter 90 of the General Statutes, G.S. 90-270.135 through G.S. 90-270.159.

SECTION 3.(b) Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 18H.

"Psychology Interjurisdictional Licensure Compact.

"**§ 90-270.160. Purpose.**

This Compact is designed to achieve the following purposes and objectives:

(1) Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology.

(2) Enhance the states' ability to protect the public's health and safety, especially client/patient safety.

(3) Encourage the cooperation of Compact States in the areas of psychology licensure and regulation.

(4) Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history.

(5) Promote compliance with the laws governing psychological practice in each Compact State.

(6) Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

"**§ 90-270.161. Definitions.**

(1) Adverse action. – Any action taken by a State Psychology Regulatory Authority which finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

(2) Association of State and Provincial Psychology Boards (ASPPB). – The recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

(3) Authority to Practice Interjurisdictional Telepsychology. – A licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

(4) Bylaws. – Those Bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to G.S. 90-270.169 for its governance or for directing and controlling its actions and conduct.

(5) Client/patient. – The recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services.

(6) Commissioner. – The voting representative appointed by each State Psychology Regulatory Authority pursuant to G.S. 90-270.169.

(7) Compact State. – A state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to G.S. 90-270.172(c) or been terminated pursuant to G.S. 90-270.171(b).

(8) Confidentiality. – The principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

(9) Coordinated Licensure Information System or Coordinated Database. – An integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(10) Day. – Any part of a day in which psychological work is performed.

(11) Distant State. – The Compact State where a psychologist is physically present (not through the use of telecommunications technologies) to provide temporary in-person, face-to-face psychological services.

(12) E.Passport. – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

(13) Executive Board. – A group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

(14) Home State. – A Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authority to Practice Interjurisdictional Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

(15) Identity History Summary. – A summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

(16) In-person, face-to-face. – Interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

(17) Interjurisdictional Practice Certificate (IPC). – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily and verification of one's qualifications for such practice.

(18) License. – Authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

(19) Non-Compact State. – Any State which is not at the time a Compact State.

(20) Psychologist. – An individual licensed for the independent practice of psychology.

(21) Psychology Interjurisdictional Compact Commission (Commission). – The national administration of which all Compact States are members.

(22) Receiving State. – A Compact State where the client/patient is physically located when the telepsychological services are delivered.

(23) Rule. – A written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to G.S. 90-270.170 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal, or suspension of an existing rule.

(24) Significant investigatory information. –

a. Investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

b. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

(25) State. – A state, commonwealth, territory, or possession of the United States or the District of Columbia.

(26) State Psychology Regulatory Authority. – The Board, office, or other agency with the legislative mandate to license and regulate the practice of psychology.

(27) Telepsychology. – The provision of psychological services using telecommunication technologies.

(28) Temporary Authorization to Practice. – A licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

(29) Temporary in-person, face-to-face practice. – Where a psychologist is physically present (not through the use of telecommunications technologies) in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

"**§ 90-270.162. Home State licensure.**

(a) The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

(b) A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(c) Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(d) Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

(e) A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

(1) Currently requires the psychologist to hold an active E.Passport;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

(f) A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

(1) Currently requires the psychologist to hold an active IPC;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

"**§ 90-270.163. Compact privilege to practice telepsychology.**

(a) Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice telepsychology in other Compact States (Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

(b) To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master's degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;

(4) Have no history of adverse action that violate the Rules of the Commission;
(5) Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;
(6) Possess a current, active E.Passport;
(7) Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background, and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and
(8) Meet other criteria as defined by the Rules of the Commission.

(c) The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

(d) A psychologist practicing in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State is restricted, suspended, or otherwise limited, the E.Passport shall be revoked and, therefore, the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

"**§ 90-270.164. Compact Temporary Authorization to Practice.**

(a) Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

(b) To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:
a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or
b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:
a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;
b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;
c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;
e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;
f. The designated director of the program must be a psychologist and a member of the core faculty;
g. The program must have an identifiable body of students who are matriculated in that program for a degree;
h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;
i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;
j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;
(4) No history of adverse action that violates the Rules of the Commission;
(5) No criminal record history that violates the Rules of the Commission;
(6) Possess a current, active IPC;
(7) Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and
(8) Meet other criteria as defined by the Rules of the Commission.

(c) A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

(d) A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State is restricted, suspended, or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

"**§ 90-270.165. Conditions of telepsychology practice in a Receiving State.**

A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

(1) The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State.
(2) Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

"**§ 90-270.166. Adverse actions.**

(a) A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

(b) A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse

action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

(c) If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

(1) All Home State disciplinary orders which impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

(2) In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

(3) Other actions may be imposed as determined by the Rules promulgated by the Commission.

(d) A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

(e) A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice which occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

(f) Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

(g) No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection (c) of this section.

"**§ 90-270.167. Additional authorities invested in a Compact State's Psychology Regulatory Authority.**

In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

(1) Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a Compact State's Psychology Regulatory Authority for the attendance and testimony of witnesses and/or the production of evidence from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

(2) Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

(3) During the course of any investigation, a psychologist may not change his/her Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his/her Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission. All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal, and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

"**§ 90-270.168. Coordinated Licensure Information System.**

(a) The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

(b) Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

(1) Identifying information;
(2) Licensure data;
(3) Significant investigatory information;
(4) Adverse actions against a psychologist's license;
(5) An indicator that a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;
(6) Nonconfidential information related to alternative program participation information;
(7) Any denial of application for licensure and the reasons for such denial; and
(8) Other information which may facilitate the administration of this Compact, as determined by the Rules of the Commission.

(c) The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

(d) Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

(e) Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

"**§ 90-270.169. Establishment of the Psychology Interjurisdictional Compact Commission.**

(a) The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

(1) The Commission is a body politic and an instrumentality of the Compact States.

(2) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(3) Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting, and Meetings. –

(1) The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary, or similar executive;

b. Current member of the State Psychology Regulatory Authority of a Compact State; or

c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

(2) Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

(3) Each Commissioner shall be entitled to one vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

(4) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

(5) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rule-making provisions in G.S. 90-270.170.

(6) The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:

a. Noncompliance of a Compact State with its obligations under the Compact;

b. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation against the Commission;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusation against any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal and state statute.

(7) If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

(c) The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including, but not limited to:

(1) Establishing the fiscal year of the Commission;

(2) Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

(3) Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;

(4) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

(6) Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;

(7) Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

(8) The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto with the appropriate agency or officer in each of the Compact States;

(9) The Commission shall maintain its financial records in accordance with the Bylaws; and

(10) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(d) The Commission shall have the following powers:

(1) The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all Compact States;

(2) To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

(3) To purchase and maintain insurance and bonds;

(4) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compact State;

(5) To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

(6) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of the same, provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

(7) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the Commission shall strive to avoid any appearance of impropriety;

(8) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(9) To establish a budget and make expenditures;

(10) To borrow money;

(11) To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;

(12) To provide and receive information from, and to cooperate with, law enforcement agencies;

(13) To adopt and use an official seal; and

(14) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice, and telepsychology practice.

(e) The Executive Board. – The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact.

(1) The Executive Board shall be comprised of six members:

a. Five voting members who are elected from the current membership of the Commission by the Commission.

b. One ex officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(2) The ex officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.

(3) The Commission may remove any member of the Executive Board as provided in Bylaws.

(4) The Executive Board shall meet at least annually.

(5) The Executive Board shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, or fees paid by Compact States such as annual dues and any other applicable fees;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Other duties as provided in Rules or Bylaws.

(f) Financing of the Commission. –

(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.

(2) The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(3) The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

(4) The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State.

(5) The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

(g) Qualified Immunity, Defense, and Indemnification. –

(1) The members, officers, Executive Director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom

the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(2) The Commission shall defend any member, officer, Executive Director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(3) The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

"**§ 90-270.170. Rule making.**

(a) The Commission shall exercise its rule-making powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

(c) Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

(d) Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rule Making:

(1) On the Web site of the Commission; and

(2) On the Web site of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

(e) The Notice of Proposed Rule Making shall include:

(1) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

(f) Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(g) The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

(1) At least 25 persons who submit comments independently of each other;
(2) A governmental subdivision or agency; or
(3) A duly appointed person in an association that has at least 25 members.

(h) If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

(1) All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.
(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.
(3) No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.
(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

(j) The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rule-making record and the full text of the rule.

(k) If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

(*l*) Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rule-making procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety, or welfare;
(2) Prevent a loss of Commission or Compact State funds;
(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or
(4) Protect public health and safety.

(m) The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the Web site of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

"**§ 90-270.171. Oversight, dispute resolution, and enforcement.**

(a) Oversight. –

(1) The executive, legislative, and judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

(2) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

(3) The Commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

(b) Default, Technical Assistance, and Termination. –

(1) If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default, and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

(2) If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States and all rights, privileges, and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(3) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.

(4) A Compact State which has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

(5) The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

(6) The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the State of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution. –

(1) Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States.

(2) The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the Commission.

(d) Enforcement. –

(1) The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

(2) By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(3) The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

"**§ 90-270.172. Date of implementation of the Psychology Interjurisdictional Compact Commission and associated rules, withdrawal, and amendments.**

(a) The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rule-making powers necessary to the implementation and administration of the Compact.

(b) Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

(c) Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

(1) A Compact State's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

(d) Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

(e) This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

"**§ 90-270.173. Construction and severability.**

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States."

SECTION 3.(c) Subsections (a) and (b) of this section become effective when at least seven states have enacted the Psychology Interjurisdictional Compact (PSYPACT) set forth in subsection (b) of this section. The North Carolina Psychology Board shall report to the Revisor of Statutes when the PSYPACT set forth in subsection (b) of this section has been enacted by seven member states.

PART IV. ALLOW LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT FIRST-LEVEL EXAMINATIONS FOR INVOLUNTARY COMMITMENT

SECTION 4.(a) G.S. 122C-263.1(a) reads as rewritten:

"**§ 122C-263.1. Secretary's authority to certify commitment examiners; training of certified commitment examiners performing first examinations; LME/MCO responsibilities.**

(a) Physicians and eligible psychologists are qualified to perform the commitment examinations required under G.S. 122C-263(c) and G.S. 122C-283(c). The Secretary of Health and Human Services may individually certify to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 other health, mental health, and substance abuse professionals whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment as follows:

(1) The Secretary has received a request:

a. To certify a licensed clinical social worker, a master's or higher level degree nurse practitioner, a licensed professional counsellor, a licensed marriage and family therapist, or a physician's assistant to conduct the first examinations described in G.S. 122C-263(c) and G.S. 122C-283(c).

b. To certify a master's level licensed clinical addictions specialist to conduct the first examination described in G.S. 122C-283(c).

...

(5) In no event shall the certification of a licensed clinical social worker, master's or higher level degree nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or master's level certified clinical addictions specialist under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or the master's level certified clinical addictions specialist.

...."

SECTION 4.(b) This section is effective October 1, 2019.

PART V. PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY REGULATORY CHANGES

SECTION 5.(a) G.S. 131E-138 reads as rewritten:

"**§ 131E-138. Licensure requirements.**

(a) ~~No~~ Except as provided in subsection (f1) of this section, no person or governmental unit shall operate a home care agency without a license obtained from the Department. Nothing in this Part shall be construed to extend or modify the licensing of individual health professionals by the licensing boards for their professions or to create any new professional license category.

...

(f1) Exceptions to Licensure. – If home care services are provided to a participant of the Program for All-Inclusive Care for the Elderly through an organization that has a valid Program for All-Inclusive Care for the Elderly agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Service, then the entity providing the home care services shall not be required to hold a license under this section.

...."

SECTION 5.(b) G.S. 131D-2.1 reads as rewritten:

"**§ 131D-2.1. Definitions.**

As used in this Article:

...

(3) Adult care home. – An assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or for scheduled needs, through formal written agreement with licensed home care or hospice ~~agencies.~~ agencies or with a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated trained staff. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

...

(5) Assisted living residence. – Any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care or hospice ~~agencies.~~ agencies, or with a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. The Department may allow nursing service exceptions on a case-by-case basis. Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or area baths. Assisted living residences are to be distinguished from nursing homes subject to provisions of G.S. 131E-102. There are three types of assisted living residences: adult care homes, adult care homes that serve only elderly persons, and multiunit assisted housing with services. As used in this section, "elderly person" means:

a. Any person who has attained the age of 55 years or older and requires assistance with activities of daily living, housing, and services, or

b. Any adult who has a primary diagnosis of Alzheimer's disease or other form of dementia who requires assistance with activities of daily living, housing, and services provided by a licensed Alzheimer's and dementia care unit.

...

(10) Multiunit assisted housing with services. – An assisted living residence in which hands-on personal care services and nursing services ~~which~~ that are arranged by housing management are provided through an individualized written care plan by a licensed home care or hospice agency ~~through an individualized written care plan.~~ or by a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. The housing management has a financial interest or financial affiliation or formal written agreement ~~which~~ that makes personal care services accessible and available through at least one licensed home care or hospice ~~agency.~~ agency or through a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the

Division of Health Benefits of the Department of Health and Human Services. The resident has a choice of any provider, and the housing management may not combine charges for housing and personal care services. All residents, or their compensatory agents, must be capable, through informed consent, of entering into a contract and must not be in need of 24-hour supervision. Assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse according to the home care agency's or the Program for All-Inclusive Care for the Elderly organization's established plan of care. Multiunit assisted housing with services programs are required to register annually with the Division of Health Service Regulation. Multiunit assisted housing with services programs are required to provide a disclosure statement to the Division of Health Service Regulation. The disclosure statement is required to be a part of the annual rental contract that includes a description of all of the following requirements:

a. Emergency response ~~system;~~system.
b. Charges for services ~~offered;~~offered.
c. Limitations of ~~tenancy;~~tenancy.
d. Limitations of ~~services;~~services.
e. Resident ~~responsibilities;~~responsibilities.
f. Financial/legal relationship between housing management and home care or hospice ~~agencies;~~agencies or Program for All-Inclusive Care for the Elderly organizations.
g. A listing of all home care or hospice agencies and other community services in the ~~area;~~area.
h. An appeals ~~process; and~~process.
i. Procedures for required initial and annual resident screening and referrals for services.

Continuing care retirement communities, subject to regulation by the Department of Insurance under Chapter 58 of the General Statutes, and temporary family health care structures, as defined in G.S. 160A-383.5, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

...."

SECTION 5.(c) G.S. 131D-2.2(b) reads as rewritten:

"(b) Multiunit Assisted Housing With Services. – Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, multiunit assisted housing with services shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator ~~dependency;~~dependency.
(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be ~~healing;~~healing.
(3) Intravenous therapy or injections directly into the vein, except for intermittent intravenous therapy managed by a home care or hospice agency licensed in this ~~State;~~State.
(4) Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common ~~cold;~~cold.
(5) Psychotropic medications without appropriate diagnosis and treatment ~~plans;~~plans.
(6) Nasogastric ~~tubes;~~tubes.

(7) Gastric tubes, except when the individual is capable of independently feeding himself or herself and caring for the tube, or as managed by a home care or hospice agency licensed in this ~~State;~~State.

(8) Individuals requiring continuous licensed nursing ~~care;~~care.

(9) Individuals whose physician certifies that placement is no longer ~~appropriate;~~appropriate.

(10) Unless the individual's independent physician determines ~~otherwise,~~ otherwise or the individual is enrolled in the Program of All-Inclusive Care for the Elderly, individuals who require maximum physical assistance as documented by a uniform assessment instrument and who meet Medicaid nursing facility level-of-care criteria as defined in the State Plan for Medical Assistance. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on a uniform assessment ~~instrument;~~instrument.

(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the ~~residence; and~~residence.

(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services."

SECTION 5.(d) G.S. 131D-2.2(d) reads as rewritten:

"(d) Obtaining Services. – The resident of an assisted living facility has the right to obtain services at the resident's own expense from providers other than the housing management. This subsection shall not be construed to relieve the resident of the resident's contractual obligation to pay the housing management for any services covered by the contract between the resident and housing management. The resident of an assisted living facility has the right to select as the resident's health care provider the Program for All-Inclusive Care for the Elderly without jeopardizing residency in the assisted living facility."

SECTION 5.(e) G.S. 131D-2.16 reads as rewritten:

"**§ 131D-2.16. Rules.**

Except as otherwise provided in this Article, the Medical Care Commission shall adopt rules necessary to carry out this Article. The Commission has the authority, in adopting rules, to specify the limitation of nursing services provided by assisted living residences. In developing rules, the Commission shall consider the need to ensure comparable quality of services provided to residents, whether these services are provided directly by a licensed assisted living provider, licensed home care agency, a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services, or hospice. In adult care homes, living arrangements where residents require supervision due to cognitive impairments, rules shall be adopted to ensure that supervision is appropriate and adequate to meet the special needs of these residents. Rule-making authority under this section is in addition to that conferred under G.S. 131D-4.3 and G.S. 131D-4.5."

SECTION 5.(f) G.S. 131D-6 reads as rewritten:

"**§ 131D-6. Certification of adult day care programs; purpose; definition; penalty.**

...

(d) ~~The~~ All of the following programs are exempted from the provisions of this section:

(1) Those that care for three people or ~~less;~~less.

(2) Those that care for two or more persons, all of whom are related by blood or marriage to the operator of the ~~facility;~~facility.

(3) Those that are required by other statutes to be licensed by the Department of Health and Human Services.

(4) Program for All-Inclusive Care for the Elderly organizations that have a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services when providing services to participants in the program."

SECTION 5.(g) This act is effective October 1, 2019.

PART VI. ELIMINATE REDUNDANCY IN ADULT CARE HOME INSPECTIONS

SECTION 6. G.S. 131D-2.11(a) reads as rewritten:

"(a) State Inspection and Monitoring. – The Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. All facilities licensed under this Article and adult care units in nursing homes are subject to inspections at all times by the Secretary. Except as provided in subsection (a1) of this section, the Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis. Beginning July 1, 2012, the Division of Health Service Regulation shall include as part of its inspection of all adult care homes a review of the facility's compliance with G.S. 131D-4.4A(b) and safe practices for injections and any other procedures during which bleeding typically occurs. In addition, the Department shall ensure that adult care homes are inspected every two years to determine compliance with physical plant and life-safety requirements.

If the annual inspection of an adult care home is conducted separately from the inspection required every two years to determine compliance with physical plant and life-safety requirements, the Division of Health Service Regulation shall not cite, as part of the annual inspection, any violation of law that overlaps with an area addressed by the physical plant and life-safety inspection, unless failure to address the violation during the annual inspection would pose a risk to resident health or safety. Nothing in this section prevents a licensing inspector from referring a concern about physical plant and life-safety requirements to the section within the Division of Health Service Regulation that conducts physical plant and life-safety inspections."

PART VII. SEVERABILITY CLAUSE AND EFFECTIVE DATE

SECTION 7.(a) If any section or 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 to be unconstitutional or invalid.

SECTION 7.(b) Except as otherwise provided, this act is effective when it becomes law.

SIGN-UP SHEETS

Senate Committee On Health Care

April 10, 2017 – Room 643 – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Ken Melton	KMA
Stephen Kouba	KMA
Amanda Donovan	K+S
Fred Bone	Bone Assoc.
Andy Chase	KMA
Jennifer Nye	Vision
Tate Appleton	Vision
Elizabeth Ruf	Wake Med
David Collins	NCSFPS
Julia Adams Schenck	Parker Poe GR
TRACY Colvard	Altise
Josh Lair	CSH
J Peters	CSS
Aaron Turner	URAC
Brittany McCullough	URAC
Amy Lyle	NWC
Mary Cross	DHHS
Megan Lamphere	DHHS

SIGN-UP SHEETS

Senate Committee On Health Care

April 10, 2017 – Room 643 – 10:00 AM

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NAME	FIRM OR AGENCY
Sabrena Lea	NC DHHS/DHB
SANDY TERRELL	NCDHHS
Deb Goda	NCDHHS
Martha Frisone	NCDHHS
MARK BENTON	NCDHHS
Debbie Parkinson	Parkinson Law
Sue Ann Forest	NCMS
Edward W. Whitesides MD	NCMS
Susan R. DeJarnette ND	NCANP
Patsy Yancey	NCANP
Meisha Evans	DRNC
Ed Shultz	
Brandon Riley	NCTC
LT McCrimmon	DHHS
Kody H. Kinsley	DHHS
Claudia Sweeney	governors office
Sarah Patterson	NM
Patricia Gibbons	Connect C

VISITOR SIGN-UP SHEET

SENATE SELECT COMMITTEE

ON

~~**PRISON SAFETY**~~ **Health Care**

~~**March 18, 2019**~~ **April 10, 2019**

~~**2:00 pm**~~ **10 AM**

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
John Cooper	Connect C
Jeff Barnhart	MWC
ADAM HYATT	ELDERHAUS
Rick Richards	Elderhaus
Thomas Chang	Carolina Senior Care
Marianne Ratcliffe	Piedmont Health Senior Care
Amy Merritt	UNCW -
Linda Shaw	NC PACE Association
BRIAN TOOMEY	PIEDMONT HEALTH SERVICES
Matt Wolfe	PPAB
Jeff Kite	NCAR
Jasmine Bissell	NCAPA
Dan Soucek	Cone Health

SIGN-UP SHEETS

Senate Committee On Health Care

April 10, 2017 – Room 643 – 10:00 AM

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NAME	FIRM OR AGENCY
Andy Munn	NVA
Lori Kroll	NH
Eliz Outlaw	NH
Lanier Hudson	UNC HCS
Christine Craig	WakeMed
Jim Harrell	~~BCH~~
Ryan Blackledge	Cone Health
Tom Lowe	Jordan Price
Zora Bohler	NCAMFT
Cathy Womack	NCAMFT
Joyce Pelow	CSS
Jeff Horton	NCSLA
[illegible]	P. Lisy Group
JOEL ANIZA	PRO WOMAN
MARISSA JARVIS	PRO WOMAN
Brian Perkins	Alliance Health
Kelly Vogel	Anthem, Inc.
DAVID POWERS	POWERS STRATEGIES LLC

SIGN-UP SHEETS

Senate Committee On Health Care

April 10, 2017 – Room 643 – 10:00 AM

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NAME	FIRM OR AGENCY
Doug HERON	DUKE / DUKE LIFEPOINT
Rod HARKLEROAD	Duke Lifepoint
Adam Sholar	NCHCA
John Hardin	MPE
David Hinson	NC Center for Nonprofits
Ross	NP
Matthew McDonald	Atrium Health
Leah Bovens	NCHA
Daniel Vanlue	V. Let
Sarah McQuillan	Kaiser Gov Affairs
Scott LASTER	KOA
Zoe Schulze	—
Martha Bulsh	PPAB
Kara Weisblatt	JA
Kari Barcuss	BPS
Payton Mayer	

SIGN-UP SHEETS

Senate Committee On Health Care

April 10, 2017 – Room 643 – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Chip Baggett	NCMS
Lauren O'Brien	BLUE CROSS NC
Mark Fleming	BCBSNC
Michelle Fraser	NP
Bo Heath	MWC
Becki Gray	John Locke Foundation
Lexi DeMuro	NCDA
M Lee	Jim Hall
T. Mansfield	NCMB

Senate Committee on Health Care
Wednesday, April 17, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on April 17, 2019 in Room 643 of the Legislative Office Building. Nine members were present.

Senator Joyce Krawiec, Chair, presided.

Andrew Fluhrer from Raleigh, Hannahlynne Gallimore from Lexington, Jackie Jewel from Davidson, Abby Scudder from Swansboro, and Taelor Jennete from Fuquay-Varina served as pages.

Senator Krawiec announced that SB 444 be pulled from today's calendar per Sen. McInnis' (the primary sponsor) request. She also heard the remaining bills in a different order than what showed on the agenda. They were presented in the order reflected below.

SB 537 Establish New Payment Methodology/ACHs. (Senators Hise, Krawiec, Bishop)
Sen. Hise was introduced to present the bill. Sen. Perry moved for a favorable report and it carried.

SB 302 Update Svc & Care Plan Req's/ACH Residents. (Senators Hise, Bishop, Krawiec)
Sen. Hise was introduced to present the bill. Sen. Krawiec offered an amendment. Sen. Jim Davis moved that the amendment be brought before the committee and it carried. Questions from the members were responded to by Sen. Hise. Sen. Ford moved unfavorable to the bill favorable to the bill as amended rolled into a Proposed Committee Substitute (PCS) and it carried.

SB 118 PED/Safekeeper Health Care Cost Recov. Pract. (Senators B. Jackson, Krawiec, Ballard)
FOR DISCUSSION ONLY
Sen. Foushee made the motion that the committee take up the PCS and it carried. Sen. Krawiec asked that Sen. Jim Davis chair for the discussion of this bill. Sen. Davis introduced Sen. Krawiec to present the bill. Jessica Boney an attorney from the Legislative Analysis Division also explained the bill. Questions from the members were responded to by Sen. Krawiec and Brent Lucas from the Program Evaluation Division. The bill will be voted out during the next Senate Health Care Committee meeting scheduled for April 18, 2019.

The meeting adjourned at 10:30 AM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Wednesday, April 17, 2019

Senator Krawiec,
submits the following with recommendations as to passage:

FAVORABLE

SB **537** Establish New Payment Methodology/ACHs.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

SB **302** Update Svc & Care Plan Req's/ACH Residents.

Draft Number:	S302-PCS35261-BP-5
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Senator Ralph Hise will handle SB 537
Senator Ralph Hise will handle SB 302

CMR303-V-1

Senate Committee on Health Care
Wednesday, April 17, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 118	PED/Safekeeper Health Care Cost Recov. Pract.	Senator B. Jackson
	FOR DISCUSSION ONLY	Senator Krawiec Senator Ballard
SB 302	Update Svc & Care Plan Req's/ACH Residents.	Senator Hise Senator Bishop Senator Krawiec
SB 444	Allow Use of Oyster Shells As Serving Dishes.	Senator McInnis
SB 537	Establish New Payment Methodology/ACHs.	Senator Hise Senator Krawiec Senator Bishop

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S D

SENATE BILL 118
PROPOSED COMMITTEE SUBSTITUTE S118-CSBP-4 [v.3]
04/16/2019 05:08:58 PM

Short Title: PED/Safekeeper Health Care Cost Recov. Pract. (Public)

Sponsors:

Referred to:

February 25, 2019

A BILL TO BE ENTITLED

AN ACT TO IMPROVE DATA COLLECTION AND COST RECOVERY PRACTICES FOR HEALTH CARE SERVICES FOR SAFEKEEPERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 162-39 reads as rewritten:

"**§ 162-39. Transfer of prisoners when necessary for safety and security; application of section to municipalities.**

(a) Whenever necessary for the safety of a prisoner held in any county jail or to avoid a breach of the peace in any county or whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the housing of such prisoners, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a fit and secure jail in some other county where the prisoner shall be held for such length of time as the judge may direct.

(b) Whenever necessary to avoid a security risk in any county jail, or whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the housing of such prisoners, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a unit of the State prison system designated by the Secretary of Public Safety or his authorized representative. For purposes of this subsection, a prisoner poses a security risk if the prisoner:

(1) Poses a serious escape risk;

(2) Exhibits violently aggressive behavior that cannot be contained and warrants a higher level of supervision;

(3) Needs to be protected from other inmates, and the county jail facility cannot provide such protection;

(4) Is a female or a person 18 years of age or younger, and the county jail facility does not have adequate housing for such prisoners;

(5) Is in custody at a time when a fire or other catastrophic event has caused the county jail facility to cease or curtail operations; or

(6) Otherwise poses an imminent danger to the staff of the county jail facility or to other prisoners in the facility.

(b1) The Department of Public Safety, Health Services Section, shall maintain records of prisoners transferred to a unit of the State prison system pursuant to subsection (b) of this section. The records shall utilize unique identifiers for each transferred prisoner and shall include all of the following information:

(1) The date the transfer order was received.

(2) The statutory basis upon which the order was granted.

(3) The date the prisoner was transferred to State custody.
(4) The State prison facility where the prisoner was transferred.
(5) The county where the prisoner was removed.
(6) The dates the prisoner received health services from the Department.
(7) A list of health services provided to the prisoner and the corresponding charges.
(8) The date the Department determined that the prisoner no longer needs health services to be provided by the State prison system.
(9) The date and method used by the Department to notify the county that the prisoner should be transferred back to the custody of the county.
(10) The date that the prisoner is returned to the custody of the county.

(c) The sheriff of the county from which the prisoner is removed shall be responsible for conveying the prisoner to the jail or prison unit where ~~he~~ the prisoner is to be held, and for returning ~~him~~ the prisoner to the common jail of the county from which ~~he~~ the prisoner was transferred. The return shall be made at the expiration of the time designated in the court order directing the transfer unless the judge, by appropriate order, ~~shall direct~~ directs otherwise. The sheriff or keeper of the jail of the county designated in the court order, or the officer in charge of the prison unit designated by the Secretary of Public Safety, shall receive and release custody of the prisoner in accordance with the terms of the court order. If a prisoner is transferred to a unit of the State prison system, the county from which the prisoner is transferred shall pay the Division of Adult Correction and Juvenile Justice of the Department of Public Safety for maintaining the prisoner for the time designated by the court at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner. The county shall also pay the Division of Adult Correction and Juvenile Justice of the Department of Public Safety for the costs of ~~extraordinary~~ medical care incurred while the prisoner was in the custody of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, defined as follows:

(1) Medical expenses incurred as a result of providing health care to a prisoner as an inpatient ~~(hospitalized);~~(hospitalized).
(2) Other medical expenses when the total cost exceeds thirty-five dollars ($35.00) per occurrence or illness as a result of providing health care to a prisoner as an outpatient ~~(nonhospitalized); and~~(nonhospitalized).
(3) Cost of replacement of eyeglasses and dental prosthetic devices if those eyeglasses or devices are broken while the prisoner is incarcerated, provided the prisoner was using the eyeglasses or devices at the time of his commitment and then only if prior written consent of the county is obtained by the Division.
(4) Transportation and custody costs associated with the transfer of prisoners receiving health care outside of the prison facility. The county shall reimburse the State for services provided to the prisoner at the same mileage reimbursement rate and hourly custody rate that are reimbursed pursuant to the Statewide Misdemeanant Confinement Program.
(5) Cost of sick call encounters at the rate charged to State prison inmates.

(c1) If the prisoner is transferred to a jail in some other county, the county from which the prisoner is transferred shall pay to the county receiving the prisoner in its jail the actual cost of maintaining the prisoner for the time designated by the court. Counties are ~~hereby~~ authorized to enter into contractual agreements with other counties to provide jail facilities to which prisoners may be transferred as deemed necessary under this section.

(c2) Whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the safekeeping of such prisoners, the resident judge of the superior court or any superior or district court judge holding court in the district may order the prisoners transferred to a unit of the Division of Adult Correction and Juvenile Justice of the

Department of Public Safety designated by the Secretary of Public Safety or ~~his~~ the Secretary's authorized representative, where the prisoners may be held for such length of time as the judge may direct, such detention to be in ~~cell~~ cells separate from ~~that~~ those used for imprisonment of persons already convicted of crimes, except when admission to an inpatient prison medical or mental health unit is required to provide services deemed necessary by a prison health care clinician. The sheriff of the county from which the prisoners are removed shall be responsible for conveying the prisoners to the prison unit or units where they are to be held, and for returning them to the common jail of the county from which they were transferred. However, if due to the number of prisoners to be conveyed the sheriff is unable to provide adequate transportation, ~~he~~ the sheriff may request the assistance of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, and the Division of Adult Correction and Juvenile Justice of the Department of Public Safety is hereby authorized and directed to cooperate with the sheriff and provide whatever assistance is available, both in vehicles and manpower, to accomplish the conveying of the prisoners to and from the county to the designated prison unit or units. The officer in charge of the prison unit designated by the Secretary of Public Safety or ~~his~~ the Secretary's authorized representative shall receive and release the custody of the prisoners in accordance with the terms of the court order. The county from which the prisoners are transferred shall pay to the Division of Adult Correction and Juvenile Justice of the Department of Public Safety the actual cost of transporting the prisoners and the cost of maintaining the prisoners at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner, provided, however, that a county is not required to reimburse the State for transporting or maintaining a prisoner who was a resident of another state or county at the time ~~he~~ the prisoner was arrested. However, if the county commissioners shall certify to the Governor that the county is unable to pay the bill submitted by the Division of Adult Correction and Juvenile Justice of the Department of Public Safety to the county for the services rendered, either in whole or in part, the Governor may recommend to the Council of State that the State of North Carolina assume and pay, in whole or in part, the obligation of the county to the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, and upon approval of the Council of State the amount so approved shall be paid from the Contingency and Emergency Fund to the Division of Adult Correction and Juvenile Justice of the Department of Public Safety.

(c3) When, due to an emergency, it is not feasible to obtain from a judge of the superior or district court a prior order of transfer, the sheriff of the county and the Division of Adult Correction and Juvenile Justice of the Department of Public Safety may exercise the authority hereinafter conferred; provided, however, that the sheriff shall, as soon as possible after the emergency, obtain an order from the judge authorizing the prisoners to be held in the designated place of confinement for such period as the judge may direct. All provisions of this ~~subsection~~ section shall be applicable to municipalities whenever prisoners are arrested in such numbers that the municipal jail facilities and the county jail facilities are insufficient and inadequate for the safekeeping of the prisoners. The chief of police is hereby authorized to exercise the authority herein conferred upon the sheriff, and the municipality shall be liable for the cost of transporting and maintaining the prisoners to the same extent as a county would be unless action is taken by the Governor and Council of State as herein provided for counties which are unable to pay such costs.

(d) Whenever a prisoner held in a county jail requires medical or mental health treatment that the county decides can best be provided by the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a unit of the State prison system designated by the Secretary of Public Safety or ~~his~~ the Secretary's authorized ~~representative.~~ representative for an initial period not to exceed 30 days. The sheriff of the county from which the prisoner is removed shall be responsible for conveying

the prisoner to the prison unit where ~~he~~ the prisoner is to be held, and for returning ~~him~~ the prisoner to the jail of the county from which ~~he~~ the prisoner was transferred. ~~The prisoner shall be returned when the attending medical or mental health professional determines that the prisoner may be returned safely.~~ The officer in charge of the prison unit designated by the Secretary of Public Safety shall receive custody of the prisoner in accordance with the terms of the ~~order and~~ order. Prior to the conclusion of the 30-day period, the Division of Adult Correction and Juvenile Justice shall conduct an assessment of treatment and venue needs. The assessment shall be conducted by the attending medical or mental health professional and shall assess the medical and mental health needs of the prisoner and make a recommendation on whether the prisoner should remain in the custody of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety or if the prisoner should be returned to the custody of the county. To extend the order beyond the initial 30-day period, the sheriff shall provide the Division of Adult Correction and Juvenile Justice assessment and any other relevant information to the resident judge of the superior court or any judge holding superior court in the district or any district court judge who shall determine whether to extend the transfer of the prisoner to a unit of the State prison system beyond the initial 30-day period. The officer in charge of the prison unit designated by the Secretary of Public Safety shall release custody of the prisoner in accordance with the court order and the instructions of the attending medical or mental health professional. The county from which the prisoner is transferred shall pay the Division of Adult Correction and Juvenile Justice of the Department of Public Safety for maintaining the prisoner for the period of treatment at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner, and for extraordinary medical expenses as set forth in subsection (c) of this section.

(e) The number of county prisoners incarcerated in the State prison system pursuant to safekeeping orders from the various counties pursuant to subsection (b) of this section or for medical or mental health treatment pursuant to subsection (d) of this section may not exceed 200 at any given time unless authorized by the Secretary of Public Safety. The Secretary may refuse to accept any safekeeper and may return any safekeeper transferred under a safekeeping order when this capacity limit is reached. The Secretary shall not refuse to accept a safekeeper because a county has failed to pay the Department of Public Safety for services rendered pursuant to this section.

(f) If, after 10 days of receiving notification and request for transfer from the Department of Public Safety pursuant to G.S. 148-19.3(a), the sheriff fails to assume custody of the county prisoner from the State prison facility to which the prisoner was assigned, then, in addition to the actual cost of transporting the prisoner and the cost of maintaining the prisoner at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner, the county shall be liable to the State for an additional per day, per inmate rate not to exceed twenty dollars ($20.00) for each day the sheriff fails to assume custody of the prisoner, unless the sheriff has obtained an extension of the order because the inmate cannot be safely housed in the local jail. The section chief of the Health Services Section may waive up to 10 days of the additional per day rate if the sheriff provides documentation of extenuating circumstances."

SECTION 2.(a) Article 2 of Chapter 148 is amended by adding a new section to read:

"**§ 148-19.3. Medicaid eligibility; county prisoners.**

(a) For county prisoners housed in the State prison system pursuant to safekeeping orders under G.S. 162-39 and who receive health care services outside the prison, the Department shall notify the county sheriff of the potential Medicaid eligibility of the safekeeper given data available to the Department. All charges that are the responsibility of the transferring county for health care services provided to prisoners held under a safekeeping order shall not be paid by the

Department and shall be submitted by the health care provider to the Inmate Medical Costs Management Plan through the North Carolina Sheriffs' Association for the Plan to review and negotiate all charges for health care services to avoid overpayment and reduce overall health care service costs. The Department shall notify the health care provider when services are being provided to the prisoner that the invoice for health care services shall be submitted by the provider directly to the Plan. In the event an invoice is sent to the Department by a health care provider for health care services provided to a safekeeper under this section, the Department shall forward the invoice to the Plan within three days of receipt. All unreimbursed charges for health care services provided shall be documented and presented to the county for payment in accordance with G.S. 162-39. Upon expiration of the terms of the order and a determination that the prisoner may be safely returned to the custody of the county, the Department shall notify the sheriff, or the sheriff's designee, by telephone and electronic mail and request the transfer of the prisoner to the custody of the county.

(b) The Department shall update the medical services schedule of charges assessed to counties for the provision of health care services to county prisoners housed in the State prison system pursuant to safekeeping orders under G.S. 162-39. In updating the schedule of charges, at a minimum, the Department shall consider the actual rate for services provided and current established Medicaid rates for respective services. The schedule of charges shall be updated annually and shall be included in the Department's policies and procedures. The Department shall assess charges to counties for health care services provided to county prisoners at all State prison facilities."

SECTION 2.(b) The Department shall submit a report on the updated medical services schedule of charges required in subsection (a) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety on or before December 1, 2019.

SECTION 3. This act becomes effective July 1, 2019.

SENATE BILL 118:
PED/Safekeeper Health Care Cost Recov. Pract.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Judiciary. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 16, 2019
Introduced by:	Sens. B. Jackson, Krawiec, Ballard	**Prepared by:**	Jessica Boney Staff Attorney
Analysis of:	PCS to First Edition S118-CSBP-4		

OVERVIEW: The PCS to Senate Bill 118 would modify the data collection and cost recovery practices for health care services provided to inmates who are transferred from a local jail to the State prison system pursuant to a safekeeping order.

CURRENT LAW: A superior or district court judge may transfer an inmate from a local jail to the State prison system for safety and security purposes[1] or when the inmate's medical or mental health needs require care beyond that which is available in the county jail. The total safekeeper population may not exceed 200 inmates at any given time without approval of the Secretary of Public Safety.

BILL ANALYSIS: The PCS to Senate Bill 118 contains several recommended changes resulting from the Program Evaluation Division's study of the efficiency and economy of medical and dental services provided for safekeepers housed in the State prison system. Specifically, **Section 1** makes the following changes:

- ***Recordkeeping.*** – Requires the Health Services Section of DPS to maintain records of prisoners transferred due to a safety risk, which include specific enumerated information, such as the dates the inmate received health services from the Department, a list of the services provided, and the date the Department determined the inmate no longer needs health services to be provided by the State prison system.
- ***Extension of Time for Safekeeping.*** – Provides a process that a sheriff can use to seek an extension beyond the initial 30-day treatment period. During the 30 days, the Division of Adult Correction and Juvenile Justice must conduct an assessment of the treatment and venue needs of the prisoner. The sheriff must then provide the assessment and any other relevant information to the resident superior court judge or any judge holding superior court in the district or any district court judge to determine whether to extend the transfer of the prisoner.
- ***No Refusal for Failure to Pay.*** – Prohibits DPS from refusing to accept a safekeeper because a county has failed to pay DPS for safekeeping services rendered.
- ***Additional Costs Payable by Counties to DPS.*** – Transportation and custody costs associated with prisoners receiving health care outside of the prison facility. Counties would be required to reimburse the State at the same reimbursement rate and hourly custody rate provided in the Statewide Misdemeanant Confinement Program.

[1]The safety and security purposes include when the inmate (1) poses a serious escape risk; (2) exhibits violently aggressive behavior; (3) needs to be protected from other inmates; (4) is a woman or person 18 years old or younger for whom the county does not have adequate housing; (5) is in custody at a time when a fire or other catastrophe has caused the jail to cease or curtail operations; (6) otherwise poses an imminent danger to the jail staff or other inmates.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- The cost of all sick call encounters at the rate charged to State prison inmates.
- An additional per day, per inmate fee of up to $20.00 if a sheriff fails to assume custody of a county prisoner within 10 days of being notified of the return. This fee may be waived for up to 10 days if the sheriff provides documentation of extenuating circumstances.

Section 2 makes the following changes:

- ***Notification of Medicaid Eligibility.*** – With respect to health care services received outside the prison, DPS must notify a county sheriff of a safekeeper's potential Medicaid eligibility based on data available to the DPS.
- ***Submission of Medical Bills to Sheriffs' Plan.*** – All unreimbursed charges for health care services must be submitted by the health care provider to the Inmate Medical Costs Management Plan through the NC Sheriffs' Association.
- ***Update Schedule of Charges.*** – Requires DPS to update annually the medical service schedule of charges assessed to counties for health care services. The schedule of charges was last revised in 2009.
- ***Report.*** – Submit a report on the updated medical services schedule to the Joint Legislative Oversight Committee on Justice and Public Safety on or before December 1, 2019.

EFFECTIVE DATE: This act becomes effective July 1, 2019.

**Staff Attorney Trina Griffin substantially contributed to this summary.*

SENATE BILL 118*

Short Title:	PED/Safekeeper Health Care Cost Recov. Pract.	(Public)
Sponsors:	Senators B. Jackson, Krawiec, and Ballard (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

February 25, 2019

A BILL TO BE ENTITLED

AN ACT TO IMPROVE DATA COLLECTION AND COST RECOVERY PRACTICES FOR HEALTH CARE SERVICES FOR SAFEKEEPERS, AS RECOMMENDED BY THE JOINT LEGISLATIVE PROGRAM EVALUATION COMMITTEE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 162-39 reads as rewritten:

"**§ 162-39. Transfer of prisoners when necessary for safety and security; application of section to municipalities.**

(a) Whenever necessary for the safety of a prisoner held in any county jail or to avoid a breach of the peace in any county or whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the housing of such prisoners, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a fit and secure jail in some other county where the prisoner shall be held for such length of time as the judge may direct.

(b) Whenever necessary to avoid a security risk in any county jail, or whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the housing of such prisoners, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a unit of the State prison system designated by the Secretary of Public Safety or his authorized representative. For purposes of this subsection, a prisoner poses a security risk if the prisoner:

(1) Poses a serious escape risk;

(2) Exhibits violently aggressive behavior that cannot be contained and warrants a higher level of supervision;

(3) Needs to be protected from other inmates, and the county jail facility cannot provide such protection;

(4) Is a female or a person 18 years of age or younger, and the county jail facility does not have adequate housing for such prisoners;

(5) Is in custody at a time when a fire or other catastrophic event has caused the county jail facility to cease or curtail operations; or

(6) Otherwise poses an imminent danger to the staff of the county jail facility or to other prisoners in the facility.

(b1) The Department of Public Safety, Health Services Section, shall maintain records of prisoners transferred to a unit of the State prison system pursuant to subsection (b) of this section. The records shall utilize unique identifiers for each transferred prisoner and shall include all of the following information:

(1) The date the transfer order was received.

(2) The statutory basis upon which the order was granted.
(3) The date the prisoner was transferred to State custody.
(4) The State prison facility where the prisoner was transferred.
(5) The county where the prisoner was removed.
(6) The dates the prisoner received health services from the Department.
(7) A list of health services provided to the prisoner and the corresponding charges.
(8) The date the Department determined that the prisoner no longer needs health services to be provided by the State prison system.
(9) The date and method used by the Department to notify the county that the prisoner should be transferred back to the custody of the county.
(10) The date that the prisoner is returned to the custody of the county.

(c) The sheriff of the county from which the prisoner is removed shall be responsible for conveying the prisoner to the jail or prison unit where ~~he~~ the prisoner is to be held, and for returning ~~him~~ the prisoner to the common jail of the county from which ~~he~~ the prisoner was transferred. The return shall be made at the expiration of the time designated in the court order directing the transfer unless the judge, by appropriate order, ~~shall direct~~ directs otherwise. The sheriff or keeper of the jail of the county designated in the court order, or the officer in charge of the prison unit designated by the Secretary of Public Safety, shall receive and release custody of the prisoner in accordance with the terms of the court order. If a prisoner is transferred to a unit of the State prison system, the county from which the prisoner is transferred shall pay the Division of Adult Correction and Juvenile Justice of the Department of Public Safety for maintaining the prisoner for the time designated by the court at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner. The county shall also pay the Division of Adult Correction and Juvenile Justice of the Department of Public Safety for the costs of ~~extraordinary~~ medical care incurred while the prisoner was in the custody of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, defined as follows:

(1) Medical expenses incurred as a result of providing health care to a prisoner as an inpatient ~~(hospitalized);~~(hospitalized).
(2) Other medical expenses when the total cost exceeds thirty-five dollars ($35.00) per occurrence or illness as a result of providing health care to a prisoner as an outpatient ~~(nonhospitalized); and~~(nonhospitalized).
(3) Cost of replacement of eyeglasses and dental prosthetic devices if those eyeglasses or devices are broken while the prisoner is incarcerated, provided the prisoner was using the eyeglasses or devices at the time of his commitment and then only if prior written consent of the county is obtained by the Division.
(4) Transportation and custody costs associated with the transfer of prisoners receiving health care outside of the prison facility. The county shall reimburse the State for services provided to the prisoner at the same mileage reimbursement rate and hourly custody rate that are reimbursed pursuant to the Statewide Misdemeanant Confinement Program.
(5) Cost of sick call encounters at the rate charged to State prison inmates.

(c1) If the prisoner is transferred to a jail in some other county, the county from which the prisoner is transferred shall pay to the county receiving the prisoner in its jail the actual cost of maintaining the prisoner for the time designated by the court. Counties are ~~hereby~~ authorized to enter into contractual agreements with other counties to provide jail facilities to which prisoners may be transferred as deemed necessary under this section.

(c2) Whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the safekeeping of such prisoners, the resident judge of the superior court or any superior or district court judge holding court in the district may order the

prisoners transferred to a unit of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety designated by the Secretary of Public Safety or ~~his~~ the Secretary's authorized representative, where the prisoners may be held for such length of time as the judge may direct, such detention to be in ~~cell~~ cells separate from ~~that~~ those used for imprisonment of persons already convicted of crimes, except when admission to an inpatient prison medical or mental health unit is required to provide services deemed necessary by a prison health care clinician. The sheriff of the county from which the prisoners are removed shall be responsible for conveying the prisoners to the prison unit or units where they are to be held, and for returning them to the common jail of the county from which they were transferred. However, if due to the number of prisoners to be conveyed the sheriff is unable to provide adequate transportation, ~~he~~ the sheriff may request the assistance of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, and the Division of Adult Correction and Juvenile Justice of the Department of Public Safety is hereby authorized and directed to cooperate with the sheriff and provide whatever assistance is available, both in vehicles and manpower, to accomplish the conveying of the prisoners to and from the county to the designated prison unit or units. The officer in charge of the prison unit designated by the Secretary of Public Safety or ~~his~~ the Secretary's authorized representative shall receive and release the custody of the prisoners in accordance with the terms of the court order. The county from which the prisoners are transferred shall pay to the Division of Adult Correction and Juvenile Justice of the Department of Public Safety the actual cost of transporting the prisoners and the cost of maintaining the prisoners at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner, provided, however, that a county is not required to reimburse the State for transporting or maintaining a prisoner who was a resident of another state or county at the time ~~he~~ the prisoner was arrested. However, if the county commissioners shall certify to the Governor that the county is unable to pay the bill submitted by the Division of Adult Correction and Juvenile Justice of the Department of Public Safety to the county for the services rendered, either in whole or in part, the Governor may recommend to the Council of State that the State of North Carolina assume and pay, in whole or in part, the obligation of the county to the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, and upon approval of the Council of State the amount so approved shall be paid from the Contingency and Emergency Fund to the Division of Adult Correction and Juvenile Justice of the Department of Public Safety.

(c3) When, due to an emergency, it is not feasible to obtain from a judge of the superior or district court a prior order of transfer, the sheriff of the county and the Division of Adult Correction and Juvenile Justice of the Department of Public Safety may exercise the authority hereinafter conferred; provided, however, that the sheriff shall, as soon as possible after the emergency, obtain an order from the judge authorizing the prisoners to be held in the designated place of confinement for such period as the judge may direct. All provisions of this ~~subsection~~ section shall be applicable to municipalities whenever prisoners are arrested in such numbers that the municipal jail facilities and the county jail facilities are insufficient and inadequate for the safekeeping of the prisoners. The chief of police is hereby authorized to exercise the authority herein conferred upon the sheriff, and the municipality shall be liable for the cost of transporting and maintaining the prisoners to the same extent as a county would be unless action is taken by the Governor and Council of State as herein provided for counties which are unable to pay such costs.

(d) Whenever a prisoner held in a county jail requires medical or mental health treatment that the county decides can best be provided by the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a unit of the State prison system designated by the Secretary of Public Safety or ~~his~~ the Secretary's authorized ~~representative.~~ representative for an initial period not to exceed fifteen

days. The sheriff of the county from which the prisoner is removed shall be responsible for conveying the prisoner to the prison unit where ~~he~~ the prisoner is to be held, and for returning ~~him~~ the prisoner to the jail of the county from which ~~he~~ the prisoner was transferred. ~~The prisoner shall be returned when the attending medical or mental health professional determines that the prisoner may be returned safely.~~ The officer in charge of the prison unit designated by the Secretary of Public Safety shall receive custody of the prisoner in accordance with the terms of the ~~order and~~ order. If the sheriff seeks to extend the order beyond the initial fifteen-day period, the sheriff shall request that the Division of Adult Correction and Juvenile Justice conduct an assessment of treatment and venue needs. The assessment shall be conducted by the attending medical or mental health professional and shall assess the medical and mental health needs of the prisoner and make a recommendation on whether the prisoner should remain in the custody of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety or if the prisoner should be returned to the custody of the county. To extend the order beyond the initial fifteen-day period, the sheriff shall provide the assessment to the resident judge of the superior court or any judge holding superior court in the district or any district court judge who shall determine whether to extend the transfer of the prisoner to a unit of the State prison system beyond the initial fifteen-day period. The officer in charge of the prison unit designated by the Secretary of Public Safety shall release custody of the prisoner in accordance with the court order and the instructions of the attending medical or mental health professional. The county from which the prisoner is transferred shall pay the Division of Adult Correction and Juvenile Justice of the Department of Public Safety for maintaining the prisoner for the period of treatment at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner, and for extraordinary medical expenses as set forth in subsection (c) of this section.

(e) The number of county prisoners incarcerated in the State prison system pursuant to safekeeping orders from the various counties pursuant to subsection (b) of this section or for medical or mental health treatment pursuant to subsection (d) of this section may not exceed 200 at any given time unless authorized by the Secretary of Public Safety. The Secretary may refuse to accept any safekeeper and may return any safekeeper transferred under a safekeeping order when this capacity limit is reached. The Secretary shall refuse to accept a safekeeper for medical or mental health treatment from a county that meets any of the following criteria:

(1) The county has failed to pay the Department of Public Safety for services rendered pursuant to this section and the bill has remained unpaid for 120 days or more.

(2) The county does not participate in the Statewide Misdemeanant Confinement Program by receiving misdemeanants for housing. This subdivision does not apply to a county that has a determination made by the North Carolina Sheriffs' Association, Inc., that the county's facilities are filled to capacity pursuant to G.S. 148-32.1(b4).

(f) If, after five days of receiving notification and request for transfer from the Department of Public Safety pursuant to G.S. 148-19.3(a) the sheriff fails to assume custody of the county prisoner from the State prison facility to which the prisoner was assigned, then, in addition to the actual cost of transporting the prisoner and the cost of maintaining the prisoner at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner, the county shall be liable to the State for an additional per day, per inmate rate not to exceed twenty dollars ($20.00) for each day the sheriff fails to assume custody of the prisoner. The section chief of the Health Services Section may waive up to ten days of the additional per day rate if the sheriff provides documentation of extenuating circumstances."

SECTION 2.(a) Article 2 of Chapter 148 is amended by adding a new section to read:

"**§ 148-19.3. Medicaid eligibility; county prisoners.**

"(a) For county prisoners housed in the State prison system pursuant to safekeeping orders under G.S. 162-39, the Department shall determine the prisoner's eligibility for enrollment in Medicaid to be used for reimbursement for qualifying health care services and shall take steps to ensure proper Medicaid applications are completed and submitted. All unreimbursed charges for health care services provided shall be documented and presented to the county for payment in accordance with G.S. 162-39. Upon expiration of the terms of the order and a determination that the prisoner may be safely returned to the custody of the county, the Department shall notify the sheriff, or the sheriff's designee, by telephone and electronic mail and request the transfer of the prisoner to the custody of the county.

(b) The Department shall update the medical services schedule of charges assessed to counties for the provision of health care services to county prisoners housed in the State prison system pursuant to safekeeping orders under G.S. 162-39. In updating the schedule of charges, at a minimum, the Department shall consider the actual rate for services provided and current established Medicaid rates for respective services. The schedule of charges shall be updated annually and shall be included in the Department's policies and procedures. The Department shall assess charges to counties for health care services provided to county prisoners at all State prison facilities."

SECTION 2.(b) The Department shall submit a report on the updated medical services schedule of charges required in subsection (a) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety on or before December 1, 2019.

SECTION 3. This act becomes effective July 1, 2019.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 302*

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S302-ASH-5 [v.1]

Amends Title [YES]
First Edition

Date _____,2019

Senator Krawiec

moves to amend the bill on page 1, line 2 through page 2, line 8, by rewriting the lines to read:

"AN ACT AUTHORIZING ADULT CARE HOMES TO USE SERVICE PLANS COMPLETED AS THE RESULT OF A MEDICAID PERSONAL CARE SERVICES ASSESSMENT TO FULFILL THE ACTIVITIES OF DAILY LIVING PORTION OF THE REQUIRED SERVICE PLANS OR CARE PLANS FOR ADULT CARE HOME RESIDENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2.15 reads as rewritten:

"**§ 131D-2.15. Resident assessments.**

(a) Initial Assessment. – The Department shall ensure that facilities conduct and complete an assessment of each resident within 72 hours of admitting the ~~resident and annually thereafter.~~ resident. In conducting the assessment, the facility shall use an assessment instrument ~~approved by the Secretary upon the advice of the Director of the Division of Aging and Adult Services.~~ approved in accordance with rules adopted by the Medical Care Commission. The Department shall provide ongoing training for facility personnel in the use of the approved assessment instrument.

(a1) ~~The~~ Assessment to Develop Service Plans and Care Plans. – Within 30 days of admission, the facility shall ~~use the~~ conduct an assessment to develop appropriate and comprehensive service plans and care plans and to determine the level and type of facility staff that is needed to meet the needs of residents. The assessment shall determine a resident's level of functioning and shall include, but not be limited to, cognitive status and physical functioning in activities of daily living. Activities of daily living are personal functions essential for the health and well-being of the resident. The assessment shall not serve as the basis for medical care. The assessment shall indicate if the resident requires referral to the resident's physician or other appropriate licensed health care professional or community resource.

(a2) Medicaid State Plan Personal Care Services Assessment. – To fulfill the activities of daily living portion of any service plan or care plan required under subsection (a1), or any rules adopted under this Article, the facility may use a service plan that was completed within 35 days of the resident's admission to the facility and represents the result of an assessment to determine the resident's eligibility for personal care services under the Medicaid State Plan. If the facility uses a service plan for personal care services under the Medicaid State Plan developed within 35

days of resident admission, the facility shall be exempt from conducting an assessment of the resident's ability to perform activities of daily living within 30 days of resident admission. For purposes of this subsection, a resident must have received an assessment to develop appropriate and comprehensive service plans and care plans no later than 35 days after resident admission or subsection (a1) applies.

(b) Review. – The Department, as part of its inspection and licensing of adult care homes, shall review assessments and related service plans and care plans for a selected number of residents. In conducting this review, the Department shall ~~determine:~~determine all of the following:

(1) Whether the appropriate assessment instrument was administered and interpreted ~~correctly;~~correctly.

(2) Whether the facility is capable of providing the necessary ~~services;~~services.

(3) Whether the service plan or care plan conforms to the results of an appropriately administered and interpreted ~~assessment; and~~assessment.

(4) Whether the service plans or care plans are being implemented fully and in accordance with an appropriately administered and interpreted assessment.

(c) Penalties. – If the Department finds that the facility is not carrying out its assessment responsibilities in accordance with this section, the Department shall notify the facility and require the facility to implement a corrective action plan. The Department shall also notify the resident of the results of its review of the assessment, service plans, and care plans developed for the resident. In addition to administrative penalties, the Secretary may suspend the admission of any new residents to the facility. The suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removing the suspension.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

SENATE BILL 302:
Update Svc & Care Plan Req's/ACH Residents.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 16, 2019
Introduced by:	Sens. Hise, Bishop, Krawiec	**Prepared by:**	Jessica Boney Staff Attorney
Analysis of:	First Edition		

OVERVIEW: Senate Bill 302 would allow adult care homes to use the Medicaid personal care services (PCS) assessment to satisfy the required resident assessment of physical functioning for activities of daily living (ADLs).

BILL ANALYSIS: SB 302 would do the following:

- Allow adult care homes to use the Medicaid PCS assessment in place of conducting a separate assessment of a resident's physical functioning for ADLs. (Adult care homes would continue to conduct an assessment of a resident's cognitive status within 30 days of admission.)
- Make technical changes.

EFFECTIVE DATE: SB 302 would become effective when it becomes law.

BACKGROUND: Adult care homes are required to assess the resident's level of functioning within 30 days after admission in order to develop care and service plans. This assessment evaluates the resident's cognitive status and physical functioning for ADLs. The Medicaid PCS program provides personal care services to qualifying individuals that need assistance in their effort to perform ADLs, which include bathing, dressing, mobility, toileting and eating. An independent entity conducts an assessment to determine a resident's Medicaid PCS eligibility.

aren Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

SENATE BILL 302*

Short Title:	Update Svc & Care Plan Req's/ACH Residents.	(Public)
Sponsors:	Senators Hise, Bishop, and Krawiec (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

March 20, 2019

A BILL TO BE ENTITLED

AN ACT AUTHORIZING ADULT CARE HOMES TO USE SERVICE PLANS COMPLETED AS THE RESULT OF A MEDICAID PERSONAL CARE SERVICES ASSESSMENT TO FULFILL THE ACTIVITIES OF DAILY LIVING PORTION OF THE REQUIRED SERVICE PLANS OR CARE PLANS FOR ADULT CARE HOME RESIDENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2.15 reads as rewritten:

"**§ 131D-2.15. Resident assessments.**

(a) The Department shall ensure that facilities conduct and complete an assessment of each resident within 72 hours ~~of~~ after admitting the resident and annually thereafter. In conducting the assessment, the facility shall use an assessment instrument approved by the Secretary upon the advice of the Director of the Division of Aging and Adult Services. The Department shall provide ongoing training for facility personnel in the use of the approved assessment instrument.

The facility shall use the assessment to develop appropriate and comprehensive service plans and care plans and to determine the level and type of facility staff that is needed to meet the needs of residents. The assessment shall determine a resident's level of functioning and shall include, but not be limited to, cognitive status and physical functioning in activities of daily living. Activities of daily living are personal functions essential for the health and well-being of the resident. To fulfill the activities of daily living portion of any service plan or care plan required under this section or any rules adopted under this Article, the facility may use a service plan, including any online service plan, that was completed as the result of an assessment to determine a resident's eligibility for personal care services under the Medicaid State Plan. The assessment shall not serve as the basis for medical care. The assessment shall indicate if the resident requires referral to the resident's physician or other appropriate licensed health care professional or community resource.

(b) The Department, as part of its inspection and licensing of adult care homes, shall review assessments and related service plans and care plans for a selected number of residents. In conducting this review, the Department shall ~~determine:~~determine all of the following:

(1) Whether the appropriate assessment instrument was administered and interpreted ~~correctly;~~correctly.

(2) Whether the facility is capable of providing the necessary ~~services;~~services.

(3) Whether the service plan or care plan conforms to the results of an appropriately administered and interpreted ~~assessment; and~~assessment.

(4) Whether the service plans or care plans are being implemented fully and in accordance with an appropriately administered and interpreted assessment.

(c) If the Department finds that the facility is not carrying out its assessment responsibilities in accordance with this section, the Department shall notify the facility and require the facility to implement a corrective action plan. The Department shall also notify the resident of the results of its review of the assessment, service plans, and care plans developed for the resident. In addition to administrative penalties, the Secretary may suspend the admission of any new residents to the facility. The suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removing the suspension."

SECTION 2. This act is effective when it becomes law.

SENATE BILL 444:
Allow Use of Oyster Shells As Serving Dishes.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 15, 2019
Introduced by:	Sen. McInnis	**Prepared by:**	Jason Moran-Bates Committee Staff
Analysis of:	First Edition		

OVERVIEW: Senate Bill 444 would permit oyster shells to be re-used to serve cooked oysters.

BILL ANALYSIS: The bill would permit restaurants to re-use oyster shells to serve cooked, shucked oysters, provided that all of the following apply:

- The restaurant posts a sign advising the public oyster shells are re-used to serve cooked oysters.
- The shell is protected from contamination by boiling it for 10 minutes, drying it, and refrigerating it until it is used.
- The shell is re-used within 48 hours after the oyster is removed from the shell.

EFFECTIVE DATE: This act would be effective October 1, 2019.

Karen Cochrane-Brown
Director

S444-SMBC-29 E1 -V-1

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S 1

SENATE BILL 444

Short Title:	Allow Use of Oyster Shells As Serving Dishes.	(Public)
Sponsors:	Senator McInnis (Primary Sponsor).	
Referred to:	Rules and Operations of the Senate	

April 2, 2019

A BILL TO BE ENTITLED

AN ACT ALLOWING FOOD ESTABLISHMENTS TO REPURPOSE OYSTER SHELLS AS SERVING DISHES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-248 is amended by adding a new subsection to read:

"(c3) Notwithstanding any provision of this Part, a food establishment may reuse an oyster shell to serve shucked oysters that are cooked, regardless if the shucked oysters are reused in the same shells from which they originated, provided the establishment does all of the following:

(1) Posts on the premises a conspicuous sign, clearly legible, and easily readable by the public, advising that the establishment reuses oyster shells to serve cooked oysters.

(2) Protects each reused oyster shell from contamination by, at a minimum, doing all of the following on the same day the oyster is removed from the shell:

a. Boils the shell for a minimum of ten minutes.

b. Thoroughly dries the shell.

c. Stores the shell in a covered container that is refrigerated until it is reused.

(3) Reuses the shell within 48 hours after the oyster is removed from the shell."

SECTION 2. This act becomes effective October 1, 2019.

SENATE BILL 537:
Establish New Payment Methodology/ACHs.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 16, 2019
Introduced by:	Sens. Hise, Krawiec, Bishop	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	First Edition		

OVERVIEW: Senate Bill 537 would direct the Department of Health and Human Services to convene a workgroup to evaluate reimbursement options under managed care for adult care homes and to develop a service definition that i) supports alternative payment models, ii) incorporates best practices for long-term services and supports, and iii) includes efficient payment methodologies. By October 1, 2020, the Department must submit a report containing the new service definition to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division, and then the Department must submit Medicaid State Plan amendments necessary to implement the new service definition to the Centers for Medicare and Medicaid Services.

[As introduced, this bill was identical to H729, as introduced by Reps. Dobson, Lambeth, Murphy, Adcock, which is currently in House Health.]

BILL ANALYSIS: SB 537 would direct the Department of Health and Human Services (DHHS) to convene a workgroup that includes adult care home industry representatives and relevant stakeholders, to evaluate reimbursement options under managed care for adult care homes. The workgroup must include all funding streams in the evaluation and must develop a service definition. In developing the service definition, the workgroup must include the following components:

1. Support for alternative payment models, including pay-for-performance initiatives, available under the State's 1115 Medicaid waiver and Medicaid transformation.
2. Best practices for long-term services and supports.
3. Efficient payment methodologies.

By October 1, 2020, the Department is required to submit a report containing the new service definition to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice and the Fiscal Research Division. Following submission of the report, DHHS is directed to submit any Medicaid State Plan amendments necessary to implement the new service definition to the Centers for Medicare and Medicaid Services.

EFFECTIVE DATE: SB 537 would become effective when it becomes law.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

SENATE BILL 537*

Short Title:	Establish New Payment Methodology/ACHs.	(Public)
Sponsors:	Senators Hise, Krawiec, and Bishop (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

April 3, 2019

A BILL TO BE ENTITLED

AN ACT TO EXAMINE AND ESTABLISH A NEW PAYMENT METHODOLOGY FOR ADULT CARE HOMES PROVIDING CARE TO NORTH CAROLINA MEDICAID BENEFICIARIES THAT PROMOTES HEALTH AS WELL AS FAIR AND REASONABLE COMPENSATION FOR THE SERVICES PROVIDED.

Whereas, approximately 30,000 adults reside in North Carolina's adult care homes; and

Whereas, the average age of an adult care home resident is over 75 years old; and

Whereas, adult care homes provide care to some of North Carolina's most vulnerable senior citizens; and

Whereas, adult care homes have not had a rate increase for State and county special assistance since 2009; and

Whereas, the General Assembly recognizes that with Medicaid managed care there are opportunities to explore new programs and payment methodologies that can provide a stable and reliable funding stream to ensure access, choice, and quality of care within adult care homes; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. It is the intent of the General Assembly to provide funding to adult care homes in the State in a manner that recognizes the importance of a stable and reliable funding stream to ensure access, choice, and quality of care within the adult care home segment of the care continuum. In furtherance of this intent, and as the North Carolina Medicaid program transitions to a managed care delivery system, the Department of Health and Human Services is directed to establish and convene a workgroup to evaluate reimbursement options under managed care for adult care homes that considers all funding streams and to develop a service definition or definitions under managed care that may accomplish this intent. The workgroup shall consist of adult care home industry representatives and other relevant stakeholders. In development of the service definition, the workgroup shall include all of the following components:

1) Support for alternative payment models, including pay-for-performance initiatives, available under the State's 1115 Medicaid waiver and Medicaid transformation.
2) Best practices for long-term services and supports.
3) Efficient payment methodologies.

SECTION 2. No later than October 1, 2020, the Department of Health and Human Services shall submit a report on the new service definition to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division. After submission of this

report, DHHS shall submit to the Centers for Medicare and Medicaid Services any amendments to the NC Medicaid State Plan necessary to implement the new service definition.

SECTION 3. This act is effective when it becomes law.

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 643 LOB

DATE: 4-17 **TIME:** 10 AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

Page Name	Hometown	Sponsoring Senator
1. Andrew Fluhrer	Raleigh	J. Alexander
2. Hannahlynne Gallimore	Lexington	Gallimore
3. ~~Taelor Jennette~~	~~Fuquay-Varina~~	[redacted]
4. Jackie Jewel	Davidson	J. Jackson
5. Abby Scudder	Swansboro	Brown
6. Taelor Jennette	Fuquay-Varina	Searcy
7.		
8.		

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Health Care

Senate Comm

April 17, 2019

10:00 AM

Senate Sergeant at Arms

Terry Barnhardt

Tom Burroughs

Frances Patterson

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

April 17, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jeff Horton	NCSLA
Joyce Peters	CSS
Kay Castillo	NASW-NC
April Neumann	MWC
[illegible]	NCACC
Amber Harris	NCACC
Sarah Patterson	WM
Mike McBrayer	Bayer
Steve Coward	NCANP
Susan DeLaney	NCANP
LT McCrimmon	DHHS
Matt Gross	DHHS
Megan Provette	NCPA
Josh Lanier	CSH
JASON Joyner	NEW FRAME
Stephen Kouba	KMA
Ben Popkin	Popkin Strategies

09-21-201

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

April 17, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Reese Holland	CMC
Arthur Agolanorio MD MPH	NCMS, Clinton Medical
Eileen Raynor, MD	NCMS
Sue Ann Forest	NCMS
David Farrell	NP
Sallie James	Governor's office
Rachel Beaulieu	RBLa
Susanna Davis	NC DPS
JUSTIN DAVIS	NC DPS
Alicia Davis	NCDPS
PEYTON MAYNARD	
Mike James	
Andy Munn	Novant
Elizabeth Outten	Novant
Leah Byrnes	NCTIR

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

April 17, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ryan Blackledge	Conn Health
Ross Burke	NP

Senate Committee on Health Care
Thursday, April 18, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on April 18, 2019 in Room 643 of the Legislative Office Building. Seven members were present.

Senator Joyce Krawiec, Chair, presided.

Sen. Krawiec welcomed everyone, acknowledged the Sergeant of Arms. No Pages were available during this meeting. Sen. Krawiec asked that Sen. Burgin stand in as chair for this meeting.

SB 118 PED/Safekeeper Health Care Cost Recov. Pract. (Senators B. Jackson, Krawiec, Ballard)
The bill was discovered in the previous meeting on April 17, 2019 and the PCS was still before the committee. Sen. Burgin recognized Sen. Krawiec to make additional statements. Questions from the members were responded to by Sen. Krawiec and Brent Lucas from the Program Evaluation Division. Sen. Davis moved for an unfavorable to the bill favorable to the PCS and it carried.

SB 444 Allow Use of Oyster Shells As Serving Dishes. (Senator McInnis)
Sen. McInnis was recognized to present the bill. Questions for the members were responded to by Sen. McInnis. Sen. Krawiec moved for a favorable report and it carried.

The meeting adjourned at 10:10 AM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

Senator Jim Burgin, Stand In Chair

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Thursday, April 18, 2019

Senator Krawiec,
submits the following with recommendations as to passage:

FAVORABLE

SB **444** Allow Use of Oyster Shells As Serving Dishes.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

SB **118** PED/Safekeeper Health Care Cost Recov. Pract.

Draft Number:	S118-PCS15332-BP-4
Sequential Referral:	Judiciary
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Senator Tom McInnis will handle SB 444
Senator Joyce Krawiec will handle SB 118

CMR313-V-1

Senate Committee on Health Care
Thursday, April 18, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 118	PED/Safekeeper Health Care Cost Recov. Pract.	Senator B. Jackson Senator Krawiec Senator Ballard
SB 444	Allow Use of Oyster Shells As Serving Dishes.	Senator McInnis

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S D

SENATE BILL 118
PROPOSED COMMITTEE SUBSTITUTE S118-CSBP-4 [v.3]

04/16/2019 05:08:58 PM

Short Title: PED/Safekeeper Health Care Cost Recov. Pract. (Public)

Sponsors:

Referred to:

February 25, 2019

A BILL TO BE ENTITLED

AN ACT TO IMPROVE DATA COLLECTION AND COST RECOVERY PRACTICES FOR HEALTH CARE SERVICES FOR SAFEKEEPERS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 162-39 reads as rewritten:

"**§ 162-39. Transfer of prisoners when necessary for safety and security; application of section to municipalities.**

(a) Whenever necessary for the safety of a prisoner held in any county jail or to avoid a breach of the peace in any county or whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the housing of such prisoners, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a fit and secure jail in some other county where the prisoner shall be held for such length of time as the judge may direct.

(b) Whenever necessary to avoid a security risk in any county jail, or whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the housing of such prisoners, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a unit of the State prison system designated by the Secretary of Public Safety or his authorized representative. For purposes of this subsection, a prisoner poses a security risk if the prisoner:

(1) Poses a serious escape risk;
(2) Exhibits violently aggressive behavior that cannot be contained and warrants a higher level of supervision;
(3) Needs to be protected from other inmates, and the county jail facility cannot provide such protection;
(4) Is a female or a person 18 years of age or younger, and the county jail facility does not have adequate housing for such prisoners;
(5) Is in custody at a time when a fire or other catastrophic event has caused the county jail facility to cease or curtail operations; or
(6) Otherwise poses an imminent danger to the staff of the county jail facility or to other prisoners in the facility.

(b1) The Department of Public Safety, Health Services Section, shall maintain records of prisoners transferred to a unit of the State prison system pursuant to subsection (b) of this section. The records shall utilize unique identifiers for each transferred prisoner and shall include all of the following information:

(1) The date the transfer order was received.
(2) The statutory basis upon which the order was granted.

(3) The date the prisoner was transferred to State custody.
(4) The State prison facility where the prisoner was transferred.
(5) The county where the prisoner was removed.
(6) The dates the prisoner received health services from the Department.
(7) A list of health services provided to the prisoner and the corresponding charges.
(8) The date the Department determined that the prisoner no longer needs health services to be provided by the State prison system.
(9) The date and method used by the Department to notify the county that the prisoner should be transferred back to the custody of the county.
(10) The date that the prisoner is returned to the custody of the county.

(c) The sheriff of the county from which the prisoner is removed shall be responsible for conveying the prisoner to the jail or prison unit where ~~he~~ the prisoner is to be held, and for returning ~~him~~ the prisoner to the common jail of the county from which ~~he~~ the prisoner was transferred. The return shall be made at the expiration of the time designated in the court order directing the transfer unless the judge, by appropriate order, ~~shall direct~~ directs otherwise. The sheriff or keeper of the jail of the county designated in the court order, or the officer in charge of the prison unit designated by the Secretary of Public Safety, shall receive and release custody of the prisoner in accordance with the terms of the court order. If a prisoner is transferred to a unit of the State prison system, the county from which the prisoner is transferred shall pay the Division of Adult Correction and Juvenile Justice of the Department of Public Safety for maintaining the prisoner for the time designated by the court at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner. The county shall also pay the Division of Adult Correction and Juvenile Justice of the Department of Public Safety for the costs of ~~extraordinary~~ medical care incurred while the prisoner was in the custody of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, defined as follows:

(1) Medical expenses incurred as a result of providing health care to a prisoner as an inpatient ~~(hospitalized);~~(hospitalized).
(2) Other medical expenses when the total cost exceeds thirty-five dollars ($35.00) per occurrence or illness as a result of providing health care to a prisoner as an outpatient ~~(nonhospitalized); and~~(nonhospitalized).
(3) Cost of replacement of eyeglasses and dental prosthetic devices if those eyeglasses or devices are broken while the prisoner is incarcerated, provided the prisoner was using the eyeglasses or devices at the time of his commitment and then only if prior written consent of the county is obtained by the Division.
(4) Transportation and custody costs associated with the transfer of prisoners receiving health care outside of the prison facility. The county shall reimburse the State for services provided to the prisoner at the same mileage reimbursement rate and hourly custody rate that are reimbursed pursuant to the Statewide Misdemeanant Confinement Program.
(5) Cost of sick call encounters at the rate charged to State prison inmates.

(c1) If the prisoner is transferred to a jail in some other county, the county from which the prisoner is transferred shall pay to the county receiving the prisoner in its jail the actual cost of maintaining the prisoner for the time designated by the court. Counties are ~~hereby~~ authorized to enter into contractual agreements with other counties to provide jail facilities to which prisoners may be transferred as deemed necessary under this section.

(c2) Whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the safekeeping of such prisoners, the resident judge of the superior court or any superior or district court judge holding court in the district may order the prisoners transferred to a unit of the Division of Adult Correction and Juvenile Justice of the

Department of Public Safety designated by the Secretary of Public Safety or ~~his~~ the Secretary's authorized representative, where the prisoners may be held for such length of time as the judge may direct, such detention to be in ~~cell~~ cells separate from ~~that~~ those used for imprisonment of persons already convicted of crimes, except when admission to an inpatient prison medical or mental health unit is required to provide services deemed necessary by a prison health care clinician. The sheriff of the county from which the prisoners are removed shall be responsible for conveying the prisoners to the prison unit or units where they are to be held, and for returning them to the common jail of the county from which they were transferred. However, if due to the number of prisoners to be conveyed the sheriff is unable to provide adequate transportation, ~~he~~ the sheriff may request the assistance of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, and the Division of Adult Correction and Juvenile Justice of the Department of Public Safety is hereby authorized and directed to cooperate with the sheriff and provide whatever assistance is available, both in vehicles and manpower, to accomplish the conveying of the prisoners to and from the county to the designated prison unit or units. The officer in charge of the prison unit designated by the Secretary of Public Safety or ~~his~~ the Secretary's authorized representative shall receive and release the custody of the prisoners in accordance with the terms of the court order. The county from which the prisoners are transferred shall pay to the Division of Adult Correction and Juvenile Justice of the Department of Public Safety the actual cost of transporting the prisoners and the cost of maintaining the prisoners at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner, provided, however, that a county is not required to reimburse the State for transporting or maintaining a prisoner who was a resident of another state or county at the time ~~he~~ the prisoner was arrested. However, if the county commissioners shall certify to the Governor that the county is unable to pay the bill submitted by the Division of Adult Correction and Juvenile Justice of the Department of Public Safety to the county for the services rendered, either in whole or in part, the Governor may recommend to the Council of State that the State of North Carolina assume and pay, in whole or in part, the obligation of the county to the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, and upon approval of the Council of State the amount so approved shall be paid from the Contingency and Emergency Fund to the Division of Adult Correction and Juvenile Justice of the Department of Public Safety.

(c3) When, due to an emergency, it is not feasible to obtain from a judge of the superior or district court a prior order of transfer, the sheriff of the county and the Division of Adult Correction and Juvenile Justice of the Department of Public Safety may exercise the authority hereinafter conferred; provided, however, that the sheriff shall, as soon as possible after the emergency, obtain an order from the judge authorizing the prisoners to be held in the designated place of confinement for such period as the judge may direct. All provisions of this ~~subsection~~ section shall be applicable to municipalities whenever prisoners are arrested in such numbers that the municipal jail facilities and the county jail facilities are insufficient and inadequate for the safekeeping of the prisoners. The chief of police is hereby authorized to exercise the authority herein conferred upon the sheriff, and the municipality shall be liable for the cost of transporting and maintaining the prisoners to the same extent as a county would be unless action is taken by the Governor and Council of State as herein provided for counties which are unable to pay such costs.

(d) Whenever a prisoner held in a county jail requires medical or mental health treatment that the county decides can best be provided by the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a unit of the State prison system designated by the Secretary of Public Safety or ~~his~~ the Secretary's authorized ~~representative.~~ representative for an initial period not to exceed 30 days. The sheriff of the county from which the prisoner is removed shall be responsible for conveying

the prisoner to the prison unit where ~~he~~ the prisoner is to be held, and for returning ~~him~~ the prisoner to the jail of the county from which ~~he~~ the prisoner was transferred. ~~The prisoner shall be returned when the attending medical or mental health professional determines that the prisoner may be returned safely.~~ The officer in charge of the prison unit designated by the Secretary of Public Safety shall receive custody of the prisoner in accordance with the terms of the ~~order and~~ order. Prior to the conclusion of the 30-day period, the Division of Adult Correction and Juvenile Justice shall conduct an assessment of treatment and venue needs. The assessment shall be conducted by the attending medical or mental health professional and shall assess the medical and mental health needs of the prisoner and make a recommendation on whether the prisoner should remain in the custody of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety or if the prisoner should be returned to the custody of the county. To extend the order beyond the initial 30-day period, the sheriff shall provide the Division of Adult Correction and Juvenile Justice assessment and any other relevant information to the resident judge of the superior court or any judge holding superior court in the district or any district court judge who shall determine whether to extend the transfer of the prisoner to a unit of the State prison system beyond the initial 30-day period. The officer in charge of the prison unit designated by the Secretary of Public Safety shall release custody of the prisoner in accordance with the court order and the instructions of the attending medical or mental health professional. The county from which the prisoner is transferred shall pay the Division of Adult Correction and Juvenile Justice of the Department of Public Safety for maintaining the prisoner for the period of treatment at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner, and for extraordinary medical expenses as set forth in subsection (c) of this section.

(e) The number of county prisoners incarcerated in the State prison system pursuant to safekeeping orders from the various counties pursuant to subsection (b) of this section or for medical or mental health treatment pursuant to subsection (d) of this section may not exceed 200 at any given time unless authorized by the Secretary of Public Safety. The Secretary may refuse to accept any safekeeper and may return any safekeeper transferred under a safekeeping order when this capacity limit is reached. The Secretary shall not refuse to accept a safekeeper because a county has failed to pay the Department of Public Safety for services rendered pursuant to this section.

(f) If, after 10 days of receiving notification and request for transfer from the Department of Public Safety pursuant to G.S. 148-19.3(a), the sheriff fails to assume custody of the county prisoner from the State prison facility to which the prisoner was assigned, then, in addition to the actual cost of transporting the prisoner and the cost of maintaining the prisoner at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner, the county shall be liable to the State for an additional per day, per inmate rate not to exceed twenty dollars ($20.00) for each day the sheriff fails to assume custody of the prisoner, unless the sheriff has obtained an extension of the order because the inmate cannot be safely housed in the local jail. The section chief of the Health Services Section may waive up to 10 days of the additional per day rate if the sheriff provides documentation of extenuating circumstances."

SECTION 2.(a) Article 2 of Chapter 148 is amended by adding a new section to read:

"**§ 148-19.3. Medicaid eligibility; county prisoners.**

(a) For county prisoners housed in the State prison system pursuant to safekeeping orders under G.S. 162-39 and who receive health care services outside the prison, the Department shall notify the county sheriff of the potential Medicaid eligibility of the safekeeper given data available to the Department. All charges that are the responsibility of the transferring county for health care services provided to prisoners held under a safekeeping order shall not be paid by the

Department and shall be submitted by the health care provider to the Inmate Medical Costs Management Plan through the North Carolina Sheriffs' Association for the Plan to review and negotiate all charges for health care services to avoid overpayment and reduce overall health care service costs. The Department shall notify the health care provider when services are being provided to the prisoner that the invoice for health care services shall be submitted by the provider directly to the Plan. In the event an invoice is sent to the Department by a health care provider for health care services provided to a safekeeper under this section, the Department shall forward the invoice to the Plan within three days of receipt. All unreimbursed charges for health care services provided shall be documented and presented to the county for payment in accordance with G.S. 162-39. Upon expiration of the terms of the order and a determination that the prisoner may be safely returned to the custody of the county, the Department shall notify the sheriff, or the sheriff's designee, by telephone and electronic mail and request the transfer of the prisoner to the custody of the county.

(b) The Department shall update the medical services schedule of charges assessed to counties for the provision of health care services to county prisoners housed in the State prison system pursuant to safekeeping orders under G.S. 162-39. In updating the schedule of charges, at a minimum, the Department shall consider the actual rate for services provided and current established Medicaid rates for respective services. The schedule of charges shall be updated annually and shall be included in the Department's policies and procedures. The Department shall assess charges to counties for health care services provided to county prisoners at all State prison facilities."

SECTION 2.(b) The Department shall submit a report on the updated medical services schedule of charges required in subsection (a) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety on or before December 1, 2019.

SECTION 3. This act becomes effective July 1, 2019.

SENATE BILL 118:
PED/Safekeeper Health Care Cost Recov. Pract.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Judiciary. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 16, 2019
Introduced by:	Sens. B. Jackson, Krawiec, Ballard	**Prepared by:**	Jessica Boney Staff Attorney
Analysis of:	PCS to First Edition S118-CSBP-4		

OVERVIEW: The PCS to Senate Bill 118 would modify the data collection and cost recovery practices for health care services provided to inmates who are transferred from a local jail to the State prison system pursuant to a safekeeping order.

CURRENT LAW: A superior or district court judge may transfer an inmate from a local jail to the State prison system for safety and security purposes[1] or when the inmate's medical or mental health needs require care beyond that which is available in the county jail. The total safekeeper population may not exceed 200 inmates at any given time without approval of the Secretary of Public Safety.

BILL ANALYSIS: The PCS to Senate Bill 118 contains several recommended changes resulting from the Program Evaluation Division's study of the efficiency and economy of medical and dental services provided for safekeepers housed in the State prison system. Specifically, **Section 1** makes the following changes:

- ***Recordkeeping.*** – Requires the Health Services Section of DPS to maintain records of prisoners transferred due to a safety risk, which include specific enumerated information, such as the dates the inmate received health services from the Department, a list of the services provided, and the date the Department determined the inmate no longer needs health services to be provided by the State prison system.
- ***Extension of Time for Safekeeping.*** – Provides a process that a sheriff can use to seek an extension beyond the initial 30-day treatment period. During the 30 days, the Division of Adult Correction and Juvenile Justice must conduct an assessment of the treatment and venue needs of the prisoner. The sheriff must then provide the assessment and any other relevant information to the resident superior court judge or any judge holding superior court in the district or any district court judge to determine whether to extend the transfer of the prisoner.
- ***No Refusal for Failure to Pay.*** – Prohibits DPS from refusing to accept a safekeeper because a county has failed to pay DPS for safekeeping services rendered.
- ***Additional Costs Payable by Counties to DPS.*** – Transportation and custody costs associated with prisoners receiving health care outside of the prison facility. Counties would be required to reimburse the State at the same reimbursement rate and hourly custody rate provided in the Statewide Misdemeanant Confinement Program.

[1]The safety and security purposes include when the inmate (1) poses a serious escape risk; (2) exhibits violently aggressive behavior; (3) needs to be protected from other inmates; (4) is a woman or person 18 years old or younger for whom the county does not have adequate housing; (5) is in custody at a time when a fire or other catastrophe has caused the jail to cease or curtail operations; (6) otherwise poses an imminent danger to the jail staff or other inmates.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- The cost of all sick call encounters at the rate charged to State prison inmates.
- An additional per day, per inmate fee of up to $20.00 if a sheriff fails to assume custody of a county prisoner within 10 days of being notified of the return. This fee may be waived for up to 10 days if the sheriff provides documentation of extenuating circumstances.

Section 2 makes the following changes:

- ***Notification of Medicaid Eligibility.*** – With respect to health care services received outside the prison, DPS must notify a county sheriff of a safekeeper's potential Medicaid eligibility based on data available to the DPS.
- ***Submission of Medical Bills to Sheriffs' Plan.*** – All unreimbursed charges for health care services must be submitted by the health care provider to the Inmate Medical Costs Management Plan through the NC Sheriffs' Association.
- ***Update Schedule of Charges.*** – Requires DPS to update annually the medical service schedule of charges assessed to counties for health care services. The schedule of charges was last revised in 2009.
- ***Report.*** – Submit a report on the updated medical services schedule to the Joint Legislative Oversight Committee on Justice and Public Safety on or before December 1, 2019.

EFFECTIVE DATE: This act becomes effective July 1, 2019.

**Staff Attorney Trina Griffin substantially contributed to this summary.*

SENATE BILL 118*

Short Title:	PED/Safekeeper Health Care Cost Recov. Pract.	(Public)
Sponsors:	Senators B. Jackson, Krawiec, and Ballard (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

February 25, 2019

A BILL TO BE ENTITLED

AN ACT TO IMPROVE DATA COLLECTION AND COST RECOVERY PRACTICES FOR HEALTH CARE SERVICES FOR SAFEKEEPERS, AS RECOMMENDED BY THE JOINT LEGISLATIVE PROGRAM EVALUATION COMMITTEE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 162-39 reads as rewritten:

"**§ 162-39. Transfer of prisoners when necessary for safety and security; application of section to municipalities.**

(a) Whenever necessary for the safety of a prisoner held in any county jail or to avoid a breach of the peace in any county or whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the housing of such prisoners, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a fit and secure jail in some other county where the prisoner shall be held for such length of time as the judge may direct.

(b) Whenever necessary to avoid a security risk in any county jail, or whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the housing of such prisoners, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a unit of the State prison system designated by the Secretary of Public Safety or his authorized representative. For purposes of this subsection, a prisoner poses a security risk if the prisoner:

(1) Poses a serious escape risk;

(2) Exhibits violently aggressive behavior that cannot be contained and warrants a higher level of supervision;

(3) Needs to be protected from other inmates, and the county jail facility cannot provide such protection;

(4) Is a female or a person 18 years of age or younger, and the county jail facility does not have adequate housing for such prisoners;

(5) Is in custody at a time when a fire or other catastrophic event has caused the county jail facility to cease or curtail operations; or

(6) Otherwise poses an imminent danger to the staff of the county jail facility or to other prisoners in the facility.

(b1) The Department of Public Safety, Health Services Section, shall maintain records of prisoners transferred to a unit of the State prison system pursuant to subsection (b) of this section. The records shall utilize unique identifiers for each transferred prisoner and shall include all of the following information:

(1) The date the transfer order was received.

(2) The statutory basis upon which the order was granted.
(3) The date the prisoner was transferred to State custody.
(4) The State prison facility where the prisoner was transferred.
(5) The county where the prisoner was removed.
(6) The dates the prisoner received health services from the Department.
(7) A list of health services provided to the prisoner and the corresponding charges.
(8) The date the Department determined that the prisoner no longer needs health services to be provided by the State prison system.
(9) The date and method used by the Department to notify the county that the prisoner should be transferred back to the custody of the county.
(10) The date that the prisoner is returned to the custody of the county.

(c) The sheriff of the county from which the prisoner is removed shall be responsible for conveying the prisoner to the jail or prison unit where ~~he~~ the prisoner is to be held, and for returning ~~him~~ the prisoner to the common jail of the county from which ~~he~~ the prisoner was transferred. The return shall be made at the expiration of the time designated in the court order directing the transfer unless the judge, by appropriate order, ~~shall direct~~ directs otherwise. The sheriff or keeper of the jail of the county designated in the court order, or the officer in charge of the prison unit designated by the Secretary of Public Safety, shall receive and release custody of the prisoner in accordance with the terms of the court order. If a prisoner is transferred to a unit of the State prison system, the county from which the prisoner is transferred shall pay the Division of Adult Correction and Juvenile Justice of the Department of Public Safety for maintaining the prisoner for the time designated by the court at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner. The county shall also pay the Division of Adult Correction and Juvenile Justice of the Department of Public Safety for the costs of ~~extraordinary~~ medical care incurred while the prisoner was in the custody of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, defined as follows:

(1) Medical expenses incurred as a result of providing health care to a prisoner as an inpatient ~~(hospitalized);~~(hospitalized).
(2) Other medical expenses when the total cost exceeds thirty-five dollars ($35.00) per occurrence or illness as a result of providing health care to a prisoner as an outpatient ~~(nonhospitalized); and~~(nonhospitalized).
(3) Cost of replacement of eyeglasses and dental prosthetic devices if those eyeglasses or devices are broken while the prisoner is incarcerated, provided the prisoner was using the eyeglasses or devices at the time of his commitment and then only if prior written consent of the county is obtained by the Division.
(4) Transportation and custody costs associated with the transfer of prisoners receiving health care outside of the prison facility. The county shall reimburse the State for services provided to the prisoner at the same mileage reimbursement rate and hourly custody rate that are reimbursed pursuant to the Statewide Misdemeanant Confinement Program.
(5) Cost of sick call encounters at the rate charged to State prison inmates.

(c1) If the prisoner is transferred to a jail in some other county, the county from which the prisoner is transferred shall pay to the county receiving the prisoner in its jail the actual cost of maintaining the prisoner for the time designated by the court. Counties are ~~hereby~~ authorized to enter into contractual agreements with other counties to provide jail facilities to which prisoners may be transferred as deemed necessary under this section.

(c2) Whenever prisoners are arrested in such numbers that county jail facilities are insufficient and inadequate for the safekeeping of such prisoners, the resident judge of the superior court or any superior or district court judge holding court in the district may order the

prisoners transferred to a unit of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety designated by the Secretary of Public Safety or ~~his~~ the Secretary's authorized representative, where the prisoners may be held for such length of time as the judge may direct, such detention to be in ~~cell~~ cells separate from ~~that~~ those used for imprisonment of persons already convicted of crimes, except when admission to an inpatient prison medical or mental health unit is required to provide services deemed necessary by a prison health care clinician. The sheriff of the county from which the prisoners are removed shall be responsible for conveying the prisoners to the prison unit or units where they are to be held, and for returning them to the common jail of the county from which they were transferred. However, if due to the number of prisoners to be conveyed the sheriff is unable to provide adequate transportation, ~~he~~ the sheriff may request the assistance of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, and the Division of Adult Correction and Juvenile Justice of the Department of Public Safety is hereby authorized and directed to cooperate with the sheriff and provide whatever assistance is available, both in vehicles and manpower, to accomplish the conveying of the prisoners to and from the county to the designated prison unit or units. The officer in charge of the prison unit designated by the Secretary of Public Safety or ~~his~~ the Secretary's authorized representative shall receive and release the custody of the prisoners in accordance with the terms of the court order. The county from which the prisoners are transferred shall pay to the Division of Adult Correction and Juvenile Justice of the Department of Public Safety the actual cost of transporting the prisoners and the cost of maintaining the prisoners at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner, provided, however, that a county is not required to reimburse the State for transporting or maintaining a prisoner who was a resident of another state or county at the time ~~he~~ the prisoner was arrested. However, if the county commissioners shall certify to the Governor that the county is unable to pay the bill submitted by the Division of Adult Correction and Juvenile Justice of the Department of Public Safety to the county for the services rendered, either in whole or in part, the Governor may recommend to the Council of State that the State of North Carolina assume and pay, in whole or in part, the obligation of the county to the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, and upon approval of the Council of State the amount so approved shall be paid from the Contingency and Emergency Fund to the Division of Adult Correction and Juvenile Justice of the Department of Public Safety.

(c3) When, due to an emergency, it is not feasible to obtain from a judge of the superior or district court a prior order of transfer, the sheriff of the county and the Division of Adult Correction and Juvenile Justice of the Department of Public Safety may exercise the authority hereinafter conferred; provided, however, that the sheriff shall, as soon as possible after the emergency, obtain an order from the judge authorizing the prisoners to be held in the designated place of confinement for such period as the judge may direct. All provisions of this ~~subsection~~ section shall be applicable to municipalities whenever prisoners are arrested in such numbers that the municipal jail facilities and the county jail facilities are insufficient and inadequate for the safekeeping of the prisoners. The chief of police is hereby authorized to exercise the authority herein conferred upon the sheriff, and the municipality shall be liable for the cost of transporting and maintaining the prisoners to the same extent as a county would be unless action is taken by the Governor and Council of State as herein provided for counties which are unable to pay such costs.

(d) Whenever a prisoner held in a county jail requires medical or mental health treatment that the county decides can best be provided by the Division of Adult Correction and Juvenile Justice of the Department of Public Safety, the resident judge of the superior court or any judge holding superior court in the district or any district court judge may order the prisoner transferred to a unit of the State prison system designated by the Secretary of Public Safety or ~~his~~ the Secretary's authorized ~~representative.~~ representative for an initial period not to exceed fifteen

days. The sheriff of the county from which the prisoner is removed shall be responsible for conveying the prisoner to the prison unit where ~~he~~ the prisoner is to be held, and for returning ~~him~~ the prisoner to the jail of the county from which ~~he~~ the prisoner was transferred. ~~The prisoner shall be returned when the attending medical or mental health professional determines that the prisoner may be returned safely.~~ The officer in charge of the prison unit designated by the Secretary of Public Safety shall receive custody of the prisoner in accordance with the terms of the ~~order and~~ order. If the sheriff seeks to extend the order beyond the initial fifteen-day period, the sheriff shall request that the Division of Adult Correction and Juvenile Justice conduct an assessment of treatment and venue needs. The assessment shall be conducted by the attending medical or mental health professional and shall assess the medical and mental health needs of the prisoner and make a recommendation on whether the prisoner should remain in the custody of the Division of Adult Correction and Juvenile Justice of the Department of Public Safety or if the prisoner should be returned to the custody of the county. To extend the order beyond the initial fifteen-day period, the sheriff shall provide the assessment to the resident judge of the superior court or any judge holding superior court in the district or any district court judge who shall determine whether to extend the transfer of the prisoner to a unit of the State prison system beyond the initial fifteen-day period. The officer in charge of the prison unit designated by the Secretary of Public Safety shall release custody of the prisoner in accordance with the court order and the instructions of the attending medical or mental health professional. The county from which the prisoner is transferred shall pay the Division of Adult Correction and Juvenile Justice of the Department of Public Safety for maintaining the prisoner for the period of treatment at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner, and for extraordinary medical expenses as set forth in subsection (c) of this section.

(e) The number of county prisoners incarcerated in the State prison system pursuant to safekeeping orders from the various counties pursuant to subsection (b) of this section or for medical or mental health treatment pursuant to subsection (d) of this section may not exceed 200 at any given time unless authorized by the Secretary of Public Safety. The Secretary may refuse to accept any safekeeper and may return any safekeeper transferred under a safekeeping order when this capacity limit is reached. The Secretary shall refuse to accept a safekeeper for medical or mental health treatment from a county that meets any of the following criteria:

(1) The county has failed to pay the Department of Public Safety for services rendered pursuant to this section and the bill has remained unpaid for 120 days or more.

(2) The county does not participate in the Statewide Misdemeanant Confinement Program by receiving misdemeanants for housing. This subdivision does not apply to a county that has a determination made by the North Carolina Sheriffs' Association, Inc., that the county's facilities are filled to capacity pursuant to G.S. 148-32.1(b4).

(f) If, after five days of receiving notification and request for transfer from the Department of Public Safety pursuant to G.S. 148-19.3(a) the sheriff fails to assume custody of the county prisoner from the State prison facility to which the prisoner was assigned, then, in addition to the actual cost of transporting the prisoner and the cost of maintaining the prisoner at the per day, per inmate rate at which the Division of Adult Correction and Juvenile Justice of the Department of Public Safety pays a local jail for maintaining a prisoner, the county shall be liable to the State for an additional per day, per inmate rate not to exceed twenty dollars ($20.00) for each day the sheriff fails to assume custody of the prisoner. The section chief of the Health Services Section may waive up to ten days of the additional per day rate if the sheriff provides documentation of extenuating circumstances."

SECTION 2.(a) Article 2 of Chapter 148 is amended by adding a new section to read:

"**§ 148-19.3. Medicaid eligibility; county prisoners.**

"(a) For county prisoners housed in the State prison system pursuant to safekeeping orders under G.S. 162-39, the Department shall determine the prisoner's eligibility for enrollment in Medicaid to be used for reimbursement for qualifying health care services and shall take steps to ensure proper Medicaid applications are completed and submitted. All unreimbursed charges for health care services provided shall be documented and presented to the county for payment in accordance with G.S. 162-39. Upon expiration of the terms of the order and a determination that the prisoner may be safely returned to the custody of the county, the Department shall notify the sheriff, or the sheriff's designee, by telephone and electronic mail and request the transfer of the prisoner to the custody of the county.

(b) The Department shall update the medical services schedule of charges assessed to counties for the provision of health care services to county prisoners housed in the State prison system pursuant to safekeeping orders under G.S. 162-39. In updating the schedule of charges, at a minimum, the Department shall consider the actual rate for services provided and current established Medicaid rates for respective services. The schedule of charges shall be updated annually and shall be included in the Department's policies and procedures. The Department shall assess charges to counties for health care services provided to county prisoners at all State prison facilities."

SECTION 2.(b) The Department shall submit a report on the updated medical services schedule of charges required in subsection (a) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety on or before December 1, 2019.

SECTION 3. This act becomes effective July 1, 2019.

SENATE BILL 444:
Allow Use of Oyster Shells As Serving Dishes.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 15, 2019
Introduced by:	Sen. McInnis	**Prepared by:**	Jason Moran-Bates Committee Staff
Analysis of:	First Edition		

OVERVIEW: Senate Bill 444 would permit oyster shells to be re-used to serve cooked oysters.

BILL ANALYSIS: The bill would permit restaurants to re-use oyster shells to serve cooked, shucked oysters, provided that all of the following apply:

- The restaurant posts a sign advising the public oyster shells are re-used to serve cooked oysters.
- The shell is protected from contamination by boiling it for 10 minutes, drying it, and refrigerating it until it is used.
- The shell is re-used within 48 hours after the oyster is removed from the shell.

EFFECTIVE DATE: This act would be effective October 1, 2019.

Karen Cochrane-Brown
Director

S444-SMBC-29 E1 -V-1

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S 1

SENATE BILL 444

Short Title:	Allow Use of Oyster Shells As Serving Dishes.	(Public)
Sponsors:	Senator McInnis (Primary Sponsor).	
Referred to:	Rules and Operations of the Senate	

April 2, 2019

A BILL TO BE ENTITLED

AN ACT ALLOWING FOOD ESTABLISHMENTS TO REPURPOSE OYSTER SHELLS AS SERVING DISHES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-248 is amended by adding a new subsection to read:

"(c3) Notwithstanding any provision of this Part, a food establishment may reuse an oyster shell to serve shucked oysters that are cooked, regardless if the shucked oysters are reused in the same shells from which they originated, provided the establishment does all of the following:

(1) Posts on the premises a conspicuous sign, clearly legible, and easily readable by the public, advising that the establishment reuses oyster shells to serve cooked oysters.

(2) Protects each reused oyster shell from contamination by, at a minimum, doing all of the following on the same day the oyster is removed from the shell:

a. Boils the shell for a minimum of ten minutes.

b. Thoroughly dries the shell.

c. Stores the shell in a covered container that is refrigerated until it is reused.

(3) Reuses the shell within 48 hours after the oyster is removed from the shell."

SECTION 2. This act becomes effective October 1, 2019.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee

ON

Health Care

April 18, 2019 – 10:00 AM

Room 643

Senate Sergeant at Arms

TOM BURROUGHS

DWIGHT GREEN

LINDA MATTHEWS

SENATE COMMITTEE ON HEALTH CARE

APRIL 18, 2019 – Room 643 – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Isabel Villa-Rocca	NCRLA
David Ferrell	NP
Ken Melton	K M A.
Zane Stilwell	TSG
Stephen Kouba	KMA
Amber Harris	NCAE
Rebecca G. Pollard	R. Ward & Assoc.

SENATE COMMITTEE ON HEALTH CARE

APRIL 18, 2019 – Room 643 – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Sallie James	Governor's Office
Anastasia Mehane	S. Dan Davis office
David V. Lee	V.A.
Ryan Blackledge	Conn Health
Leah BURNS	NCHA
Sue Ann Fargo	NCMS
Bill Rowe	NC Justice Center

Senate Committee on Health Care
Wednesday, May 1, 2019 at 10:00 AM
Room 415 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:05 AM on May 1, 2019, in Room 415 of the Legislative Office Building. Eleven members were present.

Grace Kronke sponsored by Sen. Peterson, McKenzie Cox sponsored by Sen. Gallimore, Tayess John sponsored by Sen. Mohammed, and Caroline Shelkey sponsored by Sen. Marcus served as pages.

SB 252 - Dental Bill of Rights (Senator J. Davis) - FOR DISCUSSION ONLY

Sen. Bishop recognized Sen. J. Davis to explain the bill and answer questions from committee members.

SB 574 - Modify Physical Therapy Definition (Senators J. Davis, Krawiec, Woodard)

Sen. Bishop recognized Sen. J. Davis to explain the bill and answer questions from committee members. Sen. Bishop allowed Mary Kay Hannah, a physical therapist, to speak from the audience.

Sen. Woodard moved for a favorable report for the bill with a serial referral to Rules. The motion carried.

SB 551 - Child Support Cooperation Act of 2019 (Senators Krawiec, Hise, Bishop)

Sen. Bishop recognized Sen. Krawiec to explain the bill. Questions from members were answered by Sen. Krawiec.

Sen. Woodard moved for a favorable report for the bill with a serial referral to Rules. The motion carried.

The meeting adjourned at 10:14 AM.

Senator Dan Bishop, Chair
Presiding

John Wynne, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Wednesday, May 01, 2019

Senator Bishop,
submits the following with recommendations as to passage:

FAVORABLE

SB **551** Child Support Cooperation Act of 2019.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

SB **574** Modify Physical Therapy Definition.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Senator Joyce Krawiec will handle SB 551
Senator Jim Davis will handle SB 574



Senate Committee on Health Care
Wednesday, May 1, 2019 10:00 AM
415 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 252	Dental Bill of Rights	Senator J. Davis
SB 574	Modify Physical Therapy Definition	Senator J. Davis Senator Krawiec Senator Woodard
SB 551	Child Support Cooperation Act of 2019	Senator Krawiec Senator Hise Senator Bishop

Adjournment

SENATE BILL 252:
Dental Bill of Rights.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Commerce and Insurance. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 30, 2019
Introduced by:	Sen. J. Davis	**Prepared by:**	Jessica Boney Staff Attorney
Analysis of:	PCS to First Edition S252-CSBP-8		

OVERVIEW: The Proposed Committee Substitute (PCS) for Senate Bill 252 would amend the methods of claims payment for dental services, add requirements for third party access to dental provider network contracts, and include dental plans for purposes of coverage determinations.

BILL ANALYSIS:

Methods of Claims Payment. The PCS restricts the agreement between an insurer and a provider of dental services from accepting credit card payments as the only payment method for dental services.

Third Party Access to Dental Provider Network Contracts. The PCS defines provider network contract, insurer and third party. It allows an insurer to grant third party access to its provider network contract if (i) the insurer allows any provider who is part of the carrier's provider network to choose not to participate in third party access, (ii) the insurer identifies all third parties with granted access, and (iii) the accessing third party complies with the provider network contract terms.

Coverage Determinations. The PCS prohibits an insurer from subsequently retracting its coverage determination for a dental plan after the services or supplies have been provided. The PCS defines pretreatment estimate and clarifies it is not a coverage determination.

EFFECTIVE DATE: This act is effective January 1, 2020, and applies to health benefit contracts issued, renewed, or amended on or after that date.

Karen Cochrane-Brown
Director

S252-SMBP-19 CSBP-8 -V-1

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

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SENATE BILL 252
PROPOSED COMMITTEE SUBSTITUTE S252-CSBP-8 [v.1]
04/30/2019 01:24:05 PM

Short Title: Dental Bill of Rights. (Public)

Sponsors:

Referred to:

March 14, 2019

A BILL TO BE ENTITLED

AN ACT TO CLARIFY CERTAIN PROVIDER AND PATIENT RIGHTS REGARDING HEALTH BENEFIT PLAN CONTRACTS FOR THE PROVISION OF DENTAL SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-80-290 reads as rewritten:

"**§ 58-50-290. Health benefit plans or insurers contracting for provision of dental services; no limitation on fees for noncovered ~~services.~~services or on methods of claims payment.**

(a) No agreement between an insurer or an entity that writes stand-alone dental insurance and a dentist for the provision of dental services on a preferred or in-network basis to plan members or insurance subscribers in connection with coverage under a stand-alone dental plan, but not in connection with or incidental to coverage under a medical plan or health insurance policy, may require that a dentist provide services at a fee limited or set by the plan or insurer, unless the services are reimbursed as covered services under the contract.

(b) For purposes of this section, "covered services" means a service for which reimbursement is available under an insurer's policy, without regard to contractual limitations by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or other limitation.

(c) No agreement between an insurer or another entity contracting for the provision of dental services and a provider of dental services shall contain restrictions on methods of claim payment in which the only acceptable payment method from the insurer or entity to the provider of the dental services is a credit card payment."

SECTION 2. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-50-292. Dental provider networks; confidential business information.**

(a) The following definitions apply in this section:

(1) Provider network contract. – A contract between an insurer and a dental services provider specifying the rights and responsibilities of the insurer and the provider for the delivery of and payment for dental services.

(2) Insurer. – As defined in G.S. 58-3-225(a).

(3) Third party. – A person or entity that enters into a contract with an insurer or with another entity to gain access to a dental provider network contract. Third party does not include an employer group or other group for which the insurer provides administrative services, including payment of claims.

(b) An insurer may grant access to its provider network contract to a third party if:

(1) At the time the provider network contract is entered into and at the time the provider network contract is renewed, the insurer allows any provider who is part of the carrier's provider network to choose not to participate in third party access to the provider network contract. The third party access provision of any provider network contract shall be clearly identified in the provider network contract. An insurer shall not grant third party access to the provider network contract of any provider who does not participate in third party access.

(2) The insurer includes on its Web site a listing identifying all third parties who have been granted such access.

(3) The third party accessing the provider network contract agrees to comply with all of the provider network contract's terms.

(c) This section shall not apply to the assignment of or access to a provider network contract to an entity operating under the same brand licensee program as the contracting entity or any affiliates of the contracting entity."

SECTION 3. G.S. 58-3-200(c) reads as rewritten:

"(c) Coverage Determinations. – If an insurer or its authorized representative determines that services, supplies, or other items are covered under its health benefit ~~plan, plan~~ or dental plan, including any determination under G.S. 58-50-61, the insurer shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the insured's health condition that was knowingly made by the insured or the provider of the service, supply, or other item. For purposes of this subsection, a pretreatment estimate means a voluntary request for a projection of dental benefits or payment that does not require authorization and a pretreatment estimate for dental services shall not be considered a coverage determination."

SECTION 4. This act becomes effective January 1, 2020, and applies to health benefit contracts issued, renewed, or amended on or after that date.

SENATE BILL 252

Short Title:	Dental Bill of Rights.	(Public)
Sponsors:	Senator J. Davis (Primary Sponsor).	
Referred to:	Rules and Operations of the Senate	

March 14, 2019

A BILL TO BE ENTITLED

AN ACT TO CLARIFY CERTAIN PROVIDER AND PATIENT RIGHTS REGARDING HEALTH BENEFIT PLAN CONTRACTS FOR THE PROVISION OF DENTAL SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-80-290 reads as rewritten:

"**§ 58-50-290. Health benefit plans or insurers contracting for provision of dental services; no limitation on fees for noncovered ~~services.~~services or on methods of claims payment.**

(a) No agreement between an insurer or an entity that writes stand-alone dental insurance and a dentist for the provision of dental services on a preferred or in-network basis to plan members or insurance subscribers in connection with coverage under a stand-alone dental plan, but not in connection with or incidental to coverage under a medical plan or health insurance policy, may require that a dentist provide services at a fee limited or set by the plan or insurer, unless the services are reimbursed as covered services under the contract.

(b) For purposes of this section, "covered services" means a service for which reimbursement is available under an insurer's policy, without regard to contractual limitations by a deductible, copayment, coinsurance, waiting period, annual or lifetime maximum, frequency limitation, alternative benefit payment, or other limitation.

(c) No agreement between an insurer or another entity contracting for the provision of dental services and a provider of dental services shall contain restrictions on methods of claim payment in which the only acceptable payment method from the insurer or entity to the provider of the dental services is a credit card payment."

SECTION 2. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new sections to read:

"**§ 58-50-291. Health benefit plans for the provision of dental services; limitation on expenses for marketing and administration.**

(a) An insurer who provides a health benefit plan for dental services shall not use more than twenty-five percent (25%) of its prepaid charges or premiums for marketing and administrative expenses, including all costs to solicit members of the health benefit plan or providers. For the purposes of this subsection, marketing and administrative expenses shall be defined by rule by the Commissioner.

(b) Nothing in this section shall be construed to affect the applicability of any other provision of this Chapter.

"**§ 58-50-292. Dental provider networks; confidential business information.**

(a) The following definitions apply in this section:

(1) Dental provider network contract. – A contract between an insurer and a dental services provider specifying the rights and responsibilities of the insurer and the provider for the delivery of and payment for dental services.
(2) Insurer. – As defined in G.S. 58-3-225(a).
(3) Third party. – A person or entity that enters into a contract with an insurer or with another entity to gain access to a dental provider network contract.

(b) Insurers who provide health benefit plans for dental services shall not provide a third party access to a dental provider network contract or information pertaining to discounts for services pursuant to that dental provider network contract.

(c) If a dental provider network contract has been provided to a third party in violation of this section, then no provider shall be bound or required to perform services under that dental provider network contract.

(d) An insurer's willful failure to comply with this section shall be deemed an unfair and deceptive trade practice and shall be actionable under Chapter 75 of the General Statutes. Nothing in this section shall foreclose other remedies available under the law."

SECTION 3. G.S. 58-3-200(a)(1) reads as rewritten:

"(1) "Health benefit plan" means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. ~~Dental or vision.~~Vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners insurance.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance."

SECTION 4. G.S. 58-3-190(g)(3) reads as rewritten:

"(3) "Health benefit plan" means any of the following if written by an insurer: an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; or a plan provided by a multiple employer welfare arrangement. "Health benefit plan" does not mean any plan implemented or administered through the Department of Health and Human Services or its representatives. "Health benefit plan" also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term or nursing home care.

e. Medicare supplement.
f. Specified disease.
g. ~~Dental or vision.~~Vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners insurance.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance."

SECTION 5. This act becomes effective October 1, 2019, and applies to health benefit contracts issued, renewed, or amended on or after that date.

SENATE BILL 574:
Modify Physical Therapy Definition.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 30, 2019
Introduced by:	Sens. J. Davis, Krawiec, Woodard	**Prepared by:**	Jason Moran-Bates
Analysis of:	First Edition		Committee Staff

OVERVIEW: Senate Bill 574 would remove the practice of chiropractic from the definition of physical therapy in G.S. 90-270.94(4).

CURRENT LAW: Under current law, the definition of physical therapy includes manipulation of the spine when the treatment is prescribed by a licensed physician.

BILL ANALYSIS: The bill would amend G.S. 90-270.90(4) to remove the practice of chiropractic from the definition of physical therapy.

EFFECTIVE DATE: The act would be effective October 1, 2019.

Lauren Cochrane-Brown
Director

S574-SMBC-45 E1 -V-1

Legislative Analysis
Division
919-733-2578

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GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S 1

SENATE BILL 574*

Short Title:	Modify Physical Therapy Definition.	(Public)
Sponsors:	Senators J. Davis, Krawiec, and Woodard (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

April 4, 2019

A BILL TO BE ENTITLED

AN ACT UPDATING THE DEFINITION OF PHYSICAL THERAPY TO EXCLUDE THE PRACTICE OF CHIROPRACTIC AND TO INCLUDE MANIPULATION OF THE SPINE WITHOUT A PRESCRIPTION FROM A PHYSICIAN LICENSED TO PRACTICE MEDICINE IN THIS STATE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-270.90(4) reads as rewritten:

"(4) "Physical therapy" means the evaluation or treatment of any person by the use of physical, chemical, or other properties of heat, light, water, electricity, sound, massage, or therapeutic exercise, or other rehabilitative procedures, with or without assistive devices, for the purposes of preventing, correcting, or alleviating a physical or mental disability. Physical therapy includes the performance of specialized tests of neuromuscular function, administration of specialized therapeutic procedures, interpretation and implementation of referrals from licensed medical doctors or dentists, and establishment and modification of physical therapy programs for patients. Evaluation and treatment of patients may involve physical measures, methods, or procedures as are found commensurate with physical therapy education and training and generally or specifically authorized by regulations of the Board. Physical therapy education and training shall include study of the skeletal manifestations of systemic disease. Physical therapy does not include the application of roentgen rays or radioactive materials, surgery, ~~manipulation of the spine unless prescribed by a physician licensed to practice medicine in North Carolina,~~ the practice of chiropractic, as defined by G.S. 90-143, or medical diagnosis of disease."

SECTION 2. This act becomes effective October 1, 2019.

SENATE BILL 551:
Child Support Cooperation Act of 2019.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 30, 2019
Introduced by:	Sens. Krawiec, Hise, Bishop	**Prepared by:**	Jason Moran-Bates Committee Staff
Analysis of:	First Edition		

OVERVIEW: Senate Bill 551 would require the Department of Health and Human Services, Division of Social Services to require individuals seeking Food and Nutrition Services benefits to cooperate with the Child Support Enforcement Program as a condition to eligibility for benefits.

CURRENT LAW: Currently, there is no statutory requirement that Food and Nutrition Services beneficiaries cooperate with the Child Support Enforcement Program.

BILL ANALYSIS: Senate Bill 551 would add a new Article to Chapter 110 requiring individuals who wish to receive benefits under the Food and Nutrition Services Program to cooperate with the Child Support Enforcement Program as a condition of eligibility for those benefits.

EFFECTIVE DATE: This act would be effective January 1, 2020.

BACKGROUND: Child Support Services, under the Department of Health and Human Services, is a program designed to collect as much child support money as possible for the benefit of North Carolina's children. Its duties include enforcement of child support orders and collection and processing of child support payments.

Under 7 C.F.R. § 273.11(o), states can disqualify custodial parents from eligibility for Food and Nutrition Services benefits if they do not cooperate with state agencies charged with administering a child support enforcement program.

Under 7 C.F.R. § 273.11(p), states can disqualify non-custodial parents from eligibility for Food and Nutrition Services benefits if they do not cooperate with state agencies charged with administering a child support enforcement program.

ɹren Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S 1

SENATE BILL 551

Short Title:	Child Support Cooperation Act of 2019.	(Public)
Sponsors:	Senators Krawiec, Hise, and Bishop (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

April 3, 2019

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE CHILD SUPPORT COOPERATION ACT OF 2019.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 110 of the General Statutes is amended by adding a new Article to read:

"Article 11.

"Child Support Cooperation Act.

"**§ 110-155. Title.**

This act shall be known and may be cited as the "Child Support Cooperation Act of 2019."

"**§ 110-156. Purpose.**

The purpose of this act is to reduce child poverty and dependency by ensuring parents cooperate with State efforts to collect child support for their children as authorized by federal law.

"**§ 110-157. Child support cooperation requirements.**

The Department of Health and Human Services, Division of Social Services, as the agency responsible for determining eligibility for the Food and Nutrition Services program under Part 5 of Article 2 of Chapter 108A of the General Statutes and in collaboration with the Child Support Enforcement Program, shall require individuals seeking benefits to cooperate with the Child Support Enforcement Program of this State as a condition of eligibility pursuant to 7 C.F.R. § 273.11(o) and (p)."

SECTION 2. This act becomes effective July 1, 2020.

Senate Committee on

Health Care

May 1, 2019 – Room 415 LOB – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Sarah Hardin	NCDS
Lisa Ward	NCDS
Dana Simpson	SA
Hattie Gawande	DHHS
L T McCrimmon	DHHS
Kara Weisbaar	SA
[illegible]	MFS
[illegible]	NMRS
[illegible]	FL
Mary C. Hannah	NCPTA
[illegible]	AMGA
Nelson Freeman	Kilpatrick Townsend

Senate Committee on

Health Care

May 1, 2019 – Room 415 LOB – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Patricia Cubbage	Connect C
Matt Gross	DHHS
Sarah Bales	Rivoaker & Assoc.
Jonathan Barbanel	Barbanel Assoc.
Stephen Kouba	KMA
Kari Barsness	BPS
Jim Hamm	BH
Chris Bayse	NCMS
Michelle Frazier	NP
Marty McLaughlin	Park Commercial RG
Bechi Gray	JJF

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 415 LOB

DATE: 5-1 **TIME:** 10 AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

	Page Name	Hometown	Sponsoring Senator
1.	Grace Kromke	Wilmington	Peterson
2.	McKenzie Cox	Concord	Gallimore
3.	[illegible]		
4.	~~Tayess John~~ Tayess John	Charlotte	Mohammed
5.	Caroline Shelkey	Huntersville	Marcus
6.			
7.			
8.			

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

Senate Committee on Health Care
Thursday, May 2, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on May 2, 2019 in Room 643 of the Legislative Office Building. Twelve members were present.

Senator Dan Bishop, Chair, presided.

Jack Bradford sponsored by Sen. Bishop, Tayess John sponsored by Sen. Mohammed, Andrew Washburn sponsored by Sen. Sawyer, Grace Kronke sponsored by Sen. Peterson, and McKenzie Cox sponsored by Sen. Gallimore served as pages.

SB 161 Enact the North Carolina Caregivers Act (Senators Krawiec, Bishop, Hise)

Sen. Bishop recognized Sen. Krawiec to introduce an amendment. Sen. Krawiec explained the amendment. The amendment passed and the bill was put back before the committee.

Sen. Perry moved for a favorable report to the bill as amended, rolled into a proposed committee substitute, unfavorable to the original bill, and referred to Rules. The bill received a favorable report.

SB 252 Dental Bill of Rights (Senator J. Davis)

Sen. J. Davis was recognized to explain the proposed committee substitute. Sen. Robinson moved for a favorable report. The motion carried.

The meeting adjourned at 10:06 AM.

Senator Dan Bishop, Chair
Presiding

John Wynne, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Thursday, May 02, 2019

Senator Bishop,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

SB **161** Enact the North Carolina Caregivers Act.

Draft Number:	S161-PCS15341-SH-13
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	Rules and Operations of the Senate
Long Title Amended:	No

SB **252** Dental Bill of Rights.

Draft Number:	S252-PCS45282-BP-8
Sequential Referral:	Commerce and Insurance
Recommended Referral:	Rules and Operations of the Senate
Long Title Amended:	No

TOTAL REPORTED: 2

Senator Joyce Krawiec will handle SB 161
Senator Jim Davis will handle SB 252



Senate Committee on Health Care
Thursday, May 2, 2019 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 161	Enact the North Carolina Caregivers Act	Senator Krawiec Senator Bishop Senator Hise
SB 361	Health Care Expansion Act of 2019	Senator Krawiec Senator Bishop Senator Hise
SB 252	Dental Bill of Rights	Senator J. Davis

Adjournment

SENATE BILL 161:
Enact the North Carolina Caregivers Act.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	May 1, 2019
Introduced by:	Sens. Krawiec, Bishop, Hise	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	First Edition		

OVERVIEW: ***Senate Bill 161 would enact the North Carolina Caregivers Act to provide the opportunity for a hospital patient to designate a caregiver to provide aftercare assistance.***

[As introduced, this bill was identical to H269, as introduced by Reps. White, Dobson, Lambeth, Black, which is currently in House Health.]

BILL ANALYSIS: **Section 1** of the bill would designate the act as "The North Carolina Caregivers Act."

Section 2 would add a new statute, G.S. 131E-79.5, to Chapter 131E, Article 5 which contains the Hospital Licensure Act. The new statutory subsections are outlined below.

Definitions -Subsection (a) contains definitions for the following terms: after-care, caregiver, discharge, entry, residence. A "caregiver" is defined as any individual duly designated by a patient or the patient's legal guardian as a caregiver pursuant to subsection (b) of this section and who provides after-care assistance to a patient living in the patient's residence. A residence is a dwelling the patient considers home, but does not include a rehabilitation facility, hospital, nursing home, assisted living facility, or group home licensed by the State.

Opportunity to Designate a Caregiver – Subsection (b) would require each hospital to provide each patient, or the patient's legal guardian, with at least one opportunity to designate at least one caregiver as soon as possible following the patient's entry into the hospital and prior discharge or transfer to another facility. If the patient or patient's legal guardian elects to designate a caregiver, all of the following apply:

(1) The hospital must request the written consent of the patient or the patient's legal guardian to release medical information to the patient's designated caregiver in a manner that complies with the hospital's established procedures for releasing personal health information and any applicable State and federal laws.

(2) If the patient or the patient's legal guardian declines to consent to release medical information to the patient's designated caregiver, the hospital is not required to provide to the designated caregiver the notice required by subsection (c) or the instructions described in subsection (d).

(3) The hospital must record in the patient's medical record the name of the designated caregiver, the relationship of the designated caregiver to the patient, and the name, telephone number, and address of the designated caregiver.

(4) A patient or the patient's legal guardian may elect to change a designated caregiver at any time, and the hospital must record this change in the patient's medical record within 24 hours after the patient elects to make a change.

A designation of a caregiver by a patient or a patient's legal guardian under this law does not obligate any individual to perform after-care tasks for any patient.

Hospital Notice to Designated Caregiver – Subsection (c) requires a hospital to notify the patient's designated caregiver of the patient's discharge or transfer to another hospital or licensed facility which may be after the patient's physician issues a discharge order, but not later than four hours prior to the actual discharge or transfer.

Hospital Instructions to Designated Caregiver – Subsection (d) requires hospital staff to make a good-faith effort to notify the patient's designated caregiver of the patients discharge or transfer as soon as possible prior to discharge.

Other provisions-

- Allows the Division of Health Service Regulation to adopt rules as necessary for implementation.
- Clarifies that this new statute does not interfere with a healthcare power of attorney or other advance health care directive.
- Does not require a patient or patient's legal guardian to designate a caregiver.
- Does not create a private right of action and does not make a hospital liable for services rendered or not rendered by a designated caregiver after discharge.

EFFECTIVE DATE: The act would become effective January 1, 2020, and applies to hospital admissions occurring on and after that date.

SENATE BILL 161

Short Title:	Enact the North Carolina Caregivers Act.	(Public)
Sponsors:	Senators Krawiec, Bishop, and Hise (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

February 28, 2019

A BILL TO BE ENTITLED

AN ACT ENACTING THE NORTH CAROLINA CAREGIVERS ACT.

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known and may be cited as "The North Carolina Caregivers Act."

SECTION 2. Article 5 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-79.5. Designation of caregiver.**

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

(1) Aftercare. – Any assistance provided by a caregiver to a patient after the patient's discharge from a hospital, including assistance with basic activities of daily living, instrumental activities of daily living, or carrying out medical or nursing tasks, such as managing wound care, assisting in the administration of medications, and operating medical equipment.

(2) Caregiver. – Any individual duly designated by a patient or the patient's legal guardian as a caregiver pursuant to subsection (b) of this section and who provides aftercare assistance to a patient living in the patient's residence.

(3) Discharge. – A patient's exit or release from a hospital to the patient's residence following an inpatient admission.

(4) Residence. – A dwelling that the patient considers to be home. The term does not include any rehabilitation facility, hospital, nursing home, assisted living facility, or group home licensed in this State.

(b) Opportunity to Designate Caregiver. – Each hospital licensed under this Article shall provide each patient or, if applicable, the patient's legal guardian with at least one opportunity to designate at least one caregiver as soon as possible following the patient's admission into a hospital and prior to the patient's discharge or transfer to another facility. If the patient or the patient's legal guardian declines to designate a caregiver, the hospital shall document this decision in the patient's medical record. If the patient or the patient's legal guardian elects to designate a caregiver, all of the following apply:

(1) The hospital shall request the written consent of the patient or the patient's legal guardian to release medical information to the patient's designated caregiver in a manner that complies with the hospital's established procedures for releasing personal health information and any applicable State and federal laws.

(2) If the patient or the patient's legal guardian declines to consent to release medical information to the patient's designated caregiver, the hospital is not

required to provide to the designated caregiver the notice required by subsection (c) of this section or the instructions described in subsection (d) of this section.

(3) The hospital shall record in the patient's medical record the designated caregiver's name and contact information along with the relationship of the designated caregiver to the patient.

(4) A patient or the patient's legal guardian may elect to change a designated caregiver at any time, and the hospital shall record this change in the patient's medical record as soon as possible after the patient elects to make a change.

A designation of a caregiver by a patient or a patient's legal guardian pursuant to this section does not obligate any individual to perform any aftercare tasks for any patient.

(c) Hospital Notice to Designated Caregiver. – A hospital shall make a good-faith effort to notify the patient's designated caregiver of the patient's discharge or transfer to another hospital or facility licensed in this State as soon as possible prior to discharge. If the hospital is unable to contact the designated caregiver, the hospital shall document its efforts in the patient's medical record. The lack of contact shall not interfere with, delay, or otherwise affect (i) the medical care provided by the hospital to the patient or (ii) an otherwise appropriate discharge of the patient.

(d) Hospital Instructions to Designated Caregiver. – As soon as possible prior to a patient's discharge from a hospital, the hospital shall consult with the patient along with the designated caregiver regarding the designated caregiver's capabilities and limitations and issue a discharge plan that describes a patient's aftercare needs at the patient's residence. During this consultation, the hospital shall provide the patient and the designated caregiver an opportunity for instruction in related aftercare tasks. Any instruction provided pursuant to this subsection shall be documented in the patient's medical record.

(e) Rules. – The Division of Health Service Regulation may adopt rules as necessary to implement the provisions of this section, including rules to further define the content and scope of any instruction provided to designated caregivers pursuant to this section.

(f) Noninterference With Advance Health Care Directives. – Nothing in this section shall be construed to interfere with the rights of an agent operating under a valid health care power of attorney or other valid advance health care directive.

(g) Caregiver Designation Not Required. – Nothing in this section shall be construed to require a patient or a patient's legal guardian to designate any individual as a caregiver.

(h) Limitation of Actions. – Nothing in this section shall be construed to do any of the following:

(1) Create a private right of action against a hospital, a hospital employee, or an individual with whom a hospital has a contractual relationship, or to otherwise supersede or replace existing rights or remedies under any other provision of law.

(2) Make a hospital, hospital employee, or an individual with whom a hospital has a contractual relationship liable, in any way, for the services rendered or not rendered by a designated caregiver to the patient after the patient's discharge from the hospital."

SECTION 3. This act becomes effective January 1, 2020, and applies to hospital admissions occurring on and after that date.

SENATE BILL 361:
Health Care Expansion Act of 2019.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 9, 2019
Introduced by:	Sens. Krawiec, Bishop, Hise	**Prepared by:**	Jessica Boney Theresa Matula Jason Moran-Bates Committee Staff
Analysis of:	First Edition		

OVERVIEW: Senate Bill 361 would increase innovation waiver slots, including an appropriation; repeal Certificate of Need (CON) Laws; enact the Psychology Interjurisdictional Licensure Compact (PSYPACT); allow marriage and family therapist to conduct the first-level exam for involuntary commitment; make changes to the Program for All-Inclusive Care for the Elderly (PACE) Program; and eliminate redundancy in adult care home inspections.

BILL ANALYSIS: Senate Bill 361 would make the changes outlined below.

PART I. INCREASE INNOVATION WAIVER SLOTS would increase innovation waiver slots by a maximum of 1,000 slots available on January 1, 2020 and a maximum of 1,000 slots available January 1, 2021. It would appropriate from the General Fund $10,250,000 in recurring funds for the 2019-2020 fiscal year and $30,750,000 in recurring funds for the 2020-2021 fiscal year to fund these additional slots.

PART II. REPEAL CERTIFICATE OF NEED LAWS would repeal North Carolina's Certificate of Need laws, which are found in Article 9 of Chapter 131E. It would also make changes to statutes in Chapters 6, 58, 113A, 122C, 130A, 131E, 143B, 148, and 150B to conform them to Certificate of Need repeal.

PART III. PSYCHOLOGY INTERJURISDICTIONAL LICENSURE COMPACT (PSYPACT)

Section 3(a) would recodify the current Psychology Practice Act, Article 18A of Chapter 90 of the General Statutes, as Article 18H of Chapter 90 of the General Statutes. **Section 3(b)** of the bill would enact the PSYPACT.

G.S. 90-270.160 would set forth the purpose of the PSYPACT.

G.S. 90-270.161 would establish definitions for the PSYPACT.

G.S. 90-270.162 would:

- Establish a psychologist's home state as the state in which the psychologist is licensed or physically present when practicing.
- Allow a psychologist to provide services, via telepsychology, to clients in other compact states, if those states:
    - Require the psychologist to hold an E.Passport.

- Investigate complaints against psychologists.
- Notify the PSYPACT Commission about adverse actions taken against psychologists.
- Comply with the by-laws of the Commission.
- Perform criminal background checks on psychologists.

- Allow a psychologist to provide face-to-face services in a compact state if that state:
  - Requires psychologists to hold a current Interjurisdictional Practice Certificate (IPC).
  - Investigates complaints against psychologists.
  - Notifies the PSYPACT Commission about adverse actions taken against psychologists.
  - Complies with the by-laws of the Commission.
  - Performs criminal background checks on psychologists.

G.S. 90-270.163 would allow a psychologist to practice telepsychology with clients in other compact states, provided that the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid E.Passport, and makes certain attestations.

Psychologists practicing under G.S. 90-270.163 would be subject to their home state's licensing authorities, and be subject to the compact state's rules regarding scope of practice.

G.S. 90-270.164 would allow a psychologist to practice psychology face-to-face with clients in compact states, provided the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid IPC, and makes certain attestations.

Psychologists practicing under G.S. 90-270.164 would be subject to the authority, law, and scope of practice of the compact state in which they are practicing.

G.S. 90-270.165 would allow a psychologist to practice telepsychology with patients in other compact states only when the psychologist initiates the session from the home state in which the psychologist is licensed.

G.S. 90-270.166 would allow home states, compact states in which a psychologist treats patients face-to-face, and states in which a psychologist practices via telepsychiatry to take adverse actions against the psychologist's license.

G.S. 90-270.167 would allow the regulatory authority in the compact states the power to:

- Issue subpoenas.
- Issue cease-and-desist orders.
- Prevent psychologists under investigation from changing their home state licensures.

G.S. 90-270.168 would allow the Commission to maintain a database containing the following data on licensed psychologists, which must be submitted by each compact state:

- Identifying information.
- Licensure data.
- Significant investigatory information.
- Information on adverse actions taken by the regulatory authority.

G.S. 90-270.169 would create the Psychology Interjurisdictional Compact Commission. Membership in the Commission would consist of one voting member from each compact state. All meetings of the Commission must be public unless employment, discipline, litigation, contract negotiation, or adverse action investigation are being discussed. The Commission would have all the powers necessary to administer and carry out the business of the PSYPACT.

The Commission may be financed by accepting gifts and levying assessments on member states.

Commission members would be immune from suit for their official actions.

G.S. 90-270.170 would give the Commission power to make rules for the compact. These rules would not affect the rules of practice established by the regulatory authorities of the member states. Rules may be approved by a majority vote of Commission members, and any rule rejected by the legislatures of a majority of member states would no longer have any effect.

G.S. 90-270.171 would establish oversight, default, and conflict resolution provisions for the PSYPACT.

- All branches of government of all member states must enforce the PSYPACT's purpose and intent.
- If a state is in default under the terms of the PSYPACT and refuses to cure that default, the Commission may terminate the state's membership in the PSYPACT.
- By a majority vote of members, the Commission may initiate legal action to enforce compliance with the rules of the PSYPACT.
- The Commission will attempt to resolve any dispute between member and non-member states.

G.S. 90-270.172 would:

- Make the PSYPACT effective on the date the seventh member state enacts it.
- Allow member states to leave the PSYPACT by repealing the act enacting it.
- Prevent the Commission from prohibiting any other licensure agreements between member states, so any reciprocity agreements between member states would still remain in effect.
- Allow member states to amend the PSYPACT; however, amendments would not take effect until the legislatures of all the member states enacted them.

G.S. 90-270.173 would require the PSYPACT to be construed liberally, and if any portions of the PSYPACT are struck down by a court, the remaining provisions would remain in effect.

PART IV. ALLOW LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT FIRST-LEVEL EXAM FOR INVOLUNTARY COMMITMENT would amend G.S. 122C-263.1 to permit licensed marriage and family therapists to conduct first examinations in involuntary commitment proceedings.

PART V. PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE) REGULATORY CHANGES would amend statutes pertaining to adult care homes, assisted living facilities, multiunit assisted housing with services (MAHS), and adult day care. **Section 5(a)** amends the licensure requirements for a home care agency to exempt an entity from licensure if they are providing home care services to a PACE program participant if the organization has a valid PACE agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits, Department of Health and Human Services.

Section 5(b) amends the definitions of an adult care home, assisted living residence, and multiunit assisted housing with services (MAHS), to allow services from a PACE organization with a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits, Department of Health and Human Services. **Sections 5(c) – (e)** make conforming changes to adult care home statutes to allow the incorporation of PACE. **Section 5(f)** amends the statutes that pertain to the certification of adult day care programs to exempt adult day care programs with PACE program participants from certification if the organization has a valid PACE agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits, Department of Health and Human Services.

PART VI. ELIMINATE REDUNDANCY IN ADULT CARE HOME INSPECTIONS would amend the statute pertaining to inspections, monitoring, and review of adult care homes. The amendment would provide that if the annual inspection of an adult care home is conducted separately from the physical plant and life-safety requirements inspection required every two years, the Division of Health Service Regulation, DHHS, is prohibited from citing a violation of law that overlaps with a physical plant and life-safety inspection area in the annual inspection unless failure to address poses a risk to resident health or safety.

PART VII contains a severability clause.

EFFECTIVE DATE: Except as provided below, the bill would become effective when it becomes law:

- PART II would be effective January 1, 2020. Subsection (a) of Part II would be apply to contested cases arising on or after January 1, 2020.
- PART III would be effective when at least seven states have enacted the PSYPACT set forth in Part III.
- PART IV would be effective October 1, 2019.
- PART V pertaining to changes associated with the PACE program would become effective October 1, 2019.

BACKGROUND:

PART II: Any new institutional health service, as defined in G.S. 131A-176(16), must undergo Certificate of Need review before it is offered. The process requires an application to the department of Health and Human Services, Division of Health Service Regulation. After the application is submitted, there is a public comment and hearing process before the Division approves or disapproves the application. In making a determination, the Division considers the needs identified in the State Medical Facilities Plan.

PART III: The PSYPACT is a multi-jurisdictional psychology compact. As of April 9, 2019, it has been enacted by seven states (Arizona, Nevada, Utah, Colorado, Nebraska, Missouri and Illinois). Though Illinois has enacted PSYPACT legislation, it does not become effective until January 1st, 2020, and therefore does not count as the seventh state needed to make PSYPACT operational. PSYPACT legislation is currently being considered in District of Columbia, Georgia, New Hampshire, Oklahoma, Pennsylvania, Rhode Island and Texas. It has been endorsed by the psychology licensing boards in seven states (New Mexico, Texas, Georgia, Ohio, Wisconsin, Virginia and Rhode Island). PSYPACT was recommended by the Joint Legislative Oversight Committee on Health and Human Services to the 2018 Session of the 2017 General Assembly of North Carolina.

PART IV: G.S. 122C-263(c) requires that a commitment examiner conduct an examination of a respondent within 24 hours of the respondent being presented for involuntary commitment. This examination can be conducted in person or by using telemedicine procedures. After examining the respondent, the commitment examiner can recommend outpatient treatment, treatment at a 24-hour facility prior to a court hearing on commitment, or a termination of the commitment proceedings.

PART V: Medicaid and Health Choice Clinical Coverage Policy 3B provides the following description of PACE: "The Program of All-Inclusive Care for the Elderly (PACE) is a unique model of managed care service delivery for the frail elderly living in the community. Most PACE participants are dually eligible for Medicare and Medicaid benefits, and all are certified eligible for nursing facility level of care according to the standards established by the state Medicaid agency. The PACE program uses monthly capitated payments from Medicare and NC Medicaid (Medicaid) to provide an integrated and comprehensive medical and social service delivery system for elderly individuals who choose to receive services in the least restrictive community-based setting of care. PACE uses an interdisciplinary team to provide services at the PACE Center and to case manage the services, and supports provided to PACE participants by providers in the PACE network. The PACE program is located in the community and contains a certified adult day health program. Services are provided on site and supplemented by in-home and referral to other services according to each participant's needs."

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 161

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S161-ASH-9 [v.2]

Amends Title [NO]
First Edition

Date _____,2019

Senator Krawiec

moves to amend the bill on page 1, line 23, through page 2, line 24, by deleting "shall" each time it occurs and substituting it with "may".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S 1

SENATE BILL 361

Short Title:	Health Care Expansion Act of 2019.	(Public)
Sponsors:	Senators Krawiec, Bishop, and Hise (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

March 27, 2019

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS REFORMS THAT WILL INCREASE ACCESS TO HEALTH CARE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

PART I. INCREASE INNOVATIONS WAIVER SLOTS

SECTION 1.(a) The Department of Health and Human Services, Division of Health Benefits, shall amend the North Carolina Innovations waiver to increase the number of slots available under the waiver by a maximum of 1,000 slots to be made available on January 1, 2020, and by a maximum of 1,000 slots to be made available on January 1, 2021.

SECTION 1.(b) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Health Benefits, the sum of ten million two hundred fifty thousand dollars ($10,250,000) in recurring funds for the 2019-2020 fiscal year and the sum of thirty million seven hundred fifty thousand dollars ($30,750,000) in recurring funds for the 2020-2021 fiscal year to be used to fund these additional slots.

PART II. REPEAL OF NORTH CAROLINA'S CERTIFICATE OF NEED LAWS

SECTION 2.(a) G.S. 6-19.1(a) reads as rewritten:

"(a) In any civil action, other than an adjudication for the purpose of establishing or fixing a rate, or a disciplinary action by a licensing board, brought by the State or brought by a party who is contesting State action pursuant to G.S. 150B-43 or any other appropriate provisions of law, unless the prevailing party is the State, the court may, in its discretion, allow the prevailing party to recover reasonable attorney's fees, including attorney's fees applicable to the administrative review portion of the case, in contested cases arising under Article 3 of Chapter 150B, to be taxed as court costs against the appropriate agency if:

(1) The court finds that the agency acted without substantial justification in pressing its claim against the party; and

(2) The court finds that there are no special circumstances that would make the award of attorney's fees unjust. The party shall petition for the attorney's fees within 30 days following final disposition of the case. The petition shall be supported by an affidavit setting forth the basis for the request.

~~Nothing in this section shall be deemed to authorize the assessment of attorney's fees for the administrative review portion of the case in contested cases arising under Article 9 of Chapter 131E of the General Statutes.~~

Nothing in this section grants permission to bring an action against an agency otherwise immune from suit or gives a right to bring an action to a party who otherwise lacks standing to bring the action.

Any attorney's fees assessed against an agency under this section shall be charged against the operating expenses of the agency and shall not be reimbursed from any other source."

SECTION 2.(b) G.S. 58-50-61(a) reads as rewritten:

"(a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:

...

(8) "Health care provider" means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes or the laws of another state to provide health care services in the ordinary care of business or practice or a profession or in an approved education or training program; a health care facility as defined in ~~G.S. 131E-176(9b)~~ this section or the laws of another state to operate as a health care facility; or a pharmacy.

...

(9a) "Health service facility" means 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, hospice inpatient facility, or hospice residential care facility; or ambulatory surgical facility.

...."

SECTION 2.(c) G.S. 58-55-35(a) reads as rewritten:

"(a) Whenever long-term care insurance provides coverage for the facilities, services, or physical or mental conditions listed below, unless otherwise defined in the policy and certificate, and approved by the Commissioner, such facilities, services, or conditions are defined as follows:

...

(10) "Hospice" ~~shall be defined in accordance with the terms of G.S. 131E-176(13a).~~means any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.

(11) "Intermediate care facility for ~~the mentally retarded" shall be defined in accordance with the terms of G.S. 131E-176(14a).~~individuals with intellectual disabilities" means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for individuals with intellectual disabilities, autism, cerebral palsy, epilepsy, or related conditions.

...."

SECTION 2.(d) G.S. 113A-12(3)e. reads as rewritten:

"e. A health care facility financed pursuant to Chapter 131A of the General ~~Statutes or receiving a certificate of need under Article 9 of Chapter 131E of the General~~ Statutes."

SECTION 2.(e) G.S. 122C-23.1(e) reads as rewritten:

"(e) As used in this section, "residential treatment facility" means a "residential facility" as defined in and licensed under this ~~Chapter, but not subject to Certificate of Need requirements under Article 9 of Chapter 131E of the General Statutes.~~Chapter."

SECTION 2.(f) G.S. 131E-13(a)(1) reads as rewritten:

"(1) The corporation shall continue to provide the same or similar clinical hospital services to its patients in medical-surgery, obstetrics, pediatrics, outpatient and emergency treatment, including emergency services for the indigent, that the hospital facility provided prior to the lease, sale, or conveyance. These services may be terminated only as prescribed ~~by Certificate of Need Law prescribed in Article 9 of Chapter 131E of the General Statutes, or, if Certificate of Need Law is inapplicable,~~ by review procedure designed to guarantee public participation pursuant to rules adopted by the Secretary of the Department of Health and Human Services."

SECTION 2.(g) G.S. 131E-136(4) reads as rewritten:

"(4) "Home health agency" means a home care agency which is certified to receive Medicare and Medicaid reimbursement for providing nursing care, therapy, medical social services, and home health aide services on a part-time, intermittent ~~basis as set out in G.S. 131E-176(12), and is thereby also subject to Article 9 of Chapter 131E.~~basis."

SECTION 2.(h) 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 Division of Adult Correction of the Department of Public Safety 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 of the Division of Adult Correction of the Department of Public Safety and to members of the general public, the portion of the facility that serves inmates shall be exempt from licensure.

~~(b) Any person who contracts to provide inpatient chemical dependency or substance abuse services to inmates of the Division of Adult Correction of the Department of Public Safety 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 2.(i) Article 9 of Chapter 131E of the General Statutes, G.S. 130A-45.02(i), 143B-1292, 150B-2(8a)k., and 150B-21.1(6) are repealed.

SECTION 2.(j) This section becomes effective January 1, 2020. Subsection (a) of this section applies to contested cases arising on or after January 1, 2020.

PART III. PSYCHOLOGY INTERJURISDICTIONAL LICENSURE COMPACT

SECTION 3.(a) Article 18A of Chapter 90 of the General Statutes, G.S. 90-270.1 through G.S. 90-270.22, is recodified as Article 18G of Chapter 90 of the General Statutes, G.S. 90-270.135 through G.S. 90-270.159.

SECTION 3.(b) Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 18H.

"Psychology Interjurisdictional Licensure Compact.

"**§ 90-270.160. Purpose.**

This Compact is designed to achieve the following purposes and objectives:

(1) Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology.

(2) Enhance the states' ability to protect the public's health and safety, especially client/patient safety.

(3) Encourage the cooperation of Compact States in the areas of psychology licensure and regulation.

(4) Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history.

(5) Promote compliance with the laws governing psychological practice in each Compact State.

(6) Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

"**§ 90-270.161. Definitions.**

(1) Adverse action. – Any action taken by a State Psychology Regulatory Authority which finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

(2) Association of State and Provincial Psychology Boards (ASPPB). – The recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

(3) Authority to Practice Interjurisdictional Telepsychology. – A licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

(4) Bylaws. – Those Bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to G.S. 90-270.169 for its governance or for directing and controlling its actions and conduct.

(5) Client/patient. – The recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services.

(6) Commissioner. – The voting representative appointed by each State Psychology Regulatory Authority pursuant to G.S. 90-270.169.

(7) Compact State. – A state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to G.S. 90-270.172(c) or been terminated pursuant to G.S. 90-270.171(b).

(8) Confidentiality. – The principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

(9) Coordinated Licensure Information System or Coordinated Database. – An integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(10) Day. – Any part of a day in which psychological work is performed.

(11) Distant State. – The Compact State where a psychologist is physically present (not through the use of telecommunications technologies) to provide temporary in-person, face-to-face psychological services.

(12) E.Passport. – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

(13) Executive Board. – A group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

(14) Home State. – A Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authority to Practice Interjurisdictional Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

(15) Identity History Summary. – A summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

(16) In-person, face-to-face. – Interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

(17) Interjurisdictional Practice Certificate (IPC). – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily and verification of one's qualifications for such practice.

(18) License. – Authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

(19) Non-Compact State. – Any State which is not at the time a Compact State.

(20) Psychologist. – An individual licensed for the independent practice of psychology.

(21) Psychology Interjurisdictional Compact Commission (Commission). – The national administration of which all Compact States are members.

(22) Receiving State. – A Compact State where the client/patient is physically located when the telepsychological services are delivered.

(23) Rule. – A written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to G.S. 90-270.170 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal, or suspension of an existing rule.

(24) Significant investigatory information. –

a. Investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

b. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

(25) State. – A state, commonwealth, territory, or possession of the United States or the District of Columbia.

(26) State Psychology Regulatory Authority. – The Board, office, or other agency with the legislative mandate to license and regulate the practice of psychology.

(27) Telepsychology. – The provision of psychological services using telecommunication technologies.

(28) Temporary Authorization to Practice. – A licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

(29) Temporary in-person, face-to-face practice. – Where a psychologist is physically present (not through the use of telecommunications technologies) in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

"**§ 90-270.162. Home State licensure.**

(a) The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

(b) A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(c) Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(d) Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

(e) A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

(1) Currently requires the psychologist to hold an active E.Passport;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

(f) A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

(1) Currently requires the psychologist to hold an active IPC;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

"**§ 90-270.163. Compact privilege to practice telepsychology.**

(a) Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice telepsychology in other Compact States (Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

(b) To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master's degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;

(4) Have no history of adverse action that violate the Rules of the Commission;
(5) Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;
(6) Possess a current, active E.Passport;
(7) Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background, and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and
(8) Meet other criteria as defined by the Rules of the Commission.

(c) The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

(d) A psychologist practicing in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State is restricted, suspended, or otherwise limited, the E.Passport shall be revoked and, therefore, the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

"**§ 90-270.164. Compact Temporary Authorization to Practice.**

(a) Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

(b) To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:
a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or
b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:
a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;
b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;
c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;
e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;
f. The designated director of the program must be a psychologist and a member of the core faculty;
g. The program must have an identifiable body of students who are matriculated in that program for a degree;
h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;
i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;
j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;
(4) No history of adverse action that violates the Rules of the Commission;
(5) No criminal record history that violates the Rules of the Commission;
(6) Possess a current, active IPC;
(7) Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and
(8) Meet other criteria as defined by the Rules of the Commission.

(c) A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

(d) A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State is restricted, suspended, or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

"**§ 90-270.165. Conditions of telepsychology practice in a Receiving State.**

A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

(1) The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State.
(2) Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

"**§ 90-270.166. Adverse actions.**

(a) A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

(b) A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse

action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

(c) If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

(1) All Home State disciplinary orders which impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

(2) In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

(3) Other actions may be imposed as determined by the Rules promulgated by the Commission.

(d) A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

(e) A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice which occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

(f) Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

(g) No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection (c) of this section.

"**§ 90-270.167. Additional authorities invested in a Compact State's Psychology Regulatory Authority.**

In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

(1) Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a Compact State's Psychology Regulatory Authority for the attendance and testimony of witnesses and/or the production of evidence from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

(2) Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

(3) During the course of any investigation, a psychologist may not change his/her Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his/her Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission. All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal, and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

"**§ 90-270.168. Coordinated Licensure Information System.**

(a) The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

(b) Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

(1) Identifying information;
(2) Licensure data;
(3) Significant investigatory information;
(4) Adverse actions against a psychologist's license;
(5) An indicator that a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;
(6) Nonconfidential information related to alternative program participation information;
(7) Any denial of application for licensure and the reasons for such denial; and
(8) Other information which may facilitate the administration of this Compact, as determined by the Rules of the Commission.

(c) The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

(d) Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

(e) Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

"**§ 90-270.169. Establishment of the Psychology Interjurisdictional Compact Commission.**

(a) The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

(1) The Commission is a body politic and an instrumentality of the Compact States.

(2) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(3) Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting, and Meetings. –

(1) The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary, or similar executive;

b. Current member of the State Psychology Regulatory Authority of a Compact State; or

c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

(2) Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

(3) Each Commissioner shall be entitled to one vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

(4) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

(5) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rule-making provisions in G.S. 90-270.170.

(6) The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:

a. Noncompliance of a Compact State with its obligations under the Compact;

b. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation against the Commission;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusation against any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal and state statute.

(7) If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

(c) The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including, but not limited to:

(1) Establishing the fiscal year of the Commission;

(2) Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

(3) Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;

(4) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

(6) Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;

(7) Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

(8) The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto with the appropriate agency or officer in each of the Compact States;

(9) The Commission shall maintain its financial records in accordance with the Bylaws; and

(10) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(d) The Commission shall have the following powers:

(1) The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all Compact States;

(2) To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

(3) To purchase and maintain insurance and bonds;

(4) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compact State;

(5) To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

(6) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of the same, provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

(7) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the Commission shall strive to avoid any appearance of impropriety;

(8) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(9) To establish a budget and make expenditures;

(10) To borrow money;

(11) To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;

(12) To provide and receive information from, and to cooperate with, law enforcement agencies;

(13) To adopt and use an official seal; and

(14) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice, and telepsychology practice.

(e) The Executive Board. – The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact.

(1) The Executive Board shall be comprised of six members:

a. Five voting members who are elected from the current membership of the Commission by the Commission.

b. One ex officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(2) The ex officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.

(3) The Commission may remove any member of the Executive Board as provided in Bylaws.

(4) The Executive Board shall meet at least annually.

(5) The Executive Board shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, or fees paid by Compact States such as annual dues and any other applicable fees;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Other duties as provided in Rules or Bylaws.

(f) Financing of the Commission. –

(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.

(2) The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(3) The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

(4) The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State.

(5) The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

(g) Qualified Immunity, Defense, and Indemnification. –

(1) The members, officers, Executive Director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom

the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(2) The Commission shall defend any member, officer, Executive Director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(3) The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

"**§ 90-270.170. Rule making.**

(a) The Commission shall exercise its rule-making powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

(c) Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

(d) Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rule Making:

(1) On the Web site of the Commission; and

(2) On the Web site of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

(e) The Notice of Proposed Rule Making shall include:

(1) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

(f) Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(g) The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

(1) At least 25 persons who submit comments independently of each other;
(2) A governmental subdivision or agency; or
(3) A duly appointed person in an association that has at least 25 members.

(h) If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

(1) All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.
(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.
(3) No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.
(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

(j) The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rule-making record and the full text of the rule.

(k) If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

(l) Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rule-making procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety, or welfare;
(2) Prevent a loss of Commission or Compact State funds;
(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or
(4) Protect public health and safety.

(m) The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the Web site of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

"**§ 90-270.171. Oversight, dispute resolution, and enforcement.**

(a) Oversight. –

(1) The executive, legislative, and judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

(2) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

(3) The Commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

(b) Default, Technical Assistance, and Termination. –

(1) If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default, and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

(2) If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States and all rights, privileges, and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(3) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.

(4) A Compact State which has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

(5) The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

(6) The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the State of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution. –

(1) Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States.

(2) The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the Commission.

(d) Enforcement. –

(1) The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

(2) By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(3) The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

"**§ 90-270.172. Date of implementation of the Psychology Interjurisdictional Compact Commission and associated rules, withdrawal, and amendments.**

(a) The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rule-making powers necessary to the implementation and administration of the Compact.

(b) Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

(c) Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

(1) A Compact State's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

(d) Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

(e) This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

"**§ 90-270.173. Construction and severability.**

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States."

SECTION 3.(c) Subsections (a) and (b) of this section become effective when at least seven states have enacted the Psychology Interjurisdictional Compact (PSYPACT) set forth in subsection (b) of this section. The North Carolina Psychology Board shall report to the Revisor of Statutes when the PSYPACT set forth in subsection (b) of this section has been enacted by seven member states.

PART IV. ALLOW LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT FIRST-LEVEL EXAMINATIONS FOR INVOLUNTARY COMMITMENT

SECTION 4.(a) G.S. 122C-263.1(a) reads as rewritten:

"**§ 122C-263.1. Secretary's authority to certify commitment examiners; training of certified commitment examiners performing first examinations; LME/MCO responsibilities.**

(a) Physicians and eligible psychologists are qualified to perform the commitment examinations required under G.S. 122C-263(c) and G.S. 122C-283(c). The Secretary of Health and Human Services may individually certify to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 other health, mental health, and substance abuse professionals whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment as follows:

(1) The Secretary has received a request:

a. To certify a licensed clinical social worker, a master's or higher level degree nurse practitioner, a licensed professional counsellor, a licensed marriage and family therapist, or a physician's assistant to conduct the first examinations described in G.S. 122C-263(c) and G.S. 122C-283(c).

b. To certify a master's level licensed clinical addictions specialist to conduct the first examination described in G.S. 122C-283(c).

...

(5) In no event shall the certification of a licensed clinical social worker, master's or higher level degree nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or master's level certified clinical addictions specialist under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or the master's level certified clinical addictions specialist.

...."

SECTION 4.(b) This section is effective October 1, 2019.

PART V. PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY REGULATORY CHANGES

SECTION 5.(a) G.S. 131E-138 reads as rewritten:

"**§ 131E-138. Licensure requirements.**

(a) ~~No~~ Except as provided in subsection (f1) of this section, no person or governmental unit shall operate a home care agency without a license obtained from the Department. Nothing in this Part shall be construed to extend or modify the licensing of individual health professionals by the licensing boards for their professions or to create any new professional license category.

...

(f1) Exceptions to Licensure. – If home care services are provided to a participant of the Program for All-Inclusive Care for the Elderly through an organization that has a valid Program for All-Inclusive Care for the Elderly agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Service, then the entity providing the home care services shall not be required to hold a license under this section.

...."

SECTION 5.(b) G.S. 131D-2.1 reads as rewritten:

"**§ 131D-2.1. Definitions.**

As used in this Article:

...

(3) Adult care home. – An assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or for scheduled needs, through formal written agreement with licensed home care or hospice ~~agencies.~~ agencies or with a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated trained staff. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

...

(5) Assisted living residence. – Any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care or hospice ~~agencies.~~ agencies, or with a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. The Department may allow nursing service exceptions on a case-by-case basis. Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or area baths. Assisted living residences are to be distinguished from nursing homes subject to provisions of G.S. 131E-102. There are three types of assisted living residences: adult care homes, adult care homes that serve only elderly persons, and multiunit assisted housing with services. As used in this section, "elderly person" means:

a. Any person who has attained the age of 55 years or older and requires assistance with activities of daily living, housing, and services, or

b. Any adult who has a primary diagnosis of Alzheimer's disease or other form of dementia who requires assistance with activities of daily living, housing, and services provided by a licensed Alzheimer's and dementia care unit.

...

(10) Multiunit assisted housing with services. – An assisted living residence in which hands-on personal care services and nursing services ~~which~~ that are arranged by housing management are provided through an individualized written care plan by a licensed home care or hospice agency ~~through an individualized written care plan.~~ or by a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. The housing management has a financial interest or financial affiliation or formal written agreement ~~which~~ that makes personal care services accessible and available through at least one licensed home care or hospice ~~agency.~~ agency or through a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the

Division of Health Benefits of the Department of Health and Human Services. The resident has a choice of any provider, and the housing management may not combine charges for housing and personal care services. All residents, or their compensatory agents, must be capable, through informed consent, of entering into a contract and must not be in need of 24-hour supervision. Assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse according to the home care agency's or the Program for All-Inclusive Care for the Elderly organization's established plan of care. Multiunit assisted housing with services programs are required to register annually with the Division of Health Service Regulation. Multiunit assisted housing with services programs are required to provide a disclosure statement to the Division of Health Service Regulation. The disclosure statement is required to be a part of the annual rental contract that includes a description of all of the following requirements:

a. Emergency response ~~system;~~system.
b. Charges for services ~~offered;~~offered.
c. Limitations of ~~tenancy;~~tenancy.
d. Limitations of ~~services;~~services.
e. Resident ~~responsibilities;~~responsibilities.
f. Financial/legal relationship between housing management and home care or hospice ~~agencies;~~agencies or Program for All-Inclusive Care for the Elderly organizations.
g. A listing of all home care or hospice agencies and other community services in the ~~area;~~area.
h. An appeals ~~process; and~~process.
i. Procedures for required initial and annual resident screening and referrals for services.

Continuing care retirement communities, subject to regulation by the Department of Insurance under Chapter 58 of the General Statutes, and temporary family health care structures, as defined in G.S. 160A-383.5, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

...."

SECTION 5.(c) G.S. 131D-2.2(b) reads as rewritten:

"(b) Multiunit Assisted Housing With Services. – Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, multiunit assisted housing with services shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator ~~dependency;~~dependency.
(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be ~~healing;~~healing.
(3) Intravenous therapy or injections directly into the vein, except for intermittent intravenous therapy managed by a home care or hospice agency licensed in this ~~State;~~State.
(4) Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common ~~cold;~~cold.
(5) Psychotropic medications without appropriate diagnosis and treatment ~~plans;~~plans.
(6) Nasogastric ~~tubes;~~tubes.

(7) Gastric tubes, except when the individual is capable of independently feeding himself or herself and caring for the tube, or as managed by a home care or hospice agency licensed in this ~~State;~~State.

(8) Individuals requiring continuous licensed nursing ~~care;~~care.

(9) Individuals whose physician certifies that placement is no longer ~~appropriate;~~appropriate.

(10) Unless the individual's independent physician determines ~~otherwise,~~ otherwise or the individual is enrolled in the Program of All-Inclusive Care for the Elderly, individuals who require maximum physical assistance as documented by a uniform assessment instrument and who meet Medicaid nursing facility level-of-care criteria as defined in the State Plan for Medical Assistance. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on a uniform assessment ~~instrument;~~instrument.

(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the ~~residence; and~~residence.

(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services."

SECTION 5.(d) G.S. 131D-2.2(d) reads as rewritten:

"(d) Obtaining Services. – The resident of an assisted living facility has the right to obtain services at the resident's own expense from providers other than the housing management. This subsection shall not be construed to relieve the resident of the resident's contractual obligation to pay the housing management for any services covered by the contract between the resident and housing management. The resident of an assisted living facility has the right to select as the resident's health care provider the Program for All-Inclusive Care for the Elderly without jeopardizing residency in the assisted living facility."

SECTION 5.(e) G.S. 131D-2.16 reads as rewritten:

"**§ 131D-2.16. Rules.**

Except as otherwise provided in this Article, the Medical Care Commission shall adopt rules necessary to carry out this Article. The Commission has the authority, in adopting rules, to specify the limitation of nursing services provided by assisted living residences. In developing rules, the Commission shall consider the need to ensure comparable quality of services provided to residents, whether these services are provided directly by a licensed assisted living provider, licensed home care agency, a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services, or hospice. In adult care homes, living arrangements where residents require supervision due to cognitive impairments, rules shall be adopted to ensure that supervision is appropriate and adequate to meet the special needs of these residents. Rule-making authority under this section is in addition to that conferred under G.S. 131D-4.3 and G.S. 131D-4.5."

SECTION 5.(f) G.S. 131D-6 reads as rewritten:

"**§ 131D-6. Certification of adult day care programs; purpose; definition; penalty.**

...

(d) ~~The~~ All of the following programs are exempted from the provisions of this section:

(1) Those that care for three people or ~~less;~~less.

(2) Those that care for two or more persons, all of whom are related by blood or marriage to the operator of the ~~facility;~~facility.

(3) Those that are required by other statutes to be licensed by the Department of Health and Human Services.

(4) Program for All-Inclusive Care for the Elderly organizations that have a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services when providing services to participants in the program."

SECTION 5.(g) This act is effective October 1, 2019.

PART VI. ELIMINATE REDUNDANCY IN ADULT CARE HOME INSPECTIONS

SECTION 6. G.S. 131D-2.11(a) reads as rewritten:

"(a) State Inspection and Monitoring. – The Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. All facilities licensed under this Article and adult care units in nursing homes are subject to inspections at all times by the Secretary. Except as provided in subsection (a1) of this section, the Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis. Beginning July 1, 2012, the Division of Health Service Regulation shall include as part of its inspection of all adult care homes a review of the facility's compliance with G.S. 131D-4.4A(b) and safe practices for injections and any other procedures during which bleeding typically occurs. In addition, the Department shall ensure that adult care homes are inspected every two years to determine compliance with physical plant and life-safety requirements.

If the annual inspection of an adult care home is conducted separately from the inspection required every two years to determine compliance with physical plant and life-safety requirements, the Division of Health Service Regulation shall not cite, as part of the annual inspection, any violation of law that overlaps with an area addressed by the physical plant and life-safety inspection, unless failure to address the violation during the annual inspection would pose a risk to resident health or safety. Nothing in this section prevents a licensing inspector from referring a concern about physical plant and life-safety requirements to the section within the Division of Health Service Regulation that conducts physical plant and life-safety inspections."

PART VII. SEVERABILITY CLAUSE AND EFFECTIVE DATE

SECTION 7.(a) If any section or 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 to be unconstitutional or invalid.

SECTION 7.(b) Except as otherwise provided, this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S D

SENATE BILL 361
PROPOSED COMMITTEE SUBSTITUTE S361-CSBC-19 [v.3]
04/15/2019 04:30:42 PM

Short Title: Health Care Expansion Act of 2019. (Public)

Sponsors:

Referred to:

March 27, 2019

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS REFORMS THAT WILL INCREASE ACCESS TO HEALTH CARE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

PART I. INCREASE INNOVATIONS WAIVER SLOTS

SECTION 1.(a) The Department of Health and Human Services, Division of Health Benefits, shall amend the North Carolina Innovations waiver to increase the number of slots available under the waiver by a maximum of 1,000 slots to be made available on January 1, 2020, and by a maximum of 1,000 slots to be made available on January 1, 2021.

SECTION 1.(b) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Health Benefits, the sum of ten million two hundred fifty thousand dollars ($10,250,000) in recurring funds for the 2019-2020 fiscal year and the sum of thirty million seven hundred fifty thousand dollars ($30,750,000) in recurring funds for the 2020-2021 fiscal year to be used to fund these additional slots.

PART II. REFORM NORTH CAROLINA'S CERTIFICATE OF NEED LAWS

SECTION 2.(a) G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

...

(2) "Bed capacity" means space used exclusively for inpatient ~~care,~~ care at a health service facility, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage. ~~The term "bed capacity" also refers to the number of dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~

...

(5) "Change in bed capacity" means (i) any relocation of health service facility ~~beds, or dialysis stations~~beds from one licensed facility or campus to another, or (ii) any redistribution of health service facility bed capacity among the categories of health service facility bed as defined in G.S. 131E-176(9c), or

(iii) any increase in the number of health service facility ~~beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~beds.

...

(9a) "Health service" means an organized, interrelated medical, diagnostic, therapeutic, ~~and/or~~ or rehabilitative ~~activity~~ activity, or any combination of these, that is integral to the prevention of disease or the clinical management of a sick, injured, or disabled person. "Health service" does not include administrative and other activities that are not integral to clinical ~~management.~~management, or any activities performed at a facility that does not meet the definition of a health service facility.

(9b) "Health service facility" means 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 the mentally retarded;~~ home health agency office; ~~chemical dependency treatment facility; diagnostic center;~~ hospice office, hospice inpatient facility, and hospice residential care ~~facility; and ambulatory surgical~~ facility. The term "health service facility" does not include a licensable facility, as defined in G.S. 122C-3(14)b.

(9c) "Health service facility bed" means 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 the mentally retarded; (vi) chemical dependency treatment beds; (vii)~~ hospice inpatient facility beds; ~~(viii)~~(v) hospice residential care facility beds; ~~(ix)~~(vi) adult care home beds; and ~~(x)~~or (vii) long-term care hospital beds.

...

(14a) ~~"Intermediate care facility for the mentally retarded"~~Intermediate care facility for individuals with intellectual disabilities" means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for persons with ~~mental retardation,~~intellectual disabilities, autism, cerebral palsy, epilepsy or related conditions.

...

(16) "New institutional health services" means any of the following:

...

d. The offering of ~~dialysis services or~~ home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.

...

~~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.~~

...

~~u. The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.~~

~~v. The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is reflected on the health service facility's license in effect as of January 1, 2005.~~

...."

SECTION 2.(b) G.S. 131E-177 reads as rewritten:

"**§ 131E-177. Department of Health and Human Services is designated State Health Planning and Development Agency; powers and duties.**

The Department of Health and Human Services is designated as the State Health Planning and Development Agency for the State of North Carolina, and is empowered to exercise the following powers and duties:

(1) To establish standards and criteria or plans required to carry out the provisions and purposes of this Article and to adopt rules pursuant to Chapter 150B of the General Statutes, to carry out the purposes and provisions of this ~~Article;~~Article.

(2) Adopt, amend, and repeal such rules and regulations, consistent with the laws of this State, as may be required by the federal government for grants-in-aid for health service facilities and health planning which may be made available by the federal government. This section shall be liberally construed in order that the State and its citizens may benefit from such ~~grants-in-aid;~~grants-in-aid.

(3) Define, by rule, procedures for submission of periodic reports by persons or health service facilities subject to agency review under this ~~Article;~~Article.

(4) ~~Develop~~ With respect to health service facilities planning, all of the following:

a. Develop policy, criteria, and standards for health service facilities ~~planning; shall conduct~~ planning.

b. Conduct statewide registration and inventories of and make determinations of need for health service facilities, health services as specified in G.S. 131E-176(16)f., and equipment as specified in G.S. 131E-176(16)f1., which shall include consideration of adequate geographic location of equipment and ~~services; and develop~~services.

c. Develop a State Medical Facilities ~~Plan;~~Plan, provided, however, that the State Medical Facilities Plan shall not include policies or need determinations that limit the number of operating rooms or gastrointestinal endoscopy rooms.

(5) Implement, by rule, criteria for project ~~review;~~review.

(6) Have the power to grant, deny, or withdraw a certificate of need and to impose such sanctions as are provided for by this ~~Article;~~Article.

(7) Solicit, accept, hold and administer on behalf of the State any grants or devises of money, securities or property to the Department for use by the Department in the administration of this ~~Article; and~~Article.

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

(9) Collect fees for submitting applications for certificates of need.

(10) The authority to review all records in any recording medium of any person or health service facility subject to agency review under this Article which pertain to construction and acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records the

Department deems to be reasonably necessary to determine compliance with this Article.

The Secretary of Health and Human Services shall have final decision-making authority with regard to all functions described in this section."

SECTION 2.(c) 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:~~

~~(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.~~Department."

SECTION 2.(d) G.S. 131E-183(a)(1) reads as rewritten:

"(1) The proposed project 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 that may be approved."

SECTION 2.(e) G.S. 131E-184(c) reads as rewritten:

"(c) The Department shall exempt from certificate of need review any conversion of existing acute care beds to psychiatric ~~beds provided:~~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 and/or one or more of the Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities to provide psychiatric beds to patients referred by the contracting agency or agencies; and~~

~~(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.~~"

SECTION 2.(f) G.S. 131E-184(e)(1) reads as rewritten:

"(1) The proposed capital expenditure would:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding an existing:
1. Nursing home facility, or
2. Adult care home ~~facility, or~~facility; and
~~3. Intermediate care facility for the mentally retarded; and~~

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."

SECTION 2.(g)(1) G.S. 131E-184 is amended by adding new subsections to read:

"(i) The Department shall exempt from certificate of need review the development, acquisition, construction, expansion, or replacement of a health service facility or health service that obtained certificate of need approval prior to October 1, 2019, as an ambulatory surgical facility, including an ambulatory surgical facility with one or more operating rooms or gastrointestinal endoscopy procedure rooms; a diagnostic center; kidney disease treatment center, including freestanding dialysis units; chemical dependency treatment facility; intermediate care facility for individuals with intellectual disabilities; psychiatric hospital; or any other licensable facility, as defined in G.S. 122C-3(14)b."

(j) The Department shall exempt from certificate of need review the establishment of a home health agency by a continuing care retirement community licensed under Article 64 of Chapter 58 of the General Statutes to provide home health services to one or more residents of a continuing care retirement community who have entered into a contract with the continuing care retirement community to receive continuing care services with lodging. A continuing care retirement community that seeks to provide home health services to individuals who do not reside at the continuing care retirement community pursuant to a contract to receive continuing care services with lodging shall be required to obtain a certificate of need as a home health agency prior to developing or offering home health services to any individual not a resident of the continuing care retirement community under a contract to receive continuing care services with lodging. As used in this subsection, the terms "continuing care" and "lodging" are as defined in G.S. 58-64-1. Nothing in this subsection shall be construed to exempt from the State's home health agency licensure and certification requirements a continuing care retirement community that has been exempted from certificate of need review for the provision of home health services to one or more residents pursuant to this subsection."

SECTION 2.(g)(2) G.S. 131E-184(j), as enacted by this section, applies to continuing care retirement communities engaged in the direct provision of home health services on or after October 1, 2019.

SECTION 2.(h) G.S. 131E-186(a) reads as rewritten:

"(a) Within the prescribed time limits in G.S. 131E-185, the Department shall issue a decision to "approve," "approve with conditions," or "deny," an application for a new institutional health service. ~~Approvals involving new or expanded nursing care or intermediate care for the mentally retarded bed capacity shall include a condition that specifies the earliest possible date the new institutional health service may be certified for participation in the Medicaid program. The date shall be set far enough in advance to allow the Department to identify funds to pay for care in the new or expanded facility in its existing Medicaid budget or to include these funds in its State Medicaid budget request for the year in which Medicaid certification is expected.~~"

SECTION 2.(i) G.S. 131E-188 reads as rewritten:

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

...

(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).~~ three hundred thousand dollars ($300,000) for each application that was reviewed with the application for a certificate of need that is the subject of the petition. 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, the court may 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, 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.

...

(b1) Before filing an appeal of a final decision granting a certificate of need, the affected person 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);~~ three hundred thousand dollars ($300,000) for each application that was reviewed with the application for a certificate of need that is the subject of the appeal; 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).~~ five hundred thousand dollars ($500,000). 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.

...."

SECTION 2.(j) G.S. 131E-147 is amended by adding a new subsection to read:

"(f) The Department shall not issue or renew a license to operate an ambulatory surgical facility developed, acquired, or replaced on or after October 1, 2019, unless the application includes all of the following:

(1) A commitment (i) that the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least four percent (4%) of the total revenue collected for all surgical cases performed in the facility or proposed facility or

(ii) to allocate to the nearest hospital located in a Tier 1 or Tier 2 county an amount equivalent to four percent (4%) of the total revenue collected for all surgical cases performed in the facility or proposed facility.

(2) For each year of operation, a commitment to report to the Department the total number of cases by each of the following payer categories:

a. Self-pay surgical cases.
b. Medicaid surgical cases.
c. Medicare surgical cases.
d. Commercial insurance surgical cases.
e. Managed care surgical cases.
f. Other surgical cases.

(3) A commitment to report utilization and payment data for services provided by the ambulatory surgical facility to the statewide data processor, as required by G.S. 131E-214.2.

(4) For a license to operate in any county with a population of less than 150,000 as of the effective date of this act:

a. Written documentation of support from each hospital located within that county.
b. A written transfer agreement between the ambulatory surgical facility and each hospital located within that county."

SECTION 2.(k) G.S. 131E-175(11) and (12) are repealed.

PART III. PSYCHOLOGY INTERJURISDICTIONAL LICENSURE COMPACT

SECTION 3.(a) Article 18A of Chapter 90 of the General Statutes, G.S. 90-270.1 through G.S. 90-270.22, is recodified as Article 18G of Chapter 90 of the General Statutes, G.S. 90-270.135 through G.S. 90-270.159.

SECTION 3.(b) Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 18H.

"Psychology Interjurisdictional Licensure Compact.

"**§ 90-270.160. Purpose.**

This Compact is designed to achieve the following purposes and objectives:

(1) Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology.

(2) Enhance the states' ability to protect the public's health and safety, especially client/patient safety.

(3) Encourage the cooperation of Compact States in the areas of psychology licensure and regulation.

(4) Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history.

(5) Promote compliance with the laws governing psychological practice in each Compact State.

(6) Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

"**§ 90-270.161. Definitions.**

(1) Adverse action. – Any action taken by a State Psychology Regulatory Authority which finds a violation of a statute or regulation that is identified

by the State Psychology Regulatory Authority as discipline and is a matter of public record.

(2) Association of State and Provincial Psychology Boards (ASPPB). – The recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

(3) Authority to Practice Interjurisdictional Telepsychology. – A licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

(4) Bylaws. – Those Bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to G.S. 90-270.169 for its governance or for directing and controlling its actions and conduct.

(5) Client/patient. – The recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services.

(6) Commissioner. – The voting representative appointed by each State Psychology Regulatory Authority pursuant to G.S. 90-270.169.

(7) Compact State. – A state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to G.S. 90-270.172(c) or been terminated pursuant to G.S. 90-270.171(b).

(8) Confidentiality. – The principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

(9) Coordinated Licensure Information System or Coordinated Database. – An integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(10) Day. – Any part of a day in which psychological work is performed.

(11) Distant State. – The Compact State where a psychologist is physically present (not through the use of telecommunications technologies) to provide temporary in-person, face-to-face psychological services.

(12) E.Passport. – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

(13) Executive Board. – A group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

(14) Home State. – A Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authority to Practice Interjurisdictional Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

(15) Identity History Summary. – A summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

(16) In-person, face-to-face. – Interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

(17) Interjurisdictional Practice Certificate (IPC). – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily and verification of one's qualifications for such practice.

(18) License. – Authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

(19) Non-Compact State. – Any State which is not at the time a Compact State.

(20) Psychologist. – An individual licensed for the independent practice of psychology.

(21) Psychology Interjurisdictional Compact Commission (Commission). – The national administration of which all Compact States are members.

(22) Receiving State. – A Compact State where the client/patient is physically located when the telepsychological services are delivered.

(23) Rule. – A written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to G.S. 90-270.170 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal, or suspension of an existing rule.

(24) Significant investigatory information. –

a. Investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

b. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

(25) State. – A state, commonwealth, territory, or possession of the United States or the District of Columbia.

(26) State Psychology Regulatory Authority. – The Board, office, or other agency with the legislative mandate to license and regulate the practice of psychology.

(27) Telepsychology. – The provision of psychological services using telecommunication technologies.

(28) Temporary Authorization to Practice. – A licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

(29) Temporary in-person, face-to-face practice. – Where a psychologist is physically present (not through the use of telecommunications technologies) in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

"**§ 90-270.162. Home State licensure.**

(a) The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

(b) A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(c) Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(d) Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

(e) A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

(1) Currently requires the psychologist to hold an active E.Passport;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

(f) A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

(1) Currently requires the psychologist to hold an active IPC;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

"**§ 90-270.163. Compact privilege to practice telepsychology.**

(a) Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice telepsychology in other Compact States (Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

(b) To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master's degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;

(4) Have no history of adverse action that violate the Rules of the Commission;

(5) Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;

(6) Possess a current, active E.Passport;

(7) Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background, and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

(8) Meet other criteria as defined by the Rules of the Commission.

(c) The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

(d) A psychologist practicing in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State

and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State is restricted, suspended, or otherwise limited, the E.Passport shall be revoked and, therefore, the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

"**§ 90-270.164. Compact Temporary Authorization to Practice.**

(a) Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

(b) To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;

(4) No history of adverse action that violates the Rules of the Commission;
(5) No criminal record history that violates the Rules of the Commission;
(6) Possess a current, active IPC;
(7) Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and
(8) Meet other criteria as defined by the Rules of the Commission.

(c) A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

(d) A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State is restricted, suspended, or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

"**§ 90-270.165. Conditions of telepsychology practice in a Receiving State.**

A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

(1) The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State.
(2) Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

"**§ 90-270.166. Adverse actions.**

(a) A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

(b) A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

(c) If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

(1) All Home State disciplinary orders which impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.
(2) In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.
(3) Other actions may be imposed as determined by the Rules promulgated by the Commission.

(d) A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which

occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

(e) A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice which occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

(f) Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

(g) No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection (c) of this section.

"**§ 90-270.167. Additional authorities invested in a Compact State's Psychology Regulatory Authority.**

In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

(1) Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a Compact State's Psychology Regulatory Authority for the attendance and testimony of witnesses and/or the production of evidence from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

(2) Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

(3) During the course of any investigation, a psychologist may not change his/her Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his/her Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission. All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal, and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

"**§ 90-270.168. Coordinated Licensure Information System.**

(a) The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

(b) Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

(1) Identifying information;
(2) Licensure data;
(3) Significant investigatory information;
(4) Adverse actions against a psychologist's license;
(5) An indicator that a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;
(6) Nonconfidential information related to alternative program participation information;
(7) Any denial of application for licensure and the reasons for such denial; and
(8) Other information which may facilitate the administration of this Compact, as determined by the Rules of the Commission.

(c) The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

(d) Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

(e) Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

"**§ 90-270.169. Establishment of the Psychology Interjurisdictional Compact Commission.**

(a) The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

(1) The Commission is a body politic and an instrumentality of the Compact States.
(2) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.
(3) Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting, and Meetings. –

(1) The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:
a. Executive Director, Executive Secretary, or similar executive;
b. Current member of the State Psychology Regulatory Authority of a Compact State; or
c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

(2) Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

(3) Each Commissioner shall be entitled to one vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

(4) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

(5) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rule-making provisions in G.S. 90-270.170.

(6) The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:

a. Noncompliance of a Compact State with its obligations under the Compact;

b. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation against the Commission;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusation against any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal and state statute.

(7) If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal,

subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

(c) The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including, but not limited to:

(1) Establishing the fiscal year of the Commission;

(2) Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

(3) Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;

(4) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

(6) Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;

(7) Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

(8) The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto with the appropriate agency or officer in each of the Compact States;

(9) The Commission shall maintain its financial records in accordance with the Bylaws; and

(10) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(d) The Commission shall have the following powers:

(1) The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all Compact States;

(2) To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

(3) To purchase and maintain insurance and bonds;

(4) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compact State;

(5) To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

(6) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of the same, provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

(7) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the Commission shall strive to avoid any appearance of impropriety;

(8) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(9) To establish a budget and make expenditures;

(10) To borrow money;

(11) To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;

(12) To provide and receive information from, and to cooperate with, law enforcement agencies;

(13) To adopt and use an official seal; and

(14) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice, and telepsychology practice.

(e) The Executive Board. – The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact.

(1) The Executive Board shall be comprised of six members:

a. Five voting members who are elected from the current membership of the Commission by the Commission.

b. One ex officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(2) The ex officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.

(3) The Commission may remove any member of the Executive Board as provided in Bylaws.

(4) The Executive Board shall meet at least annually.

(5) The Executive Board shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, or fees paid by Compact States such as annual dues and any other applicable fees;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;
f. Establish additional committees as necessary; and
g. Other duties as provided in Rules or Bylaws.

(f) Financing of the Commission. –

(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.

(2) The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(3) The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

(4) The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State.

(5) The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

(g) Qualified Immunity, Defense, and Indemnification. –

(1) The members, officers, Executive Director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(2) The Commission shall defend any member, officer, Executive Director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(3) The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee, or representative of the Commission for the

amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

"**§ 90-270.170. Rule making.**

(a) The Commission shall exercise its rule-making powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

(c) Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

(d) Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rule Making:

(1) On the Web site of the Commission; and

(2) On the Web site of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

(e) The Notice of Proposed Rule Making shall include:

(1) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

(f) Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(g) The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

(1) At least 25 persons who submit comments independently of each other;

(2) A governmental subdivision or agency; or

(3) A duly appointed person in an association that has at least 25 members.

(h) If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

(1) All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.

(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(3) No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.

(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

(j) The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rule-making record and the full text of the rule.

(k) If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

(*l*) Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rule-making procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety, or welfare;

(2) Prevent a loss of Commission or Compact State funds;

(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

(4) Protect public health and safety.

(m) The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the Web site of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

"**§ 90-270.171. Oversight, dispute resolution, and enforcement.**

(a) Oversight. –

(1) The executive, legislative, and judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

(2) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

(3) The Commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

(b) Default, Technical Assistance, and Termination. –

(1) If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:
a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default, and/or any other action to be taken by the Commission; and
b. Provide remedial training and specific technical assistance regarding the default.
(2) If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States and all rights, privileges, and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.
(3) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.
(4) A Compact State which has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.
(5) The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.
(6) The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the State of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution. –
(1) Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States.
(2) The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the Commission.

(d) Enforcement. –
(1) The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.
(2) By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.
(3) The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

"**§ 90-270.172. Date of implementation of the Psychology Interjurisdictional Compact Commission and associated rules, withdrawal, and amendments.**

(a) The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rule-making powers necessary to the implementation and administration of the Compact.

(b) Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

(c) Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

(1) A Compact State's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

(d) Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

(e) This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

"**§ 90-270.173. Construction and severability.**

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States."

SECTION 3.(c) Subsections (a) and (b) of this section become effective when at least seven states have enacted the Psychology Interjurisdictional Compact (PSYPACT) set forth in subsection (b) of this section. The North Carolina Psychology Board shall report to the Revisor of Statutes when the PSYPACT set forth in subsection (b) of this section has been enacted by seven member states.

PART IV. ALLOW LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT FIRST-LEVEL EXAMINATIONS FOR INVOLUNTARY COMMITMENT

SECTION 4.(a) G.S. 122C-263.1(a) reads as rewritten:

"**§ 122C-263.1. Secretary's authority to certify commitment examiners; training of certified commitment examiners performing first examinations; LME/MCO responsibilities.**

(a) Physicians and eligible psychologists are qualified to perform the commitment examinations required under G.S. 122C-263(c) and G.S. 122C-283(c). The Secretary of Health and Human Services may individually certify to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 other health, mental health, and substance abuse professionals whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment as follows:

(1) The Secretary has received a request:

a. To certify a licensed clinical social worker, a master's or higher level degree nurse practitioner, a licensed professional counsellor, a licensed marriage and family therapist, or a physician's assistant to

conduct the first examinations described in G.S. 122C-263(c) and G.S. 122C-283(c).

b. To certify a master's level licensed clinical addictions specialist to conduct the first examination described in G.S. 122C-283(c).

...

(5) In no event shall the certification of a licensed clinical social worker, master's or higher level degree nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or master's level certified clinical addictions specialist under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or the master's level certified clinical addictions specialist.

...."

SECTION 4.(b) This section is effective October 1, 2019.

PART V. PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY REGULATORY CHANGES

SECTION 5.(a) G.S. 131E-138 reads as rewritten:

"**§ 131E-138. Licensure requirements.**

(a) ~~No~~ Except as provided in subsection (f1) of this section, no person or governmental unit shall operate a home care agency without a license obtained from the Department. Nothing in this Part shall be construed to extend or modify the licensing of individual health professionals by the licensing boards for their professions or to create any new professional license category.

...

(f1) Exceptions to Licensure. – If home care services are provided to a participant of the Program for All-Inclusive Care for the Elderly through an organization that has a valid Program for All-Inclusive Care for the Elderly agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Service, then the entity providing the home care services shall not be required to hold a license under this section.

...."

SECTION 5.(b) G.S. 131D-2.1 reads as rewritten:

"**§ 131D-2.1. Definitions.**

As used in this Article:

...

(3) Adult care home. – An assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or for scheduled needs, through formal written agreement with licensed home care or hospice ~~agencies.~~ agencies or with a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated trained staff. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

...

(5) Assisted living residence. – Any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care or hospice ~~agencies.~~ agencies, or with a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. The Department may allow nursing service exceptions on a case-by-case basis. Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or area baths. Assisted living residences are to be distinguished from nursing homes subject to provisions of G.S. 131E-102. There are three types of assisted living residences: adult care homes, adult care homes that serve only elderly persons, and multiunit assisted housing with services. As used in this section, "elderly person" means:

a. Any person who has attained the age of 55 years or older and requires assistance with activities of daily living, housing, and services, or

b. Any adult who has a primary diagnosis of Alzheimer's disease or other form of dementia who requires assistance with activities of daily living, housing, and services provided by a licensed Alzheimer's and dementia care unit.

...

(10) Multiunit assisted housing with services. – An assisted living residence in which hands-on personal care services and nursing services ~~which~~ that are arranged by housing management are provided through an individualized written care plan by a licensed home care or hospice agency ~~through an individualized written care plan.~~ or by a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. The housing management has a financial interest or financial affiliation or formal written agreement ~~which~~ that makes personal care services accessible and available through at least one licensed home care or hospice ~~agency.~~ agency or through a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. The resident has a choice of any provider, and the housing management may not combine charges for housing and personal care services. All residents, or their compensatory agents, must be capable, through informed consent, of entering into a contract and must not be in need of 24-hour supervision. Assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse according to the home care agency's or the Program for All-Inclusive Care for the Elderly organization's established plan of care. Multiunit assisted housing with services programs are required to register annually with the Division of Health Service Regulation. Multiunit assisted housing with services programs are required to provide a disclosure statement to the Division of Health Service Regulation. The disclosure statement is required to be a part of the annual rental contract that includes a description of all of the following requirements:

a. Emergency response ~~system;~~system.

b. Charges for services ~~offered;~~offered.
c. Limitations of ~~tenancy;~~tenancy.
d. Limitations of ~~services;~~services.
e. Resident ~~responsibilities;~~responsibilities.
f. Financial/legal relationship between housing management and home care or hospice ~~agencies;~~agencies or Program for All-Inclusive Care for the Elderly organizations.
g. A listing of all home care or hospice agencies and other community services in the ~~area;~~area.
h. An appeals ~~process; and~~process.
i. Procedures for required initial and annual resident screening and referrals for services.

Continuing care retirement communities, subject to regulation by the Department of Insurance under Chapter 58 of the General Statutes, and temporary family health care structures, as defined in G.S. 160A-383.5, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

...."

SECTION 5.(c) G.S. 131D-2.2(b) reads as rewritten:

"(b) Multiunit Assisted Housing With Services. – Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, multiunit assisted housing with services shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator ~~dependency;~~dependency.
(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be ~~healing;~~healing.
(3) Intravenous therapy or injections directly into the vein, except for intermittent intravenous therapy managed by a home care or hospice agency licensed in this ~~State;~~State.
(4) Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common ~~cold;~~cold.
(5) Psychotropic medications without appropriate diagnosis and treatment ~~plans;~~plans.
(6) Nasogastric ~~tubes;~~tubes.
(7) Gastric tubes, except when the individual is capable of independently feeding himself or herself and caring for the tube, or as managed by a home care or hospice agency licensed in this ~~State;~~State.
(8) Individuals requiring continuous licensed nursing ~~care;~~care.
(9) Individuals whose physician certifies that placement is no longer ~~appropriate;~~appropriate.
(10) Unless the individual's independent physician determines ~~otherwise,~~ otherwise or the individual is enrolled in the Program of All-Inclusive Care for the Elderly, individuals who require maximum physical assistance as documented by a uniform assessment instrument and who meet Medicaid nursing facility level-of-care criteria as defined in the State Plan for Medical Assistance. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on a uniform assessment ~~instrument;~~instrument.

(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the ~~residence; and~~residence.

(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services."

SECTION 5.(d) G.S. 131D-2.2(d) reads as rewritten:

"(d) Obtaining Services. – The resident of an assisted living facility has the right to obtain services at the resident's own expense from providers other than the housing management. This subsection shall not be construed to relieve the resident of the resident's contractual obligation to pay the housing management for any services covered by the contract between the resident and housing management. The resident of an assisted living facility has the right to select as the resident's health care provider the Program for All-Inclusive Care for the Elderly without jeopardizing residency in the assisted living facility."

SECTION 5.(e) G.S. 131D-2.16 reads as rewritten:

"**§ 131D-2.16. Rules.**

Except as otherwise provided in this Article, the Medical Care Commission shall adopt rules necessary to carry out this Article. The Commission has the authority, in adopting rules, to specify the limitation of nursing services provided by assisted living residences. In developing rules, the Commission shall consider the need to ensure comparable quality of services provided to residents, whether these services are provided directly by a licensed assisted living provider, licensed home care agency, a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services, or hospice. In adult care homes, living arrangements where residents require supervision due to cognitive impairments, rules shall be adopted to ensure that supervision is appropriate and adequate to meet the special needs of these residents. Rule-making authority under this section is in addition to that conferred under G.S. 131D-4.3 and G.S. 131D-4.5."

SECTION 5.(f) G.S. 131D-6 reads as rewritten:

"**§ 131D-6. Certification of adult day care programs; purpose; definition; penalty.**

...

(d) ~~The~~ All of the following programs are exempted from the provisions of this section:

(1) Those that care for three people or ~~less;~~less.

(2) Those that care for two or more persons, all of whom are related by blood or marriage to the operator of the ~~facility;~~facility.

(3) Those that are required by other statutes to be licensed by the Department of Health and Human Services.

(4) Program for All-Inclusive Care for the Elderly organizations that have a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services when providing services to participants in the program."

SECTION 5.(g) This act is effective October 1, 2019.

PART VI. ELIMINATE REDUNDANCY IN ADULT CARE HOME INSPECTIONS

SECTION 6. G.S. 131D-2.11(a) reads as rewritten:

"(a) State Inspection and Monitoring. – The Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. All facilities licensed under this Article and adult care units in nursing homes are subject to inspections at all times by the Secretary. Except as provided in subsection (a1) of this section, the Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis. Beginning July 1, 2012, the Division of Health Service Regulation shall include as part of its inspection of all adult care homes a review of the facility's

compliance with G.S. 131D-4.4A(b) and safe practices for injections and any other procedures during which bleeding typically occurs. In addition, the Department shall ensure that adult care homes are inspected every two years to determine compliance with physical plant and life-safety requirements.

If the annual inspection of an adult care home is conducted separately from the inspection required every two years to determine compliance with physical plant and life-safety requirements, the Division of Health Service Regulation shall not cite, as part of the annual inspection, any violation of law that overlaps with an area addressed by the physical plant and life-safety inspection, unless failure to address the violation during the annual inspection would pose a risk to resident health or safety. Nothing in this section prevents a licensing inspector from referring a concern about physical plant and life-safety requirements to the section within the Division of Health Service Regulation that conducts physical plant and life-safety inspections."

PART VII. SEVERABILITY CLAUSE AND EFFECTIVE DATE

SECTION 7.(a) If any section or 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 to be unconstitutional or invalid.

SECTION 7.(b) Except as otherwise provided, this act is effective when it becomes law.

SENATE BILL 252:
Dental Bill of Rights.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Commerce and Insurance. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	April 30, 2019
Introduced by:	Sen. J. Davis	**Prepared by:**	Jessica Boney Staff Attorney
Analysis of:	PCS to First Edition S252-CSBP-8		

OVERVIEW: The Proposed Committee Substitute (PCS) for Senate Bill 252 would amend the methods of claims payment for dental services, add requirements for third party access to dental provider network contracts, and include dental plans for purposes of coverage determinations.

BILL ANALYSIS:

Methods of Claims Payment. The PCS restricts the agreement between an insurer and a provider of dental services from accepting credit card payments as the only payment method for dental services.

Third Party Access to Dental Provider Network Contracts. The PCS defines provider network contract, insurer and third party. It allows an insurer to grant third party access to its provider network contract if (i) the insurer allows any provider who is part of the carrier's provider network to choose not to participate in third party access, (ii) the insurer identifies all third parties with granted access, and (iii) the accessing third party complies with the provider network contract terms.

Coverage Determinations. The PCS prohibits an insurer from subsequently retracting its coverage determination for a dental plan after the services or supplies have been provided. The PCS defines pretreatment estimate and clarifies it is not a coverage determination.

EFFECTIVE DATE: This act is effective January 1, 2020, and applies to health benefit contracts issued, renewed, or amended on or after that date.

Karen Cochrane-Brown
Director

S252-SMBP-19 CSBP-8 -V-2

Legislative Analysis Division
919-733-2578

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Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 643

DATE: 5-2 **TIME:** 10 AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

	Page Name	Hometown	Sponsoring Senator
1.	John Bradford	Cornelius	Bishop
2.	Tayess John	Charlotte	Mohammed
3.	Andrew Washburn	Mooresville	Sawyer
4.	Grace Kromke	Wilmington	Peterson
5.	McKenzie Cox	Concord	Gallimore
6.			
7.			
8.			

ages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

SENATE SERGEANT-AT-ARMS

HEALTH CARE SENATE COMMITTEE

DATE: 05-02-2019 ROOM: 643

10:00 AM

SENATE SERGEANT AT ARMS

Eddie Broughton

Dwight Green

Charles Marsalis

Senate Committee on Health Care
Wednesday, May 22, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on May 22, 2019 in Room 643 of the Legislative Office Building. Seven members were present.

Senator Joyce Krawiec, Chair, presided.

Daniel Santos from Charlotte, Connor Booher from Asheville, Aidan Sher from Raleigh, Ashton Sasser from Salemburg, Clayton Cameron from Sanford, Garrett Cox from Kannapolis, and Matthew Fisher from Mooresville served as pages.

HB 388 Immunizing Pharmacists. (Representatives White, Dobson, Cunningham, Sasser)
Rep. White was recognized to speak on her bill. Sen. Burgin moved for a favorable report and it carried. Sen. Perry will manage the bill during session.

HB 656 Medicaid Changes for Transformation. (Representatives Lambeth, Dobson, Murphy, Sasser)
This bill was removed from the agenda by Sen. Krawiec

HB 70 Delay NC HealthConnex for Certain Providers. (Representatives Dobson, White, Murphy, Lambeth)
HB 70 was for discussion only.
Sen. Burgin moved that the Proposed Committee Substitute (PCS) be placed before the committee for discussion and it carried. Sen. Hise was recognized to explain the PCS. Questions from the members were responded to by Sen. Hise. Sen. Krawiec asked if any visitors would like to make comments and Dr. Lacy C. Hobgood, MC, FACP, FAAP the Clinical Associate Professor of Internal Medicine and Pediatrics from East Carolina University spoke in support.

The meeting adjourned at 10:29 AM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Wednesday, May 22, 2019

Senator Krawiec,
submits the following with recommendations as to passage:

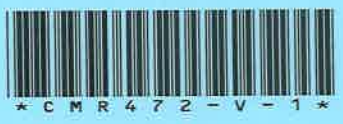
FAVORABLE

HB **388** **(CS#1)** Immunizing Pharmacists.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Jim Perry will handle HB 388



Senate Committee on Health Care
Wednesday, May 22, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 388	Immunizing Pharmacists.	Representative White Representative Dobson Representative Cunningham Representative Sasser
HB 656	Medicaid Changes for Transformation.	Representative Lambeth Representative Dobson Representative Murphy Representative Sasser
HB 70	Delay NC HealthConnex for Certain Providers. For Discussion Only	Representative Dobson Representative White Representative Murphy Representative Lambeth

HOUSE BILL 388:
Immunizing Pharmacists.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	May 21, 2019
Introduced by:	Reps. White, Dobson, Cunningham, Sasser	**Prepared by:**	Theresa Matula Committee Staff
Analysis of:	Second Edition		

OVERVIEW: ***House Bill 388 would expand the vaccinations or immunizations that may be administered by an immunizing pharmacist to allow: 1) persons age 18 and older to receive the Serogroup B meningococcal vaccines, the Human Papillomavirus vaccine, and the Hepatitis A vaccine; 2) children age 10 (now age 14) to receive the influenza vaccine; and 3) children age 6 and up to age 10 to receive the influenza vaccine following a physical examination and prescription order initiated by a provider. A screening questionnaire and safety procedures will be developed for the vaccinations and submitted to the Joint Legislative Oversight Committee on Health and Human Services.***

BILL ANALYSIS: **Section 1** of House Bill 388 amends the Pharmacy Practice Act, as it pertains to immunizing pharmacists (G.S. 90-85.15B), to expand the vaccinations or immunizations that may be administered by an immunizing pharmacist. The expanded vaccinations or immunizations that may be administered to persons at least 18 years of age include: Serogroup B meningococcal vaccines, Human Papillomavirus vaccine, and Hepatitis A vaccine. Currently, an immunizing pharmacist is allowed to administer the influenza vaccine to persons at least 14 years of age or older. The act would also allow an immunizing pharmacist to administer the influenza vaccine to persons 10 years of age or older and allow an immunizing pharmacist to administer an influenza vaccine to persons at least six (6) years of age with a specific prescription order initiated by a prescriber following a physical examination of the patient by the prescriber.

Section 2 requires a minimum standard screening questionnaire and safety procedures for written protocols for vaccinations or immunizations administered under G.S. 90-85.15B(b)(6)-(7). These will be developed by 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, North Carolina Association of Pharmacists, and the North Carolina Retail Merchants Association. The questionnaire and recommended standards must be submitted 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 on or before August 1, 2019. In the event that the questionnaire and recommended standards are not submitted by August 1, 2019, the Immunization Branch of the North Carolina Division of Public Health shall develop the questionnaire and recommended standards and submit them to the entities above by September 15, 2019

EFFECTIVE DATE: Section 1 becomes effective October 1, 2019, and the remainder becomes effective when it becomes law.

BACKGROUND: The information in this section is provided by the Centers for Disease Control.

- Serogroup B Meningococcal (MenB) - Meningococcal disease is a serious illness caused by a type of bacteria called *Neisseria meningitidis*. It can lead to meningitis (infection of the lining of the brain

...aren Cochrane-Brown
Director

H388-SMSH-62 E2 -V-1

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Division
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and spinal cord) and infections of the blood. There are at least 12 types of *N. meningitidis*, called "serogroups." Serogroups A, B, C, W, and Y cause most meningococcal disease. Serogroup B Meningococcal (MenB) vaccines can help prevent meningococcal disease caused by serogroup B. Other meningococcal vaccines are recommended to help protect against serogroups A, C, W, and Y.

- Hepatitis A – Hepatitis A is a serious liver disease caused by the hepatitis A virus. Hepatitis A Vaccines were recommended in the United States beginning in 1996. Since then, the number of cases reported each year in the U.S. has dropped from around 31,000 cases to fewer than 1,500 cases.
- Human papillomavirus (HPV) – HPV is a very common virus that can lead to cancer. Nearly 80 million people—about one in four—are currently infected with HPV in the United States. About 14 million people, including teens, become infected with HPV each year. Over 30,000 people in the United States each year are affected by a cancer caused by HPV infection. Human Papillomavirus Vaccine provides safe, effective, and lasting protection against the HPV infections that most commonly cause cancer.

The following are immunization schedules recommended by the CDC:

- Recommended Adult Immunization Schedule for ages 19 years or older
- 2019 Recommended Vaccinations for Children (7-18 Years old)
- 2019 Recommended Vaccinations for Infants and Children (birth through 6 years)

HOUSE BILL 388
Committee Substitute Favorable 4/8/19

Short Title: Immunizing Pharmacists. (Public)

Sponsors:

Referred to:

March 20, 2019

A BILL TO BE ENTITLED

AN ACT TO ALLOW IMMUNIZING PHARMACISTS TO ADMINISTER THE INFLUENZA VACCINE TO PEOPLE TEN YEARS OF AGE AND OLDER AND TO ADMINISTER VACCINES RECOMMENDED BY THE CENTER FOR DISEASE CONTROL AND PREVENTION TO PEOPLE AT LEAST EIGHTEEN YEARS OF AGE PURSUANT TO A WRITTEN PROTOCOL TO INCREASE ACCESS TO VACCINES IN THE BEST INTEREST OF THE PUBLIC HEALTH OF THE CITIZENS OF NORTH CAROLINA.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.15B reads as rewritten:

"**§ 90-85.15B. Immunizing pharmacists.**

(a) Except as provided in subsection (b) and (c) of this section, an immunizing pharmacist may administer vaccinations or immunizations only if the vaccinations or immunizations are recommended or required by the Centers for Disease Control and Prevention and administered to persons at least 18 years of age pursuant to a specific prescription order.

(b) An immunizing pharmacist may administer the vaccinations or immunizations listed in subdivisions (1) through ~~(5)~~ (7) of this subsection to persons at least 18 years of age if the vaccinations or immunizations are administered under written protocols as defined in 21 NCAC 46. 2507(b)(12) and 21 NCAC 32U. 0101(b)(12) and in accordance with the supervising physician's responsibilities as defined in 21 NCAC 46. 2507(e) and 21 NCAC 32U. 0101(e), and the physician is licensed in and has a practice physically located in North Carolina:

(1) Pneumococcal polysaccharide or pneumococcal conjugate vaccines.
(2) Herpes zoster vaccine.
(3) Hepatitis B vaccine.
(4) Meningococcal polysaccharide or meningococcal conjugate ~~vaccines.~~vaccines and Serogroup B meningococcal vaccines.
(5) Tetanus-diphtheria, tetanus and diphtheria toxoids and pertussis, tetanus and diphtheria toxoids and acellular pertussis, or tetanus toxoid vaccines. However, a pharmacist shall not administer any of these vaccines if the patient discloses that the patient has an open wound, puncture, or tissue tear.
(6) Human Papillomavirus vaccine.
(7) Hepatitis A vaccine.

(c) An immunizing pharmacist may administer the influenza vaccine to persons at least ~~14~~ 10 years of age pursuant to 21 NCAC 46. 2507 and 21 NCAC 32U. 0101. An immunizing pharmacist may administer an influenza vaccine to persons at least six years of age pursuant to a

specific prescription order initiated by a prescriber following a physical examination of the patient by the prescriber.

...."

SECTION 2. 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 are directed to cooperate and collaborate to recommend a minimum standard screening questionnaire and safety procedures for written protocols for vaccinations or immunizations administered under G.S. 90-85.15B(b)(6)-(7). The questionnaire and recommended standards shall be submitted 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 on or before August 1, 2019. In the event that the questionnaire and recommended standards are not submitted by August 1, 2019, the Immunization Branch of the North Carolina Division of Public Health shall develop the questionnaire and recommended standards 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 by September 15, 2019.

SECTION 3. Section 1 of this act becomes effective on October 1, 2019, and the remainder of this act is effective when it becomes law.

HOUSE BILL 656:
Medicaid Changes for Transformation.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	May 22, 2019
Introduced by:	Reps. Lambeth, Dobson, Murphy, Sasser	**Prepared by:**	Jennifer Hillman
Analysis of:	Third Edition		Staff Attorney

OVERVIEW: HB 656 makes changes to the Medicaid and Health Choice appeals statutes, and to other laws pertaining to Medicaid and Health Choice, that are necessary to implement Medicaid Transformation and contracts with Prepaid Health Plans on November 1, 2019.

CURRENT LAW: S.L. 2015-245, as amended, requires transition of the current Medicaid and Health Choice programs to capitated contracts with prepaid health plans (PHPs) under an 1115 waiver that was recently approved by the Centers for Medicare and Medicaid Services (CMS). Under the waiver, the Department of Health and Human Services (DHHS) has entered into contracts to pay PHPs a monthly per-person capitated rate to cover all Medicaid and Health Choice services for their enrollees. DHHS has also contracted with an enrollment broker to assist beneficiaries with enrolling in a PHP. The waiver directs that capitation payments to PHPs for enrolled beneficiaries will begin November 1, 2019.

BILL ANALYSIS: HB 656 makes changes to Medicaid and Health Choice laws that are necessary (i) to comply with federal law and regulations; (ii) for consistency with the Medicaid Transformation legislation, S.L. 2015-245, as amended; and (iii) for consistency with the PHP contracts that have been awarded. The bill has the following components:

- **Sections 1 and 6** establish a process for beneficiaries to appeal adverse decisions regarding disenrollment from a PHP in new Article 1A of Chapter 108D of the General Statutes. A Medicaid or Health Choice beneficiary may use this process to appeal decisions by DHHS or the enrollment broker regarding the beneficiary's disenrollment from a PHP. Key features of the process include the following:
    - The circumstances when disenrollment from a PHP is allowed, with or without cause, whether initiated by the enrollee or the PHP, are set out in G.S. 108D-5.3 and 108D-5.5.
    - The process for an enrollee to make an expedited request for disenrollment when the enrollee has an urgent medical need is set out in G.S. 108D-5.3(d).
    - Beneficiaries may appeal (i) the denial of their request to disenroll from a PHP or (ii) the approval by DHHS or by the enrollment broker of a PHP's request to disenroll the enrollee, under G.S. 108D-5.9.
    - The appeals process will be the same as the existing process for fee-for-service beneficiary appeals at the Office of Administrative Hearings under Part 6A of Article 2 of Chapter 108A of the General Statutes. DHHS is the respondent in these contested cases.
- **Section 1** establishes processes for beneficiaries to file grievances and appeals of adverse decisions by PHPs regarding service coverage. The processes will be the same as the existing grievance and appeals processes in Article 2 of Chapter 108D of the General Statutes, which govern grievances

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and appeals of actions by local management entities/managed care organizations (LME/MCOs), with the following exceptions:

- Health Choice beneficiaries will use this process for PHP determinations. Currently, Health Choice beneficiaries are not enrolled in LME/MCOs and do not engage in the LME/MCO appeals process. Health Choice beneficiaries will use the existing process in G.S. 108A-70.29 for appeals not related to PHPs, as set forth in **Section 7**.
- The length of time in which a LME/MCO must respond to a grievance is shortened from 90 days to 30 days under G.S. 108D-12(b), and the 30-day timeframe also applies to PHPs.
- PHP enrollees, but not LME/MCO enrollees, who are Medicaid recipients must be granted reinstatement of benefits if requested within 30 days after the adverse benefit determination notice was sent and certain other conditions are met under G.S. 108D-13(c1), 108D-14(c1), and G.S. 108D-15(g).

- **Section 1** also makes conforming changes to existing grievance and appeals processes in accordance with changes in federal law that have recently occurred.
- **Sections 4 and 5** add references to PHPs in the General Statutes.
- **Section 10** exempts contract disputes between PHPs and DHHS from Chapter 150B contested case hearings at the Office of Administrative Hearings under G.S. 150B-1.
- **Section 11** allows a PHP to be named as the sole respondent in a contested case at the Office of Administrative Hearings related to a notice of resolution issued by the PHP, under G.S. 150B-23. The circumstances when a PHP may be named as a respondent are the same as when an LME/MCO may be named as a respondent under current law.
- **Section 14** directs the codification of the Medicaid Transformation legislation, S.L. 2015-245, as amended, into the General Statutes. **Sections 2, 3, 9, 12, and 13** make technical changes related to codification.
- **Section 15** replaces references to the Division of Medical Assistance in the General Statutes with references to the Division of Health Benefits.

EFFECTIVE DATE: The changing of references in the statutes to the Division of Medical Assistance to instead reference the Division of Health Benefits is effective July 1, 2019. The remainder of the bill is effective October 1, 2019. The changes to the LME/MCO grievance and appeals processes apply to (i) appeals arising from LME/MCO notices of adverse benefit determination mailed on or after that date and (ii) grievances received by an LME/MCO on or after that date.

HOUSE BILL 656*
Committee Substitute Favorable 4/30/19
Committee Substitute #2 Favorable 5/2/19

Short Title: Medicaid Changes for Transformation. (Public)

Sponsors:

Referred to:

April 10, 2019

A BILL TO BE ENTITLED

AN ACT TO MODIFY THE LAWS PERTAINING TO MEDICAID AND NC HEALTH CHOICE AS NEEDED FOR THE IMPLEMENTATION OF MEDICAID TRANSFORMATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 108D of the General Statutes reads as rewritten:

"**Chapter 108D.**

"**Medicaid and NC Health Choice Managed Care ~~for Behavioral Health Services.~~Programs.**

"Article 1.

"General Provisions.

"**§ 108D-1. Definitions.**

The following definitions apply in this ~~Chapter, unless the context clearly requires otherwise:~~Chapter:

(1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b). In accordance with 42 C.F.R. § 457.1260, this definition applies to NC Health Choice beneficiaries in the same manner as it applies to Medicaid beneficiaries.

(2) Adverse disenrollment determination. – A determination by the Department of Health and Human Services or the enrollment broker to (i) deny a request made by an enrollee, or the enrollee's authorized representative, to disenroll from a prepaid health plan or (ii) approve a request made by a prepaid health plan to disenroll an enrollee from a prepaid health plan.

(3) Applicant. – A provider ~~of mental health, intellectual or developmental disabilities, and substance abuse services~~ who is seeking to participate in the ~~closed~~ network of one or more local management entity/managed care ~~organizations.~~organizations or prepaid health plans.

(4) Behavioral Health and Individuals with Developmental Disabilities Tailored Plan or BH IDD Tailored Plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter, including the requirements pertaining to BH IDD Tailored Plans.

(5) Beneficiary. – A person to whom or on whose behalf medical assistance or assistance through the North Carolina Health Choice for Children program is granted under Article 2 of Chapter 108A of the General Statutes.

~~(2)~~(6) Closed network. – The network of providers that have contracted with a local management entity/managed care organization to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees.

~~(3)~~(7) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under ~~G.S. 108D-15 to resolve a dispute between an enrollee and a local management entity/managed care organization about a managed care action.~~G.S. 108D-5.9 or G.S. 108D-15.

~~(4)~~(8) Department. – The North Carolina Department of Health and Human Services.

~~(5)~~(9) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.

~~(6)~~(12) Emergency services. – As defined in 42 C.F.R. § 438.114.

~~(7)~~(13) Enrollee. – A Medicaid or NC Health Choice beneficiary who is currently enrolled with a local management entity/managed care ~~organization.~~organization or a prepaid health plan.

(14) Enrollment broker. – As defined in 42 C.F.R. § 438.810(a).

(16) Fee-for-service program. – A payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice beneficiaries rather than contracting for the coverage of services through a capitated payment arrangement.

~~(8)~~(21) Local Management Entity or LME. – As defined in ~~G.S. 122C-3(20b).~~G.S. 122C-3.

~~(9)~~(22) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in ~~G.S. 122C-3(20c).~~G.S. 122C-3.

~~(10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).~~

~~(11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.~~

(23) Mail. – United States mail or, if the enrollee or the enrollee's authorized representative has given written consent to receive electronic communications, electronic mail.

(24) Managed care entity. – A local management entity/managed care organization or a prepaid health plan.

(25) Medicaid transformation demonstration waiver. – The waiver agreement entered into between the State and the Centers for Medicare and Medicaid Services under Section 1115 of the Social Security Act for the transition to prepaid health plans.

~~(12)~~(26) Mental health, intellectual or developmental disabilities, and substance abuse services or MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered by a local management entity/managed care organization under a contract ~~in effect between~~ with the Department of Health and Human Services ~~and a local management entity~~ to operate ~~a managed care organization or prepaid inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).~~the combined Medicaid waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.

~~(13)~~(27) Network provider. – An appropriately credentialed provider ~~of mental health, intellectual or developmental disabilities, and substance abuse services~~ that has entered into a contract for participation in the ~~closed~~ network of one

or more local management entity/managed care ~~organizations.~~organizations or prepaid health plans.

~~(14)~~(28) Notice of ~~managed care action.~~ adverse benefit determination. – The notice required by 42 C.F.R. § 438.404.

~~(15) Notice of resolution. The notice described in 42 C.F.R. § 438.408(e).~~

~~(16)~~(29) OAH. – The North Carolina Office of Administrative Hearings.

(30) Prepaid health plan or PHP. – A prepaid health plan, as defined in G.S. 58-93-5, or a local management entity/managed care organization operating a BH IDD Tailored Plan.

~~(17) Prepaid Inpatient Health Plan or PIHP. As defined in 42 C.F.R. § 438.2.~~

(31) Provider. – As defined in G.S. 108C-2.

~~(18)~~(32) Provider of emergency services. – A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.

(36) Standard plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter except for the requirements pertaining to a BH IDD Tailored Plan.

"**§ 108D-2. Scope; applicability of this Chapter.**

This Chapter applies to every ~~LME/MCO and to every~~ managed care entity, applicant, enrollee, provider of emergency services, and network provider of ~~an LME/MCO.~~a managed care entity. This Chapter does not apply to Medicaid or NC Health Choice services delivered through the fee-for-service program. Nothing in this Chapter shall be construed to grant a NC Health Choice beneficiary benefits in excess of what is required by G.S. 108A-70.21.

"**§ 108D-3. Conflicts; severability.**

(a) To the extent that this Chapter conflicts with the Social Security Act or 42 C.F.R. ~~Part 438,~~ Parts 438 and 457, federal law ~~prevails.~~prevails, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services.

(b) To the extent that this Chapter conflicts with any other provision of State law that is contrary to the principles of managed care that will ensure successful containment of costs for ~~behavioral~~ health care services, this Chapter prevails and applies.

(c) If any section, term, or provision of this Chapter is adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"Article 1A.

"Disenrollment from Prepaid Health Plans.

"**§ 108D-5.1. General provisions.**

(a) Nothing in this Article shall be construed to limit or prevent the Department from disenrolling, from a PHP, an enrollee who (i) is no longer eligible to receive services through the Medicaid or NC Health Choice programs or (ii) becomes a member of a population of beneficiaries that is not required to enroll in a PHP under State law.

(b) Nothing in this Article shall be construed to exclude a Medicaid or NC Health Choice beneficiary who is otherwise required by State law to enroll in a PHP from enrolling in a PHP, or to prevent a beneficiary who is otherwise exempted from enrollment in a PHP from disenrolling from a PHP and receiving services through the fee-for-service program.

"**§ 108D-5.3. Enrollee requests for disenrollment.**

(a) In General. – An enrollee, or the enrollee's authorized representative, who is requesting disenrollment from a PHP, shall submit an oral or written request for disenrollment to the enrollment broker.

(b) Without Cause Enrollee Requests or Disenrollment. – An enrollee shall be allowed to disenroll from the PHP without cause only during the times specified in 42 C.F.R. § 438.56(c)(2), except that enrollees who are in any of the following groups may disenroll at any time:

(1) Members of federally recognized tribes.
(2) Beneficiaries who are enrolled in the foster care system.
(3) Beneficiaries who are in the former foster care Medicaid eligibility category.
(4) Beneficiaries who receive Title IV-E adoption assistance.
(5) Beneficiaries under the age of 26 who formerly received Title IV-E adoption assistance.
(6) Beneficiaries who are receiving long-term services and supports in institutional or community-based settings.
(7) Any other beneficiaries who are not required to enroll in a PHP under State law.

(c) With Cause Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's authorized representative, may submit a request to disenroll from a PHP for cause at any time. For cause reasons for disenrollment from a PHP include the following:

(1) The enrollee moves out of the PHP's service area.
(2) The PHP, because of the PHP's moral or religious objections, does not cover a service the enrollee seeks.
(3) The enrollee needs concurrent, related services that are not all available within the PHP's network and the enrollee's provider determines that receiving services separately would subject the enrollee to unnecessary risk.
(4) An enrollee who receives long-term services and supports will be required to change residential, institutional, or employment supports providers due to the enrollee's provider's change from in-network to out-of-network status with the PHP and, as a result, the enrollee would experience a disruption in residence or employment.
(5) The enrollee's complex medical conditions could be better served under a different PHP. For purposes of this subsection, an enrollee is considered to have a complex medical condition if the enrollee has a condition that could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.
(6) A family member of the enrollee becomes, or is determined, eligible for Medicaid or NC Health Choice and the family member is, or becomes, enrolled in a different PHP.
(7) Poor performance by the PHP, as determined by the Department. The Department shall not make a determination of poor performance by any PHP until the Department has completed an annual PHP performance evaluation following the first year of that PHP's contract.
(8) Poor quality of care, lack of access to services covered under the PHP's contract, lack of access to providers experienced in addressing the enrollee's health care needs, or any other reasons established by the Department in the PHP's contract or in rule.

(d) Expedited Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's authorized representative, may submit an expedited request for disenrollment to the enrollment broker when the enrollee has an urgent medical need that requires disenrollment from the PHP. For purposes of this subsection, an urgent medical need means that continued enrollment in the PHP could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.

"**§ 108D-5.5. PHP requests for disenrollment.**

(a) In General. – A PHP requesting disenrollment of an enrollee from the PHP shall submit a written request for disenrollment to the enrollment broker.

(b) Limitations on PHP Requests for Disenrollment. – A PHP shall not request disenrollment of an enrollee from the PHP for any reason prohibited by 42 C.F.R. § 438.56(b)(2). A PHP may request disenrollment of an enrollee only when both of the following criteria are met:

(1) The enrollee's behavior seriously hinders the PHP's ability to care for the enrollee or other enrollees of the PHP.

(2) The PHP has documented efforts to resolve the issues that form the basis of the request for disenrollment of the enrollee.

"**§ 108D-5.7. Notices.**

(a) Notices of Resolution. – For each disenrollment request by an enrollee or a PHP, the Department shall issue a written notice of resolution approving or denying the request by mail to the enrollee before the first day of the second month following the month in which the enrollee or PHP requested disenrollment. For expedited enrollee requests for disenrollment made under G.S. 108D-5.3(d), the Department shall issue the written notice of resolution approving or denying the expedited request within three calendar days of receipt of the request. In the same mailing as the notice, the Department shall also provide the enrollee with an appeal request form that includes all of the following:

(1) A statement that in order to request an appeal, the enrollee must file the form in accordance with OAH rules, by mail or fax to the address or fax number listed on the form, no later than 30 days after the mailing date of the notice of resolution.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal the specific adverse disenrollment determination identified in the notice of resolution.

(4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the enrollee's signature and date.

(b) Notices Pertaining to Expedited Enrollee Request for Disenrollment. – If the Department determines that an enrollee's request for disenrollment does not meet the criteria for an expedited request, the Department shall do the following:

(1) No later than three calendar days after receiving the enrollee's request for disenrollment, make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of the determination by mail.

(2) Issue the notice of resolution within the time limits established for standard disenrollment requests under subsection (a) of this section.

"**§ 108D-5.9. Appeals of adverse disenrollment determinations.**

(a) Appeals. – An enrollee, or the enrollee's authorized representative, who is dissatisfied with an adverse disenrollment determination may file an appeal for a hearing with the Office of Administrative Hearings within 30 calendar days of the date on the notice of resolution. A request for a hearing to appeal an adverse disenrollment determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The appeal shall be conducted in accordance with the procedures in Part 6A of Article 2 of Chapter 108A of the General Statutes.

(b) Parties. – The Department shall be the respondent for purposes of appeals under this section.

"Article 2.

"Enrollee Grievances and Appeals.

"§ 108D-11. ~~LME/MCO~~ Managed care entity grievance and appeal procedures, generally.

(a) Each ~~LME/MCO~~ managed care entity shall establish and maintain internal grievance and appeal procedures that (i) comply with the Social Security Act and 42 C.F.R. Part 438, Subpart F, and (ii) afford ~~enrollees, and network providers authorized in writing to act on behalf of enrollees,~~ enrollees and their authorized representatives constitutional rights to due process and a fair hearing.

(b) ~~Enrollees, or network providers authorized in writing to act on behalf of enrollees,~~ An enrollee, or the enrollee's authorized representative, may file ~~requests for grievances~~ grievances and ~~LME/MCO~~ managed care entity level appeals orally or in writing. However, unless the ~~enrollee or network provider~~ enrollee, or the enrollee's authorized representative, requests an expedited appeal, the oral ~~filing~~ appeal must be followed by a written, signed ~~grievance or~~ appeal.

(c) ~~An LME/MCO~~ A managed care entity shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file a grievance, request for an ~~LME/MCO~~ managed care entity level appeal, or a contested case hearing. However, nothing in this Chapter shall be construed to prevent ~~an LME/MCO~~ a managed care entity from doing any of the following:

(1) Offering an enrollee alternative services.

(2) Engaging in clinical or educational discussions with enrollees or providers.

(3) Engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.

(d) ~~An LME/MCO~~ A managed care entity shall not take punitive action against a provider for any of the following:

(1) Filing a grievance on behalf of an enrollee or supporting an enrollee's grievance.

(2) Requesting ~~an LME/MCO~~ a managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for ~~an LME/MCO~~ a managed care entity level appeal.

(3) Requesting an expedited ~~LME/MCO~~ managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for ~~an LME/MCO~~ a managed care entity level expedited appeal.

(4) Requesting a contested case hearing on behalf of an enrollee or supporting an enrollee's request for a contested case hearing.

(e) The appeal procedures set forth in this Article shall not apply to instances in which the sole basis for the managed care entity's decision is a provision in the State Plan or in federal or State law requiring an automatic change adversely affecting some or all beneficiaries.

"§ 108D-12. ~~LME/MCO~~ Managed care entity grievances.

(a) Filing of Grievance. – An ~~enrollee, or a network provider authorized in writing to act on behalf of an~~ enrollee, or the enrollee's authorized representative, has the right to file a grievance with ~~an LME/MCO~~ a managed care entity at any time to express dissatisfaction about any matter other than ~~a managed care action.~~ an adverse benefit determination. Upon receipt of a grievance, ~~an LME/MCO~~ a managed care entity shall cause a written acknowledgment of receipt of the grievance to be sent by ~~United States~~ mail.

(b) Notice of Grievance Disposition. – The ~~LME/MCO~~ managed care entity shall resolve the grievance and cause a notice of grievance ~~disposition~~ resolution to be sent by ~~United States~~ mail to the enrollee and all other affected parties as expeditiously as the enrollee's health condition requires, but no later than ~~90~~ 30 days after receipt of the ~~grievance.~~ grievance, provided that the managed care entity may extend such time frame to the extent permitted under 42 C.F.R. § 438.408(c).

(c) Right to ~~LME/MCO Level~~ Appeal. – There is no right to appeal the resolution of a grievance to OAH or any other forum.

"§ 108D-13. Standard ~~LME/MCO~~ managed care entity level appeals.

(a) Notice of ~~Managed Care Action.~~ Adverse Benefit Determination. – ~~An LME/MCO~~ A managed care entity shall provide an enrollee with a written notice of ~~a managed care action~~ an adverse benefit determination by ~~United States~~ mail as required under 42 C.F.R. § 438.404. The notice ~~of action~~ will employ a standardized form included as a provision in the ~~contracts~~ contract between the ~~LME/MCOs~~ managed care entity and the ~~Department of Health and Human Services.~~Department.

(b) Request for Appeal. – An enrollee, or ~~a network provider authorized in writing to act on behalf of the enrollee,~~ the enrollee's authorized representative, has the right to file a request for ~~an LME/MCO~~ a managed care entity level appeal of a notice of ~~managed care action~~ adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the ~~grievance disposition or~~ notice of ~~managed care action.~~ adverse benefit determination. Upon receipt of a request for ~~an LME/MCO~~ a managed care entity level appeal, ~~an LME/MCO~~ a managed care entity shall acknowledge receipt of the request for appeal in writing by ~~United States~~ mail.

(c) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue or reinstate the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of ~~an LME/MCO~~ a managed care entity level appeal to the same extent required under ~~42 C.F.R. § 438.420.~~ 42 C.F.R. § 438.420 and subsection (c1) of this section. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation or reinstatement of benefits.

(c1) Reinstatement of Benefits for PHP Enrollees. – A PHP shall reinstate the benefits of a Medicaid enrollee if all of the following occur:

(1) The Medicaid enrollee, or the enrollee's authorized representative, files the appeal within the required time frames.

(2) The Medicaid enrollee, or the enrollee's authorized representative, files for continuation of benefits within 30 calendar days of the mailing date of the notice of adverse benefit determination, except that a request for continuation of benefits filed by a provider does not meet the requirement of this subdivision, in accordance with 42 C.F.R. § 438.402(c)(ii).

(3) The appeal involves the termination, suspension, or reduction of a previously authorized service.

(4) The service was ordered by an authorized provider.

(d) Notice of Resolution. – The ~~LME/MCO~~ managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than ~~45~~ 30 days after receiving the request for ~~appeal.~~ appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The ~~LME/MCO~~ managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by ~~United States~~ mail within this ~~45-day~~ 30-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in this section or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f).

"**§ 108D-14. Expedited ~~LME/MCO~~ managed care entity level appeals.**

(a) Request for Expedited Appeal. – When the time limits for completing a standard appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, has the right to file a request for

an expedited appeal of ~~a managed care action~~ an adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the notice of ~~managed care action.~~ adverse benefit determination. For expedited appeal requests made by ~~enrollees,~~ an enrollee, or the enrollee's authorized representative, the ~~LME/MCO~~ managed care entity shall determine if the enrollee qualifies for an expedited appeal. For expedited appeal requests made by ~~network providers on behalf of enrollees,~~ a network provider as an enrollee's authorized representative, the ~~LME/MCO~~ managed care entity shall presume an expedited appeal is necessary.

(b) Notice of Denial for Expedited Appeal. – If the ~~LME/MCO~~ managed care entity denies a request for an expedited ~~LME/MCO~~ managed care entity level appeal, the ~~LME/MCO~~ managed care entity shall make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of denial by ~~United States~~ mail ~~by~~ no later than ~~two calendar days~~ 72 hours after receiving the request for an expedited appeal. In addition, the ~~LME/MCO~~ managed care entity shall resolve the appeal within the time limits established for standard ~~LME/MCO~~ managed care entity level appeals in G.S. 108D-13.

(c) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue or reinstate the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of an expedited ~~LME/MCO~~ managed care entity level appeal to the extent required under ~~42 C.F.R. § 438.420.~~ 42 C.F.R. § 438.420 and subsection (c1) of this section. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation or reinstatement of benefits.

(c1) Reinstatement of Benefits for PHP Enrollees. – A PHP shall reinstate the benefits of a Medicaid enrollee who is a Medicaid beneficiary in accordance with G.S. 108D-13(c1).

(d) Notice of Resolution. – If the ~~LME/MCO~~ managed care entity grants a request for an expedited ~~LME/MCO~~ managed care entity level appeal, the ~~LME/MCO~~ managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, and no later than ~~three working days~~ 72 hours after receiving the request for an expedited ~~appeal.~~ appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The ~~LME/MCO~~ managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by ~~United States~~ mail within this ~~three-day~~ 72-hour period.

(e) Right to Request Contested Case Hearing. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or this ~~section.~~ section or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(f) Reasonable Assistance. – ~~An LME/MCO~~ A managed care entity shall provide the enrollee with reasonable assistance in completing forms and taking other procedural steps necessary to file an appeal, including providing interpreter services and toll-free numbers that have adequate teletypewriter/telecommunications devices for the deaf (TTY/TDD) and interpreter capability.

(g) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f).

"§ 108D-15. Contested case hearings on disputed ~~managed care actions.~~adverse benefit determinations.

(a) Jurisdiction of the Office of Administrative Hearings. – The Office of Administrative Hearings does not have jurisdiction over a dispute concerning ~~a managed care action,~~ an adverse benefit determination, except as expressly set forth in this Chapter.

(b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of resolution of an adverse benefit determination issued by ~~an LME/MCO.~~ a managed care entity.

G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not apply to enrollees contesting ~~a managed care action.~~an adverse benefit determination.

(c) Request for Contested Case Hearing. – A request for an administrative hearing to appeal a notice of resolution of an adverse benefit determination issued by ~~an LME/MCO~~ a managed care entity is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, has the right to file a request for appeal to contest a notice of resolution as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(d) Filing Procedure. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for an appeal by sending an appeal request form that meets the requirements of subsection (e) of this section to OAH and the affected ~~LME/MCO~~ managed care entity by no later than ~~30~~ 120 days after the mailing date of the notice of resolution. A request for appeal is deemed filed when a completed and signed appeal request form has been both submitted into the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the ~~LME/MCO~~ managed care entity shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

(e) Parties. – The ~~LME/MCO~~ managed care entity shall be the respondent for purposes of this appeal. The ~~LME/MCO or enrollee~~ managed care entity, the enrollee, or the enrollee's authorized representative may move for the permissive joinder of the Department under Rule 20 of the North Carolina Rules of Civil Procedure. The Department may move to intervene as a necessary party under Rules 19 and 24 of the North Carolina Rules of Civil Procedure.

(f) Appeal Request Form. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing which shall be no more than one side of one page. The form shall include at least all of the following:

(1) A statement that in order to request an appeal, the enrollee must file the form in accordance with OAH rules, by mail or fax to the address or fax number listed on the form, ~~by~~ no later than ~~30~~ 120 days after the mailing date of the notice of resolution.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal ~~a~~ the specific ~~managed care action~~ adverse benefit determination identified in the notice of resolution.

(4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the enrollee's signature and date.

(g) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue or reinstate the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of an appeal to the same extent required under ~~42 C.F.R. § 438.420.~~42 C.F.R. § 438.420, G.S. 108D-13, and G.S. 108D-14. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation or reinstatement of benefits. Notwithstanding any other provision of State law, the administrative law judge does not have the power to order and shall not order ~~an LME/MCO~~ a managed care entity to continue benefits in excess of what is required by ~~42 C.F.R. § 438.420.~~ 42 C.F.R. § 438.420, except to the extent required by G.S. 108D-13(c1) and G.S. 108D-14(c1).

(h) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge of OAH may limit and simplify the administrative hearing procedures that apply to contested case hearings conducted under this section in order to complete these cases as expeditiously as possible. Any simplified hearing procedures approved by the chief administrative law judge under this subsection must comply with all of the following requirements:

...

(2) OAH shall conduct all contested case hearings telephonically or by video technology with all parties, unless the enrollee requests that the hearing be conducted in person before the administrative law judge. An in-person hearing shall be conducted in the county that contains the headquarters of the ~~LME/MCO~~ managed care entity unless the enrollee's impairments limit travel. For enrollees with impairments that limit travel, an in-person hearing shall be conducted in the enrollee's county of residence. OAH shall provide written notice to the enrollee of the use of telephonic hearings, hearings by video conference, and in-person hearings before the administrative law judge, as well as written instructions on how to request a hearing in the enrollee's county of residence.

...

(4) The administrative law judge may allow brief extensions of the time limits imposed in this section only for good cause shown and to ensure that the record is complete. The administrative law judge shall only grant a continuance of a hearing in accordance with rules adopted by OAH for good cause shown and shall not grant a continuance on the day of a hearing, except for good cause shown. If an enrollee fails to make an appearance at a hearing that has been properly noticed by OAH by ~~United States~~ mail, OAH shall immediately dismiss the case, unless the enrollee moves to show good cause by no later than three business days after the date of dismissal. As used in this section, "good cause shown" includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.

(5) OAH shall include information on at least all of the following in its notice of hearing to an enrollee:

a. The enrollee's right to examine at a reasonable time before and during the hearing the contents of the enrollee's case file and any documents to be used by the ~~LME/MCO~~ managed care entity in the hearing before the administrative law judge.

b. The enrollee's right to an interpreter during the hearing process.

c. The circumstances in which a medical assessment may be obtained at the ~~LME/MCO's~~ managed care entity's expense and made part of the record, including all of the following:

...

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the ~~LME/MCO~~ managed care entity within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of ~~a managed care action~~ an adverse benefit determination until it has

received notice from the mediator assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. If the enrollee accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.

(j) Burden of Proof. – The enrollee has the burden of proof on all issues submitted to OAH for a contested case hearing under this section and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence in the case.

(k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of whether it was obtained before or after the ~~LME/MCO's managed care action~~ managed care entity's adverse benefit determination and regardless of whether the ~~LME/MCO~~ the managed care entity had an opportunity to consider the evidence in resolving the ~~LME/MCO~~ managed care entity level appeal. Upon the receipt of new evidence and at the request of the ~~LME/MCO,~~ managed care entity, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days in order to allow the ~~LME/MCO~~ managed care entity to review the evidence. Upon reviewing the evidence, if the ~~LME/MCO~~ managed care entity decides to reverse the ~~managed care action taken against the enrollee,~~ adverse benefit determination, it shall immediately inform the administrative law judge of its decision.

(*l*) Issue for Hearing. – For each ~~managed care action,~~ adverse benefit determination, the administrative law judge shall determine whether the ~~LME/MCO~~ managed care entity substantially prejudiced the rights of the enrollee and whether the ~~LME/MCO,~~ managed care entity, based upon evidence at the ~~hearing:~~ hearing, did any of the following:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

(m) To the extent that anything in this ~~Part,~~ Chapter, Chapter 150B of the General Statutes, or any rules or policies adopted under these Chapters is inconsistent with the Social Security Act or 42 C.F.R. Part 438, Subpart F, federal law prevails and applies to the extent of the ~~conflict.~~ conflict, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. All rules, rights, and procedures for contested case hearings concerning ~~managed care actions~~ adverse benefit determinations shall be construed so as to be consistent with applicable federal law and shall provide the enrollee with ~~no lesser and no greater~~ rights that are no less than those provided under federal law.

"§ 108D-16. Notice of final decision and right to seek judicial review.

The administrative law judge assigned to conduct a contested case hearing under G.S. 108D-15 shall hear and decide the case without unnecessary delay. The judge shall prepare a written decision that includes findings of fact and conclusions of law and send it to the parties in accordance with G.S. 150B-37. The written decision shall notify the parties of the final decision and of the right of the enrollee and the ~~LME/MCO~~ managed care entity to seek judicial review of the decision under Article 4 of Chapter 150B of the General Statutes.

"Article 3.

"Managed Care Entity Provider Networks.

"§ 108D-21. LME/MCO provider networks.

Each LME/MCO operating the combined 1915(b) and (c) waivers shall maintain and utilize a closed network of providers to furnish mental health, intellectual or developmental disabilities, and substance abuse services to its enrollees.

"§ 108D-22. PHP provider networks.

(a) Except as provided in G.S. 108D-23, each PHP shall develop and maintain a provider network that meets access to care requirements for its enrollees. A PHP may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, a PHP must include all providers in its geographical coverage area that are designated essential providers by the Department in accordance with subdivision (b) of this section, unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.

(b) The Department shall designate Medicaid and NC Health Choice providers as essential providers if, within a region defined by a reasonable access standard, the provider either (i) offers services that are not available from any other provider in the region or (ii) provides a substantial share of the total units of a particular service utilized by Medicaid and NC Health Choice beneficiaries within the region during the last three years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid and NC Health Choice enrollees. The Department shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

(1) Federally qualified health centers.
(2) Rural health centers.
(3) Free clinics.
(4) Local health departments.
(5) State Veterans Homes.

"**§ 108D-23. BH IDD Tailored Plan networks.**

Entities operating BH IDD Tailored Plans shall utilize closed provider networks only for the provision of behavioral health, intellectual and developmental disability, and traumatic brain injury services."

SECTION 1.(b) This section is effective October 1, 2019, and applies to (i) appeals arising from local management entity/managed care organization (LME/MCO) notices of adverse benefit determination mailed on or after that date and (ii) grievances received by an LME/MCO on or after that date.

SECTION 2. G.S. 90-414.4(a1)(3) reads as rewritten:

"(3) The following entities shall submit encounter and claims data, as appropriate, in accordance with the following time line:

a. Prepaid Health Plans, as defined in ~~S.L. 2015-245,~~ G.S. 108D-1, by the commencement date of a capitated contract with the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services as specified in ~~S.L. 2015-245.~~Article 4 of Chapter 108D of the General Statutes.

b. Local management entities/managed care organizations, as defined in G.S. 122C-3, by June 1, 2020."

SECTION 3. G.S. 108A-24 reads as rewritten:

"**§ 108A-24. Definitions.**

As used in Chapter 108A:

...

(3d) "Federal TANF funds" means the Temporary Assistance for Needy Families block grant funds provided for in Title IV-A of the Social Security Act.

(3e) "Fee-for-service program" means a payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice recipients

rather than contracting for the coverage of services through a capitated payment arrangement.

~~(3e) "FICA" means the taxes imposed by the Federal Insurance Contribution Act, 26 U.S.C. § 3101, et seq.~~

(3f) Repealed by Session Laws 2009-489, s. 1, effective August 26, 2009.

(3g) "FICA" means the taxes imposed by the Federal Insurance Contribution Act, 26 U.S.C. § 3101, et seq.

~~(3g)~~(3h) "Full-time employment" means employment which requires the employee to work a regular schedule of hours per day and days per week established as the standard full-time workweek by the employer, but not less than an average of 30 hours per week.

(4) Repealed by Session Laws 1983, c. 14, s. 3.

...

(4b) "Parent" means biological parent or adoptive parent, and for Work First purposes, includes a stepparent.

(4c) "Prepaid health plan" or "PHP" has the same meaning as in G.S. 108D-1.

(5) "Recipient" is a person to whom, or on whose behalf, assistance is granted under this Article.

...."

SECTION 4. G.S. 108A-56 reads as rewritten:

"**§ 108A-56. Acceptance of federal grants.**

All of the provisions of the federal Social Security Act providing grants to the states for medical assistance are accepted and adopted, and the provisions of this Part shall be liberally construed ~~in relation to such act so that the intent to comply with it shall be made effectual.~~ to effectuate compliance with the act, except to the extent the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. Nothing in this Part or the regulations made under its authority shall be construed to deprive a recipient of assistance of the right to choose the licensed provider of the care or service made available under this Part within the provisions of the federal Social Security ~~Act.~~Act, or valid waiver agreement. This section shall not be construed to prohibit a PHP from (i) requiring its enrollees to obtain services from providers that are under contract with the PHP or (ii) imposing utilization management criteria to a request for services, to the extent these actions are not otherwise prohibited by State or federal law or regulation, or by the Department."

SECTION 5. G.S. 108A-70 reads as rewritten:

"**§ 108A-70. Recoupment of amounts spent on medical care.**

(a) ~~The~~ To the extent necessary to reimburse the Department or a PHP for expenditures for costs under this Part, and provided that claims for current and past due child support shall take priority over claims for those expenditures, the Department may garnish the wages, salary, or other employment income of, and the Secretary of Revenue shall withhold amounts from State tax refunds to, any person ~~who:~~who meets all of the following criteria:

(1) Is required by court or administrative order to provide health benefit plan coverage for the cost of health care services to a child eligible for medical assistance under ~~Medicaid; and~~Medicaid.

(2) Has received payment from a third party for the costs of such ~~services; but~~services.

(3) Has not used such payments to reimburse, as appropriate, either the other parent or guardian of the child or the provider of the ~~services;~~services.

~~to the extent necessary to reimburse the Department for expenditures for such costs under this Part; provided, however, claims for current and past due child support shall take priority over any such claims for the costs of such services.~~

...."

SECTION 6. Part 6A of Article 2 of Chapter 108A of the General Statutes reads as rewritten:

"Part 6A. ~~Medicaid Recipient Appeals Process.~~Appeals Process for Certain Medicaid and NC Health Choice Determinations.

"**§ 108A-70.9A. ~~Appeals by Medicaid recipients.~~Definitions; Medicaid recipient appeals.**

(a) Definitions. – The following definitions apply in this ~~Part, unless the context clearly requires otherwise.~~Part:

(1) Adverse determination. – A determination by the Department to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a Medicaid ~~service.~~service through the fee-for-service program. An adverse benefit determination as defined in G.S. 108D-1 is not an adverse determination for purposes of this Part.

(1a) Adverse disenrollment decision. – As defined in G.S. 108D-1.

(1b) Contested Medicaid case. – A case commenced by (i) a Medicaid recipient appealing an adverse determination under this Part or (ii) a Medicaid or a NC Health Choice recipient appealing an adverse disenrollment determination under G.S. 108D-5.9.

(2) OAH. – The Office of Administrative Hearings.

(3) Recipient. – A recipient and the recipient's parent, guardian, or legal representative, unless otherwise specified.

(b) ~~General Rule.~~ Medicaid recipient appeals. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid recipient to appeal an adverse determination made by the ~~Department.~~Department and the process used by a Medicaid or NC Health Choice recipient to appeal an adverse disenrollment determination by the Department.

...

"**§ 108A-70.9B. Contested Medicaid cases.**

(a) Application. – This section applies only to contested Medicaid cases ~~commenced by Medicaid recipients under G.S. 108A-70.9A.~~ as defined in this Part. Except as otherwise provided by ~~G.S. 108A-70.9A~~ Article 1A of Chapter 108D of the General Statutes, G.S. 108A-70.9A, and this section governing time lines and procedural steps, a contested Medicaid case commenced by a Medicaid or NC Health Choice recipient is subject to the provisions of Article 3 of Chapter 150B of the General Statutes. To the extent any provision in this ~~section~~ section, Article 1A of Chapter 108D of the General Statutes, or G.S. 108A-70.9A conflicts with another provision in Article 3 of Chapter 150B of the General Statutes, this ~~section~~ section, Article 1A of Chapter 108D of the General Statutes, and G.S. 108A-70.9A control.

(b) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge may limit and simplify the procedures that apply to a contested Medicaid case involving a Medicaid or NC Health Choice recipient in order to complete the case as quickly as possible.

...

(3) The simplified procedure may include requiring that all prehearing motions be considered and ruled on by the administrative law judge in the course of the hearing of the case on the merits. An administrative law judge assigned to a contested Medicaid case shall make reasonable efforts in a case involving a Medicaid or NC Health Choice recipient who is not represented by an attorney to assure a fair hearing and to maintain a complete record of the hearing.

...

(c) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108A-70.9A(e) or other clear request for a hearing by a Medicaid or NC Health Choice recipient, OAH shall immediately notify the Mediation Network of North Carolina, which shall

contact the recipient within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the Department within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested Medicaid case until it has received notice from the mediator assigned that either: (i) the mediation was unsuccessful, or (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. If the recipient accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.

(d) Burden of Proof. – The recipient has the burden of proof on all issues submitted in a contested Medicaid case to OAH ~~for a Medicaid contested case hearing~~ and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence.

...

(f) Issue for Hearing. – For each adverse determination and each adverse disenrollment determination, the hearing shall determine whether the Department substantially prejudiced the rights of the recipient and if the Department, based upon evidence at the ~~hearing:~~hearing, did any of the following:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

...

"**§ 108A-70.9C. Informal review permitted.**

Nothing in this Part shall prevent the Department from engaging in an informal review of a contested Medicaid case with a recipient prior to issuing a notice of adverse determination ~~as provided by G.S. 108A-70.9A(c).~~under G.S. 108A-70.9A(c) or a notice of resolution under G.S. 108D-5.7."

SECTION 7. G.S. 108A-70.29 reads as rewritten:

"**§ 108A-70.29. Program review process.**

(a) Review of Eligibility and Program Enrollment Decisions. – Eligibility and Program enrollment decisions for Program applicants or recipients shall be reviewable pursuant to G.S. 108A-79. Program recipients shall remain enrolled in the NC Health Choice Program during the review of a decision to terminate or suspend enrollment. This subsection does not apply to requests for disenrollment from a PHP under Article 1A of Chapter 108D of the General Statutes.

(b) Review of Fee-for-Service Program Health Services Decisions. – This subsection applies only to health services decisions for services being provided to NC Health Choice recipients through the fee-for-service program as defined in G.S. 108A-24. This subsection does not apply to adverse benefit determinations as defined in G.S. 108D-1. In accordance with 42 C.F.R. § 457.1130 and 42 C.F.R. § 457.1150, a Program recipient may seek review of any delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services, through a two-level review process.

...."

SECTION 9. G.S. 122C-3 reads as rewritten:

"**§ 122C-3. Definitions.**

The following definitions apply in this Chapter:

...

(2a) "Area director" means the administrative head of the area authority program appointed pursuant to G.S. 122C-121.

(2b) "Behavioral Health and Individuals with Developmental Disabilities Tailored Plan or BH IDD Tailored Plan" has the same meaning as in G.S. 108D-1.

(2c) "Board of county commissioners" includes the participating boards of county commissioners for multicounty area authorities and multicounty programs.

...

(20c) "Local management entity/managed care organization" or "LME/MCO" means a local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security ~~Act.~~Act or to operate a BH IDD Tailored Plan.

...."

SECTION 10. G.S. 150B-1 reads as rewritten:

"**§ 150B-1. Policy and scope.**

...

(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

...

(17) The Department of Health and Human Services with respect to the review of North Carolina Health Choice Program determinations regarding delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of ~~services.~~services, commenced under G.S. 108A-70.29(b).

...

(25) The Department of Health and Human Services with respect to disputes involving the performance, terms, or conditions of a contract between the Department and a prepaid health plan, as defined in G.S. 108D-1.

...."

SECTION 11. G.S. 150B-23 reads as rewritten:

"**§ 150B-23. Commencement; assignment of administrative law judge; hearing required; notice; intervention.**

...

(a3) A Medicaid or NC Health Choice enrollee, or ~~network provider authorized in writing to act on behalf of the enrollee,~~ the enrollee's authorized representative, who appeals a notice of resolution issued by ~~an LME/MCO~~ a managed care entity under Chapter 108D of the General Statutes may commence a contested case under this Article in the same manner as any other petitioner. The case shall be conducted in the same manner as other contested cases initiated by Medicaid or NC Health Choice enrollees under this Article. Solely and only for the purposes of contested cases commenced ~~as Medicaid managed care enrollee appeals under Chapter 108D of the General Statutes,~~ pursuant to G.S. 108D-15 by enrollees of LME/MCOs to appeal a notice of resolution issued by the LME/MCO, an LME/MCO is considered an agency as defined in G.S. 150B-2(1a). The LME/MCO shall not be considered an agency for any other purpose. When a prepaid health plan, as defined in G.S. 108D-1, other than an LME/MCO, is under contract with the Department of Health and Human Services to issue notices of resolution under Article 2 of Chapter 108D of the General Statutes, then solely and only for the purposes of contested cases commenced pursuant to G.S. 108D-15 to appeal a notice of resolution issued by the prepaid health plan, the prepaid health plan shall be considered an agency as defined in G.S. 150B-2(1a). The prepaid health plan shall not be considered an agency for any other purpose.

...."

SECTION 12. Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17(a) of S.L. 2017-57, Section 4 of S.L. 2017-186, Section 11H.10(d) of S.L. 2018-5, and Sections 5 and 6 of S.L. 2018-48, reads as rewritten:

"**SECTION 4.** Structure of Delivery System. – The transformed Medicaid and NC Health Choice programs described in Section 1 of this act shall be organized according to the following principles and parameters:

...

(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. The capitated contracts required by this subdivision shall not cover:

a. Medicaid services ~~currently~~ covered by the local management entities/managed care organizations (LME/MCOs) under the combined 1915(b) and (c) waivers shall not be covered under any capitated PHP contract other than a BH IDD Tailored Plan, except that all capitated PHP contracts shall cover the following services: inpatient behavioral health services, outpatient behavioral health emergency room services, outpatient behavioral health services provided by direct-enrolled providers, mobile crisis management services, facility-based crisis services for children and adolescents, professional treatment services in a facility-based crisis program, outpatient opioid treatment services, ambulatory detoxification services, nonhospital medical detoxification services, partial hospitalization, medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization, research-based intensive behavioral health treatment, diagnostic assessment services, and Early and Periodic Screening, Diagnosis, and Treatment services. In accordance with this sub-subdivision, 1915(b)(3) services shall not be covered under any capitated PHP contract other than a BH IDD Tailored Plan.

...

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except for the following categories:

...

m. Recipients in the following categories shall not be covered by PHPs for a period of time to be determined by DHHS that shall not exceed five years after the date that capitated PHP contracts begin:

1. Recipients who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of 90 days or longer and (ii) are not being served through the Community Alternatives Program for Disabled Adults (CAP/DA). During the period of exclusion from PHP coverage for this population as determined by DHHS in accordance with this sub-subdivision, if an individual enrolled in a PHP resides in a nursing facility for 90 days or more, then that individual shall be excluded from PHP coverage on the first day of the month following the ninetieth day of the stay in the nursing facility and shall be disenrolled from the PHP.

2. Recipients who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing. This sub-sub-subdivision shall not include recipients being served through the Community Alternatives Program for Disabled Adults (CAP/DA).
3. Recipients who are (i) enrolled in the foster care system, (ii) receiving Title IV-E adoption assistance, (iii) under the age of 26 and formerly were in the foster care system, or (iv) under the age of 26 and formerly received adoption assistance.

...

(9) LME/MCOs. – Beginning on the date that capitated contracts begin, LME/MCOs shall cease managing Medicaid services for all Medicaid recipients other than recipients described in sub-subdivisions a., d., e., f., g., j., k., ~~and *l.*~~ *l.*, and m. of subdivision (5) of this section. Until BH IDD Tailored Plans become operational, all of the following shall occur:

a. LME/MCOs shall continue to manage the Medicaid services that are ~~currently~~ covered by the LME/MCOs under the combined 1915(b) and (c) waivers for Medicaid recipients described in sub-subdivisions a., d., e., f., g., j., k., ~~and *l.*~~ *l.*, and m. of subdivision (5) of this section.
b. The Division of Health Benefits shall negotiate actuarially sound capitation rates directly with the LME/MCOs based on the change in composition of the population being served by the LME/MCOs.
c. Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits.

...."

SECTION 13. Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121 and Section 6(b) of S.L. 2018-49, reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of DHHS during Medicaid transformation shall include the following activities and functions:

...

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All contracts shall be the result of requests for proposals (RFPs) issued by DHHS and the submission of competitive bids by PHPs. DHHS shall develop standardized contract terms, to include at a minimum, the following:

...

c. A minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by DHHS. The minimum medical loss ratio shall be neither higher nor lower than eighty-eight percent (88%). DHHS shall not require community reinvestment as a result of a PHP's failure to comply with any minimum medical loss ratio.

...."

SECTION 14.(a) The portions of S.L. 2015-245, as amended, specified in this section are codified into a new Article 4 of Chapter 108D of the General Statutes to be entitled "Prepaid Health Plans," as follows:

(1) Section 1 of S.L. 2015-245 is codified as G.S. 108D-30.
(2) Subdivision (4) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17 of S.L. 2017-57, Section 4 of S.L. 2017-186,

Section 1 of S.L. 2018-48, and Section 12 of this act, is codified as G.S. 108D-35.

(3) Subdivision (5) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 1 of S.L. 2018-48, Section 5 of S.L. 2018-49, and Section 12 of this act, is codified as G.S. 108D-40.

(4) Subdivision (5a) of Section 4 of S.L. 2015-245, as enacted by Section 5(c) of S.L. 2018-49, is codified as G.S. 108D-40.

(5) Subdivision (6) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121 and Section 1 of S.L. 2018-48, is codified as G.S. 108D-45 and the words "(statewide contracts)" and "(regional contracts)" shall be removed.

(6) Subdivision (7) of Section 4 of S.L. 2015-245 is codified as G.S. 108D-50.

(7) Subdivision (8) of Section 4 of S.L. 2015-245 is codified as G.S. 108D-55.

(8) Subdivision (9) of Section 4 of S.L. 2015-245, as amended by Section 1 of S.L. 2018-48 and Section 12 of this act, is codified as G.S. 122C-115(e), except that the tag line shall not be codified, and the words "under Article 4 of Chapter 108D of the General Statutes" shall be inserted after the words "capitated contracts."

(9) Subdivision (10) of Section 4 of S.L. 2015-245, as amended by Section 1 of S.L. 2018-48, is codified as G.S. 108D-60, except that the following are not codified:

a. The first and third sentences of the subdivision (10).

b. The language in sub-subdivision a. appearing before sub-sub-subdivision 1.

c. The word "currently" shall be removed from sub-sub-sub-subdivision II. of sub-sub-subdivision 1. of sub-subdivision a.

d. Sub-sub-subdivision 6. of sub-subdivision a.

e. Sub-subdivisions b., c., and d.

(10) Section 5 of S.L. 2015-245, as amended by Section 2(c) S.L. 2016-121, Section 6(b) of S.L. 2018-49, and Section 13 of this act, is codified as G.S. 108D-65, except that the following are not codified:

a. Sub-subdivision d. of subdivision (6) of Section 5.

b. Subdivisions (10), (11), (12), and (13) of Section 5.

(11) Section 7A of S.L. 2015-245, as enacted by Section 7 of S.L. 2018-49, is codified as G.S. 108D-70.

SECTION 14.(b) In codifying the portions of S.L. 2015-245, as amended, that are specified in subsection (a) of this section, the Revisor of Statutes is authorized to do all of the following:

(1) Replace references to DHHS with references to the Department or the Department of Health and Human Services, as appropriate.

(2) Revise references to subdivision (3) of Section 4 of the session law to instead reference the codified location of the language in subdivision (3) of Section 5 of the session law.

SECTION 15.(a) References to the Division of Medical Assistance, and any derivatives thereof, in the General Statutes are replaced with references to the Division of Health Benefits, except that references to the Division of Medical Assistance are not replaced in G.S. 108A-54, 126-5(c)(34), 143B-138.1, and 143B-216.80.

SECTION 15.(b) This section is effective July 1, 2019.

SECTION 16.(a) Except as otherwise provided, this act is effective October 1, 2019.

SECTION 16.(b) This section is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

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HOUSE BILL 70
Committee Substitute Favorable 3/12/19
PROPOSED SENATE COMMITTEE SUBSTITUTE H70-CSMG-7 [v.4]
05/21/2019 10:39:32 AM

Short Title: Delay NC HealthConnex for Certain Providers. (Public)

Sponsors:

Referred to:

February 14, 2019

A BILL TO BE ENTITLED

AN ACT EXTENDING THE DEADLINES BY WHICH CERTAIN PROVIDERS ARE REQUIRED TO CONNECT TO AND PARTICIPATE IN NORTH CAROLINA'S HEALTH INFORMATION EXCHANGE NETWORK KNOWN AS NC HEALTHCONNEX AND EXPANDING THE MEMBERSHIP OF THE NORTH CAROLINA HEALTH INFORMATION EXCHANGE ADVISORY BOARD.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-414.4 reads as rewritten:

"**§ 90-414.4. Required participation in HIE Network for some providers.**

(a) Findings. – The General Assembly makes the following findings:

(1) That controlling escalating health care costs of the Medicaid program and other State-funded health care services is of significant importance to the State, its taxpayers, its Medicaid recipients, and other recipients of State-funded health care services.

(2) That the State ~~needs~~ and covered entities in North Carolina need timely access to certain demographic and clinical information pertaining to services rendered to Medicaid and other State-funded health care program beneficiaries and paid for with Medicaid or other State-funded health care funds in order to assess performance, improve health care outcomes, pinpoint medical expense trends, identify beneficiary health risks, and evaluate how the State is spending money on Medicaid and other State-funded health care services.

(3) That making demographic and clinical information available to the State and covered entities in North Carolina by secure electronic means as set forth in subsection (b) of this section ~~will, with respect to Medicaid and other State-funded health care programs,~~ will improve care coordination within and across health systems, increase care quality for such beneficiaries, enable more effective population health management, reduce duplication of medical services, augment syndromic surveillance, allow more accurate measurement of care services and outcomes, increase strategic knowledge about the health of the population, and facilitate health care cost containment.

(a1) Mandatory Connection to HIE Network. – Notwithstanding the voluntary nature of the HIE Network under G.S. 90-414.2, the following providers and entities shall be connected to the HIE Network and begin submitting data through the HIE Network pertaining to services rendered to Medicaid beneficiaries and to other State-funded health care program beneficiaries

and paid for with Medicaid or other State-funded health care funds in accordance with the following time line:

(1) The following providers of Medicaid services licensed to operate in the State that have an electronic health record system shall begin ~~submitting~~ submitting, at a minimum, demographic and clinical data by June 1, 2018:
  a. Hospitals as defined in G.S. 131E-176(13).
  b. Physicians licensed to practice under Article 1 of Chapter 90 of the General ~~Statutes.~~Statutes, except for licensed physicians whose primary area of practice is psychiatry.
  c. Physician assistants as defined in 21 NCAC 32S.0201.
  d. Nurse practitioners as defined in 21 NCAC 36.0801.

(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, ~~2019.~~2020.

(3) The following entities shall submit encounter and claims data, as appropriate, in accordance with the following time line:
  a. Prepaid Health Plans, as defined in S.L. 2015-245, by the commencement date of a capitated contract with the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services as specified in S.L. 2015-245.
  b. Local management entities/managed care organizations, as defined in G.S. 122C-3, by June 1, 2020.

(4) The following entities shall begin submitting demographic and clinical data by June 1, 2021:
  a. Ambulatory surgical centers as defined in G.S. 131E-146.
  b. Dentists licensed under Article 2 of Chapter 90 of the General Statutes.
  c. Licensed physicians whose primary area of practice is psychiatry.

(5) The following entities shall begin submitting claims data by June 1, 2021:
  a. Pharmacies registered with the North Carolina Board of Pharmacy under Article 4A of Chapter 90 of the General Statutes.
  b. State health care facilities operated under the jurisdiction of the Secretary of the Department of Health and Human Services, including State psychiatric hospitals, developmental centers, alcohol and drug treatment centers, neuro-medical treatment centers, and residential programs for children such as the Wright School and the Whitaker Psychiatric Residential Treatment Facility.
  c. The State Laboratory of Public Health operated by the Department of Health and Human Services.

(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,~~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 and~~Technology, the Department of Health and Human ~~Services~~ 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 nor~~Technology, the Department of Health and Human ~~Services~~ 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,~~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, 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, ~~2021.~~ 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.

...

(e) Voluntary Connection for Certain Providers. – Notwithstanding the mandatory connection and data submission requirements in subsections (a1) and (b) of this section, the following providers of Medicaid services or other State-funded health care services are not required to connect to the HIE Network or submit data, but may connect to the HIE Network and submit data voluntarily:

(1) Community-based long-term services and supports providers, including personal care services, private duty nursing, and hospice care providers.
(2) Intellectual and developmental disability services and supports providers, such as day supports and supported living providers.
(3) Community Alternatives Program waiver services (including CAP/DA, CAP/C, and Innovations) providers.
(4) Eye and vision services providers.
(5) Speech, language, and hearing services providers.
(6) Occupational and physical therapy providers.
(7) Durable medical equipment providers.
(8) Non-emergency medical transportation service providers.
(9) Ambulance (emergency medical transportation service) providers.
(10) Local education agencies and school-based health providers.

(f) Confidentiality of Data. – All data submitted to or through the HIE Network containing protected health information, personally identifying information, or a combination of these, that are in the possession of the Department of Information Technology or any other agency of the State are confidential and shall not be defined as public records under G.S. 132-1. This subsection shall not be construed to prohibit the disclosure of any such data as otherwise permitted under federal law."

SECTION 2. G.S. 90-414.10(d) reads as rewritten:

"(d) Except as otherwise permitted in ~~G.S. 90-414.9(a)(3),~~ G.S. 90-414.11(a)(3), or as required by law, the protected health information of an individual who has exercised the right to opt out may not be made accessible or disclosed to covered entities or any other person or entity through the HIE Network for any purpose."

SECTION 3. This act is effective when it becomes law.

HOUSE BILL 70:
Delay NC HealthConnex for Certain Providers.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	May 21, 2019
Introduced by:	Reps. Dobson, White, Murphy, Lambeth	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	PCS to Second Edition H70-CSMG-7		

OVERVIEW: The PCS to House Bill 70 would amend G.S. 90-414.4 to (1) extend the deadline by which providers not mentioned elsewhere in the statute have to connect to the Health Information Exchange (HIE) to June 1, 2020, (2) allow psychiatrists until June 1, 2021, before they are required to connect, (3) allow DHHS to extend the connection deadline for providers making a good faith effort to connect to June 1, 2020, and (4) make connection to the HIE voluntary for several types of providers.

CURRENT LAW: Currently, G.S. 90-414.4(a1) requires most providers who provide services to Medicaid beneficiaries to submit demographic and clinical data through the HIE by June 1, 2019. G.S. 90-414.4(a2) allows DHHS and DIT to grant extensions to most providers through June 1, 2020. All providers of Medicaid or State-funded care are required to connect to the HIE.

The current HIE Advisory Board has 12 members, including three ex-officio, non-voting members.

BILL ANALYSIS: The PCS to House Bill 70 would amend G.S. 90-414.4 in the following ways:

- Extend the deadline for most providers to connect to the HIE through June 1, 2020.
- Extend the connection deadline for psychiatrists until June 1, 2021.
- Allow all providers to request an extension deadline of June 1, 2020, from DHHS.
- Make connection to the HIE voluntary for the following providers:
    - Community-based, long-term services and supports providers.
    - Intellectual and developmental disability services and supports providers..
    - Community Alternatives Program waiver services (including CAP/DA, CAP/C, and Innovations) providers.
    - Eye and vision services providers.
    - Speech, language, and hearing services providers.
    - Occupational and physical therapy providers.
    - Durable medical equipment providers.
    - Emergency and non-emergency medical transportation service providers.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- Local education agencies and school based health providers.

EFFECTIVE DATE: This act would be effective when it becomes law.

BACKGROUND: The North Caroline Health Information Exchange was first authorized and funded in S.L. 2015-241 (the 2015 Appropriations Act). Deadlines for certain providers were set forth in that Act. The deadlines were updated in S.L. 2017-57 (the 2017 Appropriations Act) and S.L. 2018-41.

**Samantha Yarborough, Staff Attorney, substantially contributed to this summary.*

HOUSE BILL 70
Committee Substitute Favorable 3/12/19

Short Title: Delay NC HealthConnex for Certain Providers. (Public)

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The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-414.4 reads as rewritten:

"**§ 90-414.4. Required participation in HIE Network for some providers.**

(a) Findings. – The General Assembly makes the following findings:

(1) That controlling escalating health care costs of the Medicaid program and other State-funded health services is of significant importance to the State, its taxpayers, its Medicaid recipients, and other recipients of State-funded health services.

(2) That the State ~~needs~~ and covered entities in North Carolina need timely access to certain demographic and clinical information pertaining to services rendered to Medicaid and other State-funded health care program beneficiaries and paid for with Medicaid or other State-funded health care funds in order to assess performance, improve health care outcomes, pinpoint medical expense trends, identify beneficiary health risks, and evaluate how the State is spending money on Medicaid and other State-funded health services.

(3) That making demographic and clinical information available to the State and covered entities in North Carolina by secure electronic means as set forth in subsection (b) of this section ~~will, with respect to Medicaid and other State-funded health care programs,~~ will improve care coordination within and across health systems, increase care quality for such beneficiaries, enable more effective population health management, reduce duplication of medical services, augment syndromic surveillance, allow more accurate measurement of care services and outcomes, increase strategic knowledge about the health of the population, and facilitate health care cost containment.

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and paid for with Medicaid or other State-funded health care funds in accordance with the following time line:

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  a. Hospitals as defined in G.S. 131E-176(13).
  b. Physicians licensed to practice under Article 1 of Chapter 90 of the General ~~Statutes.~~Statutes, except for licensed physicians whose primary area of practice is psychiatry.
  c. Physician assistants as defined in 21 NCAC 32S.0201.
  d. Nurse practitioners as defined in 21 NCAC 36.0801.

(2) Except as provided in subdivisions (3), (4), ~~and (5)~~ (5), and (6) of this subsection, all other providers of Medicaid and State-funded health care services shall begin submitting demographic and clinical data by June 1, ~~2019.~~2020.

(3) The following entities shall submit encounter and claims data, as appropriate, in accordance with the following time line:
  a. Prepaid Health Plans, as defined in S.L. 2015-245, by the commencement date of a capitated contract with the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services as specified in S.L. 2015-245.
  b. Local management entities/managed care organizations, as defined in G.S. 122C-3, by June 1, 2020.

(4) The following entities shall begin submitting demographic and clinical data by June 1, 2021:
  a. Ambulatory surgical centers as defined in G.S. 131E-146.
  b. Dentists licensed under Article 2 of Chapter 90 of the General Statutes.
  c. Licensed physicians whose primary area of practice is psychiatry.

(5) The following entities shall begin submitting claims data by June 1, 2021:
  a. Pharmacies registered with the North Carolina Board of Pharmacy under Article 4A of Chapter 90 of the General Statutes.
  b. Reserved for future codification.

(6) Upon implementation of an electronic health record system or other technology solution enabling connectivity to the HIE Network, the following entities shall begin submitting demographic and clinical data by June 1 of the following fiscal year:
  a. State health care facilities operated by the Secretary of the Department of Health and Human Services, including State psychiatric hospitals, developmental centers, alcohol and drug treatment centers, neuro-medical treatment centers, and the Whitaker Psychiatric Treatment Facility.
  b. The State Laboratory of Public Health operated by the Department of Health and Human Services.

(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, 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 and the Department of Health and Human

Services 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 nor the Department of Health and Human Services shall grant an extension of time (i) to any provider or entity that fails to provide this information to both Departments, (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,~~ 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, 2021.~~ subdivision (6) of subsection (a1) of this section connecting to the HIE Network and commencing data submission later than the date specified in that subdivision. The Department of Information Technology shall consult with the Department of Health and Human Services 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.

(a3) Exemptions from Connecting to the HIE Network. – The Department of Health and Human Services shall establish a process, in consultation with the Department of Information Technology, for the Department of Health and Human Services to grant exemptions to providers of Medicaid and other State-funded health care services for whom acquiring and implementing an electronic health record system and connecting to the HIE Network as required by this section would constitute an undue hardship. In determining whether to grant a hardship exemption, the Department may consider, without limitation, the following: (i) a provider's impending retirement or closure; (ii) lack of access to affordable broadband capacity adequate to support implementation of electronic health record technology and connection to the HIE Network; (iii) lack of financial flexibility to acquire and implement health information technology solutions needed to connect to the HIE Network; and (iv) whether exclusion of the provider from Medicaid would result in a lack of access to care under the Department's network adequacy standards. The process for granting a hardship exception must include a written request by the provider to the Department setting forth the specific bases for, and nature of, the asserted undue hardship. The Department shall promptly notify the Department of Information Technology of providers granted hardship exemptions under the process established pursuant to this subsection.

...

(e) Connection is Voluntary for Certain Providers. – Notwithstanding the mandatory connection and data submission requirements in subsections (a1) and (b), respectively, the following providers who provide services to Medicaid and other State-funded health care program beneficiaries and who receive Medicaid or other State funds are not required to connect to the HIE Network or submit data. They may connect to the HIE Network and submit data voluntarily:

(1) Respiratory, rehabilitative, restorative, assistive technology, and intellectual and developmental disability service providers.
(2) Durable medical equipment providers.
(3) Personal care, community alternatives programs, including CAP/C and Innovations, private duty nursing, and Program of All-Inclusive Care for the Elderly (PACE) service providers.
(4) Home health providers.
(5) School-based health providers, Children's Developmental Services Agencies, NC Infant-Toddler Program service providers, and providers of the residential behavioral health program for children operated by the Secretary of the Department of Health and Human Services at Wright School.
(6) Speech, language, and hearing service providers.
(7) Hospice service providers.
(8) Respite care service providers.
(9) Non-emergency medical transportation services.

(10) Occupational and physical therapy service providers.

(f) Confidentiality of Data. – All data submitted to or through the HIE Network containing protected health information or personally identifying information that are in the possession of the Department of Information Technology or other agency of the State shall be confidential and shall not be public records pursuant to G.S. 132-1."

SECTION 2. G.S. 90-414.8 reads as rewritten:

"**§ 90-414.8. North Carolina Health Information Exchange Advisory Board.**

(a) Creation and Membership. – There is hereby established the North Carolina Health Information Exchange Advisory Board within the Department of Information Technology. The Advisory Board shall consist of the following ~~12~~ 14 members:

(1) The following ~~four~~ five members appointed by the President Pro Tempore of the Senate:
   a. A licensed physician in good standing and actively practicing in a medical specialty in this State.
   b. A patient representative.
   c. An individual with technical expertise in health data analytics.
   d. A representative of a behavioral health provider.
   e. A representative of a payor.

(2) The following ~~four~~ five members appointed by the Speaker of the House of Representatives:
   a. A representative of a critical access hospital.
   b. A representative of a federally qualified health center.
   c. An individual with technical expertise in health information technology.
   d. A representative of a health system or integrated delivery network.
   e. A licensed independent primary care physician in good standing and actively practicing in this State.

(3) The following ~~three~~ four ex officio, ~~nonvoting~~ voting members:
   a. The State Chief Information Officer or a designee.
   b. The Director of GDAC or a designee.
   c. The Secretary of Health and Human Services, or a designee.
   d. The Executive Administrator of the State Health Plan for Teachers and State Employees, or a designee.

~~(4) The following ex officio, voting member:~~
   ~~a. The Executive Administrator of the State Health Plan for Teachers and State Employees, or a designee.~~

...."

SECTION 3. G.S. 90-414.10 reads as rewritten:

"**§ 90-414.10. Continuing right to opt out; effect of opt out.**

...

(d) Except as otherwise permitted in ~~G.S. 90-414.9(a)(3),~~ G.S. 90-414.11(a)(3), or as required by law, the protected health information of an individual who has exercised the right to opt out may not be made accessible or disclosed to covered entities or any other person or entity through the HIE Network for any purpose.

...."

SECTION 4. This act is effective when it becomes law.

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 643 LOB

DATE: 5-22 **TIME:** 10 AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

	Page Name	Hometown	Sponsoring Senator
1.	Daniel Santos	Charlotte	Bishop
2.	Connor Booher	Asheville	Van Duyn
3.	Aidan Sher	Raleigh	Davis
4.	Ashton Susser	Salembury.	Jackson
5.	Clayton Cameron	Sanford	Burgin
6.	Garrett Cox	Kannapolis	Newton
7.	Matthew Fisher	Mooresville	Sawyer
8.			

es: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee

On

Health Care

May 22, 2019

Room 643, LOB

10:00 AM

Senate Sergeant at Arms:

HAL ROACH

CHARLES MARSALIS

ARCHIE SMITH

VISITOR SIGN-UP SHEET

Senate Committee

On

Health Care

May 22, 2019

10:00 am

PLEASE SIGN IN BELOW

NAME	BILL NUMBER
Dana Simpson	SA
[illegible]	CSS
Cody Hand	NCHA
Kari Barsness	BPS
Heidi Johnson	NCSA
Chris Lovell	PC
Joan Mercer	PC
Jamaica Pfister	UHS
Christine Craig	WakeMed
Ryan Blankenship	ComHealth
Daniel [illegible]	[illegible] Health
Lexi Unther	NCOA
Chip Rogers	NCMS
Kara Weisharr	SA

VISITOR SIGN-UP SHEET

Senate Committee

On

Health Care

May 22, 2019

10:00 am

PLEASE SIGN IN BELOW

NAME	BILL NUMBER
Michelle Topal	HB70
Valerie Arendt	NASW-NC
Fay Castillo	NASW-NC
Martha Turner-Quest	HB70 (NCPA)
Randolph C. Thomas	R. Lloyd & assoc.
Mike McBrierty	Pfizer
Dick Carlton	Law Off. of RHC PLLC
Mc Neil Chestnut	Atty @ LAW
Dallas Perkinson	Perkinson Law
Tom Vitalione	NC CHILD
John Nash	The Arc of NC
Jacob Orman	Fetzer Lee
Jeff Horton	NCSLA
Joyce Peters	CSS
Fay Lewis	NCAHP
Monique [illegible]	NMR
Kaitlin Rothacker	Brubaker & Assoc.

VISITOR SIGN-UP SHEET

Senate Committee

On

Health Care

May 22, 2019

10:00 am

PLEASE SIGN IN BELOW

NAME	BILL NUMBER
Mysha Evans	DRNC
Chester C. Farley, BSN, RN	HB 388
Marilyn Avila	CHS
Pier Prote	Brain Injury Advocacy Council
Carol Demity	Brain Injury Assn of NC (BIANC)
Floyd Sams	DeVivo & Sams
Laura DeVivo	DeVivo & Sams
Flint Beason	SEANC
Joel Lanier	CJH
[illegible]	Southern Health
Jennifer Mahan	ASNC
Ken Melton	KMA
Brian Perkins	Alliance Health
Pam Shipman	Bu Oct
Julia Adams Schweich	Oak City GR
Hattie Haywood	DHHS
Matt Gross	DHHS
Dave Richard	DHHS
Tabitha Bryant	DHHS

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

May 22, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Chris Hollis	CHI
Jan Stewart	IIANC
Harry Kaplan	MWC
Keri Burke	MWC

09-21-201

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SENATE COMMITTEE ON HEALTH CARE
Volume II
2019-20120 Long Session

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SB 361	**Health Care Expansion Act of 2019** Senators Krawiec, Bishop, Hise	*April 10, *May 2, & June 5 & 12, 2019
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Bill also found in Volume I of the Senate Health Care Committee 2019-2020 Long Session
****Bill heard a second time with a title and content change***

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NORTH CAROLINA GENERAL ASSEMBLY

SENATE HEALTH CARE
2019 – 2020 SESSION



Sen. Dan Bishop
Chair



Sen. Joyce Krawiec
Chair



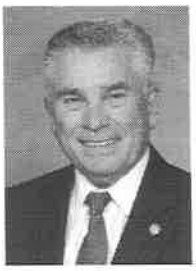
Sen. Deanna Ballard



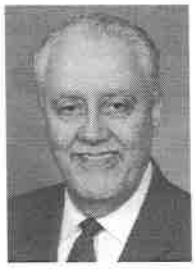
Sen. Jim Burgin



Sen. Don Davis



Sen. Jim Davis



Sen. Carl Ford



Sen. Valerie Foushee



Sen. Ralph Hise



Sen. Rick Horner



Sen. Jim Perry



Sen. Gladys Robinson



Sen. Vickie Sawyer



Sen. Terry Van Duyn



Sen. Mike Woodard

Senate Committee on Health Care
Thursday, May 23, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on May 23, 2019 in Room 643 of the Legislative Office Building. Nine members were present.

Senator Joyce Krawiec, Chair, presided.

Chris Tashner from Blowing Rock, Daniel Santos from Charlotte, Holden Bullock from Sylva, Leah Turner from Pikeville, Ashton Sasser from Salemburg, Jack Knott from Bald Head Island, Matthew Fisher from Mooresville, and Rory Boone from Raleigh served as pages.

HB 70 Delay NC HealthConnex for Certain Providers. (Representatives Dobson, White, Murphy, Lambeth)
The Proposed Committee Substitute (PCS) was before the committee from the meeting that was held the day prior. Sen. Hise brought forth an amendment and explained it. The committee voted in favor of the amendment. Sen. Robinson moved for an unfavorable report – favorable to the PCS as amended rolled into a new PCS and it carried.

The meeting adjourned at 10:16.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Thursday, May 23, 2019

Senator Krawiec,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

HB **70** **(CS#1)** Delay NC HealthConnex for Certain Providers.

Draft Number:	H70-PCS30463-MG-7
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Ralph Hise will handle HB 70



Senate Committee on Health Care
Thursday, May 23, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 70	Delay NC HealthConnex for Certain Providers.	Representative Dobson Representative White Representative Murphy Representative Lambeth

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 70

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H70-ABC-38 [v.2]

Amends Title [NO]
Second Edition

Date 5/23 ,2019

Senator Hise

moves to amend PCS H70-CSMG-7 [v.4] on page 2, lines 27-28 by inserting a line between the lines to read:

"d. The State Laboratory of Public Health operated by the Department of Health and Human Services.";

and on page 2, lines 37-38, by deleting the lines;

and on page 3, lines 10-11, by inserting a line between the lines to read:

"(a3) Exemptions from Connecting to the HIE Network. – The Secretary of Health and Human Services, or the Secretary's designee, shall have the authority to grant exemptions to classes of providers of Medicaid and other State-funded health care services for whom acquiring and implementing an electronic health record system and connecting to the HIE Network as required by this section would constitute an undue hardship. The Secretary, or the Secretary's designee, shall promptly notify the Department of Information Technology of classes of providers granted hardship exemptions under this subsection. Neither the Secretary nor the Secretary's designee shall grant any hardship exemption that would result in any class of provider connecting to the HIE Network and submitting data later than December 31, 2022.";

and on page 3, line 18, by rewriting the line to read:

"personal care services, private duty nursing, home health, and hospice care providers.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

H70-ABC-38-V-2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H D

HOUSE BILL 70
Committee Substitute Favorable 3/12/19
PROPOSED SENATE COMMITTEE SUBSTITUTE H70-CSMG-7 [v.4]
05/21/2019 10:39:32 AM

Short Title: Delay NC HealthConnex for Certain Providers. (Public)

Sponsors:

Referred to:

February 14, 2019

A BILL TO BE ENTITLED

AN ACT EXTENDING THE DEADLINES BY WHICH CERTAIN PROVIDERS ARE REQUIRED TO CONNECT TO AND PARTICIPATE IN NORTH CAROLINA'S HEALTH INFORMATION EXCHANGE NETWORK KNOWN AS NC HEALTHCONNEX AND EXPANDING THE MEMBERSHIP OF THE NORTH CAROLINA HEALTH INFORMATION EXCHANGE ADVISORY BOARD.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-414.4 reads as rewritten:

"**§ 90-414.4. Required participation in HIE Network for some providers.**

(a) Findings. – The General Assembly makes the following findings:

(1) That controlling escalating health care costs of the Medicaid program and other State-funded health care services is of significant importance to the State, its taxpayers, its Medicaid recipients, and other recipients of State-funded health care services.

(2) That the State ~~needs~~ and covered entities in North Carolina need timely access to certain demographic and clinical information pertaining to services rendered to Medicaid and other State-funded health care program beneficiaries and paid for with Medicaid or other State-funded health care funds in order to assess performance, improve health care outcomes, pinpoint medical expense trends, identify beneficiary health risks, and evaluate how the State is spending money on Medicaid and other State-funded health care services.

(3) That making demographic and clinical information available to the State and covered entities in North Carolina by secure electronic means as set forth in subsection (b) of this section ~~will, with respect to Medicaid and other State-funded health care programs,~~ will improve care coordination within and across health systems, increase care quality for such beneficiaries, enable more effective population health management, reduce duplication of medical services, augment syndromic surveillance, allow more accurate measurement of care services and outcomes, increase strategic knowledge about the health of the population, and facilitate health care cost containment.

(a1) Mandatory Connection to HIE Network. – Notwithstanding the voluntary nature of the HIE Network under G.S. 90-414.2, the following providers and entities shall be connected to the HIE Network and begin submitting data through the HIE Network pertaining to services rendered to Medicaid beneficiaries and to other State-funded health care program beneficiaries

and paid for with Medicaid or other State-funded health care funds in accordance with the following time line:

(1) The following providers of Medicaid services licensed to operate in the State that have an electronic health record system shall begin ~~submitting~~ submitting, at a minimum, demographic and clinical data by June 1, 2018:
  a. Hospitals as defined in G.S. 131E-176(13).
  b. Physicians licensed to practice under Article 1 of Chapter 90 of the General ~~Statutes.~~Statutes, except for licensed physicians whose primary area of practice is psychiatry.
  c. Physician assistants as defined in 21 NCAC 32S.0201.
  d. Nurse practitioners as defined in 21 NCAC 36.0801.

(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, ~~2019.~~2020.

(3) The following entities shall submit encounter and claims data, as appropriate, in accordance with the following time line:
  a. Prepaid Health Plans, as defined in S.L. 2015-245, by the commencement date of a capitated contract with the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services as specified in S.L. 2015-245.
  b. Local management entities/managed care organizations, as defined in G.S. 122C-3, by June 1, 2020.

(4) The following entities shall begin submitting demographic and clinical data by June 1, 2021:
  a. Ambulatory surgical centers as defined in G.S. 131E-146.
  b. Dentists licensed under Article 2 of Chapter 90 of the General Statutes.
  c. Licensed physicians whose primary area of practice is psychiatry.

(5) The following entities shall begin submitting claims data by June 1, 2021:
  a. Pharmacies registered with the North Carolina Board of Pharmacy under Article 4A of Chapter 90 of the General Statutes.
  b. State health care facilities operated under the jurisdiction of the Secretary of the Department of Health and Human Services, including State psychiatric hospitals, developmental centers, alcohol and drug treatment centers, neuro-medical treatment centers, and residential programs for children such as the Wright School and the Whitaker Psychiatric Residential Treatment Facility.
  c. The State Laboratory of Public Health operated by the Department of Health and Human Services.

(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,~~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 and~~Technology, the Department of Health and Human ~~Services~~ 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 nor~~Technology, the Department of Health and Human ~~Services~~ 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,~~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, 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, ~~2021.~~ 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.

...

(e) Voluntary Connection for Certain Providers. – Notwithstanding the mandatory connection and data submission requirements in subsections (a1) and (b) of this section, the following providers of Medicaid services or other State-funded health care services are not required to connect to the HIE Network or submit data, but may connect to the HIE Network and submit data voluntarily:

(1) Community-based long-term services and supports providers, including personal care services, private duty nursing, and hospice care providers.

(2) Intellectual and developmental disability services and supports providers, such as day supports and supported living providers.

(3) Community Alternatives Program waiver services (including CAP/DA, CAP/C, and Innovations) providers.

(4) Eye and vision services providers.

(5) Speech, language, and hearing services providers.

(6) Occupational and physical therapy providers.

(7) Durable medical equipment providers.

(8) Non-emergency medical transportation service providers.

(9) Ambulance (emergency medical transportation service) providers.

(10) Local education agencies and school-based health providers.

(f) Confidentiality of Data. – All data submitted to or through the HIE Network containing protected health information, personally identifying information, or a combination of these, that are in the possession of the Department of Information Technology or any other agency of the State are confidential and shall not be defined as public records under G.S. 132-1. This subsection shall not be construed to prohibit the disclosure of any such data as otherwise permitted under federal law."

SECTION 2. G.S. 90-414.10(d) reads as rewritten:

"(d) Except as otherwise permitted in ~~G.S. 90-414.9(a)(3),~~ G.S. 90-414.11(a)(3), or as required by law, the protected health information of an individual who has exercised the right to opt out may not be made accessible or disclosed to covered entities or any other person or entity through the HIE Network for any purpose."

SECTION 3. This act is effective when it becomes law.

HOUSE BILL 70:
Delay NC HealthConnex for Certain Providers.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	May 21, 2019
Introduced by:	Reps. Dobson, White, Murphy, Lambeth	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	PCS to Second Edition H70-CSMG-7		

OVERVIEW: ***The PCS to House Bill 70 would amend G.S. 90-414.4 to (1) extend the deadline by which providers not mentioned elsewhere in the statute have to connect to the Health Information Exchange (HIE) to June 1, 2020, (2) allow psychiatrists until June 1, 2021, before they are required to connect, (3) allow DHHS to extend the connection deadline for providers making a good faith effort to connect to June 1, 2020, and (4) make connection to the HIE voluntary for several types of providers.***

CURRENT LAW: Currently, G.S. 90-414.4(a1) requires most providers who provide services to Medicaid beneficiaries to submit demographic and clinical data through the HIE by June 1, 2019. G.S. 90-414.4(a2) allows DHHS and DIT to grant extensions to most providers through June 1, 2020. All providers of Medicaid or State-funded care are required to connect to the HIE.

The current HIE Advisory Board has 12 members, including three ex-officio, non-voting members.

BILL ANALYSIS: The PCS to House Bill 70 would amend G.S. 90-414.4 in the following ways:

- Extend the deadline for most providers to connect to the HIE through June 1, 2020.
- Extend the connection deadline for psychiatrists until June 1, 2021.
- Allow all providers to request an extension deadline of June 1, 2020, from DHHS.
- Make connection to the HIE voluntary for the following providers:
    - Community-based, long-term services and supports providers.
    - Intellectual and developmental disability services and supports providers..
    - Community Alternatives Program waiver services (including CAP/DA, CAP/C, and Innovations) providers.
    - Eye and vision services providers.
    - Speech, language, and hearing services providers.
    - Occupational and physical therapy providers.
    - Durable medical equipment providers.
    - Emergency and non-emergency medical transportation service providers.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- Local education agencies and school based health providers.

EFFECTIVE DATE: This act would be effective when it becomes law.

BACKGROUND: The North Caroline Health Information Exchange was first authorized and funded in S.L. 2015-241 (the 2015 Appropriations Act). Deadlines for certain providers were set forth in that Act. The deadlines were updated in S.L. 2017-57 (the 2017 Appropriations Act) and S.L. 2018-41.

**Samantha Yarborough, Staff Attorney, substantially contributed to this summary.*

HOUSE BILL 70
Committee Substitute Favorable 3/12/19

Short Title: Delay NC HealthConnex for Certain Providers. (Public)

Sponsors:

Referred to:

February 14, 2019

A BILL TO BE ENTITLED

AN ACT EXTENDING THE DEADLINES BY WHICH CERTAIN PROVIDERS ARE REQUIRED TO CONNECT TO AND PARTICIPATE IN NORTH CAROLINA'S HEALTH INFORMATION EXCHANGE NETWORK KNOWN AS NC HEALTHCONNEX AND EXPANDING THE MEMBERSHIP OF THE NORTH CAROLINA HEALTH INFORMATION EXCHANGE ADVISORY BOARD.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-414.4 reads as rewritten:

"**§ 90-414.4. Required participation in HIE Network for some providers.**

(a) Findings. – The General Assembly makes the following findings:

(1) That controlling escalating health care costs of the Medicaid program and other State-funded health services is of significant importance to the State, its taxpayers, its Medicaid recipients, and other recipients of State-funded health services.

(2) That the State ~~needs~~ and covered entities in North Carolina need timely access to certain demographic and clinical information pertaining to services rendered to Medicaid and other State-funded health care program beneficiaries and paid for with Medicaid or other State-funded health care funds in order to assess performance, improve health care outcomes, pinpoint medical expense trends, identify beneficiary health risks, and evaluate how the State is spending money on Medicaid and other State-funded health services.

(3) That making demographic and clinical information available to the State and covered entities in North Carolina by secure electronic means as set forth in subsection (b) of this section ~~will, with respect to Medicaid and other State-funded health care programs,~~ will improve care coordination within and across health systems, increase care quality for such beneficiaries, enable more effective population health management, reduce duplication of medical services, augment syndromic surveillance, allow more accurate measurement of care services and outcomes, increase strategic knowledge about the health of the population, and facilitate health care cost containment.

(a1) Mandatory Connection to HIE Network. – Notwithstanding the voluntary nature of the HIE Network under G.S. 90-414.2, the following providers and entities shall be connected to the HIE Network and begin submitting data through the HIE Network pertaining to services rendered to Medicaid beneficiaries and to other State-funded health care program beneficiaries

and paid for with Medicaid or other State-funded health care funds in accordance with the following time line:

(1) The following providers of Medicaid services licensed to operate in the State that have an electronic health record system shall begin ~~submitting~~ submitting, at a minimum, demographic and clinical data by June 1, 2018:
  a. Hospitals as defined in G.S. 131E-176(13).
  b. Physicians licensed to practice under Article 1 of Chapter 90 of the General ~~Statutes.~~Statutes, except for licensed physicians whose primary area of practice is psychiatry.
  c. Physician assistants as defined in 21 NCAC 32S.0201.
  d. Nurse practitioners as defined in 21 NCAC 36.0801.

(2) Except as provided in subdivisions (3), (4), ~~and (5)~~ (5), and (6) of this subsection, all other providers of Medicaid and State-funded health care services shall begin submitting demographic and clinical data by June 1, ~~2019.~~2020.

(3) The following entities shall submit encounter and claims data, as appropriate, in accordance with the following time line:
  a. Prepaid Health Plans, as defined in S.L. 2015-245, by the commencement date of a capitated contract with the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services as specified in S.L. 2015-245.
  b. Local management entities/managed care organizations, as defined in G.S. 122C-3, by June 1, 2020.

(4) The following entities shall begin submitting demographic and clinical data by June 1, 2021:
  a. Ambulatory surgical centers as defined in G.S. 131E-146.
  b. Dentists licensed under Article 2 of Chapter 90 of the General Statutes.
  c. Licensed physicians whose primary area of practice is psychiatry.

(5) The following entities shall begin submitting claims data by June 1, 2021:
  a. Pharmacies registered with the North Carolina Board of Pharmacy under Article 4A of Chapter 90 of the General Statutes.
  b. Reserved for future codification.

(6) Upon implementation of an electronic health record system or other technology solution enabling connectivity to the HIE Network, the following entities shall begin submitting demographic and clinical data by June 1 of the following fiscal year:
  a. State health care facilities operated by the Secretary of the Department of Health and Human Services, including State psychiatric hospitals, developmental centers, alcohol and drug treatment centers, neuro-medical treatment centers, and the Whitaker Psychiatric Treatment Facility.
  b. The State Laboratory of Public Health operated by the Department of Health and Human Services.

(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, 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 and the Department of Health and Human

Services 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 nor the Department of Health and Human Services shall grant an extension of time (i) to any provider or entity that fails to provide this information to both Departments, (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,~~ 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, 2021.~~ subdivision (6) of subsection (a1) of this section connecting to the HIE Network and commencing data submission later than the date specified in that subdivision. The Department of Information Technology shall consult with the Department of Health and Human Services 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.

(a3) Exemptions from Connecting to the HIE Network. – The Department of Health and Human Services shall establish a process, in consultation with the Department of Information Technology, for the Department of Health and Human Services to grant exemptions to providers of Medicaid and other State-funded health care services for whom acquiring and implementing an electronic health record system and connecting to the HIE Network as required by this section would constitute an undue hardship. In determining whether to grant a hardship exemption, the Department may consider, without limitation, the following: (i) a provider's impending retirement or closure; (ii) lack of access to affordable broadband capacity adequate to support implementation of electronic health record technology and connection to the HIE Network; (iii) lack of financial flexibility to acquire and implement health information technology solutions needed to connect to the HIE Network; and (iv) whether exclusion of the provider from Medicaid would result in a lack of access to care under the Department's network adequacy standards. The process for granting a hardship exception must include a written request by the provider to the Department setting forth the specific bases for, and nature of, the asserted undue hardship. The Department shall promptly notify the Department of Information Technology of providers granted hardship exemptions under the process established pursuant to this subsection.

...

(e) Connection is Voluntary for Certain Providers. – Notwithstanding the mandatory connection and data submission requirements in subsections (a1) and (b), respectively, the following providers who provide services to Medicaid and other State-funded health care program beneficiaries and who receive Medicaid or other State funds are not required to connect to the HIE Network or submit data. They may connect to the HIE Network and submit data voluntarily:

(1) Respiratory, rehabilitative, restorative, assistive technology, and intellectual and developmental disability service providers.
(2) Durable medical equipment providers.
(3) Personal care, community alternatives programs, including CAP/C and Innovations, private duty nursing, and Program of All-Inclusive Care for the Elderly (PACE) service providers.
(4) Home health providers.
(5) School-based health providers, Children's Developmental Services Agencies, NC Infant-Toddler Program service providers, and providers of the residential behavioral health program for children operated by the Secretary of the Department of Health and Human Services at Wright School.
(6) Speech, language, and hearing service providers.
(7) Hospice service providers.
(8) Respite care service providers.
(9) Non-emergency medical transportation services.

(10) Occupational and physical therapy service providers.

(f) Confidentiality of Data. – All data submitted to or through the HIE Network containing protected health information or personally identifying information that are in the possession of the Department of Information Technology or other agency of the State shall be confidential and shall not be public records pursuant to G.S. 132-1."

SECTION 2. G.S. 90-414.8 reads as rewritten:

"**§ 90-414.8. North Carolina Health Information Exchange Advisory Board.**

(a) Creation and Membership. – There is hereby established the North Carolina Health Information Exchange Advisory Board within the Department of Information Technology. The Advisory Board shall consist of the following ~~12~~ 14 members:

(1) The following ~~four~~ five members appointed by the President Pro Tempore of the Senate:
   a. A licensed physician in good standing and actively practicing in a medical specialty in this State.
   b. A patient representative.
   c. An individual with technical expertise in health data analytics.
   d. A representative of a behavioral health provider.
   e. A representative of a payor.

(2) The following ~~four~~ five members appointed by the Speaker of the House of Representatives:
   a. A representative of a critical access hospital.
   b. A representative of a federally qualified health center.
   c. An individual with technical expertise in health information technology.
   d. A representative of a health system or integrated delivery network.
   e. A licensed independent primary care physician in good standing and actively practicing in this State.

(3) The following ~~three~~ four ex officio, ~~nonvoting~~ voting members:
   a. The State Chief Information Officer or a designee.
   b. The Director of GDAC or a designee.
   c. The Secretary of Health and Human Services, or a designee.
   d. The Executive Administrator of the State Health Plan for Teachers and State Employees, or a designee.

~~(4) The following ex officio, voting member:~~
   ~~a. The Executive Administrator of the State Health Plan for Teachers and State Employees, or a designee.~~

...."

SECTION 3. G.S. 90-414.10 reads as rewritten:

"**§ 90-414.10. Continuing right to opt out; effect of opt out.**

...

(d) Except as otherwise permitted in ~~G.S. 90-414.9(a)(3),~~ G.S. 90-414.11(a)(3), or as required by law, the protected health information of an individual who has exercised the right to opt out may not be made accessible or disclosed to covered entities or any other person or entity through the HIE Network for any purpose.

...."

SECTION 4. This act is effective when it becomes law.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Visitors Sign-in

SENATE HEALTH CARE COMMITTEE

May 23, 2019 10:00 AM Rm. 643

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
Flint Benson	SEANC
April Harley	NFP
John M[illegible] LF	Policy Group
Nate Denny	NCDIT
Sallie James	Governor's office
Jacob Orman	Fetzer Lee
Sue Ferre	NCMJ
Cassidy Robertson	AHCL
Sarah McC[illegible]	KCAT
Sarah Patterson	WM
LAURA PURYEAR	AFNC
MO HEATH	MHC
Hattie Gawande	DHHS
Matt Gross	DHHS

09-22-2016

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Visitors Sign-in

SENATE HEALTH CARE COMMITTEE

May 23, 2019 10:00 AM Rm. 643

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
Jason Joyner	New Frame
Adam Prudhomme	NCAFCC
Courtney Crowder	CCL
Fiona Bolton	NCRMA

09-22-2016

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 643 LOB

DATE: 5-23 **TIME:** 10^A

PLEASE PRINT LEGIBLY....*or else!!!!!*

	Page Name	Hometown	Sponsoring Senator	
1.	Chris Tashner	Blowing Rock	Daniel	✓
2.	Daniel Santos	Charlotte	Bishop	
3.	Holden Bullock	Sylva	J. Davis	✓
4.	Leah Turner	Pikeville	Perry	✓
5.	Ashton Sasser	Salemburg	B. Jackson	
6.	Jack Knott	Bald Head Island	Rabon	✓
7.	Matthew Fisher	Mooresville	Sawyer	✓
8.	Rory Boone	Raleigh	Fitch	✓

ages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

SENATE SERGEANT-AT-ARMS

SENATE HEALTH CARE COMMITTEE

DATE: 05-23-2019 ROOM: 643

10:00 AM

SENATE SERGEANT AT ARMS

Jim Hamilton

Dwight Green

Frank Urben

Senate Committee on Health Care
Wednesday, June 5, 2019 at 10:00 AM
Room 421 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 5, 2019 in Room 421 of the Legislative Office Building. Nine members were present.

Senator Joyce Krawiec, Chair, presided.

Senator Krawiec asked Senator Jim Burgin to stand in as chair for this meeting.

Mary Elizabeth Morris from Hookerton, Miller Andrews from Snow Hill, Jophia Singer from High Point, Caroline Harper from Raleigh, Ty McLaughlin from Rolesville, and Jamie Wenzel from West End served as pages.

Sen. Burgin announced that bills will be heard out of order from the Agenda and below reflects the change.

HB 548 Modify Physical Therapy Definition. (Representatives Grange, Torbett, White, Dobson)
Representative Grange was recognized to explain the bill. There were no questions from the members. Senator Krawiec moved for a favorable report and it carried. Sen. Jim Davis will manage the bill on the senate floor.

SB 361 Health Care Expansion Act of 2019. (Senators Krawiec, Bishop, Hise)
Senator Burgin announced that this bill was for discussion only. Senator Ballard moved that the Proposed Committee Substitute (PCS) be brought before the committee to be considered and it carried. Senator Krawiec was introduced to explain the PCS. Questions from the members were responded to by Senator Krawiec, Senator Bishop, Jessica Boney an attorney from the Legislative Analysis Division, and Jeff Horton from the North Carolina Senior Living Association. Senator Burgin allowed comments from visitors and they were as follows: Mark Fleming/Blue Cross Blue Shield, Leah Burns/NCHA, Connie Wilson/NCOA, Lu-Ann Perryman/DLC & Associates, and Payton Maynard/Developmental Disabilities Facilities Association Incorporated.

The meeting adjourned at 10:39 AM.

Senator Jim Burgin, Acting Chair
Presiding

Debbie Lown, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Wednesday, June 05, 2019

Senator Krawiec,
submits the following with recommendations as to passage:

FAVORABLE

HB **548** Modify Physical Therapy Definition.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

Sen. Jim Burgin stood in as chair.

Senator Jim Davis will handle HB 548



Senate Committee on Health Care
Wednesday, June 5, 2019, 10:00 AM
421 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 361	Health Care Expansion Act of 2019. For discussion only.	Senator Krawiec Senator Bishop Senator Hise
HB 548	Modify Physical Therapy Definition.	Representative Grange Representative Torbett Representative White Representative Dobson

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S D

SENATE BILL 361
PROPOSED COMMITTEE SUBSTITUTE S361-CSBC-41 [v.6]
06/04/2019 04:54:32 PM

Short Title: Health Care Expansion Act of 2019. (Public)

Sponsors:

Referred to:

March 27, 2019

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS REFORMS THAT WILL INCREASE ACCESS TO HEALTH CARE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

PART I. REFORM NORTH CAROLINA'S CERTIFICATE OF NEED LAWS

SECTION 1.(a) G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

...

(2) "Bed capacity" means space used exclusively for inpatient ~~care,~~ care at a health service facility, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage. ~~The term "bed capacity" also refers to the number of dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~

...

(5) "Change in bed capacity" means (i) any relocation of health service facility ~~beds, or dialysis stations~~ beds from one licensed facility or campus to another, or (ii) any redistribution of health service facility bed capacity among the categories of health service facility bed as defined in G.S. 131E-176(9c), or (iii) any increase in the number of health service facility ~~beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~beds.

...

(9a) "Health service" means an organized, interrelated medical, diagnostic, therapeutic, ~~and/or~~ or rehabilitative ~~activity~~ activity, or any combination of these, that is integral to the prevention of disease or the clinical management of a sick, injured, or disabled person. "Health service" does not include administrative and other activities that are not integral to clinical ~~management.~~management, or any activities performed at a facility that does not meet the definition of a health service facility.

(9b) "Health service facility" means 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 the mentally retarded;~~ home health agency office; ~~chemical dependency treatment facility; diagnostic center;~~ hospice office, hospice inpatient facility, and hospice residential care ~~facility; and ambulatory surgical~~ facility. The term "health service facility" does not include a licensable facility, as defined in G.S. 122C-3(14)b.

(9c) "Health service facility bed" means 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) intermediate care beds for the mentally retarded; (vi) chemical dependency treatment beds; (vii)~~ (iv) hospice inpatient facility beds; ~~(viii)~~ (v) hospice residential care facility beds; ~~(ix)~~ (vi) adult care home beds; and ~~(x)~~ or (vii) long-term care hospital beds.

...

(14a) ~~"Intermediate care facility for the mentally retarded"~~ "Intermediate care facility for individuals with intellectual disabilities" means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for persons with ~~mental retardation,~~ intellectual disabilities, autism, cerebral palsy, epilepsy or related conditions.

...

(16) "New institutional health services" means any of the following:

...

d. The offering of ~~dialysis services or~~ home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.

...

~~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.~~

...

~~u. The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.~~

~~v. The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is reflected on the health service facility's license in effect as of January 1, 2005.~~

...."

SECTION 1.(b) G.S. 131E-177 reads as rewritten:

"**§ 131E-177. Department of Health and Human Services is designated State Health Planning and Development Agency; powers and duties.**

The Department of Health and Human Services is designated as the State Health Planning and Development Agency for the State of North Carolina, and is empowered to exercise the following powers and duties:

(1) To establish standards and criteria or plans required to carry out the provisions and purposes of this Article and to adopt rules pursuant to Chapter 150B of the General Statutes, to carry out the purposes and provisions of this ~~Article;~~Article.

(2) Adopt, amend, and repeal such rules and regulations, consistent with the laws of this State, as may be required by the federal government for grants-in-aid for health service facilities and health planning which may be made available by the federal government. This section shall be liberally construed in order that the State and its citizens may benefit from such ~~grants-in-aid;~~grants-in-aid.

(3) Define, by rule, procedures for submission of periodic reports by persons or health service facilities subject to agency review under this ~~Article;~~Article.

(4) ~~Develop~~ With respect to health service facilities planning, all of the following:

a. Develop policy, criteria, and standards for health service facilities ~~planning; shall conduct~~ planning.

b. Conduct statewide registration and inventories of and make determinations of need for health service facilities, health services as specified in G.S. 131E-176(16)f., and equipment as specified in G.S. 131E-176(16)f1., which shall include consideration of adequate geographic location of equipment and ~~services; and develop~~ services.

c. Develop a State Medical Facilities ~~Plan;~~Plan, provided, however, that the State Medical Facilities Plan shall not include policies or need determinations that limit the number of operating rooms or gastrointestinal endoscopy rooms.

(5) Implement, by rule, criteria for project ~~review;~~review.

(6) Have the power to grant, deny, or withdraw a certificate of need and to impose such sanctions as are provided for by this ~~Article;~~Article.

(7) Solicit, accept, hold and administer on behalf of the State any grants or devises of money, securities or property to the Department for use by the Department in the administration of this ~~Article; and~~Article.

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

(9) Collect fees for submitting applications for certificates of need.

(10) The authority to review all records in any recording medium of any person or health service facility subject to agency review under this Article which pertain to construction and acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records the Department deems to be reasonably necessary to determine compliance with this Article.

The Secretary of Health and Human Services shall have final decision-making authority with regard to all functions described in this section."

SECTION 1.(c) 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:~~

~~(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.~~Department."

SECTION 1.(d) G.S. 131E-181 reads as rewritten:

"**§ 131E-181. Nature of certificate of need.**

...

(d) A recipient of a certificate of need shall complete the project authorized by the certificate of need within two years after the decision to issue the certificate of need becomes final. If the recipient does not complete the project authorized by the certificate of need within this two-year time period, the certificate of need for the authorized project expires the day after the two-year time period ends. A project authorized by a certificate of need is complete when the health service or the health service facility for which the certificate of need was issued is licensed and certified and is in material compliance with the representations made in the certificate of need application.

(e) The Department shall withdraw a certificate of need issued to any recipient that ceases operating the health service or health service facility included in that certificate of need for more than one year."

SECTION 1.(e) G.S. 131E-183(a)(1) reads as rewritten:

"(1) The proposed project 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 that may be approved."

SECTION 1.(f) G.S. 131E-184(c) reads as rewritten:

"(c) The Department shall exempt from certificate of need review any conversion of existing acute care beds to psychiatric ~~beds provided:~~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 and/or one or more of the Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities to provide psychiatric beds to patients referred by the contracting agency or agencies; and~~

~~(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.~~"

SECTION 1.(g) G.S. 131E-184(e)(1) reads as rewritten:

"(1) The proposed capital expenditure would:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding an existing:

1. Nursing home facility, or

2. Adult care home ~~facility, or~~facility; and

~~3. Intermediate care facility for the mentally retarded; and~~

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."

SECTION 1.(h) G.S. 131E-184 is amended by adding new subsections to read:

"(i) The Department shall exempt from certificate of need review the development, acquisition, construction, expansion, or replacement of a health service facility or health service that obtained certificate of need approval prior to October 1, 2019, as an ambulatory surgical facility, including an ambulatory surgical facility with one or more operating rooms or gastrointestinal endoscopy procedure rooms; a diagnostic center; kidney disease treatment center, including freestanding dialysis units; chemical dependency treatment facility; intermediate care facility for individuals with intellectual disabilities; psychiatric hospital; or any other licensable facility, as defined in G.S. 122C-3(14)b.

(j) The Department shall exempt from certificate of need review the establishment of a home health agency by a continuing care retirement community licensed under Article 64 of Chapter 58 of the General Statutes to provide home health services to one or more residents of a continuing care retirement community who have entered into a contract with the continuing care retirement community to receive continuing care services with lodging. A continuing care retirement community that seeks to provide home health services to individuals who do not reside at the continuing care retirement community pursuant to a contract to receive continuing care services with lodging shall be required to obtain a certificate of need as a home health agency prior to developing or offering home health services to any individual not a resident of the continuing care retirement community under a contract to receive continuing care services with lodging. As used in this subsection, the terms "continuing care" and "lodging" are as defined in G.S. 58-64-1. Nothing in this subsection shall be construed to exempt from the State's home health agency licensure and certification requirements a continuing care retirement community that has been exempted from certificate of need review for the provision of home health services to one or more residents pursuant to this subsection."

SECTION 1.(i) G.S. 131E-184(j), as enacted by this section, applies to continuing care retirement communities engaged in the direct provision of home health services on or after October 1, 2019.

SECTION 1.(j) G.S. 131E-186(a) reads as rewritten:

"(a) Within the prescribed time limits in G.S. 131E-185, the Department shall issue a decision to "approve," "approve with conditions," or "deny," an application for a new institutional health service. ~~Approvals involving new or expanded nursing care or intermediate care for the mentally retarded bed capacity shall include a condition that specifies the earliest possible date the new institutional health service may be certified for participation in the Medicaid program. The date shall be set far enough in advance to allow the Department to identify funds to pay for care in the new or expanded facility in its existing Medicaid budget or to include these funds in its State Medicaid budget request for the year in which Medicaid certification is expected.~~"

SECTION 1.(k) 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, any ~~affected person, as defined in subsection (c) of this section,~~

~~shall be~~ proponent of an application that was reviewed with the application for that certificate of need is 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 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 days after the assignment of the administrative law judge or hearing officer.

(3) The hearing at which sworn testimony is taken and evidence is presented shall be held within 45 days after the end of the discovery period.

(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.

...

(b) Any ~~affected~~ person 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 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 who were parties to the contested hearing. The Court of Appeals, in an action for judicial review brought under this section, shall award all costs of such action, including reasonable attorney's fees to the prevailing party. For the purpose of this subsection, reasonable attorney's fees include attorney's fees incurred during the administrative review portion of the contested case arising under Article 3 of Chapter 150B of the General Statutes.

(b1) Before filing an appeal of a final decision granting a certificate of need, the ~~affected person~~ appellant 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).~~ five hundred thousand dollars ($500,000). 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.

...

~~(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.~~"

SECTION 1.(*l*) G.S. 131E-147 is amended by adding a new subsection to read:

"(f) The Department shall not issue or renew a license to operate an ambulatory surgical facility developed, acquired, or replaced on or after October 1, 2019, unless the application includes all of the following:

(1) A commitment that the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least four percent (4%) of the total revenue collected for all surgical cases performed in the facility or proposed facility.

(2) For each year of operation, a commitment to report to the Department the total number of cases by each of the following payer categories:

a. Self-pay surgical cases.

b. Medicaid surgical cases.

c. Medicare surgical cases.

d. Commercial insurance surgical cases.

e. Managed care surgical cases.

f. Other surgical cases.

(3) A commitment to report utilization and payment data for services provided by the ambulatory surgical facility to the statewide data processor, as required by G.S. 131E-214.2."

SECTION 1.(m) G.S. 131E-175(11) and (12) are repealed.

SECTION 1.(n) This section becomes effective October 1, 2019.

PART II. PSYCHOLOGY INTERJURISDICTIONAL LICENSURE COMPACT

SECTION 2.(a) Article 18A of Chapter 90 of the General Statutes, G.S. 90-270.1 through G.S. 90-270.22, is recodified as Article 18G of Chapter 90 of the General Statutes, G.S. 90-270.135 through G.S. 90-270.159.

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

"Article 18H.

"Psychology Interjurisdictional Licensure Compact.

"**§ 90-270.160. Purpose.**

This Compact is designed to achieve the following purposes and objectives:

(1) Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology.

(2) Enhance the states' ability to protect the public's health and safety, especially client/patient safety.

(3) Encourage the cooperation of Compact States in the areas of psychology licensure and regulation.

(4) Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history.

(5) Promote compliance with the laws governing psychological practice in each Compact State.

(6) Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

"**§ 90-270.161. Definitions.**

(1) Adverse action. – Any action taken by a State Psychology Regulatory Authority which finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

(2) Association of State and Provincial Psychology Boards (ASPPB). – The recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

(3) Authority to Practice Interjurisdictional Telepsychology. – A licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

(4) Bylaws. – Those Bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to G.S. 90-270.169 for its governance or for directing and controlling its actions and conduct.

(5) Client/patient. – The recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services.

(6) Commissioner. – The voting representative appointed by each State Psychology Regulatory Authority pursuant to G.S. 90-270.169.

(7) Compact State. – A state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to G.S. 90-270.172(c) or been terminated pursuant to G.S. 90-270.171(b).

(8) Confidentiality. – The principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

(9) Coordinated Licensure Information System or Coordinated Database. – An integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(10) Day. – Any part of a day in which psychological work is performed.

(11) Distant State. – The Compact State where a psychologist is physically present (not through the use of telecommunications technologies) to provide temporary in-person, face-to-face psychological services.

(12) E.Passport. – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

(13) Executive Board. – A group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

(14) Home State. – A Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authority to Practice Interjurisdictional

Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

(15) Identity History Summary. – A summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

(16) In-person, face-to-face. – Interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

(17) Interjurisdictional Practice Certificate (IPC). – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily and verification of one's qualifications for such practice.

(18) License. – Authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

(19) Non-Compact State. – Any State which is not at the time a Compact State.

(20) Psychologist. – An individual licensed for the independent practice of psychology.

(21) Psychology Interjurisdictional Compact Commission (Commission). – The national administration of which all Compact States are members.

(22) Receiving State. – A Compact State where the client/patient is physically located when the telepsychological services are delivered.

(23) Rule. – A written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to G.S. 90-270.170 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal, or suspension of an existing rule.

(24) Significant investigatory information. –

a. Investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

b. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

(25) State. – A state, commonwealth, territory, or possession of the United States or the District of Columbia.

(26) State Psychology Regulatory Authority. – The Board, office, or other agency with the legislative mandate to license and regulate the practice of psychology.

(27) Telepsychology. – The provision of psychological services using telecommunication technologies.

(28) Temporary Authorization to Practice. – A licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

(29) Temporary in-person, face-to-face practice. – Where a psychologist is physically present (not through the use of telecommunications technologies) in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

"**§ 90-270.162. Home State licensure.**

(a) The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

(b) A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(c) Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(d) Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

(e) A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

(1) Currently requires the psychologist to hold an active E.Passport;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

(f) A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

(1) Currently requires the psychologist to hold an active IPC;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

"**§ 90-270.163. Compact privilege to practice telepsychology.**

(a) Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice telepsychology in other Compact States

(Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

(b) To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master's degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;

(4) Have no history of adverse action that violate the Rules of the Commission;

(5) Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;

(6) Possess a current, active E.Passport;

(7) Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background, and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

(8) Meet other criteria as defined by the Rules of the Commission.

(c) The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

(d) A psychologist practicing in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State is restricted, suspended, or otherwise limited, the E.Passport shall be revoked and, therefore, the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

"**§ 90-270.164. Compact Temporary Authorization to Practice.**

(a) Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

(b) To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;

(4) No history of adverse action that violates the Rules of the Commission;

(5) No criminal record history that violates the Rules of the Commission;

(6) Possess a current, active IPC;

(7) Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

(8) Meet other criteria as defined by the Rules of the Commission.

(c) A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

(d) A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State is restricted, suspended, or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

"**§ 90-270.165. Conditions of telepsychology practice in a Receiving State.**

A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

(1) The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State.

(2) Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

"**§ 90-270.166. Adverse actions.**

(a) A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

(b) A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

(c) If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

(1) All Home State disciplinary orders which impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

(2) In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

(3) Other actions may be imposed as determined by the Rules promulgated by the Commission.

(d) A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

(e) A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice which occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

(f) Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

(g) No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection (c) of this section.

"**§ 90-270.167. Additional authorities invested in a Compact State's Psychology Regulatory Authority.**

In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

(1) Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a Compact State's Psychology Regulatory Authority for the attendance and testimony of witnesses and/or the production of evidence from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

(2) Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

(3) During the course of any investigation, a psychologist may not change his/her Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his/her Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission.

All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal, and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

"**§ 90-270.168. Coordinated Licensure Information System.**

(a) The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

(b) Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

(1) Identifying information;
(2) Licensure data;
(3) Significant investigatory information;
(4) Adverse actions against a psychologist's license;
(5) An indicator that a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;
(6) Nonconfidential information related to alternative program participation information;
(7) Any denial of application for licensure and the reasons for such denial; and
(8) Other information which may facilitate the administration of this Compact, as determined by the Rules of the Commission.

(c) The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

(d) Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

(e) Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

"**§ 90-270.169. Establishment of the Psychology Interjurisdictional Compact Commission.**

(a) The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

(1) The Commission is a body politic and an instrumentality of the Compact States.
(2) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.
(3) Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting, and Meetings. –

(1) The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary, or similar executive;
b. Current member of the State Psychology Regulatory Authority of a Compact State; or
c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

(2) Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

(3) Each Commissioner shall be entitled to one vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

(4) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

(5) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rule-making provisions in G.S. 90-270.170.

(6) The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:
a. Noncompliance of a Compact State with its obligations under the Compact;
b. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;
c. Current, threatened, or reasonably anticipated litigation against the Commission;
d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;
e. Accusation against any person of a crime or formally censuring any person;
f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;
g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
h. Disclosure of investigatory records compiled for law enforcement purposes;
i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or
j. Matters specifically exempted from disclosure by federal and state statute.

(7) If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of

actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

(c) The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including, but not limited to:

(1) Establishing the fiscal year of the Commission;

(2) Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

(3) Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;

(4) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

(6) Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;

(7) Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

(8) The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto with the appropriate agency or officer in each of the Compact States;

(9) The Commission shall maintain its financial records in accordance with the Bylaws; and

(10) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(d) The Commission shall have the following powers:

(1) The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all Compact States;

(2) To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

(3) To purchase and maintain insurance and bonds;
(4) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compact State;
(5) To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;
(6) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of the same, provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;
(7) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the Commission shall strive to avoid any appearance of impropriety;
(8) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;
(9) To establish a budget and make expenditures;
(10) To borrow money;
(11) To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;
(12) To provide and receive information from, and to cooperate with, law enforcement agencies;
(13) To adopt and use an official seal; and
(14) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice, and telepsychology practice.

(e) The Executive Board. – The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact.
(1) The Executive Board shall be comprised of six members:
a. Five voting members who are elected from the current membership of the Commission by the Commission.
b. One ex officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.
(2) The ex officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.
(3) The Commission may remove any member of the Executive Board as provided in Bylaws.
(4) The Executive Board shall meet at least annually.
(5) The Executive Board shall have the following duties and responsibilities:
a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, or fees paid by Compact States such as annual dues and any other applicable fees;
b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;
d. Maintain financial records on behalf of the Commission;
e. Monitor Compact compliance of member states and provide compliance reports to the Commission;
f. Establish additional committees as necessary; and
g. Other duties as provided in Rules or Bylaws.

(f) Financing of the Commission. –

(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.

(2) The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(3) The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

(4) The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State.

(5) The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

(g) Qualified Immunity, Defense, and Indemnification. –

(1) The members, officers, Executive Director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(2) The Commission shall defend any member, officer, Executive Director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(3) The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

"**§ 90-270.170. Rule making.**

(a) The Commission shall exercise its rule-making powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

(c) Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

(d) Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rule Making:

(1) On the Web site of the Commission; and

(2) On the Web site of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

(e) The Notice of Proposed Rule Making shall include:

(1) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

(f) Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(g) The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

(1) At least 25 persons who submit comments independently of each other;

(2) A governmental subdivision or agency; or

(3) A duly appointed person in an association that has at least 25 members.

(h) If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

(1) All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.

(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(3) No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not

preclude the Commission from making a transcript or recording of the hearing if it so chooses.

(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

(j) The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rule-making record and the full text of the rule.

(k) If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

(l) Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rule-making procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety, or welfare;

(2) Prevent a loss of Commission or Compact State funds;

(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

(4) Protect public health and safety.

(m) The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the Web site of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

"**§ 90-270.171. Oversight, dispute resolution, and enforcement.**

(a) Oversight. –

(1) The executive, legislative, and judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

(2) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

(3) The Commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

(b) Default, Technical Assistance, and Termination. –

(1) If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default, and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

(2) If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States and all rights, privileges, and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(3) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.

(4) A Compact State which has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

(5) The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

(6) The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the State of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution. –

(1) Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States.

(2) The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the Commission.

(d) Enforcement. –

(1) The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

(2) By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(3) The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

"**§ 90-270.172. Date of implementation of the Psychology Interjurisdictional Compact Commission and associated rules, withdrawal, and amendments.**

(a) The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rule-making powers necessary to the implementation and administration of the Compact.

(b) Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

(c) Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

(1) A Compact State's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

(d) Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

(e) This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

"**§ 90-270.173. Construction and severability.**

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States."

SECTION 2.(c) Subsections (a) and (b) of this section become effective when at least seven states have enacted the Psychology Interjurisdictional Compact (PSYPACT) set forth in subsection (b) of this section. The North Carolina Psychology Board shall report to the Revisor of Statutes when the PSYPACT set forth in subsection (b) of this section has been enacted by seven member states.

PART III. ALLOW LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT FIRST-LEVEL EXAMINATIONS FOR INVOLUNTARY COMMITMENT AND CREATE FEES

SECTION 3.(a) G.S. 122C-263.1(a) reads as rewritten:

"**§ 122C-263.1. Secretary's authority to certify commitment examiners; training of certified commitment examiners performing first examinations; LME/MCO responsibilities.**

(a) Physicians and eligible psychologists are qualified to perform the commitment examinations required under G.S. 122C-263(c) and G.S. 122C-283(c). The Secretary of Health and Human Services may individually certify to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 other health, mental health, and substance abuse professionals whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment as follows:

(1) The Secretary has received a request:

a. To certify a licensed clinical social worker, a master's or higher level degree nurse practitioner, a licensed professional counsellor, a licensed marriage and family therapist, or a physician's assistant to

conduct the first examinations described in G.S. 122C-263(c) and G.S. 122C-283(c).

b. To certify a master's level licensed clinical addictions specialist to conduct the first examination described in G.S. 122C-283(c).

...

(5) In no event shall the certification of a licensed clinical social worker, master's or higher level degree nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or master's level certified clinical addictions specialist under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or the master's level certified clinical addictions specialist.

...."

SECTION 3.(b) G.S. 90-270.54 reads as rewritten:

"**§ 90-270.54. Requirements for licensure as a marriage and family therapist.**

...

(a1) The Board shall issue a license to conduct first examinations pursuant to G.S. 122C-263.1 to applicants who meet the criteria for licensure in subsection (a) and who pay a one-time, ten dollar ($10.00) fee.

..."

SECTION 3.(c) G.S. 90-270.57 reads as rewritten:

"**§ 90-270.57. Fees.**

(a) In order to fund the Board's activities under this Article, the Board may charge and collect fees not exceeding the following:

...

(10)	Application to perform first examinations pursuant to G.S. 122C-263.1	10.00.

In addition to the examination fee provided in subdivision (1) of this subsection, the Board may charge and collect from each applicant for license examination the cost of processing test results and the cost of test materials.

(b) The Board may establish fees for the actual cost of (i) document duplication services, (ii) materials, and (iii) returned bank items as allowed by law. All fees listed in subsection (a) of this section shall be nonrefundable."

SECTION 3.(d) This section is effective October 1, 2019. Sections 3.(b) and 3.(c) apply to applications submitted on or that date.

PART IV. ELIMINATE REDUNDANCY IN ADULT CARE HOME INSPECTIONS

SECTION 4. G.S. 131D-2.11(a) reads as rewritten:

"(a) State Inspection and Monitoring. – The Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. All facilities licensed under this Article and adult care units in nursing homes are subject to inspections at all times by the Secretary. Except as provided in subsection (a1) of this section, the Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis. Beginning July 1, 2012, the Division of Health Service Regulation shall include as part of its inspection of all adult care homes a review of the facility's compliance with G.S. 131D-4.4A(b) and safe practices for injections and any other procedures during which bleeding typically occurs. In addition, the Department shall ensure that adult care homes are inspected every two years to determine compliance with physical plant and life-safety requirements.

If the annual inspection of an adult care home is conducted separately from the inspection required every two years to determine compliance with physical plant and life-safety requirements, the Division of Health Service Regulation shall not cite, as part of the annual inspection, any violation of law that overlaps with an area addressed by the physical plant and life-safety inspection, unless failure to address the violation during the annual inspection would pose a risk to resident health or safety. Nothing in this section prevents a licensing inspector from referring a concern about physical plant and life-safety requirements to the section within the Division of Health Service Regulation that conducts physical plant and life-safety inspections."

PART V. SEVERABILITY CLAUSE AND EFFECTIVE DATE

SECTION 5.(a) If any section or 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 to be unconstitutional or invalid.

SECTION 5.(b) Except as otherwise provided, this act is effective when it becomes law.

SENATE BILL 361:
Health Care Expansion Act of 2019.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 4, 2019
Introduced by:	Sens. Krawiec, Bishop, Hise	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	PCS to First Edition S361-CSBC-41		

OVERVIEW: The Proposed Committee Substitute (PCS) to Senate Bill 361 would reform Certificate of Need (CON) Laws; enact the Psychology Interjurisdictional Licensure Compact (PSYPACT); allow marriage and family therapists to conduct the first-level exam for involuntary commitment and create marriage and family therapist licensure fees; and eliminate redundancy in adult care home inspections.

BILL ANALYSIS: The PCS to Senate Bill 361 would make the changes outlined below.

PART I. REFORM CERTIFICATE OF NEED LAWS would remove psychiatric facilities, kidney disease treatment centers, intermediate care facilities for individuals with intellectual disabilities, chemical dependency treatment facilities, diagnostic centers, and ambulatory surgical facilities from the list of health services that require a Certificate of Need. It would prevent the State Medical Facilities Plan from limiting the number of operating rooms or gastrointestinal endoscopy rooms. If the project authorized by a Certificate of Need were not completed within two years, the certificate would expire, and certificates issues to facilities that ceased to operate for more than a year would be withdrawn. Home health agencies operated by continuing care retirement communities would be exempt from CON review.

PART II. PSYCHOLOGY INTERJURISDICTIONAL LICENSURE COMPACT (PSYPACT)

Section 2(a) would recodify the current Psychology Practice Act, Article 18A of Chapter 90 of the General Statutes, as Article 18H of Chapter 90 of the General Statutes. **Section 2(b)** of the bill would enact the PSYPACT.

G.S. 90-270.160 would set forth the purpose of the PSYPACT.

G.S. 90-270.161 would establish definitions for the PSYPACT.

G.S. 90-270.162 would:

- Establish a psychologist's home state as the state in which the psychologist is licensed or physically present when practicing.
- Allow a psychologist to provide services, via telepsychology, to clients in other compact states, if those states:
    - Require the psychologist to hold an E.Passport.

- Investigate complaints against psychologists.
- Notify the PSYPACT Commission about adverse actions taken against psychologists.
- Comply with the by-laws of the Commission.
- Perform criminal background checks on psychologists.

- Allow a psychologist to provide face-to-face services in a compact state if that state:
  - Requires psychologists to hold a current Interjurisdictional Practice Certificate (IPC).
  - Investigates complaints against psychologists.
  - Notifies the PSYPACT Commission about adverse actions taken against psychologists.
  - Complies with the by-laws of the Commission.
  - Performs criminal background checks on psychologists.

G.S. 90-270.163 would allow a psychologist to practice telepsychology with clients in other compact states, provided that the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid E.Passport, and makes certain attestations.

Psychologists practicing under G.S. 90-270.163 would be subject to their home state's licensing authorities, and be subject to the compact state's rules regarding scope of practice.

G.S. 90-270.164 would allow a psychologist to practice psychology face-to-face with clients in compact states, provided the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid IPC, and makes certain attestations.

Psychologists practicing under G.S. 90-270.164 would be subject to the authority, law, and scope of practice of the compact state in which they are practicing.

G.S. 90-270.165 would allow a psychologist to practice telepsychology with patients in other compact states only when the psychologist initiates the session from the home state in which the psychologist is licensed.

G.S. 90-270.166 would allow home states, compact states in which a psychologist treats patients face-to-face, and states in which a psychologist practices via telepsychiatry to take adverse actions against the psychologist's license.

G.S. 90-270.167 would allow the regulatory authority in the compact states the power to:

- Issue subpoenas.
- Issue cease-and-desist orders.
- Prevent psychologists under investigation from changing their home state licensures.

G.S. 90-270.168 would allow the Commission to maintain a database containing the following data on licensed psychologists, which must be submitted by each compact state:

- Identifying information.
- Licensure data.
- Significant investigatory information.
- Information on adverse actions taken by the regulatory authority.

G.S. 90-270.169 would create the Psychology Interjurisdictional Compact Commission. Membership in the Commission would consist of one voting member from each compact state. All meetings of the Commission must be public unless employment, discipline, litigation, contract negotiation, or adverse action investigation are being discussed. The Commission would have all the powers necessary to administer and carry out the business of the PSYPACT.

The Commission may be financed by accepting gifts and levying assessments on member states.

Commission members would be immune from suit for their official actions.

G.S. 90-270.170 would give the Commission power to make rules for the compact. These rules would not affect the rules of practice established by the regulatory authorities of the member states. Rules may be approved by a majority vote of Commission members, and any rule rejected by the legislatures of a majority of member states would no longer have any effect.

G.S. 90-270.171 would establish oversight, default, and conflict resolution provisions for the PSYPACT.

- All branches of government of all member states must enforce the PSYPACT's purpose and intent.
- If a state is in default under the terms of the PSYPACT and refuses to cure that default, the Commission may terminate the state's membership in the PSYPACT.
- By a majority vote of members, the Commission may initiate legal action to enforce compliance with the rules of the PSYPACT.
- The Commission will attempt to resolve any dispute between member and non-member states.

G.S. 90-270.172 would:

- Make the PSYPACT effective on the date the seventh member state enacts it.
- Allow member states to leave the PSYPACT by repealing the act enacting it.
- Prevent the Commission from prohibiting any other licensure agreements between member states, so any reciprocity agreements between member states would still remain in effect.
- Allow member states to amend the PSYPACT; however, amendments would not take effect until the legislatures of all the member states enacted them.

G.S. 90-270.173 would require the PSYPACT to be construed liberally, and if any portions of the PSYPACT are struck down by a court, the remaining provisions would remain in effect.

PART III. ALLOW LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT FIRST-LEVEL EXAM FOR INVOLUNTARY COMMITMENT AND CREATE FEES would amend G.S. 122C-263.1 to permit licensed marriage and family therapists to conduct first examinations in involuntary commitment proceedings. It would create a ten dollar fee for licensure as a marriage and family therapist and allow the Board to charge each applicant the cost of processing test results and the cost of test materials.

PART IV. ELIMINATE REDUNDANCY IN ADULT CARE HOME INSPECTIONS would amend the statute pertaining to inspections, monitoring, and review of adult care homes. The amendment would provide that if the annual inspection of an adult care home is conducted separately from the physical plant and life-safety requirements inspection required every two years, the Division of Health Service Regulation, DHHS, is prohibited from citing a violation of law that overlaps with a physical plant and life-safety inspection area in the annual inspection unless failure to address poses a risk to resident health or safety.

PART V contains a severability clause.

EFFECTIVE DATE: Except as provided below, the bill would become effective when it becomes law:

- PART I would be effective January 1, 2020. Subsection (a) of Part I would be apply to contested cases arising on or after January 1, 2020.
- PART II would be effective when at least seven states have enacted the PSYPACT set forth in Part II.
- PART III would be effective October 1, 2019.

BACKGROUND:

PART I: Any new institutional health service, as defined in G.S. 131A-176(16), must undergo Certificate of Need review before it is offered. The process requires an application to the department of Health and Human Services, Division of Health Service Regulation. After the application is submitted, there is a public comment and hearing process before the Division approves or disapproves the application. In making a determination, the Division considers the needs identified in the State Medical Facilities Plan.

PART II: The PSYPACT is a multi-jurisdictional psychology compact. As of April 9, 2019, it has been enacted by seven states (Arizona, Nevada, Utah, Colorado, Nebraska, Missouri and Illinois). Though Illinois has enacted PSYPACT legislation, it does not become effective until January 1st, 2020, and therefore does not count as the seventh state needed to make PSYPACT operational. PSYPACT legislation is currently being considered in District of Columbia, Georgia, New Hampshire, Oklahoma, Pennsylvania, Rhode Island and Texas. It has been endorsed by the psychology licensing boards in seven states (New Mexico, Texas, Georgia, Ohio, Wisconsin, Virginia and Rhode Island). PSYPACT was recommended by the Joint Legislative Oversight Committee on Health and Human Services to the 2018 Session of the 2017 General Assembly of North Carolina.

PART III: G.S. 122C-263(c) requires that a commitment examiner conduct an examination of a respondent within 24 hours of the respondent being presented for involuntary commitment. This examination can be conducted in person or by using telemedicine procedures. After examining the respondent, the commitment examiner can recommend outpatient treatment, treatment at a 24-hour facility prior to a court hearing on commitment, or a termination of the commitment proceedings.

SENATE BILL 361

Short Title:	Health Care Expansion Act of 2019.	(Public)
Sponsors:	Senators Krawiec, Bishop, and Hise (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

March 27, 2019

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS REFORMS THAT WILL INCREASE ACCESS TO HEALTH CARE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

PART I. INCREASE INNOVATIONS WAIVER SLOTS

SECTION 1.(a) The Department of Health and Human Services, Division of Health Benefits, shall amend the North Carolina Innovations waiver to increase the number of slots available under the waiver by a maximum of 1,000 slots to be made available on January 1, 2020, and by a maximum of 1,000 slots to be made available on January 1, 2021.

SECTION 1.(b) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Health Benefits, the sum of ten million two hundred fifty thousand dollars ($10,250,000) in recurring funds for the 2019-2020 fiscal year and the sum of thirty million seven hundred fifty thousand dollars ($30,750,000) in recurring funds for the 2020-2021 fiscal year to be used to fund these additional slots.

PART II. REPEAL OF NORTH CAROLINA'S CERTIFICATE OF NEED LAWS

SECTION 2.(a) G.S. 6-19.1(a) reads as rewritten:

"(a) In any civil action, other than an adjudication for the purpose of establishing or fixing a rate, or a disciplinary action by a licensing board, brought by the State or brought by a party who is contesting State action pursuant to G.S. 150B-43 or any other appropriate provisions of law, unless the prevailing party is the State, the court may, in its discretion, allow the prevailing party to recover reasonable attorney's fees, including attorney's fees applicable to the administrative review portion of the case, in contested cases arising under Article 3 of Chapter 150B, to be taxed as court costs against the appropriate agency if:

(1) The court finds that the agency acted without substantial justification in pressing its claim against the party; and

(2) The court finds that there are no special circumstances that would make the award of attorney's fees unjust. The party shall petition for the attorney's fees within 30 days following final disposition of the case. The petition shall be supported by an affidavit setting forth the basis for the request.

~~Nothing in this section shall be deemed to authorize the assessment of attorney's fees for the administrative review portion of the case in contested cases arising under Article 9 of Chapter 131E of the General Statutes.~~

Nothing in this section grants permission to bring an action against an agency otherwise immune from suit or gives a right to bring an action to a party who otherwise lacks standing to bring the action.

Any attorney's fees assessed against an agency under this section shall be charged against the operating expenses of the agency and shall not be reimbursed from any other source."

SECTION 2.(b) G.S. 58-50-61(a) reads as rewritten:

"(a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:

...

(8) "Health care provider" means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes or the laws of another state to provide health care services in the ordinary care of business or practice or a profession or in an approved education or training program; a health care facility as defined in ~~G.S. 131E-176(9b)~~ this section or the laws of another state to operate as a health care facility; or a pharmacy.

...

(9a) "Health service facility" means 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, hospice inpatient facility, or hospice residential care facility; or ambulatory surgical facility.

...."

SECTION 2.(c) G.S. 58-55-35(a) reads as rewritten:

"(a) Whenever long-term care insurance provides coverage for the facilities, services, or physical or mental conditions listed below, unless otherwise defined in the policy and certificate, and approved by the Commissioner, such facilities, services, or conditions are defined as follows:

...

(10) "Hospice" ~~shall be defined in accordance with the terms of G.S. 131E-176(13a).~~means any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.

(11) "Intermediate care facility for ~~the mentally retarded" shall be defined in accordance with the terms of G.S. 131E-176(14a).~~individuals with intellectual disabilities" means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for individuals with intellectual disabilities, autism, cerebral palsy, epilepsy, or related conditions.

...."

SECTION 2.(d) G.S. 113A-12(3)e. reads as rewritten:

"e. A health care facility financed pursuant to Chapter 131A of the General ~~Statutes or receiving a certificate of need under Article 9 of Chapter 131E of the General~~ Statutes."

SECTION 2.(e) G.S. 122C-23.1(e) reads as rewritten:

"(e) As used in this section, "residential treatment facility" means a "residential facility" as defined in and licensed under this ~~Chapter, but not subject to Certificate of Need requirements under Article 9 of Chapter 131E of the General Statutes.~~Chapter."

SECTION 2.(f) G.S. 131E-13(a)(1) reads as rewritten:

"(1) The corporation shall continue to provide the same or similar clinical hospital services to its patients in medical-surgery, obstetrics, pediatrics, outpatient and emergency treatment, including emergency services for the indigent, that the hospital facility provided prior to the lease, sale, or conveyance. These services may be terminated only as prescribed ~~by Certificate of Need Law prescribed in Article 9 of Chapter 131E of the General Statutes, or, if Certificate of Need Law is inapplicable,~~ by review procedure designed to guarantee public participation pursuant to rules adopted by the Secretary of the Department of Health and Human Services."

SECTION 2.(g) G.S. 131E-136(4) reads as rewritten:

"(4) "Home health agency" means a home care agency which is certified to receive Medicare and Medicaid reimbursement for providing nursing care, therapy, medical social services, and home health aide services on a part-time, intermittent ~~basis as set out in G.S. 131E-176(12), and is thereby also subject to Article 9 of Chapter 131E.~~basis."

SECTION 2.(h) 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 Division of Adult Correction of the Department of Public Safety 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 of the Division of Adult Correction of the Department of Public Safety and to members of the general public, the portion of the facility that serves inmates shall be exempt from licensure.

~~(b) Any person who contracts to provide inpatient chemical dependency or substance abuse services to inmates of the Division of Adult Correction of the Department of Public Safety 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 2.(i) Article 9 of Chapter 131E of the General Statutes, G.S. 130A-45.02(i), 143B-1292, 150B-2(8a)k., and 150B-21.1(6) are repealed.

SECTION 2.(j) This section becomes effective January 1, 2020. Subsection (a) of this section applies to contested cases arising on or after January 1, 2020.

PART III. PSYCHOLOGY INTERJURISDICTIONAL LICENSURE COMPACT

SECTION 3.(a) Article 18A of Chapter 90 of the General Statutes, G.S. 90-270.1 through G.S. 90-270.22, is recodified as Article 18G of Chapter 90 of the General Statutes, G.S. 90-270.135 through G.S. 90-270.159.

SECTION 3.(b) Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 18H.

"Psychology Interjurisdictional Licensure Compact.

"**§ 90-270.160. Purpose.**

This Compact is designed to achieve the following purposes and objectives:

(1) Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology.

(2) Enhance the states' ability to protect the public's health and safety, especially client/patient safety.

(3) Encourage the cooperation of Compact States in the areas of psychology licensure and regulation.

(4) Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history.

(5) Promote compliance with the laws governing psychological practice in each Compact State.

(6) Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

"**§ 90-270.161. Definitions.**

(1) Adverse action. – Any action taken by a State Psychology Regulatory Authority which finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

(2) Association of State and Provincial Psychology Boards (ASPPB). – The recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

(3) Authority to Practice Interjurisdictional Telepsychology. – A licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

(4) Bylaws. – Those Bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to G.S. 90-270.169 for its governance or for directing and controlling its actions and conduct.

(5) Client/patient. – The recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services.

(6) Commissioner. – The voting representative appointed by each State Psychology Regulatory Authority pursuant to G.S. 90-270.169.

(7) Compact State. – A state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to G.S. 90-270.172(c) or been terminated pursuant to G.S. 90-270.171(b).

(8) Confidentiality. – The principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

(9) Coordinated Licensure Information System or Coordinated Database. – An integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(10) Day. – Any part of a day in which psychological work is performed.

(11) Distant State. – The Compact State where a psychologist is physically present (not through the use of telecommunications technologies) to provide temporary in-person, face-to-face psychological services.

(12) E.Passport. – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

(13) Executive Board. – A group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

(14) Home State. – A Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authority to Practice Interjurisdictional Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

(15) Identity History Summary. – A summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

(16) In-person, face-to-face. – Interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

(17) Interjurisdictional Practice Certificate (IPC). – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily and verification of one's qualifications for such practice.

(18) License. – Authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

(19) Non-Compact State. – Any State which is not at the time a Compact State.

(20) Psychologist. – An individual licensed for the independent practice of psychology.

(21) Psychology Interjurisdictional Compact Commission (Commission). – The national administration of which all Compact States are members.

(22) Receiving State. – A Compact State where the client/patient is physically located when the telepsychological services are delivered.

(23) Rule. – A written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to G.S. 90-270.170 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal, or suspension of an existing rule.

(24) Significant investigatory information. –

a. Investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

b. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

(25) State. – A state, commonwealth, territory, or possession of the United States or the District of Columbia.

(26) State Psychology Regulatory Authority. – The Board, office, or other agency with the legislative mandate to license and regulate the practice of psychology.

(27) Telepsychology. – The provision of psychological services using telecommunication technologies.

(28) Temporary Authorization to Practice. – A licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

(29) Temporary in-person, face-to-face practice. – Where a psychologist is physically present (not through the use of telecommunications technologies) in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

"**§ 90-270.162. Home State licensure.**

(a) The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

(b) A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(c) Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(d) Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

(e) A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

(1) Currently requires the psychologist to hold an active E.Passport;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

(f) A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

(1) Currently requires the psychologist to hold an active IPC;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

"**§ 90-270.163. Compact privilege to practice telepsychology.**

(a) Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice telepsychology in other Compact States (Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

(b) To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master's degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;

(4) Have no history of adverse action that violate the Rules of the Commission;
(5) Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;
(6) Possess a current, active E.Passport;
(7) Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background, and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and
(8) Meet other criteria as defined by the Rules of the Commission.

(c) The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

(d) A psychologist practicing in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State is restricted, suspended, or otherwise limited, the E.Passport shall be revoked and, therefore, the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

"**§ 90-270.164. Compact Temporary Authorization to Practice.**

(a) Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

(b) To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:
a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or
b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and
(2) Hold a graduate degree in psychology that meets the following criteria:
a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;
b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;
c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;
e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;
f. The designated director of the program must be a psychologist and a member of the core faculty;
g. The program must have an identifiable body of students who are matriculated in that program for a degree;
h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;
i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;
j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;
(4) No history of adverse action that violates the Rules of the Commission;
(5) No criminal record history that violates the Rules of the Commission;
(6) Possess a current, active IPC;
(7) Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and
(8) Meet other criteria as defined by the Rules of the Commission.

(c) A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

(d) A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State is restricted, suspended, or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

"**§ 90-270.165. Conditions of telepsychology practice in a Receiving State.**

A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

(1) The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State.
(2) Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

"**§ 90-270.166. Adverse actions.**

(a) A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

(b) A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse

action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

(c) If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

(1) All Home State disciplinary orders which impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

(2) In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

(3) Other actions may be imposed as determined by the Rules promulgated by the Commission.

(d) A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

(e) A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice which occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

(f) Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

(g) No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection (c) of this section.

"**§ 90-270.167. Additional authorities invested in a Compact State's Psychology Regulatory Authority.**

In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

(1) Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a Compact State's Psychology Regulatory Authority for the attendance and testimony of witnesses and/or the production of evidence from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

(2) Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

(3) During the course of any investigation, a psychologist may not change his/her Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his/her Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission. All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal, and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

"**§ 90-270.168. Coordinated Licensure Information System.**

(a) The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

(b) Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

(1) Identifying information;
(2) Licensure data;
(3) Significant investigatory information;
(4) Adverse actions against a psychologist's license;
(5) An indicator that a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;
(6) Nonconfidential information related to alternative program participation information;
(7) Any denial of application for licensure and the reasons for such denial; and
(8) Other information which may facilitate the administration of this Compact, as determined by the Rules of the Commission.

(c) The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

(d) Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

(e) Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

"**§ 90-270.169. Establishment of the Psychology Interjurisdictional Compact Commission.**

(a) The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

(1) The Commission is a body politic and an instrumentality of the Compact States.

(2) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(3) Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting, and Meetings. –

(1) The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary, or similar executive;

b. Current member of the State Psychology Regulatory Authority of a Compact State; or

c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

(2) Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

(3) Each Commissioner shall be entitled to one vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

(4) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

(5) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rule-making provisions in G.S. 90-270.170.

(6) The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:

a. Noncompliance of a Compact State with its obligations under the Compact;

b. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation against the Commission;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusation against any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal and state statute.

(7) If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

(c) The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including, but not limited to:

(1) Establishing the fiscal year of the Commission;

(2) Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

(3) Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;

(4) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

(6) Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;

(7) Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

(8) The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto with the appropriate agency or officer in each of the Compact States;

(9) The Commission shall maintain its financial records in accordance with the Bylaws; and

(10) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(d) The Commission shall have the following powers:

(1) The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all Compact States;

(2) To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

(3) To purchase and maintain insurance and bonds;

(4) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compact State;

(5) To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

(6) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of the same, provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

(7) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the Commission shall strive to avoid any appearance of impropriety;

(8) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(9) To establish a budget and make expenditures;

(10) To borrow money;

(11) To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;

(12) To provide and receive information from, and to cooperate with, law enforcement agencies;

(13) To adopt and use an official seal; and

(14) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice, and telepsychology practice.

(e) The Executive Board. – The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact.

(1) The Executive Board shall be comprised of six members:

a. Five voting members who are elected from the current membership of the Commission by the Commission.

b. One ex officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(2) The ex officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.

(3) The Commission may remove any member of the Executive Board as provided in Bylaws.

(4) The Executive Board shall meet at least annually.

(5) The Executive Board shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, or fees paid by Compact States such as annual dues and any other applicable fees;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Other duties as provided in Rules or Bylaws.

(f) Financing of the Commission. –

(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.

(2) The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(3) The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

(4) The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State.

(5) The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

(g) Qualified Immunity, Defense, and Indemnification. –

(1) The members, officers, Executive Director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom

the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(2) The Commission shall defend any member, officer, Executive Director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(3) The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

"**§ 90-270.170. Rule making.**

(a) The Commission shall exercise its rule-making powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

(c) Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

(d) Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rule Making:

(1) On the Web site of the Commission; and

(2) On the Web site of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

(e) The Notice of Proposed Rule Making shall include:

(1) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

(f) Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(g) The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

(1) At least 25 persons who submit comments independently of each other;
(2) A governmental subdivision or agency; or
(3) A duly appointed person in an association that has at least 25 members.

(h) If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

(1) All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.
(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.
(3) No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.
(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

(j) The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rule-making record and the full text of the rule.

(k) If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

(*l*) Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rule-making procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety, or welfare;
(2) Prevent a loss of Commission or Compact State funds;
(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or
(4) Protect public health and safety.

(m) The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the Web site of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

"**§ 90-270.171. Oversight, dispute resolution, and enforcement.**

(a) Oversight. –

(1) The executive, legislative, and judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

(2) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

(3) The Commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

(b) Default, Technical Assistance, and Termination. –

(1) If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default, and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

(2) If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States and all rights, privileges, and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(3) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.

(4) A Compact State which has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

(5) The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

(6) The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the State of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution. –

(1) Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States.

(2) The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the Commission.

(d) Enforcement. –

(1) The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

(2) By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(3) The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

"**§ 90-270.172. Date of implementation of the Psychology Interjurisdictional Compact Commission and associated rules, withdrawal, and amendments.**

(a) The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rule-making powers necessary to the implementation and administration of the Compact.

(b) Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

(c) Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

(1) A Compact State's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

(d) Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

(e) This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

"**§ 90-270.173. Construction and severability.**

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States."

SECTION 3.(c) Subsections (a) and (b) of this section become effective when at least seven states have enacted the Psychology Interjurisdictional Compact (PSYPACT) set forth in subsection (b) of this section. The North Carolina Psychology Board shall report to the Revisor of Statutes when the PSYPACT set forth in subsection (b) of this section has been enacted by seven member states.

PART IV. ALLOW LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT FIRST-LEVEL EXAMINATIONS FOR INVOLUNTARY COMMITMENT

SECTION 4.(a) G.S. 122C-263.1(a) reads as rewritten:

"**§ 122C-263.1. Secretary's authority to certify commitment examiners; training of certified commitment examiners performing first examinations; LME/MCO responsibilities.**

(a) Physicians and eligible psychologists are qualified to perform the commitment examinations required under G.S. 122C-263(c) and G.S. 122C-283(c). The Secretary of Health and Human Services may individually certify to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 other health, mental health, and substance abuse professionals whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment as follows:

(1) The Secretary has received a request:

a. To certify a licensed clinical social worker, a master's or higher level degree nurse practitioner, a licensed professional counsellor, a licensed marriage and family therapist, or a physician's assistant to conduct the first examinations described in G.S. 122C-263(c) and G.S. 122C-283(c).

b. To certify a master's level licensed clinical addictions specialist to conduct the first examination described in G.S. 122C-283(c).

...

(5) In no event shall the certification of a licensed clinical social worker, master's or higher level degree nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or master's level certified clinical addictions specialist under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or the master's level certified clinical addictions specialist.

...."

SECTION 4.(b) This section is effective October 1, 2019.

PART V. PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY REGULATORY CHANGES

SECTION 5.(a) G.S. 131E-138 reads as rewritten:

"**§ 131E-138. Licensure requirements.**

(a) ~~No~~ Except as provided in subsection (f1) of this section, no person or governmental unit shall operate a home care agency without a license obtained from the Department. Nothing in this Part shall be construed to extend or modify the licensing of individual health professionals by the licensing boards for their professions or to create any new professional license category.

...

(f1) Exceptions to Licensure. – If home care services are provided to a participant of the Program for All-Inclusive Care for the Elderly through an organization that has a valid Program for All-Inclusive Care for the Elderly agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Service, then the entity providing the home care services shall not be required to hold a license under this section.

...."

SECTION 5.(b) G.S. 131D-2.1 reads as rewritten:

"**§ 131D-2.1. Definitions.**

As used in this Article:

...

(3) Adult care home. – An assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or for scheduled needs, through formal written agreement with licensed home care or hospice ~~agencies.~~ agencies or with a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated trained staff. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

...

(5) Assisted living residence. – Any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care or hospice ~~agencies.~~ agencies, or with a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. The Department may allow nursing service exceptions on a case-by-case basis. Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or area baths. Assisted living residences are to be distinguished from nursing homes subject to provisions of G.S. 131E-102. There are three types of assisted living residences: adult care homes, adult care homes that serve only elderly persons, and multiunit assisted housing with services. As used in this section, "elderly person" means:

a. Any person who has attained the age of 55 years or older and requires assistance with activities of daily living, housing, and services, or

b. Any adult who has a primary diagnosis of Alzheimer's disease or other form of dementia who requires assistance with activities of daily living, housing, and services provided by a licensed Alzheimer's and dementia care unit.

...

(10) Multiunit assisted housing with services. – An assisted living residence in which hands-on personal care services and nursing services ~~which~~ that are arranged by housing management are provided through an individualized written care plan by a licensed home care or hospice agency ~~through an individualized written care plan.~~ or by a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. The housing management has a financial interest or financial affiliation or formal written agreement ~~which~~ that makes personal care services accessible and available through at least one licensed home care or hospice ~~agency.~~ agency or through a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the

Division of Health Benefits of the Department of Health and Human Services. The resident has a choice of any provider, and the housing management may not combine charges for housing and personal care services. All residents, or their compensatory agents, must be capable, through informed consent, of entering into a contract and must not be in need of 24-hour supervision. Assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse according to the home care agency's or the Program for All-Inclusive Care for the Elderly organization's established plan of care. Multiunit assisted housing with services programs are required to register annually with the Division of Health Service Regulation. Multiunit assisted housing with services programs are required to provide a disclosure statement to the Division of Health Service Regulation. The disclosure statement is required to be a part of the annual rental contract that includes a description of all of the following requirements:

a. Emergency response ~~system;~~system.
b. Charges for services ~~offered;~~offered.
c. Limitations of ~~tenancy;~~tenancy.
d. Limitations of ~~services;~~services.
e. Resident ~~responsibilities;~~responsibilities.
f. Financial/legal relationship between housing management and home care or hospice ~~agencies;~~agencies or Program for All-Inclusive Care for the Elderly organizations.
g. A listing of all home care or hospice agencies and other community services in the ~~area;~~area.
h. An appeals ~~process; and~~process.
i. Procedures for required initial and annual resident screening and referrals for services.

Continuing care retirement communities, subject to regulation by the Department of Insurance under Chapter 58 of the General Statutes, and temporary family health care structures, as defined in G.S. 160A-383.5, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

...."

SECTION 5.(c) G.S. 131D-2.2(b) reads as rewritten:

"(b) Multiunit Assisted Housing With Services. – Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, multiunit assisted housing with services shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator ~~dependency;~~dependency.
(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be ~~healing;~~healing.
(3) Intravenous therapy or injections directly into the vein, except for intermittent intravenous therapy managed by a home care or hospice agency licensed in this ~~State;~~State.
(4) Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common ~~cold;~~cold.
(5) Psychotropic medications without appropriate diagnosis and treatment ~~plans;~~plans.
(6) Nasogastric ~~tubes;~~tubes.

(7) Gastric tubes, except when the individual is capable of independently feeding himself or herself and caring for the tube, or as managed by a home care or hospice agency licensed in this ~~State;~~State.

(8) Individuals requiring continuous licensed nursing ~~care;~~care.

(9) Individuals whose physician certifies that placement is no longer ~~appropriate;~~appropriate.

(10) Unless the individual's independent physician determines ~~otherwise,~~ otherwise or the individual is enrolled in the Program of All-Inclusive Care for the Elderly, individuals who require maximum physical assistance as documented by a uniform assessment instrument and who meet Medicaid nursing facility level-of-care criteria as defined in the State Plan for Medical Assistance. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on a uniform assessment ~~instrument;~~instrument.

(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the ~~residence; and~~residence.

(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services."

SECTION 5.(d) G.S. 131D-2.2(d) reads as rewritten:

"(d) Obtaining Services. – The resident of an assisted living facility has the right to obtain services at the resident's own expense from providers other than the housing management. This subsection shall not be construed to relieve the resident of the resident's contractual obligation to pay the housing management for any services covered by the contract between the resident and housing management. The resident of an assisted living facility has the right to select as the resident's health care provider the Program for All-Inclusive Care for the Elderly without jeopardizing residency in the assisted living facility."

SECTION 5.(e) G.S. 131D-2.16 reads as rewritten:

"**§ 131D-2.16. Rules.**

Except as otherwise provided in this Article, the Medical Care Commission shall adopt rules necessary to carry out this Article. The Commission has the authority, in adopting rules, to specify the limitation of nursing services provided by assisted living residences. In developing rules, the Commission shall consider the need to ensure comparable quality of services provided to residents, whether these services are provided directly by a licensed assisted living provider, licensed home care agency, a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services, or hospice. In adult care homes, living arrangements where residents require supervision due to cognitive impairments, rules shall be adopted to ensure that supervision is appropriate and adequate to meet the special needs of these residents. Rule-making authority under this section is in addition to that conferred under G.S. 131D-4.3 and G.S. 131D-4.5."

SECTION 5.(f) G.S. 131D-6 reads as rewritten:

"**§ 131D-6. Certification of adult day care programs; purpose; definition; penalty.**

...

(d) ~~The~~ All of the following programs are exempted from the provisions of this section:

(1) Those that care for three people or ~~less;~~less.

(2) Those that care for two or more persons, all of whom are related by blood or marriage to the operator of the ~~facility;~~facility.

(3) Those that are required by other statutes to be licensed by the Department of Health and Human Services.

(4) Program for All-Inclusive Care for the Elderly organizations that have a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services when providing services to participants in the program."

SECTION 5.(g) This act is effective October 1, 2019.

PART VI. ELIMINATE REDUNDANCY IN ADULT CARE HOME INSPECTIONS

SECTION 6. G.S. 131D-2.11(a) reads as rewritten:

"(a) State Inspection and Monitoring. – The Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. All facilities licensed under this Article and adult care units in nursing homes are subject to inspections at all times by the Secretary. Except as provided in subsection (a1) of this section, the Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis. Beginning July 1, 2012, the Division of Health Service Regulation shall include as part of its inspection of all adult care homes a review of the facility's compliance with G.S. 131D-4.4A(b) and safe practices for injections and any other procedures during which bleeding typically occurs. In addition, the Department shall ensure that adult care homes are inspected every two years to determine compliance with physical plant and life-safety requirements.

If the annual inspection of an adult care home is conducted separately from the inspection required every two years to determine compliance with physical plant and life-safety requirements, the Division of Health Service Regulation shall not cite, as part of the annual inspection, any violation of law that overlaps with an area addressed by the physical plant and life-safety inspection, unless failure to address the violation during the annual inspection would pose a risk to resident health or safety. Nothing in this section prevents a licensing inspector from referring a concern about physical plant and life-safety requirements to the section within the Division of Health Service Regulation that conducts physical plant and life-safety inspections."

PART VII. SEVERABILITY CLAUSE AND EFFECTIVE DATE

SECTION 7.(a) If any section or 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 to be unconstitutional or invalid.

SECTION 7.(b) Except as otherwise provided, this act is effective when it becomes law.

HOUSE BILL 548:
Modify Physical Therapy Definition.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 4, 2019
Introduced by:	Reps. Grange, Torbett, White, Dobson	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	First Edition		

OVERVIEW: House Bill 548 would remove the practice of chiropractic from the definition of physical therapy in G.S. 90-270.94(4).

CURRENT LAW: Under current law, the definition of physical therapy includes manipulation of the spine when the treatment is prescribed by a licensed physician.

BILL ANALYSIS: The bill would amend G.S. 90-270.90(4) to remove the practice of chiropractic from the definition of physical therapy.

EFFECTIVE DATE: The act would be effective October 1, 2019.

aren Cochrane-Brown
Director

Legislative Analysis
Division
919-733-2578

H548-SMBC-81 E1 -V-1

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

HOUSE BILL 548

Short Title:	Modify Physical Therapy Definition.	(Public)
Sponsors:	Representatives Grange, Torbett, White, and Dobson (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Insurance, if favorable, Rules, Calendar, and Operations of the House	

April 3, 2019

A BILL TO BE ENTITLED

AN ACT UPDATING THE DEFINITION OF PHYSICAL THERAPY TO EXCLUDE THE PRACTICE OF CHIROPRACTIC AND TO INCLUDE MANIPULATION OF THE SPINE WITHOUT A PRESCRIPTION FROM A PHYSICIAN LICENSED TO PRACTICE MEDICINE IN THIS STATE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-270.90(4) reads as rewritten:

"(4) "Physical therapy" means the evaluation or treatment of any person by the use of physical, chemical, or other properties of heat, light, water, electricity, sound, massage, or therapeutic exercise, or other rehabilitative procedures, with or without assistive devices, for the purposes of preventing, correcting, or alleviating a physical or mental disability. Physical therapy includes the performance of specialized tests of neuromuscular function, administration of specialized therapeutic procedures, interpretation and implementation of referrals from licensed medical doctors or dentists, and establishment and modification of physical therapy programs for patients. Evaluation and treatment of patients may involve physical measures, methods, or procedures as are found commensurate with physical therapy education and training and generally or specifically authorized by regulations of the Board. Physical therapy education and training shall include study of the skeletal manifestations of systemic disease. Physical therapy does not include the application of roentgen rays or radioactive materials, surgery, ~~manipulation of the spine unless prescribed by a physician licensed to practice medicine in North Carolina,~~ the practice of chiropractic, as defined by G.S. 90-143, or medical diagnosis of disease."

SECTION 2. This act becomes effective October 1, 2019.

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

June 5, 2019

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Alyssa Quinlan	DOA
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Sarah Wolfe	MWC
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09-21-201

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

June 5, 2019

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Alex Taylor	Benchmarks NC
Karen Mcleod	Benchmarks NC
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Dan V.P.	V.T
Kara Weishaar	SA
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09-21-201

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2019-2020

June 5, 2019

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[illegible]	CSS
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Chris Evans	BCBSNC
Chip Boger	NCMS
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[illegible]	FHLI
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09-21-201

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SENATE HEALTH CARE

2019-2020

June 5, 2019

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SUSAN DeLANEY	NCANP
JOE LANIER	TROUTMAN
Matthew Baldwin	PPAB
Debbie Parkinson	Parkinson Law
Randolph E. Pleasant	R. Pleasant + Assoc

Senate Pages Attending

COMMITTEE: Heath Care **ROOM:** 421 LOB

DATE: 6-5 **TIME:** 10 Am

PLEASE PRINT LEGIBLY....*or else!!!!!*

Page Name	Hometown	Sponsoring Senator
1. Mary Elizabeth Morris	Hookerton	D. Davis
2. Miller Andrews	Snow Hill	D. Davis
3. Sophia Singer	High Point	M. Garrett
4. Caroline Harper	Raleigh	Sen. Finch
5. Ty McLaughlin	Roksville	Wells
6. Jamie Wenzel	West End	McInnis
7.		
8.		

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.



SENATE SERGEANT-AT-ARMS

Senate Committee on Health Care

DATE: 06-05-2019 **ROOM**: 421 **TIME**: 10:00 AM

SHEREE HEDRICK

HAL ROACH

Senate Committee on Health Care
Wednesday, June 12, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 12, 2019 in Room 643 of the Legislative Office Building. Eleven members were present.

Senator Joyce Krawiec, Chair, presided.

Abbey Hamilton from Asheville, Shriya Madhavaram from Waxhaw, Sarika Kasvganti from Cary, Lily Klett from Davidson, Anne Spong from Greensboro, Christina Hamilton from Asheville, Parker Shook from Raleigh, and Will Carney from Mooresville served as pages.

Senator Krawiec altered the order of the bills and it is reflected below.

HB 658 Allow Donations of Unexpired Drugs. (Representatives Sasser, Hanig, Humphrey)
Rep. Sasser was introduced to speak on his bill. There were no questions from the members. Senator Woodard moved for a favorable report and it carried. Senator McInnis will manage this bill during session.

HB 656 Medicaid Changes for Transformation. (Representatives Lambeth, Dobson, Murphy, Sasser)
Senator Krawiec reminded the members that this bill was for discussion only. Senator Woodard moved for the proposed committee substitute (PCS) be brought before the committee and it carried. Rep Lambeth was introduce to speak on the bill. Jennifer Hillman from the Legislative Analysis Division explained the PCS. There were no questions from the members. Senator Krawiec announced that this bill will be voted on during the next meeting.

SB 361 Health Care Expansion Act of 2019. (Senators Krawiec, Bishop, Hise)
Senator Krawiec requested that Senator Burgin take the chair so she could present this bill. Senator Burgin recognized Senator Krawiec to speak on the bill. This bill was heard during the previous committee meeting and the PCS was still before the committee. Questions from the members were responded to by Senator Krawiec. Senator Burgin asked if there was anyone present that would like to comment on the bill. Five people had requested to speak and they spoke in the following order: Rob Ashore /North Carolina Ambulatory Surgery Center Association, Flint Benson/SEANC, Dr. Virginia Jones/CEO Vollygate, Denna Suko/NC Society of Eye Physicians and Surgeons, and Leah Burns/North Carolina Health Care Association. More questions were asked by the members and they were responded to by Senator Krawiec and Senator Hise. Senator Krawiec asked Chris Evan from Blue Cross Blue Shield comment on the bill. Senator Hise moved unfavorable to the bill favorable to the PCS and it carried.

The meeting adjourned at 11:05 AM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Wednesday, June 12, 2019

Senator Krawiec,
submits the following with recommendations as to passage:

FAVORABLE

HB **658** Allow Donations of Unexpired Drugs.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Tom McInnis will handle HB 658



NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Wednesday, June 12, 2019

Senator Krawiec,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

SB **361** Health Care Expansion Act of 2019.

Draft Number:	S361-PCS45303-BCf-41
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

Sen. Burgin stood in as chair for SB 361.

Senator Joyce Krawiec will handle SB 361



Senate Committee on Health Care
Wednesday, June 12, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 361	Health Care Expansion Act of 2019.	Senator Krawiec Senator Bishop Senator Hise
HB 656	Medicaid Changes for Transformation. For Discussion Only	Representative Lambeth Representative Dobson Representative Murphy Representative Sasser
HB 658	Allow Donations of Unexpired Drugs.	Representative Sasser Representative Hanig Representative Humphrey

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S D

SENATE BILL 361
PROPOSED COMMITTEE SUBSTITUTE S361-CSBC-41 [v.6]
06/04/2019 04:54:32 PM

Short Title: Health Care Expansion Act of 2019. (Public)

Sponsors:

Referred to:

March 27, 2019

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS REFORMS THAT WILL INCREASE ACCESS TO HEALTH CARE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

PART I. REFORM NORTH CAROLINA'S CERTIFICATE OF NEED LAWS

SECTION 1.(a) G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

...

(2) "Bed capacity" means space used exclusively for inpatient ~~care,~~ care at a health service facility, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage. ~~The term "bed capacity" also refers to the number of dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~

...

(5) "Change in bed capacity" means (i) any relocation of health service facility ~~beds, or dialysis stations~~ beds from one licensed facility or campus to another, or (ii) any redistribution of health service facility bed capacity among the categories of health service facility bed as defined in G.S. 131E-176(9c), or (iii) any increase in the number of health service facility ~~beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~beds.

...

(9a) "Health service" means an organized, interrelated medical, diagnostic, therapeutic, ~~and/or~~ or rehabilitative ~~activity~~ activity, or any combination of these, that is integral to the prevention of disease or the clinical management of a sick, injured, or disabled person. "Health service" does not include administrative and other activities that are not integral to clinical ~~management.~~management, or any activities performed at a facility that does not meet the definition of a health service facility.

(9b) "Health service facility" means 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 the mentally retarded;~~ home health agency office; ~~chemical dependency treatment facility; diagnostic center;~~ hospice office, hospice inpatient facility, and hospice residential care ~~facility; and ambulatory surgical~~ facility. The term "health service facility" does not include a licensable facility, as defined in G.S. 122C-3(14)b.

(9c) "Health service facility bed" means 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) intermediate care beds for the mentally retarded; (vi) chemical dependency treatment beds; (vii)~~ (iv) hospice inpatient facility beds; ~~(viii)~~ (v) hospice residential care facility beds; ~~(ix)~~ (vi) adult care home beds; and ~~(x)~~ or (vii) long-term care hospital beds.

...

(14a) ~~"Intermediate care facility for the mentally retarded"~~ "Intermediate care facility for individuals with intellectual disabilities" means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for persons with ~~mental retardation,~~ intellectual disabilities, autism, cerebral palsy, epilepsy or related conditions.

...

(16) "New institutional health services" means any of the following:

...

d. The offering of ~~dialysis services or~~ home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.

...

~~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.~~

...

~~u. The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.~~

~~v. The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is reflected on the health service facility's license in effect as of January 1, 2005.~~

...."

SECTION 1.(b) G.S. 131E-177 reads as rewritten:

"**§ 131E-177. Department of Health and Human Services is designated State Health Planning and Development Agency; powers and duties.**

The Department of Health and Human Services is designated as the State Health Planning and Development Agency for the State of North Carolina, and is empowered to exercise the following powers and duties:

(1) To establish standards and criteria or plans required to carry out the provisions and purposes of this Article and to adopt rules pursuant to Chapter 150B of the General Statutes, to carry out the purposes and provisions of this ~~Article;~~Article.

(2) Adopt, amend, and repeal such rules and regulations, consistent with the laws of this State, as may be required by the federal government for grants-in-aid for health service facilities and health planning which may be made available by the federal government. This section shall be liberally construed in order that the State and its citizens may benefit from such ~~grants-in-aid;~~grants-in-aid.

(3) Define, by rule, procedures for submission of periodic reports by persons or health service facilities subject to agency review under this ~~Article;~~Article.

(4) ~~Develop~~ With respect to health service facilities planning, all of the following:

a. Develop policy, criteria, and standards for health service facilities ~~planning; shall conduct~~ planning.

b. Conduct statewide registration and inventories of and make determinations of need for health service facilities, health services as specified in G.S. 131E-176(16)f., and equipment as specified in G.S. 131E-176(16)f1., which shall include consideration of adequate geographic location of equipment and ~~services; and develop~~ services.

c. Develop a State Medical Facilities ~~Plan;~~Plan, provided, however, that the State Medical Facilities Plan shall not include policies or need determinations that limit the number of operating rooms or gastrointestinal endoscopy rooms.

(5) Implement, by rule, criteria for project ~~review;~~review.

(6) Have the power to grant, deny, or withdraw a certificate of need and to impose such sanctions as are provided for by this ~~Article;~~Article.

(7) Solicit, accept, hold and administer on behalf of the State any grants or devises of money, securities or property to the Department for use by the Department in the administration of this ~~Article; and~~Article.

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

(9) Collect fees for submitting applications for certificates of need.

(10) The authority to review all records in any recording medium of any person or health service facility subject to agency review under this Article which pertain to construction and acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records the Department deems to be reasonably necessary to determine compliance with this Article.

The Secretary of Health and Human Services shall have final decision-making authority with regard to all functions described in this section."

SECTION 1.(c) 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:~~

~~(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.~~Department."

SECTION 1.(d) G.S. 131E-181 reads as rewritten:

"**§ 131E-181. Nature of certificate of need.**

...

(d) A recipient of a certificate of need shall complete the project authorized by the certificate of need within two years after the decision to issue the certificate of need becomes final. If the recipient does not complete the project authorized by the certificate of need within this two-year time period, the certificate of need for the authorized project expires the day after the two-year time period ends. A project authorized by a certificate of need is complete when the health service or the health service facility for which the certificate of need was issued is licensed and certified and is in material compliance with the representations made in the certificate of need application.

(e) The Department shall withdraw a certificate of need issued to any recipient that ceases operating the health service or health service facility included in that certificate of need for more than one year."

SECTION 1.(e) G.S. 131E-183(a)(1) reads as rewritten:

"(1) The proposed project 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 that may be approved."

SECTION 1.(f) G.S. 131E-184(c) reads as rewritten:

"(c) The Department shall exempt from certificate of need review any conversion of existing acute care beds to psychiatric ~~beds provided:~~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 and/or one or more of the Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities to provide psychiatric beds to patients referred by the contracting agency or agencies; and~~

~~(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.~~"

SECTION 1.(g) G.S. 131E-184(e)(1) reads as rewritten:

"(1) The proposed capital expenditure would:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding an existing:

1. Nursing home facility, or

2. Adult care home ~~facility, or~~facility; and

~~3. Intermediate care facility for the mentally retarded; and~~

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."

SECTION 1.(h) G.S. 131E-184 is amended by adding new subsections to read:

"(i) The Department shall exempt from certificate of need review the development, acquisition, construction, expansion, or replacement of a health service facility or health service that obtained certificate of need approval prior to October 1, 2019, as an ambulatory surgical facility, including an ambulatory surgical facility with one or more operating rooms or gastrointestinal endoscopy procedure rooms; a diagnostic center; kidney disease treatment center, including freestanding dialysis units; chemical dependency treatment facility; intermediate care facility for individuals with intellectual disabilities; psychiatric hospital; or any other licensable facility, as defined in G.S. 122C-3(14)b.

(j) The Department shall exempt from certificate of need review the establishment of a home health agency by a continuing care retirement community licensed under Article 64 of Chapter 58 of the General Statutes to provide home health services to one or more residents of a continuing care retirement community who have entered into a contract with the continuing care retirement community to receive continuing care services with lodging. A continuing care retirement community that seeks to provide home health services to individuals who do not reside at the continuing care retirement community pursuant to a contract to receive continuing care services with lodging shall be required to obtain a certificate of need as a home health agency prior to developing or offering home health services to any individual not a resident of the continuing care retirement community under a contract to receive continuing care services with lodging. As used in this subsection, the terms "continuing care" and "lodging" are as defined in G.S. 58-64-1. Nothing in this subsection shall be construed to exempt from the State's home health agency licensure and certification requirements a continuing care retirement community that has been exempted from certificate of need review for the provision of home health services to one or more residents pursuant to this subsection."

SECTION 1.(i) G.S. 131E-184(j), as enacted by this section, applies to continuing care retirement communities engaged in the direct provision of home health services on or after October 1, 2019.

SECTION 1.(j) G.S. 131E-186(a) reads as rewritten:

"(a) Within the prescribed time limits in G.S. 131E-185, the Department shall issue a decision to "approve," "approve with conditions," or "deny," an application for a new institutional health service. ~~Approvals involving new or expanded nursing care or intermediate care for the mentally retarded bed capacity shall include a condition that specifies the earliest possible date the new institutional health service may be certified for participation in the Medicaid program. The date shall be set far enough in advance to allow the Department to identify funds to pay for care in the new or expanded facility in its existing Medicaid budget or to include these funds in its State Medicaid budget request for the year in which Medicaid certification is expected.~~"

SECTION 1.(k) 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, any ~~affected person, as defined in subsection (c) of this section,~~

~~shall be~~ proponent of an application that was reviewed with the application for that certificate of need is 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 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 days after the assignment of the administrative law judge or hearing officer.

(3) The hearing at which sworn testimony is taken and evidence is presented shall be held within 45 days after the end of the discovery period.

(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.

...

(b) Any ~~affected~~ person 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 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 who were parties to the contested hearing. The Court of Appeals, in an action for judicial review brought under this section, shall award all costs of such action, including reasonable attorney's fees to the prevailing party. For the purpose of this subsection, reasonable attorney's fees include attorney's fees incurred during the administrative review portion of the contested case arising under Article 3 of Chapter 150B of the General Statutes.

(b1) Before filing an appeal of a final decision granting a certificate of need, the ~~affected person~~ appellant 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).~~ five hundred thousand dollars ($500,000). 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.

...

~~(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.~~"

SECTION 1.(*l*) G.S. 131E-147 is amended by adding a new subsection to read:

"(f) The Department shall not issue or renew a license to operate an ambulatory surgical facility developed, acquired, or replaced on or after October 1, 2019, unless the application includes all of the following:

(1) A commitment that the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least four percent (4%) of the total revenue collected for all surgical cases performed in the facility or proposed facility.

(2) For each year of operation, a commitment to report to the Department the total number of cases by each of the following payer categories:

a. Self-pay surgical cases.
b. Medicaid surgical cases.
c. Medicare surgical cases.
d. Commercial insurance surgical cases.
e. Managed care surgical cases.
f. Other surgical cases.

(3) A commitment to report utilization and payment data for services provided by the ambulatory surgical facility to the statewide data processor, as required by G.S. 131E-214.2."

SECTION 1.(m) G.S. 131E-175(11) and (12) are repealed.

SECTION 1.(n) This section becomes effective October 1, 2019.

PART II. PSYCHOLOGY INTERJURISDICTIONAL LICENSURE COMPACT

SECTION 2.(a) Article 18A of Chapter 90 of the General Statutes, G.S. 90-270.1 through G.S. 90-270.22, is recodified as Article 18G of Chapter 90 of the General Statutes, G.S. 90-270.135 through G.S. 90-270.159.

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

"Article 18H.

"Psychology Interjurisdictional Licensure Compact.

"**§ 90-270.160. Purpose.**

This Compact is designed to achieve the following purposes and objectives:

(1) Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology.

(2) Enhance the states' ability to protect the public's health and safety, especially client/patient safety.

(3) Encourage the cooperation of Compact States in the areas of psychology licensure and regulation.

(4) Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history.

(5) Promote compliance with the laws governing psychological practice in each Compact State.

(6) Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

"**§ 90-270.161. Definitions.**

(1) Adverse action. – Any action taken by a State Psychology Regulatory Authority which finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

(2) Association of State and Provincial Psychology Boards (ASPPB). – The recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

(3) Authority to Practice Interjurisdictional Telepsychology. – A licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

(4) Bylaws. – Those Bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to G.S. 90-270.169 for its governance or for directing and controlling its actions and conduct.

(5) Client/patient. – The recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services.

(6) Commissioner. – The voting representative appointed by each State Psychology Regulatory Authority pursuant to G.S. 90-270.169.

(7) Compact State. – A state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to G.S. 90-270.172(c) or been terminated pursuant to G.S. 90-270.171(b).

(8) Confidentiality. – The principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

(9) Coordinated Licensure Information System or Coordinated Database. – An integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(10) Day. – Any part of a day in which psychological work is performed.

(11) Distant State. – The Compact State where a psychologist is physically present (not through the use of telecommunications technologies) to provide temporary in-person, face-to-face psychological services.

(12) E.Passport. – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

(13) Executive Board. – A group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

(14) Home State. – A Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authority to Practice Interjurisdictional

Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

(15) Identity History Summary. – A summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

(16) In-person, face-to-face. – Interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

(17) Interjurisdictional Practice Certificate (IPC). – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily and verification of one's qualifications for such practice.

(18) License. – Authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

(19) Non-Compact State. – Any State which is not at the time a Compact State.

(20) Psychologist. – An individual licensed for the independent practice of psychology.

(21) Psychology Interjurisdictional Compact Commission (Commission). – The national administration of which all Compact States are members.

(22) Receiving State. – A Compact State where the client/patient is physically located when the telepsychological services are delivered.

(23) Rule. – A written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to G.S. 90-270.170 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal, or suspension of an existing rule.

(24) Significant investigatory information. –

a. Investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

b. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

(25) State. – A state, commonwealth, territory, or possession of the United States or the District of Columbia.

(26) State Psychology Regulatory Authority. – The Board, office, or other agency with the legislative mandate to license and regulate the practice of psychology.

(27) Telepsychology. – The provision of psychological services using telecommunication technologies.

(28) Temporary Authorization to Practice. – A licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

(29) Temporary in-person, face-to-face practice. – Where a psychologist is physically present (not through the use of telecommunications technologies) in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

"**§ 90-270.162. Home State licensure.**

(a) The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

(b) A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(c) Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(d) Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

(e) A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

(1) Currently requires the psychologist to hold an active E.Passport;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

(f) A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

(1) Currently requires the psychologist to hold an active IPC;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

"**§ 90-270.163. Compact privilege to practice telepsychology.**

(a) Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice telepsychology in other Compact States

(Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

(b) To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master's degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;

(4) Have no history of adverse action that violate the Rules of the Commission;

(5) Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;

(6) Possess a current, active E.Passport;

(7) Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background, and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

(8) Meet other criteria as defined by the Rules of the Commission.

(c) The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

(d) A psychologist practicing in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State is restricted, suspended, or otherwise limited, the E.Passport shall be revoked and, therefore, the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

"**§ 90-270.164. Compact Temporary Authorization to Practice.**

(a) Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

(b) To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;

(4) No history of adverse action that violates the Rules of the Commission;

(5) No criminal record history that violates the Rules of the Commission;

(6) Possess a current, active IPC;

(7) Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and

(8) Meet other criteria as defined by the Rules of the Commission.

(c) A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

(d) A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State is restricted, suspended, or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

"**§ 90-270.165. Conditions of telepsychology practice in a Receiving State.**

A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

(1) The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State.

(2) Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

"**§ 90-270.166. Adverse actions.**

(a) A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

(b) A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

(c) If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

(1) All Home State disciplinary orders which impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

(2) In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

(3) Other actions may be imposed as determined by the Rules promulgated by the Commission.

(d) A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

(e) A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice which occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

(f) Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

(g) No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection (c) of this section.

"**§ 90-270.167. Additional authorities invested in a Compact State's Psychology Regulatory Authority.**

In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

(1) Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a Compact State's Psychology Regulatory Authority for the attendance and testimony of witnesses and/or the production of evidence from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

(2) Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

(3) During the course of any investigation, a psychologist may not change his/her Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his/her Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission.

All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal, and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

"**§ 90-270.168. Coordinated Licensure Information System.**

(a) The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

(b) Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

(1) Identifying information;
(2) Licensure data;
(3) Significant investigatory information;
(4) Adverse actions against a psychologist's license;
(5) An indicator that a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;
(6) Nonconfidential information related to alternative program participation information;
(7) Any denial of application for licensure and the reasons for such denial; and
(8) Other information which may facilitate the administration of this Compact, as determined by the Rules of the Commission.

(c) The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

(d) Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

(e) Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

"**§ 90-270.169. Establishment of the Psychology Interjurisdictional Compact Commission.**

(a) The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

(1) The Commission is a body politic and an instrumentality of the Compact States.
(2) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.
(3) Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting, and Meetings. –

(1) The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary, or similar executive;
b. Current member of the State Psychology Regulatory Authority of a Compact State; or
c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

(2) Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

(3) Each Commissioner shall be entitled to one vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

(4) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

(5) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rule-making provisions in G.S. 90-270.170.

(6) The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:
a. Noncompliance of a Compact State with its obligations under the Compact;
b. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;
c. Current, threatened, or reasonably anticipated litigation against the Commission;
d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;
e. Accusation against any person of a crime or formally censuring any person;
f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;
g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
h. Disclosure of investigatory records compiled for law enforcement purposes;
i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or
j. Matters specifically exempted from disclosure by federal and state statute.

(7) If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of

actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

(c) The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including, but not limited to:

(1) Establishing the fiscal year of the Commission;

(2) Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

(3) Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;

(4) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

(6) Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;

(7) Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

(8) The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto with the appropriate agency or officer in each of the Compact States;

(9) The Commission shall maintain its financial records in accordance with the Bylaws; and

(10) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(d) The Commission shall have the following powers:

(1) The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all Compact States;

(2) To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

(3) To purchase and maintain insurance and bonds;
(4) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compact State;
(5) To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;
(6) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of the same, provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;
(7) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the Commission shall strive to avoid any appearance of impropriety;
(8) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;
(9) To establish a budget and make expenditures;
(10) To borrow money;
(11) To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;
(12) To provide and receive information from, and to cooperate with, law enforcement agencies;
(13) To adopt and use án official seal; and
(14) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice, and telepsychology practice.

(e) The Executive Board. – The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact.
(1) The Executive Board shall be comprised of six members:
a. Five voting members who are elected from the current membership of the Commission by the Commission.
b. One ex officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.
(2) The ex officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.
(3) The Commission may remove any member of the Executive Board as provided in Bylaws.
(4) The Executive Board shall meet at least annually.
(5) The Executive Board shall have the following duties and responsibilities:
a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, or fees paid by Compact States such as annual dues and any other applicable fees;
b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;
d. Maintain financial records on behalf of the Commission;
e. Monitor Compact compliance of member states and provide compliance reports to the Commission;
f. Establish additional committees as necessary; and
g. Other duties as provided in Rules or Bylaws.

(f) Financing of the Commission. –

(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.

(2) The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(3) The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

(4) The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State.

(5) The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

(g) Qualified Immunity, Defense, and Indemnification. –

(1) The members, officers, Executive Director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(2) The Commission shall defend any member, officer, Executive Director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(3) The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

"**§ 90-270.170. Rule making.**

(a) The Commission shall exercise its rule-making powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

(c) Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

(d) Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rule Making:

(1) On the Web site of the Commission; and

(2) On the Web site of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

(e) The Notice of Proposed Rule Making shall include:

(1) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

(f) Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(g) The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

(1) At least 25 persons who submit comments independently of each other;

(2) A governmental subdivision or agency; or

(3) A duly appointed person in an association that has at least 25 members.

(h) If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

(1) All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.

(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.

(3) No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not

preclude the Commission from making a transcript or recording of the hearing if it so chooses.

(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

(j) The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rule-making record and the full text of the rule.

(k) If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

(l) Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rule-making procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety, or welfare;

(2) Prevent a loss of Commission or Compact State funds;

(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or

(4) Protect public health and safety.

(m) The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the Web site of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

"**§ 90-270.171. Oversight, dispute resolution, and enforcement.**

(a) Oversight. –

(1) The executive, legislative, and judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

(2) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

(3) The Commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

(b) Default, Technical Assistance, and Termination. –

(1) If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default, and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

(2) If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States and all rights, privileges, and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(3) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.

(4) A Compact State which has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

(5) The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

(6) The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the State of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution. –

(1) Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States.

(2) The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the Commission.

(d) Enforcement. –

(1) The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

(2) By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(3) The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

"**§ 90-270.172. Date of implementation of the Psychology Interjurisdictional Compact Commission and associated rules, withdrawal, and amendments.**

(a) The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rule-making powers necessary to the implementation and administration of the Compact.

(b) Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

(c) Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

(1) A Compact State's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

(d) Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

(e) This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

"**§ 90-270.173. Construction and severability.**

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States."

SECTION 2.(c) Subsections (a) and (b) of this section become effective when at least seven states have enacted the Psychology Interjurisdictional Compact (PSYPACT) set forth in subsection (b) of this section. The North Carolina Psychology Board shall report to the Revisor of Statutes when the PSYPACT set forth in subsection (b) of this section has been enacted by seven member states.

PART III. ALLOW LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT FIRST-LEVEL EXAMINATIONS FOR INVOLUNTARY COMMITMENT AND CREATE FEES

SECTION 3.(a) G.S. 122C-263.1(a) reads as rewritten:

"**§ 122C-263.1. Secretary's authority to certify commitment examiners; training of certified commitment examiners performing first examinations; LME/MCO responsibilities.**

(a) Physicians and eligible psychologists are qualified to perform the commitment examinations required under G.S. 122C-263(c) and G.S. 122C-283(c). The Secretary of Health and Human Services may individually certify to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 other health, mental health, and substance abuse professionals whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment as follows:

(1) The Secretary has received a request:

a. To certify a licensed clinical social worker, a master's or higher level degree nurse practitioner, a licensed professional counsellor, a licensed marriage and family therapist, or a physician's assistant to

conduct the first examinations described in G.S. 122C-263(c) and G.S. 122C-283(c).

b. To certify a master's level licensed clinical addictions specialist to conduct the first examination described in G.S. 122C-283(c).

...

(5) In no event shall the certification of a licensed clinical social worker, master's or higher level degree nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or master's level certified clinical addictions specialist under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or the master's level certified clinical addictions specialist.

...."

SECTION 3.(b) G.S. 90-270.54 reads as rewritten:

"**§ 90-270.54. Requirements for licensure as a marriage and family therapist.**

...

(a1) The Board shall issue a license to conduct first examinations pursuant to G.S. 122C-263.1 to applicants who meet the criteria for licensure in subsection (a) and who pay a one-time, ten dollar ($10.00) fee.

..."

SECTION 3.(c) G.S. 90-270.57 reads as rewritten:

"**§ 90-270.57. Fees.**

(a) In order to fund the Board's activities under this Article, the Board may charge and collect fees not exceeding the following:

...

(10)	Application to perform first examinations pursuant to G.S. 122C-263.1	10.00.

In addition to the examination fee provided in subdivision (1) of this subsection, the Board may charge and collect from each applicant for license examination the cost of processing test results and the cost of test materials.

(b) The Board may establish fees for the actual cost of (i) document duplication services, (ii) materials, and (iii) returned bank items as allowed by law. All fees listed in subsection (a) of this section shall be nonrefundable."

SECTION 3.(d) This section is effective October 1, 2019. Sections 3.(b) and 3.(c) apply to applications submitted on or that date.

PART IV. ELIMINATE REDUNDANCY IN ADULT CARE HOME INSPECTIONS

SECTION 4. G.S. 131D-2.11(a) reads as rewritten:

"(a) State Inspection and Monitoring. – The Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. All facilities licensed under this Article and adult care units in nursing homes are subject to inspections at all times by the Secretary. Except as provided in subsection (a1) of this section, the Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis. Beginning July 1, 2012, the Division of Health Service Regulation shall include as part of its inspection of all adult care homes a review of the facility's compliance with G.S. 131D-4.4A(b) and safe practices for injections and any other procedures during which bleeding typically occurs. In addition, the Department shall ensure that adult care homes are inspected every two years to determine compliance with physical plant and life-safety requirements.

If the annual inspection of an adult care home is conducted separately from the inspection required every two years to determine compliance with physical plant and life-safety requirements, the Division of Health Service Regulation shall not cite, as part of the annual inspection, any violation of law that overlaps with an area addressed by the physical plant and life-safety inspection, unless failure to address the violation during the annual inspection would pose a risk to resident health or safety. Nothing in this section prevents a licensing inspector from referring a concern about physical plant and life-safety requirements to the section within the Division of Health Service Regulation that conducts physical plant and life-safety inspections."

PART V. SEVERABILITY CLAUSE AND EFFECTIVE DATE

SECTION 5.(a) If any section or 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 to be unconstitutional or invalid.

SECTION 5.(b) Except as otherwise provided, this act is effective when it becomes law.

SENATE BILL 361:
Health Care Expansion Act of 2019.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 4, 2019
Introduced by:	Sens. Krawiec, Bishop, Hise	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	PCS to First Edition S361-CSBC-41		

OVERVIEW: The Proposed Committee Substitute (PCS) to Senate Bill 361 would reform Certificate of Need (CON) Laws; enact the Psychology Interjurisdictional Licensure Compact (PSYPACT); allow marriage and family therapists to conduct the first-level exam for involuntary commitment and create marriage and family therapist licensure fees; and eliminate redundancy in adult care home inspections.

BILL ANALYSIS: The PCS to Senate Bill 361 would make the changes outlined below.

PART I. REFORM CERTIFICATE OF NEED LAWS would remove psychiatric facilities, kidney disease treatment centers, intermediate care facilities for individuals with intellectual disabilities, chemical dependency treatment facilities, diagnostic centers, and ambulatory surgical facilities from the list of health services that require a Certificate of Need. It would prevent the State Medical Facilities Plan from limiting the number of operating rooms or gastrointestinal endoscopy rooms. If the project authorized by a Certificate of Need were not completed within two years, the certificate would expire, and certificates issues to facilities that ceased to operate for more than a year would be withdrawn. Home health agencies operated by continuing care retirement communities would be exempt from CON review.

PART II. PSYCHOLOGY INTERJURISDICTIONAL LICENSURE COMPACT (PSYPACT)

Section 2(a) would recodify the current Psychology Practice Act, Article 18A of Chapter 90 of the General Statutes, as Article 18H of Chapter 90 of the General Statutes. **Section 2(b)** of the bill would enact the PSYPACT.

G.S. 90-270.160 would set forth the purpose of the PSYPACT.

G.S. 90-270.161 would establish definitions for the PSYPACT.

G.S. 90-270.162 would:

- Establish a psychologist's home state as the state in which the psychologist is licensed or physically present when practicing.
- Allow a psychologist to provide services, via telepsychology, to clients in other compact states, if those states:
    - Require the psychologist to hold an E.Passport.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- Investigate complaints against psychologists.
- Notify the PSYPACT Commission about adverse actions taken against psychologists.
- Comply with the by-laws of the Commission.
- Perform criminal background checks on psychologists.

- Allow a psychologist to provide face-to-face services in a compact state if that state:
  - Requires psychologists to hold a current Interjurisdictional Practice Certificate (IPC).
  - Investigates complaints against psychologists.
  - Notifies the PSYPACT Commission about adverse actions taken against psychologists.
  - Complies with the by-laws of the Commission.
  - Performs criminal background checks on psychologists.

G.S. 90-270.163 would allow a psychologist to practice telepsychology with clients in other compact states, provided that the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid E.Passport, and makes certain attestations.

Psychologists practicing under G.S. 90-270.163 would be subject to their home state's licensing authorities, and be subject to the compact state's rules regarding scope of practice.

G.S. 90-270.164 would allow a psychologist to practice psychology face-to-face with clients in compact states, provided the psychologist has a graduate degree in psychology, is licensed in a compact state, has no criminal record, holds a valid IPC, and makes certain attestations.

Psychologists practicing under G.S. 90-270.164 would be subject to the authority, law, and scope of practice of the compact state in which they are practicing.

G.S. 90-270.165 would allow a psychologist to practice telepsychology with patients in other compact states only when the psychologist initiates the session from the home state in which the psychologist is licensed.

G.S. 90-270.166 would allow home states, compact states in which a psychologist treats patients face-to-face, and states in which a psychologist practices via telepsychiatry to take adverse actions against the psychologist's license.

G.S. 90-270.167 would allow the regulatory authority in the compact states the power to:

- Issue subpoenas.
- Issue cease-and-desist orders.
- Prevent psychologists under investigation from changing their home state licensures.

G.S. 90-270.168 would allow the Commission to maintain a database containing the following data on licensed psychologists, which must be submitted by each compact state:

- Identifying information.
- Licensure data.
- Significant investigatory information.
- Information on adverse actions taken by the regulatory authority.

G.S. 90-270.169 would create the Psychology Interjurisdictional Compact Commission. Membership in the Commission would consist of one voting member from each compact state. All meetings of the Commission must be public unless employment, discipline, litigation, contract negotiation, or adverse action investigation are being discussed. The Commission would have all the powers necessary to administer and carry out the business of the PSYPACT.

The Commission may be financed by accepting gifts and levying assessments on member states.

Commission members would be immune from suit for their official actions.

G.S. 90-270.170 would give the Commission power to make rules for the compact. These rules would not affect the rules of practice established by the regulatory authorities of the member states. Rules may be approved by a majority vote of Commission members, and any rule rejected by the legislatures of a majority of member states would no longer have any effect.

G.S. 90-270.171 would establish oversight, default, and conflict resolution provisions for the PSYPACT.

- All branches of government of all member states must enforce the PSYPACT's purpose and intent.
- If a state is in default under the terms of the PSYPACT and refuses to cure that default, the Commission may terminate the state's membership in the PSYPACT.
- By a majority vote of members, the Commission may initiate legal action to enforce compliance with the rules of the PSYPACT.
- The Commission will attempt to resolve any dispute between member and non-member states.

G.S. 90-270.172 would:

- Make the PSYPACT effective on the date the seventh member state enacts it.
- Allow member states to leave the PSYPACT by repealing the act enacting it.
- Prevent the Commission from prohibiting any other licensure agreements between member states, so any reciprocity agreements between member states would still remain in effect.
- Allow member states to amend the PSYPACT; however, amendments would not take effect until the legislatures of all the member states enacted them.

G.S. 90-270.173 would require the PSYPACT to be construed liberally, and if any portions of the PSYPACT are struck down by a court, the remaining provisions would remain in effect.

PART III. ALLOW LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT FIRST-LEVEL EXAM FOR INVOLUNTARY COMMITMENT AND CREATE FEES would amend G.S. 122C-263.1 to permit licensed marriage and family therapists to conduct first examinations in involuntary commitment proceedings. It would create a ten dollar fee for licensure as a marriage and family therapist and allow the Board to charge each applicant the cost of processing test results and the cost of test materials.

PART IV. ELIMINATE REDUNDANCY IN ADULT CARE HOME INSPECTIONS would amend the statute pertaining to inspections, monitoring, and review of adult care homes. The amendment would provide that if the annual inspection of an adult care home is conducted separately from the physical plant and life-safety requirements inspection required every two years, the Division of Health Service Regulation, DHHS, is prohibited from citing a violation of law that overlaps with a physical plant and life-safety inspection area in the annual inspection unless failure to address poses a risk to resident health or safety.

PART V contains a severability clause.

EFFECTIVE DATE: Except as provided below, the bill would become effective when it becomes law:

- PART I would be effective January 1, 2020. Subsection (a) of Part I would be apply to contested cases arising on or after January 1, 2020.
- PART II would be effective when at least seven states have enacted the PSYPACT set forth in Part II.
- PART III would be effective October 1, 2019.

BACKGROUND:

PART I: Any new institutional health service, as defined in G.S. 131A-176(16), must undergo Certificate of Need review before it is offered. The process requires an application to the department of Health and Human Services, Division of Health Service Regulation. After the application is submitted, there is a public comment and hearing process before the Division approves or disapproves the application. In making a determination, the Division considers the needs identified in the State Medical Facilities Plan.

PART II: The PSYPACT is a multi-jurisdictional psychology compact. As of April 9, 2019, it has been enacted by seven states (Arizona, Nevada, Utah, Colorado, Nebraska, Missouri and Illinois). Though Illinois has enacted PSYPACT legislation, it does not become effective until January 1st, 2020, and therefore does not count as the seventh state needed to make PSYPACT operational. PSYPACT legislation is currently being considered in District of Columbia, Georgia, New Hampshire, Oklahoma, Pennsylvania, Rhode Island and Texas. It has been endorsed by the psychology licensing boards in seven states (New Mexico, Texas, Georgia, Ohio, Wisconsin, Virginia and Rhode Island). PSYPACT was recommended by the Joint Legislative Oversight Committee on Health and Human Services to the 2018 Session of the 2017 General Assembly of North Carolina.

PART III: G.S. 122C-263(c) requires that a commitment examiner conduct an examination of a respondent within 24 hours of the respondent being presented for involuntary commitment. This examination can be conducted in person or by using telemedicine procedures. After examining the respondent, the commitment examiner can recommend outpatient treatment, treatment at a 24-hour facility prior to a court hearing on commitment, or a termination of the commitment proceedings.

SENATE BILL 361

Short Title:	Health Care Expansion Act of 2019.	(Public)
Sponsors:	Senators Krawiec, Bishop, and Hise (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

March 27, 2019

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS REFORMS THAT WILL INCREASE ACCESS TO HEALTH CARE IN NORTH CAROLINA.

The General Assembly of North Carolina enacts:

PART I. INCREASE INNOVATIONS WAIVER SLOTS

SECTION 1.(a) The Department of Health and Human Services, Division of Health Benefits, shall amend the North Carolina Innovations waiver to increase the number of slots available under the waiver by a maximum of 1,000 slots to be made available on January 1, 2020, and by a maximum of 1,000 slots to be made available on January 1, 2021.

SECTION 1.(b) There is appropriated from the General Fund to the Department of Health and Human Services, Division of Health Benefits, the sum of ten million two hundred fifty thousand dollars ($10,250,000) in recurring funds for the 2019-2020 fiscal year and the sum of thirty million seven hundred fifty thousand dollars ($30,750,000) in recurring funds for the 2020-2021 fiscal year to be used to fund these additional slots.

PART II. REPEAL OF NORTH CAROLINA'S CERTIFICATE OF NEED LAWS

SECTION 2.(a) G.S. 6-19.1(a) reads as rewritten:

"(a) In any civil action, other than an adjudication for the purpose of establishing or fixing a rate, or a disciplinary action by a licensing board, brought by the State or brought by a party who is contesting State action pursuant to G.S. 150B-43 or any other appropriate provisions of law, unless the prevailing party is the State, the court may, in its discretion, allow the prevailing party to recover reasonable attorney's fees, including attorney's fees applicable to the administrative review portion of the case, in contested cases arising under Article 3 of Chapter 150B, to be taxed as court costs against the appropriate agency if:

(1) The court finds that the agency acted without substantial justification in pressing its claim against the party; and

(2) The court finds that there are no special circumstances that would make the award of attorney's fees unjust. The party shall petition for the attorney's fees within 30 days following final disposition of the case. The petition shall be supported by an affidavit setting forth the basis for the request.

~~Nothing in this section shall be deemed to authorize the assessment of attorney's fees for the administrative review portion of the case in contested cases arising under Article 9 of Chapter 131E of the General Statutes.~~

Nothing in this section grants permission to bring an action against an agency otherwise immune from suit or gives a right to bring an action to a party who otherwise lacks standing to bring the action.

Any attorney's fees assessed against an agency under this section shall be charged against the operating expenses of the agency and shall not be reimbursed from any other source."

SECTION 2.(b) G.S. 58-50-61(a) reads as rewritten:

"(a) Definitions. – As used in this section, in G.S. 58-50-62, and in Part 4 of this Article, the term:

...

(8) "Health care provider" means any person who is licensed, registered, or certified under Chapter 90 of the General Statutes or the laws of another state to provide health care services in the ordinary care of business or practice or a profession or in an approved education or training program; a health care facility as defined in ~~G.S. 131E-176(9b)~~ this section or the laws of another state to operate as a health care facility; or a pharmacy.

...

(9a) "Health service facility" means 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, hospice inpatient facility, or hospice residential care facility; or ambulatory surgical facility.

...."

SECTION 2.(c) G.S. 58-55-35(a) reads as rewritten:

"(a) Whenever long-term care insurance provides coverage for the facilities, services, or physical or mental conditions listed below, unless otherwise defined in the policy and certificate, and approved by the Commissioner, such facilities, services, or conditions are defined as follows:

...

(10) "Hospice" ~~shall be defined in accordance with the terms of G.S. 131E-176(13a).~~means any coordinated program of home care with provision for inpatient care for terminally ill patients and their families. This care is provided by a medically directed interdisciplinary team directly or through an agreement under the direction of an identifiable hospice administration. A hospice program of care provides palliative and supportive medical and other health services to meet the physical, psychological, social, spiritual, and special needs of patients and their families, which are experienced during the final stages of terminal illness and during dying and bereavement.

(11) "Intermediate care facility for ~~the mentally retarded" shall be defined in accordance with the terms of G.S. 131E-176(14a).~~individuals with intellectual disabilities" means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for individuals with intellectual disabilities, autism, cerebral palsy, epilepsy, or related conditions.

...."

SECTION 2.(d) G.S. 113A-12(3)e. reads as rewritten:

"e. A health care facility financed pursuant to Chapter 131A of the General ~~Statutes or receiving a certificate of need under Article 9 of Chapter 131E of the General~~ Statutes."

SECTION 2.(e) G.S. 122C-23.1(e) reads as rewritten:

"(e) As used in this section, "residential treatment facility" means a "residential facility" as defined in and licensed under this ~~Chapter, but not subject to Certificate of Need requirements under Article 9 of Chapter 131E of the General Statutes.~~Chapter."

SECTION 2.(f) G.S. 131E-13(a)(1) reads as rewritten:

"(1) The corporation shall continue to provide the same or similar clinical hospital services to its patients in medical-surgery, obstetrics, pediatrics, outpatient and emergency treatment, including emergency services for the indigent, that the hospital facility provided prior to the lease, sale, or conveyance. These services may be terminated only as prescribed ~~by Certificate of Need Law prescribed in Article 9 of Chapter 131E of the General Statutes, or, if Certificate of Need Law is inapplicable,~~ by review procedure designed to guarantee public participation pursuant to rules adopted by the Secretary of the Department of Health and Human Services."

SECTION 2.(g) G.S. 131E-136(4) reads as rewritten:

"(4) "Home health agency" means a home care agency which is certified to receive Medicare and Medicaid reimbursement for providing nursing care, therapy, medical social services, and home health aide services on a part-time, intermittent ~~basis as set out in G.S. 131E-176(12), and is thereby also subject to Article 9 of Chapter 131E.~~basis."

SECTION 2.(h) 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 Division of Adult Correction of the Department of Public Safety 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 of the Division of Adult Correction of the Department of Public Safety and to members of the general public, the portion of the facility that serves inmates shall be exempt from licensure.

~~(b) Any person who contracts to provide inpatient chemical dependency or substance abuse services to inmates of the Division of Adult Correction of the Department of Public Safety 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 2.(i) Article 9 of Chapter 131E of the General Statutes, G.S. 130A-45.02(i), 143B-1292, 150B-2(8a)k., and 150B-21.1(6) are repealed.

SECTION 2.(j) This section becomes effective January 1, 2020. Subsection (a) of this section applies to contested cases arising on or after January 1, 2020.

PART III. PSYCHOLOGY INTERJURISDICTIONAL LICENSURE COMPACT

SECTION 3.(a) Article 18A of Chapter 90 of the General Statutes, G.S. 90-270.1 through G.S. 90-270.22, is recodified as Article 18G of Chapter 90 of the General Statutes, G.S. 90-270.135 through G.S. 90-270.159.

SECTION 3.(b) Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 18H.

"Psychology Interjurisdictional Licensure Compact.

"**§ 90-270.160. Purpose.**

This Compact is designed to achieve the following purposes and objectives:

(1) Increase public access to professional psychological services by allowing for telepsychological practice across state lines as well as temporary in-person, face-to-face services into a state which the psychologist is not licensed to practice psychology.

(2) Enhance the states' ability to protect the public's health and safety, especially client/patient safety.

(3) Encourage the cooperation of Compact States in the areas of psychology licensure and regulation.

(4) Facilitate the exchange of information between Compact States regarding psychologist licensure, adverse actions, and disciplinary history.

(5) Promote compliance with the laws governing psychological practice in each Compact State.

(6) Invest all Compact States with the authority to hold licensed psychologists accountable through the mutual recognition of Compact State licenses.

"**§ 90-270.161. Definitions.**

(1) Adverse action. – Any action taken by a State Psychology Regulatory Authority which finds a violation of a statute or regulation that is identified by the State Psychology Regulatory Authority as discipline and is a matter of public record.

(2) Association of State and Provincial Psychology Boards (ASPPB). – The recognized membership organization composed of State and Provincial Psychology Regulatory Authorities responsible for the licensure and registration of psychologists throughout the United States and Canada.

(3) Authority to Practice Interjurisdictional Telepsychology. – A licensed psychologist's authority to practice telepsychology, within the limits authorized under this Compact, in another Compact State.

(4) Bylaws. – Those Bylaws established by the Psychology Interjurisdictional Compact Commission pursuant to G.S. 90-270.169 for its governance or for directing and controlling its actions and conduct.

(5) Client/patient. – The recipient of psychological services, whether psychological services are delivered in the context of health care, corporate, supervision, and/or consulting services.

(6) Commissioner. – The voting representative appointed by each State Psychology Regulatory Authority pursuant to G.S. 90-270.169.

(7) Compact State. – A state, the District of Columbia, or United States territory that has enacted this Compact legislation and which has not withdrawn pursuant to G.S. 90-270.172(c) or been terminated pursuant to G.S. 90-270.171(b).

(8) Confidentiality. – The principle that data or information is not made available or disclosed to unauthorized persons and/or processes.

(9) Coordinated Licensure Information System or Coordinated Database. – An integrated process for collecting, storing, and sharing information on psychologists' licensure and enforcement activities related to psychology licensure laws, which is administered by the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(10) Day. – Any part of a day in which psychological work is performed.

(11) Distant State. – The Compact State where a psychologist is physically present (not through the use of telecommunications technologies) to provide temporary in-person, face-to-face psychological services.

(12) E.Passport. – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that promotes the standardization in the criteria of interjurisdictional telepsychology practice and facilitates the process for licensed psychologists to provide telepsychological services across state lines.

(13) Executive Board. – A group of directors elected or appointed to act on behalf of, and within the powers granted to them by, the Commission.

(14) Home State. – A Compact State where a psychologist is licensed to practice psychology. If the psychologist is licensed in more than one Compact State and is practicing under the Authority to Practice Interjurisdictional Telepsychology, the Home State is the Compact State where the psychologist is physically present when the telepsychological services are delivered. If the psychologist is licensed in more than one Compact State and is practicing under the Temporary Authorization to Practice, the Home State is any Compact State where the psychologist is licensed.

(15) Identity History Summary. – A summary of information retained by the FBI, or other designee with similar authority, in connection with arrests and, in some instances, federal employment, naturalization, or military service.

(16) In-person, face-to-face. – Interactions in which the psychologist and the client/patient are in the same physical space and which does not include interactions that may occur through the use of telecommunication technologies.

(17) Interjurisdictional Practice Certificate (IPC). – A certificate issued by the Association of State and Provincial Psychology Boards (ASPPB) that grants temporary authority to practice based on notification to the State Psychology Regulatory Authority of intention to practice temporarily and verification of one's qualifications for such practice.

(18) License. – Authorization by a State Psychology Regulatory Authority to engage in the independent practice of psychology, which would be unlawful without the authorization.

(19) Non-Compact State. – Any State which is not at the time a Compact State.

(20) Psychologist. – An individual licensed for the independent practice of psychology.

(21) Psychology Interjurisdictional Compact Commission (Commission). – The national administration of which all Compact States are members.

(22) Receiving State. – A Compact State where the client/patient is physically located when the telepsychological services are delivered.

(23) Rule. – A written statement by the Psychology Interjurisdictional Compact Commission promulgated pursuant to G.S. 90-270.170 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission and has the force and effect of statutory law in a Compact State, and includes the amendment, repeal, or suspension of an existing rule.

(24) Significant investigatory information. –

a. Investigative information that a State Psychology Regulatory Authority, after a preliminary inquiry that includes notification and an opportunity to respond if required by state law, has reason to believe, if proven true, would indicate more than a violation of state statute or ethics code that would be considered more substantial than minor infraction; or

b. Investigative information that indicates that the psychologist represents an immediate threat to public health and safety regardless of whether the psychologist has been notified and/or had an opportunity to respond.

(25) State. – A state, commonwealth, territory, or possession of the United States or the District of Columbia.

(26) State Psychology Regulatory Authority. – The Board, office, or other agency with the legislative mandate to license and regulate the practice of psychology.

(27) Telepsychology. – The provision of psychological services using telecommunication technologies.

(28) Temporary Authorization to Practice. – A licensed psychologist's authority to conduct temporary in-person, face-to-face practice, within the limits authorized under this Compact, in another Compact State.

(29) Temporary in-person, face-to-face practice. – Where a psychologist is physically present (not through the use of telecommunications technologies) in the Distant State to provide for the practice of psychology for 30 days within a calendar year and based on notification to the Distant State.

"**§ 90-270.162. Home State licensure.**

(a) The Home State shall be a Compact State where a psychologist is licensed to practice psychology.

(b) A psychologist may hold one or more Compact State licenses at a time. If the psychologist is licensed in more than one Compact State, the Home State is the Compact State where the psychologist is physically present when the services are delivered as authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(c) Any Compact State may require a psychologist not previously licensed in a Compact State to obtain and retain a license to be authorized to practice in the Compact State under circumstances not authorized by the Authority to Practice Interjurisdictional Telepsychology under the terms of this Compact.

(d) Any Compact State may require a psychologist to obtain and retain a license to be authorized to practice in a Compact State under circumstances not authorized by Temporary Authorization to Practice under the terms of this Compact.

(e) A Home State's license authorizes a psychologist to practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only if the Compact State:

(1) Currently requires the psychologist to hold an active E.Passport;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

(f) A Home State's license grants Temporary Authorization to Practice to a psychologist in a Distant State only if the Compact State:

(1) Currently requires the psychologist to hold an active IPC;

(2) Has a mechanism in place for receiving and investigating complaints about licensed individuals;

(3) Notifies the Commission, in compliance with the terms herein, of any adverse action or significant investigatory information regarding a licensed individual;

(4) Requires an Identity History Summary of all applicants at initial licensure, including the use of the results of fingerprints or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation (FBI), or other designee with similar authority, no later than 10 years after activation of the Compact; and

(5) Complies with the Bylaws and Rules of the Commission.

"**§ 90-270.163. Compact privilege to practice telepsychology.**

(a) Compact States shall recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice telepsychology in other Compact States (Receiving States) in which the psychologist is not licensed, under the Authority to Practice Interjurisdictional Telepsychology as provided in the Compact.

(b) To exercise the Authority to Practice Interjurisdictional Telepsychology under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:

a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or

b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:

a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;

b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;

c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;

e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;

f. The designated director of the program must be a psychologist and a member of the core faculty;

g. The program must have an identifiable body of students who are matriculated in that program for a degree;

h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;

i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degree and a minimum of one academic year of full-time graduate study for master's degree;

j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;

(4) Have no history of adverse action that violate the Rules of the Commission;
(5) Have no criminal record history reported on an Identity History Summary that violates the Rules of the Commission;
(6) Possess a current, active E.Passport;
(7) Provide attestations in regard to areas of intended practice, conformity with standards of practice, competence in telepsychology technology, criminal background, and knowledge and adherence to legal requirements in the home and receiving states, and provide a release of information to allow for primary source verification in a manner specified by the Commission; and
(8) Meet other criteria as defined by the Rules of the Commission.

(c) The Home State maintains authority over the license of any psychologist practicing into a Receiving State under the Authority to Practice Interjurisdictional Telepsychology.

(d) A psychologist practicing in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology will be subject to the Receiving State's scope of practice. A Receiving State may, in accordance with that state's due process law, limit or revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology in the Receiving State and may take any other necessary actions under the Receiving State's applicable law to protect the health and safety of the Receiving State's citizens. If a Receiving State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Authority to Practice Interjurisdictional Telepsychology in any Receiving State is restricted, suspended, or otherwise limited, the E.Passport shall be revoked and, therefore, the psychologist shall not be eligible to practice telepsychology in a Compact State under the Authority to Practice Interjurisdictional Telepsychology.

"**§ 90-270.164. Compact Temporary Authorization to Practice.**

(a) Compact States shall also recognize the right of a psychologist, licensed in a Compact State in conformance with G.S. 90-270.162, to practice temporarily in other Compact States (Distant States) in which the psychologist is not licensed, as provided in the Compact.

(b) To exercise the Temporary Authorization to Practice under the terms and provisions of this Compact, a psychologist licensed to practice in a Compact State must:

(1) Hold a graduate degree in psychology from an institute of higher education that was, at the time the degree was awarded:
a. Regionally accredited by an accrediting body recognized by the U.S. Department of Education to grant graduate degrees, or authorized by Provincial Statute or Royal Charter to grant doctoral degrees; or
b. A foreign college or university deemed to be equivalent to sub-subdivision a. of this subdivision by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services (NACES) or by a recognized foreign credential evaluation service; and

(2) Hold a graduate degree in psychology that meets the following criteria:
a. The program, wherever it may be administratively housed, must be clearly identified and labeled as a psychology program. Such a program must specify in pertinent institutional catalogues and brochures its intent to educate and train professional psychologists;
b. The psychology program must stand as a recognizable, coherent, organizational entity within the institution;
c. There must be a clear authority and primary responsibility for the core and specialty areas whether or not the program cuts across administrative lines;

d. The program must consist of an integrated, organized sequence of study;
e. There must be an identifiable psychology faculty sufficient in size and breadth to carry out its responsibilities;
f. The designated director of the program must be a psychologist and a member of the core faculty;
g. The program must have an identifiable body of students who are matriculated in that program for a degree;
h. The program must include supervised practicum, internship, or field training appropriate to the practice of psychology;
i. The curriculum shall encompass a minimum of three academic years of full-time graduate study for doctoral degrees and a minimum of one academic year of full-time graduate study for master's degrees;
j. The program includes an acceptable residency as defined by the Rules of the Commission.

(3) Possess a current, full, and unrestricted license to practice psychology in a Home State that is a Compact State;
(4) No history of adverse action that violates the Rules of the Commission;
(5) No criminal record history that violates the Rules of the Commission;
(6) Possess a current, active IPC;
(7) Provide attestations in regard to areas of intended practice and work experience and provide a release of information to allow for primary source verification in a manner specified by the Commission; and
(8) Meet other criteria as defined by the Rules of the Commission.

(c) A psychologist practicing into a Distant State under the Temporary Authorization to Practice shall practice within the scope of practice authorized by the Distant State.

(d) A psychologist practicing into a Distant State under the Temporary Authorization to Practice will be subject to the Distant State's authority and law. A Distant State may, in accordance with that state's due process law, limit or revoke a psychologist's Temporary Authorization to Practice in the Distant State and may take any other necessary actions under the Distant State's applicable law to protect the health and safety of the Distant State's citizens. If a Distant State takes action, the state shall promptly notify the Home State and the Commission.

(e) If a psychologist's license in any Home State, another Compact State, or any Temporary Authorization to Practice in any Distant State is restricted, suspended, or otherwise limited, the IPC shall be revoked and therefore the psychologist shall not be eligible to practice in a Compact State under the Temporary Authorization to Practice.

"**§ 90-270.165. Conditions of telepsychology practice in a Receiving State.**

A psychologist may practice in a Receiving State under the Authority to Practice Interjurisdictional Telepsychology only in the performance of the scope of practice for psychology as assigned by an appropriate State Psychology Regulatory Authority, as defined in the Rules of the Commission, and under the following circumstances:

(1) The psychologist initiates a client/patient contact in a Home State via telecommunications technologies with a client/patient in a Receiving State.
(2) Other conditions regarding telepsychology as determined by Rules promulgated by the Commission.

"**§ 90-270.166. Adverse actions.**

(a) A Home State shall have the power to impose adverse action against a psychologist's license issued by the Home State. A Distant State shall have the power to take adverse action on a psychologist's Temporary Authorization to Practice within that Distant State.

(b) A Receiving State may take adverse action on a psychologist's Authority to Practice Interjurisdictional Telepsychology within that Receiving State. A Home State may take adverse

action against a psychologist based on an adverse action taken by a Distant State regarding temporary in-person, face-to-face practice.

(c) If a Home State takes adverse action against a psychologist's license, that psychologist's Authority to Practice Interjurisdictional Telepsychology is terminated and the E.Passport is revoked. Furthermore, that psychologist's Temporary Authorization to Practice is terminated and the IPC is revoked.

(1) All Home State disciplinary orders which impose adverse action shall be reported to the Commission in accordance with the Rules promulgated by the Commission. A Compact State shall report adverse actions in accordance with the Rules of the Commission.

(2) In the event discipline is reported on a psychologist, the psychologist will not be eligible for telepsychology or temporary in-person, face-to-face practice in accordance with the Rules of the Commission.

(3) Other actions may be imposed as determined by the Rules promulgated by the Commission.

(d) A Home State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a licensee which occurred in a Receiving State as it would if such conduct had occurred by a licensee within the Home State. In such cases, the Home State's law shall control in determining any adverse action against a psychologist's license.

(e) A Distant State's Psychology Regulatory Authority shall investigate and take appropriate action with respect to reported inappropriate conduct engaged in by a psychologist practicing under Temporary Authorization Practice which occurred in that Distant State as it would if such conduct had occurred by a licensee within the Home State. In such cases, Distant State's law shall control in determining any adverse action against a psychologist's Temporary Authorization to Practice.

(f) Nothing in this Compact shall override a Compact State's decision that a psychologist's participation in an alternative program may be used in lieu of adverse action and that such participation shall remain nonpublic if required by the Compact State's law. Compact States must require psychologists who enter any alternative programs to not provide telepsychology services under the Authority to Practice Interjurisdictional Telepsychology or provide temporary psychological services under the Temporary Authorization to Practice in any other Compact State during the term of the alternative program.

(g) No other judicial or administrative remedies shall be available to a psychologist in the event a Compact State imposes an adverse action pursuant to subsection (c) of this section.

"**§ 90-270.167. Additional authorities invested in a Compact State's Psychology Regulatory Authority.**

In addition to any other powers granted under state law, a Compact State's Psychology Regulatory Authority shall have the authority under this Compact to:

(1) Issue subpoenas, for both hearings and investigations, which require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a Compact State's Psychology Regulatory Authority for the attendance and testimony of witnesses and/or the production of evidence from another Compact State shall be enforced in the latter state by any court of competent jurisdiction, according to that court's practice and procedure in considering subpoenas issued in its own proceedings. The issuing State Psychology Regulatory Authority shall pay any witness fees, travel expenses, mileage, and other fees required by the service statutes of the state where the witnesses and/or evidence are located.

(2) Issue cease and desist and/or injunctive relief orders to revoke a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice.

(3) During the course of any investigation, a psychologist may not change his/her Home State licensure. A Home State Psychology Regulatory Authority is authorized to complete any pending investigations of a psychologist and to take any actions appropriate under its law. The Home State Psychology Regulatory Authority shall promptly report the conclusions of such investigations to the Commission. Once an investigation has been completed, and pending the outcome of said investigation, the psychologist may change his/her Home State licensure. The Commission shall promptly notify the new Home State of any such decisions as provided in the Rules of the Commission. All information provided to the Commission or distributed by Compact States pursuant to the psychologist shall be confidential, filed under seal, and used for investigatory or disciplinary matters. The Commission may create additional rules for mandated or discretionary sharing of information by Compact States.

"**§ 90-270.168. Coordinated Licensure Information System.**

(a) The Commission shall provide for the development and maintenance of a Coordinated Licensure Information System (Coordinated Database) and reporting system containing licensure and disciplinary action information on all psychologists to whom this Compact is applicable in all Compact States as defined by the Rules of the Commission.

(b) Notwithstanding any other provision of state law to the contrary, a Compact State shall submit a uniform data set to the Coordinated Database on all licensees as required by the Rules of the Commission, including:

(1) Identifying information;
(2) Licensure data;
(3) Significant investigatory information;
(4) Adverse actions against a psychologist's license;
(5) An indicator that a psychologist's Authority to Practice Interjurisdictional Telepsychology and/or Temporary Authorization to Practice is revoked;
(6) Nonconfidential information related to alternative program participation information;
(7) Any denial of application for licensure and the reasons for such denial; and
(8) Other information which may facilitate the administration of this Compact, as determined by the Rules of the Commission.

(c) The Coordinated Database administrator shall promptly notify all Compact States of any adverse action taken against, or significant investigative information on, any licensee in a Compact State.

(d) Compact States reporting information to the Coordinated Database may designate information that may not be shared with the public without the express permission of the Compact State reporting the information.

(e) Any information submitted to the Coordinated Database that is subsequently required to be expunged by the law of the Compact State reporting the information shall be removed from the Coordinated Database.

"**§ 90-270.169. Establishment of the Psychology Interjurisdictional Compact Commission.**

(a) The Compact States hereby create and establish a joint public agency known as the Psychology Interjurisdictional Compact Commission.

(1) The Commission is a body politic and an instrumentality of the Compact States.

(2) Venue is proper and judicial proceedings by or against the Commission shall be brought solely and exclusively in a court of competent jurisdiction where the principal office of the Commission is located. The Commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(3) Nothing in this Compact shall be construed to be a waiver of sovereign immunity.

(b) Membership, Voting, and Meetings. –

(1) The Commission shall consist of one voting representative appointed by each Compact State who shall serve as that state's Commissioner. The State Psychology Regulatory Authority shall appoint its delegate. This delegate shall be empowered to act on behalf of the Compact State. This delegate shall be limited to:

a. Executive Director, Executive Secretary, or similar executive;

b. Current member of the State Psychology Regulatory Authority of a Compact State; or

c. Designee empowered with the appropriate delegate authority to act on behalf of the Compact State.

(2) Any Commissioner may be removed or suspended from office as provided by the law of the state from which the Commissioner is appointed. Any vacancy occurring in the Commission shall be filled in accordance with the laws of the Compact State in which the vacancy exists.

(3) Each Commissioner shall be entitled to one vote with regard to the promulgation of Rules and creation of Bylaws and shall otherwise have an opportunity to participate in the business and affairs of the Commission. A Commissioner shall vote in person or by such other means as provided in the Bylaws. The Bylaws may provide for Commissioners' participation in meetings by telephone or other means of communication.

(4) The Commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the Bylaws.

(5) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under the rule-making provisions in G.S. 90-270.170.

(6) The Commission may convene in a closed, nonpublic meeting if the Commission must discuss:

a. Noncompliance of a Compact State with its obligations under the Compact;

b. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedures;

c. Current, threatened, or reasonably anticipated litigation against the Commission;

d. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

e. Accusation against any person of a crime or formally censuring any person;

f. Disclosure of trade secrets or commercial or financial information which is privileged or confidential;

g. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

h. Disclosure of investigatory records compiled for law enforcement purposes;

i. Disclosure of information related to any investigatory reports prepared by or on behalf of or for use of the Commission or other committee charged with responsibility for investigation or determination of compliance issues pursuant to the Compact; or

j. Matters specifically exempted from disclosure by federal and state statute.

(7) If a meeting, or portion of a meeting, is closed pursuant to this provision, the Commission's legal counsel or designee shall certify that the meeting may be closed and shall reference each relevant exempting provision. The Commission shall keep minutes which fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, of any person participating in the meeting, and the reasons therefore, including a description of the views expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release only by a majority vote of the Commission or order of a court of competent jurisdiction.

(c) The Commission shall, by a majority vote of the Commissioners, prescribe Bylaws and/or Rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of the Compact, including, but not limited to:

(1) Establishing the fiscal year of the Commission;

(2) Providing reasonable standards and procedures:

a. For the establishment and meetings of other committees; and

b. Governing any general or specific delegation of any authority or function of the Commission;

(3) Providing reasonable procedures for calling and conducting meetings of the Commission, ensuring reasonable advance notice of all meetings and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals of such proceedings, and proprietary information, including trade secrets. The Commission may meet in closed session only after a majority of the Commissioners vote to close a meeting to the public in whole or in part. As soon as practicable, the Commission must make public a copy of the vote to close the meeting revealing the vote of each Commissioner with no proxy votes allowed;

(4) Establishing the titles, duties, and authority and reasonable procedures for the election of the officers of the Commission;

(5) Providing reasonable standards and procedures for the establishment of the personnel policies and programs of the Commission. Notwithstanding any civil service or other similar law of any Compact State, the Bylaws shall exclusively govern the personnel policies and programs of the Commission;

(6) Promulgating a Code of Ethics to address permissible and prohibited activities of Commission members and employees;

(7) Providing a mechanism for concluding the operations of the Commission and the equitable disposition of any surplus funds that may exist after the termination of the Compact after the payment and/or reserving of all of its debts and obligations;

(8) The Commission shall publish its Bylaws in a convenient form and file a copy thereof and a copy of any amendment thereto with the appropriate agency or officer in each of the Compact States;

(9) The Commission shall maintain its financial records in accordance with the Bylaws; and

(10) The Commission shall meet and take such actions as are consistent with the provisions of this Compact and the Bylaws.

(d) The Commission shall have the following powers:

(1) The authority to promulgate uniform rules to facilitate and coordinate implementation and administration of this Compact. The rules shall have the force and effect of law and shall be binding in all Compact States;

(2) To bring and prosecute legal proceedings or actions in the name of the Commission, provided that the standing of any State Psychology Regulatory Authority or other regulatory body responsible for psychology licensure to sue or be sued under applicable law shall not be affected;

(3) To purchase and maintain insurance and bonds;

(4) To borrow, accept, or contract for services of personnel, including, but not limited to, employees of a Compact State;

(5) To hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of the Compact, and establish the Commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;

(6) To accept any and all appropriate donations and grants of money, equipment, supplies, materials, and services and to receive, utilize, and dispose of the same, provided that at all times the Commission shall strive to avoid any appearance of impropriety and/or conflict of interest;

(7) To lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve, or use any property, real, personal, or mixed, provided that at all times the Commission shall strive to avoid any appearance of impropriety;

(8) To sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(9) To establish a budget and make expenditures;

(10) To borrow money;

(11) To appoint committees, including advisory committees comprised of members, state regulators, state legislators or their representatives, and consumer representatives, and such other interested persons as may be designated in this Compact and the Bylaws;

(12) To provide and receive information from, and to cooperate with, law enforcement agencies;

(13) To adopt and use an official seal; and

(14) To perform such other functions as may be necessary or appropriate to achieve the purposes of this Compact consistent with the state regulation of psychology licensure, temporary in-person, face-to-face practice, and telepsychology practice.

(e) The Executive Board. – The elected officers shall serve as the Executive Board, which shall have the power to act on behalf of the Commission according to the terms of this Compact.

(1) The Executive Board shall be comprised of six members:

a. Five voting members who are elected from the current membership of the Commission by the Commission.

b. One ex officio, nonvoting member from the recognized membership organization composed of State and Provincial Psychology Regulatory Authorities.

(2) The ex officio member must have served as staff or member on a State Psychology Regulatory Authority and will be selected by its respective organization.

(3) The Commission may remove any member of the Executive Board as provided in Bylaws.

(4) The Executive Board shall meet at least annually.

(5) The Executive Board shall have the following duties and responsibilities:

a. Recommend to the entire Commission changes to the Rules or Bylaws, changes to this Compact legislation, or fees paid by Compact States such as annual dues and any other applicable fees;

b. Ensure Compact administration services are appropriately provided, contractual or otherwise;

c. Prepare and recommend the budget;

d. Maintain financial records on behalf of the Commission;

e. Monitor Compact compliance of member states and provide compliance reports to the Commission;

f. Establish additional committees as necessary; and

g. Other duties as provided in Rules or Bylaws.

(f) Financing of the Commission. –

(1) The Commission shall pay or provide for the payment of the reasonable expenses of its establishment, organization, and ongoing activities.

(2) The Commission may accept any and all appropriate revenue sources, donations, and grants of money, equipment, supplies, materials, and services.

(3) The Commission may levy on and collect an annual assessment from each Compact State or impose fees on other parties to cover the cost of the operations and activities of the Commission and its staff which must be in a total amount sufficient to cover its annual budget as approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated based upon a formula to be determined by the Commission which shall promulgate a rule binding upon all Compact States.

(4) The Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same, nor shall the Commission pledge the credit of any of the Compact States, except by and with the authority of the Compact State.

(5) The Commission shall keep accurate accounts of all receipts and disbursements. The receipts and disbursements of the Commission shall be subject to the audit and accounting procedures established under its Bylaws. However, all receipts and disbursements of funds handled by the Commission shall be audited yearly by a certified or licensed public accountant and the report of the audit shall be included in and become part of the annual report of the Commission.

(g) Qualified Immunity, Defense, and Indemnification. –

(1) The members, officers, Executive Director, employees, and representatives of the Commission shall be immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom

the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing in this subdivision shall be construed to protect any such person from suit and/or liability for any damage, loss, injury, or liability caused by the intentional or willful or wanton misconduct of that person.

(2) The Commission shall defend any member, officer, Executive Director, employee, or representative of the Commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of Commission employment, duties, or responsibilities, or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that nothing herein shall be construed to prohibit that person from retaining his or her own counsel, and provided further that the actual or alleged act, error, or omission did not result from that person's intentional or willful or wanton misconduct.

(3) The Commission shall indemnify and hold harmless any member, officer, Executive Director, employee, or representative of the Commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of employment, duties, or responsibilities, or that such person had a reasonable basis for believing occurred within the scope of Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional or willful or wanton misconduct of that person.

"**§ 90-270.170. Rule making.**

(a) The Commission shall exercise its rule-making powers pursuant to the criteria set forth in this section and the Rules adopted thereunder. Rules and amendments shall become binding as of the date specified in each rule or amendment.

(b) If a majority of the legislatures of the Compact States rejects a rule, by enactment of a statute or resolution in the same manner used to adopt the Compact, then such rule shall have no further force and effect in any Compact State.

(c) Rules or amendments to the rules shall be adopted at a regular or special meeting of the Commission.

(d) Prior to promulgation and adoption of a final rule or Rules by the Commission, and at least 60 days in advance of the meeting at which the rule will be considered and voted upon, the Commission shall file a Notice of Proposed Rule Making:

(1) On the Web site of the Commission; and

(2) On the Web site of each Compact States' Psychology Regulatory Authority or the publication in which each state would otherwise publish proposed rules.

(e) The Notice of Proposed Rule Making shall include:

(1) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon;

(2) The text of the proposed rule or amendment and the reason for the proposed rule;

(3) A request for comments on the proposed rule from any interested person; and

(4) The manner in which interested persons may submit notice to the Commission of their intention to attend the public hearing and any written comments.

(f) Prior to adoption of a proposed rule, the Commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(g) The Commission shall grant an opportunity for a public hearing before it adopts a rule or amendment if a hearing is requested by:

(1) At least 25 persons who submit comments independently of each other;
(2) A governmental subdivision or agency; or
(3) A duly appointed person in an association that has at least 25 members.

(h) If a hearing is held on the proposed rule or amendment, the Commission shall publish the place, time, and date of the scheduled public hearing.

(1) All persons wishing to be heard at the hearing shall notify the Executive Director of the Commission or other designated member in writing of their desire to appear and testify at the hearing not less than five business days before the scheduled date of the hearing.
(2) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing.
(3) No transcript of the hearing is required, unless a written request for a transcript is made, in which case the person requesting the transcript shall bear the cost of producing the transcript. A recording may be made in lieu of a transcript under the same terms and conditions as a transcript. This subsection shall not preclude the Commission from making a transcript or recording of the hearing if it so chooses.
(4) Nothing in this section shall be construed as requiring a separate hearing on each rule. Rules may be grouped for the convenience of the Commission at hearings required by this section.

(i) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing was not held, the Commission shall consider all written and oral comments received.

(j) The Commission shall, by majority vote of all members, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rule-making record and the full text of the rule.

(k) If no written notice of intent to attend the public hearing by interested parties is received, the Commission may proceed with promulgation of the proposed rule without a public hearing.

(*l*) Upon determination that an emergency exists, the Commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rule-making procedures provided in the Compact and in this section shall be retroactively applied to the rule as soon as reasonably possible, in no event later than 90 days after the effective date of the rule. For the purposes of this provision, an emergency rule is one that must be adopted immediately in order to:

(1) Meet an imminent threat to public health, safety, or welfare;
(2) Prevent a loss of Commission or Compact State funds;
(3) Meet a deadline for the promulgation of an administrative rule that is established by federal law or rule; or
(4) Protect public health and safety.

(m) The Commission or an authorized committee of the Commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the Web site of the Commission. The revision shall be subject to challenge by any person for a period of 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge shall be made in writing and delivered to the Chair of the Commission prior to the end of the notice period. If no challenge is made, the revision will take effect without further action. If the revision is challenged, the revision may not take effect without the approval of the Commission.

"**§ 90-270.171. Oversight, dispute resolution, and enforcement.**

(a) Oversight. –

(1) The executive, legislative, and judicial branches of state government in each Compact State shall enforce this Compact and take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of this Compact and the rules promulgated hereunder shall have standing as statutory law.

(2) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a Compact State pertaining to the subject matter of this Compact which may affect the powers, responsibilities, or actions of the Commission.

(3) The Commission shall be entitled to receive service of process in any such proceeding and shall have standing to intervene in such a proceeding for all purposes. Failure to provide service of process to the Commission shall render a judgment or order void as to the Commission, this Compact, or promulgated rules.

(b) Default, Technical Assistance, and Termination. –

(1) If the Commission determines that a Compact State has defaulted in the performance of its obligations or responsibilities under this Compact or the promulgated rules, the Commission shall:

a. Provide written notice to the defaulting state and other Compact States of the nature of the default, the proposed means of remedying the default, and/or any other action to be taken by the Commission; and

b. Provide remedial training and specific technical assistance regarding the default.

(2) If a state in default fails to remedy the default, the defaulting state may be terminated from the Compact upon an affirmative vote of a majority of the Compact States and all rights, privileges, and benefits conferred by this Compact shall be terminated on the effective date of termination. A remedy of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(3) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be submitted by the Commission to the Governor, the majority and minority leaders of the defaulting state's legislature, and each of the Compact States.

(4) A Compact State which has been terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations which extend beyond the effective date of termination.

(5) The Commission shall not bear any costs incurred by the state which is found to be in default or which has been terminated from the Compact, unless agreed upon in writing between the Commission and the defaulting state.

(6) The defaulting state may appeal the action of the Commission by petitioning the U.S. District Court for the State of Georgia or the federal district where the Compact has its principal offices. The prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(c) Dispute Resolution. –

(1) Upon request by a Compact State, the Commission shall attempt to resolve disputes related to the Compact which arise among Compact States and between Compact and Non-Compact States.

(2) The Commission shall promulgate a rule providing for both mediation and binding dispute resolution for disputes that arise before the Commission.

(d) Enforcement. –

(1) The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and Rules of this Compact.

(2) By majority vote, the Commission may initiate legal action in the United States District Court for the State of Georgia or the federal district where the Compact has its principal offices against a Compact State in default to enforce compliance with the provisions of the Compact and its promulgated Rules and Bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing member shall be awarded all costs of such litigation, including reasonable attorneys' fees.

(3) The remedies herein shall not be the exclusive remedies of the Commission. The Commission may pursue any other remedies available under federal or state law.

"**§ 90-270.172. Date of implementation of the Psychology Interjurisdictional Compact Commission and associated rules, withdrawal, and amendments.**

(a) The Compact shall come into effect on the date on which the Compact is enacted into law in the seventh Compact State. The provisions which become effective at that time shall be limited to the powers granted to the Commission relating to assembly and the promulgation of rules. Thereafter, the Commission shall meet and exercise rule-making powers necessary to the implementation and administration of the Compact.

(b) Any state which joins the Compact subsequent to the Commission's initial adoption of the rules shall be subject to the rules as they exist on the date on which the Compact becomes law in that state. Any rule which has been previously adopted by the Commission shall have the full force and effect of law on the day the Compact becomes law in that state.

(c) Any Compact State may withdraw from this Compact by enacting a statute repealing the same.

(1) A Compact State's withdrawal shall not take effect until six months after enactment of the repealing statute.

(2) Withdrawal shall not affect the continuing requirement of the withdrawing State's Psychology Regulatory Authority to comply with the investigative and adverse action reporting requirements of this act prior to the effective date of withdrawal.

(d) Nothing contained in this Compact shall be construed to invalidate or prevent any psychology licensure agreement or other cooperative arrangement between a Compact State and a Non-Compact State which does not conflict with the provisions of this Compact.

(e) This Compact may be amended by the Compact States. No amendment to this Compact shall become effective and binding upon any Compact State until it is enacted into the law of all Compact States.

"**§ 90-270.173. Construction and severability.**

This Compact shall be liberally construed so as to effectuate the purposes thereof. If this Compact shall be held contrary to the constitution of any state member thereto, the Compact shall remain in full force and effect as to the remaining Compact States."

SECTION 3.(c) Subsections (a) and (b) of this section become effective when at least seven states have enacted the Psychology Interjurisdictional Compact (PSYPACT) set forth in subsection (b) of this section. The North Carolina Psychology Board shall report to the Revisor of Statutes when the PSYPACT set forth in subsection (b) of this section has been enacted by seven member states.

PART IV. ALLOW LICENSED MARRIAGE AND FAMILY THERAPISTS TO CONDUCT FIRST-LEVEL EXAMINATIONS FOR INVOLUNTARY COMMITMENT

SECTION 4.(a) G.S. 122C-263.1(a) reads as rewritten:

"§ 122C-263.1. Secretary's authority to certify commitment examiners; training of certified commitment examiners performing first examinations; LME/MCO responsibilities.

(a) Physicians and eligible psychologists are qualified to perform the commitment examinations required under G.S. 122C-263(c) and G.S. 122C-283(c). The Secretary of Health and Human Services may individually certify to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 other health, mental health, and substance abuse professionals whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment as follows:

(1) The Secretary has received a request:

a. To certify a licensed clinical social worker, a master's or higher level degree nurse practitioner, a licensed professional counsellor, a licensed marriage and family therapist, or a physician's assistant to conduct the first examinations described in G.S. 122C-263(c) and G.S. 122C-283(c).

b. To certify a master's level licensed clinical addictions specialist to conduct the first examination described in G.S. 122C-283(c).

...

(5) In no event shall the certification of a licensed clinical social worker, master's or higher level degree nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or master's level certified clinical addictions specialist under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level nurse practitioner, licensed professional counsellor, a licensed marriage and family therapist, physician assistant, or the master's level certified clinical addictions specialist.

...."

SECTION 4.(b) This section is effective October 1, 2019.

PART V. PROGRAM FOR ALL-INCLUSIVE CARE FOR THE ELDERLY REGULATORY CHANGES

SECTION 5.(a) G.S. 131E-138 reads as rewritten:

"§ 131E-138. Licensure requirements.

(a) ~~No~~ Except as provided in subsection (f1) of this section, no person or governmental unit shall operate a home care agency without a license obtained from the Department. Nothing in this Part shall be construed to extend or modify the licensing of individual health professionals by the licensing boards for their professions or to create any new professional license category.

...

(f1) Exceptions to Licensure. – If home care services are provided to a participant of the Program for All-Inclusive Care for the Elderly through an organization that has a valid Program for All-Inclusive Care for the Elderly agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Service, then the entity providing the home care services shall not be required to hold a license under this section.

...."

SECTION 5.(b) G.S. 131D-2.1 reads as rewritten:

"§ 131D-2.1. Definitions.

As used in this Article:

...

(3) Adult care home. – An assisted living residence in which the housing management provides 24-hour scheduled and unscheduled personal care services to two or more residents, either directly or for scheduled needs, through formal written agreement with licensed home care or hospice ~~agencies.~~ agencies or with a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. Some licensed adult care homes provide supervision to persons with cognitive impairments whose decisions, if made independently, may jeopardize the safety or well-being of themselves or others and therefore require supervision. Medication in an adult care home may be administered by designated trained staff. Adult care homes that provide care to two to six unrelated residents are commonly called family care homes.

...

(5) Assisted living residence. – Any group housing and services program for two or more unrelated adults, by whatever name it is called, that makes available, at a minimum, one meal a day and housekeeping services and provides personal care services directly or through a formal written agreement with one or more licensed home care or hospice ~~agencies.~~ agencies, or with a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. The Department may allow nursing service exceptions on a case-by-case basis. Settings in which services are delivered may include self-contained apartment units or single or shared room units with private or area baths. Assisted living residences are to be distinguished from nursing homes subject to provisions of G.S. 131E-102. There are three types of assisted living residences: adult care homes, adult care homes that serve only elderly persons, and multiunit assisted housing with services. As used in this section, "elderly person" means:

a. Any person who has attained the age of 55 years or older and requires assistance with activities of daily living, housing, and services, or

b. Any adult who has a primary diagnosis of Alzheimer's disease or other form of dementia who requires assistance with activities of daily living, housing, and services provided by a licensed Alzheimer's and dementia care unit.

...

(10) Multiunit assisted housing with services. – An assisted living residence in which hands-on personal care services and nursing services ~~which~~ that are arranged by housing management are provided through an individualized written care plan by a licensed home care or hospice agency ~~through an individualized written care plan.~~ or by a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services. The housing management has a financial interest or financial affiliation or formal written agreement ~~which~~ that makes personal care services accessible and available through at least one licensed home care or hospice ~~agency.~~ agency or through a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the

Division of Health Benefits of the Department of Health and Human Services. The resident has a choice of any provider, and the housing management may not combine charges for housing and personal care services. All residents, or their compensatory agents, must be capable, through informed consent, of entering into a contract and must not be in need of 24-hour supervision. Assistance with self-administration of medications may be provided by appropriately trained staff when delegated by a licensed nurse according to the home care agency's or the Program for All-Inclusive Care for the Elderly organization's established plan of care. Multiunit assisted housing with services programs are required to register annually with the Division of Health Service Regulation. Multiunit assisted housing with services programs are required to provide a disclosure statement to the Division of Health Service Regulation. The disclosure statement is required to be a part of the annual rental contract that includes a description of all of the following requirements:

a. Emergency response ~~system;~~system.
b. Charges for services ~~offered;~~offered.
c. Limitations of ~~tenancy;~~tenancy.
d. Limitations of ~~services;~~services.
e. Resident ~~responsibilities;~~responsibilities.
f. Financial/legal relationship between housing management and home care or hospice ~~agencies;~~agencies or Program for All-Inclusive Care for the Elderly organizations.
g. A listing of all home care or hospice agencies and other community services in the ~~area;~~area.
h. An appeals ~~process; and~~process.
i. Procedures for required initial and annual resident screening and referrals for services.

Continuing care retirement communities, subject to regulation by the Department of Insurance under Chapter 58 of the General Statutes, and temporary family health care structures, as defined in G.S. 160A-383.5, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

...."

SECTION 5.(c) G.S. 131D-2.2(b) reads as rewritten:

"(b) Multiunit Assisted Housing With Services. – Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, multiunit assisted housing with services shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator ~~dependency;~~dependency.
(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be ~~healing;~~healing.
(3) Intravenous therapy or injections directly into the vein, except for intermittent intravenous therapy managed by a home care or hospice agency licensed in this ~~State;~~State.
(4) Airborne infectious disease in a communicable state that requires isolation of the individual or requires special precautions by the caretaker to prevent transmission of the disease, including diseases such as tuberculosis and excluding infections such as the common ~~cold;~~cold.
(5) Psychotropic medications without appropriate diagnosis and treatment ~~plans;~~plans.
(6) Nasogastric ~~tubes;~~tubes.

(7) Gastric tubes, except when the individual is capable of independently feeding himself or herself and caring for the tube, or as managed by a home care or hospice agency licensed in this ~~State;~~State.

(8) Individuals requiring continuous licensed nursing ~~care;~~care.

(9) Individuals whose physician certifies that placement is no longer ~~appropriate;~~appropriate.

(10) Unless the individual's independent physician determines ~~otherwise,~~ otherwise or the individual is enrolled in the Program of All-Inclusive Care for the Elderly, individuals who require maximum physical assistance as documented by a uniform assessment instrument and who meet Medicaid nursing facility level-of-care criteria as defined in the State Plan for Medical Assistance. Maximum physical assistance means that an individual has a rating of total dependence in four or more of the seven activities of daily living as documented on a uniform assessment ~~instrument;~~instrument.

(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the ~~residence; and~~residence.

(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services."

SECTION 5.(d) G.S. 131D-2.2(d) reads as rewritten:

"(d) Obtaining Services. – The resident of an assisted living facility has the right to obtain services at the resident's own expense from providers other than the housing management. This subsection shall not be construed to relieve the resident of the resident's contractual obligation to pay the housing management for any services covered by the contract between the resident and housing management. The resident of an assisted living facility has the right to select as the resident's health care provider the Program for All-Inclusive Care for the Elderly without jeopardizing residency in the assisted living facility."

SECTION 5.(e) G.S. 131D-2.16 reads as rewritten:

"**§ 131D-2.16. Rules.**

Except as otherwise provided in this Article, the Medical Care Commission shall adopt rules necessary to carry out this Article. The Commission has the authority, in adopting rules, to specify the limitation of nursing services provided by assisted living residences. In developing rules, the Commission shall consider the need to ensure comparable quality of services provided to residents, whether these services are provided directly by a licensed assisted living provider, licensed home care agency, a Program for All-Inclusive Care for the Elderly organization that has a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services, or hospice. In adult care homes, living arrangements where residents require supervision due to cognitive impairments, rules shall be adopted to ensure that supervision is appropriate and adequate to meet the special needs of these residents. Rule-making authority under this section is in addition to that conferred under G.S. 131D-4.3 and G.S. 131D-4.5."

SECTION 5.(f) G.S. 131D-6 reads as rewritten:

"**§ 131D-6. Certification of adult day care programs; purpose; definition; penalty.**

...

(d) ~~The~~ All of the following programs are exempted from the provisions of this section:

(1) Those that care for three people or ~~less;~~less.

(2) Those that care for two or more persons, all of whom are related by blood or marriage to the operator of the ~~facility;~~facility.

(3) Those that are required by other statutes to be licensed by the Department of Health and Human Services.

(4) Program for All-Inclusive Care for the Elderly organizations that have a valid program agreement with the Centers for Medicare and Medicaid Services and the Division of Health Benefits of the Department of Health and Human Services when providing services to participants in the program."

SECTION 5.(g) This act is effective October 1, 2019.

PART VI. ELIMINATE REDUNDANCY IN ADULT CARE HOME INSPECTIONS

SECTION 6. G.S. 131D-2.11(a) reads as rewritten:

"(a) State Inspection and Monitoring. – The Department shall ensure that adult care homes required to be licensed by this Article are monitored for licensure compliance on a regular basis. All facilities licensed under this Article and adult care units in nursing homes are subject to inspections at all times by the Secretary. Except as provided in subsection (a1) of this section, the Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis. Beginning July 1, 2012, the Division of Health Service Regulation shall include as part of its inspection of all adult care homes a review of the facility's compliance with G.S. 131D-4.4A(b) and safe practices for injections and any other procedures during which bleeding typically occurs. In addition, the Department shall ensure that adult care homes are inspected every two years to determine compliance with physical plant and life-safety requirements.

If the annual inspection of an adult care home is conducted separately from the inspection required every two years to determine compliance with physical plant and life-safety requirements, the Division of Health Service Regulation shall not cite, as part of the annual inspection, any violation of law that overlaps with an area addressed by the physical plant and life-safety inspection, unless failure to address the violation during the annual inspection would pose a risk to resident health or safety. Nothing in this section prevents a licensing inspector from referring a concern about physical plant and life-safety requirements to the section within the Division of Health Service Regulation that conducts physical plant and life-safety inspections."

PART VII. SEVERABILITY CLAUSE AND EFFECTIVE DATE

SECTION 7.(a) If any section or 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 to be unconstitutional or invalid.

SECTION 7.(b) Except as otherwise provided, this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H D

HOUSE BILL 656
Committee Substitute Favorable 4/30/19
Committee Substitute #2 Favorable 5/2/19
PROPOSED SENATE COMMITTEE SUBSTITUTE H656-CSTR-8 [v.11]
06/10/2019 12:52:31 PM

Short Title: Medicaid Changes for Transformation. (Public)

Sponsors:

Referred to:

April 10, 2019

A BILL TO BE ENTITLED

AN ACT TO MODIFY THE LAWS PERTAINING TO MEDICAID AND NC HEALTH CHOICE AS NEEDED FOR THE IMPLEMENTATION OF MEDICAID TRANSFORMATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 108D of the General Statutes reads as rewritten:

"**Chapter 108D.**

"**Medicaid and NC Health Choice Managed Care ~~for Behavioral Health Services.~~Programs.**

"Article 1.

"General Provisions.

"**§ 108D-1. Definitions.**

The following definitions apply in this ~~Chapter, unless the context clearly requires otherwise:~~Chapter:

(1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b). In accordance with 42 C.F.R. § 457.1260, this definition applies to NC Health Choice beneficiaries in the same manner as it applies to Medicaid beneficiaries.

(2) Adverse disenrollment determination. – A determination by the Department of Health and Human Services or the enrollment broker to (i) deny a request made by an enrollee, or the enrollee's authorized representative, to disenroll from a prepaid health plan or (ii) approve a request made by a prepaid health plan to disenroll an enrollee from a prepaid health plan.

(3) Applicant. – A provider ~~of mental health, intellectual or developmental disabilities, and substance abuse services~~ who is seeking to participate in the ~~closed~~ network of one or more local management entity/managed care ~~organizations.~~organizations or prepaid health plans.

(4) Behavioral health and intellectual/developmental disabilities tailored plan or BH IDD tailored plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter, including the requirements pertaining to BH IDD tailored plans.

(5) Beneficiary. – A person to whom or on whose behalf medical assistance or assistance through the North Carolina Health Choice for Children program is granted under Article 2 of Chapter 108A of the General Statutes.

~~(2)~~(6) Closed network. – The network of providers that have contracted with a local management entity/managed care organization to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees.

~~(3)~~(7) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under ~~G.S. 108D-15 to resolve a dispute between an enrollee and a local management entity/managed care organization about a managed care action.~~G.S. 108D-5.9 or G.S. 108D-15.

~~(4)~~(8) Department. – The North Carolina Department of Health and Human Services.

~~(5)~~(9) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.

~~(6)~~(12) Emergency services. – As defined in 42 C.F.R. § 438.114.

~~(7)~~(13) Enrollee. – A Medicaid or NC Health Choice beneficiary who is currently enrolled with a local management entity/managed care ~~organization.~~organization or a prepaid health plan.

(14) Enrollment broker. – As defined in 42 C.F.R. § 438.810(a).

(16) Fee-for-service program. – A payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice beneficiaries rather than contracting for the coverage of services through a capitated payment arrangement.

~~(8)~~(21) Local Management Entity or LME. – As defined in ~~G.S. 122C-3(20b).~~G.S. 122C-3.

~~(9)~~(22) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in ~~G.S. 122C-3(20c).~~G.S. 122C-3.

~~(10) Managed care action. An action, as defined in 42 C.F.R. § 438.400(b).~~

~~(11) Managed Care Organization or MCO. As defined in 42 C.F.R. § 438.2.~~

(23) Mail. – United States mail or, if the enrollee or the enrollee's authorized representative has given written consent to receive electronic communications, electronic mail.

(24) Managed care entity. – A local management entity/managed care organization or a prepaid health plan.

(25) Medicaid transformation demonstration waiver. – The waiver agreement entered into between the State and the Centers for Medicare and Medicaid Services under Section 1115 of the Social Security Act for the transition to prepaid health plans.

~~(12)~~(26) Mental health, intellectual or developmental disabilities, and substance abuse services or MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered by a local management entity/managed care organization under a contract ~~in effect between~~ with the Department of Health and Human Services ~~and a local management entity~~ to operate ~~a managed care organization or prepaid inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).~~the combined Medicaid waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.

~~(13)~~(27) Network provider. – An appropriately credentialed provider ~~of mental health, intellectual or developmental disabilities, and substance abuse services~~ that has entered into a contract for participation in the ~~closed~~ network of one or more local management entity/managed care ~~organizations.~~organizations or prepaid health plans.

~~(14)~~(28) Notice of ~~managed care action.~~ adverse benefit determination. – The notice required by 42 C.F.R. § 438.404.

~~(15) Notice of resolution. The notice described in 42 C.F.R. § 438.408(e).~~

~~(16)~~(29) OAH. – The North Carolina Office of Administrative Hearings.

(30) Prepaid health plan or PHP. – A prepaid health plan, as defined in G.S. 58-93-5, that is under a capitated contract with the Department for the delivery of Medicaid and NC Health Choice services, or a local management entity/managed care organization that is under a capitated contract with the Department to operate a BH IDD tailored plan.

~~(17) Prepaid Inpatient Health Plan or PIHP. As defined in 42 C.F.R. § 438.2.~~

(31) Provider. – As defined in G.S. 108C-2.

~~(18)~~(32) Provider of emergency services. – A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.

(36) Standard benefit plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter except for the requirements pertaining to a BH IDD tailored plan.

"**§ 108D-2. Scope; applicability of this Chapter.**

This Chapter applies to every ~~LME/MCO and to every~~ managed care entity, applicant, enrollee, provider of emergency services, and network provider of ~~an LME/MCO.~~a managed care entity. This Chapter does not apply to Medicaid or NC Health Choice services delivered through the fee-for-service program. Nothing in this Chapter shall be construed to grant a NC Health Choice beneficiary benefits in excess of what is required by G.S. 108A-70.21.

"**§ 108D-3. Conflicts; severability.**

(a) To the extent that this Chapter conflicts with the Social Security Act or 42 C.F.R. ~~Part 438,~~ Parts 438 and 457, federal law ~~prevails.~~prevails, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services.

(b) To the extent that this Chapter conflicts with any other provision of State law that is contrary to the principles of managed care that will ensure successful containment of costs for ~~behavioral~~ health care services, this Chapter prevails and applies.

(c) If any section, term, or provision of this Chapter is adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"Article 1A.

"Disenrollment from Prepaid Health Plans.

"**§ 108D-5.1. General provisions.**

(a) Nothing in this Article shall be construed to limit or prevent the Department from disenrolling, from a PHP, an enrollee who (i) is no longer eligible to receive services through the Medicaid or NC Health Choice programs or (ii) becomes a member of a population of beneficiaries that is not required to enroll in a PHP under State law.

(b) Nothing in this Article shall be construed to exclude a Medicaid or NC Health Choice beneficiary who is otherwise required by State law to enroll in a PHP from enrolling in a PHP,

or to prevent a beneficiary who is otherwise exempted from enrollment in a PHP from disenrolling from a PHP and receiving services through the fee-for-service program.

"**§ 108D-5.3. Enrollee requests for disenrollment.**

(a) In General. – An enrollee, or the enrollee's authorized representative, who is requesting disenrollment from a PHP, shall submit an oral or written request for disenrollment to the enrollment broker.

(b) Without Cause Enrollee Requests for Disenrollment. – An enrollee shall be allowed to disenroll from the PHP without cause only during the times specified in 42 C.F.R. § 438.56(c)(2), except that enrollees who are in any of the following groups may disenroll at any time:

(1) Members of federally recognized tribes.
(2) Beneficiaries who are enrolled in the foster care system.
(3) Beneficiaries who are in the former foster care Medicaid eligibility category.
(4) Beneficiaries who receive Title IV-E adoption assistance.
(5) Beneficiaries who are receiving long-term services and supports in institutional or community-based settings.
(6) Any other beneficiaries who are not required to enroll in a PHP under G.S. 108D-40.

(c) With Cause Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's authorized representative, may submit a request to disenroll from a PHP for cause at any time. For cause reasons for disenrollment from a PHP include the following:

(1) The enrollee moves out of the PHP's service area.
(2) The PHP, because of the PHP's moral or religious objections, does not cover a service the enrollee seeks.
(3) The enrollee needs concurrent, related services that are not all available within the PHP's network and the enrollee's provider determines that receiving services separately would subject the enrollee to unnecessary risk.
(4) An enrollee who receives long-term services and supports will be required to change residential, institutional, or employment supports providers due to the enrollee's provider's change from in-network to out-of-network status with the PHP and, as a result, the enrollee would experience a disruption in residence or employment.
(5) The enrollee's complex medical conditions could be better served under a different PHP. For purposes of this subsection, an enrollee is considered to have a complex medical condition if the enrollee has a condition that could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.
(6) A family member of the enrollee becomes, or is determined, eligible for Medicaid or NC Health Choice and the family member is, or becomes, enrolled in a different PHP.
(7) Poor performance by the PHP, as determined by the Department. The Department shall not make a determination of poor performance by any PHP until the Department has completed an annual PHP performance evaluation following the first year of that PHP's contract.
(8) Poor quality of care, lack of access to services covered under the PHP's contract, lack of access to providers experienced in addressing the enrollee's health care needs, or any other reasons established by the Department in the PHP's contract or in rule.

(d) Expedited Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's authorized representative, may submit an expedited request for disenrollment to the enrollment broker when the enrollee has an urgent medical need that requires disenrollment from the PHP.

For purposes of this subsection, an urgent medical need means that continued enrollment in the PHP could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.

"**§ 108D-5.5. PHP requests for disenrollment.**

(a) In General. – A PHP requesting disenrollment of an enrollee from the PHP shall submit a written request for disenrollment to the enrollment broker.

(b) Limitations on PHP Requests for Disenrollment. – A PHP shall not request disenrollment of an enrollee from the PHP for any reason prohibited by 42 C.F.R. § 438.56(b)(2). A PHP may request disenrollment of an enrollee only when both of the following criteria are met:

(1) The enrollee's behavior seriously hinders the PHP's ability to care for the enrollee or other enrollees of the PHP.

(2) The PHP has documented efforts to resolve the issues that form the basis of the request for disenrollment of the enrollee.

"**§ 108D-5.7. Notices.**

(a) Notices of Resolution. – For each disenrollment request by an enrollee or a PHP, the Department shall issue a written notice of resolution approving or denying the request by mail to the enrollee before the first day of the second month following the month in which the enrollee or PHP requested disenrollment. For expedited enrollee requests for disenrollment made under G.S. 108D-5.3(d), the Department shall issue the written notice of resolution approving or denying the expedited request within three calendar days of receipt of the request. In the same mailing as the notice, the Department shall also provide the enrollee with an appeal request form that includes all of the following:

(1) A statement that in order to request an appeal, the enrollee must file the form in accordance with OAH rules, by mail or fax to the address or fax number listed on the form, no later than 30 days after the mailing date of the notice of resolution.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal the specific adverse disenrollment determination identified in the notice of resolution.

(4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the enrollee's signature and date.

(b) Notices Pertaining to Expedited Enrollee Requests for Disenrollment. – If the Department determines that an enrollee's request for disenrollment does not meet the criteria for an expedited request, the Department shall do the following:

(1) No later than three calendar days after receiving the enrollee's request for disenrollment, make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of the determination by mail.

(2) Issue the notice of resolution within the time limits established for standard disenrollment requests under subsection (a) of this section.

"**§ 108D-5.9. Appeals of adverse disenrollment determinations.**

(a) Appeals. – An enrollee, or the enrollee's authorized representative, who is dissatisfied with an adverse disenrollment determination may file an appeal for a hearing with the Office of Administrative Hearings within 30 calendar days of the date on the notice of resolution. A request for a hearing to appeal an adverse disenrollment determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General

Statutes. The appeal shall be conducted in accordance with the procedures in Part 6A of Article 2 of Chapter 108A of the General Statutes.

(b) Parties. – The Department shall be the respondent for purposes of appeals under this section.

"Article 2.

"Enrollee Grievances and Appeals.

"§ 108D-11. ~~LME/MCO~~ Managed care entity grievance and appeal procedures, generally.

(a) Each ~~LME/MCO~~ managed care entity shall establish and maintain internal grievance and appeal procedures that (i) comply with the Social Security Act and 42 C.F.R. Part 438, Subpart F, and (ii) afford ~~enrollees, and network providers authorized in writing to act on behalf of enrollees,~~ enrollees and their authorized representatives constitutional rights to due process and a fair hearing.

(b) ~~Enrollees, or network providers authorized in writing to act on behalf of enrollees,~~ An enrollee, or the enrollee's authorized representative, may file ~~requests for grievances~~ grievances and ~~LME/MCO~~ managed care entity level appeals orally or in writing. However, unless the ~~enrollee or network provider~~ enrollee, or the enrollee's authorized representative, requests an expedited appeal, the oral ~~filing~~ appeal must be followed by a written, signed ~~grievance or~~ appeal.

(c) ~~An LME/MCO~~ A managed care entity shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file a grievance, request for ~~an LME/MCO~~ a managed care entity level appeal, or a contested case hearing. However, nothing in this Chapter shall be construed to prevent ~~an LME/MCO~~ a managed care entity from doing any of the following:

(1) Offering an enrollee alternative services.

(2) Engaging in clinical or educational discussions with enrollees or providers.

(3) Engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.

(d) ~~An LME/MCO~~ A managed care entity shall not take punitive action against a provider for any of the following:

(1) Filing a grievance on behalf of an enrollee or supporting an enrollee's grievance.

(2) Requesting ~~an LME/MCO~~ a managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for ~~an LME/MCO~~ a managed care entity level appeal.

(3) Requesting an expedited ~~LME/MCO~~ managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for ~~an LME/MCO~~ a managed care entity level expedited appeal.

(4) Requesting a contested case hearing on behalf of an enrollee or supporting an enrollee's request for a contested case hearing.

(e) The appeal procedures set forth in this Article shall not apply to instances in which the sole basis for the managed care entity's decision is a provision in the State Plan or in federal or State law requiring an automatic change adversely affecting some or all beneficiaries.

"§ 108D-12. ~~LME/MCO~~ Managed care entity grievances.

(a) Filing of Grievance. – An ~~enrollee, or a network provider authorized in writing to act on behalf of an~~ enrollee, or the enrollee's authorized representative, has the right to file a grievance with ~~an LME/MCO~~ a managed care entity at any time to express dissatisfaction about any matter other than ~~a managed care action.~~ an adverse benefit determination. Upon receipt of a grievance, ~~an LME/MCO~~ a managed care entity shall cause a written acknowledgment of receipt of the grievance to be sent by ~~United States~~ mail.

(b) Notice of Grievance Disposition. – The ~~LME/MCO~~ managed care entity shall resolve the grievance and cause a notice of grievance ~~disposition~~ resolution to be sent by ~~United States~~ mail to the enrollee and all other affected parties as expeditiously as the enrollee's health condition requires, but no later than ~~90~~ 30 days after receipt of the ~~grievance.~~grievance, provided

that the managed care entity may extend such time frame to the extent permitted under 42 C.F.R. § 438.408(c).

(c) Right to ~~LME/MCO Level~~ Appeal. – There is no right to appeal the resolution of a grievance to OAH or any other forum.

"§ 108D-13. Standard ~~LME/MCO~~ managed care entity level appeals.

(a) Notice of ~~Managed Care Action.~~ Adverse Benefit Determination. – ~~An LME/MCO~~ A managed care entity shall provide an enrollee with a written notice of ~~a managed care action~~ an adverse benefit determination by ~~United States~~ mail as required under 42 C.F.R. § 438.404. The notice ~~of action~~ will employ a standardized form included as a provision in the ~~contracts~~ contract between the ~~LME/MCOs~~ managed care entity and the ~~Department of Health and Human Services.~~Department.

(b) Request for Appeal. – An enrollee, or ~~a network provider authorized in writing to act on behalf of the enrollee,~~ the enrollee's authorized representative, has the right to file a request for ~~an LME/MCO~~ a managed care entity level appeal of a notice of ~~managed care action~~ adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the ~~grievance disposition or~~ notice of ~~managed care action.~~ adverse benefit determination. Upon receipt of a request for ~~an LME/MCO~~ a managed care entity level appeal, ~~an LME/MCO~~ a managed care entity shall acknowledge receipt of the request for appeal in writing by ~~United States~~ mail.

(c) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of ~~an LME/MCO~~ a managed care entity level appeal to the same extent required under 42 C.F.R. § 438.420. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation of benefits.

(d) Notice of Resolution. – The ~~LME/MCO~~ managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than ~~45~~ 30 days after receiving the request for ~~appeal.~~ appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The ~~LME/MCO~~ managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by ~~United States~~ mail within this ~~45-day~~ 30-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in this section or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f).

"§ 108D-14. Expedited ~~LME/MCO~~ managed care entity level appeals.

(a) Request for Expedited Appeal. – When the time limits for completing a standard appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, has the right to file a request for an expedited appeal of ~~a managed care action~~ an adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the notice of ~~managed care action.~~ adverse benefit determination. ~~For expedited appeal requests made by enrollees, the LME/MCO shall determine if the enrollee qualifies for an expedited appeal. For expedited appeal requests made by network providers on behalf of enrollees, the LME/MCO~~ In determining whether the enrollee qualifies for an expedited appeal, the managed care entity shall presume an expedited appeal is ~~necessary.~~ necessary when the expedited appeal is made by a network provider as an enrollee's authorized representative or

when a network provider has otherwise indicated to the managed care entity that an expedited appeal is necessary.

(b) Notice of Denial for Expedited Appeal. – If the ~~LME/MCO~~ managed care entity denies a request for an expedited ~~LME/MCO~~ managed care entity level appeal, the ~~LME/MCO~~ managed care entity shall make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of denial by ~~United States~~ mail ~~by~~ no later than ~~two calendar days~~ 72 hours after receiving the request for an expedited appeal. In addition, the ~~LME/MCO~~ managed care entity shall resolve the appeal within the time limits established for standard ~~LME/MCO~~ managed care entity level appeals in G.S. 108D-13.

(c) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of an expedited ~~LME/MCO~~ managed care entity level appeal to the extent required under 42 C.F.R. § 438.420. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation of benefits.

(d) Notice of Resolution. – If the ~~LME/MCO~~ managed care entity grants a request for an expedited ~~LME/MCO~~ managed care entity level appeal, the ~~LME/MCO~~ managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, and no later than ~~three working days~~ 72 hours after receiving the request for an expedited ~~appeal.~~ appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The ~~LME/MCO~~ managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by ~~United States~~ mail within this ~~three day~~ 72-hour period.

(e) Right to Request Contested Case Hearing. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or this ~~section.~~ section or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(f) Reasonable Assistance. – ~~An LME/MCO~~ A managed care entity shall provide the enrollee with reasonable assistance in completing forms and taking other procedural steps necessary to file an appeal, including providing interpreter services and toll-free numbers that have adequate teletypewriter/telecommunications devices for the deaf (TTY/TDD) and interpreter capability.

(g) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f).

"**§ 108D-15. Contested case hearings on disputed ~~managed care actions.~~adverse benefit determinations.**

(a) Jurisdiction of the Office of Administrative Hearings. – The Office of Administrative Hearings does not have jurisdiction over a dispute concerning ~~a managed care action,~~ an adverse benefit determination, except as expressly set forth in this Chapter.

(b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of resolution of an adverse benefit determination issued by ~~an LME/MCO.~~ a managed care entity. G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not apply to enrollees contesting ~~a managed care action.~~ an adverse benefit determination.

(c) Request for Contested Case Hearing. – A request for an administrative hearing to appeal a notice of resolution of an adverse benefit determination issued by ~~an LME/MCO~~ a managed care entity is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, has the right to file a request for appeal to

contest a notice of resolution as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(d) Filing Procedure. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for an appeal by sending an appeal request form that meets the requirements of subsection (e) of this section to OAH and the affected ~~LME/MCO~~ managed care entity by no later than ~~30~~ 120 days after the mailing date of the notice of resolution. A request for appeal is deemed filed when a completed and signed appeal request form has been both submitted into the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the ~~LME/MCO~~ managed care entity shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

(e) Parties. – The ~~LME/MCO~~ managed care entity shall be the respondent for purposes of this appeal. The ~~LME/MCO or enrollee~~ managed care entity, the enrollee, or the enrollee's authorized representative may move for the permissive joinder of the Department under Rule 20 of the North Carolina Rules of Civil Procedure. The Department may move to intervene as a necessary party under Rules 19 and 24 of the North Carolina Rules of Civil Procedure.

(f) Appeal Request Form. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing which shall be no more than one side of one page. The form shall include at least all of the following:

(1) A statement that in order to request an appeal, the enrollee must file the form in accordance with OAH rules, by mail or fax to the address or fax number listed on the form, ~~by~~ no later than ~~30~~ 120 days after the mailing date of the notice of resolution.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal ~~a~~ the specific ~~managed care action~~ adverse benefit determination identified in the notice of resolution.

(4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the enrollee's signature and date.

(g) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of an appeal to the same extent required under 42 C.F.R. § 438.420. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation of benefits. Notwithstanding any other provision of State law, the administrative law judge does not have the power to order and shall not order ~~an LME/MCO~~ a managed care entity to continue benefits in excess of what is required by 42 C.F.R. § 438.420.

(h) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge of OAH may limit and simplify the administrative hearing procedures that apply to contested case hearings conducted under this section in order to complete these cases as expeditiously as possible. Any simplified hearing procedures approved by the chief administrative law judge under this subsection must comply with all of the following requirements:

...

(2) OAH shall conduct all contested case hearings telephonically or by video technology with all parties, unless the enrollee requests that the hearing be

conducted in person before the administrative law judge. An in-person hearing shall be conducted in the county that contains the headquarters of the ~~LME/MCO~~ managed care entity unless the enrollee's impairments limit travel. For enrollees with impairments that limit travel, an in-person hearing shall be conducted in the enrollee's county of residence. OAH shall provide written notice to the enrollee of the use of telephonic hearings, hearings by video conference, and in-person hearings before the administrative law judge, as well as written instructions on how to request a hearing in the enrollee's county of residence.

...

(4) The administrative law judge may allow brief extensions of the time limits imposed in this section only for good cause shown and to ensure that the record is complete. The administrative law judge shall only grant a continuance of a hearing in accordance with rules adopted by OAH for good cause shown and shall not grant a continuance on the day of a hearing, except for good cause shown. If an enrollee fails to make an appearance at a hearing that has been properly noticed by OAH by ~~United States~~ mail, OAH shall immediately dismiss the case, unless the enrollee moves to show good cause by no later than three business days after the date of dismissal. As used in this section, "good cause shown" includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.

(5) OAH shall include information on at least all of the following in its notice of hearing to an enrollee:

a. The enrollee's right to examine at a reasonable time before and during the hearing the contents of the enrollee's case file and any documents to be used by the ~~LME/MCO~~ managed care entity in the hearing before the administrative law judge.

b. The enrollee's right to an interpreter during the hearing process.

c. The circumstances in which a medical assessment may be obtained at the ~~LME/MCO's~~ managed care entity's expense and made part of the record, including all of the following:

...

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the ~~LME/MCO~~ managed care entity within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of ~~a managed care action~~ an adverse benefit determination until it has received notice from the mediator assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. ~~If the enrollee accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.~~

(j) Burden of Proof. – The enrollee has the burden of proof on all issues submitted to OAH for a contested case hearing under this section and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence in the case.

(k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of whether it was obtained before or after the ~~LME/MCO's managed care action~~ managed care entity's adverse benefit determination and regardless of whether the ~~LME/MCO~~ the managed care entity had an opportunity to consider the evidence in resolving the ~~LME/MCO~~ managed care entity level appeal. Upon the receipt of new evidence and at the request of the ~~LME/MCO,~~ managed care entity, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days in order to allow the ~~LME/MCO~~ managed care entity to review the evidence. Upon reviewing the evidence, if the ~~LME/MCO~~ managed care entity decides to reverse the ~~managed care action taken against the enrollee,~~ adverse benefit determination, it shall immediately inform the administrative law judge of its decision.

(*l*) Issue for Hearing. – For each ~~managed care action,~~ adverse benefit determination, the administrative law judge shall determine whether the ~~LME/MCO~~ managed care entity substantially prejudiced the rights of the enrollee and whether the ~~LME/MCO,~~ managed care entity, based upon evidence at the ~~hearing:~~ hearing, did any of the following:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

(m) To the extent that anything in this ~~Part,~~ Chapter, Chapter 150B of the General Statutes, or any rules or policies adopted under these Chapters is inconsistent with the Social Security Act or 42 C.F.R. Part 438, Subpart F, federal law prevails and applies to the extent of the ~~conflict.~~ conflict, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. All rules, rights, and procedures for contested case hearings concerning ~~managed care actions~~ adverse benefit determinations shall be construed so as to be consistent with applicable federal law and shall provide the enrollee with ~~no lesser and no greater~~ rights that are no less than those provided under federal law.

"§ 108D-16. Notice of final decision and right to seek judicial review.

The administrative law judge assigned to conduct a contested case hearing under G.S. 108D-15 shall hear and decide the case without unnecessary delay. The judge shall prepare a written decision that includes findings of fact and conclusions of law and send it to the parties in accordance with G.S. 150B-37. The written decision shall notify the parties of the final decision and of the right of the enrollee and the ~~LME/MCO~~ managed care entity to seek judicial review of the decision under Article 4 of Chapter 150B of the General Statutes.

"Article 3.

"Managed Care Entity Provider Networks.

"§ 108D-21. LME/MCO provider networks.

Each LME/MCO operating the combined 1915(b) and (c) waivers shall develop and maintain closed network of providers to furnish mental health, intellectual or developmental disabilities, and substance abuse services to its enrollees.

"§ 108D-22. PHP provider networks.

(a) Except as provided in G.S. 108D-23, each PHP shall develop and maintain a provider network that meets access to care requirements for its enrollees. A PHP may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, a PHP must include all providers in its geographical coverage area that are designated essential providers by the Department in accordance with subdivision (b) of this section, unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.

(b) The Department shall designate Medicaid and NC Health Choice providers as essential providers if, within a region defined by a reasonable access standard, the provider either

(i) offers services that are not available from any other provider in the region or (ii) provides a substantial share of the total units of a particular service utilized by Medicaid and NC Health Choice beneficiaries within the region during the last three years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid and NC Health Choice enrollees. The Department shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

(1) Federally qualified health centers.
(2) Rural health centers.
(3) Free clinics.
(4) Local health departments.
(5) State Veterans Homes.

"**§ 108D-23. BH IDD tailored plan networks.**

Entities operating BH IDD tailored plans shall develop and maintain closed provider networks only for the provision of behavioral health, intellectual and developmental disability, and traumatic brain injury services."

SECTION 1.(b) This section is effective October 1, 2019, and applies to (i) appeals arising from local management entity/managed care organization (LME/MCO) notices of adverse benefit determination mailed on or after that date and (ii) grievances received by an LME/MCO on or after that date.

SECTION 2. G.S. 90-414.4(a1)(3) reads as rewritten:

"(3) The following entities shall submit encounter and claims data, as appropriate, in accordance with the following time line:

a. Prepaid Health Plans, as defined in ~~S.L. 2015-245,~~ G.S. 108D-1, by the commencement date of a capitated contract with the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services as specified in ~~S.L. 2015-245.~~Article 4 of Chapter 108D of the General Statutes.

b. Local management entities/managed care organizations, as defined in G.S. 122C-3, by June 1, 2020."

SECTION 3. G.S. 108A-24 reads as rewritten:

"**§ 108A-24. Definitions.**

As used in Chapter 108A:

...

(3d) "Federal TANF funds" means the Temporary Assistance for Needy Families block grant funds provided for in Title IV-A of the Social Security Act.

(3e) "Fee-for-service program" means a payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice recipients rather than contracting for the coverage of services through a capitated payment arrangement.

~~(3e) "FICA" means the taxes imposed by the Federal Insurance Contribution Act, 26 U.S.C. § 3101, et seq.~~

(3f) Repealed by Session Laws 2009-489, s. 1, effective August 26, 2009.

(3g) "FICA" means the taxes imposed by the Federal Insurance Contribution Act, 26 U.S.C. § 3101, et seq.

~~(3g)~~(3h) "Full-time employment" means employment which requires the employee to work a regular schedule of hours per day and days per week established as

the standard full-time workweek by the employer, but not less than an average of 30 hours per week.

(4) Repealed by Session Laws 1983, c. 14, s. 3.

...

(4b) "Parent" means biological parent or adoptive parent, and for Work First purposes, includes a stepparent.

(4c) "Prepaid health plan" or "PHP" has the same meaning as in G.S. 108D-1.

(5) "Recipient" is a person to whom, or on whose behalf, assistance is granted under this Article.

...."

SECTION 4. G.S. 108A-56 reads as rewritten:

"**§ 108A-56. Acceptance of federal grants.**

All of the provisions of the federal Social Security Act providing grants to the states for medical assistance are accepted and adopted, and the provisions of this Part shall be liberally construed ~~in relation to such act so that the intent to comply with it shall be made effectual.~~ to effectuate compliance with the act, except to the extent the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. Nothing in this Part or the regulations made under its authority shall be construed to deprive a recipient of assistance of the right to choose the licensed provider of the care or service made available under this Part within the provisions of the federal Social Security ~~Act.~~Act, or valid waiver agreement. This section shall not be construed to prohibit a PHP from (i) requiring its enrollees to obtain services from providers that are under contract with the PHP or (ii) imposing utilization management criteria to a request for services, to the extent these actions are not otherwise prohibited by State or federal law or regulation, or by the Department."

SECTION 5. G.S. 108A-70 reads as rewritten:

"**§ 108A-70. Recoupment of amounts spent on medical care.**

(a) ~~The~~ To the extent necessary to reimburse the Department or a PHP for expenditures for costs under this Part, and provided that claims for current and past due child support shall take priority over claims for those expenditures, the Department may garnish the wages, salary, or other employment income of, and the Secretary of Revenue shall withhold amounts from State tax refunds to, any person ~~who:~~who meets all of the following criteria:

(1) Is required by court or administrative order to provide health benefit plan coverage for the cost of health care services to a child eligible for medical assistance under ~~Medicaid; and~~Medicaid.

(2) Has received payment from a third party for the costs of such ~~services; but~~services.

(3) Has not used such payments to reimburse, as appropriate, either the other parent or guardian of the child or the provider of the ~~services;~~services.

~~to the extent necessary to reimburse the Department for expenditures for such costs under this Part; provided, however, claims for current and past due child support shall take priority over any such claims for the costs of such services.~~

...."

SECTION 6. Part 6A of Article 2 of Chapter 108A of the General Statutes reads as rewritten:

"Part 6A. ~~Medicaid Recipient Appeals Process.~~Appeals Process for Certain Medicaid and NC Health Choice Determinations.

"**§ 108A-70.9A. ~~Appeals by Medicaid recipients.~~Definitions; Medicaid recipient appeals.**

(a) Definitions. – The following definitions apply in this ~~Part, unless the context clearly requires otherwise.~~Part:

(1) Adverse determination. – A determination by the Department to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a

Medicaid ~~service.~~service through the fee-for-service program. An adverse benefit determination as defined in G.S. 108D-1 is not an adverse determination for purposes of this Part.

(1a) Adverse disenrollment decision. – As defined in G.S. 108D-1.

(1b) Contested Medicaid case. – A case commenced by (i) a Medicaid recipient appealing an adverse determination under this Part or (ii) a Medicaid or a NC Health Choice recipient appealing an adverse disenrollment determination under G.S. 108D-5.9.

(2) OAH. – The Office of Administrative Hearings.

(3) Recipient. – A recipient and the recipient's parent, guardian, or legal representative, unless otherwise specified.

(b) ~~General Rule.~~ Medicaid recipient appeals. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid recipient to appeal an adverse determination made by the ~~Department.~~Department and the process used by a Medicaid or NC Health Choice recipient to appeal an adverse disenrollment determination by the Department.

...

"§ 108A-70.9B. Contested Medicaid cases.

(a) Application. – This section applies only to contested Medicaid cases ~~commenced by Medicaid recipients under G.S. 108A-70.9A.~~ as defined in this Part. Except as otherwise provided by ~~G.S. 108A-70.9A~~ Article 1A of Chapter 108D of the General Statutes, G.S. 108A-70.9A, and this section governing time lines and procedural steps, a contested Medicaid case commenced by a Medicaid or NC Health Choice recipient is subject to the provisions of Article 3 of Chapter 150B of the General Statutes. To the extent any provision in this ~~section~~ section, Article 1A of Chapter 108D of the General Statutes, or G.S. 108A-70.9A conflicts with another provision in Article 3 of Chapter 150B of the General Statutes, this ~~section~~ section, Article 1A of Chapter 108D of the General Statutes, and G.S. 108A-70.9A control.

(b) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge may limit and simplify the procedures that apply to a contested Medicaid case involving a Medicaid or NC Health Choice recipient in order to complete the case as quickly as possible.

...

(3) The simplified procedure may include requiring that all prehearing motions be considered and ruled on by the administrative law judge in the course of the hearing of the case on the merits. An administrative law judge assigned to a contested Medicaid case shall make reasonable efforts in a case involving a Medicaid or NC Health Choice recipient who is not represented by an attorney to assure a fair hearing and to maintain a complete record of the hearing.

...

(c) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108A-70.9A(e) or other clear request for a hearing by a Medicaid or NC Health Choice recipient, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the recipient within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the Department within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested Medicaid case until it has received notice from the mediator assigned that either: (i) the mediation was unsuccessful, or (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. ~~If the recipient~~

~~accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.~~

(d) Burden of Proof. – The recipient has the burden of proof on all issues submitted in a contested Medicaid case to OAH ~~for a Medicaid contested case hearing~~ and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence.

...

(f) Issue for Hearing. – For each adverse determination and each adverse disenrollment determination, the hearing shall determine whether the Department substantially prejudiced the rights of the recipient and if the Department, based upon evidence at the ~~hearing:~~hearing, did any of the following:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

...

"§ 108A-70.9C. Informal review permitted.

Nothing in this Part shall prevent the Department from engaging in an informal review of a contested Medicaid case with a recipient prior to issuing a notice of adverse determination ~~as provided by G.S. 108A-70.9A(c).~~under G.S. 108A-70.9A(c) or a notice of resolution under G.S. 108D-5.7."

SECTION 7. G.S. 108A-70.29 reads as rewritten:

"§ 108A-70.29. Program review process.

(a) Review of Eligibility and Program Enrollment Decisions. – Eligibility and Program enrollment decisions for Program applicants or recipients shall be reviewable pursuant to G.S. 108A-79. Program recipients shall remain enrolled in the NC Health Choice Program during the review of a decision to terminate or suspend enrollment. This subsection does not apply to requests for disenrollment from a PHP under Article 1A of Chapter 108D of the General Statutes.

(b) Review of Fee-for-Service Program Health Services Decisions. – This subsection applies only to health services decisions for services being provided to NC Health Choice recipients through the fee-for-service program as defined in G.S. 108A-24. This subsection does not apply to adverse benefit determinations as defined in G.S. 108D-1. In accordance with 42 C.F.R. § 457.1130 and 42 C.F.R. § 457.1150, a Program recipient may seek review of any delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services, through a two-level review process.

...."

SECTION 9. G.S. 122C-3 reads as rewritten:

"§ 122C-3. Definitions.

The following definitions apply in this Chapter:

...

(2a) "Area director" means the administrative head of the area authority program appointed pursuant to G.S. 122C-121.

(2b) "Behavioral health and intellectual/developmental disabilities tailored plan or BH IDD tailored plan" has the same meaning as in G.S. 108D-1.

(2c) "Board of county commissioners" includes the participating boards of county commissioners for multicounty area authorities and multicounty programs.

...

(20c) "Local management entity/managed care organization" or "LME/MCO" means a local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section

1915(b) and Section 1915(c) of the Social Security ~~Act.~~Act or to operate a BH IDD tailored plan.

...

(29b) "Prepaid health plan" has the same meaning as in G.S. 108D-1.

...."

SECTION 9A.(a) G.S. 122C-55, as amended by Section 5 of S.L. 2018-33, reads as rewritten:

"**§ 122C-55. Exceptions; care and treatment.**

(a) Any facility may share confidential information regarding any client of that facility with any other facility when necessary to coordinate appropriate and effective care, treatment or habilitation of the client. For the purposes of this section, the following definitions apply:

(1) "Client" includes an enrollee as defined in G.S. 108D-1.

(1a) "Coordinate" means the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and other health or related services by one or more facilities and includes the referral of a client from one facility to another.

(2) "Facility" and "area facility" include an area ~~authority.~~authority or a prepaid health plan.

(3) "Secretary" includes any primary care case management programs that contract with the Department to provide a primary care case management program for recipients of publicly funded health and related services.

...

(a2) Any ~~or State~~ facility ~~or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill~~ may share confidential information regarding any client of that facility with any other ~~area~~ facility ~~or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill~~ when necessary to conduct payment activities relating to an individual served by the facility. Payment activities are activities undertaken by a facility to obtain payment or receive reimbursement for the provision of services and may include, but are not limited to, determinations of eligibility or coverage, coordination of benefits, determinations of cost-sharing amounts, claims management, claims processing, claims adjudication, claims appeals, billing and collection activities, medical necessity reviews, utilization management and review, precertification and preauthorization of services, concurrent and retrospective review of services, and appeals related to utilization management and review.

(a3) Whenever there is reason to believe that a client is eligible for benefits through a Department program, any ~~State or~~ facility ~~or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill~~ may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with ~~an area facility or State facility or the psychiatric services of the University of North Carolina Hospitals at Chapel Hill.~~ a facility. Disclosure is limited to that information necessary to establish initial eligibility for benefits, determine continued eligibility over time, and obtain reimbursement for the costs of services provided to the client.

(a4) An area authority or ~~county program~~ prepaid health plan may share confidential information regarding any client with any area facility, and any area facility may share confidential information regarding any client of that facility with the area authority or ~~county program.~~prepaid health plan, when the area authority or ~~county program~~prepaid health plan determines the disclosure is necessary to develop, manage, monitor, or evaluate the area authority's or ~~county program's~~prepaid health plan's network of qualified providers as provided in G.S. 122C-115.2(b)(1)b., G.S. 122C-141(a), Article 3 of Chapter 108D of the General Statutes, the State Plan, ~~and~~ rules of the ~~Secretary.~~Secretary, and contracts between the facility and the Department. For the purposes of this subsection, the purposes or activities for which confidential information may be disclosed include, but are not limited to, quality assessment and

improvement activities, provider accreditation and staff credentialing, developing contracts and negotiating rates, investigating and responding to client grievances and complaints, evaluating practitioner and provider performance, auditing functions, on-site monitoring, conducting consumer satisfaction studies, and collecting and analyzing performance data.

...."

SECTION 10. G.S. 150B-1 reads as rewritten:

"**§ 150B-1. Policy and scope.**

...

(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

...

(17) The Department of Health and Human Services with respect to the review of North Carolina Health Choice Program determinations regarding delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of ~~services.~~services, commenced under G.S. 108A-70.29(b).

...

(25) The Department of Health and Human Services with respect to disputes involving the performance, terms, or conditions of a contract between the Department and a prepaid health plan, as defined in G.S. 108D-1.

...."

SECTION 11. G.S. 150B-23 reads as rewritten:

"**§ 150B-23. Commencement; assignment of administrative law judge; hearing required; notice; intervention.**

...

(a3) A Medicaid or NC Health Choice enrollee, or ~~network provider authorized in writing to act on behalf of the enrollee,~~ the enrollee's authorized representative, who appeals a notice of resolution issued by ~~an LME/MCO~~ a managed care entity under Chapter 108D of the General Statutes may commence a contested case under this Article in the same manner as any other petitioner. The case shall be conducted in the same manner as other contested cases initiated by Medicaid or NC Health Choice enrollees under this Article. Solely and only for the purposes of contested cases commenced ~~as Medicaid managed care enrollee appeals under Chapter 108D of the General Statutes,~~ pursuant to G.S. 108D-15 by enrollees of LME/MCOs to appeal a notice of resolution issued by the LME/MCO, an LME/MCO is considered an agency as defined in G.S. 150B-2(1a). The LME/MCO shall not be considered an agency for any other purpose. When a prepaid health plan, as defined in G.S. 108D-1, other than an LME/MCO, is under contract with the Department of Health and Human Services to issue notices of resolution under Article 2 of Chapter 108D of the General Statutes, then solely and only for the purposes of contested cases commenced pursuant to G.S. 108D-15 to appeal a notice of resolution issued by the prepaid health plan, the prepaid health plan shall be considered an agency as defined in G.S. 150B-2(1a). The prepaid health plan shall not be considered an agency for any other purpose.

...."

SECTION 12. Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17(a) of S.L. 2017-57, Section 4 of S.L. 2017-186, Section 11H.10(d) of S.L. 2018-5, and Sections 5 and 6 of S.L. 2018-48, reads as rewritten:

"**SECTION 4.** Structure of Delivery System. – The transformed Medicaid and NC Health Choice programs described in Section 1 of this act shall be organized according to the following principles and parameters:

...

(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. The capitated contracts required by this subdivision shall not cover:

a. Medicaid services ~~currently~~ covered by the local management entities/managed care organizations (LME/MCOs) under the combined 1915(b) and (c) waivers shall not be covered under ~~any capitated PHP contract other than a BH IDD Tailored Plan.~~ a standard benefit plan, except that all capitated PHP contracts shall cover the following services: inpatient behavioral health services, outpatient behavioral health emergency room services, outpatient behavioral health services provided by direct-enrolled providers, mobile crisis management services, facility-based crisis services for children and adolescents, professional treatment services in a facility-based crisis program, outpatient opioid treatment services, ambulatory detoxification services, nonhospital medical detoxification services, partial hospitalization, medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization, research-based intensive behavioral health treatment, diagnostic assessment services, and Early and Periodic Screening, Diagnosis, and Treatment services. In accordance with this sub-subdivision, 1915(b)(3) services shall not be covered under ~~any capitated PHP contract other than a BH IDD Tailored Plan.~~a standard benefit plan.

...

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except for the following categories:

...

l. Recipients with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or who have survived a traumatic brain injury and who are receiving traumatic brain injury services, who are on the waiting list for the Traumatic Brain Injury waiver, or whose traumatic brain injury otherwise is a knowable fact, until BH IDD Tailored Plans become operational, at which time this population will be enrolled with a BH IDD Tailored Plan in accordance with sub-sub-subdivision 10. of sub-subdivision a. of subdivision (10) of this section. Recipients in this category shall have the option to voluntarily enroll with a PHP, provided that (i) a recipient electing to enroll with a PHP would only have access to the behavioral health services covered by PHPs according to sub-subdivision a. of subdivision (4) of this section and would no longer have access to the behavioral health services excluded under sub-subdivision a. of subdivision (4) of this section and (ii) the recipient's informed consent shall be required prior to the recipient's enrollment with a PHP. Recipients in this category shall include, at a minimum, recipients who meet any of the following criteria:

...

4. Individuals who, regardless of diagnosis, meet any of the following criteria:

...

II. Individuals receiving any of the behavioral health, intellectual and developmental disability, or traumatic brain injury services that are ~~currently~~ covered by LME/MCOs under the combined 1915(b) and (c) waivers and that shall not be covered through ~~any capitated PHP contract other than a BH IDD Tailored Plan~~ a standard benefit plan in accordance with sub-subdivision a. of subdivision (4) of this section.

...

m. Recipients in the following categories shall not be covered by PHPs for a period of time to be determined by DHHS that shall not exceed five years after the date that capitated PHP contracts begin:

1. Recipients who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of 90 days or longer and (ii) are not being served through the Community Alternatives Program for Disabled Adults (CAP/DA). During the period of exclusion from PHP coverage for this population as determined by DHHS in accordance with this sub-subdivision, if an individual enrolled in a PHP resides in a nursing facility for 90 days or more, then that individual shall be excluded from PHP coverage on the first day of the month following the ninetieth day of the stay in the nursing facility and shall be disenrolled from the PHP.

2. Recipients who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing. This sub-sub-subdivision shall not include recipients being served through the Community Alternatives Program for Disabled Adults (CAP/DA).

3. Recipients who are (i) enrolled in the foster care system, (ii) receiving Title IV-E adoption assistance, (iii) under the age of 26 and formerly were in the foster care system, or (iv) under the age of 26 and formerly received adoption assistance.

...

(9) LME/MCOs. – Beginning on the date that capitated contracts begin, LME/MCOs shall cease managing Medicaid services for all Medicaid recipients other than recipients described in sub-subdivisions a., d., e., f., g., j., k., ~~and *l.*~~ *l.*, and m. of subdivision (5) of this section. Until BH IDD Tailored Plans become operational, all of the following shall occur:

a. LME/MCOs shall continue to manage the Medicaid services that are ~~currently~~ covered by the LME/MCOs under the combined 1915(b) and (c) waivers for Medicaid recipients described in sub-subdivisions a., d., e., f., g., j., k., ~~and *l.*~~ *l.*, and m. of subdivision (5) of this section.

b. The Division of Health Benefits shall negotiate actuarially sound capitation rates directly with the LME/MCOs based on the change in composition of the population being served by the LME/MCOs.

c. Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits.

...."

SECTION 13. Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121 and Section 6(b) of S.L. 2018-49, reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of DHHS during Medicaid transformation shall include the following activities and functions:

...

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All contracts shall be the result of requests for proposals (RFPs) issued by DHHS and the submission of competitive bids by PHPs. DHHS shall develop standardized contract terms, to include at a minimum, the following:

...

c. A minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by DHHS. The minimum medical loss ratio shall be neither higher nor lower than eighty-eight percent (88%). DHHS shall not require community reinvestment as a result of a PHP's failure to comply with any minimum medical loss ratio.

...."

SECTION 13A. Section 6 of S.L. 2015-245 reads as rewritten:

"**SECTION 6.** Role of the Department of Insurance. – The transformed Medicaid and NC Health Choice system shall include the licensing of ~~PHPs~~ PHPs, as required by subdivision 2 of Section 4 of this act, based on solvency requirements established and implemented by the Department of Insurance. The Commissioner of Insurance, in consultation with the Director of the Division of Health Benefits, shall develop recommended solvency requirements that are similar to the solvency requirements for similarly situated regulated entities and recommended licensing procedures that include an annual review by the Commissioner and reporting of changes in licensure to the Division of Health Benefits. The Commissioner shall report the recommendations as well as proposed fees to offset the cost of licensure and any necessary statutory changes to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016."

SECTION 14.(a) The portions of S.L. 2015-245, as amended, specified in this section are codified into a new Article 4 of Chapter 108D of the General Statutes to be entitled "Prepaid Health Plans," as follows:

(1) Section 1 of S.L. 2015-245 is codified as G.S. 108D-30.

(2) Subdivision (4) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17 of S.L. 2017-57, Section 4 of S.L. 2017-186, Section 1 of S.L. 2018-48, and Section 12 of this act, is codified as G.S. 108D-35.

(3) Subdivision (5) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 1 of S.L. 2018-48, Section 5 of S.L. 2018-49, and Section 12 of this act, is codified as G.S. 108D-40.

(4) Subdivision (5a) of Section 4 of S.L. 2015-245, as enacted by Section 5(c) of S.L. 2018-49, is codified as G.S. 108D-40.

(5) Subdivision (6) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121 and Section 1 of S.L. 2018-48, is codified as G.S. 108D-45 and the words "(statewide contracts)" and "(regional contracts)" shall be removed.

(6) Subdivision (7) of Section 4 of S.L. 2015-245 is codified as G.S. 108D-50.

(7) Subdivision (8) of Section 4 of S.L. 2015-245 is codified as G.S. 108D-55.
(8) Subdivision (9) of Section 4 of S.L. 2015-245, as amended by Section 1 of S.L. 2018-48 and Section 12 of this act, is codified as G.S. 122C-115(e), except that the tag line shall not be codified, and the words "under Article 4 of Chapter 108D of the General Statutes" shall be inserted after the words "capitated contracts".
(9) Subdivision (10) of Section 4 of S.L. 2015-245, as amended by Section 1 of S.L. 2018-48, is codified as G.S. 108D-60, except that the following are not codified:
a. The first and third sentences of subdivision (10).
b. The language in sub-subdivision a. appearing before sub-sub-subdivision 1.
c. The word "currently" shall be removed from sub-sub-sub-subdivision I. of sub-sub-subdivision 1. of sub-subdivision a.
d. Sub-sub-subdivision 6. of sub-subdivision a.
e. Sub-subdivisions b., c., and d.
(10) Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121, Section 6(b) of S.L. 2018-49, and Section 13 of this act, is codified as G.S. 108D-65, except that the following are not codified:
a. Sub-subdivision d. of subdivision (6).
b. Subdivisions (10), (11), (12), and (13).
(11) Section 7A of S.L. 2015-245, as enacted by Section 7 of S.L. 2018-49, is codified as G.S. 108D-70.

SECTION 14.(b) In codifying the portions of S.L. 2015-245, as amended, that are specified in subsection (a) of this section, the Revisor of Statutes is authorized to do all of the following:
(1) Replace references to DHHS with references to the Department or the Department of Health and Human Services, as appropriate.
(2) Revise references to subdivision (3) of Section 4 of the session law to instead reference the codified location of the language in subdivision (3) of Section 5 of the session law.

SECTION 15.(a) References to the Division of Medical Assistance, and any derivatives thereof, in the General Statutes are replaced with references to the Division of Health Benefits, except that references to the Division of Medical Assistance are not replaced in G.S. 108A-54, 126-5(c)(34), 143B-138.1, and 143B-216.80.

SECTION 15.(b) This section is effective July 1, 2019.

SECTION 16.(a) Except as otherwise provided, this act is effective October 1, 2019.

SECTION 16.(b) This section is effective when it becomes law.

HOUSE BILL 656:
Medicaid Changes for Transformation.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 12, 2019
Introduced by:	Reps. Lambeth, Dobson, Murphy, Sasser	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to Third Edition H656-CSTR-8		

OVERVIEW: HB 656 makes changes to the Medicaid and Health Choice appeals statutes, and to other laws pertaining to Medicaid and Health Choice, that are necessary to implement Medicaid Transformation and contracts with Prepaid Health Plans on November 1, 2019.

The PCS adds sections 9A and 13A and makes other technical changes.

CURRENT LAW: S.L. 2015-245, as amended, requires transition of the current Medicaid and Health Choice programs to capitated contracts with prepaid health plans (PHPs) under an 1115 waiver that was recently approved by the Centers for Medicare and Medicaid Services (CMS). Under the waiver, the Department of Health and Human Services (DHHS) has entered into contracts to pay PHPs a monthly per-person capitated rate to cover all Medicaid and Health Choice services for their enrollees. DHHS has also contracted with an enrollment broker to assist beneficiaries with enrolling in a PHP. The waiver directs that capitation payments to PHPs for enrolled beneficiaries will begin November 1, 2019.

BILL ANALYSIS: HB 656 makes changes to Medicaid and Health Choice laws that are necessary (i) to comply with federal law and regulations; (ii) for consistency with the Medicaid Transformation legislation, S.L. 2015-245, as amended; and (iii) for consistency with the PHP contracts that have been awarded. The bill has the following components:

- **Sections 1 and 6** establish a process for beneficiaries to appeal adverse decisions regarding disenrollment from a PHP in new Article 1A of Chapter 108D of the General Statutes. A Medicaid or Health Choice beneficiary may use this process to appeal decisions by DHHS or the enrollment broker regarding the beneficiary's disenrollment from a PHP. Key features of the process include the following:
    - The circumstances when disenrollment from a PHP is allowed, with or without cause, whether initiated by the enrollee or the PHP, are set out in G.S. 108D-5.3 and 108D-5.5.
    - The process for an enrollee to make an expedited request for disenrollment when the enrollee has an urgent medical need is set out in G.S. 108D-5.3(d).
    - Enrollees may appeal (i) DHHS's denial of their request to disenroll from a PHP or (ii) DHHS's approval of a PHP's request to disenroll the enrollee, under G.S. 108D-5.9.
    - The appeals process will be the same as the existing process for fee-for-service beneficiary appeals at the Office of Administrative Hearings under Part 6A of Article 2 of Chapter 108A of the General Statutes. DHHS is the respondent in these contested cases.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- **Section 1** establishes processes for beneficiaries to file grievances and appeals of adverse decisions by PHPs regarding benefit coverage. The processes will be the same as the existing grievance and appeals processes in Article 2 of Chapter 108D of the General Statutes, which govern grievances and appeals of actions by local management entities/managed care organizations (LME/MCOs), with the following exceptions:
    - Health Choice beneficiaries will use this process for PHP determinations. Currently, Health Choice beneficiaries are not enrolled in LME/MCOs and do not engage in the LME/MCO appeals process. Health Choice beneficiaries will use the existing process in G.S. 108A-70.29 for appeals not related to PHPs, as set forth in **Section 7**.
    - The length of time in which a LME/MCO must respond to a grievance is shortened from 90 days to 30 days under G.S. 108D-12(b), and the 30-day timeframe also applies to PHPs.
- **Section 1** also makes conforming changes to existing grievance and appeals processes to conform with federal law and regulations.
- **Sections 4, 5,** and **9A** add references to PHPs in the General Statutes.
- **Section 10** exempts contract disputes between PHPs and DHHS from Chapter 150B contested case hearings at the Office of Administrative Hearings under G.S. 150B-1.
- **Section 11** allows a PHP to be named as the sole respondent in a contested case at the Office of Administrative Hearings related to a notice of resolution issued by the PHP under G.S. 150B-23. The circumstances when a PHP may be named as a respondent are the same as when an LME/MCO may be named as a respondent under current law.
- **Section 14** directs the codification of the Medicaid Transformation legislation, S.L. 2015-245, as amended, into the General Statutes. **Sections 1, 2, 3, 9, 12, 13,** and **13A** make technical changes related to codification.
- **Section 15** replaces references to the Division of Medical Assistance in the General Statutes with references to the Division of Health Benefits.

EFFECTIVE DATE: The changing of references in the statutes to the Division of Medical Assistance to instead reference the Division of Health Benefits is effective July 1, 2019. The remainder of the bill is effective October 1, 2019. The changes to the LME/MCO grievance and appeals processes apply to (i) appeals arising from LME/MCO notices of adverse benefit determination mailed on or after that date and (ii) grievances received by an LME/MCO on or after that date.

HOUSE BILL 656*
Committee Substitute Favorable 4/30/19
Committee Substitute #2 Favorable 5/2/19

Short Title: Medicaid Changes for Transformation. (Public)

Sponsors:

Referred to:

April 10, 2019

A BILL TO BE ENTITLED

AN ACT TO MODIFY THE LAWS PERTAINING TO MEDICAID AND NC HEALTH CHOICE AS NEEDED FOR THE IMPLEMENTATION OF MEDICAID TRANSFORMATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 108D of the General Statutes reads as rewritten:

"Chapter 108D.

"Medicaid and NC Health Choice Managed Care ~~for Behavioral Health Services.~~Programs.

"Article 1.

"General Provisions.

"§ 108D-1. Definitions.

The following definitions apply in this ~~Chapter, unless the context clearly requires otherwise:~~Chapter:

(1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b). In accordance with 42 C.F.R. § 457.1260, this definition applies to NC Health Choice beneficiaries in the same manner as it applies to Medicaid beneficiaries.

(2) Adverse disenrollment determination. – A determination by the Department of Health and Human Services or the enrollment broker to (i) deny a request made by an enrollee, or the enrollee's authorized representative, to disenroll from a prepaid health plan or (ii) approve a request made by a prepaid health plan to disenroll an enrollee from a prepaid health plan.

(3) Applicant. – A provider ~~of mental health, intellectual or developmental disabilities, and substance abuse services~~ who is seeking to participate in the ~~closed~~ network of one or more local management entity/managed care ~~organizations.~~organizations or prepaid health plans.

(4) Behavioral Health and Individuals with Developmental Disabilities Tailored Plan or BH IDD Tailored Plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter, including the requirements pertaining to BH IDD Tailored Plans.

(5) Beneficiary. – A person to whom or on whose behalf medical assistance or assistance through the North Carolina Health Choice for Children program is granted under Article 2 of Chapter 108A of the General Statutes.

~~(2)~~(6) Closed network. – The network of providers that have contracted with a local management entity/managed care organization to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees.

~~(3)~~(7) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under ~~G.S. 108D-15 to resolve a dispute between an enrollee and a local management entity/managed care organization about a managed care action.~~G.S. 108D-5.9 or G.S. 108D-15.

~~(4)~~(8) Department. – The North Carolina Department of Health and Human Services.

~~(5)~~(9) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.

~~(6)~~(12) Emergency services. – As defined in 42 C.F.R. § 438.114.

~~(7)~~(13) Enrollee. – A Medicaid or NC Health Choice beneficiary who is currently enrolled with a local management entity/managed care ~~organization.~~organization or a prepaid health plan.

(14) Enrollment broker. – As defined in 42 C.F.R. § 438.810(a).

(16) Fee-for-service program. – A payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice beneficiaries rather than contracting for the coverage of services through a capitated payment arrangement.

~~(8)~~(21) Local Management Entity or LME. – As defined in ~~G.S. 122C-3(20b).~~G.S. 122C-3.

~~(9)~~(22) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in ~~G.S. 122C-3(20c).~~G.S. 122C-3.

~~(10) Managed care action. An action, as defined in 42 C.F.R. § 438.400(b).~~

~~(11) Managed Care Organization or MCO. As defined in 42 C.F.R. § 438.2.~~

(23) Mail. – United States mail or, if the enrollee or the enrollee's authorized representative has given written consent to receive electronic communications, electronic mail.

(24) Managed care entity. – A local management entity/managed care organization or a prepaid health plan.

(25) Medicaid transformation demonstration waiver. – The waiver agreement entered into between the State and the Centers for Medicare and Medicaid Services under Section 1115 of the Social Security Act for the transition to prepaid health plans.

~~(12)~~(26) Mental health, intellectual or developmental disabilities, and substance abuse services or MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered by a local management entity/managed care organization under a contract ~~in effect between~~ with the Department of Health and Human Services ~~and a local management entity~~ to operate ~~a managed care organization or prepaid inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).~~the combined Medicaid waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.

~~(13)~~(27) Network provider. – An appropriately credentialed provider ~~of mental health, intellectual or developmental disabilities, and substance abuse services~~ that has entered into a contract for participation in the ~~closed~~ network of one

or more local management entity/managed care ~~organizations.~~organizations or prepaid health plans.

~~(14)~~(28) Notice of ~~managed care action.~~ adverse benefit determination. – The notice required by 42 C.F.R. § 438.404.

~~(15) Notice of resolution. – The notice described in 42 C.F.R. § 438.408(e).~~

~~(16)~~(29) OAH. – The North Carolina Office of Administrative Hearings.

(30) Prepaid health plan or PHP. – A prepaid health plan, as defined in G.S. 58-93-5, or a local management entity/managed care organization operating a BH IDD Tailored Plan.

~~(17) Prepaid Inpatient Health Plan or PIHP. – As defined in 42 C.F.R. § 438.2.~~

(31) Provider. – As defined in G.S. 108C-2.

~~(18)~~(32) Provider of emergency services. – A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.

(36) Standard plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter except for the requirements pertaining to a BH IDD Tailored Plan.

"**§ 108D-2. Scope; applicability of this Chapter.**

This Chapter applies to every ~~LME/MCO and to every~~ managed care entity, applicant, enrollee, provider of emergency services, and network provider of ~~an LME/MCO.~~a managed care entity. This Chapter does not apply to Medicaid or NC Health Choice services delivered through the fee-for-service program. Nothing in this Chapter shall be construed to grant a NC Health Choice beneficiary benefits in excess of what is required by G.S. 108A-70.21.

"**§ 108D-3. Conflicts; severability.**

(a) To the extent that this Chapter conflicts with the Social Security Act or 42 C.F.R. ~~Part 438,~~ Parts 438 and 457, federal law ~~prevails.~~prevails, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services.

(b) To the extent that this Chapter conflicts with any other provision of State law that is contrary to the principles of managed care that will ensure successful containment of costs for ~~behavioral~~ health care services, this Chapter prevails and applies.

(c) If any section, term, or provision of this Chapter is adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"Article 1A.

"Disenrollment from Prepaid Health Plans.

"**§ 108D-5.1. General provisions.**

(a) Nothing in this Article shall be construed to limit or prevent the Department from disenrolling, from a PHP, an enrollee who (i) is no longer eligible to receive services through the Medicaid or NC Health Choice programs or (ii) becomes a member of a population of beneficiaries that is not required to enroll in a PHP under State law.

(b) Nothing in this Article shall be construed to exclude a Medicaid or NC Health Choice beneficiary who is otherwise required by State law to enroll in a PHP from enrolling in a PHP, or to prevent a beneficiary who is otherwise exempted from enrollment in a PHP from disenrolling from a PHP and receiving services through the fee-for-service program.

"**§ 108D-5.3. Enrollee requests for disenrollment.**

(a) In General. – An enrollee, or the enrollee's authorized representative, who is requesting disenrollment from a PHP, shall submit an oral or written request for disenrollment to the enrollment broker.

(b) Without Cause Enrollee Requests or Disenrollment. – An enrollee shall be allowed to disenroll from the PHP without cause only during the times specified in 42 C.F.R. § 438.56(c)(2), except that enrollees who are in any of the following groups may disenroll at any time:

(1) Members of federally recognized tribes.
(2) Beneficiaries who are enrolled in the foster care system.
(3) Beneficiaries who are in the former foster care Medicaid eligibility category.
(4) Beneficiaries who receive Title IV-E adoption assistance.
(5) Beneficiaries under the age of 26 who formerly received Title IV-E adoption assistance.
(6) Beneficiaries who are receiving long-term services and supports in institutional or community-based settings.
(7) Any other beneficiaries who are not required to enroll in a PHP under State law.

(c) With Cause Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's authorized representative, may submit a request to disenroll from a PHP for cause at any time. For cause reasons for disenrollment from a PHP include the following:

(1) The enrollee moves out of the PHP's service area.
(2) The PHP, because of the PHP's moral or religious objections, does not cover a service the enrollee seeks.
(3) The enrollee needs concurrent, related services that are not all available within the PHP's network and the enrollee's provider determines that receiving services separately would subject the enrollee to unnecessary risk.
(4) An enrollee who receives long-term services and supports will be required to change residential, institutional, or employment supports providers due to the enrollee's provider's change from in-network to out-of-network status with the PHP and, as a result, the enrollee would experience a disruption in residence or employment.
(5) The enrollee's complex medical conditions could be better served under a different PHP. For purposes of this subsection, an enrollee is considered to have a complex medical condition if the enrollee has a condition that could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.
(6) A family member of the enrollee becomes, or is determined, eligible for Medicaid or NC Health Choice and the family member is, or becomes, enrolled in a different PHP.
(7) Poor performance by the PHP, as determined by the Department. The Department shall not make a determination of poor performance by any PHP until the Department has completed an annual PHP performance evaluation following the first year of that PHP's contract.
(8) Poor quality of care, lack of access to services covered under the PHP's contract, lack of access to providers experienced in addressing the enrollee's health care needs, or any other reasons established by the Department in the PHP's contract or in rule.

(d) Expedited Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's authorized representative, may submit an expedited request for disenrollment to the enrollment broker when the enrollee has an urgent medical need that requires disenrollment from the PHP. For purposes of this subsection, an urgent medical need means that continued enrollment in the PHP could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.

"**§ 108D-5.5. PHP requests for disenrollment.**

(a) In General. – A PHP requesting disenrollment of an enrollee from the PHP shall submit a written request for disenrollment to the enrollment broker.

(b) Limitations on PHP Requests for Disenrollment. – A PHP shall not request disenrollment of an enrollee from the PHP for any reason prohibited by 42 C.F.R. § 438.56(b)(2). A PHP may request disenrollment of an enrollee only when both of the following criteria are met:

(1) The enrollee's behavior seriously hinders the PHP's ability to care for the enrollee or other enrollees of the PHP.

(2) The PHP has documented efforts to resolve the issues that form the basis of the request for disenrollment of the enrollee.

"**§ 108D-5.7. Notices.**

(a) Notices of Resolution. – For each disenrollment request by an enrollee or a PHP, the Department shall issue a written notice of resolution approving or denying the request by mail to the enrollee before the first day of the second month following the month in which the enrollee or PHP requested disenrollment. For expedited enrollee requests for disenrollment made under G.S. 108D-5.3(d), the Department shall issue the written notice of resolution approving or denying the expedited request within three calendar days of receipt of the request. In the same mailing as the notice, the Department shall also provide the enrollee with an appeal request form that includes all of the following:

(1) A statement that in order to request an appeal, the enrollee must file the form in accordance with OAH rules, by mail or fax to the address or fax number listed on the form, no later than 30 days after the mailing date of the notice of resolution.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal the specific adverse disenrollment determination identified in the notice of resolution.

(4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the enrollee's signature and date.

(b) Notices Pertaining to Expedited Enrollee Request for Disenrollment. – If the Department determines that an enrollee's request for disenrollment does not meet the criteria for an expedited request, the Department shall do the following:

(1) No later than three calendar days after receiving the enrollee's request for disenrollment, make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of the determination by mail.

(2) Issue the notice of resolution within the time limits established for standard disenrollment requests under subsection (a) of this section.

"**§ 108D-5.9. Appeals of adverse disenrollment determinations.**

(a) Appeals. – An enrollee, or the enrollee's authorized representative, who is dissatisfied with an adverse disenrollment determination may file an appeal for a hearing with the Office of Administrative Hearings within 30 calendar days of the date on the notice of resolution. A request for a hearing to appeal an adverse disenrollment determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The appeal shall be conducted in accordance with the procedures in Part 6A of Article 2 of Chapter 108A of the General Statutes.

(b) Parties. – The Department shall be the respondent for purposes of appeals under this section.

"Article 2.

"Enrollee Grievances and Appeals.

"§ 108D-11. ~~LME/MCO~~ Managed care entity grievance and appeal procedures, generally.

(a) Each ~~LME/MCO~~ managed care entity shall establish and maintain internal grievance and appeal procedures that (i) comply with the Social Security Act and 42 C.F.R. Part 438, Subpart F, and (ii) afford ~~enrollees, and network providers authorized in writing to act on behalf of enrollees,~~ enrollees and their authorized representatives constitutional rights to due process and a fair hearing.

(b) ~~Enrollees, or network providers authorized in writing to act on behalf of enrollees,~~ An enrollee, or the enrollee's authorized representative, may file ~~requests for grievances~~ grievances and ~~LME/MCO~~ managed care entity level appeals orally or in writing. However, unless the ~~enrollee or network provider~~ enrollee, or the enrollee's authorized representative, requests an expedited appeal, the oral ~~filing~~ appeal must be followed by a written, signed ~~grievance or~~ appeal.

(c) ~~An LME/MCO~~ A managed care entity shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file a grievance, request for an ~~LME/MCO~~ managed care entity level appeal, or a contested case hearing. However, nothing in this Chapter shall be construed to prevent ~~an LME/MCO~~ a managed care entity from doing any of the following:

(1) Offering an enrollee alternative services.

(2) Engaging in clinical or educational discussions with enrollees or providers.

(3) Engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.

(d) ~~An LME/MCO~~ A managed care entity shall not take punitive action against a provider for any of the following:

(1) Filing a grievance on behalf of an enrollee or supporting an enrollee's grievance.

(2) Requesting ~~an LME/MCO~~ a managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for ~~an LME/MCO~~ a managed care entity level appeal.

(3) Requesting an expedited ~~LME/MCO~~ managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for ~~an LME/MCO~~ a managed care entity level expedited appeal.

(4) Requesting a contested case hearing on behalf of an enrollee or supporting an enrollee's request for a contested case hearing.

(e) The appeal procedures set forth in this Article shall not apply to instances in which the sole basis for the managed care entity's decision is a provision in the State Plan or in federal or State law requiring an automatic change adversely affecting some or all beneficiaries.

"§ 108D-12. ~~LME/MCO~~ Managed care entity grievances.

(a) Filing of Grievance. – An ~~enrollee, or a network provider authorized in writing to act on behalf of an~~ enrollee, or the enrollee's authorized representative, has the right to file a grievance with ~~an LME/MCO~~ a managed care entity at any time to express dissatisfaction about any matter other than ~~a managed care action.~~ an adverse benefit determination. Upon receipt of a grievance, ~~an LME/MCO~~ a managed care entity shall cause a written acknowledgment of receipt of the grievance to be sent by ~~United States~~ mail.

(b) Notice of Grievance Disposition. – The ~~LME/MCO~~ managed care entity shall resolve the grievance and cause a notice of grievance ~~disposition~~ resolution to be sent by ~~United States~~ mail to the enrollee and all other affected parties as expeditiously as the enrollee's health condition requires, but no later than ~~90~~ 30 days after receipt of the ~~grievance.~~ grievance, provided that the managed care entity may extend such time frame to the extent permitted under 42 C.F.R. § 438.408(c).

(c) Right to ~~LME/MCO Level~~ Appeal. – There is no right to appeal the resolution of a grievance to OAH or any other forum.

"§ 108D-13. Standard ~~LME/MCO~~ managed care entity level appeals.

(a) Notice of ~~Managed Care Action.~~ Adverse Benefit Determination. – ~~An LME/MCO~~ A managed care entity shall provide an enrollee with a written notice of ~~a managed care action~~ an adverse benefit determination by ~~United States~~ mail as required under 42 C.F.R. § 438.404. The notice ~~of action~~ will employ a standardized form included as a provision in the ~~contracts~~ contract between the ~~LME/MCOs~~ managed care entity and the ~~Department of Health and Human Services.~~Department.

(b) Request for Appeal. – An enrollee, or ~~a network provider authorized in writing to act on behalf of the enrollee,~~ the enrollee's authorized representative, has the right to file a request for ~~an LME/MCO~~ a managed care entity level appeal of a notice of ~~managed care action~~ adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the ~~grievance disposition or~~ notice of ~~managed care action.~~ adverse benefit determination. Upon receipt of a request for ~~an LME/MCO~~ a managed care entity level appeal, ~~an LME/MCO~~ a managed care entity shall acknowledge receipt of the request for appeal in writing by ~~United States~~ mail.

(c) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue or reinstate the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of ~~an LME/MCO~~ a managed care entity level appeal to the same extent required under ~~42 C.F.R. § 438.420.~~ 42 C.F.R. § 438.420 and subsection (c1) of this section. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation or reinstatement of benefits.

(c1) Reinstatement of Benefits for PHP Enrollees. – A PHP shall reinstate the benefits of a Medicaid enrollee if all of the following occur:

(1) The Medicaid enrollee, or the enrollee's authorized representative, files the appeal within the required time frames.

(2) The Medicaid enrollee, or the enrollee's authorized representative, files for continuation of benefits within 30 calendar days of the mailing date of the notice of adverse benefit determination, except that a request for continuation of benefits filed by a provider does not meet the requirement of this subdivision, in accordance with 42 C.F.R. § 438.402(c)(ii).

(3) The appeal involves the termination, suspension, or reduction of a previously authorized service.

(4) The service was ordered by an authorized provider.

(d) Notice of Resolution. – The ~~LME/MCO~~ managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than ~~45~~ 30 days after receiving the request for ~~appeal.~~ appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The ~~LME/MCO~~ managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by ~~United States~~ mail within this ~~45-day~~ 30-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in this section or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f).

"**§ 108D-14. Expedited ~~LME/MCO~~ managed care entity level appeals.**

(a) Request for Expedited Appeal. – When the time limits for completing a standard appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, has the right to file a request for

an expedited appeal of ~~a managed care action~~ an adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the notice of ~~managed care action.~~ adverse benefit determination. For expedited appeal requests made by ~~enrollees,~~ an enrollee, or the enrollee's authorized representative, the ~~LME/MCO~~ managed care entity shall determine if the enrollee qualifies for an expedited appeal. For expedited appeal requests made by ~~network providers on behalf of enrollees,~~ a network provider as an enrollee's authorized representative, the ~~LME/MCO~~ managed care entity shall presume an expedited appeal is necessary.

(b) Notice of Denial for Expedited Appeal. – If the ~~LME/MCO~~ managed care entity denies a request for an expedited ~~LME/MCO~~ managed care entity level appeal, the ~~LME/MCO~~ managed care entity shall make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of denial by ~~United States~~ mail ~~by~~ no later than ~~two calendar days~~ 72 hours after receiving the request for an expedited appeal. In addition, the ~~LME/MCO~~ managed care entity shall resolve the appeal within the time limits established for standard ~~LME/MCO~~ managed care entity level appeals in G.S. 108D-13.

(c) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue or reinstate the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of an expedited ~~LME/MCO~~ managed care entity level appeal to the extent required under ~~42 C.F.R. § 438.420.~~ 42 C.F.R. § 438.420 and subsection (c1) of this section. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation or reinstatement of benefits.

(c1) Reinstatement of Benefits for PHP Enrollees. – A PHP shall reinstate the benefits of a Medicaid enrollee who is a Medicaid beneficiary in accordance with G.S. 108D-13(c1).

(d) Notice of Resolution. – If the ~~LME/MCO~~ managed care entity grants a request for an expedited ~~LME/MCO~~ managed care entity level appeal, the ~~LME/MCO~~ managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, and no later than ~~three working days~~ 72 hours after receiving the request for an expedited ~~appeal.~~ appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The ~~LME/MCO~~ managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by ~~United States~~ mail within this ~~three day~~ 72-hour period.

(e) Right to Request Contested Case Hearing. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or this ~~section.~~ section or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(f) Reasonable Assistance. – ~~An LME/MCO~~ A managed care entity shall provide the enrollee with reasonable assistance in completing forms and taking other procedural steps necessary to file an appeal, including providing interpreter services and toll-free numbers that have adequate teletypewriter/telecommunications devices for the deaf (TTY/TDD) and interpreter capability.

(g) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f).

"**§ 108D-15. Contested case hearings on disputed ~~managed care actions.~~adverse benefit determinations.**

(a) Jurisdiction of the Office of Administrative Hearings. – The Office of Administrative Hearings does not have jurisdiction over a dispute concerning ~~a managed care action,~~ an adverse benefit determination, except as expressly set forth in this Chapter.

(b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of resolution of an adverse benefit determination issued by ~~an LME/MCO.~~ a managed care entity.

G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not apply to enrollees contesting ~~a managed care action.~~an adverse benefit determination.

(c) Request for Contested Case Hearing. – A request for an administrative hearing to appeal a notice of resolution of an adverse benefit determination issued by ~~an LME/MCO~~ a managed care entity is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, has the right to file a request for appeal to contest a notice of resolution as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(d) Filing Procedure. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for an appeal by sending an appeal request form that meets the requirements of subsection (e) of this section to OAH and the affected ~~LME/MCO~~ managed care entity by no later than ~~30~~ 120 days after the mailing date of the notice of resolution. A request for appeal is deemed filed when a completed and signed appeal request form has been both submitted into the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the ~~LME/MCO~~ managed care entity shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

(e) Parties. – The ~~LME/MCO~~ managed care entity shall be the respondent for purposes of this appeal. The ~~LME/MCO or enrollee~~ managed care entity, the enrollee, or the enrollee's authorized representative may move for the permissive joinder of the Department under Rule 20 of the North Carolina Rules of Civil Procedure. The Department may move to intervene as a necessary party under Rules 19 and 24 of the North Carolina Rules of Civil Procedure.

(f) Appeal Request Form. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing which shall be no more than one side of one page. The form shall include at least all of the following:

(1) A statement that in order to request an appeal, the enrollee must file the form in accordance with OAH rules, by mail or fax to the address or fax number listed on the form, ~~by~~ no later than ~~30~~ 120 days after the mailing date of the notice of resolution.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal ~~a~~ the specific ~~managed care action~~ adverse benefit determination identified in the notice of resolution.

(4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the enrollee's signature and date.

(g) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue or reinstate the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of an appeal to the same extent required under ~~42 C.F.R. § 438.420.~~42 C.F.R. § 438.420, G.S. 108D-13, and G.S. 108D-14. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation or reinstatement of benefits. Notwithstanding any other provision of State law, the administrative law judge does not have the power to order and shall not order ~~an LME/MCO~~ a managed care entity to continue benefits in excess of what is required by ~~42 C.F.R. § 438.420.~~ 42 C.F.R. § 438.420, except to the extent required by G.S. 108D-13(c1) and G.S. 108D-14(c1).

(h) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge of OAH may limit and simplify the administrative hearing procedures that apply to contested case hearings conducted under this section in order to complete these cases as expeditiously as possible. Any simplified hearing procedures approved by the chief administrative law judge under this subsection must comply with all of the following requirements:

...

(2) OAH shall conduct all contested case hearings telephonically or by video technology with all parties, unless the enrollee requests that the hearing be conducted in person before the administrative law judge. An in-person hearing shall be conducted in the county that contains the headquarters of the ~~LME/MCO~~ managed care entity unless the enrollee's impairments limit travel. For enrollees with impairments that limit travel, an in-person hearing shall be conducted in the enrollee's county of residence. OAH shall provide written notice to the enrollee of the use of telephonic hearings, hearings by video conference, and in-person hearings before the administrative law judge, as well as written instructions on how to request a hearing in the enrollee's county of residence.

...

(4) The administrative law judge may allow brief extensions of the time limits imposed in this section only for good cause shown and to ensure that the record is complete. The administrative law judge shall only grant a continuance of a hearing in accordance with rules adopted by OAH for good cause shown and shall not grant a continuance on the day of a hearing, except for good cause shown. If an enrollee fails to make an appearance at a hearing that has been properly noticed by OAH by ~~United States~~ mail, OAH shall immediately dismiss the case, unless the enrollee moves to show good cause by no later than three business days after the date of dismissal. As used in this section, "good cause shown" includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.

(5) OAH shall include information on at least all of the following in its notice of hearing to an enrollee:

a. The enrollee's right to examine at a reasonable time before and during the hearing the contents of the enrollee's case file and any documents to be used by the ~~LME/MCO~~ managed care entity in the hearing before the administrative law judge.

b. The enrollee's right to an interpreter during the hearing process.

c. The circumstances in which a medical assessment may be obtained at the ~~LME/MCO's~~ managed care entity's expense and made part of the record, including all of the following:

...

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the ~~LME/MCO~~ managed care entity within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of ~~a managed care action~~ an adverse benefit determination until it has

received notice from the mediator assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. If the enrollee accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.

(j) Burden of Proof. – The enrollee has the burden of proof on all issues submitted to OAH for a contested case hearing under this section and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence in the case.

(k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of whether it was obtained before or after the ~~LME/MCO's managed care action~~ managed care entity's adverse benefit determination and regardless of whether the ~~LME/MCO~~ the managed care entity had an opportunity to consider the evidence in resolving the ~~LME/MCO~~ managed care entity level appeal. Upon the receipt of new evidence and at the request of the ~~LME/MCO,~~ managed care entity, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days in order to allow the ~~LME/MCO~~ managed care entity to review the evidence. Upon reviewing the evidence, if the ~~LME/MCO~~ managed care entity decides to reverse the ~~managed care action taken against the enrollee,~~ adverse benefit determination, it shall immediately inform the administrative law judge of its decision.

(*l*) Issue for Hearing. – For each ~~managed care action,~~ adverse benefit determination, the administrative law judge shall determine whether the ~~LME/MCO~~ managed care entity substantially prejudiced the rights of the enrollee and whether the ~~LME/MCO,~~ managed care entity, based upon evidence at the ~~hearing:~~ hearing, did any of the following:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

(m) To the extent that anything in this ~~Part,~~ Chapter, Chapter 150B of the General Statutes, or any rules or policies adopted under these Chapters is inconsistent with the Social Security Act or 42 C.F.R. Part 438, Subpart F, federal law prevails and applies to the extent of the ~~conflict.~~ conflict, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. All rules, rights, and procedures for contested case hearings concerning ~~managed care actions~~ adverse benefit determinations shall be construed so as to be consistent with applicable federal law and shall provide the enrollee with ~~no lesser and no greater~~ rights that are no less than those provided under federal law.

"**§ 108D-16. Notice of final decision and right to seek judicial review.**

The administrative law judge assigned to conduct a contested case hearing under G.S. 108D-15 shall hear and decide the case without unnecessary delay. The judge shall prepare a written decision that includes findings of fact and conclusions of law and send it to the parties in accordance with G.S. 150B-37. The written decision shall notify the parties of the final decision and of the right of the enrollee and the ~~LME/MCO~~ managed care entity to seek judicial review of the decision under Article 4 of Chapter 150B of the General Statutes.

"Article 3.

"Managed Care Entity Provider Networks.

"**§ 108D-21. LME/MCO provider networks.**

Each LME/MCO operating the combined 1915(b) and (c) waivers shall maintain and utilize a closed network of providers to furnish mental health, intellectual or developmental disabilities, and substance abuse services to its enrollees.

"**§ 108D-22. PHP provider networks.**

(a) Except as provided in G.S. 108D-23, each PHP shall develop and maintain a provider network that meets access to care requirements for its enrollees. A PHP may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, a PHP must include all providers in its geographical coverage area that are designated essential providers by the Department in accordance with subdivision (b) of this section, unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.

(b) The Department shall designate Medicaid and NC Health Choice providers as essential providers if, within a region defined by a reasonable access standard, the provider either (i) offers services that are not available from any other provider in the region or (ii) provides a substantial share of the total units of a particular service utilized by Medicaid and NC Health Choice beneficiaries within the region during the last three years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid and NC Health Choice enrollees. The Department shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

(1) Federally qualified health centers.
(2) Rural health centers.
(3) Free clinics.
(4) Local health departments.
(5) State Veterans Homes.

"**§ 108D-23. BH IDD Tailored Plan networks.**

Entities operating BH IDD Tailored Plans shall utilize closed provider networks only for the provision of behavioral health, intellectual and developmental disability, and traumatic brain injury services."

SECTION 1.(b) This section is effective October 1, 2019, and applies to (i) appeals arising from local management entity/managed care organization (LME/MCO) notices of adverse benefit determination mailed on or after that date and (ii) grievances received by an LME/MCO on or after that date.

SECTION 2. G.S. 90-414.4(a1)(3) reads as rewritten:

"(3) The following entities shall submit encounter and claims data, as appropriate, in accordance with the following time line:

a. Prepaid Health Plans, as defined in ~~S.L. 2015-245,~~ G.S. 108D-1, by the commencement date of a capitated contract with the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services as specified in ~~S.L. 2015-245.~~Article 4 of Chapter 108D of the General Statutes.

b. Local management entities/managed care organizations, as defined in G.S. 122C-3, by June 1, 2020."

SECTION 3. G.S. 108A-24 reads as rewritten:

"**§ 108A-24. Definitions.**

As used in Chapter 108A:

...

(3d) "Federal TANF funds" means the Temporary Assistance for Needy Families block grant funds provided for in Title IV-A of the Social Security Act.

(3e) "Fee-for-service program" means a payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice recipients

rather than contracting for the coverage of services through a capitated payment arrangement.

~~(3e)~~ ~~"FICA" means the taxes imposed by the Federal Insurance Contribution Act, 26 U.S.C. § 3101, et seq.~~

(3f) Repealed by Session Laws 2009-489, s. 1, effective August 26, 2009.

(3g) "FICA" means the taxes imposed by the Federal Insurance Contribution Act, 26 U.S.C. § 3101, et seq.

~~(3g)~~(3h) "Full-time employment" means employment which requires the employee to work a regular schedule of hours per day and days per week established as the standard full-time workweek by the employer, but not less than an average of 30 hours per week.

(4) Repealed by Session Laws 1983, c. 14, s. 3.

...

(4b) "Parent" means biological parent or adoptive parent, and for Work First purposes, includes a stepparent.

(4c) "Prepaid health plan" or "PHP" has the same meaning as in G.S. 108D-1.

(5) "Recipient" is a person to whom, or on whose behalf, assistance is granted under this Article.

...."

SECTION 4. G.S. 108A-56 reads as rewritten:

"**§ 108A-56. Acceptance of federal grants.**

All of the provisions of the federal Social Security Act providing grants to the states for medical assistance are accepted and adopted, and the provisions of this Part shall be liberally construed ~~in relation to such act so that the intent to comply with it shall be made effectual.~~ to effectuate compliance with the act, except to the extent the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. Nothing in this Part or the regulations made under its authority shall be construed to deprive a recipient of assistance of the right to choose the licensed provider of the care or service made available under this Part within the provisions of the federal Social Security ~~Act.~~Act, or valid waiver agreement. This section shall not be construed to prohibit a PHP from (i) requiring its enrollees to obtain services from providers that are under contract with the PHP or (ii) imposing utilization management criteria to a request for services, to the extent these actions are not otherwise prohibited by State or federal law or regulation, or by the Department."

SECTION 5. G.S. 108A-70 reads as rewritten:

"**§ 108A-70. Recoupment of amounts spent on medical care.**

(a) ~~The~~ To the extent necessary to reimburse the Department or a PHP for expenditures for costs under this Part, and provided that claims for current and past due child support shall take priority over claims for those expenditures, the Department may garnish the wages, salary, or other employment income of, and the Secretary of Revenue shall withhold amounts from State tax refunds to, any person ~~who:~~who meets all of the following criteria:

(1) Is required by court or administrative order to provide health benefit plan coverage for the cost of health care services to a child eligible for medical assistance under ~~Medicaid; and~~Medicaid.

(2) Has received payment from a third party for the costs of such ~~services; but~~services.

(3) Has not used such payments to reimburse, as appropriate, either the other parent or guardian of the child or the provider of the ~~services;~~services.

~~to the extent necessary to reimburse the Department for expenditures for such costs under this Part; provided, however, claims for current and past due child support shall take priority over any such claims for the costs of such services.~~

...."

SECTION 6. Part 6A of Article 2 of Chapter 108A of the General Statutes reads as rewritten:

"Part 6A. ~~Medicaid Recipient Appeals Process.~~Appeals Process for Certain Medicaid and NC Health Choice Determinations.

"**§ 108A-70.9A. ~~Appeals by Medicaid recipients.~~Definitions; Medicaid recipient appeals.**

(a) Definitions. – The following definitions apply in this ~~Part, unless the context clearly requires otherwise.~~Part:

(1) Adverse determination. – A determination by the Department to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a Medicaid ~~service.~~service through the fee-for-service program. An adverse benefit determination as defined in G.S. 108D-1 is not an adverse determination for purposes of this Part.

(1a) Adverse disenrollment decision. – As defined in G.S. 108D-1.

(1b) Contested Medicaid case. – A case commenced by (i) a Medicaid recipient appealing an adverse determination under this Part or (ii) a Medicaid or a NC Health Choice recipient appealing an adverse disenrollment determination under G.S. 108D-5.9.

(2) OAH. – The Office of Administrative Hearings.

(3) Recipient. – A recipient and the recipient's parent, guardian, or legal representative, unless otherwise specified.

(b) ~~General Rule.~~ Medicaid recipient appeals. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid recipient to appeal an adverse determination made by the ~~Department.~~Department and the process used by a Medicaid or NC Health Choice recipient to appeal an adverse disenrollment determination by the Department.

...

"**§ 108A-70.9B. Contested Medicaid cases.**

(a) Application. – This section applies only to contested Medicaid cases ~~commenced by Medicaid recipients under G.S. 108A-70.9A.~~ as defined in this Part. Except as otherwise provided by ~~G.S. 108A-70.9A~~ Article 1A of Chapter 108D of the General Statutes, G.S. 108A-70.9A, and this section governing time lines and procedural steps, a contested Medicaid case commenced by a Medicaid or NC Health Choice recipient is subject to the provisions of Article 3 of Chapter 150B of the General Statutes. To the extent any provision in this ~~section~~ section, Article 1A of Chapter 108D of the General Statutes, or G.S. 108A-70.9A conflicts with another provision in Article 3 of Chapter 150B of the General Statutes, this ~~section~~ section, Article 1A of Chapter 108D of the General Statutes, and G.S. 108A-70.9A control.

(b) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge may limit and simplify the procedures that apply to a contested Medicaid case involving a Medicaid or NC Health Choice recipient in order to complete the case as quickly as possible.

...

(3) The simplified procedure may include requiring that all prehearing motions be considered and ruled on by the administrative law judge in the course of the hearing of the case on the merits. An administrative law judge assigned to a contested Medicaid case shall make reasonable efforts in a case involving a Medicaid or NC Health Choice recipient who is not represented by an attorney to assure a fair hearing and to maintain a complete record of the hearing.

...

(c) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108A-70.9A(e) or other clear request for a hearing by a Medicaid or NC Health Choice recipient, OAH shall immediately notify the Mediation Network of North Carolina, which shall

contact the recipient within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the Department within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested Medicaid case until it has received notice from the mediator assigned that either: (i) the mediation was unsuccessful, or (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. If the recipient accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.

(d) Burden of Proof. – The recipient has the burden of proof on all issues submitted in a contested Medicaid case to OAH ~~for a Medicaid contested case hearing~~ and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence.

...

(f) Issue for Hearing. – For each adverse determination and each adverse disenrollment determination, the hearing shall determine whether the Department substantially prejudiced the rights of the recipient and if the Department, based upon evidence at the ~~hearing:~~hearing, did any of the following:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

...

"**§ 108A-70.9C. Informal review permitted.**

Nothing in this Part shall prevent the Department from engaging in an informal review of a contested Medicaid case with a recipient prior to issuing a notice of adverse determination ~~as provided by G.S. 108A-70.9A(c).~~under G.S. 108A-70.9A(c) or a notice of resolution under G.S. 108D-5.7."

SECTION 7. G.S. 108A-70.29 reads as rewritten:

"**§ 108A-70.29. Program review process.**

(a) Review of Eligibility and Program Enrollment Decisions. – Eligibility and Program enrollment decisions for Program applicants or recipients shall be reviewable pursuant to G.S. 108A-79. Program recipients shall remain enrolled in the NC Health Choice Program during the review of a decision to terminate or suspend enrollment. This subsection does not apply to requests for disenrollment from a PHP under Article 1A of Chapter 108D of the General Statutes.

(b) Review of Fee-for-Service Program Health Services Decisions. – This subsection applies only to health services decisions for services being provided to NC Health Choice recipients through the fee-for-service program as defined in G.S. 108A-24. This subsection does not apply to adverse benefit determinations as defined in G.S. 108D-1. In accordance with 42 C.F.R. § 457.1130 and 42 C.F.R. § 457.1150, a Program recipient may seek review of any delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services, through a two-level review process.

...."

SECTION 9. G.S. 122C-3 reads as rewritten:

"**§ 122C-3. Definitions.**

The following definitions apply in this Chapter:

...

(2a) "Area director" means the administrative head of the area authority program appointed pursuant to G.S. 122C-121.

(2b) "Behavioral Health and Individuals with Developmental Disabilities Tailored Plan or BH IDD Tailored Plan" has the same meaning as in G.S. 108D-1.

(2c) "Board of county commissioners" includes the participating boards of county commissioners for multicounty area authorities and multicounty programs.

...

(20c) "Local management entity/managed care organization" or "LME/MCO" means a local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security ~~Act.~~Act or to operate a BH IDD Tailored Plan.

...."

SECTION 10. G.S. 150B-1 reads as rewritten:

"**§ 150B-1. Policy and scope.**

...

(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

...

(17) The Department of Health and Human Services with respect to the review of North Carolina Health Choice Program determinations regarding delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of ~~services.~~services, commenced under G.S. 108A-70.29(b).

...

(25) The Department of Health and Human Services with respect to disputes involving the performance, terms, or conditions of a contract between the Department and a prepaid health plan, as defined in G.S. 108D-1.

...."

SECTION 11. G.S. 150B-23 reads as rewritten:

"**§ 150B-23. Commencement; assignment of administrative law judge; hearing required; notice; intervention.**

...

(a3) A Medicaid or NC Health Choice enrollee, or ~~network provider authorized in writing to act on behalf of the enrollee,~~ the enrollee's authorized representative, who appeals a notice of resolution issued by ~~an LME/MCO~~ a managed care entity under Chapter 108D of the General Statutes may commence a contested case under this Article in the same manner as any other petitioner. The case shall be conducted in the same manner as other contested cases initiated by Medicaid or NC Health Choice enrollees under this Article. Solely and only for the purposes of contested cases commenced ~~as Medicaid managed care enrollee appeals under Chapter 108D of the General Statutes,~~ pursuant to G.S. 108D-15 by enrollees of LME/MCOs to appeal a notice of resolution issued by the LME/MCO, an LME/MCO is considered an agency as defined in G.S. 150B-2(1a). The LME/MCO shall not be considered an agency for any other purpose. When a prepaid health plan, as defined in G.S. 108D-1, other than an LME/MCO, is under contract with the Department of Health and Human Services to issue notices of resolution under Article 2 of Chapter 108D of the General Statutes, then solely and only for the purposes of contested cases commenced pursuant to G.S. 108D-15 to appeal a notice of resolution issued by the prepaid health plan, the prepaid health plan shall be considered an agency as defined in G.S. 150B-2(1a). The prepaid health plan shall not be considered an agency for any other purpose.

...."

SECTION 12. Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17(a) of S.L. 2017-57, Section 4 of S.L. 2017-186, Section 11H.10(d) of S.L. 2018-5, and Sections 5 and 6 of S.L. 2018-48, reads as rewritten:

"**SECTION 4.** Structure of Delivery System. – The transformed Medicaid and NC Health Choice programs described in Section 1 of this act shall be organized according to the following principles and parameters:

...

(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. The capitated contracts required by this subdivision shall not cover:

a. Medicaid services ~~currently~~ covered by the local management entities/managed care organizations (LME/MCOs) under the combined 1915(b) and (c) waivers shall not be covered under any capitated PHP contract other than a BH IDD Tailored Plan, except that all capitated PHP contracts shall cover the following services: inpatient behavioral health services, outpatient behavioral health emergency room services, outpatient behavioral health services provided by direct-enrolled providers, mobile crisis management services, facility-based crisis services for children and adolescents, professional treatment services in a facility-based crisis program, outpatient opioid treatment services, ambulatory detoxification services, nonhospital medical detoxification services, partial hospitalization, medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization, research-based intensive behavioral health treatment, diagnostic assessment services, and Early and Periodic Screening, Diagnosis, and Treatment services. In accordance with this sub-subdivision, 1915(b)(3) services shall not be covered under any capitated PHP contract other than a BH IDD Tailored Plan.

...

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except for the following categories:

...

m. Recipients in the following categories shall not be covered by PHPs for a period of time to be determined by DHHS that shall not exceed five years after the date that capitated PHP contracts begin:

1. Recipients who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of 90 days or longer and (ii) are not being served through the Community Alternatives Program for Disabled Adults (CAP/DA). During the period of exclusion from PHP coverage for this population as determined by DHHS in accordance with this sub-subdivision, if an individual enrolled in a PHP resides in a nursing facility for 90 days or more, then that individual shall be excluded from PHP coverage on the first day of the month following the ninetieth day of the stay in the nursing facility and shall be disenrolled from the PHP.

2. Recipients who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing. This sub-sub-subdivision shall not include recipients being served through the Community Alternatives Program for Disabled Adults (CAP/DA).
3. Recipients who are (i) enrolled in the foster care system, (ii) receiving Title IV-E adoption assistance, (iii) under the age of 26 and formerly were in the foster care system, or (iv) under the age of 26 and formerly received adoption assistance.

...

(9) LME/MCOs. – Beginning on the date that capitated contracts begin, LME/MCOs shall cease managing Medicaid services for all Medicaid recipients other than recipients described in sub-subdivisions a., d., e., f., g., j., k., ~~and l.~~ l., and m. of subdivision (5) of this section. Until BH IDD Tailored Plans become operational, all of the following shall occur:

a. LME/MCOs shall continue to manage the Medicaid services that are ~~currently~~ covered by the LME/MCOs under the combined 1915(b) and (c) waivers for Medicaid recipients described in sub-subdivisions a., d., e., f., g., j., k., ~~and l.~~ l., and m. of subdivision (5) of this section.
b. The Division of Health Benefits shall negotiate actuarially sound capitation rates directly with the LME/MCOs based on the change in composition of the population being served by the LME/MCOs.
c. Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits.

...."

SECTION 13. Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121 and Section 6(b) of S.L. 2018-49, reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of DHHS during Medicaid transformation shall include the following activities and functions:

...

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All contracts shall be the result of requests for proposals (RFPs) issued by DHHS and the submission of competitive bids by PHPs. DHHS shall develop standardized contract terms, to include at a minimum, the following:

...

c. A minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by DHHS. The minimum medical loss ratio shall be neither higher nor lower than eighty-eight percent (88%). DHHS shall not require community reinvestment as a result of a PHP's failure to comply with any minimum medical loss ratio.

...."

SECTION 14.(a) The portions of S.L. 2015-245, as amended, specified in this section are codified into a new Article 4 of Chapter 108D of the General Statutes to be entitled "Prepaid Health Plans," as follows:

(1) Section 1 of S.L. 2015-245 is codified as G.S. 108D-30.
(2) Subdivision (4) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17 of S.L. 2017-57, Section 4 of S.L. 2017-186,

Section 1 of S.L. 2018-48, and Section 12 of this act, is codified as G.S. 108D-35.

(3) Subdivision (5) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 1 of S.L. 2018-48, Section 5 of S.L. 2018-49, and Section 12 of this act, is codified as G.S. 108D-40.

(4) Subdivision (5a) of Section 4 of S.L. 2015-245, as enacted by Section 5(c) of S.L. 2018-49, is codified as G.S. 108D-40.

(5) Subdivision (6) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121 and Section 1 of S.L. 2018-48, is codified as G.S. 108D-45 and the words "(statewide contracts)" and "(regional contracts)" shall be removed.

(6) Subdivision (7) of Section 4 of S.L. 2015-245 is codified as G.S. 108D-50.

(7) Subdivision (8) of Section 4 of S.L. 2015-245 is codified as G.S. 108D-55.

(8) Subdivision (9) of Section 4 of S.L. 2015-245, as amended by Section 1 of S.L. 2018-48 and Section 12 of this act, is codified as G.S. 122C-115(e), except that the tag line shall not be codified, and the words "under Article 4 of Chapter 108D of the General Statutes" shall be inserted after the words "capitated contracts."

(9) Subdivision (10) of Section 4 of S.L. 2015-245, as amended by Section 1 of S.L. 2018-48, is codified as G.S. 108D-60, except that the following are not codified:

a. The first and third sentences of the subdivision (10).

b. The language in sub-subdivision a. appearing before sub-sub-subdivision 1.

c. The word "currently" shall be removed from sub-sub-sub-subdivision II. of sub-sub-subdivision 1. of sub-subdivision a.

d. Sub-sub-subdivision 6. of sub-subdivision a.

e. Sub-subdivisions b., c., and d.

(10) Section 5 of S.L. 2015-245, as amended by Section 2(c) S.L. 2016-121, Section 6(b) of S.L. 2018-49, and Section 13 of this act, is codified as G.S. 108D-65, except that the following are not codified:

a. Sub-subdivision d. of subdivision (6) of Section 5.

b. Subdivisions (10), (11), (12), and (13) of Section 5.

(11) Section 7A of S.L. 2015-245, as enacted by Section 7 of S.L. 2018-49, is codified as G.S. 108D-70.

SECTION 14.(b) In codifying the portions of S.L. 2015-245, as amended, that are specified in subsection (a) of this section, the Revisor of Statutes is authorized to do all of the following:

(1) Replace references to DHHS with references to the Department or the Department of Health and Human Services, as appropriate.

(2) Revise references to subdivision (3) of Section 4 of the session law to instead reference the codified location of the language in subdivision (3) of Section 5 of the session law.

SECTION 15.(a) References to the Division of Medical Assistance, and any derivatives thereof, in the General Statutes are replaced with references to the Division of Health Benefits, except that references to the Division of Medical Assistance are not replaced in G.S. 108A-54, 126-5(c)(34), 143B-138.1, and 143B-216.80.

SECTION 15.(b) This section is effective July 1, 2019.

SECTION 16.(a) Except as otherwise provided, this act is effective October 1, 2019.

SECTION 16.(b) This section is effective when it becomes law.

HOUSE BILL 658:
Allow Donations of Unexpired Drugs.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 11, 2019
Introduced by:	Reps. Sasser, Hanig, Humphrey	**Prepared by:**	Theresa Matula Legislative Analyst
Analysis of:	First Edition		

OVERVIEW: House Bill 658 would amend the criteria for drugs donated to pharmacists or free clinics participating in the Drug, Supplies, and Medical Devise Repository Program to require that the drug not have reached its expiration date, rather than having an expiration date that is six months from the date the drug was donated.

CURRENT LAW: G.S. 90-85.44(b) provides that the purpose of the Drug, Supplies, and Medical Device Repository Program is to allow an eligible donor to donate unused drugs, supplies, and medical devices to uninsured and underinsured patients in this State. The unused drugs, supplies, and medical devices must be donated to a free clinic or pharmacy that elects to participate in the Program. A free clinic that receives a donated unused drug, supplies, or medical device under the Program may distribute the drug, supplies, or medical device to another free clinic or pharmacy for use under the Program.

G.S. 90-85.44(c) provides the criteria below for drugs dispensed from the Drug, Supplies, and Medical Devise Repository Program.

(c) Requirements of Participating Pharmacists or Free Clinics. – A pharmacist may accept and dispense drugs, supplies, and medical devices donated to the Program to eligible patients if all of the following requirements are met:

(1) The drug, supplies, or medical device is in the original, unopened, sealed, and tamper-evident packaging or, if packaged in single-unit doses, the single-unit dose packaging is unopened.
(2) The pharmacist has determined that the drug, supplies, or medical device is safe for redistribution.
(3) The drug bears an expiration date that is later than six months after the date that the drug was donated.
(4) The drug, supplies, or medical device is not adulterated or misbranded, as determined by a pharmacist.
(5) The drug, supplies, or medical device is prescribed by a practitioner for use by an eligible patient and is dispensed by a pharmacist.

BILL ANALYSIS: HB 658 would amend the criteria [G.S. 90-85.44(c)(3)] for drugs donated to pharmacists or free clinics participating in the Drug, Supplies, and Medical Devise Repository Program to require that the drug not have reached its expiration date. Currently, a pharmacist may only accept drugs that bear an expiration date that is later than six months after the date the drug is donated.

EFFECTIVE DATE: HB 658 would become effective when it becomes law.

aren Cochrane-Brown
Director

H658-SMSH-64 E1 -V-1

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

HOUSE BILL 658

Short Title:	Allow Donations of Unexpired Drugs.	(Public)
Sponsors:	Representatives Sasser, Hanig, and Humphrey (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Rules, Calendar, and Operations of the House	

April 10, 2019

A BILL TO BE ENTITLED

AN ACT MODIFYING THE EXPIRED DRUG PROVISION OF THE DRUG, SUPPLIES, AND MEDICAL DEVICE REPOSITORY PROGRAM TO ALLOW FOR THE ACCEPTANCE AND DISPENSING OF DRUGS THAT HAVE NOT REACHED THEIR EXPIRATION DATE FOR THE PURPOSE OF INCREASING ACCESS FOR INDIVIDUALS WHO ARE UNINSURED OR UNDERINSURED.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-85.44(c) reads as rewritten:

"(c) Requirements of Participating Pharmacists or Free Clinics. – A pharmacist may accept and dispense drugs, supplies, and medical devices donated to the Program to eligible patients if all of the following requirements are met:

...

(3) The drug ~~bears an expiration date that is later than six months after the date that the drug was donated.~~has not reached its expiration date.

...."

SECTION 2. This act is effective when it becomes law.

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 643

DATE: 6-12 **TIME:** 10 AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

Page Name	Hometown	Sponsoring Senator
1. Abbey Hamilton	Asheville	Van Duyn
2. shriya madhavaram	waxhaw	Todd Johnson
3. Sarika Kasuganti	Cary	Toby Fitch
4. Lily Klett	Davidson	Marcus
5. Anne Spong	Greensboro	Berger
6. Christina Hamilton	Asheville	Van Duyn
7. Parker Shook	Raleigh	J. Alexander
8. Willa Carney	Mooresville	Sawyer

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

SENATE COMMITTEE

ON

HEALTH CARE

June 12, 2019

Room 643

10:00 AM

Senate Sergeant at Arms:

TERRY BARNHARDT

CHRIS MOORE

FRANK URBEN

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

June 12, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Trish Colvard	ACHC
Julia Adams Scheurich	Oak City GR
Henry M Lancaster	LCM
Rob Bashore	NC ASCA
Richard Carlton	Law Office of Richard Carlton PLLC
Elizabeth Hudgins	NCHeals
Michelle Frazier	NP
Joe Stewart	NANC
Connie Wilson	NCOA
[illegible]	NWC
Bill Lane	CSTM
Andy Chase	KMA
Rachel Barkin	PBLaw
Deb Clary	NCSP
Ken McHon	KMA
Tabitha Bryant	DHHS
Dave Todd	DHHS

09-21-201

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

June 12, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
FRANK Hill	PSG
DAVID POWERS	POWERS STRATEGIES LLC
Zane St. Iwell	TSG
Dan Sarek	Cone Health
Matt Gross	VHHS
Brendan Ryf	NC Prime Care Co
Hattie Gavande	DHHS
	NWC
Scott Lassiter	KCS
Virginia Tom	Valleygate DSC
NANCY LANE	PDA
Scott Cooper	Connect C
Kirby Consier	Novartis
Todd Tarquini	NFS
Randolph E. Ward	R. Ward & Assoc
Kay Castillo	NASW-NC
Sallie James	Governor's office

09-21-201

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

June 12, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robert Croom	NCDOI
[illegible]	NMKS
Bob Mapp	NCDOI
Jon Ares	PSG
[illegible]	OSA
Kaitlin Rothacker	BPW Workers Assoc
Jeff Barnhart	MWC
Brian Perkins	Alliance Health
Michelle Blackwelder	NC DHHS
Hannah Tedder MyC	VISTA
Joey Nichols	Other Coalition

09-21-201

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

June 12, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dana Simpson	SA
Christine Craig	WakeMed
Leah Robins	NCHA
Ryan Blackledge	Cone Health
Wendy Kelly	[illegible]
Daniel VanLierop	[illegible]
Ross Burnhardt	NP
Grace Irwin	WV
[illegible]	[illegible]
John Hatcher	NCFA
Kory Kiger	NCBMA
Sarah McQuillan	[illegible]
Chamberlain Collier	Troutman Sanders
Kayla Weldon	Troutman Sanders
JOE LANIER	TROUTMAN
Sarah Patterson	WM
Rick Zechini	Williams Mullen
John Bode	BCA

09-21-201

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

June 12, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	CSS
	Monarch
	AHCA
Sarah Wolfe	MWC
	CSS
Leah Byers	Civitas
	MWC
	HSS
	SEANC
	NCMS

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

June 12, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Vinay Saranga	NCMS
Lawrence Greenblatt	NCMS
Sue Forrest	NCMS
Lourdes Pereda, MD	NCMS
David Heiman	NC Center for Nonprofits
Doug Miskiewicz	PSG
Marissa Turner	TSS

09-21-201

Senate Committee on Health Care
Thursday, June 13, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 13, 2019, in Room 643 of the Legislative Office Building. Thirteen members were present.

Senator Dan Bishop, Chair, presided.

Carson Grainger sponsored by Sen. Newton, Savannah-Grace Jones sponsored by Sen. Britt, Rhett Freedman sponsored by Sen. Britt, Shriya Madhavaram sponsored by Sen. Johnson, Rebekah Byrd sponsored by Sen. B. Jackson, Elizabeth Cashwell sponsored by Sen. B. Jackson, Tucker Martin sponsored by Sen. T. Alexander, and Will Twilla sponsored by Sen. Perry served as pages.

HB 934 - Right to Try Adult Stem Cell Treatments (Representatives Blackwell, Lambeth, Murphy, Reives)

Sen. Bishop recognized Sen. Krawiec to amend the bill. Questions from members were answered by Sen. Krawiec. The amendment passed and the amended bill was placed before committee. Rep. Blackwell was recognized to explain the bill. Sen. Krawiec moved for a favorable report as to the bill as amended, rolled into a new proposed committee substitute unfavorable to the original bill, with a serial referral to Senate Rules. The motion carried.

Sen. Bishop allowed Sam Taylor of the North Carolina Biosciences Organization to speak from the audience.

HB 656 - Medicaid Changes for Transformation (Representatives Lambeth, Dobson, Murphy, Sasser)

Sen. Bishop recognized Rep. Sasser to explain the bill. Questions from members were answered by Jennifer Hillman of the Legislative Analysis Division. Sen. Krawiec moved for a favorable report on the proposed committee substitute, unfavorable to the original, with a serial referral to Senate Rules. The motion carried.

The meeting adjourned at 10:15 AM.

Dan Bishop

Senator Dan Bishop, Chair
Presiding

John Wynne

John Wynne, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Thursday, June 13, 2019

Senator Bishop,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

HB **934** **(CS#1)** Right to Try Adult Stem Cell Treatments.

Draft Number:	H934-PCS10661-BC-46
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Joyce Krawiec will handle HB 934



NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Thursday, June 13, 2019

Senator Bishop,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

HB **656** **(CS#2)** Medicaid Changes for Transformation.

Draft Number:	H656-PCS30478-TR-8
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Joyce Krawiec will handle HB 656



Senate Committee on Health Care
Wednesday, June 13, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 656	Medicaid Changes for Transformation.	Representative Lambeth Representative Dobson Representative Murphy Representative Sasser
HB 934	Right to Try Adult Stem Cell Treatments	Representative Blackwell Representative Lambeth Representative Murphy Representative Reives

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H D

HOUSE BILL 656
Committee Substitute Favorable 4/30/19
Committee Substitute #2 Favorable 5/2/19
PROPOSED SENATE COMMITTEE SUBSTITUTE H656-CSTR-8 [v.11]
06/10/2019 12:52:31 PM

Short Title: Medicaid Changes for Transformation. (Public)

Sponsors:

Referred to:

April 10, 2019

A BILL TO BE ENTITLED

AN ACT TO MODIFY THE LAWS PERTAINING TO MEDICAID AND NC HEALTH CHOICE AS NEEDED FOR THE IMPLEMENTATION OF MEDICAID TRANSFORMATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 108D of the General Statutes reads as rewritten:

"**Chapter 108D.**

"**Medicaid and NC Health Choice Managed Care ~~for Behavioral Health Services.~~Programs.**

"Article 1.

"General Provisions.

"**§ 108D-1. Definitions.**

The following definitions apply in this ~~Chapter, unless the context clearly requires otherwise:~~Chapter:

(1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b). In accordance with 42 C.F.R. § 457.1260, this definition applies to NC Health Choice beneficiaries in the same manner as it applies to Medicaid beneficiaries.

(2) Adverse disenrollment determination. – A determination by the Department of Health and Human Services or the enrollment broker to (i) deny a request made by an enrollee, or the enrollee's authorized representative, to disenroll from a prepaid health plan or (ii) approve a request made by a prepaid health plan to disenroll an enrollee from a prepaid health plan.

(3) Applicant. – A provider ~~of mental health, intellectual or developmental disabilities, and substance abuse services~~ who is seeking to participate in the ~~closed~~ network of one or more local management entity/managed care ~~organizations.~~organizations or prepaid health plans.

(4) Behavioral health and intellectual/developmental disabilities tailored plan or BH IDD tailored plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter, including the requirements pertaining to BH IDD tailored plans.

(5) Beneficiary. – A person to whom or on whose behalf medical assistance or assistance through the North Carolina Health Choice for Children program is granted under Article 2 of Chapter 108A of the General Statutes.

~~(2)~~(6) Closed network. – The network of providers that have contracted with a local management entity/managed care organization to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees.

~~(3)~~(7) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under ~~G.S. 108D-15 to resolve a dispute between an enrollee and a local management entity/managed care organization about a managed care action.~~G.S. 108D-5.9 or G.S. 108D-15.

~~(4)~~(8) Department. – The North Carolina Department of Health and Human Services.

~~(5)~~(9) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.

~~(6)~~(12) Emergency services. – As defined in 42 C.F.R. § 438.114.

~~(7)~~(13) Enrollee. – A Medicaid or NC Health Choice beneficiary who is currently enrolled with a local management entity/managed care ~~organization.~~organization or a prepaid health plan.

(14) Enrollment broker. – As defined in 42 C.F.R. § 438.810(a).

(16) Fee-for-service program. – A payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice beneficiaries rather than contracting for the coverage of services through a capitated payment arrangement.

~~(8)~~(21) Local Management Entity or LME. – As defined in ~~G.S. 122C-3(20b).~~G.S. 122C-3.

~~(9)~~(22) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in ~~G.S. 122C-3(20c).~~G.S. 122C-3.

~~(10) Managed care action. – An action, as defined in 42 C.F.R. § 438.400(b).~~

~~(11) Managed Care Organization or MCO. – As defined in 42 C.F.R. § 438.2.~~

(23) Mail. – United States mail or, if the enrollee or the enrollee's authorized representative has given written consent to receive electronic communications, electronic mail.

(24) Managed care entity. – A local management entity/managed care organization or a prepaid health plan.

(25) Medicaid transformation demonstration waiver. – The waiver agreement entered into between the State and the Centers for Medicare and Medicaid Services under Section 1115 of the Social Security Act for the transition to prepaid health plans.

~~(12)~~(26) Mental health, intellectual or developmental disabilities, and substance abuse services or MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered by a local management entity/managed care organization under a contract ~~in effect between~~ with the Department of Health and Human Services ~~and a local management entity~~ to operate ~~a managed care organization or prepaid inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).~~the combined Medicaid waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.

~~(13)~~(27) Network provider. – An appropriately credentialed provider ~~of mental health, intellectual or developmental disabilities, and substance abuse services~~ that has entered into a contract for participation in the ~~closed~~ network of one or more local management entity/managed care ~~organizations.~~organizations or prepaid health plans.

~~(14)~~(28) Notice of ~~managed care action.~~ adverse benefit determination. – The notice required by 42 C.F.R. § 438.404.

~~(15) Notice of resolution. The notice described in 42 C.F.R. § 438.408(e).~~

~~(16)~~(29) OAH. – The North Carolina Office of Administrative Hearings.

(30) Prepaid health plan or PHP. – A prepaid health plan, as defined in G.S. 58-93-5, that is under a capitated contract with the Department for the delivery of Medicaid and NC Health Choice services, or a local management entity/managed care organization that is under a capitated contract with the Department to operate a BH IDD tailored plan.

~~(17) Prepaid Inpatient Health Plan or PIHP. As defined in 42 C.F.R. § 438.2.~~

(31) Provider. – As defined in G.S. 108C-2.

~~(18)~~(32) Provider of emergency services. – A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.

(36) Standard benefit plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter except for the requirements pertaining to a BH IDD tailored plan.

"**§ 108D-2. Scope; applicability of this Chapter.**

This Chapter applies to every ~~LME/MCO and to every~~ managed care entity, applicant, enrollee, provider of emergency services, and network provider of ~~an LME/MCO.~~a managed care entity. This Chapter does not apply to Medicaid or NC Health Choice services delivered through the fee-for-service program. Nothing in this Chapter shall be construed to grant a NC Health Choice beneficiary benefits in excess of what is required by G.S. 108A-70.21.

"**§ 108D-3. Conflicts; severability.**

(a) To the extent that this Chapter conflicts with the Social Security Act or 42 C.F.R. ~~Part 438,~~ Parts 438 and 457, federal law ~~prevails.~~prevails, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services.

(b) To the extent that this Chapter conflicts with any other provision of State law that is contrary to the principles of managed care that will ensure successful containment of costs for ~~behavioral~~ health care services, this Chapter prevails and applies.

(c) If any section, term, or provision of this Chapter is adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"Article 1A.

"Disenrollment from Prepaid Health Plans.

"**§ 108D-5.1. General provisions.**

(a) Nothing in this Article shall be construed to limit or prevent the Department from disenrolling, from a PHP, an enrollee who (i) is no longer eligible to receive services through the Medicaid or NC Health Choice programs or (ii) becomes a member of a population of beneficiaries that is not required to enroll in a PHP under State law.

(b) Nothing in this Article shall be construed to exclude a Medicaid or NC Health Choice beneficiary who is otherwise required by State law to enroll in a PHP from enrolling in a PHP,

or to prevent a beneficiary who is otherwise exempted from enrollment in a PHP from disenrolling from a PHP and receiving services through the fee-for-service program.

"**§ 108D-5.3. Enrollee requests for disenrollment.**

(a) In General. – An enrollee, or the enrollee's authorized representative, who is requesting disenrollment from a PHP, shall submit an oral or written request for disenrollment to the enrollment broker.

(b) Without Cause Enrollee Requests for Disenrollment. – An enrollee shall be allowed to disenroll from the PHP without cause only during the times specified in 42 C.F.R. § 438.56(c)(2), except that enrollees who are in any of the following groups may disenroll at any time:

(1) Members of federally recognized tribes.
(2) Beneficiaries who are enrolled in the foster care system.
(3) Beneficiaries who are in the former foster care Medicaid eligibility category.
(4) Beneficiaries who receive Title IV-E adoption assistance.
(5) Beneficiaries who are receiving long-term services and supports in institutional or community-based settings.
(6) Any other beneficiaries who are not required to enroll in a PHP under G.S. 108D-40.

(c) With Cause Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's authorized representative, may submit a request to disenroll from a PHP for cause at any time. For cause reasons for disenrollment from a PHP include the following:

(1) The enrollee moves out of the PHP's service area.
(2) The PHP, because of the PHP's moral or religious objections, does not cover a service the enrollee seeks.
(3) The enrollee needs concurrent, related services that are not all available within the PHP's network and the enrollee's provider determines that receiving services separately would subject the enrollee to unnecessary risk.
(4) An enrollee who receives long-term services and supports will be required to change residential, institutional, or employment supports providers due to the enrollee's provider's change from in-network to out-of-network status with the PHP and, as a result, the enrollee would experience a disruption in residence or employment.
(5) The enrollee's complex medical conditions could be better served under a different PHP. For purposes of this subsection, an enrollee is considered to have a complex medical condition if the enrollee has a condition that could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.
(6) A family member of the enrollee becomes, or is determined, eligible for Medicaid or NC Health Choice and the family member is, or becomes, enrolled in a different PHP.
(7) Poor performance by the PHP, as determined by the Department. The Department shall not make a determination of poor performance by any PHP until the Department has completed an annual PHP performance evaluation following the first year of that PHP's contract.
(8) Poor quality of care, lack of access to services covered under the PHP's contract, lack of access to providers experienced in addressing the enrollee's health care needs, or any other reasons established by the Department in the PHP's contract or in rule.

(d) Expedited Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's authorized representative, may submit an expedited request for disenrollment to the enrollment broker when the enrollee has an urgent medical need that requires disenrollment from the PHP.

For purposes of this subsection, an urgent medical need means that continued enrollment in the PHP could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.

"**§ 108D-5.5. PHP requests for disenrollment.**

(a) In General. – A PHP requesting disenrollment of an enrollee from the PHP shall submit a written request for disenrollment to the enrollment broker.

(b) Limitations on PHP Requests for Disenrollment. – A PHP shall not request disenrollment of an enrollee from the PHP for any reason prohibited by 42 C.F.R. § 438.56(b)(2). A PHP may request disenrollment of an enrollee only when both of the following criteria are met:

(1) The enrollee's behavior seriously hinders the PHP's ability to care for the enrollee or other enrollees of the PHP.

(2) The PHP has documented efforts to resolve the issues that form the basis of the request for disenrollment of the enrollee.

"**§ 108D-5.7. Notices.**

(a) Notices of Resolution. – For each disenrollment request by an enrollee or a PHP, the Department shall issue a written notice of resolution approving or denying the request by mail to the enrollee before the first day of the second month following the month in which the enrollee or PHP requested disenrollment. For expedited enrollee requests for disenrollment made under G.S. 108D-5.3(d), the Department shall issue the written notice of resolution approving or denying the expedited request within three calendar days of receipt of the request. In the same mailing as the notice, the Department shall also provide the enrollee with an appeal request form that includes all of the following:

(1) A statement that in order to request an appeal, the enrollee must file the form in accordance with OAH rules, by mail or fax to the address or fax number listed on the form, no later than 30 days after the mailing date of the notice of resolution.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal the specific adverse disenrollment determination identified in the notice of resolution.

(4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the enrollee's signature and date.

(b) Notices Pertaining to Expedited Enrollee Requests for Disenrollment. – If the Department determines that an enrollee's request for disenrollment does not meet the criteria for an expedited request, the Department shall do the following:

(1) No later than three calendar days after receiving the enrollee's request for disenrollment, make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of the determination by mail.

(2) Issue the notice of resolution within the time limits established for standard disenrollment requests under subsection (a) of this section.

"**§ 108D-5.9. Appeals of adverse disenrollment determinations.**

(a) Appeals. – An enrollee, or the enrollee's authorized representative, who is dissatisfied with an adverse disenrollment determination may file an appeal for a hearing with the Office of Administrative Hearings within 30 calendar days of the date on the notice of resolution. A request for a hearing to appeal an adverse disenrollment determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General

Statutes. The appeal shall be conducted in accordance with the procedures in Part 6A of Article 2 of Chapter 108A of the General Statutes.

(b) Parties. – The Department shall be the respondent for purposes of appeals under this section.

"Article 2.

"Enrollee Grievances and Appeals.

"§ 108D-11. ~~LME/MCO~~ Managed care entity grievance and appeal procedures, generally.

(a) Each ~~LME/MCO~~ managed care entity shall establish and maintain internal grievance and appeal procedures that (i) comply with the Social Security Act and 42 C.F.R. Part 438, Subpart F, and (ii) afford ~~enrollees, and network providers authorized in writing to act on behalf of enrollees,~~ enrollees and their authorized representatives constitutional rights to due process and a fair hearing.

(b) ~~Enrollees, or network providers authorized in writing to act on behalf of enrollees,~~ An enrollee, or the enrollee's authorized representative, may file ~~requests for grievances~~ grievances and ~~LME/MCO~~ managed care entity level appeals orally or in writing. However, unless the ~~enrollee or network provider~~ enrollee, or the enrollee's authorized representative, requests an expedited appeal, the oral ~~filing~~ appeal must be followed by a written, signed ~~grievance or~~ appeal.

(c) ~~An LME/MCO~~ A managed care entity shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file a grievance, request for ~~an LME/MCO~~ a managed care entity level appeal, or a contested case hearing. However, nothing in this Chapter shall be construed to prevent ~~an LME/MCO~~ a managed care entity from doing any of the following:

(1) Offering an enrollee alternative services.

(2) Engaging in clinical or educational discussions with enrollees or providers.

(3) Engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.

(d) ~~An LME/MCO~~ A managed care entity shall not take punitive action against a provider for any of the following:

(1) Filing a grievance on behalf of an enrollee or supporting an enrollee's grievance.

(2) Requesting ~~an LME/MCO~~ a managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for ~~an LME/MCO~~ a managed care entity level appeal.

(3) Requesting an expedited ~~LME/MCO~~ managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for ~~an LME/MCO~~ a managed care entity level expedited appeal.

(4) Requesting a contested case hearing on behalf of an enrollee or supporting an enrollee's request for a contested case hearing.

(e) The appeal procedures set forth in this Article shall not apply to instances in which the sole basis for the managed care entity's decision is a provision in the State Plan or in federal or State law requiring an automatic change adversely affecting some or all beneficiaries.

"§ 108D-12. ~~LME/MCO~~ Managed care entity grievances.

(a) Filing of Grievance. – An ~~enrollee, or a network provider authorized in writing to act on behalf of an~~ enrollee, or the enrollee's authorized representative, has the right to file a grievance with ~~an LME/MCO~~ a managed care entity at any time to express dissatisfaction about any matter other than ~~a managed care action.~~ an adverse benefit determination. Upon receipt of a grievance, ~~an LME/MCO~~ a managed care entity shall cause a written acknowledgment of receipt of the grievance to be sent by ~~United States~~ mail.

(b) Notice of Grievance Disposition. – The ~~LME/MCO~~ managed care entity shall resolve the grievance and cause a notice of grievance ~~disposition~~ resolution to be sent by ~~United States~~ mail to the enrollee and all other affected parties as expeditiously as the enrollee's health condition requires, but no later than ~~90~~ 30 days after receipt of the ~~grievance.~~ grievance, provided

that the managed care entity may extend such time frame to the extent permitted under 42 C.F.R. § 438.408(c).

(c) Right to ~~LME/MCO Level~~ Appeal. – There is no right to appeal the resolution of a grievance to OAH or any other forum.

"§ 108D-13. Standard ~~LME/MCO~~ managed care entity level appeals.

(a) Notice of ~~Managed Care Action.~~ Adverse Benefit Determination. – ~~An LME/MCO~~ A managed care entity shall provide an enrollee with a written notice of ~~a managed care action~~ an adverse benefit determination by ~~United States~~ mail as required under 42 C.F.R. § 438.404. The notice ~~of action~~ will employ a standardized form included as a provision in the ~~contracts~~ contract between the ~~LME/MCOs~~ managed care entity and the ~~Department of Health and Human Services.~~ Department.

(b) Request for Appeal. – An enrollee, or ~~a network provider authorized in writing to act on behalf of the enrollee,~~ the enrollee's authorized representative, has the right to file a request for ~~an LME/MCO~~ a managed care entity level appeal of a notice of ~~managed care action~~ adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the ~~grievance disposition or~~ notice of ~~managed care action.~~ adverse benefit determination. Upon receipt of a request for ~~an LME/MCO~~ a managed care entity level appeal, ~~an LME/MCO~~ a managed care entity shall acknowledge receipt of the request for appeal in writing by ~~United States~~ mail.

(c) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of ~~an LME/MCO~~ a managed care entity level appeal to the same extent required under 42 C.F.R. § 438.420. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation of benefits.

(d) Notice of Resolution. – The ~~LME/MCO~~ managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than ~~45~~ 30 days after receiving the request for ~~appeal.~~ appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The ~~LME/MCO~~ managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by ~~United States~~ mail within this ~~45-day~~ 30-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in this section or ~~G.S. 108D-14.~~ G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f).

"§ 108D-14. Expedited ~~LME/MCO~~ managed care entity level appeals.

(a) Request for Expedited Appeal. – When the time limits for completing a standard appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, has the right to file a request for an expedited appeal of ~~a managed care action~~ an adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the notice of ~~managed care action.~~ adverse benefit determination. ~~For expedited appeal requests made by enrollees, the LME/MCO shall determine if the enrollee qualifies for an expedited appeal. For expedited appeal requests made by network providers on behalf of enrollees, the LME/MCO~~ In determining whether the enrollee qualifies for an expedited appeal, the managed care entity shall presume an expedited appeal is ~~necessary.~~ necessary when the expedited appeal is made by a network provider as an enrollee's authorized representative or

when a network provider has otherwise indicated to the managed care entity that an expedited appeal is necessary.

(b) Notice of Denial for Expedited Appeal. – If the ~~LME/MCO~~ managed care entity denies a request for an expedited ~~LME/MCO~~ managed care entity level appeal, the ~~LME/MCO~~ managed care entity shall make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of denial by ~~United States~~ mail ~~by~~ no later than ~~two calendar days~~ 72 hours after receiving the request for an expedited appeal. In addition, the ~~LME/MCO~~ managed care entity shall resolve the appeal within the time limits established for standard ~~LME/MCO~~ managed care entity level appeals in G.S. 108D-13.

(c) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of an expedited ~~LME/MCO~~ managed care entity level appeal to the extent required under 42 C.F.R. § 438.420. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation of benefits.

(d) Notice of Resolution. – If the ~~LME/MCO~~ managed care entity grants a request for an expedited ~~LME/MCO~~ managed care entity level appeal, the ~~LME/MCO~~ managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, and no later than ~~three working days~~ 72 hours after receiving the request for an expedited ~~appeal.~~ appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The ~~LME/MCO~~ managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by ~~United States~~ mail within this ~~three day~~ 72-hour period.

(e) Right to Request Contested Case Hearing. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or this ~~section.~~ section or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(f) Reasonable Assistance. – ~~An LME/MCO~~ A managed care entity shall provide the enrollee with reasonable assistance in completing forms and taking other procedural steps necessary to file an appeal, including providing interpreter services and toll-free numbers that have adequate teletypewriter/telecommunications devices for the deaf (TTY/TDD) and interpreter capability.

(g) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f).

"**§ 108D-15. Contested case hearings on disputed ~~managed care actions.~~adverse benefit determinations.**

(a) Jurisdiction of the Office of Administrative Hearings. – The Office of Administrative Hearings does not have jurisdiction over a dispute concerning ~~a managed care action,~~ an adverse benefit determination, except as expressly set forth in this Chapter.

(b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of resolution of an adverse benefit determination issued by ~~an LME/MCO.~~ a managed care entity. G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not apply to enrollees contesting ~~a managed care action.~~ an adverse benefit determination.

(c) Request for Contested Case Hearing. – A request for an administrative hearing to appeal a notice of resolution of an adverse benefit determination issued by ~~an LME/MCO~~ a managed care entity is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, has the right to file a request for appeal to

contest a notice of resolution as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(d) Filing Procedure. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for an appeal by sending an appeal request form that meets the requirements of subsection (e) of this section to OAH and the affected ~~LME/MCO~~ managed care entity by no later than ~~30~~ 120 days after the mailing date of the notice of resolution. A request for appeal is deemed filed when a completed and signed appeal request form has been both submitted into the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the ~~LME/MCO~~ managed care entity shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

(e) Parties. – The ~~LME/MCO~~ managed care entity shall be the respondent for purposes of this appeal. The ~~LME/MCO or enrollee~~ managed care entity, the enrollee, or the enrollee's authorized representative may move for the permissive joinder of the Department under Rule 20 of the North Carolina Rules of Civil Procedure. The Department may move to intervene as a necessary party under Rules 19 and 24 of the North Carolina Rules of Civil Procedure.

(f) Appeal Request Form. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing which shall be no more than one side of one page. The form shall include at least all of the following:

(1) A statement that in order to request an appeal, the enrollee must file the form in accordance with OAH rules, by mail or fax to the address or fax number listed on the form, ~~by~~ no later than ~~30~~ 120 days after the mailing date of the notice of resolution.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal ~~a~~ the specific ~~managed care action~~ adverse benefit determination identified in the notice of resolution.

(4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the enrollee's signature and date.

(g) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of an appeal to the same extent required under 42 C.F.R. § 438.420. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation of benefits. Notwithstanding any other provision of State law, the administrative law judge does not have the power to order and shall not order ~~an LME/MCO~~ a managed care entity to continue benefits in excess of what is required by 42 C.F.R. § 438.420.

(h) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge of OAH may limit and simplify the administrative hearing procedures that apply to contested case hearings conducted under this section in order to complete these cases as expeditiously as possible. Any simplified hearing procedures approved by the chief administrative law judge under this subsection must comply with all of the following requirements:

...

(2) OAH shall conduct all contested case hearings telephonically or by video technology with all parties, unless the enrollee requests that the hearing be

conducted in person before the administrative law judge. An in-person hearing shall be conducted in the county that contains the headquarters of the ~~LME/MCO~~ managed care entity unless the enrollee's impairments limit travel. For enrollees with impairments that limit travel, an in-person hearing shall be conducted in the enrollee's county of residence. OAH shall provide written notice to the enrollee of the use of telephonic hearings, hearings by video conference, and in-person hearings before the administrative law judge, as well as written instructions on how to request a hearing in the enrollee's county of residence.

...

(4) The administrative law judge may allow brief extensions of the time limits imposed in this section only for good cause shown and to ensure that the record is complete. The administrative law judge shall only grant a continuance of a hearing in accordance with rules adopted by OAH for good cause shown and shall not grant a continuance on the day of a hearing, except for good cause shown. If an enrollee fails to make an appearance at a hearing that has been properly noticed by OAH by ~~United States~~ mail, OAH shall immediately dismiss the case, unless the enrollee moves to show good cause by no later than three business days after the date of dismissal. As used in this section, "good cause shown" includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.

(5) OAH shall include information on at least all of the following in its notice of hearing to an enrollee:

a. The enrollee's right to examine at a reasonable time before and during the hearing the contents of the enrollee's case file and any documents to be used by the ~~LME/MCO~~ managed care entity in the hearing before the administrative law judge.

b. The enrollee's right to an interpreter during the hearing process.

c. The circumstances in which a medical assessment may be obtained at the ~~LME/MCO's~~ managed care entity's expense and made part of the record, including all of the following:

...

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the ~~LME/MCO~~ managed care entity within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of ~~a managed care action~~ an adverse benefit determination until it has received notice from the mediator assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. ~~If the enrollee accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.~~

(j) Burden of Proof. – The enrollee has the burden of proof on all issues submitted to OAH for a contested case hearing under this section and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence in the case.

(k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of whether it was obtained before or after the ~~LME/MCO's managed care action~~ managed care entity's adverse benefit determination and regardless of whether the ~~LME/MCO~~ the managed care entity had an opportunity to consider the evidence in resolving the ~~LME/MCO~~ managed care entity level appeal. Upon the receipt of new evidence and at the request of the ~~LME/MCO,~~ managed care entity, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days in order to allow the ~~LME/MCO~~ managed care entity to review the evidence. Upon reviewing the evidence, if the ~~LME/MCO~~ managed care entity decides to reverse the ~~managed care action taken against the enrollee,~~ adverse benefit determination, it shall immediately inform the administrative law judge of its decision.

(*l*) Issue for Hearing. – For each ~~managed care action,~~ adverse benefit determination, the administrative law judge shall determine whether the ~~LME/MCO~~ managed care entity substantially prejudiced the rights of the enrollee and whether the ~~LME/MCO,~~ managed care entity, based upon evidence at the ~~hearing:~~ hearing, did any of the following:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

(m) To the extent that anything in this ~~Part,~~ Chapter, Chapter 150B of the General Statutes, or any rules or policies adopted under these Chapters is inconsistent with the Social Security Act or 42 C.F.R. Part 438, Subpart F, federal law prevails and applies to the extent of the ~~conflict.~~ conflict, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. All rules, rights, and procedures for contested case hearings concerning ~~managed care actions~~ adverse benefit determinations shall be construed so as to be consistent with applicable federal law and shall provide the enrollee with ~~no lesser and no greater~~ rights that are no less than those provided under federal law.

"§ 108D-16. Notice of final decision and right to seek judicial review.

The administrative law judge assigned to conduct a contested case hearing under G.S. 108D-15 shall hear and decide the case without unnecessary delay. The judge shall prepare a written decision that includes findings of fact and conclusions of law and send it to the parties in accordance with G.S. 150B-37. The written decision shall notify the parties of the final decision and of the right of the enrollee and the ~~LME/MCO~~ managed care entity to seek judicial review of the decision under Article 4 of Chapter 150B of the General Statutes.

"Article 3.

"Managed Care Entity Provider Networks.

"§ 108D-21. LME/MCO provider networks.

Each LME/MCO operating the combined 1915(b) and (c) waivers shall develop and maintain closed network of providers to furnish mental health, intellectual or developmental disabilities, and substance abuse services to its enrollees.

"§ 108D-22. PHP provider networks.

(a) Except as provided in G.S. 108D-23, each PHP shall develop and maintain a provider network that meets access to care requirements for its enrollees. A PHP may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, a PHP must include all providers in its geographical coverage area that are designated essential providers by the Department in accordance with subdivision (b) of this section, unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.

(b) The Department shall designate Medicaid and NC Health Choice providers as essential providers if, within a region defined by a reasonable access standard, the provider either

(i) offers services that are not available from any other provider in the region or (ii) provides a substantial share of the total units of a particular service utilized by Medicaid and NC Health Choice beneficiaries within the region during the last three years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid and NC Health Choice enrollees. The Department shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

(1) Federally qualified health centers.
(2) Rural health centers.
(3) Free clinics.
(4) Local health departments.
(5) State Veterans Homes.

"**§ 108D-23. BH IDD tailored plan networks.**

Entities operating BH IDD tailored plans shall develop and maintain closed provider networks only for the provision of behavioral health, intellectual and developmental disability, and traumatic brain injury services."

SECTION 1.(b) This section is effective October 1, 2019, and applies to (i) appeals arising from local management entity/managed care organization (LME/MCO) notices of adverse benefit determination mailed on or after that date and (ii) grievances received by an LME/MCO on or after that date.

SECTION 2. G.S. 90-414.4(a1)(3) reads as rewritten:

"(3) The following entities shall submit encounter and claims data, as appropriate, in accordance with the following time line:

a. Prepaid Health Plans, as defined in ~~S.L. 2015-245,~~ G.S. 108D-1, by the commencement date of a capitated contract with the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services as specified in ~~S.L. 2015-245.~~Article 4 of Chapter 108D of the General Statutes.

b. Local management entities/managed care organizations, as defined in G.S. 122C-3, by June 1, 2020."

SECTION 3. G.S. 108A-24 reads as rewritten:

"**§ 108A-24. Definitions.**

As used in Chapter 108A:

...

(3d) "Federal TANF funds" means the Temporary Assistance for Needy Families block grant funds provided for in Title IV-A of the Social Security Act.

(3e) "Fee-for-service program" means a payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice recipients rather than contracting for the coverage of services through a capitated payment arrangement.

~~(3e) "FICA" means the taxes imposed by the Federal Insurance Contribution Act, 26 U.S.C. § 3101, et seq.~~

(3f) Repealed by Session Laws 2009-489, s. 1, effective August 26, 2009.

(3g) "FICA" means the taxes imposed by the Federal Insurance Contribution Act, 26 U.S.C. § 3101, et seq.

~~(3g)~~(3h) "Full-time employment" means employment which requires the employee to work a regular schedule of hours per day and days per week established as

the standard full-time workweek by the employer, but not less than an average of 30 hours per week.

(4) Repealed by Session Laws 1983, c. 14, s. 3.

...

(4b) "Parent" means biological parent or adoptive parent, and for Work First purposes, includes a stepparent.

(4c) "Prepaid health plan" or "PHP" has the same meaning as in G.S. 108D-1.

(5) "Recipient" is a person to whom, or on whose behalf, assistance is granted under this Article.

...."

SECTION 4. G.S. 108A-56 reads as rewritten:

"**§ 108A-56. Acceptance of federal grants.**

All of the provisions of the federal Social Security Act providing grants to the states for medical assistance are accepted and adopted, and the provisions of this Part shall be liberally construed ~~in relation to such act so that the intent to comply with it shall be made effectual.~~ to effectuate compliance with the act, except to the extent the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. Nothing in this Part or the regulations made under its authority shall be construed to deprive a recipient of assistance of the right to choose the licensed provider of the care or service made available under this Part within the provisions of the federal Social Security ~~Act.~~Act, or valid waiver agreement. This section shall not be construed to prohibit a PHP from (i) requiring its enrollees to obtain services from providers that are under contract with the PHP or (ii) imposing utilization management criteria to a request for services, to the extent these actions are not otherwise prohibited by State or federal law or regulation, or by the Department."

SECTION 5. G.S. 108A-70 reads as rewritten:

"**§ 108A-70. Recoupment of amounts spent on medical care.**

(a) ~~The~~ To the extent necessary to reimburse the Department or a PHP for expenditures for costs under this Part, and provided that claims for current and past due child support shall take priority over claims for those expenditures, the Department may garnish the wages, salary, or other employment income of, and the Secretary of Revenue shall withhold amounts from State tax refunds to, any person ~~who:~~who meets all of the following criteria:

(1) Is required by court or administrative order to provide health benefit plan coverage for the cost of health care services to a child eligible for medical assistance under ~~Medicaid; and~~Medicaid.

(2) Has received payment from a third party for the costs of such ~~services; but~~services.

(3) Has not used such payments to reimburse, as appropriate, either the other parent or guardian of the child or the provider of the ~~services;~~services.

~~to the extent necessary to reimburse the Department for expenditures for such costs under this Part; provided, however, claims for current and past due child support shall take priority over any such claims for the costs of such services.~~

...."

SECTION 6. Part 6A of Article 2 of Chapter 108A of the General Statutes reads as rewritten:

"Part 6A. ~~Medicaid Recipient Appeals Process.~~Appeals Process for Certain Medicaid and NC Health Choice Determinations.

"**§ 108A-70.9A. ~~Appeals by Medicaid recipients.~~Definitions; Medicaid recipient appeals.**

(a) Definitions. – The following definitions apply in this ~~Part, unless the context clearly requires otherwise.~~Part:

(1) Adverse determination. – A determination by the Department to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a

Medicaid ~~service.~~service through the fee-for-service program. An adverse benefit determination as defined in G.S. 108D-1 is not an adverse determination for purposes of this Part.

(1a) Adverse disenrollment decision. – As defined in G.S. 108D-1.

(1b) Contested Medicaid case. – A case commenced by (i) a Medicaid recipient appealing an adverse determination under this Part or (ii) a Medicaid or a NC Health Choice recipient appealing an adverse disenrollment determination under G.S. 108D-5.9.

(2) OAH. – The Office of Administrative Hearings.

(3) Recipient. – A recipient and the recipient's parent, guardian, or legal representative, unless otherwise specified.

(b) ~~General Rule.~~ Medicaid recipient appeals. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid recipient to appeal an adverse determination made by the ~~Department.~~Department and the process used by a Medicaid or NC Health Choice recipient to appeal an adverse disenrollment determination by the Department.

...

"§ 108A-70.9B. Contested Medicaid cases.

(a) Application. – This section applies only to contested Medicaid cases ~~commenced by Medicaid recipients under G.S. 108A-70.9A.~~ as defined in this Part. Except as otherwise provided by ~~G.S. 108A-70.9A~~ Article 1A of Chapter 108D of the General Statutes, G.S. 108A-70.9A, and this section governing time lines and procedural steps, a contested Medicaid case commenced by a Medicaid or NC Health Choice recipient is subject to the provisions of Article 3 of Chapter 150B of the General Statutes. To the extent any provision in this ~~section~~ section, Article 1A of Chapter 108D of the General Statutes, or G.S. 108A-70.9A conflicts with another provision in Article 3 of Chapter 150B of the General Statutes, this ~~section~~ section, Article 1A of Chapter 108D of the General Statutes, and G.S. 108A-70.9A control.

(b) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge may limit and simplify the procedures that apply to a contested Medicaid case involving a Medicaid or NC Health Choice recipient in order to complete the case as quickly as possible.

...

(3) The simplified procedure may include requiring that all prehearing motions be considered and ruled on by the administrative law judge in the course of the hearing of the case on the merits. An administrative law judge assigned to a contested Medicaid case shall make reasonable efforts in a case involving a Medicaid or NC Health Choice recipient who is not represented by an attorney to assure a fair hearing and to maintain a complete record of the hearing.

...

(c) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108A-70.9A(e) or other clear request for a hearing by a Medicaid or NC Health Choice recipient, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the recipient within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the Department within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested Medicaid case until it has received notice from the mediator assigned that either: (i) the mediation was unsuccessful, or (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. ~~If the recipient~~

~~accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.~~

(d) Burden of Proof. – The recipient has the burden of proof on all issues submitted in a contested Medicaid case to OAH ~~for a Medicaid contested case hearing~~ and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence.

...

(f) Issue for Hearing. – For each adverse determination and each adverse disenrollment determination, the hearing shall determine whether the Department substantially prejudiced the rights of the recipient and if the Department, based upon evidence at the ~~hearing:~~hearing, did any of the following:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

...

"§ 108A-70.9C. Informal review permitted.

Nothing in this Part shall prevent the Department from engaging in an informal review of a contested Medicaid case with a recipient prior to issuing a notice of adverse determination ~~as provided by G.S. 108A-70.9A(c).~~under G.S. 108A-70.9A(c) or a notice of resolution under G.S. 108D-5.7."

SECTION 7. G.S. 108A-70.29 reads as rewritten:

"§ 108A-70.29. Program review process.

(a) Review of Eligibility and Program Enrollment Decisions. – Eligibility and Program enrollment decisions for Program applicants or recipients shall be reviewable pursuant to G.S. 108A-79. Program recipients shall remain enrolled in the NC Health Choice Program during the review of a decision to terminate or suspend enrollment. This subsection does not apply to requests for disenrollment from a PHP under Article 1A of Chapter 108D of the General Statutes.

(b) Review of Fee-for-Service Program Health Services Decisions. – This subsection applies only to health services decisions for services being provided to NC Health Choice recipients through the fee-for-service program as defined in G.S. 108A-24. This subsection does not apply to adverse benefit determinations as defined in G.S. 108D-1. In accordance with 42 C.F.R. § 457.1130 and 42 C.F.R. § 457.1150, a Program recipient may seek review of any delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services, through a two-level review process.

...."

SECTION 9. G.S. 122C-3 reads as rewritten:

"§ 122C-3. Definitions.

The following definitions apply in this Chapter:

...

(2a) "Area director" means the administrative head of the area authority program appointed pursuant to G.S. 122C-121.

(2b) "Behavioral health and intellectual/developmental disabilities tailored plan or BH IDD tailored plan" has the same meaning as in G.S. 108D-1.

(2c) "Board of county commissioners" includes the participating boards of county commissioners for multicounty area authorities and multicounty programs.

...

(20c) "Local management entity/managed care organization" or "LME/MCO" means a local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section

1915(b) and Section 1915(c) of the Social Security ~~Act.~~Act or to operate a BH IDD tailored plan.

...

(29b) "Prepaid health plan" has the same meaning as in G.S. 108D-1.

...."

SECTION 9A.(a) G.S. 122C-55, as amended by Section 5 of S.L. 2018-33, reads as rewritten:

"**§ 122C-55. Exceptions; care and treatment.**

(a) Any facility may share confidential information regarding any client of that facility with any other facility when necessary to coordinate appropriate and effective care, treatment or habilitation of the client. For the purposes of this section, the following definitions apply:

(1) "Client" includes an enrollee as defined in G.S. 108D-1.

(1a) "Coordinate" means the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and other health or related services by one or more facilities and includes the referral of a client from one facility to another.

(2) "Facility" and "area facility" include an area ~~authority.~~authority or a prepaid health plan.

(3) "Secretary" includes any primary care case management programs that contract with the Department to provide a primary care case management program for recipients of publicly funded health and related services.

...

(a2) Any ~~or State~~ facility ~~or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill~~ may share confidential information regarding any client of that facility with any other ~~area~~ facility ~~or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill~~ when necessary to conduct payment activities relating to an individual served by the facility. Payment activities are activities undertaken by a facility to obtain payment or receive reimbursement for the provision of services and may include, but are not limited to, determinations of eligibility or coverage, coordination of benefits, determinations of cost-sharing amounts, claims management, claims processing, claims adjudication, claims appeals, billing and collection activities, medical necessity reviews, utilization management and review, precertification and preauthorization of services, concurrent and retrospective review of services, and appeals related to utilization management and review.

(a3) Whenever there is reason to believe that a client is eligible for benefits through a Department program, any ~~State or~~ facility ~~or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill~~ may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with ~~an area facility or State facility or the psychiatric services of the University of North Carolina Hospitals at Chapel Hill.~~ a facility. Disclosure is limited to that information necessary to establish initial eligibility for benefits, determine continued eligibility over time, and obtain reimbursement for the costs of services provided to the client.

(a4) An area authority or ~~county program~~ prepaid health plan may share confidential information regarding any client with any area facility, and any area facility may share confidential information regarding any client of that facility with the area authority or ~~county program,~~prepaid health plan, when the area authority or ~~county program~~prepaid health plan determines the disclosure is necessary to develop, manage, monitor, or evaluate the area authority's or ~~county program's~~prepaid health plan's network of qualified providers as provided in G.S. 122C-115.2(b)(1)b., G.S. 122C-141(a), Article 3 of Chapter 108D of the General Statutes, the State Plan, ~~and~~ rules of the ~~Secretary.~~Secretary, and contracts between the facility and the Department. For the purposes of this subsection, the purposes or activities for which confidential information may be disclosed include, but are not limited to, quality assessment and

improvement activities, provider accreditation and staff credentialing, developing contracts and negotiating rates, investigating and responding to client grievances and complaints, evaluating practitioner and provider performance, auditing functions, on-site monitoring, conducting consumer satisfaction studies, and collecting and analyzing performance data.

...."

SECTION 10. G.S. 150B-1 reads as rewritten:

"**§ 150B-1. Policy and scope.**

...

(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

...

(17) The Department of Health and Human Services with respect to the review of North Carolina Health Choice Program determinations regarding delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of ~~services.~~services, commenced under G.S. 108A-70.29(b).

...

(25) The Department of Health and Human Services with respect to disputes involving the performance, terms, or conditions of a contract between the Department and a prepaid health plan, as defined in G.S. 108D-1.

...."

SECTION 11. G.S. 150B-23 reads as rewritten:

"**§ 150B-23. Commencement; assignment of administrative law judge; hearing required; notice; intervention.**

...

(a3) A Medicaid or NC Health Choice enrollee, or ~~network provider authorized in writing to act on behalf of the enrollee,~~ the enrollee's authorized representative, who appeals a notice of resolution issued by ~~an LME/MCO~~ a managed care entity under Chapter 108D of the General Statutes may commence a contested case under this Article in the same manner as any other petitioner. The case shall be conducted in the same manner as other contested cases initiated by Medicaid or NC Health Choice enrollees under this Article. Solely and only for the purposes of contested cases commenced ~~as Medicaid managed care enrollee appeals under Chapter 108D of the General Statutes,~~ pursuant to G.S. 108D-15 by enrollees of LME/MCOs to appeal a notice of resolution issued by the LME/MCO, an LME/MCO is considered an agency as defined in G.S. 150B-2(1a). The LME/MCO shall not be considered an agency for any other purpose. When a prepaid health plan, as defined in G.S. 108D-1, other than an LME/MCO, is under contract with the Department of Health and Human Services to issue notices of resolution under Article 2 of Chapter 108D of the General Statutes, then solely and only for the purposes of contested cases commenced pursuant to G.S. 108D-15 to appeal a notice of resolution issued by the prepaid health plan, the prepaid health plan shall be considered an agency as defined in G.S. 150B-2(1a). The prepaid health plan shall not be considered an agency for any other purpose.

...."

SECTION 12. Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17(a) of S.L. 2017-57, Section 4 of S.L. 2017-186, Section 11H.10(d) of S.L. 2018-5, and Sections 5 and 6 of S.L. 2018-48, reads as rewritten:

"**SECTION 4.** Structure of Delivery System. – The transformed Medicaid and NC Health Choice programs described in Section 1 of this act shall be organized according to the following principles and parameters:

...

(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. The capitated contracts required by this subdivision shall not cover:

a. Medicaid services ~~currently~~ covered by the local management entities/managed care organizations (LME/MCOs) under the combined 1915(b) and (c) waivers shall not be covered under ~~any capitated PHP contract other than a BH IDD Tailored Plan,~~ a standard benefit plan, except that all capitated PHP contracts shall cover the following services: inpatient behavioral health services, outpatient behavioral health emergency room services, outpatient behavioral health services provided by direct-enrolled providers, mobile crisis management services, facility-based crisis services for children and adolescents, professional treatment services in a facility-based crisis program, outpatient opioid treatment services, ambulatory detoxification services, nonhospital medical detoxification services, partial hospitalization, medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization, research-based intensive behavioral health treatment, diagnostic assessment services, and Early and Periodic Screening, Diagnosis, and Treatment services. In accordance with this sub-subdivision, 1915(b)(3) services shall not be covered under ~~any capitated PHP contract other than a BH IDD Tailored Plan.~~a standard benefit plan.

...

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except for the following categories:

...

l. Recipients with a serious mental illness, a serious emotional disturbance, a severe substance use disorder, an intellectual/developmental disability, or who have survived a traumatic brain injury and who are receiving traumatic brain injury services, who are on the waiting list for the Traumatic Brain Injury waiver, or whose traumatic brain injury otherwise is a knowable fact, until BH IDD Tailored Plans become operational, at which time this population will be enrolled with a BH IDD Tailored Plan in accordance with sub-sub-subdivision 10. of sub-subdivision a. of subdivision (10) of this section. Recipients in this category shall have the option to voluntarily enroll with a PHP, provided that (i) a recipient electing to enroll with a PHP would only have access to the behavioral health services covered by PHPs according to sub-subdivision a. of subdivision (4) of this section and would no longer have access to the behavioral health services excluded under sub-subdivision a. of subdivision (4) of this section and (ii) the recipient's informed consent shall be required prior to the recipient's enrollment with a PHP. Recipients in this category shall include, at a minimum, recipients who meet any of the following criteria:

...

4. Individuals who, regardless of diagnosis, meet any of the following criteria:

...

II. Individuals receiving any of the behavioral health, intellectual and developmental disability, or traumatic brain injury services that are ~~currently~~ covered by LME/MCOs under the combined 1915(b) and (c) waivers and that shall not be covered through ~~any capitated PHP contract other than a BH IDD Tailored Plan~~ a standard benefit plan in accordance with sub-subdivision a. of subdivision (4) of this section.

...

m. Recipients in the following categories shall not be covered by PHPs for a period of time to be determined by DHHS that shall not exceed five years after the date that capitated PHP contracts begin:

1. Recipients who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of 90 days or longer and (ii) are not being served through the Community Alternatives Program for Disabled Adults (CAP/DA). During the period of exclusion from PHP coverage for this population as determined by DHHS in accordance with this sub-subdivision, if an individual enrolled in a PHP resides in a nursing facility for 90 days or more, then that individual shall be excluded from PHP coverage on the first day of the month following the ninetieth day of the stay in the nursing facility and shall be disenrolled from the PHP.

2. Recipients who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing. This sub-sub-subdivision shall not include recipients being served through the Community Alternatives Program for Disabled Adults (CAP/DA).

3. Recipients who are (i) enrolled in the foster care system, (ii) receiving Title IV-E adoption assistance, (iii) under the age of 26 and formerly were in the foster care system, or (iv) under the age of 26 and formerly received adoption assistance.

...

(9) LME/MCOs. – Beginning on the date that capitated contracts begin, LME/MCOs shall cease managing Medicaid services for all Medicaid recipients other than recipients described in sub-subdivisions a., d., e., f., g., j., k., ~~and *l.*~~ *l.*, and m. of subdivision (5) of this section. Until BH IDD Tailored Plans become operational, all of the following shall occur:

a. LME/MCOs shall continue to manage the Medicaid services that are ~~currently~~ covered by the LME/MCOs under the combined 1915(b) and (c) waivers for Medicaid recipients described in sub-subdivisions a., d., e., f., g., j., k., ~~and *l.*~~ *l.*, and m. of subdivision (5) of this section.

b. The Division of Health Benefits shall negotiate actuarially sound capitation rates directly with the LME/MCOs based on the change in composition of the population being served by the LME/MCOs.

c. Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits.

...."

SECTION 13. Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121 and Section 6(b) of S.L. 2018-49, reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of DHHS during Medicaid transformation shall include the following activities and functions:

...

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All contracts shall be the result of requests for proposals (RFPs) issued by DHHS and the submission of competitive bids by PHPs. DHHS shall develop standardized contract terms, to include at a minimum, the following:

...

c. A minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by DHHS. The minimum medical loss ratio shall be neither higher nor lower than eighty-eight percent (88%). DHHS shall not require community reinvestment as a result of a PHP's failure to comply with any minimum medical loss ratio.

...."

SECTION 13A. Section 6 of S.L. 2015-245 reads as rewritten:

"**SECTION 6.** Role of the Department of Insurance. – The transformed Medicaid and NC Health Choice system shall include the licensing of ~~PHPs~~ PHPs, as required by subdivision 2 of Section 4 of this act, based on solvency requirements established and implemented by the Department of Insurance. The Commissioner of Insurance, in consultation with the Director of the Division of Health Benefits, shall develop recommended solvency requirements that are similar to the solvency requirements for similarly situated regulated entities and recommended licensing procedures that include an annual review by the Commissioner and reporting of changes in licensure to the Division of Health Benefits. The Commissioner shall report the recommendations as well as proposed fees to offset the cost of licensure and any necessary statutory changes to the Joint Legislative Oversight Committee on Medicaid and NC Health Choice by March 1, 2016."

SECTION 14.(a) The portions of S.L. 2015-245, as amended, specified in this section are codified into a new Article 4 of Chapter 108D of the General Statutes to be entitled "Prepaid Health Plans," as follows:

(1) Section 1 of S.L. 2015-245 is codified as G.S. 108D-30.

(2) Subdivision (4) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17 of S.L. 2017-57, Section 4 of S.L. 2017-186, Section 1 of S.L. 2018-48, and Section 12 of this act, is codified as G.S. 108D-35.

(3) Subdivision (5) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 1 of S.L. 2018-48, Section 5 of S.L. 2018-49, and Section 12 of this act, is codified as G.S. 108D-40.

(4) Subdivision (5a) of Section 4 of S.L. 2015-245, as enacted by Section 5(c) of S.L. 2018-49, is codified as G.S. 108D-40.

(5) Subdivision (6) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121 and Section 1 of S.L. 2018-48, is codified as G.S. 108D-45 and the words "(statewide contracts)" and "(regional contracts)" shall be removed.

(6) Subdivision (7) of Section 4 of S.L. 2015-245 is codified as G.S. 108D-50.

(7) Subdivision (8) of Section 4 of S.L. 2015-245 is codified as G.S. 108D-55.

(8) Subdivision (9) of Section 4 of S.L. 2015-245, as amended by Section 1 of S.L. 2018-48 and Section 12 of this act, is codified as G.S. 122C-115(e), except that the tag line shall not be codified, and the words "under Article 4 of Chapter 108D of the General Statutes" shall be inserted after the words "capitated contracts".

(9) Subdivision (10) of Section 4 of S.L. 2015-245, as amended by Section 1 of S.L. 2018-48, is codified as G.S. 108D-60, except that the following are not codified:

a. The first and third sentences of subdivision (10).

b. The language in sub-subdivision a. appearing before sub-sub-subdivision 1.

c. The word "currently" shall be removed from sub-sub-sub-subdivision I. of sub-sub-subdivision 1. of sub-subdivision a.

d. Sub-sub-subdivision 6. of sub-subdivision a.

e. Sub-subdivisions b., c., and d.

(10) Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121, Section 6(b) of S.L. 2018-49, and Section 13 of this act, is codified as G.S. 108D-65, except that the following are not codified:

a. Sub-subdivision d. of subdivision (6).

b. Subdivisions (10), (11), (12), and (13).

(11) Section 7A of S.L. 2015-245, as enacted by Section 7 of S.L. 2018-49, is codified as G.S. 108D-70.

SECTION 14.(b) In codifying the portions of S.L. 2015-245, as amended, that are specified in subsection (a) of this section, the Revisor of Statutes is authorized to do all of the following:

(1) Replace references to DHHS with references to the Department or the Department of Health and Human Services, as appropriate.

(2) Revise references to subdivision (3) of Section 4 of the session law to instead reference the codified location of the language in subdivision (3) of Section 5 of the session law.

SECTION 15.(a) References to the Division of Medical Assistance, and any derivatives thereof, in the General Statutes are replaced with references to the Division of Health Benefits, except that references to the Division of Medical Assistance are not replaced in G.S. 108A-54, 126-5(c)(34), 143B-138.1, and 143B-216.80.

SECTION 15.(b) This section is effective July 1, 2019.

SECTION 16.(a) Except as otherwise provided, this act is effective October 1, 2019.

SECTION 16.(b) This section is effective when it becomes law.

HOUSE BILL 656:
Medicaid Changes for Transformation.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 12, 2019
Introduced by:	Reps. Lambeth, Dobson, Murphy, Sasser	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to Third Edition H656-CSTR-8		

OVERVIEW: HB 656 makes changes to the Medicaid and Health Choice appeals statutes, and to other laws pertaining to Medicaid and Health Choice, that are necessary to implement Medicaid Transformation and contracts with Prepaid Health Plans on November 1, 2019.

The PCS adds sections 9A and 13A and makes other technical changes.

CURRENT LAW: S.L. 2015-245, as amended, requires transition of the current Medicaid and Health Choice programs to capitated contracts with prepaid health plans (PHPs) under an 1115 waiver that was recently approved by the Centers for Medicare and Medicaid Services (CMS). Under the waiver, the Department of Health and Human Services (DHHS) has entered into contracts to pay PHPs a monthly per-person capitated rate to cover all Medicaid and Health Choice services for their enrollees. DHHS has also contracted with an enrollment broker to assist beneficiaries with enrolling in a PHP. The waiver directs that capitation payments to PHPs for enrolled beneficiaries will begin November 1, 2019.

BILL ANALYSIS: HB 656 makes changes to Medicaid and Health Choice laws that are necessary (i) to comply with federal law and regulations; (ii) for consistency with the Medicaid Transformation legislation, S.L. 2015-245, as amended; and (iii) for consistency with the PHP contracts that have been awarded. The bill has the following components:

- **Sections 1 and 6** establish a process for beneficiaries to appeal adverse decisions regarding disenrollment from a PHP in new Article 1A of Chapter 108D of the General Statutes. A Medicaid or Health Choice beneficiary may use this process to appeal decisions by DHHS or the enrollment broker regarding the beneficiary's disenrollment from a PHP. Key features of the process include the following:
    - The circumstances when disenrollment from a PHP is allowed, with or without cause, whether initiated by the enrollee or the PHP, are set out in G.S. 108D-5.3 and 108D-5.5.
    - The process for an enrollee to make an expedited request for disenrollment when the enrollee has an urgent medical need is set out in G.S. 108D-5.3(d).
    - Enrollees may appeal (i) DHHS's denial of their request to disenroll from a PHP or (ii) DHHS's approval of a PHP's request to disenroll the enrollee, under G.S. 108D-5.9.
    - The appeals process will be the same as the existing process for fee-for-service beneficiary appeals at the Office of Administrative Hearings under Part 6A of Article 2 of Chapter 108A of the General Statutes. DHHS is the respondent in these contested cases.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- **Section 1** establishes processes for beneficiaries to file grievances and appeals of adverse decisions by PHPs regarding benefit coverage. The processes will be the same as the existing grievance and appeals processes in Article 2 of Chapter 108D of the General Statutes, which govern grievances and appeals of actions by local management entities/managed care organizations (LME/MCOs), with the following exceptions:
    - Health Choice beneficiaries will use this process for PHP determinations. Currently, Health Choice beneficiaries are not enrolled in LME/MCOs and do not engage in the LME/MCO appeals process. Health Choice beneficiaries will use the existing process in G.S. 108A-70.29 for appeals not related to PHPs, as set forth in **Section 7**.
    - The length of time in which a LME/MCO must respond to a grievance is shortened from 90 days to 30 days under G.S. 108D-12(b), and the 30-day timeframe also applies to PHPs.
- **Section 1** also makes conforming changes to existing grievance and appeals processes to conform with federal law and regulations.
- **Sections 4, 5,** and **9A** add references to PHPs in the General Statutes.
- **Section 10** exempts contract disputes between PHPs and DHHS from Chapter 150B contested case hearings at the Office of Administrative Hearings under G.S. 150B-1.
- **Section 11** allows a PHP to be named as the sole respondent in a contested case at the Office of Administrative Hearings related to a notice of resolution issued by the PHP under G.S. 150B-23. The circumstances when a PHP may be named as a respondent are the same as when an LME/MCO may be named as a respondent under current law.
- **Section 14** directs the codification of the Medicaid Transformation legislation, S.L. 2015-245, as amended, into the General Statutes. **Sections 1, 2, 3, 9, 12, 13,** and **13A** make technical changes related to codification.
- **Section 15** replaces references to the Division of Medical Assistance in the General Statutes with references to the Division of Health Benefits.

EFFECTIVE DATE: The changing of references in the statutes to the Division of Medical Assistance to instead reference the Division of Health Benefits is effective July 1, 2019. The remainder of the bill is effective October 1, 2019. The changes to the LME/MCO grievance and appeals processes apply to (i) appeals arising from LME/MCO notices of adverse benefit determination mailed on or after that date and (ii) grievances received by an LME/MCO on or after that date.

HOUSE BILL 656*
Committee Substitute Favorable 4/30/19
Committee Substitute #2 Favorable 5/2/19

Short Title: Medicaid Changes for Transformation. (Public)

Sponsors:

Referred to:

April 10, 2019

A BILL TO BE ENTITLED

AN ACT TO MODIFY THE LAWS PERTAINING TO MEDICAID AND NC HEALTH CHOICE AS NEEDED FOR THE IMPLEMENTATION OF MEDICAID TRANSFORMATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 108D of the General Statutes reads as rewritten:

"Chapter 108D.

"Medicaid and NC Health Choice Managed Care ~~for Behavioral Health Services.~~Programs.

"Article 1.

"General Provisions.

"§ 108D-1. Definitions.

The following definitions apply in this ~~Chapter, unless the context clearly requires otherwise:~~Chapter:

(1) Adverse benefit determination. – As defined in 42 C.F.R. § 438.400(b). In accordance with 42 C.F.R. § 457.1260, this definition applies to NC Health Choice beneficiaries in the same manner as it applies to Medicaid beneficiaries.

(2) Adverse disenrollment determination. – A determination by the Department of Health and Human Services or the enrollment broker to (i) deny a request made by an enrollee, or the enrollee's authorized representative, to disenroll from a prepaid health plan or (ii) approve a request made by a prepaid health plan to disenroll an enrollee from a prepaid health plan.

(3) Applicant. – A provider ~~of mental health, intellectual or developmental disabilities, and substance abuse services~~ who is seeking to participate in the ~~closed~~ network of one or more local management entity/managed care ~~organizations.~~organizations or prepaid health plans.

(4) Behavioral Health and Individuals with Developmental Disabilities Tailored Plan or BH IDD Tailored Plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter, including the requirements pertaining to BH IDD Tailored Plans.

(5) Beneficiary. – A person to whom or on whose behalf medical assistance or assistance through the North Carolina Health Choice for Children program is granted under Article 2 of Chapter 108A of the General Statutes.

~~(2)~~(6) Closed network. – The network of providers that have contracted with a local management entity/managed care organization to furnish mental health, intellectual or developmental disabilities, and substance abuse services to enrollees.

~~(3)~~(7) Contested case hearing. – The hearing or hearings conducted at the Office of Administrative Hearings under ~~G.S. 108D-15 to resolve a dispute between an enrollee and a local management entity/managed care organization about a managed care action.~~G.S. 108D-5.9 or G.S. 108D-15.

~~(4)~~(8) Department. – The North Carolina Department of Health and Human Services.

~~(5)~~(9) Emergency medical condition. – As defined in 42 C.F.R. § 438.114.

~~(6)~~(12) Emergency services. – As defined in 42 C.F.R. § 438.114.

~~(7)~~(13) Enrollee. – A Medicaid or NC Health Choice beneficiary who is currently enrolled with a local management entity/managed care ~~organization.~~organization or a prepaid health plan.

(14) Enrollment broker. – As defined in 42 C.F.R. § 438.810(a).

(16) Fee-for-service program. – A payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice beneficiaries rather than contracting for the coverage of services through a capitated payment arrangement.

~~(8)~~(21) Local Management Entity or LME. – As defined in ~~G.S. 122C-3(20b).~~G.S. 122C-3.

~~(9)~~(22) Local Management Entity/Managed Care Organization or LME/MCO. – As defined in ~~G.S. 122C-3(20c).~~G.S. 122C-3.

~~(10) Managed care action. An action, as defined in 42 C.F.R. § 438.400(b).~~

~~(11) Managed Care Organization or MCO. As defined in 42 C.F.R. § 438.2.~~

(23) Mail. – United States mail or, if the enrollee or the enrollee's authorized representative has given written consent to receive electronic communications, electronic mail.

(24) Managed care entity. – A local management entity/managed care organization or a prepaid health plan.

(25) Medicaid transformation demonstration waiver. – The waiver agreement entered into between the State and the Centers for Medicare and Medicaid Services under Section 1115 of the Social Security Act for the transition to prepaid health plans.

~~(12)~~(26) Mental health, intellectual or developmental disabilities, and substance abuse services or MH/IDD/SA services. – Those mental health, intellectual or developmental disabilities, and substance abuse services covered by a local management entity/managed care organization under a contract ~~in effect between~~ with the Department of Health and Human Services ~~and a local management entity~~ to operate ~~a managed care organization or prepaid inpatient health plan (PIHP) under the 1915(b)/(c) Medicaid Waiver approved by the federal Centers for Medicare and Medicaid Services (CMS).~~the combined Medicaid waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security Act.

~~(13)~~(27) Network provider. – An appropriately credentialed provider ~~of mental health, intellectual or developmental disabilities, and substance abuse services~~ that has entered into a contract for participation in the ~~closed~~ network of one

or more local management entity/managed care ~~organizations.~~organizations or prepaid health plans.

~~(14)~~(28) Notice of ~~managed care action.~~ adverse benefit determination. – The notice required by 42 C.F.R. § 438.404.

~~(15) Notice of resolution. – The notice described in 42 C.F.R. § 438.408(e).~~

~~(16)~~(29) OAH. – The North Carolina Office of Administrative Hearings.

(30) Prepaid health plan or PHP. – A prepaid health plan, as defined in G.S. 58-93-5, or a local management entity/managed care organization operating a BH IDD Tailored Plan.

~~(17) Prepaid Inpatient Health Plan or PIHP. – As defined in 42 C.F.R. § 438.2.~~

(31) Provider. – As defined in G.S. 108C-2.

~~(18)~~(32) Provider of emergency services. – A provider that is qualified to furnish emergency services to evaluate or stabilize an enrollee's emergency medical condition.

(36) Standard plan. – A capitated prepaid health plan contract under the Medicaid transformation demonstration waiver that meets all of the requirements of Article 4 of this Chapter except for the requirements pertaining to a BH IDD Tailored Plan.

"**§ 108D-2. Scope; applicability of this Chapter.**

This Chapter applies to every ~~LME/MCO and to every~~ managed care entity, applicant, enrollee, provider of emergency services, and network provider of ~~an LME/MCO.~~a managed care entity. This Chapter does not apply to Medicaid or NC Health Choice services delivered through the fee-for-service program. Nothing in this Chapter shall be construed to grant a NC Health Choice beneficiary benefits in excess of what is required by G.S. 108A-70.21.

"**§ 108D-3. Conflicts; severability.**

(a) To the extent that this Chapter conflicts with the Social Security Act or 42 C.F.R. ~~Part 438,~~ Parts 438 and 457, federal law ~~prevails.~~prevails, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services.

(b) To the extent that this Chapter conflicts with any other provision of State law that is contrary to the principles of managed care that will ensure successful containment of costs for ~~behavioral~~ health care services, this Chapter prevails and applies.

(c) If any section, term, or provision of this Chapter is adjudged invalid for any reason, these judgments shall not affect, impair, or invalidate any other section, term, or provision of this Chapter, but the remaining sections, terms, and provisions shall be and remain in full force and effect.

"Article 1A.

"Disenrollment from Prepaid Health Plans.

"**§ 108D-5.1. General provisions.**

(a) Nothing in this Article shall be construed to limit or prevent the Department from disenrolling, from a PHP, an enrollee who (i) is no longer eligible to receive services through the Medicaid or NC Health Choice programs or (ii) becomes a member of a population of beneficiaries that is not required to enroll in a PHP under State law.

(b) Nothing in this Article shall be construed to exclude a Medicaid or NC Health Choice beneficiary who is otherwise required by State law to enroll in a PHP from enrolling in a PHP, or to prevent a beneficiary who is otherwise exempted from enrollment in a PHP from disenrolling from a PHP and receiving services through the fee-for-service program.

"**§ 108D-5.3. Enrollee requests for disenrollment.**

(a) In General. – An enrollee, or the enrollee's authorized representative, who is requesting disenrollment from a PHP, shall submit an oral or written request for disenrollment to the enrollment broker.

(b) Without Cause Enrollee Requests or Disenrollment. – An enrollee shall be allowed to disenroll from the PHP without cause only during the times specified in 42 C.F.R. § 438.56(c)(2), except that enrollees who are in any of the following groups may disenroll at any time:

(1) Members of federally recognized tribes.
(2) Beneficiaries who are enrolled in the foster care system.
(3) Beneficiaries who are in the former foster care Medicaid eligibility category.
(4) Beneficiaries who receive Title IV-E adoption assistance.
(5) Beneficiaries under the age of 26 who formerly received Title IV-E adoption assistance.
(6) Beneficiaries who are receiving long-term services and supports in institutional or community-based settings.
(7) Any other beneficiaries who are not required to enroll in a PHP under State law.

(c) With Cause Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's authorized representative, may submit a request to disenroll from a PHP for cause at any time. For cause reasons for disenrollment from a PHP include the following:

(1) The enrollee moves out of the PHP's service area.
(2) The PHP, because of the PHP's moral or religious objections, does not cover a service the enrollee seeks.
(3) The enrollee needs concurrent, related services that are not all available within the PHP's network and the enrollee's provider determines that receiving services separately would subject the enrollee to unnecessary risk.
(4) An enrollee who receives long-term services and supports will be required to change residential, institutional, or employment supports providers due to the enrollee's provider's change from in-network to out-of-network status with the PHP and, as a result, the enrollee would experience a disruption in residence or employment.
(5) The enrollee's complex medical conditions could be better served under a different PHP. For purposes of this subsection, an enrollee is considered to have a complex medical condition if the enrollee has a condition that could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.
(6) A family member of the enrollee becomes, or is determined, eligible for Medicaid or NC Health Choice and the family member is, or becomes, enrolled in a different PHP.
(7) Poor performance by the PHP, as determined by the Department. The Department shall not make a determination of poor performance by any PHP until the Department has completed an annual PHP performance evaluation following the first year of that PHP's contract.
(8) Poor quality of care, lack of access to services covered under the PHP's contract, lack of access to providers experienced in addressing the enrollee's health care needs, or any other reasons established by the Department in the PHP's contract or in rule.

(d) Expedited Enrollee Requests for Disenrollment. – An enrollee, or the enrollee's authorized representative, may submit an expedited request for disenrollment to the enrollment broker when the enrollee has an urgent medical need that requires disenrollment from the PHP. For purposes of this subsection, an urgent medical need means that continued enrollment in the PHP could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function.

"**§ 108D-5.5. PHP requests for disenrollment.**

(a) In General. – A PHP requesting disenrollment of an enrollee from the PHP shall submit a written request for disenrollment to the enrollment broker.

(b) Limitations on PHP Requests for Disenrollment. – A PHP shall not request disenrollment of an enrollee from the PHP for any reason prohibited by 42 C.F.R. § 438.56(b)(2). A PHP may request disenrollment of an enrollee only when both of the following criteria are met:

(1) The enrollee's behavior seriously hinders the PHP's ability to care for the enrollee or other enrollees of the PHP.

(2) The PHP has documented efforts to resolve the issues that form the basis of the request for disenrollment of the enrollee.

"**§ 108D-5.7. Notices.**

(a) Notices of Resolution. – For each disenrollment request by an enrollee or a PHP, the Department shall issue a written notice of resolution approving or denying the request by mail to the enrollee before the first day of the second month following the month in which the enrollee or PHP requested disenrollment. For expedited enrollee requests for disenrollment made under G.S. 108D-5.3(d), the Department shall issue the written notice of resolution approving or denying the expedited request within three calendar days of receipt of the request. In the same mailing as the notice, the Department shall also provide the enrollee with an appeal request form that includes all of the following:

(1) A statement that in order to request an appeal, the enrollee must file the form in accordance with OAH rules, by mail or fax to the address or fax number listed on the form, no later than 30 days after the mailing date of the notice of resolution.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal the specific adverse disenrollment determination identified in the notice of resolution.

(4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the enrollee's signature and date.

(b) Notices Pertaining to Expedited Enrollee Request for Disenrollment. – If the Department determines that an enrollee's request for disenrollment does not meet the criteria for an expedited request, the Department shall do the following:

(1) No later than three calendar days after receiving the enrollee's request for disenrollment, make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of the determination by mail.

(2) Issue the notice of resolution within the time limits established for standard disenrollment requests under subsection (a) of this section.

"**§ 108D-5.9. Appeals of adverse disenrollment determinations.**

(a) Appeals. – An enrollee, or the enrollee's authorized representative, who is dissatisfied with an adverse disenrollment determination may file an appeal for a hearing with the Office of Administrative Hearings within 30 calendar days of the date on the notice of resolution. A request for a hearing to appeal an adverse disenrollment determination of the Department under this section is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. The appeal shall be conducted in accordance with the procedures in Part 6A of Article 2 of Chapter 108A of the General Statutes.

(b) Parties. – The Department shall be the respondent for purposes of appeals under this section.

"Article 2.

"Enrollee Grievances and Appeals.

"§ 108D-11. ~~LME/MCO~~ Managed care entity grievance and appeal procedures, generally.

(a) Each ~~LME/MCO~~ managed care entity shall establish and maintain internal grievance and appeal procedures that (i) comply with the Social Security Act and 42 C.F.R. Part 438, Subpart F, and (ii) afford ~~enrollees, and network providers authorized in writing to act on behalf of enrollees,~~ enrollees and their authorized representatives constitutional rights to due process and a fair hearing.

(b) ~~Enrollees, or network providers authorized in writing to act on behalf of enrollees,~~ An enrollee, or the enrollee's authorized representative, may file ~~requests for grievances~~ grievances and ~~LME/MCO~~ managed care entity level appeals orally or in writing. However, unless the ~~enrollee or network provider~~ enrollee, or the enrollee's authorized representative, requests an expedited appeal, the oral ~~filing~~ appeal must be followed by a written, signed ~~grievance or~~ appeal.

(c) ~~An LME/MCO~~ A managed care entity shall not attempt to influence, limit, or interfere with an enrollee's right or decision to file a grievance, request for an ~~LME/MCO~~ managed care entity level appeal, or a contested case hearing. However, nothing in this Chapter shall be construed to prevent ~~an LME/MCO~~ a managed care entity from doing any of the following:

(1) Offering an enrollee alternative services.

(2) Engaging in clinical or educational discussions with enrollees or providers.

(3) Engaging in informal attempts to resolve enrollee concerns prior to the issuance of a notice of grievance disposition or notice of resolution.

(d) ~~An LME/MCO~~ A managed care entity shall not take punitive action against a provider for any of the following:

(1) Filing a grievance on behalf of an enrollee or supporting an enrollee's grievance.

(2) Requesting ~~an LME/MCO~~ a managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for ~~an LME/MCO~~ a managed care entity level appeal.

(3) Requesting an expedited ~~LME/MCO~~ managed care entity level appeal on behalf of an enrollee or supporting an enrollee's request for ~~an LME/MCO~~ a managed care entity level expedited appeal.

(4) Requesting a contested case hearing on behalf of an enrollee or supporting an enrollee's request for a contested case hearing.

(e) The appeal procedures set forth in this Article shall not apply to instances in which the sole basis for the managed care entity's decision is a provision in the State Plan or in federal or State law requiring an automatic change adversely affecting some or all beneficiaries.

"§ 108D-12. ~~LME/MCO~~ Managed care entity grievances.

(a) Filing of Grievance. – An ~~enrollee, or a network provider authorized in writing to act on behalf of an~~ enrollee, or the enrollee's authorized representative, has the right to file a grievance with ~~an LME/MCO~~ a managed care entity at any time to express dissatisfaction about any matter other than ~~a managed care action.~~ an adverse benefit determination. Upon receipt of a grievance, ~~an LME/MCO~~ a managed care entity shall cause a written acknowledgment of receipt of the grievance to be sent by ~~United States~~ mail.

(b) Notice of Grievance Disposition. – The ~~LME/MCO~~ managed care entity shall resolve the grievance and cause a notice of grievance ~~disposition~~ resolution to be sent by ~~United States~~ mail to the enrollee and all other affected parties as expeditiously as the enrollee's health condition requires, but no later than ~~90~~ 30 days after receipt of the ~~grievance.~~ grievance, provided that the managed care entity may extend such time frame to the extent permitted under 42 C.F.R. § 438.408(c).

(c) Right to ~~LME/MCO Level~~ Appeal. – There is no right to appeal the resolution of a grievance to OAH or any other forum.

"§ 108D-13. Standard ~~LME/MCO~~ managed care entity level appeals.

(a) Notice of ~~Managed Care Action.~~ Adverse Benefit Determination. – ~~An LME/MCO~~ A managed care entity shall provide an enrollee with a written notice of ~~a managed care action~~ an adverse benefit determination by ~~United States~~ mail as required under 42 C.F.R. § 438.404. The notice ~~of action~~ will employ a standardized form included as a provision in the ~~contracts~~ contract between the ~~LME/MCOs~~ managed care entity and the ~~Department of Health and Human Services.~~Department.

(b) Request for Appeal. – An enrollee, or ~~a network provider authorized in writing to act on behalf of the enrollee,~~ the enrollee's authorized representative, has the right to file a request for ~~an LME/MCO~~ a managed care entity level appeal of a notice of ~~managed care action~~ adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the ~~grievance disposition or~~ notice of ~~managed care action.~~ adverse benefit determination. Upon receipt of a request for ~~an LME/MCO~~ a managed care entity level appeal, ~~an LME/MCO~~ a managed care entity shall acknowledge receipt of the request for appeal in writing by ~~United States~~ mail.

(c) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue or reinstate the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of ~~an LME/MCO~~ a managed care entity level appeal to the same extent required under ~~42 C.F.R. § 438.420.~~ 42 C.F.R. § 438.420 and subsection (c1) of this section. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation or reinstatement of benefits.

(c1) Reinstatement of Benefits for PHP Enrollees. – A PHP shall reinstate the benefits of a Medicaid enrollee if all of the following occur:

(1) The Medicaid enrollee, or the enrollee's authorized representative, files the appeal within the required time frames.

(2) The Medicaid enrollee, or the enrollee's authorized representative, files for continuation of benefits within 30 calendar days of the mailing date of the notice of adverse benefit determination, except that a request for continuation of benefits filed by a provider does not meet the requirement of this subdivision, in accordance with 42 C.F.R. § 438.402(c)(ii).

(3) The appeal involves the termination, suspension, or reduction of a previously authorized service.

(4) The service was ordered by an authorized provider.

(d) Notice of Resolution. – The ~~LME/MCO~~ managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, but no later than ~~45~~ 30 days after receiving the request for ~~appeal.~~ appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The ~~LME/MCO~~ managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by ~~United States~~ mail within this ~~45-day~~ 30-day period.

(e) Right to Request Contested Case Hearing. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in this section or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(f) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f).

"**§ 108D-14. Expedited ~~LME/MCO~~ managed care entity level appeals.**

(a) Request for Expedited Appeal. – When the time limits for completing a standard appeal could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, an enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, has the right to file a request for

an expedited appeal of ~~a managed care action~~ an adverse benefit determination no later than ~~30~~ 60 days after the mailing date of the notice of ~~managed care action.~~ adverse benefit determination. For expedited appeal requests made by ~~enrollees,~~ an enrollee, or the enrollee's authorized representative, the ~~LME/MCO~~ managed care entity shall determine if the enrollee qualifies for an expedited appeal. For expedited appeal requests made by ~~network providers on behalf of enrollees,~~ a network provider as an enrollee's authorized representative, the ~~LME/MCO~~ managed care entity shall presume an expedited appeal is necessary.

(b) Notice of Denial for Expedited Appeal. – If the ~~LME/MCO~~ managed care entity denies a request for an expedited ~~LME/MCO~~ managed care entity level appeal, the ~~LME/MCO~~ managed care entity shall make reasonable efforts to give the enrollee and all other affected parties oral notice of the denial and follow up with a written notice of denial by ~~United States~~ mail ~~by~~ no later than ~~two calendar days~~ 72 hours after receiving the request for an expedited appeal. In addition, the ~~LME/MCO~~ managed care entity shall resolve the appeal within the time limits established for standard ~~LME/MCO~~ managed care entity level appeals in G.S. 108D-13.

(c) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue or reinstate the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of an expedited ~~LME/MCO~~ managed care entity level appeal to the extent required under ~~42 C.F.R. § 438.420.~~ 42 C.F.R. § 438.420 and subsection (c1) of this section. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation or reinstatement of benefits.

(c1) Reinstatement of Benefits for PHP Enrollees. – A PHP shall reinstate the benefits of a Medicaid enrollee who is a Medicaid beneficiary in accordance with G.S. 108D-13(c1).

(d) Notice of Resolution. – If the ~~LME/MCO~~ managed care entity grants a request for an expedited ~~LME/MCO~~ managed care entity level appeal, the ~~LME/MCO~~ managed care entity shall resolve the appeal as expeditiously as the enrollee's health condition requires, and no later than ~~three working days~~ 72 hours after receiving the request for an expedited ~~appeal.~~ appeal, provided that the managed care entity may extend such time frame as permitted under 42 C.F.R. § 438.408. The ~~LME/MCO~~ managed care entity shall provide the enrollee and all other affected parties with a written notice of resolution by ~~United States~~ mail within this ~~three-day~~ 72-hour period.

(e) Right to Request Contested Case Hearing. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for a contested case hearing under G.S. 108D-15 as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or this ~~section.~~ section or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(f) Reasonable Assistance. – ~~An LME/MCO~~ A managed care entity shall provide the enrollee with reasonable assistance in completing forms and taking other procedural steps necessary to file an appeal, including providing interpreter services and toll-free numbers that have adequate teletypewriter/telecommunications devices for the deaf (TTY/TDD) and interpreter capability.

(g) Request Form for Contested Case Hearing. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing that meets the requirements of G.S. 108D-15(f).

"§ 108D-15. Contested case hearings on disputed ~~managed care actions.~~adverse benefit determinations.

(a) Jurisdiction of the Office of Administrative Hearings. – The Office of Administrative Hearings does not have jurisdiction over a dispute concerning ~~a managed care action,~~ an adverse benefit determination, except as expressly set forth in this Chapter.

(b) Exclusive Administrative Remedy. – Notwithstanding any provision of State law or rules to the contrary, this section is the exclusive method for an enrollee to contest a notice of resolution of an adverse benefit determination issued by ~~an LME/MCO.~~ a managed care entity.

G.S. 108A-70.9A, 108A-70.9B, and 108A-70.9C do not apply to enrollees contesting ~~a managed care action.~~an adverse benefit determination.

(c) Request for Contested Case Hearing. – A request for an administrative hearing to appeal a notice of resolution of an adverse benefit determination issued by ~~an LME/MCO~~ a managed care entity is a contested case subject to the provisions of Article 3 of Chapter 150B of the General Statutes. An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, has the right to file a request for appeal to contest a notice of resolution as long as (i) the ~~enrollee~~ enrollee, or ~~network provider~~ the enrollee's authorized representative, has exhausted the appeal procedures described in G.S. 108D-13 or ~~G.S. 108D-14.~~G.S. 108D-14 or (ii) the enrollee has been deemed, under 42 C.F.R. § 438.408(c)(3), to have exhausted the managed care entity level appeals process.

(d) Filing Procedure. – An enrollee, or ~~a network provider authorized in writing to act on behalf of an enrollee,~~ the enrollee's authorized representative, may file a request for an appeal by sending an appeal request form that meets the requirements of subsection (e) of this section to OAH and the affected ~~LME/MCO~~ managed care entity by no later than ~~30~~ 120 days after the mailing date of the notice of resolution. A request for appeal is deemed filed when a completed and signed appeal request form has been both submitted into the care and custody of the chief hearings clerk of OAH and accepted by the chief hearings clerk. Upon receipt of a timely filed appeal request form, information contained in the notice of resolution is no longer confidential, and the ~~LME/MCO~~ managed care entity shall immediately forward a copy of the notice of resolution to OAH electronically. OAH may dispose of these records after one year.

(e) Parties. – The ~~LME/MCO~~ managed care entity shall be the respondent for purposes of this appeal. The ~~LME/MCO or enrollee~~ managed care entity, the enrollee, or the enrollee's authorized representative may move for the permissive joinder of the Department under Rule 20 of the North Carolina Rules of Civil Procedure. The Department may move to intervene as a necessary party under Rules 19 and 24 of the North Carolina Rules of Civil Procedure.

(f) Appeal Request Form. – In the same mailing as the notice of resolution, the ~~LME/MCO~~ managed care entity shall also provide the enrollee with an appeal request form for a contested case hearing which shall be no more than one side of one page. The form shall include at least all of the following:

(1) A statement that in order to request an appeal, the enrollee must file the form in accordance with OAH rules, by mail or fax to the address or fax number listed on the form, ~~by~~ no later than ~~30~~ 120 days after the mailing date of the notice of resolution.

(2) The enrollee's name, address, telephone number, and Medicaid or NC Health Choice identification number.

(3) A preprinted statement that indicates that the enrollee would like to appeal ~~a~~ the specific ~~managed care action~~ adverse benefit determination identified in the notice of resolution.

(4) A statement informing the enrollee of the right to be represented at the contested case hearing by a lawyer, a relative, a friend, or other spokesperson.

(5) A space for the enrollee's signature and date.

(g) Continuation of Benefits. – ~~An LME/MCO~~ A managed care entity shall continue or reinstate the ~~enrollee's~~ benefits of a Medicaid enrollee during the pendency of an appeal to the same extent required under ~~42 C.F.R. § 438.420.~~42 C.F.R. § 438.420, G.S. 108D-13, and G.S. 108D-14. In accordance with 42 C.F.R. § 457.1260, NC Health Choice enrollees shall not be entitled to continuation or reinstatement of benefits. Notwithstanding any other provision of State law, the administrative law judge does not have the power to order and shall not order ~~an LME/MCO~~ a managed care entity to continue benefits in excess of what is required by ~~42 C.F.R. § 438.420.~~ 42 C.F.R. § 438.420, except to the extent required by G.S. 108D-13(c1) and G.S. 108D-14(c1).

(h) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge of OAH may limit and simplify the administrative hearing procedures that apply to contested case hearings conducted under this section in order to complete these cases as expeditiously as possible. Any simplified hearing procedures approved by the chief administrative law judge under this subsection must comply with all of the following requirements:

...

(2) OAH shall conduct all contested case hearings telephonically or by video technology with all parties, unless the enrollee requests that the hearing be conducted in person before the administrative law judge. An in-person hearing shall be conducted in the county that contains the headquarters of the ~~LME/MCO~~ managed care entity unless the enrollee's impairments limit travel. For enrollees with impairments that limit travel, an in-person hearing shall be conducted in the enrollee's county of residence. OAH shall provide written notice to the enrollee of the use of telephonic hearings, hearings by video conference, and in-person hearings before the administrative law judge, as well as written instructions on how to request a hearing in the enrollee's county of residence.

...

(4) The administrative law judge may allow brief extensions of the time limits imposed in this section only for good cause shown and to ensure that the record is complete. The administrative law judge shall only grant a continuance of a hearing in accordance with rules adopted by OAH for good cause shown and shall not grant a continuance on the day of a hearing, except for good cause shown. If an enrollee fails to make an appearance at a hearing that has been properly noticed by OAH by ~~United States~~ mail, OAH shall immediately dismiss the case, unless the enrollee moves to show good cause by no later than three business days after the date of dismissal. As used in this section, "good cause shown" includes delays resulting from untimely receipt of documentation needed to render a decision and other unavoidable and unforeseen circumstances.

(5) OAH shall include information on at least all of the following in its notice of hearing to an enrollee:

a. The enrollee's right to examine at a reasonable time before and during the hearing the contents of the enrollee's case file and any documents to be used by the ~~LME/MCO~~ managed care entity in the hearing before the administrative law judge.

b. The enrollee's right to an interpreter during the hearing process.

c. The circumstances in which a medical assessment may be obtained at the ~~LME/MCO's~~ managed care entity's expense and made part of the record, including all of the following:

...

(i) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108D-15(f) or other clear request for a hearing by an enrollee, OAH shall immediately notify the Mediation Network of North Carolina, which shall contact the enrollee within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the ~~LME/MCO~~ managed care entity within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested case involving a dispute of ~~a managed care action~~ an adverse benefit determination until it has

received notice from the mediator assigned that either (i) the mediation was unsuccessful, (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. If the enrollee accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.

(j) Burden of Proof. – The enrollee has the burden of proof on all issues submitted to OAH for a contested case hearing under this section and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence in the case.

(k) New Evidence. – The enrollee shall be permitted to submit evidence regardless of whether it was obtained before or after the ~~LME/MCO's managed care action~~ managed care entity's adverse benefit determination and regardless of whether the ~~LME/MCO~~ the managed care entity had an opportunity to consider the evidence in resolving the ~~LME/MCO~~ managed care entity level appeal. Upon the receipt of new evidence and at the request of the ~~LME/MCO,~~ managed care entity, the administrative law judge shall continue the hearing for a minimum of 15 days and a maximum of 30 days in order to allow the ~~LME/MCO~~ managed care entity to review the evidence. Upon reviewing the evidence, if the ~~LME/MCO~~ managed care entity decides to reverse the ~~managed care action taken against the enrollee,~~ adverse benefit determination, it shall immediately inform the administrative law judge of its decision.

(*l*) Issue for Hearing. – For each ~~managed care action,~~ adverse benefit determination, the administrative law judge shall determine whether the ~~LME/MCO~~ managed care entity substantially prejudiced the rights of the enrollee and whether the ~~LME/MCO,~~ managed care entity, based upon evidence at the ~~hearing:~~ hearing, did any of the following:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

(m) To the extent that anything in this ~~Part,~~ Chapter, Chapter 150B of the General Statutes, or any rules or policies adopted under these Chapters is inconsistent with the Social Security Act or 42 C.F.R. Part 438, Subpart F, federal law prevails and applies to the extent of the ~~conflict.~~ conflict, except when the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. All rules, rights, and procedures for contested case hearings concerning ~~managed care actions~~ adverse benefit determinations shall be construed so as to be consistent with applicable federal law and shall provide the enrollee with ~~no lesser and no greater~~ rights that are no less than those provided under federal law.

"§ 108D-16. Notice of final decision and right to seek judicial review.

The administrative law judge assigned to conduct a contested case hearing under G.S. 108D-15 shall hear and decide the case without unnecessary delay. The judge shall prepare a written decision that includes findings of fact and conclusions of law and send it to the parties in accordance with G.S. 150B-37. The written decision shall notify the parties of the final decision and of the right of the enrollee and the ~~LME/MCO~~ managed care entity to seek judicial review of the decision under Article 4 of Chapter 150B of the General Statutes.

"Article 3.

"Managed Care Entity Provider Networks.

"§ 108D-21. LME/MCO provider networks.

Each LME/MCO operating the combined 1915(b) and (c) waivers shall maintain and utilize a closed network of providers to furnish mental health, intellectual or developmental disabilities, and substance abuse services to its enrollees.

"§ 108D-22. PHP provider networks.

(a) Except as provided in G.S. 108D-23, each PHP shall develop and maintain a provider network that meets access to care requirements for its enrollees. A PHP may not exclude providers from their networks except for failure to meet objective quality standards or refusal to accept network rates. Notwithstanding the previous sentence, a PHP must include all providers in its geographical coverage area that are designated essential providers by the Department in accordance with subdivision (b) of this section, unless the Department approves an alternative arrangement for securing the types of services offered by the essential providers.

(b) The Department shall designate Medicaid and NC Health Choice providers as essential providers if, within a region defined by a reasonable access standard, the provider either (i) offers services that are not available from any other provider in the region or (ii) provides a substantial share of the total units of a particular service utilized by Medicaid and NC Health Choice beneficiaries within the region during the last three years and the combined capacity of other service providers in the region is insufficient to meet the total needs of the Medicaid and NC Health Choice enrollees. The Department shall not classify physicians and other practitioners as essential providers. At a minimum, providers in the following categories shall be designated essential providers:

(1) Federally qualified health centers.
(2) Rural health centers.
(3) Free clinics.
(4) Local health departments.
(5) State Veterans Homes.

"**§ 108D-23. BH IDD Tailored Plan networks.**

Entities operating BH IDD Tailored Plans shall utilize closed provider networks only for the provision of behavioral health, intellectual and developmental disability, and traumatic brain injury services."

SECTION 1.(b) This section is effective October 1, 2019, and applies to (i) appeals arising from local management entity/managed care organization (LME/MCO) notices of adverse benefit determination mailed on or after that date and (ii) grievances received by an LME/MCO on or after that date.

SECTION 2. G.S. 90-414.4(a1)(3) reads as rewritten:

"(3) The following entities shall submit encounter and claims data, as appropriate, in accordance with the following time line:

a. Prepaid Health Plans, as defined in ~~S.L. 2015-245,~~ G.S. 108D-1, by the commencement date of a capitated contract with the Division of Health Benefits for the delivery of Medicaid and NC Health Choice services as specified in ~~S.L. 2015-245.~~Article 4 of Chapter 108D of the General Statutes.

b. Local management entities/managed care organizations, as defined in G.S. 122C-3, by June 1, 2020."

SECTION 3. G.S. 108A-24 reads as rewritten:

"**§ 108A-24. Definitions.**

As used in Chapter 108A:

...

(3d) "Federal TANF funds" means the Temporary Assistance for Needy Families block grant funds provided for in Title IV-A of the Social Security Act.

(3e) "Fee-for-service program" means a payment model for the Medicaid and NC Health Choice programs operated by the Department of Health and Human Services pursuant to its authority under Part 6 and Part 8 of Article 2 of Chapter 108A of the General Statutes in which the Department pays enrolled providers for services provided to Medicaid and NC Health Choice recipients

rather than contracting for the coverage of services through a capitated payment arrangement.

~~(3e) "FICA" means the taxes imposed by the Federal Insurance Contribution Act, 26 U.S.C. § 3101, et seq.~~

(3f) Repealed by Session Laws 2009-489, s. 1, effective August 26, 2009.

(3g) "FICA" means the taxes imposed by the Federal Insurance Contribution Act, 26 U.S.C. § 3101, et seq.

~~(3g)~~(3h) "Full-time employment" means employment which requires the employee to work a regular schedule of hours per day and days per week established as the standard full-time workweek by the employer, but not less than an average of 30 hours per week.

(4) Repealed by Session Laws 1983, c. 14, s. 3.

…

(4b) "Parent" means biological parent or adoptive parent, and for Work First purposes, includes a stepparent.

(4c) "Prepaid health plan" or "PHP" has the same meaning as in G.S. 108D-1.

(5) "Recipient" is a person to whom, or on whose behalf, assistance is granted under this Article.

…."

SECTION 4. G.S. 108A-56 reads as rewritten:

"**§ 108A-56. Acceptance of federal grants.**

All of the provisions of the federal Social Security Act providing grants to the states for medical assistance are accepted and adopted, and the provisions of this Part shall be liberally construed ~~in relation to such act so that the intent to comply with it shall be made effectual.~~ to effectuate compliance with the act, except to the extent the applicability of federal law or rules have been waived by agreement between the State and the U.S. Department of Health and Human Services. Nothing in this Part or the regulations made under its authority shall be construed to deprive a recipient of assistance of the right to choose the licensed provider of the care or service made available under this Part within the provisions of the federal Social Security ~~Act.~~Act, or valid waiver agreement. This section shall not be construed to prohibit a PHP from (i) requiring its enrollees to obtain services from providers that are under contract with the PHP or (ii) imposing utilization management criteria to a request for services, to the extent these actions are not otherwise prohibited by State or federal law or regulation, or by the Department."

SECTION 5. G.S. 108A-70 reads as rewritten:

"**§ 108A-70. Recoupment of amounts spent on medical care.**

(a) ~~The~~ To the extent necessary to reimburse the Department or a PHP for expenditures for costs under this Part, and provided that claims for current and past due child support shall take priority over claims for those expenditures, the Department may garnish the wages, salary, or other employment income of, and the Secretary of Revenue shall withhold amounts from State tax refunds to, any person ~~who:~~who meets all of the following criteria:

(1) Is required by court or administrative order to provide health benefit plan coverage for the cost of health care services to a child eligible for medical assistance under ~~Medicaid; and~~Medicaid.

(2) Has received payment from a third party for the costs of such ~~services; but~~services.

(3) Has not used such payments to reimburse, as appropriate, either the other parent or guardian of the child or the provider of the ~~services;~~services.

~~to the extent necessary to reimburse the Department for expenditures for such costs under this Part; provided, however, claims for current and past due child support shall take priority over any such claims for the costs of such services.~~

…."

SECTION 6. Part 6A of Article 2 of Chapter 108A of the General Statutes reads as rewritten:

"Part 6A. ~~Medicaid Recipient Appeals Process.~~Appeals Process for Certain Medicaid and NC Health Choice Determinations.

"**§ 108A-70.9A. ~~Appeals by Medicaid recipients.~~Definitions; Medicaid recipient appeals.**

(a) Definitions. – The following definitions apply in this ~~Part, unless the context clearly requires otherwise.~~Part:

(1) Adverse determination. – A determination by the Department to deny, terminate, suspend, or reduce a Medicaid service or an authorization for a Medicaid ~~service.~~service through the fee-for-service program. An adverse benefit determination as defined in G.S. 108D-1 is not an adverse determination for purposes of this Part.

(1a) Adverse disenrollment decision. – As defined in G.S. 108D-1.

(1b) Contested Medicaid case. – A case commenced by (i) a Medicaid recipient appealing an adverse determination under this Part or (ii) a Medicaid or a NC Health Choice recipient appealing an adverse disenrollment determination under G.S. 108D-5.9.

(2) OAH. – The Office of Administrative Hearings.

(3) Recipient. – A recipient and the recipient's parent, guardian, or legal representative, unless otherwise specified.

(b) ~~General Rule.~~ Medicaid recipient appeals. – Notwithstanding any provision of State law or rules to the contrary, this section shall govern the process used by a Medicaid recipient to appeal an adverse determination made by the ~~Department.~~Department and the process used by a Medicaid or NC Health Choice recipient to appeal an adverse disenrollment determination by the Department.

...

"**§ 108A-70.9B. Contested Medicaid cases.**

(a) Application. – This section applies only to contested Medicaid cases ~~commenced by Medicaid recipients under G.S. 108A-70.9A.~~ as defined in this Part. Except as otherwise provided by ~~G.S. 108A-70.9A~~ Article 1A of Chapter 108D of the General Statutes, G.S. 108A-70.9A, and this section governing time lines and procedural steps, a contested Medicaid case commenced by a Medicaid or NC Health Choice recipient is subject to the provisions of Article 3 of Chapter 150B of the General Statutes. To the extent any provision in this ~~section~~ section, Article 1A of Chapter 108D of the General Statutes, or G.S. 108A-70.9A conflicts with another provision in Article 3 of Chapter 150B of the General Statutes, this ~~section~~ section, Article 1A of Chapter 108D of the General Statutes, and G.S. 108A-70.9A control.

(b) Simple Procedures. – Notwithstanding any other provision of Article 3 of Chapter 150B of the General Statutes, the chief administrative law judge may limit and simplify the procedures that apply to a contested Medicaid case involving a Medicaid or NC Health Choice recipient in order to complete the case as quickly as possible.

...

(3) The simplified procedure may include requiring that all prehearing motions be considered and ruled on by the administrative law judge in the course of the hearing of the case on the merits. An administrative law judge assigned to a contested Medicaid case shall make reasonable efforts in a case involving a Medicaid or NC Health Choice recipient who is not represented by an attorney to assure a fair hearing and to maintain a complete record of the hearing.

...

(c) Mediation. – Upon receipt of an appeal request form as provided by G.S. 108A-70.9A(e) or other clear request for a hearing by a Medicaid or NC Health Choice recipient, OAH shall immediately notify the Mediation Network of North Carolina, which shall

contact the recipient within five days to offer mediation in an attempt to resolve the dispute. If mediation is accepted, the mediation must be completed within 25 days of submission of the request for appeal. Upon completion of the mediation, the mediator shall inform OAH and the Department within 24 hours of the resolution by facsimile or electronic messaging. If the parties have resolved matters in the mediation, OAH shall dismiss the case. OAH shall not conduct a hearing of any contested Medicaid case until it has received notice from the mediator assigned that either: (i) the mediation was unsuccessful, or (ii) the petitioner has rejected the offer of mediation, or (iii) the petitioner has failed to appear at a scheduled mediation. If the recipient accepts an offer of mediation and then fails to attend mediation without good cause, OAH shall dismiss the contested case.

(d) Burden of Proof. – The recipient has the burden of proof on all issues submitted in a contested Medicaid case to OAH ~~for a Medicaid contested case hearing~~ and has the burden of going forward. The administrative law judge shall not make any ruling on the preponderance of evidence until the close of all evidence.

...

(f) Issue for Hearing. – For each adverse determination and each adverse disenrollment determination, the hearing shall determine whether the Department substantially prejudiced the rights of the recipient and if the Department, based upon evidence at the ~~hearing:~~hearing, did any of the following:

(1) Exceeded its authority or jurisdiction.
(2) Acted erroneously.
(3) Failed to use proper procedure.
(4) Acted arbitrarily or capriciously.
(5) Failed to act as required by law or rule.

...

"**§ 108A-70.9C. Informal review permitted.**

Nothing in this Part shall prevent the Department from engaging in an informal review of a contested Medicaid case with a recipient prior to issuing a notice of adverse determination ~~as provided by G.S. 108A-70.9A(c).~~under G.S. 108A-70.9A(c) or a notice of resolution under G.S. 108D-5.7."

SECTION 7. G.S. 108A-70.29 reads as rewritten:

"**§ 108A-70.29. Program review process.**

(a) Review of Eligibility and Program Enrollment Decisions. – Eligibility and Program enrollment decisions for Program applicants or recipients shall be reviewable pursuant to G.S. 108A-79. Program recipients shall remain enrolled in the NC Health Choice Program during the review of a decision to terminate or suspend enrollment. This subsection does not apply to requests for disenrollment from a PHP under Article 1A of Chapter 108D of the General Statutes.

(b) Review of Fee-for-Service Program Health Services Decisions. – This subsection applies only to health services decisions for services being provided to NC Health Choice recipients through the fee-for-service program as defined in G.S. 108A-24. This subsection does not apply to adverse benefit determinations as defined in G.S. 108D-1. In accordance with 42 C.F.R. § 457.1130 and 42 C.F.R. § 457.1150, a Program recipient may seek review of any delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of services, through a two-level review process.

...."

SECTION 9. G.S. 122C-3 reads as rewritten:

"**§ 122C-3. Definitions.**

The following definitions apply in this Chapter:

...

(2a) "Area director" means the administrative head of the area authority program appointed pursuant to G.S. 122C-121.

(2b) "Behavioral Health and Individuals with Developmental Disabilities Tailored Plan or BH IDD Tailored Plan" has the same meaning as in G.S. 108D-1.

(2c) "Board of county commissioners" includes the participating boards of county commissioners for multicounty area authorities and multicounty programs.

...

(20c) "Local management entity/managed care organization" or "LME/MCO" means a local management entity that is under contract with the Department to operate the combined Medicaid Waiver program authorized under Section 1915(b) and Section 1915(c) of the Social Security ~~Act.~~Act or to operate a BH IDD Tailored Plan.

...."

SECTION 10. G.S. 150B-1 reads as rewritten:

"**§ 150B-1. Policy and scope.**

...

(e) Exemptions From Contested Case Provisions. – The contested case provisions of this Chapter apply to all agencies and all proceedings not expressly exempted from the Chapter. The contested case provisions of this Chapter do not apply to the following:

...

(17) The Department of Health and Human Services with respect to the review of North Carolina Health Choice Program determinations regarding delay, denial, reduction, suspension, or termination of health services, in whole or in part, including a determination about the type or level of ~~services.~~services, commenced under G.S. 108A-70.29(b).

...

(25) The Department of Health and Human Services with respect to disputes involving the performance, terms, or conditions of a contract between the Department and a prepaid health plan, as defined in G.S. 108D-1.

...."

SECTION 11. G.S. 150B-23 reads as rewritten:

"**§ 150B-23. Commencement; assignment of administrative law judge; hearing required; notice; intervention.**

...

(a3) A Medicaid or NC Health Choice enrollee, or ~~network provider authorized in writing to act on behalf of the enrollee,~~ the enrollee's authorized representative, who appeals a notice of resolution issued by ~~an LME/MCO~~ a managed care entity under Chapter 108D of the General Statutes may commence a contested case under this Article in the same manner as any other petitioner. The case shall be conducted in the same manner as other contested cases initiated by Medicaid or NC Health Choice enrollees under this Article. Solely and only for the purposes of contested cases commenced ~~as Medicaid managed care enrollee appeals under Chapter 108D of the General Statutes,~~ pursuant to G.S. 108D-15 by enrollees of LME/MCOs to appeal a notice of resolution issued by the LME/MCO, an LME/MCO is considered an agency as defined in G.S. 150B-2(1a). The LME/MCO shall not be considered an agency for any other purpose. When a prepaid health plan, as defined in G.S. 108D-1, other than an LME/MCO, is under contract with the Department of Health and Human Services to issue notices of resolution under Article 2 of Chapter 108D of the General Statutes, then solely and only for the purposes of contested cases commenced pursuant to G.S. 108D-15 to appeal a notice of resolution issued by the prepaid health plan, the prepaid health plan shall be considered an agency as defined in G.S. 150B-2(1a). The prepaid health plan shall not be considered an agency for any other purpose.

...."

SECTION 12. Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17(a) of S.L. 2017-57, Section 4 of S.L. 2017-186, Section 11H.10(d) of S.L. 2018-5, and Sections 5 and 6 of S.L. 2018-48, reads as rewritten:

"**SECTION 4.** Structure of Delivery System. – The transformed Medicaid and NC Health Choice programs described in Section 1 of this act shall be organized according to the following principles and parameters:

...

(4) Services covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice services, including physical health services, prescription drugs, long-term services and supports, and behavioral health services for NC Health Choice recipients, except as otherwise provided in this subdivision. The capitated contracts required by this subdivision shall not cover:

a. Medicaid services ~~currently~~ covered by the local management entities/managed care organizations (LME/MCOs) under the combined 1915(b) and (c) waivers shall not be covered under any capitated PHP contract other than a BH IDD Tailored Plan, except that all capitated PHP contracts shall cover the following services: inpatient behavioral health services, outpatient behavioral health emergency room services, outpatient behavioral health services provided by direct-enrolled providers, mobile crisis management services, facility-based crisis services for children and adolescents, professional treatment services in a facility-based crisis program, outpatient opioid treatment services, ambulatory detoxification services, nonhospital medical detoxification services, partial hospitalization, medically supervised or alcohol and drug abuse treatment center detoxification crisis stabilization, research-based intensive behavioral health treatment, diagnostic assessment services, and Early and Periodic Screening, Diagnosis, and Treatment services. In accordance with this sub-subdivision, 1915(b)(3) services shall not be covered under any capitated PHP contract other than a BH IDD Tailored Plan.

...

(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except for the following categories:

...

m. Recipients in the following categories shall not be covered by PHPs for a period of time to be determined by DHHS that shall not exceed five years after the date that capitated PHP contracts begin:

1. Recipients who (i) reside in a nursing facility and have so resided, or are likely to reside, for a period of 90 days or longer and (ii) are not being served through the Community Alternatives Program for Disabled Adults (CAP/DA). During the period of exclusion from PHP coverage for this population as determined by DHHS in accordance with this sub-subdivision, if an individual enrolled in a PHP resides in a nursing facility for 90 days or more, then that individual shall be excluded from PHP coverage on the first day of the month following the ninetieth day of the stay in the nursing facility and shall be disenrolled from the PHP.

2. Recipients who are enrolled in both Medicare and Medicaid and for whom Medicaid coverage is not limited to the coverage of Medicare premiums and cost sharing. This sub-sub-subdivision shall not include recipients being served through the Community Alternatives Program for Disabled Adults (CAP/DA).

3. Recipients who are (i) enrolled in the foster care system, (ii) receiving Title IV-E adoption assistance, (iii) under the age of 26 and formerly were in the foster care system, or (iv) under the age of 26 and formerly received adoption assistance.

...

(9) LME/MCOs. – Beginning on the date that capitated contracts begin, LME/MCOs shall cease managing Medicaid services for all Medicaid recipients other than recipients described in sub-subdivisions a., d., e., f., g., j., k., ~~and *l.*~~ *l.*, and m. of subdivision (5) of this section. Until BH IDD Tailored Plans become operational, all of the following shall occur:

a. LME/MCOs shall continue to manage the Medicaid services that are ~~currently~~ covered by the LME/MCOs under the combined 1915(b) and (c) waivers for Medicaid recipients described in sub-subdivisions a., d., e., f., g., j., k., ~~and *l.*~~ *l.*, and m. of subdivision (5) of this section.

b. The Division of Health Benefits shall negotiate actuarially sound capitation rates directly with the LME/MCOs based on the change in composition of the population being served by the LME/MCOs.

c. Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits.

...."

SECTION 13. Section 5 of S.L. 2015-245, as amended by Section 2(c) of S.L. 2016-121 and Section 6(b) of S.L. 2018-49, reads as rewritten:

"**SECTION 5.** Role of DHHS. – The role and responsibility of DHHS during Medicaid transformation shall include the following activities and functions:

...

(6) Enter into capitated PHP contracts for the delivery of the Medicaid and NC Health Choice services described in subdivision (4) of Section 4 of this act. All contracts shall be the result of requests for proposals (RFPs) issued by DHHS and the submission of competitive bids by PHPs. DHHS shall develop standardized contract terms, to include at a minimum, the following:

...

c. A minimum medical loss ratio of eighty-eight percent (88%) for health care services, with the components of the numerator and denominator to be defined by DHHS. The minimum medical loss ratio shall be neither higher nor lower than eighty-eight percent (88%). DHHS shall not require community reinvestment as a result of a PHP's failure to comply with any minimum medical loss ratio.

...."

SECTION 14.(a) The portions of S.L. 2015-245, as amended, specified in this section are codified into a new Article 4 of Chapter 108D of the General Statutes to be entitled "Prepaid Health Plans," as follows:

(1) Section 1 of S.L. 2015-245 is codified as G.S. 108D-30.

(2) Subdivision (4) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 11H.17 of S.L. 2017-57, Section 4 of S.L. 2017-186,

Section 1 of S.L. 2018-48, and Section 12 of this act, is codified as G.S. 108D-35.

(3) Subdivision (5) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121, Section 1 of S.L. 2018-48, Section 5 of S.L. 2018-49, and Section 12 of this act, is codified as G.S. 108D-40.

(4) Subdivision (5a) of Section 4 of S.L. 2015-245, as enacted by Section 5(c) of S.L. 2018-49, is codified as G.S. 108D-40.

(5) Subdivision (6) of Section 4 of S.L. 2015-245, as amended by Section 2(b) of S.L. 2016-121 and Section 1 of S.L. 2018-48, is codified as G.S. 108D-45 and the words "(statewide contracts)" and "(regional contracts)" shall be removed.

(6) Subdivision (7) of Section 4 of S.L. 2015-245 is codified as G.S. 108D-50.

(7) Subdivision (8) of Section 4 of S.L. 2015-245 is codified as G.S. 108D-55.

(8) Subdivision (9) of Section 4 of S.L. 2015-245, as amended by Section 1 of S.L. 2018-48 and Section 12 of this act, is codified as G.S. 122C-115(e), except that the tag line shall not be codified, and the words "under Article 4 of Chapter 108D of the General Statutes" shall be inserted after the words "capitated contracts."

(9) Subdivision (10) of Section 4 of S.L. 2015-245, as amended by Section 1 of S.L. 2018-48, is codified as G.S. 108D-60, except that the following are not codified:

a. The first and third sentences of the subdivision (10).

b. The language in sub-subdivision a. appearing before sub-sub-subdivision 1.

c. The word "currently" shall be removed from sub-sub-sub-subdivision II. of sub-sub-subdivision 1. of sub-subdivision a.

d. Sub-sub-subdivision 6. of sub-subdivision a.

e. Sub-subdivisions b., c., and d.

(10) Section 5 of S.L. 2015-245, as amended by Section 2(c) S.L. 2016-121, Section 6(b) of S.L. 2018-49, and Section 13 of this act, is codified as G.S. 108D-65, except that the following are not codified:

a. Sub-subdivision d. of subdivision (6) of Section 5.

b. Subdivisions (10), (11), (12), and (13) of Section 5.

(11) Section 7A of S.L. 2015-245, as enacted by Section 7 of S.L. 2018-49, is codified as G.S. 108D-70.

SECTION 14.(b) In codifying the portions of S.L. 2015-245, as amended, that are specified in subsection (a) of this section, the Revisor of Statutes is authorized to do all of the following:

(1) Replace references to DHHS with references to the Department or the Department of Health and Human Services, as appropriate.

(2) Revise references to subdivision (3) of Section 4 of the session law to instead reference the codified location of the language in subdivision (3) of Section 5 of the session law.

SECTION 15.(a) References to the Division of Medical Assistance, and any derivatives thereof, in the General Statutes are replaced with references to the Division of Health Benefits, except that references to the Division of Medical Assistance are not replaced in G.S. 108A-54, 126-5(c)(34), 143B-138.1, and 143B-216.80.

SECTION 15.(b) This section is effective July 1, 2019.

SECTION 16.(a) Except as otherwise provided, this act is effective October 1, 2019.

SECTION 16.(b) This section is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 934

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H934-ABC-42 [v.2]

Amends Title [NO]
Second Edition

Date June 13 ,2019

Senator ~~Krawiec~~ Krawiec

moves to amend the bill on page 4, lines 26-30, by rewriting the lines to read:

"(3) Is provided at an accredited medical school located in this state, an affiliated facility of an accredited medical school located in this State, or any other facility approved by the institutional review board overseeing the treatment.";

and on page 4, lines 39-40, by rewriting the lines to read:

"in this State, or an affiliated facility of an accredited medical school located in this State. An institutional review board that meets the requirements of this subsection may certify";

and on page 5, line 5, by rewriting the line to read:

"(a) Except as allowed under subsection (c) and subsection (d) of this section, it is unlawful to knowingly";

and on page 5, line 19, by rewriting the line to read:

"(d) It is an exception to the application of this section that the actor is a healthcare provider, medical researcher, or biosciences professional who is either (i) engaged in research, clinical trials, or investigational adult stem cell treatment that is being overseen and has been approved by an institutional review board that meets the requirements of G.S. 90-325.13, or (ii) otherwise engaged in legal research, clinical trials, or investigational adult stem cell treatment.

(e) A violation of this section is a Class A1 misdemeanor."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

H934-ABC-42-V-2

HOUSE BILL 934:
Right to Try Adult Stem Cell Treatments.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 12, 2019
Introduced by:	Reps. Blackwell, Lambeth, Murphy, Reives	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	Second Edition		

OVERVIEW: House Bill 934 would allow patients with chronic or terminal diseases to receive adult stem cell treatment that is in clinical trials on humans, but has not yet been approved by the Food and Drug Administration.

CURRENT LAW: Under current law, individuals with terminal illnesses may receive treatment that includes investigational drugs, biological products, and devices.

BILL ANALYSIS:

The bill would allow patients with certain severe chronic or terminal illnesses to use investigational adult stem cell treatments for those diseases.

- 90-325.11 would create definitions for "adult stem cell," "clinical trial," "investigational adult stem cell treatment," "eligible patient," "severe chronic disease," "terminal illness," and "written informed consent."
- 90-325.12 would allow eligible patients with chronic or terminal illnesses to receive adult stem cell treatment that is in clinical trials on humans, but has not yet been approved by the Food and Drug Administration, provided that treatment meets all of the following criteria:
    - It is administered by a licensed physician.
    - It is overseen by an institutional review board.
    - It is provided at a hospital, ambulatory surgical center, or accredited medical school.
- 90-325.13 would require institutional review boards to (i) be affiliated with accredited medical schools or licensed hospitals, (ii) keep records of all patients who receive adult stem cell treatment, and (iii) submit an annual report to the North Carolina Medical Board. The Board would have the power to adopt rules to regulate institutional review boards.
- 90-325.14 would make it a Class A1 misdemeanor to knowingly offer to buy, offer to sell, acquire, receive, sell, or otherwise transfer adult stem cells for valuable consideration. Reimbursement of expenses and usual medical fees would not be unlawful.
- 90-325.15 would prohibit the Board from sanctioning physicians based on their recommendation that a patient have access to adult stem cell treatment. Entities responsible for Medicare certification would also be prohibited from taking action against physicians based on their recommendation that a patient have access to adult stem cell treatment.
- 90-325.16 would prohibit State officials from interfering with eligible patients' access to adult stem cell treatment.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- 90-325.17 would clarify that health insurance is not required to provide coverage for adult stem cell treatment.

The bill would also make technical changes to G.S. 90-325 through 90-325.7.

EFFECTIVE DATE: This act would be effective December 1, 2019, and would apply to acts committed on or after that date.

HOUSE BILL 934
Committee Substitute Favorable 4/30/19

Short Title: Right to Try Adult Stem Cell Treatments. (Public)

Sponsors:

Referred to:

April 22, 2019

A BILL TO BE ENTITLED

AN ACT EXPANDING THE RIGHT TO TRY ACT TO PROVIDE ACCESS TO INVESTIGATIONAL ADULT STEM CELL TREATMENTS FOR PATIENTS DIAGNOSED WITH A TERMINAL OR CHRONIC ILLNESS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 23A of Chapter 90 of the General Statutes reads as rewritten:

"Article 23A.

"Right to Try Act.

"Part 1. Experimental Treatments.

"§ 90-325. Short title; purpose.

(a) This Article shall be known and may be cited as the Right to Try Act.

(b) The purpose of Part 1 of this Article is to authorize access to and use of experimental treatments for patients with a terminal illness; to establish conditions for use of experimental treatment; to prohibit sanctions of health care providers solely for recommending or providing experimental treatment; to clarify duties of a health insurer with regard to experimental treatment authorized under this ~~Article;~~ Part; to prohibit certain actions by State officials, employees, and agents; and to restrict certain causes of action arising from experimental treatment.

"§ 90-325.1. Definitions.

The following definitions apply in this ~~Article,~~ Part, unless the context requires otherwise:

(1) Eligible patient. – An individual who meets all of the following criteria:

a. Has a terminal illness, attested to by a treating physician.

b. Has, in consultation with a treating physician, considered all other treatment options currently approved by the United States Food and Drug Administration.

c. Has received a recommendation from the treating physician for use of an investigational drug, biological product, or device for treatment of the terminal illness.

d. Has given informed consent in writing to use of the investigational drug, biological product, or device for treatment of the terminal illness or, if the individual is a minor or is otherwise incapable of providing informed consent, the parent or legal guardian has given informed consent in writing to use of the investigational drug, biological product, or device.

e. Has documentation from the treating physician that the individual meets all of the criteria for this definition. This documentation shall include an attestation from the treating physician that the treating

physician was consulted in the creation of the written, informed consent required under this ~~Article.~~Part.

...

"§ 90-325.2. Authorized access to and use of investigational drugs, biological products, and devices.

(a) A manufacturer of an investigational drug, biological product, or device may make available to an eligible patient, and an eligible patient may request, the manufacturer's investigational drug, biological product, or device. However, nothing in this ~~Article~~ Part shall be construed to require a manufacturer of an investigational drug, biological product, or device to make such investigational drug, biological product, or device available to an eligible patient.

(b) A manufacturer of an investigational drug, biological product, or device may provide the investigational drug, biological product, or device to an eligible patient without receiving compensation or may require the eligible patient to pay the costs of, or the costs associated with, the manufacture of the investigational drug, biological product, or device.

...

"§ 90-325.6. No private right of action against manufacturers of investigational drugs, biological products, or devices.

No private right of action may be brought against a manufacturer of an investigational drug, biological product, or device, or against any other person or entity involved in the care of an eligible patient using an investigational drug, biological product, or device, for any harm caused to the eligible patient resulting from use of the investigational drug, biological product, or device as long as the manufacturer or other person or entity has made a good-faith effort to comply with the provisions of this ~~Article~~ Part and has exercised reasonable care in actions undertaken pursuant to this ~~Article.~~Part.

"§ 90-325.7. Insurance coverage of clinical trials.

Nothing in this ~~Article~~ Part shall be construed to affect a health benefit plan's obligation to provide coverage for an insured's participation in a clinical trial pursuant to G.S. 58-3-255.

"§ 90-325.8. Reserved.

"§ 90-325.9. Reserved.

"Part 2. Investigational Adult Stem Cell Treatments.

"§ 90-325.10. Purpose.

The purpose of Part 2 of this Article is to authorize access to and use of certain investigational adult stem cell treatments for patients with certain severe chronic diseases or terminal illnesses; to regulate the possession, use, and transfer of adult stem cells; and to create a criminal offense for the purchase and sale of adult stem cells for certain investigational treatments.

"§ 90-325.11. Definitions.

The following definitions apply in this Part unless the context requires otherwise:

(1) Adult stem cell. – An undifferentiated cell that is (i) found in postnatal differentiated tissue and (ii) able to renew itself and differentiate to yield all or nearly all of the specialized cell types of the tissue from which the cell originated.

(2) Clinical trial. – A research study in which one or more human subjects are prospectively assigned to one or more interventions using adult stem cells administered under United States Food and Drug Administration protocols for Investigational New Drugs or Investigational Device Exemptions.

(3) Investigational adult stem cell treatment. – Adult stem cell treatment that meets all of the following criteria:

a. Is under investigation in a clinical trial and being administered to human participants in that trial.

b. Has not yet been approved for general use by the United States Food and Drug Administration.

(4) Eligible patient. – An individual who meets all of the following criteria:
a. Has a severe chronic disease or terminal illness, attested to by a treating physician.
b. Has, in consultation with a treating physician, considered all other treatment options currently approved by the United States Food and Drug Administration.
c. Has received a recommendation from the treating physician for use of an investigational adult stem cell treatment for the severe chronic disease or terminal illness.
d. Has given informed consent in writing to use of the investigational adult stem cell treatment or, if the individual is a minor or is otherwise incapable of providing informed consent, the parent or legal guardian has given informed consent in writing to use of the investigational adult stem cell treatment.
e. Has documentation from the treating physician that the individual meets all of the criteria for this definition. This documentation shall include an attestation from the treating physician that the treating physician was consulted in the creation of the written, informed consent required under this Part.

(5) Severe chronic disease. – A condition, injury, or illness that meets all of the following criteria:
a. May be treated.
b. Is never cured or eliminated.
c. Entails significant functional impairment or severe pain.

(6) Terminal illness. – As defined in G.S. 90-325.1(3).

(7) Written, informed consent. – A written document that is signed by an eligible patient; or if the patient is a minor, by a parent or legal guardian; or if the patient is incapacitated, by a designated health care agent pursuant to a health care power of attorney, that at a minimum includes all of the following:
a. An explanation of the currently approved products and treatments for the eligible patient's severe chronic disease or terminal illness.
b. An attestation that the eligible patient concurs with the treating physician in believing that all currently approved treatments are unlikely to alleviate the significant impairment or severe pain associated with a severe chronic disease or unlikely to prolong the life of an eligible patient with a terminal illness.
c. Clear identification of the specific investigational adult stem cell treatment proposed for treatment of the eligible patient's severe chronic disease or terminal illness.
d. A description of the potentially best and worst outcomes resulting from use of the investigational adult stem cell treatment to treat the eligible patient's severe chronic disease or terminal illness, along with a realistic description of the most likely outcome. The description shall be based on the treating physician's knowledge of the proposed treatment in conjunction with an awareness of the eligible patient's severe chronic disease or terminal illness and shall include a statement acknowledging that new, unanticipated, different, or worse symptoms might result from, and that death could be hastened by, the proposed treatment.
e. A statement that eligibility for hospice care may be withdrawn if the eligible patient begins treatment of the terminal illness with an

investigational adult stem cell treatment and that hospice care may be reinstated if such treatment ends and the eligible patient meets hospice eligibility requirements.

f. A statement that the eligible patient's health benefit plan or third-party administrator and provider are not obligated to pay for any care or treatments consequent to the use of the investigational adult stem cell treatment, unless specifically required to do so by law or contract.

g. A statement that the eligible patient understands that he or she is liable for all expenses consequent to the investigational adult stem cell treatment and that this liability extends to the eligible patient's estate, unless a contract between the patient and provider of the investigational stem cell treatment states otherwise.

h. A statement that the eligible patient or, for an eligible patient who is a minor or lacks capacity to provide informed consent, that the parent or legal guardian consents to the use of the investigational adult stem cell treatment for treatment of the severe chronic disease or terminal condition.

"**§ 90-325.12. Authorized treatments.**

(a) An eligible patient is authorized to access and use an investigational adult stem cell treatment under this Part, if the investigational adult stem cell treatment meets all of the following requirements:

(1) Is administered directly by a physician certified by an institutional review board that meets the requirements of G.S. 90-325.13.

(2) Is overseen by an institutional review board that meets the requirements of G.S. 90-325.13.

(3) Is provided at one of the following:

a. A hospital licensed under Chapter 131E of the General Statutes.

b. An ambulatory surgical center licensed under Chapter 131E of the General Statutes.

c. An accredited medical school located in this State.

(b) A physician administering an investigational adult stem cell treatment under this Part shall comply with all applicable rules of the North Carolina Medical Board.

(c) This Part does not affect or authorize a person to violate any applicable laws regulating the possession, use, or transfer of human organs, fetal tissue, fetal stem cells, adult stem cells, or embryonic stem cells or their derivatives.

"**§ 90-325.13. Institutional review boards; annual report; rules.**

(a) An institutional review board that oversees investigational adult stem cell treatments administered under this Part is required to be affiliated with an accredited medical school located in this State, or a hospital licensed under Chapter 131E of the General Statutes with at least 150 beds. An institutional review board that meets the requirements of this subsection may certify physicians to provide investigational adult stem cell treatment under this Part.

(b) An institutional review board overseeing an investigational adult stem cell treatment under this Part shall keep a record on each person to whom a physician administers the treatment and document in the record the provision of each treatment and the effects of the treatment on the person throughout the period the treatment is administered to the person.

(c) Each institutional review board overseeing an investigational adult stem cell treatment under this Part shall submit an annual report to the North Carolina Medical Board on the review board's findings based on records kept under subsection (b) of this section. The report shall not include any patient-identifying information and must be made available to the public in both written and electronic form.

(d) The North Carolina Medical Board may adopt rules concerning the role and function of institutional review boards under this Part.

"**§ 90-325.14. Prohibited purchase and sale of adult stem cells for certain investigational treatments.**

(a) Except as allowed under subsection (c) of this section, it is unlawful to knowingly offer to buy, offer to sell, acquire, receive, sell, or otherwise transfer any adult stem cells for valuable consideration for use in an investigational adult stem cell treatment.

(b) Subsection (a) of this section does not prohibit the following forms of valuable consideration for investigational adult stem cell treatment:

(1) A fee paid to a health care provider for services rendered in the usual course of medical practice or a fee paid for hospital or other clinical services.

(2) Reimbursement of legal or medical expenses incurred for the benefit of the ultimate receiver of the investigational adult stem cell treatment.

(3) Reimbursement of expenses for travel, housing, and lost wages incurred by the donor of adult stem cells in connection with the donation of the adult stem cells.

(c) It is an exception to the application of this section that the actor engaged in conduct authorized under G.S. 130A-412.31.

(d) A violation of this section is a Class A1 misdemeanor.

"**§ 90-325.15. Sanctions against physicians prohibited.**

(a) A licensing board shall not revoke, fail to renew, suspend, or take any other disciplinary action against a physician licensed under this Chapter, based solely on the physician's recommendation that an eligible patient have access to an investigational adult stem cell treatment, or the physician's administration of an investigational adult stem cell treatment to the eligible patient, provided that the recommendation made or the care provided is consistent with the applicable standard of care and the requirements of this Part.

(b) An entity responsible for Medicare certification shall not take action against a physician's Medicare certification based solely on the physician's recommendation that a patient have access to an investigational adult stem cell treatment, or the physician's administration of an investigational adult stem cell treatment to the eligible patient, provided that the recommendation made or the care provided meets the applicable standard of care and the requirements of this Part.

"**§ 90-325.16. Prohibited conduct by government officials.**

No official, employee, or agent of this State or any of its political subdivisions shall interfere with or attempt to interfere with an eligible patient's access to an investigational adult stem cell treatment authorized under this Part. Counseling, advice, or a recommendation consistent with medical standards of care from a licensed health care provider does not constitute a violation of this section.

"**§ 90-325.17. Insurance of clinical trials.**

Nothing in this Part shall be construed to affect a health benefit plan's obligation to provide coverage for an insured's participation in a clinical trial pursuant to G.S. 58-3-255."

SECTION 3. This act becomes effective December 1, 2019, and applies to acts committed on or after that date.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

SENATE SERGEANT-AT-ARMS

HEALTH CARE SENATE COMMITTEE

DATE: 06-13-2019 ROOM: 643

10:00 AM

SENATE SERGEANT AT ARMS

Linda Matthews

Dwight Green

Terry Edmondson

Tom Burroughs

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 643

DATE: 6-23 **TIME:** 10 AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

Page Name	Hometown	Sponsoring Senator
1. Carson GRAINGER	Tabor City	Newton
2. Savannah-Grace Jones	Tabor City	Britt
3. Rhett Freedman	Clarkton	Britt
4. Shriya madhavaram	waxhaw	Todd Johnson
5. Rebekah Byrd	Clinton	B. Jackson
6. Elizabeth Cashwell	Garland	B. Jackson
7. Tucker Martin	Stanley	T. Alexander
8. Will Twilla	Eden	J. Perry

ges: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

Jean-Pierre Dupont

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Visitors Sign-in

HEALTH CARE SENATE COMMITTEE

June 13, 2019 10:00 AM Rm. 643

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
Hattie Gawande	DHHS

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

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HEALTH CARE SENATE COMMITTEE

June 13, 2019 10:00 AM Rm. 643

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
Sam Taylor	NC Biosciences organization
Ed Turlington	BPP
Richard Barton	Gov. off. of MHC
Toni Neumann	MWC
Alex Taylor	Benchmarks
Logan Martin	Skyline Strategies
Grayson Lamontagne	Skyline Strategies
[illegible]	NMRS
[illegible]	[illegible]
[illegible]	CSS
Catherine Moore	NC Board of Nursing
[illegible] Parkinson	Parkinson Law
Tabitha Bryant	DHHS

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NORTH CAROLINA GENERAL ASSEMBLY

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HEALTH CARE SENATE COMMITTEE

June 13, 2019 10:00 AM Rm. 643

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Matt Crois	DHHS
Julia Adams Schweich	Oak City - SR
Laura Gunter	NCBIO
Jud Lawr.	CCH
Jon Taylor	NCBIO
John Hardin	MFS
Ken Melton	K.M.A.
CS Hollis	CSA
Tom V. TAGLIONE	NC CHILD
Brendan Riley	NC Justice Center
Andrew Mathews	
	NWC
Henry M Lancaster®	LCA/NCTC

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HEALTH CARE SENATE COMMITTEE

June 13, 2019 10:00 AM Rm. 643

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Sarah Patterson	Williams Mullen
Grace Irvin	Wake West
Marissa Turner	TSS
Clarkin Sweemaker	governors of a
SarahBales	Brubaker Assoc
Susan Farrell	Fetzer, LLC
Jamaica Pfister	CHS
Marily Avila	CHS
Jon Arts	PSG
Doug Miskam	PSG
Sarah Segal	NP
Ross	NP

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HEALTH CARE SENATE COMMITTEE

June 13, 2019 10:00 AM Rm. 643

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Michelle Frazier	NP
Lori Kroll	NH
Rick Techini	WM
Emily Manning	FPA
Rhaegan Jackson	FPA
JOE STEWART	II ANC
Rachel Bamlet	RBLaw
Sarah McQuillan	KGA NC
Cassidy Robertson	AMGA
JEFF BARNHART	MWC
Dave Horne	SA
	CSS

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NORTH CAROLINA GENERAL ASSEMBLY

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HEALTH CARE SENATE COMMITTEE

June 13, 2019 10:00 AM Rm. 643

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NAME	FIRM OR AGENCY / BILL No.
Ryan Blackledge	Core Health
	C 64
Dan Soucek	Core Health
PEYTON MAYNARD	
Chip Bogart	NCAS
Sue Ann Forrest	NCAS
Lexi Arthur	NCOA
Frank Hill	PSG
Kain Baisness	BPS
Pam Shipman	Monarch

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NORTH CAROLINA GENERAL ASSEMBLY

Speakers Sign-in

HEALTH CARE SENATE COMMITTEE

June 13, 2019 10:00 AM Rm. 643

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY / BILL No.
Sam Taylor	NC Biosciences Org.

Senate Committee on Health Care
Wednesday, June 19, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 19, 2019 in Room 643 of the Legislative Office Building. Seven members were present.

Senator Joyce Krawiec, Chair, presided.

Mia Monicone from Denver, Nate Bowers from Carrboro, Alyssa Gross from Cary, Brook Fowler from Winston-Salem, Reagan Bowman from Franklinton, Will McClintock from Durham, and Kathryn Osterhout from Rocky Mount served as pages.

HB 886 Study Participation of Operators in NC Pre-K. (Representatives Horn, Dobson, Black, Strickland)
Rep. Stickland was introduced to explain the bill. Questions from the members were responded to by Rep. Strickland and Jason Moran Bates from Legislative Analysis Division. Sen. Krawiec allowed comments from the public and they spoke in the following order: Susan Gates/SAS Special Adviser and Nathan Batts/NC Bankers Association. Sen. Horner moved for a favorable report and it carried. Sen. Horner will manage this bill during session.

HB 325 Update Svc & Care Plan Req's/ACH Residents. (Representatives Dobson, White, Barnes, Black)
This bill was for discussion only. Sen. Van Dyńn moved that the proposed committee substitute (PCS) be brought before the committee and it carried. Sen. Davis was asked to explain the PCS. Questions from the members were responded to by Sen. Davis and Sen. Robinson. Sen. Krawiec announced that this bill be considered for vote during the next scheduled meeting for Senate Health.

The meeting adjourned at 10:30 AM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Wednesday, June 19, 2019

Senator Krawiec,
submits the following with recommendations as to passage:

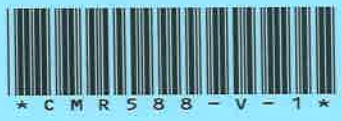
FAVORABLE

HB **886** Study Participation of Operators in NC Pre-K.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Rick Horner will handle HB 886



Senate Committee on Health Care
Wednesday, June 19, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 886	Study Participation of Operators in NC Pre-K.	Representative Horn Representative Dobson Representative Black Representative Strickland
HB 325	Update Svc & Care Plan Req's/ACH Residents. For Discussion Only	Representative Dobson Representative White Representative Barnes Representative Black

HOUSE BILL 886:
Study Participation of Operators in NC Pre-K.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 18, 2019
Introduced by:	Reps. Horn, Dobson, Black, Strickland	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	First Edition		

OVERVIEW: House Bill 886 would direct the Department of Health and Human Services, Division of Child Development and Early Education, to study and report on the challenges faced in becoming an NC Pre-K site.

BILL ANALYSIS: House Bill 886 would require the Department of Health and Human Services, Division of Child Development and Early Education (Division), to complete a study of four- and five-star centers that are not participating in NC Pre-K in order to identify the challenges associated with becoming an NC Pre-K site. This study must also include a county-by-county survey of local challenges. The Division must submit a report making recommendations to address the challenges and recommended changes in the State funding structure which would be necessary to achieve the goal of enrolling 75% of the children in each county in NC Pre-K. The report must be submitted to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee by February 1, 2020.

EFFECTIVE DATE: The act would be effective when it becomes law.

ıren Cochrane-Brown
Director

H886-SMBC-88 E1 -V-1

Legislative Analysis
Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

HOUSE BILL 886

Short Title:	Study Participation of Operators in NC Pre-K.	(Public)
Sponsors:	Representatives Horn, Dobson, Black, and Strickland (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Rules, Calendar, and Operations of the House	

April 22, 2019

A BILL TO BE ENTITLED

AN ACT TO STUDY THE CHALLENGES CHILD CARE FACILITY OPERATORS FACE IN PARTICIPATING IN THE NORTH CAROLINA PREKINDERGARTEN (NC PRE-K) PROGRAM.

Whereas, the North Carolina Prekindergarten (NC Pre-K) program has been proven, through over 15 years of rigorous research, to have lasting positive impacts, including increased reading and math proficiency, reduced placements in special education, and less grade retention, with these positive outcomes lasting through at least the eighth grade; and

Whereas, this rigorous research has confirmed that, as the number of NC Pre-K eligible children participating in the program increases, children who do not participate in the program experience some of the positive impacts as well; and

Whereas, this research confirms also that NC Pre-K is a critical foundation for increasing third grade reading proficiency and continued success in North Carolina's K-12 system, which will strengthen the talent pipeline necessary to meet the skills needs of North Carolina businesses; and

Whereas, North Carolina is nationally recognized for its early care and education system; and

Whereas, research shows investment in NC Pre-K generates a strong return on investment by reducing the number of children placed in special education classrooms in the third grade by thirty-nine percent (39%); and

Whereas, research shows children enrolled in NC Pre-K learn to socialize, make decisions, interact with others, and negotiate, which are all critical components of necessary executive function skills that translate into critical soft skills North Carolina businesses need; and

Whereas, recent increases in State funding have raised statewide participation in the NC Pre-K program to forty-seven percent (47%) of eligible children, and research shows participation by at least seventy-five percent (75%) of eligible children in every North Carolina county would increase the likelihood of success in school and in the workforce, but there are unique challenges in counties across our State to expanding the program to serve at least seventy-five percent (75%) of eligible children; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Child Development and Early Education (Division), shall complete a statewide study of operators of four- and five-star centers who are not currently participating in the North Carolina Prekindergarten (NC Pre-K) program to identify those operators' perception of the challenges associated with becoming an NC Pre-K site. In addition, the Division shall complete a

county-by-county study of additional local challenges. Findings from these two studies shall be used to make recommendations to address these challenges, including any recommended changes in the State funding structure, to facilitate achieving the goal of enrolling in the NC Pre-K program at least seventy-five percent (75%) of eligible children in each county. The Division shall submit a report on its recommendations regarding the challenges, as well as any recommendations for changes to support increased access for children eligible for the NC Pre-K program, to the Joint Legislative Oversight Committee on Health and Human Services and the Joint Legislative Education Oversight Committee by February 1, 2020.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H D

HOUSE BILL 325
Committee Substitute Favorable 4/15/19
PROPOSED SENATE COMMITTEE SUBSTITUTE H325-CSBC-51 [v.2]
06/18/2019 05:54:09 PM

Short Title: Opioid Epidemic Response Act. (Public)

Sponsors:

Referred to:

March 12, 2019

A BILL TO BE ENTITLED

AN ACT REMOVING THE REQUIREMENT THAT BUPRENORPHINE PRESCRIBERS REGISTER WITH THE STATE, IN ADDITION TO REGISTERING WITH THE FEDERAL GOVERNMENT; DECRIMINALIZING THE USE OF DRUG TESTING EQUIPMENT TO DETECT CONTAMINANTS; BROADENING THE OBJECTIVES OF SYRINGE EXCHANGE PROGRAMS TO ENCOMPASS REDUCING THE NUMBER OF DRUG OVERDOSES IN THE STATE AND REMOVING THE BAN ON THE USE OF STATE FUNDS TO PURCHASE CERTAIN SUPPLIES.

The General Assembly of North Carolina enacts:

PART I. ELIMINATION OF STATE REGISTRATION REQUIREMENT FOR BUPRENORPHINE PRESCRIBERS

SECTION 1.1. G.S. 90-101(a1) is repealed.

PART II. DECRIMINALIZATION OF DRUG TESTING EQUIPMENT USED TO DETECT CONTAMINANTS IN CONTROLLED SUBSTANCES

SECTION 2.1. G.S. 90-113.22 is amended by adding a new subsection to read:

"(d) Notwithstanding the provisions of subsection (a) of this section, it is not unlawful for (i) a person who introduces a controlled substance into his or her body, or intends to introduce a controlled substance into his or her body, to knowingly use, or to possess with intent to use, testing equipment for identifying or analyzing the strength, effectiveness, or purity of that controlled substance; or (ii) a governmental or nongovernmental organization that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors to possess such testing equipment or distribute such testing equipment to a person who intends to introduce a controlled substance into his or her body."

SECTION 2.2. G.S. 90-113.22A is amended by adding a new subsection to read:

"(c) Notwithstanding the provisions of subsection (a) of this section, it is not unlawful for (i) a person who introduces a controlled substance into his or her body, or intends to introduce a controlled substance into his or her body, to knowingly use, or to possess with intent to use, testing equipment for identifying or analyzing the strength, effectiveness, or purity of that controlled substance; or (ii) a governmental or nongovernmental organization that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors to possess such testing equipment or distribute such testing equipment to a person who intends to introduce a controlled substance into his or her body."

PART III. BROADENING THE OBJECTIVES OF SYRINGE EXCHANGE PROGRAMS TO ENCOMPASS REDUCING THE NUMBER OF DRUG OVERDOSES IN THE STATE AND REMOVING THE BAN ON THE USE OF STATE FUNDS TO PURCHASE CERTAIN SUPPLIES.

SECTION 3.1. G.S. 90-113.27 reads as rewritten:

"**§ 90-113.27. Needle and hypodermic syringe exchange programs authorized; limited immunity.**

(a) Any governmental or nongovernmental organization, including a local or district health department or an organization that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors, may establish and operate a needle and hypodermic syringe exchange program. The objectives of the program shall be to do all of the following:

(1) Reduce the spread of HIV, AIDS, viral hepatitis, and other bloodborne diseases in this State.

(2) Reduce needle stick injuries to law enforcement officers and other emergency personnel.

(3) Encourage individuals who ~~inject~~ use drugs illicitly to enroll in evidence-based treatment.

(4) Reduce the number of drug overdoses in this State.

(b) Programs established pursuant to this section shall offer all of the following:

...

(2) Needles, hypodermic syringes, and other injection supplies at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused. ~~No State funds may be used to purchase needles, hypodermic syringes, or other injection supplies.~~

...."

PART VI. EFFECTIVE DATE

SECTION 4. This act is effective when it becomes law.

HOUSE BILL 325:
Opioid Epidemic Response Act.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 18, 2019
Introduced by:	Reps. Dobson, White, Barnes, Black	**Prepared by:**	Jessica Boney Staff Attorney
Analysis of:	PCS to Second Edition H325-CSBC-51		

OVERVIEW: The Proposed Committee Substitute (PCS) to House Bill 325 removes the registration requirement for buprenorphine prescribers, decriminalizes the use of drug testing equipment, broadens the objectives of syringe exchange programs, and removes the restriction on using State funds to purchase certain supplies.

BILL ANALYSIS:

The PCS to House Bill 325 does the following:

Part I eliminates the state registration requirement for buprenorphine prescribers.

Part II decriminalizes drug testing equipment used to detect contaminants in controlled substances.

Part III adds reducing the number of drug overdoses in the State to the objectives of syringe exchange programs and removes the restriction on the use of State funds to purchase needles, hypodermic syringes, or other injection supplies.

EFFECTIVE DATE: This act is effective when it becomes law.

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H 2

HOUSE BILL 325*
Committee Substitute Favorable 4/15/19

Short Title: Update Svc & Care Plan Req's/ACH Residents. (Public)

Sponsors:

Referred to:

March 12, 2019

A BILL TO BE ENTITLED

AN ACT AUTHORIZING ADULT CARE HOMES TO USE SERVICE PLANS COMPLETED AS THE RESULT OF A MEDICAID PERSONAL CARE SERVICES ASSESSMENT TO FULFILL THE ACTIVITIES OF DAILY LIVING PORTION OF THE REQUIRED SERVICE PLANS OR CARE PLANS FOR ADULT CARE HOME RESIDENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2.15 reads as rewritten:

"**§ 131D-2.15. Resident assessments.**

(a) Initial Assessment. – The Department shall ensure that facilities conduct and complete an assessment of each resident within 72 hours of admitting the ~~resident and annually thereafter.~~ resident. In conducting the assessment, the facility shall use an assessment instrument ~~approved by the Secretary upon the advice of the Director of the Division of Aging and Adult Services.~~ approved in accordance with rules adopted by the Medical Care Commission. The Department shall provide ongoing training for facility personnel in the use of the approved assessment instrument.

(a1) ~~The~~ Assessment to Develop Service Plans and Care Plans. – Within 30 days of admission, the facility shall ~~use the~~ conduct an assessment to develop appropriate and comprehensive service plans and care plans and to determine the level and type of facility staff that is needed to meet the needs of residents. The assessment shall determine a resident's level of functioning and shall include, but not be limited to, cognitive status and physical functioning in activities of daily living. Activities of daily living are personal functions essential for the health and well-being of the resident. The assessment shall not serve as the basis for medical care. The assessment shall indicate if the resident requires referral to the resident's physician or other appropriate licensed health care professional or community resource.

(a2) Medicaid State Plan Personal Care Services Assessment. – To fulfill the activities of daily living portion of any service plan or care plan required under subsection (a1), or any rules adopted under this Article, the facility may use a service plan that was completed within 35 days of the resident's admission to the facility and represents the result of an assessment to determine the resident's eligibility for personal care services under the Medicaid State Plan. If the facility uses a service plan for personal care services under the Medicaid State Plan developed within 35 days of resident admission, the facility shall be exempt from conducting an assessment of the resident's ability to perform activities of daily living within 30 days of resident admission. For purposes of this subsection, a resident must have received an assessment to develop appropriate and comprehensive service plans and care plans no later than 35 days after resident admission or subsection (a1) applies.

(b) Review. – The Department, as part of its inspection and licensing of adult care homes, shall review assessments and related service plans and care plans for a selected number of residents. In conducting this review, the Department shall ~~determine:~~determine all of the following:

(1) Whether the appropriate assessment instrument was administered and interpreted ~~correctly;~~correctly.

(2) Whether the facility is capable of providing the necessary ~~services;~~services.

(3) Whether the service plan or care plan conforms to the results of an appropriately administered and interpreted ~~assessment; and~~assessment.

(4) Whether the service plans or care plans are being implemented fully and in accordance with an appropriately administered and interpreted assessment.

(c) Penalties. – If the Department finds that the facility is not carrying out its assessment responsibilities in accordance with this section, the Department shall notify the facility and require the facility to implement a corrective action plan. The Department shall also notify the resident of the results of its review of the assessment, service plans, and care plans developed for the resident. In addition to administrative penalties, the Secretary may suspend the admission of any new residents to the facility. The suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removing the suspension."

SECTION 2. G.S. 90-288.14 reads as rewritten:

"**§ 90-288.14. Assisted living administrator certification.**

~~An applicant shall be certified by the~~ The Department shall certify as an assisted living administrator ~~if the~~ any applicant who meets all of the following qualifications:

(1) Is at least 21 years old.

(2) Provides a satisfactory criminal background report from the State Repository of Criminal Histories, which shall be provided by the State Bureau of Investigation upon its receiving fingerprints from the applicant. If the applicant has been a resident of this State for less than five years, the applicant shall provide a satisfactory criminal background report from both the State and National Repositories of Criminal Histories.

(2a) Does not have a substantiated finding of neglect, abuse, misappropriation of property, diversion of drugs, or fraud listed on the Health Care Personnel Registry established under G.S. 131E-256.

(3) ~~Successfully~~ Has a high school diploma and successfully completes the equivalent of two years of coursework at an accredited college or ~~university~~ university, or has a minimum of 60 months of supervisory experience, or has a combination of education and experience as approved by the Department. For purposes of this section, "supervisory experience" means having full-time, direct management responsibility, including some responsibility for hiring and firing, over the equivalent of at least two full-time employees with direct resident care responsibilities. Such supervisory experience shall have been in a licensed adult care home or licensed nursing home within the seven years preceding the date of application.

(4) Successfully completes a Department approved administrator-in-training program of at least 120 hours of study in courses relating to assisted living residences.

(5) Successfully completes a written examination administered by the Department."

SECTION 3. This act is effective when it becomes law.

Visitor Sign-in

Senate Committee on Health Care

June 19, 2019 10:00 AM Room 643 LOB

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
Chip Baggett	NCMS
Kara Weishaar	SA
Michael Crowe	NCMS
Peyton Myers	
Jeff Horton	NCSLA
Cliff Gindlin	Novartis
Kirby Consier	Novartis
Hugh Johnson	WellCare
Tracy Kimbrell	Parker Poe
Kari Burgess	BPS
M Hill	Smith
Michael Weber	Smart Start

Visitor Sign-in

Senate Committee on Health Care

June 19, 2019 10:00 AM Room 643 LOB

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY
M. Kat Jarmon	ACP
Andy Ellen	NCRLM
Reska Fortsin	SEANC
Smith Worth	DMH
Neil Rowen	NCMS

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

June 10, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bruce Mildwurf	NCSBA
Amanda Donovan	KTS
Satish Mathan	NCMS
Tracy Bell	NCMS
Lindsay Strowd	NCMS
SueAnn Forest	NCMS
Ryan Hatfield	NCMS / ECU BSOM
Usman Saqib	NCMS / ECU BSOM
Atima Horio	NCMS/ECU BSOM
Veronica Lavelle	NCMS/ECU BSOM
Sarah Walk	MWC
[illegible] Parkinson	Parkinson Law
Ana Valdez	New Frame
Christy Jones	New Frame / NC Head Start Assoc.
[illegible]	NCCCS
[illegible]	CSS
Ross [illegible]	NP

CS Hoffa

CS/A

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

June 10, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joyce Peters	CSS
Jodi Levine	CSM
Connie Wilson	Smart Start Advocate

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 643

DATE: 6-19 **TIME:** 10 AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

Page Name	Hometown	Sponsoring Senator
1. Mia Manicone	Denver	Ballard
2. Nate Bowers	Carrboro	Foushee
3. Alyssa Gross	Cary	Nickel
4. Brook Fowler	Winston-Salem	Krawiec
5. Reagan Bowman	Franklinton	McKissick
6. Will McIntock	Durham	Woodard
7. Kathryn Osterhout	Rocky Mount	Horner
8.		

ages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

Senate Committee on Health Care

DATE: 06-19-2019 **TIME**: 10:00 AM **ROOM**: 643 LOB

SENATE SERGEANT-AT-ARMS

MICHAEL CAVINESS

JOHN ENLOE

BILLY FRITSCHER

Senate Committee on Health Care
Thursday, June 20, 2019 at 10:00 AM
Room 544 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 20, 2019 in Room 544 of the Legislative Office Building. Six members were present.

Senator Joyce Krawiec, Chair, presided.

Thomas Peretti from Wake Forest, Amelia Todd from Wilmington, Brook Fowler from Winston-Salem, Reagan Bowman from Franklinton, Will McClintock from Durham, and Mia Manicone from Denver served as pages.

HB 325 Update Svc & Care Plan Req's/ACH Residents. (Representatives Dobson, White, Barnes, Black)
The PCS was still before the committee. Sen. Jim Davis was recognized. Sen. Krawiec allowed comments from the visitors. Two people offered support to the PCS and they spoke in the following order: Scott Lvetgenan/Medicare Assisted Facilities and Steven Mange from the North Carolina Department of Justice. There were no questions from the members. Sen. Foushee moved unfavorable to the bill – favorable to the PCS and it carried. Sen. Jim Davis will manage the bill during session.

The meeting adjourned at 10:14.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Thursday, June 20, 2019

Senator Krawiec,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

HB **325** **(CS#1)** Update Svc & Care Plan Req's/ACH Residents.

Draft Number:	H325-PCS10671-BC-51
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Jim Davis will handle HB 325



Senate Committee on Health Care
Thursday, June 20, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 325	Update Svc & Care Plan Req's/ACH Residents.	Representative Dobson Representative White Representative Barnes Representative Black

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H D

HOUSE BILL 325
Committee Substitute Favorable 4/15/19
PROPOSED SENATE COMMITTEE SUBSTITUTE H325-CSBC-51 [v.2]
06/18/2019 05:54:09 PM

Short Title: Opioid Epidemic Response Act. (Public)

Sponsors:

Referred to:

March 12, 2019

A BILL TO BE ENTITLED

AN ACT REMOVING THE REQUIREMENT THAT BUPRENORPHINE PRESCRIBERS REGISTER WITH THE STATE, IN ADDITION TO REGISTERING WITH THE FEDERAL GOVERNMENT; DECRIMINALIZING THE USE OF DRUG TESTING EQUIPMENT TO DETECT CONTAMINANTS; BROADENING THE OBJECTIVES OF SYRINGE EXCHANGE PROGRAMS TO ENCOMPASS REDUCING THE NUMBER OF DRUG OVERDOSES IN THE STATE AND REMOVING THE BAN ON THE USE OF STATE FUNDS TO PURCHASE CERTAIN SUPPLIES.

The General Assembly of North Carolina enacts:

PART I. ELIMINATION OF STATE REGISTRATION REQUIREMENT FOR BUPRENORPHINE PRESCRIBERS

SECTION 1.1. G.S. 90-101(a1) is repealed.

PART II. DECRIMINALIZATION OF DRUG TESTING EQUIPMENT USED TO DETECT CONTAMINANTS IN CONTROLLED SUBSTANCES

SECTION 2.1. G.S. 90-113.22 is amended by adding a new subsection to read:

"(d) Notwithstanding the provisions of subsection (a) of this section, it is not unlawful for (i) a person who introduces a controlled substance into his or her body, or intends to introduce a controlled substance into his or her body, to knowingly use, or to possess with intent to use, testing equipment for identifying or analyzing the strength, effectiveness, or purity of that controlled substance; or (ii) a governmental or nongovernmental organization that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors to possess such testing equipment or distribute such testing equipment to a person who intends to introduce a controlled substance into his or her body."

SECTION 2.2. G.S. 90-113.22A is amended by adding a new subsection to read:

"(c) Notwithstanding the provisions of subsection (a) of this section, it is not unlawful for (i) a person who introduces a controlled substance into his or her body, or intends to introduce a controlled substance into his or her body, to knowingly use, or to possess with intent to use, testing equipment for identifying or analyzing the strength, effectiveness, or purity of that controlled substance; or (ii) a governmental or nongovernmental organization that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors to possess such testing equipment or distribute such testing equipment to a person who intends to introduce a controlled substance into his or her body."

PART III. BROADENING THE OBJECTIVES OF SYRINGE EXCHANGE PROGRAMS TO ENCOMPASS REDUCING THE NUMBER OF DRUG OVERDOSES IN THE STATE AND REMOVING THE BAN ON THE USE OF STATE FUNDS TO PURCHASE CERTAIN SUPPLIES.

SECTION 3.1. G.S. 90-113.27 reads as rewritten:

"**§ 90-113.27. Needle and hypodermic syringe exchange programs authorized; limited immunity.**

(a) Any governmental or nongovernmental organization, including a local or district health department or an organization that promotes scientifically proven ways of mitigating health risks associated with drug use and other high-risk behaviors, may establish and operate a needle and hypodermic syringe exchange program. The objectives of the program shall be to do all of the following:

(1) Reduce the spread of HIV, AIDS, viral hepatitis, and other bloodborne diseases in this State.

(2) Reduce needle stick injuries to law enforcement officers and other emergency personnel.

(3) Encourage individuals who ~~inject~~ use drugs illicitly to enroll in evidence-based treatment.

(4) Reduce the number of drug overdoses in this State.

(b) Programs established pursuant to this section shall offer all of the following:

...

(2) Needles, hypodermic syringes, and other injection supplies at no cost and in quantities sufficient to ensure that needles, hypodermic syringes, and other injection supplies are not shared or reused. ~~No State funds may be used to purchase needles, hypodermic syringes, or other injection supplies.~~

...."

PART VI. EFFECTIVE DATE

SECTION 4. This act is effective when it becomes law.

HOUSE BILL 325:
Opioid Epidemic Response Act.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 18, 2019
Introduced by:	Reps. Dobson, White, Barnes, Black	**Prepared by:**	Jessica Boney Staff Attorney
Analysis of:	PCS to Second Edition H325-CSBC-51		

OVERVIEW: The Proposed Committee Substitute (PCS) to House Bill 325 removes the registration requirement for buprenorphine prescribers, decriminalizes the use of drug testing equipment, broadens the objectives of syringe exchange programs, and removes the restriction on using State funds to purchase certain supplies.

BILL ANALYSIS:

The PCS to House Bill 325 does the following:

Part I eliminates the state registration requirement for buprenorphine prescribers.

Part II decriminalizes drug testing equipment used to detect contaminants in controlled substances.

Part III adds reducing the number of drug overdoses in the State to the objectives of syringe exchange programs and removes the restriction on the use of State funds to purchase needles, hypodermic syringes, or other injection supplies.

EFFECTIVE DATE: This act is effective when it becomes law.

Karen Cochrane-Brown
Director

H325-SMBP-48 CSBC-51 -V-1

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

HOUSE BILL 325*
Committee Substitute Favorable 4/15/19

Short Title: Update Svc & Care Plan Req's/ACH Residents. (Public)

Sponsors:

Referred to:

March 12, 2019

A BILL TO BE ENTITLED

AN ACT AUTHORIZING ADULT CARE HOMES TO USE SERVICE PLANS COMPLETED AS THE RESULT OF A MEDICAID PERSONAL CARE SERVICES ASSESSMENT TO FULFILL THE ACTIVITIES OF DAILY LIVING PORTION OF THE REQUIRED SERVICE PLANS OR CARE PLANS FOR ADULT CARE HOME RESIDENTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2.15 reads as rewritten:

"**§ 131D-2.15. Resident assessments.**

(a) Initial Assessment. – The Department shall ensure that facilities conduct and complete an assessment of each resident within 72 hours of admitting the ~~resident and annually thereafter.~~ resident. In conducting the assessment, the facility shall use an assessment instrument ~~approved by the Secretary upon the advice of the Director of the Division of Aging and Adult Services.~~ approved in accordance with rules adopted by the Medical Care Commission. The Department shall provide ongoing training for facility personnel in the use of the approved assessment instrument.

(a1) ~~The~~ Assessment to Develop Service Plans and Care Plans. – Within 30 days of admission, the facility shall ~~use the~~ conduct an assessment to develop appropriate and comprehensive service plans and care plans and to determine the level and type of facility staff that is needed to meet the needs of residents. The assessment shall determine a resident's level of functioning and shall include, but not be limited to, cognitive status and physical functioning in activities of daily living. Activities of daily living are personal functions essential for the health and well-being of the resident. The assessment shall not serve as the basis for medical care. The assessment shall indicate if the resident requires referral to the resident's physician or other appropriate licensed health care professional or community resource.

(a2) Medicaid State Plan Personal Care Services Assessment. – To fulfill the activities of daily living portion of any service plan or care plan required under subsection (a1), or any rules adopted under this Article, the facility may use a service plan that was completed within 35 days of the resident's admission to the facility and represents the result of an assessment to determine the resident's eligibility for personal care services under the Medicaid State Plan. If the facility uses a service plan for personal care services under the Medicaid State Plan developed within 35 days of resident admission, the facility shall be exempt from conducting an assessment of the resident's ability to perform activities of daily living within 30 days of resident admission. For purposes of this subsection, a resident must have received an assessment to develop appropriate and comprehensive service plans and care plans no later than 35 days after resident admission or subsection (a1) applies.

(b) Review. – The Department, as part of its inspection and licensing of adult care homes, shall review assessments and related service plans and care plans for a selected number of residents. In conducting this review, the Department shall ~~determine:~~determine all of the following:

(1) Whether the appropriate assessment instrument was administered and interpreted ~~correctly;~~correctly.

(2) Whether the facility is capable of providing the necessary ~~services;~~services.

(3) Whether the service plan or care plan conforms to the results of an appropriately administered and interpreted ~~assessment; and~~assessment.

(4) Whether the service plans or care plans are being implemented fully and in accordance with an appropriately administered and interpreted assessment.

(c) Penalties. – If the Department finds that the facility is not carrying out its assessment responsibilities in accordance with this section, the Department shall notify the facility and require the facility to implement a corrective action plan. The Department shall also notify the resident of the results of its review of the assessment, service plans, and care plans developed for the resident. In addition to administrative penalties, the Secretary may suspend the admission of any new residents to the facility. The suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removing the suspension."

SECTION 2. G.S. 90-288.14 reads as rewritten:

"**§ 90-288.14. Assisted living administrator certification.**

~~An applicant shall be certified by the~~ The Department shall certify as an assisted living administrator ~~if the~~ any applicant who meets all of the following qualifications:

(1) Is at least 21 years old.

(2) Provides a satisfactory criminal background report from the State Repository of Criminal Histories, which shall be provided by the State Bureau of Investigation upon its receiving fingerprints from the applicant. If the applicant has been a resident of this State for less than five years, the applicant shall provide a satisfactory criminal background report from both the State and National Repositories of Criminal Histories.

(2a) Does not have a substantiated finding of neglect, abuse, misappropriation of property, diversion of drugs, or fraud listed on the Health Care Personnel Registry established under G.S. 131E-256.

(3) ~~Successfully~~ Has a high school diploma and successfully completes the equivalent of two years of coursework at an accredited college or ~~university~~ university, or has a minimum of 60 months of supervisory experience, or has a combination of education and experience as approved by the Department. For purposes of this section, "supervisory experience" means having full-time, direct management responsibility, including some responsibility for hiring and firing, over the equivalent of at least two full-time employees with direct resident care responsibilities. Such supervisory experience shall have been in a licensed adult care home or licensed nursing home within the seven years preceding the date of application.

(4) Successfully completes a Department approved administrator-in-training program of at least 120 hours of study in courses relating to assisted living residences.

(5) Successfully completes a written examination administered by the Department."

SECTION 3. This act is effective when it becomes law.

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

June 20, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NWC
LT McCrimmon	Gov Office
Susan Kansagra	DHHS
Elyse Powell	DHHS
ALAN DELLAPENNA	DMHS
Steven Mange	DOJ
Haley Gintis	DOJ
Larkin Turman	DMH/DD/SAS
Aaron Harding	Cardinal Innovations Healthcare
TRACY Colvard	AARP
David Powers	PSLC
Sal Lopez	CSH
Matt Gray	DHHS
Abby Emanuelson	NMSS
Anna McDonald	DHHS

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

June 20, 2019

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Marissa Turner	TSS
Ken Melton	K.M.A.
Dodie Renfer	Nelson Mullins
[illegible]	[illegible]
[illegible]	CSS
[illegible]	[illegible]
[illegible]	[illegible]
[illegible]	CSS
Smith Worth	DMH / SOTA
[illegible]	NCMS
[illegible]	CLA
[illegible]	CSS

09-21-201

Senate Pages Attending

COMMITTEE: Health Care ROOM: 643

DATE: 6-20 TIME: 10AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

	Page Name	Hometown	Sponsoring Senator
1.	Thomas Puratti	Wakeforest	Wells
2.	Amelia Todd	Wilmington	Peterson
3.	Brook Fowler	Winston-Salem	Krawiec
4.	Reagan Bowman	Franklinton	McKissick
5.	Will McClintock	Durham	Woodard
6.	Mia Manicone	Denver	Ballard
7.			
8.			

Pages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee on Healthcare

June 20, 2019 10:00 AM Rm. LOB ~~643~~ 544

Senate Sergeant-At-Arms

Billy Fritscher

Archie Smith

Michael Caviness

Senate Committee on Health Care
Wednesday, June 26, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 26, 2019, in Room 643 of the Legislative Office Building. Eleven members were present.

Senator Dan Bishop, Chair, presided.

Louis Blanton sponsored by Sen. McKissick, Sara Lennon sponsored by Sen. McKissick, Dylan Thiessen sponsored by Sen. Rabon, Brooke Walls sponsored by Sen. J. Alexander, Tania Hunter sponsored by Sen. Smith, and Sydney Stathopoulos sponsored by Sen. Rabon served as pages.

HB 106 - Inmate Health Care (Representatives Horn, Farmer-Butterfield, Lucas, R. Turner) - FOR DISCUSSION ONLY

Sen. Bishop recognized Sen. Krawiec. Sen. Krawiec moved to put a proposed committee substitute to come before the committee and then to amend the proposed committee substitute. Theresa Matula of the Legislative Analysis Division was recognized to explain the amendment. The amendment passed. Rep. Horn was recognized to explain the bill. Sen. Bishop noted that the proposed committee substitute was still before the committee to be taken up at a later time.

HB 126 - Organ & Tissue Donation/Heart Heroes (Representatives Murphy, Dobson, Potts, Sasser) - FOR DISCUSSION ONLY (Title changed to Amend Certificate of Need Laws)

Sen. Krawiec moved for a proposed committee substitute to come before the committee. Sen. Perry moved to amend the bill. Sen. Bishop then recognized Sen. Perry to explain the amendment. The amendment passed.

Sen. Krawiec was recognized to explain the bill. Sen. Burgin was also recognized to explain the bill. Questions from members and the public were answered by Sen. Krawiec and Sen. Burgin. Sen. Bishop allowed five people to speak from the audience and they were as follows: Leah Burns of the North Carolina Healthcare Association, Tracy Kimbrell representing Universal Health Services, Connie Wilson representing the North Carolina Orthopedic Association, John Bode representing the North Carolina Radiologists, and Sandy Sands representing Fresenius Medical Care.

The meeting adjourned at 10:41 AM.

Senator Dan Bishop, Chair
Presiding

John Wynne, Committee Clerk

Senate Committee on Health Care
Wednesday, June 26, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 106	Inmate Health Care.	Representative Horn Representative Farmer-Butterfield Representative Lucas Representative R. Turner
HB 126	Organ & Tissue Donation/Heart Heroes.	Representative Murphy Representative Dobson Representative Potts Representative Sasser

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H D

HOUSE BILL 106
Committee Substitute Favorable 3/26/19
Committee Substitute #2 Favorable 4/26/19
Committee Substitute #3 Favorable 5/6/19
PROPOSED SENATE COMMITTEE SUBSTITUTE H106-CSSH-18 [v.3]
06/25/2019 05:36:18 PM

Short Title: Inmate Health Care & 340B Program. (Public)

Sponsors:

Referred to:

February 20, 2019

A BILL TO BE ENTITLED

AN ACT TO IMPROVE INMATE HEALTH CARE REIMBURSEMENT AND INTERNAL PROCESSES AND TO ESTABLISH A TELEMEDICINE PILOT PROGRAM; IN ADDITION TO DIRECTING THE DEPARTMENT OF PUBLIC SAFETY TO PARTNER WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THE PURCHASE OF CERTAIN MEDICATIONS FOR INMATES, TO DIRECT THE DEPARTMENT OF PUBLIC SAFETY TO ISSUE REQUESTS FOR PROPOSALS FOR PARTNERSHIPS BETWEEN NORTH CAROLINA 340B PROGRAM ENTITIES AND THE FOUR NORTH CAROLINA PRISON REGIONS, TO DIRECT THE DEPARTMENT OF PUBLIC SAFETY TO PARTNER WITH THE UNIVERSITY OF NORTH CAROLINA HEALTH SYSTEM TO SHIFT PRESCRIBING AUTHORITY ON CERTAIN MEDICATIONS, AND TO DIRECT THE DEPARTMENT OF PUBLIC SAFETY TO SUBMIT VARIOUS REPORTS TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON JUSTICE AND PUBLIC SAFETY AND THE FISCAL RESEARCH DIVISION.

The General Assembly of North Carolina enacts:

PART I. INMATE HEALTH CARE REIMBURSEMENT AND INTERNAL PROCESSES AND TELEMEDICINE PILOT

SECTION 1.(a) To contain medical costs for inmates as required by G.S. 143B-707.3(b), the Department of Public Safety shall develop a plan to increase the use of the Central Prison Healthcare Complex (hereinafter "CPHC") which shall include all of the following:

(1) Strategies, policies, and oversight mechanisms to ensure that non-life-threatening emergencies for male inmates within a 60-mile radius of Raleigh are treated at the CPHC urgent care facility. As part of this effort, DPS shall consider the use of telemedicine.

(2) A cost comparison of health care services performed at CPHC and the North Carolina Correctional Institution for Women (hereinafter "NCCIW") and health care services performed by outside contracted providers. The cost comparison shall include the cost of transporting inmates to and from outside contracted providers.

(3) A comprehensive review of the current usage of health care facilities at CPHC and NCCIW and the potential to maximize usage of those facilities through

(i) increasing the usage of CPHC's facilities for general anesthesia procedures and increasing usage of existing on-site equipment, (ii) selling equipment no longer in use or not in use due to staffing changes, (iii) increasing the provision of health care services available at CPHC to female inmates, and (iv) identifying potential CPHC expenditures that would ultimately result in demonstrated cost savings.

(4) Methods to contain costs for palliative and long-term health care services for inmates.

SECTION 1.(b) By December 1, 2019, the Department of Public Safety shall submit the plan required by subsection (a) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety. The Department of Public Safety shall also submit its progress made in achieving cost savings under the plan, the amount of any actual and estimated cost savings, and any obstacles to increasing the usage of the health services facilities at CPHC and NCCIW.

SECTION 2.(a) G.S. 143B-707.3(c) reads as rewritten:

"(c) The Department of Public Safety shall report quarterly to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on:

...

(10) The reimbursement rate for contracted providers. The Department shall randomly audit high-volume contracted providers to ensure adherence to billing at the contracted rate.

Reports submitted on August 1 shall include totals for the previous fiscal year for all the information requested."

SECTION 2.(b) By February 1, 2020, the Department of Public Safety, Health Services Section, shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and to the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on alternative methods for reimbursing providers and facilities that provide approved medical services to inmates, including Medicare rates.

SECTION 3.(a) Subpart A of Part 2 of Article 13 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"**§ 143B-707.5. Medicaid services for inmates.**

(a) The Department of Public Safety and the Department of Health and Human Services shall work together to enable social workers in the Department of Public Safety, Health Services Section, to qualify for and receive federal reimbursement for performing administrative activities related to Medicaid eligibility for inmates. The Department of Public Safety, Health Services Section, shall develop policies and procedures to account for the time social workers in the Health Services Section spend on administrative activities related to Medicaid eligibility for inmates. All social workers in the Health Services Section who perform administrative activities related to Medicaid eligibility shall be required to receive eligibility determination training provided by the Department of Health and Human Services at least quarterly.

(b) The Department of Public Safety, Health Services Section, shall require each social worker performing administrative activities related to Medicaid eligibility for inmates to document the following:

(1) The criteria used by the social worker when deciding to submit an application for Medicaid and when deciding not to submit an application for Medicaid, including any information the social worker believes disqualifies the inmate for Medicaid benefits.

(2) An indication in the social worker's data entry of an inmate's Medicaid eligibility as determined by the inmate's county department of social services.

(3) The number of 24-hour community provider stays prescreened for potential applications, the number of applications submitted, and the number and

percentage of applications approved, denied, and withdrawn, which shall be reported to the Health Services Section Director on a monthly basis.

(c) In addition to the requirements in subsection (b) of this section, each Department of Public Safety, Health Services Section, social workers performing administrative activities related to Medicaid eligibility for inmates shall submit Medicaid applications and any supporting documents electronically through the ePass portal in the Department of Health and Human Services or through other electronic means, unless paper copies are required by federal law or regulation."

SECTION 3.(b) By October 1, 2019, and quarterly thereafter until full implementation is achieved, the Department of Public Safety and the Department of Health and Human Services shall jointly report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Medicaid and North Carolina Health Choice on progress in receiving federal reimbursement for performing administrative activities related to Medicaid eligibility for inmates.

SECTION 3.(c) By October 1, 2019, the Department of Public Safety shall report to the Joint Legislative Oversight Committee on Justice and Public Safety on the implementation of the documentation of criteria for the submission of Medicaid applications and the electronic submission of Medicaid applications.

SECTION 3.(d) This section becomes effective October 1, 2019.

SECTION 4. The Department of Public Safety, Health Services Section, shall issue two requests for proposals (RFP) to develop an electronic supply inventory management system. One RFP shall be for a system to be used at all prison facilities and one RFP shall be for a system to be used exclusively at the Central Prison Healthcare Complex and the North Carolina Correctional Institution for Women. The RFPs shall be for an electronic supply inventory management system that is capable of all of the following:

(1) Recording the arrival and departure of each medical supply in use or for future use from the point of order, including all methods of requisition and main storage locations (e.g., warehouse, secondary storage location, prison unit, or infirmary).

(2) Recording the dates on which a medical supply was physically at each transition point, including the date of use or disposal.

(3) Identifying Department employees who have custody of or control over a medical supply at each transition point, including at the time of use or disposal.

(4) Ensuring that medical supplies are used prior to their expiration date.

(5) Ensuring an adequate supply of each medical product currently being used or obtained for future use at each facility. Adequate supply level shall be based on usage of each medical product by each facility.

(6) Biannually assessing the need for particular medical supplies and the accuracy of records through an audit of the system.

The Department shall report the results of the RFPs to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety by December 1, 2019.

SECTION 5.(a) The Department of Public Safety, Health Services Section, and the Office of State Human Resources shall jointly study the salaries of all in-prison health services employees to determine what adjustments are necessary to increase the salaries of new hires and existing employees of the Health Services Section to market rates.

SECTION 5.(b) The Department of Public Safety shall establish a vacancy rate benchmark for each correctional facility and shall create a plan to reduce the vacancy rates. The Department shall consider initiatives to reduce vacancy rates, including the following:

(1) Increasing salaries to market rates.

(2) Creating a student loan forgiveness program for the Health Services Section.
(3) Offering signing bonuses and annual cash incentives.
(4) Increasing the use of telemedicine positions.
(5) Creating dual appointment opportunities for doctors currently employed by the State.
(6) Offering differential pay for health services workers employed in difficult-to-staff facilities.
(7) Streamlining and potentially eliminating duplicative or unnecessary steps in the hiring process.

SECTION 5.(c) The Department of Public Safety shall establish methods to measure the effectiveness of the initiatives to reduce vacancy rates required in subsection (b) of this section and estimate the budgetary impact and anticipated savings from the Department's reduced reliance on outside contracted providers. By February 1, 2020, the Department shall submit its findings on salaries and vacancy rates, including any proposed legislation and the need for assistance required from the Office of Human Resources and the Office of Rural Health in the Department of Health and Human Services to accomplish the objectives outlined in subsections (a) and (b) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety.

SECTION 6.(a) By August 1, 2019, the Department of Public Safety, Health Services Section, shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on the feasibility study of telehealth services referenced in the February 2019 Memorandum of Agreement between the Department and UNC Health Care.

SECTION 6.(b) The Department of Public Safety, Health Services Section, shall establish a telemedicine pilot program to provide physical health services to inmates in remote correctional facilities. The pilot program shall be established with consideration of the results of the study referenced in subsection (a) of this section. The goal of the pilot program is to assess whether the use of telemedicine decreases costs for inmate transportation, custody, and outside providers while improving access to care. While designing the telemedicine pilot program, the Department of Public Safety, Health Services Section, shall consult UNC Health Care; the 2012 University of North Carolina, Kenan-Flagler Business School report on telemedicine; and Finding 6, Report Number 2018-08, from the Joint Legislative Program Evaluation Oversight Committee. The telemedicine pilot program shall initially be established in two correctional facilities serving male inmates. One pilot site shall be located in a correctional facility in the eastern portion of the State and one pilot site shall be located in a correctional facility in the western portion of the State. The pilot program design must connect the two correctional facility pilot sites with the Central Prison Healthcare Complex and its contracted providers' facilities and shall be operational on or before January 1, 2020.

SECTION 6.(c) The ability to assess, measure, and evaluate the telemedicine pilot program shall be integral to the pilot program design. Assessment of the pilot program shall include, but is not limited to, the following measures for each correctional facility pilot site:

(1) Number and cost of telemedicine encounters by service area.
(2) Comparison of the number and cost of telemedicine encounters, by service area, to:
    a. The number of in-person encounters provided the previous year to inmates housed at that facility; and
    b. The number of in-person encounters provided during the pilot period at similar correctional facilities not participating in the pilot.
(3) Comparison of the number of days lapsed between referral date and treatment date, by service area, to:
    a. The number of days lapsed the previous year in that facility; and

b. The number of days lapsed during the pilot period at similar correctional facilities not participating in the pilot.

(4) Amount of inmate transportation and custody costs avoided from receiving telemedicine.

(5) Amount of provider transportation costs avoided from providing telemedicine.

(6) Cost of initial telemedicine equipment and other related costs with descriptions.

(7) Obstacles and concerns related to expanding telemedicine to other correctional facilities.

SECTION 6.(d) On or before January 1, 2020, the Department of Public Safety, Health Services Section, shall provide an interim report on the assessment criteria outlined in subsection (c) of this section, including any additional findings and recommendations, to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Health and Human Services. On or before January 1, 2021, the Department of Public Safety, Health Services Section, shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Health and Human Services on the assessment criteria outlined in subsection (c) of this section, including any additional findings, and shall make recommendations on whether to expand the telemedicine pilot program to additional sites, including accompanying costs and anticipated savings, and recommendations on which correctional facilities would be most advantageous to include in the pilot due to lack of access or costs associated with transportation and custody.

PART II. FEDERAL 340B PROGRAM

SECTION 7.(a) The Department of Public Safety (DPS) shall establish and implement a partnership with the Department of Health and Human Services (DHHS) in order for DPS to be eligible to operate as a 340B covered entity. The Department of Public Safety shall contract for consultant services in order to implement this section. In order to implement the requirements of this section, DPS shall do all of the following:

(1) Submit an application during the next registration period to enroll in the federal 340B Program found in section 340B of the Public Health Service Act (the "340B Program") to be able to access 340B Program pricing for medications used to treat the human immune deficiency virus (HIV), the hepatitis C virus (HCV), and eligible sexually transmitted diseases (STD).

(2) Provide DHHS all data and necessary documentation as frequently as such information is needed by DHHS for the implementation of this section.

(3) Ensure that the DPS Apex Central Pharmacy, and any other DPS pharmacies necessary, are compliant dispensing pharmacies under the 340B Program.

(4) Coordinate with one or more vendors to purchase STD 340B Program medications that result in the greatest overall cost savings available to the state, whether such savings are achieved by 340B Program pricing, non-340B Program volume discounts, or a combination of both.

(5) Develop a separate inventory to track 340B Program medications.

SECTION 7.(b) The Department of Public Safety shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Fiscal Research Division by October 1, 2019, regarding the implementation of this section.

SECTION 8.(a) The Department of Public Safety shall develop a plan by December 1, 2019, to issue Requests for Proposals (RFP) as required by this section. The plan to issue RFPs shall, at a minimum, address the following:

(1) The hiring of a consultant to manage the RFP process from issuance to conclusion.

(2) The hiring of the same consultant hired for the RFP process to work with the selected 340B Program entities and DPS to implement the requirements of this section.

(3) The estimated costs for DPS to hire the consultant, issue the RFPs, evaluate RFP proposals, and implement the 340B Program correctional partnerships.

SECTION 8.(b) Regarding the RFPs in subsection 8.(a) of this section, the Department of Public Safety shall issue one RFP for each of the four prison regions. The RFPs shall seek partnerships between the prison regions and one or more 340B Program entities in the State in order to provide specialty treatment for high-cost medical conditions, and shall express a preference for bidding entities that would use DPS as a contract pharmacy for 340B Program medications. Entities interested in providing telemedicine services may bid on more than one prison region. Each RFP shall, at a minimum, require that an entity's bid include the following:

(1) An explanation of the bidding entity's ability to purchase the following:

a. Medications that treat chronic obstructive pulmonary disease (COPD), asthma, rheumatology, multiple sclerosis, mental health conditions, epilepsy, and cardiovascular disease or hypertension.

b. Factor products for inmates with hemophilia.

c. Oral suppressive therapy medications for inmates with cancer.

d. Biologics for inmates with inflammatory diseases such as Crohn's disease, irritable bowel syndrome, and rheumatoid arthritis.

e. Brand name inhalers for inmates with COPD and asthma.

f. Psychotropic drugs for inmates with schizophrenia, bipolar disorder, and other mental health conditions.

(2) A commitment, as a 340B Program covered entity, to purchase medications under the 340B Program on behalf of DPS and to pass all related savings on to the State.

(3) A description of the 340B Program correctional partnership model the bidding entity would use based on the seven correctional partnership models provided in Appendix C of the North Carolina General Assembly Report on Recommendations for a 340B Correctional Partnership on North Carolina issued on May 20, 2019. This description should also include, to the extent possible, potential savings and costs that would be realized under the chosen model.

(4) An explanation of the manner in which specialty care and 340B pharmacy services will be provided. Services shall be provided in a manner that improves or maintains quality and continuity of patient care.

SECTION 8.(c) The Department of Public Safety shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Fiscal Research Division by December 1, 2019 on the plan described in subsection 8.(a) of this section, and quarterly thereafter until RFPs for all prison regions are awarded, regarding the implementation of this section.

SECTION 9.(a) The Department of Public Safety shall partner with the University of North Carolina Healthcare System (UNC-HCS) by July 1, 2019, to begin receiving all 340B Program savings realized from medications prescribed to inmates at a 340B Program-registered UNC-HCS site for non-HIV and non-HCV medications.

SECTION 9.(b) Pursuant to subsection (c) of this section, DPS shall direct that the prescribing authority of DPS providers be transferred to UNC-HCS providers for identified inmates treated at a 340B Program-registered UNC-HCS site.

SECTION 9.(c) By October 1, 2019, DPS and UNC-HCS shall:

(1) Identify the UNC-HCS inmate patients for whom shifting prescriptive authority to UNC-HCS is feasible and appropriate.

(2) Establish a method for improving or maintaining quality and continuity of patient care once the prescriptive authority has shifted to UNC-HCS.

(3) Develop mechanisms to ensure that the communication between the UNC-HCS prescriber and the DPS physician maintains the quality and continuity of care that inmates currently receive.

(4) Select the UNC-HCS pharmacy, the DPS Apex Central Pharmacy, or a combination of both, as the pharmacy through which medications will be dispensed pursuant to this section.

SECTION 9.(d) The Department of Public Safety and UNC-HCS shall establish a Memorandum of Agreement to require UNC-HCS to pass through all of the 340B Program savings for medications referenced in this section.

SECTION 9.(e) The Department of Public Safety and UNC-HCS shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Fiscal Research Division by October 1, 2019, and monthly thereafter until implementation, regarding the progress made toward implementing the requirements of this section.

SECTION 10. Article 13 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"**§ G.S. 143B 707.5. Reports related to the federal 340B Program.**

(a) The Department of Public Safety shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Fiscal Research Division by October 1, 2020, and annually thereafter, regarding

(1) Savings achieved from its partnership with the Department of Health and Human Services for the purchasing of certain medications for inmates under the federal 340B Program.

(2) Savings achieved from its partnership with the University of North Carolina Healthcare System for the provision of inmate medications and services under the federal 340B Program.

(b) The Department of Public Safety shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Fiscal Research Division by October 1, 2021, and annually thereafter, on savings achieved from the partnerships between the four prison regions and North Carolina 340B Program entities for the provision of inmate medications and services under the federal 340B Program."

SECTION 11. Except as otherwise provided, this act is effective when it becomes law.

HOUSE BILL 106:
Inmate Health Care & 340B Program.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Judiciary. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 25, 2019
Introduced by:	Reps. Horn, Farmer-Butterfield, Lucas, R. Turner	**Prepared by:**	Theresa Matula * Legislative Analyst
Analysis of:	PCS to Fourth Edition H106-CSSH-18		

OVERVIEW: Part I (Inmate Health Care Reimbursement and Internal Processes and Telemedicine Pilot) of the PCS for House Bill 106 would do the following as it relates to inmate health care: require the Department of Public Safety (DPS) to develop a plan to increase the use of the Central Prison Healthcare Complex and to submit the plan Joint Legislative Oversight Committee on Justice and Public Safety; require a quarterly report on the reimbursement rate for contracted providers; add a new statute pertaining to Medicaid services for inmates and require progress reports; require the issuance of two Requests for Proposals (RFP) to develop an electronic inventory system for medical supplies; require DPS to study and develop initiatives pertaining to the salaries of all in-prison health services employees; and require the establishment of a telemedicine pilot program to provide physical health services to inmates. Part II (Federal 340B Program) of the PCS would require DPS to partner with the Department of Health and Human Services to access medication pricing under the federal 340B Program, require DPS to issue a RFP for partnerships between entities covered under the federal 340B Program and four prison regions, require DPS to develop a Memorandum of Agreement with the University of North Carolina Healthcare Services for the 340B Program, require periodic reporting, and codify reporting requirements. The content of HB 106 is based on recommendations contained in reports by the Program Evaluation Division.

BILL ANALYSIS: <u>PART I:</u> Inmate Health Care Reimbursement and Internal Processes and Telemedicine Pilot

Section 1 requires the Department of Public Safety to develop a plan to increase the use of the Central Prison Healthcare Complex (CPHC) and to submit this plan, including cost savings, and utilization barriers for CPHC and NCCIW, to the Joint Legislative Oversight Committee on Justice and Public Safety by December 1, 2019. Plan requirements include:

- Strategies, policies, and oversight mechanisms to ensure that non-life-threatening emergencies for male inmates within a 60-mile radius of Raleigh are treated at the CPHC urgent care facility, including the considering the use of telemedicine.
- A cost comparison of health care services performed at CPHC and the North Carolina Correctional Institution for Women (hereinafter "NCCIW") and health care services performed by outside contracted providers, including inmate transportation costs.
- A review of the usage at CPHC and NCCIW and the potential to maximize usage of those facilities through (i) increasing the usage of CPHC's facilities for general anesthesia procedures and increasing usage of existing on-site equipment, (ii) selling equipment no longer in use or not in use due to staffing changes, (iii) increasing the provision of health care services available at CPHC to female

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

inmates, and (iv) identifying potential CPHC expenditures that would ultimately result in demonstrated cost savings.

- Methods to contain costs for palliative and long-term health care services for inmates.

Section 2 requires a quarterly report on the reimbursement rate for contracted providers, and requires a report on alternative methods for reimbursing providers and facilities.
Highlights are as follows:

- Requires the Department of Public Safety to provide a quarterly report on the reimbursement rate for contracted providers to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety.
- Requires the Department of Public Safety to report to Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on alternative methods for reimbursing providers and facilities that provide approved medical services to inmates, including Medicare rates.

Section 3 adds a new statute pertaining to Medicaid services for inmates and requires progress reports. **Section 3(a)** requires the Departments of Public Safety and Health and Human Services to work together to ensure social workers in the Department of Public Safety, Health Services Section: 1) receive Medicaid eligibility determination training on at least a quarterly basis, and 2) qualify for and receive federal reimbursement for performing administrative activities related to Medicaid eligibility for inmates. Social workers in the Department of Public Safety, Health Services Section are required to report activities related to administrative activities related to Medicaid eligibility for inmates. In addition, social workers performing Medicaid eligibility activities in the Health Services Section must submit Medicaid applications and supporting documents electronically, unless prohibited. **Section 3(b)** requires the Departments of Public Safety and Health and Human Services to jointly report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on progress in receiving federal reimbursement for performing administrative activities related to Medicaid eligibility for inmates. This reporting begins October 1, 2019 and continues on a quarterly basis until full implementation is achieved. **Section 3(c)** requires the Department of Public Safety to report to the Joint Legislative Oversight Committee on Justice and Public Safety on the implementation of the documentation of criteria for the submission of Medicaid applications and the electronic submission of Medicaid applications. The report is required by October 1, 2019. Section 3 becomes effective October 1, 2019

Section 4 requires the Department of Public Safety to issue two RFPs for develop an electronic inventory system for medical supplies. One RFP is for a system to be used at all prison facilities, and one RFP is for a system to be used exclusively at the Central Prison Healthcare Complex and the North Carolina Correctional Institution for Women. The Department shall report the results of the RFPs to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety by December 1, 2019.

Section 5 requires the Department of Public Safety to study and develop initiatives pertaining to the salaries of all in-prison health services employees. **Section 5(a)** requires the Department of Public Safety, Health Services Section, and the Office of State Human Resources, to jointly study the salaries of all in-prison health services employees to determine what adjustments are necessary to increase the salaries of new hires and existing employees of the Health Services Section to market rates. **Section 5(b)** requires the Department to establish a vacancy rate benchmark for each correctional facility to create a plan to reduce the vacancy rates including certain initiatives. **Section 5(c)** requires the Department to establish

methods to measure the effectiveness of the initiatives to reduce vacancy rates required in subsection (b) and estimate the budgetary impact and anticipated savings. The Department is required submit its findings on salaries and vacancy rates, including any proposed legislation and the need for assistance required from the Office of Human Resources and the Office of Rural Health in the Department of Health and Human Services, to accomplish the objectives outlined in subsections (a) and (b) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety by February 1, 2020.

Section 6 requires the Department of Public Safety, Health Services Section to report on the feasibility study referenced in the current contract with UNC Health Care, and establish a telemedicine pilot program to provide physical health services to inmates. **Section 6(a)** requires the Department of Public Safety, Health Services Section to report to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on the feasibility study of telehealth services referenced in the February 2019 Memorandum of Agreement between the Department and UNC Health Care. **Section 6(b)** requires the establishment of a telemedicine pilot program. Two correctional facilities shall be selected for the pilot, one in the eastern part of the State and one in the western part of the State. The ability to assess, measure, and evaluate the pilot program must be an integral part of the program design and **Section 6(c)** outlines measures for each pilot site. **Section 6(d)** requires an interim report on or before January 1, 2020, and another report on or before January 1, 2021, to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Health and Human Services.

PART II of the PCS, **Federal 340B Program**, was not initially included in HB 106.

Section 7 would require DPS to partner with the Department of Health and Human Services to be able to access medication pricing under the federal 340B Program for medications used to treat the human immune deficiency virus (HIV), the hepatitis C virus (HCV), and eligible sexually transmitted diseases (STDs). The section would also require DPS to report October 1, 2019, on the implementation of this section.

Section 8 would require DPS to prepare a plan for and issue Requests for Proposals (RFPs) seeking partnerships between North Carolina entities covered under the federal 340B Program and North Carolina's four prison regions in order for DPS to avail itself of 340B Program savings through medications and treatments prescribed at these partner entities. Additionally, it would also require DPS to report on December 1, 2019, regarding its plan for the issuing of RFPs.

Section 9 would require DPS to develop a Memorandum of Agreement (MOA) with the University of North Carolina Healthcare Services (UNC-HCS) to allow DPS to avail itself of federal 340B Program medication savings when medications are prescribed at a 340B Program-registered UNC-HCS site. It would also require DPS and UNC-HCS to develop a plan for the shifting of prescription authority from DPS to UNC-HCS when this would be most cost effective. Both DPS and UNC-HCS would be directed to report on October 1, 2019, regarding the plan and methods of implementation of shifting prescription authority.

Section 10 would codify annualized reporting requirements for DPS beginning on October 1, 2020, regarding savings realized by the State based upon the actions taken as a result of Sections 7, 8, and 9.

EFFECTIVE DATE: Except as otherwise provided, this act would become effective when it becomes law.

BACKGROUND: **Part I** of House Bill 106 includes recommendations from the Joint Legislative Program Evaluation Oversight Committee. For more information, Improvements to Inmate Healthcare Reimbursement and Internal Processes Could Save $5.6 Million Annually.

Part II of House Bill 106 is a result of the Program Evaluation Division's, Final Report to the Joint Legislative Program Evaluation Oversight Committee (Report 2018-09) entitled, "Modifications to Inmate Pharmacy Purchasing and Monitoring Could Save $13.4 Million Annually."

**Susan Sitze and Jacob Davis, staff attorneys, and Brent Lucas, PED staff, substantially contributed to this summary.*

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H 4

HOUSE BILL 106*
Committee Substitute Favorable 3/26/19
Committee Substitute #2 Favorable 4/26/19
Committee Substitute #3 Favorable 5/6/19

Short Title: Inmate Health Care. (Public)

Sponsors:

Referred to:

February 20, 2019

A BILL TO BE ENTITLED

AN ACT TO IMPROVE INMATE HEALTH CARE REIMBURSEMENT AND INTERNAL PROCESSES AND TO ESTABLISH A TELEMEDICINE PILOT PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) To contain medical costs for inmates as required by G.S. 143B-707.3(b), the Department of Public Safety shall develop a plan to increase the use of the Central Prison Healthcare Complex (hereinafter "CPHC") which shall include all of the following:

(1) Strategies, policies, and oversight mechanisms to ensure that non-life-threatening emergencies for male inmates within a 60-mile radius of Raleigh are treated at the CPHC urgent care facility. As part of this effort, DPS shall consider the use of telemedicine.

(2) A cost comparison of health care services performed at CPHC and the North Carolina Correctional Institution for Women (hereinafter "NCCIW") and health care services performed by outside contracted providers. The cost comparison shall include the cost of transporting inmates to and from outside contracted providers.

(3) A comprehensive review of the current usage of health care facilities at CPHC and NCCIW and the potential to maximize usage of those facilities through (i) increasing the usage of CPHC's facilities for general anesthesia procedures and increasing usage of existing on-site equipment, (ii) selling equipment no longer in use or not in use due to staffing changes, (iii) increasing the provision of health care services available at CPHC to female inmates, and (iv) identifying potential CPHC expenditures that would ultimately result in demonstrated cost savings.

(4) Methods to contain costs for palliative and long-term health care services for inmates.

SECTION 1.(b) By December 1, 2019, the Department of Public Safety shall submit the plan required by subsection (a) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety. The Department of Public Safety shall also submit its progress made in achieving cost savings under the plan, the amount of any actual and estimated cost savings, and any obstacles to increasing the usage of the health services facilities at CPHC and NCCIW.

SECTION 2.(a) G.S. 143B-707.3(c) reads as rewritten:

"(c) The Department of Public Safety shall report quarterly to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on:

...

(10) The reimbursement rate for contracted providers. The Department shall randomly audit high-volume contracted providers to ensure adherence to billing at the contracted rate.

Reports submitted on August 1 shall include totals for the previous fiscal year for all the information requested."

SECTION 2.(b) By February 1, 2020, the Department of Public Safety, Health Services Section, shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and to the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on alternative methods for reimbursing providers and facilities that provide approved medical services to inmates, including Medicare rates.

SECTION 3.(a) Subpart A of Part 2 of Article 13 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"**§ 143B-707.5. Medicaid services for inmates.**

(a) The Department of Public Safety and the Department of Health and Human Services shall work together to enable social workers in the Department of Public Safety, Health Services Section, to qualify for and receive federal reimbursement for performing administrative activities related to Medicaid eligibility for inmates. The Department of Public Safety, Health Services Section, shall develop policies and procedures to account for the time social workers in the Health Services Section spend on administrative activities related to Medicaid eligibility for inmates. All social workers in the Health Services Section who perform administrative activities related to Medicaid eligibility shall be required to receive eligibility determination training provided by the Department of Health and Human Services at least quarterly.

(b) Beginning July 1, 2019, the Department of Public Safety, Health Services Section, shall require each social worker performing administrative activities related to Medicaid eligibility for inmates to document the following:

(1) The criteria used by the social worker when deciding to submit an application for Medicaid and when deciding not to submit an application for Medicaid, including any information the social worker believes disqualifies the inmate for Medicaid benefits.

(2) An indication in the social worker's data entry of an inmate's Medicaid eligibility as determined by the inmate's county department of social services.

(3) The number of 24-hour community provider stays prescreened for potential applications, the number of applications submitted, and the number and percentage of applications approved, denied, and withdrawn, which shall be reported to the Health Services Section Director on a monthly basis.

(c) Beginning October 1, 2019, in addition to the requirements in subsection (b) of this section, each Department of Public Safety, Health Services Section, social workers performing administrative activities related to Medicaid eligibility for inmates shall submit Medicaid applications and any supporting documents electronically through the ePass portal in the Department of Health and Human Services or through other electronic means, unless paper copies are required by federal law or regulation."

SECTION 3.(b) By October 1, 2019, and quarterly thereafter until full implementation is achieved, the Department of Public Safety and the Department of Health and Human Services shall jointly report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Medicaid and North Carolina Health Choice on progress in receiving federal reimbursement for performing administrative activities related to Medicaid eligibility for inmates.

SECTION 3.(c) By October 1, 2019, the Department of Public Safety shall report to the Joint Legislative Oversight Committee on Justice and Public Safety on the implementation of the documentation of criteria for the submission of Medicaid applications and the electronic submission of Medicaid applications.

SECTION 4. The Department of Public Safety, Health Services Section, shall issue two requests for proposals (RFP) to develop an electronic supply inventory management system. One RFP shall be for a system to be used at all prison facilities and one RFP shall be for a system to be used exclusively at the Central Prison Healthcare Complex and the North Carolina Correctional Institution for Women. The RFPs shall be for an electronic supply inventory management system that is capable of all of the following:

(1) Recording the arrival and departure of each medical supply in use or for future use from the point of order, including all methods of requisition and main storage locations (e.g., warehouse, secondary storage location, prison unit, or infirmary).

(2) Recording the dates on which a medical supply was physically at each transition point, including the date of use or disposal.

(3) Identifying Department employees who have custody of or control over a medical supply at each transition point, including at the time of use or disposal.

(4) Ensuring that medical supplies are used prior to their expiration date.

(5) Ensuring an adequate supply of each medical product currently being used or obtained for future use at each facility. Adequate supply level shall be based on usage of each medical product by each facility.

(6) Biannually assessing the need for particular medical supplies and the accuracy of records through an audit of the system.

The Department shall report the results of the RFPs to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety by December 1, 2019.

SECTION 5.(a) The Department of Public Safety, Health Services Section, and the Office of State Human Resources shall jointly study the salaries of all in-prison health services employees to determine what adjustments are necessary to increase the salaries of new hires and existing employees of the Health Services Section to market rates.

SECTION 5.(b) The Department of Public Safety shall establish a vacancy rate benchmark for each correctional facility and shall create a plan to reduce the vacancy rates. The Department shall consider initiatives to reduce vacancy rates, including the following:

(1) Increasing salaries to market rates.

(2) Creating a student loan forgiveness program for the Health Services Section.

(3) Offering signing bonuses and annual cash incentives.

(4) Increasing the use of telemedicine positions.

(5) Creating dual appointment opportunities for doctors currently employed by the State.

(6) Offering differential pay for health services workers employed in difficult-to-staff facilities.

(7) Streamlining and potentially eliminating duplicative or unnecessary steps in the hiring process.

SECTION 5.(c) The Department of Public Safety shall establish methods to measure the effectiveness of the initiatives to reduce vacancy rates required in subsection (b) of this section and estimate the budgetary impact and anticipated savings from the Department's reduced reliance on outside contracted providers. By February 1, 2020, the Department shall submit its findings on salaries and vacancy rates, including any proposed legislation and the need for assistance required from the Office of Human Resources and the Office of Rural Health in the

Department of Health and Human Services to accomplish the objectives outlined in subsections (a) and (b) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety.

SECTION 6.(a) By July 1, 2019, the Department of Public Safety, Health Services Section, shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on the feasibility study of telehealth services referenced in the February 2019 Memorandum of Agreement between the Department and UNC Health Care.

SECTION 6.(b) The Department of Public Safety, Health Services Section, shall establish a telemedicine pilot program to provide physical health services to inmates in remote correctional facilities. The pilot program shall be established with consideration of the results of the study referenced in subsection (a) of this section. The goal of the pilot program is to assess whether the use of telemedicine decreases costs for inmate transportation, custody, and outside providers while improving access to care. While designing the telemedicine pilot program, the Department of Public Safety, Health Services Section, shall consult UNC Health Care; the 2012 University of North Carolina, Kenan-Flagler Business School report on telemedicine; and Finding 6, Report Number 2018-08, from the Joint Legislative Program Evaluation Oversight Committee. The telemedicine pilot program shall initially be established in two correctional facilities serving male inmates. One pilot site shall be located in a correctional facility in the eastern portion of the State and one pilot site shall be located in a correctional facility in the western portion of the State. The pilot program design must connect the two correctional facility pilot sites with the Central Prison Healthcare Complex and its contracted providers' facilities and shall be operational on or before January 1, 2020.

SECTION 6.(c) The ability to assess, measure, and evaluate the telemedicine pilot program shall be integral to the pilot program design. Assessment of the pilot program shall include, but is not limited to, the following measures for each correctional facility pilot site:

(1) Number and cost of telemedicine encounters by service area.

(2) Comparison of the number and cost of telemedicine encounters, by service area, to:

a. The number of in-person encounters provided the previous year to inmates housed at that facility; and

b. The number of in-person encounters provided during the pilot period at similar correctional facilities not participating in the pilot.

(3) Comparison of the number of days lapsed between referral date and treatment date, by service area, to:

a. The number of days lapsed the previous year in that facility; and

b. The number of days lapsed during the pilot period at similar correctional facilities not participating in the pilot.

(4) Amount of inmate transportation and custody costs avoided from receiving telemedicine.

(5) Amount of provider transportation costs avoided from providing telemedicine.

(6) Cost of initial telemedicine equipment and other related costs with descriptions.

(7) Obstacles and concerns related to expanding telemedicine to other correctional facilities.

SECTION 6.(d) On or before January 1, 2020, the Department of Public Safety, Health Services Section, shall provide an interim report on the assessment criteria outlined in subsection (c) of this section, including any additional findings and recommendations, to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Health and Human Services. On or before January 1, 2021, the

Department of Public Safety, Health Services Section, shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Health and Human Services on the assessment criteria outlined in subsection (c) of this section, including any additional findings, and shall make recommendations on whether to expand the telemedicine pilot program to additional sites, including accompanying costs and anticipated savings, and recommendations on which correctional facilities would be most advantageous to include in the pilot due to lack of access or costs associated with transportation and custody.

SECTION 7. This act becomes effective July 1, 2019.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 106*

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H106-ASH-12 [v.1]

Amends Title [NO]
H106-CSSH-18

Date _____,2019

Senator Krawiec

moves to amend the bill on page 6, line 42, by deleting "July 1, 2019" and substituting, "October 1, 2019";

and on page 7, line 18, by rewriting the line to read:
"**§ 143B-707.5. Reports related to the federal 340B Program.**";

And on page 6, line 43, by rewriting the line to read:
"Program savings realized from medications prescribed to inmates, but not administered, at a 340B Program-registered";

and on page page 6, line 44, by rewriting the line to read:
"UNC-HCS site for non-HIV and non-HCV medications pursuant to subsections (b) and (c) of this section.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H D

HOUSE BILL 126
PROPOSED SENATE COMMITTEE SUBSTITUTE H126-CSBC-57 [v.3]
06/25/2019 05:43:58 PM

Short Title: Amend Certificate of Need Laws. (Public)

Sponsors:

Referred to:

February 21, 2019

A BILL TO BE ENTITLED

AN ACT AMENDING CERTIFICATE OF NEED LAWS.

The General Assembly of North Carolina enacts:

PART I. REFORMS EFFECTIVE OCTOBER 1, 2019

SECTION 1.1. G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

...

(2) "Bed capacity" means space used exclusively for inpatient ~~care,~~care at a health service facility, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage. ~~The term "bed capacity" also refers to the number of dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~

...

(5) "Change in bed capacity" means (i) any relocation of health service facility beds, or dialysis stations from one licensed facility or campus to another, or (ii) any redistribution of health service facility bed capacity among the categories of health service facility bed as defined in G.S. 131E-176(9c), or (iii) any increase in the number of health service facility ~~beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~beds.

...

(7a) "Diagnostic center" means a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds ~~five hundred thousand dollars ($500,000).~~one million five hundred thousand dollars ($1,500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than ~~five hundred thousand dollars ($500,000),~~one million five hundred thousand dollars ($1,500,000), the costs of the equipment, studies,

surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the 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 cost threshold amount in this sub-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.

...

(9a) "Health service" means an organized, interrelated medical, diagnostic, therapeutic, ~~and/or~~ or rehabilitative ~~activity~~ activity, or any combination of these, that is integral to the prevention of disease or the clinical management of a sick, injured, or disabled person. "Health service" does not include administrative and other activities that are not integral to clinical ~~management.~~management, or any activities performed at a facility that does not meet the definition of a health service facility.

(9b) "Health service facility" means 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 the mentally retarded;~~ home health agency office; ~~chemical dependency treatment facility;~~ diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility. The term "health service facility" does not include a licensable facility, as defined in G.S. 122C-3(14)b.

(9c) "Health service facility bed" means 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) intermediate care beds for the mentally retarded; (vi) chemical dependency treatment beds; (vii)~~ (iv) hospice inpatient facility beds; ~~(viii)~~ (v) hospice residential care facility beds; ~~(ix)~~ (vi) adult care home beds; and ~~(x)~~ or (vii) long-term care hospital beds.

...

(14a) ~~"Intermediate care facility for the mentally retarded"~~ "Intermediate care facility for individuals with intellectual disabilities" means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for persons with ~~mental retardation,~~ intellectual disabilities, autism, cerebral palsy, epilepsy or related conditions.

...

(14o) "Major medical equipment" means a single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than ~~seven hundred fifty thousand dollars ($750,000).~~two million dollars ($2,000,000). In determining whether the major medical equipment costs more than ~~seven hundred fifty thousand dollars ($750,000),~~two million dollars ($2,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the major medical 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. Major medical equipment does not include replacement equipment as defined

in this section. Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount 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.

...

(16) "New institutional health services" means any of the following:

...

b. Except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding ~~two~~ four million dollars ~~($2,000,000)~~($4,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds ~~two~~ four million dollars ~~($2,000,000).~~($4,000,000). Beginning September 30, 2022, and on September 30 each year thereafter, the amount in this sub-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.

...

d. ~~The~~ Except as otherwise allowed in G.S. 131E-184(j), the offering of ~~dialysis services or~~ home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.

...

~~u. The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.~~

~~v. The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is reflected on the health service facility's license in effect as of January 1, 2005.~~"

SECTION 1.2. G.S. 131E-177 reads as rewritten:

"**§ 131E-177. Department of Health and Human Services is designated State Health Planning and Development Agency; powers and duties.**

The Department of Health and Human Services is designated as the State Health Planning and Development Agency for the State of North Carolina, and is empowered to exercise the following powers and duties:

(1) To establish standards and criteria or plans required to carry out the provisions and purposes of this Article and to adopt rules pursuant to Chapter 150B of the General Statutes, to carry out the purposes and provisions of this ~~Article;~~Article.

(2) Adopt, amend, and repeal such rules and regulations, consistent with the laws of this State, as may be required by the federal government for grants-in-aid for health service facilities and health planning which may be made available by the federal government. This section shall be liberally construed in order that the State and its citizens may benefit from such ~~grants-in-aid;~~grants-in-aid.

(3) Define, by rule, procedures for submission of periodic reports by persons or health service facilities subject to agency review under this ~~Article;~~Article.

(4) ~~Develop~~ With respect to health service facilities planning, all of the following:

a. Develop policy, criteria, and standards for health service facilities ~~planning; shall conduct~~ planning.

b. Conduct statewide registration and inventories of and make determinations of need for health service facilities, health services as specified in G.S. 131E-176(16)f., and equipment as specified in G.S. 131E-176(16)f1., which shall include consideration of adequate geographic location of equipment and ~~services; and develop~~ services.

c. Develop a State Medical Facilities ~~Plan;~~Plan, provided, however, that the State Medical Facilities Plan shall not include policies or need determinations that limit the number of operating rooms or gastrointestinal endoscopy rooms.

(5) Implement, by rule, criteria for project ~~review;~~review.

(6) Have the power to grant, deny, or withdraw a certificate of need and to impose such sanctions as are provided for by this ~~Article;~~Article.

(7) Solicit, accept, hold and administer on behalf of the State any grants or devises of money, securities or property to the Department for use by the Department in the administration of this ~~Article; and~~Article.

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

(9) Collect fees for submitting applications for certificates of need.

(10) The authority to review all records in any recording medium of any person or health service facility subject to agency review under this Article which pertain to construction and acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records the Department deems to be reasonably necessary to determine compliance with this Article.

The Secretary of Health and Human Services shall have final decision-making authority with regard to all functions described in this section."

SECTION 1.3. G.S. 131E-183(a)(1) reads as rewritten:

"(1) The proposed project 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 that may be approved."

SECTION 1.4. G.S. 131E-184(c) reads as rewritten:

"(c) The Department shall exempt from certificate of need review any conversion of existing acute care beds to psychiatric ~~beds provided:~~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 and/or one or more of the Area Mental Health,~~

~~Developmental Disabilities, and Substance Abuse Authorities to provide psychiatric beds to patients referred by the contracting agency or agencies; and~~

~~(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.~~"

SECTION 1.5. G.S. 131E-184(e)(1) reads as rewritten:

"(1) The proposed capital expenditure would:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding an existing:

1. Nursing home facility, or

2. Adult care home ~~facility, or~~facility.

~~3. Intermediate care facility for the mentally retarded; and~~

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."

SECTION 1.6.(a) G.S. 131E-184 is amended by adding new subsections to read:

"(i) The Department shall exempt from certificate of need review the development, acquisition, construction, expansion, or replacement of a health service or health service facility that obtained certificate of need approval prior to October 1, 2019, as a kidney dialysis treatment center, including freestanding hemodialysis units; intermediate care facility for individuals with intellectual disabilities; psychiatric facility; chemical dependency treatment facility; or any other licensable facility, as defined in G.S. 122C-3(14)b.

(j) The Department shall exempt from certificate of need review the establishment of a home health agency by a continuing care retirement community licensed under Article 64 of Chapter 58 of the General Statutes to provide home health services to one or more residents of a continuing care retirement community who have entered into a contract with the continuing care retirement community to receive continuing care services with lodging. A continuing care retirement community that seeks to provide home health services to individuals who do not reside at the continuing care retirement community pursuant to a contract to receive continuing care services with lodging shall be required to obtain a certificate of need as a home health agency prior to developing or offering home health services to any individual not a resident of the continuing care retirement community under a contract to receive continuing care services with lodging. As used in this subsection, the terms "continuing care" and "lodging" are as defined in G.S. 58-64-1. Nothing in this subsection shall be construed to exempt from the State's home health agency licensure and certification requirements a continuing care retirement community that has been exempted from certificate of need review for the provision of home health services to one or more residents pursuant to this subsection."

SECTION 1.6.(b) G.S. 131E-184(j), as enacted by this section, applies to continuing care retirement communities engaged in the direct provision of home health services on or after October 1, 2019.

SECTION 1.7. G.S. 131E-186(a) reads as rewritten:

"(a) Within the prescribed time limits in G.S. 131E-185, the Department shall issue a decision to "approve," "approve with conditions," or "deny," an application for a new institutional health service. Approvals involving new or expanded nursing care ~~or intermediate care for the mentally retarded bed capacity~~ shall include a condition that specifies the earliest possible date the new institutional health service may be certified for participation in the Medicaid program. The date shall be set far enough in advance to allow the Department to identify funds to pay for care in the new or expanded facility in its existing Medicaid budget or to include these funds in its State Medicaid budget request for the year in which Medicaid certification is expected."

SECTION 1.8. G.S. 131E-189 is amended by adding a new subsection to read:

"(d) Notwithstanding any other provision of this section, a certificate of need for the construction of a health service facility expires if the holder of the certificate of need fails to initiate construction of the project authorized by the certificate of need within the following time frames:

(1) For a project that costs over fifty million dollars ($50,000,000), the holder of the certificate of need shall initiate construction of the project authorized by the certificate of need within four years after the date the Department's decision to approve the certificate of need for that project becomes final.

(2) For a project that costs fifty million dollars ($50,000,000) or less, the holder of the certificate of need shall initiate construction of the project authorized by the certificate of need within two years after the date the Department's decision to approve the certificate of need for that project becomes final."

SECTION 1.9. G.S. 131E-175(11) and (12) are repealed.

SECTION 1.10. This Part becomes effective October 1, 2019.

PART II. REFORMS EFFECTIVE JANUARY 1, 2020

SECTION 2.1. G.S. 131E-147 reads as rewritten:

"**§ 131E-147. Licensure requirement.**

...

(c1) All initial applications and renewal applications shall require the applicant to state the number of procedure rooms on the premises named in the application.

...

(f) The Department shall not issue or renew a license to operate an ambulatory surgical facility developed, acquired, or replaced on or after October 1, 2019, unless the application includes all of the following:

(1) A commitment that the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least four percent (4%) of the total revenue collected for all surgical cases performed in the facility or proposed facility.

(2) For each year of operation, a commitment to report to the Department the total number of cases by each of the following payer categories:

a. Self-pay surgical cases.

b. Medicaid surgical cases.

c. Medicare surgical cases.

d. Commercial insurance surgical cases.

e. Managed care surgical cases.

f. Other surgical cases.

(3) A commitment to report utilization and payment data for services provided by the ambulatory surgical facility to the statewide data processor, as required by G.S. 131E-214.2."

SECTION 2.2. G.S. 131E-176(16), as amended by this act, reads as rewritten:

"(16) "New institutional health services" means any of the following:

...

~~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.~~

...."

SECTION 2.3. This Part becomes effective January 1, 2020.

PART III. REFORMS EFFECTIVE JANUARY 1, 2022

SECTION 3.1. G.S. 131E-176(9b), as amended by this act, reads as rewritten:

"(9b) "Health service facility" means a hospital; long-term care hospital; rehabilitation facility; nursing home facility; adult care home; home health agency office; diagnostic center; and a hospice office, hospice inpatient facility, hospice residential care ~~facility; and ambulatory surgical~~ facility. The term "health service facility" does not include a licensable facility, as defined in G.S. 122C-3(14)b."

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-184, as amended by this act, reads as rewritten:

"(a) Except as provided in subsection (b), the Department shall exempt from certificate of need review a new institutional health service if it receives prior written notice from the entity proposing the new institutional health service, which notice includes an explanation of why the new institutional health service is required, for any of the following:

…

(10) To develop, acquire, construct, expand in number, or replace an operating room or gastrointestinal endoscopy room for which a certificate of need was issued to an ambulatory surgical facility prior to January 1, 2022.

…

(k) The Department shall exempt from certificate of need review the development, acquisition, construction, expansion, or replacement of a health service or health service facility that obtained certificate of need approval prior to January 1, 2022, as an ambulatory surgical facility, including an ambulatory surgical facility with one or more operating rooms or gastrointestinal endoscopy procedure rooms."

SECTION 3.4. This Part becomes effective January 1, 2022.

PART IV. SEVERABILITY

SECTION 4.1. If any part of this section is declared unconstitutional or invalid by the courts, it does not affect the validity of this section as a whole or any part other than the part declared to be unconstitutional or invalid.

SECTION 4.2. This Part is effective when it becomes law.

HOUSE BILL 126:
Amend Certificate of Need Laws.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 25, 2019
Introduced by:	Reps. Murphy, Dobson, Potts, Sasser	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	PCS to First Edition H126-CSBC-57		

OVERVIEW: The Proposed Committee Substitute to House Bill 126 would make several changes to the Certificate of Need (CON) laws in Article 9 of Chapter 131E. The PCS would remove psychiatric facilities, kidney disease treatment centers, intermediate care facilities, chemical dependency treatment facilities, ambulatory surgical centers, and certain continuing care retirement centers from CON review. It would raise the cost thresholds that make diagnostic center equipment and health service facility capital expenditures subject to CON review and require ambulatory surgical centers to commit to providing a certain level of charity care.

BILL ANALYSIS:

Part I of the PCS would:

- Increase the equipment dollar limit that makes diagnostic centers subject to CON review from $500,000 to $1,500,000. This new limit would be indexed for inflation starting in September 2022.
- Remove psychiatric facilities, kidney disease treatment centers, intermediate care facilities, and chemical dependency treatment facilities from CON review.
- Remove continuing care retirement centers from CON review to the extent that they provide home health services to residents who have signed a contract to receive continuing care services with lodging.
- Redefine "major medical equipment" to mean equipment that costs $2,000,000. Currently, the definitional cost is $750,000. This new amount would be indexed for inflation starting in September 2022.
- Increase the limit that subjects a capital expenditure to CON review from $2,000,000 to $4,000,000. This new limit would be indexed for inflation starting in September 2022.
- Prevent the State Medical Facilities Plan from limiting the number of operating rooms or gastrointestinal endoscopy rooms.
- Require CON recipients whose projects cost more than $50,000,000 to initiate construction within four years of receiving a CON. CON recipients whose projects cost $50,000,000 or less would have two years to begin construction.
- Repeal G.S. 131E-175(11) and (12), which are findings of fact related to gastrointestinal endoscopy services.
- Become effective October 1, 2019.

Part II of the PCS would:

- Require applicants seeking licensure for an ambulatory service center to state the number of procedure rooms on the premises named in the application.
- Require, as a condition of licensure, that ambulatory surgical centers commit to providing a certain level of charity care.
- Remove the conversion of specialty ambulatory surgical programs to multispecialty ambulatory surgical programs from CON review.
- Become effective January 1, 2020.

Part III of the PCS would:

- Exempt ambulatory surgical centers from CON review.
- Become effective January 1, 2022.

EFFECTIVE DATE: Part I would be effective October 1, 2019. Part II would be effective January 1, 2020. Part III would be effective January 1, 2022.

HOUSE BILL 126

Short Title:	Organ & Tissue Donation/Heart Heroes.	(Public)
Sponsors:	Representatives Murphy, Dobson, Potts, and Sasser (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Transportation, if favorable, Rules, Calendar, and Operations of the House	

February 21, 2019

A BILL TO BE ENTITLED

AN ACT AMENDING THE REVISED UNIFORM ANATOMICAL GIFT ACT TO INCLUDE TISSUE DONATION AS PART OF THE DRIVERS LICENSE DONOR AUTHORIZATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-412.7(a) reads as rewritten:

"(a) A donor may make an anatomical gift by any of the following methods:

(1) By authorizing that a statement or symbol be imprinted on the donor's drivers license or identification card indicating that the donor has made an anatomical gift. Anatomical gifts made by this method shall not include a donation of ~~tissue or~~ the donor's body.

(2) In a will.

(3) During a terminal illness or injury of the donor, by any form of communication addressed to at least two adults, at least one of whom is a disinterested witness.

(4) As provided in subsection (b) of this section."

SECTION 2. This act becomes effective October 1, 2019.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 126

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H126-ABC-51 [v.3]

Amends Title [NO]
First Edition

Date June 26 ,2019

Senator Perry

moves to amend the bill on page 6, line 21, by rewriting the line to read:
"number of procedure rooms on, and the number of procedures performed at, the premises named in the application.";

and on page 6, lines 23-40, by deleting the lines;

and on page 6, line 49 through page 7, line 50, by deleting the lines;

and by renumbering the remaining sections and parts accordingly.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Visitors Sign-in

HEALTH CARE, SENATE COMMITTEE

June 26, 2019 10:00 AM Rm. 643

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
Nathan Clark	R. Williams.
Mark Flaney	BCBSNC
Kelly Vogel	Anthem
J Peters	CSS
J-Ach Gyant	NSS

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NORTH CAROLINA GENERAL ASSEMBLY

Visitors Sign-in

HEALTH CARE, SENATE COMMITTEE

June 26, 2019 10:00 AM Rm. 643

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
Sarah McQuillan	KCA
Martha Ann McConnell	Atrium Health
Leah Perkins	NCHA
Tracy Kimbrell	Parker Poe
	CBS
David Powers	PSCC
Grace Irvin	Walk West
Daniel Ouellette	V.A.
Doug Heron	Duke
Clay Byrd	NCMS
Dana Sipes	SA

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NORTH CAROLINA GENERAL ASSEMBLY

Visitors Sign-in

HEALTH CARE, SENATE COMMITTEE

June 26, 2019 10:00 AM Rm. 643

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
[illegible]	[illegible]
Ken Melton	K.M.A.
Marissa Turner	TSS
Catherine Moore	NC Board of Nursing
Jamaica Pfister	CHS
Marilyn Avila	CHS
Brenton Hart	DST
[illegible]	[illegible]
Sue Ford	NCMS
Ed Rankin	NCMS
Rachel Keever MD	NC Medical Society
[illegible]	[illegible]
John T Bode	[illegible]

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Visitors Sign-in

HEALTH CARE, SENATE COMMITTEE

June 26, 2019 10:00 AM Rm. 643

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
Pat Yancey	NCANP
JUSTIN DAVIS	NC DPS
Amanda Donovan	KTS
Kay Castillo	NASW-NC
Barden Culbreth	NCSAPPB
Angel Sams	DeVivo Sams
Hattie Amanda	DHHS
Amanda Lee	DHHS
Katherine Adams	DHHS
Joyce Peters	CSS
Ardis Watkins	SEANC
Richard Carlton	Law Office
Stephen Kaiser	KMA

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 643 LOB

DATE: 6-26 **TIME:** 10 AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

	Page Name	Hometown	Sponsoring Senator
1.	Louis Blanton	Durham	McKissick
2.	Sara Lennon	Efland	Mckissick
3.	Dylan Thiessen	Wilmington	Rabon
4.	Brooke Walls	Raleigh	J. Alexander
5.	Tania Hunter	Henderson	Smith
6.	Sydney Stathopoulos	Wilmington	Rabon
7.			
8.			

ages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

SENATE SERGEANT-AT-ARMS

HEALTH CARE, SENATE COMMITTEE

DATE: 06-26-2019 ROOM: 643

10:00 AM

SENATE SERGEANT AT ARMS

Charles Harper

John Enloe

Dwight Green

Senate Committee on Health Care
Thursday, June 27, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 27, 2019, in Room 643 of the Legislative Office Building. Twelve members were present.

Senator Dan Bishop, Chair, presided.

Sara Lennon sponsored by Sen. McKissick, Brooke Walls sponsored by Sen. J. Alexander, Sam Dylan sponsored by Sen. Berger, Anika Hall sponsored by Sen. McKissick, Tania Hunter sponsored by Sen. Smith, Kate Schwanz sponsored by Sen. Marcus, Emery Pickel sponsored by Sen. Wells, and Lane Donovan sponsored by Sen. Wells served as pages.

HB 106 - Inmate Health Care (Representatives Horn, Farmer-Butterfield, Lucas, R. Turner)

Sen. Bishop recognized Rep. Horn to explain the proposed committee substitute. Sen. Woodard moved for a favorable report. Questions from members were answered by Rep. Horn. Sen. Bishop announced the motion was favorable to the proposed committee substitute as amended and rolled into a new proposed committee substitute, unfavorable to the original bill with a serial referral to the Senate Judiciary Committee. The motion carried.

HB 126 - Organ & Tissue Donation/Heart Heroes - FOR DISCUSSION ONLY (Title changed to Amend Certificate of Need Laws)

The proposed committee substitute as amended was again before the committee. Sen. Burgin and Sen. Krawiec were recognized to comment on the bill. Questions from members were answered by Sen. Krawiec.

The meeting adjourned at 10:19 AM.

Senator Dan Bishop, Chair
Presiding

John Wynne, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Thursday, June 27, 2019

Senator Bishop,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

HB **126** Organ & Tissue Donation/Heart Heroes.

Draft Number:	H126-PCS10684-BC-57
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 3, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

HB **106** **(CS#3)** Inmate Health Care.

Draft Number:	H106-PCS30492-SH-18
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Senator Joyce Krawiec will handle HB 126
Senator Joyce Krawiec will handle HB 106



Senate Committee on Health Care
Wednesday, June 27, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 106	Inmate Health Care.	Representative Horn Representative Farmer-Butterfield Representative Lucas Representative R. Turner
HB 126	Organ & Tissue Donation/Heart Heroes.	Representative Murphy Representative Dobson Representative Potts Representative Sasser

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H D

HOUSE BILL 106

Committee Substitute Favorable 3/26/19
Committee Substitute #2 Favorable 4/26/19
Committee Substitute #3 Favorable 5/6/19
PROPOSED SENATE COMMITTEE SUBSTITUTE H106-CSSH-18 [v.3]
06/25/2019 05:36:18 PM

Short Title: Inmate Health Care & 340B Program. (Public)

Sponsors:

Referred to:

February 20, 2019

A BILL TO BE ENTITLED

AN ACT TO IMPROVE INMATE HEALTH CARE REIMBURSEMENT AND INTERNAL PROCESSES AND TO ESTABLISH A TELEMEDICINE PILOT PROGRAM; IN ADDITION TO DIRECTING THE DEPARTMENT OF PUBLIC SAFETY TO PARTNER WITH THE DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR THE PURCHASE OF CERTAIN MEDICATIONS FOR INMATES, TO DIRECT THE DEPARTMENT OF PUBLIC SAFETY TO ISSUE REQUESTS FOR PROPOSALS FOR PARTNERSHIPS BETWEEN NORTH CAROLINA 340B PROGRAM ENTITIES AND THE FOUR NORTH CAROLINA PRISON REGIONS, TO DIRECT THE DEPARTMENT OF PUBLIC SAFETY TO PARTNER WITH THE UNIVERSITY OF NORTH CAROLINA HEALTH SYSTEM TO SHIFT PRESCRIBING AUTHORITY ON CERTAIN MEDICATIONS, AND TO DIRECT THE DEPARTMENT OF PUBLIC SAFETY TO SUBMIT VARIOUS REPORTS TO THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON JUSTICE AND PUBLIC SAFETY AND THE FISCAL RESEARCH DIVISION.

The General Assembly of North Carolina enacts:

PART I. INMATE HEALTH CARE REIMBURSEMENT AND INTERNAL PROCESSES AND TELEMEDICINE PILOT

SECTION 1.(a) To contain medical costs for inmates as required by G.S. 143B-707.3(b), the Department of Public Safety shall develop a plan to increase the use of the Central Prison Healthcare Complex (hereinafter "CPHC") which shall include all of the following:

(1) Strategies, policies, and oversight mechanisms to ensure that non-life-threatening emergencies for male inmates within a 60-mile radius of Raleigh are treated at the CPHC urgent care facility. As part of this effort, DPS shall consider the use of telemedicine.

(2) A cost comparison of health care services performed at CPHC and the North Carolina Correctional Institution for Women (hereinafter "NCCIW") and health care services performed by outside contracted providers. The cost comparison shall include the cost of transporting inmates to and from outside contracted providers.

(3) A comprehensive review of the current usage of health care facilities at CPHC and NCCIW and the potential to maximize usage of those facilities through

(i) increasing the usage of CPHC's facilities for general anesthesia procedures and increasing usage of existing on-site equipment, (ii) selling equipment no longer in use or not in use due to staffing changes, (iii) increasing the provision of health care services available at CPHC to female inmates, and (iv) identifying potential CPHC expenditures that would ultimately result in demonstrated cost savings.

(4) Methods to contain costs for palliative and long-term health care services for inmates.

SECTION 1.(b) By December 1, 2019, the Department of Public Safety shall submit the plan required by subsection (a) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety. The Department of Public Safety shall also submit its progress made in achieving cost savings under the plan, the amount of any actual and estimated cost savings, and any obstacles to increasing the usage of the health services facilities at CPHC and NCCIW.

SECTION 2.(a) G.S. 143B-707.3(c) reads as rewritten:

"(c) The Department of Public Safety shall report quarterly to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on:

...

(10) The reimbursement rate for contracted providers. The Department shall randomly audit high-volume contracted providers to ensure adherence to billing at the contracted rate.

Reports submitted on August 1 shall include totals for the previous fiscal year for all the information requested."

SECTION 2.(b) By February 1, 2020, the Department of Public Safety, Health Services Section, shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and to the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on alternative methods for reimbursing providers and facilities that provide approved medical services to inmates, including Medicare rates.

SECTION 3.(a) Subpart A of Part 2 of Article 13 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"**§ 143B-707.5. Medicaid services for inmates.**

(a) The Department of Public Safety and the Department of Health and Human Services shall work together to enable social workers in the Department of Public Safety, Health Services Section, to qualify for and receive federal reimbursement for performing administrative activities related to Medicaid eligibility for inmates. The Department of Public Safety, Health Services Section, shall develop policies and procedures to account for the time social workers in the Health Services Section spend on administrative activities related to Medicaid eligibility for inmates. All social workers in the Health Services Section who perform administrative activities related to Medicaid eligibility shall be required to receive eligibility determination training provided by the Department of Health and Human Services at least quarterly.

(b) The Department of Public Safety, Health Services Section, shall require each social worker performing administrative activities related to Medicaid eligibility for inmates to document the following:

(1) The criteria used by the social worker when deciding to submit an application for Medicaid and when deciding not to submit an application for Medicaid, including any information the social worker believes disqualifies the inmate for Medicaid benefits.

(2) An indication in the social worker's data entry of an inmate's Medicaid eligibility as determined by the inmate's county department of social services.

(3) The number of 24-hour community provider stays prescreened for potential applications, the number of applications submitted, and the number and

percentage of applications approved, denied, and withdrawn, which shall be reported to the Health Services Section Director on a monthly basis.

(c) In addition to the requirements in subsection (b) of this section, each Department of Public Safety, Health Services Section, social workers performing administrative activities related to Medicaid eligibility for inmates shall submit Medicaid applications and any supporting documents electronically through the ePass portal in the Department of Health and Human Services or through other electronic means, unless paper copies are required by federal law or regulation."

SECTION 3.(b) By October 1, 2019, and quarterly thereafter until full implementation is achieved, the Department of Public Safety and the Department of Health and Human Services shall jointly report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Medicaid and North Carolina Health Choice on progress in receiving federal reimbursement for performing administrative activities related to Medicaid eligibility for inmates.

SECTION 3.(c) By October 1, 2019, the Department of Public Safety shall report to the Joint Legislative Oversight Committee on Justice and Public Safety on the implementation of the documentation of criteria for the submission of Medicaid applications and the electronic submission of Medicaid applications.

SECTION 3.(d) This section becomes effective October 1, 2019.

SECTION 4. The Department of Public Safety, Health Services Section, shall issue two requests for proposals (RFP) to develop an electronic supply inventory management system. One RFP shall be for a system to be used at all prison facilities and one RFP shall be for a system to be used exclusively at the Central Prison Healthcare Complex and the North Carolina Correctional Institution for Women. The RFPs shall be for an electronic supply inventory management system that is capable of all of the following:

(1) Recording the arrival and departure of each medical supply in use or for future use from the point of order, including all methods of requisition and main storage locations (e.g., warehouse, secondary storage location, prison unit, or infirmary).

(2) Recording the dates on which a medical supply was physically at each transition point, including the date of use or disposal.

(3) Identifying Department employees who have custody of or control over a medical supply at each transition point, including at the time of use or disposal.

(4) Ensuring that medical supplies are used prior to their expiration date.

(5) Ensuring an adequate supply of each medical product currently being used or obtained for future use at each facility. Adequate supply level shall be based on usage of each medical product by each facility.

(6) Biannually assessing the need for particular medical supplies and the accuracy of records through an audit of the system.

The Department shall report the results of the RFPs to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety by December 1, 2019.

SECTION 5.(a) The Department of Public Safety, Health Services Section, and the Office of State Human Resources shall jointly study the salaries of all in-prison health services employees to determine what adjustments are necessary to increase the salaries of new hires and existing employees of the Health Services Section to market rates.

SECTION 5.(b) The Department of Public Safety shall establish a vacancy rate benchmark for each correctional facility and shall create a plan to reduce the vacancy rates. The Department shall consider initiatives to reduce vacancy rates, including the following:

(1) Increasing salaries to market rates.

(2) Creating a student loan forgiveness program for the Health Services Section.
(3) Offering signing bonuses and annual cash incentives.
(4) Increasing the use of telemedicine positions.
(5) Creating dual appointment opportunities for doctors currently employed by the State.
(6) Offering differential pay for health services workers employed in difficult-to-staff facilities.
(7) Streamlining and potentially eliminating duplicative or unnecessary steps in the hiring process.

SECTION 5.(c) The Department of Public Safety shall establish methods to measure the effectiveness of the initiatives to reduce vacancy rates required in subsection (b) of this section and estimate the budgetary impact and anticipated savings from the Department's reduced reliance on outside contracted providers. By February 1, 2020, the Department shall submit its findings on salaries and vacancy rates, including any proposed legislation and the need for assistance required from the Office of Human Resources and the Office of Rural Health in the Department of Health and Human Services to accomplish the objectives outlined in subsections (a) and (b) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety.

SECTION 6.(a) By August 1, 2019, the Department of Public Safety, Health Services Section, shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on the feasibility study of telehealth services referenced in the February 2019 Memorandum of Agreement between the Department and UNC Health Care.

SECTION 6.(b) The Department of Public Safety, Health Services Section, shall establish a telemedicine pilot program to provide physical health services to inmates in remote correctional facilities. The pilot program shall be established with consideration of the results of the study referenced in subsection (a) of this section. The goal of the pilot program is to assess whether the use of telemedicine decreases costs for inmate transportation, custody, and outside providers while improving access to care. While designing the telemedicine pilot program, the Department of Public Safety, Health Services Section, shall consult UNC Health Care; the 2012 University of North Carolina, Kenan-Flagler Business School report on telemedicine; and Finding 6, Report Number 2018-08, from the Joint Legislative Program Evaluation Oversight Committee. The telemedicine pilot program shall initially be established in two correctional facilities serving male inmates. One pilot site shall be located in a correctional facility in the eastern portion of the State and one pilot site shall be located in a correctional facility in the western portion of the State. The pilot program design must connect the two correctional facility pilot sites with the Central Prison Healthcare Complex and its contracted providers' facilities and shall be operational on or before January 1, 2020.

SECTION 6.(c) The ability to assess, measure, and evaluate the telemedicine pilot program shall be integral to the pilot program design. Assessment of the pilot program shall include, but is not limited to, the following measures for each correctional facility pilot site:

(1) Number and cost of telemedicine encounters by service area.
(2) Comparison of the number and cost of telemedicine encounters, by service area, to:
    a. The number of in-person encounters provided the previous year to inmates housed at that facility; and
    b. The number of in-person encounters provided during the pilot period at similar correctional facilities not participating in the pilot.
(3) Comparison of the number of days lapsed between referral date and treatment date, by service area, to:
    a. The number of days lapsed the previous year in that facility; and

b. The number of days lapsed during the pilot period at similar correctional facilities not participating in the pilot.

(4) Amount of inmate transportation and custody costs avoided from receiving telemedicine.

(5) Amount of provider transportation costs avoided from providing telemedicine.

(6) Cost of initial telemedicine equipment and other related costs with descriptions.

(7) Obstacles and concerns related to expanding telemedicine to other correctional facilities.

SECTION 6.(d) On or before January 1, 2020, the Department of Public Safety, Health Services Section, shall provide an interim report on the assessment criteria outlined in subsection (c) of this section, including any additional findings and recommendations, to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Health and Human Services. On or before January 1, 2021, the Department of Public Safety, Health Services Section, shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Health and Human Services on the assessment criteria outlined in subsection (c) of this section, including any additional findings, and shall make recommendations on whether to expand the telemedicine pilot program to additional sites, including accompanying costs and anticipated savings, and recommendations on which correctional facilities would be most advantageous to include in the pilot due to lack of access or costs associated with transportation and custody.

PART II. FEDERAL 340B PROGRAM

SECTION 7.(a) The Department of Public Safety (DPS) shall establish and implement a partnership with the Department of Health and Human Services (DHHS) in order for DPS to be eligible to operate as a 340B covered entity. The Department of Public Safety shall contract for consultant services in order to implement this section. In order to implement the requirements of this section, DPS shall do all of the following:

(1) Submit an application during the next registration period to enroll in the federal 340B Program found in section 340B of the Public Health Service Act (the "340B Program") to be able to access 340B Program pricing for medications used to treat the human immune deficiency virus (HIV), the hepatitis C virus (HCV), and eligible sexually transmitted diseases (STD).

(2) Provide DHHS all data and necessary documentation as frequently as such information is needed by DHHS for the implementation of this section.

(3) Ensure that the DPS Apex Central Pharmacy, and any other DPS pharmacies necessary, are compliant dispensing pharmacies under the 340B Program.

(4) Coordinate with one or more vendors to purchase STD 340B Program medications that result in the greatest overall cost savings available to the state, whether such savings are achieved by 340B Program pricing, non-340B Program volume discounts, or a combination of both.

(5) Develop a separate inventory to track 340B Program medications.

SECTION 7.(b) The Department of Public Safety shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Fiscal Research Division by October 1, 2019, regarding the implementation of this section.

SECTION 8.(a) The Department of Public Safety shall develop a plan by December 1, 2019, to issue Requests for Proposals (RFP) as required by this section. The plan to issue RFPs shall, at a minimum, address the following:

(1) The hiring of a consultant to manage the RFP process from issuance to conclusion.

(2) The hiring of the same consultant hired for the RFP process to work with the selected 340B Program entities and DPS to implement the requirements of this section.

(3) The estimated costs for DPS to hire the consultant, issue the RFPs, evaluate RFP proposals, and implement the 340B Program correctional partnerships.

SECTION 8.(b) Regarding the RFPs in subsection 8.(a) of this section, the Department of Public Safety shall issue one RFP for each of the four prison regions. The RFPs shall seek partnerships between the prison regions and one or more 340B Program entities in the State in order to provide specialty treatment for high-cost medical conditions, and shall express a preference for bidding entities that would use DPS as a contract pharmacy for 340B Program medications. Entities interested in providing telemedicine services may bid on more than one prison region. Each RFP shall, at a minimum, require that an entity's bid include the following:

(1) An explanation of the bidding entity's ability to purchase the following:

a. Medications that treat chronic obstructive pulmonary disease (COPD), asthma, rheumatology, multiple sclerosis, mental health conditions, epilepsy, and cardiovascular disease or hypertension.

b. Factor products for inmates with hemophilia.

c. Oral suppressive therapy medications for inmates with cancer.

d. Biologics for inmates with inflammatory diseases such as Crohn's disease, irritable bowel syndrome, and rheumatoid arthritis.

e. Brand name inhalers for inmates with COPD and asthma.

f. Psychotropic drugs for inmates with schizophrenia, bipolar disorder, and other mental health conditions.

(2) A commitment, as a 340B Program covered entity, to purchase medications under the 340B Program on behalf of DPS and to pass all related savings on to the State.

(3) A description of the 340B Program correctional partnership model the bidding entity would use based on the seven correctional partnership models provided in Appendix C of the North Carolina General Assembly Report on Recommendations for a 340B Correctional Partnership on North Carolina issued on May 20, 2019. This description should also include, to the extent possible, potential savings and costs that would be realized under the chosen model.

(4) An explanation of the manner in which specialty care and 340B pharmacy services will be provided. Services shall be provided in a manner that improves or maintains quality and continuity of patient care.

SECTION 8.(c) The Department of Public Safety shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Fiscal Research Division by December 1, 2019 on the plan described in subsection 8.(a) of this section, and quarterly thereafter until RFPs for all prison regions are awarded, regarding the implementation of this section.

SECTION 9.(a) The Department of Public Safety shall partner with the University of North Carolina Healthcare System (UNC-HCS) by July 1, 2019, to begin receiving all 340B Program savings realized from medications prescribed to inmates at a 340B Program-registered UNC-HCS site for non-HIV and non-HCV medications.

SECTION 9.(b) Pursuant to subsection (c) of this section, DPS shall direct that the prescribing authority of DPS providers be transferred to UNC-HCS providers for identified inmates treated at a 340B Program-registered UNC-HCS site.

SECTION 9.(c) By October 1, 2019, DPS and UNC-HCS shall:

(1) Identify the UNC-HCS inmate patients for whom shifting prescriptive authority to UNC-HCS is feasible and appropriate.

(2) Establish a method for improving or maintaining quality and continuity of patient care once the prescriptive authority has shifted to UNC-HCS.

(3) Develop mechanisms to ensure that the communication between the UNC-HCS prescriber and the DPS physician maintains the quality and continuity of care that inmates currently receive.

(4) Select the UNC-HCS pharmacy, the DPS Apex Central Pharmacy, or a combination of both, as the pharmacy through which medications will be dispensed pursuant to this section.

SECTION 9.(d) The Department of Public Safety and UNC-HCS shall establish a Memorandum of Agreement to require UNC-HCS to pass through all of the 340B Program savings for medications referenced in this section.

SECTION 9.(e) The Department of Public Safety and UNC-HCS shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Fiscal Research Division by October 1, 2019, and monthly thereafter until implementation, regarding the progress made toward implementing the requirements of this section.

SECTION 10. Article 13 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"**§ G.S. 143B 707.5. Reports related to the federal 340B Program.**

(a) The Department of Public Safety shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Fiscal Research Division by October 1, 2020, and annually thereafter, regarding

(1) Savings achieved from its partnership with the Department of Health and Human Services for the purchasing of certain medications for inmates under the federal 340B Program.

(2) Savings achieved from its partnership with the University of North Carolina Healthcare System for the provision of inmate medications and services under the federal 340B Program.

(b) The Department of Public Safety shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Fiscal Research Division by October 1, 2021, and annually thereafter, on savings achieved from the partnerships between the four prison regions and North Carolina 340B Program entities for the provision of inmate medications and services under the federal 340B Program."

SECTION 11. Except as otherwise provided, this act is effective when it becomes law.

HOUSE BILL 106:
Inmate Health Care & 340B Program.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Judiciary. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 25, 2019
Introduced by:	Reps. Horn, Farmer-Butterfield, Lucas, R. Turner	**Prepared by:**	Theresa Matula * Legislative Analyst
Analysis of:	PCS to Fourth Edition H106-CSSH-18		

OVERVIEW: Part I (Inmate Health Care Reimbursement and Internal Processes and Telemedicine Pilot) of the PCS for House Bill 106 would do the following as it relates to inmate health care: require the Department of Public Safety (DPS) to develop a plan to increase the use of the Central Prison Healthcare Complex and to submit the plan Joint Legislative Oversight Committee on Justice and Public Safety; require a quarterly report on the reimbursement rate for contracted providers; add a new statute pertaining to Medicaid services for inmates and require progress reports; require the issuance of two Requests for Proposals (RFP) to develop an electronic inventory system for medical supplies; require DPS to study and develop initiatives pertaining to the salaries of all in-prison health services employees; and require the establishment of a telemedicine pilot program to provide physical health services to inmates. Part II (Federal 340B Program) of the PCS would require DPS to partner with the Department of Health and Human Services to access medication pricing under the federal 340B Program, require DPS to issue a RFP for partnerships between entities covered under the federal 340B Program and four prison regions, require DPS to develop a Memorandum of Agreement with the University of North Carolina Healthcare Services for the 340B Program, require periodic reporting, and codify reporting requirements. The content of HB 106 is based on recommendations contained in reports by the Program Evaluation Division.

BILL ANALYSIS: PART I: Inmate Health Care Reimbursement and Internal Processes and Telemedicine Pilot

Section 1 requires the Department of Public Safety to develop a plan to increase the use of the Central Prison Healthcare Complex (CPHC) and to submit this plan, including cost savings, and utilization barriers for CPHC and NCCIW, to the Joint Legislative Oversight Committee on Justice and Public Safety by December 1, 2019. Plan requirements include:

- Strategies, policies, and oversight mechanisms to ensure that non-life-threatening emergencies for male inmates within a 60-mile radius of Raleigh are treated at the CPHC urgent care facility, including the considering the use of telemedicine.
- A cost comparison of health care services performed at CPHC and the North Carolina Correctional Institution for Women (hereinafter "NCCIW") and health care services performed by outside contracted providers, including inmate transportation costs.
- A review of the usage at CPHC and NCCIW and the potential to maximize usage of those facilities through (i) increasing the usage of CPHC's facilities for general anesthesia procedures and increasing usage of existing on-site equipment, (ii) selling equipment no longer in use or not in use due to staffing changes, (iii) increasing the provision of health care services available at CPHC to female

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

inmates, and (iv) identifying potential CPHC expenditures that would ultimately result in demonstrated cost savings.

- Methods to contain costs for palliative and long-term health care services for inmates.

Section 2 requires a quarterly report on the reimbursement rate for contracted providers, and requires a report on alternative methods for reimbursing providers and facilities.
Highlights are as follows:

- Requires the Department of Public Safety to provide a quarterly report on the reimbursement rate for contracted providers to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety.
- Requires the Department of Public Safety to report to Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on alternative methods for reimbursing providers and facilities that provide approved medical services to inmates, including Medicare rates.

Section 3 adds a new statute pertaining to Medicaid services for inmates and requires progress reports. **Section 3(a)** requires the Departments of Public Safety and Health and Human Services to work together to ensure social workers in the Department of Public Safety, Health Services Section: 1) receive Medicaid eligibility determination training on at least a quarterly basis, and 2) qualify for and receive federal reimbursement for performing administrative activities related to Medicaid eligibility for inmates. Social workers in the Department of Public Safety, Health Services Section are required to report activities related to administrative activities related to Medicaid eligibility for inmates. In addition, social workers performing Medicaid eligibility activities in the Health Services Section must submit Medicaid applications and supporting documents electronically, unless prohibited. **Section 3(b)** requires the Departments of Public Safety and Health and Human Services to jointly report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice on progress in receiving federal reimbursement for performing administrative activities related to Medicaid eligibility for inmates. This reporting begins October 1, 2019 and continues on a quarterly basis until full implementation is achieved. **Section 3(c)** requires the Department of Public Safety to report to the Joint Legislative Oversight Committee on Justice and Public Safety on the implementation of the documentation of criteria for the submission of Medicaid applications and the electronic submission of Medicaid applications. The report is required by October 1, 2019. Section 3 becomes effective October 1, 2019

Section 4 requires the Department of Public Safety to issue two RFPs for develop an electronic inventory system for medical supplies. One RFP is for a system to be used at all prison facilities, and one RFP is for a system to be used exclusively at the Central Prison Healthcare Complex and the North Carolina Correctional Institution for Women. The Department shall report the results of the RFPs to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety by December 1, 2019.

Section 5 requires the Department of Public Safety to study and develop initiatives pertaining to the salaries of all in-prison health services employees. **Section 5(a)** requires the Department of Public Safety, Health Services Section, and the Office of State Human Resources, to jointly study the salaries of all in-prison health services employees to determine what adjustments are necessary to increase the salaries of new hires and existing employees of the Health Services Section to market rates. **Section 5(b)** requires the Department to establish a vacancy rate benchmark for each correctional facility to create a plan to reduce the vacancy rates including certain initiatives. **Section 5(c)** requires the Department to establish

methods to measure the effectiveness of the initiatives to reduce vacancy rates required in subsection (b) and estimate the budgetary impact and anticipated savings. The Department is required submit its findings on salaries and vacancy rates, including any proposed legislation and the need for assistance required from the Office of Human Resources and the Office of Rural Health in the Department of Health and Human Services, to accomplish the objectives outlined in subsections (a) and (b) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety by February 1, 2020.

Section 6 requires the Department of Public Safety, Health Services Section to report on the feasibility study referenced in the current contract with UNC Health Care, and establish a telemedicine pilot program to provide physical health services to inmates. **Section 6(a)** requires the Department of Public Safety, Health Services Section to report to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on the feasibility study of telehealth services referenced in the February 2019 Memorandum of Agreement between the Department and UNC Health Care. **Section 6(b)** requires the establishment of a telemedicine pilot program. Two correctional facilities shall be selected for the pilot, one in the eastern part of the State and one in the western part of the State. The ability to assess, measure, and evaluate the pilot program must be an integral part of the program design and **Section 6(c)** outlines measures for each pilot site. **Section 6(d)** requires an interim report on or before January 1, 2020, and another report on or before January 1, 2021, to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Health and Human Services.

PART II of the PCS, **Federal 340B Program**, was not initially included in HB 106.

Section 7 would require DPS to partner with the Department of Health and Human Services to be able to access medication pricing under the federal 340B Program for medications used to treat the human immune deficiency virus (HIV), the hepatitis C virus (HCV), and eligible sexually transmitted diseases (STDs). The section would also require DPS to report October 1, 2019, on the implementation of this section.

Section 8 would require DPS to prepare a plan for and issue Requests for Proposals (RFPs) seeking partnerships between North Carolina entities covered under the federal 340B Program and North Carolina's four prison regions in order for DPS to avail itself of 340B Program savings through medications and treatments prescribed at these partner entities. Additionally, it would also require DPS to report on December 1, 2019, regarding its plan for the issuing of RFPs.

Section 9 would require DPS to develop a Memorandum of Agreement (MOA) with the University of North Carolina Healthcare Services (UNC-HCS) to allow DPS to avail itself of federal 340B Program medication savings when medications are prescribed at a 340B Program-registered UNC-HCS site. It would also require DPS and UNC-HCS to develop a plan for the shifting of prescription authority from DPS to UNC-HCS when this would be most cost effective. Both DPS and UNC-HCS would be directed to report on October 1, 2019, regarding the plan and methods of implementation of shifting prescription authority.

Section 10 would codify annualized reporting requirements for DPS beginning on October 1, 2020, regarding savings realized by the State based upon the actions taken as a result of Sections 7, 8, and 9.

EFFECTIVE DATE: Except as otherwise provided, this act would become effective when it becomes law.

BACKGROUND: **Part I** of House Bill 106 includes recommendations from the Joint Legislative Program Evaluation Oversight Committee. For more information, Improvements to Inmate Healthcare Reimbursement and Internal Processes Could Save $5.6 Million Annually.

Part II of House Bill 106 is a result of the Program Evaluation Division's, Final Report to the Joint Legislative Program Evaluation Oversight Committee (Report 2018-09) entitled, "Modifications to Inmate Pharmacy Purchasing and Monitoring Could Save $13.4 Million Annually."

**Susan Sitze and Jacob Davis, staff attorneys, and Brent Lucas, PED staff, substantially contributed to this summary.*

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H 4

HOUSE BILL 106*
Committee Substitute Favorable 3/26/19
Committee Substitute #2 Favorable 4/26/19
Committee Substitute #3 Favorable 5/6/19

Short Title: Inmate Health Care. (Public)

Sponsors:

Referred to:

February 20, 2019

A BILL TO BE ENTITLED

AN ACT TO IMPROVE INMATE HEALTH CARE REIMBURSEMENT AND INTERNAL PROCESSES AND TO ESTABLISH A TELEMEDICINE PILOT PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) To contain medical costs for inmates as required by G.S. 143B-707.3(b), the Department of Public Safety shall develop a plan to increase the use of the Central Prison Healthcare Complex (hereinafter "CPHC") which shall include all of the following:

(1) Strategies, policies, and oversight mechanisms to ensure that non-life-threatening emergencies for male inmates within a 60-mile radius of Raleigh are treated at the CPHC urgent care facility. As part of this effort, DPS shall consider the use of telemedicine.

(2) A cost comparison of health care services performed at CPHC and the North Carolina Correctional Institution for Women (hereinafter "NCCIW") and health care services performed by outside contracted providers. The cost comparison shall include the cost of transporting inmates to and from outside contracted providers.

(3) A comprehensive review of the current usage of health care facilities at CPHC and NCCIW and the potential to maximize usage of those facilities through (i) increasing the usage of CPHC's facilities for general anesthesia procedures and increasing usage of existing on-site equipment, (ii) selling equipment no longer in use or not in use due to staffing changes, (iii) increasing the provision of health care services available at CPHC to female inmates, and (iv) identifying potential CPHC expenditures that would ultimately result in demonstrated cost savings.

(4) Methods to contain costs for palliative and long-term health care services for inmates.

SECTION 1.(b) By December 1, 2019, the Department of Public Safety shall submit the plan required by subsection (a) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety. The Department of Public Safety shall also submit its progress made in achieving cost savings under the plan, the amount of any actual and estimated cost savings, and any obstacles to increasing the usage of the health services facilities at CPHC and NCCIW.

SECTION 2.(a) G.S. 143B-707.3(c) reads as rewritten:

"(c) The Department of Public Safety shall report quarterly to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on:

...

(10) The reimbursement rate for contracted providers. The Department shall randomly audit high-volume contracted providers to ensure adherence to billing at the contracted rate.

Reports submitted on August 1 shall include totals for the previous fiscal year for all the information requested."

SECTION 2.(b) By February 1, 2020, the Department of Public Safety, Health Services Section, shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and to the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on alternative methods for reimbursing providers and facilities that provide approved medical services to inmates, including Medicare rates.

SECTION 3.(a) Subpart A of Part 2 of Article 13 of Chapter 143B of the General Statutes is amended by adding a new section to read:

"**§ 143B-707.5. Medicaid services for inmates.**

(a) The Department of Public Safety and the Department of Health and Human Services shall work together to enable social workers in the Department of Public Safety, Health Services Section, to qualify for and receive federal reimbursement for performing administrative activities related to Medicaid eligibility for inmates. The Department of Public Safety, Health Services Section, shall develop policies and procedures to account for the time social workers in the Health Services Section spend on administrative activities related to Medicaid eligibility for inmates. All social workers in the Health Services Section who perform administrative activities related to Medicaid eligibility shall be required to receive eligibility determination training provided by the Department of Health and Human Services at least quarterly.

(b) Beginning July 1, 2019, the Department of Public Safety, Health Services Section, shall require each social worker performing administrative activities related to Medicaid eligibility for inmates to document the following:

(1) The criteria used by the social worker when deciding to submit an application for Medicaid and when deciding not to submit an application for Medicaid, including any information the social worker believes disqualifies the inmate for Medicaid benefits.

(2) An indication in the social worker's data entry of an inmate's Medicaid eligibility as determined by the inmate's county department of social services.

(3) The number of 24-hour community provider stays prescreened for potential applications, the number of applications submitted, and the number and percentage of applications approved, denied, and withdrawn, which shall be reported to the Health Services Section Director on a monthly basis.

(c) Beginning October 1, 2019, in addition to the requirements in subsection (b) of this section, each Department of Public Safety, Health Services Section, social workers performing administrative activities related to Medicaid eligibility for inmates shall submit Medicaid applications and any supporting documents electronically through the ePass portal in the Department of Health and Human Services or through other electronic means, unless paper copies are required by federal law or regulation."

SECTION 3.(b) By October 1, 2019, and quarterly thereafter until full implementation is achieved, the Department of Public Safety and the Department of Health and Human Services shall jointly report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Medicaid and North Carolina Health Choice on progress in receiving federal reimbursement for performing administrative activities related to Medicaid eligibility for inmates.

SECTION 3.(c) By October 1, 2019, the Department of Public Safety shall report to the Joint Legislative Oversight Committee on Justice and Public Safety on the implementation of the documentation of criteria for the submission of Medicaid applications and the electronic submission of Medicaid applications.

SECTION 4. The Department of Public Safety, Health Services Section, shall issue two requests for proposals (RFP) to develop an electronic supply inventory management system. One RFP shall be for a system to be used at all prison facilities and one RFP shall be for a system to be used exclusively at the Central Prison Healthcare Complex and the North Carolina Correctional Institution for Women. The RFPs shall be for an electronic supply inventory management system that is capable of all of the following:

(1) Recording the arrival and departure of each medical supply in use or for future use from the point of order, including all methods of requisition and main storage locations (e.g., warehouse, secondary storage location, prison unit, or infirmary).

(2) Recording the dates on which a medical supply was physically at each transition point, including the date of use or disposal.

(3) Identifying Department employees who have custody of or control over a medical supply at each transition point, including at the time of use or disposal.

(4) Ensuring that medical supplies are used prior to their expiration date.

(5) Ensuring an adequate supply of each medical product currently being used or obtained for future use at each facility. Adequate supply level shall be based on usage of each medical product by each facility.

(6) Biannually assessing the need for particular medical supplies and the accuracy of records through an audit of the system.

The Department shall report the results of the RFPs to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety by December 1, 2019.

SECTION 5.(a) The Department of Public Safety, Health Services Section, and the Office of State Human Resources shall jointly study the salaries of all in-prison health services employees to determine what adjustments are necessary to increase the salaries of new hires and existing employees of the Health Services Section to market rates.

SECTION 5.(b) The Department of Public Safety shall establish a vacancy rate benchmark for each correctional facility and shall create a plan to reduce the vacancy rates. The Department shall consider initiatives to reduce vacancy rates, including the following:

(1) Increasing salaries to market rates.

(2) Creating a student loan forgiveness program for the Health Services Section.

(3) Offering signing bonuses and annual cash incentives.

(4) Increasing the use of telemedicine positions.

(5) Creating dual appointment opportunities for doctors currently employed by the State.

(6) Offering differential pay for health services workers employed in difficult-to-staff facilities.

(7) Streamlining and potentially eliminating duplicative or unnecessary steps in the hiring process.

SECTION 5.(c) The Department of Public Safety shall establish methods to measure the effectiveness of the initiatives to reduce vacancy rates required in subsection (b) of this section and estimate the budgetary impact and anticipated savings from the Department's reduced reliance on outside contracted providers. By February 1, 2020, the Department shall submit its findings on salaries and vacancy rates, including any proposed legislation and the need for assistance required from the Office of Human Resources and the Office of Rural Health in the

Department of Health and Human Services to accomplish the objectives outlined in subsections (a) and (b) of this section to the Joint Legislative Oversight Committee on Justice and Public Safety.

SECTION 6.(a) By July 1, 2019, the Department of Public Safety, Health Services Section, shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the chairs of the House of Representatives and Senate Appropriations Committees on Justice and Public Safety on the feasibility study of telehealth services referenced in the February 2019 Memorandum of Agreement between the Department and UNC Health Care.

SECTION 6.(b) The Department of Public Safety, Health Services Section, shall establish a telemedicine pilot program to provide physical health services to inmates in remote correctional facilities. The pilot program shall be established with consideration of the results of the study referenced in subsection (a) of this section. The goal of the pilot program is to assess whether the use of telemedicine decreases costs for inmate transportation, custody, and outside providers while improving access to care. While designing the telemedicine pilot program, the Department of Public Safety, Health Services Section, shall consult UNC Health Care; the 2012 University of North Carolina, Kenan-Flagler Business School report on telemedicine; and Finding 6, Report Number 2018-08, from the Joint Legislative Program Evaluation Oversight Committee. The telemedicine pilot program shall initially be established in two correctional facilities serving male inmates. One pilot site shall be located in a correctional facility in the eastern portion of the State and one pilot site shall be located in a correctional facility in the western portion of the State. The pilot program design must connect the two correctional facility pilot sites with the Central Prison Healthcare Complex and its contracted providers' facilities and shall be operational on or before January 1, 2020.

SECTION 6.(c) The ability to assess, measure, and evaluate the telemedicine pilot program shall be integral to the pilot program design. Assessment of the pilot program shall include, but is not limited to, the following measures for each correctional facility pilot site:

(1) Number and cost of telemedicine encounters by service area.

(2) Comparison of the number and cost of telemedicine encounters, by service area, to:

a. The number of in-person encounters provided the previous year to inmates housed at that facility; and

b. The number of in-person encounters provided during the pilot period at similar correctional facilities not participating in the pilot.

(3) Comparison of the number of days lapsed between referral date and treatment date, by service area, to:

a. The number of days lapsed the previous year in that facility; and

b. The number of days lapsed during the pilot period at similar correctional facilities not participating in the pilot.

(4) Amount of inmate transportation and custody costs avoided from receiving telemedicine.

(5) Amount of provider transportation costs avoided from providing telemedicine.

(6) Cost of initial telemedicine equipment and other related costs with descriptions.

(7) Obstacles and concerns related to expanding telemedicine to other correctional facilities.

SECTION 6.(d) On or before January 1, 2020, the Department of Public Safety, Health Services Section, shall provide an interim report on the assessment criteria outlined in subsection (c) of this section, including any additional findings and recommendations, to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Health and Human Services. On or before January 1, 2021, the

Department of Public Safety, Health Services Section, shall report to the Joint Legislative Oversight Committee on Justice and Public Safety and the Joint Legislative Oversight Committee on Health and Human Services on the assessment criteria outlined in subsection (c) of this section, including any additional findings, and shall make recommendations on whether to expand the telemedicine pilot program to additional sites, including accompanying costs and anticipated savings, and recommendations on which correctional facilities would be most advantageous to include in the pilot due to lack of access or costs associated with transportation and custody.

SECTION 7. This act becomes effective July 1, 2019.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

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HOUSE BILL 126
PROPOSED SENATE COMMITTEE SUBSTITUTE H126-CSBC-57 [v.3]
06/25/2019 05:43:58 PM

Short Title: Amend Certificate of Need Laws. (Public)

Sponsors:

Referred to:

February 21, 2019

A BILL TO BE ENTITLED

AN ACT AMENDING CERTIFICATE OF NEED LAWS.

The General Assembly of North Carolina enacts:

PART I. REFORMS EFFECTIVE OCTOBER 1, 2019

SECTION 1.1. G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

...

(2) "Bed capacity" means space used exclusively for inpatient ~~care,~~care at a health service facility, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage. ~~The term "bed capacity" also refers to the number of dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~

...

(5) "Change in bed capacity" means (i) any relocation of health service facility beds, or dialysis stations from one licensed facility or campus to another, or (ii) any redistribution of health service facility bed capacity among the categories of health service facility bed as defined in G.S. 131E-176(9c), or (iii) any increase in the number of health service facility ~~beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~beds.

...

(7a) "Diagnostic center" means a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds ~~five hundred thousand dollars ($500,000).~~one million five hundred thousand dollars ($1,500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than ~~five hundred thousand dollars ($500,000),~~one million five hundred thousand dollars ($1,500,000), the costs of the equipment, studies,

surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the 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 cost threshold amount in this sub-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.

...

(9a) "Health service" means an organized, interrelated medical, diagnostic, therapeutic, ~~and/or~~ or rehabilitative ~~activity~~ activity, or any combination of these, that is integral to the prevention of disease or the clinical management of a sick, injured, or disabled person. "Health service" does not include administrative and other activities that are not integral to clinical ~~management.~~management, or any activities performed at a facility that does not meet the definition of a health service facility.

(9b) "Health service facility" means 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 the mentally retarded;~~ home health agency office; ~~chemical dependency treatment facility;~~ diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility. The term "health service facility" does not include a licensable facility, as defined in G.S. 122C-3(14)b.

(9c) "Health service facility bed" means 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) intermediate care beds for the mentally retarded; (vi) chemical dependency treatment beds; (vii)~~ (iv) hospice inpatient facility beds; ~~(viii)~~ (v) hospice residential care facility beds; ~~(ix)~~ (vi) adult care home beds; and ~~(x)~~ or (vii) long-term care hospital beds.

...

(14a) ~~"Intermediate care facility for the mentally retarded"~~ "Intermediate care facility for individuals with intellectual disabilities" means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for persons with ~~mental retardation,~~ intellectual disabilities, autism, cerebral palsy, epilepsy or related conditions.

...

(14o) "Major medical equipment" means a single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than ~~seven hundred fifty thousand dollars ($750,000).~~two million dollars ($2,000,000). In determining whether the major medical equipment costs more than ~~seven hundred fifty thousand dollars ($750,000),~~two million dollars ($2,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the major medical 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. Major medical equipment does not include replacement equipment as defined

in this section. Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount 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.

...

(16) "New institutional health services" means any of the following:

...

b. Except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding ~~two~~ four million dollars ~~($2,000,000)~~($4,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds ~~two~~ four million dollars ~~($2,000,000).~~($4,000,000). Beginning September 30, 2022, and on September 30 each year thereafter, the amount in this sub-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.

...

d. ~~The~~ Except as otherwise allowed in G.S. 131E-184(j), the offering of ~~dialysis services or~~ home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.

...

~~u. The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.~~

~~v. The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is reflected on the health service facility's license in effect as of January 1, 2005.~~"

SECTION 1.2. G.S. 131E-177 reads as rewritten:

"**§ 131E-177. Department of Health and Human Services is designated State Health Planning and Development Agency; powers and duties.**

The Department of Health and Human Services is designated as the State Health Planning and Development Agency for the State of North Carolina, and is empowered to exercise the following powers and duties:

(1) To establish standards and criteria or plans required to carry out the provisions and purposes of this Article and to adopt rules pursuant to Chapter 150B of the General Statutes, to carry out the purposes and provisions of this ~~Article;~~Article.

(2) Adopt, amend, and repeal such rules and regulations, consistent with the laws of this State, as may be required by the federal government for grants-in-aid for health service facilities and health planning which may be made available by the federal government. This section shall be liberally construed in order that the State and its citizens may benefit from such ~~grants-in-aid;~~grants-in-aid.

(3) Define, by rule, procedures for submission of periodic reports by persons or health service facilities subject to agency review under this ~~Article;~~Article.

(4) ~~Develop~~ With respect to health service facilities planning, all of the following:

a. Develop policy, criteria, and standards for health service facilities ~~planning; shall conduct~~ planning.

b. Conduct statewide registration and inventories of and make determinations of need for health service facilities, health services as specified in G.S. 131E-176(16)f., and equipment as specified in G.S. 131E-176(16)f1., which shall include consideration of adequate geographic location of equipment and ~~services; and develop~~ services.

c. Develop a State Medical Facilities ~~Plan;~~Plan, provided, however, that the State Medical Facilities Plan shall not include policies or need determinations that limit the number of operating rooms or gastrointestinal endoscopy rooms.

(5) Implement, by rule, criteria for project ~~review;~~review.

(6) Have the power to grant, deny, or withdraw a certificate of need and to impose such sanctions as are provided for by this ~~Article;~~Article.

(7) Solicit, accept, hold and administer on behalf of the State any grants or devises of money, securities or property to the Department for use by the Department in the administration of this ~~Article; and~~Article.

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

(9) Collect fees for submitting applications for certificates of need.

(10) The authority to review all records in any recording medium of any person or health service facility subject to agency review under this Article which pertain to construction and acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records the Department deems to be reasonably necessary to determine compliance with this Article.

The Secretary of Health and Human Services shall have final decision-making authority with regard to all functions described in this section."

SECTION 1.3. G.S. 131E-183(a)(1) reads as rewritten:

"(1) The proposed project 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 that may be approved."

SECTION 1.4. G.S. 131E-184(c) reads as rewritten:

"(c) The Department shall exempt from certificate of need review any conversion of existing acute care beds to psychiatric ~~beds provided:~~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 and/or one or more of the Area Mental Health,~~

~~Developmental Disabilities, and Substance Abuse Authorities to provide psychiatric beds to patients referred by the contracting agency or agencies; and~~

~~(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.~~"

SECTION 1.5. G.S. 131E-184(e)(1) reads as rewritten:

"(1) The proposed capital expenditure would:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding an existing:

1. Nursing home facility, or
2. Adult care home ~~facility, or~~facility.
~~3. Intermediate care facility for the mentally retarded; and~~

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."

SECTION 1.6.(a) G.S. 131E-184 is amended by adding new subsections to read:

"(i) The Department shall exempt from certificate of need review the development, acquisition, construction, expansion, or replacement of a health service or health service facility that obtained certificate of need approval prior to October 1, 2019, as a kidney dialysis treatment center, including freestanding hemodialysis units; intermediate care facility for individuals with intellectual disabilities; psychiatric facility; chemical dependency treatment facility; or any other licensable facility, as defined in G.S. 122C-3(14)b.

(j) The Department shall exempt from certificate of need review the establishment of a home health agency by a continuing care retirement community licensed under Article 64 of Chapter 58 of the General Statutes to provide home health services to one or more residents of a continuing care retirement community who have entered into a contract with the continuing care retirement community to receive continuing care services with lodging. A continuing care retirement community that seeks to provide home health services to individuals who do not reside at the continuing care retirement community pursuant to a contract to receive continuing care services with lodging shall be required to obtain a certificate of need as a home health agency prior to developing or offering home health services to any individual not a resident of the continuing care retirement community under a contract to receive continuing care services with lodging. As used in this subsection, the terms "continuing care" and "lodging" are as defined in G.S. 58-64-1. Nothing in this subsection shall be construed to exempt from the State's home health agency licensure and certification requirements a continuing care retirement community that has been exempted from certificate of need review for the provision of home health services to one or more residents pursuant to this subsection."

SECTION 1.6.(b) G.S. 131E-184(j), as enacted by this section, applies to continuing care retirement communities engaged in the direct provision of home health services on or after October 1, 2019.

SECTION 1.7. G.S. 131E-186(a) reads as rewritten:

"(a) Within the prescribed time limits in G.S. 131E-185, the Department shall issue a decision to "approve," "approve with conditions," or "deny," an application for a new institutional health service. Approvals involving new or expanded nursing care ~~or intermediate care for the mentally retarded bed capacity~~ shall include a condition that specifies the earliest possible date the new institutional health service may be certified for participation in the Medicaid program. The date shall be set far enough in advance to allow the Department to identify funds to pay for care in the new or expanded facility in its existing Medicaid budget or to include these funds in its State Medicaid budget request for the year in which Medicaid certification is expected."

SECTION 1.8. G.S. 131E-189 is amended by adding a new subsection to read:

"(d) Notwithstanding any other provision of this section, a certificate of need for the construction of a health service facility expires if the holder of the certificate of need fails to initiate construction of the project authorized by the certificate of need within the following time frames:

(1) For a project that costs over fifty million dollars ($50,000,000), the holder of the certificate of need shall initiate construction of the project authorized by the certificate of need within four years after the date the Department's decision to approve the certificate of need for that project becomes final.

(2) For a project that costs fifty million dollars ($50,000,000) or less, the holder of the certificate of need shall initiate construction of the project authorized by the certificate of need within two years after the date the Department's decision to approve the certificate of need for that project becomes final."

SECTION 1.9. G.S. 131E-175(11) and (12) are repealed.

SECTION 1.10. This Part becomes effective October 1, 2019.

PART II. REFORMS EFFECTIVE JANUARY 1, 2020

SECTION 2.1. G.S. 131E-147 reads as rewritten:

"**§ 131E-147. Licensure requirement.**

...

(c1) All initial applications and renewal applications shall require the applicant to state the number of procedure rooms on the premises named in the application.

...

(f) The Department shall not issue or renew a license to operate an ambulatory surgical facility developed, acquired, or replaced on or after October 1, 2019, unless the application includes all of the following:

(1) A commitment that the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases shall be at least four percent (4%) of the total revenue collected for all surgical cases performed in the facility or proposed facility.

(2) For each year of operation, a commitment to report to the Department the total number of cases by each of the following payer categories:

a. Self-pay surgical cases.

b. Medicaid surgical cases.

c. Medicare surgical cases.

d. Commercial insurance surgical cases.

e. Managed care surgical cases.

f. Other surgical cases.

(3) A commitment to report utilization and payment data for services provided by the ambulatory surgical facility to the statewide data processor, as required by G.S. 131E-214.2."

SECTION 2.2. G.S. 131E-176(16), as amended by this act, reads as rewritten:

"(16) "New institutional health services" means any of the following:

...

~~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.~~

...."

SECTION 2.3. This Part becomes effective January 1, 2020.

PART III. REFORMS EFFECTIVE JANUARY 1, 2022

SECTION 3.1. G.S. 131E-176(9b), as amended by this act, reads as rewritten:

"(9b) "Health service facility" means a hospital; long-term care hospital; rehabilitation facility; nursing home facility; adult care home; home health agency office; diagnostic center; and a hospice office, hospice inpatient facility, hospice residential care ~~facility; and ambulatory surgical~~ facility. The term "health service facility" does not include a licensable facility, as defined in G.S. 122C-3(14)b."

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-184, as amended by this act, reads as rewritten:

"(a) Except as provided in subsection (b), the Department shall exempt from certificate of need review a new institutional health service if it receives prior written notice from the entity proposing the new institutional health service, which notice includes an explanation of why the new institutional health service is required, for any of the following:

…

(10) To develop, acquire, construct, expand in number, or replace an operating room or gastrointestinal endoscopy room for which a certificate of need was issued to an ambulatory surgical facility prior to January 1, 2022.

…

(k) The Department shall exempt from certificate of need review the development, acquisition, construction, expansion, or replacement of a health service or health service facility that obtained certificate of need approval prior to January 1, 2022, as an ambulatory surgical facility, including an ambulatory surgical facility with one or more operating rooms or gastrointestinal endoscopy procedure rooms."

SECTION 3.4. This Part becomes effective January 1, 2022.

PART IV. SEVERABILITY

SECTION 4.1. If any part of this section is declared unconstitutional or invalid by the courts, it does not affect the validity of this section as a whole or any part other than the part declared to be unconstitutional or invalid.

SECTION 4.2. This Part is effective when it becomes law.

HOUSE BILL 126:
Amend Certificate of Need Laws.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 25, 2019
Introduced by:	Reps. Murphy, Dobson, Potts, Sasser	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	PCS to First Edition H126-CSBC-57		

OVERVIEW: The Proposed Committee Substitute to House Bill 126 would make several changes to the Certificate of Need (CON) laws in Article 9 of Chapter 131E. The PCS would remove psychiatric facilities, kidney disease treatment centers, intermediate care facilities, chemical dependency treatment facilities, ambulatory surgical centers, and certain continuing care retirement centers from CON review. It would raise the cost thresholds that make diagnostic center equipment and health service facility capital expenditures subject to CON review and require ambulatory surgical centers to commit to providing a certain level of charity care.

BILL ANALYSIS:

Part I of the PCS would:

- Increase the equipment dollar limit that makes diagnostic centers subject to CON review from $500,000 to $1,500,000. This new limit would be indexed for inflation starting in September 2022.
- Remove psychiatric facilities, kidney disease treatment centers, intermediate care facilities, and chemical dependency treatment facilities from CON review.
- Remove continuing care retirement centers from CON review to the extent that they provide home health services to residents who have signed a contract to receive continuing care services with lodging.
- Redefine "major medical equipment" to mean equipment that costs $2,000,000. Currently, the definitional cost is $750,000. This new amount would be indexed for inflation starting in September 2022.
- Increase the limit that subjects a capital expenditure to CON review from $2,000,000 to $4,000,000. This new limit would be indexed for inflation starting in September 2022.
- Prevent the State Medical Facilities Plan from limiting the number of operating rooms or gastrointestinal endoscopy rooms.
- Require CON recipients whose projects cost more than $50,000,000 to initiate construction within four years of receiving a CON. CON recipients whose projects cost $50,000,000 or less would have two years to begin construction.
- Repeal G.S. 131E-175(11) and (12), which are findings of fact related to gastrointestinal endoscopy services.
- Become effective October 1, 2019.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Part II of the PCS would:

- Require applicants seeking licensure for an ambulatory service center to state the number of procedure rooms on the premises named in the application.
- Require, as a condition of licensure, that ambulatory surgical centers commit to providing a certain level of charity care.
- Remove the conversion of specialty ambulatory surgical programs to multispecialty ambulatory surgical programs from CON review.
- Become effective January 1, 2020.

Part III of the PCS would:

- Exempt ambulatory surgical centers from CON review.
- Become effective January 1, 2022.

EFFECTIVE DATE: Part I would be effective October 1, 2019. Part II would be effective January 1, 2020. Part III would be effective January 1, 2022.

HOUSE BILL 126

Short Title:	Organ & Tissue Donation/Heart Heroes.	(Public)
Sponsors:	Representatives Murphy, Dobson, Potts, and Sasser (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Transportation, if favorable, Rules, Calendar, and Operations of the House	

February 21, 2019

A BILL TO BE ENTITLED

AN ACT AMENDING THE REVISED UNIFORM ANATOMICAL GIFT ACT TO INCLUDE TISSUE DONATION AS PART OF THE DRIVERS LICENSE DONOR AUTHORIZATION.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-412.7(a) reads as rewritten:

"(a) A donor may make an anatomical gift by any of the following methods:

(1) By authorizing that a statement or symbol be imprinted on the donor's drivers license or identification card indicating that the donor has made an anatomical gift. Anatomical gifts made by this method shall not include a donation of ~~tissue or~~ the donor's body.

(2) In a will.

(3) During a terminal illness or injury of the donor, by any form of communication addressed to at least two adults, at least one of whom is a disinterested witness.

(4) As provided in subsection (b) of this section."

SECTION 2. This act becomes effective October 1, 2019.

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NORTH CAROLINA GENERAL ASSEMBLY

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June 27, 2019 10:00 AM Rm. 643

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June 27, 2019 10:00 AM Rm. 643

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June 27, 2019 10:00 AM Rm. 643

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HEALTH CARE, SENATE COMMITTEE

June 27, 2019 10:00 AM Rm. 643

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Brendan Riley	NC Office Cat
Marsha Evans	DRNC
David Heinen	NC Center for nonprofits
Rhaegan Jackson	PPA
Tracy Kimbrell	Parker Poe
Christine Crews	Wakemed
Martha McConnell	Atrium Health
Scott Rissmiller	Atrium Health
Paul Sherman	NCFB
Kara Weisshaar	SA

Senate Pages Attending

COMMITTEE: Health Care **ROOM:** 643

DATE: 6-27 **TIME:** 10 AM

PLEASE PRINT LEGIBLY....*or else!!!!!*

Page Name	Hometown	Sponsoring Senator
1. Sara Lennon	Efland	Mchissick
2. Blake Walls	Raleigh	Alexander J.
3. Sam Dillon	Raleigh	Berger
4. Anika Hall	Durham	Mckissik
5. Tania Hunter	Henderson	Smith
6. Kate Schwanz	Cornelius	Marcus
7. Emery Pikel	Charlotte	Wells
8. Lane Donathan	Charlotte	Wells

ages: Present this form to either the Committee Clerk at the meeting or to the Sgt-at-Arms.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

SENATE SERGEANT-AT-ARMS

HEALTH CARE, SENATE COMMITTEE

DATE: 06-27-2019 ROOM: 643

10:00 AM

SENATE SERGEANT AT ARMS

Frances Patterson

Terry Edmondson

Dwight Green

Senate Committee on Health Care
Tuesday, July 2, 2019 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on July 2, 2019, in Room 643 of the Legislative Office Building. Twelve members were present.

Senator Dan Bishop, Chair, presided.

HB 50 - Allow Hyperbaric Oxygen Therapy for TBI/PTSD (Representatives Murphy, Grange, Martin, Speciale)

Sen. Krawiec was recognized to explain the bill. Sens. D. Davis and Perry commented in support of the bill. James Hooker, a Vietnam veteran and hyperbaric oxygen therapy advocate, was recognized to speak in support of the bill. Sen. J. Davis motioned for a favorable report, with a referral to Rules. The motion carried.

HB 228 - Modernize Laws Pertaining to NC Medical Board.-AB (Representative Murphy)

Sen. Krawiec was recognized to explain the bill. Sen. Hise moved to amend the bill and was recognized to explain the amendment. The amendment passed and the amended bill was put back before the committee. Sen. Robinson motioned for a favorable report to the bill as amended, unfavorable to the original bill, rolled into a new proposed committee substitute, with a referral to Judiciary.

The meeting adjourned at 10:16 AM.

Senator Dan Bishop, Chair
Presiding

John Wynne, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Tuesday, July 02, 2019

Senator Bishop,
submits the following with recommendations as to passage:

FAVORABLE

HB **50** **(CS#1)** Allow Hyperbaric Oxygen Therapy for TBI/PTSD.

Draft Number:	None
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Joyce Krawiec will handle HB 50



NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Tuesday, July 02, 2019

Senator Bishop,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 3, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

HB **228** **(CS#3)** Modernize Laws Pertaining to NC Medical Board.-AB

Draft Number:	H228-PCS10692-BC-63
Sequential Referral:	Judiciary
Recommended Referral:	None
Long Title Amended:	No

UNFAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL NO. 2

HB **220** **(SCS#1)** Insurance Technical Changes.-AB

Draft Number:	H220-PCS40501-BC-64
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Senator Joyce Krawiec will handle HB 228
Senator Vickie Sawyer will handle HB 220



Senate Committee on Health Care
Tuesday, July 2, 2019, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 50	Allow Hyperbaric Oxygen Therapy for TBI/PTSD.	Representative Murphy Representative Grange Representative Martin Representative Speciale
HB 228	Modernize Laws Pertaining to NC Medical Board.-AB	Representative Murphy
HB 220	Insurance Technical Changes.-AB	Representative Setzer Representative Bumgardner Representative Corbin

HOUSE BILL 50: Allow Hyperbaric Oxygen Therapy for TBI/PTSD.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	July 1, 2019
Introduced by:	Reps. Murphy, Grange, Martin, Speciale	**Prepared by:**	Jessica Boney* Staff Attorney
Analysis of:	Second Edition		

OVERVIEW: ***House Bill 50 would enact the North Carolina Veterans Traumatic Brain Injury and Posttraumatic Stress Disorder Treatment and Recovery Act of 2019. The act would allow a veteran residing in North Carolina and diagnosed with traumatic brain injury or posttraumatic stress disorder by an authorized medical professional to receive hyperbaric oxygen therapy treatment in the State. The act would become effective October 1, 2019.***

BILL ANALYSIS:

Section 1 would call for the act to be known as the North Carolina Veterans Traumatic Brain Injury and Posttraumatic Stress Disorder Treatment and Recovery Act of 2019.

Sections 2(a) and 2(c) would be reserved for future codification.

Section 2(b) would amend Chapter 122C Mental Health, Article 6 Special Provisions, to add a new Part 5 pertaining to Traumatic Brain Injury (TBI) and Posttraumatic Stress Disorder (PTSD) Services for Veterans. The new Part 5 would define: "authorized medical professional," "hyperbaric oxygen therapy treatment," and "veteran." The statute would provide that any veteran residing in North Carolina diagnosed with TBI or PTSD by an authorized medical professional could receive hyperbaric oxygen therapy treatment in this State. Authorized medical professionals who prescribed hyperbaric oxygen therapy treatment to a veteran for the treatment of TBI or PTSD would have to do so in a manner that complied with the standard approved treatment protocol for the therapy.

EFFECTIVE DATE: The act would become effective October 1, 2019.

* Legislative Analyst Theresa Matula substantially contributed to this summary.

Karen Cochrane-Brown
Director

H50-SMBP-53 E2 -V-1

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

HOUSE BILL 50
Committee Substitute Favorable 3/26/19

Short Title: Allow Hyperbaric Oxygen Therapy for TBI/PTSD. (Public)

Sponsors:

Referred to:

February 13, 2019

A BILL TO BE ENTITLED

AN ACT AUTHORIZING CERTAIN MEDICAL PROFESSIONALS TO PRESCRIBE HYPERBARIC OXYGEN THERAPY FOR VETERANS WITH TRAUMATIC BRAIN INJURY AND POSTTRAUMATIC STRESS DISORDER.

Whereas, hyperbaric oxygen therapy is a recognized and accepted treatment for wound care and inflammation disorders; and

Whereas, traumatic brain injury and posttraumatic stress disorder are recognized to result from brain injuries and subsequent inflammation; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known and may be cited as the "North Carolina Veterans Traumatic Brain Injury and Posttraumatic Stress Disorder Treatment and Recovery Act of 2019."

SECTION 2.(a) G.S. 122C-455 through G.S. 122C-464. Reserved for future codification purposes.

SECTION 2.(b) Article 6 of Chapter 122C of the General Statutes is amended by adding a new Part to read:

"Part 5. Traumatic Brain Injury and Posttraumatic Stress Disorder Services for Veterans.

"**§ 122C-465. Definitions.**

As used in this Part, the following definitions apply:

(1) Authorized medical professional. – A doctor of medicine, nurse practitioner, physician assistant, or doctor of osteopathy licensed to practice in this State.

(2) Hyperbaric oxygen therapy treatment. – Treatment with a valid prescription from an authorized medical professional in either a hyperbaric chamber approved by the United States Food and Drug Administration (FDA), or a device with an appropriate FDA-approved investigational device exemption.

(3) Veteran. – A person who served on active duty, other than for training, in any component of the Armed Forces of the United States for a period of 180 days or more, unless released earlier because of service-connected disability, and who was discharged or released from the Armed Forces of the United States under other than dishonorable conditions.

"**§ 122C-465.1. Hyperbaric oxygen therapy treatment authorized.**

(a) No person other than an authorized medical professional shall prescribe hyperbaric oxygen therapy treatment to a veteran for the treatment of traumatic brain injury or posttraumatic stress disorder. Any authorized medical professional who prescribes hyperbaric oxygen therapy treatment to a veteran for traumatic brain injury or posttraumatic stress disorder shall do so in a manner that complies with the standard approved treatment protocols for this therapy.

(b) Any veteran residing in North Carolina who has been diagnosed with a traumatic brain injury or posttraumatic stress disorder by an authorized medical professional may receive hyperbaric oxygen therapy treatment in this State."

SECTION 2.(c) G.S. 122C-465.2 through G.S. 122C-465.5. Reserved for future codification purposes.

SECTION 3. This act becomes effective October 1, 2019.

HOUSE BILL 228:
Modernize Laws Pertaining to NC Medical Board.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Judiciary. If favorable, re-refer to Finance. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	July 1, 2019
Introduced by:	Rep. Murphy	**Prepared by:**	Jason Moran-Bates Committee Staff
Analysis of:	Fifth Edition		

OVERVIEW: House Bill 228 would modernize the laws governing the North Carolina Medical Board (Board) and the practice of medicine including:

- ***Authorize the Board to collect a background check fee from applicants and to remit that fee to the Department of Public Safety.***
- ***Create an affirmative duty for licensees to report suspected sexual misconduct, fraudulent prescribing, drug diversion, or theft to the Board.***
- ***Require 130 weeks of medical education for a physician license.***
- ***Increase civil penalties for practice outside the scope of various limited purpose licenses.***
- ***Remove geographic limits on where the Board can meet (currently, Raleigh) and allow the Superior Court in the county where the Board is located to hear appeals of decisions not to issue a license and appeals of disciplinary action (currently, Wake County Superior Court).***
- ***Clarify the Board's disciplinary authority including authority over applicants and inactive licenses.***
- ***Authorize reasonable fees for copying medical records based on the actual cost of copying.***
- ***Create a new criminal offense punishable as a Class C felony for sexual contact or penetration under pretext of medical treatment.***
- ***Allow death certificates to be completed by any physician, physician assistant, or nurse practitioner who took reasonable efforts to determine the patient's cause of death.***
- ***Remove the Board's authority to set fees by regulation and maintain fees set by regulation as of June 1, 2019.***

CURRENT LAW: Current law is underlined in the Bill Analysis for each section of the bill.

BILL ANALYSIS:

Section 1 would add definitions for "licensee" and "inactive license" to G.S. 90-1.1. It would clarify that a license can enter an inactive status when a licensee requests inactive status, fails to register, voluntarily surrenders a license, or when the Board issues a disciplinary order. Currently, "licensee" and "inactive license" are not statutorily defined.

Section 2 would make a technical change to G.S. 90-2.

Section 3 would make technical changes to G.S. 90-3.

Section 4 would require the Board to meet at least once per quarter at any location in North Carolina and allow the Board to have additional meetings as necessary. Current law requires the Board to meet once annually in Raleigh and to remain in session until all eligible applicants have been examined.

Section 5 would delete the word "physicians" and substitute the word "licensees" in G.S. 90-5.1(a).

Section 6 would require licensees to report any graduate medical or osteopathic education to the Board. Current law only requires reporting of graduate education obtained at institutions accredited by certain accrediting agencies.

Section 7 would delete "physician or physician assistant" and substitute "applicant or licensee" in G.S. 90-5.3.

Section 8 would add a new section to Article 1 of Chapter 90 creating an affirmative duty for licensees to report suspected sexual misconduct, fraudulent prescribing, drug diversion, or theft to the Board. Licensees who failed to report such conduct would be subject to discipline, and any individuals who made reports in good faith would be immune from civil liability. Individuals who staff the North Carolina Physicians Health Program would not be mandatory reporters under the new section; they would continue to be governed by the Program's reporting requirements in G.S. 90-21.22. There is currently no statutory duty to report sexual misconduct, fraudulent prescribing, or drug diversion, misuse, or theft.

Section 9 would repeal the requirement that the Board's secretary give a bond for the safekeeping and proper payment of all money that comes into the secretary's hands.

Section 10 would amend G.S. 90-8.1 to clarify that once an individual submits an application to the Board, that individual is under the Board's jurisdiction.

Section 11 would amend G.S. 90-9.1 to clarify that applicants for a physician license must complete medical education that lasts at least 130 weeks. Applicants who are currently certified in a medical specialty recognized by the Board would also be eligible for licensure, provided they meet the education and examination requirements. Under current law, applicants must show they have graduated from an approved medical college and passed an exam acceptable to the Board to be licensed.

Section 12 would change the physician licensure requirements for graduates of international medical schools in G.S. 90-9.2. Under the new requirements, applicants would have to complete two years of training or provide proof of certification by a specialty board recognized by the Board, as well as pass an exam acceptable to the Board. Under current law, international graduates must complete three years of training, but cannot use proof of specialist certification as a basis for licensure. Passing an exam is not required.

Section 13 would clarify that applicants are eligible for licensure as physician assistants if they complete an education program accredited by the Accreditation Review Commission on Education for the Physician Assistant and are certified by the National Commission on Certification of Physician Assistants or its successor entities. Currently, the education program must be accredited by the Committee on Allied Health Education and Accreditation and the certification cannot be issued by a successor entity.

Section 14 would amend G.S. 90-9.4 to remove the requirement that anesthesiologist assistant applicants must pass an exam administered by the National Commission of Certification on Anesthesiologist Assistants in order to be licensed. The requirement that they be certified by the Commission would remain, and passing an examination is a prerequisite to certification.

Section 15 would add a new section to Article 1 of Chapter 90 stating that the Board retains jurisdiction over inactive licenses, regardless of how they become inactive. It would also permit the Board to retain

jurisdiction over the holder of an inactive license for all matters known or unknown to the Board at the time of inactivation of the license.

Section 16 would repeal the provision of G.S. 90-10.1 allowing the Board to accept a licensing exam administered by the medical board of another state for licensure of physicians in North Carolina. The United States Medical Licensing Exam, which is accepted in most states, will continue to be accepted by the Board.

Section 17 would allow the Board to collect a background check fee from applicants and to remit that fee to the Department of Public Safety.

Section 18 would amend G.S. 90-12.01 to require directors of graduate medical education programs to report to the Board any adverse actions taken against, and resignations made by, physicians in medical education training programs.

Section 19 would change the maximum fine for individuals who practice outside the scope of their limited volunteer licenses to $500. The current fine is $25-$50. Practicing outside the scope of a limited volunteer license would continue to be a Class 3 criminal misdemeanor.

Section 20 would change the maximum fine for individuals who practice outside the scope of their retired limited volunteer licenses to $500. The current fine is $25-$50. Practicing outside the scope of a retired limited volunteer license would continue to be a Class 3 criminal misdemeanor.

Section 21 would change the maximum fine for individuals who practice outside the scope of their special purpose licenses to $500. The current fine is $25-$50. Practicing outside the scope of a special purpose license would continue to be a Class 3 criminal misdemeanor.

Section 22 would change the maximum fine for individuals who practice outside the scope of their medical school faculty licenses to $500. It would also amend G.S. 90-12.3 to automatically inactivate a medical school faculty license if the licensee ceased to hold a full-time faculty position, ceased to be employed full-time in a North Carolina medical school, or obtained any other license to practice medicine issued by the Board. The current fine is $25-$50. Practicing outside the scope of a medical school faculty license would continue to be a Class 3 criminal misdemeanor.

Section 23 would change the maximum fine for individuals who practice outside the scope of their physician assistant limited volunteer licenses to $500. The current fine is $25-$50. Practicing outside the scope of a physician assistant limited volunteer license would continue to be a Class 3 criminal misdemeanor.

Section 24 would change the maximum fine for individuals who practice outside the scope of their physician assistant retired limited volunteer licenses to $500. The current fine is $25-$50. Practicing outside the scope of a physician assistant retired limited volunteer license would continue to be a Class 3 criminal misdemeanor.

Section 25 would make technical changes to G.S. 90 13.2.

Section 26 would amend G.S. 90-14, which deals with the discipline authority of the Board. Under the new provisions:

- Physician assistants could provide physical or mental health examinations of licensees, and licensed mental health professionals could conduct mental health examinations of licensees. Currently, only physicians may perform these exams.
- Failure to comply with a Board order for undergoing physical or mental examination would be grounds for discipline.

- Failure to comply with a Board order to demonstrate professional qualifications would be grounds for discipline.
- A violation of any provision of Article 1 of Chapter 90 or failure to make any required reports would be grounds for discipline. Currently, these acts are not grounds for discipline.
- A felony conviction of rape or another sexual offense would result in automatic denial or revocation of a license. Revocation would be permanent, with no chance of reinstatement. Licenses revoked on any other grounds would be eligible for reinstatement in two years.

Section 27 would allow appeals of decisions not to issue a license to be filed in Superior Court of the county where the Board is located. Currently, those appeals must be filed in Wake County Superior Court.

Section 28 would remove the requirement in G.S. 90-14.2 that notice of discipline must be prepared by a committee of the Board.

Section 29 would permit the Board to use an Administrative Law Judge in compliance with the Administrative Procedure Act in any cases against current or former Board members.

Section 30 would allow sworn depositions to be used as evidence in Board hearings. The Board would be permitted to receive testimony via telephone and videoconference at its discretion. Currently deposition, telephone, and videoconference testimony is not permitted in Board hearings.

Section 31 would allow appeals of disciplinary action taken by the Board to be filed in Superior Court of the county where the Board is located. Currently, those appeals must be filed in Wake County Superior Court or the county in which the licensee resides.

Section 32 would amend G.S. 90-14.13 to change the malpractice reporting requirements. Under the new provisions, hospitals would have to report resignations that took place when the individual resigning was under investigation. In addition, licensees who do not have malpractice insurance provided by a North Carolina insurer would have to report damage awards and settlements within 30 days.

Section 33 would remove the requirement that the Board include names of applicants for license in meeting minutes. It would also correct a statutory citation and would clarify that the Board may report information about a potential crime to the North Carolina Department of Justice, the U.S. Department of Justice, and the U.S. Attorney in addition to other law enforcement agencies and the district attorney.

Section 34 would amend G.S. 90-18(c), which regulates the scope of practice of medicine. Under the new provisions, osteopathy and radiology (using radiant energy or radiation to treat illness) would be considered to be within the scope of practice of medicine. Under the current language of the statute, osteopathy is not considered to be the practice of medicine. This provision has been obsolete since 2009 when osteopaths became subject to the same licensure process as physicians. An out-of-state physician who communicates, using any means of communication, with one of the physician's regular patients who is temporarily in North Carolina, would not be practicing medicine. Currently, out-of-state physicians communicating with their patients who are temporarily in North Carolina are practicing medicine in North Carolina unless they use a toll-free phone number or the internet.

Section 35 would remove the requirement that prescriptions written by physician assistants include an identification number assigned by the Board. It would also remove the requirement that a hospital's policy regarding the tests and treatments that can be ordered by a physician assistant be approved in consultation with the nursing staff.

Section 36 would remove the requirement that prescriptions written by nurse practitioners include an identification number assigned by the Board.

Section 37 would allow State-required medical and physical examinations to be conducted by physician assistants and nurse practitioners, even if the statute or rule requires physicians to conduct the exam. Under current law, only physicians may conduct these exams unless the statute or rule specifically allows physician assistants or nurse practitioners to conduct them.

Section 38 would repeal G.S. 90-18.7, which requires the Board to establish rules for the disposal of pathological materials. In 2013, a law was passed giving DHHS this authority, so G.S. 90-18.7 is obsolete.

Section 39 would allow an anesthesiologist and any combination of a physician assistant, anesthesiologist assistant, and a certified nurse anesthetist to form a professional corporation. Currently, only an anesthesiologist and a certified nurse anesthetist may form a professional corporation.

Section 40 would allow a former physician member of the Medical Board to serve on the Emergency Medical Services Disciplinary Committee.

Section 41 would amend G.S. 8-53 to extend doctor-patient confidentiality to anyone licensed under Article 1 of Chapter 90.

Section 42 would allow physicians to charge reasonable fees for copying records based on actual cost and would clarify that medical records related to workers' compensation claims would continue to be subject to the fees established by the Industrial Commission. Currently, fees may only be charged for copying records for personal injury and social security disability claims.

Section 43 would create a new crime of sexual contact or penetration under pretext of medical treatment. This crime would be a Class C felony, unless the conduct was covered under another provision of law requiring a greater penalty.

Section 44 would allow death certificates to be completed by any physician, physician assistant, or nurse practitioner who took reasonable efforts to determine the patient's cause of death. A physician, physician assistant, or nurse practitioner who completed a death certificate in good faith would be immune from civil liability. Under current law, only a treating physician, physician assistant, or nurse practitioner in charge of the patient's care at the time of death, chief medical officer of the hospital or facility in which the death occurred, or a physician performing an autopsy may complete a death certificate.

Section 45 would remove the Board's authority to set fees by regulation and maintains fees set by regulation as of June 1, 2019.

EFFECTIVE DATE: Section 2.(a) of the act would become effective October 31, 2019. Section 43 of the act would become effective December 1, 2019, and apply to offenses committed on or after that date. The remainder of the act would become effective October 1, 2019.

Brad Krehely and Greg Roney, both with the Legislative Analysis Division, contributed substantially to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H 5

HOUSE BILL 228*
Committee Substitute Favorable 3/19/19
Committee Substitute #2 Favorable 4/3/19
Committee Substitute #3 Favorable 6/5/19
Fifth Edition Engrossed 6/12/19

Short Title: Modernize Laws Pertaining to NC Medical Board.-AB (Public)

Sponsors:

Referred to:

March 4, 2019

A BILL TO BE ENTITLED

AN ACT TO MODERNIZE LAWS PERTAINING TO THE NORTH CAROLINA MEDICAL BOARD AND THE PRACTICE OF MEDICINE.

The General Assembly of North Carolina enacts:

PART I. PRACTICE OF MEDICINE

SECTION 1. G.S. 90-1.1 reads as rewritten:

"**§ 90-1.1. Definitions.**

The following definitions apply in this Article:

...

(4) License. – An authorization issued by the Board to a ~~physician or~~ physician, physician ~~assistant~~ assistant, or anesthesiologist assistant to ~~practice~~ perform medical acts, tasks, or functions.

(4a) Licensee. – Any person issued a license by the Board, whether the license is active or inactive, including an inactive license by means of surrender.

(4b) Inactive license. – A license that no longer grants the authorization to perform medical acts, tasks, or functions. A license can become inactive upon a licensee's request, a licensee's failure to register annually, a licensee's voluntary surrender, or based on any disciplinary order issued by the Board.

(4c) Modality. – A method of medical treatment.

(5) The practice of medicine or surgery. – Except as otherwise provided by this subdivision, the practice of medicine or surgery, for purposes of this Article, includes any of the following acts:

...

d. Offering or undertaking to perform any surgical ~~operation~~ procedure on any individual.

...."

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

"**§ 90-2. Medical Board.**

(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:

...

e. One shall be a duly licensed physician who is a doctor of ~~osteopathy~~ osteopathic medicine or a full-time faculty member of one of the medical schools in North Carolina who utilizes integrative medicine in that person's clinical practice, as recommended by the Review Panel pursuant to G.S. 90-3.

...."

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

"(d) Any member of the Board may be removed from office by the Governor for good cause shown. Any vacancy in the physician, physician assistant, or nurse practitioner membership of the Board shall be filled for the period of the unexpired term by the Governor from a list submitted by the Review Panel pursuant to ~~G.S. 90-3 except as provided in G.S. 90-2(a)(2)a.~~ G.S. 90-3. Any vacancy in the public membership of the Board shall be filled by the appropriate appointing authority for the unexpired term."

SECTION 2.(c) Section 2(a) becomes effective October 31, 2019.

SECTION 3. G.S. 90-3 reads as rewritten:

"**§ 90-3. Review Panel recommends certain Board members; criteria for recommendations.**

(a) There is created a Review Panel to review all applicants for the physician positions, the physician assistant position, and the nurse practitioner position on the ~~Board except as provided in G.S. 90-2(a)(2)a.~~ Board. The Review Panel shall consist of nine members, including four from the Medical Society, one from the Old North State Medical Society, one from the North Carolina Osteopathic Medical Association, one from the North Carolina Academy of Physician Assistants, one from the North Carolina Nurses Association Council of Nurse Practitioners, and one public member currently serving on the Board. All physicians, physician assistants, and nurse practitioners serving on the Review Panel shall be actively practicing in North Carolina.

The Review Panel shall contract for the independent administrative services needed to complete its functions and duties. The Board shall provide funds to pay the reasonable cost for the administrative services of the Review Panel. The Board shall convene the initial meeting of the Review Panel. The Review Panel shall elect a chair, and all subsequent meetings shall be convened by the Review Panel.

The Governor shall appoint Board members as provided in G.S. 90-2. The Review Panel shall attempt to make its recommendations to the Governor reflect the composition of the State with regard to gender, ethnic, racial, and age composition.

The Review Panel and its members and staff shall not be held liable in any civil or criminal proceeding for exercising, in good faith, the powers and duties authorized by law.

(b) To be considered qualified for a physician position, the physician assistant position, or nurse practitioner position on the Board, an applicant shall meet each of the following criteria:

...

(9) Indicate, in a manner prescribed by the Review Panel, that the applicant: (i) understands that the primary purpose of the Board is to protect the public; (ii) is willing to take appropriate disciplinary action against his or her peers for misconduct or violations of the standards of ~~care or practice of medicine;~~ medical care; and (iii) is aware of the time commitment needed to be a constructive member of the Board.

...

(f) Notwithstanding any provision of G.S. 90-16, the Board may provide confidential and nonpublic licensing and investigative information in its possession to the Review ~~Panel.~~Panel regarding applicants.

...."

SECTION 4. G.S. 90-5 reads as rewritten:

"**§ 90-5. Meetings of Board.**

The North Carolina Medical Board shall ~~assemble once in every year in the City of Raleigh, and shall remain in session from day to day until all applicants who may present themselves for examination within the first two days of this meeting have been examined and disposed of; other meetings in each year may be held at some suitable point in the State if deemed advisable.~~meet at least once quarterly within the State of North Carolina and may hold any other meetings necessary to conduct the business of the Board."

SECTION 5. G.S. 90-5.1(a) reads as rewritten:

"(a) The Board ~~shall:~~shall have the following powers and duties:

...

(8) Develop and implement methods to identify dyscompetent ~~physicians~~ licensees and ~~physicians~~ licensees who fail to meet acceptable standards of care.

(9) Develop and implement methods to assess and improve ~~physician~~ licensee practice.

...."

SECTION 6. G.S. 90-5.2(a) reads as rewritten:

"(a) The Board shall require all ~~physicians and physician assistants~~ licensees to report to the Board certain information, including, but not limited to, the following:

(1) The names of any schools of medicine or osteopathy attended and the year of graduation.

(2) Any graduate medical or osteopathic ~~education at any institution approved by the Accreditation Council of Graduate Medical Education, the Committee for the Accreditation of Canadian Medical Schools, the American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.~~education.

...."

SECTION 7. G.S. 90-5.3 reads as rewritten:

"**§ 90-5.3. Reporting and publication of medical judgments, awards, payments, and settlements.**

(a) All ~~physicians and physician assistants licensed or applying for licensure by the Board~~ applicants and licensees shall report the following to the Board:

(1) All medical malpractice judgments or awards affecting or involving the ~~physician or physician assistant.~~applicant or licensee.

(2) All settlements in the amount of seventy-five thousand dollars ($75,000) or more related to an incident of alleged medical malpractice affecting or involving the ~~physician or physician assistant~~ applicant or licensee where the settlement occurred on or after May 1, 2008.

(3) All settlements in the aggregate amount of seventy-five thousand dollars ($75,000) or more related to any one incident of alleged medical malpractice affecting or involving the ~~physician or physician assistant~~ applicant or licensee not already reported pursuant to subdivision (2) of this subsection where, instead of a single payment of seventy-five thousand dollars ($75,000) or more occurring on or after May 1, 2008, there is a series of payments made to the same claimant which, in the aggregate, equal or exceed seventy-five thousand dollars ($75,000).

(b) The report required under subsection (a) of this section shall contain the following information:

(1) The date of the judgment, award, payment, or settlement.

(2) The specialty in which the ~~physician or physician assistant~~ applicant or licensee was practicing at the time the incident occurred that resulted in the judgment, award, payment, or settlement.

(3) The city, state, and country in which the incident occurred that resulted in the judgment, award, payment, or settlement.

(4) The date the incident occurred that resulted in the judgment, award, payment, or settlement.

(c) The Board shall publish on the Board's Web site or other publication information collected under this section. The Board shall publish this information for seven years from the date of the judgment, award, payment, or settlement. The Board shall not release or publish individually identifiable numeric values of the reported judgment, award, payment, or settlement. The Board shall not release or publish the identity of the patient associated with the judgment, award, payment, or settlement. The Board shall allow the ~~physician or physician assistant~~ applicant or licensee to publish a statement explaining the circumstances that led to the judgment, award, payment, or settlement, and whether the case is under appeal. The Board shall ensure these statements:

(1) Conform to the ethics of the medical profession.

(2) Not contain individually identifiable numeric values of the judgment, award, payment, or settlement.

(3) Not contain information that would disclose the patient's identity.

(d) The term "settlement" for the purpose of this section includes a payment made from personal funds, a payment by a third party on behalf of the ~~physician or physician assistant,~~ applicant or licensee, or a payment from any other source of funds.

(e) Nothing in this section shall limit the Board from collecting information needed to administer this Article."

SECTION 8. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-5.4. Duty to report.**

(a) Every licensee has a duty to report in writing to the Board within 30 days any incidents that licensee reasonably believes to have occurred involving any of the following:

(1) Sexual misconduct of any person licensed by the Board under this Article with a patient. Patient consent or initiation of acts or contact by a patient shall not constitute affirmative defenses to sexual misconduct. For purposes of this section, the term "sexual misconduct" means vaginal intercourse, or any sexual act or sexual contact or touching as described in G.S. 14-27.20. Sexual misconduct shall not include any act or contact that is for an accepted medical purpose.

(2) Fraudulent prescribing, drug diversion, or theft of any controlled substances by another person licensed by the Board under this Article. For purposes of this section, "drug diversion" means transferring controlled substances or prescriptions for controlled substances to (i) the licensee for personal use; (ii) a licensee's immediate family member; (iii) any other person living in the same residence as the licensee; (iv) any person with whom the licensee is having a sexual relationship; or (v) any individual unless for a legitimate medical purpose by an individual practitioner acting in the usual course of his professional practice. For the purposes of this section, the term "immediate family member" means a spouse, parent, child, sibling, and any step-family member or in-law coextensive with the preceding identified relatives.

(b) For persons issued a license to practice by the Board under this Article, failure to report under this section shall constitute unprofessional conduct and shall be grounds for discipline under G.S. 90-14(a)(6). However, persons licensed by the Board who are employed

by or serving as a director or agent of the North Carolina Physicians Health Program and who obtain information exclusively while functioning in their role as employee, director, or agent of the North Carolina Physicians Health Program that causes them reasonably to believe that incidents referred to in subdivisions (1) and (2) of subsection (a) of this section occurred shall not be required to report pursuant to this section but shall comply with the reporting provisions contained in G.S. 90-21.22.

(c) Any person who reports under this section in good faith and without fraud or malice shall be immune from civil liability. Reports made in bad faith, fraudulently, or maliciously shall constitute unprofessional conduct and shall be grounds for discipline under G.S. 90-14(a)(6).

(d) The Board may adopt rules to implement this section."

SECTION 9. G.S. 90-7 is repealed.

SECTION 10. G.S. 90-8.1 is amended by adding a new subsection to read:

"(c) By submitting an application for licensure, the applicant submits to the jurisdiction of the Board."

SECTION 11. G.S. 90-9.1(a) reads as rewritten:

"(a) Except as provided in G.S. 90-9.2, to be eligible for licensure as a physician under this Article, an applicant shall submit proof satisfactory to the Board that the ~~applicant:~~applicant meets all of the following criteria:

(1) ~~Has~~ The applicant has passed each part of an examination described in ~~G.S. 90-10.1;~~G.S. 90-10.1.

(2) ~~Is a graduate of:~~The applicant has completed at least 130 weeks of medical education and satisfies any of the following:

a. ~~A~~ The applicant is a graduate of a medical college approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or an osteopathic college approved by the American Osteopathic Association and has successfully completed one year of training in a medical education program approved by the Board after graduation from medical school; or

b. ~~A~~ The applicant is a graduate of a medical college approved or accredited by the Liaison ~~Commission~~ Committee on Medical Education, the Committee ~~for the~~ on Accreditation of Canadian Medical Schools, or an osteopathic college approved by the American Osteopathic Association, is a dentist licensed to practice dentistry under Article 2 of Chapter 90 of the General Statutes, and has been certified by the American Board of Oral and Maxillofacial Surgery after having completed a residency in an Oral and Maxillofacial Surgery Residency program approved by the Board before completion of medical ~~school; and~~school.

c. The applicant may satisfy the education and graduation requirements of subdivision (2) of this subsection by providing proof of current certification by a specialty board recognized by the American Board of Medical Specialties, Certificate of the College of Family Physicians, Fellowship of the Royal College of Physicians of Canada, Fellowship of the Royal College of Surgeons of Canada, American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, or any other specialty board the Board recognizes pursuant to rules.

(3) ~~Is~~ The applicant is of good moral character."

SECTION 12. G.S. 90-9.2 reads as rewritten:

"**§ 90-9.2. Requirements for graduates of ~~foreign~~ international medical schools.**

(a) To be eligible for licensure under this section, an applicant who is a graduate of a medical school not approved by the Liaison Commission on Medical Education, the Committee for the Accreditation of Canadian Medical Schools, or the American Osteopathic Association shall submit proof satisfactory to the Board that the ~~applicant:~~applicant has met all of the following:

(1) ~~Has successfully~~ The applicant has successfully completed ~~three~~ two years of training in a medical education program approved by the Board after graduation from medical ~~school;~~school, or provides proof of current certification by a specialty board recognized by the American Board of Medical Specialties, Certificate of the College of Family Physicians, Fellowship of the Royal College of Physicians of Canada, Fellowship of the Royal College of Surgeons of Canada, American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, or any specialty board the Board recognizes pursuant to rules.

(2) ~~Is of good~~ The applicant has good moral ~~character;~~character.

(3) ~~Has a~~ The applicant has a currently valid standard certificate of Educational Commission for Foreign Medical ~~Graduates (ECFMG); and~~Graduates.

(4) ~~Is able~~ The applicant has the ability to communicate in English.

(5) The applicant has successfully passed each part of an examination described in G.S. 90-10.1.

...."

SECTION 13. G.S. 90-9.3 reads as rewritten:

"**§ 90-9.3. Requirements for licensure as a physician assistant.**

(a) To be eligible for licensure as a physician assistant, an applicant shall submit proof satisfactory to the Board that the ~~applicant:~~applicant has met all of the following:

(1) ~~Has successfully~~ The applicant has successfully completed an educational program for physician assistants or surgeon assistants accredited by the ~~Committee on Allied Health Education and Accreditation~~ Accreditation Review Commission on Education for the Physician Assistant or ~~by the Committee's~~ its predecessor or successor ~~entities;~~entities.

(2) ~~Holds or previously held a certificate~~ The applicant has a current or previous certification issued by the National Commission on Certification of Physician ~~Assistants; and~~Assistants or its successor.

(3) ~~Is~~ The applicant is of good moral character.

(b) Before initiating practice of medical acts, tasks, or functions as a physician assistant, the physician assistant shall provide the Board the name, address, and telephone number of the physician who will supervise the physician assistant in the relevant medical setting.

(c) The Board may, by rule, require an applicant to comply with other requirements or submit additional information the Board deems appropriate. ~~The Board may set fees for physician assistants pursuant to rules adopted by the Board.~~"

SECTION 14. G.S. 90-9.4 reads as rewritten:

"**§ 90-9.4. Requirements for licensure as an anesthesiologist assistant.**

Every applicant for licensure as an anesthesiologist assistant in the State shall meet the following criteria:

...

(3) Submit to the Board proof of current certification from the National Commission of Certification of Anesthesiologist Assistants (NCCAA) or its successor ~~organization, including passage of a certification examination administered by the NCCAA.~~ organization. The applicant shall take the certification exam within 12 months after completing training.

(4) Meet any additional qualifications for licensure pursuant to rules adopted by the Board."

SECTION 15. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-9.5. Inactive licenses.**

The Board retains jurisdiction over an inactive license, regardless of how it became inactive, including a request for inactivation, surrender of a license, or by operation of an order entered by the Board. The Board's jurisdiction over the licensee extends for all matters, known and unknown to the Board, at the time of the inactivation or surrender of the license."

SECTION 16. G.S. 90-10.1(1) is repealed.

SECTION 17. G.S. 90-11(b) reads as rewritten:

"(b) The Department of Public Safety may provide a criminal record check to the Board for a person who has applied for a license through the Board. The Board shall provide to the Department of Public Safety, along with the request, the fingerprints of the applicant, any additional information required by the Department of Public Safety, and a form signed by the applicant consenting to the check of the criminal record and to the use of the fingerprints and other identifying information required by the State or national repositories. The applicant's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of the fingerprints to the Federal Bureau of Investigation for a national criminal history check. The Board shall keep all information pursuant to this subsection privileged, in accordance with applicable State law and federal guidelines, and the information shall be confidential and shall not be a public record under Chapter 132 of the General Statutes.

The Department of Public Safety may charge each applicant a fee for conducting the checks of criminal history records authorized by this subsection. The Board has the authority to collect this fee from each applicant and remit it to the Department of Public Safety."

SECTION 18. G.S. 90-12.01 reads as rewritten:

"**§ 90-12.01. Limited license to practice in a medical education and training program.**

(a) As provided in rules adopted by the Board, the Board may issue a limited license known as a "resident's training license" to a physician not otherwise licensed by the Board who is participating in a graduate medical education training program.

(b) A resident's training license shall become inactive at the time its holder ceases to be a resident in a training program or obtains any other license to practice medicine issued by the Board. The Board shall retain jurisdiction over the holder of the inactive license.

(c) The program director of every graduate medical education program shall report to the Board the following actions involving a physician participating in a graduate medical education training program within 30 days of the date that the action takes effect:

(1) Any revocation or termination, including, but not limited to, any nonrenewal or dismissal of a physician from a graduate medical education training program.

(2) A resignation from, or completion of, a graduate medical education program or a transfer to another graduate medical education training program."

SECTION 19. G.S. 90-12.1A reads as rewritten:

"**§ 90-12.1A. Limited volunteer license.**

(a) The Board may issue a "limited volunteer license" to an applicant ~~who:~~who does all of the following:

(1) Has a license to practice medicine and surgery in another ~~state; and~~state.

(2) Produces a ~~letter~~ verification from the state of licensure indicating the applicant's license is active and in good standing.

(3) Repealed by Session Laws 2011-355, s. 1, effective June 27, 2011.

...

(e) The holder of a limited license under this section may practice medicine and surgery only ~~at~~ in association with clinics that specialize in the treatment of indigent patients. The holder of the limited license may not receive compensation for services rendered at clinics specializing in the care of indigent patients.

...

(f) The holder of a limited license issued pursuant to this section who practices medicine or surgery ~~at places other than~~ outside of an association with clinics that specialize in the treatment of indigent patients shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined ~~not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00)~~ not more than five hundred dollars ($500.00) for each offense. The Board, in its discretion, may revoke the limited license after due notice is given to the holder of the limited license.

...."

SECTION 20. G.S. 90-12.1B reads as rewritten:

"**§ 90-12.1B. Retired limited volunteer license.**

...

(c) The holder of a limited license under this section may practice medicine and surgery only ~~at~~ in association with clinics that specialize in the treatment of indigent patients. The holder of the limited license may not receive compensation for services rendered at clinics specializing in the care of indigent patients.

...

(e) The holder of a limited license issued pursuant to this section who practices medicine or surgery ~~at places other than~~ outside of an association with clinics that specialize in the treatment of indigent patients shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined ~~not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00)~~ not more than five hundred dollars ($500.00) for each offense. The Board, in its discretion, may revoke the limited license after due notice is given to the holder of the limited license.

...."

SECTION 21. G.S. 90-12.2A reads as rewritten:

"**§ 90-12.2A. Special purpose license.**

(a) The Board may issue a special purpose license to practice medicine to an applicant ~~who:~~who does all of the following:

(1) Holds a full and unrestricted license to practice in at least one other ~~jurisdiction; and~~jurisdiction.

(2) Does not have any current or pending disciplinary or other action against him or her by any medical licensing agency in any state or other jurisdiction.

(b) The holder of the special purpose license practicing medicine or surgery beyond the limitations of the license shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined ~~not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00)~~ not more than five hundred dollars ($500.00) for each offense. The Board, at its discretion, may revoke the special license after due notice is given to the holder of the special purpose license.

...."

SECTION 22. G.S. 90-12.3 reads as rewritten:

"**§ 90-12.3. Medical school faculty license.**

(a) The Board may issue a medical school faculty license to practice medicine and surgery to a physician ~~who:~~who has met all of the following:

(1) ~~Holds~~ The applicant holds a full-time faculty appointment as either ~~a~~ an instructor, lecturer, assistant professor, associate professor, or full professor at ~~one of the following medical schools:~~a North Carolina medical school that is certified by the Liaison Committee on Medical Education or the Commission of Osteopathic College Accreditation of the American Osteopathic Association.

~~a. Duke University School of Medicine;~~
~~b. The University of North Carolina at Chapel Hill School of Medicine;~~
~~c. Wake Forest University School of Medicine; or~~
~~d. East Carolina University School of Medicine; and~~

(2) ~~Is~~ The applicant is not subject to disciplinary order or other action by any medical licensing agency in any state or other jurisdiction.

(b) The holder of the medical school faculty license issued under this section shall not practice medicine or surgery outside the confines of the medical school or ~~an affiliate of the medical school.~~ its affiliates. The holder of the medical school faculty license practicing medicine or surgery beyond the limitations of the license shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined ~~not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00)~~ not more than five hundred dollars ($500.00) for each offense. The Board, at its discretion, may revoke the special license after due notice is given to the holder of the medical school faculty license.

(b1) A medical school faculty license shall become inactive at the time its holder does one or more of the following:

(1) Ceases to hold a full-time appointment as an instructor, lecturer, assistant professor, or full professor at a certified North Carolina medical school.
(2) Ceases to be employed in a full-time capacity by a certified North Carolina medical school.
(3) Obtains any other license to practice medicine issued by the Board.

The Board shall retain jurisdiction over the holder of the inactive license.

(c) The Board may adopt rules and set fees related to issuing medical school faculty licenses. The Board may, by rule, set a time limit for the term of a medical school faculty license."

SECTION 23. G.S. 90-12.4 reads as rewritten:

"**§ 90-12.4. Physician assistant limited volunteer license.**

...

(c) The holder of a limited license may perform medical acts, tasks, or functions as a physician assistant only ~~at~~ in association with clinics that specialize in the treatment of indigent patients. The holder of a limited license may not receive payment or other compensation for services rendered at clinics specializing in the care of indigent patients. The holder of a limited volunteer license shall practice as a physician assistant within this State for no more than 30 days per calendar year.

...

(e) The holder of a limited license issued pursuant to this section who practices as a physician assistant ~~at places other than~~ outside an association with clinics that specialize in the treatment of indigent patients shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined ~~not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00)~~ not more than five hundred dollars ($500.00) for each offense. The Board, in its discretion, may revoke the limited license after due notice is given to the holder of the limited license.

...."

SECTION 24. G.S. 90-12.4B reads as rewritten:

"**§ 90-12.4B. Physician Assistant retired limited volunteer license.**

...

(c) The holder of a retired limited volunteer license under this section may perform medical acts, tasks, or functions as a physician assistant only ~~at~~ in association with clinics that specialize in the treatment of indigent patients. The holder of a retired limited volunteer license may not receive compensation for services rendered at clinics specializing in the care of indigent patients.

...

(e) The holder of a retired limited volunteer license issued pursuant to this section who practices as a physician assistant ~~at places other than~~ outside an association with clinics that specialize in the treatment of indigent patients shall be guilty of a Class 3 misdemeanor and, upon conviction, shall be fined ~~not less than twenty-five dollars ($25.00) nor more than fifty dollars ($50.00)~~ not more than five hundred dollars ($500.00) for each offense. The Board, in its discretion, may revoke the limited license after due notice is given to the holder of the limited license.

...."

SECTION 25. G.S. 90-13.2 reads as rewritten:

"**§ 90-13.2. Registration every year with Board.**

(a) Every ~~person licensed to practice medicine by the North Carolina Medical Board~~ licensee shall register annually with the Board ~~within~~ no later than 30 days ~~of~~ after the person's birthday.

...

(d) A ~~physician~~ licensee who is not actively engaged in the ~~practice of medicine~~ performance of medical acts, tasks, or functions in North Carolina and who does not wish to register the license may direct the Board to place the license on inactive status.

...

(g) Upon payment of all accumulated fees and penalties, the license of the ~~physician~~ licensee may be reinstated, subject to the Board requiring the ~~physician~~ licensee to appear before the Board for an interview and to comply with other licensing requirements. The penalty may not exceed the applicable maximum fee for a license under G.S. 90-13.1.

...."

SECTION 26. G.S. 90-14 reads as rewritten:

"**§ 90-14. Disciplinary Authority.**

(a) The Board shall have the power to place on probation with or without ~~-~~conditions, impose limitations and conditions on, publicly reprimand, assess monetary redress, issue public letters of concern, mandate free medical services, require satisfactory completion of treatment programs or remedial or educational training, fine, deny, annul, suspend, or revoke a license, or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

...

(5) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. The Board is empowered and authorized to require ~~a physician licensed by it~~ an applicant or licensee to submit to a mental or physical examination by physicians or physician assistants, or mental examinations by other licensed health care providers acting within the scope of their practice as allowed by law designated by the Board during the pendency of a license application and before or after charges may be presented against the ~~physician,~~ applicant or licensee, and the results of the examination shall be admissible in evidence in a hearing before the Board. Failure to comply with an order pursuant to this subsection may be considered unprofessional conduct as defined in G.S. 90-14(a)(6).

(6) Unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the

licensee's practice or otherwise, and whether committed within or without North Carolina. The Board shall not revoke the license of or deny a license to a person, or discipline a licensee in any manner, solely because of that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by competent evidence, the Board can establish that the treatment has a safety risk greater than the prevailing treatment or that the treatment is generally not effective.

...

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients or failing to maintain acceptable standards of ~~one or more areas of professional physician practice.~~ care. In this connection the Board may consider repeated acts of ~~a physician indicating the physician's~~ an applicant or licensee's failure to ~~properly~~ treat a ~~patient.~~patient properly. The Board may, upon reasonable grounds, require ~~a physician~~ an applicant or licensee to submit to inquiries or examinations, written or oral, as the Board deems necessary to determine the professional qualifications of ~~such~~ that applicant or licensee. Failure to comply with an order pursuant to this subsection may be considered unprofessional conduct as defined in G.S. 90-14(a)(6). In order to annul, suspend, deny, or revoke a license of an accused person, the Board shall find by the greater weight of the evidence that the care provided was not in accordance with the standards of practice for the procedures or treatments administered.

(11a) Not actively practiced ~~medicine or practiced as a physician assistant,~~ as a licensee, or having not maintained continued competency, as determined by the Board, for the two-year period immediately preceding the filing of an application for an initial license from the Board or the filing of a request, petition, motion, or application to reactivate or reinstate an inactive, suspended, or revoked license previously issued by the Board. The Board is authorized to adopt any rules or regulations it deems necessary to carry out the provisions of this subdivision.

(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient, and upon a finding of the exploitation, the Board may order the licensee pay restitution ~~be made~~ to the payer of the bill, whether the patient or the insurer, ~~by the physician;~~ provided that a determination of the amount of restitution shall be based on credible testimony in the record.

(13) Having a license ~~to practice medicine or the authority to practice medicine~~ revoked, suspended, restricted, or acted against or having a license to practice ~~medicine~~ denied by the licensing authority of any ~~jurisdiction.~~ jurisdiction, including Canada, the United Kingdom, and Australia. For purposes of this subdivision, the licensing authority's acceptance of a license to practice ~~medicine~~ voluntarily relinquished by a ~~physician~~ licensee or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the ~~physician's~~ licensee's license, or an inactivation or voluntary surrender of a license while under investigation is an action against a license to ~~practice medicine.~~practice.

(14) The failure to comply with an order issued under this Article or the failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the Board concerning any matter affecting the license to practice medicine.

(15) The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.

(16) A violation of any provision of this Article.

(17) Failure to make reports as required by this Article.

~~The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so revoked or otherwise acted upon, except that no license that has been revoked shall be restored for a period of two years following the date of revocation.~~

...

(c) ~~A~~ Except as provided in subsection (c1) of this section, a felony conviction shall result in the automatic revocation of a license issued by the Board, unless the Board orders otherwise or receives a request for a hearing from the person within 60 days of receiving notice from the Board, after the conviction, of the provisions of this subsection. If the Board receives a timely request for a hearing in such a case, the provisions of G.S. 90-14.2 shall be followed.

(c1) A felony conviction under Article 7B of Chapter 14 of the General Statutes shall result in the automatic denial or revocation of a license issued by the Board, and that denial or revocation shall be permanent, and the applicant or licensee shall be ineligible for reapplication, relicensure, reinstatement, or restoration under subsection (c2) of this section.

(c2) Except as provided in subsection (c1) of this section, where the Board has exercised its authority pursuant to this section to revoke a license, the holder of the revoked license will not be eligible to make an application for reinstatement before two years from the effective date of the revocation.

...

(g) Prior to taking action against any licensee for providing care not in accordance with the standards ~~of practice~~ of care for the procedures or treatments administered, the Board shall whenever practical consult with a licensee who routinely utilizes or is familiar with the same modalities and who has an understanding of the standards of practice for the modality administered. Information obtained as result of the consultation shall be available to the licensee at the informal nonpublic precharge conference.

...

(i) At the time of first communication from the Board or agent of the Board to a licensee regarding a complaint or investigation, the Board shall provide notice in writing to the licensee that informs the licensee: (i) of the existence of any complaint or other information forming the basis for the initiation of an investigation; (ii) that the licensee may retain counsel; (iii) how the Board will communicate with the licensee regarding the investigation or disciplinary proceeding in accordance with subsections (m) and (n) of this ~~section;(iv)~~ section; (iv) that the licensee has a duty to respond to inquiries from the Board concerning any matter affecting the license, and all information supplied to the Board and its staff will be considered by the Board in making a determination with regard to the matter under investigation; (v) that the Board will complete its investigation within six months or provide an explanation as to why it must be extended; and (vi) that if the Board makes a decision to initiate public disciplinary proceedings, the licensee may request in writing an informal nonpublic precharge conference.

(j) After the Board has made a nonpublic determination to initiate disciplinary proceedings, but before public charges have been issued, the licensee requesting so in writing, shall be entitled to an informal nonpublic precharge conference. At least five days prior to the informal nonpublic precharge conference, the Board will provide to the licensee the following: (i) all relevant information obtained during an investigation, including exculpatory evidence except for information that would identify an anonymous complainant; (ii) the substance of any written expert opinion that the Board relied upon, not including information that would identify an anonymous complainant or expert reviewer; (iii) notice that the licensee may retain counsel,

and if the licensee retains counsel all communications from the Board or agent of the Board regarding the disciplinary proceeding will be made through the licensee's counsel; (iv) notice that if a Board member initiated the investigation then that Board member will not participate in the adjudication of the matter before the Board or hearing committee; (v) notice that the Board may use an administrative law judge or designate hearing officers to conduct hearings as a hearing committee to take evidence; (vi) notice that the hearing shall proceed in the manner prescribed in Article 3A of Chapter 150B of the General Statutes and as otherwise provided in this Article; and (vii) any Board member who serves as a hearing officer in this capacity shall not serve as part of the quorum that determines the final agency decision. The provisions of this section do not apply where the Board has exercised its authority under G.S. 150B-3(c) and issued an order of summary suspension.

(k) ~~Unless the conditions specified in G.S. 150B-3(c) exist, the Board shall not~~ When the Board has made a determination that the public health, safety, or welfare requires emergency action, the Board may seek to require of a licensee the taking of any action adversely impacting the licensee's medical practice or license without first giving notice of the proposed action, the basis for the proposed action, and information required under subsection (i) of this section.

...."

SECTION 27. G.S. 90-14.1 reads as rewritten:

"**§ 90-14.1. Judicial review of Board's decision denying issuance of a license.**

Whenever ~~the North Carolina Medical Board has determined that a person who has duly made application to take an examination to be given by the Board showing his education, training and other qualifications required by said Board, or that a person who has taken and passed an examination given by the Board, has failed to satisfy the Board of his qualifications to be examined or~~ an applicant fails to satisfy the Board of the applicant's qualifications to be issued a license, ~~for any cause other than failure to pass an examination,~~ the Board shall immediately notify such person of its decision, and indicate in what respect the applicant has so failed to satisfy the Board. Such applicant shall be given a formal hearing before the Board upon request of such applicant filed with or mailed by registered mail to the secretary of the Board ~~at Raleigh, North Carolina,~~ within 10 days after receipt of the Board's decision, stating the reasons for such request. The Board shall within 20 days of receipt of such request notify such applicant of the time and place of a public hearing, which shall be held within a reasonable time. The burden of satisfying the Board of ~~his~~ the applicant's qualifications for licensure shall be upon the applicant. Following such hearing, the Board shall determine whether the applicant ~~is qualified to be examined or~~ is entitled to be ~~licensed as the case may be.~~ licensed. Any ~~such~~ decision of the Board shall be subject to judicial review upon appeal to the ~~Superior Court of Wake County~~ superior court of the county where the Board is located upon the filing with the Board of a written notice of appeal with exceptions taken to the decision of the Board within 20 days after service of notice of the Board's final decision. Within 30 days after receipt of notice of appeal, the secretary of the Board shall certify to the clerk of the ~~Superior Court of Wake County~~ superior court of the county where the Board is located the record of the case which shall include a copy of the notice of hearing, a transcript of the testimony and evidence received at the hearing, a copy of the decision of the Board, and a copy of the notice of appeal and exceptions. Upon appeal the case shall be heard by the judge without a jury, upon the record, except that in cases of alleged omissions or errors in the record, testimony may be taken by the court. The decision of the Board shall be upheld unless the substantial rights of the applicant have been prejudiced because the decision of the Board is in violation of law or is not supported by any evidence admissible under this Article, or is arbitrary or capricious. ~~Each party to the review proceeding may appeal to the Supreme Court as hereinafter provided in G.S. 90-14.11.~~"

SECTION 28. G.S. 90-14.2(a) reads as rewritten:

"(a) Before the Board shall take disciplinary action against any license granted by it, the licensee shall be given a written notice indicating the charges made against the ~~licensee, which~~

~~notice may be prepared by a committee or one or more members of the Board designated by the Board,~~ licensee and stating that the licensee will be given an opportunity to be heard concerning the charges at a time and place stated in the notice, or at a time and place to be thereafter designated by the Board, and the Board shall hold a public hearing not less than 30 days from the date of the service of notice upon the licensee, at which the licensee may appear personally and through counsel, may cross examine witnesses and present evidence in the licensee's own behalf. A licensee who is mentally incompetent shall be represented at such hearing and shall be served with notice as herein provided by and through a guardian ad litem appointed by the clerk of the court of the county in which the licensee resides. The licensee may file written answers to the charges within 30 days after the service of the notice, which answer shall become a part of the record but shall not constitute evidence in the case."

SECTION 29. G.S. 90-14.5 reads as rewritten:

"**§ 90-14.5. Use of ~~hearing committee and depositions;~~ recommended decisions; appointment of hearing officers.**

...

(a1) The Board may use an administrative law judge consistent with Article 3A of Chapter 150B of the General Statutes in lieu of a hearing committee so long as the Board has not solely alleged that the licensee failed to meet an applicable standard of ~~medical~~ care. Notwithstanding this subsection, the Board may use an administrative law judge consistent with Article 3A of Chapter 150B of the General Statutes if the licensee is a current or former Board member.

~~(b) Evidence and testimony may be presented at hearings before the Board or a hearing committee in the form of depositions before any person authorized to administer oaths in accordance with the procedure for the taking of depositions in civil actions in the superior court.~~

...."

SECTION 30. G.S. 90-14.6 reads as rewritten:

"**§ 90-14.6. Evidence admissible.**

...

(c1) Evidence and testimony may be presented at hearings before the Board or a hearing committee in the form of depositions before any person authorized to administer oaths in accordance with the procedure for the taking of depositions in civil actions in the superior court.

(d) When evidence is not reasonably available under the Rules of Civil Procedure and Rules of Evidence to show relevant facts, then the most reliable and substantial evidence available shall be admitted. At the discretion of the presiding officer of the hearing, the Board may receive witness testimony at a hearing by means of telephone or videoconferencing."

SECTION 31. G.S. 90-14.8(b) reads as written:

"(b) A licensee against whom any public disciplinary sanction is imposed by the Board may obtain a review of the decision of the Board in the ~~Superior Court of Wake County,~~ superior court of the county where the Board is located or the county in which the licensee resides, upon filing with the secretary of the Board a written notice of appeal within 30 days after the date of the service of the decision of the Board, stating all exceptions taken to the decision of the Board and indicating the court in which the appeal is to be heard. The court shall schedule and hear the case within six months of the filing of the appeal."

SECTION 32. G.S. 90-14.13 reads as rewritten:

"**§ 90-14.13. Reports of disciplinary action by health care institutions; reports of professional liability insurance awards or settlements; immunity from liability.**

(a) The chief administrative officer of every licensed hospital or other health care institution, including Health Maintenance Organizations, as defined in G.S. 58-67-5, preferred providers, as defined in G.S. 58-50-56, and all other provider organizations that issue credentials to ~~physicians who practice medicine in the State,~~ persons licensed under this Article shall, after consultation with the chief of staff of that institution, report to the Board the following actions

involving a physician's privileges to practice in that institution within 30 days of the date that the action takes effect:

(1) A summary revocation, summary suspension, or summary limitation of privileges, regardless of whether the action has been finally determined.

(2) A revocation, suspension, or limitation of privileges that has been finally determined by the governing body of the institution.

(3) A resignation from practice or voluntary reduction of ~~privileges.~~privileges while under investigation or threat of investigation.

(4) Any action reportable pursuant to Title IV of P.L. 99-660, the Health Care Quality Improvement Act of 1986, as amended, not otherwise reportable under subdivisions (1), (2), or (3) of this subsection.

(a1) A hospital is not required to ~~report:~~report any of the following:

(1) The suspension or limitation of a ~~physician's~~ licensee's privileges for failure to ~~timely complete medical records.~~complete medical records in a timely manner.

(2) A resignation from practice due solely to the ~~physician's~~ licensee's completion of a medical residency, internship, or fellowship.

The Board is authorized to adopt rules limiting the reporting requirements of subsection (a) of this section.

...

(b) Any ~~licensed physician~~ licensee who does not possess professional liability ~~insurance~~ insurance, or possess professional liability insurance from entities not owned and operated within this State, shall report to the Board any award of damages or any settlement of any malpractice complaint affecting his or her practice within 30 days of the award or settlement.

(c) The chief administrative officer of each insurance company providing professional liability insurance for ~~physicians who practice medicine in North Carolina,~~ persons licensed under this Article, the administrative officer of the Liability Insurance Trust Fund Council created by G.S. 116-220, and the administrative officer of any trust fund or other fund operated or administered by a hospital authority, group, or provider shall report to the Board within 30 days any of the following:

(1) Any award of damages or settlement of any claim or lawsuit affecting or involving a ~~person licensed under this Article~~ licensee that it insures.

(2) Any cancellation or nonrenewal of its professional liability coverage of a ~~physician,~~ licensee, if the cancellation or nonrenewal was for cause.

(3) A malpractice payment that is reportable pursuant to Title IV of P.L. 99-660, the Health Care Quality Improvement Act of 1986, as amended, not otherwise reportable under subdivision (1) or (2) of this subsection.

For the purposes of this subsection, a "claim" means an oral or written request for compensation made by a patient or a patient's representative, or an offer of compensation to a patient or a patient's representative, based on a belief that the patient was injured due to care affecting or involving a licensee. The Board shall determine whether the patient's care affected or involved a licensee under this Article.

...."

SECTION 33. G.S. 90-16 reads as rewritten:

"**§ 90-16. Self-reporting requirements; confidentiality of Board investigative information; cooperation with law enforcement; patient protection; Board to keep public records.**

(a) The North Carolina Medical Board shall keep a regular record of its proceedings with the names of the members of the Board ~~present, the names of the applicants for license,~~ present and other information as to its actions. The North Carolina Medical Board shall publish the names of those licensed within 30 days after granting the license.

...

(c) All records, papers, investigative files, investigative reports, other investigative information and other documents containing information in the possession of or received or gathered by the Board, or its members or employees or consultants as a result of investigations, inquiries, assessments, or interviews conducted in connection with a licensing, complaint, assessment, potential impairment matter, disciplinary matter, or report of professional liability insurance awards or settlements pursuant to G.S. 90-14.13, shall not be considered public records within the meaning of Chapter 132 of the General Statutes and are privileged, confidential, and not subject to discovery, subpoena, or other means of legal compulsion for release to any person other than the Board, its employees or consultants involved in the application for license, impairment assessment, or discipline of a license holder, except as provided in ~~subsections (d) and~~ subsection (e1) of this section. For purposes of this subsection, investigative information includes information relating to the identity of, and a report made by, a physician or other person performing an expert review for the Board and transcripts of any deposition taken by Board counsel in preparation for or anticipation of a hearing held pursuant to this Article but not admitted into evidence at the hearing.

(d) Repealed by Session Laws 2016-117, s. 2(o), effective October 1, 2016.

(e) Information furnished to a licensee or applicant, or counsel for a licensee or applicant, under ~~subsection (d) of this section~~ G.S. 90-14.2(c) shall be subject to discovery or subpoena between and among the parties in a civil case in which the licensee is a party.

...

(h) If investigative information in the possession of the Board, its employees, or agents indicates that a crime may have been committed, the Board may report the information to the appropriate law enforcement ~~agency~~ agency, the North Carolina Department of Justice, the United States Department of Justice, the United States Attorney, or the district attorney of the district in which the offense was committed.

(i) The Board shall cooperate with and assist a law enforcement ~~agency~~ agency, the North Carolina Department of Justice, the United States Department of Justice, the United States Attorney, or the district attorney conducting a criminal investigation or prosecution of a licensee by providing information that is relevant to the criminal investigation or prosecution to the ~~investigating~~ agency or ~~district attorney.~~ attorney as required by this subsection. Information disclosed by the Board to an investigative agency or ~~district~~ attorney pursuant to this subsection or subsection (h) of this section remains confidential and may not be disclosed by the investigating agency except as necessary to further the ~~investigation.~~investigation or prosecution.

...

(k) The Board, its members and staff, may release confidential or nonpublic information to any health care licensure board in this State or another state or authorized Department of Health and Human Services personnel with enforcement or investigative responsibilities about the issuance, denial, annulment, suspension, or revocation of a license, or the voluntary surrender of a license by a licensee of the Board, including the reasons for the action, or an investigative report made by the Board. The Board shall notify the licensee within 60 days after the information is transmitted. A summary of the information that is being transmitted shall be furnished to the licensee. If the licensee requests in writing within 30 days after being notified that the information has been transmitted, the licensee shall be furnished a copy of all information so transmitted. The notice or copies of the information shall not be provided if the information relates to an ongoing criminal investigation by any law enforcement agency or authorized Department of Health and Human Services personnel with enforcement or investigative responsibilities."

SECTION 34. G.S. 90-18(c) reads as rewritten:

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

...

~~(9) The practice of osteopathy by any legally licensed osteopath when engaged in the practice of osteopathy as defined by law, and especially G.S. 90-129.~~

...

(12) Any person practicing radiology as hereinafter defined shall be deemed to be engaged in the practice of medicine within the meaning of this Article. ~~"Radiology" shall be defined as, that method of medical practice in which demonstration and examination of the normal and abnormal structures, parts or functions of the human body are made by use of X ray. Any person shall be regarded as engaged in the practice of radiology who makes or offers to make, for a consideration, a demonstration or examination of a human being or a part or parts of a human body by means of fluoroscopic exhibition or by the shadow imagery registered with photographic materials and the use of X rays; or holds himself out to diagnose or able to make or makes any interpretation or explanation by word of mouth, writing or otherwise of the meaning of such fluoroscopic or registered shadow imagery of any part of the human body by use of X rays; or who treats any disease or condition of the human body by the application of X rays or radium. Nothing in this subdivision shall prevent the practice of radiology by any person licensed under the provisions of Articles 2, 7, 8, and 12A of this Chapter.~~"Radiology" is a specialty branch of the practice of medicine in which illness or disease is diagnosed or treated using various techniques or modalities, including radiant energy or ionizing radiation, and ultrasound and magnetic resonance. The education and training for the practice of radiology includes extensive study in the physics of radiant energy and medical imaging, radiation protection, and the application of ionizing radiation in the diagnosis and treatment of disease.

...

(18) The practice of medicine by any nonregistered physician residing in another state or foreign country who is contacted by one of the physician's regular patients for treatment by use of ~~the Internet or a toll-free telephone number~~ any method of communication while the physician's patient is temporarily in this State.

...."

SECTION 35. G.S. 90-18.1 reads as rewritten:

"**§ 90-18.1. Limitations on physician assistants.**

(a) Any person who is licensed under the provisions of G.S. 90-9.3 to perform medical acts, tasks, and functions as ~~an assistant to~~ a physician assistant may use the title "physician ~~assistant".~~ assistant" or "PA." Any other person who uses the title in any form or holds out to be a physician assistant or to be so licensed, shall be deemed to be in violation of this Article.

(b) Physician assistants are authorized to write prescriptions for drugs under the following conditions:

...

~~(3) The North Carolina Medical Board has assigned an identification number to the physician assistant which is shown on the written prescription.~~

...

(d) Physician assistants are authorized to order medications, tests and treatments in hospitals, clinics, nursing homes, and other health facilities under the following conditions:

...

(4) The hospital or other health facility has adopted a written ~~policy, approved by the medical staff after consultation with the nursing administration,~~ policy about ordering medications, tests, and treatments, including procedures for

verification of the physician assistants' orders by nurses and other facility employees and such other procedures as are in the interest of patient health and safety.

...

(g) Any person who is licensed under G.S. 90-9.3 to perform medical acts, tasks, and functions as ~~an assistant to~~ a physician assistant shall comply with each of the following:

(1) Maintain a current and active license to practice in this State.
(2) Maintain an active registration with the Board.
(3) Have a current Intent to Practice form filed with the Board.

...."

SECTION 36. G.S. 90-18.2 reads as rewritten:

"**§ 90-18.2. Limitations on nurse practitioners.**

(a) Any nurse approved under the provisions of ~~G.S. 90-18(14)~~ G.S. 90-18(c)(14) to perform medical acts, tasks or functions may use the title "nurse practitioner." Any other person who uses the title in any form or holds out to be a nurse practitioner or to be so approved, shall be deemed to be in violation of this Article.

(b) Nurse practitioners are authorized to write prescriptions for drugs under all of the following conditions:

(1) The North Carolina Medical Board and Board of Nursing have adopted regulations developed by a joint subcommittee governing the approval of individual nurse practitioners to write prescriptions with such limitations as the boards may determine to be in the best interest of patient health and ~~safety;~~safety.
(2) The nurse practitioner has current approval from the ~~boards;~~boards.
~~(3) The North Carolina Medical Board has assigned an identification number to the nurse practitioner which is shown on the written prescription; and~~
(4) The supervising physician has provided to the nurse practitioner written instructions about indications and contraindications for prescribing drugs and a written policy for periodic review by the physician of the drugs prescribed.
(5) A nurse practitioner shall personally consult with the supervising physician prior to prescribing a targeted controlled substance as defined in Article 5 of this Chapter when all of the following conditions apply:
   a. The patient is being treated by a facility that primarily engages in the treatment of pain by prescribing narcotic medications or advertises in any medium for any type of pain management services.
   b. The therapeutic use of the targeted controlled substance will or is expected to exceed a period of 30 days.

   When a targeted controlled substance prescribed in accordance with this subdivision is continuously prescribed to the same patient, the nurse practitioner shall consult with the supervising physician at least once every 90 days to verify that the prescription remains medically appropriate for the patient.

(c) Nurse practitioners are authorized to compound and dispense drugs under the following conditions:

(1) The function is performed under the supervision of a licensed pharmacist; and
(2) Rules and regulations of the North Carolina Board of Pharmacy governing this function are complied with.

(d) Nurse practitioners are authorized to order medications, tests and treatments in hospitals, clinics, nursing homes and other health facilities under all of the following conditions:

(1) The North Carolina Medical Board and Board of Nursing have adopted regulations developed by a joint subcommittee governing the approval of

individual nurse practitioners to order medications, tests and treatments with such limitations as the boards may determine to be in the best interest of patient health and ~~safety;~~safety.

(2) The nurse practitioner has current approval from the ~~boards;~~boards.

(3) The supervising physician has provided to the nurse practitioner written instructions about ordering medications, tests and treatments, and when appropriate, specific oral or written instructions for an individual patient, with provision for review by the physician of the order within a reasonable time, as determined by the Board, after the medication, test or treatment is ~~ordered; and~~ordered.

(4) The hospital or other health facility has adopted a written policy, approved by the medical staff after consultation with the nursing administration, about ordering medications, tests and treatments, including procedures for verification of the nurse practitioners' orders by nurses and other facility employees and such other procedures as are in the interest of patient health and safety.

...."

SECTION 37. G.S. 90-18.3 reads as rewritten:

"**§ 90-18.3. ~~Physical~~ Medical or physical examination by nurse practitioners and physician assistants.**

(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's~~ 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's~~ physician assistant, as defined by G.S. 90-18.1 and G.S. 90-18.2, respectively.

...."

SECTION 38. G.S. 90-18.7 is repealed.

PART II. PROFESSIONAL CORPORATION ACT

SECTION 39. G.S. 55B-14(c) reads as rewritten:

"(c) A professional corporation may also be formed by and between or among:

...

(6) A physician practicing anesthesiology and any combination of a physician assistant, an anesthesiology assistant, or a certified nurse anesthetist to render anesthesia and related medical services that the respective stockholders are licensed, certified, or otherwise approved to provide.

...."

PART III. EMERGENCY MEDICAL SERVICES ACT

SECTION 40. G.S. 143-519(b) reads as rewritten:

"(b) The Emergency Medical Services Disciplinary Committee shall consist of seven members appointed by the Secretary of the Department of Health and Human Services to serve four-year terms. Two of the members shall be currently practicing local EMS physician medical directors. One member each shall be a current or former physician member of the North Carolina Medical Board, a current EMS administrator, a current EMS educator, and two currently practicing and credentialed EMS personnel, one of whom shall be an emergency medical technician-paramedic."

PART IV. COMPETENCY OF WITNESSES

SECTION 41. G.S. 8-53 reads as rewritten:

"**§ 8-53. Communications between ~~physician~~ health care provider and patient.**

No person, duly authorized to practice ~~physic or surgery,~~ under Article 1 of Chapter 90 of the General Statutes, shall be required to disclose any information which he may have acquired in attending a patient in a professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon, and no such information shall be considered public records under G.S. 132-1. Confidential information obtained in medical records shall be furnished only on the authorization of the patient, or if deceased, the executor, administrator, or, in the case of unadministered estates, the next of kin. Any resident or presiding judge in the district, either at the trial or prior thereto, or the Industrial Commission pursuant to law may, subject to G.S. 8-53.6, compel disclosure if in his opinion disclosure is necessary to a proper administration of justice. If the case is in district court the judge shall be a district court judge, and if the case is in superior court the judge shall be a superior court judge."

PART V. MEDICAL RECORDS

SECTION 42. G.S. 90-411 reads as rewritten:

"**§ 90-411. Record copy fee.**

A health care provider may charge a reasonable fee to cover the costs incurred in searching, handling, copying, and mailing medical records to the patient or the patient's designated representative. ~~The maximum fee for each request shall be seventy-five cents (75¢) per page for the first 25 pages, fifty cents (50¢) per page for pages 26 through 100, and twenty-five cents (25¢) for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of up to ten dollars ($10.00), inclusive of copying costs.~~ The fee for copying any document or record on file shall bear a reasonable relation to the quantity of copies supplied and the cost of purchasing or leasing and maintaining copying equipment. These fees may be changed from time to time, but a schedule of fees shall be available on request at all times. If requested by the patient or the patient's designated representative, nothing herein shall limit a reasonable professional fee charged by a physician for the review and preparation of a narrative summary of the patient's medical record. ~~This section shall only apply with respect to liability claims for personal injury, and claims for social security disability, except that charges for medical records and reports related to claims under Article 1 of Chapter 97 of the General Statutes shall be governed by the fees established by the North Carolina Industrial Commission pursuant to G.S. 97-26.1.~~ Charges for medical records and reports related to claims under Article 1 of Chapter 97 of the General Statutes shall be governed by the fees established by the North Carolina Industrial Commission pursuant to G.S. 97-26.1. This section shall not apply to Department of Health and Human Services Disability Determination Services requests for copies of medical records made on behalf of an applicant for Social Security or Supplemental Security Income disability."

PART VI. RAPE AND OTHER SEX OFFENSES

SECTION 43.(a) Article 7B of Chapter 14 of the General Statutes is amended by adding a new section to read:

"**§ 14-27.33A. Sexual contact or penetration under pretext of medical treatment.**

(a) Definitions. – The following definitions apply in this section:

(1) Incapacitated. – A patient's incapability of appraising the nature of a medical treatment, either because the patient is unconscious or under the influence of an impairing substance, including, but not limited to, alcohol, anesthetics, controlled substances listed under Chapter 90 of the General Statutes, or any other drug or psychoactive substance capable of impairing a person's physical or mental faculties.

(2) Medical treatment. – Includes an examination or a procedure.

(3) Patient. – A person who has undergone or is seeking to undergo medical treatment.

(4) Sexual contact. – The intentional touching of a person's intimate parts or the intentional touching of the clothing covering the immediate area of the person's intimate parts, if that intentional touching can reasonably be construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or done in a sexual manner.

(5) Sexual penetration. – Sexual intercourse, cunnilingus, fellatio, anal intercourse, or any other intrusion, however slight, of any part of a person's body or of any object into the genital or anal openings of another person's body, regardless of whether semen is emitted, if that intrusion can reasonably be construed as being for the purpose of sexual arousal or gratification, done for a sexual purpose, or done in a sexual manner.

(b) Offense; Penalty. – Unless the conduct is covered under some other provision of law providing greater punishment, a person who undertakes medical treatment of a patient is guilty of a Class C felony if the person does any of the following in the course of that medical treatment:

(1) Represents to the patient that sexual contact between the person and the patient is necessary or will be beneficial to the patient's health and induces the patient to engage in sexual contact with the person by means of the representation.

(2) Represents to the patient that sexual penetration between the person and the patient is necessary or will be beneficial to the patient's health and induces the patient to engage in sexual penetration with the person by means of the representation.

(3) Engages in sexual contact with the patient while the patient is incapacitated.

(4) Engages in sexual penetration with the patient while the patient is incapacitated.

(c) This section does not prohibit a person from being charged with, convicted of, or punished for any other violation of law that is committed by that person while violating this section.

(d) The court may order a term of imprisonment imposed for a violation of this section to be served consecutively to a term of imprisonment imposed for any other crime, including any other violation of law arising out of the same transaction as the violation of this section."

SECTION 43.(b) This section becomes effective December 1, 2019, and applies to offenses committed on or after that date.

PART VII. DEATH CERTIFICATES

SECTION 44. G.S. 130A-115 reads as rewritten:

"**§ 130A-115. Death registration.**

...

(c) The medical certification shall be completed and signed by the physician in charge of the patient's care for the illness or condition which resulted in death, except when the death falls within the circumstances described in G.S. 130A-383. In the absence of the physician or with the physician's approval, the certificate may be completed and signed by an associate physician, a physician assistant in a manner consistent with G.S. 90-18.1(e1), a nurse practitioner in a manner consistent with G.S. 90-18.2(e1), the chief medical officer of the hospital or facility in which the death occurred or a physician who performed an autopsy upon the decedent under the following circumstances: the individual has access to the medical history of the deceased; the individual has viewed the deceased at or after death; and the death is due to natural causes. In the absence of a treating physician, physician assistant, or nurse practitioner in charge of the patient's care at the time of death, the chief medical officer of the hospital or facility in which the death occurred,

or a physician performing an autopsy, the death certificate may be completed by any other physician, physician assistant, or nurse practitioner who undertakes reasonable efforts to ascertain the events surrounding the patient's death. When specifically approved by the State Registrar, an electronic signature or facsimile signature of the physician, physician assistant, or nurse practitioner shall be acceptable. As used in this section, the term electronic signature has the same meaning as applies in G.S. 66-58.2. The physician, physician assistant, or nurse practitioner shall state the cause of death on the certificate in definite and precise terms. A certificate containing any indefinite terms or denoting only symptoms of disease or conditions resulting from disease as defined by the State Registrar, shall be returned to the person making the medical certification for correction and more definite statement.

...

(f) A physician, physician assistant, or nurse practitioner, who completes a death certificate in good faith, and without fraud or malice, shall be immune from civil liability or professional discipline."

PART VIII. RULE MAKING

SECTION 45. Notwithstanding any other provision of law, the North Carolina Medical Board shall not set fees pursuant to rules. Any fees set pursuant to rules adopted by the Board and applicable on June 1, 2019, remain valid.

PART IX. EFFECTIVE DATES

SECTION 46. Except as otherwise provided, this act becomes effective October 1, 2019.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 228*

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H228-ABC-68 [v.1]

Amends Title [NO]
Fifth Edition

Date July 2 ,2019

Senator Hise

moves to amend the bill on page 20, lines 20-23, by rewriting the lines to read:
"representative. The maximum fee for each request shall be seventy-five cents (75¢) per page for the first 25 pages, fifty cents (50¢) per page for pages 26 through 100, and twenty-five cents (25¢) for each page in excess of 100 pages, provided that the health care provider may impose a minimum fee of up to ten dollars ($10.00), inclusive of copying costs. The fee for copying any"

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 220:
Insurance Technical Changes.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	July 2, 2019
Introduced by:	Reps. Setzer, Bumgardner, Corbin	**Prepared by:**	Kristen L. Harris Jeremy Ray Staff Attorney
Analysis of:	Third Edition		

OVERVIEW: House Bill 220 makes various changes to North Carolina's insurance laws, as recommended by the Department of Insurance (DOI), including:

- ***Incorporates model act language from the National Association of Insurance Commissioners (NAIC) regarding immunity for independent contractors hired by DOI to assist in delinquency proceedings.***
- ***Makes technical and clarifying changes to consent to rate laws.***
- ***Amends procedures for individuals to receive an expedited external review of noncertification decisions.***
- ***Amends bail bond laws.***
- ***Clarifies the rulemaking authority of the North Carolina Fire and Rescue Commission.***
- ***Makes various changes to the Prepaid Health Plan Licensing Act.***
- ***Makes Medicare Supplement changes.***
- ***Makes changes to Exclusive Provider Benefit Plans.***

[As introduced, this bill was identical to S211, as introduced by Sens. Edwards, Gunn, J. Alexander, which is currently in Senate Rules and Operations of the Senate.]

BILL ANALYSIS:

PART I. HOLDING COMPANY ACT CHANGES

SECTION 1. Adds the term "affiliates" as it relates to affiliates of the domestic insurer, as an additional type of security that a domestic insurer may invest in, provided other existing safeguards are met. Domestic insurers are currently allowed to invest in certain types of securities of "subsidiaries" of the domestic insurer as they are defined under G.S. 58-19-10(a), consistent with the same conditions.

PART II. SURPLUS LINES CHANGES

SECTION 2.(a) Deletes language referencing a quarterly report requirement for surplus lines licencees repealed in subsection 2(d).

SECTION 2.(b) Repeals statute requiring The North Carolina Surplus Lines Association to provide the COI with an annually updated list of surplus lines licensees.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

SECTION 2.(c) Adds a copy of the compliance agreement to the documents a surplus lines licensee must keep in relation to its contracts.

SECTION 2.(d) Repeals a quarterly reporting requirement for surplus lines licenees.

SECTION 2.(e) Replaces failure to maintain the required bond, with failure to pay the stamping fee to the stamping office, as a grounds for Commissioner to suspend, revoke, or refuse to renew the licensee of a surplus lines licensee.

PART III. ALIGN STATE LAW WITH NAIC MODEL LAW REGARDING IMMUNITY FOR CONTRACTORS HIRED BY THE DEPARTMENT

SECTIONS 3.(a), 3.(b), & 3.(c) Adds NAIC model language, and associated conforming changes, that extends immunity from suit and liability, to all independent contractors who are retained by the receiver or the receiver's employees, and who are hired to assist in a delinquency proceeding. This includes: attorneys, accountants, auditors, and other professional persons or firms and their employees retained by the receiver.

An independent contractor would receive immunity both personally, and in their official capacities, for certain claims arising from:

- Duties of employment
- Matters subject to review by the Court after notice and hearing that are not disapproved, or disallowed by the Court.

An independent contractor extended immunity through this section would still be held liable for damages caused by their intentional, or willful and wanton misconduct.

PART IV. CLARIFY CONSENT TO RATE

SECTIONS 4.(a) through 4.(e) Makes several clarifying and technical changes to the insurance deviations laws, otherwise known as consent to rate. This includes erroneous cross references to sections that conflict with one another.

PART V. FAST ACT CONFORMING CHANGE

SECTION 5. Makes a technical correction and conforms North Carolina law to current federal law (Gramm-Leach-Bliley Act) by providing an exception to the annual privacy notice requirement for insurance institutions or agents, if all of the following apply:

- The insurance institution or agency provides nonpublic personal information only in accordance with certain federal privacy regulations; and
- The insurance institution or agency has not changed its policies or practices with regard to disclosing nonpublic personal information that were disclosed in the most recent required disclosure sent to consumers.

If at any time any of these requirements no longer apply to the insurance institution or agency, then the insurance institution or agency must provide the annual privacy notice required under this subsection.

PART VI. STREAMLINE EXPEDITED EXTERNAL REVIEW PROCESS

SECTIONS 6.(a), 6.(b), and 6.(c) Make changes to procedures for individuals to receive an expedited external review of noncertification decisions.

Part of this change would remove the requirement that medical advice from a medical consultant not affiliated with the organization be used in the determination of whether an expedited request should be

processed on an expedited basis. Instead, if the Commissioner determines that the request is eligible, a covered person's treating provider that is the subject of the external review would be allowed to certify the request on a form prescribed by the Commissioner.

Subsections (a) and (b) would become effective October 1, 2019, and apply to requests submitted on or after that date.

PART VII. BAIL BONDSMAN CHANGES

SECTION 7.(a) Adds a definition for premium to mean an amount of money paid in exchange for a bail bondsman's services in writing a bail bond.

SECTION 7.(b) Requires a bail bondsman to return a license to the Commissioner within 10 working days of a lapse (new status), suspension, or revocation of their license.

SECTION 7.(c) Requires bail bondsmen to include the court file or docket numbers for the principal's court obligation and the certificate seal number for each bond issued in the written reports filed with the Commissioner.

SECTION 7.(d) Amends language so information is provided to the principal automatically without the principal having to request it.

PART VIII. CLARIFY RULEMAKING AUTHORITY FOR STATE FIRE AND RESCUE

SECTION 8. Gives the State Fire and Rescue Commission with rule-making authority.

PART IX. PREPAID HEALTH PLAN LICENSING ACT CLARIFYING AND TECHNICAL CHANGES.

SECTIONS 9.(a), 9.(b), and **9.(f)** Makes technical and conforming changes to statutes relating to prepaid health plans.

SECTION 9.(c) Requires the Commissioner to notify the Department of Health and Human Services (DHHS) before conducting an examination of a prepaid health plan and provide the results of the examination.

SECTION 9.(d) Requires the Commissioner, to the greatest extent possible, to give notice to DHHS before seeking an application to rehabilitate or liquidate a prepaid health plan.

SECTION 9.(e) Requires the Commissioner to provide DHHS a copy of the written notice given to a prepaid health plan stating the grounds for denial, suspension, or revocation of a license.

PART X. CLARIFY WHEN APPLICATION SENT TO NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION

SECTION 10. Requires an application for a license as a self-insurer to be filed with the North Carolina Self-Insurance Security Association at the same time the application is filed with the Commissioner.

PART XI. MEDICARE SUPPLEMENT CHANGES

SECTION 11.(a) Requires insurers to make Medicare Supplement Plan A coverage available to disabled individuals before age 65. Insurers would also have to make Medicare Standardized Plan D and G coverage available to individuals age 65 or over. Section 11 would become effective January 1, 2020.

PART XII. EXCLUSIVE PROVIDER BENEFIT PLANS

SECTION 12.

Defines certain terms as they pertain to continuity of care decisions.

Provides a process for continued care for the insured under exclusive provider benefit plans if the insured is undergoing treatment for an *ongoing special condition* from a provider, and the contract between the provider and the insurer expires, or is terminated. An insured in this scenario would be allowed to elect continuation of treatment from the current provider.

Provides a transitional period to individuals who are *newly covered* under an exclusive provider benefit plan when the employer has changed benefit plans, and the insured is undergoing treatment for a special ongoing condition. Generally, a transitional period is determined by the treating physician, but is no longer than 90 days after notice is provided by the insurer following an expired or terminated contract, or the date of enrollment in a new plan.

Provides terms and conditions that an insurer may condition coverage of continued treatment.

Requires each insurer to provide a clear description of the insured's rights under this section in its evidence of coverage and summary plan description.

EFFECTIVE DATE: Except as otherwise provided, this act would become effective when it becomes law.

**Jason Moran-Bates, Legislative Analysis Division, substantially contributed to this summary.*

HOUSE BILL 220*
Committee Substitute Favorable 4/26/19
Senate Commerce and Insurance Committee Substitute Adopted 6/27/19

Short Title: Insurance Technical Changes.-AB (Public)

Sponsors:

Referred to:

February 28, 2019

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND CLARIFYING CHANGES TO THE INSURANCE LAWS, AS RECOMMENDED BY THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

PART I. HOLDING COMPANY ACT CHANGES

SECTION 1. G.S. 58-19-10(b) reads as rewritten:

"(b) In addition to investments in common stock, preferred stock, debt obligations, and other securities permitted under this Chapter, a domestic insurer may also:

(1) Invest, in common stock, preferred stock, debt obligations, and other securities of one or more affiliates or subsidiaries, amounts that do not exceed the lesser of ten percent (10%) of the insurer's admitted assets or fifty percent (50%) of the insurer's policyholders' surplus, provided that after those investments, the insurer's policyholders' surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs. In calculating the amount of the investments, investments in domestic or foreign insurance affiliates or subsidiaries and health maintenance organizations shall be excluded, and there shall be included: (i) total net monies or other consideration expended and obligations assumed in the acquisition or formation of a subsidiary, including all organizational expenses and contributions to capital and surplus of the subsidiary whether or not represented by the purchase of capital stock or issuance of other securities; and (ii) all amounts expended in acquiring additional common stock, preferred stock, debt obligations, and other securities, and all contributions to the capital or surplus, of a subsidiary subsequent to its acquisition or formation;

...

(3) With the approval of the Commissioner, invest any greater amount in common stock, preferred stock, debt obligations, or other securities of one or more affiliates or subsidiaries; provided that after such investment the insurer's policyholders' surplus will be reasonable in relation to the insurer's outstanding liabilities and adequate to its financial needs."

PART II. SURPLUS LINES CHANGES

SECTION 2.(a) G.S. 58-21-35(b) reads as rewritten:

"(b) The licensee shall complete and retain a copy of the report in paper or electronic form as required by the Commissioner. The report required by this section ~~and the quarterly report required by G.S. 58-21-80 shall be completed on a standardized form or forms prescribed by the Commissioner and are not public records~~ is not a public record under G.S. 132-1 or G.S. 58-2-100."

SECTION 2.(b) G.S. 58-21-40(b)(3) is repealed.

SECTION 2.(c) G.S. 58-21-75 reads as rewritten:

"**§ 58-21-75. Records of surplus lines licensee.**

Each surplus lines licensee shall keep in his or her office ~~in this State~~ a full and true record of each surplus lines insurance contract placed by or through the licensee, including a copy of the policy, certificate, cover note, or other evidence of insurance. The record shall include the following items:

(1) Amount of the insurance and perils insured;
(2) Brief description of the property insured and its location;
(3) Gross premium charged;
(4) Any return premium paid;
(5) Rate of premium charged upon the several items of property;
(6) Effective date of the contract, and the terms of the contract;
(7) Name and address of the insured;
(8) Name and address of the insurer;
(9) Amount of tax and other sums to be collected from the ~~insured; and~~insured;
(10) Identity of the producing broker, any confirming correspondence from the insurer or its representative, and the ~~application.~~application; and
(11) Copy of the compliance agreement.

The record of each contract shall be kept open at all reasonable times to examination by the Commissioner without notice for a period not less than five years following termination of the contract."

SECTION 2.(d) G.S. 58-21-80 is repealed.

SECTION 2.(e) G.S. 58-21-95 reads as rewritten:

"**§ 58-21-95. Suspension, revocation or nonrenewal of surplus lines licensee's license.**

The Commissioner may suspend, revoke, or refuse to renew the license of a surplus lines licensee after notice and hearing as provided under G.S. 58-2-70 upon any one or more of the following grounds:

(1) ~~Removal of the surplus lines licensee's office from this State;~~
(2) Removal of the surplus lines licensee's office accounts and records ~~from this State~~ during the period during which such accounts and records are required to be maintained under G.S. 58-21-75;
(3) Closing of the surplus lines licensee's office for a period of more than 30 business days, unless permission is granted by the Commissioner;
(4) Failure to make and file required reports;
(5) Failure to transmit the required tax on surplus lines premiums;
(6) ~~Failure to maintain the required bond;~~Failure to pay the stamping fee to the stamping office;
(7) Violation of any provision of this Article; or
(8) For any other cause for which an insurance license could be denied, revoked, suspended, or renewal refused under the Insurance Law."

PART III. ALIGN STATE LAW WITH NAIC MODEL LAW REGARDING IMMUNITY FOR CONTRACTORS HIRED BY THE DEPARTMENT

SECTION 3.(a) G.S. 58-30-71(a) reads as rewritten:

"(a) ~~For the purposes of this section, the persons~~ Persons entitled to protection under this section are:

(1) All receivers responsible for the conduct of a delinquency proceeding under this Article, including present and former receivers; and

(2) ~~Their employees~~ All of the receiver's employees, meaning all present and former special deputies and assistant special deputies appointed by the Commissioner, staff assigned to the delinquency proceeding employed by the Attorney General's Office, and all persons whom the Commissioner, special deputies, or assistant special deputies have employed to assist in a delinquency proceeding under this Article. ~~Attorneys, accountants, auditors, and other professional persons or firms, who are retained by the receiver as independent contractors and their employees are not employees of the receiver for purposes of this section.~~

(3) All of the receiver's contractors, meaning all persons who are retained by the receiver or the receiver's employees as independent contractors to assist in a delinquency proceeding under this Article, including attorneys, accountants, auditors, and other professional persons or firms and their employees."

SECTION 3.(b) G.S. 58-30-71(b) reads as rewritten:

"(b) The ~~receiver and his employees have~~ receiver, the receiver's employees, and the receiver's contractors shall have official immunity and are immune from suit and liability, both personally and in their official capacities, for any claim for damage to or loss of property or personal injury or other civil liability caused by or resulting from any alleged act, error, or omission of the receiver or any employee arising out of or by reason of any of the following:

(1) ~~their~~ Their duties or ~~employment;~~employment.

(2) Any matters that have been subject to review by the Court after notice and opportunity to be heard, provided that the alleged act, error, or omission was not disapproved or disallowed by the Court.

~~provided that nothing~~ Provided, however, that nothing in this section holds the ~~receiver or any employee~~ receiver, the receiver's employees, or the receiver's contractors immune from suit or liability for any damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of the ~~receiver or any employee~~ receiver, the receiver's employees, or the receiver's contractors or for any bodily injury caused by the operation of a motor vehicle."

SECTION 3.(c) G.S. 58-30-71(j) reads as rewritten:

"(j) Nothing in this section deprives the ~~receiver or any employee~~ receiver, the receiver's employees, or the receiver's contractors of any immunity, indemnity, benefits of law, rights, or any defense otherwise available."

PART IV. CLARIFY CONSENT TO RATE

SECTION 4.(a) G.S. 58-36-30(b) reads as rewritten:

"(b) This subsection applies ~~only~~ to insurance against loss to automobile physical damage and related expenses. A rate in excess of that promulgated by the Bureau may be charged by an insurer on any specific risk if the higher rate is charged in accordance with rules adopted by the Commissioner. An insurer shall give notice to the insured that the rates used to calculate the premium for the policy are greater than those rates that are applicable in the State of North Carolina by including the following language in the policy on page one of the declarations page or on a separate page before the declarations page, in at least 14 point type or in a font size larger than the remainder of the document whichever is larger, bolded, and all capitalized:

NOTICE: THE PREMIUM THAT WE ARE CHARGING FOR AUTOMOBILE PHYSICAL DAMAGE AND RELATED EXPENSES THAT COVERS THE DAMAGE TO YOUR COVERED VEHICLE(S) EXCEEDS THE PREMIUM BASED UPON THE APPROVED RATES IN NORTH CAROLINA, IN ACCORDANCE WITH G.S. 58-36-30(b).

The disclosure statement noted above in this subsection shall be included on any renewal of or endorsement to the policy when the rates charged exceed the approved manual rate. The insurer shall retain consent to rate information for each insured and make this information available to the Commissioner, upon request of the Commissioner. This subsection may also be used to provide motor vehicle liability coverage limits above those required under Article 9A of Chapter 20 of the General Statutes and above those that could be ceded to the North Carolina Reinsurance Facility under Article 37 of this Chapter to persons whose personal excess liability insurance policies require that they maintain specific higher liability coverage limits. Any data obtained by the Commissioner under this subsection is proprietary and confidential and is not a public record under G.S. 132-1 or G.S. 58-2-100."

SECTION 4.(b) G.S. 58-36-30(b1) reads as rewritten:

"(b1) This subsection applies only to insurance against loss to residential property with not more than four housing units. A rate in excess of that promulgated by the Bureau may be charged by an insurer on any specific risk if the higher rate is charged in accordance with rules adopted by the Commissioner. An insurer shall give notice to the insured that the rates used to calculate the premium for the policy are greater than those rates that are applicable in the State of North Carolina by including the following language in the policy on page one of the declarations page or on a separate page before the declarations page, in at least 14 point type or in a font size larger than the remainder of the document whichever is larger, bolded, and all capitalized:

NOTICE: IN ACCORDANCE WITH G.S. 58-36-30(b1), THE PREMIUM BASED UPON THE APPROVED RATES IN NORTH CAROLINA FOR RESIDENTIAL PROPERTY INSURANCE COVERAGE APPLIED FOR WOULD BE $____. OUR PREMIUM FOR THIS COVERAGE IS $____.

The disclosure statement noted above in this subsection shall be included on any renewal of or endorsement to the policy when the rates charged exceed the approved manual rate. ~~for any subsequent increase above the.~~ The insurer shall retain consent to rate information for each insured and make this information available to the Commissioner, upon request of the Commissioner. Any data obtained by the Commissioner under this subsection is proprietary and confidential and is not a public record under G.S. 132-1 or G.S. 58-2-100."

SECTION 4.(c) G.S. 58-36-30(c) reads as rewritten:

"(c) ~~Any approved rate under subsection (b) of this section with respect~~ This subsection applies only to workers' compensation and employers' liability insurance written in connection ~~therewith shall be furnished to the Bureau.~~therewith. A rate in excess of that promulgated by the Bureau may be charged by an insurer on any specific risk if the higher rate is charged in accordance with rules adopted by the Commissioner."

SECTION 4.(d) G.S. 58-36-30(e) reads as rewritten:

"(e) Each insurer shall collect the following consent to rate data for nonfleet private passenger motor vehicle physical damage and homeowners residential property ~~(all forms excluding HO4 and HO6)~~ with not more than four housing units (all forms, excluding HO4 and HO6) and transmit the data electronically for each policy to the Commissioner on a semi-annual basis in a format prescribed and designated by the Commissioner:

…."

SECTION 4.(e) The Commissioner may adopt temporary rules to implement this section.

PART V. FAST ACT CONFORMING CHANGE

SECTION 5. G.S. 58-39-26(a) reads as rewritten:

"(a) Disclosure Required. – In addition to the notice requirements of G.S. 58-39-25, an insurance institution or agent shall provide, to all applicants and policyholders no later than (i) before the initial disclosure of personal information under G.S. 58-39-75(11) or (ii) the time of

the delivery of the insurance policy or certificate, a clear and conspicuous notice, in written or electronic form, of the insurance institution or agent's policies and practices with respect to:

(1) Disclosing nonpublic personal information to affiliates and nonaffiliated third parties, consistent with section 502 of Public Law 106-102, including the categories of information that may be disclosed.

(2) Disclosing nonpublic personal information of persons who have ceased to be customers of the financial institution.

(3) Protecting the nonpublic personal information of consumers.

These disclosures shall be made in accordance with the regulations prescribed under section ~~505~~ 504 of Public Law 106-102.

(b) Information to Be Included. – The disclosure required by subsection (a) of this section shall include:

(1) The policies and practices of the insurance institution or agent with respect to disclosing nonpublic personal information to nonaffiliated third parties, other than agents of the insurance institution or agent, consistent with section 502 of Public Law 106-102, and including:

a. The categories of persons to whom the information is or may be disclosed, other than the persons to whom the information may be provided under section 502(e) of Public Law 106-102.

b. The policies and practices of the insurance institution or agent with respect to disclosing of nonpublic personal information of persons who have ceased to be customers of the insurance institution or agent.

(2) The categories of nonpublic personal information that are collected by the insurance institution or agent.

(3) The policies that the insurance institution or agent maintains to protect the confidentiality and security of nonpublic personal information in accordance with section 501 of Public Law 106-102.

(4) The disclosures required, if any, under section 603(d)(2)(A)(iii) of the Fair Credit Reporting Act.

(c) In the case of a policyholder, the notice required by this section shall be provided not less than annually during the continuation of the policy. As used in this subsection, "annually" means at least once in any period of 12 consecutive months during which the policy is in effect.

(d) Exception to Annual Notice Requirement. – An insurance institution or agent is not required to provide the privacy notice annually as required under subsection (c) of this section if all of the following apply:

(1) The insurance institution or agent provides nonpublic personal information only in accordance with the provisions of sections 502(b)(2) or 502(e) of Public Law 106-102 or regulations prescribed under section 504(b) of Public Law 106-102.

(2) The insurance institution or agent has not changed its policies and practices with regard to disclosing nonpublic personal information from the policies and practices that were disclosed in the most recent disclosure sent to consumers in accordance with this section.

If, at any time, subdivision (1) or (2) of this subsection no longer applies to an insurance institution or agent, then the insurance institution or agent shall be required to provide the annual privacy notice required under subsection (c) of this section."

PART VI. STREAMLINE EXPEDITED EXTERNAL REVIEW PROCESS

SECTION 6.(a) G.S. 58-50-82(a) reads as rewritten:

"(a) Except as provided in subsection (g) of this section, a covered person may file a request for an expedited external review with the Commissioner at the time the covered person ~~receives:~~receives any of the following:

(1) A noncertification decision under G.S. 58-50-61(f) ~~if:~~if all of the following conditions apply:

a. The covered person has a medical condition where the time frame for completion of an expedited review of an appeal involving a noncertification set forth in G.S. 58-50-61(*l*) would be reasonably expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum ~~function; and~~function.

b. The covered person has filed a request for an expedited appeal under G.S. 58-50-61(*l*).

(2) An appeal decision under G.S. 58-50-61(k) or ~~(l)~~ G.S. 58-58-61(*l*) upholding a noncertification ~~if:~~if all of the following conditions apply:

a. The noncertification appeal decision involves a medical condition of the covered person for which the time frame for completion of an expedited second-level grievance review of a noncertification set forth in G.S. 58-50-62(i) would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum ~~function; and~~function.

b. The covered person has filed a request for an expedited second-level grievance review of a noncertification as set forth in ~~G.S. 58-50-61(i); or~~ G.S. 58-50-62(i).

(3) A second-level grievance review decision under ~~G.S. 58-60-62(h) or (i)~~ G.S. 58-50-62(h) or G.S. 58-50-62(i) upholding a ~~noncertification:~~noncertification if all of the following conditions apply:

a. If the covered person has a medical condition where the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or jeopardize the covered person's ability to regain maximum ~~function; or~~function.

b. If the second-level grievance concerns a noncertification of an admission, availability of care, continued stay, or health care service for which the covered person received emergency services, but has not been discharged from a facility."

SECTION 6.(b) G.S. 58-50-82(b) reads as rewritten:

"(b) Within two days after receiving a request for an expedited external review, the Commissioner shall complete all of the following:

(1) Notify the insurer that made the noncertification, noncertification appeal decision, or second-level grievance review decision which is the subject of the request that the request has been received and provide a copy of the request. The Commissioner shall also request any information from the insurer necessary to make the preliminary review set forth in G.S. 58-50-80(b)(2) and require the insurer to deliver the information not later than one day after the request was made.

(2) Determine whether the request is eligible for external ~~review and, if it is eligible, determine whether it is eligible for expedited review.~~review.

(3) If the request is eligible for external review and the covered person's treating provider requesting the service that is the subject of the external review has

certified the request on a form prescribed by the Commissioner, then one of the following shall apply:

a. For a request made pursuant to subdivision (a)(1) of this ~~section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether~~ section, the request ~~should~~ shall be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-61(l) would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall ~~then~~ inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered person's request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the covered person's request for an expedited external review, then the covered person shall be ~~informed by the Commissioner that the covered person must exhaust, at a minimum, the insurer's internal appeal process under G.S. 58-50-61(l) before making another request for an external review with the Commissioner.~~ notified.

b. For a request made pursuant to subdivision (a)(2) of this ~~section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether~~ section, the request ~~should~~ shall be reviewed on an expedited basis because the time frame for completion of an expedited review under G.S. 58-50-62 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall ~~then~~ inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the Commissioner has accepted the covered person's request for an expedited external review. If the Commissioner has accepted the covered person's request for an expedited external review, then the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame. If the Commissioner has not accepted the covered person's request for an expedited external review, then the covered person shall be ~~informed by the Commissioner that the covered person must exhaust the insurer's internal grievance process under G.S. 58-50-62 before making another request for an external review with the Commissioner.~~ notified.

c. For a request made pursuant to sub-subdivision (a)(3)a. of this ~~section that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall~~

~~determine, based on medical advice from a medical professional who is not affiliated with the organization that will be assigned to conduct the external review of the request, whether~~ section, the request ~~should~~ shall be reviewed on an expedited basis because the time frame for completion of a standard external review under G.S. 58-50-80 would reasonably be expected to seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. The Commissioner shall ~~then~~ inform the covered person, the covered person's provider who performed or requested the service, and the insurer whether the review will be conducted using an expedited or standard time frame and shall, in accordance with G.S. 58-50-80, assign an organization to conduct the review within the appropriate time frame.

d. For a request made pursuant to sub subdivision (a)(3)b. of this section, ~~that the Commissioner has determined meets the reviewability requirements set forth in G.S. 58-50-80(b)(2), the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the expedited review and inform the covered person, the covered person's provider who performed or requested the service, and the insurer of its decision.~~the Commissioner shall, in accordance with G.S. 58-50-80, assign an organization to conduct the expedited review and inform the covered person, the covered person's provider who performed or requested the service, and the insurer of its decision."

SECTION 6.(c) G.S. 58-50-89 reads as rewritten:

"**§ 58-50-89. Hold harmless for ~~Commissioner, medical professionals,~~ Commissioner and independent review organizations.**

~~Neither the~~ The Commissioner, ~~a medical professional rendering advice to the Commissioner under G.S. 58-50-82(b)(2),~~ an independent review organization, ~~nor shall~~ or a clinical peer reviewer working on behalf of an independent review organization shall not be liable for damages to any person for any opinions rendered during or upon completion of an external review conducted under this Part, unless the opinion was rendered in bad faith or involved gross negligence."

SECTION 6.(d) Subsections (a) and (b) of this section become effective October 1, 2019, and apply to requests for expedited review submitted on or after that date.

PART VII. BAIL BONDSMAN CHANGES

SECTION 7.(a) G.S. 58-71-1 is amended by adding a new subdivision to read:

"(6a) Premium. – An amount of money paid in exchange for a bail bondsman's services in writing a bail bond."

SECTION 7.(b) G.S. 58-71-45 reads as rewritten:

"**§ 58-71-45. Terms of licenses.**

A license issued to a bail bondsman or to a runner authorizes the licensee to act in that capacity until the license is lapsed, suspended or revoked. ~~Upon the suspension or revocation of a license, the~~ The licensee shall return the license to the ~~Commissioner.~~ Commissioner within 10 working days of the lapse, suspension, or revocation of the license. A license of a bail bondsman and a license of a runner shall be renewed in accordance with G.S. 58-71-75. After notifying the Commissioner in writing, a professional bondsman who employs a runner may cancel the runner's authority to act for the professional bondsman."

SECTION 7.(c) G.S. 58-71-165(a) reads as rewritten:

"(a) Each professional bail bondsman shall file with the Commissioner a written report in a form prescribed by the Commissioner regarding all bail bonds on which the bondsman is liable

as of the first day of each month showing (i) each individual bonded, (ii) the date the bond was given, (iii) the principal sum of the bond, (iv) the ~~State or local official to whom given, and~~ court file or docket number for the principal's court obligation, (v) the fee charged for the bonding service in each ~~instance.~~instance, and (vi) the certificate seal number for each bond issued."

SECTION 7.(d) G.S. 58-71-167 reads as rewritten:

"**§ 58-71-167. Portion of bond premium payments deferred.**

(a) In any case where the agreement between principal and surety calls for some portion of the bond premium payments to be deferred or paid after the defendant has been released from custody, a written memorandum of agreement between the principal and surety shall be kept on file by the surety with a copy provided to the ~~principal, upon request.~~ principal. The memorandum shall contain the following information:

(1) The amount of the premium payment deferred or not yet paid at the time the defendant is released from jail.

(2) The method and schedule of payment to be made by the defendant to the bondsman, which shall include the dates of payment and amount to be paid on each date.

(3) That the principal ~~is, upon the principal's request,~~ is entitled to a copy of the memorandum.

(b) The memorandum must be signed by the defendant and the bondsman, or one of the bondsman's agents, and dated at the time the agreement is made. Any subsequent modifications of the memorandum must be in writing, signed, dated, and kept on file by the surety, with a copy provided to the ~~principal, upon request.~~principal."

PART VIII. CLARIFY RULE-MAKING AUTHORITY FOR STATE FIRE AND RESCUE COMMISSION

SECTION 8. G.S. 58-78-5(a) is amended by adding a new subdivision to read:

"(a) The Commission shall have the following powers and duties:

...

(17) To adopt, modify, or repeal any rules and regulations necessary for the purpose of carrying out the provisions of this Article."

PART IX. PREPAID HEALTH PLAN LICENSING ACT CLARIFYING AND TECHNICAL CHANGES

SECTION 9.(a) G.S. 58-93-20(c) reads as rewritten:

"(c) Any person that is already a licensed health organization in this State under this Chapter shall be recognized as a PHP under this Article and shall be issued a PHP license upon the licensed health organization's demonstration to the Commissioner of its compliance with this Article. A licensed health organization shall not be required to file a PHP application, pay a PHP application fee, or provide the notice required by subsection (d) of this section as a condition of receipt of a PHP license. Unless otherwise exempted, a licensed health organization shall be subject to the remaining requirements of this Article, including deposit, minimum capital and surplus, and working capital requirements."

SECTION 9.(b) G.S. 58-93-30 reads as rewritten:

"**§ 58-93-30. Fees.**

The Commissioner shall ~~establish~~ charge an application fee ~~not to exceed~~ of two thousand dollars ($2,000) for entities filing an application to be licensed as a PHP under this Article. The Commissioner shall ~~establish~~ charge an annual PHP license continuation fee ~~not to exceed~~ of five thousand dollars ($5,000). The PHP license shall continue in full force and effect subject to timely payment of the annual PHP license continuation fee in accordance with G.S. 58-6-7(c) and subject to any other provisions of this Chapter applicable to PHPs."

SECTION 9.(c) G.S. 58-93-60 reads as rewritten:

"**§ 58-93-60. Examinations.**

The Commissioner may make an examination of the affairs of any PHP as often as the Commissioner determines it to be necessary for the protection of the interests of the enrollees or the State but not less frequently than once every five years. The Commissioner shall notify DHHS prior to any examination of a PHP and shall provide DHHS with the results of an examination in accordance with G.S. 58-93-5(e). Examinations shall otherwise be conducted under G.S. 58-2-131 through G.S. 58-2-134."

SECTION 9.(d) G.S. 58-93-90 reads as rewritten:

"**§ 58-93-90. Rehabilitation or liquidation of PHP.**

(a) Any rehabilitation or liquidation of a PHP shall be deemed to be the rehabilitation or liquidation of an insurance company and shall be conducted under the supervision of the Commissioner pursuant to Article 30 of this Chapter. The Commissioner may apply for an order directing the rehabilitation or liquidation of a PHP upon one or more grounds set out in Article 30 of this Chapter or when it is the opinion of the Commissioner that the continued operation of the PHP would be hazardous either to the enrollees or to the State. Priority shall be given to DHHS's claims over all other claims in G.S. 58-30-220, except for claims in G.S. 58-30-220(1).

(b) To the greatest extent possible, the Commissioner shall provide notice to DHHS prior to seeking an application for an order to rehabilitate or liquidate a PHP under this section. If prior notice is not possible, the Commissioner shall provide the notice to DHHS as soon as possible after seeking the order."

SECTION 9.(e) G.S. 58-93-95(a) reads as rewritten:

"(a) When the Commissioner has cause to believe that grounds for the denial of an application for a license exist, or that grounds for the suspension or revocation of a license exist, notification shall be given to the PHP in ~~writing.~~ writing and a copy of the notice shall be provided to DHHS. This notice shall specifically state the grounds for denial, suspension, or revocation and shall set a date for a hearing on the matter at least 30 days after notice is given."

SECTION 9.(f) G.S. 58-93-120(16) reads as rewritten:

"(16) G.S. 58-7-26, Asset or reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of ~~G.S. 58-7-121.~~G.S. 58-7-21."

PART X. CLARIFY WHEN APPLICATION SENT TO NORTH CAROLINA SELF-INSURANCE SECURITY ASSOCIATION

SECTION 10. G.S. 97-170(b) reads as rewritten:

"(b) An applicant for a license as a self-insurer shall file with the Commissioner the information required by subsection (d) of this section on a form prescribed by the Commissioner at least 90 days before the proposed licensing date. No application is complete until the Commissioner has received all required information. A copy of the application ~~must~~ shall also be filed with the North Carolina Self-Insurance Security Association ~~at least 90 days before the proposed licensing date.~~at the same time the application is filed with the Commissioner."

PART XI. MEDICARE SUPPLEMENT CHANGES

SECTION 11.(a) G.S. 58-54-45 reads as rewritten:

"**§ 58-54-45. By reason of disability.**

(a) ~~In~~ For Persons Whose Eligibility for Medicare Occurred Before January 1, 2020. – In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement Plan A available to persons eligible for Medicare by reason of disability before age 65 and also standardized Plan C or F if marketing either Plan to persons eligible for Medicare before January 1, 2020, due to age. This action shall be taken without regard to medical condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning

with the first month the person first enrolls in Medicare Part B. For those persons that are retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration, the application must be submitted within a six-month period beginning with the month in which the person receives notification of the retroactive eligibility decision.

(a1) For Persons Whose Eligibility for Medicare Occurs on or After January 1, 2020. – In addition to any rule adopted under this Article that is directly or indirectly related to open enrollment, an insurer shall at least make standardized Medicare Supplement Plan A available to persons eligible for Medicare by reason of disability before age 65 and also standardized Plan D or G if marketing either Plan to persons eligible for Medicare on or after January 1, 2020, due to age. This action shall be taken without regard to medical condition, claims experience, or health status. To be eligible, a person must submit an application during the six-month period beginning with the first month the person first enrolls in Medicare Part B. For those persons that are retroactively enrolled in Medicare Part B due to a retroactive eligibility decision made by the Social Security Administration, the application must be submitted within a six-month period beginning with the month in which the person receives notification of the retroactive eligibility decision.

(b) Persons eligible for Medicare by reason of disability before age 65 who are enrolled in a managed care plan and whose coverage under the managed care plan is terminated through cancellation, nonrenewal, or disenrollment have the guaranteed right to purchase Medicare Supplement Plans ~~A and C~~ A, D, or G from any insurer within 63 days after the date of termination or disenrollment.

(c) An insurer may develop premium rates specific to the disabled population. No insurer shall discriminate in the pricing of the Medicare supplement plans referred to in this section because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for the plan is submitted during an open enrollment or is submitted within 63 days after the managed care plan is terminated. The rates and any applicable rating factors for the Medicare supplement plans referred to in this section shall be filed with and approved by the Commissioner."

SECTION 11.(b) This section becomes effective January 1, 2020.

PART XII. EXCLUSIVE PROVIDER BENEFIT PLANS

SECTION 12.(a) G.S. 58-50-56(i) reads as rewritten:

"(i) ~~A person enrolled in a preferred provider benefit plan may obtain covered health care services from a provider who does not participate in the plan.~~ In accordance with rules adopted by the Commissioner and subject to G.S. 58-3-190 and G.S. 58-3-200(d), the preferred provider benefit plan may limit coverage for health care services obtained from a nonparticipating provider. The Commissioner shall adopt rules on product limitations, including payment differentials for services rendered by nonparticipating providers. These rules shall be similar in substance to rules governing HMO point-of-service products."

SECTION 12.(b) Article 50 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-56.1. Continuity of care.**

(a) Definitions. – The following definitions shall apply in this section:

(1) Exclusive provider benefit plan. – A preferred provider benefit plan in which enrollees must receive covered services from health care providers who are under contract with the insurer and under which there is no coverage for care received from a health care provider who is not under contract with the insurer, except for emergency services as required by G.S. 58-3-190 and medically necessary covered services as required by G.S. 58-3-200(d).

(2) Insurer. – As defined in G.S. 58-50-56.

(3) Ongoing special condition. – One of the following conditions:
a. An acute illness that is serious enough to require medical care or treatment to avoid a reasonable possibility of death or permanent harm.
b. A chronic illness, disease, or condition that is life-threatening, degenerative, or disabling, and that requires medical care or treatment over a prolonged period of time.
c. Pregnancy from the start of the second trimester.
d. A terminal illness for which an individual has a medical prognosis of a life expectancy of six months or less.

(4) Terminated or termination. – The expiration or nonrenewal of a contract. This term does not include an ending of the contract by an insurer for failure to meet applicable quality standards or for fraud.

(b) Termination of a Provider. – If (i) a contract between an insurer and a health care provider offering an exclusive provider benefit plan is terminated by the provider or by the insurer, or benefits or coverage provided by the insurer are terminated because of a change in the terms of provider participation in an insurer's exclusive provider benefit plan and (ii) an insured is undergoing treatment from the provider for an ongoing special condition on the date of termination, then the following shall apply:

(1) Upon termination of the contract by the insurer or upon receipt by the insurer of written notification of termination by the provider, the insurer shall notify the insured on a timely basis of the termination and of the insured's right to elect continuation of coverage of treatment by the provider. This subdivision shall apply only if the insured has a claim with the insurer for services provided by the terminated provider or the insured is otherwise known by the insurer to be a patient of the terminated provider.

(2) Subject to subsection (h) of this section, the insurer shall permit an insured to elect to continue to be covered with respect to the treatment by the terminated provider for the ongoing special condition during a transitional period, as provided under this section.

(c) Newly Covered Insured. – Each exclusive provider benefit plan offered by an insurer shall provide transition coverage to individuals who (i) are newly covered under an exclusive provider benefit plan because the individual's employer has changed benefit plans and (ii) are undergoing treatment from a provider for an ongoing special condition. On the date of enrollment, an insurer shall notify the newly covered insured of the right to elect continuation of coverage of treatment by a provider that is not contracted with the exclusive provider benefit plan and, subject to subsection (h) of this section, the insurer shall permit the newly covered insured to elect to continue to be covered with respect to the treatment by the provider of the ongoing special condition during a transitional period, as provided under this section.

(d) Transitional Period: In General. – Except as otherwise provided in this section, the length of a transitional period provided under this subsection shall be determined by the treating health care provider, so long as it does not exceed 90 days after the date of the notice to the individual described in subdivision (b)(1) of this section or the date of enrollment in a new plan described in subsection (c) of this section.

(e) Transitional Period: Scheduled Surgery, Organ Transplantation, or Inpatient Care. – If surgery, organ transplantation, or other inpatient care was scheduled for an individual, or if the individual was on an established waiting list for surgery, organ transplantation, or other inpatient care, before the date of the notice required under subdivision (b)(1) of this section or the date of enrollment described in subsection (c) of this section, then the transitional period under this subsection with respect to the surgery, transplantation, or other inpatient care shall extend through the date of discharge of the individual after completion of the surgery, transplantation,

or other inpatient care, and through post-discharge follow-up care related to the surgery, transplantation, or other inpatient care occurring within 90 days after the date of discharge.

(f) Transitional Period: Pregnancy. – If an individual has entered the second trimester of pregnancy on or before the date of the notice required under subdivision (b)(1) of this section or the date of enrollment in a new plan described in subsection (c) of this section, and the provider was treating the pregnancy before the date of the notice, or the date of enrollment in the plan, then the transitional period with respect to the provider's treatment of the pregnancy shall extend through the provision of 60 days of postpartum care.

(g) Transitional Period: Terminal Illness. – If an individual was determined to be terminally ill at the time of a provider's termination of participation under subsection (b) of this section or at the time of enrollment in the plan under subsection (c) of this section, and the provider was treating the terminal illness before the date of the termination or enrollment in the plan, then the transitional period shall extend for the remainder of the individual's life with respect to care directly related to the treatment of the terminal illness or its medical manifestations.

(h) Permissible Terms and Conditions. – An insurer may condition coverage of continued treatment by a provider under subsection (b) or (c) of this section upon the following terms and conditions:

(1) When care is provided pursuant to subsection (b) of this section, the provider agrees to accept reimbursement from the insurer and, with respect to cost-sharing, from the insured involved at the rates applicable before the start of the transitional period as payment in full.

(2) When care is provided pursuant to subsection (c) of this section, the provider agrees to accept the prevailing rate based on contracts the insurer has with the same or similar providers in the same or similar geographic area, plus the applicable copayment from the newly covered insured, as reimbursement in full from the insurer and the insured for all covered services.

(3) The provider agrees to comply with the quality assurance programs of the insurer responsible for payment under this subsection and to provide to the insurer necessary medical information related to the care provided. The insurer's quality assurance programs shall not override the professional or ethical responsibility of the provider or interfere with the provider's ability to provide information or assistance to the insured.

(4) The provider agrees to adhere to the insurer's established policies and procedures for participating providers, including procedures regarding referrals and obtaining prior authorization, providing services pursuant to a treatment plan approved by the insurer, and member hold harmless provisions.

(5) The receipt of notification from the insured within 45 days of the date of the notice described in subdivision (b)(1) of this section or the new enrollment described in subsection (c) of this section, that the insured elects to continue receiving treatment by the provider.

(6) The provider agrees to discontinue providing services at the end of the transition period and to assist the insured in an orderly transition to a network provider. Nothing in this section shall prohibit the insured from continuing to receive services from the provider at the insured's expense.

(i) Construction. – Nothing in this section shall do any of the following:

(1) Require the coverage of benefits that would not have been covered if the provider involved remained a participating provider or, in the case of a newly covered insured, require the coverage of benefits not provided under the policy in which the newly covered insured is enrolled.

(2) Require an insurer to offer a transitional period when the insurer terminates a provider's contract for reasons relating to quality of care or fraud. Refusal by

an insurer to offer a transitional period under these circumstances is not subject to the grievance review provisions of G.S. 58-50-62.

(3) Prohibit an insurer from extending any transitional period beyond that specified in this section.

(4) Prohibit an insurer from terminating the continuing services of a provider when the insurer has determined that the provider's continued provision of services may result in, or is resulting in, a serious danger to the health or safety of the insured. A termination for these reasons shall be in accordance with the contract provisions that the provider would otherwise be subject to if the provider's contract were still in effect.

(j) Disclosure of Right to Transitional Period. – Each insurer shall include a clear description of an insured's rights under this section in its evidence of coverage and summary plan description."

SECTION 12.(c) The Department of Insurance may adopt temporary rules to implement this section.

SECTION 12.(d) Subsections (a) and (b) of this section apply to insurance contracts issued, renewed, or amended on or after the effective date of this act.

PART XIII. EFFECTIVE DATE

SECTION 13. Except as otherwise provided, this act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 220*

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H220-ABC-69 [v.2]

Amends Title [NO]
Third Edition

Date 3/4 2, ,2019

Senator Perry

moves to amend the bill by deleting Part XII and renumbering the remaining sections and parts accordingly.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

SENATE COMMITTEE ON

HEALTH CARE

JULY 2, 2019 – Room 643 – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Kristen Miller	JSC
John Cooper	CONNECT C
[illegible]	NCDOJ
John Hoomani	NCDOI
Bob Rosser	NCDOI
TED HAMBY	NCDOI
Betsy McCorkle	KGANC
Leah Burns	NCHA
Tamba Mondoh	NC Governor's Office
L Harris	[illegible]
[illegible]	[illegible]

SENATE COMMITTEE ON

HEALTH CARE

JULY 2, 2019 – Room 643 – 10:00 AM

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NAME	FIRM OR AGENCY
~~Chris Evans (HB 220)~~	~~Blue Cross NC~~
Emily Manning	FPA
Rhaegan Jackson	FPA
SAM WATTS	N.C. Dept of State Treasurer
Becki Gray	Locke Foundation
Hampton Billips	KTS
J. Leyar	CSC
Sarah Bales	Bubaker & Assoc.
Catherine Moore	NC Board of Nursing
David Kalbaugh	NC Board of Nursing
Elizabeth Pope	NC Social Work Board
Kay Castillo	NASW-NC
Jack Nichols	Nichols, Chai & Lee
Courtney Crowder	CCC
Richard Bostic	NCSBA
Tom West	NCJLC
Ted Rose	Bond & Assoc.
Randolph S. Elmore	R. Elmore & Assoc.

SENATE COMMITTEE ON

HEALTH CARE

JULY 2, 2019 – Room 643 – 10:00 AM

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NAME	FIRM OR AGENCY
Marissa Turner	TSS
Brad Dawn	Sen D. Davis
Christine Craig	WakeMed

SENATE COMMITTEE ON

HEALTH CARE

JULY 2, 2019 – Room 643 – 10:00 AM

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Pat Abbott	NA
Joe Stewart	11 ANC
Peyton Mayo	
Ruth Forest	NCMS
Neil Rowen	NCMS
Chip Baggett	NCMS
Thom Mansfield	NCMB
Evelyn Comrie	NCMB
Hugh Johnson	NCACC
Ryan Blackledge	Cone Health
David Powers	PS LLC
Lottie Shuford	DHHS
	CGS
Kara Weishaar	SK
Kathryn Robinson	NCRMA

SENATE COMMITTEE ON

HEALTH CARE

JULY 2, 2019 – Room 643 – 10:00 AM

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Dick Carlton	Law Off of RHC
Dave Horne	SA
Rick Zechini	Williams Mullen
Justin Crawford	United Health
Mike Hardin	NFJ
	BTH
Sarah Patterson	WM
Tracy Kimbrell	Parker Poe
	PPAB
	Atrium Health
Resha Fortson	SEANC
Flint Benson	SEANC
	Governor
	DOI/OSFM

Senate Committee on Health Care
Monday, July 15, 2019 at 8:00 PM
Room 1027/1128 of the Legislative Building

MINUTES

The Senate Committee on Health Care met at 8:00 PM on July 15, 2019, in Room 1027/1128 of the Legislative Building. Twelve members were present.

Senator Dan Bishop, Chair, presided.

HB 126 - Amend Certificate of Need Laws (Representatives Murphy, Dobson, Potts, Sasser)

Sen. Krawiec was recognized to explain the bill and an amendment. Sen. Hise moved to adopt the amendment. The amendment passed. Sen. Hise moved for a favorable report to the bill as amended, rolled into a new proposed committee substitute with a referral to Rules. The bill passed.

Questions from members were answered by Sen. Krawiec and Jason Moran-Bates of the Legislative Analysis Division. Sen. Bishop allowed four people to speak from the audience and they were as follows: John Bode representing Wake Forest Baptist Hospital and the North Carolina Radiologists, Chris Evans representing Blue Cross North Carolina, Flint Benson representing the State Employees Association of North Carolina, and Connie Wilson representing the North Carolina Orthopedic Association.

The meeting adjourned at 8:35 PM.

Senator Dan Bishop, Chair
Presiding

John Wynne, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Monday, July 15, 2019

Senator Bishop,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL NO. 2

HB **126** **(SCS#1)** Amend Certificate of Need Laws.

Draft Number:	H126-PCS40507-BC-69
Sequential Referral:	None
Recommended Referral:	Rules and Operations of the Senate
Long Title Amended:	No

TOTAL REPORTED: 1

Senator Joyce Krawiec will handle HB 126



Senate Committee on Health Care
Monday, July 15, 2019, 15 Minutes After EVENING Session
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 126	Amend Certificate of Need Laws.	Representative Murphy Representative Dobson Representative Potts Representative Sasser

HOUSE BILL 126
Senate Health Care Committee Substitute Adopted 6/27/19

Short Title: Amend Certificate of Need Laws. (Public)

Sponsors:

Referred to:

February 21, 2019

A BILL TO BE ENTITLED

AN ACT AMENDING CERTIFICATE OF NEED LAWS.

The General Assembly of North Carolina enacts:

PART I. REFORMS EFFECTIVE OCTOBER 1, 2019

SECTION 1.1. G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

...

(2) "Bed capacity" means space used exclusively for inpatient ~~care,~~ care at a health service facility, including space designed or remodeled for licensed inpatient beds even though temporarily not used for such purposes. The number of beds to be counted in any patient room shall be the maximum number for which adequate square footage is provided as established by rules of the Department except that single beds in single rooms are counted even if the room contains inadequate square footage. ~~The term "bed capacity" also refers to the number of dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~

...

(5) "Change in bed capacity" means (i) any relocation of health service facility beds, or dialysis stations from one licensed facility or campus to another, or (ii) any redistribution of health service facility bed capacity among the categories of health service facility bed as defined in G.S. 131E-176(9c), or (iii) any increase in the number of health service facility ~~beds, or dialysis stations in kidney disease treatment centers, including freestanding dialysis units.~~beds.

...

(7a) "Diagnostic center" means a freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds ~~five hundred thousand dollars ($500,000).~~ one million five hundred thousand dollars ($1,500,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than ~~five hundred thousand dollars ($500,000),~~ one million five

hundred thousand dollars ($1,500,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the 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 cost threshold amount 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.

...

(9a) "Health service" means an organized, interrelated medical, diagnostic, therapeutic, ~~and/or~~ or rehabilitative ~~activity~~ activity, or any combination of these, that is integral to the prevention of disease or the clinical management of a sick, injured, or disabled person. "Health service" does not include administrative and other activities that are not integral to clinical ~~management.~~management or any activities performed at a facility that does not meet the definition of a health service facility.

(9b) "Health service facility" means 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 the mentally retarded;~~ home health agency office; ~~chemical dependency treatment facility;~~ diagnostic center; hospice office, hospice inpatient facility, hospice residential care facility; and ambulatory surgical facility. The term "health service facility" does not include a licensable facility, as defined in G.S. 122C-3(14)b.

(9c) "Health service facility bed" means 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) intermediate care beds for the mentally retarded; (vi) chemical dependency treatment beds; (vii)~~ (iv) hospice inpatient facility beds; ~~(viii)~~ (v) hospice residential care facility beds; ~~(ix)~~ (vi) adult care home beds; and ~~(x)~~ or (vii) long-term care hospital beds.

...

(14a) ~~"Intermediate care facility for the mentally retarded"~~ "Intermediate care facility for individuals with intellectual disabilities" means facilities licensed pursuant to Article 2 of Chapter 122C of the General Statutes for the purpose of providing health and habilitative services based on the developmental model and principles of normalization for persons with ~~mental retardation,~~ intellectual disabilities, autism, cerebral palsy, epilepsy or related conditions.

...

(14o) "Major medical equipment" means a single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than ~~seven hundred fifty thousand dollars ($750,000).~~ two million dollars ($2,000,000). In determining whether the major medical equipment costs more than ~~seven hundred fifty thousand dollars ($750,000),~~ two million dollars ($2,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the major medical 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.

Major medical equipment does not include replacement equipment as defined in this section. Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount 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.

...

(16) "New institutional health services" means any of the following:

...

b. Except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding ~~two~~ four million dollars ~~($2,000,000)~~ ($4,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds ~~two~~ four million dollars ~~($2,000,000).~~($4,000,000). Beginning September 30, 2022, and on September 30 each year thereafter, the amount in this sub-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.

...

d. ~~The~~ Except as otherwise allowed in G.S. 131E-184(j), the offering of ~~dialysis services or~~ home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.

...

~~u. The construction, development, establishment, increase in the number, or relocation of an operating room or gastrointestinal endoscopy room in a licensed health service facility, other than the relocation of an operating room or gastrointestinal endoscopy room within the same building or on the same grounds or to grounds not separated by more than a public right-of-way adjacent to the grounds where the operating room or gastrointestinal endoscopy room is currently located.~~

~~v. The change in designation, in a licensed health service facility, of an operating room to a gastrointestinal endoscopy room or change in designation of a gastrointestinal endoscopy room to an operating room that results in a different number of each type of room than is reflected on the health service facility's license in effect as of January 1, 2005.~~"

SECTION 1.2. G.S. 131E-177 reads as rewritten:

"**§ 131E-177. Department of Health and Human Services is designated State Health Planning and Development Agency; powers and duties.**

The Department of Health and Human Services is designated as the State Health Planning and Development Agency for the State of North Carolina, and is empowered to exercise the following powers and duties:

(1) To establish standards and criteria or plans required to carry out the provisions and purposes of this Article and to adopt rules pursuant to Chapter 150B of

the General Statutes, to carry out the purposes and provisions of this ~~Article;~~Article.

(2) Adopt, amend, and repeal such rules and regulations, consistent with the laws of this State, as may be required by the federal government for grants-in-aid for health service facilities and health planning which may be made available by the federal government. This section shall be liberally construed in order that the State and its citizens may benefit from such ~~grants-in-aid;~~grants-in-aid.

(3) Define, by rule, procedures for submission of periodic reports by persons or health service facilities subject to agency review under this ~~Article;~~Article.

(4) ~~Develop~~ With respect to health service facilities planning, all of the following:

a. Develop policy, criteria, and standards for health service facilities ~~planning; shall conduct~~ planning.

b. Conduct statewide registration and inventories of and make determinations of need for health service facilities, health services as specified in G.S. 131E-176(16)f., and equipment as specified in G.S. 131E-176(16)f1., which shall include consideration of adequate geographic location of equipment and ~~services; and develop~~ services.

c. Develop a State Medical Facilities ~~Plan;~~Plan, provided, however, that the State Medical Facilities Plan shall not include policies or need determinations that limit the number of operating rooms or gastrointestinal endoscopy rooms.

(5) Implement, by rule, criteria for project ~~review;~~review.

(6) Have the power to grant, deny, or withdraw a certificate of need and to impose such sanctions as are provided for by this ~~Article;~~Article.

(7) Solicit, accept, hold and administer on behalf of the State any grants or devises of money, securities or property to the Department for use by the Department in the administration of this ~~Article; and~~Article.

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

(9) Collect fees for submitting applications for certificates of need.

(10) The authority to review all records in any recording medium of any person or health service facility subject to agency review under this Article which pertain to construction and acquisition activities, staffing or costs and charges for patient care, including but not limited to, construction contracts, architectural contracts, consultant contracts, purchase orders, cancelled checks, accounting and financial records, debt instruments, loan and security agreements, staffing records, utilization statistics and any other records the Department deems to be reasonably necessary to determine compliance with this Article.

The Secretary of Health and Human Services shall have final decision-making authority with regard to all functions described in this section."

SECTION 1.3. G.S. 131E-183(a)(1) reads as rewritten:

"(1) The proposed project 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 that may be approved."

SECTION 1.4. G.S. 131E-184(c) reads as rewritten:

"(c) The Department shall exempt from certificate of need review any conversion of existing acute care beds to psychiatric ~~beds provided:~~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 and/or one or more of the Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities to provide psychiatric beds to patients referred by the contracting agency or agencies; and~~

~~(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.~~"

SECTION 1.5. G.S. 131E-184(e)(1) reads as rewritten:

"(1) The proposed capital expenditure would:

a. Be used solely for the purpose of renovating, replacing on the same site, or expanding an existing:

1. Nursing home facility, or
2. Adult care home ~~facility, or~~facility.
3. ~~Intermediate care facility for the mentally retarded; and~~

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."

SECTION 1.6.(a) G.S. 131E-184 is amended by adding new subsections to read:

"(i) The Department shall exempt from certificate of need review the development, acquisition, construction, expansion, or replacement of a health service or health service facility that obtained certificate of need approval prior to October 1, 2019, as a kidney dialysis treatment center, including freestanding hemodialysis units; intermediate care facility for individuals with intellectual disabilities; psychiatric facility; chemical dependency treatment facility; or any other licensable facility, as defined in G.S. 122C-3(14)b.

(j) The Department shall exempt from certificate of need review the establishment of a home health agency by a continuing care retirement community licensed under Article 64 of Chapter 58 of the General Statutes to provide home health services to one or more residents of a continuing care retirement community who have entered into a contract with the continuing care retirement community to receive continuing care services with lodging. A continuing care retirement community that seeks to provide home health services to individuals who do not reside at the continuing care retirement community pursuant to a contract to receive continuing care services with lodging shall be required to obtain a certificate of need as a home health agency prior to developing or offering home health services to any individual not a resident of the continuing care retirement community under a contract to receive continuing care services with lodging. As used in this subsection, the terms "continuing care" and "lodging" are as defined in G.S. 58-64-1. Nothing in this subsection shall be construed to exempt from the State's home health agency licensure and certification requirements a continuing care retirement community that has been exempted from certificate of need review for the provision of home health services to one or more residents pursuant to this subsection."

SECTION 1.6.(b) G.S. 131E-184(j), as enacted by this section, applies to continuing care retirement communities engaged in the direct provision of home health services on or after October 1, 2019.

SECTION 1.7. G.S. 131E-186(a) reads as rewritten:

"(a) Within the prescribed time limits in G.S. 131E-185, the Department shall issue a decision to "approve," "approve with conditions," or "deny," an application for a new institutional health service. Approvals involving new or expanded nursing care ~~or intermediate care for the mentally retarded bed capacity~~ shall include a condition that specifies the earliest possible date the new institutional health service may be certified for participation in the Medicaid program. The date shall be set far enough in advance to allow the Department to identify funds to pay for

care in the new or expanded facility in its existing Medicaid budget or to include these funds in its State Medicaid budget request for the year in which Medicaid certification is expected."

SECTION 1.8. G.S. 131E-189 is amended by adding a new subsection to read:

"(d) Notwithstanding any other provision of this section, a certificate of need for the construction of a health service facility expires if the holder of the certificate of need fails to initiate construction of the project authorized by the certificate of need within the following time frames:

(1) For a project that costs over fifty million dollars ($50,000,000), the holder of the certificate of need shall initiate construction of the project authorized by the certificate of need within four years after the date the Department's decision to approve the certificate of need for that project becomes final.

(2) For a project that costs fifty million dollars ($50,000,000) or less, the holder of the certificate of need shall initiate construction of the project authorized by the certificate of need within two years after the date the Department's decision to approve the certificate of need for that project becomes final."

SECTION 1.9. G.S. 131E-175(11) and (12) are repealed.

SECTION 1.10. This Part becomes effective October 1, 2019.

PART II. REFORMS EFFECTIVE JANUARY 1, 2020

SECTION 2.1. G.S. 131E-147 reads as rewritten:

"**§ 131E-147. Licensure requirement.**

...

(c1) All initial applications and renewal applications shall require the applicant to state the number of procedure rooms on, and the number of procedures performed at, the premises named in the application.

...."

SECTION 2.2. G.S. 131E-176(16), as amended by this act, reads as rewritten:

"(16) "New institutional health services" means any of the following:

...

~~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.~~

...."

SECTION 2.3. This Part becomes effective January 1, 2020.

PART III. SEVERABILITY

SECTION 3.1. If any part 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 to be unconstitutional or invalid.

SECTION 3.2. This Part is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 126

AMENDMENT NO. _____
(to be filled in by Principal Clerk)

H126-ABC-74 [v.7]

Amends Title [NO]
Second Edition

Date July 15 ,2019

Senator KRAWIEC

moves to amend the bill on page 1, line 5, through page 6, line 40, by rewriting the lines to read:

PART I. REFORMS EFFECTIVE JANUARY 1, 2020

SECTION 1.(a) G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

...

(7a) Diagnostic center. – A freestanding facility, program, or provider, including but not limited to, physicians' offices, clinical laboratories, radiology centers, and mobile diagnostic programs, in which the total cost of all the medical diagnostic equipment utilized by the facility which cost ten thousand dollars ($10,000) or more exceeds ~~five hundred thousand dollars ($500,000).~~one million five hundred thousand dollars ($1,5000,000). In determining whether the medical diagnostic equipment in a diagnostic center costs more than ~~five hundred thousand dollars ($500,000),~~one million five hundred thousand dollars ($1,500,000) the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the 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 cost threshold amount 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.

...

(14o) Major medical equipment. – A single unit or single system of components with related functions which is used to provide medical and other health services and which costs more than ~~seven hundred fifty thousand dollars ($750,000).~~two million dollars ($2,000,000). In determining whether the

major medical equipment costs more than ~~seven hundred fifty thousand dollars ($750,000),~~two million dollars ($2,000,000), the costs of the equipment, studies, surveys, designs, plans, working drawings, specifications, construction, installation, and other activities essential to acquiring and making operational the major medical 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. Major medical equipment does not include replacement equipment as defined in this section. Beginning September 30, 2022, and on September 30 each year thereafter, the cost threshold amount 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.

...

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

...

b. Except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding ~~two~~ four million dollars ~~($2,000,000)~~($4,000,000) to develop or expand a health service or a health service facility, or which relates to the provision of a health service. The cost of any studies, surveys, designs, plans, working drawings, specifications, and other activities, including staff effort and consulting and other services, essential to the acquisition, improvement, expansion, or replacement of any plant or equipment with respect to which an expenditure is made shall be included in determining if the expenditure exceeds ~~two~~ four million dollars ~~($2,000,000).~~($4,000,000). Beginning September 30, 2022, and on September 30 each year thereafter, the amount in this sub-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 1.(b) G.S. 131E-184 reads as rewritten:

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

...

(e) The Department shall exempt from certificate of need review a capital expenditure that exceeds the ~~two~~ four million dollar ~~($2,000,000)~~($4,000,000) threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

...

(g) The Department shall exempt from certificate of need review any capital expenditure that exceeds the ~~two~~ four million dollar ~~($2,000,000)~~($4,000,000) threshold set forth in G.S. 131E-176(16)b. if all of the following conditions are met:

...

(i) Notwithstanding any other provision of law to the contrary, the Department shall exempt from certificate of need review the replacement, renovation, or relocation of services or facilities that already have a certificate of need."

SECTION 1.(c) G.S. 131E-189 is amended by adding two new subsections to read:

"(d) Notwithstanding any other provision of this section, a certificate of need for the construction of a health service facility expires if the holder of the certificate of need fails to initiate construction of the project authorized by the certificate of need within the following time frames:

(1) For a project that costs over fifty million dollars ($50,000,000), the holder of the certificate of need shall initiate construction of the project authorized by the certificate of need within four years after the date the Department's decision to approve the certificate of need for that project becomes final.

(2) For a project that costs fifty million dollars ($50,000,000) or less, the holder of the certificate of need shall initiate construction of the project authorized by the certificate of need within two years after the date the Department's decision to approve the certificate of need for that project becomes final.

(e) Notwithstanding any other provision of this Article, a certificate of need that has not been used at any point in the immediately previous twelve months will expire."

SECTION 1.(d) G.S. 131E-147 reads as rewritten:

"**§ 131E-147. Licensure requirement.**

...

(c1) All initial applications and renewal applications shall require the applicant to state the number of procedure rooms on, and the number and type of procedures performed at, the premises named in the application.

...."

SECTION 1.(e) This Part becomes effective January 1, 2020.

PART II. REFORMS EFFECTIVE 18 MONTHS AFTER THE BILL BECOMES LAW

SECTION 2.(a) G.S. 131E-176 reads as rewritten:

"**§ 131E-176. Definitions.**

As used in this Article, unless the context clearly requires otherwise, the following terms have the meanings specified:

...

(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 individuals with intellectual disabilities; home health agency office; ~~chemical dependency treatment facility;~~ diagnostic center; hospice office, hospice inpatient facility, 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 the

mentally retarded; ~~(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:

...

d. ~~The~~ Except as otherwise provided in G.S. 131E-184(j), the offering of dialysis services or home health services by or on behalf of a health service facility if those services were not offered within the previous 12 months by or on behalf of the facility.

...

~~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.~~

..."

SECTION 2.(b) G.S. 131E-184(c) reads as rewritten:

"(c) The Department shall exempt from certificate of need review any conversion of existing acute care beds to psychiatric ~~beds provided:~~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 and/or one or more of the Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities to provide psychiatric beds to patients referred by the contracting agency or agencies; and~~

~~(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.~~"

SECTION 2.(c) G.S. 131E-184, as amended by section 1.(b) of this act, is amended by adding new subsections to read:

"(j) The Department shall exempt from certificate of need review the development, acquisition, construction, expansion, or replacement of a health service or health service facility that obtained certificate of need approval prior to October 1, 2019, as a psychiatric facility or chemical dependency treatment facility.

(k) The Department shall exempt from certificate of need review the establishment of a home health agency by a continuing care retirement community licensed under Article 64 of Chapter 58 of the General Statutes to provide home health services to one or more residents of a continuing care retirement community who have entered into a contract with the continuing care retirement community to receive continuing care services with lodging. A continuing care retirement community that seeks to provide home health services to individuals who do not reside at the continuing care retirement community pursuant to a contract to receive continuing care services with lodging shall be required to obtain a certificate of need as a home health agency prior to developing or offering home health services to any individual not a resident of the continuing care retirement community under a contract to receive continuing care services with

lodging. As used in this subsection, the terms "continuing care" and "lodging" are as defined in G.S. 58-64-1. Nothing in this subsection shall be construed to exempt from the State's home health agency licensure and certification requirements a continuing care retirement community that has been exempted from certificate of need review for the provision of home health services to one or more residents pursuant to this subsection."

SECTION 2.(d) G.S. 131E-184(k), as enacted by this section, applies to continuing care retirement communities engaged in the direct provision of home health services 18 months after this act becomes law.

SECTION 2.(e) Section 12F.4.(b) of Session Law 2016-94 reads as rewritten:

"**SECTION 12F.4.(b)** The Secretary shall select hospitals in the three State regions for institutional services (Eastern Region, Central Region, and Western Region) to receive funds allocated under subsection (a) of this section for the construction, conversion, or both of short-term, inpatient behavioral health beds in rural areas of the State. Notwithstanding the State Medical Facilities Plan, Article 9 of Chapter 131E of the General Statutes, or any other provision of law to the contrary, each selected rural hospital that receives funds allocated under subsection (a) of this section shall be allowed to construct new or convert unused acute care beds into licensed, inpatient behavioral health beds without undergoing certificate of need review by the Division of Health Service Regulation. All newly constructed or converted beds shall be subject to existing licensure laws and requirements. As a condition of receiving these funds, each selected rural hospital shall reserve at least ~~fifty percent (50%)~~twenty-five percent (25%) of the constructed or converted beds for (i) purchase by the Department under the State-administered, three-way contract and (ii) referrals by local management entities/managed care organizations (LME/MCOs) of individuals who are indigent or Medicaid recipients. Any hospital unit or other location with short-term, inpatient behavioral health beds constructed or converted with funds allocated under subsection (a) of this section shall be named in honor of Dorothea Dix."

PART III. REFORMS EFFECTIVE THREE YEARS AFTER THE BILL BECOMES LAW

SECTION 3.(a) G.S. 131E-184, as amended by Sections 1.(b) and 2.(c) of this act, is amended by adding a new subsection to read:

"(*l*) The Department shall exempt from certificate of need review the development, acquisition, construction, expansion, or replacement of a health service or health service facility that obtained certificate of need approval prior to October 1, 2019, as a kidney dialysis treatment center, including freestanding hemodialysis units, provided that the health service or health service facility is located in a county with a population greater than 300,000."

PART IV. SEVERABILITY

SECTION 5. If any part 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 to be unconstitutional or invalid.

PART V. EFFECTIVE DATE

SECTION 6. Except as otherwise provided, this act is effective when it becomes law. Part II becomes effective 18 months after this act becomes law. Part III becomes effective 3 years after this act becomes law.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

SIGN-IN SHEET

Healthcare, Senate Committee

July 15, 2019 – Room 1027 / 1128

Legislative Building – TBD

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Hattie Granade	DHHS
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July 15, 2019 – Room 1027 / 1128

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Michele Foster	NP

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Healthcare, Senate Committee

July 15, 2019

Room 1027 / 1128

After Session

Senate Sergeant at Arms:

CHARLES HARPER

CHRIS MOORE

BILLY FRITSCHER

EDDIE BROUGHTON

Senate Committee on Health Care
Wednesday, August 21, 2019 at 1:00 PM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 1:00 PM on August 21, 2019 in Room 643 of the Legislative Office Building. Twelve members were present and there were no Senate Pages.

Senator Joyce Krawiec, Chair, presided.

HB 555 Modernize Medicaid Telemedicine Policies. (Representatives Dobson, White, Saine, Lambeth)
Sen. Hise moved that the Proposed Committee Substitute (PCS) be brought before the committee for consideration and the motion carried. Sen. Hise was introduced to explain the bill. Sen. Hise brought forth an amendment and requested that it be considered and the motion carried. Questions from the members were responded to by Sen. Hise and Amy Jo Johnson an attorney from the Legislative Analysis Division. Sen. Hise moved for an unfavorable report to the bill – favorable to the PCS as amended – rolled into a new PCS, and it carried.

HB 918 Amend Abuse Laws/Expedite Permanency. (Representatives Jarvis, Stevens, Murphy)
Rep. Jarvis was introduced to present the bill. Sen. Hise moved to amend the bill by bringing an amendment before the committee for consideration and it carried. Rep. Jarvis continued to explain the bill. Questions from the members were responded to by Rep. Jarvis and Jason Moran-Bates an attorney from the Legislative Analysis Division. Sen. Krawiec permitted comments from the audience. They were as follows: Reginald D. O'Rourke/Assoc. Council for Guardian Ad Litem Program, Wendy C. Sotolongo/Parent Defender from the NC Office of the Parent Defender, Elisabeth Johnson, Ph.D., NP/UNC School of Medicine Director of Health Services, Tami L. Fitzgerald/NC Values Coalition Executive Director, Julie Cronin/Department of Health and Human Services, and Jamie L. Hamlett/Alamance County Social Services Staff Attorney. The discussion between the members continued and considering that the committee had gone over its time limit, Sen. Krawiec asked for a motion. Sen. Krawiec's decision was unsuccessfully challenged. A motion was made by Sen. Hise unfavorable to the bill – favorable to the bill as amended – rolled into a committee substitute bill and the motion carried.

The meeting adjourned at 2:14 PM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Bishop, Co-Chair
Senator Krawiec, Co-Chair

Wednesday, August 21, 2019

Senator Krawiec,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

HB **918** Amend Abuse Laws/Expedite Permanency.

Draft Number:	H918-PCS30511-BC-80
Sequential Referral:	Judiciary
Recommended Referral:	None
Long Title Amended:	No

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

HB **555** **(CS#1)** Modernize Medicaid Telemedicine Policies.

Draft Number:	H555-PCS10705-MRxfra-12
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Senator Joyce Krawiec will handle HB 918
Senator Ralph Hise will handle HB 555



Senate Committee on Health Care
Wednesday, August 21, 2019, 1:00 PM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 555	Modernize Medicaid Telemedicine Policies.	Representative Dobson Representative White Representative Saine Representative Lambeth
HB 918	Amend Abuse Laws/Expedite Permanency.	Representative Jarvis Representative Stevens Representative Murphy

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H D

HOUSE BILL 555
Committee Substitute Favorable 5/2/19
PROPOSED SENATE COMMITTEE SUBSTITUTE H555-CSMRa-12 [v.1]
08/20/2019 05:36:10 PM

Short Title: Medicaid Transformation Implementation. (Public)

Sponsors:

Referred to:

April 3, 2019

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS FOR THE IMPLEMENTATION OF MEDICAID TRANSFORMATION AND TO MAKE OTHER MEDICAID TRANSFORMATION-RELATED CHANGES.

The General Assembly of North Carolina enacts:

PART I. IMPLEMENTATION IN CONJUNCTION WITH STATUTORY PROCEDURES FOR BUDGET CONTINUATION

SECTION 1.1. The provisions of this act shall be implemented in conjunction with the procedures for budget continuation specified in G.S. 143C-5-4(b). If the provisions of this act and G.S. 143C-5-4(b) are in conflict, the provisions of this act shall prevail.

SECTION 1.2. If House Bill 966, 2019 Regular Session, becomes law, then Section 9D.14, Section 9D.15, Section 9D.15A, Section 9D.15B, Section 9D.16, Section 9D.17, and subsections (e) – (i) of Section 9D.18 of House Bill 966, 2019 Regular Session, are repealed.

SECTION 1.3. If House Bill 966, 2019 Regular Session, becomes law, then Part II of this act is repealed.

PART II. FUNDS FOR OPERATION OF THE MEDICAID PROGRAM

SECTION 2.1.(a) There is appropriated from the General Fund the sum of thirty-three million seven hundred fifty-eight thousand one hundred thirty-six dollars ($33,758,136) in recurring funds for the 2019-2020 fiscal year to the Department of Health and Human Services, Division of Health Benefits, to be used for the Medicaid and NC Health Choice programs rebase.

SECTION 2.1.(b) There is appropriated from the General Fund the sum of one hundred ninety-nine million seven hundred eighty-four thousand two hundred thirty-eight dollars ($199,784,238) in recurring funds for the 2020-2021 fiscal year to the Department of Health and Human Services, Division of Health Benefits, to be used for the Medicaid and NC Health Choice programs rebase.

SECTION 2.2.(a) There is appropriated from the General Fund the sum of twenty-eight million six hundred seventeen thousand six hundred fifty-five dollars ($28,617,655) in recurring funds for the 2019-2020 fiscal year to the Department of Health and Human Services, Division of Health Benefits, for the purpose of transitioning to Medicaid managed care.

SECTION 2.2.(b) There is appropriated from the General Fund the sum of forty million one hundred sixty-seven thousand six hundred fifty-five dollars ($40,167,655) in

recurring funds for the 2020-2021 fiscal year to the Department of Health and Human Services, Division of Health Benefits, for the purpose of transitioning to Medicaid managed care.

SECTION 2.3. Departmental receipts received as a result of this act are appropriated in each year of the 2019-2021 biennium for the purposes specified in this act.

PART III. USE OF MEDICAID TRANSFORMATION FUND FOR MEDICAID TRANSFORMATION NEEDS

SECTION 3.1.(a) The State Controller shall transfer the sum of two hundred twenty-four million dollars ($224,000,000) for the 2019-2020 fiscal year from funds available in the Medicaid Transformation Reserve in the General Fund to the Medicaid Transformation Fund established under Section 12H.29 of S.L. 2015-241.

SECTION 3.1.(b) The State Controller shall transfer the sum of forty-five million dollars ($45,000,000) for the 2020-2021 fiscal year from funds available in the Medicaid Transformation Reserve in the General Fund to the Medicaid Transformation Fund established under Section 12H.29 of S.L. 2015-241.

SECTION 3.2.(a) Claims Run Out. – Funds from the Medicaid Transformation Fund may be transferred to the Department of Health and Human Services, Division of Health Benefits (DHB), as needed for the purpose of paying claims related to services billed under the fee-for-service payment model for recipients who are being, or have been, transitioned to managed care, otherwise known as "claims run out." Funds may be transferred to DHB as the need to pay claims run out arises and need not be transferred in one lump sum. To the extent that any funds are transferred under this subsection, the funds are appropriated for the purpose set forth in this subsection.

SECTION 3.2.(b) Non-Claims Run Out Medicaid Transformation Needs. – Subject to the fulfillment of conditions specified in subsection (c) of this section, the sum of twenty-seven million two hundred eighty thousand nine hundred forty-seven dollars ($27,280,947) in nonrecurring funds for the 2019-2020 fiscal year and the sum of ten million nine hundred eighty-three thousand five hundred forty-eight dollars ($10,983,548) for the 2020-2021 fiscal year from the Medicaid Transformation Fund may be transferred to the Department of Health and Human Services, Division of Health Benefits (DHB), for the sole purpose of providing the State share for nonrecurring qualifying needs directly related to Medicaid transformation, as required by S.L. 2015-241, as amended. Funds may be transferred to DHB as nonrecurring qualifying needs arise during the 2019-2021 fiscal biennium and need not be transferred in one lump sum.

For the purposes of this section, the term "qualifying need" shall be limited to information technology, time-limited staffing, and contracts related to the following Medicaid transformation needs:

(1) Program design.
(2) Beneficiary experience.
(3) NC FAST upgrades related to Medicaid transformation.
(4) Data management tools.
(5) Program integrity.
(6) Technical and operational integration.
(7) Other nonrecurring needs identified by DHB, as determined in consultation with the Office of State Budget and Management.

SECTION 3.2.(c) Requests for Transfer of Funds for Qualifying Need. – A request by the Department of Health and Human Services, Division of Health Benefits (DHB), for the transfer of funds pursuant to subsection (b) of this section shall be made to the Office of State Budget and Management (OSBM) and shall include the amount requested and the specific nonrecurring qualifying need for which the funds are to be used. None of the funds identified in subsection (b) of this section shall be transferred to DHB until OSBM verifies the following information:

(1) The amount requested is to be used for a nonrecurring qualifying need in the 2019-2021 fiscal biennium.

(2) The amount requested provides a State share that will not result in total requirements that exceed one hundred ninety million dollars ($190,000,000) in nonrecurring funds for the 2019-2021 fiscal biennium.

SECTION 3.1.(d) Federal Fund Receipts. – Any federal funds received in any fiscal year by the Department of Health and Human Services, Division of Health Benefits (DHB), that represent a return of State share already expended on a qualifying need related to the funds received by the DHB under this section shall be deposited into the Medicaid Transformation Fund.

SECTION 3.1.(e) Administrative Bridge Funding. – Notwithstanding the stated purpose of the Medicaid Transformation Fund established under Section 12H.29 of S.L. 2015-241, the sum of thirty million six hundred fifty-eight thousand eight hundred eighty-eight dollars ($30,658,885) in nonrecurring funds for the 2019-2020 fiscal year and the sum of twenty-one million three hundred forty-five thousand eight hundred eight dollars ($21,345,808) in nonrecurring funds for the 2020-2021 fiscal year from the Medicaid Transformation Fund may be transferred to the Department of Health and Human Services for the purpose of providing nonrecurring funding for administrative expenses during the transition to Medicaid managed care.

PART IV. MEDICAID TRANSFORMATION ADMINISTRATIVE REDUCTION FLEXIBILITY AND REPORT

SECTION 4.1. In order to achieve a reduction in administrative costs attributable to the implementation of Medicaid transformation in the amount of thirty million six hundred fifty-eight thousand eight hundred fifty-five dollars ($30,658,855) in recurring funds for the 2019-2020 fiscal year and in the amount of forty-two million six hundred ninety-one thousand six hundred fifteen dollars ($42,691,615) in recurring funds for the 2020-2021 fiscal year, the Secretary of the Department of Health and Human Services (Secretary) may reduce administrative costs across all Divisions within the Department of Health and Human Services. In achieving these budgeted reduction amounts, the Secretary shall not reduce any funds that (i) impact direct services or (ii) are used to support the 2012 settlement agreement entered into between the United States Department of Justice and the State of North Carolina to ensure that the State will willingly meet the requirements of the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and the United States Supreme Court decision in Olmstead v. L.C., 527 U.S. 581 (1999). The prohibition on reducing funds that impact direct services shall not be construed to prohibit a reduction in administrative costs associated with contracts for the provision of direct services.

SECTION 4.2. By January 15, 2020, and January 15, 2021, the Secretary of the Department of Health and Human Services (Secretary) shall submit a report to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and North Carolina Health Choice, the House of Representatives Appropriations Committee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division on the actions taken during that fiscal year to achieve the reduction in administrative costs attributable to the implementation of Medicaid transformation required by Section 4.1 of this act. If the Secretary elects to eliminate positions, the report shall include a list of each position eliminated, along with its position number, title, and the amount of salary and fringe benefits associated with each position.

PART V. REPEAL OF PAST DIRECTIVE TO ELIMINATE GME TO ALIGN WITH MEDICAID TRANSFORMATION

SECTION 5.1. Section 12H.12(b) of S.L. 2014-100 and Section 12H.23 of S.L. 2015-241, as amended by Section 88 of S.L. 2015-264, are repealed.

PART VI. MEDICAID TRANSFORMATION HOTLINE OPTION

SECTION 6.1. The Department of Health and Human Services shall ensure that the existing DHHS Customer Service hotline is responsive to questions posed by a Medicaid beneficiary or provider or by the general public that are related to the rollout of Medicaid Transformation during the 2019-2020 fiscal year.

PART VII. TRIBAL OPTION/MEDICAID TRANSFORMATION

SECTION 7.1.(a) The Department of Health and Human Services may contract with an Indian managed care entity (IMCE) or an Indian health care provider (IHCP), as defined under 42 C.F.R. § 438.14(a), to assist in the provision of health care or health care–related services to Medicaid and NC Health Choice beneficiaries who are members of federally recognized tribes or who are eligible to enroll in an IMCE. Contracts may include health care or health care–related services as agreed upon with the IMCE or IHCP, as approved by the Secretary of the Department of Health and Human Services and as allowed by the Centers for Medicare and Medicaid Services (CMS), including, but not limited to, the following services:

(1) Primary care case management as a primary care case managed system or entity, as described in 42 C.F.R. § 438.2.
(2) Utilization management and referrals.
(3) The management or provision of home- and community-based services under a 1915(c) waiver.
(4) The management or provision of specialized services covered by a BH IDD Tailored Plan in accordance with Subdivision 10 of Section 4 of S.L. 2015-245, as amended by S.L. 2018-48.

Coverage provided by the IMCE or IHCP may be more permissive, but no more restrictive, than Medicaid or NC Health Choice medical coverage policy adopted or amended by the Department of Health and Human Services; however, the coverage shall be in compliance with federal regulations and policies related to the receipt of federal funding for these health care or health care–related services.

SECTION 7.1.(b) Subdivision 5 of Section 4 of S.L. 2015-245, as amended by Subsection 2(b) of S.L. 2016-121, S.L. 2018-48, Section 5 of 2018-49, and Section 12 of S.L. 2019-81, reads as rewritten:

"(5) Populations covered by PHPs. – Capitated PHP contracts shall cover all Medicaid and NC Health Choice program aid categories except for the following categories:

...

e. Members of federally recognized tribes. Members of federally recognized tribes shall have the option to enroll voluntarily in PHPs.

e1. Eligible recipients who are enrolled in a DHHS-contracted Indian managed care entity, as defined in 42 C.F.R. § 438.14(a).

...."

SECTION 7.1.(c) Subdivision 9 of Section 4 of S.L. 2015-245, as amended by S.L. 2018-48 and Section 12 of S.L. 2019-81, reads as rewritten:

"(9) LME/MCOs. – Beginning on the date that capitated contracts begin, LME/MCOs shall cease managing Medicaid services for all Medicaid recipients other than recipients described in sub-subdivisions a., d., e., e1., f., g., j., k., *l.*, and m. of subdivision (5) of this section. Until BH IDD Tailored Plans become operational, all of the following shall occur:

a. LME/MCOs shall continue to manage the Medicaid services that are covered by the LME/MCOs under the combined 1915(b) and (c) waivers for Medicaid recipients described in sub-subdivisions a., d., e., e1., f., g., j., k., *l.*, and m. of subdivision (5) of this section.

b. The Division of Health Benefits shall negotiate actuarially sound capitation rates directly with the LME/MCOs based on the change in composition of the population being served by the LME/MCOs.

c. Capitation payments under contracts between the Division of Health Benefits and the LME/MCOs shall be made directly to the LME/MCO by the Division of Health Benefits.

...."

SECTION 7.1.(d) The Department of Health and Human Services is authorized to seek approval from CMS and submit any necessary State Plan Amendments and waivers, or any amendments thereto, to implement the provisions of this section.

PART VIII. REVISE AND RENAME THE SUPPLEMENTAL PAYMENT PROGRAM FOR ELIGIBLE MEDICAL PROFESSIONAL PROVIDERS

SECTION 8.1.(a) The Department of Health and Human Services shall revise the supplemental payment program for eligible medical professional providers described in the Medicaid State Plan, Attachment 4.19-B, Section 5, Pages 2 and 3, as required by this section. This payment program shall be called the Average Commercial Rate Supplemental and Directed Payment Program. Effective October 1, 2019, the following two changes to the program shall be implemented:

(1) The program shall no longer utilize a limit on the number of eligible medical professional providers that may be reimbursed through the program, and instead shall utilize a limit on the total payments made under the program.

(2) Payments under the program shall consist of two components: (i) supplemental payments that increase reimbursement to the average commercial rate under the State Plan and (ii) directed payments that increase reimbursement to the average commercial rate under the managed care system.

SECTION 8.1.(b) The limitation on total payments made under the Average Commercial Rate Supplemental and Directed Payment Program for eligible medical professional providers shall apply to the combined amount of payments made as supplemental payments under the State Plan and payments made as directed payments under the managed care system and shall be based on the amount of supplemental payments for services provided during the 2018-2019 fiscal year as follows:

(1) For services provided during the period October 1, 2019, through June 30, 2020, the total annual supplemental and directed payments made under the Average Commercial Rate Supplemental and Directed Payment Program shall not exceed seventy-five percent (75%) of the gross supplemental payments for services provided by eligible medical providers during the 2018-2019 fiscal year.

(2) For services provided on or after July 1, 2020, the total annual supplemental and directed payments made under the Average Commercial Rate Supplemental and Directed Payment Program shall not exceed one hundred percent (100%) of the gross supplemental payments for services provided by eligible medical providers during the 2018-2019 fiscal year, increased at the start of each State fiscal year by an inflation factor determined by the Department of Health and Human Services, Division of Health Benefits.

SECTION 8.1.(c) Consistent with the existing supplemental payment program for eligible medical professional providers, the Department of Health and Human Services shall limit the total amount of supplemental and directed payments that may be received by the eligible providers affiliated with East Carolina University Brody School of Medicine and University of North Carolina at Chapel Hill Health Care System. Average commercial rate supplemental payments and directed payments shall not be made for services provided in Wake County.

SECTION 8.1.(d) The Department of Health and Human Services is not authorized to make any modifications to the supplemental payment program for eligible medical professional providers, except as authorized by this section.

SECTION 8.1.(e) Effective October 1, 2019, Section 12H.13(e) of S.L. 2013-360 and Sections 12H.13(b) and 12H.13A of S.L. 2014-100 are repealed.

PART IX. MEDICAID CONTINGENCY RESERVE CODIFICATION

SECTION 9.1. Article 4 of Chapter 143C of the General Statutes is amended by adding a new section to read:

"**§ 143C-4-11. Medicaid Contingency Reserve.**

(a) Medicaid Contingency Reserve. – The Medicaid Contingency Reserve is established as a reserve to be used only for budget shortfalls in Medicaid or NC Health Choice programs.

(b) Funds from the Medicaid Contingency Reserve may be allocated or expended only if all of the following criteria are met:

(1) There is an act of appropriation by the General Assembly.

(2) After the State Controller has verified that receipts are being used appropriately, the Director of the Budget has found that additional funds are needed to cover a shortfall in the Medicaid or NC Health Choice budget for the State fiscal year.

(3) The Director of the Budget has reported immediately to the Fiscal Research Division on the amount of the shortfall found in accordance with subdivision (2) of this subsection. This report shall include an analysis of the causes of the shortfall, such as (i) unanticipated enrollment and mix of enrollment, (ii) unanticipated growth or utilization within particular service areas, (iii) errors in the data or analysis used to project the Medicaid or NC Health Choice budget, (iv) the failure of the program to achieve budgeted savings, (v) other factors and market trends that have impacted the price of or spending for services, (vi) variations in receipts from prior years or from assumptions used to prepare the Medicaid and NC Health Choice budget for the current fiscal year, or (vii) other factors. The report shall also include data in an electronic format that is adequate for the Fiscal Research Division to confirm the amount of the shortfall and its causes.

(c) Nothing in this section shall be construed to limit the authority of the Governor to carry out the Governor's duties under the Constitution."

PART X. EFFECTIVE DATE

SECTION 10.1. Except as otherwise provided, this act is effective when it becomes law.

HOUSE BILL 555:
Medicaid Transformation Implementation.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	August 21, 2019
Introduced by:	Reps. Dobson, White, Saine, Lambeth	**Prepared by:**	Jennifer Hillman Staff Attorney
Analysis of:	PCS to Second Edition H555-CSMRa-12		

OVERVIEW: The PCS to House Bill 555 provides funding for the operation of the Medicaid program and the transition to managed care during the 2019-2020 fiscal year, and makes other changes necessary for the transition to managed care to begin as scheduled on November 1, 2019.

CURRENT LAW: Medicaid Transformation legislation enacted in 2015 by the General Assembly required the current Medicaid and Health Choice fee-for-service programs to transition to a managed care model.[1] Under a waiver that was approved by the federal Centers for Medicare and Medicaid Services (CMS), the State will pay commercial and nonprofit prepaid health plans a monthly per-person capitated rate to cover Medicaid and Health Choice services for their enrollees beginning November 1, 2019.

BILL ANALYSIS:

Part I – Implementation in Conjunction with Statutory Procedures for Budget Continuation

Section 1.1 requires this act to be implemented in conjunction with the procedures for budget continuation outlined in the State Budget Act, and provides that the provisions of this act prevail in the event of any conflict. **Sections 1.2 and 1.3** provide for the repeal of duplicative provisions if House Bill 966, the 2019 Appropriations Act, becomes law.

Part II – Funds for Operation of the Medicaid Program

Sections 2.1 through 2.3 appropriate funds to the Division of Health Benefits for the Medicaid and NC Health Choice programs rebase and for the purpose of transitioning to Medicaid managed care.

Part III – Use of Medicaid Transformation Fund for Medicaid Transformation Needs

Section 3.1 transfers funds to the Medicaid Transformation Fund, and **Section 3.2** allows the funds to be used for (i) claims run out as the Medicaid program transitions to managed care, (ii) specified qualifying needs related to Medicaid Transformation, as verified by the Office of State Budget and Management, and (iii) for administrative bridge funding for nonrecurring administrative expenses within the Department of Health and Human Services (DHHS).

[1] S.L. 2015-245, as amended.

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Part IV – Medicaid Transformation Administrative Reduction Flexibility and Report

Section 4.1 directs a reduction in administrative costs attributable to Medicaid Transformation that may be achieved through a reduction in administrative costs across all Divisions within DHHS. **Section 4.2** requires DHHS to submit two reports on the actions taken to achieve the reduction.

Part V – Repeal of Past GME Directives to Align with Medicaid Transformation

Section 5.1 repeals past budget provisions directing the elimination of certain Medicaid graduate medical education reimbursement.

Part VI – Medicaid Transformation Hotline Option

Section 6.1 requires DHHS to ensure that its Customer Service hotline is responsive to Medicaid Transformation questions from beneficiaries, providers, and the public.

Part VII – Tribal Option/Medicaid Transformation

Section 7.1 allows DHHS to contract with an Indian managed care entity or an Indian health care provider to assist with the provision of health-care related services to certain eligible Medicaid recipients and makes conforming changes to the legislation governing Medicaid Transformation.

Part VIII – Revise and Rename the Supplemental Payment Program for Eligible Medical Professional Providers

Section 8.1 requires DHHS to revise the current supplemental payment program for eligible medical professional providers to conform with managed care.

Part IX – Medicaid Contingency Reserve Codification

Section 9.1 codifies the establishment of the Medicaid Contingency Reserve and the use of funds in the reserve.

EFFECTIVE DATE: The PCS is effective when it becomes law, except for Section 8.1(e), which repeals certain Medicaid provisions from past budgets effective October 1, 2019.

HOUSE BILL 555
Committee Substitute Favorable 5/2/19

Short Title: Modernize Medicaid Telemedicine Policies. (Public)

Sponsors:

Referred to:

April 3, 2019

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO MEDICAID AND NC HEALTH CHOICE TELEMEDICINE AND TELEPSYCHIATRY POLICIES TO FACILITATE INCREASED ACCESS TO SERVICES, EVOLVE WITH THE LATEST TECHNOLOGY, AND ALIGN WITH BEST PRACTICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services (DHHS) shall make the following changes to the Medicaid and NC Health Choice Clinical Coverage Policy No. 1H, Telemedicine and Telepsychiatry:

(1) DHHS shall reimburse for telemedicine and telepsychiatry services performed in a recipient's home or delivered from a licensed practitioner's home.

(2) A referral shall not be required for the use of telemedicine or telepsychiatry services.

(3) The delivery of telemedicine or telepsychiatry over the phone or by video cell phone shall be covered.

(4) A referring provider and a receiving provider shall be allowed to bill for facility fees related to the provision of telemedicine or telepsychiatry on the same date of service.

(5) Telemedicine and telepsychiatry services shall not be subject to the exact same restrictions as face-to-face contacts. The clinical coverage policy shall be updated to align the policy with best practices for telemedicine and telepsychiatry.

(6) All behavioral health providers who are directly enrolled as providers in the Medicaid and NC Health Choice programs, including licensed professional counselors, licensed marriage and family therapists, certified clinical supervisors, and licensed clinical addictions specialists, shall be included in the coverage policy as providers who may bill Medicaid or NC Health Choice for telemedicine and telepsychiatry services and as providers who may bill for a facility fee.

In addition to the changes to Clinical Coverage Policy No. 1H, Telemedicine and Telepsychiatry, DHHS is directed to expand the billing code set available for telemedicine and telepsychiatry to include most outpatient billing codes, including family therapy and psychotherapy for crisis. With the exception of family therapy, the expanded billing codes shall not include group-type therapies.

SECTION 2. The Department of Health and Human Services shall submit to the Centers for Medicare and Medicaid Services any waivers or amendments to the NC Medicaid

State Plan necessary to implement this act. The changes required by Section 1 of this act shall be effective after the completion of the process for amending policy that is required under G.S. 108A-54.2.

SECTION 3. This act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 555

AMENDMENT NO._____
(to be filled in by
Principal Clerk)

H555-ATRxfr-21 [v.2]

Amends Title [NO]
PCS

Date _____,2019

Senator Hise

moves to amend the PCS on page 1, line 13, by deleting the word "and";

and on page 1, line 14, by rewriting the line:
"Section 9D.18, and Section 9D.19 of House Bill 966, 2019 Regular Session, are repealed.";

and on page 2, line 33, by inserting the following at the end of the line:
"To the extent funds are transferred under this subsection, the funds are appropriated for the purpose set forth in this subsection.";

and on page 3, line 19, by inserting the following at the end of the line:
"To the extent funds are transferred under this subsection, the funds are appropriated for the purpose set forth in this subsection.";

and on page 3, lines 23-29 by replacing those lines with the following:
"**SECTION 4.1.** The General Fund budget for the Division of Health Benefits is reduced by the sum of thirty million six hundred fifty-eight thousand eight hundred fifty-five dollars ($30,658,855) in recurring funds for the 2019-2020 fiscal year and in the amount of forty-two million six hundred ninety-one thousand six hundred fifteen dollars ($42,691,615) in recurring funds for the 2020-2021 fiscal year due to reduced administrative costs resulting from the implementation of Medicaid transformation. In order to achieve this reduction, the Secretary of the Department of Health and Human Services (Secretary) may reduce administrative costs across all Divisions within the Department of Health and Human Services.";

and on page 5, lines 14-15, by inserting the following between the lines:
"**SECTION 7.1.(e)** Subsections (b) and (c) of this section become effective October 1, 2019.";

and on page 6, lines 40-41, by inserting the following between the lines:

"**PART X. REVISE AND UPDATE HOSPITAL ASSESSMENTS**

SECTION 10.1.(a) Effective October 1, 2019, Article 7 of Chapter 108A of the General Statutes is repealed.

SECTION 10.1.(b) Effective October 1, 2019, Chapter 108A of the General Statutes is amended by adding a new Article to read:

"Article 7A.

"Hospital Assessment Act.

"Part 1. General.

"**§ 108A-130. Short title and purpose.**

This Article shall be known as the "Hospital Assessment Act." This Article does not authorize a political subdivision of the State to license a hospital for revenue or impose a tax or assessment on a hospital.

"**§ 108A-131. Definitions.**

The following definitions apply in this Article:

(1) Base assessment. – The assessment payable under G.S. 108A-142.

(2) CMS. – Centers for Medicare and Medicaid Services.

(3) Critical access hospital. – As defined in 42 C.F.R. § 400.202.

(4) Department. – The Department of Health and Human Services.

(5) Prepaid health plan. – As defined in G.S. 108D-1.

(6) Public hospital. – A hospital that certifies its public expenditures to the Department pursuant to 42 C.F.R. § 433.51(b) during the fiscal year for which the assessment applies.

(7) Secretary. – The Secretary of Health and Human Services.

(8) State's annual Medicaid payment. – An amount equal to one hundred ten million dollars ($110,000,000) for State fiscal year 2019-2020, increased each year over the prior year's payment by the percentage specified as the Medicare Market Basket Index less productivity most recently published in the Federal Register.

(9) Supplemental assessment. – The assessment payable under G.S. 108A-141.

(10) Total hospital costs. – The costs as calculated using the most recent available Hospital Cost Report Information System's cost report data available through CMS or other comparable data, including both inpatient and outpatient components, for all hospitals that are not exempt from the applicable assessment.

"**§ 108A-132. Due dates and collections.**

(a) Beginning October 1, 2019, assessments under this Article are due quarterly in the time and manner prescribed by the Secretary and shall be considered delinquent if not paid within seven calendar days of this due date.

(b) With respect to any hospital owing a past due assessment amount under this Article, the Department may withhold the unpaid amount from Medicaid or NC Health Choice payments otherwise due or impose a late payment penalty. The Secretary may waive a penalty for good cause shown.

(c) In the event the data necessary to calculate an assessment under this Article is not available to the Secretary in time to impose the quarterly assessments for a payment year, the Secretary may defer the due date for the assessment to a subsequent quarter.

"**§ 108A-133. Assessment appeals.**

A hospital may appeal a determination of the assessment amount owed through a reconsideration review. The pendency of an appeal does not relieve a hospital from its obligation to pay an assessment amount when due.

"**§ 108A-134. Allowable costs; patient billing.**

(a) Assessments paid under this Article may be included as allowable costs of a hospital for purposes of any applicable Medicaid reimbursement formula, except that assessments paid under this Article shall be excluded from cost settlement.

(b) Assessments imposed under this Article may not be added as a surtax or assessment on a patient's bill.

"**§ 108A-135. Rule-making authority.**

The Secretary may adopt rules to implement this Article.

"**§ 108A-136. Repeal.**

If CMS determines that an assessment under this Article is impermissible or revokes approval of an assessment under this Article, then that assessment shall not be imposed and the Department's authority to collect the assessment is repealed.

"Part 2. Supplemental and Base Assessments.

"**§ 108A-140. Applicability.**

(a) The assessments imposed under this Part apply to all licensed North Carolina hospitals, except as provided in this section.

(b) The following hospitals are exempt from both the supplemental assessment and the base assessment:

(1) Critical access hospitals.
(2) Freestanding psychiatric hospitals.
(3) Freestanding rehabilitation hospitals.
(4) Long-term care hospitals.
(5) State-owned and State-operated hospitals.
(6) The primary affiliated teaching hospital for each University of North Carolina medical school.

(c) Public hospitals are exempt from the supplemental assessment.

"**§ 108A-141. Supplemental assessment.**

(a) The supplemental assessment shall be a percentage, established by the General Assembly, of total hospital costs.

(b) The Department shall propose the rate of the supplemental assessment to be imposed under this section when the Department prepares its budget request for each upcoming fiscal year. The Governor shall submit the Department's proposed supplemental assessment rate to the General Assembly each fiscal year.

(c) The Department shall base the proposed supplemental assessment rate on all of the following factors:

(1) The percentage change in aggregate payments to hospitals subject to the supplemental assessment for Medicaid and NC Health Choice enrollees, excluding hospital access payments made under 42 C.F.R. § 438.6, as demonstrated in data from prepaid health plans and the State, as determined by the Department.

(2) Any changes in the federal medical assistance percentage rate applicable to the Medicaid or NC Health Choice programs for the applicable year.

(d) The rate for the supplemental assessment for each taxable year shall be the percentage rate set by law by the General Assembly.

"**§ 108A-142. Base assessment.**

(a) The base assessment shall be a percentage, established by the General Assembly, of total hospital costs.

(b) The Department shall propose the rate of the base assessment to be imposed under this section when the Department prepares its budget request for each upcoming fiscal year. The Governor shall submit the Department's proposed base assessment rate to the General Assembly each fiscal year.

(c) The Department shall base the proposed base assessment rate on all of the following factors:

(1) The change in the State's annual Medicaid payment for the applicable year.

(2) The percentage change in aggregate payments to hospitals subject to the base assessment for Medicaid and NC Health Choice enrollees, excluding hospital access payments made under 42 C.F.R. § 438.6, as demonstrated in data from prepaid health plans and the State, as determined by the Department.

(3) Any changes in the federal medical assistance percentage rate applicable to the Medicaid or NC Health Choice programs for the applicable year.

(4) Any changes as determined by the Department in (i) reimbursement under the Medicaid State Plan, (ii) managed care payments authorized under 42 C.F.R. § 438.6 for which the nonfederal share is not funded by General Fund appropriations, and (iii) reimbursement under the NC Health Choice program.

(d) The rate for the base assessment for each taxable year shall be the percentage rate set by law by the General Assembly.

"**§ 108A-143. Payment from other hospitals.**

If a hospital that is exempt from both the base and supplemental assessments under this Part (i) makes an intergovernmental transfer to the Department to be used to draw down matching federal funds and (ii) has acquired, merged, leased, or managed another hospital on or after March 25, 2011, then the exempt hospital shall transfer to the State an additional amount. The additional amount shall be a percentage of the amount of funds that (i) would be transferred to the State through such an intergovernmental transfer and (ii) are to be used to match additional federal funds that the exempt hospital is able to receive because of the acquired, merged, leased, or managed hospital. That percentage shall be calculated by dividing the amount of the State's annual Medicaid payment by the total amount collected under the base assessment under G.S. 108A-142.

"**§ 108A-144. Use of funds.**

The proceeds of the assessments imposed under this Part, and all corresponding matching federal funds, must be used to make the State's annual Medicaid payment to the State, to fund payments to hospitals made directly by the Department, to fund a portion of capitation payments to prepaid health plans attributable to hospital care, and to fund the nonfederal share of graduate medical education payments."

SECTION 10.1.(c) The percentage rate to be used in calculating the supplemental assessment under G.S. 108A-141, as enacted in subsection (b) of this section, is two and twenty-six hundredths percent (2.26%) for the taxable year October 1, 2019, through September 30, 2020.

SECTION 10.1.(d) The percentage rate to be used in calculating the base assessment under G.S. 108A-142, as enacted in subsection (b) of this section, is one and seventy-seven hundredths percent (1.77%) for the taxable year October 1, 2019, through September 30, 2020.

SECTION 10.2. Notwithstanding G.S. 143C-4-11, as enacted by Section 9.1 of this act, the State Controller shall transfer funds from the Medicaid Contingency Reserve to the Department of Health and Human Services, Division of Health Benefits (DHB), only upon request by the DHB as needed to cover any shortfall in receipts from the supplemental or base assessments under G.S. 108A-141 and G.S. 108A-142, enacted by subsection (b) of Section 10.1 of this act, and only if the following two conditions are met:

(1) The Office of State Budget and Management (OSBM) has certified that there will be a shortfall in receipts from the supplemental or base assessments.

(2) OSBM has certified that the amount requested by DHB does not exceed the shortfall in receipts certified by OSBM under subdivision (1) of this subsection.

Upon making the request to the State Controller for the transfer of funds pursuant to this section, DHB shall notify the Fiscal Research Division and the Joint Legislative Oversight Committee on Medicaid and NC Health Choice of the request and the amount of the request. To the extent any funds are transferred under this section, the funds are hereby appropriated for the purpose set forth in this section. The authority set forth in this section expires June 30, 2020.

SECTION 10.3.(a) The Department of Health and Human Services, Division of Health Benefits (DHB), shall establish a new fund code entitled "Hospital Assessment Fund" in Budget Code 24445. When setting the supplemental assessment and base assessment rates in accordance with G.S. 108A-141(d) and G.S. 108A-142(d) for the 2020-2021 taxable year, funds in the Hospital Assessment Fund shall be used to support a decrease in the supplemental assessment or base assessment rates submitted by the Governor under G.S. 108A-141(b) and G.S. 108A-142(b) that corresponds with the amount in the Hospital Assessment Fund.

SECTION 10.3.(b) For the 2019-2020 fiscal year only, if the amount of receipts collected, in aggregate, from the supplemental and base assessments under G.S. 108A-141 and G.S. 108A-142 is more than the amount, in aggregate, anticipated in the Governor's proposed base budget for the 2019-2020 fiscal year for the Department of Health and Human Services, Division of Health Benefits, as adjusted by Section 2.1 of this act, from the supplemental and base assessments, then the amount of those over-realized receipts shall be transferred as follows:

(1) Forty-five million dollars ($45,000,000) shall be transferred to the Hospital Assessment Fund created under subsection (a) of this section. If the total

amount of over-realized receipts is less than forty-five million dollars ($45,000,000), then the full amount of over-realized receipts shall be transferred to the Hospital Assessment Fund.

(2) The remaining amount of over-realized receipts not transferred under subdivision (1) of this subsection shall be transferred to the Medicaid Transformation Reserve.

(3) Prior to transferring any amount of over-realized receipts under this subsection, the Office of State Budget and Management shall certify that (i) there will be, in aggregate, over-realized receipts for the 2019-2020 fiscal year from the supplemental and base assessments and (ii) the amounts to be transferred are in compliance with this subsection.

PART XI. GROSS PREMIUMS TAX/PREPAID HEALTH PLANS

SECTION 11.(a) The title of Article 8B of Chapter 105 of the General Statutes reads as rewritten:

"Article 8B.

"Taxes Upon Insurance ~~Companies.~~Companies and Prepaid Health Plans."

SECTION 11.(b) G.S. 105-228.3 reads as rewritten:

"**§ 105-228.3. Definitions.**

The following definitions apply in this Article:

(1) Article 65 corporation. – A corporation subject to Article 65 of Chapter 58 of the General Statutes, regulating hospital, medical, and dental service corporations.

(2) Capitation payment. – Amounts paid by the Department of Health and Human Services to prepaid health plans under capitated contracts for the delivery of Medicaid and NC Health Choice services in accordance with Article 4 of Chapter 108D of the General Statutes.

~~(1a)~~(3) Captive insurance company. – Defined in G.S. 58-10-340.

~~(1b)~~(4) Foreign captive insurance company. – A captive insurance company as defined in G.S. 58-10-340(9), except that such company is not formed or licensed under the laws of this State but is formed and licensed under the laws of any jurisdiction within the United States other than this State.

~~(2)~~(5) Insurer. – An insurer as defined in G.S. 58-1-5 or a group of employers who have pooled their liabilities pursuant to G.S. 97-93 of the Workers' Compensation Act.

(6) Prepaid health plan. – As defined in G.S. 108D-1.

~~(3)~~(7) Self-insurer. – An employer that carries its own risk pursuant to G.S. 97-93 of the Workers' Compensation Act."

SECTION 11.(c) G.S. 105-228.5 reads as rewritten:

"**§ 105-228.5. Taxes measured by gross premiums.**

(a) Tax Levied. – A tax is levied in this section on insurers, Article 65 corporations, health maintenance organizations, prepaid health plans, and self-insurers. An insurer, health maintenance organization, prepaid health plan, or Article 65 corporation that is subject to the tax

levied by this section is not subject to franchise or income taxes imposed by Articles 3 and 4, respectively, of this Chapter.

(b) Tax Base. –

(1) Insurers. – The tax imposed by this section on an insurer or a health maintenance organization shall be measured by gross premiums from business done in this State during the preceding calendar year.

(2) Repealed by Session Laws 2006-196, effective for taxable years beginning on or after January 1, 2008.

(3) Article 65 Corporations. – The tax imposed by this section on an Article 65 corporation shall be measured by gross collections from membership dues, exclusive of receipts from cost plus plans, received by the corporation during the preceding calendar year.

(4) Self-insurers. – The tax imposed by this section on a self-insurer shall be measured by the gross premiums that would be charged against the same or most similar industry or business, taken from the manual insurance rate then in force in this State, applied to the self-insurer's payroll for the previous calendar year as determined under Article 36 of Chapter 58 of the General Statutes modified by the self-insurer's approved experience modifier.

(5) Prepaid Health Plans. – The tax imposed by this section on a prepaid health plan shall be measured by gross capitation payments received by the prepaid health plan from the Department of Health and Human Services for services provided to enrollees in the State Medicaid program or NC Health Choice program in the preceding calendar year.

(b1) Calculation of Tax Base. – In determining the amount of gross premiums from business in this State, all gross premiums received in this State, credited to policies written or procured in this State, or derived from business written in this State shall be deemed to be for contracts covering persons, property, or risks resident or located in this State unless one of the following applies:

(1) The premiums are properly reported and properly allocated as being received from business done in some other nation, territory, state, or states.

(2) The premiums are from policies written in federal areas for persons in military service who pay premiums by assignment of service pay.

Gross premiums from business done in this State in the case of life insurance contracts, including supplemental contracts providing for disability benefits, accidental death benefits, or other special benefits that are not annuities, means all premiums collected in the calendar year, other than for contracts of reinsurance, for policies the premiums on which are paid by or credited to persons, firms, or corporations resident in this State, or in the case of group policies, for contracts of insurance covering persons resident within this State. The only deductions allowed shall be for premiums refunded on policies rescinded for fraud or other breach of contract and premiums that were paid in advance on life insurance contracts and subsequently refunded to the insured, premium payer, beneficiary or estate. Gross premiums shall be deemed to have been collected for the amounts as provided in the policy contracts for the time in force during the year, whether satisfied by cash payment, notes, loans, automatic premium loans, applied dividend, or

by any other means except waiver of premiums by companies under a contract for waiver of premium in case of disability.

Gross premiums from business done in this State in the case of prepaid health plans means all capitation payments received by a prepaid health plan from the Department of Health and Human Services for the delivery of services to enrollees in the State Medicaid program or NC Health Choice program in the calendar year. Capitation payments refunded by a prepaid health plan to the State are the only allowable deductions.

Gross premiums from business done in this State for all other health care plans and contracts of insurance, including contracts of insurance required to be carried by the Workers' Compensation Act, means all premiums written during the calendar year, or the equivalent thereof in the case of self-insurers under the Workers' Compensation Act, for contracts covering property or risks in this State, other than for contracts of reinsurance, whether the premiums are designated as premiums, deposits, premium deposits, policy fees, membership fees, or assessments. Gross premiums shall be deemed to have been written for the amounts as provided in the policy contracts, new and renewal, becoming effective during the year irrespective of the time or method of making payment or settlement for the premiums, and with no deduction for dividends whether returned in cash or allowed in payment or reduction of premiums or for additional insurance, and without any other deduction except for return of premiums, deposits, fees, or assessments for adjustment of policy rates or for cancellation or surrender of policies.

(c) Exclusions. – Every insurer, in computing the premium tax, shall exclude all of the following from the gross amount of premiums, and the gross amount of excluded premiums is exempt from the tax imposed by this section:

(1) All premiums received on or after July 1, 1973, from policies or contracts issued in connection with the funding of a pension, annuity, or profit-sharing plan qualified or exempt under section 401, 403, 404, 408, 457 or 501 of the Code as defined in G.S. 105-228.90.

(2) Premiums or considerations received from annuities, as defined in G.S. 58-7-15.

(3) Funds or considerations received in connection with funding agreements, as defined in G.S. 58-7-16.

(4) The following premiums, to the extent federal law prohibits their taxation under this Article:

a. Federal Employees Health Benefits Plan premiums.

b. ~~Medicaid or~~ Medicare premiums.

c. Medicaid or NC Health Choice premiums, other than capitation payments, paid by or on behalf of a Medicaid or NC Health Choice beneficiary.

(d) Tax Rates; Disposition. –

(1) Workers' Compensation. – The tax rate to be applied to gross premiums, or the equivalent thereof in the case of self-insurers, on contracts applicable to liabilities under the Workers' Compensation Act is two and five-tenths percent (2.5%). The net proceeds shall be credited to the General Fund.

(2) Other Insurance Contracts. – The tax rate to be applied to gross premiums on all other taxable contracts issued by insurers or health maintenance organizations and to be applied to gross premiums and gross collections from membership dues, exclusive of receipts from cost plus plans, received by Article 65 corporations is one and nine-tenths percent (1.9%). The net proceeds shall be credited to the General Fund.

(2a) Prepaid Health Plans. – The tax rate to be applied to gross premiums from capitation payments received by prepaid health plans is one and nine-tenths percent (1.9%). The net proceeds shall be credited to the General Fund.

(3) Additional Rate on Property Coverage Contracts. – An additional tax at the rate of seventy-four hundredths percent (0.74%) applies to gross premiums on insurance contracts for property coverage. The tax is imposed on ten percent (10%) of the gross premiums from insurance contracts for automobile physical damage coverage and on one hundred percent (100%) of the gross premiums from all other contracts for property coverage. Twenty percent (20%) of the net proceeds of this additional tax must be credited to the Volunteer Fire Department Fund established in Article 87 of Chapter 58 of the General Statutes. Twenty percent (20%) of the net proceeds must be credited to the Department of Insurance for disbursement pursuant to G.S. 58-84-25. Up to twenty percent (20%), as determined in accordance with G.S. 58-87-10(f), must be credited to the Workers' Compensation Fund. The remaining net proceeds must be credited to the General Fund. The additional tax imposed on property coverage contracts under this subdivision is a special purpose assessment based on gross premiums and not a gross premiums tax. The following definitions apply in this subdivision:

a. Automobile physical damage. – The following lines of business identified by the NAIC: private passenger automobile physical damage and commercial automobile physical damage.

b. Property coverage. – The following lines of business identified by the NAIC: fire, farm owners multiple peril, homeowners multiple peril, nonliability portion of commercial multiple peril, ocean marine, inland marine, earthquake, private passenger automobile physical damage, commercial automobile physical damage, aircraft, and boiler and machinery. The term also includes insurance contracts for wind damage.

c. NAIC. – National Association of Insurance Commissioners.

(4) Repealed by Session Laws 2006-196, effective for taxable years beginning on or after January 1, 2008.

(5) Repealed by Session Laws 2003-284, s. 43.1, effective for taxable years beginning on or after January 1, 2004.

(6) Repealed by Session Laws 2005-276, s. 38.4(a), effective for taxable years beginning on or after January 1, 2007.

(e) Report and Payment. – Each taxpayer doing business in this State shall, within the first 15 days of March, file with the Secretary of Revenue a full and accurate report of the total gross premiums as defined in this section, the payroll and other information required by the Secretary in the case of a self-insurer, or the total gross collections from membership dues exclusive of receipts from cost plus plans collected in this State during the preceding calendar year. The taxes imposed by this section shall be remitted to the Secretary with the report.

(f) Installment Payments Required. – Taxpayers that are subject to the tax imposed by this section and have a premium tax liability of ten thousand dollars ($10,000) or more for business done in North Carolina during the immediately preceding year shall remit three equal quarterly installments with each installment equal to at least thirty-three and one-third percent (33 1/3%) of the premium tax liability incurred in the immediately preceding taxable year. The quarterly installment payments shall be made on or before April 15, June 15, and October 15 of each taxable year. The ~~company~~ taypayer shall remit the balance by the following March 15 in the same manner provided in this section for annual returns.

The Secretary may permit an insurance company or prepaid health plan to pay less than the required estimated payment when the insurer or prepaid health plan reasonably believes that the total estimated payments made for the current year will exceed the total anticipated tax liability for the year.

An underpayment or an overpayment of an installment payment required by this subsection accrues interest in accordance with G.S. 105-241.21. An overpayment of tax shall be credited to the ~~company~~ taxpayer and applied against the taxes imposed upon the ~~company~~ taxpayer under this Article.

(g) Exemptions. – This section does not apply to farmers' mutual assessment fire insurance companies or to fraternal orders or societies that do not operate for a profit and do not issue policies on any person except members. This section does not apply to a captive insurance company taxed under G.S. 105-228.4A."

SECTION 11.(d) G.S. 58-6-25 reads as rewritten:

"**§ 58-6-25. Insurance regulatory charge.**

...

(e) Definitions. – The following definitions apply in this section:

...

(2) Insurance company. – A company or prepaid health plan, as defined in G.S. 58-93-5, that pays the gross premiums tax levied in G.S. 105-228.5 and G.S. 105-228.8.

...."

SECTION 11.(e) G.S. 105-259 reads as rewritten:

"**§ 105-259. Secrecy required of officials; penalty for violation.**

...

(b) Disclosure Prohibited. – An officer, an employee, or an agent of the State who has access to tax information in the course of service to or employment by the State may not disclose the information to any other person except as provided in this subsection. Standards used or to be used for the selection of returns for examination and data used or to be used for determining

the standards may not be disclosed for any purpose. All other tax information may be disclosed only if the disclosure is made for one of the following purposes:

...

(49) To exchange information concerning a tax imposed by Article 8B of this Chapter with the North Carolina Department of Insurance or the North Carolina Department of Health and Human Services when the information is needed to fulfill a duty imposed on the ~~Department.~~Department of Revenue.

...."

SECTION 11.(f) This section is effective October 1, 2019, and applies to capitation payments received by prepaid health plans on or after that date.

PART XII. HOSPITAL UNCOMPENSATED CARE FUND

SECTION 12.1. Article 9 of Chapter 143 of the General Statutes is amended by adding a new section to read:

"**§ 143C-9-9. Hospital Uncompensated Care Fund.**

(a) Creation. – The Hospital Uncompensated Care Fund is established as a nonreverting special fund in the Department of Health and Human Services.

(b) Source of Funds. – The Fund shall consist of federal disproportionate share adjustment receipts arising from certified public expenditures.

(c) Utilization of Funds. – The Department of Health and Human Services is authorized to utilize funds in the Hospital Uncompensated Care Fund to make the following payments, provided the entity receiving the payment has been determined to be an eligible entity in accordance with subsection (d) of this section:

(1) Payments to institutions for mental diseases, as defined in 42 C.F.R. § 435.1010.

(2) Payments to hospitals to reimburse inpatient services uncompensated care costs or outpatient services uncompensated care costs, or both.

(d) Eligibility and Fund Allocations. – The Department of Health and Human Services shall adopt rules for determining eligibility for, and allocations of, Hospital Uncompensated Care Fund payments."";

and by renumbering the Parts accordingly.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 918:
Amend Abuse Laws/Expedite Permanency.

2019-2020 General Assembly

Committee:	Senate Health Care	**Date:**	August 20, 2019
Introduced by:	Reps. Jarvis, Stevens, Murphy	**Prepared by:**	Jason Moran-Bates Staff Attorney
Analysis of:	First Edition		

OVERVIEW: House Bill 918 amends various abuse, neglect, and dependency laws to do the following:

- ***Ensure the safety of children in out-of-home placements.***
- ***Expedite the goal of permanency for children under three years of age who have been removed from the home.***
- ***Create a presumption that foster parents with whom a child under three years of age has lived continuously for nine months are deemed nonrelative kin.***
- ***Create an aggravating circumstance for the exposure of nonmedical, controlled substances in utero.***

CURRENT LAW: Subchapter I (Abuse, Neglect, and Dependency) of Chapter 7B (Juvenile Code) of the General Statutes does the following:

- Provides procedures for hearing juvenile cases to ensure fairness and equity and to protect the constitutional rights of juveniles and parents.
- Develops dispositions in juvenile cases that reflect the facts, needs and limitations of the juvenile, and the strengths and weaknesses of the family.
- Provides services to protect juveniles by means that respect the right to family autonomy and the juveniles' needs for safety, continuity, and permanence.
- Provides standards for removal of juveniles from their homes and return of juveniles to their homes when necessary.
- Provides standards consistent with the Adoption and Safe Families Act of 1997, P.L. 105 89, for ensuring that the best interests of the juvenile are of paramount consideration by the court and that when it is not in the juvenile's best interest to be returned home, the juvenile will be placed in a safe, permanent home within a reasonable amount of time

BILL ANALYSIS:

Section 1 amends the purpose of Subchapter I of Chapter 7B to provide that juveniles under age 3 years of age who are removed from their homes are to have a prospective permanent placement within one year of the date of the initial order removing custody.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

Section 2 amends the definition of non-relative kin to include a presumption that a foster parent with whom a juvenile under 3 years of age has lived for at least nine months is nonrelative kin and adds a definition for "relative" to include an individual directly related to the juvenile.

Section 3 adds to the criteria for non-secure custody a condition providing if a juvenile is an infant who: 1) was born drug-exposed and the drug exposure was not medically based; 2) the parent is unable to discharge parental responsibilities due to a history of chronic drug abuse, and 3) there are reasonable grounds to believe that the parent's substance abuse will continue for a prolonged or indeterminate period based on the opinion of a licensed health care provider with substance abuse disorders experience, then the court will issue an order for non-secure custody.

Section 4 does the following:

- Requires a department of social services to use due diligence to identify and notify adult relatives, next of kin, and others with legal custody of a sibling of a juvenile who is in non-secure custody within 60 days of the initial order removing custody. This section also requires filing with the court information regarding attempts to make such identification and notification.
- Adds to the items that the court must consider when placing a juvenile with a relative the developmental and attachment needs of the juvenile and allows the court to not place the juvenile with the relative if doing so is contrary to those interests.

Section 5 requires the court to direct that reasonable efforts for reunification are not required if the court finds that a court has determined that aggravated circumstances exist because the parent has committed or allowed the continuation of "chronic or toxic exposure to alcohol or controlled substances that causes impairment of or addiction in the juvenile, including exposure to nonmedical controlled substances in utero."

Section 6 does the following:

- Requires the court to consider the juvenile's developmental and attachment needs when deciding whether to order placement of the juvenile with a relative when placing a juvenile in out-of-home care.
- Adds the requirement that once a child under age 3 has lived with a foster parent for at least nine months, the foster parent is deemed to be a relative. Further, if the court does not place the juvenile with a relative, the court may consider whether nonrelative kin or another person with legal custody of a sibling of the juvenile is willing and able to provide proper care and supervision of the juvenile in a safe home.
- Permits the court to order the department to notify the juvenile's State-recognized tribe of the need for non-secure custody for locating relatives or nonrelative kin for placement.
- Permits the court to order the placement of the juvenile with nonrelative kin if the court finds the placement is in the juvenile's best interest.

Section 7 does the following:

- Makes it a goal of the department to place infants under age 3 in a prospective permanent placement within 12 months of the date of the initial order removing custody.
- Adds to the items that the court must consider when making written findings at each permanency planning hearing, to include whether the parent has engaged in any of the factors under G.S. 7B-901(c) when making a finding as to whether efforts to reunite the juvenile with

their parent would be unsuccessful or inconsistent with the juvenile's health or safety and need for a safe, permanent home.

- Requires that the court may not waive or refuse to conduct a permanency planning hearing if a party files a motion seeking the hearing.

Section 8 adds a requirement that an initial dispositional order must direct that the review hearing required under G.S. 7B-906.1 be held within 90 days from the date of the initial dispositional hearing, and if practicable, shall set the date and time for the review hearing.

Section 9 requires the court to make or have made written findings in order for reunification to not be a primary or secondary plan.

Section 10 adds a foster parent to the persons who may file a petition or motion to terminate parental rights provided the foster parent is one with whom a juvenile under age 3 has resided for a continuous period of at least nine months preceding the filing of the petition or motion.

EFFECTIVE DATE: This act becomes effective October 1, 2019, and applies to actions filed or pending on or after that date.

****Tawanda N. Foster, Legislative Analysis Division, substantially contributed to this summary****

HOUSE BILL 918

Short Title:	Amend Abuse Laws/Expedite Permanency.	(Public)
Sponsors:	Representatives Jarvis, Stevens, and Murphy (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Rules, Calendar, and Operations of the House	

April 22, 2019

A BILL TO BE ENTITLED

AN ACT TO AMEND VARIOUS ABUSE, NEGLECT, AND DEPENDENCY LAWS TO ENSURE THE SAFETY OF CHILDREN IN OUT-OF-HOME PLACEMENTS, EXPEDITE THE GOAL OF PERMANENCY FOR CHILDREN UNDER THREE YEARS OF AGE WHO HAVE BEEN REMOVED FROM THE HOME, CREATE A PRESUMPTION THAT FOSTER PARENTS WITH WHOM A CHILD UNDER THREE YEARS OF AGE HAS LIVED CONTINUOUSLY FOR NINE MONTHS ARE DEEMED NONRELATIVE KIN, AND CREATE AN AGGRAVATING CIRCUMSTANCE FOR THE EXPOSURE TO NONMEDICAL, CONTROLLED SUBSTANCES IN UTERO.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 7B-100 is amended by adding a new subdivision to read:

"**§ 7B-100. Purpose.**

This Subchapter shall be interpreted and construed so as to implement the following purposes and policies:

(6) To provide juveniles under 3 years of age who are removed from custody of their homes with prospective permanent placement within one year from the date of the initial order removing custody."

SECTION 2. G.S. 7B-101 reads as rewritten:

"**§ 7B-101. Definitions.**

As used in this Subchapter, unless the context clearly requires otherwise, the following words have the listed meanings:

...

(15a) Nonrelative kin. – An individual having a substantial relationship with the ~~juvenile.~~ juvenile, including the presumption that a foster parent with whom a juvenile under 3 years of age has resided for a continuous period of at least nine months is deemed nonrelative kin for purposes of this Subchapter. In the case of a juvenile member of a State-recognized tribe as set forth in G.S. 143B-407(a), nonrelative kin also includes any member of a State-recognized tribe or a member of a federally recognized tribe, whether or not there is a substantial relationship with the juvenile.

...

(18a) Relative. – An individual directly related to the juvenile, including, but not limited to, a parent, grandparent, sibling, aunt, or uncle.

~~(18a)~~(18b) Responsible individual. – A parent, guardian, custodian, or caretaker who abuses or seriously neglects a juvenile.

~~(18b)~~(18c) Return home or reunification. – Placement of the juvenile in the home of either parent or placement of the juvenile in the home of a guardian or custodian from whose home the child was removed by court order.

...."

SECTION 3. G.S. 7B-503(a) is amended by adding a new subdivision to read:

"(a) When a request is made for nonsecure custody, the court shall first consider release of the juvenile to the juvenile's parent, relative, guardian, custodian, or other responsible adult. An order for nonsecure custody shall be made only when there is a reasonable factual basis to believe the matters alleged in the petition are true, and any of the following apply:

...

(7) The juvenile is an infant who (i) was born drug-exposed and the drug exposure was not medically based, (ii) the parent is unable to discharge parental responsibilities due to a history of chronic drug abuse, and (iii) there are reasonable grounds to believe that the parent's substance abuse will continue for a prolonged or indeterminate period based on the opinion of a licensed health care provider with substance abuse disorders experience.

...."

SECTION 4. G.S. 7B-505(b) reads as rewritten:

"(b) The court shall order the department of social services to make diligent efforts to notify relatives and other persons with legal custody of a sibling of the juvenile that the juvenile is in nonsecure custody and of any hearings scheduled to occur pursuant to G.S. 7B-506, unless the court finds the notification would be contrary to the best interests of the juvenile. The department of social services shall use due diligence to identify and notify adult relatives, next of kin, and other persons with legal custody of a sibling of the juvenile within 60 days after the initial order removing custody. The department shall file with the court information regarding attempts made to identify and notify adult relatives of the child, next of kin, and persons with legal custody of a sibling of the juvenile. In placing a juvenile in nonsecure custody under this section, the court shall first consider whether a relative of the juvenile is willing and able to provide proper care and supervision of the juvenile in a safe home. If the court finds that the relative is willing and able to provide proper care and supervision in a safe home, then the court shall order placement of the juvenile with the relative unless the court finds that placement with the relative would be contrary to the best interests of the ~~juvenile.~~juvenile, including, but not limited to, the developmental and attachment needs of the juvenile."

SECTION 5. G.S. 7B-901(c)(1)e. reads as rewritten:

"(c) If the disposition order places a juvenile in the custody of a county department of social services, the court shall direct that reasonable efforts for reunification as defined in G.S. 7B-101 shall not be required if the court makes written findings of fact pertaining to any of the following, unless the court concludes that there is compelling evidence warranting continued reunification efforts:

(1) A court of competent jurisdiction determines or has determined that aggravated circumstances exist because the parent has committed or encouraged the commission of, or allowed the continuation of, any of the following upon the juvenile:

...

e. Chronic or toxic exposure to alcohol or controlled substances that causes impairment of or addiction in the ~~juvenile.~~juvenile, including exposure to nonmedical controlled substances in utero.

...."

SECTION 6. G.S. 7B-903(a1) reads as rewritten:

"(a1) In placing a juvenile in out-of-home care under this section, the court shall first consider whether a relative of the juvenile is willing and able to provide proper care and

supervision of the juvenile in a safe home. If the court finds that the relative is willing and able to provide proper care and supervision in a safe home, then the court shall order placement of the juvenile with the relative unless the court finds that the placement is contrary to the best interests of the ~~juvenile.~~ juvenile, including, but not limited to, the developmental and attachment needs of the juvenile. Once a child under 3 years of age has resided in the home of a foster parent for a continuous period of at least nine months, the foster parent is deemed to be a relative for purposes of this subsection. In placing a juvenile in out-of-home care under this section, the court shall also consider whether it is in the juvenile's best interest to remain in the juvenile's community of residence. Placement of a juvenile with a relative outside of this State must be in accordance with the Interstate Compact on the Placement of Children.

If the court does not place the juvenile with a relative pursuant to this subsection, the court may consider whether nonrelative kin or other persons with legal custody of a sibling of the juvenile are willing and able to provide proper care and supervision of the juvenile in a safe home. The court may order the department to notify the juvenile's State-recognized tribe of the need for nonsecure custody for the purpose of locating relatives or nonrelative kin for placement. The court may order placement of the juvenile with nonrelative kin if the court finds the placement is in the juvenile's best interests."

SECTION 7. G.S. 7B-906.1 reads as rewritten:

"**§ 7B-906.1. Review and permanency planning hearings.**

(a) The court shall conduct a review hearing within 90 days from the date of the initial dispositional hearing held pursuant to G.S. 7B-901 and shall conduct a review hearing within six months thereafter. ~~Within~~ It shall be the goal of the department to place infants under 3 years of age in a prospective permanent placement within 12 months of the date of the initial order removing custody. For all other juveniles older than 3 years of age, within 12 months of the date of the initial order removing custody, there shall be a review hearing designated as a permanency planning hearing. Review hearings after the initial permanency planning hearing shall be designated as subsequent permanency planning hearings. Subsequent permanency planning hearings shall be held at least every six months thereafter or earlier as set by the court to review the progress made in finalizing the permanent plan for the juvenile, or if necessary, to make a new permanent plan for the juvenile.

...

(d) At each hearing, the court shall consider the following criteria and make written findings regarding those that are relevant:

...

(3) Whether efforts to reunite the juvenile with either parent clearly would be unsuccessful or inconsistent with the juvenile's health or safety and need for a safe, permanent home within a reasonable period of ~~time.~~ time, including whether a parent has engaged in any of the factors described under G.S. 7B-901(c). The court shall consider efforts to reunite regardless of whether the juvenile resided with the parent, guardian, or custodian at the time of removal. If the court determines efforts would be unsuccessful or inconsistent, the court shall schedule a permanency planning hearing within 30 days to address the permanent plans in accordance with this section and G.S. 7B-906.2, unless the determination is made at a permanency planning hearing.

...

(n) Notwithstanding other provisions of this Article, the court may waive the holding of hearings required by this section, may require written reports to the court by the agency or person holding custody in lieu of review hearings, or order that review hearings be held less often than every six months if the court finds by clear, cogent, and convincing evidence each of the following:

...

The court may not waive or refuse to conduct a ~~review~~ permanency planning hearing if a party files a motion seeking the ~~review.~~ hearing. However, if a guardian of the person has been appointed for the juvenile and the court has also made findings in accordance with subsection (n) of this section that guardianship is the permanent plan for the juvenile, the court shall proceed in accordance with G.S. 7B-600(b).

...."

SECTION 8. G.S. 7B-905(b) reads as rewritten:

"(b) ~~A~~ An initial dispositional order ~~under which a juvenile is removed from the custody of a parent, guardian, custodian, or caretaker~~ shall direct that the review hearing required by G.S. 7B-906.1 be held within 90 days from of the date of the initial dispositional hearing and, if practicable, shall set the date and time for the review hearing."

SECTION 9. G.S. 7B-906.2(b) reads as rewritten:

"(b) At any permanency planning hearing, the court shall adopt concurrent permanent plans and shall identify the primary plan and secondary plan. Reunification shall remain a primary or secondary plan unless the court makes or has made written findings under G.S. 7B-901(c) or makes written findings that reunification efforts clearly would be unsuccessful or would be inconsistent with the juvenile's health or safety. The court shall order the county department of social services to make efforts toward finalizing the primary and secondary permanent plans and may specify efforts that are reasonable to timely achieve permanence for the juvenile."

SECTION 10. G.S. 7B-1103(a) is amended by adding a new subdivision to read:

"(a) A petition or motion to terminate the parental rights of either or both parents to his, her, or their minor juvenile may only be filed by one or more of the following:

...

(8) Any foster parent with whom the juvenile under 3 years of age has resided for a continuous period of at least nine months next preceding the filing of the petition or motion."

SECTION 11. This act becomes effective October 1, 2019, and applies to actions filed or pending on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 918

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

H918-ABC-95 [v.1]

Amends Title [NO]
First Edition

Date 8/21 ,2019

Senator Hise

moves to amend the bill on page 1, lines 21-22, by inserting the following between the lines:

"(1) Abused juveniles. – Any juvenile less than 18 years of age (i) who is found to be a minor victim of human trafficking under G.S. 14-43.15 or (ii) whose parent, guardian, custodian, or caretaker:

...

h. Exposes the juvenile repeatedly to drugs, other than those prescribed by a licensed medical provider, while the juvenile is in utero.";

and on page 2, line 24, by deleting "60" and replacing it with "30";

and on page 3, line 6, by deleting the phrase "a relative" and replacing it with "non-relative kin".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

H918-ABC-95-V-1

HB 918—Amend Abuse Laws / Expedite Permanency

Confronting the Crisis of Babies / Children Affected by the Opioid Epidemic

New Child-Centered Legislation for At-Risk Children in North Carolina

It is past-time to help these children grow up in a stable, loving home.

How This Crisis Appears in North Carolina

An epidemic of substance abuse (notably opioids) has enveloped the country over the last twenty years, concentrated in rural areas of low employment, and now, taking root in cities and suburbs. In North Carolina, the number of babies born with opioids in their system (NAS) increased 10-fold from 2004 to 2015. (That number only reflects the babies born with obvious symptoms, as no blood testing is required at birth). The number of children entering foster care because of a parent's addiction has increased 36.5% from 2010 to 2016.

North Carolina is slightly higher than the national average of babies and children affected by the epidemic (6.9%), the western part of the state having the largest percentages of addiction. These cold statistics impact the actual lives of babies and children in the form of maltreatment, neglect, and in too many cases, death. In fact, children less than one-year old die from abuse and neglect at four times the rate of children over the age of one. Suffocation (due to co-sleeping with a substance abusing parent) now ranks as the chief cause of death in the first year of life.

A baby born on opioids requires two months of careful monitoring in a NICU, a slow weaning from the substance. They cry inconsolably for hours and days on end. Too often, the baby is released from the hospital into the same family system that fueled the addiction. There is only one treatment center in North Carolina (Horizons) that provides treatment for the mother and care for the child simultaneously. Sobriety is a particularly difficult battle in opioid addiction. The average addicted mother will relapse five times over a number of years before staying consistently clean.

What This Means for Children

Everyone in the mix of this crisis agrees that a child being cared for by a parent or grandparent is the best possible outcome, if that parent or grandparent is capable of providing care. For the past twenty years, though, social work placement and court decisions have been heavily weighted toward the needs of adults—not the developmental and safety needs of children.

It's a well-established (but disgraceful, and little known) fact that 91.4% of children who are maltreated ...are maltreated at the hands of an actual parent or paramour. A great percentage of that maltreatment can be attributed to the influence of substances and poor parenting history.

Children who suffer from the inconsistent and detrimental influence of an addicted parent get tossed around in the foster care system for years, often aging out of adoptability. They pay a price that will likely follow them for life. Adverse changes to the brain, cognitive and physical developmental delays, socio-emotional trauma, anxiety and depression—the trauma of broken and misshapen attachment is only too well known.

As the best-known trauma researcher, Harvard's Bessel Van Der Kolk, states, "there are hundreds of thousands of children [maltreated at early stages] ...and they absorb enormous resources, often without appreciable benefit. They end up filling our jails, our welfare rolls, and our medical clinics. Tens of thousands of schoolteachers, probation officers, welfare workers, judges, and mental health professionals spend their days trying to help them, and the taxpayer pays the bills."

nc values
COALITION

HB 918—Amend Abuse Laws / Expedite Permanency
Confronting the Crisis of Babies / Children Affected by the Opioid Epidemic
New Child-Centered Legislation for At-Risk Children in North Carolina

Notable Features of House Bill 918

- **Prospective permanent placement within one year for children under 3 years of age who enter state custody.**
- **Due diligence to locate and identify adult relatives within 60 days of a child entering state custody.**
- **Foster family with whom a child under 3 years of age resides for at least nine months deemed non-relative kin and eligible for permanent placement of the child.**
- **Placement shall be based on the best interests of the child, including the attachment and developmental needs of the child.**
- **Toxic exposure to non-medical drugs in utero by the parent of a child shall constitute "aggravated circumstances," in which case continued efforts for reunification shall not be required.**
- **Foster parents with whom a child under the age of 3 has resided for at least 9 months may petition for termination of the parental rights.**

Sources

These are the most current statistics from NC DHS and NC Child, as well as the yearly national report, 2018 Child Maltreatment Survey, and the National Institute on Drug Abuse, as well as North Carolina's Opioid Action Plan, 2017-2021.

The Body Keeps the Score, Bessel Van Der Kolk, Penguin Books, 2015.

Dopesick, Beth Macy, Little, Brown and Company, 2018.

Elizabeth Bartholet, "Thoughts on the Liberal Dilemma in Child Welfare Reform, William and Mary Law Journal, 2016. https://scholarship.law.wm.edu/wmborj/vol24/iss3/8/

Cassie Statuto Bevan, "The Impact of Liberal Ideology on Child Protection, William and Mary Law Journal, 2016. https://scholarship.law.wm.edu/wmborj/vol24/iss3/7/

Naomi Schaeffer Riley, "There Are Worse Things Than Foster Care," New York Times, Nov. 21, 2018 https://www.nytimes.com/2018/11/21/opinion/foster-care-child-abuse.html

Darcy Olsen, "America's Flood of Opioid Orphans, National Review, May 20, 2018. https://www.nationalreview.com/2018/05/national-foster-care-month-finding-solutions-opioid-crisis/

Paula Rinehart, "Why Do Broken Attachments Only Matter for Border-Crossing Children?" The Federalist, August, 18, 2018. https://thefederalist.com/.../press-seem-care-broken-attachments-border-crossing-child...

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SENATE HEALTH CARE

2019-2020

August 21, 2019

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Susan Osborne	DHHS
Claudia Swemaker	governors office
Julie Crouin	DHHS
ANGELA PITTMAN	DHHS
Lisa Cauley	DHHS
Regina Lucille	DOJ
Adrian Daye	Alamance DSS
Jamie Hamlett	" "
Apni Neumann	MWC
Cassidy Robertson	AHCA
Hattie Gavande	DHHS
Mo4 Grys	DHHS
Elisabeth Johnson	UNC Horizons
Starleen Scott Robbins	DMH/DD/SAS
Rhaegan Jackson	FPA

09-21-201

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

August 21, 2019

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Rick Zechini	William Mulla
Heather Robinson	NCRMA
Rong Kim	NCRMA
Dana Simpson	SA
Kara Weisland	SA
Doug Hem	DUKE
Lanier Hodgson	UNC HLS
Lee Arthur	NCOA
Ross Fan Mc L	NP
	NP
Leah Barnes	NCHA
Kate Hanley	Duke
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SENATE HEALTH CARE

2019-2020

August 21, 2019

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Nathan Honaker	Connect C
Dick Carlton	for Self & PLLC
Wendy Sotolongo	Indigent Defense Services
Reginald O'Rourke	Guardian Ad Litem Program
[illegible]	[illegible]
Logan Martin	Skyline Strategies LLC
Frank Bre[illegible]	[illegible] ASSOC.
Resha Fortson	SEANC
Flint Benson	SEANC
Andrew Snyder	NC
Zane Stilwell	TSG
Ken McHon	K.M.A.
Josh Lanier	ESH
JASON JOYNER	NEW FRAME
CSX Rollins	CSX
Dan [illegible]	DHHS

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SENATE HEALTH CARE

2019-2020

August 21, 2019

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Hugh Johnson	VolCare
Laura Grunder	NCSIO
Bruce Uhldwurf	NCSBA
Jami Fitzgerald	NC Values Coalition
Sarah Babbs	Brubaker ASSO
Michey Mouse	
Capt America	

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Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

August 21, 2019

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NAME	FIRM OR AGENCY AND ADDRESS
Tracy Kimbrell	Parker Poe

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee on Health Care

August 21, 2019

Room 643 LOB

1:00 PM

Senate Sergeant at Arms:

Tom Burroughs

Terry Edmondson

John Enloe

Bill Index
SENATE COMMITTEE ON HEALTH CARE
2020 Short Session

HB 471	**Reduce Admin. Duplication MH/DD SAS Providers** Representatives Hardister, White, Dobson, Adcock	May 27 & 28, 2020
HB678	**Amend Counselor/SA/Soc. Worker Prof. Acts** Representatives Dobson and Lambeth	May 28 & June 2, 2020
HB612	**DSS Review of Procedures/Rule Making** Representatives Steven, Riddell, White	June 2 & 3, 2020
SB730	**The No Patient Left Alone Act** Senators Daniel, Perry, Krawiec	June 9 & 11, 2020
SB708	**CPS Intake Screening/PED Recommendations** Senators Edwards, Krawiec, Burgin	June 17, 2020

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NORTH CAROLINA GENERAL ASSEMBLY

SENATE HEALTH CARE
2019 – 2020 SESSION



Sen. Joyce Krawiec
Chair



Sen. Deanna Ballard



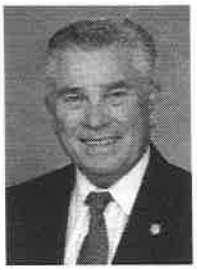
Sen. Rob Bryan



Sen. Jim Burgin



Sen. Don Davis



Sen. Jim Davis



Sen. Carl Ford



Sen. Valerie Foushee



Sen. Ralph Hise



Sen. Rick Horner



Sen. Jim Perry



Sen. Gladys Robinson



Sen. Vickie Sawyer



Sen. Terry Van Duyn



Sen. Mike Woodard

Senate Committee on Health Care
Wednesday, May 27, 2020 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on May 27, 2020 in Room 643 of the Legislative Office Building. Twelve members were present.

Senator Joyce Krawiec, Chair, presided.

Sen. Krawiec convened the meeting with opening remarks and acknowledgement of the Sargent of Arms.

HB 471 Reduce Admin. Duplication MH/DD/SAS Providers. (Representatives Hardister, White, Dobson, Adcock)
Sen. Krawiec announced that this bill was for discussion only, then introduced Sen. Burgin to explain the proposed committee substitute (PCS). Senators Hise and Perry moved to accept the PCS before the committee and it carried. Dr. Benjamin P. Fischer, MD/Internal Medicine/Fischer Clinic was introduced to further explain the PCS and offered a case example. Questions from the members were responded to by Dr. Fischer. Sen. Krawiec announced that the PCS for HB471 would be up for vote during the next meeting (May 28, 2020).

The meeting adjourned at 10:17 AM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

Senate Committee on Health Care
Wednesday, May 27, 2020, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

FOR DISCUSSION ONLY

BILL NO.	SHORT TITLE	SPONSOR
HB 471	Reduce Admin. Duplication MH/DD/SAS Providers.	Representative Hardister Representative White Representative Dobson Representative Adcock

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H D

HOUSE BILL 471
PROPOSED SENATE COMMITTEE SUBSTITUTE H471-CSBC-89 [v.6]
05/26/2020 03:46:12 PM

Short Title: Exempt Direct Primary Care from DOI Regs. (Public)

Sponsors:

Referred to:

March 28, 2019

A BILL TO BE ENTITLED

AN ACT EXEMPTING MEDICAL DIRECT PRIMARY CARE FROM REGULATION BY THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-8. Medical direct primary care agreements not subject to this Chapter.**

(a) Definitions. – The following definitions apply in this section:

(1) Medical direct primary care agreement. – A contract between a primary care provider and an individual patient or individual patient's legal representative in which the primary care provider agrees to provide primary care services to the individual patient for a specified fee and specified period of time. Under a medical direct primary care agreement, a direct primary care provider charges a specified periodic fee for health care services and does not bill any third parties on a fee-for-service basis.

(2) Primary care provider. – An individual or other legal entity that is licensed, registered, or otherwise authorized to provide primary health care services in this State under Chapter 90 of the General Statutes. This includes an individual or other legal entity alone or with others professionally associated with the individual or other legal entity.

(3) Primary care service. – Includes, but is not limited to, the screening, assessment, diagnosis, and treatment of a patient for the promotion of health or the detection and management of disease or injury within the scope of practice of the primary care provider.

(b) A medical direct primary care agreement is not insurance and is not subject to the provisions of this Chapter. Entering into a medical direct primary care agreement is not the business of insurance and is not subject to the provisions of this Chapter.

(c) Primary care providers and their agents shall not be required to be licensed or certified under this Chapter to market, sell, or offer to sell direct primary care agreements.

(d) A medical direct primary care agreement under this section must do all of the following:

(1) Be in writing.

(2) Be signed by the primary care provider, or the provider's agent, and the patient, or the patient's legal representative.

(3) Allow either party to terminate the agreement with written notice to the other party.

(4) Specify the periodic fee for the agreement.
(5) Specify the primary care services that are included in the agreement and covered by the specified periodic fee.
(6) Specify the duration of the agreement and any automatic renewal periods.
(7) Prominently state in writing that the agreement is not health insurance."

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 471:
Exempt Direct Primary Care from DOI Regs.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	May 26, 2020
Introduced by:	Reps. Hardister, White, Dobson, Adcock	**Prepared by:**	Jason Moran-Bates Committee Staff
Analysis of:	PCS to First Edition H471-CSBC-89		

OVERVIEW: The Proposed Committee Substitute to House Bill 471 would clarify that medical direct primary care agreements are not subject to the provisions of Chapter 58 (Insurance) and establish standards for medical direct primary care agreements.

CURRENT LAW: Medical direct primary care agreements are currently not regulated by the Department of Insurance. There are no requirements for what must be included in a medical direct primary care agreement.

BILL ANALYSIS: The PCS would define the terms "medical direct primary care," "primary care provider," and "primary care service." It would also clarify that medical direct primary care agreements are not insurance and are not subject to the provisions of Chapter 58. Finally, it would require that medical direct primary care agreements do all of the following:

- Be in writing.
- Be signed by the parties to the agreement.
- Allow either party to terminate the agreement with written notice to the other party.
- Specify the periodic fee for the agreement.
- Specify the primary care services that are included in the agreement.
- Specify the term of the agreement.
- Include a prominent statement that the agreement is not health insurance.

EFFECTIVE DATE: This bill would be effective when it becomes law.

BACKGROUND: Direct primary care is a method of providing health care where the patient pays a monthly or annual fee to a primary care provider that covers all or most primary care services the patient may need during the time period covered by the fee, including clinical and laboratory services. Currently, 32 states have laws on direct primary care.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

HOUSE BILL 471

Short Title:	Reduce Admin. Duplication MH/DD/SAS Providers.	(Public)
Sponsors:	Representatives Hardister, White, Dobson, and Adcock (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Rules, Calendar, and Operations of the House	

March 28, 2019

A BILL TO BE ENTITLED

AN ACT REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ESTABLISH A WORKGROUP TO EXAMINE AND MAKE RECOMMENDATIONS ABOUT HOW TO ELIMINATE ADMINISTRATIVE DUPLICATION FOR MENTAL HEALTH, INTELLECTUAL/DEVELOPMENTAL DISABILITY, AND SUBSTANCE USE DISORDER PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Secretary of the Department of Health and Human Services shall establish a workgroup to examine current administrative requirements for mental health, intellectual/developmental disability, and substance use disorder providers and how best to integrate these requirements with similar administrative requirements for physical health providers in order to avoid duplication and enhance efficiency. The workgroup shall consist of representatives from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the Division of Health Benefits, the Division of Health Service Regulation, local management entity/managed care organizations, providers, and stakeholders. The examination shall include a review of at least all of the following categories of requirements imposed on mental health, intellectual/developmental disability, and substance use disorder providers and physical health providers:

(1) Training.
(2) Service delivery.
(3) Documentation.
(4) Claims processing.
(5) Reporting.
(6) Monitoring.
(7) Oversight.
(8) Facility licensure.
(9) Medicaid enrollment.
(10) Credentialing.
(11) Accreditation.
(12) Contracts.
(13) Investigations.
(14) Audits.

SECTION 1.(b) In conducting the examination required under subsection (a) of this section, the workgroup shall identify the federal or State entity that created each requirement examined by the workgroup to include State legislation, statutes, contractual requirements,

federal Medicaid and managed care law and provide a recommendation about whether that requirement should remain, be eliminated, or be redesigned. The workgroup shall consider any requirement imposed on mental health, intellectual/developmental disability, and substance use disorder providers that:

(1) Is not federally mandated.
(2) Exceeds what is required for physical health.
(3) Does not add value to the delivery of behavioral health services.
(4) Is unable to be incorporated into standard electronic health records or does not align with meaningful use of electronic health records.

SECTION 1.(c) By March 31, 2020, the Department of Health and Human Services shall report the findings and recommendations of the workgroup to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division.

SECTION 2. This act is effective when it becomes law.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Health Care, Senate Committee

May 27, 2020 10:00 AM Rm. 643

Senate Sergeant-at-Arms

Terry Barnhardt

Frances Patterson

Sheree Hedrick

Dwight Green

John Enloe

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Visitor Sign-in

Health Care, Senate Committee

05/27/2020

SPEAKER: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
Jon Carr	Jordan Price Law Firm
Liz Fischer	Fischer Clinic
Ben Fischer	" "
Ken Melton	K.M.A

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Visitor

Speaker Sign-in

Health Care, Senate Committee

05/27/2020

SPEAKER: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
Benjamin Fischer	Fischer Clinic

Senate Committee on Health Care
Wednesday, May 28, 2020 at 10:00
Room 1027 of the Legislative Building

MINUTES

The Senate Committee on **Health Care** met at 10:20 AM on May 28, 2020 in Room 1027. Ten members were present.

Sen. Joyce Krawiec presided.

HB 471 Reduce Admin. Duplication MH/DD/SAS Providers. (Representatives Hardister, White, Dobson, Adcock)
Sen. Krawiec said that the proposed committee substitute (PCS) was still before the committee and asked if there was need for more discussion. With none, Sen. Hise motioned unfavorable to the bill – favorable to the PCS and it carried.

HB 678 Amend Counselor/SA/Soc. Worker Prof. Acts. (Representatives Dobson, Lambeth)
Sen. Krawiec announced that this bill would be for discussion only. A PCS was presented by Sen. Edwards. Sen. Hise moved that the PCS be brought before the committee for consideration and it carried. Questions from the members were responded to by Sen. Edwards. Sen. Krawiec announced that this bill will be voted on during the next Senate Health Care meeting.

The meeting adjourned at 10:44 AM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Krawiec, Chair

Thursday, May 28, 2020

Senator Krawiec,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

HB **471** Reduce Admin. Duplication MH/DD/SAS Providers.

Draft Number:	H471-PCS40643-BC-89
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Jim Burgin will handle HB 471



Senate Committee on Health Care
Thursday, May 28, 2020, 10:00 AM
1027/1128 Legislative Building

AGENDA

Welcome and Opening Remarks

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 471	Reduce Admin. Duplication MH/DD/SAS Providers.	Representative Hardister Representative White Representative Dobson Representative Adcock
HB 678	Amend Counselor/SA/Soc. Worker Prof. Acts. FOR DISCUSSION ONLY	Representative Potts Representative Dobson Representative Lambeth

HOUSE BILL 471:
Exempt Direct Primary Care from DOI Regs.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	May 26, 2020
Introduced by:	Reps. Hardister, White, Dobson, Adcock	**Prepared by:**	Jason Moran-Bates Committee Staff
Analysis of:	PCS to First Edition H471-CSBC-89		

OVERVIEW: The Proposed Committee Substitute to House Bill 471 would clarify that medical direct primary care agreements are not subject to the provisions of Chapter 58 (Insurance) and establish standards for medical direct primary care agreements.

CURRENT LAW: Medical direct primary care agreements are currently not regulated by the Department of Insurance. There are no requirements for what must be included in a medical direct primary care agreement.

BILL ANALYSIS: The PCS would define the terms "medical direct primary care," "primary care provider," and "primary care service." It would also clarify that medical direct primary care agreements are not insurance and are not subject to the provisions of Chapter 58. Finally, it would require that medical direct primary care agreements do all of the following:

- Be in writing.
- Be signed by the parties to the agreement.
- Allow either party to terminate the agreement with written notice to the other party.
- Specify the periodic fee for the agreement.
- Specify the primary care services that are included in the agreement.
- Specify the term of the agreement.
- Include a prominent statement that the agreement is not health insurance.

EFFECTIVE DATE: This bill would be effective when it becomes law.

BACKGROUND: Direct primary care is a method of providing health care where the patient pays a monthly or annual fee to a primary care provider that covers all or most primary care services the patient may need during the time period covered by the fee, including clinical and laboratory services. Currently, 32 states have laws on direct primary care.

Karen Cochrane-Brown
Director

H471-SMBC-150 CSBC-89 -V-2

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H D

HOUSE BILL 471
PROPOSED SENATE COMMITTEE SUBSTITUTE H471-CSBC-89 [v.6]
05/26/2020 03:46:12 PM

Short Title: Exempt Direct Primary Care from DOI Regs. (Public)

Sponsors:

Referred to:

March 28, 2019

A BILL TO BE ENTITLED

AN ACT EXEMPTING MEDICAL DIRECT PRIMARY CARE FROM REGULATION BY THE DEPARTMENT OF INSURANCE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-8. Medical direct primary care agreements not subject to this Chapter.**

(a) Definitions. – The following definitions apply in this section:

(1) Medical direct primary care agreement. – A contract between a primary care provider and an individual patient or individual patient's legal representative in which the primary care provider agrees to provide primary care services to the individual patient for a specified fee and specified period of time. Under a medical direct primary care agreement, a direct primary care provider charges a specified periodic fee for health care services and does not bill any third parties on a fee-for-service basis.

(2) Primary care provider. – An individual or other legal entity that is licensed, registered, or otherwise authorized to provide primary health care services in this State under Chapter 90 of the General Statutes. This includes an individual or other legal entity alone or with others professionally associated with the individual or other legal entity.

(3) Primary care service. – Includes, but is not limited to, the screening, assessment, diagnosis, and treatment of a patient for the promotion of health or the detection and management of disease or injury within the scope of practice of the primary care provider.

(b) A medical direct primary care agreement is not insurance and is not subject to the provisions of this Chapter. Entering into a medical direct primary care agreement is not the business of insurance and is not subject to the provisions of this Chapter.

(c) Primary care providers and their agents shall not be required to be licensed or certified under this Chapter to market, sell, or offer to sell direct primary care agreements.

(d) A medical direct primary care agreement under this section must do all of the following:

(1) Be in writing.

(2) Be signed by the primary care provider, or the provider's agent, and the patient, or the patient's legal representative.

(3) Allow either party to terminate the agreement with written notice to the other party.

(4) Specify the periodic fee for the agreement.
(5) Specify the primary care services that are included in the agreement and covered by the specified periodic fee.
(6) Specify the duration of the agreement and any automatic renewal periods.
(7) Prominently state in writing that the agreement is not health insurance."

SECTION 2. This act is effective when it becomes law.

HOUSE BILL 471

Short Title:	Reduce Admin. Duplication MH/DD/SAS Providers.	(Public)
Sponsors:	Representatives Hardister, White, Dobson, and Adcock (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Rules, Calendar, and Operations of the House	

March 28, 2019

A BILL TO BE ENTITLED

AN ACT REQUIRING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ESTABLISH A WORKGROUP TO EXAMINE AND MAKE RECOMMENDATIONS ABOUT HOW TO ELIMINATE ADMINISTRATIVE DUPLICATION FOR MENTAL HEALTH, INTELLECTUAL/DEVELOPMENTAL DISABILITY, AND SUBSTANCE USE DISORDER PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Secretary of the Department of Health and Human Services shall establish a workgroup to examine current administrative requirements for mental health, intellectual/developmental disability, and substance use disorder providers and how best to integrate these requirements with similar administrative requirements for physical health providers in order to avoid duplication and enhance efficiency. The workgroup shall consist of representatives from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the Division of Health Benefits, the Division of Health Service Regulation, local management entity/managed care organizations, providers, and stakeholders. The examination shall include a review of at least all of the following categories of requirements imposed on mental health, intellectual/developmental disability, and substance use disorder providers and physical health providers:

(1) Training.
(2) Service delivery.
(3) Documentation.
(4) Claims processing.
(5) Reporting.
(6) Monitoring.
(7) Oversight.
(8) Facility licensure.
(9) Medicaid enrollment.
(10) Credentialing.
(11) Accreditation.
(12) Contracts.
(13) Investigations.
(14) Audits.

SECTION 1.(b) In conducting the examination required under subsection (a) of this section, the workgroup shall identify the federal or State entity that created each requirement examined by the workgroup to include State legislation, statutes, contractual requirements,

federal Medicaid and managed care law and provide a recommendation about whether that requirement should remain, be eliminated, or be redesigned. The workgroup shall consider any requirement imposed on mental health, intellectual/developmental disability, and substance use disorder providers that:

(1) Is not federally mandated.
(2) Exceeds what is required for physical health.
(3) Does not add value to the delivery of behavioral health services.
(4) Is unable to be incorporated into standard electronic health records or does not align with meaningful use of electronic health records.

SECTION 1.(c) By March 31, 2020, the Department of Health and Human Services shall report the findings and recommendations of the workgroup to the Joint Legislative Oversight Committee on Health and Human Services, the Joint Legislative Oversight Committee on Medicaid and NC Health Choice, and the Fiscal Research Division.

SECTION 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

H D

HOUSE BILL 678
Committee Substitute Favorable 4/30/19
PROPOSED SENATE COMMITTEE SUBSTITUTE H678-CSBC-90 [v.9]
05/27/2020 03:18:29 PM

Short Title: COVID-19 Health Care Flexibility Act. (Public)

Sponsors:

Referred to:

April 11, 2019

A BILL TO BE ENTITLED

AN ACT TO MEET THE HEALTH AND HUMAN SERVICE NEEDS OF THE STATE DURING THE COVID-19 PANDEMIC AND ITS AFTERMATH.

The General Assembly of North Carolina enacts:

PART I. FACILITATING INCREASES IN HEALTH CARE RESOURCES

SECTION 1.1.(a). The authority granted to the Secretary of Health and Human Services under this Part to waive or modify regulations shall be exercised with the goals of providing health care and saving lives in response to the potential wave of illness brought on by the COVID-19 pandemic and to meet the need for additional health care facility beds and technology to treat patients.

SECTION 1.1.(b). Notwithstanding any other provision of law or executive order to the contrary, the Secretary of Health and Human Services is directed to waive or modify enforcement of any legal or regulatory constraints that would prevent or impair any of the following:

(1) An increase of bed capacity at a licensed health care facility.
(2) Relocating beds from a currently-operating hospital, nursing home facility, or adult care home to any other currently-operating hospital, nursing home facility, or adult care home.
(3) Adding dialysis stations to a kidney disease treatment center or hospital.
(4) Relocating dialysis stations from a currently-operating kidney disease treatment center to any other physical space.
(5) Acquisition by a hospital, or acquisition on a hospital's behalf, of medical imaging equipment. For purposes of this Part, "medical imaging equipment" shall mean a mobile Magnetic Resonance Imaging (MRI) scanner or a mobile Computed Tomography (CT) scanner.
(6) Allowing an ambulatory surgical facility to operate as a temporary hospital.

SECTION 1.1.(c). Notwithstanding any other provision of law or executive order to the contrary, the Secretary of Health and Human Services is directed to waive or modify enforcement of the following:

(1) Any regulations on licensed bed capacity of adult care homes, including those found in 10A NCAC 13F .0206 and 10A NCAC 13G .0206.
(2) Any regulations on licensed bed capacity of mental health, developmental disabilities, and substance abuse facilities, including those found in 10A NCAC 27G .0404(e).
(3) Any regulations related to the provisions in (1) and (2).

SECTION 1.1.(d). The Secretary's waivers and modifications must be consistent with the conditions established in Section 1.2 of this act.

SECTION 1.2. This Part allows only temporary increases, relocations, additions, acquisitions, or changes in status of health care resources. All increases, relocations, additions, or changes in status made under this Part's authority shall be allowed only through the duration of the State of Emergency declared in Executive Order No. 116, plus one year after Executive Order No. 116 is rescinded. Any equipment acquired under this Part's authority must be returned no later than thirty days following the expiration of this act.

SECTION 1.3.(a). Notwithstanding any other provision of law or executive order to the contrary, the Secretary is directed to waive any provisions in 10A NCAC 13B .3111 that limit temporary expansion in bed capacity at hospitals. A hospital may temporarily increase its acute bed capacity over its licensed bed capacity and temporarily relocate existing licensed acute care beds into physical space that meets federal life safety requirements, unless those requirements have been waived by the Centers for Medicare and Medicaid Services (CMS) when the expansion of bed capacity or relocation of beds meets all of the following criteria:

(1) The expansion or relocation must be necessary for the purposes of accommodating patients who are:
   a. Receiving treatment for COVID-19.
   b. Awaiting results of COVID-19 testing.
   c. Relocated to accommodate other patients being treated for COVID-19 elsewhere in the facility.

(2) The hospital administrator submits a written notice to the Division of Health Service Regulation that includes the following information:
   a. The number of additional beds that will be necessary.
   b. A description of the physical space where the beds will be located.
   c. How the space will be used.
   d. The anticipated duration of the expansion or relocation.
   e. A certification that the expansion or relocation is necessary for public health and safety in the hospital's service area, the physical facilities to be used are adequate to safeguard the health and safety of patients in accordance with CMS requirements, and that all patients will receive appropriate care.

SECTION 1.3.(b). Notwithstanding any other provision of law or executive order to the contrary, the Secretary is directed to waive any provisions in 10A NCAC 13D .2105 that limit temporary expansion in bed capacity at continuing care retirement communities (CCRC). A CCRC may temporarily increase its bed capacity over its licensed bed capacity and temporarily use nursing home beds for adult care home residents and adult care home beds for nursing home residents in physical space that meets federal life safety requirements, unless those requirements have been waived by CMS when the expansion of bed capacity or change in bed usage meets all of the following criteria:

(1) The expansion or change in bed usage must be necessary for the purposes of accommodating patients who are:
   a. Receiving treatment for COVID-19.
   b. Awaiting results of COVID-19 testing.
   c. Relocated to accommodate other patients being treated for COVID-19 elsewhere in the facility.

(2) The CCRC administrator submits a written notice to the Division of Health Service Regulation that includes the following information:
   a. The number of additional beds that will be necessary.
   b. A description of the physical space where the beds will be located.
   c. How the space will be used.

d. The anticipated duration of the expansion or change in usage.
e. A certification that the expansion or change in usage is necessary for public health and safety in the hospital's service area, the physical facilities to be used are adequate to safeguard the health and safety of patients in accordance with CMS.

SECTION 1.4. Notwithstanding any other provision of law or executive order to the contrary, before any increase in licensed bed capacity or relocation of beds under this Part, written notification of the intent to increase bed capacity or relocate beds must be submitted to the Division of Health Service Regulation. The notification shall do all of the following:

(1) State the number of beds that will be added or relocated.
(2) If beds are being relocated, state the facilities from which and to which the beds are being relocated.
(3) Include a description of the space that will be utilized, how it will be utilized, and the anticipated duration of the utilization.
(4) Include a certification from the facility administrator that the request is necessary for the public health and safety in the facility's service area, the physical facilities to be used are adequate to safeguard the health and safety of the patients or residents, and the patients or residents will receive appropriate care and their health and safety will be safeguarded.

SECTION 1.5. Notwithstanding any other provision of law or executive order to the contrary, before any increase in dialysis station capacity or relocation of dialysis stations under this Part, written notification of the intent to increase dialysis station capacity or relocate dialysis stations must be submitted to the Division of Health Service Regulation. The notification shall do all of the following:

(1) Be submitted on CMS Form 3427.
(2) State the number of dialysis stations that will be added or relocated.
(3) If dialysis stations are being relocated, state the facilities from which and to which the stations are being relocated.
(4) Include a description of the space that will be utilized, how it will be utilized, and the anticipated duration of the utilization.
(5) Include a certification from the facility administrator that the request is necessary for the public health and safety in the facility's service area, the physical facilities to be used are adequate to safeguard the health and safety of the patients or residents, and the patients or residents will receive appropriate care and their health and safety will be safeguarded.

SECTION 1.6. Notwithstanding any other provision of law or executive order to the contrary, before any acquisition of medical imaging equipment under this Part, written notification of the intent to acquire medical imaging equipment must be submitted to the Division of Health Service Regulation. The notification shall do all of the following:

(1) Document the preparations made for the mobile site location.
(2) Include a description of the space that will be utilized, how it will be utilized, and the anticipated duration of the utilization.
(3) Include a certification that the request is necessary for the public health and safety in the facility's service area, the physical facilities to be used are adequate to safeguard the health and safety of the patients or residents, and the patients or residents will receive appropriate care and their health and safety will be safeguarded.

SECTION 1.7. Notwithstanding any other provision of law or executive order to the contrary, before any an ambulatory surgical facility may operate as a temporary hospital under this Part, written notification of the intent to operate as a temporary hospital must be submitted to the Division of Health Service Regulation. The notification shall do all of the following:

(1) Include a description of the space that will be utilized, how it will be utilized, and the anticipated duration of the utilization.

(2) Include a certification from the facility administrator that the request is necessary for the public health and safety in the facility's service area, the physical facilities to be used are adequate to safeguard the health and safety of the patients or residents, and the patients or residents will receive appropriate care and their health and safety will be safeguarded.

SECTION 1.8.(a). Notwithstanding any other provision of law or executive order to the contrary, the Secretary is directed to allow the relocation of acute care beds, consistent with the provisions of this Part, and without the requirement to first obtain a Certificate of Need. The Secretary is also directed to waive enforcement and sanctions related to Certificate of Need requirements, under the conditions stated in this Part.

SECTION 1.8.(b) Notwithstanding any other provision of law or executive order to the contrary, the Secretary is directed to allow the addition or relocation of dialysis stations, consistent with the provisions of this Part, and without the requirement to first obtain a Certificate of Need. The Secretary is also directed to waive enforcement and sanctions related to Certificate of Need requirements, under the conditions stated in this Part.

SECTION 1.8.(c). Notwithstanding any other provision of law or executive order to the contrary, the Secretary is directed to allow the temporary acquisition of medical imaging equipment, consistent with the provisions of this Part, and without the requirement to first obtain a Certificate of Need. The Secretary is also directed to waive enforcement and sanctions related to Certificate of Need requirements, under the conditions stated in this Part.

SECTION 1.8.(d). Notwithstanding any other provision of law or executive order to the contrary, the Secretary is directed to allow the operation of an ambulatory surgical facility as a temporary hospital, consistent with the provisions of this Part, and without the requirement to first obtain a Certificate of Need. The Secretary is also directed to waive enforcement and sanctions related to Certificate of Need requirements, under the conditions stated in this Part.

SECTION 1.9.(e). This part is effective when it becomes law and expires one year after Executive Order No. 116 is rescinded.

PART II. INCREASING THE POOL OF PROFESSIONAL HEALTH CARE WORKERS

SECTION 2.1.(a). In order to meet the goal of providing health care and saving lives in response to the wave of illness brought on by the COVID-19 pandemic, and to meet the need for additional health care workers to treat patients, notwithstanding any other provision of law or executive order to the contrary, the relevant professional health care licensure boards shall have the authority to waive or modify the enforcement of any legal or regulatory constraints that would prevent or impair the following:

(1) Allowing individuals to provide health care if they are licensed in other states, territories, or the District of Columbia, but not licensed in North Carolina.

(2) Allowing individuals to provide care if they are retired or if their licenses are inactive.

(3) Allowing skilled, but unlicensed, volunteers to provide care.

(4) Allowing students at an appropriately advanced stage of professional study to provide care.

SECTION 2.1.(b). The relevant professional health care boards shall have the authority to accomplish the goals in Section 2.1.(a). by waiving or modifying any of the following regulations:

(1) The regulations on admission and licensure for the practice of medicine, in Chapter 32 of Title 21 of the North Carolina Administrative Code.

(2) The regulations on admission and licensure for the practice of nursing, in Chapter 36 of Title 21 of the North Carolina Administrative Code.
(3) The regulations on admission and licensure for the practice of midwifery, in Chapter 33 of Title 21 of the North Carolina Administrative Code.
(4) The admission and licensure regulations for the social worker profession, in Chapter 63 of Title 21 of the North Carolina Administrative Code.
(5) The regulations on admission and licensure for the practice of respiratory care, in Chapter 61 of Title 21 of the North Carolina Administrative Code.
(6) The admission and licensure regulations for the pharmacy profession, in Chapter 46 of Title 21 of the North Carolina Administrative Code.
(7) The regulations on admission and licensure for the practice of speech and language pathology and audiology, in Chapter 64 of Title 21 of the North Carolina Administrative Code.
(8) The regulations on admission and licensure for the practice of psychology, in Chapter 54 of Title 21 of the North Carolina Administrative Code.
(9) The regulations on admission and licensure for the practice of clinical mental health counseling, in Chapter 53 of Title 21 of the North Carolina Administrative Code.
(10) The admission and licensure regulations for substance abuse professionals, in Chapter 68 of Title 21 of the North Carolina Administrative Code.
(11) The regulations on admission and licensure for the practice of occupational therapy, in Chapter 38 of Title 21 of the North Carolina Administrative Code.
(12) The regulations on admission and licensure for the practice of physical therapy, in Chapter 48 of Title 21 of the North Carolina Administrative Code.
(13) The regulations on admission and licensure for the practice of recreational therapy, in Chapter 65 of Title 21 of the North Carolina Administrative Code.
(14) The admission and licensure regulations for the profession of interpreters and transliterators, in Chapter 25 of Title 21 of the North Carolina Administrative Code.
(15) The admission and licensure regulations for the profession of nursing home administrators, in Chapter 37 of Title 21 of the North Carolina Administrative Code.
(16) The admission and licensure regulations for the profession of adult care home administrators in 10A NCAC 13F .1701.
(17) The admission and licensure regulations for the perfusionist profession, in Subchapter 32V of Chapter 32 of Title 21 of the North Carolina Administrative Code.
(18) Any regulations that are related to the provisions listed above.

SECTION 2.1.(c). In each case, the professional health care licensure board shall have the authority to allow or not allow, in its discretion, these waivers or modifications, and the board shall have the authority to impose conditions on any persons authorized to provide care under this Section.

SECTION 2.1.(d). Each professional health care licensure board shall document its waivers and modifications in writing and post them on its Web site.

SECTION 2.1.(e). The professional health care licensure boards shall provide guidance on the training and qualifications necessary for their licensees to be ready to address workforce shortages in essential health care services needed to properly manage the State of Emergency declared in Executive Order No. 116 and at any other time this Act is effective.

SECTION 2.1.(f). Nothing in this section shall limit the existing statutory waiver authority of any board.

SECTION 2.1.(g). Waivers and modifications under authority of this section are temporary and shall be effective only while this act is effective. Each professional health care licensure board has the authority to reimpose, while this act is effective, any legal or regulatory constraint for which the board has waived or modified enforcement under this section.

SECTION 2.2.(a). The State Director of Emergency Management shall identify resources that are available for response to Emergency Management Assistance Compact (EMAC) requests. EMAC requests shall be coordinated through the State Director of Emergency Management and shall be fulfilled once authorized by the State Director of Emergency Management.

SECTION 2.2(b). Notwithstanding any other provision of law or executive order to the contrary, a health provider licensed, registered, or certified in good standing under another state's jurisdiction, or who is reinstated pursuant to emergency action, may apply for an emergency license with the appropriate licensing board in this State and, if deemed eligible and licensed, may deliver services in this State, including through telehealth, provided those services are within the provider's authorized scope of practice in the other state. The enforcement of any restrictions under North Carolina law restricting the use of telehealth by a health provider licensed in North Carolina, whether through a standard license or emergency license, shall be waived.

SECTION 2.2(c). Pursuant to G.S. 166A-45, when assistance is requested by North Carolina, any person who holds a license, certificate, or other permit issued by another state evidencing the meeting of qualifications for professional, mechanical, or other skills shall be deemed licensed, certified, or permitted by this State to render aid involving those skills to meet the State of Emergency declared in Executive Order No. 116 and for one year after Executive Order No. 116 is rescinded. Any requirement for a license to practice any professional, mechanical, or other skill shall not apply to emergency management workers as defined in G.S. 166A-19.60(e) who in the course of performing their duties, practice a professional, mechanical, or other skill during the State of Emergency declared in Executive Order No. 116 and for one year after Executive Order No. 116 is rescinded. The provisions of this subsection shall be construed to supplement the types of health care professionals and types of health care practice that are authorized by Section 2.1.

SECTION 2.3. All persons who are licensed or otherwise authorized under this act, or at any time under Executive Order No. 130, to perform professional skills in the field of health care in response to the to the COVID-19 pandemic are deemed to be "emergency management workers" as defined by G.S. 166A-19.60(e) to the extent they are providing emergency services to respond to the COVID-19 pandemic. All emergency management workers shall be insulated from civil liability to the maximum extent authorized by G.S. 166A-19.60, except in cases of willful misconduct, gross negligence, or bad faith.

PART III. HEALTH SERVICES LICENSURE

SECTION 3.1.(a). In order to meet the goals of providing all-inclusive care, preventing the spread of COVID-19 within a highly vulnerable population, and saving lives during the COVID-19 pandemic, and notwithstanding any other provision of law or executive order to the contrary, the Secretary of Health and Human Services is authorized to waive or modify enforcement of any legal or regulatory constraints that would prevent or impair the provision of the Program of All-Inclusive Care for the Elderly (PACE) services in an in-home setting.

SECTION 3.1.(b). Notwithstanding any other provision of law or executive order to the contrary, the Secretary of Health and Human Services is authorized to waive or modify enforcement of any regulations on licensure of home care agencies, including those found in Subchapter 13J of Chapter 13 of Title 10A of the North Carolina Administrative Code.

SECTION 3.2.(a). In order to meet the goal of providing health care and protecting the public in response to the COVID-19 pandemic, and notwithstanding any other provision of law or executive order to the contrary, the Secretary of Health and Human Services is directed to waive or modify enforcement of the following, consistent with the provisions in Section 3.2.(b) and 3.2.(c):

(1) Any regulations on initial assessment for agencies providing in-home aide services, including those found in 10A NCAC 13J .1107.

(2) Any regulations on supervisory visits for in-home caregivers, including those found in 10A NCAC 13J .1110.

(3) Any regulations that are related to the provisions listed in (1) and (2).

SECTION 3.2.(b). Initial assessments required to be conducted may be conducted using eligible technologies that allow the health care practitioner to remotely communicate and evaluate the client's functional status in the area of social, mental, physical health, environmental, economic, activities of daily living, and instrumental activities of daily living. Initial assessments can be delivered via any HIPAA-compliant, secure technology with audio and video capabilities, including, but not limited to, smart phones, tablets and computers.

SECTION 3.2.(c). Supervisory visits required to be conducted may be conducted using eligible technologies that allow the supervising registered nurse to remotely communicate and evaluate services rendered. Supervisory visits can be delivered via any HIPAA-compliant, secure technology with audio and video capabilities including, but not limited to, smart phones, tablets, and computers. If the provider is unable to conduct supervisory visits remotely, the provider must develop and implement a procedure that details the method in which the registered nurse will monitor the client's care with review of the client's general condition, progress, and response to the services provided by the in-home caregiver.

SECTION 3.2(d). In exercising the authority granted under Sections 3.1 and 3.2 of this act, the Secretary of Health and Human Services shall ensure compliance with all federal requirements for the Program of All-Inclusive Care for the Elderly.

SECTION 3.3.(a). Notwithstanding any other provision of law or executive order to the contrary, the Secretary of Health and Human Services is directed to authorize health care facilities, other than child care providers, to accept a written verification from a potential new hire's current employer, or the most recent employer within 30 days, as a temporary measure in lieu of the national portion of the Criminal History Records Check, provided that the following conditions are also satisfied:

(1) The State background check portions of the Criminal History Records Check must be completed as required by law.

(2) The authorization is only provided in areas of North Carolina where fingerprinting is not available.

(3) The national background check portions of the Criminal History Records Check must be completed for the new hire as soon as possible once fingerprinting becomes available. Under no circumstances may the national background check be completed later than within 30 days following the date the State of Emergency declared in Executive Order No. 116 ends.

(4) The current or previous employer's written verification must be in a form that meets guidelines to be established by the Division of Health Service Regulation. The verification must show that the potential new hire passed both the national background check and State background check portions of a Criminal History Records Check while at the employer providing the verification.

SECTION 3.3.(b). Notwithstanding any other provision of law or executive order to the contrary, the Secretary of Health and Human Services is directed to accomplish the goals in

Section 3.3.(a) by modifying or waiving 10A NCAC 13F .0407(a)(7), 10A NCAC 13G .0406(a)(7), and any regulations related to those two rules.

SECTION 3.3.(c). Nothing in this section shall relieve any pre-existing obligation for any health care facility to run a criminal record check based on a job applicant's name prior to the date the applicant begins work.

PART 4. SEVERABILITY AND CONFLICT WITH EXECUTIVE ORDERS

SECTION 4.1. 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.

SECTION 4.2. If there is a conflict between any provision of this act and any Executive Order, the provisions of this act shall supersede the provisions of the Executive Order.

PART 5. EFFECTIVE DATE

SECTION 5.1. Except as otherwise provided, this act is effective when it becomes law and expires one year after the date Executive Order No. 116 is rescinded.

HOUSE BILL 678:
COVID-19 Health Care Flexibility Act.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Agriculture/Environment/Natural Resources. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	May 27, 2020
Introduced by:	Reps. Potts, Dobson, Lambeth	**Prepared by:**	Jason Moran-Bates Committee Staff
Analysis of:	PCS to Second Edition H678-CSBC-90		

OVERVIEW: The Proposed Committee Substitute to House Bill 678 would facilitate an increase in health care resources, increase the pool of health care professionals, and ease restrictions on licensure for health services provided to the elderly during the COVID-19 pandemic and its aftermath.

CURRENT LAW: The provisions of this bill have been largely implemented by Executive Order No. 130. Specific differences between Executive Order No. 130 and the PCS will be in italics below.

BILL ANALYSIS: The PCS to House Bill 678 would legislatively enact many of the provisions in Executive Order No. 130 and make them effective for one year after the State of Emergency declared in Executive Order No. 116 is rescinded.

Part I of the PCS would direct the Secretary of Health and Human Services to modify or waive certain regulations on bed and equipment capacity in health care facilities, with the goal of providing health care and saving lives in response to the potential wave of illness brought on by the COVID-19 pandemic.

Section 1.1 would direct the Secretary to waive or modify enforcement of any regulations on the following:

- Increasing bed capacity at health care facilities.
- Relocating beds from one facility to another.
- Adding dialysis stations to kidney treatment centers or hospitals.
- Acquiring mobile medical imaging equipment.
- Allowing ambulatory surgical facilities to operate as temporary hospitals.
- Bed capacity in adult care homes.
- Bed capacity in mental health, developmental disabilities, and substance abuse facilities.

Section 1.2 would clarify the waivers and modifications are temporary in nature and will only apply until one year from the date Executive Order No. 116 is rescinded.

Section 1.3 would allow hospitals and continuing care retirement communities (CCRC) to expand bed capacity, relocate beds, or change bed usage after submitting written notice of the intent to do so to the Division of Health Service Regulation (DHSR).

Section 1.4 would allow health care facilities to increase the number of beds or relocate beds after submitting written notice of the intent to do so to DHSR.

Section 1.5 would allow the number of dialysis stations to be increased or dialysis stations to be relocated after submitting written notice of the intent to do so to DHSR.

Section 1.6 would allow the acquisition of mobile medical imaging equipment after submitting written notice of the intent to do so to DHSR.

Section 1.7 would allow ambulatory surgical facilities to function as temporary hospitals after submitting written notice of the intent to do so to DHSR.

Currently, Executive Order No. 130 requires DHSR to approve the changes made in Sections 1.4 through 1.7 before they can be implemented. The PCS requires that DHSR merely be notified of the changes in advance of their being made. Approval by DHSR would not be necessary.

Section 1.8 would require the Secretary to allow bed expansion or relocation, increases in dialysis stations, acquisition of mobile medical imaging equipment, and the functioning of ambulatory surgical facilities as temporary hospitals without first obtaining a Certificate of Need (CON). The Secretary would also be directed to waive CON enforcement and sanctions.

Section 1.9 would make Part I effective when it becomes law. It would expire one year after Executive Order No. 116 is rescinded.

Part II of the PCS would direct health care professional licensing boards to waive licensure requirements with the goal of providing health care and saving lives in response to the wave of illness brought on by the COVID-19 pandemic and meeting the need for additional health care workers to treat patients during the pandemic.

Section 2.1 would allow health care professional licensing boards to waive licensure regulations that prevent individuals licensed in other states, individuals who were licensed but are now retired, other skilled volunteers, and students from providing health care in North Carolina. Health care professional licensing boards would be required to post any waivers on their websites.

Section 2.2 would ensure compliance with the Emergency Management Assistance Compact and clarify that individuals licensed in other states would be permitted to practice in North Carolina while providing services pursuant to the Compact. It would also deem health care professionals providing health care within the scope of their licenses in response to the COVID-19 pandemic to be "emergency management workers" immune from liability to the extent provided in G.S. 166A-19.60, except in cases of willful misconduct, gross negligence, or bad faith.

Part III of the PCS would authorize the Secretary to waive or modify enforcement of regulations that might impair providing services to the elderly or the employment of individuals in health care facilities.

Section 3.1 would authorize the Secretary to modify or waive regulations that impair the provision of in-home services under the Program for All-Inclusive Care for the Elderly.

Section 3.2 would authorize the Secretary to waive or modify regulations requiring initial assessments and supervisory visits for in-home care givers.

Section 3.3 would allow health care providers to accept written verification from potential employees' previous employers when fingerprinting is unavailable.

Part IV of the PCS would clarify that when the act and an executive order conflict, the provisions of the act will supersede those of the executive order. It also contains a severability clause.

EFFECTIVE DATE: This bill would be effective when it becomes law and expire one year after Executive Order No. 116 is rescinded.

HOUSE BILL 678*
Committee Substitute Favorable 4/30/19

Short Title: Amend Counselor/SA/Soc. Worker Prof. Acts. (Public)

Sponsors:

Referred to:

April 11, 2019

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LICENSED PROFESSIONAL COUNSELORS ACT; TO UPDATE AND REVISE THE SUBSTANCE ABUSE PROFESSIONAL PRACTICE ACT; AND TO AMEND THE SOCIAL WORKER CERTIFICATION AND LICENSURE ACT.

The General Assembly of North Carolina enacts:

PART I. CHANGES TO THE LICENSED PROFESSIONAL COUNSELORS ACT

SECTION 1.(a) Article 24 of Chapter 90 of the General Statutes reads as rewritten:

"Article 24.

"Licensed ~~Professional~~ Clinical Mental Health Counselors Act.

"**§ 90-329. Declaration of policy.**

It is declared to be the public policy of this State that the activities of persons who render counseling services to the public be regulated to insure the protection of the public health, safety, and welfare.

"**§ 90-330. Definitions; practice of counseling.**

(a) Definitions. – ~~As used in this Article certain terms are defined as follows:~~The following definitions apply in this Article:

(1) Repealed by Session Laws 1993, c. 514, s. 1.

(1a) The "Board" means the Board of Licensed ~~Professional~~ Clinical Mental Health Counselors.

(2) A "licensed ~~professional~~ clinical mental health counselor" is a person engaged in the practice of counseling who holds a license as a licensed ~~professional~~ clinical mental health counselor issued under the provisions of this Article.

(2a) A "licensed ~~professional~~ clinical mental health counselor associate" is a person engaged in the supervised practice of counseling who holds a license as a licensed ~~professional~~ clinical mental health counselor associate issued under the provisions of this Article.

(2b) A "licensed ~~professional~~ clinical mental health counselor supervisor" is a person engaged in the practice of counseling who holds a license as a licensed ~~professional~~ clinical mental health counselor and is approved by the Board to provide clinical supervision under the provisions of this Article.

(3) The "practice of counseling" means holding oneself out to the public as a ~~professional~~ clinical mental health counselor offering counseling services that include, but are not limited to, the following:

...

The "practice of counseling" does not include the facilitation of communication, understanding, reconciliation, and settlement of conflicts by mediators at community mediation centers authorized by G.S. 7A-38.5.

(4) A "supervisor" means any licensed ~~professional~~ clinical mental health counselor supervisor or, when one is inaccessible, a licensed ~~professional~~ clinical mental health counselor or an equivalently and actively licensed mental health professional, as determined by the Board, who meets the qualifications established by the Board.

(b) Repealed by Session Laws 1993, c. 514, s. 1.

(c) Practice of Marriage and Family Therapy, Psychology, or Social Work. – No person licensed as a licensed ~~professional~~ clinical mental health counselor or licensed ~~professional~~ clinical mental health counselor associate under the provisions of this Article shall be allowed to hold himself or herself out to the public as a licensed marriage and family therapist, licensed practicing psychologist, psychological associate, or licensed clinical social worker unless specifically authorized by other provisions of law.

"**§ 90-331. Prohibitions.**

It shall be unlawful for any person who is not licensed under this Article to engage in the practice of counseling, use the title "Licensed ~~Professional~~ Clinical Mental Health Counselor Associate," "Licensed ~~Professional~~ Clinical Mental Health Counselor," or "Licensed ~~Professional~~ Clinical Mental Health Counselor Supervisor," use the letters ~~"LPCA," "LPC," or "LPCS,"~~ "LCMHCA," "LCMHC," or "LCMHCS," use any facsimile or combination of these words or letters, abbreviations, or insignia, or indicate or imply orally, in writing, or in any other way that the person is a licensed ~~professional~~ clinical mental health counselor.

"**§ 90-332. Use of title by firm.**

It shall be unlawful for any firm, partnership, corporation, association, or other business or professional entity to assume or use the title of licensed ~~professional~~ clinical mental health counselor unless each of the members of the firm, partnership, or association is licensed by the Board.

"**§ 90-332.1. Exemptions from licensure.**

...

(b) Persons who claim to be exempt under subsection (a) of this section are prohibited from advertising or offering themselves as "licensed ~~professional~~ clinical mental health counselors".

...

"**§ 90-333. North Carolina Board of Licensed ~~Professional~~ Clinical Mental Health Counselors; appointments; terms; composition.**

(a) For the purpose of carrying out the provisions of this Article, there is hereby created the North Carolina Board of Licensed ~~Professional~~ Clinical Mental Health Counselors which shall consist of seven members appointed by the Governor in the manner hereinafter prescribed. Any State or nationally recognized professional association representing ~~professional~~ clinical mental health counselors may submit recommendations to the Governor for Board membership. The Governor may remove any member of the Board for neglect of duty or malfeasance or conviction of a felony or other crime of moral turpitude, but for no other reason.

(b) At least five members of the Board shall be licensed ~~professional~~ clinical mental health counselors except that initial appointees shall be persons who meet the educational and experience requirements for licensure as licensed ~~professional~~ clinical mental health counselors under the provisions of this Article; and two members shall be public-at-large members appointed from the general public. Composition of the Board as to the race and sex of its members shall reflect the population of the State and each member shall reside in a different congressional district.

(c) At all times the Board shall include at least one counselor primarily engaged in counselor education, at least one counselor primarily engaged in the public sector, at least one counselor primarily engaged in the private sector, and two licensed ~~professional~~ clinical mental health counselors at large.

...

"§ 90-334. Functions and duties of the Board.

(a) The Board shall administer and enforce the provisions of this Article.

...

(i) The Board shall establish the criteria for determining the qualifications constituting "supervised ~~professional~~ clinical mental health practice".

(j) The Board may examine, approve, issue, deny, revoke, suspend, and renew the licenses of counselor applicants and licensees under this Article, and conduct hearings in connection with these actions.

(k) The Board shall investigate, subpoena individuals and records, and take necessary appropriate action to properly discipline persons licensed under this Article and to enforce this Article.

(l) The Board shall establish a program for licensees who may be experiencing substance use disorders, burnout, compassion fatigue, and other mental health concerns. In establishing this program, the Board is authorized to enter into agreements with existing professional health care programs. The Board is also authorized to refer any licensee to this program as part of the disciplinary process. The Board may adopt rules implementing this program.

"§ 90-335. Board general provisions.

The Board shall be subject to the provisions of Chapter 93B of the General Statutes.

"§ 90-336. Title and qualifications for licensure.

(a) Each person desiring to be a licensed ~~professional~~ clinical mental health counselor associate, licensed ~~professional~~ clinical mental health counselor, or licensed ~~professional~~ clinical mental health counselor supervisor shall make application to the Board upon such forms and in such manner as the Board shall prescribe, together with the required application fee.

(b) The Board shall issue a license as a "licensed ~~professional~~ clinical mental health counselor associate" to an applicant who applies on or before March 1, 2016, and meets all of the following criteria:

...

(b1) The Board shall issue a license as a "licensed ~~professional~~ clinical mental health counselor associate" to an applicant who applies after March 1, 2016, through June 30, 2022, and meets all of the following criteria:

...

(b2) The Board shall issue a license as a "licensed ~~professional~~ clinical mental health counselor associate" to an applicant who applies on or after July 1, 2022, and meets all of the following criteria:

...

(c) The Board shall issue a license as a "licensed ~~professional~~ clinical mental health counselor" to an applicant who meets all of the following criteria:

(1) Has met all of the requirements under subsection (b), (b1), or (b2) of this section, as applicable.

(2) Has completed a minimum of 3,000 hours of supervised ~~professional~~ clinical mental health practice as determined by the Board.

(d) A licensed ~~professional~~ clinical mental health counselor may apply to the Board for recognition as a "licensed ~~professional~~ clinical mental health counselor supervisor" and receive the credential "licensed ~~professional~~ clinical mental health counselor supervisor" upon meeting all of the following criteria:

(1) Has met all of the requirements under subsection (c) of this section.

(2) Has one of the following:
a. At least five years of full-time licensed ~~professional~~ clinical mental health counseling experience, including a minimum of 2,500 hours of direct client contact;
b. At least eight years of part-time licensed ~~professional~~ clinical mental health counseling experience, including a minimum of 2,500 hours of direct client contact; or
c. A combination of full-time and part-time ~~professional~~ clinical mental health counseling experience, including a minimum of 2,500 hours of direct client contact as determined by the Board.
(3) Has completed minimum education requirements in clinical supervision as approved by the Board.
(4) Has an active license in good standing as a licensed ~~professional~~ clinical mental health counselor approved by the Board.

"**§ 90-337. Persons credentialed in other states.**

(a) The Board may license any person who is currently licensed, certified, or registered by another state if the individual has met requirements determined by the Board to be substantially similar to or exceeding those established under this Article.

(b) The Board may enter into reciprocity agreements with another state that has requirements for licensure as a clinical mental health counselor that are substantially similar or that exceed requirements established under this Article.

"~~**§ 90-338. Exemptions.**~~

~~Applicants holding certificates of registration as Registered Practicing Counselors and in good standing with the Board shall be issued licenses as licensed professionalcounselors without meeting the requirements of G.S. 90-336(c). The following applicants shall be exempt from the academic qualifications required by this Article for licensed professional counselor associates or licensed professional counselors and shall be licensed upon passing the Board examination and meeting the experience requirements:~~

~~(1) An applicant who was engaged in the practice of counseling before July 1, 1993, and who applied to the Board prior to January 1, 1996.~~
~~(2) An applicant who holds a masters degree from a college or university accredited by one of the regional accrediting associations or from a college or university determined by the Board to have standards substantially equivalent to a regionally accredited institution, provided the applicant was enrolled in the masters program prior to July 1, 1994.~~

...

"**§ 90-340. Protection of the public.**

(a) The Board may, in accordance with the provisions of Chapter 150B of the General Statutes, deny, suspend, or revoke licensure, discipline, place on probation, limit practice, or require examination, remediation, or rehabilitation of any person licensed under this Article on one or more of the following grounds:

(1) Has been convicted of a felony or entered a plea of guilty or nolo contendere to any felony charge under the laws of the United States or of any state of the United States.
(2) Has been convicted of or entered a plea of guilty or nolo contendere to any misdemeanor involving moral turpitude, misrepresentation, or fraud in dealing with the public, or conduct otherwise relevant to fitness to practice ~~professional~~ clinical mental health counseling, or a misdemeanor charge reflecting the inability to practice ~~professional~~ clinical mental health counseling with due regard to the health and safety of clients or patients.

(3) Has engaged in fraud or deceit in securing or attempting to secure or renew a license under this Article or has willfully concealed from the Board material information in connection with application for a license or renewal of a license under this Article.

(4) Has practiced any fraud, deceit, or misrepresentation upon the public, the Board, or any individual in connection with the practice of ~~professional~~ clinical mental health counseling, the offer of ~~professional~~ clinical mental health counseling services, the filing of Medicare, Medicaid, or other claims to any third-party payor, or in any manner otherwise relevant to fitness for the practice of ~~professional~~ clinical mental health counseling.

(5) Has made fraudulent, misleading, or intentionally or materially false statements pertaining to education, licensure, license renewal, certification as a health services provider, supervision, continuing education, any disciplinary actions or sanctions pending or occurring in any other jurisdiction, professional credentials, or qualifications or fitness for the practice of ~~professional~~ clinical mental health counseling to the public, any individual, the Board, or any other organization.

(6) Has had a license or certification for the practice of ~~professional~~ clinical mental health counseling in any other jurisdiction suspended or revoked, or has been disciplined by the licensing or certification board in any other jurisdiction for conduct which would subject him or her to discipline under this Article.

(7) Has violated any provision of this Article or any rules adopted by the Board.

(8) Has aided or abetted the unlawful practice of ~~professional~~ clinical mental health counseling by any person not licensed by the Board.

(9) Has been guilty of immoral, dishonorable, unprofessional, or unethical conduct as defined in this subsection or in the current code of ethics of the American Counseling Association. However, if any provision of the code of ethics is inconsistent and in conflict with the provisions of this Article, the provisions of this Article shall control.

(10) Has practiced ~~professional~~ clinical mental health counseling in such a manner as to endanger the welfare of clients.

(11) Has demonstrated an inability to practice ~~professional~~ clinical mental health counseling with reasonable skill and safety by reason of illness, inebriation, misuse of drugs, narcotics, alcohol, chemicals, or any other substance affecting mental or physical functioning, or as a result of any mental or physical condition.

(12) Has practiced ~~professional~~ clinical mental health counseling outside the boundaries of demonstrated competence or the limitations of education, training, or supervised experience.

(13) Has exercised undue influence in such a manner as to exploit the client, patient, student, supervisee, or trainee for the financial or other personal advantage or gratification of the licensed ~~professional~~ clinical mental health counselor associate, licensed ~~professional~~ clinical mental health counselor, or a third party.

(14) Has harassed or abused, sexually or otherwise, a client, patient, student, supervisee, or trainee.

(15) Has failed to cooperate with or to respond promptly, completely, and honestly to the Board, to credentials committees, or to ethics committees of professional associations, hospitals, or other health care organizations or educational institutions, when those organizations or entities have jurisdiction.

(16) Has refused to appear before the Board after having been ordered to do so in writing by the chair.

(17) Has a finding listed on the Division of Health Service Regulation of the Department of Health and Human Services Health Care Personnel Registry.

(b) The Board may, in lieu of denial, suspension, or revocation, take any of the following disciplinary actions:

(1) Issue a formal reprimand or formally censure the applicant or licensee.

(2) Place the applicant or licensee on probation with the appropriate conditions on the continued practice of ~~professional~~ clinical mental health counseling deemed advisable by the Board.

(3) Require examination, remediation, or rehabilitation for the applicant or licensee, including care, counseling, or treatment by a professional or professionals designated or approved by the Board, the expense to be borne by the applicant or licensee.

(4) Require supervision of the ~~professional~~ clinical mental health counseling services provided by the applicant or licensee by a licensee designated or approved by the Board, the expense to be borne by the applicant or licensee.

(5) Limit or circumscribe the practice of ~~professional~~ clinical mental health counseling provided by the applicant or licensee with respect to the extent, nature, or location of the ~~professional~~ clinical mental health counseling services provided, as deemed advisable by the Board.

(6) Discipline and impose any appropriate combination of the types of disciplinary action listed in this section.

In addition, the Board may impose conditions of probation or restrictions on continued practice of ~~professional~~ clinical mental health counseling at the conclusion of a period of suspension or as a requirement for the restoration of a revoked or suspended license. In lieu of or in connection with any disciplinary proceedings or investigation, the Board may enter into a consent order relative to discipline, supervision, probation, remediation, rehabilitation, or practice limitation of a licensee or applicant for a license.

(c) The Board may assess costs of disciplinary action against an applicant or licensee found to be in violation of this Article.

(d) When considering the issue of whether an applicant or licensee is physically or mentally capable of practicing ~~professional~~ clinical mental health counseling with reasonable skill and safety with patients or clients, upon a showing of probable cause to the Board that the applicant or licensee is not capable of practicing ~~professional~~ clinical mental health counseling with reasonable skill and safety with patients or clients, the Board may petition a court of competent jurisdiction to order the applicant or licensee in question to submit to a psychological evaluation by a psychologist to determine psychological status or a physical evaluation by a physician to determine physical condition, or both. The psychologist or physician shall be designated by the court. The expenses of the evaluations shall be borne by the Board. Where the applicant or licensee raises the issue of mental or physical competence or appeals a decision regarding mental or physical competence, the applicant or licensee shall be permitted to obtain an evaluation at the applicant or licensee's expense. If the Board suspects the objectivity or adequacy of the evaluation, the Board may compel an evaluation by its designated practitioners at its own expense.

...

"**§ 90-343. Disclosure.**

Any individual, or employer of an individual, who is licensed under this Article may not charge a client or receive remuneration for ~~professional~~ clinical mental health counseling services unless, prior to the performance of those services, the client is furnished a copy of a Professional

Disclosure Statement that includes the licensee's professional credentials, the services offered, the fee schedule, and other provisions required by the Board.

...

"**§ 90-345. Criminal history record checks of applicants for licensure as ~~professional~~ clinical mental health counselors.**

(a) Definitions. – The following definitions shall apply in this section:

(1) Applicant. – A person applying for licensure as a licensed ~~professional~~ clinical mental health counselor associate pursuant to G.S. 90-336(b), 90-336(b1), or 90-336(b2) or licensed ~~professional~~ clinical mental health counselor pursuant to G.S. 90-336(c).

(2) Criminal history. – A history of conviction of a State or federal crime, whether a misdemeanor or felony, that bears on an applicant's fitness for licensure to practice ~~professional~~ clinical mental health counseling. The crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7B, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots, Civil Disorders, and Emergencies; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes also include possession or sale of drugs in violation of the North Carolina Controlled Substances Act in Article 5 of Chapter 90 of the General Statutes and alcohol-related offenses including sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5. In addition to the North Carolina crimes listed in this subdivision, such crimes also include similar crimes under federal law or under the laws of other states.

...."

SECTION 1.(b) This section is effective January 1, 2020.

PART II. TECHNICAL AND CONFORMING CHANGES RELATED TO THE RENAMING OF THE LICENSED CLINICAL MENTAL HEALTH COUNSELORS ACT

SECTION 2.(a) G.S. 8-53.8 read as rewritten:

"**§ 8-53.8. Counselor privilege.**

No person, duly licensed pursuant to Chapter 90, Article 24, of the General Statutes, shall be required to disclose any information which he or she may have acquired in rendering ~~professional~~ clinical mental health counseling services, and which information was necessary to enable him or her to render ~~professional~~ clinical mental health counseling services: Provided, that the presiding judge of a superior or district court may compel such disclosure, if in the court's opinion

the same is necessary to a proper administration of justice and such disclosure is not prohibited by other statute or regulation."

SECTION 2.(b) G.S. 48-10-103(a)(3) reads as rewritten:

"(3) Counseling services for a parent or the adoptee that are directly related to the adoption and are provided by a licensed psychiatrist, licensed psychologist, licensed marriage and family therapist, licensed ~~professional~~ clinical mental health counselor, licensed or certified social worker, fee-based practicing pastoral counselor or other licensed ~~professional~~ clinical mental health counselor, or an employee of an agency;"

SECTION 2.(c) G.S. 55B-2(6) reads as rewritten:

"(6) The term "professional service" means any type of personal or professional service of the public which requires as a condition precedent to the rendering of such service the obtaining of a license from a licensing board as herein defined, and pursuant to the following provisions of the General Statutes: Chapter 83A, "Architects"; Chapter 84, "Attorneys-at-Law"; Chapter 93, "Public Accountants"; and the following Articles in Chapter 90: Article 1, "Practice of Medicine," Article 2, "Dentistry," Article 6, "Optometry," Article 7, "Osteopathy," Article 8, "Chiropractic," Article 9A, "Nursing Practice Act," with regard to registered nurses, Article 11, "Veterinarians," Article 12A, "Podiatrists," Article 18A, "Practicing Psychologists," Article 18C, "Marriage and Family Therapy Licensure," Article 18D, "Occupational Therapy," Article 22, "Licensure Act for Speech and Language Pathologists and Audiologists," and Article 24, "Licensed ~~Professional~~ Clinical Mental Health Counselors"; Chapter 89C, "Engineering and Land Surveying"; Chapter 89A, "Landscape Architects"; Chapter 90B, "Social Worker Certification and Licensure Act" with regard to Licensed Clinical Social Workers as defined by G.S. 90B-3; Chapter 89E, "Geologists"; Chapter 89B, "Foresters"; and Chapter 89F, "North Carolina Soil Scientist Licensing Act"."

SECTION 2.(d) G.S. 55B-14(c)(4) reads as rewritten:

"(4) A physician, a licensed psychologist, a licensed clinical social worker, or each of them and a certified clinical specialist in psychiatric and mental health nursing, a licensed marriage and family therapist, a licensed ~~professional~~ clinical mental health counselor, or each of them, to render psychotherapeutic and related services that the respective stockholders are licensed, certified, or otherwise approved to provide."

SECTION 2.(e) G.S. 58-3-192(a) reads as rewritten:

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

(1) Adaptive behavior treatment. – Behavioral and developmental interventions that systematically manage instructional and environmental factors or the consequences of behavior that have been shown to be clinically effective through research published in peer reviewed scientific journals and based upon randomized, quasi-experimental, or single subject designs. Both of the following requirements must be met:

a. The intervention must be necessary to (i) increase appropriate or adaptive behaviors, (ii) decrease maladaptive behaviors, or (iii) develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

b. The treatment must be ordered by a licensed physician or licensed psychologist and the treatment must be provided or supervised by one of the following professionals, so long as the services or supervision

provided is commensurate with the professional's training, experience, and scope of practice:

1. A licensed psychologist or psychological associate.
2. A licensed psychiatrist or developmental pediatrician.
3. A licensed speech and language pathologist.
4. A licensed occupational therapist.
5. A licensed clinical social worker.
6. A licensed ~~professional~~ clinical mental health counselor.
7. A licensed marriage and family therapist.
8. A board certified behavior analyst.

...

(8) Therapeutic care. – Direct or consultative services provided by a licensed speech therapist, licensed occupational therapist, licensed physical therapist, licensed clinical social worker, licensed ~~professional~~ clinical mental health counselor, or licensed marriage and family therapists.

...."

SECTION 2.(f) G.S. 58-50-30(b)(12) reads as rewritten:

"(12) A ~~professional~~ clinical mental health counselor licensed by the North Carolina Board of Licensed ~~Professional~~ Clinical Mental Health Counselors pursuant to Article 24 of Chapter 90 of the General Statutes."

SECTION 2.(g) G.S. 90-21.41(2) reads as rewritten:

"(2) Psychotherapist. – A psychiatrist licensed in accordance with Article 1 of Chapter 90 of the General Statutes, a psychologist as defined in G.S. 90-270.2(9), a licensed ~~professional~~ clinical mental health counselor as defined in ~~G.S. 90-330(a)(2),~~ G.S. 90-330(a), a substance abuse professional as defined in G.S. 90-113.31(8), a social worker engaged in a clinical social work practice as defined in G.S. 90B-3(6), a fee-based pastoral counselor as defined in G.S. 90-382(4), a licensed marriage and family therapist as defined in G.S. 90-270.47(3), or a mental health service provider, who performs or purports to perform psychotherapy."

SECTION 2.(h) G.S. 90-270.48A(a) reads as rewritten:

"(a) This Article does not prevent members of the clergy or licensed, certified, or registered members of professional groups recognized by the Board from advertising or performing services consistent with their own profession. Members of the clergy include, but are not limited to, persons who are ordained, consecrated, commissioned, or endorsed by a recognized denomination, church, faith group, or synagogue. Professional groups the Board shall recognize include, but are not limited to, licensed or certified social workers, licensed ~~professional~~ clinical mental health counselors, fee-based pastoral counselors, licensed practicing psychologists, psychological associates, physicians, and attorneys-at-law. However, in no event may a person use the title "Licensed Marriage and Family Therapist" or "Licensed Marriage and Family Therapy Associate," use the letters "LMFT" or "LMFTA," or in any way imply that the person is a licensed marriage and family therapist or a licensed marriage and family therapy associate unless the person is licensed as such under this Article."

SECTION 2.(i) G.S. 122C-263.1(a) reads as rewritten:

"(a) Physicians and eligible psychologists are qualified to perform the commitment examinations required under G.S. 122C-263(c) and G.S. 122C-283(c). The Secretary of Health and Human Services may individually certify to perform the first commitment examinations required by G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 other health, mental health, and substance abuse professionals whose scope of practice includes diagnosing and documenting psychiatric or substance use disorders and conducting mental status examinations to determine capacity to give informed consent to treatment as follows:

(1) The Secretary has received a request:
a. To certify a licensed clinical social worker, a master's or higher level degree nurse practitioner, a licensed ~~professional~~ clinical mental health counsellor, or a physician's assistant to conduct the first examinations described in G.S. 122C-263(c) and G.S. 122C-283(c).
b. To certify a master's level licensed clinical addictions specialist to conduct the first examination described in G.S. 122C-283(c).

...

(4) A certification granted by the Secretary under this section shall be in effect for a period of up to three years and may be rescinded at any time within this period if the Secretary finds the certified individual has failed to meet the requirements of this section. Certification may be renewed every three years upon completion of a refresher training program approved by the Department.

(5) In no event shall the certification of a licensed clinical social worker, master's or higher level degree nurse practitioner, licensed ~~professional~~ clinical mental health counsellor, physician assistant, or master's level certified clinical addictions specialist under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the master's level nurse practitioner, licensed ~~professional~~ clinical mental health counsellor, physician assistant, or the master's level certified clinical addictions specialist.

...."

SECTION 2.(j) G.S. 143B-957 reads as rewritten:

"**§ 143B-957. Criminal record checks of applicants for licensure as ~~professional counselors.~~clinical mental health counselors.**

The Department of Public Safety may provide to the North Carolina Board of Licensed ~~Professional~~ Clinical Mental Health Counselors from the State and National Repositories of Criminal Histories the criminal history of any applicant for licensure or reinstatement of a license or licensee under Article 24 of Chapter 90 of the General Statutes. Along with the request, the Board shall provide to the Department of Public Safety the fingerprints of the applicant or licensee, a form signed by the applicant or licensee consenting to the criminal record check and use of fingerprints and other identifying information required by the State and National Repositories, and any additional information required by the Department of Public Safety. The applicant or licensee's fingerprints shall be forwarded to the State Bureau of Investigation for a search of the State's criminal history record file, and the State Bureau of Investigation shall forward a set of fingerprints to the Federal Bureau of Investigation for a national criminal history record check. The Board shall keep all information obtained pursuant to this section confidential. The Department of Public Safety may charge a fee to offset the cost incurred by it to conduct a criminal record check under this section. The fee shall not exceed the actual cost of locating, editing, researching, and retrieving the information."

SECTION 2.(k). The Codifier of Rules shall make any conforming rule changes necessary to reflect the name changes made by this act.

SECTION 2.(*l*) This section is effective January 1, 2020.

PART III. INDEPENDENT STUDY DEFINITION CHANGES

SECTION 3.(a) G.S. 90-113.31A reads as rewritten:

"**§ 90-113.31A. Definitions.**

The following definitions ~~shall~~ apply in this Article:

...

(18) Independent study. – ~~Any course of~~ Directed study undertaken by an individual with little or no supervision that ~~is~~ does not include traditional classroom-based study that must be preapproved by the Board or any

organization that has deemed status with the ~~Board.~~Board, or any online course of study that does not include a network-enabled transfer of skills and knowledge from teacher to student being performed at the same time.

...

(27) Traditional classroom-based study. – An educational method of learning involving face-to-face communication or other shared communication being performed in either a shared physical setting or by audio conferencing methods, video conferencing methods, or both."

SECTION 3.(b) This section becomes effective October 1, 2019.

PART IV. SUBSTANCE ABUSE PROFESSIONAL PRACTICE BOARD RESTRUCTURE

SECTION 4.(a) G.S. 90-113.32(a) reads as rewritten:

"(a) The North Carolina Addictions Specialist Professional Practice Board is created as the authority to credential substance ~~abuse~~ use disorder professionals in North Carolina."

SECTION 4.(b) G.S. 90-113.32(c) is repealed.

SECTION 4.(c) G.S. 90-113.32(c1) reads as rewritten:

"(c1) Every member of the Board shall have the right to vote on all matters before the Board, except for the ~~President~~ chair who shall vote only in case of a tie or when another member of the Board abstains on the question of whether the professional discipline the member represents shall retain its deemed status."

SECTION 4.(d) G.S. 90-113.32 is amended by adding a new subsection to read:

"(c2) The Board shall consist of nine members appointed as follows:

(1) Three members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, each of whom shall be licensed or certified in accordance with this Article. In making the appointments, the Speaker shall consider the ethnicity and gender of the Board's members in order to reflect the composition of the State's population and shall consider the experience and knowledge of the drug and alcohol recovery community when selecting members to serve on the Board.

(2) Three members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, each of whom shall be licensed or certified in accordance with this Article. In making the appointments, the President Pro Tempore shall consider the ethnicity and gender of the Board's members in order to reflect the composition of the State's population and shall consider the experience and knowledge of the drug and alcohol recovery community when selecting members to serve on the Board.

(3) Three members appointed by the Governor as follows:

a. Two members of the public who are not licensed or certified under this Article.

b. One member who is licensed or certified under this Article, selected from the allied mental health, substance use disorder and developmental disabilities treatment and prevention profession, previously known as deemed status professions.

(4) All members of the Board shall be residents of the State of North Carolina, and except for the public members, shall be certified or licensed by the Board under the provisions of this Article. Professional members of the Board must be actively engaged in the practice of substance use disorder counseling or prevention or in the education and training of students in substance use disorder counseling, and have been for at least three years prior to their

appointment to the Board. Practice during the two years preceding the appointment shall have occurred primarily in this State."

SECTION 4.(e) G.S. 90-113.32(d) is repealed.

SECTION 4.(f) G.S. 90-113.32(e) reads as rewritten:

"(e) Members of the Board shall serve for ~~four-year~~ three-year terms. No Board member shall serve for more than two consecutive terms, but a person who has been a member for two consecutive terms may be reappointed after being off the Board for a period of at least one year. ~~When a vacancy occurs in an unexpired term, the Board shall, as soon as practicable, appoint temporary members to serve until the end of the unexpired terms. Time spent as a temporary member does not count in determining the limitation on consecutive terms.~~"

SECTION 4.(g) G.S. 113.32 is amended by adding a new subsection to read:

"(e1) Initial members of the Board shall serve staggered terms. The members identified in subdivision (1) of subsection (c2) of this section shall be appointed initially for a term of one year. The members identified in subdivision (2) of subsection (c2) of this section shall be appointed initially for a term of two years. The members identified in subdivision (3) of subsection (c2) of this section shall be appointed initially for a term of three years.

At the end of their respective terms of office, their successors shall be appointed for terms of three years, effective July 1. A vacancy occurring before the expiration of the term of office shall be filled in the same manner as original appointments for the remainder of the term."

SECTION 4.(h) G.S. 113.32 is amended by adding a new subsection to read:

"(f1) A Board member may not receive compensation but may receive reimbursement as provided in G.S. 93B-5. The officers of the Board include a chair, a secretary, and any other officer deemed necessary by the Board to carry out the purposes of this Article. All officers shall be elected annually by the Board at its first meeting held after appointments are made to the Board. The Board shall hold a meeting within 45 days after the appointment of new Board members. All officers shall serve one-year terms and shall serve until their successors are elected and qualified. No person shall chair the Board for more than four consecutive years. The Board may adopt rules governing the calling, holding, and conducting of regular and special meetings. A majority of Board members constitutes a quorum."

SECTION 4.(i) This section becomes effective July 1, 2020.

PART V. INCREASE IN NUMBER OF BOARD-APPROVED EDUCATION HOURS REQUIRED FOR CERTIFICATION AS A SUBSTANCE ABUSE COUNSELOR, SUBSTANCE ABUSE PREVENTION CONSULTANT, OR CRIMINAL JUSTICE ADDICTIONS SPECIALIST, AND TERMINOLOGY MODIFICATION

SECTION 5.(a) G.S. 90-113.40(a)(6) reads as rewritten:

"(6) The applicant has completed ~~270~~ 300 hours of Board-approved education. The Board may prescribe that a certain number of hours be in a course of study for substance ~~abuse~~ use disorder counseling and that a certain number of hours be in a course of study for substance abuse prevention consulting. Independent study hours shall not compose more than fifty percent (50%) of the total number of hours required for initial credentialing."

SECTION 5.(b) G.S. 90-113.40(d1)(1) reads as rewritten:

"(1) Has attained ~~270~~ 300 hours of Board-approved education or training, unless the applicant has attained a minimum of a masters degree with a clinical application and a substance ~~abuse~~ use disorder specialty from a regionally accredited college or university whereby the applicant must only obtain 180 hours. The hours of education shall be specifically related to the knowledge and skills necessary to perform the tasks within the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated, "IC&RC/AODA, Inc.," criminal justice addictions professional performance

domains as they relate to both adults and juveniles. Independent study may compose up to fifty percent (50%) of the total number of hours obtained for initial certification or renewal."

SECTION 5.(c) This section becomes effective October 1, 2019, and applies to applications for licenses submitted on or after that date.

PART VI. ESTABLISHMENT OF PROGRAM FOR IMPAIRED SUBSTANCE ABUSE PROFESSIONALS

SECTION 6.(a) Article 5C of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-113.48. Program for impaired substance use disorder professionals.**

(a) There is created the North Carolina Impaired Professionals Program. The Board may provide funds for the administration of the Program, but the Program shall operate independently of the Board. The purpose of the Program is to provide screening, referral, monitoring, educational, and support services for professionals credentialed pursuant to this Article for treatment and rehabilitation of an impairment attributed to a physical or mental illness, a substance use disorder, or professional sexual misconduct.

(b) The Program may enter into an agreement with one or more professionals credentialed pursuant to this Article for the purposes of identifying, reviewing, and evaluating the ability of substance use disorder professionals who are referred or self-referred to the Program to (i) function in their professional capacity and (ii) coordinate regimens for treatment and rehabilitation.

(c) An agreement entered into between the Program and a credentialed professional pursuant to subdivision (b) of this section shall include guidelines for all of the following:

(1) Enrollment of credentialed professionals referred to the Program by the Board.

(2) Assessment, referral, monitoring, support, and education of credentialed professionals referred to the Program by reason of a physical or mental illness, a substance use disorder, or professional sexual misconduct.

(3) Consistent with subsection (d) of this section, criteria for the Program to report credentialed professionals to the Board.

(4) Procedures by which credentialed professionals may obtain review of Program recommendations about the credentialed professional regarding assessment or treatment.

(5) Periodic reporting of statistical information by the Program to the Board.

(6) Maintaining the confidentiality of nonpublic information.

(d) The Program shall report immediately to the Board detailed information about any professional credentialed pursuant to this Article who meets any of the following criteria:

(1) Constitutes an imminent danger to patient care by reason of mental illness, physical illness, substance use disorder, professional sexual misconduct, or any other reason.

(2) Refuses to submit to an assessment as ordered by the Program.

(3) Has entered into a monitoring contract as a Program participant and fails to comply with the terms of the monitoring contract.

(4) Is still unsafe to practice as a substance use disorder professional after completing Program services.

(e) All documents, papers, letters, recordings, electronic records, or other documentary materials in the possession of the Program or its staff, employees, legal counsel, and volunteers, relating in any way to a member's participation or prospective participation in the Program, including, but not limited to, any medical, counseling, substance abuse, or mental health records, shall not be considered public records within the meaning of Chapter 132 of the General Statutes. No person participating in good faith in the Program shall be required in a civil action or

proceeding to disclose the fact of participation in the Program or disclose any information acquired or opinions, recommendations, or evaluations acquired or developed solely in the course of participating in the Program pursuant to this section. For purposes of this subsection, "civil action or proceeding" does not include an administrative action or proceeding conducted under this Article or under Chapter 150B of the General Statutes.

(f) Activities conducted in good faith pursuant to the agreement authorized by subsection (b) of this section shall not be grounds for civil action under the laws of this State.

(g) Upon the written request of a professional credentialed pursuant to this Article, the Program shall provide the credentialed professional and his or her legal counsel with a copy of a written assessment of the credentialed professional prepared as part of his or her participation in the Program. In addition, to the extent permitted by State and federal laws, the credentialed professional shall be entitled to a copy of any written assessment created by a treatment provider or facility at the recommendation of the Program. Any information the Program furnishes to a credentialed professional pursuant to this subsection shall be inadmissible in evidence and shall not be subject to discovery in any civil action or proceeding; provided, however, that this subsection shall not be construed to make information, documents, or records otherwise available for discovery or use in a civil action or proceeding immune from discovery or use in the civil action or proceeding merely because the information, documents, or records were included as part of the Program's assessment of the credentialed professional or were the subject of information furnished to the credentialed professional pursuant to this subsection. For purposes of this subsection, "civil action or proceeding" does not include an administrative action or proceeding conducted under this Article or Chapter 150B of the General Statutes.

(h) The Board shall adopt rules to apply to the operation of the Program, with provisions for at least all of the following:

(1) Definitions of impairments attributed to physical or mental illness, substance use disorder, and professional sexual misconduct.
(2) Guidelines for Program elements.
(3) Procedures for receipt and use of information of suspected impairment.
(4) Procedures for intervention and referral.
(5) Arrangements for monitoring treatment, rehabilitation, posttreatment support, and performance.
(6) Reports of individual cases to the Board.
(7) Periodic reporting of statistical information.
(8) Assurance of confidentiality of nonpublic information."

SECTION 6.(b) This section becomes effective October 1, 2019, and applies to licenses granted or renewed on or after that date.

PART VII. TECHNICAL CHANGES TO THE CERTIFIED SUBSTANCE USE DISORDER PROFESSIONAL PRACTICE ACT

SECTION 7.(a) The title of Article 5C of Chapter 90 of the General Statutes reads as rewritten:

"Article 5C.

"North Carolina Substance ~~Abuse~~ Use Disorder Professional Practice Act."

SECTION 7.(b) G.S. 90-113.30 reads as rewritten:

"**§ 90-113.30. Declaration of purpose.**

The North Carolina ~~Substance Abuse~~ Addictions Specialist Professional Practice Board, established by G.S. 90-113.32, is recognized as the registering, certifying, and licensing authority for substance ~~abuse~~ use disorder professionals described in this Article in order to safeguard the public health, safety, and welfare, to protect the public from being harmed by unqualified persons, to assure the highest degree of professional care and conduct on the part of credentialed substance ~~abuse~~ use disorder professionals, to provide for the establishment of standards for the

education of credentialed substance ~~abuse~~ use disorder professionals, and to ensure the availability of credentialed substance ~~abuse~~ use disorder professional services of high quality to persons in need of these services. It is the purpose of this Article to provide for the regulation of Board-credentialed persons offering substance ~~abuse~~ use disorder counseling services, substance ~~abuse~~ use disorder prevention services, or any other substance ~~abuse~~ use disorder services for which the Board may grant registration, certification, or licensure."

SECTION 7.(c) G.S. 90-113.31A reads as rewritten:

"**§ 90-113.31A. Definitions.**

The following definitions shall apply in this Article:

(1) Applicant. – A person who has initiated a process to become a substance ~~abuse~~ use disorder professional pursuant to this Article.

(2) Applicant supervisor. – A person who provides supervision as required by the Board to persons applying for registration, certification, or licensure as a substance ~~abuse~~ use disorder professional pursuant to this Article.

(3) Board. – The North Carolina ~~Substance Abuse~~ Addictions Specialist Professional Practice Board.

...

(5) Certified criminal justice addictions professional. – A person certified by the Board to practice as a criminal justice addictions professional who, under supervision, provides direct services to clients or offenders exhibiting substance ~~abuse~~ use disorders and works in a program determined by the Board to be involved in a criminal justice setting.

(6) Certified ~~substance abuse~~ alcohol and drug counselor. – A person certified by the Board to practice under the supervision of a practice supervisor as a ~~substance abuse~~ alcohol and drug counselor in accordance with the provisions of this Article.

(7) Certified ~~substance abuse~~ prevention ~~consultant.~~ specialist. – A person certified by the Board to practice substance ~~abuse~~ use disorder prevention in accordance with the provisions of this Article.

...

(14) Criminal history. – A history of conviction of a State crime, whether a misdemeanor or felony, that bears on an applicant's fitness for licensure to practice substance ~~abuse~~ use disorder professional services. The crimes include the criminal offenses set forth in any of the following Articles of Chapter 14 of the General Statutes: Article 5, Counterfeiting and Issuing Monetary Substitutes; Article 5A, Endangering Executive and Legislative Officers; Article 6, Homicide; Article 7B, Rape and Other Sex Offenses; Article 8, Assaults; Article 10, Kidnapping and Abduction; Article 13, Malicious Injury or Damage by Use of Explosive or Incendiary Device or Material; Article 14, Burglary and Other Housebreakings; Article 15, Arson and Other Burnings; Article 16, Larceny; Article 17, Robbery; Article 18, Embezzlement; Article 19, False Pretenses and Cheats; Article 19A, Obtaining Property or Services by False or Fraudulent Use of Credit Device or Other Means; Article 19B, Financial Transaction Card Crime Act; Article 20, Frauds; Article 21, Forgery; Article 26, Offenses Against Public Morality and Decency; Article 26A, Adult Establishments; Article 27, Prostitution; Article 28, Perjury; Article 29, Bribery; Article 31, Misconduct in Public Office; Article 35, Offenses Against the Public Peace; Article 36A, Riots, Civil Disorders, and Emergencies; Article 39, Protection of Minors; Article 40, Protection of the Family; Article 59, Public Intoxication; and Article 60, Computer-Related Crime. The crimes also include possession or sale of drugs

in violation of the North Carolina Controlled Substances Act in Article 5 of Chapter 90 of the General Statutes and alcohol-related offenses including sale to underage persons in violation of G.S. 18B-302 or driving while impaired in violation of G.S. 20-138.1 through G.S. 20-138.5.

(16) Dual relationship. – A relationship in addition to the professional relationship with a person to whom the substance ~~abuse~~ use disorder professional delivers services in the Twelve Core Functions or the performance domains, both as defined in rules adopted by the Board, or as provided in a supervisory capacity. These relationships may result in grounds for disciplinary action.

...

(20) Practice supervisor. – A certified clinical supervisor, clinical supervisor intern, or licensed clinical addictions specialist who provides oversight and responsibility in a face-to-face capacity for each certified ~~substance abuse~~ alcohol and drug counselor or criminal justice addictions professional.

(21) Prevention. – The reduction, delay, or avoidance of alcohol and of other drug use behavior. ~~"Prevention"~~ "Prevention" includes the promotion of positive environments and individual strengths that contribute to personal health and well-being over an entire life and the development of strategies that encourage individuals, families, and communities to take part in assessing and changing their lifestyles and environments.

...

(24) Substance ~~abuse~~ use disorder counseling. – The assessment, evaluation, and provision of counseling and therapeutic service to persons suffering from substance ~~abuse~~ use disorder or dependency.

(25) ~~Substance abuse~~ Alcohol and drug counselor intern. – A registrant who successfully completes 300 hours of Board-approved supervised practical training in pursuit of credentialing as a ~~substance abuse~~ alcohol and drug counselor.

(26) Substance ~~abuse~~ use disorder professional. – A registrant, certified ~~substance abuse~~ alcohol and drug counselor, ~~substance abuse~~ alcohol and drug counselor intern, certified ~~substance abuse~~ prevention ~~consultant,~~ specialist, certified clinical supervisor, licensed clinical addictions specialist associate, licensed clinical addictions specialist, certified substance abuse residential facility director, clinical supervisor intern, or certified criminal justice addictions professional."

SECTION 7.(d) G.S. 90-113.31B reads as rewritten:

"**§ 90-113.31B. Scope of practice.**

The scope of practice is the use by all substance ~~abuse~~ use disorder professionals and their ongoing supervisees of principles, methods, and procedures of the Twelve Core Functions or performance domains as prescribed by the International Certification and Reciprocity Consortium/Alcohol and Other Drug Abuse, Incorporated, and as limited by individual credential and supervisory requirements pursuant to this Article. Specifically, the scope of practice for each individual defined as a substance ~~abuse~~ use disorder professional under G.S. 90-113.31A is as follows:

(1) The practice of a certified ~~substance abuse~~ alcohol and drug counselor consists of the Twelve Core Functions, including screening, intake, orientation, assessment, treatment planning, counseling, case management, crisis intervention, client education, report and record keeping, consultation with other professionals in regard to client treatment and services, and referral to treat addictive disorder or disease and help prevent relapse.

(2) The practice of a certified ~~substance abuse~~ prevention ~~consultant~~ specialist is based on knowledge in the performance domains to prevent or reduce the conditions that place individuals at increased risk of developing addictive disorder or disease and help prevent relapse.

(3) The practice of a certified clinical supervisor is based on knowledge in the performance domains to supervise substance ~~abuse~~ use disorder professionals who work to treat, prevent, or reduce the conditions that place individuals at risk of developing addictive disorder or disease and help prevent relapse.

...."

SECTION 7.(e) G.S. 90-113.33(9) reads as rewritten:

"(9) Adopt any rules necessary to carry out the purpose of this Article and its duties and responsibilities pursuant to this Article, including rules related to the approval of a substance ~~abuse~~ use disorder specialty curricula developed by a school, college, or university."

SECTION 7.(f) G.S. 90-113.34 reads as rewritten:

"**§ 90-113.34. Records to be kept; copies of records.**

(a) The Board shall keep a regular record of its proceedings, together with the names of the members of the Board present, the names of the applicants for registration, certification, and licensure as well as other information relevant to its actions. The Board shall cause a record to be kept that shall show the name, last known place of business, last known place of residence, and date and number of the credential assigned to each substance ~~abuse~~ use disorder professional meeting the standards set forth in this Article. Any interested person in the State is entitled to obtain a copy of Board records upon application to the Board and payment of a reasonable charge that is based on the costs involved in providing the copy.

(b) The Board may in a closed session receive evidence regarding the provision of substance ~~abuse~~ use disorder counseling or other treatment and services provided to a client who has not expressly or through implication consented to the public disclosure of such treatment as may be necessary for the protection of the rights of the client or of the accused registrant or substance ~~abuse~~ use disorder professional and the full presentation of relevant evidence. All records, papers, and other documents containing information collected and compiled by the Board, its members, or employees as a result of investigations, inquiries, or interviews conducted in connection with awarding a credential or a disciplinary matter shall not be considered public records within the meaning of Chapter 132 of the General Statutes, except any notice or statement of charges, or notice of hearing shall be a public record notwithstanding that it may contain information collected and compiled as a result of an investigation, inquiry, or interview. If any record, paper, or other document containing information collected and compiled by the Board as provided in this subsection is received and admitted in evidence in any hearing before the Board, it shall thereupon be a public record.

(c) Notwithstanding any provision to the contrary, the Board may, in any proceeding, record of any hearing, and notice of charges, withhold from public disclosure the identity of a client who has not expressly or through implication consented to such disclosure of treatment by the accused substance ~~abuse~~ use disorder professional."

SECTION 7.(g) G.S. 90-113.37A(b) reads as rewritten:

"(b) Renewal of licensure is subject to completion of at least 40 hours of the continuing education requirements established by the Board. Renewal of ~~substance abuse~~ alcohol and drug counselor or ~~substance abuse~~ prevention ~~consultant~~ specialist certification is subject to completion of at least 60 hours of the continuing education requirements established by the Board. A certified ~~substance abuse~~ alcohol and drug counselor shall submit a Board-approved supervision contract signed by the applicant and a practice supervisor documenting ongoing supervision at a ratio of one hour of supervision to every 40 hours of practice after certification is granted by the Board on a form provided by the Board. Any person certified by the Board as a

certified alcoholism counselor or certified ~~drug abuse~~ alcohol and drug counselor shall become a certified ~~substance abuse~~ alcohol and drug counselor.

A clinical supervisor shall complete at least 15 hours of substance ~~abuse~~ use disorder clinical supervision training prior to the certificate being renewed. ~~A substance abuse residential facility director shall complete at least 10 hours of substance abuse training for renewal.~~ A certified criminal justice addictions professional shall complete at least 40 hours of continuing education that must be earned in the certified criminal justice addictions professional performance domains. A certified criminal justice addictions professional shall submit a Board-approved supervision contract signed by the criminal justice addictions professional and a practice supervisor documenting ongoing supervision at a ratio of one hour of supervision to every 40 hours of practice after certification is granted by the Board on a form provided by the Board."

SECTION 7.(h) G.S. 90-113.38 reads as rewritten:

"**§ 90-113.38. Maximums for certain fees.**

(a) The fee to obtain a certificate of certification as ~~a substance abuse~~ an alcohol and drug counselor, ~~substance abuse~~ prevention ~~consultant,~~ specialist, clinical supervisor, substance abuse residential facility director, or certified criminal justice addictions professional may not exceed four hundred seventy-five dollars ($475.00). The fee to renew a certificate may not exceed one hundred fifty dollars ($150.00).

...

(f) In addition to any other prescribed fees, the Board shall charge a fee not to exceed one hundred fifty dollars ($150.00) for each administration of the test an applicant must pass to be credentialed as a United States Department of Transportation substance ~~abuse~~ use disorder professional."

SECTION 7.(i) G.S. 90-113.40 reads as rewritten:

"**§ 90-113.40. Requirements for certification and licensure.**

(a) The Board shall issue a certificate certifying an applicant as a "Certified ~~Substance Abuse~~ Alcohol and Drug Counselor" or as a "Certified ~~Substance Abuse~~ Prevention ~~Consultant"~~ Specialist" if:

...

(8) The applicant for substance ~~abuse~~ use disorder counselor has completed a total of 6,000 hours of supervised experience in the field, whether paid or volunteer. The applicant for ~~substance abuse~~ prevention ~~consultant~~ specialist has completed a total of 6,000 hours supervised experience in the field, whether paid or volunteer, or 4,000 hours if the applicant has at least a ~~bachelors~~ bachelor's degree in a human services field from a regionally accredited college or university.

...

(b) The Board shall issue a certificate certifying an individual as a "Certified Clinical Supervisor" if the applicant:

...

(3) Has 4,000 hours experience as a substance ~~abuse~~ use disorder clinical supervisor as documented by his or her certified clinical supervisor.

(4) Has 30 hours of substance ~~abuse~~ use disorder clinical supervision specific education or training. These hours shall be reflective of the Twelve Core Functions in the applicant's clinical application and practice and may also be counted toward the applicant's renewal as ~~a substance abuse~~ an alcohol and drug counselor or a clinical addictions specialist.

...

(c) The Board shall issue a license credentialing an applicant as a "Licensed Clinical Addictions Specialist" if, in addition to meeting the requirements of subdivisions (a)(1) through (5a) of this section, the applicant meets one of the following criteria:

(1) Criteria A. – The applicant:

...

b. Has two years postgraduate supervised substance ~~abuse~~ use disorder counseling experience.

c. Submits three letters of reference from licensed clinical addictions specialists or certified ~~substance abuse~~ alcohol and drug counselors who have obtained master's degrees.

...

e. Has attained 180 hours of substance ~~abuse~~ use disorder specific training from either a regionally accredited college or university, which may include unlimited independent study, or from training events of which no more than fifty percent (50%) shall be in independent study. All hours shall be credited according to the standards set forth in G.S. 90-113.41A.

...

(2) Criteria B. – The applicant:

...

e. Submits three letters of reference from either licensed clinical addictions specialists or certified ~~substance abuse~~ alcohol and drug counselors who have obtained master's degrees.

(3) Criteria C. – The applicant:

a. Has a minimum of a master's degree in a human services field with both a clinical application and a substance ~~abuse~~ use disorder specialty from a regionally accredited college or university that includes 180 hours of substance ~~abuse~~ use disorder specific education and training pursuant to G.S. 90-113.41A.

b. Has one year of postgraduate supervised substance ~~abuse~~ use disorder counseling experience.

...

d. Submits three letters of reference from licensed clinical addictions specialists or certified ~~substance abuse~~ alcohol and drug counselors who have obtained master's degrees.

(4) Criteria D. – The applicant has a substance ~~abuse~~ use disorder certification from a professional discipline that has been granted deemed status by the Board.

~~(d) The Board shall issue a certificate certifying an applicant as a "Substance Abuse Residential Facility Director" if the applicant:~~

~~(1) Has been credentialed as a substance abuse counselor or a clinical addictions specialist.~~

~~(2) Has 50 hours of Board approved academic or didactic management specific training or a combination thereof. Independent study may compose up to fifty percent (50%) of the total number of hours required for initial credentialing.~~

~~(3) Submits letters of reference from the applicant's current supervisor and a colleague or coworker.~~

(d1) The Board shall issue a certificate certifying an applicant as a "Certified Criminal Justice Addictions Professional", with the acronym "CCJP", if in addition to meeting the requirements of subdivisions (a)(1) through (5a) of this section, the applicant:

...

(3) Has provided documentation of supervised work experience providing direct service to clients or offenders involved in one of the three branches of the

criminal justice system, which include law enforcement, the judiciary, and corrections. The applicant must meet one of the following criteria:

...

e. Criteria E. – In addition to having at least a masters degree in a human services field with a specialty from a regionally accredited college or university that includes 180 hours of substance ~~abuse~~ use disorder specific education or training, the applicant has a minimum of 2,000 hours of postgraduate supervised substance ~~abuse~~ use disorder counseling experience.

...

(f) Effective January 1, 2003, only a person who is certified as a certified clinical supervisor or a clinical supervisor intern shall be qualified to supervise applicants for certified clinical supervisor and certified ~~substance abuse~~ alcohol and drug counselor and applicants for licensed clinical addictions specialist who meet the qualifications of their credential other than through deemed status as provided in G.S. 90-113.40(c)(4)."

SECTION 7.(j) G.S. 90-113.40B reads as rewritten:

"**§ 90-113.40B. Applicant supervision.**

The Board shall designate a person as an applicant supervisor of individuals applying for registration, certification, or licensure as a substance ~~abuse~~ use disorder professional as follows:

...

(2) A certified clinical supervisor or a clinical supervisor intern shall supervise ~~a substance abuse residential facility director applicant,~~ a clinical addictions specialist applicant, or ~~a substance abuse~~ an alcohol and drug counselor applicant.

...

(4) A certified ~~substance abuse~~ prevention ~~consultant~~ specialist with a minimum of three years of professional experience, a certified clinical supervisor, or a clinical supervisor intern shall supervise a registrant applying for certification as a prevention ~~consultant.~~specialist.

...."

SECTION 7.(k) G.S. 90-113.41A reads as rewritten:

"**§ 90-113.41A. Deemed status.**

(a) To be granted deemed status by the Board, a credentialing body of a professional discipline or its designee shall demonstrate that its substance ~~abuse~~ use disorder credentialing program substantially meets the following:

(1) Each person to whom the credentialing body awards credentials following the effective date of this act meets and maintains minimum requirements in substance ~~abuse~~ use disorder specific content areas. Each person also has a minimum of a master's degree with a clinical application in a human services field.

(2) The body requires 180 hours, or the equivalent thereof, of substance ~~abuse~~ use disorder specific education and training that covers the following content areas:

...

(3) The program requires one year or its equivalent of post-degree supervised clinical substance ~~abuse~~ use disorder practice. At least fifty percent (50%) of the practice shall consist of direct substance ~~abuse~~ use disorder clinical care.

...."

SECTION 7.(*l*) G.S. 90-113.42 reads as rewritten:

"**§ 90-113.42. Violations; exemptions.**

(a) It shall be unlawful for any person not licensed or otherwise credentialed as a substance ~~abuse~~ use disorder professional pursuant to this Article to engage in those activities set forth in the scope of practice of a substance ~~abuse~~ use disorder professional under G.S. 90-113.31B, unless that person is regulated by another profession or is a registrant or intern as defined by this Article.

(b) It is not the intent of this Article to regulate members of other regulated professions who provide substance ~~abuse~~ use disorder services or consultation in the normal course of the practice of their profession.

(c) This Article does not apply to any person registered, certified, or licensed by the State or federal government to practice any other occupation or profession while rendering substance ~~abuse~~ use disorder services or consultation in the performance of the occupation or profession for which the person is registered, certified, or licensed.

(d) Only individuals registered, certified, or licensed under this Article may use the title "Certified ~~Substance Abuse~~ Alcohol and Drug Counselor", "Certified ~~Substance Abuse~~ Prevention ~~Consultant",~~ Specialist", "Certified Clinical Supervisor", "Licensed Clinical Addictions Specialist Associate", "Certified Substance Abuse Residential Facility Director", "Certified Criminal Justice Addictions Professional", ~~"Substance Abuse~~ "Alcohol and Drug Counselor Intern", "Provisional Licensed Clinical Addictions Specialist", "Clinical Supervisor Intern", or "Registrant"."

SECTION 7.(m) G.S. 90-113.43(a) reads as rewritten:

"**§ 90-113.43. Illegal practice; misdemeanor penalty.**

(a) Except as otherwise authorized in this Article, no person shall:

(1) Offer substance ~~abuse~~ use disorder professional services, practice, attempt to practice, or supervise while holding himself or herself out to be a certified ~~substance abuse~~ alcohol and drug counselor, certified ~~substance abuse~~ prevention ~~consultant,~~ specialist, certified clinical supervisor, licensed clinical addictions specialist, licensed clinical addictions specialist associate, certified substance abuse residential facility director, certified criminal justice addictions professional, clinical supervisor intern, ~~substance abuse~~ alcohol and drug counselor intern, or registrant without first having obtained a notification of registration, certification, or licensure from the Board.

(2) Use in connection with any name any letters, words, numerical codes, or insignia indicating or implying that this person is a registrant, certified ~~substance abuse~~ alcohol and drug counselor, certified ~~substance abuse~~ prevention ~~consultant,~~ specialist, certified clinical supervisor, licensed clinical addictions specialist, certified substance abuse residential facility director, ~~substance abuse~~ alcohol and drug counselor intern, certified criminal justice addictions professional, or licensed clinical addictions specialist associate, unless this person is registered, certified, or licensed pursuant to this Article.

(3) Practice or attempt to practice as a certified ~~substance abuse~~ alcohol and drug counselor, certified ~~substance abuse~~ prevention ~~consultant,~~ specialist, certified clinical supervisor, licensed clinical addictions specialist, certified criminal justice addictions professional, ~~substance abuse~~ alcohol and drug counselor intern, licensed clinical addictions specialist associate, clinical supervisor intern, certified substance abuse residential facility director or registrant with a revoked, lapsed, or suspended certification or license.

(4) Aid, abet, or assist any person to practice as a certified ~~substance abuse~~ alcohol and drug counselor, certified ~~substance abuse~~ prevention ~~consultant,~~ specialist, certified criminal justice addictions professional, certified clinical supervisor, licensed clinical addictions specialist, certified substance abuse residential facility director, registrant, ~~substance abuse~~ alcohol and drug

counselor intern, licensed clinical addictions specialist associate, or clinical supervisor intern in violation of this Article.

(5) Knowingly serve in a position required by State law or rule or federal law or regulation to be filled by a registrant, certified ~~substance abuse~~ alcohol and drug counselor, certified ~~substance abuse~~ prevention ~~consultant,~~ specialist, certified criminal justice addictions professional, certified clinical supervisor, licensed clinical addictions specialist, certified substance abuse residential facility director, ~~substance abuse~~ alcohol and drug counselor intern, licensed clinical addictions specialist associate, or clinical supervisor intern unless that person is registered, certified, or licensed under this Article.

...."

SECTION 7.(n) G.S. 90-113.44 reads as rewritten:

"**§ 90-113.44. Grounds for disciplinary action.**

(a) Grounds for disciplinary action for an applicant or credentialed professional include:

(1) The employment of fraud, deceit, or misrepresentation in obtaining or attempting to obtain licensure, certification, or registration or renewal of licensure, certification, or registration.

(2) The use of drugs or alcoholic beverages to the extent that professional competency is affected.

(2a) The use of drugs or alcoholic beverages to the extent that a substance ~~abuse~~ use disorder professional suffers impairment.

(3) Conviction of an offense under any municipal, State, or federal law other than traffic laws as prescribed by Chapter 20 of the General Statutes.

(4) Conviction of a felony or other public offense involving moral turpitude. Conviction of a Class A-E felony shall result in an immediate suspension of licensure, certification, or registration for a minimum of one year.

(5) An adjudication of insanity or incompetency, until proof of recovery from this condition can be established by a licensed psychologist or psychiatrist.

(6) Engaging in any act or practice in violation of any of the provisions of this Article or any of the rules adopted pursuant to it, or aiding, abetting, or assisting any other person in such a violation.

(7) The commission of an act of malpractice, gross negligence, or incompetence while serving as a substance ~~abuse~~ use disorder professional, intern, or registrant.

(8) Repealed by Session Laws 2005-431, s. 1, effective September 22, 2005.

(9) Engaging in conduct that could result in harm or injury to the public.

(10) Entering into a dual relationship that impairs professional judgment or increases the risk of exploitation with a client or supervisee.

(11) Practicing as a credentialed substance ~~abuse~~ use disorder professional outside of his or her scope of practice pursuant to G.S. 90-113.31B.

(b) Denial of an applicant's licensure, certification, or registration or the granting of licensure, certification, or registration on a probationary or other conditional status shall be subject to substantially the same rules and procedures prescribed by the Board for review and disciplinary actions against any person holding a license, certificate, or registration. A suspension of a credential resulting from impairment due to substance use, mental health, or medical disorder shall be imposed for at least six months beginning from the date of successful discharge from a residential substance ~~abuse~~ use disorder treatment program or other appropriate treatment modality determined as a result of an assessment by a Board-approved assessor. Disciplinary actions involving a clinical addictions specialist whose licensure is achieved through deemed status shall be initially heard by the specialist's credentialing body. The specialist may appeal the

body's decision to the Board. The Board shall, however, have the discretionary authority to hear the initial disciplinary action involving a credentialed professional."

SECTION 7.(o) G.S. 90-113.46 reads as rewritten:

"**§ 90-113.46. Application of requirements of Article.**

All persons credentialed by the North Carolina ~~Substance Abuse~~ Addictions Specialist Professional Practice Board, Inc., as of July 1, 1994, shall be credentialed by the Board pursuant to this Article. All these persons are subject to all the other requirements of this Article and of the rules adopted pursuant to it."

SECTION 7.(p) This section becomes effective October 1, 2019, and applies to licenses granted or renewed on or after that date.

PART VIII. DISCONTINUE CERTIFIED SUBSTANCE ABUSE RESIDENTIAL FACILITY DIRECTOR CREDENTIALING

SECTION 8.(a) The certified substance abuse residential facility director credential is discontinued. The North Carolina Substance Abuse Professional Practice Board shall no longer issue or renew a certified substance abuse residential facility director credential to any person.

SECTION 8.(b) G.S. 90-113.31A(8) is repealed.

SECTION 8.(c) G.S. 90-113.31A(26), as amended by Section 5 of this act, reads as rewritten:

"(26) Substance use disorder professional. – A registrant, certified alcohol and drug counselor, alcohol and drug counselor intern, certified prevention specialist, certified clinical supervisor, licensed clinical addictions specialist associate, licensed clinical addictions specialist, ~~certified substance abuse residential facility director,~~ clinical supervisor intern, or certified criminal justice addictions professional."

SECTION 8.(d) G.S. 90-113.31B(5) is repealed.

SECTION 8.(e) G.S. 90-113.38(a), as amended by Section 5 of this act, reads as rewritten:

"**§ 90-113.38. Maximums for certain fees.**

(a) The fee to obtain a certificate of certification as an alcohol and drug counselor, prevention specialist, clinical supervisor, ~~substance abuse residential facility director,~~ or certified criminal justice addictions professional may not exceed four hundred seventy-five dollars ($475.00). The fee to renew a certificate may not exceed one hundred fifty dollars ($150.00)."

SECTION 8.(f) G.S. 90-113.42(d), as amended by Section 5 of this act, reads as rewritten:

"(d) Only individuals registered, certified, or licensed under this Article may use the title "Certified Alcohol and Drug Counselor", "Certified Prevention Specialist", "Certified Clinical Supervisor", "Licensed Clinical Addictions Specialist Associate", ~~"Certified Substance Abuse Residential Facility Director",~~ "Certified Criminal Justice Addictions Professional", "Alcohol and Drug Counselor Intern", "Provisional Licensed Clinical Addictions Specialist", "Clinical Supervisor Intern", or "Registrant"."

SECTION 8.(g) G.S. 90-113.43(a), as amended by Section 5 of this act, reads as rewritten:

"**§ 90-113.43. Illegal practice; misdemeanor penalty.**

(a) Except as otherwise authorized in this Article, no person shall:

(1) Offer substance use disorder professional services, practice, attempt to practice, or supervise while holding himself or herself out to be a certified alcohol and drug counselor, certified prevention specialist, certified clinical supervisor, licensed clinical addictions specialist, licensed clinical addictions specialist associate, ~~certified substance abuse residential facility director,~~ certified criminal justice addictions professional, clinical supervisor intern,

alcohol and drug counselor intern, or registrant without first having obtained a notification of registration, certification, or licensure from the Board.

(2) Use in connection with any name any letters, words, numerical codes, or insignia indicating or implying that this person is a registrant, certified alcohol and drug counselor, certified prevention specialist, certified clinical supervisor, licensed clinical addictions specialist, ~~certified substance abuse residential facility director, substance abuse~~ alcohol and drug counselor intern, certified criminal justice addictions professional, or licensed clinical addictions specialist associate, unless this person is registered, certified, or licensed pursuant to this Article.

(3) Practice or attempt to practice as a certified alcohol and drug counselor, certified prevention specialist, certified clinical supervisor, licensed clinical addictions specialist, certified criminal justice addictions professional, alcohol and drug counselor intern, licensed clinical addictions specialist associate, clinical supervisor intern, ~~certified substance abuse residential facility director~~ or registrant with a revoked, lapsed, or suspended certification or license.

(4) Aid, abet, or assist any person to practice as a certified alcohol and drug counselor, certified prevention specialist, certified criminal justice addictions professional, certified clinical supervisor, licensed clinical addictions specialist, ~~certified substance abuse residential facility director,~~ registrant, alcohol and drug counselor intern, licensed clinical addictions specialist associate, or clinical supervisor intern in violation of this Article.

(5) Knowingly serve in a position required by State law or rule or federal law or regulation to be filled by a registrant, certified alcohol and drug counselor, certified prevention specialist, certified criminal justice addictions professional, certified clinical supervisor, licensed clinical addictions specialist, ~~certified substance abuse residential facility director,~~ alcohol and drug counselor intern, licensed clinical addictions specialist associate, or clinical supervisor intern unless that person is registered, certified, or licensed under this Article.

...."

SECTION 8.(h) Subsection (a) of this section is effective July 1, 2019. The remaining subsections of this section become effective upon the expiration of the last certified substance abuse residential facility director credential issued prior to the effective date of this act by the North Carolina Substance Abuse Professional Practice Board. The North Carolina Substance Abuse Professional Practice Board shall notify the Revisor of Statutes when the last credential issued by the Board has expired.

PART IX. AMEND SOCIAL WORKER PRACTICE ACT

SECTION 9.(a) Chapter 90B of the General Statutes reads as rewritten:

"Chapter 90B.

"Social Worker Certification and Licensure Act.

...

"§ 90B-2. Purpose.

Since the profession of social work significantly affects the lives of the people of this State, it is the purpose of this Chapter to protect the public by setting standards for qualification, training, and experience for those who seek to represent themselves to the public as certified social workers or licensed clinical social workers and by promoting high standards of professional performance for those engaged in the practice of social work.

"§ 90B-3. Definitions.

The following definitions apply in this Chapter:

(1) Applicant. – An individual who has made application to the Board for the issuance, renewal, or reinstatement of any credential which the Board is authorized by law to issue.

~~(1)~~(1a) Board. – The North Carolina Social Work Certification and Licensure Board.

(2) Repealed by Session Laws 2013-410, s. 8, effective August 23, 2013.

(3) Certified ~~Master Social Worker.~~ master social worker. – A person who is certified under this Chapter to practice social work as a master social worker and is engaged in the practice of social work.

(4) Certified ~~Social Work Manager.~~ social work manager. – A person who is certified under this Chapter to practice social work as a social work manager and is engaged in the practice of social work.

(5) Certified ~~Social Worker.~~ social worker. – A person who is certified under this Chapter to practice social work as a social worker and is engaged in the practice of social work.

(6) Clinical ~~Social Work Practice.~~ social work practice. – The professional application of social work theory and methods to the biopsychosocial diagnosis, treatment, or prevention, of emotional and mental disorders. Practice includes, by whatever means of communications, the treatment of individuals, couples, families, and groups, including the use of psychotherapy and referrals to and collaboration with other health professionals when appropriate. Clinical social work practice shall not include the provision of supportive daily living services to persons with severe and persistent mental illness as defined in G.S. 122C-3(33a).

(6a) Licensed ~~Clinical Social Worker.~~ clinical social worker. – A person who is competent to function independently, who holds himself or herself out to the public as a social worker, and who offers or provides clinical social work services or supervises others engaging in clinical social work practice.

(6b) Licensed ~~Clinical Social Worker Associate.~~ clinical social worker associate. – A person issued an associate license to provide clinical social work services pursuant to G.S. 90B-7(f).

(7) Practice of ~~Social Work.~~ social work. – To perform or offer to perform services, by whatever means of communications, for other people that involve the application of social work values, principles, and techniques in areas such as social work services, consultation and administration, and social work planning and research.

(7a) Social work continuing education. – Training that, in accordance with the requirements established by the Board pursuant to G.S. 90B-6(g), (i) fosters the enhancement of generalized or specialized social work practice, values, skills, or knowledge, and (ii) includes an element addressing how the knowledge and skills may be applied to the practice of social work.

(8) Social ~~Worker.~~ worker. – A person certified, licensed, or associate licensed by this Chapter or otherwise exempt under ~~G.S. 90B-10.~~G.S. 90B-10, or a person who has earned a bachelors, masters, or doctoral degree in social work from a social work program accredited by or in candidacy for accreditation by the Council on Social Work Education.

(9) Supervision. – The professional relationship between a supervisee and the supervisor in which a supervisor provides guidance, oversight, direction, and evaluation of the services provided by the supervisee in the professional application of social work practice as defined by law. Supervision is designed to promote responsibility, competency, and accountability, and to teach the skills and techniques associated with social work practice.

"**§ 90B-4. Prohibitions.**

(a) Except as otherwise provided in this Chapter, it is unlawful for any person who is not certified as a social worker, master social worker, or social work manager under this Chapter to represent himself or herself to be certified under this Chapter or hold himself or herself out to the public by any title or description denoting that he or she is certified under this Chapter. A person who resides and practices social work in this State while credentialed in another state or jurisdiction shall clearly amend reference to his or her credential identifying the state or jurisdiction in which the credential is held.

(b) After January 1, 1992, except as otherwise provided in this Chapter, it is unlawful to engage in or offer to engage in the practice of clinical social work without first being licensed under this Chapter as a clinical social worker. A person who, pursuant to G.S. 90B-8(b), resides and practices clinical social work in this State for a period of not more than five days in any calendar year while credentialed in another state or jurisdiction, shall clearly amend reference to his or her credential identifying the state or jurisdiction in which the credential is held.

(c) Nothing herein shall prohibit school social workers who are certified by the State Board of Education from practicing school social work under the title "Certified School Social Worker." Except as provided for licensed clinical social workers, nothing herein shall be construed as prohibiting social workers who are not certified by the Board from practicing social work. Except as provided herein for licensed clinical social workers, no agency, institution, board, commission, bureau, department, division, council, member of the Council of State, or officer of the legislative, executive or judicial branches of State government or counties, cities, towns, villages, other municipal corporations, political subdivisions of the State, public authorities, private corporations created by act of the General Assembly or any firm or corporation receiving State funds shall require the obtaining or holding of any certificate issued under this Chapter or the taking of an examination held pursuant to this Chapter as a requirement for obtaining or continuing in employment.

(d) Nothing herein shall authorize the practice of medicine as defined in Article 1 of this Chapter or the practice of psychology as defined in Article 18A of this Chapter.

"**§ 90B-5. ~~North Carolina Social Work Certification and Licensure Board;~~ Board appointments; terms; composition.**

(a) For the purpose of carrying out the provisions of this Chapter, there is hereby created the North Carolina Social Work Certification and Licensure Board which shall consist of seven members appointed by the Governor as follows:

(1) At least ~~two members~~ one member of the Board shall be ~~Certified Social Workers or Certified Master Social Workers, three~~ a certified social worker, a certified master social worker, or a certified social work manager, four members shall be ~~Licensed Clinical Social Workers,~~ licensed clinical social workers, and two members shall be appointed from the public at large. Composition of the Board as to the race and sex of its members shall reflect the composition of the population of the State of North Carolina.

...

"**§ 90B-6. Functions and duties of the Board.**

...

(g) The Board shall have the power to establish or approve study or training courses and to establish reasonable standards for certification, licensure, and renewal of certification and licensure, including the power to adopt or use examination materials and accreditation standards of the Council on Social Work Education or other recognized accrediting agency and the power to establish reasonable standards for continuing social work ~~education; provided that~~ education, except that the Board shall not require an examination for ~~certificate and license~~ renewal ~~no examination shall be required; provided further, that~~ of a certificate or license, and the Board shall not have the power to withhold approval of social work study or training courses offered by

a college or university having a social work program approved by the Council on Social Work Education.

(h) Subject to the provisions of Chapter 150B of the General Statutes, the Board shall have the power to adopt rules to carry out the purposes of this Chapter, including but not limited to the power to adopt ~~ethical~~ supervision, ethical, and disciplinary standards.

(i) The Board may order that any records concerning the practice of social work and relevant to a complaint received by the Board or an inquiry or investigation conducted by or on behalf of the Board shall be produced by the custodian of the records to the Board or for inspection and copying by representatives of or counsel to the Board. A social worker licensed by the Board or an agency employing a social worker licensed by the Board shall maintain records for ~~a minimum of three~~ the longer of (i) 10 years from the date the social worker terminates services to the client and the client services record is ~~closed.~~ closed or (ii) the record retention period mandated by a third-party payee. A social worker certified or licensed by the Board shall cooperate fully and in a timely manner with the Board and its designated representatives in an inquiry or investigation of the records conducted by or on behalf of the Board.

...

"§ 90B-7. Titles and qualifications for certificates and licenses.

(a) Each person desiring to obtain a certificate or license from the Board shall make application to the Board upon such forms and in such manner as the Board shall prescribe, together with the required application fee established by the Board.

(b) The Board shall issue a certificate as "Certified Social Worker" to an applicant who meets the following qualifications:

(1) Has a bachelors degree in ~~a~~ social work ~~program~~ from a college or university ~~having a~~ social work program ~~accredited~~ approved, accredited, or admitted to candidacy for accreditation by the Council on Social Work Education for undergraduate curricula.

(2) Has passed the ~~Board examination for the certification of persons in this classification.~~ Board-approved qualifying examination.

(c) The Board shall issue a certificate as "Certified Master Social Worker" to an applicant who meets the following qualifications:

(1) Has a masters or doctoral degree in ~~a~~ social work ~~program~~ from a college or university ~~having a~~ social work program ~~approved~~ approved, accredited, or admitted to candidacy for accreditation by the Council on Social Work Education.

(2) Has passed the ~~Board examination for the certification of persons in this classification.~~ Board-approved qualifying examination.

(d) The Board shall issue a license as a "Licensed Clinical Social Worker" to an applicant who meets the following qualifications:

(1) ~~Holds or qualifies for a current certificate as a Certified Master Social Worker.~~ Has a masters or doctoral degree in social work from a college or university social work program approved, accredited, or admitted to candidacy for accreditation by the Council on Social Work Education.

(2) Shows to the satisfaction of the Board that he or she has had two years of clinical social work experience with appropriate supervision in the field of specialization in which the applicant will practice.

(3) Has passed the ~~Board examination for the certification of persons in this licensure.~~ Board-approved qualifying examination.

(e) The Board shall issue a certificate as a "Certified Social Work Manager" to an applicant who meets the following qualifications:

(1) ~~Holds or qualifies for a current certificate as a Certified Social Worker.~~Has a masters or doctoral degree in social work from a college or university social work program approved, accredited, or admitted for accreditation by the Council on Social Work Education.

(2) Shows to the satisfaction of the Board that he or she has had two years of experience in an administrative setting with appropriate supervision and training.

(3) Has passed the ~~Board examination for the certification of persons in this classification.~~Board-approved qualifying examination.

(f) The Board may issue an associate license in clinical social work to a person who has a masters or doctoral degree in ~~a~~ social work ~~program~~ from a college or university ~~having a~~ social work program ~~approved~~ approved, accredited, or in candidacy for accreditation by the Council on Social Work Education and who desires to be licensed as a licensed clinical social worker. The associate license may not be issued for a period exceeding two years and the person issued the associate license must practice under the supervision of a licensed clinical social worker or a Board-approved alternate. ~~Notwithstanding G.S. 90B-6(g), an associate licensee shall pass the qualifying clinical examination prescribed by the Board within two years to be eligible for renewal of the associate license.~~ The associate licensee shall complete all requirements for licensed clinical social worker licensure within three renewal cycles, or a total of six years, unless otherwise directed by the Board. Associate licensees who fail to satisfy all requirements for licensed clinical social worker licensure within six years from the date of associate license issuance may apply for a new associate license. However, the Board shall not issue a subsequent associate license to an applicant until the applicant has passed the qualifying examination required by the Board. Supervision and experience hours acquired under an associate license shall expire six years from the date of initial associate license issuance, and expired supervision and experience hours shall not apply toward future licensure.

"§ 90B-8. Persons from other jurisdictions.

(a) The Board may grant a reciprocal certificate or license without examination or by special examination to any person who, at the time of application, is certified, registered or licensed in good standing as a social worker by a similar board of another country, state, or territory whose certification, registration or licensing standards are substantially equivalent to those required by this Chapter. The applicant shall have passed an examination in the country, state, or territory in which he or she is certified, registered, or licensed that is equivalent to the examination required for the level of certification or licensure sought in this State.

(b) The Board may issue a temporary license to a nonresident clinical social worker who is either certified, registered, or licensed in another jurisdiction whose standards, in the opinion of the Board, at the time of the person's certification, registration, or licensure were substantially equivalent to or higher than the requirements of this Chapter. Nothing in this Chapter shall be construed as prohibiting a nonresident clinical social worker certified, registered, or licensed in another state from rendering professional clinical social work services in this State for a period of not more than five days in any calendar year. All persons granted a temporary clinical social worker license shall comply with the supervision requirements established by the ~~Board.~~Board and shall fulfill all requirements for licensure prior to the expiration of the temporary license.

(c) The Board shall issue a temporary license to a military or military spouse applicant who meets the requirements of G.S. 93B-15.1. Prior to the expiration of the temporary license, the applicant shall fulfill all requirements for licensure, in accordance with G.S. 93B-15.1 or the requirements of this Chapter.

"§ 90B-9. Renewal of certificates and licenses.

(a) All certificates and ~~licenses~~ licenses, excluding temporary licenses, shall be effective upon date of issuance by the Board, and shall be renewed on or before the ~~second June 30 thereafter.~~expiration date of the certificate or license.

(b) All certificates and licenses issued hereunder shall be renewed at the times and in the manner provided by this section. At least 45 days prior to expiration of each certificate or license, the Board shall mail a notice ~~and application for~~ of renewal to the certificate holder or licensee. Prior to the expiration date, the applicant shall submit to the Board the properly completed application ~~shall be properly completed, together with a~~ for renewal, the renewal fee ~~established by the Board~~ pursuant to ~~G.S. 90B-6.2(a)(4)~~ G.S. 90B-6.2(a)(4), and evidence of completion of the continuing education requirements established by the Board pursuant to G.S. 90B-6(g), upon receipt of which the Board shall renew the certificate or license. If the application for renewal of a certificate or license is not ~~renewed~~ received by the Board office on or before the close of business on the day prior to the expiration ~~date, date~~ of the license, an additional fee shall be charged for late renewal as provided in G.S. 90B-6.2(a)(5).

(c) A certificate or license issued under this Chapter shall be automatically suspended for failure to renew for a period of more than 60 days after the renewal date. The Board may reinstate a certificate or license suspended under this subsection upon verification of compliance with current requirements and payment of a reinstatement fee as provided in G.S. 90B-6.2(a)(6) and may require that the applicant file a new application, furnish new supervisory reports or references or otherwise update his or her credentials, or submit to examination for reinstatement. The Board shall have exclusive jurisdiction to investigate alleged violations of this Chapter by any person whose certificate or license has been suspended under this subsection and, upon proof of any violation of this Chapter, the Board may take disciplinary action as provided in G.S. 90B-11.

"**§ 90B-9.1. Nonpracticing status.**

~~(d)~~(a) Any person certified or licensed and desiring to retire temporarily from the practice of social work shall send written notice thereof to the Board. Upon receipt of such notice, his or her ~~name shall be placed upon the nonpracticing list and he or she~~ certificate or license shall be placed on nonpracticing status. During a period of nonpracticing status, the certificate or license holder shall not be subject to payment of renewal ~~fees while temporarily retired.~~ fees and shall not be subject to continuing education requirements corresponding to his or her credential. Social workers whose certificate or license has been placed on nonpracticing status shall not refer to themselves as certified or licensed by the Board and shall not engage in social work practice that requires an active certificate or license under this Chapter.

(b) In order to ~~reinstate certification or licensure, the~~ reactivate a certificate or license that has been placed on nonpracticing status, a person shall apply to the Board by making a written request for ~~reinstatement and paying~~ reactivation. Upon payment of the ~~appropriate~~ renewal fee as provided in ~~G.S. 90B-6.2.~~G.S. 90-6.2, and upon receipt of documentation to the satisfaction of the Board that continuing education requirements for the certification or licensure are complete, the Board shall reactivate the certificate or license of an applicant who is otherwise qualified under this Chapter.

"**§ 90B-10. Exemption from certain requirements.**

(a) Applicants who were engaged in the practice of social work before January 1, 1984, shall be exempt from the academic qualifications required by this act for ~~Certified Social Workers~~ certified social workers and ~~Certified Social Work Managers~~ certified social work managers and shall be certified upon passing the Board examination and meeting the experience requirements, if any, for certification of persons in that classification.

(b) The following may engage in clinical social work practice without meeting the requirements of G.S. 90B-7(d):

(1) Repealed by Session Laws 2007-379, s. 4, effective August 19, 2007.

(2) A student completing a clinical requirement for graduation while pursuing a course of study in social work in an institution accredited by or in candidacy status with the Council on Social Work Education.

(3) Repealed by Session Laws 2007-379, s. 4, effective August 19, 2007.

(c) Notwithstanding ~~the requirements of~~ G.S. 90B-4 and G.S. 90B-16, any individual who is employed by an agency of a local or State governmental entity, and who is in a position holding the title of "Social Worker" or any variation of the name, and whose position title is derived from the Office of State Human Resources ~~Social Work Series~~ Classification Specifications may use the title "Social Worker" or any variation of the title. This includes persons in such positions in counties whose classification and compensation systems have been certified as substantially equivalent by the State Human Resources Commission and persons serving in such positions in Human Services agencies created by counties pursuant to G.S. 153A-77.

"§ 90B-11. Disciplinary procedures.

(a) The Board may, in accordance with the provisions of Chapter 150B of the General Statutes, deny, suspend, or revoke an application, certificate, or license on any of the following grounds:

(1) Conviction of ~~a misdemeanor~~ or the entering of a plea of guilty or nolo contendere to ~~a~~ any misdemeanor ~~under this Chapter.~~involving moral turpitude, misrepresentation or fraud in dealing with the public, conduct otherwise relevant to fitness to practice social work, or any misdemeanor reflecting inability to practice social work with due regard to the health and safety of clients or patients.

(2) Conviction of a felony or the entering of a plea of guilty or nolo contendere to a felony under the laws of the United States or of any state of the United States.

(3) Gross unprofessional conduct, dishonest practice or incompetence in the practice of social work.

(4) Procuring or attempting to procure a certificate or license by fraud, deceit, or misrepresentation.

(5) Any fraudulent or dishonest conduct in social work.

(6) Inability of the person to perform the functions for which he or she is certified or licensed, or substantial impairment of abilities by reason of physical or mental disability.

(7) Violations of any of the provisions of this Chapter or of rules of the Board.

...

(d) In considering whether an applicant, certificate holder, or licensee is mentally or physically capable of practicing social work with reasonable skill and safety, the Board may require an applicant, certificate holder, or licensee to submit to any of the following, at his or her own expense: (i) a criminal history record check, including fingerprints, (ii) a mental examination and substance abuse assessment by a licensed clinical social worker or other licensed mental health professional designated by the ~~Board~~ Board, and ~~to~~ (iii) a physical examination by a physician or other licensed health professional designated by the Board. The examination may be ordered by the Board before or after charges are presented against the applicant, certificate holder, or licensee and the results of the examination shall be reported directly to the Board and shall be admissible in evidence in a hearing before the Board.

...

(h) The Board may assess costs of disciplinary action against an applicant, certificate holder, or licensee found to be in violation of the provisions of this Chapter or of any rules adopted by the Board pursuant to this Chapter."

SECTION 9.(b) This section becomes effective January 1, 2021. Qualifications for the certificate of Certified Social Work Manager, as amended by this act, apply only to applications for certification received by the Board on or after January 1, 2021.

PART X. EFFECTIVE DATE

SECTION 10. Except as otherwise provided, this act is effective when it becomes law.

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Health Care

Senate Committee

May 28, 2020

10:00 AM

Room 1027/1128

Senate Sergeant at Arms

Terry Edmundson

Jim Hamilton

Sheree Hedrick

Frances Patterson

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

May 28, 2020

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Liz Fischer	Fischer Clinic
Ross Bu[illegible]	NP
David Powers	PS, LLC

09-21-201

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

May 28, 2020

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jon Carr	Jordan Price Law Firm
Susan Vick	Fetzer + Vick
Ken Melton	KMA

09-21-201

Senate Committee on Health Care
Tuesday, June 2, 2020 at 10:00 AM
Room 1027/1128 of the Legislative Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 2, 2020 in Room 1027/1128 of the Legislative Building. Thirteen members were present.

Senator Joyce Krawiec, Chair, presided.

After Sen. Krawiec welcomed the guests and introduced the Sargent of Arms, she announced that HB 678 was pulled from the schedule and will be heard at another time.

HB 612 DSS Review of Procedures/Rule Making. (Representatives Stevens, Riddell, White)
Sen. Krawiec announced that this bill was for discussion only. Sen. Burgin moved to accept the proposed committee substitute (PCS) before the committee and it carried. Sen. Wells was introduced to explain the PCS. Questions from the members were responded to by Sen. Wells and Sen. Krawiec. Matt Gross from the Department of Health and Human Services was asked to comment on the bill.

HB 678 Amend Counselor/SA/Soc. Worker Prof. Acts. (Representatives Potts, Dobson, Lambeth)
Pulled.

The meeting adjourned at 10:25 AM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

Senate Committee on Health Care
Tuesday, June 2, 2020, 10:00 AM
1027/1128 Legislative Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 612	DSS Review of Procedures/Rule Making. FOR DISCUSSION ONLY	Representative Stevens Representative Riddell Representative White
HB 678	Amend Counselor/SA/Soc. Worker Prof. Acts.	Representative Potts Representative Dobson Representative Lambeth

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

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HOUSE BILL 612
PROPOSED SENATE COMMITTEE SUBSTITUTE H612-CSBH-32 [v.13]
06/01/2020 04:47:02 PM

Short Title: DSS Review of Procedures/Criminal History/OAH. (Public)

Sponsors:

Referred to:

April 8, 2019

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE SOCIAL SERVICES COMMISSION OF THE DIVISION OF SOCIAL SERVICES TO REVIEW POLICIES, GUIDELINES, AND OTHER INTERPRETIVE STATEMENTS AND SUBMIT A REPORT TO THE OFFICE OF ADMINISTRATIVE HEARINGS; CLARIFY THE AUTHORITY OF BOARDS TO REQUIRE CRIMINAL HISTORY RECORDS; AND PROHIBIT AGENCIES FROM IMPLEMENTING OR ENFORCING POLICIES, GUIDELINES, OR OTHER INTERPRETIVE STATEMENTS THAT SHOULD BE ADOPTED AS RULES UNDER THE ADMINISTRATIVE PROCEDURE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. No later than May 31, 2021, the North Carolina Division of Social Services (Division), by and through the Division's Social Services Commission (Commission), shall prepare and submit for review to the Office of Administrative Hearings (OAH), a comprehensive report of all its policies, guidelines, and other interpretive statements. This includes all policies, guidelines, and other interpretive statements that the Division or any of its subdivisions has sought to implement or enforce that may directly or substantially affect the procedural or substantive rights or duties of persons not employed by the Division or any of its subdivisions. The report shall include an explanation for any policies, guidelines, and other interpretive statements not adopted as a rule the Commission believes are not in violation of G.S. 150B-18. The report shall not include any emergency, temporary, or permanent rules, adopted by the Division in accordance with Article 2A of Chapter 150B of the General Statutes.

SECTION 2. Upon submission of its report to the OAH, the Commission shall jointly review the report with the OAH to identify any policies, guidelines, and other interpretive statements that are in violation of G.S. 150B-18. If there is disagreement between the Commission and the OAH regarding any policies, guidelines, or other interpretive statements identified in the report as being in violation of G.S. 150B-18, then the OAH shall refer the policy, guideline, or other interpretive statement in disagreement, to the Rules Review Commission (RRC). Upon referral from the OAH, the RRC shall review the policy, guideline, or other interpretive statement in disagreement, and make a determination as to whether it is in violation of G.S. 150B-18. If the Commission disagrees with a determination by the RRC as to whether any policy, guideline, or other interpretive statement is in violation of G.S. 150B-18, the Commission may file an action for declaratory judgment in Wake County Superior Court pursuant to Article 26 of Chapter 1 of the General Statutes.

SECTION 3. To ensure that administration of the Division shall continue without interruption, any policies, guidelines, or other interpretive statements identified through joint review by the Commission and the OAH, or determined by the RRC in Section 2 as being in

violation of G.S. 150B-18, shall be deemed interim rules so long as they do not conflict with any provisions of the General Statutes. Any interim rule authorized by this section shall become void July 1, 2022, if the Commission has failed to adopt that interim rule as a permanent rule by that date in accordance with Article 2A of Chapter 150B of the General Statutes. A reviewing court may extend the interim rule period pending the outcome of its review, if the Commission has filed an action for declaratory judgment under Section 2.

SECTION 4. G.S. 93B-8.1(a)(1) reads as rewritten:

"(1) Applicant. – A person who makes application for licensure from an occupational licensing ~~board.~~board or a State agency licensing board."

SECTION 5. G.S. 93B-8.1 is amended by adding a new subsection to read:

"(c1) Nothing in this section or in G.S. 93B-1 shall be construed as authorizing an occupational licensing board or a State agency licensing board to require an applicant to consent to a criminal history record check or use of fingerprints or other identifying information required by the State or National Repositories of Criminal Histories as a condition of granting or renewing a license."

SECTION 6. G.S. 150B-23(a) reads as rewritten:

"(a) A contested case shall be commenced by paying a fee in an amount established in G.S. 150B-23.2 and by filing a petition with the Office of Administrative Hearings and, except as provided in Article 3A of this Chapter, shall be conducted by that Office. The party who files the petition shall serve a copy of the petition on all other parties and, if the dispute concerns a license, the person who holds the license. A party who files a petition shall file a certificate of service together with the petition. A petition shall be signed by a party, an attorney representing a party, or other representative of the party as may specifically be authorized by law, and, if filed by a party other than an agency, shall state facts tending to establish that the agency named as the respondent has deprived the petitioner of property, has ordered the petitioner to pay a fine or civil penalty, has sought to implement or enforce against the petitioner a policy, guideline, or other interpretive statement in violation of G.S. 150B-18, or has otherwise substantially prejudiced the petitioner's rights and that the agency:

(1) Exceeded its authority or jurisdiction;
(2) Acted erroneously;
(3) Failed to use proper procedure;
(4) Acted arbitrarily or capriciously; or
(5) Failed to act as required by law or rule.

The parties in a contested case shall be given an opportunity for a hearing without undue delay. Any person aggrieved may commence a contested case hereunder.

A local government employee, applicant for employment, or former employee to whom Chapter 126 of the General Statutes applies may commence a contested case under this Article in the same manner as any other petitioner. The case shall be conducted in the same manner as other contested cases under this Article.

A business entity may represent itself using a nonattorney representative who is one or more of the following of the business entity: (i) officer, (ii) manager or member-manager, if the business entity is a limited liability company, (iii) employee whose income is reported on IRS Form W-2, if the business entity authorizes the representation in writing, or (iv) owner of the business entity, if the business entity authorizes the representation in writing and if the owner's interest in the business entity is at least twenty-five percent (25%). Authority for and prior notice of nonattorney representation shall be made in writing, under penalty of perjury, to the Office on a form provided by the Office."

SECTION 7. G.S. 150B-33(b) reads as rewritten:

"(b) An administrative law judge may:

(1) Administer oaths and affirmations;

(2) Sign, issue, and rule on subpoenas in accordance with G.S. 150B-27 and G.S. 1A-1, Rule 45;

(3) Provide for the taking of testimony by deposition and rule on all objections to discovery in accordance with G.S. 1A-1, the Rules of Civil Procedure;

(3a) Rule on all prehearing motions that are authorized by G.S. 1A-1, the Rules of Civil Procedure;

(4) Regulate the course of the hearings, including discovery, set the time and place for continued hearings, and fix the time for filing of briefs and other documents;

(5) Direct the parties to appear and confer to consider simplification of the issues by consent of the parties;

(6) Stay the contested action by the agency pending the outcome of the case, upon such terms as ~~he~~ the administrative law judge deems proper, and subject to the provisions of G.S. 1A-1, Rule 65;

(7) Determine whether the hearing shall be recorded by a stenographer or by an electronic device; and

(8) Enter an order returnable in the General Court of Justice, Superior Court Division, to show cause why the person should not be held in contempt. The Court shall have the power to impose punishment as for contempt for any act which would constitute direct or indirect contempt if the act occurred in an action pending in Superior Court.

(9) Determine that a rule as applied in a particular case is void because (1) it is not within the statutory authority of the agency, (2) is not clear and unambiguous to persons it is intended to direct, guide, or assist, or (3) is not reasonably necessary to enable the agency to fulfill a duty delegated to it by the General Assembly.

(9a) Determine that a policy, guideline, or other interpretive statement that a State agency has sought to implement or enforce is unenforceable because it is in violation of G.S. 150B-18. The administrative law judge may order the refund of any payments or receipts of any kind collected pursuant to a policy, guideline, or other interpretive statement determined to be unenforceable pursuant to this subdivision. The administrative law judge may stay the determination of unenforceability in order to allow the agency to adopt the policy, guideline, or other interpretive statement as a rule.

(10) Impose the sanctions provided for in G.S. 1A-1 or Chapter 3 of Title 26 of the North Carolina Administrative Code for noncompliance with applicable procedural rules.

(11) Order the assessment of reasonable attorneys' fees and witnesses' fees against the State agency involved in contested cases decided under this Article where the administrative law judge finds that the State agency named as respondent has substantially prejudiced the petitioner's rights and has acted arbitrarily or capriciously or under Chapter 126 where the administrative law judge finds discrimination, harassment, or orders reinstatement or back ~~pay.~~pay, or where the administrative law judge finds that the State agency has sought to implement or enforce a policy, guideline, or other interpretive statement that is in violation of G.S. 150B-18.

(12) Repealed by Session Laws 2011-398, s. 17. For effective date and applicability, see editor's note."

SECTION 8. This act is effective when it becomes law.

HOUSE BILL 612: DSS Review of Procedures/Criminal History/OAH.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 1, 2020
Introduced by:	Reps. Stevens, Riddell, White	**Prepared by:**	Jason Moran-Bates Committee Staff
Analysis of:	PCS to First Edition H612-CSBH-32		

OVERVIEW: The Proposed Committee Substitute to House Bill 612 would require the Department of Health and Human Services, Division of Social Services to identify any publications, policies, and procedures that might be considered rules under Chapter 150B of the General Statutes. Any publications, policies, and procedures identified as rules would have to be adopted through the rule-making process, or they would become void on July 1, 2022. Licensing Boards and state licensing agencies would not be permitted to require certain criminal background information as a precondition of granting a license. Finally, the PCS would allow administrative law judges to rule on contested case petitions filed by individuals seeking stays of enforcement against administrative policies that should have been adopted through the rule-making process.

BILL ANALYSIS:

Sections 1-3 of the PCS would require the Division of Social Services (DSS) to prepare a report of all its publications, policies, and procedures and to submit that report to the Office of Administrative Hearings (OAH). The report must identify any publication, policy, or procedure that meets the definition of a rule under G.S. 150B-2(8a) and provide an explanation for why any publication, policy, or procedure not identified is not a rule under G.S. 150B-2(8a). DSS would also be required to coordinate with OAH to identify publications, policies, and procedures which are subject to the rule-making provisions of Chapter 150B. Any publications, policies, and procedures so identified would be deemed interim rules, but would become null and void if not adopted as permanent rules by July 1, 2022.

Sections 4 and 5 of the PCS would clarify that occupational licensing boards and state licensing agencies cannot require applicants to submit criminal history records as a condition of receiving a license.

Sections 6 and 7 of the PCS would allow individuals to file a contested case petition with OAH when they have been injured by a policy or guideline of an administrative agency that should have been adopted through the rule-making process. Administrative law judges would have the authority to determine a policy or guideline should have been adopted through the rule-making process and to stay the enforcement of that policy or guideline.

EFFECTIVE DATE: This act would be effective when it becomes law.

Karen Cochrane-Brown
Director

Legislative Analysis Division
919-733-2578

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

HOUSE BILL 612

Short Title:	DSS Review of Procedures/Rule Making.	(Public)
Sponsors:	Representatives Stevens, Riddell, and White (Primary Sponsors). *For a complete list of sponsors, refer to the North Carolina General Assembly web site.*	
Referred to:	Health, if favorable, Rules, Calendar, and Operations of the House	

April 8, 2019

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE SOCIAL SERVICES COMMISSION OF THE DIVISION OF SOCIAL SERVICES TO REVIEW EXISTING PUBLICATIONS, POLICIES, AND PROCEDURES; SUBMIT A REPORT WITH ITS FINDINGS TO THE OFFICE OF ADMINISTRATIVE HEARINGS; AND SUBMIT FOR ADOPTION UNDER THE RULE-MAKING PROCESS THOSE PUBLICATIONS, POLICIES, AND PROCEDURES IDENTIFIED AS SATISFYING THE DEFINITION OF A RULE UNDER G.S. 150B-2(8A).

The General Assembly of North Carolina enacts:

SECTION 1. No later than May 31, 2020, The North Carolina Division of Social Services (Division), by and through the Division's Social Services Commission (Commission), shall prepare and submit for review to the Office of Administrative Hearings (OAH) a comprehensive report of its existing publications, policies, and procedures. This includes all publications, policies, and procedures used by the Division, or any of its subdivisions, which may directly or substantially affect the procedural or substantive rights or duties of persons not employed by the Division. The review shall identify any publications, policies, and procedures used by the Division that satisfy the definition of a rule under G.S. 150B-2(8A) and shall provide an explanation by the Commission for any publications, policies, and procedures it believes do not satisfy the definition of a rule and are not subject to the rule-making provisions of Chapter 150B of the General Statutes. This review does not include any existing emergency, temporary, or permanent rules, by the Division or its subdivisions, published in the North Carolina Administrative Code.

SECTION 2. Upon submission of its report to the OAH, the Commission shall jointly review the findings of its report with the OAH to identify any publications, policies, and procedures which are rules and subject to the rule-making provisions of Chapter 150B of the General Statutes. If there is disagreement between the Commission and the OAH during the joint review of any publication, policy, or procedure identified in the report as not satisfying the definition of a rule, then the OAH shall refer the publication, policy, or procedure in disagreement to the Rules Review Commission (RRC) for a determination. Upon referral from the OAH, the RRC shall review the publication, policy, or procedure in disagreement and make a determination as to whether or not it satisfies the definition of a rule under G.S. 150B-2(8A).

SECTION 3. To ensure that administration of the Division shall continue without interruption, any existing publications, policies, and procedures identified through joint review by the Commission and the OAH or determined by the RRC in Section 2 as satisfying the definition of a rule under G.S. 150B-2(8A) shall be deemed interim rules so long as they do not

conflict with any provisions of the General Statutes. Any interim rule authorized by this section shall become null and void January 1, 2021, if the Commission has failed to publish a notice of text in the North Carolina Register to adopt the interim rule as a permanent rule, as required by G.S. 150B-21.2. Any interim rule authorized by this section shall become null and void July 1, 2021, if the Commission has failed to adopt that interim rule as a permanent rule by that date in accordance with Article 2A of Chapter 150B of the General Statutes.

SECTION 4. This act is effective when it becomes law.

Visitor Registration Sheet

SENATE HEALTH CARE

2019-2020

June 2, 2020

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ken Melton	K.M.A.
Wendy Kelly	
Jon Cox	
Matt Gray	
Nathan Hunsucker	

Senate Committee on Health Care

~~Judiciary - Senate Committee~~

6-2 2020

~~December 4, 2018~~

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Matt Grouse	DHHS

Senate Committee on Health Care
Wednesday, June 3, 2020 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 3, 2020 in Room 643 of the Legislative Office Building. Fifteen members were present.

Sen. Joyce Krawiec presided.

Sen. Krawiec welcomed everyone and introduced the Sargent of Arms.

HB 612 DSS Review of Procedures/Criminal History/OAH. (Representatives Stevens, Riddell, White)

Sen. Krawiec announced that the PCS was still before the committee and then introduced Rep. Stevens to further explain the first portion of the bill. Matt Gross/DHHS was asked to offer additional comments. Sen. Burgin brought forth Amendment #1. Questions regarding this amendment was answered by Sen. Burgin and Jason Moran-Bates/an attorney from Legislative Analysis Division. A motion was made to adopt the amendment and it carried. Sen. Hise brought forth Amendment #2. Questions from the members were answered by Sen. Hise, Rep. Stevens, and Jason Moran-Bates. A motion was made to adopt the amendment and it carried. Sen. Krawiec then stated that the PCS is now before the committee as amended. Sen. Wells was introduced. He spoke on the PCS sharing his strong support and need for this legislation. Molly Masich/Codifier of Rules/Office of Administrative Hearings was introduced to the committee in the event anyone had questions for her. Questions that were raised by the members were responded to by, Sen. Wells, Rep. Stevens, Sen. Hise, and Jason Moran-Bates. Sen. Krawiec informed the committee that HB612 had a serial referral to the Senate Judiciary Committee. Sen. Hise motioned unfavorable to the bill – favorable to the PCS as amended – rolled into a new PCS and it carried.

The meeting adjourned at 11:08 AM.

Sen. Joyce Krawiec, Presiding Chair

Debbie Lown, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Krawiec, Chair

Wednesday, June 03, 2020

Senator Krawiec,
submits the following with recommendations as to passage:

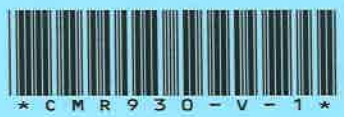
UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

HB **612** DSS Review of Procedures/Rule Making.

Draft Number:	H612-PCS40649-BC-92
Sequential Referral:	Judiciary
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Andy Wells will handle HB 612



Senate Committee on Health Care
Wednesday, June 3, 2020, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

BILL NO.	SHORT TITLE	SPONSOR
HB 612	DSS Review of Procedures/Rule Making.	Representative Stevens Representative Riddell Representative White

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

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"(c1) Nothing in this section or in G.S. 93B-1 shall be construed as authorizing an occupational licensing board or a State agency licensing board to require an applicant to consent to a criminal history record check or use of fingerprints or other identifying information required by the State or National Repositories of Criminal Histories as a condition of granting or renewing a license."

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(7) Determine whether the hearing shall be recorded by a stenographer or by an electronic device; and

(8) Enter an order returnable in the General Court of Justice, Superior Court Division, to show cause why the person should not be held in contempt. The Court shall have the power to impose punishment as for contempt for any act which would constitute direct or indirect contempt if the act occurred in an action pending in Superior Court.

(9) Determine that a rule as applied in a particular case is void because (1) it is not within the statutory authority of the agency, (2) is not clear and unambiguous to persons it is intended to direct, guide, or assist, or (3) is not reasonably necessary to enable the agency to fulfill a duty delegated to it by the General Assembly.

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HOUSE BILL 612: DSS Review of Procedures/Criminal History/OAH.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 1, 2020
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Analysis of:	PCS to First Edition H612-CSBH-32		

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EFFECTIVE DATE: This act would be effective when it becomes law.

Karen Cochrane-Brown
Director

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April 8, 2019

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE SOCIAL SERVICES COMMISSION OF THE DIVISION OF SOCIAL SERVICES TO REVIEW EXISTING PUBLICATIONS, POLICIES, AND PROCEDURES; SUBMIT A REPORT WITH ITS FINDINGS TO THE OFFICE OF ADMINISTRATIVE HEARINGS; AND SUBMIT FOR ADOPTION UNDER THE RULE-MAKING PROCESS THOSE PUBLICATIONS, POLICIES, AND PROCEDURES IDENTIFIED AS SATISFYING THE DEFINITION OF A RULE UNDER G.S. 150B-2(8A).

The General Assembly of North Carolina enacts:

SECTION 1. No later than May 31, 2020, The North Carolina Division of Social Services (Division), by and through the Division's Social Services Commission (Commission), shall prepare and submit for review to the Office of Administrative Hearings (OAH) a comprehensive report of its existing publications, policies, and procedures. This includes all publications, policies, and procedures used by the Division, or any of its subdivisions, which may directly or substantially affect the procedural or substantive rights or duties of persons not employed by the Division. The review shall identify any publications, policies, and procedures used by the Division that satisfy the definition of a rule under G.S. 150B-2(8A) and shall provide an explanation by the Commission for any publications, policies, and procedures it believes do not satisfy the definition of a rule and are not subject to the rule-making provisions of Chapter 150B of the General Statutes. This review does not include any existing emergency, temporary, or permanent rules, by the Division or its subdivisions, published in the North Carolina Administrative Code.

SECTION 2. Upon submission of its report to the OAH, the Commission shall jointly review the findings of its report with the OAH to identify any publications, policies, and procedures which are rules and subject to the rule-making provisions of Chapter 150B of the General Statutes. If there is disagreement between the Commission and the OAH during the joint review of any publication, policy, or procedure identified in the report as not satisfying the definition of a rule, then the OAH shall refer the publication, policy, or procedure in disagreement to the Rules Review Commission (RRC) for a determination. Upon referral from the OAH, the RRC shall review the publication, policy, or procedure in disagreement and make a determination as to whether or not it satisfies the definition of a rule under G.S. 150B-2(8A).

SECTION 3. To ensure that administration of the Division shall continue without interruption, any existing publications, policies, and procedures identified through joint review by the Commission and the OAH or determined by the RRC in Section 2 as satisfying the definition of a rule under G.S. 150B-2(8A) shall be deemed interim rules so long as they do not

conflict with any provisions of the General Statutes. Any interim rule authorized by this section shall become null and void January 1, 2021, if the Commission has failed to publish a notice of text in the North Carolina Register to adopt the interim rule as a permanent rule, as required by G.S. 150B-21.2. Any interim rule authorized by this section shall become null and void July 1, 2021, if the Commission has failed to adopt that interim rule as a permanent rule by that date in accordance with Article 2A of Chapter 150B of the General Statutes.

SECTION 4. This act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 612

AMENDMENT NO. 1
(to be filled in by Principal Clerk)

H612-ATR-38 [v.4]

Amends Title [NO]
H612-CSBH-32

Date 6/3/2020, 2020

Senator _____

moves to amend the bill on page 3, lines 48-49, by inserting between the lines the following:

"**SECTION 7A.(a)** G.S. 150B-1(d)(9) reads as rewritten:

"(9) The Department of Health and Human Services in adopting ~~new or amending existing medical coverage policies for the State Medicaid and NC Health Choice programs pursuant to G.S. 108A-54.2.~~ rules relating to the administration or operation of the State Medicaid or NC Health Choice program."

SECTION 7A.(b) G.S. 150B-1(d)(20) is repealed.

SECTION 7A.(c) G.S. 108A-54.1B is amended by adding a new subsection to read:

"(e) Except as provided in subsection (d) of this section and G.S. 108A-54.2, all of the following apply to rules adopted by the Department:

(1) At least 30 days prior to the adoption of a new or amended rule, the Department shall publish the proposed rule on the Department's Web site.

(2) Upon request, the Department shall provide persons copies of the proposed rule.

(3) During the 30-day period immediately following publication of the proposed new or amended rule, the Department shall accept oral and written comments on the proposed new or amended rule.

(4) If immediate adoption of the rule without notice is necessary in order to fully effectuate the purpose of the rule, then the 30-day notice period shall not be required.".

SIGNED _____
Amendment Sponsor.

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 612

AMENDMENT NO. 2
(to be filled in by Principal Clerk)

H612-ABC-126 [v.3]

Amends Title [NO]
H612-CSBH-32

Date 6/3 ,2020

Senator Hise

moves to amend the PCS on page 2, line 6, by rewriting the line to read:
"filed an action for declaratory judgment under Section 2. Any policy, guideline, or other interpretive statement issued by the Division after this act becomes effective shall become void one year after it is issued; however, prior to that deadline, the Secretary of Health and Human Services may re-issue the policy, guideline, or other interpretive statement for an additional period of one year."

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

Senate Select Committee on HEALTH CARE

June 3, 2020 10:00 AM

Room 643

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
John Easterling III	KTS
Molly Masich	OAH
	NCDOT
Justin Delaney	
	NCWQA
	DHHS

Speaker Sign-Up Sheet

Health Care

June 3, 2020 10:00 AM

ROOM 643

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Matt Gross	DHHS
Molly Masich	OAH

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee

On

Health Care

June 3, 2020 – 10:00 AM

Room 643

Senate Sergeant at Arms:

FRANCE PATTERSON

LINDA MATTHEWS

BILLY FRITSCHER

JOHN ENLOE

CHARLES HARPER

Senate Committee on Health Care
Tuesday, June 9, 2020 at 1:00 PM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 1:00 PM on June 9, 2020 in Room 643 of the Legislative Office Building. Fifteen members were present.

Senator Joyce Krawiec, Chair, presided.

Sen. Krawiec gave welcoming remarks and introduced the Sargent of Arms.

SB 730 The No Patient Left Alone Act. (Senators Daniel, Perry, Krawiec)

Sen. Krawiec announced that the bill was for discussion only and asked for a motion to bring the proposed committee substitute (PCS) before the committee. Sen. Ford made the motion and it carried. Sen. Daniel was introduced to explain the bill. Sen. Perry brought forth and explained an amendment. Sen. Krawiec asked for a motion to adopt the amendment and it was given and carried. The PCS was now before the committee as amended. Questions from the members were responded to by Sen. Warren, Sen. Krawiec, and Sen. Perry. Sen. Krawiec allowed testimonies from individuals that have been negatively impacted by a family member who either died alone or was treated without a family member present to insure that there was a clear understanding of the illness, diagnosis, and treatment. They spoke in the order below:

1. Rep. Michele Presnell
2. Suzanne Warfield
3. Cathy Dula
4. Donna McGuire
5. Ken Sharpe
6. Kay Sharpe

Sen. Krawiec had to leave the meeting and asked that Sen. Burgin preside for the remainder of the meeting.

North Carolina Amended Plan Community Services Block Grant (presented by: Tara Myers/Deputy Secretary for Human Services)

Sen. Burgin welcomed Tara Myers who joined the committee virtually. She offered a PowerPoint presentation to the members. Once the presentation concluded, Sen. Burgin asked if there were any questions from the members. There were none.

The meeting adjourned at 2:20 PM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

Senate Committee on Health Care
Tuesday, June 9, 2020, 1:00 PM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 730	The No Patient Left Alone Act. FOR DISCUSSION ONLY	Senator Daniel Senator Perry Senator Krawiec

Presentation

North Carolina Amended Plan
Community Services Block Grant
FFY 2019-2020
presented by:
Tara Myers/Deputy Secretary for Human Services
Department of Health and Human Services

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S D

SENATE BILL 730
PROPOSED COMMITTEE SUBSTITUTE S730-CSSHa-38 [v.4]
06/08/2020 03:14:19 PM

Short Title: The No Patient Left Alone Act. (Public)

Sponsors:

Referred to:

May 14, 2020

A BILL TO BE ENTITLED

AN ACT PROVIDING PATIENT VISITATION RIGHTS THAT WILL NOT BE IMPACTED DURING DECLARED DISASTERS AND EMERGENCIES; AND APPROPRIATING FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, TO DEVELOP AND DISSEMINATE TO HOSPITALS FREE INFORMATIONAL MATERIALS EXPLAINING THESE RIGHTS.

Whereas, the COVID-19 pandemic has caused great uncertainty and anxiety across our State and has significantly affected the medical community, including hospitals; and

Whereas, hospitals have made many efforts to keep patients and employees in a safe environment, and have endeavored to minimize, to the extent possible, the risk of spread of the coronavirus disease; and

Whereas, as a result of COVID-19 prevention measures, many unintended consequences have occurred to hospital patients who were not diagnosed with COVID-19; and

Whereas, the General Assembly has become aware of numerous patients across our State who were not diagnosed with COVID-19, but as a result of hospital visitation policies have been prohibited from having any visitors, including a spouse, parent, close family member, guardian, health care agent, or caregiver; and

Whereas, as a result, many patients not diagnosed with COVID-19 have been forced to be alone during their treatment for serious conditions, traumas, illnesses, heart attacks, and routine and emergency surgeries; and

Whereas some of these patients have been forced to be alone for the entire course of their treatment, and in some cases have died alone; and

Whereas, many families have been unable to be physically present with their loved ones while in the hospital setting and have been limited to electronic video communications, if any, with the patient; and

Whereas, the patients who have been affected in the above-described manner have included adults, minors, and individuals with intellectual or developmental disabilities; and

Whereas, the General Assembly finds that it is in the interest of the State and its residents that hospital patients be allowed at least one immediate family member, designated health care agent, guardian, or person standing in loco parentis physically present at reasonable times throughout the hospitalization; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as "The No Patient Left Alone Act."

SECTION 2. Article 5 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-79.3. Patient visitation rights during a disaster declaration or public health emergency.**

(a) During a period in which a disaster, emergency, or public health emergency has been declared, a hospital licensed under this Article shall ensure the opportunity for at least one visitor to visit a patient admitted to a facility. This visitation shall be subject to the guidelines, conditions, and limitations of the normal visitation policy.

(b) One parent, guardian, or person standing in loco parentis shall be allowed the opportunity to visit a minor patient admitted to a facility licensed under this Article. This visitation shall be subject to the guidelines, conditions, and limitations of the normal visitation policy. When the visitor cannot be in the room with the patient due to a medical procedure or other reason, the visitor shall have access to a waiting area.

(c) One immediate family member or designated health care agent shall have the opportunity to visit an adult patient admitted to a facility licensed under this Article. This visitation shall be subject to the guidelines, conditions, and limitations of the normal visitation policy. When the visitor cannot be in the room with the patient due to a medical procedure or other reason, the visitor shall have access to a waiting area. For purposes of this subsection, the term "immediate family member" means a spouse, child, sibling, parent, grandparent, grandchild, or the spouse of an immediate family member and the term includes stepparents, stepchildren, stepsiblings, and adoptive relationships.

(d) Notwithstanding the provisions of G.S. 131E-112, Chapter 166A of the General Statutes, or any other provision of law to the contrary, the visitation rights specified in this section may not be terminated, suspended, or waived by the hospital, the Department of Health and Human Services, or the Governor upon the declaration of a disaster or emergency under Article 1A of Chapter 166A of the General Statutes.

(e) No hospital licensed under this Article may require a patient to waive the visitation rights specified in this section.

(f) A hospital licensed under this Article may require a visitor to submit to health screenings necessary to prevent the spread of infectious diseases and may require a visitor to adhere to infection control procedures including wearing personal protective equipment.

(g) Each hospital licensed under this Article shall post in a conspicuous place on the licensed premises informational materials developed by the Department of Health and Human Services explaining the rights specified in this section."

SECTION 3. The Department of Health and Human Services, Division of Health Service Regulation, shall develop and disseminate to hospitals licensed under Article 5 of Chapter 131E of the General Statutes free informational materials explaining the rights specified in G.S. 131E-79.3, as enacted by Section 2 of this act.

SECTION 4. There is appropriated to the Department of Health and Human Services, Division of Health Service Regulation, the sum of five thousand dollars ($5,000) for the 2019-2020 fiscal year, to develop and disseminate to hospitals licensed under Article 5 of Chapter 131E of the General Statutes free informational materials about the patient rights specified in G.S. 131E-79.3, as enacted by Section 2 of this act.

SECTION 5. This act is effective when it becomes law.

SENATE BILL 730:
The No Patient Left Alone Act.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 8, 2020
Introduced by:	Sens. Daniel, Perry, Krawiec	**Prepared by:**	Theresa Matula Legislative Analyst
Analysis of:	PCS to First Edition S730-CSSHa-38		

OVERVIEW: The Proposed Committee Substitute for SB 730 would enact the No Patient Left Alone Act to ensure visitation rights for hospital patients during a disaster declaration or public health emergency.

BILL ANALYSIS: The PCS for SB 730 contains the "The No Patient Left Alone Act" which ensures the visitation rights of hospital patients during a period in which a disaster, emergency, or public health emergency has been declared.

Section 2 amends Chapter 131E, Article 5. Hospital Licensure Act, to add a new section [G.S. 131E-79.3] requiring a hospital to ensure the opportunity for at least one visitor to visit a patient admitted to a facility. The contents of each subsection of the new statute is outlined below.

- Subsection (b) pertains to visitation of minors and allows one parent, guardian, or person standing in loco parentis the opportunity to visit a minor patient.
- Subsection (c) pertains to visitation of adults and allows an immediate family member or designated health care agent the opportunity to visit an adult patient admitted to a facility. The term "immediate family member" is defined as a spouse, child, sibling, parent, grandparent, grandchild, or the spouse of an immediate family member and includes stepparents, stepchildren, stepsiblings, and adoptive relationships.
- Both subsections (b) and (c) provide that the visitation is subject to the guidelines, conditions, and limitations of the normal visitation policy and when the visitor cannot be in the room with the patient due to a medical procedure or other reason, the visitor must have access to a waiting area.
- Subsection (d) notwithstands the law [G.S. 131E-112] allowing the waiver of rules for health care facilities that provide temporary shelter or temporary services during a disaster or emergency, the contents of the North Carolina Emergency Management Act [Chapter 166A], or any law to the contrary, to provide that the visitation rights may not be terminated, suspended or waived by the hospital, the Department of Health and Human Services, or the Governor upon the declaration of a disaster or emergency under Article IA of Chapter 166A.
- Subsection (e) prohibits a hospital from requiring a patient to waive their visitation rights.
- Subsection (f) allows a hospital to require a visitor to submit to health screenings necessary to prevent the spread of infections diseases and to require a visitor to adhere to infection control procedures including wearing personal protective equipment.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

- Subsection (g) requires the Department of Health and Human Services (DHHS) to develop informational materials explaining the rights allowed by the act and requires each hospital to post the materials in a conspicuous place.

Sections 3 requires the Division of Health Service Regulation, DHHS, to develop and disseminate the free informational materials explaining the visitation rights provided by the bill.

Section 4 appropriates $5,000 for the 2019-2020 fiscal year to the Division of Health Service Regulation, DHHS, to develop and disseminate the materials explaining the visitation rights.

EFFECTIVE DATE: The bill would become effective when it becomes law.

SENATE BILL 730

Short Title:	The No Patient Left Alone Act.	(Public)
Sponsors:	Senators Daniel, Perry, and Krawiec (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

May 14, 2020

A BILL TO BE ENTITLED

AN ACT PROVIDING FOR CERTAIN UNRESTRICTED HOSPITAL PATIENT RIGHTS THAT WILL NOT BE IMPACTED DURING DECLARED DISASTERS AND EMERGENCIES; AND APPROPRIATING FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, TO DEVELOP AND DISSEMINATE TO HOSPITALS FREE INFORMATIONAL MATERIALS EXPLAINING THESE RIGHTS.

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as "The No Patient Left Alone Act."

SECTION 2. Article 5 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-79.3. Visitation rights of hospital patients.**

(a) Each minor who is admitted to a hospital licensed under this Article has the right to designate a parent, guardian, or person standing in loco parentis who shall have the unrestricted privilege of being present while the minor patient is receiving hospital care.

(b) Each adult who is admitted to a hospital licensed under this Article has the right to designate a spouse or health care agent who shall have the unrestricted privilege of being present while the adult patient is receiving hospital care.

(c) Notwithstanding the provisions of G.S. 131E-112, Chapter 166A of the General Statutes, or any other provision of law to the contrary, the rights specified in this section may not be terminated, suspended, or waived by the hospital, the Department of Health and Human Services, or the Governor upon the declaration of a disaster or emergency under Article 1A of Chapter 166A of the General Statutes.

(d) No hospital licensed under this Article may require a patient to waive the rights specified in this section.

(e) Each hospital licensed under this Article shall post in a conspicuous place on the licensed premises informational materials developed by the Department of Health and Human Services explaining the rights specified in this section."

SECTION 3. The Department of Health and Human Services, Division of Health Service Regulation, shall develop and disseminate to hospitals licensed under Article 5 of Chapter 131E of the General Statutes free informational materials explaining the rights specified in G.S. 131E-79.3, as enacted by Section 1 of this act.

SECTION 4. There is appropriated to the Department of Health and Human Services, Division of Health Service Regulation, the sum of five thousand dollars ($5,000) for the 2019-2020 fiscal year, to develop and disseminate to hospitals licensed under Article 5 of

Chapter 131E of the General Statutes free informational materials about the patient rights specified in G.S. 131E-79.3, as enacted by Section 1 of this act.

SECTION 5. This act is effective when it becomes law.

SENATE HEALTH COMMITTEE

North Carolina Amended Plan Community Services Block Grant FFY 2019-2020

Tara Myers
Department of Health and Human Services

June 9, 2020

Requirements

- Federal Law (Sec. 676 of the Community Opportunities, Accountability, And Training And Educational Services Act Of 1998; Public Law 105-285) requires one hearing in the State and at least one legislative hearing every three years in conjunction with development of the state plan.

CSBG Service Delivery System

- Composed of 33 Community Action Agencies (CAAs)

https://www.ncdhhs.gov/csbg-contacts

- Assist individuals and families with moving from poverty to economic independence

- Serves all 100 Counties in North Carolina

Governance

- Required Tripartite Board Structure:
  - Offers opportunity for the low-income population, public elected officials (or representatives) and private sector representatives to work together for the oversight, development, and evaluation of community programs.

Changes to State Plan

- Use discretionary funding in accordance with 10A NCAC 97C.0108(3) by developing programs for preparation or recovery efforts related to natural disasters (i.e. hurricanes, tornado's, flooding etc.).

- After consideration of necessary allocations for natural disasters, funds may be allocated for technology systems or to eligible entities for innovative projects.

Monitoring & Accountability

Monitoring begins with the annual funding application and continues through the closeout of each grant year.

- On-site reviews occur:

  1. After completion of first year;

  2. As needed based on requirements and/or compliance issues; and

  3. Every three years as mandated

Results

- 63,297 unduplicated persons serve
- 34,311 unduplicated families served
- With support of Community Action Agencies, the average income of clients increased to $10.72 or 40% more than the state minimum wage of $7.25
- Average income change of families with the support of Community Action Agencies increased to $12,400 yearly (this is an average on all households including single and multi-members in households)

SFY 2018-19 Outcome Achievement for CSBG Self-Sufficiency Programs

Families receiving services	10,077
Families rising above the poverty level	454
Families obtaining employment	761
Families obtaining better employment	330
The average change in annual income	$12,400
The average wage rate	$10.72
Families obtaining jobs with medical benefits	240
Families completing education/training programs	762
Families securing standard housing	375
Families provided employment support	1,086
Families provided education support	1,112
Families provided emergency assistance	2,565

Questions

North Carolina Plan for Administering Community Services Block Grant Program FFY 2019 and 2020

Senate Committee on Health Care
Tuesday, June 9, 2020, 1:00 PM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 730	The No Patient Left Alone Act. FOR DISCUSSION ONLY	Senator Daniel Senator Perry Senator Krawiec

Presentation

North Carolina Amended Plan
Community Services Block Grant
FFY 2019-2020
presented by:
Tara Myers/Deputy Secretary for Human Services
Department of Health and Human Services

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

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SENATE BILL 730
PROPOSED COMMITTEE SUBSTITUTE S730-CSSHa-38 [v.4]
06/08/2020 03:14:19 PM

Short Title: The No Patient Left Alone Act. (Public)

Sponsors:

Referred to:

May 14, 2020

A BILL TO BE ENTITLED

AN ACT PROVIDING PATIENT VISITATION RIGHTS THAT WILL NOT BE IMPACTED DURING DECLARED DISASTERS AND EMERGENCIES; AND APPROPRIATING FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, TO DEVELOP AND DISSEMINATE TO HOSPITALS FREE INFORMATIONAL MATERIALS EXPLAINING THESE RIGHTS.

Whereas, the COVID-19 pandemic has caused great uncertainty and anxiety across our State and has significantly affected the medical community, including hospitals; and

Whereas, hospitals have made many efforts to keep patients and employees in a safe environment, and have endeavored to minimize, to the extent possible, the risk of spread of the coronavirus disease; and

Whereas, as a result of COVID-19 prevention measures, many unintended consequences have occurred to hospital patients who were not diagnosed with COVID-19; and

Whereas, the General Assembly has become aware of numerous patients across our State who were not diagnosed with COVID-19, but as a result of hospital visitation policies have been prohibited from having any visitors, including a spouse, parent, close family member, guardian, health care agent, or caregiver; and

Whereas, as a result, many patients not diagnosed with COVID-19 have been forced to be alone during their treatment for serious conditions, traumas, illnesses, heart attacks, and routine and emergency surgeries; and

Whereas some of these patients have been forced to be alone for the entire course of their treatment, and in some cases have died alone; and

Whereas, many families have been unable to be physically present with their loved ones while in the hospital setting and have been limited to electronic video communications, if any, with the patient; and

Whereas, the patients who have been affected in the above-described manner have included adults, minors, and individuals with intellectual or developmental disabilities; and

Whereas, the General Assembly finds that it is in the interest of the State and its residents that hospital patients be allowed at least one immediate family member, designated health care agent, guardian, or person standing in loco parentis physically present at reasonable times throughout the hospitialization; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as "The No Patient Left Alone Act."

SECTION 2. Article 5 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-79.3. Patient visitation rights during a disaster declaration or public health emergency.**

(a) During a period in which a disaster, emergency, or public health emergency has been declared, a hospital licensed under this Article shall ensure the opportunity for at least one visitor to visit a patient admitted to a facility. This visitation shall be subject to the guidelines, conditions, and limitations of the normal visitation policy.

(b) One parent, guardian, or person standing in loco parentis shall be allowed the opportunity to visit a minor patient admitted to a facility licensed under this Article. This visitation shall be subject to the guidelines, conditions, and limitations of the normal visitation policy. When the visitor cannot be in the room with the patient due to a medical procedure or other reason, the visitor shall have access to a waiting area.

(c) One immediate family member or designated health care agent shall have the opportunity to visit an adult patient admitted to a facility licensed under this Article. This visitation shall be subject to the guidelines, conditions, and limitations of the normal visitation policy. When the visitor cannot be in the room with the patient due to a medical procedure or other reason, the visitor shall have access to a waiting area. For purposes of this subsection, the term "immediate family member" means a spouse, child, sibling, parent, grandparent, grandchild, or the spouse of an immediate family member and the term includes stepparents, stepchildren, stepsiblings, and adoptive relationships.

(d) Notwithstanding the provisions of G.S. 131E-112, Chapter 166A of the General Statutes, or any other provision of law to the contrary, the visitation rights specified in this section may not be terminated, suspended, or waived by the hospital, the Department of Health and Human Services, or the Governor upon the declaration of a disaster or emergency under Article 1A of Chapter 166A of the General Statutes.

(e) No hospital licensed under this Article may require a patient to waive the visitation rights specified in this section.

(f) A hospital licensed under this Article may require a visitor to submit to health screenings necessary to prevent the spread of infectious diseases and may require a visitor to adhere to infection control procedures including wearing personal protective equipment.

(g) Each hospital licensed under this Article shall post in a conspicuous place on the licensed premises informational materials developed by the Department of Health and Human Services explaining the rights specified in this section."

SECTION 3. The Department of Health and Human Services, Division of Health Service Regulation, shall develop and disseminate to hospitals licensed under Article 5 of Chapter 131E of the General Statutes free informational materials explaining the rights specified in G.S. 131E-79.3, as enacted by Section 2 of this act.

SECTION 4. There is appropriated to the Department of Health and Human Services, Division of Health Service Regulation, the sum of five thousand dollars ($5,000) for the 2019-2020 fiscal year, to develop and disseminate to hospitals licensed under Article 5 of Chapter 131E of the General Statutes free informational materials about the patient rights specified in G.S. 131E-79.3, as enacted by Section 2 of this act.

SECTION 5. This act is effective when it becomes law.

SENATE BILL 730:
The No Patient Left Alone Act.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 8, 2020
Introduced by:	Sens. Daniel, Perry, Krawiec	**Prepared by:**	Theresa Matula Legislative Analyst
Analysis of:	PCS to First Edition S730-CSSHa-38		

OVERVIEW: The Proposed Committee Substitute for SB 730 would enact the No Patient Left Alone Act to ensure visitation rights for hospital patients during a disaster declaration or public health emergency.

BILL ANALYSIS: The PCS for SB 730 contains the "The No Patient Left Alone Act" which ensures the visitation rights of hospital patients during a period in which a disaster, emergency, or public health emergency has been declared.

Section 2 amends Chapter 131E, Article 5. Hospital Licensure Act, to add a new section [G.S. 131E-79.3] requiring a hospital to ensure the opportunity for at least one visitor to visit a patient admitted to a facility. The contents of each subsection of the new statute is outlined below.

- Subsection (b) pertains to visitation of minors and allows one parent, guardian, or person standing in loco parentis the opportunity to visit a minor patient.
- Subsection (c) pertains to visitation of adults and allows an immediate family member or designated health care agent the opportunity to visit an adult patient admitted to a facility. The term "immediate family member" is defined as a spouse, child, sibling, parent, grandparent, grandchild, or the spouse of an immediate family member and includes stepparents, stepchildren, stepsiblings, and adoptive relationships.
- Both subsections (b) and (c) provide that the visitation is subject to the guidelines, conditions, and limitations of the normal visitation policy and when the visitor cannot be in the room with the patient due to a medical procedure or other reason, the visitor must have access to a waiting area.
- Subsection (d) notwithstands the law [G.S. 131E-112] allowing the waiver of rules for health care facilities that provide temporary shelter or temporary services during a disaster or emergency, the contents of the North Carolina Emergency Management Act [Chapter 166A], or any law to the contrary, to provide that the visitation rights may not be terminated, suspended or waived by the hospital, the Department of Health and Human Services, or the Governor upon the declaration of a disaster or emergency under Article IA of Chapter 166A.
- Subsection (e) prohibits a hospital from requiring a patient to waive their visitation rights.
- Subsection (f) allows a hospital to require a visitor to submit to health screenings necessary to prevent the spread of infections diseases and to require a visitor to adhere to infection control procedures including wearing personal protective equipment.

- Subsection (g) requires the Department of Health and Human Services (DHHS) to develop informational materials explaining the rights allowed by the act and requires each hospital to post the materials in a conspicuous place.

Sections 3 requires the Division of Health Service Regulation, DHHS, to develop and disseminate the free informational materials explaining the visitation rights provided by the bill.

Section 4 appropriates $5,000 for the 2019-2020 fiscal year to the Division of Health Service Regulation, DHHS, to develop and disseminate the materials explaining the visitation rights.

EFFECTIVE DATE: The bill would become effective when it becomes law.

SENATE BILL 730

Short Title:	The No Patient Left Alone Act.	(Public)
Sponsors:	Senators Daniel, Perry, and Krawiec (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

May 14, 2020

A BILL TO BE ENTITLED

AN ACT PROVIDING FOR CERTAIN UNRESTRICTED HOSPITAL PATIENT RIGHTS THAT WILL NOT BE IMPACTED DURING DECLARED DISASTERS AND EMERGENCIES; AND APPROPRIATING FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, TO DEVELOP AND DISSEMINATE TO HOSPITALS FREE INFORMATIONAL MATERIALS EXPLAINING THESE RIGHTS.

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as "The No Patient Left Alone Act."

SECTION 2. Article 5 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-79.3. Visitation rights of hospital patients.**

(a) Each minor who is admitted to a hospital licensed under this Article has the right to designate a parent, guardian, or person standing in loco parentis who shall have the unrestricted privilege of being present while the minor patient is receiving hospital care.

(b) Each adult who is admitted to a hospital licensed under this Article has the right to designate a spouse or health care agent who shall have the unrestricted privilege of being present while the adult patient is receiving hospital care.

(c) Notwithstanding the provisions of G.S. 131E-112, Chapter 166A of the General Statutes, or any other provision of law to the contrary, the rights specified in this section may not be terminated, suspended, or waived by the hospital, the Department of Health and Human Services, or the Governor upon the declaration of a disaster or emergency under Article 1A of Chapter 166A of the General Statutes.

(d) No hospital licensed under this Article may require a patient to waive the rights specified in this section.

(e) Each hospital licensed under this Article shall post in a conspicuous place on the licensed premises informational materials developed by the Department of Health and Human Services explaining the rights specified in this section."

SECTION 3. The Department of Health and Human Services, Division of Health Service Regulation, shall develop and disseminate to hospitals licensed under Article 5 of Chapter 131E of the General Statutes free informational materials explaining the rights specified in G.S. 131E-79.3, as enacted by Section 1 of this act.

SECTION 4. There is appropriated to the Department of Health and Human Services, Division of Health Service Regulation, the sum of five thousand dollars ($5,000) for the 2019-2020 fiscal year, to develop and disseminate to hospitals licensed under Article 5 of

Chapter 131E of the General Statutes free informational materials about the patient rights specified in G.S. 131E-79.3, as enacted by Section 1 of this act.

SECTION 5. This act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 730

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S730-ASH-42 [v.2]

Amends Title [NO]
S730-CSSHa-38

Date 6-9 ,2020

Senator Perry

moves to amend the bill on page 2, lines 7-8, by rewriting the lines to read:

"(b) In the event a minor is admitted to a hospital licensed under this Article, at least one parent, guardian, or person standing in loco parentis shall be allowed the opportunity to visit and to be present while the minor patient is receiving hospital care. If a custody order or written child custody agreement is in place, the custody order or written child custody agreement shall control. This".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

Testimony from Atrium Trauma Nurse Wendy Moeller:

Wendy Moeller quickly stepped in to fill a gap when the coronavirus restricted visits by loved ones to critically ill patients at Atrium Health's Carolinas Medical Center.

Moeller has been a registered nurse in Atrium's surgical-trauma intensive care unit for 18 years.

She is filling the gap by spending a lot of her time talking over the phone with families about their loved ones, whether to try to console them or to report a positive update, Atrium officials said.

Moeller filled another gap, too, by spending extra time with patients who now face long hours isolated from their families. She talks with them, holds their hands and offers an encouraging word.

Moeller said patients' attending doctors and other acute care practitioners also contact family members with updates from their daily rounds. Last week, she and other health care workers in the unit received iPads to communicate with families via FaceTime. "They also call us for information," she said.

"Not having our family members present has hit me especially hard during this crisis," Moeller said, referring to family members of patients. "And for them not to be able to see their loved ones, that takes a toll on you and it hurts your heart tremendously."

One day in mid-April, care was being withdrawn for a terminally ill patient while another patient took a turn for the worse.

She was on the phone with one of their family members who suddenly erupted in grief.

"To have one family member screaming, crying in the phone that they couldn't be there and was so scared they may never get to hear their voice again really impacted me, when you try to give them as much reassurance as you can that you're working hard to save their loved one," Moeller said. "I actually left that day defeated. I pretty much lost it when I got to my car."

Yet being there for those in the most distress is vital to the role she's served for so many years, she knows.

"I actually love what I do," Moeller said.

Besides working with her teammates, doctors and Atrium leadership, "just truly being there for a family member, and a patient that can't talk in a tragic, life- changing situation, and knowing I can try to impact them through education, compassion and kindness is truly the biggest reward for me."

--Charlotte Observer Sunday May, 20 by Joe Marusak--Health Care Heroes insert

Testimony from Cheryl Holtsclaw of Avery County, NC:

On May 7, 2020, we took our Dad, age 86 to Watauga Medical Center Emergency Room with kidney issues. No one was allowed to be with him past the front desk. While he waited to see the doctor, he suffered a catastrophic stroke, leaving him paralyzed on his right side and also affecting his swallowing. Our parents have been married 64 years, rarely being apart. Our mother was allowed a short visit of about an hour on two occasions over the seven day period. Dad was confused as to why his family wasn't there.

Also we have to wonder if he completely understood his course of treatment because he was unable to wear his hearing aids. He couldn't get out of bed, couldn't hold a phone or dial a number and couldn't eat or drink because of the paralysis. This surely was terrifying in his condition.

Our Daddy was a strong man with a will to live. But because no one was there to advocate for him or to encourage him, he gave up after seven days. Our Dad chose no further treatment and requested to be brought home to his family

He succumbed to death within 60 hours, surrounded by his wife and five children.

---No one should have to take this journey alone.---

Sincerely,
The Dallas Banner Family
Pansy Banner (wife)
Cheryl Holtsclaw (daughter)
Christine Vance (daughter)
Kenneth Banner (son)
Stephen Banner (son)
Micheal Banner (son)

Testimony from Robin Mayer, RN from Alexander County:

They put my mother back in the hospital on Saturday and it's been a bit of a whirlwind. I am so over this quarantine nonsense. It is enough. It has gone on for too long. Elderly patients /residents aren't dying due to their chronic conditions, they are dying due to failure to thrive! I am a nurse. 40 years a nurse. I get it. Appoint one family member (who is their caregiver), screen them, take their temperature, sanitize their hands and throw a mask on. The visitor is not there to wander around the facility or visit others. They are simply there for their loved one. For heaven's sake people ....let's be realistic. Come on America- get it together. How long do you think you can go without seeing your loved one?

My mother fell almost 2 weeks ago and broke her hip. Prior to this she was very active, made her bed and did all of her ADLs. Would challenge you in a game of corn hole or bingo or meet you at happy hour on Friday afternoons. She is now at a local rehab begging me to come to see her or just spend time together. She cannot socialize with others or leave her room due to the quarantine. She is out of her normal surroundings and out of her scheduled routine in an unfamiliar place where she knows no one. Have a little piece of empathy. Let them live what life they have left. Do the right thing America.... be smart and be safe. This is my prayer. My heart is breaking. Please keep us and all others in this situation in your daily prayers. Thank you.

Ms. Mayer sent this letter to Governor Cooper over 2 weeks ago and received no response.

Testimony from Cathy Dula, RN of Caldwell County:

North Carolina Senate,

My name is Cathy Dula. I am a Registered Nurse and have been licensed in our state for over 20 years. I am writing this letter on behalf of my dear friends Scott and Misty Starnes regarding SB 730. This bill has become one that I have grown to be very passionate about due to the events that occurred to my dear friends.

On April 26, 2020 at approximately 6:00pm, Scott Starnes was involved in a head on collusion with a young man operating his motor vehicle in excess on 100mph. This young man crossed the lane into the path of Mr. Starnes, hitting him head on. This accident occurred in Catawba County at the 1800 block of Hunsucker Drive and Boggs Road in the Claremont Community. The accident occurred within 2 miles of Scott and Misty's home. Scott had left home to go to a nearby store and was on his way back home when the accident occurred. Mr. Starnes' son, Jordan, went to look for his dad due to his delayed return to the home and unfortunately came upon the accident scene. Jordan returned to the home to advise Misty of the wreck involving his dad. Misty and Jordan returned to the scene of the accident and Catawba County EMS was loading Scott in the ambulance but would not provide Misty or Jordan with any information as to whether that was Scott they were loading into the ambulance or as to where they were taking him. Misty and Jordan assumed they are taking him to Catawba Valley Medical Center and proceeded to the hospital, they arrived just prior to EMS's arrival. Catawba County EMS proceeded to remove their patient from the ambulance and headed to the helicopter as Misty begged to be told if that was Mr. Starnes they were loading into the helicopter, but she was told to "step back and away from the stretcher." Misty and Jordan were made aware that in fact it was Mr. Starnes who was in the helicopter being transported to Atrium Healthcare in Charlotte by the NCSHP.

Mr. Starnes sustained multiple traumatic injuries in the wreck. The injuries he sustained were life threatening. Misty and Jordan proceeded to Atrium Healthcare. Upon Mr. Starnes arrival to Atrium Healthcare, he was taken to the Trauma ER for evaluation of his injuries. The CT revealed head trauma with a Sub Dural Bleed, the X-rays revealed multiple fractured ribs, bleeding within the lungs and lung contusions, fractured and crushed right pelvis. Mr. Starnes also sustained a severe laceration to his lower right leg that protruded into the muscle. Prior to the initial trauma testing being completed, Misty, Jordan, myself and my husband arrived at Atrium Healthcare. No one could enter the building. An ER Attendant did come out and request the Mrs. Starnes enter the waiting area to speak with admissions to obtain information as to the name, age, insurance on the patient and an Emergency Contact Number. Once they obtained that information, Misty had to exit the building. She returned to the outside sidewalk in the cold. Not long after her return outside, she received a call from the ER Trauma Physician stating that the Neurology Team would be taking Scott to surgery immediately to remove a piece of his skull, to allow for brain swelling, and to evacuate the Sub Dural Bleed. Mrs. Starnes nor his sons were allowed into the Trauma ER to see Mr. Starnes prior to surgery, not knowing if Mr. Starnes would even survive the surgery. Scott was in surgery for over 6 hours and following surgery he was placed in the Neuro Trauma ICU, still they were unable to see him following the surgery. The family were told by the ER Trauma physician that they would not be allowed in to see Mr. Starnes and to

consider that a "good thing" because if they did call them to the hospital to see Mr. Starnes "it would be due to him taking a turn for the worse and allow them to say their goodbyes." It was heart wrenching to observe this family being told that information.

The family decided to obtain accommodations in a nearby hotel should there be any changes to Scott's status during the night. The family remained in this hotel for 3 weeks and received updates from the Neuro MD once daily and they could FaceTime Scott daily at 3:00pm only to see him unconscious with numerous tubes coming from his body but still no visitation with him. Finally, after continued rejection I reached out to everyone I could to help this family obtain a visit with Mr. Starnes. I contacted Senator Warren Daniel to pled for this family. Mr. Starnes' injuries were traumatic and life threatening. Senator Daniel did attempt to help by contacting the Atrium Healthcare Administration. On Friday, May 1st, Mrs. Starnes could visit with her husband. Misty was the only person they would allow in to see Mr. Starnes. None of their 5 sons, his mother or his sister were allowed a visit. Mrs. Starnes was allowed to visit with him for 2 hours and that would be the last time she would see her husband alive, to hold his hand, kiss his cheek and tell him she loved him.

Mr. Starnes began to improve over the next 2 weeks, he was awake, trying to speak, and recognized his family when they were allowed to FaceTime him at 3:00pm daily. Mr. Starnes returned to surgery on 05/14 to place a tracheostomy and replace the piece of skull, initially removed, and placed in a helmet for protection. The family decided on 05/15 to return home after being denied visitation on multiple occasions and having stayed in a hotel for 3 weeks following the accident.

Mr. Starnes' condition improved to where he could be transported to a Long Term Acute Care Hospital, LTACH, Carolinas ContinueCare Hospital in Pineville, NC. Scott was transported to the LTACH on 05/22 at 5:30pm. Upon arrival to the LTACH, the family was unable to FaceTime with Scott as they had been allowed to do while he was at Atrium Healthcare. The Social Worker at Carolinas ContinueCare Hospital went out of his way on Sunday 5/24 to go to the facility and allow the family to FaceTime Scott. They could only FaceTime with him during the week when the Social Worker was on-site but they would have no communication with Scott on the weekends. The family would gather every afternoon at 3:00pm to FaceTime with Scott. He was improving and even responded to Misty when she told him that she loved him, his response was "I love you too Babe." This was Scott's normal response to Misty every day. Misty would call the facility every morning to see how his night had gone, the staff advised her on Monday that he was becoming more agitated, aggressive, and had to be restrained, which was very out of character for Scott. On Monday, during the FaceTime visit, Scott ask Misty, "Why she was not there with him?" Misty tried to explain that she could not be due to COVID-19, but he began to cry. Misty and the family ended the call very upset also due to seeing him in that state. As normal, Misty called on Tuesday morning to see how Scott had done during the night and they told her that he became agitated and aggressive to the point that he pulled his tracheostomy out but they were able to replace it. During the FaceTime visit on Tuesday, Scott again ask, "Why they were not there with him?" and Misty again tried to explain to him that due to the virus they would not let her in to be with him. Scott began to cry and stated that he did not want to live, again so out of character for Scott but due to his Frontal Lobe head injury this reaction along with the agitation and aggressiveness were symptoms of the head injury. Frontal Lobe head injuries continue to have long term memories but lose their ability to retain short term memories. On Wednesday, June 3, Misty called in to see how Scott had done through the night and again was told that he was very aggressive and agitated, the staff told Misty that Scott had ripped is IV tubing apart and removed his feeding tube. That day Scott was taken down for a Swallowing Study

and did very well, the plan for Thursday was to begin a pureed diet but unfortunately Thursday never came for Scott. The family called in to FaceTime with Scott and was advised that he was too agitated at that time and they felt that the FaceTime would only increase his agitation. During the time between the call in at 3:00pm and 4:30pm, Scott was unable to maintain his airway and went into Respiratory Arrest followed by Cardiac Arrest. The staff stated they worked to revive Scott for 20mins, but they were unable to revive him. Misty received a call from the facility just before 5:00pm stating that Scott had passed away and she needed to come to the facility. She had not been able to visit him while he was alive and breathing but now that he had expired, she was able to enter the facility to visit him.

On Friday, May 29 Atrium Healthcare made an announcement that one visitor would be allowed into the facility. Carolina ContinueCare Hospital is a division of Atrium Healthcare but denied honoring this announcement and allow Mrs. Starnes to visit with her husband. She was told that, "They were not allowing visitor and would make NO EXCEPTIONS for anyone." The last date that Misty was allowed to see her husband alive, hold his hand, kiss his cheek and tell him she loved him was on May 1st. Mr. Starnes would have no recollection of this visit due to being sedated and unconscious.

Scott Starnes was a 49 y/o man who was full of life, loved his wife, loved his family, had a tremendous love of sports. He had coached all his sons in baseball and was now coaching his youngest son, Brady. Scott was Brady's coach on his middle school team as well as the travel baseball team he played on. Scott was an avid softball player and loved the game. Scott and Misty were in the process of obtaining full custody of their grandson, Oakley when this horrific accident occurred. Now this family is left devastated knowing that they were unable to visit Scott and that he passed away alone due to the "No Visitation Policy" most hospitals, nursing home, and long term care facilities have adopted. This policy is not only devastating to the patient but slows their progression and their will to push forward, if their family members were by their side to encourage them along their journey of returning to a healthful state the patient would have the will and drive to push forward. It is too late to help Scott Starnes and his grieving family but hopefully in passing SB 730, another family will not have to endure the pain this family has suffered since April 26, 2020.

I hope this story helps you to understand the injustice patients and families are facing with being kept away from their loved one in their greatest time of need and move to pass SB 730.

Sincerely,

Cathy J. Dula, RN

Senate Bill 730 - The No Patient Left Alone Act
Testimony and NC Health News Article

The Arc
North Carolina

June 9, 2020

We want to thank the North Carolina Senate Health Committee for their consideration of Senate Bill 730.

The Arc of North Carolina has heard from parents and caregivers of individuals with intellectual/developmental disabilities (I/DD) who have not been allowed to be present in a hospital.

Even with Section 4111 of the federal CARES Act (S. 3548), which authorizes I/DD direct support professionals to accompany clients on acute care hospital visits, they were still being denied entry into a hospital.

We respectfully submit testimony from a parent who was denied entry into a hospital to be with her son while he was hospitalized, and an article from North Carolina Health News highlighting this issue.

June 4, 2020

RE: Support of Senate Bill 730- No Patient Left Alone

Dear Senator Daniel and other Members of the Senate Committee,

My name is Tracie Walker and I am a resident and educator in Wilkes County writing to voice my support for Senate Bill 730 "No Patient Left Alone".

Our 26-year-old son, Landon, suffered a traumatic brain injury 8 years ago at the age of 17 that left him intellectually and physically disabled. My husband and I provide total care for him at home with part-time skilled nursing. Landon is nonverbal and has limited to no ability to communicate his needs, so he is dependent on his father and I to communicate for him.

The need to hospitalize our son prior to Covid-19 was never an easy experience for our family. However, once doctors observed our ability to respond to his needs, we could agree that Landon needed a caregiver at his side throughout his treatment.

Unfortunately, during this pandemic, Landon was admitted into a Neuro ICU for seizures. As hard as we tried to comply with all of the hospital policies (only one person could check him in, wearing a mask, stating we had been in isolation with no exposure to COVID, and explaining that Landon is nonverbal, etc.) we were still told by one of the ICU hospitalists "No, you have to leave, but you can use Facetime or Zoom to communicate".

My husband and I were devastated to leave Landon for the first time in 8 years, alone and without a voice. I had terrible thoughts that something could go wrong, and he would need me or that he would wake up and be afraid that no one was with him. So, we requested Zoom sessions as often as possible to be sure that his needs were met. It was during a Zoom that I noticed his respiratory equipment was not in his room, which meant that he would likely develop a pneumonia if we didn't get his therapy started quickly. Sadly, Landon did have to be treated for pneumonia that could have easily been prevented had one of us been there. In addition, he returned home with bedsores on both of his feet because we were not there to maintain his preventive care regimen.

I strongly support Senate Bill 730 because no patient should ever be left alone without a present voice and advocate for their safety and wellbeing.

Thank you for your time and for allowing me to share for North Carolina families with disabilities.

Gratefully,

Tracie L. Walker

Families of disabled struggle with hospital visitor restrictions

N.C. advocates say hospitals are shutting out caregivers of disabled, potentially violating of federal law.

May 6, 2020

By Sarah Ovaska

Velvet Gammons rarely left the side of her disabled son Scottie, who had complex medical needs requiring around-the-clock care at their Mount Airy home.

But when Scottie, 32, went into Wake Forest Baptist Medical Center for treatment, staff at the Winston-Salem hospital told her that pandemic-related visitor restrictions meant she couldn't be with Scottie in the ICU, despite his well-documented cognitive issues.

Scottie died on April 7, and the mother who pleaded to be able to be by his side was not there for his final breaths.

Gammons and several disability rights groups in the state argue that hospitals' visitor restrictions in situations such as the Gammons' violates basic civil rights provisions that should allow Scottie and others with intellectual or developmental disabilities access to their caregivers, even during the COVID-19 pandemic.

"How, when you are mentally [the same as] a child, can you be by yourself when you cannot speak for yourself, you can't understand?" Gammons said she asked Wake Forest Baptist staff about Scottie.

Her son had myotonic dystrophy, a genetic condition that left him unable to speak and on ventilators and feeding tubes for much of his life.

Spokespeople for Wake Forest Baptist indicated that they could not comment on specific cases, but the hospital does "make exceptions for a number of different circumstances" and staff is committed to providing compassionate care.

Advocacy groups sound alarms

The COVID-19 pandemic has upended much of how the state's health care systems operate, initially delaying everything but the most essential surgeries as health care providers responded to the spread of the dangerous and highly contagious pathogen. Hospitals in North Carolina and elsewhere have enacted visitor restrictions to try to prevent the spread of the disease.

That means more patients are alone, although access has been given to those deemed essential such as parents or guardians for pediatric patients, as well as allowing the birth partner of a woman in labor to be by her side.

But pushed aside in some instances have been the caregivers of those with disabilities, both adults and children, said John Nash, executive director of the Arc of North Carolina, an advocacy group for those with intellectual disabilities. He has heard of four instances of caregivers in different parts of the state being denied access to their disabled loved ones in North Carolina hospitals and believes there are many more instances that he and other advocates haven't heard about.

He believes this violates long-held principles outlined in the landmark 1990 Americans with Disabilities Act and other federal laws including the CARES Act, the recently passed COVID-19 stimulus bill.

"This is not just a request," Nash said. "This is a part of a person's civil rights."

A parent or caregiver can often provide the only means a person with disabilities has to communicate or have their needs understood by hospital staff. Cutting off that connection jeopardizes health outcomes, he said.

"If we see someone in an ER or a hospital without those abilities to communicate, the chance of things going wrong goes way up," Nash said.

The Arc and other advocacy groups such as the North Carolina Down Syndrome Alliance, N.C. Developmental Disabilities Consortium and Autism Society of North Carolina issued a letter for families to use if they are facing resistance from hospital administrators. The groups have also reached out to the N.C. Department of Health and Human Services in recent weeks as well to relay their concerns, but the state agency has yet to send out specific guidance to hospitals outlining what is and isn't allowable.

That guidance is expected to come out today, however, according to N.C.DHHS.

Corye Dunn, the public policy director for Disability Rights North Carolina, said they too have heard from families encountering issues with hospital visitor restrictions. Most are able to eventually get hospital officials to relent, but even having to push to allow that access is contrary to what should happen, she said.

For its part, N.C. DHHS officials agree that those with disabilities have the right to have caregivers accompany them in the hospital, even in the midst of the COVID-19 pandemic, pointing to CDC and U.S. Health and Human Services' advice on the topic.

"For individuals with a cognitive impairment, their caregiver is an extension of the individual with the impairment, and should be treated as such," Kelly Haight Connor, a N.C. DHHS spokeswoman, said in a statement. "Unless it negatively impacts a facility's ability to ensure the safety of other patients or visitors, anyone with a cognitive impairment should be allowed to have their caregiver with them either in the ambulance or in the hospital."

Hospitals are waiting to see that guidance from NC DHHS directing them to do this, according to Cynthia Charles, a spokeswoman for the N.C. Health Association, the trade group that represents the state's hospital systems.

Meanwhile, hospitals are making case case-by-case decisions on how to handle caregiver access for those with disabilities.

Families deal with access issues

Gammons was given some access to Scottie over the course of his five-day ICU stay at Wake Forest Baptist after a Greensboro television station aired a story about her plight early in his stay. She was allotted an hour visit each day, a situation that Gammons thinks introduced more risk of introducing COVID-19 into a hospital setting than if she stayed there the entire time, as she'd hoped.

Though glad she had those hour-long daily visits, she wrestles with not being able to comfort Scottie all those hours when he was without her.

"He would just look at me, and I know he was thinking, 'why is Momma leaving me?'" Velvet Gammons said about those visits.

Gammons, who is a registered nurse with 30 years of experience, also wonders if Scottie would have survived his hospital stay had she been there. She contends hospital staff misinterpreted scar tissue on Scottie's lungs from prior issues as a current bout with pneumonia and failed to properly treat the gallbladder issues that prompted the five-day hospital stay.

The parents of 26-year-old Landon Walker of Wilkes County faced similar issues when their son needed to be airlifted to Wake Forest Baptist late last month after low blood sodium levels brought on seizures.

Walker suffered traumatic brain injuries from an ATV accident at 17, leaving him completely dependent on his parents, Tracie and Randy Walker, with medical complications that required around-the-clock care. Landon is unable to talk or walk and uses a ventilator at night to breathe while an overnight nurse sits with him to ensure he's safe while his parents sleep.

"We are his voice in every sense of the word, in every aspect of his life," Tracie Walker said.

Wake Forest Baptist staff would not let either of his parents join him during this four-day stay at the hospital, citing the visitor restrictions enacted to keep the spread of COVID-19 low in the hospital, Tracie Walker said. He's now back at the family's home recuperating.

Nurses at Wake Forest Baptist accommodated the family as best they could, Walker said, setting up Zoom conference calls several times a day. It was during one of those calls she noticed there was no equipment in the hospital room for Landon's daily chest compression therapies, which help prevent pneumonia or other complications he faces from being prone and on ventilators for several hours a day.

"We're going to have another problem if we don't get that equipment in there," Walker said she relayed to Wake Forest Baptist staff after noticing the issue on Zoom.

She's grateful that they were able to get Landon discharged and back home, knowing that a normal hospital stay can be challenging for Landon and other disabled individuals even before COVID-19 added more layers of complications.

Nonetheless, Walker worries about what they might face if he or others with similar needs have to be hospitalized again and aren't able to have caregivers with them.

"This is a much more stressful time because of COVID," she said.

See photo of Landon Walker with his father Randy during a hospital stay prior to COVID-19 on the following page. (Photo courtesy of Walker family)



SENATE HEALTH COMMITTEE

North Carolina Amended Plan Community Services Block Grant FFY 2019-2020

Tara Myers

Department of Health and Human Services

June 9, 2020

Requirements

- Federal Law (Sec. 676 of the Community Opportunities, Accountability, And Training And Educational Services Act Of 1998; Public Law 105-285) requires one hearing in the State and at least one legislative hearing every three years in conjunction with development of the state plan.

CSBG Service Delivery System

- Composed of 33 Community Action Agencies (CAAs)

https://www.ncdhhs.gov/csbg-contacts

- Assist individuals and families with moving from poverty to economic independence

- Serves all 100 Counties in North Carolina

Governance

- Required Tripartite Board Structure:
  - Offers opportunity for the low-income population, public elected officials (or representatives) and private sector representatives to work together for the oversight, development, and evaluation of community programs.

Changes to State Plan

- Use discretionary funding in accordance with 10A NCAC 97C.0108(3) by developing programs for preparation or recovery efforts related to natural disasters (i.e. hurricanes, tornado's, flooding etc.).

- After consideration of necessary allocations for natural disasters, funds may be allocated for technology systems or to eligible entities for innovative projects.

Monitoring & Accountability

Monitoring begins with the annual funding application and continues through the closeout of each grant year.

- On-site reviews occur:

  1. After completion of first year;

  2. As needed based on requirements and/or compliance issues; and

  3. Every three years as mandated

Results

- 63,297 unduplicated persons serve
- 34,311 unduplicated families served
- With support of Community Action Agencies, the average income of clients increased to $10.72 or 40% more than the state minimum wage of $7.25
- Average income change of families with the support of Community Action Agencies increased to $12,400 yearly (this is an average on all households including single and multi-members in households)

SFY 2018-19 Outcome Achievement for CSBG Self-Sufficiency Programs

Families receiving services	10,077
Families rising above the poverty level	454
Families obtaining employment	761
Families obtaining better employment	330
The average change in annual income	$12,400
The average wage rate	$10.72
Families obtaining jobs with medical benefits	240
Families completing education/training programs	762
Families securing standard housing	375
Families provided employment support	1,086
Families provided education support	1,112
Families provided emergency assistance	2,565

Questions

North Carolina Plan for Administering Community Services Block Grant Program FFY 2019 and 2020

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Speaker, Sign-in

Health Care, Senate Committee

2 min. time limit

06/09/2020

SPEAKERS, LEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
Suzanne Warfield	Personal
Cathy Dula	Personal
Donna ~~McGuire~~ McGuire	Personal
Ken Sharpe	NO PATIENTS LEFT HOME
Kay Sharpe	No Patients left alone
2nd Leah Byers. Yes	NCHA
Thurs @ 10 6 ft	
Representative: Michele Presnell	

Ken Davis

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Visitors, Sign-in

Health Care, Senate Committee

06/09/2020

PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
Reaghan Waites	NC Values
KEN SHARPE	SEN. DANIELS
RAY SHARPE	SEN DANIELS
Darrel Powers	PS, CCC
Joe Ryall	NCFPC
Matt Ryall	DHHS
Jackson Shandel	JSC
	LCA
Daniel Baum	Truveta Studies
	NVA

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Visitors, Sign-in

Health Care, Senate Committee

06/09/2020

PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
Regina McGuire	personal
Suzanne Warfield	personal
Donna McGuire	Personal
Cathy Dula	Personal
Nathan Honaker	Connect C
John Cooper	Connect C
Leah Burns	NCHA
Andy Mann	EQV
Ruth Johnson	Well-Med
Ross Reed	NP
Chris Wall	EQV

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Health Care, Senate Committee

June 09, 2020 1:00 PM Rm. 643

Senate Sergeant-at-Arms

Terry Barnhardt

Dwight Green

Charles Harper

Frances Patterson

John Enloe

Senate Committee on Health Care
Thursday, June 11, 2020 at 10:00 AM
Room 643 of the Legislative Office Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 11, 2020 in Room 643 of the Legislative Office Building. Thirteen members were present.

Senator Joyce Krawiec, Chair, presided.

Sen. Krawiec gave welcoming remarks and introduced the Sargent of Arms.

SB 730 The No Patient Left Alone Act. (Senators Daniel, Perry, Krawiec)
Sen. Krawiec announced that the proposed committee substitute (PCS) was still before the committee as amended. Sen. Daniel was introduced to make comments on the bill. Sen. Perry was recognized to bring forth Amendment #1 which he explained. Questions from the members were responded to by Sen. Perry. A motion was made to adopt Amendment #1 and it carried. Sen. Perry was recognized to bring forth Amendment #2 which he explained. Questions from the members were responded to by Sen. Perry and Sen. Daniel. A motion was made to adopt the amendment and it carried. Sen. Krawiec announced that the PCS was now before the committee as amended. Sen. Daniels was given the floor to offer further comments. Questions from the members were responded to by Sen. Daniel and Theresa Matula. Sen. Krawiec allowed comments from the public. They spoke in the below order.

1. Leah Burns representing the North Carolina Hospital Association
2. Carlton Page who is a parent of a patient

Sen. Burgin motioned unfavorable to the bill – favorable to the PCS as amended – rolled into a new PCS and it carried.

The meeting adjourned at 10:51 AM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Krawiec, Chair

Thursday, June 11, 2020

Senator Krawiec,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

SB **730** The No Patient Left Alone Act.

Draft Number:	S730-PCS45482-SHa-38
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Warren Daniel will handle SB 730



Senate Committee on Health Care
Thursday, June 11, 2020, 10:00 AM
643 Legislative Office Building

AGENDA

Welcome and Opening Remarks

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 730	The No Patient Left Alone Act.	Senator Daniel Senator Perry Senator Krawiec

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S D

SENATE BILL 730
PROPOSED COMMITTEE SUBSTITUTE S730-CSSHa-38 [v.4]
06/08/2020 03:14:19 PM

Short Title: The No Patient Left Alone Act. (Public)

Sponsors:

Referred to:

May 14, 2020

A BILL TO BE ENTITLED

AN ACT PROVIDING PATIENT VISITATION RIGHTS THAT WILL NOT BE IMPACTED DURING DECLARED DISASTERS AND EMERGENCIES; AND APPROPRIATING FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, TO DEVELOP AND DISSEMINATE TO HOSPITALS FREE INFORMATIONAL MATERIALS EXPLAINING THESE RIGHTS.

Whereas, the COVID-19 pandemic has caused great uncertainty and anxiety across our State and has significantly affected the medical community, including hospitals; and

Whereas, hospitals have made many efforts to keep patients and employees in a safe environment, and have endeavored to minimize, to the extent possible, the risk of spread of the coronavirus disease; and

Whereas, as a result of COVID-19 prevention measures, many unintended consequences have occurred to hospital patients who were not diagnosed with COVID-19; and

Whereas, the General Assembly has become aware of numerous patients across our State who were not diagnosed with COVID-19, but as a result of hospital visitation policies have been prohibited from having any visitors, including a spouse, parent, close family member, guardian, health care agent, or caregiver; and

Whereas, as a result, many patients not diagnosed with COVID-19 have been forced to be alone during their treatment for serious conditions, traumas, illnesses, heart attacks, and routine and emergency surgeries; and

Whereas some of these patients have been forced to be alone for the entire course of their treatment, and in some cases have died alone; and

Whereas, many families have been unable to be physically present with their loved ones while in the hospital setting and have been limited to electronic video communications, if any, with the patient; and

Whereas, the patients who have been affected in the above-described manner have included adults, minors, and individuals with intellectual or developmental disabilities; and

Whereas, the General Assembly finds that it is in the interest of the State and its residents that hospital patients be allowed at least one immediate family member, designated health care agent, guardian, or person standing in loco parentis physically present at reasonable times throughout the hospitalization; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as "The No Patient Left Alone Act."

SECTION 2. Article 5 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-79.3. Patient visitation rights during a disaster declaration or public health emergency.**

(a) During a period in which a disaster, emergency, or public health emergency has been declared, a hospital licensed under this Article shall ensure the opportunity for at least one visitor to visit a patient admitted to a facility. This visitation shall be subject to the guidelines, conditions, and limitations of the normal visitation policy.

(b) One parent, guardian, or person standing in loco parentis shall be allowed the opportunity to visit a minor patient admitted to a facility licensed under this Article. This visitation shall be subject to the guidelines, conditions, and limitations of the normal visitation policy. When the visitor cannot be in the room with the patient due to a medical procedure or other reason, the visitor shall have access to a waiting area.

(c) One immediate family member or designated health care agent shall have the opportunity to visit an adult patient admitted to a facility licensed under this Article. This visitation shall be subject to the guidelines, conditions, and limitations of the normal visitation policy. When the visitor cannot be in the room with the patient due to a medical procedure or other reason, the visitor shall have access to a waiting area. For purposes of this subsection, the term "immediate family member" means a spouse, child, sibling, parent, grandparent, grandchild, or the spouse of an immediate family member and the term includes stepparents, stepchildren, stepsiblings, and adoptive relationships.

(d) Notwithstanding the provisions of G.S. 131E-112, Chapter 166A of the General Statutes, or any other provision of law to the contrary, the visitation rights specified in this section may not be terminated, suspended, or waived by the hospital, the Department of Health and Human Services, or the Governor upon the declaration of a disaster or emergency under Article 1A of Chapter 166A of the General Statutes.

(e) No hospital licensed under this Article may require a patient to waive the visitation rights specified in this section.

(f) A hospital licensed under this Article may require a visitor to submit to health screenings necessary to prevent the spread of infectious diseases and may require a visitor to adhere to infection control procedures including wearing personal protective equipment.

(g) Each hospital licensed under this Article shall post in a conspicuous place on the licensed premises informational materials developed by the Department of Health and Human Services explaining the rights specified in this section."

SECTION 3. The Department of Health and Human Services, Division of Health Service Regulation, shall develop and disseminate to hospitals licensed under Article 5 of Chapter 131E of the General Statutes free informational materials explaining the rights specified in G.S. 131E-79.3, as enacted by Section 2 of this act.

SECTION 4. There is appropriated to the Department of Health and Human Services, Division of Health Service Regulation, the sum of five thousand dollars ($5,000) for the 2019-2020 fiscal year, to develop and disseminate to hospitals licensed under Article 5 of Chapter 131E of the General Statutes free informational materials about the patient rights specified in G.S. 131E-79.3, as enacted by Section 2 of this act.

SECTION 5. This act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 730

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S730-ASH-42 [v.2]

Amends Title [NO]
S730-CSSHa-38

Date _____,2020

Senator _____

moves to amend the bill on page 2, lines 7-8, by rewriting the lines to read:

"(b) In the event a minor is admitted to a hospital licensed under this Article, at least one parent, guardian, or person standing in loco parentis shall be allowed the opportunity to visit and to be present while the minor patient is receiving hospital care. If a custody order or written child custody agreement is in place, the custody order or written child custody agreement shall control. This".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

SENATE BILL 730:
The No Patient Left Alone Act.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Appropriations/Base Budget. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 8, 2020
Introduced by:	Sens. Daniel, Perry, Krawiec	**Prepared by:**	Theresa Matula Legislative Analyst
Analysis of:	PCS to First Edition S730-CSSHa-38		

OVERVIEW: The Proposed Committee Substitute for SB 730 would enact the No Patient Left Alone Act to ensure visitation rights for hospital patients during a disaster declaration or public health emergency.

BILL ANALYSIS: The PCS for SB 730 contains the "The No Patient Left Alone Act" which ensures the visitation rights of hospital patients during a period in which a disaster, emergency, or public health emergency has been declared.

Section 2 amends Chapter 131E, Article 5. Hospital Licensure Act, to add a new section [G.S. 131E-79.3] requiring a hospital to ensure the opportunity for at least one visitor to visit a patient admitted to a facility. The contents of each subsection of the new statute is outlined below.

- Subsection (b) pertains to visitation of minors and allows one parent, guardian, or person standing in loco parentis the opportunity to visit a minor patient.
- Subsection (c) pertains to visitation of adults and allows an immediate family member or designated health care agent the opportunity to visit an adult patient admitted to a facility. The term "immediate family member" is defined as a spouse, child, sibling, parent, grandparent, grandchild, or the spouse of an immediate family member and includes stepparents, stepchildren, stepsiblings, and adoptive relationships.
- Both subsections (b) and (c) provide that the visitation is subject to the guidelines, conditions, and limitations of the normal visitation policy and when the visitor cannot be in the room with the patient due to a medical procedure or other reason, the visitor must have access to a waiting area.
- Subsection (d) notwithstands the law [G.S. 131E-112] allowing the waiver of rules for health care facilities that provide temporary shelter or temporary services during a disaster or emergency, the contents of the North Carolina Emergency Management Act [Chapter 166A], or any law to the contrary, to provide that the visitation rights may not be terminated, suspended or waived by the hospital, the Department of Health and Human Services, or the Governor upon the declaration of a disaster or emergency under Article IA of Chapter 166A.
- Subsection (e) prohibits a hospital from requiring a patient to waive their visitation rights.
- Subsection (f) allows a hospital to require a visitor to submit to health screenings necessary to prevent the spread of infections diseases and to require a visitor to adhere to infection control procedures including wearing personal protective equipment.

- Subsection (g) requires the Department of Health and Human Services (DHHS) to develop informational materials explaining the rights allowed by the act and requires each hospital to post the materials in a conspicuous place.

Sections 3 requires the Division of Health Service Regulation, DHHS, to develop and disseminate the free informational materials explaining the visitation rights provided by the bill.

Section 4 appropriates $5,000 for the 2019-2020 fiscal year to the Division of Health Service Regulation, DHHS, to develop and disseminate the materials explaining the visitation rights.

EFFECTIVE DATE: The bill would become effective when it becomes law.

SENATE BILL 730

Short Title:	The No Patient Left Alone Act.	(Public)
Sponsors:	Senators Daniel, Perry, and Krawiec (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

May 14, 2020

A BILL TO BE ENTITLED

AN ACT PROVIDING FOR CERTAIN UNRESTRICTED HOSPITAL PATIENT RIGHTS THAT WILL NOT BE IMPACTED DURING DECLARED DISASTERS AND EMERGENCIES; AND APPROPRIATING FUNDS TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF HEALTH SERVICE REGULATION, TO DEVELOP AND DISSEMINATE TO HOSPITALS FREE INFORMATIONAL MATERIALS EXPLAINING THESE RIGHTS.

The General Assembly of North Carolina enacts:

SECTION 1. This act shall be known as "The No Patient Left Alone Act."

SECTION 2. Article 5 of Chapter 131E of the General Statutes is amended by adding a new section to read:

"**§ 131E-79.3. Visitation rights of hospital patients.**

(a) Each minor who is admitted to a hospital licensed under this Article has the right to designate a parent, guardian, or person standing in loco parentis who shall have the unrestricted privilege of being present while the minor patient is receiving hospital care.

(b) Each adult who is admitted to a hospital licensed under this Article has the right to designate a spouse or health care agent who shall have the unrestricted privilege of being present while the adult patient is receiving hospital care.

(c) Notwithstanding the provisions of G.S. 131E-112, Chapter 166A of the General Statutes, or any other provision of law to the contrary, the rights specified in this section may not be terminated, suspended, or waived by the hospital, the Department of Health and Human Services, or the Governor upon the declaration of a disaster or emergency under Article 1A of Chapter 166A of the General Statutes.

(d) No hospital licensed under this Article may require a patient to waive the rights specified in this section.

(e) Each hospital licensed under this Article shall post in a conspicuous place on the licensed premises informational materials developed by the Department of Health and Human Services explaining the rights specified in this section."

SECTION 3. The Department of Health and Human Services, Division of Health Service Regulation, shall develop and disseminate to hospitals licensed under Article 5 of Chapter 131E of the General Statutes free informational materials explaining the rights specified in G.S. 131E-79.3, as enacted by Section 1 of this act.

SECTION 4. There is appropriated to the Department of Health and Human Services, Division of Health Service Regulation, the sum of five thousand dollars ($5,000) for the 2019-2020 fiscal year, to develop and disseminate to hospitals licensed under Article 5 of

Chapter 131E of the General Statutes free informational materials about the patient rights specified in G.S. 131E-79.3, as enacted by Section 1 of this act.

SECTION 5. This act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 730

AMENDMENT NO. 1
(to be filled in by
Principal Clerk)

S730-ASH-46 [v.2]

Amends Title [NO]
S730-CSSHa-38

Date _____,2020

Senator _____

moves to amend the bill on page 2, line 16, by rewriting the line to read:

"other reason, the visitor shall have access to a waiting area. If the patient has the capacity to make decisions, the patient may designate the one visitor. For purposes of this subsection, the".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 730

AMENDMENT NO. 2
(to be filled in by Principal Clerk)

S730-ASH-45 [v.1]

Amends Title [NO]
S730-CSSHa-38

Date _____,2020

Senator _____

moves to amend the bill on page 2, lines 28-29, by rewriting the lines to read:

"screenings necessary to prevent the spread of infectious diseases and notwithstanding anything to the contrary in this section, a hospital may restrict a visitor who does not pass the screening requirement or who has tested positive for an infectious disease. A hospital may require a visitor to adhere to infection control procedures including wearing personal protective equipment.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Visitors, Sign-in

Health Care, Senate Committee

10:1 AM

06/11/2020

PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY / BILL No.
David Powers	PS, LLC
Lori Kroll	Mission
Andy Munn	EQV
Leah Burns	NCHA
Ryan Blackledge	Conn Health
Mary Gross	DHHS
Ken Melton	KMA
Betsy McCorkle	KGANC
Ross Burnhardt	NP
Mary Shuping	NCGS
Chris Anderson	

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Speaker, Sign-in

Health Care, Senate Committee

6/11/2020

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY / BILL No.
Leah Burns	NCHA
Caulton Page	Parent

test - 2-3 hrs.
results - some hospitals are already. Med. professionals have called me

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee On Health Care

June 11, 2020

Room 643, LOB – 10:00 AM

Senate Sergeant at Arms:

~~JOHN ENLOE~~

~~BILLY FRITSCHER~~

DWIGHT GREEN

JIM HAMILTON

FRANK URBEN

FRANCES ROBERSON

LINDA MATTHEWS

TERRY EDMONDSON

Senate Committee on Health Care
Wednesday, June 17, 2020 at 10:00 AM
Room 1027/1128 of the Legislative Building

MINUTES

The Senate Committee on Health Care met at 10:00 AM on June 17, 2020 in Room 1027/1128 of the Legislative Building. Fourteen members were present.

Senator Joyce Krawiec, Chair, presided.

Sen. Krawiec made opening remarks and introduced the Sargent of Arms.

SB 708 CPS Intake Screening/PED Recommendations. (Senators Edwards, Krawiec, Burgin)

Sen. Edwards was introduced to explain the bill. Sen. Hise brought forth three amendments and Sen. Edwards explained each one. After the first amendment was introduced there where many questions from the members. Sen. Edwards and Twanda Artis an attorney from the Legislative Division answered their questions. There was none with the second and third amendment. After each amendment, there was a motion made by the chair to adopt the amendments and all three carried. Dr. Kevin Marino from the Henderson County Department of Social Services/Real Academy spoke before the committee in support of the bill. Sen. Jim Davis made the motion – unfavorable to the original bill – favorable to the bill as amended – rolled into a proposed committee substitute and it carried.

The meeting adjourned at 10:53 AM.

Senator Joyce Krawiec, Chair
Presiding

Debbie Lown, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Krawiec, Chair

Wednesday, June 17, 2020

Senator Krawiec,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO COMMITTEE SUBSTITUTE BILL

SB **708** CPS Intake Screening/PED Recommendations.

Draft Number:	S708-PCS45487-TV-59
Sequential Referral:	Rules and Operations of the Senate
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Senator Joyce Krawiec will handle SB 708

Senate Committee on Health Care
Wednesday, June 17, 2020, 10:00 AM
1027/1128 Legislative Building

AGENDA

Welcome and Opening Remarks

Bills

BILL NO.	SHORT TITLE	SPONSOR
SB 708	CPS Intake Screening/PED Recommendations.	Senator Edwards Senator Krawiec Senator Burgin

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2019

S 1

SENATE BILL 708*

Short Title:	CPS Intake Screening/PED Recommendations.	(Public)
Sponsors:	Senators Edwards, Krawiec, and Burgin (Primary Sponsors).	
Referred to:	Rules and Operations of the Senate	

May 1, 2020

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT COUNTY DEPARTMENTS OF SOCIAL SERVICES FROM IMPLEMENTING CHILD PROTECTIVE SERVICES INTAKE SCREENING CRITERIA THAT IS MORE STRINGENT THAN, OR IN ADDITION TO, STATE POLICY AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO MAKE VARIOUS POLICY CHANGES AS A MEANS TO IMPROVE THE CHILD PROTECTIVE SERVICES INTAKE SCREENING PROCESS, AS RECOMMENDED BY THE JOINT LEGISLATIVE PROGRAM EVALUATION OVERSIGHT COMMITTEE.

The General Assembly of North Carolina enacts:

SECTION 1. Prohibit County Supplementation of State Policy. – Article 3 of Chapter 7B of the General Statutes is amended by adding a new section to read:

"**§ 7B-300.1. No county supplementation of certain State policy.**

Notwithstanding any other provision of law to the contrary, a county department of social services may not supplement child protective services intake screening criteria with county policy that is more stringent than, or in addition to, State policy."

SECTION 2.(a) Rapid Consultation System. – As a means of improving State child protective services intake screening guidance to county departments of social services, the Department of Health and Human Services, Division of Social Services (Division), shall implement a rapid consultation system to provide consultation to counties when making decisions regarding the safety of children. Specifically, the rapid consultation system shall consist of a telephone line that a county worker or supervisor can access at any time when the county worker or supervisor has concerns regarding the correct screening decision, assessment track, or applicable response time frame for a specific case. Upon receiving a request, Division staff shall consult with the county department of social services within 24 hours of receipt of the request and at least two Division staff workers shall consult on each call to ensure the advice conveyed is consistent.

SECTION 2.(b) Report. – The Division of Social Services shall implement the rapid consultation system required by this section no later than June 30, 2021, and submit a report on its implementation to the Joint Legislative Oversight Committee on Health and Human Services by December 31, 2021.

SECTION 3.(a) Assessment of Worker Comprehension and Training Needs. – The Department of Health and Human Services, Division of Social Services (Division), shall periodically assess county department of social services workers' and supervisors' comprehension and correct implementation of State policy and their training needs regarding the screening of reports of alleged child maltreatment. The Division shall assess comprehension and training needs by use of hypothetical vignettes or other assessment tools the Division deems appropriate

and, when necessary, require retraining for workers to ensure proper application of State policies regarding the screening of reports of alleged child maltreatment. Additionally, the Division shall do the following:

(1) Increase the frequency of intake training.
(2) Develop an intermediate intake screening course that bridges the gap between newer workers and those that are more experienced.
(3) Require county social services workers and supervisors to complete an intake screening training at least every three years.

SECTION 3.(b) Report. – The Division of Social Services shall implement the assessment and training requirements of this section by December 31, 2020, and submit a report on its use of those training requirements to the Joint Legislative Oversight Committee on Health and Human Services by June 30, 2021.

SECTION 4.(a) Structured Intake Form Revisions. – The Department of Health and Human Services, Division of Social Services (Division), in consultation with the Children's Research Center or a similar organization, shall revise the child protective services structured intake form, which is a tool county departments of social services use to screen reports of alleged child maltreatment. The Division shall revise the form to ensure, at a minimum, it (i) continues to meet federal and State requirements and (ii) provides consistency for use statewide. The Division shall further ensure the structured intake form is recertified every five years and shall continue to consult with the Children's Research Center or a similar organization when State policy changes require modifications to the structured intake form.

SECTION 4.(b) Report. – Beginning July 30, 2020, the Division of Social Services shall report to the Joint Legislative Oversight Committee on Health and Human Services (Committee) on its process of revising the structured intake form in accordance with this section and continue reporting to the Committee every six months thereafter until revisions are complete.

SECTION 5.(a) Program Monitoring. – For purposes of better evaluating individual county departments of social services, the Department of Health and Human Services, Division of Social Services (Division), shall implement statistically valid program monitoring for county intake screening procedures, as well as establish measurable performance benchmarks. The Division shall establish measurable and consistent intake screening benchmarks that can be applied to all counties, with the Division performing county data reviews for intake screening at least once each year beginning no later than December 31, 2024. The Division shall oversee intake screening by performing valid sampling and ensure program monitoring intake screening reviews collect sample sizes large enough to achieve a county confidence level of at least ninety percent (90%), with a margin of error of plus or minus five percent (5%).

SECTION 5.(b) Report. – Beginning June 30, 2021, and continuing each year thereafter until December 31, 2024, the Division of Social Services shall report to the Joint Legislative Oversight Committee on Health and Human Services on its progress towards improved program monitoring and continuous quality improvement in accordance with this section.

SECTION 6. Effective Date. – This act is effective when it becomes law.

SENATE BILL 708:
CPS Intake Screening/PED Recommendations.

2019-2020 General Assembly

Committee:	Senate Health Care. If favorable, re-refer to Rules and Operations of the Senate	**Date:**	June 17, 2020
Introduced by:	Sens. Edwards, Krawiec, Burgin	**Prepared by:**	Tawanda F. Artis Staff Attorney
Analysis of:	First Edition		

OVERVIEW: Senate Bill 708 prohibits county departments of social services from implementing child protective services intake screening criteria that is more stringent than, or in addition to State policy and directs the Department of Health and Human Services to make various policy changes as a means to improve the child protective services intake screening process, as recommended by the Joint Legislative Program Evaluation Oversight Committee.

[As introduced, this bill was identical to S708, as introduced by Sens. Edwards, Krawiec, Burgin, which is currently in Senate Judiciary.]

BACKGROUND: The Program Evaluation Division (PED), as a part of its 2018-2019 Work Plan, studied the effectiveness of the child protective screening process used by county departments of social services to determine whether there are differences in how counties screen the need for a child protection response. Generally, county social services workers screen allegations of child abuse, neglect, and dependency and decide if a more in-depth assessment should be conducted. County social services offices in North Carolina vary substantially in the rates of initial referrals that are screened in or out. DSS directors surveyed by PED attributed this variation to differing local policies, lack of staff familiarity with intake screening procedures, and an absence of consistent and timely central guidance by the Department of Health and Human Services (DHHS). PED's study concluded that the current structured intake tool makes the reporting process lengthy and redundant and may also contribute to screening inconsistency. Senate Bill 708 reflects the recommendations from this study. The full study may be found online here: https://www.ncleg.gov/PED/Reports/documents/CPS/CPS_Report.pdf

CURRENT LAW: Article 3 of Chapter 7B of the General Statutes governs the screening of abuse, neglect, and dependency complaints. G.S. 7B-300 requires the director of the department of social services in each county of the State to establish protective services for juveniles alleged to be abused, neglected, or dependent.

Protective services must include the screening of reports, the performance of an assessment using either a family assessment response or an investigative assessment response, casework, or other counseling services to parents, guardians, or other caretakers as provided by the director to help the parents, guardians, or other caretakers and the court to prevent abuse or neglect, to improve the quality of child care, to be more adequate parents, guardians, or caretakers, and to preserve and stabilize family life.

This bill analysis was prepared by the nonpartisan legislative staff for the use of legislators in their deliberations and does not constitute an official statement of legislative intent.

BILL ANALYSIS:

Section 1 adds a new section to current law on the screening of abuse and neglect complaints to clarify county social services departments cannot supplement child protective services intake screening criteria with county policy that is more stringent than, or in addition to, State policy.

Section 2(a) requires DHHS to implement a rapid consultation system to provide consultation to counties when making decisions regarding the safety of children.

- The rapid consultation system will consist of a telephone line that can be accessed at any time when the county has concerns regarding the correct screening decision, assessment track, or applicable response time frame for a specific case.
- DHHS staff will consult with the county department of social services within 24 hours of the call.
- At least two DHHS staff persons will consult on each call to ensure the advice conveyed is consistent.

Section 2(b) requires DHHS, Division of Social Services to implement the rapid consultation system no later than June 30, 2021, and submit a report on its implementation to the Joint Legislative Oversight Committee on Health and Human Services by December 31, 2021.

Section 3(a) requires the Division to periodically assess county department of social services workers' and supervisors' comprehension and correct implementation of State policy and their training needs regarding the screening of reports of alleged child abuse, neglect and dependency.

Section 3(b) requires the Division implement the assessment and training requirements of this section by December 31, 2020, and submit a report on its use of those training requirements to the Joint Legislative Oversight Committee on Health and Human Services by June 30, 2021.

Section 4(a) requires the Division to revise the child protective services structured intake form (a tool used by county departments of social services to screen reports of alleged child abuse, neglect, and dependency) to ensure the following:

1) It continues to meet federal and State requirements, and
2) It provides consistency for use statewide.

DHHS must recertify the structured intake form every five years and must continue to consult with the Children's Research Center or a similar organization when State policy changes require modifications to the structured intake form.

Section 4(b) requires the Division to begin reporting to the Joint Legislative Oversight Committee on Health and Human Services on its process of revising the structured intake form by July 30, 2020 and continue reporting to the Committee every six months thereafter until revisions are complete.

Section 5(a) requires the Division to implement statistically valid program monitoring for county intake screening procedures, as well as establish measurable performance benchmarks that can be applied to all counties. The Division must do the following:

- Begin performing county data reviews for intake screening at least once each year beginning no later than December 31, 2024.

- Oversee intake screening by performing valid sampling and ensure program monitoring intake screening reviews collect sample sizes large enough to achieve a county confidence level of at least ninety percent (90%), with a margin of error of plus or minus five percent (5%).

Section 5(b) requires the Division, beginning June 30, 2021, and continuing each year thereafter until December 31, 2024, to report to the Joint Legislative Oversight Committee on Health and Human Services on its progress towards improved program monitoring and continuous quality improvement in accordance with this section.

EFFECTIVE DATE: This act would become effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 708*

AMENDMENT NO. _____
(to be filled in by Principal Clerk)

S708-ATV-80 [v.6]

Amends Title [YES]
First Edition

Date _____, 2020

Senator Hise

moves to amend the bill on page 1, line 5, by deleting the period and inserting the following:
"AND TO ALLOW LEGISLATORS ACCESS TO CONFIDENTIAL ADULT PROTECTIVE SERVICES AND CHILD PROTECTIVE SERVICES RECORDS.";

And page 2, lines 40-41, by inserting between the lines:

"**SECTION 5.1.(a)** G.S. 108A-80 reads as rewritten:

"**§ 108A-80. Confidentiality of records.**

(a) Except as provided in subsections ~~(b) and (b1)~~ (b), (b1), and (b2) of this section, it shall be unlawful for any person to obtain, disclose or use, or to authorize, permit, or acquiesce in the use of any list of names or other information concerning persons applying for or receiving public assistance or social services that may be directly or indirectly derived from the records, files or communications of the Department or the county boards of social services, or county departments of social services or acquired in the course of performing official duties except for the purposes directly connected with the administration of the programs of public assistance and social services in accordance with federal law, rules and regulations, and the rules of the Social Services Commission or the Department.

(b) The Department shall furnish a copy of the recipient check register monthly to each county auditor showing a complete list of all recipients of Work First Family Assistance in Standard Program Counties and State-County Special Assistance, their addresses, and the amounts of the monthly grants. An Electing County whose checks are not being issued by the State shall furnish a copy of the recipient check register monthly to its county auditor showing a complete list of all recipients of Work First Family Assistance in the Electing County, their addresses, and the amounts of the monthly payments. These registers shall be public records open to public inspection during the regular office hours of the county auditor, but the registers or the information contained therein may not be used for any commercial or political purpose. ~~Any violation of this section shall constitute a Class 1 misdemeanor.~~

(b1) The Department may share confidential information concerning a person receiving public assistance or social services with a local school administrative unit and with the Department of Public Instruction. Disclosure is limited to that information necessary to establish, coordinate, or maintain appropriate educational services for the person receiving public assistance or social services.

(b2) Except where prohibited by federal law and notwithstanding other applicable state law, a member of the North Carolina General Assembly may request access to confidential social services information and records from the Department or from a local department of social services when necessary for oversight of programs related to child protective services or adult protective services. Upon receiving a request from a member of the North Carolina General Assembly pursuant to this subsection, the Department or a local department of social services shall disclose confidential information and records concerning adult protective services and child protective services cases to the requesting member. A member of the North Carolina General Assembly may not retain copies of any part of the record, and all information shared pursuant to this subsection shall be withheld from public inspection and maintained in a confidential manner.

(c) Any listing of recipients of benefits under any public assistance or social services program compiled by or used for official purposes by a county board of social services or a county department of social services shall not be used as a mailing list for political purposes. This prohibition shall apply to any list of recipients of benefits of any federal, State, county or mixed public assistance or social services program. Further, this prohibition shall apply to the use of such listing by any person, organization, corporation, or business, including but not limited to public officers or employees of federal, State, county, or other local governments, as a mailing list for political purposes. ~~Any violation of this section shall be punishable as a Class 1 misdemeanor.~~

(c1) A violation of subsections (a), (b), (b1), (b2), or (c) of this section shall be punishable as a Class 1 misdemeanor.

(d) The Social Services Commission may adopt rules governing access to case files for social services and public assistance programs, except the Medical Assistance Program. The Secretary of the Department of Health and Human Services shall have the authority to adopt rules governing access to medical assistance case files."

SECTION 5.1.(b) This section becomes effective on October 1, 2021, and applies to all requests for information and records in adult protective services and child protective services cases made by members of the North Carolina General Assembly on or after that date.

And moves to amend the bill on page 2, line 41, by rewriting the line to read:

"**SECTION 6.** Effective Date. – Except as otherwise provided, this act is effective when it becomes law.".

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 708*

AMENDMENT NO. 1
(to be filled in by Principal Clerk)

S708-ATV-80 [v.6]

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 708*

AMENDMENT NO. 2
(to be filled in by Principal Clerk)

S708-ATV-79 [v.4]

Amends Title [YES]
First Edition

Date _____,2020

Senator Hise

moves to amend the bill on page 1, line 4, by rewriting the line to read:
"THAT IS MORE STRINGENT OR LENIENT THAN, OR IN ADDITION TO, STATE POLICY AND TO";

And on page 1, line 10, by rewriting the line to read:
"**SECTION 1.** This act shall be known and may be cited as "The CPS Revitalization Act/A Law for Lyn."
SECTION 1.1. Prohibit County Supplementation of State Policy. – Article 3 of";

And on page 1, line 15, by rewriting the line to read:
"policy that is more stringent or lenient than, or in addition to, State policy."";

And on page 1, lines 21, by deleting the words "worker or supervisor" and substituting the words, "director or their designee";

And on page 1, line 22, by deleting the words "worker or supervisor";

And on page 1, line 35 through page 2, line 8, by rewriting the lines to read:
"reports of alleged child abuse, neglect, and dependency. The Division shall assess comprehension and training needs by use of hypothetical vignettes or other assessment tools the Division deems appropriate. Every three years, the Division shall require retraining for all child welfare workers, including supervisors and other workers who occasionally screen child abuse, neglect and dependency reports. The Division shall also require all child welfare supervisors to pass a competency pass/fail test prior to providing screening decisions or On Call duties.";

And on page 2, line 17, by deleting the word "maltreatment" and substituting the words, "abuse, neglect, and dependency".

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 708*

AMENDMENT NO. 2
(to be filled in by Principal Clerk)

S708-ATV-79 [v.4]

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 708*

AMENDMENT NO. 3
(to be filled in by
Principal Clerk)

S708-ATV-84 [v.2]

Amends Title [YES]
First Edition

Date _____,2020

Senator Hise

moves to amend the bill on page 1, line 5, by deleting the period and inserting the following:
"AND TO AUTHORIZE THE PROGRAM EVALUATION DIVISION TO STUDY THE FEASIBILITY AND EFFECTIVENESS OF IMPLEMENTING A CHILD WELFARE SIMULATION TRAINING AND CERTIFICATION PROGRAM.";

And on page 2, lines 40-41, by inserting between the lines:

"**SECTION 5.5.(a)** The Program Evaluation Division, in consultation with the Department of Health and Human Services, the Realistic Environments to Aid Learning (R.E.A.L) Academy, and Western Carolina University, shall study the feasibility and effectiveness of implementing a simulation training and certification program similar to the Realistic Environments to Aid Learning (R.E.A.L.) training pilot program. All parties shall cooperate with the Program Evaluation Division in conducting this study, including providing information on current training practices, policies, and budgets. In conducting this study, the Program Evaluation Division shall consider, among other things, the following:

(1) Current child welfare training standards and statutory requirements.
(2) Department of Health and Human Services policies regarding child welfare training.
(3) Methods used to implement or integrate simulation models of training in child welfare training in other States.
(4) Minimum standards of competence required to receive certification from a child welfare simulation training program.
(5) Effectiveness and feasibility of the pilot project, Realistic Environments to Aid Learning (R.E.A.L.) training, in use in Buncombe, Cherokee, Clay, Graham, Haywood, Henderson, Jackson, Macon, Swain, and Transylvania counties.
(6) Methods for expanding the R.E.A.L training pilot project to all North Carolina counties.
(7) Potential cost of implementation of a child welfare simulation training program in this State.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 708*

AMENDMENT NO. 3
(to be filled in by
Principal Clerk)

S708-ATV-84 [v.2]

SECTION 5.5.(b) By April 1, 2021, the Program Evaluation Division shall report the findings of its study and any recommendations for proposed legislation to the Joint Legislative Oversight Committee on Health and Human Services.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

NCGA

NORTH CAROLINA GENERAL ASSEMBLY

Senate Committee On Health Care

June 17, 2020

Room 1027 / 1128, LB – 10:00 AM

Senate Sergeant at Arms:

JIM HAMILTON

SHEREE HEDRICK

LINDA MATTHEWS

CHRIS MOORE

Senate Committee On Health Care

June 17, 2020 – Room 1027 / 1128 LB – 10:00 AM

PLEASE SIGN IN BELOW

NAME	FIRM OR AGENCY
Hampton Billips	KTS
Ken Melton	KMA
Jerrie McFalls	Henderson Co DSS
Tonya Westbrook	Western Carolina Univ
Ryan Fogarty	Real Academy
Keann Marino	Henderson Co DSS Real
J Peters	CSS
JOE LANIER	TRUSTMARK
JASON Soper	DCBSNC
Dee Hunt	Henderson County DSS

SPEAKER SIGN-UP SHEET

Senate Committee On Health Care

June 17, 2020 – Room 1027 / 1128, LOB 10:00 AM

PLEASE SIGN IN BELOW

BILL #	NAME	FIRM OR AGENCY
SB 708	Kevin Marino	HCDSS