2019

Substantive Enacted Legislation Pertaining to Health and Human Services

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Legislative Analysis Division, North Carolina General Assembly

2019 Substantive Enacted Legislation Pertaining to Health and Human Services

This document provides summaries of substantive legislation pertaining to health and human services enacted during the 2019 Session of the 2019 General Assembly. The summaries are arranged in numerical order by Session Law since the content of several large bills precluded organizing the summaries under subheadings.

The brief summaries contained in this document represent work products from the following Legislative Analysis Division staff members: Susan Barham, Jessica Boney, Jennifer Hillman, Theresa Matula, and Jason Moran-Bates. A more thorough summary of most bills may be found on the NCGA website.

SUMMARIES

Immunizing Pharmacists (S.L. 2019-21/H388)

S.L. 2019-21 expands the vaccinations 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 at least age 10 (previously 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 no later than September 15, 2019.

The authority for immunizing pharmacists to administer additional vaccinations or immunizations became effective October 1, 2019, the remainder of this act became effective June 3, 2019.

Delay NC HealthConnex for Certain Providers (S.L. 2019-23/H70)

S.L. 2019-23 amends the law (G.S. 90-414.4) pertaining to participation requirements for the Health Information Exchange (HIE) to: (1) extend the deadline to June 1, 2020, by which providers not mentioned elsewhere in the statute have to connect to the HIE; (2) allow psychiatrists and the State Laboratory of Public Health until June 1, 2021, before they are required to connect; (3) allow State health care facilities until June 1, 2021, before they are required to submit claims data; (4) allow the Department of Health and Human Services (DHHS) to extend the connection deadline for providers making a good faith effort to connect to June 1, 2020; (5) allow the Secretary of DHHS to exempt classes of providers from connecting to the HIE through December 31, 2022; and (6) make connection to the HIE voluntary for several types of providers.

This act became effective June 6, 2019.

Dental Bill of Rights (S.L. 2019-26/S252)

S.L. 2019-26 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. It creates definitions for "provider network contract", "insurer" and "third party", and adds requirements for third party access to dental provider network contracts. The act prohibits an insurer from subsequently retracting its coverage determination for a dental plan after the services or supplies have been provided. It defines pretreatment estimate and clarifies it is not a coverage determination.

This act became effective January 1, 2020, and applies to health benefit contracts issued, renewed, or amended on or after that date.

Modify Physical Therapy Definition (S.L. 2019-43/H548)

S.L. 2019-43 amends the law (G.S. 90-270.90(4)) to remove the practice of chiropractic from the definition of physical therapy contained in Article 18E, Chapter 90, of the General

Statutes which pertains to the practice of physical therapy.

This act became effective October 1, 2019.

Allow Donations of Unexpired Drugs (S.L. 2019-54/H658)

S.L. 2019-54 amends the criteria for drugs donated to pharmacists or free clinics participating in the Drug, Supplies, and Medical Device Repository Program to allow the donation of drugs that have not reached their expiration date, rather than requiring the drug to have an expiration date that is six months from the date the drug was donated.

This act became effective June 26, 2019.

Right to Try Adult Stem Cell Treatments (S.L. 2019-070/H934)

S.L. 2019-70 allows 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. It also makes conforming changes to the existing Right to Try Act.

This act became effective December 1, 2019, and applies to acts committed on or after that date.

Medicaid Changes for Transformation (S.L. 2019-81/H656)

S.L. 2019-81 makes changes to the Medicaid and Health Choice appeals statutes, and to other laws pertaining to the Medicaid and Health Choice programs, that are necessary to implement the transition of these programs to a managed care environment and to capitated contracts with Prepaid Health Plans, as required by the Medicaid Transformation legislation that was enacted in 2015.

The prior Medicaid Transformation legislation, 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 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.

S.L. 2019-81 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 act has the following components:

- **Sections 1 and 6** of this act 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.

- **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 existing law.
- **Section 12** modifies the Medicaid Transformation legislation to be consistent with the 1115 waiver approved by CMS by allowing the foster care and adoption assistance population initially to remain in the existing fee-for-service and LME/MCO system instead of enrolling in PHPs. This section requires the foster care and adoption assistance population to be phased into PHP coverage within five years of the date

that standard benefit plans begin, but does not specify what type of PHP benefit plan will eventually cover this population.

- **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.

The changes to replace references to the Division of Medical Assistance with the Division of Health Benefits was effective July 1, 2019. The remainder of the act was 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.

Study Participation of Operators in NC Pre-K (S.L. 2019-87/H886)

S.L. 2019-87 directs the Department of Health and Human Services, Division of Child Development and Early Education, to study and report on the challenges to becoming a NC Pre-K site. 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.

This act became effective July 8, 2019.

Adopt Rules Incorporating 2017 Food Code (S.L. 2019-129/H735)

S.L. 2019-129 allows the Commission for Public Health to adopt rules to incorporate all or part of the 2017 United States Food and Drug Administration Food Code.

This act became effective July 19, 2019.

Inmate Health Care & 340B Program (S.L. 2019-135/H106)

S.L. 2019-135 makes changes to improve medical care to inmates and contain costs as outlined below.

PART I of the act pertains to Inmate Health Care Reimbursement, Internal Processes, and a Telemedicine Pilot. The act requires the Department of Public Safety (DPS) 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. DPS must consider the use of telemedicine.
- A cost comparison of health care services performed at CPHC and the North Carolina Correctional Institution for Women (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 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.

The act also 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 DPS 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 DPS 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.

The act adds a new statute pertaining to Medicaid services for inmates and requires progress reports. It 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. The act also 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. Finally, it 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.

The Department of Public Safety is required to issue two Requests For Proposals (RFPs) for developing 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 must 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.

The Department of Public Safety is also required to study and develop initiatives pertaining to the salaries of all in-prison health services employees. The Department of Public Safety, Health Services Section, and the Office of State Human Resources, are required 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. The Department must establish a vacancy rate benchmark for each correctional facility to create a plan to reduce the vacancy rates including certain initiatives. The Department must also establish methods to measure the effectiveness of the initiatives to reduce vacancy rates required in subsection (b) of this section of the act 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.

The Department of Public Safety, Health Services Section is required 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. The Department of Public Safety, Health Services Section is also required 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.

The act requires the establishment of a telemedicine pilot program. Two correctional facilities must 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 outlines measures for each pilot site. An interim report is required 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 act pertains to the Federal 340B Program. The act requires 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 requires DPS to report October 1, 2019, on the implementation of this section.

The DPS must 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. DPS is required to report on December 1, 2019, regarding its plan for the issuing of RFPs.

The DPS must 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 also requires DPS and UNC-HCS to develop a plan for the shifting of prescription authority from DPS to UNC-HCS when it is most cost effective. Both DPS and UNC-HCS are directed to report on October 1, 2019, regarding the plan and methods of implementation of shifting prescription authority.

The act codifies 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 of the act.

The section of the act pertaining to Medicaid services for inmates and related reporting requirements became effective October 1, 2019, the remainder of this act became effective July 19, 2019.

Allow Use of Oyster Shells as Serving Dishes (S.L. 2019-141/S444)

S.L. 2019-141 permits oyster shells to be re-used to serve cooked oysters.

This act became effective October 1, 2019.

Organ and Tissue Donation/Heart Heroes (S.L. 2019-143/S210)

S.L. 2019-143 amends the Revised Uniform Anatomical Gift Act by removing the exclusion of tissue as an anatomical gift authorized by the placement of a symbol on the donor's driver license or identification card. Tissue donation is now authorized in this manner.

This act became effective October 1, 2019.

Opioid Epidemic Response Act (S.L. 2019-159/H325)

S.L. 2019-159 removes the State registration requirement for buprenorphine prescribers and decriminalizes the use of drug testing equipment used to detect contaminants in controlled substances. It broadens the objectives of syringe exchange programs to include reducing the number of drug overdoses in the State. The restriction on using State funds to purchase to purchase needles, hypodermic syringes, or other injection supplies is removed.

This act became effective July 22, 2019.

Allow Hyperbaric Oxygen Therapy for Traumatic Brain Injury and Posttraumatic Stress Disorder (S.L. 2019-175/H50)

S.L. 2019-175 enacts the North Carolina Veterans Traumatic Brain Injury and Posttraumatic Stress Disorder Treatment and Recovery Act of 2019. It creates definitions for "authorized medical professional," "hyperbaric oxygen therapy treatment," and "veteran." Any veteran residing in North Carolina and diagnosed with traumatic brain injury or posttraumatic stress disorder by an authorized medical professional may receive hyperbaric oxygen therapy treatment in the State. The treatment must be prescribed by an authorized medical professional

and done so in a manner that complies with the standard approved treatment protocols for hyperbaric oxygen therapy.

This act became effective October 1, 2019.

Update Adult Care Home Service & Care Plan/Board of Nursing (S.L. 2019-180/S302)

S.L. 2019-180 alters the requirements of the initial resident assessment conducted by adult care homes and allows the use of the Medicaid personal care services (PCS) assessment to satisfy the required resident assessment of physical functioning for activities of daily living (ADLs); amends the assisted living administrator qualifications; and amends the Nursing Practice Act by making a number of changes, many of which are done for process efficiency or are technical and conforming in nature.

A detailed analysis of the act is outlined below.

Part I requires that the initial **resident assessment conducted by adult care homes** be on an assessment instrument approved in accordance with rules adopted by the Medical Care Commission; requires the assessment used to develop service plans and care plans be conducted within 30 days of admission; and allows adult care homes to use the Medicaid Personal Care Services (PCS) assessment in place of conducting a separate assessment of a resident's physical functioning for activities of daily living (ADLs) no later than 35 days after admission. (Adult care homes are still required to conduct an assessment of a resident's physical functioning for ADLs within 30 days of admission if a Medicaid PCS assessment has not been developed within 35 days of admission.)

The act also requires the Department of Health and Human Services to certify that an **assisted living administrator** applicant does not have a substantiated finding of neglect, abuse, misappropriation of property, diversion of drugs, or fraud listed on the Health Care Personnel Registry; and allows an applicant with a high school diploma and two years of coursework at an accredited college or university, or, 60 months of supervisory experience, to qualify for certification under the assisted living administrator certification. Qualification under a combination of education and experience as approved by the Department remains unchanged.

Part II amends the **North Carolina Board of Nursing (BON)** licensure statutes as outlined below.

- Includes a definition for "licensee" which is a term that has been used in the Article but was not previously included in the definition section of the Article.
- Changes the term "current, unencumbered" to "active, unencumbered" as it applies to licenses registered nurse members and licensed practical nurse members must have to serve on the Board. An "active, unencumbered license" is the same terminology used in G.S. 90-171.95B(c)(5) for the Nurse Licensure Compact (S.L. 2017-140).
- Provides that a public member, whether appointed by the Governor or General Assembly under G.S. 90-171.21(b), is prohibited from being a licensed nurse or licensed health care professional; being employed by a health care institution, health

care insurer, or health care professional school; and from having an immediate family who is currently, or was previously, employed as a licensed nurse.

- Provides that daily compensation allowance for Board members is limited to $200 for time spent in the performance and discharge of duties as a member.
- Allows the BON to determine whether an applicant or licensee is mentally and physically capable of practicing nursing with reasonable skill and safety and permits the BON to require a physical or mental health examination.
- Clarifies the BON can administer appropriate disciplinary action against all regulated parties found in violation of the Nursing Practice Act or rules adopted by the BON.
- Makes a conforming change to specify the BON can withdraw approval of a nursing program (which is authority already provided in G.S. 90-171.39 and G.S. 90-171.40).
- Clarifies the BON may establish programs monitoring (rather than aiding in) the treatment, recovery, and safe practice of nurses with substance use disorders, mental health disorders, or physical conditions that impact the delivery of safe care.
- Clarifies the BON may enter into agreements (rather than establish programs) to aid in the remediation of nurses who experience practice deficiencies.
- Clarifies that the BON may order or subpoena the production of records or documents for matters before the Board.
- Removes language pertaining to the implementation of a computer adaptive licensure examination, which according to the BON is no longer needed since the system is in place.
- Clarifies the BON's disciplinary authority to include probation; implementing limitations and conditions; accepting voluntary surrender of a license; publicly reprimanding; issuing public letters of concern; requiring completion of treatment programs or remedial or educational training; denying or refusing to issue a license; denying or refusing to issue a license renewal; issuing a fine; suspending a license; and revoking a license.
- Adds items to the list of prohibited activities for which the BON can take action. The additional prohibited acts include: engaging in unprofessional or unethical conduct, or conduct that does not conform to nursing practice standards even if a patient is not injured; acts of dishonesty, injustice, or immorality in the course of practice; having had a license or privilege to practice nursing denied, revoked, suspended, restricted, or acted against by any jurisdiction; failure to respond to the Board's inquiries in a reasonable manner or time regarding a matter affecting the license to practice nursing.
- Provides that the BON retains jurisdiction over an expired, inactive, or voluntarily surrendered license.
- Provides that the Board of Nursing, members of the Board, and staff are not liable in any civil or criminal proceeding for exercising the powers and duties authorized by law, provided the person was acting in good faith.

- Allows witness testimony to be received by telephone or videoconferencing at a hearing.
- Adds three new sections to Article 9A pertaining to the right to appeal a disciplinary action, public records, and the service of notices.
- Authorizes the BON may report information indicating a crime may have been committed to the appropriate law enforcement agency or district attorney. The BON must cooperate with criminal investigations, and the information it provides will be confidential.
- Requires licensees to self-report to the Board any of the following within 30 days of arrest or indictment: any felony arrest or indictment; any arrest for driving while impaired or driving under the influence; and any arrest or indictment for the possession, use, or sale of any controlled substance.
- Requires the BON to designate people to survey proposed nursing programs, but not clinical facilities.
- Increases from 8 to 10 years the frequency with which the BON must review all nursing programs in the State. It clarifies that the BON has the responsibility to evaluate and take appropriate action, including withdrawing approval from a nursing program that fails to correct deficiencies within a reasonable time.
- Clarifies the BON has the authority to promulgate rules to enforce the provisions G.S. 90-171.43 which requires a license to practice as registered nurse, license practical nurse, or to use the "nurse" title.
- Adds a new section to allow the BON to waive requirements of the Article to allow emergency health services to the public when the Governor declares a state of emergency, or a county or municipality enacts ordinances under the following authority:
    - Power of municipalities and counties to enact ordinances to deal with state of emergency under the NC Emergency Management Act (G.S. 166A-19.31).
    - General ordinance-making power for cities and towns (G.S. 160A-174).
    - General ordinance-making power for counties (G.S. 153A-121).
    - A terrorist incident using nuclear, biological, or chemical agents (Chapter 130A, Article 22).

The changes to the Nursing Practice Act became effective October 1, 2019, and apply to licenses granted or renewed on or after that date and actions taken by the Board of Nursing on or after that date, the remainder of the act became effective July 26, 2019.

Posttraumatic Stress Injury Awareness Day/Titus's Law/Data (S.L. 2019-225/S458)

S.L. 2019-225 makes changes pertaining to posttraumatic stress injury awareness, the disposal of fetal remains, and the availability of data to guide the delivery of drug treatment and law enforcement resources. Specific changes are detailed below.

- Designates June 27th of each year as Posttraumatic Stress Injury Awareness Day in the State.
- Requires parental consent before disposing of fetal remains in every instance of unintended fetal death resulting from accidental injury, stillbirth, or miscarriage. If both parents are unable to consent within seven days, the fetal remains are to be disposed of in accordance with applicable laws and regulations.
- Directs the disposal of fetal remains only by burial, cremation, or incineration in accordance with applicable laws and regulations. Fetal remains developed beyond the second trimester of gestation must only be disposed of by burial or cremation.
- Authorizes engagement between the Department of Health and Human Services, Department of Justice, local health departments, local law enforcement agencies, and third-party toxicology laboratories to provide data to guide the delivery of drug treatment and law enforcement resources.

The section of this act addressing parental consent and the disposition of fetal remains became effective January 1, 2020, and applies to the disposition of fetal remains on or after that date. The remainder of the act became effective September 18, 2019.

Licensing, Health and Human Services Amendments, and Rural Health Stabilization (S.L. 2019-240/S537)

S.L. 2019-240 amended a wide range of laws in the health and human services area. A brief overview below is followed by a more detailed analysis of the act.

Brief Overview of the Act

- Establishes a new adult care home payment methodology.
- Amends the Licensed Professional Counselors Act effective January 1, 2020.
- Amends the Substance Abuse Professional Practice Act effective October 1, 2019, for licenses granted or renewed on or after that date and for applications for licenses on or after that date; the changes to the structure of the Board effective July 1, 2020.
- Amends the Social Worker Certification and Licensure Act effective January 1, 2021.
- Clarifies the Medicaid subrogation statute.
- Makes technical and clarifying changes to social services reform and the child support enforcement program effective July 1, 2020.
- Changes to the name of the Vocational State Rehabilitation Council.
- Repeals the Employee Assistance Professionals Article.
- Makes technical and conforming changes to the adoption preplacement assessment.
- Expands immunity for cooperating in child abuse and neglect reports and assessments.
- Amends laws pertaining to Department of Health and Human Services law enforcement and the joint security force for various facilities.
- Adds a definition for "security recordings" to the mental health statutes.

- Makes a clarifying change to the NC REACH Program.
- Adds a definition for "Traumatic Brain Injury" to the mental health statutes.
- Adds a Continuing Care Retirement Community representative to the Medical Care Commission.
- Postpones the NC FAST Case-Management Functionality for child welfare and aging and adult services.
- Implements statutes pertaining to criminal history record checks for child care institutions.
- Makes technical and conforming changes to involuntary commitment statutes.
- Enacts statutes to address rural health care stabilization.

Except as outlined above, the remainder of this act became effective November 6, 2019.

Detailed Analysis of the Act

Part I pertains to the **adult care home payment methodology** and directs 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. The workgroup must include all funding streams in the evaluation and must develop a service definition(s) under Medicaid managed care. By December 1, 2020, DHHS must submit a report containing the new service definition(s) 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. DHHS is prohibited from submitting any NC Medicaid State Plan amendments to the Centers for Medicare and Medicaid Services to implement the new service definition without prior approval from the General Assembly.

Part II-A **changes the name of the Licensed Professional Counselors Act** to the "Licensed Clinical Mental Health Counselors Act," makes conforming changes, and updates the Board's duties. Amendments broadly include:

- *Terminology Changes (G.S. 90-330)* of "professional counselor" to "clinical mental health counselor" throughout Article 24 of Chapter 90 of the General Statutes.
- *Establishes Mental Health Program (G.S. 90-334(l))* for licensees experiencing substance use disorders, burnout, compassion fatigue, and other mental health concerns.
- *Allows Reciprocity (G.S. 90-337) & Removes Certain Exemptions (G.S. 90-338)* by permitting the Board to enter into reciprocity agreements. Removes certain exemptions for applicants who did not meet academic qualifications.

Part II-B **makes technical and conforming changes** to reflect Part II-A.

Part II-A and II-B became effective January 1, 2020.

Parts II-C, D, E, F, G and H **amend the Substance Abuse Professional Practice Act** and changes the name to the "Substance Use Disorder Professional Practice Act," makes conforming changes, and amends the Board. Amendments and effective dates are outlined below.

- *Changes Title of Act* from the "North Carolina Substance Abuse Professional Practice Act" to the "North Carolina Substance Use Disorder Professional Practice Act" and makes conforming changes. These changes are contained in Section 8 which became

effective October 1, 2019, and apply to licenses granted or renewed on or after that date.

- *Amends Definition (G.S. 90-113.31A)* of "independent study" and adds a definition for "traditional classroom-based study." The changes in Section 4 became effective October 1, 2019.
- *Renames and Restructures Board (G.S. 90-113.32).* Renames the Board to the North Carolina Addictions Specialist Professional Practice Board (Addiction Specialist Board). Replaces the 19-member board with 9 members who serve 3-year staggered terms. Outlines board member reimbursements, election of officers, officer terms, terms of the chair, and vacancies. The changes to the Board in Section 5 become effective July 1, 2020.
- *Increases Required Certification Hours (G.S. 90-113.40(a)(6), G.S. 90-113.40(d1)(1)).* Increases the education hours required for certification as a substance abuse counselor, substance abuse prevention consultant, or criminal justice addictions specialist from 270 hours to 300 hours. These changes in Section 6 became effective October 1, 2019, and applies to applications for licenses submitted on or after that date.
- *Establishes North Carolina Impaired Professionals Program (G.S. 90-113.48)* with the purpose of operating independently of the Addiction Specialist Board to provide a variety of support services for credentialed professionals for treatment of an impairment due to physical or mental illness, substance use disorder, or professional sexual misconduct. Section 7 became effective October 1, 2019, and applies to licenses granted or renewed on or after that date.
- *Discontinues Certified Substances Abuse Residential Facility Director Credentialing* and removes references to the certified substance abuse residential facility director. The credential is discontinued as of the date the act becomes law and the remaining subsections of the section become effective upon the expiration of the last credential issued.

Part II-I amends the Social Worker Certification and Licensure Act effective January 1, 2021, and the qualifications for the certificate of Certified Social Work Manager apply only to applications for certification received by the Board on or after January 1, 2021. Amendments are outlined below.

- *Creates New Definitions (G.S. 90B-3)* for "applicant," "social work continuing education," and "supervision."
- *Identifies Where Credential Is Held (G.S. 90B-4).* Requires a person who resides and practices in the State while credentialed in another state to amend his or her credential to identify the state where the credential is held. A person who resides and practices in the State for a period of not more than 5 days in any calendar year, while credentialed in another state, must amend his or her credential to identify the state where the credential is held.
- *Amends Membership (G.S. 90B-5)* and amends the qualifications for the members of the North Carolina Social Worker Certification and Licensure Board (Board).

- *Amends Duties of Board (G.S. 90B-6)* to provide the power to adopt supervision standards. Extends the period of time that a licensed social worker is required to maintain records from 3 years to the longer of (i) 10 years from the date services to the client are terminated or (ii) the record retention period mandated by a third-party payee.
- *Amends Qualifications for Certificates (G.S. 90B-7).* The Board must issue a certificate as a "Certified Social Worker" or a "Certified Master Social Worker" to applicants who have, among other qualifications, the appropriate degree in social work from a college or university social work program approved by the Council on Social Work Education and have passed a Board-approved qualifying examination.
- *Amends Qualifications for Licensure (G.S. 90B-7).* The Board must issue a license as a "Licensed Clinical Social Worker" or issue a certificate as a "Certified Social Work Manager" to applicants who meet specified criteria
- *Permits Board to Issue Associate License (G.S. 90B-7)* in clinical social work to a person who meets specified criteria.
- *Allows Board to Grant Reciprocal and Temporary Licenses (G.S. 90B-8). Renewals of Certificates and Licenses (G.S. 90B-9).* All certificates and licenses, excluding temporary licenses, must be renewed on or before the expiration date of the certificate or license. The process for renewal of a certificate or license is altered. Requires written request for reactivation, payment of renewal fee and Board verification of compliance with current requirements before reinstating a certificate or license.
- *Amends Nonpracticing Status (G.S. 90B-9.1)* and requires proof of completed continuing education requirements before a certificate or license may be reactivated.
- *Alters Board's Disciplinary Procedures (G.S. 90B-11).*

Part III-A clarifies the Medicaid Subrogation statute (G.S. 108A-57) and applies to claims brought by medical assistance beneficiaries against third parties on or after that date. G.S. 108A-57 governs Medicaid subrogation, which occurs when (i) a Medicaid beneficiary has been injured by a third party, (ii) Medicaid paid for services to the beneficiary as a result of the injury, and (iii) the beneficiary later receives compensation from the third party for the injury. Under these circumstances, the law requires the beneficiary to return a portion of the recovery from the third party to the Medicaid program, as required by federal law (42 U.S.C. 1396k(1)(A)). The law establishes a presumption that the amount the beneficiary must return to the Medicaid program is either one-third of the beneficiary's recovery from the third party, or the total amount of Medicaid payments related to the injury, whichever is less. The law also establishes a process for a beneficiary to dispute the presumed amount of Medicaid's share of the recovery.

The act makes the following technical and clarifying changes to the current subrogation law:

- Defines "beneficiary" to also include the beneficiary's parent, legal guardian, or personal representative.

- Replaces references to a "personal injury or wrongful death claim" against a third party, to "any claim" against a third party, consistent with federal law (42 U.S.C. 1396k(1)(A)).

The act clarifies that disputes under the statute must be filed with a court in this State. It also clarifies, in cases where a beneficiary receives recoveries from multiple parties for the same injury, that Medicaid's combined share from all the recoveries cannot exceed the total amount of Medicaid payments related to the injury.

This part of the act also extends, from 30 to 60 days, the amount of time within which a court must hold the evidentiary hearing when a beneficiary disputes the presumed amount of Medicaid's share of the recovery.

Part III-B amends select social services statutes. The act delays from March 1, 2020, to July 1, 2020, the changes to the law (G.S. 108A-74) enacted in 2017 pertaining to counties and regional social services departments entering into annual written agreements for social services programs other than medical assistance, local department failure to comply with the written agreement or applicable law, corrective action, and state intervention in or control of service delivery. It makes further clarifying changes to the law (G.S. 108A-74) to add language in G.S. 108A-74 (h)-(*l*) that previously existed, and provide an effective date of July 1, 2020, to conform to the date above.

Part III-C amends statutes to comply with federal law for the Child Support Enforcement Program. The act adds "electronic communications or Internet service provider" to the list of entities that must provide DHHS specified information needed to locate a parent for the purpose of collecting child support or to establish or enforce an order for child support.

Part III-D changes the name of the Vocational Rehabilitation Council to the Vocational State Rehabilitation Council. The act aligns the term with the federal Workforce Innovation and Opportunity Act.

Part III-E modifies the State Consumer and Family Advisory Committee as follows:

- Eliminates the three appointments by the Council of Community Programs to the State Consumer and Family Advisory Committee due to the dissolution of the Council for Community Programs. The three appointments are redistributed – one to each of the three remaining appointment authorities (President Pro Tempore of the Senate, the Speaker of the House of Representatives, and the NC Association of County Commissioners).

- Provides instructions pertaining to the current members appointed by the Council of Community Programs to allow them to serve out the remainder of their terms and to provide staggering of the new appointments.

Part III-F repeals the Employee Assistance Professionals Article. The act repeals Article 32 of Chapter 90, enacted in 1995, which provides for the Employee Assistance Professionals board and licensure process. Under the law, (G.S. 90-500(5)) an "employee assistance professional" was defined as a person who provides the following services to the public in a program designed to assist in the identification and resolution of job performance problems in the workplace:

- Expert consultation and training of appropriate persons in the identification and resolution of job performance issues.

- Confidential and timely assessment of problems.
- Short-term problem resolution for issues that do not require clinical counseling or treatment.
- Referrals for appropriate diagnosis, treatment, and assistance to certified or licensed professionals when clinical counseling or treatment is required.
- Establishment of linkages between workplace and community resources that provide such services.
- Follow-up services for employees and dependents who use such services.

The Department of Health and Human Services reported that North Carolina was the only state that licensed these professionals and the national certification process is already part of the current NC licensure requirement in Article 32. Further, the Board of Employee Assistance Professionals, created under Article 32, agreed to dissolve.

Part III-G **provides compliance with the Multi-Ethnic Placement Act.** The act clarifies that a prospective adoptive parent's nationality, race, ethnicity, or religious preference may not be used as a determining factor when evaluating the suitability of the prospective adoptive parents in compliance with the federal Multi-Ethnic Placement Act (MEPA).

Part III-H **amends the statute (G.S. 7B-309) to provide immunity for cooperating in child abuse and neglect reports and assessments in order to comply with the federal Child Abuse Prevention and Treatment Act.** The change provides immunity for individuals who provide information or assistance, including medical evaluations or consultation in connection with a report, investigation, or legal intervention pursuant to a good faith report of child abuse or neglect. The Department of Health and Human Services reports the federal Child Abuse Prevention and Treatment Act (CAPTA) requires states to be compliant with provisions to prevent children from being abused/neglected and as a condition of funding.

Part III-I **updates statutes pertaining to DHHS law enforcement/joint security force.** The act corrects statutory references to DHHS facilities and provides that upon assignment by the Secretary or designee, to any State operated facility, the special police officers may exercise the same power within the territory of the named facility and within the county in which the facility is located. It also deletes statutes that provided for the Dorothea Dix Hospital Joint Security Force.

Part III-J **provides a definition for "security recordings" in mental health statutes.** The act defines "security recordings" as any films, videos, or electronic or other media records of a common area in a State facility that are produced for the purpose of maintaining or enhancing the health and safety of clients, residents, staff or visitors of that State facility. The term does not include recordings of a client's clinical sessions or any other recordings that are part of a client's confidential records. It provides the following: security recordings are not a public record and are confidential; a State facility is not required to disclose its security recordings unless required by federal law or compelled by a court of competent jurisdiction; permits a State facility to allow viewing by an internal client advocate; permits viewing by a client or their legally responsible person if in the best interest of the client.

Part III-K **clarifies that funds for the child welfare postsecondary support program must be used to continue providing assistance with the "cost of attendance" for the educational**

needs of youth who exit foster care to a permanent home through the Guardianship Assistance Program.

Part III-L **provides a definition of "traumatic brain injury" (TBI) in the mental health statutes.** The act defines TBI as an injury to the brain caused by an external physical force resulting in total or partial functional disability psychosocial impairment, or both, and meets all of the following criteria:

- Involves an open or closed head injury.
- Resulted from a single event or resulted from a series of events which may include multiple concussions.
- Occurs with or without a loss of consciousness at the time of injury.
- Results in impairments in one or more areas of the following functions: cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech.
- Does not include brain injuries that are congenital or degenerative.

Part III-M **amends the membership of the North Carolina Medical Care Commission to add an individual affiliated with a nonprofit Continuing Care Retirement Community.**

Part III-N **postpones deployment of NC FAST Case-Management functionality for the child welfare system.** The Department of Health and Human Services, Division of Social Services is prohibited from deploying the child welfare case-management component of the NC FAST system statewide prior to July 1, 2020. The Department must continue to develop and improve case-management functionality only in those counties that participated in the initial pilot program prior to January 1, 2019. Counties that were phased-in the NC FAST Child Welfare System after January 1, 2019, may elect to opt out of the utilization of the Intake and Assessment functionality of the NC FAST system.

The Division is required to continue developing and issuing requests for information (RFIs) to consider a vehicle for improving or replacing the child welfare case-management component but is prohibited from issuing any contracts without prior approval from the General Assembly. The Division is required to consult with the Executive Committee of the North Carolina Association of County Directors of Social Services. Additionally, the Department is required to report to the chairs of the Senate Committee on Health Care, the chairs of the Senate Appropriations Committee on Health and Human Services, the chairs of the House of Representatives Committee on Health, and the chairs of the House of Representatives Appropriations Committee on Health and Human Services no later than May 1, 2020.

The Joint Legislative Program Evaluation Oversight Committee must revise the biennial 2019-2020 work plan for the Program Evaluation Division to include a study of the case-management functionality of the child welfare component of NC FAST. The Program Evaluation Division must submit its evaluation to the Joint Legislative Program Evaluation Oversight Committee and to the Joint Legislative Oversight Committee on Health and Human Services no later than May 1, 2020.

Part III-O establishes a required criminal history record check process for employees, applicants for employment, and individuals wishing to volunteer in a child care institution as defined by Title IV-E of the Social Security Act. The language is similar to other statutorily required criminal history record check processes and was required by federal law according to the Department of Health and Human Services.

"Child care institution" is defined in Federal regulations (45 CFR 1355.20) as a private child care institution, or a public child care institution which accommodates no more than twenty-five children, and is licensed by the licensing authority responsible for licensing or approval of institutions of this type as meeting the standards established for such licensing.

According to DHHS, there are two licensing authorities for child care institutions as defined by Title IV-E of the Social Security Act – the Division of Social Services (DSS) for facilities under Chapter 131D of the North Carolina General Statutes, and the Division of Health Services Regulation for facilities under Chapter 122C. The DSS licenses both public and private residential child care facilities- private residential child care facilities are owned and operated by a private agency. Public facilities are owned and operated by a county government agency or a county DSS. There are 44 private residential child care facilities/agencies and 3 public residential child care facilities/agencies currently licensed by DSS. Some residential child care facilities may meet the definition of child care institution under Title IV-E, but not all.

Part IV makes technical and conforming changes to the Involuntary Commitment statutes.

Part V: Establishes the Rural Health Care Stabilization Fund as outlined below.

- Establishes the Rural Health Care Stabilization Fund as a nonreverting loan fund. (HB 966, would have appropriated $20m to the fund over the 2019-20 biennium but has not been enacted as of this document's publication.)
- Establishes a loan program, administered by UNC Health Care, to provide below-market interest-rate loans for the support of hospitals located in rural areas that are in financial crisis due to operation of oversized and outdated facilities and recent changes to the viability of health care delivery in their communities.
- The loan applicant may be a unit of local government, the owner of a health care facility, or a partnership that includes a public agency or the owner of a health care facility.
- The purpose of the loan is to help financially distressed hospitals transition to sustainable, efficient, and more proportionately sized health care service models in their communities.
- An award of a loan may not be made unless the Local Government Commission (LGC) approves it. The consideration process used by the LGC would be substantially similar to the consideration process it uses to assess the feasibility of local financing agreements.
- The terms of the loan may include changes to the governance structure of the hospital. The interest rate may not exceed the interest rate obtained by the State on its most recent GO bond offering. The maturity for the loan may not exceed 20 years.

- The program is flexibly designed to be able to meet different applicant needs. If the applicant is a unit of local government, there are current law requirements that a unit of local government may have to meet that are not part of this loan program.
- UNC Health Care must publish a report by November 1 each year on the Rural Health Care Stabilization Fund. The report must include the following for the prior fiscal year: the beginning and ending balances of the Fund; the amount of revenue credited to the Fund, by source; the total amount of loans awarded; and for each loan awarded: the recipient of the award, the amount of the award, the amount disbursed, and the amount remaining to be disbursed.

SUMMARY OF
VETOED LEGISLATION

Medicaid Transformation Implementation (H555)

House Bill 555 provides funding for the operation of the Medicaid program and the transition to managed care during the 2019-2021 fiscal biennium and makes other changes necessary for the transition of the Medicaid program to managed care as required by Medicaid Transformation legislation that was enacted in 2015.

The Medicaid Transformation legislation S.L. 2015-245, as amended, required the current Medicaid and Health Choice fee-for-service programs to transition to a managed care model. 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.

The following are components of the bill:

Part I – Implementation in Conjunction with Statutory Procedures for Budget Continuation. Section 1.1 requires this bill to be implemented in conjunction with the procedures for budget continuation outlined in the State Budget Act and provides that the provisions of this bill 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 those funds to be used for claims run out as the Medicaid program transitions to managed care and for specified qualifying needs related to Medicaid Transformation, as verified by the Office of State Budget and Management.

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 the Department of Health and Human Services (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.

Part X – Revise and Update Hospital Assessments. Part X replaces the two existing hospital assessments with two revised hospital assessments, each of which utilizes a fixed percentage of hospital costs. The percentages provide funding for (1) the State share of Medicaid costs associated with the anticipated increase to the hospital claims payments and (2) the State retention amount. The percentage rates will be set each year by the General Assembly, and the Department of Health and Human Services (DHHS) will annually submit proposed adjustments to the rates.

- Section 10.1(a) repeals the current assessments, and Section 10.1(b) enacts the revised assessments. The supplemental assessment in new G.S. 108A-141 replaces the equity assessment currently in G.S. 108A-123(b), and the base assessment in new G.S. 108A-142 replaces the UPL assessment currently in G.S. 108A-123(c).
- Sections 10.1(c) and (d) set the rates for the revised assessments for the first taxable year, which is October 1, 2019, through September 30, 2020. The rate for the supplemental assessment is 2.26% of total hospital costs. The rate for the base assessment is 1.77% of total hospital costs.
- Because of the uncertainty involved in converting the assessments to prospective fixed rates, Section 10.2 authorizes the State Controller to transfer funds from the Medicaid Contingency Reserve to cover a shortfall in receipts in the Medicaid program during the 2019-2020 fiscal year. In the event that the actual receipts from the hospital assessments are higher than expected during the 2019-2020 fiscal year, Section 10.3 directs that the amount of the over-realized receipts, up to $45 million, must be transferred to a Hospital Assessment Fund to be used to support a decrease in the hospital assessment rates in the next fiscal year. Any over-realized receipts over $45 million will be transferred to the Medicaid Transformation Reserve. Before any transfer is executed under Section 10.2 or 10.3, the Office of State Budget and Management must verify the amount of the shortfall or over-realized receipts. Section 10.4 makes a technical change to conform with House Bill 966, the 2019 Appropriations Act, if it becomes law.

In 2011, the General Assembly put in place two hospital assessments, the "equity assessment" and the "UPL assessment," as a mechanism to draw down increased federal Medicaid dollars to enable the State to pay hospitals additional Medicaid amounts, called "***supplemental payments***," above the revenues earned by hospitals in the form of Medicaid claims payments. A portion of the receipts the State receives from these hospital assessments, called "State retention," is also used to help fund the rest of the State Medicaid program. Each year, the State calculates how much is needed to pay the State share of the supplemental payments to hospitals. That total, combined with the State retention amount, is converted to a percentage of hospital costs, and each hospital is assessed an amount equal to that percentage of the hospital's costs.

CMS does not allow the State to make the current Medicaid supplemental payments to hospitals in a managed care arrangement. DHHS plans to ***replace the current supplemental payments*** as follows:

- DHHS will set new hospital claims payments that are intended to be equivalent to the existing claims payments plus the existing supplemental payments.
- The capitated rates that will be set for managed care will be calculated using the new, higher hospital claims payments.

Because the current methodology for calculating the hospital assessments is based on supplemental payments, which are not allowed under managed care, there will be no money collected from the existing hospital assessments once DHHS begins the new payment approach.

Part XI – Gross Premiums Tax/Prepaid Health Plans. Section 11 amends Article 8B of Chapter 105 of the General Statutes, including G.S. 105-228.3 and G.S. 105-228.5, G.S. 105-259, and G.S. 58-6-25, as follows:

- Adds prepaid health plans to the types of organizations subject to the gross premiums tax and the insurance regulatory charge.
- Includes capitation payments for the Medicaid or Health Choice programs received by a prepaid health plan in the tax base on which the gross premiums tax is imposed.
- Establishes a tax rate of 1.9% for prepaid health plan gross premiums, which is the same rate applicable to other insurance contracts.
- Allows a deduction for capitation payments refunded by a prepaid health plan to the State, consistent with the deduction allowed for other gross premiums under the statute.

The law on taxes measured by gross premiums (G.S. 105-228.5) requires insurers and health maintenance organizations to pay a 1.9% tax on gross premiums, due annually and collected in quarterly installments. The law on insurance regulatory charge (G.S. 58-6-25) imposes a regulatory charge on the premiums tax liability of entities subject to the gross premiums tax. The regulatory charge established in Section 22.2 of S.L. 2018-5 is 6.5%.

Part XII– Hospital Uncompensated Care Fund. Section 12.1 establishes the Hospital Uncompensated Care Fund as a nonreverting special fund to hold certain disproportionate share hospital adjustment (DSH) receipts to be used for payments related to uncompensated care in accordance with rules established by DHHS.

The repeal of the current hospital assessments, the enactment of the revised hospital assessments, and the assessment rates for the first taxable year are effective October 1, 2019. The changes related to the gross premiums tax in Section 11 are effective October 1, 2019, and apply to capitation payments received by prepaid health plans on or after that date. Sections 7.1(b), 7.1(c), and 8.1(e) are also effective October 1, 2019. The remainder of the bill is effective when it becomes law.