2009

SENATE
HEALTH CARE

MINUTES

Principal Clerk
Reading Clerk

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	March 4, 2009	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 188	Special Care Dentistry Collaboration.	Senator Malone
SB 193	Strengthen Disaster Planning/LTC Facilities.	Senator Malone
SB 195	Preparations for Aging Baby Boomers.	Senator Malone
SB 243	Reduce Infant Mortality and Preterm Births.	Senator Purcell

Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, March 04, 2009

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

FAVORABLE

S.B. **195** Preparations for Aging Baby Boomers.
Sequential Referral: None
Recommended Referral: None

S.B. **243** Reduce Infant Mortality and Preterm Births.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

TOTAL REPORTED: 2

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
March 4, 2009
MINUTES

The Senate Health Care Committee met on Wednesday, March 4, 2009 in Room 544 of the Legislative Office Building. Twenty-four members were in attendance along with staff, Shawn Parker, Ben Popkin, Susan Barham, Becky Hedspeth, and Judy Christoe.

Senator Purcell presided, with Co-chair Senator Bingham standing in for Senator Malone to present three of his bills (Agenda.Attachment 1). The first bill on the Agenda was Senate Bill 188 "AN ACT TO DIRECT THE DIVISIONOF MEDICAL ASSISTANCE, DIVISION OF PUBLIC HEALTH, AND DIVISION OF AGING AND ADULT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO COLLABORATE WITH THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL AND EAST CAROLINA UNIVERSITY SCHOOLS OF DENTISTRY, THE NORTH CAROLINA DENTAL SOCIETY, AND CURRENT SPECIAL CARE DENTAL PROVIDERS, TO EXAMINE DENTAL CARE OPTIONS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING" (Attachments II and III). This bill was pulled from the agenda, before discussion, for additional work before consideration by the Committee.

The first bill considered was Senate Bill 193 "AN ACT TO DIRECT THE DIVISION OF HEALTH SERVICE REGULATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO REVIEW RECOMMENDATIONS FROM THE DISABILITY AND ELDERLY EMERGENCY MANAGEMENT (DEEM) TASK FORCE AND TO TAKE APPROPRIATE ACTION TO STRENGTHEN DISASTER PLANNING AND DISASTER PREPAREDNESS FOR LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING" (Attachments IV and V). This bill was sponsored by Senator Malone and, in his absence, Senator Bingham explained the bill. After discussion and questions, the bill was withdrawn from the Agenda for further work.

The next bill considered was Senate Bill 195 "AN ACT TO DIRECT THE UNIVERSITY OF NORTH CAROLINA INSTITUTE ON AGING, AND THE DIVISION OF AGING AND ADULT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO TAKE A LEADERSHIP ROLE IN HELPING NORTH CAROLINA PREPARE FOR INCREASED NUMBERS OF OLDER ADULTS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY

COMMISSION ON AGING" (Attachments VI and VII). This bill was also sponsored by Senator Malone and explained by Senator Bingham. After discussion, the bill was given a favorable report.

Next considered was Senate Bill 243 "AN ACT TO REDUCE INFANT MORTALITY AND REDUCE PRETERM BIRTHS, AS RECOMMENDED BY THE CHILD FATALITY TASK FORCE" (Attachments VIII and IX). Senator Bingham took over the Chair in order for Senator Purcell to explain his bill. After discussion, the bill was given a favorable report, with "sequential referral to the Appropriation/Base Budget Committee".

There being no further business before the Committee, the meeting was adjourned by Senator Purcell.

Respectfully submitted,

Becky Hedspeth
Becky Hedspeth, Committee Assistant

William R Purcell
Senator William R. Purcell, M.D.
Presiding Chair

Senator Stan Bingham, Co-Chair

Attachment 1

Senate Health Care Committee
Wednesday, March 4, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 188	Special Care Dentistry Collaboration.	Senator Malone
SB 193	Strengthen Disaster Planning/LTC Facilities.	Senator Malone
SB 195	Preparations for Aging Baby Boomers.	Senator Malone
SB 243	Reduce Infant Mortality and Preterm Births.	Senator Purcell

Presentations

Other Business

Adjournment

Attachment 11

SENATE BILL 188:
Special Care Dentistry Collaboration

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	March 3, 2009
Introduced by:	Sen. Malone	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Legislative Analyst

SUMMARY: Senate Bill 188 directs various Divisions within the Department of Health and Human Services to collaborate with State's Dental Schools, the North Carolina Dental Society, and certain dental providers to examine current dental care options for special care populations.

BILL ANALYSIS: The bill directs the Division of Medical Assistance, Division of Public Health, and Division of Aging and Adult Services to collaborate with the following representatives to examine current dental options for special care populations:

- University of North Carolina at Chapel Hill School of Dentistry
- East Carolina University School of Dentistry
- North Carolina Dental Society
- Current providers of special care dentistry services.

The collaborative shall report findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission by February 1, 2010.

This is a recommendation of the North Carolina Study Commission on Aging.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: It has been reported that people with disabilities and the institutionalized aged often have more dental disease, more missing teeth, and more difficulty obtaining dental care than other segments of the population. Persons with developmental disabilities residing in community settings have significant unmet health care needs, including oral health needs, and the situation is worse for the aged and disabled living in rural and remote areas. A 2000 Surgeon General's report, *Oral Health in America*, noted that although there have been gains in oral health status for the population as a whole, the gains have not been evenly distributed across sub-populations. Profound disparities for dental care exist among racial and ethnic minorities, individuals with disabilities, elderly persons, and individuals with complicated medical and social conditions. The Medicaid program in North Carolina is one of a minority of states that offers comprehensive dental benefits for adults.[1]

S188-SMSQ-3(e1) v1

[1] North Carolina Study Commission on Aging's report to the Governor and the 2009 General Assembly.

Attachment 11

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 188

Short Title:	Special Care Dentistry Collaboration.	(Public)
Sponsors:	Senators Malone, Forrester; Brunstetter, Davis, Dorsett, Foriest, Goss, Hoyle, Jones, McKissick, Purcell, Stevens, Swindell, and Tillman.	
Referred to:	Health Care.	

February 18, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF MEDICAL ASSISTANCE, DIVISION OF PUBLIC HEALTH, AND DIVISION OF AGING AND ADULT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO COLLABORATE WITH THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL AND EAST CAROLINA UNIVERSITY SCHOOLS OF DENTISTRY, THE NORTH CAROLINA DENTAL SOCIETY, AND CURRENT SPECIAL CARE DENTAL PROVIDERS, TO EXAMINE DENTAL CARE OPTIONS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Division of Medical Assistance, Division of Public Health, and Division of Aging and Adult Services in the Department of Health and Human Services shall collaborate with the University of North Carolina at Chapel Hill and the East Carolina University Schools of Dentistry, the North Carolina Dental Society, and current providers of special care dentistry services, to examine current dental care options for special care populations. The collaboration of these groups shall result in suggestions for ways to improve the availability of services for special care populations. These groups shall report findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission on or before February 1, 2010.

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

Attachment IV

SENATE BILL 193:
Strengthen Disaster Planning/LTC Facilities

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	March 3, 2009
Introduced by:	Sen. Malone	**Prepared by:**	Ben Popkin
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 193 would direct the Division of Health Service Regulation (Division), Department of Health and Human Services, to review recommendations of the Disability and Elderly Emergency Management (DEEM) Task Force and take appropriate action to strengthen disaster planning and disaster preparedness for long-term care facilities in the State. The Act would direct the Division to report its findings, action taken, and any recommendations on or before March 1, 2010.***

[As introduced, this bill was identical to H143, as introduced by Reps. Farmer-Butterfield, Pierce, Bordsen, Mobley, which is currently in House Aging, if favorable, Homeland Security, Military, and Veterans Affairs.]

BILL ANALYSIS: Senate Bill 193 would direct the Division of Health Service Regulation (Division), Department of Health and Human Services, to review the recommendations of the Disability and Elderly Emergency Management (DEEM) Task Force and take appropriate action to strengthen disaster planning and disaster preparedness for long-term care facilities in the State. The Act would direct the Division to report its findings, action taken, and any recommendations to the North Carolina Study Commission on Aging and the Joint Select Committee on Emergency Preparedness and Disaster Management Recovery on or before March 1, 2010.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: Senate Bill 193 is the first of the recommendations presented by the North Carolina Study Commission on Aging in its report to the Governor and the 2009 Session of the 2009 General Assembly. The DEEM Initiative was co-chaired by Brian Beatty, Secretary of the Department of Crime Control and Public Safety, Dempsey Benton, Secretary of the Department of Health and Human Services, and Allison Breedlove, Disability Advocate. The DEEM Task Force report included a total of 16 recommendations addressing a range of issues relating to disaster planning and disaster preparedness of long-term care facilities in the State.

S193-SMRD-7(e1) v1

Attachment V

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 193

Short Title:	Strengthen Disaster Planning/LTC Facilities.	(Public)
Sponsors:	Senators Malone, Forrester, Swindell; Berger of Franklin, Bingham, Brunstetter, Davis, Dorsett, Foriest, Goss, Hoyle, Jones, McKissick, Purcell, Stevens, and Tillman.	
Referred to:	Health Care.	

February 18, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF HEALTH SERVICE REGULATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO REVIEW RECOMMENDATIONS FROM THE DISABILITY AND ELDERLY EMERGENCY MANAGEMENT (DEEM) TASK FORCE AND TO TAKE APPROPRIATE ACTION TO STRENGTHEN DISASTER PLANNING AND DISASTER PREPAREDNESS FOR LONG-TERM CARE FACILITIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Division of Health Service Regulation, Department of Health and Human Services, shall review recommendations from the Disability and Elderly Emergency Management (DEEM) Task Force, and shall take appropriate action to strengthen disaster planning and disaster preparedness for long-term care facilities. The Division of Health Service Regulation shall report findings, action taken, and any further recommendations to the North Carolina Study Commission on Aging and the Joint Select Committee on Emergency Preparedness and Disaster Management Recovery on or before March 1, 2010.

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

Attachment VI

SENATE BILL 195:
Preparations for Aging Baby Boomers

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	March 3, 2009
Introduced by:	Sen. Malone	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Legislative Analyst

SUMMARY: Senate Bill 195 directs the University of North Carolina Institute on Aging, and the Division of Aging and Adult Services to conduct certain activities to prepare for the increasing population of older adults.

BILL ANALYSIS: The bill provides the University of North Carolina Institute on Aging and the Division of Aging and Adult Services shall assist the State in its preparations for the projected population growth of older adults in the State by:

(1) Organizing and facilitating meetings of gerontologists, researchers, county representatives, directors of area agencies on aging, and various providers of State services to identify and prioritize issues for the State to address;

(2) Establish a website containing models of local planning efforts and information on fostering retiree and volunteer involvement after working with the NC Association of County Commissioners, the University of North Carolina School of Government, higher education departments of municipal and regional planning and area agencies on aging.

The bill directs the Institute on Aging and the Division of Aging and Adult Services to make progress reports on these activities to the Governor and to the Study Commission on Aging on or by March 1, 2009 and on or by November 1, 2010.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND:

Session Law 2007-355 directed the Department of Health and Human Services, Division of Aging and Adult Services to conduct a study of counties projected to experience significant increases to the counties' older adult populations and determine the impact on programs and services that serve those populations.

Between 2000 and 2030 the population growth for the State as a whole is projected at 52.5%, while the population age 65 and older is expected to grow 123% and those age 85 and older by 146%. According to a national report, *The Maturing of America: Getting Communities on Track for An Aging Population,* cited that, "...only 46% of American communities have started addressing the needs of the rapidly increasing aging population." ... "that local governments...as yet do not have the policies, programs or services in place to promote the quality of life and the abilities of older adults to live independently and contribute to their communities for as long as possible..."[1]

S195-SMSQ-4(e1) v1

[1] North Carolina Study Commission on Aging's report to the Governor and the 2009 General Assembly.

Attachment VII

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 195*

Short Title:	Preparations for Aging Baby Boomers.	(Public)
Sponsors:	Senators Malone, Dorsett, Bingham; Berger of Franklin, Brunstetter, Davis, Forrester, Goss, Hoyle, Jones, McKissick, Purcell, Queen, Stein, Stevens, and Tillman.	
Referred to:	Health Care.	

February 18, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE UNIVERSITY OF NORTH CAROLINA INSTITUTE ON AGING, AND THE DIVISION OF AGING AND ADULT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO TAKE A LEADERSHIP ROLE IN HELPING NORTH CAROLINA PREPARE FOR INCREASED NUMBERS OF OLDER ADULTS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The University of North Carolina Institute on Aging, and the Division of Aging and Adult Services, Department of Health and Human Services, shall help the State prepare for increased numbers of older adults, due to the aging of the baby boomer generation and the influx of elderly retirees into the State. Activities shall include, but are not limited to, the following:

(1) Organizing and facilitating meetings of gerontologists, researchers, county representatives, directors of area agencies on aging, and providers of State services, to collectively identify and prioritize issues for the State to address.

(2) Working with the North Carolina Association of County Commissioners, the University of North Carolina School of Government, higher education departments of municipal and regional planning and their partners, and area agencies on aging to establish a Web site containing:

a. Information on fostering retiree and volunteer involvement, and

b. Models of local planning efforts, in order to assist municipalities in addressing accessibility and service delivery for increasing numbers of older adults.

SECTION 2. The University of North Carolina Institute on Aging, and the Division of Aging and Adult Services, Department of Health and Human Services, shall make progress reports on the activities required by this act to the Governor and to the North Carolina Study Commission on Aging on or before March 1, 2010, and on or before November 1, 2010.

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

Attachment VIII

SENATE BILL 243:
Reduce Infant Mortality and Preterm Births

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	March 3, 2009
Introduced by:	Sen. Purcell	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***Senate Bill 243 would direct the Division of Medical Assistance (Division), of the Department of Health and Human Services, to seek a Medicaid 1115 waiver or implement other Medicaid options to provide interconceptional care to women with incomes below 185% of the federal poverty level who have given birth to a high risk infant. Coverage would be limited to either two years following the birth of the high risk infant or the birth of a subsequent child, whichever comes first.***

The Act would authorize the Division to develop a benefit package to provide care to decrease poor birth outcomes in subsequent pregnancies and would direct the Division to provide estimates of cost savings attributable to improved birth outcomes to offset costs of providing Medicaid coverage to this population.

CURRENT LAW: An existing program of the Division – Medicaid for Families with Dependent Children – provides medical care for parents or other caretakers of children 18 or younger who have no more than $3,000 in total assets and make no more than the following monthly income[1]:

Family Size	Caretakers and Children age 19 and 20
1	$362
2	$472
3	$544
4	$594

For a family of two, the annual income limit would be $5,664 (39% of the federal poverty level).

BILL ANALYSIS: Senate Bill 243 would direct the Division of Medical Assistance (Division), of the Department of Health and Human Services, to seek a Medicaid 1115 waiver or implement other Medicaid options to provide interconceptional care to women with incomes below 185% of the federal poverty level who have given birth to a high risk infant.

Coverage would be limited to either two years following the birth of the high risk infant or the birth of a subsequent child, whichever comes first.

The Act would authorize the Division to develop a benefit package to decrease poor birth outcomes in subsequent pregnancies and would direct the Division to provide estimates of cost savings attributable to improved birth outcomes to offset costs of providing Medicaid coverage to this population.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: Senate Bill 243 is a recommendation of the Child Fatality Task Force.

S243-SMRD-8(e1) v1

[1] http://www.ncdhhs.gov/dma/medicaid/families.htm

Attachment IX

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 243

Short Title:	Reduce Infant Mortality and Preterm Births.	(Public)
Sponsors:	Senators Purcell; Allran and Bingham.	
Referred to:	Health Care.	

February 23, 2009

A BILL TO BE ENTITLED

AN ACT TO REDUCE INFANT MORTALITY AND REDUCE PRETERM BIRTHS, AS RECOMMENDED BY THE CHILD FATALITY TASK FORCE.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall seek a Medicaid 1115 waiver or implement other available Medicaid options to provide interconceptional coverage to low-income women with incomes below one hundred eight-five percent (185%) of the federal poverty guidelines who have given birth to a high-risk infant. A high-risk infant is defined as weighing less than 1500 grams, is born less than 34 weeks gestation, is born with a congenital anomaly, or who has died within the first 28 days of life.

SECTION 2. Interconceptional care shall be limited to two years following the birth of a high-risk infant, or until a subsequent birth, whichever comes first.

SECTION 3. The Division is authorized to develop a benefit package to improve interconceptional care to decrease poor birth outcomes in subsequent pregnancies.

SECTION 4. The Division shall provide estimates of the cost savings from improved birth outcomes that will offset the cost of providing Medicaid coverage to this targeted population.

SECTION 5. This act is effective when it becomes law.

ATTACHMENT 7

VISITOR REGISTRATION

Name of Committee **SENATE HEALTH CARE COMMITTEE**

Date
March 4, 2009

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michelle Frazier	MFS
Erin McLaughlin	NHAHC
Bob Thompson	Covenant
Tom Vitaglione	Child Fatality Task Force
Sheyna Alterovitz	AARP
Janet Schrimsher Lynch	Smith Anderson
Kathryn Harvell	NCPS
Steve Shore	NC Pediatric Soc.
Jamal Jones	NCHA
Carol Ostrach	NCHA
Marlowe Foster	Pfizer

ATTACHMENT 4

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
SANEEN WEEKS	SEN. GRAHAM INTERN
John McMullan	MF&S
Jessica Meed	SEN. Boger intern
Thar Offenbury	Sen. Elizabeth Kinnaird, Intern
William Floras	Leg Assistant

Briefing Sheet on S243 – Medicaid Waiver to Reduce Preterm Births

- North Carolina ranks 44th in infant mortality nationally (8.5 deaths per 100,000 live births in 2007). The rate for minorities is twice the rate for whites.

- One of the primary underlying causes of infant mortality is prematurity, defined as a gestational period of less than 38 weeks. In 2005, 13.7% of births in North Carolina were preterm, a rank of 40th nationally.

- Preterm births account for more than 70% of neonatal deaths (less than 28 days of life) and almost half of long-term neurological disabilities. Children born preterm are also at higher risk for respiratory distress, jaundice, necrotizing enterocolitis and a host of other serious conditions.

- Preterm births are also very costly. For example, in 2005 NC Medicaid paid an average of $3,640 in maternity and hospital charges for healthy term newborns. However, the cost for a very preterm or very low birthweight newborn averaged $60,000!

- Research shows that the health of the mother is a prime determinant of birth outcomes. Risk factors include diabetes, hypertension, obesity, smoking, as well as a history of preterm birth.

- While NC Medicaid covers prenatal care and delivery for women with incomes less than 185% of the federal poverty level (or about 40% of all births annually), it does not cover care before the pregnancy. Thus, we must rely on the short prenatal period to deal with all the high risk conditions a woman might have. This is not particularly effective, and North Carolina pays the price in poor birth outcomes and enormous expenditures.

- This bill proposes to have Medicaid cover pre-pregnancy care for low-income who have had a previous high-risk infant, defined as weighing less than 1500 grams, born less than 34 weeks gestation, born with a congenital anomaly, or has died within 28 days of birth. This target group is approximately 3600 women annually. By covering basic, relatively low-cost care to reduce health risks before pregnancy, a significant percentage of high-risk, high-cost births can be averted, saving both lives and money.

- To provide this "interconceptional" care (for two years or the next pregnancy, whichever comes first), a federal waiver must be obtained. This bill directs the Division of Medical Assistance to seek such a waiver. Because these waivers must show the potential for "cost neutrality", such coverage, if approved, would likely reduce North Carolina's Medicaid costs while attaining the goal of reducing infant mortality.

Senate Health Care Committee
Wednesday, March 11, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 356	**Amend Nursing Practice Act.**	**Senator Rand**
SB 324	**Medicaid/Hemophilic Drugs/No Prior Auth.**	**Senator Queen**
SB 188	**Special Care Dentistry Collaboration.**	**Senator Malone**
SB 354	**Social Security Increase/Medicaid Elig.**	**Sen. Kinnaird**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, March 12, 2009

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

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

S.B.	**188**	Special Care Dentistry Collaboration.	
		Draft Number:	55193
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	Yes
S.B.	**356**	Amend Nursing Practice Act.	
		Draft Number:	15104
		Sequential Referral:	None
		Recommended Referral:	None
		Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, March 11, 2009

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

FAVORABLE

S.B. **324** Medicaid/Hemophilic Drugs/No Prior Auth.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, March 11, 2009, at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, March 11, 2009, in Room 544 of the Legislative Office Building, with nineteen members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Bingham told Committee Members that Senate Bill 354, ***Social Security Increase/Medicaid Elig.***, would be pulled from the Agenda today.

Senator Bingham recognized Senator Queen to present Senate Bill 324, ***Medicaid/Hemophilic Drugs/No Prior Auth***. Sen. Queen explained it would remove a sunset from previous legislation that was started as a pilot program four years ago. He stated it was a sunset on the pre-approval of drugs for the hemophilic patients, whose conditions are very time sensitive and they need their prescription. Senator Bingham pointed out that Senate Bill 324 had a sequential referral to Appropriations. Senator Rucho asked if there was a cost in changing the sunset on the bill. Sen. Queen stated there would be no additional cost. Sen. Queen requested that Tara Larson with the Department of Health and Human Services be allowed to respond. Tara Larson, Acting Director, Division of Medical Assistance, stated that there would be no cost implication by moving forward with Senate Bill 324 and pointed out that the Department strongly supports the bill. Senator Rucho asked why there was a sunset to begin with. Tara Larson stated that many of these drugs can be costly, however with the timeliness and the cost benefit, the review was needed to see exactly how the drugs would be used and if the utilization would be increased. They found that did not happen and it continued to be the best medical practice. Also she stated there had not been any abuse or fraud detected in this process. Senator Dorsett moved for a favorable report. The motion passed.

Senator Rand was recognized to explain Senate Bill 356, ***Amend Nursing Practice.***, which had a (PCS) Proposed Committee Substitute. Senator Dannelly moved to adopt the PCS for discussion. Senator Rand stated that Senate Bill 356 was requested by The Nursing Board. Sen. Rand pointed out he was not aware of any opposition and stated it was mainly technical. He went over each section as listed in the Bill Analysis. Senator Dannelly moved for a favorable report, unfavorable to the original bill, but favorable as to the Proposed Committee Substitute. The motion carried.

Senator Bingham recognized Senator Malone to present Senate Bill 188, ***Special Care Dentistry Collaboration***, which had a (PCS) Proposed Committee Substitute. Senator Foriest made the motion to adopt the PCS for discussion and the motion carried. Senator Malone stated the bill had come from The Committee on Aging. Senator Malone explained that the bill would direct five or six different agencies, which are involved in

providing services for adults in the area of dentistry, to collaborate on a way to better provide the services and to prepare and present their findings back to the Committee on Aging. The bill will direct (DHHS) the Department of Health and Human Services to combine the reports, rather than having all the entities sending individuals reports. Senator Dorsett moved for a favorable report, unfavorable as to the original bill, but favorable as to the Proposed Committee Substitute. The motion carried.

The meeting adjourned at 11:25.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

S 1

SENATE BILL 356

Short Title:	Amend Nursing Practice Act.	(Public)
Sponsors:	Senator Rand.	
Referred to:	Health Care.	

March 3, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS REVISIONS TO THE NURSING PRACTICE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-171.23(b) reads as rewritten:

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

(1) Administer this Article.

(2) Issue its interpretations of this Article.

(3) Adopt, amend or repeal rules and regulations as may be necessary to carry out the provisions of this Article.

(4) Establish qualifications of, employ, and set the compensation of an executive officer who shall be a registered nurse and who shall not be a member of the Board.

(5) Employ and fix the compensation of other personnel that the Board determines are necessary to carry into effect this Article and incur other expenses necessary to effectuate this Article.

(6) Examine, license, and renew the licenses of duly qualified applicants for licensure.

(7) Cause the prosecution of all persons violating this Article.

(8) Establish standards to be met by the students, and to pertain to faculty, curricula, facilities, resources, and administration for any nursing program as provided in G.S. 90-171.38.

(9) Review all nursing programs at least every eight years or more often as considered necessary by the Board or program director.

(10) Grant or deny approval for nursing programs as provided in G.S. 90-171.39.

(11) Upon request, grant or deny approval of continuing education programs for nurses as provided in G.S. 90-171.42.

(12) Keep a record of all proceedings and make available ~~to the Governor and licensees~~ an annual summary of all actions taken.

(13) Appoint, as necessary, advisory committees which may include persons other than Board members to deal with any issue under study.

(14) Appoint and maintain a subcommittee of the Board to work jointly with the subcommittee of the North Carolina Medical Board to develop rules and regulations to govern the performance of medical acts by registered nurses and to determine reasonable fees to accompany an application for approval or renewal of such approval as provided in G.S. 90-6. The fees and rules developed by this subcommittee shall govern the performance of medical

acts by registered nurses and shall become effective when they have been adopted by both Boards.

(15) Recommend and collect such fees for licensure, license renewal, examinations and reexaminations as it deems necessary for fulfilling the purposes of this Article.

(16) Adopt a seal containing the name of the Board for use on all certificates, licenses, and official reports issued by it.

(17) Enter into interstate compacts to facilitate the practice and regulation of nursing.

(18) Establish programs for aiding in the recovery and rehabilitation of nurses who experience chemical addiction or abuse or mental or physical disabilities and programs for monitoring such nurses for safe practice.

(18a) Establish programs for aiding in the remediation of nurses who experience practice deficiencies.

(19) Request that the Department of Justice conduct criminal history record checks of applicants for licensure pursuant to G.S. 114-19.11.

(20) Adopt rules requiring an applicant to submit to the Board evidence of the applicant's continuing competence in the practice of nursing at the time of license renewal or reinstatement.

(21) Proceed in accordance with G.S. 90-171.37A, notwithstanding G.S. 150B-40(b), when conducting a contested case hearing in accordance with Article 3A of Chapter 150B of the General Statutes.

(22) Designate one or more of its employees to serve papers or subpoenas issued by the Board. Service under this subdivision is permitted in addition to any other methods of service permitted by law.

(23) Acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as a private person or corporation, subject only to approval of the Governor and the Council of State. Collateral pledged by the Board for an encumbrance is limited to the assets, income, and revenues of the Board.

(24) Order the production of any records concerning the practice of nursing relevant to a complaint received by the Board or an inquiry or investigation conducted by or on behalf of the Board."

SECTION 2. G.S. 90-171.24 reads as rewritten:

"**§ 90-171.24. Executive director.**

The executive director shall perform the duties prescribed by the ~~Board,~~Board and serve as secretary/treasurer to the ~~Board, and furnish a surety bond as provided in G.S. 128-8. The bond shall be made payable to the Board.~~Board."

SECTION 3. G.S. 90-171.34 reads as rewritten:

"**§ 90-171.34. Licensure renewal.**

Every unencumbered license, except temporary license, issued under this Article shall be renewed for two years. On or before the date the current license expires, every person who desires to continue to practice nursing shall apply for licensure renewal to the Board on forms furnished by the Board and shall also file the required fee. ~~The Board shall provide space on the renewal form for the licensee to specify the amount of continuing education received during the renewal period.~~ Failure to renew the license before the expiration date shall result in automatic forfeiture of the right to practice nursing in North Carolina until such time that the license has been reinstated."

SECTION 4. G.S. 90-171.37 reads as rewritten:

"**§ 90-171.37. Revocation, discipline, suspension, probation, or denial of licensure.**

The Board ~~shall~~ may initiate an investigation upon receipt of information about any practice that might violate any provision of this Article or any rule or regulation promulgated by the Board. In accordance with the provisions of Chapter 150B of the General Statutes, the Board shall have the power and authority to: (i) refuse to issue a license to practice nursing; (ii) refuse to issue a certificate of renewal of a license to practice nursing; (iii) revoke or suspend a license to practice nursing; and (iv) invoke other such disciplinary measures, censure, or probative terms against a licensee as it deems fit and proper; in any instance or instances in which the Board is satisfied that the applicant or licensee:

(1) Has given false information or has withheld material information from the Board in procuring or attempting to procure a license to practice nursing.

(2) Has been convicted of or pleaded guilty or nolo contendere to any crime which indicates that the nurse is unfit or incompetent to practice nursing or that the nurse has deceived or defrauded the public.

(3) Has a mental or physical disability or uses any drug to a degree that interferes with his or her fitness to practice nursing.

(4) Engages in conduct that endangers the public health.

(5) Is unfit or incompetent to practice nursing by reason of deliberate or negligent acts or omissions regardless of whether actual injury to the patient is established.

(6) Engages in conduct that deceives, defrauds, or harms the public in the course of professional activities or services.

(7) Has violated any provision of this Article.

(8) Has willfully violated any rules enacted by the Board.

The Board may take any of the actions specified above in this section when a registered nurse approved to perform medical acts has violated rules governing the performance of medical acts by a registered nurse; provided this shall not interfere with the authority of the North Carolina Medical Board to enforce rules and regulations governing the performance of medical acts by a registered nurse.

The Board may reinstate a revoked license, revoke censure or probative terms, or remove other licensure restrictions when it finds that the reasons for revocation, censure or probative terms, or other licensure restrictions no longer exist and that the nurse or applicant can reasonably be expected to safely and properly practice nursing."

SECTION 5. G.S. 90-171.38(b) reads as rewritten:

"(b) Any individual, organization, association, corporation, or institution may establish a program for the purpose of training or educating any registered nurse licensed under G.S. 90-171.30, 90-171.32, or 90-171.33 in the skills, procedures, and techniques necessary to conduct ~~medical~~ examinations for the purpose of collecting evidence from the victims of first-degree rape as defined in G.S. 14-27.2, second-degree rape as defined in G.S. 14-27.3, statutory rape as defined in G.S. 14-27.7A, first-degree sexual offense as defined in G.S. 14-27.4, second-degree sexual offense as defined in G.S. 14-27.5 or attempted first-degree or second-degree rape or attempted first-degree or second-degree sexual offense as defined in G.S. 14-27.6. The Board, pursuant to ~~G.S. 90-171.23(b)(14) and, in cooperation with the North Carolina Medical Board as described in G.S. 90-6,~~G.S. 90-171.23(b)(14), shall establish, revise, or repeal standards for any such program. Any individual, organization, association, corporation, or institution which desires to establish a program under this subsection shall apply to the Board and submit satisfactory evidence that it will meet the standards prescribed by the Board."

SECTION 6. G.S. 90-171.48 reads as rewritten:

"**§ 90-171.48. Criminal history record checks of applicants for licensure.**

(a) Definitions. – The following definitions shall apply in this section:

(1) Applicant. – A person applying for initial licensure as a registered nurse or licensed practical nurse either by examination pursuant to G.S. 90-171.29 ~~and~~ or G.S. 90-171.30 or without examination pursuant to G.S. 90-171.32. The term "applicant" shall also include a person applying for reinstatement of licensure pursuant to G.S. 90-171.35 or returning to active status pursuant to G.S. 90-171.36 as a registered nurse or licensed practical nurse.

(2) 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 nursing. 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 7A, 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 and Civil Disorders; 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.

(b) All applicants for licensure shall consent to a criminal history record check. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny licensure to an applicant. The Board shall ensure that the State and national criminal history of an applicant applying for initial licensure as a registered nurse or licensed practical nurse either by examination pursuant to G.S. 90-171.29 or G.S. 90-171.30 or without examination pursuant to G.S. 90-171.32 is checked. The Board may request a criminal history record check for applicants applying for reinstatement of licensure pursuant to G.S.90-171.35 or return to active status pursuant to G.S. 90-171.36 as a registered nurse or licensed practical nurse.

The Board shall be responsible for providing to the North Carolina Department of Justice the fingerprints of the applicant to be checked, a form signed by the applicant consenting to the criminal record check and the use of fingerprints and other identifying information required by the State or National Repositories, and any additional information required by the Department of Justice. The Board shall keep all information obtained pursuant to this section confidential.

(c) If an applicant's criminal history record check reveals one or more convictions listed under subsection (a)(2) of this section, the conviction shall not automatically bar licensure. The Board shall consider all of the following factors regarding the conviction:

(1) The level of seriousness of the crime.

(2) The date of the crime.

(3) The age of the person at the time of the conviction.

(4) The circumstances surrounding the commission of the crime, if known.

(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.

(6) The person's prison, jail, probation, parole, rehabilitation, and employment records since the date the crime was committed.

(7) The subsequent commission by the person of a crime listed in subsection (a) of this section.

If, after reviewing the factors, the Board determines that the grounds set forth in subsections (1), (2), (3), (4), (5), or (6) of G.S. 90-171.37 exist, the Board may deny licensure of the applicant. The Board may disclose to the applicant information contained in the criminal history record check that is relevant to the denial. The Board shall not provide a copy of the criminal history record check to the applicant. The applicant shall have the right to appear before the Board to appeal the Board's decision. However, an appearance before the full Board shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.

(d) Limited immunity. – The Board, its officers and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for denying licensure to an applicant based on information provided in the applicant's criminal history record check."

SECTION 7. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 356
PROPOSED COMMITTEE SUBSTITUTE S356-CSRD-5 [v.1]

3/10/2009 5:13:09 PM

Short Title: Amend Nursing Practice Act. (Public)

Sponsors:

Referred to:

March 3, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS REVISIONS TO THE NURSING PRACTICE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-171.23(b) reads as rewritten:

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

(1) Administer this Article.

(2) Issue its interpretations of this Article.

(3) Adopt, amend or repeal rules and regulations as may be necessary to carry out the provisions of this Article.

(4) Establish qualifications of, employ, and set the compensation of an executive officer who shall be a registered nurse and who shall not be a member of the Board.

(5) Employ and fix the compensation of other personnel that the Board determines are necessary to carry into effect this Article and incur other expenses necessary to effectuate this Article.

(6) Examine, license, and renew the licenses of duly qualified applicants for licensure.

(7) Cause the prosecution of all persons violating this Article.

(8) Establish standards to be met by the students, and to pertain to faculty, curricula, facilities, resources, and administration for any nursing program as provided in G.S. 90-171.38.

(9) Review all nursing programs at least every eight years or more often as considered necessary by the Board or program director.

(10) Grant or deny approval for nursing programs as provided in G.S. 90-171.39.

(11) Upon request, grant or deny approval of continuing education programs for nurses as provided in G.S. 90-171.42.

(12) Keep a record of all proceedings and make an annual summary of all actions available.~~available to the Governor and licensees an annual summary of all actions taken.~~

(13) Appoint, as necessary, advisory committees which may include persons other than Board members to deal with any issue under study.

(14) Appoint and maintain a subcommittee of the Board to work jointly with the subcommittee of the North Carolina Medical Board to develop rules and regulations to govern the performance of medical acts by registered nurses

and to determine reasonable fees to accompany an application for approval or renewal of such approval as provided in ~~G.S. 90-6.~~ G.S. 90-8.2. The fees and rules developed by this subcommittee shall govern the performance of medical acts by registered nurses and shall become effective when they have been adopted by both Boards.

(15) Recommend and collect such fees for licensure, license renewal, examinations and reexaminations as it deems necessary for fulfilling the purposes of this Article.

(16) Adopt a seal containing the name of the Board for use on all certificates, licenses, and official reports issued by it.

(17) Enter into interstate compacts to facilitate the practice and regulation of nursing.

(18) Establish programs for aiding in the recovery and rehabilitation of nurses who experience chemical addiction or abuse or mental or physical disabilities and programs for monitoring such nurses for safe practice.

(18a) Establish programs for aiding in the remediation of nurses who experience practice deficiencies.

(19) Request that the Department of Justice conduct criminal history record checks of applicants for licensure pursuant to G.S. 114-19.11.

(20) Adopt rules requiring an applicant to submit to the Board evidence of the applicant's continuing competence in the practice of nursing at the time of license renewal or reinstatement.

(21) Proceed in accordance with G.S. 90-171.37A, notwithstanding G.S. 150B-40(b), when conducting a contested case hearing in accordance with Article 3A of Chapter 150B of the General Statutes.

(22) Designate one or more of its employees to serve papers or subpoenas issued by the Board. Service under this subdivision is permitted in addition to any other methods of service permitted by law.

(23) Acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as a private person or corporation, subject only to approval of the Governor and the Council of State. Collateral pledged by the Board for an encumbrance is limited to the assets, income, and revenues of the Board.

(24) Order the production of any records concerning the practice of nursing relevant to a complaint received by the Board or an inquiry or investigation conducted by or on behalf of the Board."

SECTION 2. G.S. 90-171.24 reads as rewritten:

"**§ 90-171.24. Executive director.**

The executive director shall perform the duties prescribed by the ~~Board,~~Board and serve as secretary/treasurer to the ~~Board, and furnish a surety bond as provided in G.S. 128-8. The bond shall be made payable to the Board.~~Board."

SECTION 3. G.S. 90-171.34 reads as rewritten:

"**§ 90-171.34. Licensure renewal.**

Every unencumbered license, except temporary license, issued under this Article shall be renewed for two years. On or before the date the current license expires, every person who desires to continue to practice nursing shall apply for licensure renewal to the Board on forms furnished by the Board and shall also file the required fee. ~~The Board shall provide space on the renewal form for the licensee to specify the amount of continuing education received during the renewal period.~~ Failure to renew the license before the expiration date shall result in automatic forfeiture of the right to practice nursing in North Carolina until such time that the license has been reinstated."

SECTION 4. G.S. 90-171.37 reads as rewritten:

"**§ 90-171.37. Revocation, discipline, suspension, probation, or denial of licensure.**

The Board ~~shall~~ may initiate an investigation upon receipt of information about any practice that might violate any provision of this Article or any rule or regulation promulgated by the Board. In accordance with the provisions of Chapter 150B of the General Statutes, the Board shall have the power and authority to: (i) refuse to issue a license to practice nursing; (ii) refuse to issue a certificate of renewal of a license to practice nursing; (iii) revoke or suspend a license to practice nursing; and (iv) invoke other such disciplinary measures, censure, or probative terms against a licensee as it deems fit and proper; in any instance or instances in which the Board is satisfied that the applicant or licensee:

(1) Has given false information or has withheld material information from the Board in procuring or attempting to procure a license to practice nursing.

(2) Has been convicted of or pleaded guilty or nolo contendere to any crime which indicates that the nurse is unfit or incompetent to practice nursing or that the nurse has deceived or defrauded the public.

(3) Has a mental or physical disability or uses any drug to a degree that interferes with his or her fitness to practice nursing.

(4) Engages in conduct that endangers the public health.

(5) Is unfit or incompetent to practice nursing by reason of deliberate or negligent acts or omissions regardless of whether actual injury to the patient is established.

(6) Engages in conduct that deceives, defrauds, or harms the public in the course of professional activities or services.

(7) Has violated any provision of this Article.

(8) Has willfully violated any rules enacted by the Board.

The Board may take any of the actions specified above in this section when a registered nurse approved to perform medical acts has violated rules governing the performance of medical acts by a registered nurse; provided this shall not interfere with the authority of the North Carolina Medical Board to enforce rules and regulations governing the performance of medical acts by a registered nurse.

The Board may reinstate a revoked license, revoke censure or probative terms, or remove other licensure restrictions when it finds that the reasons for revocation, censure or probative terms, or other licensure restrictions no longer exist and that the nurse or applicant can reasonably be expected to safely and properly practice nursing."

SECTION 5. G.S. 90-171.38(b) reads as rewritten:

"(b) Any individual, organization, association, corporation, or institution may establish a program for the purpose of training or educating any registered nurse licensed under G.S. 90-171.30, 90-171.32, or 90-171.33 in the skills, procedures, and techniques necessary to conduct ~~medical~~ examinations for the purpose of collecting evidence from the victims of first-degree rape as defined in G.S. 14-27.2, second-degree rape as defined in G.S. 14-27.3, statutory rape as defined in G.S. 14-27.7A, first-degree sexual offense as defined in G.S. 14-27.4, second-degree sexual offense as defined in G.S. 14-27.5 or attempted first-degree or second-degree rape or attempted first-degree or second-degree sexual offense. ~~offense as defined in G.S. 14-27.6.~~ The Board, pursuant to ~~G.S. 90-171.23(b)(14) and, in cooperation with the North Carolina Medical Board as described in G.S. 90-6,~~ G.S. 90-171.23(b)(14), shall establish, revise, or repeal standards for any such program. Any individual, organization, association, corporation, or institution which desires to establish a program under this subsection shall apply to the Board and submit satisfactory evidence that it will meet the standards prescribed by the Board."

SECTION 6. G.S. 90-171.48 reads as rewritten:

"**§ 90-171.48. Criminal history record checks of applicants for licensure.**

(a) Definitions. – The following definitions shall apply in this section:

(1) Applicant. – A person applying for initial licensure as a registered nurse or licensed practical nurse either by examination pursuant to G.S. 90-171.29 ~~and~~ or G.S. 90-171.30 or without examination pursuant to G.S. 90-171.32. The term "applicant" shall also include a person applying for reinstatement of licensure pursuant to G.S. 90-171.35 or returning to active status pursuant to G.S. 90-171.36 as a registered nurse or licensed practical nurse.

(2) 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 nursing. 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 7A, 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 and Civil Disorders; 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.

(b) All applicants for licensure shall consent to a criminal history record check. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny licensure to an applicant. The Board shall ensure that the State and national criminal history of an applicant applying for initial licensure as a registered nurse or licensed practical nurse either by examination pursuant to G.S. 90-171.29 or G.S. 90-171.30 or without examination pursuant to G.S. 90-171.32 is checked. The Board may request a criminal history record check for applicants applying for reinstatement of licensure pursuant to G.S.90-171.35 or return to active status pursuant to G.S. 90-171.36 as a registered nurse or licensed practical nurse.

The Board shall be responsible for providing to the North Carolina Department of Justice the fingerprints of the applicant to be checked, a form signed by the applicant consenting to the criminal record check and the use of fingerprints and other identifying information required by the State or National Repositories, and any additional information required by the Department of Justice. The Board shall keep all information obtained pursuant to this section confidential.

(c) If an applicant's criminal history record check reveals one or more convictions listed under subsection (a)(2) of this section, the conviction shall not automatically bar licensure. The Board shall consider all of the following factors regarding the conviction:

(1) The level of seriousness of the crime.

(2) The date of the crime.

(3) The age of the person at the time of the conviction.

(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The person's prison, jail, probation, parole, rehabilitation, and employment records since the date the crime was committed.
(7) The subsequent commission by the person of a crime listed in subsection (a) of this section.

If, after reviewing the factors, the Board determines that the grounds set forth in subsections (1), (2), (3), (4), (5), or (6) of G.S. 90-171.37 exist, the Board may deny licensure of the applicant. The Board may disclose to the applicant information contained in the criminal history record check that is relevant to the denial. The Board shall not provide a copy of the criminal history record check to the applicant. The applicant shall have the right to appear before the Board to appeal the Board's decision. However, an appearance before the full Board shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.

(d) Limited immunity. – The Board, its officers and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for denying licensure to an applicant based on information provided in the applicant's criminal history record check."

SECTION 7. This act is effective when it becomes law.

SENATE BILL 356:
Amend Nursing Practice Act

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	March 10, 2009
Introduced by:	Sen. Rand	**Prepared by:**	Ben Popkin
Analysis of:	PCS to First Edition S356-CSRD-5		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute to Senate Bill 356 would make a series of changes to the Nursing Practice Act, including: authorize the Board to establish remediation programs for nurses with practice deficiencies, authorize the Board to subpoena records relevant to complaint-driven Board investigations, repeal obsolete provisions and references, grant Board discretion (rather than require) to conduct investigations about possible violations of the Act, eliminate required cooperation with the Medical Board in developing programs to train nurses in conducting sexual assault examinations, and authorize the Board to conduct criminal background checks of applicants for reinstatement or reactivation of a nursing license.***

The Proposed Committee Substitute made technical changes to the bill, correcting or removing references to repealed provisions.

BILL ANALYSIS: The Proposed Committee Substitute to Senate Bill 356 would make the following changes:

Section 1 – would amend G.S. 90-171.23(b) (duties and powers of the Board of Nursing) to remove the direction to make annual summaries of Board actions available to the Governor and licensees (summaries are currently available online to all); insert a new power, authorizing the Board to establish programs for remediation of nurses with practice deficiencies; and authorize the Board to subpoena records relating to complaints received by the Board, or investigations conducted by or for the Board.

Section 2 – would delete obsolete language referencing a repealed statute.

Section 3 – would delete the requirement that the Board provide a dedicated space on its renewal form for licensees to specify continuing education received.

Section 4 – would give the Board discretion in determining whether to initiate investigations into possible violations of the Nursing Practice Act.

Section 5 – would amend the provision on development of programs to train nurses to conduct examinations of victims of sexual assaults, removing language calling the examination a medical examination and removing the direction to cooperate with the Board of Medicine in establishing, revising, or repealing standards for this training.

Section 6 – would authorize the Board to conduct criminal record checks of applicants for reinstatement or reactivation of licensure as a registered nurse or licensed practical nurse.

EFFECTIVE DATE: This act is effective when it becomes law.

S356-SMRD-16(CSRD-5) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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SENATE BILL 356
PROPOSED COMMITTEE SUBSTITUTE S356-PCS15104-RD-5

Short Title: Amend Nursing Practice Act. (Public)

Sponsors:

Referred to:

March 3, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE VARIOUS REVISIONS TO THE NURSING PRACTICE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-171.23(b) reads as rewritten:

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

(1) Administer this Article.

(2) Issue its interpretations of this Article.

(3) Adopt, amend or repeal rules and regulations as may be necessary to carry out the provisions of this Article.

(4) Establish qualifications of, employ, and set the compensation of an executive officer who shall be a registered nurse and who shall not be a member of the Board.

(5) Employ and fix the compensation of other personnel that the Board determines are necessary to carry into effect this Article and incur other expenses necessary to effectuate this Article.

(6) Examine, license, and renew the licenses of duly qualified applicants for licensure.

(7) Cause the prosecution of all persons violating this Article.

(8) Establish standards to be met by the students, and to pertain to faculty, curricula, facilities, resources, and administration for any nursing program as provided in G.S. 90-171.38.

(9) Review all nursing programs at least every eight years or more often as considered necessary by the Board or program director.

(10) Grant or deny approval for nursing programs as provided in G.S. 90-171.39.

(11) Upon request, grant or deny approval of continuing education programs for nurses as provided in G.S. 90-171.42.

(12) Keep a record of all proceedings and make an annual summary of all actions available.~~available to the Governor and licensees an annual summary of all actions taken.~~

(13) Appoint, as necessary, advisory committees which may include persons other than Board members to deal with any issue under study.

(14) Appoint and maintain a subcommittee of the Board to work jointly with the subcommittee of the North Carolina Medical Board to develop rules and regulations to govern the performance of medical acts by registered nurses

and to determine reasonable fees to accompany an application for approval or renewal of such approval as provided in ~~G.S. 90-6.~~G.S. 90-8.2. The fees and rules developed by this subcommittee shall govern the performance of medical acts by registered nurses and shall become effective when they have been adopted by both Boards.

(15) Recommend and collect such fees for licensure, license renewal, examinations and reexaminations as it deems necessary for fulfilling the purposes of this Article.

(16) Adopt a seal containing the name of the Board for use on all certificates, licenses, and official reports issued by it.

(17) Enter into interstate compacts to facilitate the practice and regulation of nursing.

(18) Establish programs for aiding in the recovery and rehabilitation of nurses who experience chemical addiction or abuse or mental or physical disabilities and programs for monitoring such nurses for safe practice.

(18a) Establish programs for aiding in the remediation of nurses who experience practice deficiencies.

(19) Request that the Department of Justice conduct criminal history record checks of applicants for licensure pursuant to G.S. 114-19.11.

(20) Adopt rules requiring an applicant to submit to the Board evidence of the applicant's continuing competence in the practice of nursing at the time of license renewal or reinstatement.

(21) Proceed in accordance with G.S. 90-171.37A, notwithstanding G.S. 150B-40(b), when conducting a contested case hearing in accordance with Article 3A of Chapter 150B of the General Statutes.

(22) Designate one or more of its employees to serve papers or subpoenas issued by the Board. Service under this subdivision is permitted in addition to any other methods of service permitted by law.

(23) Acquire, hold, rent, encumber, alienate, and otherwise deal with real property in the same manner as a private person or corporation, subject only to approval of the Governor and the Council of State. Collateral pledged by the Board for an encumbrance is limited to the assets, income, and revenues of the Board.

(24) Order the production of any records concerning the practice of nursing relevant to a complaint received by the Board or an inquiry or investigation conducted by or on behalf of the Board."

SECTION 2. G.S. 90-171.24 reads as rewritten:

"**§ 90-171.24. Executive director.**

The executive director shall perform the duties prescribed by the ~~Board,~~Board and serve as secretary/treasurer to the ~~Board, and furnish a surety bond as provided in G.S. 128-8. The bond shall be made payable to the Board.~~Board."

SECTION 3. G.S. 90-171.34 reads as rewritten:

"**§ 90-171.34. Licensure renewal.**

Every unencumbered license, except temporary license, issued under this Article shall be renewed for two years. On or before the date the current license expires, every person who desires to continue to practice nursing shall apply for licensure renewal to the Board on forms furnished by the Board and shall also file the required fee. ~~The Board shall provide space on the renewal form for the licensee to specify the amount of continuing education received during the renewal period.~~ Failure to renew the license before the expiration date shall result in automatic forfeiture of the right to practice nursing in North Carolina until such time that the license has been reinstated."

SECTION 4. G.S. 90-171.37 reads as rewritten:

"**§ 90-171.37. Revocation, discipline, suspension, probation, or denial of licensure.**

The Board ~~shall~~ may initiate an investigation upon receipt of information about any practice that might violate any provision of this Article or any rule or regulation promulgated by the Board. In accordance with the provisions of Chapter 150B of the General Statutes, the Board shall have the power and authority to: (i) refuse to issue a license to practice nursing; (ii) refuse to issue a certificate of renewal of a license to practice nursing; (iii) revoke or suspend a license to practice nursing; and (iv) invoke other such disciplinary measures, censure, or probative terms against a licensee as it deems fit and proper; in any instance or instances in which the Board is satisfied that the applicant or licensee:

(1) Has given false information or has withheld material information from the Board in procuring or attempting to procure a license to practice nursing.

(2) Has been convicted of or pleaded guilty or nolo contendere to any crime which indicates that the nurse is unfit or incompetent to practice nursing or that the nurse has deceived or defrauded the public.

(3) Has a mental or physical disability or uses any drug to a degree that interferes with his or her fitness to practice nursing.

(4) Engages in conduct that endangers the public health.

(5) Is unfit or incompetent to practice nursing by reason of deliberate or negligent acts or omissions regardless of whether actual injury to the patient is established.

(6) Engages in conduct that deceives, defrauds, or harms the public in the course of professional activities or services.

(7) Has violated any provision of this Article.

(8) Has willfully violated any rules enacted by the Board.

The Board may take any of the actions specified above in this section when a registered nurse approved to perform medical acts has violated rules governing the performance of medical acts by a registered nurse; provided this shall not interfere with the authority of the North Carolina Medical Board to enforce rules and regulations governing the performance of medical acts by a registered nurse.

The Board may reinstate a revoked license, revoke censure or probative terms, or remove other licensure restrictions when it finds that the reasons for revocation, censure or probative terms, or other licensure restrictions no longer exist and that the nurse or applicant can reasonably be expected to safely and properly practice nursing."

SECTION 5. G.S. 90-171.38(b) reads as rewritten:

"(b) Any individual, organization, association, corporation, or institution may establish a program for the purpose of training or educating any registered nurse licensed under G.S. 90-171.30, 90-171.32, or 90-171.33 in the skills, procedures, and techniques necessary to conduct ~~medical~~ examinations for the purpose of collecting evidence from the victims of first-degree rape as defined in G.S. 14-27.2, second-degree rape as defined in G.S. 14-27.3, statutory rape as defined in G.S. 14-27.7A, first-degree sexual offense as defined in G.S. 14-27.4, second-degree sexual offense as defined in G.S. 14-27.5 or attempted first-degree or second-degree rape or attempted first-degree or second-degree sexual offense. ~~offense as defined in G.S. 14-27.6.~~ The Board, pursuant to ~~G.S. 90-171.23(b)(14) and, in cooperation with the North Carolina Medical Board as described in G.S. 90-6,~~ G.S. 90-171.23(b)(14), shall establish, revise, or repeal standards for any such program. Any individual, organization, association, corporation, or institution which desires to establish a program under this subsection shall apply to the Board and submit satisfactory evidence that it will meet the standards prescribed by the Board."

SECTION 6. G.S. 90-171.48 reads as rewritten:

"**§ 90-171.48. Criminal history record checks of applicants for licensure.**

(a) Definitions. – The following definitions shall apply in this section:

(1) Applicant. – A person applying for initial licensure as a registered nurse or licensed practical nurse either by examination pursuant to G.S. 90-171.29 ~~and~~ or G.S. 90-171.30 or without examination pursuant to G.S. 90-171.32. The term "applicant" shall also include a person applying for reinstatement of licensure pursuant to G.S. 90-171.35 or returning to active status pursuant to G.S. 90-171.36 as a registered nurse or licensed practical nurse.

(2) 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 nursing. 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 7A, 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 and Civil Disorders; 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.

(b) All applicants for licensure shall consent to a criminal history record check. Refusal to consent to a criminal history record check may constitute grounds for the Board to deny licensure to an applicant. The Board shall ensure that the State and national criminal history of an applicant applying for initial licensure as a registered nurse or licensed practical nurse either by examination pursuant to G.S. 90-171.29 or G.S. 90-171.30 or without examination pursuant to G.S. 90-171.32 is checked. The Board may request a criminal history record check for applicants applying for reinstatement of licensure pursuant to G.S.90-171.35 or returning to active status pursuant to G.S. 90-171.36 as a registered nurse or licensed practical nurse.

The Board shall be responsible for providing to the North Carolina Department of Justice the fingerprints of the applicant to be checked, a form signed by the applicant consenting to the criminal record check and the use of fingerprints and other identifying information required by the State or National Repositories, and any additional information required by the Department of Justice. The Board shall keep all information obtained pursuant to this section confidential.

(c) If an applicant's criminal history record check reveals one or more convictions listed under subsection (a)(2) of this section, the conviction shall not automatically bar licensure. The Board shall consider all of the following factors regarding the conviction:

(1) The level of seriousness of the crime.

(2) The date of the crime.

(3) The age of the person at the time of the conviction.

(4) The circumstances surrounding the commission of the crime, if known.
(5) The nexus between the criminal conduct of the person and the job duties of the position to be filled.
(6) The person's prison, jail, probation, parole, rehabilitation, and employment records since the date the crime was committed.
(7) The subsequent commission by the person of a crime listed in subsection (a) of this section.

If, after reviewing the factors, the Board determines that the grounds set forth in subsections (1), (2), (3), (4), (5), or (6) of G.S. 90-171.37 exist, the Board may deny licensure of the applicant. The Board may disclose to the applicant information contained in the criminal history record check that is relevant to the denial. The Board shall not provide a copy of the criminal history record check to the applicant. The applicant shall have the right to appear before the Board to appeal the Board's decision. However, an appearance before the full Board shall constitute an exhaustion of administrative remedies in accordance with Chapter 150B of the General Statutes.

(d) Limited immunity. – The Board, its officers and employees, acting in good faith and in compliance with this section, shall be immune from civil liability for denying licensure to an applicant based on information provided in the applicant's criminal history record check."

SECTION 7. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 324

Short Title:	Medicaid/Hemophilic Drugs/No Prior Auth.	(Public)
Sponsors:	Senators Queen; Atwater, Berger of Franklin, Bingham, Boseman, Foriest, Forrester, Goss, Hartsell, Malone, Nesbitt, Purcell, Rand, Snow, Stevens, and Tillman.	
Referred to:	Health Care.	

February 26, 2009

A BILL TO BE ENTITLED

AN ACT TO REMOVE THE SUNSET ON AN ACT TO EXEMPT FROM PRIOR AUTHORIZATION REQUIREMENTS FOR PRESCRIPTION DRUGS UNDER THE MEDICAID PROGRAM ANTIHEMOPHILIC DRUGS PRESCRIBED FOR THE TREATMENT OF HEMOPHILIA AND BLOOD DISORDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Section 2 of S.L. 2003-179, as amended by Section 1 of S.L. 2005-83, reads as rewritten:

"**SECTION 2.** This act is effective when it becomes ~~law and expires July 1, 2009.~~ law."

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

SENATE BILL 324:
Medicaid/Hemophilic Drugs/No Prior Auth

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	March 9, 2009
Introduced by:	Sen. Queen	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	First Edition		

SUMMARY: Senate Bill 324 removes the sunset from the law exempting antihemophilic factor drugs from prior authorization requirements established by the Department of Health and Human Services under the Medicaid program.

BILL ANALYSIS: Currently the provision in Part 6 of Article 2 of Chapter 108A of the General Statutes that exempts antihemophilic factor drugs prescribed for the treatment of hemophilia and blood disorders (where there is no generically equivalent drug available) from prior authorization requirements, expires July 1, 2009[1]. If Senate Bill 324 were enacted, this sunset would be extended indefinitely.

This act is effective when it becomes law.

BACKGROUND: According to the Division of Medical Assistance, Department of Health and Human Services, during fiscal year 2006, the Medicaid program spent $1,108,467 on outpatient pharmacy benefits for Medicaid recipients. The pharmacy benefit is one of the most costly components of the Medicaid budget. To help control costs, prescribers are required to obtain prior authorization for certain designated drugs. The list of these drugs is not in statute, but is maintained by DMA and communicated to providers. Currently, prior authorization is required for certain drugs under the following therapeutic class descriptions: Neuromuscular Blocking Agents; Growth Hormones; Brand Name Schedule II Narcotics; Hematinics; Non-Steroidal Anti-inflammatory Drugs including COX-2 inhibitors (Celebrex) Proton Pump Inhibitors; Second Generation Antihistamines, and Sedative Hypnotics[2].

Generally, these drugs were chosen because of their high cost or because of the potential for overutilizaton or abuse. Prior approval is administered by ACS (Affiliated Computer Systems) in Atlanta. The prescriber contacts ACS directly for prior approval by telephone, fax, email, or mail. Prior approval requests are generally processed within 24 hours.

Should a pharmacy need to dispense medication to a recipient in an emergency, the pharmacist can call ACS for approval. If it is after ACS hours, the pharmacist can dispense a 72-hour supply.

Blood disorders and hemophilia: Bleeding disorders, characterized by a tendency to bleed easily, may result from defects in the blood vessels or from abnormalities in the blood itself. The abnormalities may be in the blood clotting factors or the platelets. Hemophilia is an inherited bleeding disorder that affects 18,000 persons (primarily males) in the United States. The disorder results from deficiencies in blood clotting factors and can lead to spontaneous internal bleeding and bleeding following injuries or surgery. Antihemophilic factor drugs are used to help the blood form clots and are administered by IV or injection. Currently, there are no generic equivalents for these drugs.

[1] G.S. 108A-68.1

[2] http://www.ncmedicaidpbm.com/priorauthorization.htm

SENATE BILL 188

Short Title:	Special Care Dentistry Collaboration.	(Public)
Sponsors:	Senators Malone, Forrester; Brunstetter, Davis, Dorsett, Foriest, Goss, Hoyle, Jones, McKissick, Purcell, Stevens, Swindell, and Tillman.	
Referred to:	Health Care.	

February 18, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF MEDICAL ASSISTANCE, DIVISION OF PUBLIC HEALTH, AND DIVISION OF AGING AND ADULT SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO COLLABORATE WITH THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL AND EAST CAROLINA UNIVERSITY SCHOOLS OF DENTISTRY, THE NORTH CAROLINA DENTAL SOCIETY, AND CURRENT SPECIAL CARE DENTAL PROVIDERS, TO EXAMINE DENTAL CARE OPTIONS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. The Division of Medical Assistance, Division of Public Health, and Division of Aging and Adult Services in the Department of Health and Human Services shall collaborate with the University of North Carolina at Chapel Hill and the East Carolina University Schools of Dentistry, the North Carolina Dental Society, and current providers of special care dentistry services, to examine current dental care options for special care populations. The collaboration of these groups shall result in suggestions for ways to improve the availability of services for special care populations. These groups shall report findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission on or before February 1, 2010.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 188
PROPOSED COMMITTEE SUBSTITUTE S188-CSSQ-1 [v.2]

3/9/2009 2:24:04 PM

Short Title: Special Care Dentistry Collaboration. (Public)

Sponsors:

Referred to:

February 18, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH IN COLLABORATION WITH THE DIVISION OF MEDICAL ASSISTANCE, DIVISION OF AGING AND ADULT SERVICES, THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL AND EAST CAROLINA UNIVERSITY SCHOOLS OF DENTISTRY, THE NORTH CAROLINA DENTAL SOCIETY, AND CURRENT SPECIAL CARE DENTAL PROVIDERS, TO EXAMINE DENTAL CARE OPTIONS FOR SPECIAL CARE POPULATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Public Health shall collaborate with Division of Medical Assistance, the Division of Aging and Adult Services, the University of North Carolina at Chapel Hill and the East Carolina University Schools of Dentistry, the North Carolina Dental Society, and current providers of special care dentistry services, to examine current dental care options for special care populations. The collaboration of these groups shall result in suggestions for ways to improve the availability of services for special care populations. The Department shall report findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission on or before February 1, 2010.

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

SENATE BILL 188:
Special Care Dentistry Collaboration

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	March 9, 2009
Introduced by:	Sen. Malone	**Prepared by:**	Shawn Parker
Analysis of:	PCS to First Edition S188-CSSQ-1		Legislative Analyst

SUMMARY: The Proposed Committee Substitute for Senate Bill 188 directs the Department of Health and Human Services, Division of Public Health to collaborate with the Division of Medical Assistance, the Division of Aging and Adult Services, the State's Dental Schools, the North Carolina Dental Society, and certain dental providers to examine current dental care options for special care populations.

BILL ANALYSIS: The bill directs the Division of Public Health to collaborate with the following representatives to examine current dental options for special care populations:

- Division of Medical Assistance
- Division of Aging and Adult Services
- University of North Carolina at Chapel Hill School of Dentistry
- East Carolina University School of Dentistry
- North Carolina Dental Society
- Current providers of special care dentistry services.

The Department shall report findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission by February 1, 2010.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: It has been reported that people with disabilities and the institutionalized aged often have more dental disease, more missing teeth, and more difficulty obtaining dental care than other segments of the population. Persons with developmental disabilities residing in community settings have significant unmet health care needs, including oral health needs, and the situation is worse for the aged and disabled living in rural and remote areas. A 2000 Surgeon General's report, *Oral Health in America*, noted that although there have been gains in oral health status for the population as a whole, the gains have not been evenly distributed across sub-populations. Profound disparities for dental care exist among racial and ethnic minorities, individuals with disabilities, elderly persons, and individuals with complicated medical and social conditions. The Medicaid program in North Carolina is one of a minority of states that offers comprehensive dental benefits for adults.[1]

[1] North Carolina Study Commission on Aging's report to the Governor and the 2009 General Assembly.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 188
PROPOSED COMMITTEE SUBSTITUTE S188-PCS55193-SQ-1

Short Title:	Special Care Dentistry Collaboration.	(Public)
Sponsors:		
Referred to:		

February 18, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH, IN COLLABORATION WITH THE DIVISION OF MEDICAL ASSISTANCE, DIVISION OF AGING AND ADULT SERVICES, THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL AND EAST CAROLINA UNIVERSITY SCHOOLS OF DENTISTRY, THE NORTH CAROLINA DENTAL SOCIETY, AND CURRENT SPECIAL CARE DENTAL PROVIDERS, TO EXAMINE DENTAL CARE OPTIONS FOR SPECIAL CARE POPULATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Public Health, shall collaborate with the Division of Medical Assistance, the Division of Aging and Adult Services, the University of North Carolina at Chapel Hill and the East Carolina University Schools of Dentistry the North Carolina Dental Society, and current providers of special care dentistry services to examine current dental care options for special care populations. The collaboration of these groups shall result in suggestions for ways to improve the availability of services for special care populations. The Department shall report findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission on or before February 1, 2010.

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

SENATE BILL 354

Short Title:	Social Security Increase/Medicaid Elig.	(Public)
Sponsors:	Senators Kinnaird; Atwater, Berger of Franklin, Foriest, McKissick, Nesbitt, and Stevens.	
Referred to:	Health Care.	

March 2, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ADOPT A POLICY ALLOWING A CERTAIN INCOME DISREGARD UNDER THE MEDICAID PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall adopt and implement a policy that will prevent a Medicaid recipient from losing Medicaid eligibility when the annual Social Security and Railroad Retirement Cost of Living Adjustments (COLAs) and the annual Federal Poverty Level adjustment cause a Medicaid recipient to become income-ineligible for Medicaid. The policy shall apply only in cases where Medicaid income eligibility is affected only by Social Security and Railroad Retirement COLAs and Federal Poverty Level adjustments and shall not render a Medicaid recipient eligible if all other eligibility requirements are not met. If approval from the Centers for Medicare and Medicaid Services (CMS) is required for this policy to be implemented, the Department shall apply to CMS for approval.

SECTION 2. This act becomes effective July 1, 2009.

SENATE BILL 354:
Social Security Increase/Medicaid Elig

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	March 11, 2009
Introduced by:	Sen. Kinnaird	**Prepared by:**	Ben Popkin
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 354 would direct the Department of Health and Human Services to adopt and implement a policy to prevent Medicaid recipients from losing their eligibility due to annual Social Security and Railroad Retirement cost of living adjustments and annual Federal Poverty Level adjustments.***

CURRENT LAW: Medicaid is a health benefits program administered by the Division of Medical Assistance (DMA) within the Department of Health and Human Services. Medicaid provides health insurance coverage for low-income parents, children, seniors, and people with disabilities and applies differing eligibility criteria (income as a percentage of the federal poverty level and resource limits) for each of the groups covered[1].

In 2006-2007, Medicaid served approximately 1.7 million children, aged, blind and/or disabled individuals in North Carolina.

BILL ANALYSIS: Senate Bill 354 would direct the Department of Health and Human Services (Department) to adopt and implement a policy to prevent Medicaid recipients from losing their eligibility due to annual Social Security and Railroad Retirement cost of living adjustments (COLAs) and annual Federal Poverty Level (FPL) adjustments. The policy would not make a Medicaid recipient eligible if they did not meet all other applicable eligibility requirements.

The act would direct the Department to apply to the Centers for Medicare and Medicaid Services (CMS) for approval, if required for implementation of the policy.

EFFECTIVE DATE: This act becomes effective July 1, 2009.

S354-SMRD-17(e1) v1

[1] http://www.dhhs.state.nc.us/dma/medicaid/

VISITOR REGISTRATION SHEET

Senate Health Care — **March 11, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sheyna Altervitz	AARP
[illegible]	NCDS & NCPTA
Sue Caswell	Hemophilia of NC
Chip Killian	[illegible]
Kristi Huff	NCHCFA
ANN LOVE	DVRC
DAVID BARNES	Pfizer Summit
Terry Herlosky	[illegible]
Kevin T. Mikus	NCMS - Doctor of the Day
Marcia Stephens	SRMC - Nurse of the Day
David Bass	MWC

VISITOR REGISTRATION SHEET

Senate Health Care — **March 11, 2009**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Thom Mansfield	Medical Board
Christina Apparsm	"
Caroline Guerra	UNC - CH
Brigitte Acosta	UNC - CH
Olivia Miller	"
Barbara Canales	BSCGR
Lu-Ann C. [illegible]	NCPA
David Kolbaktion	NC Board of Nursing
Julia Boorge	NC Board of Nursing
Joanne Stevens	NCBON
Jessie Goodmon	DHHS

VISITOR REGISTRATION SHEET

Senate Health Care — **March 11, 2009**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	[signature]
[signature]	[signature]
[signature]	[signature]

SENATE HEALTH CARE COMMITTEE
March 18, 2009
MINUTES

The Senate Health Care Committee met on Wednesday, March 18, 2009 in Room 544 of the Legislative Office Building. Twenty-three members were in attendance, along with staff members Shawn Parker, Ben Popkin, Susan Barham, and Becky Hedspeth.

Senator Purcell, Co-Chair, opened the meeting by introducing Dr. Jeffrey Engel, the new Director of Public Health in the Department of Health & Human Services for remarks.

The agenda is attached to these minutes as Attachment I, and all bills were heard with the exception of SB208 "People First", which was withdrawn from the agenda.

First considered was Senate Bill 258 "AN ACT TO AUTHORIZE THE DIVISION OF EMERGENCY MANAGEMENT TO ESTABLISH A VOLUNTARY MODEL REGISTRY FOR USE BY COUNTIES AND MUNICIPALITIES IN IDENTIFYING FUNCTIONALLY AND MEDICALLY FRAGILE PERSONS IN NEED OF ASSISTANCE DURING A DISASTER; AND TO AUTHORIZE COUNTIES AND MUNICIPALITIES TO OPERATE SIMILAR REGISTRIES, AS RECOMMENDED BY THE JOINT SELECT COMMITTEE ON EMERGENCY PREPAREDNESS AND DISASTER MANAGEMENT RECOVERY". A Committee Substitute (Attachment II) was presented and adopted by Committee for consideration. Bill sponsor, Senator Snow, explained the bill and a summary is attached as Attachment III. After discussion, the bill was given an unfavorable report; the Committee Substitute was given a favorable report.

Next considered was Senate Bill 345 "AN ACT TO ADD PUBLIC HEALTH PREPAREDNESS AND QUALITY IMPROVEMENT TO THE LIST OF ESSENTIAL PUBLIC HEALTH SERVICES, AS RECOMMENDED BY THE JOINT SELECT COMMITTEE ON EMERGENCY PREPAREDNESS AND DISASTER MANAGEMENT RECOVERY (Attachment IV and Attachment V is the summary. Bill sponsor, Senator Malone, explained the bill and the bill was given a favorable report.

Senate Bill 354 entitled "AN ACT TO DIRECT THE DEPARTMENT OF HEALTH & HUMAN SERVICES TO ADOPT A POLICY ALLOWING A CERTAIN INCOME DISREGARD UNDER THE MEDICAID PROGRAM" (Attachment VI) was discussed next with bill sponsor, Senator Kinnaird, explaining

her bill. An explanation is included as Attachment VII. Tara Larsen, Acting Director with the Division of Medicaid Agency, was called on for explanation as well. The bill was given a favorable report, with sequential referral to the Committee on Appropriations.

The final bill considered was Senate Bill 409 entitled " AN ACT TO ENACT VARIOUS LAWS TO IMPROVE THE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES SYSTEM, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES" (Attachment VIII). An explanation is attached as Attachment IX. A Committee Substitute was presented to the committee for consideration. Bill sponsor, Senator Nesbitt, explained the bill. Bill was given an unfavorable report, the Committee Substitute a favorable report.

There being no further business before the Committee, Senator Purcell adjourned the meeting.

Respectfully submitted,

Becky Hedspeth

Becky Hedspeth, Committee Assistant

Senator William R. Purcell, M.D.
Co-Chairman

William R Purcell

Attachment I

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	March 18, 2009	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 208	People First.	Senator Dorsett
SB 354	Social Security Increase/Medicaid Elig.	Senator Kinnaird
SB 409	Recommendations of MH/DD/SA Oversight Comm.	Senator Nesbitt, Jr.
SB 345	Public Health Technical Changes.	Senator Malone
SB 258	Authorize Voluntary Medical Registry Program.	Senator Snow

Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, March 18, 2009

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

FAVORABLE

S.B.	**345**	Public Health Technical Changes.	
		Sequential Referral:	None
		Recommended Referral:	None
S.B.	**354**	Social Security Increase/Medicaid Elig.	
		Sequential Referral:	Appropriations/Base Budget
		Recommended Referral:	None

TOTAL REPORTED: 2

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT

Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Thursday, March 19, 2009

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

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

S.B. **258** Authorize Voluntary Medical Registry Program.

Draft Number:	35223
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **409** Recommendations of MH/DD/SA Oversight Comm.

Draft Number:	55234
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comments:

Attachment II

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 258*
PROPOSED COMMITTEE SUBSTITUTE S258-CSRD-8 [v.1]

3/17/2009 3:23:03 PM

Short Title: Authorize Voluntary Medical Registry Program. (Public)

Sponsors:

Referred to:

February 23, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE DIVISION OF EMERGENCY MANAGEMENT TO ESTABLISH A VOLUNTARY MODEL REGISTRY FOR USE BY COUNTIES AND MUNICIPALITIES IN IDENTIFYING FUNCTIONALLY AND MEDICALLY FRAGILE PERSONS IN NEED OF ASSISTANCE DURING A DISASTER; AND TO AUTHORIZE COUNTIES AND MUNICIPALITIES TO OPERATE SIMILAR REGISTRIES, AS RECOMMENDED BY THE JOINT SELECT COMMITTEE ON EMERGENCY PREPAREDNESS AND DISASTER MANAGEMENT RECOVERY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 166A-5(3) is amended by adding a new sub-subdivision to read:

"(3) Functions of State Emergency Management. – The functions of the State emergency management program include:

...

b2. Establishment of a voluntary model registry for use by political subdivisions in identifying functionally and medically fragile persons in need of assistance during a disaster. All records, data, information, correspondence, and communications relating to the registration of persons with special needs or of functionally and medically fragile persons obtained pursuant to this sub-subdivision is confidential and is not a public record pursuant to G.S. 132-1 or any other applicable statute, except that this information shall be available to emergency response agencies, as determined by the local emergency management director. This information shall be used only for the purposes set forth in this sub-subdivision.

...."

SECTION 2. G.S. 166A-7(d) is amended by adding a new subdivision to read:

"(d) In carrying out the provisions of this Article each political subdivision is authorized:

...

(5) To coordinate the voluntary registration of functionally and medically fragile persons in need of assistance during a disaster either through a registry established by this subdivision or by the State. All records, data, information, correspondence, and communications relating to the registration of persons with special needs or of functionally and medically fragile persons obtained pursuant to this sub-subdivision is confidential and

is not a public record pursuant to G.S. 132-1 or any other applicable statute, except that this information shall be available to emergency response agencies, as determined by the local emergency management director. This information shall be used only for the purposes set forth in this subdivision."

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

Attachment III

SENATE BILL 258:
Authorize Voluntary Medical Registry Program

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	March 17, 2009
Introduced by:	Sen. Snow	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	PCS to First Edition S258-CSRD-8		

SUMMARY: ***The Proposed Committee Substitute to Senate Bill 258 would authorize the Division of Emergency Management to establish a voluntary model registry for use by counties and municipalities to identify the location of 'functionally and medically fragile' persons in need of assistance during a disaster and would authorize political subdivisions to coordinate registration of these individuals in the registry.***

The Proposed Committee Substitute corrects a drafting formatting issue, revises the language addressing the confidentiality of information collected as part of creating the registry, and provides that the information may be made available to emergency response agencies, as determined by the local emergency management director.

[As introduced, this bill was identical to H382, as introduced by Reps. Martin, Wainwright, Farmer-Butterfield, which is currently in House Judiciary III.]

BILL ANALYSIS: The PCS to Senate Bill 258 would authorize the Division of Emergency Management to establish a voluntary model registry for use by counties and municipalities to identify the location of 'functionally and medically fragile' persons in need of assistance during a disaster and would authorize political subdivisions to coordinate registration of these individuals in the registry.

Section 1 – would add as a function of the State emergency management program the establishment of a voluntary model registry for use by political subdivisions to aid in identifying functionally and medically fragile persons in need of assistance during a disaster and would provide that any health information obtained pursuant to this provision would be confidential.

Section 2 – would authorize political subdivisions to coordinate the voluntary registration of functionally and medically fragile persons in need of assistance during a disaster and would provide that any health information obtained pursuant to this provision would be confidential.

The PCS revises language in both sections relating to confidentiality of the information collected as part of the registry, and specifies that it may be shared with emergency response agencies, as determined by the local emergency management director.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: Senate Bill 258 is a recommendation of the Joint Select Committee on Emergency Preparedness and Disaster Management Recovery.

S258-SMRD-23(CSRD-8) v1

Attachment IV

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 345*

Short Title:	Public Health Technical Changes.	(Public)
Sponsors:	Senators Malone, Atwater, Goss, Nesbitt, Snow; Albertson, Dannelly, Dorsett, Jones, Purcell, Stevens, Swindell, and Weinstein.	
Referred to:	Health Care.	

March 2, 2009

A BILL TO BE ENTITLED

AN ACT TO ADD PUBLIC HEALTH PREPAREDNESS AND QUALITY IMPROVEMENT TO THE LIST OF ESSENTIAL PUBLIC HEALTH SERVICES, AS RECOMMENDED BY THE JOINT SELECT COMMITTEE ON EMERGENCY PREPAREDNESS AND DISASTER MANAGEMENT RECOVERY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-1.1 reads as rewritten:

"**§ 130A-1.1. Mission and essential services.**

(a) The General Assembly recognizes that unified purpose and direction of the public health system is necessary to ensure that all citizens in the State have equal access to essential public health services. The General Assembly declares that the mission of the public health system is to promote and contribute to the highest level of health possible for the people of North Carolina by:

(1) Preventing health risks and disease;
(2) Identifying and reducing health risks in the community;
(3) Detecting, investigating, and preventing the spread of disease;
(4) Promoting healthy lifestyles;
(5) Promoting a safe and healthful environment;
(6) Promoting the availability and accessibility of quality health care services through the private sector; and
(7) Providing quality health care services when not otherwise available.

(b) As used in this section, the term "essential public health services" means those services that the State shall ensure because they are essential to promoting and contributing to the highest level of health possible for the citizens of North Carolina. The Departments of Environment and Natural Resources and Health and Human Services shall attempt to ensure within the resources available to them that the following essential public health services are available and accessible to all citizens of the State, and shall account for the financing of these services:

(1) Health Support:
  a. Assessment of health status, health needs, and environmental risks to health;
  b. Patient and community education;
  c. Public health laboratory;
  d. Registration of vital events;
  e. Quality improvement; and
(2) Environmental Health:

a. Lodging and institutional sanitation;
b. On-site domestic sewage disposal;
c. Water and food safety and sanitation; and

(3) Personal Health:
a. Child health;
b. Chronic disease control;
c. Communicable disease control;
d. Dental public health;
e. Family planning;
f. Health promotion and risk reduction;
g. Maternal ~~health~~ health; and

(4) Public Health Preparedness.

The Commission for Public Health shall determine specific services to be provided under each of the essential public health services categories listed above.

(c) The General Assembly recognizes that there are health-related services currently provided by State and local government and the private sector that are important to maintaining a healthy social and ecological environment but that are not included on the list of essential public health services required under this section. Omission of these services from the list of essential public health services shall not be construed as an intent to prohibit or decrease their availability. Rather, such omission means only that the omitted services may be more appropriately assured by government agencies or private entities other than the public health system.

(d) The list of essential public health services required by this section shall not be construed to limit or restrict the powers and duties of the Commission for Public Health or the Departments of Environment and Natural Resources and Health and Human Services as otherwise conferred by State law."

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

Attachment V

SENATE BILL 345:
Public Health Technical Changes

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	March 17, 2009
Introduced by:	Sen. Malone	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Legislative Analyst

SUMMARY: Senate Bill 345 adds "Public Health Preparedness" and "Quality Improvement" to the list of essential public health services that the Department of Environment and Natural Resources and the Department of Health and Human Services within resources available are to make available and accessible to all citizens of North Carolina.

[As introduced, this bill was identical to H374, as introduced by Reps. Martin, Glazier, Farmer-Butterfield, which is currently in House Homeland Security, Military, and Veterans Affairs.]

CURRENT LAW:

The General Assembly recognizes that unified purpose and direction of the public health system is necessary to ensure all citizens in the State have equal access to essential public health services.[1]

Essential public health services are services that the State shall ensure because they are essential to promoting and contributing to the highest level of health possible for citizens of North Carolina.[2]

BILL ANALYSIS: The bill amends G.S. 130A-1.1(b) by adding a new subdivision of Public Health Preparedness and adding quality improvement to the subdivision of Health Support under the list of essential public health services.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: This is a recommendation of the Joint Select Committee on Emergency Preparedness and Disaster Management Recovery.

S345-SMSQ-11(e1) v1

[1] G.S. 130A-1.1(a)
[2] G.S. 130A-1.1(b)

Attachment VI

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 354

Short Title:	Social Security Increase/Medicaid Elig.	(Public)
Sponsors:	Senators Kinnaird; Atwater, Berger of Franklin, Foriest, McKissick, Nesbitt, and Stevens.	
Referred to:	Health Care.	

March 2, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO ADOPT A POLICY ALLOWING A CERTAIN INCOME DISREGARD UNDER THE MEDICAID PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall adopt and implement a policy that will prevent a Medicaid recipient from losing Medicaid eligibility when the annual Social Security and Railroad Retirement Cost of Living Adjustments (COLAs) and the annual Federal Poverty Level adjustment cause a Medicaid recipient to become income-ineligible for Medicaid. The policy shall apply only in cases where Medicaid income eligibility is affected only by Social Security and Railroad Retirement COLAs and Federal Poverty Level adjustments and shall not render a Medicaid recipient eligible if all other eligibility requirements are not met. If approval from the Centers for Medicare and Medicaid Services (CMS) is required for this policy to be implemented, the Department shall apply to CMS for approval.

SECTION 2. This act becomes effective July 1, 2009.

Attachment VII

SENATE BILL 354:
Social Security Increase/Medicaid Elig

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	March 11, 2009
Introduced by:	Sen. Kinnaird	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***Senate Bill 354 would direct the Department of Health and Human Services to adopt and implement a policy to prevent Medicaid recipients from losing their eligibility due to annual Social Security and Railroad Retirement cost of living adjustments and annual Federal Poverty Level adjustments.***

CURRENT LAW: Medicaid is a health benefits program administered by the Division of Medical Assistance (DMA) within the Department of Health and Human Services. Medicaid provides health insurance coverage for low-income parents, children, seniors, and people with disabilities and applies differing eligibility criteria (income as a percentage of the federal poverty level and resource limits) for each of the groups covered[1].

In 2006-2007, Medicaid served approximately 1.7 million children, aged, blind and/or disabled individuals in North Carolina.

BILL ANALYSIS: Senate Bill 354 would direct the Department of Health and Human Services (Department) to adopt and implement a policy to prevent Medicaid recipients from losing their eligibility due to annual Social Security and Railroad Retirement cost of living adjustments (COLAs) and annual Federal Poverty Level (FPL) adjustments. The policy would not make a Medicaid recipient eligible if they did not meet all other applicable eligibility requirements.

The act would direct the Department to apply to the Centers for Medicare and Medicaid Services (CMS) for approval, if required for implementation of the policy.

EFFECTIVE DATE: This act becomes effective July 1, 2009.

S354-SMRD-17(e1) v1

[1] http://www.dhhs.state.nc.us/dma/medicaid/

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 409
PROPOSED COMMITTEE SUBSTITUTE S409-CSSQ-2 [v.1]

3/17/2009 11:53:42 AM

Short Title: Recommendations of MH/DD/SA Oversight Comm. (Public)

Sponsors:

Referred to:

March 5, 2009

A BILL TO BE ENTITLED

AN ACT TO ENACT VARIOUS LAWS TO IMPROVE THE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES SYSTEM, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Merger or Consolidation of LMEs. –

(1) The Secretary of the Department of Health and Human Services shall not take any action prior to June 1, 2010, that would result in the merger or consolidation of local management entities (LMEs), or that would establish consortia or regional arrangements for the same purpose.

(2) Notwithstanding the provisions of subdivision (1) of this section, contiguous LMEs may implement a merger or consolidation if at least one of the following criteria is satisfied:

a. At least one of the LMEs does not meet the catchment area requirements of G.S. 122C-115 and the merger or consolidation is to overcome noncompliance with G.S. 122C-115; or

b. Each board of county commissioners within the multicounty area comprising each of the LMEs involved in the proposed merger or consolidation has approved the merger or consolidation.

(3) Contracts between LMEs for service authorization, utilization review, and utilization management functions do not constitute a merger or consolidation as addressed in this section.

SECTION 2. LME Peer Training. – Beginning July 1, 2009, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in consultation with the Mental Health Leadership Academy, shall hold at least one meeting each calendar quarter to facilitate peer training and peer sharing among LMEs with respect to best practices and innovations in management and coordination of mental health, developmental disabilities, and substance abuse services.

SECTION 3. Medicaid Waivers. –

(1) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, may develop and apply to the Centers for Medicare and Medicaid Services (CMS) for

additional 1915(b) and 1915(c) Medicaid waivers in order to increase the flexibility of LMEs with respect to management and coordination of mental health, developmental disabilities, and substance abuse services. If approved, the Department shall not implement any waiver except as authorized by an act of the General Assembly appropriating funds for this purpose. The Department shall report on the status of any waiver developed or applied for pursuant to this subdivision to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division not later than March 1, 2010.

(2) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall apply to the Centers for Medicare and Medicaid Services for a 1915(c) waiver to permit individuals who sustain traumatic brain injury after age 22 to access home and community-based Medicaid services. If approved, the Department shall not implement the waiver except as authorized by an act of the General Assembly appropriating funds for this purpose. The Department shall report on the status of the waiver to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division not later than March 1, 2010.

(3) Not later than six months after the effective date of this act, the Department of Health and Human Services, Division of Medical Assistance, in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall submit a written report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services summarizing its implementation of Tiers 1 and 4 of the CAP-MR/DD program and future plans for implementation of Tiers 2 and 3 of the CAP-MR/DD program. The summary shall include an explanation of (i) the planned array and intensity level of services to be made available under each of the four tiers, (ii) the range of costs for the planned array and intensity level of services to be made available under each of the four tiers, (iii) how the relative intensity of need for each CAP eligible individual will be reliably determined, and (iv) how the determination will be used to assign individuals appropriately into one of the four tiers. The Department shall not develop or submit an application to the Centers for Medicare and Medicaid Services for additional Medicaid waivers for Tiers 2 and 3 of the CAP-MR/DD program until it has submitted the report required by this subdivision.

SECTION 4. State/County Special Assistance Residency Requirements. – G.S. 108A-41(b) reads as rewritten:

"(b) Assistance shall be granted to any person who:

(1) Is 65 years of age and older, or is between the ages of 18 and 65 and is permanently and totally disabled; and

(2) Has insufficient income or other resources to provide a reasonable subsistence compatible with decency and health as determined by the rules and regulations of the Social Services Commission; and

(3) Is one of the following:

a. A resident of North Carolina for at least ~~90~~180 days immediately prior to receiving this assistance;

b. A person coming to North Carolina to join a close relative who has resided in North Carolina for at least 180 consecutive days immediately prior to the person's application. The close relative shall furnish verification of his or her residency to the local department of social services at the time the applicant applies for special assistance. As used in this sub-subdivision, a close relative is the person's parent, grandparent, brother, sister, spouse, or child; or

c. A person discharged from a State facility who was a patient in the facility as a result of an interstate mental health compact. As used in this sub-subdivision the term State facility is a facility listed under G.S. 122C-181."

The Department shall study issues relating to consumers with mental illness residing in adult care homes and report its findings and any recommendations to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by March 1, 2010.

SECTION 5. Billing Changes. –

(1) The Department of Health and Human Services shall create an "incurred but not reported" category of expenditures such that services are paid based on the actual date of services rather than the date when the invoice is received. The Department may only implement this change with the approval of the Office of State Budget and Management.

(2) The Department of Health and Human Services may require that providers of mental health, developmental disabilities, and substance abuse services submit bills to the LME for State-funded services within 60 days of the date the services were provided.

SECTION 6. Service Dollar Reallocations. – The Department of Health and Human Services may create a midyear process by which it can reallocate State service dollars away from LMEs that do not appear to be on track to spend the LMEs' full appropriation and towards LMEs that appear able to spend the additional funds

SECTION 7. Screening Tool / Individuals with Developmental Disabilities. –

(1) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall identify a screening tool to assess level and intensity of need of all individuals with developmental disabilities receiving publicly-funded services.

(2) Not later than March 1, 2010, the Department of Health and Human Services shall report on the identification of the screening tool to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION 8. Death Reporting in Facilities Providing MH/DD/SA Services. –

(1) The Department of Health and Human Services shall establish and maintain a database of all deaths occurring in facilities subject to regulation under Chapter 122C of the General Statutes. The database shall include the name and location of the facility, the time and date of death, and the cause of death, as well as all details surrounding the death. All facilities regulated under Chapter 122C of the General Statutes, and all facilities required by

law to report death occurring in the facility to the State Medical Examiner, shall report the information to the database within 10 days of the date of the death.

(2) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall provide training on death reporting to administrative and direct care employees that are employed in State facilities subject to regulation under G.S. 122C-181.

SECTION 9. Service Authorization, Utilization Review, and Utilization Management. –

(1) The Department of Health and Human Services shall continue to implement its plan to return the service authorization, utilization review, and utilization management functions to LMEs for all clients. Not later than January 1, 2011, the Department shall return utilization review, utilization management, and service authorization for publicly funded mental health, developmental disabilities, and substance abuse services to LMEs representing in total at least sixty percent (60%) of the State's population. An LME must be accredited for national accreditation under behavioral health care standards by a national accrediting entity approved by the Secretary and must demonstrate readiness to meet all requirements of the existing vendor contract with the Department for such services in order to provide service authorization, utilization review, and utilization management to Medicaid recipients in the LME catchment area. Not later than July 1, 2010, the Department shall designate those LMEs that will be performing utilization review, utilization management, and service authorization on and after January 1, 2011, in accordance with this section.

(2) The Department shall not contract with an outside vendor for service authorization, utilization review, or utilization management functions, or otherwise obligate the State for these functions beyond September 30, 2010. The Department shall require LMEs to include in their service authorization, utilization management, and utilization review a review of assessments, as well as person-centered plans and random or triggered audits of services and assessments.

SECTION 10. The North Carolina Institute of Medicine (NCIOM) shall conduct a study of mental health, developmental disabilities, and substance abuse services that are funded with Medicaid funds and with State funds. The purpose of the study is to determine what services are currently available to active, reserve, and veteran members of the military and National Guard and the need for increased State services to these individuals. The NCIOM shall report its findings and recommendations to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before the convening of the 2010 Regular Session of the 2009 General Assembly.

SECTION 11. This act is effective when it becomes law.

Attachment VIII

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 409

Short Title:	Recommendations of MH/DD/SA Oversight Comm.	(Public)
Sponsors:	Senators Nesbitt, Allran, Atwater, Dannelly, Forrester, Malone, Purcell, Shaw; Berger of Franklin, Kinnaird, McKissick, Queen, Snow, and Vaughan.	
Referred to:	Health Care.	

March 5, 2009

A BILL TO BE ENTITLED

AN ACT TO ENACT VARIOUS LAWS TO IMPROVE THE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES SYSTEM, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. Merger or Consolidation of LMEs. –

(1) The Secretary of the Department of Health and Human Services shall not take any action prior to June 1, 2010, that would result in the merger or consolidation of local management entities (LMEs), or that would establish consortia or regional arrangements for the same purpose.

(2) Notwithstanding the provisions of subdivision (1) of this section, contiguous LMEs may implement a merger or consolidation if at least one of the following criteria is satisfied:

a. At least one of the LMEs does not meet the catchment area requirements of G.S. 122C-115 and the merger or consolidation is to overcome noncompliance with G.S. 122C-115; or

b. Each board of county commissioners within the multicounty area comprising each of the LMEs involved in the proposed merger or consolidation has approved the merger or consolidation.

(3) Contracts between LMEs for service authorization, utilization review, and utilization management functions do not constitute a merger or consolidation as addressed in this section.

SECTION 2. LME Peer Training. – Beginning July 1, 2009, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, in consultation with the Mental Health Leadership Academy, shall hold at least one meeting each calendar quarter to facilitate peer training and peer sharing among LMEs with respect to best practices and innovations in management and coordination of mental health, developmental disabilities, and substance abuse services.

SECTION 3. Medicaid Waivers. –

(1) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, may develop and apply to the Centers for Medicare and Medicaid Services (CMS) for additional 1915(b) and 1915(c) Medicaid waivers in order to increase the flexibility of LMEs with respect to management and coordination of mental

health, developmental disabilities, and substance abuse services. If approved, the Department shall not implement any waiver except as authorized by an act of the General Assembly appropriating funds for this purpose. The Department shall report on the status of any waiver developed or applied for pursuant to this subdivision to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division not later than March 1, 2010.

(2) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall apply to the Centers for Medicare and Medicaid Services for a 1915(c) waiver to permit individuals who sustain traumatic brain injury after age 22 to access home and community-based Medicaid services. If approved, the Department shall not implement the waiver except as authorized by an act of the General Assembly appropriating funds for this purpose. The Department shall report on the status of the waiver to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Fiscal Research Division not later than March 1, 2010.

(3) Not later than September 30, 2009, the Department of Health and Human Services, Division of Medical Assistance, in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall submit a written report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services summarizing its implementation of Tiers 1 and 4 of the CAP-MR/DD program and future plans for implementation of Tiers 2 and 3 of the CAP-MR/DD program. The summary shall include an explanation of (i) the planned array and intensity level of services to be made available under each of the four tiers, (ii) the range of costs for the planned array and intensity level of services to be made available under each of the four tiers, (iii) how the relative intensity of need for each CAP eligible individual will be reliably determined, and (iv) how the determination will be used to assign individuals appropriately into one of the four tiers. The Department shall not develop or submit an application to the Centers for Medicare and Medicaid Services for additional Medicaid waivers for Tiers 2 and 3 of the CAP-MR/DD program until it has submitted the report required by this subdivision.

SECTION 4. State/County Special Assistance Residency Requirements. – G.S. 108A-41(b) reads as rewritten:

"(b) Assistance shall be granted to any person who:

(1) Is 65 years of age and older, or is between the ages of 18 and 65 and is permanently and totally disabled; and

(2) Has insufficient income or other resources to provide a reasonable subsistence compatible with decency and health as determined by the rules and regulations of the Social Services Commission; and

(3) Is one of the following:

a. A resident of North Carolina for at least ~~90~~180 days immediately prior to receiving this assistance;

b. A person coming to North Carolina to join a close relative who has resided in North Carolina for at least 180 consecutive days immediately prior to the person's application. The close relative shall furnish verification of his or her residency to the local department of social services at the time the applicant applies for special assistance. As used in this sub-subdivision, a close relative is the person's parent, grandparent, brother, sister, spouse, or child; or

c. A person discharged from a State facility who was a patient in the facility as a result of an interstate mental health compact. As used in this sub-subdivision the term State facility is a facility listed under G.S. 122C-181."

The Department shall study issues relating to consumers with mental illness residing in adult care homes and report its findings and any recommendations to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by March 1, 2010.

SECTION 5. Billing Changes. –

(1) The Department of Health and Human Services shall create an "incurred but not reported" category of expenditures such that services are paid based on the actual date of services rather than the date when the invoice is received. The Department may only implement this change with the approval of the Office of State Budget and Management.

(2) The Department of Health and Human Services may require that providers of mental health, developmental disabilities, and substance abuse services submit bills to the LME for State-funded services within 60 days of the date the services were provided.

SECTION 6. Service Dollar Reallocations. – The Department of Health and Human Services may create a midyear process by which it can reallocate State service dollars away from LMEs that do not appear to be on track to spend the LMEs' full appropriation and towards LMEs that appear able to spend the additional funds

SECTION 7. Screening Tool for ICF/MR Placement. –

(1) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall identify a screening tool that will determine how consumers currently access services from Intermediate Care Facilities for the Mentally Retarded (ICF/MR) and that will ensure that consumers of these services are served at the appropriate level of care. The screening tool identified by the Department shall be administered by the LMEs to ensure that the screening is provided independent of the service provider and that LMEs are involved in actively managing the care of consumers in the LMEs' catchment area who are residents in ICF/MR.

(2) Not later than March 1, 2010, the Department of Health and Human Services shall report on the identification and implementation of the screening tool to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

SECTION 8. Death Reporting in Facilities Providing MH/DD/SA Services. –

(1) The Department of Health and Human Services shall establish and maintain a database of all deaths occurring in facilities subject to regulation under Chapter 122C of the General Statutes. The database shall include the name and location of the facility, the time and date of death, and the cause of death, as well as all details surrounding the death. All facilities regulated under Chapter 122C of the General Statutes, and all facilities required by law to report death occurring in the facility to the State Medical Examiner, shall report the information to the database within 10 days of the date of the death.

(2) The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall provide training on death reporting to administrative and direct care employees that are employed in State facilities subject to regulation under G.S. 122C-181.

SECTION 9. Service Authorization, Utilization Review, and Utilization Management. –

(1) The Department of Health and Human Services shall continue to implement its plan to return the service authorization, utilization review, and utilization management functions to LMEs for all clients. Not later than January 1, 2011, the Department shall return utilization review, utilization management, and service authorization for publicly funded mental health, developmental disabilities, and substance abuse services to LMEs representing in total at least sixty percent (60%) of the State's population. An LME must be accredited for national accreditation under behavioral health care standards by a national accrediting entity approved by the Secretary and must demonstrate readiness to meet all requirements of the existing vendor contract with the Department for such services in order to provide service authorization, utilization review, and utilization management to Medicaid recipients in the LME catchment area. Not later than July 1, 2010, the Department shall designate those LMEs that will be performing utilization review, utilization management, and service authorization on and after January 1, 2011, in accordance with this section.

(2) The Department shall not contract with an outside vendor for service authorization, utilization review, or utilization management functions, or otherwise obligate the State for these functions beyond September 30, 2010. The Department shall require LMEs to include in their service authorization, utilization management, and utilization review a review of assessments, as well as person-centered plans and random or triggered audits of services and assessments.

SECTION 10. The North Carolina Institute of Medicine (NCIOM) shall conduct a study of mental health, developmental disabilities, and substance abuse services that are funded with Medicaid funds and with State funds. The purpose of the study is to determine what services are currently available to active, reserve, and veteran members of the military and National Guard and the need for increased State services to these individuals. The NCIOM shall report its findings and recommendations to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on or before the convening of the 2010 Regular Session of the 2009 General Assembly.

SECTION 11. This act is effective when it becomes law.

AH. 1X

SENATE BILL 409: Recommendations of MH/DD/SA Oversight Comm

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	March 17, 2009
Introduced by:	Sen. Nesbitt	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	PCS to First Edition S409-CSSQ-2		

SUMMARY: ***Senate Bill 409 would implement recommendations of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services by enacting various laws affecting the Department of Health and Human Services (Department), Local Management Entities (LMEs), and the North Carolina Institute of Medicine (NCIOM).***

The Proposed Committee Substitute amends the original bill draft to reflect changes approved by the Joint Legislative Oversight Committee on MH/DD/SAS on February 17, 2009.

[As introduced, this bill was identical to H458, as introduced by Reps. Insko, England, Farmer-Butterfield, Braxton, which is currently in House Mental Health Reform, if favorable, Appropriations.]

BILL ANALYSIS:

Section 1 extends a prohibition on LME mergers and consolidation until June 1, 2010 with an exception for mergers initiated by **contiguous** LMEs which either do not meet catchment area requirements of G.S. 122C-115 or have approval from each board of county commissioners within the multi-county area comprising each LME. The section further provides that contracts between LMEs for service authorization, utilization review, and utilization management functions are not considered mergers or consolidations.

Section 2 directs the Department, beginning July 1, 2009, to hold meetings at least quarterly to facilitate peer training and peer sharing among LMES.

Section 3 provides a number of directions to the Department relating to the application of Medicaid waivers:

- authorizes the Department to apply for 1915(b) and (c) Medicaid waivers to provide LME flexibility in management functions;
- directs the Department to apply to the Centers for Medicare and Medicaid Services for a 1915(c) waiver to permit individuals who sustain a Traumatic Brain Injury after age 22 to access home and community-based Medicaid-funded services, and
- directs the Department to submit a report summarizing the implementation of Tiers 1 and 4 and the future plans for implementing Tiers 2 and 3 of the CAP-MR/DD waiver program to the Joint Legislative Oversight on MH/DD/SAS within six months of this provision's enactment.

Section 4 changes the residency requirement for eligibility for special assistance from 90 days to 180 days and directs the Department to study and report to the Joint legislative Oversight Committee on MH/DD/SAS by March 10, 2010 on issues relating to adult care home residents with mental illness.

Sections 5 and 6 provide directions to the Department to implement recommendations for increasing expenditures of funds appropriated to LMEs for direct services:

- directs the Department upon approval of the Office of State Budget and Management to create an "Incurred but Not Reported" category of expenditures such that services are paid based on the actual date of service rather than the date when the invoice is received;
- authorizes the Department to require providers to bill LMEs for state-funded services within 60 days of the date that the service was provided, and
- authorizes the Department to create a formal mid-year process by which to reallocate State service dollars among LMEs.

Section 7 directs the Department to identify a screening tool to assess level and intensity of need of all individuals with developmental disabilities receiving publicly-funded services and report its findings by March 1, 2010.

Section 8 directs the Department to create and maintain a database of all deaths that occur in facilities governed by Chapter 122C of the North Carolina General Statutes. The section further directs the Department to provide training to administrative and direct care staff on the death reporting requirements of facilities operated in accordance with G.S. 122C-181.

Section 9 directs the Department to continue to implement its plan to return the service authorization, utilization review, and utilization management functions to LMEs by increasing the number of LMEs performing these functions to encompass at least sixty percent (60%) of the State's population by January 1, 2011. The section provides the Department must designate by July 1, 2010, which LMEs will be authorized to perform these functions on or after January 1, 2011 and extends the date that the Department may contract with an outside vendor for service authorization, utilization review, or utilization management functions, or otherwise obligate the State for these functions from September 30, 2009 to September 30, 2010.

Section 10 directs the North Carolina Institute of Medicine (NCIOM) to study and report on issues relating to State-funded and Medicaid-funded mental health, developmental disability and substance abuse services currently available to active, reserve and veteran members of the military and National Guard.

EFFECTIVE DATE: This act is effective when it becomes law.

S409-SMSQ-13(CSSQ-2) v1

Senate Health Care Committee
Wednesday, April 1, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 208	**People First.**	**Senator Dorsett**
SB 675	**Amend Public Health-Related Laws.**	**Senator Purcell**
SB 228	**DHHS/Office of Men's Health.**	**Senator Forrester**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, April 02, 2009

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

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

S.B. **208** People First.

Draft Number:	85189
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, April 01, 2009

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

FAVORABLE

S.B. **228** DHHS/Office of Men's Health.

Sequential Referral:	None
Recommended Referral:	Appropriations/Base Budget

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

S.B. **675** Amend Public Health-Related Laws.

Draft Number:	15235
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, April 1, 2009at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, April 1, 2009, in Room 544 of the Legislative Office Building, with twenty-one members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Bingham recognized Senator Dorsett to present Senate Bill 208, ***People First***. Sen. Rand moved to adopt the (PCS) Proposed Committee Substitute for discussion and the motion passed. Senator Dorsett pointed out the bill was brought to the Legislators by the Disability Community, The Association of Self Advocacy of North Carolina, a non-profit organization that supports the concepts of self-advocacy together with the self-determination of its members. Senator Dorsett stated the bill would direct the legislative drafting offices and state agencies to use certain respectful references to people with disabilities in the preparation of legislation and rules. Senator Dorsett pointed out this legislation does not invalidate any state statutes, resolutions, or rules. Also she pointed out this legislation is written so that it will not impede Federal Funding directed to the State of NC. Senator Dorsett noted that similar legislation had passed in New York, Nevada, the District of Columbia, Florida, Louisiana, and Minnesota and that several other states had removed the term mental retardation from their departments and division names. Senator Dorsett called on Staff, Shawn Parker, to explain the bill, whom explained each section. Senator Dorsett stated she had three speakers. Senator Atwater moved for approval of the bill at the appropriate time. Senator Bingham held the motion in order for Senator Dorsett's speaker to speak. Julia Leggett, the policy coordinator with The Arc of NC, spoke in support of the bill. Jennifer Manham, the policy director with the Mental Health Association of North Carolina, also asked for support for this bill, and stated language is an important tool used to shape the world we live in. The last speaker was Fred Johnson, from Alliance of Disability Advocates Center for Independent Living, who strongly supported the bill. Sen. Rand questioned Section 5. He asked why obtaining money by false representation only applied to physical defects and not any disability. Shawn Parker replied that the original wording of the sections began in 1909 and had not been adjusted. This bill only changed the terms that were deemed unappropriate. Sen. Dorsett stated it could be amended beyond the committee before it gets to the floor. Senator Blake asked how do you communicate about disabilities if the law passes. Senator Dorsett and Julia Leggett with The Arc of NC, pointed out that the bill only directed the bill drafters and the rules drafters to use People First Language and did not direct the citizens of NC how to speak, but they both are hopeful the bill will start the discussion of appropriate language to use and how to communicate more effectively and more respectively with the people in the disability community. Sen. Blake stated the intent of the bill is OK but he is paranoid about lawyers and he is afraid the bill will be misused, not enhanced. Sen. Goodall expressed his appreciation for the changes in the Proposed Committee Substitute and will vote for the bill, but stated he felt we could learn the words to use without laws to tell us. Senator Brunstetter inquired of staff; other than gender neutrality language that is seen throughout the General Statutes; is there any other place where we go ahead and direct specific terminology to be used in our statutes particularly as it relates to individuals. Shawn Parker responded he was aware of the

gender neutrality where, when you read "he", you could read it as he or she, but was unaware of any other terms like that. Shawn pointed out that not too long ago, maybe in 2005, there was an effort in some of the statutes to try to change the terms to the person first or person with disability language, but this is much more extensive. Senator Stein commented that language matters and that all this bill was seeking to do, was to direct staff when drafting legislation, to use language that is sensitive to the community effected by the language. Senator Malone stated this bill was very much needed. Senator Hartsell directed his question to staff, and stated he wanted to be sure this bill would not have some potential unintended consequences. He stated the goal was appropriate and admiral, but in reflections of what Senator Blake had said, and being in that questionable category as a lawyer, and paranoid in that regard as well, he was concerned that by adopting this language in a generic sense it might affect the Criminal Statute Laws, that are required to be spelled out articulately and well. He noted that criminal defense lawyers are very creative in looking at words. Senator Hartsell wanted assurance that by changing existing terminology the bill would not modify the law in other regards or give any kind of basis for defense or otherwise, which could be detrimental to the community with this new language. Shawn Parker, Staff Attorney, explained it would have the General Statutes Commission in their review and also they could have a further detailed study. Shawn Parker also stated the direction goes to the General Assembly in directing the drafters to be aware of the terminology. Senator Rand stated he had practiced criminal law a long time and stated "disabled" means they are incapable of independent movement, while it said before "crippled or otherwise physical defective", which is far more descriptive as far as criminal law is concerned. Sen. Rand stated he still thinks it should say "mental illness", which is a part of this stating you would not have to be disabled in order to show a physical defect. Sen. Rand pointed out that there is nothing that is more nit picking than the criminal law. Sen. Clary asked if this language was conforming to the Federal Medicaid Policy. Sharnese Ransome with the Department of Health and Human Services responded that federal law supersedes state statutes and administrative rules. Senator Clary had a follow-up question and asked if this bill had a serial referral to a Judiciary Committee. Sen. Bingham responded, "No it does not". Senator Dorsett asked if the committee would move the bill forward and amend it on the floor. Senator Hartsell mentioned that Section 5 was where the problem was and it could be removed and worked on later. Shawn Parker, Staff Attorney, stated that section 5 was an example. Senator Rand did not want to eliminate Section 5; he wanted to include mental illness. Senator Stein stated that physical disability might have too narrow of a notation of a person's mind. The language needed to capture that anyone who was preying on one's sympathy by faking a physical or mental defect or condition needed to be included and Senator Dorsett had suggested amending it before it got heard on the floor. Senator Bingham stated he already had a motion made earlier by Senator Atwater, unfavorable to the original bill, favorable as to the proposed committee substitute. The motion passed.

Senator Bingham called on Senator Purcell to present Senator Bill 675, ***Amend Public Health-Related Laws***. Senator Foriest moved to adopt the (PCS) Proposed Committee Substitute for discussion and the motion carried. Senator Purcell stated the

purpose of the bill was to clarify the procedure for investigating and controlling communicable diseases. The first part of the bill is to provide protection for police officers that have a non-sexual exposure, like biting or spitting. The second section of the bill stated that physicians and persons in charge of medical facilities should, upon request and proper identification, permit the local or state health director to examine, review, and obtain, a copy of medical or other records under their control. Senator Rand asked why would you remove the word "was exposed" and replaced it with, "non-sexual exposure" or would the sexual exposure be covered elsewhere. Sen. Purcell called on Dr. Engel, the State Health Director. Dr. Jeff Engel, the State Health Director responded that sexual exposures would be covered in §15A-615. Senator Rand moved for an unfavorable report as to the original bill, favorable to the proposed committee substitute. The motion passed.

Senator Bingham recognized Senator Forrester to present Senate Bill 228, ***DHHS/Office of Men's Health***. Senator Forrester pointed out that the Public Health Study Commission, which Senator Purcell and Senator Forrester both served on, recommended Senate Bill 228. The bill would establish an Office of Men's Health, similar to the Office of Woman's Health which was established back five or six years ago. Senate Bill 228 would recognize Men's Health Problems which are an issue not just for the men, but for the wives, mothers, daughters, and sisters. It would focus on preventive health. Senator Forrester stated sixteen states have bills such as this. Senator Forrester pointed out he had introduced a bill like this a couple of years ago and the Fiscal Note stated it was $160,000.00 and this year's Fiscal Note was for $215,000.00. Senator Forrester stated there was no known opposition and that he had one speaker in the audience. Daivd Kalbacker spoke as a consumer and a prostrate cancer survivor. He was with the NC Board of Nursing, but removed his Board of Nursing ID. He stated he and his wife both had cancer at the same time. Women's information was much more readily available. Senator Nesbitt said they had discussed this in the Appropriations Sub-Committee. He felt there should be more emphasis on screening for men. Senator Nesbitt moved for a favorable report with a sequential referral to Appropriations. The motion passed.

The meeting adjourned at 11:55 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

S 1

SENATE BILL 208

Short Title:	People First.	(Public)
Sponsors:	Senators Dorsett; Albertson, Bingham, Brown, Clary, Dannelly, Forrester, Hoyle, Jenkins, Kinnaird, Malone, Preston, Purcell, Shaw, Stevens, and Tillman.	
Referred to:	Rules and Operations of the Senate.	

February 18, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT LEGISLATIVE DRAFTING OFFICES AND STATE AGENCIES TO USE CERTAIN RESPECTFUL REFERENCE TO PEOPLE WITH DISABILITIES IN THE PREPARATION OF LEGISLATION AND RULES.

Whereas, the General Assembly recognizes that language used in reference to individuals with disabilities shapes and reflects society's attitudes towards people with disabilities; and

Whereas, many of the terms currently used diminish the humanity and natural condition of having a disability; and

Whereas, certain terms are demeaning and create an invisible barrier to inclusion as equal community members; and

Whereas, the General Assembly finds it necessary to clarify preferred language for new and revised laws and rules by requiring the use of terminology that puts the person before the disability; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 7 of Chapter 120 of the General Statutes is amended by adding a new section to read:

"**§ 120-32.04. People first in drafting.**

(a) The General Assembly directs the Legislative Services Office to avoid all references to the terms in Column A below. Drafters shall replace the terms referenced in Column A with the terms listed in Column B in any new statute or resolution, and change those references in drafts for any existing statute as those statutes are amended for other reasons. This section does not apply where a reference to a word or phrase in Column A is required by federal law or regulation.

Column A	Column B
Handicapped	People with disabilities
Mentally retarded	Intellectual disability
Afflicted with	Someone who has/had
Crippled	Physical disability
Mentally disabled	Mental illness

(b) The Legislative Services Office is directed in drafting statutes and resolutions to avoid language that implies that the person as a whole is disabled (e.g., the mentally ill or the learning disabled), equates persons with their condition (e.g., epileptics, autistics, or quadriplegics), has negative overtones (e.g., afflicted with cerebral palsy, suffering from multiple sclerosis, confined to a wheelchair or wheelchair bound), or is regarded as derogatory

or demeaning (e.g., handicapped or mentally deficient), and replace nonrespectful language by referring to persons with disabilities as persons first where appropriate.

(c) No statute or resolution is invalid because it does not comply with this section."

SECTION 2. Part 2 of Article 2A of Chapter 150B of the General Statutes is amended by adding a new section to read:

"**§ 150B-21.6A. People first in drafting.**

(a) The General Assembly directs all agencies adopting rules to avoid all references to the terms in Column A below. Drafters shall replace the terms referenced in Column A with the terms listed in Column B in any new rule, and change those references in drafts for any existing rule as those rules are amended for other reasons. This section does not apply where a reference to a word or phrase in Column A is required by federal law or regulation or State statute.

Column A	Column B
Handicapped	People with disabilities
Mentally retarded	Intellectual disability
Afflicted with	Someone who has/had
Crippled	Physical disability
Mentally disabled	Mental illness

(b) Agencies are directed in drafting rules to avoid language that implies that the person as a whole is disabled (e.g., the mentally ill or the learning disabled), equates persons with their condition (e.g., epileptics, autistics or quadriplegics), has negative overtones (e.g., afflicted with cerebral palsy, suffering from multiple sclerosis, confined to a wheelchair or wheelchair bound), or is regarded as derogatory or demeaning (e.g., handicapped or mentally deficient), and replace nonrespectful language by referring to persons with disabilities as persons first where appropriate.

(c) No rule is invalid because it does not comply with this section.".

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 208
PROPOSED COMMITTEE SUBSTITUTE S208-CSSQ-10 [v.2]

3/30/2009 3:52:25 PM

Short Title: People First. (Public)

Sponsors:

Referred to:

February 18, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT LEGISLATIVE DRAFTING OFFICES AND STATE AGENCIES TO USE CERTAIN RESPECTFUL REFERENCE TO PEOPLE WITH DISABILITIES IN THE PREPARATION OF LEGISLATION AND RULES.

Whereas, the General Assembly recognizes that language used in reference to individuals with disabilities shapes and reflects society's attitudes towards people with disabilities; and

Whereas, many of the terms currently used diminish the humanity and natural condition of having a disability; and

Whereas, certain terms are demeaning and create an invisible barrier to inclusion as equal community members; and

Whereas, the General Assembly finds it necessary to clarify preferred language for new and revised laws and rules by requiring the use of terminology that puts the person before the disability; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 7 of Chapter 120 of the General Statutes is amended by adding a new section to read:

"**§ 120-32.04. Preferred drafting language; people with disabilities.**

(a) It is the intent of the General Assembly to refer to a person with a disability as a person first when directing the drafting of statutes and resolutions. To this extent, where appropriate the drafting divisions of the Legislative Service Office shall avoid language that implies a person as a whole is disabled, equates a person with their condition, or is regarded as derogatory or demeaning.

(b) This section does not apply where a word or phrase is required by federal law or regulation, is describing a medical diagnosis, or is referring to non-living entities such as facilities, organizations, programs, services, or zone designations.

(c) No statute or resolution is invalid because it does not comply with this section."

SECTION 2. The Office of Administrative Hearings shall direct the Rules Division to implement provisions substantial equivalent to those in G.S. 120-32.04. The Rules Division shall inform all agency rulemaking coordinators in writing of these changes.

SECTION 3. The General Statutes Commission shall review current statutes and make recommendations on any modifications that can be made to the 2010 Session of the 2009 General Assembly.

SECTION 4. The North Carolina Council on Developmental Disabilities shall annually provide a list of nationally recognized descriptors to the Legislative Service Office to be incorporated into the training of legislative drafters.

SECTION 5. G.S. 14-113 reads as rewritten:

"**§ 14-113. Obtaining money by false representation of physical ~~defect.~~disability.**

It shall be unlawful for any person to falsely represent himself or herself in any manner whatsoever as ~~blind, deaf, dumb, or crippled or otherwise physically defective~~ a person who is blind, deaf, mute, or physically disabled for the purpose of obtaining money or other thing of value or of making sales of any character of personal property. Any person so falsely representing himself or herself as ~~blind, deaf, dumb, crippled or otherwise physically defective,~~a person who is blind, deaf, mute, or physically disabled and securing aid or assistance on account of such representation, shall be deemed guilty of a Class 2 misdemeanor."

SECTION 6. This act is effective when it becomes law.

SENATE BILL 208: People First

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	March 30, 2009
Introduced by:	Sen. Dorsett	**Prepared by:**	Shawn Parker
Analysis of:	PCS to First Edition S208-CSSQ-10		Legislative Analyst

SUMMARY: ***The Proposed Committee Substitute (PCS) to Senate Bill 208 provides that it is the intent of the General Assemble to refer to persons with disabilities as people first when directing the drafting of legislation, directs the Rules Division of the Office of Administrative Hearings to implement substantial equivalent provisions for proposed rules, directs the General Statutes Commission to study current statutes and make recommendation on modifications, directs the North Carolina Council on Developmental Disabilities to provide a list of appropriate descriptors to the Legislative Service Office annually for incorporation in legislative drafting training, and revises a current statute which utilized antiquated language.***

BILL ANALYSIS:

Section 1 creates a new section within Article 7 of Chapter 120 of the General Statutes which provides the General Assembly when referring to persons with disabilities in its drafting of statutes and resolutions will utilize "person first" language when possible. The section will not apply when the use of the term is required by federal law, describes a medical diagnosis, or is referring to a non-living proper noun and no statute or resolution is invalid for failing to comply.

Section 2 directs the Office of Administrative Hearings to inform all agency rule makers and to implement provisions similar to those in G.S. 120-32.04.

Section 3 directs the General Statutes Commission to review current statutes and recommend changes to the 2010 session of the 2009 General Assembly.

Section 4 directs the North Carolina Council on Developmental Disabilities to annually provide the Legislative Service Office with a list of nationally recognized descriptors to be incorporated into the training of legislative drafters.

Section 5 revises G.S.14-113 to use more appropriate terminology.

EFFECTIVE DATE: This act is effective when it becomes law.

S208-SMSQ-20(CSSQ-10) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 208
PROPOSED COMMITTEE SUBSTITUTE S208-PCS85189-SQ-10

Short Title: People First. (Public)

Sponsors:

Referred to:

February 18, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT LEGISLATIVE DRAFTING OFFICES AND STATE AGENCIES TO USE CERTAIN RESPECTFUL REFERENCE TO PEOPLE WITH DISABILITIES IN THE PREPARATION OF LEGISLATION AND RULES.

Whereas, the General Assembly recognizes that language used in reference to individuals with disabilities shapes and reflects society's attitudes towards people with disabilities; and

Whereas, many of the terms currently used diminish the humanity and natural condition of having a disability; and

Whereas, certain terms are demeaning and create an invisible barrier to inclusion as equal community members; and

Whereas, the General Assembly finds it necessary to clarify preferred language for new and revised laws and rules by requiring the use of terminology that puts the person before the disability; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Article 7 of Chapter 120 of the General Statutes is amended by adding a new section to read:

"**§ 120-32.04. Preferred drafting language; people with disabilities.**

(a) It is the intent of the General Assembly to refer to a person with a disability as a person first when directing the drafting of statutes and resolutions. To this extent, where appropriate, the drafting divisions of the Legislative Services Office shall avoid language that implies a person as a whole is disabled, equates a person with his or her condition, or is regarded as derogatory or demeaning.

(b) This section does not apply where a word or phrase is required by federal law or regulation, is describing a medical diagnosis, or is referring to nonliving entities such as facilities, organizations, programs, services, or zone designations.

(c) No statute or resolution is invalid because it does not comply with this section."

SECTION 2. The Office of Administrative Hearings shall direct the Rules Division to implement provisions substantially equivalent to those in G.S. 120-32.04. The Rules Division shall inform all agency rule-making coordinators in writing of these changes.

SECTION 3. The General Statutes Commission shall review current statutes and make recommendations on any modifications that can be made to the 2010 Regular Session of the 2009 General Assembly.

SECTION 4. The North Carolina Council on Developmental Disabilities shall annually provide a list of nationally recognized descriptors to the Legislative Services Office to be incorporated into the training of legislative drafters.

SECTION 5. G.S. 14-113 reads as rewritten:

"**§ 14-113. Obtaining money by false representation of physical ~~defect.~~disability.**

It shall be unlawful for any person to falsely represent himself or herself in any manner whatsoever as ~~blind, deaf, dumb, or crippled or otherwise physically defective~~ a person who is blind, deaf, mute, or physically disabled for the purpose of obtaining money or other thing of value or of making sales of any character of personal property. Any person so falsely representing himself or herself as ~~blind, deaf, dumb, crippled or otherwise physically defective,~~a person who is blind, deaf, mute, or physically disabled and securing aid or assistance on account of such representation, shall be deemed guilty of a Class 2 misdemeanor."

SECTION 6. This act is effective when it becomes law.

SENATE BILL 675

Short Title:	Amend Public Health-Related Laws.	(Public)
Sponsors:	Senator Purcell.	
Referred to:	Health Care.	

March 19, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND PUBLIC HEALTH-RELATED LAWS TO CLARIFY PROCEDURES FOR INVESTIGATING AND CONTROLLING COMMUNICABLE DISEASES AND FOR FILING BIRTH CERTIFICATES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 15A-534.3 reads as rewritten:

"**§ 15A-534.3. Detention for communicable diseases.**

If a judicial official conducting an initial appearance or first appearance hearing finds probable cause that an individual ~~was exposed~~ had a nonsexual exposure to the defendant in a manner that poses a significant risk of transmission of the AIDS virus or Hepatitis B by such defendant, the judicial official shall order the defendant to be detained for a reasonable period of time, not to exceed 24 hours, for investigation by public health officials and for testing for AIDS virus infection and Hepatitis B infection if required by public health officials pursuant to G.S. 130A-144 and G.S. 130A-148. (1989, c. 499.)."

SECTION 2. G.S. 130A-144(b) reads as rewritten:

"**§ 130A-144. Investigation and control measures.**

(b) ~~Physicians and~~ Physicians, persons in charge of medical facilities or ~~laboratories~~ laboratories, and other persons shall, upon request and proper identification, permit a local health director or the State Health Director to examine, review, and obtain a copy of medical or other records in their possession or under their control which the State Health Director or a local health director determines pertain to the (i) diagnosis, treatment, or prevention of a communicable disease or communicable condition for a person infected, exposed, or reasonably suspected of being infected or exposed to such a disease or condition, or (ii) the investigation of a known or reasonably suspected outbreak of a communicable disease or communicable condition."

SECTION 3. G.S. 130A-101(a) reads as rewritten:

"(a) A certificate of birth for each live birth, regardless of the gestation period, which occurs in this State shall be filed with the local registrar of the county in which the birth occurs within ~~10~~five days after the birth and shall be registered by the registrar if it has been completed and filed in accordance with this Article and the rules."

SECTION 4. G.S. 130A-101(b) reads as rewritten:

"(b) When a birth occurs in a hospital or other medical facility, the person in charge of the facility shall obtain the personal data, prepare the certificate, secure the signatures required by the certificate and file it ~~with the local registrar within five days after the birth.~~ in accordance with subsection (a) of this section. The physician or other person in attendance shall provide the medical information required by the certificate."

SECTION 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 675
PROPOSED COMMITTEE SUBSTITUTE S675-CSRD-15 [v.1]

3/31/2009 5:53:08 PM

Short Title: Amend Public Health-Related Laws. (Public)

Sponsors:

Referred to:

March 19, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND PUBLIC HEALTH-RELATED LAWS TO CLARIFY PROCEDURES FOR INVESTIGATING AND CONTROLLING COMMUNICABLE DISEASES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 15A-534.3 reads as rewritten:

"**§ 15A-534.3. Detention for communicable diseases.**

If a judicial official conducting an initial appearance or first appearance hearing finds probable cause that an individual ~~was exposed~~ had a nonsexual exposure to the defendant in a manner that poses a significant risk of transmission of the AIDS virus or Hepatitis B by such defendant, the judicial official shall order the defendant to be detained for a reasonable period of time, not to exceed 24 hours, for investigation by public health officials and for testing for AIDS virus infection and Hepatitis B infection if required by public health officials pursuant to G.S. 130A-144 and G.S. 130A-148. (1989, c. 499.)."

SECTION 2. G.S. 130A-144(b) reads as rewritten:

"**§ 130A-144. Investigation and control measures.**

(b) ~~Physicians and~~ Physicians, persons in charge of medical facilities or ~~laboratories~~ laboratories, and other persons shall, upon request and proper identification, permit a local health director or the State Health Director to examine, review, and obtain a copy of medical or other records in their possession or under their control which the State Health Director or a local health director determines pertain to the (i) diagnosis, treatment, or prevention of a communicable disease or communicable condition for a person infected, exposed, or reasonably suspected of being infected or exposed to such a disease or condition, or (ii) the investigation of a known or reasonably suspected outbreak of a communicable disease or communicable condition."

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

SENATE BILL 675:
Amend Public Health-Related Laws

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	March 31, 2009
Introduced by:	Sen. Purcell	**Prepared by:**	Ben Popkin
Analysis of:	PCS to First Edition S675-CSRD-15		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute to Senate Bill 675 would amend the communicable disease detention provision of the General Statutes to change the contact that may substantiate an order to detain a defendant for investigation and testing for the AIDS virus or Hepatitis B from "was exposed" to "had a nonsexual exposure". The PCS would also amend the provision setting forth communicable disease investigation and control measures to authorize "other persons" to permit local health directors or the State Health Director to examine medical or other records pertaining to either the diagnosis, treatment, or preventions of communicable disease or the investigation of known or suspected outbreaks of communicable diseases.***

The PCS deletes provisions in the original bill relating to birth certificates.

CURRENT LAW:

G.S. 15A-534.3 "Detention for communicable diseases" currently directs judicial officials conducting first appearances finding probable cause that a person *was exposed* to a defendant in a manner that poses a significant risk of transmission of the AIDS virus or Hepatitis B to order the defendant to be detained for a reasonable period of time, not to exceed 24 hours, for investigation and testing for the infections if required by the public health officials pursuant to G.S. 130A-144 (Investigation and control measures) or G.S. 130A-148 (Laboratory tests for AIDS virus infection).

G.S. 130A-144 "Investigation and control measures" currently directs *physicians and persons in charge of medical facilities or laboratories* to permit local health directors or the State Health Director to examine, review, and obtain a copy of medical and other records in their possession or under their control that the health directors have determined pertain to:

1. the diagnosis, treatment, or prevention of a communicable disease or condition for a person infected, exposed (or reasonable suspected to have been) to a communicable disease or condition, or
2. the investigation of a known or reasonably suspected outbreak of a communicable disease or condition.

BILL ANALYSIS: Section 1 – would amend the communicable disease detention provision of the General Statutes to direct a judicial official finding probable cause that a person had *nonsexual exposure* to a defendant in a manner that posed a significant risk of transmission of the AIDS virus or Hepatitis B to order the defendant detained for a reasonable period for investigation and testing for infection.

Section 2 – would amend the provision setting forth communicable disease investigation and control measures to direct *"other persons"* to permit local health directors or the State Health Director to examine medical or other records pertaining to either the diagnosis, treatment, or preventions of communicable disease or the investigation of known or suspected outbreaks of communicable diseases.

EFFECTIVE DATE: This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 675
PROPOSED COMMITTEE SUBSTITUTE S675-PCS15235-RD-15

Short Title: Amend Public Health-Related Laws. (Public)

Sponsors:

Referred to:

March 19, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND PUBLIC HEALTH-RELATED LAWS TO CLARIFY PROCEDURES FOR INVESTIGATING AND CONTROLLING COMMUNICABLE DISEASES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 15A-534.3 reads as rewritten:

"**§ 15A-534.3. Detention for communicable diseases.**

If a judicial official conducting an initial appearance or first appearance hearing finds probable cause that an individual ~~was exposed~~had a nonsexual exposure to the defendant in a manner that poses a significant risk of transmission of the AIDS virus or Hepatitis B by such defendant, the judicial official shall order the defendant to be detained for a reasonable period of time, not to exceed 24 hours, for investigation by public health officials and for testing for AIDS virus infection and Hepatitis B infection if required by public health officials pursuant to G.S. 130A-144 and G.S. 130A-148."

SECTION 2. G.S. 130A-144(b) reads as rewritten:

"(b) ~~Physicians and~~ Physicians, persons in charge of medical facilities or ~~laboratories~~ laboratories, and other persons shall, upon request and proper identification, permit a local health director or the State Health Director to examine, review, and obtain a copy of medical or other records in their possession or under their control which the State Health Director or a local health director determines pertain to the (i) diagnosis, treatment, or prevention of a communicable disease or communicable condition for a person infected, exposed, or reasonably suspected of being infected or exposed to such a disease or condition, or (ii) the investigation of a known or reasonably suspected outbreak of a communicable disease or communicable condition."

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

SENATE BILL 228

Short Title:	DHHS/Office of Men's Health.	(Public)
Sponsors:	Senators Forrester, Purcell, Dorsett, Malone; Goss, and Swindell.	
Referred to:	Health Care.	

February 19, 2009

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE OFFICE OF MEN'S HEALTH WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, AS RECOMMENDED BY THE PUBLIC HEALTH STUDY COMMISSION.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 130A of the General Statutes is amended by adding the following new Article to read:

"Article 5A.

"Men's Health.

"**§ 130A-131.26. Office of Men's Health established.**

(a) There is established in the Department the Office of Men's Health. The purpose of the Office is to expand the State's public health concerns and focus to include a comprehensive outlook on the overall health status of men. The primary goals of the Office shall be the prevention of disease and improvement in the quality of life for men over their entire lifespan. The Department shall develop strategies for achieving these goals which shall include, but not be limited to:

(1) Developing a strategic plan to improve public services and programs targeting men;

(2) Conducting policy analyses on specific issues related to men's health;

(3) Facilitating communication among the Department's programs and between the Department and external men's health groups and community-based organizations;

(4) Building public health awareness and capacity regarding men's health issues by providing a series of services, including evaluation, recommendation, technical assistance, and training; and

(5) Developing initiatives for modification or expansion of health services oriented towards men's health issues with the intent of establishing meaningful public/private partnerships in the future.

(b) The Office shall study the feasibility of establishing initiatives for:

(1) Early intervention services for men infected with HIV; and

(2) Outreach, treatment, and follow-up services to men at high risk for contracting sexually transmitted diseases.

In conducting the study, the Department shall take into consideration related services already in place in the Department and at the local level."

SECTION 2. The Department of Health and Human Services shall use funds available for the 2009-2010 and 2010-2011 fiscal years to implement this act.

SECTION 3. This act becomes effective July 1, 2009.

SENATE BILL 228:
DHHS/Office of Men's Health

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	March 30, 2009
Introduced by:	Sen. Forrester	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Legislative Analyst

SUMMARY: ***Senate Bill 228 would enact a new Article 5A (Men's Health) of Chapter 130A (Public Health) that would establish the Office of Men's Health. The Office would be housed within the Department of Health and Human Services and would have as its primary goals "...the prevention of disease and improvement in the quality of life for men over their entire lifespan."[1]***

Senate Bill 228 would direct the Department to use funds available for the 2009-2010 and 2010-2011 fiscal years to implement the provisions of the act.

[As introduced, this bill was identical to H259, as introduced by Reps. England, Current, which received a favorable report in House Health and is currently in House Appropriations.]

BILL ANALYSIS: Senate Bill 228 would enact a new Article 5A (Men's Health) of Chapter 130A (Public Health) that would establish the Office of Men's Health. The Office would be housed within the Department of Health and Human Services and would be charged with "...expand(ing) the State's public health concerns and focus to include a comprehensive outlook on the overall health status of men."[2]

The bill would direct the Department to develop strategies for achieving the goals of the Office including as it relates to men's health:

- A plan to improve public services and programs;
- Policy analyses of specific issues;
- Public health awareness;
- Building capacity;
- Modifying or expanding certain health services.

The bill directs the Office to study the feasibility of establishing initiatives for early intervention services for men infected with HIV and providing outreach, treatment and follow-up services to men at high risk of contracting sexually transmitted diseases.

EFFECTIVE DATE: This act becomes effective July 1, 2009.

BACKGROUND: This bill is a recommendation of the Public Health Study Commission.

Currently 16 states have established an Office of Men's Health, Coordinator for Men's Health, or State Commission on Men's Health:

Florida; Georgia; Illinois; Kansas; Louisiana; Maryland; Massachusetts; Michigan; Montana; Nebraska; Nevada; New Hampshire; New York; Ohio; Oklahoma; Pennsylvania.[3]

S228-SMSQ-19(e1) v1

[1] Proposed G.S. 130A-131.26(a).
[2] Proposed G.S. 130A-131.26(a).
[3] www.menshealtnetwork.org

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Fiscal Note

BILL NUMBER: Senate Bill 228 (First Edition)

SHORT TITLE: DHHS/Office of Men's Health.

SPONSOR(S): Senator Forrester

FISCAL IMPACT

Yes ( ) **No ( )** **No Estimate Available ( )**

	FY 2009-10	FY 2010-11	FY 2011-12	FY 2012-13	FY 2013-14
REVENUES	0	0	0	0	0
EXPENDITURES	$215,000	$219,300	$223,686	$228,160	$232,723
POSITIONS (cumulative):	2	2	2	2	2

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED:
Department of Health and Human Services, Division of Public Health

EFFECTIVE DATE: July 1, 2009

BILL SUMMARY:
Amends GS130A-131.26 to establish an Office of Men's Health in the Department of Health and Human Services (DHHS). The purpose of the office is to expand the Department's attention on preventing disease and improving the quality of life for men during their entire lifespan. The Department is to develop public health policies and public awareness programs to achieve this goal. Effective July 1, 2009.

ASSUMPTIONS AND METHODOLOGY

- An Office of Men's Health would be established within the Chronic Disease Prevention and Control Office (Office) in the Division of Public Health, DHHS. Within the division, the Office would be given the responsibility for ensuring that public health programs provide the necessary attention to the prevention of diseases and improvement in the quality of life for men. This includes:
  - Facilitating communication between state, local, and private non-profit organizations with an interest in improving men's health
  - Building public awareness and capacity through print and electronic media.

- A Public Health Manager in the Chronic Disease Prevention and Control Office would be given the responsibility to develop a strategic plan to improve men's health care services, build public health awareness, and develop initiatives within existing division programs.

- Only State General Funds are available for this activity. Therefore, out-year costs are held to a 2% increase annually.

- In SFY 2009-10 the costs associated with establishing an Office of Men's Health are shown below.

SFY 2009-10 Costs	
Salaries and Benefits	$141,473
Public Health Manager II	
Administrative Assistant I	
Public Awareness Campaign	$21,000
Supplies, Rent, Telephone, Copying	$43,827
Furniture & Equipment	$8,700
Total	$215,000

SOURCES OF DATA:
Division of Public Health

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910
PREPARED BY: Lee Dixon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: March 31, 2009

Signed Copy Located in the NCGA Principal Clerk's Offices

VISITOR REGISTRATION SHEET

Senate Health Care — **April 1, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Shemeriah Harrington	DHHS
Shawn	~~DHHS~~
[illegible]	DHHS - DPA
Jeff Engel	DHHS/DPH
Jamal Jones	NCHA
Mia Bailey	Electricities of NC
Gus Tulloss	
Cam Casey	BPMLC
JE Hobbs	HANC

VISITOR REGISTRATION SHEET

Senate Health Care
Name of Committee

April 1, 2009
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kelly Hook	GA
Ryan Pinion	Alliance of Disability Advocates
Mallory Hatcher	MWC
J. Michael Atkins	ADA-CFL
Annaliese Dolan	DRNC
Dale Arnold	T. Mc
James Shannahan	Quality Consulting
TINA GORDON	NC Nurses Assoc.
Joanne Stevens	nursing
David Kirkpatrick	N.C. Board of Nursing
Catherine Moore	UNCG MSN Student

VISITOR REGISTRATION SHEET

Senate Health Care — **April 1, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DAVID BARNES	Poyner Spruill
ANN LORE	OURE
[signature]	JD, AL, PA
Mari Wildy	Novant
Christy Agner	DOA
[signature]	NMSS-NC
Jeh Malem	MHAONC
[signature]	AOA-CIC
Joyce Allen	Alliance of Disability Advocates
Rene Cummins	Alliance of Disability Advocates.
[signature]	MHM

Attachment I

Senate Health Care Committee
Wednesday, April 8, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 674	Amend Rabies Laws.	Senator Purcell
SB 799	Increase Transparency of MH/DD/SA Facilities.	Senator Rand
SB 834	Rewrite Sanitarian Examiners Laws/Fees.	Senator Bingham
SB 1042	Tech. & Org. Changes/Certain DHHS Facilities.	Senator Nesbitt, Jr.

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, April 08, 2009

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

FAVORABLE

S.B. **799** Increase Transparency of MH/DD/SA Facilities.
Sequential Referral: None
Recommended Referral: None

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

S.B. **834** Rewrite Sanitarian Examiners Laws/Fees.
Draft Number: 55332
Sequential Referral: None
Recommended Referral: Finance
Long Title Amended: No

TOTAL REPORTED: 2

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, April 8, 2009 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 AM on April 8, 2009, in Room 544 of the Legislative Office Building. Twenty-one members of the committee were present. Senator Purcell, Co-chair, presided.

Agenda item, Senate Bill 1042 "AN ACT TO MAKE TECHNICAL AND ORGANIZATIONAL CHANGES TO THE LAW REGARDING THE LICENSURE AND INSPECTION OF FACILITIES FOR AGED AND DISABLED INDIVIDUALS (Attachment XII) was withdrawn from the agenda at the beginning of the meeting at the request of the bill sponsor, Senator Nesbitt.

The first bill heard on the agenda was Senate Bill 799 (Attachment I) "AN ACT TO INCREASE TRANSPARENCY OF STATE FACILITIES THAT PROVIDE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES BY REQUIRING THE DISCLOSURE OF CERTAIN INFORMATION ABOUT DEATH REPORTS, FACILITY POLICE REPORTS, AND INCIDENT REPORTS" (Attachment II). Bill sponsor, Senator Rand, explained his bill, and a bill explanation is attached to these minutes as Attachment III. Motion was made for a favorable report; motion carried.

Next on the agenda was Senate Bill 834 "AN ACT REWITING THE LAWS REGULATING SANITARIANS AND AUTHORIZING THE STATE BOARD OF SANITARIAN EXAMINERS TO INCREASE CERTAIN FEES, sponsored by Senator Bingham (Attachment IV). A Committee Substitute was presented and motion made for its consideration (Attachment V). A motion was made and passed to adopt the Committee Substitute for discussion, and discussion resulted in Senators Bingham and Brunstetter offering amendments (Attachments VI and VII). Motions were made for passage of both; both were accepted, and a motion was made to incorporate them into a new Committee Substitute. A subsequent motion was made for an unfavorable report for the bill and a favorable report for the Committee Substitute and with a recommended referral to the Committee on Finance.

Senate Bill 674 "AN ACT TO AMEND THE RABIES LAWS TO CONFORM WITH RECOMMENDATIONS FROM THE CENTERS FOR DISEASE CONTROL AND THE NATIONAL ASSOCIATION OF STATE PUBLIC HEALTH VETERINARIANS AND TO ALLOW STRAY OR FERAL ANIMALS TO BE IMMEDIATELY EUTHANIZED AND TESTED FOR RABIES AFTER BITING A HUMAN", sponsored by Senator Purcell, was considered next (Attachment VIII). A proposed Committee Substitute was presented and motion made to consider it passed (Attachment IX). An explanation for the Substitute is attached as Attachment X. After discussion, there still were a few questions at adjournment time, so the bill was carried over to the next Committee meeting.

There being no further business before the Committee, Senator Purcell adjourned the meeting.

William R Purcell
Senator William R. Purcell, Presiding

Becky Hedspeth
Becky Hedspeth, Committee Clerk

Attachment II

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 799

Short Title:	Increase Transparency of MH/DD/SA Facilities.	(Public)
Sponsors:	Senator Rand.	
Referred to:	Health Care.	

March 25, 2009

A BILL TO BE ENTITLED

AN ACT TO INCREASE TRANSPARENCY OF STATE FACILITIES THAT PROVIDE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES BY REQUIRING THE DISCLOSURE OF CERTAIN INFORMATION ABOUT DEATH REPORTS, FACILITY POLICE REPORTS, AND INCIDENT REPORTS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-31(e) reads as rewritten:

"(e) ~~Nothing~~ Except as provided in subsections (g) and (h) of this section, nothing in this section abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Secretary or the agency. In carrying out the requirements of this section, the Secretary and the agency shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information."

SECTION 2. G.S. 122C-31(g) reads as rewritten:

"(g) In addition to the reporting requirements specified in subsections (a) through (e) of this section, and pursuant to G.S. 130A-383, every State facility shall report ~~the~~ all of the following, without redactions other than to protect confidential personnel information:

(1) The death of any client of the facility, and, if known, the death of any former client of a facility who dies within seven days of release from the facility, regardless of the manner of death, to the medical examiner of the county in which the body of the deceased is ~~found.~~found; and

(2) The death of any client of the facility and, if known, the death of any former client of a facility who dies within seven days of release from the facility, regardless of the manner of death, to the State protection and advocacy agency designated under the Developmental Disabilities Assistance and Bill of Rights Act 2000, P.L. 106-402. The State protection and advocacy agency shall use the information in accordance with its powers and duties under applicable State or federal law and regulations."

SECTION 3. G.S. 122C-31 is amended by adding a new subsection to read:

"(h) Notwithstanding G.S. 122C-52, and unless otherwise prohibited by State or federal law or requirements, in order to provide for greater transparency in connection with the reporting requirements specified in subsections (a) through (g) of this section, the following information in reports made pursuant to this section shall be public records within the meaning of G.S. 132-1 when reported by a State facility:

(1) The name, sex, age, and date of birth of the deceased.
(2) The name of the facility providing the report.
(3) The date, time, and location of the death.
(4) A brief description of the circumstances of death, including the manner of death, if known.
(5) A list of all entities to whom the event was reported."

SECTION 4. G.S. 122C-52(a) reads as rewritten:

"(a) Except as provided in G.S. 132-5 and G.S. 122C-31(h), confidential information acquired in attending or treating a client is not a public record under Chapter 132 of the General Statutes."

SECTION 5. G.S. 122C-54 is amended by adding the following new subsections:

"(i) G.S. 132-1.4 shall apply to the records of criminal investigations conducted by any law enforcement unit of a State facility, and information described in G.S. 132-1.4(c) that is collected by the State facility law enforcement unit shall be public records within the meaning of G.S. 132-1.

(j) Notwithstanding any other provision of this Chapter, the Secretary may inform any person of any incident or event involving the welfare of a client or former client when the Secretary determines that the release of the information is essential to maintaining the integrity of the Department. However, the release shall not include information that identifies the client directly, or information for which disclosure is prohibited by State or federal law or requirements, or information for which, in the Secretary's judgment, by reference to publicly known or available information, there is a reasonable basis to believe the client will be identified."

SECTION 6. This act is effective when it becomes law.

Attachment III

SENATE BILL 799:
Increase Transparency of MH/DD/SA Facilities

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	April 7, 2009
Introduced by:	Sen. Rand	**Prepared by:**	Ben Popkin
Analysis of:	First Edition		Committee Counsel

SUMMARY: Senate Bill 799 would amend G.S. 122C-31 "Report required upon death of client" and related provisions to expand the amount of detail to be released about deaths of clients in State facilities and expand the breadth of the reporting requirement to include deaths of former clients of the facilities if the death occurs within seven days of the client's release from the facility.

CURRENT LAW: State facilities are required to notify the Secretary immediately upon the death of a client that occurs within seven days of physical restraint or seclusion, to notify the Secretary within three days of any death resulting from violence, accident, suicide, or homicide, and to report the death of any client of the facility to the county medical examiner, regardless of the manner of the death.[1]

BILL ANALYSIS: Senate Bill 799 would expand the existing requirement to report deaths of clients in State facilities to the county medical examiner to include deaths of former clients of the facilities if the death occurs within seven days of the client's release from the facility. The bill would also require the facility to report these deaths to the State protection and advocacy agency designated under the Developmental Disabilities Assistance and Bill of Rights Act (P.L 106-402), and would direct that agency to use the information in accordance with its powers and duties. The bill would specify that the information must be reported without redactions other than to protect confidential personnel information.

The bill would provide that, when included in facility reports, the following information would be public record: the name, sex, age, and date of birth of the deceased; the name of the reporting facility; the date, time and location of the death; a brief description of the circumstances and manner of the death; and a list of all entities to whom the event was reported.

The bill would make conforming changes to confidentiality provisions to allow for the release of the listed information as public record.[2] Finally the bill would amend current law allowing for disclosure of confidential information when under court order to classify records of criminal investigations conducted by law enforcement units of State facilities as not being public record, with an exception to allow for release of information as currently provided under State public records law.[3]

Finally, the bill would provide an exception authorizing the Secretary to inform any person of any incident or event involving the welfare of a client or former client when release of the information is determined to be "...essential to maintaining the integrity of the Department." and is done in such a way as to avoid revealing the client's identity.

EFFECTIVE DATE: This act is effective when it becomes law.

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[1] N.C.G.S. 122C-31
[2] N.C.G.S. 122C-52
[3] N.C.G.S. 132-1.4(c)

BACKGROUND: State facilities included within the scope of this bill are the following:[4]

(1) Psychiatric Hospitals:
- Cherry Hospital.
- Central Regional Hospital.
- Dorothea Dix Hospital.
- John Umstead Hospital.
- Broughton Hospital.

(2) Developmental Centers:
- Caswell Developmental Center.
- J. Iverson Riddle Developmental Center.
- Murdoch Developmental Center.

(3) Alcohol and Drug Treatment Centers:
- Walter B. Jones Alcohol and Drug Abuse Treatment Center.
- Julian F. Keith Alcohol and Drug Abuse Treatment Center.
- R.J. Blackley Alcohol and Drug Treatment Center.

(4) Neuro-Medical Treatment Centers:
- Black Mountain Neuro-Medical Treatment Center.
- O'Berry Neuro-Medical Treatment Center.
- Longleaf Neuro-Medical Treatment Center.

(5) Residential Programs for Children:
- Whitaker School.
- Wright School.

S799-SMRD-40(e1) v1

[4] N.C.G.S. 122C-181(a)

Attachment IV

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 834

Short Title:	Rewrite Sanitarian Examiners Laws/Fees.	(Public)
Sponsors:	Senators Bingham; Albertson, Goss, Hartsell, Kinnaird, Purcell, Stevens, and Swindell.	
Referred to:	Health Care.	

March 25, 2009

A BILL TO BE ENTITLED

AN ACT REWRITING THE LAWS REGULATING SANITARIANS AND AUTHORIZING THE STATE BOARD OF SANITARIAN EXAMINERS TO INCREASE CERTAIN FEES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The title of Article 4 of Chapter 90A of the General Statutes reads as rewritten:

"Article 4.

Registrations of ~~Sanitarians~~ Environmental Health Specialists."

SECTION 1.(b) G.S. 90A-50 reads as rewritten:

"**§ 90A-50. State Board of ~~Sanitarian~~ Environmental Health Specialist Examiners.**

(a) There is hereby created a State Board of ~~Sanitarian~~ Environmental Health Specialist Examiners to register qualified ~~sanitarians~~ environmental health specialists to practice within the State.

(b) It is the sole purpose of this Article to safeguard the health, safety, and general welfare of the public from adverse environmental factors and to register those environmental health professionals practicing as registered environmental health specialists or registered environmental health specialist interns who are qualified by education, training, and experience to work in the public sector in the field of environmental health within the scope of practice as defined in this Article."

SECTION 2. G.S. 90A-51 reads as rewritten:

"**§ 90A-51. Definitions.**

The words and phrases defined below shall when used in this Article have the following meaning unless the context clearly indicates otherwise:

(1) "Board" means the Board of ~~Sanitarian~~ Environmental Health Specialist Examiners.

(2) "Certificate of registration" ~~is~~ means a document issued by the Board as evidence of registration and qualification to practice as a ~~sanitarian or a sanitarian intern~~registered environmental health specialist or a registered environmental health specialist intern under this Article. The certificate shall bear the designation ~~"registered sanitarian" or "sanitarian intern"~~'Registered Environmental Health Specialist' or 'Registered Environmental Health Specialist Intern' and show the name of the person, date of issue, serial number, seal, and signatures of the members of the Board.

(2a) 'Environmental health practice' means the provision of environmental health services, including administration, organization, management, education,

enforcement, and consultation regarding environmental health services provided to or for the public. These services are offered to prevent environmental hazards and promote and protect the health of the public in the following areas: food, lodging, and institutional sanitation; on-site wastewater treatment and disposal; milk and dairy sanitation; shellfish sanitation; recreational water quality; public swimming pool sanitation; childhood lead poisoning prevention; well permitting and inspection; tattoo parlor sanitation; and all other areas of environmental health requiring the delegation of authority by the Division of Environmental Health to State and local environmental health professionals to enforce rules adopted by the Commission for Public Health. The definition also includes local environmental health professionals enforcing rules of local boards of health for on-site wastewater systems and wells.

(2b) 'Environmental health specialist' means a public health professional who meets the educational requirements under this Article and has attained specialized training and acceptable environmental health field experience to effectively plan, organize, manage, provide, execute, and evaluate one or more of the many diverse elements comprising the field of environmental health practice.

~~(3) "Registered sanitarian" is a sanitarian registered in accordance with the provisions of this Article.~~

(4) ~~"Sanitarian" is a public health professional qualified by education in the arts and sciences, specialized training, and acceptable environmental health field experience to effectively plan, organize, manage, execute and evaluate one or more of the many diverse elements comprising the field of environmental health. Practice in the field of environmental health within the meaning of this Article includes, but is not limited to, organization, management, education, enforcement, and consultation for the purpose of prevention of environmental health hazards and the promotion and protection of the public health and the environment in the following areas: food, lodging and institutional sanitation, on-site sewage treatment and disposal, and milk and dairy sanitation.~~

'Registered environmental health specialist' means an environmental health specialist registered in accordance with the provisions of this Article.

For purposes of this Article the following are not included within the definition of ~~"sanitarian"~~ 'registered environmental health specialist' unless the person is working as an environmental health specialist:

a. A person teaching, lecturing, or engaging in research.

b. A person who is a sanitary engineer, public health engineer, public health engineering assistant, registered professional engineer, industrial hygienist, health physicist, chemist, epidemiologist, toxicologist, geologist, hydrogeologist, waste management specialist, or soil ~~scientist, except when the person is working as a sanitarian.~~scientist.

c. A public health officer or public health department director.

d. A person who holds a North Carolina license to practice medicine, veterinary medicine, or nursing.

e. Laboratory personnel when performing or supervising the performance of sanitation related laboratory functions.

~~It is the sole purpose of this Article to safeguard the health, safety, and general welfare of the public from adverse environmental factors and to~~

~~register those environmental health professionals practicing as sanitarians who are qualified by education, training, and experience to work, or are working, in the public sector in the field of environmental health within the scope of practice as defined in this Article.~~

(5) ~~"Sanitarian intern" is~~'Registered environmental health specialist intern' means a person who possesses the necessary educational qualifications as prescribed in ~~G.S. 90A-53(3),~~G.S. 90A-53, but who has not completed the experience and specialized training requirements in the field of public health sanitation as required for registration."

SECTION 3. G.S. 90A-52 reads as rewritten:

"**§ 90A-52. Practice without certificate unlawful.**

(a) In order to safeguard life, health and the environment, it shall be unlawful for any person to practice as ~~a sanitarian~~ an environmental health specialist or an environmental health specialist intern in the State of North Carolina or use the title ~~"registered sanitarian"~~'Registered Environmental Health Specialist' or 'Registered Environmental Health Specialist Intern' unless ~~such~~ the person shall have obtained a certificate of registration from the Board. No person shall offer ~~his~~ services as a registered ~~sanitarian~~ environmental health specialist or registered environmental health specialist intern or use, assume or advertise in any way any title or description tending to convey the impression that ~~he~~ the person is a registered ~~sanitarian~~ environmental health specialist or registered environmental health specialist intern unless ~~he~~ the person is the holder of a current certificate of registration issued by the Board.

(b) Notwithstanding the provisions of subsection (a), a person may practice as a ~~sanitarian intern~~environmental health specialist intern for a period not to exceed three years from the date of the initial registration, provided ~~he~~ the person has obtained a temporary certificate of registration from the Board."

SECTION 4. G.S. 90A-53 reads as rewritten:

"**§ 90A-53. Qualifications and examination for registration as ~~a sanitarian.~~an environmental health specialist or environmental health specialist intern.**

(a) The Board shall issue ~~certificates~~ a certificate to a qualified ~~persons~~ person as a registered ~~sanitarians.~~environmental health specialist or a registered environmental health specialist intern. A certificate as a registered ~~sanitarian~~ environmental health specialist or a registered environmental health specialist intern shall be issued to any person upon the Board's determination that such person:

(1) Has made application to the Board on a form prescribed by the Board;

(2) Is of good moral ~~character;~~and ethical character as attested by an agreement signed by the applicant to adhere to the Code of Ethics adopted by the Board;

(3) Has ~~received~~ graduated from a baccalaureate or postgraduate degree ~~from a post-secondary educational institution rated as acceptable by the Board with a minimum of 30 semester hours or its equivalent in the physical and/or biological sciences;~~program that is:

a. Accredited by the National Environmental Health Science and Protection Accreditation Council (EHAC) and has one or more years of experience in the field of environmental health practice; or

b. Accredited by an accrediting organization recognized by the United States Department of Education, Council for Higher Education Accreditation (CHEA) or received a baccalaureate degree from a postsecondary educational institution rated as acceptable by the Board and:

1. Earned a minimum of 30 semester hours or its equivalent in the physical or biological sciences; and

2. Has two or more years of experience in the field of environmental health practice.

(4) Has satisfactorily completed a course in specialized instruction and training approved by the ~~Board which course shall be designed as to content and so administered as to present sufficient knowledge of the needs properly to be served by public health sanitation, the elements of good environmental health sanitation, the laws and regulations governing sanitation in environmental health and the protection of the public health;~~Board;

~~(5) Has had at least two years' experience in the field of environmental health as defined in this Article. Provided, however, that only one year of experience in the field of environmental health as defined in this Article is required of a sanitarian intern who is a graduate of a bachelor's or master's degree program that is accredited by the National Accreditation Council for Environmental Health Curricula of the National Environmental Health Association;~~

(6) Has passed an examination administered by the Board designed to test for competence in the subject matters of environmental health sanitation. The examination shall be in a form prescribed by the Board and may be oral, written, or both. The examination for applicants shall be held annually or more frequently as the Board may by rule prescribe, at a time and place to be determined by the Board. A person shall not be registered if such person fails to meet the minimum grade requirements for examination specified by the Board. Failure to pass an examination shall not prohibit such person from being examined at subsequent times and places as specified by the Board; and

(7) Has paid a fee set by the Board not to exceed the cost of purchasing the ~~examination.~~examination and an administrative fee not to exceed one hundred fifty dollars ($150.00).

(b) The Board may issue a certificate to a person serving as a registered environmental health specialist intern without the person meeting the full requirements for experience of a registered environmental health specialist for a period not to exceed three years from the date of initial registration as a registered environmental health specialist intern, provided, the person meets the educational requirements in G.S. 90A-53 and is in the field of environmental health practice."

SECTION 5. G.S. 90A-54 is repealed.

SECTION 6. G.S. 90A-55 reads as rewritten:

"**§ 90A-55. State Board of ~~Sanitarian~~ Environmental Health Specialist Examiners; appointment and term of office.**

(a) Board Membership. – The Board shall consist of ~~nine members:~~12 members who shall serve staggered terms: the Secretary of Environment and Natural Resources, or the Secretary's duly authorized representative, one public-spirited citizen, one environmental sanitation educator from an accredited college or university, one local health director, a representative of the Division of Environmental Health of the Department of Environment and Natural Resources, and ~~four~~ seven practicing ~~sanitarians~~ environmental health specialists who qualify by education and experience for registration under this Article, ~~three~~ six of whom ~~will~~ shall represent the Western, Piedmont, and Eastern Regions of the State as described more specifically in the rules adopted by the Board.

(b) Term of Office. – Each member of the State Board of ~~Sanitarian~~ Environmental Health Specialist Examiners shall be appointed by the Governor for a term of four years. As the term of each current member expires, the Governor shall appoint a successor in accordance with the provisions of this section. If a vacancy occurs on the Board for any other reason than

the expiration of a member's term, the Governor shall appoint a successor for the remainder of the unexpired term. No person shall serve as a member of the Board for more than two consecutive four-year terms.

(c) The Environmental Health Section of the North Carolina Public Health Association, Inc., shall submit a recommended list of Board member candidates to the Governor for ~~his~~ the Governor's consideration in ~~appointments.~~appointments, except for the two representatives of the Department of Environment and Natural Resources recommended by the Secretary of Environment and Natural Resources and the local health director recommended by the North Carolina Local Health Directors Association.

(d) The Governor may remove an appointee member for misconduct in office, incompetency, neglect of duty, or other sufficient cause."

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"**§ 90A-56. Compensation of Board members; expenses; employees.**

Members of the Board ~~shall~~ may receive compensation and be reimbursed for travel expenses in accordance with G.S. 93B-5. Notwithstanding G.S. 93B-5(a), the per diem for eligible Board members shall not exceed fifty dollars ($50.00). The Board may employ necessary personnel for the performance of its functions and fix the compensation therefor, within the limits of funds available to the Board. The total expenses of the administration of this Article shall not exceed the total income therefrom and none of the expenses of said Board or the compensation or expenses of any officer thereof or any employee shall ever be paid or payable out of the treasury of the State of North Carolina; and neither the Board nor any officer or employee thereof shall have any power or authority to make or incur any expense, debt, or other financial obligation binding upon the State of North Carolina."

SECTION 8. G.S. 90A-57(a) reads as rewritten:

"(a) The Board shall annually elect a ~~chairman, vice-chairman and a secretary~~chair, vice-chair, and a secretary-treasurer from among its membership. The officers may serve more than one term. The Board shall meet annually in the City of Raleigh, at a time set by the Board, and it may hold additional meetings and conduct business at any place in the State. Five members of the Board shall constitute a quorum to do business. The Board may designate any member to conduct any proceeding, hearing, or investigation necessary to its purpose, but any final action requires a quorum of the Board. The Board is authorized to adopt such rules and ~~regulations~~ regulations, including accreditation and qualifications, as may be necessary for the efficient operation of the Board."

SECTION 9. G.S. 90A-59 reads as rewritten:

"**§ 90A-59. Record of proceedings; register of applications; ~~register~~ registry of registered ~~sanitarians and sanitarian interns.~~environmental health specialists and environmental health specialist interns.**

(a) The Board shall keep a record of its proceedings..

(b) The Board shall maintain ~~a register of all applications~~records for registration, which shall ~~show:~~include:

(1) The place of residence, name and age of each applicant;
(2) The name and address of the employer of each applicant;
(3) The date of application;
(3a) The date of employment;
(4) Complete information of educational and experience qualifications;
(4a) A signed Code of Ethics;
(5) The action taken by the Board;
(6) The serial number of the certificate of registration issued to the applicant;
(7) The date on which the Board reviewed and acted upon the application; ~~and~~
(7a) Information on continuing education required to maintain registration; and
(8) Such other pertinent information as may be deemed necessary by the Board.

(c) The Board shall maintain a current registry of all ~~sanitarians and sanitarian interns~~environmental health specialists and environmental health specialist interns in the State of North Carolina that have been registered in accordance with the provisions of this Article.

(d) ~~These records shall be~~ Records of the Board are public records as defined in Chapter 132 of the General Statutes of North Carolina. However, college transcripts, examinations, and medical information submitted to the Board shall not be considered public records."

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SECTION 11. G.S. 90A-62 reads as rewritten:

"**§ 90A-62. Certification and registration of ~~sanitarians certified~~environmental health specialists registered in other states.**

The Board may, without examination, grant a certificate as a registered ~~sanitarian~~ environmental health specialist to any person who at the time of application, is ~~certified~~ registered as a registered sanitarian by a similar board of another state, district or territory whose standards are determined to be acceptable to the Board ~~but not lower than those required by this Article.~~and comply with rules adopted by the Board. A fee to be determined by the Board and not to exceed ~~thirty-five dollars ($35.00)~~one hundred dollars ($100.00) shall be paid by the applicant to the Board for the issuance of a certificate under the provisions of this section."

SECTION 12. G.S. 90A-63 reads as rewritten:

"**§ 90A-63. Renewal of certificates.**

(a) A certificate as a registered ~~sanitarian or sanitarian intern~~ environmental health specialist or registered environmental health specialist intern issued pursuant to the provisions of this Article will expire on the thirty-first day of December of the current year and must be renewed annually on or before the first day of January. Each application for renewal must be accompanied by a renewal fee to be determined by the Board, but not to exceed ~~thirty-five dollars ($35.00).~~one hundred twenty-five dollars ($125.00). However, for renewals postmarked before January 1 of each year, the renewal fee shall not exceed one hundred dollars ($100.00). The Board is authorized to charge an extra five dollar late renewal fee for renewals made after the first day of January of each year.

(b) Registrations expired for failure to pay renewal fees may be reinstated under the rules and regulations adopted by the Board.

(c) A registered ~~sanitarian~~ environmental health specialist shall complete any continuing education requirements specified by the Board for renewal of a certificate."

SECTION 13. G.S. 90A-64 reads as rewritten:

"**§ 90A-64. Suspensions and revocations of certificates.**

(a) The Board shall have the power to refuse to grant, or may suspend or revoke, any certificate issued under provisions of this Article for any of the causes hereafter enumerated:

(1) Fraud, deceit, or perjury in obtaining registration under the provisions of this ~~Article;~~Article as determined by the Board;

(2) ~~Addiction to narcotics;~~Inability to practice with reasonable skill and safety due to drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material;

(3) ~~Drunkenness on duty;~~Unprofessional conduct, including departure from or failure to conform to the standards of acceptable and prevailing practice or the ethics of the profession;

(4) Defrauding the public or attempting to do so;

(5) Failing to renew certificate as required;

(6) Dishonesty;

(7) Incompetency;

(8) Inexcusable neglect of duty;

(9) ~~Guilty of any unprofessional or dishonorable conduct unworthy of and affecting the practice of his profession.~~Conviction in any court of a crime involving moral turpitude or conviction of a felony;

(10) Failing to adhere to the Code of Ethics; or

(11) Failing to meet qualifications for renewal.

(a1) A registered environmental health specialist or registered environmental health specialist intern who is convicted of a felony or a crime of moral turpitude shall report the conviction to the Board within 30 days from the date of the conviction. A felony conviction shall result in the automatic suspension of a certificate issued by the Board for 60 days until further action is taken by the Board. The Board shall immediately begin the hearing process in accordance with Article 3A of Chapter 150B of the General Statutes. Nothing in this section shall preclude the Board from taking further action.

(b) The procedure to be followed by the Board when refusing to allow an applicant to take an examination, or revoking or suspending a certificate issued under the provisions of this Article, shall be in accordance with the provisions of Chapter 150B of the General Statutes of North Carolina.

(c) The Board may conduct investigations for any complaints alleged under subsection (a) of this section. The Board may subpoena individuals and records to determine if action is necessary to enforce this Article.

(d) The Board and its members, individually, or its staff shall not be held liable for any civil or criminal proceeding when exercising in good faith its powers and duties authorized under the provisions of this Article."

SECTION 14. G.S. 90A-65 reads as rewritten:

"**§ 90A-65. Representing oneself as a registered ~~sanitarian.~~environmental health specialist or registered environmental health specialist intern.**

A holder of a current certificate of registration may append to his or her name the letters, ~~"R.S."~~'R.E.H.S.' or 'R.E.H.S.I.'."

SECTION 15. Article 4 of Chapter 90A is amended by adding a new section to read:

"**§ 90A-67. Code of Ethics.**

The Board shall prepare and adopt, by rule, a Code of Ethics to be made available in writing to all registered environmental health specialists and registered environmental health specialist interns and each applicant for registration under this Article. Publication of the Code of Ethics shall serve as due notice to all certificate holders of its contents."

SECTION 16. Every person registered as an environmental health specialist or environmental health specialist intern on the effective date of this act shall sign a Code of Ethics pursuant to G.S. 90A-67, as enacted in Section 15 of this act. Each registered environmental health specialist or registered environmental health specialist intern shall submit a copy of the signed Code of Ethics with his or her application for registration renewal the following year from the effective date of this act.

SECTION 17. The three registered environmental health specialists to be appointed to the State Board of Environmental Health Specialist Examiners pursuant to G.S. 90A-55, as enacted in Section 6 of this act, shall each be appointed for four-year terms. The members described in this section shall serve for the term for which he or she was appointed and until his or her successor is appointed and qualified.

SECTION 18. This act is effective when it becomes law.

Attachment V

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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SENATE BILL 834
PROPOSED COMMITTEE SUBSTITUTE S834-CSRD-18 [v.1]

4/7/2009 6:27:43 PM

Short Title: Rewrite Sanitarian Examiners Laws/Fees. (Public)

Sponsors:

Referred to:

March 25, 2009

A BILL TO BE ENTITLED

AN ACT REWRITING THE LAWS REGULATING SANITARIANS AND AUTHORIZING THE STATE BOARD OF SANITARIAN EXAMINERS TO INCREASE CERTAIN FEES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The title of Article 4 of Chapter 90A of the General Statutes reads as rewritten:

"Article 4.

Registrations of ~~Sanitarians.~~Environmental Health Specialists."

SECTION 1.(b) G.S. 90A-50 reads as rewritten:

"**§ 90A-50. State Board of ~~Sanitarian~~ Environmental Health Specialist Examiners.**

(a) There is hereby created a State Board of ~~Sanitarian~~ Environmental Health Specialist Examiners to register qualified ~~sanitarians~~ environmental health specialists to practice within the State. Each Registered Sanitarian and Registered Sanitarian Intern on the effective date of the Act shall be a Registered Environmental Health Specialist or a Registered Environmental Health Specialist Intern as applicable on and after the effective date of the Act.

(b) It is the sole purpose of this Article to safeguard the health, safety, and general welfare of the public from adverse environmental factors and to register those environmental health professionals practicing as registered environmental health specialists or registered environmental health specialist interns who are qualified by education, training, and experience to work in the public sector in the field of environmental health within the scope of practice as defined in this Article."

SECTION 2. G.S. 90A-51 reads as rewritten:

"**§ 90A-51. Definitions.**

The words and phrases defined below shall when used in this Article have the following meaning unless the context clearly indicates otherwise:

(1) "Board" means the Board of ~~Sanitarian~~ Environmental Health Specialist Examiners.

(2) "Certificate of registration" ~~is~~ means a document issued by the Board as evidence of registration and qualification to practice as a ~~sanitarian or a sanitarian intern~~registered environmental health specialist or a registered environmental health specialist intern under this Article. The certificate shall bear the designation ~~"registered sanitarian" or "sanitarian intern"~~"Registered Environmental Health Specialist' or 'Registered Environmental Health

Specialist Intern' and show the name of the person, date of issue, serial number, seal, and signatures of the members of the Board.

(2a) 'Environmental health practice' means the provision of environmental health services, including administration, organization, management, education, enforcement, and consultation regarding environmental health services provided to or for the public. These services are offered to prevent environmental hazards and promote and protect the health of the public in the following areas: food, lodging, and institutional sanitation; on-site wastewater treatment and disposal; milk and dairy sanitation; shellfish sanitation; recreational water quality; public swimming pool sanitation; childhood lead poisoning prevention; well permitting and inspection; tattoo parlor sanitation; and all other areas of environmental health requiring the delegation of authority by the Division of Environmental Health to State and local environmental health professionals to enforce rules adopted by the Commission for Public Health or the Environmental Management Commission. The definition also includes local environmental health professionals enforcing rules of local boards of health for on-site wastewater systems and wells.

(2b) 'Environmental health specialist' means a public health professional who meets the educational requirements under this Article and has attained specialized training and acceptable environmental health field experience to effectively plan, organize, manage, provide, execute, and evaluate one or more of the many diverse elements comprising the field of environmental health practice.

~~(3) "Registered sanitarian" is a sanitarian registered in accordance with the provisions of this Article.~~

(4) ~~"Sanitarian" is a public health professional qualified by education in the arts and sciences, specialized training, and acceptable environmental health field experience to effectively plan, organize, manage, execute and evaluate one or more of the many diverse elements comprising the field of environmental health. Practice in the field of environmental health within the meaning of this Article includes, but is not limited to, organization, management, education, enforcement, and consultation for the purpose of prevention of environmental health hazards and the promotion and protection of the public health and the environment in the following areas: food, lodging and institutional sanitation, on-site sewage treatment and disposal, and milk and dairy sanitation.~~

'Registered environmental health specialist' means an environmental health specialist registered in accordance with the provisions of this Article.

For purposes of this Article the following are not included within the definition of ~~"sanitarian"~~ 'registered environmental health specialist' unless the person is working as an environmental health specialist:

a. A person teaching, lecturing, or engaging in research.

b. A person who is a sanitary engineer, public health engineer, public health engineering assistant, registered professional engineer, industrial hygienist, health physicist, chemist, epidemiologist, toxicologist, geologist, hydrogeologist, waste management specialist, or soil ~~scientist, except when the person is working as a sanitarian.~~scientist.

c. A public health officer or public health department director.

d. A person who holds a North Carolina license to practice medicine, veterinary medicine, or nursing.

e. Laboratory personnel when performing or supervising the performance of sanitation related laboratory functions.

~~It is the sole purpose of this Article to safeguard the health, safety, and general welfare of the public from adverse environmental factors and to register those environmental health professionals practicing as sanitarians who are qualified by education, training, and experience to work, or are working, in the public sector in the field of environmental health within the scope of practice as defined in this Article.~~

(5) ~~"Sanitarian intern" is~~'Registered environmental health specialist intern' means a person who possesses the necessary educational qualifications as prescribed in ~~G.S. 90A-53(3),~~G.S. 90A-53, but who has not completed the experience and specialized training requirements in the field of public health sanitation as required for registration."

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SECTION 12. G.S. 90A-63 reads as rewritten:

"**§ 90A-63. Renewal of certificates.**

(a) A certificate as a registered ~~sanitarian or sanitarian intern~~ environmental health specialist or registered environmental health specialist intern issued pursuant to the provisions of this Article will expire on the thirty-first day of December of the current year and must be renewed annually on or before the first day of January. Each application for renewal must be accompanied by a renewal fee to be determined by the Board, but not to exceed ~~thirty-five dollars ($35.00).~~one hundred twenty-five dollars ($125.00). However, for renewals postmarked before January 1 of each year, the renewal fee shall not exceed one hundred dollars ($100.00). ~~The Board is authorized to charge an extra five dollar late renewal fee for renewals made after the first day of January of each year.~~

(b) Registrations expired for failure to pay renewal fees may be reinstated under the rules and regulations adopted by the Board.

(c) A registered ~~sanitarian~~ environmental health specialist shall complete any continuing education requirements specified by the Board for renewal of a certificate."

SECTION 13. G.S. 90A-64 reads as rewritten:

"**§ 90A-64. Suspensions and revocations of certificates.**

(a) The Board shall have the power to refuse to grant, or may suspend or revoke, any certificate issued under provisions of this Article for any of the causes hereafter ~~enumerated:~~enumerated, as determined by the Board:

(1) Fraud, deceit, or perjury in obtaining registration under the provisions of this Article;
(2) ~~Addiction to narcotics;~~Inability to practice with reasonable skill and safety due to drunkenness, excessive use of alcohol, drugs, chemicals, or ~~any other~~ type of material;
(3) ~~Drunkenness on duty;~~Unprofessional conduct, including departure from or failure to conform to the standards of acceptable and prevailing practice or the ethics of the profession;

(4) Defrauding the public or attempting to do so;
(5) Failing to renew certificate as required;
(6) Dishonesty;
(7) Incompetency;
(8) Inexcusable neglect of duty;
(9) ~~Guilty of any unprofessional or dishonorable conduct unworthy of and affecting the practice of his profession.~~Conviction in any court of a crime involving moral turpitude or conviction of a felony;
(10) Failing to adhere to the Code of Ethics; or
(11) Failing to meet qualifications for renewal.

(a1) A registered environmental health specialist or registered environmental health specialist intern who is convicted of a felony or a crime of moral turpitude shall report the conviction to the Board within 30 days from the date of the conviction. A felony conviction shall result in the automatic suspension of a certificate issued by the Board for 60 days until further action is taken by the Board. The Board shall immediately begin the hearing process in accordance with Article 3A of Chapter 150B of the General Statutes. Nothing in this section shall preclude the Board from taking further action.

(b) The procedure to be followed by the Board when refusing to allow an applicant to take an examination, or revoking or suspending a certificate issued under the provisions of this Article, shall be in accordance with the provisions of Chapter 150B of the General Statutes of North Carolina.

(c) The Board may conduct investigations for any complaints alleged or upon its own motion for any allegations or causes for disciplinary action under subsection (a) of this section. The Board may subpoena individuals and records to determine if action is necessary to enforce this Article.

(d) The Board and its members, individually, or its staff shall not be held liable for any civil or criminal proceeding when exercising in good faith its powers and duties authorized under the provisions of this Article."

SECTION 14. G.S. 90A-65 reads as rewritten:

"**§ 90A-65. Representing oneself as a registered ~~sanitarian.~~environmental health specialist or registered environmental health specialist intern.**

A holder of a current certificate of registration may append to his or her name the letters, ~~"R.S."~~"R.E.H.S.' or 'R.E.H.S.I.'."

SECTION 15. Article 4 of Chapter 90A is amended by adding a new section to read:

"**§ 90A-67. Code of Ethics.**

The Board shall prepare and adopt, by rule, a Code of Ethics to be made available in writing to all registered environmental health specialists and registered environmental health specialist interns and each applicant for registration under this Article. All registered environmental health specialist and registered environmental health specialist interns shall adhere to the Code of Ethics adopted by the Board. Publication of the Code of Ethics shall serve as due notice to all certificate holders of its contents."

SECTION 16. Every person registered as an environmental health specialist or environmental health specialist intern on the effective date of this act shall sign a Code of Ethics pursuant to G.S. 90A-67, as enacted in Section 15 of this act. Each registered environmental health specialist or registered environmental health specialist intern shall submit a copy of the signed Code of Ethics with his or her application for registration renewal the following year from the effective date of this act.

SECTION 17. The three registered environmental health specialists to be appointed to the State Board of Environmental Health Specialist Examiners pursuant to G.S. 90A-55, as enacted in Section 6 of this act, shall each be appointed for four-year terms.

The members described in this section shall serve for the term for which he or she was appointed and until his or her successor is appointed and qualified.

SECTION 18. This act is effective when it becomes law.

Attachment VI

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 834

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

S834-ARD-15 [v.1]

Comm. Sub. [YES]
Amends Title [NO]
First Edition

Date _____,2009

Senator Bingham

moves to amend the bill on page 3, lines 47-49, by rewriting the lines to read:

" a. Accredited by the National Environmental Health Science and Protection Accreditation Council (EHAC) and:

1. has one or more years of experience in the field of environmental health practice; or".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

Attachment VII

NORTH CAROLINA GENERAL ASSEMBLY AMENDMENT

(Please type or use ballpoint pen)

EDITION No. _____

H. B. No. _____ DATE 4/8/09

S. B. No. 834 Amendment No. _____ (to be filled in by Principal Clerk)

COMMITTEE SUBSTITUTE X

Rep.)
Sen) Brunstetter

moves to amend the bill on page 6, lines 47-48

( ) WHICH CHANGES THE TITLE

by rewriting the LINES to read:

"due to drunkeness, excessive use of alcohol, drugs or chemicals.";

and on page 6, line 49 by inserting between the terms "including" and 'departure' the terms ~~[illegible]~~ 'a material'.

SIGNED _____

ADOPTED ✓ FAILED _____ TABLED _____

PRINCIPAL CLERK'S OFFICE (FOR ENGROSSMENT)

Attachment V

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 834
PROPOSED COMMITTEE SUBSTITUTE S834-PCS55332-RD-18

Short Title: Rewrite Sanitarian Examiners Laws/Fees. (Public)

Sponsors:

Referred to:

March 25, 2009

A BILL TO BE ENTITLED

AN ACT REWRITING THE LAWS REGULATING SANITARIANS AND AUTHORIZING THE STATE BOARD OF SANITARIAN EXAMINERS TO INCREASE CERTAIN FEES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The title of Article 4 of Chapter 90A of the General Statutes reads as rewritten:

"Article 4.

Registrations of ~~Sanitarians.~~Environmental Health Specialists."

SECTION 1.(b) G.S. 90A-50 reads as rewritten:

"**§ 90A-50. State Board of ~~Sanitarian~~ Environmental Health Specialist Examiners.**

(a) There is hereby created a State Board of ~~Sanitarian~~ Environmental Health Specialist Examiners to register qualified ~~sanitarians~~ environmental health specialists to practice within the State. Each registered sanitarian and registered sanitarian intern on the effective date of this act shall be a registered environmental health specialist or a registered environmental health specialist intern as applicable on and after the effective date of this act.

(b) It is the sole purpose of this Article to safeguard the health, safety, and general welfare of the public from adverse environmental factors and to register those environmental health professionals practicing as registered environmental health specialists or registered environmental health specialist interns who are qualified by education, training, and experience to work in the public sector in the field of environmental health within the scope of practice as defined in this Article."

SECTION 2. G.S. 90A-51 reads as rewritten:

"**§ 90A-51. Definitions.**

The words and phrases defined below shall when used in this Article have the following meaning unless the context clearly indicates otherwise:

(1) "Board" means the Board of ~~Sanitarian~~ Environmental Health Specialist Examiners.

(2) "Certificate of registration" ~~is~~ means a document issued by the Board as evidence of registration and qualification to practice as a ~~sanitarian or a sanitarian intern~~registered environmental health specialist or a registered environmental health specialist intern under this Article. The certificate shall bear the designation ~~"registered sanitarian" or "sanitarian intern"~~'Registered Environmental Health Specialist' or 'Registered Environmental Health

Specialist Intern' and show the name of the person, date of issue, serial number, seal, and signatures of the members of the Board.

(2a) 'Environmental health practice' means the provision of environmental health services, including administration, organization, management, education, enforcement, and consultation regarding environmental health services provided to or for the public. These services are offered to prevent environmental hazards and promote and protect the health of the public in the following areas: food, lodging, and institutional sanitation; on-site wastewater treatment and disposal; milk and dairy sanitation; shellfish sanitation; recreational water quality; public swimming pool sanitation; childhood lead poisoning prevention; well permitting and inspection; tattoo parlor sanitation; and all other areas of environmental health requiring the delegation of authority by the Division of Environmental Health to State and local environmental health professionals to enforce rules adopted by the Commission for Public Health or the Environmental Management Commission. The definition also includes local environmental health professionals enforcing rules of local boards of health for on-site wastewater systems and wells.

(2b) 'Environmental health specialist' means a public health professional who meets the educational requirements under this Article and has attained specialized training and acceptable environmental health field experience to effectively plan, organize, manage, provide, execute, and evaluate one or more of the many diverse elements comprising the field of environmental health practice.

~~(3) "Registered sanitarian" is a sanitarian registered in accordance with the provisions of this Article.~~

(4) ~~"Sanitarian" is a public health professional qualified by education in the arts and sciences, specialized training, and acceptable environmental health field experience to effectively plan, organize, manage, execute and evaluate one or more of the many diverse elements comprising the field of environmental health. Practice in the field of environmental health within the meaning of this Article includes, but is not limited to, organization, management, education, enforcement, and consultation for the purpose of prevention of environmental health hazards and the promotion and protection of the public health and the environment in the following areas: food, lodging and institutional sanitation, on-site sewage treatment and disposal, and milk and dairy sanitation.~~

'Registered environmental health specialist' means an environmental health specialist registered in accordance with the provisions of this Article.

For purposes of this Article the following are not included within the definition of ~~"sanitarian".~~'registered environmental health specialist' unless the person is working as an environmental health specialist:

a. A person teaching, lecturing, or engaging in research.

b. A person who is a sanitary engineer, public health engineer, public health engineering assistant, registered professional engineer, industrial hygienist, health physicist, chemist, epidemiologist, toxicologist, geologist, hydrogeologist, waste management specialist, or soil ~~scientist, except when the person is working as a sanitarian.~~scientist.

c. A public health officer or public health department director.

d. A person who holds a North Carolina license to practice medicine, veterinary medicine, or nursing.

e. Laboratory personnel when performing or supervising the performance of sanitation related laboratory functions.

~~It is the sole purpose of this Article to safeguard the health, safety, and general welfare of the public from adverse environmental factors and to register those environmental health professionals practicing as sanitarians who are qualified by education, training, and experience to work, or are working, in the public sector in the field of environmental health within the scope of practice as defined in this Article.~~

(5) ~~"Sanitarian intern" is~~'Registered environmental health specialist intern' means a person who possesses the necessary educational qualifications as prescribed in ~~G.S. 90A-53(3),~~G.S. 90A-53, but who has not completed the experience and specialized training requirements in the field of public health sanitation as required for registration."

SECTION 3. G.S. 90A-52 reads as rewritten:

"**§ 90A-52. Practice without certificate unlawful.**

(a) In order to safeguard life, health and the environment, it shall be unlawful for any person to practice as ~~a sanitarian~~ an environmental health specialist or an environmental health specialist intern in the State of North Carolina or use the title ~~"registered sanitarian"~~'registered environmental health specialist' or 'registered environmental health specialist intern' unless ~~such~~ the person shall have obtained a certificate of registration from the Board. No person shall offer ~~his~~ services as a registered ~~sanitarian~~ environmental health specialist or registered environmental health specialist intern or use, assume or advertise in any way any title or description tending to convey the impression that ~~he~~ the person is a registered ~~sanitarian~~ environmental health specialist or registered environmental health specialist intern unless ~~he~~ the person is the holder of a current certificate of registration issued by the Board.

(b) Notwithstanding the provisions of subsection (a), a person may practice as ~~a~~ an ~~sanitarian intern~~environmental health specialist intern for a period not to exceed three years from the date of the initial registration, provided ~~he~~ the person has obtained a temporary certificate of registration from the Board."

SECTION 4. G.S. 90A-53 reads as rewritten:

"**§ 90A-53. Qualifications and examination for registration as ~~a sanitarian.~~an environmental health specialist or environmental health specialist intern.**

(a) The Board shall issue ~~certificates~~ a certificate to a qualified ~~persons~~ person as a registered ~~sanitarians.~~environmental health specialist or a registered environmental health specialist intern. A certificate as a registered ~~sanitarian~~ environmental health specialist or a registered environmental health specialist intern shall be issued to any person upon the Board's determination that such person:

(1) Has made application to the Board on a form prescribed by the Board;

(2) Is of good moral ~~character;~~and ethical character and has signed an agreement to adhere to the Code of Ethics adopted by the Board;

(3) Has ~~received~~ graduated from a baccalaureate or postgraduate degree ~~from a post-secondary educational institution rated as acceptable by the Board with a minimum of 30 semester hours or its equivalent in the physical and/or biological sciences;~~program that is:

a. Accredited by the National Environmental Health Science and Protection Accreditation Council (EHAC) and:

1. Has one or more years of experience in the field of environmental health practice; or

b. Accredited by an accrediting organization recognized by the United States Department of Education, Council for Higher Education Accreditation (CHEA) or received a baccalaureate degree from a postsecondary educational institution rated as acceptable by the Board and:

1. Earned a minimum of 30 semester hours or its equivalent in the physical or biological sciences; and
2. Has two or more years of experience in the field of environmental health practice.

(4) Has satisfactorily completed a course in specialized instruction and training approved by the ~~Board which course shall be designed as to content and so administered as to present sufficient knowledge of the needs properly to be served by public health sanitation, the elements of good environmental health sanitation, the laws and regulations governing sanitation in environmental health and the protection of the public health;~~Board in the practice of environmental health;

~~(5) Has had at least two years' experience in the field of environmental health as defined in this Article. Provided, however, that only one year of experience in the field of environmental health as defined in this Article is required of a sanitarian intern who is a graduate of a bachelor's or master's degree program that is accredited by the National Accreditation Council for Environmental Health Curricula of the National Environmental Health Association;~~

(6) Has passed an examination administered by the Board designed to test for competence in the subject matters of environmental health sanitation. The examination shall be in a form prescribed by the Board and may be oral, written, or both. The examination for applicants shall be held annually or more frequently as the Board may by rule prescribe, at a time and place to be determined by the Board. A person shall not be registered if such person fails to meet the minimum grade requirements for examination specified by the Board. Failure to pass an examination shall not prohibit such person from being examined at subsequent times and places as specified by the Board; and

(7) Has paid a fee set by the Board not to exceed the cost of purchasing the ~~examination.~~examination and an administrative fee not to exceed one hundred fifty dollars ($150.00).

(b) The Board may issue a certificate to a person serving as a registered environmental health specialist intern without the person meeting the full requirements for experience of a registered environmental health specialist for a period not to exceed three years from the date of initial registration as a registered environmental health specialist intern, provided, the person meets the educational requirements in G.S. 90A-53 and is in the field of environmental health practice."

SECTION 5. G.S. 90A-54 is repealed.

SECTION 6. G.S. 90A-55 reads as rewritten:

"**§ 90A-55. State Board of ~~Sanitarian~~ Environmental Health Specialist Examiners; appointment and term of office.**

(a) Board Membership. – The Board shall consist of ~~nine members:~~12 members who shall serve staggered terms: the Secretary of Environment and Natural Resources, or the Secretary's duly authorized representative, one public-spirited citizen, one environmental sanitation educator from an accredited college or university, one local health director, a representative of the Division of Environmental Health of the Department of Environment and

Natural Resources, and ~~four~~ seven practicing ~~sanitarians~~ environmental health specialists who qualify by education and experience for registration under this Article, ~~three~~ six of whom ~~will~~ shall represent the Western, Piedmont, and Eastern Regions of the State as described more specifically in the rules adopted by the Board.

(b) Term of Office. – Each member of the State Board of ~~Sanitarian~~ Environmental Health Specialist Examiners shall be appointed by the Governor for a term of four years. As the term of each current member expires, the Governor shall appoint a successor in accordance with the provisions of this section. If a vacancy occurs on the Board for any other reason than the expiration of a member's term, the Governor shall appoint a successor for the remainder of the unexpired term. No person shall serve as a member of the Board for more than two consecutive four-year terms.

(c) The Environmental Health Section of the North Carolina Public Health Association, Inc., shall submit a recommended list of Board member candidates to the Governor for ~~his~~ the Governor's consideration in ~~appointments.~~ appointments, except for the two representatives of the Department of Environment and Natural Resources recommended by the Secretary of Environment and Natural Resources and the local health director recommended by the North Carolina Local Health Directors Association.

(d) The Governor may remove an appointee member for misconduct in office, incompetency, neglect of duty, or other sufficient cause."

SECTION 7. G.S. 90A-56 reads as rewritten:

"§ 90A-56. Compensation of Board members; expenses; employees.

Members of the Board ~~shall~~ may receive compensation and be reimbursed for travel expenses in accordance with G.S. 93B-5. Notwithstanding G.S. 93B-5(a), the per diem for eligible Board members shall not exceed fifty dollars ($50.00). The Board may employ necessary personnel for the performance of its functions and fix the compensation therefor, within the limits of funds available to the Board. The total expenses of the administration of this Article shall not exceed the total income therefrom and none of the expenses of said Board or the compensation or expenses of any officer thereof or any employee shall ever be paid or payable out of the treasury of the State of North Carolina; and neither the Board nor any officer or employee thereof shall have any power or authority to make or incur any expense, debt, or other financial obligation binding upon the State of North Carolina."

SECTION 8. G.S. 90A-57(a) reads as rewritten:

"(a) The Board shall annually elect a ~~chairman, vice-chairman and a secretary~~chair, vice-chair, and a secretary-treasurer from among its membership. The officers may serve more than one term. The Board shall meet annually in the City of Raleigh, at a time set by the Board, and it may hold additional meetings and conduct business at any place in the State. ~~Five~~ Seven members of the Board shall constitute a quorum to do business. The Board may designate any member to conduct any proceeding, hearing, or investigation necessary to its purpose, but any final action requires a quorum of the Board. The Board is authorized to adopt such rules and regulations as may be necessary for the efficient operation of the Board."

SECTION 9. G.S. 90A-59 reads as rewritten:

"§ 90A-59. Record of proceedings; register of applications; ~~register~~ registry of registered ~~sanitarians and sanitarian interns.~~ environmental health specialists and environmental health specialist interns.

(a) The Board shall keep a record of its proceedings.

(b) The Board shall maintain ~~a register of all applications~~ records for registration, which shall ~~show:~~ include:

(1) The place of residence, name and age of each applicant;

(2) The name and address of the employer of each applicant;

(3) The date of application;

(3a) The date of employment;

(4) Complete information of educational and experience qualifications;
(4a) A signed Code of Ethics;
(5) The action taken by the Board;
(6) The serial number of the certificate of registration issued to the applicant;
(7) The date on which the Board reviewed and acted upon the application; ~~and~~
(7a) Information on continuing education required to maintain registration; and
(8) Such other pertinent information as may be deemed necessary by the Board.

(c) The Board shall maintain a current registry of all ~~sanitarians and sanitarian interns~~environmental health specialists and environmental health specialist interns in the State of North Carolina that have been registered in accordance with the provisions of this Article.

(d) ~~These records shall be~~ Records of the Board are public records as defined in Chapter 132 of the General Statutes of North Carolina. However, college transcripts, examinations, and medical information submitted to the Board shall not be considered public records."

SECTION 10. G.S. 90A-60 and G.S. 90A-61 are repealed.

SECTION 11. G.S. 90A-62 reads as rewritten:

"**§ 90A-62. Certification and registration of ~~sanitarians certified~~environmental health specialists registered in other states.**

The Board may, without examination, grant a certificate as a registered ~~sanitarian~~ environmental health specialist to any person who at the time of application, is ~~certified~~ registered as a registered sanitarian by a similar board of another state, district or territory whose standards are determined to be acceptable to the Board ~~but not lower than those required by this Article.~~and comply with rules adopted by the Board. A fee to be determined by the Board and not to exceed ~~thirty-five dollars ($35.00)~~one hundred dollars ($100.00) shall be paid by the applicant to the Board for the issuance of a certificate under the provisions of this section."

SECTION 12. G.S. 90A-63 reads as rewritten:

"**§ 90A-63. Renewal of certificates.**

(a) A certificate as a registered ~~sanitarian or sanitarian intern~~ environmental health specialist or registered environmental health specialist intern issued pursuant to the provisions of this Article will expire on the thirty-first day of December of the current year and must be renewed annually on or before the first day of January. Each application for renewal must be accompanied by a renewal fee to be determined by the Board, but not to exceed ~~thirty-five dollars ($35.00).~~one hundred twenty-five dollars ($125.00). However, for renewals postmarked before January 1 of each year, the renewal fee shall not exceed one hundred dollars ($100.00). ~~The Board is authorized to charge an extra five dollar late renewal fee for renewals made after the first day of January of each year.~~

(b) Registrations expired for failure to pay renewal fees may be reinstated under the rules and regulations adopted by the Board.

(c) A registered ~~sanitarian~~ environmental health specialist shall complete any continuing education requirements specified by the Board for renewal of a certificate."

SECTION 13. G.S. 90A-64 reads as rewritten:

"**§ 90A-64. Suspensions and revocations of certificates.**

(a) The Board shall have the power to refuse to grant, or may suspend or revoke, any certificate issued under provisions of this Article for any of the causes hereafter ~~enumerated:~~enumerated, as determined by the Board:

(1) Fraud, deceit, or perjury in obtaining registration under the provisions of this Article;
(2) ~~Addiction to narcotics;~~Inability to practice with reasonable skill and safety due to drunkenness, excessive use of alcohol, drugs, or chemicals;

(3) ~~Drunkenness on duty;~~Unprofessional conduct, including a material departure from or failure to conform to the standards of acceptable and prevailing practice or the ethics of the profession;
(4) Defrauding the public or attempting to do so;
(5) Failing to renew certificate as required;
(6) Dishonesty;
(7) Incompetency;
(8) Inexcusable neglect of duty;
(9) ~~Guilty of any unprofessional or dishonorable conduct unworthy of and affecting the practice of his profession.~~Conviction in any court of a crime involving moral turpitude or conviction of a felony;
(10) Failing to adhere to the Code of Ethics; or
(11) Failing to meet qualifications for renewal.

(a1) A registered environmental health specialist or registered environmental health specialist intern who is convicted of a felony or a crime of moral turpitude shall report the conviction to the Board within 30 days from the date of the conviction. A felony conviction shall result in the automatic suspension of a certificate issued by the Board for 60 days until further action is taken by the Board. The Board shall immediately begin the hearing process in accordance with Article 3A of Chapter 150B of the General Statutes. Nothing in this section shall preclude the Board from taking further action.

(b) The procedure to be followed by the Board when refusing to allow an applicant to take an examination, or revoking or suspending a certificate issued under the provisions of this Article, shall be in accordance with the provisions of Chapter 150B of the General Statutes of North Carolina.

(c) The Board may conduct investigations for any complaints alleged or upon its own motion for any allegations or causes for disciplinary action under subsection (a) of this section. The Board may subpoena individuals and records to determine if action is necessary to enforce this Article.

(d) The Board and its members, individually, or its staff shall not be held liable for any civil or criminal proceeding when exercising in good faith its powers and duties authorized under the provisions of this Article."

SECTION 14. G.S. 90A-65 reads as rewritten:

"**§ 90A-65. Representing oneself as a registered ~~sanitarian.~~environmental health specialist or registered environmental health specialist intern.**

A holder of a current certificate of registration may append to his or her name the letters, ~~"R.S."~~'R.E.H.S.' or 'R.E.H.S.I.'."

SECTION 15. Article 4 of Chapter 90A of the General Statutes is amended by adding a new section to read:

"**§ 90A-67. Code of Ethics.**

The Board shall prepare and adopt, by rule, a Code of Ethics to be made available in writing to all registered environmental health specialists and registered environmental health specialist interns and each applicant for registration under this Article. All registered environmental health specialists and registered environmental health specialist interns shall adhere to the Code of Ethics adopted by the Board. Publication of the Code of Ethics shall serve as due notice to all certificate holders of its contents."

SECTION 16. Every person registered as an environmental health specialist or environmental health specialist intern on the effective date of this act shall sign a Code of Ethics pursuant to G.S. 90A-67, as enacted by Section 15 of this act. Each registered environmental health specialist or registered environmental health specialist intern shall submit a copy of the signed Code of Ethics with his or her application for registration renewal the following year from the effective date of this act.

SECTION 17. The three registered environmental health specialists to be appointed to the State Board of Environmental Health Specialist Examiners pursuant to G.S. 90A-55, as enacted by Section 6 of this act, shall each be appointed for four-year terms. The members described in this section shall serve for the term for which the members were appointed and until the members' successors are appointed and qualified.

SECTION 18. This act is effective when it becomes law.

Attachment VII

SENATE BILL 834:
Rewrite Sanitarian Examiners Laws/Fees

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	April 7, 2009
Introduced by:	Sen. Bingham	**Prepared by:**	Ben Popkin
Analysis of:	PCS to First Edition S834-CSRD-18		Committee Counsel

SUMMARY: ***Senate Bill 834 would amend Article 4 (Registrations of Sanitarians) of Chapter 90A of the General Statutes to rename sanitarians as environmental health specialists, add relevant new definitions to the Article, revise training requirements, limit per diem, add or raise certain fees, add and require adherence to a code of ethics, add three members to the State Board of Sanitarian Examiners, amend and add grounds for suspension or revocation of certificates, and require Board notification of and suspension of certification for certain criminal convictions.***

CURRENT LAW: Article 4 of Chapter 90A of the General Statutes sets forth provisions governing the certification and practice of sanitarians in the State.

BILL ANALYSIS: Senate Bill 834 would amend Article 4 as follows:

- Amending the title of the article to reflect the new title of Environmental Health Specialists and making conforming changes throughout the article.
- Adding a purpose section to the article.
- Adding definitions for 'environmental health practice', 'environmental health specialist', 'registered environmental health specialist', and 'registered environmental health specialist intern', and makes conforming changes to reflect these new titles throughout the article.
- Amending the qualifications and examination for registration as a sanitarian (now includes 'registered environmental health specialist', and 'registered environmental health specialist intern') to add the following:
    - Require signed agreement to adhere to code of ethics
    - Revise existing training provision to require graduation from accredited baccalaureate or postgraduate degree programs plus either one year of experience in the field (EHAC accredited) or two years and 30 semester hours of physical or biological science credit (CHEA accredited). Current law requires two year's experience, one year for sanitarian intern who is a graduate of an accredited degree program.
    - Authorize an administrative examination fee up to $150 (was up to cost of examination).
    - Authorize Board to issue a certificate to a registered environmental health specialist intern working in the field who does not meet the experience requirement, for a period of up to three years from initial registration, provided the intern satisfies the educational requirement.
- Adding three members to the Board, to now total 12, specifying that seven members are practicing environmental health specialists, six of whom will represent the Western, Piedmont, and Eastern regions of the State, that members' terms are to be staggered, and that two members be representatives of DENR recommended by the Secretary of Environment and Natural

Resources and one be a local health director recommended by the NC Local Health Directors Association.

- Make compensation for travel expenses permissive and limit per diem to no more than $50.00.
- Revise Board officer terminology.
- Adding date of employment, a signed code of ethics, and information on required continuing education, to the list of items included in the records for registration maintained by the Board.
- Specifying that college transcripts, examinations, and medical information submitted to the Board are not public record.
- Repealing G.S. 90A-60 (Rating of educational institutions) and G.S. 90A-61 (temporary provisions dating from 1982 regarding certification and registration of sanitarians).
- Allowing for Board certification of environmental health specialists registered in another state if the state's standards are determined to be acceptable to the Board and comply with Board rules, and raising the ceiling on the fee to be paid with this type of application from $35.00 to $100.00.
- Raising the ceiling on renewal fees from $35.00 to $125.00 or $100.00 (if paid before January 1).
- Revising the grounds for Board suspension or revocation of certification, to include: inability to practice due to substance abuse, unprofessional conduct, conviction of a felony or a crime involving moral turpitude, failing to adhere to the code of ethics, and failing to meet qualifications for renewal.
- Adding new provisions directing registered environmental health specialist and registered environmental health specialist interns to report conviction of a felony or a crime involving moral turpitude within 30 days of the conviction, directing the Board to suspend the person's certificate for 60 days, and directing the Board to immediately begin a hearing process.
- Authorizing the Board to conduct investigations into complaints of grounds that could lead to suspension or revocation of a certificate and authorizing the Board to subpoena persons and records, and protecting the Board and its staff from liability when exercising its powers and duties in good faith.
- Directing the Board to prepare and adopt a Code of Ethics, and requiring that registered environmental health specialist and registered environmental health specialist interns submit a signed copy of the code of ethics with their application for registration renewal.
- Providing that the three new Board members be appointed for four-year terms and will serve until their successors are appointed and qualified.

EFFECTIVE DATE: This act is effective when it becomes law.

S834-SMRD-39(CSRD-18) v1

Attachment V III

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 674

Short Title:	Amend Rabies Laws.	(Public)
Sponsors:	Senator Purcell.	
Referred to:	Health Care.	

March 19, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND THE RABIES LAWS TO CONFORM WITH RECOMMENDATIONS FROM THE CENTERS FOR DISEASE CONTROL AND THE NATIONAL ASSOCIATION OF STATE PUBLIC HEALTH VETERINARIANS AND TO ALLOW STRAY OR FERAL ANIMALS TO BE IMMEDIATELY EUTHANIZED AND TESTED FOR RABIES AFTER BITING A HUMAN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-184 reads as rewritten:

"Part 6. Rabies.

"§ 130A-184. Definitions.

The following definitions shall apply throughout this Part:

(1) 'Animal Control Officer' means a city or county employee designated as dog warden, animal control officer, animal control official or other designations that may be used whose responsibility includes animal control.

(2) 'Cat' means a domestic feline.

(3) 'Certified rabies vaccinator' means a person appointed and certified to administer rabies vaccine to animals in accordance with this Part.

(4) 'Dog' means a domestic canine.

(4a) 'Feral' means any dog, cat, or ferret that is born in the wild and is not socialized; is the offspring of a dog, cat, or ferret that is owned or born in the wild and is not socialized; or is a formerly owned dog, cat, or ferret that has been abandoned and is no longer socialized.

(4b) 'Ferret' means a domestic mammal of the type mustela putorius furo.

(5) 'Rabies vaccine' means an animal rabies vaccine licensed by the United States Department of Agriculture and approved for use in this State by the Commission.

(6) 'State Public Health Veterinarian' means a person appointed by the Secretary to direct the State public health veterinary program.

(6a) 'Stray' means any dog, cat, or ferret that is (i) beyond the limits of confinement or lost and (ii) not wearing any tags, microchips, tattoos, or other methods of identification.

(7) 'Vaccination' means the administration of rabies vaccine by a licensed veterinarian or by a certified rabies vaccinator."

SECTION 2. G.S. 130A-185(a) reads as rewritten:

"§ 130A-185. Vaccination of all ~~dogs and cats.~~dogs, cats, and ferrets.

(a) The owner of every ~~dog and cat~~ dog, cat, and ferret over four months of age shall have the animal vaccinated against rabies. The time or times of vaccination shall be established

by the Commission. Rabies vaccine shall be administered only by a licensed veterinarian or by a certified rabies vaccinator."

SECTION 3. G.S. 130A-187 reads as rewritten:

"**§ 130A-187. County rabies vaccination clinics.**

The local health director shall organize or assist other county departments to organize at least one countywide rabies vaccination clinic per year for the purpose of vaccinating ~~dogs and cats.~~ dogs, cats, and ferrets. Public notice of the time and place of rabies vaccination clinics shall be published in a newspaper having general circulation within the area."

SECTION 4. G.S. 130A-188 reads as rewritten:

"**§ 130A-188. Fee for vaccination at county rabies vaccination clinics.**

The county board of commissioners is authorized to establish a fee to be charged at the county rabies vaccination clinics. The fee ~~shall~~ may include an administrative charge ~~not to exceed four dollars ($4.00) per vaccination,~~ and a charge for the actual cost of the vaccine, the vaccination certificate, and the rabies vaccination tag."

SECTION 5. G.S. 130A-189 reads as rewritten:

"**§ 130A-189. Rabies vaccination certificates.**

A licensed veterinarian or a certified rabies vaccinator who administers rabies vaccine to a ~~dog or cat~~ dog, cat, or ferret shall complete a three-copy rabies vaccination ~~certificate.~~ certificate that includes, at a minimum, all of the following items:

(1) The owner's name, address, and telephone number.
(2) The animal's species, age, sex, weight, breed, name, and predominant colors or markings.
(3) The animal's rabies tag number.
(4) The animal's microchip number, if any.
(5) The date the animal was vaccinated and the date the next vaccination is due.
(6) The name of the product used to vaccinate the animal, the first three letters of the vaccine manufacturer, and the vaccine serial number or lot number.
(7) The veterinarian's name, address, license number, and signature.

The Secretary may adopt rules requiring that additional items be included on the rabies vaccination certificate.

The original rabies vaccination certificate shall be given to the owner of each dog or cat that receives rabies vaccine. One copy of the rabies vaccination certificate shall be retained by the licensed veterinarian or the certified rabies vaccinator. The other copy shall be given to the county agency responsible for animal control, provided the information given to the county agency shall not be used for commercial purposes."

SECTION 6. G.S. 130A-190 reads as rewritten:

"**§ 130A-190. Rabies vaccination tags.**

(a) Issuance. – A licensed veterinarian or a certified rabies vaccinator who administers rabies vaccine to a ~~dog or cat~~ dog, cat, or ferret shall issue a rabies vaccination tag to the owner of the animal. The rabies vaccination tag shall show the year issued, a vaccination number, the words "North Carolina" or the initials "N.C." and the words "rabies vaccine." ~~Dogs and cats~~Dogs, cats, and ferrets shall wear rabies vaccination tags at all times. However, cats and ferrets may be exempted from wearing the tags by local ordinance.

(b) Fee. – Rabies vaccination tags, links, and rivets may be obtained from the Department. The Secretary is authorized to establish by rule a fee for the rabies tags, links, and rivets in accordance with this subsection. The fee for each tag is the sum of the following:

(1) The actual cost of the rabies tag, links, and rivets.
(2) Transportation costs.
(3) Five cents (5¢). This portion of the fee shall be used to fund rabies education and prevention programs.

(4) Twenty cents (20¢). This portion of the fee shall be credited to the Spay/Neuter Account established in G.S. 19A-62 and used to fund statewide spay/neuter programs. This portion of the fee shall not be imposed for tags provided to persons who operate establishments primarily for the purpose of boarding or training hunting dogs or who own and vaccinate 10 or more dogs per year.

(c) Repealed by Session Laws 2007-487, s. 1, effective January 1, 2008."

SECTION 7. G.S. 130A-192 reads as rewritten:

"**§ 130A-192. ~~Dogs and cats~~ Dogs, cats, and ferrets not wearing required rabies vaccination tags.**

The Animal Control Officer shall canvass the county to determine if there are any ~~dogs or cats~~dogs, cats, or ferrets not wearing the required rabies vaccination tag. If a ~~dog or cat~~dog, cat, or ferret is found not wearing the required tag, the Animal Control Officer shall check to see if the owner's identification can be found on the animal. If the animal is wearing an owner identification tag, or if the Animal Control Officer otherwise knows who the owner is, the Animal Control Officer shall notify the owner in writing to have the animal vaccinated against rabies and to produce the required rabies vaccination certificate to the Animal Control Officer within three days of the notification. If the animal is not wearing an owner identification tag and the Animal Control Officer does not otherwise know who the owner is, the Animal Control Officer may impound the animal. The duration of the impoundment of these animals shall be established by the county board of commissioners, but the duration shall not be less than 72 hours. During the impoundment period, the Animal Control Officer shall make a reasonable effort to locate the owner of the animal. If the animal is not reclaimed by its owner during the impoundment period, the animal shall be disposed of in one of the following manners: returned to the owner; adopted as a pet by a new owner; sold to institutions within this State registered by the United States Department of Agriculture pursuant to the Federal Animal Welfare Act, as amended; or put to death by a procedure approved by the American Veterinary Medical Association, the Humane Society of the United States or of the American Humane Association. The Animal Control Officer shall maintain a record of all animals impounded under this section which shall include the date of impoundment, the length of impoundment, the method of disposal of the animal and the name of the person or institution to whom any animal has been released."

SECTION 8. G.S. 130A-193 reads as rewritten:

"**§ 130A-193. Vaccination and confinement of ~~dogs and cats~~dogs, cats, and ferrets brought into this State.**

(a) A ~~dog or cat~~dog, cat, or ferret brought into this State shall immediately be securely confined and shall be vaccinated against rabies within one week after entry. The animal shall remain confined for two weeks after vaccination.

(b) The provisions of subsection (a) shall not apply to:

(1) A ~~dog or cat~~dog, cat, or ferret brought into this State for exhibition purposes if the animal is confined and not permitted to run at large; or

(2) A ~~dog or cat~~dog, cat, or ferret brought into this State accompanied by a certificate issued by a licensed veterinarian showing that the ~~dog or cat~~dog, cat, or ferret is apparently free from and has not been exposed to rabies and that the ~~dog or cat has received rabies vaccine within the past year.~~dog, cat, or ferret is currently vaccinated against rabies."

SECTION 9. G.S. 130A-194 reads as rewritten:

"**§ 130A-194. Quarantine of districts infected with rabies.**

An area may be declared under quarantine against rabies by the local health director when the disease exists to the extent that the lives of persons are endangered. When quarantine is declared, each ~~dog and cat~~dog, cat, and ferret in the area shall be confined on the premises of

the owner or in a veterinary hospital. However, ~~dogs or cats~~a dog, cat, or ferret on a leash or under the control and in the sight of a responsible adult may be permitted to leave the premises of the owner or the veterinary hospital."

SECTION 10. G.S. 130A-195 reads as rewritten:

"**§ 130A-195. Destroying stray dogs and cats in quarantine districts.**

When quarantine has been declared and ~~dogs and cats~~dogs, cats, and ferrets continue to run uncontrolled in the area, any peace officer or Animal Control Officer shall have the right, after reasonable effort has been made to apprehend the animals, to destroy the uncontrolled ~~dogs and cats~~dogs, cats, and ferrets and properly dispose of their bodies."

SECTION 11. G.S. 130A-196 reads as rewritten:

"**§ 130A-196. Confinement of all biting ~~dogs and cats~~dogs, cats, and ferrets; notice to local health director; reports by physicians; certain dogs exempt.**

When a person has been bitten by a ~~dog or cat~~,dog, cat, or ferret, the person or parent, guardian or person standing in loco parentis of the person, and the person owning the animal or in control or possession of the animal shall notify the local health director immediately and give the name and address of the person bitten and the owner of the animal. A dog, cat, or ferret that bites a person may be immediately euthanized if, in the opinion of the local health director or an Animal Control Officer, the animal is a stray or feral. If the animal is immediately euthanized, the head of the animal shall be immediately sent to the State Laboratory of Public Health for rabies diagnosis. All ~~dogs and cats~~other dogs, cats, and ferrets that bite a person shall be immediately confined for 10 days in a place designated by the local health director. However, the local health director may authorize a dog trained and used by a law enforcement agency to be released from confinement to perform official duties upon submission of proof that the dog has been vaccinated for rabies in compliance with this Part. After reviewing the circumstances of the particular case, the local health director may allow the owner to confine the animal on the owner's property. An owner who fails to confine ~~his~~ an animal in accordance with the instructions of the local health director shall be guilty of a Class 2 misdemeanor. If the owner or the person who controls or possesses a ~~dog or cat~~ dog, cat, or ferret that has bitten a person refuses to confine the animal as required by this section, the local health director may order seizure of the animal and its confinement for 10 days at the expense of the owner. A physician who attends a person bitten by an animal known to be a potential carrier of rabies shall report within 24 hours to the local health director the name, age and sex of that person. A veterinarian who has knowledge of any mammal biting a person shall report to the local health director the name, age, and sex of that person, if known, and the type and whereabouts of the mammal responsible for the bite, if known."

SECTION 12. G.S. 130A-197 reads as rewritten:

"**§ 130A-197. Infected ~~dogs and cats~~dogs, cats, and ferrets to be destroyed; protection of vaccinated ~~dogs and cats.~~dogs, cats, and ferrets.**

When the local health director reasonably suspects that a ~~dog or cat~~dog, cat, or ferret has been exposed to the saliva or nervous tissue of a proven rabid animal or animal reasonably suspected of having rabies that is not available for laboratory diagnosis, the ~~dog or cat~~dog, cat, or ferret shall be considered to have been exposed to rabies. A ~~dog or cat~~dog, cat, or ferret exposed to rabies shall be destroyed immediately by its owner, the county Animal Control Officer or a peace officer unless the ~~dog or cat~~dog, cat, or ferret has been vaccinated against rabies in accordance with this Part and the rules of the Commission more than ~~three weeks~~ twenty-eight days prior to being exposed, and is given a booster dose of rabies vaccine within ~~three~~five days of the exposure. As an alternative to destruction, the ~~dog or cat~~ dog, cat, or ferret may be quarantined at a facility approved by the local health director for a period up to six months, and under reasonable conditions imposed by the local health director."

SECTION 13. G.S. 130A-198 reads as rewritten:

"**§ 130A-198. Confinement.**

A person who owns or has possession of an animal which is suspected of having rabies shall immediately notify the local health director or county Animal Control Officer and shall securely confine the animal in a place designated by the local health director. ~~Dogs and cats~~Dogs, cats, and ferrets shall be confined for a period of 10 days. Other animals may be destroyed at the discretion of the State Public Health Veterinarian."

SECTION 14. G.S. 130A-199 reads as rewritten:

"**§ 130A-199. Rabid animals to be destroyed; heads to be sent to State Laboratory of Public Health.**

An animal diagnosed as having rabies by a licensed veterinarian shall be destroyed and its head sent to the State Laboratory of Public Health. The heads of all ~~dogs and cats~~dogs, cats, and ferrets that die during the 10-day confinement period required by G.S. 130A-196, shall be immediately sent to the State Laboratory of Public Health for rabies diagnosis."

SECTION 15. This act is effective when it becomes law.

Attachment IX

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 674
PROPOSED COMMITTEE SUBSTITUTE S674-CSMG-9 [v.3]

3/27/2009 11:29:55 AM

Short Title: Amend Rabies Laws. (Public)

Sponsors:

Referred to:

March 19, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND THE RABIES LAWS TO CONFORM WITH RECOMMENDATIONS FROM THE CENTERS FOR DISEASE CONTROL AND THE NATIONAL ASSOCIATION OF STATE PUBLIC HEALTH VETERINARIANS AND TO ALLOW STRAY OR FERAL ANIMALS TO BE IMMEDIATELY EUTHANIZED AND TESTED FOR RABIES AFTER BITING A HUMAN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-184 reads as rewritten:

"**§ 130A-184. Definitions.**

The following definitions shall apply throughout this Part:

(1) 'Animal Control Officer' means a city or county employee designated as dog warden, animal control officer, animal control official or other designations that may be used whose responsibility includes animal control.

(2) 'Cat' means a domestic ~~feline.~~ feline of the genus and species Felis catus.

(3) 'Certified rabies vaccinator' means a person appointed and certified to administer rabies vaccine to animals in accordance with this Part.

(4) 'Dog' means a domestic ~~canine.~~ canine of the genus and species Canis lupus familiaris.

(4a) 'Feral' means any dog, cat, or ferret that is born in the wild and is not socialized; is the offspring of a dog, cat, or ferret that is owned or born in the wild and is not socialized; or is a formerly owned dog, cat, or ferret that has been abandoned and is no longer socialized.

(4b) 'Ferret' means a domestic mammal of the genus and species Mustela putorius furo.

(5) 'Rabies vaccine' means an animal rabies vaccine licensed by the United States Department of Agriculture and approved for use in this State by the Commission.

(6) 'State Public Health Veterinarian' means a person appointed by the Secretary to direct the State public health veterinary program.

(6a) 'Stray' means any dog, cat, or ferret that is (i) beyond the limits of confinement or lost and (ii) not wearing any tags, microchips, tattoos, or other methods of identification.

(7) 'Vaccination' means the administration of rabies vaccine by a licensed ~~veterinarian~~ veterinarian, by a registered veterinary technician under the

direct supervision of a licensed veterinarian, or by a certified rabies vaccinator."

SECTION 2. G.S. 130A-185(a) reads as rewritten:

"**§ 130A-185. Vaccination of all ~~dogs and cats.~~dogs, cats, and ferrets.**

(a) The owner of every ~~dog and cat~~ dog, cat, and ferret over four months of age shall have the animal vaccinated against rabies. The time or times of vaccination shall be established by the Commission. Rabies vaccine shall be administered only by a licensed ~~veterinarian~~ veterinarian, by a registered veterinary technician under the direct supervision of a licensed veterinarian, or by a certified rabies vaccinator."

SECTION 3. G.S. 130A-187 reads as rewritten:

"**§ 130A-187. County rabies vaccination clinics.**

The local health director shall organize or assist other county departments to organize at least one countywide rabies vaccination clinic per year for the purpose of vaccinating ~~dogs and cats.~~ dogs, cats, and ferrets. Public notice of the time and place of rabies vaccination clinics shall be published in a newspaper having general circulation within the area."

SECTION 4. G.S. 130A-188 reads as rewritten:

"**§ 130A-188. Fee for vaccination at county rabies vaccination clinics.**

The county board of commissioners is authorized to establish a fee to be charged at the county rabies vaccination clinics. The fee ~~shall~~ may include an administrative charge ~~not to exceed four dollars ($4.00) per vaccination,~~ and a charge for the actual cost of the vaccine, the vaccination certificate, and the rabies vaccination tag."

SECTION 5. G.S. 130A-189 reads as rewritten:

"**§ 130A-189. Rabies vaccination certificates.**

A licensed veterinarian or a certified rabies vaccinator who administers rabies vaccine to a ~~dog or cat~~ dog, cat, or ferret shall complete a ~~three-copy~~ rabies vaccination certificate. The Commission shall adopt rules establishing the specific information required to be included on the certificate. ~~The~~An original rabies vaccination certificate shall be given to the owner of each ~~dog or cat~~ dog, cat, or ferret that receives rabies vaccine. ~~One~~A copy of the rabies vaccination certificate shall be retained by the licensed veterinarian or the certified rabies vaccinator. ~~The other~~ A copy shall also be given to the county agency responsible for animal control, provided the information given to the county agency shall not be used for commercial purposes."

SECTION 6. G.S. 130A-190(a) reads as rewritten:

"(a) Issuance. – A licensed veterinarian or a certified rabies vaccinator who administers rabies vaccine to a ~~dog or cat~~ dog, cat, or ferret shall issue a rabies vaccination tag to the owner of the animal. The rabies vaccination tag shall show the year issued, a vaccination number, the words "North Carolina" or the initials "N.C." and the words "rabies vaccine." ~~Dogs and cats~~Dogs, cats, and ferrets shall wear rabies vaccination tags at all times. However, cats and ferrets may be exempted from wearing the tags by local ordinance."

SECTION 7. G.S. 130A-192 reads as rewritten:

"**§ 130A-192. ~~Dogs and cats~~ Dogs, cats, and ferrets not wearing required rabies vaccination tags.**

The Animal Control Officer shall canvass the county to determine if there are any ~~dogs or cats~~dogs, cats, or ferrets not wearing the required rabies vaccination tag. If a ~~dog or cat~~dog, cat, or ferret is found not wearing the required tag, the Animal Control Officer shall check to see if the owner's identification can be found on the animal. If the animal is wearing an owner identification tag, or if the Animal Control Officer otherwise knows who the owner is, the Animal Control Officer shall notify the owner in writing to have the animal vaccinated against rabies and to produce the required rabies vaccination certificate to the Animal Control Officer within three days of the notification. If the animal is not wearing an owner identification tag and the Animal Control Officer does not otherwise know who the owner is, the Animal Control Officer may impound the animal. The duration of the impoundment of these animals shall be

established by the county board of commissioners, but the duration shall not be less than 72 hours. During the impoundment period, the Animal Control Officer shall make a reasonable effort to locate the owner of the animal. If the animal is not reclaimed by its owner during the impoundment period, the animal shall be disposed of in one of the following manners: returned to the owner; adopted as a pet by a new owner; sold to institutions within this State registered by the United States Department of Agriculture pursuant to the Federal Animal Welfare Act, as amended; or put to death by a procedure approved by the American Veterinary Medical Association, the Humane Society of the United States or of the American Humane Association. The Animal Control Officer shall maintain a record of all animals impounded under this section which shall include the date of impoundment, the length of impoundment, the method of disposal of the animal and the name of the person or institution to whom any animal has been released."

SECTION 8. G.S. 130A-193 reads as rewritten:

"**§ 130A-193. Vaccination and confinement of ~~dogs and cats~~dogs, cats, and ferrets brought into this State.**

(a) A ~~dog or cat~~dog, cat, or ferret brought into this State shall immediately be securely confined and shall be vaccinated against rabies within one week after entry. The animal shall remain confined for two weeks after vaccination.

(b) The provisions of subsection (a) shall not apply to:

(1) A ~~dog or cat~~dog, cat, or ferret brought into this State for exhibition purposes if the animal is confined and not permitted to run at large; or

(2) A ~~dog or cat~~dog, cat, or ferret brought into this State accompanied by a certificate issued by a licensed veterinarian showing that the ~~dog or cat~~dog, cat, or ferret is apparently free from and has not been exposed to rabies and that the ~~dog or cat has received rabies vaccine within the past year.~~dog, cat, or ferret is currently vaccinated against rabies."

SECTION 9. G.S. 130A-194 reads as rewritten:

"**§ 130A-194. Quarantine of districts infected with rabies.**

An area may be declared under quarantine against rabies by the local health director when the disease exists to the extent that the lives of persons are endangered. When quarantine is declared, each ~~dog and cat~~dog, cat, and ferret in the area shall be confined on the premises of the owner or in a veterinary hospital. However, ~~dogs or cats~~a dog, cat, or ferret on a leash or under the control and in the sight of a responsible adult may be permitted to leave the premises of the owner or the veterinary hospital."

SECTION 10. G.S. 130A-195 reads as rewritten:

"**§ 130A-195. Destroying stray dogs and cats in quarantine districts.**

When quarantine has been declared and ~~dogs and cats~~dogs, cats, and ferrets continue to run uncontrolled in the area, any peace officer or Animal Control Officer shall have the right, after reasonable effort has been made to apprehend the animals, to destroy the uncontrolled ~~dogs and cats~~dogs, cats, and ferrets and properly dispose of their bodies."

SECTION 11. G.S. 130A-196 reads as rewritten:

"**§ 130A-196. Confinement of all biting ~~dogs and cats~~dogs, cats, and ferrets; notice to local health director; reports by physicians; certain dogs exempt.**

When a person has been bitten by a ~~dog or cat,~~dog, cat, or ferret, the person or parent, guardian or person standing in loco parentis of the person, and the person owning the animal or in control or possession of the animal shall notify the local health director immediately and give the name and address of the person bitten and the owner of the animal. A dog, cat, or ferret that bites a person may be immediately euthanized if, in the opinion of the local health director or an Animal Control Officer, the animal is a stray or feral. If the animal is immediately euthanized, the head of the animal shall be immediately sent to the State Laboratory of Public Health for rabies diagnosis. All ~~dogs and cats~~other dogs, cats, and ferrets that bite a person

shall be immediately confined for 10 days in a place designated by the local health director. However, the local health director may authorize a dog trained and used by a law enforcement agency to be released from confinement to perform official duties upon submission of proof that the dog has been vaccinated for rabies in compliance with this Part. After reviewing the circumstances of the particular case, the local health director may allow the owner to confine the animal on the owner's property. An owner who fails to confine ~~his~~ an animal in accordance with the instructions of the local health director shall be guilty of a Class 2 misdemeanor. If the owner or the person who controls or possesses a ~~dog or cat~~ dog, cat, or ferret that has bitten a person refuses to confine the animal as required by this section, the local health director may order seizure of the animal and its confinement for 10 days at the expense of the owner. A physician who attends a person bitten by an animal known to be a potential carrier of rabies shall report within 24 hours to the local health director the name, age and sex of that person."

SECTION 12. G.S. 130A-197 reads as rewritten:

"**§ 130A-197. Infected ~~dogs and cats~~dogs, cats, and ferrets to be destroyed; protection of vaccinated ~~dogs and cats.~~dogs, cats, and ferrets.**

When the local health director reasonably suspects that a ~~dog or cat~~dog, cat, or ferret has been exposed to the saliva or nervous tissue of a proven rabid animal or animal reasonably suspected of having rabies that is not available for laboratory diagnosis, the ~~dog or cat~~dog, cat, or ferret shall be considered to have been exposed to rabies. A ~~dog or cat~~dog, cat, or ferret exposed to rabies shall be destroyed immediately by its owner, the county Animal Control Officer or a peace officer unless the ~~dog or cat~~dog, cat, or ferret has been vaccinated against rabies in accordance with this Part and the rules of the Commission more than ~~three weeks~~ twenty-eight days prior to being exposed, and is given a booster dose of rabies vaccine within ~~three~~five days of the exposure. As an alternative to destruction, the ~~dog or cat~~ dog, cat, or ferret may be quarantined at a facility approved by the local health director for a period up to six months, and under reasonable conditions imposed by the local health director."

SECTION 13. G.S. 130A-198 reads as rewritten:

"**§ 130A-198. Confinement.**

A person who owns or has possession of an animal which is suspected of having rabies shall immediately notify the local health director or county Animal Control Officer and shall securely confine the animal in a place designated by the local health director. ~~Dogs and cats~~Dogs, cats, and ferrets shall be confined for a period of 10 days. Other animals may be destroyed at the discretion of the State Public Health Veterinarian."

SECTION 14. G.S. 130A-199 reads as rewritten:

"**§ 130A-199. Rabid animals to be destroyed; heads to be sent to State Laboratory of Public Health.**

An animal diagnosed as having rabies by a licensed veterinarian shall be destroyed and its head sent to the State Laboratory of Public Health. The heads of all ~~dogs and cats~~dogs, cats, and ferrets that die during the 10-day confinement period required by G.S. 130A-196, shall be immediately sent to the State Laboratory of Public Health for rabies diagnosis."

SECTION 15. This act is effective when it becomes law.

Attachment X

SENATE BILL 674: Amend Rabies Laws

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	April 7, 2009
Introduced by:	Sen. Purcell	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	PCS to First Edition S674-CSMG-9		

SUMMARY: ***Senate Bill 674 amends Part 6 (Rabies) of Article 6 (Communicable Diseases) of the Chapter 130A (Public Health law of North Carolina) of the General Statutes to include domestic ferrets to the provisions relating to rabies vaccinations for dogs and cats. The bill authorizes the immediate euthanization of a stray or feral dog, cat, or ferret that has bitten a person.***

The Proposed Committee Substitute clarifies the definition of cat, dog, and ferret; directs the Commission for Public Health to adopt rules establishing what information must be included on a rabies vaccination certificate; and makes conforming changes.

CURRENT LAW:

The owner of every dog and cat over four months of age shall have the animal vaccinated against rabies.[1] Each county shall have at least one rabies vaccination clinic per year for the purpose of vaccinating dogs and cats.[2] The Administer of the rabies vaccine issues a rabies vaccination tag to the owner of the vaccinated animal. Absent a local ordinance to the contrary, the animal shall wear the tag at all times.[3] Animal Control Officers are directed to canvass their county to determine if there are any dogs or cats not wearing the required rabies vaccination tag.

BILL ANALYSIS:

Senate Bill 674 adds the domestic ferret to the animals required to be vaccinated against rabies and makes conforming changes to this effect throughout Part 6 of Article 6 of Chapter 130A. *Current law applies only to dogs and cats.*

The bill authorizes registered veterinary technicians under the direct supervision of a licensed veterinarian to administer a rabies vaccine.

The bill authorizes county board of commissioners to establish an administrative fee to be charged at the county's rabies vaccination clinic. *Current law caps the administrative fee at $4.00*

The bill provides a dog, cat, or ferret that bites a person may be immediately euthanized, if the local health director or Animal Control Officer determines the animal is feral or a stray. The bill provides a definition for "Feral" and "Stray" to be applied throughout Part 6 of Article 6 of Chapter 130A.

EFFECTIVE DATE: This act is effective when it becomes law.

S674-SMSQ-29(CSMG-9) v1

[1] G.S. 130A-185
[2] G.S. 130A-187
[3] G.S. 130A-190

Attachment X1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 1042*

Short Title:	Tech. & Org. Changes/Certain DHHS Facilities.	(Public)
Sponsors:	Senator Nesbitt.	
Referred to:	Health Care.	

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND ORGANIZATIONAL CHANGES TO THE LAW REGARDING THE LICENSURE AND INSPECTION OF FACILITIES FOR AGED AND DISABLED INDIVIDUALS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 131D of the General Statutes is amended by adding the following new Article to read:

"Article 1B.
"Licensing of Maternity Homes."

SECTION 1.(b) G.S. 131D-1 is recodified as G.S. 131D-10.10 under Article 1B of Chapter 131D of the General Statutes.

SECTION 1.(c) The title of Article 1 of Chapter 131D reads as rewritten:

"Article 1.
~~Licensing of Facilities.~~
Adult Care Homes."

SECTION 1.(d) G.S. 131D-2 is repealed.

SECTION 1.(e) Article 1 of Chapter 131D of the General Statutes, as amended by Section 1(c) of this act, is amended by adding the following new Parts to read:

"Part 1. Licensing.

"**§ 131D-2.1. Definitions.**

As used in this Article:

(1) "Abuse." – The willful or grossly negligent infliction of physical pain, injury, or mental anguish, unreasonable confinement, or the willful or grossly negligent deprivation by the administrator or staff of an adult care home of services which are necessary to maintain mental and physical health.

(2) "Administrator." – A person approved by the Department of Health and Human Services who has the responsibility for the total operation of a licensed domiciliary home.

(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. 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.

(4) "Amenities." – Services such as meals, housekeeping, transportation, and grocery shopping that do not involve hands-on personal care.

(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. 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. Housing programs for two or more unrelated adults that target their services to elderly or disabled persons in which the only services provided by the housing management, either directly or through an agreement or other arrangements, are amenities that include, at a minimum, one meal a day and housekeeping services, are exempt from licensure, but are required to be listed with the Division of Aging and Adult Services, providing information on their location and number of units operated. This type of housing is not considered assisted living. 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.

(6) "Compensatory agent." – A spouse, relative, or other caretaker who lives with a resident and provides care to a resident.

(7) "Department." – The Department of Health and Human Services unless some other meaning is clearly indicated from the context.

(8) "Exploitation." – The illegal or improper use of an aged or disabled resident or the aged or disabled resident's resources for another's profit or advantage.

(9) "Family care home." – An adult care home having two to six residents. The structure of a family care home may be no more than two stories high, and none of the aged or physically disabled persons being served there may be housed in the upper story without provision for two direct exterior ground-level accesses to the upper story.

(10) "Multiunit assisted housing with services." – An assisted living residence in which hands-on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement which makes personal care services accessible and available through at least one licensed home care or hospice agency. 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 established plan of care. Multiunit assisted housing with services programs are required to register with the Division of Health Service Regulation and to provide a disclosure statement. The disclosure statement is required to be a part of the annual rental contract that includes a description of the following requirements:

a. Emergency response system;
b. Charges for services offered;
c. Limitations of tenancy;
d. Limitations of services;
e. Resident responsibilities;
f. Financial/legal relationship between housing management and home care or hospice agencies;
g. A listing of all home care or hospice agencies and other community services in the area;
h. An appeals process; and
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, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

(11) "Neglect." – The failure to provide the services necessary to maintain a resident's physical or mental health.

(12) "Personal care services." – Any hands-on services allowed to be performed by In-Home Aides II or III as outlined in Department rules.

(13) "Registration." – The submission by a multiunit assisted housing with services provider of a disclosure statement containing all the information as outlined in subdivision (10) of this section.

(14) "Resident." – A person living in an assisted living residence for the purpose of obtaining access to housing and services provided or made available by housing management.

(15) "Secretary." – The Secretary of Health and Human Services unless some other meaning is clearly indicated from the context.

"**§ 131D-2.2. Persons not to be cared for in adult care homes and multiunit assisted housing with services; hospice care.**

(a) Adult Care Homes. – 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, adult care homes shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator dependency;
(2) Individuals requiring continuous licensed nursing care;
(3) Individuals whose physician certifies that placement is no longer appropriate;
(4) Individuals whose health needs cannot be met in the specific adult care home as determined by the residence; and
(5) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in an adult care home.

(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;

(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be 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;

(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;

(5) Psychotropic medications without appropriate diagnosis and treatment plans;

(6) Nasogastric 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;

(8) Individuals requiring continuous licensed nursing care;

(9) Individuals whose physician certifies that placement is no longer appropriate;

(10) Unless the individual's independent physician determines otherwise, 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;

(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the residence; and

(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services.

(c) Hospice Care. – At the request of the resident, hospice care may be provided in an assisted living residence under the same requirements for hospice programs as described in Article 10 of Chapter 131E of the General Statutes.

(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.

"**§ 131D-2.3. Exemptions from licensure.**

(a) The following are excluded from this Article and are not required to be registered or obtain licensure under this Article:

(1) Facilities licensed under Chapter 122C or Chapter 131E of the General Statutes;

(2) Persons subject to rules of the Division of Vocational Rehabilitation Services;

(3) Facilities that care for no more than four persons, all of whom are under the supervision of the United States Veterans Administration;

(4) Facilities that make no charges for housing, amenities, or personal care service, either directly or indirectly; and

(5) Institutions that are maintained or operated by a unit of government and that were established, maintained, or operated by a unit of government and exempt from licensure by the Department on September 30, 1995.

"**§ 131D-2.4. Licensure of adult care homes for aged and disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.**

(a) Licensure. – Except for those facilities exempt under G.S. 131D-2.3, the Department of Health and Human Services shall inspect and license all adult care homes. The Department shall issue a license for a facility not currently licensed as an adult care home for a period of six months. If the licensee demonstrates substantial compliance with Articles 1 and 3 of this Chapter and rules adopted thereunder, the Department shall issue a license for the balance of the calendar year.

(b) Compliance History Review. – Prior to issuing a new license or renewing an existing license, the Department shall conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its principals or affiliates, or otherwise demonstrates disregard for the health, safety, and welfare of residents in current or past facilities. The Department shall require compliance history information and make its determination according to rules adopted by the Medical Care Commission.

(c) Prior Violations. – No new license shall be issued for any adult care home to an applicant for licensure who:

(1) Was the owner, principal, or affiliate of a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 of the General Statutes that had its license revoked until one full year after the date of revocation;

(2) Is the owner, principal, or affiliate of an adult care home that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with the correction plan established pursuant to G.S. 131D-34 and substantial compliance has been certified by the Department;

(3) Is the owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provisional status as a result of Type A or Type B violations until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable; or

(4) Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C or Article 1 of Chapter 131D of the General Statutes or had its license summarily suspended or denied under Article 7 of Chapter 110 of the General Statutes until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

An applicant for new licensure may appeal a denial of certification of substantial compliance under subdivision (2) of this subsection by filing with the Department a request for review by the Secretary within 10 days of the date of denial of the certification. Within 10 days of receipt of the request for review, the Secretary shall issue to the applicant a written determination that either denies certification of substantial compliance or certifies substantial compliance. The decision of the Secretary is final.

(d) License Renewals. – License renewals shall be valid for one year from the date of renewal unless revoked earlier by the Secretary for failure to comply with any part of this

section or any rules adopted hereunder. Licenses shall be renewed annually upon filing and the Department's approval of the renewal application. The Department shall not renew a license if outstanding fees, fines, and penalties imposed by the State against the home have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration. The renewal application shall contain all necessary and reasonable information that the Department may require.

(e) In order for an adult care home to maintain its license, it shall not hinder or interfere with the proper performance of duty of a lawfully appointed community advisory committee, as defined by G.S. 131D-31 and G.S. 131D-32.

"**§ 131D-2.5. License fees.**

The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of two hundred fifty dollars ($250.00). The Department shall charge each adult care home with more than six beds a nonrefundable annual license fee in the amount of three hundred fifty dollars ($350.00) plus a nonrefundable annual per-bed fee of twelve dollars and fifty cents ($12.50).

"**§ 131D-2.6. Legal action by Department.**

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may, in the manner provided by law, maintain an action in the name of the State for injunction or other process against any person to restrain or prevent the establishment, conduct, management, or operation of an adult care home without a license. Such action shall be instituted in the superior court of the county in which any unlicensed activity has occurred or is occurring.

(b) If any person shall hinder the proper performance of duty of the Secretary or his representative in carrying out this section, the Secretary may institute an action in the superior court of the county in which the hindrance has occurred for injunctive relief against the continued hindrance, irrespective of all other remedies at law.

(c) Actions under this section shall be in accordance with Article 37 of Chapter 1 of the General Statutes and Rule 65 of the Rules of Civil Procedure.

"**§ 131D-2.7. Provisional license; license revocation.**

(a) Provisional License. – Except as otherwise provided in this section, the Department may amend a license by reducing it from a full license to a provisional license for a period of not more than 90 days whenever the Department finds that:

(1) The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles;

(2) There is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and

(3) There is a reasonable probability that the licensee will be able thereafter to remain in compliance with the licensure rules for the foreseeable future.

The Department may extend a provisional license for not more than one additional 90-day period upon finding that the licensee has made substantial progress toward remedying the licensure deficiencies that caused the license to be reduced to provisional status.

The Department may also issue a provisional license to a facility, pursuant to rules adopted by the Medical Care Commission, for substantial failure to comply with the provisions of this section or rules adopted pursuant to this section. Any facility wishing to contest the issuance of a provisional license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails written notice of the issuance of the provisional license.

(b) License Revocation. – The Department may revoke a license whenever:

(1) The Department finds that:

a. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and

b. It is not reasonably probable that the licensee can remedy the licensure deficiencies within a reasonable length of time; or

(2) The Department finds that:

a. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and

b. Although the licensee may be able to remedy the deficiencies within a reasonable time, it is not reasonably probable that the licensee will be able to remain in compliance with licensure rules for the foreseeable future; or

c. The licensee has failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles, and the failure to comply endangered the health, safety, or welfare of the patients in the facility.

"**§ 131D-2.8. Penalties.**

(a) Any individual or corporation that establishes, conducts, manages, or operates a facility subject to licensure under this section without a license is guilty of a Class 3 misdemeanor and, upon conviction, shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense.

(b) In addition, the Department may summarily suspend a license pursuant to G.S. 150B-3(c) whenever it finds substantial evidence of abuse, neglect, exploitation, or any condition which presents an imminent danger to the health and safety of any resident of the home. Any facility wishing to contest summary suspension of a license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of summary suspension to the licensee.

"**§§ 131D-2.9 and 2.10: Reserved for future codification purposes.**

"Part 2. Other Laws Pertaining to the Inspection and Operation of Adult Care Homes.

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

(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. The Division of Health Service Regulations shall inspect all adult care homes and adult care units in nursing homes on an annual basis. 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.

(b) Monitoring by County. – The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this monitoring and perform any required follow-up inspection. The county departments of social services shall document in a written report all on-site visits, including monitoring visits, revisits, and complaint investigations. The county departments of

social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit.

(c) State Review of County Compliance. – The Division of Health Service Regulation shall conduct and document annual reviews of the county departments of social services' performance. When monitoring is not done timely or there is failure to identify or document noncompliance, the Department may intervene in the particular service in question. Department intervention shall include one or more of the following activities:

(1) Sending staff of the Department to the county departments of social services to provide technical assistance and to monitor the services being provided by the facility.

(2) Advising county personnel as to appropriate policies and procedures.

(3) Establishing a plan of action to correct county performance.

The Secretary may determine that the Department shall assume the county's regulatory responsibility for the county's adult care homes.

"**§ 131D-2.12. Training requirements; county departments of social services.**

(a) The county departments of social services' adult home specialists and their supervisors shall complete:

(1) Eight hours of prebasic training within 60 days of employment;

(2) Thirty-two hours of basic training within six months of employment;

(3) Twenty-four hours of postbasic training within six months of the basic training program;

(4) A minimum of eight hours of complaint investigation training within six months of employment; and

(5) A minimum of 16 hours of statewide training annually by the Division of Health Service Regulation.

(b) The joint training requirements by the Department shall be as provided in G.S. 143B-139.5B.

"**§ 131D-2.13. Departmental duties.**

(a) Enforcement of Room Ventilation and Temperature. – The Department shall monitor regularly the enforcement of rules pertaining to air circulation, ventilation, and room temperature in resident living quarters. These rules shall include the requirement that air conditioning or at least one fan per resident bedroom and living and dining areas be provided when the temperature in the main center corridor exceeds 80 degrees Fahrenheit.

(b) Administrator Directory. – The Department shall keep an up-to-date directory of all persons who are administrators as defined in G.S. 131D-2.1.

(c) Departmental Complaint Hotline. – Adult care homes shall post the Division of Health Service Regulation's complaint hotline number conspicuously in a public place in the facility.

(d) Provider File. – The Department of Health and Human Services shall establish and maintain a provider file to record and monitor compliance histories of facilities, owners, operators, and affiliates of nursing homes and adult care homes.

(e) Report on Use of Restraint. – The Department shall report annually on October 1 to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by

the investigation to be related to the adult care home's use of physical restraint or physical hold.

"**§ 131D-2.14. Confidentiality.**

Notwithstanding G.S. 8-53 or any other law relating to confidentiality of communications between physician and patient, in the course of an inspection conducted under G.S. 131D-2.11:

(1) Department representatives may review any writing or other record concerning the admission, discharge, medication, care, medical condition, or history of any person who is or has been a resident of the facility being inspected, and

(2) Any person involved in giving care or treatment at or through the facility may disclose information to Department representatives unless the resident objects in writing to review of his records or disclosure of such information.

(3) The facility, its employees, and any other person interviewed in the course of an inspection shall be immune from liability for damages resulting from disclosure of any information to the Department. The Department shall not disclose:

a. Any confidential or privileged information obtained under this section unless the resident or his legal representative authorizes disclosure in writing or unless a court of competent jurisdiction orders disclosure, or

b. The name of anyone who has furnished information concerning a facility without that person's consent.

The Department shall institute appropriate policies and procedures to ensure that unauthorized disclosure does not occur. All confidential or privileged information obtained under this section and the names of persons providing such information shall be exempt from Chapter 132 of the General Statutes.

(4) Notwithstanding any law to the contrary, Chapter 132 of the General Statutes, the Public Records Law, applies to all records of the State Division of Social Services of the Department of Health and Human Services and of any county department of social services regarding inspections of domiciliary care facilities except for information in the records that is confidential or privileged, including medical records, or that contains the names of residents or complainants.

"**§ 131D-2.15. Resident assessments.**

(a) The Department shall ensure that facilities conduct and complete an assessment of each resident within 72 hours of 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. 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:

(1) Whether the appropriate assessment instrument was administered and interpreted correctly;

(2) Whether the facility is capable of providing the necessary services;

(3) Whether the service plan or care plan conforms to the results of an appropriately administered and interpreted assessment; and

(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.

"**§ 131D-2.16. Suspension of admissions.**

(a) In addition to the administrative penalties described in G.S. 131D-2.8, the Secretary may suspend the admission of any new residents to an adult care home where the conditions of the adult care home are detrimental to the health or safety of the residents. This 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.

(b) In imposing a suspension under this section, the Secretary shall consider the following factors:

(1) The degree of sanctions necessary to ensure compliance with this section and rules adopted hereunder; and

(2) The character and degree of impact of the conditions at the home on the health or safety of its residents.

(c) The Secretary of Health and Human Services shall adopt rules to implement this section.

(d) Any facility wishing to contest a suspension of admissions shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of suspension of admissions to the licensee.

"**§ 131D-2.17. 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, 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.

"**§ 131D-2.18. Impact on other laws; severability.**

(a) Nothing in this section shall be construed to supersede any federal or State antitrust, antikickback, or safe harbor laws or regulations.

(b) If any provisions of this section or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the section which can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

"**§ 131D-2.19. Application of other laws.**

(a) Certification of assisted living administrators shall be as provided under Article 20A of Chapter 90 of the General Statutes.

(b) Compliance with the Health Care Personnel Registry shall be as provided under G.S. 131E-256.

(c) Rules for the operation of the adult care portion of a combination home, as defined in G.S. 131E-101, shall be as provided in G.S. 131E-104."

SECTION 2. G.S. 131D-41 and G.S. 131D-42 are repealed.

SECTION 3. This act becomes effective October 1, 2009. Licenses issued pursuant to G.S. 131D-2 remain effective until the date of annual renewal at which time Part 1 of Article 1 of Chapter 131D of the General Statutes shall apply. In all other respects, beginning October 1, 2009, Part 1 of Article 1 of Chapter 131D shall apply to the operation of facilities currently licensed under G.S. 131D-2.

SENATE BILL 1042:
Tech. & Org. Changes/Certain DHHS Facilities

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	**Date:**	April 7, 2009
Introduced by:	Sen. Nesbitt	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	First Edition		

SUMMARY: ***Senate Bill 1042 makes technical and organizational changes to the laws regarding licensure and inspection of facilities for aged and disabled individuals.***

[As introduced, this bill was identical to H456, as introduced by Reps. Insko, England, Farmer-Butterfield, Earle, which is currently in House Aging, if favorable, Judiciary II.]

BILL ANALYSIS:

The following chart tracts the proposed changes:

Comparison			
Provision title	**SB 1042**	**Existing NC law**	**Difference**
Definitions	proposed G. 131D-2.1	GS 131D-2	Renumbers defined terms
Persons not to be cared for in adult care homes & multiunit assisted housing with services; hospice care	proposed GS 131D-2.2	GS 131D-2(a1), GS 131D-2(a2), GS 131D-2(a3), & GS 131D-2(c1)	Reorganizes; Section (d) in proposed GS 131D-2.2 - Obtaining services rewritten from original language in GS 131D-2(c1)
Exemptions from licensure	proposed GS 131D-2.3	GS 131D-2(c)	
Licensure of adult care homes for aged & disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.	proposed GS 131D-2.4	GS 131D-2(b)(1), GS 131D-2(b)(6), GS 131D-2(b1),	
License fees	proposed GS 131D-2.5	GS 131D-2(b)(1)	
Legal action by department	proposed GS 131D-2.6	GS 131D-2(i)	
Provisional license; license revocation	proposed GS 131D-2.7	GS 131D-2(b)(1)	
Penalties	proposed GS 131D-2.8	GS 131D-2(b)(2), GS 131D-2(b)(3)	
Inspections, monitoring, and review by State agency and county departments of social services	proposed GS 131D-2.11	GS 131D-2(b)(1a)	
Training requirements; county departments of social services	proposed GS 131D-2.12	GS 131D-2(b)(1a)(d)	Proposed GS 131D-2.12(b) new language that references joint training requirements by the Department in GS 143B-139.5B

Provision title	SB 1042	Existing NC law	Difference
Departmental duties	proposed GS 131D-2.13(a), GS 131D -2.13(b), GS 131D-2.13(c), GS 131D-2.13(d), GS 131D-2.13(e)	GS 131D-2(b)(1a)(e), GS 131D-2(b)(1a)(f), GS 131D-2(j), GS 131D-41, GS 131D-42	
Confidentiality	proposed GS 131D-2.14	GS 131D-2(b)(4)	
Resident assessments	proposed GS 131D-2.15	GS 131D-2(e)	
Suspension of admissions	proposed GS 131D-2.16	GS 131D-2(h)	
Rules	proposed GS 131D-2.17	GS 131D-2(c2)	
Impact on other laws; severability	proposed GS 131D-2.18	GS 131D-2(c3), GS 131D-2(f)	
Application of other laws	proposed GS 131D-2.19	N/A	

This chart was prepared by Susan Barham, Senate Health Care Committee staff.

EFFECTIVE DATE:

This act becomes effective October 1, 2009. Licenses issued pursuant to G.S. 131D-2 remain effective until the date of annual renewal at which time Part 1 of Article 1 of Chapter 131D of the General Statutes shall apply. In all other respects, beginning October 1, 2009, Part 1 of Article 1 of Chapter 131D shall apply to the operation of facilities currently licensed under G.S. 131D-2.

BACKGROUND: Senate Bill 915 received a favorable report in the Senate Health Care Committee on March 19, 2007. The provisions of Senate Bill 1042 are substantially equivalent to the provisions in Senate Bill 915.

S1042-SMSQ-28(e1) v1

Senate Health Care Committee
Wednesday, April 15, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 674	**Amend Rabies Laws.**	**Senator Purcell**
SB 1042	**Tech. & Org. Changes/Certain DHHS Facilities.**	**Senator Nesbitt, Jr.**
SB 331	**MH/National Accred. Benchmarks.**	**Senator Berger**
SB 906	**Establish Adult Day Health Overnight Respite.**	**Senator Clary**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, April 16, 2009

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

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

S.B. **674** Amend Rabies Laws.

Draft Number:	75238
Sequential Referral:	None
Recommended Referral:	Finance
Long Title Amended:	Yes

S.B. **1042** Tech. & Org. Changes/Certain DHHS Facilities.

Draft Number:	55337
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, April 15, 2009 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, April 15, 2009, in Room 544 of the Legislative Office Building, with twenty members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Bingham called on Senator Purcell to discuss Senate Bill 674, ***Amend Rabies Laws***, which was discussed at length last week. Senate Bill 674 had a new PCS, which Senator Dannelly moved to hear, and the motion passed. Senator Purcell asked Shawn Parker, Staff Attorney, to explain the new PCS, who explained the PCS incorporated the amendment adopted from last meeting, which changed the four definitions. Senator Purcell offered another amendment and explained that Senator Allran had raised some concerns from the last meeting and also some hunters were concerned that it could take a day or two for them to find their dogs after a hunt. The original bill stated if a dog, cat, or ferret bites someone the animal could be euthanized immediately and the head sent to Raleigh for testing to see if the animal had rabies. This amendment would allow for the animal to be retained for seventy-two hours while the owner was located. Senator Purcell moved for approval of the amendment, which passed. Senator Forrester asked about the veterinarian technicians giving vaccines. Senator Berger of Franklin, had an amendment last time, but he had since withdrawn. The veterinarian technicians could give the vaccines, but only with a veterinarian present. Sen. Forrester asked if the vet tech could issue the rabies tag. Sen. Purcell requested Dr. Carl Williams NC State Veterinarian to respond to the question. Dr. Carl Williams, Division of Public Health, stated the registered veterinarian technician could administer the vaccine, but the certificate would still be issued and signed by the supervising veterinarian meaning the veterinarian would issue the tag. Senator Bingham stated that Shawn Parker, Staff Attorney, would like to make a comment, who pointed out the licensed veterinarian that administered the vaccine and provided the tags, could allow the certified rabies vaccinator to issue certificates and tags, according to the Statutes. Senator Berger of Franklin asked how often was the training available for the certified technicians, stating that their local animal control officer did not have the ability to do rabies shots and had to wait four months for training. Dr. Carl Williams, State Veterinarian, stated that they are the ones that offer the training and that it was made available on an as needed bases. He pointed out they wait and do the training when they have 10 or 15 in the class, normally one training each quarter. Senator Allran stated he liked the amendment and asked if it meant they would wait 72 hours before euthanizing the animal instead of euthanizing immediately. Senator Purcell responded that was correct. Senator Allran also asked about the meaning for strays on page one. It stated, "Beyond the limits of confinements"; his question was what would be the limits of confinements for a cat. Dr. Carl Williams, State Veterinarian explained it would depend on local ordinances, if there were a leash law. Typically he would define, "Beyond the

limits of confinement," to mean the animal is off the owner's property and was not under the control of the owner. Senator Purcell stated that if a cat bites a child, you have to decide right away if the child needs Rabies Treatment, that being the reason for this law. Senator Forrester moved for a favorable report, to roll the amendment into a new PCS, unfavorable to original bill, favorable as to the PCS, and a recommended referral to Finance. The motion passed.

Senator Bingham recognized Senator Nesbitt to present SB 1042, ***Tech.& Org. Changes/Certain DHHS Facilities***, which comes to the committee as a Proposed Committee Substitute, PCS. Senator Forrester moved to hear the PCS and the motion passed. Senator Nesbitt explained SB 1042 was a technical rewrite of the statutes governing licensure and inspection of facilities for aged and disabled individuals. Senator Stein asked for staff to walk though the bill. Shawn Parker, Staff Attorney, stated that in the analysis there was a crosswalk that spoke to where these provisions are currently in statute and where this bill would place them. Lou Wilson, Director of the Long Term Care Association stated they worked with DHHS and AARP. She pointed out it was just a rewrite, and stated that NC first started writing residential care laws over sixty years ago. She stated the law had become so overlapped it was hard to follow and there was no definition section left. Jeff Horton, Department of Health and Human Services, stated they worked with the industries and bill drafting and they have no opposition-n to the bill. Senator Forrester asked how often the homes are monitored. Lou Wilson, Long Term Care Association, responded that there were two groups who do monitoring and compliance issues. They are the counties Department of Social Services (DSS), who visit the facilities no less than once every 90 days, and surveyors from the state, which come every year. Senator Nesbitt moved for a favorable report, unfavorable as to the original bill, but favorable as to the proposed committee substitute, with a sequential referral to Finance. The motion passed.

Senate Bill 331, ***MH/National Accred. Benchmarks***. and SB 906, ***Establish Adult Day Health Overnight Respite***., were removed from today's agenda.

The meeting adjourned at 11:30 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

SENATE BILL 674

Short Title:	Amend Rabies Laws.	(Public)
Sponsors:	Senator Purcell.	
Referred to:	Health Care.	

March 19, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND THE RABIES LAWS TO CONFORM WITH RECOMMENDATIONS FROM THE CENTERS FOR DISEASE CONTROL AND THE NATIONAL ASSOCIATION OF STATE PUBLIC HEALTH VETERINARIANS AND TO ALLOW STRAY OR FERAL ANIMALS TO BE IMMEDIATELY EUTHANIZED AND TESTED FOR RABIES AFTER BITING A HUMAN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-184 reads as rewritten:

"Part 6. Rabies.

"**§ 130A-184. Definitions.**

The following definitions shall apply throughout this Part:

(1) 'Animal Control Officer' means a city or county employee designated as dog warden, animal control officer, animal control official or other designations that may be used whose responsibility includes animal control.

(2) 'Cat' means a domestic feline.

(3) 'Certified rabies vaccinator' means a person appointed and certified to administer rabies vaccine to animals in accordance with this Part.

(4) 'Dog' means a domestic canine.

(4a) 'Feral' means any dog, cat, or ferret that is born in the wild and is not socialized; is the offspring of a dog, cat, or ferret that is owned or born in the wild and is not socialized; or is a formerly owned dog, cat, or ferret that has been abandoned and is no longer socialized.

(4b) 'Ferret' means a domestic mammal of the type mustela putorius furo.

(5) 'Rabies vaccine' means an animal rabies vaccine licensed by the United States Department of Agriculture and approved for use in this State by the Commission.

(6) 'State Public Health Veterinarian' means a person appointed by the Secretary to direct the State public health veterinary program.

(6a) 'Stray' means any dog, cat, or ferret that is (i) beyond the limits of confinement or lost and (ii) not wearing any tags, microchips, tattoos, or other methods of identification.

(7) 'Vaccination' means the administration of rabies vaccine by a licensed veterinarian or by a certified rabies vaccinator."

SECTION 2. G.S. 130A-185(a) reads as rewritten:

"**§ 130A-185. Vaccination of all ~~dogs and cats~~dogs, cats, and ferrets.**

(a) The owner of every ~~dog and cat~~dog, cat, and ferret over four months of age shall have the animal vaccinated against rabies. The time or times of vaccination shall be established

by the Commission. Rabies vaccine shall be administered only by a licensed veterinarian or by a certified rabies vaccinator."

SECTION 3. G.S. 130A-187 reads as rewritten:

"**§ 130A-187. County rabies vaccination clinics.**

The local health director shall organize or assist other county departments to organize at least one countywide rabies vaccination clinic per year for the purpose of vaccinating ~~dogs and cats.~~ dogs, cats, and ferrets. Public notice of the time and place of rabies vaccination clinics shall be published in a newspaper having general circulation within the area."

SECTION 4. G.S. 130A-188 reads as rewritten:

"**§ 130A-188. Fee for vaccination at county rabies vaccination clinics.**

The county board of commissioners is authorized to establish a fee to be charged at the county rabies vaccination clinics. The fee ~~shall~~ may include an administrative charge ~~not to exceed four dollars ($4.00) per vaccination,~~ and a charge for the actual cost of the vaccine, the vaccination certificate, and the rabies vaccination tag."

SECTION 5. G.S. 130A-189 reads as rewritten:

"**§ 130A-189. Rabies vaccination certificates.**

A licensed veterinarian or a certified rabies vaccinator who administers rabies vaccine to a ~~dog or cat~~ dog, cat, or ferret shall complete a three-copy rabies vaccination ~~certificate.~~ certificate that includes, at a minimum, all of the following items:

(1) The owner's name, address, and telephone number.
(2) The animal's species, age, sex, weight, breed, name, and predominant colors or markings.
(3) The animal's rabies tag number.
(4) The animal's microchip number, if any.
(5) The date the animal was vaccinated and the date the next vaccination is due.
(6) The name of the product used to vaccinate the animal, the first three letters of the vaccine manufacturer, and the vaccine serial number or lot number.
(7) The veterinarian's name, address, license number, and signature.

The Secretary may adopt rules requiring that additional items be included on the rabies vaccination certificate.

The original rabies vaccination certificate shall be given to the owner of each dog or cat that receives rabies vaccine. One copy of the rabies vaccination certificate shall be retained by the licensed veterinarian or the certified rabies vaccinator. The other copy shall be given to the county agency responsible for animal control, provided the information given to the county agency shall not be used for commercial purposes."

SECTION 6. G.S. 130A-190 reads as rewritten:

"**§ 130A-190. Rabies vaccination tags.**

(a) Issuance. – A licensed veterinarian or a certified rabies vaccinator who administers rabies vaccine to a ~~dog or cat~~ dog, cat, or ferret shall issue a rabies vaccination tag to the owner of the animal. The rabies vaccination tag shall show the year issued, a vaccination number, the words "North Carolina" or the initials "N.C." and the words "rabies vaccine." ~~Dogs and cats~~Dogs, cats, and ferrets shall wear rabies vaccination tags at all times. However, cats and ferrets may be exempted from wearing the tags by local ordinance.

(b) Fee. – Rabies vaccination tags, links, and rivets may be obtained from the Department. The Secretary is authorized to establish by rule a fee for the rabies tags, links, and rivets in accordance with this subsection. The fee for each tag is the sum of the following:

(1) The actual cost of the rabies tag, links, and rivets.
(2) Transportation costs.
(3) Five cents (5¢). This portion of the fee shall be used to fund rabies education and prevention programs.

(4) Twenty cents (20¢). This portion of the fee shall be credited to the Spay/Neuter Account established in G.S. 19A-62 and used to fund statewide spay/neuter programs. This portion of the fee shall not be imposed for tags provided to persons who operate establishments primarily for the purpose of boarding or training hunting dogs or who own and vaccinate 10 or more dogs per year.

(c) Repealed by Session Laws 2007-487, s. 1, effective January 1, 2008."

SECTION 7. G.S. 130A-192 reads as rewritten:

"**§ 130A-192. ~~Dogs and cats~~ Dogs, cats, and ferrets not wearing required rabies vaccination tags.**

The Animal Control Officer shall canvass the county to determine if there are any ~~dogs or cats~~dogs, cats, or ferrets not wearing the required rabies vaccination tag. If a ~~dog or cat~~dog, cat, or ferret is found not wearing the required tag, the Animal Control Officer shall check to see if the owner's identification can be found on the animal. If the animal is wearing an owner identification tag, or if the Animal Control Officer otherwise knows who the owner is, the Animal Control Officer shall notify the owner in writing to have the animal vaccinated against rabies and to produce the required rabies vaccination certificate to the Animal Control Officer within three days of the notification. If the animal is not wearing an owner identification tag and the Animal Control Officer does not otherwise know who the owner is, the Animal Control Officer may impound the animal. The duration of the impoundment of these animals shall be established by the county board of commissioners, but the duration shall not be less than 72 hours. During the impoundment period, the Animal Control Officer shall make a reasonable effort to locate the owner of the animal. If the animal is not reclaimed by its owner during the impoundment period, the animal shall be disposed of in one of the following manners: returned to the owner; adopted as a pet by a new owner; sold to institutions within this State registered by the United States Department of Agriculture pursuant to the Federal Animal Welfare Act, as amended; or put to death by a procedure approved by the American Veterinary Medical Association, the Humane Society of the United States or of the American Humane Association. The Animal Control Officer shall maintain a record of all animals impounded under this section which shall include the date of impoundment, the length of impoundment, the method of disposal of the animal and the name of the person or institution to whom any animal has been released."

SECTION 8. G.S. 130A-193 reads as rewritten:

"**§ 130A-193. Vaccination and confinement of ~~dogs and cats~~dogs, cats, and ferrets brought into this State.**

(a) A ~~dog or cat~~dog, cat, or ferret brought into this State shall immediately be securely confined and shall be vaccinated against rabies within one week after entry. The animal shall remain confined for two weeks after vaccination.

(b) The provisions of subsection (a) shall not apply to:

(1) A ~~dog or cat~~dog, cat, or ferret brought into this State for exhibition purposes if the animal is confined and not permitted to run at large; or

(2) A ~~dog or cat~~dog, cat, or ferret brought into this State accompanied by a certificate issued by a licensed veterinarian showing that the ~~dog or cat~~dog, cat, or ferret is apparently free from and has not been exposed to rabies and that the ~~dog or cat has received rabies vaccine within the past year.~~dog, cat, or ferret is currently vaccinated against rabies."

SECTION 9. G.S. 130A-194 reads as rewritten:

"**§ 130A-194. Quarantine of districts infected with rabies.**

An area may be declared under quarantine against rabies by the local health director when the disease exists to the extent that the lives of persons are endangered. When quarantine is declared, each ~~dog and cat~~dog, cat, and ferret in the area shall be confined on the premises of

the owner or in a veterinary hospital. However, ~~dogs or cats~~a dog, cat, or ferret on a leash or under the control and in the sight of a responsible adult may be permitted to leave the premises of the owner or the veterinary hospital."

SECTION 10. G.S. 130A-195 reads as rewritten:

"**§ 130A-195. Destroying stray dogs and cats in quarantine districts.**

When quarantine has been declared and ~~dogs and cats~~dogs, cats, and ferrets continue to run uncontrolled in the area, any peace officer or Animal Control Officer shall have the right, after reasonable effort has been made to apprehend the animals, to destroy the uncontrolled ~~dogs and cats~~dogs, cats, and ferrets and properly dispose of their bodies."

SECTION 11. G.S. 130A-196 reads as rewritten:

"**§ 130A-196. Confinement of all biting ~~dogs and cats~~dogs, cats, and ferrets; notice to local health director; reports by physicians; certain dogs exempt.**

When a person has been bitten by a ~~dog or cat,~~dog, cat, or ferret, the person or parent, guardian or person standing in loco parentis of the person, and the person owning the animal or in control or possession of the animal shall notify the local health director immediately and give the name and address of the person bitten and the owner of the animal. A dog, cat, or ferret that bites a person may be immediately euthanized if, in the opinion of the local health director or an Animal Control Officer, the animal is a stray or feral. If the animal is immediately euthanized, the head of the animal shall be immediately sent to the State Laboratory of Public Health for rabies diagnosis. All ~~dogs and cats~~other dogs, cats, and ferrets that bite a person shall be immediately confined for 10 days in a place designated by the local health director. However, the local health director may authorize a dog trained and used by a law enforcement agency to be released from confinement to perform official duties upon submission of proof that the dog has been vaccinated for rabies in compliance with this Part. After reviewing the circumstances of the particular case, the local health director may allow the owner to confine the animal on the owner's property. An owner who fails to confine ~~his~~ an animal in accordance with the instructions of the local health director shall be guilty of a Class 2 misdemeanor. If the owner or the person who controls or possesses a ~~dog or cat~~ dog, cat, or ferret that has bitten a person refuses to confine the animal as required by this section, the local health director may order seizure of the animal and its confinement for 10 days at the expense of the owner. A physician who attends a person bitten by an animal known to be a potential carrier of rabies shall report within 24 hours to the local health director the name, age and sex of that person. A veterinarian who has knowledge of any mammal biting a person shall report to the local health director the name, age, and sex of that person, if known, and the type and whereabouts of the mammal responsible for the bite, if known."

SECTION 12. G.S. 130A-197 reads as rewritten:

"**§ 130A-197. Infected ~~dogs and cats~~dogs, cats, and ferrets to be destroyed; protection of vaccinated ~~dogs and cats.~~dogs, cats, and ferrets.**

When the local health director reasonably suspects that a ~~dog or cat~~dog, cat, or ferret has been exposed to the saliva or nervous tissue of a proven rabid animal or animal reasonably suspected of having rabies that is not available for laboratory diagnosis, the ~~dog or cat~~dog, cat, or ferret shall be considered to have been exposed to rabies. A ~~dog or cat~~dog, cat, or ferret exposed to rabies shall be destroyed immediately by its owner, the county Animal Control Officer or a peace officer unless the ~~dog or cat~~dog, cat, or ferret has been vaccinated against rabies in accordance with this Part and the rules of the Commission more than ~~three weeks~~ twenty-eight days prior to being exposed, and is given a booster dose of rabies vaccine within ~~three~~five days of the exposure. As an alternative to destruction, the ~~dog or cat~~ dog, cat, or ferret may be quarantined at a facility approved by the local health director for a period up to six months, and under reasonable conditions imposed by the local health director."

SECTION 13. G.S. 130A-198 reads as rewritten:

"**§ 130A-198. Confinement.**

A person who owns or has possession of an animal which is suspected of having rabies shall immediately notify the local health director or county Animal Control Officer and shall securely confine the animal in a place designated by the local health director. ~~Dogs and cats~~Dogs, cats, and ferrets shall be confined for a period of 10 days. Other animals may be destroyed at the discretion of the State Public Health Veterinarian."

SECTION 14. G.S. 130A-199 reads as rewritten:

"**§ 130A-199. Rabid animals to be destroyed; heads to be sent to State Laboratory of Public Health.**

An animal diagnosed as having rabies by a licensed veterinarian shall be destroyed and its head sent to the State Laboratory of Public Health. The heads of all ~~dogs and cats~~dogs, cats, and ferrets that die during the 10-day confinement period required by G.S. 130A-196, shall be immediately sent to the State Laboratory of Public Health for rabies diagnosis."

SECTION 15. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 674
PROPOSED COMMITTEE SUBSTITUTE S674-CSSQ-17 [v.1]

4/14/2009 3:28:15 PM

Short Title: Amend Rabies Laws. (Public)

Sponsors:

Referred to:

March 19, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND THE RABIES LAWS TO CONFORM WITH RECOMMENDATIONS FROM THE CENTERS FOR DISEASE CONTROL AND THE NATIONAL ASSOCIATION OF STATE PUBLIC HEALTH VETERINARIANS AND TO ALLOW STRAY OR FERAL ANIMALS TO BE IMMEDIATELY EUTHANIZED AND TESTED FOR RABIES AFTER BITING A HUMAN.

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The following definitions shall apply throughout this Part:

(1) 'Animal Control Officer' means a city or county employee designated as dog warden, animal control officer, animal control official or other designations that may be used whose responsibility includes animal control.

(2) 'Cat' means a domestic ~~feline.~~ feline of the genus and species Felis catus.

(3) 'Certified rabies vaccinator' means a person appointed and certified to administer rabies vaccine to animals in accordance with this Part.

(4) 'Dog' means a domestic ~~canine.~~ canine of the genus, species, and subspecies Canis lupus familiaris.

(4a) 'Feral' means any animal that is born in the wild and is not socialized; is the offspring of a dog, cat, or ferret that is owned or born in the wild and is not socialized; or is a formerly owned dog, cat, or ferret that has been abandoned and is no longer socialized.

(4b) 'Ferret' means a domestic mammal of the genus, species, and subspecies Mustela putorius furo.

(5) 'Rabies vaccine' means an animal rabies vaccine licensed by the United States Department of Agriculture and approved for use in this State by the Commission.

(6) 'State Public Health Veterinarian' means a person appointed by the Secretary to direct the State public health veterinary program.

(6a) 'Stray' means any animal that is (i) beyond the limits of confinement or lost and (ii) not wearing any tags, microchips, tattoos, or other methods of identification.

(7) 'Vaccination' means the administration of rabies vaccine by a licensed ~~veterinarian~~ veterinarian, by a registered veterinary technician under the

direct supervision of a licensed veterinarian, or by a certified rabies vaccinator."

SECTION 2. G.S. 130A-185(a) reads as rewritten:

"**§ 130A-185. Vaccination of all ~~dogs and cats.~~dogs, cats, and ferrets.**

(a) The owner of every ~~dog and cat~~ dog, cat, and ferret over four months of age shall have the animal vaccinated against rabies. The time or times of vaccination shall be established by the Commission. Rabies vaccine shall be administered only by a licensed ~~veterinarian~~ veterinarian, by a registered veterinary technician under the direct supervision of a licensed veterinarian, or by a certified rabies vaccinator."

SECTION 3. G.S. 130A-187 reads as rewritten:

"**§ 130A-187. County rabies vaccination clinics.**

The local health director shall organize or assist other county departments to organize at least one countywide rabies vaccination clinic per year for the purpose of vaccinating ~~dogs and cats.~~ dogs, cats, and ferrets. Public notice of the time and place of rabies vaccination clinics shall be published in a newspaper having general circulation within the area."

SECTION 4. G.S. 130A-188 reads as rewritten:

"**§ 130A-188. Fee for vaccination at county rabies vaccination clinics.**

The county board of commissioners is authorized to establish a fee to be charged at the county rabies vaccination clinics. The fee ~~shall~~ may include an administrative charge ~~not to exceed four dollars ($4.00) per vaccination,~~ and a charge for the actual cost of the vaccine, the vaccination certificate, and the rabies vaccination tag."

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"**§ 130A-189. Rabies vaccination certificates.**

A licensed veterinarian or a certified rabies vaccinator who administers rabies vaccine to a ~~dog or cat~~ dog, cat, or ferret shall complete a ~~three copy~~ rabies vaccination certificate. The Commission shall adopt rules establishing the specific information required to be included on the certificate. ~~The~~An original rabies vaccination certificate shall be given to the owner of each ~~dog or cat~~ dog, cat, or ferret that receives rabies vaccine. ~~One~~A copy of the rabies vaccination certificate shall be retained by the licensed veterinarian or the certified rabies vaccinator. ~~The other~~ A copy shall also be given to the county agency responsible for animal control, provided the information given to the county agency shall not be used for commercial purposes."

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"(a) Issuance. – A licensed veterinarian or a certified rabies vaccinator who administers rabies vaccine to a ~~dog or cat~~ dog, cat, or ferret shall issue a rabies vaccination tag to the owner of the animal. The rabies vaccination tag shall show the year issued, a vaccination number, the words "North Carolina" or the initials "N.C." and the words "rabies vaccine." ~~Dogs and cats~~Dogs, cats, and ferrets shall wear rabies vaccination tags at all times. However, cats and ferrets may be exempted from wearing the tags by local ordinance."

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The Animal Control Officer shall canvass the county to determine if there are any ~~dogs or cats~~dogs, cats, or ferrets not wearing the required rabies vaccination tag. If a ~~dog or cat~~dog, cat, or ferret is found not wearing the required tag, the Animal Control Officer shall check to see if the owner's identification can be found on the animal. If the animal is wearing an owner identification tag, or if the Animal Control Officer otherwise knows who the owner is, the Animal Control Officer shall notify the owner in writing to have the animal vaccinated against rabies and to produce the required rabies vaccination certificate to the Animal Control Officer within three days of the notification. If the animal is not wearing an owner identification tag and the Animal Control Officer does not otherwise know who the owner is, the Animal Control Officer may impound the animal. The duration of the impoundment of these animals shall be

established by the county board of commissioners, but the duration shall not be less than 72 hours. During the impoundment period, the Animal Control Officer shall make a reasonable effort to locate the owner of the animal. If the animal is not reclaimed by its owner during the impoundment period, the animal shall be disposed of in one of the following manners: returned to the owner; adopted as a pet by a new owner; sold to institutions within this State registered by the United States Department of Agriculture pursuant to the Federal Animal Welfare Act, as amended; or put to death by a procedure approved by the American Veterinary Medical Association, the Humane Society of the United States or of the American Humane Association. The Animal Control Officer shall maintain a record of all animals impounded under this section which shall include the date of impoundment, the length of impoundment, the method of disposal of the animal and the name of the person or institution to whom any animal has been released."

SECTION 8. G.S. 130A-193 reads as rewritten:

"**§ 130A-193. Vaccination and confinement of ~~dogs and cats~~dogs, cats, and ferrets brought into this State.**

(a) A ~~dog or cat~~dog, cat, or ferret brought into this State shall immediately be securely confined and shall be vaccinated against rabies within one week after entry. The animal shall remain confined for two weeks after vaccination.

(b) The provisions of subsection (a) shall not apply to:

(1) A ~~dog or cat~~dog, cat, or ferret brought into this State for exhibition purposes if the animal is confined and not permitted to run at large; or

(2) A ~~dog or cat~~dog, cat, or ferret brought into this State accompanied by a certificate issued by a licensed veterinarian showing that the ~~dog or cat~~dog, cat, or ferret is apparently free from and has not been exposed to rabies and that the ~~dog or cat has received rabies vaccine within the past year.~~dog, cat, or ferret is currently vaccinated against rabies."

SECTION 9. G.S. 130A-194 reads as rewritten:

"**§ 130A-194. Quarantine of districts infected with rabies.**

An area may be declared under quarantine against rabies by the local health director when the disease exists to the extent that the lives of persons are endangered. When quarantine is declared, each ~~dog and cat~~dog, cat, and ferret in the area shall be confined on the premises of the owner or in a veterinary hospital. However, ~~dogs or cats~~a dog, cat, or ferret on a leash or under the control and in the sight of a responsible adult may be permitted to leave the premises of the owner or the veterinary hospital."

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"**§ 130A-196. Confinement of all biting ~~dogs and cats~~dogs, cats, and ferrets; notice to local health director; reports by physicians; certain dogs exempt.**

When a person has been bitten by a ~~dog or cat,~~dog, cat, or ferret, the person or parent, guardian or person standing in loco parentis of the person, and the person owning the animal or in control or possession of the animal shall notify the local health director immediately and give the name and address of the person bitten and the owner of the animal. A dog, cat, or ferret that bites a person may be immediately euthanized if, in the opinion of the local health director or an Animal Control Officer, the animal is a stray or feral. If the animal is immediately euthanized, the head of the animal shall be immediately sent to the State Laboratory of Public Health for rabies diagnosis. All ~~dogs and cats~~other dogs, cats, and ferrets that bite a person

shall be immediately confined for 10 days in a place designated by the local health director. However, the local health director may authorize a dog trained and used by a law enforcement agency to be released from confinement to perform official duties upon submission of proof that the dog has been vaccinated for rabies in compliance with this Part. After reviewing the circumstances of the particular case, the local health director may allow the owner to confine the animal on the owner's property. An owner who fails to confine ~~his~~ an animal in accordance with the instructions of the local health director shall be guilty of a Class 2 misdemeanor. If the owner or the person who controls or possesses a ~~dog or cat~~ dog, cat, or ferret that has bitten a person refuses to confine the animal as required by this section, the local health director may order seizure of the animal and its confinement for 10 days at the expense of the owner. A physician who attends a person bitten by an animal known to be a potential carrier of rabies shall report within 24 hours to the local health director the name, age and sex of that person."

SECTION 12. G.S. 130A-197 reads as rewritten:

"**§ 130A-197. Infected ~~dogs and cats~~dogs, cats, and ferrets to be destroyed; protection of vaccinated ~~dogs and cats.~~dogs, cats, and ferrets.**

When the local health director reasonably suspects that a ~~dog or cat~~dog, cat, or ferret has been exposed to the saliva or nervous tissue of a proven rabid animal or animal reasonably suspected of having rabies that is not available for laboratory diagnosis, the ~~dog or cat~~dog, cat, or ferret shall be considered to have been exposed to rabies. A ~~dog or cat~~dog, cat, or ferret exposed to rabies shall be destroyed immediately by its owner, the county Animal Control Officer or a peace officer unless the ~~dog or cat~~dog, cat, or ferret has been vaccinated against rabies in accordance with this Part and the rules of the Commission more than ~~three weeks~~ twenty-eight days prior to being exposed, and is given a booster dose of rabies vaccine within ~~three~~five days of the exposure. As an alternative to destruction, the ~~dog or cat~~ dog, cat, or ferret may be quarantined at a facility approved by the local health director for a period up to six months, and under reasonable conditions imposed by the local health director."

SECTION 13. G.S. 130A-198 reads as rewritten:

"**§ 130A-198. Confinement.**

A person who owns or has possession of an animal which is suspected of having rabies shall immediately notify the local health director or county Animal Control Officer and shall securely confine the animal in a place designated by the local health director. ~~Dogs and cats~~Dogs, cats, and ferrets shall be confined for a period of 10 days. Other animals may be destroyed at the discretion of the State Public Health Veterinarian."

SECTION 14. G.S. 130A-199 reads as rewritten:

"**§ 130A-199. Rabid animals to be destroyed; heads to be sent to State Laboratory of Public Health.**

An animal diagnosed as having rabies by a licensed veterinarian shall be destroyed and its head sent to the State Laboratory of Public Health. The heads of all ~~dogs and cats~~dogs, cats, and ferrets that die during the 10-day confinement period required by G.S. 130A-196, shall be immediately sent to the State Laboratory of Public Health for rabies diagnosis."

SECTION 15. This act is effective when it becomes law.

SENATE BILL 674: Amend Rabies Laws

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	April 14, 2009
Introduced by:	Sen. Purcell	**Prepared by:**	Shawn Parker
Analysis of:	PCS to First Edition S674-CSSQ-17		Committee Staff

SUMMARY: ***Senate Bill 674 amends Part 6 (Rabies) of Article 6 (Communicable Diseases) of the Chapter 130A (Public Health law of North Carolina) of the General Statutes to include domestic ferrets to the provisions relating to rabies vaccinations for dogs and cats and to direct the Commission for Public Health to adopt rules establishing what information must be included on a rabies vaccination certificate. The bill authorizes the immediate euthanization of a stray or feral dog, cat, or ferret that has bitten a person.***

The Proposed Committee Substitute clarifies the definition of dog, feral, ferret, and stray by incorporating Adopted Amendment ASQ-16.

CURRENT LAW:

The owner of every dog and cat over four months of age shall have the animal vaccinated against rabies.[1] Each county shall have at least one rabies vaccination clinic per year for the purpose of vaccinating dogs and cats.[2] The Administer of the rabies vaccine issues a rabies vaccination tag to the owner of the vaccinated animal. Absent a local ordinance to the contrary, the animal shall wear the tag at all times.[3] Animal Control Officers are directed to canvass their county to determine if there are any dogs or cats not wearing the required rabies vaccination tag.

BILL ANALYSIS:

Senate Bill 674 adds the domestic ferret to the animals required to be vaccinated against rabies and makes conforming changes to this effect throughout Part 6 of Article 6 of Chapter 130A. *Current law applies only to dogs and cats.*

The bill authorizes registered veterinary technicians under the direct supervision of a licensed veterinarian to administer a rabies vaccine.

The bill authorizes county board of commissioners to establish an administrative fee to be charged at the county's rabies vaccination clinic. *Current law caps the administrative fee at $4.00*

The bill provides a dog, cat, or ferret that bites a person may be immediately euthanized, if the local health director or Animal Control Officer determines the animal is feral or a stray. The bill provides a definition for "Feral" and "Stray" to be applied throughout Part 6 of Article 6 of Chapter 130A.

EFFECTIVE DATE: This act is effective when it becomes law.

S674-SMSQ-38(CSSQ-17) v1

[1] G.S. 130A-185
[2] G.S. 130A-187
[3] G.S. 130A-190

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 674

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

S674-ASQ-38 [v.1]

Comm. Sub. [YES]
Amends Title [YES]
First Edition

Date April 15 ,2009

Senator Purcell

moves to amend the bill on page 1, line 5, by deleting the term "IMMEDIATELY";

and on page 3, lines 47-51, by rewriting the lines to read:
"give the name and address of the person bitten and the owner of the animal. All ~~dogs and cats~~dogs, cats, and ferrets that bite a person";

And on page 4, lines 1-2, by inserting in between the lines the following:
"However, in the event a stray or feral dog, cat, or ferret bites a person, the local agency responsible for animal control shall make a reasonable attempt to locate the owner of the animal. If the owner cannot be identified within 72 hours of the event the local health director may authorize the animal be euthanized and the head of the animal shall be immediately sent to the State Laboratory of Public Health for rabies diagnosis.".

SIGNED William N Purcell
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 674
PROPOSED COMMITTEE SUBSTITUTE S674-PCS75238-SQ-17

Short Title: Amend Rabies Laws. (Public)

Sponsors:

Referred to:

March 19, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND THE RABIES LAWS TO CONFORM WITH RECOMMENDATIONS FROM THE CENTERS FOR DISEASE CONTROL AND THE NATIONAL ASSOCIATION OF STATE PUBLIC HEALTH VETERINARIANS AND TO ALLOW STRAY OR FERAL ANIMALS TO BE EUTHANIZED AND TESTED FOR RABIES AFTER BITING A HUMAN.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 130A-184 reads as rewritten:

"**§ 130A-184. Definitions.**

The following definitions shall apply throughout this Part:

(1) 'Animal Control Officer' means a city or county employee designated as dog warden, animal control officer, animal control official or other designations that may be used whose responsibility includes animal control.

(2) 'Cat' means a domestic ~~feline.~~ feline of the genus and species Felis catus.

(3) 'Certified rabies vaccinator' means a person appointed and certified to administer rabies vaccine to animals in accordance with this Part.

(4) 'Dog' means a domestic ~~canine.~~ canine of the genus, species, and subspecies Canis lupus familiaris.

(4a) 'Feral' means any animal that is born in the wild and is not socialized; is the offspring of a dog, cat, or ferret that is owned or born in the wild and is not socialized; or is a formerly owned dog, cat, or ferret that has been abandoned and is no longer socialized.

(4b) 'Ferret' means a domestic mammal of the genus, species, and subspecies Mustela putorius furo.

(5) 'Rabies vaccine' means an animal rabies vaccine licensed by the United States Department of Agriculture and approved for use in this State by the Commission.

(6) 'State Public Health Veterinarian' means a person appointed by the Secretary to direct the State public health veterinary program.

(6a) 'Stray' means any animal that is (i) beyond the limits of confinement or lost and (ii) not wearing any tags, microchips, tattoos, or other methods of identification.

(7) 'Vaccination' means the administration of rabies vaccine by a licensed ~~veterinarian~~ veterinarian, by a registered veterinary technician under the

direct supervision of a licensed veterinarian, or by a certified rabies vaccinator."

SECTION 2. G.S. 130A-185(a) reads as rewritten:

"**§ 130A-185. Vaccination of all ~~dogs and cats.~~dogs, cats, and ferrets.**

(a) The owner of every ~~dog and cat~~ dog, cat, and ferret over four months of age shall have the animal vaccinated against rabies. The time or times of vaccination shall be established by the Commission. Rabies vaccine shall be administered only by a licensed ~~veterinarian~~ veterinarian, by a registered veterinary technician under the direct supervision of a licensed veterinarian, or by a certified rabies vaccinator."

SECTION 3. G.S. 130A-187 reads as rewritten:

"**§ 130A-187. County rabies vaccination clinics.**

The local health director shall organize or assist other county departments to organize at least one countywide rabies vaccination clinic per year for the purpose of vaccinating ~~dogs and cats.~~ dogs, cats, and ferrets. Public notice of the time and place of rabies vaccination clinics shall be published in a newspaper having general circulation within the area."

SECTION 4. G.S. 130A-188 reads as rewritten:

"**§ 130A-188. Fee for vaccination at county rabies vaccination clinics.**

The county board of commissioners is authorized to establish a fee to be charged at the county rabies vaccination clinics. The fee ~~shall~~ may include an administrative charge ~~not to exceed four dollars ($4.00) per vaccination,~~ and a charge for the actual cost of the vaccine, the vaccination certificate, and the rabies vaccination tag."

SECTION 5. G.S. 130A-189 reads as rewritten:

"**§ 130A-189. Rabies vaccination certificates.**

A licensed veterinarian or a certified rabies vaccinator who administers rabies vaccine to a ~~dog or cat~~ dog, cat, or ferret shall complete a ~~three copy~~ rabies vaccination certificate. The Commission shall adopt rules establishing the specific information required to be included on the certificate. ~~The~~An original rabies vaccination certificate shall be given to the owner of each ~~dog or cat~~ dog, cat, or ferret that receives rabies vaccine. ~~One~~A copy of the rabies vaccination certificate shall be retained by the licensed veterinarian or the certified rabies vaccinator. ~~The other~~ A copy shall also be given to the county agency responsible for animal control, provided the information given to the county agency shall not be used for commercial purposes."

SECTION 6. G.S. 130A-190(a) reads as rewritten:

"(a) Issuance. – A licensed veterinarian or a certified rabies vaccinator who administers rabies vaccine to a ~~dog or cat~~ dog, cat, or ferret shall issue a rabies vaccination tag to the owner of the animal. The rabies vaccination tag shall show the year issued, a vaccination number, the words "North Carolina" or the initials "N.C." and the words "rabies vaccine." ~~Dogs and cats~~Dogs, cats, and ferrets shall wear rabies vaccination tags at all times. However, cats and ferrets may be exempted from wearing the tags by local ordinance."

SECTION 7. G.S. 130A-192 reads as rewritten:

"**§ 130A-192. ~~Dogs and cats~~ Dogs, cats, and ferrets not wearing required rabies vaccination tags.**

The Animal Control Officer shall canvass the county to determine if there are any ~~dogs or cats~~dogs, cats, or ferrets not wearing the required rabies vaccination tag. If a ~~dog or cat~~dog, cat, or ferret is found not wearing the required tag, the Animal Control Officer shall check to see if the owner's identification can be found on the animal. If the animal is wearing an owner identification tag, or if the Animal Control Officer otherwise knows who the owner is, the Animal Control Officer shall notify the owner in writing to have the animal vaccinated against rabies and to produce the required rabies vaccination certificate to the Animal Control Officer within three days of the notification. If the animal is not wearing an owner identification tag and the Animal Control Officer does not otherwise know who the owner is, the Animal Control Officer may impound the animal. The duration of the impoundment of these animals shall be

established by the county board of commissioners, but the duration shall not be less than 72 hours. During the impoundment period, the Animal Control Officer shall make a reasonable effort to locate the owner of the animal. If the animal is not reclaimed by its owner during the impoundment period, the animal shall be disposed of in one of the following manners: returned to the owner; adopted as a pet by a new owner; sold to institutions within this State registered by the United States Department of Agriculture pursuant to the Federal Animal Welfare Act, as amended; or put to death by a procedure approved by the American Veterinary Medical Association, the Humane Society of the United States or of the American Humane Association. The Animal Control Officer shall maintain a record of all animals impounded under this section which shall include the date of impoundment, the length of impoundment, the method of disposal of the animal and the name of the person or institution to whom any animal has been released."

SECTION 8. G.S. 130A-193 reads as rewritten:

"**§ 130A-193. Vaccination and confinement of ~~dogs and cats~~dogs, cats, and ferrets brought into this State.**

(a) A ~~dog or cat~~dog, cat, or ferret brought into this State shall immediately be securely confined and shall be vaccinated against rabies within one week after entry. The animal shall remain confined for two weeks after vaccination.

(b) The provisions of subsection (a) shall not apply to:

(1) A ~~dog or cat~~dog, cat, or ferret brought into this State for exhibition purposes if the animal is confined and not permitted to run at large; or

(2) A ~~dog or cat~~dog, cat, or ferret brought into this State accompanied by a certificate issued by a licensed veterinarian showing that the ~~dog or cat~~dog, cat, or ferret is apparently free from and has not been exposed to rabies and that the ~~dog or cat has received rabies vaccine within the past year.~~dog, cat, or ferret is currently vaccinated against rabies."

SECTION 9. G.S. 130A-194 reads as rewritten:

"**§ 130A-194. Quarantine of districts infected with rabies.**

An area may be declared under quarantine against rabies by the local health director when the disease exists to the extent that the lives of persons are endangered. When quarantine is declared, each ~~dog and cat~~dog, cat, and ferret in the area shall be confined on the premises of the owner or in a veterinary hospital. However, ~~dogs or cats~~a dog, cat, or ferret on a leash or under the control and in the sight of a responsible adult may be permitted to leave the premises of the owner or the veterinary hospital."

SECTION 10. G.S. 130A-195 reads as rewritten:

"**§ 130A-195. Destroying stray dogs and cats in quarantine districts.**

When quarantine has been declared and ~~dogs and cats~~dogs, cats, and ferrets continue to run uncontrolled in the area, any peace officer or Animal Control Officer shall have the right, after reasonable effort has been made to apprehend the animals, to destroy the uncontrolled ~~dogs and cats~~dogs, cats, and ferrets and properly dispose of their bodies."

SECTION 11. G.S. 130A-196 reads as rewritten:

"**§ 130A-196. Confinement of all biting ~~dogs and cats~~dogs, cats, and ferrets; notice to local health director; reports by physicians; certain dogs exempt.**

When a person has been bitten by a ~~dog or cat,~~dog, cat, or ferret, the person or parent, guardian or person standing in loco parentis of the person, and the person owning the animal or in control or possession of the animal shall notify the local health director immediately and give the name and address of the person bitten and the owner of the animal. All ~~dogs and cats~~ dogs, cats, and ferrets that bite a person shall be immediately confined for 10 days in a place designated by the local health director. However, in the event a stray or feral dog, cat, or ferret bites a person, the local agency responsible for animal control shall make a reasonable attempt to locate the owner of the animal. If the owner cannot be identified within 72 hours of the event

the local health director may authorize the animal be euthanized and the head of the animal shall be immediately sent to the State Laboratory of Public Health for rabies diagnosis. However, the local health director may authorize a dog trained and used by a law enforcement agency to be released from confinement to perform official duties upon submission of proof that the dog has been vaccinated for rabies in compliance with this Part. After reviewing the circumstances of the particular case, the local health director may allow the owner to confine the animal on the owner's property. An owner who fails to confine ~~his~~ an animal in accordance with the instructions of the local health director shall be guilty of a Class 2 misdemeanor. If the owner or the person who controls or possesses a ~~dog or cat~~ dog, cat, or ferret that has bitten a person refuses to confine the animal as required by this section, the local health director may order seizure of the animal and its confinement for 10 days at the expense of the owner. A physician who attends a person bitten by an animal known to be a potential carrier of rabies shall report within 24 hours to the local health director the name, age and sex of that person."

SECTION 12. G.S. 130A-197 reads as rewritten:

"**§ 130A-197. Infected ~~dogs and cats~~dogs, cats, and ferrets to be destroyed; protection of vaccinated ~~dogs and cats.~~dogs, cats, and ferrets.**

When the local health director reasonably suspects that a ~~dog or cat~~dog, cat, or ferret has been exposed to the saliva or nervous tissue of a proven rabid animal or animal reasonably suspected of having rabies that is not available for laboratory diagnosis, the ~~dog or cat~~dog, cat, or ferret shall be considered to have been exposed to rabies. A ~~dog or cat~~dog, cat, or ferret exposed to rabies shall be destroyed immediately by its owner, the county Animal Control Officer or a peace officer unless the ~~dog or cat~~dog, cat, or ferret has been vaccinated against rabies in accordance with this Part and the rules of the Commission more than ~~three weeks~~ 28 days prior to being exposed, and is given a booster dose of rabies vaccine within ~~three~~five days of the exposure. As an alternative to destruction, the ~~dog or cat~~ dog, cat, or ferret may be quarantined at a facility approved by the local health director for a period up to six months, and under reasonable conditions imposed by the local health director."

SECTION 13. G.S. 130A-198 reads as rewritten:

"**§ 130A-198. Confinement.**

A person who owns or has possession of an animal which is suspected of having rabies shall immediately notify the local health director or county Animal Control Officer and shall securely confine the animal in a place designated by the local health director. ~~Dogs and cats~~Dogs, cats, and ferrets shall be confined for a period of 10 days. Other animals may be destroyed at the discretion of the State Public Health Veterinarian."

SECTION 14. G.S. 130A-199 reads as rewritten:

"**§ 130A-199. Rabid animals to be destroyed; heads to be sent to State Laboratory of Public Health.**

An animal diagnosed as having rabies by a licensed veterinarian shall be destroyed and its head sent to the State Laboratory of Public Health. The heads of all ~~dogs and cats~~dogs, cats, and ferrets that die during the 10-day confinement period required by G.S. 130A-196, shall be immediately sent to the State Laboratory of Public Health for rabies diagnosis."

SECTION 15. This act is effective when it becomes law.

SENATE BILL 1042*

Short Title:	Tech. & Org. Changes/Certain DHHS Facilities.	(Public)
Sponsors:	Senator Nesbitt.	
Referred to:	Health Care.	

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND ORGANIZATIONAL CHANGES TO THE LAW REGARDING THE LICENSURE AND INSPECTION OF FACILITIES FOR AGED AND DISABLED INDIVIDUALS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 131D of the General Statutes is amended by adding the following new Article to read:

"Article 1B.

"Licensing of Maternity Homes."

SECTION 1.(b) G.S. 131D-1 is recodified as G.S. 131D-10.10 under Article 1B of Chapter 131D of the General Statutes.

SECTION 1.(c) The title of Article 1 of Chapter 131D reads as rewritten:

"Article 1.

~~Licensing of Facilities.~~

Adult Care Homes."

SECTION 1.(d) G.S. 131D-2 is repealed.

SECTION 1.(e) Article 1 of Chapter 131D of the General Statutes, as amended by Section 1(c) of this act, is amended by adding the following new Parts to read:

"Part 1. Licensing.

"**§ 131D-2.1. Definitions.**

As used in this Article:

(1) "Abuse." – The willful or grossly negligent infliction of physical pain, injury, or mental anguish, unreasonable confinement, or the willful or grossly negligent deprivation by the administrator or staff of an adult care home of services which are necessary to maintain mental and physical health.

(2) "Administrator." – A person approved by the Department of Health and Human Services who has the responsibility for the total operation of a licensed domiciliary home.

(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. 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.

(4) "Amenities." – Services such as meals, housekeeping, transportation, and grocery shopping that do not involve hands-on personal care.

(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. 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. Housing programs for two or more unrelated adults that target their services to elderly or disabled persons in which the only services provided by the housing management, either directly or through an agreement or other arrangements, are amenities that include, at a minimum, one meal a day and housekeeping services, are exempt from licensure, but are required to be listed with the Division of Aging and Adult Services, providing information on their location and number of units operated. This type of housing is not considered assisted living. 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.

(6) "Compensatory agent." – A spouse, relative, or other caretaker who lives with a resident and provides care to a resident.

(7) "Department." – The Department of Health and Human Services unless some other meaning is clearly indicated from the context.

(8) "Exploitation." – The illegal or improper use of an aged or disabled resident or the aged or disabled resident's resources for another's profit or advantage.

(9) "Family care home." – An adult care home having two to six residents. The structure of a family care home may be no more than two stories high, and none of the aged or physically disabled persons being served there may be housed in the upper story without provision for two direct exterior ground-level accesses to the upper story.

(10) "Multiunit assisted housing with services." – An assisted living residence in which hands-on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement which makes personal care services accessible and available through at least one licensed home care or hospice agency. 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 established plan of care. Multiunit assisted housing with services programs are required to register with the Division of Health Service Regulation and to provide a disclosure statement. The disclosure statement is required to be a part of the annual rental contract that includes a description of the following requirements:

a. Emergency response system;
b. Charges for services offered;
c. Limitations of tenancy;
d. Limitations of services;
e. Resident responsibilities;
f. Financial/legal relationship between housing management and home care or hospice agencies;
g. A listing of all home care or hospice agencies and other community services in the area;
h. An appeals process; and
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, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

(11) "Neglect." – The failure to provide the services necessary to maintain a resident's physical or mental health.

(12) "Personal care services." – Any hands-on services allowed to be performed by In-Home Aides II or III as outlined in Department rules.

(13) "Registration." – The submission by a multiunit assisted housing with services provider of a disclosure statement containing all the information as outlined in subdivision (10) of this section.

(14) "Resident." – A person living in an assisted living residence for the purpose of obtaining access to housing and services provided or made available by housing management.

(15) "Secretary." – The Secretary of Health and Human Services unless some other meaning is clearly indicated from the context.

"**§ 131D-2.2. Persons not to be cared for in adult care homes and multiunit assisted housing with services; hospice care.**

(a) Adult Care Homes. – 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, adult care homes shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator dependency;
(2) Individuals requiring continuous licensed nursing care;
(3) Individuals whose physician certifies that placement is no longer appropriate;
(4) Individuals whose health needs cannot be met in the specific adult care home as determined by the residence; and
(5) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in an adult care home.

(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;
(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be 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;
(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;
(5) Psychotropic medications without appropriate diagnosis and treatment plans;
(6) Nasogastric 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;
(8) Individuals requiring continuous licensed nursing care;
(9) Individuals whose physician certifies that placement is no longer appropriate;
(10) Unless the individual's independent physician determines otherwise, 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;
(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the residence; and
(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services.

(c) Hospice Care. – At the request of the resident, hospice care may be provided in an assisted living residence under the same requirements for hospice programs as described in Article 10 of Chapter 131E of the General Statutes.

(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.

"**§ 131D-2.3. Exemptions from licensure.**

(a) The following are excluded from this Article and are not required to be registered or obtain licensure under this Article:

(1) Facilities licensed under Chapter 122C or Chapter 131E of the General Statutes;
(2) Persons subject to rules of the Division of Vocational Rehabilitation Services;
(3) Facilities that care for no more than four persons, all of whom are under the supervision of the United States Veterans Administration;

(4) Facilities that make no charges for housing, amenities, or personal care service, either directly or indirectly; and

(5) Institutions that are maintained or operated by a unit of government and that were established, maintained, or operated by a unit of government and exempt from licensure by the Department on September 30, 1995.

"**§ 131D-2.4. Licensure of adult care homes for aged and disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.**

(a) Licensure. – Except for those facilities exempt under G.S. 131D-2.3, the Department of Health and Human Services shall inspect and license all adult care homes. The Department shall issue a license for a facility not currently licensed as an adult care home for a period of six months. If the licensee demonstrates substantial compliance with Articles 1 and 3 of this Chapter and rules adopted thereunder, the Department shall issue a license for the balance of the calendar year.

(b) Compliance History Review. – Prior to issuing a new license or renewing an existing license, the Department shall conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its principals or affiliates, or otherwise demonstrates disregard for the health, safety, and welfare of residents in current or past facilities. The Department shall require compliance history information and make its determination according to rules adopted by the Medical Care Commission.

(c) Prior Violations. – No new license shall be issued for any adult care home to an applicant for licensure who:

(1) Was the owner, principal, or affiliate of a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 of the General Statutes that had its license revoked until one full year after the date of revocation;

(2) Is the owner, principal, or affiliate of an adult care home that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with the correction plan established pursuant to G.S. 131D-34 and substantial compliance has been certified by the Department;

(3) Is the owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provisional status as a result of Type A or Type B violations until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable; or

(4) Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C or Article 1 of Chapter 131D of the General Statutes or had its license summarily suspended or denied under Article 7 of Chapter 110 of the General Statutes until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

An applicant for new licensure may appeal a denial of certification of substantial compliance under subdivision (2) of this subsection by filing with the Department a request for review by the Secretary within 10 days of the date of denial of the certification. Within 10 days of receipt of the request for review, the Secretary shall issue to the applicant a written determination that either denies certification of substantial compliance or certifies substantial compliance. The decision of the Secretary is final.

(d) License Renewals. – License renewals shall be valid for one year from the date of renewal unless revoked earlier by the Secretary for failure to comply with any part of this

section or any rules adopted hereunder. Licenses shall be renewed annually upon filing and the Department's approval of the renewal application. The Department shall not renew a license if outstanding fees, fines, and penalties imposed by the State against the home have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration. The renewal application shall contain all necessary and reasonable information that the Department may require.

(e) In order for an adult care home to maintain its license, it shall not hinder or interfere with the proper performance of duty of a lawfully appointed community advisory committee, as defined by G.S. 131D-31 and G.S. 131D-32.

"**§ 131D-2.5. License fees.**

The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of two hundred fifty dollars ($250.00). The Department shall charge each adult care home with more than six beds a nonrefundable annual license fee in the amount of three hundred fifty dollars ($350.00) plus a nonrefundable annual per-bed fee of twelve dollars and fifty cents ($12.50).

"**§ 131D-2.6. Legal action by Department.**

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may, in the manner provided by law, maintain an action in the name of the State for injunction or other process against any person to restrain or prevent the establishment, conduct, management, or operation of an adult care home without a license. Such action shall be instituted in the superior court of the county in which any unlicensed activity has occurred or is occurring.

(b) If any person shall hinder the proper performance of duty of the Secretary or his representative in carrying out this section, the Secretary may institute an action in the superior court of the county in which the hindrance has occurred for injunctive relief against the continued hindrance, irrespective of all other remedies at law.

(c) Actions under this section shall be in accordance with Article 37 of Chapter 1 of the General Statutes and Rule 65 of the Rules of Civil Procedure.

"**§ 131D-2.7. Provisional license; license revocation.**

(a) Provisional License. – Except as otherwise provided in this section, the Department may amend a license by reducing it from a full license to a provisional license for a period of not more than 90 days whenever the Department finds that:

(1) The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles;

(2) There is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and

(3) There is a reasonable probability that the licensee will be able thereafter to remain in compliance with the licensure rules for the foreseeable future.

The Department may extend a provisional license for not more than one additional 90-day period upon finding that the licensee has made substantial progress toward remedying the licensure deficiencies that caused the license to be reduced to provisional status.

The Department may also issue a provisional license to a facility, pursuant to rules adopted by the Medical Care Commission, for substantial failure to comply with the provisions of this section or rules adopted pursuant to this section. Any facility wishing to contest the issuance of a provisional license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails written notice of the issuance of the provisional license.

(b) License Revocation. – The Department may revoke a license whenever:

(1) The Department finds that:

a. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and

b. It is not reasonably probable that the licensee can remedy the licensure deficiencies within a reasonable length of time; or

(2) The Department finds that:

a. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and

b. Although the licensee may be able to remedy the deficiencies within a reasonable time, it is not reasonably probable that the licensee will be able to remain in compliance with licensure rules for the foreseeable future; or

c. The licensee has failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles, and the failure to comply endangered the health, safety, or welfare of the patients in the facility.

"**§ 131D-2.8. Penalties.**

(a) Any individual or corporation that establishes, conducts, manages, or operates a facility subject to licensure under this section without a license is guilty of a Class 3 misdemeanor and, upon conviction, shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense.

(b) In addition, the Department may summarily suspend a license pursuant to G.S. 150B-3(c) whenever it finds substantial evidence of abuse, neglect, exploitation, or any condition which presents an imminent danger to the health and safety of any resident of the home. Any facility wishing to contest summary suspension of a license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of summary suspension to the licensee.

"**§§ 131D-2.9 and 2.10: Reserved for future codification purposes.**

"Part 2. Other Laws Pertaining to the Inspection and Operation of Adult Care Homes.

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

(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. The Division of Health Service Regulations shall inspect all adult care homes and adult care units in nursing homes on an annual basis. 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.

(b) Monitoring by County. – The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this monitoring and perform any required follow-up inspection. The county departments of social services shall document in a written report all on-site visits, including monitoring visits, revisits, and complaint investigations. The county departments of

social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit.

(c) State Review of County Compliance. – The Division of Health Service Regulation shall conduct and document annual reviews of the county departments of social services' performance. When monitoring is not done timely or there is failure to identify or document noncompliance, the Department may intervene in the particular service in question. Department intervention shall include one or more of the following activities:

(1) Sending staff of the Department to the county departments of social services to provide technical assistance and to monitor the services being provided by the facility.

(2) Advising county personnel as to appropriate policies and procedures.

(3) Establishing a plan of action to correct county performance.

The Secretary may determine that the Department shall assume the county's regulatory responsibility for the county's adult care homes.

"**§ 131D-2.12. Training requirements; county departments of social services.**

(a) The county departments of social services' adult home specialists and their supervisors shall complete:

(1) Eight hours of prebasic training within 60 days of employment;

(2) Thirty-two hours of basic training within six months of employment;

(3) Twenty-four hours of postbasic training within six months of the basic training program;

(4) A minimum of eight hours of complaint investigation training within six months of employment; and

(5) A minimum of 16 hours of statewide training annually by the Division of Health Service Regulation.

(b) The joint training requirements by the Department shall be as provided in G.S. 143B-139.5B.

"**§ 131D-2.13. Departmental duties.**

(a) Enforcement of Room Ventilation and Temperature. – The Department shall monitor regularly the enforcement of rules pertaining to air circulation, ventilation, and room temperature in resident living quarters. These rules shall include the requirement that air conditioning or at least one fan per resident bedroom and living and dining areas be provided when the temperature in the main center corridor exceeds 80 degrees Fahrenheit.

(b) Administrator Directory. – The Department shall keep an up-to-date directory of all persons who are administrators as defined in G.S. 131D-2.1.

(c) Departmental Complaint Hotline. – Adult care homes shall post the Division of Health Service Regulation's complaint hotline number conspicuously in a public place in the facility.

(d) Provider File. – The Department of Health and Human Services shall establish and maintain a provider file to record and monitor compliance histories of facilities, owners, operators, and affiliates of nursing homes and adult care homes.

(e) Report on Use of Restraint. – The Department shall report annually on October 1 to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by

the investigation to be related to the adult care home's use of physical restraint or physical hold.

"**§ 131D-2.14. Confidentiality.**

Notwithstanding G.S. 8-53 or any other law relating to confidentiality of communications between physician and patient, in the course of an inspection conducted under G.S. 131D-2.11:

(1) Department representatives may review any writing or other record concerning the admission, discharge, medication, care, medical condition, or history of any person who is or has been a resident of the facility being inspected, and

(2) Any person involved in giving care or treatment at or through the facility may disclose information to Department representatives unless the resident objects in writing to review of his records or disclosure of such information.

(3) The facility, its employees, and any other person interviewed in the course of an inspection shall be immune from liability for damages resulting from disclosure of any information to the Department. The Department shall not disclose:

a. Any confidential or privileged information obtained under this section unless the resident or his legal representative authorizes disclosure in writing or unless a court of competent jurisdiction orders disclosure, or

b. The name of anyone who has furnished information concerning a facility without that person's consent.

The Department shall institute appropriate policies and procedures to ensure that unauthorized disclosure does not occur. All confidential or privileged information obtained under this section and the names of persons providing such information shall be exempt from Chapter 132 of the General Statutes.

(4) Notwithstanding any law to the contrary, Chapter 132 of the General Statutes, the Public Records Law, applies to all records of the State Division of Social Services of the Department of Health and Human Services and of any county department of social services regarding inspections of domiciliary care facilities except for information in the records that is confidential or privileged, including medical records, or that contains the names of residents or complainants.

"**§ 131D-2.15. Resident assessments.**

(a) The Department shall ensure that facilities conduct and complete an assessment of each resident within 72 hours of 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. 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:

(1) Whether the appropriate assessment instrument was administered and interpreted correctly;

(2) Whether the facility is capable of providing the necessary services;

(3) Whether the service plan or care plan conforms to the results of an appropriately administered and interpreted assessment; and

(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.

"**§ 131D-2.16. Suspension of admissions.**

(a) In addition to the administrative penalties described in G.S. 131D-2.8, the Secretary may suspend the admission of any new residents to an adult care home where the conditions of the adult care home are detrimental to the health or safety of the residents. This 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.

(b) In imposing a suspension under this section, the Secretary shall consider the following factors:

(1) The degree of sanctions necessary to ensure compliance with this section and rules adopted hereunder; and

(2) The character and degree of impact of the conditions at the home on the health or safety of its residents.

(c) The Secretary of Health and Human Services shall adopt rules to implement this section.

(d) Any facility wishing to contest a suspension of admissions shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of suspension of admissions to the licensee.

"**§ 131D-2.17. 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, 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.

"**§ 131D-2.18. Impact on other laws; severability.**

(a) Nothing in this section shall be construed to supersede any federal or State antitrust, antikickback, or safe harbor laws or regulations.

(b) If any provisions of this section or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the section which can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

"**§ 131D-2.19. Application of other laws.**

(a) Certification of assisted living administrators shall be as provided under Article 20A of Chapter 90 of the General Statutes.

(b) Compliance with the Health Care Personnel Registry shall be as provided under G.S. 131E-256.

(c) Rules for the operation of the adult care portion of a combination home, as defined in G.S. 131E-101, shall be as provided in G.S. 131E-104."

SECTION 2. G.S. 131D-41 and G.S. 131D-42 are repealed.

SECTION 3. This act becomes effective October 1, 2009. Licenses issued pursuant to G.S. 131D-2 remain effective until the date of annual renewal at which time Part 1 of Article 1 of Chapter 131D of the General Statutes shall apply. In all other respects, beginning October 1, 2009, Part 1 of Article 1 of Chapter 131D shall apply to the operation of facilities currently licensed under G.S. 131D-2.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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SENATE BILL 1042*
PROPOSED COMMITTEE SUBSTITUTE S1042-CSSQ-16 [v.1]

4/14/2009 10:44:41 AM

Short Title: Tech. & Org. Changes/Certain DHHS Facilities. (Public)

Sponsors:

Referred to:

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND ORGANIZATIONAL CHANGES TO THE LAW REGARDING THE LICENSURE AND INSPECTION OF FACILITIES FOR AGED AND DISABLED INDIVIDUALS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 131D of the General Statutes is amended by adding the following new Article to read:

"Article 1B.
"Licensing of Maternity Homes."

SECTION 1.(b) G.S. 131D-1 is recodified as G.S. 131D-10.10 under Article 1B of Chapter 131D of the General Statutes.

SECTION 1.(c) The title of Article 1 of Chapter 131D reads as rewritten:

"Article 1.
~~Licensing of Facilities.~~
Adult Care Homes."

SECTION 1.(d) G.S. 131D-2 is repealed.

SECTION 1.(e) Article 1 of Chapter 131D of the General Statutes, as amended by Section 1(c) of this act, is amended by adding the following new Parts to read:

"Part 1. Licensing.

"**§ 131D-2.1. Definitions.**

As used in this Article:

(1) "Abuse." – The willful or grossly negligent infliction of physical pain, injury, or mental anguish, unreasonable confinement, or the willful or grossly negligent deprivation by the administrator or staff of an adult care home of services which are necessary to maintain mental and physical health.

(2) "Administrator." – A person approved by the Department of Health and Human Services who has the responsibility for the total operation of a licensed domiciliary home.

(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. 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.

(4) "Amenities." – Services such as meals, housekeeping, transportation, and grocery shopping that do not involve hands-on personal care.

(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. 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. Housing programs for two or more unrelated adults that target their services to elderly or disabled persons in which the only services provided by the housing management, either directly or through an agreement or other arrangements, are amenities that include, at a minimum, one meal a day and housekeeping services, are exempt from licensure, but are required to be listed with the Division of Aging and Adult Services, providing information on their location and number of units operated. This type of housing is not considered assisted living. 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.

(6) "Compensatory agent." – A spouse, relative, or other caretaker who lives with a resident and provides care to a resident.

(7) "Department." – The Department of Health and Human Services unless some other meaning is clearly indicated from the context.

(8) "Exploitation." – The illegal or improper use of an aged or disabled resident or the aged or disabled resident's resources for another's profit or advantage.

(9) "Family care home." – An adult care home having two to six residents. The structure of a family care home may be no more than two stories high, and none of the aged or physically disabled persons being served there may be housed in the upper story without provision for two direct exterior ground-level accesses to the upper story.

(10) "Multiunit assisted housing with services." – An assisted living residence in which hands-on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement which makes personal care services accessible and available

through at least one licensed home care or hospice agency. 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 established plan of care. Multiunit assisted housing with services programs are required to register annually with the Division of Health Service Regulation. The Department shall charge each registered multiunit assisted housing with services program a nonrefundable annual registration fee of three hundred and fifty dollars ($350.00). Any individual or corporation that establishes, conducts, manages, or operates a multiunit housing with services program, subject to registration under this section, that fails to register is guilty of a Class 3 misdemeanor, and upon conviction shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense. 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 the following requirements:

a. Emergency response system;
b. Charges for services offered;
c. Limitations of tenancy;
d. Limitations of services;
e. Resident responsibilities;
f. Financial/legal relationship between housing management and home care or hospice agencies;
g. A listing of all home care or hospice agencies and other community services in the area;
h. An appeals process; and
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, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

(11) "Neglect." – The failure to provide the services necessary to maintain a resident's physical or mental health.

(12) "Personal care services." – Any hands-on services allowed to be performed by In-Home Aides II or III as outlined in Department rules.

(13) "Registration." – The submission by a multiunit assisted housing with services provider of a disclosure statement containing all the information as outlined in subdivision (10) of this section.

(14) "Resident." – A person living in an assisted living residence for the purpose of obtaining access to housing and services provided or made available by housing management.

(15) "Secretary." – The Secretary of Health and Human Services unless some other meaning is clearly indicated from the context.

"**§ 131D-2.2. Persons not to be cared for in adult care homes and multiunit assisted housing with services; hospice care.**

(a) Adult Care Homes. – 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, adult care homes shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator dependency;
(2) Individuals requiring continuous licensed nursing care;
(3) Individuals whose physician certifies that placement is no longer appropriate;
(4) Individuals whose health needs cannot be met in the specific adult care home as determined by the residence; and
(5) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in an adult care home.

(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;
(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be 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;
(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;
(5) Psychotropic medications without appropriate diagnosis and treatment plans;
(6) Nasogastric 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;
(8) Individuals requiring continuous licensed nursing care;
(9) Individuals whose physician certifies that placement is no longer appropriate;
(10) Unless the individual's independent physician determines otherwise, 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;
(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the residence; and
(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services.

(c) Hospice Care. – At the request of the resident, hospice care may be provided in an assisted living residence under the same requirements for hospice programs as described in Article 10 of Chapter 131E of the General Statutes.

(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.

"**§ 131D-2.3. Exemptions from licensure.**

(a) The following are excluded from this Article and are not required to be registered or obtain licensure under this Article:

(1) Facilities licensed under Chapter 122C or Chapter 131E of the General Statutes;

(2) Persons subject to rules of the Division of Vocational Rehabilitation Services;

(3) Facilities that care for no more than four persons, all of whom are under the supervision of the United States Veterans Administration;

(4) Facilities that make no charges for housing, amenities, or personal care service, either directly or indirectly; and

(5) Institutions that are maintained or operated by a unit of government and that were established, maintained, or operated by a unit of government and exempt from licensure by the Department on September 30, 1995.

"**§ 131D-2.4. Licensure of adult care homes for aged and disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.**

(a) Licensure. – Except for those facilities exempt under G.S. 131D-2.3, the Department of Health and Human Services shall inspect and license all adult care homes. The Department shall issue a license for a facility not currently licensed as an adult care home for a period of six months. If the licensee demonstrates substantial compliance with Articles 1 and 3 of this Chapter and rules adopted thereunder, the Department shall issue a license for the balance of the calendar year.

(b) Compliance History Review. – Prior to issuing a new license or renewing an existing license, the Department shall conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its principals or affiliates, or otherwise demonstrates disregard for the health, safety, and welfare of residents in current or past facilities. The Department shall require compliance history information and make its determination according to rules adopted by the Medical Care Commission.

(c) Prior Violations. – No new license shall be issued for any adult care home to an applicant for licensure who:

(1) Was the owner, principal, or affiliate of a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 of the General Statutes that had its license revoked until one full year after the date of revocation;

(2) Is the owner, principal, or affiliate of an adult care home that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with the correction plan established pursuant to G.S. 131D-34 and substantial compliance has been certified by the Department;

(3) Is the owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provisional status as a result of Type A or Type B violations until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable; or

(4) Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C or Article 1 of Chapter 131D of the General Statutes or had its license summarily suspended or denied under Article 7 of Chapter 110 of the General Statutes until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

An applicant for new licensure may appeal a denial of certification of substantial compliance under subdivision (2) of this subsection by filing with the Department a request for review by the Secretary within 10 days of the date of denial of the certification. Within 10 days of receipt of the request for review, the Secretary shall issue to the applicant a written determination that either denies certification of substantial compliance or certifies substantial compliance. The decision of the Secretary is final.

(d) License Renewals. – License renewals shall be valid for one year from the date of renewal unless revoked earlier by the Secretary for failure to comply with any part of this section or any rules adopted hereunder. Licenses shall be renewed annually upon filing and the Department's approval of the renewal application. The Department shall not renew a license if outstanding fees, fines, and penalties imposed by the State against the home have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration. The renewal application shall contain all necessary and reasonable information that the Department may require.

(e) In order for an adult care home to maintain its license, it shall not hinder or interfere with the proper performance of duty of a lawfully appointed community advisory committee, as defined by G.S. 131D-31 and G.S. 131D-32.

"**§ 131D-2.5. License fees.**

The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of two hundred fifty dollars ($250.00). The Department shall charge each adult care home with more than six beds a nonrefundable annual license fee in the amount of three hundred fifty dollars ($350.00) plus a nonrefundable annual per-bed fee of twelve dollars and fifty cents ($12.50).

"**§ 131D-2.6. Legal action by Department.**

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may, in the manner provided by law, maintain an action in the name of the State for injunction or other process against any person to restrain or prevent the establishment, conduct, management, or operation of an adult care home without a license. Such action shall be instituted in the superior court of the county in which any unlicensed activity has occurred or is occurring.

(b) If any person shall hinder the proper performance of duty of the Secretary or his representative in carrying out this section, the Secretary may institute an action in the superior court of the county in which the hindrance has occurred for injunctive relief against the continued hindrance, irrespective of all other remedies at law.

(c) Actions under this section shall be in accordance with Article 37 of Chapter 1 of the General Statutes and Rule 65 of the Rules of Civil Procedure.

"**§ 131D-2.7. Provisional license; license revocation.**

(a) Provisional License. – Except as otherwise provided in this section, the Department may amend a license by reducing it from a full license to a provisional license for a period of not more than 90 days whenever the Department finds that:

(1) The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles;

(2) There is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and

(3) There is a reasonable probability that the licensee will be able thereafter to remain in compliance with the licensure rules for the foreseeable future.

The Department may extend a provisional license for not more than one additional 90-day period upon finding that the licensee has made substantial progress toward remedying the licensure deficiencies that caused the license to be reduced to provisional status.

The Department may also issue a provisional license to a facility, pursuant to rules adopted by the Medical Care Commission, for substantial failure to comply with the provisions of this section or rules adopted pursuant to this section. Any facility wishing to contest the issuance of a provisional license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails written notice of the issuance of the provisional license.

(b) License Revocation. – The Department may revoke a license whenever:

(1) The Department finds that:

a. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and

b. It is not reasonably probable that the licensee can remedy the licensure deficiencies within a reasonable length of time; or

(2) The Department finds that:

a. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and

b. Although the licensee may be able to remedy the deficiencies within a reasonable time, it is not reasonably probable that the licensee will be able to remain in compliance with licensure rules for the foreseeable future; or

c. The licensee has failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles, and the failure to comply endangered the health, safety, or welfare of the patients in the facility.

"**§ 131D-2.8. Penalties.**

(a) Any individual or corporation that establishes, conducts, manages, or operates a facility subject to licensure under this section without a license is guilty of a Class 3 misdemeanor and, upon conviction, shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense.

(b) In addition, the Department may summarily suspend a license pursuant to G.S. 150B-3(c) whenever it finds substantial evidence of abuse, neglect, exploitation, or any condition which presents an imminent danger to the health and safety of any resident of the home. Any facility wishing to contest summary suspension of a license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of summary suspension to the licensee.

"**§§ 131D-2.9 and 2.10: Reserved for future codification purposes.**

"Part 2. Other Laws Pertaining to the Inspection and Operation of Adult Care Homes.

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

(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. The Division of Health Service Regulations shall inspect all adult care homes and adult care units in nursing homes on an annual basis. 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.

(b) Monitoring by County. – The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this monitoring and perform any required follow-up inspection. The county departments of social services shall document in a written report all on-site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit.

(c) State Review of County Compliance. – The Division of Health Service Regulation shall conduct and document annual reviews of the county departments of social services' performance. When monitoring is not done timely or there is failure to identify or document noncompliance, the Department may intervene in the particular service in question. Department intervention shall include one or more of the following activities:

(1) Sending staff of the Department to the county departments of social services to provide technical assistance and to monitor the services being provided by the facility.

(2) Advising county personnel as to appropriate policies and procedures.

(3) Establishing a plan of action to correct county performance.

The Secretary may determine that the Department shall assume the county's regulatory responsibility for the county's adult care homes.

"**§ 131D-2.12. Training requirements; county departments of social services.**

(a) The county departments of social services' adult home specialists and their supervisors shall complete:

(1) Eight hours of prebasic training within 60 days of employment;

(2) Thirty-two hours of basic training within six months of employment;

(3) Twenty-four hours of postbasic training within six months of the basic training program;

(4) A minimum of eight hours of complaint investigation training within six months of employment; and

(5) A minimum of 16 hours of statewide training annually by the Division of Health Service Regulation.

(b) The joint training requirements by the Department shall be as provided in G.S. 143B-139.5B.

"**§ 131D-2.13. Departmental duties.**

(a) Enforcement of Room Ventilation and Temperature. – The Department shall monitor regularly the enforcement of rules pertaining to air circulation, ventilation, and room temperature in resident living quarters. These rules shall include the requirement that air conditioning or at least one fan per resident bedroom and living and dining areas be provided when the temperature in the main center corridor exceeds 80 degrees Fahrenheit.

(b) Administrator Directory. – The Department shall keep an up-to-date directory of all persons who are administrators as defined in G.S. 131D-2.1.

(c) Departmental Complaint Hotline. – Adult care homes shall post the Division of Health Service Regulation's complaint hotline number conspicuously in a public place in the facility.

(d) Provider File. – The Department of Health and Human Services shall establish and maintain a provider file to record and monitor compliance histories of facilities, owners, operators, and affiliates of nursing homes and adult care homes.

(e) Report on Use of Restraint. – The Department shall report annually on October 1 to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by the investigation to be related to the adult care home's use of physical restraint or physical hold.

"**§ 131D-2.14. Confidentiality.**

Notwithstanding G.S. 8-53 or any other law relating to confidentiality of communications between physician and patient, in the course of an inspection conducted under G.S. 131D-2.11:

(1) Department representatives may review any writing or other record concerning the admission, discharge, medication, care, medical condition, or history of any person who is or has been a resident of the facility being inspected, and

(2) Any person involved in giving care or treatment at or through the facility may disclose information to Department representatives unless the resident objects in writing to review of his records or disclosure of such information.

(3) The facility, its employees, and any other person interviewed in the course of an inspection shall be immune from liability for damages resulting from disclosure of any information to the Department. The Department shall not disclose:

a. Any confidential or privileged information obtained under this section unless the resident or his legal representative authorizes disclosure in writing or unless a court of competent jurisdiction orders disclosure, or

b. The name of anyone who has furnished information concerning a facility without that person's consent.

The Department shall institute appropriate policies and procedures to ensure that unauthorized disclosure does not occur. All confidential or privileged information obtained under this section and the names of persons providing such information shall be exempt from Chapter 132 of the General Statutes.

(4) Notwithstanding any law to the contrary, Chapter 132 of the General Statutes, the Public Records Law, applies to all records of the State Division of Social Services of the Department of Health and Human Services and of any county department of social services regarding inspections of domiciliary care facilities except for information in the records that is confidential or privileged, including medical records, or that contains the names of residents or complainants.

"**§ 131D-2.15. Resident assessments.**

(a) The Department shall ensure that facilities conduct and complete an assessment of each resident within 72 hours of 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. 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:

(1) Whether the appropriate assessment instrument was administered and interpreted correctly;

(2) Whether the facility is capable of providing the necessary services;

(3) Whether the service plan or care plan conforms to the results of an appropriately administered and interpreted assessment; and

(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.

"**§ 131D-2.16. Suspension of admissions.**

(a) In addition to the administrative penalties described in G.S. 131D-2.8, the Secretary may suspend the admission of any new residents to an adult care home where the conditions of the adult care home are detrimental to the health or safety of the residents. This 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.

(b) In imposing a suspension under this section, the Secretary shall consider the following factors:

(1) The degree of sanctions necessary to ensure compliance with this section and rules adopted hereunder; and

(2) The character and degree of impact of the conditions at the home on the health or safety of its residents.

(c) The Secretary of Health and Human Services shall adopt rules to implement this section.

(d) Any facility wishing to contest a suspension of admissions shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of suspension of admissions to the licensee.

"**§ 131D-2.17. 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, 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.

"**§ 131D-2.18. Impact on other laws; severability.**

(a) Nothing in this section shall be construed to supersede any federal or State antitrust, antikickback, or safe harbor laws or regulations.

(b) If any provisions of this section or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the section which can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

"**§ 131D-2.19. Application of other laws.**

(a) Certification of assisted living administrators shall be as provided under Article 20A of Chapter 90 of the General Statutes.

(b) Compliance with the Health Care Personnel Registry shall be as provided under G.S. 131E-256.

(c) Rules for the operation of the adult care portion of a combination home, as defined in G.S. 131E-101, shall be as provided in G.S. 131E-104."

SECTION 2. G.S. 131D-41 and G.S. 131D-42 are repealed.

SECTION 3. This act becomes effective October 1, 2009. Licenses issued pursuant to G.S. 131D-2 remain effective until the date of annual renewal at which time Part 1 of Article 1 of Chapter 131D of the General Statutes shall apply. In all other respects, beginning October 1, 2009, Part 1 of Article 1 of Chapter 131D shall apply to the operation of facilities currently licensed under G.S. 131D-2.

SENATE BILL 1042:
Tech. & Org. Changes/Certain DHHS Facilities

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	**Date:**	April 14, 2009
Introduced by:	Sen. Nesbitt	**Prepared by:**	Shawn Parker Committee Staff
Analysis of:	PCS to First Edition S1042-CSSQ-16		

SUMMARY: ***Senate Bill 1042 makes technical and organizational changes to the laws regarding licensure and inspection of facilities for aged and disabled individuals.***

The Proposed Committee Substitute incorporates S.L. 2008-166 which required multiunit housing with services programs to register annually and to pay a registration fee. This requirement is recodified within proposed G.S. 131D-2.1(10).

[As introduced, this bill was identical to H456, as introduced by Reps. Insko, England, Farmer-Butterfield, Earle, which is currently in House Aging, if favorable, Judiciary II.]

BILL ANALYSIS:

Section 1(a) and (b) of House Bill 456 pertain to statutory revisions for Maternity Homes.

- Section 1(a) of the bill adds the title of a new Article, Article 1B. Licensing of Maternity Homes, to Chapter 131D of the General Statutes.
- Section 1(b) recodifies G.S. 131D-1 as G.S. 131D-10.10 to place the contents which pertain to the licensing of maternity homes under the new Article 1B.

Section 1(c) changes the title of Article 1 of Chapter 131D from "Licensing of Facilities" to "Adult Care Homes".

The statutory revisions contained in Sections 1(d) and (e) and Section 2 of the bill are depicted in the chart below:

Statute Section Title Used in Section 1(e) of SB 1042	Statutory Section Added by Section 1(e) of SB1042	Cross Reference to Current Law and Repeal of Current Law	Additional Information on Change
Definitions	GS 131D-2.1 *proposed*	GS 131D-2 *Repealed by Sec. 1(d) of the bill.*	Renumbers defined terms
Persons not to be cared for in adult care homes & multiunit assisted housing with services; hospice care	GS 131D-2.2 *proposed*	GS 131D-2(a1), GS 131D-2(a2), GS 131D-2(a3), GS 131D-2(c1) *Repealed by Sec. 1(d) of the bill.*	Reorganizes; Section (d) in proposed GS 131D-2.2 - Obtaining services rewritten from original language in GS 131D-2(c1)
Exemptions from licensure	GS 131D-2.3 *proposed*	GS 131D-2(c) *Repealed by Sec. 1(d) of the bill.*	

Licensure of adult care homes for aged & disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.	GS 131D-2.4 *proposed*	GS 131D-2(b)(1), GS 131D-2(b)(6), GS 131D-2(b1) *Repealed by Sec. 1(d) of the bill.*	
License fees	GS 131D-2.5 *proposed*	GS 131D-2(b)(1) *Repealed by Sec. 1(d) of the bill.*	
Legal action by department	GS 131D-2.6 *proposed*	GS 131D-2(i) *Repealed by Sec. 1(d) of the bill.*	
Provisional license; license revocation	GS 131D-2.7 *proposed*	GS 131D-2(b)(1) *Repealed by Sec. 1(d) of the bill.*	
Penalties	GS 131D-2.8 *proposed*	GS 131D-2(b)(2), GS 131D-2(b)(3) *Repealed by Sec. 1(d) of the bill.*	
Inspections, monitoring, and review by State agency and county departments of social services	GS 131D-2.11 *proposed*	GS 131D-2(b)(1a) *Repealed by Sec. 1(d) of the bill.*	
Training requirements; county departments of social services	GS 131D-2.12 *proposed*	GS 131D-2(b)(1a)(d) *Repealed by Sec. 1(d) of the bill.*	Proposed GS 131D-2.12(b) new language that references joint training requirements by the Department in GS 143B-139.5B
Departmental duties	GS 131D-2.13(a), GS 131D -2.13(b), GS 131D-2.13(c), GS 131D-2.13(d), GS 131D-2.13(e) *All proposed*	GS 131D-2(b)(1a)(e), GS 131D-2(b)(1a)(f), GS 131D-2(j) *Repealed by Sec. 1(d) of the bill.* GS 131D-41, GS 131D-42 *Repealed by Sec. 2 of the bill.*	
Confidentiality	GS 131D-2.14 *proposed*	GS 131D-2(b)(4) *Repealed by Sec. 1(d) of the bill.*	
Resident assessments	GS 131D-2.15 *proposed*	GS 131D-2(e) *Repealed by Sec. 1(d) of the bill.*	
Suspension of admissions	GS 131D-2.16 *proposed*	GS 131D-2(h) *Repealed by Sec. 1(d) of the bill.*	
Rules	GS 131D-2.17 *proposed*	GS 131D-2(c2) *Repealed by Sec. 1(d) of the bill.*	
Impact on other laws; severability	GS 131D-2.18 *proposed*	GS 131D-2(c3), GS 131D-2(f) *Repealed by Sec. 1(d) of the bill.*	
Application of other laws	GS 131D-2.19 *proposed*	N/A	

EFFECTIVE DATE:

This act becomes effective October 1, 2009. Licenses issued pursuant to G.S. 131D-2 remain effective until the date of annual renewal at which time Part 1 of Article 1 of Chapter 131D of the General Statutes shall apply. In all other respects, beginning October 1, 2009, Part 1 of Article 1 of Chapter 131D shall apply to the operation of facilities currently licensed under G.S. 131D-2.

BACKGROUND: Senate Bill 915 received a favorable report in the Senate Health Care Committee on March 19, 2007. The provisions of Senate Bill 1042 are substantially equivalent to the provisions in Senate Bill 915.

Theresa Matula substantially contributed to this summary.

S1042-SMSQ-39(CSSQ-16) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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SENATE BILL 1042*
PROPOSED COMMITTEE SUBSTITUTE S1042-PCS55337-SQ-16

Short Title: Tech. & Org. Changes/Certain DHHS Facilities. (Public)

Sponsors:

Referred to:

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND ORGANIZATIONAL CHANGES TO THE LAW REGARDING THE LICENSURE AND INSPECTION OF FACILITIES FOR AGED AND DISABLED INDIVIDUALS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 131D of the General Statutes is amended by adding the following new Article to read:

"Article 1B.
"Licensing of Maternity Homes."

SECTION 1.(b) G.S. 131D-1 is recodified as G.S. 131D-10.10 under Article 1B of Chapter 131D of the General Statutes.

SECTION 1.(c) The title of Article 1 of Chapter 131D of the General Statutes reads as rewritten:

"Article 1.
~~Licensing of Facilities.~~
Adult Care Homes."

SECTION 1.(d) G.S. 131D-2 is repealed.

SECTION 1.(e) Article 1 of Chapter 131D of the General Statutes, as amended by Section 1(c) of this act, is amended by adding the following new Parts to read:

"Part 1. Licensing.

"**§ 131D-2.1. Definitions.**

As used in this Article:

(1) Abuse. – The willful or grossly negligent infliction of physical pain, injury, or mental anguish, unreasonable confinement, or the willful or grossly negligent deprivation by the administrator or staff of an adult care home of services which are necessary to maintain mental and physical health.

(2) Administrator. – A person approved by the Department of Health and Human Services who has the responsibility for the total operation of a licensed domiciliary home.

(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. 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.

(4) Amenities. – Services such as meals, housekeeping, transportation, and grocery shopping that do not involve hands-on personal care.

(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. 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. Housing programs for two or more unrelated adults that target their services to elderly or disabled persons in which the only services provided by the housing management, either directly or through an agreement or other arrangements, are amenities that include, at a minimum, one meal a day and housekeeping services, are exempt from licensure, but are required to be listed with the Division of Aging and Adult Services, providing information on their location and number of units operated. This type of housing is not considered assisted living. 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.

(6) Compensatory agent. – A spouse, relative, or other caretaker who lives with a resident and provides care to a resident.

(7) Department. – The Department of Health and Human Services unless some other meaning is clearly indicated from the context.

(8) Exploitation. – The illegal or improper use of an aged or disabled resident or the aged or disabled resident's resources for another's profit or advantage.

(9) Family care home. – An adult care home having two to six residents. The structure of a family care home may be no more than two stories high, and none of the aged or physically disabled persons being served there may be housed in the upper story without provision for two direct exterior ground-level accesses to the upper story.

(10) Multiunit assisted housing with services. – An assisted living residence in which hands-on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement which makes personal care services accessible and available

through at least one licensed home care or hospice agency. 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 established plan of care. Multiunit assisted housing with services programs are required to register annually with the Division of Health Service Regulation. The Department shall charge each registered multiunit assisted housing with services program a nonrefundable annual registration fee of three hundred fifty dollars ($350.00). Any individual or corporation that establishes, conducts, manages, or operates a multiunit housing with services program, subject to registration under this section, that fails to register is guilty of a Class 3 misdemeanor and, upon conviction shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense. 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 the following requirements:

a. Emergency response system;
b. Charges for services offered;
c. Limitations of tenancy;
d. Limitations of services;
e. Resident responsibilities;
f. Financial/legal relationship between housing management and home care or hospice agencies;
g. A listing of all home care or hospice agencies and other community services in the area;
h. An appeals process; and
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, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

(11) Neglect. – The failure to provide the services necessary to maintain a resident's physical or mental health.

(12) Personal care services. – Any hands-on services allowed to be performed by In-Home Aides II or III as outlined in Department rules.

(13) Registration. – The submission by a multiunit assisted housing with services provider of a disclosure statement containing all the information as outlined in subdivision (10) of this section.

(14) Resident. – A person living in an assisted living residence for the purpose of obtaining access to housing and services provided or made available by housing management.

(15) Secretary. – The Secretary of Health and Human Services unless some other meaning is clearly indicated from the context.

"§ 131D-2.2. Persons not to be cared for in adult care homes and multiunit assisted housing with services; hospice care.

(a) Adult Care Homes. – 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, adult care homes shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator dependency;
(2) Individuals requiring continuous licensed nursing care;
(3) Individuals whose physician certifies that placement is no longer appropriate;
(4) Individuals whose health needs cannot be met in the specific adult care home as determined by the residence; and
(5) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in an adult care home.

(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;
(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be 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;
(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;
(5) Psychotropic medications without appropriate diagnosis and treatment plans;
(6) Nasogastric 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;
(8) Individuals requiring continuous licensed nursing care;
(9) Individuals whose physician certifies that placement is no longer appropriate;
(10) Unless the individual's independent physician determines otherwise, 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;
(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the residence; and
(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services.

(c) Hospice Care. – At the request of the resident, hospice care may be provided in an assisted living residence under the same requirements for hospice programs as described in Article 10 of Chapter 131E of the General Statutes.

(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.

"**§ 131D-2.3. Exemptions from licensure.**

(a) The following are excluded from this Article and are not required to be registered or obtain licensure under this Article:

(1) Facilities licensed under Chapter 122C or Chapter 131E of the General Statutes;

(2) Persons subject to rules of the Division of Vocational Rehabilitation Services;

(3) Facilities that care for no more than four persons, all of whom are under the supervision of the United States Veterans Administration;

(4) Facilities that make no charges for housing, amenities, or personal care service, either directly or indirectly; and

(5) Institutions that are maintained or operated by a unit of government and that were established, maintained, or operated by a unit of government and exempt from licensure by the Department on September 30, 1995.

"**§ 131D-2.4. Licensure of adult care homes for aged and disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.**

(a) Licensure. – Except for those facilities exempt under G.S. 131D-2.3, the Department of Health and Human Services shall inspect and license all adult care homes. The Department shall issue a license for a facility not currently licensed as an adult care home for a period of six months. If the licensee demonstrates substantial compliance with Articles 1 and 3 of this Chapter and rules adopted thereunder, the Department shall issue a license for the balance of the calendar year.

(b) Compliance History Review. – Prior to issuing a new license or renewing an existing license, the Department shall conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its principals or affiliates, or otherwise demonstrates disregard for the health, safety, and welfare of residents in current or past facilities. The Department shall require compliance history information and make its determination according to rules adopted by the Medical Care Commission.

(c) Prior Violations. – No new license shall be issued for any adult care home to an applicant for licensure who:

(1) Was the owner, principal, or affiliate of a licensable facility under Chapter 122C, Chapter 131D, or Article 7 of Chapter 110 of the General Statutes that had its license revoked until one full year after the date of revocation;

(2) Is the owner, principal, or affiliate of an adult care home that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with the correction plan established pursuant to G.S. 131D-34 and substantial compliance has been certified by the Department;

(3) Is the owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provisional status as a result of Type A or Type B violations until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable; or

(4) Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under Chapter 122C or Article 1 of Chapter 131D of the General Statutes or had its license summarily suspended or denied under Article 7 of Chapter 110 of the General Statutes until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

An applicant for new licensure may appeal a denial of certification of substantial compliance under subdivision (2) of this subsection by filing with the Department a request for review by the Secretary within 10 days of the date of denial of the certification. Within 10 days of receipt of the request for review, the Secretary shall issue to the applicant a written determination that either denies certification of substantial compliance or certifies substantial compliance. The decision of the Secretary is final.

(d) License Renewals. – License renewals shall be valid for one year from the date of renewal unless revoked earlier by the Secretary for failure to comply with any part of this section or any rules adopted hereunder. Licenses shall be renewed annually upon filing and the Department's approval of the renewal application. The Department shall not renew a license if outstanding fees, fines, and penalties imposed by the State against the home have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration. The renewal application shall contain all necessary and reasonable information that the Department may require.

(e) In order for an adult care home to maintain its license, it shall not hinder or interfere with the proper performance of duty of a lawfully appointed community advisory committee, as defined by G.S. 131D-31 and G.S. 131D-32.

"**§ 131D-2.5. License fees.**

The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of two hundred fifty dollars ($250.00). The Department shall charge each adult care home with more than six beds a nonrefundable annual license fee in the amount of three hundred fifty dollars ($350.00) plus a nonrefundable annual per-bed fee of twelve dollars and fifty cents ($12.50).

"**§ 131D-2.6. Legal action by Department.**

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may, in the manner provided by law, maintain an action in the name of the State for injunction or other process against any person to restrain or prevent the establishment, conduct, management, or operation of an adult care home without a license. Such action shall be instituted in the superior court of the county in which any unlicensed activity has occurred or is occurring.

(b) If any person shall hinder the proper performance of duty of the Secretary or the Secretary's representative in carrying out this section, the Secretary may institute an action in the superior court of the county in which the hindrance has occurred for injunctive relief against the continued hindrance, irrespective of all other remedies at law.

(c) Actions under this section shall be in accordance with Article 37 of Chapter 1 of the General Statutes and Rule 65 of the Rules of Civil Procedure.

"**§ 131D-2.7. Provisional license; license revocation.**

(a) Provisional License. – Except as otherwise provided in this section, the Department may amend a license by reducing it from a full license to a provisional license for a period of not more than 90 days whenever the Department finds that:

(1) The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles;

(2) There is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and

(3) There is a reasonable probability that the licensee will be able thereafter to remain in compliance with the licensure rules for the foreseeable future.

The Department may extend a provisional license for not more than one additional 90-day period upon finding that the licensee has made substantial progress toward remedying the licensure deficiencies that caused the license to be reduced to provisional status.

The Department also may issue a provisional license to a facility, pursuant to rules adopted by the Medical Care Commission, for substantial failure to comply with the provisions of this section or rules adopted pursuant to this section. Any facility wishing to contest the issuance of a provisional license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails written notice of the issuance of the provisional license.

(b) License Revocation. – The Department may revoke a license whenever:

(1) The Department finds that:

a. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and

b. It is not reasonably probable that the licensee can remedy the licensure deficiencies within a reasonable length of time; or

(2) The Department finds that:

a. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and

b. Although the licensee may be able to remedy the deficiencies within a reasonable time, it is not reasonably probable that the licensee will be able to remain in compliance with licensure rules for the foreseeable future; or

c. The licensee has failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles, and the failure to comply endangered the health, safety, or welfare of the patients in the facility.

"**§ 131D-2.8. Penalties.**

(a) Any individual or corporation that establishes, conducts, manages, or operates a facility subject to licensure under this section without a license is guilty of a Class 3 misdemeanor and, upon conviction, shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense.

(b) In addition, the Department may summarily suspend a license pursuant to G.S. 150B-3(c) whenever it finds substantial evidence of abuse, neglect, exploitation, or any condition which presents an imminent danger to the health and safety of any resident of the home. Any facility wishing to contest summary suspension of a license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of summary suspension to the licensee.

"**§§ 131D-2.9 and 2.10: Reserved for future codification purposes.**

"Part 2. Other Laws Pertaining to the Inspection and Operation of Adult Care Homes.

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

(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. The Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis. 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.

(b) Monitoring by County. – The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this monitoring and perform any required follow-up inspection. The county departments of social services shall document in a written report all on-site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit.

(c) State Review of County Compliance. – The Division of Health Service Regulation shall conduct and document annual reviews of the county departments of social services' performance. When monitoring is not done timely or there is failure to identify or document noncompliance, the Department may intervene in the particular service in question. Department intervention shall include one or more of the following activities:

(1) Sending staff of the Department to the county departments of social services to provide technical assistance and to monitor the services being provided by the facility.

(2) Advising county personnel as to appropriate policies and procedures.

(3) Establishing a plan of action to correct county performance.

The Secretary may determine that the Department shall assume the county's regulatory responsibility for the county's adult care homes.

"**§ 131D-2.12. Training requirements; county departments of social services.**

(a) The county departments of social services' adult home specialists and their supervisors shall complete:

(1) Eight hours of prebasic training within 60 days of employment;

(2) Thirty-two hours of basic training within six months of employment;

(3) Twenty-four hours of postbasic training within six months of the basic training program;

(4) A minimum of eight hours of complaint investigation training within six months of employment; and

(5) A minimum of 16 hours of statewide training annually by the Division of Health Service Regulation.

(b) The joint training requirements by the Department shall be as provided in G.S. 143B-139.5B.

"**§ 131D-2.13. Departmental duties.**

(a) Enforcement of Room Ventilation and Temperature. – The Department shall monitor regularly the enforcement of rules pertaining to air circulation, ventilation, and room temperature in resident living quarters. These rules shall include the requirement that air conditioning or at least one fan per resident bedroom and living and dining areas be provided when the temperature in the main center corridor exceeds 80 degrees Fahrenheit.

(b) Administrator Directory. – The Department shall keep an up-to-date directory of all persons who are administrators as defined in G.S. 131D-2.1.

(c) Departmental Complaint Hotline. – Adult care homes shall post the Division of Health Service Regulation's complaint hotline number conspicuously in a public place in the facility.

(d) Provider File. – The Department of Health and Human Services shall establish and maintain a provider file to record and monitor compliance histories of facilities, owners, operators, and affiliates of nursing homes and adult care homes.

(e) Report on Use of Restraint. – The Department shall report annually on October 1 to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by the investigation to be related to the adult care home's use of physical restraint or physical hold.

"**§ 131D-2.14. Confidentiality.**

Notwithstanding G.S. 8-53 or any other law relating to confidentiality of communications between physician and patient, in the course of an inspection conducted under G.S. 131D-2.11:

(1) Department representatives may review any writing or other record concerning the admission, discharge, medication, care, medical condition, or history of any person who is or has been a resident of the facility being inspected, and

(2) Any person involved in giving care or treatment at or through the facility may disclose information to Department representatives unless the resident objects in writing to review of the resident's records or disclosure of such information.

(3) The facility, its employees, and any other person interviewed in the course of an inspection shall be immune from liability for damages resulting from disclosure of any information to the Department. The Department shall not disclose:

a. Any confidential or privileged information obtained under this section unless the resident or the resident's legal representative authorizes disclosure in writing or unless a court of competent jurisdiction orders disclosure, or

b. The name of anyone who has furnished information concerning a facility without that person's consent.

The Department shall institute appropriate policies and procedures to ensure that unauthorized disclosure does not occur. All confidential or privileged information obtained under this section and the names of persons providing such information shall be exempt from Chapter 132 of the General Statutes.

(4) Notwithstanding any law to the contrary, Chapter 132 of the General Statutes, the Public Records Law, applies to all records of the State Division of Social Services of the Department of Health and Human Services and of any county department of social services regarding inspections of domiciliary care facilities except for information in the records that is confidential or privileged, including medical records, or that contains the names of residents or complainants.

"**§ 131D-2.15. Resident assessments.**

(a) The Department shall ensure that facilities conduct and complete an assessment of each resident within 72 hours of 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. 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:

(1) Whether the appropriate assessment instrument was administered and interpreted correctly;

(2) Whether the facility is capable of providing the necessary services;

(3) Whether the service plan or care plan conforms to the results of an appropriately administered and interpreted assessment; and

(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.

"**§ 131D-2.16. Suspension of admissions.**

(a) In addition to the administrative penalties described in G.S. 131D-2.8, the Secretary may suspend the admission of any new residents to an adult care home where the conditions of the adult care home are detrimental to the health or safety of the residents. This 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.

(b) In imposing a suspension under this section, the Secretary shall consider the following factors:

(1) The degree of sanctions necessary to ensure compliance with this section and rules adopted hereunder; and

(2) The character and degree of impact of the conditions at the home on the health or safety of its residents.

(c) The Secretary of Health and Human Services shall adopt rules to implement this section.

(d) Any facility wishing to contest a suspension of admissions shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of suspension of admissions to the licensee.

"§ 131D-2.17. 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, 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.

"**§ 131D-2.18. Impact on other laws; severability.**

(a) Nothing in this section shall be construed to supersede any federal or State antitrust, antikickback, or safe harbor laws or regulations.

(b) If any provisions of this section or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the section which can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

"**§ 131D-2.19. Application of other laws.**

(a) Certification of assisted living administrators shall be as provided under Article 20A of Chapter 90 of the General Statutes.

(b) Compliance with the Health Care Personnel Registry shall be as provided under G.S. 131E-256.

(c) Rules for the operation of the adult care portion of a combination home, as defined in G.S. 131E-101, shall be as provided in G.S. 131E-104."

SECTION 2. G.S. 131D-41 and G.S. 131D-42 are repealed.

SECTION 3. This act becomes effective October 1, 2009. Licenses issued pursuant to G.S. 131D-2 remain effective until the date of annual renewal at which time Part 1 of Article 1 of Chapter 131D of the General Statutes shall apply. In all other respects, beginning October 1, 2009, Part 1 of Article 1 of Chapter 131D shall apply to the operation of facilities currently licensed under G.S. 131D-2.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

SENATE BILL 331

Short Title:	MH/National Accred. Benchmarks.	(Public)
Sponsors:	Senator Berger of Franklin.	
Referred to:	Health Care.	

February 26, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO NATIONAL ACCREDITATION BENCHMARK REQUIREMENTS FOR CERTAIN MEDICAID ENROLLED FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-81(d) reads as rewritten:

"(d) Providers enrolled in the Medicaid program or contracting for State-funded services on or after July 1, 2008, and providing services which require national accreditation shall successfully complete all accreditation requirements and be awarded national accreditation within ~~one year~~ 18 months of enrollment in the Medicaid program or within two years following the provider's first contract to deliver a State-funded service requiring national accreditation. Providers providing services that require national accreditation shall be required to discontinue service delivery and shall have their Medicaid enrollment and any service contracts terminated if they do not meet the following benchmarks for demonstrating sufficient progress in achieving national accreditation following the date of enrollment in the Medicaid program or initial contract for State-funded services:

(1) ~~Three~~ Six months – On-site accreditation review scheduled by accrediting agency as documented by a letter from the agency to the provider and completion of self-study and self-evaluation protocols distributed by the selected accrediting agency.

(2) ~~Six~~ Twelve months – On-site accreditation review scheduled by accrediting agency as documented by a letter from the agency to the provider.

(3) ~~Nine~~ Fifteen months – Completion of on-site accreditation review, receipt of initial feedback from accrediting agency, plan to address any deficiencies identified developed.

(4) If a provider's Medicaid enrollment or service delivery contracts are terminated as a result of failure to meet accreditation benchmarks or failure to continue to be nationally accredited, the provider will work with the LME to transition consumers served by the provider to other service providers in an orderly fashion within 60 days of notification by the LME of such failure.

(5) A provider that has its Medicaid enrollment or service delivery contracts terminated as a result of failure to meet accreditation benchmarks or failure to continue to be nationally accredited may not reapply for enrollment in the Medicaid program or enter into any new service delivery contracts for at least one year following enrollment or contract termination."

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

SENATE BILL 906

Short Title:	Establish Adult Day Health Overnight Respite.	(Public)
Sponsors:	Senator Clary.	
Referred to:	Health Care.	

March 26, 2009

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH ADULT DAY HEALTH OVERNIGHT RESPITE PROGRAMS AND TO DIRECT THE DIVISION OF MEDICAL ASSISTANCE TO PURSUE A MEDICAID WAIVER TO PROVIDE COVERAGE FOR RESPITE CARE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 1 of Chapter 131D is amended by adding a new section to read:

"**§ 131D-6.1. Certification of adult day health overnight respite programs; purpose; definition.**

(a) It is the policy of the State to support unpaid caregivers that provide care for individuals who would otherwise need full-time care. Adult day health overnight respite programs provide respite for unpaid caregivers.

(b) As used in this section, 'adult day health overnight respite program' means the provision of 24-hour group care and supervision on a temporary basis to six or fewer unrelated adults who may be physically or mentally disabled. Care provided to an individual in an adult day health overnight respite program shall not exceed seven consecutive calendar days, or more than a total of 21 calendar days of 24-hour care during a 365-day period.

(c) All rules adopted by the Social Services Commission and applicable to an adult day care program as defined in this Article shall apply to an adult day health overnight respite program.

(d) The Social Services Commission shall adopt rules to protect the health, safety, and welfare of persons in adult day health overnight respite programs. These rules shall include minimum standards relating to management of the program, staffing requirements, building requirements, fire safety, sanitation, nutrition, and program activities.

(d) The Department of Health and Human Services shall enforce the rules of the Social Services Commission and shall annually inspect and certify all adult day health overnight respite programs, under rules adopted by the Social Services Commission."

SECTION 2. G.S. 143B-181.10 reads as rewritten:

"**§ 143B-181.10. Respite care program established; eligibility; services; administration; payment rates.**

(a) A respite care program is established to provide needed relief to caregivers of impaired adults who cannot be left alone because of mental or physical problems.

(b) Those eligible for respite care under the program established by this section are limited to those unpaid primary caregivers who are caring for people 60 years of age or older and their spouses, or those unpaid primary caregivers 60 years of age or older who are caring for persons 18 years of age or older, who require constant supervision and who cannot be left

alone either because of memory impairment, physical immobility, or other problems that renders them unsafe alone.

(c) Respite care services provided by the programs established by this section may include:

(1) Counseling and training in the caregiving role, including coping mechanisms and behavior modification techniques;
(2) Counseling and accessing available local, regional, and State services;
(3) Support group development and facilitation;
(4) Assessment and care planning for the patient of the caregiver;
(5) Attendance and companion services for the patient in order to provide release time to the caregiver;
(6) Personal care services, including meal preparation, for the patient of the caregiver;
(7) Temporarily placing the person out of his home to provide the caregiver total respite when the mental or physical stress on the caregiver necessitates this type of respite.

Program funds may provide no more than the current adult care. An out of home placement is defined as placement in a hospital, skilled or intermediate nursing facility, adult care home, adult day health center, ~~or~~ adult day care ~~center.~~center, or adult day health overnight respite program. Duration of the service period may extend beyond a year.

(d) The respite care program established by this section shall be administered by the Division of Aging consistent with the policies and procedures of the Older Americans Act. The programs shall be coordinated with other appropriate Divisions in the Department of Health and Human Services, and with agencies and organizations concerned with the delivery of services to frail older adults and their unpaid caregivers. The Division shall choose respite care provider agencies in accordance with procedures outlined under the Older Americans Act and shall include the following criteria: documented capacity to provide care, adequacy of quality assurance, training, supervision, abuse prevention, complaint mechanisms, and cost. All funds allocated by the Division pursuant to this section shall be allocated on the same basis as funding under the Older Americans Act.

(e) Funding for the Division of Aging to administer this program shall not exceed the percentage allowed for administration as provided in the Older Americans Act but shall not be less than that budgeted for administration in fiscal year 1988-89.

(f) Unless prohibited by federal law, caregivers receiving respite care services through the program established by this section shall pay for some of the services on a sliding scale depending on their ability to pay. The Division of Aging, in consultation with the Councils of Governments in each region, shall specify rates of payment for the services."

SECTION 3. The Division of Medical Assistance of the Department of Health and Human Services shall pursue a Medicaid waiver to provide coverage for respite care including respite care provided in an adult day health overnight respite program.

SECTION 4. Sections 1 and 2 of this act become effective January 1, 2010. The remainder of this act is effective when it becomes law.

VISITOR REGISTRATION SHEET

Senate Health Care — **April 15, 2009**
Name of Committee — **Date**

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VISITOR REGISTRATION SHEET

Senate Health Care — **April 15, 2009**
Name of Committee — **Date**

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TINA GORDON	NC Nurses Assoc.
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Senate Health Care — **April 15, 2009**
Name of Committee — **Date**

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Jud Wadal	Eastern Seal UCP NC
Jessie Gibbons	DHHS/DHSR
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Lee Hunter	"
Marilyn Haskett	NCDHHS
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Dana Sutis	Intern for Senator Blake

VISITOR REGISTRATION SHEET

Senate Health Care — **April 15, 2009**
Name of Committee — **Date**

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Amanda Dillard, RVT	NC Association of Veterinary Technicians
THOMAS MICKEY	NC VETERINARY MEDICAL BOARD
GEORGE HEARN	N.C. Veterinary Medical Board
[illegible]	BCBSNC
Melvine Foster	Pfizer

VISITOR REGISTRATION SHEET

Senate Health Care — **April 15, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennie Dorsett	NCAHP
Joyce Peters	JP Assoc
Mary Kay	MWC
Joanne Stevens	NCNA

Senate Health Care Committee
Wednesday, April 22; 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 2	Prohibit Smoking in Public & Work Places.	Representative Barnhart Representative Weiss Representative Holliman Representative Glazier
SB 805	DHHS Study/Influenza Vaccine Public Schools.	Senator Purcell

Presentations

Other Business

Adjournment

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 2

Committee Substitute Favorable 3/3/09
Committee Substitute #2 Favorable 3/25/09
Fourth Edition Engrossed 4/2/09
Corrected Copy 4/3/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H2-PCS80347-LN-11

Short Title: Prohibit Smoking in Public & Workplaces. (Public)

Sponsors:

Referred to:

January 29, 2009

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT SMOKING IN PUBLIC PLACES AND PLACES OF EMPLOYMENT.

The General Assembly of North Carolina enacts:

SECTION 1. Effective January 2, 2010, Article 23 of Chapter 130A of the General Statutes reads as rewritten:

"Article 23.

"Smoking Prohibited in Public ~~Places.~~Places and Places of Employment.

~~Part 1. Smoking in State Government Buildings.~~"Part 1A. Findings and Intent.

"**§ 130A-491. Legislative findings and intent.**

(a) Findings. – The General Assembly finds that secondhand smoke has been proven to cause cancer, heart disease, and asthma attacks in both smokers and nonsmokers. In 2006, a report issued by the United States Surgeon General stated that the scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.

(b) Intent. – It is the intent of the General Assembly to protect the health of individuals in public places and places of employment and riding in State government vehicles ~~working in or visiting State government buildings~~ from the risks related to secondhand smoke. It is further the intent of the General Assembly to ~~protect the health of individuals driving or riding in State-controlled passenger-carrying vehicles assigned permanently or temporarily to State employees or State agencies or institutions for official State business.~~allow local governments to adopt local laws governing smoking within their jurisdictions that are more restrictive than the State law.

"**§ 130A-492. Definitions.**

The following definitions apply in this Article:

(1) "Cigar bar". – An establishment with a permit to sell alcoholic beverages pursuant to subdivisions (1), (3), (5), or (10) of G.S. 18B-1001 that satisfies all of the following:

a. Generates sixty percent (60%) or more of its quarterly gross revenue from the sale of alcoholic beverages and twenty-five percent (25%) or more of its quarterly gross revenue from the sale of cigars;

b. Has a humidor on the premises; and
c. Does not allow individuals under the age of 21 to enter the premises.

Revenue generated from other tobacco sales, including cigarette vending machines, shall not be used to determine whether an establishment satisfies the definition of cigar bar.

(1a) "Employee". – A person who is employed by an employer, or who contracts with an employer or third person to perform services for an employer, or who otherwise performs services for an employer with or without compensation.

(2) "Employer". – An individual person, business, association, political subdivision, or other public or private entity, including a nonprofit entity, that employs or contracts for or accepts the provision of services from one or more employees.

(3) "Enclosed area". – An area with a roof or other overhead covering of any kind and walls or side coverings of any kind, regardless of the presence of openings for ingress and egress, on all sides or on all sides but one.

(4) "Grounds". – An unenclosed area owned, leased, or occupied by State or local government.

(5) "Local government". – A local political subdivision of this State, an airport authority, or an authority or body created by an ordinance, joint resolution, or rules of any such entity.

(6) "Local government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by a local government.

(7) "Lodging establishment". – An establishment that provides lodging for pay to the public.

(8) "Local vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by local government and assigned permanently or temporarily by local government to local government employees, agencies, institutions, or facilities for official local government business.

(8a) "Place of employment". – An enclosed area under the control of a public or private employer that employees use during the course of employment or for any other purpose.

(8b) "Private club". – organization that maintains selective members, is operated by the membership, does not provide food or lodging for pay to anyone who is not a member or a member's guest, does not allow individuals under the age of 21 to enter the premises, and is either incorporated as a nonprofit corporation in accordance with Chapter 55A of the General Statutes or is exempt from federal income tax under the Internal Revenue Code as defined in G.S. 105-130.2(1).

(8c) "Private residence". – A private dwelling that is not a child care facility, as defined in G.S. 110-86(3), and not a long-term care facility, as defined in G.S. 131E-114.3(a)(1).

(8d) "Private vehicle". – A privately owned vehicle that is not used for commercial or employment purposes.

(8e) "Public place". – An enclosed area to which the public is invited or in which the public is permitted.

(9) "Smoking". – The use or possession of a lighted cigarette, lighted cigar, lighted pipe, or any other lighted tobacco product.

(10) "State government". – The political unit for the State of North Carolina, including all agencies of the executive, judicial, and legislative branches of government.

(11) "State government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by State government.

(12) "State vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by the State and assigned permanently or temporarily to a State employee or State agency or institution for official State business.

(13) "Tobacco shop". – A business establishment, the main purpose of which is the sale of tobacco, tobacco products, and accessories for such products, that receives no less than seventy-five percent (75%) of its total annual revenues from the sale of tobacco, tobacco products, and accessories for such products, and does not serve food or alcohol on its premises.

"Part 1B. Smoking Prohibited in State Government Buildings and Vehicles.

"§ 130A-493. Smoking prohibited in State government buildings and State ~~vehicles prohibited.~~vehicles.

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes pertaining to State-controlled buildings, smoking is prohibited inside State government buildings except as provided in subsection (b) of this section. ~~As to smoking rooms in residence halls that were permitted by G.S. 143-597(a)(6), this Article becomes effective beginning with the 2008-2009 academic year.~~

(b) Smoking is permitted inside State government buildings that are used for medical or scientific research to the extent that smoking is an integral part of the research. Smoking permitted under this subsection shall be confined to the area where the research is being conducted.

(c) The individual in charge of the State government building or the individual's designee shall post signs in conspicuous areas of the building. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. In addition, ~~in any State psychiatric hospital, the person who owns, manages, operates, or otherwise controls the hospital shall:~~the individual in charge of the building or the individual's designee shall:

(1) Direct ~~any~~ a person who is smoking inside the ~~facility~~ building to extinguish the lighted smoking product.

(2) ~~Provide~~ In a State psychiatric hospital, provide written notice to individuals upon admittance that smoking is prohibited inside the ~~facility~~ building and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c1) Smoking is prohibited inside State vehicles. The individual or the individual's designee in charge of assigning the vehicle shall place one or more signs in conspicuous areas of the vehicle. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. If the vehicle is used for undercover law enforcement operations, a sign is not required to be placed in the vehicle as provided in this subsection.

(d) Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a misdemeanor.

"§ 130A-494. Other prohibitions.

Nothing in this Article repeals any other law prohibiting smoking, nor does it limit any law allowing regulation or prohibition of smoking on walkways or on the grounds of buildings.

"§ 130A-495. Rules.

The Commission shall adopt rules to implement this Part.

"Part 1C. Smoking Prohibited in Public Places and Places of Employment.

"§ 130A-496. Smoking prohibited in public places and places of employment.

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes, smoking is prohibited in public places and places of employment, except as provided in subsection (b) of this section.

(b) Smoking may be permitted in the following places:

(1) A private residence.

(2) A private vehicle.

(3) A tobacco shop if smoke from the business does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A tobacco shop that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the tobacco shop and smoke from the shop does not migrate into an enclosed area where smoking is prohibited pursuant to this Article.

(4) All of the premises, facilities, and vehicles owned, operated, or leased by any tobacco products processor or manufacturer, or any tobacco leaf grower, processor, or dealer.

(5) A designated smoking guest room in a lodging establishment. No greater than twenty percent (20%) of a lodging establishment's guest rooms may be designated smoking guest rooms.

(6) A cigar bar if smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A cigar bar that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the cigar bar and smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. To qualify under this subsection, the cigar bar must satisfactorily report on a quarterly basis to the Department, on a form prescribed by the Department, the revenue generated from the sale of alcoholic beverages and cigars as a percentage of quarterly gross revenue. The Department shall determine whether any additional documentation is required of the cigar bar to authenticate or verify revenue data submitted by the cigar bar. This subdivision shall not apply to any business that is established for the purpose of avoiding compliance with this Article.

(7) A private club.

"**§ 130A-497. Implementation and enforcement.**

(a) A person who manages, operates, or controls a public place or place of employment in which smoking is prohibited shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited. The signs may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Remove all indoor ashtrays and other smoking receptacles.

(3) Direct a person who is smoking to extinguish the lighted tobacco product.

(b) Continuing to smoke in a nonsmoking area described in this Part following oral or written notice by the person in charge of the area or the person's designee constitutes an infraction, and the person committing the infraction may be punished by a fine of not more than fifty dollars ($50.00).

(c) Conviction of an infraction under this section has no consequence other than payment of a penalty. A person found responsible for a violation of this section may not be assessed court costs.

(d) Notwithstanding G.S. 130A-25, a violation of this Part shall not be punishable as a misdemeanor.

(e) Administrative penalties imposed under G.S. 130A-22(h1) against a person who manages, operates, or controls a public place or place of employment and fails to comply with the provisions of this Article and the rules adopted by the Commission to implement the provisions of this Article shall only be enforced by a local health director.

(f) The Commission shall adopt rules to implement the provisions of this Article.

"Part 2. Local Government Regulation of Smoking.

"§ 130A-498. Local governments may restrict smoking in public places.

(a) ~~Notwithstanding~~ Except as otherwise provided in subsection (b1) of this section, and notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to the contrary, a local government may adopt ~~an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this section.~~and enforce ordinances, board of health rules, and other laws or policies restricting or prohibiting smoking that are more restrictive than State law and that apply in local government buildings, on local government grounds, in local vehicles, or in public places. The definitions set forth in G.S. 130A-492 in Part 1A of this Article apply to this section and shall apply to any local ordinance, rule, or law adopted by a local government under this section.

~~(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:~~

~~(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;~~

~~(2) Building and grounds wherein local health departments and departments of social services are housed;~~

~~(3) Repealed by Session Laws 2007-193, s. 3.1, effective August 1, 2008.~~

~~(4) Any place on a public transportation vehicle owned or leased by local government and used by the public; and~~

~~(5) Any place in a local vehicle.~~

(b1) A local ordinance or other rules, laws, or policies adopted under this section may not restrict or prohibit smoking in the following places:

(1) A private residence.

(2) A private vehicle.

(3) A tobacco shop if smoke from the business does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A tobacco shop that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the tobacco shop and smoke from the shop does not migrate into an enclosed area where smoking is prohibited pursuant to this Article.

(4) All of the premises, facilities, and vehicles owned, operated, or leased by any tobacco products processor or manufacturer, or any tobacco leaf grower, processor, or dealer.

(5) A designated smoking guest room in a lodging establishment. No greater than twenty percent (20%) of a lodging establishment's guest rooms may be designated smoking guest rooms.

(6) A cigar bar if smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A cigar bar that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the cigar bar and smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. To qualify under this subsection, the cigar bar must satisfactorily report on a quarterly basis to the Department, on a form prescribed by the Department, the revenue generated from the sale of alcoholic beverages and cigars as a percentage of quarterly gross revenue.

The Department shall determine whether any additional documentation is required of the cigar bar to authenticate or verify revenue data submitted by the cigar bar. This subdivision shall not apply to any business that is established for the purpose of avoiding compliance with this Article.

(7) A private club.

~~(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity. As used in this Part, "local government" does not include community colleges as defined in G.S. 115D-2(2).~~

(c1) Continuing to smoke in violation of a local ordinance or other rules, laws, or policies adopted under this section constitutes an infraction, and the person committing the infraction may be punished by a fine of not more than fifty dollars ($50.00). Conviction of an infraction under this section has no consequence other than payment of a penalty. A person smoking in violation of a local ordinance or other rules, laws, or policies adopted under this section may not be assessed court costs.

~~(d) As used in this Part, "grounds" means the area located within 50 linear feet of a building wherein a local health department or a local department of social services is housed.~~

(d1) Notwithstanding G.S. 130A-25 or any other provision of law, a violation of a local ordinance, rule, law, or policy adopted under this section shall not be punishable as a misdemeanor.

(d2) A local government may enforce an ordinance, rule, law, or policy under this section against a person who manages, operates, or controls a public place only as provided in G.S. 130A-22(h1).

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122.

"**§§ 130A-499 through 130A-500: Reserved for future codification purposes.**"

SECTION 2. Effective January 2, 2010, G.S. 130A-22 is amended by adding a new subsection to read:

"(h1) A local health director may take the following actions and may impose the following administrative penalty on a person who manages, operates, or controls a public place or place of employment and fails to comply with the provisions of Part 1C of Article 23 of this Chapter or with rules adopted thereunder or with local ordinances, rules, laws, or policies adopted pursuant to Part 2 of Article 23 of this Chapter:

(1) First violation. – Provide the person in violation with written notice of the person's first violation and notification of action to be taken in the event of subsequent violations.

(2) Second violation. – Provide the person in violation with written notice of the person's second violation and notification of administrative penalties to be imposed for subsequent violations.

(3) Subsequent violations. – Impose on the person in violation an administrative penalty of not more than two hundred dollars ($200.00) for the third and subsequent violations.

Each day on which a violation of this Article or rules adopted pursuant to this Article occurs may be considered a separate and distinct violation. Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a criminal violation."

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

HOUSE BILL 2:
Prohibit Smoking in Public & Workplaces

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	April 20, 2009
Introduced by:	Reps. Holliman, Weiss, Glazier, Barnhart	**Prepared by:**	Shawn Parker
Analysis of:	PCS to Fifth Edition		Ben Popkin
	H2-CSLN-11		Committee Staff

SUMMARY: ***The Senate Proposed Committee Substitute to House Bill 2 (fourth edition) amends Article 23 (Smoking in Public Places) of Chapter 130A (Public Health) of the General Statutes to provide for the regulation of smoking in enclosed public places and places of employment.***

CURRENT LAW: Article 23 (Smoking in Public Places) of Chapter 130A (Public Health) of the General Statutes currently consists of two parts – Part 1 "Smoking in State Government Buildings", which prohibits smoking in State government buildings, with certain limited exceptions, and Part 2 "Local Government Regulation of Smoking", which authorizes local governments to adopt ordinances to restrict smoking in buildings owned or leased by local government, buildings and grounds of local health departments or department of social services, and on public transportation vehicles owned or leased by local government.

BILL ANALYSIS: House Bill 2 would amend Article 23 of Chapter 130A of the General Statutes by amending the title of Article 23 to read, "Smoking in Public Places and Places of Employment" and by restructuring the Article to include the following Parts and provisions:

Part 1A. Findings and Intent – The bill provides a new "findings" section, revises the existing intent language in G.S. 130A-491, and inserts additional definitions to G.S. 130A-492. As used in the Article:

- Cigar bar- an establishment with a permit to sell alcoholic beverages, generates 60% or more of its quarterly gross revenue from the sale of alcoholic beverages and 25% or more of its quarterly gross revenues from the sale of cigars, has a humidor on the premises, and does not allow individuals under the age of 21 to enter the premises.
- Enclosed area- an area with a roof or other overhead covering of any kind and walls or side coverings of any kind on all sides or on all but one side.
- Lodging Establishment- an establishment that provides lodging for pay to the public.
- Place of employment- An ***enclosed*** area under the control of a public or private employer that employees use during the course of employment or for any other purpose.
- Private club- is an organization that maintains selective membership, is operated by the membership, does not provide food or lodging to persons who are not either members or guest of members, does not allow individuals under the age of 21 to enter the premises, and is either incorporated as a nonprofit or is exempt from federal income tax under the Internal Revenue Code.
- Private residence- a private residence that is ***not*** used as a child care facility or a long-term care facility.
- Public Place- an ***enclosed*** area to which the public is invited or permitted.
- Tobacco Shop- A business establishment that ***does not serve*** food or alcohol on its premises and receives no less than 75% of its total annual revenues from the sale of tobacco, tobacco products, and product related accessories.

Part 1B. Smoking Prohibited in State Government Buildings and Vehicles – The bill provides technical changes to the existing G.S. 130A-493, by amending it to eliminate an obsolete provision relating to residence halls and restructuring language applying to State psychiatric hospitals.

Part 1C. Smoking Prohibited in Public Places and Places of Employment – The bill creates the following two new sections:

G.S. 130A-496. Prohibits smoking in public places and places of employment, with the following exceptions:

- Public places and places of employment that are not considered enclosed areas.
- Private residences, except when used as a child care facility as defined in G.S. 110-86(3) or a long-term care facility as defined in G.S. 131E-114.3(a)(1).
- Privately owned vehicles that are not used for commercial or employment purposes.
- A tobacco shop, if smoke doesn't migrate into an enclosed nonsmoking area.
- The premises, facilities, and vehicles of tobacco product manufacturers or processors.
- A designated smoking guest room in a lodging establishment (up to 20% of guest rooms).
- A cigar bar, if smoke doesn't migrate into an enclosed nonsmoking area. Cigar bars that begin operation after July 1, 2009 must be freestanding structures.
- Private clubs as defined in G.S. 130A-492.

G.S. 130A-497. Directs the Commission for Public Health to adopt rules to implement the provisions of Article 23 and directs the person who manages, operates, or controls a public place or place of employment where smoking is prohibited to do the following:

- Conspicuously post signs stating smoking is prohibited.
- Remove all indoor ashtrays and other smoking receptacles.
- Direct a person who is smoking to extinguish the lighted tobacco product.

Administrative penalties may only be enforced by a local health director.

The section further provides that persons continuing to smoke in a nonsmoking area after being given notice would be committing an infraction and could be punished by a fine of not more than $50. Persons convicted of this infraction would not be assessed court costs and would suffer no consequence beyond payment of the fine.

Part 2. Local Government Regulation of Smoking – Amends G.S. 130A-498 authorizing a local government to adopt ordinances, rules, laws or policies restricting smoking that are more restrictive than State law and that apply in local government buildings, *on local government grounds*, in local vehicles, or in public places. The Part provides that the definitions set forth in Part 1A of the Article apply to any local ordinance, rule, or law adopted by a local government. The exceptions to a restriction by ordinance, rule, law or policy mirror those provided in Part 1C.

Section 2 of the bill amends the administrative penalty provision of the Public Health Chapter by adding a new subsection (h1) into G.S. 130A-22. The subsection provides a local health director with the authority to impose the following administrative penalty on persons in control of a public place or a place of employment who fail to comply with the provisions of Article 23:

- First violation – written notice of violation and notification of action for later violations.
- Second violation – written notice of violation and notice of action for later violations.
- Third and subsequent violations – Impose administrative penalty of not more than $200.

EFFECTIVE DATE: The act is effective when it becomes law with the provisions of the act becoming effective January 2, 2010.

H2-SMSQ-44(CSLN-11) v2

Senate Health Care Committee
Wednesday, April 29, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 2	Prohibit Smoking in Public & Work Places.	Representative Holliman Representative Barnhardt Representative Glazier Representative Weiss

Presentations

Other Business

Adjournment

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	April 29, 2009	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 2	Prohibit Smoking in Public & Work Places.	Representative Holliman Representative Weiss Representative Barnhardt Representative Glazier

Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, April 29, 2009

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

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #2) **2** Prohibit Smoking in Public & Work Places.

Draft Number:	PCS 10896
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, April 29, 2009 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 AM on April 29, 2009, in Room 544 of the Legislative Office Building. Twenty-six members of the committee were present. Senator Purcell, Co-Chair, presided.

Senator Purcell called on Representative Holliman to present his bill House Bill 2 entitled "AN ACT TO PROHIBIT SMOKING IN PUBLIC PLACES AND PLACES OF EMPLOYMENT" (Attachment I). A Senate Committee Substitute (Attachment II) was brought forth (a summary is included as Attachment III), and Senator Bingham moved its adoption for consideration; motion carried.

Representative Holliman spoke on his bill and stated that 2/3 of North Carolinians support this bill. Senator Purcell then called on two speakers who are restaurant owners; then recognized Dr. Plescia, Chief of the Chronic Disease & Injury Section of Public Health in the Department of Health & Human Services; and Michael Shannon of the Lorillard Company.

Senator Goodall presented an amendment to the bill (Attachment IV) and moved its adoption; motion failed. Senator Jacumin then presented another amendment (Attachment V) and moved its adoption; motion failed.

Senator Dannelly moved an unfavorable report for the 5th edition of the House Bill and a favorable report for the Senate Committee Substitute for HB 2; motion carried. The meeting was then adjourned.

William R Purcell
Senator William R. Purcell, Presiding

Becky Hedspeth
Becky Hedspeth, Committee Clerk

Attachment I

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H 5

HOUSE BILL 2

Committee Substitute Favorable 3/3/09
Committee Substitute #2 Favorable 3/25/09
Fourth Edition Engrossed 4/2/09
Corrected Copy 4/3/09

Short Title: Prohibit Smoking in Public & Workplaces. (Public)

Sponsors:

Referred to:

January 29, 2009

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT SMOKING IN PUBLIC PLACES AND PLACES OF EMPLOYMENT.

The General Assembly of North Carolina enacts:

SECTION 1. Effective January 2, 2010, Article 23 of Chapter 130A of the General Statutes reads as rewritten:

"Article 23.

"Smoking Prohibited in Public ~~Places.~~Places and Places of Employment.

~~Part 1. Smoking in State Government Buildings.~~"Part 1A. Findings and Intent.

"**§ 130A-491. Legislative findings and intent.**

(a) Findings. – The General Assembly finds that secondhand smoke has been proven to cause cancer, heart disease, and asthma attacks in both smokers and nonsmokers. In 2006, a report issued by the United States Surgeon General stated that the scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.

(b) Intent. – It is the intent of the General Assembly to protect the health of individuals in public places and places of employment and riding in State government vehicles ~~working in or visiting State government buildings~~ from the risks related to secondhand smoke. It is further the intent of the General Assembly to ~~protect the health of individuals driving or riding in State-controlled passenger-carrying vehicles assigned permanently or temporarily to State employees or State agencies or institutions for official State business.~~allow local governments to adopt local laws governing smoking within their jurisdictions that are more restrictive than the State law.

"**§ 130A-492. Definitions.**

The following definitions apply in this Article:

(1) "Cigar bar". – An establishment with a permit to sell alcoholic beverages pursuant to subdivisions (1), (3), (5), or (10) of G.S. 18B-1001 that satisfies all of the following:

a. Generates sixty percent (60%) or more of its quarterly gross revenue from the sale of alcoholic beverages and twenty-five percent (25%) or more of its quarterly gross revenue from the sale of cigars;

b. Has a humidor on the premises; and

c. Does not allow minors to enter the premises.

Revenue generated from other tobacco sales, including cigarette vending machines, shall not be used to determine whether an establishment satisfies the definition of cigar bar.

(1a) "Employee". – A person who is employed by an employer, or who contracts with an employer or third person to perform services for an employer, or who otherwise performs services for an employer with or without compensation.

(2) "Employer". – An individual person, business, association, political subdivision, or other public or private entity, including a nonprofit entity, that employs or contracts for or accepts the provision of services from one or more employees.

(3) "Enclosed area". – An area with a roof or other overhead covering of any kind and walls or side coverings of any kind, regardless of the presence of openings for ingress and egress, on all sides or on all sides but one.

(4) "Grounds". – An unenclosed area owned, leased, or occupied by State or local government.

(5) "Local government". – A local political subdivision of this State, an airport authority, or an authority or body created by an ordinance, joint resolution, or rules of any such entity.

(6) "Local government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by a local government.

(7) "Lodging establishment". – An establishment that provides lodging for pay to the public.

(8) "Local vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by local government and assigned permanently or temporarily by local government to local government employees, agencies, institutions, or facilities for official local government business.

(8a) "Place of employment". – An enclosed area under the control of a public or private employer that employees use during the course of employment or for any other purpose. A privately owned workplace is not a place of employment under this Article if it satisfies all of the following:

a. The employer is an individual person and consents to allow smoking in the workplace or, in the case of a private employer other than an individual person, all owners of the employer consent to allow smoking in the workplace;

b. The workplace is not open to employees other than owners of the employer and is not open to the public;

c. The workplace does not allow entry to minors; and

d. Smoke does not migrate into an enclosed area in which smoking is prohibited under this Article.

(8b) "Private club". – An establishment that is organized and operated solely for a social, recreational, patriotic, or fraternal purpose and that is not open to the general public, but is open only to the members of the organization and their bona fide guests, and is either incorporated as a nonprofit corporation in accordance with Chapter 55A of the General Statutes or is exempt from federal income tax under the Internal Revenue Code as defined in G.S. 105-130.2(1).

(8c) "Private residence". – A private dwelling that is not a child care facility, as defined in G.S. 110-86(3), and not a long-term care facility, as defined in G.S. 131E-114.3(a)(1).

(8d) "Private vehicle". – A privately owned vehicle that is not used for commercial or employment purposes.

(8e) "Public place". – An enclosed area to which the public is invited or in which the public is permitted.

(9) "Smoking". – The use or possession of a lighted cigarette, lighted cigar, lighted pipe, or any other lighted tobacco product.

(10) "State government". – The political unit for the State of North Carolina, including all agencies of the executive, judicial, and legislative branches of government.

(11) "State government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by State government.

(12) "State vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by the State and assigned permanently or temporarily to a State employee or State agency or institution for official State business.

(13) "Tobacco shop". – A business establishment the main purpose of which is the sale of tobacco, tobacco products, and accessories for such products that receives no less than seventy-five percent (75%) of its total annual revenues from the sale of tobacco, tobacco products, and accessories for such products, and does not serve food or alcohol on its premises.

"Part 1B. Smoking Prohibited in State Government Buildings and Vehicles.

"§ 130A-493. Smoking prohibited in State government buildings and State ~~vehicles prohibited.~~vehicles.

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes pertaining to State-controlled buildings, smoking is prohibited inside State government buildings except as provided in subsection (b) of this section. ~~As to smoking rooms in residence halls that were permitted by G.S. 143-597(a)(6), this Article becomes effective beginning with the 2008-2009 academic year.~~

(b) Smoking is permitted inside State government buildings that are used for medical or scientific research to the extent that smoking is an integral part of the research. Smoking permitted under this subsection shall be confined to the area where the research is being conducted.

(c) The individual in charge of the State government building or the individual's designee shall post signs in conspicuous areas of the building. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. In addition, ~~in any State psychiatric hospital, the person who owns, manages, operates, or otherwise controls the hospital shall:~~the individual in charge of the building or the individual's designee shall:

(1) Direct ~~any~~ a person who is smoking inside the ~~facility~~ building to extinguish the lighted smoking product.

(2) ~~Provide~~ In a State psychiatric hospital, provide written notice to individuals upon admittance that smoking is prohibited inside the ~~facility~~ building and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c1) Smoking is prohibited inside State vehicles. The individual or the individual's designee in charge of assigning the vehicle shall place one or more signs in conspicuous areas of the vehicle. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. If the vehicle is used for undercover law enforcement operations, a sign is not required to be placed in the vehicle as provided in this subsection.

(d) Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a misdemeanor.

"**§ 130A-494. Other prohibitions.**

Nothing in this Article repeals any other law prohibiting smoking, nor does it limit any law allowing regulation or prohibition of smoking on walkways or on the grounds of buildings.

"**§ 130A-495. Rules.**

The Commission shall adopt rules to implement this Part.

"Part 1C. Smoking Prohibited in Public Places and Places of Employment.

"**§ 130A-496. Smoking prohibited in public places and places of employment.**

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes, smoking is prohibited in public places and places of employment, except as provided in subsection (b) of this section.

(b) Smoking may be permitted in the following places:

(1) A private residence.

(2) A private vehicle.

(3) A tobacco shop if smoke from the business does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A tobacco shop that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the tobacco shop and smoke from the shop does not migrate into an enclosed area where smoking is prohibited pursuant to this Article.

(4) All of the premises, facilities, and vehicles owned, operated, or leased by any tobacco products processor or manufacturer, or any tobacco leaf grower, processor or dealer.

(5) A designated smoking guest room in a lodging establishment. No greater than twenty percent (20%) of a lodging establishment's guest rooms may be designated smoking guest rooms.

(6) A cigar bar in operation on or before January 1, 2009 if smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. To qualify under this subsection, the cigar bar must satisfactorily report on a quarterly basis to the Department, on a form prescribed by the Department, the revenue generated from the sale of alcoholic beverages and cigars as a percentage of quarterly gross revenue. The Department shall determine whether any additional documentation is required of the cigar bar to authenticate or verify revenue data submitted by the cigar bar. This subdivision shall not apply to any business that is established for the purpose of avoiding compliance with this Article.

(7) A public place or place of employment that does not provide service to or allow entry to any person younger than 18 years old, if smoke does not migrate into an enclosed area in which smoking is prohibited pursuant to this Article, and which conspicuously posts signs at all entrances and provides notice in all advertising and employment materials stating that smoking is permitted.

(8) A private club.

"**§ 130A-497. Implementation and enforcement.**

(a) A person who manages, operates, or controls a public place or place of employment in which smoking is prohibited shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited. The signs may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Remove all indoor ashtrays and other smoking receptacles.
(3) Direct a person who is smoking to extinguish the lighted tobacco product.

(b) Continuing to smoke in a nonsmoking area described in this Part following oral or written notice by the person in charge of the area or the person's designee constitutes an infraction, and the person committing the infraction may be punished by a fine of not more than fifty dollars ($50.00).

(c) Conviction of an infraction under this section has no consequence other than payment of a penalty. A person found responsible for a violation of this section may not be assessed court costs.

(d) Notwithstanding G.S. 130A-25, a violation of this Part shall not be punishable as a misdemeanor.

(e) Administrative penalties imposed under G.S. 130A-22(h1) against a person who manages, operates, or controls a public place or place of employment and fails to comply with the provisions of this Article and the rules adopted by the Commission to implement the provisions of this Article shall only be enforced by a local health director.

(f) The Commission shall adopt rules to implement the provisions of this Article.

"Part 2. Local Government Regulation of Smoking.

"§ 130A-498. Local governments may restrict smoking in public places.

(a) ~~Notwithstanding~~ Except as otherwise provided in subsection (b1) of this section, and notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to the contrary, a local government may adopt ~~an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this section.~~and enforce ordinances, board of health rules, and other laws or policies restricting or prohibiting smoking that are more restrictive than State law and that apply in local government buildings, on local government grounds, in local vehicles, or in public places. The definitions set forth in G.S. 130A-492 in Part 1A of this Article apply to this section and shall apply to any local ordinance, rule, or law adopted by a local government under this section.

~~(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:~~

~~(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;~~
~~(2) Building and grounds wherein local health departments and departments of social services are housed;~~
~~(3) Repealed by Session Laws 2007-193, s. 3.1, effective August 1, 2008.~~
~~(4) Any place on a public transportation vehicle owned or leased by local government and used by the public; and~~
~~(5) Any place in a local vehicle.~~

(b1) A local ordinance or other rules, laws, or policies adopted under this section may not restrict or prohibit smoking in the following places:

(1) A private residence.
(2) A private vehicle.
(3) A tobacco shop if smoke from the business does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A tobacco shop that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the tobacco shop and smoke from the shop does not migrate into an enclosed area where smoking is prohibited pursuant to this Article.
(4) All of the premises, facilities, and vehicles owned, operated, or leased by any tobacco products processor or manufacturer, or any tobacco leaf grower, processor or dealer.

(5) A designated smoking guest room in a lodging establishment. No greater than twenty percent (20%) of a lodging establishment's guest rooms may be designated smoking guest rooms.

(6) A cigar bar in operation on or before January 1, 2009 if smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. To qualify under this subsection, the cigar bar must satisfactorily report on a quarterly basis to the Department, on a form prescribed by the Department, the revenue generated from the sale of alcoholic beverages and cigars as a percentage of quarterly gross revenue. The Department shall determine whether any additional documentation is required of the cigar bar to authenticate or verify revenue data submitted by the cigar bar. This subdivision shall not apply to any business that is established for the purpose of avoiding compliance with this Article.

(7) A public place or place of employment that does not provide service to or allow entry to any person younger than 18 years old, if smoke does not migrate into an enclosed area in which smoking is prohibited pursuant to this Article, and which conspicuously posts signs at all entrances and provides notice in all advertising and employment materials stating that smoking is permitted.

(8) A private club.

~~(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity. As used in this Part, "local government" does not include community colleges as defined in G.S. 115D-2(2).~~

(c1) Continuing to smoke in violation of a local ordinance or other rules, laws, or policies adopted under this section constitutes an infraction, and the person committing the infraction may be punished by a fine of not more than fifty dollars ($50.00). Conviction of an infraction under this section has no consequence other than payment of a penalty. A person smoking in violation of a local ordinance or other rules, laws, or policies adopted under this section may not be assessed court costs.

~~(d) As used in this Part, "grounds" means the area located within 50 linear feet of a building wherein a local health department or a local department of social services is housed.~~

(d1) Notwithstanding G.S. 130A-25 or any other provision of law, a violation of a local ordinance, rule, law, or policy adopted under this section shall not be punishable as a misdemeanor.

(d2) A local government may enforce an ordinance, rule, law, or policy under this section against a person who manages, operates, or controls a public place only as provided in G.S. 130A-22(h1).

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122.

"**§§ 130A-499 through 130A-500: Reserved for future codification purposes.**"

SECTION 2. Effective January 2, 2010, G.S. 130A-22 is amended by adding a new subsection to read:

"(h1) A local health director may take the following actions and may impose the following administrative penalty on a person who manages, operates, or controls a public place or place of employment and fails to comply with the provisions of Part 1C of Article 23 of this Chapter or with rules adopted thereunder or with local ordinances, rules, laws, or policies adopted pursuant to Part 2 of Article 23 of this Chapter:

(1) First violation. – Provide the person in violation with written notice of the person's first violation and notification of action to be taken in the event of subsequent violations.

(2) Second violation. – Provide the person in violation with written notice of the person's second violation and notification of administrative penalties to be imposed for subsequent violations.

(3) Subsequent violations. – Impose on the person in violation an administrative penalty of not more than two hundred dollars ($200.00) for the third and subsequent violations.

Each day on which a violation of this Article or rules adopted pursuant to this Article occurs may be considered a separate and distinct violation. Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a criminal violation."

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

Attachment II

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 2

Committee Substitute Favorable 3/3/09
Committee Substitute #2 Favorable 3/25/09
Fourth Edition Engrossed 4/2/09
Corrected Copy 4/3/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H2-CSSQ-23 [v.3]

4/28/2009 8:56:09 AM

Short Title: Prohibit Smoking in Public & Workplaces. (Public)

Sponsors:

Referred to:

January 29, 2009

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT SMOKING IN PUBLIC PLACES AND PLACES OF EMPLOYMENT.

The General Assembly of North Carolina enacts:

SECTION 1. Effective January 2, 2010, Article 23 of Chapter 130A of the General Statutes reads as rewritten:

"Article 23.

"Smoking Prohibited in Public ~~Places.~~Places and Places of Employment.

~~Part 1. Smoking in State Government Buildings.~~"Part 1A. Findings and Intent.

"**§ 130A-491. Legislative findings and intent.**

(a) Findings. – The General Assembly finds that secondhand smoke has been proven to cause cancer, heart disease, and asthma attacks in both smokers and nonsmokers. In 2006, a report issued by the United States Surgeon General stated that the scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.

(b) Intent. – It is the intent of the General Assembly to protect the health of individuals in public places and places of employment and riding in State government vehicles ~~working in or visiting State government buildings~~ from the risks related to secondhand smoke. It is further the intent of the General Assembly to ~~protect the health of individuals driving or riding in State-controlled passenger-carrying vehicles assigned permanently or temporarily to State employees or State agencies or institutions for official State business.~~allow local governments to adopt local laws governing smoking within their jurisdictions that are more restrictive than the State law.

"**§ 130A-492. Definitions.**

The following definitions apply in this Article:

(1) "Cigar bar". – An establishment with a permit to sell alcoholic beverages pursuant to subdivisions (1), (3), (5), or (10) of G.S. 18B-1001 that satisfies all of the following:

a. Generates sixty percent (60%) or more of its quarterly gross revenue from the sale of alcoholic beverages and twenty-five percent (25%) or more of its quarterly gross revenue from the sale of cigars;

b. Has a humidor on the premises; and
c. Does not allow individuals under the age of 21 to enter the premises.

Revenue generated from other tobacco sales, including cigarette vending machines, shall not be used to determine whether an establishment satisfies the definition of cigar bar.

(1a) "Employee". – A person who is employed by an employer, or who contracts with an employer or third person to perform services for an employer, or who otherwise performs services for an employer with or without compensation.

(2) "Employer". – An individual person, business, association, political subdivision, or other public or private entity, including a nonprofit entity, that employs or contracts for or accepts the provision of services from one or more employees.

(3) "Enclosed area". – An area with a roof or other overhead covering of any kind and walls or side coverings of any kind, regardless of the presence of openings for ingress and egress, on all sides or on all sides but one.

(4) "Grounds". – An unenclosed area owned, leased, or occupied by State or local government.

(5) "Local government". – A local political subdivision of this State, an airport authority, or an authority or body created by an ordinance, joint resolution, or rules of any such entity.

(6) "Local government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by a local government.

(7) "Lodging establishment". – An establishment that provides lodging for pay to the public.

(8) "Local vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by local government and assigned permanently or temporarily by local government to local government employees, agencies, institutions, or facilities for official local government business.

(8a) "Place of employment". – An enclosed area under the control of a public or private employer that employees use during the course of employment or for any other purpose.

(8b) "Private club". – organization that maintains selective members, is operated by the membership, does not provide food or lodging for pay to anyone who is not a member or a member's guest, does not allow individuals under the age of 21 to enter the premises, and is either incorporated as a nonprofit corporation in accordance with Chapter 55A of the General Statutes or is exempt from federal income tax under the Internal Revenue Code as defined in G.S. 105-130.2(1).

(8c) "Private residence". – A private dwelling that is not a child care facility, as defined in G.S. 110-86(3), and not a long-term care facility, as defined in G.S. 131E-114.3(a)(1).

(8d) "Private vehicle". – A privately owned vehicle that is not used for commercial or employment purposes.

(8e) "Public place". – An enclosed area to which the public is invited or in which the public is permitted.

(9) "Smoking". – The use or possession of a lighted cigarette, lighted cigar, lighted pipe, or any other lighted tobacco product.

(10) "State government". – The political unit for the State of North Carolina, including all agencies of the executive, judicial, and legislative branches of government.

(11) "State government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by State government.

(12) "State vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by the State and assigned permanently or temporarily to a State employee or State agency or institution for official State business.

(13) "Tobacco shop". – A business establishment, the main purpose of which is the sale of tobacco, tobacco products, and accessories for such products, that receives no less than seventy-five percent (75%) of its total annual revenues from the sale of tobacco, tobacco products, and accessories for such products, and does not serve food or alcohol on its premises.

"Part 1B. Smoking Prohibited in State Government Buildings and Vehicles.

"§ 130A-493. Smoking prohibited in State government buildings and State ~~vehicles prohibited.~~vehicles.

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes pertaining to State-controlled buildings, smoking is prohibited inside State government buildings except as provided in subsection (b) of this section. ~~As to smoking rooms in residence halls that were permitted by G.S. 143-597(a)(6), this Article becomes effective beginning with the 2008-2009 academic year.~~

(b) Smoking is permitted inside State government buildings that are used for medical or scientific research to the extent that smoking is an integral part of the research. Smoking permitted under this subsection shall be confined to the area where the research is being conducted.

(c) The individual in charge of the State government building or the individual's designee shall post signs in conspicuous areas of the building. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. In addition, ~~in any State psychiatric hospital, the person who owns, manages, operates, or otherwise controls the hospital shall:~~the individual in charge of the building or the individual's designee shall:

(1) Direct ~~any~~ a person who is smoking inside the ~~facility~~ building to extinguish the lighted smoking product.

(2) ~~Provide~~ In a State psychiatric hospital, provide written notice to individuals upon admittance that smoking is prohibited inside the ~~facility~~ building and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c1) Smoking is prohibited inside State vehicles. The individual or the individual's designee in charge of assigning the vehicle shall place one or more signs in conspicuous areas of the vehicle. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. If the vehicle is used for undercover law enforcement operations, a sign is not required to be placed in the vehicle as provided in this subsection.

(d) Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a misdemeanor.

"§ 130A-494. Other prohibitions.

Nothing in this Article repeals any other law prohibiting smoking, nor does it limit any law allowing regulation or prohibition of smoking on walkways or on the grounds of buildings.

"§ 130A-495. Rules.

The Commission shall adopt rules to implement this Part.

"Part 1C. Smoking Prohibited in Public Places and Places of Employment.

"§ 130A-496. Smoking prohibited in public places and places of employment.

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes, smoking is prohibited in public places and places of employment, except as provided in subsection (b) of this section.

(b) Smoking may be permitted in the following places:

(1) A private residence.

(2) A private vehicle.

(3) A tobacco shop if smoke from the business does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A tobacco shop that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the tobacco shop and smoke from the shop does not migrate into an enclosed area where smoking is prohibited pursuant to this Article.

(4) All of the premises, facilities, and vehicles owned, operated, or leased by any tobacco products processor or manufacturer, or any tobacco leaf grower, processor, or dealer.

(5) A designated smoking guest room in a lodging establishment. No greater than twenty percent (20%) of a lodging establishment's guest rooms may be designated smoking guest rooms.

(6) A cigar bar if smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A cigar bar that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the cigar bar and smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. To qualify under this subsection, the cigar bar must satisfactorily report on a quarterly basis to the Department, on a form prescribed by the Department, the revenue generated from the sale of alcoholic beverages and cigars as a percentage of quarterly gross revenue. The Department shall determine whether any additional documentation is required of the cigar bar to authenticate or verify revenue data submitted by the cigar bar. This subdivision shall not apply to any business that is established for the purpose of avoiding compliance with this Article.

(7) A private club.

(8) A motion picture, television, theater or other live production set. This exemption applies only to the actor or performer portraying the use of tobacco products during the production.

"**§ 130A-497. Implementation and enforcement.**

(a) A person who manages, operates, or controls a public place or place of employment in which smoking is prohibited shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited. The signs may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Remove all indoor ashtrays and other smoking receptacles.

(3) Direct a person who is smoking to extinguish the lighted tobacco product.

(b) Continuing to smoke in a nonsmoking area described in this Part following oral or written notice by the person in charge of the area or the person's designee constitutes an infraction, and the person committing the infraction may be punished by a fine of not more than fifty dollars ($50.00).

(c) Conviction of an infraction under this section has no consequence other than payment of a penalty. A person found responsible for a violation of this section may not be assessed court costs.

(d) Notwithstanding G.S. 130A-25, a violation of this Part shall not be punishable as a misdemeanor.

(e) Administrative penalties imposed under G.S. 130A-22(h1) against a person who manages, operates, or controls a public place or place of employment and fails to comply with the provisions of this Article and the rules adopted by the Commission to implement the provisions of this Article shall only be enforced by a local health director.

(f) The Commission shall adopt rules to implement the provisions of this Article.

"Part 2. Local Government Regulation of Smoking.

"§ 130A-498. Local governments may restrict smoking in public places.

(a) ~~Notwithstanding~~ Except as otherwise provided in subsection (b1) of this section, and notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to the contrary, a local government may adopt ~~an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this section.~~and enforce ordinances, board of health rules, and other laws or policies restricting or prohibiting smoking that are more restrictive than State law and that apply in local government buildings, on local government grounds, in local vehicles, or in public places. The definitions set forth in G.S. 130A-492 in Part 1A of this Article apply to this section and shall apply to any local ordinance, rule, or law adopted by a local government under this section.

~~(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:~~

~~(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;~~

~~(2) Building and grounds wherein local health departments and departments of social services are housed;~~

~~(3) Repealed by Session Laws 2007-193, s. 3.1, effective August 1, 2008.~~

~~(4) Any place on a public transportation vehicle owned or leased by local government and used by the public; and~~

~~(5) Any place in a local vehicle.~~

(b1) A local ordinance or other rules, laws, or policies adopted under this section may not restrict or prohibit smoking in the following places:

(1) A private residence.

(2) A private vehicle.

(3) A tobacco shop if smoke from the business does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A tobacco shop that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the tobacco shop and smoke from the shop does not migrate into an enclosed area where smoking is prohibited pursuant to this Article.

(4) All of the premises, facilities, and vehicles owned, operated, or leased by any tobacco products processor or manufacturer, or any tobacco leaf grower, processor, or dealer.

(5) A designated smoking guest room in a lodging establishment. No greater than twenty percent (20%) of a lodging establishment's guest rooms may be designated smoking guest rooms.

(6) A cigar bar if smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A cigar bar that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the cigar bar and smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. To qualify under this subsection, the cigar bar must satisfactorily report on a quarterly basis to the Department, on

a form prescribed by the Department, the revenue generated from the sale of alcoholic beverages and cigars as a percentage of quarterly gross revenue. The Department shall determine whether any additional documentation is required of the cigar bar to authenticate or verify revenue data submitted by the cigar bar. This subdivision shall not apply to any business that is established for the purpose of avoiding compliance with this Article.

(7) A private club.

(8) A motion picture, television, theater or other live production set. This exemption applies only to the actor or performer portraying the use of tobacco products during the production.

~~(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity. As used in this Part, "local government" does not include community colleges as defined in G.S. 115D-2(2).~~

(c1) Continuing to smoke in violation of a local ordinance or other rules, laws, or policies adopted under this section constitutes an infraction, and the person committing the infraction may be punished by a fine of not more than fifty dollars ($50.00). Conviction of an infraction under this section has no consequence other than payment of a penalty. A person smoking in violation of a local ordinance or other rules, laws, or policies adopted under this section may not be assessed court costs.

~~(d) As used in this Part, "grounds" means the area located within 50 linear feet of a building wherein a local health department or a local department of social services is housed.~~

(d1) Notwithstanding G.S. 130A-25 or any other provision of law, a violation of a local ordinance, rule, law, or policy adopted under this section shall not be punishable as a misdemeanor.

(d2) A local government may enforce an ordinance, rule, law, or policy under this section against a person who manages, operates, or controls a public place only as provided in G.S. 130A-22(h1).

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122.

"**§§ 130A-499 through 130A-500: Reserved for future codification purposes.**"

SECTION 2. Effective January 2, 2010, G.S. 130A-22 is amended by adding a new subsection to read:

"(h1) A local health director may take the following actions and may impose the following administrative penalty on a person who manages, operates, or controls a public place or place of employment and fails to comply with the provisions of Part 1C of Article 23 of this Chapter or with rules adopted thereunder or with local ordinances, rules, laws, or policies adopted pursuant to Part 2 of Article 23 of this Chapter:

(1) First violation. – Provide the person in violation with written notice of the person's first violation and notification of action to be taken in the event of subsequent violations.

(2) Second violation. – Provide the person in violation with written notice of the person's second violation and notification of administrative penalties to be imposed for subsequent violations.

(3) Subsequent violations. – Impose on the person in violation an administrative penalty of not more than two hundred dollars ($200.00) for the third and subsequent violations.

Each day on which a violation of this Article or rules adopted pursuant to this Article occurs may be considered a separate and distinct violation. Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a criminal violation."

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

Attachment III

HOUSE BILL 2:
Prohibit Smoking in Public & Workplaces

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	April 28, 2009
Introduced by:	Reps. Holliman, Weiss, Glazier, Barnhart	**Prepared by:**	Shawn Parker
Analysis of:	PCS to Fifth Edition H2-CSSQ-23		Legislative Analyst

SUMMARY: ***The Senate Proposed Committee Substitute to House Bill 2 (fifth edition) amends Article 23 (Smoking in Public Places) of Chapter 130A (Public Health) of the General Statutes to provide for the regulation of smoking in enclosed public places and places of employment.***

The SPCS changes the fifth edition of the bill as follows:

- *Deletes from the definition of "place of employment" the exception for privately owned work spaces.*
- *Authorizes smoking in cigar bars that meet certain standards and are or become operational after January 1, 2009.*
- *Removes from the provisions permitting smoking (and prohibiting local governments from enacted laws to restrict smoking) in public places or places of employment that do not provide service to or allow entry to persons under the age of 18.*
- *Exempts actors and other performers portraying the use of tobacco products as part of a production on a motion picture, television, theater, and other live production set.*

CURRENT LAW: Article 23 (Smoking in Public Places) of Chapter 130A (Public Health) of the General Statutes currently consists of two parts – Part 1 "Smoking in State Government Buildings", which prohibits smoking in State government buildings, with certain limited exceptions, and Part 2 "Local Government Regulation of Smoking", which authorizes local governments to adopt ordinances to restrict smoking in buildings owned or leased by local government, buildings and grounds of local health departments or department of social services, and on public transportation vehicles owned or leased by local government.

BILL ANALYSIS: House Bill 2 would amend Article 23 of Chapter 130A of the General Statutes by amending the title of Article 23 to read, "Smoking in Public Places and Places of Employment" and by restructuring the Article to include the following Parts and provisions:

Part 1A. Findings and Intent – The bill provides a new "findings" section, revises the existing intent language in G.S. 130A-491, and inserts additional definitions to G.S. 130A-492. As used in the Article:

- Cigar bar- an establishment with a permit to sell alcoholic beverages, generates 60% or more of its quarterly gross revenue from the sale of alcoholic beverages and 25% or more of its quarterly gross revenues from the sale of cigars, has a humidor on the premises, and does not allow individuals under the age of 21 to enter the premises.
- Enclosed area- an area with a roof or other overhead covering of any kind and walls or side coverings of any kind on all sides or on all but one side.
- Lodging Establishment- an establishment that provides lodging for pay to the public.
- Place of employment- An ***enclosed*** area under the control of a public or private employer that employees use during the course of employment or for any other purpose.

- Private club- is an organization that maintains selective membership, is operated by the membership, does not provide food or lodging to persons who are not either members or guest of members, does not allow individuals under the age of 21 to enter the premises, and is either incorporated as a nonprofit or is exempt from federal income tax under the Internal Revenue Code.
- Private residence- a private residence that is ***not*** used as a child care facility or a long-term care facility.
- Public Place- an ***enclosed*** area to which the public is invited or permitted.
- Tobacco Shop- A business establishment that ***does not serve*** food or alcohol on its premises and receives no less than 75% of its total annual revenues from the sale of tobacco, tobacco products, and product related accessories.

Part 1B. Smoking Prohibited in State Government Buildings and Vehicles – The bill provides technical changes to the existing G.S. 130A-493, by amending it to eliminate an obsolete provision relating to residence halls and restructuring language applying to State psychiatric hospitals.

Part 1C. Smoking Prohibited in Public Places and Places of Employment – The bill creates the following two new sections:

G.S. 130A-496. Prohibits smoking in public places and places of employment, with the following exceptions:

- Public places and places of employment that are not considered enclosed areas.
- Private residences, except when used as a child care facility as defined in G.S. 110-86(3) or a long-term care facility as defined in G.S. 131E-114.3(a)(1).
- Privately owned vehicles that are not used for commercial or employment purposes.
- A tobacco shop, if smoke doesn't migrate into an enclosed nonsmoking area.
- The premises, facilities, and vehicles of tobacco product manufacturers or processors.
- A designated smoking guest room in a lodging establishment (up to 20% of guest rooms).
- A cigar bar, if smoke doesn't migrate into an enclosed nonsmoking area. Cigar bars that begin operation after July 1, 2009 must be freestanding structures.
- Private clubs as defined in G.S. 130A-492.
- Motion picture, television, theater or other live production set, the exemption applies only to the actor or performer portraying the use of tobacco products during the production.

G.S. 130A-497. Directs the Commission for Public Health to adopt rules to implement the provisions of Article 23 and directs the person who manages, operates, or controls a public place or place of employment where smoking is prohibited to do the following:

- Conspicuously post signs stating smoking is prohibited.
- Remove all indoor ashtrays and other smoking receptacles.
- Direct a person who is smoking to extinguish the lighted tobacco product.

Administrative penalties may only be enforced by a local health director.

The section further provides that persons continuing to smoke in a nonsmoking area after being given notice would be committing an infraction and could be punished by a fine of not more than $50. Persons convicted of this infraction would not be assessed court costs and would suffer no consequence beyond payment of the fine.

Part 2. Local Government Regulation of Smoking – Amends G.S. 130A-498 authorizing a local government to adopt ordinances, rules, laws or policies restricting smoking that are more restrictive than State law and that apply in local government buildings, *on local government grounds*, in local vehicles, or in public places. The Part provides that the definitions set forth in Part 1A of the Article apply to any local ordinance, rule, or law adopted by a local government. The exceptions to a restriction by ordinance, rule, law or policy mirror those provided in Part 1C.

Section 2 of the bill amends the administrative penalty provision of the Public Health Chapter by adding a new subsection (h1) into G.S. 130A-22. The subsection provides a local health director with the authority to impose the following administrative penalty on persons in control of a public place or a place of employment who fail to comply with the provisions of Article 23:

- First violation – written notice of violation and notification of action for later violations.
- Second violation – written notice of violation and notice of action for later violations.
- Third and subsequent violations – Impose administrative penalty of not more than $200.

EFFECTIVE DATE: The act is effective when it becomes law.

Ben Popkin, counsel to House Health, contributed to this summary.

H2-SMSQ-49(CSSQ-23) v1

North Carolina Department of Health and Human Services
Division of Public Health
1931 Mail Service Center • Raleigh, North Carolina 27699-1931
Beverly Eaves Perdue, Governor
Lanier Cansler, Secretary
Jeffrey P. Engel, M.D.
State Health Director

Proposed Education and Enforcement for HB 2
March 3, 2009

- **This law would be enforced through a complaint driven system,** meaning that individual citizens must take the step to make a complaint for enforcement processes to be engaged.

- **The law would also be self-enforcing by the general public.**
Other states that have passed similar laws have found that once the public knows about the law and businesses understand their simple and practical responsibilities, the law becomes self enforcing. North Carolinians want this law, and are law abiding; a polite request will be all that is needed in the vast majority of cases.

- **Requirements are simple and practical.**
A business owner must:
  1) Conspicuously post signs clearly stating that smoking is prohibited.
  2) Remove all indoor ashtrays and other smoking receptacles.
  3) Direct a person who is smoking to extinguish the lighted tobacco product.
  4) On the rare occasion when a person refuses to put out a lighted tobacco product when asked, the law allows the owner to call in local law enforcement, as they are skilled in public safety and handling people who are unruly. (This is no different than when law enforcement is called to address other situations of unruly behavior, such as patrons who drink too much.)
  5) In these circumstances, law enforcement ***may*** determine there is an infraction and ***may*** issue a fine to the individual of not more than fifty dollars ($50.00).

- **Local Health Departments, with assistance from the NC DPH, will be responsible for helping businesses take the steps outlined above to come into compliance.** However, if a business fails to comply with the indoor smoking restrictions ***and*** a complaint is registered with the local health department, then the following process may be followed:
  - The administrative rules will propose that local health departments send educational letters to business owners based on the first two documented complaints. These letters provide specific information about the law, the reported violations, and educational materials to assist the business owner with coming into compliance with the law.
  - The complaint is substantiated by the local health department and a first written warning is issued;
  - Upon a second complaint, the complaint is substantiated by the local health department and a second written notice is issued;
  - Upon a third complaint, a fine of not more than $200 ***may*** be pursued by the local health department based upon inspection and validation of all subsequent complaints.

- **Education is Key.** The Health and Wellness Trust Fund and the Tobacco Prevention and Control Branch, NC Division of Public Health will be asked to work to educate the public and the business community about the benefits of the new law through existing resources and to work with local health directors and local boards of health to provide assistance with the implementation of this law including providing smoking cessation and prevention resources.

North Carolina's Secondhand Smoke Healthcare Cost Burden

Prepared by:
Susan Pfannenschmidt
Daryl Wansink

Clinical Informatics Department
Blue Cross and Blue Shield of North Carolina

- Blue Cross Blue Shield of Minnesota (BCBSMN) and Johns Hopkins Bloomberg School of Public Health (JHBSPH) collaborated to build a model that estimated the economic burden of secondhand smoke exposure in the state of Minnesota for 2006. The results were recently published in the American Journal of Public Health[1].

- The NC Division of Public Health approached BCBSNC to replicate the study.

- Clinical Informatics replicated the methodology used by BCBSMN and JHBSPH:

    - BCBSNC data were used to estimate disease prevalence and healthcare costs.
    - US census and Medical Expenditure Panel Survey data were used to extrapolate prevalence and cost from BCBSNC members to the entire state of North Carolina.

- Dr. Hugh Waters of JHBSPH reviewed the BCBSNC methodology and approved the methodology and results.

- It is estimated that second hand smoke resulted in $288.8 million (Table 1) in excess medical costs in North Carolina in 2006 (adjusted to 2008 dollars).

- This estimate does not consider other costs such as lost productivity, long-term care and disability services not covered by BCBSNC, or the impact on quality of life.

Table 1. Medical Costs of Health Conditions Caused by Secondhand Smoke Exposure in North Carolina, 2006

Condition[2]	Number of North Carolinians Treated for Conditions Caused by Secondhand Smoke[3]	Total Cost (in 2008 dollars)[4]
Birth to Age 17		
Low Birth Weight (under 5.5 lbs.)[5]	2,087	$75,976,172
Acute Lower Respiratory Illness (birth to age 3 only)	14,158	$7,678,715
Otitis Media and Middle Ear Effusion	50,092	$14,561,054
Asthma	30,289	$25,972,081
Ages 18+		
Lung Cancer	559	$32,269,388
Heart Attacks and Other Heart Diseases	9,883	$132,378,807
TOTAL	107,067	$288,836,216

[1] Hugh R. Waters, Steven S. Foldes, Nina L. Alesci, and Jonathan Samet. The Economic Impact of Exposure to Secondhand Smoke in Minnesota. *Am J Public Health, Feb 2009*; doi:10.2105/AJPH.2008.137430.

[2] The US Surgeon general determined a causal link between these conditions and secondhand smoke exposure in a 2006 report, The Health Consequences of Involuntary Exposure to Secondhand Smoke Available online at http://www.surgeongeneral.gov/library/secondhandsmoke/ .

[3] See Table 2 for calculations to derive these numbers.

[4] Based on BCBSNC allowed amounts for episodes of care related to these conditions occurring in 2006.

[5] NC Vital Statistics 2006, BCBSNC data not used for this estimate.

Table 2. Treated Prevalence of Conditions Causally Related to Secondhand Tobacco Smoke Exposure: North Carolina, 2006

Condition	North Carolina Susceptible Population[6]	Treated Prevalence[7]	Number with Episodes	PAR[8]	No. of Episodes Attributable to SHS
Birth to Age 17					
Low Birth Weight (under 5.5 lbs.)	127,646	9.084%	11,595	18.0%	2,087
Acute Lower Respiratory Illness (birth to age 3 only)	473,306	11.965%	56,629	25.0%	14,158
Otitis Media and Middle Ear Effusion	2,151,548	16.630%	357,798	14.0%	50,092
Asthma	2,151,548	4.022%	86,528	35.0%	30,289
Ages 18-64					
Lung Cancer	5,660,468	0.077%	4,369	4.9%	214
Heart Attacks and Other Heart Diseases	5,660,468	1.874%	106,095	6.9%	7,332
Ages 65+					
Lung Cancer	1,057,639	0.664%	7,028	4.9%	344
Heart Attacks and Other Heart Diseases	1,057,639	3.496%	36,973	6.9%	2,551

[6] *U.S. Census Bureau, Housing and Household Economic Statistics Division* Available at: http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

[7] BCBSNC prevalence of episodes of care for members who were residents of NC in 2006.

[8] PAR = Population Attributable Risk indicates the proportion of disease incidence due to secondhand smoke using the following sources:

U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office of Smoking and Health, 2006 . Available online at http://www.surgeongeneral.gov/library/secondhandsmoke/ .

Zollinger TW, et al. (2004) Estimating the Economic Impact of Secondhand Smoke on the Health of a Community. Am J Health Promotion; 18: 232-238.

The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General, U.S. Department of Health and Human Services

6 Major Conclusions of the Surgeon General Report

Smoking is the single greatest avoidable cause of disease and death. In this report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*, the Surgeon General has concluded that:

1. Many millions of Americans, both children and adults, are still exposed to secondhand smoke in their homes and workplaces despite substantial progress in tobacco control.

   Supporting Evidence

   - Levels of a chemical called cotinine, a biomarker of secondhand smoke exposure, fell by 70 percent from 1988-91 to 2001-02. In national surveys, however, 43 percent of U.S. nonsmokers still have detectable levels of cotinine.
   - Almost 60 percent of U.S. children aged 3-11 years—or almost 22 million children—are exposed to secondhand smoke.
   - Approximately 30 percent of indoor workers in the United States are not covered by smoke-free workplace policies.

2. Secondhand smoke exposure causes disease and premature death in children and adults who do not smoke.

   Supporting Evidence

   - Secondhand smoke contains hundreds of chemicals known to be toxic or carcinogenic (cancer-causing), including formaldehyde, benzene, vinyl chloride, arsenic, ammonia, and hydrogen cyanide.
   - Secondhand smoke has been designated as a *known human carcinogen* (cancer-causing agent) by the U.S. Environmental Protection Agency, National Toxicology Program and the International Agency for Research on Cancer (IARC). The National Institute for Occupational Safety and Health has concluded that secondhand smoke is an occupational carcinogen.

3. Children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.

   Supporting Evidence

   - Children who are exposed to secondhand smoke are inhaling many of the same cancer-causing substances and poisons as smokers. Because their bodies are developing, infants and young children are especially vulnerable to the poisons in secondhand smoke.
   - Both babies whose mothers smoke while pregnant and babies who are exposed to secondhand smoke after birth are more likely to die from sudden infant death syndrome (SIDS) than babies who are not exposed to cigarette smoke.
   - Babies whose mothers smoke while pregnant or who are exposed to secondhand smoke after birth have weaker lungs than unexposed babies, which increases the risk for many health problems.
   - Among infants and children, secondhand smoke cause bronchitis and pneumonia, and increases the risk of ear infections.
   - Secondhand smoke exposure can cause children who already have asthma to experience more frequent and severe attacks.

4. Exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.

   Supporting Evidence

   - Concentrations of many cancer-causing and toxic chemicals are higher in secondhand smoke than in the smoke inhaled by smokers.
   - Breathing secondhand smoke for even a short time can have immediate adverse effects on the cardiovascular system and interferes with the normal functioning of the heart, blood, and vascular systems in ways that increase the risk of a heart attack.
   - Nonsmokers who are exposed to secondhand smoke at home or at work increase their risk of developing heart disease by 25 - 30 percent.
   - Nonsmokers who are exposed to secondhand smoke at home or at work increase their risk of developing lung cancer by 20 - 30 percent.

5. The scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.

Supporting Evidence

- Short exposures to secondhand smoke can cause blood platelets to become stickier, damage the lining of blood vessels, decrease coronary flow velocity reserves, and reduce heart rate variability, potentially increasing the risk of a heart attack.
- Secondhand smoke contains many chemicals that can quickly irritate and damage the lining of the airways. Even brief exposure can result in upper airway changes in healthy persons and can lead to more frequent and more asthma attacks in children who already have asthma.

6. Eliminating smoking in indoor spaces fully protects nonsmokers from exposure to secondhand smoke. Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposures of nonsmokers to secondhand smoke.

Supporting Evidence

- Conventional air cleaning systems can remove large particles, but not the smaller particles or the gases found in secondhand smoke.
- Routine operation of a heating, ventilating, and air conditioning system can distribute secondhand smoke throughout a building.
- The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), the preeminent U.S. body on ventilation issues, has concluded that ventilation technology cannot be relied on to control health risks from secondhand smoke exposure.

The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General was prepared by the Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC). The Report was written by 22 national experts who were selected as primary authors. The Report chapters were reviewed by 40 peer reviewers, and the entire Report was reviewed by 30 independent scientists and by lead scientists within the Centers for Disease Control and Prevention and the Department of Health and Human Services. Throughout the review process, the Report was revised to address reviewers' comments.

Citation

U.S. Department of Health and Human Services. *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General.* U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health, 2006.

For more information, please refer to the Resources page. Additional highlight sheets are also available at www.cdc.gov/tobacco.

Last revised: January 4, 2007

Secondhand Smoke is toxic

Cancer Causing Chemicals

All are extremely toxic

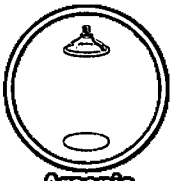
Metals

Can cause cancer
Can cause death
Can damage the brain and kidneys

Formaldehyde
Used to embalm dead bodies

Chromium
Used to make steel

Benzene
Found in gasoline



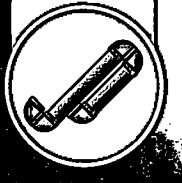
Arsenic
Used in pesticides

Secondhand smoke has more than 4,000 chemicals.

Polonium-210
Radioactive and very toxic

Lead
Once used in paint

Many of these chemicals are toxic and cause cancer.



Vinyl Chloride
Used to make pipes

Cadmium
Used in making batteries

You breathe in these chemicals when you are around someone who is smoking.

Carbon Monoxide
Found in car exhaust

Toluene
Found in paint thinners

Hydrogen Cyanide
Used in chemical weapons

Butane
Used in lighter fluid

Ammonia
Used in household cleaners

Poison Gases

Can cause death
Can affect heart and respiratory functions
Can burn your throat, lungs, and eyes
Can cause unconsciousness

Secondhand smoke
It hurts you. It doesn't take much. It doesn't take long.

CDC

U.S. Department of Health & Human Services

Office of the Surgeon General

The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General, U.S. Department of Health and Human Services

There is No Risk-Free Level of Exposure to Secondhand Smoke

The U.S. Surgeon General has concluded that breathing even a little secondhand smoke poses a risk to your health.

- Scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke. Breathing even a little secondhand smoke can be harmful to your health.

Secondhand smoke causes lung cancer.

- Secondhand smoke is a known human carcinogen and contains more than 50 chemicals that can cause cancer.
- Concentrations of many cancer-causing and toxic chemicals are potentially higher in secondhand smoke than in the smoke inhaled by smokers.

Secondhand smoke causes heart disease.

- Breathing secondhand smoke for even a short time can have immediate adverse effects on the cardiovascular system, interfering with the normal functioning of the heart, blood, and vascular systems in ways that increase the risk of heart attack.
- Even a short time in a smoky room can cause your blood platelets to become stickier, damage the lining of blood vessels, decrease coronary flow velocity reserves, and reduce heart rate variability.
- Persons who already have heart disease are at especially high risk of suffering adverse affects from breathing secondhand smoke, and should take special precautions to avoid even brief exposure.

Secondhand smoke causes acute respiratory effects.

- Secondhand smoke contains many chemicals that can quickly irritate and damage the lining of the airways.
- Even brief exposure can trigger respiratory symptoms, including cough, phlegm, wheezing, and breathlessness.
- Brief exposure to secondhand smoke can trigger an asthma attack in children with asthma.
- Persons who already have asthma or other respiratory conditions are at especially high risk for being affected by secondhand smoke, and should take special precautions to avoid secondhand smoke exposure.

Secondhand smoke can cause sudden infant death syndrome and other health consequences in infants and children.

- Smoking by women during pregnancy has been known for some time to cause SIDS.
- Infants who are exposed to secondhand smoke after birth are also at greater risk of SIDS.
- Children exposed to secondhand smoke are also at an increased risk for acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.

Separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate secondhand smoke exposure.

- The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), the preeminent U.S. standard-setting body on ventilation issues, has concluded that ventilation technology cannot be relied on to completely control health risks from secondhand smoke exposure.
- Conventional air cleaning systems can remove large particles, but not the smaller particles or the gases found in secondhand smoke.
- Operation of a heating, ventilating, and air conditioning system can distribute secondhand smoke throughout a building.

Information contained on this highlight sheet has been taken directly from The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. For more information, please refer to the Resources and How to Protect Yourself and Your Loved Ones from Secondhand Smoke highlight sheets. Additional highlight sheets are also available at www.cdc.gov/tobacco.

Last revised: January 4, 2007

Am. IV
amendment failed

(V)

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 2

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

H2-ARD-16 [v.1]

Comm. Sub. [YES]
Amends Title [NO]
Fifth Edition

Date _____,2009

Senator Goodall

moves to amend the bill on page 2, lines 30-32, by rewriting the lines to read:

"(8a) "Place of employment". – An enclosed area under the control of a public or private employer that employees use during the course of employment or for any other purpose. A privately owned workplace is not a place of employment under this Article if it satisfies all of the following:

a. The employer is an individual person and consents to allow smoking in the workplace or, in the case of a private employer other than an individual person, all owners of the employer consent to allow smoking in the workplace;

b. The workplace is not open to employees other than owners of the employer and is not open to the public;

c. The workplace does not allow entry to minors; and

d. Smoke does not migrate into an enclosed area in which smoking is prohibited under this Article.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

Aft. V
Jacumin amendment. Failed:

Amendment to HB 2, Committee Substitute **H2-CSSQ-23 [v.3]**

Moves to amend bill on page 1, line 8, by inserting between the lines:

"(9) A public place and place of employment in which no employee is younger than 18 years old if smoke does not migrate into an enclosed area in wich smoking is prohibited pursuant to this Article, and which conspicuously posts signs at all entrances and provides notice in all advertising and employment materials stating that smoking is permitted.";

And on page 4, line 8, by inserting between the lines:

"(9) A public place and place of employment in which no employee is younger than 18 years old if smoke does not migrate into an enclosed area in wich smoking is prohibited pursuant to this Article, and which conspicuously posts signs at all entrances and provides notice in all advertising and employment materials stating that smoking is permitted."

Senate Health Care Committee
Wednesday, May 6, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 2	**Prohibit Smoking in Public & Work Places.**	**Rep. Barnhart Representative Weiss Rep. Holliman Representative Glazier**
SB 1022	**Comparative Effectiveness Task Force.**	**Senator Stein**
SB 765	**Clarify Patient Data/Medical Care Data Act.**	**Senator Stein**
SB 694	**Amend Dentistry Laws/Out of State Dentists.**	**Senator Garrou**
SB 917	**Cancer Patient Assistance.**	**Senator Dorsett**
SB 331	**MH/National Accred. Benchmarks.**	**Senator Berger**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 06, 2009

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

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

S.B. **1022** Comparative Effectiveness Task Force.

Draft Number:	15256
Sequential Referral:	None
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

H.B.(SCS #1) **2** Prohibit Smoking in Public & Work Places.

Draft Number:	80406
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 06, 2009

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

FAVORABLE

S.B. **765** Clarify Patient Data/Medical Care Data Act.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, May 07, 2009

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

FAVORABLE

S.B. **917** Cancer Patient Assistance.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, May 07, 2009

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

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

S.B. **331** MH/National Accred. Benchmarks.

Draft Number:	15241
Sequential Referral:	None
Recommended Referral:	Select Committee on Employee Hospital and Medical Benefits
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, May 6, 2009 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, May 6, 2009, in Room 544 of the Legislative Office Building, with twenty-three members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Bingham recognized Senator Stein to present Senate Bill 1022, ***Comparative Effectiveness Task Force***. Senator Dannelly moved to hear the PCS, which passed. Senator Stein stated Senate Bill 1022 would establish a Comparative Effectiveness Task Force, which would be comprised of key North Carolina stakeholders in research, education, and delivery of health care. The purpose of Senate Bill 1022 was to study the comparative effectiveness of various medical treatments and prescription medications in order to identify the health care practice methods and protocols that best improve the health of North Carolina's citizens and still contain health care costs. After much discussion Senator Rand moved for an unfavorable report as to the original bill, favorable as to the PCS. The motion passed.

Again Senator Bingham recognized Senator Stein to present Senate Bill 765, ***Clarify Patient Data/Medical Care Data Act***. Senator Stein explained this was an act to clarify that emergency department data and ambulatory surgical data were to be included in the patient data submission requirements of the Medical Care Data Act. There was no opposition. Senator Dorsett moved for a favorable report. The motion passed.

Senator Bingham introduced Representative Holliman to present House Bill 2, ***Prohibit Smoking in Public and Work Places***. Senator Dorsett moved to hear the PCS and the motion passed. Representative Holliman pointed out the PCS made major changes including a title change. Restaurants will be able to have outside smoking, if all sides are open except one. Senator Dannelly moved for an unfavorable report as to the original bill, favorable as to the PCS. The motion passed.

Senator Bingham called on Senator Dorsett to present Senate Bill 917, ***Cancer Patient Assistance***. Senate Bill 917 directs the Department of Health and Human Services to establish a cancer patient navigation pilot program to begin with an initial implementation of the state-wide pilot in Guilford and Mecklenburg Counties. Senator Forrester moved for a favorable report. Senator Bingham noted the bill has a sequential referral to Appropriation. The motion passed.

Senator Bingham recognized Senator Berger of Franklin to present Senate Bill 331, ***NH/National Accred. Benchmarks***. Senator Dannelly moved to hear the PCS, which passed. The Proposed Committee Substitute completely rewrites the first edition of Senate 331. The PCS authorizes the Five County Mental Health Authority, a Local

Management Entity (LME) to enroll its employees and retirees in the State Health Plan. There was an Actuarial Note. The proposed legislation would permit the Five County Mental Health Authority (Franklin, Granville, Halifax Vance, and Warren) to participate. Janet Schanzenback, NC Council of Community Programs, spoke in support of the bill. Senator Rand moved for an unfavorable report as to the original bill, favorable as to the PCS, with a recommendation to be referred to The Senate Select Committee on Employee Hospital and Medical Benefits. The motion passed.

Senator Bingham called on Senator Garrou to present Senate Bill 694, ***Amend Dentistry Laws/Out of State Dentists***. Senator Rand moved to hear the PCS and the motion passed. Senator Garrou explained that Senate Bill 694 authorizes the North Carolina State Board of Dental Examiners to waive for a period of up to twelve months in-State practice requirements of dentist issued a license by credentialing. William Potter, NC Dental Society, stated the license by credential law would be used to try to get more dentists into North Carolina. After several minutes of discussion, the committee's time ran out. The bill was not voted on and will be finalized at a later date.

The meeting adjourned at 11:55

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

HOUSE BILL 2

Committee Substitute Favorable 3/3/09
Committee Substitute #2 Favorable 3/25/09
Fourth Edition Engrossed 4/2/09
Corrected Copy 4/3/09
Senate Health Care Committee Substitute Adopted 4/29/09

Short Title: Prohibit Smoking in Public & Workplaces. (Public)

Sponsors:

Referred to:

January 29, 2009

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT SMOKING IN PUBLIC PLACES AND PLACES OF EMPLOYMENT.

The General Assembly of North Carolina enacts:

SECTION 1. Effective January 2, 2010, Article 23 of Chapter 130A of the General Statutes reads as rewritten:

"Article 23.

"Smoking Prohibited in Public ~~Places.~~Places and Places of Employment.

~~Part 1. Smoking in State Government Buildings.~~"Part 1A. Findings and Intent.

"§ 130A-491. Legislative findings and intent.

(a) Findings. – The General Assembly finds that secondhand smoke has been proven to cause cancer, heart disease, and asthma attacks in both smokers and nonsmokers. In 2006, a report issued by the United States Surgeon General stated that the scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.

(b) Intent. – It is the intent of the General Assembly to protect the health of individuals in public places and places of employment and riding in State government vehicles ~~working in or visiting State government buildings~~ from the risks related to secondhand smoke. It is further the intent of the General Assembly to ~~protect the health of individuals driving or riding in State-controlled passenger-carrying vehicles assigned permanently or temporarily to State employees or State agencies or institutions for official State business.~~allow local governments to adopt local laws governing smoking within their jurisdictions that are more restrictive than the State law.

"§ 130A-492. Definitions.

The following definitions apply in this Article:

(1) "Cigar bar". – An establishment with a permit to sell alcoholic beverages pursuant to subdivisions (1), (3), (5), or (10) of G.S. 18B-1001 that satisfies all of the following:

a. Generates sixty percent (60%) or more of its quarterly gross revenue from the sale of alcoholic beverages and twenty-five percent (25%) or more of its quarterly gross revenue from the sale of cigars;

b. Has a humidor on the premises; and

c. Does not allow individuals under the age of 21 to enter the premises.

Revenue generated from other tobacco sales, including cigarette vending machines, shall not be used to determine whether an establishment satisfies the definition of cigar bar.

(1a) "Employee". – A person who is employed by an employer, or who contracts with an employer or third person to perform services for an employer, or who otherwise performs services for an employer with or without compensation.

(2) "Employer". – An individual person, business, association, political subdivision, or other public or private entity, including a nonprofit entity, that employs or contracts for or accepts the provision of services from one or more employees.

(3) "Enclosed area". – An area with a roof or other overhead covering of any kind and walls or side coverings of any kind, regardless of the presence of openings for ingress and egress, on all sides or on all sides but one.

(4) "Grounds". – An unenclosed area owned, leased, or occupied by State or local government.

(5) "Local government". – A local political subdivision of this State, an airport authority, or an authority or body created by an ordinance, joint resolution, or rules of any such entity.

(6) "Local government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by a local government.

(7) "Lodging establishment". – An establishment that provides lodging for pay to the public.

(8) "Local vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by local government and assigned permanently or temporarily by local government to local government employees, agencies, institutions, or facilities for official local government business.

(8a) "Place of employment". – An enclosed area under the control of a public or private employer that employees use during the course of employment or for any other purpose.

(8b) "Private club". – Organization that maintains selective members, is operated by the membership, does not provide food or lodging for pay to anyone who is not a member or a member's guest, does not allow individuals under the age of 21 to enter the premises, and is either incorporated as a nonprofit corporation in accordance with Chapter 55A of the General Statutes or is exempt from federal income tax under the Internal Revenue Code as defined in G.S. 105-130.2(1).

(8c) "Private residence". – A private dwelling that is not a child care facility, as defined in G.S. 110-86(3), and not a long-term care facility, as defined in G.S. 131E-114.3(a)(1).

(8d) "Private vehicle". – A privately owned vehicle that is not used for commercial or employment purposes.

(8e) "Public place". – An enclosed area to which the public is invited or in which the public is permitted.

(9) "Smoking". – The use or possession of a lighted cigarette, lighted cigar, lighted pipe, or any other lighted tobacco product.

(10) "State government". – The political unit for the State of North Carolina, including all agencies of the executive, judicial, and legislative branches of government.

(11) "State government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by State government.

(12) "State vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by the State and assigned permanently or temporarily to a State employee or State agency or institution for official State business.

(13) "Tobacco shop". – A business establishment, the main purpose of which is the sale of tobacco, tobacco products, and accessories for such products, that receives no less than seventy-five percent (75%) of its total annual revenues from the sale of tobacco, tobacco products, and accessories for such products, and does not serve food or alcohol on its premises.

"Part 1B. Smoking Prohibited in State Government Buildings and Vehicles.

"§ 130A-493. Smoking prohibited in State government buildings and State ~~vehicles prohibited.~~vehicles.

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes pertaining to State-controlled buildings, smoking is prohibited inside State government buildings except as provided in subsection (b) of this section. ~~As to smoking rooms in residence halls that were permitted by G.S. 143-597(a)(6), this Article becomes effective beginning with the 2008-2009 academic year.~~

(b) Smoking is permitted inside State government buildings that are used for medical or scientific research to the extent that smoking is an integral part of the research. Smoking permitted under this subsection shall be confined to the area where the research is being conducted.

(c) The individual in charge of the State government building or the individual's designee shall post signs in conspicuous areas of the building. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. In addition, ~~in any State psychiatric hospital, the person who owns, manages, operates, or otherwise controls the hospital shall:~~the individual in charge of the building or the individual's designee shall:

(1) Direct ~~any~~ a person who is smoking inside the ~~facility~~ building to extinguish the lighted smoking product.

(2) ~~Provide~~ In a State psychiatric hospital, provide written notice to individuals upon admittance that smoking is prohibited inside the ~~facility~~ building and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c1) Smoking is prohibited inside State vehicles. The individual or the individual's designee in charge of assigning the vehicle shall place one or more signs in conspicuous areas of the vehicle. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. If the vehicle is used for undercover law enforcement operations, a sign is not required to be placed in the vehicle as provided in this subsection.

(d) Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a misdemeanor.

"§ 130A-494. Other prohibitions.

Nothing in this Article repeals any other law prohibiting smoking, nor does it limit any law allowing regulation or prohibition of smoking on walkways or on the grounds of buildings.

"§ 130A-495. Rules.

The Commission shall adopt rules to implement this Part.

"Part 1C. Smoking Prohibited in Public Places and Places of Employment.

"§ 130A-496. Smoking prohibited in public places and places of employment.

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes, smoking is prohibited in public places and places of employment, except as provided in subsection (b) of this section.

(b) Smoking may be permitted in the following places:

(1) A private residence.

(2) A private vehicle.

(3) A tobacco shop if smoke from the business does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A tobacco shop that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the tobacco shop and smoke from the shop does not migrate into an enclosed area where smoking is prohibited pursuant to this Article.

(4) All of the premises, facilities, and vehicles owned, operated, or leased by any tobacco products processor or manufacturer, or any tobacco leaf grower, processor, or dealer.

(5) A designated smoking guest room in a lodging establishment. No greater than twenty percent (20%) of a lodging establishment's guest rooms may be designated smoking guest rooms.

(6) A cigar bar if smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A cigar bar that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the cigar bar and smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. To qualify under this subsection, the cigar bar must satisfactorily report on a quarterly basis to the Department, on a form prescribed by the Department, the revenue generated from the sale of alcoholic beverages and cigars as a percentage of quarterly gross revenue. The Department shall determine whether any additional documentation is required of the cigar bar to authenticate or verify revenue data submitted by the cigar bar. This subdivision shall not apply to any business that is established for the purpose of avoiding compliance with this Article.

(7) A private club.

(8) A motion picture, television, theater or other live production set. This exemption applies only to the actor or performer portraying the use of tobacco products during the production.

"**§ 130A-497. Implementation and enforcement.**

(a) A person who manages, operates, or controls a public place or place of employment in which smoking is prohibited shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited. The signs may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Remove all indoor ashtrays and other smoking receptacles.

(3) Direct a person who is smoking to extinguish the lighted tobacco product.

(b) Continuing to smoke in a nonsmoking area described in this Part following oral or written notice by the person in charge of the area or the person's designee constitutes an infraction, and the person committing the infraction may be punished by a fine of not more than fifty dollars ($50.00).

(c) Conviction of an infraction under this section has no consequence other than payment of a penalty. A person found responsible for a violation of this section may not be assessed court costs.

(d) Notwithstanding G.S. 130A-25, a violation of this Part shall not be punishable as a misdemeanor.

(e) Administrative penalties imposed under G.S. 130A-22(h1) against a person who manages, operates, or controls a public place or place of employment and fails to comply with the provisions of this Article and the rules adopted by the Commission to implement the provisions of this Article shall only be enforced by a local health director.

(f) The Commission shall adopt rules to implement the provisions of this Article.

"Part 2. Local Government Regulation of Smoking.

"§ 130A-498. Local governments may restrict smoking in public places.

(a) ~~Notwithstanding~~ Except as otherwise provided in subsection (b1) of this section, and notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to the contrary, a local government may adopt ~~an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this section.~~ and enforce ordinances, board of health rules, and other laws or policies restricting or prohibiting smoking that are more restrictive than State law and that apply in local government buildings, on local government grounds, in local vehicles, or in public places. The definitions set forth in G.S. 130A-492 in Part 1A of this Article apply to this section and shall apply to any local ordinance, rule, or law adopted by a local government under this section.

~~(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:~~

~~(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;~~

~~(2) Building and grounds wherein local health departments and departments of social services are housed;~~

~~(3) Repealed by Session Laws 2007-193, s. 3.1, effective August 1, 2008.~~

~~(4) Any place on a public transportation vehicle owned or leased by local government and used by the public; and~~

~~(5) Any place in a local vehicle.~~

(b1) A local ordinance or other rules, laws, or policies adopted under this section may not restrict or prohibit smoking in the following places:

(1) A private residence.

(2) A private vehicle.

(3) A tobacco shop if smoke from the business does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A tobacco shop that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the tobacco shop and smoke from the shop does not migrate into an enclosed area where smoking is prohibited pursuant to this Article.

(4) All of the premises, facilities, and vehicles owned, operated, or leased by any tobacco products processor or manufacturer, or any tobacco leaf grower, processor, or dealer.

(5) A designated smoking guest room in a lodging establishment. No greater than twenty percent (20%) of a lodging establishment's guest rooms may be designated smoking guest rooms.

(6) A cigar bar if smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A cigar bar that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the cigar bar and smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. To qualify under this subsection, the cigar bar must satisfactorily report on a quarterly basis to the Department, on

a form prescribed by the Department, the revenue generated from the sale of alcoholic beverages and cigars as a percentage of quarterly gross revenue. The Department shall determine whether any additional documentation is required of the cigar bar to authenticate or verify revenue data submitted by the cigar bar. This subdivision shall not apply to any business that is established for the purpose of avoiding compliance with this Article.

(7) A private club.

(8) A motion picture, television, theater or other live production set. This exemption applies only to the actor or performer portraying the use of tobacco products during the production.

~~(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity. As used in this Part, "local government" does not include community colleges as defined in G.S. 115D-2(2).~~

(c1) Continuing to smoke in violation of a local ordinance or other rules, laws, or policies adopted under this section constitutes an infraction, and the person committing the infraction may be punished by a fine of not more than fifty dollars ($50.00). Conviction of an infraction under this section has no consequence other than payment of a penalty. A person smoking in violation of a local ordinance or other rules, laws, or policies adopted under this section may not be assessed court costs.

~~(d) As used in this Part, "grounds" means the area located within 50 linear feet of a building wherein a local health department or a local department of social services is housed.~~

(d1) Notwithstanding G.S. 130A-25 or any other provision of law, a violation of a local ordinance, rule, law, or policy adopted under this section shall not be punishable as a misdemeanor.

(d2) A local government may enforce an ordinance, rule, law, or policy under this section against a person who manages, operates, or controls a public place only as provided in G.S. 130A-22(h1).

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122.

"**§ 130A-499 through 130A-500: Reserved for future codification purposes.**"

SECTION 2. Effective January 2, 2010, G.S. 130A-22 is amended by adding a new subsection to read:

"(h1) A local health director may take the following actions and may impose the following administrative penalty on a person who manages, operates, or controls a public place or place of employment and fails to comply with the provisions of Part 1C of Article 23 of this Chapter or with rules adopted thereunder or with local ordinances, rules, laws, or policies adopted pursuant to Part 2 of Article 23 of this Chapter:

(1) First violation. – Provide the person in violation with written notice of the person's first violation and notification of action to be taken in the event of subsequent violations.

(2) Second violation. – Provide the person in violation with written notice of the person's second violation and notification of administrative penalties to be imposed for subsequent violations.

(3) Subsequent violations. – Impose on the person in violation an administrative penalty of not more than two hundred dollars ($200.00) for the third and subsequent violations.

Each day on which a violation of this Article or rules adopted pursuant to this Article occurs may be considered a separate and distinct violation. Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a criminal violation."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 2

Committee Substitute Favorable 3/3/09
Committee Substitute #2 Favorable 3/25/09
Fourth Edition Engrossed 4/2/09
Corrected Copy 4/3/09
Senate Health Care Committee Substitute Adopted 4/29/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H2-CSSQ-30 [v.2]

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Short Title: Prohibit Smoking in Certain Public Places. (Public)

Sponsors:

Referred to:

January 29, 2009

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT SMOKING IN CERTAIN PUBLIC PLACES AND CERTAIN PLACES OF EMPLOYMENT.

The General Assembly of North Carolina enacts:

SECTION 1. Effective January 2, 2010, Article 23 of Chapter 130A of the General Statutes reads as rewritten:

"Article 23.

"Smoking Prohibited in Public ~~Places.~~Places and Places of Employment.

~~Part 1. Smoking in State Government Buildings.~~"Part 1A. Findings and Intent.

"§ 130A-491. Legislative findings and intent.

(a) Findings. – The General Assembly finds that secondhand smoke has been proven to cause cancer, heart disease, and asthma attacks in both smokers and nonsmokers. In 2006, a report issued by the United States Surgeon General stated that the scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.

(b) Intent. – It is the intent of the General Assembly to protect the health of individuals in public places and places of employment and riding in State government vehicles ~~working in or visiting State government buildings~~ from the risks related to secondhand smoke. It is further the intent of the General Assembly to ~~protect the health of individuals driving or riding in State-controlled passenger-carrying vehicles assigned permanently or temporarily to State employees or State agencies or institutions for official State business.~~allow local governments to adopt local laws governing smoking within their jurisdictions that are more restrictive than the State law.

"§ 130A-492. Definitions.

The following definitions apply in this Article:

(1) "Bar". – An establishment with a permit to sell alcoholic beverages pursuant to subdivisions (1), (3), (5), or (10) of G.S. 18B-1001.

(1a) "Cigar bar". – An establishment with a permit to sell alcoholic beverages pursuant to subdivisions (1), (3), (5), or (10) of G.S. 18B-1001 that satisfies all of the following:

a. Generates sixty percent (60%) or more of its quarterly gross revenue from the sale of alcoholic beverages and twenty-five percent (25%) or more of its quarterly gross revenue from the sale of cigars;
b. Has a humidor on the premises; and
c. Does not allow individuals under the age of 21 to enter the premises.

Revenue generated from other tobacco sales, including cigarette vending machines, shall not be used to determine whether an establishment satisfies the definition of cigar bar.

(1b) "Employee". – A person who is employed by an employer, or who contracts with an employer or third person to perform services for an employer, or who otherwise performs services for an employer with or without compensation.

(2) "Employer". – An individual person, business, association, political subdivision, or other public or private entity, including a nonprofit entity, that employs or contracts for or accepts the provision of services from one or more employees.

(3) "Enclosed area". – An area with a roof or other overhead covering of any kind and walls or side coverings of any kind, regardless of the presence of openings for ingress and egress, on all sides or on all sides but one.

(4) "Grounds". – An unenclosed area owned, leased, or occupied by State or local government.

(5) "Local government". – A local political subdivision of this State, an airport authority, or an authority or body created by an ordinance, joint resolution, or rules of any such entity.

(6) "Local government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by a local government.

(7) "Lodging establishment". – An establishment that provides lodging for pay to the public.

(8) "Local vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by local government and assigned permanently or temporarily by local government to local government employees, agencies, institutions, or facilities for official local government business.

(8a) "Private club". – A country club or an organization that maintains selective members, is operated by the membership, does not provide food or lodging for pay to anyone who is not a member or a member's guest, and is either incorporated as a nonprofit corporation in accordance with Chapter 55A of the General Statutes or is exempt from federal income tax under the Internal Revenue Code as defined in G.S. 105-130.2(1). For the purposes of this Article, private club includes country club.

(8b) "Private residence". – A private dwelling that is not a child care facility, as defined in G.S. 110-86(3), and not a long-term care facility, as defined in G.S. 131E-114.3(a)(1).

(8c) "Private vehicle". – A privately owned vehicle that is not used for commercial or employment purposes.

(8d) "Public place". – An enclosed area to which the public is invited or in which the public is permitted.

(8e) "Restaurant". – A food and lodging establishment that prepares and serves drink or food as regulated by the Commission pursuant to Part 6 of Article 8 of this Chapter.

(9) "Smoking". – The use or possession of a lighted cigarette, lighted cigar, lighted pipe, or any other lighted tobacco product.

(10) "State government". – The political unit for the State of North Carolina, including all agencies of the executive, judicial, and legislative branches of government.

(11) "State government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by State government.

(12) "State vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by the State and assigned permanently or temporarily to a State employee or State agency or institution for official State business.

(13) "Tobacco shop". – A business establishment, the main purpose of which is the sale of tobacco, tobacco products, and accessories for such products, that receives no less than seventy-five percent (75%) of its total annual revenues from the sale of tobacco, tobacco products, and accessories for such products, and does not serve food or alcohol on its premises.

"Part 1B. Smoking Prohibited in State Government Buildings and Vehicles.

"§ 130A-493. Smoking prohibited in State government buildings and State ~~vehicles prohibited.~~vehicles.

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes pertaining to State-controlled buildings, smoking is prohibited inside State government buildings except as provided in subsection (b) of this section. ~~As to smoking rooms in residence halls that were permitted by G.S. 143-597(a)(6), this Article becomes effective beginning with the 2008-2009 academic year.~~

(b) Smoking is permitted inside State government buildings that are used for medical or scientific research to the extent that smoking is an integral part of the research. Smoking permitted under this subsection shall be confined to the area where the research is being conducted.

(c) The individual in charge of the State government building or the individual's designee shall post signs in conspicuous areas of the building. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. In addition, ~~in any State psychiatric hospital, the person who owns, manages, operates, or otherwise controls the hospital shall:~~the individual in charge of the building or the individual's designee shall:

(1) Direct ~~any~~ a person who is smoking inside the ~~facility~~ building to extinguish the lighted smoking product.

(2) ~~Provide~~ In a State psychiatric hospital, provide written notice to individuals upon admittance that smoking is prohibited inside the ~~facility~~ building and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c1) Smoking is prohibited inside State vehicles. The individual or the individual's designee in charge of assigning the vehicle shall place one or more signs in conspicuous areas of the vehicle. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. If the vehicle is used for undercover law enforcement operations, a sign is not required to be placed in the vehicle as provided in this subsection.

(d) Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a misdemeanor.

"§ 130A-494. Other prohibitions.

Nothing in this Article repeals any other law prohibiting smoking, nor does it limit any law allowing regulation or prohibition of smoking on walkways or on the grounds of buildings.

"§ 130A-495. Rules.

The Commission shall adopt rules to implement this Part.

"Part 1C. Smoking Prohibited in Restaurants and Bars.

"**§ 130A-496. Smoking prohibited in restaurants and bars.**

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes, smoking is prohibited in all enclosed areas of restaurants and bars, except as provided in subsection (b) of this section.

(b) Smoking may be permitted in the following places:

(1) A designated smoking guest room in a lodging establishment. No greater than twenty percent (20%) of a lodging establishment's guest rooms may be designated smoking guest rooms.

(2) A cigar bar if smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A cigar bar that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the cigar bar and smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. To qualify under this subsection, the cigar bar must satisfactorily report on a quarterly basis to the Department, on a form prescribed by the Department, the revenue generated from the sale of alcoholic beverages and cigars as a percentage of quarterly gross revenue. The Department shall determine whether any additional documentation is required of the cigar bar to authenticate or verify revenue data submitted by the cigar bar. This subdivision shall not apply to any business that is established for the purpose of avoiding compliance with this Article.

(3) A private club.

"**§ 130A-497. Implementation and enforcement.**

(a) A person who manages, operates, or controls a restaurant or bar in which smoking is prohibited shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited. The signs may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Remove all indoor ashtrays and other smoking receptacles.

(3) Direct a person who is smoking to extinguish the lighted tobacco product.

(b) Continuing to smoke in a nonsmoking area described in this Part following oral or written notice by the person in charge of the area or the person's designee constitutes an infraction, and the person committing the infraction may be punished by a fine of not more than fifty dollars ($50.00).

(c) Conviction of an infraction under this section has no consequence other than payment of a penalty. A person found responsible for a violation of this section may not be assessed court costs.

(d) Notwithstanding G.S. 130A-25, a violation of this Part shall not be punishable as a misdemeanor.

(e) Administrative penalties imposed under G.S. 130A-22(h1) against a person who manages, operates, or controls a restaurant or bar and fails to comply with the provisions of this Article and the rules adopted by the Commission to implement the provisions of this Article shall only be enforced by a local health director.

(f) The Commission shall adopt rules to implement the provisions of this Article.

"Part 2. Local Government Regulation of Smoking.

"**§ 130A-498. Local governments may restrict smoking in public places.**

(a) ~~Notwithstanding~~ Except as otherwise provided in subsection (b1) of this section, and notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to

the contrary, a local government may adopt ~~an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this section.~~and enforce ordinances, board of health rules, and other laws or policies restricting or prohibiting smoking that are more restrictive than State law and that apply in local government buildings, on local government grounds, in local vehicles, or in public places. The definitions set forth in G.S. 130A-492 in Part 1A of this Article apply to this section and shall apply to any local ordinance, rule, or law adopted by a local government under this section.

~~(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:~~

~~(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;~~

~~(2) Building and grounds wherein local health departments and departments of social services are housed;~~

~~(3) Repealed by Session Laws 2007-193, s. 3.1, effective August 1, 2008.~~

~~(4) Any place on a public transportation vehicle owned or leased by local government and used by the public; and~~

~~(5) Any place in a local vehicle.~~

(b1) A local ordinance or other rules, laws, or policies adopted under this section may not restrict or prohibit smoking in the following places:

(1) A private residence.

(2) A private vehicle.

(3) A tobacco shop if smoke from the business does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A tobacco shop that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the tobacco shop and smoke from the shop does not migrate into an enclosed area where smoking is prohibited pursuant to this Article.

(4) All of the premises, facilities, and vehicles owned, operated, or leased by any tobacco products processor or manufacturer, or any tobacco leaf grower, processor, or dealer.

(5) A designated smoking guest room in a lodging establishment. No greater than twenty percent (20%) of a lodging establishment's guest rooms may be designated smoking guest rooms.

(6) A cigar bar if smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A cigar bar that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the cigar bar and smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. To qualify under this subsection, the cigar bar must satisfactorily report on a quarterly basis to the Department, on a form prescribed by the Department, the revenue generated from the sale of alcoholic beverages and cigars as a percentage of quarterly gross revenue. The Department shall determine whether any additional documentation is required of the cigar bar to authenticate or verify revenue data submitted by the cigar bar. This subdivision shall not apply to any business that is established for the purpose of avoiding compliance with this Article.

(7) A private club.

(8) A motion picture, television, theater or other live production set. This exemption applies only to the actor or performer portraying the use of tobacco products during the production.

~~(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity. As used in this Part, "local government" does not include community colleges as defined in G.S. 115D-2(2).~~

(c1) Continuing to smoke in violation of a local ordinance or other rules, laws, or policies adopted under this section constitutes an infraction, and the person committing the infraction may be punished by a fine of not more than fifty dollars ($50.00). Conviction of an infraction under this section has no consequence other than payment of a penalty. A person smoking in violation of a local ordinance or other rules, laws, or policies adopted under this section may not be assessed court costs.

~~(d) As used in this Part, "grounds" means the area located within 50 linear feet of a building wherein a local health department or a local department of social services is housed.~~

(d1) Notwithstanding G.S. 130A-25 or any other provision of law, a violation of a local ordinance, rule, law, or policy adopted under this section shall not be punishable as a misdemeanor.

(d2) A local government may enforce an ordinance, rule, law, or policy under this section against a person who manages, operates, or controls a public place only as provided in G.S. 130A-22(h1).

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122.

"**§ 130A-499 through 130A-500: Reserved for future codification purposes.**"

SECTION 2. Effective January 2, 2010, G.S. 130A-22 is amended by adding a new subsection to read:

"(h1) A local health director may take the following actions and may impose the following administrative penalty on a person who manages, operates, or controls a public place or place of employment and fails to comply with the provisions of Part 1C of Article 23 of this Chapter or with rules adopted thereunder or with local ordinances, rules, laws, or policies adopted pursuant to Part 2 of Article 23 of this Chapter:

(1) First violation. – Provide the person in violation with written notice of the person's first violation and notification of action to be taken in the event of subsequent violations.

(2) Second violation. – Provide the person in violation with written notice of the person's second violation and notification of administrative penalties to be imposed for subsequent violations.

(3) Subsequent violations. – Impose on the person in violation an administrative penalty of not more than two hundred dollars ($200.00) for the third and subsequent violations.

Each day on which a violation of this Article or rules adopted pursuant to this Article occurs may be considered a separate and distinct violation. Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a criminal violation."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 2

Committee Substitute Favorable 3/3/09
Committee Substitute #2 Favorable 3/25/09
Fourth Edition Engrossed 4/2/09
Corrected Copy 4/3/09
Senate Health Care Committee Substitute Adopted 4/29/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H2-PCS80406-SQ-30

Short Title: Prohibit Smoking in Certain Public Places. (Public)

Sponsors:

Referred to:

January 29, 2009

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT SMOKING IN CERTAIN PUBLIC PLACES AND CERTAIN PLACES OF EMPLOYMENT.

The General Assembly of North Carolina enacts:

SECTION 1. Effective January 2, 2010, Article 23 of Chapter 130A of the General Statutes reads as rewritten:

"Article 23.

"Smoking Prohibited in Public ~~Places.~~Places and Places of Employment.

~~Part 1. Smoking in State Government Buildings.~~"Part 1A. Findings and Intent.

"§ 130A-491. Legislative findings and intent.

(a) Findings. – The General Assembly finds that secondhand smoke has been proven to cause cancer, heart disease, and asthma attacks in both smokers and nonsmokers. In 2006, a report issued by the United States Surgeon General stated that the scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.

(b) Intent. – It is the intent of the General Assembly to protect the health of individuals in public places and places of employment and riding in State government vehicles ~~working in or visiting State government buildings~~ from the risks related to secondhand smoke. It is further the intent of the General Assembly to ~~protect the health of individuals driving or riding in State-controlled passenger-carrying vehicles assigned permanently or temporarily to State employees or State agencies or institutions for official State business.~~allow local governments to adopt local laws governing smoking within their jurisdictions that are more restrictive than the State law.

"§ 130A-492. Definitions.

The following definitions apply in this Article:

(1) "Bar". – An establishment with a permit to sell alcoholic beverages pursuant to subdivision (1), (3), (5), or (10) of G.S. 18B-1001.

(1a) "Cigar bar". – An establishment with a permit to sell alcoholic beverages pursuant to subdivision (1), (3), (5), or (10) of G.S. 18B-1001 that satisfies all of the following:

a. Generates sixty percent (60%) or more of its quarterly gross revenue from the sale of alcoholic beverages and twenty-five percent (25%) or more of its quarterly gross revenue from the sale of cigars;
b. Has a humidor on the premises; and
c. Does not allow individuals under the age of 21 to enter the premises.

Revenue generated from other tobacco sales, including cigarette vending machines, shall not be used to determine whether an establishment satisfies the definition of cigar bar.

(1b) "Employee". – A person who is employed by an employer, or who contracts with an employer or third person to perform services for an employer, or who otherwise performs services for an employer with or without compensation.

(2) "Employer". – An individual person, business, association, political subdivision, or other public or private entity, including a nonprofit entity, that employs or contracts for or accepts the provision of services from one or more employees.

(3) "Enclosed area". – An area with a roof or other overhead covering of any kind and walls or side coverings of any kind, regardless of the presence of openings for ingress and egress, on all sides or on all sides but one.

(4) "Grounds". – An unenclosed area owned, leased, or occupied by State or local government.

(5) "Local government". – A local political subdivision of this State, an airport authority, or an authority or body created by an ordinance, joint resolution, or rules of any such entity.

(6) "Local government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by a local government.

(7) "Lodging establishment". – An establishment that provides lodging for pay to the public.

(8) "Local vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by local government and assigned permanently or temporarily by local government to local government employees, agencies, institutions, or facilities for official local government business.

(8a) "Private club". – A country club or an organization that maintains selective members, is operated by the membership, does not provide food or lodging for pay to anyone who is not a member or a member's guest, and is either incorporated as a nonprofit corporation in accordance with Chapter 55A of the General Statutes or is exempt from federal income tax under the Internal Revenue Code as defined in G.S. 105-130.2(1). For the purposes of this Article, private club includes country club.

(8b) "Private residence". – A private dwelling that is not a child care facility, as defined in G.S. 110-86(3), and not a long-term care facility, as defined in G.S. 131E-114.3(a)(1).

(8c) "Private vehicle". – A privately owned vehicle that is not used for commercial or employment purposes.

(8d) "Public place". – An enclosed area to which the public is invited or in which the public is permitted.

(8e) "Restaurant". – A food and lodging establishment that prepares and serves drink or food as regulated by the Commission pursuant to Part 6 of Article 8 of this Chapter.

(9) "Smoking". – The use or possession of a lighted cigarette, lighted cigar, lighted pipe, or any other lighted tobacco product.

(10) "State government". – The political unit for the State of North Carolina, including all agencies of the executive, judicial, and legislative branches of government.

(11) "State government building". – A building owned, leased as lessor, or the area leased as lessee and occupied by State government.

(12) "State vehicle". – A passenger-carrying vehicle owned, leased, or otherwise controlled by the State and assigned permanently or temporarily to a State employee or State agency or institution for official State business.

(13) "Tobacco shop". – A business establishment, the main purpose of which is the sale of tobacco, tobacco products, and accessories for such products, that receives no less than seventy-five percent (75%) of its total annual revenues from the sale of tobacco, tobacco products, and accessories for such products, and does not serve food or alcohol on its premises.

"Part 1B. Smoking Prohibited in State Government Buildings and Vehicles.

"§ 130A-493. Smoking prohibited in State government buildings and State ~~vehicles prohibited.~~vehicles.

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes pertaining to State-controlled buildings, smoking is prohibited inside State government buildings except as provided in subsection (b) of this section. ~~As to smoking rooms in residence halls that were permitted by G.S. 143-597(a)(6), this Article becomes effective beginning with the 2008-2009 academic year.~~

(b) Smoking is permitted inside State government buildings that are used for medical or scientific research to the extent that smoking is an integral part of the research. Smoking permitted under this subsection shall be confined to the area where the research is being conducted.

(c) The individual in charge of the State government building or the individual's designee shall post signs in conspicuous areas of the building. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. In addition, ~~in any State psychiatric hospital, the person who owns, manages, operates, or otherwise controls the hospital shall:~~the individual in charge of the building or the individual's designee shall:

(1) Direct ~~any~~ a person who is smoking inside the ~~facility~~ building to extinguish the lighted smoking product.

(2) ~~Provide~~ In a State psychiatric hospital, provide written notice to individuals upon admittance that smoking is prohibited inside the ~~facility~~ building and obtain the signature of the individual or the individual's representative acknowledging receipt of the notice.

(c1) Smoking is prohibited inside State vehicles. The individual or the individual's designee in charge of assigning the vehicle shall place one or more signs in conspicuous areas of the vehicle. The signs shall state that "smoking is prohibited" and may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it. If the vehicle is used for undercover law enforcement operations, a sign is not required to be placed in the vehicle as provided in this subsection.

(d) Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a misdemeanor.

"§ 130A-494. Other prohibitions.

Nothing in this Article repeals any other law prohibiting smoking, nor does it limit any law allowing regulation or prohibition of smoking on walkways or on the grounds of buildings.

"§ 130A-495. Rules.

The Commission shall adopt rules to implement this Part.

"Part 1C. Smoking Prohibited in Restaurants and Bars.

"**§ 130A-496. Smoking prohibited in restaurants and bars.**

(a) Notwithstanding Article 64 of Chapter 143 of the General Statutes, smoking is prohibited in all enclosed areas of restaurants and bars, except as provided in subsection (b) of this section.

(b) Smoking may be permitted in the following places:

(1) A designated smoking guest room in a lodging establishment. No greater than twenty percent (20%) of a lodging establishment's guest rooms may be designated smoking guest rooms.

(2) A cigar bar if smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A cigar bar that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the cigar bar and smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. To qualify under this subsection, the cigar bar must satisfactorily report on a quarterly basis to the Department, on a form prescribed by the Department, the revenue generated from the sale of alcoholic beverages and cigars as a percentage of quarterly gross revenue. The Department shall determine whether any additional documentation is required of the cigar bar to authenticate or verify revenue data submitted by the cigar bar. This subdivision shall not apply to any business that is established for the purpose of avoiding compliance with this Article.

(3) A private club.

"**§ 130A-497. Implementation and enforcement.**

(a) A person who manages, operates, or controls a restaurant or bar in which smoking is prohibited shall:

(1) Conspicuously post signs clearly stating that smoking is prohibited. The signs may include the international "No Smoking" symbol, which consists of a pictorial representation of a burning cigarette enclosed in a red circle with a red bar across it.

(2) Remove all indoor ashtrays and other smoking receptacles.

(3) Direct a person who is smoking to extinguish the lighted tobacco product.

(b) Continuing to smoke in a nonsmoking area described in this Part following oral or written notice by the person in charge of the area or the person's designee constitutes an infraction, and the person committing the infraction may be punished by a fine of not more than fifty dollars ($50.00).

(c) Conviction of an infraction under this section has no consequence other than payment of a penalty. A person found responsible for a violation of this section may not be assessed court costs.

(d) Notwithstanding G.S. 130A-25, a violation of this Part shall not be punishable as a misdemeanor.

(e) Administrative penalties imposed under G.S. 130A-22(h1) against a person who manages, operates, or controls a restaurant or bar and fails to comply with the provisions of this Article and the rules adopted by the Commission to implement the provisions of this Article shall only be enforced by a local health director.

(f) The Commission shall adopt rules to implement the provisions of this Article.

"Part 2. Local Government Regulation of Smoking.

"**§ 130A-498. Local governments may restrict smoking in public places.**

(a) ~~Notwithstanding~~ Except as otherwise provided in subsection (b1) of this section, and notwithstanding any other provision of Article 64 of Chapter 143 of the General Statutes to

the contrary, a local government may adopt ~~an ordinance, law, or rule restricting smoking in accordance with subsection (b) of this section.~~and enforce ordinances, board of health rules, and other laws or policies restricting or prohibiting smoking that are more restrictive than State law and that apply in local government buildings, on local government grounds, in local vehicles, or in public places. The definitions set forth in G.S. 130A-492 in Part 1A of this Article apply to this section and shall apply to any local ordinance, rule, or law adopted by a local government under this section.

~~(b) Any local ordinance, law, or rule authorized under this section may restrict smoking only in:~~

~~(1) Buildings owned, leased as lessor, or the area leased as lessee and occupied by local government;~~

~~(2) Building and grounds wherein local health departments and departments of social services are housed;~~

~~(3) Repealed by Session Laws 2007-193, s. 3.1, effective August 1, 2008.~~

~~(4) Any place on a public transportation vehicle owned or leased by local government and used by the public; and~~

~~(5) Any place in a local vehicle.~~

(b1) A local ordinance or other rules, laws, or policies adopted under this section may not restrict or prohibit smoking in the following places:

(1) A private residence.

(2) A private vehicle.

(3) A tobacco shop if smoke from the business does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A tobacco shop that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the tobacco shop and smoke from the shop does not migrate into an enclosed area where smoking is prohibited pursuant to this Article.

(4) All of the premises, facilities, and vehicles owned, operated, or leased by any tobacco products processor or manufacturer, or any tobacco leaf grower, processor, or dealer.

(5) A designated smoking guest room in a lodging establishment. No greater than twenty percent (20%) of a lodging establishment's guest rooms may be designated smoking guest rooms.

(6) A cigar bar if smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. A cigar bar that begins operation after July 1, 2009, may only allow smoking if it is located in a freestanding structure occupied solely by the cigar bar and smoke from the cigar bar does not migrate into an enclosed area where smoking is prohibited pursuant to this Article. To qualify under this subsection, the cigar bar must satisfactorily report on a quarterly basis to the Department, on a form prescribed by the Department, the revenue generated from the sale of alcoholic beverages and cigars as a percentage of quarterly gross revenue. The Department shall determine whether any additional documentation is required of the cigar bar to authenticate or verify revenue data submitted by the cigar bar. This subdivision shall not apply to any business that is established for the purpose of avoiding compliance with this Article.

(7) A private club.

(8) A motion picture, television, theater, or other live production set. This exemption applies only to the actor or performer portraying the use of tobacco products during the production.

~~(c) As used in this Part, "local government" means any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity. As used in this Part, "local government" does not include community colleges as defined in G.S. 115D-2(2).~~

(c1) Continuing to smoke in violation of a local ordinance or other rules, laws, or policies adopted under this section constitutes an infraction, and the person committing the infraction may be punished by a fine of not more than fifty dollars ($50.00). Conviction of an infraction under this section has no consequence other than payment of a penalty. A person smoking in violation of a local ordinance or other rules, laws, or policies adopted under this section may not be assessed court costs.

~~(d) As used in this Part, "grounds" means the area located within 50 linear feet of a building wherein a local health department or a local department of social services is housed.~~

(d1) Notwithstanding G.S. 130A-25 or any other provision of law, a violation of a local ordinance, rule, law, or policy adopted under this section shall not be punishable as a misdemeanor.

(d2) A local government may enforce an ordinance, rule, law, or policy under this section against a person who manages, operates, or controls a public place only as provided in G.S. 130A-22(h1).

(e) A county ordinance adopted under this section is subject to the provisions of G.S. 153A-122.

"**§ 130A-499 through 130A-500: Reserved for future codification purposes.**"

SECTION 2. Effective January 2, 2010, G.S. 130A-22 is amended by adding a new subsection to read:

"(h1) A local health director may take the following actions and may impose the following administrative penalty on a person who manages, operates, or controls a public place or place of employment and fails to comply with the provisions of Part 1C of Article 23 of this Chapter or with rules adopted thereunder or with local ordinances, rules, laws, or policies adopted pursuant to Part 2 of Article 23 of this Chapter:

(1) First violation. – Provide the person in violation with written notice of the person's first violation and notification of action to be taken in the event of subsequent violations.

(2) Second violation. – Provide the person in violation with written notice of the person's second violation and notification of administrative penalties to be imposed for subsequent violations.

(3) Subsequent violations. – Impose on the person in violation an administrative penalty of not more than two hundred dollars ($200.00) for the third and subsequent violations.

Each day on which a violation of this Article or rules adopted pursuant to this Article occurs may be considered a separate and distinct violation. Notwithstanding G.S. 130A-25, a violation of Article 23 of this Chapter shall not be punishable as a criminal violation."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 1022

Short Title:	Comparative Effectiveness Task Force.	(Public)
Sponsors:	Senators Stein; Garrou, Nesbitt, Purcell, Snow, and Stevens.	
Referred to:	Health Care.	

March 26, 2009

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE COMPARATIVE EFFECTIVENESS TASK FORCE TO IMPROVE HEALTH CARE QUALITY AND CONTAIN HEALTH CARE COSTS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is established the Joint Legislative Comparative Effectiveness Task Force (Task Force). The purpose of the Task Force is to ascertain how to improve people's health and contain health care costs by studying the comparative effectiveness of various medical treatments and prescription drugs.

SECTION 1.(b) The Task Force shall be comprised of eleven members, one appointed by each of the following:

(1) One member of the Senate to serve as cochair of the Task Force appointed by the President Pro Tempore of the Senate.
(2) One member of the House of Representatives to serve as cochair of the Task Force appointed by the Speaker of the House of Representatives.
(3) The NC Institute of Medicine.
(4) The North Carolina Hospital Association.
(5) The North Carolina Medical Society.
(6) The University of North Carolina at Chapel Hill.
(7) Duke University.
(8) North Carolina Association of Health Plans.
(9) Division of Medical Assistance of the Department of Health and Human Services, appointed by the Secretary of the Department.
(10) The Research Triangle Institute.

SECTION 1.(c) The Task Force shall study the following:

(1) How to develop and even more robust research effort in our State, including the development of initiatives to draw down additional federal funds.
(2) How to organize our State-level efforts in a way that maximizes our opportunities for additional joint efforts with Agency for Health Care Research and Quality.
(3) How to organize providers and payors in our State so that dissemination of comparative effectiveness research findings is as rapid and far-reaching as possible.
(4) How to develop mechanisms for the ongoing monitoring of these efforts.

SECTION 1.(d) Members of the Task Force shall not be compensated for their services but shall receive per diem and travel costs as authorized by law.

SECTION 1.(e) On or before February 1, 2011, the Task Force shall report its findings and recommendations to the Governor and the 2011 General Assembly. Upon submitting its final report the Task Force shall terminate.

SECTION 2. The Legislative Services Office shall allocate funds appropriated to the General Assembly to support the activities of the Task Force.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 1022
PROPOSED COMMITTEE SUBSTITUTE S1022-PCS15256-LN-16

Short Title: Comparative Effectiveness Task Force. (Public)

Sponsors:

Referred to:

March 26, 2009

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE COMPARATIVE EFFECTIVENESS TASK FORCE TO IMPROVE HEALTH CARE QUALITY AND CONTAIN HEALTH CARE COSTS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is established the Joint Legislative Comparative Effectiveness Task Force (Task Force). The purpose of the Task Force is to ascertain how to improve people's health and contain health care costs by studying the comparative effectiveness of various medical treatments and prescription drugs.

SECTION 1.(b) The Task Force shall be comprised of 15 members appointed as follows:

(1) Seven members appointed by the President Pro Tempore of the Senate, as follows:
   a. One member of the Senate to serve as cochair of the Task Force.
   b. One member representing and recommended by the NC Institute of Medicine.
   c. One member representing and recommended by NC Hospital Association.
   d. One representative of Area Health Education Centers.
   e. One member representing and recommended by Duke University.
   f. One member representing and recommended by East Carolina University Medical Center.
   g. One member who is a researcher representing the pharmaceutical industry.

(2) Seven members appointed by the Speaker of the House of Representatives, as follows:
   a. One member of the House of Representatives to serve as cochair of the Task Force.
   b. One member representing and recommended by the North Carolina Medical Society.
   c. One member representing and recommended by the University of North Carolina at Chapel Hill.
   d. One member representing and recommended by the North Carolina Association of Health Plans.

e. One member representing and recommended by Wake Forest University Medical Center.

f. One member who is a researcher representing a school of pharmacy of a North Carolina university.

g. One member representing and recommended by the Research Triangle Institute.

(3) The Director of the Division of Medical Assistance of the Department of Health and Human Services, ex officio, or the Director's designee.

SECTION 1.(c) The Task Force shall study the following:

(1) How to develop an even more robust research effort in our State, including the development of initiatives to draw down additional federal funds.

(2) How to organize our State-level efforts in a way that maximizes our opportunities for additional joint efforts with Agency for Health Care Research and Quality.

(3) How to organize providers and payors in our State so that dissemination of comparative effectiveness research findings is as rapid and far-reaching as possible.

(4) How to develop mechanisms for the ongoing monitoring of these efforts.

SECTION 1.(d) Members of the Task Force shall not be compensated for their services but shall receive per diem and travel costs as authorized by law.

SECTION 1.(e) On or before February 1, 2011, the Task Force shall report its findings and recommendations to the Governor and the 2011 General Assembly. Upon submitting its final report the Task Force shall terminate.

SECTION 2. The Legislative Services Office shall allocate funds appropriated to the General Assembly to support the activities of the Task Force.

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

SENATE BILL 1022:
Comparative Effectiveness Task Force

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 5, 2009
Introduced by:	Sen. Stein	**Prepared by:**	Susan Barham
Analysis of:	PCS to First Edition S1022-CSLN-16		Research Assistant

SUMMARY: ***Senate Bill 1022 creates the Comparative Effectiveness Task Force to study the comparative effectiveness of various medical treatments and prescription medications in order to identify the health care practice methods and protocols that best improve the health of North Carolina's citizens and still contain health care costs.***

The Proposed Committee Substitute makes changes to the membership of the Task Force.

BILL ANALYSIS: Senate Bill 1022 establishes the Comparative Effectiveness Task Force and directs the Task Force to study:

- Increasing research efforts in North Carolina.
- Organizing at the State-level to increase opportunities for participation in national initiatives led by the federal Agency for Healthcare Research and Quality.
- Organizing providers and payors in the State so that comparative effectiveness research (CER) is disseminated as effectively and efficiently as possible.
- Developing a mechanism for the ongoing monitoring of CER information dissemination.

The bill provides that the Task Force would consist of the following 15 members:

- Seven members appointed by the President Pro Tempore of the Senate as follows:
  - One member of the Senate to serve as cochair.
  - One member representing and recommended by the North Carolina Institute of Medicine.
  - One member representing and recommended by the North Carolina Hospital Association.
  - One representative of Area Health Education Centers.
  - One member representing and recommended by Duke University.
  - One member representing and recommended by East Carolina University Medical Center.
  - One member who is a researcher representing the pharmaceutical industry.
- Seven members appointed by the Speaker of the House of Representatives as follows:
  - One member of the House of Representatives to serve as cochair.
  - One member representing and recommended by the North Carolina Medical Society.
  - One member representing and recommended by the University of North Carolina at Chapel Hill.
  - One member representing and recommended by the North Carolina Association of Health Plans.

- One member representing and recommended by Wake Forest University Medical Center.
- One member representing a school of pharmacy of a North Carolina university that is a researcher.
- One member representing and recommended by the Research Triangle Institute.

The bill directs the Task Force to report findings and recommendations to the Governor and the 2011 General Assembly on or before February 1, 2011 at which time the Task Force will terminate.

EFFECTIVE DATE: This act is effective when it becomes law.

S1022-SMTE-6(CSLN-16) v2

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 1022
PROPOSED COMMITTEE SUBSTITUTE S1022-PCS15256-LN-16

Short Title: Comparative Effectiveness Task Force. (Public)

Sponsors:

Referred to:

March 26, 2009

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE COMPARATIVE EFFECTIVENESS TASK FORCE TO IMPROVE HEALTH CARE QUALITY AND CONTAIN HEALTH CARE COSTS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) There is established the Joint Legislative Comparative Effectiveness Task Force (Task Force). The purpose of the Task Force is to ascertain how to improve people's health and contain health care costs by studying the comparative effectiveness of various medical treatments and prescription drugs.

SECTION 1.(b) The Task Force shall be comprised of 15 members appointed as follows:

(1) Seven members appointed by the President Pro Tempore of the Senate, as follows:
   a. One member of the Senate to serve as cochair of the Task Force.
   b. One member representing and recommended by the NC Institute of Medicine.
   c. One member representing and recommended by NC Hospital Association.
   d. One representative of Area Health Education Centers.
   e. One member representing and recommended by Duke University.
   f. One member representing and recommended by East Carolina University Medical Center.
   g. One member who is a researcher representing the pharmaceutical industry.

(2) Seven members appointed by the Speaker of the House of Representatives, as follows:
   a. One member of the House of Representatives to serve as cochair of the Task Force.
   b. One member representing and recommended by the North Carolina Medical Society.
   c. One member representing and recommended by the University of North Carolina at Chapel Hill.
   d. One member representing and recommended by the North Carolina Association of Health Plans.

e. One member representing and recommended by Wake Forest University Medical Center.

f. One member who is a researcher representing a school of pharmacy of a North Carolina university.

g. One member representing and recommended by the Research Triangle Institute.

(3) The Director of the Division of Medical Assistance of the Department of Health and Human Services, ex officio, or the Director's designee.

SECTION 1.(c) The Task Force shall study the following:

(1) How to develop an even more robust research effort in our State, including the development of initiatives to draw down additional federal funds.

(2) How to organize our State-level efforts in a way that maximizes our opportunities for additional joint efforts with Agency for Health Care Research and Quality.

(3) How to organize providers and payors in our State so that dissemination of comparative effectiveness research findings is as rapid and far-reaching as possible.

(4) How to develop mechanisms for the ongoing monitoring of these efforts.

SECTION 1.(d) Members of the Task Force shall not be compensated for their services but shall receive per diem and travel costs as authorized by law.

SECTION 1.(e) On or before February 1, 2011, the Task Force shall report its findings and recommendations to the Governor and the 2011 General Assembly. Upon submitting its final report the Task Force shall terminate.

SECTION 2. The Legislative Services Office shall allocate funds appropriated to the General Assembly to support the activities of the Task Force.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 765

Short Title:	Clarify Patient Data/Medical Care Data Act.	(Public)
Sponsors:	Senator Stein.	
Referred to:	Health Care.	

March 24, 2009

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT EMERGENCY DEPARTMENT DATA AND AMBULATORY SURGICAL DATA ARE INCLUDED IN THE PATIENT DATA SUBMISSION REQUIREMENTS OF THE MEDICAL CARE DATA ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-214.1(4) reads as rewritten:

"(4) **(Effective until January 1, 2010)** "Patient data" means inpatient, emergency department, and ambulatory surgical data that includes a patient's age, sex, zip code, third-party coverage, principal and other diagnosis, date of admission, procedure and discharge date, principal and other procedures, total charges and components of the total charges, attending physician identification number, and hospital or freestanding ambulatory surgical facility identification number.

(4) **(Effective January 1, 2010)** "Patient data" means inpatient, emergency department, and ambulatory surgical data that includes a patient's age, sex, race, ethnicity, zip code, third-party coverage, principal and other diagnosis, date of admission, procedure and discharge date, principal and other procedures, total charges and components of the total charges, attending physician identification number, and hospital or freestanding ambulatory surgical facility identification number."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 694

Short Title:	Amend Dentistry Laws/Out of State Dentists.	(Public)
Sponsors:	Senator Garrou.	
Referred to:	Health Care.	

March 24, 2009

A BILL TO BE ENTITLED

AN ACT AMENDING THE LAWS PERTAINING TO THE PRACTICE OF DENTISTRY AS PERFORMED BY PERSONS PRACTICING DENTISTRY OUT OF STATE UNDER CERTAIN CIRCUMSTANCES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-36(e) reads as rewritten:

"(e) The holder of a license issued under this section shall establish a practice location and actively practice dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), in North Carolina within one year from the date the license is issued. The license issued under this section shall be void upon a finding by the Board that the licensee fails to limit the licensee's practice to North Carolina or that the licensee no longer actively practices dentistry in North Carolina. However, when a dentist licensed under this section faces possible Board action to void the dentist's license for failure to limit the dentist's practice to North Carolina, if the dentist demonstrates to the Board that out-of-state practice actions were in connection with formal contract or employment arrangements for the dentist to provide needed clinical dental care to patients who are part of an identified ethnic or racial minority group living in a region of the other state with low access to dental care, the Board, in its discretion, may waive the in-State limitations on the out-of-state practice for a maximum of 12 months."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 694
PROPOSED COMMITTEE SUBSTITUTE S694-PCS35302-LU-1

Short Title: Amend Dentistry Laws/Out of State Dentists. (Public)

Sponsors:

Referred to:

March 24, 2009

A BILL TO BE ENTITLED

AN ACT AMENDING THE LAWS PERTAINING TO THE PRACTICE OF DENTISTRY AS PERFORMED BY PERSONS PRACTICING DENTISTRY OUT OF STATE UNDER CERTAIN CIRCUMSTANCES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-36(e) reads as rewritten:

"(e) The holder of a license issued under this section shall establish a practice location and actively practice dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), in North Carolina within one year from the date the license is issued. The license issued under this section shall be void upon a finding by the Board that the licensee fails to limit the licensee's practice to North Carolina or that the licensee no longer actively practices dentistry in North Carolina. However, when a dentist licensed under this section faces possible Board action to void the dentist's license for failure to limit the dentist's practice to North Carolina, if the dentist demonstrates to the Board that out-of-state practice actions were in connection with formal contract or employment arrangements for the dentist to provide needed clinical dental care to patients who are part of an identified ethnic or racial minority group living in a region of the other state with low access to dental care, the Board, in its discretion, may waive the in-State limitations on the out-of-state practice for a maximum of 12 months, if in the opinion of the Board the overall access to care and service to needy North Carolina populations and the purposes of this State's credentials licensing laws are not unreasonably or significantly compromised."

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

SENATE BILL 694:
Amend Dentistry Laws/Out of State Dentists

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 5, 2009
Introduced by:	Sen. Garrou	**Prepared by:**	Shawn Parker
Analysis of:	PCS to First Edition S694-CSLU-1		Legislative Analyst

SUMMARY: ***Senate Bill 694 authorizes the North Carolina State Board of Dental Examiners to waive for a period of up to twelve months in-State practice requirements of dentist issued a license by credentialing.***

CURRENT LAW: The North Carolina State Board of Dental Examiners may issue a license by credentials to an applicant who has been licensed to practice dentistry in any state or territory of the United States if the applicant produces satisfactory evidence to the Board that the applicant has the required education, training, and qualifications, is in good standing with the licensing jurisdiction, has passed satisfactory examinations of proficiency in the knowledge and practice of dentistry as determined by the Board, and meets all other requirements of this section and rules adopted by the Board.

Dental practitioners who are issued a license by credentialing must maintain practice in North Carolina and are prohibited from practicing outside of the State. The North Carolina State Board of Dental Examiners is directed to void such licensees by a finding of fact as to the failure to meet either condition.

BILL ANALYSIS:
Senate Bill 694 authorizes the North Carolina State Board of Dental Examiners to waive the in-State limitation on the out of state practice requirement for dentists licensed under G.S. 90-36 a maximum period of twelve months provided:
The dentist demonstrates to the Board that the out-of-state practice actions

- were in connection with a formal employment arrangement
- were to provide needed dental care to patients who are part of an identified ethnic or racial minority group living in a region of another state with low access to dental care,

and the Board determines:

- the overall access to care and service to needy North Carolina populations is not unreasonably and significantly compromised
- the State's licensure by credentialing laws are not unreasonably and significantly compromised.

EFFECTIVE DATE: This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 917*

Short Title:	Cancer Patient Assistance.	(Public)
Sponsors:	Senators Dorsett; Clodfelter, Dannelly, Graham, and Vaughan.	
Referred to:	Health Care.	

March 26, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH, TO ASSIST CANCER PATIENTS WITH THE MANAGEMENT OF THE DISEASE.

The General Assembly of North Carolina enacts:

SECTION 1. Part 1 of Article 7 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-216. Cancer patient navigation program.**

The Department shall establish a cancer patient navigation pilot program. The purpose of the program shall be to provide education about and assistance with the management of cancer. At a minimum, the program shall do the following:

(1) Initially serve breast and cervical cancer patients statewide with the intent of future expansion to all other cancer types.

(2) Employ a multidisciplinary team approach to assist cancer patients in identifying and gaining access to available health care, financial and legal assistance, transportation, psychological support, and other related issues.

(3) Work with an existing cancer service agency that is not affiliated with a particular health care institution so that program clients may have access to any cancer health care facility in the State."

SECTION 2. The Department may adopt rules necessary to carry out the provisions of this act. The Department shall begin initial implementation of the statewide pilot program established under Section 1 of this act in Guilford and Mecklenburg Counties.

SECTION 3. The Department shall report its progress on the implementation of this program to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division not later than May 1, 2010.

SECTION 4. This act is effective when it becomes law.

SENATE BILL 917:
Cancer Patient Assistance

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	May 5, 2009
Introduced by:	Sen. Dorsett	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	First Edition		

SUMMARY: ***Senate Bill 917 directs the Department of Health and Human Services to establish a cancer patient navigation pilot program.***

BILL ANALYSIS:

Section 1 amends Part 1 (Cancer) of Article 7 (Chronic Diseases) of Chapter 130A (Public Health) by adding a new section which requires the Department to establish a cancer patient navigation pilot program. The new section provides that the program shall provide education and assistance with the management of cancer. At a minimum the program will:

- Serve breast and cervical cancer patients across the State;
- Employ a multidisciplinary team to identify and assist patients with access to health care, financial and legal assistance, transportation, and other supports;
- Work with an existing cancer service agency not affiliated with a particular health care institution.

Section 2 directs the Department to adopt rules to carry out the provisions of the act. The section requires the Department to begin an initial implementation of the state-wide pilot in Guilford and Mecklenburg Counties.

Section 3 directs the Department to report its progress on the implementation of the program by May 1, 2010 to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

EFFECTIVE DATE: This act is effective when it becomes law.

S917-SMSQ-58(e1) v1

SENATE BILL 331

Short Title:	MH/National Accred. Benchmarks.	(Public)
Sponsors:	Senator Berger of Franklin.	
Referred to:	Health Care.	

February 26, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO NATIONAL ACCREDITATION BENCHMARK REQUIREMENTS FOR CERTAIN MEDICAID ENROLLED FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-81(d) reads as rewritten:

"(d) Providers enrolled in the Medicaid program or contracting for State-funded services on or after July 1, 2008, and providing services which require national accreditation shall successfully complete all accreditation requirements and be awarded national accreditation within ~~one year~~ 18 months of enrollment in the Medicaid program or within two years following the provider's first contract to deliver a State-funded service requiring national accreditation. Providers providing services that require national accreditation shall be required to discontinue service delivery and shall have their Medicaid enrollment and any service contracts terminated if they do not meet the following benchmarks for demonstrating sufficient progress in achieving national accreditation following the date of enrollment in the Medicaid program or initial contract for State-funded services:

(1) ~~Three~~ Six months – On-site accreditation review scheduled by accrediting agency as documented by a letter from the agency to the provider and completion of self-study and self-evaluation protocols distributed by the selected accrediting agency.

(2) ~~Six~~ Twelve months – On-site accreditation review scheduled by accrediting agency as documented by a letter from the agency to the provider.

(3) ~~Nine~~ Fifteen months – Completion of on-site accreditation review, receipt of initial feedback from accrediting agency, plan to address any deficiencies identified developed.

(4) If a provider's Medicaid enrollment or service delivery contracts are terminated as a result of failure to meet accreditation benchmarks or failure to continue to be nationally accredited, the provider will work with the LME to transition consumers served by the provider to other service providers in an orderly fashion within 60 days of notification by the LME of such failure.

(5) A provider that has its Medicaid enrollment or service delivery contracts terminated as a result of failure to meet accreditation benchmarks or failure to continue to be nationally accredited may not reapply for enrollment in the Medicaid program or enter into any new service delivery contracts for at least one year following enrollment or contract termination."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 331
PROPOSED COMMITTEE SUBSTITUTE S331-PCS15241-LN-10

Short Title: Five County LME/State Health Plan. (Local)

Sponsors:

Referred to:

February 26, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE FIVE COUNTY MENTAL HEALTH AUTHORITY, A LOCAL MANAGEMENT ENTITY, TO ENROLL ITS EMPLOYEES AND RETIREES IN THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. Section 31.26(j) of S.L. 2004-124, as amended by Section 29.32 of S.L. 2005-276, and as further amended by S.L. 2007-405, reads as rewritten:

"**SECTION 31.26.(j)** This section applies to:

(1) Bladen, Cherokee, Mitchell, Rutherford, Washington, and Wilkes Counties only,~~ and~~

(2) The Towns of Biltmore Forest, Black Creek, Black Mountain, Blowing Rock, Forest City, Ocean Isle Beach, Sunset Beach, and Tabor City ~~only.~~only, and

(3) The Five County Mental Health Authority serving Franklin, Granville, Halifax, Vance, and Warren Counties only."

SECTION 2. This act becomes effective July 1, 2009.

SENATE BILL 331:
Add Five County LME to State Health Plan

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 5, 2009
Introduced by:	Sen. Berger of Franklin	**Prepared by:**	Shawn Parker
Analysis of:	PCS to First Edition S331-CSLN-10		Legislative Analyst

SUMMARY: ***The proposed Committee Substitute to Senate Bill 331 authorizes the Five County Mental Health Authority, a Local Management Entity, to enroll its employees and retirees in the State Health Plan.***

The PCS completely rewrites the first edition of the bill.

CURRENT LAW:

S.L. 2004-124 as amended by S.L. 2005-276, and S.L. 2007-405 authorized several local governments to participate in the Teachers' and State Employees' Comprehensive Major Medical Plan (Plan). To participate, the local government must adopt a resolution approved by the Plan and make contributions required by the the Plan. All employees and retirees, and their enrolled spouses and dependent children, must participate in disease management, case management, and all other mandatory and voluntary cost containment measures implemented by the Plan.

If a local government elects to participate, the election is irrevocable.

Currently, the following local governments are authorized to participate: Bladen County, Cherokee County, Rutherford County, Washington County, Wilkes County, the Towns of Biltmore Forrest, Black Creek, Black Mountain, Forest City, Ocean Island Beach, Sunset Beach, and Tabor City.

The Five County Mental Health Authority is an area authority and is considered a local political subdivision of the State.

BILL ANALYSIS: Senate Bill 331 would authorize the Five County Local Management Entity to participate in the State Teachers' and State Employees' Comprehensive Major Medical Plan.

EFFECTIVE DATE: This act becomes effective July 1, 2009.

S331-SMSQ-56(CSLN-10) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 331
PROPOSED COMMITTEE SUBSTITUTE S331-PCS15241-LN-10

Short Title: Five County LME/State Health Plan. (Local)

Sponsors:

Referred to:

February 26, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE FIVE COUNTY MENTAL HEALTH AUTHORITY, A LOCAL MANAGEMENT ENTITY, TO ENROLL ITS EMPLOYEES AND RETIREES IN THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. Section 31.26(j) of S.L. 2004-124, as amended by Section 29.32 of S.L. 2005-276, and as further amended by S.L. 2007-405, reads as rewritten:

"**SECTION 31.26.(j)** This section applies to:

(1) Bladen, Cherokee, Mitchell, Rutherford, Washington, and Wilkes Counties only,~~and~~

(2) The Towns of Biltmore Forest, Black Creek, Black Mountain, Blowing Rock, Forest City, Ocean Isle Beach, Sunset Beach, and Tabor City ~~only.~~only, and

(3) The Five County Mental Health Authority serving Franklin, Granville, Halifax, Vance, and Warren Counties only."

SECTION 2. This act becomes effective July 1, 2009.

GENERAL ASSEMBLY OF NORTH CAROLINA

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Proposed Committee Substitute to SB 331 (S331-PCS15241-LN-10)

SHORT TITLE: Five County LME/State Health Plan

SPONSOR(S): Senator Berger of Franklin

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY:

The Senate Proposed Committee Substitute to Senate Bill 331 amends Section 31.26(j) of Session Law 2004-124 (2004 Appropriations Act), as further amended by Section 29.32 of Session Law 2005-276 (2005 Appropriations Act). Proposed legislation permits the Five County Mental Health Authority (Franklin, Granville, Halifax, Vance, and Warren) with the option to become an employing unit under the Plan for the purpose of providing health benefits to the Authority's employees, retired employees, and their eligible spouses and dependent children.

If a local government elects to participate as an employer under the Plan, it must do so by legal resolution of its governing board. An irrevocable election is required by the local government if it enrolls its retired employees, and their eligible spouses and dependent children. The local government must also agree to make any premium contributions required by the Plan. All enrolled employees, retired employees, and their family members of a participating local government will be required to participate in disease management, case management, and all other cost containment measures implemented by the Plan. Employees and retired employees of local governments authorized for benefit coverage under the Plan will pay the same premium rates as those charged by the Plan for other participating active and retired employees and their dependents.

In addition, an irrevocable election by a local government to cover retired employees also requires it to make financial contributions to the Local Governmental Employees' Retirement System for the purpose of financing retired employee employees' health benefits offered under the Plan. If a local government does not participate in the Local Governmental Employees' Retirement System, but has another formally established retirement plan, and elects to cover its retired employees, it is required to make premium contributions to the Plan on behalf of its retired employees.

EFFECTIVE DATE: July 1, 2009

ESTIMATED IMPACT ON STATE:

The consulting actuary for the Plan, Aon Consulting, estimates a financial impact to the Plan if the Five County Mental Health Authority elects to participate in the Plan. Aon Consulting estimates the Authority group would generate a mid-point loss of $440,586 to the Plan for the 2009-2010 fiscal year assuming an average loss ratio of 230% for the Authority's participating group. In the absence of actual prior claims experience for the Authority Aon Consulting used an estimated loss ratio to account for potential adverse selection against the Plan where the premiums charged to the group for coverage may not be sufficient to cover their respective medical claims.

Hartman & Associates, consulting actuary for the General Assembly's Fiscal Research Division, estimates an average annual cost of between $75,000 and $100,000 to the Plan year if the Authority were to become a participating employer under the Plan beginning with the 2009-2010 fiscal year. Hartman and Associates noted that the Authority's age and sex demographics compare adversely to similar measures for the Plan's membership. Hartman and Associates also noted that prior claims experience for the Authority was not available and that adverse selection could potentially occur for this group and thereby increase costs to the Plan by more than estimated in this analysis.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

There was requested from the Authority two years of claims related data, but their incumbent insurer declined to provide the information to the Authority since they are part of a small group pool.

The following Distribution of Participants table for Five County Mental Health Authority was used for this analysis.

Distribution of Participants – Five County Mental Health Authority

	Active Employees			Dependents of Active Employees			Retired Employees			Dependents of Retired Employees		
Ages	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-4			0			0			0			0
5-9			0			0			0			0
10-14			0			0			0			0
15-19			0		1	1			0			0
20-24			0			0			0			0
25-29			0			0			0			0
30-34	1	3	4			0			0			0
35-39		5	5			0			0			0
40-44		2	2			0			0			0
45-49	1	5	6			0			0			0
50-54	3	17	20	1		1			0			0
55-59	6	11	17			0	1	2	3			0
60-64	5	7	12			0	5	2	7			0
65-69		1	1			0		3	3			0
70-74			0			0	1	1	2			0
75-79			0			0		2	2			0
>79			0			0	1	2	3			0
Unknown			U			U			0			0
TOTAL	16	51	67	1	1	2	8	12	20	0	0	0

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

As of July 1, 2009, the State will continue to finance the Plan on a self-funded basis and administer benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts will be derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage will be paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.5 billion for FY 2009-10 and $2.7 billion for FY 2010-11. The Plan's PPO benefit design will include two alternative benefit levels listed below:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; and

2) The "Standard" 80/20 plan.

The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised Summer 2008) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year were projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.4 billion in claim-

payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss was projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses were expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year.

Financial Projection (Revised April 2009) for FY 2008-09 – For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $49.0 million from Medicare Part D subsidies, $3.3 million from investment earnings, and $250.0 million from a direct General Fund appropriation from the Rainy Day Fund (Savings Reserve Account) for a total of approximately $2.6 billion in receipt income for the year. The $250 million from a direct General Fund appropriation was provided by Session Law 2009-16 (Senate Bill 287) to finance a shortfall in funds available to pay health care benefits, administrative costs, and adequately fund the Plan's beginning cash balance on July 1, 2009. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $180.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating income is projected to be approximately $7.1 million for the fiscal year, assuming a 9% annual claims growth trend.

Financial Projection 2009-11 Biennium (April 2009) – Session Law 2009-16 (Senate Bill 287) appropriates funds from various sources, authorizes annual premium rate increases, makes various benefit and provider related changes to achieve financial savings, and directs other various changes to the Plan. The enacted law also appropriates the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. The following summarized financial projections by fiscal year for the 2009-11 biennium assume the changes enacted in Session Law 2009-16 (Senate Bill 287).

For the fiscal year beginning July 1, 2009, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.4 billion from premium collections, $56.3 million from Medicare Part D subsidies, and $8.0 million from investment earnings for a total of approximately $2.5 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.3 billion in claim-payment expenses and $185.6 million in administration and claims-processing expenses for projected total expenses of nearly $2.5 billion for FY 2008-09. The Plan's net operating income is projected to be approximately $14.8 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.7 billion from premium collections, $50.4 million from Medicare Part D subsidies, and $8.8 million from investment earnings for a total of approximately $2.7 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.5 billion in claim-payment expenses and $191.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.7 billion for FY 2010-11. The Plan's net operating income is projected to be approximately $30.6 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Other Information

Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium. However, the annual premium increases authorized in Session Law 2009-16 (Senate Bill 287) changes that methodology to an annual increase at the beginning of each fiscal year of the 2009-11 biennium.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, "Senate Bill 715: An Act to Authorize the Five County Mental Health Authority to Enroll Its Employees and Retirees in the State Health Plan for Teachers and State Employee", April 30, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Senate Bill 715 [v.0] Five County Mental Health Authority/State Health Plan",, May 5, 2009, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY: Marilyn Chism, Director
Fiscal Research Division

DATE: May 5, 2009

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

SENATE BILL 715[V.0]

FIVE COUNTY MENTAL HEALTH AUTHORITY/ STATE HEALTH PLAN

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30305

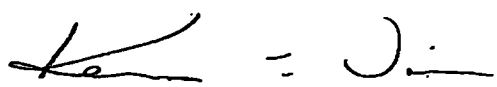
May 2009

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to Senate Bill 715[v.0] entitled "A Bill to be Entitled An Act To Authorize The Five County Mental Health Authority, A Local Management Entity, To Enroll Its Employees And Retirees In The State Health Plan For Teachers And State Employees".

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.



Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

May 4, 2009
Date

OPTIONAL PLAN COVERAGE FOR THE FIVE COUNTY MENTAL HEALTH AUTHORITY.

PLAN CHANGES

The General Assembly of North Carolina enacts:

SECTION 1. Section 31.26(j) of S.L. 2004-124, as amended by Section 29.32 of S.L. 2005-276, reads as rewritten:

"**SECTION 31.26.(j)** This section applies to:

(1) Bladen, Cherokee, Mitchell, Rutherford, Washington, and Wilkes Counties only, ~~and~~

(2) The Towns of Biltmore Forest, Black Creek, Black Mountain, Blowing Rock, Forest City, Hobgood, Ocean Isle Beach, Sunset Beach, and Tabor City ~~only.~~only, and

(3) The Five County Mental Health Authority serving Franklin, Granville, Halifax, Vance, and Warren Counties only."

SECTION 2. This act becomes effective July 1, 2009.

PROJECTED COSTS/SAVINGS

Plan Design Change	Projected Costs/Savings
The Five County Mental Health Authority Authorized to Participate in Plan Optional Coverage	Estimated FY10 Cost: $440,586

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note:

- A census report was received from Fiscal Research that shows a distribution of the Five County Mental Health Authority dependents and retirees by age and gender. The membership levels were compared to those in the State Health Plan. The results showed that the Five County Mental Health Authority members would produces claims that were 42% more than those expected by the average SHP membership. These calculations were based solely on the submitted age and sex distributions and have no relationship to the actual claims experience of the Five County Mental Health Authority members.

- The only additional cost to the plan for covering these employees would be the cost of any excess risk for these members. That would result in potential losses to the plan, where claims and expenses exceed collected premiums.

- No experience data was received for the Five County Mental Health Authority. If this group, currently not participating in the State Health Plan, is made eligible, it is very likely that the group will have "adverse selection". Claims factors for these types of risk typically range from 125-200% of expected Plan costs, with some instances being as high as 300%. With a 150% assumed adverse selection, in combination with a 142% age/sex factor, we would expect a loss ratio of 213%. Adding expenses would put the loss ratio at approximately 230%.

- There are currently 87 employees and retirees participating in the Five County Mental Health Authority Plan. Assuming the same membership patterns as current, we would expect 89 total members. With an average cost of $3,800 per member, we expect a cost of 89 x $3,800 x 130% or $440,586. Due to the size of this group, varied assumptions would have negligible impact on the plan.

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

hartman@triad.rr.com

ıe: (336) 731-4038
(336) 731-2583

668 Link Road
Lexington, NC 27295

April 30, 2009

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 715: An Act to Authorize the Five County Mental Health Authority to Enroll Its Employees and Retirees in the State Health Plan for Teachers and State Employees

Dear Mr. Trogdon:

This bill amends Section 31.26(j) of S.L. 2004-124, as amended, to provide the option for the Five County Mental Health Authority serving Franklin, Granville, Halifax, Vance, and Warren counties to participate in the State Health Plan. This act is effective July 1, 2009.

S.L. 2004-124 provides the option for certain local government employers to elect to cover employees under the Plan. To participate, the employer must adopt a resolution to have its employees become eligible to participate, pay the required contributions, and make the Plan available to all of its eligible employees and retirees. Spouses and dependent children of employees may also participate. Covered members are required to participate in disease management, case management, and all other cost containment measures of the Plan. Employee coverage may be on a partially contributory basis as determined by the employer. The Plan's regular employee and dependent premium rates apply to employees who participate.

I reviewed the census data for 67 active employees and 20 retirees of the Authority. The demographics of this group indicate expected claims for this group would be approximately 20-25% higher than expected under the State Plan. We do not have prior claims experience of this group to compare to Plan experience, and the potential exists for anti-selection against the Plan. Based on the demographic data, I estimate the cost of the bill on the Plan at $75,000 - $100,000 per year.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

VISITOR REGISTRATION SHEET

Senate Health Care — **May 6, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Paige Stone	NCRLA
[illegible]	DPA
Chris Hayes	Civitas
Jake Cashion	WS Chamber
[illegible]	NLAC
Bobby D. White	Dental Board
Melissa Brawley	Capstrat
Charles Hodges	Capstrat
Shereeaah Wilson	DNHS
Emily Sallimore	NCBA
[illegible]	BPMHC

VISITOR REGISTRATION SHEET

Senate Health Care — **May 6, 2009**
Name of Committee — **Date**

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Chris Kelly	K&L Gates
Bruce Thompson	Parker Poe
Ken Wyatt	BCBSNC
Frank Gray	NCRLA
Fran Piercy	Ragsdale Liggett
Elizabeth Dalton	NCEMA
Joy Peterson	NCASA
David Boaz	MWC
John Boerdeck	AstraZeneca
Barbara Cansler	BBRGR
Dirk Barnes	GSA

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Senate Health Care — **May 6, 2009**

Name of Committee — **Date**

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Yvonne Copeland	NC Council of Comm Programs
Janet Schanzenbach	Sandoz
Tammy Beasley	GIC
Sandy Sands	WCSR
Amy McConkey	Smith Anderson
Butch Gunnells	NC Bev A
Annaliese Dolph	DRNC
Meghan Jones	DRNC

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Senate Health Care — **May 6, 2009**
Name of Committee — **Date**

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Clay Byrd	NCMS
[signature]	NCALHD
Earl Jaggers	Alamance County — BCTGM317T Cope Comm.
John Ledbetter	BCTGM 317-T COPE committee
Bobby Tisdale	BCTGM 317-T Cope Committee
Ralph Day	BCTGM 317-T
DARsey Campbell	BCTGM-317-T
Randy W. Fulk	317-T LORILLARD
Barry Jenkins	317-T

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Michael Shannon	Corillard
Chris Whanri	Corillard
Lori Ann Harris	LAHA
Fred Baron	Baron & Asso.
Kathy Hartkopf	Freedom Works
Julia Leggett	The Arc of NC
Jennifer Mahan	MHANC
Jud Waldhalm	Easter Seals UCP NC
Abby Emanuelson	NMSS-NC
MaryBe McMillan	NC AFL-CIO
Laura Bannon	John Locke Foundation

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Senate Health Care — **May 6, 2009**
Name of Committee — **Date**

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Rochelle Brooks	UHS.
	ACAS
Linda Dunlap	NCAA
Bill Wilson	AARP
Jim Jarrard	NC DMH/DD/SAS - DHHS
Betsy Vetter	American Heart Assn
Ashley J Bell	American Cancer Society
Jon Carr	" " "
Mark Essell	HWTF
Rob Thompson	Covenant w/ NC's Children
Mandy Ahleidiger	Action for Children NC

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Senate Health Care — **May 6, 2009**
Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Sally Henderson Mabel	NC DPH TPCB
Rosa Familio	NC Alliance for Health
Demetra Hawes	ALA
Cherie Conley	AHA
[illegible]	NCALHD
J Engel	NC DPH
Jim Martin	NC DPH / TPCB
Marcia Plesa	NC DPH
Jeff Hoffman	DHHS - DHSR
Chuck Stone	SEANC
Pam Seamans	NC Alliance for Health

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Senate Health Care — **May 6, 2009**
Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Layton Long	NCHAHD
Kim Genardo	NBC 17 News / WNCN
Erin Schwabpaly	UNC-GA
Chris Fitzsimon	NC Policy Watch
Harry Kaplan	MWC
Ken Melton	Ken Melton & Assoc.

VISITOR REGISTRATION SHEET

Senate Health Care — **May 6, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TINA GORDON	NC Nurses Assoc.
Marci Wilding	Novant Health
TOMMY SOTER	NOVARTIS
[illegible]	GSK
BART BAREFOOT	GSK

Senate Health Care Committee
Tuesday, May 12, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 877	Health Plan Provider Contracts/Transparency .	Senator Clodfelter

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Tuesday, May 12, 2009

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

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

S.B. **877** Health Benefit Plan Provider Contracts.

Draft Number:	75257
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
May 12, 2009
Rom 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 on Tuesday, May 12, 2009 in Room 544 of the Legislative Office Building. Sixteen committee members were present; Co-Chair Senator Purcell presided.

Senate Bill 877 entitled AN ACT RELATING TO CONTRACTS BETWEEN HEALTH BENEFIT PLANS AND HEALTH CARE PROVIDERS (Attachment I), sponsored by Senator Clodfelter was heard. A Committee Substitute (Attachment II) was offered, and Senator Bingham motioned its approval for consideration; motion carried.

Senator Clodfelter explained the Committee Substitute, referring to a summary (Attachment III) attached to these minutes. There was also an Actuarial Note (Attachment IV). At conclusion of discussion, Senator Atwater moved a favorable report for the Committee Substitute and an unfavorable report for the original bill.

There being no further business before the committee, Senator Purcell adjourned the meeting.

Respectfully submitted,

William R Purcell Becky Hedspeth

Sen. William R. Purcell, M.D. Becky Hedspeth, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 877
PROPOSED COMMITTEE SUBSTITUTE S877-PCS75257-SQ-34

Short Title: Health Plan Provider Contracts/Transparency. (Public)

Sponsors:

Referred to:

March 26, 2009

A BILL TO BE ENTITLED

AN ACT RELATING TO CONTRACTS BETWEEN HEALTH BENEFIT PLANS AND HEALTH CARE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new Part to read:

"Part 7. Contracts between health benefit plans and health care providers.

"**§ 58-50-270. Definitions.**

Unless the context clearly requires otherwise, the following definitions apply in this Part.

(1) "Affiliated payer" – A health benefit plan, employer, or insurer eligible to access contracted network of another health benefit plan or insurer.

(2) "Amendment" – An amendment includes any of the following:

a. Changes in the terms of the contract;

b. Additions or deletions in products, affiliated vendors, or rental networks associated with a contract;

c. Changes in fee schedules;

d. Changes in the policies or procedures of a health plan or insurer that decreases a health care provider's aggregate compensation under a contract;

e. Changes in the policies and procedures of a health plan or insurer that increase administrative expenses for a health care provider.

(3) "Affiliated vendor" – A vendor contracted by a health benefit plan or insurer to manage certain benefits applicable to a health care provider's contract.

(4) "Contract" – An agreement between a health benefit plan or insurer and one or more health care providers.

(5) "Delegated entity" – An entity, other than a health maintenance organization authorized to engage in business itself, or through subcontracts with one or more entities, undertaking to arrange for or provide medical care or health care to an enrollee in exchange for a predetermined payment and that accepts responsibility for performing on behalf of the health maintenance organization specific functions as applicable to a health maintenance organization.

(6) "Health benefit plan" – A policy, certificate, contract, or plan as defined in G.S. 58-3-167.

(7) "Insurer" – An entity as defined in G.S. 58-3-167.

(8) "Rental network" – Networks of participating providers offered to employers, insurers, and other parties not in direct contractual relationship with participating provider.

"**§ 58-50-271. Notice contact provisions.**

(a) All contracts shall contain a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed amendments and other notices, pertaining to the contractual relationship between parties shall be provided. Each party to a contract shall designate its notice contact under such contract.

(b) Date of receipt for all notices provided under a contract shall be calculated as five business days following the date the notice is placed, first-class postage prepaid, in the United States mail.

"**§ 58-50-272. Contract amendments.**

(a) A health benefit plan or insurer shall send any proposed contract amendment to the notice contact of a health care provider pursuant to G.S. 58-50-271. The proposed amendment shall be dated, labeled "Amendment," signed by the health benefit plan or insurer, and include an effective date for the proposed amendment.

(b) A health care provider receiving a proposed amendment shall be given at least 60 days from the date of receipt to accept the proposed amendment. Acceptance of a proposed amendment shall only be effective upon the health care provider signing the amendment and returning it to the initiating health benefit plan or insurer.

(c) If a health care provider does not accept a proposed amendment within 60 days, then the initiating health benefit plan or insurer shall be entitled to terminate the contract upon 90 days' written notice to the health care provider.

"**§ 58-50-273. Policies and procedures.**

(a) A health benefit plan or insurer shall provide a copy of its policies and procedures to a health care provider concurrently when initiating negotiation of a new or amended contract and annually to all contracted health care providers. Such policies and procedures may be provided to the health care provider in hard copy, CD, or other electronic format, and may also be provided by posting the policies and procedures on the Web site of the health plan or insurer.

(b) The policies and procedures of a health benefit plan or insurer shall not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in a contract, the contract language shall prevail.

"**§ 58-50-274. Fee schedule, bundling, and contract disclosures.**

(a) Fee schedule disclosures required under G.S. 58-3-227 shall include at a minimum:

(1) The description of the service, primary fee source, or reference schedule including:

a. The version, edition or publication date, description of the payment methodology, and

b. The actual payment amount or percentage of the primary fee source or reference schedule.

(2) When payment or compensation is based on a publicly available relative value unit system (RVU system) such as the Medicare Resource-Based Relative Value Scale, the contract shall identify the specific RVU system, its version, edition, or publication date, and any applicable conversion or geographic factors used.

(3) When payment or compensation is based on an insurer-determined fee schedule, the entire fee schedule including professional, facility, and global fees shall be identified.

(b) Health benefit plans and insurers shall make available on their Web site a pre-adjudication tool that provides information to providers regarding the manner in which its claim system adjudicates claims for specific Current Procedural Terminology codes or combinations of such codes.

(c) When a health benefit plan or insurer offers a contract to a health care provider, or upon written request by a contracted health care provider, the health benefit plan or insurer shall provide the following information:

(1) A copy of any new or existing contract and its attachments;

(2) Fee schedules, methodologies, and adjudication rules applicable to any new or existing contract;

(3) A list of affiliated payers and rental networks eligible to access a health care provider's negotiated fees under a contract;

(4) A list of delegated entities and affiliated vendors doing business with the health benefit plan or insurer.

SECTION 2. This act becomes effective January 1, 2010, and applies to health benefit plan contracts between health care providers and health benefit plans or insurers delivered, amended, or renewed on and after that date.

Attachment II

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 877
PROPOSED COMMITTEE SUBSTITUTE S877-CSSQ-34 [v.4]

5/11/2009 10:24:56 AM

Short Title: Health Plan Provider Contracts/Transparency. (Public)

Sponsors:

Referred to:

March 26, 2009

A BILL TO BE ENTITLED

AN ACT RELATING TO CONTRACTS BETWEEN HEALTH BENEFIT PLANS AND HEALTH CARE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new Part to read:

"Part 7. Contracts between health benefit plans and health care providers.

"**§ 58-50-270. Definitions.**

Unless the context clearly requires otherwise, the following definitions apply in this Part.

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(2) "Amendment" – An amendment includes any of the following:

a. Changes in the terms of the contract;

b. Additions or deletions in products, affiliated vendors, or rental networks associated with a contract;

c. Changes in fee schedules;

d. Changes in the policies or procedures of a health plan or insurer that decreases a health care provider's aggregate compensation under a contract;

e. Changes in the policies and procedures of a health plan or insurer that increase administrative expenses for a health care provider.

(3) "Affiliated vendor" – A vendor contracted by a health benefit plan or insurer to manage certain benefits applicable to a health care provider's contract.

(4) "Contract" – An agreement between a health benefit plan or insurer and one or more health care providers.

(5) "Delegated entity" – An entity, other than a health maintenance organization authorized to engage in business itself, or through subcontracts with one or more entities, undertaking to arrange for or provide medical care or health care to an enrollee in exchange for a predetermined payment and that accepts responsibility for performing on behalf of the health maintenance organization specific functions as applicable to a health maintenance organization.

(6) "Health benefit plan" – A policy, certificate, contract or plan as defined in G.S. 58-3-167.

(7) "Insurer" – An entity as defined in G.S. 58-3-167.

(9) "Rental network" – Networks of participating providers offered to employers, insurers, and other parties not in direct contractual relationship with participating provider.

"**§ 58-50-271. Notice contact provisions.**

(a) All contracts must contain a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed amendments and other notices, pertaining to the contractual relationship between parties must be provided. Each party to a contract shall designate its notice contact under such contract.

(b) Date of receipt for all notices provided under a contract shall be calculated as five business days following the date the notice is placed, first-class postage prepaid, in the United States mail.

"**§ 58-50-272. Contract amendments.**

(a) A health benefit plan or insurer shall send any proposed contract amendment to the notice contact of a health care provider pursuant to G.S. 58-50-271. The proposed amendment shall be dated, labeled "Amendment," signed by the health benefit plan or insurer, and include an effective date for the proposed amendment.

(b) A health care provider receiving a proposed amendment shall be given at least 60 days from the date of receipt to accept the proposed amendment. Acceptance of a proposed amendment shall only be effective upon the health care provider signing the amendment and returning it to the initiating health benefit plan or insurer.

(c) If a health care provider does not accept a proposed amendment within 60 days, then the initiating health benefit plan or insurer shall be entitled to terminate the contract upon 90 days' written notice to the health care provider.

"**§ 58-50-273. Policies and procedures.**

(a) A health benefit plan or insurer shall provide a copy of its policies and procedures to a health care provider concurrently when initiating negotiation of a new or amended contract and annually to all contracted health care providers. Such policies and procedures may be provided to the health care provider in hard copy, CD, or other electronic format, and may also be provided by posting the policies and procedures on the Web site of the health plan or insurer.

(b) The policies and procedures of a health benefit plan or insurer shall not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in a contract, the contract language shall prevail.

"**§ 58-50-274. Fee schedule, bundling, and contract disclosures.**

(a) Fee schedule disclosures required under G.S. 58-3-227 shall include at a minimum:

(1) The description of the service, primary fee source, or reference schedule including:

a. The version, edition or publication date, description of the payment methodology, and

b. The actual payment amount or percentage of the primary fee source or reference schedule.

(2) When payment or compensation is based on a publicly available relative value unit system (RVU system) such as the Medicare Resource-Based Relative Value Scale, the contract shall identify the specific RVU system, its version, edition, or publication date, and any applicable conversion or geographic factors used.

(3) When payment or compensation is based on an insurer-determined fee schedule, the entire fee schedule including professional, facility, and global fees shall be identified.

(b) Health benefit plans and insurers shall make available on their Web site a pre-adjudication tool that provides information to providers regarding the manner in which its claim system adjudicates claims for specific Current Procedural Terminology codes or combinations of such codes.

(c) When a health benefit plan or insurer offers a contract to a health care provider, or upon written request by a contracted health care provider, the health benefit plan or insurer shall provide the following information:

(1) A copy of any new or existing contract and its attachments;

(2) Fee schedules, methodologies, and adjudication rules applicable to any new or existing contract;

(3) A list of affiliated payers and rental networks eligible to access a health care provider's negotiated fees under a contract;

(4) A list of delegated entities and affiliated vendors doing business with the health benefit plan or insurer.

SECTION 2. This act becomes effective January 1, 2010, and applies to health benefit plan contracts between health care providers and health benefit plans or insurers delivered, amended, or renewed on and after that date.

Attachment III

SENATE BILL 877:
Health Benefit Plan Provider Contracts

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 11, 2009
Introduced by:	Sen. Clodfelter	**Prepared by:**	Shawn Parker
Analysis of:	PCS to First Edition S877-CSSQ-34		Legislative Analyst

SUMMARY: ***Senate Bill 877 amends Article 50 (General Accident and Health Insurance Regulations) of Chapter 58 (Insurance Law of North Carolina) to add a new part regulating contracts between health care providers and health benefit plans or insurers.***

BILL ANALYSIS:

The bill adds a new Part 7 to Article 50 of the North Carolina Insurance Law relating to contracts between health care providers and health benefit plans or insurers. Specifically the bill requires such contracts to contain notice provisions; provides the process for amending contracts; and sets criteria for fee schedule disclosure required under G.S. 58-3-227.

58-50-270 provides the relevant definitions to be applied in the new Part including the following new terms: *affiliated payer, affiliated vendor, delegated entity, and rental network.*

58-50-271 provides that all contracts shall contain a notice contact including the name or title and address of the person whom all correspondence is to be provided to, and provides the date of receipt for notices is calculated as five (5) business days following the date the notice is properly placed in the mail.

58-50-272 provides the process for sending, receiving, and accepting proposed amendments to a contract between a health care provider and a health benefit plan or ad insurer. Proposed contract amendments must be dated, properly labeled, and signed by the health benefit plan or insurer and contain an effective date for the proposed amendment. The recipient has at least sixty (60) days from receipt to accept or reject the amendment. A health care benefit plan or insurer may terminate the original contract upon the failure of the recipient to accept the proposed amendment within 60 days and by providing 90 days written notice to the health care provider.

58-50-273 requires a health benefit plan or insurer to provide a copy of its policies and procedures to the health care provider when initiating the negotiation of a new or amended contract. If the policies and procedures of the plan/insurer contradict language in a contract, the contract language prevails.

58-50-274 Provides that at a minimum, fee scheduled disclosures required by G.S. 50-3-274 must contain the description of the service, primary fee source or reference schedule. If the payment or compensation is based on a publicly available relative value unit system, the contract shall identify the RVU system, if the payment of compensation is based on an insurer-determined fee schedule, the entire schedule shall be identified.

The new section further directs health care benefit plans and insurers to publish on its website a pre-adjudication tool which provides the manner in which its claims system adjudicates claims for specific CPT® codes.

The new section requires the health benefit plan or insurer is to provide the following upon written request by a contracted health care provider:

- A copy of any new or existing contract and its attachments.

- Fee schedule methodologies and adjudication rules to such contract.
- A list of affiliated payers and rental networks eligible to access a health care provider's negotiated fees under the contract.
- A list of delegated entities and affiliated vendors doing business with the health benefit plan or insurer.

EFFECTIVE DATE: This act is effective January 1, 2010 and applies to contracts delivered amended or renewed on or after that date.

S877-SMSQ-68(CSSQ-34) v1

GENERAL ASSEMBLY OF NORTH CAROLINA

Attachment IV

Session 2009

Legislative Actuarial Note

HEALTH BENEFITS

BILL NUMBER: Proposed Committee Substitute to Senate Bill 877 (S877-CSSQ-34 [v.4])

SHORT TITLE: Health Benefit Plan Provider Contracts.

SPONSOR(S):

SYSTEM OR PROGRAM AFFECTED: State Health Plan for Teachers and State Employees (Plan).

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts; premium payments for dependents of active employees and retired employees of State agencies and universities, local public schools and local community colleges; premium payments for coverages selected by eligible former employees; premium payments for coverages selected by firefighters, rescue squad workers, members of the National Guard, and certain authorized local governments.

BILL SUMMARY:

The Proposed Committee Substitute adds a new Part 7 to Chapter 58 of the General Statutes relating to contracts between health benefit plans and health care providers. The proposed changes provide for the following: definition of certain terminology, specification of a contact person by each party to a contract, establishing of time periods for reviewing potential amendments to contracts, specifying the rights of a health benefit plan to terminate a provider contract upon a provider's refusal of a proposed contract amendment, and disclosure of a health benefit plan's policies, procedures, fee schedules and other contract related information.

The provisions of the Proposed Committee Substitute may affect the Plan based on the applicability of the changes to the Plan's Claims Processing Contractor. The Plan's Claims Processing Contractor currently provides to the Plan its current medical provider and facility network through contracts negotiated by the Claims Processing Contractor.

EFFECTIVE DATE: January 1, 2010

ESTIMATED IMPACT ON STATE:

Aon Consulting, consulting actuary for the Plan cannot estimate the impact to the Plan based on present available information needed to evaluate the provisions of the proposed committee substitute. Based on information provided by the Plan, Aon Consulting notes that some potential administrative and other costs incurred by the Plan's Claims Processing Contractor may be passed on to the Plan.

Hartman and Associates, consulting actuary for the General Assembly's Fiscal Research Division, cannot quantify the impact to the Plan based on the information currently available from which to analyze the provisions included in the proposed legislation. Based on information provided by the Plan, Hartman and Associates noted that a potential for increased administrative and benefit costs to the Plan exists via increased costs to provide the Plan's third party provider network through its Claims Processing Contractor.

ASSUMPTIONS AND METHODOLOGY: The actuarial analyses used by each respective consulting actuary are on file with the Fiscal Research Division. Copies of each respective consulting actuary's analysis, including assumptions, are also attached to the original copy of this Legislative Actuarial note.

Summary Information and Data about the Plan

The Plan administers health benefit coverage for active employees from employing units of State agencies and departments, universities, local public schools, and local community colleges. Eligible retired employees of authorized employing units may also access health benefit coverage under the Plan. Eligible dependents of active and retired employees are authorized to participate in the Plan provided they meet certain requirements. Employees and retired employees of selected local governments may also participate in the Plan under certain conditions. Members of fire, rescue squads, and the National Guard may also obtain coverage under the Plan provided they meet certain eligibility criteria.

As of July 1, 2008, the State finances the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts are derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage are paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.6 billion for FY 2008-09. The Plan's PPO benefit design includes three alternative benefit levels offered to plan members. The three alternative benefit levels include the following:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums;

2) The "Standard" 80/20 plan; and

3) The "Plus" 90/10 plan with enhanced benefits via lower out-of pocket requirements as compared to the other PPO plan alternatives offered.

As of July 1, 2009, the State will continue to finance the Plan on a self-funded basis and administers benefit coverage under a Preferred Provider Option (PPO) arrangement. The Plan's receipts will be derived through premium contributions, investment earnings and other receipts. Premiums for health benefit coverage will be paid by (1) employing agencies for active employees, (2) the Retiree Health Benefit Fund for retired employees, and (3) employees and retirees who elect dependent coverage. Total requirements for the Plan are estimated to be $2.5 billion for FY 2009-10 and $2.7 billion for FY 2010-11. The Plan's PPO benefit design will include two alternative benefit levels listed below:

1) The "Basic" 70/30 plan that offers higher out-of pocket requirements in return for lower fully contributory dependent premiums; and

2) The "Standard" 80/20 plan.

The Basic and Standard plans offer coverage to employees and retired employees on a noncontributory basis. Coverage for dependents under both plans is offered on a fully contributory basis.

Financial Condition

Financial Projection (Revised Summer 2008) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year were projected to be $2.3 billion from premium collections, $53.9 million from Medicare Part D subsidies, and $2.7 million from investment earnings, for a total of slightly over $2.3 billion in receipt income for the year. Projected disbursements from the Plan were expected to be $2.4 billion in claim-payment expenses and $168.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating loss was projected to be approximately $264.4 million for the fiscal year, assuming a 9% annual claims growth trend.

Projected operating losses were expected to deplete the Plan's cash balance of $139.8 million and leave it without sufficient operating resources to continue operations for the fiscal year.

Financial Projection (Revised April 2009) for FY 2008-09 -- For the fiscal year beginning July 1, 2008, the Plan began its operations with a beginning cash balance of $139.8 million. Receipts for the year are projected to be $2.3 billion from premium collections, $49.0 million from Medicare Part D subsidies, $3.3 million from investment earnings, and $250.0 million from a direct General Fund appropriation from the Rainy Day Fund (Savings Reserve Account) for a total of approximately $2.6 billion in receipt income for the year. The $250 million from a direct General Fund appropriation was provided by Session Law 2009-16 (Senate Bill 287) to finance a shortfall in funds available to pay health care benefits, administrative costs, and adequately fund the Plan's beginning cash balance on July 1, 2009. Projected disbursements from the Plan are expected to be $2.4 billion in claim-payment expenses and $180.7 million in administration and claims-processing expenses for projected total expenses of nearly $2.6 billion for FY 2008-09. The Plan's net operating income is projected to be approximately $7.1 million for the fiscal year, assuming a 9% annual claims growth trend.

Financial Projection 2009-11 Biennium (April 2009) – Session Law 2009-16 (Senate Bill 287) appropriates funds from various sources, authorizes annual premium rate increases, makes various benefit and provider related changes to achieve financial savings, and directs other various changes to the Plan. The enacted law also appropriates the sum of $250 million from the Savings Reserve Account ("Rainy Day Fund") of the General Fund for the 2008-09 fiscal year. The following summarized financial projections by fiscal year for the 2009-11 biennium assume the changes enacted in Session Law 2009-16 (Senate Bill 287).

For the fiscal year beginning July 1, 2009, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.4 billion from premium collections, $56.3 million from Medicare Part D subsidies, and $8.0 million from investment earnings for a total of approximately $2.5 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.3 billion in claim-payment expenses and $185.6 million in administration and claims-processing expenses for projected total expenses of nearly $2.5 billion for FY 2008-09. The Plan's net operating income is projected to be approximately $14.8 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2009.

For the fiscal year beginning July 1, 2010, the Plan is projected to begin its operations with a beginning cash balance of $146.9 million. Receipts for the year are projected to be $2.7 billion from premium collections, $50.4 million from Medicare Part D subsidies, and $8.8 million from investment earnings for a total of approximately $2.7 billion in receipt income for the year. Projected disbursements from the Plan are expected to be $2.5 billion in claim-payment expenses and $191.7 million in administration and

claims-processing expenses for projected total expenses of nearly $2.7 billion for FY 2010-11. The Plan's operating income is projected to be approximately $30.6 million for the fiscal year, assuming a 9% annual claims growth trend and an annual premium increase of 8.9% effective July 1, 2010.

Other Information

Historically, the Plan has applied a premium increase in October of the first fiscal year of a biennium. However, the annual premium increases authorized in Session Law 2009-16 (Senate Bill 287) changes that methodology to an annual increase at the beginning of each fiscal year of the 2009-11 biennium.

Additional assumptions include Medicare benefit "carve-outs," cost containment strategies including prior approval for certain medical services, utilization of the "Blue Options" provider network, case and disease management for selected medical conditions, mental health case management, coordination of benefits with other payers, a prescription drug benefit manager with manufacturer rebates from formularies, and fraud detection, and other authorized actions by the Executive Administrator and Board of Trustees to manage the Plan to maintain and improve the Plan's operation and financial condition where possible. Claim cost trends are expected to increase at a rate of 9% annually according to the Plan's consulting actuary. Investment earnings are based upon a 4.5% return on available cash balances.

Enrollment Data as of December 31, 2008

I. No. of Participants	Basic	Standard	Plus	Total	Percent of Total
Actives					
Employees	11,623	271,243	47,687	330,553	49.6%
Dependents	20,454	115,875	28,156	164,485	24.7%
Sub-total	32,077	387,118	75,843	495,038	74.2%
Retired					
Employees	1,726	127,081	17,967	146,774	22.0%
Dependents	1,117	14,935	3,476	19,528	2.9%
Sub-total	2,843	142,016	21,443	166,302	24.9%
Former Employees with Continuation Coverage					
Employees	60	1,349	344	1,753	0.3%
Dependents	61	501	182	744	0.1%
Sub-total	121	1,850	526	2,497	0.4%
Firefighters, Rescue Squad & National Guard					
Employees	-	3	2	5	0.0%
Dependents	-	3	-	3	0.0%
Sub-total	-	6	2	8	0.0%
Local Governments					
Employees	72	1,577	319	1,968	0.3%
Dependents	141	637	218	996	0.1%
Sub-total	213	2,214	537	2,964	0.4%
Total					
Employees	13,481	401,253	66,319	481,053	72.1%
Dependents	21,773	131,951	32,032	185,756	27.9%
Grand Total	**35,254**	**533,204**	**98,351**	**666,809**	**100%**
Percent of Total	**5.3%**	**80.0%**	**14.7%**	**100.0%**	

II. Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	2,684	328,635	49,246	380,565
Employee Child(ren)	4,958	36,903	8,589	50,450
Employee Spouse	2,274	18,145	4,469	24,888
Employee Family	3,565	17,570	4,015	25,150
Total	**13,481**	**401,253**	**66,319**	**481,053**

Percent Enrollment by Contract	Basic	Standard	Plus	Total
Employee Only	19.9%	81.9%	74.3%	79.1%
Employee Child(ren)	36.8%	9.2%	13.0%	10.5%
Employee Spouse	16.9%	4.5%	6.7%	5.2%
Employee Family	26.4%	4.4%	6.1%	5.2%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Enrollment Data Continued

III. Enrollment by Sex	Basic	Standard	Plus	Total
Female	18,837	334,917	61,752	415,506
Male	16,417	198,287	36,599	251,303
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Sex	Basic	Standard	Plus	Total
Female	53.4%	62.8%	62.8%	62.3%
Male	46.6%	37.2%	37.2%	37.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

IV. Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	17,390	136,277	27,211	180,878
30 to 44	8,125	107,375	17,315	132,815
45 to 54	5,164	94,548	18,277	117,989
55 to 64	3,195	102,901	23,452	129,548
65 & Over	1,380	92,103	12,096	105,579
Total	**35,254**	**533,204**	**98,351**	**666,809**

Percent Enrollment by Age	Basic	Standard	Plus	Total
29 & Under	49.3%	25.6%	27.7%	27.1%
30 to 44	23.0%	20.1%	17.6%	19.9%
45 to 54	14.6%	17.7%	18.6%	17.7%
55 to 64	9.1%	19.3%	23.8%	19.4%
65 & Over	3.9%	17.3%	12.3%	15.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**

V. Retiree Enrollment by Category	Employee	Dependents	Total
Non-Medicare Eligible	49,534	12,080	61,614
Medicare Eligible	97,240	7,448	104,688
Total	**146,774**	**19,528**	**166,302**

Percent by Category (Retiree)	Employee	Dependents	Total
Non-Medicare Eligible	33.7%	61.9%	37.0%
Medicare Eligible	66.3%	38.1%	63.0%
Total	**100.0%**	**100.0%**	**100.0%**

SOURCES OF DATA:

-Actuarial Note, Hartman & Associates, "Senate Bill 877 Proposed Committee Substitute (S877-CSSQ-34 [v.4]) An Act Relating to Contracts Between Health Benefit Plans and Health Care Providers", May 11, 2009, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, "Senate Bill 877 Proposed Committee Substitute (S877-CSSQ-34 [v.4]) Health Plan Provider Contracts/Transparency", May 11, 2009, original of which is on file with the State Health Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION: (919) 733-4910

PREPARED BY: Mark Trogdon

APPROVED BY:

Marilyn Chism, Director
Fiscal Research Division

DATE: May 11, 2009

NORTH CAROLINA STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES

SENATE BILL 877
PROPOSED COMMITTEE SUBSTITUTE
S877-CSSQ-34 [V.4]

HEALTH PLAN PROVIDER CONTRACTS/TRANSPARENCY

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30305

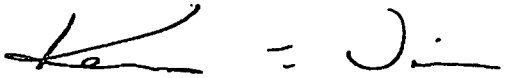
May 2009

ACTUARIAL STATEMENT

The North Carolina State Health Plan for Teachers and State Employees has requested that Aon Consulting prepare an Actuarial Note in response to Senate Bill 877 Proposed Committee Substitute S877-CSSQ-34 [v.4] entitled "An Act Relating To Contracts Between Health Benefit Plans And Health Care Providers."

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.



May 11, 2009

Kenneth C. Vieira, F.S.A., M.A.A.A.
Senior Vice President

Date

May 11, 2009

Kirsten R. Schatten, A.S.A., M.A.A.A.
Assistant Vice President

Date

HEALTH PLAN PROVIDER CONTRACTS/TRANSPARENCY

PLAN CHANGES

The proposed legislation changes contract terms between the Plan's Claims Processing Contractor (CPC) and health care providers. The full text of the bill is attached to this actuarial note.

PROJECTED COSTS

	Based on "Midpoint" Increase (in millions)		
Plan Design Change	2009-2010 Fiscal Year Cost	2010-2011 Fiscal Year Cost	Total Biennium Cost
Change contract terms between CPC and health care providers	Fiscal impact cannot be quantified		

* Based on total projected expenses of $2,486,310,245 and $2,681,918,655 for the 2010 and 2011 fiscal years respectively.

PRICING APPROACH AND COMMENTS

The following information was compiled and utilized in determining the projected costs or savings of each benefit component addressed in this actuarial note:

- Aon expects the bill will have a fiscal impact on the Plan; however, we do not believe the impacts can be quantified for purposes of a fiscal note. Some fiscal impact considerations include the following:

    1. Section 58-50-272 allows providers to accept or reject any and all amendments to contracts. Potential results for the Plan include terminated provider contracts resulting in access issues or additional administrative costs resulting from multiple differing contracts.
    2. Section 58-50-273 states all new policies and procedures of the Plan are superseded by the provider contract. A potential result for the Plan could be additional administrative costs resulting from multiple differing contracts.
    3. Section 58-50-274 requires the Plan to make available a pre-adjudication tool for providers on their Web site. A potential impact for the Plan includes cost of this system.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 877
PROPOSED COMMITTEE SUBSTITUTE S877-CSSQ-34 [v.4]

5/11/2009 10:24:56 AM

Short Title: Health Plan Provider Contracts/Transparency. (Public)

Sponsors:

Referred to:

March 26, 2009

A BILL TO BE ENTITLED

AN ACT RELATING TO CONTRACTS BETWEEN HEALTH BENEFIT PLANS AND HEALTH CARE PROVIDERS.

The General Assembly of North Carolina enacts:

SECTION 1. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new Part to read:

"Part 7. Contracts between health benefit plans and health care providers.

"**§ 58-50-270. Definitions.**

Unless the context clearly requires otherwise, the following definitions apply in this Part.

(1) "Affiliated payer" – A health benefit plan, employer, or insurer eligible to access contracted network of another health benefit plan or insurer.

(2) "Amendment" – An amendment includes any of the following:

a. Changes in the terms of the contract;

b. Additions or deletions in products, affiliated vendors, or rental networks associated with a contract;

c. Changes in fee schedules;

d. Changes in the policies or procedures of a health plan or insurer that decreases a health care provider's aggregate compensation under a contract;e. Changes in the policies and procedures of a health plan or insurer that increase administrative expenses for a health care provider.

(3) "Affiliated vendor" – A vendor contracted by a health benefit plan or insurer to manage certain benefits applicable to a health care provider's contract.

(4) "Contract" – An agreement between a health benefit plan or insurer and one or more health care providers.

(5) "Delegated entity" – An entity, other than a health maintenance organization authorized to engage in business itself, or through subcontracts with one or more entities, undertaking to arrange for or provide medical care or health care to an enrollee in exchange for a predetermined payment and that accepts responsibility for performing on behalf of the health maintenance organization specific functions as applicable to a health maintenance organization.

(6) "Health benefit plan" – A policy, certificate, contract or plan as defined in G.S. 58-3-167.

(7) "Insurer" – An entity as defined in G.S. 58-3-167.

Deleted: ¶

(9) "Rental network" – Networks of participating providers offered to employers, insurers, and other parties not in direct contractual relationship with participating provider.

"**§ 58-50-271. Notice contact provisions.**

(a) All contracts must contain a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed amendments and other notices, pertaining to the contractual relationship between parties must be provided. Each party to a contract shall designate its notice contact under such contract.

(b) Date of receipt for all notices provided under a contract shall be calculated as five business days following the date the notice is placed, first-class postage prepaid, in the United States mail.

"**§ 58-50-272. Contract amendments.**

(a) A health benefit plan or insurer shall send any proposed contract amendment to the notice contact of a health care provider pursuant to G.S. 58-50-271. The proposed amendment shall be dated, labeled "Amendment," signed by the health benefit plan or insurer, and include an effective date for the proposed amendment.

(b) A health care provider receiving a proposed amendment shall be given at least 60 days from the date of receipt to accept the proposed amendment. Acceptance of a proposed amendment shall only be effective upon the health care provider signing the amendment and returning it to the initiating health benefit plan or insurer.

(c) If a health care provider does not accept a proposed amendment within 60 days, then the initiating health benefit plan or insurer shall be entitled to terminate the contract upon 90 days' written notice to the health care provider."**§ 58-50-273. Policies and procedures.**

(a) A health benefit plan or insurer shall provide a copy of its policies and procedures to a health care provider concurrently when initiating negotiation of a new or amended contract and annually to all contracted health care providers. Such policies and procedures may be provided to the health care provider in hard copy, CD, or other electronic format, and may also be provided by posting the policies and procedures on the Web site of the health plan or insurer.

(b) The policies and procedures of a health benefit plan or insurer shall not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in a contract, the contract language shall prevail.

"**§ 58-50-274. Fee schedule, bundling, and contract disclosures.**

(a) Fee schedule disclosures required under G.S. 58-3-227 shall include at a minimum:

(1) The description of the service, primary fee source, or reference schedule including:

a. The version, edition or publication date, description of the payment methodology, and

b. The actual payment amount or percentage of the primary fee source or reference schedule.

(2) When payment or compensation is based on a publicly available relative value unit system (RVU system) such as the Medicare Resource-Based Relative Value Scale, the contract shall identify the specific RVU system, its version, edition, or publication date, and any applicable conversion or geographic factors used.

(3) When payment or compensation is based on an insurer-determined fee schedule, the entire fee schedule including professional, facility, and global fees shall be identified.

(b) Health benefit plans and insurers shall make available on their Web site a pre-adjudication tool that provides information to providers regarding the manner in which its

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claim system adjudicates claims for specific Current Procedural Terminology codes or combinations of such codes.

(c) When a health benefit plan or insurer offers a contract to a health care provider, or upon written request by a contracted health care provider, the health benefit plan or insurer shall provide the following information:

(1) A copy of any new or existing contract and its attachments;

(2) Fee schedules, methodologies, and adjudication rules applicable to any new or existing contract;

(3) A list of affiliated payers and rental networks eligible to access a health care provider's negotiated fees under a contract;

(4) A list of delegated entities and affiliated vendors doing business with the health benefit plan or insurer.

SECTION 2. This act becomes effective January 1, 2010, and applies to health benefit plan contracts between health care providers and health benefit plans or insurers delivered, amended, or renewed on and after that date.

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

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Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

May 11, 2009

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Senate Bill 877 Proposed Committee Substitute (S877-CSSQ-34 [v.4]): An Act Relating to Contracts Between Health Benefit Plans and Health Care Providers

Dear Mr. Trogdon:

This proposed committee substitute to the bill amends G.S. 58-50 by adding a new part relating to contracts between health benefit plans and health care providers. The new section requires certain provisions and procedures in contracts between health benefit plans and health care providers. These include:

- All contracts must provide a "notice contact" provision listing the name and address of the person to whom all correspondence is directed.
- To amend a contract, a plan must allow a provider 60 days to accept a proposed amendment. If the provider does not accept the amendment, the plan is entitled to terminate the contract upon 90 days written notice.
- The plan shall provide a copy of its policies and procedures to a provider when initiating negotiations of a new or amended contract and annually to all contracted providers.
- The policies and procedures of a plan must not conflict with or override any contract terms, including fee schedules.
- Fee schedule disclosures must include a description of the service, primary fee source, or the reference schedule.
- The plan shall make available on its web site a pre-adjudication tool that provides information to providers regarding the manner in which its claim system adjudicates claims.
- When a plan offers a contract or upon request by a provider, the plan must provide a copy of any new or existing contract, fee schedules and adjudication rules, a list of affiliated payers and rental networks eligible to access the provides fees under a contract, and a list of delegated entities and affiliated vendors doing business with the plan.

This act is effective January 1, 2010 and applies to contracts delivered, amended, or renewed on and after that date.

The North Carolina State Health Plan for Teachers and State Employees (the "Plan") utilizes a third party preferred provider network to provide benefits. The contracts under this network would be subject to the provisions of this bill; thus, this bill is expected to have an impact on the Plan. Based on information received from the Plan, the contract requirements may create

additional administrative costs and have the potential to increase benefit costs to the Plan. However, based on the available information, we do not believe the financial impact can be quantified at this time.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, FCA, EA
Consulting Actuary

MVH/mt

Senate Health Care Committee
Wednesday, May 13, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 694	**Amend Dentistry Laws/Out of State Dentists.**	**Senator Garrou**
SB 804	**CON Changes.**	**Senator Rand**
SB 595	**The Terri Schiavo Act.**	**Senator Goodall**
SB 628	**Release Contr. Subst. Rep. Data To CME.**	**Senator Purcell**
SB 940	**Flexibility for Certified Nurse Midwives.**	**Senator Davis**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 13, 2009

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

FAVORABLE

S.B. **628** Release Contr. Subst. Rep. Data To CME.
Sequential Referral: None
Recommended Referral: None

S.B. **694** Amend Dentistry Laws/Out of State Dentists.
Sequential Referral: None
Recommended Referral: None

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

S.B. **940** Flexibility for Certified Nurse Midwives.
Draft Number: 55386
Sequential Referral: None
Recommended Referral: Rules and Operations of the Senate
Long Title Amended: Yes

TOTAL REPORTED: 3

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 13, 2009

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

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

S.B. **804** CON Changes.

Draft Number:	55400
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 13, 2009

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

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

S.B. **595** The Terri Schiavo Act.

Draft Number:	15283
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, May 13, 2009 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, May 13, 2009, in Room 544 of the Legislative Office Building, with twenty-four members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Bingham asked Senator Purcell, Co-Chair to present his bill, Senate Bill 628, ***Release Controlled Substances Reporting Data To CME***. Senator Purcell explained that the problem this bill would resolve was when doing investigations into deaths, due to prescription drugs, the investigations are often delayed while the pathologist tries to determine what medication the individual might have been taking. This bill would authorize the DHHS to release confidential data, in the controlled substances reporting system, to the Chief Medical Examiner and the County Medical Examiners for the purpose of investigating deaths. Senator Dannelly moved for a favorable report. The bill passed.

Senator Bingham recognized David Strong, CEO of Rex Hospital in Raleigh, whom was in the audience.

Senator Bingham called on Senator Rand to present Senate Bill 804, ***CON Changes***. Senator Rand stated the purpose of Senate Bill 804 was to establish a definite time line for issuance of Certificates of Needs. In previous times CON, Certificates of Needs, have been going through the appeal process at the same time the hospital was being built. One hospital was already built when the CON was reversed. This bill would make it clear that the CON does not become final until the Appellant process is completed. The bill will set up time lines, specific time lines, for going through the process. Senator Rand stated there was an amendment on the bond amount and that all parties have agreed. Ben Popkin, Staff Attorney, explained that the amendment would allow for posting of a higher bond amount, up to $300,000.00. Senator Rand reiterated that all parties were in agreement. Senator Rand made the motion to pass the amendment. The motion passed. Senator Bingham then brought the bill before the committee for a vote. Senator Dannelly moved for a favorable report, to roll the amendment into a new PCS, unfavorable to the original bill, favorable as to the Proposed Committee Substitute Bill.

Senator Bingham brought Senate Bill 595, ***The Terri Schiavo Act***, before the committee. Senator Foriest moved to hear the PCS and the motion passed. Senator Goodall was recognized to explain the bill. Senate Goodall stated Senate Bill 595 would simply direct the Division of Motor Vehicles to denote on your drivers licenses if you have a living will on file with the Advance Health Care Directive Registry, which is maintained by the Secretary of State. He pointed out, this would be very similar to the

organ donorship that the state already has. Senator Goodall explained the Advance Health Care Directive Registry was a document that tells your Doctor what kind of care you would like to have if you are unable to make a medical decision. Tara Greer, Carolinas Cancer Associates, spoke in favor of the bill. She stated that only twenty-seven percent of the population actually had an Advance Directive. Also she pointed out that eighty percent of health care cost would be spent in the last two weeks of life, which would be futile end of life care, especially if it was not what the patient would have wanted anyway. Dr. Ed Yellig, Medical Director of Hospice of Wake County, spoke about the stressfulness of the end of life decisions, when no preparation had been made. Senator Hartsell moved for a favorable report to the PCS, but also had a question. He stated that if you were an organ donor, a bill was adopted last session, to note that on your driver's licenses. So his question was, should there be something in section one about that? Staff Attorney Shawn Parker stated that was not included on what was required of the format of the Department of Motor Vehicle Drivers License. Senator Hartsell felt these situations were very much alike and should be together on the driver's license. Senator Goodall wanted to vote on the bill now and then do a floor amendment on the format. Senator Rand stated that a floor amendment would be all right. Senator Goodall stated that the DMV was OK with Senate Bill 595 and the Fiscal Note was for $80,000.00 for the software, which would be about twelve days in intensive care in NC. Senator Allran wanted to include Health Care Power of Attorney. Senator Hartsell responded that the reason it was not included, was for simplicity. The Living Will Registry already exists with the Secretary of State; in case of an emergency a health care official can easily go to the Secretary of State Website and find the Living Will. There is no central registry to record The Health Care Power of Attorney where health care officials could readily access it, like the Advance Health Care Directive's Registry for Living Wills. The driver's license would just alert them that there was a Living Will in place. Senator Goss asked what if there was a dispute over the Living Will and the next of kin said the patient had changed his mind. Senator Purcell answered that any physician in charge when there was a dispute about the living will would not cut off life support. Senator Rand stated this was just to make them aware there is a living will and it is a public record, but if there were a dispute nothing would happen. Senator Hartsell had previously made a motion unfavorable as to the original bill, but favorable as the Proposed Committee Substitute Bill. The motion passed.

Senator Bingham recognized Senator Garrou to present Senate Bill 694, ***Amend Dentistry Laws/Out of State***. She stated the bill would allow dentists who had been licensed by credentialing to be able to go and offer pro bono services out of the state and then come back. It allows the Dental Society the discretion to have the ability to make that decision. Senator Dannelly moved for a favorable report. The motion carried.

Senator Bingham recognized Senator Davis to present Senate Bill 940, ***Flexibility for Certified Nurse Midwives***. Senator Dorsett moved to hear the Proposed Committee

Substitute. The motion passed. Senator Davis stated this bill came from a group of Midwives at East Carolina University, in his district. They pointed out that in existing law it defines Midwifery occurring under the supervision of the physician. NC is one of six states, which continue to address supervision, and does not allow collaboration. This bill would formulate a study commission to explore how midwifes may operate in collaboration with the physicians. Senator Davis pointed out the bill was not opposed by the Medical Society, Obstetrics, or the Midwives. Senator Rand moved for a favorable report and referred the bill to the Committee on Rules, the motion being, unfavorable to the original bill, favorable as to the PCS with a committee recommended referral to Rules to be included in the Study Bill.

The meeting adjourned at 11:50 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 694

Short Title:	Amend Dentistry Laws/Out of State Dentists.	(Public)
Sponsors:	Senator Garrou.	
Referred to:	Health Care.	

March 24, 2009

A BILL TO BE ENTITLED

AN ACT AMENDING THE LAWS PERTAINING TO THE PRACTICE OF DENTISTRY AS PERFORMED BY PERSONS PRACTICING DENTISTRY OUT OF STATE UNDER CERTAIN CIRCUMSTANCES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-36(e) reads as rewritten:

"(e) The holder of a license issued under this section shall establish a practice location and actively practice dentistry, as defined in G.S. 90-29(b)(1) through (b)(9), in North Carolina within one year from the date the license is issued. The license issued under this section shall be void upon a finding by the Board that the licensee fails to limit the licensee's practice to North Carolina or that the licensee no longer actively practices dentistry in North Carolina. However, when a dentist licensed under this section faces possible Board action to void the dentist's license for failure to limit the dentist's practice to North Carolina, if the dentist demonstrates to the Board that out-of-state practice actions were in connection with formal contract or employment arrangements for the dentist to provide needed clinical dental care to patients who are part of an identified ethnic or racial minority group living in a region of the other state with low access to dental care, the Board, in its discretion, may waive the in-State limitations on the out-of-state practice for a maximum of 12 months."

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

SENATE BILL 694:
Amend Dentistry Laws/Out of State Dentists

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 12, 2009
Introduced by:	Sen. Garrou	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Legislative Analyst

SUMMARY: ***Senate Bill 694 authorizes the North Carolina State Board of Dental Examiners to waive for a period of up to twelve months in-State practice requirements of dentist issued a license by credentialing.***

CURRENT LAW: The North Carolina State Board of Dental Examiners may issue a license by credentials to an applicant who has been licensed to practice dentistry in any state or territory of the United States if the applicant produces satisfactory evidence to the Board that the applicant has the required education, training, and qualifications, is in good standing with the licensing jurisdiction, has passed satisfactory examinations of proficiency in the knowledge and practice of dentistry as determined by the Board, and meets all other requirements of this section and rules adopted by the Board.

Dental practitioners who are issued a license by credentialing must maintain practice in North Carolina and are prohibited from practicing outside of the State. The North Carolina State Board of Dental Examiners is directed to void such licensees by a finding of fact as to the failure to meet either condition.

BILL ANALYSIS:
Senate Bill 694 authorizes the North Carolina State Board of Dental Examiners to waive the in-State limitation on the out of state practice requirement for dentists licensed under G.S. 90-36 a maximum period of twelve months when the out of state practice actions were in connection with formal contract or employment arrangements and were to provide needed clinical dental care to patients who are part of an identified ethnic or racial minority group living in a region with low access to dental care.

EFFECTIVE DATE: This act is effective when it becomes law.

S694-SMSQ-74(e1) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 804

Short Title:	CON Changes.	(Public)
Sponsors:	Senator Rand.	
Referred to:	Health Care.	

March 25, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE CERTIFICATE OF NEED LAW WITH RESPECT TO TIME LINES FOR ISSUANCE OF A CERTIFICATE OF NEED.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-187 reads as rewritten:

"**§ 131E-187. Issuance of a certificate of need.**

~~(a) The Department shall issue a certificate of need within 35 days of the date of the decision referenced in G.S. 131E-186, when no request for a contested case hearing has been filed in accordance with G.S. 131E-188, and all applicable conditions of approval that can be satisfied before issuance of the certificate of need have been met.~~

~~(b) The Department shall issue a certificate of need within five days after a request for a contested case hearing has been withdrawn or the final agency decision has been made following a contested case hearing, and all applicable conditions of approval that can be satisfied before issuance of the certificate of need have been met.~~

The Department shall issue a certificate of need in accordance with the time line requirements of this section but only after all applicable conditions of approval that can be satisfied before issuance of the certificate of need have been met. The Department shall issue a certificate of need within:

(1) Thirty-five days of the date of the decision referenced in G.S. 131E-186, when no request for a contested case hearing has been filed in accordance with G.S. 131E-188.

(2) Five business days after it receives a file-stamped copy of the notice of voluntary dismissal, unless the voluntary dismissal is a stipulation of dismissal without prejudice.

(3) Thirty-five days of the date of the written notice of the final agency decision affirming or approving the issuance, unless a notice of appeal to the North Carolina Court of Appeals is timely filed.

(4) Twenty days after a mandate is issued by the North Carolina Court of Appeals affirming the issuance of a certificate of need, unless a notice of appeal or petition for discretionary review to the North Carolina Supreme Court is timely filed.

(5) Five business days after the North Carolina Supreme Court issues a mandate affirming the issuance of a certificate of need or an order declining to certify the case for discretionary review if the order declining to certify the case disposes of the appeal in its entirety."

SECTION 2. This act is effective when it becomes law and applies to all final agency decisions made on or after that date.

SENATE BILL 804: CON Changes

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 12, 2009
Introduced by:	Sen. Rand	**Prepared by:**	Ben Popkin
Analysis of:	First Edition		Committee Counsel

SUMMARY: Senate Bill 804 would amend G.S. 131E-187 "Issuance of a certificate of need" to restructure existing timelines for issuance of certificates of need, and to establish timelines for issuance of certificates of need following certain types of court decisions.

CURRENT LAW:

G.S. 131E-187(a) directs the Department of Health and Human Services to issue a certificate of need (CON) within 35 days of the Department's issuance of a decision on a CON application, when no request for a contested care hearing has been filed and all applicable conditions of approval have been met.

G.S. 131E-187(b) directs the Department to issue a CON within five days after a request for a contested case hearing has been withdrawn or the final agency decision has been made, and all applicable satisfied conditions of approval have been met.

BILL ANALYSIS:

Senate Bill 804 would restructure and add to the CON timeline requirements in G.S 131E-187, to require the Department to issue CONs within the following periods:

- Thirty-five days of the date the Department issues a CON decision and no contested case hearing has been requested.
- Five business days after receipt of a notice of voluntary dismissal, unless the dismissal is a stipulation of dismissal without prejudice.
- Thirty-five days of the date of the written notice of the final agency decision affirming or approving the issuance, unless appealed to the NC Court of Appeals.
- Twenty days after the NC Court of Appeals issues a mandate affirming issuance of a CON, unless appealed or petitioned for review by the NC Supreme Court.
- Five business days after the NC Supreme Court issues a mandate affirming issuance of a CON or declines to certify the case for discretionary review, thereby disposing of the appeal.

EFFECTIVE DATE: This act is effective when it becomes law and applies to all final agency decision made on or after that date.

S804-SMRD-108(e1) v3

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 804

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

S804-ASQ-69 [v.2]

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Date _____,2009

Senator Rand

moves to amend the bill on page 1, lines 36-37, by rewriting the lines to read:

"**SECTION 2.** G.S. 131E-188(b1) reads as rewritten:

'(b1) Before filing an appeal of a final decision by the Department granting a certificate of need, the affected person shall deposit a bond with the Clerk of the Court of Appeals.

(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 holder of the certificate of need may petition the Court of Appeals for a higher bond amount for the payment of such costs and damages as may be awarded pursuant to subdivision (2) of this subsection. This amount shall be determined by the Court in its discretion, not to exceed three hundred thousand dollars ($300,000). A holder of a certificate of need who is appealing only a condition in the certificate is not required to file a bond under this subsection.

(2) If the Court of Appeals finds that the appeal was frivolous or filed to delay the applicant, the court shall remand the case to the superior court of the county where a bond was filed for the contested case hearing on the certificate of need. The superior court may award the holder of the certificate of need part or all of the bond. The court shall award the holder of the certificate of need reasonable attorney fees and costs incurred in the appeal to the Court of Appeals. If the Court of Appeals does not find that the appeal was frivolous or filed to delay the applicant and does not remand the case to superior court for a possible award of all or part of the bond to the holder of the certificate of need, the person originally filing the bond shall be entitled to a return of the bond.'

SECTION 3. This act is effective when it becomes law and applies to all final agency decisions made on or after that date.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 804
PROPOSED COMMITTEE SUBSTITUTE S804-PCS55400-RD-50

Short Title: CON Changes. (Public)

Sponsors:

Referred to:

March 25, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE CERTIFICATE OF NEED LAW WITH RESPECT TO TIME LINES FOR ISSUANCE OF A CERTIFICATE OF NEED.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-187 reads as rewritten:

"**§ 131E-187. Issuance of a certificate of need.**

~~(a) The Department shall issue a certificate of need within 35 days of the date of the decision referenced in G.S. 131E-186, when no request for a contested case hearing has been filed in accordance with G.S. 131E-188, and all applicable conditions of approval that can be satisfied before issuance of the certificate of need have been met.~~

~~(b) The Department shall issue a certificate of need within five days after a request for a contested case hearing has been withdrawn or the final agency decision has been made following a contested case hearing, and all applicable conditions of approval that can be satisfied before issuance of the certificate of need have been met.~~

The Department shall issue a certificate of need in accordance with the time line requirements of this section but only after all applicable conditions of approval that can be satisfied before issuance of the certificate of need have been met. The Department shall issue a certificate of need within:

(1) Thirty-five days of the date of the decision referenced in G.S. 131E-186, when no request for a contested case hearing has been filed in accordance with G.S. 131E-188.

(2) Five business days after it receives a file-stamped copy of the notice of voluntary dismissal, unless the voluntary dismissal is a stipulation of dismissal without prejudice.

(3) Thirty-five days of the date of the written notice of the final agency decision affirming or approving the issuance, unless a notice of appeal to the North Carolina Court of Appeals is timely filed.

(4) Twenty days after a mandate is issued by the North Carolina Court of Appeals affirming the issuance of a certificate of need, unless a notice of appeal or petition for discretionary review to the North Carolina Supreme Court is timely filed.

(5) Five business days after the North Carolina Supreme Court issues a mandate affirming the issuance of a certificate of need or an order declining to certify

the case for discretionary review if the order declining to certify the case disposes of the appeal in its entirety."

SECTION 2. G.S. 131E-188(b1) reads as rewritten:

"(b1) Before filing an appeal of a final decision by the Department granting a certificate of need, the affected person shall deposit a bond with the Clerk of the Court of Appeals.

(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 holder of the certificate of need may petition the Court of Appeals for a higher bond amount for the payment of such costs and damages as may be awarded pursuant to subdivision (2) of this subsection. This amount shall be determined by the Court in its discretion, not to exceed three hundred thousand dollars ($300,000). A holder of a certificate of need who is appealing only a condition in the certificate is not required to file a bond under this subsection.

(2) If the Court of Appeals finds that the appeal was frivolous or filed to delay the applicant, the court shall remand the case to the superior court of the county where a bond was filed for the contested case hearing on the certificate of need. The superior court may award the holder of the certificate of need part or all of the bond. The court shall award the holder of the certificate of need reasonable attorney fees and costs incurred in the appeal to the Court of Appeals. If the Court of Appeals does not find that the appeal was frivolous or filed to delay the applicant and does not remand the case to superior court for a possible award of all or part of the bond to the holder of the certificate of need, the person originally filing the bond shall be entitled to a return of the bond."

SECTION 3. This act is effective when it becomes law and applies to all final agency decisions made on or after that date.

SENATE BILL 595

Short Title:	The Terri Schiavo Act.	(Public)
Sponsors:	Senators Goodall; Apodaca, Brunstetter, East, Preston, Purcell, Rucho, Soles, Stevens, Tillman, and Vaughan.	
Referred to:	Rules and Operations of the Senate.	

March 16, 2009

A BILL TO BE ENTITLED

AN ACT TO REQUEST THAT THE LEGISLATIVE RESEARCH COMMISSION STUDY THE ISSUE OF INTEGRATING A LIVING WILL, OR OTHER ADVANCED HEALTH CARE DIRECTIVE, WITH THE DRIVERS LICENSE PROCESS, SIMILAR TO ORGAN DONATION, WITH A STANDARDIZED LIVING WILL OR OTHER HEALTH CARE DIRECTIVE.

The General Assembly of North Carolina enacts:

SECTION 1. The Legislative Research Commission is requested to study the feasibility of integrating, with the drivers license application process, a process, similar to the organ donor question, regarding the desire for a living will by drivers license applicants. In addition to the question of whether or not the licensee wanted to have a living will, or some other form of advanced health care directive, the Legislative Research Commission is requested to study a method of adapting a standardized version of a valid North Carolina living will, or some other advanced health care directive, into the drivers license application process, and having the contents published on the Secretary of State's Advanced Health Care Directive's Registry.

SECTION 2. The report requested by this act shall be made to the General Assembly at least 10 days before the 2010 Regular Session of the 2009 General Assembly reconvenes.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 595
PROPOSED COMMITTEE SUBSTITUTE S595-CSMA-11 [v.4]

5/11/2009 2:28:38 PM

Short Title: Advanced Directives on Drivers License. (Public)

Sponsors:

Referred to:

March 16, 2009

A BILL TO BE ENTITLED

AN ACT TO PROVIDE LOVED ONES WITH CLEAR CERTAINTY OF A LOVED ONE'S END OF LIFE DECISIONS BY NOTATING LIVING WILL DECISIONS ON DRIVERS LICENSES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-7(n) reads as rewritten:

"(n) Format. – A drivers license issued by the Division must be tamperproof and must contain all of the following information:

(1) An identification of this State as the issuer of the license.
(2) The license holder's full name.
(3) The license holder's residence address.
(4) A color photograph, or a properly applied laser engraved picture on polycarbonate material, of the license holder, taken by the Division.
(5) A physical description of the license holder, including sex, height, eye color, and hair color.
(6) The license holder's date of birth.
(7) An identifying number for the license holder assigned by the Division. The identifying number may not be the license holder's social security number.
(8) Each class of motor vehicle the license holder is authorized to drive and any endorsements or restrictions that apply.
(9) The license holder's signature.
(10) The date the license was issued and the date the license expires.
(11) A living will designation that identifies applicants that have a living will on file in the Secretary of State's Advance Healthcare Directive Registry.

In taking photographs of license holders, the Division must distinguish between license holders who are less than 21 years old and license holders who are at least 21 years old by using different color backgrounds or borders for each group. The Division shall determine the different colors to be used. The Commissioner shall ensure that applicants 21 years old or older are issued drivers licenses and special identification cards that are printed in a horizontal format. The Commissioner shall ensure that applicants under the age of 21 are issued drivers licenses and special identification cards that are printed in a vertical format, that distinguishes them from the horizontal format, for ease of identification of individuals under age 21 by members of industries that regulate controlled products that are sale restricted by age and law enforcement officers enforcing these laws.

At the request of an applicant for a drivers license, a license issued to the applicant must contain the applicant's race.

SECTION 2. This act becomes effective October 1, 2009, and applies to licenses issued on or after that date.

SENATE BILL 595:
Advanced Directives on Drivers License

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 12, 2009
Introduced by:	Sen. Goodall	**Prepared by:**	Shawn Parker
Analysis of:	PCS to First Edition S595-CSMA-11		Legislative Analyst

SUMMARY: Senate Bill 595 adds a living will designation to the contents of a drivers license issued by the Division of Motor Vehicles.

CURRENT LAW:

To drive a motor vehicle on a highway in North Carolina a person must be licensed by the Division of Motor Vehicles (Division) and must carry the license while driving the vehicle.[1] A drivers license issued by the Division must be tamperproof and contain the following information:

- An identification of this State as the issuer of the license.
- The license holder's full name.
- The license holder's residence address.
- A color photograph, or a properly applied laser engraved picture on polycarbonate material, of the license holder, taken by the Division.
- A physical description of the license holder, including sex, height, eye color, and hair color.
- The license holder's date of birth.
- An identifying number for the license holder assigned by the Division. The identifying number may not be the license holder's social security number.
- Each class of motor vehicle the license holder is authorized to drive and any endorsements or restrictions that apply.
- The license holder's signature.
- The date the license was issued and the date the license expires.

Article 23 of Chapter 90 authorizes "Living Wills". Voluntary declarations filed with the Advance Health Care Directive Registry are maintained by the Secretary of State.

BILL ANALYSIS: Senate Bill 595 provides that drivers licenses issued by the Division of Motor Vehicles shall contain, as part of its format, a living will designation that identifies the holder has a living will on file with the Advance Health Care Directive Registry.

EFFECTIVE DATE: This act becomes effective October 1, 2009.

S595-SMSQ-75(CSMA-11) v1

[1] G.S. 20-7

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 595
PROPOSED COMMITTEE SUBSTITUTE S595-PCS15283-MA-11

Short Title: Advanced Directives on Drivers License. (Public)

Sponsors:

Referred to:

March 16, 2009

A BILL TO BE ENTITLED

AN ACT TO PROVIDE LOVED ONES WITH CLEAR CERTAINTY OF A LOVED ONE'S END OF LIFE DECISIONS BY NOTATING LIVING WILL DECISIONS ON DRIVERS LICENSES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 20-7(n) reads as rewritten:

"(n) Format. – A drivers license issued by the Division must be tamperproof and must contain all of the following information:

(1) An identification of this State as the issuer of the license.
(2) The license holder's full name.
(3) The license holder's residence address.
(4) A color photograph, or a properly applied laser engraved picture on polycarbonate material, of the license holder, taken by the Division.
(5) A physical description of the license holder, including sex, height, eye color, and hair color.
(6) The license holder's date of birth.
(7) An identifying number for the license holder assigned by the Division. The identifying number may not be the license holder's social security number.
(8) Each class of motor vehicle the license holder is authorized to drive and any endorsements or restrictions that apply.
(9) The license holder's signature.
(10) The date the license was issued and the date the license expires.
(11) A living will designation that identifies applicants that have a living will on file in the Secretary of State's Advance Healthcare Directive Registry.

In taking photographs of license holders, the Division must distinguish between license holders who are less than 21 years old and license holders who are at least 21 years old by using different color backgrounds or borders for each group. The Division shall determine the different colors to be used. The Commissioner shall ensure that applicants 21 years old or older are issued drivers licenses and special identification cards that are printed in a horizontal format. The Commissioner shall ensure that applicants under the age of 21 are issued drivers licenses and special identification cards that are printed in a vertical format, that distinguishes them from the horizontal format, for ease of identification of individuals under age 21 by members of industries that regulate controlled products that are sale restricted by age and law enforcement officers enforcing these laws.

At the request of an applicant for a drivers license, a license issued to the applicant must contain the applicant's race."

SECTION 2. This act becomes effective October 1, 2009, and applies to licenses issued on or after that date.

SENATE BILL 628

Short Title:	Release Contr. Subst. Rep. Data To CME.	(Public)
Sponsors:	Senators Purcell; and Atwater.	
Referred to:	Health Care.	

March 17, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO RELEASE CONFIDENTIAL DATA IN THE CONTROLLED SUBSTANCES REPORTING SYSTEM TO THE CHIEF MEDICAL EXAMINER AND COUNTY MEDICAL EXAMINERS FOR THE PURPOSE OF INVESTIGATING DEATHS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-113.74(c) reads as rewritten:

"(c) The Department shall release data in the controlled substances reporting system to the following persons only:

(1) Persons authorized to prescribe or dispense controlled substances for the purpose of providing medical or pharmaceutical care for their patients.

(2) An individual who requests the individual's own controlled substances reporting system information.

(3) Special agents of the North Carolina State Bureau of Investigation who are assigned to the Diversion & Environmental Crimes Unit and whose primary duties involve the investigation of diversion and illegal use of prescription medication and who are engaged in a bona fide specific investigation related to enforcement of laws governing licit drugs. The SBI shall notify the Office of the Attorney General of North Carolina of each request for inspection of records maintained by the Department.

(4) Primary monitoring authorities for other states pursuant to a specific ongoing investigation involving a designated person, if information concerns the dispensing of a Schedule II through V controlled substance to an ultimate user who resides in the other state or the dispensing of a Schedule II through V controlled substance prescribed by a licensed health care practitioner whose principal place of business is located in the other state.

(5) To a court pursuant to a lawful court order in a criminal action.

(6) The Division of Medical Assistance for purposes of administering the State Medical Assistance Plan.

(7) Licensing boards with jurisdiction over health care disciplines pursuant to an ongoing investigation by the licensing board of a specific individual licensed by the board.

(8) Any county medical examiner appointed by the Chief Medical Examiner pursuant to G.S. 130A-382 and the Chief Medical Examiner, for the purpose of investigating the death of an individual."

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

SENATE BILL 628:
Release Contr. Subst. Rep. Data To CME

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 11, 2009
Introduced by:	Sen. Purcell	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Legislative Analyst

SUMMARY: Senate Bill 628 directs the Department of Health and Human Services to release data collected under the Controlled Substance Reporting Act to the Chief Medical Examiner or duly appointed county medical examiner for purposes of investigating the death of an individual.

CURRENT LAW: The Controlled Substances Reporting System Act of Article 5E of Chapter 90 was enacted to improve the State's ability to identify controlled substance abusers or misusers and refer them for treatment, and to identify and stop diversion of prescription drugs in an efficient and cost-effective manner that will not impede the appropriate medical utilization of licit controlled substances.

The Department of Health and Human Services maintains a reporting system of prescriptions for all Schedule II through V controlled substances. Prescription information submitted to the Department is privileged and confidential, is not a public record pursuant to G.S. 132-1, is not subject to subpoena or discovery or any other use in civil proceedings, and except as otherwise provided below may only be used for investigative or evidentiary purposes related to violations of State or federal law and regulatory activities. Prescription information shall not be disclosed or disseminated to any person or entity by any person or entity authorized to review prescription information.

The Department shall release data in the controlled substance reporting system to the following people only:

- Persons authorized to prescribe or dispense controlled substances for the purpose of providing medical or pharmaceutical care for their patients.
- An individual who requests the individual's own controlled substances reporting system information.
- Special agents of the North Carolina State Bureau of Investigation who are assigned to the Diversion & Environmental Crimes Unit and whose primary duties involve the investigation of diversion and illegal use of prescription medication and who are engaged in a bona fide specific investigation related to enforcement of laws governing licit drugs. The SBI shall notify the Office of the Attorney General of North Carolina of each request for inspection of records maintained by the Department.
- Primary monitoring authorities for other states pursuant to a specific ongoing investigation involving a designated person, if information concerns the dispensing of a Schedule II through V controlled substance to an ultimate user who resides in the other state or the dispensing of a Schedule II through V controlled substance prescribed by a licensed health care practitioner whose principal place of business is located in the other state.
- To a court pursuant to a lawful court order in a criminal action.
- The Division of Medical Assistance for purposes of administering the State Medical Assistance Plan.
- Licensing boards with jurisdiction over health care disciplines pursuant to an ongoing investigation by the licensing board of a specific individual licensed by the board.

BILL ANALYSIS: Senate Bill 628 adds the Chief medical examiner or county medical examiner in the course of investigating a death of an individual to the list of persons whom the Department shall release data gathered in accordance with the Controlled Substance Reporting System Act.

EFFECTIVE DATE: This act is effective when it becomes law.

S628-SMSQ-71(e1) v1

S 1

SENATE BILL 940

Short Title:	Flexibility for Certified Nurse Midwives.	(Public)
Sponsors:	Senator Davis.	
Referred to:	Health Care.	

March 26, 2009

A BILL TO BE ENTITLED

AN ACT TO ALLOW CERTIFIED NURSE MIDWIVES FLEXIBILITY IN THE PRACTICE OF MIDWIFERY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-178.3(b) reads as rewritten:

"(b) A person approved pursuant to this Article may practice midwifery in a hospital or non-hospital setting and ~~shall~~ may practice ~~under the supervision of~~ midwifery in collaboration with a physician licensed to practice medicine under Article 1 of this Chapter who is actively engaged in the practice of ~~obstetrics.~~obstetrics until the midwife's patient is admitted to a hospital. After the patient is admitted to a hospital, a person approved to practice midwifery shall practice under the supervision of the physician licensed to practice medicine who is actively engaged in the practice of obstetrics. A registered nurse approved pursuant to this Article is authorized to write prescriptions for drugs in accordance with the same conditions applicable to a nurse practitioner under G.S. 90-18.2(b)."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 940
PROPOSED COMMITTEE SUBSTITUTE S940-PCS55386-LU-3

Short Title: Study Flexibility/Certified Nurse Midwives. (Public)

Sponsors:

Referred to:

March 26, 2009

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE LEGISLATIVE RESEARCH COMMISSION TO STUDY WHETHER CERTIFIED NURSE MIDWIVES SHOULD BE GIVEN MORE FLEXIBILITY IN THE PRACTICE OF MIDWIFERY.

The General Assembly of North Carolina enacts:

SECTION 1. The Legislative Research Commission is authorized to study whether certified nurse midwives should be given more flexibility in the practice of midwifery. In conducting the study, the Commission shall consider whether a certified nurse midwife should be allowed to practice midwifery in collaboration with, rather than under the supervision of, a physician licensed to practice medicine under Article 1 of Chapter 90 of the General Statutes who is actively engaged in the practice of obstetrics.

SECTION 2. The Legislative Research Commission shall submit a final report of its findings and recommendations to the 2010 Regular Session of the 2009 General Assembly upon its convening by filing the report with the President Pro Tempore of the Senate and the Speaker of the House of Representatives.

SECTION 3. From funds appropriated to the General Assembly for the 2009-2010 fiscal year, the Legislative Services Commission shall allocate funds for the purpose of conducting the study provided for in this act.

SECTION 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 940
PROPOSED COMMITTEE SUBSTITUTE S940-PCS55386-LU-3

Short Title: Study Flexibility/Certified Nurse Midwives. (Public)

Sponsors:

Referred to:

March 26, 2009

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE LEGISLATIVE RESEARCH COMMISSION TO STUDY WHETHER CERTIFIED NURSE MIDWIVES SHOULD BE GIVEN MORE FLEXIBILITY IN THE PRACTICE OF MIDWIFERY.

The General Assembly of North Carolina enacts:

SECTION 1. The Legislative Research Commission is authorized to study whether certified nurse midwives should be given more flexibility in the practice of midwifery. In conducting the study, the Commission shall consider whether a certified nurse midwife should be allowed to practice midwifery in collaboration with, rather than under the supervision of, a physician licensed to practice medicine under Article 1 of Chapter 90 of the General Statutes who is actively engaged in the practice of obstetrics.

SECTION 2. The Legislative Research Commission shall submit a final report of its findings and recommendations to the 2010 Regular Session of the 2009 General Assembly upon its convening by filing the report with the President Pro Tempore of the Senate and the Speaker of the House of Representatives.

SECTION 3. From funds appropriated to the General Assembly for the 2009-2010 fiscal year, the Legislative Services Commission shall allocate funds for the purpose of conducting the study provided for in this act.

SECTION 4. This act is effective when it becomes law.

SENATE BILL 940:
Flexibility for Certified Nurse Midwives

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 12, 2009
Introduced by:	Sen. Davis	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	PCS to First Edition S940-CSLU-3		

SUMMARY: Senate Bill 940 would authorize the Legislative Research Commission to study whether certified nurse midwives should be given more flexibility in the practice of midwifery.

The Proposed Committee Substitute replaces proposed codified language amending G.S. 90-178.3 with uncodified language authorizing the Legislative Research Commission to study the issue.

CURRENT LAW: Article 10A of Chapter 90 of the General Statutes, the Midwifery Practice Act, sets forth provisions governing the practice of midwifery in this State. G.S. 90-178.3 "Regulation of midwifery" directs persons approved to practice midwifery in this State to practice, "...under the supervision of a physician licensed to practice medicine who is actively engaged in the practice of obstetrics."

BILL ANALYSIS: Senate Bill 940 would authorize the Legislative Research Commission (Commission) to study whether certified nurse midwives should be given more flexibility in the practice of midwifery. In particular, the Commission would be directed to consider whether a certified nurse midwife should be allowed to practice midwifery in collaboration with, rather than under the supervision of, a physician licensed to practice medicine and actively engaged in the practice of obstetrics.

The bill would direct the Commission to submit a final report of its findings and recommendations to the 2010 Regular Session of the 2009 General Assembly upon its convening.

EFFECTIVE DATE: This act is effective when it becomes law.

S940-SMRD-107(CSLU-3) v1

VISITOR REGISTRATION SHEET

Senate Health Care — **May 13, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TINA GORDON	NC Nurses Assoc
	Pfizer Specialty
Alan Skipper	NC Med. Soc.
DAVID BARNES	Pfizer Specialty
Michelle Brooks	UHS of Eastern NC
Jamal Jones	NCHA
Christine Craig	WakeMed
Hugh Tilson	NCHA
David Strong	Rex
Patrick Buffkin	

VISITOR REGISTRATION SHEET

Senate Health Care — **May 13, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jess Goodmon	DHHS
Jeff Hatton	DHHS - DHSR
Allison Clay	NCMS
Chyleeth French	NCMS
David Ballenger	NC Board of Nursing
Rev. Mark Creech	CAL
Marci Wilding	Novant
Marshall McConnell	Carolinas HealthCare Sys.
Ann Lucke	DUKE
Kay Paksoy	National Association of Social Workers, NC
Amy McConkey	Smith Anderson
Evelyn Hawthorne	NCATM; NCTTA; NCOTA

VISITOR REGISTRATION SHEET

Senate Health Care — **May 13, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
NED KELLY, MD	HOSPICE OF WAKE CTY 1300 ST. MARY'S ST. RAL. NC 27605
Tara Greer, Nurse practitioner	Carolinas Cancer Associates 1650 Faulk St Suite A Monroe NC 28112
Henry Hunter	Coca Cola
Rhena Trent	NCACC
Shereniah Wilson	DNNS
TRACY GLOVER	AHHC
Dana Sutis	Sen. Blake intern
Emily Gallimore	NCBA
Penny Griffin	School of Gov.
Michael Jamison	NC DMV - DRIVER LICENSE
Brenda Freeman	DMV
Will Flowers	intern

VISITOR REGISTRATION SHEET

Senate Health Care — **May 13, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DHARMI TAILOR	MS Secrecy Intern
Wayne Williams	State Budget Office
[illegible]	Civitas
Colleen Kochanek	NCCEP
[illegible]	Pfizer
Michelle Frazier	MFS
[illegible]	MFS
[illegible]	MWC
Kristi Huff	NCHCFA

VISITOR REGISTRATION SHEET

Senate Health Care — May 13, 2009

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[illegible]	NCMS
Chip Baggett	NCMS
[illegible]	[illegible]
Daniel Bean	K&L Gates
Andrew Cagle	DLC+Assoc.
Lee-Ann C. [illegible]	NCANPHA
Joyce Peters	JPAssoc
Tracy Kimbrell	Parker Poe
Barbara Condon	[illegible]

Senate Health Care Committee
Wednesday, May 27, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 436	Fairness in CON Determinations/Inflation Adj.	Representative Folwell Representative Lewis
HB 925	Data Sharing/DHHS Agencies.	Representative Boles, Jr. Representative Earle Representative Farmer-Butterfield
HB 1014	Organ Donation Month.	Representative Alexander Representative Brisson Representative Folwell Representative Holliman Representative Burris-Floyd Representative Wainwright
HB 1315	Amend NC SIDS Law/Medical Waivers.	Representative Alexander
HB 1331	Educate the Public About Cord Blood Banking.	Representative Dickson
SB 906	Establish Adult Day Health Overnight Respite.	Senator Clary

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, May 27, 2009 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 AM on May 27, 2009, in Room 544 of the Legislative Office Building. Twenty-five members of the committee were present. Senator Purcell, Co-Chair, presided.

Senator Purcell called the meeting to order, and the first bill on the agenda considered was House Bill 925 entitled "AN ACT TO AUTHORIZE THE SHARING OF CONFIDENTIAL INFORMATION AMONG AGENCIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IN ORDER TO CONDUCT QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES, AND COORDINATE APPROPRIATE AND EFFECTIVE CARE, TREATMENT, OR HABILITATION OF DHHS CLIENTS (Attachment I). Representative Alexander, bill sponsor, explained her bill and a copy of a summary is included with these minutes as Attachment II. Senator Bingham moved a favorable report; motion carried.

Next considered was House Bill 1315 entitled AN ACT TO AMEND CHILD CARE LAWS TO REDEFINE WHO MAY SIGN A MEDICAL WAIVER FOR AN ALTERNATIVE SLEEP POSITION FOR INFANTS IN CHILD CARE" (Attachment III). Bill sponsor, Representative Alexander, explained the bill, and a summary is included as Attachment IV. Senator Bingham moved a favorable report; motion carried.

Committee considered House Bill 436 entitled "AN ACT TO EXEMPT FROM CERTIFICATE OF NEED REVIEW CERTAIN CAPITAL EXPENDITURES FOR NURSING HOMES, ADULT CARE HOMES, AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED THAT ENTAIL INNOVATIVE RENOVATIONS AND EXPANSIONS TO IMPROVE QUALITY OF LIFE" (Attachment V). There was a Proposed Senate Committee Substitute, and Senator Purcell moved its acceptance for consideration; motion carried. Representative Folwell, bill sponsor, explained the bill, with Senator Allran moving a favorable report; motion carried.

Next scheduled was House Bill 1014 entitled "AN ACT ESTABLISHING ORGAN DONATION AWARENESS MONTH" (Attachment VII) by Representative Folwell, which was pulled from the agenda because customarily the Senate does not designate "months".

House Bill 1331 entitled "EDUCATE THE PUBLIC ABOUT CORD BLOOD BANKING" (Attachment VIII) by Representative Dickson was considered next. A bill summary is included with these minutes as Attachment IX. Senator Allran moved a favorable report; motion carried.

Senate 906 entitled "AN ACT TO ESTABLISH AND LICENSE ADULT OVERNIGHT RESPITE PROGRAMS AND TO DIRECT THE DIVISION OF MEDICAL ASSISTANCE TO PURSUE A MEDICAID WAIVER TO PROVIDE COVERAGE FOR RESPITE CARE" (Attachment X), sponsored by Senator Clary, was considered. A summary is included as Attachment XI. No vote was taken on the bill.

There being no further business before the Committee, Senator Purcell adjourned the meeting at 12:00 p.m.

Respectfully submitted,

William R Purcell — Becky Hedspeth

Sen. William R. Purcell, Co-Chair — Becky Hedspeth, Committee Assistant

Becky Hedspeth (Sen. Purcell)

From: Becky Hedspeth (Sen. Purcell)

Sent: Thursday, May 21, 2009 10:54 AM

To: @Senate Principal Clerk's Office; @Senate/Health Care; @SenateCommitteeNotice; Alice Falcone (Sen. Jacumin); Anna Kidd (Sen. Blake); Becky Hedspeth (Sen. Purcell); Ben Popkin (Research); Bonnie McNeil (Sen. Malone); Brice Bratcher (Sen. Doug Berger); Candace Finley (Sen. Stein); Carol Resar (Sen. Atwater); Carole Walker (Sen. Allran); Cindy Garrison (Sen. Goss); Dee Hodge (Sen. Dannelly); Evelyn Costello (Sen. Rand); Evelyn Hawthorne; Genie Clark (Sen. Brunstetter); Gerry Johnson (Sen. Hartsell); Glenn Jernigan; Helen Long (Sen. Rucho); Interested Persons; Jack Register, MSW, LCSW; Jackie Ray (Sen. Foriest); Janette Lee (Sen. Nesbitt); Joseph Stansbury (Sen. Goodall); Judy Chriscoe (Sen. Bingham); Judy Edwards (Sen. Rouzer); Kathie Young (Sen. Kinnaird); Layton Long; Lisa Nelson (Sen. Queen); Mary Watson Cannon (Sen. Forrester); Misty Greene (Sen. Clary); Penny Williams (Sen. Hoyle); Phyllis Cameron (Sen. Dorsett); Regina George-Bowden (Sen. Graham); Roger Berliner; Sharon Pearce; Shawn Parker (Research); Steve Shore; Susan Barham (Research); Susanne Gunter (Sen. Brown); Sylvia Sears (Sen. Davis)

Cc: Sen. Debbie Clary; Rep. Dale Folwell; Rep. Martha Alexander; Rep. Margaret H. Dickson

Principal Clerk _____
Reading Clerk _____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	May 27, 2009	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
SB 906	Establish Adult Day Health Overnight Respite.	Senator Clary
HB 436	Fairness in CON Determinations/Inflation Adj.	Representative Folwell Representative Lewis Representative Boles, Jr.
HB 925	Data Sharing/DHHS Agencies.	Representative Earle Representative Farmer-Butterfield Representative Alexander Representative Brisson
HB 1014	Organ Donation Month.	Representative Folwell Representative Holliman

		Representative Burris-Floyd Representative Wainwright
HB 1331	Educate the Public About Cord Blood Banking.	Representative Dickson
HB 1315	Amend NC SIDS Law/Medical Waivers.	Representative Alexander

Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, May 27, 2009

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

FAVORABLE

H.B. **925** Data Sharing/DHHS Agencies.
Sequential Referral: None
Recommended Referral: None

H.B. **1315** Amend NC SIDS Law/Medical Waivers.
Sequential Referral: None
Recommended Referral: None

H.B. **1331** Educate the Public About Cord Blood Banking.
Sequential Referral: None
Recommended Referral: None

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **436** Fairness in CON Determinations/Inflation Adj.
Draft Number: 70445
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 4

Committee Clerk Comments:

Attachment I

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H 2

HOUSE BILL 925
Committee Substitute Favorable 4/28/09

Short Title: Data Sharing/DHHS Agencies. (Public)

Sponsors:

Referred to:

April 1, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SHARING OF CONFIDENTIAL INFORMATION AMONG AGENCIES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES IN ORDER TO CONDUCT QUALITY ASSESSMENT AND IMPROVEMENT ACTIVITIES AND COORDINATE APPROPRIATE AND EFFECTIVE CARE, TREATMENT, OR HABILITATION OF DHHS CLIENTS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 122C-55(a1) reads as rewritten:

"(a1) Any ~~State or area facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill~~ facility 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 or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill~~ a facility when ~~the responsible professional or the Secretary determines that disclosure is~~ necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment or habilitation of the client. For purposes of this subsection and subsection (a6) of this section, the purposes or activities for which confidential information may be disclosed include, but are not limited to, case management and care coordination, disease management, outcomes evaluation, the development of clinical guidelines and protocols, the development of care management plans and systems, population-based activities relating to improving or reducing health care costs, and the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and related services. As used in this section, "Secretary" includes the Department's Community Care of North Carolina Program or other 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."

SECTION 1.(b) G.S. 122C-55 is amended by adding the following new subsection to read:

"(a6) When necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment, or habilitation of the client, a DHHS primary care case manager may disclose confidential information acquired pursuant to subsection (a1) of this section to a health care provider or other entity that has entered into a written agreement with the Department's Community Care of North Carolina Program, or other primary care case management program, to participate in the care management support network and systems developed and maintained by the primary care case manager for the purpose of coordinating and improving the quality of care for recipients of publicly funded health and related services. Health care providers and other entities receiving confidential information from a Department's Community Care of North Carolina Program or other primary care case

management program pursuant to this subsection may use and disclose the information as authorized by G.S. 122C-53 through G.S. 122C-56 or as permitted or required by other applicable State or federal law."

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

Attachment II

HOUSE BILL 925:
Data Sharing/DHHS Agencies

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 26, 2009
Introduced by:	Reps. M. Alexander, Brisson, Farmer-Butterfield, Earle	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	Second Edition		

SUMMARY: ***House Bill 925 would expand the statutory provisions in the Mental Health, Developmental Disabilities, and Substance Abuse Act that allow for the use and sharing of otherwise confidential client information. The current statutes provide that such information may be shared between the Secretary of DHHS and any State or area facility or the psychiatric service at UNC hospitals in Chapel Hill "...when necessary to coordinate appropriate and effective care, treatment or habilitation..." of a client of those facilities.***

HB 925 would also allow disclosure of confidential information necessary to "...conduct quality assessment and improvement activities..." and would allow such disclosure by "any facility" to the Secretary and the Secretary to share such information with any facility. The bill would specifically add Community Care of North Carolina and any other primary care case management programs contracted with the Department of Health and Human Services to serve recipients of publicly funded health and related services, to those allowed to share confidential client information for the stated purposes.

CURRENT LAW: G.S. 122C-52 sets forth a client's right to confidentiality. Confidential information acquired in treating a client is not a public record, and except as authorized by statute, may not be disclosed by either an individual with access to the information or by the facility.

G.S. 122C-55 provides exceptions to the non disclosure rule for the care and treatment of a client. The statute currently authorizes "...any area or State facility or the psychiatric service of the University of North Carolina Hospitals at Chapel Hill..." to share confidential information regarding any client of the facility with the Secretary, who may then share the information with any other area or State facility or the psychiatric service of UNC Hospitals, "...when necessary to coordinate appropriate and effective care, treatment or habilitation of the client."

BILL ANALYSIS: **Section 1(a)** would add the conduct of quality assessment and improvement activities to the allowable bases for the sharing of confidential client information, specifically listing the following purposes and activities for which the information may be shared:

- care management and care coordination, disease management, outcomes evaluation, the development of clinical guidelines and protocols, the development of care management plans and systems, population-based activities relating to improving or reducing health care costs, and the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and related services.

Section 1(a) then specifies that the following entities are included within the term "Secretary" for the purposes of information sharing under G.S. 122C-55: the Department's Community Care of North Carolina Program (CCNC) and other primary care case management (PCCM) programs under contract with the Department to provide PCCM for recipients of publicly funded health and related services.

Section 1(b) would authorize DHHS PCCMs to disclose confidential information acquired under G.S. 122C-55(a1) (as set forth in Section 1(a) of this bill) to health care providers or others with written

agreements with the Department's CCNC program to participate in the care management support network, "...when necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment, or habilitation of the client..." This section specifies that health care providers and other entities receiving confidential information from CCNC or other PCCMs pursuant to this subsection may use and disclose the information as provided by State or federal law.

EFFECTIVE DATE: This act is effective when it becomes law.

Barbara Riley, counsel to House Judiciary I, substantially contributed to this summary.

H925-SMRD-128(e2) v1

Attachment III

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

HOUSE BILL 1315

Short Title:	Amend NC SIDS Law/Medical Waivers.	(Public)
Sponsors:	Representatives M. Alexander; Faison, Insko, and Lucas.	
Referred to:	Health, if favorable, Judiciary I.	

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND CHILD CARE LAWS TO REDEFINE WHO MAY SIGN A MEDICAL WAIVER FOR AN ALTERNATIVE SLEEP POSITION FOR INFANTS IN CHILD CARE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 110-91(15)a. reads as rewritten:

"All child care facilities shall comply with all State laws and federal laws and local ordinances that pertain to child health, safety, and welfare. Except as otherwise provided in this Article, the standards in this section shall be complied with by all child care facilities. However, none of the standards in this section apply to the school-age children of the operator of a child care facility but do apply to the preschool-age children of the operator. Children 13 years of age or older may receive child care on a voluntary basis provided all applicable required standards are met. The standards in this section, along with any other applicable State laws and federal laws or local ordinances, shall be the required standards for the issuance of a license by the Secretary under the policies and procedures of the Commission except that the Commission may, in its discretion, adopt less stringent standards for the licensing of facilities which provide care on a temporary, part-time, drop-in, seasonal, after-school or other than a full-time basis.

...

(15) Safe Sleep Policy. – Operators of child care facilities that care for children ages 12 months or younger shall develop and maintain a written safe sleep policy, in accordance with rules adopted by the Commission. The safe sleep policy shall address maintaining a safe sleep environment and shall include the following requirements:

a. A caregiver in a child care facility shall place a child age 12 months or younger on the child's back for sleeping, unless: (i) for a child age 6 months or younger, the operator of the child care facility obtains a written waiver of this requirement from a health care ~~provider as defined in G.S. 58-50-61(a)(8);~~professional, as defined in rules adopted by the Commission; or (ii) for a child older than 6 months, the operator of the child care facility obtains a written waiver of this requirement from a health care ~~provider as defined in G.S. 58-50-61(a)(8);~~professional, as defined in rules adopted by the Commission, a parent, or a legal guardian."

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

Attachment IVL

HOUSE BILL 1315:
Amend NC SIDS Law/Medical Waivers

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 26, 2009
Introduced by:	Rep. M. Alexander	**Prepared by:**	Ben Popkin
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1315 would amend Article 7 (Child Care Facilities) of Chapter 110 (Child Welfare) of the General Statutes to modify one of the existing mandatory standards for licensure of a child care facility in the State. The bill would change the definition of what health care professional is authorized to waive the requirement that a facility must place children 12 months old or younger on their backs for sleeping. The bill would provide that a "health care professional" as defined in rule by the Child Care Commission, would be able to waive this requirement.***

CURRENT LAW: All child care facilities in the State must comply with the standards set forth in G.S. 110-91 "Mandatory standards for a license" for licensure and operation in the State. With certain limited exceptions, child care facilities include child care centers (three or more preschool-age children or nine or more school age children at any one time) and family child care homes (child care located in a residence where 3 – 8 children receive child care at any one time).

G.S. 110-91(15) "Safe Sleep Policy" requires that operators of child care facilities caring for children 12 months old or younger develop and maintain a written safe sleep policy, in accordance with the Commission rules, and directs caregivers in child care facilities to place children 12 months or younger on their backs for sleeping unless they obtain one of the following waivers:

- (for 6 months and younger) written waiver of the requirement by a health care provider, as defined in G.S. 58-50-61(a)(8), as follows "...any person licensed, registered or certified under Chapter 90 of the General Statutes or the laws of another state to provide health care services...";
- (for older than 6 months and up to 12 months old) written waiver from a health care provider (as defined above), a parent, or a legal guardian.

BILL ANALYSIS: House Bill 1315 would amend G.S. 110-91(15) to replace the existing reference to the Chapter 58 definition of health care provider with the following: "...health care professional, as defined in rules adopted by the [Child Care] Commission..."

EFFECTIVE DATE: This act is effective when it becomes law.

H1315-SMRD-129(e1) v1

Attachment ✓

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H 2

HOUSE BILL 436
Committee Substitute Favorable 5/7/09

Short Title: Fairness in CON Determinations/Inflation Adj. (Public)

Sponsors:

Referred to:

March 9, 2009

A BILL TO BE ENTITLED

AN ACT TO EXEMPT FROM CERTIFICATE OF NEED REVIEW CERTAIN CAPITAL EXPENDITURES FOR NURSING HOMES, ADULT CARE HOMES, AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED THAT ENTAIL INNOVATIVE RENOVATIONS AND EXPANSIONS TO IMPROVE QUALITY OF LIFE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-184 is amended by adding the following new subsection to read:

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

(1) The proposed capital expenditure would:

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

1. Nursing home facility,
2. Adult care home facility, or
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.

(2) The entity proposing to incur the capital expenditure provides prior written notice to the Department, which notice includes documentation indicating that the proposed capital expenditure would be used for only one of the following purposes:

a. Conversion of semiprivate resident rooms to private rooms.

b. Providing innovative, homelike residential dining spaces, such as cafes, kitchenettes, or private dining areas to accommodate residents and their families or visitors.

c. Renovating, replacing, or expanding residential living or common areas to improve the quality of life of residents."

SECTION 2. G.S. 131E-176(16)b. reads as rewritten:

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

...

b. ~~The~~ Except as otherwise provided in G.S. 131E-184(e), the obligation by any person of a capital expenditure exceeding two

million dollars ($2,000,000) 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 million dollars ($2,000,000).

...."

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

Attachment VI

HOUSE BILL 436:
Fairness in CON Determinations/Inflation Adj

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 26, 2009
Introduced by:	Reps. Folwell, Lewis, Boles	**Prepared by:**	Shawn Parker
Analysis of:	Second Edition		Legislative Analyst

SUMMARY: ***House Bill 436 would exempt certain capital expenditures for nursing homes, adult care homes, and intermediate care facilities for the mentally retarded (ICF-MR) from certificate of need (CON) review.***

CURRENT LAW: State law prohibits health care providers from acquiring, replacing, or adding to their facilities and equipment over unless the provider obtains a Certificate of Need from the Department of Health and Human Services (Department). A Certificate of Need is also required before beginning to offer certain health services or purchasing certain equipment, such as cardiac angioplasty equipment. The purpose of the CON is to control health care costs by preventing the unnecessary duplication of medical facilities and services and to help ensure the geographic distribution of health care facilities and services. All new hospitals, psychiatric facilities, chemical dependency treatment facilities, nursing homes, adult care homes, kidney disease treatment centers, intermediate care facilities for the mentally retarded, rehabilitation facilities, home health agencies, hospices, diagnostic centers, oncology treatment centers, and ambulatory surgical facilities must first obtain a CON before developing new facilities or offering new services. [1]

The Certificate of Need Section in the Department's Division of Health Service Regulation is responsible for the administration of CON in North Carolina. Anyone desiring a certificate of need must apply to the CON Section, and furnish information upon which the section can find that the application is consistent with specified "review criteria." The section may approve or deny an application outright, or it may approve the application with such conditions, as it finds necessary to bring the project into compliance with the mandated criteria.[2]

BILL ANALYSIS:

Section 1 directs the Department to exempt from CON review capital expenditures exceeding two million dollars if the following conditions are met:

The proposed capital expenditure:

- Would be used for renovating, replacing, or expanding an existing Nursing home facility, adult care home facility, or ICF-MR, **and**
- Would not result in a change in bed capacity r the addition of a health service facility or any other new institutional health services other than what is allowed under G.S. 131E-176(16)b.

The entity proposing to incur the capital expenditure provides prior written notice to the Department including documentation indicating that the capital expenditure would be used for only on of the following purposes:

- Conversion of semi-private resident room to a private resident room, **or**

[1] Article 9 of Chapter 131E of the General Statutes
[2] http://www.ncdhhs.gov/dhsr/coneed/index.html

- Providing homelike residential dining spaces to accommodate residents and their families or vistors, **or**
- Renovating, replacing, or expanding residential living or common areas to improve the quality of life for its residents.

Section 2 amends the definition of "New institutional health services" to conform with provisions of this Act.

EFFECTIVE DATE: This act is effective when it becomes law.

H436-SMSQ-89(e2) v1

Attachment VII

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

HOUSE BILL 1014

Short Title:	Organ Donation Month.	(Public)
Sponsors:	Representatives Folwell, Holliman, Wainwright, Burris-Floyd (Primary Sponsors); Dockham, Gillespie, Glazier, Harrison, Hughes, Hurley, Jackson, Lucas, Neumann, Pierce, Samuelson, Tarleton, and Wray.	
Referred to:	State Government/State Personnel.	

April 2, 2009

A BILL TO BE ENTITLED

AN ACT ESTABLISHING ORGAN DONATION AWARENESS MONTH.

Whereas, the Heart Prevails legislation was introduced by State Representatives Dale Folwell, Hugh Holliman, Debbie Clary, and William Wainwright and signed into law by Governor Michael F. Easley in 2007, and

Whereas, North Carolina may have had one of the single largest increases in organ donation transplants in the United States in 2008; and

Whereas, 180 people died in 2008 in North Carolina waiting for a transplant; and

Whereas, more than 3,000 North Carolinians are currently on the waiting list for organ donation; and

Whereas, one tissue donation can save or improve the lives of as many as 50 people; and

Whereas, one organ donor can save the lives of up to eight people; and

Whereas, according to the North Carolina Eye Bank there was over a 50% increase in corneal transplants in 2008 in North Carolina; and

Whereas, the Heart Prevails legislation was supported by the North Carolina Hospital Association, North Carolina Medical Society, North Carolina Hospice, North Carolina Eye and Tissue Bank, North Carolina Funeral Home Examining Board, North Carolina Medical Examiner, North Carolina Department of Motor Vehicles, Mrs. United States of America 2006–Shannon Devine, North Carolina Trial Lawyers, and various organ procurement organizations; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 103 of the General Statutes is amended by adding a new section to read:

"**§ 103-12. Organ Donation Awareness Month.**

The month of April of each year is designated as Organ Donation Awareness Month in North Carolina."

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

HOUSE BILL 1014:
Organ Donation Month

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 26, 2009
Introduced by:	Reps. Folwell, Holliman, Wainwright, Burris-Floyd	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	First Edition		

SUMMARY: House Bill 1014 would designate April as Organ Donation Awareness Month in North Carolina.

CURRENT LAW: Chapter 103 provides for Sundays, Holidays, and Special Days in North Carolina. G.S. 103-4 lists the dates of legal public holidays and the following statutes provide special day, week, month designations:

§ 103-6. Arbor Week.
The week in March of each year containing March 15 is hereby designated as Arbor Week in North Carolina.

§ 103-7. American Family Day.
The first Sunday in August of each year is designated as American Family Day in North Carolina.

§ 103-8. Indian solidarity week.
The last full week in September of each year is designated as Indian solidarity week in North Carolina.

§ 103-9. Prisoner of War Day.
The ninth of April of each year is designated as Prisoner of War Recognition Day.

§ 103-10. Pearl Harbor Remembrance Day.
The seventh of December of each year is designated as Pearl Harbor Remembrance Day in North Carolina.

§ 103-11. Disability History and Awareness Month.
The month of October of each year is designated as Disability History and Awareness Month in North Carolina.

BILL ANALYSIS: House Bill 1014 amends Chapter 103 by adding a new section to designate April as Organ Donation Awareness Month.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: Proposed designations this session:

HB 455- G.S. 103-12- March as Kidney Month

HB 596- G.S. 103-12- April as Woodworking Month

HB 683- G.S. 103-12- second Saturday of September as Hot Sauce Day

HB 696-G.S. 103-12-May as Motorcycle Awareness Month

HB 1014- G.S. 103-12- April as Organ Donation Awareness Month

HB 1115- G.S. 103-12- August as Psoriasis Awareness Month

HB 1249- G.S. 103-12- March as Deep Vein Thrombosis Awareness Month

HB 1251- G.S. 103-12-June as Cancer Screening Awareness Month

H1014-SMSQ-88(e1) v1

Attachment VIII

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

HOUSE BILL 1331

Short Title:	Educate the Public About Cord Blood Banking.	(Public)
Sponsors:	Representatives Dickson; Faison, Glazier, Jones, and Lucas.	
Referred to:	Science and Technology, if favorable, Health.	

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO MAKE AVAILABLE TO THE PUBLIC, AND TO ENCOURAGE HEALTH CARE PROFESSIONALS TO MAKE AVAILABLE TO PREGNANT PATIENTS, EDUCATIONAL INFORMATION REGARDING UMBILICAL CORD STEM CELLS AND UMBILICAL CORD BLOOD BANKING.

The General Assembly of North Carolina enacts:

SECTION 1. Part 2 of Article 5 of Chapter 130A of the General Statutes is amended by adding a new section to read:

"**§ 130A-128A. Department to provide free educational information about umbilical cord stem cells and umbilical cord blood banking.**

(a) As used in this section:

(1) Health care professional. – A person who is licensed pursuant to Chapter 90 of the General Statutes to practice as a physician, physician assistant, or registered nurse or who is approved pursuant to Chapter 90 of the General Statutes to practice midwifery.

(2) Umbilical cord blood. – The blood that remains in the umbilical cord and placenta after the birth of a newborn child.

(b) Effective January 1, 2010, the Department of Health and Human Services shall make available free of charge to the general public on its Internet Web site printable publications, in a format that can be downloaded, containing medically accurate information regarding umbilical cord stem cells and umbilical cord blood banking that is sufficient to allow a pregnant woman to make an informed decision about whether to participate in a public or private umbilical cord blood banking program. The publications shall include at least all of the following information:

(1) An explanation of the medical processes involved in the collection of umbilical cord blood.

(2) An explanation of any risks associated with umbilical cord blood collection to the mother and the newborn child.

(3) The options available to a mother regarding stem cells contained in the umbilical cord blood after delivery of the mother's newborn child, including:

a. Having the stem cells discarded.

b. Donating the stem cells to a public umbilical cord blood bank.

c. Storing the stem cells in a private umbilical cord blood bank for use by immediate and extended family members.

d. Storing the stem cells for use by the family through a family or sibling donor banking program that provides free collection,

processing, and storage of the stem cells where there is a medical need.

(4) The current and potential future medical uses, risks, and benefits of umbilical cord blood collection to (i) the mother, newborn child, and biological family and (ii) individuals who are not biologically related to the mother or newborn child.

(5) An explanation of the differences between public and private umbilical cord blood banking.

(6) Options for ownership and future use of the donated umbilical cord blood.

(c) The Department may satisfy the requirements of subsection (b) of this section by including on its Internet Web site a link to a federally sponsored Internet Web site that North Carolina citizens may access so long as the federally sponsored Internet Web site contains all of the information specified in subdivisions (1) through (6) of subsection (b) of this section.

(d) The Department shall encourage health care professionals who provide health care services that are directly related to a woman's pregnancy to provide each woman with the publications described in subsection (b) of this section prior to the woman's third trimester of pregnancy.

(e) A health care professional or health care institution shall not be liable for damages in a civil action, subject to prosecution in a criminal proceeding, or subject to disciplinary action by the North Carolina Medical Board or the North Carolina Board of Nursing for acting in good faith with respect to informing a pregnant woman prior to her third trimester of pregnancy about the publications described in subsection (b) of this section."

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

Attachment IX

HOUSE BILL 1331:
Educate the Public About Cord Blood Banking

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 26, 2009
Introduced by:	Rep. Dickson	**Presented by:**	Shawn Parker
Analysis of:	First Edition		Legislative Analyst

SUMMARY: ***House Bill 1331 would require DHHS to make available on its website printable publications containing specified information regarding umbilical cord stem cells and umbilical cord blood banking, or to include on its website a link to a federally sponsored website containing the specified information. The bill would also require DHHS to encourage health care professionals to provide the information to patients prior to their third trimester of pregnancy. The bill specifies that health care professionals would not be subject to legal proceedings or disciplinary action for acting in good faith with respect to providing the information.***

BILL ANALYSIS: House Bill 1331 would require the Department of Health and Human Services (DHHS) to make available on its website printable publications containing specified information regarding umbilical cord stem cells and umbilical cord blood banking. The bill would require:

- An explanation of the medical processes involved
- An explanation of any risks to the mother and the newborn child
- Options available to the mother concerning discarding, donating, or storing the stem cells
- Current and future medical uses, risks, and benefits of cord blood collection
- An explanation of differences between public and private umbilical cord blood banking
- Options for ownership and future us of donated umbilical cord blood

As an alternative to providing the downloadable publication on its website, DHHS may include on its website a link to a federally sponsored website that contains all of the specified information. The bill would also require DHHS to encourage licensed physicians, physician assistants, nurses, and midwives to provide patients with the described publications prior to the woman's third trimester of pregnancy. The bill provides that a health care professional or health care institution would not be liable for civil damages, subject to criminal prosecution, or subject to discipline by a licensing board for acting in good faith with respect to informing a patient about the publications.

EFFECTIVE DATE: The bill would be effective when it becomes law.

BACKGROUND: Information available on the National Institute of Health website indicates that stem cells have the potential to develop into many different cell types in the body. Serving as a sort of repair system for the body, they can theoretically divide without limit to replenish other cells as long as the person or animal is still alive. When a stem cell divides, each new cell has the potential to either remain a stem cell or become another type of cell with a more specialized function, such as a muscle cell, a red blood cell, or a brain cell. Research on stem cells is advancing knowledge about how an organism develops from a single cell and how healthy cells replace damaged cells in adult organisms. This area of science is also leading scientists to investigate the possibility of cell-based therapies to treat disease, which is often referred to as regenerative or reparative medicine. [1]

According to a June 2008 NCSL report, at least 10 states have enacted legislation that will expand the storage of cord blood. Science has found that post-natal blood is a rich source of the stem cells that can be used in lieu of bone marrow for certain transplants and for medical research into treatments for illnesses such as Parkinson's disease. Educational efforts similar to what is proposed in House Bill 1331 have been included in recent laws in Illinois, Louisiana, Oklahoma, Pennsylvania, Texas, and Washington.[2]

Brenda J. Carter, counsel to House Science and Technology, prepared this summary.

H1331-SMSQ-87(e1) v1

[1] http://stemcells.nih.gov/info/basics/basics1.asp ;National Institute of Health

[2] Matthew Gever; "States Banking Newborn Blood to Promote Medical Advances", NCSL State Health Notes Volume 29, Issue 518; June 23, 2008

An Overview of Cord Blood Banking and Transplantation

Joanne Kurtzberg, MD
Pediatric Blood and Marrow Transplant Program
Carolinas Cord Blood Bank
Duke University Medical Center

What is Cord Blood?

- Cord blood (CB) is the *baby's blood*, left over in the placenta (afterbirth);
- In the past, CB was discarded as medical waste;
- CB contains stem and progenitor cells;
- CB can be collected from the placenta after the birth of the baby and frozen and stored for future use.

CBT History

- 1st Transplant, NC child in France 1988
- 1st bank, NYBC 1992
- 1st unrelated transplant, Duke 1993
- Now >15,000 transplants
  - Malignancies, Hemoglobinopathies, immuneodeficiency, marrow failures, in herited metabolic diseases
- >100 banks worldwide
- Inventory ~100K US, 350K worldwide

Cord Blood Banking

- Public Banking
  - 1992 NYBC
  - 1996 COBLT
  - 1998 Netcord
  - 1999 NMDP
  - 2006 CW Bill Young CTP; NCBI
- Private Banking
- Directed donor or Sibling Banking

The Carolinas Cord Blood Bank

- Established 1997 through COBLT (NHLBI)
- Current inventory >20,000 units
- 8 collection sites in NC with access to ~30,000 births
- Staff collection model
- Units listed and distributed through NMDP
- ARC bank 1999-2001
- NMDP Member bank 2004
- CORD:USE Partnership, 2005
- FACT accreditation 2005, 2008
- NCBI Bank 2006
- Netcord Bank 2007

The Carolinas Cord Blood Bank

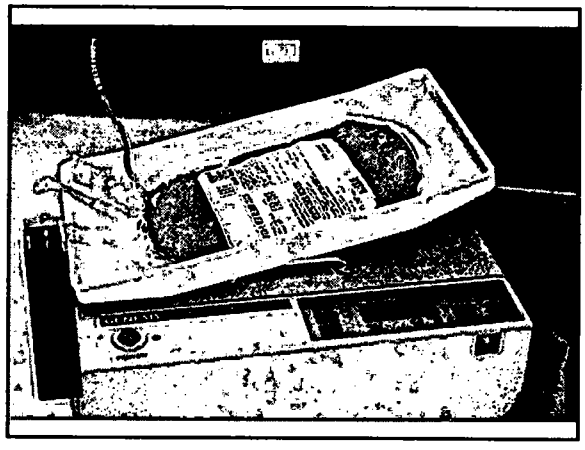
- Established 1997 through COBLT (NHLBI)
- Current inventory >20,000 units
- Kit model
- 8 staffed collection sites (7) in NC
  - Duke
  - Durham Regional Hospital
  - UNC Memorial Hospital
  - Rex Hospital
  - Greensboro Women's Hospital
  - Wake Med Cary
  - Womack Army Medical Center
  - Brigham and Womens Hospital
  - ◆ Kit model for donors at non-collection sites

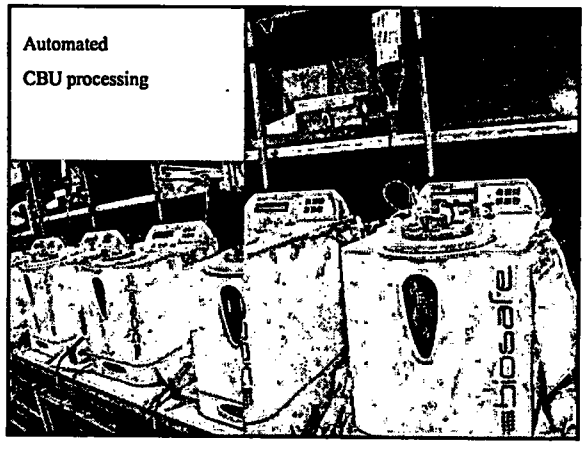
Aspects of Unrelated Donor UCB Banking

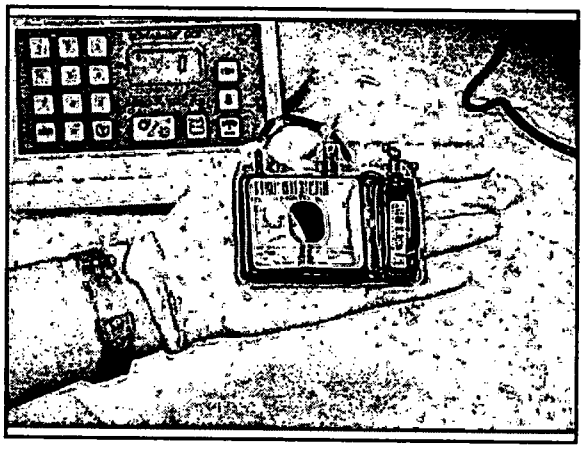
- Donor recruitment/screening/consent
- Collection
- Processing
- Testing
- Cryopreservation
- Quarantine and Release
- Long term storage
- Search and Registry Functions
- Shipping for transplantation, thawing training programs
- Outcomes analysis
- Quality management, proficiency

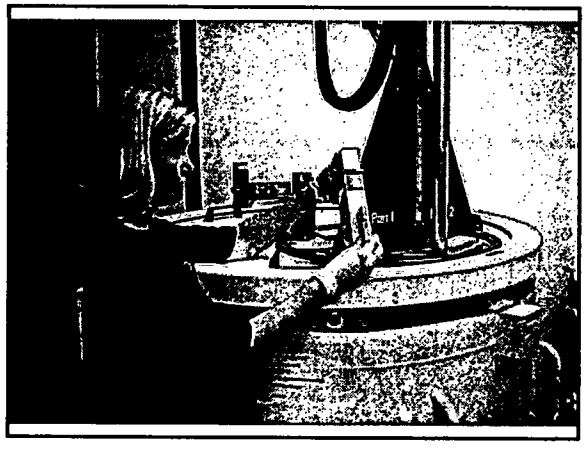
Informed Consent

- Donation is voluntary
- Sample of maternal blood for ID testing
  - Feedback of positive results to Mom, MD, State
- No guarantee unit will be banked
- Genetic disease testing
- Confidentiality
- Other options presented: Discard, Research, Private Banking




Automated
CBU processing
biosafe



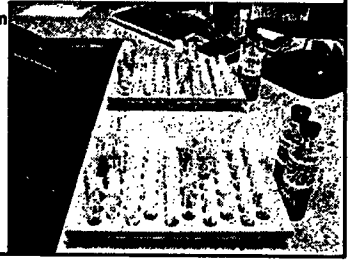


Tests Performed

- Counts
- Viability
- CD34
- CD3
- CFUs
- Sterility
- HLA
- Hemoglobinopathy
- IDMs maternal +/- cord blood
  - CMV IgG, IgM, DNA

Aspects of Unrelated Donor UCB Banking

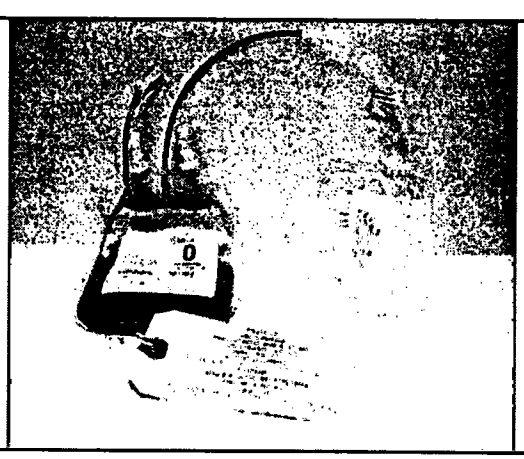
- Testing Samples
  - Maternal
    - DNA
    - Plasma or serum
  - UCB
    - DNA
    - Plasma
    - Cells in DMSO
    - Segments

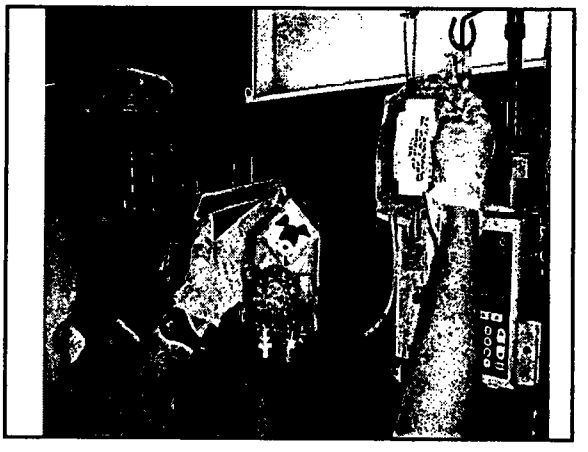


CBU Banking and Distribution

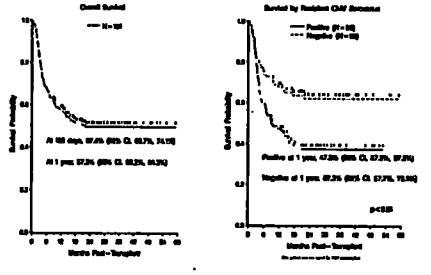
- Eligibility for banking
- Sign outs, listing on National Registry
- Provides access to donors for all patients undergoing consideration for transplantation
- Distributed through national registry

Dry Shippers





Survival
Pediatric Malignancies

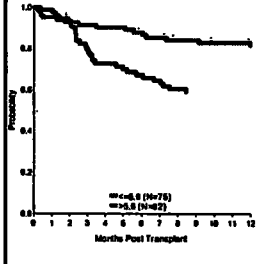


Correction of lethal hemoglobinopathies with UCB transplantation

Both sickle cell anemia and thalassemia major can be Cured with UCB transplantation early in life.

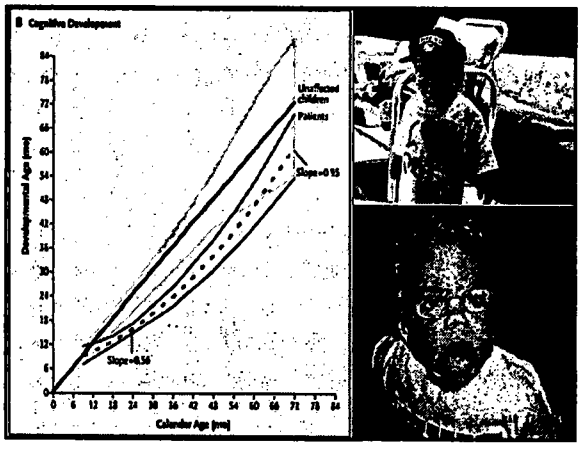
Christopher, transplanted At 2.5 months of age for Correction of thalassemia Major. Shown in Family portrait at age 1 year.

CFUs and ALDHbright* cells define a high quality CBU

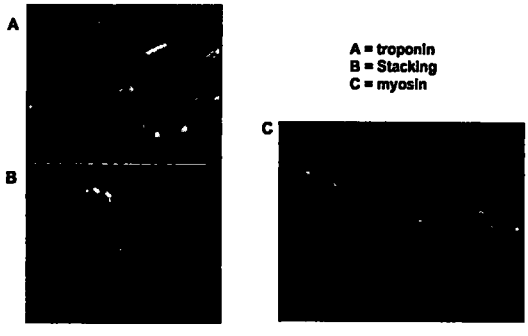


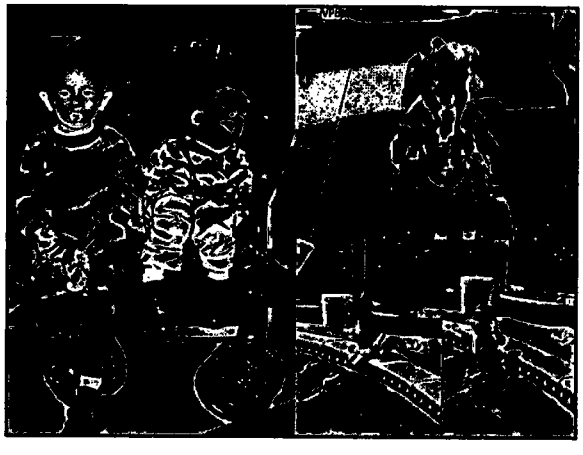
Population	No. of cells containing 1 CFU
TNCC	133
MNC	48
CD34pos	2.5
ALDHbr	1.2
ALDHbrCD34pos	0.93

* Aldagen, Inc, Durham, NC



Differentiation of Donor Cells into Cardiac Myocytes





Engraftment of UCB cells in Brain

Cortical White Matter

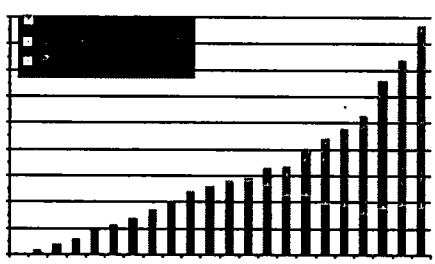
Brain sections of a female Krabbe patient who died 1 year post UCBT. XY Fish demonstrates male (donor, blue dot) cells engrafting in and differentiating in brain.

Directed Donor Banking

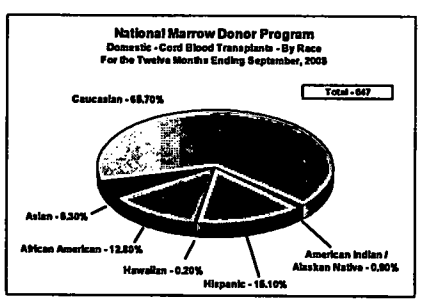
- **Indications:**
  - **Biologic sibling with cancer, hemoglobinopathy, inborn error of metabolism, congenital RBC/WBC/Platelet disorder, congenital immunodeficiency**
  - **Baby with know congenital disorder potentially treatable with gene therapy. E.G. hemoglobinopathy, immunodeficiency**

Transplants Performed

NMDP Facilitated 1987–2008



NMDP CB Transplants – Race, Domestic



Research

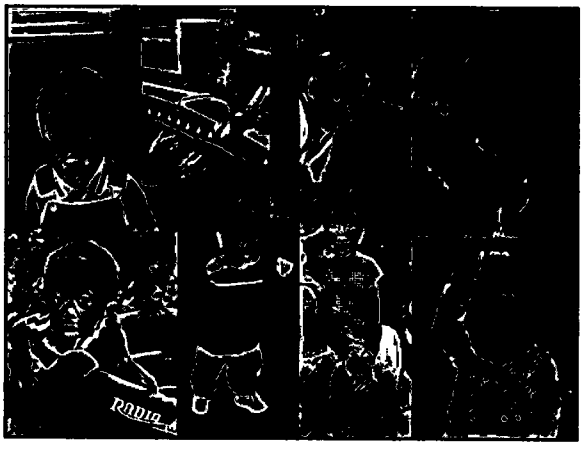
- Cord Blood Potency
- Augmentation of immune reconstitution
- Acquired and traumatic brain injury
  - HIE, CP, Stroke, Drowning, ECMO
- Type I Diabetes
- Cardiovascular Diseases
  - PVD, Ischemic Heart Diseases

Private vs Public Banking

- Private
  - Fee based
  - Parent initiated
  - Saved for family
  - Varying Quality
  - Minimal Regulations
  - Few proven applications

  >400K saved, ~120 used
- Public
  - No cost to donor
  - Higher quality
  - HRSA/HHS support
  - Regulated
  - FDA licensure pending

  >350K saved, >15,000 used, now ~3-4,000 transplants/year



Cord Blood and North Carolina

- 1st patient transplant with CB from Salisbury NC, 1988
- 1st unrelated donor CB transplant performed at Duke, 1993
- Largest CB transplant program at Duke
- NCBI public CB Bank: The Carolinas Cord Blood Bank
- Lead Investigators in CBB and CBT

Cord Blood and North Carolina

- The CCBB supports and practices education of all potential mothers;
- The CCBB *does not* support any legislation that requires Obs to collect for private donations other than directed donations until there is evidence to support the routine use of autologous cord blood in clinical practice.

Attachment X

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 906
PROPOSED COMMITTEE SUBSTITUTE S906-CSRD-37 [v.4]

5/26/2009 11:54:02 AM

Short Title: Establish/License Adult Overnight Respite. (Public)

Sponsors:

Referred to:

March 26, 2009

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH AND LICENSE ADULT OVERNIGHT RESPITE PROGRAMS AND TO DIRECT THE DIVISION OF MEDICAL ASSISTANCE TO PURSUE A MEDICAID WAIVER TO PROVIDE COVERAGE FOR RESPITE CARE.

The General Assembly of North Carolina enacts:

SECTION 1. Article 1 of Chapter 131D is amended by adding a new section to read:

"**§ 131D-6.1. Licensure of adult overnight respite programs; purpose; definition.**

(a) It is the policy of the State to support unpaid caregivers that provide care for individuals who would otherwise need full-time care. Adult overnight respite programs provide respite for unpaid caregivers.

(b) As used in this section, 'adult overnight respite program' means the provision of 24-hour group care to, and supervision on a temporary basis of, no more than six unrelated adults who may be physically or mentally disabled. Care and supervision provided to an individual in an adult overnight respite program shall not exceed seven consecutive calendar days, or more than a total of 21 calendar days of 24-hour care during a 365-day period.

(c) The Department of Health and Human Services shall inspect and license, under rules adopted by the North Carolina Medical Care Commission, all adult overnight respite programs. Licenses issued under the authority of this section shall be valid for one year from the date of issuance unless revoked earlier by the Secretary for failure to comply with any part of this section or any rules adopted pursuant to this section. Licenses shall be renewed annually upon filing and the Department's approval of the renewal application.

(d) The adult overnight respite program shall contact the responsible person or the designated representative of any individual receiving respite services and be informed of the need to remove the individual from the facility if either of the following conditions exist:

(1) The individual's condition is such that the individual either is a danger to him or herself or poses a direct threat to the health of others.

(2) The safety of individuals in the adult overnight respite setting is threatened by the behavior of one of the individuals currently receiving respite services.

(e) All adult overnight respite settings shall have current sanitation and fire and building safety inspection reports. Nothing in this statute shall be construed as providing relief from compliance with the North Carolina Building and Fire codes as determined by the North Carolina Department of Insurance Engineering Division or the local Building or Fire Code enforcement official.

(f) The Department shall charge each adult overnight respite program a nonrefundable annual license fee in the amount of two hundred fifty dollars ($250)."

SECTION 2. G.S. 143B-181.10 reads as rewritten:

"**§ 143B-181.10. Respite care program established; eligibility; services; administration; payment rates.**

(a) A respite care program is established to provide needed relief to caregivers of impaired adults who cannot be left alone because of mental or physical problems.

(b) Those eligible for respite care under the program established by this section are limited to those unpaid primary caregivers who are caring for people 60 years of age or older and their spouses, or those unpaid primary caregivers 60 years of age or older who are caring for persons 18 years of age or older, who require constant supervision and who cannot be left alone either because of memory impairment, physical immobility, or other problems that renders them unsafe alone.

(c) Respite care services provided by the programs established by this section may include:

(1) Counseling and training in the caregiving role, including coping mechanisms and behavior modification techniques;
(2) Counseling and accessing available local, regional, and State services;
(3) Support group development and facilitation;
(4) Assessment and care planning for the patient of the caregiver;
(5) Attendance and companion services for the patient in order to provide release time to the caregiver;
(6) Personal care services, including meal preparation, for the patient of the caregiver;
(7) Temporarily placing the person out of his home to provide the caregiver total respite when the mental or physical stress on the caregiver necessitates this type of respite.

Program funds may provide no more than the current adult care. An out of home placement is defined as placement in a hospital, skilled or intermediate nursing facility, adult care home, adult day health center, ~~or~~ adult day care ~~center.~~center, or adult overnight respite program. Duration of the service period may extend beyond a year.

(d) The respite care program established by this section shall be administered by the Division of Aging consistent with the policies and procedures of the Older Americans Act. The programs shall be coordinated with other appropriate Divisions in the Department of Health and Human Services, and with agencies and organizations concerned with the delivery of services to frail older adults and their unpaid caregivers. The Division shall choose respite care provider agencies in accordance with procedures outlined under the Older Americans Act and shall include the following criteria: documented capacity to provide care, adequacy of quality assurance, training, supervision, abuse prevention, complaint mechanisms, and cost. All funds allocated by the Division pursuant to this section shall be allocated on the same basis as funding under the Older Americans Act.

(e) Funding for the Division of Aging to administer this program shall not exceed the percentage allowed for administration as provided in the Older Americans Act but shall not be less than that budgeted for administration in fiscal year 1988-89.

(f) Unless prohibited by federal law, caregivers receiving respite care services through the program established by this section shall pay for some of the services on a sliding scale depending on their ability to pay. The Division of Aging, in consultation with the Councils of Governments in each region, shall specify rates of payment for the services."

SECTION 3. The Division of Medical Assistance of the Department of Health and Human Services shall pursue a Medicaid waiver to provide coverage for respite care services,

including respite care provided in an adult overnight respite program. The Division shall pursue a Medicaid waiver as well as any other available options to add respite as a Medicaid coverage service. The Medicaid waiver application submitted to the Centers for Medicare and Medicaid Services shall include but not be limited to the following:

1) A definition of periodic and overnight respite care services.
2) Identification of target populations to be eligible for participation in periodic and overnight respite care programs.
3) Establishment of provider qualifications for periodic and overnight respite care services, including:
    a. Minimum licensure or certification for all respite service options.
    b. Additional staffing ratios, staff qualifications, and staff training that are applicable to any special populations served and services provided.
    c. The delivery of respite care models that are supportive of the practices and programs authorized by the Department of Health and Human Services.
    d. Other qualifications that maintain the health, safety and well-being of recipients of overnight and periodic respite care services.
4) Identification of relevant documentation requirements.
5) Establishment of billing and service limitations.
6) Establishment of monitoring and accountability benchmarks for the provision of overnight and periodic respite care services.

In developing its Medicaid waiver application, the Department shall solicit input from families, providers and interested stakeholders. The Department shall develop rules as appropriate to implement the provisions of this section.

SECTION 4. Sections 1 and 2 of this act become effective January 1, 2010. The remainder of this act is effective when it becomes law.

Attachment #1

SENATE BILL 906:
Establish/License Adult Overnight Respite

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 26, 2009
Introduced by:	Sen. Clary	**Prepared by:**	Ben Popkin
Analysis of:	PCS to First Edition S906-CSRD-37		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute for Senate Bill 906 would enact a new provision to allow for the licensure and operation of 'adult overnight respite programs'. These programs would provide 24-hour care for up to seven consecutive days, limited to no more than 21 total days per year, to provide respite for unpaid caregivers of adults who may be physically or mentally disabled. The bill would direct the Department of Health and Human Services to inspect and license the programs, under rules adopted by the North Carolina Medical Care Commission, and would make a conforming change to existing law to include reference to the adult overnight respite programs (G.S. 143B-181.10).***

The bill would also direct the Division of Medical Assistance to pursue a Medicaid waiver to provide coverage for respite care services, including the adult overnight respite programs, and includes a series of core items to be included in the Medicaid waiver application (definitions, provider qualifications, monitoring and accountability benchmarks, etc.).

[As introduced, this bill was identical to H1237, as introduced by Reps. Moore, England, Burris-Floyd, which is currently in House Health, if favorable, Appropriations.]

CURRENT LAW: G.S. 131D-6 "Certification of adult day care programs; purpose; definitions; penalty." Currently states that adult day care programs may provide group care and supervision "...in a place other than their usual place of abode *on a less than 24-hour basis* to adults who may be physically or mentally disabled."

In order for a facility to provide care to adults on a 24-hour basis, it must fall within one of the current existing categories of licensure that allows for the provision of overnight care. Included are:

- Adult care homes (Article 1 of Chapter 131D);
- Nursing homes (Part 1 of Article 6 of Chapter 131E);
- Hospitals (Article 2 of Chapter 131E); and
- Mental Health/Developmental Disability/Substance Abuse Services facilities (Article 2 of Chapter 122C).

Other than these facilities, current options for the provision of overnight respite services include a range of home-based options (family members, volunteers, paid caregivers, etc.).

BILL ANALYSIS: Section 1 of the bill would add a new section to Chapter 131D to establish licensed 'adult overnight respite programs' to provide respite for unpaid caregivers. Care provided by these programs would be limited to seven consecutive days, with a limit of 21 total days per year. The Department of Health and Human Services would inspect and license the facilities (annual fee of $250), under rules adopted by the Medical Care Commission. The section would provide for notice and removal of individuals posing a risk to themselves or other residents, and would specifically require compliance with applicable North Carolina Building and Fire Code provisions.

Section 2 of the bill would amend G.S. 143B-181.10 "Respite care program established; eligibility; services; administration; payment rates." to include adult overnight respite programs among the settings in which out of home placement may occur (now lists – hospital, skilled or intermediate nursing facility, adult care home, adult day health center, or adult day care center.)

Section 3 of the bill would direct the Division of Medical Assistance of the Department of Health and Human Services to pursue a Medicaid waiver to provide coverage for respite care services, including respite care provided in an adult overnight respite program. The section includes a list of six specific items (definitions, provider qualifications, monitoring and accountability benchmarks, etc.) which must be part of the waiver application and would direct the Department to solicit input from families, providers, and interested stakeholders, when developing its Medicaid waiver application. Additionally, the Department would be directed to develop rules as appropriate to implement the provisions of this section.

EFFECTIVE DATE: Sections 1 and 2 of the act become effective January 1, 2010 and the remainder of the act is effective when it becomes law.

S906-SMRD-130(CSRD-37) v2

DENTAL BILL BULLET POINTS

- To recap the story told last week: Some time ago, a NC Dentist in good standing, almost lost his license for pro bono work he performed to a needy, Native American population in OK. The Dentist, Dr. Rothermel, was licensed by credentialing, an expedited form of licensing that requires the dentist practice only in NC.
- This bill simply allows the Board to waive that requirement—*should it so desire*- for dentists performing out of state aid to minority populations for a limited period of time.
- Understand that the law mandating Dentists practice only here in North Carolina applies only to dentists who are licensed by credentialing. Dentists that are licensed through examination are permitted to practice in any number of states.
- This bill still empowers the NC Dental Board to exercise discretion on whether or not it is appropriate to waive this requirement.
- I would appreciate your support!

Representative Dale R. Folwell
2007-2008 Republican Joint Caucus Leader
State House District 74
Winston-Salem / Forsyth County

not on agenda

House Bill 1372: THE HEART PREVAILS

Sponsors: Representatives Folwell, Clary, Holliman, and Wainwright

The following organizations/individuals have endorsed House Bill 1372:

1. **North Carolina Hospital Association**
2. **North Carolina Medical Society**
3. **North Carolina Hospice**
4. **North Carolina Eye and Tissue Bank**
5. **North Carolina Funeral Home Examining Board**
6. **North Carolina Medical Examiner**
7. **North Carolina Department of Motor Vehicles**
8. **Various Organ Procurement Organizations**
9. **Mrs. United States of America for 2006, Shannon Devine**
10. **North Carolina Trial Lawyers**

REPRESENTATIVE DALE R. FOLWELL
REPUBLICAN JOINT CAUCUS LEADER
N. C. HOUSE OF REPRESENTATIVES
74TH DISTRICT - WINSTON-SALEM

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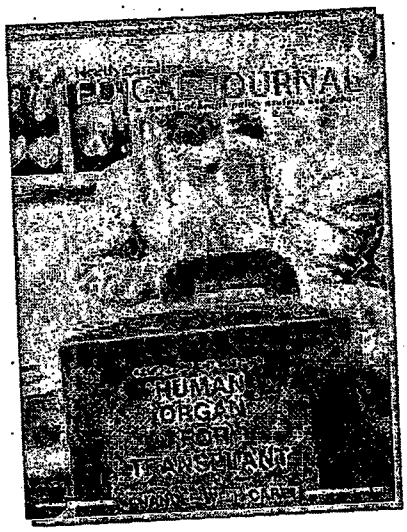
Readers' Forum

Dear Editor:



The Heart Prevails: It sounds like the title of a country music song, but in actuality it is much more than that. The Heart Prevails Act is an important and successful piece of legislation that I introduced in a bipartisan effort with Representatives Hugh Holliman, Debbie A. Clary, and William L. Wainwright. Governor Easley signed the bill into law over one year ago. The new law converts the existing heart symbol on the North Carolina Driver's License from an intention to legal consent for organ and eye donation. Since October 2007, there has been an overwhelming increase in donations. The North Carolina Eye Bank reports that during the first full year of the law's existence, transplants have increased by 56% in North Carolina.

Last year, North Carolina was fifth in the nation in the percentage of citizens consenting to be a donor. Over three million people had shown their willingness to be an organ donor by allowing the organ donor heart symbol to be printed on their driver's license. At the same time, the state was 16th in the nation in organs actually recovered due to uncertainty about relying on the donor heart symbol in making critical decisions to aid in the recovery of organs.

Prior to the passage of the Heart Prevails Act, North Carolinians were able to indicate their preference to become an organ donor by including a heart on their license, but the graphic did not allow emergency or hospital personnel to rely on the heart symbol as a first-person directive. Most North Carolinians were unaware that selecting the heart to be displayed on their driver licenses did not automatically mean their wishes to become a donor would be legally honored. The Heart Prevails legislation puts this practice into action by making each individual's wish a reality.

"This is excellent news for those on the transplant waiting list," said Lloyd Jordan, president and CEO of Carolina Donor Services. "There is a shortage of organ donors and as a result there are thousands waiting for transplants. This law puts the decision-making power in the hands of the donor."

Three years ago, there was no donor registry in North Carolina. The new law covers all current drivers with hearts on their licenses and also makes it easier for citizens to change their donor status online by visiting http://www.donatelifenc.org, a registry created and maintained by the North Carolina Department of Motor Vehicles. If a person has indicated that he or she would like to be an organ donor, the procurement agencies work with families to walk them through the process of honoring their loved one's wishes.

In the 2008 Short Session, the Heart Prevails Act was altered to allow 16-year-olds to donate blood in North Carolina. This has the potential of adding 25,000 pints a year to the North Carolina blood supply.

The public may request additional information or download a uniform donor card by calling 1.800.200.2672 or by visiting http://www.carolinadonorservices.org.

Dale R. Folwell
74th District (Winston-Salem)
North Carolina House of Representatives
Republican Joint Caucus Leader
dalef (at) ncleg.net

The success of the Heart Prevail Act would not have been possible without the interest and passion of the North Carolina Division of Motor Vehicles under the direction of Commissioner William Gore and Program Director Tony Spence, along with the efforts of the North Carolina Division of Motor Vehicles Driver's License Examiners, the North Carolina Hospital Association, the North Carolina Medical Association, North Carolina Hospice, North Carolina Eye and Tissue Bank, the North Carolina Funeral Home Examining Board, the Funeral Directors & Morticians Association of North Carolina, the North Carolina Medical Examiner, various organ procurement organizations, Mrs. United States of America for 2006, Shannon Devine, the North Carolina Trial Lawyers Association, and the NC General Assembly.

Editor's Note:
The article on Inclusive Health in the Sept/Oct 2008 issue inaccurately characterized maternity benefits. Please visit http://www.inclusivehealth.org for the most up-to-date information on benefits and program requirements.

Senate Health Care Committee
Wednesday, June 3, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 18	**Speech Language Pathologist Qualifications.**	**Representative Faison** **Representative Alexander**
HB 896	**Cancer Drug Coverage Changes.**	**Representative Faison** **Representative England, M.D.** **Representative Harrell**
HB 1309	**Residential Treatment Facil./TBI.**	**Representative Insko**
HB 886	**Allow Dietetics/Nutrition Bd./Recover Costs.**	**Representative Ross**
HB 1342	**RVAP/Ensure Grant Eligibility.**	**Representative Bordsen** **Representative Justus** **Representative Howard** **Representative McLawhorn**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, June 03, 2009

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

FAVORABLE

H.B. **18** Speech Language Pathologist Qualifications.
Sequential Referral: None
Recommended Referral: None

H.B. **886** Allow Dietetics/Nutrition Bd./Recover Costs.
Sequential Referral: Finance
Recommended Referral: None

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

H.B. **1309** Residential Treatment Facil./TBI.
Draft Number: PCS50725
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

H.B. **1342** RVAP/Ensure Grant Eligibility.
Draft Number: PCS50724
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 4

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, June 3, 2009 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, June 3, 2009, in Room 544 of the Legislative Office Building, with nineteen members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Bingham recognized Representative Insko to present HB 1309, ***Residential Treatment Facil./TBI***. Rep. Insko stated that House Bill 1309 was not controversial and it had to do with treatment for Traumatic Brain Injuries. Senator Bingham interrupted in order for Senator Purcell to present a technical amendment. Senator Purcell asked Ben Popkin, Staff Attorney, to explain the amendment. Ben stated the amendment was purely technical in nature and would ensure that the commission was authorized to adopt temporary rules to enforce the provisions in the bill. Sen. Brown moved for a favorable report on the amendment. The motion passed. Rep. Insko stated the facilities that treat patients with TBI, Traumatic Brain Injuries, are currently licensed under the Adult Care Home Provisions. The Adult Care Home Provisions are not the appropriate licensure for this population. This bill would set up a separate licensure so that people with Traumatic Brain Injuries could be in facilities that have more appropriate treatment for that type of injury. The Traumatic Brain Injury Advisory Council recommended this language and the Department supported it. Senator Hoyle moved for a favorable report. Senator Forrester asked how many facilities were certified to care for TBI. Rep. Insko responded there were three or four facilities across the state that only had Traumatic Brain Injury patients. She also pointed out a lot of TBI patients ended up in Adult Care Homes and they could have been better served in facilities that would give immediate treatment for specific TBI. There are specific services that are more appropriate to help patients regain functions. Senator Goodall asked if this would preclude the use of some of the existing Adult Care Homes from being used. Rep. Insko stated that TBI patients would still use Adult Care Homes. Senator Hoyle had already made the motion for a favorable report; the motion was to roll the amendment into a Proposed Committee Substitute, unfavorable to original bill, favorable to PCS. The motion passed.

Senator Bingham called on Representative Faison to present House Bill 18, ***Speech Language Pathologist Qualifications***. Rep. Faison explained that House Bill 18 was a correction from two years ago when the language was inaccurately written to require speech language pathologist to complete 800 hours of supervised, direct clinical experience with individuals who present a variety of communication disorders, instead of 400 hours. Senator Dorsett moved for a favorable report. Senator Forrester asked why the two hundred hours were changed to twenty. Rep. Faison replied that it was supposed to have been twenty to begin with, but accidentally it got changed to 200, four times, therefore it went from 80 hours to 800 hours and the total process should only be 400

hours. Senator Brown moved for a favorable report, however, Senator Dorsett had already moved for a favorable report. The motion passed.

Senator Purcell, Co-Chair, introduced two physicians in the audience, Doctor Craig Burkhart, UNC Hospital, Dermatology Department, and Doctor John Albertini, President of the NC Dermatology Association, from Winston-Salem, NC.

Senator Bingham recognized Representative Ross to present House Bill 886, ***Allow Dietetics/Nutrition Bd./Recover Costs***. Senator Bingham pointed out it had a sequential referral to Finance. Rep. Ross stated House Bill 886 would allow the Dietetics and Nutrition Board to collect cost if they had to go against someone who was improperly holding them out as a dietitian or nutritionist and got in trouble with the licensing board. Rep. Ross pointed out this was the exact same language several other boards utilize. Senator Allan moved for a favorable report. Senator Forrester asked what would be the penalty for someone who stated they were a dietician and in reality they were not. Kim Dove, a licensed dietician and a member of the NC Dietetic Association, responded that someone operating without a license, would be a class one misdemeanor, and for a licensee that violated the law, the penalty would be revocation or suspension. Senator Allan had already moved for a favorable report, with a sequential referral to Finance. The motion passed.

Senator Bingham recognized Representative Bordsen to present House Bill 1342, ***RVAP/Ensure Grant Eligibility***. Senator Bingham asked for a motion to hear the PCS and Senator Atwater moved to hear it. The motion passed. Senator Bingham also stated that Senator Purcell had an amendment and asked Ben Popkin, Staff Attorney, to explain. Ben explained the amendment would correct what was an inadvertent omission in crafting the PCS. Section 2 included a subsection A, Page 2; lines 46-51, which would be rendered obsolete by the other provisions of the bill. Sen. Davis made the motion to adopt the amendment, which passed. Rep. Bordsen explained that when this bill was passed a couple of years ago, the bill created a problem with the Justice Department, in that, when they made their remedy, for the forensic evidence gathering to be collected on victims of Rape and Sex Offenses at no cost to the victims. Before, the victims had to pay for the collection of their own evidence. The problem was the bill created two populations, those with insurance and those without insurance. Everyone had to be treated the same. The definition of a forensic examine is very narrow, and currently the maximum amount of money the state will pay for evidence gathering is fixed at $800.00. The state will pay for all of it, and where there is any other payer, the state will collect the money from that payer. Now the two populations are as one. Rep. Bordsen also stated there was a change in the discretionary amount that the Director of the Commission on the Victims Assistance Fund, whom had always had a certain amount of money they could award without going to the full board. The full board only meets quarterly. The bill proposes an increase from $7,500.00 to $12,500.00 and beyond that amount the

director would have to go to the full commission and get authorization. The amount had not been changed in ten years. Senator Forrester asked if the bill goes to Appropriation. Senator Bingham stated the bill had a sequential referral to Appropriation. Senator Forrester asked about the fiscal note and Rep. Bordsen responded they have a General Fund of $5,400,000. She also said they get some money from the Federal Victims of Crime Act. They also get money from the Department of Corrections Enterprise Fund. There are three primary sources of funding. Senator Atwater moved for a favorable report. The motion was to roll the amendment into a new PCS, unfavorable as to bill, but favorable as to the Proposed Committee Substitute. The motion passed.

Senator Prucell recognized some volunteers that attended the meeting from Betsy Johnson Memorial Hospital, in Dunn, North Carolina. They were Mary Hardison, Patricia McLamb, Barbara Bynam, and Gene Moore. He expressed that everyone appreciated all the services they provided.

The meeting adjourned at 11:25 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

H 1

HOUSE BILL 18

Short Title:	Speech Language Pathologist Qualifications.	(Public)
Sponsors:	Representatives Faison and M. Alexander (Primary Sponsors).	
Referred to:	Rules, Calendar, and Operations of the House.	

February 2, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND SPECIFIC EXPERIENCE HOURS OF THE FOUR HUNDRED CLOCK HOURS REQUIRED FOR PERMANENT LICENSURE AS A SPEECH AND LANGUAGE PATHOLOGIST.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-295(a)(3) reads as rewritten:

"(3) Submit evidence of the completion of a minimum of 400 clock hours of supervised, direct clinical experience with individuals who present a variety of communication disorders. This experience must have been obtained within the training institution or in one of its cooperating programs in the following areas: (i) Speech – Adult (~~200~~20 diagnostic and ~~200~~20 therapeutic); Children (~~200~~20 diagnostic and ~~200~~20 therapeutic); or (ii) Language – Adult (~~200~~20 diagnostic and ~~200~~20 therapeutic); Children (~~200~~20 diagnostic and ~~200~~20 therapeutic). Each new applicant must submit a verified clinical clock hour summary sheet signed by the clinic or program director, in addition to completion of the license application."

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

HOUSE BILL 18:
Speech Language Pathologist Qualifications

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 2, 2009
Introduced by:	Reps. Faison, M. Alexander	**Prepared by:**	Susan Barham
Analysis of:	First Edition		Research Assistant

SUMMARY: ***House Bill 18 amends G.S. 90-295(a)(3) to correct the number of specific area experience hours required for licensure as a speech and language pathologist, so that the required hours in specific areas do not exceed the total required hours.***

CURRENT LAW: To be eligible for permanent licensure as a speech and language pathologist, the applicant must meet several qualifications. G.S. 90-295(a)(3) requires an applicant submit evidence that the applicant has completed a minimum of 400 clock hours of supervised, direct clinical experience with individuals who present a variety of communication disorders. The statute further requires that the experience hours must include either 800 clock hours in the area of Speech or 800 clock hours in the area of Language.

BILL ANALYSIS: House Bill 18 provides that of the minimum 400 supervised clinical hours required for licensure as a speech and language pathologist, 80 hours (not 800 hours) are to be obtained within a proper training institution in the following areas:

i. Speech- Adult (20 diagnostic and 20 therapeutic); Children (20 diagnostic and 20 therapeutic)

OR

ii. Language- Adult (20 diagnostic and 20 therapeutic); Children (20 diagnostic and 20 therapeutic)

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: Session Law 2007-436 amended a series of provisions in the Licensure Act for Speech and Language Pathologist and Audiologists (Article 22 of Chapter 90 of the General Statutes). A provision of this session law increased the number of clock hours of supervised, direct clinical experience for an applicant for permanent licensure as a speech and language pathologist from 300 hours to 400 hours and provided that of these experience hours a certain number are to be obtained in specific areas of Adult and Child diagnostic and therapeutic hours in either Speech or Language. After the law was enacted, it was discovered the amount of hours required in these areas was more than the total hours required.

Shawn Parker, Legislative Analyst, substantially contributed to this summary.

H18-SMTE-7(e1) v1

HOUSE BILL 896

Short Title:	Cancer Drug Coverage Changes.	(Public)
Sponsors:	Representatives Harrell, England, Faison (Primary Sponsors); K. Alexander, Bell, Glazier, Hall, Harrison, Insko, Jones, Lucas, Pierce, Stevens, Stewart, Wainwright, and Whilden.	
Referred to:	Health, if favorable, Insurance.	

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE CANCER COMPENDIA STATUTE TO REFLECT NEW COMPENDIA THAT ARE AVAILABLE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-59 reads as rewritten:

"**§ 58-51-59. Coverage of certain prescribed drugs for cancer treatment.**

(a) No policy or contract of accident or health insurance, and no preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) ~~The American Medical Association Drug Evaluations;~~ The National Comprehensive Cancer Network Drugs & Biologics Compendium;

(2) ~~The American Hospital Formulary Service Drug Information; or~~ The ThomsonMicromedex DrugDex;

(3) ~~The United States Pharmacopeia Drug Information.~~ The Elsevier Gold Standard's Clinical Pharmacology; or

(4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition."

SECTION 2. G.S. 58-65-94 reads as rewritten:

"**§ 58-65-94. Coverage of certain prescribed drugs for cancer treatment.**

(a) No insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and no preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after

January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) ~~The American Medical Association Drug Evaluations;~~ The National Comprehensive Cancer Network Drugs & Biologics Compendium;

(2) ~~The American Hospital Formulary Service Drug Information; or~~ The ThomsonMicromedex DrugDex;

(3) ~~The United States Pharmacopeia Drug Information.~~ The Elsevier Gold Standard's Clinical Pharmacology; or

(4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition."

SECTION 3. G.S. 58-67-78 reads as rewritten:

"**§ 58-67-78. Coverage of certain prescribed drugs for cancer treatment.**

(a) No health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) ~~The American Medical Association Drug Evaluations;~~ The National Comprehensive Cancer Network Drugs & Biologics Compendium;

(2) ~~The American Hospital Formulary Service Drug Information; or~~ The ThomsonMicromedex DrugDex;

(3) ~~The United States Pharmacopeia Drug Information.~~ The Elsevier Gold Standard's Clinical Pharmacology; or

(4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition."

SECTION 4. This act is effective when it becomes law.

HOUSE BILL 896:
Cancer Drug Coverage Changes

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 1, 2009
Introduced by:	Reps. Harrell, England, Faison	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Legislative Analyst

SUMMARY: ***House Bill 896 updates the statutorily established reference compendia relating to the coverage of cancer treatment drugs by various health insurance policies.***

CURRENT LAW: Chapter 58 is cited and is known as North Carolina's Insurance Law.

Article 51 provides for the Nature of Insurance Policies and Section 59 of this Article provides for the required coverage of certain prescribed drugs for cancer treatment.

Article 65 governs any corporation organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital or medical or dental service plan whereby hospital care or medical or dental service may be provided in whole or in part by the corporation or by hospitals, physicians, or dentists participating in the plan and Section 94 provides for the coverage of certain prescribed drugs for cancer treatment.

Article 67 governs Health Maintenance Organizations in North Carolina and Section 78 of this Article provides for the coverage of certain prescribed drugs for cancer treatment.

BILL ANALYSIS: House Bill 896 amends G.S. 58-51-59, G.S. 58-65-94, and G.S. 58-67-78 by replacing the current accepted reference compendia with the following:

- The National Comprehensive Cancer Network Drugs and Biological Compendium
- The Thomson Micromedex DrugDex
- The Elsevier Gold Standard's Clinical Pharmacology
- Any other authoritative compendia recognized periodically by the United States Secretary of Health and Human Services.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: In 1993, the U.S. Congress directed the Medicare program to refer to 3 existing published compendia, *American Medical Association Drug Evaluations*, *United States Pharmacopoeia Drug Information for the Health Professional*, and *American Hospital Formulary Service Drug Information*, to identify unlabeled but medically accepted uses of drugs and biologicals in anticancer chemotherapy regimens.[1]

American Medical Association Drug Evaluations is no longer published; *United States Pharmacopeia Drug Information for the Health Professional* was discontinued subsumed its contents. *United States Pharmacopeia Drug Information for the Health Professional* was discontinued in 2007 and its contents were rolled into a successor, DrugPoints. In 2008, (CMS) added *Clinical Pharmacology*, DRUGDEX, and *National Comprehensive Cancer Network Drugs and Biologics Compendium* to its list of approved

[1] http://www.annals.org/cgi/content/full/0000605-200903030-00109v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

HOUSE BILL 1309

Short Title:	Residential Treatment Facil./TBI.	(Public)
Sponsors:	Representatives Insko; Dickson, Faison, Glazier, and Parmon.	
Referred to:	Mental Health Reform, if favorable, Health.	

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO ADOPT RULES PROVIDING FOR THE LICENSURE AND ACCREDITATION OF RESIDENTIAL TREATMENT FACILITIES FOR PERSONS WITH TRAUMATIC BRAIN INJURY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-26 reads as rewritten:

"**§ 122C-26. Powers of the Commission.**

In addition to other powers and duties, the Commission shall exercise the following powers and duties:

(1) Adopt, amend, and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this Article;

(2) Issue declaratory rulings needed to implement the provisions and purposes of this Article;

(3) Adopt rules governing appeals of decisions to approve or deny licensure under this Article;

(4) Adopt rules for the waiver of rules adopted under this Article; and

(5) Adopt rules applicable to facilities licensed under this Article:

a. Establishing personnel requirements of staff employed in facilities;

b. Establishing qualifications of facility administrators or directors;

c. Establishing requirements for death reporting including confidentiality provisions related to death reporting;

d. Establishing requirements for patient advocates; and

e. Requiring facility personnel who refer clients to provider agencies to disclose any pecuniary interest the referring person has in the provider agency, or other interest that may give rise to the appearance of impropriety.

(6) Adopt rules providing for the licensure and accreditation of residential treatment facilities that provide services to persons with traumatic brain injury."

SECTION 2. This act is effective when it becomes law. The Commission may adopt temporary rules to carry out the provisions of this act.

HOUSE BILL 1309:
Residential Treatment Facil./TBI

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 2, 2009
Introduced by:	Rep. Insko	**Prepared by:**	Ben Popkin
Analysis of:	First Edition		Committee Counsel

SUMMARY: House Bill 1309 would authorize the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services to adopt rules for the licensure and accreditation of residential treatment facilities that provide services for persons with traumatic brain injury.

CURRENT LAW:

G.S. 122C-26 "Powers of the Commission" directs the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services to exercise the following powers and duties:

1. Adopt, amend and repeal rules to implement the provisions of Article 2 of Chapter 122C of the General Statutes (Licensure of Facilities for the Mentally Ill, Developmentally Disabled, and Substance Abusers.)
2. Implement declaratory rulings to implement the provisions and purposes of Article 2.
3. Adopt rules governing appeals of Article 2 licensure decisions.
4. Adopt rules for waiver of ruled adopted under Article 2.
5. Adopt rules to establish the following, applicable to facilities licensed under Article 2:
    - Personnel requirements of staff employed in facilities.
    - Qualifications of facility administrators or directors.
    - Requirements for death reporting, including confidentiality provisions.
    - Require facility personnel referring clients to provider agencies to disclose any pecuniary interests or other interests that may give the appearance of impropriety.

BILL ANALYSIS: House Bill 1309 would amend G.S. 122C-26 "Powers of the Commission" to add the following item to the five powers and duties listed above:

6. Adopt rules providing for the licensure and accreditation of residential treatment facilities that provide services to person with traumatic brain injury.

EFFECTIVE DATE: This act is effective when it becomes law.

Shawn Parker, staff to House Health, substantially contributed to this summary.

H1309-SMRD-145(e1) v2

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1309

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

H1309-ARD-24 [v.1]

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Date 6/4/09 ,2009

Senator Purcell

moves to amend the bill on page 1, lines 32-33 by rewriting the lines to read:

"**SECTION 2.** The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services may adopt temporary rules to carry out the provisions of this act until July 1, 2010.

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

SIGNED William R Purcell
Amendment Sponsor

SIGNED William R Purcell
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1309
PROPOSED SENATE COMMITTEE SUBSTITUTE H1309-PCS50725-RD-63

Short Title: Residential Treatment Facil./TBI. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO ADOPT RULES PROVIDING FOR THE LICENSURE AND ACCREDITATION OF RESIDENTIAL TREATMENT FACILITIES FOR PERSONS WITH TRAUMATIC BRAIN INJURY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-26 reads as rewritten:

"**§ 122C-26. Powers of the Commission.**

In addition to other powers and duties, the Commission shall exercise the following powers and duties:

(1) Adopt, amend, and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this Article;

(2) Issue declaratory rulings needed to implement the provisions and purposes of this Article;

(3) Adopt rules governing appeals of decisions to approve or deny licensure under this Article;

(4) Adopt rules for the waiver of rules adopted under this Article; and

(5) Adopt rules applicable to facilities licensed under this Article:

a. Establishing personnel requirements of staff employed in facilities;

b. Establishing qualifications of facility administrators or directors;

c. Establishing requirements for death reporting including confidentiality provisions related to death reporting;

d. Establishing requirements for patient advocates; and

e. Requiring facility personnel who refer clients to provider agencies to disclose any pecuniary interest the referring person has in the provider agency, or other interest that may give rise to the appearance of impropriety.

(6) Adopt rules providing for the licensure and accreditation of residential treatment facilities that provide services to persons with traumatic brain injury."

SECTION 2. The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services may adopt temporary rules to carry out the provisions of this act until July 1, 2010.

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

HOUSE BILL 886

Short Title:	Allow Dietetics/Nutrition Bd./Recover Costs.	(Public)
Sponsors:	Representatives Ross; and Lucas.	
Referred to:	Health, if favorable, Judiciary I, if favorable, Finance.	

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO ALLOW THE BOARD OF DIETETICS/NUTRITION TO RECOVER COSTS INCURRED BY THE BOARD IN CONNECTION WITH DISCIPLINARY PROCEEDINGS OF THE BOARD.

The General Assembly of North Carolina enacts:

SECTION 1. Article 25 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-370. Costs.**

The Board may assess the costs of disciplinary actions against a licensee or person found to be in violation of this Article or rules adopted by the Board. Costs recovered pursuant to this section shall be the property of the Board."

SECTION 2. This act becomes effective October 1, 2009, and applies to acts or omissions committed on or after that date.

HOUSE BILL 886:
Allow Dietetics/Nutrition Bd./Recover Costs

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	**Date:**	June 1, 2009
Introduced by:	Rep. Ross	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	First Edition		

SUMMARY: ***House Bill 886 authorizes the Board of Dietetics/Nutrition to assess the costs associated with disciplinary proceedings against a licensee found to be in violation of the licensing statutes or rules and provides that the costs recovered are the property of the Board.***

CURRENT LAW: The North Carolina Board of Dietetics/Nutrition licenses and regulates persons engaged in the practice of dietetics/nutrition in order to protect the public from being harmed by unqualified persons.[1] "Dietetics/nutrition" is defined as the integration and application of principles derived from the science of nutrition, biochemistry, physiology, food, and management, and from behavioral and social sciences to achieve and maintain a healthy status.

The Board has the authority to deny, refuse to renew, suspend, revoke, or impose probationary conditions upon a licensee after a hearing is held in accordance with Chapter 150B of the General Statutes.[2] The Board may make an application to any appropriate court for an order enjoining violations of Article 25 of Chapter 90 of the General Statutes.[3]

BILL ANALYSIS: House Bill 886 authorizes the North Carolina Board of Dietetics/Nutrition to assess the costs of disciplinary actions against persons found to be in violation of rules adopted by the Board or in violation of Article 25 of Chapter 90 of the General Statutes. The bill further provides that costs so recovered are property of the Board.

EFFECTIVE DATE: This act becomes effective October 1, 2009, and applies to acts or omissions committed after that date that result in the Board initiating disciplinary proceedings.

BACKGROUND:

Currently, a number of licensure boards have this authority and the following Boards utilize this same phraseology including the North Carolina Board of Nursing (G.S. 90-171.27), the North Carolina Psychology Board (G.S. 90-270.15), the North Carolina Board of Occupational Therapy (G.S. 90-270.80A), the North Carolina Board of Massage and Bodywork Therapy (G.S. 90-626), the North Carolina Respiratory Care Board (G.S. 90-666), the Perfusionist Advisory Committee of the North Carolina Medical Board (G.S. 90-693), and the North Carolina Interpreter and Transliterator Licensing Board (G.S. 90D-14).

H886-SMSQ-96(e1) v1

[1] G.S. 90-351
[2] G.S. 90-363
[3] G.S. 90-367

HOUSE BILL 1342

Short Title:	RVAP/Ensure Grant Eligibility.	(Public)
Sponsors:	Representatives Bordsen, McLawhorn, Howard, Justus (Primary Sponsors); Cotham, Dickson, Faison, Glazier, Harrison, Insko, Lucas, Luebke, Mobley, Parmon, Ross, and Weiss.	
Referred to:	State Government/State Personnel, if favorable, Appropriations.	

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT NORTH CAROLINA CONTINUES TO BE ELIGIBLE FOR STOP VIOLENCE AGAINST WOMEN FORMULA GRANT PROGRAM FUNDING; AND TO INCREASE THE AUTHORITY OF THE DIRECTOR OF THE CRIME VICTIMS COMPENSATION COMMISSION AND THE COMMISSION ITSELF TO CONSIDER PROXIMATE CAUSE WHEN DETERMINING WHETHER TO MAKE AN AWARD; AND TO MAKE VARIOUS OTHER CHANGES TO THE RAPE VICTIMS ASSISTANCE PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 143B-480.2 is repealed.

SECTION 1.(b) G.S. 143B-480.1 reads as rewritten:

"**§ 143B-480.1. Assistance Program for Victims of Rape and Sex Offenses.**

(a) Establishment of Program. – There is established an Assistance Program for Victims of Rape and Sex Offenses, hereinafter referred to as the "Program." The Secretary shall administer and implement the Program and shall have authority over all assistance awarded through the Program. The Secretary shall promulgate rules and guidelines for the Program.

(b) Victims to Be Provided Free Forensic Medical Examinations. – It is the policy of this State to arrange for victims to obtain forensic medical examinations free of charge. Whenever a forensic medical examination is conducted as a result of a sexual assault or an attempted sexual assault that occurred in this State, the Program shall pay for the cost of the examination. A medical facility or medical professional that performs a forensic medical examination on the victim of a sexual assault or attempted sexual assault shall not seek payment for the examination except from the Program.

(c) No Billing of Victim. – A medical facility or medical professional that performs a forensic medical examination shall accept payment made under this section as payment in full of the amount owed for the cost of the examination and other eligible expenses and shall not bill victims, their personal insurance, Medicaid, Medicare, nor any other collateral source for the examination. Furthermore, a medical facility or medical professional shall not seek reimbursement from the Program after one year from the date of the examination.

(d) Eligible Expenses. – Medical facilities and medical professionals who perform forensic medical examinations shall do so using a Sexual Assault Evidence Collection Kit. Payments by the Program for the forensic medical examination shall be limited to the following:

Service	**Maximum Amount Paid by Program**
Physician or SANE Nurse	$350.00

Hospital/Facility Fee	$250.00
Other Expenses Deemed Eligible by the Program	$200.00
Total:	**$800.00**

(e) Payment Directly to Provider. – The Program shall make payment directly to the medical facility or medical professional. Bills submitted to the Program for payment shall specify which of the categories of expense set forth in subsection (d) of this section the services billed for fall within.

(f) Additional Victim Notification Requirements. – A medical facility or medical professional who performs a forensic medical examination shall encourage victims to submit an application for reimbursement of medical expenses beyond the forensic examination to the Crime Victims Compensation Commission for consideration of those expenses. The victim must meet the eligibility requirements of the Crime Victims Compensation Commission to be reimbursed for those additional expenses. A medical facility or medical professional who performs a forensic medical examination shall also inform victims before providing any services that are not covered by the Program. Medical facilities and medical professionals shall not seek reimbursement from the Program after one year from the date of the exam.

(g) Judicial Review. – Upon an adverse determination by the Secretary on a claim for assistance under this Part, a victim is entitled to judicial review of that decision. The person seeking review shall file a petition in the Superior Court of Wake County.

(h) The Secretary shall adopt rules to encourage, whenever practical, the use of licensed registered nurses trained under G.S. 90-171.38(b) to conduct medical examinations and procedures.

(i) Definitions. – The following definitions apply in this section:

(1) Forensic medical examination. – An examination provided to a sexual assault victim by medical personnel trained to gather evidence of a sexual assault in a manner suitable for use in a court of law. The examination should include at a minimum an examination of physical trauma, a patient interview, a determination of penetration or force, and a collection and evaluation of evidence. This definition shall be interpreted consistently with 28 C.F.R. § 90.2(b) and other relevant federal law.

(2) SANE nurse. – A Sexual Assault Nurse Examiner that is a licensed registered nurse trained pursuant to G.S. 90-171.38(b) who obtains preliminary histories, conducts in-depth interviews, and conducts medical examinations of rape victims or victims of related sexual offenses.

(3) Sexual assault. – Any of the following crimes:

a. First-degree rape as defined in G.S. 14-27.2.

b. Second degree rape as defined in G.S. 14-27.3.

c. First-degree sexual offense as defined in G.S. 14-27.4.

d. Second degree sexual offense as defined in G.S. 14-27.5.

e. Statutory rape as defined in G.S. 14-27.7A.

(4) Sexual Assault Evidence Collection Kit. – The kit assembled and paid for by the Program and used to conduct forensic medical examinations in this State."

SECTION 2. G.S. 143B-480.3 reads as rewritten:

"**§ 143B-480.3. Reduction of benefits; restitution; actions.**

(a) Assistance shall be reduced or denied to the extent the medical expenses are recouped through a public or private insurance plan or other victim benefit ~~source, except that the Program shall pay any co-payment that the victim is required to pay in connection with the forensic medical examination up to the maximum amount that the Program will pay for a forensic medical exam under G.S. 143B-480.2(c).~~source.

(b) The Program shall be an eligible recipient for restitution or reparation under G.S. 15A-1021, 15A-1343, 148-33.1, 148-33.2, 148-57.1, and any other applicable statutes.

(c) When any victim who:

(1) Has received assistance under this Part;

(2) Brings an action for damages arising out of the rape, attempted rape, sexual offense, or attempted sexual offense for which she received that assistance; and

(3) Recovers damages including the expenses for which she was awarded assistance,

the court shall make as part of its judgment an order for reimbursement to the Program of the amount of any assistance awarded less reasonable expenses allocated by the court to that recovery.

(d) Funds appropriated to the Department of Crime Control and Public Safety for this program may be used to purchase and distribute rape evidence collection kits approved by the State Bureau of Investigation."

SECTION 3. G.S. 15B-10 reads as rewritten:

"**§ 15B-10. Awarding claims.**

(a) The Director shall decide the award of compensation for an initial claim or follow-up claim when the claim does not exceed ~~seven thousand five hundred dollars ($7,500)~~twelve thousand five hundred dollars ($12,500) and does not include future economic loss. The Director shall report all awards under this subsection to the Commission.

(b) The Director shall recommend the award of compensation for an initial claim or follow-up claim when the claim exceeds ~~seven thousand five hundred dollars ($7,500)~~twelve thousand five hundred dollars ($12,500) or involves future economic loss. The Commission shall decide the award of compensation for a claim based on a review of written evidence submitted to the Commission by the Director.

(c) In reporting a decision under subsection (a) or recommending a decision under subsection (b), the Director shall submit to the Commission documentation to establish the economic loss of the claimant by substantial evidence.

(d) The Director shall send each claimant a written statement of a decision made under subsection (a) or (b) that gives the reasons for the decision. A claimant who is dissatisfied with a decision may commence a contested case under Article 3 of Chapter 150B of the General Statutes."

SECTION 4. G.S. 15B-11 reads as rewritten:

"**§ 15B-11. Grounds for denial of claim or reduction of award.**

(a) An award of compensation shall be denied if:

(1) The claimant fails to file an application for an award within two years after the date of the criminally injurious conduct that caused the injury or death for which the claimant seeks the award;

(2) The economic loss is incurred after one year from the date of the criminally injurious conduct that caused the injury or death for which the victim seeks the award, except in the case where the victim for whom compensation is sought was 10 years old or younger at the time the injury occurred. In that case an award of compensation will be denied if the economic loss is incurred after two years from the date of the criminally injurious conduct that caused the injury or death for which the victim seeks the award;

(3) The criminally injurious conduct was not reported to a law enforcement officer or agency within 72 hours of its occurrence, and there was no good cause for the delay;

(4) The award would benefit the offender or the offender's accomplice, unless a determination is made that the interests of justice require that an award be approved in a particular case;

(5) The criminally injurious conduct occurred while the victim was confined in any State, county, or city prison, correctional, youth services, or juvenile facility, or local confinement facility, or half-way house, group home, or similar facility; or

(6) The victim was participating in a felony at or about the time that the victim's injury occurred.

(b) A claim may be denied or an award of compensation may be reduced if:

(1) The victim was participating in a nontraffic misdemeanor at or about the time that the victim's injury occurred; or

(2) The claimant or a victim through whom the claimant claims engaged in contributory misconduct.

(b1) The Commission or Director, whichever has the authority to decide a claim under G.S. 15B-10, shall use its discretion in determining whether to deny a claim under ~~this subsection.~~subsection (b) of this section. In exercising its discretion, the Commission ~~may~~or Director shall consider whether any proximate cause exists between the injury and the misdemeanor or contributory ~~misconduct.~~misconduct, when applicable. The Director or Commission shall deny claims when it finds that there was contributory misconduct that is a proximate cause of becoming a victim. However, contributory misconduct that is not a proximate cause of becoming a victim shall not lead to an automatic denial of a claim."

SECTION 5. This act becomes effective July 1, 2009.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1342
PROPOSED SENATE COMMITTEE SUBSTITUTE H1342-CSRD-62 [v.1]

6/2/2009 5:51:33 PM

Short Title: Free Med. Exam-Victims of Rape/Sex Offenses. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FREE FORENSIC MEDICAL EXAMINATIONS FOR VICTIMS OF RAPE AND SEX OFFENSES; TO INCREASE THE AUTHORITY OF THE DIRECTOR OF THE CRIME VICTIMS COMPENSATION COMMISSION AND THE COMMISSION ITSELF TO CONSIDER PROXIMATE CAUSE WHEN DETERMINING WHETHER TO MAKE AN AWARD; AND TO MAKE VARIOUS OTHER CHANGES TO THE RAPE VICTIMS ASSISTANCE PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 143B-480.2 is repealed.

SECTION 1.(b) G.S. 143B-480.1 reads as rewritten:

"**§ 143B-480.1. Assistance Program for Victims of Rape and Sex Offenses.**

(a) Establishment of Program. – There is established an Assistance Program for Victims of Rape and Sex Offenses, hereinafter referred to as the "Program." The Secretary shall administer and implement the Program and shall have authority over all assistance awarded through the Program. The Secretary shall promulgate rules and guidelines for the Program.

(b) Victims to Be Provided Free Forensic Medical Examinations. – It is the policy of this State to arrange for victims to obtain forensic medical examinations free of charge. Whenever a forensic medical examination is conducted as a result of a sexual assault or an attempted sexual assault that occurred in this State, the Program shall pay for the cost of the examination. A medical facility or medical professional that performs a forensic medical examination on the victim of a sexual assault or attempted sexual assault shall not seek payment for the examination except from the Program.

(c) No Billing of Victim. – A medical facility or medical professional that performs a forensic medical examination shall accept payment made under this section as payment in full of the amount owed for the cost of the examination and other eligible expenses and shall not bill victims, their personal insurance, Medicaid, Medicare, nor any other collateral source for the examination. Furthermore, a medical facility or medical professional shall not seek reimbursement from the Program after one year from the date of the examination.

(d) Eligible Expenses. – Medical facilities and medical professionals who perform forensic medical examinations shall do so using a Sexual Assault Evidence Collection Kit. Payments by the Program for the forensic medical examination shall be limited to the following:

Service	Maximum Amount Paid by Program
Physician or SANE Nurse	$350.00

Hospital/Facility Fee	$250.00
Other Expenses Deemed Eligible by the Program	$200.00
Total:	**$800.00**

(e) Payment Directly to Provider. – The Program shall make payment directly to the medical facility or medical professional. Bills submitted to the Program for payment shall specify which of the categories of expense set forth in subsection (d) of this section the services billed for fall within.

(f) Additional Victim Notification Requirements. – A medical facility or medical professional who performs a forensic medical examination shall encourage victims to submit an application for reimbursement of medical expenses beyond the forensic examination to the Crime Victims Compensation Commission for consideration of those expenses. The victim must meet the eligibility requirements of the Crime Victims Compensation Commission to be reimbursed for those additional expenses. A medical facility or medical professional who performs a forensic medical examination shall also inform victims before providing any services that are not covered by the Program. Medical facilities and medical professionals shall not seek reimbursement from the Program after one year from the date of the exam.

(g) Judicial Review. – Upon an adverse determination by the Secretary on a claim for assistance under this Part, a victim is entitled to judicial review of that decision. The person seeking review shall file a petition in the Superior Court of Wake County.

(h) The Secretary shall adopt rules to encourage, whenever practical, the use of licensed registered nurses trained under G.S. 90-171.38(b) to conduct medical examinations and procedures.

(i) Definitions. – The following definitions apply in this section:

(1) Forensic medical examination. – An examination provided to a sexual assault victim by medical personnel trained to gather evidence of a sexual assault in a manner suitable for use in a court of law. The examination should include at a minimum an examination of physical trauma, a patient interview, a determination of penetration or force, and a collection and evaluation of evidence. This definition shall be interpreted consistently with 28 C.F.R. § 90.2(b) and other relevant federal law.

(2) SANE nurse. – A Sexual Assault Nurse Examiner that is a licensed registered nurse trained pursuant to G.S. 90-171.38(b) who obtains preliminary histories, conducts in-depth interviews, and conducts medical examinations of rape victims or victims of related sexual offenses.

(3) Sexual assault. – Any of the following crimes:

a. First-degree rape as defined in G.S. 14-27.2.
b. Second degree rape as defined in G.S. 14-27.3.
c. First-degree sexual offense as defined in G.S. 14-27.4.
d. Second degree sexual offense as defined in G.S. 14-27.5.
e. Statutory rape as defined in G.S. 14-27.7A.

(4) Sexual Assault Evidence Collection Kit. – The kit assembled and paid for by the Program and used to conduct forensic medical examinations in this State."

SECTION 2. G.S. 143B-480.3 reads as rewritten:

"**§ 143B-480.3. Reduction of benefits; restitution; actions.**

(a) Assistance shall be reduced or denied to the extent the medical expenses are recouped through a public or private insurance plan or other victim benefit ~~source, except that the Program shall pay any co-payment that the victim is required to pay in connection with the forensic medical examination up to the maximum amount that the Program will pay for a forensic medical exam under G.S. 143B-480.2(c).~~source.

(b) The Program shall be an eligible recipient for restitution or reparation under G.S. 15A-1021, 15A-1343, 148-33.1, 148-33.2, 148-57.1, and any other applicable statutes.

(c) When any victim who:

(1) Has received assistance under this Part;

(2) Brings an action for damages arising out of the rape, attempted rape, sexual offense, or attempted sexual offense for which she received that assistance; and

(3) Recovers damages including the expenses for which she was awarded assistance,

the court shall make as part of its judgment an order for reimbursement to the Program of the amount of any assistance awarded less reasonable expenses allocated by the court to that recovery.

(d) Funds appropriated to the Department of Crime Control and Public Safety for this program may be used to purchase and distribute rape evidence collection kits approved by the State Bureau of Investigation."

SECTION 3. G.S. 15B-10 reads as rewritten:

"**§ 15B-10. Awarding claims.**

(a) The Director shall decide the award of compensation for an initial claim or follow-up claim when the claim does not exceed ~~seven thousand five hundred dollars ($7,500)~~twelve thousand five hundred dollars ($12,500) and does not include future economic loss. The Director shall report all awards under this subsection to the Commission.

(b) The Director shall recommend the award of compensation for an initial claim or follow-up claim when the claim exceeds ~~seven thousand five hundred dollars ($7,500)~~twelve thousand five hundred dollars ($12,500) or involves future economic loss. The Commission shall decide the award of compensation for a claim based on a review of written evidence submitted to the Commission by the Director.

(c) In reporting a decision under subsection (a) or recommending a decision under subsection (b), the Director shall submit to the Commission documentation to establish the economic loss of the claimant by substantial evidence.

(d) The Director shall send each claimant a written statement of a decision made under subsection (a) or (b) that gives the reasons for the decision. A claimant who is dissatisfied with a decision may commence a contested case under Article 3 of Chapter 150B of the General Statutes."

SECTION 4. G.S. 15B-11 reads as rewritten:

"**§ 15B-11. Grounds for denial of claim or reduction of award.**

(a) An award of compensation shall be denied if:

(1) The claimant fails to file an application for an award within two years after the date of the criminally injurious conduct that caused the injury or death for which the claimant seeks the award;

(2) The economic loss is incurred after one year from the date of the criminally injurious conduct that caused the injury or death for which the victim seeks the award, except in the case where the victim for whom compensation is sought was 10 years old or younger at the time the injury occurred. In that case an award of compensation will be denied if the economic loss is incurred after two years from the date of the criminally injurious conduct that caused the injury or death for which the victim seeks the award;

(3) The criminally injurious conduct was not reported to a law enforcement officer or agency within 72 hours of its occurrence, and there was no good cause for the delay;

(4) The award would benefit the offender or the offender's accomplice, unless a determination is made that the interests of justice require that an award be approved in a particular case;

(5) The criminally injurious conduct occurred while the victim was confined in any State, county, or city prison, correctional, youth services, or juvenile facility, or local confinement facility, or half-way house, group home, or similar facility; or

(6) The victim was participating in a felony at or about the time that the victim's injury occurred.

(b) A claim may be denied or an award of compensation may be reduced if:

(1) The victim was participating in a nontraffic misdemeanor at or about the time that the victim's injury occurred; or

(2) The claimant or a victim through whom the claimant claims engaged in contributory misconduct.

(b1) The Commission or Director, whichever has the authority to decide a claim under G.S. 15B-10, shall use its discretion in determining whether to deny a claim under ~~this subsection.~~subsection (b) of this section. In exercising its discretion, the Commission ~~may~~or Director shall consider whether any proximate cause exists between the injury and the misdemeanor or contributory ~~misconduct.~~misconduct, when applicable. The Director or Commission shall deny claims when it finds that there was contributory misconduct that is a proximate cause of becoming a victim. However, contributory misconduct that is not a proximate cause of becoming a victim shall not lead to an automatic denial of a claim."

SECTION 5. This act becomes effective July 1, 2009.

HOUSE BILL 1342:
Free Med. Exam-Victims of Rape/Sex Offenses

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	June 2, 2009
Introduced by:	Reps. Bordsen, McLawhorn, Howard, Justus	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	PCS to First Edition H1342-CSRD-62		

SUMMARY: ***House Bill 1342 would amend the Assistance Program for Victims of Rape and Sex Offenses with regard to the payment of forensic medical examinations, increase the threshold amount for a claim for an award of compensation that can be approved by the Director of Crime Victims Compensation Commission, and require the Director or Commission to deny claims when it finds that there was contributory misconduct that is a proximate cause of becoming a victim.***

The Proposed Committee Substitute would repeal G.S. 143B-480.3(a) as its contents are rendered ineffectual by the provisions of the bill, and would amend the section catchline accordingly.

BILL ANALYSIS:

Section 1(a) would repeal portions of the victims assistance program established under G.S. 143B-480.2. Some of the provisions have been placed under G.S. 143B-480.1 in an amended form.

Currently, G.S. 143B-480.2 provides for limited assistance with certain expenses. **Section 1(b)** of the bill would amend G.S. 143B-480.1 as follows:

- Subsection (b) of G.S. 143B-480.1. establishes that it is the policy of the State to arrange for victims to obtain forensic medical examination (exam) free of charge. The subsection further provides that when a forensic medical exam is conducted as a result of a sexual assault or attempted sexual assault that occurred in the State, the Program is required to pay for the cost of the exam and that a medical facility or medical professional that performs a forensic medical exam on the victim is not permitted to seek payment except from the Program.
- Subsection (c) further clarifies that a medical facility or medical professional that performs a forensic medical exam must accept payment made by the Assistance Program for Victims of Rape and Sex Offenses (Program) as payment in full and is not allowed to bill other entities (including the victim, their personal insurance, Medicaid, Medicare, or other sources). A medical facility or medical professional is not allowed to seek reimbursement from the Program after one year from the date of the exam.
- Subsection (d) requires the use of Sexual Assault Evidence Collection Kits by medical facilities and medical professionals performing forensic medical exams. This subsection also sets out the rates paid for services under the Program. These rates are the same as the rates that were in place under G.S. 143B-480.2(c) which is being repealed.
- Subsection (e) provides that bills must specify the category of services provided and payments will be made directly to the medical facility or medical professional.
- Subsection (f) directs the medical facility or medical professional performing an exam to encourage victims to submit an application for reimbursement of medical expenses beyond the exam to the Crime Victims Compensation Commission.
- Subsection (g) allows a victim to file a petition in the Superior Court of Wake County to seek a judicial review in the event of an adverse determination on a claim for assistance.

- Subsection (h) directs the Secretary of Crime Control and Public Safety to adopt rules encouraging the use of licensed registered nurses to conduct medical exams and procedures.
- Subsection (i) provides definitions for the following terms: "forensic medical examination", "SANE nurse", "sexual assault", and "Sexual Assault Evidence Collection Kit".

Section 2 of the PCS would make a conforming change to G.S. 143B-480.3 to repeal subsection (a) as the Program would now be the payer of first resort and assistance rendered by the Program would not be reduced or denied due to any other source of payment. This section would amend the catchline to reflect the repeal of subsection (a).

Section 3 would amend G.S. 15B-10 to increase the threshold amount from $7,500 to $12,500 that the Director of the Crime Victims Compensation Commission, of the Department of Crime Control and Public Safety, can award for an initial or follow-up claim when the claim does not exceed that amount and does not include future economic loss. This section would also make a corresponding change to the threshold amount to provide that the Director shall make a recommendation to the Commission regarding the award of compensation for an initial or follow-up claim when the claim exceeds $12,500 or involves future economic loss.

Section 4 would amend G.S. 15B-11 to require the Director or Commission to deny claims when it finds that there was contributory misconduct that is a proximate cause of becoming a victim, but specifies that contributory misconduct that is not a proximate cause of becoming a victim would not lead to an automatic denial of a claim.

EFFECTIVE DATE: This act becomes effective July 1, 2009.

Theresa Matula, staff to House State Government/State Personnel, substantially contributed to this summary.

H1342-SMRD-146(CSRD-62) v1

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1342

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

H1342-ARD-25 [v.1]

Comm. Sub. [YES]
Amends Title [NO]
First Edition

Date _____,2009

Senator _____

moves to amend the bill on page 2, lines 46-51, by rewriting the lines to read:

"**§ 143B-480.3. ~~Reduction of benefits; restitution;~~ Restitution; actions.**

~~(a) Assistance shall be reduced or denied to the extent the medical expenses are recouped through a public or private insurance plan or other victim benefit source, except that the Program shall pay any co-payment that the victim is required to pay in connection with the forensic medical examination up to the maximum amount that the Program will pay for a forensic medical exam under G.S. 143B-480.2(c).~~".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1342
PROPOSED SENATE COMMITTEE SUBSTITUTE H1342-PCS50724-RD-62

Short Title: Free Med. Exam-Victims of Rape/Sex Offenses. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO PROVIDE FREE FORENSIC MEDICAL EXAMINATIONS FOR VICTIMS OF RAPE AND SEX OFFENSES; TO INCREASE THE AUTHORITY OF THE DIRECTOR OF THE CRIME VICTIMS COMPENSATION COMMISSION AND THE COMMISSION ITSELF TO CONSIDER PROXIMATE CAUSE WHEN DETERMINING WHETHER TO MAKE AN AWARD; AND TO MAKE VARIOUS OTHER CHANGES TO THE RAPE VICTIMS ASSISTANCE PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 143B-480.2 is repealed.

SECTION 1.(b) G.S. 143B-480.1 reads as rewritten:

"**§ 143B-480.1. Assistance Program for Victims of Rape and Sex Offenses.**

(a) Establishment of Program. – There is established an Assistance Program for Victims of Rape and Sex Offenses, hereinafter referred to as the "Program." The Secretary shall administer and implement the Program and shall have authority over all assistance awarded through the Program. The Secretary shall promulgate rules and guidelines for the Program.

(b) Victims to Be Provided Free Forensic Medical Examinations. – It is the policy of this State to arrange for victims to obtain forensic medical examinations free of charge. Whenever a forensic medical examination is conducted as a result of a sexual assault or an attempted sexual assault that occurred in this State, the Program shall pay for the cost of the examination. A medical facility or medical professional that performs a forensic medical examination on the victim of a sexual assault or attempted sexual assault shall not seek payment for the examination except from the Program.

(c) No Billing of Victim. – A medical facility or medical professional that performs a forensic medical examination shall accept payment made under this section as payment in full of the amount owed for the cost of the examination and other eligible expenses and shall not bill victims, their personal insurance, Medicaid, Medicare, or any other collateral source for the examination. Furthermore, a medical facility or medical professional shall not seek reimbursement from the Program after one year from the date of the examination.

(d) Eligible Expenses. – Medical facilities and medical professionals who perform forensic medical examinations shall do so using a Sexual Assault Evidence Collection Kit. Payments by the Program for the forensic medical examination shall be limited to the following:

Service	Maximum Amount Paid by Program
Physician or SANE Nurse	$350.00

Hospital/Facility Fee	$250.00
Other Expenses Deemed Eligible by the Program	$200.00
Total:	**$800.00**

(e) Payment Directly to Provider. – The Program shall make payment directly to the medical facility or medical professional. Bills submitted to the Program for payment shall specify under which categories of expense set forth in subsection (d) of this section the billed services fall.

(f) Additional Victim Notification Requirements. – A medical facility or medical professional who performs a forensic medical examination shall encourage victims to submit an application for reimbursement of medical expenses beyond the forensic examination to the Crime Victims Compensation Commission for consideration of those expenses. The victim must meet the eligibility requirements of the Crime Victims Compensation Commission to be reimbursed for those additional expenses. A medical facility or medical professional who performs a forensic medical examination shall also inform victims before providing any services that are not covered by the Program. Medical facilities and medical professionals shall not seek reimbursement from the Program after one year from the date of the exam.

(g) Judicial Review. – Upon an adverse determination by the Secretary on a claim for assistance under this Part, a victim is entitled to judicial review of that decision. The person seeking review shall file a petition in the Superior Court of Wake County.

(h) The Secretary shall adopt rules to encourage, whenever practical, the use of licensed registered nurses trained under G.S. 90-171.38(b) to conduct medical examinations and procedures.

(i) Definitions. – The following definitions apply in this section:

(1) Forensic medical examination. – An examination provided to a sexual assault victim by medical personnel trained to gather evidence of a sexual assault in a manner suitable for use in a court of law. The examination should include at a minimum an examination of physical trauma, a patient interview, a determination of penetration or force, and a collection and evaluation of evidence. This definition shall be interpreted consistently with 28 C.F.R. § 90.2(b) and other relevant federal law.

(2) SANE nurse. – A Sexual Assault Nurse Examiner that is a licensed registered nurse trained pursuant to G.S. 90-171.38(b) who obtains preliminary histories, conducts in-depth interviews, and conducts medical examinations of rape victims or victims of related sexual offenses.

(3) Sexual assault. – Any of the following crimes:

a. First-degree rape as defined in G.S. 14-27.2.
b. Second degree rape as defined in G.S. 14-27.3.
c. First-degree sexual offense as defined in G.S. 14-27.4.
d. Second degree sexual offense as defined in G.S. 14-27.5.
e. Statutory rape as defined in G.S. 14-27.7A.

(4) Sexual Assault Evidence Collection Kit. – The kit assembled and paid for by the Program and used to conduct forensic medical examinations in this State."

SECTION 2. G.S. 143B-480.3 reads as rewritten:

"**§ 143B-480.3. ~~Reduction of benefits; restitution;~~ Restitution; actions.**

~~(a) Assistance shall be reduced or denied to the extent the medical expenses are recouped through a public or private insurance plan or other victim benefit source, except that the Program shall pay any co-payment that the victim is required to pay in connection with the forensic medical examination up to the maximum amount that the Program will pay for a forensic medical exam under G.S. 143B-480.2(c).~~

(b) The Program shall be an eligible recipient for restitution or reparation under G.S. 15A-1021, 15A-1343, 148-33.1, 148-33.2, 148-57.1, and any other applicable statutes.

(c) When any victim who:

(1) Has received assistance under this Part;

(2) Brings an action for damages arising out of the rape, attempted rape, sexual offense, or attempted sexual offense for which she received that assistance; and

(3) Recovers damages including the expenses for which she was awarded assistance,

the court shall make as part of its judgment an order for reimbursement to the Program of the amount of any assistance awarded less reasonable expenses allocated by the court to that recovery.

(d) Funds appropriated to the Department of Crime Control and Public Safety for this program may be used to purchase and distribute rape evidence collection kits approved by the State Bureau of Investigation."

SECTION 3. G.S. 15B-10 reads as rewritten:

"**§ 15B-10. Awarding claims.**

(a) The Director shall decide the award of compensation for an initial claim or follow-up claim when the claim does not exceed ~~seven thousand five hundred dollars ($7,500)~~twelve thousand five hundred dollars ($12,500) and does not include future economic loss. The Director shall report all awards under this subsection to the Commission.

(b) The Director shall recommend the award of compensation for an initial claim or follow-up claim when the claim exceeds ~~seven thousand five hundred dollars ($7,500)~~twelve thousand five hundred dollars ($12,500) or involves future economic loss. The Commission shall decide the award of compensation for a claim based on a review of written evidence submitted to the Commission by the Director.

(c) In reporting a decision under subsection (a) or recommending a decision under subsection (b), the Director shall submit to the Commission documentation to establish the economic loss of the claimant by substantial evidence.

(d) The Director shall send each claimant a written statement of a decision made under subsection (a) or (b) that gives the reasons for the decision. A claimant who is dissatisfied with a decision may commence a contested case under Article 3 of Chapter 150B of the General Statutes."

SECTION 4. G.S. 15B-11 reads as rewritten:

"**§ 15B-11. Grounds for denial of claim or reduction of award.**

(a) An award of compensation shall be denied if:

(1) The claimant fails to file an application for an award within two years after the date of the criminally injurious conduct that caused the injury or death for which the claimant seeks the award;

(2) The economic loss is incurred after one year from the date of the criminally injurious conduct that caused the injury or death for which the victim seeks the award, except in the case where the victim for whom compensation is sought was 10 years old or younger at the time the injury occurred. In that case an award of compensation will be denied if the economic loss is incurred after two years from the date of the criminally injurious conduct that caused the injury or death for which the victim seeks the award;

(3) The criminally injurious conduct was not reported to a law enforcement officer or agency within 72 hours of its occurrence, and there was no good cause for the delay;

(4) The award would benefit the offender or the offender's accomplice, unless a determination is made that the interests of justice require that an award be approved in a particular case;

(5) The criminally injurious conduct occurred while the victim was confined in any State, county, or city prison, correctional, youth services, or juvenile facility, or local confinement facility, or half-way house, group home, or similar facility; or

(6) The victim was participating in a felony at or about the time that the victim's injury occurred.

(b) A claim may be denied or an award of compensation may be reduced if:

(1) The victim was participating in a nontraffic misdemeanor at or about the time that the victim's injury occurred; or

(2) The claimant or a victim through whom the claimant claims engaged in contributory misconduct.

(b1) The Commission or Director, whichever has the authority to decide a claim under G.S. 15B-10, shall use ~~its~~ the Commission's/Director's discretion in determining whether to deny a claim under ~~this subsection.~~subsection (b) of this section. In exercising its discretion, the Commission ~~may~~or Director shall consider whether any proximate cause exists between the injury and the misdemeanor or contributory ~~misconduct.~~misconduct, when applicable. The Director or Commission shall deny claims when it finds that there was contributory misconduct that is a proximate cause of becoming a victim. However, contributory misconduct that is not a proximate cause of becoming a victim shall not lead to an automatic denial of a claim."

SECTION 5. This act becomes effective July 1, 2009.

VISITOR REGISTRATION SHEET

Senate Health Care — **June 3, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Barbara Canales	BCBSA
John Bowdich	AstraZeneca
Jorge Pedraza	HDassoc
Karen Gillespie	Bristol-Myers Squibb
Lee-Ann Allen	NCPA
Victoria Lawrence	Bone & Assoc.
Gary Sutherland	GSK

VISITOR REGISTRATION SHEET

Senate Health Care — **June 3, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Maria C. Fryer Intern: McKenzie Guy	The Governor's Crime Commission CCPS
TINA GORDON	NC Nurses Association
John Albertini MD	NC Dermatology Association / NCMS
Craig Barkhaut MD	UNC Hospitals + NCMS
Leslie Arnold	SOG - Daily Bulletin
SCOTT PRUESS COULBELL	DHHS - DPH - INJVNY
Jennifer Woody	DHHS - DPH - injury prevention
Alicea Lieberman	DHHS-DPH - injury
Michelle Brooks	University Health Systems
DAVID LONG	PENDER HOSPITAL, BURGAW NC
Kim Dove	NCBON

VISITOR REGISTRATION SHEET

Senate Health Care — **June 3, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Henry Jones	Attorney - Raleigh
Emily Dayn	NCPAPA
Evelyn Hawthorne	EHGR
Thomas C. Cavey Jr.	CCPS
Daniel Baum	K&L GATES
Scott Wagstaff	New Hanover Regional Medical Center
Marshall McEwen	CUS
Chip Bryant	NCMS
Regina Mayer	
Brian Forrest MD	NC Academy of Family Physicians
Hugh Tilson	NCOM

VISITOR REGISTRATION SHEET

Senate Health Care — **June 3, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jeff Horton	DHHS DHSR
Jessi Goodman	DHHS
S Wilson	DHHS
Karen Rowe	NCAST
Will Underwood	NCAST
Anna liese Nolph	DRNC
Linda Dunlap	NCAE
Emily Gallimore	NCBA
Alesia Diggs	YAIO
OSIRIS DIOMANDE	YAIO
Theresa Tant	NCHCC

VISITOR REGISTRATION SHEET

Senate Health Care — **June 3, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Lynn Holmes	NCCTA
Kevin FitzGerald	UNC
Alan Skipper	NC Med. Soc.
David Boaz	MWC
Mary W. Hardeson	Betsy Johnson Memorial Hosp.
Patricia McLamb	"
Barbara Bynum	"
Gene Moore	"

Principal Clerk
Reading Clerk

CORRECTED NOTICE: H 703 REMOVED; H 1271 ADDED

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	June 10, 2009	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 243	Mental Health/Law Enforcement Custody.	Representative Steen, II Representative Barnhart Representative Insko
HB 456	Tech. & Org. Changes/Certain DHHS Facilities.	Representative Earle Representative England, M.D. Representative Farmer-Butterfield Representative Insko
HB 896	Cancer Drug Coverage Changes.	Representative Faison Representative England, M.D. Representative Harrell
HB 1186	DHHS/Update current inspection practices.-AB	Representative Earle Representative England, M.D. Representative Alexander Representative Lucas
HB 1189	DHHS/Tracking Outpatient Commitments.-AB	Representative Earle Representative England, M.D. Representative Alexander Representative Insko
HB 1271	Clarify Social Services Commission Authority.	Representative Goodwin Representative Cotham

Senate Health Care Committee
Wednesday, June 10, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 243	Mental Health/Law Enforcement Custody.	Representative Steen, II Representative Barnhart
HB 456	Tech. & Org. Changes/Certain DHHS Facilities.	Representative Insko Representative Earle Representative England, M.D. Representative Farmer-Butterfield
HB 896	Cancer Drug Coverage Changes.	Representative Insko Representative Faison Representative England, M.D.
HB 1186	DHHS/Update current inspection practices.-AB	Representative Harrell Representative Earle Representative England, M.D. Representative Alexander
HB 1189	DHHS/Tracking Outpatient Commitments.-AB	Representative Lucas Representative Earle Representative England, M.D. Representative Alexander
HB 1271	Clarify Social Services Commission Authority.	Representative Insko Representative Goodwin Representative Cotham Representative Glazier

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, June 10, 2009

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

FAVORABLE

H.B. **896** Cancer Drug Coverage Changes.
Sequential Referral: None
Recommended Referral: None

H.B.(CS #1) **1271** Clarify Social Services Commission Authority.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 2

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, June 10, 2009 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 AM on June 10, 2009, in Room 544 of the Legislative Office Building. Eighteen members of the committee were present. Senator Purcell, Co-Chair, presided.

An agenda is attached to these minutes as Attachment I. Senator Purcell opened the meeting and announced that due to a just-called meeting, Representative Insko had withdrawn her bills from the Agenda: HB 243, HB 456, and HB 1189.

The meeting began with the consideration of House Bill 1271 entitled AN ACT TO CLARIFY AUTHORITY OF THE SOCIAL SERVICES COMMISSION IN SETTING QUALIFICATIONS FOR STAFF OF RESIDENTIAL CHILD CARE AGENCIES, RESIDENTIAL MATERNITY CARE AGENCIES, AND CHILD PLACING AGENCIES (Attachment II). Representative Goodwin, bill sponsor, explained her bill (Attachment III). Senator Dannelly moved a favorable report for the bill; motion carried.

The next bill brought forth for discussion was House Bill 896 entitled AN ACT TO UPDATE THE CANCER COMPENDIA STATUTE TO REFLECT NEW COMPENDIA THAT ARE AVAILABLE (Attachment IV). Representative Harrell, bill sponsor, explained the bill. A summary is attached as Attachment V. Senator Dorsett moved a favorable report for the bill; motion carried.

Considered next was House Bill 1186 entitled AN ACT TO AUTHORIZE COUNTY DEPARTMENTS OF SOCIAL SERVICES TO CONDUCT FOLLOW-UP MONITORING OF ADULT CARE HOMES TO ENSURE COMPLIANCE WITH STATE AND FEDERAL LAW (Attachment VI). In the absence of bill sponsor, Representative Earle, Senator Purcell called on Shawn Parker of staff to explain the bill (Attachment VIII). A Proposed Senate Committee Substitute (Attachment VII) was sent forth, and its adoption for consideration was moved by Senator Dannelly; motion carried. Discussion followed, questions were raised, and the bill was held until the next meeting for clarification purposes, as requested by Senator Rand.

There being no further business before the Committee, the meeting adjourned at 11:25 a.m..

William R Purcell

Senator William R. Purcell, M.D.
Presiding Co-Chair

Rebecca G Wood

Rebecca Wood, Committee Clerk

fav.
Attachment II

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H 2

HOUSE BILL 1271
Committee Substitute Favorable 5/6/09

Short Title: Clarify Social Services Commission Authority. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO CLARIFY AUTHORITY OF THE SOCIAL SERVICES COMMISSION IN SETTING QUALIFICATIONS FOR STAFF OF RESIDENTIAL CHILD CARE AGENCIES, RESIDENTIAL MATERNITY CARE AGENCIES, AND CHILD PLACING AGENCIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-1 reads as rewritten:

"**§ 131D-1. Licensing of maternity homes.**

(a) The Department of Health and Human Services shall inspect and license all maternity homes established in the State under rules adopted by the Social Services Commission. The Commission shall adopt rules establishing educational ~~requirements~~ requirements; minimum age, relevant experience, and criminal record status for executive directors and staff employed in maternity homes.

(b) Facilities subject to the provisions of this section shall include:

(1) Institutions or homes maintained for the purpose of receiving pregnant women for care before, during, and after delivery, and

(2) Institutions or lying-in homes maintained for the purpose of receiving pregnant women for care before and after delivery, when delivery takes place in a licensed hospital."

SECTION 2. G.S. 131D-10.5 reads as rewritten:

"**§ 131D-10.5. Powers and duties of the Commission.**

In addition to other powers and duties prescribed by law, the Commission shall exercise the following powers and duties:

(1) Adopt, amend and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this Article;

(2) Issue declaratory rulings as may be needed to implement the provisions and purposes of this Article;

(3) Adopt rules governing procedures to appeal Department decisions pursuant to this Article granting, denying, suspending or revoking licenses;

(4) Adopt criteria for waiver of licensing rules adopted pursuant to this Article;

(5) Adopt rules on documenting the use of physical restraint in residential child-care facilities; ~~and~~

(6) Adopt rules establishing personnel and training requirements related to the use of physical restraints and time-out for staff employed in residential child-care ~~facilities.~~facilities; and

(7) Adopt rules establishing educational ~~requirements~~ requirements, minimum age, relevant experience, and criminal record status for executive directors and staff employed by child placing agencies and residential child care facilities."

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

Attachment 11

HOUSE BILL 1271:
Clarify Social Services Commission Authority

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 9, 2009
Introduced by:	Reps. Goodwin, Glazier, Cotham	**Prepared by:**	Shawn Parker
Analysis of:	Second Edition		Legislative Analyst

SUMMARY: House Bill 1271 direct the Social Services Commission to adopt additional qualifications for staff of residential child care, residential maternity care and child placing agencies to include age, experience, and criminal status requirements.

CURRENT LAW:

G.S. 131D-1 authorizes the Department of Health and Human Services (DHHS) to inspect and license all maternity homes in the State under the rules and regulations adopted by the Social Services Commission (Commission).

G.S. 131D-10.5 establishes the powers and duties of the Commission with regard to child placement and child care, which includes rule-making authority.

BILL ANALYSIS: House Bill 1271 would direct the Social Services Commission to adopt rules to establish qualifications (in addition to educational requirements) for executive directors and staff employed in maternity homes and employed by child placing agencies and residential child care facilities. Qualifications would include educational requirements as well as other requirements such as *experience*, *minimum age standards*, and provisions for executive directors and staff with *criminal records*.

The changes proposed in House Bill 1271 would bring consistency in the licensing of child placing agencies for foster care and adoption, residential child care facilities and maternity homes, and would make the educational and experience requirements for executive directors consistent across all agencies.

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

Shirley Iorio contributed to this summary.

H1271-SMSQ-109(e2) v1

fav.
Att. IV

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

HOUSE BILL 896

Short Title:	Cancer Drug Coverage Changes.	(Public)
Sponsors:	Representatives Harrell, England, Faison (Primary Sponsors); K. Alexander, Bell, Glazier, Hall, Harrison, Insko, Jones, Lucas, Pierce, Stevens, Stewart, Wainwright, and Whilden.	
Referred to:	Health, if favorable, Insurance.	

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO UPDATE THE CANCER COMPENDIA STATUTE TO REFLECT NEW COMPENDIA THAT ARE AVAILABLE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-51-59 reads as rewritten:

"**§ 58-51-59. Coverage of certain prescribed drugs for cancer treatment.**

(a) No policy or contract of accident or health insurance, and no preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) ~~The American Medical Association Drug Evaluations;~~ The National Comprehensive Cancer Network Drugs & Biologics Compendium;

(2) ~~The American Hospital Formulary Service Drug Information; or~~ The ThomsonMicromedex DrugDex;

(3) ~~The United States Pharmacopeia Drug Information.~~ The Elsevier Gold Standard's Clinical Pharmacology; or

(4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition."

SECTION 2. G.S. 58-65-94 reads as rewritten:

"**§ 58-65-94. Coverage of certain prescribed drugs for cancer treatment.**

(a) No insurance certificate or subscriber contract under any hospital service plan or medical service plan governed by this Article and Article 66 of this Chapter, and no preferred provider benefit plan under G.S. 58-50-56, that is issued, renewed, or amended on or after

January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) ~~The American Medical Association Drug Evaluations;~~ The National Comprehensive Cancer Network Drugs & Biologics Compendium;

(2) ~~The American Hospital Formulary Service Drug Information; or~~ The ThomsonMicromedex DrugDex;

(3) ~~The United States Pharmacopeia Drug Information.~~ The Elsevier Gold Standard's Clinical Pharmacology; or

(4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition."

SECTION 3. G.S. 58-67-78 reads as rewritten:

"**§ 58-67-78. Coverage of certain prescribed drugs for cancer treatment.**

(a) No health care plan written by a health maintenance organization and in force, issued, renewed, or amended on or after January 1, 1994, and that provides coverage for prescribed drugs approved by the federal Food and Drug Administration for the treatment of certain types of cancer shall exclude coverage of any drug on the basis that the drug has been prescribed for the treatment of a type of cancer for which the drug has not been approved by the federal Food and Drug Administration. The drug, however, must be approved by the federal Food and Drug Administration and must have been proven effective and accepted for the treatment of the specific type of cancer for which the drug has been prescribed in any one of the following established reference compendia:

(1) ~~The American Medical Association Drug Evaluations;~~ The National Comprehensive Cancer Network Drugs & Biologics Compendium;

(2) ~~The American Hospital Formulary Service Drug Information; or~~ The ThomsonMicromedex DrugDex;

(3) ~~The United States Pharmacopeia Drug Information.~~ The Elsevier Gold Standard's Clinical Pharmacology; or

(4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services.

(b) Notwithstanding subsection (a) of this section, coverage shall not be required for any experimental or investigational drugs or any drug that the federal Food and Drug Administration has determined to be contraindicated for treatment of the specific type of cancer for which the drug has been prescribed.

(c) This section shall apply only to cancer drugs and nothing in this section shall be construed, expressly or by implication, to create, impair, alter, limit, notify, enlarge, abrogate, or prohibit reimbursement for drugs used in the treatment of any other disease or condition."

SECTION 4. This act is effective when it becomes law.

Attachment V

HOUSE BILL 896:
Cancer Drug Coverage Changes

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 1, 2009
Introduced by:	Reps. Harrell, England, Faison	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	First Edition		

SUMMARY: House Bill 896 updates the statutorily established reference compendia relating to the coverage of cancer treatment drugs by various health insurance policies.

CURRENT LAW: Chapter 58 is cited and is known as North Carolina's Insurance Law.

Article 51 provides for the Nature of Insurance Policies and Section 59 of this Article provides for the required coverage of certain prescribed drugs for cancer treatment.

Article 65 governs any corporation organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital or medical or dental service plan whereby hospital care or medical or dental service may be provided in whole or in part by the corporation or by hospitals, physicians, or dentists participating in the plan and Section 94 provides for the coverage of certain prescribed drugs for cancer treatment.

Article 67 governs Health Maintenance Organizations in North Carolina and Section 78 of this Article provides for the coverage of certain prescribed drugs for cancer treatment.

BILL ANALYSIS: House Bill 896 amends G.S. 58-51-59, G.S. 58-65-94, and G.S. 58-67-78 by replacing the current accepted reference compendia with the following:

- The National Comprehensive Cancer Network Drugs and Biological Compendium
- The Thomson Micromedex DrugDex
- The Elsevier Gold Standard's Clinical Pharmacology
- Any other authoritative compendia recognized periodically by the United States Secretary of Health and Human Services.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: In 1993, the U.S. Congress directed the Medicare program to refer to 3 existing published compendia, *American Medical Association Drug Evaluations*, *United States Pharmacopoeia Drug Information for the Health Professional*, and *American Hospital Formulary Service Drug Information*, to identify unlabeled but medically accepted uses of drugs and biologicals in anticancer chemotherapy regimens.[1]

American Medical Association Drug Evaluations is no longer published; *United States Pharmacopeia Drug Information for the Health Professional* was discontinued subsumed its contents. *United States Pharmacopeia Drug Information for the Health Professional* was discontinued in 2007 and its contents were rolled into a successor, DrugPoints. In 2008, (CMS) added *Clinical Pharmacology*, DRUGDEX, and *National Comprehensive Cancer Network Drugs and Biologics Compendium* to its list of approved

[1] http://www.annals.org/cgi/content/full/0000605-200903030-00109v1

HOUSE BILL 1186
Committee Substitute Favorable 4/23/09

Short Title: DHHS/Update Current Inspection Practices.-AB (Public)

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE COUNTY DEPARTMENTS OF SOCIAL SERVICES TO CONDUCT FOLLOW-UP MONITORING OF ADULT CARE HOMES TO ENSURE COMPLIANCE WITH STATE AND FEDERAL LAW.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 131D-2(b)(1a)b. reads as rewritten:

"...

(b) Licensure; inspections. –

...

(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this subsection:

a. 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. The Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis, effective July 1, 2007, and thereafter. 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.

b. The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this ~~monitoring and perform any required follow-up inspection.~~monitoring. The county departments of social services shall document in a written report all on-site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit.

...."

SECTION 1.(b) If House Bill 456, 2009 Regular Session, becomes law, this section is repealed.

SECTION 2. If House Bill 456, 2009 Regular Session, becomes law, G.S. 131D-2.11(b) reads as rewritten:

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

...

(b) Monitoring by County. – The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this monitoring. ~~monitoring and perform any required follow up inspection.~~ The county departments of social services shall document in a written report all on site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit."

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

Attachment VII

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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HOUSE BILL 1186
Committee Substitute Favorable 4/23/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H1186-CSSQ-59 [v.1]

6/9/2009 11:26:39 AM

Short Title: DHHS/Update Current Inspection Practices.-AB (Public)

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE COUNTY DEPARTMENTS OF SOCIAL SERVICES TO CONDUCT FOLLOW-UP MONITORING OF ADULT CARE HOMES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2(b)(1a)b. reads as rewritten:

"...

(b) Licensure; inspections. –

...

(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this subsection:

a. 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. The Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis, effective July 1, 2007, and thereafter. 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.

b. The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this ~~monitoring and perform any required follow-up inspection.~~monitoring. The county departments of social services shall document in a written report all on-site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit.

...."

SECTION 2. If House Bill 456, 2009 Regular Session, becomes law, section 1 of this act is repealed.

SECTION 3. If House Bill 456, 2009 Regular Session, becomes law, G.S. 131D-2.11(b) reads as rewritten:

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

...

(b) Monitoring by County. – The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this monitoring. ~~monitoring and perform any required follow up inspection.~~ The county departments of social services shall document in a written report all on site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit."

SECTION 4. This act is effective when it becomes law.

Attachment VIII

HOUSE BILL 1186:
DHHS/Update Current Inspection Practices.-AB

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 9, 2009
Introduced by:	Reps. Earle, M. Alexander, Lucas, England	**Prepared by:**	Shawn Parker
Analysis of:	PCS to Second Edition H1186-CSSQ-59		Legislative Analyst

SUMMARY: ***HB 1186 removes the direction to the Department of Health Service Regulation perform any required follow-up inspections.***

The Proposed Committee substitute corrects the long title and the numbering of the bill sections.

CURRENT LAW:

G.S. 131D-2(b)(1a)b. requires the Department of Health and Human Services to work with county departments of social services to perform routine monitoring in adult care homes. The purpose of the monitoring is to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation. The Division of Health Service Regulation is responsible for oversight of the monitoring and for performing any required follow-up inspections.

BILL ANALYSIS:

Section 1 of House Bill 1186 amends G.S. 131D-2(b)(1a)b. to delete the requirement of Division of Health Service Regulation for performing required follow up inspections.

Section 2 and Section 3 contemplate the enactment of HB 456 which recodifies the current G.S. 131D-2. (House Bill 456 is currently in the Senate Health Care Committee with a serial referral to Finance)

- Section 2 repeals section 1 if House Bill 456, 2009 Regular Session, becomes law.
- If House Bill 456 is enacted, Section 3 amends G.S. 131D-2.11(b) to conform with the amendments in section 1 of House Bill 1186.

EFFECTIVE DATE:

House Bill 1186 would become effective when it becomes law.

Theresa Matula substantially contributed to this summary.

H1186-SMSQ-108(CSSQ-59) v1

Senate Health Care Committee
Wednesday, June 17, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 703	**Disapprove NCMB Rule/Pet. Pub. Certain Japs**	**Representative England, M.D.** **Representative Allen** **Representative Glazier**
HB 819	**Polysomnography Practice Act.**	**Representative Alexander** **Representative Moore** **Representative Wainwright**
HB 672	**Accountability for State Funding/MH/DD/SA.**	**Representative Earle** **Representative Hurley** **Representative Hughes** **Representative Brisson**
HB 1187	**DHHS Technical Changes/Health Care Personnel.**	**Representative Earle** **Representative England, M.D.** **Representative Alexander** **Representative Lucas**
HB 1186	**DHHS/Update current inspection practices.-AB**	**Representative Earle** **Representative England, M.D.** **Representative Alexander** **Representative Lucas**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, June 17, 2009

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

FAVORABLE

H.B.(CS #1) **672** Accountability for State Funding/MH/DD/SA.
Sequential Referral: None
Recommended Referral: None

H.B.(CS #2) **819** Polysomnography Practice Act.
Sequential Referral: Finance
Recommended Referral: None

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **703** Disapprove NCMB Rule/Pet. Pub. Certain Japs
Draft Number: 30412
Sequential Referral: None
Recommended Referral: None
Long Title Amended: Yes

TOTAL REPORTED: 3

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, June 18, 2009

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

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **1186** DHHS/Update current inspection practices.-AB

Draft Number:	50739
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

HB 1186 Senator Purcell to handle on the floor

SENATE HEALTH CARE COMMITTEE
Wednesday, June 17, 2009 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, June 17, 2009, in Room 544 of the Legislative Office Building, with twenty-one members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Bingham asked for a motion to hear the Proposed Committee Substitute for House Bill 703, ***Disapprove NCMB Rule/Pet. Pub. Certain JAPS***. Senator Queen made the motion to hear the PCS, which passed. Representative Glazier explained it had several sections, but stated essentially it resolved a legitimate dispute between the NC Medical Society and the NC Medical Board. Last session Rep. Allen lead a very omnibus bill that dealt with public disclosure of situations in which there were judgments, awards, payments, and settlements (JAPS) relating to certain types of medical mal-practice cases and medical negligence cases in order to provide significant consumer information to the public. Following the legislation, part of it allowed certain components to go into rule making. At the rule making stage there were disagreements that developed on a couple of the minor provisions. This bill, HB 703, disapproved the rules and would seek to correct them and put into place the appropriate provisions and settle the dispute. Representative Glazer pointed out that in Section 3 the bill sets out the reporting and publications of medical judgments awards, payments and settlements. It would require disclosure for all payments in aggregated amounts of seventy-five thousand dollars ($75,000.00) or more. Rep. Glazer stated that there would be an amendment, which would cover some small language that the parties have agreed on. He also stated there was no opposition. Rep. Allen spoke in favor of the bill and complimented Rep. Glazer and The Medical Board and The Medical Society for working hard and agreeing on the $75,000.00. Sen. Purcell was recognized to present his amendment, who called on, Shawn Parker, Staff Attorney to explain. Shawn Parker stated it applied to section 3 under subsection (a) and subdivision (3) and it clarified that language. Senator Rand asked if this applied to the aggregate amount or present value. Shawn Parker, Staff Attorney, replied it would be the aggregate amount. Senator Rand also inquired after looking at the language, that it did not contain individual identified numeric value, meaning you do not report the monetary amount. Rep. Glazier stated the monetary amount was not a part of the report. Senator Allran moved for a favorable report on the amendment and it passed. Senator Allran also moved to pass the bill too. Senator Bingham asked to hold that motion in order for committee members to ask questions. Senator Forrester asked if Nurse Practitioners would be included. Rep. Allen responded that it only applied to the two groups mentioned, Physicians or Physician Assistants. Senator Forrester asked where did the seven years come from. Rep. Allen stated it was language agreed on by The Medical Society and Medical Board. Senator Forrester asked about publishing the information if there was an appeal, referring to the top of page three. Rep. Glazier responded that simply because the case was on appeal,

the public should still know, after all it was already quite public; the jury would have already told them they were guilty. Senator Rucho also agreed that the person's reputation would be damaged, even if the appeal were overturned. Rep. Glazier stated this report would be to inform the consumers and also allow the Physicians a chance for a rebuttal to inform that their case was on appeal. Senator Allran pointed out not many judgments in this state get that far. He also stated that if a case gets that far, normally other physicians want them weeded out too. Senator Allran also stated he felt if there were any problems with this bill, the medical committee would be here today to oppose it. Senator Dannelly asked if the appeal was carried out and reverted, would that also be reported. Rep. Glazier stated, "absolutely". Senator Allran made the motion to roll the amendment into another Proposed Committee Substitute, unfavorable as to the original bill, favorable as to the PCS. The motion passed.

Senator Bingham called on Rep. Alexander to present House bill 819, ***Polysomnography Practice Act.*** Rep. Alexander explained that polysomnography dealt with sleep. She also pointed out that Senator Atwater had the senate companion bill. Basically the bill would establish registration procedures from the medical personnel who perform sleep studies under the directions and supervision of a physician. She stated this field was growing very rapidly and this bill would allow the patients and others to know if the sleep technologists were certified and had achieved the appropriate level of training. The NC Association of Sleep Technologist, the NC Medical Board, the NC Medical Society, the NC Hospital Association, the NC Nurses Association, the NC Respiratory Care Board, and the NC Society supported HB 819. Senator Dannelly moved for a favorable report. Senator Allran asked where the bill came from. Rep. Alexander answered the people involved, the physicians and the technologist. Senator Bingham stated there was a sequential referral to Finance. Senator Dannelly had already moved for a favorable report. The motion carried and the bill was referred to Finance.

Senator Bingham called on Rep. Earle to present HB 672, ***Accountability for State Funding/MH/DD/SA.*** Rep. Earle stated HB 672 had support of the advocates, the providers, Department of Health and Human Services (DHHS), and the Local Management Entity (LME). The first section of the bill requires LME's that use single stream funding to report all allocations of service dollars on a bi-annual basic and to have comments at their regularly scheduled meetings. The second section focuses on HUD, Group Homes, and Apartments. Rep. Earle stated that the General Assembly appropriated funds for Group Homes and it was used in conjunctions with Federal Funding. The removal of any of our state dollars could possibility jeopardize the agreement with the FED's as far as getting Federal Funds. The last section directs DHHS to analyze the effectiveness of single streamed funding and to report to the Mental Health Oversight Committee and the Health and Human Services (sub) committees. Senator Kinnaird stated she had spoken to someone that had a non-profit which provided services and stated that one problem they had was, LME's were withholding money they have

already received from the state, instead of disbursing it to the providers. She questioned would this bill make a difference in making sure the providers were getting their monies. Rep. Earle responded she did not think this bill would have any direct impact on that issue. Senator Kinnaird pointed out that maybe the reporting requirement might affect it; in the sense that they may have to show they were not dispersing the money. Senator Rand asked about the prompt pay legislation, inquiring if it applied to LME's. Leza Wainwright, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, DHHS, stated that they do have in their contracts with the Local Management Entities prompt pay requirements and they can deal with the LMEs. DHHS contracts with each of the LME entities per the directions of the NC General Assembly. Part of the contractual agreement is obligating them to promptly pay their providers. Senator Rand asked if the provider could charge interest. Leza Wainwright, Division of Mental Health, stated currently their prompt pay does not include a requirement to pay interest. Senator Rand also asked what single streamed funding means. Rep. Earle replied that LMEs gets a lump sum and then it was provided out from there, while the others get their monies as a line item. Senator Rand asked what determined if they were single streamed or other funding. Leza Wainwright, DHHS, Mental Health, responded that they have to apply and meet the right criteria, and if they do not meet the criteria the single streamed funding can be removed. Sen. Rand asked how many qualify. Leza Wainwright replied there are 24 LMEs and 11 are on single streamed funding. Senator Rand asked if any had applied and been turned down. Leza replied yes, some have been turned down. Senator Dannelly moved for a favorable report. Senator Brunstetter asked about the public comment portion, and inquired, do they have public comments now. Rep. Earle stated they do not have public comments now, but the bill now required a public hearing on a bi-annual basis. Senator Dannelly had previously moved for a favorable report. The bill passed.

Senator Bingham again called on Rep. Earle to explain, HB 1187, ***DHHS Technical Changes/Health Care Personnel.*** Rep. Earle stated that this was an agency bill from the Department of Health and Human Services. Rep. Earl explained it made some technical changes. It changed the word "nurse aid" to "health care personnel". It clarified that only a single finding of residential neglect may be considered for removal, which conforms to existing Federal Law. It also clarified that a petition for a contested case hearing had to be filed within 30 days of the mailing of the written notice of the Department's denial of removal of the finding. The last section permits the health care facility to provide the social security number just to make sure they are dealing with the right person. Senator Rand asked if a person had their name added to the registry and after the passage of a year could they petition for the removal of their name. Jesse Goodman, Division of Health Services Regulation in DHHS, stated that at the end of a

year, and if they only have one violation, they can petition the Department to have their name removed so long as they meet certain conditions. Senator Rand asked if they had another violation in five years could they have it removed again. Jesse Goodman replied that would probable be no, due to the fact they had already had a previous finding of neglect. Although their name was removed from the registry the fact that the act happened would still be recorded. Sen. Rand expressed concerns that he could not see that in the bill and stated it should be spelled out clearly; that it would not be allowed more than once. Senator Rand inquired of staff their opinion. Ben Popkin, Staff Attorney stated it did not appear that there was anything in the language of the statutes which, really provided certain clarity that one would not be allowed to petition again for removal. He stated that one could certainly include language limiting it to a one-time occurrence. Senator Rand stated he would like to run an amendment. The bill was displaced, due to shortage of time, in order to get the amendment crafted.

Senator Bingham asked Rep. Earle, to explain her last bill, HB 1186, ***DHHS/Update current inspection practices.-AB***. which, was discussed at length during the last meeting. Senator Foriest made the motion to hear the PCS, which passed. Rep. Earle explained that currently the law required DHHS to work with the county departments of social services to perform routine monitoring in adult care homes. HB 1186 would remove the direction to the Department of Health Service Regulation to perform any required follow-up inspections. DHHS would still do annual inspections. Senator Rand had asked at the last meeting about the state portion being in the statutes. Shawn Parker, Staff Attorney stated that the statute in its entirety was included in the packet of material today. He pointed out subsection C addressed the question that was asked at the previous meeting. Senator Dannelly moved for an unfavorable report as to the original bill, favorable as to the Proposed Committee Substitute. The motion passed.

The meeting adjourned at 11:50 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee

HOUSE BILL 703
Committee Substitute Favorable 3/24/09
Third Edition Engrossed 3/31/09

Short Title: Disapprove NCMB Rule/Rept. Pub. Certain JAPS. (Public)

Sponsors:

Referred to:

March 23, 2009

A BILL TO BE ENTITLED

AN ACT TO DISAPPROVE RULES ADOPTED BY THE NORTH CAROLINA MEDICAL BOARD AND APPROVED BY THE RULES REVIEW COMMISSION AND TO REQUIRE THE NORTH CAROLINA BOARD OF MEDICINE TO PUBLISH CERTAIN JUDGMENTS, AWARDS, PAYMENTS, AND SETTLEMENTS.

The General Assembly of North Carolina enacts:

SECTION 1. Pursuant to G.S. 150B-21.3(b1), 21 NCAC 32X .0103 (Reporting of Medical Judgments, Awards, Payments or Settlements) and 21 NCAC 32X .0105 (Publication of Judgments, Awards, Payments or Settlements), as adopted by the North Carolina Medical Board on July 16, 2008, and approved by the Rules Review Commission on August 21, 2008, are disapproved.

SECTION 2. G.S. 90-5.2(a) reads as rewritten:

"**§ 90-5.2. Board to collect and publish certain data.**

(a) The Board shall require all physicians and physician assistants 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.

(3) Any specialty board of certification as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.

(4) Specialty area of practice.

(5) Hospital affiliations.

(6) Address and telephone number of the primary practice setting.

(7) An e-mail address or facsimile number which shall not be made available to the public and shall be used for the purpose of expediting the dissemination of information about a public health emergency.

(8) Any final disciplinary order or other action required to be reported to the Board pursuant to G.S. 90-14.13 that results in a suspension or revocation of privileges.

(9) Any final disciplinary order or action of any regulatory board or agency including other state medical boards, the United States Food and Drug Administration, the United States Drug Enforcement Administration, Medicare, or the North Carolina Medicaid program.
(10) Conviction of a felony.
(11) Conviction of certain misdemeanors, occurring within the last 10 years, in accordance with rules adopted by the Board.
(12) Any medical license, active or inactive, granted by another state or country.
(13) Certain malpractice information received pursuant to ~~G.S. 90-14.13~~G.S. 90-5.3, G.S. 90-14.13, or from other sources in accordance with rules adopted by the Board."

SECTION 3. Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 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 shall report to the Board:
(1) All medical malpractice judgments or awards affecting or involving the physician or physician assistant.
(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 where the settlement occurred on or after May 1, 2008.
(3) All payments in the aggregate 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 not already reported pursuant to subdivision (2) of this subsection where the full payment or first payment of a series of payments occurred on or after May 1, 2008.

(b) The report required under subsection (a) of this section shall contain the following information:
(1) The date of judgment, award, payment, or settlement.
(2) The specialty in which the physician or physician assistant 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 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, 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 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 703
Committee Substitute Favorable 3/24/09
Third Edition Engrossed 3/31/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H703-CSRO-61 [v.1]

6/16/2009 10:18:59 PM

Short Title: Disapprove NCMB Rule/Rept. Pub. Certain JAPS. (Public)

Sponsors:

Referred to:

March 23, 2009

A BILL TO BE ENTITLED

AN ACT TO DISAPPROVE RULES ADOPTED BY THE NORTH CAROLINA MEDICAL BOARD AND APPROVED BY THE RULES REVIEW COMMISSION, TO REQUIRE THE NORTH CAROLINA BOARD OF MEDICINE TO PUBLISH CERTAIN JUDGMENTS, AWARDS, PAYMENTS, AND SETTLEMENTS, TO DISAPPROVE A RULE ADOPTED BY THE DEPARTMENT OF LABOR AND TO AUTHORIZE THE ADOPTION OF A TEMPORARY RULE TO REPLACE THE DISAPPROVED RULE.

The General Assembly of North Carolina enacts:

SECTION 1. Pursuant to G.S. 150B-21.3(b1), 21 NCAC 32X .0103 (Reporting of Medical Judgments, Awards, Payments or Settlements) and 21 NCAC 32X .0105 (Publication of Judgments, Awards, Payments or Settlements), as adopted by the North Carolina Medical Board on July 16, 2008, and approved by the Rules Review Commission on August 21, 2008, are disapproved.

SECTION 2. G.S. 90-5.2(a) reads as rewritten:

"**§ 90-5.2. Board to collect and publish certain data.**

(a) The Board shall require all physicians and physician assistants 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.

(3) Any specialty board of certification as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.

(4) Specialty area of practice.

(5) Hospital affiliations.

(6) Address and telephone number of the primary practice setting.

(7) An e-mail address or facsimile number which shall not be made available to the public and shall be used for the purpose of expediting the dissemination of information about a public health emergency.

(8) Any final disciplinary order or other action required to be reported to the Board pursuant to G.S. 90-14.13 that results in a suspension or revocation of privileges.

(9) Any final disciplinary order or action of any regulatory board or agency including other state medical boards, the United States Food and Drug Administration, the United States Drug Enforcement Administration, Medicare, or the North Carolina Medicaid program.

(10) Conviction of a felony.

(11) Conviction of certain misdemeanors, occurring within the last 10 years, in accordance with rules adopted by the Board.

(12) Any medical license, active or inactive, granted by another state or country.

(13) Certain malpractice information received pursuant to ~~G.S. 90-14.13~~G.S. 90-5.3, G.S. 90-14.13, or from other sources in accordance with rules adopted by the Board."

SECTION 3. Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 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 shall report to the Board:

(1) All medical malpractice judgments or awards affecting or involving the physician or physician assistant.

(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 where the settlement occurred on or after May 1, 2008.

(3) All payments in the aggregate 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 not already reported pursuant to subdivision (2) of this subsection where the full payment or first payment of a series of payments occurred on or after May 1, 2008.

(b) The report required under subsection (a) of this section shall contain the following information:

(1) The date of judgment, award, payment, or settlement.

(2) The specialty in which the physician or physician assistant 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 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, 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 4. Notwithstanding G.S. 150B-21.3(b1), 13 NCAC 07F.0901 (Scope) as adopted by the Department of Labor on February 19, 2009, and approved by the Rules Review Commission on March 19, 2009, is disapproved.

SECTION 5. Notwithstanding G.S. 150B-21.1, upon the effective date of this act, the Department of Labor shall immediately adopt a temporary rule that is consistent with the requirements of Section 6 of this act without prior notice or hearing. When the Department adopts the rule, it shall submit the rule and a copy of this act to the Codifier of Rules. Within two business days after submission of the rule, the Codifier must review the rule to determine whether the rule as adopted is consistent with the requirements of this act. If the Codifier of Rules finds that the rule as adopted is consistent with the requirements of this act, the Codifier shall notify the Department and enter the rule in the North Carolina Administrative Code on the sixth business day following approval by the Codifier of Rules. The rule shall become effective and shall expire in accordance with G.S. 150B-21.1(d).

SECTION 6. The Department of Labor shall adopt a temporary rule in accordance with the procedure set forth in Section 5 of this act. The temporary rule shall establish the scope of application for the Department's rules governing the standards for cranes and derricks in a manner substantially identical to the rule disapproved by this act, except that the temporary rule shall include an exclusion for service trucks with mobile lifting devices designed specifically for use in the power line and electric service industries such as digger derricks (radial boom derricks).

SECTION 7. This act is effective when it becomes law.

HOUSE BILL 703: Disapprove NCMB Rule/Rept. Pub. Certain JAPS

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 9, 2009
Introduced by:	Reps. Glazier, Allen, England	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	Third Edition		

SUMMARY: ***House Bill 703 disapproves two rules adopted by the North Carolina Medical Board pursuant to G.S. 90-5.2(a)(13) relating to the required reporting and subsequent publication of certain medical judgments, awards, payments, or settlements.***

The bill adds a new section to Chapter 90 which requires physicians and physician assistants to report certain medical judgments, awards, payments, or settlements, provides details on what must be included in the report, directs the Board to publish this information, and sets standards for that publication.

CURRENT LAW: Article 1 of Chapter 90 (Practice of Medicine) directs the North Carolina Medical Board to collect and publish as provided certain data. This includes certain malpractice information received pursuant to current law and in accordance with rules adopted by the Board.

The Administrative Procedures Act, Chapter 150B of the North Carolina General Statutes, provides permanent rules approved by the Rules Review Commission become effective on the first day of the month following the month the rule is approved unless the Commission receives written objections from 10 or more people clearly requesting legislative review.

A rule cannot then become effective before the 31st legislative day of the next General Assembly. Prior to the 31st legislative day, any member may introduce a bill to disapprove the rule. Once a bill is introduced, the rule cannot become effective until an unfavorable action is taken on the bill or the General Assembly adjourns without ratifying the bill.

BILL ANALYSIS:

Section 1 disapproves rule 21 NCAC 32X.0103 and rule 21 NCAC 32X.0105 which relate to the reporting and publication of medical judgments, awards, payments, and settlements. **The rules are attached to this summary.**

Section 2 amends Chapter 90 of the General Statutes by adding a new section which requires licensed physician and physician assistants or candidates for licensure to report to the North Carolina Medical Board:

- All medical judgments or awards.
- All settlements $75,000 or greater occurring on or after May 1, 2008.
- All payments in the aggregate amount of $75,000 or more where the full or first payment occurs on or after May 1, 2008.

The section provides that the report must contain specifics relating to the date and location of the incident and date of the award as well as the specialty the physician/physician assistant was practicing at the time of the incident.

The section further directs the Board to publish the information for a period of *7 years* from the date of the judgment, award, payment, or settlement (award). The section provides the publication **shall not** include individually identifiable numerical values of the award, nor the identity of the patient associated with the award, but shall allow the physician or physician assistant to publish an explanatory statement so long as it conforms with the ethics of the profession and the previously identified standards.

EFFECTIVE DATE: This act is effective when it becomes law.

21 NCAC 32X .0103 REPORTING OF MEDICAL JUDGMENTS, AWARDS, PAYMENTS AND SETTLEMENTS

(a) All physicians and physician assistants licensed by the Board or applying for licensure by the Board shall report all medical malpractice judgments, awards, payments and settlements or more occurring on or after, affecting or involving the physician or physician assistant on an application for licensure and annual renewal. Additionally, all physicians and physician assistant licensed by the Board shall report all medical malpractice judgments, awards, payments and settlements greater than twenty-five thousand dollars ($25,000) occurring on or after October 1, 2007, affecting or involving the physician or physician assistant within 60 days of the judgment, award, payment or settlement. If a physician or physician assistant is unsure whether a medical malpractice judgment, award, payment, or settlement affects or involves him or her, he/she shall report that information, and the Board shall determine whether the information shall be published.

(b) A settlement shall include a lump sum payment or the first payment of multiple payments (whichever comes first), a payment made from personal funds, or payment by a third party on behalf of a physician or physician assistant.

21 NCAC 32X .0105 PUBLICATION OF JUDGMENTS, AWARDS, PAYMENTS OR SETTLEMENTS

(a) "Publish" means posting on the Board's Web site or other publications.

(b) For each physician or physician assistant, the Board shall publish:

(1) all judgments, awards, payments or settlements greater than twenty-five thousand dollars ($25,000) within the past seven years. However, the Board shall not publish any judgment, award, payment or settlement prior to October 1, 2007, the effective date of G.S. 90-5.2;

(2) the date of the incident that led to the judgment, award, payment or settlement and the date of the judgment, award, payment or settlement; and

(3) whether public disciplinary action was taken based on the Board's review of the care that led to the judgment, award, payment, or settlement.

(c) The Board shall not release or publish the individually identifiable numeric values of the reported judgment, award, payment or settlement or the identity of the patient associated with the judgment, award, payment or settlement.

(d) For each malpractice judgment, award, payment or settlement that is published, the physician or physician assistant may provide a statement explaining the circumstances that led to the judgment, award, payment or settlement, and whether the case is under appeal. The statement must conform to the ethics of the medical profession. The physician or physician assistant shall not publish identifiable numeric values of reported judgments, awards, payments or settlements. The physician or physician assistant shall not disclose the patient's identity, including information relating to dates and places of treatment or any other information that would tend to identify the patient. The Board may edit such statements to ensure conformity with this rule.

H703-SMSQ-106(e3) v1

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 703

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

H703-ASQ-89 [v.2]

Comm. Sub. [YES]
Amends Title [NO]
Third Edition

Date _____,2009

Senator Purcell

moves to amend the PCS on page 2, lines 30-35, by rewriting the lines to read:

"(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 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 are a series of payments made to the same claimant which, in the aggregate equal or exceed seventy-five thousand dollars ($75,000).".

SIGNED William R Purcell
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 703
Committee Substitute Favorable 3/24/09
Third Edition Engrossed 3/31/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H703-PCS30412-RO-61

Short Title: Disapprove NCMB Rule/Rept. Pub. Certain JAPS. (Public)

Sponsors:

Referred to:

March 23, 2009

A BILL TO BE ENTITLED

AN ACT TO DISAPPROVE RULES ADOPTED BY THE NORTH CAROLINA MEDICAL BOARD AND APPROVED BY THE RULES REVIEW COMMISSION, TO REQUIRE THE NORTH CAROLINA BOARD OF MEDICINE TO PUBLISH CERTAIN JUDGMENTS, AWARDS, PAYMENTS, AND SETTLEMENTS, TO DISAPPROVE A RULE ADOPTED BY THE DEPARTMENT OF LABOR AND TO AUTHORIZE THE ADOPTION OF A TEMPORARY RULE TO REPLACE THE DISAPPROVED RULE.

The General Assembly of North Carolina enacts:

SECTION 1. Pursuant to G.S. 150B-21.3(b1), 21 NCAC 32X .0103 (Reporting of Medical Judgments, Awards, Payments or Settlements) and 21 NCAC 32X .0105 (Publication of Judgments, Awards, Payments or Settlements), as adopted by the North Carolina Medical Board on July 16, 2008, and approved by the Rules Review Commission on August 21, 2008, are disapproved.

SECTION 2. G.S. 90-5.2(a) reads as rewritten:

"**§ 90-5.2. Board to collect and publish certain data.**

(a) The Board shall require all physicians and physician assistants 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.

(3) Any specialty board of certification as approved by the American Board of Medical Specialties, the Bureau of Osteopathic Specialists of American Osteopathic Association, or the Royal College of Physicians and Surgeons of Canada.

(4) Specialty area of practice.

(5) Hospital affiliations.

(6) Address and telephone number of the primary practice setting.

(7) An e-mail address or facsimile number which shall not be made available to the public and shall be used for the purpose of expediting the dissemination of information about a public health emergency.
(8) Any final disciplinary order or other action required to be reported to the Board pursuant to G.S. 90-14.13 that results in a suspension or revocation of privileges.
(9) Any final disciplinary order or action of any regulatory board or agency including other state medical boards, the United States Food and Drug Administration, the United States Drug Enforcement Administration, Medicare, or the North Carolina Medicaid program.
(10) Conviction of a felony.
(11) Conviction of certain misdemeanors, occurring within the last 10 years, in accordance with rules adopted by the Board.
(12) Any medical license, active or inactive, granted by another state or country.
(13) Certain malpractice information received pursuant to ~~G.S. 90-14.13~~G.S. 90-5.3, G.S. 90-14.13, or from other sources in accordance with rules adopted by the Board."

SECTION 3. Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 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 shall report to the Board:
(1) All medical malpractice judgments or awards affecting or involving the physician or physician assistant.
(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 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 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 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 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, 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 4. Notwithstanding G.S. 150B-21.3(b1), 13 NCAC 07F.0901 (Scope) as adopted by the Department of Labor on February 19, 2009, and approved by the Rules Review Commission on March 19, 2009, is disapproved.

SECTION 5. Notwithstanding G.S. 150B-21.1, upon the effective date of this act, the Department of Labor shall immediately adopt a temporary rule that is consistent with the requirements of Section 6 of this act without prior notice or hearing. When the Department adopts the rule, it shall submit the rule and a copy of this act to the Codifier of Rules. Within two business days after submission of the rule, the Codifier must review the rule to determine whether the rule as adopted is consistent with the requirements of this act. If the Codifier of Rules finds that the rule as adopted is consistent with the requirements of this act, the Codifier shall notify the Department and enter the rule in the North Carolina Administrative Code on the sixth business day following approval by the Codifier of Rules. The rule shall become effective and shall expire in accordance with G.S. 150B-21.1(d).

SECTION 6. The Department of Labor shall adopt a temporary rule in accordance with the procedure set forth in Section 5 of this act. The temporary rule shall establish the scope of application for the Department's rules governing the standards for cranes and derricks in a manner substantially identical to the rule disapproved by this act, except that the temporary rule shall include an exclusion for service trucks with mobile lifting devices designed specifically for use in the power line and electric service industries such as digger derricks (radial boom derricks).

SECTION 7. This act is effective when it becomes law.

HOUSE BILL 819*
Committee Substitute Favorable 5/28/09
Committee Substitute #2 Favorable 6/3/09

Short Title: Polysomnography Practice Act. (Public)

Sponsors:

Referred to:

March 30, 2009

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE POLYSOMNOGRAPHY PRACTICE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"Article 39A.

"Polysomnography Practice Act.

"**§ 90-677.1. Definitions.**

The following definitions apply in this Article:

(1) Board. – The Board of Registered Polysomnographic Technologists (BRPT), a member of the National Organization of Certification Associations and accredited by the National Commission for Certifying Agencies (NCCA), the accreditation body of the National Organization for Competency Assurance (NOCA).

(2) Direct supervision. – An act whereby a registered polysomnographic technologist who is providing supervision is present in the area where the polysomnographic procedure is being performed and immediately available to furnish assistance and direction throughout the performance of the procedure.

(3) General supervision. – The authority and responsibility to direct the performance of activities as established by policies and procedures for safe and appropriate completion of polysomnography services whereby the physical presence of a licensed physician is not required during the performance of the polysomnographic procedure, but the licensed physician must be available for assistance, if needed.

(4) Licensed physician. – A physician licensed to practice medicine under Article 1 of Chapter 90 of the General Statutes.

(5) Polysomnography. – The allied health specialty involving the process of attended and unattended monitoring, analysis, and recording of physiological data during sleep and wakefulness to assist in the assessment of sleep and wake disorders and other sleep disorders, syndromes, and dysfunctions that are sleep-related, manifest during sleep, or disrupt normal sleep and wake cycles and activities.

(6) Registered polysomnographic technologist. – A person who is credentialed by the Board and entitled to use 'Registered Polysomnographic Technologist' (RPSGT) as the person's credential.

(7) Secretary. – The Secretary of State of North Carolina.
(8) Student. – A person who is enrolled in a polysomnography educational program approved by the Board as an acceptable pathway to meet eligibility requirements for credentialing.

"**§ 90-677.2. Practice of polysomnography.**

(a) The 'practice of polysomnography' means the performance of any of the following tasks:

(1) Monitoring and recording physiological data during the evaluation of sleep-related disorders, including sleep-related respiratory disturbances, by applying the following techniques, equipment, or procedures:
a. Positive airway pressure (PAP) devices, such as continuous positive airway pressure (CPAP), and bilevel and other approved devices, providing forms of pressure support used to treat sleep disordered breathing on patients using a mask or oral appliance; provided, the mask or oral appliance does not attach to an artificial airway or extend into the trachea.
b. Supplemental low flow oxygen therapy, up to eight liters per minute, utilizing nasal cannula or administered with continuous or bilevel positive airway pressure during a polysomnogram.
c. Capnography during a polysomnogram.
d. Cardiopulmonary resuscitation.
e. Pulse oximetry.
f. Gastroesophageal pH monitoring.
g. Esophageal pressure monitoring.
h. Sleep staging, including surface electroencephalography, surface electrooculagraphy, and surface submental or masseter electromyography.
i. Surface electromyography.
j. Electrocardiography.
k. Respiratory effort monitoring, including thoracic and abdominal movement.
l. Plethysmography blood flow monitoring.
m. Snore monitoring.
n. Audio and video monitoring.
o. Body movement.
p. Nocturnal penile tumescence monitoring.
q. Nasal and oral airflow monitoring.
r. Body temperature monitoring.
s. Actigraphy.

(2) Observing and monitoring physical signs and symptoms, general behavior, and general physical response to polysomnographic evaluation and determining whether initiation, modification, or discontinuation of a treatment regimen is warranted based on protocol and physician's order.

(3) Analyzing and scoring data collected during the monitoring described in subdivisions (1) and (2) of this subsection for the purpose of assisting a licensed physician in the diagnosis and treatment of sleep and wake disorders.

(4) Implementing a written or verbal order from a licensed physician that requires the practice of polysomnography.

(5) Educating a patient regarding polysomnography and sleep disorders.

(b) The practice of polysomnography shall be performed under the general supervision of a licensed physician.

(c) The practice of polysomnography shall take place in a hospital, a stand-alone sleep laboratory or sleep center, or a patient's home. However, the scoring of data and education of patients may take place in settings other than a hospital, stand-alone sleep laboratory or sleep center, or patient's home.

"**§ 90-677.3. Unlawful acts; injunctive relief.**

(a) On or after January 1, 2012, it shall be unlawful for a person to practice polysomnography; to represent, orally or in writing, that the person is credentialed to practice polysomnography; or to use the title 'Registered Polysomnographic Technologist' or the initials 'RPSGT' unless that person is currently listed with the Secretary as provided in this Article.

(b) Complaints and investigations of violations of this Article shall be directed to and conducted by the Board.

(c) A violation of subsection (a) of this section is a Class 1 misdemeanor. The court may issue injunctions or restraining orders to prevent further violations under this Article.

"**§ 90-677.4. Exemptions.**

The provisions of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State if the person is performing work incidental to or within the scope of practice of that profession or occupation and the person does not represent himself or herself as a registered polysomnographic technologist.

(2) An individual employed by the United States government when performing duties associated with that employment.

(3) Research investigation that monitors physiological parameters during sleep or wakefulness provided that the research investigation has been approved and deemed acceptable by an institutional review board, follows conventional safety measures required for the procedures, and the information is not obtained or used for the practice of clinical medicine.

(4) A physician licensed to practice medicine under Article 1 of Chapter 90 of the General Statutes or a physician's assistant or nurse practitioner licensed to perform medical acts, tasks, and functions under Article 1 of Chapter 90 of the General Statutes.

(5) A student actively enrolled in a polysomnography education program if:

a. Polysomnographic services and post-training experience are performed by the student as an integral part of the student's course of study;

b. The polysomnographic services are performed under the direct supervision of a registered polysomnographic technologist; and

c. The student adheres to post-training examination guidelines established by the Board.

"**§ 90-677.5. Listing by Secretary.**

(a) Before engaging in the practice of polysomnography pursuant to this Article, each registered polysomnographic technologist shall remit to the Secretary a fee of fifty dollars ($50.00) and file with the Secretary the following:

(1) The registered polysomnographic technologist's full legal name.

(2) The registered polysomnographic technologist's complete address and telephone number.

(3) The date the registered polysomnographic technologist was credentialed by the Board.

The Secretary shall not list a registered polysomnographic technologist until the registered polysomnographic technologist has presented to the Secretary a copy of the registered polysomnographic technologist's Board-credentialing document or has arranged for the Board to electronically notify the Secretary of the registered polysomnographic technologist's credentials and the Secretary has received notice from the Board. The Secretary shall develop a form for applicants seeking to file as registered polysomnographic technologists and may require that filing be made by electronic filing and electronic fee payment. A filing with the Secretary is void if a check or other payment of a required fee is returned to the Secretary by the issuing institution for insufficient funds or other similar reason.

(b) The Secretary shall maintain a listing of all current registered polysomnographic technologists. All fees paid to the Secretary shall be used to pay the costs incurred in administering this Article. The Board shall promptly notify the Secretary, by mail or electronic means, when a person's credential is revoked or no longer in effect. If the Secretary is notified that a registrant's credential is revoked or no longer in effect, the Secretary shall promptly amend the listing in accordance with the Board's notice.

(c) A listing automatically expires on the 30th day of September of each year. A listing shall be renewed annually upon the filing of a new listing form, credential verification, and filing fee."

SECTION 2. No later than six months from the effective date of this act, the North Carolina Medical Board shall identify the standards of physician supervision of persons registered to practice as registered polysomnographic technologists under Article 39A of Chapter 90 of the General Statutes, as enacted in Section 1 of this act. The North Carolina Medical Board shall communicate the standards of supervision to all physicians licensed to practice medicine under Article 1 of Chapter 90 of the General Statutes.

SECTION 3. This act becomes effective October 1, 2009.

HOUSE BILL 819:
Polysomnography Practice Act

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	**Date:**	June 16, 2009
Introduced by:	Reps. M. Alexander, Wainwright, Moore	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	Third Edition		

SUMMARY: ***House Bill 819 makes it unlawful for a person to practice polysomnography, or to represent that they are credentialed to practice polysomnography, unless the person has filed a copy of their credentials as a registered polysomnologist from the Board of Registered Polysomnographic Technologists (BRPT) with the Secretary of State and paid a $50 filing fee by January 1, 2012. Polysomnography is defined as an allied health specialty involving the process of attended and unattended monitoring, analysis, and recording of physiological data during sleep and wakefulness to assist in the assessment of sleep and sleep related disorders.***

BILL ANALYSIS: ***Section 1*** of House Bill 819 adds a new Article 39A to Chapter 90 of the General Statutes, the Polysomnography Practice Act.

G.S. 90-677.1 sets forth definitions of terms used in the act, including the definition of "polysomnography", the "Board of Registered Polysomnographic Technologists" (BRPT), and "registered polysomnographic technologist". Polysomnography is defined as an allied health specialty involving the process of attended and unattended monitoring, analysis, and recording of physiological data during sleep and wakefulness to assist in the assessment of sleep and wake disorders and dysfunctions that are sleep related. The BRPT is the credentialing organization for registered polysomnographic technologists. A "registered polysomnographic technologist" is a person credentialed by the Board.

G.S. 90-677.2 defines the practice of polysomnography to include:

- Monitoring and recording physiological data during the evaluation of sleep-related disorders through listed procedures, techniques, and equipment.
- Observing and monitoring physical signs and symptoms, general behavior and physical response to polysonmographic evaluation and determining treatment regimens based on protocols and physician order.
- Analyzing and scoring data collected during monitoring.
- Implementing physician orders that require the practice of polysomnography.
- Patient education regarding sleep disorders and polysomnography.

Except for the scoring of data and patient education, the practice of polysomnography shall take place in a hospital, sleep laboratory or clinic or in the patient's home.

G.S. 90-677.3 makes it unlawful, on or after January 1, 2012, to practice polysomnography, or to represent that one is credentialed to practice unless the person is listed with the Secretary of State. Complaints and investigations of violations of the Article shall be directed to and conducted by the Board. The practice of polysomnography without listing with the Secretary is a Class 1 misdemeanor, and a court may issue an injunction or restraining order to prevent further violations.

G.S. 90-677.4 lists the exemptions to the Article. Exemptions include:

- Persons registered, credentialed or licensed to engage in another profession or occupation, or person working under the supervision of such a person, if the person is performing work incidental to or within the scope of practice of that profession or occupation and the person does not represent themselves to be a registered polysomnographic technologist.
- A person employed by the federal government when performing their government duties.
- Research investigations that monitor physiological parameters during sleep/wakefulness provided the research investigations have been approved by an institutional review board, follow conventional safety measures, and are not obtained/used for the practice of clinical medicine.
- A licensed physician, physician's assistant, or nurse practitioner.
- A student in a polysomnographic education program if the activities are part of the student's course of study, are performed under direct supervision, and the student adheres to post training examination guidelines established by the Board.

G.S. 90-677.5 requires a person to file a copy of their Board credentialing document with the Secretary of State and pay a $50 fee. This is an annual fee. The Secretary is to develop a form for applicants seeking to file and may require electronic filing and electronic fee payment.

The Secretary is to maintain a listing of all current registered polysomnographic technologists. Fees are to used to pay the costs incurred in administering the Article. The Board shall notify the Secretary when a person's credentials have been revoked or are no longer in effect and the Secretary shall promptly amend the listing.

Listings automatically expire on September 30 each year. Listings must be renewed annually by filing a new listing form, credential verification and payment of the filing fee.

Section 2 of House Bill 819 directs the North Carolina Medical Board, within 6 months of the effective date of the act, to identify the standards of physician supervision of persons registered to practice as registered polysomnographic technologists. The Medical Board shall communicate those standards to all licensed physicians in the State.

EFFECTIVE DATE: The act becomes effective October 1, 2009.

Barbara Riley, counsel to House Judiciary I, and Martha Walston, counsel to House Finance, substantially contributed to this summary.

H819-SMSQ-117(e3) v1

HOUSE BILL 672
Committee Substitute Favorable 4/16/09

Short Title: Accountability for State Funding/MHDDSA. (Public)

Sponsors:

Referred to:

March 19, 2009

A BILL TO BE ENTITLED

AN ACT RELATING TO LOCAL MANAGEMENT ENTITIES USE OF STATE FUNDS FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITY, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-117(a) is amended by adding the following new subdivisions to read:

"**§ 122C-117. Powers and duties of the area authority.**

(a) The area authority shall do all of the following:

...

(15) An LME that utilizes single stream funding shall, on a biannual basis, report on the allocation of service dollars and allow for public comment at a regularly scheduled LME board of directors meeting.

(16) Before an LME proposes to reduce State funding to HUD group homes and HUD apartments below the original appropriation of State funds, the LME must:

a. Receive approval of the reduction in funding from the Department, and

b. Hold a public hearing at an open LME board meeting to receive comment on the reduction in funding."

SECTION 2. The Department of Health and Human Services shall analyze the effectiveness of single stream funding in the expenditure of State funds and review the allocation of service dollars to specific disabilities of LMEs that utilize single stream funding for a year or more and report its findings to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division by June 1, 2010.

SECTION 3. This act becomes effective July 1, 2009.

HOUSE BILL 672:
Accountability for State Funding/MHDDSA

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 17, 2009
Introduced by:	Reps. Earle, Brisson, Hurley, Hughes	**Prepared by:**	Ben Popkin
Analysis of:	Second Edition		Committee Counsel

SUMMARY: ***House Bill 672 would direct Local Management Entities (LMEs) that utilize single stream funding to report on the allocation of service dollars, on a biannual basis, and allow for public comment at regularly scheduled LME meetings. The bill would also require that LMEs must receive Department approval and hold a public hearing before proposing to reduce State funding to HUD group homes and HUD apartments below the original appropriated amount of State funds.***

CURRENT LAW: Under State law, an area authority is a local political subdivision of the State except that a single county area authority is considered a department of the county in which it is located for local government finance purposes.[1] An area authority or county program is the locus of coordination among public services for clients of its catchment area.[2] G.S. 122C-117 provides the powers and duties of the area authority.

BILL ANALYSIS: **Section 1** of House bill 672 would amend G.S. 122C-117 by adding two new subdivisions to accomplish the following:

- (15) Direct LMEs that utilize single stream funding to:
  - Report on the allocation of service dollars, on a biannual basis; and
  - Allow for public comment at a regularly scheduled LME Board of Directors Meeting.
- (16) Require that before an LME may propose a reduction in State funding to HUD group homes and HUD apartments below the original appropriation of State funds, the LME must first:
  - Receive Department approval for the reduction in funding; and
  - Hold a public hearing at an open LME Board meeting to receive comment on the reduction in funding.

Section 2 of the bill would direct the Department to analyze the effectiveness of single stream funding and review the allocation of service dollars to specific disabilities (for LMEs utilizing single stream funding for a year or more). The Department would report its findings to the Joint Legislative Oversight Committee on MH/DD/SAS, the House and Senate Health and Human Services appropriations (sub)committees, and the Fiscal Research Division by June 1, 2010.

EFFECTIVE DATE: This act becomes effective July 1, 2009.

BACKGROUND: As of July 2008, 13 LMEs had converted or were converting to single stream funding: CenterPoint; Crossroads; Durham; East Carolina Behavioral Health; Five County; Guilford ; Mecklenburg; Pathways; Piedmont Behavioral Health; Sandhills; Smoky Mountain; Southeastern Regional; Western Highlands Network.

Shawn Parker, staff to House Mental Health Reform, substantially contributed to this summary.

h672-SMRD-157(e2) v1

[1] G.S. 122C-116
[2] G.S. 122C-101

HOUSE BILL 1187

Short Title:	DHHS Technical Changes/Health Care Personnel.	(Public)
Sponsors:	Representatives Earle, M. Alexander, Lucas, England (Primary Sponsors); Brisson and Insko.	
Referred to:	Health, if favorable, Judiciary III.	

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL CHANGES TO THE HEALTH STATUTES PERTAINING TO HEALTH CARE PERSONNEL AND HEALTH CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131E-256(i) reads as rewritten:

"**§ 131E-256. Health Care Personnel Registry.**

...

(i) In the case of a finding of neglect under subdivision (1) of subsection (a) of this section, the Department shall establish a procedure to permit health care personnel to petition the Department to have his or her name removed from the registry upon a determination that:

(1) The employment and personal history of the ~~nurse aid~~health care personnel does not reflect a pattern of abusive behavior or neglect;

(1a) The health care personnel's name was added to the registry for a single finding of neglect;

(2) The neglect involved in the original finding was a singular occurrence; and

(3) The petition for removal is submitted after the expiration of the one-year period which began on the date the petitioner's name was added to the registry under subdivision (1) of subsection (a) of this section.

...."

SECTION 2. G.S. 131E-256 is amended by adding two new subsections, new subsection (i1) after subsection (i) and new subsection (g1) after subsection (g), to read:

"(i1) Health care personnel who wish to contest a decision by the Department to deny a removal of a single finding of neglect from the Health Care Personnel Registry under subdivision (1a) of subsection (i) of this section are entitled to an administrative hearing under Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's denial of a removal of a finding of neglect.

(g1) Health care facilities defined in subsection (b) of this section are permitted to provide confidential or other identifying information to the Health Care Personnel Registry, including social security numbers, taxpayer identification numbers, parent's legal surname prior to marriage, and dates of birth, for verifying the identity of accused health care personnel. Confidential or other identifying information received by the Health Care Personnel Registry are not public records under Chapter 132 of the General Statutes."

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

HOUSE BILL 1187: DHHS Technical Changes/Health Care Personnel

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 16, 2009
Introduced by:	Reps. Earle, M. Alexander, Lucas, England	**Prepared by:**	Ben Popkin
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1187 would allow health care personnel to petition to have their names removed from the Health Care Personnel Registry if they were added for a single finding of neglect, would allow health care personnel to petition for an administrative hearing contesting Department decisions denying removal of a single finding of neglect, and would permit health care facilities to provide confidential or identifying information to the Registry for verification of identities of accused health care personnel.***

BILL ANALYSIS:

G.S. 131E-256(i) currently provides that in the case of a finding of neglect, the Department of Health and Human Services must establish a procedure to permit health care personnel to petition the Department to have their names removed from the registry upon a determination that:

- The employment and personal history of the nurse aid does not reflect a pattern of abusive behavior or neglect;
- The neglect involved in the original finding was a singular occurrence; and
- The petition for removal is submitted after the expiration of the one-year period which began on the date the petitioner's name was added to the registry.

Section 1 of House Bill 1187 would amend G.S. 131-256(i) to change "nurse aid" to "health care personnel" and would add the following:

- The health care personnel's name was added to the registry for a single finding of neglect.

Section 2 of the bill would add two new subsections to G.S. 131-256.

- The first addition, (i1), corresponds to the addition in Section 1 and specifies that health care personnel wishing to contest a decision by the Department denying that person's request to remove a single finding of neglect are entitled to an administrative hearing under Chapter 150B and requires the petition to be filed within 30 days of the mailing of the written notice of the Department's denial of removal of the finding.
- The second addition, (g2), allows health care facilities to provide confidential or other identifying information to the Health Care Personnel Registry for verification of the identities of accused health care personnel. Identifying information includes the following:
  - Social security numbers.
  - Taxpayer identification numbers.
  - Parent's legal surname prior to marriage.
  - Date of birth.

  The above information is considered confidential and is not considered a public record under Chapter 132.

EFFECTIVE DATE:
House Bill 1187 would become effective when it becomes law.

CURRENT LAW:
G.S. 131E-256 establishes the **Health Care Personnel Registry** which requires the Department of Health and Human Services to establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in the State who have been subject to findings by the Department regarding the acts below, or have been accused of any of the acts listed below and the Department has screened the allegation and determined that an investigation was required.

- Neglect or abuse
- Misappropriation of the property.
- Diversion of drugs
- Fraud.

"Health care facilities" include:

Adult Care Homes as defined in G.S. 131D-2.

Home Care Agencies as defined in G.S. 131E-136.

Hospices as defined by G.S. 131E-201.

State-Operated Facilities as defined in G.S. 122C-3(14)f.

24-Hour Facilities as defined in G.S. 122C-3(14)g.

Agencies providing in-home aide services funded through the Home and Community Care Block Grant Program in accordance with G.S. 143B-181.1(a)11.

Multiunit Assisted Housing with Services as defined in G.S. 131D-2.

Hospitals as defined in G.S. 131E-76.

Nursing Pools as defined by G.S. 131E-154.2.

Nursing Facilities as defined by G.S. 131E-255.

Residential Facilities as defined in G.S. 122C-3(14)e.

Licensable Facilities as defined in G.S. 122C-3(14)b.

Community-Based Providers of Services for the Mentally Ill, the Developmentally Disabled, and Substance Abusers that are not required to be licensed under Article 2 of Chapter 122C of the General Statutes.

"Health care personnel" are any unlicensed staff of a health care facility that have direct access to residents, clients, or their property. Direct access includes any health care facility unlicensed staff that during the course of employment have the opportunity for direct contact with an individual or an individual's property, when that individual is a resident or person to whom services are provided.

Theresa Matula, staff to House Health, substantially contributed to this summary.

H1187-SMRD-156(e1) v1

HOUSE BILL 1186
Committee Substitute Favorable 4/23/09

Short Title: DHHS/Update Current Inspection Practices.-AB (Public)

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE COUNTY DEPARTMENTS OF SOCIAL SERVICES TO CONDUCT FOLLOW-UP MONITORING OF ADULT CARE HOMES TO ENSURE COMPLIANCE WITH STATE AND FEDERAL LAW.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 131D-2(b)(1a)b. reads as rewritten:

"...

(b) Licensure; inspections. –

...

(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this subsection:

a. 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. The Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis, effective July 1, 2007, and thereafter. 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.

b. The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this ~~monitoring and perform any required follow-up inspection.~~monitoring. The county departments of social services shall document in a written report all on-site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit.

...."

SECTION 1.(b) If House Bill 456, 2009 Regular Session, becomes law, this section is repealed.

SECTION 2. If House Bill 456, 2009 Regular Session, becomes law, G.S. 131D-2.11(b) reads as rewritten:

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

...

(b) Monitoring by County. – The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this monitoring. ~~monitoring and perform any required follow up inspection.~~ The county departments of social services shall document in a written report all on site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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HOUSE BILL 1186
Committee Substitute Favorable 4/23/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H1186-CSSQ-59 [v.1]

6/9/2009 11:50:47 AM

Short Title: DHHS/Update Current Inspection Practices.-AB (Public)

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE COUNTY DEPARTMENTS OF SOCIAL SERVICES TO CONDUCT FOLLOW-UP MONITORING OF ADULT CARE HOMES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2(b)(1a)b. reads as rewritten:

"...

(b) Licensure; inspections. –

...

(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this subsection:

a. 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. The Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis, effective July 1, 2007, and thereafter. 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.

b. The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this ~~monitoring and perform any required follow-up inspection.~~monitoring. The county departments of social services shall document in a written report all on-site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit.

...."

SECTION 2. If House Bill 456, 2009 Regular Session, becomes law, section 1 of this act is repealed.

SECTION 3. If House Bill 456, 2009 Regular Session, becomes law, G.S. 131D-2.11(b) reads as rewritten:

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

...

(b) Monitoring by County. – The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this monitoring. ~~monitoring and perform any required follow up inspection.~~ The county departments of social services shall document in a written report all on site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit."

SECTION 4. This act is effective when it becomes law.

Reference to Answer to Committee question on H1186 from 6/10/09 is highlighted

(b) Licensure; inspections. –

(1) The Department of Health and Human Services shall inspect and license, under rules adopted by the Medical Care Commission, all adult care homes for persons who are aged or mentally or physically disabled except those exempt in subsection (c) of this section. Licenses issued under the authority of this section shall be valid for one year from the date of issuance unless revoked earlier by the Secretary for failure to comply with any part of this section or any rules adopted hereunder. Licenses shall be renewed annually upon filing and the Department's approval of the renewal application. The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of two hundred fifty dollars ($250.00). The Department shall charge each adult care home with more than six beds a nonrefundable annual license fee in the amount of three hundred fifty dollars ($350.00) plus a nonrefundable annual per-bed fee of twelve dollars and fifty cents ($12.50). A license shall not be renewed nor a new license issued for a change of ownership of an adult care home if outstanding fees, fines, and penalties imposed by the State against the home have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration. The renewal application shall contain all necessary and reasonable information that the Department may by rule require. Except as otherwise provided in this subdivision, the Department may amend a license by reducing it from a full license to a provisional license for a period of not more than 90 days whenever the Department finds that:

a. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles;

b. There is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and

c. There is a reasonable probability that the licensee will be able thereafter to remain in compliance with the licensure rules for the foreseeable future.

The Department may extend a provisional license for not more than one additional 90-day period upon finding that the licensee has made substantial progress toward remedying the licensure deficiencies that caused the license to be reduced to provisional status.

The Department may revoke a license whenever:

a. The Department finds that:
   1. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and
   2. It is not reasonably probable that the licensee can remedy the licensure deficiencies within a reasonable length of time; or

b. The Department finds that:
   1. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and
   2. Although the licensee may be able to remedy the deficiencies within a reasonable time, it is not reasonably probable that the licensee will be able to remain in compliance with licensure rules for the foreseeable future; or

c. The Department finds that the licensee has failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles, and the failure to comply endangered the health, safety, or welfare of the patients in the facility.

The Department may also issue a provisional license to a facility, pursuant to rules adopted by the Medical Care Commission, for substantial failure to comply with the provisions of this section or rules adopted pursuant to this section. Any facility wishing to contest the issuance of a provisional license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails written notice of the issuance of the provisional license.

(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this subsection:

a. 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. The Division of Health Service Regulation shall inspect all adult care homes and adult care units in

nursing homes on an annual basis, effective July 1, 2007, and thereafter. 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.

b. The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this monitoring and perform any required follow-up inspection. The county departments of social services shall document in a written report all on-site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit.

c. The Division of Health Service Regulation shall conduct and document annual reviews of the county departments of social services' performance. When monitoring is not done timely or there is failure to identify or document noncompliance, the Department may intervene in the particular service in question. Department intervention shall include one or more of the following activities:

1. Sending staff of the Department to the county departments of social services to provide technical assistance and to monitor the services being provided by the facility.
2. Advising county personnel as to appropriate policies and procedures.
3. Establishing a plan of action to correct county performance.

The Secretary may determine that the Department shall assume the county's regulatory responsibility for the county's adult care homes.

d. The county departments of social services' adult home specialists and their supervisors shall complete:

1. Eight hours of prebasic training within 60 days of employment;
2. Thirty-two hours of basic training within six months of employment;

3. Twenty-four hours of postbasic training within six months of the basic training program;
4. A minimum of eight hours of complaint investigation training within six months of employment; and
5. A minimum of 16 hours of statewide training annually by the Division of Health Service Regulation.

e. The Department shall monitor regularly the enforcement of rules pertaining to air circulation, ventilation, and room temperature in resident living quarters. These rules shall include the requirement that air conditioning or at least one fan per resident bedroom and living and dining areas be provided when the temperature in the main center corridor exceeds 80 degrees Fahrenheit.

f. The Department shall keep an up-to-date directory of all persons who are administrators as defined in subdivision (1a) of subsection (a) of this section.

HOUSE BILL 1186:
DHHS/Update Current Inspection Practices.-AB

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 9, 2009
Introduced by:	Reps. Earle, M. Alexander, Lucas, England	**Prepared by:**	Shawn Parker
Analysis of:	PCS to Second Edition H1186-CSSQ-59		Legislative Analyst

SUMMARY: ***HB 1186 removes the direction to the Department of Health Service Regulation perform any required follow-up inspections.***

The Proposed Committee substitute corrects the long title and the numbering of the bill sections.

CURRENT LAW:

G.S. 131D-2(b)(1a)b. requires the Department of Health and Human Services to work with county departments of social services to perform routine monitoring in adult care homes. The purpose of the monitoring is to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation. The Division of Health Service Regulation is responsible for oversight of the monitoring and for performing any required follow-up inspections.

BILL ANALYSIS:

Section 1 of House Bill 1186 amends G.S. 131D-2(b)(1a)b. to delete the requirement of Division of Health Service Regulation for performing required follow up inspections.

Section 2 and Section 3 contemplate the enactment of HB 456 which recodifies the current G.S. 131D-2. (House Bill 456 is currently in the Senate Health Care Committee with a serial referral to Finance)

- Section 2 repeals section 1 if House Bill 456, 2009 Regular Session, becomes law.
- If House Bill 456 is enacted, Section 3 amends G.S. 131D-2.11(b) to conform with the amendments in section 1 of House Bill 1186.

EFFECTIVE DATE:

House Bill 1186 would become effective when it becomes law.

Theresa Matula substantially contributed to this summary.

H1186-SMSQ-108(CSSQ-59) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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HOUSE BILL 1186
Committee Substitute Favorable 4/23/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H1186-PCS50739-SQ-59

Short Title: DHHS/Update Current Inspection Practices.-AB (Public)

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE COUNTY DEPARTMENTS OF SOCIAL SERVICES TO CONDUCT FOLLOW-UP MONITORING OF ADULT CARE HOMES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 131D-2(b) reads as rewritten:

"...

(b) Licensure; inspections. –

...

(1a) In addition to the licensing and inspection requirements mandated by subdivision (1) of this subsection:

a. 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. The Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis, effective July 1, 2007, and thereafter. 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.

b. The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this ~~monitoring and perform any required follow-up inspection.~~monitoring. The county departments of social services shall document in a written report all on-site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit.

...."

SECTION 2. If House Bill 456, 2009 Regular Session, becomes law, Section 1 of this act is repealed.

SECTION 3. If House Bill 456, 2009 Regular Session, becomes law, G.S. 131D-2.11(b) reads as rewritten:

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

...

(b) Monitoring by County. – The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this monitoring. ~~monitoring and perform any required follow-up inspection.~~ The county departments of social services shall document in a written report all on site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit."

SECTION 4. This act is effective when it becomes law.

VISITOR REGISTRATION SHEET

Senate Health Care — **June 17, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
	JDAPA
	BMS
	GSK
ANN LOM	DUKE
Jawad Jus	NCHA
Andrew Meehan	NCAEC
	TPG
Geoffrey Louder	DOA
Lindsay Clifton	Gov's Office
	DMH/DD/SAS
Beth Lacey	Delta Sigma Theta Sorority
Angela M. Grimes	Delta Sigma Theta Sorority

VISITOR REGISTRATION SHEET

Senate Health Care — **June 17, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Daniel Baum	K+L Gates
Barbara Cansler	BSCGA
John Bowdish	Astra Zeneca
George Everett	Duke Energy
Lisa Pierce	Ragsdale Liggett / Duke Energy
[illegible]	[illegible]
[illegible]	JP Assoc
Andrew Cagle	DLC

VISITOR REGISTRATION SHEET

Senate Health Care — **June 17, 2009**
Name of Committee — Date

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NAME	FIRM OR AGENCY AND ADDRESS
Floyd E. Boyer RRT	NC Respiratory Care Board
Jennifer Makan	MHANC
Holly Lemieux	The Arc of Haywood County
Robert Broadstock	The Arc of N.C.
Dave Richard	The Arc of NC
Lora Wannamaker	DHHS - DMH/DD/SAS
Rhett Melton	Pathways LME
Peggy Mayer	
Chip Baggett	NCMS
Amy McConkey	Smith Anderson
Patrick Buffaloe	

VISITOR REGISTRATION SHEET

Senate Health Care — **June 17, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Haigwood	NCDOL
Meredith Cook	NCDOL
Art Britt	NCDOL
John Hamon	NCDOL
Diane Littlejohn	NCDOL
Scott Gronow	Duke Energy
[illegible]	NC Farm Bureau / NCFPC
[illegible]	NCACC
S. Wilson	DHHS
Jesse Goodman	DHHS
Ralph D. Walls, RCP	NC Respiratory Care Board

VISITOR REGISTRATION SHEET

Senate Health Care — **June 17, 2009**
Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
JAMES EDMONDSON	
Colene Brown	
Tanika Davis	
Ray S.	
Barbara Cestaro	
Mrs. Hannah M. Morris	
Nakisha Wilson	Group Homes of Forsyth 526 West First St Winston Salem NC 27101
Marguerite Abdallah	Group Homes of Forsyth 526 West 1st St Winston-Salem NC 27101
JACK REGISTER	NATIONAL ASSN. Social Workers - NC Chapter
Jennifer Franklin	Betsy Johnson Regional Hospital - Harnett Health 800 Tilghman Dr. Dunn, NC 28334
Zach McMichael	Civitas

VISITOR REGISTRATION SHEET

Senate Health Care — **June 17, 2009**
Name of Committee — **Date**

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NAME	FIRM OR AGENCY AND ADDRESS
Will Underwood	NCAST
Bradley V. Vaughn	UNC
[illegible]	[illegible]
Robin Huffman	NC Psychiatric Assoc.
Mark Flemming	- work for Oliver
Peter McCann	DAV Dept of N.C.
George BALL II	DAV Dept of N.C.
[illegible]	MHM Services Inc
EMILY WILBOURNE	TPG
JUSTIN PLUMMER	Senate Intern
Block David-Young	Intern - Senator Atwater

VISITOR REGISTRATION SHEET

Senate Health Care — **June 17, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ali Rahimzadeh	Group Homes of Forsyth 526 West 1st Street Winston-Salem, NC 27101
Chris Kiricoples	BC DC 1534 W. 5th Washington NC
Janet Schanzenbach	Vendor Consultants
Mildred Simmons	Barbara's Love and Love Home W Vernon Ave. Kinston, NC 28501
Leslie Arnold	SOG - Daily Bulletin
Karen Still	MAG Mutual Ins Co.
Mary Powell	NC Substance Abuse Federation
Donna Cotter	Recovery NC
Emily Gaultmore	NLBA
Hal Pell	NCAJ
Kara Rowe	NCAJ

Senate Health Care Committee
Wednesday, June 24, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 535	Health Insurance Coverage/Lymphedema.	Representative England, M.D. Representative Cotham Representative Stewart Representative Insko
HB 243	Mental Health/Law Enforcement Custody.	Representative Steen, II Representative Barnhart Representative Insko
HB 456	Tech. & Org. Changes/Certain DHHS Facilities.	Representative Earle Representative England, M.D. Representative Farmer-Butterfield Representative Insko
HB 1189	DHHS/Tracking Outpatient Commitments.-AB	Representative Earle Representative England, M.D. Representative Alexander Representative Insko
HB 1187	DHHS Technical Changes/Health Care Personnel.	Representative Earle Representative England, M.D. Representative Alexander Representative Lucas

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, June 24, 2009

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

FAVORABLE

H.B.(CS #1) **456** Tech. & Org. Changes/Certain DHHS Facilities.
Sequential Referral: Finance
Recommended Referral: None

H.B.(CS #1) **535** Health Insurance Coverage/Lymphedema.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

H.B.(CS #1) **1189** DHHS/Tracking Outpatient Commitments.-AB
Sequential Referral: Judiciary II
Recommended Referral: None

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #2) **243** Mental Health/Law Enforcement Custody.
Draft Number: 50747
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 4

Committee Clerk Comments:

HB 535 - Senator Rand
HB 243 - Senator Purcell
HB 456 - Senator Purcell
HB 1189 - Senator Purcell

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, June 25, 2009

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

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **1187** DHHS Technical Changes/Health Care Personnel.

Draft Number:	80475
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

HB 1187 Senator Purcell

SENATE HEALTH CARE COMMITTEE
Wednesday, June 24, 2009 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 AM on June 24, 2009, in Room 544 of the Legislative Office Building. Nineteen members of the committee were present. Senator Bingham, Co-Chair, presided.

Senator Bingham called the meeting to order and introduced the Sergeant-at-Arms and the pages serving this meeting.

The first item on the agenda was the Senate Committee Substitute for House Bill 1187 "AN ACT TO MAKE TECHNICAL CHANGES TO THE HEALTH STATUTES PERTAINING TO HEALTHCARE PERSONNEL AND HEALTH CARE FACILITIES" (Attachment I). This bill, sponsored by Representative Earle, was discussed thoroughly at last week's meeting and was continued at this meeting for the adoption and discussion of an amendment (Attachment II) submitted by Senator Purcell. Ben Popkin explained the amendment, with Senator Purcell moving its adoption; motion carried. Mr. Popkin then gave a short summary of the bill (Attachment III). There was a motion for a favorable report with the amendment to be rolled into a new Committee Substitute; motion carried.

Next discussed was the Senate Committee Substitute for House Bill 535 "AN ACT TO REQUIRE HEALTH INSURERS, INCLUDING THE STATE HEALTH PLAN, TO PROVIDE COVERAGE FOR THE DIAGNOSIS AND TREATMENT OF LYMPHEDEMA AND TO ENACT CHANGES TO THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES" (Attachment IV). Representative Cotham presented her bill (Attachment V), and Senator Purcell moved for a favorable report; motion carried. The bill has a sequential referral to the Appropriations Committee.

House Bill 243, a Proposed Committee Substitute" AN ACT TO AUTHORIZE THE FACILITY OF FIRST COMMITMENT EXAMINTION TO TERMINATE THE INPATIENT COMMITMENT PROCEEDINGS IN APPROPRIATE CIRCUMSTANCES WHEN A TWENTY-FOUR-HOUR FACILITY IS NOT AVAILABLE" (Attachment VI), sponsored by Representative Insko was considered next. Substitute was adopted for consideration, with Representative Insko explaining her bill (Attachment VII). Senator Davis presented an amendment (Attachment VIII) and moved its adoption; motion carried. After discussion, Senator Purcell moved an unfavorable report for the original bill and a favorable report for the Committee Substitute and that the amendment be rolled into the Committee Substitute; motion carried.

Next considered was House Bill 456 entitled "AN ACT TO MAKE TECHNICAL AND ORGANIZATIONAL CHANGES TO THE LAW REGARDING THE LICENSURE AND INSPECTION OF FACILITIES FOR AGED AND DISABLED INDIVIDUALS" (Attachment IX) by Representative Insko. After explanation by her (Attachment X), Senator Stein moved a favorable report; motion carried. This bill has a sequential referral to Finance.

Last to be considered today was House Bill 1189 "AN ACT REQUIRING PHYSICIANS OR ELIGIBLE PSYCHOLOGISTS CONDUCTING EXAMINATIONS TO INFORM THE LOCAL MANAGEMENT ENTITITY THAT AN INDIVIDUAL HAS BEEN SCHEDULED FOR AN APPOINTMENT WITH AN OUTPATIENT TREATMENT PHYSICIAN OR CENTER; TO ALLOW FIRST COMMITMENTS TO BE CONDUCTED VIA TELEMEDICINE; AND PERTAINING TO SECURITY FORCES AT CERTAIN MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES FACILITIES" (Attachment XI). Bill sponsor, Representative Insko, explained her bill (Attachment XII), and Senator Kinnaird moved a favorable report; motion carried. This bill has a sequential referral to Judiciary II.

There being no further business before the Committee, Senator Bingham adjourned the meeting.

Respectfully submitted,

Senator Stan Bingham, Co-Chair

Becky Hedspeth, Committee Assistant

Attachment I

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1187
PROPOSED SENATE COMMITTEE SUBSTITUTE H1187-PCS80475-RD-70

Short Title: DHHS Technical Changes/Health Care Personnel. (Public)

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL CHANGES TO THE HEALTH STATUTES PERTAINING TO HEALTH CARE PERSONNEL AND HEALTH CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) G.S. 131E-256(i) reads as rewritten:

"**§ 131E-256. Health Care Personnel Registry.**

...

(i) In the case of a finding of neglect under subdivision (1) of subsection (a) of this section, the Department shall establish a procedure to permit health care personnel to petition the Department to have his or her name removed from the registry upon a determination that:

(1) The employment and personal history of the ~~nurse aid~~health care personnel does not reflect a pattern of abusive behavior or neglect;

(1a) The health care personnel's name was added to the registry for a single finding of neglect;

(2) The neglect involved in the original finding was a singular occurrence; and

(3) The petition for removal is submitted after the expiration of the one-year period which began on the date the petitioner's name was added to the registry under subdivision (1) of subsection (a) of this section.

...."

SECTION 1.(b) G.S. 131E-256 is amended by adding a new subsection to read:

"(j) Removal of a finding of neglect from the registry under this section may occur only once with respect to any person."

SECTION 2. G.S. 131E-256 is amended by adding two new subsections, new subsection (g1) after subsection (g) and new subsection (i1) after subsection (i), to read:

"(g1) Health care facilities defined in subsection (b) of this section are permitted to provide confidential or other identifying information to the Health Care Personnel Registry, including social security numbers, taxpayer identification numbers, parent's legal surname prior to marriage, and dates of birth, for verifying the identity of accused health care personnel. Confidential or other identifying information received by the Health Care Personnel Registry is not a public record under Chapter 132 of the General Statutes.

(i1) Health care personnel who wish to contest a decision by the Department to deny a removal of a single finding of neglect from the Health Care Personnel Registry under subdivision (1a) of subsection (i) of this section are entitled to an administrative hearing under Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed

within 30 days of the mailing of the written notice of the Department's denial of a removal of a finding of neglect."

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

HOUSE BILL 1187: DHHS Technical Changes/Health Care Personnel

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 16, 2009
Introduced by:	Reps. Earle, M. Alexander, Lucas, England	**Prepared by:**	Ben Popkin
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***House Bill 1187 would allow health care personnel to petition to have their names removed from the Health Care Personnel Registry if they were added for a single finding of neglect, would allow health care personnel to petition for an administrative hearing contesting Department decisions denying removal of a single finding of neglect, and would permit health care facilities to provide confidential or identifying information to the Registry for verification of identities of accused health care personnel.***

BILL ANALYSIS:

G.S. 131E-256(i) currently provides that in the case of a finding of neglect, the Department of Health and Human Services must establish a procedure to permit health care personnel to petition the Department to have their names removed from the registry upon a determination that:

- The employment and personal history of the nurse aid does not reflect a pattern of abusive behavior or neglect;
- The neglect involved in the original finding was a singular occurrence; and
- The petition for removal is submitted after the expiration of the one-year period which began on the date the petitioner's name was added to the registry.

Section 1 of House Bill 1187 would amend G.S. 131-256(i) to change "nurse aid" to "health care personnel" and would add the following:

- The health care personnel's name was added to the registry for a single finding of neglect.

Section 2 of the bill would add two new subsections to G.S. 131-256.

- The first addition, (i1), corresponds to the addition in Section 1 and specifies that health care personnel wishing to contest a decision by the Department denying that person's request to remove a single finding of neglect are entitled to an administrative hearing under Chapter 150B and requires the petition to be filed within 30 days of the mailing of the written notice of the Department's denial of removal of the finding.
- The second addition, (g2), allows health care facilities to provide confidential or other identifying information to the Health Care Personnel Registry for verification of the identities of accused health care personnel. Identifying information includes the following:
  - Social security numbers.
  - Taxpayer identification numbers.
  - Parent's legal surname prior to marriage.
  - Date of birth.

  The above information is considered confidential and is not considered a public record under Chapter 132.

EFFECTIVE DATE:
House Bill 1187 would become effective when it becomes law.

CURRENT LAW:
G.S. 131E-256 establishes the **Health Care Personnel Registry** which requires the Department of Health and Human Services to establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in the State who have been subject to findings by the Department regarding the acts below, or have been accused of any of the acts listed below and the Department has screened the allegation and determined that an investigation was required.

- Neglect or abuse
- Misappropriation of the property.
- Diversion of drugs
- Fraud

"**Health care facilities**" include:

Adult Care Homes as defined in G.S. 131D-2.

Home Care Agencies as defined in G.S. 131E-136.

Hospices as defined by G.S. 131E-201.

State-Operated Facilities as defined in G.S. 122C-3(14)f.

24-Hour Facilities as defined in G.S. 122C-3(14)g.

Agencies providing in-home aide services funded through the Home and Community Care Block Grant Program in accordance with G.S. 143B-181.1(a)11.

Multiunit Assisted Housing with Services as defined in G.S. 131D-2.

Hospitals as defined in G.S. 131E-76.

Nursing Pools as defined by G.S. 131E-154.2.

Nursing Facilities as defined by G.S. 131E-255.

Residential Facilities as defined in G.S. 122C-3(14)e.

Licensable Facilities as defined in G.S. 122C-3(14)b.

Community-Based Providers of Services for the Mentally Ill, the Developmentally Disabled, and Substance Abusers that are not required to be licensed under Article 2 of Chapter 122C of the General Statutes.

"**Health care personnel**" are any unlicensed staff of a health care facility that have direct access to residents, clients, or their property. Direct access includes any health care facility unlicensed staff that during the course of employment have the opportunity for direct contact with an individual or an individual's property, when that individual is a resident or person to whom services are provided.

Theresa Matula, staff to House Health, substantially contributed to this summary.

H1187-SMRD-156(e1) v1

AH. 11

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1187

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

H1187-ARD-29 [v.1]

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Date _____,2009

Senator Purcell

moves to amend the bill on page 1, lines 19-20 by adding the following between the lines:

"**SECTION 1.5.** G.S. 131E-256 is amended by adding a new subsection to read:

'(j) Removal of a finding of neglect from the registry under this section may occur only once with respect to any person.'".

SIGNED William R Purcell
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

AH. 111

HOUSE BILL 535:
Health Insurance Coverage/Lymphedema

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	June 24, 2009
Introduced by:	Reps. Cotham, Insko, England, Stewart	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	PCS to Second Edition H535-CSSQ-67		

SUMMARY: ***House Bill 535 requires all health benefit plans, including the Teachers' and State Employees' Comprehensive Major Medical Plan (the "State Health Plan") to provide coverage for the diagnosis, evaluation and treatment of lymphedema and to apply the same cost sharing measures (deductibles, coinsurance, etc.) to lymphedema as are applied to similar covered services.***

The Senate Proposed Committee Substitute amends the law governing the State Health Plan (Article 3A of Chapter 135) relating to participant ineligibility due to fraudulent representations and to require an act by the General Assembly to make premium adjustments effective.

BILL ANALYSIS:

Current law is provided after each section's analysis

Section 1 of House Bill 535 would enact a new G.S. 58-3-280 "Coverage for the diagnosis and treatment of lymphedema" to direct all health benefit plans to provide coverage for the diagnosis, evaluation and treatment of lymphedema. The bill would require that this coverage include:

> "...benefits for equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be medically necessary and it provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice."

The bill requires health benefit plans to apply the same cost sharing measures (deductibles, coinsurance, etc.) to lymphedema as are applied to similar covered services.

The bill specifies that 'gradient compression garments' are custom-fit items that require a prescription and do not include disposable or over-the-counter items.

Insurance law currently requires health benefit plans to include coverage for medically necessary services and supplies, which are those that are, "[p]rovided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease...not for experimental, investigational, or cosmetic purposes..." and are "...[n]ecessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms."[1]

Section 2 amends G.S. 135-45 to require that the State Health Plan provide coverage for the diagnosis and treatment of lymphedema equivalent to the new G.S. 58-3-280.

The State Health Plan currently provides coverage for lymphedema diagnosis, evaluation and treatment.

Section 3 adds making a false claim for reimbursement for pharmacy services and making a false attestation and representation to the State Health Plan as ground for ineligibility in participation. The

[1] G.S. 58-3-200(b)(1)&(2).

section reduces the period of time a person who is ineligible for fraudulent reason would have to remain off the plan (from five years to "up to" five years) until the Executive Administrator and Board may make an exception to reauthorize participation.

No person shall be eligible for coverage... upon a finding by the Executive Administrator or Board or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan.

The Executive Administrator and Board may make an exception once that person has had a cessation in coverage for five years and has made a full restitution to the plan in the amount of the fraudulent claim. [2]

Section 4 authorizes the Executive Administrator and Board of Trustees to recommend establishing premiums or adjusting premiums set by the General Assembly and provides any premium rates established or adjusted cannot become effective absent an act of the General Assembly.

The Executive Administrator and Board of Trustees may establish premium rates for the State Health Plan except as established by the General Assembly in the current budget.[3]

EFFECTIVE DATE: This act is effective when it becomes law. Sections 1 and 2 of the act become effective January 1, 2010. Sections 3 and 4 apply to the Plan year beginning July 1, 2009.

Ben Popkin, counsel to House Insurance, contributed to this summary.

H535-SMSQ-121(CSSQ-67) v2

[2] G.S. 135-42 Eligibility
[3] G.S. 135-44.6 Premiums set

A-11 . IV

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 535
Committee Substitute Favorable 5/5/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H535-CSSQ-67 [v.3]

6/23/2009 5:08:15 PM

Short Title: Health Ins. Covrge/Lymphedema SHP changes. (Public)

Sponsors:

Referred to:

March 12, 2009

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH INSURERS, INCLUDING THE STATE HEALTH PLAN, TO PROVIDE COVERAGE FOR THE DIAGNOSIS AND TREATMENT OF LYMPHEDEMA AND TO ENACT CHANGES TO THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-280. Coverage for the diagnosis and treatment of lymphedema.**

(a) Every health benefit plan, as defined in G.S. 58-3-167, shall provide coverage for the diagnosis, evaluation, and treatment of lymphedema. The coverage required by this section shall include benefits for equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be medically necessary and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.

(b) The same deductibles, coinsurance, and other limitations as apply to similar services covered under the health benefit plan apply to coverage for the diagnosis, evaluation, and treatment of lymphedema required to be covered under this section. Nothing in this section requires a health benefit plan to provide a separate set of benefit limitations or maximums for the diagnosis, evaluation, or treatment of lymphedema.

(c) As used in this section, gradient compression garments:

(1) Require a prescription;

(2) Are custom-fit for the covered individual; and

(3) Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products."

SECTION 2. G.S. 135-45 is amended by adding the following new subsection to read:

"(h) The Plan shall provide coverage under its Basic and Standard PPO options for the diagnosis and treatment of lymphedema. The coverage shall be the equivalent of coverage under G.S. 58-3-280."

SECTION 3. G.S. 135-45.2(j) reads as rewritten:

"(j) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the Executive Administrator or Board of Trustees or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical or pharmacy services under the ~~Plan.~~Plan or in any representation or attestation to the Plan.

The Executive Administrator and Board of Trustees may make an exception to the provisions of this subsection when persons subject to this subsection have had a cessation of coverage for a period of up to five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subsection shall be construed to obligate the Executive Administrator and Board of Trustees to make an exception as allowed for under this subsection."

SECTION 4. G.S. 135-44.6 reads as rewritten:

"**§ 135-44.6. Premiums set.**

(a) The Executive Administrator and Board of Trustees shall, from time to time, ~~establish premium rates for the Plan except as they may be established by the General Assembly in the Current Operations Appropriations Act, and establish~~ recommend to the General Assembly the establishment or adjustment of premium rates for the Plan and based on premium rates enacted by the General Assembly shall adopt rules for payment of the premiums. Premium rates shall be established for coverages where Medicare is the primary payer of health benefits separate and apart from the rates established for coverages where Medicare is not the primary payer of health benefits. The amount of State funds contributed for optional coverage for employees and retirees on a partially contributory basis shall not be more than the Plan's total noncontributory premium for Employee Only coverage, with the person selecting the coverage paying the balance of the partially contributory premium not paid by the Plan. The amount of State funds contributed shall not exceed the Plan's cost for Employee Only coverage. The Executive Administrator and Board of Trustees shall not impose a partially contributory premium until after it has consulted on the premium and the optional coverage design with the Committee on Employee Hospital and Medical Benefits.

(b) The Executive Administrator and Board of Trustees shall establish separate premium rates for the long-term care benefits provided by Part 4 of this Article if the benefits are administered on a self-insured basis.

(c) Repealed by Session Laws 2008-107, s. 10.13(a), effective July 1, 2008.

(d) In setting premiums for firefighters, rescue squad workers, and members of the national guard, and their eligible dependents, the Executive Administrator and Board of Trustees shall establish rates separate from those affecting other members of the Plan. These separate premium rates shall include rate factors for incurred but unreported claim costs, for the effects of adverse selection from voluntary participation in the Plan, and for any other actuarially determined measures needed to protect the financial integrity of the Plan for the benefit of its served employees, retired employees, and their eligible dependents.

(e) The total amount of premiums due the Plan from charter schools as employing units, including amounts withheld from the compensation of Plan members, that is not remitted to the Plan by the fifteenth day of the month following the due date of remittance shall be assessed interest of one and one-half percent (1 1/2%) of the amount due the Plan, per month or fraction thereof, beginning with the sixteenth day of the month following the due date of the remittance. The interest authorized by this section shall be assessed until the premium payment plus the accrued interest amount is remitted to the Plan. The remittance of premium payments under this section shall be presumed to have been made if the remittance is postmarked in the United States mail on a date not later than the fifteenth day of the month following the due date of the remittance.

(f) Premium rates established or adjusted under this section shall not become effective except by an act of the General Assembly."

SECTION 5. Sections 1 and 2 of this act become effective January 1, 2010, and apply to all health benefits plans that are delivered, issued for delivery, or renewed on and after that date. Sections 3 and 4 of this act become effective when the act becomes law and apply to Plan year beginning July 1, 2009. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H 2

HOUSE BILL 535
Committee Substitute Favorable 5/5/09

Short Title: Health Insurance Coverage/Lymphedema. (Public)

Sponsors:

Referred to:

March 12, 2009

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH INSURERS, INCLUDING THE STATE HEALTH PLAN, TO PROVIDE COVERAGE FOR THE DIAGNOSIS AND TREATMENT OF LYMPHEDEMA.

The General Assembly of North Carolina enacts:

SECTION 1. Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-280. Coverage for the diagnosis and treatment of lymphedema.**

(a) Every health benefit plan, as defined in G.S. 58-3-167, shall provide coverage for the diagnosis, evaluation, and treatment of lymphedema. The coverage required by this section shall include benefits for equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be medically necessary and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.

(b) The same deductibles, coinsurance, and other limitations as apply to similar services covered under the health benefit plan apply to coverage for the diagnosis, evaluation, and treatment of lymphedema required to be covered under this section. Nothing in this section requires a health benefit plan to provide a separate set of benefit limitations or maximums for the diagnosis, evaluation, or treatment of lymphedema.

(c) As used in this section, gradient compression garments:

(1) Require a prescription;

(2) Are custom-fit for the covered individual; and

(3) Do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products."

SECTION 2. G.S. 135-45 is amended by adding the following new subsection to read:

"(h) The Plan shall provide coverage under its Basic and Standard PPO options for the diagnosis and treatment of lymphedema. The coverage shall be the equivalent of coverage under G.S. 58-3-280."

SECTION 3. This act becomes effective January 1, 2010, and applies to all health benefits plans that are delivered, issued for delivery, or renewed on and after that date.

Att. V

HOUSE BILL 535:
Health Insurance Coverage/Lymphedema

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	June 24, 2009
Introduced by:	Reps. Cotham, Insko, England, Stewart	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	PCS to Second Edition H535-CSSQ-67		

SUMMARY: ***House Bill 535 requires all health benefit plans, including the Teachers' and State Employees' Comprehensive Major Medical Plan (the "State Health Plan") to provide coverage for the diagnosis, evaluation and treatment of lymphedema and to apply the same cost sharing measures (deductibles, coinsurance, etc.) to lymphedema as are applied to similar covered services.***

The Senate Proposed Committee Substitute amends the law governing the State Health Plan (Article 3A of Chapter 135) relating to participant ineligibility due to fraudulent representations and to require an act by the General Assembly to make premium adjustments effective.

BILL ANALYSIS:

Current law is provided after each section's analysis

Section 1 of House Bill 535 would enact a new G.S. 58-3-280 "Coverage for the diagnosis and treatment of lymphedema" to direct all health benefit plans to provide coverage for the diagnosis, evaluation and treatment of lymphedema. The bill would require that this coverage include:

> "...benefits for equipment, supplies, complex decongestive therapy, gradient compression garments, and self-management training and education, if the treatment is determined to be medically necessary and it provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice."

The bill requires health benefit plans to apply the same cost sharing measures (deductibles, coinsurance, etc.) to lymphedema as are applied to similar covered services.

The bill specifies that 'gradient compression garments' are custom-fit items that require a prescription and do not include disposable or over-the-counter items.

Insurance law currently requires health benefit plans to include coverage for medically necessary services and supplies, which are those that are, "[p]rovided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease...not for experimental, investigational, or cosmetic purposes..." and are "...[n]ecessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms."[1]

Section 2 amends G.S. 135-45 to require that the State Health Plan provide coverage for the diagnosis and treatment of lymphedema equivalent to the new G.S. 58-3-280.

The State Health Plan currently provides coverage for lymphedema diagnosis, evaluation and treatment.

Section 3 adds making a false claim for reimbursement for pharmacy services and making a false attestation and representation to the State Health Plan as ground for ineligibility in participation. The

[1] G.S. 58-3-200(b)(1)&(2).

section reduces the period of time a person who is ineligible for fraudulent reason would have to remain off the plan (from five years to "up to" five years) until the Executive Administrator and Board may make an exception to reauthorize participation.

No person shall be eligible for coverage... upon a finding by the Executive Administrator or Board or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan.

The Executive Administrator and Board may make an exception once that person has had a cessation in coverage for five years and has made a full restitution to the plan in the amount of the fraudulent claim. [2]

Section 4 authorizes the Executive Administrator and Board of Trustees to recommend establishing premiums or adjusting premiums set by the General Assembly and provides any premium rates established or adjusted cannot become effective absent an act of the General Assembly.

The Executive Administrator and Board of Trustees may establish premium rates for the State Health Plan except as established by the General Assembly in the current budget.[3]

EFFECTIVE DATE: This act is effective when it becomes law. Sections 1 and 2 of the act become effective January 1, 2010. Sections 3 and 4 apply to the Plan year beginning July 1, 2009.

Ben Popkin, counsel to House Insurance, contributed to this summary.

H535-SMSQ-121(CSSQ-67) v2

[2] G.S. 135-42 Eligibility
[3] G.S. 135-44.6 Premiums set

Rep. Tricia Cotham

Lymphedema Overview

What Is Lymphedema?: Lymphedema is a condition caused by injury, trauma or congenital defects involving the lymph system. When the impairment becomes so great that the lymphatic fluid exceeds the lymphatic transport capacity, an abnormal amount of protein-rich fluid collects in the tissues of the affected area. There are two types of lymphedema. Primary lymphedema, which can be present at birth (congenital), develop at the onset of puberty (praecox) or in adulthood (tarda). Secondary Lymphedema can be caused by surgeries or radiation treatments and is a common side effect of cancer treatments that remove or damage lymph nodes resulting in the chronic swelling of a body area or part nearest the damaged portion of the lymph system.

Stages of Lymphedema:

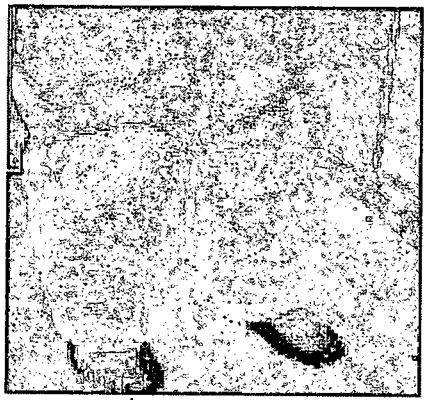
Stage 1: Tissue is still at the "pitting" stage, which means that when pressed by fingertips, the area indents and holds the indentation. **When lymphedema is diagnosed and treatment is begun in Stage1, and received consistently, the disease in almost all cases cases will be prevented from progressing, there will be few complications and the patient will live a long, healthy and virtually normal life.**

Stage 2: The tissue now has a spongy consistency and is "non-pitting," meaning that when pressed by fingertips, the tissue bounces back without any indentation forming. Fibrosis found in Stage 2 lymphedema marks the beginning of the hardening of the limbs and increasing size. **When diagnosis and treatment are not received until Stage 2 it is rarely possible that through treatment a patient will return to stage one, but progression to Stage 3 can be prevented. In Stage 2 the patient will have more frequent complications, the disease will have effected his/her ability to lead a normal life in some regards and varying degrees of constant discomfort may be present.**

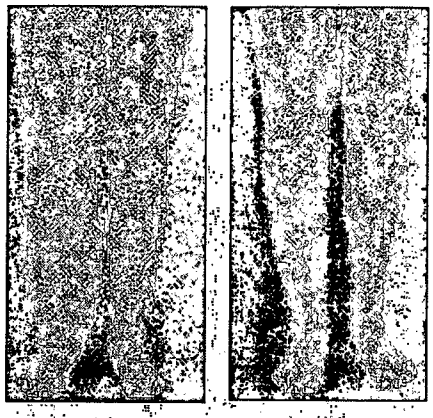
Stage 3: At this stage the swelling is irreversible and usually the limb(s) is/are very large. The tissue is hard (fibrotic) and unresponsive; at this stage some patients consider undergoing reconstructive surgery called "debulking". **The damage is now irreversible; there is chronic pain and the lymphedema patient faces recurring, difficult and expensive to treat complications. A person with Stage 3 lymphedema is often fully disabled by the disease.**

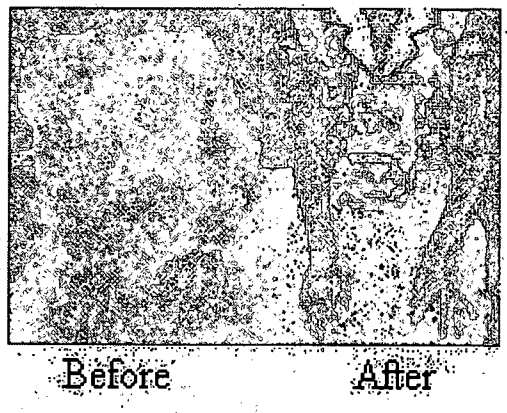
In virtually all cases, lymphedema can be halted from progressing once diagnosis is made and treatment is begun and continued consistently.

Typical examples of Stage 3 are below – this can be prevented!

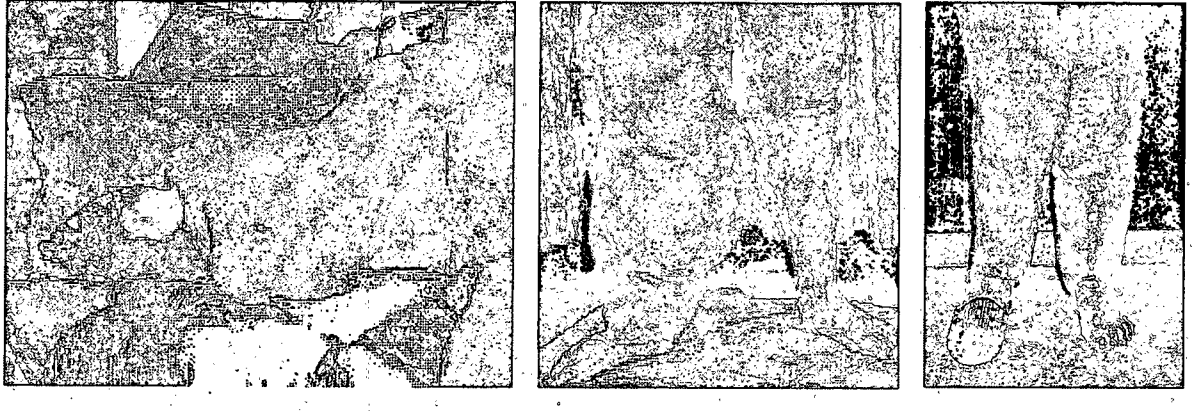


Treatment for Lymphedema: Lifetime treatment is necessary - at the present time the disease can only be managed, but not cured. Lymphedema treatment includes a specially developed massage administered by a trained medical professional, bandaging, the use of custom fitted compression garments, specialized skin care and a regimen that includes lymph draining exercises and attention to diet. The massage and special garments are essential to the overall care of the lymphedema patient. This treatment is referred to as Complex Decongestive Therapy (CDT) which consist of: a) manual lymphatic drainage; b) bandaging; c) proper skin care & diet; d) compression garments (sleeves, stockings, devices such as Reid Sleeve, CircAid, Tribute, as well as other alternative approaches); e) remedial exercises; f) self-manual lymphatic drainage & bandaging; g) continue to follow prophylactic methods at all times.





Complications: When lymphedema remains untreated, protein-rich fluid continues to accumulate, leading to an increase of swelling and a hardening or fibrosis of the tissue. In this state, the swollen limb(s) becomes a perfect culture medium for bacteria and subsequent recurrent lymphangitis (infections). Moreover, untreated lymphedema can lead into a decrease or loss of functioning of the limb(s), skin breakdown, chronic infections and, sometimes, irreversible complications. In the most severe cases, untreated lymphedema can develop into a rare form of lymphatic cancer called Lymphangiosarcoma (most often in secondary lymphedema). Since lymphedema is disfiguring, causes difficulties in daily living and can lead to lifestyle becoming severely limited, it may also result in psychological distress.



GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 243
Committee Substitute Favorable 5/11/09
Committee Substitute #2 Favorable 5/13/09
Fourth Edition Engrossed 5/14/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H243-PCS50747-RD-69

Short Title: Mental Health/Law Enforcement Custody. (Public)

Sponsors:

Referred to:

February 23, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE FACILITY OF FIRST COMMITMENT EXAMINATION TO TERMINATE THE INPATIENT COMMITMENT PROCEEDINGS IN APPROPRIATE CIRCUMSTANCES WHEN A TWENTY-FOUR-HOUR FACILITY IS NOT AVAILABLE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-261(d) reads as rewritten:

"(d) If the affiant is a physician or eligible psychologist, the affiant may execute the affidavit before any official authorized to administer oaths. This affiant is not required to appear before the clerk or magistrate for this purpose. This affiant shall file the affidavit with the clerk or magistrate by delivering to the clerk or magistrate the original affidavit or a copy in paper form that is printed through the facsimile transmission of the affidavit. If the affidavit is filed through facsimile transmission, the affiant shall mail the original affidavit no later than five days after the facsimile transmission of the affidavit to the clerk or magistrate to be filed by the clerk or magistrate with the facsimile copy of the affidavit. This affiant's examination shall comply with the requirements of the initial examination as provided in G.S. 122C-263(c). If the physician or eligible psychologist recommends outpatient commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for outpatient commitment, the clerk or magistrate shall issue an order that a hearing before a district court judge be held to determine whether the respondent will be involuntarily committed. The physician or eligible psychologist shall provide the respondent with written notice of any scheduled appointment and the name, address, and telephone number of the proposed outpatient treatment physician or center. If the physician or eligible psychologist recommends inpatient commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order for transportation to or custody at a 24-hour facility described in G.S. ~~122C-252.~~122C-252, provided that if a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision and, upon further examination, released in accordance with G.S. 122C-263(d)(2). ~~However, if~~ If the clerk or magistrate finds probable cause to believe that the respondent, in addition to being mentally ill, is also mentally retarded, the clerk or

magistrate shall contact the area authority before issuing the order and the area authority shall designate the facility to which the respondent is to be transported. If a physician or eligible psychologist executes an affidavit for inpatient commitment of a respondent, a second physician shall be required to perform the examination required by G.S. 122C-266."

SECTION 2. G.S. 122C-263(d) reads as rewritten:

"**§ 122C-263. Duties of law-enforcement officer; first examination by physician or eligible psychologist.**

...

(d) After the conclusion of the examination the physician or eligible psychologist shall make the following determinations:

(1) If the physician or eligible psychologist finds that:

a. The respondent is mentally ill;

b. The respondent is capable of surviving safely in the community with available supervision from family, friends, or others;

c. Based on the respondent's psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined by G.S. 122C-3(11); and

d. The respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision to seek voluntarily or comply with recommended treatment.

The physician or eligible psychologist shall so show on the examination report and shall recommend outpatient commitment. In addition the examining physician or eligible psychologist shall show the name, address, and telephone number of the proposed outpatient treatment physician or center. The person designated in the order to provide transportation shall return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county, and the respondent shall be released from custody.

(2) If the physician or eligible psychologist finds that the respondent is mentally ill and is dangerous to self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., the physician or eligible psychologist shall recommend inpatient commitment, and shall so show on the examination report. If, in addition to mental illness and dangerousness, the physician or eligible psychologist also finds that the respondent is known or reasonably believed to be mentally retarded, this finding shall be shown on the report. The law enforcement officer or other designated person shall take the respondent to a 24-hour facility described in G.S. 122C-252 pending a district court hearing. If there is no area 24-hour facility and if the respondent is indigent and unable to pay for care at a private 24-hour facility, the law enforcement officer or other designated person shall take the respondent to a State facility for the mentally ill designated by the Commission in accordance with G.S. 143B-147(a)(1)a. for custody, observation, and treatment and immediately notify the clerk of superior court of this action. <u>If a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision at the site of the first examination, provided that at anytime that a physician or eligible psychologist determines that the respondent is no longer in need of inpatient commitment, the proceedings shall be terminated and the respondent</u>

transported and released in accordance with subdivision (3) of this subsection. However, if the physician or eligible psychologist determines that the respondent meets the criteria for outpatient commitment, as defined in subdivision (1) of this subsection, the physician or eligible psychologist may recommend outpatient commitment, and the respondent shall be transported and released in accordance with subdivision (1) of this subsection. Any decision to terminate the proceedings or to recommend outpatient commitment after an initial recommendation of inpatient commitment shall be documented and reported to the clerk of superior court in accordance with subsection (e) of this section. If the respondent is temporarily detained and a 24-hour facility is not available or medically appropriate seven days after the issuance of the custody order, a physician or psychologist shall report this fact to the clerk of superior court and the proceedings shall be terminated.

In the event an individual known or reasonably believed to be mentally retarded is transported to a State facility for the mentally ill, in no event shall that individual be admitted to that facility except as follows:

a. Persons described in G.S. 122C-266(b);
b. Persons admitted pursuant to G.S. 15A-1321;
c. Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee; and
d. Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee.

Individuals transported to a State facility for the mentally ill who are not admitted by the facility may be transported by law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed.

(3) If the physician or eligible psychologist finds that neither condition described in subdivisions (1) or (2) of this subsection exists, the proceedings shall be terminated. The person designated in the order to provide transportation shall return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county and the respondent shall be released from custody."

SECTION 3. Section 1(5) of S.L. 2003-178, as amended by Section 10.27 of S.L. 2006-66, and as further amended by Section 1.1(a)(5) of S.L. 2007-504, reads as rewritten:

"(5) The Secretary may grant a waiver under this section to up to ~~10~~ 15 LMEs."

SECTION 4. Section 3 of this act becomes effective July 1, 2009. The remainder of this act becomes effective October 1, 2009.

Att. VI

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 243
Committee Substitute Favorable 5/11/09
Committee Substitute #2 Favorable 5/13/09
Fourth Edition Engrossed 5/14/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H243-CSRD-66 [v.1]

6/11/2009 12:57:04 PM

Short Title: Mental Health/Law Enforcement Custody. (Public)

Sponsors:

Referred to:

February 23, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE FACILITY OF FIRST COMMITMENT EXAMINATION TO TERMINATE THE INPATIENT COMMITMENT PROCEEDINGS IN APPROPRIATE CIRCUMSTANCES WHEN A TWENTY-FOUR-HOUR FACILITY IS NOT AVAILABLE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-261(d) reads as rewritten:

"(d) If the affiant is a physician or eligible psychologist, the affiant may execute the affidavit before any official authorized to administer oaths. This affiant is not required to appear before the clerk or magistrate for this purpose. This affiant shall file the affidavit with the clerk or magistrate by delivering to the clerk or magistrate the original affidavit or a copy in paper form that is printed through the facsimile transmission of the affidavit. If the affidavit is filed through facsimile transmission, the affiant shall mail the original affidavit no later than five days after the facsimile transmission of the affidavit to the clerk or magistrate to be filed by the clerk or magistrate with the facsimile copy of the affidavit. This affiant's examination shall comply with the requirements of the initial examination as provided in G.S. 122C-263(c). If the physician or eligible psychologist recommends outpatient commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for outpatient commitment, the clerk or magistrate shall issue an order that a hearing before a district court judge be held to determine whether the respondent will be involuntarily committed. The physician or eligible psychologist shall provide the respondent with written notice of any scheduled appointment and the name, address, and telephone number of the proposed outpatient treatment physician or center. If the physician or eligible psychologist recommends inpatient commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order for transportation to or custody at a 24-hour facility described in G.S. ~~122C-252.~~122C-252, provided that if a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision and, upon further examination, released in accordance with G.S. 122C-263(d)(2). ~~However, if~~ If the clerk or magistrate finds probable cause to believe that the respondent, in addition to being mentally ill, is also mentally retarded, the clerk or

magistrate shall contact the area authority before issuing the order and the area authority shall designate the facility to which the respondent is to be transported. If a physician or eligible psychologist executes an affidavit for inpatient commitment of a respondent, a second physician shall be required to perform the examination required by G.S. 122C-266."

SECTION 2. G.S. 122C-263(d) reads as rewritten:

"**§ 122C-263. Duties of law-enforcement officer; first examination by physician or eligible psychologist.**

...

(d) After the conclusion of the examination the physician or eligible psychologist shall make the following determinations:

(1) If the physician or eligible psychologist finds that:

a. The respondent is mentally ill;

b. The respondent is capable of surviving safely in the community with available supervision from family, friends, or others;

c. Based on the respondent's psychiatric history, the respondent is in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness as defined by G.S. 122C-3(11); and

d. The respondent's current mental status or the nature of the respondent's illness limits or negates the respondent's ability to make an informed decision to seek voluntarily or comply with recommended treatment.

The physician or eligible psychologist shall so show on the examination report and shall recommend outpatient commitment. In addition the examining physician or eligible psychologist shall show the name, address, and telephone number of the proposed outpatient treatment physician or center. The person designated in the order to provide transportation shall return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county, and the respondent shall be released from custody.

(2) If the physician or eligible psychologist finds that the respondent is mentally ill and is dangerous to self, as defined in G.S. 122C-3(11)a., or others, as defined in G.S. 122C-3(11)b., the physician or eligible psychologist shall recommend inpatient commitment, and shall so show on the examination report. If, in addition to mental illness and dangerousness, the physician or eligible psychologist also finds that the respondent is known or reasonably believed to be mentally retarded, this finding shall be shown on the report. The law enforcement officer or other designated person shall take the respondent to a 24-hour facility described in G.S. 122C-252 pending a district court hearing. If there is no area 24-hour facility and if the respondent is indigent and unable to pay for care at a private 24-hour facility, the law enforcement officer or other designated person shall take the respondent to a State facility for the mentally ill designated by the Commission in accordance with G.S. 143B-147(a)(1)a. for custody, observation, and treatment and immediately notify the clerk of superior court of this action. <u>If a 24-hour facility is not immediately available or appropriate to the respondent's medical condition, the respondent may be temporarily detained under appropriate supervision at the site of the first examination, provided that at anytime that a physician or eligible psychologist determines that the respondent is no longer in need of inpatient commitment, the proceedings shall be terminated and the respondent</u>

transported and released in accordance with subdivision (3) of this subsection. However, if the physician or eligible psychologist determines that the respondent meets the criteria for outpatient commitment, as defined in subdivision (1) of this subsection, the physician or eligible psychologist may recommend outpatient commitment, and the respondent shall be transported and released in accordance with subdivision (1) of this subsection. Any decision to terminate the proceedings or to recommend outpatient commitment after an initial recommendation of inpatient commitment shall be documented and reported to the clerk of superior court in accordance with subsection (e) of this section. If the respondent continues to meet the criteria for inpatient commitment but a 24-hour facility is not available or medically appropriate seven days after the issuance of the custody order, a physician or psychologist shall report this fact to the clerk of superior court and the proceedings shall be terminated.

In the event an individual known or reasonably believed to be mentally retarded is transported to a State facility for the mentally ill, in no event shall that individual be admitted to that facility except as follows:

a. Persons described in G.S. 122C-266(b);
b. Persons admitted pursuant to G.S. 15A-1321;
c. Respondents who are so extremely dangerous as to pose a serious threat to the community and to other patients committed to non-State hospital psychiatric inpatient units, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee; and
d. Respondents who are so gravely disabled by both multiple disorders and medical fragility or multiple disorders and deafness that alternative care is inappropriate, as determined by the Director of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services or his designee.

Individuals transported to a State facility for the mentally ill who are not admitted by the facility may be transported by law enforcement officers or designated staff of the State facility in State-owned vehicles to an appropriate 24-hour facility that provides psychiatric inpatient care.

No later than 24 hours after the transfer, the responsible professional at the original facility shall notify the petitioner, the clerk of court, and, if consent is granted by the respondent, the next of kin, that the transfer has been completed.

(3) If the physician or eligible psychologist finds that neither condition described in subdivisions (1) or (2) of this subsection exists, the proceedings shall be terminated. The person designated in the order to provide transportation shall return the respondent to the respondent's regular residence or, with the respondent's consent, to the home of a consenting individual located in the originating county and the respondent shall be released from custody."

SECTION 3. Section 1(5) of S.L. 2003-178, as amended by Section 10.27 of S.L. 2006-66, and as further amended by Section 1.1(a)(5) of S.L. 2007-504, reads as rewritten:

"(5) The Secretary may grant a waiver under this section to up to ~~10~~ 15 LMEs."

SECTION 4. Section 3 of this act becomes effective July 1, 2009. The remainder of this act becomes effective October 1, 2009.

Att. VII

HOUSE BILL 243:
Mental Health/Law Enforcement Custody

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 23, 2009
Introduced by:	Reps. Insko, Steen, Barnhart	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	PCS to Fourth Edition H243-CSRD-66		

SUMMARY: ***House Bill 243 would provide authority for the facility providing the first commitment examination to temporarily detain the respondent at that facility and to terminate the inpatient commitment proceedings in appropriate circumstances where a 24-hour facility is unavailable or no longer medically appropriate, would require written documentation of termination of certain inpatient proceedings, and would authorize the Secretary of Health and Human Services to authorize up to 15 LMEs to participate in the First Commitment Pilot Program.***

The Proposed Committee Substitute removes language from Section 2 of the original bill that would have required new involuntary commitment proceedings to be initiated if a person has been detained at the site of the first examination for seven days after issuance of the custody order without being placed in a 24-hour facility.

CURRENT LAW: G.S. 122C-251 governs the provision of transportation of a person subject to involuntary commitment proceedings by a city or county. Subdivision (e) allows for the use of reasonable force in restraining the person being transported if necessary to protect the officer, the person being transported or others. Subdivision (g) allows a city or county to plan for the transportation of respondents in involuntary commitment proceedings. Law enforcement personnel, volunteers, or public or private agency personnel may be designated to provide the necessary transportation. Subdivision (h) covers responsibility for the costs of such transportation. The costs and expenses are the responsibility of the county of residence of the respondent. Costs may be recovered from a respondent if the respondent is not indigent, the person liable for the respondent's support if there is sufficient property to pay the costs, any person or entity that is responsible for the cost or is otherwise liable for the costs.

G.S. 122C-261 provides for the affidavit and petition to the magistrate, or clerk or deputy clerk of superior court, by anyone with knowledge that a person is mentally ill, and either dangerous to self or others, or in need of treatment in order to prevent further deterioration that would result in dangerousness. A magistrate or clerk finding reasonable grounds to believe that the allegations are true shall order the person taken into custody for examination.. Subsection (d) of G.S. 122C-261 provides, in pertinent part, that if the person filing the affidavit is a physician, the physician's examination complies with the requirement for a first examination. If the physician recommends inpatient treatment, and the clerk or magistrate finds reasonable cause to believe the respondent meets the criteria for inpatient commitment, an order for transportation to a 24 hour facility shall be ordered.

G.S. 122C-263 governs the first examination of a respondent by a physician or eligible psychologist. Subsection (d) sets forth the determinations that a physician is to make at the end of the examination – for either outpatient treatment, inpatient commitment, or neither. If inpatient commitment is determined to be necessary, a law enforcement officer or other person shall take the respondent to an area 24 hour facility. If no area facility is available, the respondent is to be taken to a State facility.

BILL ANALYSIS: **Section 1** of the bill would amend G.S. 122C-261(d) to provide that if a physician recommends inpatient treatment, but a 24 hour facility is not immediately available or appropriate for

the respondents medical condition, the respondent may be temporarily detained under supervision, and on further examination, released in accordance with G.S. 122C-263(d)(2).

Section 2 of the bill would amend G.S. 122C-263(d) to provide that if a physician upon first examination determines that inpatient treatment is warranted, and a 24-hour facility is not immediately available or appropriate, the respondent may be detained at the site of the first examination and the custody order would remain in effect. If at anytime the physician determines that the respondent is no longer in need of inpatient commitment, then proceedings would either be terminated and the respondent transported and released, or the physician could recommend outpatient commitment. Decisions to terminate inpatient proceedings would be documented and reported to the clerk of superior court. If a respondent continues to meet the criteria for inpatient commitment but a 24-hour facility is not available 7 days after the issuance of the custody order, the proceedings would be terminated, and the matter reported to the clerk.

Section 3 of the bill would amend the Session Laws which authorized the Secretary of Health and Human Services to grant a temporary waiver of certain requirements for involuntary commitment of persons who are mentally ill or who are substance abusers for up to 10 LME's to participate in the conduct of the First Commitment Pilot Program. The amendment would increase the number of LME's that may be granted waivers and allowed to participate in the pilot program from 10 to 15.

EFFECTIVE DATE: Section 3 of the act becomes effective July 1, 2009. The remainder of the act becomes effective October 1, 2009

Barbara Riley, counsel to House Mental Health Reform, substantially contributed to this summary.

H243-SMRD-163(CSRD-66) v1

Am. V111

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 243

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

H243-ARD-30 [v.1]

Comm. Sub. [YES]
Amends Title [NO]
Fourth Edition

Date _____,2009

Senator _____

X → 1 moves to amend the bill on page 3, lines 10-11, by rewriting the lines to read:
→ 2 "in accordance with subsection (e) of this section. If the respondent is temporarily detained and
3 a 24-hour facility is not".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

AH. TX

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H 2

HOUSE BILL 456
Committee Substitute Favorable 4/15/09

Short Title: Tech. & Org. Changes/Certain DHHS Facilities. (Public)

Sponsors:

Referred to:

March 9, 2009

A BILL TO BE ENTITLED

AN ACT TO MAKE TECHNICAL AND ORGANIZATIONAL CHANGES TO THE LAW REGARDING THE LICENSURE AND INSPECTION OF FACILITIES FOR AGED AND DISABLED INDIVIDUALS.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Chapter 131D of the General Statutes is amended by adding the following new Article to read:

"Article 1B.
"Licensing of Maternity Homes."

SECTION 1.(b) G.S. 131D-1 is recodified as G.S. 131D-10.10 under Article 1B of Chapter 131D of the General Statutes.

SECTION 1.(c) The title of Article 1 of Chapter 131D of the General Statutes reads as rewritten:

"Article 1.
~~Licensing of Facilities.~~
Adult Care Homes."

SECTION 1.(d) G.S. 131D-2 is repealed.

SECTION 1.(e) Article 1 of Chapter 131D of the General Statutes, as amended by Section 1(c) of this act, is amended by adding the following new Parts to read:

"Part 1. Licensing.

"**§ 131D-2.1. Definitions.**

As used in this Article:

(1) Abuse. – The willful or grossly negligent infliction of physical pain, injury, or mental anguish, unreasonable confinement, or the willful or grossly negligent deprivation by the administrator or staff of an adult care home of services which are necessary to maintain mental and physical health.

(2) Administrator. – A person approved by the Department of Health and Human Services who has the responsibility for the total operation of a licensed adult care home.

(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. 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.

(4) Amenities. – Services such as meals, housekeeping, transportation, and grocery shopping that do not involve hands-on personal care.

(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. 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.

(6) Compensatory agent. – A spouse, relative, or other caretaker who lives with a resident and provides care to a resident.

(7) Department. – The Department of Health and Human Services unless some other meaning is clearly indicated from the context.

(8) Exploitation. – The illegal or improper use of an aged or disabled resident or the aged or disabled resident's resources for another's profit or advantage.

(9) Family care home. – An adult care home having two to six residents. The structure of a family care home may be no more than two stories high, and none of the aged or physically disabled persons being served there may be housed in the upper story without provision for two direct exterior ground-level accesses to the upper story.

(10) Multiunit assisted housing with services. – An assisted living residence in which hands-on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement which makes personal care services accessible and available through at least one licensed home care or hospice agency. 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 established plan of care. Multiunit assisted housing with services programs are required to register with the Division of Health Service Regulation and to provide a disclosure statement. The disclosure

statement is required to be a part of the annual rental contract that includes a description of the following requirements:

a. Emergency response system;
b. Charges for services offered;
c. Limitations of tenancy;
d. Limitations of services;
e. Resident responsibilities;
f. Financial/legal relationship between housing management and home care or hospice agencies;
g. A listing of all home care or hospice agencies and other community services in the area;
h. An appeals process; and
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, are exempt from the regulatory requirements for multiunit assisted housing with services programs.

(11) Neglect. – The failure to provide the services necessary to maintain a resident's physical or mental health.

(12) Personal care services. – Any hands-on services allowed to be performed by In-Home Aides II or III as outlined in Department rules.

(13) Registration. – The submission by a multiunit assisted housing with services provider of a disclosure statement containing all the information as outlined in subdivision (10) of this section.

(14) Resident. – A person living in an assisted living residence for the purpose of obtaining access to housing and services provided or made available by housing management.

(15) Secretary. – The Secretary of Health and Human Services unless some other meaning is clearly indicated from the context.

"**§ 131D-2.2. Persons not to be cared for in adult care homes and multiunit assisted housing with services; hospice care; obtaining services.**

(a) Adult Care Homes. – 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, adult care homes shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator dependency;
(2) Individuals requiring continuous licensed nursing care;
(3) Individuals whose physician certifies that placement is no longer appropriate;
(4) Individuals whose health needs cannot be met in the specific adult care home as determined by the residence; and
(5) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in an adult care home.

(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;
(2) Dermal ulcers III and IV, except those stage III ulcers which are determined by an independent physician to be 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;
(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;
(5) Psychotropic medications without appropriate diagnosis and treatment plans;
(6) Nasogastric 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;
(8) Individuals requiring continuous licensed nursing care;
(9) Individuals whose physician certifies that placement is no longer appropriate;
(10) Unless the individual's independent physician determines otherwise, 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;
(11) Individuals whose health needs cannot be met in the specific multiunit assisted housing with services as determined by the residence; and
(12) Such other medical and functional care needs as the Medical Care Commission determines cannot be properly met in multiunit assisted housing with services.

(c) Hospice Care. – At the request of the resident, hospice care may be provided in an assisted living residence under the same requirements for hospice programs as described in Article 10 of Chapter 131E of the General Statutes.

(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.

"**§ 131D-2.3. Exemptions from licensure.**

(a) The following are excluded from this Article and are not required to be registered or obtain licensure under this Article:
(1) Facilities licensed under Chapter 122C or Chapter 131E of the General Statutes;
(2) Persons subject to rules of the Division of Vocational Rehabilitation Services;
(3) Facilities that care for no more than four persons, all of whom are under the supervision of the United States Veterans Administration;
(4) Facilities that make no charges for housing, amenities, or personal care service, either directly or indirectly; and
(5) Institutions that are maintained or operated by a unit of government and that were established, maintained, or operated by a unit of government and exempt from licensure by the Department on September 30, 1995.

"**§ 131D-2.4. Licensure of adult care homes for aged and disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.**

(a) Licensure. – Except for those facilities exempt under G.S. 131D-2.3, the Department of Health and Human Services shall inspect and license all adult care homes. The Department shall issue a license for a facility not currently licensed as an adult care home for a period of six months. If the licensee demonstrates substantial compliance with Articles 1 and 3 of this Chapter and rules adopted thereunder, the Department shall issue a license for the balance of the calendar year.

(b) Compliance History Review. – Prior to issuing a new license or renewing an existing license, the Department shall conduct a compliance history review of the facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its principals or affiliates, or otherwise demonstrates disregard for the health, safety, and welfare of residents in current or past facilities. The Department shall require compliance history information and make its determination according to rules adopted by the Medical Care Commission.

(c) Prior Violations. – No new license shall be issued for any adult care home to an applicant for licensure who:

(1) Was the owner, principal, or affiliate of a licensable facility under this Chapter, Chapter 122C, or Article 7 of Chapter 110 of the General Statutes that had its license revoked until one full year after the date of revocation;

(2) Is the owner, principal, or affiliate of an adult care home that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with the correction plan established pursuant to G.S. 131D-34 and substantial compliance has been certified by the Department;

(3) Is the owner, principal, or affiliate of an adult care home that had its license summarily suspended or downgraded to provisional status as a result of Type A or Type B violations until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable; or

(4) Is the owner, principal, or affiliate of a licensable facility that had its license summarily suspended or downgraded to provisional status as a result of violations under this Article or Chapter 122C of the General Statutes or had its license summarily suspended or denied under Article 7 of Chapter 110 of the General Statutes until six months from the date of the reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

An applicant for new licensure may appeal a denial of certification of substantial compliance under subdivision (2) of this subsection by filing with the Department a request for review by the Secretary within 10 days of the date of denial of the certification. Within 10 days of receipt of the request for review, the Secretary shall issue to the applicant a written determination that either denies certification of substantial compliance or certifies substantial compliance. The decision of the Secretary is final.

(d) License Renewals. – License renewals shall be valid for one year from the date of renewal unless revoked earlier by the Secretary for failure to comply with any part of this section or any rules adopted hereunder. Licenses shall be renewed annually upon filing and the Department's approval of the renewal application. The Department shall not renew a license if outstanding fees, fines, and penalties imposed by the State against the home have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration. The renewal application shall contain all necessary and reasonable information that the Department may require.

(e) In order for an adult care home to maintain its license, it shall not hinder or interfere with the proper performance of duty of a lawfully appointed community advisory committee, as defined by G.S. 131D-31 and G.S. 131D-32.

(f) The Department shall not issue a new license for a change of ownership of an adult care home if outstanding fees, fines, and penalties imposed by the State against the home have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration.

"**§ 131D-2.5. License fees.**

The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of two hundred fifty dollars ($250.00). The Department shall charge each adult care home with more than six beds a nonrefundable annual license fee in the amount of three hundred fifty dollars ($350.00) plus a nonrefundable annual per-bed fee of twelve dollars and fifty cents ($12.50).

"**§ 131D-2.6. Legal action by Department.**

(a) Notwithstanding the existence or pursuit of any other remedy, the Department may, in the manner provided by law, maintain an action in the name of the State for injunction or other process against any person to restrain or prevent the establishment, conduct, management, or operation of an adult care home without a license. Such action shall be instituted in the superior court of the county in which any unlicensed activity has occurred or is occurring.

(b) Any individual or corporation that establishes, conducts, manages, or operates a facility subject to licensure under this section without a license is guilty of a Class 3 misdemeanor and, upon conviction, shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense.

(c) If any person shall hinder the proper performance of duty of the Secretary or the Secretary's representative in carrying out this section, the Secretary may institute an action in the superior court of the county in which the hindrance has occurred for injunctive relief against the continued hindrance, irrespective of all other remedies at law.

(d) Actions under this section shall be in accordance with Article 37 of Chapter 1 of the General Statutes and Rule 65 of the Rules of Civil Procedure.

"**§ 131D-2.7. Provisional license; license revocation; summary suspension of license; suspension of admission.**

(a) Provisional License. – Except as otherwise provided in this section, the Department may amend a license by reducing it from a full license to a provisional license for a period of not more than 90 days whenever the Department finds that:

(1) The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of this Chapter and the rules adopted pursuant to these Articles;

(2) There is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and

(3) There is a reasonable probability that the licensee will be able thereafter to remain in compliance with the licensure rules for the foreseeable future.

The Department may extend a provisional license for not more than one additional 90-day period upon finding that the licensee has made substantial progress toward remedying the licensure deficiencies that caused the license to be reduced to provisional status.

The Department also may issue a provisional license to a facility, pursuant to rules adopted by the Medical Care Commission, for substantial failure to comply with the provisions of this section or rules adopted pursuant to this section. Any facility wishing to contest the issuance of a provisional license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested

case shall be filed within 30 days after the Department mails written notice of the issuance of the provisional license.

(b) License Revocation. – The Department may revoke a license whenever:

(1) The Department finds that:

a. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of this Chapter and the rules adopted pursuant to these Articles; and

b. It is not reasonably probable that the licensee can remedy the licensure deficiencies within a reasonable length of time; or

(2) The Department finds that:

a. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of this Chapter and the rules adopted pursuant to these Articles; and

b. Although the licensee may be able to remedy the deficiencies within a reasonable time, it is not reasonably probable that the licensee will be able to remain in compliance with licensure rules for the foreseeable future; or

c. The licensee has failed to comply with the provisions of Articles 1 and 3 of this Chapter and the rules adopted pursuant to these Articles, and the failure to comply endangered the health, safety, or welfare of the patients in the facility.

(c) Summary Suspension. – The Department may summarily suspend a license pursuant to G.S. 150B-3(c) whenever it finds substantial evidence of abuse, neglect, exploitation, or any condition which presents an imminent danger to the health and safety of any resident of the home. Any facility wishing to contest summary suspension of a license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of summary suspension to the licensee.

(d) Suspension of Admissions.

(1) In addition to the administrative penalties described in this Article, the Secretary may suspend the admission of any new residents to an adult care home where the conditions of the adult care home are detrimental to the health or safety of the residents. This 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.

(2) In imposing a suspension under this section, the Secretary shall consider the following factors:

a. The degree of sanctions necessary to ensure compliance with this section and rules adopted hereunder; and

b. The character and degree of impact of the conditions at the home on the health or safety of its residents.

(3) The Secretary of Health and Human Services shall adopt rules to implement this section.

(4) Any facility wishing to contest a suspension of admissions shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 20 days after the Department mails a notice of suspension of admissions to the licensee.

"**§§ 131D-2.8 through 2.10: Reserved for future codification purposes.**

"Part 2. Other Laws Pertaining to the Inspection and Operation of Adult Care Homes.

"**§ 131D-2.11. Inspections, monitoring, and review by State agency and county departments of social services.**

(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. The Division of Health Service Regulation shall inspect all adult care homes and adult care units in nursing homes on an annual basis. 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.

(b) Monitoring by County. – The Department shall work with county departments of social services to do the routine monitoring in adult care homes to ensure compliance with State and federal laws, rules, and regulations in accordance with policy and procedures established by the Division of Health Service Regulation and to have the Division of Health Service Regulation oversee this monitoring and perform any required follow-up inspection. The county departments of social services shall document in a written report all on-site visits, including monitoring visits, revisits, and complaint investigations. The county departments of social services shall submit to the Division of Health Service Regulation written reports of each facility visit within 20 working days of the visit.

(c) State Review of County Compliance. – The Division of Health Service Regulation shall conduct and document annual reviews of the county departments of social services' performance. When monitoring is not done timely or there is failure to identify or document noncompliance, the Department may intervene in the particular service in question. Department intervention shall include one or more of the following activities:

(1) Sending staff of the Department to the county departments of social services to provide technical assistance and to monitor the services being provided by the facility.

(2) Advising county personnel as to appropriate policies and procedures.

(3) Establishing a plan of action to correct county performance.

The Secretary may determine that the Department shall assume the county's regulatory responsibility for the county's adult care homes.

"**§ 131D-2.12. Training requirements; county departments of social services.**

(a) The county departments of social services' adult home specialists and their supervisors shall complete:

(1) Eight hours of prebasic training within 60 days of employment;

(2) Thirty-two hours of basic training within six months of employment;

(3) Twenty-four hours of postbasic training within six months of the basic training program;

(4) A minimum of eight hours of complaint investigation training within six months of employment; and

(5) A minimum of 16 hours of statewide training annually by the Division of Health Service Regulation.

(b) The joint training requirements by the Department shall be as provided in G.S. 143B-139.5B.

"**§ 131D-2.13. Departmental duties.**

(a) Enforcement of Room Ventilation and Temperature. – The Department shall monitor regularly the enforcement of rules pertaining to air circulation, ventilation, and room temperature in resident living quarters. These rules shall include the requirement that air conditioning or at least one fan per resident bedroom and living and dining areas be provided when the temperature in the main center corridor exceeds 80 degrees Fahrenheit.

(b) Administrator Directory. – The Department shall keep an up-to-date directory of all persons who are administrators as defined in G.S. 131D-2.1.

(c) Departmental Complaint Hotline. – Adult care homes shall post the Division of Health Service Regulation's complaint hotline number conspicuously in a public place in the facility.

(d) Provider File. – The Department of Health and Human Services shall establish and maintain a provider file to record and monitor compliance histories of facilities, owners, operators, and affiliates of nursing homes and adult care homes.

(e) Report on Use of Restraint. – The Department shall report annually on October 1 to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by the investigation to be related to the adult care home's use of physical restraint or physical hold.

"**§ 131D-2.14. Confidentiality.**

Notwithstanding G.S. 8-53 or any other law relating to confidentiality of communications between physician and patient, in the course of an inspection conducted under G.S. 131D-2.11:

(1) Department representatives may review any writing or other record concerning the admission, discharge, medication, care, medical condition, or history of any person who is or has been a resident of the facility being inspected.

(2) Any person involved in giving care or treatment at or through the facility may disclose information to Department representatives unless the resident objects in writing to review of the resident's records or disclosure of such information.

(3) The facility, its employees, and any other person interviewed in the course of an inspection shall be immune from liability for damages resulting from disclosure of any information to the Department. The Department shall not disclose:

a. Any confidential or privileged information obtained under this section unless the resident or the resident's legal representative authorizes disclosure in writing or unless a court of competent jurisdiction orders disclosure, or

b. The name of anyone who has furnished information concerning a facility without that person's consent.

The Department shall institute appropriate policies and procedures to ensure that unauthorized disclosure does not occur. All confidential or privileged information obtained under this section and the names of persons providing such information shall be exempt from Chapter 132 of the General Statutes.

(4) Notwithstanding any law to the contrary, Chapter 132 of the General Statutes, the Public Records Law, applies to all records of the State Division of Social Services of the Department of Health and Human Services and of any county department of social services regarding inspections of adult care facilities except for information in the records that is confidential or privileged, including medical records, or that contains the names of residents or complainants.

"§ 131D-2.15. Resident assessments.

(a) The Department shall ensure that facilities conduct and complete an assessment of each resident within 72 hours of 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. 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:

(1) Whether the appropriate assessment instrument was administered and interpreted correctly;

(2) Whether the facility is capable of providing the necessary services;

(3) Whether the service plan or care plan conforms to the results of an appropriately administered and interpreted assessment; and

(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.

"§ 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, 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.

"§ 131D-2.17. Impact on other laws; severability.

(a) Nothing in this section shall be construed to supersede any federal or State antitrust, antikickback, or safe harbor laws or regulations.

(b) If any provisions of this section or the application of it to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the section which can be given effect without the invalid provision or application, and to this end the provisions of this section are severable.

"§ 131D-2.18. Application of other laws.

(a) Certification of assisted living administrators shall be as provided under Article 20A of Chapter 90 of the General Statutes.

(b) Compliance with the Health Care Personnel Registry shall be as provided under G.S. 131E-256.

(c) Rules for the operation of the adult care portion of a combination home, as defined in G.S. 131E-101, shall be as provided in G.S. 131E-104."

SECTION 2. G.S. 131D-41 and G.S. 131D-42 are repealed.

SECTION 3.(a) G.S. 131D-2.1(10), as enacted by Section 1 of this act, reads as rewritten:

"(10) "Multiunit assisted housing with services." – An assisted living residence in which hands-on personal care services and nursing services which are arranged by housing management are provided by a licensed home care or hospice agency through an individualized written care plan. The housing management has a financial interest or financial affiliation or formal written agreement which makes personal care services accessible and available through at least one licensed home care or hospice agency. 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 established plan of care. Multiunit assisted housing with services programs are required to register annually with the Division of Health Service Regulation. ~~Regulation and to provide a disclosure statement.~~ 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 the following requirements:

a. Emergency response system;
b. Charges for services offered;
c. Limitations of tenancy;
d. Limitations of services;
e. Resident responsibilities;
f. Financial/legal relationship between housing management and home care or hospice agencies;
g. A listing of all home care or hospice agencies and other community services in the area;
h. An appeals process; and
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, are exempt from the regulatory requirements for multiunit assisted housing with services programs."

SECTION 3.(b) G.S. 131D-2.5, as enacted by Section 1 of this act, reads as rewritten:

"**§ 131D-2.5. License and registration fees.**

(a) The Department shall charge each adult care home with six or fewer beds a nonrefundable annual license fee in the amount of two hundred fifty dollars ($250.00). The

Department shall charge each adult care home with more than six beds a nonrefundable annual license fee in the amount of three hundred fifty dollars ($350.00) plus a nonrefundable annual per-bed fee of twelve dollars and fifty cents ($12.50).

(b) The Department shall charge each registered multiunit assisted housing with services program a nonrefundable annual registration fee of three hundred fifty dollars ($350.00). Any individual or corporation that establishes, conducts, manages, or operates a multiunit housing with services program, subject to registration under this section, that fails to register is guilty of a Class 3 misdemeanor and, upon conviction shall be punishable only by a fine of not more than fifty dollars ($50.00) for the first offense and not more than five hundred dollars ($500.00) for each subsequent offense. Each day of a continuing violation after conviction shall be considered a separate offense."

SECTION 3.(c) S.L. 2008-166 is repealed.

SECTION 4. Section 3 of this act becomes effective January 1, 2010, and the remainder of this act becomes effective October 1, 2009. Licenses issued pursuant to G.S. 131D-2 remain effective until the date of annual renewal at which time Part 1 of Article 1 of Chapter 131D of the General Statutes shall apply. In all other respects, beginning October 1, 2009, Part 1 of Article 1 of Chapter 131D shall apply to the operation of facilities currently licensed under G.S. 131D-2.

AH. X

HOUSE BILL 456:
Tech. & Org. Changes/Certain DHHS Facilities

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Finance	**Date:**	June 10, 2009
Introduced by:	Reps. Insko, England, Farmer-Butterfield, Earle	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	Second Edition		

SUMMARY: ***House Bill 456 makes technical and organizational changes to the laws regarding licensure and inspection of facilities for aged and disabled individuals.***

BILL ANALYSIS:

Section 1(a) and (b) of PCS for House Bill 456 pertain to statutory revisions for Maternity Homes.

- Section 1(a) of the bill adds the title of a new Article, Article 1B. Licensing of Maternity Homes, to Chapter 131D of the General Statutes.
- Section 1(b) recodifies G.S. 131D-1 as G.S. 131D-10.10 to place the contents which pertain to the licensing of maternity homes under the new Article 1B.

Section 1(c) changes the title of Article 1 of Ch 131D to "Adult Care Homes". The statutory revisions contained in Sections 1(d) and (e) and Section 2 of the bill are as follows:

Statute Section Title Used in Section 1(e) of HB 456	Statutory Section Added by Section 1(e) of HB 456	Cross Reference to Current Law and Repeal of Current Law	Additional Information on Change
Definitions	GS 131D-2.1 *proposed*	GS 131D-2 *Repealed by Sec. 1(d) of the bill.*	Renumbers the definitions, replaces reference to domiciliary home with adult care home
Persons not to be cared for in adult care homes & multiunit assisted housing with services; hospice care; obtaining services	GS 131D-2.2 *proposed*	GS 131D-2(a1), GS 131D-2(a2), GS 131D-2(a3), GS 131D-2(c1) *Repealed by Sec. 1(d) of the bill.*	Reorganizes; Section (d) in proposed GS 131D-2.2 - Obtaining services rewritten from original language in GS 131D-2(c1)
Exemptions from licensure	GS 131D-2.3 *proposed*	GS 131D-2(c) *Repealed by Sec. 1(d) of the bill.*	
Licensure of adult care homes for aged & disabled individuals; impact of prior violations on licensure; compliance history review; license renewal.	GS 131D-2.4 *proposed*	GS 131D-2(b)(1), GS 131D-2(b)(6), GS 131D-2(b1) GS 131D-2(b)(1b) *Repealed by Sec. 1(d) of the bill.*	
License fees	GS 131D-2.5 *proposed*	GS 131D-2(b)(1) *Repealed by Sec. 1(d) of the bill.*	Also see Section 3 which will rename this section to include registration fees enacted by S.L. 2008-166
Legal action by department	GS 131D-2.6 *proposed*	GS 131D-2(b)(2) GS 131D-2(i)	

		Repealed by Sec. 1(d) of the bill.	
Provisional license; license revocation; summary suspension; suspension of admission	GS 131D-2.7 *proposed*	GS 131D-2(b)(1) GS 131D-2(b)(3) GS 131D-2(h) *Repealed by Sec. 1(d) of the bill.*	
Inspections, monitoring, and review by State agency and county departments of social services	GS 131D-2.11 *proposed*	GS 131D-2(b)(1a) *Repealed by Sec. 1(d) of the bill.*	
Training requirements; county departments of social services	GS 131D-2.12 *proposed*	GS 131D-2(b)(1a)(d) *Repealed by Sec. 1(d) of the bill.*	Proposed GS 131D-2.12(b) new language that references joint training requirements by the Department in GS 143B-139.5B
Departmental duties	GS 131D-2.13(a), GS 131D -2.13(b), GS 131D-2.13(c), GS 131D-2.13(d), GS 131D-2.13(e) *All proposed*	GS 131D-2(b)(1a)(e), GS 131D-2(b)(1a)(f), GS 131D-2(j) *Repealed by Sec. 1(d) of the bill.* GS 131D-41, GS 131D-42 *Repealed by Sec. 2 of the bill.*	
Confidentiality	GS 131D-2.14 *proposed*	GS 131D-2(b)(4) GS 131D-2(b)(5) *Repealed by Sec. 1(d) of the bill.*	Replaced reference to domiciliary care to adult care home
Resident assessments	GS 131D-2.15 *proposed*	GS 131D-2(e) *Repealed by Sec. 1(d) of the bill.*	
Rules	GS 131D-2.16 *proposed*	GS 131D-2(c2) *Repealed by Sec. 1(d) of the bill.*	
Impact on other laws; severability	GS 131D-2.17 *proposed*	GS 131D-2(c3), GS 131D-2(f) *Repealed by Sec. 1(d) of the bill.*	
Application of other laws	GS 131D-2.18 *proposed*	N/A	

Section 2 of the PCS repeals G.S. 131D-41 and G.S. 131D-42 which are covered by the new G.S. 131D-2.13(d) and (c).

Section 3 of the PCS incorporates the changes enacted by 2008-166 regarding Multiunit assisted housing with services (MAHS) fees which were omitted from the original bill. This Section has an effective date of January 1, 2010 which conforms to S.L. 2008-166. Section 3 (c) repeals S.L. 2008-166 because it was drafted using the current statutory structure and will not fit if this bill is enacted.

EFFECTIVE DATE: Section 3 of this PCS would become effective January 1, 2010, the remainder of this bill would become effective October 1, 2009. Licenses issued pursuant to G.S. 131D-2 remain effective until the date of annual renewal at which time Part 1 of Article 1 of Chapter 131D of the General Statutes apply. In all other respects, beginning October 1, 2009, Part 1 of Article 1 of Chapter 131D applies to the operation of facilities currently licensed under G.S. 131D-2.

Theresa Matula and Susan Barham substantially contributed to this summary.

Att. XI

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H 2

HOUSE BILL 1189
Committee Substitute Favorable 5/12/09

Short Title: DHHS/Tracking Outpatient Commitments.-AB (Public)

Sponsors:

Referred to:

April 8, 2009

A BILL TO BE ENTITLED

AN ACT REQUIRING PHYSICIANS OR ELIGIBLE PSYCHOLOGISTS CONDUCTING EXAMINATIONS TO INFORM THE LOCAL MANAGEMENT ENTITY THAT AN INDIVIDUAL HAS BEEN SCHEDULED FOR AN APPOINTMENT WITH AN OUTPATIENT TREATMENT PHYSICIAN OR CENTER; TO ALLOW FIRST COMMITMENTS TO BE CONDUCTED VIA TELEMEDICINE; AND PERTAINING TO SECURITY FORCES AT CERTAIN MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-261(d) reads as rewritten:

"(d) If the affiant is a physician or eligible psychologist, the affiant may execute the affidavit before any official authorized to administer oaths. This affiant is not required to appear before the clerk or magistrate for this purpose. This affiant shall file the affidavit with the clerk or magistrate by delivering to the clerk or magistrate the original affidavit or a copy in paper form that is printed through the facsimile transmission of the affidavit. If the affidavit is filed through facsimile transmission, the affiant shall mail the original affidavit no later than five days after the facsimile transmission of the affidavit to the clerk or magistrate to be filed by the clerk or magistrate with the facsimile copy of the affidavit. This affiant's examination shall comply with the requirements of the initial examination as provided in G.S. 122C-263(c). If the physician or eligible psychologist recommends outpatient commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for outpatient commitment, the clerk or magistrate shall issue an order that a hearing before a district court judge be held to determine whether the respondent will be involuntarily committed. The physician or eligible psychologist shall provide the respondent with written notice of any scheduled appointment and the name, address, and telephone number of the proposed outpatient treatment physician or center. The physician or eligible psychologist shall contact the local management entity that serves the county where the respondent resides or the local management entity that coordinated services for the respondent to inform the local management entity that the respondent has been scheduled for an appointment with an outpatient treatment physician or center. If the physician or eligible psychologist recommends inpatient commitment and the clerk or magistrate finds probable cause to believe that the respondent meets the criteria for inpatient commitment, the clerk or magistrate shall issue an order for transportation to or custody at a 24-hour facility described in G.S. 122C-252. However, if the clerk or magistrate finds probable cause to believe that the respondent, in addition to being mentally ill, is also mentally retarded, the clerk or magistrate shall contact the area authority before issuing the order and the area authority shall designate the facility to which the respondent is to be transported. If a physician or eligible psychologist executes an affidavit for inpatient

commitment of a respondent, a second physician shall be required to perform the examination required by G.S. 122C-266."

SECTION 2. G.S. 122C-263(c) reads as rewritten:

"(c) The physician or eligible psychologist described in subsection (a) of this section shall examine the respondent as soon as possible, and in any event within 24 hours, after the respondent is presented for examination. When the examination set forth in subsection (a) of this section is performed by a physician or eligible psychologist the respondent may either be in the physical face-to-face presence of the physician or eligible psychologist or may be examined utilizing telemedicine equipment and procedures. A physician or eligible psychologist who examines a respondent by means of telemedicine must be satisfied to a reasonable medical certainty that the determinations made in accordance with subsection (d) of this section would not be different if the examination had been done in the physical presence of the physician or eligible psychologist. A physician or eligible psychologist who is not so satisfied must note that the examination was not satisfactorily accomplished, and the respondent must be taken for a face-to-face examination in the physical presence of a person authorized to perform examinations under this section. As used in this subsection, "telemedicine" is the use of two-way real-time interactive audio and video between places of lesser and greater medical capability or expertise to provide and support health care when distance separates participants who are in different geographical locations. A recipient is referred by one provider to receive the services of another provider via telemedicine.

The examination shall include but is not limited to an assessment of the respondent's:

(1) Current and previous mental illness and mental retardation including, if available, previous treatment history;

(2) Dangerousness to self, as defined in G.S. 122C-3(11)a. or others, as defined in G.S. 122C-3(11)b.;

(3) Ability to survive safely without inpatient commitment, including the availability of supervision from family, friends or others; and

(4) Capacity to make an informed decision concerning treatment."

SECTION 3. Article 6 of Chapter 122C of the General Statues is amended by adding the following new Part to read:

"Part 2D. Long Leaf Neuro-Medical Treatment Center and Eastern North Carolina School for the Deaf Joint Security Force.

"**§ 122C-430.30. Joint security force.**

The Secretary may designate one or more special police officers who shall make up a joint security force to enforce the law of North Carolina and any ordinance or regulation adopted pursuant to G.S. 143-116.6 or G.S. 143-116.7 or pursuant to the authority granted the Department by any other law on the territory of the Long Leaf Neuro-Medical Treatment Center and the Eastern North Carolina School for the Deaf in Wilson County. After taking the oath of office for law enforcement officers as set out in G.S. 11-11, these special police officers have the same powers as peace officers now vested in sheriffs within the territory embraced by the named facilities. These special police officers may arrest persons outside the territory of the named institutions but within the confines of Wilson County when the person arrested has committed a criminal offense within that territory for which the officers could have arrested the person within that territory, and the arrest is made during the person's immediate and continuous flight from that territory."

SECTION 4. This act is effective when it becomes law.

AH. XII

HOUSE BILL 1189:
DHHS/Tracking Outpatient Commitments.-AB

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Judiciary II	**Date:**	June 10, 2009
Introduced by:	Reps. Insko, Earle, M. Alexander, England	**Prepared by:**	Ben Popkin
Analysis of:	Second Edition		Committee Counsel

SUMMARY: House Bill 1189 would require a physician or eligible psychologist to contact the LME serving the county where a respondent resides or the LME that coordinated services for the respondent to inform the LME that the respondent has been scheduled for an appointment with an outpatient treatment center. The bill also would provide for first examinations to be conducted by telemedicine and for special police to be designated to provide a security force for the Long Leaf Neuro-Medical Treatment Center and the Eastern North Carolina School for the Deaf in Wilson County.

CURRENT LAW: Subsection (d) of G.S. 122C-261 provides, in pertinent part, that if the person filing the affidavit is a physician or eligible psychologist, then their examination complies with the requirement for a first examination. If the physician recommends outpatient treatment, and the clerk or magistrate finds reasonable cause to believe the respondent meets the criteria for outpatient commitment, the magistrate or clerk shall issue an order for a hearing to determine whether the respondent should be involuntarily committed. The physician or psychologist is required to provide the respondent with written notice of any scheduled appointment and name address, and telephone number of the proposed outpatient treatment center or physician.

G.S. 122C-263(c) requires that a respondent's first examination shall occur within 24 hours after the respondent is presented for examination.

BILL ANALYSIS: Section 1 of House Bill 1189 would require a physician or eligible psychologist recommending outpatient commitment after performing a first examination to contact the LME serving the county where a respondent resides or the LME that coordinated services for the respondent to inform the LME that the respondent has been scheduled for an appointment with an outpatient treatment center.

Section 2 of the bill would allow the first examination of a respondent to be done using telemedicine. "Telemedicine" is defined as the use of two-way real-time interactive audio and video between places of greater and lesser medical capability or expertise to provide support health care when the participants are in different geographical locations. The physician using telemedicine must be satisfied that the determinations that are made would not be different if the exam were done face to face. If not satisfied, the respondent must be taken for a face to face evaluation.

Section 3 would allow the Secretary of DHHS to designate one or more special police officers to constitute a joint security force to enforce the law of North Carolina and any ordinance or regulation adopted by DHHS for State owned institutions under DHHS jurisdiction, including traffic rules and regulations for the use of buildings and grounds, on the territory of the Long Leaf Neuro-Medical Treatment Center and the Eastern North Carolina School for the Deaf in Wilson County. The special police would have arrest authority outside the territory in cases where the offense was committed within their territory and the arrest is made in hot pursuit of the offender.

EFFECTIVE DATE: The act is effective when it becomes law.

Barbara Riley, counsel to House Mental Health Reform, substantially contributed to this summary.

H1189-SMRD-151(e2) v1

Senate Health Care Committee
Wednesday, July 1, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 878	**EMS Personnel/Recovery Rehab./DHHS.**	**Representative Wainwright**
HB 1296	**Est. Drug And Medical Device Repository/BOP.**	**Representative Stewart**
HB 1297	**Provider Credentialing/Insurers.**	**Representative Jackson** **Representative Stewart**
HB 1309	**Residential Treatment Facil./TBI.**	**Representative Insko**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, July 01, 2009

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

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

H.B. **878** EMS Personnel/Recovery Rehab./DHHS.

Draft Number:	70461
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

Senator Foriest

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, July 01, 2009

Senator ,
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

H.B.(SCS #1) **1309** Residential Treatment Facil./TBI.

Draft Number:	30422
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

Senator Purcell

SENATE HEALTH CARE COMMITTEE
Wednesday, July 1, 2009 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, July 1, 2009, in Room 544 of the Legislative Office Building, with twenty members present. Senator, William R. Purcell Co-Chair, presided. Senator Purcell and Senator Bingham, Co-Chairs, welcomed the committee members present, introduced the pages, and thanked the sergeants-at-arms staff.

Senator Purcell explained that at the last minute two bills were pulled from the Agenda, House Bill 1296, ***Est. Drug and Medical Device Repository/BOP***. and House Bill 1297, ***Provider Credentialing/Insurers***.

Senator Purcell welcomed Rep. Wainwright to explain House Bill 878, ***EMS Personal/Recovery Rehab./DHHS***. The bill had a Proposed Committee Substitute and Senator Blake moved to adopt the PCS for the purpose of discussion and the motion passed. Rep. Wainwright explained that House Bill 878 would amend the Emergency Medical Services Act of 1973 (Article 56 of Chapter 143) to direct the Secretary to establish programs for aiding in recovery and rehabilitation of Emergency Medical Services personnel experiencing chemical addiction or abuse, and programs for monitoring these EMS personnel for safe practice. The bill would extend the NC Physicians Health Program to cover all licensees of the NC Medical Board and would provide that documents relating to impairment assessments under the Program are not public record. Senator Forrester asked if they randomly test, urine drug screening, EMS personnel for drugs. Rep. Wainwright replied, yes they are random tested and if they test positive the EMS employee must appear before the disciplinary committee. Senator Allan asked if HB 878 would call for an appropriation. Rep. Wainwright responded no, the EMS personnel would have to pay for the treatment. Senator Brunstetter asked if this had been a particular problem and pointed out he had not heard of this being a particular issue. Rep. Wainwright stated at present the disciplinary committee currently has no other option than to revoke their license. DHHS is seeking to allow them to enter into treatment and once they have satisfactory completed the program the disciplinary committee can make a determination whether they are able to continue to serve. Senator Goss moved for a favorable report, unfavorable as to the original bill, favorable as to the Proposed Committee Substitute. The motion passed.

Senator Purcell brought before the committee, House Bill 1309, ***Residential Treatment Facil./TBI***. as a PCS. Senator Atwater moved to adopt the PCS for discussion. The motion passed. Senator Purcell called on Rep. Martin to explain the PCS, who stated he was pleased to be there on behalf of Rep. Insko. He stated that Rep. Insko had allowed him to draft legislation onto her bill, House Bill 1309 that deals with Traumatic Brain Injury, TBI. Rep. Martin explained that Rep. Insko's portion of the bill would make a small tweak to the law that would allow the Division of Health Services

Regulation to more intelligently regulate facilities that take care of folks with brain injuries. Under the current regime the rules as they are set up often produce results not intended because the best practice for taking care of folks with TBI don't always match up. The other portion of the bill deals with the North Carolina Traumatic Brain Injury Advisory Council, which deletes the term Traumatic to indicate a greater focus of the Council on all brain injuries. The Council itself requested the changes. Senator Purcell stated that he had an amendment and asked Shawn Parker, Staff Attorney to explain the amendment, who stated it changed some of the membership between voting and non-voting memberships. Also it added a fourth family member within the Governors appointees. Senator Brown pointed out he liked adding a veteran to the board. Shawn Parker, Staff Attorney stated a veteran or veteran family member was already in place under Sub A sub l subdivision C. The reason for this amendment was; after all the changes to the members, the number was an even number that needed to be changed due to the possibility of a tie vote. Senator Purcell asked if there were any questions about the amendment and made a motion to vote. The vote was taken and the amendment passed. Senator Purcell recognized Senator Stien who moved for a favorable report of the PCS as amended. Senator Forrester asked how many residential treatment facilities there were in the NC and would it cost more to get accreditation under this bill. Jeff Horton, Division of Health Services Regulations answered that currently the facilities were licensed as Adult Care Homes and some were general mental health facilities that are called "supervised living". In terms of getting licensed, the licensure fee would be no different than under existing categories. There would be a charge for accreditation, which would be voluntary. Senator Forrester asked about how many patients were there in the state considered TBI patients and were not most of them treated in nursing homes. Sandra Farmer, President of the Brain Injury Association of NC, answered that CDC estimated there to be 2% of the population, which would be 180,000 people. Senator Kinnaird questioned if the 180,000 included stroke victims. Sandra Farmer responded it does not include stroke patients. Senator Purcell stated Sen. Stein had made a motion, to roll the amendment into a New PCS, unfavorable as to the original bill, favorable as to the PCS. The motion passed.

The meeting adjourned at 11:25 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

HOUSE BILL 878

Short Title:	EMS Personnel/Recovery Rehab./DHHS.	(Public)
Sponsors:	Representatives Wainwright; Harrison, Lucas, Pierce, and Wray.	
Referred to:	Homeland Security, Military, and Veterans Affairs, if favorable, Health.	

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO IDENTIFY PROGRAMS FOR AIDING IN THE RECOVERY AND REHABILITATION OF EMS PERSONNEL WITH CHEMICAL ADDICTION OR ABUSE.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-509 reads as rewritten:

"**§ 143-509. Powers and duties of Secretary.**

The Secretary of the Department of Health and Human Services has full responsibilities for supervision and direction of the emergency medical services program and, to that end, shall accomplish all of the following:

(1) After consulting with the Emergency Medical Services Advisory Council and with any local governments that may be involved, seek the establishment of a Statewide Emergency Medical Services System, integrated with other health care providers and networks including, but not limited to, public health, community health monitoring activities, and special needs populations.

(2) Repealed by Session Laws 1989, c. 74.

(3) Establish and maintain a comprehensive statewide trauma system in accordance with the provisions of Article 7A of Chapter 131E of the General Statutes and the rules of the North Carolina Medical Care Commission.

(4) Establish and maintain a statewide emergency medical services communications system including designation of EMS radio frequencies and coordination of EMS radio communications networks within FCC rules and regulations.

(5) Establish and maintain a statewide emergency medical services information system that provides information linkage between various public safety services and other health care providers.

(6) Credential emergency medical services providers, vehicles, EMS educational institutions, and personnel after documenting that the requirements of the North Carolina Medical Care Commission are met.

(7) (8) Repealed by Session Laws 2001-220, s. 1, effective January 1, 2002.

(9) Promote a means of training individuals to administer life-saving treatment to persons who suffer a severe adverse reaction to agents that might cause anaphylaxis. Individuals, upon successful completion of this training program, may be approved by the North Carolina Medical Care Commission to administer epinephrine to these persons, in the absence of the availability of physicians or other practitioners who are authorized to administer the

treatment. This training may also be offered as part of the emergency medical services training program.

(10) Establish and maintain a collaborative effort with other community resources and agencies to educate the public regarding EMS systems and issues.

(11) Collaborate with community agencies and other health care providers to integrate the principles of injury prevention into the Statewide EMS System to improve community health.

(12) Establish and maintain a means of medical direction and control for the Statewide EMS System.

(13) Establish programs for aiding in the recovery and rehabilitation of EMS personnel who experience chemical addiction or abuse and programs for monitoring these EMS personnel for safe practice."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 878
PROPOSED SENATE COMMITTEE SUBSTITUTE H878-CSSQ-73 [v.4]

6/30/2009 3:21:54 PM

Short Title: EMS Prsnl/Recvry Rehab./DHHS/NCPHP. (Public)

Sponsors:

Referred to:

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO IDENTIFY PROGRAMS FOR AIDING IN THE RECOVERY AND REHABILITATION OF EMS PERSONNEL WITH CHEMICAL ADDICTION OR ABUSE AND TO MAKE CHANGES TO THE NORTH CAROLINA PHYSICIANS HEALTH PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-509 reads as rewritten:

"**§ 143-509. Powers and duties of Secretary.**

The Secretary of the Department of Health and Human Services has full responsibilities for supervision and direction of the emergency medical services program and, to that end, shall accomplish all of the following:

(1) After consulting with the Emergency Medical Services Advisory Council and with any local governments that may be involved, seek the establishment of a Statewide Emergency Medical Services System, integrated with other health care providers and networks including, but not limited to, public health, community health monitoring activities, and special needs populations.

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anaphylaxis. Individuals, upon successful completion of this training program, may be approved by the North Carolina Medical Care Commission to administer epinephrine to these persons, in the absence of the availability of physicians or other practitioners who are authorized to administer the treatment. This training may also be offered as part of the emergency medical services training program.

(10) Establish and maintain a collaborative effort with other community resources and agencies to educate the public regarding EMS systems and issues.

(11) Collaborate with community agencies and other health care providers to integrate the principles of injury prevention into the Statewide EMS System to improve community health.

(12) Establish and maintain a means of medical direction and control for the Statewide EMS System.

(13) Establish programs for aiding in the recovery and rehabilitation of EMS personnel who experience chemical addiction or abuse and programs for monitoring these EMS personnel for safe practice."

SECTION 2. G.S. 90-14(b) reads as rewritten:

"(b) The Board shall refer to the North Carolina Physicians Health Program all ~~physicians and physician assistants~~licensees whose health and effectiveness have been significantly impaired by alcohol, drug addiction or mental illness. Sexual misconduct shall not constitute mental illness for purposes of this subsection."

SECTION 3. G.S. 90-14(f) reads as rewritten:

"(f) A person, partnership, firm, corporation, association, authority, or other entity acting in good faith without fraud or malice shall be immune from civil liability for (i) reporting, investigating, assessing, monitoring, or providing an expert medical opinion to the Board regarding the acts or omissions of a licensee or applicant that violate the provisions of subsection (a) of this section or any other provision of law relating to the fitness of a licensee or applicant to practice medicine and (ii) initiating or conducting proceedings against a licensee or applicant if a complaint is made or action is taken in good faith without fraud or malice. A person shall not be held liable in any civil proceeding for testifying before the Board in good faith and without fraud or malice in any proceeding involving a violation of subsection (a) of this section or any other law relating to the fitness of an applicant or licensee to practice medicine, or for making a recommendation to the Board in the nature of peer review, in good faith and without fraud and malice."

SECTION 4. G.S. 90-16(c) reads as rewritten:

"(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~~inquiries, assessments, or interviews conducted in connection with a licensing, ~~complaint or~~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 ~~agents~~consultants involved in the application for ~~license~~license, impairment assessment, or discipline of a license holder, except as provided in subsections (d) and (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."

SECTION 5. This act is effective when it becomes law.

HOUSE BILL 878:
EMS Personnel/Recovery Rehab./DHHS

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 30, 2009
Introduced by:	Rep. Wainwright	**Prepared by:**	Shawn Parker
Analysis of:	PCS to First Edition H878-CSSQ-73		Legislative Analyst

SUMMARY: ***The Senate Proposed Committee Substitute for House Bill 878 would amend the Emergency Medical Services Act of 1973 (Article 56 of Chapter 143) to direct the Secretary to establish 1) programs for aiding in recovery and rehabilitation of Emergency Medical Services personnel experiencing chemical addiction or abuse, and 2) programs for monitoring these EMS personnel for safe practice. The bill would extend the North Carolina Physicians Health Program to cover all licensees of the North Carolina Medical Board and would provide that document relating to impairment assessments under the Program are not public record.***

CURRENT LAW:

G.S. 143-509 gives the Secretary of the Department of Health and Human Services responsibility "...for supervision and direction of the emergency medical services program..."

G.S. 90-14(b) directs the North Carolina Medical Board to refer a physician or physician assistant whose health and effectiveness has been significantly impaired by alcohol, drugs, or mental illness to the NC Physicians Health Program.

G.S. 90-16(c) provides records, papers, files...gathered in connection with an investigation of a licensee are privileged and are not considered a public record.

BILL ANALYSIS:

Section 1 directs the Secretary to establish two types of programs: 1) to assist EMS personnel with recovery and rehabilitation from chemical addiction or abuse problems, and 2) to monitor these EMS personnel for safe practice.

Section 2 directs the Board of Medicine to refer all licensees (was physician and physician assistant) whose health and effectiveness is significantly impaired by alcohol, drug addiction, or mental illness to the North Carolina Physicians Health Program.

Section 3 includes "assessing" and "monitoring" to activities which when in good faith are performed in the course of 90-14(f) provide immunity from civil liability.

Section 4 provides records relating to assessments for drug and alcohol impairment and mental illness gathered under the Board's disciplinary authority are confidential and are not public record.

EFFECTIVE DATE: This act is effective when it becomes law.

H878-SMSQ-125(CSSQ-73) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 878
PROPOSED SENATE COMMITTEE SUBSTITUTE H878-PCS70461-SQ-73

Short Title: EMS Prsnl/Recvry Rehab./DHHS/NCPHP. (Public)

Sponsors:

Referred to:

March 31, 2009

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO IDENTIFY PROGRAMS FOR AIDING IN THE RECOVERY AND REHABILITATION OF EMS PERSONNEL WITH CHEMICAL ADDICTION OR ABUSE AND TO MAKE CHANGES TO THE NORTH CAROLINA PHYSICIANS HEALTH PROGRAM.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-509 reads as rewritten:

"**§ 143-509. Powers and duties of Secretary.**

The Secretary of the Department of Health and Human Services has full responsibilities for supervision and direction of the emergency medical services program and, to that end, shall accomplish all of the following:

(1) After consulting with the Emergency Medical Services Advisory Council and with any local governments that may be involved, seek the establishment of a Statewide Emergency Medical Services System, integrated with other health care providers and networks including, but not limited to, public health, community health monitoring activities, and special needs populations.

(2) Repealed by Session Laws 1989, c. 74.

(3) Establish and maintain a comprehensive statewide trauma system in accordance with the provisions of Article 7A of Chapter 131E of the General Statutes and the rules of the North Carolina Medical Care Commission.

(4) Establish and maintain a statewide emergency medical services communications system including designation of EMS radio frequencies and coordination of EMS radio communications networks within FCC rules and regulations.

(5) Establish and maintain a statewide emergency medical services information system that provides information linkage between various public safety services and other health care providers.

(6) Credential emergency medical services providers, vehicles, EMS educational institutions, and personnel after documenting that the requirements of the North Carolina Medical Care Commission are met.

(7), (8) Repealed by Session Laws 2001-220, s. 1, effective January 1, 2002.

(9) Promote a means of training individuals to administer life-saving treatment to persons who suffer a severe adverse reaction to agents that might cause

anaphylaxis. Individuals, upon successful completion of this training program, may be approved by the North Carolina Medical Care Commission to administer epinephrine to these persons, in the absence of the availability of physicians or other practitioners who are authorized to administer the treatment. This training may also be offered as part of the emergency medical services training program.

(10) Establish and maintain a collaborative effort with other community resources and agencies to educate the public regarding EMS systems and issues.

(11) Collaborate with community agencies and other health care providers to integrate the principles of injury prevention into the Statewide EMS System to improve community health.

(12) Establish and maintain a means of medical direction and control for the Statewide EMS System.

(13) Establish programs for aiding in the recovery and rehabilitation of EMS personnel who experience chemical addiction or abuse and programs for monitoring these EMS personnel for safe practice."

SECTION 2. G.S. 90-14(b) reads as rewritten:

"(b) The Board shall refer to the North Carolina Physicians Health Program all ~~physicians and physician assistants~~licensees whose health and effectiveness have been significantly impaired by alcohol, drug addiction or mental illness. Sexual misconduct shall not constitute mental illness for purposes of this subsection."

SECTION 3. G.S. 90-14(f) reads as rewritten:

"(f) A person, partnership, firm, corporation, association, authority, or other entity acting in good faith without fraud or malice shall be immune from civil liability for (i) reporting, investigating, assessing, monitoring, or providing an expert medical opinion to the Board regarding the acts or omissions of a licensee or applicant that violate the provisions of subsection (a) of this section or any other provision of law relating to the fitness of a licensee or applicant to practice medicine and (ii) initiating or conducting proceedings against a licensee or applicant if a complaint is made or action is taken in good faith without fraud or malice. A person shall not be held liable in any civil proceeding for testifying before the Board in good faith and without fraud or malice in any proceeding involving a violation of subsection (a) of this section or any other law relating to the fitness of an applicant or licensee to practice medicine, or for making a recommendation to the Board in the nature of peer review, in good faith and without fraud and malice."

SECTION 4. G.S. 90-16(c) reads as rewritten:

"(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~~inquiries, assessments, or interviews conducted in connection with a licensing, ~~complaint or~~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 ~~agents~~consultants involved in the application for ~~license~~license, impairment assessment, or discipline of a license holder, except as provided in subsections (d) and (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."

SECTION 5. This act is effective when it becomes law.

HOUSE BILL 1296
Committee Substitute Favorable 5/13/09

Short Title: Est. Drug And Medical Device Repository/BoP. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE DRUG, SUPPLIES, AND MEDICAL DEVICE REPOSITORY PROGRAM IN THE NORTH CAROLINA BOARD OF PHARMACY.

The General Assembly of North Carolina enacts:

SECTION 1. Part 1 of Article 7 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-216. Drug and medical device repository program established.**

(a) As used in this section unless the context clearly requires otherwise, the following definitions apply:

(1) Board. – The North Carolina Board of Pharmacy.

(2) Drug. – A human drug required by federal law or regulation to be dispensed only by a prescription, including finished dosage forms and active ingredients subject to 21 U.S.C. § 353(b).

(3) Dispense. – To deliver a drug to an eligible patient pursuant to the lawful order of a practitioner, including the administering, prescribing, packaging, labeling, or compounding necessary to prepare the drug for that delivery.

(4) Eligible patient. – An uninsured or underinsured patient who meets the eligibility criteria established by the Department, health care facility, or pharmacy.

(5) Free clinic facility. – A private, nonprofit, community-based organization that (i) provides health care services at little or no charge to low-income, uninsured, and underinsured persons through the use of volunteer health care professionals and partnerships with other health providers and (ii) is licensed by the State.

(6) Pharmacist. – A person licensed by the North Carolina Board of Pharmacy to practice pharmacy.

(7) Pharmaceutical care. – The provision of drug therapy and other patient-care services related to drug therapy intended to achieve definite outcomes that improve a patient's quality of life, including identifying potential and actual drug-related problems, resolving actual drug-related problems, and preventing potential drug-related problems.

(8) Pharmacy. – A licensed place of business where drugs are compounded or dispensed and pharmaceutical care is provided.

(9) Practitioner or health care practitioner. – A physician or other provider of health services licensed or otherwise permitted to distribute, dispense, or administer drugs or medical devices.

(10) Supplies. – Supplies associated with or necessary for the administration of a drug.

(b) The Board shall establish and administer a drug and medical device repository program (program). The purpose of the program is to allow a patient or the patient's family to donate unused drugs, supplies to administer the drug, and medical devices to uninsured and underinsured patients in this State. The unused drugs, supplies, and medical devices shall be donated to a free clinic facility or pharmacy that elects to participate in the program. A free clinic facility 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 facility or pharmacy for use under the program.

(c) 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 its 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 health care practitioner for use by an eligible patient and is dispensed by a pharmacist.

(d) A drug, supplies, or a medical device donated to the program shall not be resold. A free clinic facility or pharmacy may charge an eligible patient a handling fee to receive a donated drug, supplies, or medical device, which shall not exceed the amount specified in rules adopted by the Board.

(e) Nothing in this section requires a free clinic facility or pharmacy to participate in the program.

(f) The Board shall establish eligibility criteria for individuals to receive donated drugs, supplies, or medical devices. Dispensing shall be prioritized to patients who are uninsured or underinsured. Dispensing to other patients shall be permitted if an uninsured or underinsured patient is not available.

(g) The Board shall adopt rules necessary for the implementation of the program. Rules adopted by the Board shall provide for the following:

(1) Requirements for free clinic facilities and pharmacies to accept and dispense donated drugs, supplies, and medical devices pursuant to the program, including eligibility criteria and standards and procedures for a free clinic facility or pharmacy to accept, and safely store and dispense donated drugs and medical devices.

(2) The amount of the maximum handling fee that a free clinic facility or pharmacy may charge for distributing or dispensing donated drugs, supplies, or medical devices.

(3) A list of drugs, supplies to administer drugs, and medical devices, arranged either by category or by individual drug, supply or medical device, that the program will accept for dispensing.

(h) Unless a pharmaceutical manufacturer exercises bad faith, the manufacturer is not subject to criminal or civil liability for injury, death, or loss to a person or property for matters related to the donation, acceptance, or dispensing of a drug or medical device manufactured by the manufacturer that is donated by any person under the program, including liability for failure

to transfer or communicate product or consumer information or the expiration date of the donated drug or medical device.

(i) The following individuals or entities are immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the drug, supplies, or medical device that is dispensed under the program, and no disciplinary action may be taken against a pharmacist or practitioner as long as the drug, supply, or device is donated in accordance with the requirements of this section.

(1) A pharmacy or free clinic facility participating in the program.

(2) A pharmacist dispensing a drug, supply, or medical device pursuant to the program.

(3) A practitioner administering a drug or supply pursuant to the program.

(4) The donor of a drug, supply, or medical device donated pursuant to the program."

SECTION 2. Article 4A of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-85.42. Pharmacies may elect to participate in the drug and medical device repository program.**

A pharmacy operating in this State may elect to participate in the cancer drug and medical device repository program established under G.S. 130A-216."

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1296
Committee Substitute Favorable 5/13/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H1296-CSRD-72 [v.1]

6/30/2009 5:42:17 PM

Short Title: Est. Drug And Medical Device Repository/BoP. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE DRUG, SUPPLIES, AND MEDICAL DEVICE REPOSITORY PROGRAM IN THE NORTH CAROLINA BOARD OF PHARMACY.

The General Assembly of North Carolina enacts:

SECTION 1. Part 1 of Article 7 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-216. Drug and medical device repository program established.**

(a) As used in this section unless the context clearly requires otherwise, the following definitions apply:

(1) Board. – The North Carolina Board of Pharmacy.

(2) Drug. – As defined in G.S. 90-85.3.

(3) Dispense. – As defined in G.S. 90-85.3.

(4) Eligible patient. – An uninsured or underinsured patient who meets the eligibility criteria established by the Department, health care facility, or pharmacy.

(5) Free clinic facility. – A private, nonprofit, community-based organization that (i) provides health care services at little or no charge to low-income, uninsured, and underinsured persons through the use of volunteer health care professionals and partnerships with other health providers and (ii) is licensed by the State.

(6) Medical device. – A device as defined in G.S. 90-85.3(e).

(7) Pharmacist. – As defined in G.S. 90-85.3.

(8) Pharmaceutical care. – The provision of drug therapy and other patient-care services related to drug therapy intended to achieve definite outcomes that improve a patient's quality of life, including identifying potential and actual drug-related problems, resolving actual drug-related problems, and preventing potential drug-related problems.

(9) Pharmacy. – As defined in G.S. 90-85.3.

(10) Practitioner. – A physician or other provider of health services licensed or otherwise permitted to distribute, dispense, or administer drugs or medical devices.

(11) Supplies. – Supplies associated with or necessary for the administration of a drug.

(b) The Board shall establish and administer a drug and medical device repository program (program). The purpose of the program is to allow a patient or the patient's family to donate unused drugs, supplies to administer the drug, and medical devices to uninsured and underinsured patients in this State. The unused drugs, supplies, and medical devices shall be donated to a free clinic facility or pharmacy that elects to participate in the program. A free clinic facility 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 facility or pharmacy for use under the program.

(c) 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 its 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 health care practitioner for use by an eligible patient and is dispensed by a pharmacist.

(d) A drug, supplies, or a medical device donated to the program shall not be resold. A free clinic facility or pharmacy may charge an eligible patient a handling fee to receive a donated drug, supplies, or medical device, which shall not exceed the amount specified in rules adopted by the Board.

(e) Nothing in this section requires a free clinic facility or pharmacy to participate in the program.

(f) The Board shall establish eligibility criteria for individuals to receive donated drugs, supplies, or medical devices. Dispensing shall be prioritized to patients who are uninsured or underinsured. Dispensing to other patients shall be permitted if an uninsured or underinsured patient is not available.

(g) The Board shall adopt rules necessary for the implementation of the program. Rules adopted by the Board shall provide for the following:

(1) Requirements for free clinic facilities and pharmacies to accept and dispense donated drugs, supplies, and medical devices pursuant to the program, including eligibility criteria and standards and procedures for a free clinic facility or pharmacy to accept, and safely store and dispense donated drugs and medical devices.

(2) The amount of the maximum handling fee that a free clinic facility or pharmacy may charge for distributing or dispensing donated drugs, supplies, or medical devices.

(3) A list of drugs, supplies to administer drugs, and medical devices, arranged either by category or by individual drug, supply or medical device, that the program will accept for dispensing.

(h) Unless a pharmaceutical manufacturer exercises bad faith, the manufacturer is not subject to criminal or civil liability for injury, death, or loss to a person or property for matters related to the donation, acceptance, or dispensing of a drug or medical device manufactured by the manufacturer that is donated by any person under the program, including liability for failure to transfer or communicate product or consumer information or the expiration date of the donated drug or medical device.

(i) The following individuals or entities are immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the drug, supplies, or medical device that is dispensed under the program, and no disciplinary action may be taken against a pharmacist or practitioner as long as the drug, supplies, or medical device is donated in accordance with the requirements of this section.

(1) A pharmacy or free clinic facility participating in the program.

(2) A pharmacist dispensing a drug, supplies, or medical device pursuant to the program.

(3) A practitioner administering a drug or supplies pursuant to the program.

(4) The donor of a drug, supplies, or medical device donated pursuant to the program."

SECTION 2. Article 4A of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-85.42. Pharmacies may elect to participate in the drug and medical device repository program.**

A pharmacy operating in this State may elect to participate in the drug and medical device repository program established under G.S. 130A-216."

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

HOUSE BILL 1296:
Est. Drug And Medical Device Repository/BoP

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 30, 2009
Introduced by:	Rep. Stewart	**Prepared by:**	Ben Popkin
Analysis of:	PCS to Second Edition H1296-CSRD-72		Committee Counsel

SUMMARY: ***House Bill 1296 would establish the Drug and Medical Device Repository Program to allow for the donation of unused drugs, supplies and medical devices for use by participating pharmacies and free clinics offering care to the un and underinsured in the State. The Program would be voluntary and would be administered by the North Carolina Board of Pharmacy.***

The Proposed Committee Substitute amends the definition section of the bill to reference existing definitions in the Pharmacy Practice Act (Article 4A of Chapter 90 of the General Statutes) and corrects a reference to the Program in Section 2 of the bill.

BILL ANALYSIS: Section 1 of House Bill 1296 would establish the Drug and Medical Device Repository Program to allow patients and their families to donate unused drugs, supplies and medical devices for use by participating pharmacies and free clinics. The Program would be administered by the Board of Pharmacy, which would be directed to adopt rules necessary for the implementation of the Program, including at least the following areas:

- Requirements for clinics and pharmacies to accept and dispense donated items.
- A maximum handling fee that may be charged for dispensing donated items.
- A list of drugs, supplies and medical devices that the Program will accept for dispensing.

Participation in the Program would be voluntary, as decided by each free clinic or pharmacy and in no cases may donated items be resold. The Board would set eligibility criteria for individuals to receive donated items, with priority given to uninsured or underinsured patients, though others may receive items if no un or underinsured patients are available. Pharmacists would be able to accept and dispense drugs, supplies, and devices if all of the following are met:

- The item is in its original, unopened, sealed and tamper-evident packaging.
- A pharmacist has determined that the item is not adulterated or misbranded and is safe for redistribution.
- The drug expiration date is at least six months later than the donation date.
- The drug, supply, or medical device is prescribed by a health care practitioner for use by an eligible patient and is dispensed by a pharmacist.

The bill would provide that, unless the manufacturer exercises bad faith, a pharmaceutical manufacturer may not be subject to criminal or civil liability for death, injury or loss for matters relating to the donation of any items under the program. Similarly, the bill would provide that the following individuals and entities would be immune from civil liability for injuries or deaths of individuals to whom items had been dispensed under the program: a pharmacy or free clinic participating in the Program; a pharmacist dispensing an item under the Program; a practitioner administering a drug or supply under the Program; and the donor of a drug, supply, or medical device donated under the Program.

Section 2 of the bill would add a new provision to the Pharmacy Practice Act to authorize pharmacies operating in the State to elect to participate in the Program.

EFFECTIVE DATE: This act is effective when it becomes law.

H1296-SMRD-168(CSRD-72) v1

HOUSE BILL 1297
Committee Substitute Favorable 5/11/09

Short Title: Provider Credentialing/Insurers. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE CREDENTIALING OF HEALTH CARE PROVIDERS UNDER HEALTH BENEFIT PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-230 reads as rewritten:

"**§ 58-3-230. Uniform provider credentialing.**

(a) An insurer that provides a health benefit plan and that credentials providers for its networks shall maintain a process to assess and verify the qualifications of a licensed health care practitioner within 60 days of receipt of a completed provider credentialing application form approved by the Commissioner. If the insurer has not approved or denied the provider credentialing application form within 60 days of receipt of the completed application, upon receipt of a written request from the applicant and within five business days of its receipt, the insurer shall issue a temporary credential to the applicant if the applicant has a valid North Carolina professional or occupational license to provide the health care services to which the credential would apply. The insurer shall not issue a temporary credential if the applicant has reported on the application a history of medical malpractice claims, a history of substance abuse or mental health issues, or a history of Medical Board disciplinary action. The temporary credential shall be effective upon issuance and shall remain in effect until the provider's credentialing application is approved or denied by the insurer. When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner's participation in the health benefit plan network shall be the date the insurer approves the practitioner's credentialing application.

(b) The Commissioner shall by rule adopt a uniform provider credentialing application form that will provide health benefit plans with the information necessary to adequately assess and verify the qualifications of an applicant. The Commissioner may update the uniform provider credentialing application form, as necessary. No insurer that provides a health benefit plan may require an applicant to submit information that is not required by the uniform provider credentialing application form.

(c) As used in this section, the terms "health benefit plan" and "insurer" shall have the meaning provided under G.S. 58-3-167."

SECTION 2. This act becomes effective January 1, 2010.

HOUSE BILL 1297:
Provider Credentialing/Insurers

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 30, 2009
Introduced by:	Reps. Stewart, Jackson	**Prepared by:**	Ben Popkin
Analysis of:	Second Edition		Committee Counsel

SUMMARY: ***House Bill 1297 would amend G.S. 58-3-230 "Uniform provider credentialing" to require an insurer that provides health benefit plans and credentials providers for its networks to issue temporary credentials to the provider if the insurer has not approved or denied the provider credentialing application within 60 days and the provider has submitted a written request to the insurer.***

The bill would require that the applicant have a valid, unrestricted North Carolina professional or occupational license to provide the health care services to which the credential would apply and would prohibit issuance of temporary credentials to applicants reporting a history of medical malpractice claims, substance abuse or mental health issues, or Medical Board discipline.

CURRENT LAW: G.S. 58-3-230(a) currently directs insurers that provide health benefit plans and credential providers for their networks to "...maintain a process to assess and verify the qualifications of a licensed health care practitioner within 60 days of receipt of a completed provider credentialing application..."

Existing provisions do not address any actions to be taken by either party in the event of a decision not being made on the application within this 60 day time period.

BILL ANALYSIS: House Bill 1297 would amend G.S. 58-3-230 "Uniform provider credentialing" to require an insurer that provides health benefit plans and credentials providers for its networks to issue temporary credentials to the provider if:

- The insurer has not approved or denied the provider credentialing application within 60 days;
- The provider has submitted a written request to the insurer;
- The applicant has a valid, unrestricted North Carolina professional or occupational license to provide the health care services to which the credential would apply; and
- The applicant has not reported a history or medical malpractice claims, a history of substance abuse or mental health issues, or of Medical Board disciplinary actions.

The insurer must issue the temporary credential within five business days of receipt of a written request from the applicant if all the above criteria have been met. The bill provides that the temporary credential would remain effective until the insurer has approved or denied the provider's credentialing application.

EFFECTIVE DATE: This act becomes effective January 1, 2010.

H1297-SMRD-169(e2) v1

HOUSE BILL 1309
Senate Health Care Committee Substitute Adopted 6/3/09

Short Title: Residential Treatment Facil./TBI. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO ADOPT RULES PROVIDING FOR THE LICENSURE AND ACCREDITATION OF RESIDENTIAL TREATMENT FACILITIES FOR PERSONS WITH TRAUMATIC BRAIN INJURY.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-26 reads as rewritten:

"**§ 122C-26. Powers of the Commission.**

In addition to other powers and duties, the Commission shall exercise the following powers and duties:

(1) Adopt, amend, and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this Article;

(2) Issue declaratory rulings needed to implement the provisions and purposes of this Article;

(3) Adopt rules governing appeals of decisions to approve or deny licensure under this Article;

(4) Adopt rules for the waiver of rules adopted under this Article; and

(5) Adopt rules applicable to facilities licensed under this Article:

a. Establishing personnel requirements of staff employed in facilities;

b. Establishing qualifications of facility administrators or directors;

c. Establishing requirements for death reporting including confidentiality provisions related to death reporting;

d. Establishing requirements for patient advocates; and

e. Requiring facility personnel who refer clients to provider agencies to disclose any pecuniary interest the referring person has in the provider agency, or other interest that may give rise to the appearance of impropriety.

(6) Adopt rules providing for the licensure and accreditation of residential treatment facilities that provide services to persons with traumatic brain injury."

SECTION 2. The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services may adopt temporary rules to carry out the provisions of this act until July 1, 2010.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1309
Senate Health Care Committee Substitute Adopted 6/3/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H1309-CSSQ-74 [v.1]

6/30/2009 10:55:08 AM

Short Title: TBI Residential Treatment Facil/TBI Council. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO ADOPT RULES PROVIDING FOR THE LICENSURE AND ACCREDITATION OF RESIDENTIAL TREATMENT FACILITIES FOR PERSONS WITH TRAUMATIC BRAIN INJURY AND TO MAKE CHANGES TO THE NORTH CAROLINA TRAUMATIC BRAIN INJURY ADVISORY COUNCIL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-26 reads as rewritten:

"**§ 122C-26. Powers of the Commission.**

In addition to other powers and duties, the Commission shall exercise the following powers and duties:

(1) Adopt, amend, and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this Article;

(2) Issue declaratory rulings needed to implement the provisions and purposes of this Article;

(3) Adopt rules governing appeals of decisions to approve or deny licensure under this Article;

(4) Adopt rules for the waiver of rules adopted under this Article; and

(5) Adopt rules applicable to facilities licensed under this Article:

a. Establishing personnel requirements of staff employed in facilities;

b. Establishing qualifications of facility administrators or directors;

c. Establishing requirements for death reporting including confidentiality provisions related to death reporting;

d. Establishing requirements for patient advocates; and

e. Requiring facility personnel who refer clients to provider agencies to disclose any pecuniary interest the referring person has in the provider agency, or other interest that may give rise to the appearance of impropriety.

(6) Adopt rules providing for the licensure and accreditation of residential treatment facilities that provide services to persons with traumatic brain injury."

SECTION 2. The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services may adopt temporary rules to carry out the provisions of Section 1 of this act until July 1, 2010.

SECTION 3. Part 33 of Article 3 of Chapter 143B of the General Statutes reads as rewritten:

"Part 33. North Carolina ~~Traumatic~~ Brain Injury Advisory Council.

"§ 143B-216.65. North Carolina ~~Traumatic~~ Brain Injury Advisory Council – creation and duties.

There is established the North Carolina ~~Traumatic~~ Brain Injury Advisory Council in the Department of Health and Human ~~Services.~~Services to review traumatic and other acquired brain injuries in North Carolina. The Council shall have duties including the following:

(1) Review how the term "traumatic brain injury" is defined by State and federal regulations and to determine whether changes should be made to the State definition to include "acquired brain injury" or other appropriate conditions.

(2) Promote interagency coordination among State agencies responsible for services and support of individuals that have ~~sustained~~ traumatic brain injury.

(3) Study the needs of individuals with traumatic brain injury and their families.

(4) Make recommendations to the Governor, the General Assembly, and the Secretary of Health and Human Services regarding the planning, development, funding, and implementation of a comprehensive statewide service delivery system.

(5) Promote and implement injury prevention strategies across the State.

"§ 143B-216.66. North Carolina ~~Traumatic~~ Brain Injury Advisory Council – membership; quorum; compensation.

(a) The Council shall consist of ~~29 members,~~22 voting and 10 ex officio nonvoting members, appointed as follows:

(1) Three members by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, as follows:

a. ~~The Executive Director, or designee thereof, of the Brain Injury Association of North Carolina.~~A representative of the North Carolina Medical Society or other organization with interest in brain injury prevention or treatment.

b. A nurse with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine.

c. ~~A physician with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine.~~One at-large member who shall be a veteran or family member of a veteran who has suffered a brain injury.

(2) Three members by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, as follows:

a. ~~The Chair of the Board, or designee thereof, of the Brain Injury Association of North Carolina.~~One at-large member who may have experience as a school nurse or rehabilitation specialist.

b. ~~A nurse with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine.~~A representative of the North Carolina Hospital Association or other organization interested in brain injury prevention or treatment.

c. A physician with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine.

(3) ~~Eleven~~ Thirteen members by the Governor, as follows:
a. Three survivors of brain injury, one each representing the eastern, central, and western regions of the State.
b. Three family members of persons with brain ~~injury.~~injury with consideration for geographic representation.
c. A brain injury service provider in ~~private practice.~~the private sector.
d. The director of ~~an area program or county program~~ a local management entity of mental health, developmental disabilities, and substance abuse services.
e. The Executive Director, or designee thereof, of ~~the North Carolina Academy of Trial Lawyers.~~North Carolina Advocates for Justice.
f. ~~The Executive Vice President, or designee thereof, of the North Carolina Medical Society.~~The Executive Director, or designee thereof, of the Brain Injury Association of North Carolina.
g. ~~The President, or designee thereof, of the North Carolina Hospital Association.~~The Chair of the Board, or designee thereof, of the Brain Injury Association of North Carolina.
h. The Executive Director, or designee thereof, of the North Carolina Protection and Advocacy System.
i. One stroke survivor, as recommended by the American Heart Association.

(4) ~~Eight~~ Nine ex officio members by the Secretary of Health and Human Services, ~~one from each of the following:~~as follows:
a. ~~The~~ One member from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.
b. ~~The~~ One member from the Division of Vocational Rehabilitation.
c. ~~The~~One member from the Council on Developmental Disabilities.
d. ~~The~~ One member from the Division of Medical Assistance.
e. ~~The~~ Two members from the Division of Health Service Regulation.
f. ~~The~~ One member from the Division of Social Services.
g. ~~The~~ One member from the Office of Emergency Medical Services.
h. ~~The~~One member from the Division of Public Health.

(5) Two members by the Superintendent of Public Instruction, ~~at least~~ one of whom is ex officio, nonvoting, and employed with ~~from~~ the Division of Exceptional Children.

(6) One member by the Commissioner of ~~Insurance.~~Insurance, or the Commissioner's designee.

(7) One member by the Secretary of Administration representing veterans affairs.

(b) The terms of the initial members of the Council shall commence October 1, 2003. In his initial appointments, the Governor shall designate four members who shall serve terms of four years, four members who shall serve terms of three years, and three members who shall serve terms of two years. After the initial appointees' terms have expired, all members shall be appointed for a term of four years. No member appointed by the Governor shall serve more than two successive terms.

Any appointment to fill a vacancy on the Council created by the resignation, dismissal, death, or disability of a member shall be for the balance of the unexpired term. Terms for ex officio, nonvoting members do not expire.

(c) The initial chair of the Council shall be designated by the Secretary of the Department of Health and Human Services from the Council members. The chair shall hold this office for not more than four years. Subsequent chairs will be elected by the Council.

(d) The Council shall meet quarterly and at other times at the call of the chair. A majority of voting members of the Council shall constitute a quorum.

(e) Council members shall be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5 and G.S. 138-6, as applicable.

(f) The Secretary of the Department of Health and Human Services shall provide clerical and other assistance as needed."

SECTION 4. This act is effective when it becomes law. Each appointment made under G.S. 143B-216.66, as enacted by Section 3 of this act, shall become effective at the expiration of the term of the member serving on the Council prior to the effective date of this act.

HOUSE BILL 1309:
Residential Treatment Facil./TBI

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 30, 2009
Introduced by:	Rep. Insko	**Prepared by:**	Shawn Parker
Analysis of:	PCS to Second Edition H1309-CSSQ-74		Legislative Analyst

SUMMARY: ***House Bill 1309 would authorize the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services to adopt rules for the licensure and accreditation of residential treatment facilities that provide services for persons with traumatic brain injury.***

The Senate Committee Substitute would add provisions renaming the North Carolina Traumatic Brain Injury Advisory Council and amending the Council membership.

CURRENT LAW:

The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services of the Department of Health and Human Services (Commission) has the authority to adopt rules for the licensing of facilities governed by Article 2 of Chapter 122C.

G.S. 143B-216.65 establishes the North Carolina Traumatic Brain Injury Advisory Council and outlines the duties of the Council.

G.S. 143B-216.66 provides for the membership of the North Carolina Traumatic Brain Injury Advisory Council which consists of 29 members.

BILL ANALYSIS:

Section 1 amends G.S. 122C-26 (Powers of the Commission) to provide the Commission with the authority to adopt rules for the licensure and accreditation of residential treatment facilities that provide services to persons with traumatic brain injury.

Section 2 authorizes the Commission to adopt temporary rules to carry out the provisions of Section 1 of the act.

Section 3 renames the "North Carolina Traumatic Brain Injury Advisory Council" as the "North Carolina Brain Injury Advisory Council" and provides its purpose is to review traumatic and other acquired brain injuries in North Carolina.

The section further changes the total Council membership from 29 members to 32 members (22 voting members and nine ex officio nonvoting members) as follows:

- Makes the following changes with regard to the appointments made by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate:
    - Replaces the Executive Director of the Brain Injury Association of North Carolina, or designee, with a "representative of the NC Medical Society or other organization with interest in brain injury prevention or treatment".
    - Replaces a physician with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine, with "One at-large member who shall be a veteran or family member of a veteran who has suffered a brain injury".

- Makes the following changes with regard to the appointments made by the General Assembly, upon the recommendation of the Speaker of the House:
    - Replaces the Chair of the Board of the Brain Injury Association of NC, or designee, with "One at-large member who may have experience as a school nurse or rehabilitation specialist.
    - Replaces a nurse with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine, with "A representative of the North Carolina Hospital Association or other organization interested in brain injury prevention or treatment.
- Increases the Governor's appointments from 11 to 13 members and amends them as follows:
    - Requires that consideration for geographic representation be given for the three members who are family members of persons with brain injury.
    - Requires that the brain injury service provider be from the private sector rather than in private practice.
    - Uses the term Local Management Entity (LME) for area program or county program.
    - Uses the name North Carolina Advocates for Justice to reflect a recent name change for the NC Academy of Trial Lawyers.
    - Replaces the Executive Vice President of the North Carolina Medical Society, or designee, with the Executive Director of the Brain Injury Association of North Carolina, or designee.
    - Replaces the President of the North Carolina Hospital Association, or designee, with the Chair of the Board of the Brain Injury Association of North Carolina, or designee.
    - Adds the Executive Director of the North Carolina Protection and Advocacy System, or designee, to the Governor's appointments.
    - Adds a stroke survivor as recommended by the American Heart Association.
- Changes the Secretary of Health and Human Services appointments from eight members to nine ex officio members by adding an additional member from the Division of Health Service Regulation.
- Specifies that the one of the two members appointed by the Superintendent of Public instruction will be an ex officio, nonvoting member and must be employed with the Division of Exceptional Children.
- Specifies that the member appointed by the Commissioner of Insurance, may be appointed by the Commissioner's designee.

The section further provides that:

- The terms for the ex officio, nonvoting members do not expire.
- The initial chair of the Council will be designated by the Secretary of the Department of Health and Human Services and subsequence chairs will be elected.
- A majority of the voting members of the Council constitute a quorum

Section 4 provides the act is effective when it becomes law with new appointments becoming effective at the expiration of the term of the current member serving.

Theresa Matula substantially contributed to portions of this summary.

H1309-SMSQ-126(CSSQ-74) v1

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1309

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

H1309-ASQ-102 [v.1]

Comm. Sub. [YES]
Amends Title [NO]
Second Edition

Date _____,2009

Senator _____

moves to amend the bill on page 2, line 26, by deleting "22 voting" and substituting with "23 voting"; and

on page 3, lines 1- 4, by rewriting the lines to read:

"(3) ~~Eleven~~ Fourteen members by the Governor, as follows:

a. Three survivors of brain injury, one each representing the eastern, central, and western regions of the State.

b. ~~Three~~Four family members of persons with brain ~~injury.~~injury with".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1309
Senate Health Care Committee Substitute Adopted 6/3/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H1309-PCS30422-SQ-74

Short Title: TBI Residential Treatment Facil/TBI Council. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE COMMISSION FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES TO ADOPT RULES PROVIDING FOR THE LICENSURE AND ACCREDITATION OF RESIDENTIAL TREATMENT FACILITIES FOR PERSONS WITH TRAUMATIC BRAIN INJURY AND TO MAKE CHANGES TO THE NORTH CAROLINA TRAUMATIC BRAIN INJURY ADVISORY COUNCIL.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 122C-26 reads as rewritten:

"**§ 122C-26. Powers of the Commission.**

In addition to other powers and duties, the Commission shall exercise the following powers and duties:

(1) Adopt, amend, and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this Article;

(2) Issue declaratory rulings needed to implement the provisions and purposes of this Article;

(3) Adopt rules governing appeals of decisions to approve or deny licensure under this Article;

(4) Adopt rules for the waiver of rules adopted under this Article; and

(5) Adopt rules applicable to facilities licensed under this Article:

a. Establishing personnel requirements of staff employed in facilities;

b. Establishing qualifications of facility administrators or directors;

c. Establishing requirements for death reporting including confidentiality provisions related to death reporting;

d. Establishing requirements for patient advocates; and

e. Requiring facility personnel who refer clients to provider agencies to disclose any pecuniary interest the referring person has in the provider agency, or other interest that may give rise to the appearance of impropriety.

(6) Adopt rules providing for the licensure and accreditation of residential treatment facilities that provide services to persons with traumatic brain injury."

SECTION 2. The Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services may adopt temporary rules to carry out the provisions of Section 1 of this act until July 1, 2010.

SECTION 3. Part 33 of Article 3 of Chapter 143B of the General Statutes reads as rewritten:

"Part 33. North Carolina ~~Traumatic~~ Brain Injury Advisory Council.

"**§ 143B-216.65. North Carolina ~~Traumatic~~ Brain Injury Advisory Council – creation and duties.**

There is established the North Carolina ~~Traumatic~~ Brain Injury Advisory Council in the Department of Health and Human ~~Services.~~Services to review traumatic and other acquired brain injuries in North Carolina. The Council shall have duties including the following:

(1) Review how the term "traumatic brain injury" is defined by State and federal regulations and to determine whether changes should be made to the State definition to include "acquired brain injury" or other appropriate conditions.

(2) Promote interagency coordination among State agencies responsible for services and support of individuals that have ~~sustained~~ traumatic brain injury.

(3) Study the needs of individuals with traumatic brain injury and their families.

(4) Make recommendations to the Governor, the General Assembly, and the Secretary of Health and Human Services regarding the planning, development, funding, and implementation of a comprehensive statewide service delivery system.

(5) Promote and implement injury prevention strategies across the State.

"**§ 143B-216.66. North Carolina ~~Traumatic~~ Brain Injury Advisory Council – membership; quorum; compensation.**

(a) The Council shall consist of ~~29 members,~~23 voting and 10 ex officio nonvoting members, appointed as follows:

(1) Three members by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, as follows:

a. ~~The Executive Director, or designee thereof, of the Brain Injury Association of North Carolina.~~A representative of the North Carolina Medical Society or other organization with interest in brain injury prevention or treatment.

b. A nurse with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine.

c. ~~A physician with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine.~~One at-large member who shall be a veteran or family member of a veteran who has suffered a brain injury.

(2) Three members by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, as follows:

a. ~~The Chair of the Board, or designee thereof, of the Brain Injury Association of North Carolina.~~One at-large member who may have experience as a school nurse or rehabilitation specialist.

b. ~~A nurse with expertise in trauma, neurosurgery, neuropsychology, physical medicine and rehabilitation, or emergency medicine.~~A representative of the North Carolina Hospital Association or other organization interested in brain injury prevention or treatment.

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(3) ~~Eleven~~ Fourteen members by the Governor, as follows:
a. Three survivors of brain injury, one each representing the eastern, central, and western regions of the State.
b. ~~Three~~Four family members of persons with brain ~~injury.~~injury with consideration for geographic representation.
c. A brain injury service provider in ~~private practice.~~the private sector.
d. The director of ~~an area program or county program~~ a local management entity of mental health, developmental disabilities, and substance abuse services.
e. The Executive Director, or designee thereof, of ~~the North Carolina Academy of Trial Lawyers.~~North Carolina Advocates for Justice.
f. ~~The Executive Vice President, or designee thereof, of the North Carolina Medical Society.~~The Executive Director, or designee thereof, of the Brain Injury Association of North Carolina.
g. ~~The President, or designee thereof, of the North Carolina Hospital Association.~~The Chair of the Board, or designee thereof, of the Brain Injury Association of North Carolina.
h. The Executive Director, or designee thereof, of the North Carolina Protection and Advocacy System.
i. One stroke survivor, as recommended by the American Heart Association.

(4) ~~Eight~~ Nine ex officio members by the Secretary of Health and Human Services, ~~one from each of the following:~~as follows:
a. ~~The~~ One member from the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.
b. ~~The~~ One member from the Division of Vocational Rehabilitation.
c. ~~The~~One member from the Council on Developmental Disabilities.
d. ~~The~~ One member from the Division of Medical Assistance.
e. ~~The~~ Two members from the Division of Health Service Regulation.
f. ~~The~~ One member from the Division of Social Services.
g. ~~The~~ One member from the Office of Emergency Medical Services.
h. ~~The~~One member from the Division of Public Health.

(5) Two members by the Superintendent of Public Instruction, ~~at least~~ one of whom is ex officio, nonvoting, and employed with ~~from~~ the Division of Exceptional Children.

(6) One member by the Commissioner of ~~Insurance.~~Insurance, or the Commissioner's designee.

(7) One member by the Secretary of Administration representing veterans affairs.

(b) The terms of the initial members of the Council shall commence October 1, 2003. In his initial appointments, the Governor shall designate four members who shall serve terms of four years, four members who shall serve terms of three years, and three members who shall serve terms of two years. After the initial appointees' terms have expired, all members shall be appointed for a term of four years. No member appointed by the Governor shall serve more than two successive terms.

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(c) The initial chair of the Council shall be designated by the Secretary of the Department of Health and Human Services from the Council members. The chair shall hold this office for not more than four years. Subsequent chairs will be elected by the Council.

(d) The Council shall meet quarterly and at other times at the call of the chair. A majority of voting members of the Council shall constitute a quorum.

(e) Council members shall be reimbursed for expenses incurred in the performance of their duties in accordance with G.S. 138-5 and G.S. 138-6, as applicable.

(f) The Secretary of the Department of Health and Human Services shall provide clerical and other assistance as needed."

SECTION 4. This act is effective when it becomes law. Each appointment made under G.S. 143B-216.66, as enacted by Section 3 of this act, shall become effective at the expiration of the term of the member serving on the Council prior to the effective date of this act.

VISITOR REGISTRATION SHEET

Senate Health Care — **July 1, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sarah Sams	WCSR
Martha McEnnen	Carolinas HealthCare Sys.
Michelle Brooks	University Health Systems
TINA GORDON	NC Nurses Assoc.
DANIEL BLUM	K+L GATES
Elizabeth Dalton	NCPMA
JESSE GOODMAN	DHHS
S Wilson	DHHS
S. Smith	NC GA
Jeff Horton	DHHS - DMSR
Abby Gronau	NMSS-NC

VISITOR REGISTRATION SHEET

Senate Health Care — **July 1, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Michelle Frazier	MF+S
John McMillan	MF+S
Emily Wilbourne	RHA
Matt Farrell	TPG
Kristi Huff	NCHCFA
HUGH TILSON	NCHA
Margaret Barber	Greensboro
Marian Hartman	Brain Injury Assn of NC
Sandra Farmer	Brain Injury Assn. of N.C.
Christine Craig	WakeMed
Dana Simpson	Smith Anderson

VISITOR REGISTRATION SHEET

Senate Health Care — **July 1, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Andrews	PFFPNC
Donald Ragacags	PFFPNC
Colleen Kochanek	NCCEP
Debra DeCamillis	UNC-IOG

VISITOR REGISTRATION SHEET

Senate Health Care — **July 1, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
DHARMI TAILOR	National MS Society
Patrick Duffy	
DAVID BARNES	Poyner Spruill
	NC Food Banks
K Wright	BCBSNC

Principal Clerk ____
Reading Clerk ____

SENATE
NOTICE OF COMMITTEE MEETING
AND
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DAY	DATE	TIME	ROOM
Wednesday	July 15, 2009	11:00 AM	544 LOB

The following will be considered:

BILL NO.	SHORT TITLE	SPONSOR
HB 1296	Est. Drug And Medical Device Repository/BOP.	Representative Stewart

Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, July 15, 2009

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

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **1296** Est. Drug And Medical Device Repository/BOP.

Draft Number:	50767
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, July 15, 2009 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 AM on July 15, 2009, in Room 544 of the Legislative Office Building. Eighteen members of the committee were present. Senator Bingham, Co-Chair, presided.

There was one bill on the agenda: House Bill 1296 entitled "AC ACT TO ESTABLISH THE DRUG, SUPPLIES, AND MEDICAL DEVICE REPOSITORY PROGRAM IN THE NORTH CAROLINA BOARD OF PHARMACY" (Attachment I). Senator Bingham recognized Representative Stewart, bill sponsor, to present this bill. A Committee Substitute was brought forth, and a motion made by Senator Goss to adopt the Substitute for discussion; motion carried. During discussion, Senator Brown sent forth an amendment (Attachment II) and moved its adoption; motion carried. Discussion followed with Senator Blake moving a favorable report for the Committee Substitute, with the amendment to be rolled into the Substitute, and an unfavorable report for the original bill; motion carried.

There being no further business before the Committee, the meeting adjourned at 11:50 a.m.

Senator Bingham, Presiding

Becky Hedspeth, Committee Clerk

Attachment I

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H 2

HOUSE BILL 1296
Committee Substitute Favorable 5/13/09

Short Title: Est. Drug And Medical Device Repository/BoP. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE DRUG, SUPPLIES, AND MEDICAL DEVICE REPOSITORY PROGRAM IN THE NORTH CAROLINA BOARD OF PHARMACY.

The General Assembly of North Carolina enacts:

SECTION 1. Part 1 of Article 7 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-216. Drug and medical device repository program established.**

(a) As used in this section unless the context clearly requires otherwise, the following definitions apply:

(1) Board. – The North Carolina Board of Pharmacy.

(2) Drug. – A human drug required by federal law or regulation to be dispensed only by a prescription, including finished dosage forms and active ingredients subject to 21 U.S.C. § 353(b).

(3) Dispense. – To deliver a drug to an eligible patient pursuant to the lawful order of a practitioner, including the administering, prescribing, packaging, labeling, or compounding necessary to prepare the drug for that delivery.

(4) Eligible patient. – An uninsured or underinsured patient who meets the eligibility criteria established by the Department, health care facility, or pharmacy.

(5) Free clinic facility. – A private, nonprofit, community-based organization that (i) provides health care services at little or no charge to low-income, uninsured, and underinsured persons through the use of volunteer health care professionals and partnerships with other health providers and (ii) is licensed by the State.

(6) Pharmacist. – A person licensed by the North Carolina Board of Pharmacy to practice pharmacy.

(7) Pharmaceutical care. – The provision of drug therapy and other patient-care services related to drug therapy intended to achieve definite outcomes that improve a patient's quality of life, including identifying potential and actual drug-related problems, resolving actual drug-related problems, and preventing potential drug-related problems.

(8) Pharmacy. – A licensed place of business where drugs are compounded or dispensed and pharmaceutical care is provided.

(9) Practitioner or health care practitioner. – A physician or other provider of health services licensed or otherwise permitted to distribute, dispense, or administer drugs or medical devices.

(10) Supplies. – Supplies associated with or necessary for the administration of a drug.

(b) The Board shall establish and administer a drug and medical device repository program (program). The purpose of the program is to allow a patient or the patient's family to donate unused drugs, supplies to administer the drug, and medical devices to uninsured and underinsured patients in this State. The unused drugs, supplies, and medical devices shall be donated to a free clinic facility or pharmacy that elects to participate in the program. A free clinic facility 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 facility or pharmacy for use under the program.

(c) 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 its 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 health care practitioner for use by an eligible patient and is dispensed by a pharmacist.

(d) A drug, supplies, or a medical device donated to the program shall not be resold. A free clinic facility or pharmacy may charge an eligible patient a handling fee to receive a donated drug, supplies, or medical device, which shall not exceed the amount specified in rules adopted by the Board.

(e) Nothing in this section requires a free clinic facility or pharmacy to participate in the program.

(f) The Board shall establish eligibility criteria for individuals to receive donated drugs, supplies, or medical devices. Dispensing shall be prioritized to patients who are uninsured or underinsured. Dispensing to other patients shall be permitted if an uninsured or underinsured patient is not available.

(g) The Board shall adopt rules necessary for the implementation of the program. Rules adopted by the Board shall provide for the following:

(1) Requirements for free clinic facilities and pharmacies to accept and dispense donated drugs, supplies, and medical devices pursuant to the program, including eligibility criteria and standards and procedures for a free clinic facility or pharmacy to accept, and safely store and dispense donated drugs and medical devices.

(2) The amount of the maximum handling fee that a free clinic facility or pharmacy may charge for distributing or dispensing donated drugs, supplies, or medical devices.

(3) A list of drugs, supplies to administer drugs, and medical devices, arranged either by category or by individual drug, supply or medical device, that the program will accept for dispensing.

(h) Unless a pharmaceutical manufacturer exercises bad faith, the manufacturer is not subject to criminal or civil liability for injury, death, or loss to a person or property for matters related to the donation, acceptance, or dispensing of a drug or medical device manufactured by the manufacturer that is donated by any person under the program, including liability for failure

to transfer or communicate product or consumer information or the expiration date of the donated drug or medical device.

(i) The following individuals or entities are immune from civil liability for an act or omission that causes injury to or the death of an individual to whom the drug, supplies, or medical device that is dispensed under the program, and no disciplinary action may be taken against a pharmacist or practitioner as long as the drug, supply, or device is donated in accordance with the requirements of this section.

(1) A pharmacy or free clinic facility participating in the program.

(2) A pharmacist dispensing a drug, supply, or medical device pursuant to the program.

(3) A practitioner administering a drug or supply pursuant to the program.

(4) The donor of a drug, supply, or medical device donated pursuant to the program."

SECTION 2. Article 4A of Chapter 90 of the General Statutes is amended by adding the following new section to read:

"**§ 90-85.42. Pharmacies may elect to participate in the drug and medical device repository program.**

A pharmacy operating in this State may elect to participate in the cancer drug and medical device repository program established under G.S. 130A-216."

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

Attachment 11

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1296

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

H1296-ARD-35 [v.1]

Comm. Sub. [YES]
Amends Title [NO]
Second Edition

Date _____ ,2009

Senator _____

moves to amend the bill on page 1, line 28, by rewriting the line to read:
"professionals.";

And on page 2, line 36, by inserting between the words "devices." and "Dispensing" the following:
"Board eligibility criteria shall provide that individuals meeting free clinic or pharmacy eligibility criteria are eligible patients.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

Senate Health Care Committee
Wednesday, July 22, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 1297	**Provider Credentialing/Insurers.**	**Representative Jackson** **Representative Stewart**
HB 1020	**Cancer Patient Assistance.**	**Representative Adams** **Representative Earle**

Presentations

Other Business

Adjournment

SENATE HEALTH CARE COMMITTEE
Wednesday, July 22, 2009at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, July 22, 2009, in Room 544 of the Legislative Office Building, with eleven members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham welcomed the committee members present and introduced the pages.

Senator Bingham did not bring any bills before the committee, due to the fact; the Democratic Caucus had not adjourned. The committee members waited until 11:20 A.M. at which time Senator Bingham adjourned the Health Care Meeting.

The meeting adjourned at 11:20 A. M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H 2

HOUSE BILL 1297
Committee Substitute Favorable 5/11/09

Short Title: Provider Credentialing/Insurers. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE CREDENTIALING OF HEALTH CARE PROVIDERS UNDER HEALTH BENEFIT PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-230 reads as rewritten:

"**§ 58-3-230. Uniform provider credentialing.**

(a) An insurer that provides a health benefit plan and that credentials providers for its networks shall maintain a process to assess and verify the qualifications of a licensed health care practitioner within 60 days of receipt of a completed provider credentialing application form approved by the Commissioner. If the insurer has not approved or denied the provider credentialing application form within 60 days of receipt of the completed application, upon receipt of a written request from the applicant and within five business days of its receipt, the insurer shall issue a temporary credential to the applicant if the applicant has a valid North Carolina professional or occupational license to provide the health care services to which the credential would apply. The insurer shall not issue a temporary credential if the applicant has reported on the application a history of medical malpractice claims, a history of substance abuse or mental health issues, or a history of Medical Board disciplinary action. The temporary credential shall be effective upon issuance and shall remain in effect until the provider's credentialing application is approved or denied by the insurer. When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner's participation in the health benefit plan network shall be the date the insurer approves the practitioner's credentialing application.

(b) The Commissioner shall by rule adopt a uniform provider credentialing application form that will provide health benefit plans with the information necessary to adequately assess and verify the qualifications of an applicant. The Commissioner may update the uniform provider credentialing application form, as necessary. No insurer that provides a health benefit plan may require an applicant to submit information that is not required by the uniform provider credentialing application form.

(c) As used in this section, the terms "health benefit plan" and "insurer" shall have the meaning provided under G.S. 58-3-167."

SECTION 2. This act becomes effective January 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1297
Committee Substitute Favorable 5/11/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H1297-CSRD-78 [v.4]

7/21/2009 .6:48:19 PM

Short Title: Provider Credentials/Insurer/Provider Contrac. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE CREDENTIALING OF HEALTH CARE PROVIDERS UNDER HEALTH BENEFIT PLANS; ADDING A DEFINITION, AND AMENDING NOTICE AND CONTRACT NEGOTIATION PROVISIONS FOR HEALTH BENEFIT PLAN AND PROVIDER CONTRACTING; CLARIFYING A CON EXEMPTION CRITERION; AND MODIFYING INSPECTION PRACTICES OF CERTAIN HOSPITAL OUTPATIENT LOCATIONS.

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(c) As used in this section, the terms "health benefit plan" and "insurer" shall have the meaning provided under G.S. 58-3-167."

SECTION 2(a). If Senate Bill 877 becomes law, G.S. 58-50-270, as enacted in Section 1 of Senate Bill 877, is amended by adding a new subdivision to read:

"(3a) 'Health care provider' – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients."

SECTION 2(b). If Senate Bill 877 becomes law, G.S. 58-50-271(b), as enacted in Section 1 of Senate Bill 877, reads as rewritten:

"(b) ~~Date of receipt for~~ Means for sending all notices provided under a contract shall be one or more of the following, calculated as (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States ~~mail.~~ mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic medium for a communication other than an amendment if agreed to by the insurer and the provider."

SECTION 2(c). If Senate Bill 877 becomes law, G.S. 58-50-272, as enacted in Section 1 of Senate Bill 877, is amended by adding a new subsection to read:

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

SECTION 3. G.S. 131E-184(e), as enacted by Session Law 2009-145, reads as rewritten:

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

(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,
      2. Adult care home facility, or
      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.

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

SECTION 4(a). G.S. 131E-76(3) reads as rewritten:

"(3) "Hospital" means any facility which has an organized medical staff and which is designed, used, and operated to provide health care, diagnostic and therapeutic services, and continuous nursing care primarily to inpatients where such care and services are rendered under the supervision and direction of physicians licensed under Chapter 90 of the General Statutes, Article 1, to two or more persons over a period in excess of 24 hours. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific health specialties. The term does not include private mental facilities licensed under Article 2 of Chapter 122C of the General Statutes, nursing homes licensed under G.S. 131E-102, ~~and~~ adult care homes licensed under G.S. ~~131D-2.~~131D-2, and any outpatient department including a portion of a Hospital operated as an outpatient department, on or off of the Hospital's main campus, that is operated under the Hospital's control or ownership and is classified as Business Occupancy by the Life Safety Code of the National Fire Protection Association as referenced under 42 CFR 482.41. Provided, however, if the Business Occupancy outpatient location is to be operated within thirty (30) feet of any Hospital facility, or any portion thereof, which is classified as Health Care Occupancy or Ambulatory Health Care Occupancy under the Life Safety Code of the National Fire Protection Association, the Hospital shall provide plans and specifications to the Department for review and approval as required for Hospital construction or renovations in a manner described by the Department."

SECTION 4(b). G.S. 131E-80(a) reads as rewritten:

"(a) The Department shall make or cause to be made inspections as it may deem necessary. Any hospital licensed under this Part shall at all times be subject to inspections by the Department according to the rules of the Commission. Except as provided under G.S. 131E-77(b) of this Part, after the Hospital's initial licensing, any outpatient location included or added to the Hospital's accreditation through an accrediting body approved pursuant to Section 1865(a) of the Social Security Act, shall be deemed to be part of the Hospital's license; provided, however, that all outpatient locations may be subject to inspections which the Department deems necessary to validate compliance with the requirements set forth in this Part."

SECTION 5. Section 1 of this act becomes effective January 1, 2010. Sections 2(a), 2(b), and 2(c) of this act become effective January 1, 2010 and apply to health benefit plan contracts between health care providers and health benefit plans or insurers delivered, amended, or renewed on or after that date. The remainder of this act is effective when it becomes law.

HOUSE BILL 1020
Corrected Copy 5/19/09

Short Title:	Cancer Patient Assistance.	(Public)
Sponsors:	Representatives Earle, Adams (Primary Sponsors); M. Alexander, Burris-Floyd, Faison, Glazier, Harrison, Lucas, Mobley, Stewart, Tarleton, Wainwright, and Wray.	
Referred to:	Health, if favorable, Appropriations.	

April 2, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH, TO ASSIST CANCER PATIENTS WITH THE MANAGEMENT OF THE DISEASE.

The General Assembly of North Carolina enacts:

SECTION 1. Part 1 of Article 7 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-216. Cancer patient navigation program.**

The Department shall establish a cancer patient navigation program under the Breast and Cervical Cancer Control Program. The purpose of the program shall be to provide education about and assistance with the management of cancer. At a minimum, the program shall do the following:

(1) Initially serve breast and cervical cancer patients statewide with the intent of future expansion to all other cancer types.

(2) Employ a multidisciplinary team approach to assist cancer patients in identifying and gaining access to available health care, financial and legal assistance, transportation, psychological support, and other related issues.

(3) Work with an existing cancer service agency that is not affiliated with a particular health care institution so that program clients may have access to any cancer health care facility in the State."

SECTION 2. The Department may adopt rules necessary to carry out the provisions of this act. The Department shall begin initial implementation of the statewide program established under Section 1 of this act in Mecklenburg and Guilford Counties.

SECTION 3. The Department shall report its progress on the implementation of this program to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division not later than May 1, 2010.

SECTION 4. This act is effective when it becomes law.

HOUSE BILL 1020:
Cancer Patient Assistance

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	July 16, 2009
Introduced by:	Reps. Earle, Adams	**Prepared by:**	Shawn Parker
Analysis of:	Second Edition		Legislative Analyst

SUMMARY: House Bill 1020 directs the Department of Health and Human Services to establish a cancer patient navigation pilot program.

[As introduced, this bill was identical to S917, as introduced by Sen. Dorsett, which received a favorable report in Senate Health Care on May 6th, 2009 and is currently in Senate Appropriations.]

BILL ANALYSIS:

Section 1 amends Part 1 (Cancer) of Article 7 (Chronic Diseases) of Chapter 130A (Public Health) by adding a new section which requires the Department to establish a cancer patient navigation pilot program. The new section provides that the program shall provide education and assistance with the management of cancer. At a minimum the program will:

- Serve breast and cervical cancer patients across the State;
- Employ a multidisciplinary team to identify and assist patients with access to health care, financial and legal assistance, transportation, and other supports;
- Work with an existing cancer service agency not affiliated with a particular health care institution.

Section 2 directs the Department to adopt rules to carry out the provisions of the act. The section requires the Department to begin an initial implementation of the state-wide pilot in Guilford and Mecklenburg Counties.

Section 3 directs the Department to report its progress on the implementation of the program by May 1, 2010 to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

EFFECTIVE DATE: This act is effective when it becomes law.

H1020-SMSQ-130(e2) v1

VISITOR REGISTRATION SHEET

Senate Health Care — **July 22, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rebecca Troutman	NCACC
Kevin FitzGerald	UNC
Heather Dalton	NCRMA
Jeff Horton	DHHS - DHSR
S Wilson	DHHS
[illegible]	[illegible]
Mark Flemming	BCBSNC
Jamel Jones	NCHA
Michelle Brooks	UHS
Martha L McConnell	Consolidated Health Care
Steve Lundeen	ACP

VISITOR REGISTRATION SHEET

Senate Health Care — **July 22, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
TED Hamby	NC DOI
Julia Leggett	The Arc of NC
JACK REGISTER	NATIONAL ASSN OF SOCIAL WORKERS - NC Chapter
Charles Ogiba	" " " " "
Emily Swingly	" "
Michelle Stanley	" "
Penny Griffin	School of Gov.
Christine Ogden	NC DPH / CDIS
Chris Hoke	DPH
Sapna Kalsy	DPH

Senate Health Care Committee
Wednesday, July 22, 2009, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 1297	**Provider Credentialing/Insurers.**	**Representative Jackson** **Representative Stewart**
HB 1020	**Cancer Patient Assistance.**	**Representative Adams** **Representative Earle**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, July 29, 2009

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

FAVORABLE

H.B. **1020** Cancer Patient Assistance.
Sequential Referral: Appropriations Base Budget
Recommended Referral: None

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **1297** Provider Credentialing/Insurers.
Draft Number: 30441
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 2

Committee Clerk Comments:

HB 1020 Sen. Dorsett
HB 1297 Sen. Brunstetter

SENATE HEALTH CARE COMMITTEE
Wednesday, July 29, 2009at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, July 29, 2009, in Room 544 of the Legislative Office Building, with sixteen members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages.

Senator Bingham brought House Bill 1020, ***Cancer Patient Assistance.***, before the committee. He pointed out that Senator Dorsett's companion bill had already been discussed and voted on and passed unanimously. Rep. Earl was recognized to explain her bill and she just asked for a favorable report. Senator Forrester pointed out this bill was for breast and cervical cancer patients and expressed concerns that men were still getting neglected concerning prostate, colon, and skin cancer. Senator Jacumin echoed Senator Forrester's thoughts and moved for a favorable report with a sequential referral to Appropriation/Base Budget. The motion passed.

Senator Bingham asked for a motion to hear the Proposed Committee Substitute for House Bill 1297, ***Provider Credentialing/Insurers***. Senator Dannelly moved to hear the PCS, which passed. Senator Bingham stated there was an amendment and Senator Brunstetter asked staff to explain the amendment. Ben Popkin, Staff Attorney, explained that the amendment would include within the term of "facility" to include Local Management Entity, LME, for the purpose of sharing data. Leza Wainwright, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, stated this was an amendment to previous legislation that was recently enacted. At the time the previous bill was written, their intent all along was to permit data sharing between the Community Care Networks of NC and the Local Management Entities (LME). After the bill was passed certain members of the legal community questioned whether the use of the term "facility" could be construed to include LME. Since that was the intent from the beginning, DHHS requested this amendment, to make it very clear to LMEs and their attorneys and all of the legal communities that for the purpose of the data sharing, to insure quality of care and better coordination of care between the physical health side and the behavioral health development disability side, that data sharing was intended. There were no more questions and Senator Bingham made the motion to pass the amendment, which passed. Rep. Stewart was called on the explain HB 1297. He stated the original bill was brought forth in an effort to try to facilitate the process of credentialing health care professionals in NC. Current law required that insurers, which provide health benefits plans, to credential providers within sixty days, but there was no real effort to address what happened if that did not take place. HB 1297 simply stated that if a provider comes forth with a clean application, no history of medical malpractice or substance abuse disciplinary action; if they are not credentialed in sixty days they may request to be issued a temporary credential and it would actually require the insurer to do so. Rep. Stewart explained all the PCS changes, section 2, section 3, and section 4. Ben

Popkin, Staff Attorney, expanded on the explanation of the PCS changes. Senator Hoyle asked if anybody's ox would be gorged with any of these changes. He was concerned if there were any opposition to the PCS changes. Rep. Stewart stated that everyone was on board. Senator Hoyle moved for a favorable report at the appropriate time. Jeff Horton, Division of Health Services Regulation, spoke in favor of the bill. Dr. Forrester asked how the Certificate of Need (CON) felt about the bill because they would be losing money because the people would not have to apply for applications and send in the big fee. Jeff Horton respond that the CON section was in their division and they were fully supportive of these changes and stated that all the money they take-in goes to the general fund anyways. Senator Atwater asked why the temporary application would be issued with what the person had stated on their application. Staff Attorney Ben Popkins pointed out that it was self reported information but to keep in mind this provision had to do with credentialing to join a network of providers. These individuals are all already licensed to practice in their respective area and would be required to already be licensed. The credentialing is not for the practice of whatever area they are trained in, it is rather just credential to join a network of providers that a particular insurer has put together, therefore their licensure is required for them to qualify. Senator Atwater asked if it was the insurer that was not providing the temporary approval. Rep. Stewart replied the insurer issued the credential and explained that once you are licensed and you make plans to be in practice or operate in health care you must apply to be reimbursed by various plans and networks and there are various requirements that have to be met in order to be issued a credential. Senator Bingham stated he had a motion from Senator Hoyle to roll the amendment into a new PCS, unfavorable report to the original bill, favorable as to the new PCS. The motion passed.

The meeting adjourned at 11:30 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

HOUSE BILL 1297
Committee Substitute Favorable 5/11/09

Short Title: Provider Credentialing/Insurers. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE CREDENTIALING OF HEALTH CARE PROVIDERS UNDER HEALTH BENEFIT PLANS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-230 reads as rewritten:

"**§ 58-3-230. Uniform provider credentialing.**

(a) An insurer that provides a health benefit plan and that credentials providers for its networks shall maintain a process to assess and verify the qualifications of a licensed health care practitioner within 60 days of receipt of a completed provider credentialing application form approved by the Commissioner. If the insurer has not approved or denied the provider credentialing application form within 60 days of receipt of the completed application, upon receipt of a written request from the applicant and within five business days of its receipt, the insurer shall issue a temporary credential to the applicant if the applicant has a valid North Carolina professional or occupational license to provide the health care services to which the credential would apply. The insurer shall not issue a temporary credential if the applicant has reported on the application a history of medical malpractice claims, a history of substance abuse or mental health issues, or a history of Medical Board disciplinary action. The temporary credential shall be effective upon issuance and shall remain in effect until the provider's credentialing application is approved or denied by the insurer. When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner's participation in the health benefit plan network shall be the date the insurer approves the practitioner's credentialing application.

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(c) As used in this section, the terms "health benefit plan" and "insurer" shall have the meaning provided under G.S. 58-3-167."

SECTION 2. This act becomes effective January 1, 2010.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1297
Committee Substitute Favorable 5/11/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H1297-CSRD-78 [v.4]

7/21/2009 6:48:19 PM

Short Title: Provider Credentials/Insurer/Provider Contrac. (Public)

Sponsors:

Referred to:

April 9, 2009

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"(3a) 'Health care provider' – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program; and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients."

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"(b) ~~Date of receipt for~~ Means for sending all notices provided under a contract shall be one or more of the following, calculated as (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States ~~mail.~~ mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic medium for a communication other than an amendment if agreed to by the insurer and the provider."

SECTION 2(c). If Senate Bill 877 becomes law, G.S. 58-50-272, as enacted in Section 1 of Senate Bill 877, is amended by adding a new subsection to read:

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

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

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    2. Adult care home facility, or
    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.

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

SECTION 4(a). G.S. 131E-76(3) reads as rewritten:

"(3) "Hospital" means any facility which has an organized medical staff and which is designed, used, and operated to provide health care, diagnostic and therapeutic services, and continuous nursing care primarily to inpatients where such care and services are rendered under the supervision and direction of physicians licensed under Chapter 90 of the General Statutes, Article 1, to two or more persons over a period in excess of 24 hours. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific health specialties. The term does not include private mental facilities licensed under Article 2 of Chapter 122C of the General Statutes, nursing homes licensed under G.S. 131E-102, ~~and~~ adult care homes licensed under G.S. ~~131D-2.~~131D-2, and any outpatient department including a portion of a Hospital operated as an outpatient department, on or off of the Hospital's main campus, that is operated under the Hospital's control or ownership and is classified as Business Occupancy by the Life Safety Code of the National Fire Protection Association as referenced under 42 CFR 482.41. Provided, however, if the Business Occupancy outpatient location is to be operated within thirty (30) feet of any Hospital facility, or any portion thereof, which is classified as Health Care Occupancy or Ambulatory Health Care Occupancy under the Life Safety Code of the National Fire Protection Association, the Hospital shall provide plans and specifications to the Department for review and approval as required for Hospital construction or renovations in a manner described by the Department."

SECTION 4(b). G.S. 131E-80(a) reads as rewritten:

"(a) The Department shall make or cause to be made inspections as it may deem necessary. Any hospital licensed under this Part shall at all times be subject to inspections by the Department according to the rules of the Commission. Except as provided under G.S. 131E-77(b) of this Part, after the Hospital's initial licensing, any outpatient location included or added to the Hospital's accreditation through an accrediting body approved pursuant to Section 1865(a) of the Social Security Act, shall be deemed to be part of the Hospital's license; provided, however, that all outpatient locations may be subject to inspections which the Department deems necessary to validate compliance with the requirements set forth in this Part."

SECTION 5. Section 1 of this act becomes effective January 1, 2010. Sections 2(a), 2(b), and 2(c) of this act become effective January 1, 2010 and apply to health benefit plan contracts between health care providers and health benefit plans or insurers delivered, amended, or renewed on or after that date. The remainder of this act is effective when it becomes law.

HOUSE BILL 1297:
Provider Credentialing/Insurers

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	July 21, 2009
Introduced by:	Reps. Stewart, Jackson	**Prepared by:**	Ben Popkin
Analysis of:	PCS to Second Edition H1297-CSRD-78		Committee Counsel

SUMMARY: ***House Bill 1297 would amend G.S. 58-3-230 "Uniform provider credentialing" to require an insurer that provides health benefit plans and credentials providers for its networks to issue temporary credentials to the provider if the insurer has not approved or denied the provider credentialing application within 60 days and the provider has submitted a written request to the insurer.***

The bill would require that the applicant have a valid, unrestricted North Carolina professional or occupational license to provide the health care services to which the credential would apply and would prohibit issuance of temporary credentials to applicants reporting a history of medical malpractice claims, substance abuse or mental health issues, or Medical Board discipline.

The Proposed Committee Substitute adds modifications to the recently ratified Senate Bill 877 "Health Plan Provider Contracts/Transparency" to add a definition of 'health care provider', allow for alternate means for providing notice and determining date of receipt of notice, and allow for providers and insurers to negotiate contract terms regarding mutual consent to amendments, processes for reaching consent, and alternative notice contacts.

The PCS modifies a recently enacted provision to exempt certain facilities from CON requirements when making certain types of renovations or modifications to their facilities that do not add new services or expand bed capacity of the facility.

The PCS expands the types of facilities exempted from hospital licensure to include hospital owned or controlled facilities that are business occupancy only, and conforms the statutes with current rules that exempt from routine Division of Health Service Regulation State licensure inspections, outpatient locations that have been added to a hospital's accreditation by an accrediting body recognized by the Centers for Medicare and Medicaid Services (CMS).

CURRENT LAW: G.S. 58-3-230(a) currently directs insurers that provide health benefit plans and credential providers for their networks to "...maintain a process to assess and verify the qualifications of a licensed health care practitioner within 60 days of receipt of a completed provider credentialing application..."

Existing provisions do not address any actions to be taken by either party in the event of a decision not being made on the application within this 60 day time period.

BILL ANALYSIS: House Bill 1297 would amend G.S. 58-3-230 "Uniform provider credentialing" to require an insurer that provides health benefit plans and credentials providers for its networks to issue temporary credentials to the provider if:

- The insurer has not approved or denied the provider credentialing application within 60 days;
- The provider has submitted a written request to the insurer;
- The applicant has a valid, unrestricted North Carolina professional or occupational license to provide the health care services to which the credential would apply; and

- The applicant has not reported a history or medical malpractice claims, a history of substance abuse or mental health issues, or of Medical Board disciplinary actions.

The insurer must issue the temporary credential within five business days of receipt of a written request from the applicant if all the above criteria have been met. The bill provides that the temporary credential would remain effective until the insurer has approved or denied the provider's credentialing application.

Sections 2(a), (b), and (c) of the Proposed Committee Substitute make the following modifications to the recently ratified Senate Bill 877 "Health Plan Provider Contracts/Transparency":

(a) Adds a definition of 'health care provider' (consistent with current definitions in Chapter 58).

(b) Allows for alternate means for providing notice and alternate methods for determining the date of receipt of notice.

(Currently sets date of receipt of notice as five business days after notice is placed by first-class mail.)

(c) Allows for providers and insurers to negotiate contract terms that provide for: (i) mutual consent to amendments, (ii) a process for reaching mutual consent, or (iii) alternative notice contacts.

(Current provision allows for proposed amendment to be sent by provider or insurer and allows receiving party 60 days to object to the amendment. If no objection is raised, amendment is effective at expiration of 60 days. If Provider objects, insurer may terminate contract upon 60 days written notice to provider.)

Section 3 of the PCS modifies the recently enacted G.S. 131E-184(e) to allow for multiple types of renovations to be done to facilities under the subsection's exemption from CON requirements.

(As enacted, the provision allows for only one of three specifically identified types of renovations to be done by a facility under the exemption from CON provided under subsection (e).)

Section 4(a) of the PCS expands the types of facilities exempted from hospital licensure to include hospital owned or controlled facilities that are business occupancy only. *(Current provision exempts licensed private mental facilities, licensed nursing homes, and licensed adult care homes)*

Section 4(b) conforms the statutes with current rules (10A NCAC 13B) that exempt from routine Division of Health Services Regulation (DHSR) State licensure inspections, outpatient locations that have been added to a hospital's accreditation by an accrediting body recognized by the Centers for Medicare and Medicaid Services (CMS). The new provision specifically provides that all outpatient locations will continue to be subject to inspections as the Department deems necessary.

EFFECTIVE DATE: Section 1 of this act becomes effective January 1, 2010. Section 2 of this act becomes effective January 1, 2010 and applies to health benefit plan contracts between health care providers and health benefit plans or insurers delivered, amended, or renewed on or after that date. The remainder of this act is effective when it becomes law.

H1297-SMRD-187(CSRD-78) v2

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1297

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

H1297-ARD-40 [v.1]

Comm. Sub. [YES]
Amends Title [NO]
Second Edition

Date _____,2009

Senator Brunstetter

moves to amend the bill on page 3, line 35, by rewriting the line to read:

SECTION 5. G.S. 122C-55(a1) reads as rewritten:

"(a1) Any facility may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with a facility when necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment or habilitation of the client. For purposes of this subsection and subsection (a6) of this section, the purposes or activities for which confidential information may be disclosed include, but are not limited to, case management and care coordination, disease management, outcomes evaluation, the development of clinical guidelines and protocols, the development of care management plans and systems, population-based activities relating to improving or reducing health care costs, and the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and related services. As used in this section, "facility" includes an LME and "Secretary" includes the Department's Community Care of North Carolina Program or other 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."

And by renumbering the remaining section accordingly.

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1297
Committee Substitute Favorable 5/11/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H1297-PCS30441-RD-78

Short Title: Provider Credentials/Insurer/Provider Contrac. (Public)

Sponsors:

Referred to:

April 9, 2009

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE CREDENTIALING OF HEALTH CARE PROVIDERS UNDER HEALTH BENEFIT PLANS; ADDING A DEFINITION, AND AMENDING NOTICE AND CONTRACT NEGOTIATION PROVISIONS FOR HEALTH BENEFIT PLAN AND PROVIDER CONTRACTING; CLARIFYING A CON EXEMPTION CRITERION; AND MODIFYING INSPECTION PRACTICES OF CERTAIN HOSPITAL OUTPATIENT LOCATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 58-3-230 reads as rewritten:

"**§ 58-3-230. Uniform provider credentialing.**

(a) An insurer that provides a health benefit plan and that credentials providers for its networks shall maintain a process to assess and verify the qualifications of a licensed health care practitioner within 60 days of receipt of a completed provider credentialing application form approved by the Commissioner. If the insurer has not approved or denied the provider credentialing application form within 60 days of receipt of the completed application, upon receipt of a written request from the applicant and within five business days of its receipt, the insurer shall issue a temporary credential to the applicant if the applicant has a valid North Carolina professional or occupational license to provide the health care services to which the credential would apply. The insurer shall not issue a temporary credential if the applicant has reported on the application a history of medical malpractice claims, a history of substance abuse or mental health issues, or a history of Medical Board disciplinary action. The temporary credential shall be effective upon issuance and shall remain in effect until the provider's credentialing application is approved or denied by the insurer. When a health care practitioner joins a practice that is under contract with an insurer to participate in a health benefit plan, the effective date of the health care practitioner's participation in the health benefit plan network shall be the date the insurer approves the practitioner's credentialing application.

(b) The Commissioner shall by rule adopt a uniform provider credentialing application form that will provide health benefit plans with the information necessary to adequately assess and verify the qualifications of an applicant. The Commissioner may update the uniform provider credentialing application form, as necessary. No insurer that provides a health benefit plan may require an applicant to submit information that is not required by the uniform provider credentialing application form.

(c) As used in this section, the terms "health benefit plan" and "insurer" shall have the meaning provided under G.S. 58-3-167."

SECTION 2.(a) If Senate Bill 877 becomes law, G.S. 58-50-270, as enacted in Section 1 of Senate Bill 877, is amended by adding a new subdivision to read:

"(3a) 'Health care provider' – An individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients."

SECTION 2.(b) If Senate Bill 877 becomes law, G.S. 58-50-271(b), as enacted in Section 1 of Senate Bill 877, reads as rewritten:

"(b) ~~Date of receipt for~~ Means for sending all notices provided under a contract shall be one or more of the following, calculated as (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States ~~mail.~~ mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic medium for a communication other than an amendment if agreed to by the insurer and the provider."

SECTION 2.(c) If Senate Bill 877 becomes law, G.S. 58-50-272, as enacted in Section 1 of Senate Bill 877, is amended by adding a new subsection to read:

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

SECTION 3. G.S. 131E-184(e), as enacted by Session Law 2009-145, reads as rewritten:

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

(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,
    2. Adult care home facility, or
    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.

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

SECTION 4.(a) G.S. 131E-76(3) reads as rewritten:

"(3) "Hospital" means any facility which has an organized medical staff and which is designed, used, and operated to provide health care, diagnostic and therapeutic services, and continuous nursing care primarily to inpatients where such care and services are rendered under the supervision and direction of physicians licensed under Chapter 90 of the General Statutes, Article 1, to two or more persons over a period in excess of 24 hours. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific health specialties. The term does not include private mental facilities licensed under Article 2 of Chapter 122C of the General Statutes, nursing homes licensed under G.S. 131E-102, ~~and~~ adult care homes licensed under G.S. ~~131D-2.~~131D-2, and any outpatient department including a portion of a hospital operated as an outpatient department, on or off of the hospital's main campus, that is operated under the hospital's control or ownership and is classified as Business Occupancy by the Life Safety Code of the National Fire Protection Association as referenced under 42 C.F.R. § 482.41. Provided, however, if the Business Occupancy outpatient location is to be operated within 30 feet of any hospital facility, or any portion thereof, which is classified as Health Care Occupancy or Ambulatory Health Care Occupancy under the Life Safety Code of the National Fire Protection Association, the hospital shall provide plans and specifications to the Department for review and approval as required for hospital construction or renovations in a manner described by the Department."

SECTION 4.(b) G.S. 131E-80(a) reads as rewritten:

"(a) The Department shall make or cause to be made inspections as it may deem necessary. Any hospital licensed under this Part shall at all times be subject to inspections by the Department according to the rules of the Commission. Except as provided under G.S. 131E-77(b) of this Part, after the hospital's initial licensing, any location included or added to the hospital's accreditation through an accrediting body approved pursuant to section 1865(a) of the Social Security Act, shall be deemed to be part of the hospital's license; provided, however, that all locations may be subject to inspections which the Department deems necessary to validate compliance with the requirements set forth in this Part."

SECTION 5. G.S. 122C-55(a1) reads as rewritten:

"(a1) Any facility may share confidential information regarding any client of that facility with the Secretary, and the Secretary may share confidential information regarding any client with a facility when necessary to conduct quality assessment and improvement activities or to coordinate appropriate and effective care, treatment or habilitation of the client. For purposes of this subsection and subsection (a6) of this section, the purposes or activities for which confidential information may be disclosed include, but are not limited to, case management and care coordination, disease management, outcomes evaluation, the development of clinical guidelines and protocols, the development of care management plans and systems, population-based activities relating to improving or reducing health care costs, and the provision, coordination, or management of mental health, developmental disabilities, and substance abuse services and related services. As used in this section, "facility" includes an LME and "Secretary" includes the Department's Community Care of North Carolina Program or other 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."

SECTION 6. Section 1 of this act becomes effective January 1, 2010. Sections 2(a), 2(b), and 2(c) of this act become effective January 1, 2010, and apply to health benefit plan contracts between health care providers and health benefit plans or insurers delivered,

amended, or renewed on or after that date. The remainder of this act is effective when it becomes law.

HOUSE BILL 1020
Corrected Copy 5/19/09

Short Title:	Cancer Patient Assistance.	(Public)
Sponsors:	Representatives Earle, Adams (Primary Sponsors); M. Alexander, Burris-Floyd, Faison, Glazier, Harrison, Lucas, Mobley, Stewart, Tarleton, Wainwright, and Wray.	
Referred to:	Health, if favorable, Appropriations.	

April 2, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH, TO ASSIST CANCER PATIENTS WITH THE MANAGEMENT OF THE DISEASE.

The General Assembly of North Carolina enacts:

SECTION 1. Part 1 of Article 7 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-216. Cancer patient navigation program.**

The Department shall establish a cancer patient navigation program under the Breast and Cervical Cancer Control Program. The purpose of the program shall be to provide education about and assistance with the management of cancer. At a minimum, the program shall do the following:

(1) Initially serve breast and cervical cancer patients statewide with the intent of future expansion to all other cancer types.

(2) Employ a multidisciplinary team approach to assist cancer patients in identifying and gaining access to available health care, financial and legal assistance, transportation, psychological support, and other related issues.

(3) Work with an existing cancer service agency that is not affiliated with a particular health care institution so that program clients may have access to any cancer health care facility in the State."

SECTION 2. The Department may adopt rules necessary to carry out the provisions of this act. The Department shall begin initial implementation of the statewide program established under Section 1 of this act in Mecklenburg and Guilford Counties.

SECTION 3. The Department shall report its progress on the implementation of this program to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division not later than May 1, 2010.

SECTION 4. This act is effective when it becomes law.

HOUSE BILL 1020:
Cancer Patient Assistance

2009-2010 General Assembly

Committee:	Senate Ref to Health Care. If fav, re-ref to Appropriations/Base Budget	**Date:**	July 16, 2009
Introduced by:	Reps. Earle, Adams	**Prepared by:**	Shawn Parker
Analysis of:	Second Edition		Legislative Analyst

SUMMARY: House Bill 1020 directs the Department of Health and Human Services to establish a cancer patient navigation pilot program.

[As introduced, this bill was identical to S917, as introduced by Sen. Dorsett, which received a favorable report in Senate Health Care on May 6th, 2009 and is currently in Senate Appropriations.]

BILL ANALYSIS:

Section 1 amends Part 1 (Cancer) of Article 7 (Chronic Diseases) of Chapter 130A (Public Health) by adding a new section which requires the Department to establish a cancer patient navigation pilot program. The new section provides that the program shall provide education and assistance with the management of cancer. At a minimum the program will:

- Serve breast and cervical cancer patients across the State;
- Employ a multidisciplinary team to identify and assist patients with access to health care, financial and legal assistance, transportation, and other supports;
- Work with an existing cancer service agency not affiliated with a particular health care institution.

Section 2 directs the Department to adopt rules to carry out the provisions of the act. The section requires the Department to begin an initial implementation of the state-wide pilot in Guilford and Mecklenburg Counties.

Section 3 directs the Department to report its progress on the implementation of the program by May 1, 2010 to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division.

EFFECTIVE DATE: This act is effective when it becomes law.

H1020-SMSQ-130(e2) v1

VISITOR REGISTRATION SHEET

Senate Health Care — **July 29, 2009**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kristi Huff	NCHCFA
Jeff Horton	DHHS-DMHSA
Jessi Goodman	DHHS-DHSR
SWilson	DHHS
Ann Lucas	Duke
Michelle Frazier	MFTS
[signature]	JD, AL, PA
Meredith Williford	GPM and assoc.
Joel Maynard	GPM & Assoc.
[signature]	NMRS
[signature]	DHHS- DMH/DD/SAS

VISITOR REGISTRATION SHEET

Senate Health Care
Name of Committee

July 21, 2009
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Linwood Jones	NCHA
Dana Simpson	Smith Anders
TED Hamby	NC DOI
Debra DeCamillis	UNC-IOG
Victoria Hawkins	Bond & Assoc
[signature]	MHM Services, Inc.

SENATE HEALTH CARE COMMITTEE
Thursday, August 6, 2009
At
7:40 p.m.
Room Sen. Purcell's Desk, in the Senate Chamber

MINUTES

The Senate Health Care Committee met at 7:40 p.m. on August 6, 2009, in Room Sen. Purcell's Desk in the Senate Chamber. Twelve members of the committee were present. Senator Purcell presided.

Senator Rand moved the adoption of the Proposed Committee Substitute for House Bill 1002, Medical Examiner/Presc. Drug Information. Senator Purcell explained the bill and upon motion by Senator Brunstetter, the Proposed Committee Substitute received a favorable report; unfavorable report for the original bill.

The meeting adjourned at 7:48 p.m.

William R Purcell
Sen. William R. Purcell, Presiding

Joyce C. Hodge
Joyce Hodge , Committee Clerk

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H 2

HOUSE BILL 1002
Senate Health Care Committee Substitute Adopted 8/6/09

Short Title: Amend Public Health-Related Laws. (Public)

Sponsors:

Referred to:

April 2, 2009

A BILL TO BE ENTITLED

AN ACT TO AMEND PUBLIC HEALTH-RELATED LAWS TO CLARIFY PROCEDURES FOR INVESTIGATING AND CONTROLLING COMMUNICABLE DISEASES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 15A-534.3 reads as rewritten:

"**§ 15A-534.3. Detention for communicable diseases.**

If a judicial official conducting an initial appearance or first appearance hearing finds probable cause that an individual ~~was exposed~~had a nonsexual exposure to the defendant in a manner that poses a significant risk of transmission of the AIDS virus or Hepatitis B by such defendant, the judicial official shall order the defendant to be detained for a reasonable period of time, not to exceed 24 hours, for investigation by public health officials and for testing for AIDS virus infection and Hepatitis B infection if required by public health officials pursuant to G.S. 130A-144 and G.S. 130A-148."

SECTION 2. G.S. 130A-144(b) reads as rewritten:

"(b) ~~Physicians and~~ Physicians, persons in charge of medical facilities or ~~laboratories~~ laboratories, and other persons shall, upon request and proper identification, permit a local health director or the State Health Director to examine, review, and obtain a copy of medical or other records in their possession or under their control which the State Health Director or a local health director determines pertain to the (i) diagnosis, treatment, or prevention of a communicable disease or communicable condition for a person infected, exposed, or reasonably suspected of being infected or exposed to such a disease or condition, or (ii) the investigation of a known or reasonably suspected outbreak of a communicable disease or communicable condition."

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

2009-2010 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H0002=	Holliman	PROHIBIT SMOKING IN CERTAIN PUBLIC PLACES.	*SR	Ch. SL 2009-27	04-06-09	04-29-09
)002=	Holliman	PROHIBIT SMOKING IN CERTAIN PUBLIC PLACES.	*SR	Ch. SL 2009-27	05-05-09	05-06-09
..J018	Faison	SPEECH LANGUAGE PATHOLOGIST QUALIFICATIONS.	SR	Ch. SL 2009-138	04-01-09	06-03-09
H0088=	England	HEALTHY YOUTH ACT.	*SR	Ch. SL 2009-213	04-20-09	04-29-09
H0143=	Farmer-Butterfie	STRENGTHEN DISASTER PLANNING/LTC FACILITIES.	S	Ref To Com On Health Care	05-11-09	
H0144=	Farmer-Butterfie	NO SET FEE/NONCOVERED DENTAL SERVICES.	*SR	Ch. SL 2010-138	03-26-09	06-03-10
H0144=	Farmer-Butterfie	NO SET FEE/NONCOVERED DENTAL SERVICES.	*SR	Ch. SL 2010-138	06-07-10	06-22-10
H0243	Insko	MENTAL HEALTH/LAW ENFORCEMENT CUSTODY.	*SR	Ch. SL 2009-340	05-19-09	06-24-09
H0382=	Martin	HEALTH CHOICE PROGRAM REVIEW PROCESS	*SR	Ch. SL 2010-70	03-31-09	06-10-10
H0436	Folwell	FAIRNESS IN CON DETERMINATIONS/ INFLATION ADJ.	*SR	Ch. SL 2009-145	05-19-09	05-27-09
H0456=	Insko	TECH. & ORG. CHANGES/ CERTAIN DHHS FACILITIES.	*SR	Ch. SL 2009-462	05-19-09	06-24-09
H0535	Cotham	HEALTH INSURANCE COVERAGE/LYMPHEDEMA.	*SR	Ch. SL 2009-313	06-04-09	06-24-09
H0672	Earle	ACCOUNTABILITY FOR STATE FUNDING/MH/DD/ SA.	*SR	Ch. SL 2009-191	05-20-09	06-17-09
)703	Glazier	DISAPPROVE NCMB RULE/ REPT. PUB. CERTAIN JAPS	*SR	Ch. SL 2009-217	04-01-09	06-17-09
H0819=	M. Alexander	POLYSOMNOGRAPHY PRACTICE ACT.	*SR	Ch. SL 2009-434	06-09-09	06-17-09
H0878	Wainwright	EMS PRSNL/RECVRY REHAB./DHHS/NCPHP.	*SR	Ch. SL 2009-363	05-14-09	07-01-09
H0886	Ross	ALLOW DIETETICS/ NUTRITION BD./RECOVER COSTS.	SR	Ch. SL 2009-271	05-19-09	06-03-09
H0896	Harrell	CANCER DRUG COVERAGE CHANGES.	SR	Ch. SL 2009-170	05-04-09	06-10-09
H0925	M. Alexander	DATA SHARING/DHHS AGENCIES.	*SR	Ch. SL 2009-65	05-04-09	05-27-09
H1002	Farmer-Butterfie	AMEND PUBLIC HEALTH-RELATED LAWS.	*SR	Ch. SL 2009-501	05-19-09	08-06-09
H1014	Folwell	ORGAN DONATION MONTH.	S	Ref To Com On Health Care	04-27-09	
H1020	Earle	CANCER PATIENT ASSISTANCE.	SR	Ch. SL 2009-502	05-19-09	07-29-09
H1186	Earle	DHHS/UPDATE CURRENT INSPECTION PRACTICES.-AB	*SR	Ch. SL 2009-232	05-20-09	06-18-09
H1187	Earle	DHHS TECHNICAL CHANGES/HEALTH CARE PERSONNEL.	*SR	Ch. SL 2009-316	05-19-09	06-25-09

'$' indicates the bill is an appropriation bill.
A bold line indicates the bill is an appropriation bill.
'*' indicates that the text of the original bill was changed by some action.
'=' indicates that the original bill is identical to another bill.

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
H1189	Insko	DHHS/TRACKING OUTPATIENT COMMITMENTS.-AB	*SR	Ch. SL 2009-315	05-20-09	06-24-09
.271	Goodwin	CLARIFY SOCIAL SERVICES COMMISSION AUTHORITY.	*SR	Ch. SL 2009-188	05-11-09	06-10-09
H1296	Stewart	EST. DRUG AND MEDICAL DEVICE REPOSITORY/BOP.	*SR	Ch. SL 2009-423	05-20-09	07-15-09
H1297	Stewart	PROVIDER CREDENTIALS/ INSURER/PROVIDER CONTRAC.	*SR	Ch. SL 2009-487	05-20-09	07-29-09
H1309	Insko	TBI RESIDENTIAL TREATMENT FACIL/TBI COUNCIL.	*SR	Ch. SL 2009-361	05-20-09	06-03-09
H1309	Insko	TBI RESIDENTIAL TREATMENT FACIL/TBI COUNCIL.	*SR	Ch. SL 2009-361	06-08-09	07-01-09
H1315	M. Alexander	AMEND NC SIDS LAW/ MEDICAL WAIVERS.	SR	Ch. SL 2009-64	05-20-09	05-27-09
H1331	Dickson	EDUCATE THE PUBLIC ABOUT CORD BLOOD BANKING.	SR	Ch. SL 2009-67	05-14-09	05-27-09
H1342	Bordsen	FREE MEDICAL EXAM-VICTIMS OF RAPE/SEX OFFENSES.	*SR	Ch. SL 2009-354	05-20-09	06-03-09
H1692=	Farmer-Butterfie	MEDICAID DENTAL/ SPECIAL NEEDS POPULATION.	*SR	Ch. SL 2010-88	06-10-10	06-23-10
H1693=	Farmer-Butterfie	DEVELOP SPECIAL NEEDS DENTAL CARE WORKFORCE.	*SR	Ch. SL 2010-92	06-10-10	06-23-10
.694=	Farmer-Butterfie	COMSN. ON CHILDREN WITH SPECIAL NEEDS-DENTIST.	SR	Ch. SL 2010-12	06-01-10	06-09-10
H1698=	Farmer-Butterfie	UPDATE LONG-TERM CARE STATUTES.	*SR	Ch. SL 2010-66	06-14-10	06-23-10
H1705=	Pierce	CONSUMER GUIDELINES FOR HEARING AID PURCHASES.	*SR	Ch. SL 2010-121	06-14-10	06-30-10
H1726=	Weiss	IMPROVE CHILD CARE NUTRITION/ACTIVITY STNDS.	*SR	Ch. SL 2010-117	06-29-10	07-01-10
S0188=	Vernon Malone	SPECIAL CARE DENTISTRY COLLABORATION.	*SR	Ch. SL 2009-100	02-18-09	03-12-09
S0192=	Vernon Malone	ADULT CARE HOME MEDICATION QI PILOT ANALYSIS.	S	Ref To Com On Health Care	02-18-09	
S0193=	Vernon Malone	STRENGTHEN DISASTER PLANNING/LTC FACILITIES.	S	Ref To Com On Health Care	02-18-09	
S0195=	Vernon Malone	PREPARATIONS FOR AGING BABY BOOMERS.	SR	Ch. SL 2009-407	02-18-09	03-04-09
S0196=	Vernon Malone	DHHS WORKGROUP ON MIXED POPULATIONS ACH.	S	Ref To Com On Health Care	02-18-09	
S0208=	Katie G. Dorsett	PEOPLE FIRST.	*SR	Ch. SL 2009-264	03-10-09	04-02-09
S0228=	James Forrester	DHHS/OFFICE OF MEN'S	S	Ref To Com On	02-19-09	04-01-09

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		HEALTH.		Appropriations/ Base Budget		
)232	David W. Hoyle	DISAPPROVE MEDICAL CARE COMMISSION RULES.	S	Ref To Com On Health Care	02-19-09	
)243=	William R. Purce	REDUCE INFANT MORTALITY AND PRETERM BIRTHS.	S	Re-ref Com On Appropriations/ Base Budget	02-23-09	03-04-09
S0258=	John Snow	AUTHORIZE VOLUNTARY MEDICAL REGISTRY PROGRAM.	*SR	Ch. SL 2009-225	02-23-09	03-19-09
S0302	Larry Shaw	MEDICAID WAIVER/HIV AIDS PATIENT ELIG.	S	Ref to Health Care. If fav, re-ref to Appropriations/ Base Budget	02-25-09	
S0324	Joe Sam Queen	MEDICAID/HEMOPHILIC DRUGS/NO PRIOR AUTH.	SR	Ch. SL 2009-210	02-26-09	03-11-09
S0331	Doug Berger	FIVE COUNTY LME/STATE HEALTH PLAN.	*S	Re-ref Com On Select Committee on Employee Hospital and Medical Benefits	02-26-09	05-07-09
S0345=	Vernon Malone	PUBLIC HEALTH TECHNICAL CHANGES.	SR	Ch. SL 2009-442	03-02-09	03-18-09
S0354	Eleanor Kinnaird	CONTINUING CARE RETIRE. COMMUNITY/ HOME CARE.	*SR	Ch. SL 2010-128	03-02-09	03-18-09
S0356	Tony Rand	AMEND NURSING PRACTICE ACT.	*SR	Ch. SL 2009-133	03-03-09	03-12-09
S0409=	Martin L. Nesbit	RECOMMENDATIONS OF MH/ DD/SA OVERSIGHT COMM.	*S	Re-ref Com On Appropriations/ Base Budget	03-05-09	03-19-09
)595	W. Edward (Eddie	PEDESTRIAN SAFETY IMPROVEMENTS.	*SR	Ch. SL 2010-37	05-11-09	05-13-09
S0619	Fletcher L. Hart	PEDORTHIST LICENSURE.	S	Ref to Health Care. If fav, re-ref to Finance	03-17-09	
S0628	William R. Purce	RELEASE CONTR. SUBST. REP. DATA TO CME.	*SR	Ch. SL 2009-438	03-17-09	05-13-09
S0646	Martin L. Nesbit	DISAPPROVE MEDICAL BOARD RULES.	S	Ref To Com On Health Care	03-19-09	
S0671=	William R. Purce	ESTABLISH POLICY/ SMOKING/FOSTER CARE.	S	Ref To Com On Health Care	03-19-09	
S0673=	William R. Purce	BAN SMOKING IN FOSTER CARE SETTING/INFANTS.	S	Ref To Com On Health Care	03-19-09	
S0674	William R. Purce	AMEND RABIES LAWS.	*SR	Ch. SL 2009-327	03-19-09	04-16-09
S0675	William R. Purce	PROHIBIT MEDICAID FRAUD/KICKBACKS.	*SR	Ch. SL 2010-185	03-19-09	04-01-09
S0694	Linda Garrou	AMEND DENTISTRY LAWS/ OUT OF STATE DENTISTS.	SR	Ch. SL 2009-289	03-24-09	05-13-09
S0752	Daniel G. Clodfe	AUTHORIZE RULES FOR FOOD SAFETY TRAINING.	S	Ref To Com On Health Care	03-24-09	
S0765=	Josh Stein	POOLED TRUSTS/ MEDICAID REIMBUR.	*SR	Ch. SL 2010-118	03-24-09	05-06-09
S0799	Tony Rand	INCREASE TRANSPARENCY OF MH/DD/SA	*SR	Ch. SL 2009-299	03-25-09	04-09-09

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Bill	Introducer	Short Title		Latest Action	In Date	Out Date
		FACILITIES.				
S0804	Tony Rand	CON CHANGES.	*SR	Ch. SL 2009-373	03-25-09	05-13-09
0805	William R. Purce	DHHS STUDY/INFLUENZA VACCINE PUBLIC SCHOOLS.	S	Ref To Com On Health Care	03-25-09	
S0834	Stan Bingham	REWRITE SANITARIAN EXAMINERS LAWS/FEES.	*SR	Ch. SL 2009-443	03-25-09	04-09-09
S0877	Daniel G. Clodfe	HEALTH PLAN PROVIDER CONTRACTS/ TRANSPARENCY .	*SR	Ch. SL 2009-352	05-04-09	05-12-09
S0890	William R. Purce	TANNING EQUIP/RAISE AGE FOR PRESCRIPTION.	S	Ref To Com On Health Care	03-26-09	
S0892=	Bob Atwater	POLYSOMNOGRAPHY ' PRACTICE ACT.	S	Ref to Health Care. If fav, re-ref to Finance	03-26-09	
S0906=	Debbie A. Clary	ESTABLISH ADULT DAY HEALTH OVERNIGHT RESPITE.	S	Ref To Com On Health Care	03-26-09	
S0917	Katie G. Dorsett	CANCER PATIENT ASSISTANCE.	S	Re-ref Com On Appropriations/ Base Budget	03-26-09	05-07-09
S0940	Don Davis	STUDY FLEXIBILITY/ CERTIFIED NURSE MIDWIVES.	*S	Re-ref Com On Rules and Operations of the Senate	03-26-09	05-13-09
S0956=	Martin L. Nesbit	AMEND PROFESSIONAL COUNSELORS ACT/FEES.	S	Ref to Health Care. If fav, re-ref to Finance	03-26-09	
$ S0977	**Stan Bingham**	**OBESITY PREVENTION IN THE PUBLIC SCHOOLS.**	**S**	**Ref To Com On Health Care**	**03-26-09**	
.022	Josh Stein	SCHOOL CALENDAR FLEXIBILITY/INCLEMENT WEATHER	*S	Ref To Com On Rules and Operations of the Senate	03-26-09	05-06-09
S1042=	Martin L. Nesbit	TECH. & ORG. CHANGES/ CERTAIN DHHS FACILITIES.	*S	Re-ref Com On Finance	03-31-09	04-16-09
S1043	Eleanor Kinnaird	NATUROPATHIC DOCTORS LICENSING ACT.	S	Ref.to Health Care. If fav, re-ref to Judiciary I	03-31-09	
S1151=	William R. Purce	SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM.	*SR	Ch. SL 2010-160	05-17-10	05-26-10
S1152=	William R. Purce	STUDY CHILD NUTRITION PROGRAM.	*SR	Ch. SL 2010-115	05-17-10	05-26-10
S1153=	William R. Purce	LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.	*S	Ref To Com On Rules, Calendar, and Operations of the House	05-17-10	05-26-10
S1189=	A. B Swindell	ADULT DAY CARE CRIMINAL RECORD CHECK PROCESS.	S	Ref To Com On Health Care	05-18-10	
S1190=	A. B Swindell	UPDATE LONG-TERM CARE STATUTES.	S	Ref To Com On Health Care	05-18-10	
S1191=	A. B Swindell	NURSE AIDE TRAINING REVIEW.	*SR	Ch. SL 2010-69	05-18-10	06-03-10

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2009-2010 Biennium

Bill	Introducer	Short Title		Latest Action	In Date	Out Date
S1192=	A. B Swindell	MEDICAID DENTAL/ SPECIAL NEEDS POPULATION.	S	Ref To Com On Health Care	05-18-10	
.193=	A. B Swindell	IMPLEMENT LTC PARTNERSHIP PROGRAM.	*SR	Ch. SL 2010-68	05-18-10	06-03-10
S1194=	A. B Swindell	DEVELOP SPECIAL NEEDS DENTAL CARE WORKFORCE.	S	Ref To Com On Health Care	05-18-10	
S1203=	A. B Swindell	CONSUMER GUIDELINES FOR HEARING AID PURCHASES.	S	Ref To Com On Health Care	05-18-10	
S1204=	A. B Swindell	COMSN. ON CHILDREN WITH SPECIAL NEEDS-DENTIST.	S	Ref To Com On Health Care	05-18-10	
S1265=	William R. Purce	TREATMENT OF AUTISM DISORDERS.	S	Ref To Com On Health Care	05-20-10	
S1286=	William R. Purce	SCREEN FOR BMI CHILDREN CCNC NETWORK.	*S	Re-ref Com On Rules, Calendar, and Operations of the House	05-20-10	06-03-10
S1287=	William R. Purce	IMPROVE CHILD CARE NUTRITION/ACTIVITY STNDS.	S	Ref To Com On Health Care	05-20-10	
S1289=	William R. Purce	UPDATE STATEWIDE NUTRITION STANDARDS.	S	Ref To Com On Health Care	05-20-10	
S1304=	Martin L. Nesbit	MODIFY CABHA CERTIFICATION PROCESS.	S	Ref to the Com on Mental Health Reform, if favorable, Appropriations	05-20-10	05-26-10
S1306=	Martin L. Nesbit	PILOT INDEPENDENT ASSESSMENTS BY LMES.	S	Ref To Com On Health Care	05-20-10	
.307=	Martin L. Nesbit	MODIFY MHDDSAS REPORTING REQUIREMENTS.	*S	Ref to the Com on Mental Health Reform, if favorable, Appropriations	05-20-10	05-26-10
S1308=	Martin L. Nesbit	EXPAND USE OF SIS ASSESSMENT TOOL.	S	Ref To Com On Health Care	05-20-10	
S1309=	Martin L. Nesbit	EXTEND AND EXPAND FIRST COMMIT PILOT.	*SR	Ch. SL 2010-119	05-20-10	05-26-10
S1319=	Martin L. Nesbit	EXAMINE AND ADJUST RATES/CLUBHOUSES.	S	Ref to the Com on Mental Health Reform, if favorable, Appropriations	05-20-10	05-26-10

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SENATE HEALTH CARE COMMITTEE

Sen. William R. Purcell, M.D., Co-Chair **Becky Hedspeth, 733-5953**	**Sen. Stan Bingham, Co-Chair** **Judy Chriscoe, 733-5665**
Sen. Katie G. Dorsett, Vice Chair **Phyllis Cameron, 715-3042**	**Sen. Tony Foriest, Vice Chair** **Jackie Ray, 301-1446**
Sen. Jim Forrester, Vice-Chair **Katherine Herrington, 715-3050**	**Sen. Steve Goss** **Cindy Garrison, 733-5742**
Sen. Austin Allran **Carole Walker, 733-5876**	**Sen. Malcolm Graham** **Jasmine Rascoe, 733-5650**
Sen. Bob Atwater **Carol Resar, 715-3036**	**Sen. Fletcher Hartsell, Jr.** **Gerry Johnson, 733-7223**
Sen. Doug Berger **Brice Bratcher, 715-8363**	**Sen. David Hoyle** **Penny Williams, 733-5734**
Sen. Harris Blake **Anna Kidd, 733-4809**	**Sen. Jim Jacumin** **Alice Falcone, 715-7823**
Sen. Harry Brown **Susanne Gunter, 715-3034**	**Sen. Ellie Kinnaird** **Kathie Young, 733-5804**
Sen. Pete Brunstetter **Genie Clark, 733-7850**	**Sen. Martin Nesbitt** **Janette Lee, 715-3001**
Sen. Debbie A. Clary **Misty Greene, 715-3038**	**Sen. Joe Sam Queen** **Lisa Nelson, 733-3460**
Sen. Charlie Dannelly **Dee Hodge, 733-5955**	**Sen. David Rouzer** **Judy Edwards, 733-5748**
Sen. Don Davis **Monica Yelverton 733-5621**	**Sen. Bob Rucho** **Helen Long, 733-5655**
Sen. Eddie Goodall **Joey Stansbury, 733-7659**	**Sen. Josh Stein** **Candace Finley, 715-6400**
Becky Hedspeth, 733-5953 **Judy Chriscoe, 733-5665** **Committee Assistants**	**Shawn Parker, Research 733-2578** **Ben Popkin, Research 733-2578** **Susan Barham, Research 733-2578**

Senate Health Care Committee
Wednesday, May 26, 2010, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 1151	Supplemental Nutrition Assistance Program.	Senator Purcell
SB 1152	Study Child Nutrition Program.	Senator Purcell
SB 1153	Legislative Task Force on Childhood Obesity.	Senator Purcell
SB 1304	Modify CABHA Certification Process.	Senator Nesbitt, Jr.
SB 1307	Modify MHDDSAS Reporting Requirements.	Senator Nesbitt, Jr.
SB 1309	Extend and Expand First Commit Pilot.	Senator Nesbitt, Jr.
SB 1319	Examine and Adjust Rates/Clubhouses.	Senator Nesbitt, Jr.

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 26, 2010

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

FAVORABLE

S.B.	**1151**	Supplemental Nutrition Assistance Program.	
		Sequential Referral:	None
		Recommended Referral:	None
S.B.	**1152**	Study Child Nutrition Program.	
		Sequential Referral:	None
		Recommended Referral:	None
S.B.	**1304**	Modify CABHA Certification Process.	
		Sequential Referral:	None
		Recommended Referral:	None
S.B.	**1319**	Examine and Adjust Rates/Clubhouses.	
		Sequential Referral:	None
		Recommended Referral:	None

TOTAL REPORTED: 4

Committee Clerk Comments:

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, May 26, 2010

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

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

S.B. **1153** Legislative Task Force on Childhood Obesity.

Draft Number:	PCS35458
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

S.B. **1307** Modify MHDDSAS Reporting Requirements.

Draft Number:	PCS55606
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **1309** Extend and Expand First Commit Pilot.

Draft Number:	PCS35459
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 3

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
May 26, 2010
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 a.m. on Wednesday, May 26, 2010 in Room 544 of the Legislative Office Building. Twenty-five committee members were present, along with staff: Shawn Parker, Ben Popkin, Susan Barham, Becky Hedspeth and Judy Christoe.

Senator Bingham, Co-Chair, presided. The first bill on the agenda was Senate Bill 1151 entitled "AN ACT TO DIRECT THE DIVISION OF SOCIAL SERVICES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EXAMINE WAYS TO EXPAND AND ENHANCE THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM IN NORTH CAROLINA, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY", sponsored by Senator Purcell. He presented his bill to the committee, with Senator Dannelly moving a favorable report; motion carried.

Next considered was Senate Bill 1152 entitled "AN ACT AUTHORIZING THE JOINT LEGISLATIVE PROGRAM EVALUATION OVERSIGHT COMMITTEE TO DIRECT THE PROGRAM EVALUATION DIVISION TO STUDY INDIRECT COSTS UNDER CHILD NUTRITION PROGRAMS, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY", sponsored by Senator Purcell. He presented his bill, with Senator Davis moving for a favorable report; motion carried.

Next considered was Senate Bill 1153 entitled "AN ACT TO REESTABLISH THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY". Senator Purcell was the sponsor, and he presented a Committee Substitute and moved its adoption for consideration; motion carried. After discussion, Senator Goodall moved a favorable report for the Committee Substitute and an unfavorable report for the original bill.

Senate Bill 1304 entitled "AN ACT TO REQUIRE THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP AND REPORT ON A PLAN FOR MODIFYING THE CERTIFICATION PROCESS FOR CRITICAL ACCESS BEHAVIORAL HEALTH AGENCIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES" was considered next. Senator Atwater explained the bill for the sponsor, Senator Nesbitt. Senator Dannelly moved for a favorable report; motion carried.

The bill next considered was Senate Bill 1307 entitled "AN ACT TO MODIFY REPORTING REQUIREMENTS PERTAINING TO MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES", sponsored by Senator Nesbitt. An amendment was offered by Senator Atwater, with Senator Dannelly moving its adoption; motion carried. Senator Nesbitt explained the bill and, after discussion,

Senator Dannelly moved for a favorable report for the bill as amended and that the amendment be rolled into a committee substitute; motion carried.

Next on the agenda was Senate Bill 1309 entitled "AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO WAIVE TEMPORARILY CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES FOR PARTICIPANTS IN THE FIRST EVALUATION PILOT PROGRAM AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY CERTAIN ISSUES RELATING TO THE PROGRAM, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES". Bill sponsor, Senator Nesbitt, explained the bill and offered an amendment. Senator Hoyle moved adoption of the amendment for consideration; motion carried. After discussion, Senator Dannelly moved a favorable report for the committee substitute as amended, an unfavorable report for the original bill, and that the amendment be rolled into a committee substitute; motion carried.

The last bill on the agenda was Senate Bill 1319 entitled "AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, IN CONSULTATION WITH THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, TO EXAMINE AND ADJUST THE RATES FOR SERVICES PROVIDED THROUGH THE INTERNATIONAL CENTER FOR CLUBHOUSE DEVELOPMENT CLUBHOUSE MODEL OF PSYCHOSOCIAL REHABILITATION". Bill sponsor, Senator Nesbitt explained the bill, with Senator Atwater moving for a favorable report; motion carried.

After this bill in the Committee Book is included a memorandum, dated May 26th at 6:07 p.m., from Shawn Parker to the Chairs and Committee members, clarifying staff response to Senate Bill 1309.

There being no further business before the Committee, Senator Bingham adjourned the meeting at 12:00 p.m.

Respectfully submitted,

Becky Hedspeth

Becky Hedspeth, Committee Assistant

William R Purcell

Senator Purcell, Co-Chair

Stan Bingham

Senator Bingham, Presiding Co-Chair

SENATE BILL 1151:
Supplemental Nutrition Assistance Program

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 25, 2010
Introduced by:	Sen. Purcell	**Prepared by:**	Ben Popkin
Analysis of:	First Edition		Committee Counsel

SUMMARY: ***Senate Bill 1151 would direct the Division of Social Services to study and recommend ways to expand and enhance the Supplemental Nutrition Assistance Program Education (SNAP-Ed Program) in the State, and would direct the Department of Health and Human Services to solicit proposals for local and State programs to use social marketing techniques to educate consumers on nutrition, physical activity, and obesity prevention.***

[As introduced, this bill was identical to H1775, as introduced by Reps. Yongue, Brown, Hughes, Insko, which is currently in House Education, if favorable, Health.]

BILL ANALYSIS: Section 1 – would direct the Division of Social Services to study and recommend ways to expand and enhance the Supplemental Nutrition Assistance Program Education (SNAP-Ed Program) in the State, with specific direction to make recommendation on the following:

1. An expanded definition and use of in-kind resources to draw down additional federal funds to expand SNAP-Ed in the State.
2. A three-year plan to expand and enhance the SNAP-Ed Program.
3. The feasibility of placing responsibility for the SNAP-Ed Program at either North Carolina State University or North Carolina A&T State University, or both.

The bill would direct the Department to report its findings and recommendations on the above items to the Public Health Study Commission, the Fiscal Research Division, and the Legislative Task Force on Childhood Obesity (if it is reestablished for the 2011-2012 session), not later than September 1, 2011.

Section 2 – would direct the Department of Health and Human Services to begin soliciting proposals from nonprofit organizations in October 2010, to develop and implement, by April 2011, new local and State programs emphasizing social marketing techniques to educate consumers on nutrition, physical activity, and obesity prevention.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: The goal of the SNAP-Ed program is to improve the likelihood that individuals eligible for the Supplemental Nutrition Assistance Program (prior to October 1, 2008, was known as the Food Stamp Program) will make healthy food choices within a limited budget and will choose physically active lifestyles.

Senate Bill 1151 is a recommendation of the Legislative Task Force on Childhood Obesity.

Research Division *O. Walker Reagan, Director* *(919) 733-2578*

Fav.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 1151*

Short Title:	Supplemental Nutrition Assistance Program.	(Public)
Sponsors:	Senators Purcell, Dannelly, Preston, Tillman, Walters; and Atwater.	
Referred to:	Health Care.	

May 17, 2010

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF SOCIAL SERVICES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EXAMINE WAYS TO EXPAND AND ENHANCE THE SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM IN NORTH CAROLINA, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Social Services, shall examine and recommend ways to expand and enhance Supplemental Nutrition Assistance Program Education (SNAP-Ed Program) in this State. The recommendations shall include all of the following:

(1) An expanded definition and use of in-kind resources in order to draw down additional federal funds to expand the SNAP-Ed Program in North Carolina.

(2) A three-year plan to expand and enhance the SNAP-Ed Program.

(3) A determination as to the feasibility of placing the responsibility for the SNAP-Ed Program at North Carolina State University or North Carolina A&T State University, or both.

Not later than September 1, 2011, the Department shall report its findings and recommendations on the directives outlined in subdivisions (1) through (3) of this section to the Legislative Task Force on Childhood Obesity if reestablished for the 2011-2012 Session, to the Public Health Study Commission, and to the Fiscal Research Division.

SECTION 2. Beginning in October 2010, the Department shall solicit proposals from nonprofit organizations across the State for the development and implementation by April 2011 of new local and State programs that emphasize social marketing techniques to educate consumers about nutrition, physical activity, and obesity prevention.

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

SENATE BILL 1152:
Study Child Nutrition Program

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 25, 2010
Introduced by:	Sen. Purcell	**Prepared by:**	Ben Popkin
Analysis of:	First Edition		Committee Counsel

SUMMARY: Senate Bill 1152 would direct the Program Evaluation Division to study the operations of the Child Nutrition Program, with particular attention to assessment of indirect costs to local child nutrition programs.

[As introduced, this bill was identical to H1777, as introduced by Reps. Yongue, Brown, Insko, Parfitt, which is currently in House Education, if favorable, Health.]

BILL ANALYSIS:

Section 1.(a) – would direct the Joint Legislative Program Evaluation Oversight Committee to include a study of the operations of the Child Nutrition Program in the 2010 work plan for the Program Evaluation Division, with specific direction to examine the following:

1. Guidelines for assessing indirect costs to local child nutrition programs in local school administrative units.
2. Financial impact on local child nutrition programs and local school administrative units, of prohibiting assessment of indirect costs until local child nutrition programs have amassed a three-month operating balance.

Section 1.(b) – would direct the Program Evaluation Division to submit its findings and recommendations to the Joint Legislative Program Evaluation Oversight Committee, to the Legislative Task Force on Obesity (if reestablished for he 2011-2012 session), and to the Fiscal Research Division.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: Senate Bill 1152 is a recommendation of the Legislative Task Force on Childhood Obesity.

S1152-SMRD-203(e1) v1

FAV.

GENERAL ASSEMBLY OF NORTH CAROLINA
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SENATE BILL 1152*

Short Title:	Study Child Nutrition Program.	(Public)
Sponsors:	Senators Purcell, Dannelly, Davis, Preston, Tillman, and Walters.	
Referred to:	Health Care.	

May 17, 2010

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE JOINT LEGISLATIVE PROGRAM EVALUATION OVERSIGHT COMMITTEE TO DIRECT THE PROGRAM EVALUATION DIVISION TO STUDY INDIRECT COSTS UNDER CHILD NUTRITION PROGRAMS, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Joint Legislative Program Evaluation Oversight Committee shall include in the 2010 Work Plan for the Program Evaluation Division of the General Assembly a study of the operation of the Child Nutrition Program. The Division shall examine (i) the guidelines for assessing indirect costs to local child nutrition programs in local school administrative units and (ii) the financial impact upon local child nutrition programs and local school administrative units of a policy prohibiting the assessment of indirect costs to a child nutrition program until that program has achieved and sustained a three-month operating balance.

SECTION 1.(b) The Program Evaluation Division shall submit its findings and recommendations to the Joint Legislative Program Evaluation Oversight Committee, to the Legislative Task Force on Childhood Obesity, if reestablished for the 2011-2012 Session, and to the Fiscal Research Division at a date to be determined by the Joint Legislative Program Evaluation Oversight Committee.

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

SENATE BILL 1153:
Legislative Task Force on Childhood Obesity

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 25, 2010
Introduced by:	Sen. Purcell	**Prepared by:**	Susan Barham
Analysis of:	PCS to First Edition S1153-CSTE-2		Research Assistant

SUMMARY: The Proposed Committee Substitute for Senate Bill 1153 would extend the Legislative Task Force on Childhood Obesity until the convening of the 2012 Regular Session of the 2011 General Assembly, as recommended by the Legislative Task Force on Childhood Obesity.

[As introduced, this bill was identical to H1827, as introduced by Reps. Yongue, Brown, Hughes, Insko, which is currently in Education, if favorable, Rules, Calendar, and Operations of the House.]

BILL ANALYSIS:

The PCS for Senate Bill 1153 amends Part XLIX of S.L. 2009-574 and would provide that the Legislative Task Force on Childhood Obesity:

- May continue to meet as appointed through the 2010 interim and further extends the Task Force until the convening of the 2012 Session, but requires new appointments in 2011.
- May submit a report of the results of its study and recommendations to the 2011 General Assembly.
- Must submit a report to the 2012 Regular Session of the 2011 General Assembly.
- Shall terminate upon the convening of the 2012 Regular Session of the 2011 General Assembly.

EFFECTIVE DATE: This act is effective April 30, 2010.

BACKGROUND:

This bill is a recommendation from the Legislative Task Force on Childhood Obesity. The Task Force met six times from January 26, 2010 until April 19, 2010 and submitted a report to the 2010 Regular Session of the 2009 General Assembly.

S.L. 2009-574, Part XLIX (HB 945, Part XLIX) created the 12-member Legislative Task Force on Childhood Obesity consisting of six members of the House of Representatives and six members of the Senate. The cochairs for the Task Force must be designated by the Speaker of the House and the President Pro Tempore of the Senate from among the appointees. Vacancies must be filled by the appointing authority, a quorum is a majority of the members, and the Task Force must meet upon the call of the cochairs.

The Task Force is directed to consider and recommend strategies for addressing childhood obesity through:

- Early childhood intervention.
- Childcare facilities.
- Before and after-school programs.
- Physical education and physical activity in schools.
- Higher nutrition standards in schools.
- Increased access to recreational activities for children.
- Community initiatives and public awareness.
- Other means.

Unfav. original bill

GENERAL ASSEMBLY OF NORTH CAROLINA
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SENATE BILL 1153*

Short Title:	Legislative Task Force on Childhood Obesity.	(Public)
Sponsors:	Senators Purcell, Dannelly, Davis, Preston, Tillman, Walters; and Allran.	
Referred to:	Health Care.	

May 17, 2010

A BILL TO BE ENTITLED

AN ACT TO REESTABLISH THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1. The Legislative Task Force on Childhood Obesity, as created in Part XLIX of S.L. 2009-574, is reestablished for the 2011-2012 Session of the General Assembly.

SECTION 2. The Task Force may make an interim report of the results of its study and recommendations to the 2011 General Assembly and shall submit a final report of the results of its study and recommendations to the 2011 General Assembly, Regular Session 2012. The Task Force shall terminate on May 1, 2012, or upon the filing of its final report, whichever occurs first.

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

FAV.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 1153*
PROPOSED COMMITTEE SUBSTITUTE S1153-PCS35458-TE-2

Short Title: Legislative Task Force on Childhood Obesity. (Public)

Sponsors:

Referred to:

May 17, 2010

A BILL TO BE ENTITLED

AN ACT TO CONTINUE THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1. Part XLIX of S.L. 2009-574 reads as rewritten:

"**PART XLIX. LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY (Yongue)**

"**SECTION 49.1.** There is created the Legislative Task Force on Childhood Obesity.

"**SECTION 49.2.** The Task Force shall consist of 12 members as follows:

(1) Six members of the House of Representatives.

(2) Six members of the Senate.

"**SECTION 49.3.** The Speaker of the House of Representatives shall designate one Representative as cochair, and the President Pro Tempore of the Senate shall designate one Senator as cochair. Terms of the initial members begin on appointment and continue until the convening of the 2011 Session of the General Assembly. Subsequent appointments begin during the 2011 Session of the General Assembly and continue until the Task Force terminates. Vacancies on the Task Force shall be filled by the same appointing authority that made the initial appointment. A quorum of the Task Force shall be a majority of its members.

"**SECTION 49.4.** The Task Force shall include, but should not be limited to, study of issues relating to childhood obesity. In the course of the study, the Task Force shall consider and recommend to the General Assembly strategies for addressing the problem of childhood obesity and encouraging healthy eating and increased physical activity among children through:

(1) Early childhood intervention;

(2) Childcare facilities;

(3) Before and after-school programs;

(4) Physical education and physical activity in schools;

(5) Higher nutrition standards in schools;

(6) Comprehensive nutrition education in schools;

(7) Increased access to recreational activities for children;

(8) Community initiatives and public awareness; and

(9) Other means.

"**SECTION 49.5.** The Task Force shall encourage input from public nonprofit organizations, promoting healthy lifestyles for children, addressing the problems related to childhood obesity, encouraging healthy eating, and increasing physical activity among children.

"**SECTION 49.6.** Members of the Task Force shall receive per diem, subsistence, and travel allowances in accordance with G.S. 120-3.1, 138-5, or 138-6, as appropriate. The Task Force, while in the discharge of its official duties, may exercise all powers provided for under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4. The Task Force may meet at anytime upon the joint call of the cochairs. The Task Force may meet in the Legislative Building or the Legislative Office Building.

With approval of the Legislative Services Commission, the Legislative Services Officer shall assign professional staff to assist the Task Force in its work. The House of Representatives' and the Senate's Directors of Legislative Assistants shall assign clerical staff to the Task Force, and the expenses relating to the clerical employees shall be borne by the Task Force. The Task Force may contract for professional, clerical, or consultant services as provided by G.S. 120-32.02. If the Task Force hires a consultant, the consultant shall not be a State employee or a person currently under contract with the State to provide services.

All State departments and agencies and local governments and their subdivisions shall furnish the Task Force with any information in their possession or available to them.

"**SECTION 49.7.** The Task Force shall submit a ~~final~~ report of the results of its study and its recommendations to the 2010 Regular Session of the 2009 General Assembly. The Task Force may make a report of the results of its study and recommendations to the 2011 General Assembly and shall submit a report to the 2012 Regular Session of the 2011 General Assembly. The Task Force shall terminate ~~on May 1, 2010, or upon the filing of its final report, whichever occurs first.~~ upon the convening of the 2012 Regular Session of the 2011 General Assembly."

SECTION 2. This act becomes effective April 30, 2010.

SENATE BILL 1304:
Modify CABHA Certification Process

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 25, 2010
Introduced by:	Sen. Nesbitt	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Legislative Analyst

SUMMARY: ***Senate Bill 1304 would direct the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to develop a plan to modify the current certification process for Critical Access Behavioral Health Agencies (CABHA) to enable new provider agencies to qualify for participation in the CABHA network.***

[As introduced, this bill was identical to H1795, as introduced by Reps. Insko, England, Earle, Farmer-Butterfield, which is currently in House Mental Health Reform, if favorable, Appropriations.]

CURRENT LAW:

Effective July 1, 2010, CABHAs will be the only category of providers authorized to offer services in three key categories: Community Support Teams for adults, Intensive In-Home Treatment for children, and Day Treatment for children and adults. Pending approval from the Centers for Medicare and Medicaid Services (CMS), Case Management and Peer Support for recovery initiatives will also be provided exclusively within the CABHA structure.

BILL ANALYSIS:

The bill directs the Department of Health and Human Services, Division of MH/DD/SAS to develop a plan for modify the current certification process for CABHAs in a manner that would ensure new provider agencies are able to qualify to participate in the CABHA network. The bill further directs the Division to report on this plan to the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services and the Fiscal Research Division on or before October 1, 2010.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: For a mental health service provider to be designated as a CABHA, the provider must meet the certification process. First, a provider submits an attestation letter with documentation evidencing the provider's ability to meet basic certification requirements, specifically:

- Delivery of three core services: comprehensive clinical assessment, medication management, and outpatient therapy;
- Delivery of at least two enhanced services in the same location where it provides the three core services to create a continuum of care;
- Active National Accreditation of at least 3 years;
- A Full-Time or Part-Time Medical Director, depending upon the number of consumers served (100% FTE for providers serving more than 750 consumers – 60% billing; 50% FTE for providers serving less than 376 – 749 consumers – 60% billing; 8 hours per week – 0 – 375 consumers – no billing)
- A Full-Time Clinical Director
- A Full-Time Quality Management/Staff Training Director

Second, the provider undergoes a desk review of the letter of attestation and supporting documentation, which is conducted by DMH/DD/SAS, in collaboration with DMA and DHSR staff, and verified by an LME. Third, the provider must undergo an onsite review conducted by DMH/DD/SAS, DMA, and LME staff. The onsite review includes staff interviews of the Medical Director, Clinical Director, Quality Improvement/Training Director, and other provider agency staff as deemed appropriate.

S1304-SMSQ-143(e1) v1

fav.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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SENATE BILL 1304*

Short Title:	Modify CABHA Certification Process.	(Public)
Sponsors:	Senators Nesbitt; and Atwater.	
Referred to:	Health Care.	

May 20, 2010

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO DEVELOP AND REPORT ON A PLAN FOR MODIFYING THE CERTIFICATION PROCESS FOR CRITICAL ACCESS BEHAVIORAL HEALTH AGENCIES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall develop a plan for modifying the current certification process for Critical Access Behavioral Health Agencies (CABHAs) in a manner that will ensure new provider agencies are able to qualify for participation in the CABHA network. The Division shall submit a report of the modification plan to the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services and the Fiscal Research Division not later than October 1, 2010.

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

SENATE BILL 1307:
Modify MHDDSAS Reporting Requirements

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 25, 2010
Introduced by:	Sen. Nesbitt	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Legislative Analyst

SUMMARY: ***Senate Bill 1309 directs a number of reports to be provided to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.***

[As introduced, this bill was identical to H1890, as introduced by Rep. Insko, which is currently in House Mental Health Reform, if favorable, Appropriations.]

BILL ANALYSIS: The bill directs the following reports:

Community Support Services

Directs the Division of MH/DD/SAS to report to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on community support services on or before January 1, 2011. The report shall include the status on former recipients of community supports services in respect to new services, costs associated with service changes, and the status of any new service definition.

Death Reporting

Directs the Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services to report annually on all deaths subject to G.S. 122C-31 beginning September 1, 2010.

Mental Health Trust Fund

Includes the Joint Legislative Oversight Committee as a recipient of annual reports on expenditures made from the Trust Fund for Mental Health, Developmental Disabilities, and Substance Abuse Services and Bridge Funding Needs. *Currently the Secretary is directed by statute to make this report to Fiscal Research Division.*

Funding Services through Local Management Entities

Directs the Division of MH/DD/SAS to provide an **annual report** to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services and the Fiscal Research Division on a strategic plan for organizing State and local resources to fund services provided through local management entities beginning January 1, 2011. The report shall include:

- Allocation of funds
- Guidleins for utilization of funds
- Restrictions on uses of funds
- Listing of expenditures

LME quarterly reports

Makes LME quarterly reports directed in Section 10.19A (c) of SL 2009-451 annual beginning May 1, 2011.

Tiered Waivers

Amends Section 10.65A(a) of SL 2009-451 to direct the Department of Health and Human Services to provide a status report on the implementation plan for the CAP-MR/DD Tiered Waiver in addition to the original reporting requirements the report shall include: criteria and cost associated with moving individuals within the tiers.

State Performance Measures

Directs the Department to include a mechanism for measuring the following matters within the performance measures of the State Plan for MH/DD/SAS:

- Equitable allocation of resources
- Prevention and early intervention
- Statewide system of crisis response for adults and children
- Management of the utilization of State facilities

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: This is a recommendation of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

S1307-SMSQ-142(e1) v1

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 1307*

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

S1307-ASQ-120 [v.1]

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Date _____,2010

Senator Atwater

moves to amend the bill on page 2, lines 11 and 21, by deleting the word "G.S." each time it appears and substituting the word "Section".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

rolled into Committee Sub.

unfav.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 1307*

Short Title:	Modify MHDDSAS Reporting Requirements.	(Public)
Sponsors:	Senators Nesbitt; and Atwater.	
Referred to:	Health Care.	

May 20, 2010

A BILL TO BE ENTITLED

AN ACT TO MODIFY REPORTING REQUIREMENTS PERTAINING TO MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Not later than January 1, 2011, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall provide a final report on community support services, to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The final report shall include a summary of the following information with respect to former recipients of community support services:

(1) The number of individuals no longer receiving any services.

(2) The number of individuals transferred to other mental health services, broken down by the specific type of service and the number of individuals transferred to each service.

(3) The amount of any cost increase or cost savings resulting from the transfer of those individuals to other mental health services.

(4) The status of any new service definitions developed in response to the elimination of community support services.

SECTION 1.(b) By September 1, 2010, and annually thereafter, the Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services shall submit a report summarizing all deaths, subject to the reporting requirements set forth in G.S. 122C-31 that occurred during the one-year period preceding the date of the report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

SECTION 1.(c) G.S. 143C-9-2(d) reads as rewritten:

"(d) Beginning ~~July 1, 2007,~~ July 1, 2010, the Secretary of the Department of Health and Human Services shall report annually to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services and the Fiscal Research Division on the expenditures made during the preceding fiscal year from the Trust Fund. The report shall identify each expenditure by recipient and purpose and shall indicate the authority under subsection (b) of this section for the expenditure."

SECTION 1.(d) Beginning January 1, 2011, and annually thereafter, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall report to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division on a strategic plan for organizing State and local resources to fund services provided through local management entities. The report shall include criteria for the allocation of funds, guidelines for utilization of funds, restrictions on use of funds, and a list of expenditures.

SECTION 1.(e) G.S. 10.19A(c) of S.L. 2009-451 reads as rewritten:

"**SECTION 10.19A.(c)** The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall require quarterly reporting from LMEs in the format required under subsection (a) of this section. The Department of Health and Human Services shall report the results of the quarterly reports to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division on or before ~~May 1, 2010.~~May 1, 2011, and annually thereafter."

SECTION 1.(f) G.S. 10.65A(a) of S.L. 2009-451 reads as rewritten:

"**SECTION 10.65A.(a)** ~~For the purposes of improving efficiency in the expenditure of available funds and effectively identifying and meeting the needs of CAP-MR/DD eligible individuals, on or before April 1, 2010, the~~ By January 1, 2011, the Department of Health and Human Services, Division of Medical Assistance, in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall submit to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services a ~~plan for~~ status report on the implementation ~~of Tiers 1 through 4 of~~plan for the CAP-MR/DD ~~program.~~ Tiered Waiver. The plan shall describe the implementation of each of the Tiers ~~1 and 4 and the proposed implementation of Tiers 2 and 3, and revisions of Tier 4,~~ and shall include detail on each of the following:

(1) The array and intensity level of services that will be available under each of the ~~four~~ Tiers.~~;~~

(2) The range of costs for the array and intensity level of services under each of the ~~four~~ Tiers.~~;~~

(3) How the relative intensity of need for each current and future CAP-MR/DD eligible individual will be reliably determined.~~; and~~

(4) How the determination of intensity of need will be used to assign current and future CAP-MR/DD eligible individuals appropriately into one of the ~~four~~ Tiers.

(5) The criteria for moving individuals from one Tier to another and any costs associated with that movement.

~~The Department may develop an application to the Centers for Medicare and Medicaid services for additional Medicaid waivers for Tiers 2 and 3 of the CAP-MR/DD program. The Department shall not submit the application until after it has submitted the plan required under this subdivision.~~ Nothing in this subdivision obligates the General Assembly to appropriate additional funds for the CAP-MR/DD waiver."

SECTION 1.(g) G. S. 122C-102(c) reads as rewritten:

"(c) State Performance Measures. – The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following matters: access

to services, consumer-focused outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, ~~and prevention and early intervention. Beginning October 1, 2006,~~equitable allocation of resources, prevention and early intervention, statewide system of crisis response for adults and children, and management of the utilization of State facilities. Beginning January 1, 2011, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, on the State's progress in these performance areas."

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

fav

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 1307*
PROPOSED COMMITTEE SUBSTITUTE S1307-PCS55606-SQ-83

Short Title: Modify MHDDSAS Reporting Requirements. (Public)

Sponsors:

Referred to:

May 20, 2010

A BILL TO BE ENTITLED

AN ACT TO MODIFY REPORTING REQUIREMENTS PERTAINING TO MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1.(a) Not later than January 1, 2011, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall provide a final report on community support services to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The final report shall include a summary of the following information with respect to former recipients of community support services:

(1) The number of individuals no longer receiving any services.

(2) The number of individuals transferred to other mental health services, broken down by the specific type of service and the number of individuals transferred to each service.

(3) The amount of any cost increase or cost savings resulting from the transfer of those individuals to other mental health services.

(4) The status of any new service definitions developed in response to the elimination of community support services.

SECTION 1.(b) By September 1, 2010, and annually thereafter, the Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services shall submit a report summarizing all deaths, subject to the reporting requirements set forth in G.S. 122C-31, that occurred during the one-year period preceding the date of the report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

SECTION 1.(c) G.S. 143C-9-2(d) reads as rewritten:

"(d) Beginning ~~July 1, 2007,~~ July 1, 2010, the Secretary of the Department of Health and Human Services shall report annually to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services and the Fiscal Research Division on the expenditures made during the preceding fiscal year from the Trust Fund. The

report shall identify each expenditure by recipient and purpose and shall indicate the authority under subsection (b) of this section for the expenditure."

SECTION 1.(d) Beginning January 1, 2011, and annually thereafter, the Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall report to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division on a strategic plan for organizing State and local resources to fund services provided through local management entities. The report shall include criteria for the allocation of funds, guidelines for utilization of funds, restrictions on use of funds, and a list of expenditures.

SECTION 1.(e) Section 10.19A(c) of S.L. 2009-451 reads as rewritten:

"**SECTION 10.19A.(c)** The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall require quarterly reporting from LMEs in the format required under subsection (a) of this section. The Department of Health and Human Services shall report the results of the quarterly reports to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, and the Fiscal Research Division on or before ~~May 1, 2010.~~May 1, 2011, and annually thereafter."

SECTION 1.(f) Section 10.65A(a) of S.L. 2009-451 reads as rewritten:

"**SECTION 10.65A.(a)** ~~For the purposes of improving efficiency in the expenditure of available funds and effectively identifying and meeting the needs of CAP-MR/DD eligible individuals, on or before April 1, 2010, the~~ By January 1, 2011, the Department of Health and Human Services, Division of Medical Assistance, in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall submit to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services a ~~plan for~~ status report on the implementation ~~of Tiers 1 through 4 of~~plan for the CAP-MR/DD ~~program.~~ Tiered Waiver. The plan shall describe the implementation of each of the Tiers ~~1 and 4 and the proposed implementation of Tiers 2 and 3, and revisions of Tier 4,~~ and shall include detail on each of the following:

(1) The array and intensity level of services that will be available under each of the ~~four Tiers;~~Tiers.

(2) The range of costs for the array and intensity level of services under each of the ~~four Tiers;~~Tiers.

(3) How the relative intensity of need for each current and future CAP-MR/DD eligible individual will be reliably ~~determined; and~~determined.

(4) How the determination of intensity of need will be used to assign current and future CAP-MR/DD eligible individuals appropriately into one of the ~~four~~ Tiers.

(5) The criteria for moving individuals from one Tier to another and any costs associated with that movement.

~~The Department may develop an application to the Centers for Medicare and Medicaid services for additional Medicaid waivers for Tiers 2 and 3 of the CAP-MR/DD program. The Department shall not submit the application until after it has submitted the plan required under this subdivision.~~ Nothing in this ~~subdivision~~ subsection obligates the General Assembly to appropriate additional funds for the CAP-MR/DD waiver."

SECTION 1.(g) G. S. 122C-102(c) reads as rewritten:

"(c) State Performance Measures. – The State Plan shall also include a mechanism for measuring the State's progress towards increased performance on the following matters: access to services, consumer-focused outcomes, individualized planning and supports, promotion of best practices, quality management systems, system efficiency and effectiveness, ~~and prevention and early intervention. Beginning October 1, 2006,~~equitable allocation of resources, prevention and early intervention, statewide system of crisis response for adults and children, and management of the utilization of State facilities. Beginning January 1, 2011, and every six months thereafter, the Secretary shall report to the General Assembly and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, on the State's progress in these performance areas."

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

SENATE BILL 1309:
Extend and Expand First Commit Pilot

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 25, 2010
Introduced by:	Sen. Nesbitt	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Legislative Analyst

SUMMARY: Senate Bill 1309 would extend the First Commitment Pilot Program until October 1, 2012 and would authorize the Secretary to expand program to up to 20 LMEs.

[As introduced, this bill was identical to H1797, as introduced by Reps. Insko, England, Farmer-Butterfield, Brisson, which is currently in House Mental Health Reform, if favorable, Appropriations.]

CURRENT LAW: - *The process for inpatient involuntary commitment requires a number of steps:*

Anyone who has knowledge of an individual who is mentally ill and either (i) dangerous to self, as defined in G.S. 122C-3(11)a., or dangerous to others, as defined in G.S. 122C-3(11)b., or (ii) in need of treatment in order to prevent further disability or deterioration that would predictably result in dangerousness, may appear before a magistrate or clerk and execute an Affidavit and Petition for Involuntary Commitment.

If the magistrate or clerk finds reasonable grounds to believe the facts alleged in the affidavit, the magistrate or clerk must issue and order for law enforcement* to take the respondent (person who is the subject to the petition) into custody for an examination by a *physician or eligible psychologist.* [1] This is the first examination in the commitment process.

The first examination must occur within 24 hours after the respondent is presented for examination.[2]

Under the "First Commitment Pilot Program" the Secretary is authorized to approve LME requests to substitute appropriately trained *licensed clinical social workers, masters level psychiatric nurses,* or *masters level certified clinical addictions specialists* to conduct first-level examinations.[3]

Currently 15 LMEs utilize the program which will expire October 1, 2010.

BILL ANALYSIS:

Section 1: extends the sunset on the First Commitment Pilot Program until October 1, 2012 and authorizes the Secretary to expand the program to up to 20 local management entities.

Section 2: directs the Division of MH/DD/SAS to expand its training requirements to include refresher training. The section further directs the Division to evaluate the participation rate of eligible examiners and report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: This is a recommendation of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

S1309-SMSQ-140(e1) v2

[1] G.S. 122C-261
[2] G.S. 122C-263(c)
[3] SL 2003-178, as amended by SL 2006-66, SL 2007-50, and SL 2009-304

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 1309

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

S1309-ASQ-119 [v.1]

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Date _____,2010

Senator _____

moves to amend the bill on page 2, line 25, by rewriting the line to read:
"~~October 1, 2010.~~October 1, 2012.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

unfav.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S 1

SENATE BILL 1309

Short Title:	Extend and Expand First Commit Pilot.	(Public)
Sponsors:	Senators Nesbitt; and Atwater.	
Referred to:	Health Care.	

May 20, 2010

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO WAIVE TEMPORARILY CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES FOR PARTICIPANTS IN THE FIRST EVALUATION PILOT PROGRAM AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY CERTAIN ISSUES RELATING TO THE PROGRAM, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. S.L. 2003-178, as amended by Section 10.27 of S.L. 2006-66, as amended by Section 1.1(a)(5) of S.L. 2007-504, and as further amended by Section 3 of S.L. 2009-340 reads as rewritten:

"**SECTION 1.** The Secretary of Health and Human Services may, upon request of an LME, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the LME shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist are within the individual's scope of practice.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver. The Secretary shall send a report on the evaluation to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substances Abuse Services by October 1, 2009. The report shall include data gathered from all participating LMEs since the beginning of the pilot.

(4) The waiver granted by the Secretary under this section shall be in effect until October 1, 2010.

(5) The Secretary may grant a waiver under this section to up to ~~15~~20 LMEs.

(6) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist.

(7) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver. The Department shall involve stakeholders including, but not limited to, the North Carolina Psychiatric Association, The North Carolina Nurses Association, National Association of Social Workers, The North Carolina Substance Abuse Professional Certification Board, North Carolina Psychological Association, The North Carolina Society for Clinical Social Work, and the North Carolina Medical Society in developing required staff competencies.

(8) The LME shall assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary.

SECTION 2. This act becomes effective July 1, 2003, and expires ~~October 1, 2010.~~October 1, 2012.".

SECTION 2. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall expand it standardized certification training program to include refresher training for all certified providers and shall report to the Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services on the participation rate of licensed clinical social worker, the master's level psychiatric nurse, or the master's level

certified clinical addictions specialist in the pilot program and whether the program should include other licensed or certified health care professionals.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

fav.

S D

SENATE BILL 1309
PROPOSED COMMITTEE SUBSTITUTE S1309-PCS35459-SQ-84

Short Title: Extend and Expand First Commit Pilot. (Public)

Sponsors:

Referred to:

May 20, 2010

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE SECRETARY OF HEALTH AND HUMAN SERVICES TO WAIVE TEMPORARILY CERTAIN REQUIREMENTS OF THE MENTAL HEALTH COMMITMENT STATUTES FOR PARTICIPANTS IN THE FIRST EVALUATION PILOT PROGRAM AND TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO STUDY CERTAIN ISSUES RELATING TO THE PROGRAM, AS RECOMMENDED BY THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

The General Assembly of North Carolina enacts:

SECTION 1. S.L. 2003-178, as amended by Section 10.27 of S.L. 2006-66, as amended by Section 1.1(a)(5) of S.L. 2007-504, and as further amended by Section 3 of S.L. 2009-340, reads as rewritten:

"**SECTION 1.** The Secretary of Health and Human Services may, upon request of an LME, waive temporarily the requirements of G.S. 122C-261 through G.S. 122C-263 and G.S. 122C-281 through G.S. 122C-283 pertaining to initial (first-level) examinations by a physician or eligible psychologist of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a), as applicable, as follows:

(1) The Secretary has received a request from an LME to substitute for a physician or eligible psychologist, a licensed clinical social worker, a masters level psychiatric nurse, or a masters level certified clinical addictions specialist to conduct the initial (first-level) examinations of individuals meeting the criteria of G.S. 122C-261(a) or G.S. 122C-281(a). The waiver shall be implemented on a pilot-program basis. The request from the LME shall specifically describe:

a. How the purpose of the statutory requirement would be better served by waiving the requirement and substituting the proposed change under the waiver.

b. How the waiver will enable the LME to improve the delivery or management of mental health, developmental disabilities, and substance abuse services.

c. How the services to be provided by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level

certified clinical addictions specialist under the waiver are within each of these professional's scope of practice.

d. How the health, safety, and welfare of individuals will continue to be at least as well protected under the waiver as under the statutory requirement.

(2) The Secretary shall review the request and may approve it upon finding that:

a. The request meets the requirements of this section.

b. The request furthers the purposes of State policy under G.S. 122C-2 and mental health, developmental disabilities, and substance abuse services reform.

c. The request improves the delivery of mental health, developmental disabilities, and substance abuse services in the counties affected by the waiver and also protects the health, safety, and welfare of individuals receiving these services.

d. The duties and responsibilities performed by the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist are within the individual's scope of practice.

(3) The Secretary shall evaluate the effectiveness, quality, and efficiency of mental health, developmental disabilities, and substance abuse services and protection of health, safety, and welfare under the waiver. The Secretary shall send a report on the evaluation to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substances Abuse Services by October 1, 2009. The report shall include data gathered from all participating LMEs since the beginning of the pilot.

(4) The waiver granted by the Secretary under this section shall be in effect until ~~October 1, 2010.~~October 1, 2012.

(5) The Secretary may grant a waiver under this section to up to ~~15~~20 LMEs.

(6) In no event shall the substitution of a licensed clinical social worker, masters level psychiatric nurse, or masters level certified clinical addictions specialist under a waiver granted under this section be construed as authorization to expand the scope of practice of the licensed clinical social worker, the masters level psychiatric nurse, or the masters level certified clinical addictions specialist.

(7) The Department shall assure that staff performing the duties are trained and privileged to perform the functions identified in the waiver. The Department shall involve stakeholders including, but not limited to, the North Carolina Psychiatric Association, The North Carolina Nurses Association, National Association of Social Workers, The North Carolina Substance Abuse Professional Certification Board, North Carolina Psychological Association, The North Carolina Society for Clinical Social Work, and the North Carolina Medical Society in developing required staff competencies.

(8) The LME shall assure that a physician is available at all times to provide backup support to include telephone consultation and face-to-face evaluation, if necessary.

"**SECTION 2.** This act becomes effective July 1, 2003, and expires ~~October 1, 2010.~~October 1, 2012."

SECTION 2. The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services shall expand its standardized certification training program to include refresher training for all certified providers and shall report to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse

Services on the participation rate of licensed clinical social worker, the master's level psychiatric nurse, or the master's level certified clinical addictions specialist in the pilot program and whether the program should include other licensed or certified health care professionals.

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

SENATE BILL 1319:
Examine and Adjust Rates/Clubhouses

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 25, 2010
Introduced by:	Sen. Nesbitt	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Legislative Analyst

SUMMARY: Senate Bill 1319 directs the Department of Health and Human Services to examine and adjust rates for community support services provided under the Clubhouse model by providers that have received national certification from the International Center for Clubhouse Development.

[As introduced, this bill was identical to H1885, as introduced by Rep. Insko, which is currently in House Mental Health Reform, if favorable, Appropriations.]

BILL ANALYSIS:

The bill would direct the Department of Health and Human Services to examine and adjust rates as necessary for community support services provided under the Clubhouse model by providers that have received national certification from the International Center for Clubhouse Development. The bill further directs the Department to report any rate adjustment made pursuant to the act to to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services not later than October 1, 2010.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND:

The Clubhouse Model is a type of psychosocial rehabilitation designed to address the needs of the whole person in his/her recovery from serious mental illness. Supporting psychiatric and healthcare symptom management, the Clubhouses offer vocational supports, community-based employment, education, housing, outreach, advocacy and access to health care and substance abuse services as well as social and recreational opportunities. Using a membership concept, the Clubhouses are founded on the importance of "consumer ownership". Each member shares in the operation of the community center. The Clubhouse model is outcome based and in North Carolina, the Clubhouses work closely with Universities to provide internship sites, collaborative research projects and service integration.

There are currently 85 licensed Psychosocial Rehabilitation providers in the state and 44 of these follow the Clubhouse model. Eight N.C. Clubhouses have received national certification by the International Center for Clubhouse Development having met the ICCD standards.

SENATE BILL 1319*

Short Title:	Examine and Adjust Rates/Clubhouses.	(Public)
Sponsors:	Senators Nesbitt; and Atwater.	
Referred to:	Health Care.	

May 20, 2010

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE, IN CONSULTATION WITH THE DIVISION OF MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, TO EXAMINE AND ADJUST THE RATES FOR SERVICES PROVIDED THROUGH THE INTERNATIONAL CENTER FOR CLUBHOUSE DEVELOPMENT CLUBHOUSE MODEL OF PSYCHOSOCIAL REHABILITATION.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, in conjunction with the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall examine and, as the Divisions deem necessary, adjust the rates for community support services provided through the International Center for Clubhouse Development (ICCD) clubhouse model of psychosocial rehabilitation. The Department shall report on any adjustment in rates to the Senate Appropriations Committee on Health and Human Services, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Fiscal Research Division, and the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services no later than October 1, 2010.

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

Becky Hedspeth (Sen. Purcell)

From: Shawn Parker (Research)
Sent: Wednesday, May 26, 2010 6:07 PM
To: Sen. William Purcell; Sen. Stan Bingham; Sen. James Forrester; Sen. Josh Stein; @Senate/Health Care
Cc: Ben Popkin (Research); Susan Barham (Research)
Subject: Clarification on staff response Senate Health Care

Committee Members,

I would like to follow up on two questions raised in Committee today that I would have like to have provided a clearer response.

Question 1- Process for Voluntary Admissions-
Any individual (compatent adult) in need of treatment for mental health or substance abuse may seek voluntary admission at any facility by presenting themself to the facility.

- No physician's statement is necessary, but a written application for evaluation or admission is required.
- A facility may elect not to admit the adult if it determines that the adult does not need, or cannot benefit from available services.
- Once admitted the adult must be discahrged within 72 hours of his or her written request

Incompetent adults and admission of minors although deemed voluntary when performed under Part 3 of Chapter 122C, are subject to judicial review since someone other than the client signs the application.

Question 2- Time period allowed between 1st and 2nd evaluation for involuntary commitments.
Generally the second examination is performed within 24 hours of arrival to the IVC facility.

- If the facility is the same facility that the first evaluation was performed, the 2nd evaluation shall occur not later than the next business day.
- if upon first examination inpatient treatment is warranted, and a 24-hour facility is not immediately available or appropriate, the respondent may be detained at the site of the first examination and the custody order remains in effect. If a respondent continues to meet the criteria for inpatient commitment but a 24-hour facility is not available **7 days** after the issuance of the custody order, the proceedings would be terminated, and the matter reported to the clerk.

As staff we attempt to anticipate questions as part of our preparation, but unfortunately I was a bit sidetracked. I apologize if it was detrimental to your debate and discusion.

Please let me know if I can provide any additional information.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — **MAY 26, 2010**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Rob Thompson	Lobbyist w/ NC's Children
Sally Cameron	NC Psychological Assoc
Dr. David Wiesner	NC Psychological Assoc - Raleigh
Dr Richard Kedin	NC Psychological Assoc Raleigh
R Kevin Jones	American Association of Orthopaedic Surgeons
Will Siler (MD)	Triangle Orthopaedic Associates
Dr. Spencer Lyerly	NC Psychological Assoc - Raleigh
Dr. Madeleine Crockett	Central Regional Hospital, Butner, NC
Linda Parker	NCAE
Marcus Little	Sen Dorsett
Shilanka Ware	Sen Dorsett Intern

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — **MAY 26, 2010**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Henry Hataff	N.C.B.A
Butch Gunnells	NC Beverage Assoc
Amy McConkey	NC Beverage Assoc

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — **MAY 26, 2010**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jane Smith	DHHS
Michael Watson	DHHS
Sonya Summerlin	DHHS - DMH/DD/SAS
Jillayne Hallifield, PhD	Private practice - previously Durham VA Hosp.
Vivian Barnette, PhD Licensed Psychologist	NC Psychological Association NC A+T State University
Joanne Hernandez PhD MSPH	NC Psychological association Private Practice, Durham
John A. Edwards, PhD. HSPP RET.	NC Psych. Assoc. Greensboro, NC
Scott Gibson	Goldsboro Orthopaedic Associates Goldsboro, NC.
Dr. David Rockwell	Goldsboro Orthopaedic Associates Goldsboro, NC.
GRACE HUTCHINS	Sen. Stein office
Marcia Trapp	NCACC

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — MAY 26, 2010

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
JAMES KIRBY	OFFICE OF SEN. QUEEN
Bo Heath	MWC
DAVID BARNES	Poyner Spruill
Emily Williams	TPG
Linda Sugg	Ed Consultant
Jack Register	Natl. Assoc of Social Workers - NC Chap
Deona Hooper	NASW intern
Tiffany Christensen	NASW
DANIEL BAILEY	TROUTMAN SANDERS
[illegible]	NCAHD
[illegible]	[illegible]

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — **MAY 26, 2010**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Janet Schanzenbach	Ander Consulting
Annaliese Dolph	DRNC
Jim stegall	U.C.P.S.
ANGIE Whitener	NCPC
Erica Nelson	NC council Community MH/DD/SAS Programs
Lou Wilson	NCALTCF
[illegible]	Raleigh, N C
David Gardner	NCDPI
Peggy Badgett	The Sagamon Group
Betsy MacMichael	First In Families of NC
David Thompson	High Point NC
[illegible]	NCBA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — **MAY 26, 2010**
Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Susan Harrison	WCPSS
Andrew Meehan	Capstrat
Katherine Joyce	NCASA
Jon Carr	Jordan Price Law Firm
TARA FIELDS	CFSA-NC
Christine Wesson	American Cancer Society
Paula Hudson Collins	DPI/SBE
Lynn Harvey	DPI
Ben Matthews	"
Julia Adams	The Arc of NC
Dave Richard	The Arc of NC

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — **MAY 26, 2010**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Will Culpepper	MVA
W. Gordon Pellegrin	NCNA
Wendy Kelly	Policy Group
[illegible] Walston	YA10
[illegible]	[illegible]
Mike Rhodes	RHA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — **MAY 26, 2010**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Harold Tyson	Resourceful Solutions II Behavioral Health Agency, Charlotte, N.C.
Stephanie Tyson	Resourceful Solutions II
Fred Aikens	The Aikens Group LLC
April Harris Britt	Psychologist - Private Practice
Mary Mumelaketa	Pfizer Specialty
[illegible] Poole	Ward and Smith
Dean Simpson	DHHS/ DSS
Monique L. Batchelor	Wake Med
Julia Messer	Psychologist - Private Practice
Kevin O'Neal, MD	Western Wake Eye, Cary
Keli Coleman	Eisai / keli_coleman@eisai.com

Senate Health Care Committee
Wednesday, June 2, 2010, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

SB 1191	**Nurse Aide Training Review.**	**Senator Swindell IV**
SB 1193	**Implement LTC Partnership Program.**	**Senator Swindell IV**
SB 1286	**Screen and Reduce BMI Levels in Children.**	**Senator Purcell**
HB 144	**Special Care Dentistry Collaboration.**	**Representative Bordsen Representative Mobley Representative Pierce Representative. Farmer-Butterfield**

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

CORRECTED REPORT#2

Thursday, June 03, 2010

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

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

S.B. **1191** Nurse Aide Training Review.

Draft Number:	75397
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **1193** Implement LTC Partnership Program.

Draft Number:	55615
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **1286** Screen and Reduce BMI Levels in Children.

Draft Number:	75396
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **144** Special Care Dentistry Collaboration.

Draft Number:	50928
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 4

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, June 2, 2010 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, June 2, 2010, in Room 544 of the Legislative Office Building, eighteen members present. Senator William Purcell, Co-Chair, presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present, introduced the pages, and thanked the Sergeant-at-Arms.

Senator Purcell recognized Senator Swindell to present SB 1191, ***Nurse Aide Training Review***. Senator Dannelly moved to hear the Proposed Committee Substitute. The motion passed. Sen. Swindell stated that SB 1191 would direct the Division of Health Service Regulations and Department of Health and Human Services (DHHS) to coordinate a review of the education and training requirements for Nurse Aides. He pointed out it was recommended from the Study Commission on Aging. He also explained that there were many Nurse Aides employed in hospitals, in long-term care facilities, and in nursing home facilities and there were variances of what were required for Nurse Aides in different places. At the appropriate time Senator Dannelly moved for a favorable report for the PCS. Senator Purcell held the request and called upon Senator Forrester. Senator Forrester asked if NC reciprocated with other states. Senator Swindell called on anyone in the audience that might be able to answer the question. Jesse Goodman, Chief Operation Officer for the Division of Health Services Regulations in the Department of Health and Human (DHHS), responded that there was no reciprocity of Nurse Aides coming into NC. He said that any person that wanted to work as a Nurse Aide must pass the NC Nurse Aide I Exam in order to be listed on the registry. Senator Dannelly's motion, unfavorable as to original bill, but favorable as to the Proposed Committee Substitute, passed.

Sen. Purcell asked Senator Swindell to stay at the microphone to present SB 1193, ***Implement LTC Partnership Program***, which had a Proposed Committee Substitute. Sen. Dannelly moved to adopt the Proposed Committee Substitute for discussion. The motion passed. Senator Swindell explained that in these economic times when IRAs and 401Ks and our savings effect so many lives, this bill would help the Baby Boomers. He stated that several years ago the NC General Assembly authorized the Department of Health and Human Services (DHHS) to work with the Department of Insurance (DOI) to create what was called a Long Term Care Partnership Program for NC. It was designed to encourage people to buy Long Term Care Insurance so there would be less burden on the Medicaid System. If this bill would be adopted, the Federal Government through the Deficit Reduction Act of 2005 would allow NC to exempt Long Term Care Benefits from a state recovery as long as NC had the partnership. There are thirty-three states now that participate in this partnership. Senator Swindell explained that if you purchase a Long Term Care Policy it pays for your care; then instead of having to liquidate all of your assets when it is time to apply for Medicaid, Medicaid will

deduct from your resources every dollar you have put into a long term care policy and paid out. Therefore when you die the Medicaid will not go after the money that the long term care policy paid to that facility on your behalf. Senator Dorsett asked if Medicare is a part of this program. Sen. Swindell responded it is only Medicaid. Sen. Dorsett asked if Medicare people purchase Long Term Care, are their assets protected as well. Carolyn McClanhan, Chief of Medicaid Eligibility at the Division of Medical Assistance, stated that if they do not apply for Medicaid she is not sure Medicare would do anything. Medicare just pays part of their nursing home care. Sen. Goss moved for a favorable report. Sen. Brown stated his Mom was in a nursing home and probably would lose all her assets. Sen. Stein asked what the savings would be to the state. Rose Williams, Department of Insurance, stated they only have numbers from other states. Connecticut as of 2007 with its partnership program had saved $5,500,000. in Medicaid benefits and as of Sept. 30, 2008 California had saved over $16,000,000. Sen. Allran asked if somebody had made their payments and then when they needed it the facility was closed what would happen. Ben answered that this is an insurance policy and can be used at any facility. Sen. Allran stated he had asked his question wrong, he meant if the insurance company was out of business. Sen. Allran stated this was one of the riskiest types of insurance you could buy. Judge Rose Williams, Department of Insurance, said the burden was on the Department of Insurance to make sure these companies can pay the claims that they are contracting to pay. Senator Blake asked if anyone had looked into the Federal Plan. Ben Popkins stated this bill would authorize the appropriate agencies to contract with the interested parties. Sen. Purcell stated there was a motion before the committee from Senator Goss to give this bill a favorable report. The motion was unfavorable as to the original bill, but favorable as to the Proposed Committee Substitute. The motion passed.

Senator Purcell brought before the committee House Bill 144, ***Special Care Dentistry Collaboration***, which was presented to the committee by Senator Swindell. Senator Purcell pointed out it was a Proposed Committee Substitute and Senator Forrester moved to give the PCS a favorable report for the purpose of discussion which passed. Senator Swindell explained that HB 144 would prohibit insurers from limiting the fees a dentist may charge unless services are covered for reimbursements. He stated there was no known opposition to the bill. Senator Swindell asked the chair to allow William Potter to speak on the bill. William Potter, representing the North Carolina Dental Society, stated HB 144 was strongly supported by the Dental Society. He explained that insurance companies have been using this as a marketing tool, where insurance companies say they would limit the fees that your dentist charges for certain procedures, but the problem is the procedures are not covered under the plan. It is only a marketing tool. There are twenty-eight states that have introduced this legislation this calendar year. Eleven of them have been ratified and they have all passed overwhelmingly. Senator Brown moved for a favorable report on the PCS. The motion before the committee was unfavorable as to the original bill, but favorable as to the Proposed Committee Substitute. The motion passed.

Senator Purcell asked Vice-Chair Senator Dorsett, to come forward and chair the meeting while Senator Purcell presented his bill, Senate Bill 1286, ***Screen and Reduce BMI Levels in Children***. Senator Dorsett pointed out there was a Proposed Committee Substitute and Senator Dannelly made the motion to hear the PCS, which passed. Mr. Chair, Dr. Purcell gave the committee a formula to calculate Body Mass Index (BMI). The formula was: your body weight in pounds multiplied by 703, then divided by your height in inches squared. If your BMI comes out over 25-30 you are overweight and if you are over 30-40 you are obese. Senate Bill 1286 came from the Study Committee on Childhood Obesity and it directs the Department of Health and Human Service (DHHS), Division of Medical Assistance to study the feasibility of requiring providers enrolled in the Community Care of North Carolina (CCNC) to implement body mass index (BMI) screening for children who are receiving Medicaid or participating in the NC Health Choice Program. Senator Dannelly made the motion unfavorable to the original bill, but favorable to the Proposed Committee Substitute. The motion passed.

Vice-Chair Senator Dorsett turned the meeting back over to Chairman Purcell and he adjourned the meeting at 11:33 A.M.

William R Purcell
Senator William R. Purcell, Co-Chair

Stan Bingham
Senator Stan Bingham, Co-Chair

Judy F. Chriscoe
Judy F. Chriscoe, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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SENATE BILL 1191*

Short Title:	Nurse Aide Training Review.	(Public)
Sponsors:	Senators Swindell, Bingham, Dorsett, Forrester, Queen; Atwater, Davis, Goss, Purcell, Snow, and Vaughan.	
Referred to:	Health Care.	

May 18, 2010

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF HEALTH SERVICE REGULATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO COORDINATE A REVIEW OF THE EDUCATION AND TRAINING REQUIREMENTS FOR NURSE AIDES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Division of Health Service Regulation, Department of Health and Human Services, shall coordinate a review of the education and training requirements for nurse aides. In conducting the review, the Division shall include an equal number of representatives from the Division of Health Service Regulation; Division of Aging and Adult Services; the North Carolina Board of Nursing; the Direct Care Workers Association of North Carolina; the North Carolina Health Care Facilities Association; the North Carolina Hospital Association; the Association for Home and Hospice Care of North Carolina; and individuals representing residents in long-term care. The review shall include an evaluation of the current education and training requirements for nurse aides.

SECTION 1.(b) The Division of Health Service Regulation shall report findings and recommendations on the appropriate levels of education and training for nurse aides to the North Carolina Study Commission on Aging on or before November 1, 2010.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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SENATE BILL 1191*
PROPOSED COMMITTEE SUBSTITUTE S1191-CSTE-3 [v.1]

5/28/2010 2:14:17 PM

Short Title: Nurse Aide Training Review. (Public)

Sponsors:

Referred to:

May 18, 2010

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DIVISION OF HEALTH SERVICE REGULATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO COORDINATE A REVIEW OF THE EDUCATION AND TRAINING REQUIREMENTS FOR NURSE AIDES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Division of Health Service Regulation, Department of Health and Human Services, shall coordinate a review of the education and training requirements for nurse aides. In conducting the review, the Division shall include an equal number of representatives from the Division of Health Service Regulation; Division of Aging and Adult Services; the North Carolina Board of Nursing; the Direct Care Workers Association of North Carolina; the North Carolina Medical Society; the North Carolina Health Care Facilities Association; the North Carolina Hospital Association; the Association for Home and Hospice Care of North Carolina; and individuals representing residents in long-term care. The review shall include an evaluation of the current education and training requirements for nurse aides.

SECTION 1.(b) The Division of Health Service Regulation shall report findings and recommendations on the appropriate levels of education and training for nurse aides to the North Carolina Study Commission on Aging on or before November 1, 2010.

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

SENATE BILL 1191:
Nurse Aide Training Review

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 1, 2010
Introduced by:	Sen. Swindell	**Prepared by:**	Shawn Parker
Analysis of:	PCS to First Edition S1191-CSTE-3		Legislative Analyst

SUMMARY: ***Senate Bill 1191 directs the Division of Health Service Regulation to coordinate a review of the education and training requirements for Nurse Aides.***

CURRENT LAW:

The North Carolina Health Care Personnel Registry Section operates within the Division of Health Service Regulation (Division), Department of Health and Human Services and among other responsibilities manages the Nurse Aide I registry and regulates aide testing and training programs.

Anyone who works as a nurse aide in a nursing home must be listed on the Nurse Aide I Registry.[1]

To qualify as Nurse Aide I, the candidate must complete **one** of the following:

- Pass a state-approved (or comparable) Nurse Aide training* and pass the State approved Nurse Aide I competency test **or**
- Pass the State approved Nurse Aide I competency test **or**
- Request listing based on a qualified North Carolina Nursing License

* Training is required if an individual fails three consecutive competency evaluation attempts.

State- approved Nurse Aide I Training Programs are offered at community colleges, health care facilities, and private companies. North Carolina high schools, through Health Occupations Education programs, have the opportunity to offer state-approved Nurse Aide I training.[2]

BILL ANALYSIS: The bill directs the Division to evaluate current education and training requirements for Nurse Aides and report its findings to the North Carolina Commission on Aging by November 1, 2010.

As part of the review the Division shall include representatives from the Division of Aging and Adult Services; the NC Board of Nursing; the Direct Care Workers Association of NC; the NC Health Care Facilities Association; the NC Hospital Association; the Association for Home and Hospice Care of NC; individuals representing residents in long-term care, and the *North Carolina Medical Society.*

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: This bill is a recommendation on the North Carolina Study Commission on Aging.

S1191-SMSQ-145(CSTE-3) v1

[1] G.S. 131E-255
[2] https://www.ncnar.org

SENATE BILL 1193*

Short Title:	Implement LTC Partnership Program.	(Public)
Sponsors:	Senators Swindell, Dorsett, Bingham, Forrester, Queen; Atwater, Davis, Goss, Purcell, Snow, and Vaughan.	
Referred to:	Health Care.	

May 18, 2010

A BILL TO BE ENTITLED

AN ACT TO IMPLEMENT THE LONG-TERM CARE PARTNERSHIP PROGRAM, TO ENSURE THAT NORTH CAROLINA'S LONG-TERM CARE INSURANCE LAWS COMPORT WITH THE LONG-TERM CARE PARTNERSHIP PROVISIONS IN THE FEDERAL DEFICIT REDUCTION ACT OF 2005, AND TO AUTHORIZE THE SHARING OF CONFIDENTIAL INFORMATION BETWEEN THE NORTH CAROLINA DEPARTMENT OF INSURANCE, ENTITIES THAT CONTRACT WITH THE FEDERAL GOVERNMENT, AND OTHER GOVERNMENTAL AGENCIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. Part 6, Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-70.4. Long-Term Care Partnership Program.**

(a) As used in this section, the terms:

(1) "Asset" means resources and income.

(2) "Department" means the Department of Health and Human Services, Division of Medical Assistance.

(3) "Estate recovery" means the placing of a statutory claim pursuant to G.S. 108A-70.5 on the estate of the deceased Medicaid recipient.

(4) "Long-term care partnership policy" means a long-term care insurance policy approved by the North Carolina Department of Insurance as meeting all of the regulations and requirements of the model act promulgated by the National Association of Insurance Commissioners.

(5) "Medicaid" means the federal medical assistance program established under Title XIX of the Social Security Act.

(6) "Resource" means cash or its equivalent and/or real or personal property that is available to the applicant or recipient.

(7) "Resource disregard" means the amount of resources owned by the long-term care Medicaid applicant that is equal to the amount of benefits paid by a long-term care partnership policy for the applicant which will not be counted when determining long-term care Medicaid eligibility.

(8) "Resource protection" means an amount equal to the resource disregard given to the recipient at long-term care Medicaid eligibility that will be deducted from the total estate value at estate recovery.

(b) Since the Deficit Reduction Act of 2005 repealed the restrictions to resource protection contained in the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66, 107 Stat.

312, there is established the North Carolina Long-Term Care Partnership Program to be administered by the Department with assistance from the North Carolina Department of Insurance. The North Carolina Long-Term Care Partnership Program shall:

(1) Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under Medicaid without first being required to substantially exhaust their resources.

(2) Provide counseling services to individuals planning for their long-term care needs.

(3) Alleviate the financial burden on the State's medical assistance program by encouraging the pursuit of private insurance.

(c) In the case of an individual who has received benefits under a long-term care partnership policy, an equal amount of resources shall not be considered by the Department during the determination of the following:

(1) Eligibility for long-term care Medicaid.

(2) Any subsequent recovery by the State from a deceased recipient's estate for payment of Medicaid paid services.

(d) The Department shall promulgate necessary rules and amendments to the State Plan to allow for resource disregard at long-term care Medicaid eligibility determination and resource protection at estate recovery. To provide resource disregards for purchases of a long-term care partnership policy, the Department shall count insurance benefits paid under the policy prior to the date of the first application for long-term care Medicaid made after the implementation of the program toward resource disregard and resource protection to the extent the payments are for covered services under the long-term care partnership policy.

(e) After January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later, a qualified long-term care partnership policy shall contain a disclosure detailing in plain language the current law pertaining to resource disregard and resource protection. A duplicate disclosure shall be given to the insured individual with the delivery of the policy document.

(f) The Department shall enter into a reciprocal agreement with other states that enter into a national reciprocity agreement to extend the resource disregard and resource protection to residents of the State who purchased, or purchased and used, a qualified long-term care policy in another state.

(g) The Department and the Department of Insurance are authorized to adopt rules to implement the provisions of this program for its administration.

(h) In the case of an individual who has received benefits under a long-term care partnership policy, the provisions of G.S. 108A-70.5 remain in effect for purposes of estate recovery, with the exception of the definition of "estate" under G.S. 108A-70.5(b)(2). In accordance with Title XIX of the Social Security Act, 42 U.S.C. § 1396p(b)(4)(B), the definition of "estate" for an individual who has received benefits under a long-term care partnership policy includes any other real or personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement."

SECTION 2. G.S. 108A-70.5 reads as rewritten:

"**§ 108A-70.5. Medicaid Estate Recovery Plan.**

(a) There is established in the Department of Health and Human Services, the Medicaid Estate Recovery Plan, as required by the Omnibus Budget Reconciliation Act of 1993, to recover from the estates of recipients of medical assistance an equitable amount of the State and federal shares of the cost paid for the recipient. The Department shall administer the program in accordance with applicable federal law and regulations, including those under Title XIX of the Social Security Act, 42 U.S.C. § 1396(p).

(b) As used in this section:

(1) "Medical assistance" means medical care services paid for by the North Carolina Medicaid Program on behalf of the recipient:

a. If the recipient of any age is receiving medical care services as an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and cannot reasonably be expected to be discharged to return home; or

b. If the recipient is 55 years of age or older and is receiving one or more of the following medical care services:

1. Nursing facility services.
2. Home and community-based services.
3. Hospital care.
3a. Prescription drugs.
4. Personal care services.
5 through 9. Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007.

(2) "Estate" means all the real and personal property considered assets of the estate available for the discharge of debt pursuant to G.S. 28A-15-1. For individuals who have received long-term care benefits as described in G.S. 108A-70.4, "estate" also includes any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including such assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(3) Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007.

(c) The amount the Department recovers from the estate of any recipient shall not exceed the amount of medical assistance made on behalf of the recipient and shall be recoverable only for medical care services prescribed in subsection (b) of this section. The Department is a fifth-class creditor, as prescribed in G.S. 28A-19-6, for purposes of determining the order of claims against an estate; provided, however, that judgments in favor of other fifth-class creditors docketed and in force before the Department seeks recovery for medical assistance shall be paid prior to recovery by the Department.

(d) The Department of Health and Human Services shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance.

(e) Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007."

SECTION 3. Article 55 of Chapter 58 of the General Statutes is amended by designating G.S. 58-55-1 through G.S. 58-55-50 as "Part 1. General Provisions."

SECTION 4. Article 55 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 2. Long-Term Care Partnership.

"**§ 58-55-55. Long-term care partnership.**

(a) A long-term care partnership policy is a long-term care insurance policy including a certificate issued under a group insurance contract.

(b) A long-term care partnership policy must satisfy all of the following requirements:

(1) The policy must be a qualified long-term care insurance contract, as defined in section 7702B of the Internal Revenue Code of 1986 (26 U.S.C.

§7702B(b)) and must provide insurance benefits on a reimbursement, case benefit basis, indemnity insurance basis, or on a per diem or other periodic basis.

(2) The effective date of the coverage is on or after January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later.

(3) The policy covers an insured who was a resident of North Carolina or another state that has entered into a reciprocal agreement with North Carolina when coverage first became effective under the policy.

(4) The policy meets the federal consumer protection requirements of section 1917(b)(5)(A) of the Social Security Act (42 U.S.C. §1396p(b)(5)(A). In addition, the policy must:

a. Provide that the insurer will issue a 90-day notice prior to exhaustion of a long-term care partnership policy. The notice shall instruct the insured to go to his local department of social services to apply for Medicaid.

b. Designate a third party who shall receive premium due notices in addition to the insured, including the notice required in sub-subdivision a. of this subdivision to prevent loss of benefits due to nonpayment.

(5) The policy is issued with and retains inflation coverage which meets the following inflation coverage limitations:

a. Policies or certificates issued to an individual who is under 61 years old must provide compound annual inflation protection.

b. Policies or certificates issued to an individual who is 61 to 76 years old must provide some level of inflation protection. This may include simple interest or compound inflation protection.

c. For purchasers 76 years old or older, inflation protection may be offered but is not required.

(6) The policy states that it is intended to be a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.

(7) The policy is issued in North Carolina or issued for delivery in North Carolina and shall include a "Partnership Status Disclosure Notice." The notice shall state the following in at least 12-point font:

"At the time of issuance, this long-term care insurance policy qualifies as a North Carolina Long-Term Care Partnership Program policy. For Medicaid applicants applying for help with the cost of long-term care, this means that an amount of your resources equal to the dollar amount of long-term care insurance benefits paid to you or on your behalf under this policy may be disregarded for purposes of determining your eligibility for long-term care Medicaid. The amount that will be disregarded at eligibility will be equal to the amount of the long-term care partnership benefits paid out prior to the time you apply for long-term care Medicaid. As a result, you may qualify for coverage of the cost of your long-term care needs under Medicaid without first being required to substantially exhaust your personal resources. If you are already a recipient of long-term care Medicaid, this policy will not allow a resource disregard or estate recovery resource protection.

Please note that this policy may lose long-term care partnership program status if you move to a different state that does not recognize North Carolina's Long Term Care Partnership Program or you modify this policy

after issuance. This policy may also lose long-term care partnership program status due to changes in federal or state laws.

If you have questions regarding long-term care insurance and the North Carolina Long-Term Care Partnership Program, you may contact the Seniors' Health Insurance Information Program of the Department of Insurance at 1-800-443-9354."

In the case of a group insurance contract, such Notice shall be provided to the insured upon the issuance of the certificate. The insurer shall include in that notice that the amount of the insured resources that will be disregarded at eligibility will be equal to the amount of long-term care partnership policy benefits paid prior to the time the insured applied for long-term care Medicaid. The insurer shall also include in the notice a warning to the insured that the policy may lose long-term care partnership program status if the insured moves to another state that does not recognize North Carolina's Long-Term Care Partnership Program, or if the policy is modified after issuance.

"**§ 58-55-56. Compliance with federal regulations.**

(a) The Commissioner may adopt rules to conform long-term care policies and certificates to the requirements of federal law and regulations, including any changes required by Congress or the U.S. Department of Health and Human Services, or any successor agencies.

(b) The tax-qualified long-term care provisions required of the Health Insurance Portability and Accountability Act of 1996, including subsequent amendments and editions, are hereby incorporated into Article 55 of Chapter 58 of the General Statutes.

(c) The long-term care partnership provisions required of the Deficit Reduction Act of 2005, including subsequent amendments and editions, are hereby incorporated into Article 55 of Chapter 58 of the General Statutes.

"**§ 58-55-57. Disclosure notices.**

(a) Prior to an insured making a change to the policy that will result in the loss of long-term care partnership status, the insurer shall provide to the policyholder a written explanation of how such action impacts the insured and shall obtain the insured's signature indicating consent to the change.

(b) If a long-term care partnership plan subsequently loses long-term care partnership status, the insurer shall explain in writing to the policyholders the reason for the loss of status.

(c) The disclosures required in this section shall be provided to any insured who exchanges a policy for a long-term care partnership policy.

"**§ 58-55-58. Exchange of long-term care policies for long-term care partnership policies.**

A long-term care insurance policy that does not qualify as a long-term care partnership policy and that was issued prior to January 1, 2011, or 60 days following approval of the Medicaid State Plan amendment, whichever is later, shall be eligible for long-term care partnership status if those policies meet the federal requirements of a long-term care partnership policy. If an exchange occurs, the insurer shall notify the insured in writing that the new long-term care partnership policy may be subject to underwriting criteria and premium adjustment. The effective date of the long-term care partnership policy shall be the date the policy was exchanged."

SECTION 5. Article 55 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-55-36. Information sharing.**

(a) In order to assist in the performance of the Commissioner's duties under the long-term care partnership program specified in the federal Deficit Reduction Act of 2005, the Commissioner may:

(1) Share information, including identifying information, related to the long-term care partnership program with other state and federal agencies, the National Association of Insurance Commissioners, and any entity contracting with the federal government under the Program, provided that the recipient agrees to maintain the confidentiality and privileged status of the information.

(2) Receive information, including identifying information, related to the long-term care partnership program from other state and federal agencies, the National Association of Insurance Commissioners, and any entity contracting with the federal government under the Program, and shall maintain as confidential or privileged any identifying information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(3) Enter into agreements governing sharing and use of information consistent with this section.

(b) No waiver of an existing privilege or claim of confidentiality in the identifying information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (a) of this section.

(c) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this section shall be available and enforced in any proceeding in, and in any court of, this State.

(d) As used in this section, "identifying information" has the same meaning as in G.S. 14-113.20(b)."

SECTION 6. The Department of Health and Human Services and the Department of Insurance may adopt rules to implement the Long-Term Care Partnership Program in North Carolina.

SECTION 7. The Department of Health and Human Services shall pursue a Medicaid State Plan amendment to allow the Long-Term Care Partnership Program to operate in North Carolina.

SECTION 8. Sections 7 and 8 of this act are effective when they become law. The remainder of this act becomes effective January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

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SENATE BILL 1193*
PROPOSED COMMITTEE SUBSTITUTE S1193-CSSH-69 [v.9]

6/1/2010 6:07:26 PM

Short Title: Implement LTC Partnership Program. (Public)

Sponsors:

Referred to:

May 18, 2010

A BILL TO BE ENTITLED

AN ACT TO IMPLEMENT THE LONG-TERM CARE PARTNERSHIP PROGRAM, TO ENSURE THAT NORTH CAROLINA'S LONG-TERM CARE INSURANCE LAWS COMPORT WITH THE LONG-TERM CARE PARTNERSHIP PROVISIONS IN THE FEDERAL DEFICIT REDUCTION ACT OF 2005, AND TO AUTHORIZE THE SHARING OF CONFIDENTIAL INFORMATION BETWEEN THE NORTH CAROLINA DEPARTMENT OF INSURANCE, ENTITIES THAT CONTRACT WITH THE FEDERAL GOVERNMENT, AND OTHER GOVERNMENTAL AGENCIES, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. Part 6, Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-70.4. Long-Term Care Partnership Program.**

(a) The following definitions apply in this section:

(1) Asset. – Resources and income.

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

(3) Division. – The Division of Medical Assistance.

(4) Estate recovery. – The placing of a statutory claim on the estate of a deceased Medicaid recipient, as provided by G.S. 108A-70.5.

(5) Medicaid. – The federal medical assistance program established under Title XIX of the Social Security Act.

(6) Qualified long-term care partnership policy. – A long-term care insurance policy approved for use in North Carolina and meeting all the requirements of the Federal Deficit Reduction Act of 2005, P.L. 109-171.

(7) Resource. – Cash or its equivalent and/or real or personal property that is available to an applicant or recipient.

(8) Resource disregard. – The amount of resources owned by a long-term care Medicaid applicant that is equal to the amount of benefits paid to the applicant by a long-term care partnership policy. This amount shall not be taken into consideration when determining the applicant's long-term care Medicaid eligibility.

(9) Resource protection. – An amount equal to the resource disregard given to a Medicaid recipient during the long-term care Medicaid eligibility

determination process. This amount shall be deducted from the total value of the estate for estate recovery purposes.

(b) There is established the North Carolina Long-Term Care Partnership Program (Partnership Program) to be administered by the Division with assistance from the Department of Insurance. The Partnership Program shall:

(1) Provide a mechanism for individuals to qualify for coverage of the cost of their long-term care needs under Medicaid without first being required to substantially exhaust their resources.

(2) Provide counseling services to individuals planning for their long-term care needs.

(3) Reduce the financial burden on the State medical assistance program by encouraging the pursuit of private insurance.

(c) In the case of an individual who has received benefits under a long-term care partnership policy, an equal amount of resources shall not be considered by the Department during the determination of the following:

(1) Eligibility for long-term care Medicaid.

(2) Any subsequent recovery by the State from a deceased recipient's estate for payment of Medicaid paid services.

(d) The Department shall promulgate necessary rules and amendments to the State Plan to allow for resource disregard at long-term care Medicaid eligibility determination and resource protection at estate recovery. To provide resource disregards for purchases of a long-term care partnership policy, the Department shall count insurance benefits paid under the policy prior to the date of the first application for long-term care Medicaid made after the implementation of the program toward resource disregard and resource protection to the extent the payments are for covered services under the long-term care partnership policy.

(e) Effective January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later, a qualified long-term care partnership policy shall be accompanied by a disclosure detailing in plain language the current law pertaining to the Partnership Program, resource disregard, and resource protection.

(f) The Department may enter into a reciprocal agreement with other states that enter into a national reciprocity agreement to extend the resource disregard and resource protection to residents of the State who purchased, or purchased and used, a qualified long-term care policy in another state.

(g) The Department and the Department of Insurance are authorized to adopt rules to implement the provisions of the Partnership Program and to provide for its administration.

(h) In the case of an individual who has received benefits under a long-term care partnership policy, the provisions of G.S. 108A-70.5 remain in effect for purposes of estate recovery, with the exception of the definition of "estate" under G.S. 108A-70.5(b)(2). In accordance with Title XIX of the Social Security Act, 42 U.S.C. § 1396p(b)(4)(B), the definition of "estate" for an individual who has received benefits under a long-term care partnership policy includes any other real or personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement."

SECTION 2. G.S. 108A-70.5 reads as rewritten:

"**§ 108A-70.5. Medicaid Estate Recovery Plan.**

(a) There is established in the Department of Health and Human Services, the Medicaid Estate Recovery Plan, as required by the Omnibus Budget Reconciliation Act of 1993, to recover from the estates of recipients of medical assistance an equitable amount of the State and federal shares of the cost paid for the recipient. The Department shall administer the

program in accordance with applicable federal law and regulations, including those under Title XIX of the Social Security Act, 42 U.S.C. § 1396(p).

(b) ~~As used in this section:~~The following definitions apply in this section:

(1) ~~"Medical assistance" means~~ Medical assistance. ~~medical~~ Medical care services paid for by the North Carolina Medicaid Program on behalf of the recipient:

a. If the recipient of any age is receiving medical care services as an inpatient in a nursing facility, intermediate care facility for the mentally retarded, or other medical institution, and cannot reasonably be expected to be discharged to return home; or

b. If the recipient is 55 years of age or older and is receiving one or more of the following medical care services:

1. Nursing facility services.
2. Home and community-based services.
3. Hospital care.
3a. Prescription drugs.
4. Personal care services.
5 through 9. Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007.

(2) ~~"Estate" means all~~ Estate. – All the real and personal property considered assets of the estate available for the discharge of debt pursuant to G.S. 28A-15-1. For individuals who have received long-term care benefits as described in G.S. 108A-70.4, "estate" also includes any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest), including assets conveyed to a survivor, heir, or assign of the deceased individual through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement.

(3) Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007.

(c) The amount the Department recovers from the estate of any recipient shall not exceed the amount of medical assistance made on behalf of the recipient and shall be recoverable only for medical care services prescribed in subsection (b) of this section. The Department is a fifth-class creditor, as prescribed in G.S. 28A-19-6, for purposes of determining the order of claims against an estate; provided, however, that judgments in favor of other fifth-class creditors docketed and in force before the Department seeks recovery for medical assistance shall be paid prior to recovery by the Department.

(d) The Department of Health and Human Services shall adopt rules pursuant to Chapter 150B of the General Statutes to implement the Plan, including rules to waive whole or partial recovery when this recovery would be inequitable because it would work an undue hardship or because it would not be administratively cost-effective and rules to ensure that all recipients are notified that their estates are subject to recovery at the time they become eligible to receive medical assistance.

(e) Repealed by Session Laws 2007-442, s. 1, effective August 23, 2007."

SECTION 3. Article 55 of Chapter 58 of the General Statutes is amended by designating G.S. 58-55-1 through G.S. 58-55-50 as "Part 1. General Provisions."

SECTION 4. Article 55 of Chapter 58 of the General Statutes is amended by adding a new Part to read:

"Part 2. Long-Term Care Partnership.

"**§ 58-55-55. Definitions.**

The following definitions apply in this section:

(1) Asset. – Resources and income.

(2) Estate recovery. – The placing of a statutory claim on the estate of a deceased Medicaid recipient, as provided by G.S. 108A-70.5.

(3) Medicaid. – The federal medical assistance program established under Title XIX of the Social Security Act.

(4) Qualified long-term care partnership policy. – A long-term care insurance policy approved for use in North Carolina and meeting all the requirements of the Federal Deficit Reduction Act of 2005, P.L. 109-171 that when issued is determined by the issuing insurance company to meet the qualifications for a partnership policy and includes the required disclosure of this qualification.

(5) Resource. – Cash or its equivalent and/or real or personal property that is available to an applicant or recipient.

(6) Resource disregard. – The amount of resources owned by a long-term care Medicaid applicant that is equal to the amount of benefits paid to the applicant by a long-term care partnership policy. This amount shall not be taken into consideration when determining the applicant's long-term care Medicaid eligibility.

(7) Resource protection. – An amount equal to the resource disregard given to a Medicaid recipient during the long-term care Medicaid eligibility determination process. This amount shall be deducted from the total value of the estate for estate recovery purposes.

"**§ 58-55-60. Long-term care partnership policy.**

A qualified long-term care partnership policy is a long-term care insurance policy or a certificate issued under a group long-term care insurance policy that satisfies all of the following requirements:

(1) The policy meets the requirements for a qualified long-term care insurance contract, as defined in section 7702B of the Internal Revenue Code of 1986 (26 U.S.C. §7702B(b)).

(2) The effective date of the coverage is on or after January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later.

(3) The policy covers an insured who was a resident of North Carolina or another reciprocal partnership state when coverage first became effective under the policy.

(4) The policy meets the federal consumer protection requirements of section 1917(b) of the Social Security Act as amended by section 6021(a) of the Deficit Reduction Act of 2005, P.L. 109-171 of the Social Security Act (42 U.S.C. §1396p(b)(5)(A)).

(5) The policy is issued with and retains inflation protection coverage which meets the inflation standards based on the insured's then attained age as defined in the subsections a., b., and c. below:

a. Policies or certificates issued to an individual who is under 61 years old must provide compound annual inflation protection.

b. Policies or certificates issued to an individual who is 61 to 76 years old must provide some level of inflation protection. This may include simple interest or compound inflation protection.

c. For purchasers 76 years old or older, inflation protection may be offered but is not required.

Notwithstanding the above, purchasers of long-term care insurance policies which meet partnership criteria may adjust their inflation protection as they age. However, their policies shall maintain partnership status as long as the

inflation protection continues to meet the minimum requirements for the insured's attained age.

(6) The policy states that it is intended to be a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.

(7) A partnership policy issued, executed, and delivered in North Carolina shall be accompanied by a Partnership Disclosure Notice explaining the benefits associated with a partnership policy and indicating that at the time issued, the policy is a qualified long-term care insurance partnership policy in North Carolina. The Partnership Disclosure Notice shall also include a statement indicating that by purchasing this partnership policy, the insured does not automatically qualify for Medicaid. Notices providing additional information may be used in conjunction with the Partnership Disclosure Notice described in this section if filed and approved by the Commissioner. The notice shall state the following in at least 12-point font:

"Partnership Policy Status: Your long-term care insurance policy is intended to qualify as a Partnership Policy under the North Carolina Long-Term Care Partnership Program as of your policy's effective date. For Medicaid applicants applying for help with the cost of long-term care, this means that an amount of your resources equal to the dollar amount of long-term care insurance benefits paid to you or on your behalf under this policy may be disregarded for purposes of determining your eligibility for long-term care Medicaid. The amount that may be disregarded at eligibility will be equal to the amount of the long-term care partnership benefits paid out prior to the time you apply for long-term care Medicaid. As a result, you may qualify for coverage of the cost of your long-term care needs under Medicaid without first being required to substantially exhaust your personal resources. If you are already a recipient of long-term care Medicaid, this policy will not allow a resource disregard or estate recovery resource protection. The purchase of a Partnership Policy does not automatically qualify you for Medicaid.

Please note that this policy may lose long-term care partnership program status if you move to a different state that does not recognize North Carolina's Long Term Care Partnership Program or you modify this policy after issuance. This policy may also lose long-term care partnership program status due to changes in federal or state laws.

If you have questions regarding long-term care insurance and the North Carolina Long-Term Care Partnership Program, you may contact the Seniors' Health Insurance Information Program of the Department of Insurance at 1-800-443-9354."

In the case of a group insurance contract, this Notice shall be provided to the insured upon the issuance of the certificate. The insurer shall include in that notice that the amount of the insured resources that may be disregarded at eligibility will be equal to the amount of long-term care partnership policy benefits paid prior to the time the insured applied for long-term care Medicaid. The insurer shall also include in the notice a warning to the insured that the policy may lose long-term care partnership program status if the insured moves to another state that does not recognize North Carolina's

Long-Term Care Partnership Program, or if the policy is modified after issuance.

(8) When the insured's remaining lifetime maximum benefit is equal to 90 times the current daily benefit, or three times the current monthly benefit, the insurer shall notify the insured in writing advising the insured to go to the local department of social services to apply for Medicaid if the insured had not already done so.

"**§ 58-55-65. Compliance with federal regulations.**

(a) The Commissioner may adopt rules to conform long-term care policies and certificates to the requirements of federal law and regulations, including any changes required by Congress or the U.S. Department of Health and Human Services, or any successor agencies.

(b) The tax-qualified long-term care provisions required of the Health Insurance Portability and Accountability Act of 1996, including subsequent amendments and editions, are hereby incorporated into Article 55 of Chapter 58 of the General Statutes.

(c) The long-term care partnership provisions required of the Deficit Reduction Act of 2005, including subsequent amendments and editions, are hereby incorporated into Article 55 of Chapter 58 of the General Statutes.

"**§ 58-55-70. Disclosure notices.**

(a) Prior to making a change requested by the policyholder to a policy that would result in the loss of long-term care partnership status, the insurer shall provide to the policyholder a written explanation within thirty (30) calendar days of how this action would affect the insured and shall obtain the insured's signature indicating consent to the change.

(b) If a long-term care partnership policy form subsequently loses long-term care partnership status, the insurer shall explain in writing within thirty (30) calendar days to the policyholders the reason for the loss of status.

(c) The disclosures required in this section shall be provided to any insured who exchanges a policy for a long-term care partnership policy.

"**§ 58-55-75. Exchange of long-term care policies for long-term care partnership policies.**

An insurer shall offer, on a one-time basis, in writing, to all existing policyholders that were issued a long-term care policy on or after February 8, 2006, the option to exchange their existing long-term care coverage for coverage that is intended to qualify under North Carolina's long-term care partnership program. The insurer shall provide notification of this one time offer within 180 days from the date on which the company begins to offer partnership coverage in the state. The mandatory offer of an exchange shall only apply to products issued by the insurer that are comparable to the type of policy form, such as group policies and individual policies, and on the policy series that the company has certified as partnership qualified. This exchange may be subject to underwriting and premium adjustment. A policy received in an exchange after the effective date of North Carolina's partnership program is treated as newly issued and is eligible for partnership policy status. For purposes of applying the Medicaid rules relating to Qualified Long-Term Care Partnership Policies, the addition of a rider, endorsement, or change in schedule page for a policy may be treated as giving rise to an exchange. The effective date of the long-term care partnership policy shall be the date the policy was exchanged."

SECTION 5. Article 55 of Chapter 58 of the General Statutes is amended by adding a new section under Part 2 to read:

"**§ 58-55-80. Information sharing.**

(a) In order to assist in the performance of the Commissioner's duties under the long-term care partnership program specified in the federal Deficit Reduction Act of 2005, the Commissioner may:

(1) Share information, including identifying information, related to the long-term care partnership program with other state and federal agencies, the

National Association of Insurance Commissioners, and any entity contracting with the federal government under the Program

(2) Receive information, including identifying information, related to the long-term care partnership program from other state and federal agencies, the National Association of Insurance Commissioners, and any entity contracting with the federal government under the Program, and shall maintain as confidential or privileged any identifying information received with notice or the understanding that it is confidential or privileged under the laws of the jurisdiction that is the source of the document, material, or information.

(3) Enter into agreements governing sharing and use of information consistent with this section.

(b) No waiver of an existing privilege or claim of confidentiality in the identifying information shall occur as a result of disclosure to the Commissioner under this section or as a result of sharing as authorized in subsection (a) of this section.

(c) A privilege established under the law of any state or jurisdiction that is substantially similar to the privilege established under this section shall be available and enforced in any proceeding in, and in any court of, this State.

(d) As used in this section, "identifying information" has the same meaning as in G.S. 14-113.20(b)."

SECTION 6. The Department of Health and Human Services and the Department of Insurance may adopt rules to implement the Long-Term Care Partnership Program in North Carolina.

SECTION 7. The Department of Health and Human Services shall pursue a Medicaid State Plan amendment to allow the Long-Term Care Partnership Program to operate in North Carolina.

SECTION 8. Sections 7 and 8 of this act are effective when they become law. The remainder of this act becomes effective January 1, 2011, or 60 days after approval of the Medicaid State Plan amendment, whichever is later.

SENATE BILL 1193:
Implement LTC Partnership Program

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 28, 2010
Introduced by:	Sen. Swindell	**Prepared by:**	Ben Popkin
Analysis of:	First Edition		Committee Counsel

SUMMARY: The Proposed Committee Substitute for Senate Bill 1193 would create the Long-Term Care Partnership Program which would allow policyholders to set aside an amount of assets equal to their policy benefit amount from Medicaid eligibility and estate recovery determinations.

BILL ANALYSIS: Section 1 – would establish the North Carolina Long-Term Care Partnership Program (Program), which would allow individuals with these policies to carve out the amount of assets specified in their policies from consideration for the purposes of 1) determining eligibility for enrollment into long-term care Medicaid (resource disregard), and 2) estate recovery actions for payment of care provided to the enrollee, once they are deceased (resource protection).

The Program would be administered by the Division of Medical Assistance with assistance from the Department of Insurance (DOI). The Department of Health and Human Services (DHHS) would be authorized to adopt rules and amendments to the State Medicaid Plan to allow for resource disregard and protection, DHHS would be authorized to enter into reciprocal agreements with other states, and DHHS and DOI would be authorized to adopt rules to implement the provisions of the Program.

Section 2 – would amend the existing Medicaid Estate Recovery Plan provision (G.S. 108A-70.5) to specify that, for persons who received long-term care benefits under the new Program, "estate" would also include any real or personal property or other assets in which the person had any legal title or interest at the time of death.

Section 3 & 4 – would restructure Article 55 (Long-Term Care Insurance) of Chapter 58 (Insurance), and add a new Part 2 "Long-Term Care Partnership", which sets forth the relevant defined terms; lists the elements required of a long-term care insurance policy; authorizes the Commissioner of Insurance to adopt rules to conform State long-term care policies and certificates to the requirements of federal law and regulations; requires disclosure notices relating to loss of long-term care partnership status; and provides for a one-time exchange of existing long-term care policies (issued on or after February 8, 2006) for coverage under this new long-term care partnership program.

Section 5 – would authorize the Commissioner of Insurance to share and receive information related to the long-Term Care Partnership Program with other state and federal agencies, the National Association of Insurance Commissioners, and any entity contracting with the federal government under the Program. Information would remain confidential or privileged under the laws of the source jurisdiction.

Section 6 – would authorize DHHS and DOI to adopt rules to implement the Long-Term Care Partnership Program in North Carolina; and **Section 7** – would direct DHHS to pursue a Medicaid State Plan amendment to allow the Program to operate in North Carolina.

EFFECTIVE DATE: Sections 7 & 8 would become effective when the act becomes law. The remaining sections would become effective the later of January 1, 2011 or 60 days after approval of the Medicaid State Plan amendment.

BACKGROUND: Senate Bill 1193 is a recommendation of the Study Commission on Aging.

S1193-SMRD-205(e1) v3

SENATE BILL 1286*

Short Title:	Screen and Reduce BMI Levels in Children.	(Public)
Sponsors:	Senators Purcell, Dannelly, Davis, Preston, Tillman, Walters; Atwater, Bingham, Dorsett, Foriest, Graham, Jacumin, Jones, Kinnaird, and Snow.	
Referred to:	Health Care.	

May 20, 2010

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EXPLORE WAYS TO IMPLEMENT BODY MASS INDEX SCREENING FOR CERTAIN CHILDREN WHO ARE AT RISK OF BECOMING OBESE AND TO REDUCE BODY MASS INDEX LEVELS FOR ALL CHILDREN, AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services, Division of Medical Assistance, shall explore the feasibility of requiring Community Care of North Carolina (CCNC) to implement body mass index (BMI) screening for children at risk of becoming obese and developing diabetes or other chronic diseases, who are receiving Medicaid or participating in the North Carolina Health Choice for Children Program.

SECTION 1.(b) As part of its exploration into the feasibility of requiring BMI screening pursuant to subsection (a) of this section, the Department shall work toward the development of each of the following items:

(1) Establishing performance goals within each CCNC network that includes each of the following components:
   a. Care management for children who are at risk of becoming obese and developing diabetes or other chronic diseases.
   b. Annual BMI screening to identify the percentage of children who have a BMI test and the percentage of children who have a decrease in BMI levels.

(2) Developing a uniform protocol across the CCNC network to ensure the integrity and confidentiality of information collected through BMI screening.

(3) Implementing reliable methods of collecting data utilizing fitness assessment and reporting programs for youth that include health-related physical fitness tests to assess aerobic capacity; muscular strength, muscular endurance, and flexibility; and body composition.

SECTION 2. The Department shall require CCNC networks to collaborate with local health departments, county departments of social services, Eat Smart, Move More coalitions, and local education agencies on ways to reduce BMI levels in all children.

SECTION 3. Not later than September 1, 2011, the Department shall report its findings and recommendations to the Legislative Task Force on Childhood Obesity, if

reestablished for the 2011-2012 Session, to the Public Health Commission, and to the Fiscal Research Division.

SECTION 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

S D

SENATE BILL 1286*
PROPOSED COMMITTEE SUBSTITUTE S1286-CSSQ-87 [v.4]

6/2/2010 8:20:16 AM

Short Title: Screen for BMI Children CCNC network. (Public)

Sponsors:

Referred to:

May 20, 2010

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES TO EXPLORE WAYS TO IMPLEMENT BODY MASS INDEX SCREENING FOR CHILDREN WHO ARE ENROLLED IN MEDICAID OR ARE PARTICIPATING IN NORTH CAROLINA HEALTH CHOICE FOR CHILDREN PROGRAM AS RECOMMENDED BY THE LEGISLATIVE TASK FORCE ON CHILDHOOD OBESITY.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Medical Assistance, shall study the feasibility of requiring providers enrolled in Community Care of North Carolina (CCNC) to implement body mass index (BMI) screening for children who are receiving Medicaid or participating in the North Carolina Health Choice for Children Program. As part of the study the Division shall consider:

(1) Establishing performance goals related to using BMI to monitor a child's development within each CCNC network.

(2) Developing a uniform protocol across the CCNC network to ensure the integrity and confidentiality of information collected through BMI screenings.

(3) Implementing other methods of collecting data that would assist in screening weight categories that may lead to health problems.

SECTION 2. The Department shall encourage CCNC networks to collaborate with local health departments, county departments of social services, Eat Smart, Move More coalitions, and local education agencies on ways to use results from BMI screening to improve the health of children.

SECTION 3. Not later than September 1, 2011, the Department shall report its findings and any recommendations to the Legislative Task Force on Childhood Obesity, to the Public Study Health Commission, and to the Fiscal Research Division.

SECTION 4. This act is effective when it becomes law.

SENATE BILL 1286:
Screen for BMI Children CCNC Network

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 2, 2010
Introduced by:	Sen. Purcell	**Prepared by:**	Shawn Parker
Analysis of:	PCS to First Edition S1286-CSSQ-87		Legislative Analyst

SUMMARY: ***The Proposed Committee Substitute for Senate Bill 1286 directs the Department of Health and Human service to explore ways to implement Body Mass Index (BMI) screenings for children who are enrolled in Medicaid or North Carolina Health Choice for Children Program.***

BILL ANALYSIS:

Section 1 directs the Department of Health and Human Services, Division of Medical Assistance (Division) to study the feasibility of requiring providers enrolled in Community Care of North Carolina (CCNC) to implement BMI screenings for children who receive Medicaid or are enrolled in North Carolina Health Choice for Children. The bill further provides as part of this study the Division should consider:

- Establishing performance goals utilizing BMI measures within each CCNC network;
- Develop uniform protocol across the CCNC network to ensure information collected through BMI screenings remain confidential;
- Implement other methods of collecting data to assist in screening weight categories that may lead to health problems.

Section 2 directs the Department to encourage CCNC networks to collaborate with local health departments, county departments of social services, Eat Smart Move More coalitions, and local education agencies on ways to use results from BMI screenings to improve the health of children.

Section 3 directs the Department to report its findings and any recommendations to the Legislative Task Force on Childhood Obesity, the Public Health Study Commission, and the Fiscal Research Division by September 1, 2011.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND: This is a recommendation from the Legislative Task Force on Childhood Obesity

Community Care North Carolina consists of fourteen regional provider networks with more than 1,380 practices across the State. The practices work with local health departments, hospitals, social service agencies to manage the care of 970,558 Medicaid and North Carolina Health Choice for Children Program recipients. [1]

Body Mass Index is a number calculated from a child's weight and height. BMI correlates to direct measures of body fat, but does not measure body fat directly. For children, BMI is used to screen for obesity, overweight, healthy weight, or under weight. [2]

[1] www.communitycarenc.com
[2] www.cdc.gov/healthyweight/assessing/bmi.html

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H 2

HOUSE BILL 144*
Committee Substitute Favorable 3/19/09

Short Title: Special Care Dentistry Collaboration. (Public)

Sponsors:

Referred to:

February 12, 2009

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, DIVISION OF PUBLIC HEALTH, IN COLLABORATION WITH THE DIVISION OF MEDICAL ASSISTANCE, DIVISION OF AGING AND ADULT SERVICES, THE UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL AND EAST CAROLINA UNIVERSITY SCHOOLS OF DENTISTRY, THE NORTH CAROLINA DENTAL SOCIETY, AND CURRENT SPECIAL CARE DENTAL PROVIDERS, TO EXAMINE DENTAL CARE OPTIONS FOR SPECIAL CARE POPULATIONS.

The General Assembly of North Carolina enacts:

SECTION 1. The Department of Health and Human Services, Division of Public Health, shall collaborate with the Division of Medical Assistance, the Division of Aging and Adult Services, the University of North Carolina at Chapel Hill and the East Carolina University Schools of Dentistry, the North Carolina Dental Society, and current providers of special care dentistry services, to examine current dental care options for special care populations. The collaboration of these groups shall result in suggestions for ways to improve the availability of services for special care populations. The Department shall report findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission on or before February 1, 2010.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 144*
Committee Substitute Favorable 3/19/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H144-CSSQ-86 [v.7]

6/1/2010 7:59:20 PM

Short Title: No Set fee/ Non-covered Dental Srvcs. (Public)

Sponsors:

Referred to:

February 12, 2009

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT HEALTH BENEFIT PLANS AND INSURERS FROM LIMITING OR FIXING THE FEE A DENTIST MAY CHARGE PATIENTS FOR SERVICES UNLESS THE SERVICES ARE COVERED FOR REIMBURSEMENT UNDER THE PLAN OR INSURER CONTRACT WITH THE DENTIST.

The General Assembly of North Carolina enacts:

SECTION 1. Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-50-290. Health benefit plans or insurers contracting for provision of dental services; no limitation on fees for non-covered services.**

(a) No contract between a health benefit plan or insurer and a dentist for the provision of dental services to plan members or insurance subscribers 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) This section applies to dental plans and dental insurance policies offered by health benefit plans or insurers which provide for coverage of dental services not in connection with or incidental to coverage under a basic medical plan or health insurance policy, and the section shall further apply to Dental Service Corporations regulated under Article 65 of this Chapter.

SECTION 2. G.S. 58-65-2 reads as rewritten:

"**§ 58-65-2. Other laws applicable to service corporations.**

The following provisions of this Chapter are applicable to service corporations that are subject to this Article:

G.S. 58-2-125.	Authority over all insurance companies; no exemptions from license.
G.S. 58-2-150.	Oath required for compliance with law.
G.S. 58-2-155.	Investigation of charges.
G.S. 58-2-160.	Reporting and investigation of insurance and reinsurance fraud and the financial condition of licensees; immunity from liability.
G.S. 58-2-162.	Embezzlement by insurance agents, brokers, or administrators.
G.S. 58-2-185.	Record of business kept by companies and agents; Commissioner may inspect.

G.S. 58-2-190.	Commissioner may require special reports.
G.S. 58-2-195.	Commissioner may require records, reports, etc., for agencies, agents, and others.
G.S. 58-2-200.	Books and papers required to be exhibited.
G.S. 58-3-50.	Companies must do business in own name; emblems, insignias, etc.
G.S. 58-3-100(c),(e).	Insurance company licensing provisions.
G.S. 58-3-115.	Twisting with respect to insurance policies; penalties.
G.S. 58-7-46.	Notification to Commissioner for president or chief executive officer changes.
Part 7 of Article 10.	Annual Financial Reporting.
G.S. 58-50-35.	Notice of nonpayment of premium required before forfeiture.
G.S. 58-50-290.	Health benefit plans or insurers contracting for the provision of dental services; no limitation on fees for non-covered services.
G.S. 58-51-15(a)(2)b.	Accident and health policy provisions.
G.S. 58-51-17	Portability for accident and health insurance.
G.S. 58-51-25.	Policy coverage to continue as to mentally retarded or physically handicapped children.
G.S. 58-51-95(h),(i),(j).	Approval by Commissioner of forms, classification and rates; hearings; exceptions.".

SECTION 3. This act is effective when it becomes law and applies to contracts between dentists and heath benefit plans or insurers delivered, amended, or renewed on or after that date.

HOUSE BILL 144:
Special Care Dentistry Collaboration

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	May 28, 2010
Introduced by:	Reps. Farmer-Butterfield, Pierce, Bordsen, Mobley	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	PCS to Second Edition H144-CSSQ-86		

SUMMARY: ***The Proposed Committee Substitute for House Bill 144 would prohibit health benefit plan or insurer contracts with providers of dental services from limiting fees for dental services provided unless the service in question is covered under the contract. The new provision would apply to dental service coverage that is not in connection with or incidental to coverage under a basic medical plan or health insurance policy, and would apply to Dental Service Corporations.***

BILL ANALYSIS: **Section 1** of the PCS for House Bill 144 would enact a new G.S. 58-50-290 that would prohibit health benefit plan or insurer contracts with providers of dental services from limiting fees unless the service in question is covered under the contract. The new provision would apply only to dental plans or dental insurance that offer coverage beyond that which is covered as being in connection with or incidental to coverage under a basic medical plan or health insurance policy. The provision would also apply Dental Service Corporations regulated under Article 65 of Chapter 58 of the General Statutes.

Section 2 – would insert reference to the new G.S. 58-50-290 in G.S. 58-65-2, which would make Dental Service Corporations regulated under Article 65 subject to the provisions in the new statute set forth in Section 1 of this bill.

EFFECTIVE DATE: This act is effective when it becomes law and applies to contracts between dentists and health benefit plans or insurers delivered, amended, or renewed on or after that date.

H144-SMRD-206(CSSQ-86) v3

VISITOR REGISTRATION SHEET

Senate Health Care
Name of Committee

June 2, 2010
Date

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Tracey Dyer	Action Health Staffing
Shew Batchelor	Action Health Staffing
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VISITOR REGISTRATION SHEET

Senate Health Care — June 2, 2010

Name of Committee — **Date**

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Marsue Davidson	Maxim Healthcare Services
Emily Johnston	Maxim Healthcare Service
Kimberly Joyner	Maxim Healthcare Services
Cathy Hales	Bayada Nurses (Home Care)
JoAnn Reed	Bayada Nurses (Home Care)
Mary Leslie Yount	Bayada Nurses

VISITOR REGISTRATION SHEET

Senate Health Care — June 2, 2010

Name of Committee — **Date**

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Vicki Bless	Randolph Hospital Asheboro, N.C.
Kimberly Canter	Randolph Hospital Asheboro, N.C.
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VISITOR REGISTRATION SHEET

Senate Health Care — June 2, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Sheria Reid	SOG
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BRACE HALTIAMP	SEN. STEIN'S OFFICE 300 N. SALISBURY (ROOM 400)
Geoffrey Louden	Governor's Office
Snayha Nath	"
Jimmy Varga	ResCare Homecare
Rodney Murphy	ResCare Home Care
Rebecca Hunter	ResCare HomeCare

VISITOR REGISTRATION SHEET

Senate Health Care — June 2, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jennifer Baney	Bayada Nurses - Hickory, NC
Tom Minowicz	Bayada Nurses - Morganton, NC
Cathy Poston	Bayada Nurses - Shelby, N.C.
Elizabeth Romero	Bayada Nurses - Winston-Salem NC
Stephanie Zaraniri	Bayada Nurses - Winston-Salem, NC
Cheryl Kemp	Bayada Nurses Winston Salem, NC
Laura Whisenant	Bayada nurses - Winston Salem, NC
Olga Silva	Bayada Nurses - Winston-Salem, NC
Cynthia Trivett	Bayada Nurses - Winston-Salem, NC

VISITOR REGISTRATION SHEET

Senate Health Care
Name of Committee

June 2, 2010
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Oby Onuorah	3625 Dewing Drive Raleigh NC 27616
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Bob Konrad	PO Box 664 Chapel Hill, NC 27514
Ed Sudlofton	Brooks Pierce
[signature]	DHHS

Senate Health Care Committee
Wednesday, June 9, 2010, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 382	Authorize Voluntary Medical Registry Program.	Representative Martin Representative Farmer-Butterfield
HB 1694	Comsn. on Children with Special Needs-Dentist.	Representative Wainwright Representative England, M.D. Representative Pierce Representative Farmer-Butterfield
SB 1265	Treatment of Autism Disorders.	Representative Weiss Senator Purcell

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, June 09, 2010

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

FAVORABLE

H.B. **1694** Comsn. on Children with Special Needs-Dentist.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

Senator Dr. Forrester will be handling this bill on the floor.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Thursday, June 10, 2010

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

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 2, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #2) **382** Authorize Voluntary Medical Registry Program.

Draft Number:	PCS 80630
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, June 9, 2010 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 AM on June 9, 2010, in Room 544 of the Legislative Office Building. Nineteen members of the Committee were present. Senator Bingham, Co-Chair, presided.

The first bill on the agenda was House Bill 382 entitled "HEALTH CHOICE PROGRAM REVIEW PROCESS", sponsored by Representative Martin. There was a Senate Committee Substitute, which Senator Dannelly moved be accepted for consideration; motion carried. Senator Purcell explained the Substitute, with Senator Dorsett moving for a favorable report for the Committee Substitute and an unfavorable report for the original bill; motion carried (there was a title change in the long title, and that was so reported).

House Bill 1694 entitled "AN ACT TO ADD A LICENSED DENTIST TO THE COMMISSION ON CHILDREN WITH SPECIAL HEALTH CARE NEEDS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING" was considered next. Senator Forrester explained the bill for Committee, with Senator Dorsett moving for a favorable report; motion carried.

Last on the agenda was Senate Bill 1265 entitled "AN ACT TO REQUIRE HEALTH BENEFIT PLANS, INCLUDING THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES, TO PROVIDE COVERAGE FOR TREATMENT OF AUTISM SPECTRUM DISORDERS, AS RECOMMENDED BY THE JOINT STUDY COMMITTEE ON AUTISM SPECTRUM DISORDER AND PUBLIC SAFETY", sponsored by Senator Garrou. This bill was brought before the Committee for discussion and explained by Senator Purcell. No vote was taken on the bill at this meeting.

There being no further business before the Committee, Senator Bingham adjourned the meeting at 12:00.

Senator Bingham, Presiding Co-Chair

Becky Hedspeth, Committee Clerk

Senator Purcell, Co-Chair

HOUSE BILL 382:
Health Choice Program Review Process

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 7, 2010
Introduced by:	Reps. Martin, Wainwright, Farmer-Butterfield	**Prepared by:**	Ben Popkin
Analysis of:	PCS to Third Edition H382-CSRD-89		Committee Counsel

SUMMARY: ***The Proposed Committee Substitute for House Bill 382 would continue use of the existing review process for applicants and recipients of North Carolina Health Choice for Children program (Health Choice) to appeal eligibility and enrollment decisions and would create a two-level review process for Health Choice recipients to appeal health services decisions.***

BILL ANALYSIS: Section 1 – would set forth a new section located in Part 8 (Health Insurance Program for Children) of Article 2 (Programs of Public Assistance) of Chapter 108A (Social Services) of the General Statutes that would authorize continued use of the review process currently used by Health Choice applicants and recipients appealing eligibility and enrollment decisions. Program recipients would remain enrolled during the review of a decision to suspend or terminate enrollment.

Section 1 would also create a new, two-level review process for decisions to delay, deny, reduce, suspend, or terminate services to Health Choice recipients, as well as for determinations of the type or level of services provided. The process would consist of both internal (filed within 30 days of initial decision) and external (filed within 15 days of internal review decision) reviews. Written decisions must be rendered by the hearing officer within 90 days of the review request, and an expedited review process (within 72 hours) is provided for instances in which the enrollee's "life or health or ability to attain, maintain or regain maximum function" would be jeopardized by the 90 day time frame. Program recipients would continue to receive services during health services reviews.

Decisions made pursuant to federal or State law provisions requiring automatic changes in eligibility, enrollment, or coverage of services which apply to all or all of a group of applicants or enrollees would not be reviewable under this review process.

The review process would require that notice be given to recipients and would include the following information: reasons for the decision, explanation of applicable rights and time frames for review of the decision, the method to request a review, and the circumstances under which enrollment may continue pending review.

Section 2 – would insert a new subdivision into G.S. 150B-1(e) to add the review of Health Choice health services determinations to the existing list of agencies and proceedings exempted from the contested case provisions of the Administrative Procedure Act.

EFFECTIVE DATE: This act becomes effective July 1, 2010, and applies to reviews of Health Choice Program enrollment, eligibility, or health services decisions requested by applicants or recipients on or after that date.

BACKGROUND: Pursuant to G.S. 135-47, currently and until June 30, 2010, the responsibility for administering and processing claims for benefits provided under Health Choice rests with the Executive Administrator and Board of Trustees of the State Health Plan for Teachers and State Employees. On July 1, 2010, this responsibility will shift to the Department of Health and Human Services.

H382-SMRD-208(CSRD-89) v2

FAV.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 382*
Committee Substitute Favorable 3/10/09
Committee Substitute #2 Favorable 3/25/09
PROPOSED SENATE COMMITTEE SUBSTITUTE H382-CSRD-89 [v.4]

6/9/2010 10:05:37 AM

Short Title: Health Choice Program Review Process. (Public)

Sponsors:

Referred to:

March 4, 2009

A BILL TO BE ENTITLED

AN ACT TO CREATE THE HEALTH CHOICE PROGRAM REVIEW PROCESS TO CONTINUE THE CURRENT REVIEW PROCESS FOR PROGRAM APPLICANTS AND RECIPIENTS APPEALING ENROLLMENT AND ELIGIBILITY DECISIONS, AND CREATE A REVIEW PROCESS FOR PROGRAM RECIPIENTS TO APPEAL HEALTH SERVICES DECISIONS, AND TO ADD THE HEALTH SERVICES REVIEW PROCESS TO THE AGENCIES AND PROCEEDINGS CURRENTLY EXEMPTED FROM THE CONTESTED CASE PROVISIONS OF THE ADMINISTRATIVE PROCEDURE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. Part 8 of Article 2 of Chapter 108A of the General Statutes is amended by adding a new section to read:

"**§ 108A-70.29. Program Review Process.**

(a) Review of eligibility and enrollment decisions.- Eligibility and enrollment decisions for Program applicants or recipients shall be reviewable pursuant to G.S. 108A-79. Program recipients shall remain enrolled during the review of a decision to terminate or suspend enrollment.

(b) Review of health services decisions.- 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.

(1) Internal review.- Within 30 days from the date of the decision subject to review under subsection (b), a recipient may request a first level internal review, which shall be conducted by Division of Medical Assistance's Clinical Medical Director or clinical designee.

(2) External review.- If the recipient is dissatisfied with the first level review decision, then within 15 days after the internal review decision is rendered the recipient may request a second level independent external review by the Department of Health and Human Services Hearing Office. The external review process shall comply with the provisions of 42 C.F.R. § 457.1140. The Department's Hearing Office shall assign the matter to a hearing officer

who will preside over the review. The hearing may be in person at the Hearing Office in Raleigh or by telephone. Recipients may:

a. Represent themselves or have representatives of their choosing in the review process.

b. Timely review their files and other applicable information relevant to the review of the decision.

c. Fully participate in the review process, including the opportunity to present supplemental information during the review process.

(3) Time frames.- The hearing officer shall render a written decision within 90 calendar days of the date the recipient requested first-level review, as specified at 42 C.F.R. § 457.1160. If the recipient's physician or health plan determines that operating under the standard 90-day time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain or regain maximum function, then each level of review must be completed within 72 hours, except that this expedited time frame may be extended by up to 14 calendar days if the recipient requests an extension.

(4) Coverage of services during review.- When the decision is a reduction, suspension, termination, or denied request for increase of existing services, notwithstanding the request for review, the services shall be covered in accordance with the decision under review, and services which are terminated or suspended services shall not be covered, unless and until the decision is overturned on review.

(c) Review of decisions pursuant to Programmatic changes.- The Program review process set forth in this section shall not apply to instances in which the sole basis for the decision is a provision in the State plan or in Federal or State law requiring an automatic change in eligibility, enrollment, or a change in coverage under the health benefits package that affects all applicants or enrollees or a group of applicants or enrollees without regard to their individual circumstances.

(d) Notice.- A recipient shall receive timely written notice of any decision subject to review under this section in accordance with the requirements of 42 C.F.R. § 457.1180. The notice shall include the reasons for the decision, an explanation of applicable rights to review of that decision, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue pending review.

(e) Rulemaking authority.- The Department shall have the authority to adopt rules for the implementation and operation of the Program review process."

SECTION 2. G.S. 150B-1(e) is amended by adding a new subdivision to read:

"(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."

SECTION 3. This act becomes effective July 1, 2010 and applies to reviews of Health Choice Program enrollment, eligibility or health services decisions requested by Health Choice Program applicants or recipients on or after that date.

Fav.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

HOUSE BILL 1694*

Short Title:	Comsn. on Children with Special Needs-Dentist.	(Public)
Sponsors:	Representatives Farmer-Butterfield, Pierce, Weiss, England (Primary Sponsors); Adams, M. Alexander, Brisson, Carney, Dockham, Fisher, E. Floyd, Gill, Glazier, Harrison, Hughes, Insko, Jones, McLawhorn, Mobley, Moore, Parfitt, Parmon, Ross, Tarleton, Wainwright, R. Warren, and Whilden.	
Referred to:	Health, if favorable, Ways and Means/Broadband Connectivity.	

May 13, 2010

A BILL TO BE ENTITLED

AN ACT TO ADD A LICENSED DENTIST TO THE COMMISSION ON CHILDREN WITH SPECIAL HEALTH CARE NEEDS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 143-682 reads as rewritten:

"**§ 143-682. Commission established.**

(a) There is established the Commission on Children With Special Health Care Needs. The Department of Health and Human Services shall provide staff services and space for Commission meetings. The purpose of the Commission is to monitor and evaluate the availability and provision of health services to special needs children in this State, and to monitor and evaluate services provided to special needs children under the Health Insurance Program for Children established under Part 8 of Article 2 of Chapter 108A of the General Statutes.

(b) The Commission shall consist of ~~eight~~ nine members appointed by the Governor, as follows:

(1) Two parents, not of the same family, each of whom has a special needs child. In appointing parents, the Governor shall consider appointing one parent of a child with chronic illness and one parent of a child with a developmental disability or behavioral disorder.

(2) A licensed psychiatrist recommended by the North Carolina Psychiatric ~~Association;~~Association.

(3) A licensed psychologist recommended by the North Carolina Psychological ~~Association;~~Association.

(4) A licensed pediatrician whose practice includes services for special needs children, recommended by the Pediatric Society of North ~~Carolina;~~Carolina.

(5) A representative of one of the children's hospitals in the State, recommended by the Pediatric Society of North ~~Carolina;~~Carolina.

(6) A local public health director recommended by the Association of Local Health ~~Directors; and~~ Directors.

(7) An educator providing education services to special needs children, recommended by the North Carolina Council of Administrators of Special Education.

(8) A licensed dentist who provides services to children with special needs, recommended by the North Carolina Dental Society.

(c) The Governor shall appoint from among Commission members the person who shall serve as chair of the Commission. Of the initial appointments, two shall serve one-year terms, three shall serve two-year terms, and three shall serve three-year terms. Thereafter, terms shall be for two years. Vacancies occurring before expiration of a term shall be filled from the same appointment category in accordance with subsection (b) of this section."

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

HOUSE BILL 1694:
Comsn. on Children with Special Needs-Dentist

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 7, 2010
Introduced by:	Reps. Farmer-Butterfield, Pierce, Weiss, England	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	First Edition		

SUMMARY: ***House Bill 1694 adds a licensed dentist who provides services to children with special needs to the Commission on Children with Special Health Care Needs.***

CURRENT LAW:

The Commission on Children with Special Health Care Needs is directed to monitor and evaluate the availability and provision of health services in North Carolina for children with special needs and in addition to monitor and evaluate services for such children under the Health insurance Program for Children. The Commission is appointed by the Governor and the Department of Health and Human Services provides staff assistance and meeting space.

The current Commission consists of the following appointees:

- Two parents of children with special needs
- A licensed psychiatrist
- A licensed psychologist
- A licensed pediatrician whose practices includes services for children with special needs
- A representative of a children's hospital
- A local public health director
- An educator of children with special needs

BILL ANALYSIS: House Bill 1694 adds a licensed dentist who provides services to children with special needs as a ninth member to the Commission on Children with Special Health Care Needs. The member would be appointed by the Governor as recommended by the North Carolina Dental Society.

EFFECTIVE DATE: This act is effective when it becomes law.

BACKGROUND:

This is a North Carolina Study Commission on Aging recommendation based on the findings and recommendations of the Special Care Dentistry Collaboration established in Session Law 2009-100.

H1694-SMSQ-151(e1) v1

SENATE BILL 1265*

Short Title:	Treatment of Autism Disorders.	(Public)
Sponsors:	Senators Purcell; Atwater, Bingham, Dorsett, Foriest, Garrou, Graham, Jones, Kinnaird, Queen, and Snow.	
Referred to:	Health Care.	

May 20, 2010

A BILL TO BE ENTITLED

AN ACT TO REQUIRE HEALTH BENEFIT PLANS, INCLUDING THE STATE HEALTH PLAN FOR TEACHERS AND STATE EMPLOYEES, TO PROVIDE COVERAGE FOR TREATMENT OF AUTISM SPECTRUM DISORDERS AS RECOMMENDED BY THE JOINT STUDY COMMITTEE ON AUTISM SPECTRUM DISORDER AND PUBLIC SAFETY.

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:

"**§ 58-3-192. Coverage for autism spectrum disorders.**

(a) Definitions. – As used in this section:

(1) Autism services provider. – Any person, entity, or group that provides treatment of autism spectrum disorders.

(2) Autism spectrum disorders. – Any of the pervasive developmental disorders as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), or subsequent edition published by the American Psychiatric Association, or the International Statistical Classification of Diseases and Related Health Problems (ICD-10), or subsequent edition published by the World Health Organization.

(3) Behavioral care. – Any practices for the purpose of any or all of the following:

a. Increasing appropriate or adaptive behaviors.

b. Decreasing maladaptive behaviors.

c. Developing, maintaining, or restoring, to the maximum extent practicable, the functioning of an individual, including the systematic management of environmental factors or the consequences of behaviors.

(4) Diagnosis of autism spectrum disorder. – Any medically necessary assessment, evaluations, or tests to diagnose whether an individual has an autism spectrum disorder.

(5) Health plan. – As defined in G.S. 58-3-167. For purposes of this section, "health benefit plan" includes the State Health Plan for Teachers and State Employees.

(6) Licensed or certified. – Licensed or certified by the State of North Carolina for services provided in North Carolina or by the state in which the care is provided.

(7) Medically necessary. – Any care, treatment, intervention, service, or item that does, or is reasonably expected to do any of the following:

a. Prevent the onset or worsening of an illness, condition, injury, or disability.

b. Reduce or ameliorate the physical, mental, behavioral, or developmental effects of an illness, condition, injury, or disability.

c. Assist to achieve or maintain functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals the same age.

(8) Pharmacy care. – Medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need for or effectiveness of the medications.

(9) Psychiatric care. – Direct or consultative services provided by a licensed psychiatrist.

(10) Psychological care. – Direct or consultative services provided by a licensed psychologist or licensed psychological associate.

(11) Therapeutic care. – Services provided by a licensed or certified speech therapist, occupational therapist, or physical therapist.

(12) Treatment for autism spectrum disorders. – Any of the following care prescribed or ordered by a licensed physician or a licensed psychologist for an individual diagnosed with an autism spectrum disorder:

a. Behavioral care- when provided or supervised by a licensed or certified health care professional as defined in G.S. 58-3-192(6) within the scope of practice as defined by law.

b. Pharmacy care.

c. Psychiatric care.

d. Psychological care.

e. Therapeutic care.

(b) Every health benefit plan, including the State Health Plan for Teachers and State Employees, shall provide coverage for the diagnosis and treatment of autism spectrum disorders in individuals. No insurer shall terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage to an individual solely because the individual is diagnosed with one of the autism spectrum disorders or has received treatment for autism spectrum disorders.

(c) Coverage under this section shall not be subject to any limits on the number of visits an individual may make to an autism services provider.

(d) Coverage under this section shall not be denied on the basis that the treatments are habilitative or educational in nature.

(e) Coverage under this section may be subject to co-payment, deductible, and coinsurance provisions of a health benefit plan that are not less favorable than the co-payment, deductible, and coinsurance provisions that apply to other medical services covered by the health benefit plan.

(f) This section shall not be construed as limiting benefits that are otherwise available to an individual under a health benefit plan.

(g) Coverage for behavioral therapy under this section will be subject to a maximum benefit of seventy-five thousand dollars ($75,000) per year. Payments made by an insurer on behalf of a covered individual for any care, treatment, intervention, service, or item unrelated to

autism spectrum disorders shall not be applied toward any maximum benefit established under this section.

(h) Except for inpatient services, if an individual is receiving treatment for autism spectrum disorders, a health benefit plan shall have the right to request a review of that treatment not more than once every 12 months unless the insurer and the individual's licensed medical doctor or licensed psychologist agree that a more frequent review is necessary. The cost of obtaining any review shall be borne by the insurer."

SECTION 2. G.S. 135-45 reads as rewritten:

"**§ 135-45. Undertaking.**

(a) The State of North Carolina undertakes to make available a State Health Plan (hereinafter called the "Plan") exclusively for the benefit of eligible employees, eligible retired employees, and certain of their eligible dependents, which will pay benefits in accordance with the terms of this Article. The Plan shall have all the powers and privileges of a corporation and shall be known as the State Health Plan for Teachers and State Employees. The Executive Administrator and Board of Trustees shall carry out their duties and responsibilities as fiduciaries for the Plan. The Plan shall administer one or more group health plans that are comprehensive in coverage and shall provide eligible employees and retired employees coverage on a noncontributory basis under at least one of the group plans with benefits equal to that specified in subsection (g) of this section. The Executive Administrator and Board of Trustees may operate group plans as a preferred provider option, or health maintenance, point-of-service, or other organizational arrangement and may offer the plans to employees and retirees on a noncontributory or partially contributory basis. Plans offered on a partially contributory basis must provide benefits that are additional to that specified in subsection (g) of this section and may not be offered unless approved in an act of the General Assembly.

...

(g) The Executive Administrator and Board of Trustees shall not change the Plan's comprehensive health benefit coverage, co-payments, deductibles, out-of-pocket expenditures, and lifetime maximums in effect on ~~July 1, 2009~~January 1, 2011, that would result in a net increased cost to the Plan or in a reduction in benefits to Plan members unless and until the proposed changes are directed to be made in an act of the General Assembly.

(h) The Plan shall provide coverage under its Basic and Standard PPO options for the diagnosis and treatment of lymphedema. The coverage shall be the equivalent of coverage under G.S. 58-3-280.

(i) The Plan shall provide coverage under its Basic and Standard PPO options for the diagnosis and treatment of autism spectrum disorder. The coverage shall be the equivalent of coverage under G.S. 58-3-192."

SECTION 3. This act becomes effective January 1, 2011, and applies to all health benefit plans that are delivered, issued for delivery, or renewed within this State, or outside this State if insuring North Carolina residents, on and after that date.

SENATE BILL 1265:
Treatment of Autism Disorders

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 7, 2010
Introduced by:	Sen. Purcell	**Prepared by:**	Shawn Parker
Analysis of:	First Edition		Legislative Analyst

SUMMARY: Senate Bill 1265 requires all health benefit plans, including the Teachers' and the State Employees' Comprehensive Major Medical Plan (State Health Plan) to provide coverage for the diagnosis and treatment of autism spectrum disorders.

[As introduced, this bill was identical to H1897, as introduced by Rep. England, which is currently in House Health, if favorable, Insurance, if favorable, Appropriations.]

CURRENT LAW:

Insurance law currently requires health benefit plans to include coverage for medically necessary services and supplies, which are those that are, "[p]rovided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease...not for experimental, investigational, or cosmetic purposes..." and are "...[n]ecessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms."[1]

The State Health Plan currently covers medically necessary treatment of autism based on clinical guidelines adopted by the Plan. Covered benefits include diagnosis and evaluation of autism, and treatment services for plan members diagnosed with autism, including coverage for prescription medications and other services such as physical, occupational and speech therapies."

BILL ANALYSIS: Senate Bill 1265 would enact a new G.S. 58-3-192 "Coverage for autism spectrum disorder" to direct all health benefit plans to provide coverage for the diagnosis and treatment of autisms in individuals. Treatment includes behavioral care (when provided or supervised by a licensed or certified health care professional), pharmacy care, psychiatric care, psychological care, and therapeutic care all further defined within the act.

The bill would require that this coverage not limit the number of visits and individual may make to a provider nor limit coverage on the basis the treatment is habilitative or educational in nature. Coverage for behavioral therapy is subject to a maximum benefit of $75,000 a year.

The bill provides a health benefit plan may request a review of autism spectrum disorder treatment (except for inpatient services) not more than once a year unless the insurer and the individual's doctor or psychologist agree on the need for more frequent review.

The bill further amends G.S. 135-45 to require that the State Health Plan provide coverage for the diagnosis and treatment of autism equivalent to the new G.S. 58-3-192.

EFFECTIVE DATE: This act becomes effective January 1, 2011 and applies to all health benefits plans that are delivered, issued for delivery, or renewed on or after this date.

BACKGROUND: This is a recommendation of the Joint Study Committee on Autism Spectrum Disorder and Public Safety.

S1265-SMSQ-152(e1) v3

[1] G.S. 58-3-200(b)(1)&(2).

VISITOR REGISTRATION SHEET

Senate Health Care — 6/9/2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Shea Crutchfield	1855 Ammons Dr CLEMMONS, NC 27012
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VISITOR REGISTRATION SHEET

Senate Health Care — 6/9/2010

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Mattie Nicholas	UNC Chapel Hill Manning Dr. Chapel Hill, NC
Sarah Prim	UNC Chapel Hill
Kathleen Clarke-Pearson MD	Sandhills Pediatrics So. Pines NC
Chuck Stone	SEANC
Jon Pace	ABC of NC Winston-Salem, NC
[illegible]	ABC of NC Winston-Salem, NC
Julia Adams	The Arc of NC ASNC
Bill Wilson	AARP
Angie Tiffany	ABC OF NC - WS, NC
J. Dan Shaw	ASNC Durham, NC

VISITOR REGISTRATION SHEET

Senate Health Care — 6/9/2010

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NAME	FIRM OR AGENCY AND ADDRESS
Annaliese Dolph	DRNC
Lisa Townsend Jordan Williams	ASNC
Jaime King	NCMS
Mark Fleming	BCBSNC
Draxdal	DHHS / OEMS
Dave Lloyd	ASNC
PAUL WENDLER	ASNC
Kerri Erb	ASNC
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Jillian Phillips	GHA " " Albemarle
Kristen Feldman	ASNC
Merab Faulkner	DRNC
Rachel Faultersack	DRNC

Katy B Hurn	Orange County Schools
Tommy Suter	Novartis
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Melissa L. Carden	Autism Society of NC 505 Oberlin Rd, Suite 230 Raleigh 27605
Michelle Munoz	Autism Society of NC 505 Oberlin, Suite 230 Raleigh 27605
John Bourdeau	AstraZeneca
W. Gardner Culpepper	NCNA
Bill Scoggin	TBS
[illegible]	JD, A.L., PA
Kelley E. Haven	NC Academy of Family Physicians
Grace Holtkamp	NCGA
Peggie Potter	NCDS

VISITOR REGISTRATION SHEET

Senate Health Care — 6/9/2010

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VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
STEPHANIE ROTZ	3728 SORREY WAY CT W-S, NC 27106
GARY WALLACH	301 WESTBURY DR C.H. NC 27516
DARRYL MARSCH	913 Ackley Glen Dr. Winston-Salem, NC 27104
Sylvia Barkley	1406 Garfield Ave Winston-Salem, NC 27105
Audrey Niblock	ABC of NC 1834 W. Academy St. Whstn Slm NC 27103
Cherise Jones	4413 Indian Wells Drive Greensboro, NC 27406 PARENT
Claire Greer	DPI 301 N Wilmington, Raleigh
Mary Watson	" DPI
Kim Saunders	Co. 133 Mill Pass Dr. Holly Springs, NC 27540
CINNAMON JOHNSON	12 MANDELA CT GBORO, NC 27401 PARENT
Chris Hawthorne	
Whitney Griffin	Autism Society of NC

VISITOR REGISTRATION SHEET

Senate Health Care — 6/9/2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Ingrid Branigan	1811 W. Chapman Ct. Hillsborough, NC 27278
Whitney Shaff	1210 Lempster Dr NW Concord, NC 28027
Millard Shaff	1210 Lempster Dr NW Concord, NC 28027
Rob Romero	2511 Fernwood Dr. Greensboro NC 27409
Nicole Romero	2511 Fernwood Dr. Greensboro NC 27409
Oluwaseun Onofoye	ANCAFP
Brian Forrest M.D.	NC Academy of Family Physicians
Scott Konopka, M.D.	NC Academy of family Physicians
Robert "Chuck" Rich, MD	NCAFP
CARSON ROUNDS MD	NCAFP
Viviana. Martinez-Bianchi, MD	NCAFD
MATTHEW HANCOCK	8613 CARLTON OAKS DR WAKE FOREST NC

VISITOR REGISTRATION SHEET

Senate Health Care — 6/9/2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Pamela Dixon	ASNC Durham, NC
Sarah Tomkinson ABC of NC	3904 Old Vineyard Rd Winston-Salem NC 27104
Eileen Hancox	2208 STAFFORD AV. 102 Raleigh, NC 27607 ASNC GRANDPARENT
Kay Emanuel	UNC School of Government
Lori Flinchum	ABC of NC and parent Winston-Salem NC,
Amy Perry	Autism Society of North Carolina Parent Fayetteville NC
Patti + Keyton Stanier	205 Prince William Dr. Elizabeth City NC 27909
Brittany Bell	2517 A Lourance Blvd. Greensboro, NC 27407
Debra Merchant	499 Quick Rd ABC of N/C Parent Ruffin, N.C. 27326
Cynthia Andree Bowen	ABC of NC 3904 old Vineyard Rd. Winston-Salem, NC 27103

VISITOR REGISTRATION SHEET

Senate Finance Committee
Name of Committee

June 2, 2010
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO DeANNE MANGUM

NAME	FIRM OR AGENCY AND ADDRESS
Harry Taylor	MLRC
Lori Urich	Autism Speaks
Bob D'Amelio	Autism Speaks
Whitney Tinnin	Chair, Board Autism Society of North Carolina
David Cantor	Durham, NC
Chris Fitzsimon	NC Policy Watch
Brad Steiner	Piedmont Health Services
Janice Hedgepeth	Parent
Alan Cohen	ASNC
Matt Mosteller	Randolph Cloud
Katie Faulkner	Randolph Cloud

Name	Firm / Agency Name Address
Tonia Diggs	GNA, Inc. 213 W 2nd St Albemarle NC
Jane Mahan	Autism Comm. Initiative - 7001 Knotty Pine Chapel Hill, NC
Neal Mahan	AUTISM COMMUNITY INITIATIVE 7001 KNOTTY PINE DR CHAPEL HILL
Cynthia Barnett	2004 Flagstone Place Raleigh NC 27612 The Christian Science Church
Casey Palmer MEd.	New Hope ASD Consulting LLC 1202 Braxton Bragg Ct Hillsborough NC 27278
ANGELA BATTLE	Autism Society of NC
Maria Anthony	Parent, Autism Society in Cabarrus County

2009 - 2010

SENATE
HEALTH CARE

MINUTES

Senate Health Care Committee
Wednesday, June 23, 2010, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 1692	Medicaid Dental/Special Needs Population.	Representative England, M.D. Representative Pierce Representative Farmer-Butterfield Representative Weiss
HB 1693	Develop Special Needs Dental Care Workforce.	Representative England, M.D. Representative Pierce Representative Farmer-Butterfield Representative Weiss
HB 1698	Update Long-Term Care Statutes.	Representative England, M.D. Representative Pierce Representative Farmer-Butterfield Representative Weiss
HB 1705	Consumer Guidelines for Hearing Aid Purchases.	Representative England, M.D. Representative Pierce Representative Farmer-Butterfield Representative Weiss

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator Stan Bingham, Co-Chair
Senator William R. Purcell, Co-Chair

Wednesday, June 23, 2010

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

FAVORABLE

H.B.(CS #1) **1698** Update Long-Term Care Statutes.
Sequential Referral: None
Recommended Referral: None

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

H.B. **1693** Develop Special Needs Dental Care Workforce.
Draft Number: PCS60091
Sequential Referral: None
Recommended Referral: None
Long Title Amended: Yes

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **1692** Medicaid Dental/Special Needs Population.
Draft Number: PCS30533
Sequential Referral: None
Recommended Referral: None
Long Title Amended: Yes

TOTAL REPORTED: 3

Committee Clerk Comments:
Senator Purcell will be handling HB 1692 and HB 1693
Senator Swindell will be handling HB 1698

SENATE HEALTH CARE COMMITTEE
Wednesday, June 23, 2010 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 A.M. on Wednesday, June 23, 2010, in Room 544 of the Legislative Office Building, with seventeen members present. Senator Stan Bingham, Co-Chair, presided. Senator Bingham and Senator Purcell, Co-Chairs, welcomed the committee members present and introduced the pages and sergeants-at arms.

Senator Bingham asked the visiting Physicians to come to the microphone and introduce themselves.

Following the introductions Senator Bingham recognized Rep. Farmer-Butterfield to present HB 1692, ***Medicaid Dental/Special Needs Population***. She explained that HB 1692 required the Division of Medical Assistance and the Division of Public Health to explore issues to facilitate dental care and improve outcomes for the special needs population in NC. The Department of Health and Human Services would report its findings and recommendations to the NC Study Commission on Aging by November 15th or before. HB 1692 was a recommendation from the NC Study Commission on Aging. Senator Atwater stated he had an amendment to offer and asked Ben Popkins to explain it. Mr. Popkins explained the amendment made some largely technical changes to some of the language and also added the reporting language to include the Public Health Study Commission in addition to the NC Study Commission on Aging. Rep. Butterfield stated the sponsors of the bill supported the amendment. Senator Dorsett moved for a favorable report on the amendment, which passed. Senator Bingham asked for discussion or questions on HB 1692. No one had any comments or questions. Senator Brunstetter moved for a favorable report, the motion being, to roll the amendment into a new Proposed Committee Substitute, favorable to the Proposed Committee Substitute, unfavorable to the original bill. The bill passed.

Senator Bingham stated that Rep. Farmer-Butterfield also had the next bill, HB 1693, ***Develop Special Needs Dental Care Workforce.*** Rep. Farmer-Butterfield said the bill directed the area health education centers across the state to come together and coordinate the workforce development for the special needs population to assure their dental needs were being met. Sen. Atwater stated he had an amendment. Ben Popkins explained that similarly to the previous bill, this amendment broadened the reporting provision to include the Public Health Study Commission to receive a report in addition to the NC Study Commission on Aging. Senator Dorsett moved to approve the amendment. The amendment passed. No one had any discussion on the bill. Sen. Dorsett and Sen. Brunstetter moved to roll the amendment into a Proposed Committee Substitute, favorable to the PCS, unfavorable to the original bill. The bill passed.

Senator Bingham called on Rep. Weiss to present HB 1698, ***Update Long-Term Care Statutes.*** Rep. Weiss pointed out HB 1698 came from the NC Study Commission on Aging. Rep. Weiss explained the bill updates statutory language on aging and long-term care to reflect the current descriptions and definitions of the programs. Sections one was enacted in 1979 and had not been amended since and used some antiquated terms. Section two was most recently amended in 1995. Sen. Allran asked don't we do this all the time, like once every couple of years. Rep. Weiss stated we have been here before on other statutes, but these specific statutes have not been updated since 1979 and 1995. Senator Stein moved for a favorable report. The bill passed.

Senator Bingham stated they had pulled HB 1705, ***Consumer Guidelines for Hearing Aid Purchases***, but hopefully it would be heard in a couple of weeks. Senator Bingham called on Joni Alberg; President of the North Carolina Hearing Aids Dealers and Licensing Board, to give an explanation of where the confusion had arose. Joni Alberg stated that HB 1705 was really a consumer protection bill. It was not regulatory or mandating anything new. It only asked that a task force to be formed naming specific groups that should have representation on the task force board and to develop guide lines for consumers to help them as they go to purchase a hearing aid anywhere in the state. Senator Hoyle asked if this task force would be a new board. Jonie Asburn responded that this would be a temporary task force assigned for a specific time period to do a specific task. Senator Hoyle asked if the task force would be appointed by the Hearing Aid Dealers and Fitters Board and also would they be responsible for any cost associated with the task force. Joni Alberg did not know about the cost. Sen. Hoyle wanted this question answered if the bill would be heard again. Senator Bingham asked Rep.Weiss to say a few words about the bill, where it come from, etc. Rep. Weiss said that HB 1705 came from the NC Study Commission on Aging. Sen. Kinnaird pointed out that hearing aids were very expensive and Medicare does not cover them. Sen. Bingham stated that HB 1705 was being heard today for discussion only.

The meeting adjourned at 11:30 A.M.

Senator Stan Bingham, Co-Chair

Senator William R. Purcell, Co-Chair

Judy F. Chriscoe, Committee Assistant

Visiting Physicians

Ben Fischer	MD, Internal Med, Raleigh
Darrell E. Hester, M.D.	Ophthalmology, Wilmington, NC
Brian Caveney MD	Occupational Medicine - Durham
Craig Burkhart MD	Pediatric Dermatology - Chapel Hill
MARIAN CRANFORD, PA-C	PRIVATE PRACTICE, CHAPEL HILL
Donald Metzger, MHS, PA-C	Lumberton, NC Cardiology Emergency Med
Steven Muscoreil, MD	Lumberton, NC, General Surgery
Mary Lane, MD	OB/GYN, Lumberton, NC
David Cook, MD	Raleigh, NC, Neurology
Arleen Smith, NP	Wake Forest Univ Dept. Medical W-5
Ann Newman, RN, Ph.D	UNC Charlotte

PAGES ATTENDING

Date: 6-23-2010

Committee: Health Care (Purcell) **Room:** 544 LOB 11 AM

PLEASE PRINT LEGIBILY!!!!!

Page Name	Hometown	Sponsoring Senator
1 Deirdre Curran	Chapel Hill	Kinnaird
2 Kelly Anderson	Charlotte	Rucho
3 Lauren Bateman	Raleigh	Stein
4 Brianna Tate	Greensboro	Vaughan
5 Kelly Archer	Carrboro	Kinnaird
6 Rebecca Connor	Raleigh	Hunt
7		
8		
9		

Do not add additional names below the grid.

Pages: Please present this form to either the Committee Clerk at the meeting or a Sgt. at Arms.

HOUSE BILL 1692*
Committee Substitute Favorable 5/26/10

Short Title: Medicaid Dental/Special Needs Population. (Public)

Sponsors:

Referred to:

May 13, 2010

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DIVISION OF MEDICAL ASSISTANCE, AND THE DIVISION OF PUBLIC HEALTH, IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO EXPLORE ISSUES RELATED TO PROVIDING DENTAL SERVICES TO THE SPECIAL NEEDS POPULATION, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Division of Medical Assistance, and the Division of Public Health, in the Department of Health and Human Services, shall explore issues that would facilitate dental care and improved dental outcomes for the special needs population. Issues explored must include, but are not limited to, the following:

(1) The feasibility and anticipated impact of expanding Medicaid dental services to include reimbursement for evidenced-based topical fluoride treatment and other chemotherapeutic agents used to prevent periodontal disease in high-risk adults with special health care needs.

(2) The feasibility and anticipated impact of implementing facility code policies that would allow certified providers to bill for each patient seen in a long-term care facility or group home on the date of service.

SECTION 1.(b) The Department of Health and Human Services shall report findings and recommendations on the issues in this section on or before November 15, 2011, to the North Carolina Study Commission on Aging.

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

HOUSE BILL 1692:
Medicaid Dental/Special Needs Population

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 18, 2010
Introduced by:	Reps. Farmer-Butterfield, Weiss, Pierce, England	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	Second Edition		

SUMMARY: ***House Bill 1692 directs the Division of Medical Assistance and the Division of Public Health, Department of Health and Human Services, to study ways to facilitate dental care and improved dental outcomes for populations with special needs and to report findings and recommendations to the North Carolina Study Commission on Aging by November 15, 2011. The bill is a recommendation of the North Carolina Study Commission on Aging.***

[As introduced, this bill was identical to S1192, as introduced by Sen. Swindell, which is currently in Senate Health Care.]

BILL ANALYSIS:

House Bill 1692 directs the Divisions of Medical Assistance and Public Health in the Department of Health and Human Services to explore issues that would facilitate dental care and improved dental outcomes for individuals with special needs. The study must examine, but is not limited to the:

- Feasibility and impact of expanding Medicaid dental services to include reimbursement for evidence-based topical fluoride treatment and other chemotherapeutic agents used to prevent periodontal disease in high-risk adults with special health care needs.
- Feasibility and impact of implementing facility code policies to allow certified providers to bill each patient seen in a long-term care facility or group home on the date of the service.

The Department is required to report findings and recommendations to the Study Commission on Aging by November 15, 2011. The bill would become effective when it becomes law.

** Sara Kamprath and Theresa Matula contributed to this summary.*
H1692-SMSQ-157(e2) v1

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1692*

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

H1692-ARD-52 [v.1]

Comm. Sub. [NO]
Amends Title [NO]
Second Edition

Date _____ ,2010

Senator _____

moves to amend the bill on page 1, lines 5-6, by rewriting the lines to read:
"SERVICES TO THE SPECIAL NEEDS POPULATION.";

And on page 1, lines 8-9, by rewriting the lines to read:
"**SECTION 1.(a)** The Department of Health and Human Services, Divisions of Medical Assistance and Public Health, shall study issues that may";

And on page 1, line 11, by rewriting the line to read:
"studied shall include at least the following:";

And on page 1, lines 20-21 by rewriting the lines to read:
"its findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission on or before November 15, 2011.".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1692*
Committee Substitute Favorable 5/26/10
PROPOSED SENATE COMMITTEE SUBSTITUTE H1692-PCS30533-RD-91

Short Title: Medicaid Dental/Special Needs Population. (Public)

Sponsors:

Referred to:

May 13, 2010

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DIVISION OF MEDICAL ASSISTANCE AND THE DIVISION OF PUBLIC HEALTH, IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO EXPLORE ISSUES RELATED TO PROVIDING DENTAL SERVICES TO THE SPECIAL NEEDS POPULATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services, Divisions of Medical Assistance and Public Health, shall study issues that may facilitate dental care and improved dental outcomes for the special needs population. Issues studied shall include at least the following:

(1) The feasibility and anticipated impact of expanding Medicaid dental services to include reimbursement for evidenced-based topical fluoride treatment and other chemotherapeutic agents used to prevent periodontal disease in high-risk adults with special health care needs.

(2) The feasibility and anticipated impact of implementing facility code policies that would allow certified providers to bill for each patient seen in a long-term care facility or group home on the date of service.

SECTION 1.(b) The Department of Health and Human Services shall report its findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission on or before November 15, 2011.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1692*
Committee Substitute Favorable 5/26/10
PROPOSED SENATE COMMITTEE SUBSTITUTE H1692-PCS30533-RD-91

Short Title: Medicaid Dental/Special Needs Population. (Public)

Sponsors:

Referred to:

May 13, 2010

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE DIVISION OF MEDICAL ASSISTANCE AND THE DIVISION OF PUBLIC HEALTH, IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO EXPLORE ISSUES RELATED TO PROVIDING DENTAL SERVICES TO THE SPECIAL NEEDS POPULATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Department of Health and Human Services, Divisions of Medical Assistance and Public Health, shall study issues that may facilitate dental care and improved dental outcomes for the special needs population. Issues studied shall include at least the following:

(1) The feasibility and anticipated impact of expanding Medicaid dental services to include reimbursement for evidenced-based topical fluoride treatment and other chemotherapeutic agents used to prevent periodontal disease in high-risk adults with special health care needs.

(2) The feasibility and anticipated impact of implementing facility code policies that would allow certified providers to bill for each patient seen in a long-term care facility or group home on the date of service.

SECTION 1.(b) The Department of Health and Human Services shall report its findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission on or before November 15, 2011.

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

HOUSE BILL 1693*

Short Title:	Develop Special Needs Dental Care Workforce.	(Public)
Sponsors:	Representatives Farmer-Butterfield, England, Weiss, Pierce (Primary Sponsors); Adams, M. Alexander, Brisson, Carney, Dockham, Fisher, E. Floyd, Gill, Glazier, Harrison, Hughes, Parfitt, Parmon, Ross, Wainwright, R. Warren, and Whilden.	
Referred to:	Aging, if favorable, Health.	

May 13, 2010

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE NORTH CAROLINA AREA HEALTH EDUCATION CENTERS (AHEC) PROGRAM TO COORDINATE WORKFORCE DEVELOPMENT EFFORTS TO INCREASE THE NUMBER OF DENTAL CARE PROVIDERS SERVING THE SPECIAL NEEDS POPULATION, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The North Carolina Area Health Education Centers (AHEC) Program shall coordinate efforts to increase the number of dental care providers serving the special needs population. These efforts shall include, but are not limited to, the following:

(1) Working with the dental schools at the University of North Carolina at Chapel Hill and East Carolina University, the North Carolina Community College System, and current dental providers serving the special needs population to identify opportunities to increase the dental care workforce supply that is available and willing to treat the special needs population. These opportunities shall include, but are not limited to, options that could be undertaken without additional funding.

(2) Working with the North Carolina State Board of Dental Examiners to explore the feasibility of allowing dental students, dental hygiene students, and assisting students the opportunity to receive training in long-term care facilities under the direction of nonprofit special care dental organizations.

SECTION 1.(b) The North Carolina Area Health Education Centers (AHEC) Program shall report findings and recommendations to the North Carolina Study Commission on Aging on or before August 1, 2011.

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

HOUSE BILL 1693:
Develop Special Needs Dental Care Workforce

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 21, 2010
Introduced by:	Reps. Farmer-Butterfield, England, Weiss, Pierce	**Prepared by:**	Ben Popkin Committee Counsel
Analysis of:	First Edition		

SUMMARY: ***House Bill 1693 would direct the North Carolina Area Health Education Centers (AHEC) Program to coordinate efforts to increase the number of dental care providers serving persons with special needs and to report findings and recommendations to the Study Commission on Aging by August 1, 2011.***

BILL ANALYSIS: House Bill 1693 would direct AHEC to coordinate efforts to increase the number of dental care providers for special needs populations. AHEC efforts would have to include at least the following:

- Work with the State's dental schools, the Community College System, and dental providers currently serving individuals with special needs, to identify opportunities to increase the dental care workforce treating this population, including opportunities that could be undertaken without additional funding.
- Work with the North Carolina State Board of Dental Examiners to explore the feasibility of allowing dental students, dental hygiene students, and assisting students to receive training in long-term care facilities under the direction of nonprofit special care dental organizations.

The bill would direct AHEC to report findings and recommendations to the North Carolina Study Commission on Aging by August 1, 2011.

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

BACKGROUND: A legislatively-directed report (S.L. 2009-100) estimated that the State may be home to 450,000 individuals requiring special care dentistry services. This figure includes individuals with intellectual and/or other developmental disabilities, those with long term needs due to a Traumatic Brain Injury, and older adults living with Alzheimer's disease or other types of dementia. The report noted that only a small number of dental facilities and practices employ providers with the skills and abilities to safely serve dental patients with special health care needs, and pointed to research indicating that dental school graduates are more likely to treat individuals with special needs if they gained experience caring for these patients while in dental school.

House Bill 1693 is a recommendation of the North Carolina Study Commission on Aging.

**Sara Kamprath and Theresa Matula contributed to this summary.*

H1693-SMRD-214(e1) v1

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1693*

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

H1693-ARD-51 [v.1]

Comm. Sub. [NO]
Amends Title [NO]
First Edition

Date _____,2010

Senator _____

moves to amend the bill on page 1, lines 5-6, by rewriting the lines to read:
"THE SPECIAL NEEDS POPULATION.";

And on page 1, lines 23-24 by rewriting the lines to read:
"Program shall report its findings and recommendations to the Public Health Study Commission on or before August 1, 2011.". (North Carolina Study Commission on Aging and the

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1693*
PROPOSED SENATE COMMITTEE SUBSTITUTE H1693-PCS60091-RD-92

Short Title: Develop Special Needs Dental Care Workforce. (Public)

Sponsors:

Referred to:

May 13, 2010

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE NORTH CAROLINA AREA HEALTH EDUCATION CENTERS (AHEC) PROGRAM TO COORDINATE WORKFORCE DEVELOPMENT EFFORTS TO INCREASE THE NUMBER OF DENTAL CARE PROVIDERS SERVING THE SPECIAL NEEDS POPULATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The North Carolina Area Health Education Centers (AHEC) Program shall coordinate efforts to increase the number of dental care providers serving the special needs population. These efforts shall include, but are not limited to, the following:

(1) Working with the dental schools at the University of North Carolina at Chapel Hill and East Carolina University, the North Carolina Community College System, and current dental providers serving the special needs population to identify opportunities to increase the dental care workforce supply that is available and willing to treat the special needs population. These opportunities shall include, but are not limited to, options that could be undertaken without additional funding.

(2) Working with the North Carolina State Board of Dental Examiners to explore the feasibility of allowing dental students, dental hygiene students, and assisting students the opportunity to receive training in long-term care facilities under the direction of nonprofit special care dental organizations.

SECTION 1.(b) The North Carolina Area Health Education Centers (AHEC) Program shall report its findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission on or before August 1, 2011.

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

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H D

HOUSE BILL 1693*
PROPOSED SENATE COMMITTEE SUBSTITUTE H1693-PCS60091-RD-92

Short Title: Develop Special Needs Dental Care Workforce. (Public)

Sponsors:

Referred to:

May 13, 2010

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE NORTH CAROLINA AREA HEALTH EDUCATION CENTERS (AHEC) PROGRAM TO COORDINATE WORKFORCE DEVELOPMENT EFFORTS TO INCREASE THE NUMBER OF DENTAL CARE PROVIDERS SERVING THE SPECIAL NEEDS POPULATION.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The North Carolina Area Health Education Centers (AHEC) Program shall coordinate efforts to increase the number of dental care providers serving the special needs population. These efforts shall include, but are not limited to, the following:

(1) Working with the dental schools at the University of North Carolina at Chapel Hill and East Carolina University, the North Carolina Community College System, and current dental providers serving the special needs population to identify opportunities to increase the dental care workforce supply that is available and willing to treat the special needs population. These opportunities shall include, but are not limited to, options that could be undertaken without additional funding.

(2) Working with the North Carolina State Board of Dental Examiners to explore the feasibility of allowing dental students, dental hygiene students, and assisting students the opportunity to receive training in long-term care facilities under the direction of nonprofit special care dental organizations.

SECTION 1.(b) The North Carolina Area Health Education Centers (AHEC) Program shall report its findings and recommendations to the North Carolina Study Commission on Aging and the Public Health Study Commission on or before August 1, 2011.

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

HOUSE BILL 1698*
Corrected Copy 5/14/10
Committee Substitute Favorable 5/26/10

Short Title: Update Long-Term Care Statutes. (Public)

Sponsors:

Referred to:

May 13, 2010

A BILL TO BE ENTITLED

AN ACT TO UPDATE AND CLARIFY NORTH CAROLINA'S GENERAL STATUTES ON OLDER ADULTS AND LONG-TERM SERVICES AND SUPPORTS, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

Whereas, the North Carolina General Assembly is committed to having North Carolina recognized as a leader in supporting long-term services and supports; and

Whereas, the State is building on the following federal and State supported person-centered initiatives: aging and disability resource centers or Community Resource Connections for Aging and Disabilities, evidence-based health promotion, caregiver supports for persons with Alzheimer's disease, lifespan respite programs, consumer-directed care, transitional care, and promotion of community living for persons who might otherwise become Medicaid eligible if placed in a skilled nursing facility; Now, therefore,

The General Assembly of North Carolina enacts:

SECTION 1. Part 14A, Article 3, Chapter 143B of the General Statutes reads as rewritten:

"Part 14A. ~~Policy Act for the Aging.~~ Older Adults.

"**§ 143B-181.3. ~~Statement of principles.~~ Older adults – findings; policy.**

~~To utilize effectively the resources of our State, to provide a better quality of life for our senior citizens, and to assure older adults the right of choosing where and how they want to live, the following principles are hereby endorsed:~~

(a) The North Carolina General Assembly finds the following:

(1) Older ~~people~~ adults should be able to live as ~~normal a life~~ independently as ~~possible.~~ possible, and to live free from abuse, neglect, and exploitation.

(2) Older adults should have opportunities to be involved in their communities in ways they desire.~~a choice of life styles which will allow them to remain contributing members of society for as long as possible.~~

(3) Preventive and primary health care are necessary to ~~keep older adults active and contributing members of society.~~ assure optimal health and to enable active social and civic engagement by older adults.

(4) Sufficient opportunities for ~~Appropriate~~ training in gerontology and geriatrics should be developed and readily available for individuals serving older adults.

(5) ~~Transportation to meet daily needs and to make accessible a broad range of services should be provided so that older persons may realize their full potential.~~Older adults should have access to a broad range of services, supports, and opportunities, and they should have transportation options

available to allow access to these services and to meet their daily needs and interests.

(6) Services for older adults should be person-centered and coordinated so that ~~all their~~ an individual's needs can be ~~served efficiently and effectively.~~met efficiently, effectively, and in the least restrictive environment.

(7) Information should be readily available in each county on all programs and services for older adults. ~~citizens and advocacy for these services should be available in each county.~~

(8) ~~Increased employment opportunities for older adults should be made available.~~Older adults should have adequate opportunities for employment.

(9) Each county should have available a variety of housing options, including retirement housing, accessible affordable rental housing, and opportunities for residential home modifications, in order to allow older adults to remain in their communities. ~~Options in housing should be made available.~~

(10) Older adults and their caregivers should have input in the planning and evaluation of programs and services for older adults, and they should have opportunities to advocate for these programs and services. ~~Planning for programs for older citizens should always be done in consultation with them.~~

(11) The State should ~~aid~~ assist older ~~people~~ adults who desire to remain as independent as possible ~~to help themselves~~ and should encourage and support families in caring for their older members.

(b) It is the policy of the State to effectively utilize its resources to support and enhance the quality of life for older adults in North Carolina."

SECTION 2. Part 14B, Article 3, Chapter 143B of the General Statutes reads as rewritten:

"Part 14B. Long-Term ~~Care.~~Services and Supports.

"**§ 143B-181.5. Long-term ~~care~~ services and supports – findings.~~policy.~~**

The North Carolina General Assembly finds that the aging of the population and advanced medical technology have resulted in a growing number of persons who require ~~assistance.~~ long-term services and supports. The primary ~~resource~~ resources for long-term ~~care provision~~ assistance continues to be ~~the~~ family and friends. However, these traditional caregivers are increasingly employed outside the home. There is growing demand for improvement and expansion of home and community-based long-term ~~care services to support and~~ services and supports to complement the ~~services~~ care provided by these informal caregivers.

The North Carolina General Assembly further finds that the public interest would best be served by a broad array of long-term ~~care~~ services and supports that ~~support~~ enable persons who need such services to remain in the home or in the community whenever practicable and that promote individual ~~autonomy, dignity, and choice.~~autonomy and dignity as these individuals exercise choice and control over their lives.

The North Carolina General Assembly finds that as other long-term ~~care~~ service and support options become more readily available, the ~~relative~~ need for institutional care will stabilize or decline relative to the growing ~~aging population.~~population of older adults and people living with disabilities. The General Assembly recognizes, however, that institutional care will continue to be a critical part of the State's long-term ~~care~~ service and support options and that such ~~services~~ care should promote individual dignity, autonomy, and a home like environment.

"**§ 143B-181.6. Purpose and intent.**

~~It is the North Carolina General Assembly's intent in the State's development and implementation of long-term care policies that:~~The development and implementation of policies for long-term services and supports should reflect the intent of the North Carolina General Assembly as follows:

(1) Long-term ~~care~~ services and supports administered by the Department of Health and Human Services and other State and local agencies shall include a balanced array of health, social, and supportive services that are well coordinated to promote individual choice, dignity, and the highest practicable level of ~~independence;~~ independence.

(2) Home and community-based services shall be developed, expanded, or maintained in order to meet the needs of consumers in the least confusing and least restrictive manner. ~~manner and~~ Services should be based on the desires of ~~the elderly~~ older adults, persons with disabilities, ~~and~~ their ~~families;~~families, and others that support them.

(3) All services shall be responsive and appropriate to individual need and shall be delivered through a uniform and seamless system that is flexible and responsive regardless of funding ~~source;~~ source. Information and services shall be available through the effective use of Community Resource Connections for Aging and Disabilities as they are developed throughout the State.

(4) Services shall be available to all ~~elderly~~ persons who need ~~them~~ them, but shall be targeted primarily to ~~the~~ those citizens who are the most ~~frail,~~ frail and those with the greatest need. ~~needy elderly;~~

(5) State and local agencies shall maximize the use of limited resources by establishing a fee system for persons who have the ability to ~~pay;~~pay.

(6) ~~Institutional care~~ Care provided in facilities shall be ~~provided~~ offered in such a manner and in such an environment as to promote for each resident, maintenance of health, ~~or~~ enhancement of the quality of ~~life of each resident~~ life, and timely discharge to a less restrictive care setting when ~~appropriate;~~ ~~and~~ appropriate.

(7) State health planning for institutional bed supply shall take into account increased availability of ~~other~~ home and community-based services options.

(8) In an effort to maximize the use of limited resources, State and local agencies shall invest in supports for families and other informal caregivers of persons requiring assistance.

(9) Emphasis shall be placed on offering evidence-based activities to promote healthy aging, prevent injuries, and manage chronic diseases and conditions.

(10) Individuals and families shall be encouraged and supported in planning for and financing their own future needs for long-term services and supports."

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

HOUSE BILL 1698:
Update Long-Term Care Statutes

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 22, 2010
Introduced by:	Reps. Farmer-Butterfield, Pierce, Weiss, England	**Prepared by:**	Susan Barham Research Assistant
Analysis of:	Third Edition		

SUMMARY: House Bill 1698 makes changes to the statutory language on aging and long-term care to reflect contemporary descriptions of current programs and services. This bill was a recommendation by the NC Study Commission on Aging.

[As introduced, this bill was identical to S1190, as introduced by Sen. Swindell, which is currently in Senate Health Care.]

BILL ANALYSIS:

Section 1 of HB 1698 amends Part 14A, Article 3, Chapter 143B. Part 14A, currently titled "Policy Act for the Aging", was enacted in 1979 and has not been amended since. This section of the bill amends Part 14A, G.S. 143B-181.3 which contains inconsistent and antiquated references to older adults. The amendments to this section also include a reference to person-centered services. The amendments reflect the way the State currently views older adults and delivers programs and services to them.

Section 2 of HB 1698 amends Part 14B, Article 3, Chapter 143B, which was enacted in 1981 and was amended in 1995. Part 14B contains sections G.S. 143B-181.5 and G.S. 143B-181.6. This bill changes references in Part 14B from "long-term care" to "long-term services and support" which is consistent with terminology changes made by the Department of Health and Human Services. This section also references the use of "Community Resource Connections for Aging and Disabilities" which is the title North Carolina has given to their aging and disability resource centers.

House Bill 1698 would become effective when it becomes law.

BACKGROUND:

The Division of Aging and Adult Services recommended the changes in this bill to the NC Study Commission on Aging.

Person-Centered Services - The Office of Long-Term Services and Supports, Department of Health and Human Services, defines person-centered services and supports as "those that help people establish the right balance between what is important to their day-to-day quality of life and what is important for their health and safety. The person is the expert in his or her own life, and professionals are there to provide support and guidance, but not control."

Aging and disability resource centers were part of a federal grant initiative. Community Resource Connections for Aging and Disabilities (CRC) represents a collaboration of agencies and organizations that link resources within the community and strengthen relationships between existing providers through partnerships and facilitate a "no wrong door" approach to services. The Department states that a, "CRC is considered to be one of the primary vehicles to modernize long-term care systems, particularly in relation to helping people avoid unnecessary institutionalization by supporting individuals of all disabilities and incomes to make informed, cost-effective choices."

Theresa Matula, Legislative Analyst, substantially contributed to this summary.
H1698-SMTE-12(e3) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H 2

HOUSE BILL 1705*
Committee Substitute Favorable 6/9/10

Short Title: Consumer Guidelines for Hearing Aid Purchases. (Public)

Sponsors:

Referred to:

May 17, 2010

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE HEARING AID DEALERS AND FITTERS BOARD TO COORDINATE A TASK FORCE THAT WILL DEVELOP GUIDELINES FOR CONSUMERS TO USE WHEN PURCHASING A HEARING AID, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Hearing Aid Dealers and Fitters Board shall coordinate a task force to develop recommended guidelines for consumers seeking information and assistance in the treatment of hearing loss and the purchase of a hearing aid. The task force shall include representatives of the NC Hearing Aid Dealers and Fitters Board; the Division of Services for the Deaf and Hard of Hearing, Department of Health and Human Services; the Consumer Protection Division, Office of the Attorney General; a practicing audiologist, as recommended by the NC Board of Examiners for Speech and Language Pathologists and Audiologists; a physician who treats patients with hearing loss, as recommended by the NC Medical Board; and may include other interested stakeholders.

SECTION 1.(b) The Hearing Aid Dealers and Fitters Board shall report the findings and recommendations of the task force, along with recommendations on methods to disseminate hearing aid purchasing guidelines, to the North Carolina Study Commission on Aging on or before October 15, 2010.

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

HOUSE BILL 1705:
Consumer Guidelines for Hearing Aid Purchases

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 22, 2010
Introduced by:	Reps. Pierce, Farmer-Butterfield, England, Weiss	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	Second Edition		

SUMMARY: House Bill 1705 requires the Hearing Aid Dealers and Fitters Board to coordinate a task force to develop guidelines for consumers seeking information and assistance in the treatment of hearing loss and the purchase of a hearing aid. This bill is a recommendation from the NC Study Commission on Aging.

BILL ANALYSIS:

House Bill 1705 requires the Hearing Aid Dealers and Fitters Board to coordinate a task force to develop guidelines for consumers seeking information and assistance in the treatment of hearing loss and the purchase of a hearing aid. The task force will include representatives from the following:

- Hearing Aid Dealers and Fitters Board;
- Division of Services for the Deaf and Hard of Hearing, DHHS;
- Consumer Protection Division, Office of the Attorney General;
- A practicing audiologist, recommended by the NC Board of Examiners for Speech and Language Pathologists and Audiologists;
- A physician who treats patients with hearing loss, as recommended by the NC Medical Board; and
- Other Interested Stakeholders.

On or before October 15, 2010, the Board is required to report findings and recommendations, including methods to disseminate hearing aid purchasing guidelines, to the North Carolina Study Commission on Aging.

House Bill 1705 would become effective when it becomes law.

Theresa Matula substantially contributed to this summary.

H1705-SMSQ-158(e2) v1

VISITOR REGISTRATION SHEET

Senate Health Care — 6/23/2010

Name of Committee — **Date**

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Teresa Miller	NCAE
Stephanie Humphrey	NCAE
Bethany Banks	Durham / NCAE
Paul Mandsager	NC Institute of Medicine
Lauren Shor	NC Instit. of Medicine
Cynthia Barnett	Citizen
John McMillan	MFDS
Bob Lamm	RL & Assoc
Mark Casey	DHHS / DMA

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Senate Health Care — 6/23/2010

Name of Committee — **Date**

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Snayha Nath	Governor's office
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Craig Burkhart	UNC Hospitals / NCMS / NCDA
Brian Caveney, MD	NC Medical Society
Darrell Hester, MD	Ophthalmology Wilmington, NC NC medical Societ,
Ben Fischer, MD	INTERNAL Medicine, Raleigh Medical Group NC Medical Society
DON METZGER, PA-C	NC MEDICAL SOCIETY - HOKE LUMBERTON, NC 28358
David Cook, MD	Raleigh, NC
Mary Lane, MD	OB/GYN, Lumberton, NC
Richard Skinner	NC Medical Society
Steven Musgorei MD	General Surgery Lumberton NC

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Senate Health Care — 6/23/2010

Name of Committee — **Date**

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Shelia Reid	SOG
Kristi Hefty	NCHCPA
Jamal Jones	NCHA
Nitin Goel	Sen. Intern
Bo Heath	MWC
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[illegible]	JPAssoc
Daniel Blum	Troutman Sanders
[illegible]	
Karl Rove	GW
Cam Cover	BMHL
Evan Lambeth	NCHA

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Senate Health Care — 6/23/2010

Name of Committee — **Date**

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Erica Nelson	NCCCP
Jennifer Willis	NCCS
Kelsey Umstead	WAKEMED
Melissa Parker	Rex Healthcare
Elizabeth Ireland	Covenant with NC's Children
Rebecca King	Oral Health, Div. of P-H.
Ann Newman, RN	Nurse of the Day
Aileen Smith NP	Nurse of the Day (WFUBMC)
Weatherly Rose	Hunton + Williams
Jesse Goodman	DHHS
Janet Scharzenbach	Indigo Consulting

VISITOR REGISTRATION SHEET

Senate Health Care — 6/23/2010

Name of Committee — **Date**

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Tom Akins	NCANDHA
[illegible]	HLC-Inc.
Barbara Cansler	Bacon
John Bowditch	Astrazeneca
W. Gordon Culpepper	NCMS
Joanne Stevens	Stevens & Assoc. s
Channing Carter	

Senate Health Care Committee
Wednesday, June 30, 2010, 11:00 AM
544 LOB

AGENDA

Welcome and Opening Remarks

Introduction of Pages

Bills

HB 1705	Consumer Guidelines for Hearing Aid Purchases.	Representative England, M.D. Representative Pierce Representative Farmer-Butterfield Representative Weiss
HB 1726	Improve Child Care Nutrition/Activity Stnds.	Representative England Representative Weiss

Presentations

Other Business

Adjournment

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Wednesday, June 30, 2010

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

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1, BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1) **1705** Consumer Guidelines for Hearing Aid Purchases.

Draft Number:	PCS 60095
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comments:

SENATE HEALTH CARE COMMITTEE
Wednesday, June 30, 2010 at 11:00 AM
Room 544, Legislative Office Building

MINUTES

The Senate Health Care Committee met at 11:00 AM on June 30, 2010, in Room 544 of the Legislative Office Building. Seventeen members of the committee were present. Senator Purcell, Co-Chair, presided.

House Bill 1726 entitled "AN ACT TO REQUIRE THE CHILD CARE COMMISSION, IN CONSULTATION WITH THE DIVISION OF CHILD DEVELOPMENT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO DEVELOP IMPROVED NUTRITION STANDARDS FOR CHILD CARE FACILITIES, TO DIRECT THE DIVISION OF CHILD DEVELOPMENT TO STUDY AND RECOMMEND GUIDELINES FOR INCREASED LEVELS OF PHYSICAL ACTIVITY IN CHILD CARE FACILITIES, AND TO DIRECT THE DIVISION OF PUBLIC HEALTH TO WORK WITH OTHER ENTITIES TO EXAMINE AND MAKE RECOMMENDATATIONS FOR IMPROVING NUTURTION STANDARDS IN CHILD CARE FACILITIES" was considered first. Representative Weiss, sponsor, presented her bill, with Senator Bingham offering an amendment to change the effective date. He moved its acceptance; motion carried. After discussion, Senator Foriest moved a favorable report for the bill as amended and that the amendment be rolled into a Committee Substitute; motion carried.

House Bill 1705 entitled "AN ACT TO REQUIRE THE HEARING AID DEALERS AND FITTERS BOARD TO COORDINATE A TASK FORCE THAT WILL DEVELOP GUIDELINES FOR CONSUMERS TO USE WHEN PURCHASING A HEARING AID, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING" was the last bill on the agenda. Representative Weiss, sponsor, presented this bill to Committee. A Senate Committee Substitute was before Committee, with Senator Purcell moving its adoption; motion carried. After discussion, Senator Dannelly moved a favorable report for the bill and an unfavorable report for the original bill; motion carried. Senator Purcell will handle this bill on the Senate floor.

There being no further business before the Committee, Senator Purcell adjourned the meeting at 11:45 a.m.

William R Purcell
Senator Purcell, Presiding

Becky Hedspeth
Becky Hedspeth, Committee Assistant

Stan Bingham
Senator Bingham, Co-Chair

HOUSE BILL 1705:
Consumer Guidelines for Hearing Aid Purchases

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 29, 2010
Introduced by:	Reps. Pierce, Farmer-Butterfield, England, Weiss	**Prepared by:**	Shawn Parker Legislative Analyst
Analysis of:	PCS to Second Edition H1705-CSSQ-92		

SUMMARY: House Bill 1705 directs the Hearing Aid Dealers and Fitters Board to coordinate a task force to develop guidelines for consumers seeking information and assistance in the treatment of hearing loss and the purchase of a hearing aid. This bill is a recommendation from the NC Study Commission on Aging.

BILL ANALYSIS: the Senate Proposed Committee Substitute to House Bill 1705 requires the Hearing Aid Dealers and Fitters Board to coordinate a task force to develop guidelines for consumers seeking information and assistance in the treatment of hearing loss and the purchase of a hearing aid. The task force shall include:

- ***A current licensee*** of the North Carolina Hearing Aid Dealers and Fitters Board;
- ***A hearing aide consumer***, recommended by the Division of Services for the Deaf and Hard of Hearing, DHHS;
- A practicing audiologist, recommended by the NC Board of Examiners for Speech and Language Pathologists and Audiologists;
- A physician who treats patients with hearing loss, recommended by the NC Medical Board;

A representative from

- The Consumer Protection Division, Office of the Attorney General;
- the Division of Services for the Deaf and Hard of Hearing, DHHS;
- Other Interested Stakeholders.

On or before ***November 15, 2010***, the Board is required to report findings and recommendations, including methods to disseminate hearing aid purchasing guidelines, to the North Carolina Study Commission on Aging and the ***Joint Legislative Health Care Oversight Committee***.

House Bill 1705 would become effective when it becomes law.

Theresa Matula substantially contributed to this summary.

H1705-SMSQ-160(CSSQ-92) v1

fav.
= unfav.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

H **D**

original bill.

HOUSE BILL 1705*

Committee Substitute Favorable 6/9/10
PROPOSED SENATE COMMITTEE SUBSTITUTE H1705-CSSQ-92 [v.1]

6/29/2010 12:09:42 PM

Short Title: Consumer Guidelines for Hearing Aid Purchases. (Public)

Sponsors:

Referred to:

May 17, 2010

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE HEARING AID DEALERS AND FITTERS BOARD TO COORDINATE A TASK FORCE THAT WILL DEVELOP GUIDELINES FOR CONSUMERS TO USE WHEN PURCHASING A HEARING AID, AS RECOMMENDED BY THE NORTH CAROLINA STUDY COMMISSION ON AGING.

The General Assembly of North Carolina enacts:

SECTION 1.(a) The Hearing Aid Dealers and Fitters Board shall coordinate a task force to develop recommended guidelines for consumers seeking information and assistance in the treatment of hearing loss and the purchase of a hearing aid. The task force shall include a licensed practicing fitter and seller of hearing aides, as recommended by the NC Hearing Aid Dealers and Fitters Board; a consumer of hearing aides, as recommended by the Division of Services for the Deaf and Hard of Hearing, Department of Health and Human Services; a practicing audiologist, as recommended by the NC Board of Examiners for Speech and Language Pathologists and Audiologists; a physician who treats patients with hearing loss, as recommended by the NC Medical Board; a representative of the Division of Services for the Deaf and Hard of Hearing, Department of Health and Human Services; a representative of the Consumer Protection Division, Office of the Attorney General; and may include other interested stakeholders.

SECTION 1.(b) The Hearing Aid Dealers and Fitters Board shall report the findings and recommendations of the task force, along with recommendations on methods to disseminate hearing aid purchasing guidelines, to the North Carolina Study Commission on Aging and the Joint Legislative Health Care Oversight Committee on or before November 15, 2010.

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

HOUSE BILL 1726:
Improve Child Care Nutrition/Activity Stnds

2009-2010 General Assembly

Committee:	Senate Health Care	**Date:**	June 30, 2010
Introduced by:	Reps. Weiss, England, McLawhorn, Yongue	**Prepared by:**	Shawn Parker
Analysis of:	Fourth Edition		Legislative Analyst

SUMMARY: ***House Bill 1726 directs the Child Care Commission to consult with the Division of Child Development, DHHS, (was State Health Director) when developing nutrition standards for child care facilities and requires the Division to examine current levels of physical activity children receive in child care facilities and to report findings and recommendations to the Legislative Task Force on Childhood Obesity, the Public Health Study Commission, and the Fiscal Research Division. This bill is a recommendation from the Legislative Task Force on Childhood Obesity.***

CURRENT LAW:

G.S. 110-91(2) provides health-related activity standards for licensed child care facilities and requires the Child Care Commission to adopt rules to ensure that all children receive nutritious food and beverages according to their developmental needs. The rules adopted by the Commission in accordance with this section currently require that "*meals and snacks served shall comply with the Meal Patterns for Children in Child Care standards...*". In addition, the rules provide that "*Foods and beverages with little or no nutritional value served as a snack, such as sweets, fruit drinks, soft drinks, etc., will be available only for special occasions.*" (10A NCAC 09 .0901)

Child Care Facility - G.S. 110-86 specifies that a "child care facility" includes child care centers, family child care homes, and any other child care arrangement, not excluded by the definition of child care specified in G.S. 110-86(2), that provides child care, regardless of the time of day, wherever operated, and whether or not operated for profit.

a. A child care center is an arrangement where, at any one time, there are three or more preschool-age children or nine or more school-age children receiving child care.

b. A family child care home is a child care arrangement located in a residence where, at any one time, more than two children, but less than nine children, receive child care.

BILL ANALYSIS:

Section 1 of House Bill 1726 amends G.S. 110-91(2) to require the Child Care Commission to consult with the Division of Child Development, DHHS, to develop the following nutrition standards for child care facilities.

The section directs the Commission to consider the following recommendations when developing its standards:

- Limiting or prohibiting serving sugar sweetened beverages (other than 100% juice) to children of any age.
- Limiting or prohibiting serving whole milk to children two years of age or older or flavored milk to children of any age.
- Limiting or prohibiting serving more than six ounces of juice per day to children of any age.
- Limiting or prohibiting serving juice in a bottle.
- Providing exemptions for parents with children who have medical needs, special diets, or food allergies.

Section 2 requires the Division of Child Development, DHHS, to examine the current levels of physical activity children receive in child care facilities and to review model physical activity guidelines. Not later than September 1, 2011, the Division is required to report findings and recommendations for increasing physical activity levels in child care facilities, with a goal of reaching model guidelines. The Division must provide the report to the Legislative Task Force on Childhood Obesity, if reestablished, the Public Health Study Commission, and the Fiscal Research Division.

Section 3 directs the Division of Public Health, DHHS, in conjunction with the Division of Child Development, nutritionists, pediatricians, and child care providers to examine current nutrition standards for children in child care facilities. The Division of Public Health shall report its findings and recommendations for improving nutrition standards to the Legislative Task Force on Childhood Obesity, if reestablished, the Public Health Study Commission, and the Fiscal Research Division, no later than December 1, 2010.

EFFECTIVE DATE: House Bill 1726 would become effective when it becomes law.

BACKGROUND:

This bill is a recommendation from the Task Force on Childhood Obesity. During the Task Force meeting on February 11th, Sara Benjamin, Duke University Medical Center's Department of Community and Family Medicine, informed the Task Force that nearly three-fourths of children ages two to six years are in some form of child care. Dr. Benjamin pointed out that there is evidence to suggest that child care attendance does contribute to childhood obesity and she presented the Task Force with model child care policies on healthy eating and physical activity and with state rankings for healthy eating and physical activity regulations that gave North Carolina an overall grade C. The Task Force recommended the General Assembly enact the language contained in HB 1726.

Theresa Matula, staff to House Health, substantially contributed to this summary.

H1726-SMSQ-161(e4) v1

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

Fav.

H 4

HOUSE BILL 1726*

Committee Substitute Favorable 5/24/10
Committee Substitute #2 Favorable 6/23/10
Fourth Edition Engrossed 6/28/10

Short Title: Improve Child Care Nutrition/Activity Stnds. (Public)

Sponsors:

Referred to:

May 17, 2010

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THE CHILD CARE COMMISSION, IN CONSULTATION WITH THE DIVISION OF CHILD DEVELOPMENT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO DEVELOP IMPROVED NUTRITION STANDARDS FOR CHILD CARE FACILITIES, TO DIRECT THE DIVISION OF CHILD DEVELOPMENT TO STUDY AND RECOMMEND GUIDELINES FOR INCREASED LEVELS OF PHYSICAL ACTIVITY IN CHILD CARE FACILITIES, AND TO DIRECT THE DIVISION OF PUBLIC HEALTH TO WORK WITH OTHER ENTITIES TO EXAMINE AND MAKE RECOMMENDATIONS FOR IMPROVING NUTRITION STANDARDS IN CHILD CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 110-91(2) reads as rewritten:

"(2) Health-Related Activities. – The Commission shall adopt rules for child care facilities to ensure that all children receive nutritious food and beverages according to their developmental needs. ~~After consultation with the State Health Director,~~ The Commission shall consult with the Division of Child Development of the Department of Health and Human Services to develop nutrition standards ~~shall~~ to provide for requirements appropriate for children of different ages. In developing nutrition standards, the Commission shall consider the following recommendations:

a. Limiting or prohibiting the serving of sweetened beverages, other than 100% fruit juice, to children of any age.
b. Limiting or prohibiting the serving of whole milk to children two years of age or older or flavored milk to children of any age.
c. Limiting or prohibiting the serving of more than six ounces of juice per day to children of any age.
d. Limiting or prohibiting the serving of juice from a bottle.
e. Creating an exception from the rules for parents of children who have medical needs, special diets, or food allergies.

Each child care facility shall have a rest period for each child in care after lunch or at some other appropriate time and arrange for each child in care to be out-of-doors each day if weather conditions permit."

SECTION 2. The Department of Health and Human Services, Division of Child Development, shall examine the current levels of physical activity children receive in child care

facilities and review model physical activity guidelines. Not later than September 1, 2011, the Division shall report its findings and recommendations for increasing physical activity levels in child care facilities, with a goal of reaching model guidelines, to the Legislative Task Force on Childhood Obesity, if reestablished, to the Public Health Study Commission, and to the Fiscal Research Division.

SECTION 3. The Department of Health and Human Services, Division of Public Health, in conjunction with the Division of Child Development, nutritionists, pediatricians, and child care providers, shall examine the current nutrition standards for children in child care facilities. This examination shall be conducted in consideration of any potential changes in the federal guidelines related to the Child and Adult Care Food Program. Not later than December 1, 2010, the Division of Public Health shall report its findings and recommendations for improving nutrition standards in child care facilities to the Legislative Task Force on Childhood Obesity, if reestablished, to the Public Health Study Commission, and to the Fiscal Research Division.

SECTION 4. This act is effective when it becomes law.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
House Bill 1726*

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

H1726-ASQ-128 [v.1]

Comm. Sub. [NO]
Amends Title [NO]
Fourth Edition

Date _____,2010

Senator _____

moves to amend the bill on page 2, lines 10-11, by deleting the phrase "December 1, 2010," and substituting the phrase "January 1, 2011,".

SIGNED Stan Bingham
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE
Name of Committee

JUNE 30, 2010
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

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Amber Lewis	WakeMed - OT
Nancy Nau	Wake Med - OT
Heatherly Rose	Hunter + Williams
Michael Thomas MD	Carolina Endocrine, Wake County Medical Society
Kascia Henderson	Goldsboro Orthopaedic Associates
Amy Gallaway	Goldsboro Orthopaedic Associates
WILLIAM DE ARAUJO MD	GOLDSBORO ORTHOPEDIC ASSOC.
DANIEL BAUM	TROUTMAN SANDERS
Katherine Joyce	NCASA
[signature]	WCPSS
Seth Morris	Rep. Weiss' Office
Christine Wilson	A.C.S.

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SENATE HEALTH CARE
Name of Committee

JUNE 30, 2010
Date

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Mary Bethel	AARP-NC
	DHHS
Erica Nelson	NCCCP
Leah Bracken	TWC
Juliana Deitch	Ellie Kinaird
PAIGE WORSHAM	SCHOOL OF GOVERNMENT
	MWC
Brian Dempsey	"

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SENATE HEALTH CARE
Name of Committee

JUNE 30, 2010
Date

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John Darvin	Governor's Office
Ian Cole	Carolinas medical Center
D. Matthew Sullivan	Carolinas Medical center 1000 Blythe Blvd. Charlotte, NC 28232
Elizabeth Rostan	Dermatology & Cosmetic Surg Cnt Charlotte NC
Brenda Crain	Gastonia, NC
[signature]	SEANC
John Todd Hamm	NCAHCP
Tommy Adkins	Moreland City NC
Mary Edwards	DAAS
Paula H. Hopper	P H Hopper

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE
Name of Committee

JUNE 30, 2010
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
ANN LOVE	DUKE
HUGH TILSON	NCHA
Andrea Cagle	DLC + Assoc.
Joyce Peters	JP Assoc.
Lu-Ann [illegible]	NCAANPHA
Joni Allen	BEGINNINGS
Barbara Carsler	BCCA
Fred Bone	Bone & Assoc.
Butch Gunnells	NC Beverage Assoc

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — JUNE 30, 2010

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Elizabeth Ireland	Covenant with NC's Children
[illegible] Thompson	Covenant w/ NC's Children
Pam Seamans	NC Alliance for Health
Amy McConkey	NC Beverage Ass'n
Amy Whited	NC medical Society
Betsey Vetter	American Heart Assn
Janet Schanzenbach	Indigo Consulting
Cheryl Brewer, RN	N.C. Nurses Association
Jani Kozlowski	DCD
Deb Cassidy	DCD
Anna Carter	DCD

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE
Name of Committee

JUNE 30, 2010
Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Alan Skipper	NCMS
Joanne Stevens	NCNA
W. Gaston Pedigo	NCNA
Roslyn Savitt	NCCCC
Glenn R. Jernigan	Agri-Alliance & N.C. NCVDA
Jon Cecil	American Cancer Society
Doug Heron	WM

SENATE HEALTH CARE COMMITTEE
Thursday, July 1, 2010
Chairman Purcell's Senate Seat in Chambers

MINUTES

The Senate Health Care Committee met at Senator Purcell's desk in Chambers before the Legislative Session began on July 1, 2010. Ten committee members were present.

House Bill 1726 entitled "Improve Child Care Nutrition Activity Standards." was reconsidered. This bill had been considered at the regular Health Care meeting on June 30 but not reported out.

At this meeting, Senator Bingham moved that the vote by which the PCS for House Bill 1726 be given a favorable report be reconsidered.

He then moved that the PCS for House Bill 1726 be reconsidered and withdrawn. He next moved that House Bill 1726 be given a favorable report. Motion carried.

The meeting was adjourned.

William R. Purcell, Presiding

Becky Hedspeth, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Co-Chair
Senator Stan Bingham, Co-Chair

Thursday, July 01, 2010

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

FAVORABLE

H.B.(CS #2) **1726** Improve Child Care Nutrition/Activity Stnds.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comments:

HB 1726 -- Senator Purcell will handle on Floor.

GENERAL ASSEMBLY OF NORTH CAROLINA
SESSION 2009

SESSION LAW 2010-117
HOUSE BILL 1726

AN ACT TO REQUIRE THE CHILD CARE COMMISSION, IN CONSULTATION WITH THE DIVISION OF CHILD DEVELOPMENT OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TO DEVELOP IMPROVED NUTRITION STANDARDS FOR CHILD CARE FACILITIES, TO DIRECT THE DIVISION OF CHILD DEVELOPMENT TO STUDY AND RECOMMEND GUIDELINES FOR INCREASED LEVELS OF PHYSICAL ACTIVITY IN CHILD CARE FACILITIES, AND TO DIRECT THE DIVISION OF PUBLIC HEALTH TO WORK WITH OTHER ENTITIES TO EXAMINE AND MAKE RECOMMENDATIONS FOR IMPROVING NUTRITION STANDARDS IN CHILD CARE FACILITIES.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 110-91(2) reads as rewritten:

"(2) Health-Related Activities. – The Commission shall adopt rules for child care facilities to ensure that all children receive nutritious food and beverages according to their developmental needs. ~~After consultation with the State Health Director,~~ The Commission shall consult with the Division of Child Development of the Department of Health and Human Services to develop nutrition standards ~~shall~~ to provide for requirements appropriate for children of different ages. In developing nutrition standards, the Commission shall consider the following recommendations:

a. Limiting or prohibiting the serving of sweetened beverages, other than 100% fruit juice, to children of any age.
b. Limiting or prohibiting the serving of whole milk to children two years of age or older or flavored milk to children of any age.
c. Limiting or prohibiting the serving of more than six ounces of juice per day to children of any age.
d. Limiting or prohibiting the serving of juice from a bottle.
e. Creating an exception from the rules for parents of children who have medical needs, special diets, or food allergies.
f. Creating an exception from the rules to allow a parent or guardian, or to allow the center upon the request of a parent or guardian, to provide to a child food and beverages that may not meet the nutrition standards.

Each child care facility shall have a rest period for each child in care after lunch or at some other appropriate time and arrange for each child in care to be out-of-doors each day if weather conditions permit."

SECTION 2. The Department of Health and Human Services, Division of Child Development, shall examine the current levels of physical activity children receive in child care facilities and review model physical activity guidelines. Not later than September 1, 2011, the Division shall report its findings and recommendations for increasing physical activity levels in child care facilities, with a goal of reaching model guidelines, to the Legislative Task Force on Childhood Obesity, if reestablished, to the Public Health Study Commission, and to the Fiscal Research Division.

SECTION 3. The Department of Health and Human Services, Division of Public Health, in conjunction with the Division of Child Development, nutritionists, pediatricians, and child care providers, shall examine the current nutrition standards for children in child care facilities. This examination shall be conducted in consideration of any potential changes in the federal guidelines related to the Child and Adult Care Food Program. Not later than December

1, 2010, the Division of Public Health shall report its findings and recommendations for improving nutrition standards in child care facilities to the Legislative Task Force on Childhood Obesity, if reestablished, to the Public Health Study Commission, and to the Fiscal Research Division.

SECTION 4. This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 9th day of July, 2010.

s/ Walter H. Dalton
President of the Senate

s/ Joe Hackney
Speaker of the House of Representatives

s/ Beverly E. Perdue
Governor

Approved 3:23 p.m. this 20th day of July, 2010

Box #14 Contents - Standing Committee Minutes Item 25894

14	2009	Senate	Judiciary I
14	2009-2010	Senate	Judiciary II
14	2009	Senate	Mental Health & Youth Services